DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Safety Concerns When Providing Care in the Community at the VA Southern Nevada Healthcare System in North Las Vegas

HEALTHCARE INSPECTION | REPORT #19-09410-203 | JULY 14, 2020

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Southern Nevada Healthcare System (facility) in North Las Vegas, in response to a referral submitted by the U.S. Office of Special Counsel. The referral contained allegations of inadequate responses by facility leaders after a patient attacked and threatened a facility social worker (Social Worker A):

- Facility leaders inadequately responded to a home visit attack by a patient on Social Worker A and failed to address Social Worker A's safety and health needs.
- Two weeks passed before facility leaders notified Social Worker A that the patient had reportedly threatened to kill the social worker.

The OIG identified additional issues affecting the safe provision of care in the community, including a delay in the placement of a disruptive behavior flag following the assault, deficiencies in VA police participation on the Disruptive Behavior Committee, and frequent vacancies and staff turnover in the facility's multidisciplinary Housing and Urban Development-Veterans Affairs Supporting Housing (HUD-VASH) program.[1]

Synopsis of Events[2]

Social Worker A attempted to complete a home visit in spring 2019 (day 1). After receiving no response at the patient's apartment, Social Worker A left and was returning to the government vehicle when the patient approached with metal socket wrenches in each hand. The patient began shouting, calling the social worker a liar, and started to swing one of the wrenches. A socket dislodged but did not strike Social Worker A. The patient continued to approach the vehicle after Social Worker A got in and locked the doors. The patient swung a wrench towards the window, which stopped short of impact. Social Worker A drove to a safe location and notified a supervisor of the event by phone. After returning to work, Social Worker A completed a

[1] VHA Directive 2010-053, *Patient Record Flags*, December 03, 2010. The Disruptive Behavior Committee evaluates the risk of violence in a given setting or situation with a given patient and may recommend measures to mitigate the risk such as a patient record flag of disruptive behavior. The flag is placed in the electronic health record to alert VHA employees to patients whose behavior, medical status, or characteristics may pose an immediate threat to themselves or others in the initial moments of the patient encounter. U.S. Department of Veterans Affairs, *U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program.* HUD-VASH is a collaborative program that connects homeless veterans and their families with Housing Choice Vouchers and VA supportive services to find and sustain permanent housing. A HUD-VASH social worker often provides care in the community through home visits. https://www.va.gov/homeless/hud-vash.asp. (The website was accessed on December 11, 2019.)

[2] The synopsis summarizes events described in the witness statement, and VHA and police reports completed in response to the assault and reported threat.

disruptive behavior report and a VA police report. Social Worker A reported the incident to the Las Vegas Metropolitan Police Department (community police) the next day.[3] Community police visited the patient's residence soon after Social Worker A submitted the report; however, they were unsuccessful in locating the patient.

Just over three weeks after the assault (day 23), another social worker (Social Worker B) heard that the patient expressed wanting to kill Social Worker A. Social Worker B notified the HUD-VASH supervisor, documented a report of contact, and submitted a disruptive behavior report. On day 37, the HUD-VASH supervisor notified Social Worker A of the threat. On day 57, community police arrested the patient for assault on Social Worker A.

Approximately one month after the threat notification, a state court issued a temporary order of protection for Social Worker A against stalking, aggravated stalking, or harassment from the patient. That order was later extended. On day 117, the patient pled guilty to the offense and was sentenced to jail for six months.

Healthcare Inspection Results

The OIG substantiated that facility managers lacked a timely response to the assault on Social Worker A while conducting a home visit. Specifically, Social Worker A's supervisor failed to immediately report the incident to community police, and once informed, VA police contributed to a delayed arrest by not liaising with community police.[4]

The Veterans Health Administration (VHA) requires that employees immediately report possible violations of criminal law related to public safety to their supervisor or any management official, who must then immediately report the criminal violation to state or local law enforcement officials with jurisdictional responsibility.[5] VA police are tasked with ensuring the protection of VHA property and staff. This task becomes more complex when incidents occur in areas that are outside the jurisdiction of VA police. Basic requirements for the proper development and implementation of VA law enforcement capabilities include establishing liaison with appropriate federal, state, and local law enforcement agencies and establishing procedures for promptly requesting assistance of local public safety agencies in life threatening situations.[6]

[3] Community police had jurisdiction for the assault that occurred outside of VA grounds. VA police coordinate responses to events occurring outside of VA grounds.

[4] The supervisor told the OIG about not appreciating the need to immediately report the assault to the community police as the social worker had been able to seek safety.

[5] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration Facilities,* September 27, 2012. The OIG noted that Facility Policy 116-18-07, *Code Gray Prevention and De-escalation of Disruptive Behaviors*, March 2018, does not provide clear direction and timelines for reporting incidents of workplace violence or disruptive behavior that occur outside of the facility.

[6] VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

Following the assault, Social Worker A acted in accordance with facility guidance by driving to a safe location and immediately contacting a supervisor.[7] When Social Worker A returned to the facility, the supervisor debriefed Social Worker A and gave instructions to complete both a VA police report and a community police report. As noted above, Social Worker A reported the assault to VA police that day, and to community police the next day. The VA police chief told the OIG that the officer who initially was alerted to the assault did not follow standard protocol by failing to assist Social Worker A in communicating the assault to community police.[8] While the OIG could not confirm that the patient would have been arrested earlier, the OIG concluded that the facility's failure to immediately communicate the event to community police may have delayed the patient's arrest, which did not occur until day 57.

The OIG substantiated that facility managers failed to address Social Worker A's health needs after the assault by the patient. The supervisor did not ensure Social Worker A was medically evaluated.

VHA policy requires that service line managers and supervisors facilitate employees receiving prompt and appropriate medical attention after a workplace injury.[9] The two possible options for the treatment of a workplace injury are occupational health and workers compensation.[10]

The OIG found that the supervisor did not refer Social Worker A to the facility's Occupational Health Department believing that department could not provide care for mental health injuries. Occupational health staff affirmed this belief stating that it is their practice to refer employees with non-emergent mental or emotional injury to the Employee Assistance Program for mental health evaluation and referral. The supervisor did not think that Social Worker A was in need of urgent mental health care and offered a referral to the Employee Assistance Program.

The Employee Occupational Health Service Handbook defines traumatic injury as "a wound or other condition of the body caused by external force. It must be identifiable by date and time, member of body affected, and it must be caused by a specific event or incident or series of events or incidents within a single day or work shift."[11] Based on this definition, the OIG determined that Social Worker A should have been medically evaluated for a traumatic injury on the day of the assault.

[7] During an OIG interview, the supervisor acknowledged that the social worker should have been instructed to contact community police to report the incident prior to returning to the facility.

[8] Facility Standard Operating Procedure, *Police Service,* October 18, 2017.

[9] VHA Directive 7701, *Comprehensive Occupational Safety and Health Program*, May 5, 2017; Facility Policy 111-18-04, *Occupational Health Services,* February 2018.

[10] Facility Policy 111-18-04.

[11] VHA Handbook 2019, *Employee Occupational Health Service*, March 27, 2015.

Within two days of the assault, social work leaders referred Social Worker A to the Human Resources Office of Workers' Compensation (Human Resources) as required by policy.[12] Human Resources did not provide the information for Social Worker A to seek medical treatment until 15 days after the assault.[13] The OIG found that, although a process is available for documentation and treatment of physical injuries, there is no clear guidance on how to respond to an emotional or mental health injury. The OIG concluded that the facility lacked clear and specific policies to guide employees, supervisors, Occupational Health Department staff, and Human Resources in their response to emotional and mental health injuries.

The OIG substantiated that the supervisor did not notify Social Worker A for two weeks following a report that the patient had made homicidal threats.[14] The OIG found there was a communication failure between the supervisor and the Deputy Chief of Police that resulted in a delay in communication to Social Worker A, as well as the threat not being reported to community police who had jurisdictional oversight. Due to conflicting stories from the supervisor and the police, the OIG was unable to determine the reason for the failed communication between them.

When notified, facility policy directs VA police to take necessary action to protect threatened individuals, and to determine if a violation of state or federal law occurred and to act accordingly.[15] Upon learning of the threat, Social Worker B informed a supervisor who directed Social Worker B to submit a Disruptive Behavior Reporting System report and a report of contact, which were both completed.[16] According to the supervisor, the threat was communicated to VA police through the report of contact, as well as during a call between the supervisor and the Deputy Chief of VA Police, who agreed to communicate the threat to community police. The supervisor assumed VA police would notify Social Worker A. When interviewed, the Deputy Chief of VA Police disagreed with the supervisor's assertion, did not recall being contacted by the supervisor, and indicated that VA police did not have the report of contact on file.[17]

Community police arrested the patient based on the assault warrant; they were unaware of the threat or possible ongoing danger to Social Worker A at the time of the arrest. Had the community police known about the threat at an earlier date, an arrest may have occurred sooner.

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[12] VHA Directive 7701.

[13] The OIG attributed at least part of the delay to staff's confusion regarding how to file a worker's compensation claim.

[14] The social worker was on leave at the time facility leaders were made aware of the threat and did not return to work until day 37.

[15] Facility Policy 07B-19-02, *Threatening Correspondence*, June 2016.

[16] VHA Directive 2010-053.

[17] The supervisor had the responsibility to notify the VA police of the threat. Had the VA police been aware of the threat, they would have had a responsibility to take action.

The Disruptive Behavior Committee met and received the report outlining the circumstances of the attack on day 17. The OIG found that the facility's Disruptive Behavior Committee, which met bi-monthly, did not enter a patient record flag or an order of behavioral restriction in the patient's chart until day 46.[18]

When asked about the 46-day time frame, the facility's Disruptive Behavior Committee chairperson informed the OIG that when the Disruptive Behavior Committee reviewed the incident, it determined that a patient record flag and an order of behavioral restriction were warranted but that immediate placement was not necessary. The Disruptive Behavior Committee chairperson, who was the only person with access to place flags and orders of behavioral restriction in the electronic health record, indicated being unable to complete these tasks until day 46 due to other duties. The OIG concluded that while the delay did not result in immediate problems in this instance, it did not meet the goal of addressing immediate safety issues.

The OIG found that VA police did not follow VHA Workplace Violence Prevention protocol for acting on criminal information that was available for review and action on two occasions: (1) when Social Worker B submitted a Disruptive Behavior Reporting System report describing the threat, and (2) when the event was discussed during a Disruptive Behavior Committee meeting.[19]

The Deputy Chief of VA Police acknowledged being a recipient of all alerts for newly generated disruptive behavior reports but informed the OIG that the reports were not triaged to identify potential criminal violations. This failure to review alerts precluded VA police from identifying a potential criminal act or safety risk that may not be reported through other means. The OIG reviewed the Disruptive Behavior Reporting System report of the homicidal threat toward Social Worker A submitted on day 23, and determined that it included information that warranted action by VA police. In addition, the threat was discussed during the day 52 Disruptive Behavior Committee meeting that the Deputy Chief of VA Police attended.

It is imperative that VA police be more than passive participants in the Disruptive Behavior Reporting System process. VA police did not fulfill their obligation to take action in response to the Disruptive Behavior Reporting System report or during the Disruptive Behavior Committee meeting. Acceptable responses would have included requesting an emergent flag be placed to notify VA police when the patient was on VA grounds after the day 23 report to the Disruptive Behavior Committee, communicating the threat to the intended target, and coordinating a response with community police to implement safety measures in the event the patient intended to act on VA property.

[18] VHA Directive 2010-053. An order of behavioral restriction, by the Chief of Staff or designee, restricts the time, place, and/or manner of the provision of a patient's medical care.

[19] VHA Workplace Violence Prevention Fact Sheet: VA Police Criminal Investigations, March 26, 2019. This document is located on a secure VHA website and is not available to the public.

While on site, the OIG found high turnover of HUD-VASH staff and a lack of consistent leadership. The chief and assistant chief for social work and the HUD-VASH program manager positions were vacant or occupied by acting staff. The staff turnover left the remaining HUD-VASH staff with high caseloads and required supervisors to conduct extensive training for new staff. In addition, the OIG learned that due to understaffing, HUD-VASH staff were often unable to take a colleague with them on patient home visits if needed for safety concerns. During times of low staffing, patient care plans that recommended two staff conduct visits when safety was a concern could not be consistently followed.[20]

The OIG is concerned that the vacancies and high turnover in HUD-VASH positions could pose a risk to employee safety by increasing workload, which limits resources for social workers to complete home visits together.

The OIG made recommendations to the Facility Director related to staff and supervisor awareness and compliance with reporting requirements arising from off-VA grounds patient disruptive behavior incidents, traumatic injury needs of staff who may be experiencing an emotional or mental health injury as a result of a work-related incident, and timely notification of threats to targeted staff. Other recommendations addressed placement of patient record flags to address immediate safety issues, VA police participation in the Disruptive Behavior Committee process, and a review of HUD-VASH staffing and training needs.

Comments

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

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

[20] Facility Policy 116-19-05, *Prevention and Management of Patient Generated Disruptive Behavior*, January 2019.

Contents

Abbreviations

DBC	Disruptive Behavior Committee
DBRS	Disruptive Behavior Reporting System
HUD	Housing and Urban Development
OIG	Office of Inspector General
PRF	patient record flag
VASH	Veterans Affairs Supportive Housing
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

At the request of the U.S. Office of Special Counsel, the VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations concerning social worker safety at the VA Southern Nevada Healthcare System (facility) in North Las Vegas.

Background

The facility, part of Veterans Integrated Service Network (VISN) 21, provides inpatient and outpatient healthcare services, including mental health and home care. It operates six community-based outpatient clinics. VA classifies the facility as a Level 1b—high complexity facility.[1] Between October 1, 2017, and September 30, 2018, the facility served 63,409 patients and had a total of 90 hospital operating beds.

Disruptive Behavior in Healthcare

According to the U.S. Bureau of Labor Statistics, healthcare workers are more likely to be victims of violence in their workplaces than workers in most other industries.[2] VHA facility staff are susceptible to the risks of patient violence. VHA facility leaders are challenged with balancing the rights and healthcare needs of patients that exhibit violent and disruptive behavior with the health and safety of other patients, staff, and visitors. According to policy, VHA leaders are committed to reducing and preventing disruptive and violent behaviors through the development of policies aimed at patient, visitor, and employee safety.[3]

[1] The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex. Level 3 facilities are the least complex. VHA Office of Productivity, Efficiency and Staffing. (The website was accessed on August 12, 2019, and is an internal VA website not publicly accessible.)

[2] U.S. Department of Labor, Occupational Safety and Health Administration, OSHA 3148-06R 2016. *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*. The National Institute for Occupational Safety and Health defines workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty."

[3] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration Facilities,* September 27, 2012. "Disruptive behavior is behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, VA employees, or individuals at the facility."

Federal regulation does not permit VHA facilities to ban disruptive or violent patients from receiving care; however, VHA facilities may limit the time, place, or manner of providing services to them.[4]

Request to Review Allegations

In summer 2019, the OIG received a referral from the U.S. Office of Special Counsel that contained allegations of inadequate responses by facility leaders after a patient attacked and threatened Social Worker A:

- Facility leaders inadequately responded to a home visit attack by a patient on Social Worker A and failed to address Social Worker A's safety and health needs.
- Two weeks passed before facility leaders notified Social Worker A that the patient had reportedly threatened to kill the social worker.

The OIG identified additional issues affecting the safe provision of care in the community including a delay in the placement of a disruptive behavior flag following the assault, deficiencies in VA police participation on the Disruptive Behavior Committee (DBC), and frequent vacancies and staff turnover in the facility's multidisciplinary Housing and Urban Development-Veterans Affairs Supporting Housing (HUD-VASH) program.[5]

Scope and Methodology

The OIG initiated the inspection in summer 2019, and conducted a site visit October 21–25, 2019. The OIG reviewed the circumstances surrounding the 2019 assault and subsequent homicidal threat of Social Worker A by a patient. The patient's electronic health record was also reviewed with a focus on HUD-VASH program participation for a 16-month time frame that included several months before and after the day of the assault.

The OIG interviewed 25 staff members in-person or via telephone including the complainant, Facility Director, Chief of Police, Deputy Chief of VA Police, Chief of Social Work, DBC Chair,

[4] VA OIG, *Combined Assessment Program Summary Management of Disruptive and Violent Behavior in Veterans Health Administration Facilities,* Report No. 17-04460-84, January 30, 2018.

[5] VHA 2012-026. A DBC is "a facility-level, interdisciplinary committee whose primary charge is using evidence-based and data-driven practices for preventing, identifying, assessing, managing, reducing, and tracking patient-generated disruptive behavior." U.S. Department of Veterans Affairs, *U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program.* HUD-VASH is a collaborative program that connects homeless veterans and their families with Housing Choice Vouchers and VA supportive services to find and sustain permanent housing. Public housing authorities provide rental assistance through Housing Choice Vouchers for privately owned housing to veterans who are eligible for VA health care services and experiencing homelessness. A HUD-VASH social worker often provides care in the community through home visits. https://www.va.gov/homeless/hud-vash.asp. (The website was accessed on December 11, 2019.)

Prevention and Management of Disruptive Behavior Coordinator, HUD-VASH supervisors, and social work staff.

Documents reviewed included VHA and facility directives, handbooks, policies and procedures, committee meeting minutes, Occupational Safety and Health Administration guidelines, and applicable Nevada statutes. Additionally, the OIG reviewed VA and metropolitan police reports and pleadings relating to the criminal prosecution of the assault on Social Worker A.

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

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

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

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

Patient Case History and Sequence of Events[6]

The patient's past medical history was significant for mental health issues necessitating multiple inpatient psychiatric hospitalizations with no outpatient behavioral health follow-up. The patient's social history included chronic homelessness and incarceration for violent offenses including assault. Throughout the three years and six-month time frame of the housing process, the patient displayed ongoing mental health issues, hoarding behaviors, and poor self-care. Documentation in the electronic health record during the two and a half months prior to the assault noted that the patient was unable to be contacted and was at-risk for losing a Housing Choice Voucher.[7] In 2019, the patient assaulted and reportedly threatened Social Worker A.

The Assault and Reported Threat

On a day in 2019 (day 1), Social Worker A attempted to complete a home visit at the patient's address.[8] After receiving no response at the patient's apartment, Social Worker A left a card and note, and returned to the government vehicle. While returning to the vehicle, Social Worker A heard the patient and turned to see the patient approaching with metal socket wrenches in each hand. Social Worker A walked toward the patient to continue the visit, at which time the patient began shouting, calling the social worker a liar, and started to swing a wrench towards Social Worker A's head. A socket dislodged from one of the wrenches but did not strike Social Worker A.[9]

Social Worker A retreated to the government vehicle and locked the doors. The patient approached the vehicle and swung a wrench towards the window, which stopped short of impact. Social Worker A drove to a nearby parking lot and telephoned a supervisor to report the incident. The supervisor advised Social Worker A to return to the facility to document the incident. Upon returning to work, Social Worker A debriefed with the supervisor, completed a disruptive behavior report and a VA police report, and contacted the property manager of the patient's apartment complex.

Social Worker A reported the incident to the Las Vegas Metropolitan Police Department (community police) the day after the assault (day 2). Since the incident occurred off the facility

[6] The sequence of events is summarized from the witness statement and the VHA and police report that were completed in response to the assault and reported threat.

[7] VHA Directive 1162.05(1), *Housing and Urban Development Department of Veterans Affairs Supportive Housing Program,* June 29, 2017, amended October 31, 2017. The Housing Choice Voucher program allows very low-income families to lease or purchase privately-owned rental housing at a location of their choice.

[8] Issues being addressed included hoarding behaviors, operating a business out of the apartment, excessive items on outside patio, and excessive use of the dumpster.

[9] The employee and other facility staff reported no concerns regarding the patient's prior behavior and indicated no reason to suspect that the patient would become violent during the visit.

grounds, community police had jurisdiction.[10] Community police visited the patient's residence the next day (day 3); however, they were unsuccessful in locating the patient.

A little more than three weeks after the assault (day 23), another social worker (Social Worker B), while providing care in the community, heard that the patient expressed wanting to kill Social Worker A. Social Worker B notified the HUD-VASH supervisor, documented a report of contact, and submitted a disruptive behavior report. Two weeks later, on day 37, the HUD-VASH supervisor notified Social Worker A of the threat. On day 57, community police arrested the patient for assault on Social Worker A.[11] On day 65, a state court issued a temporary order of protection for Social Worker A against stalking, aggravated stalking, or harassment from the patient. On day 101, the Court extended the order of protection for another 330 days. On day 117, the patient pled guilty to the offense and was sentenced to jail for six months.

Inspection Results

1. Facility Managers' Response to Attack on Social Worker

The OIG substantiated that facility managers lacked a timely response to an assault on Social Worker A while conducting a home visit. Specifically, Social Worker A's supervisor failed to immediately report the incident to community and VA police, which potentially contributed to a delayed arrest by VA police not liaising with community police.[12]

Title 38 of the Code of Federal Regulations (C.F.R.) §§ 1.200-203 establishes the mechanism for VHA employees to report information about criminal violations to appropriate law enforcement entities.[13] VHA requires that employees immediately report possible violations of criminal law related to public safety to their supervisor or any management official, who must then immediately report the criminal violation to state or local law enforcement officials with jurisdictional responsibility.[14] Facility policy does not provide clear direction and timelines for

[10] The facility maintains memorandums of understanding that grant community police agencies full rights to exercise law enforcement functions on medical center grounds. In addition, VA police coordinate responses to events occurring off-VA grounds, or outside of VA police jurisdiction.

[11] NV Rev Stat § 200.471(a) (2017) defines assault as (1) unlawfully attempting to use physical force against another person, or (2) intentionally placing another person in reasonable apprehension of immediate bodily harm. Because the assault occurred while Social Worker A, a healthcare provider, was performing duties, the social worker was considered to be an "officer" pursuant to 200.471(b) and the crime was classified as a category B felony. The patient, however, pled guilty to a gross misdemeanor.

[12] The supervisor told the OIG about not appreciating the need to immediately report the assault to the community police as the social worker had been able to seek safety.

[13] 38 C.F.R. §§ 1.200-203 (2003).

[14] VHA Directive 2012-026.

reporting incidents of workplace violence or disruptive behavior that occur outside of VHA facilities.[15]

VA police are tasked with ensuring the protection of VHA property and staff. This task becomes more complex when incidents occur in areas that are outside the jurisdiction of VA police. Federal Regulation 38 C.F.R. § 1.203 provides that if there is no VA police component with jurisdiction over the offense, the information will be reported to federal, state, or local law enforcement officials, as appropriate.[16] Basic requirements for the proper development and implementation of VA law enforcement capabilities include establishing liaison with appropriate federal, state, and local law enforcement agencies and establishing procedures for promptly requesting assistance of local public safety agencies in life threatening situations.[17]

Following the assault, Social Worker A acted in accordance with facility guidance by driving to a safe location and immediately contacting a supervisor.[18] When Social Worker A returned to the facility after the assault, the supervisor debriefed and instructed Social Worker A to complete both a VA police report and a community police report. The supervisor did not provide a timeline or assist the employee in reporting. Social Worker A reported the assault to VA police the day it occurred and to community police the following day. Per the VA police chief, the officer who initially was alerted to the assault did not follow standard protocol by failing to assist Social Worker A in communicating the assault to community police.[19]

The OIG determined that Social Worker A's supervisor erred by not reporting the event to community police immediately, and that VA police potentially contributed to a delayed arrest by not liaising with community police. While the OIG could not confirm that the patient would have been arrested earlier, the OIG concluded that the facility's failure to immediately communicate the event to community police may have delayed the patient's arrest until almost two months after the assault.

[15] Facility Policy 116-18-07, *Code Gray Prevention and De-escalation of Disruptive Behaviors*, March 2018.

[16] 38 C.F.R. §§ 1.200-203 (2003); VHA Directive 2012-026.

[17] VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

[18] During an OIG interview, the supervisor acknowledged that the social worker should have been instructed to contact community police to report the incident prior to returning to the facility.

[19] Facility Standard Operating Procedure, *Police Service*, October 18, 2017.

2. Facility Managers' Response to Social Worker A's Health Needs After the Assault

The OIG substantiated that facility managers failed to address Social Worker A's health needs after the assault by the patient. The OIG determined that the supervisor did not ensure Social Worker A was medically evaluated.[20]

Early responses to trauma can include confusion, detachment, blunted affect, sadness, nervousness, agitation, numbness, altered cognition, and fatigue. Late reactions to trauma can include continued tiredness, sleep disorders, fear of return or repetition, concern centered on flashbacks, depression, and avoidance of feelings, sensations, or activities that are linked with the trauma, even vaguely.[21] VHA policy requires that service line managers and supervisors facilitate employees receiving prompt and appropriate medical attention after a workplace injury.[22] The two possible options for the treatment of a workplace injury are occupational health and workers compensation. [23]

The OIG found that the supervisor thought that occupational health staff could not provide care for mental health injuries and did not refer Social Worker A to occupational health. Occupational health staff affirmed this belief stating that it is their practice to refer employees with non-emergent mental or emotional injury to the Employee Assistance Program for mental health evaluation and referral.[24] The supervisor did not believe Social Worker A was in need of urgent mental health care and offered a referral to the Employee Assistance Program.

VA policy provides direction to employees on responding to traumatic injuries or occupational illnesses.[25] The Employee Occupational Health Service Handbook defines traumatic injury as "a wound or other condition of the body caused by external force. It must be identifiable by date and time, member of body affected, and it must be caused by a specific event or incident or

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[20] VHA Directive 7701, *Comprehensive Occupational Safety and Health Program*, May 5, 2017; Facility Policy 111-18-04, *Occupational Health Services,* February 2018.

[21] Center for Substance Abuse Treatment (US). Treatment Improvement Protocol (TIP) Series, No. 57. *Trauma-Informed Care in Behavioral Health Services.* https://www.ncbi.nlm.nih.gov/books/NBK207191/. (The website was accessed on January 14, 2020.)

[22] VHA Directive 7701.

[23] Facility Policy 111-18-04.

[24] U.S. Office of Personnel Management, *What is an Employee Assistance Program?* https://www.opm.gov/policy-data-oversight/worklife/worklife-faqs/?cid=514f2983-ecdf-4ae7-bdd6-bd3e3ee2c5b0. (The website was accessed on April 16, 2020.) "An Employee Assistance Program (EAP) is a voluntary, work-based program that offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal and/or work-related problems."

[25]VA Handbook 2019, *Employee Occupational Health Service*, March 27, 2015. An occupational illness is a condition produced in the work environment over a period exceeding one workday or shift. "This may result from systemic infection, repeated stress or strain, exposure to toxins, poisons or fumes; or other continuing condition(s) of the work environment."

series of events or incidents within a single day or work shift." Based on this definition, the OIG determined that Social Worker A should have been medically evaluated for a traumatic injury on the day of the assault.

Within two days of the assault, social work leaders referred the employee to the Human Resources Office of Workers' Compensation (Human Resources) as required by policy.[26] Human Resources did not provide the information for Social Worker A to seek medical treatment until 15 days after the assault.[27] The OIG found that, although there is a process for documentation and treatment of physical injuries, there is no clear process on how to respond to an emotional or mental health injury. The OIG concluded that the facility lacks clear and specific policies to guide employees, supervisors, occupational health staff, and Human Resources in their response to emotional and mental health injuries.

3. Facility Managers' Response to Homicidal Threat

The OIG substantiated that the supervisor did not notify Social Worker A for two weeks following a report that the patient homicidally threatened the social worker.[28] The OIG found there was a communication failure between the supervisor and the Deputy Chief of Police that resulted in a delay in communication to Social Worker A, as well as the threat not being reported to community police who had jurisdictional oversight.

VHA policy requires employees to report public safety incidents, including threats of a serious nature, to supervisory staff, who in turn, must immediately report incidents to VA police and facility leaders.[29] When notified, facility policy directs VA police to take necessary action to protect the threatened individual, and to determine if a violation of state or federal law occurred and to act accordingly.[30]

Upon learning of the threat, Social Worker B informed the supervisor who directed Social Worker B to submit a Disruptive Behavior Reporting System (DBRS) report and a report of contact to document the incident.[31] As directed, Social Worker B submitted both a DBRS report

[26] VHA Directive 7701; Facility Policy 111-18-04.

[27] The OIG attributed at least part of the delay to staff's confusion regarding how to file a worker's compensation claim.

[28] The social worker was on leave at the time facility leaders were made aware of the threat and did not return to work until day 37.

[29] VHA Directive 2012-026.

[30] Facility Policy 07B-19-02, *Threatening Correspondence,* June 2016.

[31] VHA Directive 2010-053, *Patient Record Flags*, December 03, 2010. The purpose of Disruptive Behavior Committees is to evaluate the risk of violence in a given setting or situation with a given patient and to recommend measures that may be taken to mitigate that violence risk. VHA Directive 1162.05(1). The Disruptive Behavior Reporting System is a web-based system for reporting, tracking, and managing disruptive behavior incidents.

and a report of contact on day 23.[32] According to the supervisor, the threat was communicated to VA police through the report of contact as well as during a call between the supervisor and the Deputy Chief of VA Police, who agreed to communicate the threat to community police. The supervisor assumed VA police would notify Social Worker A. When interviewed, the Deputy Chief of VA Police disagreed with the supervisor's assertion, did not recall being contacted by the supervisor, and indicated that the VA police did not have a report of contact on file.[33]

The OIG concluded that the supervisor erred by not notifying Social Worker A at the earliest opportunity about the homicidal threat. Due to conflicting stories from the supervisor and the police, the OIG was unable to determine the reason for the failed communication between the two parties. Community police arrested the patient, based on the assault warrant; they were unaware of the threat or possible ongoing danger to Social Worker A at the time of the arrest. Had the community police known about the threat earlier, an arrest may have occurred sooner.

4. Other Findings

The OIG identified additional issues impacting the safe provision of care in the community including a delay in the placement of a disruptive behavior flag and order of behavioral restriction following the assault, deficiencies in VA police participation on the DBC, and frequent vacancies and staff turnover in the facility's multidisciplinary HUD-VASH program.[34]

Delay in Placement of Patient Record Flag

The OIG found that the facility DBC did not enter a patient record flag (PRF) that included an order of behavioral restriction in the patient's chart until day 46. The OIG concluded the time frame for the placement of the PRF did not meet the goal of addressing immediate safety issues and found that the delay compromised VHA staff safety.

All staff must report incidents of disruptive behavior through the DBRS.[35] Actions available to the DBC in response to reports of disruptive behavior include entering a PRF and an order of behavioral restriction. The use of PRFs is limited to addressing immediate safety issues by alerting VHA employees to patients whose "behavior, medical status, or characteristics may pose

[32] Disruptive behavior reports and reports of contact are two different reporting mechanisms used by VHA employees.

[33] Facility Policy 07B-19-02.

[34] VHA Directive 2010-053. A disruptive behavior notice (patient record flag) is placed in the electronic health record to alert VHA employees to patients whose behavior, medical status, or characteristics may pose a threat to themselves or others. An order of behavioral restriction is an order that is signed by the Chief of Staff or designee that restricts the time, place, and/or manner of the provision of a patient's medical care.

[35] The Disruptive Behavior Reporting System aides VA police in performance of their duties by generating a list of upcoming appointments for patients who have an order of behavioral restriction that calls for a police escort.

an immediate threat either to the patient's safety, the safety of other patients or employees, or may otherwise compromise the delivery of safe health care in the initial moments of the patient encounter."[36] Neither VHA nor facility policy specify a required time frame for a PRF to be entered into the electronic health record.[37]

Per facility policy, the DBC meets bi-monthly to review reports of disruptive behavior. An order of behavioral restriction may be implemented when a record review supports an assessment of high-risk for violence.[38] The OIG found that the DBC met and reviewed the report outlining the circumstances of the attack on day 17. A PRF and order of behavioral restriction were initiated on day 46.

When asked about the time frame, the facility DBC chairperson informed the OIG that when the DBC reviewed the incident, it determined that a PRF and an order of behavioral restriction were warranted but that immediate placement was not necessary. The DBC chairperson, who was the only person with access to place flags and orders of behavioral restriction in the medical record, indicated being unable to complete these tasks until day 46 due to other duties. The delay did not result in immediate problems but did not meet the goal of addressing immediate safety issues.

Deficiencies in Disruptive Behavior Committee Participation

The OIG found that VA police did not follow VHA Workplace Violence Prevention protocol for acting on criminal information that was available for their review and action on two occasions: (1) when Social Worker B submitted a DBRS describing the threat on day 23, and (2) when the event was discussed during a DBC meeting on day 52.[39]

Under 38 U.S.C. § 902(a)(1)(E), Enforcement and arrest authority of Department police officers, VA police are required to conduct investigations of suspected or alleged criminal offenses that may have occurred on VA property. VA police must also comply with 38 C.F.R. § 1.201, requiring all employees with knowledge or information about actual or possible violations of criminal law related to VA programs to ensure the violation is reported to authorities with jurisdictional oversight.[40]

DBCs receive information about events that occur on and off VA properties.[41] According to the DBC chairperson, designated VA police who serve on the DBC are notified electronically when new disruptive behavior reports are generated. The Deputy Chief of VA Police acknowledged

[36] VHA Directive 2010-053.

[37] VHA Directive 2010-053; Facility Policy 116-19-05.

[38] Facility Policy 116-19-05.

[39] VHA Workplace Violence Prevention Fact Sheet: VA Police Criminal Investigations Obligations, March 26, 2019. This document is located on a secure VHA website and is not available to the public.

[40] VHA Workplace Violence Prevention Fact Sheet.

[41] VHA Workplace Violence Prevention Fact Sheet.

being a recipient of all alerts for newly generated disruptive behavior reports but informed the OIG that the reports were not triaged to identify potential criminal violations. This failure to review alerts precluded VA police from identifying a potential criminal act or safety risk that may not be reported through other means. The OIG reviewed the DBRS report of the homicidal threat toward Social Worker A that was submitted on day 23, and determined that it included information that warranted action by VA police. In addition, the threat was discussed on day 52 at a DBC meeting that the Deputy Chief of VA Police attended.

Because healthcare workers are more likely to be victims of violence in their workplaces than workers in most other industries, the OIG determined it is imperative that VA police be more than passive participants in the DBRS process. VA police did not fulfill their obligation in response to the DBRS report or during the DBC meeting. Acceptable responses would have included communicating the threat to the intended target, coordinating a response with community police, implementing safety measures in the event the patient intended to act on VA property, and requesting an emergent flag be placed to notify VA police when the patient was on VA grounds.

HUD-VASH Staffing Turnover

During interviews, HUD-VASH staff reported high turnover and a lack of consistent leadership.[42] At the time of the inspection, the chief and assistant chief for social work and the HUD-VASH program manager positions were vacant or occupied by acting staff. In addition, of four HUD-VASH supervisory positions, two were vacant, and one was acting. The staff turnover left the remaining HUD-VASH staff with high caseloads and required supervisors to conduct extensive training for new staff. The OIG also learned that, due to understaffing, HUD-VASH staff were often unable to take a colleague with them on patient home visits, if needed, for safety concerns.

Specifically, the facility director is responsible for "maintaining adequate staffing levels to safely and appropriately provide the necessary clinical services for the vulnerable veterans served in HUD-VASH."[43] At the facility, high turnover led to episodic periods of low staffing and an influx of new staff with training needs that could be difficult to meet due to leadership and supervisor vacancies. Frequent turnover decreases employee institutional and program knowledge, and increases employee training time.

[42] The HUD-VASH program includes multidisciplinary staff that participate in home visits including social workers, nurses, peer supports, housing assistants and specialists, occupational therapists, employment specialists, motor vehicle operators, and addiction therapists.

[43] VHA Directive 1162.05(1).

Facility policy recommends two staff conduct visits when safety is a concern.[44] However, this guidance could not be consistently followed when staffing was low.

The OIG is concerned that the vacancies and high turnover in HUD-VASH positions can pose a risk to employee safety by increasing workload, which limits resources for social workers to complete home visits together.

Conclusion

The OIG substantiated that facility managers failed to timely respond after Social Worker A reported an assault when conducting a home visit. Social Worker A's supervisor failed to immediately report the incident to community police and VA police, which potentially contributed to a delayed arrest by not liaising with community police. The OIG substantiated that facility managers did not address Social Worker A's health needs after the assault by the patient. While processes were in place for physical injuries, there was no clear process on how to respond to an emotional or mental health injury. The OIG concluded that the facility lacks clear and specific policies to guide employees, supervisors, occupational health staff, and Human Resources in their responses to emotional and mental health injuries.

The OIG substantiated that Social Worker A was not informed by a supervisor of a homicidal threat until two weeks after facility leaders became aware of the threat. Additionally, deficient communication between the supervisor and the Deputy Chief of VA Police resulted in a delay in notification to Social Worker A as well as a failure to coordinate with the community police who had jurisdictional oversight.

While not part of the original complaint, the OIG identified three other issues related to the safe provision of care in the community: a PRF and order of behavioral restriction were not placed in the patient's electronic health record until day 46, VA police participation in the DBRS process did not identify the potential criminal act and safety risk that was summarized in the report submitted to the DBC by Social Worker B, and the HUD-VASH program faced challenges as a result of frequent turnover and long-term position vacancies.

Recommendations 1–6

1. The VA Southern Nevada Healthcare System Director reviews VA Southern Nevada Healthcare System policies and makes changes to ensure staff and supervisors are aware of and follow reporting requirements arising from off-facility patient disruptive behavior incidents.

[44] Facility Policy 116-19-05, *Prevention and Management of Patient Generated Disruptive Behavior*, January, 2019.

2. The VA Southern Nevada Healthcare System Director reviews VA Southern Nevada Healthcare System policies and implements changes to address traumatic injury needs of staff who may be experiencing an emotional or mental health injury as a result of a work-related incident.
3. The VA Southern Nevada Healthcare System Director reviews VA Southern Nevada Healthcare System policies and implements changes to ensure timely notification of threats to targeted staff.
4. The VA Southern Nevada Healthcare System Director reviews VA Southern Nevada Healthcare System policies for the placement of behavioral flags and makes changes to ensure patient record flags are placed to address immediate safety issues.
5. The VA Southern Nevada Healthcare System Director ensures that VA Southern Nevada Healthcare System VA police fulfill their obligation to fully participate with the Disruptive Behavior Committee, including the triage of Disruptive Behavior Response System entries, and confirms that potential criminal or safety issues are timely addressed.
6. The VA Southern Nevada Healthcare System Director reviews the VA Southern Nevada Healthcare System Housing and Urban Development-Veterans Affairs Supporting Housing staffing levels and practices to ensure staffing and training safely meet the demands of the program.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 8, 2020

From: Director, VA Sierra Pacific Network (VISN 21)

Subj: Healthcare Inspection—Safety Concerns When Providing Care in the Community at the VA Southern Nevada Healthcare System in North Las Vegas

To: Director, (54HL06)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review the draft report. I concur with the actions that the Las Vegas Facility has implemented in response to the findings.
2. Should you have any questions please contact the Sierra Pacific Network Office.

(*Original signed by*:)

John A. Brandecker
Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 5, 2020

From: Director, VA Southern Nevada Healthcare System (593)

Subj: Healthcare Inspection—Safety Concerns When Providing Care in the Community at the VA Southern Nevada Healthcare System in North Las Vegas

To: Director, Sierra Pacific Network (VISN 21)

1. We appreciate the opportunity to review the draft report of recommendations for safety concerns when providing care in the community conducted on-site at VA Southern Nevada Healthcare System during October 21-25, 2019.
2. Please find the attached response to each recommendation included in the report. We have completed, or in the process of completing, actions to resolve these issues.

(*Original signed by*:)

William J. Caron
Medical Center Director

Facility Director Response

Recommendation 1

The VA Southern Nevada Healthcare System Director reviews VA Southern Nevada Healthcare System policies and makes changes to ensure staff and supervisors are aware of and follow reporting requirements arising from off-facility patient disruptive behavior incidents.

Concur.

Target date for completion: July 31, 2020

Director Comments

Supervisor reporting requirements are outlined in Medical Center Memorandum (MCM) 116-19-05, Prevention and Management of Patient-Generated Disruptive Behavior. Supervisors and staff in HUD-VASH were re-educated on the requirements as outlined in MCM 116-19-05 on 05/03/2019 during an all-staff meeting. All employees in HUD-VASH completed retraining in Prevention and Management of Disruptive Behavior (PMDB) on 06/28/2019. An annual competency was created titled "Safety and Security of VA Community Based Workers" and has been added to field-based staff's annual competency evaluations. All field staff were initially evaluated using the competency in October 2019 and then it will be used to evaluate field staff annually during the end of year performance evaluation period. The Social Work Service Standard Operating Procedure SOP-122-SWS 2, Community Safety and Violence Safety Plan, was revised on June 03, 2020 to include appropriate reporting of safety incidents by supervisors and employees. Social Work leadership will ensure all supervisors and employees are educated on policy revisions by July 31, 2020.

Recommendation 2

The VA Southern Nevada Healthcare System Director reviews VA Southern Nevada Healthcare System policies and implements changes to address traumatic injury needs of staff who may be experiencing an emotional or mental health injury as a result of a work-related incident.

Concur.

Target date for completion: July 31, 2020

Director Comments

Standard operating procedures (SOP) for providing emotional or mental health care to staff as a result of a work-related incident are outlined in VA Southern Nevada Healthcare System Emergency Operations Plan, annex F, appendix 1. Mental Health First Aid is provided by trained staff in both Social Work Service and Behavioral Health Services immediately following the

report of an incident. The employee can receive six counseling sessions at no cost to the employee through the Employee Assistance Program. Additional counseling sessions may be covered by Workers Compensation. The Social Work Service Standard Operating Procedure SOP-122-SWS 2, Community Safety and Violence Safety Plan, was revised on June 03, 2020 to include reference to procedures as outlined in Emergency Operations Plan, annex F, appendix 1 for offering Mental Health First Aid to employees. Social Work leadership will ensure all supervisors and employees are educated on policy revisions by July 31, 2020.

Recommendation 3

The VA Southern Nevada Healthcare System Director reviews VA Southern Nevada Healthcare System policies and implements changes to ensure timely notification of threats to targeted staff.

Concur.

Target date for completion: July 31, 2020

Director Comments

Policies and procedures on the timely reporting of threats are found in Medical Center Memorandum 116-19-05, Prevention and Management of Patient-Generated Disruptive Behavior. All HUD-VASH staff were retrained on this policy on 05/03/2019. Duty to warn requirements and procedures were added to the Social Work Service Standard Operating Procedure SOP-122-SWS 2, Community Safety and Violence Safety Plan on June 03, 2020. All Social Work Service supervisors and employees will be educated on policy revisions by July 31, 2020.

Recommendation 4

The VA Southern Nevada Healthcare System Director reviews VA Southern Nevada Healthcare System policies for the placement of behavioral flags and makes changes to ensure patient record flags are placed to address immediate safety issues.

Concur.

Target date for completion: July 31, 2020

Director Comments

The Disruptive Behavior Committee chairperson role, responsibilities, and expectations have been reviewed and dedicated time granted to ensure timely review of cases and placement of behavioral flags. Other members of the committee will be trained on placing behavioral flags to ensure placement of behavioral flags when the chair is unavailable by July 31, 2020.

Recommendation 5

The VA Southern Nevada Healthcare System Director ensures that VA Southern Nevada Healthcare System VA police fulfill their obligation to fully participate with the Disruptive Behavior Committee, including the triage of Disruptive Behavior Response System entries, and confirms that potential criminal or safety issues are timely addressed.

Concur.

Target date for completion: Completed February 20, 2020.

Director Comments

VA Police Chief worked closely with the Chair, Disruptive Behavior Committee (DBC) to develop a triage process: Police review reports daily and any disruptive events are forwarded to the Chair DBC. All investigations receive an incident report number and appropriate actions taken to ensure potential criminal or safety issues are addressed timely.

The Chairman of Disruptive Behavior Committee (DBC) has partnered with VA Police and developed a Police Report folder on the Medical Center workgroup drive to expedite uploads of police reports into the system for tracking purposes. This ensures investigations are followed until resolved. VA Police have added representatives to the DBC committee to ensure police are represented at each meeting.

The Chairman DBC has conducted two trainings for Police Services to reinforce established guidelines including an outline of police responsibilities, expectations of Police staff, and review of criteria for Behavioral Flags so that VA police can fulfill their obligations and fully participate in the Disruptive Behavior Committee. All actions completed by February 20, 2020.

OIG Comment

The OIG considers this recommendation open and will follow up on the actions recently implemented by the VA Southern Nevada Healthcare System Director to allow time for the facility to submit documentation of actions taken and to ensure that corrective actions have been effective and sustained.

Recommendation 6

The VA Southern Nevada Healthcare System Director reviews the VA Southern Nevada Healthcare System Housing and Urban Development-Veterans Affairs Supporting Housing staffing levels and practices to ensure staffing and training safely meet the demands of the program.

Concur.

Target date for completion: July 31, 2020

Director Comments

Currently 35 out of 39 social worker positions are filled in the HUD-VASH program and there is active recruitment for the remaining four positions. On January 21, 2020 the HUD-VASH supervisors created a retention workgroup with the goal of reducing staff turnover rates.

Several practical applications have been implemented to address safety, such as the formation of a safety committee in HUD-VASH on 08/16/2019. This employee-led safety committee is made up of staff from each HUD-VASH team. They meet monthly to discuss safety concerns experienced in the field and decide which locations are either 2-person visit only or off-limits due to safety concerns. HUD-VASH and Social Work Service leadership are supportive of the Safety Committee's decisions.

Safety is a standing item at each weekly mini-team meeting and monthly all-staff meeting since May 2019. Staff and supervisors are trained to review charts for behavioral flags and restrict visits to the facility for those Veterans with behavior flags. Staff are instructed to, and supported in, cancelling a visit when they feel unsafe. A HUD-VASH supervisor has been a member of the Disruptive Behavior Committee since February 2019. All HUD-VASH employees are required to take PMDB and have a Safety competency. The HUD-VASH employees were provided with the PMDB Supplement for Community Based Workers on June 02, 2020. All HUD-VASH supervisors and employees will be educated on the revised Social Work Service Standard Operating Procedure SOP-122-SWS 2, Community Safety and Violence Safety Plan by July 31, 2020.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Judy Montano, MS, Director Amanda Barry, MSW, LCSW Dannette Johnson, DO John Johnson, MD, FAAFP Casey McCollum, MSW, LCSW Thomas Parsons, BSN, RN Clarissa Reynolds, NHA, MBA Dawn Rubin, JD
Other Contributors	Kathy Gudgell, JD, RN Natalie Sadow, MBA Robyn Stober, JD, MBA

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