



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 13-03089-104

Healthcare Inspection

Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program Miami VA Healthcare System Miami, Florida

March 27, 2014

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to the unexpected death of a patient in the substance abuse residential rehabilitation treatment program (SARRTP) at the Miami VA Medical Center (the facility), Miami, FL. Autopsy results indicated that the death was a result of acute cocaine and heroin toxicity.

We found that the security surveillance camera for the SARRTP was not operational at the time of the patient's death and remained non-operational at the time of our site visit 3 months later. Some SARRTP staff members, including the Nurse Manager, were unaware that the camera was not working. The facility did not make alternative arrangements to monitor patients in the absence of an operational camera.

We found that evening, night, and weekend SARRTP staff often remained in a back room in the SARRTP unit with an extremely limited view of the unit and no view of the unit's entrance/exits.

VHA mandates that a staff member be physically present on the SARRTP unit at all times. We found staff were not present at all times as required.

Staff were not consistent in searching patients for contraband and did not monitor patient whereabouts as required.

We reviewed the electronic health records of other patients in the SARRTP at the time of the patient's death to determine the frequency of illicit substance use among program participants. Excluding patients with potential false positive results, we found that 7 of 21 patients had a positive urine drug screen or breathalyzer test while in the SARRTP.

We found that the methods used for monitoring SARRTP patients for illicit drug use could be strengthened. We concluded that the facility's system of surveillance and staff supervision of patients did not adhere to VHA policy. We recommended that the System Director ensure adequate surveillance and monitoring of patients and staff supervision on the SARRTP unit as required. We also recommended that the facility implement consistent contraband search and documentation processes.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 8–12 for the Directors' comments.) We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection in response to the unexpected death of a patient in the substance abuse residential rehabilitation treatment program (SARRTP) at the Miami VA Medical Center (facility), part of the Miami VA Healthcare System (system). The VA OIG Criminal Investigations Division (CID) referred this patient death for OHI review to evaluate if the SARRTP provided a safe environment for patients in accordance with VHA requirements.

Background

Residential Rehabilitation Treatment Programs (RRTPs). In 1995, VHA established the residential rehabilitation treatment program (RRTP) level of care for patients with mental illness and/or addictive disorders who do not warrant acute psychiatric inpatient admission but require additional structure and support to address multiple and severe psychosocial deficits.¹ RRTPs vary in purposes and types. Examples include:

- SARRTP for patients requiring treatment for alcohol and substance use disorders
- Post-Traumatic Stress Disorder (PTSD) RRTP for patients requiring an intensive therapeutic environment for PTSD treatment
- Psychosocial RRTP (PRRTP) for patients requiring a residential program to address a variety of issues, including mental health, homelessness, and unemployment

Generally, patients admitted to RRTPs must be capable of self-care.² Some RRTP patients may be dependent on staff for medication administration, while others are either semi-independent or independent in medication administration. Patients are allowed to leave the RRTP unit on a pass,³ including overnight and weekend hours, to make aftercare plans and practice recovery skills in unstructured settings prior to program discharge. Without a pass, patients may be permitted to leave the unit for short periods of time.⁴ Because program staff members are not in the patient rooms on a continual basis to assist patients or provide medications, and patients are allowed some freedom to leave the unit, VHA developed guidelines for monitoring and tracking the whereabouts of patients in RRTPs.⁵

Individualized interdisciplinary treatment plans are developed based on the needs of the patient and emphasize personal responsibility, with overall goals to improve medical,

¹ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, December 22, 2010.

² Self-care includes the ability to perform activities of daily living such as grooming, bathing, dressing, and eating.

³ A pass is an approved absence from the unit for a specified time. Passes can range from a few hours to 3 days.

⁴ At this facility, patients were allowed to leave the unit without a pass for up to 2 hours but were required to sign in and sign out.

⁵ VHA Handbook 1162.02.

psychological, and social functioning, and re-integrate the patient successfully back into the community. Patients who relapse while in a SARRTP are not automatically discharged, as relapse may be viewed as a symptom that the patient needs further treatment.

Miami VA Healthcare System. The system is part of Veterans Integrated Service Network (VISN) 8, also known as the VA Sunshine Healthcare Network. It provides acute medical and surgical care, as well as a full range of primary, specialty, and subspecialty services throughout southeastern Florida. The facility has three types of MH RRTPs:

- SARRTP: 24 beds
- PTSD RRTP: 16 beds
- PRRTTP: 18 beds

The facility's RRTPs are located in three units on the fifth floor of the main hospital building. Each program occupies a separate wing with its own entrances and exits. Staff in one RRTP unit cannot view or hear what is happening in the other RRTP units.

Scope and Methodology

We conducted a site visit on September 4–6, 2013. We interviewed clinical staff involved in the treatment of SARRTP patients and other clinical and administrative staff knowledgeable about RRTP operations. We toured the SARRTP and PRRTTP units. We reviewed autopsy results for the subject patient as well as evidence collected by the OIG CID.

We reviewed VHA and local policies, clinical guidelines, Quality Management documents, program reviews completed by external consultants, Northeast Program Evaluation Center (NEPEC) data,⁶ and the electronic health records (EHRs) of 22 patients.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

⁶ NEPEC is part of VHA's Mental Health Service and performs program evaluations of RRTPS and other mental health services across VHA.

Inspection Results

Case Summary

The patient was an Operation Enduring Freedom (Afghanistan) combat veteran in his twenties, who was diagnosed with polysubstance dependence, PTSD, sleep apnea, mood disorder, and traumatic brain injury. In 2012, he was referred to the facility's PR RTP from another VISN 8 VA Medical Center "with the ultimate goal of proceeding into PTSD residential treatment once he improves coping skills, mood stability, and functioning." He was admitted to the PR RTP later that year.

While in the PR RTP, the patient was periodically tested for illicit substance use. He had four positive urine drug screen (UDS) results for amphetamines⁷ within 2 months of entering the program; however, the patient was prescribed one or more medications that could have caused false positive results.⁸ The patient agreed to undergo a breathalyzer⁹ test that was positive in late 2012. One week later, PR RTP staff documented suspicions that the patient had been consuming alcohol, but he refused to take the breathalyzer test.

In early 2013, he was transferred from the PR RTP to the PTSD RRTP.

A UDS approximately 1 month following the transfer was positive for cocaine. Staff addressed the results with the patient and informed him that substance abuse would not be tolerated.

The following month, the patient tested positive for cocaine and alcohol, was discharged from the PTSD RRTP, and was transferred to the acute inpatient mental health unit at the facility. Several days later, after detoxification, he was transferred to the SAR RTP for further treatment.

Upon admission to the SAR RTP, UDS results were negative for illicit substances. Two days later, UDS results were positive for cocaine. The SAR RTP psychiatrist addressed the results with the patient. The patient admitted that he used cocaine after admission to the SAR RTP. He had left the unit to pick up money that had been wired to him and used the funds to purchase cocaine. He was placed on pass restriction (no overnight or weekend passes) for 3 weeks. However, he was permitted to leave the unit for up to 2 hours without a pass.

UDS results from the next month were again positive for cocaine. The SAR RTP psychologist addressed this with the patient and he was placed back on pass restriction for another three weeks.

⁷ Amphetamines are a class of drugs that are stimulants to the central nervous system.

⁸ Laboratory equipment manual Roche Diagnostics *On Line DAT Cross-Reactivity Booklet Version 1.1*.

⁹ A breathalyzer is a device that estimates blood alcohol content using a breath sample.

The day before his death, the patient left the SARRTP on a pass in the early afternoon. Upon his return that evening, a breathalyzer test was completed with negative results (no alcohol detected). A staff nurse documented at that time, “bag(s) checked: no.” SARRTP patients who were interviewed by CID agents reported that while on the SARRTP that evening, the patient was intoxicated from illicit drugs and required assistance to get into bed.

The patient was found dead in his room on the SARRTP unit the next morning. The medical examiner determined that the official cause of death was acute cocaine and heroin toxicity.

Issue 1: Patient Monitoring and Supervision

We found multiple lapses in SARRTP security safeguards required by VHA and local policy.

Inoperable Surveillance Camera. We found that camera surveillance was not present as required. VHA policy requires that RRTP unit entrance doors be monitored by Closed Circuit Television (CCTV). Additionally, CCTV with recording capability must be used to monitor RRTP public areas such as hallways.¹⁰ Local policy mandates that closed circuit video cameras be focused on each MHR RTP entrance and hallway and viewed and recorded in Police Service. The recordings are to be kept for at least 2 weeks.

We met with Police Service staff to review the surveillance conducted on the SARRTP unit. A Police Service employee was unable to correctly identify which screen was showing feed from the SARRTP. We were subsequently told by the Chief of Police that the camera which monitors the main hallway on the SARRTP unit had been inoperable since at least December 2012. The Police Service employee who was monitoring the CCTV feeds at the time of our visit was unaware the SARRTP camera was inoperable. Similarly, key SARRTP staff were unaware that the camera was inoperable, including the Nurse Manager.

VA Handbook 0730 requires that when surveillance television systems are in use, performance checks be conducted daily and substitute coverage be provided during maintenance or breakdown periods.¹¹ We found no evidence that the facility provided substitute coverage or other means of securing the unit during camera failure.

Unit Access. We found that access to the SARRTP was not monitored or controlled appropriately. Access to the SARRTP unit is controlled by a keyless entry badge-activated system. Individuals without a badge ring a buzzer and request entrance. Local policy states that only authorized patients, staff, and visitors may be allowed access to the unit.

¹⁰ VHA Handbook 1162.02.

¹¹ VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

At the time of our inspection, we visited the SAR RTP unit twice unannounced. SAR RTP staff did not request identification or verify the purpose of the visit on either occasion. During a day shift visit, an OIG inspector was “buzzed in” without displaying a badge or credentials or explaining the reason for the visit; the inspector walked through the unit and after several minutes, approached unit staff to identify himself. During the evening shift, three inspectors, dressed in casual clothes and not wearing badges, followed two patients into the unit without SAR RTP staff’s knowledge of an unauthorized entry.

During staff interviews, we learned that SAR RTP staff on evening, night, and weekend tours routinely sit in a back room that does not have visibility of most of the main hallway of the unit, nor the entrance and exit doors. During our evening site visit, we found the staff in this back room. Had the staff been present at the nurses’ station, they would have been able to observe and monitor the main hallway and entrance and exit doors.

Patient Sign-In/Sign-Out. We found that patients’ whereabouts were not being monitored as required. VHA requires that RRTP programs have a system for tracking the whereabouts of patients, typically by maintaining a sign-in and sign-out list.¹² Local policy states that patients can sign themselves off the unit for up to 2 hours without a pass but must include their destination, remain on campus, and sign back in upon return so that their whereabouts are always known to staff. We found that the sign in/sign out list on the SAR RTP unit was not being reviewed by staff for suspicious activity (patterns of leaving the unit) and that patients did not consistently sign in/sign out. The sign in/sign out entries that we observed did not include dates.

Contraband Searches. We found a lack of consistency among staff in performing contraband searches. According to local policy, nursing staff will conduct and document inspections of all patients being admitted to the program and returning from pass in order to detect any possible contraband that could be brought onto the unit. We interviewed staff to determine how contraband searches were conducted upon a patient’s return from pass and received conflicting information. Several staff reported that they were not permitted to search patients’ pockets or to request patients to empty their pockets as this was equivalent to a body search and not allowed. However, the RRTP Program Manager told us that he expected pockets to be emptied as part of a routine contraband search.

We also found that the EHR template progress note used to document whether bags had been searched upon a patient’s return from pass was unclear. A line item in a note stated “bag(s) checked: no.” We could not determine from the “no” documentation if there were no bags to check or that bags were not searched.

¹² VHA Handbook 1162.02.

Issue 2: Staff Presence

We found that staff were not always physically present on the SAR RTP unit as required. Both VHA¹³ and local policy require that a staff person be physically present on each RRTP unit when there is more than one unit on a floor and there are physical barriers between the units.

Staff leave the SAR RTP unit for a variety of reasons. During evening, night, and weekend tours, one staff member is assigned to the unit. If that staff member leaves, the patients on the unit are unsupervised. Three times each day, RRTP staff go with patients to the dining room for meals, located one floor below in the same building. RRTP staff stay in the dining hall until all patients have finished eating. However, patients who opt not to go to the dining hall, or return to the unit after eating, are unsupervised when the only SAR RTP staff member on duty is in the dining hall.

Staff from either the PTSD RRTP or the PR RTP may cover the SAR RTP unit when the single SAR RTP staff member on duty must leave the unit. However, the other RRTP units are also typically staffed with one staff member on evenings, nights, and weekends; therefore, providing coverage for the SAR RTP staff would result in a lack of supervision of patients on the PTSD RRTP or the PR RTP unit.

Issue 3: Substance Use Among SAR RTP Participants

The facility is located in a part of Miami with reported high drug activity. Patients who are allowed to leave the unit unsupervised have potentially easy access to illicit drugs. We reviewed the EHRs of other patients in the SAR RTP at the time of the patient's death to determine the extent of illicit drug use among patients. In addition to the patient under review, we found that 7 of 21 patients had a positive UDS and/or breathalyzer test at some point in their substance abuse program stay. Five additional patients had a positive UDS but were not included in the 33 percent positive result category, as either the UDS was completed at admission and positive results could have been from drug use prior to admission or patients were prescribed medications that are associated with a false positive result.

We found that the methods used for monitoring SAR RTP patients for illicit drug use could be strengthened. UDS were collected every Sunday in the late afternoon or early evening. Staff told us they were consistent with the time of day and day of the week for collections. As the timing of the collection was predictable, patients were aware of when the UDS would be done and could modify their behavior accordingly. Some random UDS were collected during the week, but staff told us this tended to be on the same days of the week, so the pattern of collection times was again fairly predictable.

According to the substance abuse recovery model the SAR RTP follows, patients who relapse during treatment are not automatically discharged, since recovering from

¹³ VHA Handbook 1162.02.

relapse in a structured environment is important for learning how to deal with challenges when not in a structured environment. Relapses were addressed by the treatment team and resulted in a minimum of a 3 week suspension of passes from the unit. We found that while pass suspensions generally did occur, one of the seven patients we reviewed who had a positive UDS or breathalyzer while in treatment, was granted a pass 6 days after the team documented he would be suspended from passes for 4 weeks.

Conclusions

We reviewed an unexpected patient death in the facility's SARRTP unit. SARRTPs should provide a safe recovery environment for the treatment of patients with substance use disorders who require a controlled and sober environment. We found this patient died due to cocaine and heroin toxicity. We found that the SARRTP unit at the facility did not consistently follow VHA policies that help establish a safe and secure environment.

We found that the SARRTP surveillance camera was inoperable and that access to the SARRTP was not monitored or controlled appropriately, patient whereabouts were not monitored as required, and confusion among staff existed concerning appropriate contraband searches. We also found that staff presence on the SARRTP unit was not maintained as required.

We identified opportunities to strengthen the supervision of patients in the SARRTP program to include ensuring that the surveillance camera is repaired and maintained and that staff are visibly present on the unit at all times. We also found that contraband search procedures and documentation could be improved.

Recommendations

1. We recommended that the System Director ensure that the camera surveillance system is repaired and maintained and that surveillance is conducted as required on the SARRTP unit.
2. We recommended that the System Director ensure that the SARRTP unit is appropriately staffed at all times, as required by VHA and local policy.
3. We recommended that the System Director ensure that SARRTP staff implement a consistent and comprehensive approach to check patients returning to the unit for contraband and document results clearly.
4. We recommended that the System Director ensure that SARRTP staff more aggressively monitor patients for illicit drug use, to include increasing the use of random UDS and adhering to local and VHA policy when patients leave the unit.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 10, 2014

From: Director, VA Sunshine Healthcare Network (10N8)

Subject: **Healthcare Inspection – Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, FL**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

Director, Management Review Service (VHA 10AR MRS OIG Hotline)

I have reviewed and concur with the findings and recommendations in this report.

Corrective action plans have been established with planned completion dates, as detailed in the attached report.

(original signed by:)

Joleen Clark, MBA, FACHE

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 7, 2014

From: Director, Miami VA Healthcare System (546/00)

**Subject: Healthcare Inspection – Unexpected Patient Death in a
Substance Abuse Residential Rehabilitation Treatment
Program, Miami VA Healthcare System, Miami, FL**

To: Director, VA Sunshine Healthcare Network (10N8)

Enclosed you will find the Miami VA Healthcare System's response to the Healthcare Inspection of Quality of Care issues performed by the Office of Inspector General.

(original signed by:)

Paul M. Russo, MHSA, FACHE, RD
Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the System Director ensure that the camera surveillance system is repaired and maintained and that surveillance is conducted as required on the SARRTP unit.

Concur

Target date for completion: Full completion by August 1, 2014; some actions are completed.

Facility response: The FY13 MHR RTP Annual Safety and Security Assessment noted that video cameras were installed but the monitors and recording equipment were not working. An action plan to remedy this was accepted by VACO. The Medical Center Director approved upgrades and enhancements to the facility wide system in April 2013. Police Service submitted a modernization and enhanced functionality contract for our facility wide camera and monitoring surveillance system in April 2013. Procurement solicitation was completed on January 24, 2014. The estimated start date of the facility wide surveillance system upgrade and enhancements is May 1, 2014. The target completion date for this project is August 1, 2014.

The cameras currently located on the SARRTP were assessed to determine if they could be repaired for use until an upgraded system was in place. The existing cameras were repaired and are functioning properly which includes monitoring capability as of February 2, 2014. While the systems were not functioning properly, in accordance with VA Handbook 0730 and VHA Handbook 1162.02, police and nursing staff had mechanisms in place including increased checks, and the use of sitters to monitor the area.

The unit remains in full compliance with the requirement for single point access onto the unit utilizing keyless entry. As of January 24, 2014 the following actions have been completed: MH RTP staff reminded Veterans to sign in and out in the log books when leaving and returning to the units. Veterans have also been reminded to complete all of the required fields. MHR RTP staff began checking the log books during the 2 hour rounds to ensure the Veterans whereabouts are documented. By February 3, 2014, the rounding sheets were revised to include staff checking the log book, a place to document any variance between round results and log book, and a place to document any missing information from log book. By May 7, 2014, the SARRTP Nurse Manager will monitor documentation of patient observation rounds, and the log book sign in/out process for 90 days to ensure any discrepancies in the log book are addressed.

Recommendation 2. We recommended that the System Director ensure that the SARRTP unit is appropriately staffed at all times, as required by VHA and local policy.

Concur

Target date for completion: Actions completed January 24, 2014; will monitor for compliance through May 7, 2014.

Facility response: As of January 24, 2014, MHR RTP staffing schedules and coverage have been adjusted to ensure that there is one staff member on each unit at all times. Nursing Staffing Sheets will be monitored for 90 days. Compliance will be reported monthly to the Performance Improvement Sub-Committee and appropriate corrective action will be taken.

Recommendation 3. We recommended that the System Director ensure that SARRTP staff implement a consistent and comprehensive approach to check patients returning to the unit for contraband and document results clearly.

Concur

Target date for completion: Actions completed January 29, 2014; will monitor for compliance through May 18, 2014.

Facility response: Procedures were revised for checking and documenting Veterans' and Visitors' belongings upon returning from pass, to include search of pockets. The medical record template for checking and documenting inspection of Veterans' and Visitors' belongings upon return from pass was revised to clearly reflect that Veteran and Visitor belongings, to include pockets, have been checked. The template was updated to include the outcome of the inspections. Staff have been trained on the use of the new template and how to conduct inspections. Monitoring of staff compliance will occur by reviewing documentation in CPRS for 90 days. Compliance will be reported monthly to the Performance Improvement Sub-Committee and appropriate corrective action will be taken.

Recommendation 4. We recommended that the System Director ensure that SARRTP staff more aggressively monitor patients for illicit drug use, to include increasing the use of random UDS and adhering to local and VHA policy when patients leave the unit.

Concur

Target date for completion: Completed on January 24, 2014; will monitor for compliance through May 7, 2014.

Facility response: SARRTP psychiatrists have increased frequency and variety of timing of collection of Urine Drug Screens. For Veterans with a history of substance abuse, at least one UDS will be collected upon return from any weekend pass, and at least one additional screen will be collected during the week at a random time. Additional screens will be monitored for administration and for variety as to day of week

collected for 90 days. Compliance will be reported monthly to the Performance Improvement Sub-committee and appropriate corrective action will be taken.

OIG Contact and Staff Acknowledgments

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