Report on Critical Incidents in Virginia's State Operated Mental Health Facilities October 1, 2018 - September 30, 2019

Prepared by
The disAbility Law Center of Virginia
August 2020

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 2019, dLCV received a total of 291 Critical Incident Reports from mental health facilities operated by the Department.

EXECUTIVE SUMMARY

Beginning with data from FY 2017m each year dLCV has brought areas of concern arising from the Critical Incident Reports to the attention of the Department of Behavioral Health and Developmental Services (DBHDS). The high number of deaths—especially ones occurring soon after admission—has been a key concern that DBHDS has agreed to investigate. During Federal Fiscal Year 2019 (FY 19), we saw a decrease in deaths at state hospitals. While we acknowledge this improvement, dLCV remains concerned about the continued high number of medically complex and terminally ill consumers being served in State Mental Health Institutions, rather than in appropriate medical facilities.

Furthermore, recent data shows that DBHDS facilities are not completing critical, mandatory reports as required by state law. Facilities have reported to dLCV that they are unable to access the pertinent databases and have not received support from DBHDS to do so. This lack of reporting limits the ability of watchdog organizations, including dLCV, the Office of the State Inspector General, and DBHDS itself to fully monitor and assess conditions at DBHDS-operated facilities. It violates state law. The conclusions drawn by this report are based on what we know to be inconsistent data. While the data may not accurately depict conditions in a State Hospital, this is the data that DBHDS provides.

BACKGROUND

Virginia's 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 or death. This report will detail CIR trends in DBHDS-operated mental health (MH) facilities during the 2019 Federal Fiscal Year (FY 19).

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.

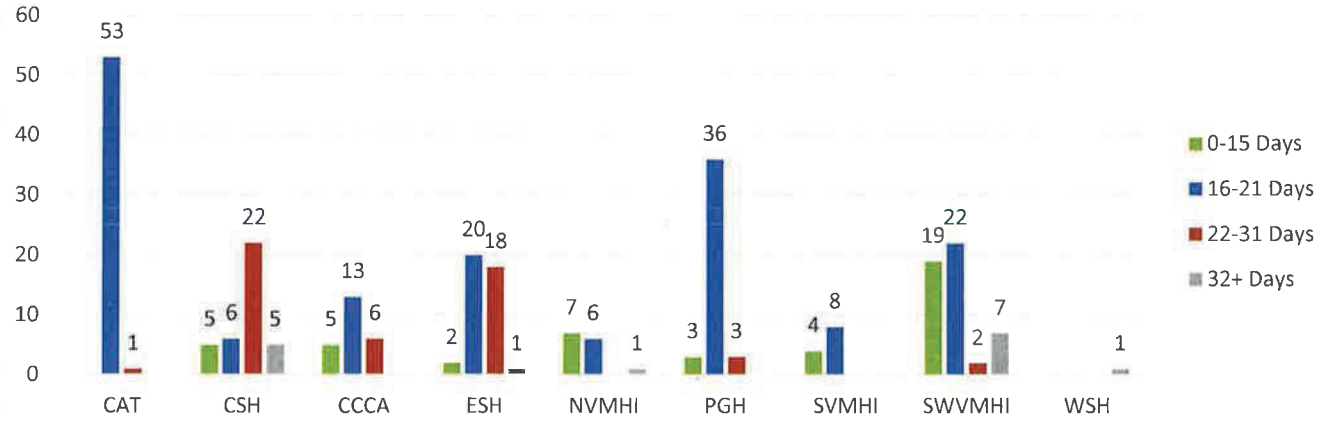
MH Data

Overall Reporting

In FY 19, DBHDS-operated MH facilities reported 291 Critical Incidents—moderately fewer than during the last two fiscal years. CAT reported the greatest number of incidents (59), followed by SWVMHI (51). The number of incidents CAT reported is concerning because it is a relatively small facility with just over 100 beds and a partially-geriatric population. One might expect a partially-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 shocking that PGH's residents were reportedly subject to a greater number of serious injuries than facilities with substantially more psychiatrically acute admissions. Likewise, SWVMHI serves a partially-geriatric population with an "average-sized" census of around 170. For comparison, ESH, the Commonwealth's largest State Psychiatric Hospital, with just over 300 beds, reported only 40 incidents during FY 19, although it was the most prolific reporter the previous year.

Most egregiously, WSH, which served over 230 individuals during nearly all of FY 19, only reported 7 critical incidents during that time. WSH has, historically, reported fewer critical incidents than similarly-sized facilities, but has never made so few reports. dLCV is aware, based on monitoring and complaints, of incidents that were never reported through the CIR/PAIRS reporting process. On multiple occasions, dLCV notified WSH that they were violating legal reporting requirements. In response, WSH provided dLCV with a handful of additional reports, though these reports were often late and, in all but one instance, failed to include the required follow-up information. WSH's obstruction in this regard has hindered dLCV's and DBHDS' ability to effectively monitor the facility and enforce individuals' rights.

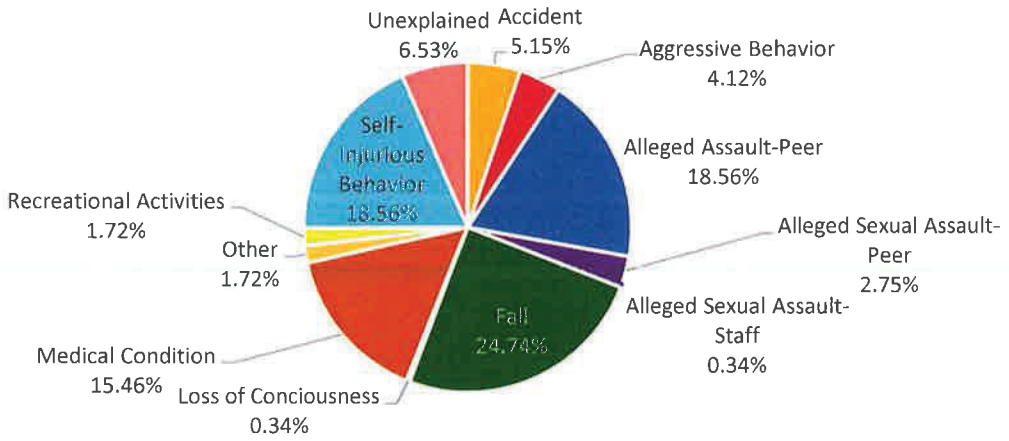
Number of Days Between Discovery Date and CIR 15-Day Report at DBHDS-Operated MH Facilities FY 19



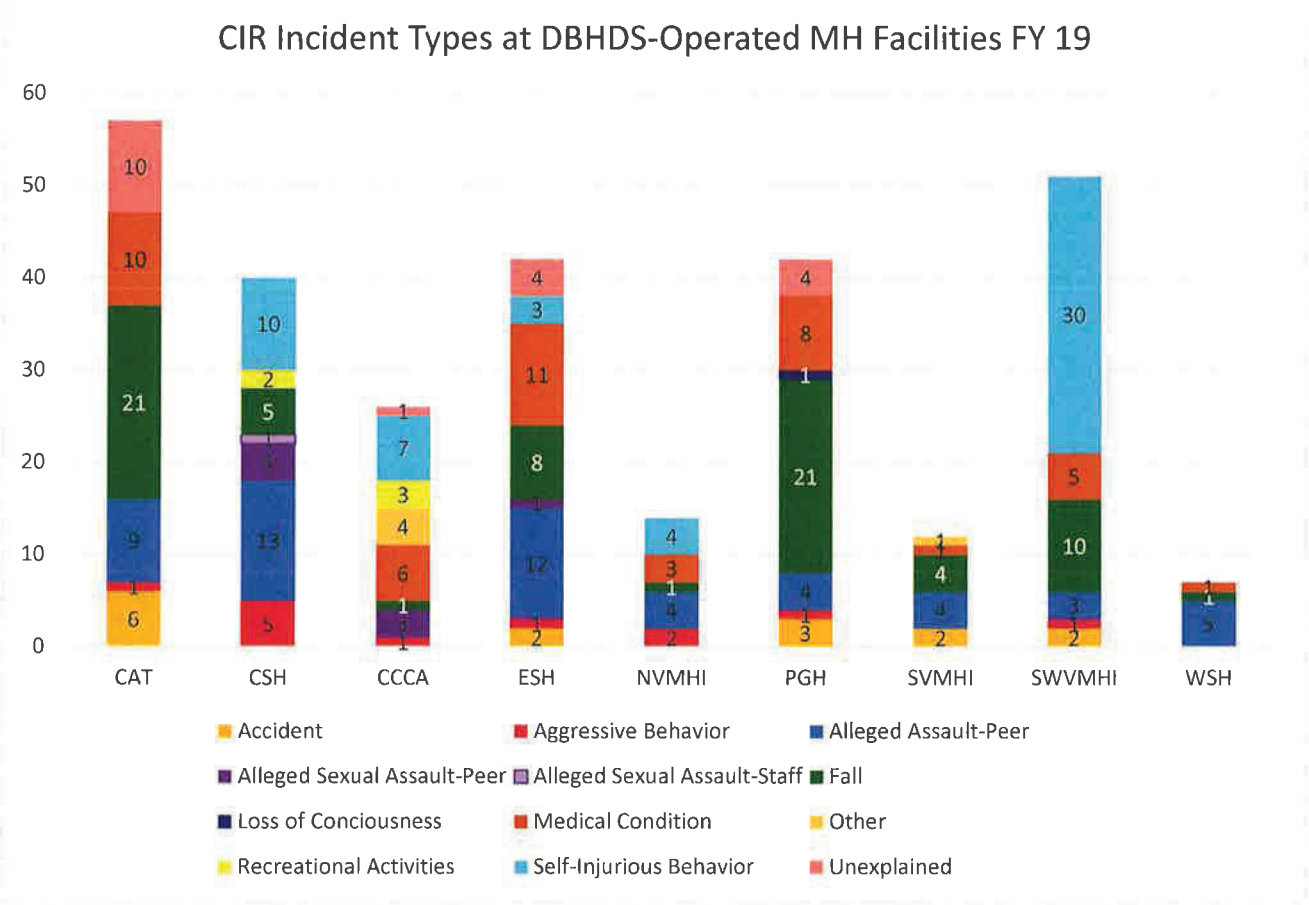
DBHDS' Departmental Instruction 401 requires facilities to provide a "15 day follow-up report" to all CIRs. Upon discussion with DBHDS staff, we learned that DBHDS facilities have chosen to interpret the "15 Day" rule to mean 15 business days, rather than calendar days. If we apply DBHDS' standard of 15 business days, most MH facilities submitted their follow up reports in a timely manner during FY 19. CSH submitted the greatest number of delinquent reports, with 27 of CSH's 40 reports being submitted after 22 days (and 2 not submitted at all). SWVMHI was also delinquent in much of their follow-up reporting, with 9 of their 51 reports coming in late, and 7 of these reports coming in more than a month late.

Incident Categories

Proportion of CIR Incident Types at All DBHDS-Operated MH Facilities FY 19

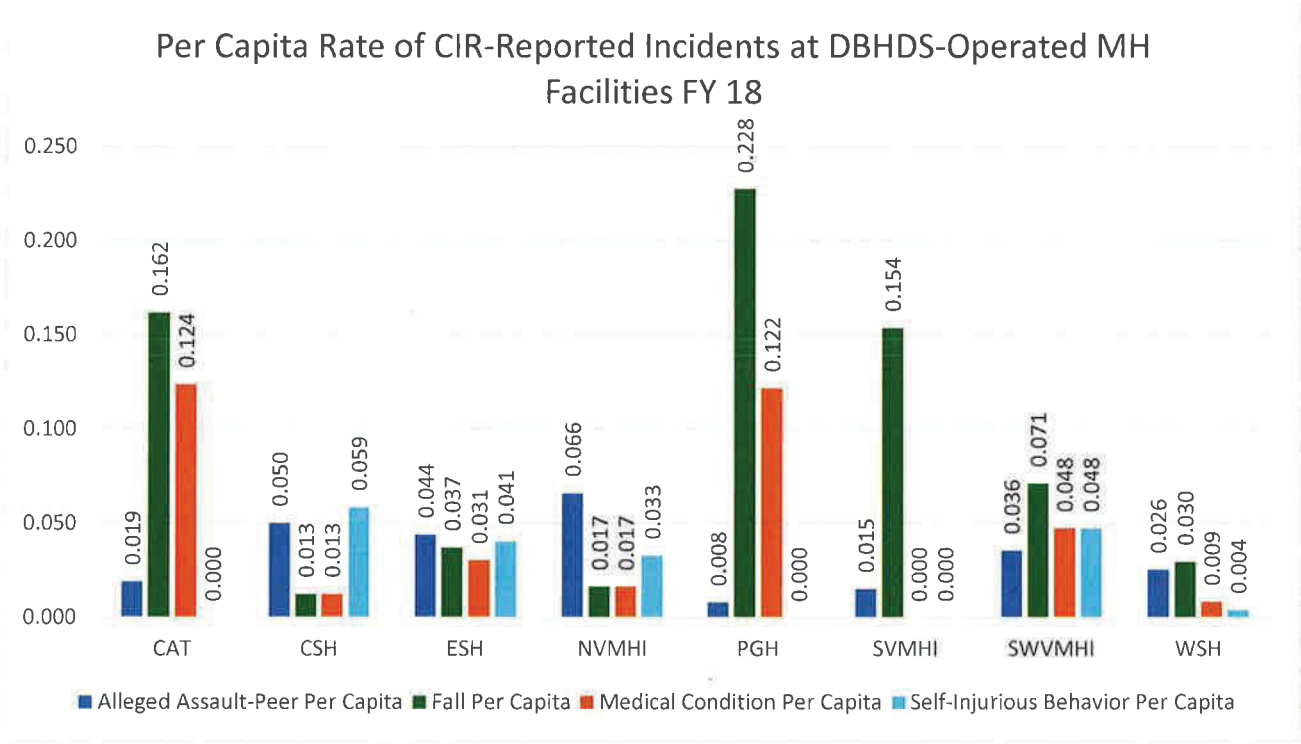


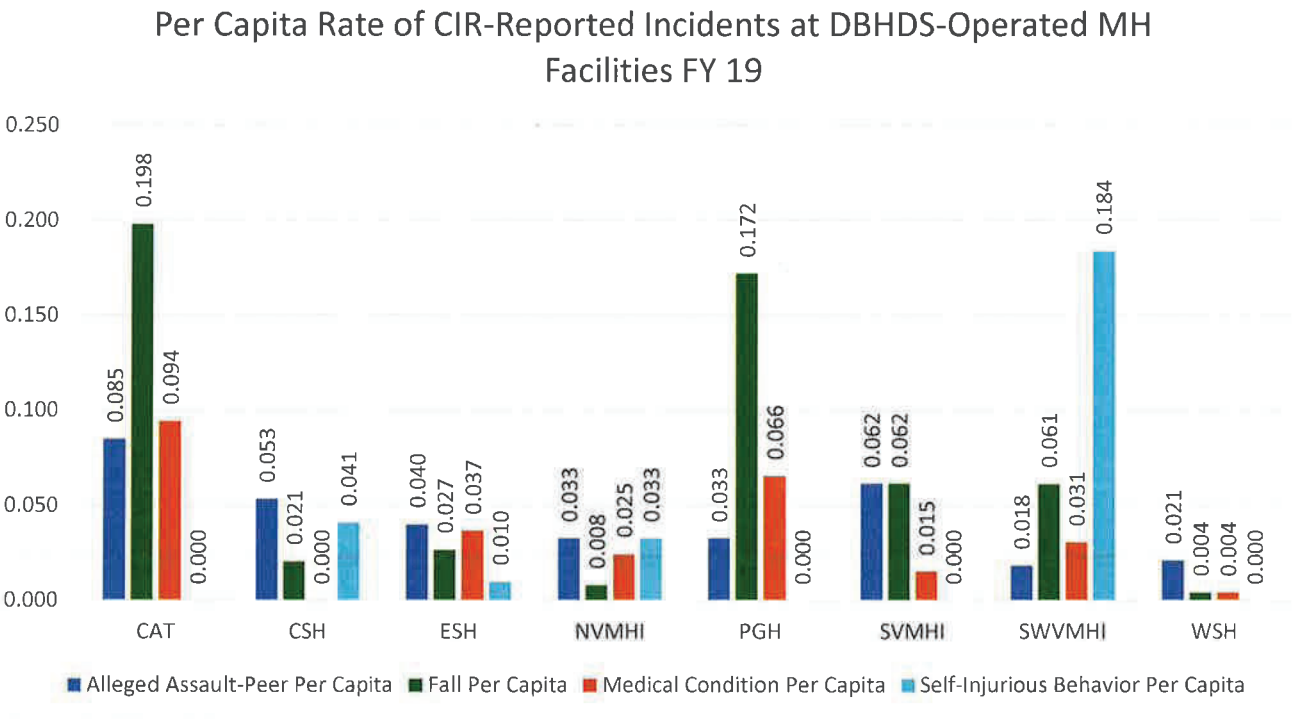
Despite a small decrease, falls are still the most prevalent incident type, accounting for 24.74% of incidents. The proportion of injuries attributed to Self-Injurious Behaviors (SIB) and alleged peer assaults increased slightly in FY 19, with each category making up 18.56% of all incidents, compared to FY 18, when peer assaults accounted for 15.41% of incidents, and SIB only 13.21%.



dLCV has long been concerned about Peer-to-Peer Assaults in DBHDS-operated hospitals. CSH and ESH, in particular, have been heavily affected by 2016 legislation requiring that individuals in jails be transferred to State Hospitals for Restoration within 10 days of receipt of a court order. Staff and residents have told dLCV that these psychiatrically-acute individuals have contributed to a rise in Peer-to-Peer violence, as well as self-injury and injuries stemming from other "aggressive behavior." FY 19 CIR data initially appears to supports staffs' assertions that the populations of CSH and ESH continue to be far more prone to peer assault, as evidenced by the fact that they reported the highest number of peer-to-peer assaults (CSH reported 13 and ESH reported 12). However, while the number of peer assaults remains high, it is consistent with the number of peer assaults reported by these facilities last year (CSH reported 12 and ESH reported 13). Moreover, the *per capita* rate of peer-to-peer incidents at CSH and ESH is far less than at other, smaller facilities.

We compared the 4 most prevalent incident types—peer assaults, falls, medical conditions, and self-injurious behaviors (SIB)—across the facilities with the context of population. Below are the *per capita* statistics for FY 18 and FY 19. We exclude CCCA because its uniquely small population and high bed turnover can lead to misinterpretation of the data.

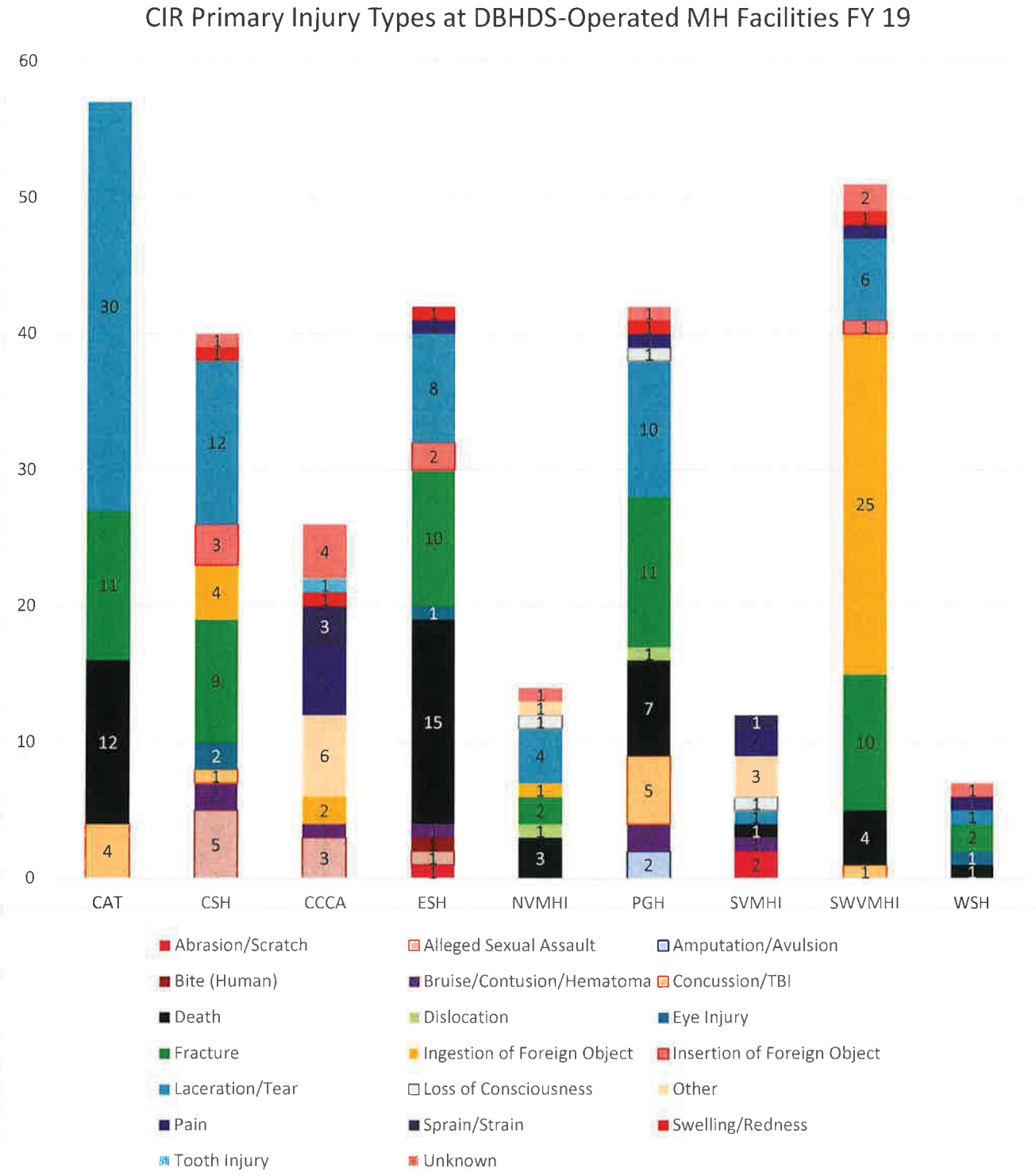




Most notably, the rate of SIB increased substantially at SWVMHI, from 0.048 *per capita* (or about 5%) to 0.184 *per capita* (or about 18%). This increase was primarily driven by 2-3 individuals at SWVMHI who self-injured many times during FY 19. The rate of falls was fairly stable at most facilities, except at SVMHI where the rate decreased sharply (from 0.154 *per capita*, or about 15%, to 0.062, or about 6%), and at CAT, where the rate increased moderately (from 0.162 *per capita*, or about 16%, to 0.198, or about 20%). The rate of peer assaults

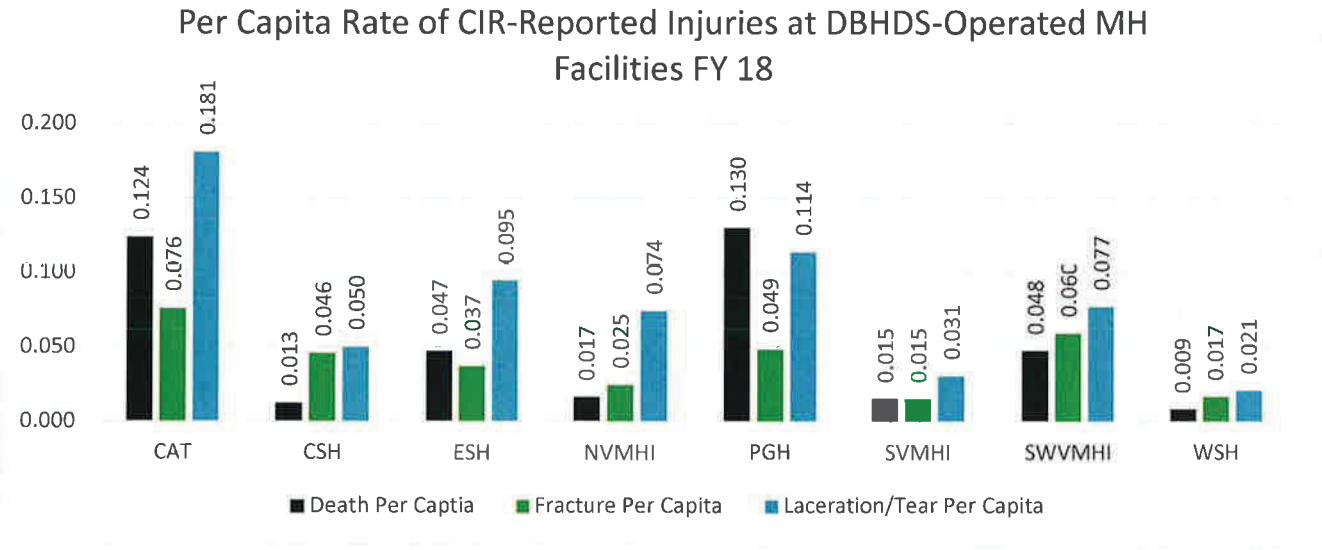
was fairly stable at CSH and ESH, despite our initial expectation of an increase. The rate of peer assaults at CAT, however, increased remarkably from 0.019 *per capita*, (or about 2%) to 0.085 *per capita* (or about 9%).

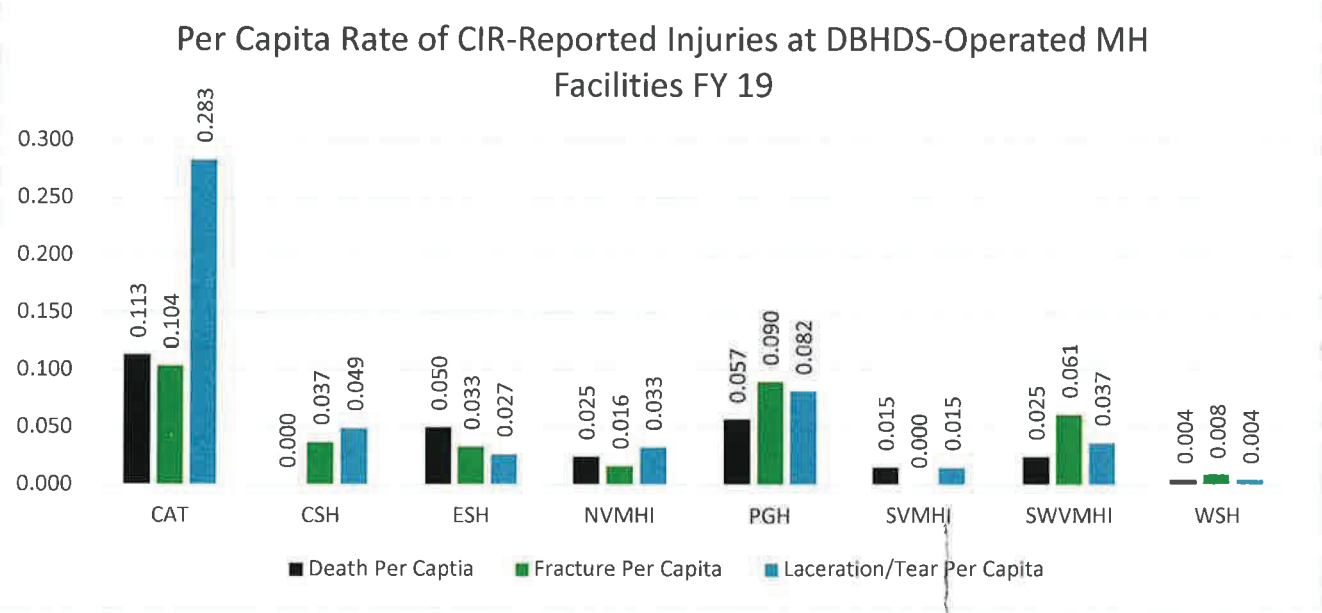
Injury Types



Most of the injuries reported by MH facilities in FY 19 were lacerations and skin tears (72 total, or 24.74% of all injuries), followed by fractures (55 total, or 18.9%) and deaths (43 total, or 14.78%). While Laceration/Tear was certainly the most prevalent injury category in the FY 19 reports, most facilities actually reported *fewer* instances of lacerations than they did in FY 18. We suspect that the decrease is related to poor compliance with reporting requirements, rather than an actual decrease in injuries. This drop is offset by an astronomical increase in the number of lacerations reported by CAT, which increased from 19 (in FY 18) to 30 (in FY 19). The number of foreign-object ingestions also increased sharply at SWVMHI over the last FY, from 5 (in FY 18) to 25 (in FY 19). Unsurprisingly, this is closely correlated with the steep rise in SIB at SWVMHI over the last year.

For the reasons stated previously, we have not included CCCA in our *per capita* analysis of injuries.

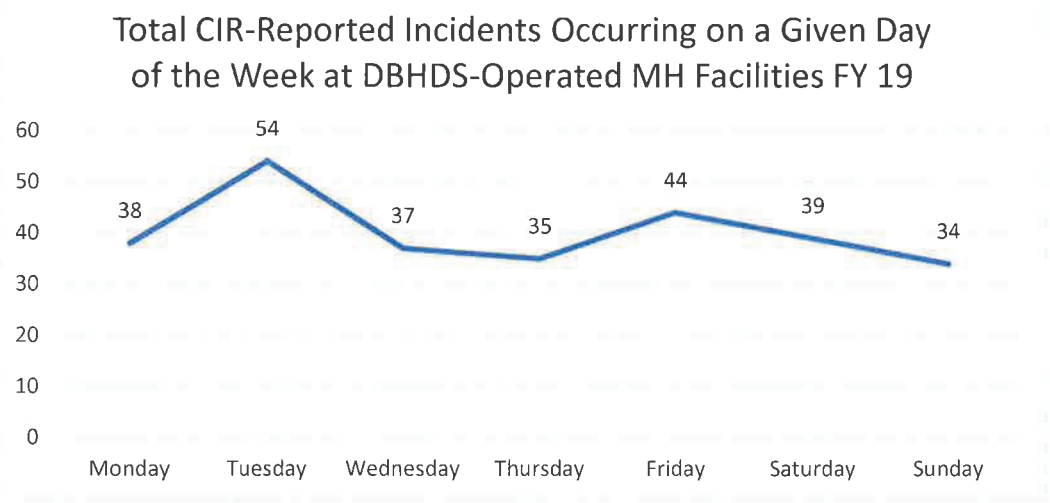




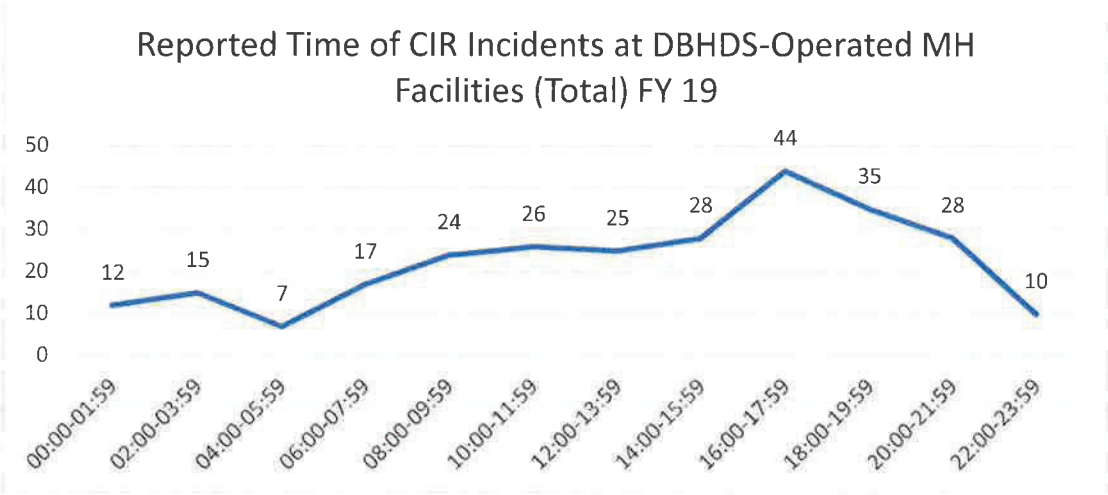
Among *per capita* injuries, the rate of lacerations at CAT increased substantially in FY 19, from .181 *per capita*, or about 18% (which was already very high), to 0.283 *per capita*, or about 28%.

Deaths decreased at all facilities except ESH during FY 19, with the most substantial drop being at PGH (from 0.13 *per capita,* or about 13%, to 0.057 *per capita*, or about 6%)[1].

TIMING OF INCIDENTS

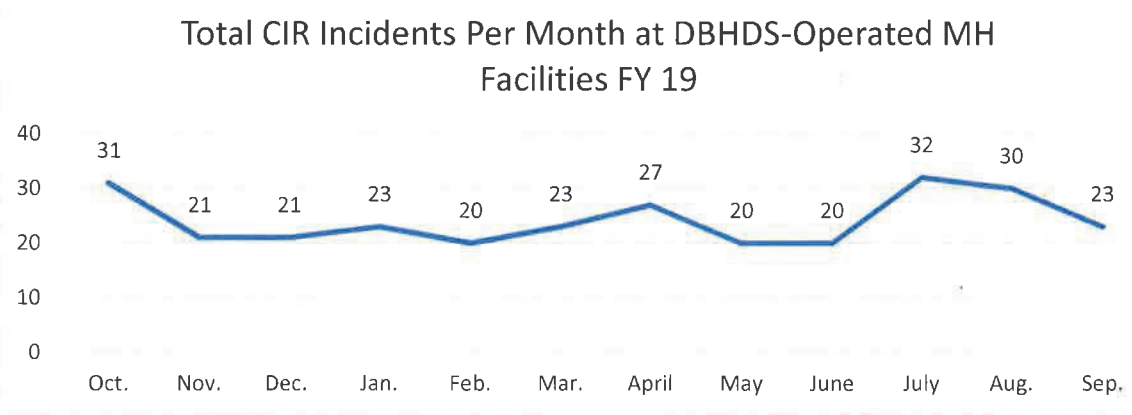


Facilities reported a moderate "bump" in incidents occurring on Tuesdays (54 total incidents). Reporting seems to be fairly consistent across other days of the week. This "bump" was driven primarily by PGH, which reported a disproportionate 13 incidents on Tuesdays. This was the case during FY 18 as well, but dLCV has not been able to identify why. It is unclear what caused these "bumps" in the data, but advocates will use this information to guide monitoring in FY 20.



As expected, most of the incidents were reported during periods of higher activity, such as lunch and unstructured leisure times.

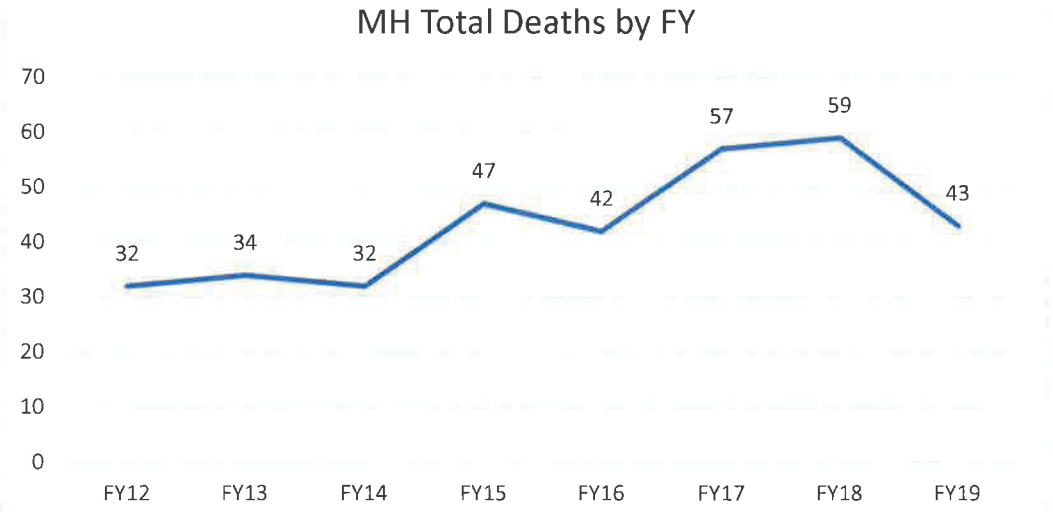
[1] See page 10 for more information on deaths.



FY 19 CIR reporting at MH facilities peaked in July (32), with the fewest reports coming in February, May, and June (20). Similar variations occur each year. This could be the result of poor reporting compliance.

DEATHS AT MH FACILITIES

TOTAL DEATHS

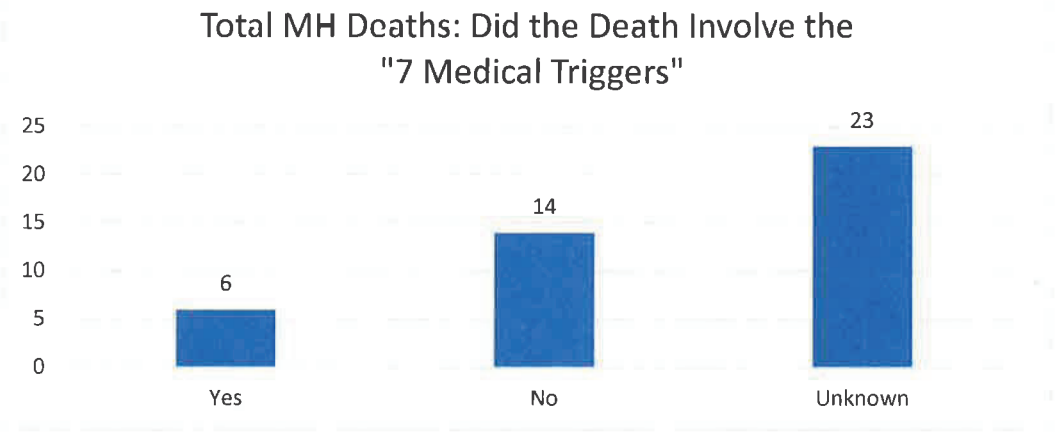


In FY 19, the number of deaths reported by DBHDS-operated MH facilities decreased for the first time since FY 16 (from 59 deaths in FY 18 to 43 deaths in FY 19). The facilities recording the greatest number of deaths were ESH, CAT and PGH (15, 12, and 7 respectively), which have been the most prolific reporters of deaths since FY 17. Following dLCV's previous report on Deaths at State Hospitals, DBHDS pledged to take steps to better analyze the cause of these deaths and the role that "facility of last resort legislation"[2] has played in increasing deaths at DBHDS Facilities. It appears that in FY 19, we are finally seeing the payoff of DBHDS' efforts, though the number of deaths remains higher than in years preceding the 2014 legislation.

[2] Virginia Code § 37.2-809, which went into effect in 2014, and designated the DBHDS hospitals as "facilities of last resort."

THE "7 MEDICAL TRIGGERS"

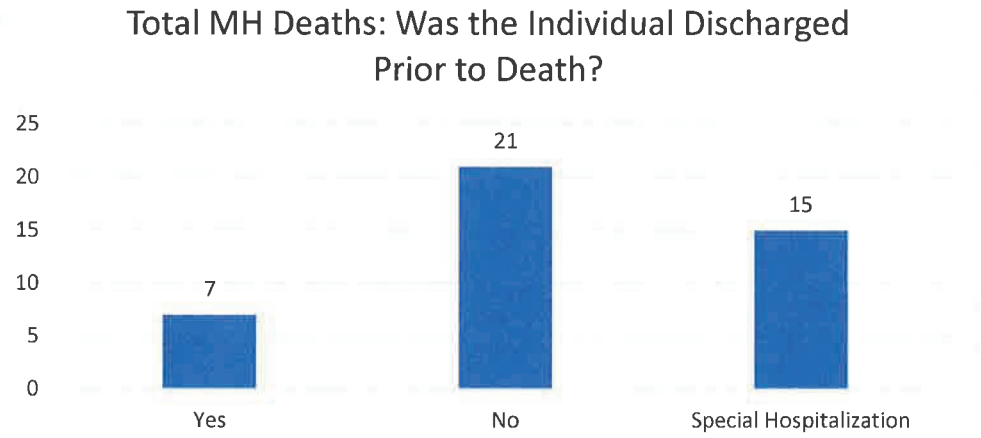
Incidents preceding death at DBHDS-operated facilities are most often coded as "Medical Condition." Medical Conditions made up 36 of the 43 deaths (83%) reported by MH facilities in FY 19. In our FY 18 report, dLCV expressed concerns that facilities were using the "Loss of Consciousness" category to describe 11.8% percent of deaths, despite the fact that "Loss of Consciousness" provides no information on why the individual lost consciousness or died. In FY 19, the State Hospitals wholly refrained from using Loss of Consciousness as a descriptor. This does coincide, however, with an increase in the use of "Unexplained" as a category to describe deaths. In FY 19, facilities—specifically CAT and ESH—coded 6 deaths (14%) as Unexplained, compared to only 1 death (>2%) in FY 18. Needless to say, it is extremely troubling when Facilities are not able to explain how or why their patients died, even when given fifteen days to investigate and collect information.



In addition to these unexplained deaths, 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 23 of the FY 19 deaths (53%) involved the "7 Medical Triggers."[3]

[3] Aspiration/Aspiration Pneumonia, Bowel Obstruction/Constipation, Decubitus Ulcers, Dehydration, Seizures, Sepsis, and Urinary Tract Infections

Discharge Prior to Death



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. In FY 19, we saw a significant increase in the number of deaths occurring on DBHDS' watch.

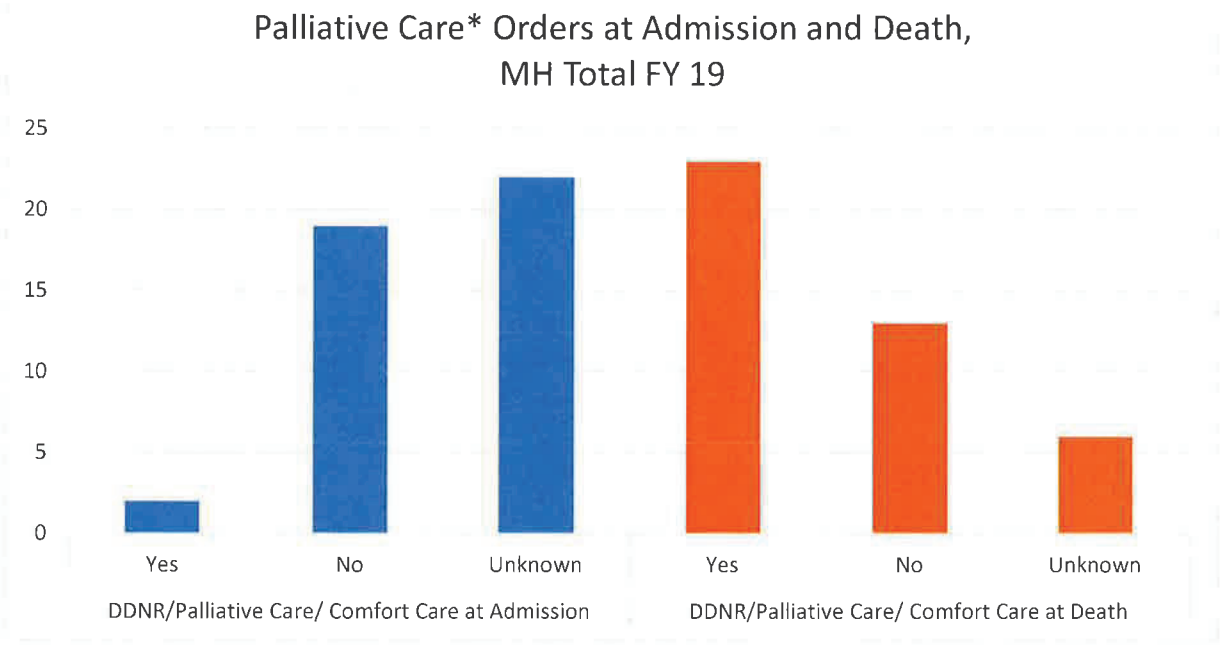
While the greatest number of deaths occurred on the grounds of the State Hospitals (21 deaths or 49%), both the number and proportion of deaths occurring among individuals on "Special Hospitalization[4]" increased for the third consecutive year (from 12 or 20% in FY 18 to 15 or 35% in FY 19). This increase corroborates our long-stated concerns about individuals with complex medical needs being admitted to psychiatric hospitals.

An increasing proportion of DBHDS patients are dying of long-term or chronic illnesses that strictly necessitate medical hospitalization—a service that DBHDS simply cannot provide. These individuals are not dying of unforeseen heart attacks or strokes. Rather, an overwhelming number are sick when they are admitted and they continue to deteriorate while in DBHDS' care. This does not mean that all of these deaths are preventable, but it does mean that many of these individuals were failed by a system that had no chance to succeed. State Hospitals are Psychiatric Hospitals. They are not Medical Hospitals. While we generally believe that DBHDS does the best it can with the resources available, they cannot meet the needs of most medically fragile adults and the continued admission of such patients is neglectful.

[4] Special Hospitalization occurs when an individual is still committed to a DBHDS facility, but is sent out to a private, medical hospital to receive care for an injury or condition.

Palliative Care Orders

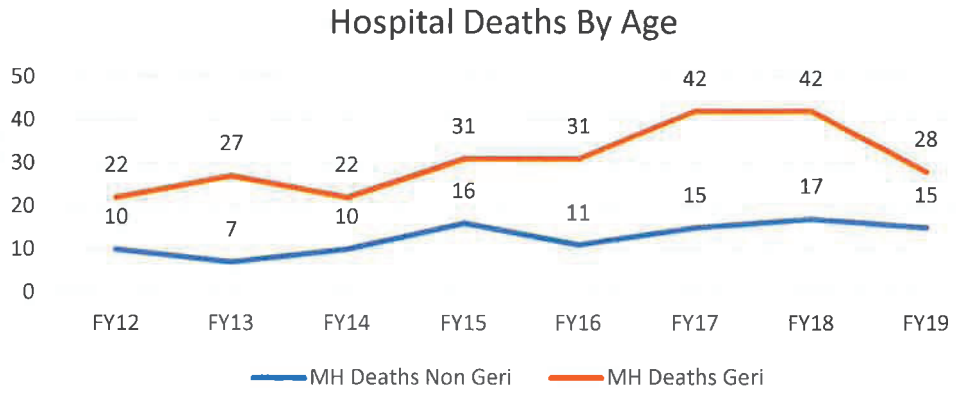
This year, dLCV began tracking data on deceased individual's Palliative Care Status[5] at the time of their admission and the time of their death. CAT noted that some type of Palliative Care was in place for 2 individuals at admission, but was the only hospital to do so. In the majority of cases, hospitals did not clearly note whether an individual was admitted with any type of Palliative Care orders.



While it appears that most deceased individuals did not have orders in place for palliative care at admission, the majority of individuals certainly had these orders or instructions in place at the time of their death. The number of individuals actively receiving some type of end of life care at the time of their death in FY 19 outnumbers the individuals who were discharged or on special hospitalization before their deaths. The data (as well as narrative information from the CIR reports) clearly shows that medically-deteriorating patients were kept at or sent back to the relative chaos of the State Psychiatric Hospitals to die. It is difficult to fathom what effect this must have had on the morale of other residents and staff, but we have seen no evidence that this was a concern of the providers involved.

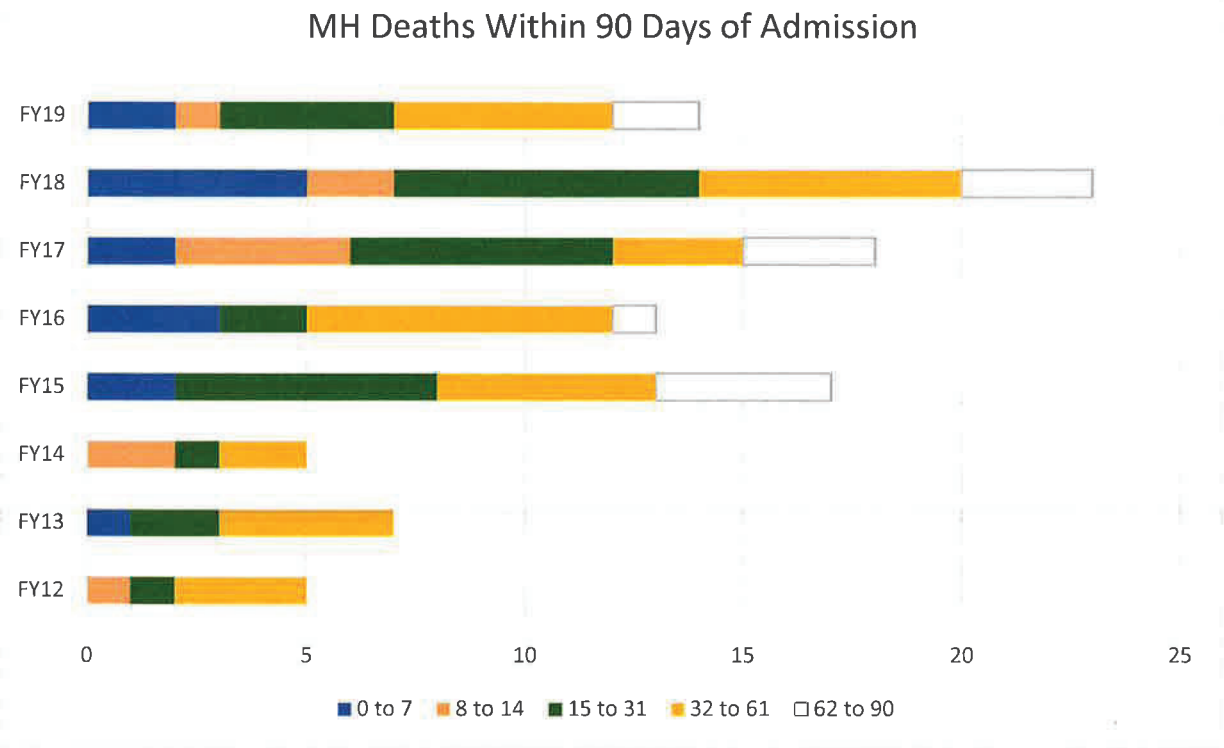
[5] In looking at this data, we included any record of "DDNR." "Do Not Resuscitate," "Palliative Care," "Comfort Care," "Comfort Measures," or "Hospice Care."

Deaths by Age



In FY 19, the number of geriatric deaths decreased dramatically, though geriatric individuals still make up a majority of deaths.

Proximity to Admission



dLCV has been tracking deaths within close proximity to admission for the last 2 years, due to concerns about increasing "medically complex" admissions. The number of deaths occurring within 90 days of admission had increased substantially since 2014 and reached an all-time high in FY 18. In FY 19, the number of deaths

occurring within 90 days of admission decreased from 23 to 14 instances. Within this dataset, the number of deaths occurring in the first week after admission dropped most significantly—from 5 cases in FY 18 to just 2 in FY 19. Again, we believe these decreases to be a product of DBHDS' efforts in the last year to investigate and analyze the rate of deaths occurring in State Hospitals.

CONCLUSION

There are two significant takeaways from dLCV's analysis of FY 19 Critical Incident Data. First of all, fewer people are dying at State Hospitals, but the number of deaths is still too high. While no one deserves to die in a DBHDS facility, some deaths are sudden and unpredictable. However, there is a subset of patients at the State Psychiatric Hospitals who are critically ill and are expected to die, yet they remain in the hospital. With the available information, we have no way of knowing whether DBHDS believes that keeping these individuals is in their best interest, or if the Department is at the mercy of other, external forces.

As we have previously asserted, it is unfair to both staff and consumers to ask psychiatric hospitals to moonlight as skilled nursing and hospice facilities. Staff are forced to take on roles that they are not prepared for and are far outside their job descriptions. The data alone cannot show what impact the State Hospital environments have on medically-involved consumers, but dLCV has heard from scores of consumers who feel they are receiving substandard care and cannot understand why they are not being cared for in their own communities, by their own providers. A State Hospital is not an appropriate place for someone who needs intensive medical care. To place someone in a psychiatric bed who would be better served in a medical bed is neglect.

The second takeaway is that facilities are not adhering to their reporting duties and are in violation of State Law and Departmental Policy. DBHDS' own Departmental Instruction #401 requires facility Risk Managers to report all injuries requiring *at least* first aid by a physician or physician extender (including loss of consciousness), as well as any injury of greater severity, to dLCV as the designated Protection and Advocacy Organization for the Commonwealth of Virginia within 48 hours of the incident or discovery.

The Code of Virginia[6] further clarifies that it is the Commissioner's duty to provide dLCV's Director with "the known facts" of critical incidents, deaths, and serious injuries "within 15 working days." Although DBHDS policy requires risk managers to report "the known fact" of incidents, as well as "a chronology of good faith efforts the facility has taken to address the complaint or observation of the injury prior to the discovery date indicated on the report" to dLCV, the overwhelming majority of initial and follow up reports from state hospitals do not include full and accurate information. Below we have included de-identified examples of report narratives that Hospitals have tried to present as adequate:

> *"Patient on 1:1 in ERC in seclusion room with the door open when peer ran in and attacked him. Patient sustained a laceration to face and neck requiring 5 sutures."*

> *"Patient was on pod, mumbling and pacing. He was noted not to be voiding and to have swelling in his legs. He was sent to [medical hospital] for assessment."*

[6] § 37.2-304. Duties of Commissioner, paragraph 7

"Patient wiggled hand out of wrist-waist restraints, grabbed a bendy pen from the table in the dayroom ad [sic] swallowed it before staff could reach him. Was sent to local emergency department for x-ray and endoscopy if indicated."

"Patient stated that she had swallowed part of a sign over a door (required room number sign). She gave staff two additional pieces of the sign. Sent to local emergency department for evaluation and treatment."

"The patient swallowed batteries from a cordless phone."

"AT [sic] 10:15 the patient slipped from the couch and had a superficial abrasion on the chin. The patient was not allowing staff to come near him. At 10:25 the patient continued to pace and suddenly threw himself forward and hit his head on the floor."

These reports, each show that a serious incident occurred, but say nothing about staff's response, what treatment was provided, how the individual was recovering, or what the facilities were doing to address the underlying causes of the incidents.

Among DBHDS' Mental Health facilities, WSH has been the exemplar of poor reporting, submitting only 7 Critical Incident Reports and one follow-up report during the entirety of FY 19. Several facilities, including WSH, have told dLCV that critical system failures have prevented them from properly accessing or entering reports. These same facilities have, in most instances, made no effort to communicate reports to dLCV in any other way. While individual facilities are responsible for reporting incidents to dLCV, it is the Department's responsibility to ensure that all state-operated facilities can access all mandatory reporting databases.

As always, the disAbility Law Center of Virginia welcomes any opportunity to discuss these findings with the Department of Behavioral Health and Developmental Services and with state legislators. In particular, we welcome the opportunity to assist with training of facility staff on their reporting responsibilities under Virginia Law.