

Report on Critical Incidents
In Virginia's State-Operated Facilities
October 1, 2019 - September 30, 2020



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 attention.

During Federal Fiscal Year 2020, dLCV received a total of 362 Critical Incident Reports from State Hospitals and Training Centers operated by the Department.

EXECUTIVE SUMMARY

Since 2018, 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). During Federal Fiscal Year 2020 (FY 20), we saw an overall increase in deaths at DBHDS-Operated Facilities, and particularly at Piedmont Geriatric Hospital. While it is true that the COVID-19 pandemic was responsible for a number of these deaths, the vast majority of deaths in state facilities were the result of other long-term medical conditions. dLCV remains concerned about the continued high number of medically complex and terminally ill consumers being served in State Mental Health Institutions. We are particularly concerned about individuals’ ability to access critical, off-site medical services from a specialist.

While reporting compliance increased in FY 20, we still believe some facilities are under-reporting incidents. It is also clear that the reports they do submit are vague, incomplete, and often late. Poor reporting practices limit 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 also violates the law. The conclusions drawn by this report are based on what we know to be inconsistent data. Therefore, while the data may not accurately depict life in a State Hospital, it is ultimately a portrait that DBHDS has painted of itself.

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 Facilities during the 2020 Federal Fiscal Year (FY 20).

dLCV’s 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)

- Hiram Davis Medical Center (HDMC)
- Northern Virginia Mental Health Institute (NVMHI)
- Piedmont Geriatric Hospital (PGH)
- Southeastern Virginia Training Center (SEVTC)
- Southern Virginia Mental Health Institute (SVMHI)
- Southwestern Virginia Mental Health Institute (SWVMHI)
- Western State Hospital (WSH)

In previous years we have analyzed data from HDMC and SEVTC separately from the State Hospital data, as the populations of the facilities are drastically different. However, as the vast majority of Virginia’s Training Centers have closed, there are no comparable State-Operated DD facilities with which to compare that data. We understand that the facilities represented in this report have very specific and often disparate roles—such as CCCA and PGH, which serve opposite age-specific populations. We have taken these variances into consideration during our analysis and have avoided making comparisons between dissimilar facilities as much as possible. When we have excluded certain facilities from our analysis, we have stated which facilities and why. For further clarity, please be aware that charts with the following titles reflect the following facility makeups:

- Adult State Hospitals: CAT, CSH, ESH, NVMHI, PGH, SVMHI, SWVMHI, and WSH
- All State Hospitals: CAT, CSH, CCCA, ESH, NVMHI, PGH, SVMHI, SWVMHI, and WSH
- All DBHDS-Operated Facilities: CAT, CSH, CCCA, ESH, HDMC, NVMHI, PGH, SEVTC, SVMHI, SWVMHI, and WSH

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.

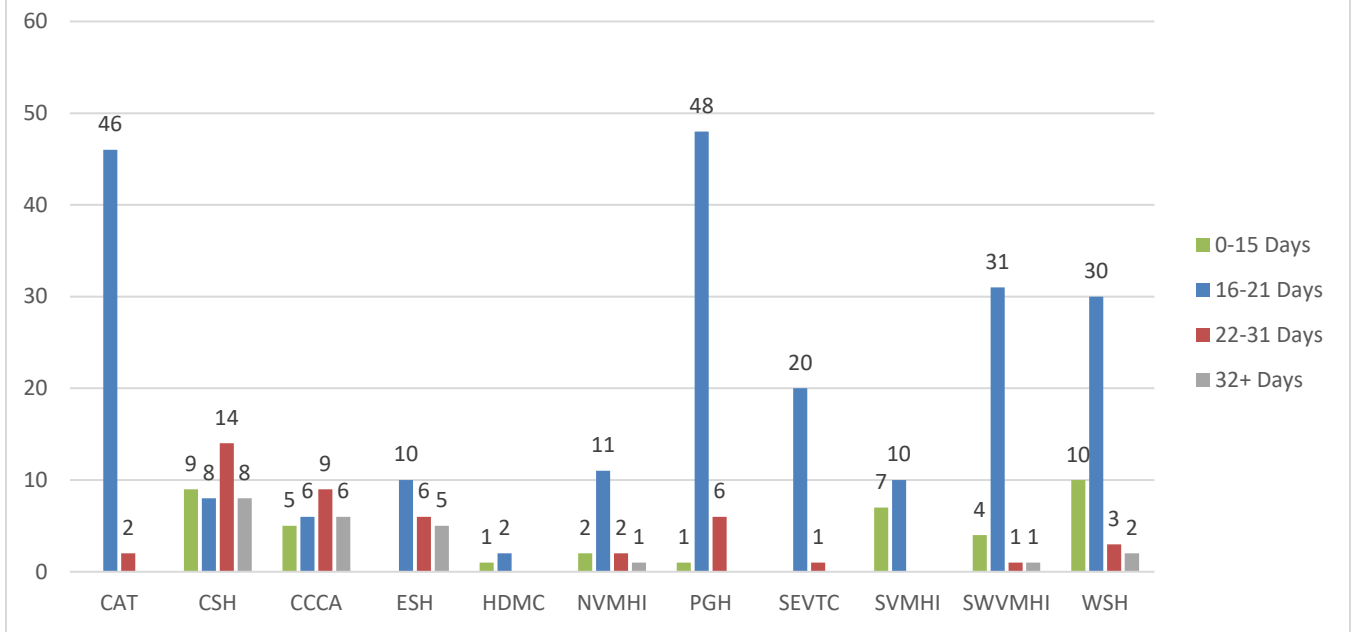
OVERALL REPORTING

In FY 20 CIR reporting increased substantially. DBHDS-Operated Facilities reported 362 Critical Incidents compared to last year’s total of 291 reports. Part of this increase can be attributed to the inclusion of HDMC and SEVTC data. It should be noted that, the combined 35 reports from HDMC and SEVTC make up less than half of the 71 report increase. The largest increase in the data set was WSH, which reported only 7 incidents in FY 19, but reported 46 incidents in FY 20. WSH’s increased reporting does not represent an increase in incidents, but improved reporting. This is corroborated by discussions with WSH leadership and a number of additional late reports sent for incidents that occurred during FY 19 (these are not included in this data set).

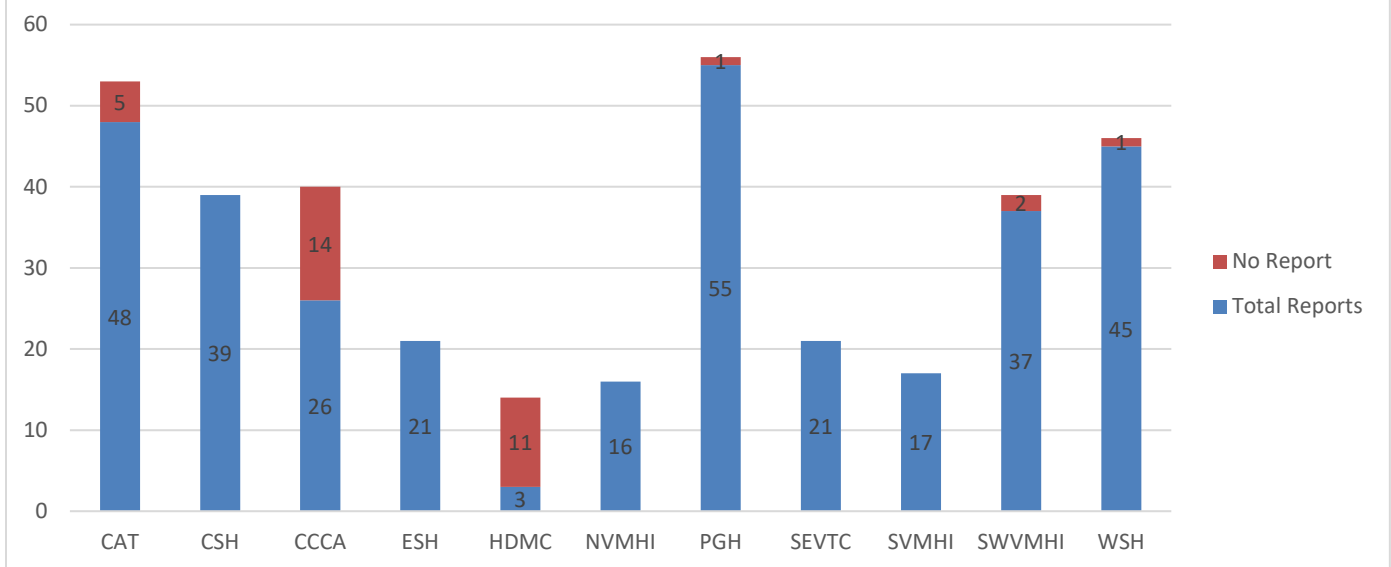
PGH reported the greatest number of incidents in FY 20 (56), followed by CAT (53). Both of these facilities are relatively small, but serve significant geriatric populations. The large number of reports from these facilities appears to be a combination of diligent reporting and higher acuity of injuries. Additionally, both facilities had significant COVID outbreaks that, in the case of PGH, lead to a sizeable number of deaths.

Reporting by ESH raised significant concerns, both in the quality and quantity of reports. The reports from ESH that dLCV received in FY 20 were almost universally lacking in meaningful detail. Also, while ESH is the Commonwealth’s largest State Psychiatric Hospital, with just over 300 beds, they reported only 21 incidents during FY 20, despite reporting 40 incidents the previous year.

Number of Days Between Discovery Date and CIR 15-Day Report at All DBHDS-Operated Facilities FY 20



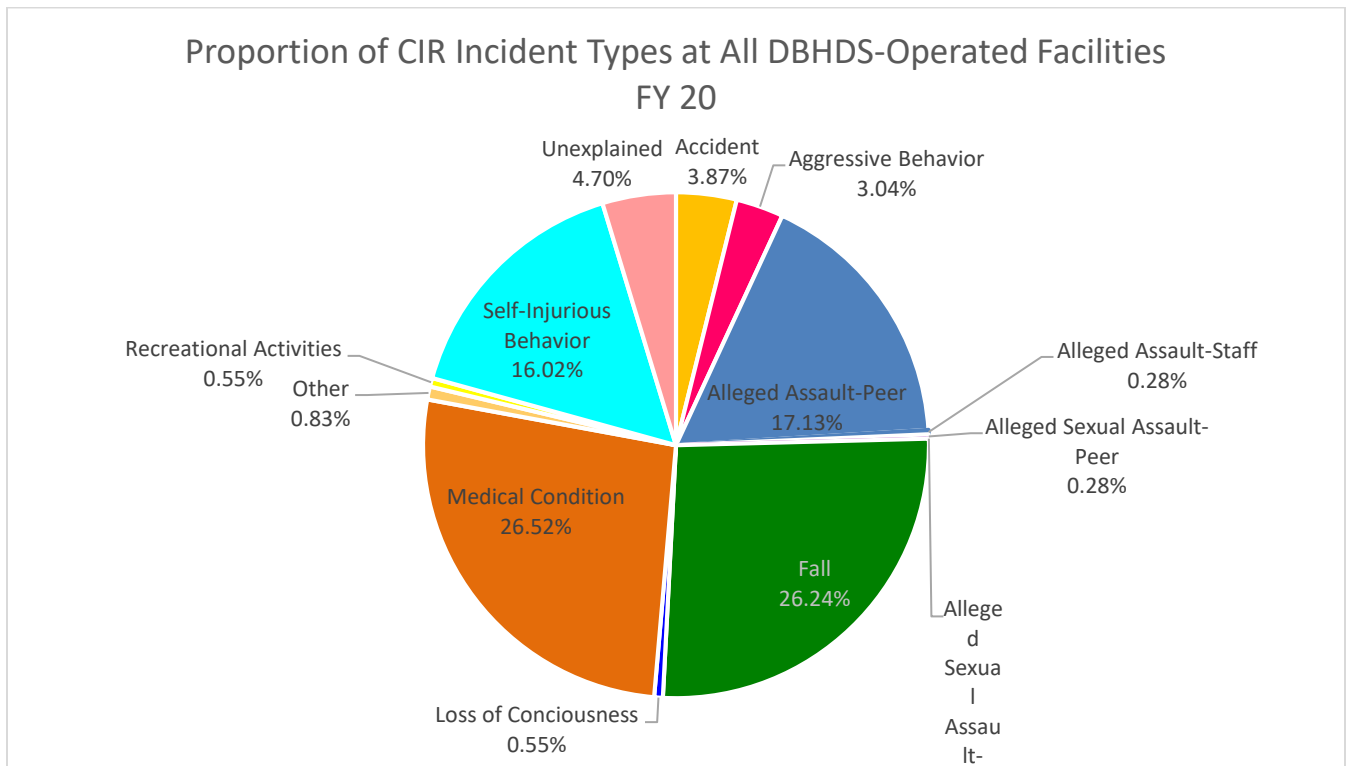
Number of 15-Day CIR Reports Submitted or Not Received for All DBHDS-Operated Facilities FY 20



DBHDS-Operated Facilities had far less reporting compliance in their follow-up reports. 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 facilities submitted their

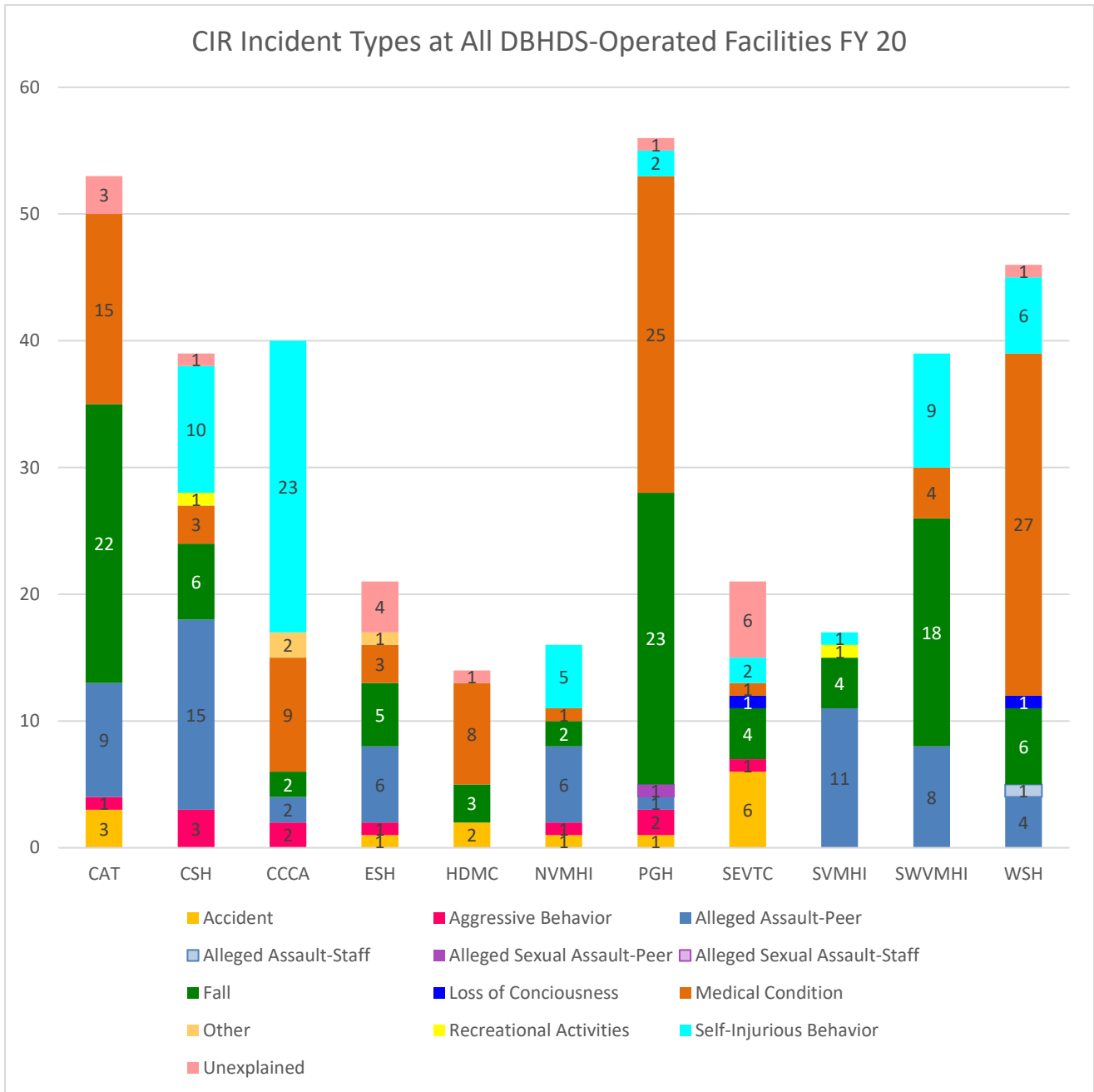
follow up reports in a timely manner during FY 20. CSH, for the second consecutive year, submitted the greatest number of delinquent reports, with 22 of CSH’s 39 reports being submitted after 22 calendar days. CCCA and HDMC both failed to submit follow-ups for a significant number of reports.

INCIDENT CATEGORIES



The most notable aspect of the FY 20 data is the high incidence of injuries attributed to “medical conditions.” The proportion of incidents attributed to medical conditions increased 11% from 15.46% in FY 19 to 26.52% in FY 20. For context, hospitals only reported 45 “medical condition” incidents last year, compared to 96 this year. This overwhelming increase was driven by two primary factors: better reporting and COVID-19. As WSH improved their reporting, they sent us 27 reports concerning medical conditions that required medical care, but were not the result of an injury. Additionally, hospitals submitted many reports detailing the extensive medical care that COVID-positive patients received. Tragically, a significant number of these included deaths were due to COVID-19.

The prevalence of incident types shifted in other areas as well. For the first time since dLCV’s analysis began, DBHDS-Operated Facilities reported a greater number of medical conditions than falls. Falls still made up 26.24% of incidents—a slight increase from 24.47% in FY 19. The proportions of incidents attributed to peer assaults and self-injurious behaviors (SIB) decreased slightly in FY 20 (with each category making up 18.56% of all incidents in FY 19, compared to FY 20 when SIB made up 16.02% of reports, and peer assaults made up 17.13% of reports).



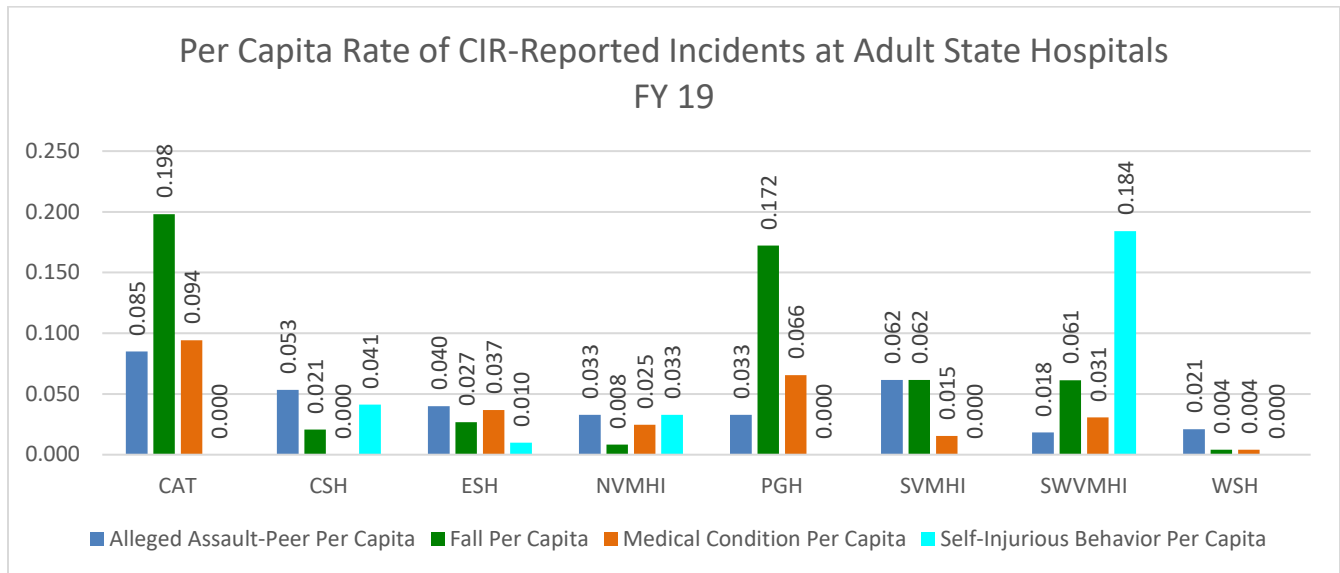
Falls were most common at facilities with geriatric populations, particularly CAT, PGH, and SWVMHI. This is consistent with previous years' data. The distribution of incidents involving medical conditions changed dramatically since FY 19. The above graph shows that WSH reported the most medical conditions (27), followed by PGH (25) and CAT (15). Strangely, ESH, which has geriatric units and has had COVID outbreaks in the last year, reported a decrease in medical conditions, from 11 in FY 19 to 3 in FY 20.

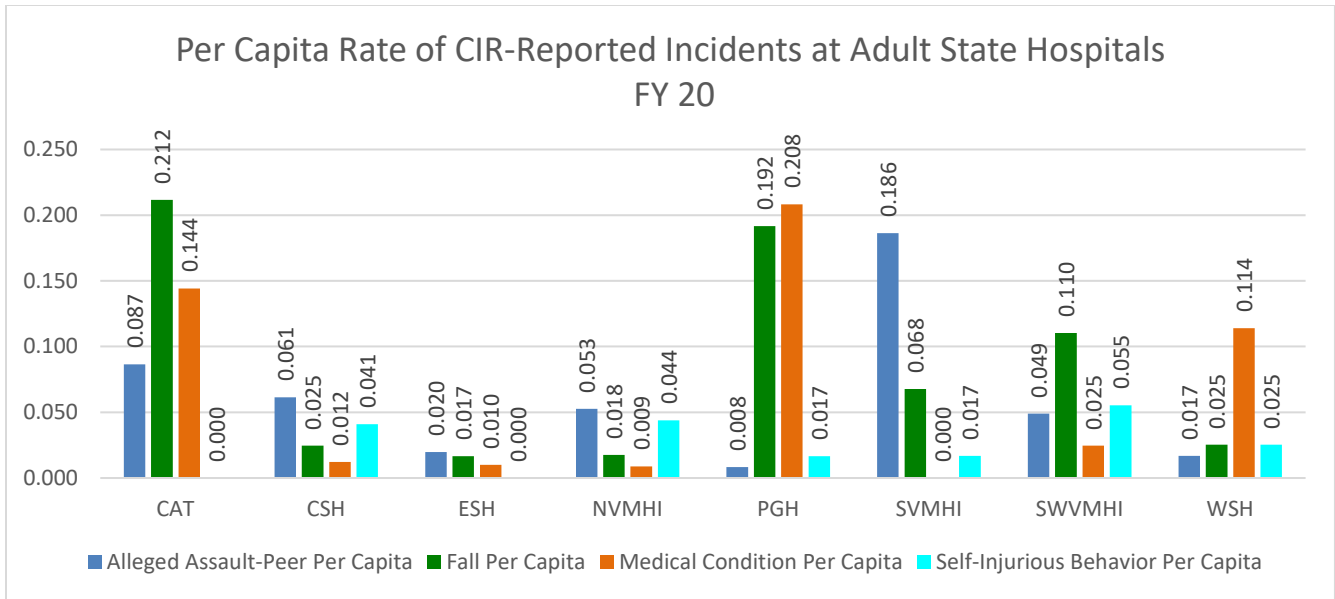
SIB continues to be a problem, but the facilities that reported the greatest amount of SIB shifted during FY 20. During the last two FYs, CSH, CCCA, and SVMHI have reported the greatest number of SIB incidents; while the number of SIBs reported by CSH in FY 20 (10) is consistent with last year (10), CCCA reported substantially more

SIB in FY 20 (23 incidents, compared to 7 in FY 19), and SVMHI reported substantially fewer SIB incidents (9 in FY 20, compared to 30 in FY 19). The rise in SIB at CCCA is disheartening, but is consistent with its small, acute, adolescent population. The sharp decrease in SIB incidents at SWVMHI is encouraging, and should be explored in greater depth to identify best practices.

Peer-to-peer incidents remained prevalent at CSH in FY 20 (15 incidents, compared to 13 in FY 19), but dropped sharply at ESH (6, compared to 12 in FY 19). Given that ESH has a long history of poor reporting and reported drastically fewer incidents in FY 20 overall, we do believe that this drop in peer assaults is at least partially the result of poor reporting on their part. Meanwhile, the number of peer-to-peer incidents at SVMHI and SWVMHI increased considerably during FY 20. dLCV has been aware of this trend, which is corroborated by anecdotal evidence, and will use this data to continue informing monitoring efforts.

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 19 and FY 20. We exclude CCCA because its uniquely small population and high bed turnover can lead to misinterpretation of the data, and excluded HDMC and SEVTC, because DBHDS did not give us reliable census data during FY 20.



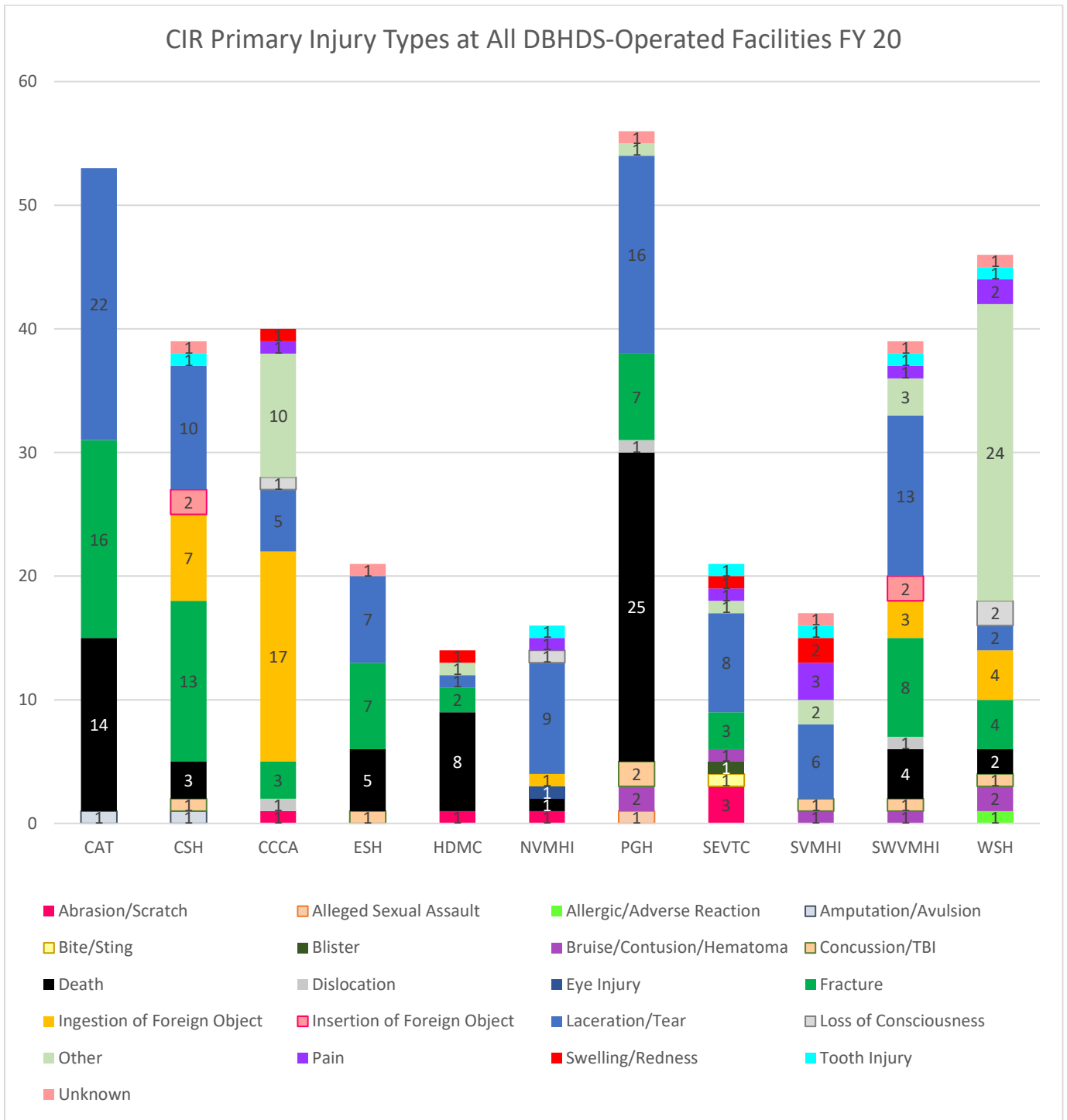


As we previously discussed, the number of injuries attributed to medical conditions rose sharply during FY 20; this trend was further reflected in the *per capita* data. The rate of medical conditions rose most sharply at PGH (from 0.066 *per capita*, or about 7%, to 0.208, or about 21%) and WSH (from 0.004 *per capita*, or about 0.4%, to 0.114, or about 11%). The rate of injuries attributed to medical conditions also increased at CAT (from 0.094 *per capita*, or about 9%, to 0.144, or about 14%) and CSH (from zero incidents to 0.012, or about 1%), though not nearly as dramatically. Surprisingly, the *per capita* rates of incidents involving medical conditions at all other facilities decreased in FY 20, despite all facilities reporting at least one COVID-19 outbreak.

Notably, the *per capita* rates of peer assaults increased at most facilities during FY 20. The greatest increase by far was at SVMHI, where peer-to-peer incidents tripled, from 0.062 *per capita* in FY 19, or about 6%, to 0.186, or about 19% in FY 20. PGH, WSH, and ESH reported slight decreases in peer assaults during FY 20.

SIB incidents were largely stable across facilities, with small increases reported at NVMHI, PGH, SVMHI, and WSH. The rate of SIB at SVMHI decreased substantially, from 0.184 *per capita* in FY 19, or about 18%, to 0.055, or about 6% in FY 20.

INJURY TYPES



The injury types most reported by DBHDS-Operated Facilities in FY 20 were somewhat consistent with those reported in FY 19. Most of the injuries reported by facilities in FY 20 were lacerations and skin tears (99 total, or

27.35% of all injuries), followed by fractures (63 total, or 17.4%) and deaths (62 total, or 17.13%)¹¹. Both Laceration/Tears and deaths saw numerical and proportional increases from FY 19: both increased by about 3%, with lacerations increasing from 72 to 99, and deaths increasing from 43 to 62. Meanwhile, the proportion of fractures decreased slightly, from 18.9% in FY 19 to 17.4%, despite a numerical increase from 55 total in FY 19 to 63 in FY 20, due to increased reporting overall.

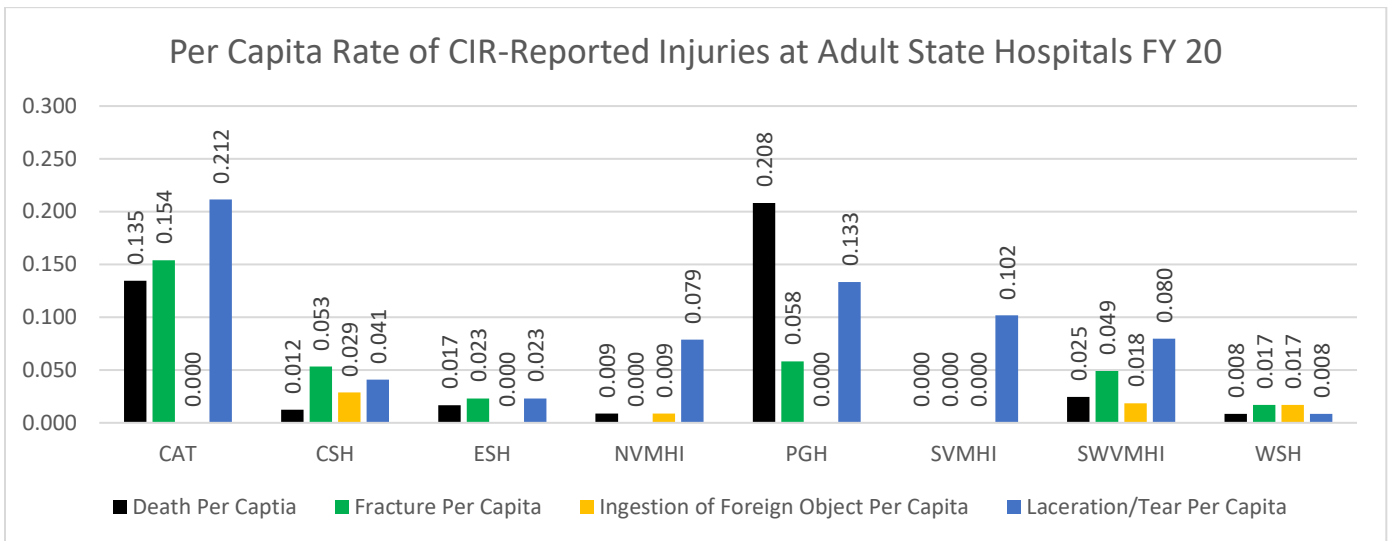
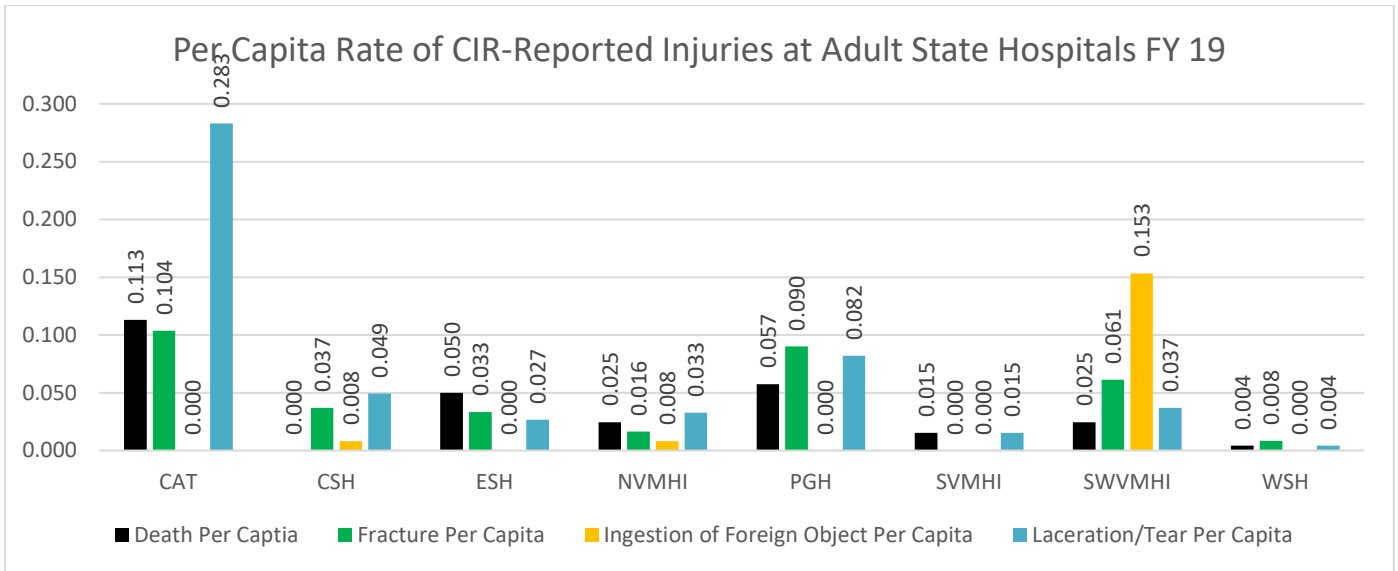
Most notably, the number of deaths increased across facilities. At PGH in particular, deaths nearly quadrupled in the last year, from just 7 in FY 19 to 25 in FY 20. This increase was driven largely by deaths associated with COVID-19 outbreaks at PGH, where the virus proved far more lethal than at any other DBHDS facility. Deaths also increased slightly at CAT and CSH, while staying the same or decreasing at every other facility that was counted in FY 19 (HDMC also reported a substantial number of deaths, 8, in FY 20, but was not included in FY 19 data). The decrease in deaths at ESH was quite stark—from 15 incidents in FY 19 to just 5 in FY 20. It is unclear why this number decreased so significantly; dLCV will speak with ESH leadership to examine the decrease and any related best practices.

As stated previously, the number of incidents resulting in lacerations increased considerably in FY 20, particularly at NVMHI (from 4 to 9), PGH (from 10 to 16), SVMHI (from 1 to 6) and SWVMHI (from 6 to 13). CAT, meanwhile, saw a moderate decrease in lacerations, from 30 in FY 19 to 22 in FY 20; CAT's decrease in lacerations coincided with an increase in fractures, leading to concerns that the level of injury acuity at that facility is increasing.

We can also see considerable increases in the number of foreign object ingestions at CSH, CCCA, and WSH during FY 20. In particular, the number of ingestions at CCCA increased from just 2 in FY 19 to 17 in FY 20. At the same time, we saw an astronomical *decrease* in the number of ingestion episodes at SWVMHI, from 25 in FY 19 to 3 in FY 20.

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

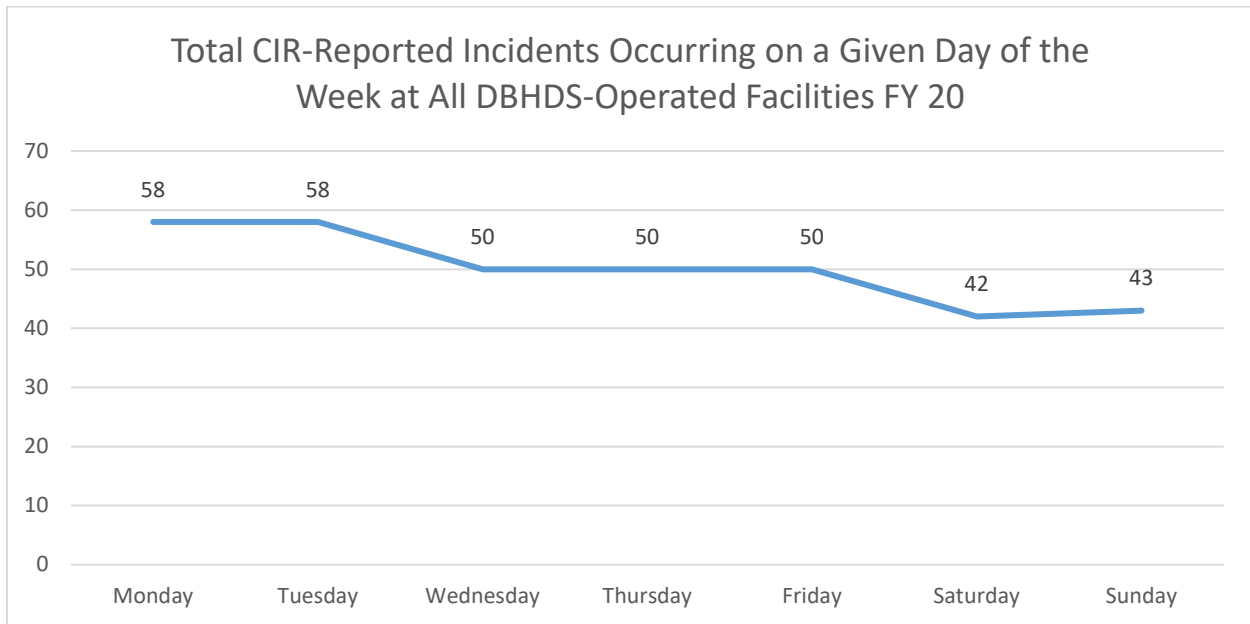
¹¹ In FY 20, ESH and HDMC both reported on the death of one individual, who was originally an ESH resident, but was transferred to HDMC for intensive nursing care. As the purpose of this report is, in part, to evaluate the quality of reporting, we have chosen to include both reports in the data set.



We can best understand the increase in deaths at PGH by examining *per capita* injuries, which show that the rate of deaths at PGH increased markedly in FY 20, from .0057 *per capita*, or about 6% (which was already relatively high), to 0.208 *per capita*, or about 21%².

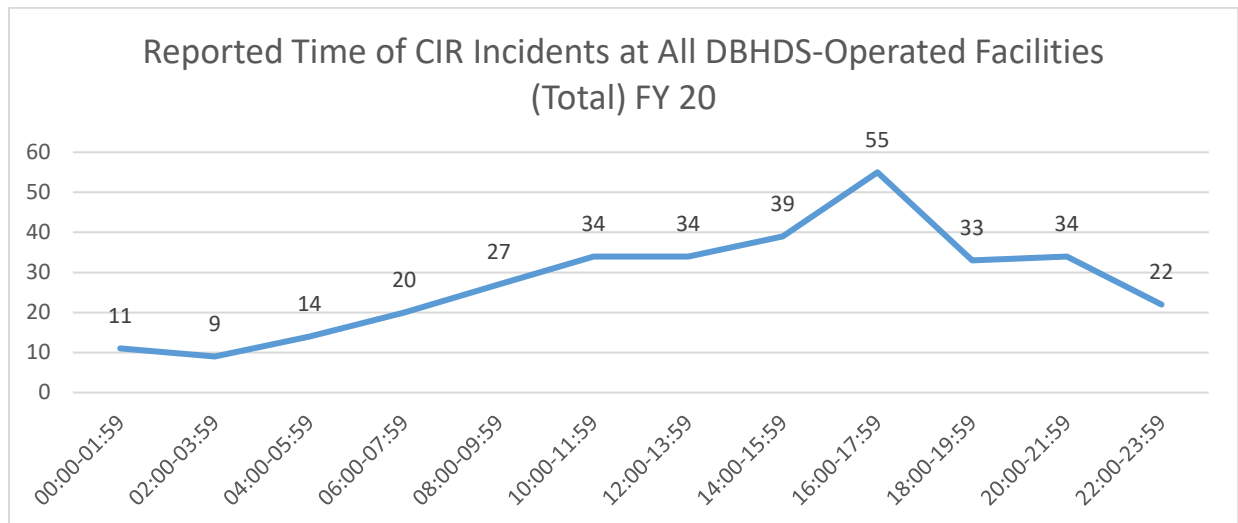
² See page 13 for more information on deaths.

TIMING OF INCIDENTS

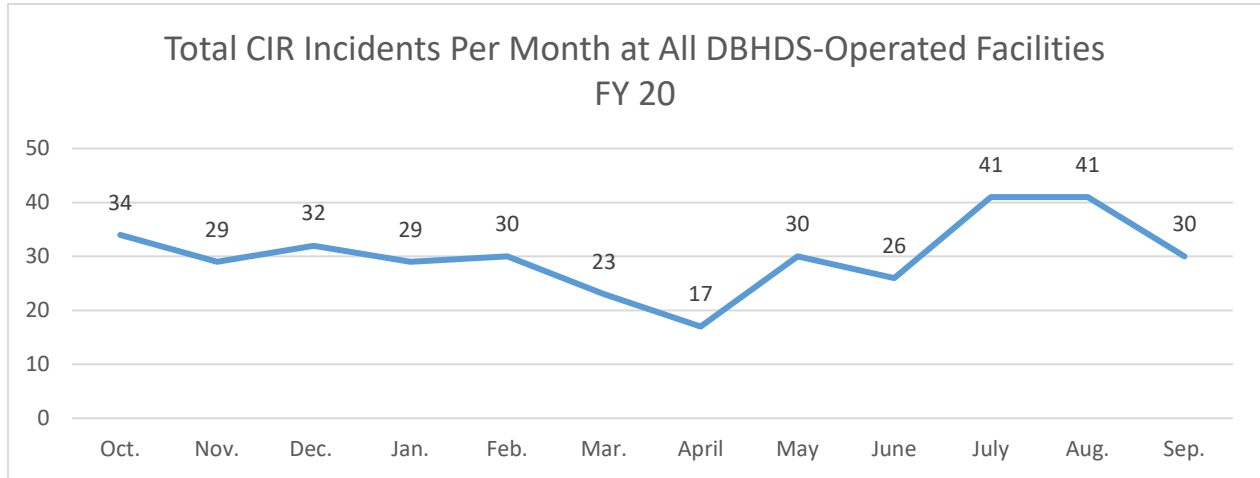


Facilities reported the greatest number of injuries on Mondays and Tuesdays (58), with the fewest number of incidents occurring on weekends (42 on Saturdays and 43 on Sundays). This pattern is fairly consistent across all facilities, which raises a concern: with fewer staff present on weekends and fewer structured activities, wouldn't we expect to see an increase in incidents during the weekend?

One reason for this pattern may be reporting culture. While facilities are expected to report an "incident date" as the date on which the incident occurs, some facilities appear to report this field as the discovery or report date. This practice is more evident when examining the time of day at which injuries occur, when unobserved or unexplained injuries are routinely ascribed a specific time. It seems likely, then, that incidents occurring on the weekend are being reported at the beginning of the week, leading to an artificial "bump" in incidents occurring on Mondays, and an artificial "slump" in weekend reporting.



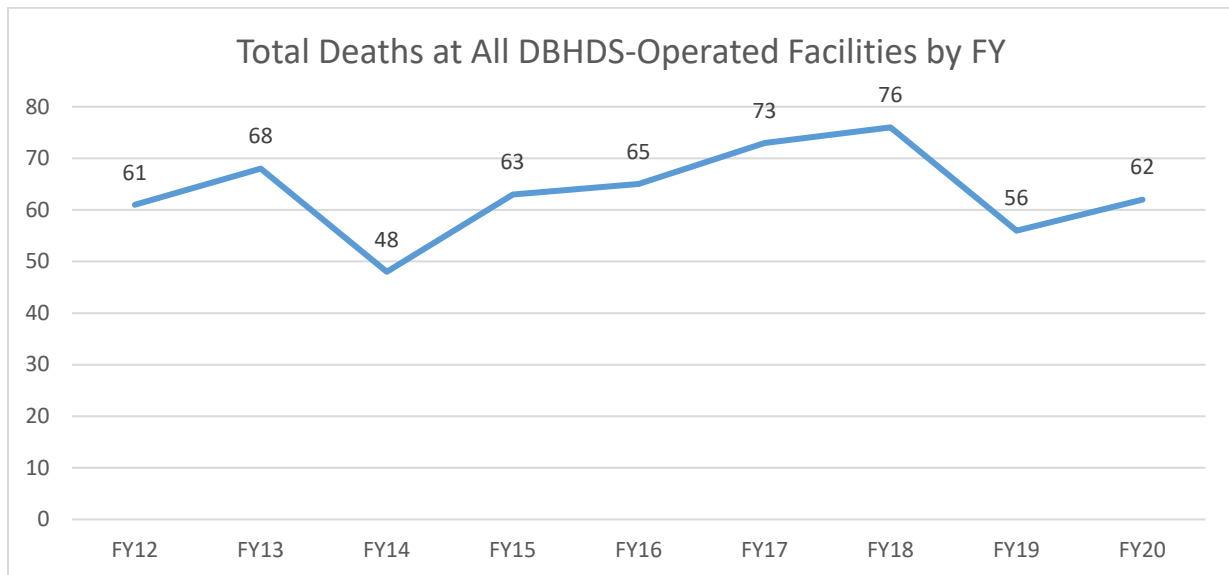
As expected, most incidents were reported during periods of higher activity, such as lunch and unstructured leisure times. There was a notable spike in incidents occurring between 16:00 and 17:59, which appears to have been largely driven by an unusual number of incidents occurring at CAT and SWVMHI during this time period. dLCV will use this data to inform our monitoring efforts.



FY 20 CIR reporting peaked in July and August (41), with the fewest reports coming in April (17). While a spike in incidents during the summer months is consistent with previous years' data, the drop in incidents during the spring is anomalous. The precipitous decline in incidents during March and April coincides with the onset of the COVID-19 pandemic; most facilities began suspending programming and isolating units during this period of time, which appears to have led to a temporary drop in incidents.

DEATHS

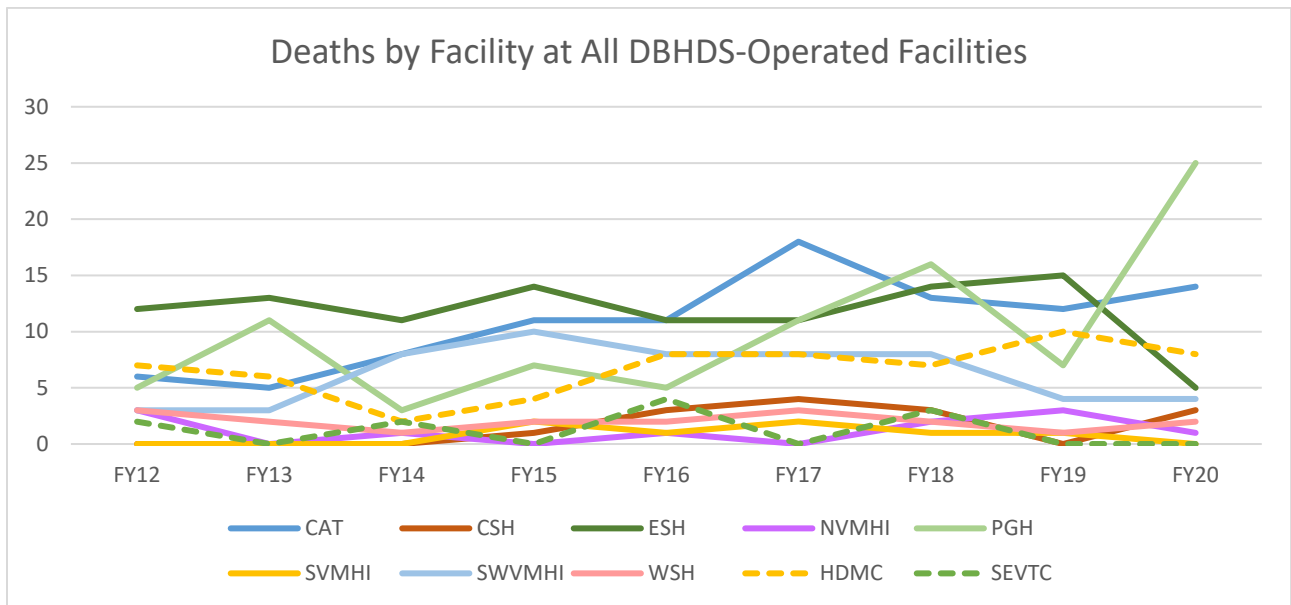
TOTAL DEATHS



In FY 20, the number of deaths across DBHDS-Operated Facilities rose somewhat from the previous drop between FY 18 and FY19. While the number of deaths in FY 20 has not reached FY 18 levels, the rise is deeply concerning.

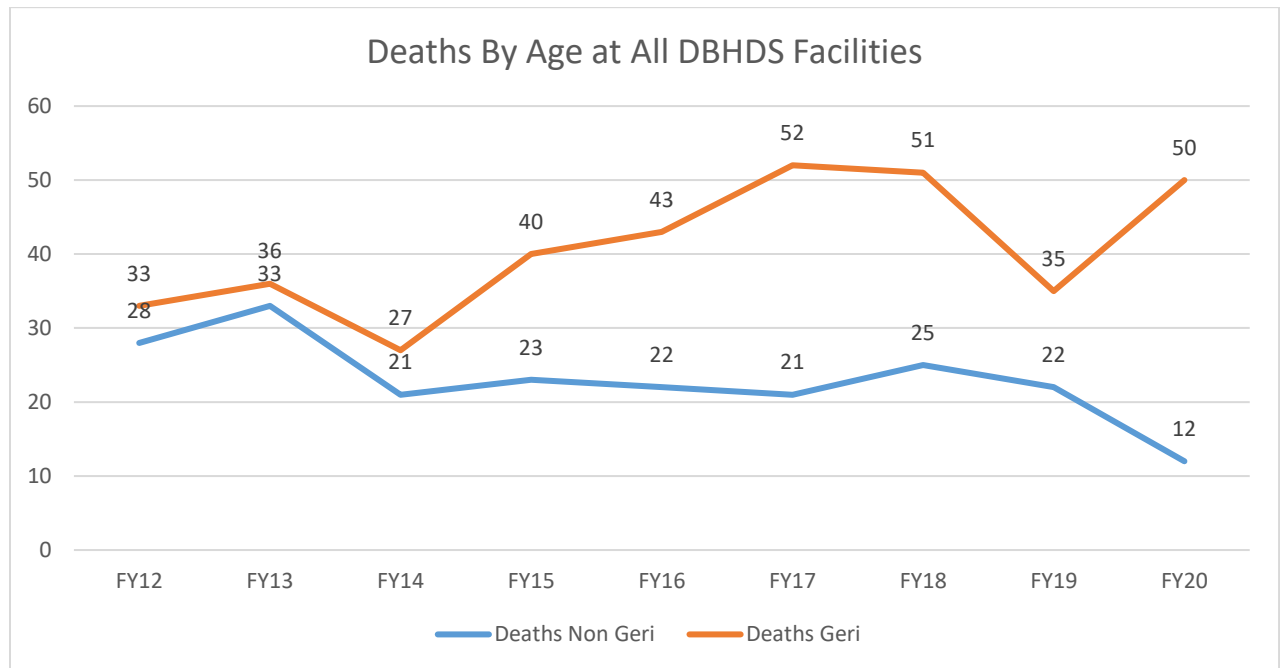
It should be noted that the above graph references deaths across All DBHDS State Hospitals, Training Centers and HDMC, and that part of the decrease in deaths has simply been the result of training center closures, and fewer people residing in DBHDS facilities.

Please note that CCCA is not included in our analysis of deaths because they have not reported any patient deaths during the data collection period.



The facilities recording the greatest number of deaths were PGH, CAT and HDMC (25, 14, and 8 respectively). In FY 20, PGH reported more deaths than any facility in at least the last 8 years. PGH was the only facility to clearly report COVID-related deaths during FY 20, with 7 of their 25 reports being due to or concurrent with COVID-19 infection. While COVID-19 clearly played a large role in the number of PGH deaths in FY 20, the number of non-COVID deaths they reported is still remarkably high. PGH reported 18 deaths that were either not related to COVID-19, or not identified as such in the CIR reports; 18 deaths is still higher than the number of deaths they reported in any other FY over the last 8 years, and it is equivalent only to the number of deaths reported by CAT in FY 17 (the previous high water mark in facility deaths).

DEATHS BY AGE

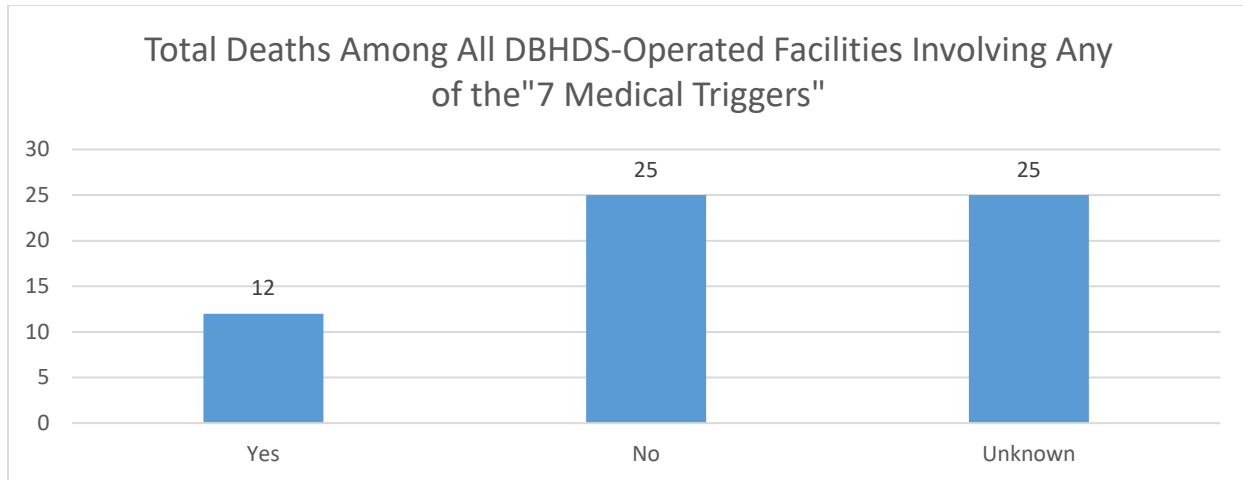


In FY 20, the number of geriatric deaths increased dramatically, following a drop in FY 19. While deaths increased overall in FY 20, the number of deaths among individuals under 65 decreased to just 12 individuals (19% of deaths). This is the lowest number of non-geriatric deaths recorded in the 8 years that dLCV has been tracking this data.

CAUSE OF DEATH

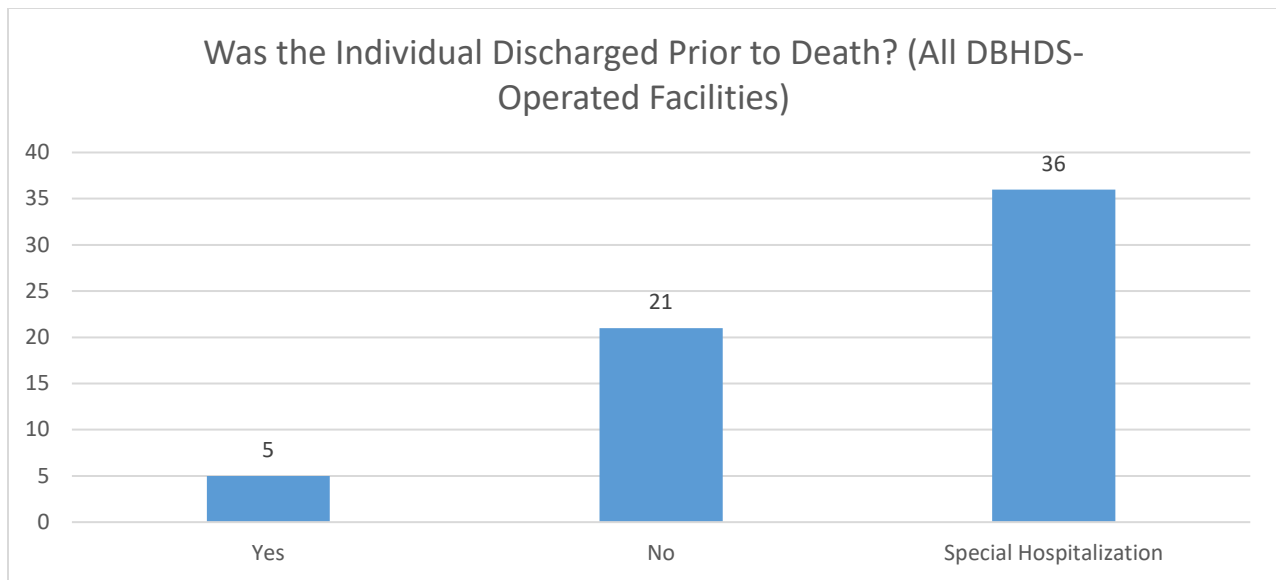
Incidents preceding death at DBHDS-Operated Facilities are most often coded as “Medical Condition.” Medical Conditions made up 59 of the 62 deaths (95%) reported by DBHDS-Operated Facilities in FY 20. While this designation appears to be largely accurate, facilities use “Medical Condition” to describe a vast array of conditions. In at least two cases, facilities used “medical condition” to describe deaths due to injuries sustained in earlier falls. It is true that a subdural hematoma is a medical condition, but classifying nearly all deaths as “medical conditions,” regardless of what the medical condition was or where it originated, creates a monolith devoid of nuance that is very difficult to analyze quantitatively.

While it is true that the narrative of these reports is intended to provide this nuance and give greater context to incidents, the narratives are not reliably doing so. Some facilities provide so little information in both their initial and follow up reports that it is impossible to determine why an individual actually died, or whether the death was expected, in spite of the statutory requirement to provide all known details in the 15 day report.



We attempt to review all death reports and determine whether certain common but preventative conditions, often called the “7 Medical Triggers,” were present. In 25 of the 62 reports (40%) we could not determine whether or not deaths involved the “7 Medical Triggers.”³ This is actually an improvement over FY 19 data, when 53% of deaths included too little detail to determine whether they involved the “7 Medical Triggers.” It should be noted, however, that incidents in which individuals were found to have COVID-19 were automatically classified as *not* involving medical triggers, because these reports often did not include further detail, despite Aspiration Pneumonia and Sepsis being common among patients with severe cases of COVID-19.

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 sharp increase in the number of deaths occurring after facilities “discharged” an individual to a medical hospital. This tendency to discharge individuals to medical hospitals, rather than placing the individual on special hospitalization, was strongly correlated to a facility’s

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

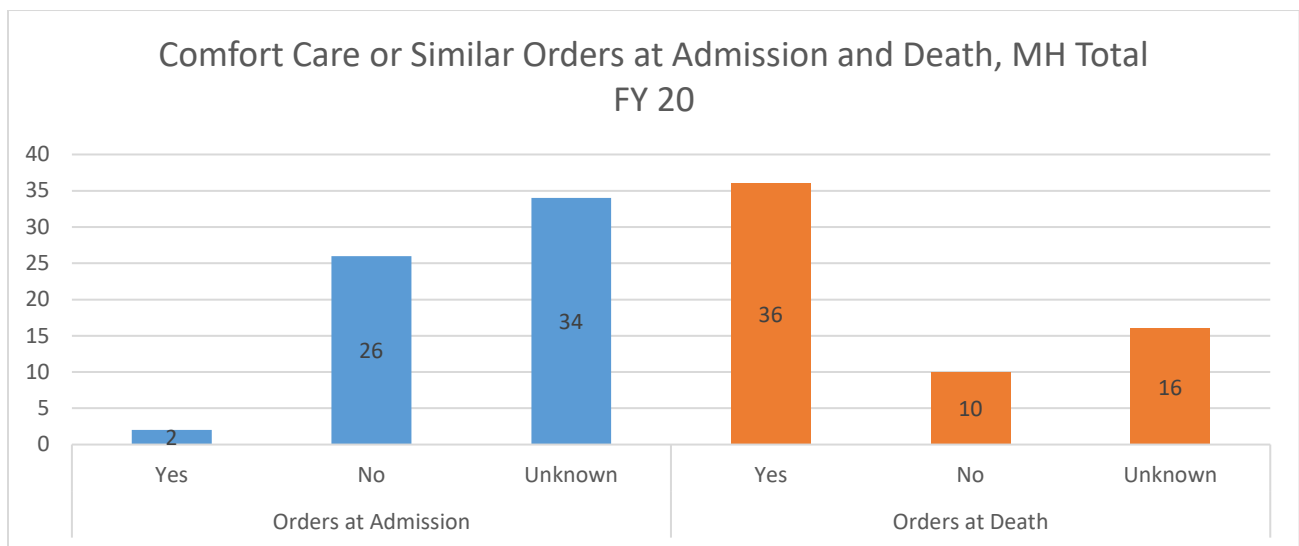
specific culture, rather than the individual’s actual medical needs or condition. In response, we included all discharges to inpatient hospitals with our special hospitalization, to better reflect the level of care required, rather than a facility’s bureaucratic practices.

With this minor change, we can see a very substantial proportional increase in deaths occurring during Special Hospitalization. The rate of deaths during special hospitalization has increased consistently every year since FY 18 (from 12 or 20% in FY 18, to 15 or 35% in FY 19, to 36 or 58% in FY 20). This increase corroborates our long-stated concerns about individuals with complex medical needs being admitted to DBHDS facilities (and Psychiatric Hospitals in particular). The fact that 80% of these deaths were of individuals over 65 suggests that these medically complex individuals are disproportionately geriatric.

DDNRs, DNRs, COMFORT CARE, AND PALLIATIVE CARE ORDERS

In FY 19, dLCV began tracking data on deceased individuals’ Durable Do Not Resuscitate Orders (DDNRs), Do Not Resuscitate Orders (DNRs), Comfort Care, and Palliative Care orders⁴ at the time of their admission and the time of their death. While we understand that DDNRs, DNRs, Comfort Care Orders and Palliative Care Orders are all different, hospitals often use the terms interchangeably during reporting, and the presence of any one of these orders is usually a good indicator that a death is expected. Though not unique to terminally ill individuals in medical hospitals or the community, dLCV has seen a consistent effort by DBHDS-Operated Facilities to work with terminally ill patients and their families to implement DDNRs or DNRs.

In all but 2 cases, hospitals did not clearly note whether an individual was admitted with any type of Palliative Care orders. In two additional cases, PGH indicated that DDNRs were dated on the same day as the individual was admitted, but it was not clear whether these were completed shortly prior to admission, during admission, or if they were simply logged at admission, when PGH received them.



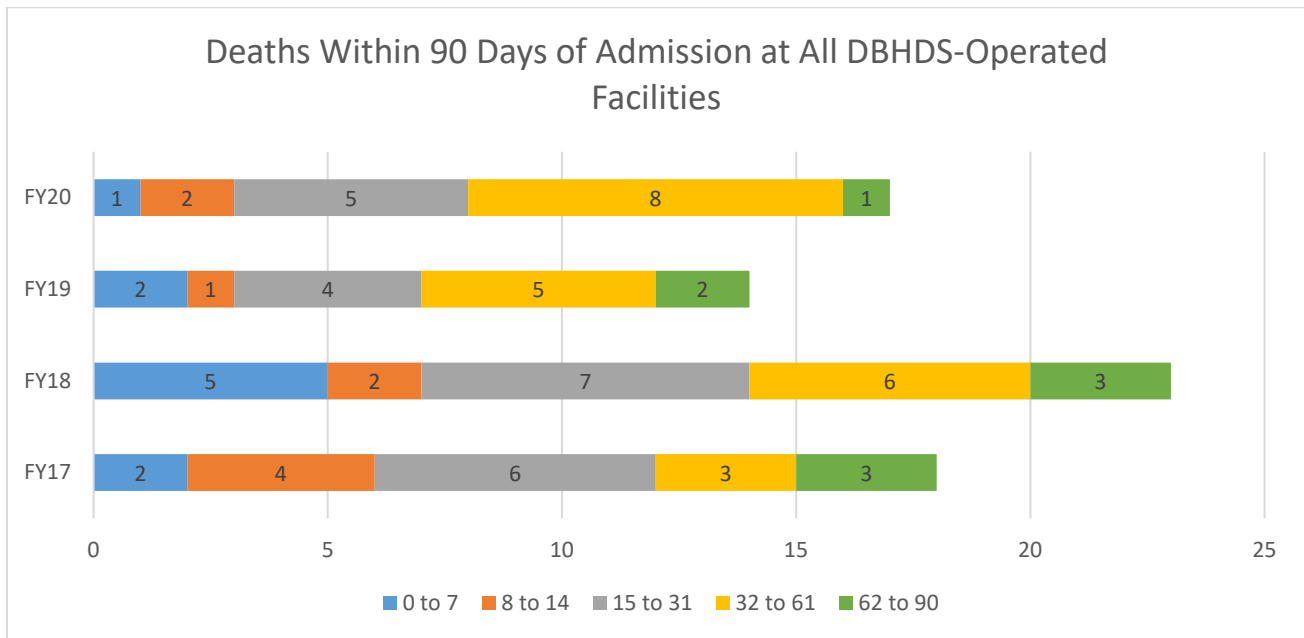
While it appears that most deceased individuals did not have DDNRs, DNRs, Palliative Care, or Comfort Care orders at admission, the majority of individuals (36, or 58%) certainly had these orders or instructions in place at the time of their death. This is one of our only concrete indications that these deaths may have been expected.

⁴ In looking at this data, we included any record of “DDNR,” “Do Not Resuscitate,” “Palliative Care,” “Comfort Care,” “Comfort Measures,” or “Hospice Care.”

The fact that it was not clear whether 16 individuals (25%) had some kind of palliative care order at the time of their death once again speaks to the poor quality of reporting by facilities.

dLCV also has significant concerns about who is consenting to these orders. In many cases, it is clear that consent was given by Authorized Representatives or other Substitute Decision Makers with no indication whether the actual patient was consulted, consented to, or even knew about the order. The potential for abuse by Substitute Decision Makers is tremendous in cases where the patients in question have not previously given end of life instructions. DBHDS facilities must endeavor to include individuals in every aspect of care, including end of life care. Resources for creating Advance Directives have also been available to State Hospitals for years, with almost none of them making long-term efforts to distribute these resources to residents.

PROXIMITY TO ADMISSION



Due to dLCV’s concerns about increasing “medically complex” admissions, we are tracking the number of deaths occurring shortly after admission. Please note that, due to earlier data irregularities, only our FY 20 data includes data from HDMC and SEVTC, though neither of these facilities commonly report deaths within 90 days of admission. It does not appear that including HDMC and SEVTC in our analysis impacted our review of Deaths within 90 days of admission in any meaningful way.

While the raw number of deaths occurring within 90 days of admission increased from 14 to 17 in FY 20, this actually represents a slight proportional *decrease* of all deaths within 90 days of admission making up 33% of all deaths⁵ in FY 19, compared to 27% in FY 20.

⁵ Excluding HDMC and Training Center Deaths

AREA OF CONCERN: PIEDMONT GERIATRIC HOSPITAL

In the past, dLCV has been reluctant to draw facility-specific conclusions from CIR data, however the data provided by PGH is too overwhelming to ignore.

First and foremost, PGH needs help. In FY 20, PGH reported 25 deaths, despite only having 123 licensed beds. If 1 out of 5 patients died at any other facility, it would be a front-page news story. Yet, because the deaths occurred across a year and only impacted geriatric people, they are considered somehow “allowable.” Even before the COVID-19 pandemic, PGH was woefully understaffed. In October 2019, dLCV staff interviewed PGH residents about patient care at the facility. While some patients reported no concerns, a significant number of the 36 residents we interviewed said that they were not able to access staff’s help for basic care needs. When asked how often/whether staff assist them with toileting, bathing, or changing, patients said the following:

“It has been as long as 9 hours [between toileting help].”

“[I] need helps but staff don’t supply helps [sic], so tries [sic] not to ask for help.”

“Once [I] had soiled clothes for 7 days.”

When asked how often staff help her bathe: “[they] give me a washcloth once or twice a week.”

“Staff don’t encourage showers, 1x a week, need appt. for shower. Hard to get and keep appt.”

“I don’t get baths or showers—[I] get bed baths once every couple weeks.”

“I don’t shower much. You have to arrange shower and it’s hard to do.”

“[Staff] couldn’t find pants for [me] last week, so just put a sheet over [my] lap”

We acknowledge that not all patients have complaints about their care, and realize that some residents’ diagnoses (including dementia) lead to less accurate reporting. However, the frequency and consistency of these reports raises significant concerns. In particular, a lack of consistent toileting assistance can lead to severe, sometimes fatal medical conditions, including Urinary Tract Infections, Bowel Obstructions, and Decubitus Ulcers.

One thing that is indisputable, is that PGH residents who are not independently mobile have no real way to alert staff when they are in distress. Unlike a medical hospital, PGH does not have any “call buttons” in any rooms. Their units are set up along very long, mostly concrete hallways. Often, due to staffing shortages, there will only be one “free” staff to monitor the hallway. Some patients are on routine 15-minute checks, but this far from universal. This means that a patient in distress must walk/ambulate down the hall to get staff (something that often leads to falls), or call out loud enough for staff to hear them and come help. dLCV has heard PGH residents attempt to call out for staff, and can attest to the fact that it’s extremely hard to hear someone in distress unless you are very close to their bedroom door. PGH residents in our survey had this to say about calling for staff:

“I have to wait until someone comes. They’ve been very negligent.”

“[I] call out, eventually someone comes in. [I] can’t count on them for help.”

“[I] have to yell which I find very disturbing.”

“Girls who change diapers [staff] do their best.”

"You can tell them [you need help] but they ignore you. Certain patients, they'll help."

"Staff [are] almost invisible, [I don't] want to get staff fired."

dLCV strongly believes that, to be able to serve its residents with an appropriate standard of care, PGH needs far more staff and major architectural changes, including the addition of "call bells." PGH leadership seems to understand this need and has attempted to make up staffing vacancies with staff retention efforts and the hiring of "temporary" nurses through various independent nursing services. While these efforts have helped, they have not solved the problem, as the data shows.

AREA OF CONCERN: EASTERN STATE HOSPITAL

In FY 20, we not only saw a continuation of ESH's poor reporting practices, but a stark drop in reporting overall. As the largest facility in our sample and as a facility with a significant number of geriatric patients, we would expect more reports from ESH. If this level of reporting was consistent with ESH's history, it would not be so concerning. However, ESH reported almost twice as many incidents in FY 19. While our greatest concern is ESH's quality of reporting, we plan on investigating the frequency of reporting moving forward.

Much has been written by both the Office of the State Inspector General and dLCV on the poor quality of reporting at ESH. Despite warnings and pleas from oversight agencies, ESH appears to have made no effort to improve the quality of their report narratives in FY 20. ESH's reports almost universally lacked clarity and were incomplete. For reference, here is a sampling of 3 random redacted report narratives in their entirety:

"Patient [redacted] fell forward from wheel chair resulting in laceration to area above right eyebrow. Patient was transported to [hospital] for further evaluation, 4 sutures were placed at [hospital] before returning to ESH. [Follow-up:] First aid applied at ESH, neuros initiated, transported to [hospital] where sutures were applied. Patient being escorted back to bedroom in wheel chair by staff. Patient being transported in wheelchair without leg rests."

"Patient [redacted] observed in bedroom unresponsive. Code medic alert called, CPR initiated, IM EPI administered x3, EMS notified and on unit at [time] took over CPR at [time], patient pronounced deceased at [time]. [Follow up:] Code medic called, CPR administered until EMS arrived on unit and assumed care. Patient was resting in bed following consuming breakfast meal. Patient had multiple medical comorbidities."

"Patient on unescorted off grounds pass, reported feeling light headed and falling onto curb. [Follow up:] Patient reported feeling light headed prior to fall, however was unable to remember further specific detail. Peer also on unescorted off grounds pass."

All three of these reports fail to explain the circumstances that led to the injury. They leave glaring questions unanswered: how does someone fall face-first out of a wheel chair while being pushed by staff? What medical co-morbidities did the individual have, and did ESH consider them to be terminal? Where was this individual taking passes and what injury did they sustain? While this is a relatively small number of reports, their lack of detail is representative of ESH reporting overall.

CONCLUSION

While our concerns about medically complex individuals being inappropriately placed in acute Psychiatric Hospitals remain, that concern was muddled in FY 20, due to the COVID-19 pandemic. Clearly, all hospitals, both public and private, are at increased risk for COVID-19 outbreaks due to their size and inability to provide isolation but, early in the pandemic, DBDHS facilities were doing relatively well. Unlike many private hospitals, DBHDS facilities do not have emergency rooms where admittees are likely to come into contact with infected individuals seeking medical help. DBHDS facilities had robust screening and testing protocols for staff and new admission. When facilities did begin having outbreaks, they were sometimes able to halt admissions until it was safe.

On the other hand, the pandemic appears to have caused more people—particularly geriatric residents—to get “stuck” in State Facilities, as nursing homes, assisted living facilities and even some apartments “froze” admissions. While these “freezes” were intended to protect people with disabilities, they ultimately trapped many of these individuals in DBHDS facilities that were not necessarily designed for medically complex individuals, and may not have been able to provide the appropriate level of care. It certainly appears likely that the pandemic delayed the discharges of a number of individuals who ended up dying at State Hospitals or while on special hospitalization. It is unclear how many ready-for-discharge individuals were affected, however, due to the opacity of DBHDS’s Extraordinary Barriers List⁶.

The data clearly shows that an increasing proportion of DBHDS patients are dying of long-term illnesses that strictly necessitate medical hospitalization—a service that DBHDS generally cannot provide. Though HDMC and SEVTC are generally accepted to be long term care facilities for individuals who (usually) have very complex medical conditions in addition to psychiatric or behavioral needs, this is not the case at the State Psychiatric Hospitals. The nature of some mental illnesses, as well as the complications of the NGRI (not guilty by reason of insanity) and URIST (unrestorably incompetent to stand trial) designations and processes do mean that some people will stay in State Hospitals for years. However, these conditions and designations apply to relatively few patients, and this is not the norm. DBHDS has an explicit responsibility to serve individuals in the least restrictive setting possible: a psychiatric hospital is the most restrictive setting in the DBHDS system. This is to say that we should not be seeing individuals staying in the hospitals for months or years—much less dying there. If this phenomenon was unique to FY 20, we could likely attribute it to COVID-19, but it has been a problem for years.

While a number of individuals did appear to die from sudden medical events, such as heart attacks or strokes, these individuals were in the minority. 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 real chance to succeed. State Hospitals are Psychiatric Hospitals; they are not Medical Hospitals. The COVID-19 pandemic has only served to make this impossible situation even worse. Many hospitals have been severely limited in their ability to send individuals out for non-emergency medical services that might mitigate the rate of deaths, or at least provide medical coverage the hospitals are unable to provide.

At this time, vague and inconsistent reporting limit dLCV’s ability to truly understand the conditions of DBHDS-Operated Facilities, which is a significant problem and a violation of Virginia Code. The Code of Virginia⁷ clarifies

⁶ DBHDS’s Extraordinary Barriers list does not include data on individuals at HDMC or SEVTC.

⁷ § 37.2-304. Duties of Commissioner, paragraph 7

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, many of the reports we receive and, in particular, reports from ESH do not include full and accurate information.

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.