



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Care and
Excessive Use of Restraints
for a Patient Who Died at
the Charlie Norwood VA
Medical Center in Augusta,
Georgia



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate allegations that a patient died at the Charlie Norwood VA Medical Center (facility) in Augusta, Georgia, due to overmedication, lack of psychiatric provider coverage, and lack of staff communication. The complaint also alleged that the Facility Director failed to ensure adequate psychiatric provider coverage at the facility's Downtown Division.¹ The OIG identified other concerns related to mismanagement of the patient's mental health needs, deficient Disruptive Behavior Committee processes and oversight, and facility leaders' insufficient review and response to the patient's death.

Synopsis of Events

The underlined terms below are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

The patient received primary care and mental health treatment at the facility for multiple conditions including [schizophrenia](#), [chronic obstructive pulmonary disease](#), chronic pain, [hypertension](#), tobacco abuse, and [hyponatremia](#) for many years. The patient had a long history of inpatient mental health treatment admissions including 36 inpatient mental health admissions at the facility since the 1990s. For more than 15 years, outpatient psychiatric providers prescribed [long-acting antipsychotic injectable medication](#) and daily oral medications for the patient's mental illness.

In 2015, facility staff assigned the patient a [category 1 behavioral patient record flag](#) due to a pattern of disruptive behaviors that included credible threats, use of threatening language, and aggressive behaviors toward staff. Starting in fall 2018, the patient received primary care and mental health treatment at another VA medical center.

In spring 2019, the patient received the scheduled, monthly, long-acting antipsychotic injectable medication. Twelve days later, the patient presented to the Uptown Division "walk-in [mental health] clinic" and requested an injection. The patient denied hallucinations, thoughts of suicide, and harm to others. A psychiatrist described the patient as irritable, cooperative, logical, and goal directed, and noted that the patient's next antipsychotic medication injection was not due for another 24 days. The psychiatrist documented the patient's homelessness as a psychosocial

¹ The facility, part of Veterans Integrated Service Network (VISN) 7, consists of the Downtown and Uptown Divisions that are located approximately three miles apart. The Downtown Division includes outpatient and inpatient medicine and surgery; and an emergency department. The Uptown Division includes psychiatry and rehabilitation medicine, and restorative/nursing home beds.

factor and the plan of care included referring the patient to the facility's homeless services program for housing assistance.

The patient presented to the Uptown Division Healthcare for Homeless Veterans the day after the walk-in mental health clinic visit (day 1), as instructed by the psychiatrist. The patient was yelling, cursing, and not appropriately dressed. Healthcare for Homeless Veterans staff called police, and a [code gray](#) was initiated.

The code gray team psychiatrist completed a Form 1013, and the patient was transported to the Downtown Division Emergency Department for an involuntary mental health evaluation.² The patient's blood sodium level was low, and the Emergency Department physician decided to admit the patient to an Inpatient Medical Unit for treatment of hyponatremia.

A medicine resident physician (resident physician 1) placed a routine mental health consultation request for evaluation of medication management and decision-making capacity.³ Upon arrival to the Inpatient Medical Unit, approximately two hours later, a nurse documented that the patient wanted to smoke and was increasingly verbally aggressive and threatening when not allowed to do so. Staff initiated a code gray and the patient continued to be verbally aggressive and threatened to kill a medicine resident physician (resident physician 2). The patient was placed in [four-point restraints](#) and nursing staff administered three intramuscular sedating medications.

The Inpatient Medical Unit physician and resident physician 2 consulted with the Intensive Care Unit (ICU) physician and decided to transfer the patient to the ICU for "more advanced monitoring and treatment." The patient was transferred with supplemental oxygen via facemask for "tentative [intubation](#)."

The patient was continued in restraints on both wrists and was "groggy" and "minimally responsive to pain" with [oxygen saturation](#) in the "80's" while receiving 40 percent of oxygen by facemask. The patient was intubated for acute respiratory distress, placed on a ventilator, and received medication for sedation. The admitting ICU resident physician prescribed a [heparin](#) injection to prevent blood clots.

The patient remained sedated and intubated throughout the night and the following day (day 2). Around noon on day 2, the mental health nurse practitioner (nurse practitioner) reviewed the patient's electronic health record and, although unable to assess the patient "due to sedation,"

² Georgia Form 1013, *Certificate Authorizing Transport to Emergency Receiving Facility & Report of Transportation (Mental Health)*, authorizes peace officers or "other person" to transport an individual to an emergency care facility for the purpose of addressing the individual's mental health symptoms including suicidal and homicidal actions or intent.

³ Facility Policy 6106, *Mental Health (Psychiatric) Referrals & Consults from Clinics, Wards, and the Emergency Department (ED)*, January 25, 2019. Facility policy requires routine (versus urgent or emergency) requests for mental health consultation to be answered within 24 hours. If a request is made outside of normal duty hours, the consult should be responded to on the next business day.

recommended medication management as well as the patient's transfer for an involuntary admission to a non-VA inpatient psychiatric facility when the patient was medically stable. Throughout day 2, and into the early hours of day 3, the patient received medications for chronic medical, but not psychiatric, conditions. The patient remained sedated, intubated, and in restraints.

On day 3 in the early morning, the patient dislodged the ventilator tube but was able to breathe with assistance from supplemental oxygen provided via face mask and the ventilator tube was not replaced. Late in the morning of day 3, the patient was not fully oriented, less agitated, and had paranoid thoughts. By early afternoon, the patient's sodium levels improved, and the inpatient physician (physician 2) documented that the patient was medically stable to be transferred to a mental health treatment facility for continued observation and treatment.

The patient remained in restraints throughout day 3 and nursing staff documented that the patient refused two of the three prescribed daily dosages of heparin. On day 4, nursing staff administered intramuscular sedating medication. Physician 2 renewed the restraint order and the patient continued to be restrained. At 1:00 p.m., the patient refused the scheduled heparin dosage. At approximately 2:00 p.m., physician 3 discharged the patient to the care of the VA Police, who escorted the patient to the medical transport, in bilateral wrist restraints, for involuntary transfer to a non-VA mental health treatment facility. Four hours later, social worker 2 reported that the patient could not be accepted by the non-VA mental health treatment facility due to being in restraints.

At 8:07 p.m., the patient arrived back at the facility's Emergency Department via medical transport on a stretcher and in restraints. On arrival, the patient was loud and argumentative, and staff removed the restraints. The patient walked to the bathroom and appeared disoriented. The nurse documented the patient did not want restraints or medications and was laying on the bed with eyes closed. At approximately 8:40 p.m., the nurse administered the three intramuscular medications ordered by the Emergency Department physician (physician 4) and documented that the patient was breathing with visible rise and fall to the chest wall; however, the patient was not registering a blood pressure. Physician 4 noted that although the monitor indicated a pulse and oxygen saturation in the 90s, the patient was not breathing. The medical team started [cardiopulmonary resuscitation](#) and the patient's heart showed electrical activity but was not beating. At 9:23 p.m., the Emergency Department physician pronounced the patient deceased.

OIG Findings

The OIG did not substantiate that the patient died due to overmedication because the medical examiner listed the cause of death as bilateral [pulmonary thromboemboli](#) with antemortem history of prolonged restraint and noted that the toxicology findings were "noncontributory." However, the OIG identified significant deficiencies throughout the patient's care in the

Emergency Department, Inpatient Medical Unit, and ICU that likely contributed to the patient's death. Emergency Department and Inpatient Medical Unit staff provided inadequate assessment and monitoring of the patient's vital signs, administered unnecessary sedative medication, and Inpatient Medical Unit nurses inaccurately documented medication administration. The OIG concluded that facility staff's failure to monitor the patient's response to medications and vital signs placed the patient at an increased risk of an adverse clinical outcome.⁴ Additionally, due to inaccurate documentation of medication administration times, the OIG was unable to confirm actual medication administration times and could not thoroughly evaluate the patient's care.

The OIG also found that Inpatient Medical Unit and ICU staff improperly ordered and initiated medical surgical restraint for the patient when documentation reflected use of restraint for behavioral control.⁵ Further, ICU staff kept the patient in restraints excessively without a physician's order. Additionally, the Inpatient Medical Unit and ICU nurses did not receive consistent ongoing education on restraint use and monitoring, as required by facility policy. The OIG concluded that staff's failure to properly implement orders and document observations consistently throughout the patient's restraint led to the prolonged restraint use that contributed to the patient's death.

Moreover, nursing staff documented that the patient refused heparin doses, but the OIG found no documented efforts to inform physicians or address the importance of deep vein thrombosis prophylaxis with the patient or a family member, as the OIG would have expected. The OIG team did not find documentation regarding the patient being in restraints upon discharge. Given that the patient was restrained for approximately 71 hours, the OIG concluded that the staff's failure to effectively address the patient's deep vein thrombosis prophylaxis needs contributed to the patient's death.

The OIG also found that staff did not assess the patient for nicotine replacement therapy upon admission or upon a request to smoke, as required by Veterans Health Administration (VHA).⁶ Given the patient's schizophrenia diagnosis, the staff's failure to address the patient's nicotine

⁴ Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for a higher level of care.

⁵ The required frequency of staff's assessment and observations of a patient depends on whether the restraint is used for medical surgical control or behavioral control. Restraints for behavioral control require more frequent assessment and observation.

⁶ VHA Directive 1056, *National Smoking and Tobacco Use Cessation Program*, February 10, 2014. This directive was rescinded and replaced with VHA Directive 1056, *National Smoking and Tobacco Use Cessation Program*, September 5, 2019. VHA Patient Care Services, "Schizophrenia & Tobacco Use," https://www.mentalhealth.va.gov/quit-tobacco/docs/SchizophreniaandTobaccoUse_508.pdf. (The website was accessed on December 2, 2019.) Individuals diagnosed with schizophrenia are more likely to smoke than the general population and almost half of VHA patients with schizophrenia smoke cigarettes. Research suggests that smoking may be a self-medicating process and provides relief from schizophrenia symptoms.

dependence may have contributed to the worsening of the patient's agitation and distress that led to the second code gray event and subsequent medication, sedation, intubation, and restraint.

The OIG found that facility leaders and staff failed to comply with the Georgia State involuntary commitment process requirements, which may have contributed to the mismanagement of the patient's mental health treatment needs and the patient's death.⁷ Specifically, the OIG found that staff proceeded on day 1 as if the facility was a Georgia State-approved emergency receiving facility. Had the patient been taken to an emergency receiving facility, staff at that facility likely would have evaluated the patient's "mental illness and substantial risk of imminent harm to self or others," and determined the need for an involuntary or voluntary mental health treatment admission.⁸ The OIG concluded that the patient's mental health treatment needs could have been prioritized immediately at an emergency receiving facility and the problems that emerged as a result of the patient's admission to the facility's Inpatient Medical Unit for hyponatremia, a nonemergent chronic medical condition, may have been avoided.

Due to the OIG concerns about the facility's assessment of this patient's decision-making capacity, the OIG reviewed decision-making capacity consult requests for the 79 mental health inpatient consults placed during a 12-month period that included the time frame of the patient's hospital stay and death. Thirteen consults included a decision-making capacity assessment request. A psychologist responded to 8 of the 13 decision-making capacity assessment requests. Staff failed to complete four decision-making capacity assessments including the patient. Of these four consults, a nurse practitioner completed medication management for three patients, and one patient was transferred to another facility prior to an evaluation but after the required time frame for consult completion.

The OIG concluded that facility staff's failure to determine the patient's decision-making capacity contributed to the patient's negative outcomes by not evaluating the patient's ability to provide informed consent for treatment and further precluded their consideration of involving the patient's family in major decisions including deep vein thrombosis prophylaxis. Although the OIG did not identify adverse clinical outcomes for the three other patients who did not receive a requested decision-making capacity assessment, the failure to evaluate decision-making capacity may place patients at increased risk for adverse clinical outcomes.

⁷ Georgia Department of Behavioral Health and Developmental Disabilities, *Emergency Admission Process Map*, March 29, 2016. https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Emergency%20Admission%20Process%20Map%203.29.16.pdf. (The website was accessed on October 13, 2019.) Georgia Department of Behavioral Health and Developmental Disabilities, *Legal Status for DBHDD Hospitals, 24-106*, <http://gadbhdd.policystat.com/policy/2583641/>. July 6, 2016. (The website was accessed on March 9, 2020.)

⁸ Georgia Form 1013 and *Form 2013-Certificate Authorizing Transport to Emergency Receiving Facility and Report of Transportation*, 01-110, *December 1, 2014*. <https://gadbhdd.policystat.com/policy/1136700/latest/>, *December 1, 2014*. (The website was accessed on March 9, 2020.)

The OIG substantiated that the lack of mental health provider involvement likely contributed to the patient's death. The OIG would have expected a mental health provider to be involved on day 1 to provide recommendations regarding the patient's mental health treatment and symptom management prior to the second code gray event. If a mental health provider was involved earlier, the patient's nicotine dependence may have been handled more effectively and strategies other than sedation and restraint may have been identified to manage the patient's agitation. Although a psychiatric nurse practitioner addressed medication management issues, the consult did not occur until day 2 when the patient was already intubated.⁹

The OIG substantiated that facility staff failed to inform the receiving non-VA mental health treatment facility that the patient was in restraints. The receiving facility would not accept patients in restraints and therefore the patient endured an unnecessary four-hour ambulance trip in restraints that likely contributed to the development of pulmonary thromboemboli. The attending provider (physician 3) did not complete an interfacility transfer note, communicate with the receiving provider, or document the patient's informed consent to transfer, as required. The attending provider told the OIG team that speaking with receiving providers was not typically done by attending providers and that the facility staff did not complete transfer note documentation. Further, no staff informed the receiving facility that the patient was held in bilateral wrist restraints. The OIG also found that the administrative officer did not participate in the after-hours transfer, as required by facility policy, because the administrative officer assumed a social worker arranges transport for patients on a Form 1013.¹⁰

The OIG substantiated that the Downtown Division lacked adequate psychiatric providers to manage code gray events, as required by facility policy. The OIG determined that leaders failed to ensure the Downtown Division included a consultation liaison psychiatrist on the code gray team, as required by facility policy. The OIG concluded that the lack of a consultation liaison psychiatrist likely contributed to staff's failure to respond effectively to the patient's behavioral emergency and therefore contributed to mismanagement of the patient's mental health needs.

The OIG also found that nurse practitioners had been cancelling Uptown Division outpatient appointments to respond to Downtown Division mental health consult requests. Additionally, the OIG found that providers did not consistently answer mental health consults within the time

⁹ Facility Policy 6106. The routine mental health consult was to be completed within 24 hours, and the psychiatric nurse practitioner responded to the consult on day 2, following the patient's second code gray event, sedation, and subsequent intubation.

¹⁰ VHA Directive 1096, *Administrative Officer of the Day (AOD)*, December 5, 2014. This directive was in effect during the time frame of the events discussed in this report. The directive was rescinded and replaced by VHA Directive 1096, *Administrative Officer of the Day*, March 27, 2020. The two directives contained the same or similar language concerning administrative officer of the day operations and duty hours. The administrative officer of the day maintains the operations of all administrative activities during other than normal duty hours (usually consists of Monday through Friday, 8:00 a.m. to 4:30 p.m.).

frames required by facility policy.¹¹ The OIG concluded that the staff's failure to promptly respond to mental health inpatient consultation requests may contribute to delays in the provision of critical treatment interventions and decision-making capacity evaluations.

Following the OIG's June 2019 site visit, the Facility Director completed a review of mental health coverage at the Uptown and Downtown Divisions and in August 2019 reported that a proposal to expand mental health coverage at the Uptown and Downtown Divisions was in place, but the staff had not yet started. In January 2020, the Chiefs of Mental Health and Social Work reported that the expanded mental health coverage occurred in the Emergency Department at the Downtown Division and was partially implemented in the outpatient mental health areas at the Uptown Division. However, the facility Accreditation Specialist reported that the Downtown Division mental health consult request coverage remained the same.

The OIG found that facility staff failed to review the patient's category 1 patient record flag placed in 2015 until after a disruptive incident occurred in 2018. Further, the OIG found that the Disruptive Behavior Committee did not provide input into the patient's management to mitigate violence risk following two incidents in late 2018, as expected. Additionally, the Disruptive Behavior Committee did not provide oversight of the code gray team activities, as required by facility policy.¹² However, the Chair, Disruptive Behavior Committee told the OIG that the Disruptive Behavior Committee's role included review of disruptive behavior reports and not oversight of code gray events. The OIG concluded that the Disruptive Behavior Committee failed to provide effective input on the patient's treatment plan to address factors that may have reduced the patient's risk of violence throughout the patient's care and that this failure may have contributed to a mismanagement of the patient's mental health treatment needs throughout the patient's final episode of care.

The OIG found that staff did not complete code gray evaluation forms and that the Disruptive Behavior Committee did not ensure review of code gray events, as required by facility policy. The OIG concluded that facility staff did not receive education in completion of the code gray evaluation forms, responsible oversight staff did not review code gray incidents, and leaders did not receive any aggregate reports that identify trends or lessons learned from code gray events. As such, leaders did not have the data regarding gaps and areas for improvement to implement performance improvement plans.

¹¹ The language in Facility Policy 6106, *Mental Health (Psychiatric) Referrals & Consults from Clinics, Wards, and the Emergency Department (ED)*, January 25, 2019, was not consistent with the electronic health record consult request form. The language difference allowed for confusion and the potential for providers to choose an incorrect option within the template that could affect response time to address patients' mental health needs.

¹² Facility Policy 6012.

While the OIG team was on-site, the Facility Director initiated a root cause analysis regarding the patient's death.¹³ The OIG identified deficiencies in the patient's care not found by the root cause analysis team including that the patient (1) remained in restraints for approximately 22 hours without a provider's order, (2) was placed in four-point restraints although the provider's order was for two-point restraints, and (3) the Disruptive Behavior Committee lacked expected input and code gray oversight. Given these OIG-identified care deficits, facility leaders should consider an institutional disclosure, conduct a full review of the patient's care from day 1 until the patient's death, and consult with Human Resources and General Counsel Offices to determine whether personnel actions are warranted.

Recommendations

The OIG made 18 recommendations to the Facility Director related to a full review of the patient's care, consideration of an institutional disclosure and personnel actions, vital sign assessment and monitoring of patients receiving sedating medications, medication administration documentation, restraint management and education, communication of patients' refusal of treatment, nicotine replacement therapy processes, informed consent procedures and treatment decisions, decision-making capacity consults, management of patients presenting under a Form 1013, interfacility transfer policies and procedures, inclusion of a consult liaison psychiatrist on the code gray team, inpatient mental health consult processes, code gray policy staff education, and Disruptive Behavior Committee processes and oversight functions.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to allow time for the facility to submit documentation of actions taken and to ensure they have been effective and sustained.



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¹³ The Acting Chief of Quality Management told the OIG that the patient's death did not meet criteria for a root cause analysis at the time of death but that additional clinical reviews led to the decision to conduct the root cause analysis. RCA results are considered confidential medical quality-assurance records pursuant to 38 U.S.C. § 5705.

Contents

Executive Summary	i
Abbreviations	xi
Introduction.....	1
Allegations and Concerns	3
Scope and Methodology	4
Patient Case Summary	6
Inspection Results	10
1. Overmedication and Patient Care Deficiencies.....	10
2. Lack of Mental Health Provider Involvement	23
3. Lack of Communication.....	26
4. Inadequate Downtown Division Psychiatric Coverage.....	28
5. Other Concern: Deficient Disruptive Behavior Committee Processes and Oversight.....	32
6. Other Concern: Lack of Facility Review and Response	35
Conclusion	37
Recommendations 1–18.....	41
Appendix A: VISN Director Memorandum	43
Appendix B: Facility Director Memorandum.....	44
Facility Director Response.....	45

Glossary56

OIG Contact and Staff Acknowledgments60

Report Distribution61

Abbreviations

ERF	emergency receiving facility
ICU	Intensive Care Unit
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate allegations that a patient died at the Charlie Norwood VA Medical Center (facility), Augusta, Georgia, due to overmedication, lack of psychiatric provider coverage, and lack of staff communication, and that the Facility Director failed to ensure adequate psychiatric provider coverage at the facility's Downtown Division. The OIG identified other concerns related to mismanagement of the patient's mental health needs, deficient Disruptive Behavior Committee processes and oversight, and facility leaders' insufficient review and response to the patient's death.

Background

The facility, part of Veterans Integrated Service Network (VISN) 7, is composed of the Downtown and Uptown Divisions that are located approximately three miles apart. The facility provides tertiary care in medicine, surgery, neurology, psychiatry, rehabilitation medicine, and spinal cord injury. From October 1, 2017, through September 30, 2018, the facility served 45,949 patients and had a total of 407 operating beds including medicine and surgery beds at the Downtown Division and psychiatry and rehabilitation medicine beds at the Uptown Division. The facility's Emergency Department is located at the Downtown Division. The Uptown Division includes a 132-bed restorative/nursing home care unit and a 60-bed domiciliary. The facility operates three community-based outpatient clinics located in Athens and Statesboro, Georgia, and Aiken, South Carolina. The facility has sharing agreements with the Eisenhower Army Medical Center at Fort Gordon, Georgia, and is affiliated with the Augusta University Medical College of Georgia.

Involuntary Commitment Process

Involuntary commitment is the process whereby individuals who are a danger to themselves or others, may, under state law, be temporarily detained and placed in a hospital setting for mental health evaluation and treatment. Involuntary admissions must be managed according to state law.¹⁴ The Veterans Health Administration (VHA) requires facilities to establish policy that addresses transfer of a patient following psychiatric stabilization to provide a needed higher level of care or involuntary admission if that facility does not have the capability.¹⁵

¹⁴ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

¹⁵ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017.

Under Georgia law, certain individuals (licensed physician, psychologist, clinical social worker, and clinical nurse specialist in psychiatric mental health) can issue a *Certificate Authorizing Transport to Emergency Receiving Facility & Report of Transportation (Mental Health)* (Form 1013) that authorizes transport of an individual to an emergency receiving facility (ERF) for examination to determine whether admission is necessary when patients present with a substantial risk of imminent harm to self or others. Form 1013 authorizes an individual's transportation to an ERF for examination to determine whether admission is necessary treatment.¹⁶ Form 1013 specifies that a patient "should not be referred to Emergency Rooms for 'medical clearance,' but for a specific complaint that would normally be seen in an emergency department" (such as chest pain, delirium, or shortness of breath). Further, a completed Form 1013 does not establish authority for a non-ERF to hold a person involuntarily.¹⁷ The Georgia Department of Behavioral Health and Developmental Disabilities may designate any state-owned and private hospital as an ERF.¹⁸ Georgia State Code § 37-3-102 (a) addresses the authority of the state with regard to Georgia patients who are eligible for VA care and who are involuntarily committed.¹⁹ Specifically, after appropriate notification from the VA, the patient will be evaluated by the nearest ERF.²⁰ The facility's ERF status is discussed later in this report.

Within 48 hours of arrival at the ERF, a mental health provider must either discharge the patient or complete the *Certificate Authorizing Transfer from Emergency Receiving Facility to Evaluating Facility* (Form 1014). The mental health provider completes a Form 1014 to certify that the patient may be mentally ill and may present a substantial risk of imminent harm to self or others and should be assessed in an evaluating facility for possible admission to a treatment facility.²¹ Within five days, the evaluating facility mental health provider must discharge the

¹⁶ Georgia Department of Behavioral Health and Developmental Disabilities, *Form 1013 - Certificate Authorizing Transport to Emergency Receiving Facility and Report of Transportation (Mental Health)*, last revised February 14, 2017. <https://gadbhdd.policystat.com/policy/1136700/latest/>. (The website was accessed on March 9, 2020.)

¹⁷ Georgia Department of Behavioral Health and Developmental Disabilities, *Frequently Asked Questions*, <https://gadbhdd.policystat.com/policy/1136700/latest/>. Version October 4, 2018. (The website was accessed on November 30, 2019.)

¹⁸ Georgia Code § 37.3.40, Designation by Department of Emergency Receiving Facilities, October 14, 2016. <https://law.onecle.com/georgia/title-37/37-3-40.html>. (The website was accessed on October 8, 2019.)

¹⁹ Georgia Code § 37.3.102, Transfer of patients to custody of federal agencies for diagnosis, care, or treatment; retention of jurisdiction by Georgia courts; and jurisdiction in federal hospitals and institutions located in Georgia, August 20, 2013. <http://ga.elaws.us/law/section37-3-102>. (The website was accessed on October 8, 2019.)

²⁰ Georgia Code § 37.3.102, Transfer of patients to custody of federal agencies for diagnosis, care, or treatment; retention of jurisdiction by Georgia courts; and jurisdiction in federal hospitals and institutions located in Georgia, August 20, 2013. <http://ga.elaws.us/law/section37-3-102>. (The website was accessed on October 8, 2019.)

²¹ Georgia Department of Behavioral Health and Developmental Disabilities, *Form 1014 - Certificate Authorizing Transfer from Emergency Receiving Facility to Evaluating Facility*. <https://gadbhdd.policystat.com/policy/2583641/latest/>, July 15, 2015. (The website was accessed on March 9, 2020.)

patient, admit the patient voluntarily, or initiate legal proceedings to admit the patient involuntarily.²²

Prior OIG Reports

In the 2019 report, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center*, the OIG identified concerns with facility staff not feeling supported by leadership, an inefficient hiring process, and inadequate communication of policies, among other administrative issues. The OIG made 27 recommendations, 14 of which remained open as of May 2020.²³

Allegations and Concerns

In spring 2019, the OIG received allegations and subsequently identified concerns related to a patient who died at the facility:

Allegation 1. A patient death due to overmedication

Related Concern: Mismanagement of a patient's mental health treatment needs

Allegation 2. A patient death due to a lack of mental health provider involvement

Allegation 3. A patient death due to a lack of staff communication

Allegation 4. Facility Director's failure to ensure adequate psychiatric provider coverage at the Downtown Division

5. Other Concern: Deficient Disruptive Behavior Committee processes and oversight

6. Other Concern: Lack of facility review and response²⁴

²² Georgia Department of Behavioral Health and Developmental Disabilities, *Emergency Admission Process Map*, March 29, 2016.
https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Emergency%20Admission%20Process%20Map%203.29.16.pdf. (The website was accessed on October 13, 2019.) Georgia Department of Behavioral Health and Developmental Disabilities, *Legal Status for DBHDD Hospitals, 24-106*, <http://gadbhdd.policystat.com/policy/2583641/>, Effective July 6, 2016. (The website was accessed on March 9, 2020.)

²³ VA OIG, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No. 19-00497-161, July 11, 2019.

²⁴ The original allegation referred to a lack of psychiatric provider involvement. For purposes of this inspection, the OIG team reviewed involvement of all mental health providers including psychiatrists, psychologists, and psychiatric nurse practitioners.

Scope and Methodology

The OIG initiated the healthcare inspection on May 9, 2019, and conducted a site visit from June 17–20, 2019.

The OIG team reviewed applicable VHA and facility policies and procedures related to mental health services, relevant provisions of Georgia State law, medication administration, restraint use, inter-facility transfers, informed consent, consults, on-call coverage, outpatient clinic scheduling, and patient safety. Other documents reviewed included relevant empirical literature and The Joint Commission guidelines.

The OIG team reviewed nursing restraint education records from May 27, 2016, through August 7, 2019, for the Intensive Care Unit (ICU) and Inpatient Medical Unit nurses. The OIG team reviewed meeting minutes for the Medical Center Resource Committee, Operational Resources Management Council, Organizational Resource Board, and Disruptive Behavior Committee. Additionally, the OIG team reviewed documentation related to the patient including issue briefs, incident reports, police reports, and disruptive behavior reports. The OIG team reviewed the patient’s electronic health record and the medical examiner’s autopsy report.

The OIG team interviewed VHA, VISN, and facility leaders, who were knowledgeable about relevant processes, and facility staff who were involved in the patient’s care.²⁵ The OIG team conducted a tour of the Emergency Department and ICU.

The OIG team reviewed a random sample of 79 electronic health records (60 unique patients) related to inpatient mental health consult service requests from July 1, 2018, through June 30, 2019, at the Downtown Division to evaluate consult response times, consult discontinuations and cancellations, and patients’ decision-making capacity assessments.²⁶ The OIG team also reviewed 313 “canceled by clinic” outpatient mental health clinic appointments for two nurse practitioners from July 1, 2018, to June 30, 2019.²⁷

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).

²⁵ The OIG interviewed the VHA Director of Inpatient and Outpatient Mental Health Recovery and Deputy Chief Consultant Mental Health Services; VISN 7 Chief Mental Health Officer; and Deputy Chief Counsel, Office of General Counsel; and the facility Director, Chief of Staff, Associate Director of Patient Care Services, Associate Director, Chief of Mental Health, Chief Nurses of Mental Health and Medicine, and Associate Chief of Social Work.

²⁶ The random sample of 79 (60 unique patients) electronic health record reviews was identified from the 545 (409 unique patients) inpatient mental health consult requests submitted from July 1, 2018, to June 30, 2019.

²⁷ The two nurse practitioners covered the Downtown Division inpatient mental health consult service.

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.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, § 7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leadership on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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.

Patient Case Summary

The underlined terms below are hyperlinks to a glossary. To return from the glossary, press and hold the “alt” and “left arrow” keys together.

The patient was in their 60s at the time of death and had received primary care and mental health treatment at the facility for many years.²⁸ The patient’s medical history included [schizophrenia](#), [schizoaffective disorder, bipolar type](#), [alcohol abuse](#), [chronic obstructive pulmonary disease](#), chronic pain, [cocaine dependence](#), [gastro-esophageal reflux disease](#), [hypertension](#), tobacco abuse, and chronic [hyponatremia](#). The patient had a long history of inpatient mental health treatment admissions including 36 inpatient mental health admissions at the facility since the 1990s. For more than 15 years, outpatient psychiatric providers prescribed [long-acting antipsychotic injectable medication](#) for the patient’s mental illness. Throughout the patient’s treatment, providers prescribed other daily oral medications in addition to the long-acting antipsychotic injectable medication.

In 2015, facility staff assigned the patient a [category 1 behavioral patient record flag](#) due to a pattern of disruptive behaviors that included credible threats, use of threatening language, and aggressive behaviors toward staff. The patient record flag instructed staff to request assistance from police during patient interactions.²⁹ Starting in fall 2018, after a non-VA psychiatric admission, the patient received primary care and mental health treatment at another VA medical center until the patient’s death.

In spring 2019, the patient received a scheduled, monthly, long-acting antipsychotic injectable medication at the other VA medical center and was scheduled there for the next injection the next month. However, 12 days after the spring 2019 injection, the patient presented to the Uptown Division “walk-in [mental health] clinic” and requested another injection. The patient denied hallucinations, thoughts of suicide, and harm to others. A psychiatrist described the patient as irritable, cooperative, logical, and goal directed and noted that the patient’s next antipsychotic medication injection was not due for another 24 days. The psychiatrist documented the patient’s homelessness as a psychosocial factor and the plan of care included referring the patient to the facility’s homeless services program for housing assistance.

The day after the visit to the facility’s walk-in mental health clinic (day 1) at approximately noon, the patient presented to the Uptown Division Healthcare for Homeless Veterans. A social worker documented that the patient was “yelling and asking to see someone in the homeless

²⁸ The OIG uses the singular form of they (their) in this context for the purpose of patient privacy.

²⁹ VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010. A “category 1 patient record flag – violent or disruptive behavior” is an alert in a patient’s electronic health record that identifies a patient who poses a safety risk to administrative and clinical staff. A category 1 patient record flag is shared across all known treating facilities for a given patient to ensure that all staff are aware of all safety risks within VHA.

program. Veteran was very loud and aggressive in tone, cursing, etc. Veteran was not appropriately dressed, [the patient] had [the patient's] trouser down not zipped or buttoned in the front.”

Healthcare for Homeless Veterans staff called police and a [code gray](#) was initiated.³⁰ The patient was with police in front of the Uptown Division's entrance when the code gray team arrived. The police told the code gray team psychiatrist that the patient “had been to see Homeless Program staff, had become angry and left.” The code gray team psychiatrist described the patient as angry, aggressive, intoxicated, and threatening.

The code gray team psychiatrist completed a Form 1013, and a medical transport driver and the VA Police received copies.³¹ The patient was then transported to the Downtown Division Emergency Department for an involuntary mental health evaluation. The patient arrived at the Emergency Department approximately 30 minutes later, and staff documented that the patient was aggressive, yelling, would not answer questions, and refused an examination. Nursing staff administered intramuscular [ziprasidone](#), as ordered by the physician. A social worker (social worker 1) assessed the patient as angry, agitated, “mostly non-cooperative,” alert, oriented to person and place, and with disorganized thought processes. Social worker 1 described the patient's speech as “ranging from loud to mumbled (cursing at times), slurred, rambling.” Social worker 1 recommended that the patient be admitted to a non-VA inpatient mental health unit once medically cleared.

The patient's blood sodium level was low, and the Emergency Department physician decided to admit the patient to an Inpatient Medical Unit for treatment of hyponatremia. The patient's toxicology laboratory test results did not detect alcohol or illicit drug use.³² That afternoon, the Inpatient Medical Unit physician (physician 1) wrote orders for the patient's medical inpatient admission and listed the patient's condition as stable. While the patient slept, an internal medicine resident physician (resident physician 1) completed an admission history and physical examination in the Emergency Department.

³⁰ Facility Policy 6012, *Behavioral Emergency—Code Gray*, February 7, 2019. Facility staff may initiate a code gray to dispatch a special team in the event of a behavioral emergency.

³¹ Georgia Form 1013 authorizes peace officers or “other person” to transport an individual to an emergency care facility for the purpose of addressing the individual's mental health symptoms including suicidal and homicidal actions or intent.

³² The facility Emergency Department urine toxicology screen tested for the presence of opiates, amphetamines, barbiturates, cannabinoids, benzodiazepines, cocaine, and oxycodone.

Resident physician 1 also wrote orders for one-to-one observation and for medications for the patient's chronic medical conditions, and placed a routine mental health consultation request.³³ Approximately seven hours after arrival, the patient was discharged from the Emergency Department and transported by wheelchair for admission to the medical unit.

Shortly after arrival to the Inpatient Medical Unit, a nurse documented that the patient wanted to go outside and smoke and was increasingly verbally aggressive and threatening when not allowed to do so. Staff further documented that the patient was unable to be redirected or calmed down. Within an hour, staff initiated a code gray, and the patient continued to be verbally aggressive and threatened to kill a medicine resident physician (resident physician 2). The patient was placed in [four-point restraints](#). The patient "continued to be verbally abusive and attempted to bite, kick and spit at staff." Nursing staff administered intramuscular ziprasidone 10 milligrams, [diphenhydramine](#) 50 milligrams, and [lorazepam](#) 6 milligrams, as ordered by resident physician 2.

Physician 1 and resident physician 2 consulted with the ICU physician and decided to transfer the patient to the ICU for "more advanced monitoring and treatment." Resident physician 2 documented that the patient was easily arousable after the medication administration and the patient was transferred with supplemental oxygen via facemask. An Inpatient Medical Unit nurse documented that the patient was transferred for "tentative intubation."

ICU staff continued restraints on both the patient's wrists. The patient was described by the receiving ICU nurse as "groggy" and "minimally responsive to pain" with [oxygen saturation](#) in the "80's" while receiving 40 percent oxygen by facemask. Approximately two hours after arrival in the ICU, the patient was [intubated](#) for acute respiratory distress and placed on a ventilator, which resulted in 100 percent oxygen saturation. The nurses administered medication for sedation. Additionally, the admitting ICU resident physician (resident physician 3) prescribed a [heparin](#) injection to prevent blood clots.

The patient remained sedated and intubated throughout the night and the following day (day 2). Around noon on day 2, the mental health nurse practitioner (nurse practitioner) reviewed the patient's electronic health record and was unable to assess the patient "due to sedation." The nurse practitioner recommended administering the patient the most recently prescribed outpatient psychiatric medications. Further, the nurse practitioner recommended two intramuscular medications "as needed" for agitation and transfer for an involuntary admission to an inpatient psychiatric facility when the patient was medically stable. Throughout day 2, and into the early

³³ Facility Policy 6106, *Mental Health (Psychiatric) Referrals & Consults from Clinics, Wards, and the Emergency Department (ED)*, January 25, 2019. Facility policy requires routine (versus urgent or emergency) requests for mental health consultation to be answered within 24 hours. If a request is made outside of normal duty hours, the consult should be responded to on the next business day.

hours of day 3, the patient received medications for chronic medical, but not psychiatric, conditions. The patient remained sedated, intubated, and in restraints.

On day 3 in the early morning, the patient dislodged the ventilator tube but was able to breathe with assistance from supplemental oxygen provided via face mask, so the ventilator tube was not replaced. Late in the morning of day 3, the nurse practitioner documented that the patient was oriented to name but was unable to identify place or date. The patient was less agitated with a “labile mood, blunt affect and unpredictability.” The patient endorsed racing thoughts, irritability, and paranoia. The patient denied hallucinations and “vehemently” denied suicidal and homicidal ideation, intent, or plan. The nurse practitioner noted the patient had limited insight and again recommended starting the additional psychiatric medications and transferring the patient for involuntary mental health treatment, when medically stable. By early afternoon, the patient’s sodium levels improved, and the inpatient physician (physician 2) documented that the patient was medically stable to be transferred to a mental health treatment facility for continued observation and treatment.

The patient remained in restraints throughout day 3 and nursing staff documented that the patient refused two of the three prescribed daily dosages of heparin. Social worker 1 documented that the patient was ready for transfer to an inpatient mental health unit and that the patient’s being in restraints may be a barrier to placement at another facility. Social worker 1 sent referral packets to 10 inpatient mental health treatment facilities with no final disposition by the end of day 3.

By mid-morning of day 4, another physician (physician 3) documented that the patient still wanted to smoke and continued to have disruptive behavior and further noted “I hope that [the patient] does not need intubation for reasons of providing sedation.” Physician 3 documented the need for continued use of restraints. One hour later, a nurse administered 10 milligrams [olanzapine](#) by intramuscular injection to the patient for agitation. A social worker (social worker 2) documented that the patient was accepted to a non-VA mental health treatment facility. Shortly thereafter, physician 2 renewed the restraint order, and the patient continued to be restrained. The patient refused the afternoon scheduled heparin dosage.

A nurse documented the name and contact information for a nurse at the accepting non-VA mental health treatment facility. Mid-afternoon, physician 3 discharged the patient to the care of the VA Police who escorted the patient, in bilateral wrist restraints, to the medical transport for involuntary transfer to the non-VA mental health treatment facility.

Four hours after the departure, social worker 2 received a phone call from the non-VA mental health treatment facility and was told that the patient arrived but could not be accepted due to being in restraints. Social worker 2 documented being unaware that the patient was in restraints. Social worker 2 notified the ICU charge nurse that the patient was returning to the facility and was informed that the patient could not be readmitted to the ICU and would need to go to the Emergency Department upon arrival.

After another four hours, the patient arrived at the Emergency Department via medical transport on a stretcher and in restraints. Medical transport staff reported that the patient was quiet and then unpredictably explosive during transport. On arrival, the patient was loud and argumentative, and staff removed restraints. The patient walked to the bathroom and appeared disoriented. A nurse documented that the patient did not want restraints or medications and that the patient laid on the bed with eyes closed. To assist with sedation, the Emergency Department physician (physician 4) prescribed 5 milligrams intramuscular [haloperidol](#), 2 milligrams intramuscular lorazepam, and 50 milligrams intramuscular diphenhydramine.

The nurse administered the intramuscular medications about 40 minutes after the patient's return and documented that the patient was breathing with visible rise and fall to the chest wall; however, the patient was not registering a blood pressure. The Emergency Department physician reassessed the patient and noted that although the monitor indicated a pulse was present and oxygen saturation in the 90s, the patient was not breathing.

The medical team started [cardiopulmonary resuscitation](#) and moved the patient to a critical care bed in the Emergency Department.³⁴ The team noted that the patient's heart showed electrical activity but was not beating. The patient was intubated and placed on a ventilator. The team continued compressions and administered resuscitative medications without changes in the patient's condition. Less than an hour after admission, the Emergency Department physician pronounced the patient deceased. The medical examiner listed the cause of death as bilateral [pulmonary thromboemboli](#) with antemortem history of prolonged restraint and noted that the toxicology findings were "noncontributory."

Inspection Results

1. Overmedication and Patient Care Deficiencies

The OIG did not substantiate that the patient died due to overmedication, because the medical examiner listed the cause of death as bilateral pulmonary thromboemboli with antemortem history of prolonged restraint and noted that the toxicology findings were "noncontributory." However, the OIG identified significant care deficiencies during the patient's care in the Emergency Department, Inpatient Medical Unit, and ICU that likely contributed to the patient's death. Specifically, the OIG found that Emergency Department and Inpatient Medical Unit staff provided inadequate assessment and monitoring of the patient's vital signs, administered unnecessary sedative medication, and Inpatient Medical Unit nurses inaccurately documented medication administration. The OIG also found that Inpatient Medical Unit and ICU staff

³⁴ Facility Policy 02-15-36, *Cardiopulmonary Resuscitation Alert (Code Blue)*, December 9, 2015. Facility staff may initiate a code blue to dispatch a special team in the event of a cardiopulmonary arrest.

improperly ordered and documented medical surgical restraints for behavioral control of the patient. Further, the ICU staff kept the patient in restraints excessively without a physician's order. The OIG also found that Inpatient Medical Unit and ICU nurses did not receive consistent ongoing education on restraint use and monitoring, as required by facility policy.

Further, nursing staff documented that the patient refused heparin doses, but the OIG found no documented efforts to inform physicians or address the importance of deep vein thrombosis prophylaxis with the patient or family member, as the OIG team would have expected. The OIG also found that staff did not assess the patient for nicotine replacement therapy upon admission or upon a request to smoke, as required by VHA.³⁵

Emergency Department Care

The OIG found that Emergency Department staff provided inadequate assessment and monitoring of the patient's vital signs and administered unnecessary sedative medication that likely contributed to the patient's death. VHA requires Emergency Department staff to perform examinations to diagnose medical conditions that may be responsible for a patient's psychiatric condition.³⁶ The OIG found that staff failed to obtain the patient's vital signs and therefore may have missed abnormal or warning signs of patient deterioration such as low oxygen saturation or changes in heart rate and blood pressure.

On day 4, upon the patient's return to the Emergency Department from the round-trip ambulance transport, the physician documented that the patient was agitated, restrained, and due to the patient's aggression, it was too dangerous to take the patient's vital signs. On arrival, the patient was loud and argumentative, and staff removed restraints. Facility police were called to the patient's bedside and the patient calmed down. The patient walked to the bathroom and appeared disoriented. Nursing staff helped the patient walk to a bed. The patient voiced a desire to not be in restraints or medicated and did not respond further to nursing staff. Nursing staff then administered haloperidol, lorazepam, and diphenhydramine, as ordered by physician 4, and subsequently documented that the patient was breathing, but staff were unable to find a pulse. Emergency Department staff initiated cardiopulmonary resuscitation efforts but were unable to resuscitate the patient.

³⁵ VHA Directive 1056, *National Smoking and Tobacco Use Cessation Program*, February 10, 2014. This directive has been rescinded and replaced with VHA Directive 1056, *National Smoking and Tobacco Use Cessation Program*, September 5, 2019. VHA Directive 1085, *Smoke-Free Policy for Patients, Visitors, Contractors, Volunteers, and Vendors at VA Health Care Facilities*, March 5, 2019. VHA required that all VHA healthcare facilities be smoke-free for patients, visitors, contractors, volunteers, and vendors effective October 1, 2019. For the time frame reviewed for this report the facility was not required to be smoke-free.

³⁶ VHA Directive 1101.05(2).

The OIG would have expected Emergency Department staff to obtain the patient's vital signs given that the patient was calm and disoriented. Testing should have been pursued to identify potential underlying medical conditions causing the patient's change in demeanor and disorientation, such as [hypoxia](#) or delirium. Although the patient was calm, nursing staff administered sedating medication without examination to identify possible underlying medical causes for the patient's presenting symptoms.³⁷ The OIG concluded that although the medical examiner noted that the toxicology findings were "noncontributory" to the patient's death, staff failed to complete a medical examination of the patient and administered sedation medication unnecessarily. If staff had evaluated vital signs, they may have identified the patient's pulmonary thrombosis and provided treatment to prevent the patient's death.

Medication Administration During Hospitalization

VHA requires that facilities comply with The Joint Commission standards of quality and safety.³⁸ The Joint Commission requires that patient health record documentation include the medication administered, dosage, route given, and date and time of administration.³⁹ Facility policy requires that licensed nurses administer only those medications that they personally sign out.⁴⁰

Day 1 electronic health record documentation indicated that over the course of four minutes, Inpatient Medical Unit staff administered five intramuscular medications, all with potential sedative effects, for the patient's agitated and combative behavior. Barcode medication administration records indicated that an Inpatient Medical Unit nurse (nurse 1) administered three intramuscular lorazepam doses that totaled six milligrams within four minutes.⁴¹ Nurse 1 told the OIG that she may have administered the first dose, but then went to another floor to retrieve additional ordered medications for the patient. Nurse 1 acknowledged that the recorded medication administration times did not actually reflect the time the patient received the medication. Another Inpatient Medical Unit nurse (nurse 2) reported administering one medication dose. Nurses 1 and 2 documented the total lorazepam dosages administered but not who administered the dosage, the amount given, and the time administered. The medication

³⁷ VHA Directive 1101.05(2).

³⁸ VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. The Joint Commission is an accrediting body that sets hospital quality and performance standards.

³⁹ The Joint Commission, *Standards Manual*, RC.02.01.01, January 1, 2019.

⁴⁰ Facility Policy 6203, *Bar Code Medication Administration*, February 2, 2019.

⁴¹ Facility Policy 6203, *Bar Code Medication Administration*, February 2, 2019. Bar code medication administration is a VISTA software application that validates medications against active orders prior to administration to the patient. Six milligrams of lorazepam is a large dose in a short period of time for the treatment of agitation. Generally, the dosage is two milligrams lorazepam via intramuscular injection every four to six hours as needed for agitation. If it is needed within a shorter time frame, staff should closely monitor vitals and respiration to ensure patient safety.

dispensing system transaction record indicated that nurse 2 removed four lorazepam doses, another nurse (nurse 3) removed one lorazepam dose, and subsequently nurse 2 returned two doses. The OIG could not determine who administered the third dose of lorazepam to the patient because documentation did not reflect accurate administration times, amount given at each administration, or which nurse actually administered the lorazepam.

After medication administration, nursing staff did not obtain the patient's vital signs while on the Inpatient Medical Unit. The OIG team determined that given the amount of medications administered in a short period of time and the potential sedating side effects, nursing staff should have taken and monitored the patient's vital signs. Nurse 2 acknowledged that vital signs should have been obtained but could not recall why vital signs were omitted. When the patient was transferred to the ICU at approximately 9:30 p.m., about an hour after the final medication administration, staff obtained vital signs that indicated the patient's respiration was compromised despite supplemental oxygenation, and the patient was "not arousable." Resident physician 3 told the OIG that the patient was intubated for airway protection purposes because the patient's "respiratory status could become compromised" due to the effects of the administered medications. The OIG determined that the significant amounts of sedating medication over a short period of time caused respiratory depression that subsequently required intubation of the patient. The OIG team also concluded that facility staff's failure to monitor the patient's response to medications and vital signs placed the patient at an increased risk of an adverse clinical outcome.⁴² Additionally, due to the staff's failure to accurately document the medication administration times, the OIG was unable to confirm the actual medication administration times and therefore could not thoroughly evaluate the patient's care.

Restraint

Restraint is used in a medical setting to limit a patient's movement to prevent self-harm or harming others including medical personnel. Restraint may be used to prevent a patient's movement such as during surgery or removal of medical tubes and intravenous lines (medical surgical restraint), and to control or prevent harmful behavior due to behavioral health symptomatology (behavioral restraint).⁴³ When restraint is needed, the least restrictive restraint should be used, and restraint removal should occur immediately when no longer necessary.⁴⁴

⁴² Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for a higher level of care.

⁴³ American Psychiatric Nurses Association, *APNA Position on the Use of Seclusion and Restraint*, April 8, 2014.

⁴⁴ American Medical Association, *Use of Restraints*. <https://www.ama-assn.org/delivering-care/ethics/use-restraints>. (The website was accessed on June 5, 2019.)

The Joint Commission requires that restraint orders be consistent with facility policy and that documentation of restraint assessment occur.⁴⁵ Facility policy requires that a licensed independent practitioner or resident physician physically assess the patient, provide justification for restraint use, and complete a written order for initial restraint. The required frequency of staff's assessment and observations of a patient depends on whether the restraint is used for medical/surgical control or behavioral health management.⁴⁶

Facility policy requires a licensed independent practitioner or resident physician to complete a written order every calendar day for medical surgical restraint and every four hours for behavioral restraint. For patients with medical surgical restraint, nursing staff must complete and document ongoing observations every two hours, and complete a reassessment every shift, not to exceed 12 hours.⁴⁷ For behaviorally restrained patients, nursing staff must provide one-to-one observation, conduct an assessment every 15 minutes, and document an electronic health record assessment note every two hours.⁴⁸

Facility policy also requires nurses to report patients in medical surgical restraint through VA Form 10-2913, *Report of Patient's Condition and Nursing Unit Activities*, and will include the times the patient was placed in and removed from restraint and the total time in restraint. Senior clinical leaders must be notified every 24 hours when a patient remains in restraint for more than 12 hours or is in restraint for two or more episodes of restraint for any duration within 12 hours.⁴⁹

Restraint Orders and Assessment

The OIG found that Inpatient Medical Unit and ICU staff improperly ordered and documented medical surgical restraint for behavioral control of the patient. Further, ICU staff kept the patient in restraints excessively without a physician's order.

⁴⁵ The Joint Commission, *Standards Manual*, RC.02.01.01.

⁴⁶ Facility Policy 03-15-12, *Restraint Use for Non-Behavioral Purposes*, December 23, 2015. This policy was in effect during the time frame of the events discussed in this report. The policy was rescinded and replaced by Facility Policy 6008, *Restraint and Seclusion Use*, May 10, 2019. The two policies contain the same or similar language related to reason for restraints and expected assessment and observations. Facility Policy 03-16-28, *Emergency Restraint Use for Behavioral Health Purposes*, January 13, 2016. This policy was in effect during the time frame of the events discussed in this report and was rescinded and replaced by Facility Policy 6008. The two policies contain the same or similar language related to restraints and expected assessment and observations.

⁴⁷ Facility Policy 03-15-12; Facility Policy 6008.

⁴⁸ Facility Policy 03-16-28; Facility Policy 6008. The two policies contain the same or similar language related to one-to-one observation and reassessment.

⁴⁹ Facility Policy 03-15-12; Facility Policy 6008. The 2019 policy included similar language but did not include the requirement for nursing staff to complete VA Form 10-2913, *Report of Patient's Condition and Nursing Unit Activities*.

On day 1, resident physician 2 ordered bilateral wrist restraints “for medical reasons” although the prompting event was a behavioral incident in which the patient was verbally disruptive, spitting, and threatening to kill a staff member during a code gray. Despite the order for bilateral wrist restraints, both resident physician 2 and nurse 2 documented that the patient was placed in four-point restraints. Resident physician 2 told the OIG team that the order should have been changed to four-point restraints, but orders were going to be rewritten given the patient’s planned transfer to the ICU.

Upon the patient’s transfer to the ICU, the Inpatient Medical Unit providers’ orders were discontinued, and the admitting ICU provider was required to place new orders. The OIG found that the patient remained in bilateral wrist restraints in the ICU for approximately nine and a half hours (day 1 into day 2) without a restraint order written. The OIG also found that a provider did not place a restraint order when the previous order expired at the 24-hour mark on day 3. The patient therefore continued in restraints for an additional 12 hours without a restraint order on day 3, which left the patient in restraints for a total of approximately 22 hours without an order. Additionally, the OIG found that ICU nursing staff failed to document 4 of 33 (12 percent) every two-hour restraint observations for the patient, as required.⁵⁰ The OIG team found that nursing staff did not receive education or use the then-required Form 10-2913, *Report of Patient’s Condition and Nursing Unit Activities*. However, the OIG did not make a recommendation, because the completion of this form is no longer required in the updated 2019 facility policy.⁵¹

The OIG determined that staff improperly ordered and initiated medical surgical restraint for the patient when documentation reflected use of restraint for behavioral control. The patient remained in restraints for approximately 22 hours without a physician’s order for restraint use because staff did not monitor the time of patient’s restraint and orders expiration. The OIG concluded that staff’s failure to properly implement orders and document observation consistently throughout the patient’s restraint led to the prolonged restraint use that contributed to the patient’s death.

Nursing Restraint Education

The OIG found that Inpatient Medical Unit and ICU nurses did not receive consistent continuing education on restraint use and monitoring, as required by facility policy. Both the 2015 and updated 2019 facility policies required nursing staff be competent to apply, monitor, and provide care to a patient in restraints and that nurses receive ongoing education.⁵² Facility nursing leaders acknowledged that nurses should receive restraint education in new employee orientation and

⁵⁰ Facility Policy 03-15-12; Facility Policy 6008.

⁵¹ Facility Policy 03-15-12; Facility Policy 6008.

⁵² Facility Policy 03-15-12; Facility Policy 6008; Facility Policy 03-16-28. Facility Policy 6008.

then ongoing restraint education. The 2015 facility policy did not define “ongoing” and the nurse leaders interviewed did not provide definitive expectations for frequency of ongoing education. However, the 2019 facility policy required nurses in the Inpatient Medical Unit and ICU to receive restraint education annually in addition to the initial orientation.⁵³ The February 2019 employee ongoing restraint education highlighted that nurses must have an active restraint order by a physician, complete a restraint assessment at least every 12 hours, and conduct safety checks every two hours.

The OIG found that Inpatient Medical Unit nurses received initial new employee orientation restraint education, as expected. Fourteen applicable Inpatient Medical Unit nurses received ongoing restraint education in either 2017 or 2018, including the three nurses involved in the patient’s care.⁵⁴ Thirty-three of 40 (83 percent) applicable ICU nurses last received ongoing restraint education in June 2017.⁵⁵ The OIG found that on February 1, 2019, 23 of 40 (58 percent) applicable ICU nurses received ongoing restraint education. Two of the four applicable ICU nurses who provided care for the patient received restraint education in 2017 but did not receive the 2019 education.⁵⁶

The OIG found that Inpatient Medical Unit and ICU nurses received new employee restraint education and ongoing education between 2016 and 2019. However, ICU nursing staff did not receive consistent ongoing education on restraint use and monitoring, as required by facility policy. The lack of ongoing education may have contributed to the ICU nurses’ failure (1) to ensure a physician’s order for restraints was in place and (2) to document consistent restraint assessment for the patient. Although facility managers implemented a training plan that included ICU staff’s restraint and policy education, facility staff failed to comply with the restraint policy, which likely contributed to the patient’s deficient care and death.

Deep Vein Thrombosis Prophylaxis

The Centers for Disease Control and Prevention reported that [deep vein thrombosis](#) affects as many as 900,000 Americans annually, leading to approximately 100,000 premature deaths, and that 50 percent of venous thromboembolisms are healthcare-associated. Prolonged bed rest may

⁵³ Facility Policy 6008.

⁵⁴ The OIG did not include 6 of 20 Inpatient Medical Unit nurses in this analysis. At the time of this inspection, three nurses completed new employee orientation within a year and three nurses were no longer employed at the facility and did not provide care for the patient. Therefore, the OIG team did not include these six nurses in the analysis of completed ongoing restraint education.

⁵⁵ Five ICU nurses were excluded from the review due to hire dates.

⁵⁶ One of the five ICU nurses who cared for the patient was not employed until March 2019 and received new employee restraint education but would not be expected to receive ongoing education.

increase the development of deep vein thrombosis.⁵⁷ As many as 70 percent of hospital-acquired deep vein thromboses are preventable through prevention measures that include blood thinning medications or use of compression stockings.⁵⁸ The Joint Commission reported that accurate and consistent risk assessment and the use of appropriate medication and support aids, such as compression stockings, may reduce the development of deep vein thrombosis.⁵⁹

Upon the patient's transfer to the ICU on day 1, resident physician 3 ordered heparin every eight hours, thromboembolic disease stockings, and a venodyne compression system.⁶⁰ On day 3, the patient self-extubated and was oriented to name but was unable to identify place or date. Nursing staff documented that the patient "refused" three of five heparin doses. Physician 3 stated not knowing about the patient's heparin refusal, and the other ICU attending physician (physician 5) stated having heard indirectly through other staff that the patient refused the medication. The OIG would have expected nursing to document that a physician was informed if an order was not carried out. Additionally, the OIG found that in two of the six documented assessments, ICU nursing staff did not document whether compression stockings or a venodyne compression system was in place as ordered.

On day 4, nursing staff documented that the patient refused the bed compression system. The OIG did not find evidence that nursing staff informed a provider of the patient's refusal. The patient was then restrained for approximately four to seven hours during transport to the non-VA mental health treatment facility. The OIG team did not find documentation regarding the patient being in restraints upon discharge or discussion with the patient or a family member that addressed the importance of deep vein thrombosis prophylaxis. Given that the patient was restrained for approximately 71 hours, the OIG concluded that the staff's failure to effectively address the patient's deep vein thrombosis prophylaxis needs contributed to the patient's death.

⁵⁷ Mayo Clinic, *Deep Vein Thrombosis (DVT)*, <https://www.mayoclinic.org/diseases-conditions/deep-vein-thrombosis/symptoms-causes/syc-20352557>. (The website was accessed on September 26, 2019.)

⁵⁸ Centers for Disease Control and Prevention, *Data and Statistics on Hospital Acquired-Venous Thromboembolism (blood clots)*, March 14, 2019. <https://www.cdc.gov/ncbddd/dvt/ha-vte-data.html>. (The website was accessed on October 1, 2019.)

⁵⁹ The Joint Commission Center for Transforming Healthcare, "Venous Thromboembolism (VTE) Prevention," <https://www.centerfortransforminghealthcare.org/improvement-topics/venous-thromboembolism-prevention>. (The website was accessed on October 1, 2019.) Cleveland Clinic, "Deep Vein Thrombosis (DVT) Prevention." <https://my.clevelandclinic.org/departments/heart/patient-education/recovery-care/general/dvt#compression-stockings-tab>. (The website was accessed on May 7, 2020.)

⁶⁰ A venodyne compression system is an intermittent compression device used for long periods of immobility or during and after surgery to prevent deep vein thrombosis. Johns Hopkins University, *Health*. <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/dvt-prevention-intermittent-pneumatic-compression-devices>, 2020. (The website was accessed on January 29, 2020.)

Smoking Policy

The OIG found that staff did not assess the patient for nicotine replacement therapy upon admission or upon a request to smoke, as required by VHA, and that the failure to address the patient's nicotine dependence timely may have contributed to the worsening of the patient's agitation and distress.⁶¹ The Centers for Disease Control and Prevention reports that nicotine dependence affects most individuals who smoke and that nicotine withdrawal symptoms may include, "feeling irritable, angry, or anxious."⁶² VHA requires that patients admitted to the hospital are screened for tobacco use and that nicotine replacement therapy is prescribed for inpatients identified as current tobacco users.⁶³ Facility policy discouraged patient tobacco use, but if a patient was classified as a safety risk to themselves or others, the patient was allowed to smoke in a designated area under the supervision of staff.⁶⁴

Individuals diagnosed with schizophrenia are more likely to smoke than the general population and almost half of VHA patients with schizophrenia smoke cigarettes. Research suggests that smoking may be a self-medicating process and provides relief from schizophrenia symptoms.⁶⁵

On day 1, soon after the patient's transfer to the Inpatient Medical Unit, the patient repeatedly asked to go out to smoke and became increasingly verbally aggressive when staff did not allow the patient to go smoke, and staff called a code gray. On day 3, physician 2 ordered nicotine replacement therapy for the patient. The patient received a nicotine patch on day 3, and refused the nicotine patch the next day.

The OIG found that staff did not assess the patient for nicotine therapy replacement upon admission or upon the patient's request to smoke, and that staff ordered the nicotine patch two days after admission. Given the patient's schizophrenia diagnosis, the staff's failure to address the patient's nicotine dependence may have contributed to the worsening of the patient's agitation and distress that led to the second code gray event and subsequent medication, sedation, intubation, and restraint.

⁶¹ VHA Directive 1085. VHA Directive 1056.

⁶² Centers for Disease Control and Prevention, *Quitting Smoking*, December 11, 2017. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm. (The website was accessed on October 17, 2019.)

⁶³ VHA Directive 1085. VHA Directive 1056.

⁶⁴ Facility Policy 01-16-10, *Medical Center Smoke-Free Policy*, January 13, 2016.

⁶⁵ Sherry Leonard, Sharon Mexal, and Robert Freedman, "Smoking, Genetics and Schizophrenia: Evidence for Self Medication," *Journal of Dual Diagnosis*, 2007 November 1; 3(3-4): 43-59.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2613326/>. (The website was accessed on December 2, 2019.)
Veterans Health Administration, Patient Care Services, "Schizophrenia & Tobacco Use." https://www.mentalhealth.va.gov/quit-tobacco/docs/SchizophreniaandTobaccoUse_508.pdf. (The website was accessed on December 2, 2019.)

Related Concern—Mismanagement of the Patient’s Mental Health Treatment Needs

The OIG found that facility leaders and staff failed to comply with the Georgia State involuntary commitment process requirements, which may have contributed to the mismanagement of the patient’s mental health treatment needs and the patient’s death.⁶⁶ Specifically, the OIG found that staff proceeded as if the facility was an ERF; however, if the patient had been taken to an ERF, staff likely would have evaluated the patient’s “mental illness and substantial risk of imminent harm to self or others,” and determined the need for an involuntary or voluntary mental health treatment admission.⁶⁷ The OIG concluded that the patient’s mental health treatment needs could have been prioritized immediately at an ERF and thereby, the problems that emerged as a result of the patient’s admission to an Inpatient Medical Unit for hyponatremia, a non-emergent chronic medical condition, may have been avoided.

Facility’s ERF Status

As of May 23, 2018, the facility was not listed as an ERF by the Georgia Department of Behavioral Health and Developmental Disabilities.⁶⁸ The VA National Director of Inpatient and Outpatient Mental Health Recovery and the Deputy Chief Consultant of Mental Health Services informed the OIG that the decision to become an ERF occurred at the facility level and that this information was not tracked. The Deputy Chief Counsel, Office of General Counsel, interpreted Georgia Code § 37-3-102(a) as providing the basis for Georgia VA facilities to be considered ERFs without having to complete a formal application.⁶⁹ The OIG did not find that the Georgia

⁶⁶ Georgia Department of Behavioral Health and Developmental Disabilities, *Emergency Admission Process Map*, March 29, 2016. https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Emergency%20Admission%20Process%20Map%203.29.16.pdf. (The website was accessed on October 13, 2019.) Georgia Department of Behavioral Health and Developmental Disabilities, *Legal Status for DBHDD Hospitals, 24-106*. <http://gadbhdd.policystat.com/policy/2583641/>, Effective July 6, 2016. (The website was accessed on March 9, 2020.)

⁶⁷ Georgia Form 1013 and *Form 2013-Certificate Authorizing Transport to Emergency Receiving Facility and Report of Transportation*, 01-110, December 1, 2014. [https://gadbhdd.policystat.com/policy/1136700/latest/December 1, 2014](https://gadbhdd.policystat.com/policy/1136700/latest/December%201,%202014). (The website was accessed on March 9, 2020.)

⁶⁸ Georgia Department of Behavioral Health and Developmental Disabilities, Georgia Department of Behavioral Health and Developmental Disabilities Emergency Receiving (ER), Evaluation (E), Treatment (T) Facilities- By County, May 23, 2018. https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/ERET%20Listing%2052318.pdf. (The website was accessed on June 25, 2020.); The OIG team contacted the Georgia Department of Behavioral Health and Developmental Disabilities in March 2020 to inquire about the requirements of an ERF and if the facility was an ERF but did not receive a response.

⁶⁹ Georgia Code § 37.3.102, Transfer of patients to custody of federal agencies for diagnosis, care, or treatment; retention of jurisdiction by Georgia courts; jurisdiction in federal hospitals and institutions located in Georgia, August 20, 2013. <http://ga.elaws.us/law/section37-3-102>. (The website was accessed on October 8, 2019.)

Code provided clear authority for a VA facility to be considered an ERF, but noted that after appropriate notification from the VA, a patient will be evaluated by the nearest ERF.⁷⁰ Although the Chief of Staff erroneously reported that the facility admitted involuntary patients, other VISN and facility leaders and staff noted that the facility only accepted voluntary mental health inpatient admissions at the Uptown Division. The OIG determined that as of May 2018, the facility was not listed as an ERF by the Georgia Department of Behavioral Health and Developmental Disability, facility leaders and staff did not perceive it as such, and that facility leaders and staff were not familiar with procedural requirements consistent with Georgia State law applicable to ERFs. Staff's failure to adhere to Georgia State laws applicable to the mental health treatment involuntary commitment process may have contributed to the mismanagement of the patient's mental health treatment needs and the patient's death.

Specifically, facility staff proceeded as if the facility was an ERF and sent the patient to the Emergency Department for medical clearance, which is contrary to Georgia State agency guidance.⁷¹ As such, Emergency Department staff focused on the patient's sodium levels reflective of the patient's chronic, known condition. If the patient had been taken to an ERF, staff would likely have evaluated the patient's "mental illness and substantial risk of imminent harm to self or others," and determined the need for an involuntary or voluntary mental health treatment admission.⁷² At an ERF, the patient's mental health treatment needs would have been prioritized immediately and thereby, the problems that emerged as a result of the patient's admission to an Inpatient Medical Unit for hyponatremia, a non-emergent chronic medical condition, may have been avoided.

Further, although a licensed physician is required to complete a Form 1013, the OIG found that a resident physician (resident physician 4), who was not considered a licensed physician, erroneously completed a second Form 1013 on the patient. According to Georgia State requirements, the facility either needed to obtain the patient's consent for a voluntary admission

⁷⁰ Georgia Code § 37.3.102, Transfer of patients to custody of federal agencies for diagnosis, care, or treatment; retention of jurisdiction by Georgia courts; jurisdiction in federal hospitals and institutions located in Georgia, August 20, 2013. <http://ga.elaws.us/law/section37-3-102>. (The website was accessed on October 8, 2019.)

⁷¹ Georgia Department of Behavioral Health and Developmental Disabilities oversees the ERF and involuntary commitment processes, including Georgia Form 1013.

⁷² Georgia Form 1013 and Form 2013.

or complete a Form 1014 for the patient to be assessed in an evaluating facility for possible admission to a treatment facility.⁷³

Facility Staff Patient Care and Process Failures

VHA facilities are required to establish policies to address appropriate transfer of a psychiatric patient following stabilization to a facility that can provide a higher level of care or involuntary admission if that VHA facility does not have the capability.⁷⁴ Facility policy requires a licensed independent provider to complete a physical examination, place the patient under constant supervision, and complete a Form 1013 for patients determined to be a danger to self or others. Following the execution of Form 1013, the licensed independent provider initiates the transfer process.⁷⁵

Georgia requires a licensed physician to complete Form 1013.⁷⁶ A completed Form 1013 does not establish authority for a non-ERF Emergency Department or hospital to hold a person involuntarily.⁷⁷ Additionally, the Form 1013 Procedure for Completion specifies “individuals should not be referred to Emergency Rooms for ‘medical clearance,’ but for a specific complaint” such chest pain or shortness of breath.⁷⁸

On day 1, the Uptown Division code gray team psychiatrist completed a Form 1013 and documented that the patient was “acutely intoxicated + physically aggressive.” Contrary to Form 1013 Procedure for Completion, the code gray team psychiatrist described to the OIG team the understanding that patients go to an Emergency Department for medical clearance on a Form 1013. Emergency medical services transported the patient to the facility’s Emergency Department for medical evaluation. The Emergency Department physician and physician 1 told the OIG that although the patient had a chronic history of hyponatremia, an Inpatient Medical Unit admission for sodium level stabilization was in the patient’s best interest prior to transfer to a mental health treatment facility.

⁷³ Georgia Department of Behavioral Health and Developmental Disabilities, *Emergency Admission Process Map*, March 29, 2016, https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Emergency%20Admission%20Process%20Map%203.29.16.pdf. (The website was accessed on October 13, 2019.) Georgia Department of Behavioral Health and Developmental Disabilities, *Legal Status for DBHDD Hospitals, 24-106*, <http://gadbhdd.policystat.com/policy/2583641/>, Effective July 6, 2016. (The website was accessed on March 9, 2020.)

⁷⁴ VHA Directive 1101.05(2).

⁷⁵ Facility Policy 26-16-47, *Management of Committable Psychiatric Patients*, October 11, 2016.

⁷⁶ Form 1013 Procedure for Completion also specifies that a licensed psychologist, licensed clinical social worker, or clinical nurse specialist in Psychiatric/Mental Health can complete a Form 1013.

⁷⁷ Georgia Form 1013 and Form 2013.

⁷⁸ Georgia Form 1013 and Form 2013.

Facility staff incorrectly believed that a Form 1013 authorized the facility to hold the patient for 72 hours and therefore completed another Form 1013.⁷⁹ On day 4, 70 hours after the first Form 1013 was completed, resident physician 4 completed a second Form 1013. Resident physician 4 documented on the second Form 1013 that the patient was “violent to staff, repeated threatening physical harm to providers, spitting.” Resident physician 4 told the OIG that staff were concerned that the prior Form 1013 would expire, and the emergency medical service would not transport the patient without a new order. The patient was admitted on day 1 and staff attempted a transfer to a non-VA mental health treatment facility on day 4, inconsistent with Georgia policy.⁸⁰

The Joint Commission requires that facilities maintain complete and accurate medical records for each patient including information needed to justify the patient’s care, treatment, and services.⁸¹ The first Form 1013 that the code gray psychiatrist completed was not in the patient’s electronic health record. Further, resident physician 4 reported being unable to recall evaluating the patient in person, and the patient’s electronic health record did not include documentation completed by resident physician 4.

Georgia law distinguishes between a licensed physician and a resident physician. A resident physician is authorized to participate in a postgraduate medical education program subject to limitations as specified by Georgia statute and rules.⁸² The OIG did not find evidence that a licensed physician (psychiatrist) evaluated the patient on day 4. The OIG team concluded that a licensed physician and not a resident physician should have evaluated the patient and determined mental health status and treatment needs to comply with Georgia law.

The OIG concluded that facility leaders and staff admitted the patient to the Inpatient Medical Unit without consent because they wrongly believed that Form 1013 provided authority to detain the patient. According to Georgia law, the facility either needed to obtain the patient’s consent for a voluntary admission or complete a Form 1014 for the patient to be evaluated in an

⁷⁹ Georgia Department of Behavioral Health and Developmental Disabilities, *Emergency Admission Process Map*, March 29, 2016, https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Emergency%20Admission%20Process%20Map%203.29.16.pdf. (The website was accessed on October 13, 2019.) The Form 1013 is “Good for 48 [hours]” at an ERF. If the facility was an ERF, staff needed to discharge the patient or admit the patient involuntarily within 48 hours of holding the patient.

⁸⁰ Georgia Department of Behavioral Health and Developmental Disabilities, *Legal Status for DBHDD Hospitals, 24-106*, <http://gadbhdd.policystat.com/policy/2583641/>, Effective July 6, 2016. (The website was accessed on March 9, 2020.)

⁸¹ The Joint Commission, *Standards Manual*, RC.02.01.01.

⁸² Georgia Compilation of Rules & Regulations. 360-2-.09, *Temporary Postgraduate Training Permits*, May 31, 2012.

evaluating facility for possible admission to a treatment facility.⁸³ The staff's lack of compliance with the Georgia involuntary commitment process requirements led to a failure to address the patient's mental health assessment and treatment needs. If the patient had been transported to an ERF on day 1, as intended by completion of Form 1013, the patient's mental health treatment needs may have been more appropriately managed. If the ERF providers determined hyponatremia was of concern, medical consultation may have been obtained. The OIG concluded that the facility staff's failure to follow the Georgia emergency mental health evaluation procedures likely contributed to the prolonged use of restraints and therefore may have contributed to the patient's death.

2. Lack of Mental Health Provider Involvement

The OIG substantiated that the lack of mental health provider involvement likely contributed to the patient's death. The OIG would have expected a mental health provider to be involved on day 1 to provide recommendations regarding the patient's mental health treatment and symptom management prior to the second code gray event. If a mental health provider was involved earlier, the patient's nicotine dependence may have been handled more effectively and strategies other than sedation and restraint may have been identified to manage the patient's agitation. Although a psychiatric nurse practitioner addressed medication management issues, the consult did not occur until day 2 when the patient was already intubated.⁸⁴ However, the OIG found that facility mental health staff failed to complete a decision-making capacity assessment that may have contributed to treatment without proper informed consent or family involvement. The OIG found that staff failed to involve the patient or the patient's family in the patient's care planning particularly in a discussion of the importance of heparin and other interventions in the prevention of pulmonary thromboemboli. Additionally, the absence of a mental health provider on the Downtown Division code gray team likely contributed to staff's failure to respond effectively to the patient's behavioral emergency, and therefore contributed to mismanagement of the patient's mental health needs as discussed in allegation 4 below.

⁸³ Georgia Department of Behavioral Health and Developmental Disabilities, *Emergency Admission Process Map*, March 29, 2016, https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Emergency%20Admission%20Process%20Map%203.29.16.pdf. (The website was accessed on October 13, 2019.) Georgia Department of Behavioral Health and Developmental Disabilities, *Legal Status for DBHDD Hospitals, 24-106*, <http://gadbhdd.policystat.com/policy/2583641/>, effective July 6, 2016. (The website was accessed on March 9, 2020.)

⁸⁴ Facility Policy 6106. As discussed in the *Facility Mental Health Consult Procedures* section of the report, the routine mental health consult was to be completed within 24 hours, and the psychiatric nurse practitioner responded to the consult on day 2, following the patient's second code gray event, sedation, and subsequent intubation.

Informed Consent and Decision-Making Capacity

VHA patients have the right to accept or refuse any medical treatment or procedure. Patients must provide prior, voluntary informed consent for treatments and procedures. If the patient lacks decision-making capacity, the patient's authorized surrogate may provide informed consent.⁸⁵ During a medical emergency, reasonable attempts to contact a patient's surrogate must be made as soon as possible, before or after treatment initiation.⁸⁶

Patients are presumed to have decision-making capacity unless a clinician completes a clinical assessment stating otherwise or a court has declared the patient to be incompetent. Major decision-making factors include a 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.⁸⁷

A practitioner must perform and document a clinical decision-making assessment for any patient who may lack capacity for medical decision-making "with respect to informed consent for that treatment or procedure."⁸⁸ If the loss of capacity is suspected to be ongoing, then a surrogate decision-maker must be assigned.⁸⁹

Form 1013 authorizes an individual's transport to an ERF for evaluation to determine if an involuntary mental health admission is necessary but does not authorize involuntary medical treatment.⁹⁰ However, staff did not document discussion of consent with the patient or obtain the patient's consent for medical treatment. Despite this legal requirement, the facility's Accreditation Specialist informed the OIG that "there wasn't a consent as the patient was a 1013 admission."⁹¹

Mental Health Decision-Making Capacity Assessment

Facility policy states that mental health consults could be completed by an independent licensed mental health provider, such as a psychiatrist, psychologist, social worker, physician assistant, or advanced practical nurse. Facility policy requires answering a routine mental health consult

⁸⁵ VHA Handbook 1004.01(2), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended September 20, 2017, and April 4, 2019.

⁸⁶ VHA Handbook 1004.01(2). If patient consent is not obtained due to an emergency, the practitioner must document the patient's inability to provide consent, imminent danger to the health of the patient, or others, decision to undertake a particular treatment or procedure and its rationale and attempts to identify and contact a surrogate.

⁸⁷ VHA Handbook 1004.01(2).

⁸⁸ VHA Handbook 1004.01(2).

⁸⁹ VHA Handbook 1004.01(2). Once a surrogate is identified, the surrogate assumes decision-making on behalf of the patient in the informed consent process for treatment.

⁹⁰ Georgia Form 1013.

⁹¹ VHA Handbook 1004.01(2).

within 24 hours and a consult request submitted outside of normal duty hours would be responded to the next business day. Consultants are required to respond to urgent or emergent consults immediately.⁹² The facility's consult template included a list of reasons for the consult request and the responsible discipline for each request reason. Psychology service was listed as responsible for the assessments for suicidal or homicidal risk and medical decision-making capacity; psychiatry was responsible for the medication and complex medical issues "that will likely involve pharmacological intervention."⁹³

On day 1, the patient was admitted to the Inpatient Medical Unit and a medical support assistant documented that the patient was unable to sign the facility's Patient Admission Counseling Checklist that included the patient's rights and responsibilities. Medical resident physician 1 placed a routine mental health consult to assess suicidal or homicidal risk, medical decision-making capacity, medication issues, and complex medical issues. On day 2, a psychiatric nurse practitioner consulted with staff and reviewed the patient's electronic health record. The nurse practitioner documented that the patient was unable to be assessed further due to the patient's sedation. The nurse practitioner recommended restarting the patient's three outpatient medications, ordering two medications to be used as needed for aggression, and transferring the patient to an "acceptable inpatient psychiatry facility for further psychiatry treatment on a [Form] 1013, when medically stable."

On day 2, a psychologist documented being unable to complete an assessment due to the patient's intubation. The psychologist told the OIG team that, typically, inpatient staff or mental health nurse practitioners would inform the psychologist that a patient was "still waiting to be seen for capacity." However, the psychologist could not recall that this occurred with the patient. The Chief, Mental Health reported not knowing why the patient's capacity assessment was not completed. On day 3, the nurse practitioner spoke with the patient and completed a suicidal and homicidal risk assessment but did not complete a medical decision-making capacity assessment. The nurse practitioner told the OIG that capacity assessment was not part of a nurse practitioner's clinical privileges at the facility. The Chief, Mental Health told the OIG that facility practice was for psychologists to complete the capacity assessment.

Physician 1 told the OIG that the patient did not have decision-making capacity although did not recall contacting the patient's family. The OIG found no documentation of the patient's or surrogate decision-maker's consent for treatment. The Emergency Department social worker reported believing that the patient did not have any close family and not contacting the patient's family because collateral information was not needed. The patient's electronic health record did

⁹² Facility Policy 6106. VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016. A routine consult status refers to the time frame when the consult should be addressed. Routine indicates the patient should be seen in accordance with the clinically indicated date.

⁹³ Psychiatry prescribing staff included psychiatrists and mental health nurse practitioners.

not include documentation that reflected staff's attempts to contact the patient's family during admission, discharge planning, or transfer. Facility staff and leaders acknowledged that family contact should have been pursued. However, within hours of the patient's death, physician 4 easily contacted two of the patient's family members and described the timeline of events.

Although the patient's medical decision-making capacity and the ability to obtain patient consent was undetermined, facility staff documented and complied with the patient's refusal for three of five heparin doses. The OIG would have expected nursing staff to alert providers of the patient's heparin refusal to clarify the treatment plan and to follow up on the medical decision-making capacity consult. The staff's failure to obtain proper informed consent from the patient or the patient's family members likely contributed to the patient not receiving the heparin which was prescribed to prevent the thromboemboli from which the patient ultimately died.

To further evaluate the completion of decision-making capacity consult requests, the OIG team reviewed the 13 of 79 mental health inpatient consults placed from July 1, 2018, through June 30, 2019, that included a decision-making capacity assessment request. A psychologist responded to 8 of the 13 decision-making capacity assessment requests. Staff failed to complete four decision-making capacity assessments including the patient. Of the four consults, the nurse practitioner completed medication management for three patients, including the patient discussed above, and one patient was transferred to another facility prior to an evaluation but after the required time frame for consult completion.

The OIG concluded that facility staff's failure to determine the patient's decision-making capacity contributed to the patient's negative outcomes by not evaluating the patient's ability to provide informed consent for treatment and further precluded their consideration of involving the patient's family in major decisions including deep vein thrombosis prophylaxis. Although the OIG did not identify adverse clinical outcomes for the three other patients who did not receive a requested decision-making capacity assessment, the failure to evaluate decision-making capacity may place patients at increased risk for adverse clinical outcomes.

3. Lack of Communication

The OIG substantiated that facility staff failed to inform the receiving non-VA mental health treatment facility that the patient was in restraints. The receiving facility did not accept patients in restraints and therefore the patient endured an unnecessary four-hour ambulance trip in restraints that likely contributed to the development of pulmonary thromboemboli. VHA requires that when a patient is transferred to or from another medical facility, the referring provider must speak directly with the accepting physician and document that the patient or surrogate decision-maker provides informed consent to transfer and must complete the transfer form. VHA notes that a nurse-to-nurse verbal patient report is essential, and nurses are responsible for giving and receiving hand-off patient information so that transfers may happen timely, per facility

policy. Neither VHA nor the facility required electronic health record documentation of the nurse-to-nurse report.⁹⁴ Facility policy requires the after-hours administrative officer instructs the facility provider to complete the electronic health record transfer note and to coordinate a call between the referring and accepting providers.⁹⁵

The OIG found that the attending provider did not speak to the receiving provider or complete transfer documentation, as required. The attending provider told the OIG team that speaking with receiving providers was not typically done and that the facility staff did not complete transfer note documentation. Further, no staff informed the receiving facility that the patient was held in bilateral wrist restraints. The OIG also found that the administrative officer did not participate in the after-hours transfer, as required by facility policy.⁹⁶

In an interview with the OIG, the administrative officer who was present on the day of the patient's transfer, reported not arranging the transfer because a social worker arranges transport for patients on a Form 1013. However, the OIG team did not identify facility policies that required social workers to arrange transportation for patients under a Form 1013. Social worker 2 arranged the patient's transfer to the non-VA psychiatric facility. However, social worker 2 did not document informing the receiving facility that the patient was in bilateral wrist restraints. Social worker 2 admitted overlooking the patient's restraint documentation and did not have a face-to-face encounter with the patient on the day of discharge. Social worker 2 told the OIG team that the receiving facility would not have accepted the patient had the facility had knowledge that the patient was in restraints.

Although the ICU nurse was "pretty sure" about reporting the patient's bilateral wrist restraints to the receiving nurse, the ICU nurse did not document this hand-off communication. Physician 3 did not complete an inter-facility transfer note, communicate with the receiving provider, or document the patient's informed consent to transfer, as required.

The OIG determined that because facility staff failed to adhere to policy, the patient underwent an unnecessary four-hour ambulance trip in restraints that likely contributed to the development of pulmonary thromboemboli.

⁹⁴ VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017. Facility Policy 6003, *Patient Transfers*, February 20, 2019.

⁹⁵ Facility Policy 6003.

⁹⁶ VHA Directive 1096, *Administrative Officer of the Day (AOD)*, December 5, 2014. This directive was in effect during the time frame of the events discussed in this report. The directive was rescinded and replaced by VHA Directive 1096, *Administrative Officer of the Day*, March 27, 2020. The two directives contained the same or similar language regarding administrative officer of the day operations and duty hours. The administrative officer of the day maintains the operations of all administrative activities during other than normal duty hours (which are typically Monday through Friday, 8:00 a.m. to 4:30 p.m.). Day 4 was a Saturday.

4. Inadequate Downtown Division Psychiatric Coverage

The OIG substantiated that the Downtown Division lacked adequate psychiatric providers to manage code gray events, as required by facility policy. Further, the OIG found that nurse practitioners had been cancelling Uptown Division outpatient appointments to be able to respond to Downtown Division mental health consult requests. Following the OIG's June 2019 site visit, the Facility Director requested a review of the mental health staffing levels and approved hiring as requested subsequently by facility mental health leaders.

Code Gray Team

Facility policy specifies that the Downtown Division code gray team includes a consultation liaison psychiatrist, a unit charge nurse, a unit nurse manager or patient care coordinator, a police officer, inpatient nurse managers' designees, and any available staff trained in the prevention and management of disruptive behavior.⁹⁷ However, facility leaders noted that psychiatrists were not stationed at the Downtown Division. Two psychiatric nurse practitioners stationed at the Uptown Division were designated half-time at the Uptown Division outpatient mental health clinic and half-time to the Downtown Division mental health consultation service.⁹⁸ No consultation liaison psychiatrist was routinely present when code gray events occurred at the Downtown Division, including for the reviewed patient. The Inpatient Medical Unit staff called a code gray for the patient because of verbal aggression and the patient threatened to kill resident physician 2. In the absence of a mental health consult liaison, a non-psychiatric medical team provided a code gray response that included the patient being restrained and administered multiple sedating medications.

The OIG determined that leaders failed to ensure the Downtown Division included a consultation liaison psychiatrist on the code gray team, as required by facility policy. The OIG concluded that the lack of a consultation liaison psychiatrist likely contributed to staff's failure to respond

⁹⁷ Facility Policy 6106 identifies independent licensed mental health providers who may respond to consultation requests from other clinical departments and the emergency department, which includes psychiatrists, psychologists, social workers, physician assistants, and advanced practice nurses. Facility Policy 6012, specifies, however, that the code gray team must include a consultation liaison psychiatrist, or psychiatrist who performs the consultation services. VA's Prevention and Management of Disruptive Behavior program is an employee education and training component of their Workplace Violence Prevention Program. The objectives of the Prevention and Management of Disruptive Behavior Program are to ensure the training program reflects current practices in the field, addresses the risks to VHA employees working in the healthcare setting, and provides VHA staff the necessary information through adequate training methodology. <https://www.publichealth.va.gov/about/occhealth/violence-prevention.asp> (The website was accessed on September 25, 2019.)

⁹⁸ American Psychiatric Nurses Association. Psychiatric nurse practitioners possess masters or doctoral degrees and specialize in advanced psychiatric-mental health nursing practice. Psychiatric nurse practitioners apply the nursing process to assess, diagnose, and treat individuals or families with psychiatric disorders and identify risk factors for such disorders. <https://www.apna.org/i4a/pages/index.cfm?pageID=3292#1>. (The website was accessed on September 23, 2019.)

effectively to the patient’s behavioral emergency and therefore contributed to mismanagement of the patient’s mental health needs.

Mental Health Consults and Outpatient Cancellations

The OIG found that prior to the patient’s 2019 admission, the nurse practitioners had been canceling some outpatient appointments at the Uptown Division to meet inpatient mental health consult coverage needs at the Downtown Division. Additionally, the OIG found that providers did not answer mental health consults within the time frames required by facility policy. The OIG also found that the facility policy language related to consult requests was not consistent with the electronic health record consult request form.⁹⁹

The OIG team found from July 1, 2018, through June 30, 2019, almost 10 percent of the two nurse practitioners’ Uptown Division outpatient mental health clinic appointments were “canceled by clinic” to accommodate the Downtown Division mental health consult request completion requirements.¹⁰⁰ Facility administrative staff documented that appointments were canceled because of Downtown Division consultation needs for 30 of 313 canceled appointments (10 percent). Of the 30 canceled appointments, staff canceled 12 (40 percent) appointments because of Downtown Division consultation needs on the same day as the scheduled appointment (see table 1).

Table 1. Uptown Division Outpatient Mental Health Appointment Cancellations

Cancellation Documented as Related to Downtown Division Coverage Need	Number of Appointments Canceled	Percentage Canceled
Yes	30	9.6
No	61	19.5
Unable to determine	222	70.9
Total	313	100.0

Source: OIG analysis of appointments “canceled by clinic” in the two nurse practitioners’ outpatient mental health clinics from July 1, 2018, through June 30, 2019.

To ensure patient safety and prevent patient harm, VHA and facility policies require facility staff to report all identified patient safety concerns, close calls, and adverse events to a Patient Safety

⁹⁹ Facility Policy 6106.

¹⁰⁰ VHA Directive 1230(1), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended July 12, 2019, and January 22, 2020. Canceled by clinic is an appointment canceled by the clinic, not the patient. Examples of reasons that may result in an appointment being canceled by clinic are appointment is no longer required, clinic is canceled, or clinic staffing.

Manager using the designated national reporting system.¹⁰¹ The Patient Safety Manager reported that the facility did not have any patient safety reports related to mental health consults and mental health coverage at the Downtown Division from October 1, 2017, through August 29, 2019.

Canceled and rescheduled mental health outpatient clinic appointments may contribute to delays in patients' access to care. Additionally, same day and other appointment cancellations may inconvenience patients who have taken off work or arranged transportation to attend the scheduled appointment.

Facility Mental Health Consult Procedures

Facility policy requires that when sending providers place routine mental health consults, the consults are to be answered within 24 hours unless consult placement occurs outside of normal duty hours, in which case the consult would be responded to the next business day.¹⁰² Facility policy also defined "urgent and emergency" consults, which require personal contact from the requesting provider to the consultant provider and an expectation that the consultant responds immediately or provides recommendations via telephone until the patient can be evaluated in person.¹⁰³ Consistent with VHA standard operating procedure, the facility's mental health consult template included only routine and "stat" as the two allowed entries in the consult urgency field.¹⁰⁴ Facility policy defines a completed consult as "completion of the requested service" and a discontinued consult is a consult service that is "no longer wanted or needed."¹⁰⁵

Of the 79 mental health inpatient consults placed from July 1, 2018, through June 30, 2019, 78 were routine status and one was "stat." The OIG found that staff did not document a response to 12 of 78 (15 percent) routine consults within the required time frame. The 12 consults ranged in completion from a little over 24 hours to almost 19 days. However, staff completed 9 of the

¹⁰¹ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. VHA defines a close call as "an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention." VHA defines adverse events as "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility." Facility Policy 3400, *Patient Safety Program*, 01-26-2019. For purposes of this report, the OIG uses the term adverse clinical outcome to be the equivalent of adverse event.

¹⁰² Facility Policy 6106. A routine consult status refers to the time frame when the consult should be addressed. Routine indicates the patient should be seen in accordance with the clinically indicated date. VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016.

¹⁰³ Facility Policy 6106.

¹⁰⁴ Merriam-Webster Dictionary, *Stat*. Stat is defined as without delay, immediately. <https://www.merriam-webster.com/dictionary/stat>. (The website was accessed on November 14, 2019.) "VHA Consult SOP," July 26, 2018. A facility Program Specialist, Clinical Informatics informed the OIG that the use of routine and stat as urgency levels was implemented nationally about four to five years ago.

¹⁰⁵ Facility Policy 6011, *Consultation and Consults Scheduling Processes*, February 2, 2019.

12 consults between a little over 24 and 48 hours. The OIG concluded that staff's failure to promptly respond to mental health inpatient consultation requests may contribute to delays in the provision of critical treatment interventions and decision-making capacity evaluations.

Further, staff documented 6 of the 79 (7.6 percent) consults were completed when the more appropriate designation would have been discontinued, primarily due to patients' discharge prior to the mental health provider's evaluation. The OIG team did not identify electronic health record documentation to indicate adverse events occurred as a result of the six discontinued consults. However, one of the six patients did not receive mental health treatment follow-up after a 2019 consult was "completed." During its 2020 review, the OIG team found that approximately two months earlier, an outpatient primary care staff member noted "Please reconnect with mh [mental health]. cannot [sic] sleep" but failed to include an additional signer and no further action was taken. The OIG team immediately informed the Facility Director and a facility psychologist reached out to the patient and scheduled a mental health appointment.

Medical literature supports that suicidal patients require prompt coordinated intervention.¹⁰⁶ Fourteen of the 78 routine consult requests identified suicide attempt or suicidal or homicidal ideation as the reason for consult. The OIG found that 13 of the 14 patients received evaluations within the required time frame.¹⁰⁷ Additionally, the 14 patients required medical stabilization and were placed on one-to-one observation prior to transfer to inpatient mental health treatment or discharge.

VHA requires that providers change a consult status to discontinued when the consult is no longer needed and that an automatic alert is sent to the sending service.¹⁰⁸ The OIG determined that instead of discontinuing consults when patients were not present or not able to be assessed as required, providers marked consults as completed, thereby missing opportunities for providers to be alerted and for patient mental health follow-up to occur.

Facility policy requires providers to designate a mental health consult as routine, urgent, or emergent. However, the mental health consult template options that providers could choose included routine or stat, and routine was the default choice.¹⁰⁹ The language difference between policy and provider template options allowed for confusion and potential for providers to choose the incorrect option within the template, ultimately affecting response time to address patients' mental health needs.

¹⁰⁶ Laura Bonner, et al., "Suicide Risk Response: Enhancing Patient Safety Through Development of Effective Institutional Policies," *Advances in Patient Safety*, Volume 3: 507–519. <https://www.ahrq.gov/downloads/pub/advances/vol3/Bonner.pdf>. (The website was accessed on October 19, 2019.)

¹⁰⁷ The one patient, whose consult was completed beyond 24 hours (approximately 37 hours) after entry, was monitored closely and admitted to a medical unit.

¹⁰⁸ VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016.

¹⁰⁹ Facility Policy 6106.

Facility Director Oversight of Mental Health Staffing

VHA facility directors are responsible for providing appropriate resources to manage clinic access.¹¹⁰ The Facility Director told the OIG that mental health coverage was re-evaluated following the departure of a facility mental health leader. Following the OIG site visit, the Facility Director completed a review of mental health coverage at the Uptown and Downtown Divisions and, in August 2019, reported that a proposal to expand mental health coverage at the Uptown and Downtown Divisions was in place, but the staff had not yet started. In January 2020, the Chiefs of Mental Health and Social Work reported that the expanded mental health coverage occurred in the Emergency Department at the Downtown Division and was partially implemented in the outpatient mental health areas at the Uptown Division. However, the facility's Accreditation Specialist reported that the Downtown Division mental health consult request coverage remained the same.

The OIG team reviewed the facility's Medical Center Resource Committee meeting minutes from January 2018 through March 2019.¹¹¹ The meeting minutes reflected facility leaders' approval of psychiatric provider positions and showed the Facility Director approved mental health staffing requests. The Facility Director told the OIG team that in March 2019, the approval process changed to a centralized staffing request system that the Operational Resources Management Council oversaw and reported on to the Organizational Resource Board that the Facility Director chaired to expedite the hiring process. The OIG team reviewed the meeting minutes from April 2019 to July 2019 and was unable to determine if the Facility Director denied or approved mental health staffing requests due to the changed process.

5. Other Concern: Deficient Disruptive Behavior Committee Processes and Oversight

The OIG found that facility staff failed to review the patient's category 1 patient record flag placed in 2015 until after a disruptive incident occurred in 2018. Further, the OIG found that the Disruptive Behavior Committee did not provide input into the patient's management to mitigate violence risk following two incidents in late 2018, as expected. Additionally, the Disruptive

¹¹⁰ VHA Directive 1230(1), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended July 12, 2019.

¹¹¹ Facility Medical Center Resource Committee, November 19, 2015. The Medical Center Resource Committee served in an advisory capacity to the Facility Director on issues relating to budget, finance, human resources, equipment, and space management including approval of the filling of staff vacancies or establishing new positions.

Behavior Committee did not provide oversight of the code gray team activities, as required by facility policy.¹¹²

Since 2010, VHA has required each facility to establish a Disruptive Behavior Committee, an interdisciplinary committee that implements evidence-based and data-driven practices to prevent, identify, assess, manage, reduce, and track disruptive patient disruptive behavior events. Facility directors are responsible to ensure that each category 1 patient record flag is reviewed at least every two years, or anytime a patient's violence risk factors change. Disruptive behavior committees are responsible for coordinating with clinicians who provide the patient's medical care and providing input on treatment plans to address factors that may reduce the patient's risk of violence.¹¹³

Patient Record Flag

In 2015, facility staff assigned the patient a category 1 behavioral patient record flag due to a pattern of disruptive behaviors that included credible threats, use of threatening language, and aggressive behaviors toward staff. The OIG did not find evidence that the Disruptive Behavior Committee reviewed the patient's record flag in two years, as minimally required.¹¹⁴

The Chair, Disruptive Behavior Committee (Chair), did not review the patient's record flag in December 2017 as expected because of competing priorities, such as direct clinical care and membership on additional committees. The Chair told the OIG team that serving on the Disruptive Behavior Committee was a collateral duty and did not allow time to do more of what should be done in this role. As early as 2016, the Chair regularly communicated concerns about insufficient dedicated time and staffing to cover the Disruptive Behavior Committee duties. Leaders assigned additional staff to the Disruptive Behavior Committee in 2017 and again in May 2019. Additionally, leaders appointed a new Chair as of November 2019.

The patient had incidents of disruptive behavior that involved police twice in 2018, approximately four months apart. The Chair reviewed the first incident three months later and

¹¹² Facility Policy 6012. A code gray can be called by facility staff for assistance when a behavioral emergency occurs at the medical center. When called, a team of designated trained providers responds to the location of the behavioral emergency to provide clinical assessment and intervention as indicated.

¹¹³ VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012. VHA defines disruptive behavior as intimidating, threatening, dangerous behavior that threatens the health or safety of patients, employees, or visitors. VHA Directive 2010-053.

¹¹⁴ VHA Directive 2010-053. A "category 1 patient record flag—violent or disruptive behavior" is an alert in a patient's electronic health record that identifies a patient who poses a safety risk to administrative and clinical staff. A category 1 patient record flag is shared across all known treating facilities for a given patient to ensure that all staff are aware of all safety risks within VHA.

recommended follow-up with mental health providers.¹¹⁵ The day after the second 2018 event, the Chair recommended the patient “be watched closely” while on the inpatient mental health unit where the event occurred and continued the patient’s record flag with a 2020 review date.

The OIG did not find electronic health record documentation that indicated that Disruptive Behavior Committee members contacted mental health providers or coordinated with clinicians responsible for the patient’s medical care or provided input on the treatment plan to address factors that may reduce the patient’s risk of violence, as expected by VHA policy.¹¹⁶ Following the Chair’s review of the disruptive behavior events, the Chair documented in the patient’s electronic health record that an event occurred and advised calling the Disruptive Behavior Committee for more information.

The OIG determined that the Disruptive Behavior Committee failed to: (1) review the patient’s record flag within the two years as required, (2) review and provide feedback regarding the patient’s disruptive behavior event involving the patient until approximately three months later, and (3) coordinate with treating clinicians as required in response to the patient’s disruptive behavior incidents. The OIG concluded that the Disruptive Behavior Committee failed to provide effective input on the patient’s treatment plan to address factors that may have reduced the patient’s risk of violence throughout the patient’s care and that this failure may have contributed to a mismanagement of the patient’s mental health treatment needs throughout the patient’s final episode of care.

Code Gray Oversight

The OIG found that staff did not complete code gray evaluation forms and that the Disruptive Behavior Committee did not ensure review of code gray events as required by facility policy. A nurse manager, charge nurse, or designee of a unit was required to ensure the code gray evaluation form be completed and the Chair’s and Quality Management review were required to complete code gray evaluation forms.¹¹⁷

¹¹⁵ From August through November 2018, the Disruptive Behavior Committee met only in September 2018 but did not document meeting minutes. The 2015 facility policy required semi-annual meetings while the 2019 policy required “Scheduling regularly scheduled meetings of the DBC and additional meetings, as needed, to address the consults that are placed to the [Disruptive Behavior Committee].” Facility Policy 02-15-27, *Disruptive Behavior Prevention*, December 9, 2015, was rescinded and replaced by Facility Policy 6001, *Disruptive Behavior Prevention Program*, February 2, 2019.

¹¹⁶ VHA Directive 2010-053.

¹¹⁷ Facility Policy 26-16-11, *Behavioral Emergency—Code Gray*, January 22, 2016. This policy was in effect during the review period of Code Gray Evaluation Forms and was rescinded and replaced by Facility Policy 6012, *Behavioral Emergency—Code Gray*, February 7, 2019. The two policies contain the same or similar language related to Code Gray Evaluation Form completion and oversight requirements.

A completed code gray evaluation form includes detailed information about the patient involved, code process, interventions, and plans for corrective actions.¹¹⁸ Facility staff did not complete code gray evaluation forms from October 1, 2018, through September 30, 2019, including the code gray events involving the patient, as required. The Chair reported no involvement in education. The Nurse Educator for Mental Health and Rehabilitation told the OIG that “mental health unit employees” received education on the facility policy including the completion of the code gray evaluation form. However, facility leaders did not report that staff outside of the inpatient mental health unit received education.

The Chair and Chief of Quality Management confirmed that the Disruptive Behavior Committee reviewed disruptive behavior reports that sometimes included code gray information, but staff did not complete code gray evaluation forms as required by facility policy. Facility policy did not include submission of a disruptive behavior report.¹¹⁹ Although the Chair expressed awareness of the facility policy requirement for Disruptive Behavior Committee review of code gray evaluation forms to the OIG, the Disruptive Behavior Committee had not reviewed code gray events since May 2017. The Chair told the OIG that the Disruptive Behavior Committee’s role included review of disruptive behavior reports and not oversight of code gray events although required by facility policy. The Chief of Quality Management acknowledged that the facility’s policy should be updated to reflect current practice. However, as of February 2020, the facility’s policy remained unchanged. The OIG concluded that facility staff did not receive education in completion of the code gray evaluation forms, responsible oversight staff did not review code gray incidents, and leaders did not receive any aggregate reports that identified trends or lessons learned from code gray events. As such, leaders did not have the data regarding gaps and areas for improvement to implement performance improvement plans.

6. Other Concern: Lack of Facility Review and Response

In 1999, the VA established the National Center for Patient Safety to facilitate a culture of safety and lead patient safety efforts throughout VHA. The goal of the National Center for Patient Safety is to reduce and prevent inadvertent adverse patient events as a consequence of medical care.¹²⁰

¹¹⁸ Facility Policy 6012.

¹¹⁹ Facility Policy 6012. The Chief of Quality Management’s last official day at the facility was October 26, 2019.

¹²⁰ VA Brochure, National Center for Patient Safety Brochure, 2016.

The National Center for Patient Safety provides guidance on conducting root cause analyses. The root cause analysis process utilizes a focused review with a multidisciplinary team approach to identify system and process factors that contribute to healthcare-related adverse events.¹²¹

While the OIG team was on-site conducting the inspection, the Facility Director initiated a root cause analysis regarding the patient's death.¹²² The Acting Chief of Quality Management told the OIG that the patient's death did not meet criteria for a root cause analysis at the time of death but that additional clinical reviews led to the decision to conduct the root cause analysis. The OIG-identified deficiencies in the patient's care including that the patient: (1) remained in restraints for approximately 22 hours without a provider's order, (2) was placed in four-point restraints although the provider's order was for two-point restraints, and (3) the Disruptive Behavior Committee lacked the expected input and code gray oversight.

An adverse event may warrant institutional disclosure, which is a formal process for facility leaders and clinicians to inform the patient or patient's personal representative that an adverse event occurred, and includes specific information about the patient's rights and recourse.¹²³ Although a root cause analysis and select peer reviews were completed, facility leaders did not conduct a comprehensive review of the patient's care beginning with day 1 or make an institutional disclosure to the patient's next of kin.¹²⁴ Throughout this report, the OIG identified staff's failure to adhere to VHA and facility policies and Georgia law that led to the mismanagement of the patient's treatment and likely contributed to the patient's death. The Acting Chief of Quality Management reported that "[a]n institutional disclosure was not performed in this incident as management reviews determined the cause of death was likely cardiopulmonary related." Given the OIG-identified care deficits, facility leaders should consider an institutional disclosure and conduct a full review of the patient's care from day 1 until the patient's death to determine whether personnel actions are warranted.

¹²¹ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. VHA defines adverse events as harmful occurrences directly associated with facility care or services.

¹²² RCA results are considered confidential medical quality-assurance records pursuant to 38 U.S.C. § 5705.

¹²³ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

¹²⁴ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. Peer review is intended to promote confidential and non-punitive assessments of care at the individual clinician level.

Conclusion

The OIG did not substantiate that the patient died due to overmedication because the medical examiner listed the cause of death as bilateral pulmonary thromboemboli with antemortem history of prolonged restraint and noted that the toxicology findings were “noncontributory.” However, the OIG identified significant care deficiencies during the patient’s care in the Emergency Department, Inpatient Medical Unit, and ICU that likely contributed to the patient’s death. Specifically, the OIG found that Emergency Department and Inpatient Medical Unit staff provided inadequate assessment and monitoring of the patient’s vital signs, administered unnecessary sedative medication, and Inpatient Medical Unit nurses inaccurately documented medication administration. The OIG team determined that facility staff’s failure to monitor the patient’s response to medications and vital signs placed the patient at an increased risk of an adverse clinical outcome.¹²⁵

The OIG also found that Inpatient Medical Unit and ICU staff improperly ordered and documented medical surgical restraints for behavioral control of the patient. Further, the ICU staff kept the patient in restraints excessively without a physician’s order. The OIG found that Inpatient Medical Unit and ICU nurses did not receive consistent ongoing education on restraint use and monitoring, as required by facility policy. The OIG determined that staff’s failure to properly implement orders and document observations consistently throughout the patient’s restraint led to the prolonged restraint use that contributed to the patient’s death.

Further, nursing staff documented that the patient refused heparin doses, but the OIG found no documented efforts to inform physicians or address the importance of deep vein thrombosis prophylaxis with the patient or family members, as the OIG team would have expected. Given that the patient was restrained for approximately 71 hours, the OIG determined that the staff’s failure to effectively address the patient’s deep vein thrombosis prophylaxis needs contributed to the patient’s death.

The OIG also found that staff did not assess the patient for nicotine replacement therapy upon admission or upon a request to smoke, as required by VHA.¹²⁶ Given the patient’s schizophrenia diagnosis, the staff’s failure to address the patient’s nicotine dependence may have contributed to the worsening of the patient’s agitation and distress that led to the second code gray event and subsequent medication, sedation, intubation, and restraint.

The OIG found that facility leaders and staff failed to comply with the Georgia State involuntary commitment process requirements, which contributed to the mismanagement of the patient’s

¹²⁵ Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level care.

¹²⁶ VHA Directive 1056. VHA Directive 1085.

mental health treatment needs and may have contributed to the patient's death.¹²⁷ Specifically, the OIG found that staff proceeded as if the facility was an ERF; however, if the patient had been taken to an ERF, staff are expected to evaluate the patient's "mental illness and substantial risk of imminent harm to self or others" and determine the need for an involuntary or voluntary mental health treatment admission.¹²⁸ The patient's mental health treatment needs could have been prioritized immediately and the problems that emerged as a result of the patient's admission to an Inpatient Medical Unit for hyponatremia, a non-emergent chronic medical condition, would have been avoided.

The OIG concluded that facility staff's failure to determine the patient's decision-making capacity contributed to the patient's negative outcomes by not evaluating the patient's ability to provide informed consent for treatment and further precluded their consideration of involving the patient's family in major decisions including deep vein thrombosis prophylaxis. Although the OIG did not identify adverse clinical outcomes for the three other patients who did not receive a requested decision-making capacity assessment, the failure to evaluate decision-making capacity may place patients at increased risk for adverse clinical outcomes.

The OIG substantiated that the lack of mental health provider involvement likely contributed to the patient's death. The OIG would have expected a mental health provider to be involved on day 1 to provide recommendations regarding the patient's mental health treatment and symptom management prior to the second code gray event. If a mental health provider was involved earlier, the patient's nicotine dependence may have been handled more effectively and strategies other than sedation and restraint may have been identified to manage the patient's agitation. Although a psychiatric nurse practitioner addressed medication management issues, the consult did not occur until day 2 when the patient was already intubated.¹²⁹ The OIG also found that facility mental health staff failed to complete a decision-making capacity assessment that may have contributed to treatment without proper informed consent or family involvement. The OIG found that staff failed to involve the patient or the patient's family in the patient's care planning particularly in a discussion of the importance of heparin in the prevention of pulmonary thromboemboli. Additionally, the absence of a mental health provider on the Downtown

¹²⁷ Georgia Department of Behavioral Health and Developmental Disabilities, *Emergency Admission Process Map*, March 29, 2016, https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Emergency%20Admission%20Process%20Map%203.29.16.pdf. (The website was accessed on October 13, 2019.) Georgia Department of Behavioral Health and Developmental Disabilities, *Legal Status for DBHDD Hospitals, 24-106*, <http://gadbhdd.policystat.com/policy/2583641/>, Effective July 6, 2016. (The website was accessed on March 9, 2020.)

¹²⁸ Georgia Form 1013 and Form 2013.

¹²⁹ As discussed in the *Facility Mental Health Consult Procedures* section of the report, the routine mental health consult was to be completed within 24 hours, and the psychiatric nurse practitioner responded to the consult on day 2, following the patient's second code gray event, sedation, and subsequent intubation. Facility Policy 6106.

Division code gray team likely contributed to staff's failure to respond effectively to the patient's behavioral emergency, and therefore contributed to mismanagement of the patient's mental health needs.

The OIG substantiated that facility staff failed to inform the receiving non-VA mental health treatment facility that the patient was in restraints. The receiving facility would not accept patients in restraints and therefore the patient endured an unnecessary four-hour ambulance trip in restraints that likely contributed to the development of pulmonary thromboemboli. The OIG found no staff informed the receiving facility that the patient was held in bilateral wrist restraints. Additionally, the OIG found that the administrative officer did not participate in the after-hours transfer, as required by facility policy, because of the assumption that a social worker arranges transport for patients on a Form 1013.¹³⁰ The OIG determined that because facility staff failed to adhere to policy, the patient underwent an unnecessary four-hour ambulance trip in restraints that likely contributed to the development of pulmonary thromboemboli.

The OIG substantiated that the Downtown Division lacked adequate psychiatric providers to manage code gray events, as required by facility policy. Further, the OIG found that nurse practitioners canceled Uptown Division outpatient appointments to respond to Downtown Division mental health consult requests. Additionally, the OIG found that providers did not answer mental health consults within the time frames required by facility policy. The OIG also found that the facility policy language related to consult requests was not consistent with the electronic health record consult request form.¹³¹

The Facility Director told the OIG that mental health coverage was re-evaluated following the departure of a facility mental health leader. Following the OIG's June 2019 site visit, the Facility Director completed a review of mental health coverage at the Uptown and Downtown Divisions and in August 2019 reported that a proposal to expand mental health coverage at the Uptown and Downtown Divisions was in place, but the staff had not yet started. In January 2020, the Chiefs of Mental Health and Social Work reported that the expanded mental health coverage occurred in the Emergency Department at the Downtown Division and was partially implemented in the outpatient mental health areas at the Uptown Division. However, the facility Accreditation Specialist reported that the Downtown Division mental health consult request coverage remained the same.

The OIG found that facility staff failed to review the patient's category 1 patient record flag placed in 2015 until after a disruptive incident occurred in 2018. Further, the OIG found that the Disruptive Behavior Committee did not provide input into the patient's management to mitigate

¹³⁰ VHA Directive 1096. The administrative officer of the day maintains the operations of all administrative activities during other than normal duty hours.

¹³¹ Facility Policy 6106.

violence risk following two incidents in late 2018, as expected. Additionally, the Disruptive Behavior Committee did not provide oversight of the code gray team activities, as required by facility policy.¹³² The OIG determined that the Disruptive Behavior Committee failed to provide effective input on the patient's treatment plan to address factors that may have reduced the patient's risk of violence throughout the patient's care and that this failure may have contributed to a mismanagement of the patient's mental health treatment needs throughout the patient's final episode of care.

The OIG found that staff did not complete code gray evaluation forms and that the Disruptive Behavior Committee did not ensure review of code gray events, as required by facility policy. The OIG concluded that facility staff did not receive education in completion of the code gray evaluation forms, responsible oversight staff did not review code gray incidents, and leaders did not receive aggregate reports to identify trends or lessons learned from code gray events.

While the OIG team was on-site conducting the inspection, the Facility Director initiated a root cause analysis regarding the patient's death. The Acting Chief of Quality Management told the OIG that the patient's death did not meet criteria for a root cause analysis at the time of death but that additional clinical reviews led to the decision to conduct the root cause analysis. The OIG identified deficiencies in the patient's care including that the patient (1) remained in restraints for approximately 22 hours without a provider's order, (2) was placed in four-point restraints although the provider's order was for two-point restraints, and (3) the Disruptive Behavior Committee lacked expected input and code gray oversight. Given these care deficits, facility leaders should consider an institutional disclosure and conduct a full review of the patient's care from day 1 until the patient's death to determine whether personnel actions are warranted.

¹³² Facility Policy 6012. A code gray can be called by facility staff for assistance when a behavioral emergency occurs at the medical center. When called, a team of designated trained providers responds to the location of the behavioral emergency to provide clinical assessment and intervention as indicated.

Recommendations 1–18

1. The Charlie Norwood VA Medical Center Director conducts a full review of the patient’s final episode of care and determines whether an institutional disclosure is warranted.
2. The Charlie Norwood VA Medical Center Director conducts a full review of the patient’s final episode of care and consults with the appropriate Human Resources and General Counsel Offices to determine whether any personnel actions are warranted.
3. The Charlie Norwood VA Medical Center Director ensures Emergency Department and Inpatient Medical Unit staff performs vital sign assessment and monitors patients who received sedating medications.
4. The Charlie Norwood VA Medical Center Director ensures Intensive Care Unit nurses accurately document medication administration.
5. The Charlie Norwood VA Medical Center Director ensures Intensive Care Unit staff implement patient restraint management according to the Charlie Norwood VA Medical Center policy, including documentation, physician orders, and education requirements.
6. The Charlie Norwood VA Medical Center Director ensures Intensive Care Unit nursing staff communicate with providers regarding patients’ refusal of treatment.
7. The Charlie Norwood VA Medical Center Director strengthens Inpatient Medical Unit nicotine replacement therapy processes and monitors compliance.
8. The Charlie Norwood VA Medical Center Director strengthens processes to include the patient, family members, or surrogate in informed consent procedures and treatment decisions, as appropriate, and monitors compliance.
9. The Charlie Norwood VA Medical Center Director evaluates the inpatient mental health consult process, and addresses timeliness and completion of decision-making capacity consult requests, and monitors compliance.
10. The Charlie Norwood VA Medical Center Director consults with the Office of General Counsel regarding policies related to the management of patients presenting under a Form 1013 and advises policy and practices consistent with Georgia State mental health laws and takes action, as appropriate.
11. The Charlie Norwood VA Medical Center Director ensures staff adhere to inter-facility transfer policies and procedures, including accurate communication of patients’ restraint management status, and monitors compliance.
12. The Charlie Norwood VA Medical Center Director ensures that a consultation liaison psychiatrist is included on code gray teams at both divisions.

13. The Charlie Norwood VA Medical Center Director evaluates inpatient mental health consult staffing and establishes a plan to ensure adequate staffing to complete consult requests as required without outpatient mental health appointment cancellations and monitors compliance.
14. The Charlie Norwood VA Medical Center Director establishes consistent urgency levels in the applicable Charlie Norwood VA Medical Center policies and the corresponding mental health consult template.
15. The Charlie Norwood VA Medical Center Director ensures that staff respond to consults within required time frames and with accurate status designations.
16. The Charlie Norwood VA Medical Center Director ensures that the Disruptive Behavior Committee reviews patient record flags and provides input into patients' management to mitigate violence, as required by Veterans Health Administration, and monitors compliance.
17. The Charlie Norwood VA Medical Center Director makes certain that staff receive education in code gray policy and procedures, including completion of the code gray evaluation form, and monitors compliance.
18. The Charlie Norwood VA Medical Center Director ensures that the Disruptive Behavior Committee provides oversight of the code gray team activities, as required by Charlie Norwood VA Medical Center policy, and monitors compliance.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 10, 2020

From: Director, VA Southeast Network (10N7)

Subj: Healthcare Inspection—Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia

To: Director, Office of Healthcare Inspections (54MH00)
Director, GAO/OIG Accountability Liaison office (VHA 10EG GOAL Action)

1. I have had the opportunity to review the Draft Report: Healthcare Inspection—Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center.
2. VISN 7 submits concurrence to the findings of recommendations 1-18. VISN 7 concurs with the attached Charlie Norwood VA Medical Center action plan and the completion of recommendations 4-5, 7, 9 and 12-15.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(Original signed by:)

Joe D. Battle
Interim Director, VA Southeast Network

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 10, 2020

From: Director, Charlie Norwood VA Medical Center (509/00)

Subj: Healthcare Inspection— Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia

To: Director, VA Southeast Network (10N7)

1. I, along with the members of the Charlie Norwood VA Medical Center (CNVAMC), thank the Office of Inspector General for their evaluation on the use of restraints in the care of this Veteran. We take every OIG report very seriously and work very hard to implement all their recommendations in an effort of continuous improvement.
2. We will address each recommendation in this report with the same assertiveness as we did their Leadership and Clinical Concerns report in which 22 of the 27 recommendations are corrected and closed. Our most recent update requests closure of three of the five open recommendations. Through focused actions, Charlie Norwood VA Medical Center was able to close out FY2019 as the 9th most improved VA Medical Center on the VA All Employee Survey (AES) and achieve the highest best place to work (BPTW) scores in the facility's history.
3. I concur on all 18 of the recommendations. We have completed 8 and recommend their closure.

(Original signed by:)

Robin E. Jackson, Ph.D.
Medical Center Director

Facility Director Response

Recommendation 1

The Charlie Norwood VA Medical Center Director conducts a full review of the patient's final episode of care and determines whether an institutional disclosure is warranted.

Concur.

Target date for completion: September 30, 2020

Director Comments

CNVAMC Clinical Leaders completed a review of the patient's final episode of care and made a recommendation concerning institutional disclosure. [The Medical Center Director] MCD has forwarded the Office of the Inspector General (OIG) report and clinical leader recommendations to the Office of General Counsel (OGC) Healthcare Law Department for consultation/recommendations. Awaiting consultative advice for final determination.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 2

The Charlie Norwood VA Medical Center Director conducts a full review of the patient's final episode of care and consults with the appropriate Human Resources and General Counsel Offices to determine whether any personnel actions are warranted.

Concur.

Target date for completion: November 15, 2020

Director Comments

Administrative actions have occurred for the three nursing leaders responsible for oversight and practice compliance. A second Administrative Investigation Board was chartered with medical and Human Resources (HR) professionals internal and external to CNVAMC on August 19, 2020 to further evaluate the case, interview personnel and make recommendations for additional personnel actions if warranted. The board will convene using face-to-face and virtual sessions to facilitate expediting investigation. Upon receipt of board recommendations/results the MCD will work with VISN HR and OGC on appropriate actions as warranted.

Recommendation 3

The Charlie Norwood VA Medical Center Director ensures Emergency Department and Inpatient Medical Unit staff performs vital sign assessment and monitors patients who received sedating medications.

Concur.

Target date for completion: November 1, 2020

Director Comments

The [Chief of Staff] COS and Acting [Associate Director of Patient Care Services] ADPCS are establishing written standard work processes for meeting restraint requirements for Emergency Department and Inpatient Medical Unit staff. Standard work process will include a defined process for performing vital sign assessments and monitoring patients who receive sedating medications. Competency documentation will be completed and recorded. Hospital Education is implementing a consistent process for completing competency training with documentation for new providers and nurses in orientation prior to release to their work unit of responsibility. Chart reviews will be conducted to evaluate assessment and monitoring patients who received sedating medications. A team in collaboration with Mental Health Pharm D will develop protocols for managing agitated patients.

Recommendation 4

The Charlie Norwood VA Medical Center Director ensures Intensive Care Unit nurses accurately document medication administration.

Concur.

Target date for completion: Completed

Director Comments

The Acting ADPCS has reviewed the personnel and training records for all nurses within the Intensive Care Unit (ICU). All ICU nurses received re-training for competency on accurately documenting medication administration between August 17 through August 28, 2020. Bar Code Medication Administration (BCMA) was present in the ICU at the time of this event and the Medical Center Policy was current and in effect. The Acting ADPCS determined this was a matter of non-compliance. She is consulting with VISN Employee Relations/Labor Relations (ER/LR) on appropriate personnel actions in relation to recommendation number 2.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 5

The Charlie Norwood VA Medical Center Director ensures Intensive Care Unit staff implement patient restraint management according to the Charlie Norwood VA Medical Center policy, including documentation, physician orders, and education requirements.

Concur.

Target date for completion: Completed

Director Comments

Restraint policy remediation training was provided to all ICU staff in March and June 2020. Restraint policy training is included in all nurse new hire education. The [VA Central Office] VACO Mock Joint Commission Surveyor evaluated 10 days of restraint management cases during his visit between August 10-11, 2020 and found no issues with the records reviewed. CNVAMC has validated the facility policy is compliant and consistent with VHA requirements. The Acting ADPCS completed a written standard work processes on August 5, 2020 for ICU that ensures the Charge Nurse conducts restraint reviews on all cases for appropriateness and implements immediate corrective actions. The reviews are provided to the Associate Chief Nurses and the Acting ADPCS who review daily. Patient Safety conducts weekly spot audits to evaluate appropriateness of and compliance with restraint use in the facility and provides a monthly report to the Executive Leadership Board. It is important to note per this OIG draft report, this is mostly an issue of non-compliance which will require further assessment after the [Administrative Investigation Board] AIB referenced in recommendation 2 is completed.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 6

The Charlie Norwood VA Medical Center Director ensures Intensive Care Unit nursing staff communicate with providers regarding patients' refusal of treatment.

Concur.

Target date for completion: September 29, 2020

Director Comments

The Acting ADPCS will ensure remediation training for all ICU nurses surrounding communication to providers. Written standard work processes was finalized and implemented on August 5, 2020. The Standard work process was provided to all current ICU nurses and is in process of becoming a part of new nurse orientation. Medical Center Nursing Education will

develop and ensure a competency is established related to communication expectations for all ICU nurses. A Social Worker has been assigned to assist nurses and providers with issues of patient self-determination and patient rights. The Social Worker is scheduled to begin assignment September 11, 2020.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 7

The Charlie Norwood VA Medical Center Director strengthens Inpatient Medical Unit nicotine replacement therapy processes and monitors compliance.

Concur.

Target date for completion: Completed

Director Comments

The CNVAMC Nurses will continue to routinely complete the nicotine screening during admission and provide consults to the unit social workers. The CNVAMC Social Workers complete the tobacco counseling and documentation for all inpatients during their psychosocial assessments within 48 hrs. of admission. The Social Worker submits a consult to providers for evaluation of nicotine replacement therapy for patients as appropriate based on counseling responses. The Quality Management Performance Measure Nurse monitors compliance and provides monthly updates to the CNVAMC QSV [Quality, Safety, Value] council. Audits will be conducted to evaluate completion of inpatient tobacco screenings.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 8

The Charlie Norwood VA Medical Center Director strengthens processes to include the patient, family members, or surrogate in informed consent procedures and treatment decisions, as appropriate, and monitors compliance.

Concur.

Target date for completion: October 30, 2020

Director Comments

The Chief of Social Work Service is providing refresher training to all Medical Center Social Workers on Medical Center Policy Memorandum (MCPM) No. 6904 patient, family member and /or surrogate informed consent procedures. CNVAMC will ensure that a Licensed Clinical Social worker is assigned for all patient treatment areas. The COS will ensure the Social Worker psycho-social assessment will include evaluation for family member, surrogate, informed consent and decision-making capacity. Hospital Education will work with Chief of Social Work to provide education for providers and nurses on informed consent and decision-making procedures. The training will also include reminder information on the robust CNVAMC Ethics Consultation program. Patient Safety Audits are being incorporated into the oversight monitors for monthly reporting through the governance structure. Audits are intended to evaluate compliance with completing informed consent and psychosocial assessments.

Recommendation 9

The Charlie Norwood VA Medical Center Director evaluates the inpatient mental health consult process, and addresses timeliness and completion of decision-making capacity consult requests, and monitors compliance.

Concur.

Target date for completion: Completed

Director Comments

The Medical Center has strengthened its Consult Liaison Process. The Emergency Department (ED) was staffed with a Licensed Clinical Social Worker, onsite Mental Health Nurse Practitioner and psychotherapist with on-call psychiatrist support from the downtown facility 5 miles away. March 16, 2020 a fulltime [consult liaison] CL psychiatrist was hired and assigned in the ED area to provide Downtown Division Psychiatric consult liaison (C/L) responsibilities. This provides a cadre of Mental Health providers to support the ED providers with Mental Health (MH)/decision-making capacity consultations as needed. Refresher competency training was provided to all CL providers to ensure comfort with the process and when to elevate for additional support as needed. Since the hiring and training of the designated psych C/L staff, there have been no instances of STAT or routine consults or requests for capacity evaluations being answered outside of established timeframes.

The COS, through the Group Practice Manager (GPM), has established a consult monitoring process to ensure consistent oversight of consult response timeliness.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 10

The Charlie Norwood VA Medical Center Director consults with the Office of General Counsel regarding policies related to the management of patients presenting under a Form 1013 and advises policy and practices consistent with Georgia State mental health laws and takes action, as appropriate.

Concur.

Target date for completion: October 29, 2020

Director Comments

CNVAMC is not a 1013 receiving facility. The MCD, COS and MH Chief, in consultation with OGC Healthcare Law Department, is evaluating current policies and practices surrounding the transfer out of patient deemed 1013 appropriate. Extensive work has been completed in partnership with the Atlanta VAMC and OGC regarding GA 1013 laws. CNVAMC will incorporate policy and practices consistent with the state mental health laws into its current policies and processes. Robust training and education will be accomplished for all impacted Mental Health, Social Work, Emergency Department and Nursing Staff on any changes and/or improvements to the processes.

Recommendation 11

The Charlie Norwood VA Medical Center Director ensures staff adhere to inter-facility transfer policies and procedures, including accurate communication of patients' restraint management status, and monitors compliance.

Concur.

Target date for completion: September 29, 2020

Director Comments

The COS and the Acting ADPCS are developing remediation training for all associated staff surrounding inter-facility transfer policies and procedures to include communication of restraints. Written Standard Work Processes are in development for Nursing, Social Work and Providers surrounding the use of restraints and required monitoring. As previously mentioned, restraint standard work guidelines for ICU staff was completed August 5, 2020. Social Work standard work process will mandate an eyes on review and psychosocial assessment for all patients requiring inter-facility transfer. Nursing Performance Improvement and Patient Safety

conduct routine monitoring of restraint usage allowing for immediate corrective education and actions.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 12

The Charlie Norwood VA Medical Center Director ensures that a consultation liaison psychiatrist is included on code gray teams at both divisions.

Concur.

Target date for completion: Completed

Director Comments

The Code Gray process and membership for both medical center divisions was reviewed by the [Disruptive Behavior Committee] DBC in July 2020. Uptown Code Gray is covered by the in-house on-call outpatient Mental Health Provider during the day and the Downtown Mental Health Provider provides coverage for the division Code Gray alerts. Night-time and weekend Code Grays are covered through a two-tiered primary on-call Mental Health Provider and secondary in-house [Medical Officer of the Day] MOD Mental Health Provider uptown through consultation. The Code gray facility Standard Operating Procedure (SOP) has been updated to reflect the process changes.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 13

The Charlie Norwood VA Medical Center Director evaluates inpatient mental health consult staffing and establishes a plan to ensure adequate staffing to complete consult requests as required without outpatient mental health appointment cancellations and monitors compliance.

Concur.

Target date for completion: Completed

Director Comments

The MCD evaluated the two assigned C/L psychiatric nurse practitioners' schedules. No outpatient appointments were inappropriately cancelled to cover C/L duties. Only 2 and ½ days

of appointments were cancelled due to C/L coverage within a 1-year period. This was due to the unexpected illness of one of the practitioners requiring coverage changes. The Psychiatric Nurse Practitioners (NP) alternate their time in scheduled appointments and C/L responsibilities. At no time are they scheduled in clinic when covering C/L duties. Routine leaves and absences are managed within the leave scheduling policy and are done 45 days in advance. CNVAMC has hired a full-time C/L psychiatrist who is stationed at the downtown facility. The assignment of this full-time Psychiatrist to the C/L team provides an additional layer of redundancy that eliminates the need for shifting coverage or cancellation of appointments. The Medical Director for Mental Health is responsible to designate surrogate coverage for MH provider absences, planned and unplanned.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 14

The Charlie Norwood VA Medical Center Director establishes consistent urgency levels in the applicable Charlie Norwood VA Medical Center policies and the corresponding mental health consult template.

Concur.

Target date for completion: Completed

Director Comments

The CNVAMC consult management policy was updated July 8, 2019 to include consistent urgency levels. Additionally, the current MH consult template allows for the designation of STAT and Routine options in compliance with VHA Guidance. The designated psychiatrist hired March 16, 2020 to cover Psychiatric C/L responsibilities has ensured urgent responses to STAT MH consults. The Psychiatric NP's were retrained on completing decision-making capacity evaluations to ensure redundancy.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 15

The Charlie Norwood VA Medical Center Director ensures that staff respond to consults within required time frames and with accurate status designations.

Concur.

Target date for completion: Completed

Director Comments

The MH consult has been revised in the electronic health record to add a dropdown menu for the requesting provider to choose the services which include:

- a) Suicide or homicide risk assessment.
- b) Decision-making capacity.
- c) Psychopharmacology/Medication recommendations.
- d) Complex psychiatric issues (e.g., delirium verses dementia, behavioral management, use of behavioral, physical or chemical restraint).
- e) OTHER (free text option).

The fulltime C/L Psychiatrist and Psychiatric Nurse Practitioners ensure prompt response to all MH consults. All assigned providers can independently respond to all requests, eliminating the need for multiple evaluations by different providers.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 16

The Charlie Norwood VA Medical Center Director ensures that the Disruptive Behavior Committee reviews patient record flags and provides input into patients' management to mitigate violence, as required by Veterans Health Administration, and monitors compliance.

Concur.

Target date for completion: September 30, 2020

Director Comments

The DBC committee has been retooled with dual chair and co-chair. The membership has been expanded and is compliant with VHA guidance. Current minutes are on file for all meetings held since December 2019. Disruptive Behavior Committee reports quarterly to the Executive Leadership Board and monthly to the Health Care Delivery Council providing updates on violence mitigation, patient flags and overall compliance. A fulltime DBC coordinator is under recruitment and a final selection will be completed [no later than] NLT September 18, 2020 to ensure continual compliance and sustainability of the program. Meeting minutes are shared with

all members who then vote to approve/amend the contents prior to signature and posting on the facility's Governance SharePoint. Quality Management provides routine audit reports on meeting frequency and outcomes to the Executive Leadership Board.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 17

The Charlie Norwood VA Medical Center Director makes certain that staff receive education in code gray policy and procedures, including completion of the code gray evaluation form, and monitors compliance.

Concur.

Target date for completion: September 30, 2020

Director Comments

Hospital Education will evaluate the code gray policy and ensure compliance with VHA directives. All staff will complete education on current policy No Later Than (NLT) September 30, 2020 and will be educated on newly revised policy by September 30, 2020. Quality Management will perform on-going evaluation of the code gray process, monitor compliance and provide bi-monthly updates to the Executive Leadership Board.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 18

The Charlie Norwood VA Medical Center Director ensures that the Disruptive Behavior Committee provides oversight of the code gray team activities, as required by Charlie Norwood VA Medical Center policy, and monitors compliance.

Concur.

Target date for completion: September 30, 2020

Director Comments

The Disruptive Behavior Committee is working on the following action items and will complete NLT September 30, 2020, or has already completed as noted:

- a) Update the committee's agenda to include all Code Gray calls as a standing business item and ensure the information is captured in the minutes. The DBC will call a quorum committee meeting for any emergent Code Gray review needs in between regularly scheduled meetings as needed. Action completed August 2020.
- b) The DBC's charter has been updated to ensure proper oversight activities are appropriately defined for all Code Gray calls. Action completed August 2020.
- c) The DBC's two Medical Center Policies (MCP) are being merged into one facility-wide policy to clarify DBC oversight responsibilities to prevent any confusion on roles and responsibilities of the DBC and the management of Code Grays.

The new Workplace Violence Prevention Program Coordinator has been provided with guidance and directed to ensure medical center staff are trained in appropriate response to Code Gray Calls (including Disruptive Behavior Response System reporting); determine Code Gray team changes in composition and coverage; and notify DBC chairs immediately after Code Gray events.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Glossary

To go back, press “alt” and “left arrow” keys.

alcohol abuse. Characterized by a pattern of alcohol use leading to clinically significant impairment or distress.¹³³

cardiopulmonary resuscitation. A procedure designed to restore normal breathing after cardiac arrest.¹³⁴

category 1 behavioral patient record flag. An alert of violent or disruptive behavior entered into a patient’s electronic health record that identifies a patient who poses a safety risk to administrative and clinical staff. A category 1 patient record flag is shared across all known treating facilities for a given patient to ensure that all staff are aware of all safety risks within VHA.¹³⁵

chronic obstructive pulmonary disease. A disease of the lungs that makes it hard to breathe and is most commonly caused by smoking.¹³⁶

cocaine dependence. Characterized by a pattern of cocaine use leading to clinically significant impairment or distress as well as signs of tolerance and withdrawal.¹³⁷

code gray. A call for assistance from a special team in the event of a behavioral emergency.¹³⁸

deep vein thrombosis. The formation of a blood clot in one or more of the deep veins of the body that may break loose and travel to another part of the body.¹³⁹

diphenhydramine. An antihistamine medication that can be used to induce sedation and treat some of the motor-related side effects of antipsychotic medications.¹⁴⁰

¹³³ Office of the Surgeon General (US), National Institute on Alcohol Abuse and Alcoholism (US), Substance Abuse and Mental Health Services Administration (US), *The Surgeon General's Call to Action To Prevent and Reduce Underage Drinking*, 2007, Appendix B. <https://www.ncbi.nlm.nih.gov/books/NBK44358/>. (The website was accessed on October 13, 2019.)

¹³⁴ Merriam-Webster Dictionary, *Cardiopulmonary Resuscitation*, <https://www.merriam-webster.com/dictionary/cardiopulmonary%20resuscitation>, updated September 15, 2019. (The website was accessed on October 20, 2019.)

¹³⁵ VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.

¹³⁶ American Academy of Family Physicians, *Chronic Obstructive Pulmonary Disease*, updated June 2018.

¹³⁷ American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition, 2000.

¹³⁸ Facility Policy 6012, *Behavioral Emergency – Code Gray*, February 7, 2019.

¹³⁹ The Mayo Clinic, *Deep vein thrombosis (DVT)*. <https://www.mayoclinic.org/diseases-conditions/deep-vein-thrombosis/symptoms-causes/syc-20352557>. (The website was accessed on September 26, 2019.) The Joint Commission Center for Transforming Healthcare, “Venous Thromboembolism (VTE) Prevention.”

¹⁴⁰ Prescribers’ Digital Reference, *diphenhydramine hydrochloride – Drug Summary*, <https://www.pdr.net/drug-summary/Diphenhydramine-Hydrochloride--diphenhydramine-hydrochloride-1140>, 2019. (The website was accessed on October 13, 2019.)

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four-point restraints. Restraint of all extremities (arms and legs), typically used for violent patients who pose a danger to themselves or others.¹⁴¹

gastro-esophageal reflux disease. Sometimes called “acid reflux” and occurs when the acid from the food and liquid in the stomach backs up into the throat.¹⁴²

haloperidol. An antipsychotic medication used to treat schizophrenia.¹⁴³

heparin. A medication used to prevent blood clots that can develop when patients are bedbound for extended periods of time. Developing deep vein thrombi, or clots in the deep veins of the legs, can lead to a life-threatening blood vessel blockage in the lung (pulmonary embolism) when a clot travels from the leg.¹⁴⁴

hypertension. Also called high blood pressure, occurs when the blood moves through the arteries at a higher pressure than normal. Uncontrolled hypertension places patients at higher risk for stroke, heart disease, heart attack, and kidney failure.¹⁴⁵

hyponatremia. An abnormally low blood level of sodium that can cause mild to life-threatening conditions. There is an increased incidence of hyponatremia in people taking antipsychotic medications to treat schizophrenia and is found in about 10 percent of patients who take these medications.¹⁴⁶

¹⁴¹ American Nurse, *Choosing the right restraint*, January 13, 2015, <https://www.myamericannurse.com/choosing-restraints/>. (The website was accessed on March 11, 2020.)

¹⁴² American Academy of Family Physicians, *Reflux/Acid Reflux*, <http://online.statref.com/...nId=2C8E713QLTXUVDIC&Scroll=4&goBestMatch=true&Index=0&searchContext=Gastroesophageal+Reflux+Disease|c0|10|1|0|0|0|0|c0&minimalSize=1>, updated July 2019. (The website was accessed on August 26, 2019.)

¹⁴³ U.S. National Library of Medicine, *Haloperidol*, Updated February 18, 2020, <https://medlineplus.gov/druginfo/meds/a615023.html>. (The website was accessed on March 11, 2020.)

¹⁴⁴ Clinical Key, Drug Monograph, Heparin, https://www.clinicalkey.com/#!/content/drug_monograph/6-s2.0-289, 2019. (The website was accessed on August 31, 2019.) Mayo Clinic, *Deep vein thrombosis (DVT)*, <https://www.mayoclinic.org/diseases-conditions/deep-vein-thrombosis/symptoms-causes/syc-20352557>, March 6, 2018. (The website was accessed on August 31, 2019.)

¹⁴⁵ American Academy of Family Physicians, *High Blood Pressure*, <http://online.statref.com/...QorOPxFrw!!&SessionId=2C8E713QLTXUVDIC&Scroll=1&goBestMatch=true&Index=3&searchContext=hypertension|c0|10|1|0|0|0|0|c0&minimalSize=1>, updated October 2017. (The website was accessed on August 26, 2019.)

¹⁴⁶ Mayo Clinic, *Hyponatremia*, <https://www.mayoclinic.org/diseases-conditions/hyponatremia/symptoms-causes/syc-20373711>, May 8, 2018. Meulendijks, Didier, *Antipsychotic-Induced Hyponatraemia A Systematic Review of the Published Evidence*, Drug Saf 2010; 33 (2): 101–114 <https://link.springer.com/content/pdf/10.2165%2F11319070-000000000-00000.pdf>. Sarah Naz Ali and Lydia A. Bazzano, *Hyponatremia in Association With Second-Generation Antipsychotics: A Systematic Review of Case Reports*, Ochsner Journal 18:230–235, 2018, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6162139/pdf/230Ali.pdf>. (The websites were accessed on August 27, 2019.)

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hypoxia. A deficiency of oxygen reaching the tissues of the body.¹⁴⁷

intubate. The introduction of a tube into a hollow organ (as the trachea or intestine) to keep it open or restore its patency if obstructed.¹⁴⁸

long-acting antipsychotic injectable medication. A medication administered biweekly or monthly to reduce the symptoms of schizophrenia and improve the behavior of schizophrenic patients, particularly for patients who have challenges adhering to daily medication schedules.¹⁴⁹

lorazepam. Medication that is considered a first-line therapy for the treatment of acute agitation in an emergency. Lorazepam is a benzodiazepine with anti-anxiety and sedative effects and potential side effects that include difficulty breathing and drowsiness.¹⁵⁰

olanzapine. An atypical antipsychotic medication that is used to treat the symptoms of schizophrenia. Drowsiness is a potential side effect.¹⁵¹

oxygen saturation. The amount of oxygen in the bloodstream. Values below 90 percent are considered low blood oxygen with saturation between 94 to 99 percent considered normal.¹⁵²

pulmonary thromboemboli. A potentially life-threatening condition, caused typically by blood clots that travel from the legs or other parts of the body and become lodged in arteries in the lungs, resulting in blood flow blockage.¹⁵³

¹⁴⁷ Merriam-Webster Dictionary, *Hypoxia*, <https://www.merriam-webster.com/dictionary/hypoxia>. (The website was accessed on January 5, 2020.)

¹⁴⁸ Merriam-Webster Dictionary, *Intubate*, <https://www.merriam-webster.com/dictionary/intubation>. (The website was accessed on December 30, 2019.)

¹⁴⁹ George M. Brenner and Craig W. Stevens, *Pharmacology*, Fifth Edition, Chapter 22, 243–260, 2018, <https://www.clinicalkey.com/#!/content/book/3-s2.0-B9780323391665000220?scrollTo=%23h10000873>. (The website was accessed on August 31, 2019.) Flavio Guzman, *Long-Acting Injectable Antipsychotics: A Practical Guide for Prescribers*, Updated June 27, 2019. <https://psychopharmacologyinstitute.com/publication/long-acting-injectable-antipsychotics-a-practical-guide-for-prescribers-2201>. (The website was accessed on October 13, 2019.)

¹⁵⁰ Shauna Garris and Caitlin Hughes, *Tintinalli's Emergency Medicine: A Comprehensive Study Guide, 8e*, Chapter 287, <https://accessmedicine.mhmedical.com/book.aspx?bookid=1658>, 2016. (The website was accessed on August 31, 2019.) MedlinePlus, *Lorazepam*, September 11, 2019. <https://medlineplus.gov/druginfo/meds/a682053.html>. (The website was accessed on September 19, 2019.) The Mayo Clinic, *Lorazepam*, September 1, 2019. <https://www.mayoclinic.org/drugs-supplements/lorazepam-injection-route/description/drg-20072326>. (The website was accessed on September 26, 2019.) United States. Food and Drug Administration, *Lorazepam*, April 27, 2017. https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/018140s041s042lbl.pdf. (The website was accessed on September 30, 2019.)

¹⁵¹ U.S. National Library of Medicine, *Olanzapine*, Updated February 18, 2020, <https://medlineplus.gov/druginfo/meds/a601213.html>. (The website was accessed on March 11, 2020.)

¹⁵² Lung Institute, *Oxygen Saturation and What It Means for You*, 2019, <https://lunginstitute.com/blog/oxygen-saturation-means/>. (The website was accessed on October 13, 2019.)

¹⁵³ Mayo Clinic, *Pulmonary Embolism*, <https://www.mayoclinic.org/diseases-conditions/pulmonary-embolism/symptoms-causes/syc-20354647>. (The website was accessed on October 21, 2019.)

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schizoaffective disorder, bipolar type. A mental disorder in which a person experiences a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania. The bipolar type includes episodes of mania and sometimes major depression.¹⁵⁴

schizophrenia. A chronic and severe mental illness that affects an individual’s thoughts and behaviors, and the symptoms can be disabling. Symptoms may include delusions and hallucinations that may cause a person to lose touch with reality and impair information processing and decision-making. 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.¹⁵⁵

ziprasidone. An antipsychotic medication used to manage the symptoms of psychotic disorders such as schizophrenia and for the treatment of acute agitation in an emergency. Drowsiness is a potential side effect.¹⁵⁶

¹⁵⁴ Mayo Clinic, *Schizoaffective Disorder*, <https://www.mayoclinic.org/diseases-conditions/schizoaffective-disorder/symptoms-causes/syc-20354504>, October 27, 2017. (The website was accessed on October 12, 2019.)

¹⁵⁵ 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 12, 2019.) Jan Volavka and Leslie Citrome, “Pathways to Aggression in Schizophrenia Affect Results of Treatment,” *Schizophrenia Bulletin*, vol. 37, no. 5, 2011: 921–929.

¹⁵⁶ Prescribers’ Digital Reference, *ziprasidone hydrochloride; ziprasidone mesylate – Drug Summary*, <https://www.pdr.net/drug-summary/Geodon-ziprasidone-hydrochloride---ziprasidone-mesylate-2532>, 2019. (The website was accessed on October 13, 2019.)

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