Report on Critical Incidents in Virginia’s State Operated Mental Health Facilities October 1, 2016 - September 30, 2017

Prepared by
The disAbility Law Center of Virginia
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INTRODUCTION

The disAbility Law Center is a private non profit organization, operating under the authority of federal law and designated by state law to act as the protection and advocacy system for people with disabilities in Virginia.

The Code of Virginia requires that all facilities operated by the Department of Behavioral Health and Developmental Services must report to the disAbility Law Center of Virginia within 48 hours of a "critical incident." DBHDS is then required to provide all other known information within 15 days. A "critical incident" is any event resulting in death or loss of consciousness or an event requiring medical attention.

During federal fiscal year 2017, dLCV received a total of 333 Critical Incident Reports from mental health facilities operated by the Department.

EXECUTIVE SUMMARY

The disAbility law Center of Virginia has identified three areas of concern arising from Critical Incident Reports received in Federal Fiscal Year 2017 (FY 17).

First, dLCV suspects that facilities operated by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) are underreporting incidents. Although the number of incident reports in FY 17 was the highest in the last five (5) years, dLCV is aware of qualifying incidents at multiple state hospitals that have gone unreported to dLCV. Monitoring activities suggest that some of the disparities in reporting are the result of the Department's policy on critical incident reporting. The Department's policy unnecessarily constrains the interpretation of critical incident reporting obligations found in Virginia Code § 37.2-709 and § 37.2-709.1, which has caused confusion and inconsistency among DBHDS facilities and third-party reporters.

Second, state facilities are experiencing an increase in peer on peer assaults. As the hospitals struggle to cope with the number of acute jail transfers, we have seen an increase in the rates of peer-to-peer assaults and self-injury at CSH and ESH—facilities that serve a particularly high number of incarcerated individuals.

Finally, the number of deaths at DBHDS-operated MH facilities reached an all-time high in FY 17, warranting a closer look. CAT and PGH reported particularly high rates of death. Sources have voiced concerns that state mental health hospitals are receiving individuals with substantial medical needs, which often cannot be met by the facilities. Accordingly, the proportion of incidents resulting from medical conditions increased substantially between FY 16 and FY 17 (from 13.06% to 20.42% of all incidents). The number of individuals dying within 3 months of admission to a state facility has increased dramatically since the 2014 Legislation (Virginia Code 37.2-809) designated the state hospitals as "beds of last resort."

BACKGROUND

Virginia Department of Behavioral Health and Developmental Services (DBHDS) generates Critical Incident Reports (CIRs) on occurrences in their institutions resulting in injury that necessitated medical treatment and on occurrences resulting in loss of consciousness and death. As the populations the state facilities serve are substantially different, dLCV evaluates data from State Hospitals and Training Centers separately. This report will detail CIR trends in DBHDS operated mental health (MH) facilities during the 2017 Federal Fiscal Year (FY 17).

dLCV's MH CIR data is based on reporting from:

- Catawba Hospital (CAT)
- Central State Hospital (CSH)
- Commonwealth Center for Children and Adolescents (CCCA)
- Eastern State Hospital (ESH)
- Northern Virginia Mental Health Institute (NVMHI)
- Piedmont Geriatric Hospital (PGH)
- Southern Virginia Mental Health Institute (SVMHI)
- Southwestern Virginia Mental Health Institute (SWVMHI)
- Western State Hospital (WSH)

While CCCA and PGH serve age-specific populations, they are still designed to be psychiatric treatment facilities, rather than facilities for individuals with Developmental Disabilities (DD); for this reason, CCCA and PGH are compared with other State Hospitals to comprise our MH Data.

dLCV regularly monitors conditions in state facilities, and responds to complaints from residents and consumers. dLCV reviews CIRs on a weekly basis and analyzes quantitative data from the reports to identify overarching trends. Qualitative and quantitative data from the reports inform dLCV's work in the state facilities.

MH DATA

OVERALL REPORTING

In FY 17, DBHDS-Operated MH facilities reported 333 Critical Incidents—a moderate increase from the 291 reported in FY 16. CSH reported the greatest number of incidents (66), followed by ESH (50). Although these are two of DBHDS's largest State Hospitals, CSH and ESH have historically reported a relatively *low* number of incidents. ESH, despite having the largest census of any facility in the dataset (an average of 300 for FY 17) only reported 29 incidents in FY 16. Both facilities have been heavily affected by new legislation requiring that individuals in jails be transferred to State Hospitals for Restoration within 10 days of receipt of a court order. FY 17 CIR data supports staffs' assertions that the populations of CSH and ESH have become far more acute and prone to self-injury and peer assault, as evidenced by the fact that they reported the highest numbers of self-injurious behavior (SIB) (CSH reported 24 and ESH reported 17) *and* alleged peer-assault (CSH reported 13 and ESH reported 8).

CCCA, NVMHI and SVMHI reported the fewest incidents (15, 17, and 19, respectively). While NVMHI and SVMHI are historically low reporters—they reported 18 and 10 incidents respectively in FY 16—CCCA's number of CIRs have dropped significantly. In FY 16, they reported 32 incidents, compared to 15 in FY 17. CCCA's population is small and, historically, highly self-injurious, which has led to disproportionate rates of reporting—particularly SIB—in the past. It is unclear whether CCCA's reduction in CIRs is due to improved health and safety, the discharge of certain acute individuals, or a lack of reliable reporting. Given dLCV advocates' communication with CCCA and direct knowledge of incidents that were not reported, it would appear that the number of incidents reported by CCCA in FY 17 does not reflect the number of serious injuries that occurred. CCCA also submitted the greatest number of seriously delinquent reports, with 5 of their 15 total reports being reported more than a month after incident discovery.

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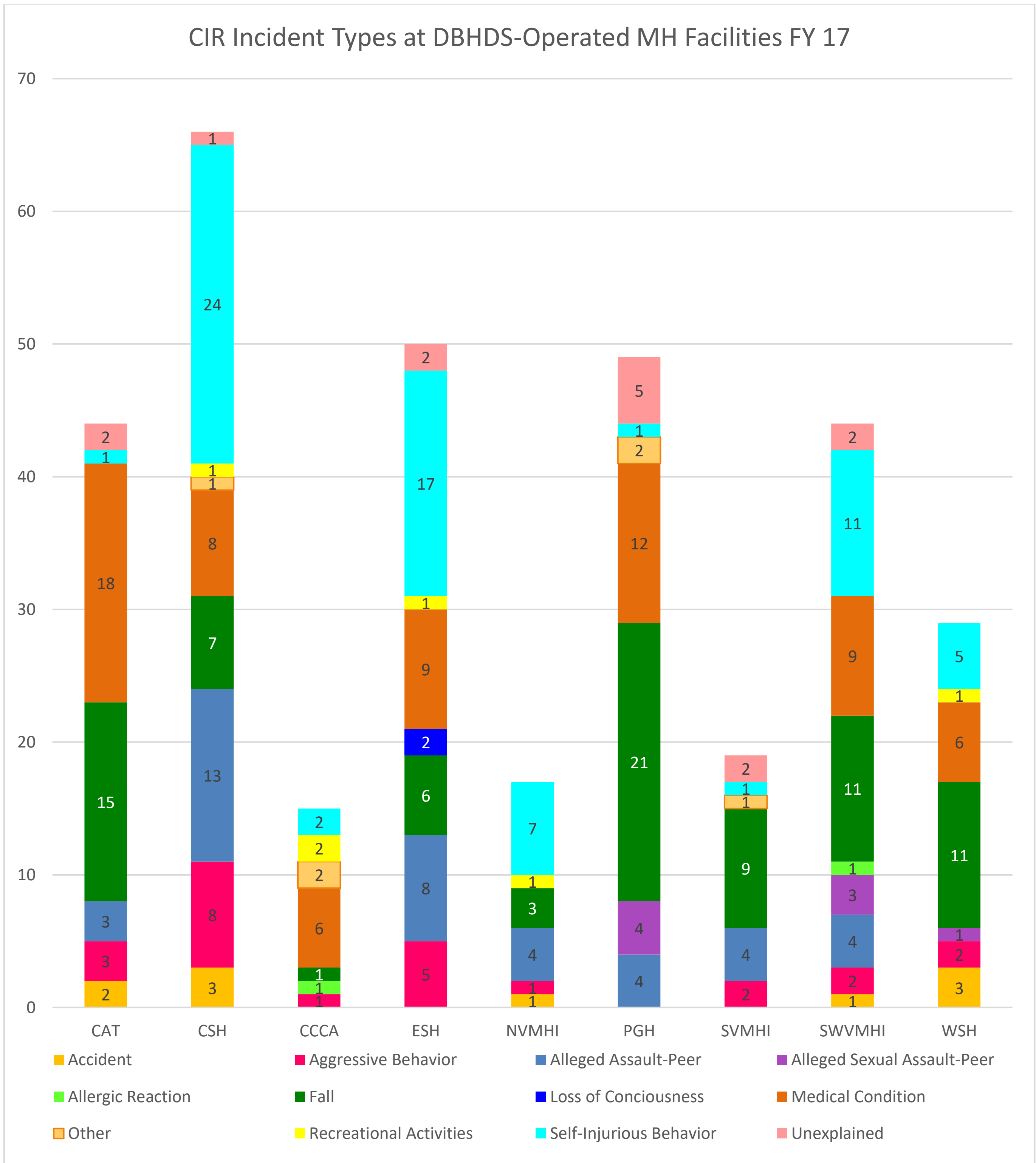
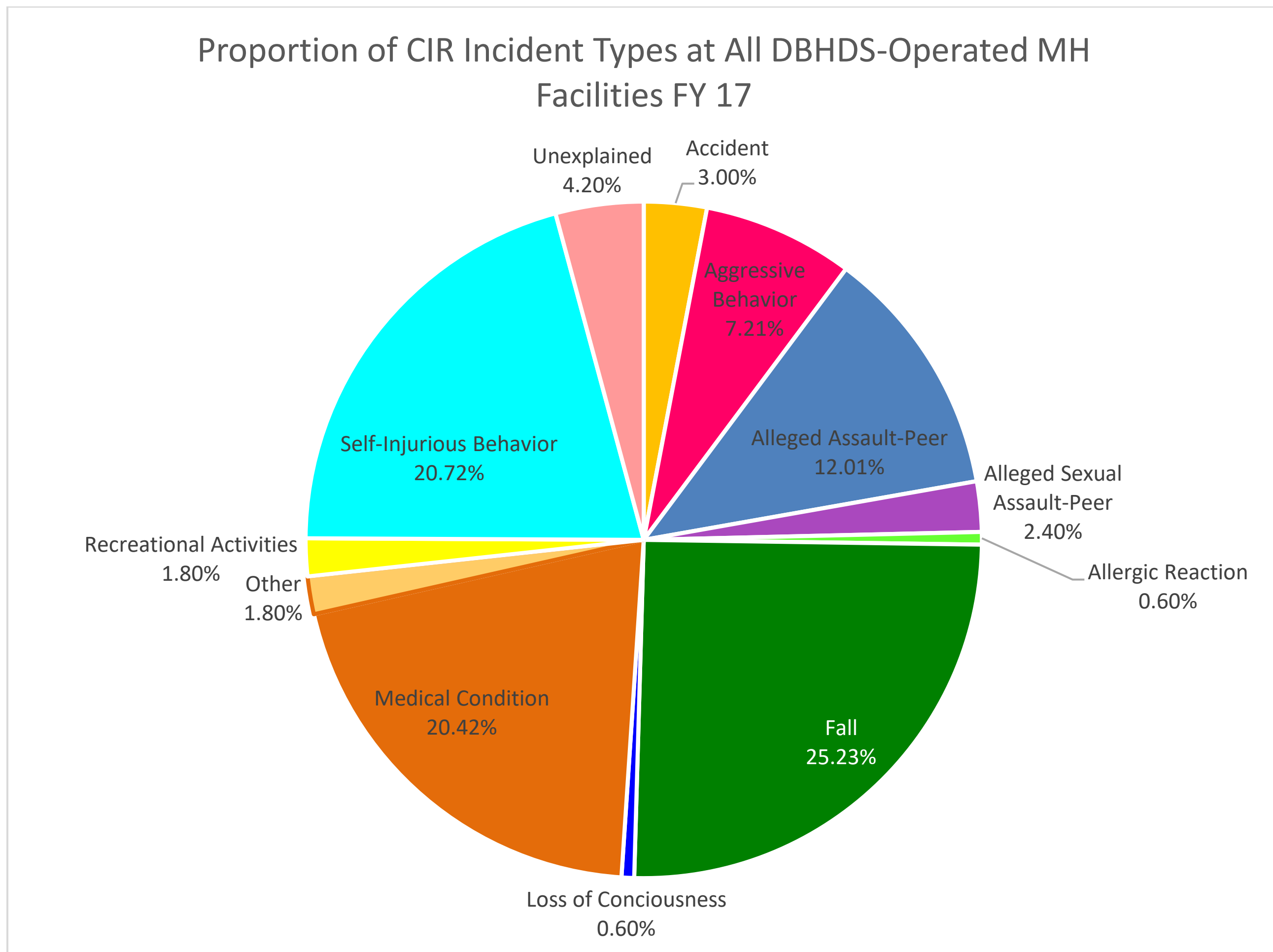
Incident Categories



In previous years, falls and SIB made up the vast majority of MH CIRs. Falls and SIB are still the most common incident categories, but both made up smaller proportions of injuries than they did in FY 16 (falls decreased from 28.18% to 25.23%, and SIB decreased from 24.74% to 20.72%). Meanwhile, the proportion of injuries

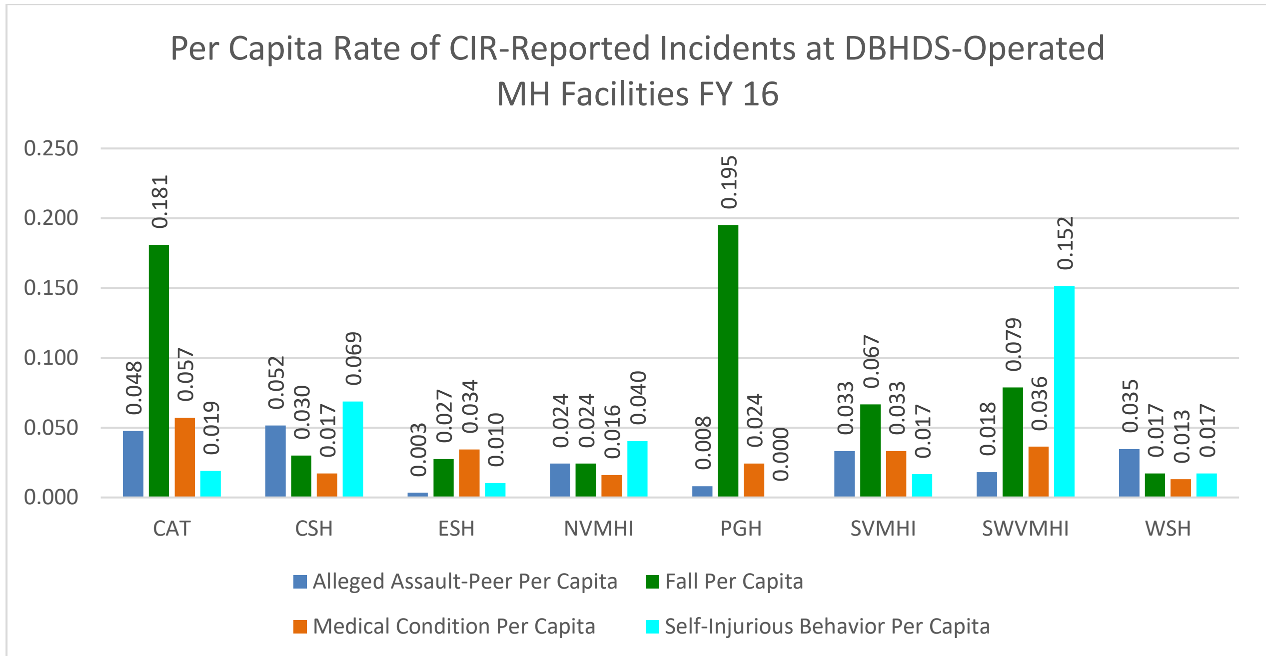
resulting from medical conditions increased considerably, from 13.06% in FY 16 to 20.42% in FY 17. This increase is likely due, in part, to a rise in falls attributed to seizures, which dLCV classifies internally as an injury resulting from a medical condition.

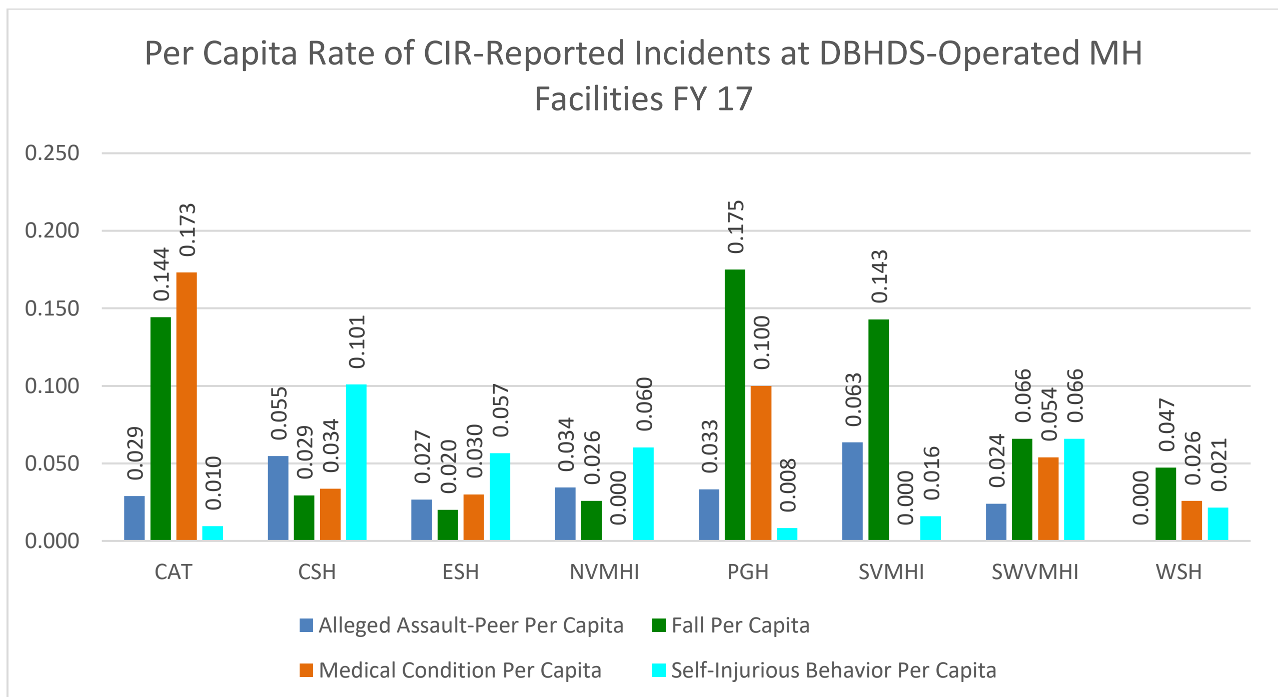


We compared the 4 most prevalent incident types—peer assaults, falls, medical conditions, and SIB—across the facilities with the context of population. Below are the *per capita* statistics for FY 16 and FY 17. Due to CCCA's uniquely small population and high bed turnover, including them in the *per capita* analysis can lead to misinterpretation of the data. While the rate of CCCA incidents is correct within the context of dLCV's analysis, it is not a comparable statistic and has been excluded from our per capita analysis of incidents. The rate of incidents secondary to Medical Conditions increased notably during FY 17, particularly at CAT and PGH; the rate at CAT increased from 0.057 *per capita*, or about 6%[1] to 0.173 *per capita*, or about 17%, and increased from 0.024 *per capita*, or about 2% to 0.1 *per capita*, or about 10% at PGH. The rate of SIB decreased substantially at SWVMHI (from 0.152 *per capita*, or about 15% to 0.066 *per capita*, or about 7%), but increased at most other facilities. At SVMHI the rate of falls spiked during FY 17 from 0.067 *per capita*, or about 7% to 0.143 *per capita*,

[1] Percentages expressed in *per capita* comparisons refer to the proportion of the facility's average census that might experience a particular type of incident or injury. The percentage does not take into account bed turnover or multiple incidents of the same type attributed to one person.

or about 14%. This rate of falls is more consistent with PGH and CAT, which house geriatric residents who are prone to falls, than it is with other, non-geriatric hospitals.





Injury Types

Most of the injuries reported by MH facilities in FY 17 were lacerations or skin tears (101 total, or 30.33%), followed by fractures (68 total, or 20.42%) and deaths (57 total, or 17.12%). Overall, the proportion of primary injuries reported in FY 17 was very similar that from FY 16.

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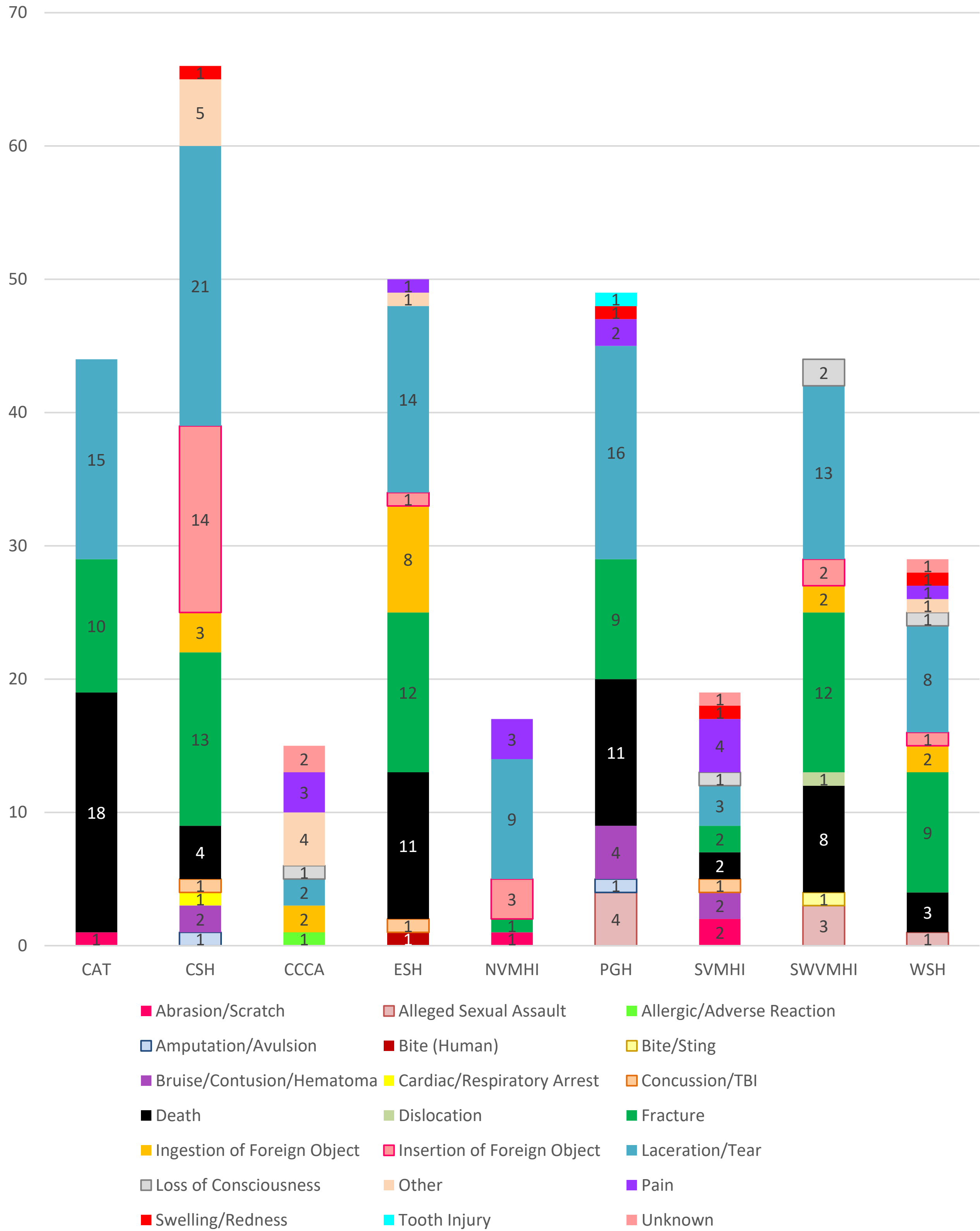
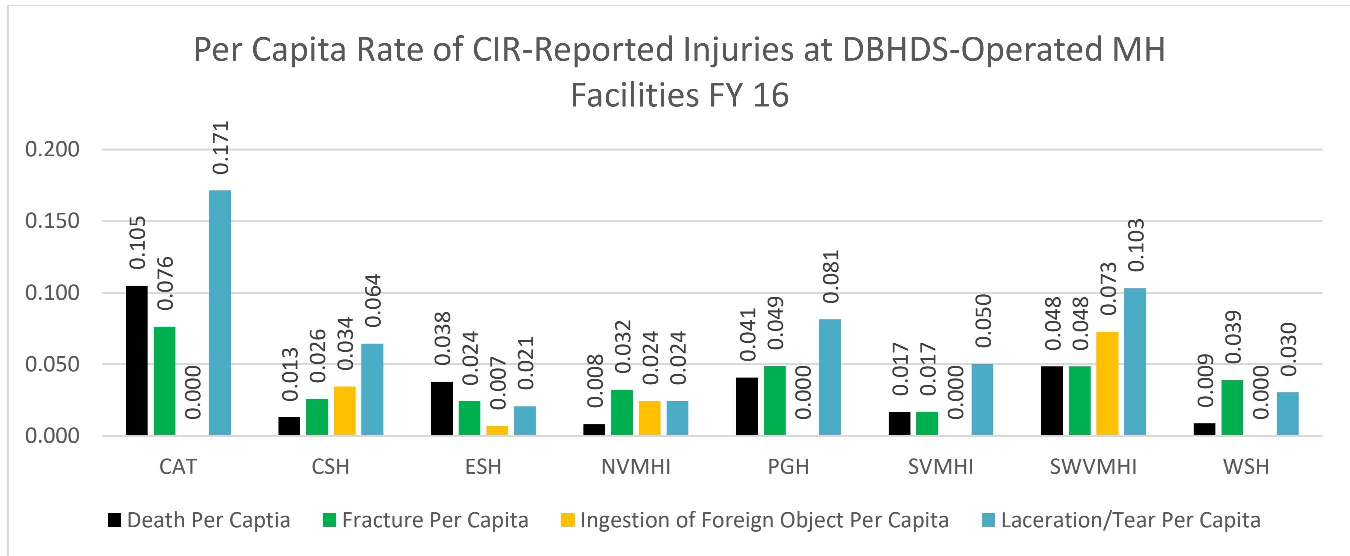
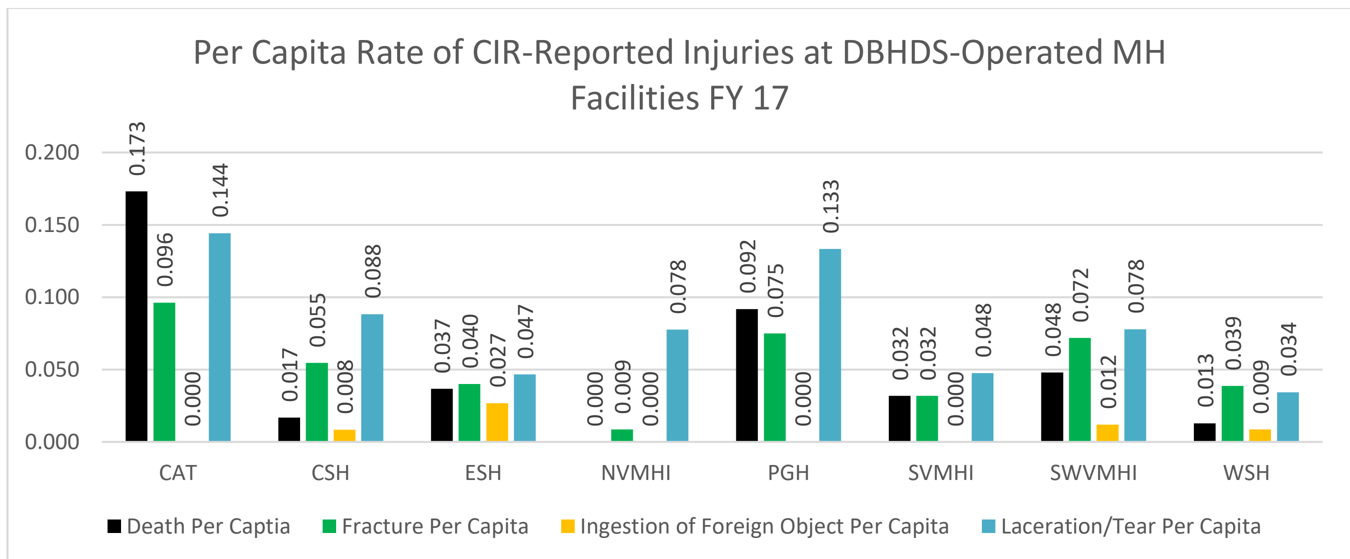

CIR Primary Injury Types at DBHDS-Operated MH Facilities FY 17
70
60
50
40
30
20
10
0
CAT
CSH
CCCA
ESH
NVMHI
PGH
SVMHI
SWVMHI
WSH
Abrasion/Scratch
Alleged Sexual Assault
Allergic/Adverse Reaction
Amputation/Avulsion
Bite (Human)
Bite/Sting
Bruise/Contusion/Hematoma
Cardiac/Respiratory Arrest
Concussion/TBI
Death
Dislocation
Fracture
Ingestion of Foreign Object
Insertion of Foreign Object
Laceration/Tear
Loss of Consciousness
Other
Pain
Swelling/Redness
Tooth Injury
Unknown

For the reasons stated previously, we have not included CCCA in our *per capita* analysis of injuries. The rate of fractures remained static or increased at all MH facilities in FY 17. The rate of foreign object ingestions, on the other hand, decreased at most facilities, but increased slightly at ESH and WSH. The rate of deaths increased substantially at CAT (from .105 *per capita* or about 10%, to .173 *per capita* or about 17%) and PGH (from .041 per *capita* or about 4%, to .092 *per capita* or about 9%). This high rate of deaths is due, at least in part, to the large proportion of geriatric residents at both CAT and PGH. That said, in FY 17, CAT reported more deaths than any other injury type, which has not been the case in previous years.

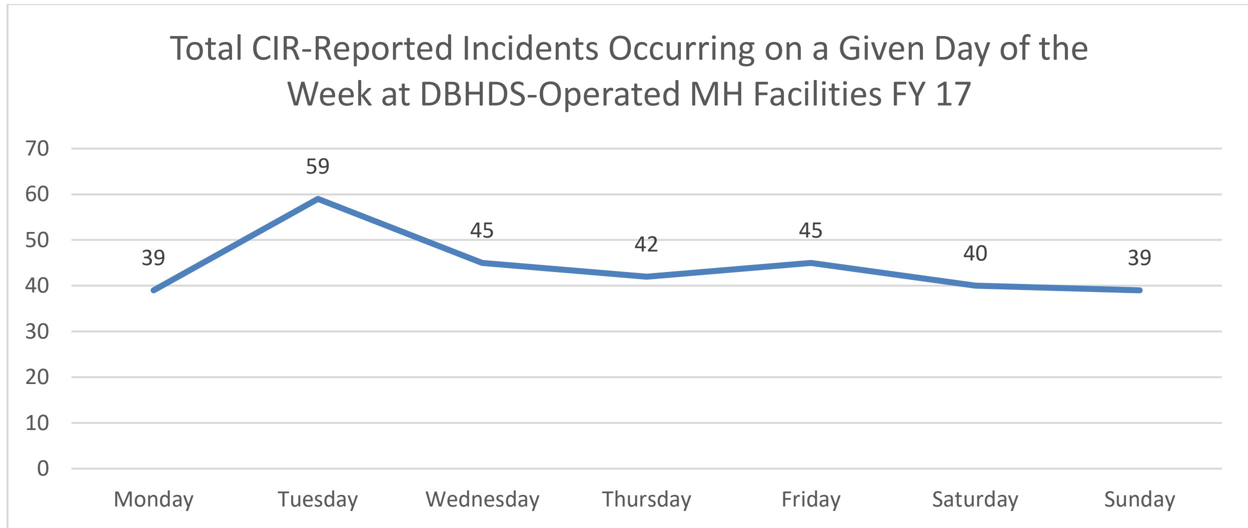




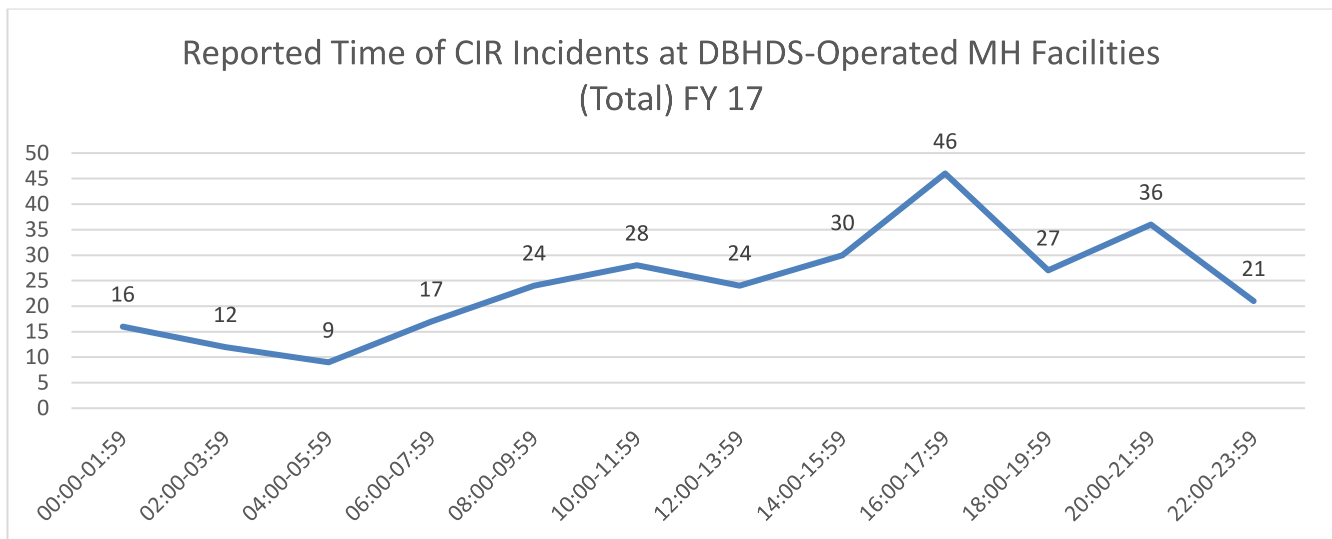
TIMING OF INCIDENTS

Facilities reported a noticeable "bump" in incidents occurring on Tuesdays (59 total incidents). This increase is not due to one facility's disproportionate reporting, and is echoed in half of the facilities' individual data (CAT,

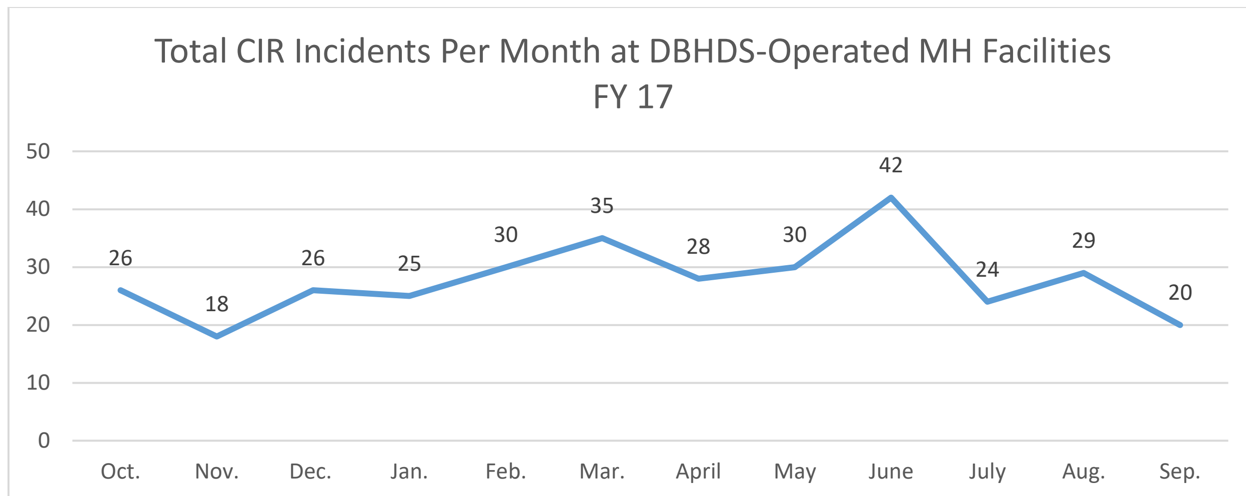
CSH, ESH, and PGH). It is unclear why a higher concentration of events occurred during Tuesdays in FY 17, but advocates will use this information to guide monitoring in FY18.



In FY 17, DBHDS-operated MH facilities reported a number of incidents occurring between 4-5:59pm that was much higher than in previous fiscal years. The data is not necessarily representative of true trends, however, because several facilities were unable to attribute a time to a large number of their incidents. Still, advocates will try to determine whether factors like staffing contributed to this “spike.”



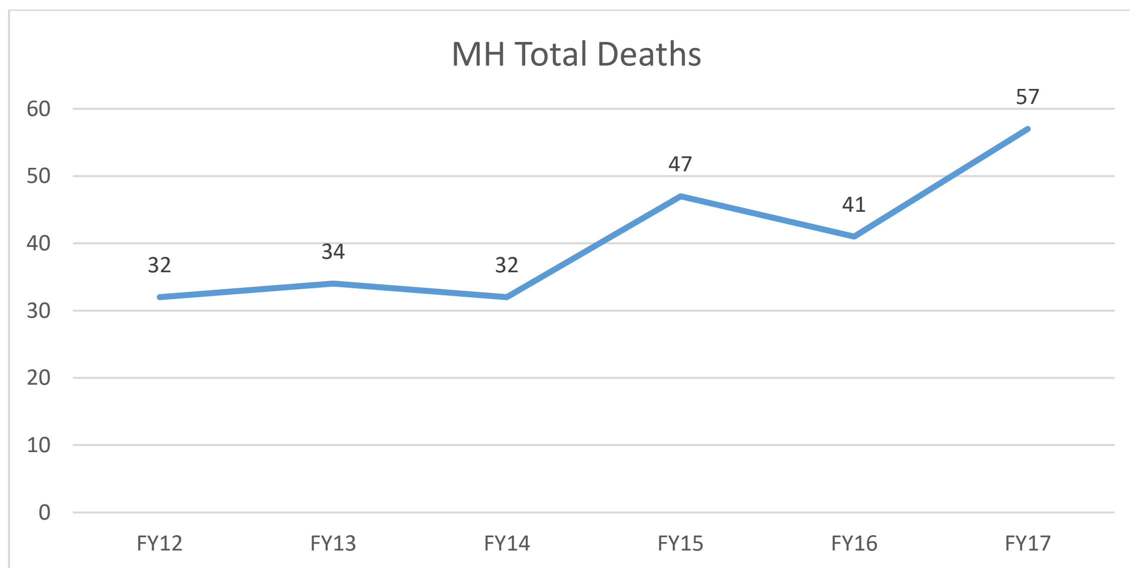
FY 17 CIR reporting at MH facilities peaked in June (42), with the fewest reports coming in November (18). Monthly reporting during FY 17 was far less consistent than in FY 16 (high of 36, low of 20).

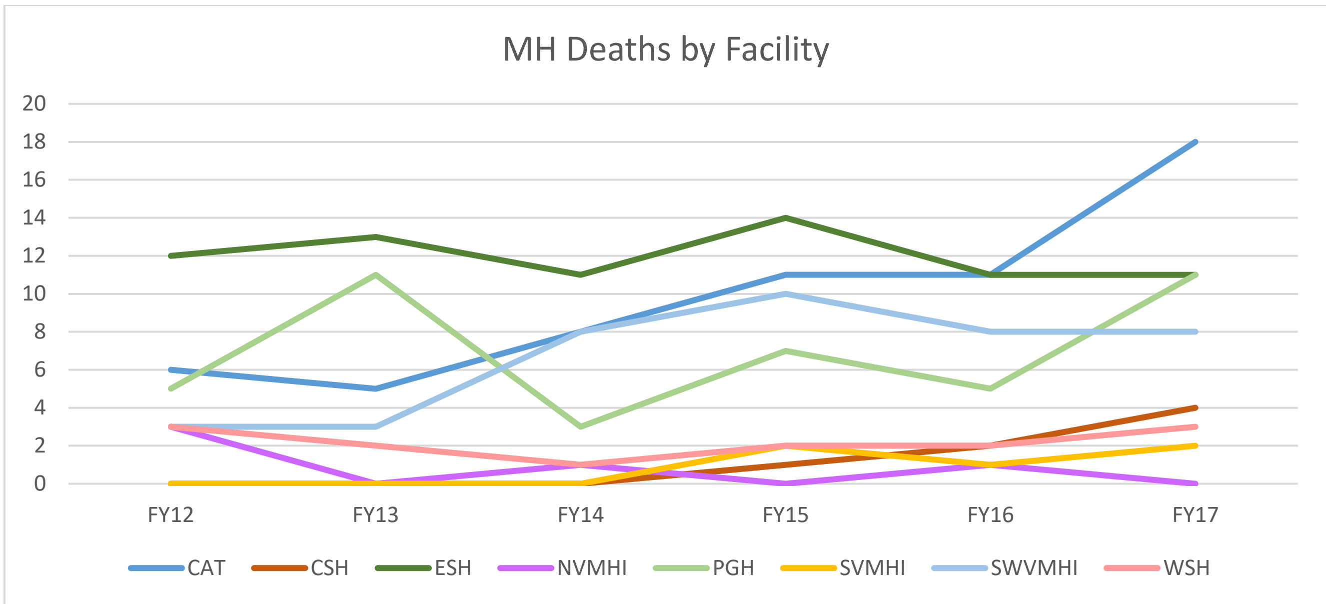


Deaths at MH Facilities

Total Deaths

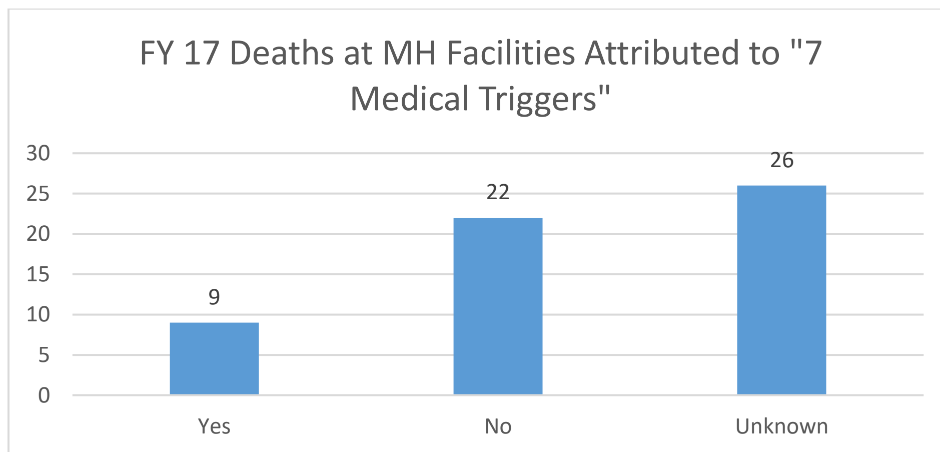
The number of deaths reported by DBHDS-operated MH facilities increased dramatically from 41 in FY 16 to 57 in FY 17. Overall, FY 17 was the "deadliest" year at MH facilities since at least FY12. All MH facilities (except NVMHI, which reported no deaths) reported the same number or more incidents, compared to FY 16.





THE "7 MEDICAL TRIGGERS"

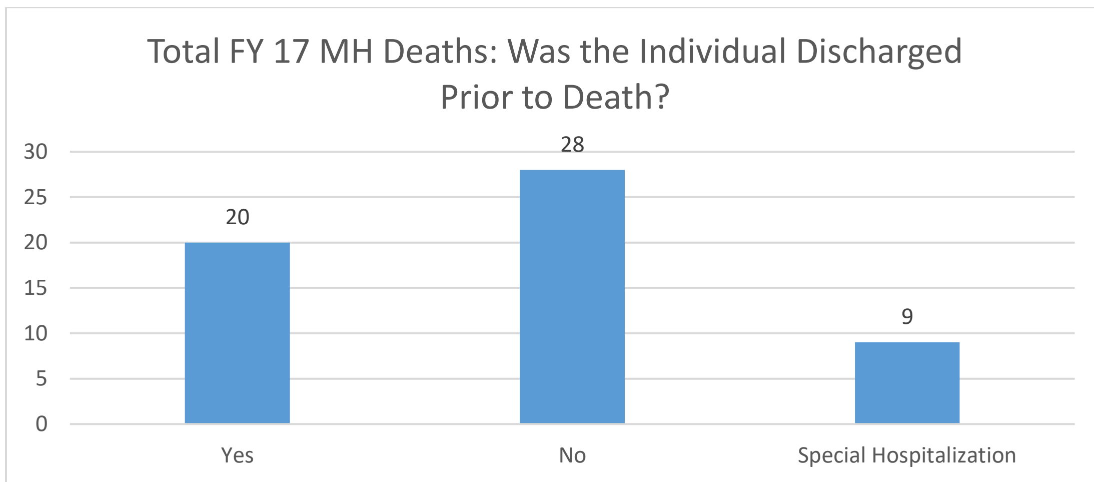
Incidents preceding death at DBHDS-operated facilities have historically been (and remain) primarily "Medical Condition;" Medical Conditions made up 51 of the 57 deaths (89.5%) reported by MH facilities in FY 17. While the number of unexplained incidents resulting in death dropped from 8 to 2 between FY 16 and FY 17, facilities generally did not provide details on the deaths attributed to Medical Conditions or "Loss of Consciousness" (2 incidents in FY 17), in spite of the statutory requirement to provide all known details in the 15 day report. As a result, we could not determine whether or not 26 FY 17 deaths (45.6%) involved the "7 Medical Triggers[2]."

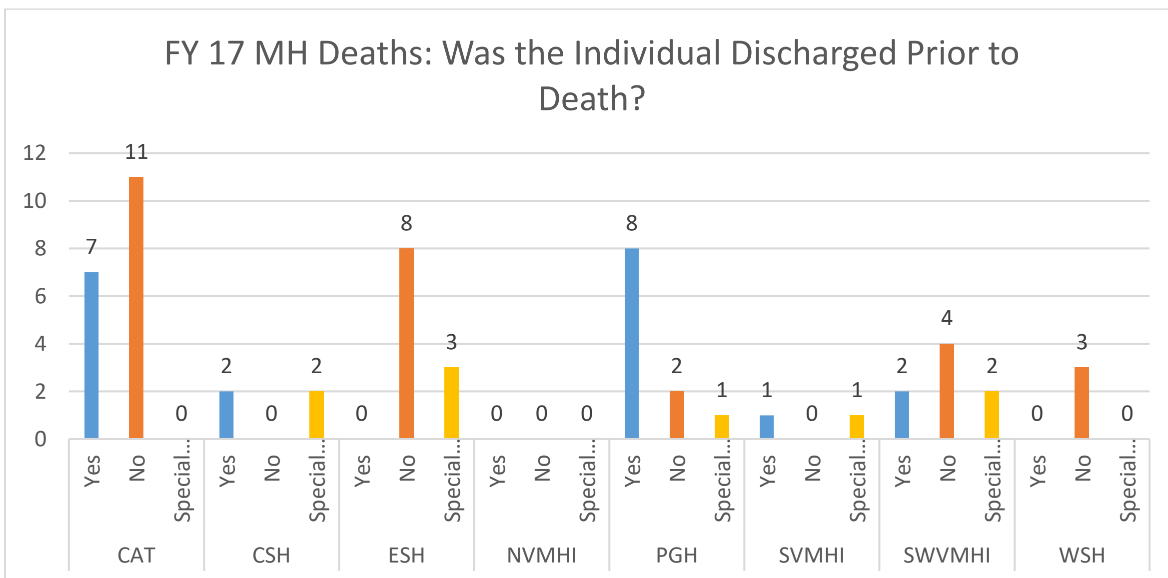


[2] As defined by CVTC's Community Provider Training: Aspiration/Aspiration Pneumonia, Bowel Obstruction/Constipation, Decubitus Ulcers, Dehydration, Seizures, Sepsis, and Urinary Tract Infections

DISCHARGE PRIOR TO DEATH

In reviewing CIRs, we noted a number of individuals who were discharged or placed on "special hospitalization" prior to their deaths[3]. The data revealed some disturbing patterns. For example, at PGH, 8 of 11 deaths (72.7%) occurred shortly after the individual was discharged to another setting. CSH and SVMHI both reported that no individuals died *at* their facilities—any deaths occurred either after discharge or while the individual was on Special Hospitalization at a medical facility. As a geriatric facility, PGH discharged many of its residents to Nursing Homes or hospice providers in anticipation of their decline or death. By contrast, CSH and SVMHI do not house geriatric residents and reported a low number of deaths (4 and 2, respectively). While some of the CSH and SVMHI deaths were due to medical conditions, few of the deaths were expected.

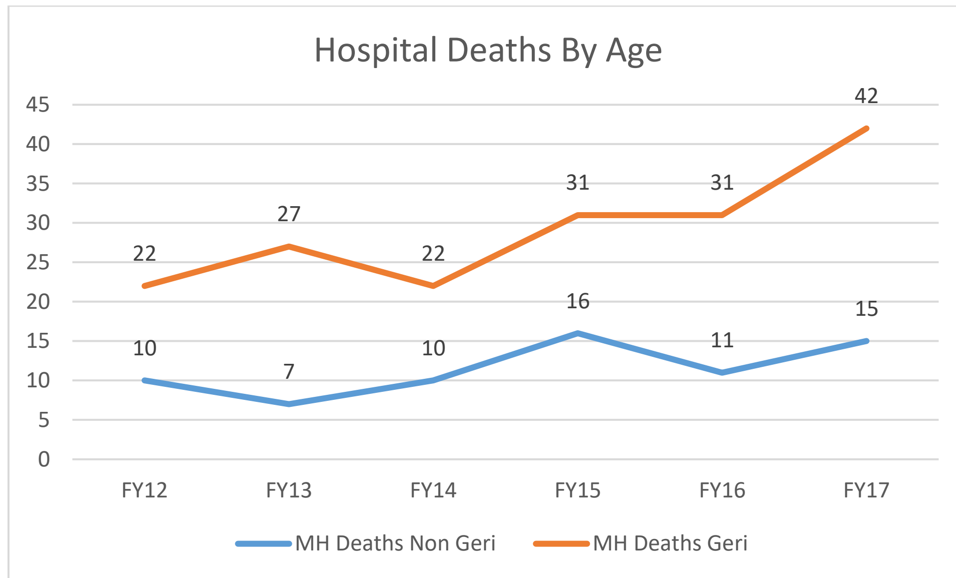




[3] Facilities are required to submit CIRs for any death that occurred at their facility, or within 21 days of an individual's discharge, per DI 401.

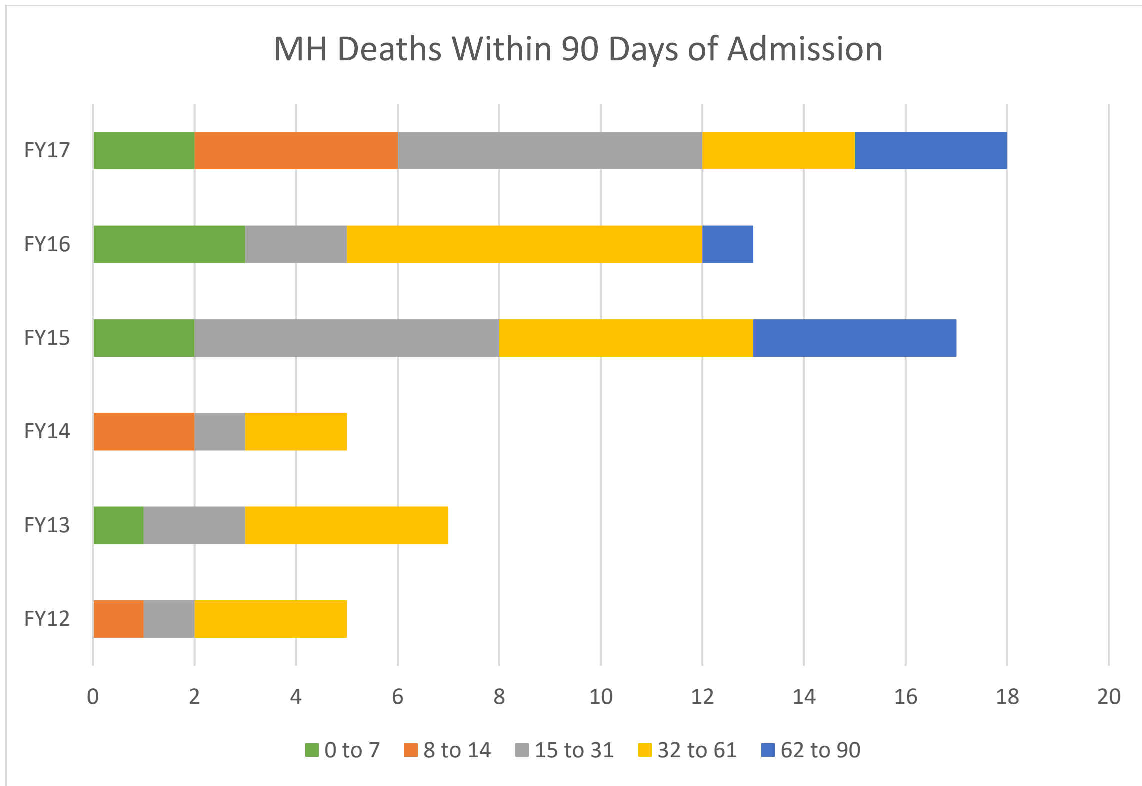
DEATHS BY AGE

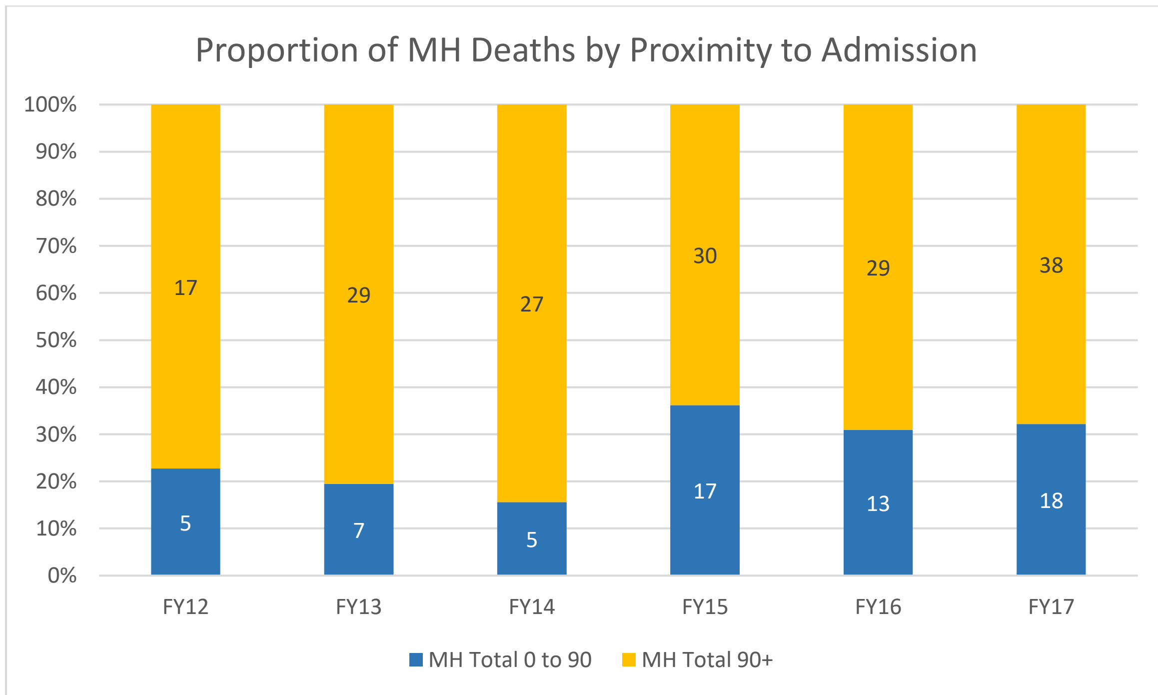
As expected, geriatric deaths at MH facilities have considerably outnumbered non-geriatric deaths since our record-keeping began. In FY 17, the gap between geriatric (42) and non-geriatric (51) deaths widened.



PROXIMITY TO ADMISSION

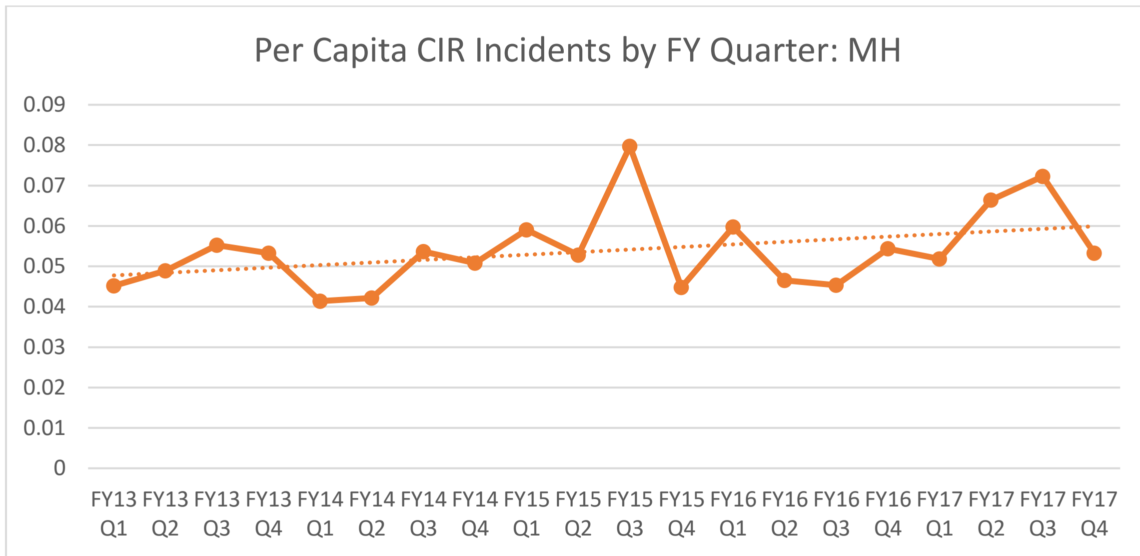
A number of facility directors expressed concern with the number of "inappropriate medical admissions" that they have received since revisions to Virginia Code § 37.2-809 went into effect in 2014, which designated the DBHDS hospitals as "facilities of last resort." We reviewed the number of deaths occurring within given time intervals after admission. The number of deaths occurring within 90 days of admission has increased substantially since 2014 and reached an all-time high in FY 17. The *proportion* of MH deaths occurring within 90 days of admission has also increased since 2014. Before the 2014 Legislation was in effect, deaths did not exceed 22.7% (in FY12), and reached their lowest point in FY14 (15.6%). From FY15 through FY 17, the proportion of deaths occurring within 90 days did not dip below 30%, reaching 36.2% in FY15, 31% in FY 16, and 32.1% in FY 17.


MH Deaths Within 90 Days of Admission
FY17
FY16
FY15
FY14
FY13
FY12
0
2
4
6
8
10
12
14
16
18
20
0 to 7
8 to 14
15 to 31
32 to 61
62 to 90

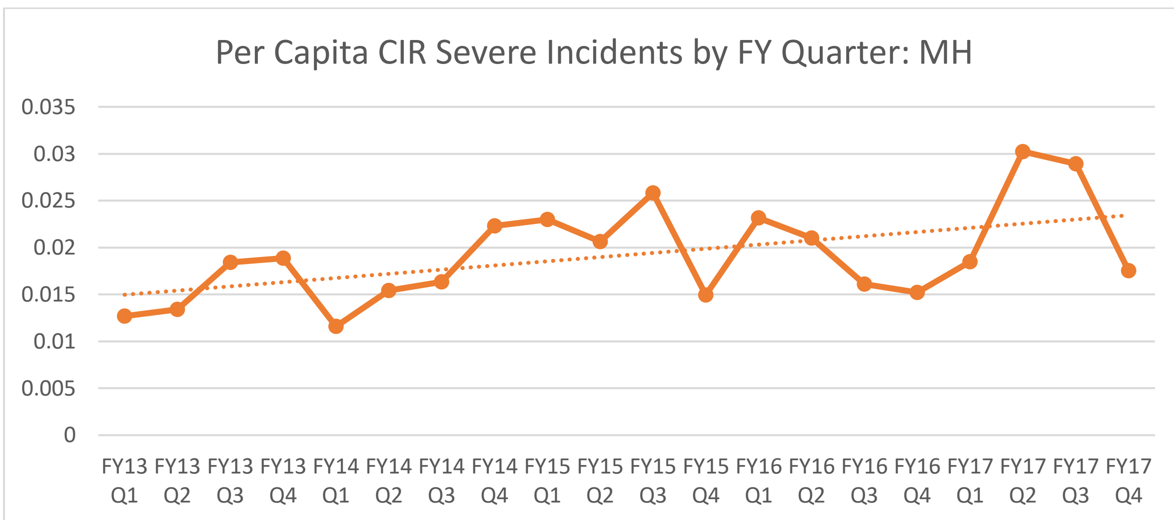

Proportion of MH Deaths by Proximity to Admission
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
17
29
27
30
29
38
5
7
5
17
13
18
FY12
FY13
FY14
FY15
FY16
FY17
MH Total 0 to 90
MH Total 90+

CONSISTENCY OF REPORTING

Based on observations during monitoring and information gathered from sources, dLCV is concerned that DBHDS facilities may be underreporting critical incidents. We examined the number of reported incidents per quarter for the last 5 fiscal years. To account for fluctuations in census, we divided the number of incidents by the average census for each quarter, resulting in a *per capita* analysis of reporting. During FY 17 the per capita rate of CIR reporting across MH Facilities was highly variable. During the 2nd and 3rd Quarters, reporting increased, before dropping in the 4th Quarter. Despite this variability, the rate of MH CIR reporting does appear to have increased slightly over the last five years, based on trendline analysis (see below).



dLCV narrowed the scope of this analysis and prepared data on quarterly *per capita* reporting of Fractures, Loss of Consciousness and Death—three injury types that must be treated by a physician or are explicitly required to be reported by DI 401. Over the last 5 years, these “must-report” incidents (or “Severe Incidents”) show a moderate increase over time, driven mainly by high levels of reporting the 2nd and 3rd quarters of FY 17.



Despite this apparent increase in reporting, dLCV is aware of qualifying incidents at multiple state hospitals that have not been reported through the CIRs. We learned of the unreported incidents through our monitoring activities and from sources and are confident that there are many incidents occurring at State Hospitals of which dLCV does not have direct knowledge. As facilities that serve thousands of psychiatrically acute (and often geriatric) patients each year, it seems unlikely that some facilities would go for months without reporting any serious injuries.

It appears, based on our monitoring, that some of the disparities in reporting have to do with inconsistent interpretations of Virginia State Code and Departmental Instruction 401. Section 37.2-709.1 of Virginia State Code details reporting requirements for DBHDS facilities and defines a “critical incident” as “serious bodily injury or loss of consciousness requiring medical treatment.” DI 401 puts further constraints on CIR reporting that do not appear in State Code. Specifically, DI 401 states that facility Risk Managers only need to report incidents to “VOPA” (dLCV) if they have a “clinical outcome severity levels 03 through 06,” meaning that the incident involved a death, or was an “injury requiring medical treatment beyond first aid […] by a physician or physician extender […]” (generally a Physician’s Assistant, nurse practitioner, or doctor). dLCV is well aware that certain facilities routinely render a lower level of treatment than others due to lack of resources. Under DI 401, this lack of resources makes the incidents essentially not reportable, in apparent violation of state law. The constraints imposed by DI 401 are inconsistent with State Code and impair dLCV’s ability to consistently monitor DBHDS facilities and seek systemic improvements.

CONCLUSION

The disAbility Law Center of Virginia welcomes any opportunity to discuss these findings with the Department of Behavioral Health and Developmental Services. In particular, we invite the Department to discuss with us ways in which the timeliness, consistency and accuracy of reporting can be improved, as well as discussing possible solutions to the systemic challenges faced by state mental health facilities as a result of recent legislative changes.