Report on Critical Incidents in Virginia's State Operated Mental Health Facilities October 1, 2017 - September 30, 2018

Prepared by
The disAbility Law Center of Virginia
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INTRODUCTION

The disAbility Law Center of Virginia (dLCV) 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 (DBHDS) must report to dLCV 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 treatment.

During federal fiscal year 2018 (FY 18), dLCV received a total of 318 Critical Incident Reports from mental health facilities operated by the Department.

EXECUTIVE SUMMARY

In 2018, following review of FY 17 data, dLCV contacted DBHDS about concerns arising from the Critical Incident Reports. We noted an increase in deaths at DBHDS-Operated mental health facilities and a corresponding increase in deaths occurring soon after admission. There appeared to be a correlation between the bed of last resort legislation and the admission of individuals with higher healthcare (as opposed to strictly mental health care) needs.

In FY18, deaths and the numbers of deaths within three months of admission continue to be major concerns. The number of deaths reported by DBHDS-operated mental health facilities increased for the 2nd consecutive year, from 57 in FY 17 to 59 in FY 18. FY 18 unseated the previous year to become the "deadliest" year at mental health facilities since at least FY 12. All adult hospitals reported at least one death during FY 18. Piedmont Geriatric Hospital, Eastern State Hospital, and Catawba Hospital reported the greatest number of deaths (16, 14, and 13, respectively).

DBHDS psychiatric hospitals are not designed to act as primary medical providers nor, generally, as nursing facilities. DBHDS should identify any underlying reasons for the increased deaths of individuals recently admitted – including the inappropriate admissions of individuals who would be more appropriately served in medical hospitals, or an inability to provide healthcare within the DBHDS system. Once reasons are identified, corrective action can commence and, hopefully, we will see a decrease in state hospital mortality.

BACKGROUND

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) generates Critical Incident Reports (CIRs) on occurrences in their institutions resulting in injuries requiring 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 2018 Federal Fiscal Year (FY 18).

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

- Catawba Hospital (CAT)

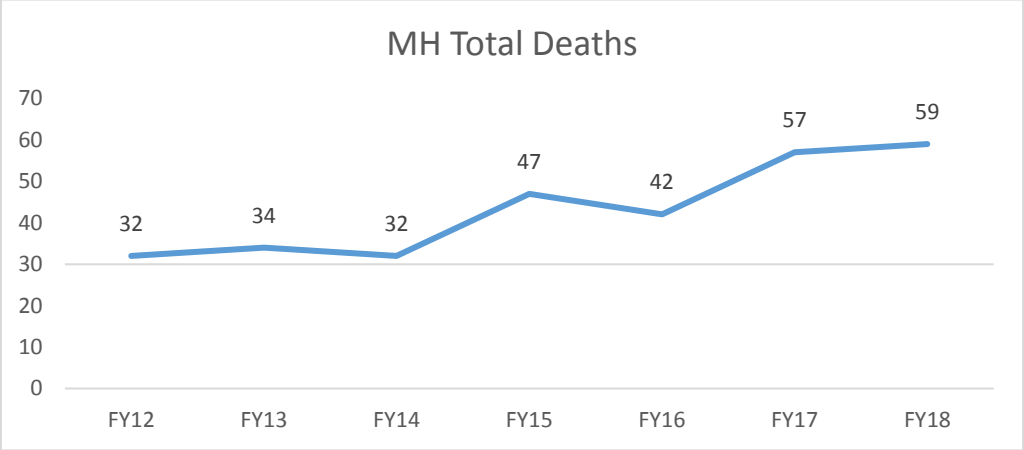
- Central State Hospital (CSH)
- Commonwealth Center for Children and Adolescents (CCCA)
- Eastern State Hospital (ESH)
- Northern Virginia Mental Health Institute (NVMHI)
- Piedmont Geriatric Hospital (PGH)
- Southern Virginia Mental Health Institute (SVMHI)
- Southwestern Virginia Mental Health Institute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

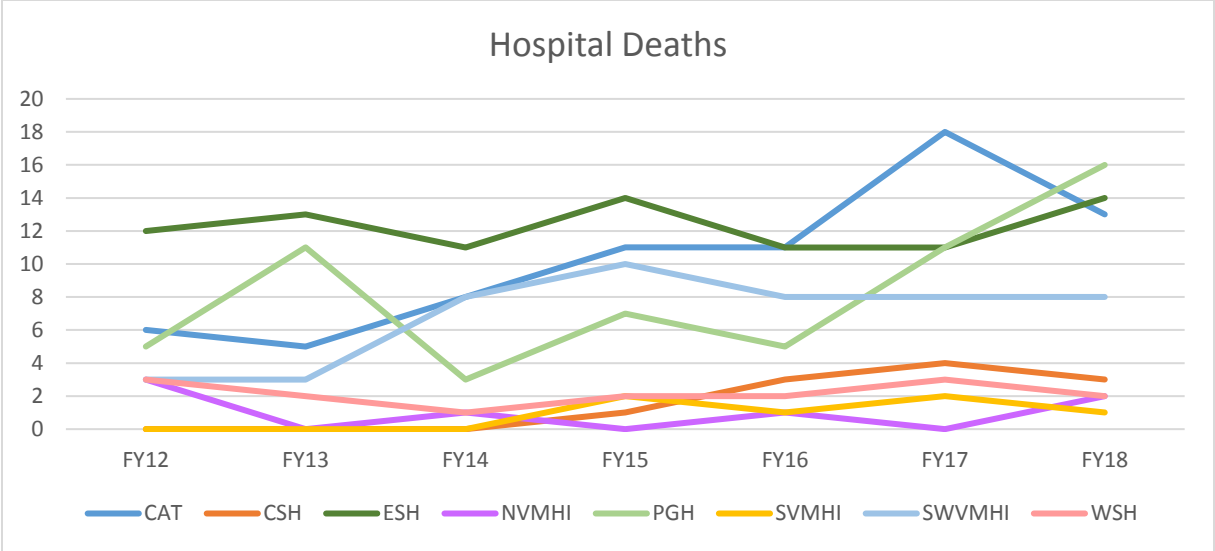
dLCV regularly monitors conditions in state facilities and responds to questions and complaints from residents and their families. dLCV reviews CIRs on a weekly basis and analyzes quantitative data from the reports to identify trends. Qualitative and quantitative data from the reports inform dLCV's work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

DEATHS AT MH FACILITIES

TOTAL DEATHS

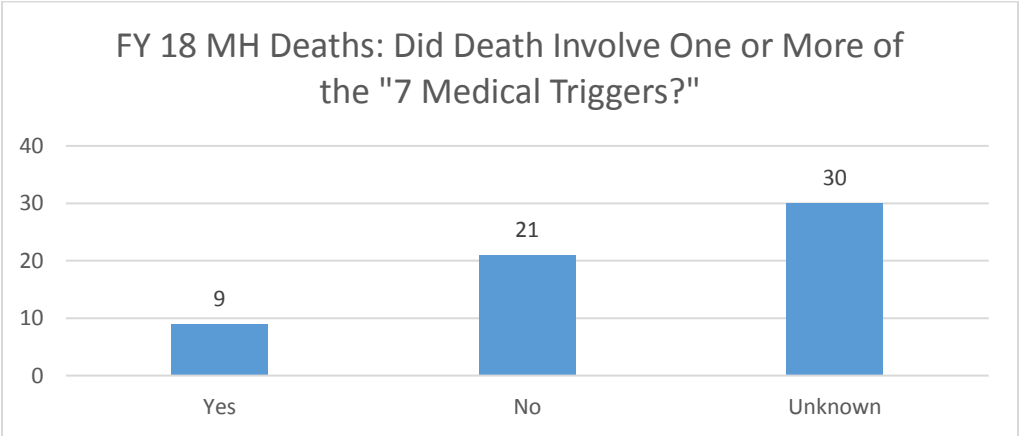
The number of deaths reported by DBHDS-operated MH facilities increased for the 2nd consecutive year, from 57 in FY 17 to 59 in FY 18. While FY 2017 saw the highest number of deaths in mental health facilities in many years, FY 18 is now the "deadliest" year at MH facilities since at least FY 12. All adult MH facilities reported at least one death during FY 18. PGH, ESH and CAT reported the greatest number of deaths (16, 14, and 13, respectively). The steady rate with which PGH deaths in particular have increased over the last 2 years raises significant concerns.





THE "7 MEDICAL TRIGGERS"

Incidents preceding death at DBHDS-operated facilities have historically been primarily "Medical Condition." Medical Conditions were the basis for 49 of the 59 deaths (83%) reported by MH facilities in FY 18. Facilities used the essentially meaningless "Loss of Consciousness" to explain 7 of the deaths (11.8%); this is the most that this category has been used since our recordkeeping began. While the number of unexplained incidents resulting in death dropped to just 1 in FY18, facilities generally did not provide much detail on the deaths, 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 30 of the FY 18 deaths (50.8%) involved the "7 Medical Triggers[1]."

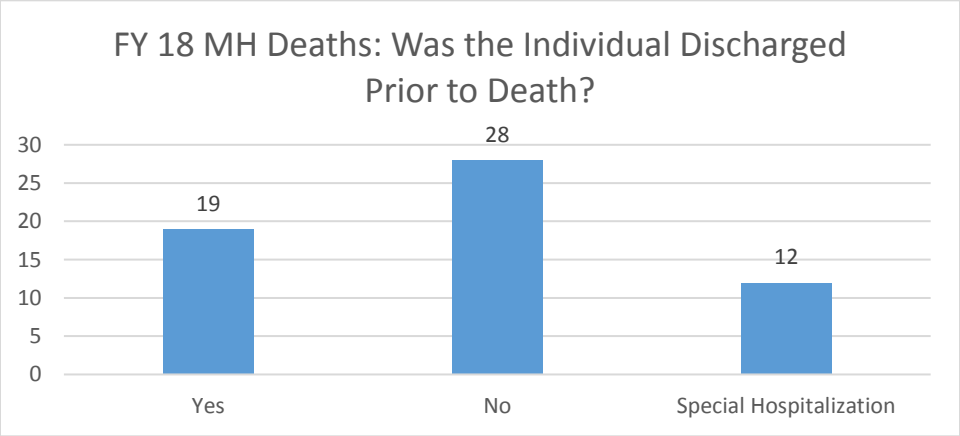


[1] As defined by DBHDS: Aspiration/Aspiration Pneumonia, Bowel Obstruction/Constipation, Decubitus Ulcers, Dehydration, Seizures, Sepsis, and Urinary Tract Infections. (CVTC Community Provider Training)

Discharge Prior to Death[2]

At both PGH and SWVMHI, the majority of reported deaths (62.5% and 50%, respectively) occurred after the decedent had been discharged from the hospital. As a geriatric facility, PGH discharged many of its residents to Nursing Homes or hospice providers in anticipation of their decline or death. We do not question the appropriateness of those discharges, but merely note it. By contrast, facilities like CSH and NVMHI do not house geriatric residents and reported a low number of deaths (3 and 2, respectively). While some of the CSH and NVMHI deaths were due to medical conditions, few of the deaths were expected.

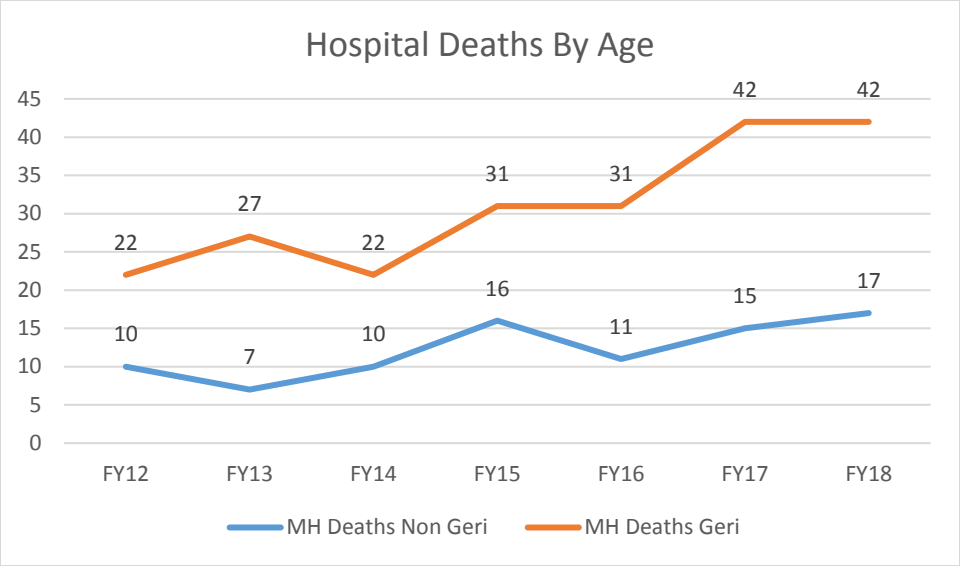
The number of deaths occurring during a special hospitalization increased from 9 to 12 in FY 18.



Deaths by Age

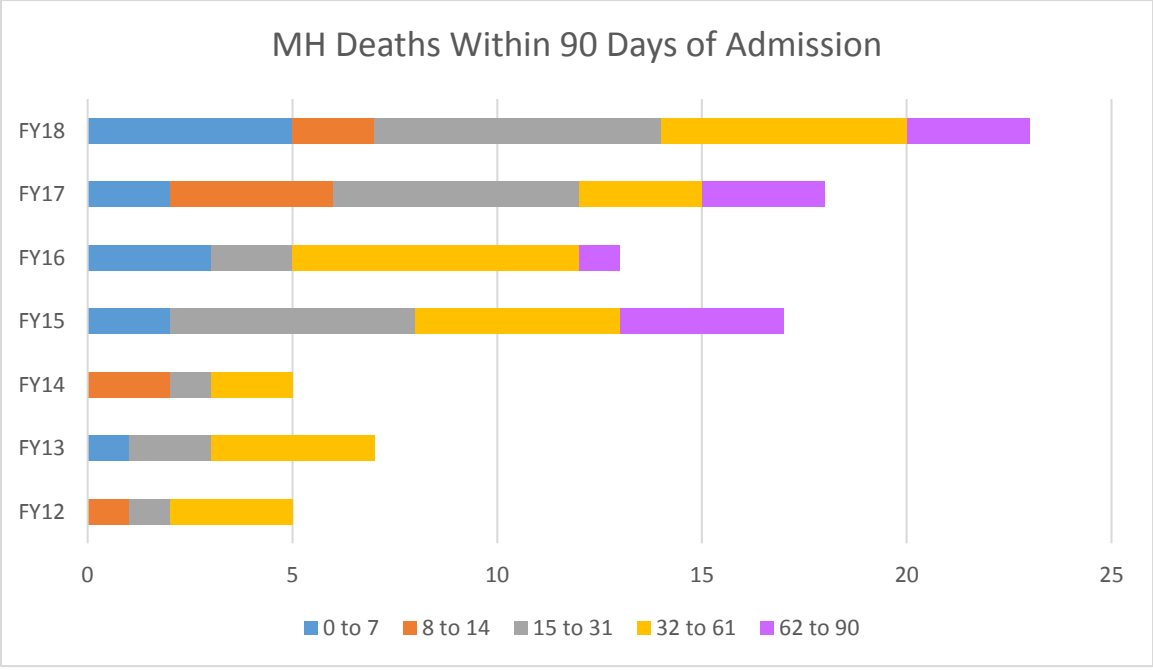
As expected, geriatric deaths at MH facilities have considerably outnumbered non-geriatric deaths since our record-keeping began. In FY 18, the number of non-geriatric deaths increased slightly.

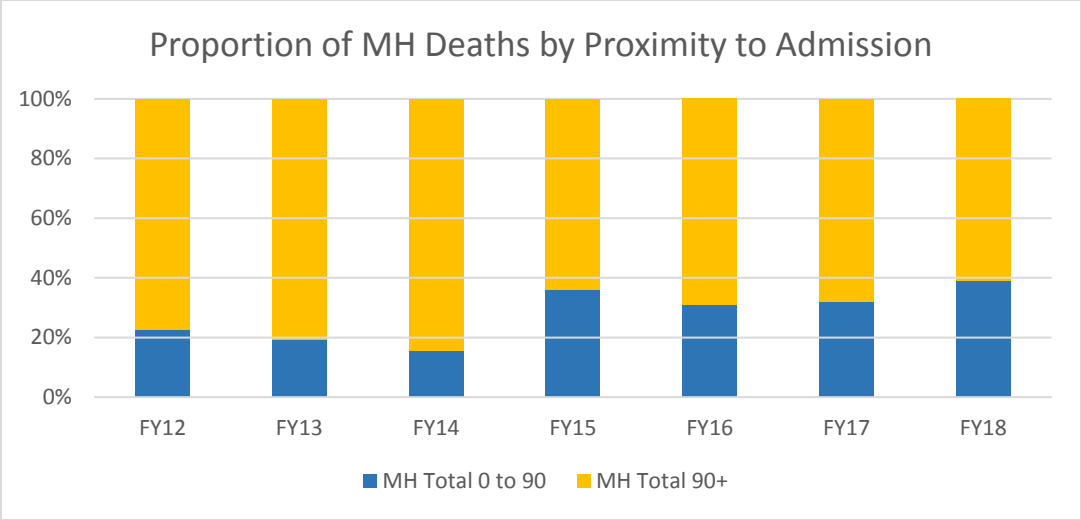
[2] Facilities are required to submit CIRs for any death that occurred at their facility, or within 21 days of an individual's discharge, per DI 401.



Proximity to Admission

For several years, a number of facility directors have 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, designating 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 18. The *proportion* of MH deaths occurring within 90 days of admission has also increased since 2014. Before the 2014 Legislation was in effect, deaths within 90 days of admission did not exceed 22.7% (in FY 12), and reached their lowest point in FY 14 (15.6%). From FY 15 through FY 18, the proportion of deaths occurring within 90 days did not dip below 30%, reaching 36.2% in FY 15, 31% in FY 16, 32.1% in FY 17, and 38.9% in FY 18.





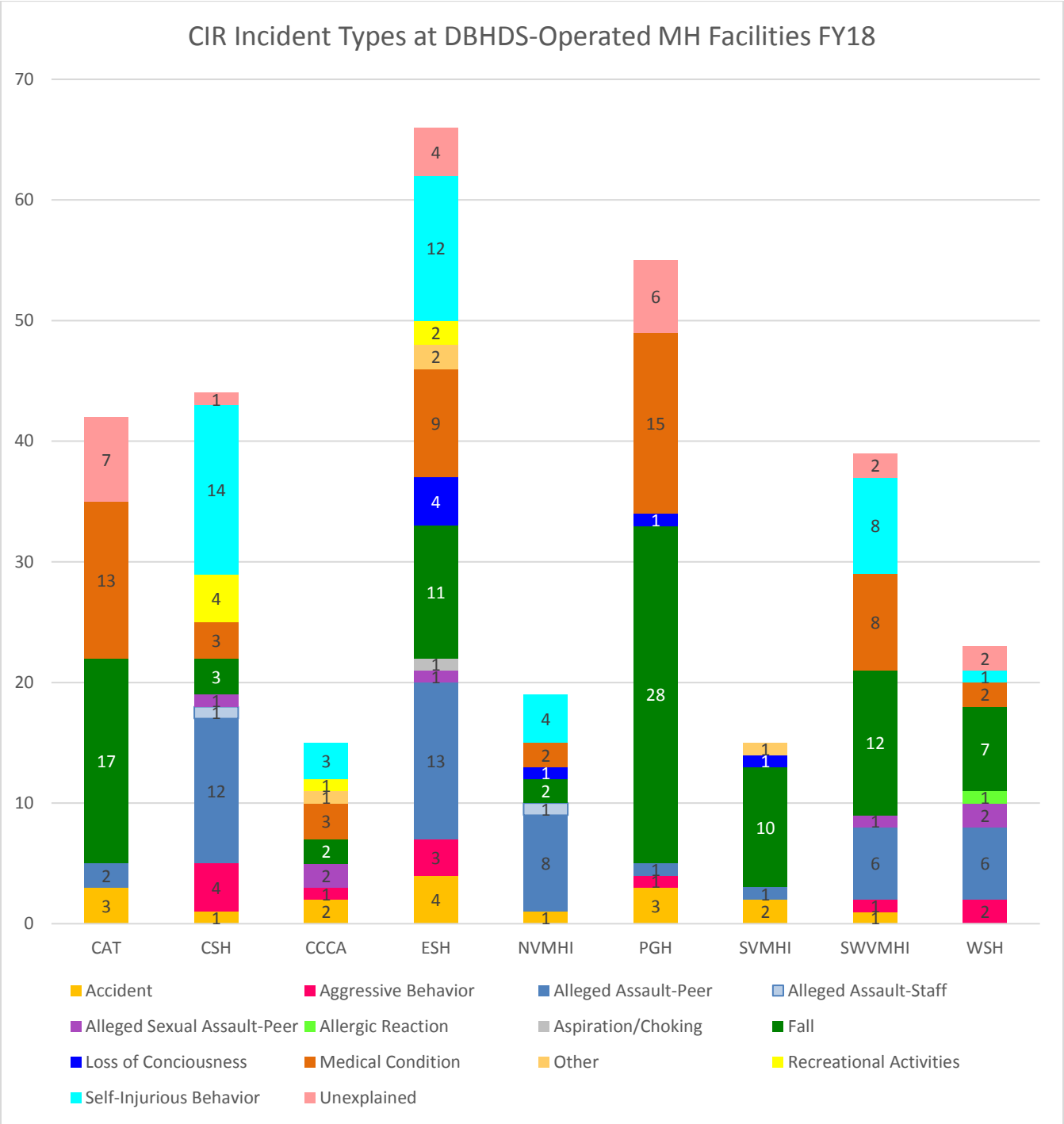
Overall Incident Reporting

dLCV is concerned that specific mental health facilities may be failing to comply fully with reporting requirements, resulting in underreporting. We are addressing issues with specific facilities as we identify the issue. Inconsistent compliance necessarily impacts the reliability of our conclusions below. More importantly, however, inconsistent compliance with reporting requirements may indicate the absence of quality improvement and risk management oversight by DBHDS and by facility management.

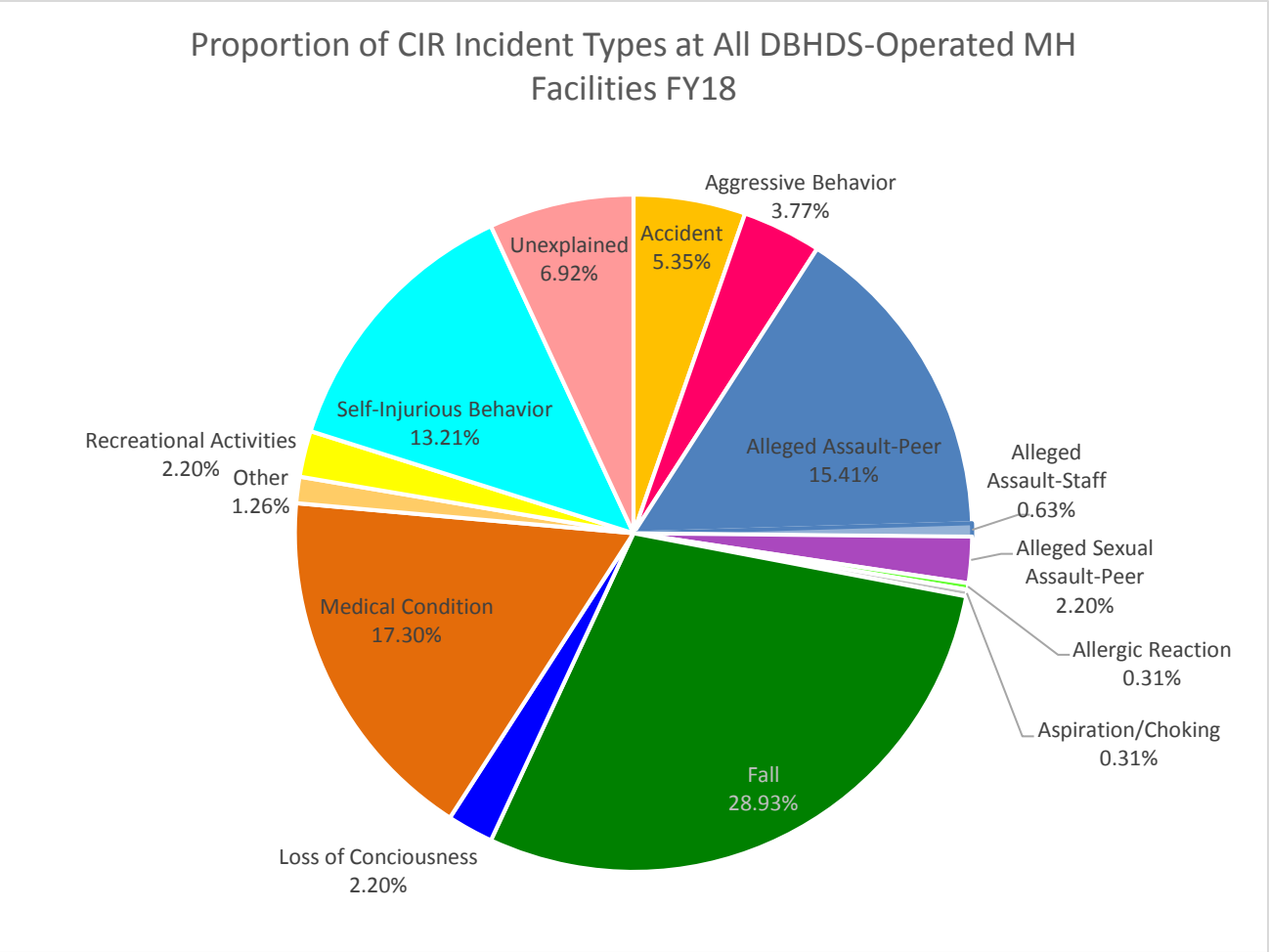
In FY 18, DBHDS-Operated MH facilities reported 318 Critical Incidents—a very slight decrease from the 333 reported in FY 17. ESH reported the greatest number of incidents (66), followed by PGH (55). ESH is the largest DBHDS-Operated MH facility in Virginia, so their status as highest reporter is expected. PGH, however, is a relatively small facility with 123 beds and an entirely geriatric population. One might expect a geriatric MH facility to have a higher rate of certain incidents, such as falls and deaths, compared to facilities serving a younger population; still, it is concerning that PGH residents were subject to a greater number of serious injuries than facilities with substantially more psychiatrically acute admissions.

For comparison, CSH, the second largest hospital, houses Virginia's maximum security forensic unit. CSH was the third-largest CIR reporter, with 44 serious injuries in FY 18—eleven fewer than PGH. FY 18 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 behaviors (SIB) (CSH reported 14 and ESH reported 12). These rates of injury may also be related to the transfer of individuals from jails for restoration of competence. While numbers remain high, the number of SIB incidents at CSH and ESH have decreased substantially in the last year; in FY 17, they reported 24 and 17 incidents of SIB, respectively.

Incident Categories

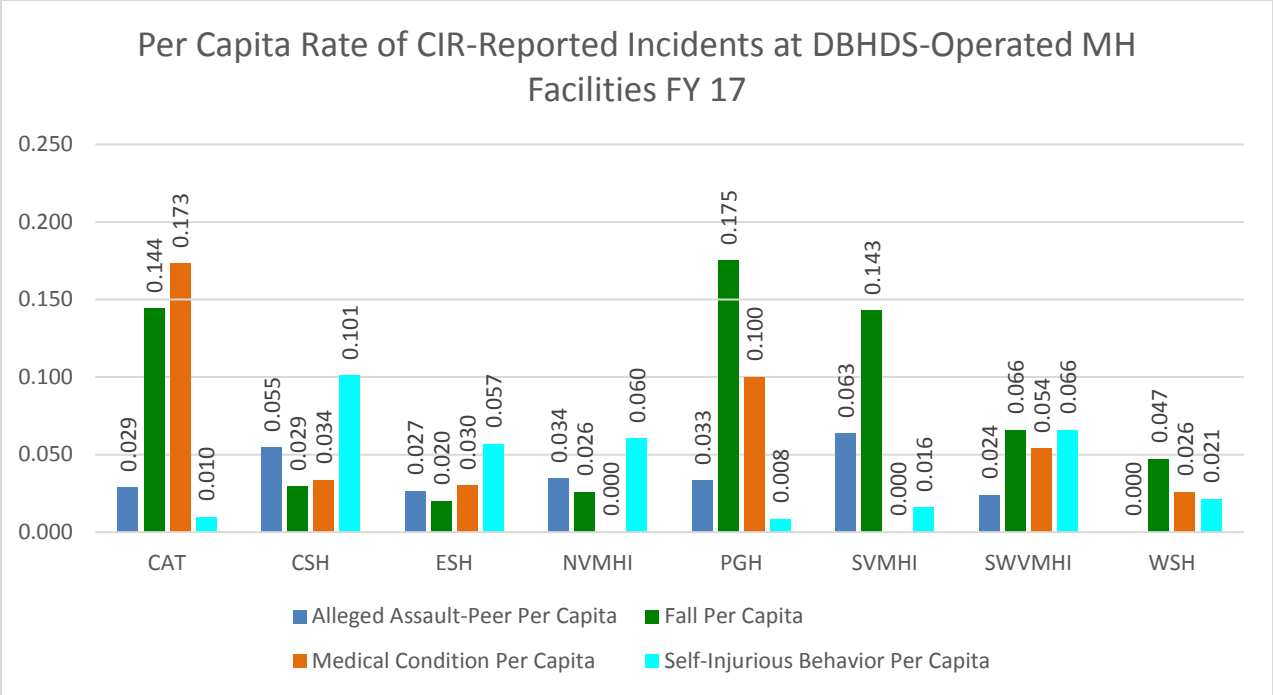


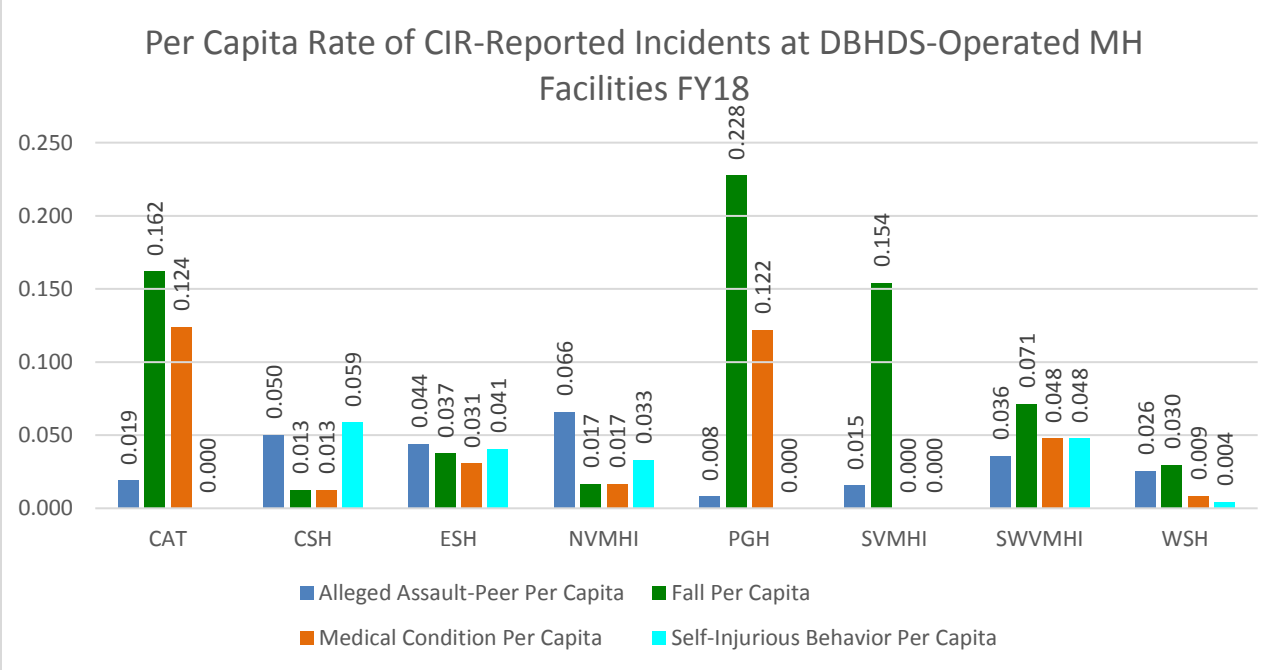
In previous years, falls and SIB made up the vast majority of MH CIRs. Falls are still the most prevalent incident type, accounting for 28.93% of incidents. Meanwhile, SIB decreased substantially in the last year, dropping from 20.72% of incidents in FY17 to just 13.21% of incidents in FY18. Peer assaults and medical conditions continue to make up a sizeable proportion of incidents.



We compared the 4 most prevalent incident types—peer assaults, falls, medical conditions, and SIB—across the facilities within the context of population. Below are the *per capita* statistics for FY 17 and FY 18. 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, we do not believe it is a comparable statistic; it has been excluded from our *per capita* analysis of incidents.

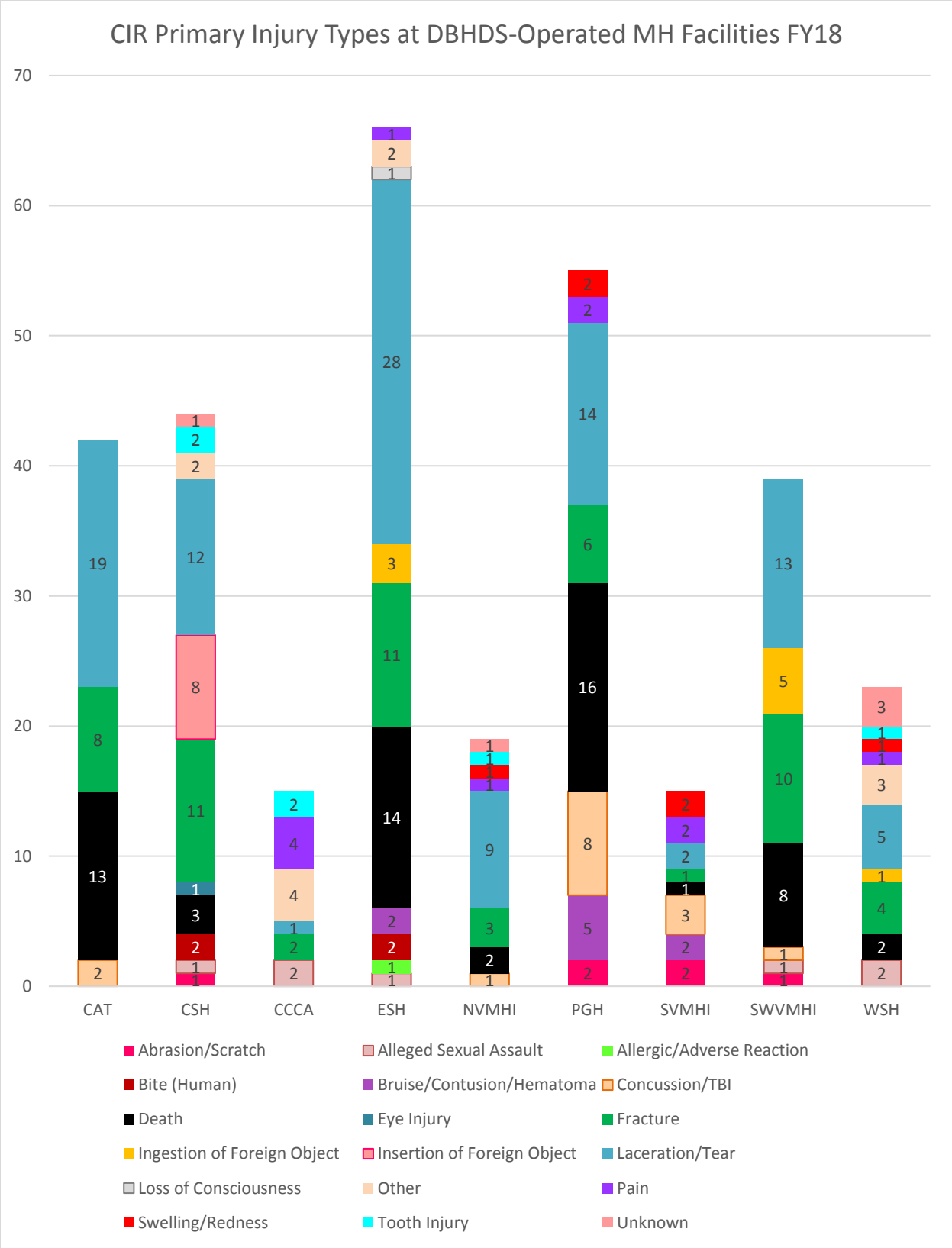
The rate of incidents secondary to falls increased during FY 18, particularly at PGH, where the rate increased from 0.175 *per capita*, or about 17% to 0.228 *per capita*, or about 23%. At SVMHI, the rate of falls remains unusually high at 0.154 *per capita*, or about 15%. This rate of falls is more consistent with PGH and CAT, which house geriatric residents, than it is with other, non-geriatric hospitals. The rate of SIB decreased at every facility.





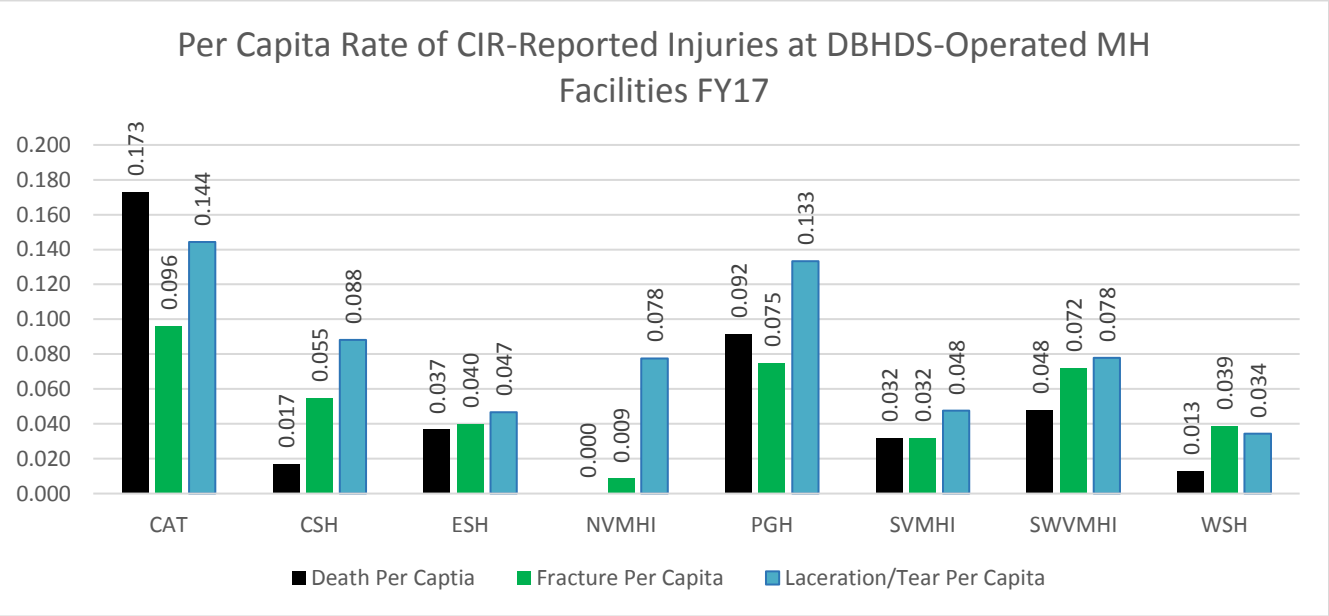
Injury Types

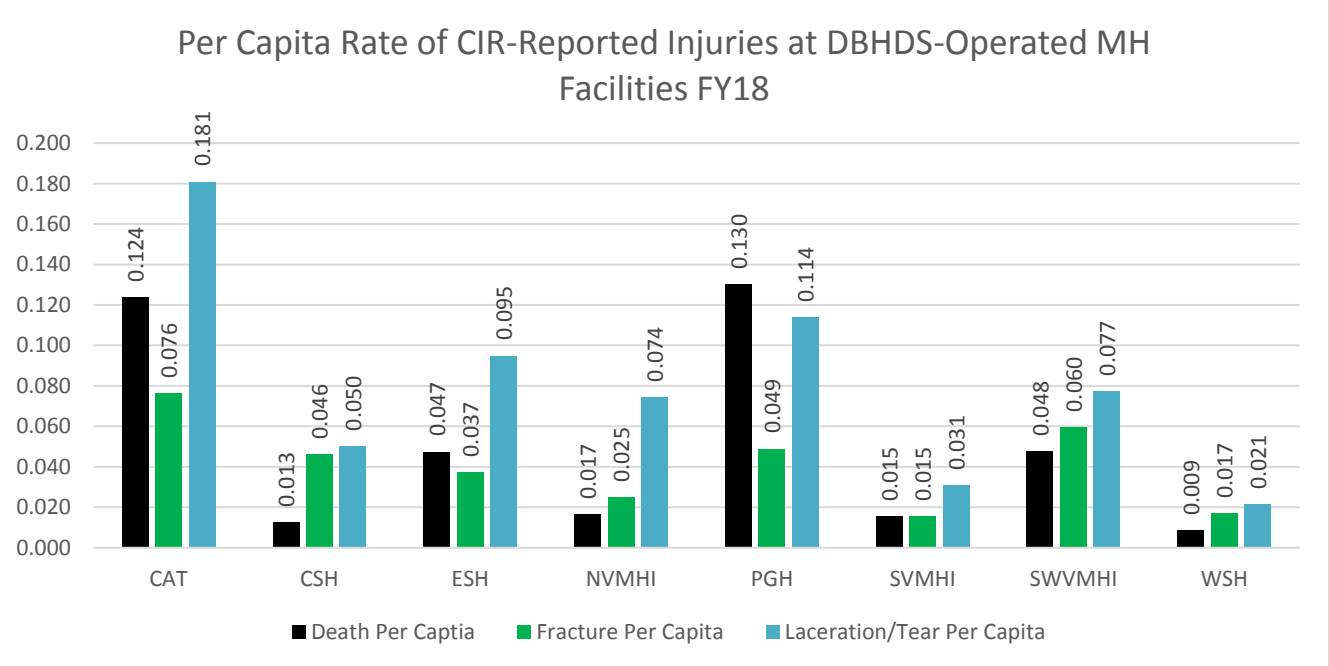
Most of the injuries reported by MH facilities in FY 18 were lacerations or skin tears (108 total, or 32.39%), followed by deaths (59 total, or 18.55%) and fractures (56 total, or 17.61%). Overall, the proportion of primary injuries reported in FY 18 was very similar to that from FY 17.


CIR Primary Injury Types at DBHDS-Operated MH Facilities FY18
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
Bite (Human)
Bruise/Contusion/Hematoma
Concussion/TBI
Death
Eye Injury
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. Fractures decreased at all facilities except NVMHI during FY18.

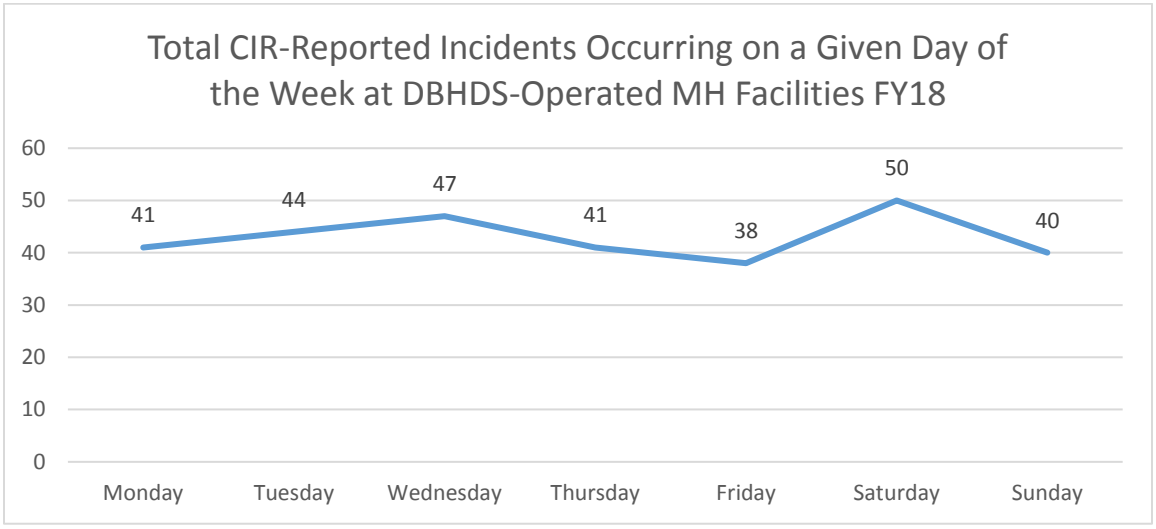
The rate of deaths decreased slightly at CAT (from .173 *per capita* or about 17% to .124 *per capita* or about 12%). Deaths increased substantially at PGH, however, from .092 *per capita* or about 9% in FY 17 to .13 *per* capita or about 13%. The increase at PGH is more dramatic when you consider that the FY 17 rate was already a huge increase from FY 16, when the rate was only .041 per *capita* or about 4%. The high rate of deaths at CAT and PGH is due, at least in part, to the large proportion of geriatric residents at both facilities. Still, as we previously stated, DBHDS must endeavor to identify causal factors to this increase in deaths if they hope to reduce mortality in the state hospitals.

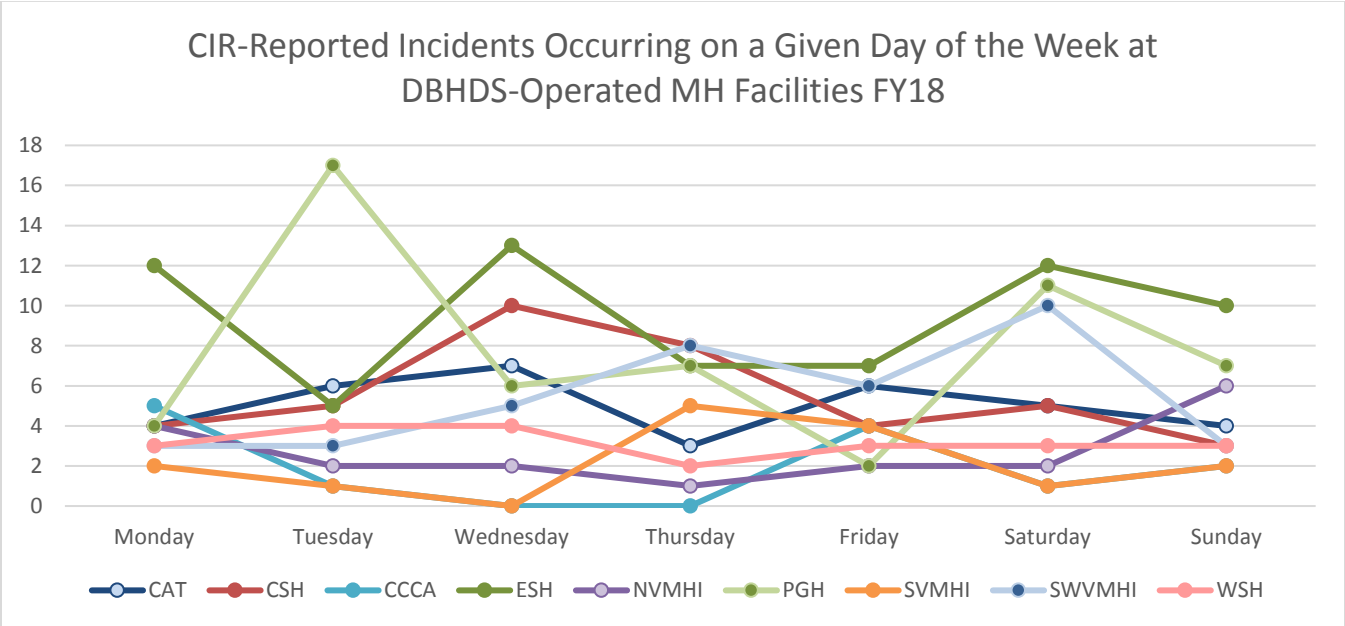




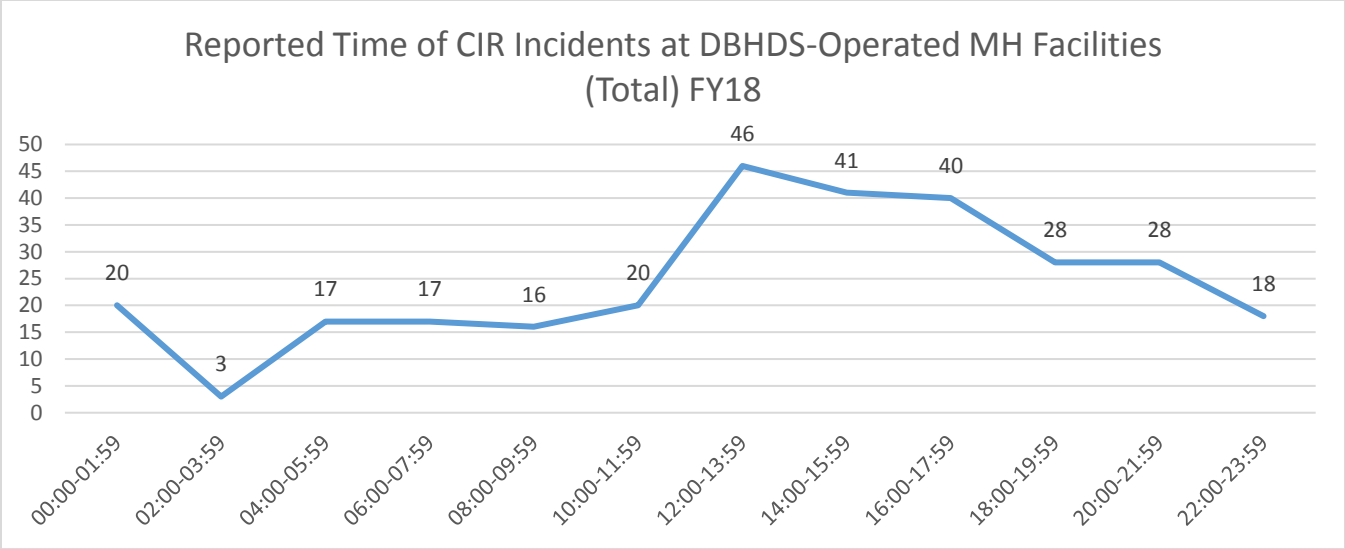
Timing of Incidents

Facilities reported a slight "bump" in incidents occurring on Saturdays (50 total incidents). Reporting seems to be fairly consistent across other days of the week. The only real outlier among the "day of week" data is PGH, which reported a disproportionate 16 incidents on Tuesdays. It is unclear what caused these "bumps" in the data, but dLCV advocates will use this information to guide monitoring in FY19.

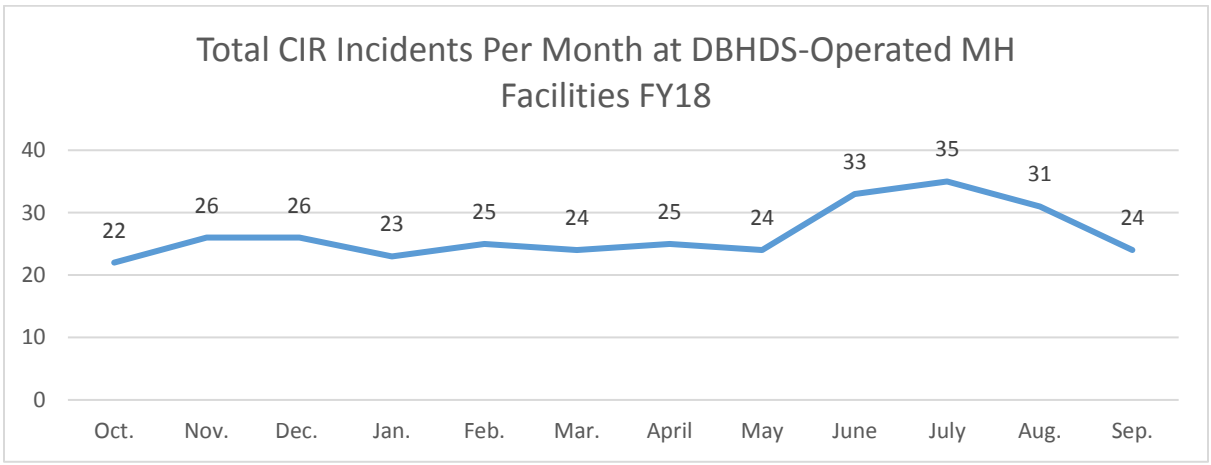




As expected, most of the incidents were reported during periods of higher social activity, such as lunch and leisure times. That said, there are much higher number of incidents reported during the lunch hour (12pm-1:59pm) during FY 18 (46) than in FY 17 (24).



FY 18 CIR reporting at MH facilities peaked in July (35), with the fewest reports coming in October (22). Monthly reporting during FY 18 was more consistent than in FY 17 (high of 42, low of 18).



CONCLUSION

dLCV continues to have serious concerns about the ability of DBHDS mental health facilities to manage the increasingly acute and medically fragile individuals admitted to their care. This is not necessarily an indictment of the care provided, but may be a result of the inability to provide that care in a facility designed for psychiatric purposes. In Federal Fiscal Year 2018 (FY 18), dLCV notified DBHDS of these concerns, particularly the increase in deaths and the corresponding increase of deaths occurring soon after admission. We shared with the Department our speculation that there is a correlation between the bed of last resort legislation and the admission of individuals with higher healthcare (as opposed to strictly mental health care) needs.

RECOMMENDATIONS

The Department of Behavioral Health, together with other relevant state resources, should take immediate steps to identify the causes of the increased death rates at state mental health facilities. Specifically, the Department should

- Determine the source of admission for every death that occurred within 90 days of admission, in every mental health facility operated by the state, to determine whether there are any obvious problematic sources of admission,

- Conduct a complete analysis of each death, regardless of admission date, to determine whether any death was related to one of the "7 Triggers." In our experience, many deaths related to one of these triggers (aspiration, bowel obstruction, decubitus ulcers, dehydration, seizure, sepsis, and urinary tract infection) can be avoided with improved staff training and appropriate resources,

- Evaluate staffing levels at each facility, especially for medical staff,

- Increase staff training to be able to identify and respond to medical conditions, and

- Review the falls protocol in each of the state's mental health facilities

As always, the disAbility Law Center of Virginia welcomes any opportunity to discuss these findings with the Department of Behavioral Health and Developmental Services, with relevant policy makers or with other concerned parties.