



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 14-03183-317

Healthcare Inspection

Alleged Patient Safety Concerns Miami VA Healthcare System Miami, Florida

June 7, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Chairman Jeff Miller, Committee on Veterans' Affairs, US House of Representatives, and Chairman Mike Coffman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, US House of Representatives. The OIG team assessed allegations that the Miami VA Healthcare System (system), Miami, FL, lacked adequate patient safety policies and procedures to safeguard patients when they "come and go" from the Community Living Center (CLC) and whether additional safety measures could have prevented a patient's suicide.

We did not substantiate the allegation that the CLC lacked adequate safety policies and procedures regarding patients' "comings and goings" in the CLC. We found that the system had policies and procedures addressing various aspects of patient safety in the CLC. These policies and procedures addressed expectations for both system staff, as well as patients, for ensuring safety. However, we found that system staff did not consistently enforce certain policies and procedures when the patient did not comply with them. The patient had a disabling injury and had lived in the CLC for many years. CLC staff continually faced the choice of enforcing safety policies versus allowing concessions that permitted the patient to exercise greater autonomy, which is a CLC patient centered goal.

We could not substantiate the allegation that the system should have instituted additional safety precautions given the patient's past medical and mental health history. Based on our review of the electronic health record and interviews, the mental health and CLC providers and staff involved in the patient's care did not find the patient to be at increased risk for elopement, wandering, or suicide. A mental health provider assessed the patient's risk of suicide approximately 1 month prior to his death and determined that the patient was not at high risk. However, we identified additional potential suicide risk factors known to at least one staff member that were not documented or discussed in the CLC Interdisciplinary Team meetings.

Staff did not initiate an Integrated Ethics consult, which could have been done to assist them and the patient in making informed decisions and applying appropriate healthcare ethics standards regarding medical care, treatment, and patient autonomy. By failing to consistently enforce certain policies and procedures and initiate an Integrated Ethics consult, system staff missed opportunities to intervene with this patient.

Although a system internal review addressed some specific issues pertaining to the patient's care, it did not reflect and document an in-depth exploration of possible event causes.

We recommended that the System Director ensure that:

- CLC patients, families, and staff know the circumstances and guidelines under which they should initiate Integrated Ethics consults, have access to the Ethics Consultation Service, and know how to request an ethics consultation.

- CLC staff receive training regarding suicide risk factors and the importance of documenting and communicating identified suicide risk factors during Interdisciplinary Team meetings.
- System clinical leadership reviews current practices of the ordering and administration of sleeping medications in the CLC to determine if those practices optimize patient safety.
- Reviews of incidents involving patient safety are comprehensive and accurately reflect and document all components as outlined in the Veterans Health Administration National Patient Safety Improvement Handbook guidelines.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and initiated a comprehensive corrective action plan to address all recommendations. (See Appendixes A and B, pages 11–14 for the Directors' comments.) We reviewed evidence that demonstrated system managers have completed all elements of the corrective action plan for recommendations 1, 3, and 4; we consider those recommendations closed. We will follow up on the planned actions for the remaining recommendation.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Chairman Jeff Miller, Committee on Veterans' Affairs, US House of Representatives, and Chairman Mike Coffman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, US House of Representatives. The OIG team assessed allegations that the Miami VA Healthcare System (system), Miami, FL, lacked adequate patient safety policies and procedures to safeguard patients when they "come and go" from the Community Living Center (CLC) and whether additional safety measures could have prevented a patient's suicide. The purpose of the inspection was to determine whether the allegations had merit.

Background

The system is part of Veterans Integrated Service Network (VISN) 8 and serves an estimated veteran population of 153,789 in the South Florida counties of Miami-Dade, Broward, and Monroe. The system provides medicine, surgery, and mental health (MH) services, and operates 432 hospital beds at the Bruce W. Carter Medical Center, a tertiary hospital, and an attached four-story CLC located in the city of Miami. In addition, the system includes a spinal cord injury (SCI) rehabilitation center and a geriatric research, education, and clinical center.

For security purposes, a metal fence surrounds the perimeter of the system's campus. Other than the main entrance, VA Police keep outside doors and gates locked and monitor access. VA Police grant access to authorized persons with appropriate identification, including patient identification (ID) bracelets, VA visitor passes, and VA personal identification verification cards for employees and volunteers.¹ VA Police restrict system access during emergencies and outside of established visiting hours.

Patient Autonomy

Patient autonomy is at the core of all ethical medical decision-making. Autonomy, as it pertains to health care decisions, means patient "personal self-governance" as long as the patient has the mental ability to understand information about a medical decision, appreciate the consequences of a decision, formulate what the result of a decision might be, and communicate a decision (independently make informed decisions). Autonomous patient decisions must also be voluntary without external restraints or interference.² Veterans Health Administration (VHA) policy specifies that all patients have the right to accept or refuse treatment or procedures offered to them unless incapacitated (mentally or physically unable to make informed health care decisions) or incompetent (legally declared by a court as unable to make decisions about many matters including health and finances).

¹ Healthcare System Policy Memorandum 132-01-12, *Security Management Program*, July 3, 2012.

² Liliana Kalogjera Barry, *Health Care Decision Making in the Veterans Health Administration: The Legal Significance for Informed Consent and Advance Directives*, Marquette Elder's Advisor, Vol. 14, No. 2, 2013, Article 4.

A physician who has primary responsibility for the patient determines whether the patient is incapacitated. This process involves both mental and physical assessments, but it is not a legal determination and would only affect health care decisions as long as the patient was incapacitated (such as in a coma or under the influence of debilitating drugs).³

CLC Patient/Resident-Centered Care

CLC patient/resident-centered care is an approach to providing health care where the needs, preferences, and life-long habits of the CLC patient drive the treatment plan. Because patients can represent several different generations, special attention is paid to age and generation-specific requirements. The CLC environment, policies, and practices are designed to support the needs of the patient and are flexible to meet patients' individual needs. Life in the CLC should be similar to the way people would live in their own homes, and based on patients' preferences, staff may adjust diets and meal times, bath and grooming schedules, and sleep and wake times. Trust between patients and caregivers is ideally the foundation of this care.⁴

Integrated Ethics

VHA requires all medical systems to have Integrated Ethics Councils and processes to address issues when uncertainties, concerns, or conflicts about values arise. Such conflicts may occur when patient decisions regarding treatment or safety policies conflict with provider treatment plans or system safety policies. To help resolve conflicts, staff, patients, or family can initiate an ethics consult.⁵

Allegations

The OIG received allegations from Chairman Jeff Miller, Committee on Veterans' Affairs, US House of Representatives, and Chairman Mike Coffman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, US House of Representatives. Specifically, the OIG was asked to determine whether:

1. The system had adequate safety policies and procedures regarding patients' "comings and goings" in the CLC.
2. The system should have initiated additional safety procedures given the subject patient's history and medical issues.

³ VHA Handbook 1004.01, *Informed Consent for Clinical Treatment and Procedures*, August 14, 2009. This Handbook was scheduled for recertification on or before the last working day of August 2014 but has not yet been recertified.

⁴ VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. This VHA Handbook was scheduled for re-certification on or before the last working day of August 2013 but has not yet been recertified.

⁵ VHA Handbook 1004.06, *Integrated Ethics*, June 16, 2009. The June 16, 2009 Handbook was current during the events discussed in this report; it was rescinded and replaced on August 29, 2013. The 2009 and the 2013 Handbooks contain same or similar language regarding the initiation of an ethics consult.

Scope and Methodology

The period of our review was May 2014 through January 2015, and we conducted a site visit June 11–13, 2014. We interviewed CLC staff members and managers, VA Police, and system leadership. We reviewed relevant VHA and system policies and procedures, the patient’s electronic health record (EHR) and autopsy report, the VA Police report of the investigation into the CLC patient’s unexpected death, medical literature, and an internal review of the patient’s death.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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

Case Summary

The patient was admitted to the system's CLC with a severe disabling injury for long-term rehabilitation. With the exception of brief hospitalizations and family trips, he remained a patient of the CLC until his death.

Staff reported that, while a patient in the CLC, he achieved two masters' degrees from an accredited State university and made several unsuccessful attempts at gainful employment. Providers frequently wrote orders to allow him to leave the premises "on pass." He attended classes as well as music concerts, and independently navigated the public transportation system.

The patient developed several medical conditions and was dependent on staff for many activities of daily living. His medications included long-term narcotics for pain and sedatives for sleeping. Approximately 5 months before his death, physicians evaluated the patient and advised surgery that would have necessitated a transfer from the CLC and a temporary loss of independence. Staff told us that the patient refused the surgery and opted to remain in the CLC to receive medical and nursing care for his condition.

According to the patient's EHR, MH assessments, and our interviews with staff, the patient was alert, oriented, dysthymic (mildly depressed mood), and cognitively intact during the 6 months prior to his death. The patient independently made informed decisions, and staff described him as "well-adjusted to the unit." However, the EHR reflected that the patient frequently refused medical and MH care, and staff documented that the patient often demonstrated harsh and aggressive behavior towards them.

During the year immediately preceding the patient's death, a MH provider repeatedly documented that the patient denied suicidal ideation and plans. Five months prior to his death, the CLC MH provider assessed the patient as low acute risk for suicide. Approximately 1 month prior his death, an interdisciplinary team (IDT) meeting was held to discuss the patient's on-going and increasing medical concerns. In addition to the meeting, the MH provider documented a plan to support medical interventions and expressed concern about the patient's mental status given his worsening medical condition. The MH provider planned to monitor the patient more closely with visits and EHR reviews every 1 to 2 weeks, but often the patient was not available during visit attempts.

A few weeks prior to the patient's death, the MH provider performed a quarterly assessment of his mental status, behavioral profile, and potential for ongoing inclusion in regular MH sessions with psychology service. The MH provider documented that the patient denied suicidal and homicidal ideation, intent, or plans of self-harm. The provider further documented that the patient said he had "hope for the future despite negative prospects related to medical issues."⁶

On the day of the patient's death, staff documented that the patient requested and received his sleeping medication. Between 1 to 2 hours later, staff became aware of the patient's

⁶ EHR, Psychology Quarterly Progress Note – MH Assessment July 17, 2013.

absence and after searching the unit, notified VA police. Around this time, VA police received notification from Miami municipal police about an unidentified body just outside VA grounds. VA police contacted CLC nursing staff, who identified the body as the missing patient. The system's leadership followed established procedures by immediately notifying the West Palm Beach investigative branch of the OIG.

The family later recovered a "goodbye letter to family" from the patient's laptop computer.

Inspection Results

Issue 1: Safety Policies and Procedures for Leaving the CLC

We did not substantiate the allegation that the CLC lacked adequate safety policies and procedures regarding patients' "comings and goings" in the CLC. We found that the system had policies and procedures addressing various aspects of patient safety in the CLC. These policies and procedures addressed expectations for both system staff, as well as patients, for ensuring safety. However, we found that system staff did not consistently enforce certain policies and procedures when the patient did not comply with them.

Applicable System Policies and Procedures

- The system's policy on the management of missing and wandering patients states that patients should be assessed for risk of wandering or elopement. When patients are determined to be at-risk, the CLC utilizes an electronic elopement management system wherein the patient wears an electronic monitoring bracelet that alarms if he or she attempts to exit through a monitored door.⁷
- The system's policy on patient ID bracelets requires Medical Administration Service to issue an ID bracelet to all patients admitted to the system and, after confirming identity, nursing staff to place the bracelet on the patient.⁸
- The system's Geriatrics and Extended Care Resident Handbook requires patients to notify and receive authorization from a nurse manager, charge nurse, or provider prior to leaving their assigned unit. It also requires patients to wear an ID bracelet at all times, particularly when off the unit.⁹

Non-Enforcement of Policies

According to staff we interviewed, the patient routinely (at least daily) left the CLC without informing the staff, despite being aware of the requirement to do so. However, in the 2 years prior to the patient's death, his EHR did not contain documentation of any concern about this behavior. Staff told us that, although they were aware this behavior was contrary to policy, they had not reported or documented it, as the behavior did not meet elopement

⁷ HPM 11-14-13, *Management of Wandering and Missing Patients*, July 19, 2013.

⁸ HPM Patient Identification Policy 11-54-13 *Patient Identification*, January 8, 2013.

⁹ Miami VA Healthcare System, *Geriatric and Extended Care Residents Handbook*, January 16, 2011.

risk criteria. To meet risk criteria for the electronic monitoring system, the patient must have a mental or physical impairment/disability, and have a “propensity to stray beyond the view or control of employees.”¹⁰ Staff told us that the patient did not meet the elopement criteria, as he always returned.

Providers told us that in addition to leaving the CLC without authorization, during the patient’s years in the CLC, he would occasionally return from an authorized pass later than the system’s established curfew. He also repeatedly removed his identification wristband, insisted on taking his sleeping medication at other than the designated time, and refused to go to bed prior to taking his sleeping medication. He also had past incidences of harsh and aggressive behavior directed at staff for which a contract outlining expected and acceptable behavior was developed and implemented. Although the patient displayed these non-compliant and challenging behaviors, the staff described him as “well-adjusted.”

We found that several factors contributed to CLC staff not enforcing CLC safety policies and procedures with this patient.

Psychosocial Considerations. The patient was living with a severe disabling injury. According to staff, he was, nonetheless, very independent and would go in and out of the building whenever he wanted, but usually did not notify the staff that he was leaving. He controlled his medication schedule and regularly requested his sleeping medication before he went to bed. He refused to wear an ID bracelet and often refused to participate in IDT meetings. Staff did not respond to his behavior because his behavior had become routine and commonplace (“he does it all the time” or “he always returns”). The IDT discussed the patient’s refusal to wear an ID bracelet in 2012 and 2013 team meetings without resolution. During an IDT meeting held approximately 3 months prior to the patient’s death, the IDT reported that the patient told them that he would not wear the ID bracelet, and he would instead identify himself verbally as needed. The IDT accepted this compromise although it was contrary to system policy.

Some staff referred to the patient as their “baby” and others spoke about having to “cajole” him into medical decisions that they believed were best for him, both of which suggest some loosening of professional boundaries. The staff’s interactions with the patient and management of his non-compliant behavior demonstrated the staff’s willingness, in the context of this complex psychosocial milieu, including the patient’s right to be as independent as possible, to let the patient continue to break rules and not comply with system policies and practices.

Long-Term Patient Behaviors/Staff Passivity. The patient had been a patient of the CLC for many years and, over time, the staff had become accustomed to his routines and behaviors, which included refusing to comply with certain CLC policies and practices. For example, he demanded that his sleeping medication be given to him when he wanted it, even though this was in opposition to the CLC nursing practice of administering sleeping medication after a patient went to bed. On the night of his death, staff administered sleeping medication to the patient before he was in bed for the night. He left the unit while

¹⁰ HPM 11-14-13.

presumably affected by the medication. Staff allowed for these behaviors as they struggled with the choice of enforcing CLC policies and practices or allowing concessions that permitted the patient to exercise some control and freedom of movement. For instance, staff told us that when the patient left the unit without notice, he always returned, so, over the years they allowed this behavior. In fact, a provider noted in the EHR that when the patient was discovered missing from the unit on the night of his death (staff were unaware that he had left), he would not have been considered a high-risk missing patient, but rather as absent. Thus, although the system had policies and procedures in place regarding patients' "comings and goings" in the CLC, in practical terms the patient became individually exempted from them through long-term non-enforcement.

Lack of Practical Consequences. Although the patient could have theoretically been discharged from the CLC for failing to comply with certain policies,¹¹ the staff were reluctant to pursue this as the patient did not have financial or other means to live independently and would not have had the system's unique resources available to him. The CLC had been the patient's home and the staff and other patients part of his social environment for so many years that discharge could have been emotionally as well as medically and economically burdensome. Thus, staff did not consider initiating discharge for failure to adhere to CLC and system policies to be a viable option for this patient. According to staff, the patient was never a candidate for a wandering patient tracking device because he did not have dementia or memory problems and always returned to the unit.

We acknowledge the difficulties in balancing the principles of patient/resident-centered care and the patient's need for and right to autonomy with the CLC's requirement to assure patient safety. CLC staff continually faced the choice of enforcing safety policies versus allowing concessions that permitted the patient to exercise some control and freedom of movement. However, an Integrated Ethics consult could have been valuable in clarifying the issues, resolving conflicts, and suggesting interventions to address the patient's refusal to follow CLC policies as well as his refusal of potentially lifesaving surgery. We found no evidence that this occurred. By failing to consistently enforce certain policies and procedures and initiate an Integrated Ethics consult, system staff missed opportunities to intervene with this patient.

We found that system leadership had formulated plans to promote and track staff compliance and use of procedures regarding administration of sleeping medications and resolution of patient behavior and conflicts.

Issue 2: Patient-Specific Suicide Safety Precautions

We could not substantiate the allegation that staff should have initiated additional safety precautions for this patient due to his history and medical issues. Generally, system staff follow several safety precautions in relationship to the prevention of falls, medication administration, and other medical/psychological processes. Safety precautions can encompass a variety of measures ranging from simple interventions such as signage

¹¹ HPM 11A-07-13, *Admission and Discharge Criteria for the Miami VA Healthcare System Community Living Center*, April 8, 2013.

alerting staff to a patient's risk for falls to one-on-one observation to prevent acutely psychotic patients from hurting themselves or others. Assessment is critical in determining the level of risk and the need for safety measures. In this case, the issue pertains to whether the patient required additional safety precautions related to the risk of suicide. The MH provider assessed the patient's risk for suicide approximately 1 month prior to his death and documented that the patient denied thoughts of suicide, as he had for the past 2 years, and appeared optimistic for his future.

System policy requires that providers complete patient suicide-risk assessments on MH units, in outpatient clinics, as part of some MH consults, and when prompted via an electronic clinical reminder. In other clinical settings, including the CLC, providers should use their own judgment in deciding when to evaluate patients for suicidal ideation, intentions, and plans.¹² The VA/Department of Defense Guideline cautions that providers should reassess patients if risk factors or other predictors change.¹³

The patient's existing suicide risk factors included depression, chronic pain from back spasms, living with a severe disability, and a previous suicide attempt close in time to his original injury.

New risk factors developed in the months preceding the patient's death, including:

- The need for surgery that could have represented a perceived loss of independence/autonomy.
- The suicide of a friend 3–4 months earlier.

The MH provider became concerned enough about the patient's emotional status related to the surgery and loss of independence that he/she planned to increase MH monitoring. The patient, however, often refused MH assessment and intervention. IDT meeting notes from the last meeting before the patient's death did not reflect that the team knew about or discussed the friend's suicide although at least one staff member on the unit had knowledge of this event. Furthermore, although the MH provider attended the last IDT meeting, the team did not address the MH provider's apprehension regarding the relationship between the patient's emotional status and concern about the proposed surgical intervention and loss of independence. At the time of the meeting, the patient had refused the proposed surgery and associated treatment; however, the IDT did not discuss this. The patient's refusal of treatment could have caused a significant deterioration in the patient's overall health and potentially threaten the patient's life. Without knowledge or discussion of the information discussed above, the IDT could not have adequately assessed the patient's suicide risk, nor would they have modified the treatment plan to include additional safety measures.

Based on our review of the EHR and interviews, MH and CLC providers and staff reported that the patient did not present with suicide ideation and had no additional factors that

¹² HPM 116-06-13, *Suicide Risk: Assessment and Management*, March 13, 2013. (revised January 9, 2014)

¹³ VA/DoD Guideline, *Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide*, June 2013.

elevated his suicide risk enough to institute additional safety measures specifically tailored for suicide such as one-to-one constant surveillance. Although the patient's MH provider documented that the patient's mood and reactions to the proposed surgical treatment plan should be closely monitored, the provider did not closely monitor the patient due to the logistics of arranging patient appointments. The IDT did not document any discussion regarding the MH provider's concerns.

Issue 3: System Review

The system's internal review of the patient's unexpected death did not reflect and document an in-depth exploration of possible event causes and, therefore, did not identify potential actions and outcomes measures.¹⁴

An assigned review panel completed an internal review of the patient's death and the circumstances surrounding his death. We reviewed the internal process, the patient's EHR, relevant policies and procedures, pictures from the event site, a description of the scene at the time of the death, interviews with staff, and other relevant data.

The review documentation was incomplete and lacked a full discussion of issues pertinent to a comprehensive review of the circumstances surrounding the patient's death.

Conclusions

We did not substantiate the allegation that the system lacked adequate safety policies and procedures regarding patients' "comings and goings" in the CLC. We found that system policies and unit procedures required patients to wear an ID bracelet and notify staff when leaving. However, in practical terms, the patient became individually exempted from these rules through long-term non-enforcement by staff.

Although staff attempted to balance the patient's need for autonomy with the CLC's requirements for patient safety, an Integrated Ethics consult could have been valuable in clarifying the issues, resolving conflicts, and suggesting interventions.

We could not substantiate that given the patient's history and medical issues the system should have initiated additional safety procedures. Based on our review of the EHR and interviews, MH and CLC providers and staff did not consider the patient to be at increased risk for elopement, wandering, or suicide and therefore did not institute additional safety measures.

Because the quarterly IDT meeting notes did not reflect that system staff shared or were aware of specific patient behaviors and clinical information regarding possible suicide risks, the IDT did not fully discuss possible suicide risk factor changes.

¹⁴ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

Although it addressed certain issues pertaining to the patient's care, we found that the internal review involving the patient's unexpected death did not fully reflect and document the entirety of the event circumstances.

Recommendations

1. We recommended that the System Director ensure that Community Living Center patients, families, and staff know the circumstances and guidelines under which they should initiate Integrated Ethics consults, have access to the Ethics Consultation Service, and know how to request an ethics consultation.
2. We recommended that the System Director ensure that Community Living Center staff receive training regarding suicide risk factors and the importance of documenting and communicating identified suicide risk factors during Interdisciplinary Team meetings.
3. We recommended that the System Director ensure that system clinical leadership review current practices of the ordering and administration of sleeping medications in the Community Living Center to determine if those practices optimize patient safety.
4. We recommended that the System Director ensure that reviews of incidents involving patient safety are comprehensive and accurately reflect and document all components as outlined in the Veterans Health Administration National Patient Safety Improvement Handbook guidelines.

VISN Director Comments

Department of Veterans Affairs

Memorandum

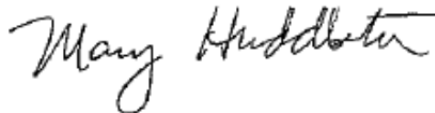
Date: January 22, 2016

From: Director, VA Sunshine Healthcare Network (10N8)

Subj: Healthcare Inspection—Alleged Patient Safety Concerns, Miami VA Healthcare System, Miami, Florida

To: Director, Bedford Office of Healthcare Inspections (54BN)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed and concur with the response submitted by the Miami VA Health Care System for their Healthcare Inspection – Alleged Patient Safety Concerns.
2. The facility has initiated and/ or completed actions as detailed in the status update response. Thank you!



(Original signed by Mary Huddleston (VISN 8 Quality Management Officer) on behalf of)

Thomas Wisnieski, MPA, FACHE
Acting Network Director, VISN 8

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 22, 2016
From: Director, Miami VA Healthcare System (546/00)
Subj: Healthcare Inspection—Alleged Patient Safety Concerns, Miami VA Healthcare System, Miami, Florida
To: Director, VA Sunshine Healthcare Network (10N8)

Enclosed you will find the Miami VA Healthcare System's response to the Healthcare Inspection of Alleged Patient Safety Concerns performed by the Office of Inspector General.


Paul M. Russo, MHSA, FACHE, RD Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the System Director ensure that Community Living Center patients, families, and staff know the circumstances and guidelines under which they should initiate Integrated Ethics consults, have access to the Ethics Consultation Service, and know how to request an ethics consultation.

Concur

Target date for completion: Actions completed January 11, 2016

System response:

Ethics education regarding the availability and function of ethics consultation services was reviewed during the Interdisciplinary staff meeting on January 11, 2016. In addition, Social Workers assigned to the CLC provide a pamphlet to the veterans and their families when they become residents of the unit which outlines their rights and responsibilities and their involvement with the ethics consult process.

The 2011 and 2015 issue of the CLC resident handbook also has instructions on how to assist the resident and/or family in making arrangements to meet with the Ethics Committee when there is an ethical or potential ethical concern that cannot be resolved through their healthcare team.

Ethics education to staff is ongoing; current compliance for CLC staff is 97%.

Recommendation 2. We recommended that the System Director ensure that Community Living Center staff receive training regarding suicide risk factors and the importance of documenting and communicating identified suicide risk factors during Interdisciplinary Team meetings.

Concur

Target date for completion: February 29, 2016

System response: TMS [Talent Management System] course 6201 Suicide Risk Management training to be completed by all clinical staff to include the interdisciplinary team.

Request for modification of the Interdisciplinary treatment team template to include "Are there any suicide risk factors, yes or no" was submitted to the health informatics team on January 20, 2016. If the answer is yes, the staff will be prompted to explain, document and communicate to the appropriate provider.

Recommendation 3. We recommended that the System Director ensure that system clinical leadership reviews current practices of the ordering and administration of sleeping medications in the Community Living Center to determine if those practices optimize patient safety.

Concur

Target date for completion: Completed January 3, 2014, monitored for compliance through March 7, 2014

System response:

An interdisciplinary team comprised of Nursing, Pharmacy and a Provider reviewed the practice of ordering and the administration of sleep medications in the CLC. Recommendations included patient education for patients receiving sleep medication. In addition, prior to administration an automatic pop-up dialogue box, which states, "Remind patient to stay in bed after administration" was implemented.

Recommendation 4. We recommended that the System Director ensure that reviews of incidents involving patient safety are comprehensive and accurately reflect and document all components as outlined in the VHA National Patient Safety Improvement Handbook guidelines.

Concur

Target date for completion: Completed January 1, 2014

System response:

Quality Management oversight process checks are in place to ensure that reviews of incidents that meet the criteria for a patient safety review are comprehensive and accurately reflect and document all components as outlined by the Veterans Health Administration National Patient Safety Improvement Handbook.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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