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VETERANS HEALTH ADMINISTRATION

Deficiencies in Quality of Care and the Root Cause Analysis Process at the Overton Brooks VA Medical Center in Shreveport, Louisiana

Healthcare Inspection | **25-00400-189** | **August 20, 2025**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the quality of care provided to a patient while hospitalized at the Overton Brooks VA Medical Center (facility) in Shreveport, Louisiana. The OIG also had concerns with staff's application of the root cause analysis (RCA) process related to this patient's hospital admission.

Synopsis of Patient's Care

The patient, who was in their fifties, presented to the facility's emergency department in early 2024 for worsening dementia and violent behaviors.[1] Admission documentation reflected the patient's dementia symptoms included visual hallucinations and delusions, and that the patient recently experienced increased agitation and was more difficult to redirect. The patient also had diabetes and an elevated blood sugar level. The emergency department physician discussed the patient's care with a psychiatrist, who recommended admission to a medical floor with psychiatric consultation.[2]

The admitting hospitalist documented the patient was undergoing evaluation for significant behavioral changes and may have Lewy body dementia, though non-VA records were not available for review.[3] A resident physician ordered insulin to treat the patient's blood sugar, restarted olanzapine for agitation, and placed the patient on one-to-one observation for "harm to self or others."[4]

Mental health providers evaluated the patient on hospital days 1 and 2 and learned the patient was started on olanzapine the previous summer during an admission to a non-VA psychiatric unit. The prescription for olanzapine ran out a month or two prior to the facility admission and the patient was unable to refill the medication. Mental health providers recommended continuing olanzapine and consulting neurology as features of the patient's presentation did not align with a

[1] The OIG uses the singular form of they, "their" in this instance, for privacy purposes.

[2] During interviews, a psychiatrist informed the OIG that patients with diabetes need to have stabilized blood glucose levels prior to a mental health unit admission.

[3] The evaluation was at a non-VA facility and VA staff did not obtain the patient's outside medical records for review. "Lewy body dementia is the second most common type of dementia after Alzheimer's disease. Protein deposits called Lewy bodies develop in nerve cells in the brain and affect brain regions involved in thinking, memory and movement." Mayo Clinic, "Lewy body dementia." accessed September 27, 2024, https://www.mayoclinic.org/diseases-conditions/lewy-body-dementia/symptoms-causes/syc-20352025.

[4] Resident physicians are in training programs and participate in patient care under the direction of supervising practitioners. VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019; Olanzapine is an antipsychotic medication used to treat psychosis. Cleveland Clinic, "Antipsychotic Medications," accessed March 20, 2025, https://my.clevelandclinic.org/health/treatments/24692-antipsychotic-medications. The family reported the medication had previously been prescribed after the patient was admitted to the non-VA hospital for aggressive behavior.

dementia diagnosis. On hospital day 3, a neurology provider evaluated the patient and recommended continuing the mental health team's recommendations.

Two days later, the patient's spouse informed a social worker of being unable to care for the patient at home and requested assistance placing the patient in a care facility. On hospital day 8, a hospitalist (subject hospitalist) assumed the patient's care and documented "in view of lewy [*sic*] body dementia will try to avoid antipsychotics." Under the instruction of the subject hospitalist, a resident physician discontinued the patient's olanzapine and prescribed a new medication (zolpidem) to assist with sleep.

On hospital day 11, a social worker documented a care facility accepted the patient with the caveat that the patient needed to be off one-to-one observation for 72 hours. The following day, the one-to-one observation was discontinued and over the next week and a half, placement efforts were pursued. On hospital day 22, at 6:37 a.m., a resident physician ordered the patient a one-time dose of olanzapine for "agitation."[5] The next day at 11:10 p.m., nursing documentation reflected the patient was pacing, confused, and agitated. A few hours later, a nurse documented the "patient became combative towards staff," and VA police and the covering physician were called for assistance.[6] At about 1:20 a.m. on hospital day 24, a resident physician ordered a dose of olanzapine for "agitation" and about 40 minutes later, ordered non-behavioral physical restraints "for safety."[7]

Between hospital days, 25 and 28, the patient displayed periods of agitation and was treated with lorazepam (a sedative). On hospital day 29, a resident physician documented a plan to consult mental health services after the patient's nurse reported the patient endorsed homicidal ideation and "tried to [harm] another [patient]" (the event). The following day, a Physician's Emergency Certificate was executed as the medical team deemed the patient dangerous to others and gravely

[5] The resident physician did not document the rationale for prescribing olanzapine. A disruptive behavior report and VA police report indicated that at approximately 6:00 a.m., while a nursing assistant was providing care, the patient grabbed the nursing assistant by the neck and punched the nursing assistant in the side. The OIG did not find physician or nursing documentation in the patient's electronic health record pertaining to the incident.

[6] A disruptive behavior report and VA police report indicated that at approximately 1:00 a.m., the patient attempted to elope, became aggressive, and punched a nurse when the nurse attempted to redirect the patient. The OIG did not find physician documentation in the patient's electronic health record pertaining to the incident.

[7] Non-behavioral restraints are used for patients who do "not exhibit violent or self-destructive behavior." They are used "to support medical healing, to maintain a therapeutic environment, prevent the patient from removing vital equipment, or for the inability to comply with safety instructions." Facility Memorandum 118-13, *Restraint and Seclusion*, August 12, 2020.

disabled.[8] A psychiatrist evaluated the patient and recommended restarting olanzapine. The psychiatrist noted that the inpatient mental health unit did not provide the appropriate level of care for a "higher need patient with dementia" and recommended placement at a community psychiatric facility. Later that day, a resident physician restarted the patient's olanzapine.

On hospital day 33, a third hospitalist's documentation described the patient as "polite" and "cooperative" and noted the one-to-one sitter reported the patient was confused but not aggressive. As a result of the event, law enforcement staff later escorted the patient off the medical floor.[9]

Inspection Results

The OIG found deficiencies with the clinical management of the patient while hospitalized; specifically, the subject hospitalist's mismanagement of medication and the staff's mismanagement of the patient's distressed behaviors. Additionally, deficiencies with staff's application of the RCA process may have affected the credibility of the RCA.

Mismanagement of Medication

The subject hospitalist did not have a complete understanding of the patient's clinical history, which included the previous non-VA hospital admission, or previous response to olanzapine prior to discontinuing the medication. While admitted to a non-VA inpatient psychiatric unit, the patient was started on olanzapine for aggressive behavior but ran out of the medication one to two months prior to the facility admission. At the time of facility admission, a resident physician restarted the patient's medication to treat agitation.

The patient's electronic health record (EHR) reflected that approximately a week later, the subject hospitalist discontinued the medication to avoid antipsychotic medication use in a patient diagnosed with Lewy body dementia. However, the subject hospitalist did not document a plan for behavioral management or reengagement of psychiatry or neurology services to discuss discontinuing the recommended antipsychotic medication. This may have affected the patient's quality of care and resulted in an escalation of distressed behaviors.

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[8] Under LA Rev. Stat. 28 §53, any licensed physician (or other provider type, including a federal provider, as specified in LA Rev. Stat. 28 §2(26)) "may execute an emergency certificate only after an actual examination of a person alleged to have a mental illness." This certificate allows a person who has a mental illness ... to be admitted and detained at a treatment facility for observation, diagnosis, and treatment for a period not to exceed fifteen days. Louisiana State Legislature, LA Rev. Stat. 28 §53, accessed on August 22, 2024, https://legis.la.gov/Legis/Law.aspx?d=85245#:~:text=NOTE:%20Subsection%20F%20as%20amended,during%20authorized%20periods%20of%20detention; Facility Memorandum 11-56, *Voluntary/Involuntary Admission*, April 9, 2020.

[9] The patient was taken into custody, criminally charged, and as a result of a legal proceeding, placed in a federal psychiatric facility.

Clinical evidence supports the potential negative effects of antipsychotics in patients with Lewy body dementia.[10] Nonetheless, based on the patient's reported history of psychotic symptoms with aggressive behaviors, the OIG would have expected the subject hospitalist to review the non-VA medical records to confirm the diagnosis and obtain information about treatment history (including response to olanzapine and other medications) prior to discontinuing the olanzapine.

Additionally, during interviews, facility leaders identified concerns with the management of the patient's care, yet the OIG did not find that a retrospective assessment of care was completed. The use of quality management improvement processes, such as a peer review, would have allowed for a comprehensive evaluation of the patient's care and potentially have identified opportunities for practice improvement.

Mismanagement of Patient's Distressed and Assaultive Behaviors

The patient exhibited distressed behaviors that escalated to physical assaults on two staff members and one patient.[11] The OIG determined that facility staff did not: (1) implement one-to-one observation according to facility policy, (2) activate a behavioral patient record flag (an established safety tool for distressed behaviors), or (3) use the EHR as a communication tool between disciplines.

Use of One-to-One Observation

According to facility procedures, one-to-one observation is implemented for patients who verbalize homicidal ideation or exhibit "high-risk behaviors that may lead to untoward patient outcomes."[12] Over the first 13 days of the patient's hospitalization, medical providers initiated, discontinued, and then reinstated multiple one-to-one observation orders when needed based on the patient's behaviors. On hospital day 12, the subject hospitalist discontinued one-to-one observation after the social worker documented a care facility accepted the patient with the caveat that the patient needed to be off both restraints and one-to-one observation for 72 hours. Over the next 17 days, the patient physically assaulted two staff members and entered other patients' rooms. However, not until the patient assaulted another patient and had violent ideation was one-to-one observation reinstated. The OIG determined that one-to-one observation, a tool used to maintain patient and staff safety, was intentionally discontinued to facilitate the patient's discharge and was not restarted despite the patient's escalating distressed behaviors.

[10] "Treatment of Behavioral Symptoms: When to Consider Antipsychotic medications in LBD," Lewy Body Dementia Association, accessed February 13, 2025, https://www.lbda.org/treatment-of-behavioral-symptoms-when-to-consider-antipsychotic-medications-in-lbd/.

[11] For purposes of this report, "assault" is used colloquially and is not meant to convey a particular legal or criminal meaning.

[12] Facility Standard Operating Procedure 118-61, "Telesitter Monitoring Close Observation and Continuous Observation," September 1, 2023.

Lack of an Interim Behavioral Patient Record Flag

Veterans Health Administration (VHA) policy recognizes the necessity for staff knowledge and awareness of a patient's behavior in order to protect the health and safety of the patient, other patients, VA staff, or guests.[13] The Disruptive Behavior Reporting System is VHA's mechanism to capture employee reports regarding patient "behaviors that cause a safety concern."[14] A behavioral patient record flag is a safety tool used to alert staff about patients who "pose a significant risk for disruptive behavior or violence and to quickly describe appropriate measures staff should take to ensure safety."[15] The disruptive behavior committee chair can place an interim behavioral patient record flag "on an emergency basis when warranted by the level of imminent risk and when the clear risk to health and safety of patients, VA staff or visitors outweighs the potential privacy concerns raised."[16]

Facility staff immediately entered disruptive behavior reports following each of the patient's assaults on staff. The disruptive behavior committee chairperson reviewed the reports within one business day; however, an interim behavioral patient record flag was not implemented. The disruptive behavior committee chairperson stated in hindsight an earlier placement of an interim behavioral patient record flag "probably would have helped." The OIG determined the placement of a flag would have prompted the implementation of safety strategies, alerted clinical staff of the patient's escalating distressed behaviors, and may have prevented subsequent assaults.

Lack of Documentation

Health record documentation is "an important element to high-quality care" that facilitates "communication and continuity of care among VA medical staff members."[17] VHA underscores the need for all patient care documentation to be included in the patient's EHR.[18] The OIG determined the patient's EHR did not provide an accurate account of the patient's condition. Resident physicians ordered the patient medications for agitation after both assaults on staff members; however, the EHR did not include corresponding documentation reflecting the patient's complete clinical status nor information regarding the extent of the distressed

[13] VHA Directive 1166, *Patient Record Flags*, November 6, 2023.

[14] VHA Directive 1160.08(1), *VHA Workplace Violence Prevention Program*, August 23, 2021, amended February 22, 2022. Disruptive behaviors include "intimidating, threatening, or dangerous" behaviors that endanger others and may include threats of assault, verbal abuse, physical assaults, or other actions that create anxiety or fear.

[15] VHA Directive 1166.

[16] VHA Directive 1166.

[17] VHA Health Information Management (HIM), *Health Record Documentation Program Guide Version 1.2*, September 29, 2023.

[18] VHA HIM, *Health Record Documentation Program Guide Version 1.2*.

behaviors.[19] Further, nursing documentation did not reflect the patient's first assault on staff. After the second assault on staff, a nurse documented that the "patient became combative towards staff," however, details such as safety needs or the patient's psychosocial status were not documented. Notably, after the second staff member was assaulted, a resident physician ordered the patient to be placed in physical restraints but the required clinical assessment and documentation indicating the need for restraints was not completed. Facility leaders, physicians, and nurses involved in the patient's care expressed an expectation that assaults on staff and the assessment for restraints should have been documented in the EHR but could not explain why it was absent. The lack of information prevented the EHR from functioning as a communication tool between disciplines.

Deficiencies in the Root Cause Analysis Process

Facility staff completed an RCA as required to determine contributing factors of the patient-to-patient assault.[20] However, the OIG determined deficiencies with the RCA process may have affected the credibility of the RCA. Notably, the RCA team included an individual involved with the event, which conflicts with VHA guidelines regarding a team member's objectivity and ability to remain impartial. Although the team member brought this concern to the former patient safety manager, who reportedly consulted with the Veterans Integrated Service Network patient safety officer, the staff member remained on the RCA team. The Veterans Integrated Service Network patient safety officer could not recall specific details, and the Facility Director reported being unaware that an RCA team member had direct involvement with the patient's care.

Additionally, similar to findings in an April 2025 OIG report, *Deficiencies in Trainee Onboarding, Physician Oversight, and A Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana*, the OIG identified issues with the RCA team's execution of RCA steps and timeliness to completion.[21] The recommendation remains open; therefore, a recommendation regarding the RCA process was not made in this report.

The OIG made five recommendations to the Facility Director related to a comprehensive review of the patient's hospitalization, obtaining outside medical records, one-to-one observation policy adherence, interim behavioral patient record flag processes, and ensuring behavioral events are accurately documented.

[19] Facility Memorandum 118-13. "A restraint is any method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to his or her body." Physicians are responsible for "documenting clinical justification for the restraint."

[20] An RCA would not include information regarding assaults on staff.

[21] VA OIG, *Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana*, Report No. 24-01566-100, April 24, 2025.

Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Contents

Abbreviations

EHR	electronic health record
OIG	Office of Inspector General
RCA	root cause analysis
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the care of a patient while hospitalized at the Overton Brooks VA Medical Center (facility) in Shreveport, Louisiana. The OIG also had concerns related to a root cause analysis (RCA).

Background

The facility is part of Veterans Integrated Service Network (VISN) 16, the South Central VA Health Care Network, and consists of one inpatient hospital and four outpatient clinics.[1] The facility provides comprehensive health care, including medicine, surgery, mental health, and primary care, to patients in Louisiana, southern Arkansas, and eastern Texas. The Veterans Health Administration (VHA) classifies the facility as level 1c with 77 operational inpatient beds.[2]

Prior OIG Reports

An April 2025 OIG report substantiated allegations related to deficiencies in trainee onboarding and physician oversight and found concerns regarding an RCA. One of the three recommendations made to the Facility Director was related to RCA process deficiencies and as of May 2025, the recommendation remained open.[3]

OIG Concerns

On November 6, 2024, based on a referral from the OIG Office of Investigations, the Office of Healthcare Inspections opened an inspection to review the quality of care provided to a patient with reported dementia who assaulted another patient (the event).[4] Additionally, the OIG identified concerns with the RCA completed after facility leaders became aware of the event.

[1] The clinics are in: Longview, Texas; Shreveport and Monroe, Louisiana; and Texarkana, Arkansas.

[2] VHA Office of Productivity, Efficiency, and Staffing (OPES), "Data Definitions: VHA Facility Complexity Model," accessed October 30, 2024. VHA facilities are classified at levels 1a, 1b, 1c, 2, or 3. Level "1a facilities are the most complex and the level 3 facilities are the least complex."; According to the July 12, 2024, facility Trip Pack, the facility was finalizing conversion to single occupancy inpatient unit rooms.

[3] VA OIG, *Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana*, Report No. 24-01566-100, April 24, 2025.

[4] For purposes of this report "assault" is used colloquially and is not meant to convey a particular legal or criminal meaning.

Scope and Methodology

The OIG conducted a virtual site visit and completed interviews from December 16, 2024, through February 6, 2025. The OIG interviewed selected current and former facility leaders, providers, and staff who had knowledge of the patient's care or related facility processes. The OIG reviewed relevant VHA and facility policies, procedures, bylaws, disruptive behavior reports, police reports, and quality reviews.[5] The OIG also reviewed the patient's electronic health record (EHR) for care received from early 2024 through mid-summer 2024.

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).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. 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.

[5] The Disruptive Behavior Reporting System is a "VA-approved secure web-based reporting mechanism providing means for all VA employees to alert the [disruptive behavior committee] or [employee threat assessment team] about behaviors that cause a safety concern, and about disruptive or violent events occurring within the health care setting." VHA Directive 1160.08(1), *VHA Workplace Violence Prevention Program*, August 23, 2021, amended February 22, 2022.

Patient Case Summary

The patient, who was in their fifties with a medical history that included type II diabetes, presented to the facility's emergency department in early 2024.[6] The patient's spouse informed the emergency department physician that the patient was experiencing worsening dementia and was "becoming violent … [which] could be due to medication."[7] While assessing the patient in the emergency department, staff found the patient had an elevated blood sugar level. The emergency department physician discussed the patient's care with a psychiatrist, who recommended admission to a medical floor with psychiatric consultation.[8] The patient was admitted to a medical floor that evening.[9]

Admission documentation reflected that the patient's spouse and family informed a resident physician that the patient's dementia began approximately five years earlier.[10] Symptoms included visual hallucinations and delusions but over the past two months, the patient experienced increased agitation and was more difficult to redirect. The resident physician documented that the patient's prescribed medications included a daily dose of olanzapine.[11] The resident physician ordered the patient olanzapine, one-to-one observation for "harm to self or others," and insulin for high blood sugar level.[12] The admitting hospitalist documented the patient was "in the process of being worked up [evaluated] for significant behavioral changes

[6] The OIG uses the singular form of they, "their" in this instance, for privacy purposes.

[7] Additional details regarding the patient's dementia and violent behavior were not documented in the emergency department physician's note. Further, the only medications listed in the note were aspirin and a multivitamin, neither are typically associated with violent behavior.

[8] During interviews, a psychiatrist informed the OIG that patients with diabetes need to have stabilized blood glucose levels prior to a mental health unit admission.

[9] During the patient's hospitalization, the patient's blood glucose levels trended downward but did not reach a normal level. However, the patient's blood glucose levels were in an acceptable range for a hospitalized patient.

[10] A resident physician "is engaged in a … training program for physicians … and who participates in patient care under the direction of supervising practitioners." VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019; The term "resident physician" in this report does not represent one specific person. The OIG found EHR documentation from 12 resident physicians who were all under the direction of supervising practitioners.

[11] Cleveland Clinic, "Antipsychotic Medications," accessed March 20, 2025, https://my.clevelandclinic.org/health/treatments/24692-antipsychotic-medications. Olanzapine is an antipsychotic medication used to "treat psychosis, a collection of symptoms that affect your ability to tell what's real ..."

[12] Facility SOP 118-61, *Telesitter Monitoring Close Observation and Continuous Observation*, September 1, 2023. One-to-one observation is implemented when a patient verbalizes suicidal or homicidal ideation or exhibits high-risk behaviors that may lead to untoward outcomes. The staff member assigned to one-to-one observation is responsible for watching the patient and intervening as necessary to ensure patient safety. The staff member is required to maintain uninterrupted visual contact with the patient at arm's length. Patients may be placed on or taken off one-to-one observation based on ongoing assessments of their condition and risk-level change.

and dementia, and … may have Lewy body dementia."[13] The admitting hospitalist also noted the patient was evaluated for dementia at a non-VA facility and the records were not available for review.[14] Later that evening, nursing staff notified a resident physician that the patient attempted to elope, and upon redirection became "aggressive and combative" with staff. A resident physician then ordered physical restraints for the patient.

The following afternoon, (hospital day 1) a resident physician consulted mental health services, noting "[the patient] has been agitated since admission to the floor, required chemical and physical restraint, with [one-to-one observation]."[15] A psychiatry physician assistant and psychiatrist evaluated the patient later in the day and recommended (1) continuation of olanzapine, albeit administration at bedtime as the medication can cause sleepiness; and (2) consultation with neurology as features of the patient's presentation, particularly age, did not align with a dementia diagnosis.

In the morning of hospital day 2, a resident physician discontinued the order for restraints. Later that day, the mental health team obtained additional history from the patient's spouse, who reported the patient became agitated and physically aggressive during the previous summer. This resulted in an admission to a non-VA inpatient psychiatric unit where the patient was started on olanzapine. After discharge from the psychiatric unit, the patient was referred to a non-VA neurologist; however, the neurologist left the practice and the patient went several months without care. The patient's spouse also shared that a month or two prior to this admission, the prescription for olanzapine ran out and the patient was unable to refill the medication. The patient's spouse also reported the patient had a slow progressive cognitive decline over the past four to five years, but a rapid deterioration and acute confusion and irritability over the past six weeks. The psychiatrist documented that the patient's symptoms did not "fit the pattern of Dementia alone, but would point more toward encephalopathy of some origin."[16]

A resident physician documented on hospital day 3 that the patient was calm and slept throughout the night. That same day, a neurology resident physician evaluated the patient and

[13] A hospitalist is a physician who cares for inpatients and has expertise in treating the most common conditions that bring people to the hospital. "What Is a Hospitalist?" Yale Medicine, accessed March 20, 2025, https://www.yalemedicine.org/news/what-is-hospitalist; "Lewy body dementia is the second most common type of dementia after Alzheimer's disease. Protein deposits called Lewy bodies develop in nerve cells in the brain. The protein deposits affect brain regions involved in thinking, memory and movement." Mayo Clinic, "Lewy body dementia." accessed September 27, 2024, https://www.mayoclinic.org/diseases-conditions/lewy-body-dementia/symptoms-causes/syc-20352025.

[14] The medical team did not add Lewy body dementia to the patient's problem list in the electronic health record.

[15] In addition to physical restraints, the patient received lorazepam (a sedative), diphenhydramine (an antihistamine), and additional doses of olanzapine for agitation.

[16] "Hypoxic Ischemic Encephalopathy," National Institute of Neurological Disorders and Stroke, accessed November 12, 2019, https://www.ninds.nih.gov/Disorders/All-Disorders/Encephalopathy-Information-Page. Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure. The hallmark of encephalopathy is an altered mental state.

noted a history of Lewy body dementia and documented the patient "is back to … baseline."[17] The neurology resident physician recommended a magnetic resonance imaging of the brain, specific laboratory tests, and continuing to follow the recommendations from the mental health team.[18] A neurologist documented agreement with the neurology resident's findings, assessment, and treatment plan. Later that day, a resident physician discontinued the patient's one-to-one observation.

A resident physician's note on hospital day 4 stated the patient had no complaints and "to discharge [the patient] in the morning." The following day, the patient's spouse informed a social worker of being unable to care for the patient at home and requested placement in a care facility. Later that day, a nursing assistant documented the patient seemed confused and was attempting to leave the room with medical equipment. A resident physician placed an order to resume one-to-one observation. On hospital day 5, the patient was taken off one to-one observation for most of the day. However, the following day, a resident physician re-ordered one-to-one observation.[19]

On hospital day 8, a different hospitalist (subject hospitalist) assumed the patient's care and documented "in view of lewy [*sic*] body dementia will try to avoid antipsychotics." A resident physician discontinued the patient's olanzapine for agitation and prescribed a new medication (zolpidem) as a "sleep aid."[20]

On hospital day 11, a social worker documented a care facility accepted the patient with the caveat that the patient needed to be off both restraints and one-to-one observation for 72 hours. The next day, the subject hospitalist documented the patient "will need 72 hr [hour] off period for 1:1 sitter before NH [nursing home] will accept," and a resident physician entered an order to discontinue one-to-one observation. On hospital day 14, a resident physician documented that the patient's sleep improved.

On hospital day 15, a social worker documented that a liaison from the accepting care facility visited with the patient the previous day. The patient "was observed [by the liaison] having hallucinations, talking to people and things that were not in [the] room and attempted to get out of bed with no assistance. Patient behaviors must be address[ed] prior to admitting to any NH [nursing home] facility." The following day, a resident physician documented the patient had "occasional visual hallucinations (baseline)" and from hospital days 18 to 21, a resident physician documented the patient was "at baseline mentally" and "pending placement."

[17] The patient's EHR does not reflect a description of the patient's baseline status.

[18] The results of the magnetic resonance imaging of the brain identified no acute abnormalities and laboratory testing results were within normal range.

[19] The patient's one-to-one observation remained in place until hospital day 12.

[20] Zolpidem is a medication used to treat insomnia. It should only be used for a short period of time. Cleveland Clinic, "Zolpidem Tablets," accessed March 20, 2025, https://my.clevelandclinic.org/health/drugs/20871-zolpidem-tablets.

On hospital day 22, at 6:37 a.m., a resident physician ordered the patient a one-time dose of olanzapine for "agitation."[21] Later that afternoon, another resident physician documented "last night was agitated, patient received one dose of olanzapine [ordered at 6:37 a.m.]. Back to baseline."

On hospital day 23 at about 11:15 p.m., the patient was pacing, confused, and agitated, and attempts at redirection were unsuccessful according to nursing documentation. A few hours later, on hospital day 24, a nurse documented the "patient became combative towards staff," and VA police and the covering physician were called for assistance.[22] At around 1:25 a.m., a resident physician ordered a dose of olanzapine for "agitation" and at 2:10 a.m., ordered non-behavioral physical restraints "for safety."[23] Later that day, a resident physician documented the patient was agitated overnight and restraints were briefly ordered but discontinued when the patient remained calm. The resident physician also placed an order for lorazepam as needed for agitation.

On hospital day 25, documentation reflected the patient received a dose of lorazepam for agitation at 8:00 p.m., and that restraints were briefly ordered but removed as the patient remained calm. Later that day, a nurse documented the patient was walking in the hallway and entered another patient's room. The nurse noted the patient could not be redirected and that a staff member was following the patient.[24] Lorazepam was administered, and the patient was subsequently redirected back to the patient's assigned room.

The next day, the subject hospitalist documented "the pt [patient] does not show any sign of aggression but does sometimes try to walk in the Hallways and walks into other patient's [*sic*] rooms."[25] On hospital days 27 and 28, a resident physician characterized the patient as calm and noted that there were no adverse events overnight.[26]

On hospital day 29, a resident physician documented a plan to consult mental health services after the patient's nurse reported that the patient endorsed homicidal ideation and "tried to [harm]

[21] The resident physician did not document the rationale for prescribing olanzapine. A disruptive behavior report and VA police report indicated that at approximately 6:00 a.m., while a nursing assistant was providing care, the patient grabbed the nursing assistant by the neck and punched the nursing assistant in the side. The OIG did not find physician or nursing documentation in the EHR pertaining to the incident.

[22] A disruptive behavior report and VA police report indicated that at approximately 1:00 a.m., the patient attempted to elope, became aggressive, and punched a nurse when the nurse attempted to redirect the patient. The OIG did not find physician documentation in the EHR pertaining to the incident.

[23] Facility Memorandum 118-13, *Restraint and Seclusion*, August 12, 2020. Non-behavioral restraints are used for patients who do "not exhibit violent or self-destructive behavior." They are used "to support medical healing, to maintain a therapeutic environment, prevent the patient from removing vital equipment, or for the inability to comply with safety instructions."

[24] The note did not identify the staff member's position.

[25] The subject hospitalist was the assigned hospitalist during both incidents when the patient assaulted staff members.

[26] On hospital day 28, the patient was moved from a single occupancy room to a double occupancy room with a roommate across from the nurses' station.

another [patient]" (the event). Documentation also reflected the "patient spoke with nurse about 'hearing voices' that are telling [the patient] to harm people." The note further stated the patient described an out of body experience and "doing things that [the patient] does not want to do." The nurse spoke with a resident physician about the possibility of moving the patient to the psychiatric unit. The resident physician documented a plan to consult psychiatry after the patient's nurse reported that the patient endorsed homicidal ideation and "tried to [harm] another [patient]."[27] The chief of social work documented that care facility placement efforts were discontinued.

At approximately 3:30 p.m., a nurse contacted the on-call medical team to notify them the patient was "very agitated, verbally aggressive towards staff and wandering down halls."[28] At approximately 6:45 p.m., another nurse documented that the patient stated, "I don't need to be in the room by myself, I get to killing," and "Come here. They told me to get you." At approximately 7:20 p.m., a third hospitalist (newly assigned that day) contacted a nurse to inquire if the patient was on one-to-one observation and was informed that the patient was not. A short time later, a resident physician ordered one-to-one observation.

On hospital day 30, a Physician's Emergency Certificate was executed as the medical team deemed the patient dangerous to others and gravely disabled.[29]

A psychiatrist evaluated the patient and recommended restarting olanzapine. The psychiatrist noted that the inpatient mental health unit did not provide the appropriate level of care for a "higher need patient with dementia" and recommended placement at a community psychiatric facility. Later that day, a resident physician restarted the patient's olanzapine.

On hospital day 33, the third hospitalist's documentation described the patient as "polite" and "cooperative" and noted that the one-to-one sitter reported the patient was confused but not aggressive. As a result of the event, law enforcement staff later escorted the patient off the medical floor.[30]

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[27] A resident physician ordered another mental health consult by psychiatry service (hospital day 30).

[28] The OIG did not locate any documentation from a physician evaluation resulting from this contact.

[29] Under LA Rev. Stat. 28 §53, any licensed physician (or other provider type, including a federal provider, as specified in LA Rev. Stat. 28 §2(26)) "may issue an emergency certificate only after an actual examination of a person alleged to have a mental illness." This certificate allows a person who has a mental illness ... to be admitted and detained at a treatment facility for observation, diagnosis, and treatment for a period not to exceed 15 days. Louisiana State Legislature, LA Rev. Stat. 28 §53, accessed on August, 22, 2024, https://legis.la.gov/Legis/Law.aspx?d=85245#:~:text=NOTE:%20Subsection%20F%20as%20amended,during%20authorized%20periods%20of%20detention; Facility Memorandum 11-56, *Voluntary/Involuntary Admission*, April 9, 2020.

[30] The patient was taken into custody, criminally charged, and as a result of a legal proceeding, was placed in a federal psychiatric facility.

Inspection Results

1. Clinical Management Deficiencies

The OIG determined there were quality of care deficiencies with the clinical management of the patient while hospitalized; specifically, the subject hospitalist's mismanagement of medication and the staff's mismanagement of the patient's distressed behaviors.

Mismanagement of Medication

A provider may discontinue a patient's medication if it is potentially harmful or no longer required.[31] To make this determination, the provider should be familiar with the indication for which the medication was prescribed, the patient's response to the medication, side effects, and risks and benefits of continued use.[32] Additionally, monitoring the patient post discontinuation is beneficial to assess for reoccurrence of the symptom or condition the medication was originally prescribed to treat.[33]

The OIG found the subject hospitalist did not have a complete understanding of the patient's clinical history that included the previous non-VA hospital admission, or response to olanzapine prior to discontinuing the medication. The patient was started on olanzapine while admitted to a non-VA inpatient psychiatric unit for aggressive behavior.[34] The patient ran out of olanzapine one to two months prior to the facility admission, and experienced visual hallucinations and delusions, worsening memory, confusion, and agitation with violent behavior. At the time of facility admission, a resident physician restarted the patient's olanzapine to treat agitation; psychiatry and neurology consultants later endorsed this treatment.

Eight days after restarting the olanzapine, a resident physician (with the subject hospitalist's oversight) discontinued the medication to avoid antipsychotic use in a patient with a Lewy body dementia diagnosis.[35] The OIG found the subject hospitalist did not document a plan for behavioral management or reengage psychiatry or neurology services to discuss discontinuing

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[31] VHA Directive 1164, *Essential Medication Information*, July 13, 2023; VHA Directive 1345, *Medication Reconciliation,* March 9, 2022.

[32] VHA Directive 1310(1), *Medical Management of Enrolled Veterans Receiving Self-Directed Care from External Health Care Providers*, October 4, 2021, amended April 13, 2022; VHA Directive 1164; and VHA Directive 1345.

[33] VHA Directive 1164; VHA Directive 1345.

[34] VHA Directive 1310(1).

[35] "Treatment of Behavioral Symptoms: When to Consider Antipsychotic medications in LBD," Lewy Body Dementia Association, accessed February 13, 2025, https://www.lbda.org/treatment-of-behavioral-symptoms-when-to-consider-antipsychotic-medications-in-lbd/. The Lewy Body Dementia Association (LBDA) notes that severe reactions may occur in patients with Lewy body dementia treated with antipsychotics, including worsening cognition; sedation; symptoms of Parkinsonism; and neuroleptic malignant syndrome, which can be fatal. However, LBDA notes that newer antipsychotics (such as olanzapine) may be beneficial for individuals with Lewy body dementia if used cautiously.

the recommended antipsychotic medication. Documentation also showed the patient became increasingly agitated and violent toward others after the medication was discontinued.

Clinical evidence supports the potential negative effects of antipsychotic medication in patients with Lewy body dementia.[36] However, given the patient's history of psychotic symptoms with aggressive behavior, the OIG would have expected the subject hospitalist to take certain steps prior to discontinuing the olanzapine. These steps include reviewing outside records to confirm the diagnosis of Lewy body dementia, obtaining information about treatment history (including response to olanzapine and other medications), documenting risks and benefits associated with the use of antipsychotics, and re-engaging psychiatry or neurology for a better understanding of the rationale for prescribing olanzapine and for guidance on treatment alternatives.

The subject hospitalist informed the OIG the patient was not experiencing side effects from the olanzapine but patients with Lewy body dementia can have severe reactions to antipsychotics, including death, and that "… most of the psychiatrists will stay away from the antipsychotics in patients with Lewy body dementia … all of neurologists will stay away from it [antipsychotics]." The subject hospitalist also told the OIG that outside records were not obtained to confirm the diagnosis or review the patient's clinical course and treatment history because it is "extremely hard to get notes—outside notes—from other hospitals, especially clinics."

During an interview, a facility psychiatrist, who was involved in the patient's care, informed the OIG that the combination of discontinuing an antipsychotic medication and starting a sleep medication may have exacerbated the patient's distressed behaviors. The former Chief of Staff told the OIG that psychiatry should have been reconsulted prior to discontinuation of the antipsychotic medication because hospitalists lack the necessary expertise to make that determination. The Chief of Staff also opined that psychiatry expertise could have helped in decisions regarding medication management. Additionally, the former Chief of Staff, Chief of Staff, and chief of medicine told the OIG of an expectation that outside records should have been obtained to assist with medical management. Although facility leaders identified concerns with the management of the patient's care, a thorough review of the patient's care was not completed. The OIG would have expected the use of quality management improvement processes such as a peer review, which would have allowed for a comprehensive evaluation of the patient's care and potentially have identified opportunities for practice improvement.[37]

The OIG is concerned that the subject hospitalist discontinued the olanzapine prior to ensuring a complete understanding of the patient's medical history. The hospitalist did not acquire the non-

[36] "Treatment of Behavioral Symptoms: When to Consider Antipsychotic medications in LBD," Lewy Body Dementia Association.

[37] VHA Directive 1190(1), *Peer Review for Quality Management,* November 21, 2018, amended July 19, 2024. A peer review for quality management is a confidential, non-punitive process a peer evaluates a provider's care to determine if the standard of care was met.

VA medical records, consult relevant specialists, or implement a treatment plan; this may have affected the patient's quality of care and resulted in an escalation of distressed behaviors.

Mismanagement of Patient's Distressed and Assaultive Behaviors

The OIG determined that although the patient exhibited distressed behaviors throughout the hospitalization that escalated to assaults on staff and another patient, facility staff did not

- implement one-to-one observation according to facility policy,
- activate a behavioral patient record flag (an established safety tool for distressed behaviors), or
- use the EHR as a communication tool between disciplines.[38]

Use of One-to-One Observation

One-to-one observation is an intervention staff use to "redirect a patient from engaging in a harmful act."[39] According to facility procedures, one-to-one observation requires the staff member monitoring the patient to maintain "uninterrupted visual contact always with the patient at arm's length." Specifically, this type of observation "is immediately implemented any time a patient verbalizes suicidal/homicidal ideation or exhibits intractable, high-risk behaviors that may lead to untoward patient outcomes. The staff member who the ideation is reported to ensures that the patient is not left unattended." The staff member also notifies the nurse, who then performs an assessment "and contacts the medical provider for further" evaluation and places a one-to-one observation order if needed.[40] The medical provider is then responsible for consulting with nursing staff and entering a one-to-one observation order every 24 hours if the patient continues to exhibit high-risk behaviors.[41]

The OIG found the subject hospitalist, nocturnists, and nursing staff did not implement one-to-one observation when the patient's distressed behaviors increased in severity prior to and following the assaults on staff.[42] At the time of the patient's admission, a resident physician with the admitting hospitalist's oversight ordered one-to-one observation for the patient indicating "harm to self or others (violent) and not suicidal/homicidal." Over the first 13 days of the patient's hospitalization, medical providers initiated, discontinued, and then reinstated multiple

[38] EHR documentation of the patient's distressed behaviors included wandering, combativeness, and hallucinations with accompanying statements, "You're all trying to kill me. You all need to die," but did not include information about the assaults.

[39] VA Evidence Synthesis Program (ESP) Center, *One-to-One Observation: A Systemic Review*, August 2019.

[40] Facility SOP 118-61.

[41] Facility SOP 118-61.

[42] Nocturnists are attending hospitalists that work overnight. At the facility, nocturnists work from 7:00 p.m. to 7:00 a.m.

one-to-one observation orders based on the patient's behavior.[43] On the 12th day, the subject hospitalist documented the 'patient needs to be off' of one-to-one observation for 72 hours before a care facility would accept the patient. Over the next 17 days, after one-to-one observation was discontinued, the patient physically assaulted two staff members and entered other patients' rooms. However, it was not until the patient assaulted another patient and had violent ideation that the one-to-one observation was reinstated by a resident physician, noting the indication as "suicidal/homicidal" behaviors.[44]

The subject hospitalist told the OIG of not knowing two staff were assaulted and would have placed the patient on one-to-one observation if aware. Additionally, the nocturnists on duty reported not being aware of the assaults on staff. A nursing leader, nursing assistant, and social worker reported believing the one-to-one observation had been discontinued to assist with the facilitation of the patient's discharge to a care facility. The chief of medicine told the OIG that based on the patient's behaviors escalating, one-to-one observation of the patient should have been considered. Prior to speaking with the OIG, the former Chief of Staff reviewed the patient's chart and expressed being "mortified" to learn the one-to-one observation was discontinued to facilitate a discharge.[45]

The OIG determined that one-to-one observation, a tool used to maintain patient and staff safety, was intentionally discontinued to facilitate the patient's discharge and was not reinstituted, despite the patient's escalating distressed behaviors, which included assaults on three individuals.

Lack of an Interim Behavioral Patient Record Flag

According to VHA, "Health care workers experience high rates of injury from violence in the work setting."[46] VHA has also identified future episodes of violence could be reduced with proper identification and planning. "[I]t is necessary for … staff to know, in the initial moments of a patient encounter, information about the patient's behavior or safety status in order to protect the patient's health and safety, or the health and safety of other patients, VA staff or guests at the VA medical facility."[47]

[43] The greatest amount of time the patient was without one-to-one observation orders was approximately 61 hours. Additionally, four different resident physicians under the supervision of attending hospitalists discontinued and reinstated one-to-one observation orders over the same general period. The Chief of Staff explained that the rotation of resident physicians is based upon educational program requirements.

[44] Of note, a resident physician under the supervision of a hospitalist discontinued the one-to-one observation order; however, nursing EHR documentation reflected one-to-one observation of the patient continued until the following day.

[45] The OIG recognizes the challenges in placement of patients with distressed behaviors into care facilities. During the patient's hospitalization, social workers made 11 referrals.

[46] VHA Directive 1166, *Patient Record Flags*, November 6, 2023.

[47] VHA Directive 1166.

The Disruptive Behavior Reporting System is VHA's mechanism to capture employee reports regarding "behaviors that cause a safety concern, and … disruptive or violent events occurring within the health care setting."[48] The disruptive behavior committee chairperson must review the disruptive behavior event report within one business day of receipt and facilitate the disruptive behavior committee review process.[49] This committee's actions include completing behavioral threat assessments, potential referrals for medical care, and the placement of a behavioral patient record flag in a patient's EHR.[50] A behavioral patient record flag is used to alert staff about patients who "pose a significant risk for disruptive behavior or violence and to quickly describe appropriate measures staff should take to ensure safety and enable the provision of high-quality health care."[51] The disruptive behavior committee chairperson can place an interim behavioral patient record flag "on an emergency basis when warranted by the level of imminent risk and when the clear risk to health and safety of patients, VA staff or visitors outweighs the potential privacy concerns raised."[52] The disruptive behavior committee then reviews placement of the flag "as soon as possible, but not later than the next scheduled meeting."[53]

The OIG learned facility staff immediately entered disruptive behavior reports following each of the patient's assaults on nursing staff. The disruptive behavior committee chairperson reviewed the reports within one business day and contacted nursing leaders to ensure staff involved in the assault received follow-up care. However, the disruptive behavior committee chairperson did not place an interim behavioral patient record flag.

After learning the patient assaulted another patient, the disruptive behavior committee chairperson placed a behavioral patient record flag in the patient's EHR and recommended at least two staff members be present when engaging with the patient. The OIG is concerned that an interim behavioral patient record flag was not placed after either the first or second assault on staff. The placement of a flag would have triggered immediate safety actions.

When asked, the disruptive behavior committee chairperson stated that in hindsight, an earlier placement of an interim behavioral patient record flag "probably would have helped," and

[48] VHA Directive 1160.08(1). Disruptive behaviors include "intimidating, threatening, or dangerous" behaviors that endanger others and may include threats of assault, verbal abuse, physical assaults, or other actions that create anxiety or fear.

[49] VHA Directive 1160.08(1). The Disruptive Behavior Committee meets "to address patient-generated disruptive behavior, threats, or violence that undermine a culture of safety within the VA medical facility." The Disruptive Behavior Committee reviewed the patient's assaults on staff approximately two weeks after the event occurred. Committee meeting notes documented a plan to consult with the patient's "behavioral health team/provider … on ways to set appropriate boundaries" with the patient.

[50] VHA Directive 1160.08(1). A behavioral threat assessment is VHA's evidence-based approach identifying factors to characterize the potential risk of violence an individual poses within the healthcare environment.

[51] VHA Directive 1166.

[52] VHA Directive 1166.

[53] VHA Directive 1166.

recalled that a flag was not placed earlier because the patient's EHR indicated the use of one-to-one observation after the assaults. However, as noted previously, the OIG found no orders or documentation of the patient being placed on one-to-one observation following the assaults on staff.

Facility leaders told the OIG:

- "I would have expected a behavioral flag—to have all staff aware of this patient's potential for violence. This should prepare any staff and offer some protection."
- "Given the two documented staff assaults, a temporary behavioral patient record flag should have been considered in accordance with … directives."
- "My expectation is that it would have been clinically assessed and if it was appropriate, it would have been flagged."

The OIG concluded that had the disruptive behavior committee chairperson placed the interim behavioral patient record flag after the first assault, it (1) would have prompted the implementation of safety strategies, (2) alerted clinical staff of the patient's escalating distressed behaviors, and (3) may have prevented subsequent assaults.[54]

Lack of Documentation

Health record documentation is "an important element to high-quality care" that facilitates "communication and continuity of care among VA medical staff members."[55] Further, VHA underscores the need for all patient care documentation to be included in an EHR, as it allows medical staff and other health care professionals the ability "to evaluate and plan the patient's immediate treatment and to monitor the patient's health care over time."[56]

Attending physicians, in this case hospitalists, are responsible for ensuring their EHR documentation is accurate and complete. This includes a timely and reliable assessment of a patient's psychological needs, clinical observations, health history, present illness, and course of treatment.[57] Nurses are required to document elements of the assessment, which include safety needs, psychosocial status, and discharge planning.[58] Facility policy highlights that "accurate, timely documentation of nursing process enhances communication, cooperation and

[54] VHA Directive 1160.08(1).

[55] VHA Health Information Management (HIM), *Health Record Documentation Program Guide Version 1.2*, September 29, 2023.

[56] VHA HIM, *Health Record Documentation Program Guide Version 1.2*.

[57] VHA HIM, *Health Record Documentation Program Guide Version 1.2*; Facility, *Bylaws And Rules of The Medical Staff of the Overton Brooks Department of Veterans Affairs Medical Center, Shreveport, Louisiana*, April 22, 2019.

[58] Facility SOP 118-19, "Documentation of Nursing Care," March 12, 2021.

collaboration among all members of the health care team."[59] Social workers are responsible for ensuring documentation in the EHR is accurate, comprehensive, timely, and reflects multidisciplinary staff awareness of discharge plans.[60]

The OIG found staff EHR documentation did not accurately reflect the extent of known events, including the severity of the patient's distressed behaviors. The OIG surmised this prevented the EHR from functioning as a communication tool between disciplines resulting, in part, in consulting specialties such as mental health not being reengaged in care.

Resident physicians ordered the patient medications for agitation after both assaults on staff members; however, the resident physicians did not document the patient's complete clinical status nor information regarding the extent of the distressed behaviors. Notably, after the second staff member was assaulted, a resident physician under the supervision of a nocturnist ordered the patient to be placed in physical restraints. However, the required clinical assessment and documentation indicating the need for restraints was not completed.[61]

The OIG also found that nursing staff did not document the patient's first assault on staff in the patient's EHR. However, following the second assault on staff, a nurse documented that the "patient became combative towards staff" but further details such as patient and staff safety needs or the patient's psychosocial status were not recorded. Social work staff documentation reflected continued efforts toward the patient's discharge to a care facility and the need for the patient to be off one-to-one observation, while the patient's behaviors escalated.[62]

In interviews, facility leaders, as well as physicians and nurses involved in the patient's care, acknowledged that assaults on staff and the assessment of the need for restraints should have been documented in the EHR, but they could not explain why it was not documented. Further, the Chief of Staff, chief of medicine, and Associate Director for Patient Care Services shared concerns about the quality of physician and nursing documentation. The former Chief of Staff explained how the lack of documentation related to the patient's assaults may have prevented reengagement of psychiatry or other resources since the treatment team may not have understood the degree of the patient's escalating behaviors. Additionally, the social workers involved with the patient's discharge planning reported being unaware of the assaults and stated the type of placement the patient needed would have been different if the EHR reflected the assaults.

[59] Facility SOP 118-19.

[60] VHA HIM, *Health Record Documentation Program Guide Version 1.2*; Facility Memorandum 122-02, *Discharge Planning*, April 25, 2019.

[61] Facility Memorandum 118-13. "A restraint is any method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to his or her body." Physicians are responsible for "documenting clinical justification for the restraint."

[62] After the patient assaulted the other patient, the former Chief of Staff stopped social work placement efforts for discharge to a care facility.

Although the EHR reflected changes in the patient's treatment such as the ordering of medication and restraints, the documentation did not provide context to communicate the patient's escalating distressed behaviors or the assaults. Therefore, the OIG asked how such information was communicated between clinical staff. The OIG learned through interviews that physicians, nurses, and social work staff may have communicated the patient's plan of care verbally through handoffs and interdisciplinary team meetings.[63] However, some nurses reported minimal nursing involvement at the interdisciplinary team meetings and a social worker clarified that discussions regarding the patient's discharge plan did not include information about the assaults. The OIG could not verify if verbal communication included critical information about the patient's distressed behaviors.

The OIG concluded that the EHR was not used as an effective communication tool. Without documentation that accurately reflected the extent of known events, including the severity of the patient's distressed behaviors, the patient's medical status was not communicated among medical staff. This documentation deficiency contributed to the staff's incomplete understanding of the patient's clinical presentation and the need to reevaluate the plan of care, including reengagement of specialists and the discharge plan.

2. Deficiencies in the Root Cause Analysis Process

RCAs are used "to study health care-related adverse events and close calls" with a goal of "find[ing] out what happened, why it happened, and how to prevent it from happening again."[64] VHA outlines the specific process an RCA team should follow to increase understanding of an event, identify knowledge gaps, and collect and analyze information. VHA provides specific instructions regarding RCA team composition, process steps, and timeliness.[65]

The OIG determined deficiencies with staff's application of the RCA process may have affected the credibility of the RCA. The OIG determined the RCA team included an individual involved with the processes and systems under review and did not properly execute RCA steps or complete the RCA within required time frames. In an April 2025 report, the OIG identified similar issues with the facility's RCA process and issued a recommendation related to team

[63] Facility SOP 122-02. Interdisciplinary team meetings consist of a utilization management nurse case manager, a social worker, a physician, and if available nursing staff and other professionals who assess patients' "continuity of care needs based on [a patient's] medical, psychiatric, nursing, rehabilitation, social and emotional needs."

[64] "Root Cause Analysis," VHA National Center for Patient Safety, accessed February 13, 2025, https://www.patientsafety.va.gov/professionals/onthejob/rca.asp.

[65] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, version 12, January 2024; VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, version 13, February 2024; VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, version 14, March 2024. The three versions of the guidebook were in place at varying times from the event to the RCA concurrence. All three contain the same or similar language regarding team composition, the RCA process, and timeliness.

composition, process steps, and timeliness. The recommendation remains open; therefore, a recommendation regarding the RCA process was not made in this report.[66]

During an interview with the OIG, the Facility Director recalled learning in early 2024 of the patient's assault on another patient.[67] The Facility Director told the OIG that after being notified of the event, the decision was made to charter an RCA to identify contributing factors to the patient-to-patient assault.[68] According to the Facility Director, the RCA was not chartered until approximately two weeks later due to a concurrent investigation of the event.[69]

Team Composition

An RCA charter identifies the participants who form the RCA team and establishes that team members will be convened to examine the contributing factors of an event. The team should be composed of four to six members to complete a thorough analysis of the event and in the interest of objectivity must "exclude individuals directly involved in the adverse event or close call under review."[70]

The OIG found the RCA team included an individual directly involved with post-event actions associated with the assault. Of note, the team member told the OIG of recognizing the lack of impartiality, "I've been doing this long enough to know that if there's an investigative process, that you usually don't have the people writing the actions … that were involved in the case." The team member further stated expressing these concerns to the former patient safety manager who prepared the RCA charter.[71]

The former patient safety manager told the OIG that the VISN patient safety officer was consulted regarding the RCA but could not recall specific details. However, the former patient safety manager recalled, "the [team member's] membership was in question, but permission was given by the [Facility Director] as the charter for the RCA team was signed." The VISN patient safety officer stated awareness of the RCA but did not recall a "formal consultation" about the team's composition. The Facility Director reported not being aware of the RCA team member's involvement in the event at the time of signing the RCA charter. The Facility Director further

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[66] VA OIG, *Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana*.

[67] The RCA's analysis did not include information regarding the two assaults on staff.

[68] VHA Directive 1160.08(1); VHA National Center for Patient Safety, JPSR [Joint Patient Safety Report] Guidebook, December 2023. Patient safety staff are not responsible for reviewing physical assaults or disruptive behavior involving staff if an event did not result in patient injury. Staff should enter these incidents into the Disruptive Behavior Reporting System.

[69] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. RCAs are performed after completion of formal investigations of intentionally unsafe acts.

[70] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[71] The patient safety manager told the OIG that the previous patient safety manager (who prepared the RCA charter) left the position approximately one month into the RCA process.

expressed concerns that the team member was not identified as someone that should be excluded from participating on the RCA team.

As VHA policy excludes persons directly involved with an event from serving on the RCA team, the OIG identified a team member's participation in the RCA that could affect the RCA's credibility. The OIG notified the Facility Director of this concern in early 2025.

RCA Process

Proper execution of RCA steps is a vital component of an RCA's credibility and occurs in part through the team's understanding of the event and identification of knowledge gaps.[72] The OIG determined the RCA team improperly executed RCA steps that may have precluded a thorough examination of the event.

- Limited information was gathered from involved facility staff, which contributed to deficiencies in the team's ability to gain a thorough understanding of the event.
- The final understanding did not incorporate a comprehensive analysis of the event and lacked the identification of missing information recognized in the initial understanding, resulting in unresolved knowledge gaps.[73]

The OIG concluded that if the RCA team had properly executed the RCA steps, more likely than not, the team would have identified how system vulnerabilities discussed previously in this report contributed to the event's occurrence:

- Facility staff did not implement one-to-one observation when indicated.[74]
- The interim behavioral patient record flag process was not followed after the patient assaulted staff.
- The patient's EHR was not used as an effective communication tool.

Timeliness

Completing an RCA "allow[s] for more accurate and rapid assessment of potential and actual causes of patient harm" with a goal of eliminating or correcting the root cause or contributing factors to "prevent the problem from reoccurring." Medical center directors are responsible for

[72] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[73] 38 U.S.C. § 5705, Confidentiality of medical quality assurance records. VHA Directive 1320, *Quality Management and Patient Safety Activities that can Generate Confidential Records and Documents*, July 10, 2020; An RCA is a protected quality management activity under 38 U.S.C. §5705; associated documents, including identifying information contained in the RCA, are protected and confidential and, therefore, the OIG may not disclose this information.

[74] Facility SOP 118-61.

ensuring RCAs are completed within 45 calendar days from the day facility leaders are aware that an RCA is needed.[75]

The Facility Director chartered the RCA in early 2024 and signed the RCA concurrence over 100 days later. Both the patient safety manager and the chief of quality, safety and value told the OIG of a backlog of RCA's pending completion due to staff vacancy. However, the chief of quality, safety and value shared that as of June 2024, the backlog had been resolved. The Facility Director also reported awareness of the backlog and attributed the delays to patient safety staffing and a concurrent investigation. The Facility Director further commented that according to quality management staff, timeliness had improved. The OIG concluded the RCA for the event was not completed within the 45-day time frame as policy required.[76] Failing to complete RCA's per VHA established time frames may prolong the identification and correction of patient safety risks.

Conclusion

The OIG identified deficiencies with the quality of care received during the clinical management of a patient. Specifically, the subject hospitalist's mismanagement of medication and the staff's mismanagement of the patient's distressed behaviors. The subject hospitalist discontinued the medication olanzapine prior to developing a complete understanding of the patient's medical history. The subject hospitalist did not obtain non-VA medical records, reconsult relevant specialists, or implement a treatment plan. This may have affected the patient's quality of care and resulted in an escalation of the patient's distressed behaviors, resulting in assaults on three individuals. Although facility leaders identified concerns with the management of the patient's care, quality management improvement processes (such as a peer review), which would allow for a comprehensive evaluation of the patient's care, were not completed and potential care improvements were left unidentified.

Further, when the patient exhibited escalating distressed behaviors, staff did not (1) implement one-to-one observation in order to facilitate the patient's discharge, (2) activate a behavioral patient record flag prompting implementation of safety strategies, or (3) use the EHR as a communication tool to alert additional staff of the severity of the patient's behaviors. The mismanagement of the patient's behaviors may have contributed to continued assaults and facility staff's incomplete understanding of the patient's clinical presentation and staff's need to reengage specialists and reevaluate the discharge plan.

Deficiencies with staff's use of the RCA process may have affected the credibility of the RCA and left system vulnerabilities unresolved. The OIG determined VHA required guidelines to

[75] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*. "The date the facility Director signs-off on the RCA is the date the RCA is complete." VHA Directive 1050.01(1).

[76] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

exclude individuals involved with the processes under review, properly execute RCA steps, or complete the RCA within required time frames were not followed.

Recommendations 1–5

1. The Overton Brooks VA Medical Center Director conducts a comprehensive review of the patient's hospitalization and takes action as indicated, including quality management improvement processes such as a peer review.

2. The Overton Brooks VA Medical Center Director ensures medical staff recognize the importance of obtaining hospitalized patients' non-VA medical records and assesses the current processes for obtaining non-VA medical records, identifies any barriers to completion, and takes action as warranted.

3. The Overton Brooks VA Medical Center Director assesses the application of the one-to-one observation policy and practices at the facility, and takes action as warranted.

4. The Overton Brooks VA Medical Center Director reviews interim behavioral patient record flag processes to ensure implementation of safety strategies for staff and patients, and takes action as warranted.

5. The Overton Brooks VA Medical Center Director evaluates whether documentation of patient and patient-related behavioral events are reflected accurately in the electronic health record to facilitate continuity of care and communication among medical staff and takes action as necessary.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 7, 2025

From: Interim Network Director, South Central Department of Veterans Affairs (VA), Health Care Network (10N16)

Subj: VA Office of Inspector General (OIG) Report, Deficiencies in Quality of Care and the Root Cause Analysis Process at the Overton Brooks VA Medical Center in Shreveport, Louisiana

To: Director, Office of Healthcare Inspections (54HL06)
Chief Integrity and Compliance Officer (10OIC)

1. The South Central VA Health Care Network (10N16) has reviewed and concurs with the facility's response to the five recommendations contained in the draft report Healthcare Inspection – Deficiencies in Quality of Care and the Root Cause Analysis Process at the Overton Brooks VA Medical Center in Shreveport, Louisiana.

2. Should you need further information, please contact the Quality Management Officer.

(*Original signed by:*)

Fernando O. Rivera, FACHE

[OIG comment: The OIG received the above memorandum from VHA on July 8, 2025.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 7, 2025

From: Director, Department of Veterans Affairs (VA) Overton Brooks VA Medical Center (667)

Subj: VA Office of Inspector General (OIG) Report—Deficiencies in Quality of Care and the Root Cause Analysis Process at the Overton Brooks VA Medical Center in Shreveport, Louisiana

To: Director, South Central VA Health Care Network (10N16)

1. I have reviewed and concur with the OIG report, Health Care Inspection – Deficiencies in Quality of Care and the Root Cause Analysis Process at the Overton Brooks VA Medical Center in Shreveport, LA. The Overton Brooks VA Medical Center action plan is included as an attachment.

2. I would like to thank the OIG for their thorough review and their recommendations. The Overton Brooks VA Medical Center will continue working with the OIG to implement actions that will improve our processes. We remain committed to providing high quality care to the nation's Veterans.

3. Should you need further information, please contact the Chief of Quality Management.

(*Original signed by*:)

Richard L. Crockett, MBA

[OIG comment: The OIG received the above memorandum from VHA on July 8, 2025.]

Facility Director Response

Recommendation 1

The Overton Brooks VA Medical Center Director conducts a comprehensive review of the patient's hospitalization and takes action as indicated, including quality management improvement processes such as a peer review.

_X _Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The Overton Brooks Department of Veterans Affairs (VA) Medical Center (MC) Director will initiate a comprehensive clinical review of the Veteran's hospitalization to ensure standards of care were met. This review will include an assessment of the patient's clinical care, including the application of one-to-one observation, orders for medication, and clinical documentation. After review, appropriate action will be taken if warranted.

Recommendation 2

The Overton Brooks VA Medical Center Director ensures medical staff recognize the importance of obtaining hospitalized patients' non-VA medical records and assesses the current processes for obtaining non-VA medical records, identifies any barriers to completion, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The Overton Brooks VA Medical Center Director will ensure a review of our current process for obtaining hospitalized Veterans' non-VA medical records is completed. This review will address clinical needs and identify any barriers. Additionally, the VAMC will work in collaboration with the appropriate stakeholders to ensure that our efforts are aligned with the current process. Findings and corrective actions will be shared with applicable staff, including the significance of obtaining hospitalized patients' non-VA medical records.

Recommendation 3

The Overton Brooks VA Medical Center Director assesses the application of the one-to-one observation policy and practices at the facility, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The Overton Brooks VA Medical Center Director will ensure a review of adherence to the facility's Standard Operating Procedure (SOP) regarding telesitter monitoring and close and continuous observations. The care of patients on one-to-one observation and patients with reported disruptive behavior on our inpatient medical-surgical units will be reviewed to ensure our one-to-one SOP is being followed.

Recommendation 4

The Overton Brooks VA Medical Center Director reviews interim behavioral patient record flag processes to ensure implementation of safety strategies for staff and patients, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The Medical Center Director will initiate a review of our local practice for interim behavioral patient record flags to ensure it aligns with VHA Directive 1166, "Patient Record Flags", the Disruptive Behavior Guidebook, guidance from the national Workplace Violence Prevention Program in the Office of Mental Health, and the 2021 Order of Behavioral Restriction Fact Sheet. After the review, revisions in the processes will be made if warranted.

Recommendation 5

The Overton Brooks VA Medical Center Director evaluates whether documentation of patient and patient-related behavioral events are reflected accurately in the electronic health record to facilitate continuity of care and communication among medical staff and takes action as necessary.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

The Overton Brooks VA Medical Center Director will ensure a review and evaluation of the medical staff documentation regarding patient and patient-related behavioral events for Veterans receiving inpatient care is completed. Findings and recommendations from the review will be addressed, including staff education, peer review, and administrative action.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Ariel Drobnes, LCSW, MBE, Director Debbie Davis, JD Carrie Mitchell, LCSW Robin Moyer, MD Nancy Short, LCSW
Other Contributors	Shelby Assad, LCSW Carol Lukasewicz, BSN, RN Natalie Sadow, MBA

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