

OFFICE OF THE STATE INSPECTOR GENERAL

**Unannounced Inspections
of
Behavioral Health and Developmental Services
Facilities**

Fiscal Years 2018 and 2019



**Michael C. Westfall, CPA
State Inspector General
Report No. 2020-BHDS-002**



COMMONWEALTH OF VIRGINIA
Office of the State Inspector General

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November 13, 2019

Governor Ralph Northam
P.O. Box 1475
Richmond, VA 23219

Dear Governor Northam,

The Office of the State Inspector General (OSIG) performed unannounced inspections at all facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) pursuant to *Code of Virginia* § 2.2-309.1[B](1). The overall goal of unannounced inspections is to review the quality of services provided and make policy and operational recommendations to prevent problems, abuses and deficiencies, as well as improve the effectiveness of programs and services.

On behalf of OSIG, I would like to express our appreciation to DBHDS Acting Commissioner Mira Signer and her staff within Central Office and facility directors and staff during these inspections.

Sincerely,

Michael C. Westfall, CPA
State Inspector General

CC: Clark Mercer, Chief of Staff to Governor Northam
Suzette P. Denslow, Deputy Chief of Staff to Governor Northam
Daniel Carey, M.D., Secretary of Health and Human Resources
Senator Rosalyn R. Dance, Chair of the Joint Commission on Health Care
Delegate T. Scott Garrett, Vice Chair of the Joint Commission on Health Care
Mira Signer, Acting Commissioner, DBHDS
Daniel Herr, Deputy Commissioner for Facility Services, DBHDS
Dev Nair, Assistant Commissioner of Quality Management & Development, DBHDS
Alvie Edwards, Director of Internal Audit, DBHDS

Behavioral Health and Developmental Services Unannounced Inspections

What OSIG Found

SIX DBHDS STATE FACILITIES DO NOT LIMIT THE NUMBER OF OVERTIME HOURS TO INCLUDE THE NUMBER OF CONSECUTIVE HOURS OR SHIFTS THEIR DIRECT CARE NURSING STAFF CAN WORK

Six of the 13 DBHDS facilities (46 percent) do not have an approved overtime policy for their direct care nursing staff that limits the number of hours or consecutive days of overtime. Direct care nursing staff includes registered nurses, licensed practical nurses, certified nursing assistants, direct support associate and psychiatric technicians. Central Office has not implemented an agency wide policy regulating the number of hours an individual can work in a given week or the total number of consecutive days that they may work overtime.

SEVEN DBHDS FACILITIES HAD UNDERSTAFFED SHIFTS BETWEEN JULY 1, 2017, AND MARCH 31, 2019

During the period of fiscal year (FY) 2018 to the third quarter of FY 2019, seven of 13 (54 percent) facilities had shifts that were not properly staffed per their shift staffing logs. Four of 13 facilities (31 percent) were unable to provide the requested staffing logs. In three cases, the same facilities that did not have proper minimum staffing levels were also unable to provide staffing logs for other shifts.

DBHDS EVENT REPORTING REQUIREMENTS ARE AMBIGUOUS AND INCONSISTENT (NOTE: THIS IS A REPEAT FINDING FROM OSIG's [MARCH 2018 INSPECTION REPORT](#))

DBHDS has yet to comprehensively review and revise Facility Event Report Form 158 (Form 158). The current clinical outcome severity levels are based solely on severity of the injury, and do not take into account any other factors impacting the severity of the situation. DBHDS has not revised Departmental Instructions (DI) 401 Risk and Liability Management since a reissue date of February 15, 2013.

November 2019

HIGHLIGHTS

Why OSIG Performed This Audit

OSIG completed this review in accordance with *Code of Virginia* § 2.2-309.1.B.1, which requires OSIG to, “Provide inspections of and make policy and operational recommendations for state facilities and for providers, including licensed mental health treatment units in state correctional facilities, in order to prevent problems, abuses, and deficiencies in and improve the effectiveness of their programs and services.”

What OSIG Recommends

- Implement an agency wide policy, consistent with the Institute of Medicine’s recommendation, limiting the number of overtime hours per week and the number of consecutive hours and consecutive shifts that direct care nursing staff are allowed to work.
- Continue with current efforts to implement across the board strategies that assist facilities with recruitment and retention of staff.
- Create workforce plans that include strategies to mitigate recruitment and retention challenges for direct care staff given each facility’s unique talent pool and geographical factors.
- Ensure that a complete review and update of DI 401 and Form 158 is performed.



For more information, contact OSIG at 804-625-3255 or www.osig.virginia.gov.

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REPORT ACRONYMS

The following is an alphabetical list of acronyms used in the report. This page should be helpful in identifying what each acronym stands for.

ANA – American Nurses Association
APNA – American Psychiatric Nurses Association
CAT – Catawba Hospital
CCCA – Commonwealth Center for Children and Adolescents
CFR – Code of Federal Regulations
CHRIS – Computerized Human Rights Information System
CSB – Community Services Board
CSH – Central State Hospital
CVTC – Central Virginia Training Center
DBHDS – Department of Behavioral Health and Developmental Services
DHRM – Department of Human Resource Management
DI – Departmental Instruction
ESH – Eastern State Hospital
FTDO – Forensic Temporary Detention Order
HDMC – Hiram Davis Medical Center
ID/DD – Intellectual Disability/Developmental Disability
KPI – Key Performance Indicators
NGRI – Not Guilty by Reason of Insanity
NVMHI – Northern Virginia Mental Health Institute
OSIG – Office of the State Inspector General
OT – Overtime
PAIRS – Protection and Advocacy Incident Reporting System
PGH – Piedmont Geriatric Hospital
QAPI – Quality Assurance and Performance Improvement
SEVTC – Southeast Virginia Training Center
SVMHI – Southern Virginia Mental Health Institute
SWMHI – Southwestern Virginia Mental Health Institute
TDO – Temporary Detention Order
TJC – The Joint Commission
TOVA – Therapeutic Options of Virginia
VCBR – Virginia Center for Behavioral Rehabilitation
WSH – Western State Hospital

BACKGROUND

Every year, pursuant to *Code of Virginia (Code)* § 2.2-309.1 “Additional powers and duties; behavioral health and developmental services,” OSIG conducts an unannounced inspection of each facility operated by DBHDS. In accordance with the Code of Virginia OSIG “provides inspections of and make policy and operations recommendations for state facilities and for providers, including licensed mental health treatment units in state correctional facilities, in order to prevent problems, abuses, and deficiencies in and improve the effectiveness of their programs and services.”

OSIG researches industry and regulatory standards to assist with evaluating DBHDS facilities and make recommendations to improve the quality of care and in order to prevent problems, abuses and deficiencies, and improve the effectiveness of DBHDS facilities’ programs and services. This includes making recommendations to DBHDS Central Office to ensure proper and consistent management and oversight of the facilities.

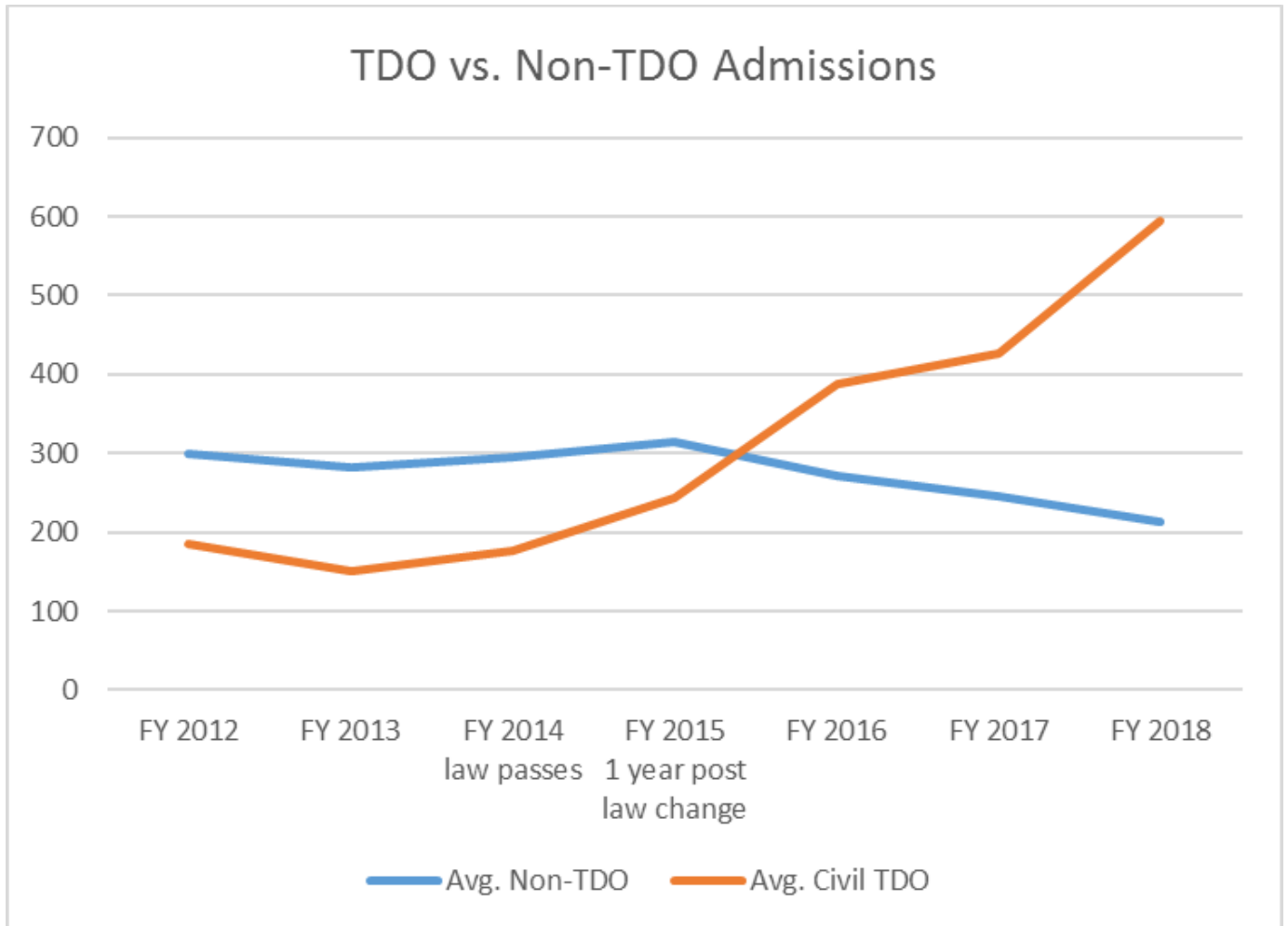
DBHDS is established in the executive branch of government responsible to the Governor. DBHDS is under the supervision and management of the Commissioner, and the Commissioner carries out the management and supervisory responsibilities in accordance with policies and regulations of the State Board of Behavioral Health and Developmental Services (the Board) and applicable federal and state statutes and regulations. The Board has the statutory authority, as outlined in § 37.2-203, to develop and establish policies governing the operations of DBHDS, state facilities and CSBs. CSBs act as the doorway to the Virginia mental health system. When an individual is experiencing a mental health crisis and a TDO is issued, the CSB in their area is tasked with finding that individual an available bed in a mental health facility. CSBs first attempt to secure a bed within a private facility, but if none are available, the CSB then contacts the various state facilities to locate a bed for that individual.

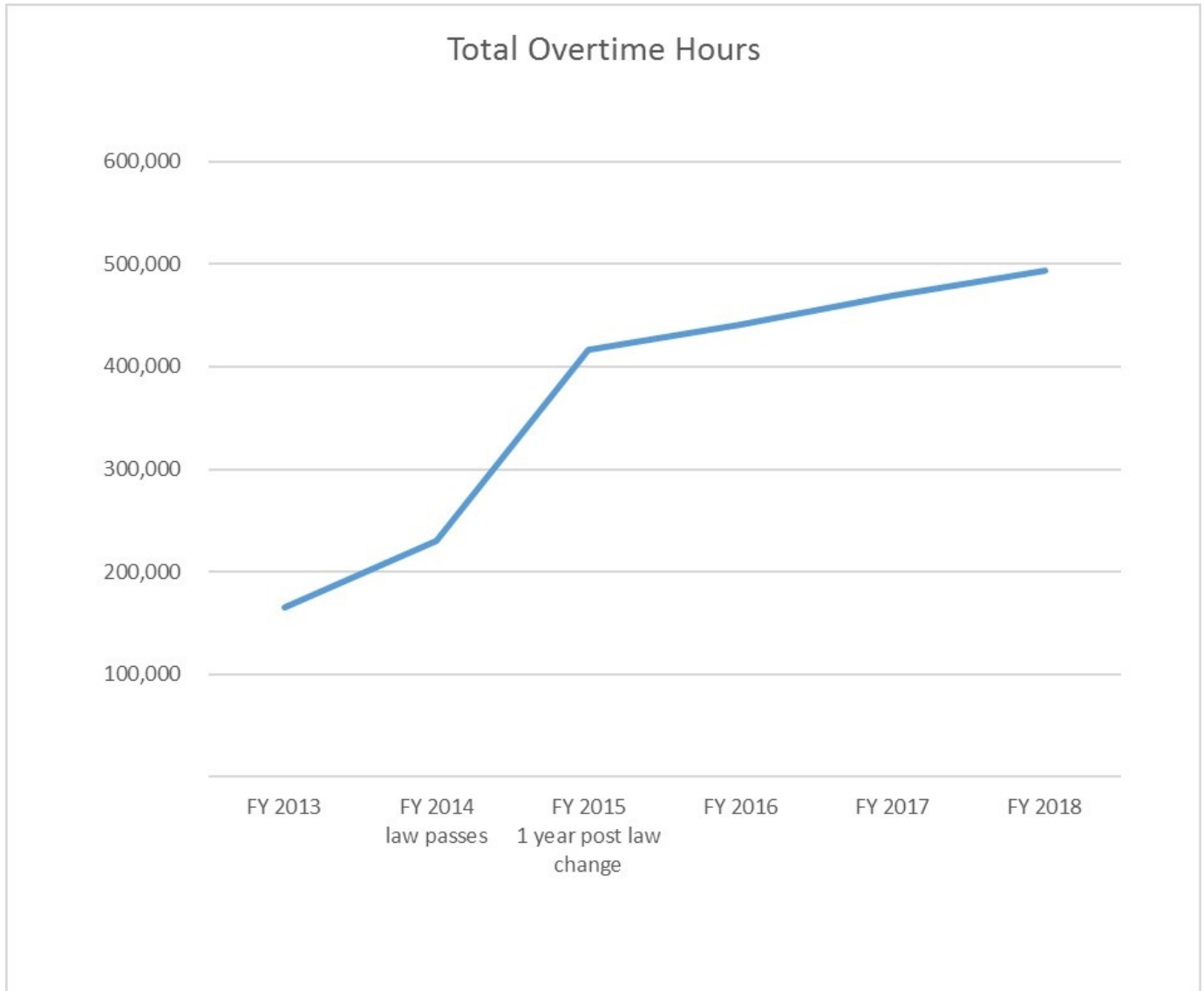
DBHDS operates 13 facilities across the Commonwealth of Virginia: eight behavioral health facilities for adults, two training centers (one of which is scheduled to close in FY 2020), a psychiatric facility for children and adolescents, a medical center and a center for behavioral rehabilitation. State facilities provide highly structured, intensive services for individuals with mental illness, developmental disabilities or who are in need of substance use disorder services.

During the 2014 General Assembly Session, the General Assembly passed Senate Bill 260/House Bill 293 and codified in the *Code of Virginia* §37.2-808, 37.2-809, and 37.2-809.1. *Code of Virginia* §37.2-809.1 requires a CSB to locate and notify the DBHDS facility serving the area that an individual currently under a TDO will be transported to that facility if an alternative facility cannot be identified within an eight-hour period (§37.2-808). This legislative change states that if a bed is not found for someone within eight hours, then state hospitals are required to make a bed available and admit that individual. Additionally, it increased the time that an individual can be held by a TDO to 72 hours (§ 37.2-809. H.) The law went into effect on July 1, 2014. It ensures that those individuals who are potentially a danger to themselves or to others are receiving necessary treatment, rather than being held temporarily for several hours and then released.

From FY 2015 to FY 2018, state facilities have seen a 76 percent increase in TDO admissions and an overall admissions spike of 276 percent (2014-2018) according to data provided by DBHDS, leading to extraordinarily high occupancy rates and census pressures. The DBHDS 2018 Annual Report cited the increase in TDO admissions as a “major state hospital issue.” According to the annual report, the increase in TDO admissions has led to state hospitals operating with a 95 percent or higher occupancy rate in FY 2018, and these rates pose operational challenges and risks. Additionally, total medical costs for individuals in state hospitals have grown from \$3.1 million in FY 2013 to nearly \$7 million in FY 2018.

The information included in the graph below represent the trend as calculated by OSIG based on information provided by DBHDS. It shows the trend in TDO admissions versus the non-TDO admissions for the same time period. Also represented in the second graph below is the overall overtime hours as provided by DBHDS for comparison with the admissions data for the same time frame.





SCOPE

The scope of these unannounced inspections covered operations at DBHDS facilities from July 1, 2017, through March 31, 2019, and analyzed the impact on DBHDS facilities from changes in the *Code of Virginia* § 37.2-809.1 “Facility of temporary detention,” and its response to those changes. (Note: These changes require DBHDS to provide a bed for all TDOs.) These requirements were implemented on July 1, 2014, for adults and July 1, 2015, for minors. DBHDS has had four years to measure the impact of its responses to these changes. DBHDS changes should include, but are not be limited to, changes in policies, staffing, training, security and reporting.

SB260 and HB293, as approved, require that DBHDS submit a report annually on June 30 of each year to the Governor and Chairs of the House Appropriations and Senate Finance committees and include the following:

- Number of notifications of individuals in need of facility services by CSBs.
- Number of alternative facilities contacted by CSBs and state facilities.
- Number of temporary detentions provided by state facilities and alternative facilities.
- Length of stay in state facilities and alternative facilities.
- Cost of the detentions in state facilities and alternative facilities.

OBJECTIVES

The objectives of these inspections were to:

1. Conduct qualitative and quantitative analyses using data related to the intake of patients at DBHDS facilities between July 1, 2017, and March 31, 2019, to identify trends in data to determine if DBHDS is effectively responding to the increase in demand for bed usage and/or changes in patient type (legal group) due to increased TDOs. This will include data by facility on TDO admissions, patient numbers by staffing, overtime hours and staff injuries as reported in workers' compensation claims.
2. Determine if changes to staffing protocols have been implemented since July 1, 2014. If so, assess the quality of changes by facility and determine if these changes effectively manage the change in patient requirements to ensure:
 - a. Safety of the patient.
 - b. Proper nursing staff-to-patient ratio.
 - c. Proper support staff to assist the nursing and medical staff with patients, including security, where warranted.
3. Review DBHDS facility staff safety programs including assessments, education programs, performance improvement programs and actions. Determine if these programs help support a culture of safety.
4. Review DBHDS training requirements and verify that training requirements meet the needs of the facility, thereby ensuring effective care of patients. Ensure that each facility properly complies with DBHDS training requirements, including program content and attendance.
5. Review DBHDS reporting requirements and determine if DBHDS facilities are reporting promptly in accordance with the requirements. Further, determine that the required information is being transmitted to the appropriate Central Office personnel. Determine if DBHDS is properly collecting reports from the facilities and reporting key data consistently to both DBHDS management and the General Assembly.

METHODOLOGY

OSIG conducted this inspection in accordance with the Principles and Standards for Offices of Inspector General. Additionally, OSIG applied various methodologies during the inspection process to gather and analyze information pertinent to the project scope and to assist with developing and testing the project objectives. The methodologies included the following:

- Interviewing senior Central Office officials.
- Examining policies and procedures promulgated by Central Office to instruct DBHDS facility management on how to operate the facilities.

- Examining data provided by Central Office and the Department of Human Resource Management (DHRM) on workers' compensation claims, overtime usage, the number of admissions at DBHDS state facilities, peer-to-peer with no injury incidents and the number of vacancies of direct care staff at DBHDS facilities from FY 2012 to FY 2019.
- Reviewing incident reporting system implementation plans with DBHDS IT officials.
- Conducting multiday site visits at each of the 13 DBHDS facilities from May 2019 through June 2019.
- Performing walkthroughs of each of the 13 DBHDS facilities designed to assess the facility layout and safety measures employed by the facility.
- Conducting interviews with officials at each of the 13 DBHDS facilities.
- Examining policies and procedures of all 13 DBHDS facilities.
- Examining data provided by all 13 facilities, including data on staffing, overtime usage, and behavioral management training, among others.
- Conducting a staff survey at all 13 DBHDS facilities pertaining to staffing, safety and training. This survey was conducted from May - June 2019.

ACKNOWLEDGEMENTS

ELEVEN DBHDS STATE FACILITIES DISPLAYED POSTERS WITH THE OSIG COMPLAINT NUMBER

OSIG determined that in 11 of 13 DBHDS facilities, DBHDS prominently displayed the OSIG Complaint Line number and commends them for this. OSIG had previously requested that DBHDS display the Complaint Line number in its facilities so patients experiencing issues could call the Complaint Line and voice their concerns regarding their care and treatment in the facilities. Staff and family members with concerns regarding the treatment and care of patients can also call the Complaint Line. Of the 13 DBHDS facilities, ESH and NVMHI did not have the OSIG Complaint Line displayed when OSIG visited. HDMC and CVTC did not have the official OSIG Complaint Line poster displayed, but included OSIG's number on other posters that they designed, which contained other numbers. The CCCA did not have posters with the Complaint Line number displayed at the beginning of OSIG's inspection, but put the provided posters up during the visit. We commend DBHDS for supporting this effort and assisting with making the Complaint Line information available to patients and their visitors at the facilities.

FINDINGS

Findings were submitted to DBHDS agency management on October 7, 2019, for review and discussion. Management responded to the findings as documented below, and OSIG provided additional information based on their response. OSIG thanks DBHDS agency management for taking the time to review and respond to the findings.

OSIG requests agency management provide a corrective action plan by December 13, 2019, to address this report's recommendations as documented in the findings below. Upon receipt of the corrective action plan, OSIG will follow-up to verify implementation of changes.

SIX DBHDS FACILITIES DO NOT LIMIT THE NUMBER OF OVERTIME HOURS TO INCLUDE THE NUMBER OF CONSECUTIVE HOURS OR SHIFTS THAT DIRECT CARE NURSING STAFF CAN WORK

Six of the 13 DBHDS facilities (46 percent) do not have an approved overtime policy for their direct care nursing staff that limits the number of hours or consecutive days of overtime. Direct care nursing staff includes registered nurses, licensed practical nurses, certified nursing assistants, direct support associate and psychiatric technicians.

The following facilities have not implemented an overtime policy that limits the number of overtime hours to include the number of consecutive hours or shifts:

- CSH
- ESH
- HDMC
- SVMHI
- WSH
- CCCA

Central Office has not implemented an agency wide policy regulating the number of hours an individual can work in a given week or the total number of consecutive days that they may work overtime. Central Office has not required the various facilities under its jurisdiction to do the same. Staffing shortages, patient observations (1:1 nurse to patient observation and 2:1 nurse to patient observation) and leave are among the primary reasons facilities require overtime.

The Institute of Medicine recommends that registered nurses not exceed 12 hours of work in a 24-hour period and 60 total hours of work within seven days. The ANA has taken a position prohibiting the use of mandatory overtime for nurse staffing and made it part of legislative and regulatory reform efforts. Six of the 13 facilities visited have already implemented limits on the number of overtime hours or consecutive days an individual can work. For facilities with overtime policies, overtime limits range between 16 and 32 hours a week.

By not placing a limit on the number of overtime hours per week and consecutive shifts or consecutive hours of overtime worked by direct care nursing staff at facilities, DBHDS runs the risk of staff working excessive amounts of time and becoming too fatigued to carry out their duties. This could lead to lapses in adherence to safety policies or healthcare standards, which in turn will lead to substandard conditions and care for patients at DBHDS facilities. Officials at ESH cited this as a primary concern given the hospital's current staffing shortages. As of May 17, 2019, ESH had a nurse staffing shortage rate that exceeded 50 percent of its positions.

Recommendation(s):

1. The Commissioner should implement an agency wide policy consistent with the Institute of Medicine's recommendation, limiting the number of overtime hours per week and the number of consecutive hours and consecutive shifts that direct care nursing staff are allowed to work.
2. The Commissioner should mandate the implementation of the recommended policy at all DBHDS facilities.
3. Where staffing shortages are significant, the Commissioner should provide additional assistance to the facilities and take appropriate step to fill vacancies.

Management Response(s):

Management partially agreed with the condition observed and OSIG's recommendations as follows:

The primary factor contributing to overtime at the DBHDS hospitals is a result of the legislative changes that began on July 1, 2014. DBHDS hospitals are now required to serve as the facility of last resort for individuals under TDO and to admit incompetent defendants within 10 days of receipt of a court order. When compared to FY 2013, DBHDS hospitals have experienced a 333% increase in civil TDO admissions and a 199 percent increase in forensic admissions. This has contributed to DBHDS hospital average daily census growing from 87 percent in FY 2014 to more than 96 percent in FY 2019. At any point in time, one third or more of the hospitals are operating at 100 percent of their capacity. However, DBHDS hospitals were only funded to operate at 85 percent of capacity. Effective July 1, 2019, the General Assembly allocated additional funds to support DBHDS hospitals operating at 90% capacity. Even with these additional funds, the state hospitals continue to consistently operate well above their funded and staffed levels and these census trends are projected to continue at a 2 percent growth rate annually. The conditions observed and recommendations as stated infer that overtime and safety issues will be ameliorated with an umbrella OT policy for all state facilities; however, each facility's unique staffing needs must be recognized and managed accordingly. In addition, five of the seven facilities named above (CSH, HDMC, SWVMHI, WSH, and CCCA) have submitted policies and/or guidance documents (in place at the time of the OSIG unannounced visits) that support management decisions related to the review and approval of OT for direct care nursing staff.

In Finding #2, "OSIG recognizes that Central Office management is making significant strides with facilities to support staff recruitment and retention. It was noted at all of the facilities that DBHDS is making noticeable and appreciated efforts to help facilities recruit and retain staff." DBHDS will continue to support the facilities in these efforts.

DBHDS will convene a work group with representatives from Facility Chief Nurse Executives who will review existing practices and unique realities of each facility and then provide recommendations for guidelines to DBHDS. DBHDS will then ensure that each facility has a policy, tailored to its unique needs and funded staffing levels that provides guidance on the number of overtime hours worked within a week, the number of consecutive hours worked, and the amount of time between shifts. The facility policy will also establish a process for making an exception to this guidance when required by patient care and safety needs. DBHDS will review and approve the policy for each facility.

OSIG's Follow-up to Management's Response:

It is the responsibility of DBHDS Central Office management to set policies regarding the management and oversight of their state facilities. A proper overtime policy would require each facility to review and consider industry requirements to establish limits on the hours direct care staff can work both on consecutive days and over the course of a limited timeframe (week, 2 weeks, etc.). Setting an agency policy without exceptions or modifications will also allow DBHDS Central Office management to review the facilities ability to comply and use the information to take corrective action. This will assist the individual facilities where data shows that facilities are not in compliance. It would also significantly reduce time to write one policy instead of 13 different policies that would still require submission to and approval of central office management.

SEVEN DBHDS FACILITIES HAD UNDERSTAFFED SHIFTS BETWEEN JULY 1, 2017, AND MARCH 31, 2019

During the period of FY 2018 to the third quarter of FY 2019, seven of 13 (54 percent) facilities had shifts that were not properly staffed per their shift staffing logs. Four of the 13 facilities (31 percent) were unable to provide the requested staffing logs. In three cases, the same facilities that did not have proper minimum staffing levels were also unable to provide staffing logs for other shifts.

Seven facilities (53 percent) had shifts that were not properly staffed with the minimum number of individuals required, as recorded on the appropriate staff log. These facilities include:

- CAT (1 of 25)
- CSH (1 of 25)
- CCCA (1 of 4) - CCCA includes four patient “pods” on a single shift log instead of separate shift logs for each pod.
- ESH (8 of 25)
- NVMHI (3 of 25)
- SVMHI (1 of 25)
- VCBR (6 of 25)

Additionally, four of the 13 facilities were not able to provide staffing logs for the requested shifts. These facilities include:

- CSH (2 of 25)
- CCCA (3 of 4) – As noted above, CCCA includes four patient pods on a single shift log instead of separate shift logs for each pod.
- WSH (1 of 25)
- VCBR (5 of 25)

For shift logs that management could not provide, the facilities were unable to provide the requested shift logs because they were missing and therefore unavailable for testing.

Per individual facility management, the facility had difficulty staffing shifts due to the ability to recruit and retain direct care staff for the following reasons:

- Excessive overtime of staff reducing retention rates of direct care staff employed.
- Competition with other local medical facilities for direct care staff.
- Education and experience levels of available candidates and overall number of available candidates, as well as the location of the institutions away from major cities, particularly Piedmont Geriatric Hospital.

Facilities are required to be staffed 24 hours a day, seven days a week. Facilities’ management also expressed that when staff called in sick, it was difficult to find replacements to fill the positions. This also leads to increases in overtime, including the use of mandatory overtime.

OSIG recognizes that Central Office management is making significant strides with facilities to support staff recruitment and retention. It was noted at all of the facilities that DBHDS is making noticeable and appreciated efforts to help facilities recruit and retain staff.

Each DBHDS facility has a policy for a minimum number of direct care staff needed to provide care for the facility's patients. The minimum number of staff needed at some facilities fluctuates with the number of patients admitted to the facility or to specific units within the facility. Additionally, 42 CFR § 482.23(a) states that "The director of the nursing service...is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital..." CFR 482.23(b) states that, "The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed." Furthermore: "There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for the bedside care of any patient. The hospital must provide 24-hour nursing services furnished or supervised by a registered nurse." In addition, The Joint Commission Standard LD.03.06.01 states that "Leaders provide for a sufficient number and mix of staff to support safe, quality care, treatment, or services...those who work in the organization are competent to complete their assigned responsibilities."

For missing shift logs, Records Retention and Disposition Specific Schedule No. 720-001 states that logs documenting facility operations must be retained for three years after the last action, at which time they may be confidentially destroyed.

Irregular staffing of state facilities could lead to risks for both the patient population under their care and direct care staff having to cover more responsibilities than intended. This could lead to inadequate supervision and medical treatment of patients.

Recommendation(s):

1. The Commissioner should continue with efforts to implement across the board strategies that assist facilities with recruitment and retention of staff. They have made a noticeable impact on the facilities for staff morale.
2. The Commissioner should, in consultation with the individual DBHDS facilities, create workforce plans that include strategies to mitigate recruitment and retention challenges for direct care staff given each facility's unique talent pool and geographical factors.
3. Workforce plans should focus on facilities with the highest vacancy rates of direct care staff to assist facilities with the greatest needs and where current efforts are not having significant impacts on the ability of facilities to fill each shift properly.
4. The Commissioner should work with risk management at the facilities that were missing shift logs to ensure the facilities create a process to maintain shift log records in accordance with Records Retention and Disposition Specific Schedule No. 720-001.

Management Response(s):

Management partially agrees with the condition observed and OSIG's recommendations as follows:

State Facility Salary Action Plans adopted by each facility, reviewed, and approved by Central Office are specifically tailored by each facility to address their unique workforce needs and challenges. As a point of reference, regulation 42 CFR § 482.23(a) does not apply to VCBR. The information shared by OSIG does not support overarching generalized statements that the state's facilities do not comply with 42 CFR § 482.23(a). This is particularly noteworthy given several facilities' CMS certification. In a similar manner, while OSIG makes generalized statements regarding the Joint Commission accredited facilities' noncompliance with staffing requirements, it does not provide enough evidence to support its findings that those facilities have consistently failed to meet Joint Commission standards.

Regarding shift log documentation observations, CCCA utilizes a facility shift log vs. single unit log due to its unique layout, size, and staffing needs.

DBHDS will ensure state facilities address the findings on records retention as it relates to the maintenance of shift logs. DBHDS will also continue to support facilities with recruitment and retention efforts ongoing.

OSIG's Follow-up to Management's Response:

TJC's standards are known as the national and international elements that represent thorough and credible healthcare standards across the industry. The standards set by TJC, and those referenced in OSIG's findings, target important elements of patient care and functions within the facilities in order to provide quality and safe patient care as well as efficient workflow of facilities. TJC references should encourage DBHDS and the 13 state facilities to continuously strive towards improving healthcare so that consistent excellence in quality and safety outcomes are achieved.

OSIG tested shift logs based on the minimum requirements established at each facility, including the minimum requirements established by VCBR management for VCBR. As part of Central Office's management and oversight of the state facilities, it is important that they are working with the facilities to ensure that minimum staffing requirements are met based on a defined set of industry standards and regulations.

DBHDS EVENT REPORTING REQUIREMENTS ARE AMBIGUOUS AND INCONSISTENT (REPEAT FINDING FROM OSIG'S [MARCH 2018 INSPECTION REPORT](#))

DBHDS has yet to comprehensively review and revise Facility Event Report Form 158. This condition has previously been reported to DBHDS management.

During inspections, OSIG noted the following items:

- Clinical Outcome Severity Level definitions continue to be ambiguous and subjective.
- The current clinical outcome severity levels are based solely on severity of the injury and do not take into account any other factors impacting the severity of the situation (e.g. of 493 events at WSH, 365 were level 00 even though more than 10 percent of the 365 events involved violent actions).
- Of 3,054 events at ESH reviewed, 2,298 (75 percent) were given a clinical outcome severity level of 00, including one event of incorrect anti-convulsing medication dosage being administered to a patient.
- There remains no section on Form 158 to document whether or not the same patient was involved in subsequent facility events. Although this has not been included into current development of the new facility event tracking system, Central Office staff is open to including this item.
- DBHDS management is not ensuring that Form 158 is consistently retained in accordance with DI 401, Library of Virginia Records Retention and Disposition Specific Schedule No. 720-001, which requires three years of record retention (e.g. WSH did not retain paper copies of Form 158 from prior to the database implementation).
- There are inconsistencies among facility Risk Managers in the type or amount of documentation maintained for each event. For example, as part of VCBR's event review practice, managers save only the information from Form 158 for each event that they deem is the best articulation of what occurred during the event. All other accounts of the incidents are deleted, which also does not agree with the DI 401 retention schedule of three years.
- State facilities are not consistently reporting potentially criminal events, such as sexual assault, to law enforcement. When reviewing a sample of 25 Form 158 events at SVMHI, there was one reported sexual assault incident that was not reported to law enforcement.
- There is no reference in DI 401, or a cross reference to DI 201, nor on Form 158 stating what events require the facility to notify law enforcement agencies.
- The process for assigning clinical outcome severity levels to events does not always involve direct witnesses to the events. Instead, the severity levels are assigned by the Risk Manager, who assigns the severity based on information filled out on Form 158.
- DI 401 states that it is the Risk Manager's responsibility to conduct any necessary investigations and appropriate reviews of events; however, they are not direct witnesses to

the reported event. Whether an investigation is required depends on the severity of the event, which is determined by the Risk Manager.

- Duties are not segregated for determining the facts, severity and necessary follow-up actions relating to events that could create conflicts of interest.
- Facilities do not consistently report events as required by DBHDS DI 401. For example, SEVTC has instructed its staff to use separate forms to report injuries to employees and injuries to patients, even though all incident events should be reported using the same form per DI 401.

DBHDS has not revised DI 401 since a reissue date of February 15, 2013. DBHDS states that the DI 401 is in the initial review and revision phase in order for it to be in alignment with the facility event tracking system. The current version is not finalized at this time but will be updated once the event tracking system is updated. Other actions to address the following have not been taken:

- Ensure DI 401 includes information on reporting any significant event accurately, reporting events to law enforcement and documenting when patients at facilities are involved in multiple events.
- Ensure that facilities retain facility event reports in accordance with records retention requirements for all documentation related to incidents, including multiple event reports for the same incident.
- Identify or implement proper segregation of duties among reviewing and assigning clinical outcome severity levels for events, recording events into subsequent databases as required by law or DBHDS departmental instruction or initiating follow-up actions at the facility level.
- Create a process where witnesses of events are involved in assigning the appropriate clinical outcome severity level associated for that event.

DBHDS management is currently developing the facility event tracking system internally. OSIG verified that the system is in development and separately provided DBHDS with suggestions to ensure the system meets event reporting needs.

The criteria for reporting, managing and investigating incidents are included in DBHDS DI 401. This includes the requirement that any event be reported on Form 158 by each and every DBHDS employee who witnessed and/or was involved in the event. Further, DI 401 requires that each event be reviewed and approved by the employee's supervisor. Upon approval by the employee supervisor, Form 158 is provided to the facility Risk Manager to review the event, determine the severity code level and conduct an investigation, depending on the incident type and severity. Severity codes of 03 or higher (out of 06) are required to be reported in PAIRS by the Risk Manager.

In addition, the following requirements should govern the handling of incidents and the incident report documents:

- The Library of Virginia Records Retention and Disposition Specific Schedule No. 720-001 states that logs documenting facility operations must be retained for three years after the last action, at which time they may be confidentially destroyed. This should be incorporated in DI 401. No exception is provided to maintain only one version of the events or to dispose of Form 158s if the event is subsequently recorded in facility databases.
- For suspected criminal acts, DI 201 (*Reporting and Investigating Abuse and Neglect of Clients*) states that “the facility director shall immediately contact local law enforcement...in all cases of suspected criminal activity.”
- TJC report *Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation* states “communication is a critical factor in safety; the lack of communication is often noted as a contributing factor in adverse events...faulty communication...presents risks for the safety of caregivers and patients alike.” Incident reporting is key to communicating what is occurring in the facilities with patients regarding injury, violence and other factors that should be considered for reporting severity measurement. Ensuring proper segregation of duties among documenting events, determining severity and performing investigations will assist with improving results of the events.

Having subjective clinical outcome severity level definitions can lead to inconsistencies in identifying the severity of events. Events of the same nature may be classified differently depending on the individual assigning the level, both within the facility itself as well as among the 13 DBHDS facilities. In addition:

- Assigning a level of severity to an incident by assessing only the level of injury resulting from the event, rather than assessing the severity of the event as a whole, does not capture additional violent events that are occurring within the facilities that may not have resulted in serious injury. Such incidents reduce the safety of individuals receiving services or staff working in the facilities. This includes events where patients or staff were physically handled by employees, including actions with violence.
- Tracking whether or not the same patient or employee was involved in multiple events would allow the healthcare team to properly assess if that patient’s treatment plan needs to be revised. Without such revisions to treatment plans of patients involved in multiple adverse events, DBHDS is further placing others within the facility at risk of being involved in potentially preventable unsafe situations as patients involved in multiple events could have a much higher risk of being involved in subsequent events.
- By not retaining records, there is no evidence to support that event reporting forms were properly prepared, assigned the appropriate clinical outcome severity level or reviewed at any level. Not retaining records of event reports violates the Library of Virginia Records Retention and Disposition Specific Schedule No. 720-001. Additionally, the variation of

maintaining files may create risks when oversight bodies or accrediting bodies conduct their investigations.

- By not having DI 401 dictate when law enforcement is required to be notified, serious incidents and potentially illegal incidents, such as sexual assault events, could go unreported to law enforcement.
- Having only the Risk Manager responsible for assigning the clinical outcome severity code levels, entering the appropriate events into subsequent databases such as PAIRS and providing the event follow-up creates a conflict of interest by having the Risk Manager as the sole individual assigning outcome levels to the events and following-up on the event. Managers may assign incorrect codes to events in order to avoid triggering follow-up actions for that event. This could lead to serious events not receiving proper follow-up from facility staff. This could also lead to key stakeholders not being notified when required.

Recommendation(s):

The Commissioner should ensure that a complete review and update of DI 401 and Form 158 is performed to address the following:

- Retaining reports consistently across all 13 DBHDS facilities in accordance with the Library of Virginia Records Retention and Disposition Specific Schedule No. 720-001.
- Reporting events involving sexual assault to law enforcement and maintaining the report in the event reporting system currently being built.
- Implementing a review and approval process for facility event reports in order to ensure that roles are defined clearly and that there are no conflicting responsibilities of the individuals involved in the review and reporting of events.
- Requiring that the direct witness of incidents be the responsible individual filling out the initial Form 158.
- Removing the responsibility of assigning the severity codes from the Risk Manager in order to segregate the assigning and investigating functions.
- Improving Clinical Outcome Severity Level definitions to remove ambiguity and subjectivity.
- Updating the Clinical Outcome Severity Level to ensure that levels are assigned and based on multiple factors and not solely the severity of the injury. Event reporting records all events, and injury degree should not be the only factor for consideration, especially in instances where violence has not been considered.
- Adding a requirement in DI 401 and a field to Form 158 to document and track whether or not the same patient was involved in multiple incidents and developing reports to track incidents involving the same patient to allow changes in patient treatment plans based on additional information of value.

Management Response(s):

Management agreed with the condition observed and partially agreed with OSIG's recommendation as follows:

We agree with the observations and recommendations with the exception of the recommendation to remove the responsibility of assigning the severity codes from the Risk Manager in order to segregate the assigning and investigating functions. The Risk Manager has received training related to determining severity levels and additional training will be conducted when the codes are updated. Assigning this task to someone else in the facility with no training would not be effective or efficient and could result in erroneous severity codes. To address concerns about conflict of interest the Department can require in DI 401 that investigations be conducted by a multidisciplinary team and not only the Risk Manager. DBHDS will also explore the option to do periodic look-behind, or inter-rater reliability studies to validate the severity rating made by the Risk Manager.

OSIG's Follow-up to Management's Response:

OSIG agrees with the change in recommendation documented by DBHDS. OSIG appreciates their thoughtful consideration of the Event Reporting process, including a separate, ongoing development of an incident reporting system underway in Central Office.

DBHDS IS NOT FORMALLY OR ROUTINELY ANALYZING REPORTED PATIENT INCIDENTS

Reports of incidents that occur at DBHDS facilities that are entered into PAIRS and CHRIS databases are not formally or routinely reviewed by facility services senior leadership. DBHDS senior officials reported that information on incident reports is only pulled from the PAIRS and CHRIS databases as needed to support specific inquiries related to significant events or to reconcile information reported at the facility level for such significant events. Central Office officials were unable to articulate how they ensure CHRIS or PAIRS data accuracy, what decisions, if any, are made using reports generated from CHRIS or PAIRS or if analyses of incidents are communicated to the Commissioner and/or facility management.

Central Office has neither determined nor developed a process for periodically reviewing CHRIS and PAIRS data. This includes not assigning responsibility for developing reports or analyzing data for management decision-making. DBHDS also has not considered how to communicate the results of these reviews to the management of the facilities where the incidents took place.

Standard PI 01.01.01 of The Joint Commission Comprehensive Accreditation Manual for Behavioral Health Care states that a behavioral health organization should "collect(s) data to monitor its performance." Performance elements of this standard include "The leaders set priorities for data collection" and "the leaders identify the frequency of data collection." Standard PI 02.01.01 states that "The organization analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations...and uses the results to identify improvement opportunities." Additionally, The Joint Commission Comprehensive Accreditation Manual for Hospitals states that, "When the hospital identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care, it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes."

Without an established process to periodically analyze data in the PAIRS and CHRIS databases and communicate the results of that analysis to facility directors, Central Office management and facility directors are not identifying trends across the facilities. That analysis would support strategies that could decrease patient incidents or potential abuse and neglect reports. Such strategies may include additions to TOVA training or other training beneficial for staff.

Because no systematic analyses of patient incidents from these two databases are taking place, Central Office cannot judge the adequacy or effectiveness of any strategies they do utilize to decrease patient incidents at state facilities or standards to determine if the incidents are accurately entered in the databases. By not analyzing the adequacy or effectiveness of strategies to decrease patient incidents at state facilities, Central Office will be hindered in its efforts to prevent patient incidents and prevent adequate follow up to patient incidents at state facilities.

Recommendation(s):

1. The Commissioner should create a formal policy for periodic review of PAIRS and CHRIS data and implement a utilization strategy to collect and analyze the data in order to make decisions regarding safety measures at the DBHDS facilities.
2. The Commissioner should develop a process to ensure that these reviews and any outcomes from those reviews are communicated to facility management where it would assist facilities with responding to incident trends.

Management Response(s):

Management did not agree with the condition observed by OSIG and partially agreed with the recommendation as follows:

OSIG appears to apply the Joint Commission standards to Central Office oversight when those standards apply only to each accredited state facility. Each of the accredited facilities are in compliance with the applicable standards regarding analysis of incident data, prevention, and implementation of safety measures.

Additionally, there are dramatically different patient populations across the facilities and limited utility of comparisons across diverse populations. PAIRS was created to comply with the Code requirements that DBHDS report serious patient injuries to the disability Law Center of Virginia and was not designed to support quantitative data collection and analysis contemplated by OSIG. The CHRIS system is used to report data related to abuse and neglect and human rights complaints of individuals receiving services. Select data related to abuse and neglect investigations and complaints is reviewed by DBHDS monthly with follow-up to facilities as needed.

DBHDS is in agreement with Central Office tracking and analyzing trends related to deaths and the most serious incidents, and providing data and feedback to the facilities.

OSIG's Follow-up to Management's Response:

OSIG recognizes the purpose and value of both PAIRS and CHRIS and reiterates the value of analyzing data available, specifically data that is being reported to non-DBHDS parties to assist it in analyzing the types of significant events occurring. This could be a useful tool for management to utilize to consider safety decisions for the facilities, specifically if patterns in the data are identified.

DBHDS IS NOT EVALUATING THE EFFECTIVENESS OF TOVA TRAINING AT STATE FACILITIES

Central Office has not properly assessed the effectiveness of TOVA training techniques required for direct care staff. TOVA training is intended to provide direct care staff, in addition to their experience and medical training, with the tools and techniques to:

- Recognize patients who are agitated or distressed.
- Deescalate situations with patients through nonphysical interventions.
- Deescalate situations that have become physical with minimal harm to the patient and staff.

Central Office has not updated its TOVA behavioral management program since 2012. Central Office has seen significant changes in facility operations for providing direct care to staff since the implementation of the *Code of Virginia* § 37.2-809.1. Facility of Temporary Detention in FY 2014. TOVA requirements are managed by Central Office, including the analysis and approval of TOVA techniques that agencies are allowed to use for managing patient situations. The following concerns were identified:

- For the nine facilities impacted by the *Code of Virginia* § 37.2-809.1, only VCBR has independently requested from Central Office the ability for its staff to use expanded behavioral management techniques and alternative physical restraint moves not originally authorized in the current TOVA manual published in 2012. DBHDS approved this request in 2018.
- Officials at several DBHDS facilities report that TOVA training, as currently applied, does not meet the behavioral management needs of their facility's patient population due to physical characteristics and/or patient behavior, specifically an increase in more aggressive patients. Examples of facilities expressing that TOVA training, as currently constituted, does not meet the needs of their staff and does not provide staff with the tools to manage the increase in the number of patients with more volatile behavior includes:
 - CCCA stated that TOVA techniques designed for adults do not work as well and are potentially more dangerous to implement with children.
 - PGH stated that its training is done with VCBR; therefore, the training is not preparing the employees at PGH to feel properly trained to meet the needs of their patient population. Per the PGH facility director, there has been a request to Central Office to have separate TOVA training from VCBR, but says this request has been denied.
 - SVMHI, SWMH and CAT said TOVA training needs to include additional training on how to handle the more aggressive patients they are admitting since the legislative change, in addition to the increase in the number of patients being admitted who have a charge of NGRI.

- CSH has requested from Central Office that the physical section of TOVA be expanded; however, this is still under consideration.
 - WSH would like to see additional TOVA techniques and an update to the manual in order to be more effective with its patient population, but these have not been provided to date.
 - NVMHI has requested more training to handle the increase in the number of patients admitted with an ID/DD diagnosis.
- Neither the effectiveness of the TOVA annual recertification training nor the ability of the trainers is being properly evaluated to determine if the recertification training meets its intent to properly reinforce TOVA as follows:
 - Annual TOVA recertification training for direct care staff is only required to be 4-8 hours of class training and does not require regular reinforcement training. Facility management does not agree that this is enough to properly reinforce the TOVA requirements. ESH and NVMHI have addressed this concern internally and implemented regular TOVA training requirements, including hands-on training for staff. This does not only benefit the direct care staff, but also benefits the TOVA instructors to better understand the situations that staff manage. Staff confidence that the TOVA techniques are effective was highest in these facilities.
 - The TOVA training course is not being evaluated on its effectiveness in providing direct care staff with the resources and strategies needed to deliver quality patient care. Several facilities do not have staff complete post-TOVA training surveys; these facilities include PGH, SEVTC, VCBR and HDMC.

Current TOVA techniques offered are not considered effective for handling the increase in the more aggressive patient population, including patients admitted under forensic TDOs. A common theme among facility management was concern that these patients are more aggressive, intimidating and manipulative toward staff. TOVA instructors certified to teach the TOVA course, as well as direct care staff at DBHDS facilities, are not being tracked to ensure that their certifications are up-to-date, thus not adhering to the departmental instructions guidelines in keeping certifications up-to-date. Facilities where a lapse in TOVA instructor certifications occurred include HDMC, NVMHI and SEVTC. As a result, direct care staff at these facilities received TOVA training from a non-certified TOVA instructor.

Central Office staff charged with TOVA training administration are not evaluating the effectiveness or impact the TOVA program has in providing their direct care staff with the ability and skills needed to manage their patient population. Further, OSIG noted that even though the DBHDS Office of Facility Quality Improvement and Risk Management is projecting an update for the TOVA manual in FY 2021, the current manual has not been updated in seven years. Additionally, Central Office is not assessing, in consultation with the management of all

13 DBHDS facilities, whether or not the facilities would benefit from additional techniques beyond those approved in the TOVA manual or that the appropriate training methods and hours to ensure the current TOVA techniques are reinforced enough to be effective for direct care staff.

As mandated by the DBHDS DI 104, TOVA instructors are required to be recertified every two years and are to meet with the DBHDS Office of Facility Quality Improvement and Risk Management three times per year. Additionally, as a best practice, TJC endorses three de-escalation models with different skills and interventions and multiple intervention techniques for defusing aggression in inpatient psychiatric settings, in addition to three approaches to decrease aggression throughout behavioral health units. The three cyclical de-escalation models include the *Dix and Page*, the *Turnbull, et al.* and the *Safewards Model*. Using a multidimensional aggression assessment process, the three approaches that can be used to decrease aggression throughout inpatient behavioral health units recommended by TJC include patient-centered care, staffing-centered and environmental-centered.

Because Central Office is not effectively overseeing and managing TOVA's application at each of the different DBHDS facilities, Central Office cannot identify gaps in the application that could be addressed by increased technical assistance to each individual facility specific to the facility's population, changes in policy or updates to the TOVA manual/techniques that are needed. By not effectively managing TOVA's application in each of the facilities, Central Office cannot be assured that TOVA, DBHDS' chosen behavioral management system, is working as designed to provide safe and adequate care to patients across the state in the 13 DBHDS facilities.

Recommendation(s):

1. The Commissioner should analyze TOVA's implementation at the 13 DBHDS facilities in order to develop a corrective action plan that will close gaps in training programs, taking into account the unique nature of the individual facilities by analyzing the effectiveness of the current program at each facility, to include the number of hours of training necessary and training type.
2. The Commissioner should evaluate what specific needs are not being met in regards to the current TOVA training program, instructor certification process and other behavioral management needs, then consider revisions and additions to the TOVA manual to effectively assist the diverse patient population that facilities now serve.
3. The Commissioner should consider additional training resources to assist employees in safely handling the rise in admissions of patients with various mental health diagnoses and age ranges.
4. The Commissioner should create a policy mandating that DBHDS facilities institutionalize and implement a consistent post-class survey process after TOVA training sessions to assess the effectiveness of the training.

5. The Commissioner should track TOVA certified instructor certification dates to ensure that recertification of its instructors do not lapse.

Management Response(s):

Management partially agreed with the condition observed by OSIG and partially agreed with the recommendation as follows:

DBHDS will evaluate our current program and research alternative options including the OSIG recommended models.

OSIG recommended that DBHDS track TOVA certifications. Currently this information is available, but in paper copy only. The Office of Human Rights staff will assist with transferring this information into an electronic database. Moving forward, all instructor certification dates will be entered in real time.

OSIG's Follow-up to Management's Response:

OSIG appreciates DBHDS thoughtful consideration of the TOVA training process.

DIRECT CARE STAFF ARE NOT CROSS-TRAINED TO MEET THE NEEDS OF PATIENT POPULATIONS SERVED

Twelve of the 13 DBHDS facilities do not have a formalized policy for cross-training staff, which would provide for care of patients by the same individuals across different types of units or care environments as staffing needs require. SWMHI was the facility with a cross training requirement in their Nursing Orientation policy, which included a corresponding cross-training observation/monitoring checklist

- CCCA: training on ID/DD in addition to forensic patients. Also, senior officials report that nursing staff feel their initial onboarding orientation to the various units is not adequate training to provide them with the knowledge of how each unit operates.
- CAT: training on forensic and geriatric patients.
- CSH: training on forensic and maximum security patients, NGRI patients and geriatrics patients.
- ESH: training on NGRI patients, forensic patients, geriatrics and admissions unit. Senior officials at ESH report that they are not fully staffed to have a nurse in their admissions unit, which requires a nurse to be there full-time 24 hours a day. Therefore, they have to ask other nurses from various units to come and fill a role as the admissions nurse.
- SVMHI: training on NGRI and forensic patients.
- SWMHI: training on geriatric, forensic and NGRI patients.
- NVMHI: training on NGRI patients, forensic and ID/DD patients.
- WSH: training on NGRI, forensic and ID/DD patients.
- HDMC: training on ID/DD patients.
- VCBR: training on ID/DD patients.
- Nine mental health facilities: training on forensic TDO patients.
- All facilities: training on ID/DD patients.

Central Office does not have a policy in place that requires facilities to cross-train their direct care staff. This is important in facilities where the facility serves multiple patient populations and in which direct care staff are asked to float to the various units. In these situations, it is important to create and implement a cross-training policy for direct care staff that meets the needs of each facility's operational environment and patient mix. This is due to the fact that staff have generally served the same population type in the past. With the increase in certain patient populations and patient turnover at the facilities, more medical personnel are being asked to provide patient services for which they have not received direct training.

Not having staff members cross-trained puts the employee and patients at risk for not effectively providing and receiving the patient-specific care needed. This causes discomfort among staff when they are asked to provide direct care for patients with needs they have not been properly trained to manage. If Central Office implemented a policy requiring those DBHDS facilities that service various patient populations to create a process to properly cross-train their direct care nursing staff, the facilities would be better positioned to meet the behavioral health care needs of its patients. This would also adhere to TJC's healthcare standards for caring for patients with

different needs and acuities. Staff within DBHDS facilities are frequently asked to provide nursing support in their non-primary units. A facility with an effectively cross-trained staff would be able to provide adequate care to multiple patient types. Staff would also be better positioned to fill in gaps in different units of the facility when healthcare workers are absent, as they would possess the skills needed to care for the different types of patients that the facility serves.

Recommendation(s):

1. DBHDS should implement a policy for those facilities that serve multiple patient populations to provide proper cross-training to their direct care staff related to the various units and specific patient types served.
2. Once the cross-training process has been implemented, DBHDS should also evaluate and verify whether the process has improved the ability of the facilities to adequately provide for population types within their facility.

Management Response(s):

The Joint Commission standards apply to accredited hospitals and not to DBHDS oversight of the state operated hospitals. The Joint Commission interprets and applies its accreditation standards, and if a hospital is found not to meet a standard, the hospital must develop a plan of correction within the established time frame for the specific finding regarding a discrete element related to staffing. There are no outstanding plans of correction for the Joint Commission related to staff training. OSIG has made broad statements about staff training but has not provided the level of evidence necessary to support its conclusion that DBHDS hospitals are failing to meet the Joint Commission standards for training staff as it relates to their assigned duties on units with individuals with varying clinical diagnoses, behavioral needs, age ranges, or criminal justice involvement.

In particular, the state hospitals have no outstanding findings with regards to staff training in age related competencies and OSIG has not provided specific findings relative to discrete Joint Commission standards to support its conditions observed and recommendations. More generally, in its conditions observed, OSIG appears to assume that individuals with criminal justice involvement have distinctly different clinical profiles, behaviors, and supervision and related security needs, and that they are always housed separately from civil individuals. However, more than one third of the patient population consists of individuals with criminal justice involvement, those individuals are housed in every single unit across the hospital settings, and their clinical and behavioral management needs are as diverse as their civil counterparts. Working with this population is a core skill set for staff.

State facilities provide training (such as ID/DD, Geriatric, NGRI, CST, Autism, etc...) for different populations typically admitted to their specific facility during New

Employee Orientation with expectation for annual refresher and considers this a part of their core curriculum for direct care nursing staff. In addition, SWVMHI submitted a policy (in place at the time of the OSIG unannounced visits), which covers the details of cross-training and the cross-training competency forms are attached to the policy. Facilities also provide cross-training for employees who may be assigned to different units across hospital settings.

DBHDS is in the process of reviewing staff training needs and associated competencies for working with individuals with Developmental Disabilities.

OSIG's Follow-up to Management's Response:

In accordance with the *Code of Virginia (Code)* § 2.2-309.1[B](1). It is OSIG's responsibility to "Provide inspections of and make policy and operational recommendations for state facilities and for providers, including licensed mental health treatment units in state correctional facilities, in order to prevent problems, abuses, and deficiencies in and improve the effectiveness of their programs and services." TJC's standards are known as the national and international elements that represent thorough and credible healthcare standards across the industry. The standards set by TJC, and those referenced in OSIG's findings, target important elements of patient care and functions within the facilities in order to provide quality and safe patient care as well as efficient workflow of facilities. TJC references should encourage DBHDS and the 13 state facilities to continuously strive towards improving healthcare so that consistent excellence in quality and safety outcomes are achieved.

DBHDS Central Office needs to implement a policy for cross-training direct care staff for those facilities that serve multiple patient populations to provide proper cross-training to their direct care staff related to the various units and specific patient types served. The finding fully supports this need within the agency. SWVMHI did submit a policy which covers the details of cross-training. OSIG corrected the finding to reflect SWVMHI's policy.

INSPECTION RESULTS

This report presents the results of OSIG's review of DBHDS. The following project testing was performed with immaterial, if any, discrepancies noted:

- As part of the unannounced inspections, OSIG requested and reviewed documentation relating to:
 - Admissions
 - Overtime
 - Workers' Compensation
 - TOVA training, instructor certification and policy review and updates
 - Facility operations and safety policies and procedures
 - Reporting, both to Central Office and internally with Central Office management
- OSIG noted that DBHDS facilities experience a heavy overtime burden on their payroll appropriations.
- OSIG noted that DBHDS is experiencing a significant increase in the number of TDO admissions at the nine facilities that accept TDO admissions.
- OSIG noted that the mental health facilities are, in some cases, admitting ID/DD patients that in previous times would have been sent to the training centers.
- OSIG determined that DBHDS has experienced a reduction in the number of workers' compensation claims at DBHDS facilities. OSIG compared workers' compensation data from all 13 DBHDS facilities for FY 2017 to FY 2019, and found that workers' compensation claims had no statistical correlation or negative correlation with vacancies of different types of direct care staff, overtime hours or TDO admissions. This means that for the years studied, any increase in direct care staff vacancies, overtime hours or TDO admissions has not caused an increase in workers' compensation claims at DBHDS facilities. DBHDS senior management informed OSIG that while there have been no large scale initiatives implemented in recent years to help reduce workers' compensation claims at DBHDS facilities, each facility's management reviews their facility's human resource data to identify risks and prevention opportunities for workers' compensation incidents.

Based on the results and findings of the project test work conducted for the unannounced inspection of DBHDS facilities, OSIG concluded that internal controls were operating properly as it relates to scope of objectives tested for this year's project, except as identified in the report findings.