Report on Critical Incidents in Virginia's State Operated Mental Health Facilities October 1, 2020 - September 30, 2021

Prepared by
The disAbility Law Center of Virginia
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Introduction

The disAbility Law Center (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 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 2021, dLCV received a total of 468 Critical Incident Reports from facilities 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). The high number of deaths—especially ones occurring soon after admission—has been a key concern that DBHDS has agreed to investigate. For the second year in a row, the number of deaths in state facilities has increased. During Federal Fiscal Year 2021 (FY 21), there were a total of 66 deaths, compared to 62 the previous year. Additionally, the number of deaths that occurred within 90 days of admission continues to rise.

Furthermore, there is an alarming number of people receiving palliative care, hospice care, or comfort measures and care who are dying in DBHDS state hospitals, or who die within days of being discharged to a medical facility. dLCV remains concerned that medically complex and terminally ill consumers are being served in State Mental Health Institutions, rather than in appropriate medical facilities.

DBHDS facilities have shown improvement in both the quantity and quality of critical incidents reported in FY 21. However, dLCV notes that issues remain regarding data integrity. While we are working to resolve these data issues it is important to emphasize that we believe the overall trends gathered from the data remain accurate.

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 2021 Federal Fiscal Year (FY 21).

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)
- Southeastern Virginia Training Center (SEVTC)
- Southern Virginia Mental Health Institute (SVMHI)
- Southwestern Virginia Mental Health Institute (SWVMHI)
- Western State Hospital (WSH)

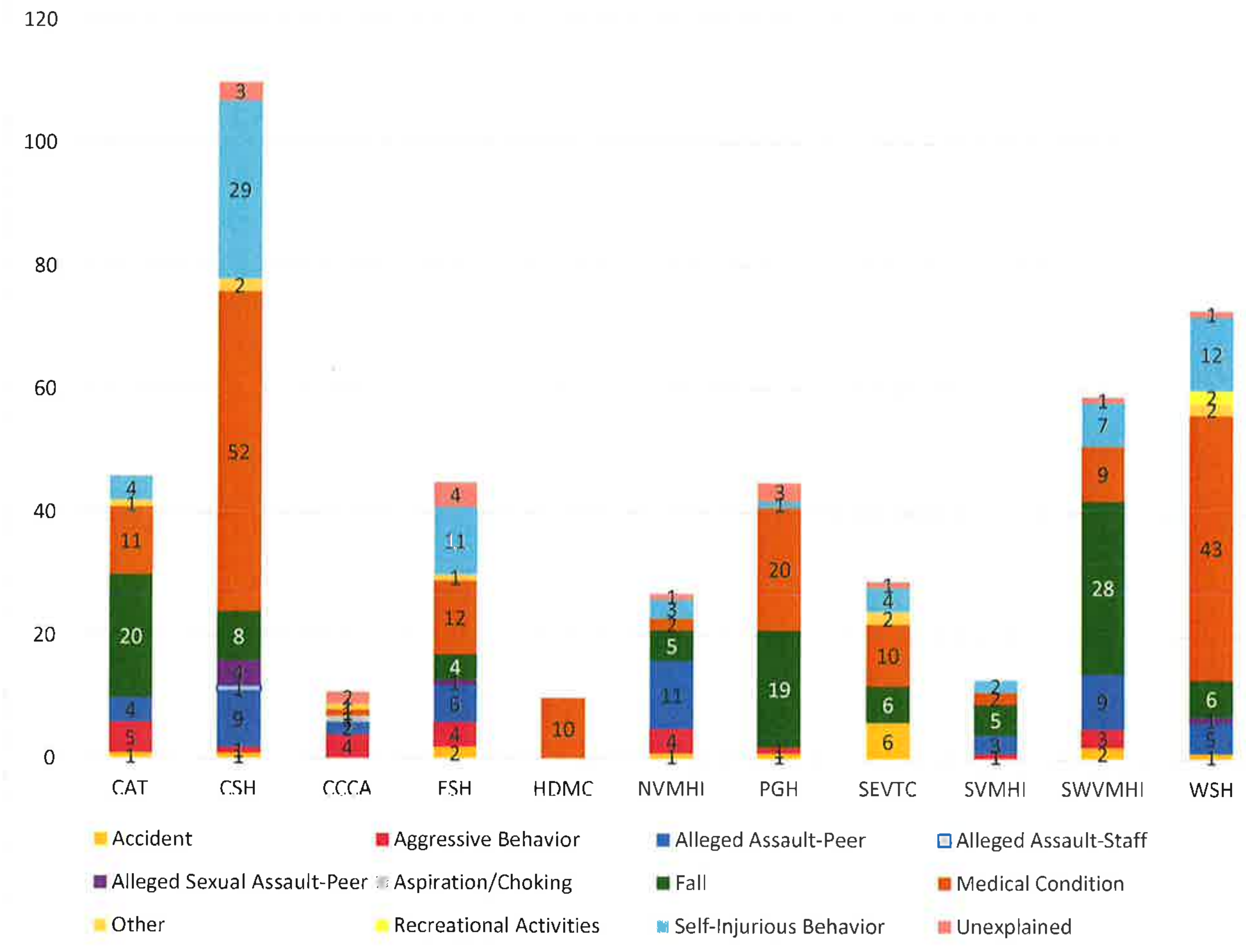
While CCCA and PGH serve age-specific populations, they are still designed to be mental health (MH) treatment facilities, rather than facilities for individuals with Developmental Disabilities (DD); for this reason, CCCA and PGH are compared with other State Hospitals for the majority of the report.

There are two State-Operated facilities included in the sample that are not primarily designated as MH facilities. SEVTC specifically serves individuals with DD and is not considered to be a hospital. HDMC serves both individuals with MH and DD, but primarily provides nursing and other medical care. We have included SEVTC and HDMC in the majority of the data analysis, except where the data specifically references "MH Facilities."

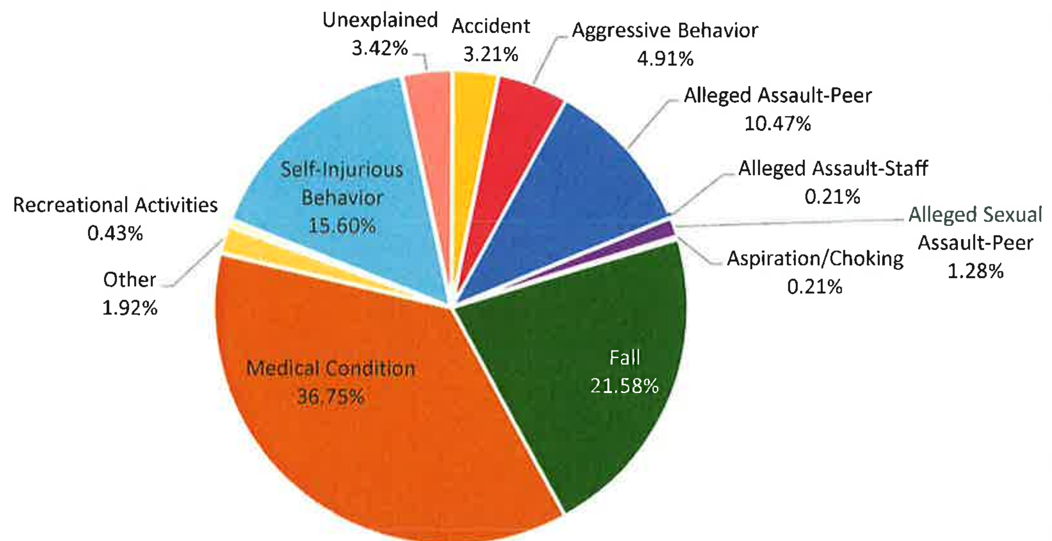
dLCV regularly monitors conditions in state facilities and responds to complaints from residents and consumers. dLCV reviews CIRs on a weekly basis and analyzes quantitative data from the reports to identify overarching trends. Qualitative and quantitative data from the reports inform dLCV's work in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

Incident Types and Reporting

CIR Incident Types at DBHDS-Operated Facilities FY 21



In FY 21, DBHDS-operated facilities reported 468 Critical Incidents. CSH reported the greatest number of incidents (110), followed by WSH (73). It is important to note that WSH has improved with regard to the frequency of their reporting. At first glance, it appears the number of CIRs at CSH is extremely high. However, nearly half of the CIRs reported by CSH (52) and over half of the CIRs reported by WSH (43) were medical conditions that the hospital reported voluntarily, but may not have been strictly required under state law. While medical conditions do not always have to be reported under Virginia Code, it is immensely helpful to have this logged somewhere. State Hospitals, unlike licensed community providers, do not report unexpected illnesses to DBHDS. This can result in less accountability. By voluntarily reporting medical and other incidents, State Hospitals add a level of transparency to their practices and better contextualize their services.



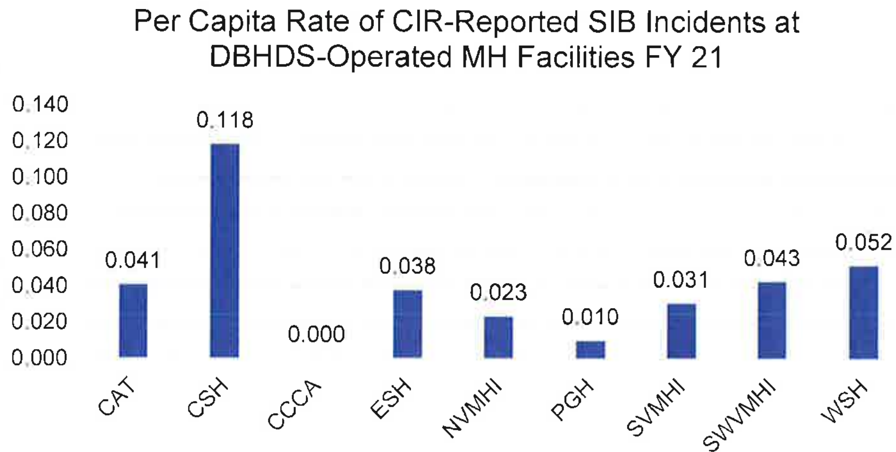
There was a significant increase in medical conditions reported across all DBHDS facilities, though, as we stated previously, some of these were voluntarily reported. In FY 21, medical conditions accounted for 36.75% of all incidents reported. For comparison, in FY 20 medical conditions accounted for only 26.52% of all incidents reported. Falls were the second most prolific incident type reported across all DBHDS facilities, accounting for 21.58% of all incidents reported. Although this number remains high, it has continued its downward trend since dLCV has been publishing CIR reports. Self-Injurious Behavior is the third most common incident type, accounting for 15.6% of all incidents reported.

Self-Injurious Behavior

Self-Injurious Behavior (SIB) may have made up only 15.6% of incidents in FY 21, but it is an acute category that deserves further scrutiny.

SIB was most common at large facilities with many court-involved residents. CSH reported the highest rate of SIB, with 29 instances, which made up 26.6% of all their FY 21 critical incidents. ESH reported 11 incidents of SIB, which made up 24.44% of their reports. WSH reported 12 instances of SIB, making up 16.44% of their reports.

When adjusted for population, we can see that the per capita rate of self-injurious behaviors is still exceptionally high at CSH (0.118 incidents *per capita*), but does not appear as prolific at ESH (0.038 incidents *per capita*) or WSH (0.052 incidents *per capita*).



While looking at the data is important to examining SIB at DBHDS-operated facilities, nuance and context are also important. At CSH in particular, it appears that the rate of SIB was largely driven by a small number of acute residents with multiple SIB episodes. It is also worth noting that CCCA, which usually reports a high number of SIB episodes, reported no instances of SIB in FY 21. It is unclear if this is due to an actual decrease in incidents or simply due to poor reporting practices, which we have cited in previous public reports.

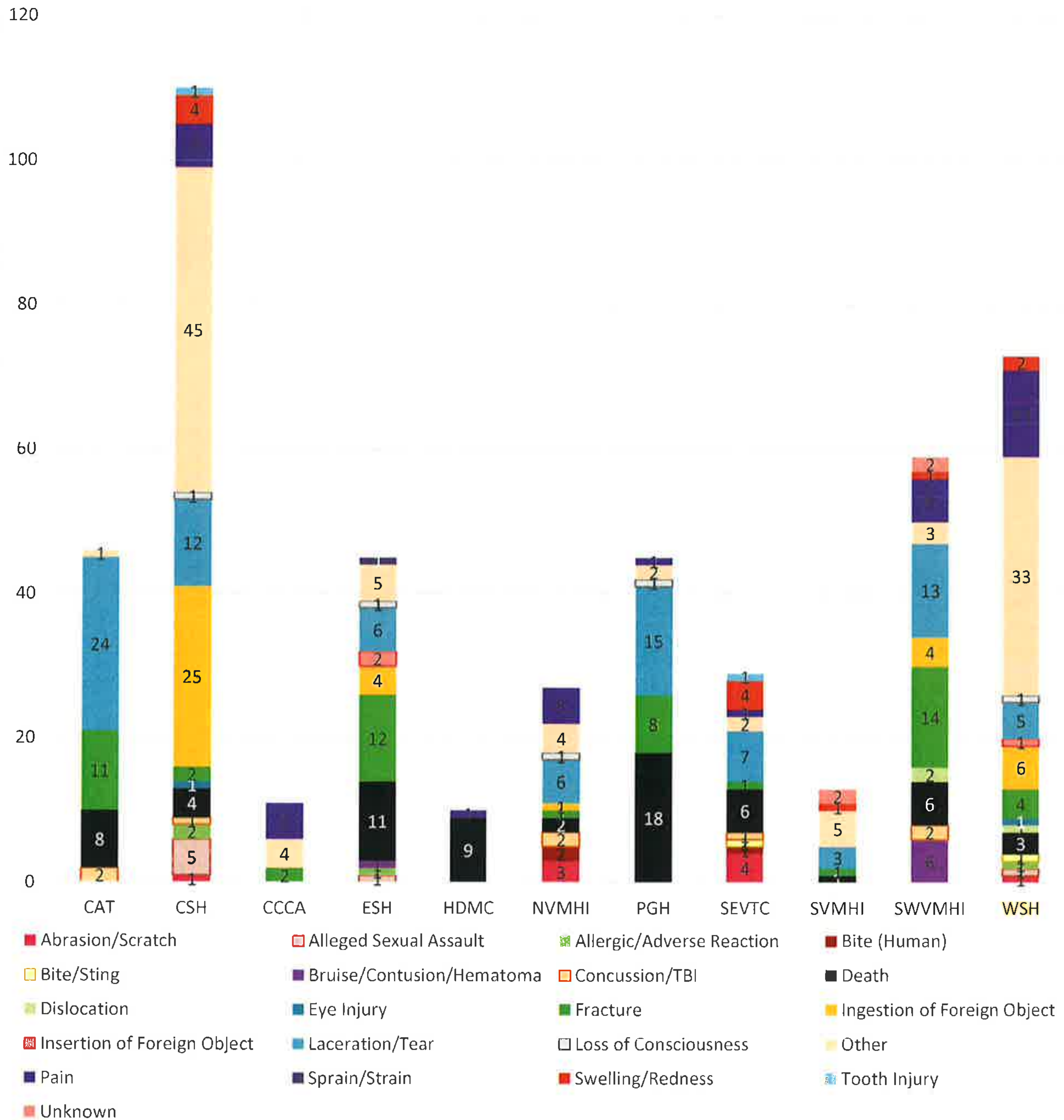
State Hospitals are currently allocating substantial resources to preventing SIB, in the form of increased staffing ratios for at-risk patients and environmental precautions. While the facilities should absolutely be taking steps to prevent SIB, dLCV wonders if their efforts might be at least partially misplaced.

The vast majority of individuals who engage in SIB as part of their clinical presentation have long histories of trauma. The link between trauma—particularly in childhood or young adulthood—and self-harm is well-documented. DBHDS has long given lip-service to the concept of Trauma Informed Care[1], training staff, and including the language and general principles of Trauma Informed Care in their daily practice. That said, dLCV has heard from countless residents that they rarely, if ever, receive individual therapies, that trauma-informed treatment modalities (such as Dialectical Behavioral Therapy) are not widely available, and that trauma triggers are often not documented, or are ignored during behavioral crises. Providing patients with meaningful Trauma Informed Care at a clinical level, specifically dialectical behavior therapy, would be essential in addressing high rates of SIB across DBHDS facilities.

[1] Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

Injury Types and Reporting

CIR Primary Injury Types at DBHDS-Operated Facilities FY 21



dLCV also monitors the types of injuries reported at all DBHDS facilities every year. Due to the increase in reporting of medical conditions during FY 21, the injury category labeled "other[2]" is unusually high. The "other"

[2] The Category "Other" is used to describe incidents in which an individual was impacted with physical symptoms or a diagnosis that does not fit into any other defined category. As categories were developed to generally describe injury

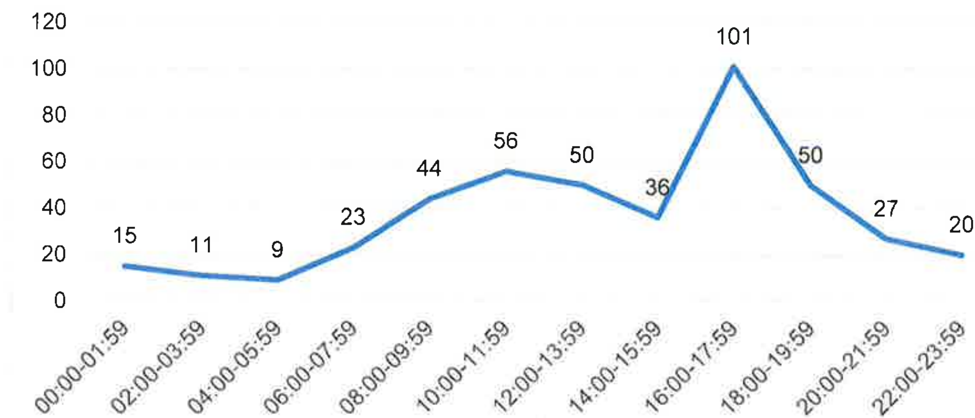
category made up the largest proportion of CIR injury types at all DBHDS facilities, accounting for 104 instances, or 22.22% of all injury types.

Laceration/Tears made up the second-highest proportion of CIR injury types reported, accounting for 94 instances, or 19.44% of injury types reported. Laceration/Tear was most common at CAT, which reported 24 instances in this category.

Deaths made up the third-highest proportion of CIR injury types reported, accounting for 66 instances, or 14.53% of injuries reported. We will explore Deaths in greater detail beginning on page 9.

While only 40 instances of "Ingestion of Foreign Object" were reported in FY 21, the overwhelming majority of these (25) occurred at CSH and are tied to that facility's unusually high rate of SIB.

Incident Timing



dLCV observed a disproportionate number of Critical Incidents occurring between 4-6pm. Upon closer inspection, it appears this trend is being driven almost exclusively by CSH, which also reported an unusually high number of incidents occurring on Wednesdays. More information is needed to understand why there is such a significant increase in incidents at that time. Possible factors include staff shortages and lack of structured programming.

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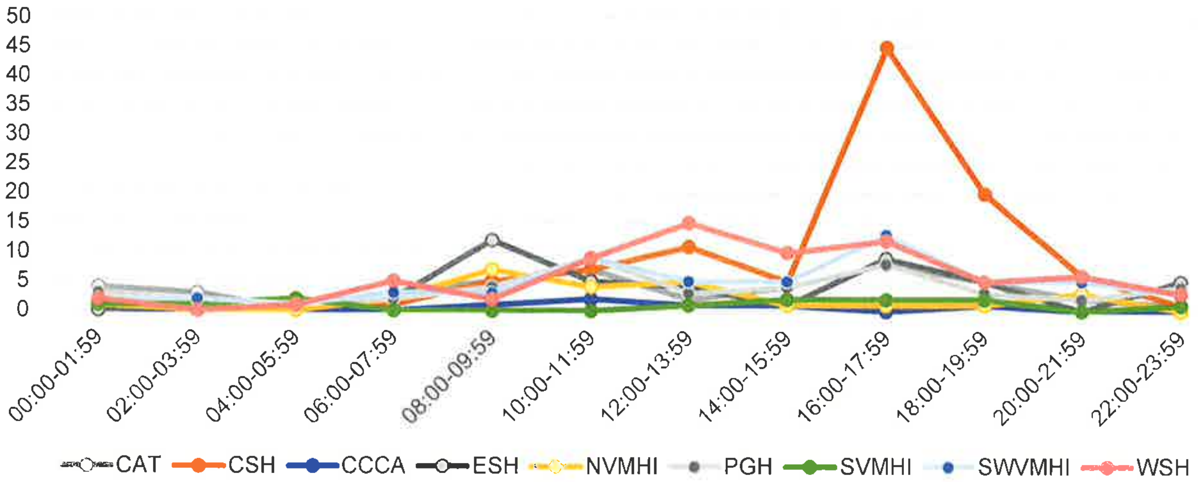
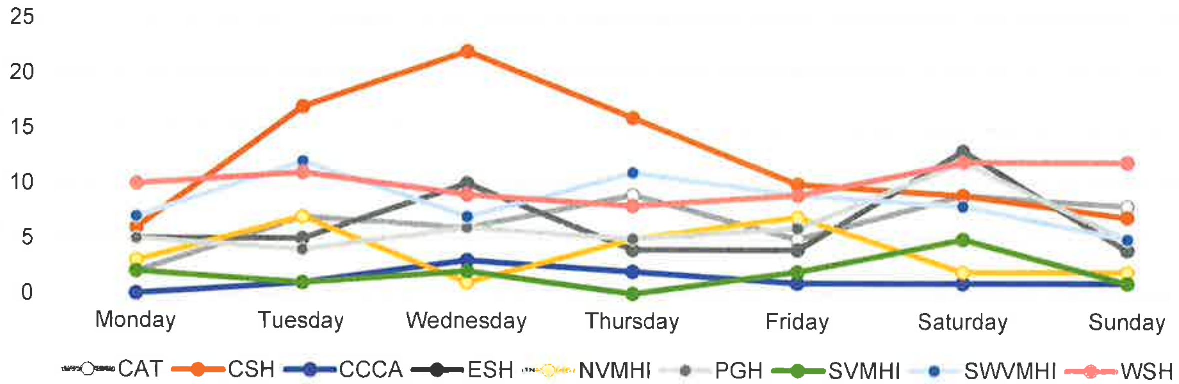
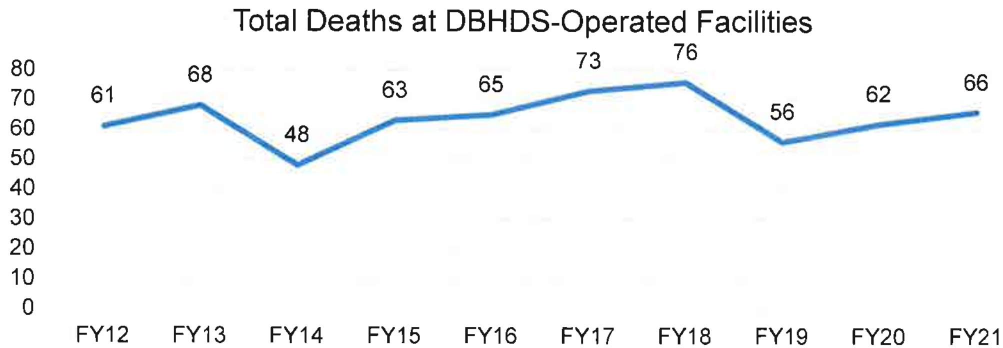
instead of illness, the majority of "medical conditions" that do not result in death can only be described using the "other" category.



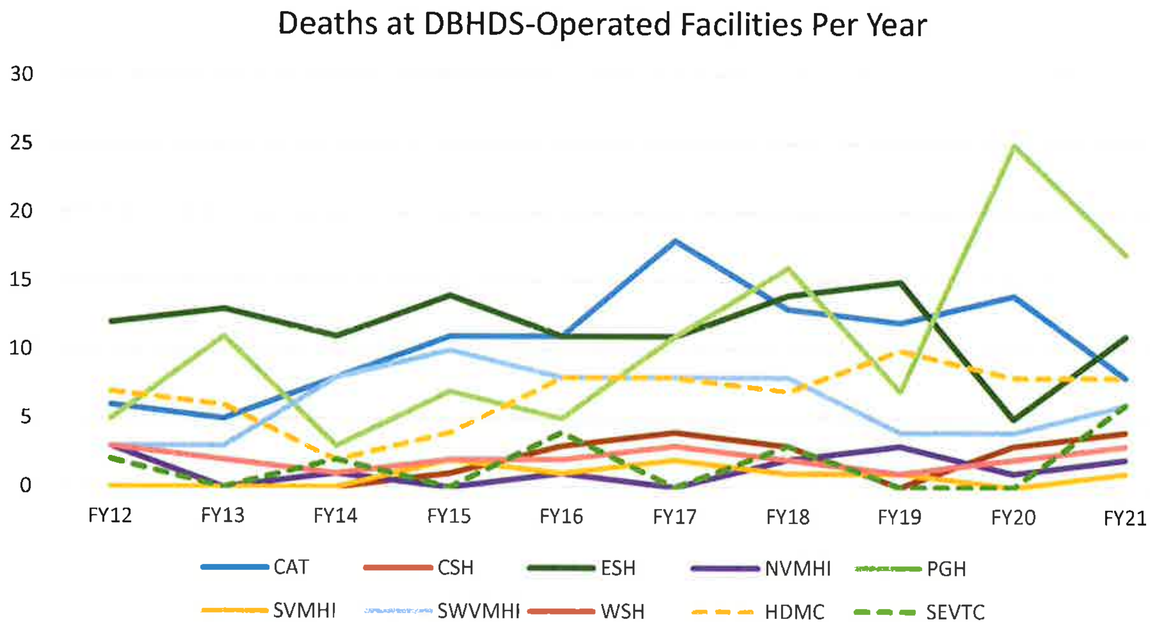


Data on Reported Deaths

Reported deaths made up an alarmingly large proportion of the CIR injuries, accounting for 14.53%. State facilities are not generally intended to serve medically acute or terminally ill individuals, so the increasingly high rate of deaths is deeply concerning to dLCV. The following data will hopefully provide readers with a comprehensive understanding of this issue.



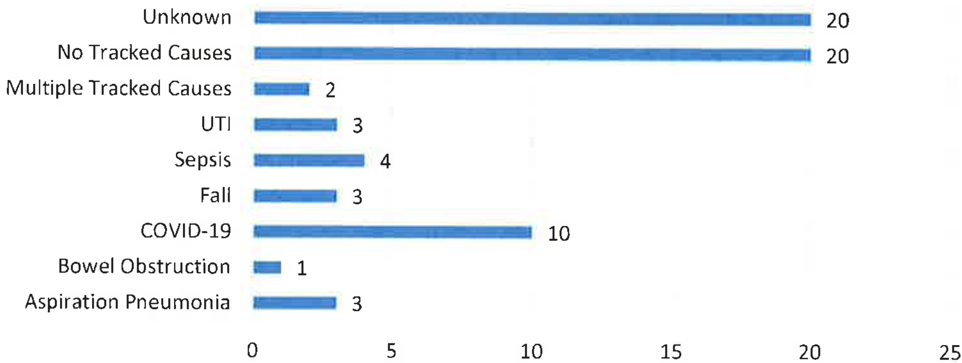
The above graph depicts the steady increase in numbers of deaths reported at all DBHDS facilities for the second year in a row, reaching a total of 66 deaths in FY 21. While it is important to note the overall positive trend of death rates in DBHDS facilities, it is equally important to understand the breakdown of deaths occurring at each DBHDS facility, shown in the graph below.



Every DBHDS facility that serves adults had at least one death in FY 21. Southeastern Virginia Training Center reported 6 deaths in FY 21. This is a significant increase, considering they reported no deaths in FY 19 and FY 20. ESH also reported a higher number of deaths reported in FY 21, totaling 11 deaths in FY 21 compared to 5 deaths in FY 20.

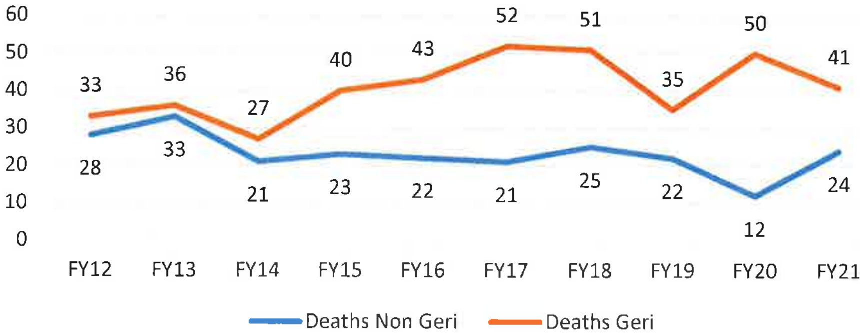
PGH reported, by far, the highest number of deaths in FY 22. This is likely due to the fact that they care for an older population compared to the other facilities, but it must be noted that the deaths at PGH far outpaced other facilities with geriatric populations. PGH reported fewer deaths in FY 21 (17), compared to FY 20 (25). In FY 20, the COVID-19 Pandemic and poor staffing ratios appeared to drive the bulk of deaths at that facility. While there certainly were COVID-19 deaths at PGH in FY 21, the pandemic was not as lethal as it was the previous year, meaning that we must examine why so many Virginians are dying at Piedmont Geriatric Hospital.

It is crucial that we understand what is driving the rate of deaths. The graph below addresses the six conditions that dLCV has committed to tracking on an ongoing basis. These are: Aspiration Pneumonia, Bowel Obstruction, COVID-19, Falls, Sepsis, and Urinary Tract Infections (UTI).



Of immediate concern is the fact that 20 out of the 66 total patients that died (30.3%) are identified as having an unknown cause of death. We understand that it is not always possible to determine an individual's cause of death immediately if the death is unexpected, but even in follow-up reporting that the facilities submit weeks after the incident, facilities are often failing to identify even a probable cause of death.

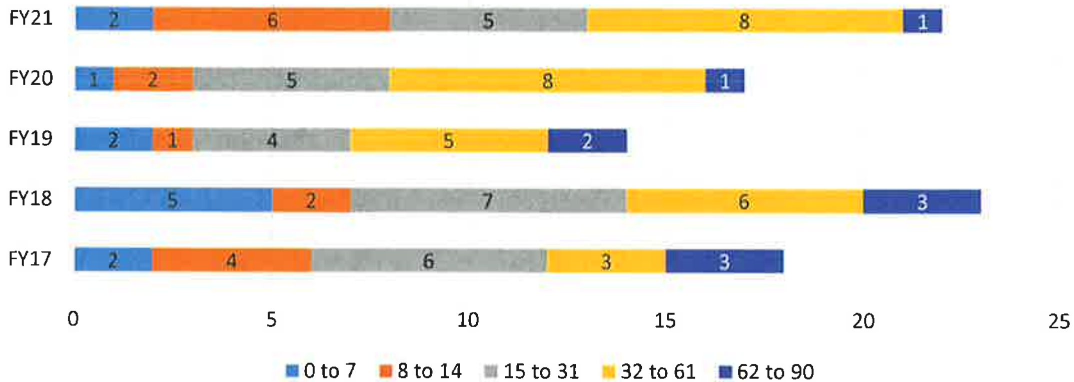
As one might expect, among the tracked causes of death, COVID-19 was the primary cause of death. Out of the 17 that occurred at PGH, 7 of the deaths were due to COVID-19 infections.



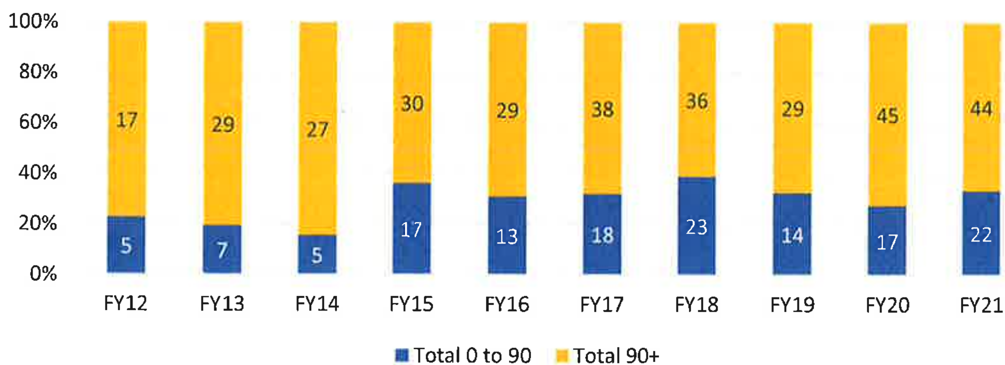
The majority of the deaths that occurred at DBHDS facilities were attributed to geriatric patients. However, there was a considerable rise in the deaths of non-geriatric patients: There were only 12 non-geriatric deaths in FY 20 compared to 24 non-geriatric deaths in FY 21.

DEATHS, ADMISSION, AND DISCHARGE

dLCV is particularly concerned with the number of deaths occurring within the first 90 days of admission, as these deaths are often tied to medically-inappropriate admissions.

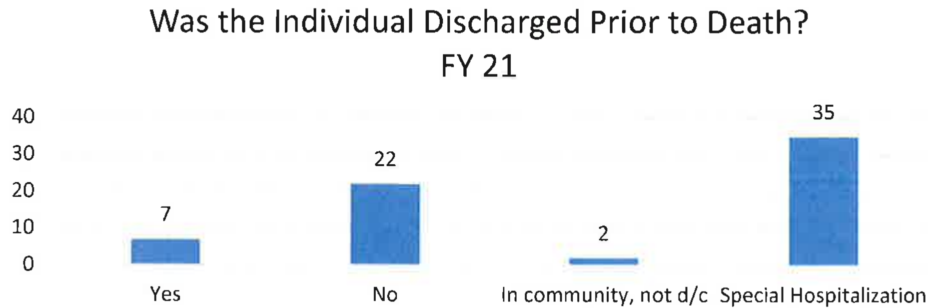


In recent years, dLCV has observed a dramatic increase in deaths occurring within the first 90 days in DBHDS facilities. In FY 2 19, there were only 14 deaths that occurred within the first 90 days of admission, compared to FY 21 where there were 22 deaths. While we understand that some of this increase may pertain to the COVID-19 pandemic, staff and residents we have interviewed have consistently cited concerns about medically acute individuals being admitted to the State Hospitals, despite the hospitals not having the staff or other resources to serve them. Currently dLCV is investigating to see if the individuals who died within the first 90 days of admission were admitted inappropriately to a psychiatric hospital when in fact, they had medical conditions that required treatment at a medical hospital.



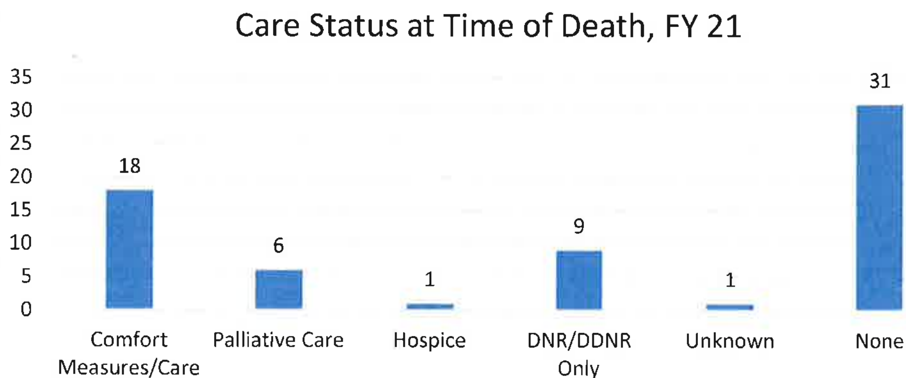
It is important to note that, while the number of deaths within the first 90 days are increasing, they still do not account for the majority of deaths occurring at DBHDS-operated facilities. It is also interesting that, despite the increase in the raw *number* of deaths occurring within the first 90 days of admission, the *proportion* of deaths by proximity to admission changes only slightly. What this ultimately means is that there are a lot of individuals

dying in DBHDS-operated facilities after languishing there for months or years. Many of these individuals experience the inevitable physical deteriorations that occur with aging (in some cases), but their circumstances keep them tied to the State Hospitals, rather than somewhere more dignified and appropriate.



A great deal of FY 21 deaths occurred when the individual was on "special hospitalization." This includes individuals who were officially admitted to DBHDS facilities while receiving care at medical hospitals, and individuals who were discharged to medical hospitals, rather than community providers, just a few days before their deaths[3]. PGH reported the highest number of special hospitalization deaths among the DBHDS facilities, likely due to the fact that PGH has a larger geriatric population who require treatment for more complex medical needs.

It is important to note that, across DBHDS facilities, 22 individuals died or experienced medical emergencies leading to their deaths while at DBHDS facilities. dLCV is concerned about this for multiple reasons. First, why were these individuals not being cared for in a medical facility? Second, other patients on the unit are inevitably impacted after seeing their peer die. Third, the patients that die on the locked unit of a state mental health facility do not have consistent access to friends and family at the end of their life.



For the past few years, dLCV has attempted to analyze the data provided by DBHDS to determine if the deaths happened expectedly or unexpectedly. dLCV does this by examining which patients had comfort measures/ care,

[3] We understand this is not the traditional definition of Special Hospitalization, but considering some hospitals' propensity to officially discharge individuals to medical hospitals when the individual appears close to death, combining traditional hospitalization and discharge to medical hospitals allows us to compare two functionally similar practices that are different only in technicality.

palliative care, hospice, a DNR/DDNR only, or none of the above at the time of their death. We understand that these statuses do have nuance and that, particularly for individuals who have Do Not Resuscitate (DNR) or Durable Do Not Resuscitate (DDNR) orders, death is not always immediate or expected. However, from a functional perspective, we most commonly see individuals and family members being approached about DNR/DDNR orders once the individual has reached a stage where they are not expected to live.

In our analysis, dLCV concluded that just over half of the individuals who died while in DBHDS had a DNR or were enrolled in an end-of life care status shortly before death, suggesting that about 51% of the deaths reported by DBHDS-operated facilities were at least somewhat expected. While many of these individuals were put on special hospitalization, dLCV questions whether they would have benefitted from being placed in more medically-intensive facilities earlier or in lieu of admission to a DBHDS facility. We also question, for those whose death could not have been prevented, why more people were not allowed to spend their final days at home with their loved ones.

Conclusion

The disAbility Law Center of Virginia is concerned about the number of deaths occurring within the first ninety days of admission. dLCV is also concerned about the number of deaths that occurred in DBHDS facilities that appear to have been expected. For the second year in a row, the number of deaths in state facilities has increased. During FY 21, there were a total of 66 deaths, a third of which occurred within 90 days of admission.

To put it plainly, deaths within 90 days of admission should not happen at this rate. While accidents and unforeseen circumstances may occasionally occur, the fact that we have needed to bring this issue to DBHDS' attention over and over is unacceptable. DBHDS-operated facilities have pre-screening processes that should identify individuals who are too medically complex to be placed in state hospitals, but private hospitals seem to be bypassing these processes to ensure that they are not responsible for behaviorally complex sick people.

To address staff burnout and patient safety, it is imperative that the General Assembly revisit the Bed of Last Resort Legislation and address its many glaring inadequacies. Since said legislation was enacted, private hospitals across the Commonwealth have used it as a permission slip to "dump" patients who are perceived as difficult in State facilities, resulting in poor health outcomes. Action is needed to ensure that patients are appropriately placed in facilities that can provide the level of care they need to ensure their safety and wellbeing. dLCV is eager to work with DBHDS leadership to address these situations.

We have seen, both in the CIRs and through our monitoring, that staffing shortages and burnout are driving substandard patient care. This is clearly a systemic issue and not limited to certain hospitals and certain staff.

It is also impossible to address patient outcomes and staff burnout without addressing the large number of people who are being held in State Hospitals despite being clinically ready for discharge (RFD). As of 2/28/22 (the most recent available data), DBHDS facilities were housing 210 individuals who were RFD and no longer needed to be there. It is unconscionable to continue to hold RFD individuals in a clinical environment where they are at increased risk of abuse, neglect, peer-to-peer violence, decompensation, and infectious disease. If DBHDS focused on improving community health systems, rather than adding beds at hospitals that cannot staff their existing beds, we strongly believe that both staff and patients at these facilities would be safer and happier.

Another measure DBHDS can take to address both patient safety and staff burnout is to reduce aggression and self-injury by providing patients with meaningful Trauma Informed Care at a clinical level, specifically with

widespread availability of treatment like individual talk therapy Dialectical Behavioral Therapy. Again, dLCV is very interested in working with DBHDS towards this goal.

Though we have seen improved reporting at several DBHDS-operated facilities in FY 21, dLCV remains concerned about reporting adequacy. DBHDS facilities have shown improvement in both the quantity and quality of critical incidents reported in FY 21. However, dLCV notes that issues remain regarding data integrity. Many reports dLCV receives do not contain basic information. Additionally, the absence of some categories of reporting (such as SIB at CCCA) raise concerns about whether facilities are reporting all applicable incidents. While we are working to resolve these data issues it is important to emphasize that the overall trends gathered from the data remain accurate.