



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

**Office of Healthcare Inspections**

**Report No. 17-04460-84**

# **Combined Assessment Program Summary Report**

## **Management of Disruptive and Violent Behavior in Veterans Health Administration Facilities**

**January 30, 2018**

**Washington, DC 20420**

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## Executive Summary

The VA Office of Inspector General completed a healthcare inspection of the management of disruptive and violent behavior in Veterans Health Administration (VHA) facilities. The purpose of the inspection was to evaluate facility compliance with selected VHA requirements.

VHA's leaders have stated that they are committed to reducing and preventing disruptive and violent behaviors through the development of policies aimed at patient, visitor, and employee safety.<sup>1</sup> In addition, 38 United States Code § 1709, as amended by Public Law 112-154, directed VHA to develop and implement a comprehensive policy on the reporting and tracking of public safety incidents that occur at each medical facility.<sup>2</sup>

According to the U.S. Bureau of Labor Statistics, health care workers are more likely to be victims of nonfatal assaults or violent acts in their work places than workers in most other industries, and many of these assaults and violent acts are perpetrated by patients.<sup>3</sup> Employees at VHA facilities are not immune to the risks associated with caring for violent patients, and balancing the rights and health care needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff is a significant challenge for VHA facilities' leaders.

OIG conducted a review of workplace violence in 2011 and a review of disruptive patient behavior in 2012. At that time, VHA had no guidance addressing the management of disruptive or violent behavior by patients, employees, and/or others. OIG recommended that VHA formalize such guidance; issue guidelines for what information facilities should collect and analyze; and require managers to periodically assess all work areas for risk of violence and provide specialized violence prevention training to all employees who work in high-risk areas, assess competence annually, and provide refresher training as necessary. In 2012, in response to Public Law 112-154, VHA leaders issued a directive that addressed the management of disruptive or violent behavior, and in 2013, VHA issued a memorandum that provided detailed training requirements.

OIG observed several areas of high compliance during the current inspection, including that all facilities had implemented policies addressing prevention and management of disruptive/violent behavior and had conducted annual Workplace Behavioral Risk

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<sup>1</sup> VHA Directive 2012-026, *Sexual Assaults And Other Defined Public Safety Incidents In Veterans Health Administration Facilities*, September 27, 2012. This Directive expired February 28, 2015, and has not yet been updated.

<sup>2</sup> Public Law 112-154, *Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012*, August 6, 2012.

<sup>3</sup> U.S. Bureau of Labor Statistics News Release, *Nonfatal Occupational Injuries And Illnesses Requiring Days Away From Work, 2014*, November 19, 2015. [https://www.bls.gov/news.release/archives/osh2\\_11192015.pdf](https://www.bls.gov/news.release/archives/osh2_11192015.pdf) Accessed June 8, 2017.

Assessments. Facilities had completed physical security assessments in the 12 months prior to OIG's site visits that generally included monitoring systems and panic alarms for each area where used. However, Facility Directors needed to address employee-generated violence by establishing Employee Threat Assessment Teams as required. Additionally, while facilities had established Disruptive Behavior Committees or Boards, Facility Directors need to ensure attendance at meetings by all required members.

Patient Record Flags (PRFs) in patients' electronic health records communicate to clinicians that certain patients have exhibited disruptive/violent behavior. Most of the time, clinicians appropriately documented new flags and most clinicians had reviewed previously placed flags as required. However, OIG found noncompliance with a VHA policy to inform patients about the PRFs and about the right to request to amend or appeal placement of the PRFs. OIG's inspection prompted discussions between field staff and the VHA Workplace Violence Prevention program office director, who decided that this policy needed to change to decrease risk to clinicians. OIG agreed with limiting notification to just those patients affected when Orders of Behavioral Restriction (a type of therapeutic limit setting sometimes required to manage care for patients whose behavior is disruptive) were issued. When OIG analyzed PRFs associated with new OBRs, OIG still found noncompliance with requirements to notify patients and to inform patients about their right to request to amend or appeal the OBR.

Leaders at each of the facilities visited had implemented security training plans that used the official Prevention and Management of Disruptive Behavior training curriculum and included basic (Level I) training to all employees and additional levels based on the type and severity of risk for exposure to disruptive behaviors. However, facilities need to improve in providing newly hired employees with Level I Prevention and Management of Disruptive Behavior training and additional levels as indicated. The most compliant facilities included multiple levels of training in the formal New Employee Orientation and OIG suggested that all facilities consider doing the same.

VHA guidance focuses on managing patients who exhibit disruptive/violent behavior but does not provide specific guidance concerning assaults that involve non-patients (employees, visitors, students, and others) as victims or perpetrators. This is an important consideration when the goal is to have a safe workplace. Most facilities managed non-patient assaults appropriately according to their local policies or standard practices. However, OIG suggested that VHA leaders consider providing system-wide guidance for managing assaults that involve non-patients.

OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure that facility senior managers:

- Establish Employee Threat Assessment Teams.
- Require attendance by VA Police Officers, Patient Safety Managers and/or Risk Management Officials, and Patient Advocates at Disruptive Behavior Committee/Board meetings and monitor compliance.

- Ensure when Chiefs of Staff (or designees) issue Orders of Behavioral Restriction, they document that they informed patients that the Order was issued and that patients have the right to appeal the decision and monitor compliance.
- Ensure that within 90 days of hire, all employees complete Level I Prevention and Management of Disruptive Behavior training and additional levels based on the type and severity of risk for exposure to disruptive/violent behaviors and monitor compliance.

## Comments

The Executive in Charge, Office of the Under Secretary for Health, concurred with OIG's recommendations and provided acceptable action plans. (See Appendix C, pages 18–21 for the Executive in Charge's comments.) OIG will follow up on the planned actions for the recommendations until they are completed.



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## Purpose

The VA Office of Inspector General (OIG) completed a healthcare inspection of the management of disruptive and violent behavior in Veterans Health Administration (VHA) facilities. The purpose of the inspection was to evaluate facility compliance with selected VHA requirements.

## Background

VHA policy states a commitment to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety.<sup>4</sup> In addition, 38 United States Code §1709, as amended by Public Law 112-154, directed VA to develop and implement a comprehensive policy on the reporting and tracking of public safety incidents that occur at each medical facility.<sup>5</sup>

According to the U.S. Bureau of Labor Statistics, health care workers are more likely to be victims of violence in their work places than workers in most other industries.<sup>6</sup> Employees at VHA facilities are not immune to the risks of violent patients, and balancing the rights and health care needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff is a significant challenge for VHA facilities' leaders. In 2016, VHA received 34,341 reports of disruptive behavior. Under federal regulation, there is no option for VHA facilities to ban disruptive/violent patients from receiving care, although VHA facilities may limit the time, place, and/or manner of providing services to them.<sup>7</sup>

Prior Reports. OIG conducted a review of workplace violence in 2011<sup>8</sup> and a review of disruptive patient behavior in 2012<sup>9</sup> and recommended that:

- VHA leaders formalize guidance in a directive(s) or a handbook that addresses the management of disruptive or violent behavior by patients, employees, and others.

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<sup>4</sup> VHA Directive 2012-026, *Sexual Assaults And Other Defined Public Safety Incidents In Veterans Health Administration Facilities*, September 27, 2012. This Directive expired February 28, 2015, and has not yet been updated.

<sup>5</sup> Public Law 112-154. *Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012*. August 6, 2012.

<sup>6</sup> U.S. Bureau of Labor Statistics. *Nonfatal Occupational Injuries And Illnesses Requiring Days Away From Work, 2014*. News Release. November 19, 2015. [https://www.bls.gov/news.release/archives/osh2\\_11192015.pdf](https://www.bls.gov/news.release/archives/osh2_11192015.pdf) Accessed June 8, 2017.

<sup>7</sup> Title 38 U.S. Code of Federal Regulations (38 CFR) Sec. 17.107. VA Response to Disruptive Behavior of Patients.

<sup>8</sup> *Combined Assessment Program Summary Report – Management of Workplace Violence in Veterans Health Administration Facilities*, Report No. 11-00215-194, June 14, 2012.

<sup>9</sup> *Healthcare Inspection – Management of Disruptive Patient Behavior at VA Medical Facilities*, Report No. 11-02585-129, March 7, 2013.

- VHA leaders develop guidelines for what information employees should document regarding disruptive or violent incidents and for what information employees should collect and analyze.
- Facilities' managers periodically assess all work areas for risk of violence.
- Facilities' managers provide specialized violence prevention training to all employees who work in high-risk areas, assess competence annually, and provide refresher training as necessary.
- Facilities' managers ensure timely assignment of Patient Record Flags (PRF).

In 2012, in response to Public Law 112-154, VHA issued a directive that addressed the management of all individuals in VHA facilities whose behavior could jeopardize the health or safety of others, undermine a culture of safety in VHA, or otherwise interfere with the delivery of health care at a facility.<sup>10</sup> In 2013, the Acting Deputy Under Secretary for Health for Operations and Management issued a memorandum that provided more detailed training requirements.<sup>11</sup>

See Appendix B for other relevant OIG reports published in the past 3 years.

## Scope and Methodology

OIG performed this inspection at 29 facilities during Combined Assessment Program reviews conducted from October 1, 2016 through March 31, 2017. The facilities OIG visited were a stratified random sample of all VHA facilities and represented a mix of facility size, affiliation, geographic location, and Veterans Integrated Service Networks. OIG generated an individual Combined Assessment Program report for each facility. In this report, OIG summarized the data collected from each facility.

OIG reviewed facilities' policies, assessments, meeting minutes, training plans, other relevant documents, and 1,025 electronic health records (EHR) of patients involved in a disruptive behavior incident from July 1, 2015 through June 30, 2016. OIG also reviewed 53 assaults that involved non-patients (employees, visitors, students, and others) as victims or perpetrators over the past 12 months and interviewed managers with disruptive and violent behavior management responsibilities. Additionally, OIG reviewed 730 training files of employees hired within 6 months of the onsite visits. If compliance with VHA guidelines was below 90 percent for a given activity, OIG considered making recommendations.

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<sup>10</sup> VHA Directive 2012-026.

<sup>11</sup> Acting Deputy Under Secretary for Health for Operations and Management. "Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum." Memorandum. November 7, 2013.

Two policies cited in this report were expired:

1. VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012 (expired February 28, 2015).
2. VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected copy February 3, 2011) (expired December 31, 2015).

OIG considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),<sup>12</sup> the VA Under Secretary for Health mandated the "...continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."<sup>13</sup> The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "...the timely rescission or recertification of policy documents over which their program offices have primary responsibility."<sup>14</sup>

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

## Inspection Results

### Issue 1: Facilities' Assessments, Committees, and Teams

OIG determined that all facilities had implemented policies to prevent and manage disruptive/violent behavior and conducted annual Workplace Behavioral Risk Assessments. All facilities completed physical security assessments in the 12 months prior to OIG's site visits that included monitoring systems and panic alarms for each area where used. However, Facility Directors needed to establish Employee Threat Assessment Teams (ETAT) and ensure attendance at Disruptive Behavior Committee or Board (DBC/B) meetings by all required members.

Employee Threat Assessment Teams. VHA requires that Facility Directors ensure ETATs are present and operate successfully.<sup>15</sup> An ETAT is a facility-level, interdisciplinary team whose primary charge is to address the risk of violence posed by

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<sup>12</sup> VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

<sup>13</sup> VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.

<sup>14</sup> Ibid.

<sup>15</sup> VHA Directive 2012-026.

employee-generated behavior(s) that is disruptive or that undermines a culture of safety.<sup>16</sup> According to VHA's ETAT Guidebook:<sup>17</sup>

The ETAT represents a preemptive strategy for addressing employee-generated violence. The very existence of the ETAT Program (and the training employees receive related to ETAT reporting) demonstrates an organizational rejection of workplace violence and supports an environment that seeks resolution of conflict at low-levels of engagement.

Thirty-four percent of facilities had not established ETATs or acceptable alternatives. Some reasons Facility Directors gave OIG for not establishing ETATs included confusion about a prior ban on ETATs due to some union opposition and reluctance to create an acceptable alternative group. OIG recommended that all Facility Directors establish ETATs.

Disruptive Behavior Committees or Boards. VHA requires that Facility Directors ensure DBCs/Bs operate successfully.<sup>18</sup> A DBC/B is a facility-level, interdisciplinary committee whose primary charge is to prevent, identify, assess, manage, reduce, and track patient-generated disruptive behavior. According to VHA Directive 2010-053, each facility's DBC/B is responsible for:<sup>19</sup>

1. Coordinating, when possible and appropriate, with the clinicians responsible for the patient's medical care, and recommending amendments to the treatment plan that may reduce the patient's risk of violence.
2. Implementing the PRF standards.
3. Collecting and analyzing incidents of patient disruptive, threatening, or violent behavior.
4. Assessing the risk of violence in individual patients.
5. Informing patients they have a right to amend the contents of a PRF, and providing the information for contacting the facility Privacy Officer in the event the patient wants to pursue an amendment.
6. Identifying system problems.
7. Identifying training needs relating to the prevention and management of disruptive behavior.
8. Recommending to the facility Chief of Staff other actions related to the problem of patient violence.

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<sup>16</sup> VHA Directive 2012-026.

<sup>17</sup> VHA Center for Engineering and Occupational Safety and Health, *Employee Threat Assessment Team: a Guidebook for Managing Risks Posed by the Disruptive and Threatening Employee*, April 2016.

<sup>18</sup> VHA Directive 2012-026.

<sup>19</sup> VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010. This Directive expired December 31, 2015, and has not yet been updated.

Facility DBC or DBB membership must include:<sup>20</sup>

1. A senior clinician chair who has knowledge of, and experience in, assessment of violence.
2. A representative of the prevention and management of disruptive behavior (PMDB) program in the facility.
3. VA Police.
4. Health Information Management Service and/or Privacy Officer (ad hoc).
5. Patient Safety and/or Risk Management Official.
6. Regional Counsel (ad hoc).
7. Patient Advocate.
8. Other members as needed, with special attention to representatives of facility areas that are at high risk for violence, (for example, Emergency Department, Community Living Center, inpatient psychiatry, and community based outpatient clinics).
9. Representative of the Union Safety Committee.
10. Clerical and administrative support staff to accomplish the required tasks.

Most facilities had established a DBC/B and had a senior clinician listed in their policy as chair who attended at least half of the meetings in the 12-month period reviewed. While most facilities had a VA Police Officer, Patient Safety and/or Risk Management Official, and Patient Advocate listed in their policy as members, these members did not attend at least half of the meetings in the 12-month period reviewed. VA Police Officers did not attend at least half the meetings at 18 percent of facilities, Patient Safety and/or Risk Management Officials did not attend at least half the meetings at 25 percent of facilities, and Patient Advocates did not attend at least half the meetings at 39 percent of facilities. Some reasons staff gave OIG for not attending meetings regularly included lack of time and not making attendance a high priority. OIG recommended that facilities' senior managers ensure that VA Police Officers, Patient Safety and/or Risk Management Officials, and Patient Advocates regularly attend DBC/B meetings and monitor compliance.

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<sup>20</sup> VHA Directive 2010-053.

## **Issue 2: Patient Record Flag Placement, Follow-Up, and Notification**

VHA requires that clinicians use PRFs in patients' EHRs to identify and track disruptive and violent patients.<sup>21</sup> According to VHA Directive 2010-053:<sup>22</sup>

- A PRF alerts VHA employees about patients whose behavior, medical status, or characteristics may pose an immediate threat either to that patient's safety or the safety of other patients or employees.
- PRFs enhance both the right of all patients to receive confidential, safe, and appropriate health care as well as the right of employees to have a safe work environment.
- PRFs permit employees to develop strategies for offering health care to even the most behaviorally challenging patients who, in an earlier era, might have been excluded from receiving VHA health care.
- The PRF becomes national information and is displayed at all VHA facilities where the patient is registered. As a result, patients with a PRF who present an immediate safety risk for seriously disruptive, threatening, or violent behavior may be safely treated within VHA wherever they are registered and seek care.
- The decision to enter a PRF is made by the DBC/B only after completion of an evidence-based, multidisciplinary, and multi-dimensional threat assessment.

OIG found that when placing most new PRFs, DBC/B clinician members entered progress notes associated with the PRF. Additionally, when clinicians had placed PRFs for a previous incident of disruptive behavior, OIG found that most clinicians had reviewed the PRFs within the previous 2 years and that the reviews of previous PRFs were discussed in the DBC/B.

In 27 percent of reviewed EHRs, OIG found no evidence that clinicians notified patients of the PRF placement. As mentioned above, the DBC/B is responsible for informing patients they have a right to amend the contents of a PRF.<sup>23</sup> In 49 percent of EHRs, OIG found no evidence that DBC/B clinician members informed patients of this right.

OIG learned after the review concluded that field staff had raised concerns about a potential safety issue to the VHA Workplace Violence Prevention program office director. Some patients escalated their disruptive behavior when they received the notification letters and directed it toward the individuals who signed the letters. After discussion, the program office director discouraged routinely sending signed letters to notify patients of PRFs. Rather, she suggested that clinicians should base notification on individual patient assessment. She encouraged field staff to limit routine notification

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<sup>21</sup> VHA Directive 2010-053.

<sup>22</sup> Ibid.

<sup>23</sup> Ibid.

to just those patients where Orders of Behavioral Restriction (OBR) were issued (which are required to be accompanied by a PRF).

VHA defines an OBR as a type of therapeutic limit setting sometimes required to manage VHA care for patients whose behavior is disruptive. The restrictions on care may include but are not limited to:<sup>24</sup>

1. Specifying the hours in which non-emergent outpatient care is provided;
2. Arranging for medical and any other services to be provided in a particular patient care area (e.g., private exam room near an exit);
3. Arranging for medical and any other services to be provided at a specific site of care;
4. Specifying the healthcare provider and related personnel who will be involved with the patient's care;
5. Requiring a police escort; or
6. Authorizing VA providers to terminate an encounter immediately if certain behaviors occur.

In OIG's sample of disruptive and violent behavior incidents, facilities issued 67 new OBRs. OIG still found opportunities for improvement in documentation. When new OBRs were issued, OIG found no evidence in 13 percent of EHRs that patients were informed. In 25 percent of EHRs, OIG found no evidence that patients were informed they had the right to request to amend or appeal the OBRs. Additionally, VHA requires facility Chiefs of Staff (or designees) to be responsible for approving or disapproving OBRs recommended by the DBC/B.<sup>25</sup> In facilities compliant with this requirement, OIG generally found this evidence in the signature blocks of notification letters. In 15 percent of EHRs, OIG found no evidence that the Chiefs of Staff or designees approved the OBRs. Some reasons Chiefs of Staff gave OIG for not approving OBRs and informing patients about them included that OBRs are fairly rare, and they did not have a notification process in place, and there was a lack of communication between the DBC/B chair and the Chief of Staff when an OBR was issued.

The program office director provided an updated draft directive that limits routine notification of OBRs. OIG agreed with this change in policy. Therefore, OIG recommended that when Chiefs of Staff (or designees) issue an OBR, they document that they informed the patient the OBR was issued and of the right to appeal the OBR decision and that facility senior managers monitor compliance.

### **Issue 3: Employee Training**

VHA requires that Facility Directors ensure each employee completes required training in security issues, including awareness, preparedness, precautions, and police assistance.<sup>26</sup> Training must use VHA's PMDB curriculum. OIG found that all facilities

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<sup>24</sup> VHA Directive 2012-026.

<sup>25</sup> Ibid.

<sup>26</sup> Acting Deputy Under Secretary for Health for Operations and Management. Memorandum. November 7, 2013.

had implemented security training plans that used the official PMDB training curriculum. The PMDB curriculum includes four levels of training:<sup>27</sup>

- Level I: Employees working in areas at minimal risk
- Level II: Employees working in areas at low risk (exposure to only verbal disruptive behaviors)
- Level III: Employees working in areas at moderate risk (exposure to both verbal and physical disruptive behaviors)
- Level IV: Employees working in areas at high risk (exposure to physically disruptive behaviors requiring therapeutic containment response)

VHA requires that all employees complete Level I PMDB training within 90 days of hire.<sup>28</sup> Facilities need to ensure that employees working in areas of low, moderate, and high risk complete additional levels of PMDB training as appropriate, also within 90 days of hire. OIG found that each facility’s training plans included providing Level I PMDB training to all employees and additional levels based on the type and severity of risk for exposure to disruptive and unsafe behaviors. However, 26 percent of employees did not complete Level I PMDB training within 90 days of hire as required or additional levels as needed (60–75 percent). Some reasons managers gave OIG for not providing PMDB training included lack of allocated time to complete training, lack of leadership support, and misunderstanding the requirement. OIG recommended that facility senior managers ensure that within 90 days of hire, all employees complete Level I PMDB training and additional training levels based on the type and severity of risk for exposure to disruptive and unsafe behaviors and monitor compliance.

Although OIG noted several possible ways to accomplish the necessary training within 90 days of hire, the most compliant facilities included multiple levels of training in the formal New Employee Orientation that is required for all newly hired employees (see Table). The percentage of employees completing training was higher for each risk category in those facilities that included multiple levels of training in New Employee Orientation. OIG suggests that the best way to ensure that newly hired employees receive multiple levels of PMDB training is during New Employee Orientation.

**Table. Percent of Employees Who Received Training**

<b>Facilities’ Trainers Provided Multiple PMDB Levels to New Employees at New Employee Orientation</b>	<b>PMDB Level I</b>	<b>PMDB Level II*</b>	<b>PMDB Level II–III*</b>	<b>PMDB Level II, III and IV*</b>	<b>Overall Level II–IV*</b>
No (15 facilities)	72.1	28.3	30.7	18.9	26.7
Yes (14 facilities)	76.8	51.7	46.6	31.5	43.8

*Source: OIG CAP Review Data Analysis*

\*Some facilities did not have Level II, III, and/or IV areas

<sup>27</sup> Acting Deputy Under Secretary for Health for Operations and Management. Memorandum. November 7, 2013.

<sup>28</sup> Ibid.

## Issue 4: Management of Non-Patient Assaults

VHA guidance focuses on managing patients who exhibit disruptive/violent behavior and does not provide guidance about non-patients (employees, visitors, students, and others) who were the victims or perpetrators of such behavior. This is an important consideration when the goal is to have a safe workplace. OIG reviewed facilities' policies, where available, and had managers describe standard practices when no formal policies were in place. OIG reviewed non-patient assaults and found that most facilities managed them appropriately according to their policies or practices. When assaults involved employees as perpetrators (31 cases), the employees' disruptive behavior was addressed through appropriate administrative processes. Although not required, OIG gathered information about actions that seem reasonable—managers conducted risk assessments (86 percent) and interdisciplinary reviews (70 percent)—and found that managers offered resources (such as time off for affected employees) to handle issues due to the incident 67 percent of the time.

OIG suggested that VHA provide system-wide guidance for managing non-patient assaults.

## Conclusions

All facilities had implemented policies that addressed preventing and managing disruptive/violent behavior and had conducted annual Workplace Behavioral Risk Assessments. All facilities completed physical security assessments in the 12 months prior to OIG's site visits that included monitoring systems and panic alarms for each area where used. However, Facility Directors needed to establish ETATs and ensure attendance at DBC/B meetings by all required members.

PRFs in patients' EHRs communicate to clinicians that flagged patients have exhibited disruptive and violent behavior. Most of the time, DBC/B clinician members entered progress notes associated with new PRFs, and most clinicians had reviewed previously placed PRFs within the past 2 years. However, OIG found noncompliance with requirements to inform patients about the PRFs and to inform patients about the right to request to amend or appeal PRF placement. Because of OIG's review, field staff and program office staff held discussions and decided that these directives needed to change because of the risk that informing patients of PRF placements could increase the incidence of violent behaviors. OIG agreed with limiting routine notification to just those patients where OBRs were issued. However, when OIG analyzed PRFs associated with new OBRs, OIG still found noncompliance with requirements to inform patients about the PRF and to inform patients about the right to request to amend or appeal PRF placement.

All facilities had implemented security training plans that used the official PMDB training curriculum, and training plans at the facilities inspected included Level I PMDB training for all employees and additional levels based on the type and severity of risk for exposure to disruptive/violent behavior. However, facilities need to improve in providing

newly hired employees with Level I PMDB training and additional levels as indicated. The most compliant facilities included multiple levels of training in the formal New Employee Orientation, and OIG suggested that all facilities consider doing the same.

VHA guidance focuses on managing patients who exhibit disruptive/violent behavior but does not provide specific guidance concerning non-patients (employees, visitors, students, and others) who exhibit such behavior. This is an important consideration when the goal is to have a safe workplace. Most facilities' leaders managed non-patient assaults appropriately according to their local policies or processes. However, OIG suggested that VHA leaders consider providing system-wide guidance for managing non-patient assaults.

## Recommendations

1. OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure Facility Directors establish Employee Threat Assessment Teams.
2. OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure facility senior managers require attendance by VA Police Officers, Patient Safety and/or Risk Management Officials, and Patient Advocates at Disruptive Behavior Committee/Board meetings and monitor compliance.
3. OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that when Chiefs of Staff (or designees) issue Orders for Behavioral Restriction, they document that they informed patients that the Orders were issued and of the right to appeal the decisions and that facility senior managers monitor compliance.
4. OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure facility senior managers require that within 90 days of hire, all employees complete Level I Prevention and Management of Disruptive Behavior training and additional training levels based on the type and severity of risk for exposure to disruptive and unsafe behaviors and monitor compliance.

## Project Questions and Data

**Table 1. Facilities' Policies, Assessments, and Committees.**

Project Questions	Yes	Percent Yes	No	Percent No	NA	Total
1. Does the facility have a policy, procedure, or guideline that addresses preventing and managing disruptive/violent behavior? If yes,	29	100%	0	0%	0	29
Does it define a process for use of PRFs for disruptive behavior?	27	93%	2	7%	0	29
2. Did the facility conduct an annual Workplace Behavioral Risk Assessment within the past 12 months?	29	100%	0	0%	0	29
3. Did the facility implement the Employee Threat Assessment Team?	19	66%	10	34%	0	29
4. Did the facility implement the DBC/B? If yes,	28	97%	1	3%	0	29
Is a senior clinician listed on the policy defining DBC/B membership as chair?	26	93%	2	7%	0	28
Did a senior clinician chair attend at least half of the meetings?	27	96%	1	4%	0	28
Is a VA Police Officer listed on the policy defining DBC/B membership?	27	96%	1	4%	0	28
Did a VA Police Officer attend at least half of the meetings?	23	82%	5	18%	0	28
Is the Patient Safety Manager and/or Risk Manager listed on the policy defining DBC/B membership?	26	93%	2	7%	0	28
Did the Patient Safety Manager and/or Risk Manager attend at least half of the meetings?	21	75%	7	25%	0	28
Is the Patient Advocate listed on the policy defining DBC/B membership?	25	89%	3	11%	0	28
Did the Patient Advocate attend at least half of the meetings?	17	61%	11	39%	0	28
5. Did the facility implement the Disruptive Behavior Reporting System or acceptable alternate system?	27	93%	2	7%	0	29
If using an alternate (ePIR), does it link with the Disruptive Behavior Reporting System?	2	100%	0	0%	25	2

Project Questions	Yes	Percent Yes	No	Percent No	NA	Total
6. Did the facility collect information about disruptive or violent behavior incidents? If yes,	27	93%	2	7%	0	29
Was there evidence that the information was analyzed? If yes,	27	100%	0	0%	0	27
Were any problems or opportunities for improvement identified? If yes,	17	63%	10	37%	0	27
Were specific action items documented? If yes,	16	94%	1	6%	0	17
Were actions fully implemented? If yes,	11	100%	0	0%	5	11
Were fully implemented changes monitored?	9	100%	0	0%	2	9
7. Did the facility complete a physical security assessment(s) in the past 12 months?	29	100%	0	0%	0	29
8. Did the facility use the following physical security equipment:						
SSTVs/CCTVs? If yes,	28	97%	1	3%	0	29
• Were SSTVs/CCTVs included in the physical security assessment for each area where used?	27	96%	1	4%	0	28
• Were SSTVs/CCTVs tested in accordance with the physical security assessment (or other document) for each area where used?	26	93%	2	7%	0	28
Computer-based panic alarm systems? If yes,	19	66%	10	34%	0	29
• Were computer-based panic alarm systems included in the physical security assessment for each area where used?	18	95%	1	5%	0	19
• Were computer-based panic alarm systems tested in accordance with the physical security assessment (or other document)?	18	95%	1	5%	0	19
Stationary panic alarms? If yes,	21	72%	8	28%	0	29
• Were stationary panic alarms included in the physical security assessment for each area where used?	21	100%	0	0%	0	21
• Were stationary panic alarms tested in accordance with the physical security assessment?	21	100%	0	0%	0	21
Electronic personal panic alarms? If yes,	12	41%	17	59%	0	29
• Were electronic personal panic alarms included in the physical security assessment for each area where used?	10	83%	2	17%	0	12
• Were electronic personal panic alarms tested in accordance with the physical security assessment?	10	83%	2	17%	0	12

Project Questions	Yes	Percent Yes	No	Percent No	NA	Total
9. Does the facility have a security training plan? If yes,	29	100%	0	0%	0	29
Does it use the official PMDB training?	29	100%	0	0%	0	29
Do any of the facility's high-risk workplaces have a Behavioral Emergency Response Team?	10	34%	19	66%	0	29
10. Does the facility security training plan include:						
• Level I PMDB training for all employees	29	100%	0	0%	0	29
• Additional levels of PMDB training based on the type and severity of risk for exposure to disruptive and unsafe behaviors	29	100%	0	0%	0	29
• Supervisor training	20	69%	9	31%	0	29
11. Does the facility provide multiple PMDB levels to all new employees at New Employee Orientation	14	48%	15	52%	0	29

Source: VA OIG Review Guide.

NA=Not applicable

**Table 2. Electronic Health Record Review Results.**

Project Questions	Yes	Percent Yes	No	Percent No	NA	Total
1. Was this a new incident of disruptive behavior?	786	80%	239	20%	0	1,025
2. What intervention(s) did facility staff use to prevent reoccurrence? (Incidents could have zero, one, or more than one intervention; therefore, the numbers will not match those in #1 above.)						
• PRF for disruptive behavior	347					
• PRF for OBR	67					
• Police check-in or escort required	91					
• Letter to patient	157					
• Category II PRF (local)	7					
• Care transferred from Community Based Outpatient Clinic to main facility or barred from clinic	48					
• Counseling of patient	197					
• Clinical warnings	23					
• Reported on disruptive behavior reporting and tracking system	334					
• No action	47					
• Other	186					
3. If a new PRF was placed, did a DBC/B clinician member enter a progress note associated w/ the PRF?	327	95%	19	5%	1	347
4. If a new PRF was placed, is there evidence that the patient was informed that:						
• The PRF was placed in the EHR?	251	73%	95	27%	1	347
• The patient has the right to request to amend or appeal placement of the PRF?	174	51%	170	49%	3	347
5. If a new OBR was issued, is there evidence that the Chief of Staff or designee approved the OBR?	57	85%	10	15%	0	67
6. If a PRF was placed for a previous incident of disruptive behavior, is there evidence that the PRF was reviewed w/in past 2 years?	177	92%	15	8%	833	1,025
7. Was the review of previous PRF discussed in the DBC/B?	164	93%	13	7%	0	177

Source: VA OIG Review Guide.

NA=Not applicable

**Table 3. Employee Training Record Review Results.**

Project Questions	Yes	Percent Yes	No	Percent No	NA	Total
1. Did the employee complete Level I PMDB training within 90 days of hire?	543	74%	187	26%	0	730
2. If assigned to work in a low-risk area, did the employee complete Level II PMDB training within 90 days of hire?	100	40%	149	60%	481	730
3. If assigned to work in a moderate-risk area, did the employee complete Level II and III PMDB training within 90 days of hire?	107	38%	176	62%	447	730
4. If assigned to work in a high-risk area, did the employee complete Level II, III, and IV PMDB training within 90 days of hire?	46	25%	136	75%	548	730

Source: VA OIG Review Guide.

NA=Not applicable

**Table 4. Non-Patient Assault Management.**

Project Questions	Yes	Percent Yes	No	Percent No	NA	Total
1. Was the assault managed appropriately according to the facility's policies?	50	94%	3	6%	0	53
• Did the facility do a risk assessment to determine appropriate mitigation	31	86%	5	14%	0	36
• Was there an interdisciplinary review	30	70%	13	30%	0	43
• Were resources (such as time off) offered to handle issues due to the incident	20	67%	10	33%	0	30
• Was the employee's disruptive behavior addressed through correct processes	31	100%	0	0%	14	45

Source: VA OIG Review Guide.

NA=Not applicable

**Prior OIG Reports  
May 1, 2014 through May 1, 2017**

***Topic Related Reports***<sup>29</sup>

**Healthcare Inspection – Alleged Program Mismanagement and Other Concerns at the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon**

5/17/2017 | 15-01653-226

**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Amarillo VA Health Care System, Amarillo, Texas**

6/23/2016 | 15-01653-226

**Healthcare Inspection – Mental Health-Related Deficiencies and Inadequate Leadership Responsiveness, Central Alabama VA Health Care System, Montgomery, Alabama** 7/29/2015 | 14-04530-414

***Facility Clinical Assessment Program Review Reports***<sup>30</sup>

Altoona, PA – James E. Van Zandt VA Medical Center

Birmingham, AL – Birmingham VA Medical Center

Boise, ID – Boise VA Medical Center

Canandaigua, NY – Canandaigua VA Medical Center

Cleveland, OH – Louis Stokes Cleveland VA Medical Center

Columbia, MO – Harry S. Truman Memorial Veterans' Hospital

Decatur, GA – Atlanta VA Medical Center

Denver, CO – VA Eastern Colorado Health Care System

Des Moines, IA – VA Central Iowa Health Care System

El Paso, TX – El Paso VA Health Care System

Fort Harrison, MT – VA Montana Health Care System

Fort Wayne, IN – VA Northern Indiana Health Care System

Houston, TX – Michael E. DeBakey VA Medical Center

Iron Mountain, MI – Oscar G. Johnson VA Medical Center

Lebanon, PA – Lebanon VA Medical Center

<sup>29</sup> These reports can be found at <https://www.va.gov/oig/>.

<sup>30</sup> Ibid.

Lexington, KY – Lexington VA Medical Center  
Loma Linda, CA – VA Loma Linda Healthcare System  
New Orleans, LA – Southeast Louisiana Veterans Health Care System  
Orlando, FL – Orlando VA Medical Center  
Portland, OR – VA Portland Health Care System  
Saginaw, MI – Aleda E. Lutz VA Medical Center  
Salisbury, NC – W.G. (Bill) Hefner VA Medical Center  
Salt Lake City, UT – VA Salt Lake City Health Care System  
San Juan, PR – VA Caribbean Healthcare System  
Shreveport, LA – Overton Brooks VA Medical Center  
Syracuse, NY – Syracuse VA Medical Center  
Tucson, AZ – Southern Arizona VA Health Care System  
White River Junction, VT – White River Junction VA Medical Center  
Wilmington, DE – Wilmington VA Medical Center

## Executive in Charge Comments

**Department of  
Veterans Affairs**

# Memorandum

**Date:** December 14, 2017

**From:** Executive in Charge, Office of the Under Secretary for Health (10)

**Subject:** **OIG Draft Report, Management of Disruptive and Violent Behavior in Veterans Health Administration Facilities (VAIQ 7858623)**

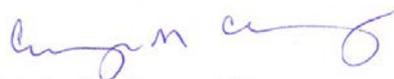
**To:** Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report, Management of Disruptive and Violent Behavior in Veterans Health Administration Facilities. The Veterans Health Administration (VHA) concurs with recommendations 1–4, and provides the attached action plan.

2. The Office of Mental Health and Suicide Prevention's Workplace Violence Prevention Program (WVPP) will develop guidance requiring the implementation of Employee Threat Assessment Teams, utilization of the Disruptive Behavior Reporting System, and ensuring staff complete Level 1 Prevention and Management of Disruptive Behavior training at each VA medical facility.

3. WVPP will continue efforts to revise VHA Directive 2010-053, "Patient Record Flags" concerning attendance of appropriate personnel at Disruptive Behavior Committee/Board meetings.

4. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at [VHA10E1DMRSAction@va.gov](mailto:VHA10E1DMRSAction@va.gov).



Carolyn M. Clancy, M.D.

Attachment

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

**OIG Draft Report, Management of Disruptive and Violent Behavior in  
Veterans Health Administration Facilities**

**Date of Draft Report: November 9, 2017**

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<b>Recommendations/ Actions</b>	<b>Status</b>	<b>Completion Date</b>
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**OIG Recommendations**

**Recommendation 1.** We recommended that the Executive in Charge, Under Secretary for Health office, in conjunction with Veterans Integrated Service Network senior managers, ensure Facility Directors implement Employee Threat Assessment Teams.

**VHA Comments:** Concur

The Office of Mental Health and Suicide Prevention's Workplace Violence Prevention Program (WVPP) will develop guidance issued via a Deputy Under Secretary for Health for Operations and Management (DUSHOM) memorandum requiring the implementation of Employee Threat Assessment Teams (ETAT) at each VA medical facility. This guidance will include ensuring an ETAT is required by a facility policy (e.g., Medical Center Memorandum) and each ETAT be staffed; adequately resourced; its Chair, Co-Chair, and members appropriately trained in accordance with WVPP requirements; and its operations adherent to processes defined in the ETAT Guidebook published in the VHA Center for Engineering & Occupational Safety and Health.

Each VISN [Veterans Integrated Service Network] is to attest quarterly to compliance with the ETAT DUSHOM Memo until two consecutive quarters with 90 percent compliance are achieved. VISNs must be able to provide, upon request, documentation of ETAT operations. Facilities not meeting the required two consecutive quarters of 90 percent ETAT implementation must submit a corrective action plan to WVPP through their respective VISN.

Status:  
In Process

Target Completion Date:  
December 2018

**Recommendation 2.** We recommended that the Executive in Charge, Under Secretary for Health office, in conjunction with Veterans Integrated Service Network senior managers, ensure facility senior managers require attendance by VA Police Officers, Patient Safety and/or Risk Management Officials, and Patient Advocates at Disruptive Behavior Committee/Board meetings and monitor compliance.

**VHA Comments:** Concur

The Office of Mental Health and Suicide Prevention’s Workplace Violence Prevention Program (WVPP) will continue efforts to revise VHA Directive 2010-053, “Patient Record Flags,” to ensure the attendance of VA Police Officers, Patient Safety and/or Risk Management Officials, and Patient Advocates at Disruptive Behavior Committee/Disruptive Behavior Board (DBC/DBB) meetings. Additionally, WVPP will develop guidance issued from the Deputy Under Secretary for Health for Operations and Management requiring VISNs to monitor the attendance of these positions to all held DBC/DBB meetings at each medical facility within their respective network.

Attendance compliance monitoring will be achieved by two consecutive quarterly attestations by the VISN to the WVPP that 90 percent of DBC/DBB meetings are attended by each position. VISNs must be able to provide, upon request, documentation of DBC meeting annual attendance rates for these positions at each facility. Facilities not meeting the required two consecutive quarters of a 90 percent or better attendance rate requirement for these positions must submit a corrective action plan to WVPP through their respective VISN.

Status:	Target Completion Date:
In Process	December 2018

**Recommendation 3.** We recommended that the Executive in Charge, Under Secretary for Health office, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that when Chiefs of Staff (or designees) issue Orders for Behavioral Restriction, they document that they informed patients that the Orders were issued and of the right to appeal the decisions, and that facility senior managers monitor compliance.

**VHA Comments:** Concur

The Office of Mental Health and Suicide Prevention’s Workplace Violence Prevention Program (WVPP) will develop guidance issued via a Deputy Undersecretary for Health for Operations and Management memorandum requiring each VA medical facility Chief of Staff’s designee and Disruptive Behavior Committee to use the Disruptive Behavior Reporting System (DBRS) to document a decision to implement an Order of Behavioral Restriction (OBR) and notification of a patient when an OBR is issued. Notifications must describe the patient’s right to appeal the OBR and delineate the appeal process as established in 38 CFR 17.107.

Each VISN is to monitor and attest compliance. Additionally, facilities must be able to provide documentation, upon request, of OBR documentation in DBRS and patient notifications. Facilities will be considered successful once two consecutive quarters of 90 percent compliance reports are documented. Facilities not meeting the required two consecutive quarters of 90 percent or better OBR DBRS documentation and notification rate must submit a corrective action plan to WVPP through their respective VISN.

Status:	Target Completion Date:
In Process	December 2018

**Recommendation 4.** We recommended that the Executive in Charge, Under Secretary for Health office, in conjunction with Veterans Integrated Service Network senior managers, ensure facility senior managers require that within 90 days of hire, all employees complete Level I Prevention and Management of Disruptive Behavior training and additional training levels based on the type and severity of risk for exposure to disruptive and unsafe behaviors and monitor compliance.

**VHA Comments:** Concur

The Office of Mental Health and Suicide Prevention's Workplace Violence Prevention Program (WVPP) will develop guidance issued via a Deputy Under Secretary for Health for Operations and Management memorandum requiring facility senior managers to ensure all new employees complete Level I Prevention and Management of Disruptive Behavior (PMDB) training, and all applicable additional levels of PMDB training based on the risk for exposure to disruptive/violent behaviors as determined by the Workplace Behavioral Risk Assessment (WBRA). Each VISN will ensure that PMDB trainers and coordinators are adequately resourced to be able to provide training during New Employee Orientation for new employees within 90 days of hire.

Training compliance monitoring will be achieved by two consecutive quarterly attestations by the VISN that 90 percent of new employees have completed all required levels of training within 90 days of hire. VISNs must be able to provide, upon request, documentation of PMDB training rates for new employees at each facility. Facilities not meeting the required two consecutive quarters of a 90 percent or better quarterly PMDB training completion rate for new employees within 90 days of hire must submit a corrective action plan to WVPP through their respective VISN.

Status:	Target Completion Date:
In Process	December 2018

## OIG Contact and Staff Acknowledgments

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