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OSIG NEWS

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OSIG RECOMMENDS IMPROVEMENTS AT DBHDS FACILITIES

The Virginia Office of the State Inspector General (OSIG) found that Department of Behavioral Health and Developmental Services (DBHDS) facilities do not have an approved overtime policy that limits overtime for their direct care nursing staff, are experiencing a significant increase in the number of temporary detention order (TDO) admissions at the nine facilities that accept TDO admissions, had several understaffed shifts during the nearly two-year period reviewed and have event reporting requirements that are ambiguous and inconsistent. Those are some of the findings in a just-released report on OSIG's unannounced inspections at the 13 DBHDS facilities.

State Inspector General Michael C. Westfall said OSIG performed the unannounced visits as part of its statutory obligations.

"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."

Among the recommendations made by OSIG is the need to implement a policy for cross-training for staff who work at facilities that serve multiple patient populations.

"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," said Westfall. "Not having staff members cross-trained puts the employee and patients at risk for not effectively providing and receiving the patient-specific care needed."

The report recommends implementing an agency wide policy 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, and to 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. The report also recommends 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.

OSIG did find that most DBHDS facilities had prominently displayed posters for the OSIG Complaint Line so patients experiencing issues could voice their concerns. The Complaint Line (833-333-6744) is available to residents, patients, authorized representatives, citizens and state

employees to report situations where abuse, neglect or inadequate care is suspected in any program or facility operated, licensed or funded by DBHDS.

Read “Unannounced Inspections of Behavioral Health and Developmental Services Facilities: Fiscal Years 2018 and 2019” on the OSIG website: https://www.osig.virginia.gov/reports/

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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.