

2006 INVESTIGATION HIGHLIGHTS

By statute, VOPA receives Critical Incident Reports (CIR) submitted by State-operated institutions. VOPA also receives reports from Adult Protective Services (APS), Psychiatric Residential Treatment Facilities, and others. Every report is read by VOPA staff and pertinent information is entered into a database. All reports that involve injuries within current program objectives and other alarming or unusual reports are identified and further reviewed. In addition, the Executive Director conducts a weekly meeting to address the reports, their implications, and possible remedial action. In conjunction with this review, VOPA routinely requests that the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and others produce internal investigation reports and supporting materials.

VOPA received 180 APS reports during FY06. That constitutes a 44% increase in referrals over the previous year. The increase in referrals is attributable to VOPA's efforts at developing a collaborative relationship with the Department of Social Services and the local DSS offices.

VOPA received 122 Psychiatric Residential Treatment Facility (PRTF) serious occurrence reports during FY06. That constitutes a 61% increase in serious occurrence reporting over the previous year. The increase is attributable to VOPA's outreach and education effort. VOPA conducted site visits at each PRTF in the state and provided information regarding their reporting obligation and VOPA.

VOPA received a total of 411 CIRs from the state mental health institutions in FY06. Of those, 58 were reports of patient deaths. VOPA received a total of 580 CIRs from the state training centers. Of those, 15 were reports of resident deaths.

VOPA conducted four preliminary inquiries and three full investigations of deaths at state-operated institutions. A significant portion of the reports of patient deaths did not rise to the level of probable cause that abuse or neglect occurred.

In one instance, an individual was found who had hung herself with a sheet from her bed frame. In interviewing unit residents and former residents, many indicated that they believed that rounds were not properly conducted on the unit. However, there were no specific examples that could be verified. Several residents believed that rounds are to be conducted every 15 minutes – this is not a requirement in normal situations. There was no clear proof that any problems with observations were directly linked to the death. Nonetheless, VOPA was concerned that current and former residents fairly consistently reported that they believed rounds were not properly done. This concern was shared with the institution's risk manager who then added the proper conducting of rounds as a

performance measure for direct care staff and supervision of rounds as a performance measure for the nursing staff. These performance measures are regularly reviewed by management.

VOPA worked on 21 investigations of alleged abuse or neglect in mental health institutional settings. In one instance, an improper restraint allegation was filed under the DMHMRSAS Human Rights procedures. The case was settled before reaching the Local Human Rights Committee hearing. Personnel action was taken against the staff involved and his supervisor for failure to correct subordinate or to make proper reports of the incident. All facility direct care staff are now required to attend training on the difference between re-direction and restraint, restraint criteria and the Virginia facility behavior management technique (TOVA).

In one case, VOPA received a complaint of a peer-on-peer assault that occurred while staff were assisting the client. The client received a hip fracture during the incident. VOPA met with institution representatives several times and achieved the following results: 1) a new policy on physician orders relating to patient behaviors, 2) new policy on collecting and analyzing data in order to identify trends of peer on peer assaults and 3) purchase of a new x-ray machine and 4) collaboration with a local medical center to better address medical needs.

In another investigation stemming from a CIR, VOPA found that a resident was the victim of patient-on-patient abuse. Systemic changes put into place following our investigation include increased monitoring of patient behaviors and staff interventions, and increased use of a facility-developed database to track peer-on-peer assaults. This work is being carried over to FY07 due to its serious nature.

Complaints were made to an internal patient advocate at a state facility that when an individual was assigned a Legally Authorized Representative, the individual was not then provided all of the information necessary to provide informed consent. The Local Human Rights Committee (LHRC) reviewed the facility's documentation and found that they did not adequately explain options other than medication and were otherwise only marginally adequate. (VOPA staff are regular attendees at the LHRC meetings.) These concerns were shared with the facility's administration. The facility modified its informed consent form which was reviewed by LHRC and adopted by the facility last November.

VOPA investigated the use of a "time out" room at a state training center. We reviewed the facility's documentation for the use of "time out" rooms at an ICF/MR. In this case, the time out room appeared to be used to compensate for a lack of staff and programming. The facility agreed to stop using the time out room.

VOPA investigated unexplained injuries sustained by a resident of a training center. Our investigation found that staff rounds and reports were conducted in accordance with facility policy and that direct care staffing conformed to the regulatory minimum. There was some question whether the resident's behavior plan was properly implemented. However, there was insufficient evidence to support a finding of abuse or neglect.

VOPA received 180 APS reports/referrals during FY06. VOPA investigated 5 new cases and continued investigation on 3 carry-over cases that appeared to reflect incidents of abuse or neglect.

In one facility, we substantiated systemic problems involving medication administration and documentation. Working with the Department of Social Services, we reached an agreement to correct the problems.

An APS report to VOPA noted a client received unexplained bruising during a seizure. VOPA's investigation revealed problems with supervision at the sheltered workshop. VOPA recommended a transfer to another group home that could better meet the client's needs. Client is now in another residential setting and a day support setting that is more meaningful to her.

Staff made ten monitoring visits to various assisted living facilities throughout the state to identify medication practices and staff training.

A large number of complaints of abuse and neglect have been received regarding one particular Psychiatric Residential Treatment Facility (PRTF) as a result of VOPA's monitoring activity. Seven individual investigations and four preliminary inquiries were conducted concerning current and former patients at that facility. The complaints involve high levels of violence, sexual activity between staff and residents, misuse of seclusion and restraint, and inadequate staff qualifications, levels, and training. Staffing was so inadequate that police are regularly called to the facility to quell riots. VOPA sought remedial action from licensing authorities and other enforcement agencies. VOPA collaborated with the state survey agency (Office of Licensure and Certification of the Department of Health), DMHMRSAS Office of Licensing, and the Attorney General's Medicaid Fraud Unit in an effort to obtain greater oversight of the facility.

VOPA completed five investigations involving inmates who were allegedly denied needed psychiatric medications or treatment. VOPA responded to complaints from individuals at two city jails and three regional jails. One client with serious mental illness had been in a regional jail for more than a month without a psychiatric evaluation or medications despite repeated promises to the contrary. VOPA intervened and he was promptly seen by a psychiatrist, evaluated and medications were prescribed. The client reported improvement. However, staff then denied him a scheduled specialist appointment for a painful chronic

condition. Initial advocacy measures were not successful and VOPA then issued a formal demand letter. The client was then taken to the specialist, evaluated, and treatment prescribed.

VOPA was informed of two other individuals whose family members were very concerned that their incarcerated loved ones may not be receiving appropriate mental health treatment. However, when interviewed by VOPA, both individuals noted they did not need any assistance in this area. Following client direction, VOPA closed the inquiries.

Another family contacted VOPA about their concern that their family member may not be receiving appropriate mental health treatment. Upon inquiry, VOPA learned that the individual at times would refuse his medication and then be transferred to another facility that was a hardship for the family to visit. VOPA provided the family and the individual with information and clarification about the limitations of the facility to provide in-patient services.

VOPA completed its investigation into DMHMRSAS' failure to discharge people with mental illness from institutions. VOPA submitted a report to DMHMRSAS and is now working with DMHMRSAS to implement the major suggestions made by VOPA. Since that time, VOPA has collaborated with DMHMRSAS to secure the discharge of two people with mental illness who were denied discharge by Virginia courts. In both cases, VOPA, at DMHMRSAS' request, represented a person with mental illness found not guilty by reason of insanity of a misdemeanor. Although DMHMRSAS certified that the individuals should be discharged, the discharge was opposed by localities and initially denied by local courts. VOPA represented each person at a trial and secured their discharges.