



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Inappropriate Surveillance James A. Haley Veterans' Hospital Tampa, Florida

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Contents

	Page
Executive Summary	i
Introduction	1
Purpose.....	1
Background	1
Scope and Methodology	5
Results and Conclusions	10
Issue 1: The Quality and Appropriateness of the Medical, Nursing, and Social Work Care provided by JAHVH to the Patient.	10
Issue 2: Nurse Staffing	11
Issue 3: The Installation, Use, and Eventual Discontinuation of Video Surveillance of the Patient in his Room at JAHVH.....	11
Issue 4: Number of Video Surveillance Cameras in VA Healthcare Facilities	24
Issue 5: Location of Video Surveillance Cameras in VA Healthcare Facilities	25
Issue 6: Signage to Notify Others of the Use of Video Surveillance Cameras.....	26
Issue 7: Hidden Video Surveillance Camera Usage in Individual Patient Rooms	27
Issue 8: Use of Video Surveillance Cameras with Audio Capability	28
Issue 9: Identification of Video Surveillance Camera Policy Usage in VA Healthcare Facilities.....	29
Recommendation	30
Appendixes	
A. Under Secretary for Health Comments	31
B. OIG Contact and Staff Acknowledgments	33
C. Report Distribution	34

Executive Summary

Introduction

At the request of Senator Bill Nelson of Florida, Chairman Jeff Miller, House Veterans' Affairs Committee, and Congressman Mike Michaud, Ranking Member, House Veterans' Affairs Committee, the VA Office of Inspector General initiated a review into a media report that a hidden camera was placed in a brain-damaged patient's room without consent of next-of-kin.

In August 2011, the patient was transferred from the Miami VA Healthcare System, Miami, FL, to James A. Haley Veterans' Hospital (JAHVH), in Tampa, FL. A 399-day hospital stay ensued concluding with the patient's transfer to the Atlanta VA Medical Center, Decatur, GA, in September 2012. The patient's JAHVH stay abounded with clinical and social challenges. There was broad tension over discharge planning. JAHVH did not meet many of the patient's family's expectations; and, in turn, many JAHVH staff felt abused by some of the patient's family members.

This state of affairs came to a head in June 2012. A nurse documented in a Report of Contact, dated June 13, 2012, that the patient's family became aware of a video camera in a smoke-detector-like cover that had been placed in the patient's hospital room that same day by JAHVH staff.

In order to be responsive to Senator Nelson's request to learn whether any other VA facility in the country has used video surveillance cameras (VSC), we developed a questionnaire to ascertain the usage of all surveillance cameras in VA Medical Centers, and the policies that governed their employment. We then followed up with a second questionnaire focusing exclusively on the use or presence, current and past, of hidden cameras in patient rooms. Explanation and elaboration were requested if we received an affirmative response to our question about hidden camera placement in a patient room.

Results

Throughout the course of medical care spanning more than 15 years, the patient was treated by primary care and specialist providers at several VA healthcare facilities. He was hospitalized continuously at VA medical facilities from July 8, 2011, until October 10, 2012. VA medical records document occasional minor lapses in quality of care. These minor lapses had no significant clinical sequelae and the totality of the medical record indicates that the patient received extensive, even exhaustive, high-quality care at JAHVH.

The decision-making process surrounding the installation of a video camera into the patient's room is well documented by an extensive contemporaneous email record.

Interviews and additional documents were consistent with the email record. It is correct, as alleged and reported, that the patient's family had no input into the decision to install a VSC in the patient's room. Nevertheless, the patient's family was aware of the VSC when it was activated and began to record video images.

From interviews with staff, reports of contact, and personal notes from leadership, it appears that the intent of placing the VSC was for patient safety. It was expected that the camera would ascertain who or what was interfering with nursing care of the patient, e.g., changing the incline position of the patient's bed, changing the rate of infusion on the patient's feeding and medication pumps, and/or repositioning the patient without orders to do so or apparent explanation. We concluded that given the documented evidence, the use of the camera for these patient safety concerns was reasonable.

Our nation-wide survey of VSC usage in VA healthcare facilities revealed that all VA healthcare facilities are currently using VSCs. The average number of VSCs currently installed in VA healthcare facilities is 148. The total number of VSCs installed at JAHVH is 279.

The Veterans Health Administration has some requirements for VSC usage in specific areas of facilities. Mental Health Residential Rehabilitation Treatment Programs must secure all entrance and egress doors and points of access are monitored utilizing Closed Circuit TV (CCTV). A camera system that records all activity is recommended in pharmacy vaults and all storage areas containing working stocks of controlled substances. Childcare facilities and canteens are required to utilize CCTV for security reasons. In non-clinical areas of high traffic such as parking lots and garages, building entrances and exits, common areas, waiting rooms, canteens, stairwells, and research areas, the use of VSCs is standard.

We found that 74.5 percent of facilities reported that VSCs were located in clinical areas. Clinical areas that often use VSCs include: Mental Health Units, Domiciliaries, Pharmacies, Emergency Departments, Intensive Care Units, and Geriatrics/Extended Care Units. These VSCs are typically monitored by clinical staff.

We found that nearly half of VA healthcare facilities had signage posted notifying the public of the presence of VSCs. No facilities reported current use of a hidden camera. We also determined that there are currently no hidden cameras in patient rooms at JAHVH. Seven facilities had employed hidden VSCs in the past. All instances identified contained a law enforcement component and/or involved suspected criminal activity.

Not including the use of audio-video cameras to limit access to restricted space, ten medical centers reported that they were currently using VSCs with audio capability. This capability is used in the common area of the VA Manila, PI Outpatient Clinic, located on U.S. Embassy property; in police interview rooms; in sleep laboratories; and in mental health seclusion rooms.

Of the 141 total respondents to the national survey, 104 facilities reported that they had a policy that addressed the use of VSCs.

Recommendation

We recommended that the Under Secretary for Health ensures that VHA policy addresses the clinical uses of covert and overt video surveillance cameras in a clinical setting, including public notification, informed consent, approval, and responsibility for use of these devices, as well as detail procedures for staff to follow in obtaining video recordings for teaching, patient care and treatment, patient safety, healthcare operations, general security, and law enforcement purposes. Restrictions on the use of personal electronic devices within a VA facility to photograph and video should also be considered.

Comments

The Under Secretary for Health concurred with our recommendation and provided an acceptable action plan. (See Appendix A, pages 43–44, for the Under Secretary's comments.) We will follow up on the planned actions until they are completed.



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Introduction

Purpose

At the request of Senator Bill Nelson of Florida, Chairman Jeff Miller, House Veterans' Affairs Committee, and Congressman Mike Michaud, Ranking Member, House Veterans' Affairs Committee, the VA Office of Inspector General initiated a review on August 2, 2012, into a media report that a hidden camera was placed in a brain-damaged patient's room without consent of next-of-kin.

In August 2011, a patient was transferred from the Miami VA Healthcare System (VAHCS), Miami, FL, to James A. Haley Veterans' Hospital (JAHVH), in Tampa, FL. A 399-day hospital stay ensued concluding with the patient's transfer to Atlanta VA Medical Center (VAMC), Decatur, GA, in September 2012. This patient's JAHVH stay was associated with numerous medical, nursing, social work, and legal concerns. The latter, in particular, surrounded first the placement of a video surveillance camera (VSC) in the patient's room on June 13, 2012, and its activation 2 days later against the patient's family's wishes. These issues engendered extensive Congressional, Secretarial, and media interest. The purpose of this inspection was to review the numerous facets of the patient's care, video surveillance at JAHVH, and video surveillance in the Veterans Health Administration (VHA) generally.

Background

A. Inspection Overview

In August 2011, a then 79-year-old Korean War veteran was transferred from Miami, FL, VAHCS to JAHVH in Tampa, FL. The patient's JAHVH stay abounded with clinical and social challenges. There was broad tension over discharge planning. Further, from a social perspective, JAHVH did not meet many of the patient's family's expectations; and, in turn, many JAHVH staff felt abused by some of the patient's family members. Many of these controversies, which are detailed in this report, quickly came to the attention of JAHVH's senior management, followed soon thereafter by VA's Central Office (VACO), and Congress.

The state of affairs came to a head in June 2012. A nurse documented in a Report of Contact, dated June 13, 2012, that the patient's family became aware of a video camera in a smoke-detector-like cover that had been placed in the patient's hospital room that same day by JAHVH staff. The patient lacked sufficient mental capacity to give permission for installation of this VSC and it had been placed without the permission of the patient's family. Two days later, on June 15, the VSC was activated despite the patient's family's objections.

On August 2, 2012, Senator Bill Nelson (D-Florida) wrote to VA's Inspector General¹:

I'm seeing news reports on the use of a hidden camera in the room of at least one patient at the James A. Haley VA Medical Center.

The Tampa Bay Times reported that a covert camera — apparently designed to look like a smoke detector — was installed in the room of a severely brain-damaged veteran without the hospital notifying his family. I am enclosing this article.

In it, hospital officials offer differing accounts of the incident including whether the camera was capable of or used for recording.

It goes without saying that this incident raises serious questions. Therefore, I am requesting a full investigation not only of this incident, but also of whether Haley ever used hidden cameras before and whether any other VA facility in the country has ever used them.

VA's Office of Inspector General (OIG), Office of Healthcare Inspections (OHI), conducted an inspection to address these concerns. In addition to Congressional inquiries, media reports, and repeated family complaints to various VA officials, on August 14, 2012, and again on October 14, 2012, the patient's family sent letters directly to OIG raising many similar issues.

B. James A. Haley Veterans' Hospital

JAHVH is a tertiary care facility located in downtown Tampa, FL. It serves as one of the seven major units that comprise Veterans Integrated Service Network (VISN) 8, the "VA Sunshine Healthcare Network." VISN 8 covers all or parts of Georgia, Florida, and Puerto Rico, and is comprised of Bay Pines VAHCS, Caribbean VAHCS, Orlando VAMC, Miami VAHCS, North Florida/South Georgia VAHCS, JAHVH and Clinics, and West Palm Beach VAMC.

¹ Letter quoted in its entirety.



Figure 1. VA Sunshine Healthcare Network²

JAHVH has approximately 415 beds, is a teaching hospital, and is classified as a Clinical Referral Level 1 Facility — the highest referral level. As a teaching hospital, it is affiliated with The Morsani College of Medicine at the University of South Florida and provides medical student and residency training in medical and surgical specialties and subspecialties. Many JAHVH staff have academic appointments at The Morsani College. It has four community-based outpatient clinics located in New Port Richey, Brooksville, Lakeland, and Zephyrhills, FL. The hospital serves a veteran population of approximately 177,400, primarily in a 4-county area in central and western Florida, to include Hernando, Pasco, Hillsborough, and Polk counties. It provides a broad range of inpatient and outpatient healthcare services in medicine, surgery, psychiatry, physical medicine and rehabilitation, spinal cord injury, neurology, oncology, dentistry, geriatrics, and extended care. It is home to one of the VHA's four primary nationwide polytrauma centers. In addition to approximately 415 hospital beds, JAHVH has a 118-bed community living center (CLC).

² From: <http://www.visn8.va.gov/> (accessed 12/28/2012).

C. Identification of Video Surveillance Camera Policy Usage in VA Healthcare Facilities

The VACO Office of Security and Law Enforcement issued a Standard Operating Procedure (SOP) Manual that is to be customized and used by each facility. One part of the SOP is entitled, “Chapter V, Section A Use of the [Security Surveillance Television System] SSTV System.” SSTV is defined as Security Surveillance Television System. This particular portion of the SOP is commonly referred to as “SOP 5A.” The template version of the VACO SOP has prompts for each facility to customize portions of the document. For example, the facility would customize who would have the responsibility for the overall operation and day-to-day operation of the system. The VACO SOP has 13 numbered paragraphs.

The stated purpose of the SSTV system in the SOP “is to deter and, at times, detect criminal activity.” The SSTV system appears to be operational 24 hours a day, 7 days a week. The system is monitored by police officers and is linked to a recording device that is programmed to record 24 hours a day without interruption. SOP 5A is intended for VA police practices and does not apply to clinicians for patient monitoring. SOP 5A does not address notification to individuals who may be viewed and recorded by the SSTV system.

In addition, VA Handbooks 0730, 0730/1, and 0730/2 (entitled, “Security and Law Enforcement”) refer to SSTV systems as part of police operations and technical support to be used for observation of potential criminal activity. Many facilities extracted the SSTV sections from VA Handbook 0730 and submitted the extractions as their “policy” addressing video surveillance cameras.

Also, the VHA “Physical Security Design Manual for VA Facilities” (dated July 2007) was used as a local policy. This VHA manual, section 10, “Security Systems” stated, “This chapter addresses physical security standards associated with the selection, application, and performance of electronic security systems (ESS).” Notification and consent were not addressed in the VHA manual.

The SSTV system appears to have surveillance cameras which are installed permanently, and the cameras are *overt* surveillance cameras; they are clearly visible in order to deter criminal activity. Some of the facilities post signs to alert anyone on the grounds or in the building(s) to the presence of the cameras and an SSTV system. By contrast, *covert* surveillance cameras are not addressed in SOP 5A.

Scope and Methodology

A. Onsite Visits, Meetings, and Interviews

OHI inspectors visited JAHVH on September 4–7, September 17–18, and October 9–12, 2012. Additionally, in the context of developing a nationwide survey of VCS at VA healthcare facilities, OHI staff visited Dallas, TX, VAMC on November 28, 2012, in order to inspect its VSC system with its Chief of Police Service.

On September 4, 2012, we interviewed several members of the patient's family. We were unable to interview the patient because he was in a persistent comatose state. We inspected the patient's room where he was hospitalized and in which the VSC had been placed.

At JAHVH, staff at all levels were interviewed, including clinicians that directly cared for the patient and medical center administrators involved in decisions regarding the patient. Clinical staff included physicians, nurses from all wards and units on which the patient resided, social workers, and respiratory therapists. With regard to nursing staff in particular, we interviewed nursing staff at every level: managerial nurses, registered nurses, licensed practical nurses (LPNs), and certified nursing assistants.

We interviewed JAHVH quality assurance staff, patient advocates, a member of the Bioethics Committee, utilization management staff, and patient safety experts involved in this patient's care, assessment, and evaluation.

We interviewed relevant parties to the video camera procurement and installation. These interviewees included staff from JAHVH's Bioengineering Service, including bio-engineering personnel who ordered and installed the video camera, and Procurement Service personnel, who placed the order for the video camera and associated equipment.

Since the JAHVH Police Service was summoned on numerous occasions to intervene in disputes between family members and staff, and the JAHVH Chief of Police (COP) Service was privy to discussions prior to the VSC placement, he was interviewed.

A staff attorney from the Regional Counsel Office who consulted with JAHVH management regarding placement of the VSC and after its activation was interviewed. Relevant officials in VACO including VHA's Chief Nursing Officer and the Director, Network Support, were interviewed.

Materials and allegations provided to us by the patient's family were extensive and expansive. We performed a comprehensive review of the patient's VA care and JAHVH care in particular, and attempted to identify major clinical themes in the patient's care. A review of each of the patient's family's allegations against JAHVH, many of a personal nature, was beyond the scope of this review. Their clinical allegations had already been

carefully reviewed by JAHVH and we reviewed JAHVH's reviews. We are aware of, but do not report on either police issues or alleged staff harassment by the patient's family.

B. Document Reviews

We examined the patient's JAHVH electronic health records (EHRs) using VA's Compensation and Pension Record Interchange (CAPRI) system. This included review of over 3,400 JAHVH progress notes. Multiple additional EHR notes were reviewed from Richmond, VA, and Gainesville, Tallahassee, and Miami, FL, VA healthcare facilities. Clinical documents not contained in CAPRI were obtained and reviewed.

Various JAHVH committee documents were obtained and reviewed including JAHVH's Bioethics Committee meeting minutes, Patient Safety Committee meeting minutes, Patient Advocate records and associated Patient Advocacy Tracking System reports showing complaints related to the patient, and Quality Management meeting minutes.

The patient's stay generated voluminous reports and documents. These were obtained and reviewed and included incident, adverse events and police reports, family and staff complaints, Reports of Contact, and internal facility and VACO documents.

We identified an American Federation of Government Employees/National Nurses United grievance filed by nurses concerning interaction with patient's family and documents sent from unions to Human Resources.

The purchase order for video cameras, digital video recorder (DVR) and the associated specifications and manuals were reviewed.

Throughout this patient's JAHVH stay, administrative correspondence was generated including issue briefs to VISN 8 and VACO, as well as Congressional correspondence. These materials were obtained and reviewed.

We reviewed extensive email correspondence from the patient's family to JAHVH staff and management, among JAHVH staff, and email surrounding the decision to install the VSC system. VA Police were summoned on numerous occasions to address disturbances between the patient's family members and JAHVH staff. We obtained and reviewed the resulting police reports.

We reviewed relevant VA, VHA and facility policies such as: VHA's National Patient Safety Improvement Handbook, VHA Handbook 0730, SOP 5A (title), VHA Manual 10.1, *CCTV Monitoring and Surveillance*, Hospital Policy Memo 142B-02 (title), VHA Taking and Disclosing of Photographs, VHA Form 1002, Handbook 1605.1, Consent Handbook 1907.01.

C. Video Recording

OIG's Office of Investigations took possession of the video camera recordings made between June 15 and July 27, 2012, (43 days). The VSC sent image data via a video feed to a DVR and monitor. The DVR stored the image data. The VSC transmitted continuously to the telemetry room located on ward 4N. OHI and Office of Investigations staff reviewed some, but not all, of these 43 days of continuous monitoring. There was no audio component to the recordings. In addition to the original VSC recordings, copies were made by and reside in the possession of JAHVH and VACO. We took steps to account for these copies.

D. Nationwide Survey of Video Surveillance Camera Usage in VA Healthcare Facilities

Through the work described above, we were largely able to determine JAHVH's policies regarding VSC, current usage of VSC devices in other locations of the facility, and JAHVH's past uses of VSCs. In order to be responsive to Senator Nelson's additional request that OIG learn "whether *any other VA facility in the country* [emphasis added] has ever used them [hidden cameras]" OHI developed an extensive, broad-based questionnaire to ascertain the usage of all surveillance cameras in VAMCs, and the policies that governed their employment. We then followed up with a second questionnaire focusing exclusively on the use or presence, current and past, of hidden cameras in patient rooms. Explanation and elaboration were requested if we received an affirmative response to our question about hidden camera placement in a patient room.

Each VISN Director and VAMC Director was initially sent a memorandum requesting completion of our extensive questionnaire about the current use of VSCs in the facility for which they had responsibility. For VAHCSs that consist of two or more campuses or divisions, we requested that a separate questionnaire be completed for *each campus or division* of that VAHCS. We did not include VA Community Based Outpatient Clinics in our data collection requests.

All responses were submitted online via a questionnaire web link. We also requested a copy of facility policies and procedures governing the local use of VSCs, as well as an electronic copy or picture of at least one sign notifying the public of surveillance cameras in use, if indeed such signage was in use. The total number of HCSs asked and completing the questionnaire was 141. However, because many VAHCSs consist of multiple campuses and divisions, the number of completed questionnaires totaled 178.

This inspection was performed in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Clinical Case Summary

The patient is an elderly man who has received care at multiple VA healthcare facilities. The EHR reveals that he was hospitalized at four VA medical facilities, including Gainesville VAMC for 16 days in August 2008; Miami VAHCS from July—August 2011; JAHVH from August 2011—September 2012; and Atlanta VAMC from September—October 2012.

The patient has a history of being seen at VA facilities dating to 1987 (Richmond, VA VAMC). In August 1999, he was seen at Tallahassee VA Outpatient Clinic's (VAOPC's) Eye Clinic. Later that year, he was evaluated at Tallahassee VAOPC Primary Care Clinic.

During the ensuing nine years, the patient was seen only intermittently at VA healthcare facilities. In March 2004, the veteran received treatment at the Tallahassee VAOPC Primary Care Clinic. In January 2008, the patient again received treatment at Tallahassee VAOPC.

The patient was first hospitalized at the Gainesville, FL, VAMC in August 2008. During the 4 months following discharge from Gainesville VAMC, the patient was seen at Tallahassee VAOPC.

In July 2009, approximately 11 months after discharge from Gainesville VAMC, the patient was taken by ambulance to that VAMC after he was reportedly found to be unresponsive by a family member.

In March 2010, the patient was seen again at Tallahassee VAOPC. Fifteen months later, in June 2011, the patient was seen at Gainesville VAMC's Urgent Care Clinic.

One week later, while traveling with the patient in southern Florida, the patient's daughter contacted VISN 8's telecare line and related that the patient was having medical complaints. It was advised that the patient seek medical care. Approximately 24 hours later, the patient was brought to Miami VAHCS's ED. From there, he was admitted to the medical intensive care unit (MICU).

JAHVH

In August 2011, the patient was transferred to the JAHVH VAMC and admitted to ward 5 South (5S), a medical unit, in stable condition. At that time, the patient was receiving feedings by Gastrojejunostomy (GJ) tube.

The question of power of attorney (POA)³ arose. A registered nurse wrote in a note signed at 8:10 a.m. on August 10, that at “0030 [12:30 a.m.] [I was] approached by family member [family member named] [who] states she is pt’s [the patient’s] POA no papers avail. [available].”

On JAHVH HD 293, a nurse documented an incident in which a family member increased the level of the patient’s oxygen concentration. The nurse documented a discussion with family member regarding how to improve patient’s oxygenation without initially increasing oxygen concentration. The family member informed the nurse that “he was taught to do this.” The nurse discussed the family member’s comment with the respiratory therapist who denied any education or training with the patient’s family.

On JAHVH HD 305, a nurse wrote that a family member was at the bedside and said that the patient “had sheet over his head when coming to bedside although this was not the case when nurse left out of room just minutes prior [emphasis added].” Later on the following day, continuous one-on-one staff observation of the patient was instituted.

On June 14, a staff nurse documented that family members were concerned about a newly installed device smoke-detector-like cover on the ceiling and stated that a maintenance man had informed them it was a camera. The staff nurse also documented that she was “unaware of the situation and they [the family members] could speak with the nurse manager in the morning.”

This device was indeed a camera that had been installed a day earlier. However, it was inactive at the time of installation, and was not activated until two days later, on June 15. This camera activation was done despite the patient’s family’s protestations. On July 27, the VSC placed on June 13 and activated on June 15, was removed from the patient’s room. In September 2012 (JAHVH HD 398), the patient was discharged from JAHVH and transported by air ambulance to Atlanta VAMC.

³ A power of attorney (POA) is a written authorization to represent or act on another's behalf in private affairs, business, or some other matter, including health care decisions.

Results and Conclusions

Issue 1: The Quality and Appropriateness of the Medical, Nursing, and Social Work Care provided by JAHVH to the Patient.

Throughout the course of medical care spanning more than 15 years, the patient was treated by primary care and specialist providers at several VA healthcare facilities. As his condition worsened, he was hospitalized at four different VA medical facilities, and he was hospitalized continuously from July 2011, until October 2012. The EHR documents minor lapses in quality of care in this patient's clinical care at JAHVH. However, the totality of the medical record indicates that the patient consistently received extensive, even exhaustive, high-quality care at JAHVH.

He suffered a witnessed cardiopulmonary arrest at JAHVH on JAHVH HD 8. In that the arrest was witnessed, a Code Blue was called immediately and cardiopulmonary resuscitation was initiated immediately. The patient's family alleged that the patient's cardiopulmonary arrest was avoidable and even the result of negligence. We could not substantiate this allegation based on an extensive review of the EHR.

Documentation in the EHR shows that during his Miami VAHCS and Tampa VAMC hospitalizations, the patient received comprehensive care delivered by a broad range of healthcare professionals, including physicians, nurses, social workers, and therapists. Consultations with numerous medical and surgical specialists were obtained and extensive diagnostic and therapeutic interventions were undertaken.

Because of the patient's condition, often difficult, almost irreconcilable clinical situations occurred and had to be balanced. JAHVH staff recognized and worked very hard to balance the concerns.

The EHR and associated documents reveal that many nursing and social work staff worked to exhaustion and beyond in the care of this patient. Several JAHVH staff alleged instances of interference with care by the patient's family. The VA Police were summoned to quell, diffuse, or react to disruptions on multiple occasions. JAHVH leadership and staff asserted that the interactions with some of the patient's family members contributed to staff "burnout." In addition, the staff alleged that they were verbally and emotionally abused and threatened by some members of the patient's family.

There were extensive disputes about placement of this patient which are well documented in the EHR and elsewhere. These appeared to be legitimate differences of opinion. The patient's family was very concerned about his welfare in a non-acute medical setting, despite the JAHVH's Director's exercise of her prerogative to waive the service-connection requirement for JAHVH CLC admission and the presence of very high level skilled nursing facility with extensive experience caring for patients such as the case

patient in the Tampa metropolitan area. In turn, JAHVH clinical staff often felt an acute Medical Service ward bed was not required. This was compounded by the family's refusal to consider a nursing home situation, citing cultural reasons. This dilemma was also aggravated by the fact that even as JAHVH pushed for a less acute setting, the patient would indeed often take a significant turn for the worse that would require acute medical care. We are unable to resolve this dispute, except to the extent when it became egregious.

Social workers played a key role in coordinating discharge planning and providing case management services to this patient. The EHR reflected that the needs and decisions of the patient and family members were respected and accommodated within the dictates of sound medical practice, family support systems, and available resources. The EHR documented social work involvement for the patient that included interdisciplinary collaboration with various disciplines for effective health care planning and discussions for long term care placement in an extended care facility if indicated.

Issue 2: Nurse Staffing

We interviewed the Chief and Associate Chief of Patient Care Services regarding the facility's nurse staffing methodology. We obtained nurse-staffing data for each unit for each day the patient was there, with the exception of the patient's 1-day stay in the SICU. We compared the facility's Target nursing hours per patient days (NHPPD) to the Actual nursing hours per patient days.

In conclusion, while staffing varied somewhat from day-to-day and unit-to-unit, average Target and Actual were close and we found no correlation between quality of care and nurse staffing.

Issue 3: The Installation, Use, and Eventual Discontinuation of Video Surveillance of the Patient in his Room at JAHVH.

The patient's EHR does not reveal discussion of use of video surveillance of the patient as a part of his ongoing JAHVH care. However, it does document a number of events which played a large part in a VSC being placed in the patient's room.

On June 8, 2012, a nurse wrote that a family member was at the bedside and said that the patient "had sheet over his head when coming to bedside *although this was not the case when nurse left out of room just minutes prior* [emphasis added]."

A June 5 email from the Nurse Manager of ward 4N to the Chief Nurse, Acute Care; and Chief Nurse, Ambulatory Care contained the following:

"I have some concerns about the care of [the patient]...My primary concern is that on several occasions, nurses have reported supplies missing and

settings changed to tube feeding, bed settings, suctioning/oxygen settings which they believe were done by the family.”

“Earlier today, [2 JAHVH nursing staff] reported that [they] had just finished am [morning] care and [the patient’s] [medical device] was intact...shortly thereafter, [a family member] arrived and complained that [the] [medical device] was off.”

“I have prior report of contact where the nurse reported that the rate of IV [intravenous] infusion was changed.”

“The nurse yesterday believes the family put the tube feed on hold.”

The author concluded this communication by writing, “I don’t know if it is possible, but I think the patient should be on 24 hr surveillance monitoring.” The Nurse Manager wondered, “Are there any monitored rooms?”

The next day, June 6, the Chief Nurse, Acute Care responded to the ward 4N Nurse Manager (with copies to the Chief Nurse, Ambulatory Care and JAHVH’s Associate Director (AD), Patient Care/Nursing Services) as follows:

“There are not any camera-monitored rooms in Acute Care.”

“The family has been encouraged to perform hands-on care with the goal of taking him home, so I don’t know who would monitor the video (if we had it) and make the distinction between appropriate and inappropriate ‘touching’ by the family. I share your concerns.”

On June 8, the ward 4N Nurse Manager wrote a formal memorandum to the Chief Nurse, Acute Care. The subject line was “Patient safety concern” and in this memorandum, six specific incidents of concern over the previous 13 days were detailed:

5/27/12 [H]ead of bed noted to be less than 30%. Was discovered at shift change, however, nurse from previous tour states head of bed was at 30%

5/29/12 Nurse noted that [medication] rate changed Nurse decreased rate to ordered setting

5/31/12 [A family member] told assigned nurse that Nurse Manager told them they could do everything for the patient. This statement was false. There is a skills check-off folder which includes skills that can be performed by the family. No documentation of managing oxygen is present.

6/4/12 [A family member] noted to change O2 settings ... for patient. Nurse verbally reported that family placed tube feeding on hold.

6/5/12 Nursing assistant reported that her and assigned LPN had just finished am care and [a medical device] was intact. Per the NA [nursing assistant], shortly thereafter, son arrived and complained that [the medical device] was off.

6/8/12 Nurse had performed ...care and left [the] room. Approximated five to ten minutes later, [A family member] approached nurse's station stating that top sheet was pulled over the patient's head. The nurse had just left the room and reports that sheet was pulled under arms to mid chest. Nurse witnessed that sheet was pulled over patient's head.

“My primary concern is that on several occasions, nurses have reported supplies missing and settings changed to tube feeding, bed settings, suctioning/oxygen settings which they believe were done by the family.”

The ward 4N Nurse Manager concluded as follows: “I think the patient should be on 24 hr [hour] surveillance monitoring to ensure patient safety.”

The data reviewed by OHI, indicate that the June 8, incident in which a nurse who had taken care of the patient and left him positioned with the sheet under his arms at the mid-chest level, and then soon thereafter observed a sheet to be pulled over the patient's head, was the pivotal event that set in motion the actual placement of VSC monitoring.

Later on June 8, the Chief Nurse, Acute Care emailed JAHVH's AD, Patient Care/Nursing Services; the JAHVH Chief of Staff (COS); a JAHVH staff physician; and JAHVH's COP reiterating and elaborating upon the concerns in the June 8, ward 4N Nurse Manager's memorandum described above. Specially, with regard to the incident of the sheet found over the patient's head, this email stated:

The latest incident was this morning, so I talked to [employee identified], the RN assigned to the patient. She said she had gotten report, went directly to the [patient's initial] family room, [performed care on the patient], repositioned the patient and the top sheet (pulled it out from under him and up to chest level), checked his tubes and pumps, etc. He was perfect and he was alone (no family). She said that approximately 10 minutes later, the [family member identified] pulled her into room and said something like, ‘Look at how you left him.’ The sheet was up over the patient's head and tube feeding pump was on hold/occluded. [The employee] repositioned him and restarted his pump. *She said no one else had been in the room in that 10 min [minute], and this patient couldn't have possibly pulled the sheet up over his head [emphasis added].* The staff believes the family is deliberately creating small sabotage situations so they can document incompetent care.

The AD, Patient Care/Nursing Services responded, again that same day, with copies to the COS, the staff physician, and the COP, stating: “If so, this is obstructing the patient’s care – Is it possible for a hidden camera be placed in room to detect if this is occurring?” Soon thereafter, again on June 8, the COP replied, “We have discussed with [the] COS to install a camera for patient care monitoring through BIO MED [bio-medical] to be monitored at the Nurses station,” (with copies to the COS, the staff physician, and the Chief Nurse, Acute Care).

VSC installation continued to be discussed via email. On June 11, a Health Systems Specialist wrote to the COP and JAHVH’s Chief, Biomedical Section, (with the Chief Nurse, Acute Care; the AD, Patient Care/Nursing Services; and the ward 4N Nurse Manager copied) inquiring what else might be needed for a camera to be “installed on 4N to monitor this patient?” The Chief, Biomedical Section responded on June 11, including the COP; the Chief Nurse, Acute Care; the AD, Patient Care/Nursing Services; the ward 4N Nurse Manager; and a JAHVH general engineer in the response: “Are we talking about a hidden camera or one in plain sight?”

The AD, Patient Care/Nursing Services responded to the Chief, Biomedical Section only on June 11, “*Hidden in the patient room*, [emphasis added] as we suspect the family members may be doing things to the patient that interferes [sic] with his care.”

The Chief, Biomedical Section responded to the AD, Patient Care/Nursing Services, also on June 11, (copied to the COP and a JAHVH general engineer), “I thought when we spoke that it was not to be hidden.”

The AD, Patient Care/Nursing Services then responded to the Chief, Biomedical Section, again on June 11, (including the COP and the JAHVH general engineer in this response, “We don’t want the family to know that they are being videotaped. The goal is to detect if they are tampering with the patient’s treatment.”

The Chief, Biomedical Section responded to the AD, Patient Care/Nursing Services, yet again on June 11, 2012, (including the COP and the JAHVH general engineer in the response, “We are looking to buy one right now.”

The AD, Patient Care/Nursing Services responded to the Supervisory Biomedical Engineer, on June 11, 2012, including the COP and the general engineer on her response, “Thanks, [Chief of the Biomedical Section named].”

In a parallel exchange of emails, on June 8, when the COP replied, “We have discussed with [the] COS to install a camera for patient care monitoring through BIO MED [biomedical engineering] to be monitored at the Nurses station,” (with copies to the COS, the staff physician, and the Chief Nurse, Acute Care), the AD, Patient Care/Nursing Services replied to the COP and included the Chief Nurse, Acute Care; the COS; and a JAHVH staff physician stating, “The nurses will not be able to constantly monitor the

camera, so can it be recorded for viewing later as with the camera monitors in the ER [emergency room]?” Again on June 8, the AD, Patient Care/Nursing Services sent an additional email to the COP; the Chief Nurse, Acute Care; the COS; and a JAHVH staff physician asking, “Is it necessary for SWS [Social Work Services] to notify protective services if suspect [sic] family interference with patient’s care, or wait until there is solid evidence?” The COP forwarded this email string to JAHVH’S Police Officer Instructor on June 8, as an “fyi” and without replying to the parties on the email.

Additionally, the AD, Patient Care/Nursing Services forwarded the Chief Nurse, Acute Care’s initial email of June 8, to VHA’s Chief Nursing Officer (CNO) that same day. VHA’s CNO responded to the AD, Patient Care/Nursing Services the same day stating, “Has protective services been notified?” The AD, Patient Care/Nursing Services responded to VHA’s CNO, also on June 8, stating, “Don’t believe so, [VHA’s CNO], as this just reported – I will ask. Will need to provide evidence – I’ve asked our Police to install a camera in the room in order to validate the staff’s perceptions. They have agreed to do so.”

An undated, handwritten note by the AD, Patient Care/Nursing Services states, “Discussed at Director’s report. Asked for hidden camera since concerns that the family obstructing/tampering with care. [The COS] suggested 1:1 [one-to-one staff to patient observation], I objected due to resource intensity of 1:1. [The COP] objected to [the] camera. [The Medical Center] Director asked him what else he suggested then. And then [the Medical Center] Director authorized installation of the camera as I’d requested.”

On June 12, an inventory manager in the JAHVH Logistics Service placed a Purchase Card Order from MCM Electronics⁴ and completed a “Request, Turn-In, and Receipt for Property or Services” form which listed the following:

- “Standalone DVR system to provide 24 hr monitoring for patients” (quantity ordered: 1)”
- “AC Power Transformer to operate camera” (quantity ordered: 2)” “Color smoke detector camera to monitor patient” (quantity ordered: 1)”
- “Covert camera to monitor patient” (quantity ordered: 2)”
- “Special Remarks: Require overnight shipping.”
- “*Justification of Need or Turn-In ... This [sic] DVR and cameras is [sic] to ensure that patients are being treated to the standards set forth by the VA health administration. [emphasis added]*”

On June 13, the camera was installed in the patient’s room, but not activated. The precise time of installation is not known. The type of camera was a “color smoke detector camera.” However, the installation of the wiring to the DVR device and the set up of the

⁴ See <http://www.mcmelectronics.com/> (accessed 12/31/2012)

video monitor, which was to be placed in the telemetry room, was not completed at this time.



Figure 2: Color smoke detector camera like the one installed in patient's room.⁵

Also on June 13, the ward 4N Nurse Manager wrote in an email to the COP (copied to a JAHVH Administrative Officer) with a subject line of "patient monitoring," "We are installing a surveillance monitor in a patient room. Do we have to post any kind of sign stating that the room is under monitoring?"

The COP responded to the ward 4N Nurse Manager the same day, and also sent the email to the JAHVH's staff attorney from the Regional Counsel Office, "I will ask Regional Counsel advise [sic] but my interpretation is NO. This is for patient care and safety and it is a single room, correct?"

The ward 4N Nurse Manager responded on the same day, June 13, to the COP: "Yes it is." The ward 4N Nurse Manager also forwarded a copy of this email to the Chief Nurse, Acute Care.

VAMC management consulted with VA Regional Counsel regarding the placement of the VSC in the patient's room. JAHVH management decided not to inform the family that they would place a camera in the patient's room.

On June 14, the next day, the Chief Nurse, Acute Care responded to all recipients on the email (staff attorney from Regional Counsel Office; the ward 4N Nurse Manager; the COP; and the AD, Patient Care/Nursing Services):

[The ward 4N Nurse Manager named] informed me this morning that his staff called him during the night, apparently a 'maintenance worker' informed them

⁵ See <http://www.mcmelectronics.com/> (accessed 12/31/2012)

[the patient's family] that it [the newly installed device] was a camera. We have instructed the staff to state that it is for patient care. The staff on 4N is wondering if the video is considered protected health information and will the [patient's family member] be able to review it daily as [patient's family member] does the hospital record and nurses notes. I didn't know what to tell them, do you know?

On June 14, the COP responded to all recipients, stating:

Yes, this is an open monitoring of the patient and it falls under the same guidelines of Freedom of Information [the Freedom of Information Act]. If she has approval to view patient's records then this falls under the same. If she has to request approval through ROI [Release of Information] to obtain documents, then the same apply. This is an *overt* [emphasis added] recording for patient safety. I heard this morning that a camera disguised as a smoke detector was going to be utilized. I disagree with this option as it will give the impression of concealment/covert recording which has other legal consequences. Should remain as an open recording for patient care and safety."

On June 14, a Report of Contact describing the previous evening's event was submitted by the charge nurse, who was also the nurse for the patient. The nurse stated:

This nurse to pt's [patient's] room upon request of family members, [family members named]. Family upset and requesting information about 'new device' on ceiling. According to pt [the patient's] family, the maintenance man informed them that the device was a camera. Nurse informed family members that she was not aware of situation and should speak to management about situation in the morning. Family members, [family members named], informed nurse that they were going to speak to AOD [Administrative Officer on Duty or Administrative Officer of the Day]. Nurse manager informed via telephone about situation @ 2145 and [JAHVH employee named], assistant nurse manager, notified in morning 6/14/12 @ 0700.

On June 14, a family member of the patient emailed the AD, Patient Care/Nursing Services; the ward 4N Nurse Manager; JAHVH's Chief, Medical Service; a JAHVH staff physician; the COS; JAHVH's Deputy Director; JAHVH's Director; and the Chief Nurse, CLC; under the subject line: "HIDDEN CAMERA" writing: "[ward 4N Nurse Manager named], How come the family wasn't notified in reference to the hidden camera in [the patient's] room?"

The AD, Patient Care/Nursing Services requested advice from Regional Counsel regarding the proper response to this email.

Also on June 14, a family member attempted to telephone JAHVH's Chief of Facilities Management Service (FMS) regarding the "hidden camera" that was installed in the

patient's room. The family member spoke with an FMS secretary, who emailed the COP (with copies to the Chief, Biomedical Section and a JAHVH general engineer), writing:

I received a call this morning from a patient family member at 11:00 am. The caller's name was [family member's name and telephone number given] and [the family member] stated that [the patient] is currently in 4N RM 468. [The family member] desired to speak with the Chief of FMS regarding a hidden camera that has been installed in [the patient's] room. [The family member] was very upset and said [the family member] has contacted [the family member's] family attorney. I took the message and told her I would direct the message to appropriate personnel. I spoke with [the Chief, Biomedical Section] (who is acting Chief for [employee named] today) and [Chief, Biomedical Section] suggested I direct the message to you. Thanks.

On June 14, the Chief, Biomedical Section replied to [the FMS secretary], and included the COP, (with copies to the JAHVH general engineer; JAHVH's Assistant Director; and the AD, Patient Care/Nursing Services; writing, "I am including [the JAHVH Assistant Director] and [the AD, Patient Care/Nursing Services] for their information. As I said in Morning Report today, *the camera is NOT in operation* [emphasis added]."

JAHVH's Assistant Director (who, at that time, was also serving as Acting AD), responded to all recipients again on June 14 writing, "I am just talking to [the JAHVH general engineer] — the Director has decided to install the camera and make sure it is in working order. The family does know and it is ok — the camera is for monitoring purposes."

The Chief, Biomedical Section responded, again that same day, to all recipients as follows: "Do we want to change the type of camera or leave the one in the smoke detector (since it is no longer 'hidden')?"

The Assistant Director responded the same day to all recipients, "I think change it out — [the AD, Patient Care/Nursing Services named], what do you think?" There is no documentation as to the AD, Patient Care/Nursing Services' response.

In another set of emails on June 14, the Chief, Biomedical Section sent a high priority email to the Assistant Director and the COP (with copies to the JAHVH general engineer and AD, Patient Care/Nursing Services, writing, "My staff just went to complete the installation and the nurse manager stopped them. I will await further instructions."

The Health Systems Specialist responded to the Chief, Biomedical Section; the Assistant Director; and the COP; (with copies to the general engineer; the AD, Patient Care/Nursing Services; and ward 4N Nurse Manager, on June 14, writing:

I talked to [the ward 4N Nurse Manager] a few minutes ago and [the ward 4N Nurse Manager] was fine with the installation, apparently [the ward 4N Nurse Manager] asked them to hold off for a few minutes, because [the ward 4N Nurse Manager] wanted to talk with the [patient's] family. [The ward 4N Nurse Manager] is calling bio-med now.

On June 15, 2012, [the ward 4N Nurse Manager] wrote a Report of Contact, which stated:

On 6-14-12, I had conversation with [a family member] and [another family member] regarding video monitoring of [the patient's] care. [Acting Chief Nurse, Acute Care named] and [an Assistant Nurse Manager named] [were] also present. This family vocalized their discontent with installation of a video monitor in [the patient's] room without their consent. It was explained that the camera was deemed appropriate to more closely monitor [the patient's] care. Both family members were shown the area where the video monitor was to be viewed. Family informed this writer that they would be contacting a lawyer as they felt the monitoring was unlawful without their consent. [Acting Chief Nurse, Acute Care named], [the] Acting Chief Nurse Acute Care stated that we would wait to initiate monitoring after confirming that it was okay with the hospital lawyer. *Video monitoring was initiated on [Thursday] 6-15-12 [emphasis added].*

On June 15, JAHVH's Privacy/Freedom of Information Act (FOIA) Officer sent an email to the Assistant Director; the AD, Patient Care/Nursing Services; and the COP; and copied a JAHVH FOIA Officer, with a subject line of "Privacy Complaint re: Video Surveillance," writing:

The Privacy Office has received a privacy complaint from [a family member] regarding the placement of a video camera in [the patient's] room. I have entered the complaint into NSOC.

I understand that this camera was placed for patient safety reasons based on the individual needs of the comatose patient. I am not aware of the details and ask that the most appropriate person please call or e-mail so I can document and respond to complaint.

It is my recommendation that signage be posted in the room, as soon as possible, to state to the effect "Video Surveillance for Patient Safety." This has been a common privacy practice to alert patients, as well as visitors.

I will work on a HPM [High Priority Memorandum/Mail] regarding photographs, videotapes and other recordings next week *as this is a recurring topic of questions [emphasis added].*"

The Privacy/FOIA Officer forwarded the above email to the staff attorney of the Regional Counsel Office and copied the Assistant Director; AD, Patient Care/Nursing Services; and COP stating, "Including Regional Counsel also. Thank you."

On June 15, video surveillance and recording commenced.

The biomedical tech who installed the VSC stated that the camera transmitted and DVR system recorded a video feed only. We found no evidence of the camera having capability to transmit an audio feed. Additionally, the specifications and description of the camera that we reviewed only describe the video capacities of the device.

The VSC created images from June 15 – July 27. The video feed went to a DVR system and simultaneously to a live feed monitor. The DVR had an internal digital hard disk drive (HDD) storage system with a capacity of 500 gigabytes which recorded the video digital signal. At one point in this 43-day period, the facility discovered that the digital storage capacity on the HDD was full, due to an error in the setting of the number of image per second to be stored. Thus, there was a period of a few days to an approximately one week period that video images are not available because the DVR system automatically "wrote over" the older images that were stored on the internal HDD.

During the July 15 – July 27 period when the VSC was making images, there was a live feed to the telemetry room. According to the biomedical technician, the live feed monitor was always "on" while the camera was operational. The telemetry technicians, as well as, on occasion, nurses filling in for a telemetry technician, were tasked to also monitor the live feed video projection, in addition to their normal job of monitoring the telemetry devices.

All frontline staff we interviewed stated they were not informed prior to the camera installation. While some nurses were not informed of the camera after the installation, the camera installation was discussed among staff as word of mouth and only confirmed specifically by the nurse manager with some staff members.

According to the telemetry technician, the camera was installed and a monitor was placed in the telemetry room during a morning when the family was not in the patient's room. When two staff members witnessed seeing the patient's image on the monitor they inquired to the nurse manager and were told that they did not have to worry about it, but just take a look at it every now and then. One staff told us that the next day the monitor showed an image of both the patient and the family members. According to the staff member, she never heard any audio, but it was very uncomfortable watching the family sleep. Several days later the staff member overheard the family screaming down the hallway saying that "they can see everything we are doing; if I bend over they can see all of my private parts." Again, this made the staff member very uncomfortable.

Copies of the VSC HDD images were made. Some copies were placed onto DVDs, some on flash drives, and some copies of the original digital recordings were sent to other DVR systems.

The camera was removed from the room 43 days later on July 27, as documented on a Biomedical Service work order. OHI inspectors heard conflicting testimony as to the emanation of the directive to remove the VSC. Some sources suggested this was a local, JAHVH decision, other sources suggested that the decision was made above the local level.

Discussion and Conclusions Regarding Issue 3

A. Overview

The decision-making process surrounding the installation of a video camera into the patient's room on ward 4N is well documented by an extensive *contemporaneous* email record. OHI's interviews, as well as additional documents which complement the email record, were consistent with that record.

Although contained within the narrative above, several points bear reiteration. It is correct, as alleged and widely reported, that the patient's family had no input into the decision to install a video camera in mid-June 2012. Nevertheless, *the patient's family was aware of the camera when it was activated and began to make and acquire and record video images*. Thus, during the 43-day period from June 13 — July 27, that the patient was monitored and recorded, while he was monitored and recorded without his family's permission, it did not take place without his family's awareness and notification.

The decision-making process was detailed indicating that it was not taken lightly or casually. Furthermore, opinions from Regional Counsel were sought.

B. What was the intent of using video surveillance?

From interviews with the staff, reports of contact, and personal notes from leadership, it appears that the intent of placing a VSC was patient safety, including, among several possibilities, to ascertain if the family members were interfering with the nursing care of the patient. The record indicates that the question on the minds of JAHVH staff and leadership was whether the patient's family members were doing things such as change the incline position of the patient's bed; change the rate of infusion on the patient's feeding and medication pumps; and/or reposition the patient.

We concluded that given the documented evidence, these were reasonable JAHVH concerns. It would have been remiss not to address them. These concerns are

summarized most poignantly in the ward 4N Nurse Manager's June 8 formal memorandum to the Chief Nurse, Acute Care as documented earlier.

Other theories for VSC placement were offered while in the course of our site visits. For example, unwarranted changes in the rate of infusion on the patients feeding and medication pumps could have been the result of mechanical malfunction. Changes in incline position of the patient's bed, repositioning issues, and the presence of the sheet over the patient's head could have been a result of JAHVH staff intervention. Nevertheless, the contemporaneous record reflects that the primary theory in real time was family behavior and the impact on the patient's safety.

We found no evidence that a VSC was installed to embarrass the patient or his family; for voyeuristic reasons; to harass the patient or his family; as retaliation due to the family's numerous complaints to the staff, management, and leadership of JAHVH or to local and national politicians; to deprive the patient or his family of legal rights; or for any other inappropriate purposes.

While the contemporaneous record reflects that a concern in real time was family behavior, the email record, other documents reviewed, and testimony heard by OHI inspectors, indicate that the motivation for video camera installation was the patient's safety. However, JAHVH staff did not monitor the video images real-time; did not train the telemetry technologists as to troubling signs to which they were to alert nursing staff; and did not put in place education, policies, processes, or procedures defining responses by the telemetry technologists and nursing staff if the video feed revealed situations that impacted the patient's well-being.

The nurses, physicians, and leadership reported threats by the family of filing complaints to their various licensing boards as well as threats of litigation. In addition, nurses, physicians, and leadership reported on and documented in Reports of Contact the fragile mental state, caused by bullying and intimidation by family members of the patient, of the nurses and medical staff who interacted with the family on a day-to-day basis.

From interviews with staff, reports of contact, and personal notes from leadership, it appears that the intent of placing the VSC was for patient safety. It was expected that the camera would ascertain who or what was interfering with nursing care of the patient, i.e., changing the incline position of the patient's bed, changing the rate of infusion on the patient's feeding and medication pumps, and/or repositioning the patient. We concluded that given the documented evidence, the use of the camera for these patient safety concerns was reasonable.

C. Covert or overt video surveillance?

There is clear documentation in emails, along with information gathered during interviews, that the video surveillance was to be covert surveillance. The facility took

affirmative actions demonstrating that the surveillance was to be covert by purchasing a covert video camera disguised as a smoke detector, and not notifying the family about the video surveillance or getting consent to have video surveillance from the legally authorized representative. In addition, the camera installation took place when the family was not present. This was on purpose, as the testimony states that the installation was incomplete because the technicians installing the camera were told to clean up and leave the area because the family had arrived on site. The email strings above clearly indicate that the intent was for video surveillance to be covert.

On June 11, facility leadership had discussed possible courses of action to monitor the patient—one-to-one nursing and video surveillance. Several attendees came away from the meeting with the understanding that placing a camera in the patient's room was likely to happen. Post-meeting communications revealed confusion over whether nursing or police would install a camera, and if so, whether the camera would be covert. Whatever the intent of the facility, the family was aware of the camera before it became operational and knew when it was in use.

D. Privacy and Consent

Privacy and consent are issues raised by the placement of the VSC and the family's objection to it. By the time of camera activation, all relevant parties, namely the patient's family and JAHVH staff knew of the camera's existence.

i. Video Surveillance in Hospitals

The use of video surveillance cameras in hospitals is commonplace and has become the industry standard to provide general security measures for hospitals. Hospitals also routinely use photography, videotaping, digital imaging, and other visual recordings during patient care to assist with treatment of patients. Physicians and hospitals also use these videotapes for seminars, teaching, and community education.

Video surveillance for general security purposes is used in common areas where a person does not have a reasonable expectation of privacy. For example, in the hospital parking lot, in the Emergency Department, in waiting rooms, in the cafeteria, and in hallways. Video surveillance is also employed in treatment areas (MRI or CT scan areas to ensure patient safety) where a patient might have an expectation of increased privacy over other common areas in the hospital.

A person's right of privacy may be violated if the person has a reasonable expectation of privacy. A patient in a healthcare setting has a lower expectation of privacy than a person has in their own home. Although a patient waives certain rights to privacy when admitted to a hospital and in the presence of nurses and doctors, the patient can still expect some form of privacy in their hospital room. Visitors to a hospital have an even lower expectation of privacy.

Generally, photographs taken to document abuse or neglect do not require consent from the patient or his or her legally authorized representative. Such photographs are submitted to an appropriate investigating agency, but they should not be used for other purposes, such as teaching, without authorization.

ii. VA Privacy Guidelines

VHA includes in its VA Patient Rights and Responsibilities the commitment that a patient's "privacy will be protected." Likewise, The Joint Commission requires the protection of privacy by requiring that patients give consent to any photography for purposes other than care (diagnosis and treatment). VHA policy does not require written consent to take a photograph or record video/voice for treatment purposes. The facility policy follows VHA policy—consent is not needed for photography or videotaping that is intended to be used for treatment purposes.

VHA facilities are permitted to use protected health information without a patient's authorization for treatment and healthcare operations.

iii. Consent

If the VSC was to be used to observe possible criminal activity, then consent from the patient would not be required.

If the VSC was to be used for treatment purposes, then under VHA and HIPAA guidelines consent from the patient would not be required.

Issue 4: Number of Video Surveillance Cameras in VA Healthcare Facilities⁶

Our nationwide survey of VSC usage in VA healthcare facilities revealed that all VA medical centers are currently using VSCs. The average number of VSCs currently installed in VA healthcare medical centers is 148. The total number of VSCs installed at JAHVH is 279. The number and corresponding percentage of the VSCs installed at a medical center, grouped into bins of 100 VSCs, is displayed in Figure 1 on the next page.

⁶ The healthcare sites surveyed are those that participate in the Combined Assessment Program survey process

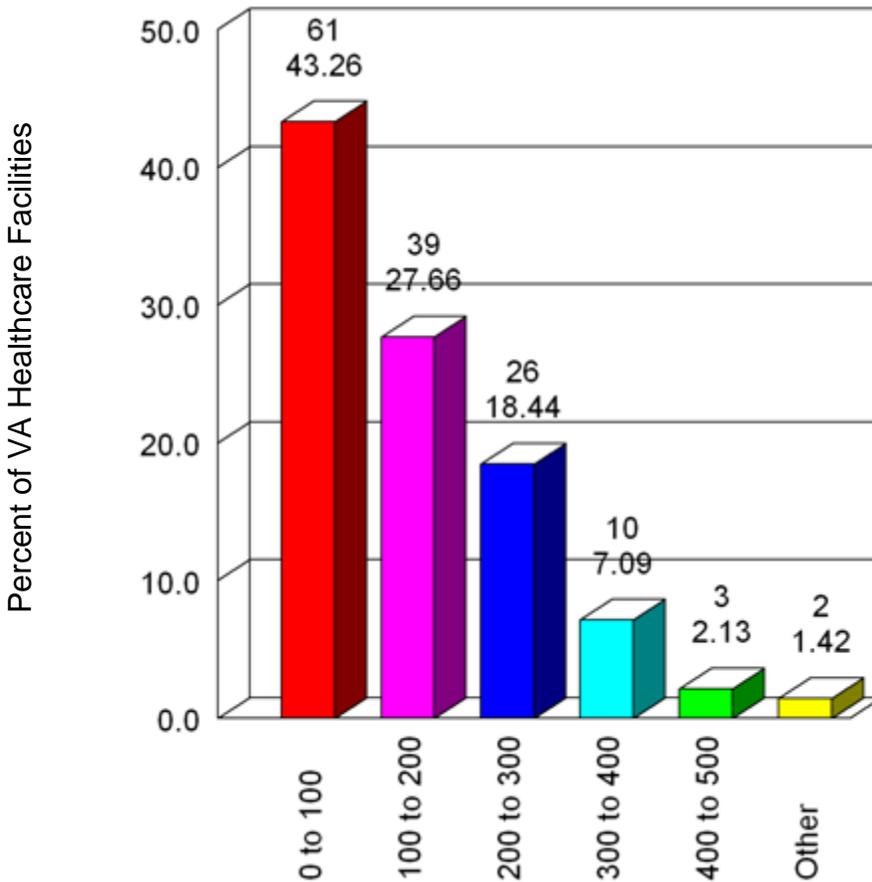


Figure 3: The number and percent of VSCs installed at VA Healthcare Facilities

Issue 5: Location of Video Surveillance Cameras in VA Healthcare Facilities

VHA has some requirements for VSC usage in specific areas of facilities. Some examples of requirements are that facilities must ensure that each Mental Health Residential Rehabilitation Treatment Program (MH RRTP) secures all entrance and egress doors to the unit and maintains points of access utilizing Closed Circuit TV (CCTV) monitoring.⁷ A camera system that records all activity is recommended in the pharmacy vaults and all storage areas containing working stocks of controlled substances.⁸ Childcare facilities and canteens are required to utilize CCTV for security reasons.⁹ We found this to be consistent with data collected from the survey.

⁷ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

⁸ VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.

⁹ VA Handbook 0730/2, *Security And Law Enforcement*, May 27, 2010.

In non-clinical areas of high traffic such as parking lots and garages, building entrances and exits, common areas, waiting rooms, canteens, stairwells, and research areas, the use of VSCs is standard. We found that 74.5 percent of facilities reported that devices were located in clinical areas. Clinical areas that often use VSCs include:

- Mental Health Units
- Domiciliary
- Pharmacies
- Emergency Departments
- Intensive Care Units
- Geriatrics/extended care units

JAHVH uses VSCs in clinical areas of the facility to include the ED, poly trauma, Spinal Cord Injury, Nuclear Medicine, Mental Health, and Radiology. Video surveillance in patient care areas is used to closely monitor patients at high risk.

Issue 6: Signage to Notify Others of the Use of Video Surveillance Cameras

We found that nearly half of VA healthcare facilities had signage posted notifying the public of the presence of VSCs. Typically, signs were located at entry and exit points of buildings with the majority of signs located at main entrances to the facility. Additionally, signs were often posted at other entry or exit areas throughout facilities.

JAHVH reported there were no signs posted at JAHVH to notify individuals of the VSC usage at the time of our data collection, but noted that signage has been ordered to be installed at each entrance. The JAHVH signage will read, “This area is under 24 hour video surveillance.”

We found that of the 49 VA healthcare facilities that have VSCs currently installed in a patient room, the majority (83.7 percent) do not have a sign posted in the patient room notifying individuals that a VSC is in use. A typical sign notifying individuals of the use of VSC surveillance is shown on the next page:

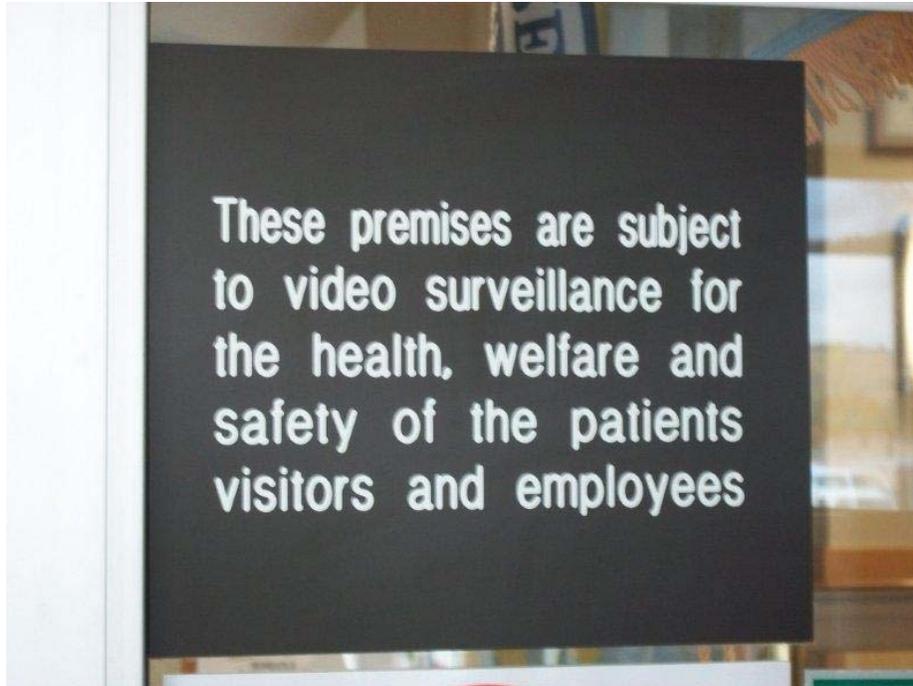


Figure 4: Example of a notification sign at a facility entrance
(Supplied by Black Hills VAMC)



Figure 5: Example of a notification sign covering a patient care area
(Supplied by New Jersey HCS)

Issue 7: Hidden Video Surveillance Camera Usage in Individual Patient Rooms

In a secondary follow-up nationwide survey completed in January 2013, no facilities reported current use of a hidden camera. We also determined that there are currently no hidden cameras in patient rooms at JAHVH.

When queried as to the usage of this practice in the past, we found that seven facilities had employed VSCs in this capacity. All instances identified contained a law enforcement component and/or involved suspected criminal activity. Several of the instances are summarized below:

- Four of seven facilities reported past use of a covert camera in a patient room during a VA Police investigation for possible theft involving staff. Two facility investigations resulted in identification of the thief. At one facility, the camera was never activated and later removed. At the other facility, no theft was identified. In two of the instances, the facility reported that cameras were installed with patient consent.
- Two of seven facilities reported past use of a covert camera in a patient room during a past investigation for unspecified allegations. The other facility reported a previous OIG investigation using a hidden camera with the patient's consent.
- At one facility, a report documents past use of a covert camera in a patient room during the investigation of a patient's spouse who was suspected of poisoning the patient's beverages. This investigation involved VA Police, OIG, and the FBI. Per the OIG's Semi-Annual Report, Issue 63:

The wife of a Veteran was sentenced to 30 months incarceration, 3 years' supervised release, and was ordered to pay a \$1,000 fine after pleading guilty to poisoning her husband while he was an inpatient at the Temple, TX, VAMC. The Veteran survived the poisoning. A joint OIG, FBI, and VA Police investigation revealed that the defendant introduced various toxic substances into her husband's beverages over a period of approximately 5 weeks, causing him to repeatedly lose consciousness and require multiple hospital admissions. Video surveillance of the Veteran's hospital room revealed that the defendant continued to poison her husband even after he was admitted to the facility for treatment of previous poisonings committed outside the facility.

There was self-evidently no signage because these cameras were covert.

Issue 8: Use of Video Surveillance Cameras with Audio Recording Capability

Ten medical centers reported that they were currently using VSCs with audio capability. This capability is used in the common area on embassy property, in police interview rooms, in sleep laboratories, and in mental health seclusion rooms. Not included in this data is the use of audio-visual door entry systems.

Issue 9: Identification of Video Surveillance Camera Policy Usage in VA Healthcare Facilities

We found that most facilities use portions of the VACO Office of Security and Law Enforcement Standard Operating Procedures (SOP) Manual and identified it as the guidance they use for video surveillance.

Of the 141 total respondents to the national survey, 104 facilities reported that they had a policy that addressed the use of VSCs. In a content analysis of the information provided by these 104 facilities:

- Ninety-two list SOP 5A and/or VA Handbook 0730 as the only policy they use to address video surveillance and notification or consent for video surveillance.
- Five facilities use portions of either SOP 5A and/or VA Handbook 0730 and incorporate the information into a local policy or memorandum.
- Three facilities responded that they use local policies created to address intrusion, panic, or duress alarm systems and the associated video surveillance as their local video surveillance guidance.
- Two facilities use a policy addressing only mental health video monitoring as their local policy.
- One facility cited the VHA Physical Security and Design Manual as their local policy.
- One facility cited VHA Handbook 1008.01, *Veterans Canteen Service Procedures*, April 20, 2010, as their local policy.

JAHVH uses SOP 5A as guidance.

Three facilities, Southern Arizona VAHCS; Sheridan, WY, VAMC; and Syracuse, NY, VAMC; created original documents that provide some guidance on the use of VSCs in clinical areas.

The Southern Arizona VAHCS policy created procedures to ensure the confidentiality and security of all audio, video, and digital taping of patient encounters. Staff and trainees are prohibited from making recordings without first obtaining patient consent.

Sheridan VAMC's policy established procedures for the use of VSCs in patient care areas, the use of digital video recording devices, and made staff members and VA Police responsible for monitoring the VSCs. In addition, signs are required on certain units to notifying individuals of the use of the closed circuit video monitoring.

The Syracuse VAMC used a version of SOP 5A; however, the facility also created three other documents addressing the use of VSCs when related to patient care. The VSCs are to provide for patient safety and to "provide observation of multiple areas within the unit

simultaneously.” The policy cautions that the VSCs will not be used in a manner which violates a patient’s right to privacy.

SOP 5A states that the use of VSCs is “not intended to infringe upon the expectation of the right to privacy of others,” but does not elaborate on proper procedures for using VSCs in a clinical setting or how to balance a patient’s expectation of privacy with treatment needs and healthcare operations. In general, the local policies submitted by the facilities did not detail how, when, and who may videotape patients, or detail procedures on how to maintain patient privacy.

VHA policy guidance should address the clinical uses of covert and overt VSCs in a clinical setting, including public notification, informed consent, approval, and responsibility for use of these devices, as well as detail procedures for staff to follow in obtaining video recordings for teaching, patient care and treatment, patient safety, healthcare operations, general security, and law enforcement purposes. Restrictions on the use of personal electronic devices within a VA facility to photograph and video should also be considered.

Recommendation

We recommended that the Under Secretary for Health ensures that VHA policy addresses the clinical uses of covert and overt VSCs in a clinical setting, including public notification, informed consent, approval, and responsibility for use of these devices, as well as detail procedures for staff to follow in obtaining video recordings for teaching, patient care and treatment, patient safety, healthcare operations, general security, and law enforcement purposes. Restrictions on the use of personal electronic devices within a VA facility to photograph and video should also be considered.

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 5, 2013

From: Under Secretary for Health (10)

Subject: **OIG Draft Report, Alleged Inappropriate Surveillance, James A. Haley Veterans' Hospital, Tampa, Florida (VAIQ 7326738)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendation.
2. Thank you for the opportunity to review the draft report. Attached is the complete corrective action plan for the report's recommendation. If you have any questions, please contact Dr. Karen M. Rasmussen, Acting Director, Management Review Service (10AR) at 202-461-6643.

(original signed by)
Robert A. Petzel, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan**

**OIG Draft Report, Healthcare Inspection: Alleged Inappropriate Surveillance
James A. Haley Veterans' Hospital Tampa, Florida**

Date of Draft Report: February 7, 2013

Recommendations/Status Actions	Completion Date
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Recommendation 1. We recommended that the Under Secretary for Health ensures that VHA policy addresses the clinical uses of covert and overt video surveillance cameras in a clinical setting, including public notification, informed consent, approval, and responsibility for use of these devices, as well as detail procedures for staff to follow in obtaining video recordings for teaching, patient care and treatment, patient safety, healthcare operations, general security, and law enforcement purposes. Restrictions on the use of personal electronic devices within a VA facility to photograph and video should also be considered.

VHA Comments

Concur

The Veterans Health Administration (VHA) Information Access and Privacy Office (IAP) have developed the draft directive titled, *Privacy of Photographs Video, and Audio Recordings and Digital Images*, which addresses the use of video and audio recordings in treatment settings, public notification, informed consent, and approval and responsibility for the use of these devices. The draft VHA Directive addresses VHA staff requirements prior to using these recordings for teaching, treatment, patient safety, general security, and law enforcement purposes. The draft VHA Directive also provides guidance to VHA health care facilities on the use of personal electronic devices on VA premises.

Status: In process

Target Completion Date: November 15, 2013

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