US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Informed Consent for Admission and Against Medical Advice Discharge Processes for a Patient at the VA Southern Nevada Healthcare System in Las Vegas

Healthcare Inspection | **24-00160-212** | **August 1, 2024**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations regarding staff failure to follow informed consent and against medical advice (AMA) discharge processes at the VA Southern Nevada Healthcare System (facility) in Las Vegas and involuntarily holding a patient for 48 hours.[1] During the inspection, the OIG identified a related concern regarding alignment of a medical center policy (MCP) with Nevada state law and Veterans Health Administration (VHA) requirements.

The patient initially presented to the Emergency Department on Day 1 requesting assistance with substance withdrawal and was subsequently admitted to the facility's locked inpatient mental health unit for management of withdrawal symptoms.[2] Upon arriving on the unit, the patient complained to multiple staff members regarding the restrictive environment and severity of mental illness exhibited by fellow patients. However, the patient agreed to remain on the unit after verbally requesting an AMA discharge. On Day 2, the patient completed a written AMA request form, and on Day 3 of the hospitalization, the patient was discharged to home. In the months following discharge, the patient declined care from VA mental health providers.

The OIG substantiated that facility staff failed to have an informed consent discussion with the patient as required, prior to admission to the locked inpatient mental health unit.[3] Additionally, the OIG found, upon review of facility documents and interviews with staff and leaders, that the facility lacked a standardized informed consent discussion process to inform patients of the restrictions and potentially severe mental health conditions that are treated in the locked inpatient mental health unit.

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[1] An AMA discharge is defined as when a patient "wants to leave prior to the completion of the recommended inpatient treatment plan." MCP)116-22-10, *Psychiatric Inpatient Unit Admissions, Transfers, and Discharges,* May 18, 2022.

[2] The patient had one previous inpatient admission for substance withdrawal management on an unlocked medical unit at a different VHA medical facility; *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5). "Substance-Related and Addictive Disorders," accessed January 8, 2024, https://dsm.psychiatryonline.org/doi/10.1176/appi.books.9780890425787.x16_Substance_Related_Disorders. Substance withdrawal can occur after prolonged heavy consumption is reduced or ceased; MCP 116-22-10. For medically stable patients, the facility provides inpatient substance withdrawal management on the mental health unit.

[3] VHA Handbook 1004.01(5), *Informed Consent for Clinical Treatments and Procedures,* August 14, 2009, amended September 17, 2021. This handbook was in place during the time of the events discussed in this report. The handbook was rescinded and replaced by VHA Directive 1004.01, *Informed Consent for Clinical Treatments and Procedures,* December 12, 2023, which was amended January 12, 2024, with VHA Directive 1004.01(1), which was amended February 22, 2024, with VHA Directive 1004.01(2), which was amended May 1, 2024, with VHA Directive 1004.01(3). Unless otherwise specified, language regarding informed consent is the same in the Handbook and Directives. On a locked inpatient mental health unit, patients may not leave without a provider entering an order in the EHR. As such a patient's civil liberty could be impacted. For the purposes of this report, the OIG did not make a finding relating to the patient's civil liberty as that was not within the scope of this healthcare inspection.

The OIG did not substantiate that inpatient mental health unit staff failed to follow the AMA discharge process as outlined in the MCP 116-22-10, *Psychiatric Inpatient Unit Admissions, Transfers, and Discharges*, or that facility staff did not discharge the patient for 48 hours following the patient's written request to leave AMA as required. However, the OIG found that the facility's policy permitting delay of an AMA discharge for 24 hours was inconsistent with state law, and according to VHA policy, issues impacting a patient's choice to remain admitted to an inpatient mental health unit must comply with relevant state laws.

During an interview with the OIG, a provider cited the patient's clinical history and initial presentation warranted additional observation as the patient could have been at risk for an adverse outcome. Staff followed the process as outlined in the MCP and discharged the patient within 24 hours of signing a request for an AMA discharge. However, staff did not adhere to Nevada state law, which states that any patient admitted voluntarily must be released immediately after the filing of a written request for release "unless the facility changes the status of the person to an emergency admission [involuntary admission]."[4] Ultimately, no action was taken to convert the patient's voluntary admission status to involuntary as the patient did not meet criteria.

The OIG found the Chief, Behavioral Health Service, should have been assigned oversight and guidance responsibilities to ensure the facility policy complied with applicable state laws. However, for unknown reasons, the Facility Director failed to adhere to VHA requirements and assign those responsibilities to the responsible owner, or anyone else. This failure provided a gap, which may have led to the MCP not aligning with state law.[5]

The OIG made seven recommendations to the Facility Director related to the informed consent discussion process; ensuring that MCPs for the inpatient mental health unit are reviewed, updated, and approved appropriately to adhere to applicable requirements; and that staff are educated on the policies.

[4] Nevada Revised Statutes (NRS) § 433A.140 ¶ 3 (2022). Nevada state law provides three types of admissions to mental health facilities: voluntary, emergency, and court-ordered. NRS 433A.120. Both emergency and court-ordered admissions are involuntary. NRS 433A.0163, NRS 433A.0167.

[5] "VHA Local Policy Support," *Medical Center Policy (MCP) Template,* VHA Office of Regulations, Appeals, and Policy, accessed March 20, 2024, https://dvagov.sharepoint.com/sites/VHARAP/SitePages/VHA-Local-Policy-Support.aspx. (This website is not publicly accessible).

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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

Contents

Abbreviations

AMA	Against Medical Advice
EHR	electronic health record
OIG	Office of Inspector General
NRS	Nevada Revised Statutes
MCP	medical center policy
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) evaluated allegations regarding staff failure to follow the informed consent and the against medical advice (AMA) discharge processes at the VA Southern Nevada Healthcare System (facility) in Las Vegas.[1] During the inspection, the OIG identified a related concern regarding alignment of a medical center policy (MCP) with Nevada state law and Veterans Health Administration (VHA) requirements.

Background

The facility is part of Veterans Integrated Service Network (VISN) 21 and consists of one medical center and seven community-based outpatient clinics. The medical center is designated as Level 1b complexity and offers emergency care and inpatient services, including 20 mental health care beds.[2]

Allegations and Related Concern

On September 5, 2023, a complainant alleged that facility staff did not follow the informed consent process for a patient prior to admission to a locked inpatient mental health unit. Further, the complainant alleged that facility staff did not follow the AMA discharge process and held the patient on the mental health unit involuntarily for 48 hours.

The OIG reviewed the allegations and sent the facility a request for further review on October 11, 2023. The OIG identified concerns with the facility's response, and on December 8, 2023, opened a healthcare inspection to review the patient's informed consent for admission and the AMA discharge process. In deciding to initiate an inspection, the OIG factored in how admission to the locked inpatient mental health unit impacted the patient's civil liberty and the right to make informed decisions regarding care.[3] In reviewing relevant facility documents, the OIG identified a related concern regarding deficiencies in an MCP.

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[1] An AMA discharge is defined as when a patient "wants to leave prior to the completion of the recommended inpatient treatment plan." MCP 116-22-10, *Psychiatric Inpatient Unit Admissions, Transfers, and Discharges,* May 18, 2022.

[2] VHA Office of Productivity, Efficiency and Staffing (OPES), "Data Definitions: VHA Facility Complexity Model," October 1, 2023. The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex; MCP 116-22-10.

[3] Substance Abuse and Mental Health Services Administration (SAMHSA), *Detoxification and Substance Abuse Treatment, A Treatment Improvement Protocol, TIP 45*, HHS Publication No. (SMA) 15-4131, printed 2006, revised 2015.

Scope and Methodology

The OIG conducted an on-site visit February 6–8, 2024, and interviewed the complainant, facility executive leaders, Emergency Department and inpatient mental health unit leaders and staff, the associate chief of staff for behavioral health, a hospitalist, and an administrative officer of the day.[4]

The OIG reviewed relevant VHA policies, Nevada state laws, and facility policies. The OIG also reviewed the patient's electronic health record (EHR) entries dated from June 2023 to March 2024.

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

[4] The administrative officer of the day assists with administrative elements of an admission such as receiving and safeguarding patients' belongings. VHA Directive 1096, *Administrative Officer of the Day,* March 27, 2020.

Inspection Results

1. Informed Consent Failure

The OIG substantiated that facility staff failed to follow the informed consent process when admitting the patient to the inpatient mental health unit for substance withdrawal management. Specifically, facility staff failed to engage the patient in an informed consent discussion to provide the patient with information necessary to make an informed choice regarding admission for treatment.

VHA requires a patient's informed consent prior to undertaking any voluntary, not medically emergent, treatment.[5] As a part of the process, the physician, or delegated healthcare team member, must engage the patient in an informed consent discussion about the treatment, which includes "information that a reasonable person in the patient's situation would expect to receive in order to make an informed choice about whether or not to undergo the treatment."[6] If the discussion is delegated to a team member, the physician is obligated to confirm with the patient that they were informed and voluntarily consented to care.

The OIG determined that a "reasonable person" consenting to an inpatient mental health unit admission would expect to be informed the unit is locked and provides services to patients with mental health disorders who may be experiencing acute and severe emotional or behavioral symptoms.[7]

The patient, in their thirties, was receiving outpatient treatment for anxiety, mood, and substance use disorders with a prior history of a medical complication related to substance use withdrawal.[8] On Day 1, the patient presented to the facility's Emergency Department reporting no substance use for 48 hours and expressing a desire for assistance with managing potential withdrawal symptoms.[9] An Emergency Department physician evaluated the patient and facilitated a voluntary, non-emergent, admission to the inpatient mental health unit for substance withdrawal

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[5] VHA Handbook 1004.01(5), *Informed Consent for Clinical Treatments and Procedures,* August 14, 2009, amended September 17, 2021. This handbook was in place during the time of the events discussed in this report. The handbook was rescinded and replaced by VHA Directive 1004.01, *Informed Consent for Clinical Treatments and Procedures,* December 12, 2023, which was amended January 12, 2024, with VHA Directive 1004.01(1), which was amended February 22, 2024, with VHA Directive 1004.01(2), which was amended May 1, 2024, with VHA Directive 1004.01(3). Unless otherwise specified, language regarding informed consent is the same in the Handbook and Directives.

[6] VHA Handbook 1004.01(5).

[7] On a locked inpatient mental health unit, patients may not leave without a provider entering an order in the EHR. As such, a patient's civil liberty could be impacted. For the purposes of this report, the OIG did not make a finding relating to the patient's civil liberty as that was not within the scope of this healthcare inspection.

[8] The OIG uses the singular form of they, "their" in this instance, for privacy purposes.

[9] The patient had one previous inpatient admission for substance withdrawal management on an unlocked medical unit at a different VHA medical facility.

management; the administrative officer of the day completed admission paperwork with the patient.[10]

After the patient arrived on the unit, a nurse documented the patient stated staff

> lied to me about this unit, [staff] said [it] was for detox—not a locked ward, I do not wish to be here . . . as soon as I saw this was a psych unit, my mood changed. I didn't sign up for this.

A physician later documented the patient's report that "[the patient] probably would not" have agreed to admission had the patient known "this is how it is in here."

The OIG reviewed EHR documentation completed prior to the inpatient mental health unit admission and did not find evidence of a physician or team member holding an informed consent discussion with the patient specific to the inpatient mental health unit. In OIG interviews, several facility staff recalled other patients becoming distressed after admission to the inpatient mental health unit and learning that it is locked.

Although a provider cited precedence of affording patients who decline withdrawal management on the inpatient mental health unit alternative treatment in a non-locked unit, the OIG was unable to find evidence that this option was considered after the patient voiced concerns related to the locked nature of the inpatient mental health unit.

The OIG interviewed 17 facility leaders and staff regarding the informed consent discussion process specific to voluntary admission to the inpatient mental health unit. Five staff reported being unsure or unaware of who participates in providing the information to patients. The remaining staff provided differing answers regarding who completes the informed consent discussion. Facility executive leaders acknowledged the need to provide patients with information about the inpatient mental health unit, including that it is a locked unit that provides services to patients with mental health disorders.[11]

The OIG found that facility staff failed to provide information necessary for the patient to make an informed choice regarding admission to an inpatient mental health unit. Further, the OIG found the facility lacks a process to ensure patients are aware, prior to a voluntary admission, that the inpatient mental health unit is locked and provides services to patients with mental health disorders. The OIG is concerned that failure to provide patients with information to make

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[10] *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5). "Substance-Related and Addictive Disorders," accessed January 8, 2024, https://dsm.psychiatryonline.org/doi/10.1176/appi.books.9780890425787.x16_Substance_Related_Disorders. Substance withdrawal can occur after prolonged heavy consumption is reduced or ceased; MCP 116-22-10. For medically stable patients, the facility provides inpatient substance withdrawal management on the mental health unit.

[11] Facility executive leaders included the Facility Director, Chief of Staff, and acting associate director for patient care services.

informed decisions regarding treatment may lead to patients' mistrust of the healthcare system and negatively impact engagement in future health care.

2. Against Medical Advice Discharge

The OIG did not substantiate that inpatient mental health unit staff failed to follow the AMA discharge process as outlined in the MCP 116-22-10, *Psychiatric Inpatient Unit Admissions, Transfers, and Discharges,* or that facility staff did not discharge the patient for 48 hours following the patient's written request to leave AMA. However, the OIG found that the MCP permitting delay of an AMA discharge for 24 hours was inconsistent with state law, and according to VHA policy, issues impacting a patient's choice to remain admitted to an inpatient mental health unit must comply with relevant state laws.

Adherence to the Discharge Process

The MCP specific to inpatient mental health unit discharges states,

> any patient admitted voluntarily must be released immediately . . . after filing a written request . . . **or unless within 24 hours after the request**, the facility changes the patient's status to an Emergency Admission status [emphasis added by the OIG].[12]

On Day 1, multiple staff documented the patient's verbal requests for an AMA discharge. Staff also told the OIG in interviews of having conversations with the patient, who did not complete a written request and subsequently agreed to stay on the inpatient mental health unit. One inpatient mental health unit leader told the OIG, " . . . every time that the staff ask[ed the patient], would you like AMA paperwork? . . . they were able to convince [the patient] to stay in the unit a little bit longer." The OIG did not find EHR documentation of the conversations citing the patient's agreement to stay on Day 1.

On Day 2, the patient signed a written request for an AMA discharge noting that conditions on the inpatient mental health unit had negatively impacted recovery. Approximately half an hour later, the provider documented the patient would not be discharged at that time due to safety concerns. In an interview with the OIG, the provider cited the patient's clinical history and initial presentation warranted additional observation as the patient could have been at risk for an adverse outcome. The provider also stated that "per policy the patient could sign the AMA form and we have 24 hours to" determine if the patient meets criteria for an emergency admission status. Ultimately, no action was taken to convert the voluntary admission status to involuntary as the patient did not meet criteria.

[12] VHA does not have agency-wide directive or handbook guidance for AMA discharges; MCP 116-22-10.

On Day 3, approximately 48 hours after first verbalizing a desire to leave the unit, and within 24 hours of submitting the written request for an AMA discharge, a different provider discharged the patient home. In the months following discharge, the patient declined VA mental health care.

The OIG found that facility inpatient mental health unit staff followed the facility policy governing discharges in that the patient was discharged within 24 hours of signing a written request for AMA discharge, however, the facility policy was inconsistent with state law.

Medical Center Policy Deficiencies

The OIG identified that the Facility Director failed to ensure the MCP specific to inpatient mental health unit discharges included all elements from the VHA template required for use when creating an MCP. Specifically, the policy failed to assign oversight responsibilities, including a review of applicable laws, which may have contributed to the policy's inaccuracy.

VHA policy requires providers to follow applicable state laws governing involuntary mental health evaluation and treatment, including time limited holds for evaluation.[13] According to Nevada state law, any patient admitted voluntarily "must be released immediately after the filing of a written request for release" with the provider, "unless the facility changes the status of the person to an emergency admission [involuntary admission]."[14] In Nevada, criteria for changing a patient's status to an involuntary admission includes the patient having a mental illness and that the patient's capacity be diminished as a result of the mental illness, which creates a substantial likelihood of causing harm to self or others.[15]

In contrast to state law, for patients who are voluntarily admitted and requesting an AMA discharge, facility policy, at the time of inspection, allowed inpatient mental health staff 24 hours to determine whether the patient's status should be changed to an involuntary admission.[16] Based on state law, however, the OIG would have expected the MCP to require inpatient mental health unit staff to immediately discharge a patient or, if the patient met criteria consistent with state law, change a patient's voluntary admission status to an emergency admission following a patient's written request to leave the unit.

[13] VHA Handbook 1160.06, *Inpatient Mental Health Services,* September 16, 2013. This handbook was rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023. Unless otherwise specified, language regarding state laws is the same in the Handbook and Directive.

[14] Nevada Revised Statutes (NRS) § 433A.140 ¶ 3 (2022). Nevada state law provides three types of admissions to mental health facilities: voluntary, emergency, and court-ordered. NRS 433A.120. Both emergency and court-ordered admissions are involuntary. NRS 433A.0163, NRS 433A.0167.

[15] NRS § 433A.145 provides the criteria to be met in order to change a patient's status from a voluntary admission to an emergency [involuntary] admission if the person is in a mental health crisis. NRS § 433A.0175 defines a person in a mental health crisis.

[16] VHA does not have agency-wide directive or handbook guidance for AMA discharges; MCP 116-22-10.

In February 2024, the OIG communicated concern to the Facility Director regarding the language in the MCP that was inconsistent with state law, allowing the staff to retain a patient for 24 hours for evaluation purposes. In written correspondence with the OIG in March 2024, the Facility Director indicated awareness of the issue and reported taking actions to ensure the MCP's compliance with state law, including consultation with the Office of General Counsel to review an amended policy.[17] Additionally, the Chief of Staff issued guidance to mental health and social work staff that "if a patient is voluntarily admitted and chooses to leave, they may do so unless they meet the criteria" for an emergency admission.

The VHA directive on policy management requires facility directors to use a standardized MCP template when creating new MCPs and provides guidance stating facility directors are responsible for ensuring use of the template.[18] The template includes a paragraph entitled "Responsibilities" and a section for a "responsible owner" for the identified purpose of "oversight and guidance" of the policy.[19] The VHA directive states

> Oversight refers to the actions taken to guide, control, monitor and evaluate the organization to help ensure policies are being implemented as intended . . . [and are in] compliance with applicable laws . . . [20]

A facility standard operating procedure (SOP) establishes procedures regarding the preparation, publication, and maintenance of MCPs. The SOP defines the policy owner as the "person responsible for the review, revision, or rescission of the [MCP]" and includes the VHA template for MCPs as an appendix.[21] The SOP requires the policy owner to submit the MCP to the facility policy and procedure committee for review with final approval and signature by the Facility Director. When submitting the policy, a cover sheet is included. The cover sheet specifies whether the policy is new or revised, that the policy "meets legal/regulatory requirements," and includes a brief summary of the contents or revisions.[22]

The OIG found facility MCP 116-22-10 identified the "responsible owner" as the chief of behavioral health service, but did not assign the responsible owner, or anyone else, oversight and guidance responsibilities to ensure compliance with applicable laws. The cover sheet and MCP, submitted by the deputy associate nurse executive for behavioral health to the policy and

[17] VHA Directive 1160.06. VHA recommends consultation with the District Counsel due to the wide variation in state laws governing involuntary treatment on inpatient mental health units.

[18] VHA Directive 0999(1), *VHA Policy Management,* March 29, 2022.

[19] "VHA Local Policy Support," *Medical Center Policy (MCP) Template,* VHA Office of Regulations, Appeals, and Policy, accessed March 20, 2024, https://dvagov.sharepoint.com/sites/VHARAP/SitePages/VHA-Local-Policy-Support.aspx. (This website is not publicly accessible).

[20] VHA Directive 0999(1).

[21] FW-SOP 00-21-06, "Medical Center Policy, Standard Operating Procedure, Facility-Wide Standard Operating Procedure," June 16, 2021.

[22] FW-SOP 00-21-06.

procedure committee, indicated a policy revision but did not reflect a review of "legal/regulatory requirements" was completed.

The OIG concluded that the Facility Director's failure to fully utilize the MCP template and assign oversight and guidance responsibilities to the "responsible owner," or anyone else, of the policy provided a gap, which may have led to the MCP not aligning with state law. Further, the OIG found the cover sheet submitted with the MCP did not confirm the MCP met "legal/regulatory requirements."

While inpatient mental health unit staff followed the MCP, the failure to ensure the MCP was consistent with state law—which does not allow a 24-hour evaluation period for a voluntary admission—may have resulted in the delay in the patient's AMA discharge.

Conclusion

At the time of admission to the inpatient mental health unit, the facility lacked an informed consent process to ensure patients were told that the inpatient mental health unit was locked and provided services to persons with mental health disorders. As a result, the patient did not have an informed consent discussion with a provider or delegated team member prior to admission to the locked inpatient mental health unit.

While staff followed the MCP when coordinating the patient's AMA discharge, the policy did not align with state law. Specifically, the MCP allowed an AMA discharge to be delayed for 24 hours, but state law requires immediate discharge.

The OIG identified that the Facility Director's failure to assign oversight responsibilities to the MCP owner and ensure the policy included all elements from the required VHA MCP template may have contributed to the policy inaccuracy.

The OIG is concerned that failure to provide patients with information to make informed decisions regarding treatment may lead to patients' mistrust of the healthcare system and negatively impact engagement in future health care.

The OIG made seven recommendations.

Recommendations 1–7

1. The VA Southern Nevada Healthcare System Director develops a process consistent with Veterans Health Administration Directive 1004.01(3) to ensure patients are informed, prior to voluntary admission to the inpatient mental health unit, that the unit is locked and provides services to patients with mental health disorders.
2. The VA Southern Nevada Healthcare System Director ensures staff are educated following development of the informed consent process for voluntary admission to the inpatient mental health unit.
3. The VA Southern Nevada Healthcare System Director confirms that medical center policy 116-22-10 adheres to Nevada state law relevant to admission to mental health units and is approved in accordance with Veterans Health Administration policies.
4. The VA Southern Nevada Healthcare System Director confirms that medical center policy 116-22-10 includes the responsible owners' oversight and guidance responsibilities as required by Veterans Health Administration Directive 0999(1).
5. The VA Southern Nevada Healthcare System Director ensures staff education regarding changes to the medical center policy 116-22-10.
6. The VA Southern Nevada Healthcare System Director ensures that any facility policies involving state law addressing voluntary or involuntary mental health commitments be reviewed by the Office of General Counsel.
7. The VA Southern Nevada Healthcare System Director develops a process to ensure facility policies adhere to the Veterans Health Administration Directive 0999(1), medical center policy standardized template.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 25, 2024

From: Director, Sierra Pacific Network (10N21)

Subj: Healthcare Inspection—Deficiencies in Informed Consent for Admission and Against Medical Advice Discharge Process for a Patient at the VA Southern Nevada Healthcare System in Las Vegas

To: Director, Office of Healthcare Inspections (54HL05)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed the draft report Healthcare Inspection-Deficiencies in Informed Consent for Admission and Against Medical Advice Discharge Process for a Patient at the VA Southern Nevada Healthcare System in Las Vegas.

2. The VA Southern Nevada Healthcare System (VASNHS) is committed to honoring our Veterans by ensuring they receive high-quality healthcare services. I support the Director's response and action plans.

3. I would like to thank the Office of Inspector General for their review of this case. If you have any additional questions, please contact the VISN 21 Quality Management Officer (QMO).

(*Original signed by:*)

Ada Clark, FACHE, MPH
Network Director
VA Sierra Pacific Network

[**OIG comment:** The OIG received the above memorandum from VHA on June 26, 2024.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 28, 2024

From: Director, VA Southern Nevada Healthcare System (593)

Subj: Healthcare Inspection—Deficiencies in Informed Consent for Admission and Against Medical Advice Discharge Process for a Patient at the VA Southern Nevada Healthcare System in Las Vegas

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations from the OIG Office of Healthcare Inspections on-site visit conducted at the VA Southern Nevada Healthcare System from February 6–8, 2024.

2. Please find the attached response to each recommendation included in the report. We have completed, or are in the process of completing, actions to resolve these issues. We will take actions as recommended by the OIG to strengthen the care we provide.

(*Original signed by*:)

Kristan M. Murray, MHA, FACHE
Acting Medical Center Director/Deputy Director
VA Southern Nevada Healthcare System

[**OIG comment:** The OIG received the above memorandum from VHA on June 26, 2024.]

Facility Director Response

Recommendation 1

The VA Southern Nevada Healthcare System Director develops a process consistent with Veterans Health Administration Directive 1004.01(3) to ensure patients are informed, prior to voluntary admission to the inpatient mental health unit, that the unit is locked and provides services to patients with mental health disorders.

_X _Concur

____Nonconcur

Target date for completion: August 30, 2024

Director Comments

The VA Southern Nevada Healthcare System Director (VASNHS) developed a process to ensure patients are informed, prior to voluntary admission to the inpatient mental health unit (2 East), that the unit is locked and provides services to patients with mental health disorders. The Nurse Manager of 2 East reviewed the admission pamphlet which states that the 2 East unit is a locked unit, but it did not state that it provides services to patients with mental health disorders. Also, there was no documentation in the Electronic Health Record (EHR) to support that this pamphlet was provided to the patient or that the patient was informed that 2 East was a locked unit and provides services to patients with mental health disorders. Therefore, the pamphlet was updated to include that 2 East provides services to patients with mental health disorders. Additionally, for voluntary admissions, a documentation template will be created in the EHR, so that the staff, either the Emergency Department (ED) Behavioral Health Social Worker or the ED Registered Nurse (RN) can document that the pamphlet was provided and discussed. Additionally, documentation that this was completed will also be added to the 2 East Situation Background Assessment Recommendation (SBAR) form and validated during handoff from the ED RN to the 2 East receiving RN.

Recommendation 2

The VA Southern Nevada Healthcare System Director ensures staff are educated following development of the informed consent process for voluntary admission to the inpatient mental health unit.

_X _Concur

____Nonconcur

Target date for completion: December 31, 2024

Director Comments

The VA Southern Nevada Healthcare System Director ensured staff are educated following development of the process to ensure patients are informed, prior to voluntary admission to the inpatient mental health unit (2 East), that the unit is locked and provides services to patients with mental health disorders. The necessary stakeholders, including, ED Behavioral Health Social Workers, ED RN's, ED providers and 2 East staff, including RN's, providers and Social Workers will be educated on the new process for voluntary admissions to the locked inpatient mental health unit. A monthly audit of a sample of patients who were voluntarily admitted to the locked inpatient mental health unit will be conducted to ensure that the documentation in the EHR has been completed and that the 2 East SBAR has been completed as described above until 90% is achieved for 3 months. Audit results will be reported at the Behavioral Health Executive Committee until results achieved.

Recommendation 3

The VA Southern Nevada Healthcare System Director confirms that medical center policy 116-22-10 adheres to Nevada state law relevant to admission to mental health units and is approved in accordance with Veterans Health Administration policies.

_X _Concur

____Nonconcur

Target date for completion: March 26, 2024

Director Comments

The VA Southern Nevada Healthcare System Director confirmed that medical center policy (MCP) 116-22-10 adheres to relevant laws, regulations, national policy, and state laws. The Medical Center Director reached out to the Deputy Chief Counsel, Pacific District for legal guidance in regard to the version of MCP that was in effect at the time of the survey, and it was identified that the local MCP was not aligned with current Nevada State Law. It was determined that while the provisions to hold a patient up to 24 hours to determine whether to convert a voluntarily admitted patient to an involuntary 72-hour emergency admission had been consistent with Nevada law as of several years ago, that law changed in or around 2019, and since then, the law provides that a voluntary patient must be released immediately upon written request unless the facility changes status to an emergency admission following the procedures for such an admission. Additionally, the Deputy Chief Counsel Pacific District recommended immediate suspension of this part of the MCP as well as revising the current version of the MCP with review of the final draft by the Office of General Counsel (OGC). Therefore, a Memo was sent by Chief of Staff on February 29, 2024, to Behavioral Health Staff, that explained that effective immediately the current language in the MCP which allowed a patient to be kept up to 24 hours

after filing a written request for release was suspended and the new requirements as outlined by current Nevada State Law that, "Any person admitted to a public or private mental health facility as a voluntary consumer must be released immediately after the filing of a written request for release with the responsible physician or that physician's designee within the normal working day, unless the facility changes the status of the person to an emergency admission" would immediately be implemented.

The Quality, Safety, Value (QSV) Executive revised the MCP to include the recommended updates and an urgent request was submitted to OGC on February 27, 2024 to review the final draft. The OGC responded on February 28, 2024, with additional edits and the QSV Executive created a final draft of the MCP. The MCP was approved at Medical Executive Committee on March 14, 2024 and Executive Leadership Board on March 25, 2024, signed by the Medical Center Director, and posted onto the facility intranet on March 26, 2024. MCP 116-22-10 will continue to be regularly reviewed per VHA Directive 0999(1).

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 4

The VA Southern Nevada Healthcare System Director confirms that medical center policy 116-22-10 includes the responsible owners' oversight and guidance responsibilities as required by Veterans Health Administration Directive 0999(1).

_X _Concur

____Nonconcur

Target date for completion: July 19, 2024

Director Comments

The VA Southern Nevada Healthcare System Director confirmed that medical center policy 116-22-10 includes the responsible owners' oversight and guidance responsibilities as required by VHA Directive 0999(1). On May 21, 2024, MCP 116-22-10 was revised to include the Associate Chief, Behavioral Health oversight and guidance responsibilities. The MCP will be approved through the Policy and Procedure Committee, Medical Executive Committee and Executive Leadership Board and will be signed by the Medical Center Director.

Recommendation 5

The VA Southern Nevada Healthcare System Director ensures staff education regarding changes to the medical center policy 116-22-10.

_X _Concur

____Nonconcur

Target date for completion: July 19, 2024

Director Comments

The VA Southern Nevada Healthcare System Director ensured staff education regarding changes to the medical center policy 116-22-10 occurred. A Memo was sent by Chief of Staff on February 29, 2024 to Behavioral Health Staff, that explained that effective immediately the current language in the MCP which allowed a patient to be kept up to 24 hours after filing a written request was suspended and the new requirements as outlined by current Nevada State Law that, "Any person admitted to a public or private mental health facility as a voluntary consumer must be released immediately after the filing of a written request for release with the responsible physician or that physician's designee within the normal working day, unless the facility changes the status of the person to an emergency admission" would immediately be implemented. The MCP was approved at Medical Executive Committee on March14, 2024 and Executive Leadership Board on March 25, 2024, signed by the Medical Center Director and was posted onto the facility intranet on March 26, 2024. After the MCP was posted onto the intranet, an all-employee email was sent on March 26, 2024, informing staff that the policy had been updated with a link to the facility intranet. Additionally, the Associate Chief, Behavioral Health will be informed of the oversight and guidance responsibilities per MCP 116-10.

Recommendation 6

The VA Southern Nevada Healthcare System Director ensures that any facility policies involving state law addressing voluntary or involuntary mental health commitments be reviewed by the Office of General Counsel.

_X _Concur

____Nonconcur

Target date for completion: July 19, 2024

Director Comments

The VA Southern Nevada Healthcare System Director ensured that any facility policies involving state law addressing voluntary or involuntary mental health commitments will be reviewed by the Office of General Counsel. On May 21, 2024, the QSV Executive reviewed the

policy cover sheet that is submitted to the Policy and Procedure Committee when a policy is submitted. Instructions were added to include that any policies involving voluntary or involuntary mental health commitments need to be reviewed by the Office of General Counsel. The revised policy cover sheet was also included in SOP 00-06 Medical Center Policy, Standard Operating Procedures, Facility-wide Standard Operating Procedures and will be approved through the Policy and Procedure Committee, Executive Leadership Board and will be signed by the Medical Center Director.

Recommendation 7

The VA Southern Nevada Healthcare System Director develops a process to ensure facility policies adhere to the Veterans Health Administration Directive 0999(1), medical center policy standardized template.

_X _Concur

____Nonconcur

Target date for completion: July 19, 2024

Director Comments

The VA Southern Nevada Healthcare System Director developed a process to ensure policies adhere to VHA Directive 0999(1), medical center policy standardized template. On May 21, 2024, the QSV Executive reviewed the national MCP template and revised SOP 00-06 Medical Center Policy, Standard Operating Procedures, Facility-wide Standard Operating Procedures to include the current national MCP template, which has all of the elements including oversight responsibilities of the MCP owner. Additionally, oversight responsibilities in SOP 00-06 were added under the Service Chief and/or Responsible Owner. The SOP will be approved through the Policy and Procedure Committee, Executive Leadership Board and will be signed by the Medical Center Director.

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