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Report to the Chairman, Committee on Veterans Affairs, and the Honorable Charles S. Robb, U.S. Senate

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VA HEALTH CARE

VA Medical Centers Need to Improve Monitoring of High-Risk Patients

GAO/HRD-94-27

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Human Resources Division

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December 10, 1993

The Honorable John D. Rockefeller IV
Chairman, Committee on Veterans' Affairs
United States Senate

The Honorable Charles S. Robb
United States Senate

On May 14, 1992, a request was made that we review the Department of Veterans Affairs' (VA) procedures for locating patients missing from its medical facilities. At the time of this request, two patients had been found dead on the grounds of a VA medical center, and questions were being raised about the effectiveness of VA efforts to locate missing patients. Consequently, we were asked to determine (1) whether patients missing from VA medical centers is a pervasive, nationwide problem; (2) how many patients are unaccounted for and what is being done to find them; (3) whether VA's missing-patient reporting and search procedures are effective; and (4) the extent to which VA investigates patient disappearances.

This report addresses each of these issues and includes an assessment of five VA medical centers' efforts to prevent patients who are at risk to themselves or others from leaving a facility or treatment setting without proper staff authorization.[1]

We did this assessment through reviews of patient records, interviews with clinical personnel, and examinations of pertinent policies and procedures. Four of these centers were selected for review because most of the patients who left the grounds of a medical center without authorization from October 1, 1990, to September 30, 1992, and were still unaccounted for in October 1992, came from these centers.[2] The fifth center was selected for review because two patients were found dead on the grounds of the facility after they had previously left the center's patient care area without staff permission. (See app. I for further information about our scope and methodology.)

[1]VA refers to this situation as "patient elopement."

[2]These four centers accounted for 62 percent of the individuals cited in VA's October 1992 survey as being unaccounted for. We conducted on-site verification of records for unaccounted-for patients at these centers.

Background

VA operates the largest health care delivery system in the United States, consisting of 158 medical centers, 240 outpatient clinics, 126 nursing care units, and 32 domiciliaries. In fiscal year 1992, over 935,000 patients were treated in VA medical centers on an inpatient basis.

Upon admission to a VA medical center, every patient's medical needs are to be determined and a treatment plan developed. Patients who are (1) legally committed, (2) have a legal guardian, (3) are considered to be a danger to themselves or others, or (4) lack the cognitive ability to make decisions are considered to be high risk and are required to receive closer monitoring by VA personnel than other patients in the general population. If any of these patients wander away or leave their assigned unit without staff authorization, a search will be initiated immediately. Searches also may be initiated at the discretion of the medical center director for missing patients who have intact decisionmaking abilities and are believed to be at minimal risk for their safety.

Results in Brief

High-risk patients leaving a treatment setting without staff authorization is a significant problem at 39 of VA's 158 medical centers.[3] During the 2-year period October 1, 1990, through September 30, 1992, 20 VA medical centers were involved in more than 100 searches for high-risk patients. An additional 19 medical centers conducted between 50 and 99 patient searches. These facilities accounted for 70 percent of the total number of searches conducted for high-risk missing patients systemwide during this period. Our work at five medical centers indicates that patients leave their treatment settings without staff knowledge primarily when medical center staff (1) inadequately assess patients' potential to leave the treatment setting without authorization and (2) do not closely monitor all high-risk patients while they are in the patient care area or on the grounds of the facility. These centers were selected for review because they either had large numbers of unaccounted-for missing patients or had missing patients found dead on the grounds of the facility.

Systemwide, about 7,000 searches were conducted for high-risk patients who were reported as missing from their treatment settings during the 2-year period. While 99 percent of these patients were ultimately found

[3]VA designates 14 of these medical centers as psychiatric facilities: Battle Creek, Michigan; Canandaigua, New York; Coatesville, Pennsylvania; Lebanon, Pennsylvania; Marion, Indiana; Montrose, New York; Murfreesboro, Tennessee; Perry Point, Maryland; Pittsburgh (Highland Drive), Pennsylvania; St. Cloud, Minnesota; Salisbury, North Carolina; Sheridan, Wyoming; Tomah, Wisconsin; and Tuscaloosa, Alabama.

unharmed, VA officials discovered that 34 others were dead and 19 were injured. Further, 25 remained unaccounted for as of June 1, 1993.

VA has concentrated its efforts on developing search procedures to find high-risk patients who leave a medical center treatment setting without staff knowledge and approval. In these procedures, emphasis is placed on finding patients reported as missing before too much time elapses and they leave the grounds of the medical center. But VA also should be concentrating on reducing the need for searches by taking measures to closely monitor high-risk patients to prevent their unauthorized departure from the patient care area. Further, VA can do more to locate unaccounted-for patients.

Significant Numbers of High-Risk Patients Leave Treatment Settings Without the Knowledge of Responsible Staff

The number of high-risk patients who leave VA medical center treatment settings without the knowledge and approval of staff is significant at 39 medical centers. In fact, 70 percent of the 6,996 searches conducted for physically impaired, mentally disoriented, or other high-risk patients who left their treatment settings without the knowledge of medical center staff between October 1, 1990, and September 30, 1992, were conducted in these centers.[4] Fourteen of these centers have been designated by VA as psychiatric facilities.

Patient searches were conducted by VA personnel, and 6,918 individuals were found unharmed. However, VA officials discovered that 34 others were dead, 19 more were injured, and, as of June 1, 1993, 25 patients remained unaccounted for. Two of the medical centers conducted more than 300 patient searches; 4 medical centers conducted between 200 and 299 patient searches; 14 medical centers conducted between 100 and 199 patient searches; and 19 medical centers conducted between 50 and 99 patient searches.

Of the approximately 7,000 searches conducted systemwide, the 14 medical centers serving primarily psychiatric patients accounted for about 1,900, or 27 percent, of the total (see app. II). The 25 remaining facilities conducted about 3,000 searches, or 42 percent, of the total number of searches conducted systemwide (see app. III). Table 1 contains a numerical breakout of the searches conducted.

[4]Data were obtained from an October 1992 VA survey of all medical centers.

Table 1: VA Medical Centers Conducting 50 or More Searches for Patients Reported Missing From Treatment Areas, October 1, 1990, to September 30, 1992

VA medical center characteristics	Number of facilities	Number of searches	Percent of searches conducted systemwide
Primarily psychiatric conducting 50 or more searches	14	1,894	27
Nonpsychiatric conducting 300 or more searches	2	675	10
Nonpsychiatric with 200-299 searches	2	430	6
Nonpsychiatric with 100-199 searches	7	945	14
Nonpsychiatric with 50-99 searches	14	923	13
Total	**39**	**4,867**	**70**

Source: October 1992 VA survey of all medical centers.

More Can Be Done to Preclude High-Risk Patients From Leaving Without Approval

None of the five medical centers we visited is taking sufficient steps to preclude high-risk patients from leaving their treatment settings without the knowledge and approval of cognizant staff. Specifically, our review of patient records showed that physicians and nurses at these centers are not consistently assessing a patient's potential for leaving without authorization when they take a patient's medical history upon admission to the facility. Further, although a variety of methods to better monitor the whereabouts of high-risk patients were being considered or implemented, monitoring of high-risk patients' activities both in the facility and on facility grounds needs improvement.

Assessments of a patient's propensity to leave a treatment setting without the knowledge and approval of staff are not being consistently made in the five centers we visited. Further, neither the physicians nor the nurses at these facilities are adhering to established standards of clinical practice that pertain to assessment of a patient's needs and mental status at the time of entry to a medical facility. Standards of both the American Nurses' Association and the Joint Commission on Accreditation of Healthcare Organizations call for a patient's needs and mental status to be assessed upon entry to a medical facility. The psychiatric screening criteria published in the American Psychiatric Association's Manual of Psychiatric Quality Assurance[5] also state that psychiatrists are to evaluate and

[5]Marlin R. Mattson, ed. "Generic Quality Screens-Psychiatric, Developed by the Health Care Financing Administration for Use by Peer Review Organizations" (Washington, D.C.: 1992), pp. 207-213.

address, in a patient's treatment plan, the patient's potential to leave a medical facility without approval.[6]

Neither the physicians nor the nurses at the five facilities we visited consistently assessed patients to determine whether (1) they had a history of leaving a facility or treatment area without authorization or (2) there was some other indication in their medical history that they might attempt to leave without staff knowledge. Specifically, our review of the medical records for 24 psychiatric and other high-risk patients who disappeared from the 5 facilities we visited showed that adequate assessments and followup were taken in only 2 cases. In 15 cases the patient's history was not assessed to determine his/her potential to leave without the approval of cognizant staff, and in 7 cases patient assessments were made but no action taken to assure that the treatment plan was followed.

Monitoring of a patient while he/she is in a medical center is hampered by a variety of situations including lack of sufficient staff for effective visual observation and medical center policies that grant patients increased privileges—including less supervision—as they respond to treatment. Some medical centers are trying to offset these problems with such techniques as placing electronic monitoring devices on high-risk patients.

Failure to properly assess and monitor high-risk patients results in significant numbers of unauthorized patient departures from a medical center's treatment setting. At the 5 medical centers we visited, 966 searches were made for psychiatric and other high-risk patients who left their patient care area without staff knowledge or permission during the period October 1, 1990, to September 30, 1992. As of June 1, 1993, 957 of these patients had been found unharmed, 3 were dead, and 5 remained unaccounted for.

Most of the patients VA classifies as high risk are psychiatric cases, and the majority of these individuals voluntarily admit themselves to the facility. Thus, they can leave at any time on their own volition. However, VA is responsible for all patients under its care, and high-risk patients such as those who are physically impaired, mentally disoriented, or who are legally committed require effective assessment and close monitoring by medical center personnel.

[6]VA does not acknowledge the American Nurses' Association requirements or the American Psychiatric Association Manual as its official standard of care but does subscribe to Joint Commission quality standards of accreditation for each of its medical centers. VA's guidance for assessing psychiatric patients states that a detailed history of attitudes toward and responses to past treatment is especially relevant in treatment planning.

Improper assessment of a patient's propensity to leave a treatment setting without staff knowledge can have serious consequences. For example, one medical record we reviewed showed the following:

- A 57-year-old veteran, diagnosed with chronic paranoid schizophrenia and delusional behavior, had a documented history of suicide attempts and expressed a desire to kill himself. He was treated for 6 months in the medical center's hospital and then transferred to the nursing home care unit. Nursing home staff assessed the patient and concluded that he was depressed but not suicidal. There was no indication in the medical record that his potential to leave without staff permission was considered; however, the patient left the nursing home 14 days after being transferred to that unit. Further, after the patient's initial transfer to the unit, his medical record showed no additional assessment of his status during the 2 weeks he spent on the unit.

  The patient's psychiatrist had increased the patient's dosage of antipsychotic medication 1 day before the patient left the treatment area without approval and the patient was subsequently found dead. But the psychiatrist did not explain in the patient's medical record why this dosage was changed. A VA report on the patient's death, prepared by the medical center's morbidity and mortality committee, failed to acknowledge that the patient was at risk of hurting himself. In fact, the report erroneously stated that the veteran was not a high-risk patient and had never made any attempts to harm himself.

In another case involving the death of a patient who left his treatment setting without staff approval, medical center personnel failed to recognize numerous indications that the patient was having psychological problems:

- A 68-year-old patient was admitted to a medical center for treatment of severe chronic obstructive pulmonary disease. At that time, he complained that he was seeing bugs on his clothes. In addition to this diagnosis, the patient was also scheduled to have prostate surgery for benign prostatic hypertrophy (enlarged prostate noncancerous). During his stay it was also determined that his retinas were deteriorating. After the patient was told that he had a vision problem, he told the nurse that (1) it was nerve-wracking not being able to see and (2) he thought he was going blind. Compounding these problems, the patient was told that the special examination for his eyes could not be scheduled for a year and that his prostate surgery could not be scheduled for another 3 months. Although an emergency appointment for an eye examination was obtained, the

patient began to make statements that questioned his future ability to independently care for himself.

Approximately 6 weeks after his admission to the medical center, the patient, returning from an ophthalmology consultation at another hospital, told the van driver that he was trying to get a gun to kill himself. The patient's reason for such action was that he was going blind and could not cope with all of his physical problems. The van driver told the social worker who, in turn, charted the information and reported the incident to the nurse on the patient care unit to which the patient was assigned. However, no one followed up with the patient to discuss his suicidal feelings. That night, the patient left the unit and hung himself on the front porch of the medical center's staff quarters.

A review of the aforementioned case shows that the medical center needs to reeducate its staff on several important assessment and monitoring issues such as (1) taking threats of suicide seriously, (2) closely monitoring any patient who makes a suicide threat, (3) recognizing the symptoms of depression, and (4) knowing the conditions that can cause depression. For example, chronic obstructive pulmonary disease at any age causes depression because of the chemical imbalance of arterial blood gases and the great difficulty patients have in breathing. Prognosis for cure of this disease is poor. Prostate disease increases patients' fears about aging and the debilitating illnesses that can accompany the aging process; of particular concern to patients are the tests, surgical procedures, and outcomes for prostate disease. Fear and depression are common reactions to the threat of blindness. These attributes warrant close observation and attention to the patient.

VA policy recognizes a patient's right to the least restrictive conditions necessary to achieve treatment purposes. In line with this policy, each of the medical centers that we visited has procedures for granting privileges to high-risk psychiatric patients that allow them to move about with increasing freedom as their condition improves.[7] This increased mobility, however, also provides the patient with an opportunity to leave the facility without staff knowledge or permission.

For example, in one case that we reviewed, an extremely delusional patient with disorganized thinking and a history of hospitalizations

[7]The West Los Angeles VA Medical Center utilizes four levels of increasing privileges for its psychiatric patients. All patients start out as fully restricted to the unit and may not leave the unit except in the case of an emergency or appointment. Progress to full grounds privileges depends on the treatment team's clinical judgment and is based on such factors as the risk that the patient may leave the facility.

progressed through the privileging system and ultimately left the medical center without the permission of cognizant staff. The patient attended required activities, complied with his treatment plan, and advanced through various privilege levels to eventually be granted a day pass. He did not return from the pass and, as of March 1, 1993, had been unaccounted for 514 days. The patient was administratively discharged from the medical center 3 days after his disappearance. In the discharge summary, the patient was described as unstable and in need of follow-up in the mental health clinic. In this case, VA followed its procedures, and the patient failed to return.

Insufficient numbers of nursing staff to monitor the activities of high-risk psychiatric patients can also provide patients with opportunities to leave a treatment setting without staff knowledge. For example, one medical center relied on visual observation to monitor high-risk patients but had insufficient nursing staff assigned to such patients for adequate coverage. In July 1992, this center had 1 registered nurse for every 38 high-risk patients. In late 1992, the center's staffing improved to 1 registered nurse for every 19 high-risk patients. But if a nurse does not report for duty, the ratio immediately reverts to 1 to 38 because there is no nursing backup assistance. The facility ranked seventeenth highest among the 158 VA medical centers in terms of the number of searches (114) conducted for missing high-risk patients during fiscal years 1991 and 1992.

High-risk patients sometimes make it unmistakably clear that they want to leave the medical center. For example, a 61-year-old psychiatric patient, eager to go home, left the medical center 8 days into a 28-day court-ordered commitment. Before he left, he told staff that he wanted to leave the hospital to pick up money that had been wired to him. The patient was not allowed to do so. Ultimately, he left the facility without staff approval and was located 244 days later.

Another patient, committed by court order for 28 days and diagnosed with chronic paranoid schizophrenia, made it clear that he did not want to stay past the commitment period. The patient was initially required to wear pajamas at all times and not leave the hospital's psychiatric unit without an escort. After 11 days, however, the patient was allowed to wear street clothes, leave the unit for as long as an hour without an escort, and went on one group outing without any problems. Medical staff discussed indefinite commitment with the patient on the last day of his 28-day stay and told him of a scheduled court appearance the next day. He expressed his desire then not to stay beyond the existing court commitment because

of "business" and was seen by another patient later that day with his luggage getting into a cab. The patient's whereabouts were unknown for 4 months.

The medical centers that we visited are either considering or beginning to implement a variety of methods to monitor the location and movement of their high-risk patients within the facility. One center is placing electronic bracelets on high-risk nursing home patients, and another dresses high-risk psychiatric patients in recognizable special blue pajamas. A third center places red wrist bracelets on high-risk psychiatric patients for visual recognition and has installed a security fence to separate center buildings from isolated areas on hospital grounds and flood-lighting to illuminate the fence line and other areas. This center is also considering an electronic bracelet alert system for high-risk psychiatric patients and is increasing the number of nursing staff assigned to its psychiatric units. A fourth center is increasing the number of staff who escort groups leaving restricted hospital units to visit areas such as the canteen. The fifth center is making increased use of a locked nursing home unit with a secured outdoor recreation area for high-risk patients. The expectation in each facility is that with implementation of these measures, the number of unauthorized patient departures will decrease over time.

New Search Procedures Have Been Developed for Locating Missing Patients

In September 1992, VA central office issued a directive to all medical centers entitled "Search for Missing Patients" (see app. IV). The purpose of this directive was to establish procedures to ensure that each VA medical center has an effective plan to search for patients who are missing from their treatment setting. The effort was prompted by a VA Inspector General (IG) report issued in February 1992 entitled Review of Patient Care and Patient Search Procedures-VA Medical Center, Pittsburgh, Pennsylvania. The IG found, among other things, that VA central office guidelines and regulations describing search procedures for missing patients were out of date. The Chief Medical Director agreed with the IG findings and targeted the VA circular governing searches for missing patients for revision by March 1992.

VA's new search directive requires that every medical center have a detailed plan that meets minimum criteria for the identification, search, and location of patients who wander away from or leave the treatment setting without staff knowledge or permission. The directive requires that patients be separated into two categories: (1) those who have been clinically assessed to have intact decisionmaking abilities at the time of

their absence and are not believed to be at risk for their safety and (2) those who, because of age, physical disability, and/or emotional or cognitive status, are incapacitated and may be in danger.

The directive concentrates on how the search should be conducted within the facility and on facility grounds. Specifically, a search is to consist of a thorough inspection of the facility and its grounds. The medical center director or his/her designate is responsible for the search and ultimately determines when a search should be terminated. When a facility search does not locate the missing patient, VA police file a missing person report with local police. VA personnel lack jurisdiction outside medical center grounds and generally do not go into the community to find a patient. Once an unsuccessful search is terminated, VA personnel periodically contact the missing patient's family to determine what they know of the patient's whereabouts.

Between January and April 1993, each of the VA regional offices compared medical center search procedures with the requirements of the VA central office search directive to determine whether the elements of the national directive that the central office considered to be critical were addressed. The regions found that several medical centers had not updated their search procedures and/or did not address one or more of the requirements cited in the national directive. Our review of 47 medical center search procedures that were in effect in January/February 1993 revealed that none contained all the provisions required by the national directive.

Upon completion of their review, officials in each region advised the medical centers to make their search procedures compatible with the central office search directive. However, according to regional office quality assurance personnel, no effort was made to follow up with the cognizant medical centers to determine whether (1) they had changed their local search procedures to coincide with the new systemwide search directive or (2) they had followed the search procedures in the new directive. When we brought this situation to the attention of regional office personnel in June and July 1993, they stated that follow-up action would be taken to ensure that the provisions of the new directive are contained in medical center search policies.

Two of VA's four regions subsequently directed each medical center that had previously failed to comply with each of the requirements in the national directive to resubmit its local search procedures to the region for review. The remaining two regions accepted medical center statements

that they had made the changes in their local search procedures that were previously recommended by regional office personnel. None of the regions, however, made any effort to determine whether the medical centers were, in fact, adhering to the provisions of the new directive.

VA Needs to Collect Better Information on Unaccounted-for Patients

VA medical centers are required to inform regional offices of every incident in which a high-risk patient leaves a treatment setting without staff knowledge or permission and a search has been conducted. The data are accumulated by the regional offices and submitted quarterly to the central office. But, central office personnel do not aggregate this information. Thus, until the October 1992 survey was completed, no one in VA had a systemwide perspective on how many searches for high-risk patients were unsuccessful and how many patients were unaccounted for. However, VA central office personnel found that because of a failure on the part of some medical centers to incorporate current data in the patient medical records, the number of "unaccounted-for" patients cited in this survey may have been significantly overstated.

Specifically, when VA completed its October 1992 survey, it determined that 110 high-risk patients who left a VA medical center without staff knowledge and permission during the period October 1, 1990, through September 30, 1992, were unaccounted for at the time the survey was completed. However, subsequent analysis of medical center data by VA central office staff in February 1993 showed that 65 of these patients had either returned to the same medical center (31 patients) or visited other VA medical centers (34 patients) for treatment after they had been listed by a medical center as unaccounted for. The reason patients were cited as unaccounted for was that (1) medical center records had not been adequately reviewed or updated by medical center staff and (2) existing VA databases that contain current information on patients had not been accessed by medical center personnel.

In addition, VA's benefit payment records showed that another 2 unaccounted-for patients were dead, and 14 more were still being sent checks. VA concluded that if an individual is sent a check, he or she is accounted for and no follow-up action is necessary to ensure that the patient is, in fact, alive and actually receiving these checks.[8] As a result, 81

[8]In July 1990, we reported that VA relied on voluntary information from relatives or other knowledgeable persons to avoid improper benefit payments. We identified millions of dollars in erroneous payments to hundreds of veterans—some of whom had been dead for 10 years or longer [Veterans' Benefits: VA Needs Death Information From Social Security to Avoid Erroneous Payments (GAO/HRD-90-110, July 27, 1990)].

of the 110 patients who were considered by VA to be unaccounted for were actually accounted for.

Conclusions

Given the significant numbers of high-risk patients that are leaving patient treatment areas without staff knowledge or permission, VA needs to improve its medical centers' assessment and monitoring procedures. While it is unreasonable to expect that VA will be able to completely stop all psychiatric and other high-risk patients from leaving either a treatment area or the medical center grounds without authority, VA can and should take steps to reduce the number of such incidents that are occurring. To do this, VA must identify patients who have the potential to leave without permission early in their hospital stay, and these patients must be closely monitored either through direct staff observation, electronic detection devices, or both. Some centers are initiating programs to better monitor their high-risk patents through electronic and other means. However, such efforts to date have been sporadic and somewhat limited. The VA central office should emphasize to medical centers that better monitoring of high-risk patients is needed. Further, successful initiatives taken by medical centers to reduce the incidence of missing patients should be disseminated throughout the VA hospital system.

VA must also ensure that the local search policies of each of its medical centers are in full compliance with its new search directive and are being complied with. Further, upon termination of an unsuccessful search, VA medical centers can do more than they are now doing to locate unaccounted-for high-risk patients. Specifically, medical centers can make better use of VA's network of benefits offices, clinical facilities, and computer programs, as well as veterans' service organizations, to locate these individuals. This can be done by (1) disseminating information on the patient to service organizations and other VA offices and (2) annotating missing patients' names in VA's computerized payment and medical records. Thus, as soon as an unaccounted-for patient seeks to use a service or his/her records are accessed, he/she can be immediately identified.

Recommendations

We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to

- emphasize to medical center management and staff the importance of identifying and closely monitoring high-risk patients with a propensity to leave a treatment area or facility without staff knowledge or permission;
- identify successful approaches taken by medical centers to more effectively monitor the activities of high-risk patients while in the facility or on facility grounds and disseminate this information to medical centers systemwide;
- ensure that medical centers have incorporated the provisions of the VA central office's September 1992 search directive in their local policies and procedures and are adhering to them; and
- require medical centers from which a patient has left without staff permission and is unaccounted for to disseminate information on that patient to other VA facilities and veterans' organizations in the area that, in coordination with the VA facility, establish local programs for locating missing patients.

Agency Comments

We requested written comments from the Department of Veterans Affairs, but none were provided. We met with agency officials, however, to discuss the draft report and made changes, where appropriate, in response to their comments. VA officials generally agreed with our recommendations but said the conclusions significantly overstate the missing persons issue.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, copies will be sent to appropriate congressional committees; the Secretary of Veterans Affairs; the Director, Office of Management and Budget; and other interested parties. If you have any questions about this report, please call me at (202) 512-7101. Other major contributors to this report are listed in appendix V.

David P. Baine

David P. Baine
Director, Federal Health
Care Delivery Issues

Contents

Abbreviations

IG	Inspector General
VA	Department of Veterans Affairs

Objectives, Scope, and Methodology

In a letter dated May 14, 1992, Senator Alan Cranston, the former Chairman, Senate Committee on Veterans' Affairs, and Senator Charles S. Robb jointly requested that we review the Department of Veterans Affairs' (VA) missing patient reporting and search procedures. The requesters asked us to assess the extent of the problem; determine the extent to which patient disappearances are investigated; identify how many patients are unaccounted for and what is being done to find them; and determine whether VA's missing patient reporting and search procedures are effective.

In conducting this review, we interviewed key management officials and obtained relevant information at VA's central office, Washington, D.C.; Veterans' Health Administration Region 3, Jackson, Mississippi; and five VA medical centers: Oklahoma City, Oklahoma; Dayton, Ohio; Palo Alto, California; West Los Angeles, California; and Salem, Virginia. We also interviewed officials at VA's central office to determine reporting requirements for missing patients, search procedures, and investigative practices. We obtained and reviewed VA policies on missing patient searches and on the reporting of search incidents. We examined recent VA Inspector General (IG) and Medical Inspector reports on missing patient reporting and on specific missing patient incidents. We also obtained data on VA efforts to locate unaccounted-for missing patients and reviewed the results.

To determine the number of patients missing from VA medical centers who were unaccounted for, we used data that the VA central office developed in surveys conducted in May and October 1992—the only summary data available on unaccounted-for missing patients. The survey identified a number of psychiatric and other high-risk patients who left a VA medical center's treatment setting without staff knowledge during the period October 1, 1990, through September 30, 1992, and reported their status. The numbers contained in the survey are not exact, however. At the time of the survey, VA medical centers did not maintain accurate records on (1) patients who had left a center's treatment area without staff knowledge or permission, (2) efforts to find them, and (3) eventual outcomes of the search. Further, medical centers did not always comply with central office criteria in responding to the survey and made reporting errors.

We did not attempt a complete verification of VA survey data. We did, however, examine records on unaccounted-for patients at four VA medical centers—Dayton, West Los Angeles, Palo Alto, and Oklahoma City—and reviewed the accuracy of survey data obtained from these facilities. We

selected these four locations because they had 62 percent of the individuals cited in VA's October 1992 survey of missing patients as being unaccounted for. At the time of our review, the fifth center we visited, in Salem, did not have any unaccounted-for patients. However, we included this center in our review because the bodies of two missing patients who had left the facility without staff permission had been found on the medical center's grounds in March 1992.

At four of the medical centers visited, we examined the medical files of each unaccounted-for patient to document the circumstances of each case. In each center we visited, we interviewed such key personnel as the medical center director, hospital service chiefs, risk managers, and VA police to determine the medical center's reporting, search, and investigative procedures for missing patients. Through these efforts, we also developed data on each medical center's procedures for assessing and monitoring high-risk patients who have a propensity to leave a facility without staff knowledge or permission. Specifically, we reviewed 64 patient records to evaluate whether risk assessment had been done and what actions were taken as a result of this assessment. We also reviewed the records of nine patients from VA Region 3 for the same purpose.

To determine what the VA central office and medical centers were doing to locate missing and unaccounted-for patients, we reviewed investigative measures taken to locate the unaccounted-for patients reported in VA's survey. In our review of unaccounted-for patients' medical records, we sought to verify each patient's reported status and compared our determinations to VA's investigative findings. For cases that we did not review, we evaluated whether VA had a reliable basis for concluding that an unaccounted-for patient had been found.

We determined the extent of regional office involvement in reporting and searching for missing patients by interviewing VA quality assurance officials in the Jackson, Mississippi, regional office. This office was judgmentally selected for evaluation. We also discussed with quality assurance personnel this region's efforts to ensure that the provisions of the new central office search directive are being carried out by the medical centers in the region. Through these officials, we obtained copies of the search procedures for missing patients in effect during December 1992 through February 1993 at each of the region's 43 medical centers. We compared these procedures with the VA central office's September 25, 1992, directive on missing patient searches. We made the

same comparison at the four medical centers that we visited outside of the region.

We did our work from June 1992 through July 1993 in accordance with generally accepted government auditing standards.

VA Psychiatric Facilities That Conducted 50 or More Searches for Missing Patients, October 1, 1990, to September 30, 1992

VA medical center	Number of searches conducted
St. Cloud, Minnesota	281
Lebanon, Pennsylvania	224
Coatesville, Pennsylvania	198
Salisbury, North Carolina	186
Canandaigua, New York	178
Perry Point, Maryland	139
Battle Creek, Michigan	138
Marion, Indiana	112
Tomah, Wisconsin	102
Sheridan, Wyoming	81
Pittsburgh (Highland Drive), Pennsylvania	72
Tuscaloosa, Alabama	66
Murfreesboro, Tennessee	61
Montrose, New York	56
Total number of searches	**1,894**

VA Medical Centers That Conducted 50 or More Searches for Missing Patients, October 1, 1990, to September 30, 1992

VA medical center	Number of searches conducted
Dayton, Ohio	354
Palo Alto, California	321
Tucson, Arizona	214
Syracuse, New York	216
North Chicago, Illinois	199
West Los Angeles, California	141
Philadelphia, Pennsylvania	135
Little Rock, Arkansas	125
Topeka, Kansas	118
Salem, Virginia	114
Albuquerque, New Mexico	113
West Haven, Connecticut	96
Augusta, Georgia	86
Leavenworth, Kansas	86
Tacoma, Washington	82
Gainesville, Florida	69
Cleveland, Ohio	62
Salt Lake City, Utah	61
Wilkes-Barre, Pennsylvania	59
Denver, Colorado	58
New Orleans, Louisiana	56
Tuskegee, Alabama	55
Temple, Texas	52
Omaha, Nebraska	51
Miami, Florida	50
Total number of searches	**2,973**

Note: Table excludes medical centers that deal primarily with psychiatric patients.

VA Search Policy

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 10-92-102

September 25, 1992

TO: Regional Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, and Regional Offices with Outpatient Clinics

SUBJ: Search for Missing Patients

1. PURPOSE: The purpose of this VHA (Veterans Health Administration) directive is to establish procedures to ensure that each VA (Department of Veterans Affairs) medical facility has an effective and reliable plan regarding searches for patients who are missing from their treatment setting. This directive will be incorporated into M-1, part I.

2. BACKGROUND: In VHA facilities, patients straying beyond the normal view or control of employees have met with injury or death. Although VA has responsibility for all patients under its care, physically impaired or mentally disoriented patients require a distinctly higher degree of monitoring and protection. To prevent accidental deaths and injuries, VHA must:

a. Improve staff accountability,

b. Detect missing patients early, and

c. Initiate prompt search procedures.

3. POLICY

a. It is VHA policy for all VA facilities which regularly see patients, to have a detailed plan for identification, search, and location of patients who wander away from, or leave the treatment setting without staff knowledge or permission. This includes:

(1) Inpatient, domiciliary, and nursing care facilities,

(2) VA-owned or leased, off-ground health care facilities,

(3) Independent clinics,

(4) Satellite clinics,

(5) Day centers,

(6) Outreach centers, and

(7) Residential bed care facilities (psychiatric residential rehabilitation and treatment programs).

b. VA facilities shall assign the responsibility to review local policies on searching for missing patients to a designated committee which includes the relevant chiefs of services and representation from District Counsel to consider local/state variations in the laws pertaining to these activities. On a yearly basis, this committee shall review its policy on missing patients to ensure its continuing relevance and report findings to the clinical and executive leadership of the medical center.

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c. VA facility policies shall:

(1) Address patients who may be hospitalized on any service, undergoing emergency room or admission processing, or attending clinics or outpatient programs on the grounds.

(2) Distinguish at least two categories of patients:

(a) Those who have been clinically assessed to have had intact decision making abilities at the time of their absence and are subsequently believed to be at minimal risk for their safety, and

(b) Those who are incapacitated. A missing incapacitated patient is one who, because of age, physical disability, and/or emotional or cognitive status, may be in danger. At a minimum, the following categories shall be included if the patient:

1. Has a court-appointed legal guardian,

2. Is considered a danger to self or others,

3. Is legally committed, or

4. Lacks cognitive ability to make decisions.

(3) Establish a "missing incapacitated patient list" controlled by Medical Administration Service. When located, patients may be removed from the list.

(4) Designate who may declare a patient "missing" from the various settings.

(5) Address time frames for initiating searches, notifying relatives, and the time spent searching for an incapacitated missing patient before the search process is considered to be unsuccessful as well as what level of search is required for each category (high risk/low risk) of patient.

(6) Designate a service to communicate with relatives, guardians, other responsible persons, and nearby treatment facilities, as appropriate until missing patients are found.

(7) Address patient privileging, ward counts, and surveillance procedures with regard to early identification of missing patients.

NOTE: *Local law enforcement agencies and officials should be oriented and become involved with the search activities of the VA medical center by being invited to policy and operational planning sessions.*

4. ACTION

a. A detailed Search for Missing Patients Plan shall be developed and implemented at VA facilities. VA health care facilities vary greatly in size, activity, and number of buildings; thus, each facility shall adopt a plan suited to its particular needs and circumstances.

b. The facility Search for Missing Patients Plan shall define responsibility for each service involved, e.g., Medical Administration Service, Nursing Service, Engineering Service, Police and Security Service, etc.

c. The Plan shall define the categories of patients for whom a search should be initiated if they are identified as missing.

d. The plan shall include the following:

(1) Command responsibilities and procedures both during administrative hours and non-administrative hours, including designation of a Search Command Post and Search Coordinator.

(2) A Preliminary Search, coordinated by nursing service staff, to include ward areas, offices and adjacent areas such as lobbies, stairwells, elevators, etc.

(3) A Full Search, authorized by the medical center Director, Associate Director, or Chief of Staff, with participation of VA Police and Security Service and appropriate medical center staff on duty, to include all areas of the facility in addition to those covered by the preliminary search:

(a) All grounds areas, parking lots, ball fields, tennis courts, outdoor seating and picnic areas, woods, and, areas off, but contiguous to the property (e.g. local neighborhood attractions), as appropriate.

(b) All other buildings, elevators, designated smoking areas, accessible areas for outpatient clinics, construction sites, and other structures.

(4) Specific staff will be assigned to given areas to ensure that all areas are searched and to avoid random or uncoordinated searches.

(5) Notification of the following appropriate officials:

(a) Designated senior clinical and administrative officials during both administrative and non-administrative hours regarding results of the preliminary search.

(b) Medical Administration Service regarding notification of next of kin when a patient has been determined to be missing and, when the search for the patient has been completed, the results of the search.

NOTE: *When the search has been unsuccessful, VA Police and Security Service will contact the appropriate law enforcement agencies to assist in finding the patient. These agencies shall be promptly informed when the patient is located.*

(6) Initiation of a SF 10-2633, Report of Special Incident Involving a Beneficiary, and notification of the Regional Director/VA Central Office as required by M-2, part I, chapter 35.

(7) Systematic training of all staff who may be involved in the search for missing patients, including VA and local police.

(8) Quality Review Criteria. Search for Missing Patients procedures should be integrated into the medical center's quality management plan using appropriate monitors. Reports of missing patients, patient searches, and outcomes of searches shall be recorded in the minutes of the facility-wide Safety Committee, or equivalent oversight body as designated by the Chief of Staff or medical center Director.

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5. REFERENCES

a. M-1, part I, Chapter 10, Absences, dated April 18, 1989.

b. M-1, part I, Chapter 13, Releases from Inpatient Care, dated September 9, 1991.

c. M-2, part I, Chapter 35, Patient Incident Review Policy, dated August 7, 1992.

6. FOLLOW-UP RESPONSIBILITY: Associate Chief Medical Director for Clinical Programs (11).

7. RESCISSIONS: Circular 10-75-158 dated July 18, 1975. This directive will expire September 27, 1993.

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