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The high cost of low staffing: Some families say nursing homes' failures led to patients' deaths

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His brother Pat could be a pain in the neck as a nursing home resident — Rocco DeLauri knows that

"He would yell at the nurses that the woman across the hall was ringing her bell for an hour, sitting in a (dirty) diaper," DeLauri recalls.

But as far as his brother was concerned, the Sentara Nursing Center in Chesapeake was home.

The nursing home didn't see it the same way. They'd been trying to get DeLauri's brother out for months, almost since the time the brothers complained that Pat DeLauri's roommate was routinely left in a soaking diaper that leaked, including on DeLauri's bed, inflaming the stump of his amputated leg.

What happened, disclosed in an obscure Medicaid agency record — like the stories that emerge in court cases around Hampton Roads — is an account that's not to be found in the records of official inspections that show many of the region's nursing homes are understaffed and have above average incidences of falls and wounds.

After the Daily Press reported on the issue a month ago, Rocco DeLauri and relatives of others who've experienced problems at nursing homes came forward with their stories.

The day DeLauri brought his brother back to Sentara Chesapeake from a hospital stay to treat soaring bloodstream ammonia levels, they were greeted at the door by the home's administrator, Celia Soper, a Department of Medical Assistance Services report found. She told him he would not be readmitted.

She would not allow DeLauri to fetch his one-legged brother's medications — he took 19 to manage his liver disease and other aliments — or his wheelchair or other possessions.

Since his brother couldn't cope with the stairs at home, DeLauri checked him in to a hotel, while he tried desperately to get refills on his prescriptions. He needed someone to issue an override, since Medicaid's records indicated his brother hadn't run out of his medications, which included a potent painkiller.

When DeLauri tried to bathe his brother, Pat screamed with pain when the shower water hit. He did the same when his brother tried to fill the bathtub. Rocco did his best, dabbing at Pat with a washcloth.

“He looked at me and said, ‘Sentara did this to me,’” DeLauri recalled. “That was the last thing he ever told me.”

The next day, on the phone with his mother, he could hear as the police came to her door and then asked her to sit down because they had some bad news.

DMAS, the state agency that runs Virginia’s Medicaid program, ruled Sentara had improperly refused Pat DeLauri his right to return to the home. But DMAS declined to make a decision on the family’s assertion, backed by Pat’s doctor, that withholding his medication had contributed to his death. The medical system giant sued to overturn and suppress the finding.

Sentara spokesman Dale Gauding said he could not comment because the DeLauri family is suing the nursing home.

“We can say that we strive to maintain a safe clinical and social environment for all patients and residents. Any incident of harm prompts a thorough internal review, process change as needed, reeducation of staff and appropriate discipline. We cooperate fully with regulatory agencies and welcome opportunities for improvement,” he added, in a written statement.

Medications

Medication was an issue in Patrick Venditti’s death last year, court records show. It started with a simple urinary tract infection, a fairly common and easily treatable problem for nursing home residents. And when a test showed the 85-year-old was suffering such an infection, Sentara Nursing Center-Windermere gave him a fairly standard treatment, an antibiotic called Sulfamethozasole 800-mg-trimethoprim, or Bactrim.

A new round of tests two weeks later would find he still had an infection, and his doctors ordered another 10 days of Bactrim. But, court documents allege, they did not read an additional test result showing the infection had spread to Venditti’s bloodstream, a potentially lethal condition.

They also did not notice that the strain of bacteria infecting Venditti was resistant to Bactrim.

Venditti developed a fever, chills and pain. He was unable to get out of bed. This continued for two weeks. His family says the nursing home ignored their requests to have a doctor examine him.

Venditti died a month after his urinary tract infection was first diagnosed.

“You’re not supposed to die from a urinary tract infection,” said the family’s lawyer, Carlton Bennett.

“The No. 1 problem is a lack of staffing,” he said. No. 2, he adds, after considering the several hundred lawsuits he’s filed and settled with nursing homes, is the way lack of time and ease of simply filling in a

check mark on electronic records mean nurses tend not to write out the kind of observations that raise concerns about gaps in care.

Bennett said he's heard three key things over the years. One is from nursing home employees who quietly tell him the lawsuits led executives to boost spending on staffing and equipment.

The second is what families tell him they hear after asking home employees if poor care accelerated a relative's death — a variation of "it was her time."

And the third also comes from families.

"They always tell me, 'I trusted those people,'" he said.

A wanderer

A staff member at Cedar Manor Assisted Living Center, a kind of less-intensive care facility, found Beulah Bryan, 93, lying in the rain, in the facility parking lot, and singing "Jesus loves me," where she had fallen after wandering out of the facility.

She was a known "wanderer," suffering from severe dementia, and had already been redirected to her room twice that same day when staff found her roaming around the facility. But the reception desk wasn't staffed after 4:30 p.m., and when the elderly woman left her room again that evening, she was able to walk past the kitchen area and leave through an unlocked rear door.

She fell face first, resulting in a cut and huge lump on her forehead and so much damage to her knee that surgeons could not repair it — the wanderer was now bedridden, though because of her dementia, she did not realize it.

Nor could she use a call bell, while her room's location 150 feet from the nursing station meant it would be easy for her to try to get out of bed. That's what she did several days later when she fell, broke her hip and began the final decline to her death.

C.K. Crawford's mom had been getting better at Bon Secours Maryview Nursing Care Center, or so she seemed during a Saturday visit April 27 — despite the ignored call buttons, ignored food preferences, infrequent fresh towels and irregular administration of medications, Crawford said. Crawford, who visited daily, often several times a day, said the bed checks ordered every two hours rarely occurred. Bedridden, she was left in an inclined position at meal time, instead of being raised upright — the result was a much higher risk of aspirating food.

Which happened.

She was in respiratory distress from a seizure, gurgling from aspirated food, when Crawford came by to visit that Sunday.

She was rushed to the hospital, where doctors found her in a dire state, with sepsis from aspiration pneumonia, a C.difficule bacterial infection and urinary tract infection. Crawford doesn't know if she'll ever recover.

Little oversight, few rulings

It's rare for a judge or jury to rule on nursing home care, and not all that common for family members or residents to release the investigations that result from their complaints to state licensing officials.

When legal cases do emerge, they're usually quietly settled. But initial complaints can raise questions about the treatment of people who are often bed-ridden or disabled. Complaints are generally resolved, if state investigators find they are valid, with a promise by the home's staff to file a "plan of correction."

That's what happened when investigators asked Maryview about why one untrained nurse's aide tried on her own to use a so-called "sit-stand" lift, a device designed to help patients stand with the help of two nurses — if the patient is able to grab the lift's handles. But the woman was not strong enough, and staff were supposed to use a different kind of lift to get her out of bed.

Unable to hold on, she fell, and as she did, she slumped hard against the device's safety belt, breaking her shoulder. Beginning to choke, she and the aide screamed for help.

That wasn't the end of her troubles, court records show. After a hospitalization for another problem a few months later, she returned to Maryview, with doctor's order that she be repositioned in bed every two hours to let a small bed sore heal. It did, and the home stopped repositioning her on the two-hour schedule. She developed another sore within a week. Over the following three three weeks it grew and deepened, with so much dead tissue that staff couldn't evaluate whether it had destroyed muscle and reached the bone. The resident, whose family asked that she not be named, died Feb. 21.

Bon Secours spokeswoman Emma Swann said she couldn't comment on specific patients out of concern for their privacy

"However, Bon Secours is committed to delivering safe, compassionate, high-quality care to all of our residents. We care deeply about the well-being of the elderly and vulnerable in our community," she said in a written statement.

Bed sores can be deadly if untreated, but there are no records that Autumn Care of Suffolk kept track of a 2-inch-by-½-inch open wound on Wanda Mae Mills' back for several weeks, even as the home took three weeks to get around resuming a protein supplement that her doctor had ordered to help heal her wound, according to court records.

The home had run out of it. Her wound worsened, with no records indicating the home did anything to regularly reposition her in her bed to ease the pressure that causes sores and allows them to grow.

By the time the home sent her to the hospital, she'd lost 17 pounds and had an open wound three inches by 1½ inches that was half an inch deep.

The hospital discharged her to a hospice, where she died two weeks later.

Rosalind Austin's amputated leg was healing fine when she was admitted to The Gardens at Warwick Forest, but within five days she had developed an open bed sore, already sloughing off dead skin and smelling bad, court records show.

The stump on her leg also grew inflamed and started exuding fluid.

There's no note in her records of wound care, but the nursing home said in a court filing that it had provided some.

The sore on Austin's back would grow to be nearly a foot long and eight inches wide in the weeks that followed, exposing some of the muscle tissue next to her bones, her hospital admission record shows.

She died the day after the home sent her to the hospital, of an infection, a blood clot in her lung and a heart attack.

Warning signs

Those who've handled cases against nursing homes say they sometimes fail to monitor already frail patients for signs of more serious conditions. That neglect can be fatal.

Barbara Ann Credle was weak after her chest surgery, but still able to walk 400 feet without help, but a week after her admission to James River Convalescent Center, she began vomiting, court records show.

By the second day of that and after her worried call to her daughter, the nursing home staff finally decided to send her to the hospital, where admission notes reported she need more help moving around and tests showed a highly elevated white blood cell count and out-of-balance blood acidity. When the ambulance crew arrived for what the home said was a nonurgent transport, they took one look and handled her as an emergency.

That kind of vomiting, and the kind of pain Credle was reporting in her belly, far from the her surgical incision, ought to be warning signs of infection, said Kathy Clark, a nurse who works with Bennett deciphering case notes about nursing home care.

"She'd come to the facility after major surgery, where you need to be watched like a hawk, and they were treating her like an ordinary rehab patient who needed to rebuild her strength," Clark said.

Credle got some morphine for pain, and a trip back to the home. Her diagnosis was that she was suffering from vomiting — that is, her symptom, with nothing about a possible cause or treatment. Her lab work couldn't be completed because the home drew an insufficient blood sample. Nobody took new samples. Nobody followed up. Nobody at the home thought to tell her doctor, as required by regulation, court records say.

Back at the home, Credle developed a high fever. Nursing notes say she "didn't look good," and that she reported pain all over her body.

When staff got around to taking vital signs a couple of hours later, they found she was still vomiting and that her blood pressure had dropped. They still didn't tell her doctor, but did send her back to the hospital. Once again, the home ordered nonurgent transport, but the ambulance crew, after seeing Credle's condition, handled it as an emergency.

She died in the hospital two days later, just two weeks after the surgery from which the home was supposed to help her recover.

Training

Clark thinks cases like Credle's point to a lack of staff and a lack of training for the people who work there.

Ironically, perhaps, Lorenzo Lazo-Santos suffered a traumatic brain injury when a Virginia Beach Healthcare and Rehabilitation Center physical therapist, helping him onto a bench, turned to give a group of PT students a pointer about care.

She took her hands off Lazo-Santos, in the home for rehabilitation after a stroke that nearly paralyzed his right side. He was perched on the edge the bench. Off balance, he fell, face first, on the hard tile floor. He fell hard, too — hard enough to cause a brain bleed. Facility administrator Patrick Shuler said he couldn't comment because of the federal health records privacy law.

Paying attention is critical when caring for the extremely vulnerable adults who depend on nursing home or assisted living facility care, Clark said.

Attention seems to have been elsewhere, though, when Helena Sutton's doctor ordered an antidepressant the day after she returned to The Gardens at Warwick Forest following shoulder surgery, court records show.

But Sutton didn't receive the medication for another 27 days, when a nurse noticed it had been ordered.

And, though her admission record asked staff to watch out for a urinary tract infection, because she was prone to it on her stay, she developed another infection within a couple of weeks — one that was not properly noted in her medical file, according to court records.

Although she was supposed to be repositioned in bed every two hours to prevent sores, there was little documentation that ever happened, and it took 22 days for the home to provide the pressure-relieving mattress she was supposed to have.

After a month in the home's care, during which she lost 20 pounds, staff decided to give her eight ounces of a protein shake a day because she hadn't been eating.

The day before, she described the pain she was suffering as being a 9 out of 10.

After three days on the protein shake, with a note of her increasing lethargy, the home sent her the hospital. Her admission records noted dulled consciousness, with a minimal response to light, and that

she needed a bag-ventilator to breathe. Lab results showed a urinary tract infection had become a life-threatening blood infection.

She died three days later, of shock, acute renal failure and heart failure.

In a court filing, her son noted Medicare had graded the home as having average staffing, based on its inspection that year, but that the home's own records showed staffing was at the lowest level in Medicare's rating system. He estimated the well-below-average level of staffing saved the home $1.4 million that year.

A state investigation of his complaint said the Department of Health found the home had violated regulations, and that it promised to submit a plan of correction.

A trip with the lone company chasing menhaden in a 140-year tradition on the Chesapeake Bay

https://www.dailypress.com/news/environment/dp-nw-menhaden-20190915-35b7ycwjpndwzdwdffxzos2zxq-story.html

The second set went fast — the 150,000 menhaden in the net not as "heavy" — that is, as frisky swimmers — as the fish in the Cockrells Creek's first haul, farther down along the York Spit Channel a half hour earlier.

As the boat's giant vacuum hose gathered in the last flopping menhaden, the spotter plane pilot circling overhead said they should drop everything and move off to port where another 150,000 fish were schooling. So the men on the Cockrells Creek's two 40-foot "purse boats" hastened away — still tied together with ropes and a giant 1,500-foot-long purse seine net, half on one boat, half on the other.

It didn't go as fast the rest of the day in Virginia's 140-year old menhaden fishery, these days shrunken to one company with eight vessels operating out of a tiny port in one of the most rural corners of the state.

It's an industry that once made the village of Reedville one of the most prosperous in the state — big, brightly-painted three-story Victorian mansions, bedecked with gingerbread woodwork under their generous shade trees line Main Street in testimony to those long gone days.

These days, menhaden are at the center of an obscure, if fiercely fought, political battle over who should catch them where, and whether the Omega Proteins fleet that still sails from Reedville is harvesting too many from the Bay. Among the reasons for that concern: Menhaden are an important food source for striped bass.

"We're the last people who want to be overfishing them. We want there to be lots of fish," said Alan Hinson, captain of Omega's newest boat, the 185-foot long Cockrells Creek, trying not to be too

disappointed that the day's final set — a school he'd spotted off the Mathews County shore — totaled just 60,000 menhaden, plus the ray one of his crew had carefully tipped out of the net as the last several hundred fish were sucked into the hold.

Those 60,000 fish weighed about 9.5 metric tons, given the average six-ounce weight of an eight- to nine-inch, 2-year-old fish, like those caught that day.

In 2013, when the Atlantic States Marine Fisheries Commission cut its coastwide cap on the menhaden catch by 20%, Omega cut two boats from its fleet, which meant 45 fishermen lost their jobs.

At the same time, the commission cut its separate limit on the Bay catch by purse-seining vessels like Cockrells Creek by 20%, to 87,000 metric tons a year. Purse seiners are called that because they encircle schools of fish with long seine nets which are rigged to be drawn shut and tightened, like an old-fashioned money purse, to trap their prey.

"We've adjusted," Hinson said. "We can live with that."

But in 2017, when the commission decided the stock of menhaden was healthy enough to allow for an 8% increase in the coastwide quota — the third straight year the limit increased — it went the other way with its cap on the Bay catch by purse-seiners. That it slashed by 41.5%, to 51,000 tons.

Omega lobbied hard, and successfully, to convince the Virginia General Assembly not to adopt the commission's new Bay cap, meaning the state operates under the old 87,000-ton limit.

Earlier this month, with weeks to go before the end of the season, federal fisheries officials told Omega it had exceeded the new 51,000 Bay cap by 400 tons.

"We had no intention going into the season to exceed it, and never imagined we would as we've been doing so much fishing just outside the Bay the past few years, but this year those fish didn't show out there but instead showed just inside the line designating it being caught in the Bay," said Monty Deihl, Omega's vice president for ocean fleet services.

Deihl said there's no way Omega's Bay catch would exceed the older cap.

"If a company is going to be fishing, it needs to comply with state and regional rules and regulations ... not only have they not done that, they don't anticipate doing that," since Omega isn't saying it will not stop fishing in the Bay, said Chris Moore, a senior scientist with the Chesapeake Bay Foundation.

So far, the commission has not pushed the matter, by recommending the U.S. Department of Commerce impose sanctions on Virginia that could include a moratorium on commercial fisheries — a recommendation likely to find little support in the Trump administration, commission members have said.

The commission said its aim with the lower Bay cap is to make sure the menhaden harvested to be processed into fish oil and fishmeal at Omega's plant don't all come from the Chesapeake Bay. The total

catch for fish oil and fishmeal in recent years, including what Omega's boats catch in the ocean from New Jersey to North Carolina, has averaged under 140,000 metric tons.

More to the point, the latest Bay quota cut was intended as a precautionary measure, as scientists work for a better understanding of the Bay's menhaden stock and how it fits into the entire Chesapeake ecosystem, Moore said.

It was pegged at the average of the past five years, "plus a fudge factor," Moore said. So far Omega hasn't caught more, so it seems like a precaution that doesn't hurt the company, he said.

But the commission increased its cap on menhaden caught in Maryland waters and the Potomac River, where Omega's boats are not allowed to fish, by 60%, its 2017 management plan amendment shows. Instead of being processed, the menhaden caught there are used as bait to catch edible fish and crabs. The cap on Omega's Bay catch is eight times as large as the limits on the Maryland and Potomac River harvest.

Watching the fish

To spot menhaden from a boat, even with binoculars from the pilot house of the Cockrells Creek, the equivalent of four stories up above the waves, isn't easy.

A purplish patch among the waves could be fish or simply a current or quirk of wind. The whipping of waves from the flipping of diving fish's tail, the circling gulls or pelicans — though there are far more of the latter these days than back when the fishery started — can all be clues.

But you can plow along miles of the lower Bay without spotting any, unless your luck is good, as it was for Hinson, spotting the Cockrells Creek's last set of the day.

Which is why Omega's boats work hand in glove with spotter pilots. After a Sunday flight by the spotters found the best spot on their New Jersey to North Carolina patrol was likely to lie between Cape Charles and Mobjack Bay, the Cockrells Creek got underway from Reedville at 2 a.m. Monday, in order to be in place at dawn, when the planes could take off again.

"It's like fishing from the air," said Omega vice president Deihl, while watching the boats prepare for the overnight voyage from Reedville to the mouth of the Bay .

The sky above the black silhouette of the Eastern Shore was just reddening with the dawn when mate Tim Crandall let the Cockrells Creek drift slowly just outside an anchorage dotted with a half dozen coal ships, waiting to load at Newport News and Lamberts Point.

The spotter planes arrived shortly after 6 a.m., and the Cockrells Creek would circle, impatiently, for nearly two hours before one sent word of a big, nearby school.

Another boat, which had made a slightly earlier start, was down closer to the Thimble Shoals light where, as things would turn out, the heavier schools, fresher from the ocean, would be that day. It's not just that those fish move around more, making them harder to handle in the net; they can be bigger and, at least on this day, gather in larger schools.

The Omega boats couldn't go too much farther out — they can't fish too near the Chesapeake Bay Bridge Tunnel and have what Hinson calls a "gentleman's agreement" not to fish near the Lynnhaven River or closer than three miles off the Virginia Beach Oceanfront. And while the boats will range as far as New Jersey and North Carolina, Hinson's hunch was the fish this year were more inclined to spend time in the Bay than in past years.

"You have to go where the fish are," he said.

The Bay Cap

That's why the new Bay cap of 51,000 tons worries Omega.

Even though its catch in the Bay doesn't always reach that point, when autumn's nor-easters and hurricanes brush by, its boats can't safely go out off the Carolina shore to chase the bigger, oilier late season fish that congregate there.

The fish don't like the bad weather either — "the plant runs 24 hours a day during the fishing season when we have fish, having fish is very weather dependent," Deihl said.

"Fish show in different areas at different times depending on many factors — weather, winds, tides, sunshine, atmospheric pressure, etc. — and since we need to be able to see what we are after, we will normally travel, within reason, to where the fish are showing, fully realizing that we are normally passing tens of millions of fish which are too far below the surface for us to effectively see and catch at that moment," he added.

Menhaden stocks are growing, particularly to the north, where a new fishery is developing chasing the fish for use as bait for lobsters and other seafood, but Moore said there are troubling signs about the Bay population.

While the commission has not found any overfishing of menhaden, with its data showing the catch has been sustainable since the early 2000s, Moore is concerned that there's limited information on the size of the stock in the Bay, the nursery for about a third of all Atlantic menhaden.

He's also concerned that the number of young fish has been flat, rather than growing. The commission's data shows this number ranging from around 12 billion to 18 billion a year since 1990. That's down from the more variable numbers of the 1980s, which were as high as around 30 billion.

But besides his questions about population trends in the Bay, Moore also worries that Omega's lobbying against the new Bay cap — which included convincing the Virginia General Assembly not to amend state

law to incorporate the cut — puts the whole interstate system of managing fisheries at risk, even for such hard-pressed species as striped bass.

"When the biggest actor says it's not going to accept the rule, that's a bad signal, he said.

Time and money

"If you can step it up, we've got some really good stuff popping up to the west," Crandall radioed to the purse boats as they closed up and began tightening the net around the first school of the day. He had just heard that the spotter found a second, big school of menhaden a few hundred yards away.

But that first school was even better than the spotter had estimated — there'd be 300,000 in all. And because they were heavy — swimming hard to try to escape — they were difficult to handle.

When Crandall eased the Cockrells Creek next to the purse boats juggling the several tons of fish in the net between them — a feat of seamanship that Omega won't allow its boats to try when there's more than three- to four-foot seas — he knew they'd have to take a pass on the second school the spotter reported.

Crandall ended up using the boat's "hardening rig" — the large crane amidships — to make three separate grabs at the net, as if it was securing three big handfuls of the mesh in order to keep the fish tightly corralled for the vacuum hose to take up. For the rest of the day's much smaller sets, the purse boats' much smaller power winches were enough to handle that task.

"Time money, time is money," Crandall muttered, as the slow unloading continued and the spotter directed another Omega boat to the second school that Crandall hoped to hurry after.

The chase

But 40 minutes later, the spotters found another school for the Cockrells Creek: Hinson pulled the lever that sounded the bell to tell the purse boats' crews — five each, including Hinson himself on the starboard boat — to get into their heavy waders, sea boots and hard hats and climb up to the stern ramp where the purse boats were secured.

It took just a minute or two to motor out to the school. On the way out, the two boats move as one, secured by lines bow and stern as well as by the giant net, filling the rear half of each boat.

From the Cockrells Creek, Crandall watched carefully, glancing back and forth to the darker spot the school made in the water and the sun.

"I want to get in position — if they're going to break out, I want to get between them and the sun. They'll head to the sun," he said.

"But I'm going to want to end up on the other side," he continued, pointing to the open end of the "V" the two purse boats were making, as they started hauling the net in. The opening of that V would need to be tight against the Cockrells Creek when it was time to start transferring the fish.

His careful jockeying of the boat and the lighter load in the net made for a faster transfer of the second set — and allowed the purse boats to chase quickly after another school when they got the word from the spotter.

Teamwork

It takes a lot of teamwork to chase menhaden.

The five men in each purse boat have set positions: one at the bow, handling lines; Hinson at the controls in one boat, bosun Lionel Waddy in the other; one man at the power winch; and two at the stern, handling lines and carefully stowing the net as the winch man guides it through the winch's big rubber wheels.

When the Cockrells Creek approaches purse boats and their full net, hand signals and gestures coordinate Larry Lander's precise toss of lines to the purse boats as well as, a bit later, Crandall's control of the big hardening rig with the purse boats and Hinson's and Waddy's directions to one another and to their purse boat crews.

Hinson's sharp downward thrust of his arm, for instance, alerted Irvin Ball, at the stern in Hinson's purse boat, to the thrashing of a big red drum fish in the third set; reaching down, Ball was able to roll the fish out so it could swim away.

Radio calls from the half dozen spotter planes, circling more than 500 feet above, keep the team on track.

After the purse boats transferred the second set to the Cockrells Creek, it was the spotter's radio call — "Let it go, let it go," that told the purse boats it was time to start circling the third school of the day.

Then, the spotter's call: "You're off a little bit" to the bosun, to let him know he hadn't quite reached the edge of the school and needed to ease off to starboard some, before the boats and neatly encircled the fish.

Sometimes, it doesn't work as well — as when the spotter found a fourth school in hard by the second set of buoys in the York Spit channel.

But as the purse boats approached, came the bad news.

"They're really not moving all that much," the spotter radioed.

The fish were too close to the buoy to go after — even if the purse boats could keep the net clear, there was too big a risk the buoy would tear up the net.

Hits and misses

The fifth school, on the other hand, moved too fast.

“They’re not breaking. They’re not breaking,” Crandall muttered, watching through his binoculars as the purse boats tightened the net,

“Maybe they’re late breakers … they’re not breaking. There’s not going to be any fish.”

There weren’t — just several hundred, barely worth putting the suction hose down.

A day that had started strong was turning sour.

“Tell me which way to go,” Hinson grumbled into the radio after clambering back up to the pilot house.

But the spotters had nothing good to tell him.

Hinson didn’t really want to turn south, back toward Thimble light, since that would put him behind another, faster boat — that would mean a choice of coming in late back to Reedville, and maybe not unloading his fish until the next morning, putting him back among the schools too late in the day for good fishing, or else staying out overnight.

Overnight would mean the fish would begin to soften, despite the Cockrells Creek’s refrigerated holds.

Since the crew’s pay depends in large part on the volume of fish they land — and since softer fish can get chewed up at dockside during unloading, and get squished down more than firmer, fresher fish in the tanks where they’re measured — there’s a cost to delay in returning to Reedville.

“Sometimes, playing the plant is more important than playing the fish,” Hinson said.

Being first — or not

Headed north, off the Mathews County shore, Hinson got some good news: One of the spotters found a school of menhaden — a big one, maybe 200,000 or 250,000 fish.

But dead ahead, right next to the school was a small white powerboat, and a couple of men happily casting.

They were going after cobia, Hinson reckoned.

Menhaden aren’t particularly good to eat — it is their oil, full of omega-3 fatty acids, that makes them taste bad but also makes them a valuable source of nutritional supplements, especially for people trying to manage triglyceride levels in their blood or boost the effectiveness of anti-inflammatory drugs for treating rheumatoid arthritis.

But fish and birds feed on them — when the purse boats encircle a school, they’ll draw flocks of gulls and pelicans.

Recreational fisherman say menhaden are a favorite prey of striped bass.

A Virginia Institute of Marine Science study shows menhaden account for about 8% of what stripers eat. Other studies, though, suggest that menhaden account for about a third of what large striped bass eat,

while computer modeling by a team of fisheries scientists from the University of Maryland's Chesapeake Biological Laboratory and Humboldt State University in 2017 estimated the population of striped bass is nearly 30% below where it would be if there were no commercial menhaden fishery.

Watching one of the men on the power boat cast again, Hinson cut the Cockrells Creek's engines.

"What are you doing here on a work day?" he joked. "Maybe they'll move on."

But another small power boat sped towards them, eyeing what its captain obviously thought was a fish hotspot.

"We won't disturb them," Hinson said, watching the second boat settle in the water off his port beam.

"They were here first."

Sharp eyes

Hinson cut the engine to let the Cockrells Creek drift for a bit, hoping the two power boats would move on, but after several minutes, reluctantly, gave up and started heading back to Reedville.

After three decades chasing menhaden, he can read the water, and spotted a darker patch with the tell-tale small splashes of menhaden fins breaking the surface. He radioed a spotter, to see if the pilot saw the school that he was sure he was seeing.

He had.

It wasn't the biggest school, but it was tight-packed, and right there. He rang the bell, stepped back into his boots and waders, and headed to the purse boats, poised on the Cockrells Creek's stern ramp.

The 60,000 fish the purse boats unloaded a half hour later would put the Cockrells Creek's take that day at just over 800,000 menhaden.

"A little above average," Hinson said.

With the Lancaster shore off to port, Hinson — a native of that Northern Neck county — says he remembers his grandfather's pound nets there — the stakes that held those nets are long gone.

Hinson' father fished for two decades with the menhaden fleet, while his great-grandfather was also a pound net fisherman in Lancaster.

An avid recreational fisherman himself — Hinson just came in fourth in a mackerel tournament — he knows that menhaden are an important source of food for other species. But he's pretty sure there are more than enough to go around for the striped bass and other game fish that themselves generate a multimillion-dollar Virginia business and for Reedville's big menhaden boats.

"I think there's more fish now than when I was a boy," he said, making the final turn into the channel for Reedville.

Virginia's state psychiatric hospitals say they're in "crisis," with beds filled and not enough money

https://www.dailypress.com/news/health/dp-nw-virginia-mental-hospitals-crowded-20191119-fegsghjyoza3vhnzljhcu23u54-story.html

The day after the state's top health official clashed, again, with legislators over plans to add beds at a western Virginia state mental hospital to ease overcrowding, the head of Eastern State Hospital thought she'd caught a break.

A couple of patients had done well enough to be discharged, freeing up a couple of beds. But a couple more had slipped into a mental health crisis, with nowhere else to go, and the mental health safety net for Tidewater Virginia was once again full to capacity — 302 people for 302 beds.

Virginia's nine public psychiatric hospitals — housing a larger number, proportionately, than almost any other state — have been operating at more than 90% of capacity for the past three years. They peaked above 100% this summer and again in September and have been above 95% pretty much every week since Feburary, state Department of Behavioral Health and Developmental Services data show.

Eastern State, just outside Williamsburg, has hit that 100% or higher level more than once this year.

"We are in a crisis," Virginia Secretary of Health and Human Resources Daniel Carey told the General Assembly's joint subcommittee on mental health services last week.

He's seeking $19.6 million over the next two years, on top of $4.1 million this year, to add a total of 56 beds at Catawba State Hospital in Roanoke County, a facility designed for older patients with mental illnesses complicated by dementia or other cognitive disabilities, who can be particularly hard to find places for in the state's community services.

But that's going in exactly the wrong direction, state Sen. Creigh Deeds, D-Warm Springs, chairman of the mental health subcommittee, told Carey last week. Deeds has been pushing hard for six years now to boost the state's efforts to help people struggling with mental illness before things get so bad that they need a hospital — or, as was the case with his son Gus, before the lack of a hospital bed means they harm themselves. Gus Deeds killed himself in 2013, as his dad desperately pressed the local mental health agency to find a bed for him, without success.

Appalled by their much-loved colleague's tragedy, the General Assembly enacted laws requiring state hospitals to take patients in a crisis. In addition to this "bed of last resort" law for people under a Temporary Detention Order, or TDO, the legislature also promised to boost funding for community mental health services.

That's a promise that's been made before. The idea is that better access to community services can keep people from falling into the kind of crisis that requires hospital treatment, and makes it easier for people to leave the hospital because they can get services they need to deal with their mental illnesses.

But the increases the General Assembly approved still left per-capita spending on community mental health services well below the national average — at $54.62, compared to the national average the year before Gus Deeds's suicide of $93.50. That year, Virginia's number was $42.46, or less than half the national average.

That gap was pretty much the pattern through the 1990s and into fiscal year 2014.

The result: Virginians get much less community care than do most Americans. The utilization rate here is 14.25 people per 100,000, or barely 60% the national average of 22.99, according to data collected by the federal Substance Abuse and Mental Health Services Administration.

Virginia's utilization rate is down from where it was before the legislature's previous promise to boost the system, after the 2007 Virginia Tech mass shooting.

State hospital utilization, at 0.87 people per 100,000, is more than twice the national rate, the SAMHSA data show.

But the results aren't as good. Readmission rates — that is, returns to the hospital because the care received didn't have an effect before 30 days — exceeded the national average, and are up from 2013.

While access to community care continues to lag the nation, the bed of last resort law has meant the number of people sent to state hospitals under a TDO ballooned, from 2,192 in fiscal year 2015 to 5,877 last year, state data show. Private hospitals, which account for the bulk of TDO admissions, saw a matching decline.

The change is even starker in this part of the state. Eastern State took in 39 patients under a TDO the year of Gus Deeds' suicide. Last year, the total hit 541. It is still climbing, said Daniel Herr, assistant commissioner of the behavioral health department.

"Look, if you have someone in your E.R. acting up and you know there is someone else who has to take them, what do you think will happen?" he said.

Even as more people are coming into state hospitals, the number of people stuck there because they can't get services in the community has been rising. At Eastern State, that number has climbed from an average of about 31 in 2013 to about 45 now. Statewide, it grew from 125 people to 218, Department of Behavioral Health data show.

Overcrowding means putting patients in housing units where they may not fit well with other residents, or where there may not be enough staff, said Eastern State's interim director, Donna Moore.

At Eastern State this month, it's meant one 18-year-old in crisis could only go to a unit of the hospital designed for geriatric patients, where he was able to smash a water fountain — not "hardened" as are the ones in other parts of the hospital — flooding the housing unit with four inches of water.

"We were here till 8 p.m. mopping that up," Moore said.

A pregnant 18-year-old created a different challenge on a former geriatric unit a few days later when she discharged a fire extinguisher.

A blistering accreditation review by the Joint Commission on Health Care this summer noted that in just the months of May and June, 26 Eastern State staff were injured by patients. In one case, a patient under restraint was attacked by another patient when, the commission reported, the hospital did not provide physical security from other patients or have a staff member monitoring the situation. The commission found lack of enough staff was a common problem.

Carey, the health secretary, told the mental health subcommittee that when nearly 100% of state hospitals' authorized beds are full, the issue is not just the number of beds. Looking at what experts advise on best practices for a psychiatric hospital, Virginia's state system is actually operating at about 127% of capacity, he said.