



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Mismanagement and Safety Issues Battle Creek VA Medical Center Battle Creek, Michigan

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Executive Summary

The purpose of this inspection was to determine the validity of multiple allegations pertaining to mismanagement, safety issues, and undesirable outcomes for four patients at the Battle Creek VA Medical Center (the medical center).

We substantiated that: closure of an inpatient psychiatric ward resulted in conditions that may negatively impact patient and staff safety; closure of the Transitional Living Program and conversion of the Substance Abuse Residential Rehabilitation Treatment Program to the Substance Abuse Clinic (SAC) were done without Veterans Health Administration (VHA) approval; and there were changes in arrangements for medical and mental health coverage and the detoxification of substance abuse patients. We substantiated that organizational changes in mental health were initiated during the former Director's tenure, there was turnover in psychiatry staff, and the medical center faced ongoing challenges with recruitment of psychiatrists. We identified opportunities for improvement and identified environment of care concerns.

We did not substantiate that patients lodged as part of the SAC were unsupervised or that there was a lack of management support for the substance abuse program.

We made recommendations that the Veterans Integrated Service Network (VISN) Director collaborate with the Medical Center Director to reassess inpatient mental health services and create appropriate plans and programs to optimize patient and staff safety with regard to the following factors: most appropriate physical location of inpatient mental health unit(s) and type, designation of bed capacity per unit based on patient acuity, and program structuring to ensure a therapeutic milieu for patients. We further recommended that the VISN Director initiate a review of mental health provider staffing and workload and make discipline-specific recommendations based on current and projected patient care needs.

We also recommended that the Medical Center Director take actions to: comply with policy regarding VHA approvals for program restructuring and/or changes to authorized or operating beds or program capacity; require mental health staff complete periodic training on the management of medical and psychiatric emergencies; clarify and review procedures for patient privileges and establish policy for contraband searches and random urine drug screens; comply with VHA's Patient Safety Alert on louvered heating, ventilating, and air conditioning grilles; meet patient safety standards in seclusion rooms; and correct environmental, patient privacy, and safety deficiencies identified by the Office of Healthcare Inspections team during ward inspections. Management submitted appropriate action plans, and we will follow up on all actions not yet completed.

Introduction

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding mismanagement, safety issues, and undesirable outcomes for four patients at the Battle Creek VA Medical Center (the medical center) in Battle Creek, Michigan.

Background

The medical center provides tertiary psychiatric care, primary and secondary medical care, specialty care, extended and long-term care, preventive medicine, related social support services, and a variety of outpatient services for veterans in the western and lower peninsula of Michigan. The medical center has 484 operating beds and provides nursing home care, a medical care unit, a primary care clinic, physical medicine, and a mental health clinic. The medical center is part of Veterans Integrated Service Network (VISN) 11.

A complainant contacted the OIG hotline with multiple allegations that the closure of inpatient psychiatric ward 14-2 resulted in:

- An increase in the number of inpatients on psychiatric wards 39-1 and 39-2 from 30 to 40 patients per ward. The complainant alleged that the overcrowding increased the potential for violence and adverse outcomes due to limited staff ability to track patient behavior and properly attend to patients.
- Professional staff on wards 39-1 and 39-2 were forced to use rooms as offices on enclosed porches that were formerly used to store housekeeping supplies. The complainant alleged that the enclosed porches and office spaces had poor temperature control, were unsafe for staff, and would potentially be difficult to escape in the event of a fire.
- Serious problems with staff morale that may be compromising teamwork and endangering patients and staff.
- The residential Transitional Living Program (TLP) was closed and the Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) was converted to an outpatient Substance Abuse Clinic (SAC), without prior approval from VA Headquarters and resulted in the elimination of residential beds.
- Conversion to the outpatient SAC resulted in changes to medical coverage for substance abuse patients. Lack of availability of mental health and medical services formerly available to patients with increased likelihood of negative outcomes related to substance abuse, homelessness, and medical problems.

- Medical center policy (Psychiatry Service MCM 116A-1001, dated July 2003) for 23-hour detoxification may not meet InterQual Behavioral Health Criteria¹ and may be endangering patients.
- Increased risks to patients and staff from housing substance abuse patients in unsupervised lodging beds on ward 8.
- Negative commentary from medical center administration regarding substance abuse patients (“We don’t treat drunks here”).
- Ineffective support from management to accept and act on mid-level and front-line staff concerns regarding safety, quality of care, and VA regulations.
- Hiring and promotion practices that pad the medical center with managers and decrease the funding available to hire clinicians necessary to maintain safe and appropriate patient care.
- Staffing problems and lack of stability in patient care settings and treatment teams due to poor retention of psychiatrists.

In addition to the above allegations, the complainant alleged that related factors contributed to undesirable care outcomes for four patients. These included:

- A patient suffered a seizure while lodging on ward 8 in 2005, after going through 23-hour detoxification and being transferred to the SAC. (Case A)
- A patient suffered a seizure while in 23-hour detoxification in 2006. (Case B)
- Outbreak of a violent episode, described as a “near riot,” on ward 39-2, resulting in several significant staff injuries and requiring the use of mace and clubs by VA Police. (Case C)
- Death of a patient on ward 39-2 on May 14, 2006. (Case D)

Scope and Methodology

We conducted on-site inspections on August 28–31 and November 13–17, 2006. We interviewed the complainant, employees, managers, and VISN 11 and VHA officials. We reviewed patient medical records, medical center and service-level policies, incident reports, and other applicable medical center documents; VHA policies and InterQual standards; and community standards of care. We performed the inspection in accordance

¹ Criteria developed by clinical research staff including physicians, registered nurses, and other healthcare professionals. The clinical content is reviewed and validated by a national panel of clinicians and medical experts, including those in community and academic practice settings, as well as within the managed care industry throughout the United States. The clinical content is a synthesis of evidence-based standards of care, current practices, and consensus from licensed specialists and/or primary care physicians.

with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Closure of Inpatient Psychiatric Ward 14-2

We substantiated that the closure of inpatient psychiatric ward 14-2 resulted in conditions in Building 39 that may negatively impact patient and staff safety.

Number of Patients. The complainant alleged that the closure of ward 14-2 caused overcrowded conditions in Building 39, increasing the potential for violence and adverse outcomes. Ward 14-2 was a locked psychiatric admission unit with a 30-bed capacity. As of December 31, 2004, the average daily census (ADC) on 14-2 was 25 patients. Prior to the closure, ward 39-1 was a locked psychiatric ward, with 17 psychiatric rehabilitation and 13 geriatric psychiatry beds, and an ADC of 27.4 patients. Ward 39-2 was a locked chronic psychiatry ward with a 30-bed capacity and an ADC of 26 patients.

In February 2005, management closed ward 14-2. Ward 39-1 was increased to 40 beds, including 23 psychiatric rehabilitation and 17 geriatric psychiatry beds. Ward 39-2 was also increased to 40 beds and was changed to a psychiatric admission ward, with acute and intermediate length-of-stay patients. Both wards remained locked wards after the move. Management also directed that intoxicated patients were no longer to be admitted to acute psychiatry beds unless there was a psychiatric/behavioral reason to do so. Nine beds were added to ward 82-1 for the management of intoxicated patients or those needing 23-hour observation beds for detoxification. Staff from ward 14-2 were reassigned, many to 39-1 and 39-2, and to other areas of the medical center.

We interviewed staff from both wards who told us that the increased number of patients makes the monitoring of patient behavior and the ward milieu challenging. We reviewed the medical center's gains and losses census reports for the period of April 26–May 14, 2006. Ward 39-1 ranged from a census of 31 to 37 patients, and ward 39-2 ranged from 28 to 34 patients.

Physical Layout. The complainant alleged that rooms formerly used for storage, prior to the closure of ward 14-2, were now being used for staff offices, had poor temperature control, and were unsafe. We inspected wards 39-1 and 39-2 with nurse managers or employees who had worked on these wards prior to the closure of ward 14-2. The employees pointed out several rooms, particularly on the enclosed porches on both ends of the wards, which were used as storage rooms prior to the closure of ward 14-2. We noted that these rooms were converted into staff offices without any additional physical alterations other than adding office furniture. Although panic alarms were available in staff offices on the wards, there were some employees who were not comfortable meeting with patients in their offices because of safety concerns about not

being able to escape and the physical layout of the offices. Selected staff told us they felt their safety concerns were known but had not been addressed by service-line management. We found that those staff who had safety concerns appropriately discussed the issues with supervisors, who in turn, brought their concerns to the Associate Chief of Staff (ACOS) for Mental Health. While alternative office spaces were offered, they generally were off the ward, requiring the patients to leave the locked environment to meet with the clinicians. None of the staff offered alternate office spaces accepted the arrangements.

VA Handbook 7610, *Space Planning Criteria for VA Facilities*, provides general guidelines for square footage requirements for staff offices, treatment rooms, waiting areas, and storage. For example, the handbook requirement for a psychologist's office is 120 square feet. We noted that some of the converted staff offices on the enclosed porches in Building 39 were approximately 80 square feet, and barely accommodated office furniture with tight walk around space. We also noted portable heating and cooling devices in offices where staff were attempting to maintain adequate temperature control.

Staff Morale. The staff we interviewed on wards 39-1 and 39-2 expressed enthusiasm for their jobs, were forthcoming in identifying opportunities to improve patient care, and recognized opportunities to address concerns through appropriate channels such as their local American Federation of Government Employees (union).

Issue 2: Closure of TLP and Conversion of SARRTP to SAC

We substantiated that the closure of the TLP and conversion of SARRTP to the SAC were done without VHA approval and contrary to policy.

Bed Section Changes. VHA policy requires that medical centers and VISNs proposing to restructure programs or make changes to authorized or operating beds or program capacity are responsible for submitting requests and receiving proper VHA approvals prior to implementation. Information on changes in beds and/or program related beds available at a given medical center is included in the web-based National Bed Control Database. The TLP, a residential treatment program with a capacity for 29 veterans, was moved from a leased building in the Battle Creek community to ward 3 (a 27-bed unit) at the medical center in June 2000. Program numbers began to decline, and by September 2004 the ADC was 15. Senior managers recognized that supporting the TLP on station required expenditures associated with 24-hour staffing, upkeep of the building, utilities, food for patients, and other resources. The medical center supported three existing community-based programs including 9 compensated work therapy (CWT) beds (in 2 homes supported by the medical center's CWT program), 14 Jesse House beds (in 3 homes owned by the City of Battle Creek in which veterans pay minimal rent from their earnings), and 20 contract halfway house beds (paid for by the medical center at the cost of \$65 per day). Managers concluded that veterans in the TLP could be transferred to

one of the three programs, would receive the same level of treatment, but would be living off station and interacting with the community. Managers closed the TLP in November 2004; however, there was no record of a request or approval from VHA officials for this change. We received documentation from October 2004 to support that VISN 11 managers gave approval to the former Medical Center Director to proceed.

On July 27, 2005, the VISN 11 Director sent a memorandum to the Under Secretary for Health, through the Deputy Under Secretary for Health for Operations and Management, requesting a change in bed levels at the medical center. The memorandum requested to “permanently close the Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) at VAMC Battle Creek, Michigan.” The medical center grouped SARRTP under the umbrella of the Psychosocial Residential Rehabilitation Treatment Program (PRRTP). The request would have resulted in the decrease of 50 operating Residential Rehabilitation Treatment Program beds, reducing the total beds from 115 to 65 remaining PRRTP beds. The request also proposed changing from treating SARRTP patients in a residential rehabilitation setting to an intensive outpatient setting, with use of available lodger beds (equivalent to the number of former SARRTP beds) for patients who require housing services while in outpatient treatment. The proposed effective date of the requested change was February 8, 2005.

An August 25 electronic mail message from the Program Manager for Special Projects of VHA’s Mental Health Strategic Healthcare Group (MSHHG) was sent to the VISN 11 Director with a non-concurrence of the medical center’s proposed bed change request. The message read, “...the MSHHG does not support the use of Lodger beds as an appropriate replacement for the Residential Rehabilitation beds in a SARRTP program. The Lodger program, while meeting the housing needs of the veterans, is not an equivalent therapeutic milieu and does not provide the essential residential rehabilitation services that are so critical to the recovery of the veteran. Thus, the MSHHG cannot concur with the bed reduction proposed for the 50 SARRTP beds.” The MSHHG recommended that the medical center maintain at least 12 SARRTP beds and that a cost analysis “on the overhead for SARRTP beds be performed at the 12 and 20 bed level as the results may indicate that the cost differential is minimal and the extra beds will provide a cushion for an increased demand for these types of services.” The MSHHG suggested the beds could be designed as a Supportive Residential Model, where veterans receive their primary treatment services in outpatient clinics rather than on the unit and receive the additional benefit of residential rehabilitation rather than just housing.

Despite this non-concurrence, the former Medical Center Director initiated the conversion in February 2005 of the SARRTP to the SAC.

On August 11, 2006, medical center managers submitted an addendum to the bed change and program restructuring request, based on the MSHHG recommendations. The modified plan recommended a 12-bed Supportive Residential Component (SRC), using

American Society of Addiction Management (ASAM) criteria² for admission to and discharge from the SRC beds, with the plan to be completed by October 13, 2006. The addendum also involved increased Medical/Psychiatric provider and direct service provider staffing for the SRC.

Change in Medical and Mental Health Coverage in Conversion from SARRTP to SAC. We substantiated that there were staffing changes in the transition from the SARRTP to the SAC. The SARRTP's full-time psychiatrist was reduced to approximately 0.275 FTE, the full-time physician assistant was reduced to 0.25 FTE, and two full-time psychologists were reduced to 1.50 FTE coverage in the SAC. Additionally, the SARRTP included 7 days per week programming, while the SAC operates 5 days per week, with no weekend programming.

The manner in which medical coverage was provided changed in the conversion from the SARRTP to the SAC. During administrative hours, on-ward physician assistant coverage was provided for patients in Building 8 as part of the SARRTP, while patients enrolled in the SAC receive medical care from their usual primary care providers in Building 2.

Lodging. We did not substantiate that patients who were considered lodgers as part of the conversion to the SAC were left unsupervised. Prior to the conversion, substance abuse patients in the SARRTP occupied residential beds in Building 8 while they were participating in the treatment program. The patients received medical care and were monitored by a compliment of professional staff 24 hours per day. Since the SAC was considered an outpatient program, management concluded that patients participating in the program would be allowed to lodge in Building 8 beds and would no longer require the level of supervision and staffing as that of the residential program. Nursing Service policy was to provide full staffing 7:30 a.m. to 4:00 p.m., Monday through Friday, and provide "skeletal staff" on evenings, weekends, and holidays. The Building 8 nurse manager reported that she assigned one nursing assistant on the evening shift and one nursing assistant on the night shift. The night shift nursing assistant was instructed to page the Nursing Officer of the Day (Nursing Supervisor) if a patient's condition warranted. Nursing managers and staff expressed reservations with the transition to reduced staffing and managing the patients' needs through an outpatient Primary Care Service model.

² The ASAM criteria allow a clinician to systematically evaluate the severity of a patient's need for treatment along six dimensions, and then utilize a fixed combination rule to determine which of four levels of care a substance abusing patient will respond to with the greatest success. These levels include outpatient treatment, intensive outpatient/partial hospitalization, medically monitored intensive inpatient treatment, and medically managed intensive inpatient treatment.

VHA Directive 2003-009, *Temporary Lodging and Hoptel Programs*,³ requires that

...facility Directors are responsible for: (a) ensuring that decisions concerning temporary lodging are made by the person responsible for coordinating the temporary lodging program at the VA health care facility and that this decision is based on determinations made by the VHA health care provider of the veteran's medical stability, self-care, and ability to stay in an unsupervised setting, and (b) ensuring that domiciliary beds or other forms of residential treatment or transitional housing (Psychiatric Residential Rehabilitation Treatment Programs, including PTSD and Substance Abuse Residential Rehabilitation Programs, community-based homeless programs, etc.) are not used for temporary lodging.

The directive also requires patients who are temporarily lodging to

...sign a statement of understanding that, among other requirements, no medical or nursing services will be provided in the temporary lodging facility. Veterans with behavioral or medical conditions requiring monitoring or supervision must not be accepted for temporary lodging.

Management Support of Substance Abuse Programming. We were unable to substantiate or refute a lack of support for substance abuse programming by prior management. The complainant alleged that management, and most specifically the former Medical Center Director, was not supportive of the substance abuse program and made public derogatory references to substance abuse patients as “crack heads” and “drunks.” It was alleged that the former Director was also not supportive of residential treatment programs. However, the medical center was known as a provider of choice for residential substance abuse treatment for the northern tier of VISN 11. We were unable to substantiate the allegations regarding the former Director. However, we did not identify a lack of support for substance abuse programming by present leadership. We identified a strong commitment by substance abuse program staff toward providing quality care for the patients seeking treatment, despite programmatic changes that were mandated by the former Director.

Issue 3: Human Resources Concerns

Hiring and Promotion. During the former Director's tenure there were Mental Health Service organizational changes. Prior to the changes, Mental Health Service was organized by discipline with service-level chiefs of psychiatry, psychology, and social work. Senior managers planned to develop a service line model for mental health, which included recruiting an ACOS for Mental Health Service, who would have administrative responsibility for all mental health disciplines. VA facilities have implemented service lines extensively, with over 75 percent of all VA facilities having mental health and/or primary care service lines. We found their decision to move to service line management

³ Issued February 7, 2003.

in mental health was consistent with other VA facilities, and the recruitment process for the ACOS position was appropriately administered. We did not substantiate that the creation of this position and commitment of salary had an impact on filling other mental health positions.

Retention of Psychiatrists. We substantiated that there was psychiatry staff turnover in recent years and that recruitment was challenging. The ACOS for Mental Health Service reported to us that within the first few months of her arrival in 2004 there were several staff who were “close to retirement” and four psychiatrists left shortly after her arrival. The Chief of Human Resources Management Service stated that management has supported filling psychiatrist vacancies; however, it has been difficult to recruit them to the Battle Creek area. The ACOS for Mental Health Service also acknowledged difficulties in recruiting psychiatrists for inpatient care.

The medical center has a Resource Management Committee that reviews requests for positions on a bimonthly basis. At the time of our inspection, managers were actively recruiting one psychiatrist vacancy. One psychologist position was approved for recruitment out-of-committee during the summer of 2006, and the Acting Medical Center Director recommended that an additional full-time psychologist position be considered.

During the inspection, some staff members voiced concerns about inadequate staffing and workload expectations in mental health, especially to meet patient treatment needs on wards 39-1 and 39-2 and in the Substance Abuse Program. VHA has informal guidelines for mental health provider workload.⁴ These guidelines are not formal policy requirements and require consideration of the unique local circumstances at each medical center.

Issue 4: Patient Case Summary Findings

Case Summary Patient A

The patient was a 55-year-old male who served in the United States Army from March 1968 to January 1970. The patient was 80 percent service-connected including 50 percent for Post-Traumatic Stress Disorder (PTSD), 40 percent for paralysis of the sciatic nerve, 20 percent for arteriosclerosis, 10 percent for a thigh muscle injury, 10 percent for back muscle impairment, and 0 percent for malaria and scars.⁵ The patient requested substance abuse treatment at the medical center. On July 15, 2005, the patient participated in a SAC telephone screening interview with a registered nurse. The veteran was seeking treatment for alcohol addiction and for mental health counseling related to his nightmares and flashbacks. The patient reported that he had consumed a fifth or more

⁴ *Mental Health Provider Workload Guidelines*, Version 2, March 2003, Department of Veterans Affairs Mental Health Strategic Health Care Group.

⁵ Service-connected veterans may be rated in increments of 10 percent per medical condition. They also receive a “total” service-connected rating. The sum of the individual ratings may or may not equal the total rating.

of alcohol daily for the past year. He also reported that he had hypertension that was treated with atenolol; depression that was treated with citalopram; and leg and back pain at a level 6 on a 1–10 severity scale. During screening, he reported that his depression was a level 6 and anxiety a level 9 on a 1–10 severity scale. The patient was assessed to meet ASAM criteria for the SAC/Hoptel⁶ level of care, pending further evaluation of the patient’s hypertension and mental health status.

On July 21, the patient arrived at Building 8 to begin the SAC program. He was tremulous, and alcohol was detected on his breath. The patient was directed to Building 2 for evaluation for 23-hour observation. A psychiatrist interviewed the patient, and assessed him to be at a level 10 on the revised Clinical Institute Withdrawal Assessment (CIWA-Ar) scale.⁷ The patient denied a history of delirium tremens or a seizure disorder and had no suicidal or homicidal thoughts. He was diagnosed as being in alcohol withdrawal and having a history of PTSD. The patient was placed in a 23-hour observation bed for alcohol detoxification. The detoxification beds are located on unit 82-1, which is an inpatient medical unit. Medications ordered for the patient included Librium® (anti-anxiety), thiamine (vitamin), and folic acid (vitamin).

On July 22, the physician managing the patient’s detoxification evaluated the patient and released him from 23-hour observation. The physician assessed the patient to be at CIWA-Ar level 6 with no severe withdrawal signs and symptoms that would require admission to an inpatient medical or psychiatric ward. The physician ordered thiamine and Librium as needed for the weekend. The patient would complete detoxification in the SAC program. The patient was accepted for transfer to SAC/Hoptel in Building 8.

On July 22, a nursing assistant found the patient unresponsive in a stairway in Building 8, and staff called a medical emergency at approximately 7:00 p.m. The medical center’s Fire Department paramedics arrived at 7:02 p.m. and found the patient on the floor, conscious, with confused responses to all questions other than his name. He was transported to medical unit 82-1 and was awake upon arrival. An abrasion/laceration to his left hand was also noted. The patient had been incontinent of urine. The staff psychiatrist assessed the patient and documented that the patient had a probable alcohol withdrawal seizure. The physician ordered telemetry and immediate laboratory testing. The plan was to continue monitoring the patient and medicating him with Librium. The patient had no further seizure activity, and he was transferred back to the SAC/Hoptel on July 26.

⁶ A Hoptel provides temporary lodging that is furnished at a VA health care facility.

⁷ The CIWA-Ar is a validated 10-item assessment tool that can be used to quantify the severity of alcohol withdrawal syndrome and to monitor and medicate patients going through withdrawal. CIWA-Ar scores of 8 points or fewer correspond to mild withdrawal, scores of 9 to 15 points correspond to moderate withdrawal, and scores of greater than 15 points correspond to severe withdrawal symptoms and an increased risk of delirium tremens and seizures.

Findings:

At the time of the patient incident, employees used Medical Center Memorandum 116A-1001, dated July 2003, to address policy and procedures for detoxification. When managers subsequently realized that the local policy was not written in conformity with InterQual Criteria, the medical center policy for 23-hour observation for withdrawal was revised.

Case Summary Patient B

The patient was a 57-year-old male who served in the United States Navy from September 1967 to July 1969. The patient was 80 percent service-connected including ratings of 70 percent for PTSD and 20 percent for diabetes mellitus. The patient presented to the medical center on December 2, 2005, requesting help for alcohol addiction. He reported a greater than 35-year history of alcohol use, with his last drink of 2–4 ounces of whiskey at 6:00 a.m. on the date of arrival. The patient denied a history of delirium tremens, seizures, or blackouts. In the initial history and physical, the staff psychiatrist documented that the patient's medical records showed a history of alcohol-related seizures. The patient was placed on 23-hour observation status on ward 82-1 for alcohol dependence and intoxication. His diagnoses included alcohol intoxication, diabetes mellitus, and hypertension. The physician's plan was to prescribe Librium, thiamine, folic acid, insulin, and continue his outpatient medications. The plan also included referring the patient to be screened for substance abuse treatment. The patient's initial CIWA-Ar score was noted as 10. A nursing progress note at 5:35 p.m. stated that the veteran was tremulous and vomiting. The Psychiatry Officer of the Day (POD) was called, and promethazine (anti-nausea) and Librium were ordered and given.

On December 3 at 9:29 a.m., the staff psychiatrist documented plans to discharge him from observation status and admit him to ward 39-2 (an inpatient psychiatric unit) for further management of alcohol withdrawal symptoms. The plan was for the patient to continue with the currently prescribed medications. The patient's CIWA-Ar score was 14 at 7:23 a.m., including bilateral tremor of the hands and unsteady gait. The staff psychiatrist also noted that the patient had a history of alcohol-related seizures, a long history of alcohol use, impulsive behavior, prior suicide attempts, limited primary support, and firearms in his home.

At 11:11 a.m., the patient was being escorted to Building 39 when he had a seizure in the covered walkway between Buildings 82 and 39. Staff called a medical emergency, and the medical center's Fire Department paramedics responded to the area. The team assessed the patient and found that he was conscious but lethargic, incontinent, and unable to respond to questions. His skin was described as pale with cyanosis, his respirations were fast and shallow, and there was a superficial abrasion to the forehead and a minor puncture wound to the tongue. He was transported by ambulance to ward 82-1. The physician ordered immediate medications to include intravenous Ativan®

(anti-anxiety) and the anti-convulsant medications fosphenytoin, and Dilantin®. The patient was continued on Librium by mouth.

Later that day, staff documented that the patient was having visual hallucinations and was tremulous. At 6:38 p.m., he received Librium 50 mg orally, and his CIWA-Ar score was assessed as 29. The Medical Officer on the Day (MOD) saw the patient on this evening and again on the morning of December 4, as the patient's CIWA-Ar score was 45. He continued to be restless with visual and auditory hallucinations. He was given Ativan 1 mg by intramuscular injection and was later given Valium® (anti-anxiety) 10 mg by intravenous line. A nursing progress note on December 5 at 5:04 p.m. documented that the patient was on telemetry, denied any pain or discomfort, and was alert and visiting with family.

The patient's condition continued to improve, and on December 12, he was discharged to home. He was given the phone number to call to be screened for acceptance into the SAC program. Referrals were made for follow up with outpatient mental health and primary care providers. Following the initial telephone screening, the patient was instructed to report to the SAC program on December 15 at 9:00 a.m.

Findings:

On the morning of transfer to Building 39 the patient had a CIWA-Ar score of 14 and displayed a bilateral tremor indicative of moderate withdrawal. The patient had reported a history of alcohol withdrawal seizures but denied a history of delirium tremens. After the 23-hour observation period, the patient was not discharged home which would not have been appropriate, but was transferred to an acute psychiatry unit for further psychiatric treatment. In light of the patient's history of withdrawal seizures and his CIWA-Ar score, the more conservative approach would have been to continue detoxification on the medical unit. However, in many hospitals, it is not uncommon for medically stable patients with concomitant psychiatric issues and alcohol dependence to receive detoxification treatment on an acute psychiatric unit. When the patient seized during transport to ward 39-2, he was appropriately re-admitted, monitored, and treated on ward 82-1.

Case Summary Patient C

The patient was a 38-year-old male who served in the United States Army from June 1986 to September 1988. He was non-service connected and was voluntarily admitted to ward 39-2 on March 10, 2006. The patient reported that he had developed homicidal ideation toward his significant other. He also indicated a history of violent incidents, such as putting his fist through a glass plate and damaging a television set while in jail. He had been in jail from February 27 to March 7, 2006. He reported being homeless and that he had not had medication since his release from jail. After release from jail, he admitted to drinking a pint of liquor and 10 beers daily.

The patient had a history of schizoaffective disorder with paranoid tendencies and unstable mood. He also reported experiencing PTSD symptoms and “problems with authority figures.” He reported being “upset with the VA due to his disability not having been processed.” The patient had previous psychiatric admissions for mood disorder and depression at the John D. Dingell VA Medical Center, Detroit, MI, in June 2005 and January 2006. He had been prescribed psychotropic medications at discharge that included Celexa® (anti-depressant), Depakote® (anti-convulsant used as a mood stabilizer), and quetiapine (anti-psychotic). He related a past history of aggressive behaviors including assault, physical restraint of his significant other, setting a person on fire, and job losses after angry outbursts.

He arrived on ward 39-2 March 10, 2006, at 5:40 p.m. The initial plan was for staff to observe his mood and behavior every 15 minutes. The physician ordered the medications citalopram (anti-depressant) and quetiapine, among others. On March 11, staff developed the initial treatment plan, with goals to reduce depression, alleviate homicidal ideation, and increase the patient’s coping skills. The patient’s physician also increased his bedtime medication quetiapine from 100 mg to 200 mg on March 11 and increased the dosage further to 400 mg on March 13 to reduce proneness to violence and help stabilize paranoia. On March 11, the physician ordered the patient to be transferred from the admission section to the rehabilitation section of ward 39-2. Some patients on locked psychiatric wards are granted privileges by their physicians that allow periods of time off the ward. The following table depicts the levels of privileges that may be granted:

| Privilege Level: | Authorized Time off Ward: |
|-------------------------------------|---|
| Category I (Full Privileges) | May leave ward unescorted from 6–6:45 a.m.; 9–11 a.m.; 1–3 p.m.; 5–9 p.m.; and attend therapeutic activities unescorted |
| Category II (Partial Privileges) | May leave ward unescorted from 6–6:45 a.m.; 9–11 a.m.; 1–3 p.m.; and attend therapeutic activities unescorted |
| Category III | Restricted to ward; cannot leave ward without a staff escort |
| Category IV | Restricted to ward; assigned a staff member one-on-one at all times |

The patient was granted category III privileges,⁸ with staff observations every 15–30 minutes. He was allowed to go off the ward to smoke with staff supervision.

On March 15, the patient reported to a staff nurse that he felt his medication needed to be adjusted because of his anger. On March 15, the patient talked with the physician assistant regarding continued anxiety and poor sleep, complaining that the current medication was not helpful for paranoia or reducing vivid dreams. He also requested medication to control anxiety and reduce his rage. The patient agreed to try trazodone

⁸ Usual protocol during the patient’s first 3 days on the unit. Category III patients may only leave the unit with staff escort.

50 mg at bedtime (for reduction of dreams) and hydroxyzine 50 mg three times a day as needed for anxiety. He attended psychology group therapy on the ward on March 13, 14, 15, and 17, participated in discussions, and at times displayed anger with verbal hostility toward the mediator that resulted in his leaving the group.

On March 18 at 2:48 p.m., the nurse documented that the patient requested a dose of hydroxyzine 50 mg “at lunch” for anxiety. The nurse had documented that he had a prior dose at 6:30 a.m. and was under the impression that the patient would need to wait until 2:30 p.m. for the next dose. The physician’s order for this medication, effective March 15, was 50 mg capsule TID⁹ PRN¹⁰ for anxiety.

On March 19 at 9:07 a.m., the nurse documented that the patient was “telling stories, laughing, and joking with peers” while standing in the medication line in the dayroom. The patient asked the nurse for his “anxiety pill” when it was his turn in line. The nurse informed him that his observed behavior did not warrant the administration of the medication and that it would not be given to him. The patient became upset, stating that the nurse “didn’t know what he was talking about” and that he “was judging him.” The patient refused his regular medication and left the medication area cursing at the nurse. At 9:42 a.m., the patient came to the nursing station to confront the nurse with cursing and threats. The medication nurse on the north side of the ward gave the patient hydroxyzine 50 mg.

At 10:00 a.m., the nurse documented that the patient again approached the nurse saying, “the next time I want my meds you better give them to me....” The patient advanced toward the nurse in a confrontational, aggressive manner. A nursing assistant intervened and encouraged the patient to go to the dayroom. The patient went to the dayroom, but he continued to threaten and curse at the nurse. The nurse elected to call the medical center’s Protective Services. Two police officers responded to the ward and assessed the situation. The officers attempted to use verbal persuasion to de-escalate the situation and gain his voluntary compliance. The patient was neither compliant nor cooperative. The officers continued to use verbal commands to gain compliance and then told him that the use of oleoresin capsicum (OC) spray¹¹ would be the next step. The patient disregarded the warning and placed one of the officers in a headlock, while the second officer employed a 1-second shot of OC spray to the patient’s face, which was deemed ineffective. The patient continued his hold on the officer and was loudly instructed by the second officer to let go. When he did not, the officer struck the patient one time in

⁹ TID (*ter in die*) is a medication that is administered three times a day.

¹⁰ PRN (*pro re nata* – as the occasion arises) is a medication that is administered on an as-needed basis. Administration is left to the caregiver or the patient’s prerogative.

¹¹ An agent, commonly known as pepper spray, that is a chemical compound that irritates the eyes to cause tears, pain, and even temporary blindness, and is used in riot control, crowd control, and personal self-defense.

the right leg, aiming for the common peroneal nerve, with the PR-24 side handle baton.¹² The patient was given loud verbal commands before and after each subsequent strike, with a total of five strikes delivered. The patient finally let go of the officer and, with assistance from nursing staff, was then taken down to the floor and restrained. During the altercation, a psychiatric emergency¹³ had been called. Both officers and three ward staff members were injured during the incident. Additionally, one ward staff member reported a reaction to the OC spray.

Staff who were involved in the incident participated in an after-action review on March 20. The review team determined that the psychiatric emergency should have been called before the medical center's Protective Services officers were dispatched to the scene and before physically engaging the patient. The Uniform Offense Report documented by Protective Services was forwarded to VA Central Office's Office of Security and Law Enforcement for review, which is standard policy when any officer employs OC spray, the PR-24 side handle baton, or a firearm. It was determined that there were no issues with the execution of the incident or any objections to the levels of force employed.

Medical center policy also requires the review of violent incidents by the Disruptive Behavior Committee. The committee's review resulted in a violent history flag being placed in the patient's medical record, and the patient was issued a letter that he could no longer receive treatment at the medical center, but could apply for reinstatement after a 1-year period. The committee also determined that the "use of force" was justified in the events on the ward. The patient received an irregular discharge from inpatient hospital care on March 20. On April 28, the Chief of Staff documented in the patient's medical record progress note, "Effective March 30, 2006, pt [*sic*¹⁴] is banned from services of Battle Creek VAMC and its CBOCs for a period of one year. This ban is based upon his behaviour [*sic*] of March 19, 2006 that was verbally and physically abusive."

Findings:

BCMA records show that on the day prior to the assault incident, patient C had the first dose of hydroxyzine 50 mg TID PRN medication at 6:24 a.m., and the patient requested another dose "at lunch." The nurse documented that the patient was told he could not receive another dose until 2:30 p.m. A TID PRN medication may be requested by the patient, three times a day, as needed. The nurse should assess the patient and also determine that sufficient time had passed since the last dose of the medication. On

¹² The PR-24 side handle baton is a device issued to VA police officers to gain control of a subject without excessive use of force. The baton may be used when other attempts to de-escalate the violent person have failed. Officers are required to complete an annual training certification on use of this device.

¹³ A psychiatric emergency alerts a team of employees with special training in managing disruptive behavior. The team members are usually dispatched by pager and respond immediately to the incident area.

¹⁴ The Latin word "*sic*" means "thus" or "so"; used to indicate that a quoted passage has been retained exactly as shown in its original form.

March 19, the following day, the patient requested an “anxiety pill” at 9:07 a.m. The nurse chose not to administer the medication based on the assessment of the patient’s behavior while standing and waiting his turn in the medication line. Documentation does not support that further assessment or clinical intervention was initiated after the patient’s request. The refusal of the patient’s request for the PRN medication and the lack of further clinical intervention may have contributed to the patient’s escalated behavior.

The medical center’s Disruptive Behavior Committee determined that the psychiatric emergency for patient C should have been initiated sooner and that a show of force earlier by the team may have de-escalated the patient. Medical center managers need to reinforce psychiatric emergency procedures including timeliness of calling psychiatric emergencies.

On our inspection, the ward environment was noisy, crowded, hallways echoed, and the enclosed porches and dayroom areas were used for multiple purposes such as storage of equipment, patient clothing, and chairs used for group therapy. We determined that most patients had significant amounts of unstructured time every day.

The VA Protective Service collected and trended data monthly on patient assault rates and provided a report to senior managers for the period of February 1, 2004 to January 31, 2005. Managers were interested in assault rates prior to and after the closure of ward 14-2. The report showed an increase in the number of physical and verbal patient assaults at the medical center, especially on wards 39-1 and 39-2. In response, the Acting Medical Center Director initiated a workgroup to analyze these patient care areas and make recommendations. The workgroup identified a lack of consistent and structured treatment modalities, with only one group therapy session, led by psychology, meeting regularly. There was a lack of evening and weekend activities for patients. The workgroup also determined the day of the week when the highest number of restraints occur, use of PRN medications, and the times and locations where the highest number of assaults were occurring. The workgroup identified that despite an increase in assault rates, psychiatric emergency rates in FY 2006 remained low, and there was confusion among staff about when to call a psychiatric emergency. The workgroup also identified a need for additional staffing (psychiatry, psychology, social work, and police coverage) on both wards. Other contributing factors identified included:

- Prevention and Management of Disturbed Behavior training was decreased to 2 days, focused mainly on physical intervention, and required more verbal skills training.
- Assaultive patients were not always seen by the treatment team following the incident, and the treatment plan was not adjusted or individualized.
- Significant treatment team points were not communicated to front line staff.

- Treatment team meetings required significant staff time, leaving minimal time for team members to see individual patients.
- The number of patients in one small location increases chances for agitation and assaultive behavior.
- The environment of the building plays a role because the noisiness, the physical layout of the floor plan, and the location of the quiet room may agitate patients.
- Inadequate space for patients and inadequate office space for the professional staff.
- No visitors room on ward 39-2.
- The lack of proper physical and therapeutic accommodations for female veterans.
- Inconsistent physician coverage on ward 39-2 and issues with medication management.
- An increase in patient workload.

In response, the workgroup made recommendations to increase staffing levels; consider the use of medication and other types of interventions for assaultive patients; debrief patients and staff after an assault; arrange for the assaultive patient to meet with the treatment team the next day, modify the patient's treatment plan as needed, and communicate critical information to front line staff on all tours; develop and implement a programmatic approach to treatment to include evening and weekend activities; relocate to Building 14; implement two admission wards with each having a rehabilitation component; admit and house female veterans on ward 14-1 within the psychiatric admission unit; and monitor future assaults against identified criteria that will be tracked, trended, and reported to the Assault Analysis Workgroup and medical center leadership.

Case Summary Patient D

The patient was a 36-year-old male who served in the United States Army from February 2002 to 2005, including being stationed in Afghanistan from March to July 2003. The patient was 70 percent service-connected including ratings of 50 percent for PTSD, 20 percent for a lower-leg condition, impaired hearing, and lumbar-sacral and cervical strain. The medical center's Mental Health Clinic provided ongoing outpatient care. On April 20, 2006, the patient called a nurse at the facility and expressed interest in substance abuse treatment but stated he could not attend a day program due to needing to work at his job during those hours. The patient indicated that he had been charged with two counts of assault in March. He was also evaluated by a psychiatrist and referred for screening for entry into the SAC program. On April 24, the patient met with his

outpatient provider and reported that he “was getting worse,” was unable to sleep, was responding to any frustration with anger, had increased alcohol use, and was fearful of hurting someone. He was willing to be admitted to the acute psychiatric ward, yet wanted to discuss plans with his parents and make some personal arrangements prior to his admission. The patient contracted with his provider to relinquish his weapons, not to consume alcohol, and return to the medical center for admission on April 26, 2006.

On April 25, the patient was screened by telephone for the SAC. He did not meet ASAM Criteria for the SAC level of care, based on his emotional instability and planned acute psychiatry admission. Pending legal issues also had to be resolved prior to entering treatment. During this assessment, the patient admitted to increased alcohol use, in addition to using one sixteenth of a gram of cocaine on April 23, 2006. He denied use of cocaine during the previous 15-year period. The patient also reported having multiple stress fractures in both legs and lower back pain due to “jumps in the military” for which he was receiving a service-connected disability pension. He reported his pain level as 4–5 on a 1–10 severity scale. Outpatient pain medications included hydrocodone 5 mg/acetaminophen (pain medication) 500 mg and cyclobenzaprine HCL (muscle relaxant) 10 mg.

The patient was admitted, as planned, on April 26. The admission assessment note shows that he reported experiencing an increase in flashbacks and nightmares related to his tour of duty in Afghanistan in addition to increased arousal, severe temper outbursts, depressed mood, nightmares, and auditory hallucinations. He endorsed feelings of guilt for surviving when fellow unit members did not. The patient reported consuming approximately one fifth of alcohol daily “during the past couple of months,” with episodes of momentary blackouts, with no recollection of his actions. The patient recounted that he recently had been driving his truck and realized that he had a loaded gun in the seat beside him with 50-round magazine clips. He had no recollection of when he put the gun in his truck. The patient also reported a recent altercation with a person from the community and a police officer for which he had a pending court appearance. The patient was admitted to ward 39-2, and his pain medications included hydrocodone 5 mg/acetaminophen 500 mg, cyclobenzaprine HCL 10 mg, and naproxen (pain medication) 500 mg. He was ordered to be on category III privileges. His admission urine drug screen was positive for cocaine.

On April 28, 2006, the patient was changed from acute treatment to rehabilitation status on ward 39-2, with partial off-ward privileges beginning, upon treatment team concurrence, on April 29. The staff psychiatrist’s recommendation, per April 29 progress note, was for the patient to attend Alcoholics Anonymous, substance abuse treatment, individual and group psychotherapy to address PTSD symptoms, and develop coping skills with anger control. Medical records indicate that the patient complained of lower back and leg pain, usually rated as 7 on a 1–10 severity scale, and his physician ordered vicodin 5/500 mg every 8 hours PRN for pain. On May 1, he was granted full privileges.

At the treatment team meeting on May 6, the patient reported that his anger was increasing, and he was isolating to avoid confrontation with others. He expressed his belief that the antidepressant and mood stabilizer medications were ineffective and that he was sleeping less and was “tired all the time.” He denied suicidal or homicidal thoughts. He complained of continued leg and back pain and swelling in his lower legs.

On May 9, 2006, he was seen by the clinical psychologist for individual psychotherapy. The patient reported ongoing intrusive combat-related thoughts, anger problems, nightmares, and feelings of inability to control his emotions. He was encouraged to attend any activities offered as part of the ward milieu. On May 11, he requested to see his treatment team. Clinicians documented that the patient had a depressed affect with a “general look of despair.” The patient reported not sleeping and awoke “a few nights ago striking his vent.” The patient shared that he was isolating, feeling angry and suspicious of others, and “slipping back” to his emotional state prior to hospitalization. He stated that he felt that someday he was “going to snap,” hurt someone, and go to prison for the rest of his life. Additionally, he requested a pass for May 11 and 12 for a court appearance, which was granted by the physician. On May 12, the patient was seen as a clinic walk-in by his outpatient psychologist. The patient wanted the clinician to write a statement for the court about his PTSD and requested to be transferred to the PTSD focused PR RTP residential rehabilitation program housed in Building 12. The clinician told the patient that the treatment team’s plan was for him to begin the PTSD Program as soon as he stabilized.

On May 13, the treatment team convened and documented that the patient was compliant with the ward milieu and appropriate with peers and staff, with no indication of suicidal or homicidal ideations. The team also documented that the patient showed no indication of flashbacks or signs of irritation since the last team review (May 11), was participating in individual counseling, and was going out on privileges (off the ward) without incident. A nursing progress note on May 13 documented that the patient continued to complain of poor sleep, feeling “all wound up,” and preferred to isolate most of the time. He expressed concerns that he might be “slipping back” into depression and anger and had recurring nightmares about his tour of duty in Afghanistan. He again requested to be considered for therapy in the medical center’s PTSD Program.

On May 14 at 9:30 a.m., a registered nurse found the patient unresponsive in his bed. He was without respirations and pulse. A medical emergency was called, and staff initiated cardiopulmonary resuscitation (CPR). A patient on the ward, who identified himself as a medic in the service, initially administered chest compressions. The patient was transported by the medical center’s Fire Department paramedics and was admitted to the medical unit, 82-1. CPR continued until the patient was pronounced dead at 10:19 a.m. The physician who participated in CPR on 82-1 documented suspicions of a “possible drug overdose.” An 80 mg blue tablet was found on the patient by VA Protective Services officers, and the results of testing showed the tablet to be OxyContin® (a pain

medication). At the time of the patient's death, his medication profile did not include OxyContin as a prescribed medication. The Calhoun County Medical Examiner was called to review the case. Blood and urine were sent for toxicology. The case-specific decision on whether or not to perform an autopsy is up to discretion of the Medical Examiner. An autopsy was not pursued by the Medical Examiner.

On May 15, the patient's physician met with the family to discuss the incident. The family agreed to a medical center-arranged autopsy to determine the cause of death.

Findings:

An autopsy was performed 2 days after patient D's death. The patient's OxyContin level was 10 times the upper limit of the reference range. The autopsy report noted oxycodone¹⁵ intoxication as the probable cause of death. Edema and early mild patchy bronchopneumonia were seen on post-mortem examination of the lungs. Many of the airspaces contained pigmented foreign material indicative of either aspiration or inhalation. The pathologist noted that given the relatively diffuse presence of material in many of the smaller airspaces and elevated narcotic level, inhalation was most likely. "This is also probably the explanation for the early bronchopneumonia, since terminal aspiration would not be associated with an inflammatory response."

On April 29, the patient had started category II privileges, and he received category I privileges on May 1 and remained on full privileges until the time of his death. Patients and staff alleged that illegal drugs are known to be available on the medical center grounds. Our interviews revealed that staff do not consistently search for contraband and other dangerous items on patients who are returning from passes and privileges off the wards. The patient presented to the medical center with increased alcohol use and recent use of cocaine. Because patients have significant time off the wards when granted partial or full privileges, and staff do not consistently search patients, there is potential for patients to acquire contraband and other dangerous items during these times that may not be detected upon their return. The patient had a urine drug screen on April 29, 3 days after admission. We did not find an order for a subsequent urine drug screen. A random urine drug screen may have been indicated subsequent to granting off-ward privileges. The medical center did not have policies on random urine drug screens or contraband searches at the time of the incident.

When the nurse found the patient unresponsive in his bed she called out to a nearby nursing assistant to come help, and staff on the ward ran toward the patient's room with code equipment. Staff called a medical code, and the medical center's Fire Department paramedics came to the ward. We were told that at the outset of the episode, a nearby

¹⁵ OxyContin contains oxycodone, a very strong narcotic pain reliever similar to morphine. OxyContin is designed so that the oxycodone is slowly released over time. OxyContin tablets should never be broken, chewed, or crushed since this causes a large amount of oxycodone to be released from the tablet all at once, potentially resulting in a dangerous or fatal drug overdose.

patient identified himself as a medic while in the military and proceeded to perform chest compressions while staff members were attempting to establish an airway. A second nurse who had entered the room told us that he did not recognize that the person performing compressions was a patient. The second nurse assessed that the compressions appeared effective, took over rescue breathing, and concentrated on establishing an airway. While some staff in the room were aware that a patient was performing chest compressions, we did not find documentation that staff members offered to take over chest compressions or directed the patient to relinquish performance to a staff member. Upon arrival on the scene, a Fire Department paramedic took over chest compressions. Once additional ward staff had arrived, the decision to allow a patient from the ward to continue chest compressions was imprudent.

An autopsy was performed on May 16, 2006. During our second site visit we examined the patient's Certificate of Death and incidentally found that item 40, "Was an autopsy performed?" was documented as "No." Managers submitted documentation during our on-site review to have the Certificate of Death officially corrected to indicate that an autopsy had, in fact, been performed.

Issue 5: Other Concerns Identified During the Inspection

Louvered Heating, Ventilating, and Air Conditioning Grilles. VHA issued a patient safety alert on February 28, 2005, warning about the risk of unprotected louvered grilles in locked Behavioral Health Units (patient care areas) that could be used as an anchor point for a noose made from clothing or other flexible material. VHA required that by March 31, 2005, medical centers install woven wire cloth with tamper-proof screws over the existing grilles or replace them with suitable coverings. On October 10, 2005, medical center managers had submitted a non-recurring maintenance project application to VISN 11 requesting funds to replace the existing grilles in Building 39, as well as additional corrective action to determine the cause of corrosion to sprinkler heads and replacement throughout the campus. The project also included a request to fund replacement of elevated stair structures in Buildings 83 and 84. Design and construction of the project was planned for FY 2006. The project was ranked as fifth in priority of all projects requested to the VISN and was approved by the VISN Director for the medical center to complete the preliminary steps of the National Acquisition Center approval process on March 23, 2006. During our inspections of wards 39-1 and 39-2, we observed that grilles remained accessible, and no corrective action was taken. At the time of the inspection, we suggested that unit managers and/or medical center leadership contact the National Center for Patient Safety for advice regarding possible interim safety measures.

Seclusion Room Safety. Managers must ensure that seclusion rooms are designed to minimize risk to patients who may wish to harm themselves or others. We observed that seclusion rooms on wards 39-1 and 39-2 had uncovered electrical outlets and light coverings that could be removed by standing on the bed, allowing access to the bulbs and electrical components within the fixture. At the time of our first on-site visit, we

recommended that senior managers take immediate steps to correct these conditions. Corrective actions were completed prior to our second onsite inspection in November 2006.

Other Environmental, Patient Privacy, and Safety Concerns. We observed ceiling tiles on the wards that had mold growth due to water leaks. We also noted that the enclosed porch areas were improperly used for storage of patient care supplies and equipment. Unlocked cabinets with temperature control fixtures, including mercury glass thermometers that could be used for self injury or to harm others, were accessible in patient shower areas. White marker boards with patient names and level of privileges were visible to other patients and visitors on the wards, a patient privacy issue. Staff reported that the wards, especially the enclosed porches, had poor temperature control. We reported these environmental, privacy, and safety concerns to senior managers during the inspection.

Conclusions

We substantiated that the closure of inpatient psychiatric ward 14-2 resulted in conditions in Building 39 that might negatively impact patient and staff safety, because the physical layout of the unit is less conducive to patient observation. We substantiated that the closure of the TLP and the conversion of the SARRTP to the SAC were done without VHA approval; also there were changes in arrangements for medical and mental health coverage and the detoxification of substance abuse patients. We substantiated that organizational changes in mental health were initiated during the former Director's tenure, there was turnover in psychiatry staff, and the medical center faced ongoing challenges with recruitment of psychiatrists. We identified opportunities for improvement in care based on our review of the four patient cases cited by the complainant. Additionally, we identified environment of care concerns during the inspection that were not part of the complainant's original allegations.

We did not substantiate that patients who were lodging as part of the SAC were unsupervised. We did find that medical and nursing care was available to lodgers. We did not substantiate a lack of management support for the substance abuse program.

Recommendations

Recommendation 1. We recommended that the VISN Director collaborate with the Medical Center Director to reassess inpatient mental health services and create appropriate plans and programs to optimize patient and staff safety, with regard to the following factors: most appropriate physical location of inpatient mental health unit(s) and type (such as locked, open, rehabilitation, geriatric, assessment, and others), designation of bed capacity per unit based on patient acuity, and program structuring to ensure a therapeutic milieu for patients.

Recommendation 2. We recommended that the VISN Director initiate a review of mental health provider staffing and workload at the medical center and make discipline-specific (such as, psychiatry, psychology, and social work) recommendations based on current and projected patient care needs.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director complies with policy regarding VHA approvals for program restructuring and/or changes to authorized or operating beds or program capacity.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires mental health staff to complete periodic training on the management of medical and psychiatric emergencies.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director clarifies and reviews procedures for patient privileges and establishes policy for contraband searches and random urine drug screens.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director takes immediate action to comply with VHA's Patient Safety Alert on louvered HVAC grilles, meet patient safety standards in seclusion rooms, and correct environmental, patient privacy, and safety deficiencies identified by the Office of Healthcare Inspections team during ward inspections.

Comments

The VISN and Medical Center Directors agreed with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 23–32 for the full text of their comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 8, 2007

From: Network Director, VISN 11 (10N11)

Subject: **Response to Draft Report—Alleged Mismanagement and Safety Issues, Battle Creek VA Medical Center**

To: Director, Chicago Office of Healthcare Inspections
Thru: Director, Management Review Service (10B5)

Per your request, attached is the report from Battle Creek VAMC.

If you have any questions, please contact Jim Rice, VISN 11 QMO at 734-222-4314.

(original signed by:)

Linda W. Belton, FACHE

Attachment

Medical Center Director Comments

VAMC Battle Creek Director's Comments to Office of Inspector General's Report

The following Medical Center Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director collaborate with the Medical Center Director to reassess inpatient mental health services and create appropriate plans and programs to optimize patient and staff safety, with regard to the following factors: most appropriate physical location of inpatient mental health unit(s) and type (such as, locked, open, rehabilitation, geriatric, assessment, and others), designation of bed capacity per unit based on patient acuity, and program structuring to ensure therapeutic milieu for patients.

Concur **Target Completion Date: January 2008**

Response: The following is a synopsis of the completed and planned actions.

Physical Location and Bed Capacity: The Medical Center leadership, Mental Health leadership and a Mental Health Think Tank established by the Director have reviewed the space needs of Mental Health globally and the Psychiatric wards in Building 39 specifically. The proposed plan, based on the demographics of the patients served on the Psychiatric wards, is to create two 30-bed wards in Building 39. The 30-bed unit on 39-1 would provide a self-contained space with 10 beds for the acutely ill psychiatric patients and a separate space for 20 intermediate rehabilitation beds. The unit on 39-2 would provide 5 beds for the psychiatrically acutely ill geriatric patients, 5 beds to be used for 23-hour psychiatric observation, or rapid stabilization beds, and 20 long-term rehabilitation beds. While the intent is to maintain "like" patients on the same unit, we have found maintaining acutely ill geriatric patients on the 39-2 acute mental health unit provides the best management option. The balance of the beds formerly in Building 39 utilized for the long-term, geriatric psychiatric patients are to be relocated to the Community Living Center (CLC)

(formerly known as the Nursing Home Care Unit) on the first floor of Building 84. The proposal to relocate beds to the CLC is under active discussion with Extended Care and Quality Resource Service staff.

The configuration noted above will effectively reduce the total inpatient psychiatry beds in Building 39 from 80 to 60, and will mitigate the issues of overcrowding and its consequences, including the issue of adequate staff office space. It is anticipated that the recent opening of the 40-bed Domiciliary, which has the Seriously Mentally Ill (SMI), homeless, and substance abuse patients requiring longer-term placements as target populations will reduce the demand for inpatient psychiatry beds. This program has already begun to provide a viable option to decompress the acute psychiatry unit.

Program Structure and Therapeutic Milieu: The Medical Center Director has appointed a Unit Coordinator, the Assistant Chief of Social Work, to implement a variety of structure and program changes identified by the Mental Health Think Tank for both wards in Building 39. The Coordinator will work with the established Unit Leadership Teams, composed of the Psychiatrists and Nurse Managers. The recommendations address the processes of assessment, treatment, and therapeutic milieu. A Recreation Therapist Case Manager position has been established that will be dedicated to the Psychiatry Wards. The Chief of Staff, a psychiatrist, has started a weekly education group on Ward 39-2.

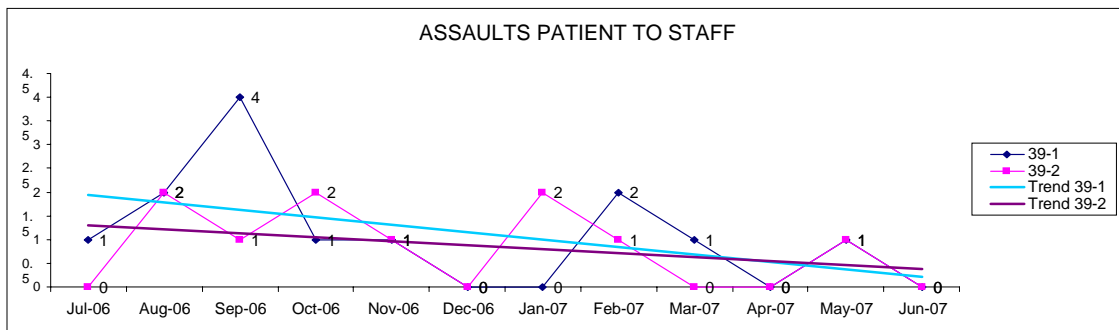
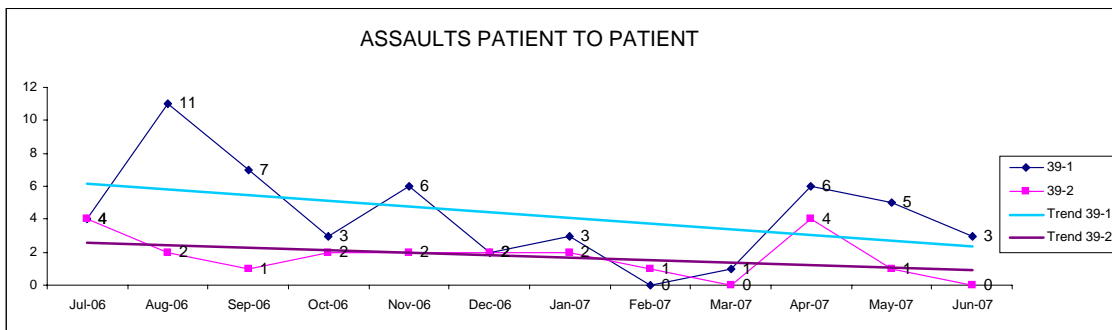
Impact of Mental Health Initiatives: The following new positions established through the Mental Health Initiatives will also help to optimize staff and patient safety. The Suicide Prevention Coordinator has been selected and will be working with all of Mental Health in identifying those patients most at risk for suicide and providing staff and patient education to address the identified needs. The Recovery Coordinator is in place and will educate staff and patients on the Recovery Model for Mental Health, a paradigm shift that is expected to increase patient and staff satisfaction. The new Recovery Center Coordinator is in the process of establishing a variety of recovery-based classes and educational opportunities that will significantly improve the therapeutic milieu available for mental health patients throughout the Medical Center, including Wards 39-1 and 2. To optimize resources, a “VA University” approach to programming will be utilized to increase access to all current groups and educational opportunities. The Think Tank for Mental Health is a performance improvement project composed mostly of front line staff that made recommendations for implementation within 30 days and 90 days. The group discussed treatment planning, programming, documentation,

assessments, space, staffing, program coordination, care delivery models, patient-centered care and staff education. The Unit Coordinator is assigned to provide leadership to implement these recommendations.

Accomplished Changes to Staffing and Ward Practice/Policy and the Ward Milieu: Psychology FTEE has been increased from 1.5 FTEE to 2 FTEE and an increase in therapeutic programming has occurred. The use of patient privileges was reviewed and has been limited to therapeutic privileges only. The VA police are patrolling the area more frequently. Nursing staffing has been reviewed and realigned according to staff strengths. A Nursing Case Management was implemented as of July 2007. Patients are now being searched for contraband after receiving visitors.

Outcomes:

Assault Rates



The Psychiatric Emergency Rates continue to be low as previously noted in the report.

2007 Q1 & Q2 Inpatient SHEP

| | Access | Coordination of Care | Courtesy | Education & Information | Emotional Support |
|----------|--------|----------------------|----------|-------------------------|-------------------|
| National | 74.75 | 73.06 | 82.43 | 58.06 | 51.46 |
| BCVAMC | 78.4+ | 80.8+ | 84.3+ | 61.3+ | 62.5+ |

| | Family Involvement | Physical Comfort | Preferences | Transition | Overall Quality |
|----------|--------------------|------------------|-------------|------------|-----------------|
| National | 70.54 | 76.58 | 62.76 | 56.24 | 65.63 |
| BCVAMC | 81.7+ | 81.7+ | 69.7+ | 54.8- | 84.7+ |

With the exception of the Transition score, all scores are significantly higher than the national average for psychiatry. This is a significant increase over previous scores.

Recommendation 2. We recommended that the VISN Director initiate a review of mental health providers staffing and workload at the medical center and make discipline-specific (such as, psychiatry, psychology, and social work) recommendations based on current and projected patient care needs.

Concur **Target Completion Date: Completed**

Response:

Current Inpatient Staffing: Although there continue to be nursing staff vacancies on the psychiatric units, they do not operate with a shortage in the day-to-day operation. The current staffing on Ward 39-2 is 1.5 FTEE Psychiatrists, 2.0 FTEE Physician Assistants, 2.0 FTEE Social Workers, and 2.0 FTEE Psychologists. There is currently one Psychiatrist vacancy and one Psychologist vacancy being recruited. On Ward 39-1 the staffing is 1.0 FTEE (two .5 FTEE) Psychiatrists, 1.0 FTEE Social Worker, 1.0 FTEE Psychologist, and .5 FTEE Physician Assistant. In addition, it is noted that there is 1.0 FTEE Psychiatrist and 1.0 Physician Assistant that provides the initial work-ups for patients being admitted on the inpatient units.

The Gains and Losses Report for the BCVAMC indicates that the cumulative Average Daily Census (ADC) for the various wards/acuity levels for the fiscal year-to-date is as follows:

| <u>Ward</u> | <u>Cum ADC</u> | <u>Ward</u> | <u>Cum ADC</u> | <u>Total CumADC</u> |
|-------------|----------------|-------------|----------------|---------------------|
| 39-1 L | 19.9 | 39-1G | 12.4 | 32.3 |
| 39-2A | 3.6 | 39.2R | 30.2 | 33.8 |

The “Mental Health Provider Workload Guidelines”, page 7, provides the following guidance on the provider to patient ratios:

Acute, High Intensity Inpatient Setting

- 10 patients/1.0 FTEE Psychiatrist or 14 patients/one Psychiatrist with a full-time MD extender
- 9.4 patients/1.0 FTEE Social Worker
- 24 patients/1.0 FTEE Psychologist
- 1.1 patients/1 .0 FTEE total nursing staff (all levels)

The guidance assumes an average length of stay (ALOS) of 10 days and notes that individual workload increases as ALOS decreases. Only two models are present in the document. The above guidance only approximates the nature of Ward 39-2. The document states that the document “is not intended to address the issue of staffing standards or patterns in mental health treatment programs. The number and mix of interdisciplinary staff for mental health programs would require a separate analysis and was not the focus of the present work group (p.2).” Previous local analysis of the workload of Wards 39-1 and 39-2 by Mental Health leadership, based on programming needs, established the existing staffing mix. As previously mentioned, Ward 39-2 has a 1.0 FTEE vacant psychiatrist position that is being partially covered by an existing staff psychiatrist from another program.

A brief survey of the other Medical Centers within VISN 11 is being conducted. Following is a brief table giving the psychiatrist and physician extender utilization comparison from responses received thus far.

| | BCVAMC | NIHCS | Ann Arbor | Indianapolis |
|-------------|--------|-------|-----------|--------------|
| MD FTEE | 3 | 2 | 1 | 1 |
| MD Extender | 2.5 | 0 | 0 | 0 |
| Beds (all) | 80 | 63 | 16 | 16 |

Evaluating staffing needs is an ongoing practice at BCVAMC, and the staffing needs on the psychiatric wards will be evaluated further as the planned programmatic changes and full implementation of the mental health initiatives occur, and the impact on the Average Daily Census is known. Management briefings are conducted annually and provide an opportunity to review workload and staffing trends. In addition, workload needs are reviewed when considering replacement of positions as part of the resource management process. Finally, we are aware that an update to the Mental Health workload guidelines is currently being prepared by the VACO Office of Mental Health Services, and we will incorporate recommendations from those guidelines when they become available.

Concur **Target Completion Date: Completed**

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director complies with policy regarding VHA approvals for program restructuring and/or changes to authorized or operating beds or program capacity.

Concur **Target Completion Date: Completed**

Response: The compliance issues regarding the closure of the Transitional Living Program (TLP) and the changes to the Substance Abuse Program have been discussed and resolved. The Gains and Losses Report and the KLF Bed Management System now reflect the accurate number of residential beds at the BCVAMC. The Substance Abuse Residential Rehabilitation Program (SARRTP) has 23 beds total, and 40 of the total authorized residential beds were converted to Domiciliary beds. This was accomplished through the Bed Letter documents processed according to policy and is set for Auto Approve on August 2, 2007 per KLF. Any further program changes will be made only in compliance with VHA regulations.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires mental health staff to complete periodic training on the management of medical and psychiatric emergencies.

Concur **Target Completion Date: November 2007**

Response: A review of the training provided to the staff regarding management of medical and psychiatric emergencies was conducted. It is felt additional training is needed and will be provided by the Fire Department in conjunction with Primary Care, Nursing and Psychiatry by

November 2007. Medical emergencies will be reviewed at Primary Care Committee, and Psychiatric emergencies will be reviewed at Mental Health Committee. Recommendations from both committees will then be reviewed at Clinical Executive Board.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director clarifies and reviews procedures for patient privileges and establishes policy for contraband searches and random urine drug screens.

Concur **Target Completion Date: October 2007**

Response: Patient Privileges and contraband searches were discussed by an interdisciplinary team, and a policy has been drafted and will be published in the near future. The policy sets forth the requirement for routine random drug screens. In the interim, the ward has limited patient privileges to therapeutic activities only. Searches for contraband are now conducted following visitors. Searches for patients following passes will begin on August 9, 2007.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director takes immediate action to comply with the VHA's Patient Safety Alert on louvered HVAC grilles, meet patient safety standards in seclusion rooms, and correct environmental, patient privacy, and safety deficiencies identified by the Office of Health Care Inspections team during ward inspections.

Concur **Target Completion Date: All non-contracted projects will be complete by September 30, 2007**

Response: Immediate corrections following the OIG site visits included: Lights were secured with tamperproof screws, and the lights were covered on both units. Ceiling tiles were replaced and continue to be monitored during environmental rounds. Porch areas are not used for excess equipment storage. Locks have been installed for all shower cabinets. Mercury thermometers have been replaced with plastic. White marker boards have been moved to decrease visibility and maintain privacy. Plans are being developed to create additional space on the floors to relocate staff from the enclosed porches. This will improve temperature control issues in this area.

The interim fix for the HVAC grilles was completed June 2007. The identified patient safety deficiencies identified by the Office of Healthcare Inspections Team have been completed. Risk assessments are completed

annually and on an ongoing basis with a change in the patient population by the Patient Safety Officer, Risk Manager, Safety Officer, Nurse Manager and others; these are approved by Mental Health leadership. The Director has also begun Patient Safety walk-arounds by executive management to increase visibility of senior staff and demonstrate support of patient safety throughout the Medical Center. Two additional patient safety inspections have occurred, and additional changes will have to be made for buildings to be in full compliance with all recommendations. Noise reduction on the psychiatric wards was evaluated, and materials that can be utilized to ameliorate the noise problem have been addressed in the plans below.

Vital Corrections

- A list of items that are in need of attention within existing resources are currently being addressed, including shortening TV and phone cords, securing patient lockers to the floor and wall, replacement of rusty vents in the shower rooms, replacement of breakable mirrors, and securing picture frames with tamperproof screws. All of these corrections are scheduled to be completed by September 1, 2007.

Corrections Pending FY07 Project Award

- 515-06-101 Correct Patient and Life Safety Deficiencies — This project will replace the temporary screening placed over the existing HVAC diffusers in response to the Patient Safety Alert, secure patient room lighting with tamperproof screws, and replace the existing outlets with those recommended for a psychiatric environment. Construction award is expected 9/15/07 with a contract completion date of 4/1/08.
- 515-07-105 Replace Windows B39 – This project will replace the existing windows throughout the building, eliminating the need for detention screens and web-shades. Construction award is expected 9/15/07 with a contract completion date of 4/1/08.

Corrections Scheduled In FY08 (Funding Required)

- 515-08-104 Replace Ceramic Tile in Shower Rooms B39, 83, 84. This project will replace the ceramic tile in the shower areas of Building 39, as well as the NHCU located in Buildings 83 & 84. This tile was previously re-glazed, however the finish did not last and is continually peeling. In addition, new central exhaust fans will be installed to eliminate the existing window units which are difficult to keep clean. The current estimated cost of this project is \$490,000. If funding is received in early FY08, construction completion is expected by 5/1/08.

• 515-08-106 Correct EOC Deficiencies B39. This project will address numerous recommendations received from the inspections identified above. These recommendations include redesign of floor layout for better observation, change in door swings and hardware for several patient rooms, installation of drywall ceilings in dayrooms, replacement of corridor handrails, restroom renovations to conceal piping and correct other hazards, and install video surveillance throughout the patient care areas. The current estimated cost of this project is \$1,100,000. If funding is received in early FY08, construction completion is expected by 10/1/08.

Until the projects identified above are completed, staff will continue to monitor and screen patients closely. Those with more severe diagnosis will be placed in close proximity to the existing nurse's station resulting in closer observation.

OIG Contact and Staff Acknowledgments

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