



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Discharge
Planning for a Mental Health
Inpatient Who Transitioned
to the Judicial System from a
Veterans Integrated Service
Network 4 Medical Facility



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations related to the discharge of a patient from an inpatient mental health unit at a Veterans Integrated Service Network (VISN) 4 Medical Facility (facility), and subsequent transfer to a Federal Detention Center (FDC) where the patient died while incarcerated.¹ During the inspection, the OIG identified additional concerns for review including the facility staff's discharge planning processes, compliance with voluntary and involuntary admission policies, use of available guidance regarding the patient's legal and psychiatric status, and patient record flag (PRF) management.

The OIG did not substantiate that the patient died by suicide two days after discharge from the facility inpatient mental health unit and while incarcerated at the FDC. The patient was arrested by VA Police in 2017, discharged from the inpatient mental health unit to the federal judicial system, and subsequently placed in the FDC. The patient died at the FDC eight days following discharge. The Associate Medical Examiner identified the patient's cause of death as hypertensive and atherosclerotic cardiovascular disease and the manner of death as natural.

The OIG substantiated that facility inpatient mental health staff failed to engage in proper discharge planning for the patient prior to and after the patient's transfer to the FDC. Additionally, the OIG team found that inpatient mental health staff failed to engage in proper treatment planning processes. Specifically, the OIG team determined that inpatient mental health staff failed to

- Include the patient and the patient's family member in treatment and discharge planning decisions,
- Address the patient's decision-making capacity to determine if the patient could adequately provide consent for treatment options and participate in discharge planning,
- Identify and document the patient's surrogate consistently throughout the electronic health record (EHR),
- Provide clinical hand-off communication to the patient's receiving mental health providers, and

¹ The name of the facility is not being disclosed to protect the privacy rights of the subject of the report pursuant to 38 U.S.C. §7332, Confidentiality of Certain Medical Records, January 3, 2012. The FDC is a housing complex managed by the Federal Bureau of Prisons for individuals in federal custody with a conviction or still pending court cases. <https://www.bop.gov/locations/institutions>. (The website was accessed on August 15, 2018.)

- Assign a mental health treatment coordinator responsible for overall care and discharge planning coordination.

The OIG team found no documentation that indicated that the interdisciplinary treatment team engaged the patient or the patient's family member in discharge placement discussions or disclosed to the patient or the patient's family member that the decision was made that the patient would not return to the patient's and the patient's family member's preferred placement, the community living center. Although the Inpatient Psychiatry Nurse Practitioner knew of the patient's pending arrest one day prior to the discharge, staff did not inform the patient, nor contact the patient's family member until after the patient had been removed from the facility.

There was no direct communication between facility and FDC staff regarding the patient, despite the patient's medical and psychiatric acuity, multiple comorbid health issues, and complex medication regimen. Such direct communication might have circumvented deficiencies in the patient's clinical management, such as abrupt modifications to the patient's medication regimen and the lack of notification of cardiovascular vulnerabilities. The multiple failures of communication with the patient, patient's family member, and receiving treatment providers during the transition from facility to FDC care settings might have been improved by the assignment of a mental health treatment coordinator. Further, the OIG found that although there was opportunity to do so, facility staff did not obtain a release of information from the patient or surrogate for the VA Police to obtain discharge information.

Facility staff did not comply with Veterans Health Administration (VHA) policy regarding the patient's voluntary and involuntary admissions to the inpatient mental health unit. The OIG found that facility staff did not obtain consent for voluntary admissions from the patient's surrogate as required for patients who lack decision-making capacity. Additionally, during the patient's final two inpatient mental health unit admissions, facility staff did not obtain proper consent, utilize the state law involuntary commitment options, and offer the patient a 72-hour notice in response to repeated requests to return to the community living center.²

Facility staff did not consider accessing available consultative resources prior to the patient's discharge to the FDC. The absence of expert consultation may have contributed to the failure of facility leaders and staff to evaluate, plan, and prepare more effectively for this patient's treatment and discharge to the judicial system.

The Disruptive Behavior Committee (DBC) failed to notify the patient of the 2011 PRF assignment or the patient's right to amend the PRF contents, as was required at that time. However, given the May 2018 VHA interim guidance that the notification of a PRF or the right to amend is no longer required, the OIG will not make a recommendation. The OIG also found

² A voluntary mental health inpatient may request to leave the treatment unit by signing a 72-hour notice and must be evaluated by the attending physician within 24 hours. Facility Policy.

that the DBC failed to review the patient's PRF in 2013 although did so in 2015 and 2017, as required. The facility's fiscal year 2016 implementation of the Disruptive Behavior Reporting System and DBC co-chairs' increased focus on the PRF review process led to evidence of improved performance. Therefore, OIG is not making a recommendation regarding these two PRF management domains.

The OIG made 10 recommendations related to an ethics consultation regarding the patient's final episode of care; inclusion of family in inpatient mental health treatment and discharge planning decisions; assessment of patients' decision-making capacity and voluntary admission status; accurate documentation of a patient's surrogate; provision of a complete medical and psychiatric diagnostic summary to receiving providers; assignment of a mental health treatment coordinator; release of information processes; inpatient mental health unit voluntary and involuntary admission processes; and access to consultative resources.

Comments

The VISN and Facility Directors concurred with the recommendations and provided an acceptable action plan. (See Appendixes D and E, pages 40–47, for the Directors' comments.) The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.



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Contents

Executive Summary	i
Abbreviations	v
Introduction	1
Scope and Methodology	6
Inspection Results	8
1. Patient Death Following Recent Discharge.....	8
2. Discharge Planning Deficiencies.....	8
3. Admission Processes	17
4. Failure to Access Relevant Consultative Resources	19
5. PRF Management	22
Conclusion	23
Recommendations 1–10.....	25
Appendix A: Additional Background and Patient Case Summary.....	27
Appendix B: Discharge Medications	39
Appendix C: Inpatient Mental Health Unit Admissions.....	40
Appendix D: VISN Director Comments.....	41
Appendix E: Facility Director Comments	43
OIG Contact and Staff Acknowledgments	49
Report Distribution	50

Abbreviations

CLC	community living center
DBC	Disruptive Behavior Committee
EHR	electronic health record
FDC	Federal Detention Center
ITT	interdisciplinary treatment team
mg	milligrams
MHTC	mental health treatment coordinator
OGC	Office of General Counsel
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
PCH	personal care home
PRF	patient record flag
SMI	serious mental illness
TJC	The Joint Commission
TMS	Talent Management System
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations related to the discharge of a patient from an inpatient mental health unit at a Veterans Integrated Service Network (VISN) 4 Medical Facility (facility), and subsequent transfer to a Federal Detention Center (FDC) where the patient died while incarcerated.³

Background

Serious Mental Illness

The National Institute of Mental Health defines serious mental illness (SMI) as “a mental, behavioral, or emotional disorder resulting in serious functional impairment which substantially interferes with or limits one or more major life activities.”⁴ The psychiatric disorders schizophrenia, major depressive disorder, and bipolar disorder are examples of SMI.⁵ In 2016, an estimated 10.4 million, or 4.2 percent of United States adults lived with SMI.⁶ Individuals with SMI often have multiple mental health disorders and are at higher risk for heart disease, diabetes, and smoking related illnesses. People in the United States with SMI die an average of 25 years earlier than the general population.⁷ Effective treatment for SMI includes a combination of medication management, evidence-based psychotherapy, and a continuum of services including outpatient treatment, community treatment, and inpatient psychiatric care.⁸

³ The FDC is a housing complex managed by the Federal Bureau of Prisons for individuals in federal custody with a conviction or still pending court cases. <https://www.bop.gov/locations/institutions>. (The website was accessed on August 15, 2018.)

⁴ National Institute of Mental Health, *Mental Illness*, November 2017, www.nimh.nih.gov/health/statistics/mental-illness.shtml. (The website was accessed on August 2, 2018.)

⁵ Interdepartmental Serious Mental Illness Coordinating Committee Report to Congress, December 13, 2017, https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf#page=18 (The website was accessed on October 16, 2018.)

⁶ National Institute of Mental Health, *Mental Illness*, November 2017, www.nimh.nih.gov/health/statistics/mental-illness.shtml. (The website was accessed on August 2, 2018.)

⁷ Mark J. Viron and Theodore A. Stern, “The Impact of Serious Mental Illness on Health and Healthcare,” *Psychosomatics* 51, *The Journal of Consultation-Liaison Psychiatry*. (November–December 2010): Volume 51, Issue 6, Pages 458-465. [https://www.psychosomaticsjournal.com/article/S0033-3182\(10\)70737-4/fulltext](https://www.psychosomaticsjournal.com/article/S0033-3182(10)70737-4/fulltext), (The website was accessed October 17, 2018.)

⁸ Interdepartmental Serious Mental Illness Coordinating Committee Report to Congress, December 13, 2017.

Veterans Health Administration Mental Health Treatment

Veterans Health Administration (VHA) offers a continuum of care to SMI patients including inpatient, residential care, and outpatient services that can provide medication management, individual and group psychotherapy, and peer support.⁹ Inpatient mental health care is the highest level of care focused on acute symptom stabilization and treatment.¹⁰ Inpatient mental health staff must work in coordinated care teams to ensure optimal treatment effectiveness.¹¹ Each inpatient is assigned an interdisciplinary treatment team (ITT). The ITT is responsible for the development and implementation of a treatment plan in collaboration with the patient and the patient's mental health treatment coordinator (MHTC).¹²

Discharge Planning

VHA requires that a mental health inpatient's discharge planning begins promptly after admission. The ITT determines discharge criteria and is responsible for the initiation and coordination of the discharge plan.¹³

The ITT must include the patient and the patient's authorized surrogate in discharge planning, as appropriate. Family members, significant others, and outpatient providers may also participate to support the patient's recovery and continuity of care. VHA requires that the program or facility to which the patient is being discharged should be actively involved in the process to encourage patient engagement and facilitate timely follow-up care.¹⁴

Facility staff are expected to offer a face-to-face meeting with the patient to discuss discharge planning issues. At the time of discharge to a non-VA facility, the patient's status regarding goals and objectives, strengths, needs and preferences, and plans for continuity of care will be documented in the transfer or discharge note.¹⁵

⁹ VHA, *Guide to VA Mental Health Services for Veterans & Families*, published July 2012, https://www.mentalhealth.va.gov/docs/MHG_English.pdf. (The website was accessed on August 2, 2018.)

¹⁰ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. This VHA handbook was scheduled for re-certification on or before the last working day of September 2018 and has not been recertified.

¹¹ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. This VHA handbook was scheduled for re-certification on or before the last working day of September 2013 and was amended November 16, 2015.

¹² VHA Handbook 1160.06.

¹³ Facility Bylaws.

¹⁴ VHA Handbook 1160.06.

¹⁵ Facility Policy.

Family Involvement

Family involvement may be critical to the success of a patient's treatment and discharge plan. VHA requires compliance with The Joint Commission (TJC) standards of quality and safety.¹⁶ TJC requires that "the plan for care, treatment, or services addresses the family's involvement."¹⁷ Additionally, TJC requires that staff document family involvement, with the patient's consent, unless clinically contraindicated.¹⁷ TJC specifically advises that staff should provide information regarding medications to the patient and family upon discharge.¹⁸ Consistently, VHA requires that family members be included in the care of mental health inpatients, as appropriate, and as desired by the patient. This includes involving the family in treatment and discharge planning.¹⁹ Facility policy requires that the patient's family or legal surrogate be included in treatment planning and that discharge instructions be provided to the patient or family member at time of discharge. The social worker's discharge note must document staff contact with family members.²⁰

Hand-Off Communication

Most adverse events after inpatient discharge are caused by care transition process deficits such as if discharge communications lack essential information or fail to reach the receiving provider timely. Prior to discharge, it is critical to assess a patient's ability for self-care as well as the patient's and family member's understanding of diagnoses and follow-up needs.²¹

Structured hand offs or discharge communications may improve care transitions.²² A hand-off is the process of transferring responsibility for patient care including communication of patient information between providers.²³ Since 2006, TJC requires health care providers to "implement a standardized approach to 'hand off' communications, including an opportunity to ask and

¹⁶ The Joint Commission is an accrediting body that sets quality performance standards; VHA Directive 1100.16, *Accreditation of Medical Facility And Ambulatory Programs*, May 9, 2017.

¹⁷ The Joint Commission, *Behavioral Health Standard CTS.03.01.05*, Effective date January 13, 2018.

¹⁸ The Joint Commission, *National Patient Safety Goals*, Effective date January 2018.

¹⁹ VHA Handbook 1160.06.

²⁰ Facility Policy.

²¹ Agency for Healthcare Research and Quality, "Readmissions and Adverse Events After Discharge," Patient Safety Primer, August 2018. <https://psnet.ahrq.gov/primers/primer/11/Readmissions-and-Adverse-Events-After-Discharge>. (The website was accessed on October 29, 2018.)

²² Agency for Healthcare Research and Quality, "Readmissions and Adverse Events After Discharge," Patient Safety Primer, August 2018. <https://psnet.ahrq.gov/primers/primer/11/Readmissions-and-Adverse-Events-After-Discharge>. (The website was accessed on October 29, 2018.)

²³ Agency for Healthcare Research and Quality, "Handoffs and Signouts," Patient Safety Primer, August 2018. <https://psnet.ahrq.gov/primers/primer/9/Handoffs-and-Signouts>. (The website was accessed on October 29, 2018.)

respond to questions.”²⁴ Additionally, effective hand-off communications include information about the patient’s illness severity, diagnoses, and treatment plan and actions for the receiving provider to complete.²⁵

VHA requires a hand-off between clinicians that includes “allergies, medications, problems, H&P [History & Physical], admitting diagnosis, laboratory results, and consults” to be communicated during a transition in care including “changes in setting, service, practitioner, or level of care.”²⁶ VHA requires that mental health services are continued and follow-up medical care is coordinated upon a patient’s discharge from an inpatient mental health unit. Specifically, VHA requires that providers directly communicate “to facilitate transition to follow-up care.” Further, VHA requires that the receiving program or facility be actively involved in the discharge process.²⁷ When there is a change in provider, facility policy expects provider-to-provider hand offs.²⁸

Facility providers must complete a discharge summary within two days of discharge that includes significant findings, procedures performed including care, treatment, and services provided while on the unit, status of ongoing care, and condition of the patient at time of transfer. Discharge instructions are provided to the patient or family at the time of discharge.²⁹

Decision-Making Capacity

VHA outlines major decision-making components that include the patient’s ability to understand and appreciate the significance of healthcare decisions including known benefits and risks of treatment options; and the ability to formulate a judgment and communicate a clear healthcare decision.³⁰ A clinician must perform and document a clinical decision-making assessment for any patient who may lack capacity for medical decision-making in a specific, limited situation.³¹ The assessment is best conducted in person and includes an analysis of the patient’s ability to understand risk and benefits, clearly communicate a choice, recognize relevant facts, and use

²⁴ The Joint Commission, “2006 National Patient Safety Goal 2E.” http://www.ed-qual.com/Emergency_Medicine_News/ED_News_2006_JCAHO_Patient_Safety_Goals.htm. (The website was accessed on October 29, 2018.)

²⁵ AHRQ “Handoffs and Signouts,” Patient Safety Primer, August 2018. <https://psnet.ahrq.gov/primers/primer/9/Handoffs-and-Signouts>. (The website was accessed on October 29, 2018.)

²⁶ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015; VHA Handbook 1160.06.

²⁷ VHA Handbook 1160.06.

²⁸ Facility Policy.

²⁹ Facility Policy.

³⁰ VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009. This handbook was revised September 20, 2017.

³¹ VHA Handbook 1907.01.

reason to compare options and understand consequences.³² Patients with mental illness such as schizophrenia, especially those who are hospitalized, are at a higher risk for decision-making impairments.³³

When a court determines that a person is incompetent, the court may appoint a legal guardian to make decisions and act on behalf of that individual.³⁴ The terms capacity and competency are often used interchangeably; however, the legal system and not a clinician, determines competency.³⁵

Patients are presumed to have capacity unless a clinician completed a clinical evaluation indicating otherwise or a court has declared the patient to be incompetent. By law, a person deemed incompetent lacks the capacity to make medical decisions. If the loss of capacity is temporary, the clinician must wait to obtain informed consent for treatment. If the loss of capacity is suspected to be ongoing, then a surrogate decision-maker must be assigned.³⁶

A Health Care Agent, the highest priority surrogate, is a person identified by the patient prior to losing decision-making capacity in a Durable Power of Attorney for Health Care document. Other authorized surrogates include legal guardian, next-of-kin, and close friend, in descending priority order.³⁷ The process of determining the decision-making surrogate must be clearly documented in the electronic health record (EHR) and include the surrogate's name, relationship to the patient, type of surrogate, and how the consent was obtained (in person, by telephone, by mail, or by facsimile).³⁸ Once identified, the surrogate assumes decision-making on behalf of the patient in the informed consent process for treatment. A surrogate must be provided with all information that would be shared with a patient who has capacity.³⁹

Allegations and Related Concerns

On March 28, 2018, the OIG received an anonymous complaint alleging that after assaulting a VA employee, a patient was improperly discharged from the facility to a county prison where the

³² VHA Handbook 1160.06.

³³ VHA Handbook 1004.01; Jason Karlawish, Steven DeKosky, Janet Wilterdink, and David Solomon, "Assessment of Decision-Making Capacity In Adults," September 20, 2017. <https://www.uptodate.com/contents/assessment-of-decision-making-capacity-in-adults>. (The website was accessed on January 10, 2019.)

³⁴ VHA Directive 1605.01 *Privacy and Release of Information*, August 31, 2016.

³⁵ Black's Law Dictionary, "How to Legally Declare Someone as Mentally Incompetent?" <https://thelawdictionary.org/article/how-to-legally-declare-someone-as-mentally-incompetent/>. (The website was accessed on October 25, 2018.)

³⁶ VHA Handbook 1004.01.

³⁷ VHA Handbook 1004.01.

³⁸ VHA Handbook 1004.01.

³⁹ VHA Handbook 1004.01.

patient reportedly completed suicide two days later.⁴⁰ In April 2018, the Office of Healthcare Inspections (OHI) Hotline Workgroup reviewed the patient's care and requested facility leaders provide a response to the following questions:

- What charges were brought against the patient and by whom?
- What was the psychiatric disposition as none were noted in the patient's medical record?
- What provisions for continuity of care were made prior to discharge?
- Was an Ethics Consult considered for the care? If no, why not?

OHI determined that responses received from facility leaders in April 2018 and again in June 2018 did not fully address the OHI Hotline Workgroup's concerns. OHI accepted the complaint as a hotline on July 24, 2018. The inspection addressed the original allegation from the anonymous complainant, additional quality of care concerns identified by the OHI Hotline Workgroup, and other findings that the OIG inspection team identified:

- 1: The patient reportedly completed suicide two days after being discharged from the facility inpatient mental health unit.
- 2: Facility staff failed to engage in proper discharge planning for the patient in the inpatient mental health unit prior to and during the patient's transfer to the FDC.
- 3: Facility staff failed to comply with VHA policy regarding the patient's voluntary and involuntary admission to the inpatient mental health unit.
- 4: Facility staff failed to seek guidance prior to the patient's discharge regarding the patient's legal and psychiatric status from relevant resources, such as forensic mental health experts and legal and ethics consultants.
- 5: Facility staff failed to comply with patient record flag (PRF) management requirements.

Scope and Methodology

The OIG team initiated the inspection on July 24, 2018, and conducted a site visit from October 1–3, 2018.

The OIG team reviewed VHA and facility policies and procedures related to mental health services, inpatient discharge planning processes, coordination of care, assessment of patient decision-making capacity, ethics consults, the VA Office of General Counsel (OGC), and VA

⁴⁰ Although the complainant reported that the patient was discharged to a county prison, the OIG team determined that the patient was discharged to the FDC.

Police authority. The OIG team also reviewed relevant empirical literature and TJC and Agency for Healthcare Research and Quality guidelines.

The OIG team reviewed relevant meeting minutes, a police report, patient incident reporting data, and PRF data. The OIG team reviewed the patient's EHR; the patient's FDC medical record; and the Medical Examiner's Autopsy Report.

The OIG team interviewed the patient's family member and the FDC Chief of Psychology. Interviews were also conducted with facility leaders and employees familiar with the patient's care, including the: Facility Director; Chief of Staff; Associate Director, Patient Care Services; Risk Manager; Disruptive Behavior Committee (DBC) Co-Chair, Inpatient Mental Health Director; community living center (CLC) Psychiatrist; Inpatient Mental Health Nurse; two inpatient mental health social workers; VA Police Chief, VA Police Sergeant; CLC Social Worker; Inpatient Mental Health Psychiatrist; Ethics Committee Chair; Social Work Supervisor; Privacy Officer; former CLC Unit Manager; CLC Registered Nurse; and CLC Nursing Assistant.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

1. Patient Death Following Recent Discharge

The OIG did not substantiate that the patient died by suicide two days after discharge from the facility inpatient mental health unit and while incarcerated at the FDC.⁴¹ (See Appendix A for the Patient Case Summary.) In 2017, the patient was arrested by VA Police, discharged from the inpatient mental health unit to the federal judicial system, and subsequently placed in the FDC. The patient died at the FDC eight days following discharge. The Associate Medical Examiner identified the patient's cause of death as hypertensive and atherosclerotic cardiovascular disease and the manner of death as natural.

2. Discharge Planning Deficiencies

The OIG substantiated that facility inpatient mental health staff failed to engage in proper discharge planning for the patient prior to and after the patient's transfer to the FDC. Additionally, the OIG team found that the inpatient mental health staff failed to engage in proper treatment planning processes.

Specifically, the OIG team determined that the inpatient mental health staff failed to

- Include the patient and the patient's family member in treatment and discharge planning decisions,⁴²
- Address the patient's decision-making capacity to determine if the patient could adequately provide consent for treatment options and participate in discharge planning,
- Identify and document the patient's surrogate consistently throughout the EHR,
- Provide clinical hand-off communication to the patient's receiving mental health providers, and⁴³
- Assign an MHTC responsible for overall care and discharge planning coordination.⁴⁴

⁴¹ The FDC is accredited by the American Correctional Association as a healthcare facility. American Correctional Association.

http://www.aca.org/ACA_Prod_IMIS/ACA_Member/Standards_and_Accreditation/SAC_AccFacHome.aspx?WebsiteKey=139f6b09-e150-4c56-9c66-284b92f21e51&hkey=f53cf206-2285-490e-98b7-66b5ecf4927a&CCO=2%20-%20CCO. (The website was accessed on October 29, 2018.) Each FDC inmate is assigned a Unit Classification Team that includes a unit manager, a case manager, a unit counselor, and may include an education advisor, and a psychology services representative.

⁴² VHA Handbook 1160.06; Facility policy.

⁴³ VHA Handbook 1160.06.

⁴⁴ Facility policy.

Engaging Family and Surrogate in Treatment and Discharge Planning

A facility Inpatient Psychiatrist noted in 2017, that the Inpatient Social Worker would work on a discharge plan taking into “account legal restrictions (legal charges against the patient).”⁴⁵ The Inpatient Psychiatrist reported being informed by the Chief of Staff that legal charges were pending and the patient could not return to the CLC upon discharge. The Chief of Staff, the Associate Director, Patient Care Services, and the Director of the Geriatric unit made the determination to not return the patient to the CLC.

The patient’s family member visited the patient in the CLC regularly and until mid-2016 when the patient’s condition deteriorated, took the patient on overnight passes. The patient’s family member visited the patient regularly during the final episode of inpatient care. The patient’s family member reportedly expressed concerns to treatment providers regarding the patient’s treatment, medical status, and quality of life on the unit. In documentation from the patient’s final inpatient mental health admission, four of five treatment plans indicated that the patient’s family agreed to the plans and that the plans were developed in collaboration with the patient’s family member. A progress note entered in mid-2017, indicated that an inpatient social worker provided the patient’s family member with an update on the treatment plan. However, the patient’s family member told the OIG team that the family did not participate in treatment team meetings and was not informed about discussions that took place during these meetings despite numerous attempts to obtain information regarding the patient’s treatment and discharge plan.

The OIG team did not find documentation that indicated that the ITT engaged the patient or the patient’s family member in discharge placement discussions or disclosed to the patient or the patient’s family member that the decision was made that the patient would not return to the patient’s preferred placement, the CLC.⁴⁶ Facility staff and the Chief of Staff confirmed that the patient’s family member was not included in treatment or discharge planning. Although the Inpatient Psychiatry Nurse Practitioner knew of the patient’s pending arrest one day prior to the discharge, staff did not inform the patient, nor contact the patient’s family member until after the patient had been removed from the facility. When asked who made the decision to not contact the patient’s family member, the Chief of Staff told the OIG that the facility leaders did not think it out very well.

⁴⁵ The facility Inpatient Psychiatrist refers to facility Inpatient Psychiatrist 4 in the patient case summary in appendix A.

⁴⁶ VHA Handbook 1160.06.

Patient's Decision-Making, Capacity, Competency, and Guardianship Status

Background

For a voluntary inpatient mental health unit admission, VHA requires patients have decision-making capacity including the ability to demonstrate understanding of the risks and benefits of admission. Further, a patient's decision-making capacity to choose a less restrictive setting is critical in discharge planning. VHA requires the patient or the patient's authorized surrogate to participate in discharge planning. The process of informed consent and utilization of surrogates for patients who lack capacity must occur when the patient is facing criminal charges.⁴⁷

OIG Findings

The OIG determined that facility staff failed to adequately address the patient's decision-making capacity and seek appropriate determination of competency and guardianship. Throughout the years of the patient's treatment, clinicians documented capacity and competency status inconsistently and sometimes inaccurately. Despite inconsistent documentation regarding the patient's decision-making capacity, the OIG team found that treatment providers did not perform or obtain a clinical assessment of decision-making capacity as required by VHA and facility policy.⁴⁸

From 2003 until the patient's death in 2017, the patient had 16 admissions to the facility's acute mental health unit for stabilization of symptoms related to schizophrenia including paranoid ideation, persecutory delusions, auditory hallucinations, and agitation. During this time, the patient was treated with an extensive medication regimen, but the illness was treatment resistant.⁴⁹ Throughout the years of this patient's treatment, clinicians documented the patient's decision-making capacity and competency status as well as the role of the patient's family member inconsistently and sometimes inaccurately.

In 2015, while the patient was in the CLC, facility staff concluded that the patient was unable to provide consent to participate in a research study due to probable severe cognitive impairment; however, staff did not pursue formal clinical assessment to determine treatment decision-making

⁴⁷ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

⁴⁸ VHA Handbook 1004.01; Facility policy.

⁴⁹ Treatment resistance is defined by ongoing symptoms despite two adequate trials of second generation antipsychotics. Helio Elkis, "Treatment-Resistant Schizophrenia."

capacity at that time or after.⁵⁰ In the patient’s next inpatient mental health unit admission starting in mid-2017, clinicians identified the patient as lacking capacity or having impaired capacity in four of nine EHR notes. (See Table 1.) The OIG team found no evidence of documentation of a formal assessment of the patient’s decision-making capacity, including evaluation of the patient’s understanding of treatment options, risks and benefits, nor informed choice.

The OIG team found 39 EHR entries from 2003 through 2017, including four during the patient’s final inpatient mental health treatment episode that identified the patient’s family member as the patient’s surrogate or legal guardian. Despite a documented lack of decision-making capacity and ready access to the patient’s family member, the patient signed a document consenting to a 2017 voluntary inpatient mental health unit admission.

**Table 1. Patient’s Documented Decision-Making Status
2003–2017**

Documented Status	2003–Mid-2017 101 EHR Entries	Mid-2017–Late 2017 9 EHR Entries	2003–2017 110 Total EHR Entries
Impaired or Lacking Decision-Making Capacity	43	4	47
Incompetent	5	3	8
Family Member as Legal Guardian or Surrogate	35	4	39

Source: VA OIG analysis of the patient’s EHR

Continuity of Care and Hand-Off Communication

The OIG found that facility staff did not provide clinical hand-off communication to clinicians at the FDC following the patient’s discharge to the judicial system. Although the patient’s ITT and facility leaders were aware that the patient would likely be discharged to the judicial system, the OIG found no evidence of discussion or preparation for discharge with the patient or the

⁵⁰ VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. This VHA handbook was scheduled for re-certification on or before the last working day of August 2013 and has not been recertified. CLCs provide a residential treatment setting for individuals whose mental health conditions may be stable, but who require assistance with daily living or a more supportive structure. CLCs offer care to patients with “chronic stable mental illness coupled with geriatric or other syndromes that render them less able to function in non-institutional settings.”

patient's family member. The OIG determined that in addition to not informing the patient's family member, there was no direct communication between facility and FDC staff regarding the patient, despite the patient's medical and psychiatric acuity, multiple comorbid health issues, and complex medication regimen. Further, the OIG found that although there was opportunity to do so, facility staff did not obtain a release of information from the patient or the patient's surrogate for the VA Police to obtain discharge information.

Facility ITT Discharge Process

A facility Inpatient Psychiatrist told the OIG team that when a patient has an arrest warrant, it is common practice to treat until the patient is psychiatrically stable and then release the patient to the police. The Inpatient Psychiatrist clarified that the discharge plan is for the patient to be followed by medical staff at the receiving judicial facility. The Inpatient Psychiatrist also stated that they have never called a detention facility when a patient is released into police custody and that there was no written policy to do so. An inpatient mental health social worker informed the OIG team that there were no preparatory discussions regarding the patient's mental health treatment while incarcerated because the ITT had no contact with the judicial system. The ITT did not document discussions related to a specific discharge placement or attempt to identify the receiving medical staff to ensure that the patient's medical and mental health needs would be met in the new placement, as required by VHA and facility policies.⁵¹ The FDC Chief of Psychology reported that the FDC received very little information about the patient.

The VA Police informed the Inpatient Psychiatry Nurse Practitioner that the patient required one day of medications and that the "federal jail will then be able to supply medications." Facility inpatient staff provided the Discharge Summary/Instructions on the day of discharge, along with a one-day supply of medications except for the benzodiazepine. Staff completed an incident report regarding the failure to provide the patient with the prescribed benzodiazepine upon discharge.

According to the Inpatient Psychiatry Nurse Practitioner who prepared the patient's discharge instructions, the discharge information provided to the patient contained the routine documentation given to all patients upon discharge. As required, the document contained the patient's discharge date, activity level, mental health diagnosis, diet, a list of 21 prescriptions, pain management, and instructions, such as to call 911 for emergencies and the Veterans Crisis Line number.⁵²

However, the OIG found that the Discharge Summary/Instructions did not include information about non-psychiatric health issues such as recent cardiac complaints or active diagnoses including seizure disorder, hypertension, viral hepatitis C, cerebral infarction, a history of head

⁵¹ VHA Handbook 1160.06; Facility policy.

⁵² VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

trauma, and peripheral vascular disease. The Inpatient Psychiatry Nurse Practitioner performed a physical assessment in preparation for discharge and noted abnormal liver function lab results, edema, and gait and balance dysfunction, none of which were noted on the Discharge Summary/Instructions. On the day of the patient's discharge, the facility Inpatient Psychiatrist documented that the patient "had significant history of unstable psychiatric condition. [The patient] was admitted sixteen times with poor response to several medication adjustments." This information was not included in the Discharge Summary/Instructions either.

At the time of discharge, the patient was prescribed 18 medications, including a benzodiazepine and three antipsychotic medications; olanzapine, haloperidol, and quetiapine. See Appendix B for full medication list.⁵³ At the facility, the patient's three antipsychotic medications were dosed significantly higher than maximal effective dosing recommendations.⁵⁴ Given the empirical evidence for dose related increase and the risk of sudden cardiac death with antipsychotics, the patient's cardiac condition warranted close monitoring and there is no evidence that facility staff provided this information to FDC staff.⁵⁵

The Discharge Summary/Instructions follow-up plan was "Veteran will be escorted by VA Police to Federal Prison to await arraignment, [the patient] will not require follow-up appointments." The document also included "If you have any questions or concerns that arise after your discharge, please contact your provider" but did not contain the designated treatment provider's name or other contact information. Further, the document noted that the patient/patient's representative was provided with a reconciled list of medications with advisement to keep an accurate list and update as changes are made. Given the patient's mental illness and documented impaired capacity and staff's failure to include the patient's family member in the process, the Discharge Summary/Instructions misrepresented the patient's discharge process. Further, this document implied that the discharge process was conducted as required to ensure the patient's (or patient's representative's) understanding of patient's medication needs.

⁵³ Appendix B lists total medication dosages and therefore the list contains 18 rather than 20 medications since the benzodiazepine and the quetiapine were prescribed at two different doses to be taken at different times during the day.

⁵⁴ John Davis and Nancy Chen, "Dose response and dose equivalence of antipsychotics," *Journal of Clinical Psychopharmacology* 24, no. 2, (2004): 192-208.

⁵⁵ Wayne Ray, Cecilia Chung, Katherine Murray, Kathi Hall, and C. Michael Stein, "Atypical Antipsychotic Drugs and the Risk of Sudden Cardiac Death," *New England Journal of Medicine* 360, (2009): 225-235.

VA Police

Background

VA Police are responsible for maintaining law and order as well as the protection of persons and property on VA property.⁵⁶ VA Police have authority to arrest persons on VA property for offenses committed on the property and in response to warrants issued by a judicial authority in coordination with local jurisdictions.⁵⁷

VA Police must ensure the rights and privileges of the arrested individual are protected, including appropriate Miranda warnings. In addition, the arrested individual must promptly be transported off VA property to a detention center or the appropriate judicial authority by the United States Marshals or local police. VA Police are only permitted to transport an individual in collaboration and coordination with the United States Attorney or a local prosecutor.⁵⁸

Findings

The VA Police reported that they gave the Discharge Summary/Instructions and medications to the United States Marshals when they and the patient arrived at the federal courthouse. Information that can be used to identify or locate a patient may be provided to VA Police Officers without a written request including a patient's name and address, date and place of birth, social security number, date and time of treatment, and a description of physical characteristics. Additionally, VHA may disclose individually-identifiable health information to the VA Police if there is a serious and imminent threat to the health and safety of an individual or the public. All other disclosures of individually-identifiable health information would require compliance with VHA's privacy and release of information processes including obtaining a signed release of information from a patient or surrogate.⁵⁹ The facility Privacy Officer confirmed that the patient needed to sign a release of information or give verbal consent for the VA Police or United States Marshals to obtain medical record documentation. The Privacy Officer did not find release of information documentation from the patient for this purpose. The Privacy Officer told the OIG that the Discharge Summary/Instructions was printed for the patient at time of discharge "so it may be possible that they handed it to the police if the Veteran's hand [*sic*] were handcuffed. In the presence of the Veteran, if [the patient] said it was alright to do that then there is no issue." Although the inpatient mental health staff knew the day prior to discharge that the patient would be handcuffed, they did not obtain a release of information.

⁵⁶ VA Directive 0730, *Security and Law Enforcement*, December 12, 2012.

⁵⁷ VA Handbook 0730/3, *Security and Law Enforcement*, July 11, 2014.

⁵⁸ VA Handbook 0730/3.

⁵⁹ VHA Directive 1605.01, *Privacy and Release of Information*, August 31, 2016.

FDC Medication Management

FDC staff erroneously listed the haloperidol as one-fifth the amount of the patient's dose at discharge from the facility. Upon admission to the FDC, the dosages of the three antipsychotic medications were significantly reduced without a medically appropriate strategic plan to reduce these medications.⁶⁰ Physical symptoms of antipsychotic withdrawal include nausea, vomiting, diaphoresis, headaches, insomnia, restlessness, anxiety, and agitation.⁶¹

Further, FDC staff did not list the benzodiazepine on the health screen intake and the FDC physician did not order it for the patient, putting the patient at risk of withdrawal.⁶²

Benzodiazepine withdrawal symptoms include sleep disturbances, irritability, increased tension and anxiety, panic attacks, hand tremors, sweating, difficulty in concentration, nausea, palpitations, headaches, muscular pain and stiffness, hallucinations, and seizures. Thus, the patient's underlying cardiac condition could have been worsened. Withdrawal is more severe following cessation of high dose and long-term usage of benzodiazepines such as in the patient's medication history.⁶³

The medical examiner's autopsy on the patient showed moderate atherosclerosis of the right coronary artery, "marked" atherosclerosis of the aorta, and cardiac hypertrophy.⁶⁴ The patient's cause of death was listed as hypertensive and atherosclerotic cardiovascular disease. In the context of the patient's vulnerable medical condition, the potential physiological burden of withdrawal from these antipsychotic and benzodiazepine medications including agitation and the

⁶⁰ Stephen Stahl, *The Prescriber's Guide*, 4th edition. (Cambridge University Press, 2011), pages 259, 430, 504.

⁶¹ SC Dilsaver and NE Alessi, "Antipsychotic withdrawal symptoms: Phenomenology and pathophysiology," *Acta Psychiatrica Scandinavica* 77, (1988):241-246.

⁶² Clonazepam, the prescribed benzodiazepine, has an elimination half-life of 30-40 hours and withdrawal symptoms can occur within one to three days of abrupt cessation. Food and Drug Administration, Klonopin® Tablets (clonazepam), October 2013, https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/017533s053.020813s009lbl.pdf. (The website was accessed on January 22, 2019.)

⁶³ H. Petursson, "The benzodiazepine withdrawal syndrome," *Addiction* 89, (1994): 1455-1459.

⁶⁴ *Atherosclerosis* is the buildup of fat, cholesterol, or other substances on the artery wall, restricting blood flow through the artery. Atherosclerosis can occur in any of the arteries in the body, not just in the heart. Atherosclerosis in the coronary arteries can cause chest pain, heart failure, or a heart attack. Mayo Clinic, "Arteriosclerosis/Atherosclerosis," April 24, 2018. <https://www.mayoclinic.org/diseases-conditions/arteriosclerosis-atherosclerosis/symptoms-causes/syc-20350569> The *aorta* is the main artery that carries blood from the heart to the rest of the body. Narrowing of the aorta (by atherosclerosis for example) places the entire body's blood supply at risk. American Heart Association, "Your Aorta," June 1, 2015. <http://www.heart.org/en/health-topics/aortic-aneurysm/your-aorta-the-pulse-of-life> *Cardiac hypertrophy* is the enlargement of the heart's "pumping chamber" by thickening of its walls and it is most often caused by uncontrolled high blood pressure. The enlarged heart loses elasticity and weakens, leading to reduced blood supply to the heart, decreased efficiency in pumping blood to the rest of the body, higher risk of stroke, cardiac arrhythmia, and sudden cardiac death. Mayo Clinic, "Left ventricular hypertrophy," June 13, 2018. <https://www.mayoclinic.org/diseases-conditions/left-ventricular-hypertrophy/symptoms-causes/syc-20374314> (The websites were accessed on November 15, 2018.)

likely consequent increased blood pressure may have contributed to the patient's hypertension related death. Direct communication between the health care providers might have circumvented deficiencies in the patient's clinical management such as these abrupt modifications to the patient's medication regimen and the lack of notification of cardiovascular vulnerabilities.

MHTC Assignment

Background

VHA requires the assignment of an MHTC to all patients receiving mental health care.⁶⁵ The MHTC ensures continuity of care by coordinating mental health treatment and serving as the point of contact while the patient receives mental health services and through transitions of care.⁶⁶ Facility policy requires that each inpatient on the mental health unit have an inpatient staff member assigned as the MHTC for the length of stay. The Director of Mental Health and the Social Work Executive are responsible for ensuring that the MHTC assignment is documented in the patient's EHR.⁶⁷

OIG Findings

The OIG found that an MHTC was not assigned to the patient as required by VHA, either in the CLC or during the last inpatient mental health admission. The ITT identified the Inpatient Psychiatrist as the patient's MHTC in the initial 2017, treatment plan. However, the four subsequent treatment plans did not include an assigned MHTC. The OIG team also did not find evidence of an MHTC Assignment Note in the patient's EHR, as required by facility policy.⁶⁸ The role of the MHTC is to ensure continuity of care by coordinating mental health treatment, and serving as the point of contact while a patient receives mental health services and through transitions of care. The multiple failures of communication with the patient, patient's family member, and receiving treatment providers during the transition from the facility to FDC care settings might have been improved by the assignment of an MHTC.⁶⁹ More broadly, the absence of an assigned MHTC may have contributed to the failures of communication among facility leaders, staff, family, and the patient in the evaluation, planning, and preparation for this patient's discharge to the judicial system and subsequent treatment.

⁶⁵ Deputy Under Secretary for Health for Operations and Management Memorandum, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

⁶⁶ VHA, *Guide to VA Mental Health Services for Veterans & Families*, July 2012
https://www.mentalhealth.va.gov/docs/MHG_English.pdf. (The website was accessed on August 2, 2018.)

⁶⁷ Facility policy.

⁶⁸ Facility policy.

⁶⁹ VHA Handbook 1160.06; Deputy Under Secretary for Health for Operations and Management Memorandum, *Assignment of the Mental Health Treatment Coordinator*.

3. Admission Processes

Background

VHA requires that staff complete an assessment of voluntary or involuntary admission status for mental health inpatients.⁷⁰ Staff must obtain a written voluntary informed consent from patients, including those suspected of criminal wrongdoing, prior to any treatment or procedures related to an admission on the inpatient mental health unit.⁷¹ When a patient lacks decision-making capacity, an authorized surrogate may sign the informed consent on the patient's behalf.⁷²

Facility policy requires that a physician

- Evaluate a patient who presents for voluntary admission to the inpatient mental health unit,
- Review and obtain the patient's signature on the "Consent for Voluntary Mental Health Inpatient Treatment" form,
- Evaluate the patient for involuntary commitment if the patient refuses voluntary admission,
- Include the patient's surrogate in discussions when the patient is unable to provide informed consent, and
- Document actions taken in evaluating the patient and obtaining consent in the EHR.⁷³

A voluntary mental health inpatient may request to leave the treatment unit by signing a "72-hour notice" and must be evaluated by the attending physician within 24 hours. The patient's discharge may be delayed up to 72 hours for additional assessment and discharge planning. If the physician determines that the patient needs additional treatment to mitigate the risk of harm to themselves or others, a time limited involuntary admission may be pursued through the court system.⁷⁴ VHA facilities must adhere to local state laws governing involuntary admission.⁷⁵

State law dictates that an involuntary admission emergency examination and treatment are appropriate when a person is severely mentally disabled. A person is considered severely mentally disabled when:

⁷⁰ VHA Handbook 1160.06.

⁷¹ VHA Handbook 1004.01.

⁷² VHA Handbook 1160.06.

⁷³ Facility policy.

⁷⁴ Facility policy.

⁷⁵ VHA Handbook 1160.06.

as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself.⁷⁶

State law allows a physician to admit a patient involuntarily for an emergency examination and treatment for up to 120 hours. The physician may petition the court to extend the time for emergency treatment.⁷⁷

Consistent with state law, facility policy advised that the physician continues “to assess the patient’s mental capacity and need for involuntary treatment” once the patient is admitted to the inpatient mental health unit.⁷⁸

OIG Findings

The OIG found that facility staff did not comply with VHA policy regarding the patient’s voluntary and involuntary admissions to the inpatient mental health unit.⁷⁹ See Appendix C for the patient’s inpatient mental health unit admission status. The OIG found that facility staff did not obtain consent for voluntary admissions from the patient’s surrogate as required for patients who lack decision-making capacity.⁸⁰ Additionally, during the patient’s final two inpatient mental health unit admissions, facility staff did not obtain proper consent, or utilize the state law involuntary commitment options, and offer the patient a 72-hour notice in response to the repeated requests to return to the CLC.

In the patient’s 2014 inpatient mental health unit admission, documentation indicated that the patient refused to voluntarily sign consent on multiple occasions. The patient “was hostile, verbally threatening others, and refused to walk to unit by [him/her] self” and was placed in seclusion. However, the patient signed the “Consent for Voluntary Inpatient Admission Treatment” form that day. There was no evidence that facility staff included the patient’s family member in the consent process or considered an involuntary admission. In the patient’s final facility inpatient mental health unit admission in 2017, the patient was admitted for 14 days without a signed “Consent for Voluntary Inpatient Admission Treatment” form or a court authorized involuntary commitment. One day after admission, the facility Inpatient Psychiatrist cosigned an EHR note that described the patient as having impaired capacity, which may have signified cause to include the patient’s family member in the consent process.

⁷⁶ To protect the patient's privacy, the state law will not be further identified.

⁷⁷ To protect the patient's privacy, the state law will not be further identified.

⁷⁸ Facility policy.

⁷⁹ VHA Handbook 1004.01; VHA Handbook 1160.06; Facility policy.

⁸⁰ VHA Handbook 1160.06.

Beginning in 2003, the patient's EHR included inconsistent and contradictory documentation regarding the patient's decision-making capacity, competency status, and the legal decision-making status of the patient's family member. The day after admission on the last 2017 admission, a covering social worker documented that the patient's family member was the patient's legal guardian. However, the Inpatient Mental Health Social Worker told the OIG that they learned that the patient's family member was not the patient's legal guardian. A Social Worker informed OIG that following consultation with the Acting Chief of Staff/Chief of Psychiatry Service, the Social Worker signed a "Consent for Voluntary Inpatient Admission Treatment" form with the patient 14 days later, that reflected the initial admission date.⁸¹ The Inpatient Psychiatrist documented that the patient "expressed delusions of persecution by the hospital staff" and "continues to suffer from psychosis and anxiety." The OIG did not find consideration that mental illness lessened this patient's capacity to exercise self-control, judgment, and discretion in the conduct of affairs; and therefore, obtaining a voluntary consent was not appropriate.

Approximately a month after admission, the patient reported chest pains and was discharged to a non-VA hospital for cardiac evaluation. The patient returned to the facility the next day. The Medical Officer signed the "Consent for Voluntary Inpatient Treatment" form, but the form lacked the patient's signature. The patient remained on the inpatient mental health unit until discharged to the judicial system.

During this final inpatient mental health unit admission, staff documented that the patient expressed a desire to return to the CLC to multiple providers during the admission; however, the OIG found no evidence that staff offered the patient the 72-hour notice document, as required.⁸²

4. Failure to Access Relevant Consultative Resources

The OIG found that facility staff did not consider accessing available consultative resources prior to the patient's discharge to the FDC. The absence of expert consultation may have contributed to the failure of facility leaders and staff to evaluate, plan, and prepare more effectively for this patient's treatment and discharge to the judicial system.

⁸¹ The OIG team was unable to interview the Acting Chief of Staff and the Chief of Psychiatry to confirm this meeting.

⁸² Facility policy.

Forensic Mental Health

Background

Forensic psychiatrists engage in research and clinical practice and focus on many issues where psychiatry and the law intersect, including violence, criminal responsibility, civil and criminal competency, and involuntary treatment.⁸³ Forensic psychologists conduct psychological assessments of individuals who are involved in the legal system, including criminal defendants. Forensic psychologists can perform threat assessments, competency evaluations, and develop and implement treatment plans.⁸⁴

OIG Findings

The OIG found that the patient's ITT did not consult with a forensic specialist, such as a forensic psychologist or a forensic psychiatrist, to further assess the patient's condition and risk factors relative to the legal situation. The OIG found no evidence of a forensic mental health consult in the patient's EHR. The facility Chief of Staff reported that while no forensic mental health consult was sought, it would have been a good idea.

OGC

Background

The OGC provides legal counsel to VHA employees. VHA employees are required to complete an annual training that includes instruction on obtaining a legal or ethical consult.⁸⁵ Employees are encouraged to seek advice from an ethics official in the OGC if they are facing an ethical dilemma in the workplace.⁸⁶ VHA staff may consult OGC regarding guardianship and surrogacy issues for patients who lack decision-making capacity for healthcare decisions.⁸⁷ VHA staff must consult OGC or local Integrated Ethics program staff in cases where there is no surrogate and

⁸³ American Academy of Psychiatry and the Law, *What is Forensic Psychiatry?*, <http://www.aapl.org/organization>, 2014. (The website was accessed on December 20, 2018.)

⁸⁴ American Psychological Association, *What is forensic psychology?*, <https://www.apa.org/ed/precollege/psn/2013/09/forensic-psychology.aspx>, September 2013. (The website was accessed on January 3, 2019.)

⁸⁵ Office of General Counsel, <https://www.va.gov/OGC/> (The website was accessed on October 22, 2018.); Office of General Counsel Ethics Specialty Team Department of Veterans Affairs, *Government Ethics – The Essentials*, Talent Management System (TMS) Number 3812493

⁸⁶ On February 15, 2013, the VA Chief of Staff mandated employees to complete annual Government Ethics training. VHA Handbook 1004.01.

⁸⁷ VHA Handbook 1004.01.

“there is doubt regarding whether a treatment or procedure is consistent with the patient’s values, wishes, or best interests.”⁸⁸

OIG Findings

The OIG found multiple occasions of conflicting EHR documentation regarding the patient’s decision-making ability, guardianship, and competency. However, the OIG found no evidence that facility staff discussed or sought legal assistance from the OGC to consider issues such as guardianship, competency, surrogacy, or alternative placements for the patient who may have lacked decision-making ability.⁸⁹

The Chief of Staff confirmed that the patient’s pending discharge to an FDC was the subject of discussions, but they did not consider options, including consultation regarding legal status. The Associate Director, Patient Care Services reported that the VA Police worked with legal counsel regarding the criminal charges, and that the patient remained on the locked inpatient mental health unit due to pending legal charges despite the patient’s desire to return to the CLC. The OIG found no evidence in the EHR of discussions regarding the appropriateness of a judicial system setting for the patient. Additionally, despite the facility staff’s awareness of the patient’s medical conditions, pending arrest and discharge, they did not seek assistance from the OGC.

Ethics Consult

Background

Ethics encompasses moral judgment and decision-making when faced with conflicting values.⁹⁰ The National Center for Ethics in Health Care is the VA’s resource for clinical, organizational, and research ethics questions. Clinical ethics includes promotion of shared decision-making with patients, evaluation of decision-making capacity/competency, and surrogate decision-making.⁹¹ When the local facility’s ethics consultation team is unable to resolve an issue or requests further guidance, the National Center for Ethics in Health Care provides additional support.⁹²

⁸⁸ VHA Handbook 1004.01.

⁸⁹ VHA Handbook 1004.01.

⁹⁰ VHA Directive 1004, *National Center for Ethics in Health Care*, September 6, 2013. This directive was in effect for the timeframe of the events discussed in this report; it was rescinded and replaced by VHA Directive 1004, National Center for Ethics in Health Care, October 31, 2018. Both directives contain the same or similar language regarding the discipline of ethics; Merriam-Webster, “Ethics.” <https://www.merriam-webster.com/dictionary/ethics>. (The website was accessed on October 25, 2018.)

⁹¹ VHA Directive 1004.

⁹² VHA Handbook 1004.01.

The facility offers an ethics consultation service to patients, family members, and staff.⁹³ The Ethics Committee Chair told the OIG team that once the consult has been completed, the Ethics Consultation Service will document the values in conflict and the possible justifiable actions. The consultation process may take weeks but can be expedited if necessary. Facility clinicians and other employees, patients, and family members may consult the ethics service when conflicts arise in patient care or they have questions regarding a patient's decision-making capacity or healthcare surrogacy.⁹⁴ The service helps stakeholders by gathering information, identifying options, making recommendations, and providing education to staff and family members.

OIG Findings

In the April 20, 2018, response to the OIG Hotline Workgroup inquiry on whether an ethics consult was considered, facility leaders responded that an ethics consult was not considered.⁹⁵ Facility leaders confirmed that the patient's pending discharge to an FDC was the subject of multiple conversations among senior leaders. The OIG team did not find evidence that leaders sought assistance from the Ethics Consultation Service regarding the patient's medical conditions, pending arrest, and discharge. The facility Ethics Committee Chair reported that any employee can ask for an ethics consult and confirmed that the committee did not receive a consult regarding the patient's medical conditions, pending arrest, and discharge.

5. PRF Management

Background

To enhance safety, VHA established the assignment of PRFs in the EHR to alert staff to patients that may present a risk to VHA employees, other patients, and visitors. A Category I PRF must be assigned for patients who "present an immediate safety risk for seriously disruptive, threatening, or violent behavior." A Category I PRF EHR note must include the rationale for the PRF and the Facility Director must ensure that the PRF is reviewed at least every two years.⁹⁶ From 2010 until May 2018, VHA required that a patient be informed that a PRF was assigned, the contents of the PRF, that the patient had the right to amend the contents of the PRF, and the process to pursue PRF amendment.⁹⁷ On May 16, 2018, the Director, VHA Workplace Violence Prevention Program disseminated interim guidance that patient notification of PRF placement in the EHR is only required for PRFs that include restrictions on the patient's care, such as

⁹³ VHA Directive 1004.

⁹⁴ VHA Directive 1004; Facility policy.

⁹⁵ The Medical Center Director, Chief of Staff, and Associate Director, Patient Care Services signed this response.

⁹⁶ Individual VISNs or facilities may establish a Category II PRF for a range of purposes including flagging patients who are high-risk for suicidal behavior, missing and wandering, and have spinal cord injuries.

⁹⁷ VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010. This directive expired December 31, 2015, and has not been updated.

specification of hours in which non-emergent outpatient care can be provided or the health care personnel involved in the patient's care.

OIG Findings

The OIG found that the DBC failed to notify the patient of the 2011 PRF assignment or the patient's right to amend the PRF contents, as was required at that time. In 2011, the DBC assigned a Category I PRF in response to the patient's assaultive behavior, agitation, and threats towards other patients. The OIG found no evidence that the patient was notified of the PRF assignment or the patient's right to amend the PRF contents.⁹⁸ In May 2018, VHA issued interim guidance that patient notification of a PRF assignment or the right to amend is no longer required. Therefore, the OIG will not make a recommendation regarding this finding.

The OIG also found that the DBC failed to review the patient's Category I PRF in 2013, two years after it was assigned, as required.⁹⁹ The DBC reviewed the patient's EHR in 2015 and 2017, agreed to continue the PRF, and made no changes to the PRF contents. A DBC co-chair told the OIG that the facility's fiscal year 2016 implementation of the Disruptive Behavior Reporting System improved timely PRF renewal reviews by automated tracking and alerting due dates.¹⁰⁰ Three of 19 fiscal year 2018 PRF renewal reviews were conducted after the due date. Specifically, the renewal reviews were completed within the review month but five, eight, and 12 days after the review due date. The DBC co-chair told the OIG that this occurred because the DBC monthly meeting was after the PRF renewal date due to holidays and no events occurred to trigger an earlier review. In first quarter fiscal year 2019, all six PRF renewal reviews were completed timely. The DBC co-chair also said that since August 2018, the DBC meets twice a month and recently established the practice to review PRFs 60 days prior to the due date to ensure compliance. The facility's fiscal year 2016 implementation of Disruptive Behavior Reporting System and DBC co-chairs' increased focus on the PRF review process led to evidence of improved performance. Therefore, OIG will not make recommendations regarding these two PRF management domains.

Conclusion

The OIG did not substantiate that the patient died by suicide two days after discharge from the facility inpatient mental health unit and while incarcerated at the FDC. The patient was arrested by VA Police in 2017, discharged from the inpatient mental health unit to the federal judicial

⁹⁸ VHA Directive 2010-053.

⁹⁹ VHA Directive 2010-053.

¹⁰⁰ The Disruptive Behavior Reporting System is a web-based system for event reporting and data management that VHA developed and installed in every facility. VHA's Workplace Violence Prevention Program (WVPP), <https://www.publichealth.va.gov/about/occhealth/violence-prevention.asp>. (The website was accessed on January 20, 2019.)

system, and subsequently placed in the FDC. The patient died at the FDC eight days following discharge. The Associate Medical Examiner identified the patient's cause of death as hypertensive and atherosclerotic cardiovascular disease and the manner of death as natural.

The OIG substantiated that facility inpatient mental health staff failed to engage in proper discharge planning for the patient prior to and after the patient's transfer to the FDC. Additionally, the OIG team found that inpatient mental health staff failed to engage in proper treatment planning processes. Specifically, the OIG team determined that inpatient mental health staff failed to

- Include the patient and the patient's family member in treatment and discharge planning decisions,
- Address the patient's decision-making capacity to determine if the patient could adequately provide consent for treatment options and participate in discharge planning,
- Identify and document the patient's surrogate consistently throughout the EHR,
- Provide clinical hand-off communication to the patient's receiving mental health providers, and
- Assign an MHTC responsible for overall care and discharge planning coordination.

Further, the OIG did not find documentation that indicated that the ITT engaged the patient or the patient's family member in discharge placement discussions or disclosed to the patient or the patient's family member that the decision was made that the patient would not return to the patient's preferred placement, the CLC. Although the Inpatient Psychiatry Nurse Practitioner knew of the patient's pending arrest one day prior to the discharge, staff did not inform the patient, nor contact the patient's family member until after the patient had been removed from the facility.

There was no direct communication between facility staff and FDC staff regarding the patient, despite the patient's medical and psychiatric acuity, multiple comorbid health issues, and complex medication regimen. Such direct communication might have circumvented deficiencies in the patient's clinical management such as abrupt modifications to the patient's medication regimen and the lack of notification of cardiovascular vulnerabilities. The multiple failures of communication with the patient, patient's family member, and receiving treatment providers during the transition from facility to FDC care settings might have been improved by the assignment of an MHTC. Further, the OIG found that although there was opportunity to do so, facility staff did not obtain a release of information from the patient or surrogate for the VA Police to obtain discharge information.

The OIG found that facility staff did not comply with VHA policy regarding the patient's voluntary and involuntary admissions to the inpatient mental health unit. The OIG found that facility staff did not obtain consent for voluntary admissions from the patient's surrogate as required for patients who lack decision-making capacity. Additionally, during the patient's final two inpatient mental

health unit admissions, facility staff did not obtain proper consent, utilize the state law involuntary commitment options, and offer the patient a 72-hour notice in response to the repeated requests to return to the CLC.

The OIG found that facility staff did not consider accessing available consultative resources prior to the patient's discharge to the FDC. The absence of expert consultation may have contributed to the failure of facility leaders and staff to evaluate, plan, and prepare more effectively for this patient's treatment and discharge to the judicial system.

The OIG found that the DBC failed to notify the patient of the 2011 PRF assignment or the patient's right to amend the PRF contents, as was required at that time. However, May 2018 VHA interim guidance states that the notification of a PRF or the right to amend is no longer required. The OIG also found that the DBC failed to review the patient's Category I PRF in 2013 although did so in 2015 and 2017, as required. The facility's fiscal year 2016 implementation of Disruptive Behavior Reporting System and DBC co-chairs' increased focus on the PRF review process has led to evidence of improved performance. Therefore, OIG will not make a recommendation regarding these two PRF management domains.

Recommendations 1–10

1. The Veterans Integrated Service Network Director solicits an ethics consult regarding the patient's final episode of care and treatment course including the failure to inform the patient or family of impending arrest and lack of family inclusion in decision-making.
2. The Facility Director strengthens inpatient mental health unit processes to include the patient, family members, or surrogate in treatment and discharge planning decisions.
3. The Facility Director evaluates the inpatient mental health unit assessment practices of patients' decision-making capacity and voluntary admission status, and takes actions as appropriate.
4. The Facility Director ensures that facility staff identify and document patients' surrogates accurately.
5. The Facility Director ensures that inpatient mental health unit discharge processes include a complete medical and psychiatric diagnostic summary to patients' receiving mental health providers.
6. The Facility Director develops inpatient mental health unit discharge processes that include a clinical hand-off communication to patients' receiving mental health providers.
7. The Facility Director ensures that a mental health treatment coordinator is assigned for patients during all episodes and levels of mental health care.

8. The Facility Director ensures that informed consent is obtained from patients or authorized surrogates for release of information as required.
9. The Facility Director evaluates inpatient mental health unit admission practices and develops processes in compliance with Veterans Health Administration policy regarding voluntary and involuntary admissions.
10. The Facility Director provides guidance to clinical staff regarding access to consultative resources such as forensic mental health experts, Office of General Counsel, and Ethics Consultation Service.

Appendix A: Additional Background and Patient Case Summary

Schizophrenia

Schizophrenia is a chronic SMI that affects an individual's thoughts and behaviors, and the symptoms can be disabling.¹⁰¹ The National Institute of Mental Health estimates that up to eight of 1,000 people will have schizophrenia during their lifetimes.¹⁰² Symptoms may include delusions and hallucinations that may cause a person to lose touch with reality and impair information processing and decision-making.¹⁰³ Additional symptoms of schizophrenia include hostility, perceived threat due to hallucinations or delusions, impulsivity, neurocognitive impairment, and limited insight that may lead to acts of violence.¹⁰⁴

Due to the chronicity of schizophrenia, treatment goals include reduced symptoms, maximized function, and sustained recovery. During an acute psychotic episode, the treatment goal is to prevent harm to the patient and to others through reduction of psychotic symptoms, agitation, aggression, or mood changes. Treatment may include antipsychotic medications and other psychiatric medications, behavioral intervention to address precipitating factors, and development of long-term treatment plans including community integration. Antipsychotic medications, especially clozapine, remain the treatment of choice for aggression in schizophrenia. Augmentation with benzodiazepines or anti-epileptic medications do not further

¹⁰¹ National Institute of Mental Health. Health Topics, Schizophrenia. February 2016. <https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml>. (The website was accessed on October 11, 2018.)

¹⁰² National Institute of Mental Health, 2015, *Schizophrenia* (NIH Publication No. 15-3517). https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml#part_145426. (The website was accessed on August 2, 2018.)

¹⁰³ Delusions are fixed beliefs along a variety of themes including persecutory and grandiose. Hallucinations are the non-voluntarily controlled perception-like experiences that are not caused by external stimulus. Auditory hallucinations are usually experienced as voices distinct from the patient's own thoughts. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, American Psychiatric Association, 2013, page 87; The Mayo Clinic. Symptoms and Causes: *Schizophrenia*, 2018. <https://www.mayoclinic.org/diseases-conditions/schizophrenia/symptoms-causes/syc-20354443?p=1>. (The website was accessed on August 15, 2018.); American Psychiatric Association. *DSM Library Psychiatry Online: Schizophrenia Spectrum and Other Psychotic Disorders*. <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm02>. (The website was accessed on August 15, 2018.); National Institute of Mental Health, 2015, *Schizophrenia* (NIH Publication No. 15-3517).

¹⁰⁴ Jan Volavka and Leslie Citrome, "Pathways to Aggression in Schizophrenia Affect Results of Treatment," *Schizophrenia Bulletin*, vol. 37, no. 5, 2011: 921-929.

reduce aggression.¹⁰⁵ Schizophrenia typically involves a waxing and waning of symptoms, but abrupt exacerbations or relapses are most commonly due to antipsychotic medication nonadherence, substance use disorders, and life stressors.¹⁰⁶

Treatment resistant schizophrenia is defined by ongoing symptoms despite two adequate trials of second generation antipsychotic medications.¹⁰⁷ Clozapine is considered the antipsychotic medication of choice for treatment resistant patients.¹⁰⁸ However, up to 30 percent of patients treated with clozapine do not have beneficial clinical response.¹⁰⁹ These patients are often prescribed multiple antipsychotic medications despite little clinical trial evidence about the efficacy of such polypharmacy and an unfavorable risk-benefit profile.¹¹⁰ Antipsychotic polypharmacy also increases the practice of prescribing high dose antipsychotics despite the evidence that high doses of medication do not result in increased efficacy, even in treatment resistant patients.¹¹¹ High dose antipsychotic medications increase the risk of adverse effects including extrapyramidal symptoms, metabolic problems like insulin resistant diabetes, increased risk of cardiovascular disease, cardiac arrhythmias, and increased risk of mortality.¹¹² Therefore, patients on antipsychotic medications should be monitored regularly for changes in physical health including routine blood pressure, weight, body mass index, serum lipids, fasting glucose, and cardiac functioning.¹¹³

¹⁰⁵ A benzodiazepine is a type of sedative and anti-anxiety medication including alprazolam, diazepam, and clonazepam. Long-term use can lead to dependence and withdrawal symptoms when discontinued; Mark R. Serper, "Aggression in Schizophrenia," *Schizophrenia Bulletin*, 37(5), 897-898, September 2011, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160226/>. (The website was accessed on December 12, 2018.)

¹⁰⁶ Anthony F. Lehman, Jeffrey A. Lieberman, Lisa B. Dixon, et al. , "Practice Guideline for the Treatment of Patients with Schizophrenia, Second Edition," *American Journal of Psychiatry* 161(2 SUPPL.) (2004).

¹⁰⁷ Helio Elkis, "Treatment-Resistant Schizophrenia," *Psychiatric Clinics of North America* 30, (2007): 511-533.

¹⁰⁸ UK National Institute of Clinical Excellence, "Psychosis and schizophrenia in adults," Quality Standard 80, Updated February 2015. <https://www.nice.org.uk/guidance/qs80/chapter/quality-statement-4-treatment-with-clozapine>. (The website was accessed on November 11, 2018.)

¹⁰⁹ Helio Elkis, "Treatment-Resistant Schizophrenia."

¹¹⁰ Polypharmacy is the concurrent use of multiple medications by a patient to treat usually coexisting conditions. Merriam-Webster Dictionary, <https://www.merriam-webster.com/dictionary/polypharmacy>. (The website was accessed on January 25, 2019.); Thomas Barnes and Carol Paton, "Antipsychotic Polypharmacy in Schizophrenia," *CNS Drugs* 25, no.5 (2011): 383-399.

¹¹¹ Barnes and Paton, "Antipsychotic polypharmacy."; John Davis and Nancy Chen, "Dose response and dose equivalence of antipsychotics," *Journal of Clinical Psychopharmacology* 24, no. 2, (2004): 192-208.

¹¹² Extrapyramidal symptoms include gait disturbances, muscle spasms, restlessness, rigidity, tremor, and slowed movement; Helio Elkis, "Treatment-Resistant Schizophrenia."

¹¹³ Daniel Casey, Dan Haupt, John Newcomer, et al., "Antipsychotic-Induced Weight Gain and Metabolic Abnormalities: Implications for Increased Mortality in Patients With Schizophrenia," *Journal of Clinical Psychiatry* 65, supplement 7, (2004):4-18.; Sabine Straus, Gysele Bleumink, Jeanne Dieleman, Johan van der Lei, Geert W. 't Jong, J. Herre Kingma, Miriam Sturkenboom, and Bruno Stricker, "Antipsychotics and the Risk of Sudden Cardiac Death," *Archives of Internal Medicine* 164, (June 28, 2004): 1293-1297.

Patient Case Summary

The patient, who was in their 50s at the time of death, was diagnosed with multiple medical conditions including schizophrenia, alcohol dependence, head injuries, seizure disorder, hypertension, cerebral infarction, and peripheral vascular disease.¹¹⁴ The patient first saw a mental health clinician at age 15 or 16 but was only intermittently compliant with treatment through the years due to baseline paranoid delusions about care providers and medications. The patient was approximately 20 years old when diagnosed with schizophrenia and was repeatedly admitted to inpatient psychiatric units in non-VA facilities, including state hospitals. In addition to chronic, mental illness, the patient suffered a traumatic brain injury in 2000.

For approximately 10 years starting in the late 1990's, the patient lived in a Department of Human Services community residential rehabilitation or personal care home (PCH). The patient's outpatient mental health treatment from the 1980's to 2003 included treatment at a non-VA outpatient clinic, a day treatment program, and with a private psychiatrist in the community. Beginning in 2003, while living at the PCH, the patient participated in facility outpatient SMI programs including day treatment programs and Mental Health Intensive Case Management. Although the patient wanted to live independently, a case manager noted that the patient "tends to decompensate quickly when not in a structured environment."

2003–2007

While living in the PCH, the patient began outpatient mental health treatment at the facility in early 2003 and was then admitted to the facility inpatient mental health unit for 33 days. In the patient's discharge summary, facility Inpatient Psychiatrist 1 documented, "In regard to competency, the patient is NOT considered COMPETENT for VA purposes." The patient began attending day treatment groups at the facility in mid-2003, and had a Mental Health Intensive Case Management intake in late 2003. The patient presented with persistent delusional content and suspiciousness.

In 2004, the patient was no longer prescribed clozapine since it "did not seem to be all that effective and the patient was not considered all that reliable about compliance with medication and abstaining from alcohol or other substances of abuse." In 2005, the patient became increasingly noncompliant with medications and required inpatient admissions for worsening symptoms. In 2006, facility Outpatient Psychiatrist 1 recommended neuropsychological testing to determine whether the patient's deficits were related to a cognitive disorder or schizophrenia. The neuropsychologist was unable to complete testing due to the patient's persistent delusions and perseveration on auditory hallucinations. The neuropsychologist noted that "...a structured,

¹¹⁴ The OIG uses the singular form of they (their/them) to protect the patient's privacy. A cerebral infarction is a stroke caused by brain blood vessel blockages that deprive the brain of oxygen and nutrients (glucose) resulting in brain tissue damage and related symptoms.

[routinized], supported, and supervised living environment is strongly recommended to support [the patient's] overall level of functioning." In mid-2006, the patient wandered away from the day treatment center, boarded a bus "to visit a friend," and was missing for more than five hours. Almost two months later, the patient suffered a stroke and appeared to incorporate residual stroke symptoms into delusional ideation. For example, the patient stated that "less stren[g]th on [the patient's] left side due to the testing that was done on [the patient] in the military."

In early 2007, facility Outpatient Psychiatrist 2 noted that the patient "presents [as] very psychotic but not significantly more so than at baseline... [The patient] is sexually preoccupied and very delusional with bizarre paranoid and sexual content (as on previous occasions)." In 2007, while living at the PCH, the patient relapsed on alcohol and began drinking products such as aftershave lotion and hand sanitizer. In mid-2007, the patient experienced two seizures likely caused by encephalomalacia in the right side of the patient's brain.¹¹⁵ In late 2007, the patient was admitted to the inpatient mental health unit for exacerbation of delusions, verbally aggressive behavior towards PCH peers and staff, and medication nonadherence. The patient was readmitted to the locked inpatient mental health unit for 31 days, after throwing water and spitting on a PCH staff member. Although PCH staff told the admitting physician that the patient "cannot be managed at PCH," the PCH staff later agreed the patient could return at discharge with psychiatric follow-up at the facility.

2008

In early 2008, the patient exhibited paranoid delusions, admitted to drinking mouthwash and hair tonic, and requested inpatient admission. The patient was admitted that day to the inpatient mental health unit until discharged 112 days later. The patient was described as initially being "demanding, hostile, verbally threatening and difficult to redirect." With staff intervention, the patient became more agreeable, but insight and judgment remained poor. In mid-2008, the treatment team educated the PCH staff on the extensive behavioral measures the unit staff utilized to support the patient's improved interpersonal interactions and encouraged them to use these techniques with the patient at the PCH. The patient was discharged to the PCH with psychiatric follow-up at the facility.

At the patient's first psychiatric follow-up visit in mid-2008, PCH staff informed the psychiatrist they felt the patient required more structure than they were capable of providing. Nine days later, the patient had a physical altercation with a peer at the PCH due to delusions that the peer was coughing and spitting in the food. Four days later, the patient was admitted to the facility involuntarily when the patient threatened to kill people at the PCH in response to a belief that

¹¹⁵ Encephalomalacia is softening or loss of brain tissue following a stroke, infection, head trauma, or other injury. National Library of Medicine, MeSH (Medical Subject Headings), "Encephalomalacia," <https://www.ncbi.nlm.nih.gov/mesh?Cmd=DetailsSearch&Term=%22Encephalomalacia%22%5BMeSH+Terms%5D>. (The website was accessed on October 31, 2018.)

they wanted to kill the patient. The inpatient staff told the patient that the patient could not return to the PCH at discharge. After a meeting of the inpatient team and the PCH staff, the PCH staff agreed to accept the patient back to the PCH after discharge, though they highlighted concerns about the “recent escalation in aggressive behaviors at the home, which they believe are driven, in part, by paranoid ideation.”

In late 2008, a PCH supervisor called the facility to state that the patient “attempted to grab the arm of a female staff member while in the van.” A few days later, the patient was transferred from a non-VA hospital to the facility for inpatient mental health admission after starting a fire in a trash can at the PCH and threatening to kill a staff member in response to a paranoid delusion. During the admission, the patient became physically violent, charging at a staff person and requiring intramuscular injections for sedation.

Approximately two months later, PCH staff petitioned for emergency involuntary commitment of the patient for threatening and assaultive behavior towards PCH peers and staff. The patient was admitted to the facility’s acute inpatient mental health unit, where the patient remained for almost two years. While receiving inpatient treatment, the patient was discharged from the facility’s outpatient case management program due to requiring a higher level of care to manage the patient’s aggressive behaviors.

2009–2010

Numerous medication changes were made to improve behavioral dysregulation and mood stabilization, but the patient developed side effects necessitating further changes and medical monitoring. A staff member documented that the patient could be generally cooperative and agreeable but was unable to tolerate limit setting or negative answers in response to demands, often escalating to shouting, name calling, and occasionally physical violence.

In early 2010, the patient was found drinking hand sanitizer for the alcohol content. Providers reported the patient’s typical presentation as “moody and usually delusional,” and that given the severity of the symptoms, no longer appropriate to live in the community. In late 2010, after two years on the inpatient mental health unit, the patient was admitted to the facility CLC. At this time, the patient was being prescribed a complex medication regimen that included three antipsychotic medications, a benzodiazepine medication, a mood stabilizer, and injectable medications to be used as needed for agitation or threatening behavior. Following transfer to the CLC, Inpatient Psychiatrist 2 noted, “[The patient] continues to be a behavioral problem at times on the unit but is more difficult to manage off the unit.” The patient eloped while escorted, was described as impatient and “cannot wait even short periods for anything that delays immediate gratification...All of this suggests very poor impulse control likely related to [the patient’s] brain damage second to CVA [cerebrovascular accident].”

2011–2014

In mid-2011, the patient had a behavioral outburst in response to a persecutory delusion about nursing staff. The patient attempted to jump the nursing station wall, spit at staff, and threw a book bag at another staff member. The patient then threatened to murder people and assumed a threatening posture. Staff called security and administered an intramuscular medication for sedation. One week later, the patient physically assaulted a peer without provocation, predicated on delusional beliefs. The patient was transferred to the acute inpatient mental health unit and was described as “doing progressively worse despite the attempts of the primary team to stabilize the pt [patient] with pharmacotherapy.” The next day, the DBC assigned a PRF in response to the patient’s assaultive behavior, agitation, and threats towards other patients. The patient was accepted back to the facility CLC.

Inpatient Psychiatrist 2 titrated the patient’s antipsychotic medications upwards for management of delusions, but the patient continued at a baseline level of functioning and psychosis. In late 2011, when the patient struck another patient in the face, facility Inpatient Psychiatrist 2 documented the patient’s “judgment and behavioral control are particularly impaired.” As with prior assault events, the patient exhibited no insight and “redirect[ed] the conversation to paranoid and persecutory delusions about the staff and other [patients].” Eight days later, the patient was transferred to the inpatient mental health unit after attempting to punch a nurse in the face and then threatening a peer on the unit. Facility Inpatient Psychiatrist 2 noted that the patient “is generally refractory to medications and is on a complex regimen with waning effect.” The Inpatient Social Worker attempted to submit a referral to a state facility for the patient’s placement but was informed that the referral needed to come from a county mental health department.

The patient remained in the facility’s CLC from late 2011 to early 2014. During that time, the ITT regularly reviewed the patient’s progress and the patient remained at baseline with delusions, and periodic angry outbursts marked by verbal aggression towards staff and peers. In late 2013, the patient assaulted a staff member. The CLC Physician Assistant contacted the patient’s family member, who reported that the patient “has been more delusional lately, making obscene remarks and threatening perfect strangers.” In early 2014, the patient assaulted another patient, unprovoked, and was admitted to the inpatient mental health unit. A nurse documented that the patient “was hostile, verbally threatening others, and refused to walk to unit [alone],” and was placed in seclusion. After multiple refusals, the patient signed a voluntary consent for admission. The next morning, a facility physician assistant noted that the patient was “quite suspicious [*sic*]and still very parnoid [*sic*].”

Less than 48 hours later, the patient returned to the CLC. The patient’s behavior improved, and the patient was able to go on an overnight pass with the patient’s family member in mid-2014. However, the patient continued to demonstrate poor emotional and behavioral regulation, occasionally yelling at staff, and causing disturbances in public areas of the facility. In late 2014,

the patient threatened a staff member for allegedly raping [the patient's] sister and mother and harming the patient's father. The patient threatened to "put this writer in prison with a head stone." The patient was described as having "episodes of aggressive, physically threatening behavior and verbally abusive behavior" due to persecutory delusions.

2015–2016

In 2015, the patient continued to be "verbally abusive and continued delusional, and paranoid about everyone..." but was generally cooperative with medications and passively participatory in groups. In mid-2015, a CLC staff nurse reported that the patient became "angry when [the patient] is asked to wait until staff is able to answer [the patient's] questions or help with what [the patient] asked...[the patient] can become assaultive related to [the patient's] paranoid ideation."

In mid-2015, the patient was evaluated for participation in a research study. The patient scored a four on the Brief Interview for Mental Status, indicating probable severe cognitive impairment and consequent inability to provide informed consent for the study.¹¹⁶ Inpatient Psychiatrist 3 wrote, "Today writer try [*sic*] to interview [the patient] but patient was delusional and [the patient] was not able to get the idea that if you want privileges your behavior towards staff needs to improved [*sic*]. Patient perseverates with [the patient's] privileges and [the patient] is not stable enough to go out... [alone] and needs to go with staff, wich [*sic*] [the patient] does not want." The patient's family member also noted deterioration in behavior during an overnight away from campus, and described the patient as anxious, paranoid, and demanding.

By mid-2016, the patient's family member discontinued requesting overnight passes due to difficulty controlling the patient's behavior, but continued with visits. In late 2016, the patient left the campus during unescorted time. Staff launched an extensive ground search before contacting the local police department. The patient was located 24 hours later and reported spending the night outside in a field. The patient's family member brought the patient back to the facility. Following this episode, the facility Inpatient Internist documented the patient "lacks capacity for ddecision [*sic*] making regarding [the patient's] personal safety or the safety of thers [*sic*]" and the patient "...lacks the capaccity [*sic*] to make medical decisions, both simple and complex, regarding [the patient's] health." The Inpatient Internist noted that the patient was an

¹¹⁶ The Brief Interview for Mental Status (BIMS), is a short screening test for cognitive impairment used in nursing homes and research protocols to determine baseline cognitive performance.
[https://www.thecalculator.co/health/Brief-Interview-for-Mental-Status-\(BIMS\)-Calculator-915.html](https://www.thecalculator.co/health/Brief-Interview-for-Mental-Status-(BIMS)-Calculator-915.html). (The website was accessed on November 14, 2018.)

elopement risk and required a staff escort when off the unit. By late 2016, the patient began wearing a wander guard.¹¹⁷

The patient's behavior became more frequently physically and verbally aggressive and in late 2016, the patient was in two physical altercations with other patients on the CLC. The patient punched one patient in the face and shoved another patient to the floor and then kicked the patient in the face and stomach. Facility Psychiatrist 3 noted that the patient was unable to have a meaningful conversation about the events afterwards, stating, the patient "continues to be dilusional [*sic*], with poor insight into what happen[ed], or awareness of the consequences of [the patient's] actions."

2017

In early 2017, the facility Inpatient Social Worker began exploring community nursing home placement options. The Social Worker contacted five nursing homes due to the patient's extensive care needs including problems with hygiene and activities of daily living, fall risk and gait instability, urinary incontinence and associated skin breakdown, and ongoing behavioral disturbances. In early 2017, without apparent provocation, the patient assaulted another patient and lacerated the other patient's right eyebrow. The patient was unable to discuss the event without expressing delusional thought content. A month later, multiple nursing homes denied the patient admission due to the patient's disruptive behaviors. The Social Worker contacted additional facilities in an effort to find appropriate placement.

In early 2017, the DBC renewed the PRF for "multiple episodes of assaultive behavior." Due to these aggressive behaviors, the patient continued to be denied admission to community nursing homes. The Social Worker documented receipt of a letter from a state Department of Human Services Office of Mental Health and Substance Abuse Services that stated the patient "is not appropriate for nursing facility placement at this time due to [the patient's] need for the current level of psychiatric services [the patient] is receiving." Following consultation with a supervisor, the Social Worker documented a plan to follow-up with a state Office of Mental Health and Substance Abuse Services.

Final Admission: 2017

In mid-2017, the patient was highly agitated, screaming, and calling people names at the nursing station. Less than an hour later, the patient became agitated and demanded a haircut without waiting in line. A staff member attempted to redirect the patient, and staff observed the patient "charging at the staff member" and punching the staff member in the face. Staff held the patient

¹¹⁷ Wander guards are wrist or ankle devices designed for dementia patients that allow staff to monitor patient locations within set boundaries (for example, a hospital unit) and alert staff if a patient attempts to leave a secure location.

back. Police escorted the patient to the inpatient mental health unit. The patient threatened to kill the staff member and stated that the staff member had “scratched [the patient’s] eyes out” and tried to kill the patient. Facility Inpatient Psychiatrist 3 observed, “[The patient] who continue [sic] to be belligerent and threatening and delusional. Patient was given medications, and convince [sic] to come...” to the inpatient mental health unit. Facility Inpatient Psychiatrist 3 also documented that the patient was having delusions about the police wanting to rob the patient. Intramuscular antipsychotic medication was administered, and the patient continued to have paranoid delusions. The patient was put on one-to-one monitoring.¹¹⁸

The following day, a facility inpatient physician assistant noted that, “Patient’s capacity is impaired,” and a different Social Worker noted that the patient’s family member was the legal guardian. Facility Inpatient Psychiatrist 4 documented the patient continued to have persecutory delusions about staff on the CLC. Over the next few days, the patient continued to demonstrate a lack of understanding regarding admission and need for a one-to-one monitor despite multiple attempts at education by staff.

Initially, the documented discharge plan was for the patient to return to the facility CLC. In mid-2017, the patient was described as “remains on 1:1 status, controlled behavior, pleasant and cooperative with staff and peers. [Patient] cooperating with meals and medications.” The next day, facility Inpatient Psychiatrist 4 documented legal charges against the patient potentially affecting discharge planning. Thirteen days later, facility Inpatient Psychiatrist 4 wrote, “Case was discussed with...Chief of staff and with...acting Chief of psychiatry service. Recommendation was made to continue current treatment on the unit until legal proceedings completed.” The patient continued to exhibit persecutory delusions regarding staff and peers. A week later, the patient threatened to hit a nurse, believing that the nurse had stabbed the patient in the neck.

Approximately a week later, the patient complained of chest pain, saying, “I’m having a heart attack.” The patient received full dose aspirin and sublingual nitroglycerin without effect and was transferred to a non-VA facility for assessment. Due to the patient’s psychiatric symptoms and “extreme resistance,” the non-VA facility staff were unable to perform comprehensive testing. Documented results indicated that the patient’s chest x-ray was normal and electrocardiogram showed no acute changes. The cardiologist cleared the patient for discharge the following day noting that acute coronary syndrome was ruled out.¹¹⁹ The patient was readmitted to the facility inpatient mental health unit the next day.

¹¹⁸ One-to-one monitoring is the assignment of one staff member to observe and monitor a patient at risk of harm with the goal of ensuring safety.

¹¹⁹ Acute coronary syndrome describes a range of conditions associated with sudden, reduced blood to the heart including myocardial infarction (heart attack). Mayo Clinic, *Acute coronary syndrome*, <https://www.mayoclinic.org/diseases-conditions/acute-coronary-syndrome/symptoms-causes/syc-20352136>, August 2, 2017. (The website was accessed on February 26, 2019.)

Twenty days later, the treatment plan documented that the patient was on the unit for 21 days with ongoing one-to-one monitoring. The patient was described as exhibiting continued paranoia, inability to comprehend why the patient is on the unit, “minimal aggressive behaviors, largely being cooperative with staff direction.” Additionally, it was noted that the patient was frustrated with being on unit and that there was no “clear disposition plan.” Five days later, at the request of the United States Attorney’s Office, the United States District Court issued a warrant for the patient’s arrest.

About a week later, the patient experienced chest pain again. The facility Inpatient Internist responded to the call for medical assistance and documented that the patient was complaining of a “heart attack.” The internist ordered an electrocardiogram that showed incomplete right branch bundle block that was unchanged since 2011.¹²⁰ The internist ordered Haldol as needed “for agitation and increasing aggression.” That same day, the facility Inpatient Psychiatry Nurse Practitioner documented speaking with a VA Police Officer regarding the discharge process. The Nurse Practitioner wrote that the patient “. . . will be discharged tomorrow [redacted] at 8:30am [sic] in the custody of VA Police, in handcuffs, out the back entrance of [the inpatient mental health unit] for the safety and dignity of this veteran. There is a warrant for [the patient’s] arrest. [The patient] will be taken via VA Police custody to the Federal Courthouse and placed into the custody of Federal Marshalls. [The patient] will remain in Federal Custody pending arraignment [sic] for [the patient’s] federal charges. [The patient] will require one day of medications and the federal jail will then be able to supply medications.”¹²¹

An inpatient nurse documented, “Veteran discharged at 845am. Veteran was discharged to Federal Courthouse and was transported via VA Police. Veteran was discharged with supply of VA issued prescribed medications. VA Police instructed staff to keep personal belongings at the [facility]. [The patient] was compliant with hand-cuffing process and calmly left the unit while police escorted [the patient] to their vehicle.” The patient’s discharge summary listed 21 prescriptions including briefs for incontinence and 18 medications.¹²² See Appendix B for a list of discharge medications. The patient was discharged with a one-day supply of the medications except for clonazepam, which was not provided.¹²³

¹²⁰ Bundle branch block is a delay of the electrical impulse that generates heart beats. A right bundle branch block may be caused by a congenital heart abnormality, a heart attack, a heart muscle infection, high blood pressure in the pulmonary arteries, or a blood clot in the lungs. Mayo Clinic, “Bundle Branch Block,” May 15, 2018. <https://www.mayoclinic.org/diseases-conditions/bundle-branch-block/symptoms-causes/syc-20370514> (The website was accessed on November 14, 2018.)

¹²¹ All instances of redacted information are pursuant to 5 U.S.C. § 552a(b) (2013) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936.

¹²² Two medications, clonazepam and quetiapine fumarate, had two prescribed dosages thereby increasing the 18 to 20 medication prescriptions.

¹²³ Staff completed an incident report regarding the failure to provide the patient with clonazepam upon discharge.

FDC: 2017

The patient initially appeared before the judge on the day of discharge and a temporary detention was granted, with a detention hearing and arraignment scheduled five days later. The patient's FDC health screen included a list of the current medications, but the list did not include the benzodiazepine, clonazepam. The dosage for another medication, haloperidol, was a total daily dose of 20 milligrams (mg) instead of the 100 mg the patient was administered at the facility. The FDC physician prescribed reduced total daily doses of the three antipsychotic medications: haloperidol 20 mg, olanzapine 15 mg, and quetiapine 400 mg with a plan to taper the patient off the quetiapine due to formulary constraints. The patient did not receive the morning medications on the second day. Additionally, the patient received quetiapine 400 mg day two through day five and on day eight but did not receive the medication on days six and seven.

On day five, an FDC psychologist described the patient as having grandiose delusions including having special powers. The next day, the FDC Chief Psychologist noted that an effort was made to transition the patient from psychiatric observation status to the general population, but the patient was found in the common area in underpants and trying to touch another inmate. The patient "displayed a basic understanding" of why the patient was not at the VA, "but [the patient's] acute thought disorder was a potential barrier to education." The FDC Chief Psychologist documented that the patient was not able to function appropriately in a general population. The patient appeared in court on day six, was detained and a competency examination was ordered with continuation of pretrial detention and arraignment scheduled for 10 days later. On day seven, the patient continued to describe delusions, including having been cremated.

On the afternoon of day nine, the FDC psychologist described the patient as agitated, irritable, cursing, and kicking at the door. Shortly after the patient and psychologist met, the medical team was called to the patient's room for an emergency. The medical team entered the patient's room at 4:45 p.m. and observed no respirations, slight bleeding from the mouth, and no palpable heart rate via multiple sites. They initiated cardiopulmonary resuscitation at 4:46 p.m. and provided oxygen. An automatic external defibrillator was applied although no shock was administered. Fire Department emergency medical services arrived at 5:20 p.m. Fire Department medics arrived at 5:40 p.m., obtained intravenous access and administered fluids. The medics intubated the patient at 5:48 p.m. Epinephrine was administered three times per protocol and the patient remained unresponsive.¹²⁴ The patient's time of death was 6:00 p.m.

The following day, the Associate Medical Examiner performed an autopsy on the patient. The cardiovascular examination showed moderate atherosclerosis of the right coronary artery,

¹²⁴ Epinephrine is a medication included in cardiopulmonary resuscitation protocols to restore cardiac circulation.

“marked” atherosclerosis of the aorta, and cardiac hypertrophy.¹²⁵ The patient’s cause of death was listed as hypertensive and atherosclerotic cardiovascular disease.

¹²⁵ *Atherosclerosis* is the buildup of fat, cholesterol, or other substances on the artery wall, restricting blood flow through the artery. Atherosclerosis can occur in any of the arteries in the body, not just in the heart. Atherosclerosis in the coronary arteries can cause chest pain, heart failure, or a heart attack. Mayo Clinic, “Arteriosclerosis/Atherosclerosis,” April 24, 2018. <https://www.mayoclinic.org/diseases-conditions/arteriosclerosis-atherosclerosis/symptoms-causes/syc-20350569>. The *aorta* is the main artery that carries blood from the heart to the rest of the body. Narrowing of the aorta (by atherosclerosis for example) places the entire body’s blood supply at risk. American Heart Association, “Your Aorta,” June 1, 2015. <http://www.heart.org/en/health-topics/aortic-aneurysm/your-aorta-the-pulse-of-life>. *Cardiac hypertrophy* is the enlargement of the heart’s “pumping chamber” by thickening of its walls and it is most often caused by uncontrolled high blood pressure. The enlarged heart loses elasticity and weakens, leading to reduced blood supply to the heart, decreased efficiency in pumping blood to the rest of the body, higher risk of stroke, cardiac arrhythmia, and sudden cardiac death. Mayo Clinic, “Left ventricular hypertrophy,” June 13, 2018. <https://www.mayoclinic.org/diseases-conditions/left-ventricular-hypertrophy/symptoms-causes/syc-20374314>. (The websites were accessed on November 15, 2018.)

Appendix B: Discharge Medications

Table B.1. Patient's 2017 Discharge Medications

	Medication	Total Daily Dosage	Documented Targeted Condition
1	Aluminum-Magnesium Hydroxide, and Simethicone	Two tablespoonfuls every 4 hours as needed	Indigestion
2	Aspirin	81 mg	Cardioprotection
3	Atenolol	25 mg	High Blood Pressure
4	Cholecalciferol (Vitamin D3)	2000 units	Vitamin D Deficiency
5	Clonazepam	4 mg	Anxiety
6	Diphenhydramine	50 mg	Restlessness
7	Docusate Sodium	200 mg	Stool Softening
8	Doxycycline Monohydrate	200 mg	Furuncle
9	Fluticasone	100 mcg	Allergies
10	Haloperidol	100 mg	Psychosis
11	Lamotrigine	400 mg	Mood Stabilization
12	Milk of Magnesia	One tablespoon at bedtime as needed	Constipation
13	Olanzapine	35 mg	Thought Disorder
14	Phenytoin	300 mg	Seizure Disorder
15	Quetiapine Fumarate	800 mg	Psychosis and Agitation
16	Ranitidine	300 mg	Acid Reflux
17	Simvastatin	40 mg	Cholesterol
18	Tamsulosin	0.8 mg	Prostate

Source: VA OIG analysis of patient's 2017 discharge summary

Appendix C: Inpatient Mental Health Unit Admissions

Table C.1. Patient’s Facility Inpatient Mental Health Unit Admissions

Inpatient Admission Dates	Number of Days	Admission Legal Status
2003 Admission 1	33	Voluntary
2003 Admission 2	17	Voluntary
2004 Admission	36	Involuntary to Voluntary
2005 Admission	24	Voluntary
2006 Admission	19	Voluntary
2007 Admission 1	14	Voluntary
2007 Admission 2	31	Voluntary
2008 Admission 1	112	Voluntary
2008 Admission 2	23	Voluntary
2008 Admission 3	19	Involuntary to Voluntary
2008 Admission 4	722	Involuntary to Voluntary
2011 Admission 1	9	Involuntary
2011 Admission 2	12	Involuntary to Voluntary
2014 Admission	2	Voluntary, although patient previously refused to sign
2017 Admission 1	37	Voluntary—signed consent for voluntary admission 14 days after admission
2017 Admission 2	32	Status not defined; voluntary consent signed by a physician but not by patient.

Source: VA OIG analysis of the patient’s EHR

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 3, 2019

From: Interim Director, VA Healthcare (10N4)

Subj: Healthcare Inspection—Alleged Deficiencies in Care and Discharge Planning for
a Mental Health Inpatient Who Transitioned to the Judicial System from a VISN 4
Medical Facility

To: Director, Baltimore Office of Healthcare Inspections (54HL01)

Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

I have reviewed the responses provided by the facility and I am submitting to your office
as requested. I concur with their responses.

(Original signed by:)

Timothy R Burke, MD

VISN 4 Chief Medical Officer for Timothy W. Liezert, Acting Network Director

Comments to OIG's Report

Recommendation 1

The Veterans Integrated Service Network Director solicits an ethics consult regarding the patient's final episode of care and treatment course including the failure to inform the patient or family of impending arrest and lack of family inclusion in decision-making.

Concur.

Target date for completion: November 4, 2019

Director Comments

VISN 4 Integrated Ethics Officer and facility Integrated Ethics Officer will coordinate a review of this case for the specific issues identified. The VISN will provide oversight and facilitation to ensure all areas are covered appropriately, with the VISN Ethical Officer having ultimate oversight. (Note: Recommendation 1 stated the VISN would complete an ethics consultation. It is outside the scope of the Ethics Consultation Service to retrospectively determine unethical behavior or investigate an allegation of serious misconduct. Had an ethics consult been requested at the time of situation, the consultation would have been provided and referrals made as applicable. Integrated ethics, in this case, would be best suited to determine the need for a preventative ethics ISSUES cycle to address policy revisions, education needs, and process changes as it applies to informed consent and the determination of decision-making capacity and assigning a surrogate. The VISN and facility will use the information provided by the OIG report and put together a Preventative Ethics cycle that will work on process improvement to identify the education that needs to be completed and the processes and policies that need to be updated to prevent this from occurring in the future. Preventative Ethics would address both Informed Consent and Decision-Making Capacity which both are noted in this report).

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: June 3, 2019

From: Director

Subj: Healthcare Inspection—Alleged Deficiencies in Care and Discharge Planning for
a Mental Health Inpatient Who Transitioned to the Judicial System from a VISN 4
Medical Facility

To: Interim Director, VA Healthcare (10N4)

Thank you to the OIG Healthcare Inspection Team for the professional review of the organization that was completed. I have reviewed the draft report and concur with the findings and recommendations.

Attached are the facility responses to the recommendations, including actions that are in progress to correct the identified opportunities for improvement.

(Original signed by:)

Facility Director

Comments to OIG's Report

Recommendation 2

The Facility Director strengthens inpatient mental health unit processes to include the patient, family members, or surrogate, in treatment and discharge planning decisions.

Concur.

Target date for completion: November 4, 2019

Director Comments

The Psychosocial Assessment Template is used for each mental health unit admission to query patients if they would like to include family or others. If a person(s) is identified, a Release of Information (ROI) Form will be completed and scanned into the patient's electronic medical record.

Education will be provided to inpatient mental health social worker staff by July 15, 2019, and education will be tracked for 100% compliance.

The social work supervisor for inpatient mental health will conduct monthly audits of all inpatient admissions to ensure compliance, starting August 5, 2019. This will be monitored until 90% compliance is maintained for three consecutive months. When monthly compliance audits have met their goal, a quarterly monitor for 90% compliance of 30 random inpatient mental health charts will begin to monitor sustainability of this action.

Recommendation 3

The Facility Director evaluates the inpatient mental health unit assessment practices of patients' decision-making capacity and voluntary admission status, and takes actions as appropriate.

Concur.

Target date for completion: February 3, 2020

Director Comments

Decision making capacity to provide informed consent will be evaluated and documented by a provider when admitting a patient to inpatient mental health unit.

A Decision-Making Capacity Note template will be created by October 1, 2019. Education of the providers to this new requirement will be completed by November 1, 2019.

Audits of the Decision-Making Capacity notes will begin by November 18, 2019, for 90% documentation compliance for three consecutive months. When monthly compliance audits have

met their goal, a quarterly monitor of 90% compliance of 30 random inpatient mental health charts for use of this note will begin to monitor sustainability of this action.

Recommendation 4

The Facility Director ensures that facility staff identify and document patients' surrogates accurately.

Concur.

Target date for completion: November 18, 2019

Director Comments

The Psychosocial Assessment Template for inpatient mental health admissions will be revised to include a review of surrogate information. This revision will be completed by August 5, 2019, with education to the inpatient mental health social workers.

Audits of the inpatient Psychosocial Assessment including documentation of surrogate information will begin by August 19, 2019 and will be monitored for 90% compliance for three consecutive months. When monthly compliance audits have met their goal, a quarterly monitor for 90% compliance of 30 random inpatient mental health charts will begin to monitor sustainability of this action.

Recommendation 5

The Facility Director ensures that inpatient mental health unit discharge processes include a complete medical and psychiatric diagnostic summary to patients' receiving mental health provider.

Concur.

Target date for completion: December 16, 2019

Director Comments

The medical center will review and revise the inpatient mental health discharge documentation sent to non-VA facilities/providers on the day of discharge to include a complete medical and psychiatric treatment summary. The inpatient and covering psychiatrists will be re-educated by August 1, 2019, to complete the patient's discharge summary before the discharge.

Audits of the inpatient mental health documentation that include medical and psychiatric treatment summaries for compliance will begin by September 16, 2019, and these audits will be monitored for 90 % compliance for three months. When monthly compliance audits have met their goal, a quarterly monitor for 90% compliance of 30 notes, or if there are less than 30

discharges to non -VA facility/provider all discharges will be audited for sustainability of this action.

Recommendation 6

The Facility Director develops inpatient mental health unit discharge processes that include a clinical hand-off communication to patients' receiving mental health providers.

Concur.

Target date for completion: December 16, 2019

Director Comments

The medical center will review and revise the inpatient mental health discharge hand-off communication process to non-VA facilities/providers and the inpatient and covering mental health staff will be re-educated by August 1, 2019.

Audits of the inpatient mental health hand-off communication process to non- VA facilities/providers for compliance will begin by September 16, 2019. These audits will be monitored for 90 % compliance for three consecutive months. When monthly compliance audits have met their goal, a quarterly monitor for 90% compliance of 30 instances of hand-off communication, or if there are less than 30 discharges to a non -VA facility/provider all discharges will be audited for sustainability of this action.

Recommendation 7

The Facility Director ensures that a mental health treatment coordinator is assigned for patients during all episodes and levels of mental health care.

Concur.

Target date for completion: Completed

Director Comments

A mental health treatment coordinator is assigned to patients admitted to the mental health unit who do not have a mental health treatment coordinator already assigned as per policy. Once discharged, a new mental health treatment coordinator is assigned to patients at the next episode of care based on mental health needs and according to policy. This standard of care is a VA National Mental Health (MHTC1) Metric with an established benchmark of 90%, and facility's current compliance is 97.83%.

OIG Update: The OIG considers this recommendation open to allow the submission of documentation to support closure.

Recommendation 8

The Facility Director ensures that informed consent is obtained from patients or authorized surrogates for release of information as required.

Concur.

Target date for completion: December 4, 2019

Director Comments

All inpatient mental health social workers (100%) will be re-educated on this process by August 5, 2019. This process will become a part of the social workers' orientation. Audits to assess use of the Release of Information form when patients are to receive care at a Non-VA facility or with Non-VA providers will begin on September 9, 2019 and will be monitored until 90% compliance is met for three consecutive months. When monthly compliance audits have met their goal, a quarterly monitor for 90% compliance of 30 random inpatient mental health charts for use of this form will begin to monitor sustainability of this action.

Recommendation 9

The Facility Director evaluates inpatient mental health unit admission practices and develops processes in compliance with Veterans Health Administration policy regarding voluntary and involuntary admission.

Concur.

Target date for completion: April 30, 2020

Director Comments

The mental health inpatient admission policies and processes will be reviewed by November 4, 2019, with development of a mental health admission decision tool in compliance with VHA policy regarding voluntary and involuntary admissions. All clinical staff who write admission orders on the inpatient mental health unit will be educated by January 3, 2020.

Audits for the accurate use of the mental health admission decision tool will begin January 6, 2020, for 90% compliance for three consecutive months. Once achieved, quarterly random audits of 30 inpatient mental health charts for 90% compliance will continue to ensure sustainment.

Recommendation 10

The Facility Director provides guidance to clinical staff regarding access to consultative resources such as forensic mental health experts, Office of General Counsel, and Ethics Consultation Service.

Concur.

Target date for completion: August 30, 2019

Director Comments

A list of consultative resources including forensic mental health experts, Office of General Counsel, and Ethics Consultation Service will be created by August 5, 2019, and posted on the medical center intranet page. Notification of these resources will be provided to all inpatient mental health clinical staff by August 30, 2019.

OIG Contact and Staff Acknowledgments

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