



**CHAMPIONING BETTER GOVERNMENT PERFORMANCE**

# OSIG NEWS

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**For Immediate Release:** March 29, 2021

## **OSIG CONDUCTS DBHDS MORTALITY REVIEW AND RECOMMENDS BETTER TRAINING AND DOCUMENTATION**

The Virginia Office of the State Inspector General (OSIG) conducted a review of patient deaths in facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) to identify opportunities for active prevention of patient deaths through risk reduction and mitigation.

“As mandated by *Code of Virginia* § 2.2-309.1(1), OSIG provides inspections of and makes policy and operational recommendations for state facilities and providers in order to prevent problems and abuses and to improve the effectiveness of their programs and services,” said State Inspector General Michael C. Westfall.

As part of this mortality review process, OSIG requested autopsy reports for 95 patients. The review focused on patient-specific issues identified during the review of individual patient records whose deaths occurred between January 1, 2018, and June 30, 2019.

Among the recommendations made in the report, OSIG advised that DBHDS staff document examination findings such as bruising, lacerations and/or injuries to reflect that staff consider trauma as a potential cause and that it was, or was not, ruled out. This consideration is especially important for patients who are elderly, intellectually disabled, diagnosed with dementia or non-communicative.

“OSIG also recommended that DBHDS require more frequent documentation that outlines the normal baseline of the patient and status changes, especially in patients with co-morbidities,” said Healthcare Compliance Manager Keith Davies. “Documentation reflecting both normal and abnormal conditions of the patient will alert staff to ensure medical intervention is administered timely, when necessary.” Another recommendation from OSIG was to ensure that staff are trained on the importance of using medical back up when needed to address complex medical issues.

DBHDS operates 12 facilities across the Commonwealth of Virginia: eight behavioral health facilities for adults, one training center, a psychiatric facility for children and adolescents, a medical center and a center for behavioral health 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.

Read the entire mortality review report on OSIG’s website [here](#).

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Established in 2012, the Virginia Office of the State Inspector General manages the State Fraud, Waste and Abuse Hotline; conducts investigations and performance audits of state agencies; provides training and standards for the commonwealth’s internal audit programs; and conducts inspections and reviews of Virginia Department of Behavioral Health and Developmental Services-run facilities and programs.