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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds

Mental Health Inspection | **24-01859-62** | **March 5, 2025**

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Executive Summary

The mission of the VA Office of Inspector General (OIG) Mental Health Inspection Program is to evaluate VA's continuum of mental healthcare services. This inspection addresses the mental health care delivered in the acute inpatient setting at the Edward P. Boland VA Medical Center, part of the VA Central Western Massachusetts Healthcare System (facility) in Leeds.

The OIG evaluated acute inpatient mental health care across six domains, summarized below. The OIG assessed processes in each of the domains, and identified successes and challenges that affected the provision of quality care on the inpatient mental health unit (inpatient unit). The OIG issued 16 recommendations to facility leaders.

For more information on the background of each domain, see appendix A. For more information on the OIG's data collection methods, see appendix B.

Domain	OIG Summary
Leadership and Organizational Culture 	Healthcare system leaders can nurture a positive, safety-oriented culture by building effective reporting and communication structures, incorporating stakeholder feedback, and supporting continuous performance improvement. The OIG looked at reporting channels, committee structures, oversight and monitoring provided by leaders, and staffing practices. At the time of the inspection, the Acting Facility Director reported that four of the five executive leaders were assigned to acting roles when the Facility Director was detailed to another healthcare system. The Acting Chief of Staff and Associate Director for Patient Care Services supervised service directors and program chiefs, including the Chief of Mental Health and Associate Nurse Executive. The Chief of Mental Health oversaw all mental health programs, including the inpatient unit. The OIG found that the facility did not have a local mental health executive council. The Veterans Integrated Service Network (VISN) Chief Mental Health Officer reported providing oversight of and support for inpatient unit operations within the network. The VISN Chief Mental Health Officer chaired the VISN Mental Health Executive Council, which had responsibility for monitoring quality and access across the VISN's continuum of mental health care. OIG recommendation: • The Facility Director establishes a mental health executive council that operates in accordance with Veterans Health Administration (VHA) requirements.

Domain	OIG Summary
High Reliability Principles 	High reliability principles center on empowering workers to find and report concerns before the related issues cause harm to veterans or the organization. The OIG surveyed staff and leader perceptions of psychological safety and performance improvement. The OIG also evaluated whether leaders and staff engaged in continuous process improvement and solicited veteran input on mental health care. Questionnaire results related to facility staff and leader perceptions of psychological safety and performance improvement were generally positive. Mental health leaders reported collecting inpatient unit providers' input for process improvements but did not have processes to solicit veteran input. OIG recommendation: • The Facility Director ensures staff consistently solicit and incorporate veteran input into process improvements.
Recovery-Oriented Principles 	Recovery-oriented mental health treatment is personalized to a veteran's abilities, resources, preferences, and values, and empowers the veteran to make decisions and meet treatment goals. To assess the inpatient unit team's integration of recovery-oriented principles, the OIG examined aspects of leadership, programming, and the care environment. The OIG found that the Chief of Mental Health ensured the integration of the local recovery coordinator into recovery-oriented activities on the inpatient unit. Additionally, inpatient unit staff provided a minimum of four hours of recovery-oriented, interdisciplinary programming on weekdays and weekends. Facility leaders met the requirement to have a plan across the mental health care continuum for continued transformation to recovery-oriented services. The inpatient unit had aspects of a recovery-oriented environment that met VHA standards for a safe, hopeful, and healing environment. The OIG found that the facility did not have a secure outdoor space for veterans on the inpatient unit. While staff accompanied some veterans on outdoor breaks, they did not have written processes to support this practice. OIG recommendation: • The Chief of Mental Health develops written guidance to ensure staff and veteran safety during outdoor breaks.

Domain	OIG Summary
Clinical Care Coordination 	Care coordination, which involves intentionally sharing a veteran's information and organizing healthcare activities, is crucial for those with complex health and social needs. To assess the quality of clinical care coordination, the OIG reviewed access to services, local procedures for involuntary treatment, interdisciplinary treatment planning, medication management, and discharge planning. Although the facility had a standard operating procedure for admission, the procedure did not include processes for the admission of veterans on an involuntary hold to the inpatient unit for mental health treatment. The OIG found that the facility had an established policy for interfacility transfers among VISN healthcare systems for veterans needing inpatient mental health care, as required. The facility did not have formal processes to monitor and track compliance with involuntary commitment requirements. The facility had written guidance for the transition of care following inpatient unit discharge, per VHA requirements. The OIG found that veterans and the interdisciplinary treatment team were involved in treatment planning; however, staff did not comply with required documentation for medication risks and benefits discussions. Additionally, most discharge instructions included abbreviations and acronyms that could be difficult for veterans and caregivers to understand. OIG recommendations: • The Facility Director ensures the development of written processes for the admission of veterans on an involuntary hold and monitors and tracks compliance with involuntary commitment requirements. • The Chief of Staff ensures timely documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications and monitors for compliance. • The Chief of Staff ensures discharge instructions for veterans include follow-up appointment location and contact information in easy-to-understand language. • The Chief of Staff ensures discharge instructions include the purpose for each medication listed and are written in easy-to-understand language.

Domain	OIG Summary
Suicide Prevention 	The underlying causes of suicide can be complex and multifactorial, and suicide prevention may require coordinated systems, services, and resources to effectively support veterans at risk of suicide. To evaluate suicide prevention activities on the inpatient unit, the OIG reviewed compliance with required suicide risk screening and evaluation, safety planning, and training. The OIG found noncompliance with suicide risk screening and evaluation. Staff did not consistently complete the Columbia-Suicide Severity Rating Scale within the 24 hours before discharge, and the safety plans reviewed did not consistently address ways to make the veteran's environment safer from potentially lethal means. The OIG found staff completed VA S.A.V.E. and lethal means safety training, but not all staff completed the Skills Training for Evaluation and Management of Suicide requirement. OIG recommendations: • The Chief of Staff ensures staff complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge and monitors for compliance. • The Chief of Staff ensures staff address ways to make veterans' environments safer from potentially lethal means in safety plans and monitors for compliance. • The Facility Director ensures staff comply with Skills Training for Evaluation and Management of Suicide requirements and monitors for compliance.
Safety 	The primary goal of inpatient mental health services is to stabilize veterans who are experiencing acute distress by providing a safe, secure environment with staff trained to recognize and minimize the potential for self-harm. The OIG evaluated aspects of safety, compliance with ongoing assessment of suicide hazards, and completion of mandatory staff training. Although leaders and staff conducted the Mental Health Environment of Care Checklist inspections twice per year, the OIG found that facility leaders did not establish the required interdisciplinary safety inspection team. The OIG also found that leaders did not ensure synchronization of the sally port unit entrance doors, as required by VHA. Further, the OIG found that physical restraint rooms did not meet Mental Health Environment of Care Checklist standards. Leaders did not ensure that policy aligned with practices described for the use of a physical restraint chair. Additionally, although a national leader expressed expectations for a written process outlining chair use, no national policy had been established at the time of the inspection. The OIG observed that the unweighted and unsecured chairs in the group room created a potential safety risk. The OIG also determined that inpatient unit staff did not complete VHA required Mental Health Environment of Care Checklist annual trainings. OIG recommendations: • The Facility Director establishes an interdisciplinary safety inspection team in alignment with VHA requirements and ensures ongoing compliance. • The Chief of Staff ensures that the sally port unit doors are synchronized and monitors for compliance.

Domain	OIG Summary
	• The Facility Director uses VHA guidelines to develop facility-specific policy for the use of restraint chairs. • The Facility Director ensures alignment between physical restraint policies and practices. • The Chief of Staff ensures mental health leaders update inpatient unit furniture to meet safety requirements and implements processes to reduce associated safety risks. • The Chief of Staff ensures compliance with VHA requirements for Mental Health Environment of Care Checklist training completion.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with recommendations 2–16 and concurred in principle with recommendation 1. Acceptable action plans were provided (see appendixes D and E). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, M.D.
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Contents

Abbreviations

ADPCS	Associate Director for Patient Care Services
C-SSRS	Columbia-Suicide Severity Rating Scale
CMHO	Chief Mental Health Officer
EHR	electronic health record
FY	fiscal year
HCS	healthcare system or health care system
ISIT	interdisciplinary safety inspection team
LRC	local recovery coordinator
MHEC	Mental Health Executive Council
MHEOCC	Mental Health Environment of Care Checklist
OIG	Office of Inspector General
PSAT	Patient Safety Assessment Tool
SOP	standard operating procedure
STEMS	Skills Training for Evaluation and Management of Suicide
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The mission of the VA Office of Inspector General (OIG) is to conduct meaningful independent oversight of VA. The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care through 1,380 healthcare facilities to over 9.1 million enrolled veterans.[1] The OIG established the Mental Health Inspection Program to regularly evaluate VHA's continuum of mental healthcare services. This inspection, which the OIG conducted from May 20 through June 14, 2024, evaluated acute inpatient mental health care provided at the Edward P. Boland VA Medical Center, part of the VA Central Western Massachusetts Healthcare System (facility) in Leeds.[2]

VHA's "mental health services are organized across a continuum of care" and "in a team-based, interprofessional, patient-centered, recovery-oriented structure" (see figure 1).[3] VHA healthcare system (HCS) leaders are expected to ensure all veterans who are eligible for care have access to recovery-oriented inpatient, residential, and outpatient mental health programs.[4]

All HCSs must provide assessment, diagnosis, and treatment for the full range of mental health illnesses. Required services include psychological and neuropsychological evaluation, evidence-based individual and group psychotherapy, pharmacotherapy, peer support, and vocational rehabilitation counseling.[5]

[1] "Mission, Vision, Values," OIG, accessed June 10, 2024, https://www.vaoig.gov/about/mission-vision-values; "About VHA," VA, accessed January 21, 2025, www.va.gov/health/aboutvha.asp.

[2] "VA Central Western Massachusetts health care," VA, accessed November 15, 2024, https://www.va.gov/central-western-massachusetts-health-care/.

[3] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023; VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 13, 2019.

[4] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015; VHA Directive 1160.01. The policies contain similar language related to recovery-oriented mental health programs; In this report, the OIG refers to veterans instead of patients to support recovery-oriented language; For the purposes of this report, the OIG defines the term "healthcare system" as a parent facility and its associated medical centers, outpatient clinics, and other related VA services or programs. The OIG considers "VHA" and "VA" interchangeable when referring to a medical facility.

[5] VHA Directive 1160.01. If an HCS does not offer required services, those services must be available through another VA resource.

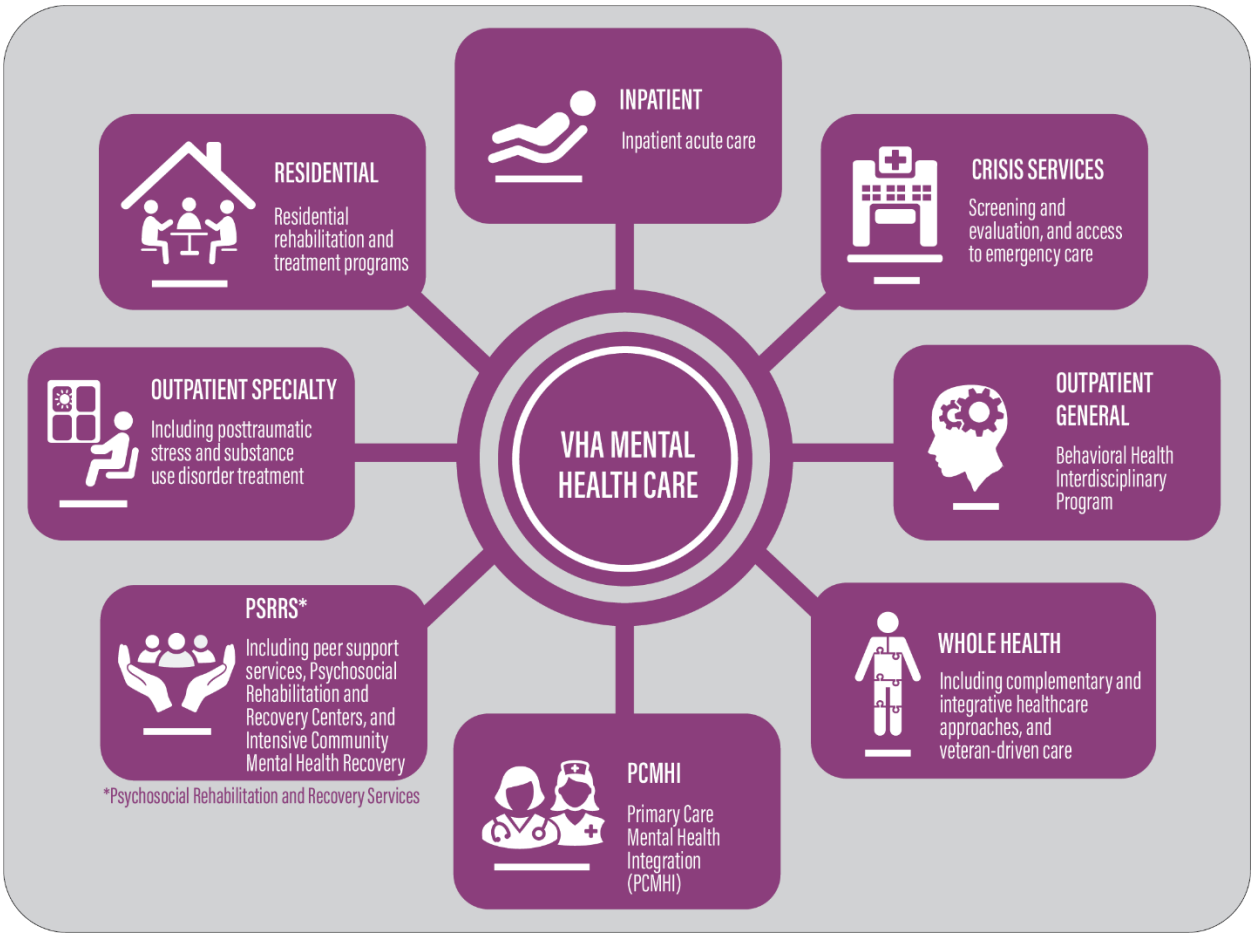

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163.

According to VHA, inpatient mental health services are considered the most intensive level of mental health care used to treat veterans safely and effectively during periods of acute mental distress (see appendix A for additional background).[6] In fiscal year (FY) 2023, VHA HCSs delivered inpatient mental health care for 62,966 veteran stays.[7]

To evaluate the quality of inpatient mental health care at the facility, the OIG assessed specific processes across six topic domains: leadership and organizational culture, high reliability

[6] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023, amended December 24, 2024; The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

[7] VHA identifies a "patient stay" as a distinct instance of a veteran staying on a specific unit for a defined time frame. "ADT Using NUMA," VHA Support Service Center, accessed April 30, 2024, https://vssc.med.va.gov/webrm/vssc_links.aspx?rpt_id=1552&index=1. (This site is not publicly accessible.); A fiscal year is a "12-month operating cycle" that runs from October 1 to September 30 of the following year. VA, "VA Finance Terms and Definitions," enclosure 14 in *VA/VHA Employee Health Promotion Disease Prevention Guidebook*, July 2011, accessed May 5, 2024, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf.

principles, recovery-oriented principles, clinical care coordination, suicide prevention, and safety.

About the VA Central Western Massachusetts Healthcare System

The HCS is part of Veterans Integrated Service Network (VISN) 1. Acute inpatient mental health care is provided at the Edward P. Boland VA Medical Center in Leeds. Outpatient care is provided at six community-based outpatient clinics in Massachusetts.[8]

In FY 2023, the facility provided health care to nearly 26,413 veterans, with approximately 8,380 receiving mental health care. During this same time frame, the acute inpatient mental health unit (inpatient unit) maintained an approximate average daily census of 11, with staff caring for 263 veterans.[9] In FY 2023, facility staff did not submit any consults for inpatient mental health care in the community. At the time of the OIG's inspection, the inpatient mental health unit had 20 approved operating beds.[10]

[8] The six community-based outpatient clinics are in the cities of Worcester, Fitchburg, Springfield, Greenfield, and Pittsfield in Massachusetts.

[9] The average daily census was rounded from 11.08.

[10] "Corporate Data Warehouse," VA Health Systems Research, accessed November 15, 2024, https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm.

Leadership and Organizational Culture

"Leaders usually impose structure, systems, and processes [on an organization], which, if successful, become shared parts of the culture. And once processes have become taken for granted, they become the elements of the culture that may be the hardest to change."[11] HCS leaders can nurture a positive, safety-oriented culture by building effective reporting and communication structures, incorporating stakeholder feedback, and supporting continuous performance improvement.[12]

The OIG reviewed the facility's leadership structure, VISN oversight, and inpatient unit staffing practices. The OIG evaluated how these elements support inpatient unit operations, compliance with requirements, and delivery of quality care.

Leadership Structure

The facility's executive leadership team consisted of the Acting Director, Acting Associate Director, Acting Chief of Staff, Acting Assistant Director, and Associate Director for Patient Care Services (ADPCS).[13] At the time of the inspection, the Acting Facility Director reported that four of the five executive leaders were assigned to acting roles when the Facility Director was detailed to another HCS.[14] The OIG learned that the Acting Chief of Staff supervised the Chief of Mental Health and the ADPCS supervised the Associate Nurse Executive. The Chief of Mental Health served as the required chief mental health lead and provided oversight of all mental health programs, including the inpatient unit.[15] (See figure 2 for relevant organizational structure.)

[11] Edgar H. Schein, *Organizational Culture and Leadership, 4th Edition, 2010*, accessed June 25, 2024, https://ia800809.us.archive.org/14/items/EdgarHScheinOrganizationalCultureAndLeadership/Edgar_H_Schein_Organizational_culture_and_leadership.pdf.

[12] "*Leader's Guide to Foundational High Reliability Organization (HRO) Practices*," May 2024, accessed June 25, 2024, https://dvagov.sharepoint.com/sites/vhahrojourney/Shared%20Documents/Forms/HRO%20Assessment%20and%20Planning%20Resources.aspx?id=%2Fsites%2Fvhahrojourney%2FShared%20Documents%2FHRO%20Leaders%20Guide%20to%20Foundational%20HRO%20Practices%2Epdf&parent=%2Fsites%2Fvhahrojourney%2FShared%20Documents. (This site is not publicly accessible).

[13] "Leadership," VA, accessed July 29, 2024, https://www.va.gov/central-western-massachusetts-health-care/about-us/leadership/.

[14] The Acting Facility Director reported that the Acting Chief of Staff was detailed to the position following the previous Chief of Staff's departure.

[15] VHA Directive 1160.01.

At the time of the inspection, the facility had a required inpatient mental health program manager (program coordinator).[16] The program coordinator supervised inpatient unit social workers and psychologists. The inpatient unit nurse manager supervised nursing staff. The Chief of Mental Health reported providing direct oversight of inpatient unit psychiatrists and a plan for the recently hired Deputy Chief of Mental Health to assume the responsibilities (see appendix C for a more detailed organizational structure).

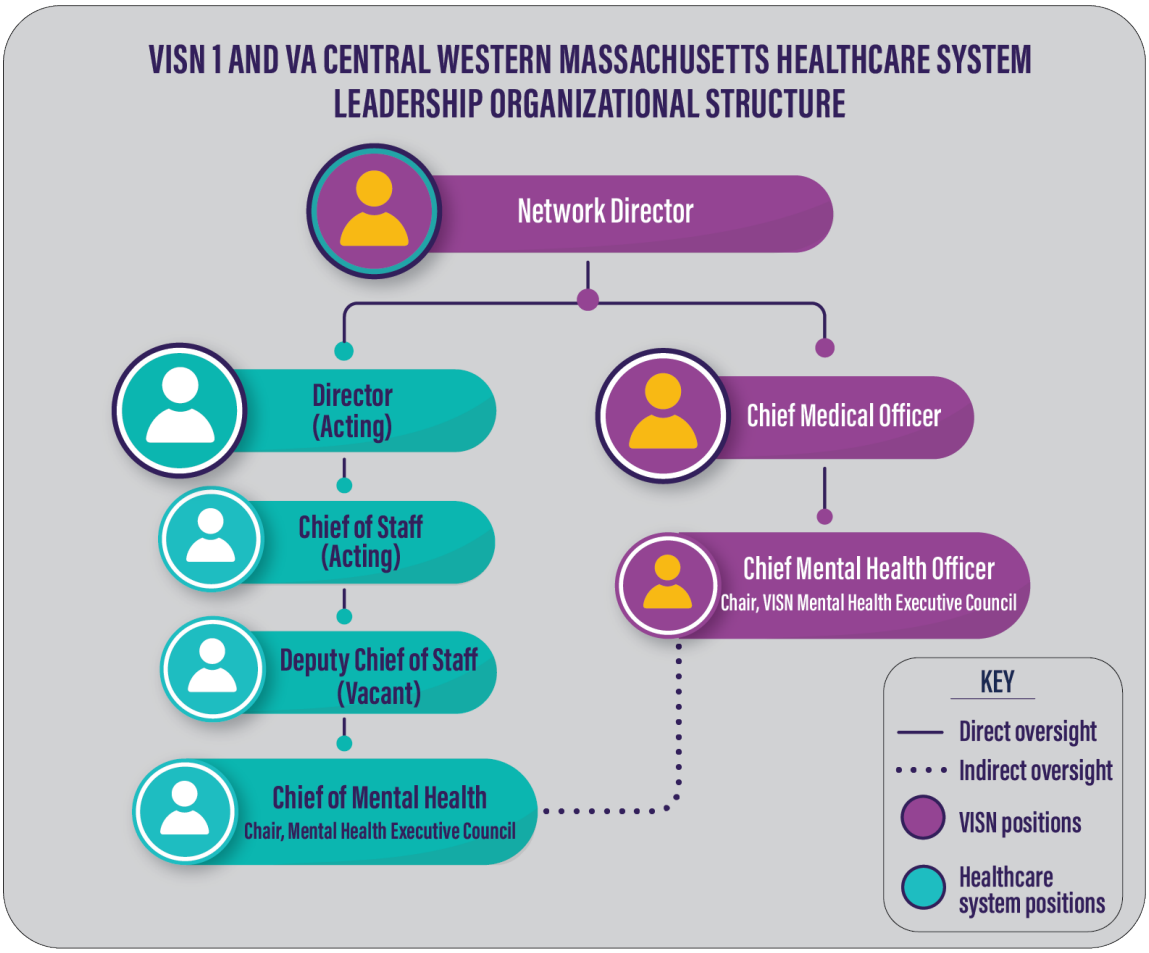

Figure 2. *VISN 1 and facility leadership organizational structure.*
Source: OIG analysis of interviews and facility documents received from May 20, 2024, through November 22, 2024; VHA Directive 1160.06; VHA Directive 1160.01.
Note: This figure represents the facility and network leadership positions relevant to this inspection.

[16] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. This handbook was in place during the time frames discussed in this report. It was rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023, amended to VHA Directive 1160.06(1), December 24, 2024. The rescinded handbook used the term inpatient program coordinator to refer to the position assigned to coordinate inpatient mental health unit programming. The 2023 directive updated the term to inpatient mental health program manager. The facility still refers to the position as the program coordinator. For the purposes of this report, the 2024 amendment did not change the relevant requirements included in the 2023 directive.

Although the Chief of Mental Health acknowledged the importance of a local mental health executive council (MHEC), the facility did not have an MHEC during the 12-month review period, as required by VHA.[17] Without an MHEC, the facility did not have a formal mental health governance body to oversee care delivery and quality improvement.[18]

VISN Oversight

In compliance with VHA requirements, the VISN Chief Mental Health Officer (CMHO) chaired a VISN-level MHEC that included participation from each of the VISN's HCS chief mental health leads.[19] The VISN CMHO described mechanisms to provide oversight and support of inpatient unit operations, including action item tracking, site visits, and at least monthly meetings with mental health leads from each HCS. The Chief of Mental Health and the VISN CMHO reported having bidirectional communication that was both consultative and collaborative.

Inpatient Unit Staffing

At the time of the inspection, facility leaders identified challenges with nurse and psychiatrist staffing to support the inpatient unit. Mental health leaders described using scheduled overtime and compensatory time to support inpatient unit operations, such as weekend program coverage. Additionally, mental health leaders indicated a need for overtime to ensure continuous nurse rounding to mitigate safety risks. The Chief of Mental Health reported a need for weekend prescriber coverage but not having approval to recruit for this position.[20] Facility leaders indicated challenges with recruiting psychiatrists due to limited availability of candidates for the specialty position.

Leaders reported the use of recruitment incentives, such as an education debt reduction program and competitive salary restructuring for various clinical positions, to address staffing challenges. The ADPCS explained that recruitment for licensed practical nurses and nursing assistants for the inpatient unit was ongoing.

Facility leaders acknowledged using retention strategies such as upgraded and special salary rates for social workers, psychologists, and psychiatrists. However, facility leaders described

[17] VHA Directive 1160.01. The facility provided documentation of an MHEC charter effective November 15, 2023.

[18] VHA Directive 1160.01.

[19] VHA Directive 1160.01. VA administers healthcare services through a nationwide network of 18 regional systems referred to as VISNs. VISN 1 refers to its MHEC as the VISN 1 Mental Health Integrated Clinical Community Sub-Committee; "Veterans Integrated Services Networks (VISNs)," VHA, accessed November 18, 2024, https://www.va.gov/HEALTH/visns.asp.

[20] VHA Directive 1108.07(1), *General Pharmacy Service Requirements*, November 28, 2022, amended October 4, 2023. Directive 1108.07(1) states that a prescriber is a provider who is "authorized by law or VA policy to prescribe medications in accordance with their facility approved privileges or scope of practice."

barriers to recruitment and retention, including an inability to offer flexible options such as remote or part-time telework schedules. Detailed staffing information is provided in appendix C.

Recommendation

1. The VA Central Western Massachusetts Healthcare System Director establishes a mental health executive council that operates in accordance with VHA requirements.

For a detailed action plan, see appendix E.

High Reliability Principles

High reliability organization principles promote "a 'high sensitivity' approach towards potential failures and prioritize their identification and mitigation."[21] VHA considers staff responsible for identifying and addressing risks by empowering them to "keep Veterans the safest they can be on our watch." VHA asserts that "a strong culture of safety will positively impact Veterans, their family members, and caregivers."[22]

The OIG disseminated a questionnaire evaluating staff and leader perceptions related to psychological safety and performance improvement activities (see appendix B for methodology). In addition, the OIG determined whether staff and leaders engaged in process improvements and solicited veteran input on mental health care, as required.[23]

[21] Chris Ekai, "What are the 5 principles of Hro," *Risk Publishing* (blog), January 11, 2024, https://riskpublishing.com/what-are-the-5-principles-of-hro/.

[22] "VHA's HRO journey officially begins," VHA National Center for Patient Safety, March 29, 2019, https://www.patientsafety.va.gov/features/VHA_s_HRO_journey_officially_begins.asp.

[23] VHA Directive 1160.01; The Joint Commission, *Standards Manual e-dition*, PI.04.01.01, January 2024. "The hospital uses improvement tools or methodologies to improve its performance."; The Joint Commission accredits and certifies healthcare organizations and programs in the US. "The Joint Commission (TJC)," VHA Office of Quality and Patient Safety, accessed June 13, 2024, https://vaww.qps.med.va.gov/divisions/qm/ea/jointcommission.aspx. (This site is not publicly accessible.)

Psychological Safety

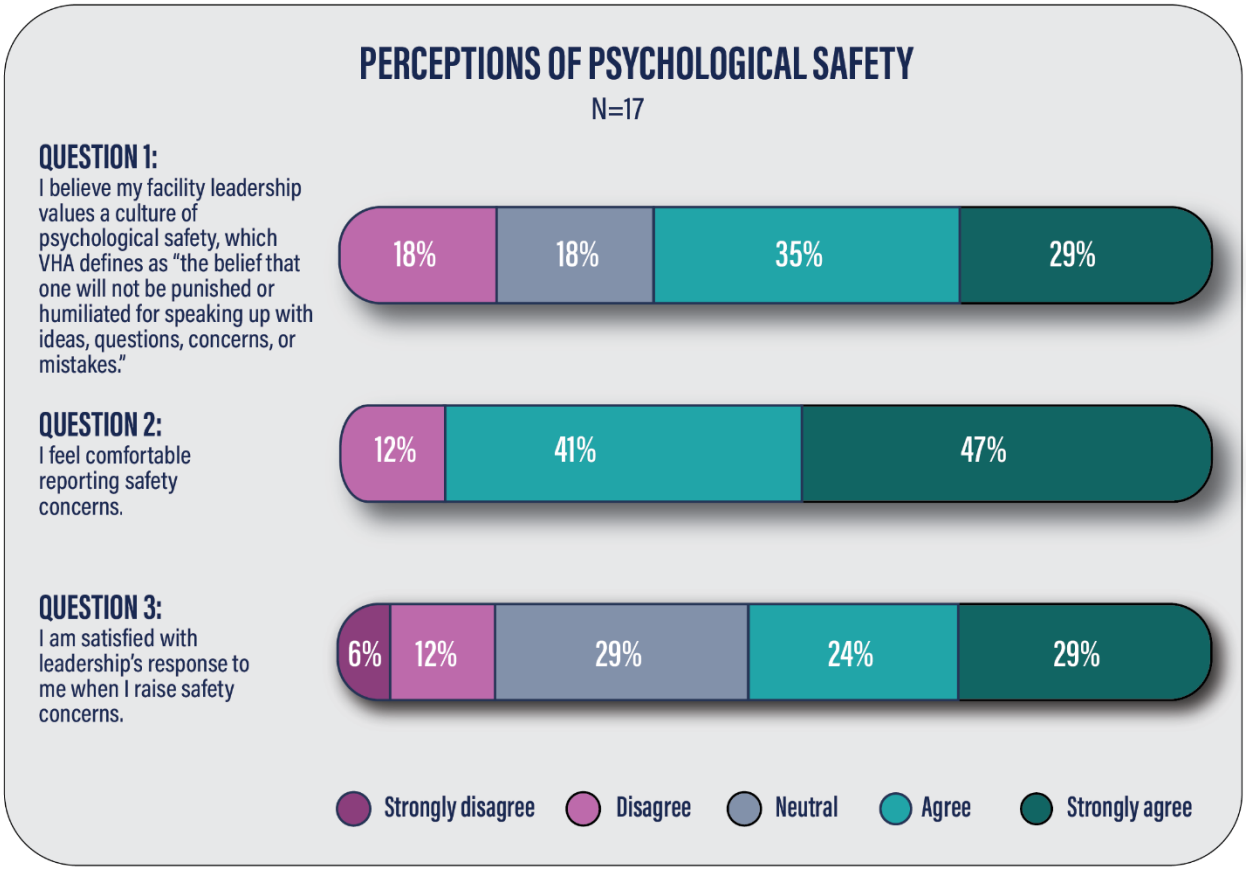

Figure 3. *Mental health staff and leader perceptions of psychological safety.*
Source: OIG analysis of staff questionnaire responses. VA, "VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)," September 2022.
Note: The order of the colors in the key corresponds to the order in the scales above.

Most respondents agreed or strongly agreed with statements regarding a culture of safety, reporting safety concerns, and leaders' responses to safety concerns (see figure 3).

Performance Improvement

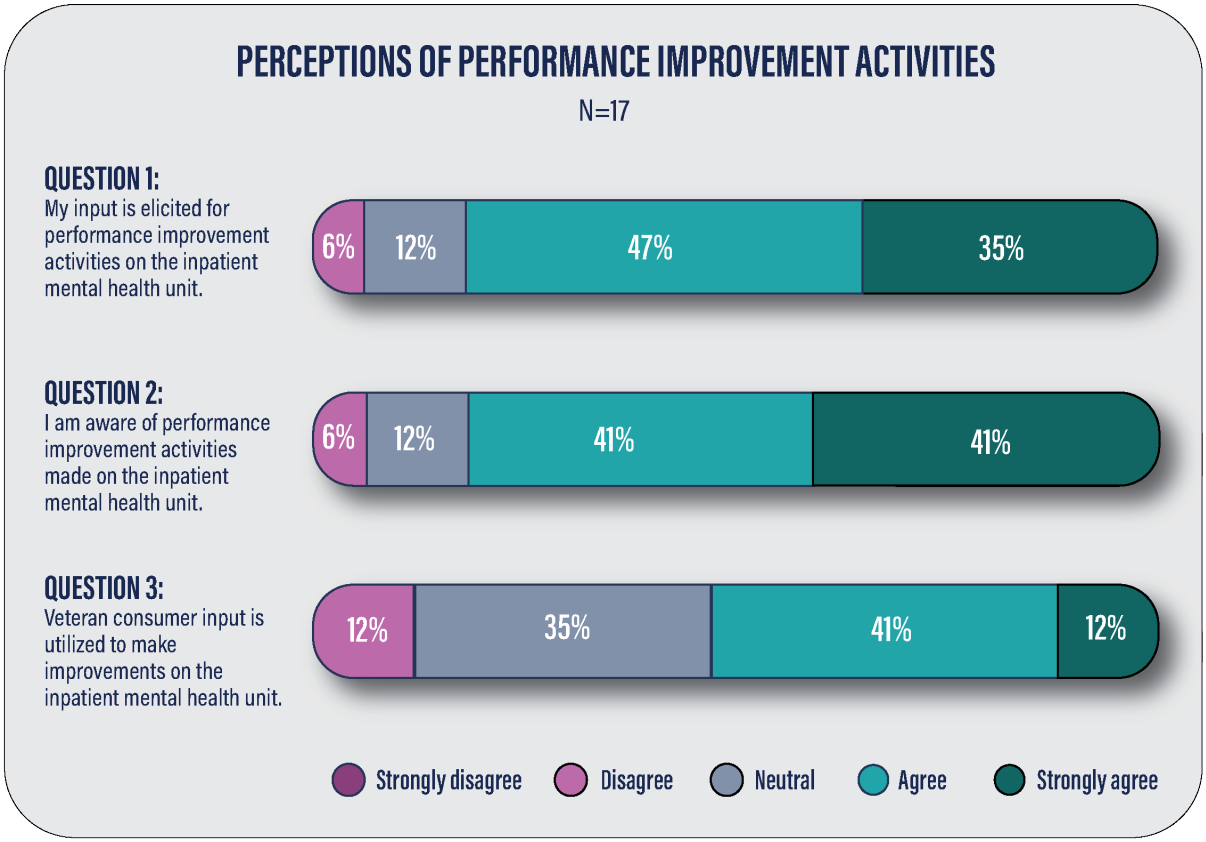

Figure 4. *Mental health staff and leader perceptions of performance improvement activities.*
Source: OIG analysis of staff questionnaire responses.
Note: The order of the colors in the key corresponds to the order in the scales above.

Most respondents agreed or strongly agreed with statements related to staff's input and awareness of performance improvement activities and veteran input for improvements on the inpatient unit (see figure 4).

Mental health leaders reported collecting inpatient unit providers' input, as required, through team meetings and huddles to discuss improvements needed.[24] The OIG found that facility staff did not solicit input from veterans who utilized mental health services, as required; therefore, veteran input was not incorporated into process improvement efforts.[25] Incorporating veteran

[24] A huddle is a brief meeting that includes "appropriate discipline-specific team members to communicate information about the patient care work for a specified period of time." VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024; VHA Directive 1160.01.

[25] VHA Directive 1160.01; The Joint Commission, *Standards Manual*, e-dition, PI.04.01.01, January 2024. "The hospital uses improvement tools or methodologies to improve its performance."

feedback into process improvement efforts may lead to meaningful changes in healthcare delivery and increase patient satisfaction.

Recommendation

2. The VA Central Western Massachusetts Healthcare System Director ensures staff consistently solicit and incorporate veteran feedback into process improvements.

For a detailed action plan, see appendix E.

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on a veteran's "strengths, talents, coping abilities, resources, and inherent values."[26] When a veteran understands the risks and benefits of treatment options and the provider understands the veteran's preferences and values, the veteran is empowered to make decisions and meet treatment goals.[27]

The OIG examined aspects of leadership, programming, and the physical care environment to evaluate the facility's integration of recovery-oriented principles, as required, on the inpatient unit (see appendix B for methodology).[28]

Leadership

VHA expects the program coordinator to organize and promote consistent, sustained, high-quality therapeutic programming on the inpatient unit.[29] The Chief of Mental Health reported that the program coordinator oversaw inpatient unit programming and collaborated with the local recovery coordinator (LRC) to provide recovery education for inpatient unit staff.

The facility met the VHA requirement to have a full-time LRC. The LRC reported having responsibilities within and beyond the inpatient unit.[30] The Chief of Mental Health reported that the LRC is integrated into recovery-oriented activities on the inpatient unit, such as staff training and attendance at a weekly meeting. Facility leaders met the requirement to have a plan across the mental health care continuum for continued transformation to recovery-oriented services.[31]

[26] "Recovery and Recovery Support," Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, accessed September 19, 2022, https://www.samhsa.gov/find-help/recovery.

[27] "Shared Decision-Making in Mental Health Care," Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, accessed May 12, 2022, https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4371.pdf.

[28] VHA Handbook 1160.06; VHA Directive 1160.06.

[29] VHA Handbook 1160.06; VHA Directive 1160.06. Per the handbook, the inpatient program coordinator is responsible for coordination of inpatient unit "therapeutic programming." Per the directive, the inpatient mental health program manager is responsible for oversight of all inpatient unit clinical services. The program coordinator assumed the responsibilities of an inpatient mental health program manager at the facility on May 20, 2024, the first date of the OIG inspection.

[30] VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 13, 2019; "Local Recovery Coordinators – Home," VA Central Office, accessed November 21, 2024, https://dvagov.sharepoint.com/sites/VACOMentalHealth/LRC. (This site is not publicly accessible.)

[31] VHA Directive 1163.

Recovery-Oriented Programming

The OIG found the inpatient unit staff offered at least four hours of recovery-oriented programming on both weekdays and weekends.[32] The program coordinator reported staffing was a challenge to consistently provide weekend programming and required using compensatory time for weekend group coverage.

The program coordinator reported that veterans were educated on recovery-oriented care at admission, as required.[33] The inpatient unit programming schedule included a weekly recovery action planning group for veteran education. The program coordinator reported notifying staff weekly of the programming schedule, which was updated to meet the specific needs of veterans on the inpatient unit. The program coordinator provided the example of staff offering a group focused on alcohol use disorder, based on the needs of individual veterans.

Physical Environment

The OIG found that the inpatient unit had aspects of a recovery-oriented environment that met VHA standards for a safe, hopeful, and healing environment, which can promote veterans' engagement in their personal recovery.[34] In general, the inpatient unit was clean, with warm paint colors and natural lighting. Aspects of the inpatient unit that were recovery-oriented included soft night lighting in veterans' bedrooms and surrounding the nurses' station, and artwork on the doors of the women's bathrooms. The inpatient unit also had a female-only common area, an accessible telephone in the day room, a designated computer area with internet

[32] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to programming hours.

[33] VHA Handbook 1160.06; VHA Directive 1160.06; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06," September 29, 2023. The standard operating procedure (SOP) uses similar language related to orientation to recovery-oriented care as the rescinded handbook; The OIG learned from the Director of VHA Risk Management that, as of April 25, 2024, the Office of Mental Health and Suicide Prevention was formally separated and operating as the Office of Mental Health and the Office of Suicide Prevention, with staff realigned to the respective offices.

[34] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*, January 2021, accessed March 27, 2024, https://dvagov.sharepoint.com/:b:/r/sites/VACOMentalHealth/mhrrtp/Resources/Program%20Development/MH%20RRTP%20and%20Inpatient%20Design%20Guide%202021.pdf?csf=1&web=1&e=ow3N0D. (This site is not publicly accessible.)

access for veterans, and a nurses' station free of plexiglass or other barriers (see figure 5 for relevant images).

Figure 5. *Nurses' station, veterans' computer station, and women veterans' bathroom doors.*
Source: Photos of the facility's inpatient unit taken by OIG staff, June 11, 2024.

Although the facility did not have a safe and secure outdoor space designated for inpatient unit veterans, staff reported accompanying some veterans for outdoor breaks.[35] Facility leaders did not establish written processes to support this practice. In the absence of a secure outdoor space, the OIG would expect clearly defined written processes for staff use when taking veterans outdoors.[36] The absence of written guidance may hinder staff's ability to consistently ensure veterans remain safe during outdoor breaks.[37]

Recommendation

3. The VA Central Western Massachusetts Healthcare System Chief of Mental Health develops written guidance to ensure staff and veteran safety during outdoor breaks.

For a detailed action plan, see appendix E.

[35] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023.
[36] VHA Handbook 1160.06.
[37] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

Clinical Care Coordination

"Care coordination involves deliberately organizing patient care activities and sharing information among all the participants concerned with a patient's care to achieve safer and more effective" treatment.[38] For veterans with "complex health and social needs, care coordination is crucial for improving access to services, clinical outcomes, and care experiences."[39] VHA's inpatient mental health services use a recovery-oriented approach with a goal of expediting the transition to a less-intensive level of care.[40]

The OIG evaluated the quality of clinical care coordination for veterans receiving inpatient mental health treatment and assessed access to services, local procedures for involuntary treatment, interdisciplinary team treatment planning, medication management, and discharge planning (see appendix B for methodology).

Access to Care

Successful coordination of mental health care requires well-defined screening and admission processes that ensure veterans have timely "access to mental health evaluation and clinically appropriate treatment provided in a safe and secure environment."[41] The OIG found facility leaders established a standard operating procedure for inpatient unit admission processes, as required by VHA.[42]

Facility leaders also established a policy for interfacility transfers among VISN HCSs for veterans needing inpatient mental health care, as required by VHA.[43] Mental health leaders

[38] "Care Coordination," Agency for Healthcare Research and Quality, accessed April 30, 2024, https://www.ahrq.gov/ncepcr/care/coordination.html.

[39] Denise M. Hynes et al., "Understanding Care Coordination for Veterans with Complex Care Needs: Protocol of a Multiple-Methods Study to Build Evidence for an Effectiveness and Implementation Study," *Frontiers in Health Services* 3, no. 3 (August 15, 2023), https://www.doi.org/10.3389/frhs.2023.1211577.

[40] VHA Directive 1160.06.

[41] VHA Directive 1160.06; VHA Directive 1160.01.

[42] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to admission for acute inpatient care; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023. The SOP updated the requirement to include procedures and processes for facility staff responsible for admission of veterans to the inpatient units; The Joint Commission, *Standards Manual e-dition*, PC.01.01.01, August 2023. "The hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs."; VA Central Western Massachusetts Health Care System SOP 116-10, "Mental Health Admissions," November 10, 2022.

[43] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."; Under the rescinded 2013 handbook, the VISN Director is responsible for ensuring VISN hospitals have established interfacility transfers policies or agreements. The SOP updated the requirement to specify that "receiving facilities should have SOPs that outline admission processes"; Memorandum of Understanding Between VISN 1 VA Medical Centers, "Interfacility Inpatient Transfer Agreement," April 23, 2020.

described processes used for veteran transfer to another VA HCS and interfacility transfers, when needed, to maintain continuity of care.

As previously discussed, facility data indicated an average daily census of 11 with 20 approved operating beds, and staff did not submit consults for inpatient mental health care in the community in FY 2023.[48] The Chief of Mental Health and inpatient unit staff explained the lack of need for care in the community was due to the accessibility of inpatient mental health care at the facility.

An involuntary hold "is a brief involuntary detention of a person presumed to have a mental illness in order to determine whether the individual meets criteria for" involuntary hospitalization.[44]

An involuntary hospitalization is the "legal intervention by which a judge, or someone acting in a judicial capacity, may order that a person with symptoms of a serious mental disorder, and meeting other specified criteria, be confined in a psychiatric hospital."[45]

Standards and procedures are provided by state law and vary by state.[46] VHA requires that leaders consult with the Office of General Counsel, as necessary, to ensure that processes are consistent with applicable laws.[47]

Involuntary Hospitalization and Treatment

The facility's admission policy did not include processes for the admission of veterans on an involuntary hold to the inpatient unit for mental health treatment.[49]

VHA requires facility leaders ensure compliance with involuntary commitment laws. Mental health leaders stated that inpatient unit staff were aware of state laws on involuntary commitment. However, facility leaders did not establish written processes to monitor and track compliance with involuntary commitment requirements, and instead relied on psychiatrists' knowledge of state laws.[50] The absence of written processes for monitoring regulatory compliance may result in staff confusion about state law requirements and could contribute to the illegal hospitalization of a veteran.

VHA policy requires documentation of voluntary or involuntary legal status within 24 hours of admission to the

[44] Leslie C. Hedman et al., "State Laws on Emergency Holds for Mental Health Stabilization," *Psychiatric Services*, 67, no. 5 (May 2016): 529–535, https://doi.org/10.1176/appi.ps.201500205.

[45] "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," Substance Abuse and Mental Health Services Administration, accessed July 27, 2023, https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf.

[46] "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," Substance Abuse and Mental Health Services Administration.

[47] VHA Directive 1160.01.

[48] "Corporate Data Warehouse," VA Health Systems Research.

[49] VHA Directive 1160.06; The directive published on September 27, 2023, allowed HCSs nine months to establish compliance with requirements; VA Central Western Massachusetts Health Care System SOP 116-10.

[50] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to requirements for VA facilities to develop clear guidelines for involuntary hospitalization.

inpatient unit.[51] The OIG found that facility staff documented the required legal status in 90 percent of the veterans' electronic health records (EHRs) reviewed.[52]

Treatment Planning

As required by VHA, the facility standard operating procedure outlined the inpatient unit treatment planning process, including recovery-oriented elements such as veterans' involvement in setting individualized goals. Corresponding with VHA's requirement for specified timelines, the standard operating procedure included guidance to develop a mental health treatment plan within 24 hours of admission.[53]

All EHRs reviewed by the OIG had evidence that staff developed treatment plans fewer than 24 hours from the veteran's admission. Additionally, 94 percent of the reviewed EHRs indicated veterans were involved in treatment planning. The same percentage of records indicated the interdisciplinary treatment team was involved in treatment planning.[54]

Medication Treatment

VHA requires a discussion between the prescriber and veteran on the risks and benefits of medication treatment. The OIG found 70 percent of EHRs reviewed included prescriber documentation of the required discussion.[55] When providers and veterans do not consistently discuss the risks and benefits of medication use, veterans may be deprived of the ability to make informed decisions.

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[51] VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care" (SOP), September 20, 2022, updated November 2, 2023.

[52] VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care" (SOP).

[53] Acting Deputy Under Secretary for Health for Operations and Management (10N), "Mental Health Treatment Planning and Software Tools," memorandum to Veterans Integrated Service Network (VISN) Director (10N1-23) et al., May 3, 2019; Central Western Massachusetts VA Medical Center SOP 116-13, "Inpatient Mental Health Treatment Planning and Implementation," September 1, 2021.

[54] Acting Deputy Under Secretary for Health for Operations and Management (10N), "Mental Health Treatment Planning and Software Tools," memorandum; Central Western Massachusetts VA Medical Center SOP 116-13, "Inpatient Mental Health Treatment Planning and Implementation."; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[55] VHA Directive 1108.07(1), *General Pharmacy Service Requirements*, November 28, 2022, amended October 4, 2023. Directive 1108.07(1) states that a prescriber is a provider who is "authorized by law or VA policy to prescribe medications in accordance with their facility approved privileges or scope of practice."; VHA Handbook 1004.01(5), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended September 17, 2021; VHA Directive 1004.01, *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023; The OIG reviewed for documentation of a risk and benefit discussion specific to veterans who were newly prescribed central nervous system medication during the inpatient stay; Central nervous system medications are used for the treatment of "a wide range of neurologic and psychiatric conditions." John A. Gray, "Introduction to the Pharmacology of CNS Drugs," chap. 21 in *Basic & Clinical Pharmacology*, 14th edition, ed. Bertram G. Katzung (McGraw-Hill Education, 2017), https://accesspharmacy.mhmedical.com/content.aspx?bookid=2249&sectionid=175218675.

Discharge Planning

The facility had written guidance on coordination of care processes for veterans transitioning from inpatient care, per VHA requirements. However, facility leaders provided a policy that was implemented two days after the OIG inspection was initiated. The OIG was unable to determine if the facility had written guidance prior to this date.[56] The standard operating procedure outlined processes for discharge coordination to include the veteran, the mental health treatment coordinator, and relevant outpatient providers.[57] The inpatient unit social worker reported that the facility had a walk-in outpatient mental health clinic to ensure veterans had timely access to outpatient follow-up care.

The OIG found general compliance with documentation of the discharge summary within two days of a veteran's discharge, scheduling outpatient mental health follow-up appointments prior to discharge, and offering the veteran a copy of the discharge instructions.[58]

The OIG found that most discharge instructions included abbreviations and acronyms for outpatient appointments that could be difficult for veterans and caregivers to understand (see figure 6).[59] The Chief of Mental Health reported that inpatient unit social workers verbally explain the appointment location to veterans. Indecipherable details in discharge instructions may create barriers for veterans to attend follow-up appointments and receive timely mental health care.

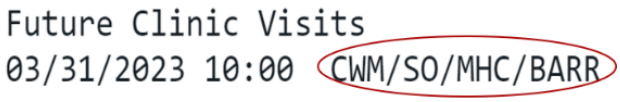

Figure 6. *Example from discharge instructions with indecipherable appointment information circled in red. Source: OIG review of veterans' EHRs.*

The OIG found that all EHRs included a medication list in discharge instructions, as required by VHA. However, only 21 percent of the records identified the reason for prescribing the medication.[60]

[56] VHA Directive 1160.01; VA Central Western Massachusetts Health Care System SOP 116-57, "Discharge Planning from Acute Psychiatric Unit," May 22, 2024.

[57] VA Central Western Massachusetts Health Care System SOP 116-57, "Discharge Planning from Acute Psychiatric Unit."

[58] VHA Health Information Management Program Office, *Health Record Documentation Program Guide 1.1*, November 29, 2022; VHA Health Information Management Program Office, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023. The policies contain similar language related to discharge summary requirements.

[59] VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules," May 24, 2023.

[60] VHA Directive 1345, *Medication Reconciliation*, March 9, 2022.

Forty-five percent of the reviewed EHRs had discharge instructions with medical abbreviations.[61] Fifteen percent of the EHRs included discharge instructions with generic and trade medication names used interchangeably without an explanation that they are the same medication (see figure 7). Accurate and easy-to-understand discharge instructions could potentially prevent medication errors at home following veterans' hospitalization.[62]

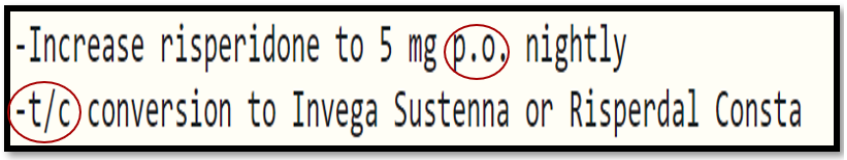

Figure 7. *Example of discharge instructions, including a Latin abbreviation circled in red and use of both generic and trade names, provided to a veteran. Source: OIG review of veterans' EHRs.*
Note: Risperidone is an antipsychotic medication with a trade name of Risperdal Consta. The Latin term "p.o." is used to describe how medications should be taken. The OIG does not recognize the term "t/c" (circled in red) as a standard medical abbreviation.

Recommendations

4. The VA Central Western Massachusetts Healthcare System Director ensures the development of written processes for the admission of veterans on an involuntary hold and monitors and tracks compliance with involuntary commitment requirements.
5. The VA Central Western Massachusetts Healthcare System Chief of Staff ensures timely documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications and monitors for compliance.
6. The VA Central Western Massachusetts Healthcare System Chief of Staff ensures discharge instructions for veterans include follow-up appointment location and contact information in easy-to-understand language.
7. The VA Central Western Massachusetts Healthcare System Chief of Staff ensures discharge instructions include the purpose for each medication listed and are written in easy-to-understand language.

For detailed action plans, see appendix E.

[61] Randa Hilal-Dandan and Laurence L. Brunton, "Appendix I: Principles of Prescription Order Writing and Patient Compliance," in *Goodman and Gilman's Manual of Pharmacology and Therapeutics, 2e* (McGraw-Hill Education, 2016), https://accesspharmacy.mhmedical.com/content.aspx?bookid=1810&sectionid=124489535.
[62] VHA Directive 1345.

Suicide Prevention

The underlying causes of death by suicide can be complex and multifactorial. Preventing suicide may require coordinated systems, services, and resources to effectively support at-risk veterans. [63]

VA is dedicated to preventing suicide and defines prevention as "participating in activities that are implemented prior to the onset of suicidal events and are designed to reduce the potential for suicidal events." [64] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors. [65]

To evaluate suicide prevention activity on the inpatient unit, the OIG assessed compliance with required suicide risk screening and evaluation, safety planning, and training (see appendix B for methodology).

Suicide Risk Screening and Evaluation

The OIG found 92 percent of the reviewed EHRs included evidence of a completed Columbia-Suicide Severity Rating Scale (C-SSRS). Eighty-six percent of the EHRs had evidence that a C-SSRS was completed within the 24 hours before discharge, as required.[66]

Failure to complete a suicide risk assessment within the required time frame may result in lack of awareness of a veteran's suicide risk, leading to an insufficient understanding of readiness for discharge and post-discharge care coordination needs.

[63] VA, *National Strategy for Preventing Veteran Suicide 2018–2028*.

[64] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021.

[65] VA, *National Strategy for Preventing Veteran Suicide 2018–2028*.

[66] VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting," November 4, 2021; VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting," updated May 10, 2023; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), et al., November 23, 2022. While VHA requires C-SSRSs to be completed within 24 hours before discharge, the OIG also considered C-SSRSs compliant if completed on the day of discharge.

Safety Planning

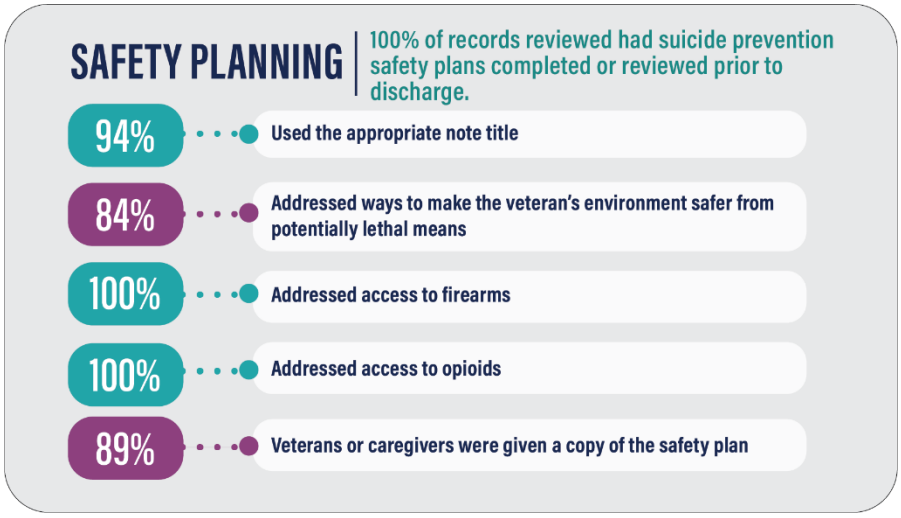

Figure 8. *Facility staff's compliance with VHA safety planning guidance. Source: OIG review of veterans' EHRs.*

The OIG found staff generally used the nationally standardized note title and completed or reviewed selected elements in safety plan documentation, as required by VHA (see appendix A for more detail on requirements).[67]

The OIG found 84 percent of the reviewed safety plans addressed ways to make the environment safer from potentially lethal means (see figure 8), including safety considerations beyond access to firearms and opioids. The identification of all potential lethal means in the environment may reduce the risk of veteran harm.[68]

Training

Skills Training for Evaluation and Management of Suicide (STEMS) and VA S.A.V.E. help clinicians and nonclinical staff, respectively, identify the warning signs of suicide risk and appropriate interventions.[69] Lethal means safety training provides guidance on how to work with

[67] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The SOP uses similar language related to providing veterans a written copy of the safety plan as the rescinded handbook; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11), "Update to Use of National Standardized Suicide Prevention Safety Plan Progress Notes," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., August 17, 2022.

[68] VA, *VA Safety Planning Intervention Manual*, February 23, 2022.

[69] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; "Suicide prevention webinar: VA S.A.V.E.," VA, accessed August 12, 2024, https://vaww.insider.va.gov/suicide-prevention-webinar-va-s-a-v-e/. (This site is not publicly accessible.) VHA identifies the VA S.A.V.E. acronym as: signs of suicide, asking about suicide, validating feelings, and encouraging help and expediting treatment; STEMS is a suicide risk and intervention training for VHA healthcare providers.

veterans and their families to reduce suicide risk, which includes "firearm and medication safe storage practices."[70]

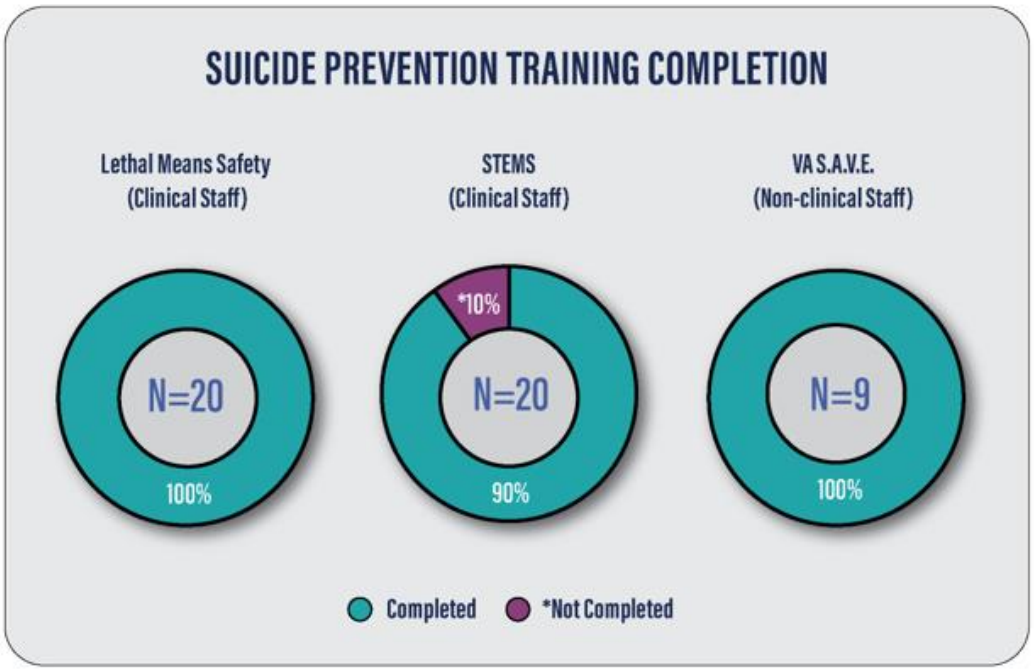

Figure 9. *Inpatient unit staff completion of mandatory suicide prevention training.*
Source: OIG document review of clinical and nonclinical staff training certificates.
Note: The OIG evaluated completion of STEMS and VA S.A.V.E. trainings during the time frame of May 20, 2023, through May 20, 2024. The OIG evaluated whether clinical staff completed Lethal Means Safety Training once during employment.

The OIG found facility staff compliant with VA S.A.V.E. and lethal means safety training, as required; however, staff were noncompliant with completion of the required STEMS training (see figure 9).[71] Staff's failure to complete required STEMS training may contribute to deficiencies in identifying suicide risk factors and lack of awareness of resources and interventions to enhance veterans' safety.

[70] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Lethal Means Safety (LMS) Education and Counseling," memorandum to VISN Director (10N1-23) et al., March 17, 2022; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network Directors (10N1-23), May 2, 2024. Both memoranda have similar language related to Lethal Means Safety Education and Counseling training requirements.

[71] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification," memorandum to VISN Director (10N1-23) et al., June 9, 2022; VHA Directive 1108.13(1), *Provision and Use of Nursing Medication Management Protocols in Outpatient Team-based Practice Settings*, February 6, 2019, amended on March 13, 2019; VHA Directive 2013-006, *The Use of Unlicensed Assistive Personnel (UAP) in Administering Medication*, March 5, 2013; VHA Directive 1071(1).

Recommendations

8. The VA Central Western Massachusetts Healthcare System Chief of Staff ensures staff complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge and monitors for compliance.
9. The VA Central Western Massachusetts Healthcare System Chief of Staff ensures staff address ways to make veterans' environments safer from potentially lethal means in safety plans and monitors for compliance.
10. The VA Central Western Massachusetts Healthcare System Director ensures staff comply with Skills Training for Evaluation and Management of Suicide requirements and monitors for compliance.

For detailed action plans, see appendix E.

Safety

The primary goal of inpatient mental health care is to stabilize veterans experiencing acute distress through the provision of a safe and secure therapeutic environment.[72] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[73]

To assess the inpatient mental health environment, the OIG evaluated aspects of compliance with ongoing assessment of suicide hazards and completion of mandatory staff training (see appendix B for methodology).

Mental Health Environment of Care

The OIG found facility leaders did not establish an interdisciplinary safety inspection team (ISIT). The ISIT is responsible for conducting environment of care inspections and monitoring compliance with the Mental Health Environment of Care Checklist (MHEOCC). The MHEOCC is used to "identify and abate suicide hazards" on inpatient mental health units (see figure 10).[74] Although staff conducted environment of care inspections at the required frequency, the OIG could not confirm which staff conducted MHEOCC inspections and if required annual training was completed (see appendix A).[75]

In a physical inspection of randomized MHEOCC safety elements, the OIG found the inpatient unit had tamper-resistant windows, fire sprinklers without ligature points, and nonbreakable mirrors.[76]

[72] VHA Directive 1160.06.

[73] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

[74] VHA Directive 1167; The MHEOCC "consists of criteria applicable to all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion rooms, and staff work stations."

[75] VHA Directive 1167.

[76] The Joint Commission, "Special Report: Suicide Prevention in Health Care Settings," *Perspectives* 37, no. 11 (November 2017): 1–16. The Joint Commission defines the term "ligature resistant" as, "Without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create a sustain-able point of attachment that may result in self-harm or loss of life."

The OIG observed that the inpatient unit sally port entrance doors were locked to prevent veterans from leaving without staff awareness.[77] However, the entrance doors were not synchronized and both doors could be opened concurrently. The Chief of Facilities reported the sally port doors' electronic synchronization mechanism had been installed and that an incompatible software system resulted in nonfunctional synchronization since June 2022. The OIG observed an occurrence when the two doors were unlocked at the same time, potentially posing a security risk.[78] The lack of an established ISIT may have resulted in a missed opportunity to track the installation of the sally port doors' electronic synchronization mechanism to completion.

Figure 10. *MHEOCC categories. Source: OIG analysis of facility MHEOCC documents (received May 21, 2024) and VHA Directive 1167.*

Per VHA, inpatient units must have a MHEOCC-compliant room available for physical restraint.[79] The OIG found the restraint room, which is separate from veterans' bedrooms, did not meet MHEOCC standards due to the absence of a bed. When asked why the facility did not meet these standards, facility leaders stated that all veterans' bedrooms can be utilized for restraint because the beds are bolted to the floor.

Facility leaders and a staff member further explained that when physical restraint was needed, a restraint chair was utilized in a vacant room or the veteran's bedroom. The OIG observed that the restraint chair was stored in a locked office on the unit.

Although the National Director, Inpatient Mental Health Services verbally expressed an expectation to OIG staff for HCSs to provide guidance on the use of a restraint chair, no national policy addressed this issue at the time of the inspection.[80] The facility policy did not include processes related to the use of a restraint chair or the use of

[77] VHA Handbook 1160.06; VHA Directive 1160.06. The directive and rescinded handbook contain similar language related to requirements for a locked inpatient unit; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," March 7, 2022. The sally port is "the space between two locked doors that must be traversed to enter the unit."

[78] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist."

[79] VHA Handbook 1160.06; VHA Directive 1106.06.

[80] On October 11, 2024, VHA published SOP 1160.06.1, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06." The SOP provides guidance for the use and maintenance of restraint chairs.

veterans' bedrooms for restraint. The OIG found that the practices described by facility leaders did not align with policy.[81]

Further, the OIG observed that the group room had unweighted and unsecured chairs, which could be thrown or used to block the door to the room. Facility leaders reported a plan to replace the chairs with weighted furniture but did not identify a plan to temporarily mitigate the safety risk. Facility leaders' failure to take timely actions to identify and resolve environmental risks on the inpatient unit could result in veteran or staff harm.

The MHEOCC offers a practical checklist of environmental elements that ensure the safety of veterans and staff on the inpatient unit. When staff do not use these elements to identify and resolve environmental risks and engage in practices not supported by standardized written procedures, veterans and staff are potentially at risk for harm.

Training

VHA requires staff to be trained on environmental hazards and oriented to the "content and proper use" of the MHEOCC and the Patient Safety Assessment Tool (PSAT).[82] Each of the inpatient MHEOCC categories listed above includes multiple individual items that staff must evaluate during semiannual inspections (figure 10).[83]

[81] VHA Handbook 1160.06; VHA Directive 1106.06; VA Central Western Massachusetts SOP 116-52, "Use of Restraint," November 14, 2023.

[82] VHA Directive 1167. Staff assigned to the inpatient unit and staff conducting MHEOCC inspections are required to complete the training. The OIG used 90 percent as the expected level of compliance.

[83] VHA Directive 1167.

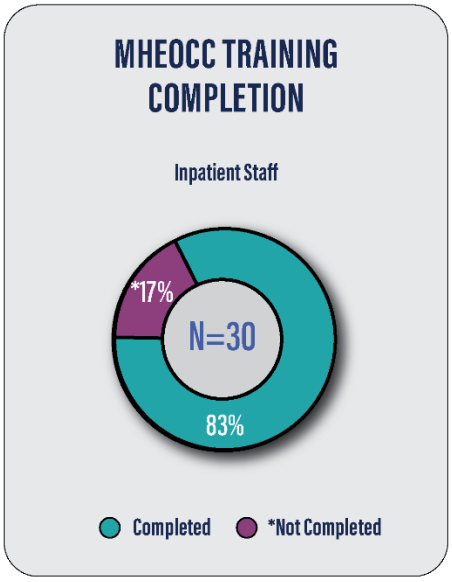

Figure 11. *MHEOCC training completion, May 20, 2023–May 20, 2024. Source: OIG document review of staff training certificates.*

The OIG found inpatient unit staff did not consistently complete annual MHEOCC training, as required. Completing annual training on environmental hazards and VHA safety requirements may reduce safety risks for veterans and staff on the inpatient unit.[84]

[84] VHA Directive 1167.

Recommendations

11. The VA Central Western Massachusetts Healthcare System Director establishes an interdisciplinary safety inspection team in alignment with Veterans Health Administration requirements and ensures ongoing compliance.
12. The VA Central Western Massachusetts Healthcare System Chief of Staff ensures that the sally port inpatient unit doors are synchronized and monitors for compliance.
13. The VA Central Western Massachusetts Healthcare System Director uses VHA guidelines to develop facility-specific policy for the use of restraint chairs.
14. The VA Central Western Massachusetts Healthcare System Director ensures alignment between physical restraint policies and practices.
15. The VA Central Western Massachusetts Healthcare System Chief of Staff ensures mental health leaders update inpatient unit furniture to meet safety requirements and implements processes to reduce associated safety risks.
16. The VA Central Western Massachusetts Healthcare System Chief of Staff ensures compliance with VHA requirements for Mental Health Environment of Care Checklist training completion.

For detailed action plans, see appendix E.

Conclusion

VA Central Western Massachusetts HCS demonstrated compliance with some, but not all, requirements evaluated for inpatient mental health care.

During the 12-month review period, facility leaders did not have an established local MHEC to oversee the quality of mental health care. The VISN had an MHEC that is responsible for monitoring quality and access across the VISN's continuum of mental health care.

Most staff responded positively to questions about psychological safety and continuous performance improvement. Additionally, the OIG's EHR reviews indicated that most veterans and the interdisciplinary treatment team were involved in treatment planning, and veterans had documented safety plans.

The facility's policy for admission to the mental health inpatient unit was not inclusive of veterans on an involuntary hold status. Facility leaders did not have formal processes to monitor and track compliance with involuntary commitment state laws. Mental health leaders indicated that the inpatient unit's admission policy did not address involuntary admission; instead, facility staff relied on psychiatrists' knowledge of state commitment laws.

Staff provided the requisite amount of interdisciplinary programming on weekdays and weekends. The inpatient unit included aspects of a recovery-oriented physical environment, such as soft night lighting in the nurses' station and veterans' rooms. However, the OIG identified multiple safety concerns. The unit's sally port entrance doors were not synchronized, potentially resulting in veterans leaving without staff awareness. Leaders did not establish written processes for staff to accompany veterans on outdoor breaks. Facility staff did not have a policy that addressed the use of a restraint chair. The inpatient unit also had unweighted and unsecured chairs in the group room that could be thrown or used to block the door.

Although staff conducted the required twice-yearly MHEOCC inspections, facility leaders did not have a formal ISIT. Multiple staff did not complete MHEOCC or STEMS requirements. Correspondingly, some EHRs reviewed did not have evidence of timely suicide risk screenings. Staff offered veterans written discharge instructions that were difficult to understand and lacked important details for appointment follow-up and medication management.

The OIG issued 16 recommendations to the Facility Director, Chief of Staff, and Chief of Mental Health. These recommendations, once addressed, may improve the quality and delivery of veteran-centered, recovery-oriented care on the inpatient mental health unit and beyond.

Appendix A: Background

Inpatient Mental Health Services

VHA offers acute inpatient mental health services as a "high-intensity" treatment option for veterans experiencing "acute and severe emotional or behavioral symptoms" that pose a safety risk or result in compromised mental function. When a healthcare provider determines that inpatient mental health care is appropriate, the veteran should be immediately admitted, ensuring safety and stabilization.[85]

VHA requires inpatient unit staff use a veteran-centered, evidence-based, recovery-oriented approach that incorporates evaluation and monitoring, interdisciplinary treatment, discharge planning, adequate staffing, privacy, and respect.[86] To evaluate the quality of recovery-oriented care provided at the facility, the OIG assessed compliance with VHA requirements in the six domains described below.

Leadership and Organizational Culture

Organizational structure plays a critical role in the quality of healthcare delivery. Elements such as formal reporting channels, committee structures, and staffing practices should support inpatient unit operations and align with care delivery needs.

According to VHA's requirements, the HCS director is responsible for overseeing inpatient mental health services. The chief of staff, in collaboration with the ADPCS, should ensure inpatient units have adequate staffing to establish interdisciplinary teams, provide services, and fully implement program requirements.[87]

Each HCS must have a dedicated mental health lead with overall responsibility for mental health service operations, including mental health services that may be aligned under a different department. The mental health lead may also be referred to as the mental health service line director, chief of mental health, or other comparable title.[88] The mental health lead serves as the chair of the HCS MHEC, which ensures staff provide high-quality care and are responsive to veterans' preferences. Each MHEC must include at least one veteran, ideally one who is receiving mental health services and not employed at the HCS. The MHEC should meet quarterly and "record minutes that are accessible to all mental health clinical staff."[89]

[85] VHA Handbook 1160.06; VHA Directive 1160.06.

[86] VHA Handbook 1160.06; VHA Directive 1160.06.

[87] VHA Handbook 1160.06; VHA Directive 1160.06. The directive assigns the responsibility of ensuring adequate staffing of the inpatient unit to the chief of staff in collaboration with the ADPCS.

[88] VHA Directive 1160.01.

[89] VHA Directive 1160.01.

The VISN Director is responsible for ensuring inpatient mental health services "are accessible without delay to all eligible Veterans in the VISN" and that the programs offered on the inpatient unit are compliant "with relevant law, regulation, policy, and procedures."[90]

VHA requires the appointment of a full-time VISN CMHO to "ensure transparency of decision-making and to promote communication between the field and central office."[91] The CMHO chairs the VISN MHEC; each HCS's mental health lead is expected to participate. The VISN MHEC oversees and monitors quality, identifies areas of concern, and communicates critical matters to VISN and senior VHA leaders.[92]

The HCS mental health lead must assign an inpatient mental health program manager who coordinates programming and ensures it is effectively integrated into the inpatient unit setting.[93] In addition, each HCS is required to have an LRC who spends 75 percent of their time ensuring mental health services demonstrate recovery-oriented principles and "no more than 25 percent" of their time providing direct clinical care. The LRC collaborates with local mental health leaders to implement a continuous improvement plan that must be updated every three years.[94]

VHA employs peer support staff, veterans who are actively engaged in their own personal recovery, to serve as role models for other veterans receiving healthcare services.[95] "Peer Specialists help veteran patients develop skills to manage their recovery from illness, improve their quality of life, support their individualized goals, facilitate support from others, and achieve independence from institutional setting."[96] Peer support staff must be available for veterans when clinically indicated and may serve as members of an interdisciplinary treatment team.[97]

[90] VHA Handbook 1160.06; VHA Directive 1160.06.

[91] "Mental Health Required Staff Listing," VA Office of Mental Health, accessed February 8, 2023, https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MH_Staffing_Req.aspx. (This site is not publicly accessible.)

[92] VHA Directive 1160.01.

[93] VHA Handbook 1160.06; VHA Directive 1160.06.

[94] VHA Directive 1163.

[95] VHA Directive 1163. Peer support staff may also be referred to as peer specialists.

[96] VHA Directive 1163.

[97] VHA Directive 1160.06; VHA Directive 1163.

High Reliability Principles

VHA expects VISN and HCS directors to integrate the high reliability concepts of psychological safety and continuous performance improvement into care delivery.[98] A high reliability organization focuses on patient safety, "zero harm," and continual process improvement.[99] Psychological safety is "the belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes" and continuous process improvement includes the actions to improve processes within the organization that affect veteran care.[100]

Recovery-Oriented Principles

The Substance Abuse and Mental Health Services Administration "defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential."[101]

VHA requires adherence to principles of veteran-centered, recovery-oriented mental health care and ongoing evaluation of services provided on the inpatient unit.[102] VHA recognizes the inpatient unit's physical environment as an element of recovery-oriented mental health care, and therefore, requires HCSs to create a hopeful and healing environment while maintaining safety.[103] VHA requires inpatient unit staff to provide "evidence-based medication management, psychosocial rehabilitation, evidence-based psychotherapy, patient education, medical care" and other therapies using recovery-oriented methods.[104]

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[98] VA, "VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)," September 2022, accessed October 26, 2023, https://dvagov.sharepoint.com/sites/vhahrojourney/Shared%20Documents/Forms/HRO%20Assessment%20and%20Planning%20Resources.aspx?id=%2Fsites%2Fvhahrojourney%2FShared%20Documents%2FHRO%20Enterprise%20Operating%20Plan%20Guidance%2Epdf&parent=%2Fsites%2Fvhahrojourney%2FShared%20Documents. (This site is not publicly accessible.)

[99] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

[100] VA, "VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)"; VA, "VHA High Reliability Organization (HRO) Reference Guide," April 2023, accessed October 26, 2023, https://dvagov.sharepoint.com/sites/vhahrojourney/Shared%20Documents/Forms/Edit_View.aspx?viewid=d00dd726%2D93d3%2D4e54%2Db90b%2D2c82cada6a83&id=%2Fsites%2Fvhahrojourney%2FShared%20Documents%2FHRO%20Reference%20Guide%2Epdf&parent=%2Fsites%2Fvhahrojourney%2FShared%20Documents. (This site is not publicly accessible.)

[101] "Recovery and Recovery Support," Substance Abuse and Mental Health Services Administration, accessed September 19, 2022, https://www.samhsa.gov/find-help/recovery#.

[102] VHA Directive 1160.06; VHA Directive 1163; VHA Directive 1160.01.

[103] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

[104] VHA Handbook 1160.06; VHA Directive 1160.06. Per the directive, "A patient-centered recovery-oriented approach must be reflected in all VHA inpatient mental health units, including the services and treatments provided, language in new and existing inpatient documents and in the environment of care."

Clinical Care Coordination

Care coordination poses a major challenge to healthcare safety, especially for chronically ill individuals who receive services from multiple providers in a variety of settings.[105] VHA requires inpatient units to have an interdisciplinary treatment team composed of individuals who are responsible for the assessment, planning, and implementation of a veteran's care. An interdisciplinary approach is critical to ensure comprehensive, coordinated, and holistic care.[106]

VHA requires HCSs to have standard operating procedures outlining admission processes, and to provide access to mental health treatment for veterans who are either voluntarily or involuntarily held on an inpatient unit.[107] When treatment is not available within the HCS, staff may transfer a veteran to another VHA or non-VHA HCS for inpatient mental health care.[108]

The federal government does not have civil commitment laws; therefore, HCS leaders are required to have clear guidelines that align with state civil commitment laws.[109] HCS staff must be aware of a veteran's legal status (voluntary or involuntary admission) to safeguard against potential civil rights violations, including illegal detainment in a locked inpatient unit.[110]

The interdisciplinary treatment team must ensure the recovery-oriented treatment plan includes the veteran's personally identified goals and is completed in collaboration with the veteran.[111] The interdisciplinary treatment team must also ensure outpatient mental health care is coordinated with the veteran prior to discharge, including a scheduled post-discharge outpatient follow-up appointment.[112]

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[105] The Joint Commission, *Standards Manual e-dition*, PC.02.02.01, January 2024. "The hospital coordinates the patient's care, treatment, and services based on the patient's needs."

[106] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to the role of the interdisciplinary treatment team.

[107] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The directive and rescinded handbook contain similar language related to requirements for a locked inpatient unit that can also "accommodate involuntary" veterans; The Joint Commission, *Standards Manual e-dition*, PC.01.01.01, August 2023. "The hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs."

[108] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to timely access and admission to inpatient mental health care.

[109] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to treatment access for veterans with involuntary status.

[110] VHA Handbook 1160.06; VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," revised April 5, 2023.

[111] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to the veteran's input in treatment plan goals.

[112] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The SOP contains similar language related to post-discharge care as the rescinded handbook.

VHA requires that veterans receive a copy of the written discharge plan and a copy of the safety plan, as applicable, at discharge. The written discharge plan must include the provider's name if available, as well as scheduling information for the follow-up appointments.[113]

Suicide Prevention

According to the *2023 National Veteran Suicide Prevention Annual Report*, "suicide was the 13th-leading cause of death for Veterans overall, and the second-leading cause of death among Veterans under age 45" in 2021.[114] Immediately following inpatient hospitalization, there is an increased risk for suicide attempt or completion.[115] Therefore, there is a critical need for suicide risk assessment prior to discharge from inpatient mental health care, as well as linkage to follow-up mental health care.[116]

Inpatient unit clinical staff are required to complete the C-SSRS, an evidence-based risk assessment tool, for veterans within 24 hours prior to discharge. A positive C-SSRS then requires the "timely completion of the Comprehensive Suicide Risk Evaluation."[117] Staff may complete the Comprehensive Suicide Risk Evaluation in lieu of the suicide risk screening prior to discharge.[118]

VHA requires providers to collaborate with veterans to create a suicide prevention safety plan, a written document emphasizing coping skills and sources of support, used to prevent and manage

[113] VHA Handbook 1160.06*;* VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The SOP uses the term *written discharge plans* instead of *discharge instructions* when inpatient unit staff must provide the veteran with information regarding the written discharge plans.

[114] VA Suicide Prevention Office of Mental Health and Suicide Prevention, *2023 National Veteran Suicide Prevention Annual Report*, November 2023.

[115] VA, *National Strategy for Preventing Veteran Suicide 2018-2028*.

[116] Deputy Under Secretary for Health for Operations and Management, "Eliminating Veteran Suicide: Enhancing Acute Inpatient Mental Health and Residential Rehabilitation Treatment Program (RRTP) Discharge Planning and Follow-up," memorandum to Network Directors (10N1-23) et al., June 12, 2017.

[117] VA, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020.

[118] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting," updated November 4, 2021; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., November 23, 2022. VHA's two-phase process to screen and assess for suicide risk in clinical settings includes the C-SSRS and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive; VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Frequently Asked Questions (FAQ)," updated December 13, 2022.

a crisis.[119] These plans must include, but are not limited to, discussion of environmental safety strategies, safety options, and access to firearms and lethal medications.[120]

VHA requires healthcare providers complete STEMS and nonclinical staff complete VA S.A.V.E. training within 90 days of entering the position and annually.[121] In addition, all VHA healthcare providers must complete a one-time Lethal Means Safety Education and Counseling training within 90 days of entering the position.[122] In June 2022, VHA issued a memorandum indicating a target of at least 95 percent completion for mandatory suicide prevention trainings.[123]

Safety

In VHA HCSs, inpatient mental health units must be designed to ensure veteran safety while still integrating recovery-oriented principles into the environment. ISIT members and all inpatient unit staff are responsible for ensuring a safe environment.[124] Additionally, an ISIT is required to assess the inpatient unit every six months for suicide hazards using the MHEOCC, and the patient safety manager or other designated mental health staff track corrective actions taken for identified environmental risks.[125]

An ISIT is a mandatory subcommittee of the HCS environment of care committee, with membership and date of members' last MHEOCC training documented in the ISIT meeting minutes. The ISIT "should include the Suicide Prevention Coordinator, a Patient Safety Manager, a Facility Safety Officer, a Mental Health Unit Nurse Manager, a non-mental health

[119] VHA Directive 1160.07.

[120] VA, "VA Safety Planning Intervention Manual."

[121] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022.

[122] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), March 17, 2022; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network Directors (10N1-23), May 2, 2024. Both memoranda have similar language related to Lethal Means Safety Education and Counseling training requirements.

[123] VHA Directive 1071(1); Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11), "Lethal Means Safety (LMS) Education and Counseling," memorandum; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification." As of June 2022, VHA required at least 95 percent compliance with mandatory suicide prevention trainings.

[124] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

[125] VHA Directive 1167. The MHEOCC is a "checklist designed to help identify and abate suicide hazards on mental health units and other areas treating patients at high acute risk for suicide. It consists of criteria applicable to all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion rooms, and staff work stations."

Unit Nurse Manager, an inpatient Licensed Independent Practitioner, the Local Recovery Coordinator, an outpatient mental health provider (e.g., an outpatient case manager, clinician, or Peer Specialist), a representative from Engineering, a representative from Environmental Services and a Pharmacist."[126]

[126] VHA Directive 1167.

Appendix B: Methodology

The Mental Health Inspection Program began inspections in FY 2024 and focused on the quality of care provided by VHA's inpatient mental health services.[127] The OIG randomly selected the VHA HCSs included in FY 2024 inspections from all facilities with inpatient mental health beds.[128]

The OIG conducted a virtual and on-site inspection at the facility from May 20 through June 14, 2024. The OIG did not receive a complaint beyond the scope of this inspection that required referral to the OIG hotline.

The OIG reviewed data specific to the facility, prior OIG reports related to the inpatient unit, documents, and EHRs. Additionally, the OIG distributed a questionnaire to mental health staff and leaders, conducted a physical inspection of the inpatient unit, and interviewed key staff and leaders. Except for a 95 percent threshold for mandatory suicide prevention training completion, the OIG used 90 percent as the expected level of compliance for MHEOCC training and for record review.

The OIG's analysis relied on inspector identification of salient information based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.* The OIG did not analyze compliance with individual HCS policies.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA leaders complete corrective actions. Leaders' responses to the report recommendations appear in appendix D and appendix E.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issues.

Oversight authority to inspect the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[129] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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[127] The OIG conducts cyclic reviews of select areas of focus within VHA's continuum of mental health care.

[128] The OIG identified HCSs with inpatient mental health beds using the Monthly Program Cost Report (MPCR) code of 1310 (High Intensity General Psychiatric Inpatient Unit). For FY 2024, the OIG excluded inpatient mental health beds visited in FY 2023 for preliminary research. Allocation Resource Center, "Monthly Program Cost Report (MPCR) Handbook," October 2014, updated March 2017.

[129] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Electronic Health Record Review

The OIG reviewed 50 randomly selected EHRs of veterans discharged from an acute inpatient mental health stay of more than 48 hours at the facility from October 1, 2022, through September 30, 2023.[130]

Table B.1. EHR Review Results

Domain	Topic	Inspection Element Reviewed	Number of Records Included	Percent Compliant (%)
Clinical Care Coordination	Voluntary or involuntary treatment status	Documented within 24 hours of admission	50	90
	Inpatient mental health treatment plan	Completed	50	100
		Veteran involved in development or offered opportunity	50	94
		Included interdisciplinary treatment team input	50	94
	New Central Nervous System medication	Risk and benefits discussed with veteran	20	70
	Discharge summary	Completed	50	100
		Completed within two business days of discharge	50	96
	Outpatient mental health follow-up appointment	Scheduled prior to discharge	47	100
	Discharge instructions	Completed	47	100
		Included outpatient mental health appointment	47	98
		Copy offered to veteran	47	100
		Included location of follow-up appointment in easy-to-understand language	46	11
		Included medication list	47	100
		Included reasons for prescribed medications	47	21

[130] The OIG identified the EHR sample from a list of all individuals with a Monthly Program Cost Report discharge code of 1310 (High Intensity General Psychiatric Inpatient Unit) and excluded all other records. For veterans with multiple admissions during the review period, the OIG included veterans' first admissions only.

Domain	Topic	Inspection Element Reviewed	Number of Records Included	Percent Compliant (%)
		Free of medication abbreviations that could be difficult to understand by a nonmedically trained individual	47	55
		Free of generic and medication trade names used interchangeably with no explanation that they are the same medication	13	15
Suicide Prevention	Columbia-Suicide Severity Rating Scale	Completed prior to discharge	50	92
		Completed within 24 hours prior to discharge	50	86
	Suicide Prevention Safety Plan	Completed or reviewed prior to discharge	48	100
		Used appropriate note title	48	94
		Addressed ways to make the veteran's environment safe from potentially lethal means	45	84
		Addressed access to firearms	45	100
		Addressed access to opioids	45	100
		Offered veteran or caregiver a copy	45	89

Source: OIG review of the facility Mental Health Inpatient Unit EHRs.
Note: The OIG considers the words "addressed" and "completed" to be equivalent related to the reviewed inspection elements. Due to exclusion criteria, the number of included records does not always equal 50.

Questionnaire

To assess perceptions of psychological safety and performance improvement activities, the OIG sent a questionnaire to 32 individuals identified as staff and leaders who had interactions with the inpatient unit. Additionally, all questions in the report appear as written in the questionnaire and the OIG did not provide respondents with instructions on how to interpret questions. The OIG received 17 completed questionnaires (53 percent).

OIG Inspection of the Physical Environment

The OIG inspected selected areas of the inpatient unit to evaluate if the HCS provided a therapeutic, recovery-oriented environment and maintained veteran safety.[131] The OIG team visually assessed the inpatient unit environment for warm and inviting design elements such as natural lighting, artwork, and calming paint colors. The OIG also observed the unit for general cleanliness and veteran access to private and outdoor space.[132] Further, the OIG's physical inspection of areas in the inpatient unit focused on additional selected safety elements specific to this HCS.

The OIG reviewed the PSAT for MHEOCC inspections completed in FYs 2022, 2023, and 2024, and assessed corrective actions taken for deficiencies unresolved for more than six months.

[131] VHA Handbook 1160.01; VHA Handbook 1160.06; VHA Directive 1160.06. Handbook 1160.06 and Directive 1160.06 contain similar language related to expectations for a safe and recovery-oriented environment; A unit is an "area in a medical facility and especially a hospital that is specially staffed and equipped to provide a particular type of care." *Merriam-Webster.com Dictionary*, "unit," accessed August 10, 2022, https://www.merriam-webster.com/dictionary/unit.

[132] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

Appendix C: Organizational Structure and Staffing

The OIG evaluated the leadership organizational structure within VISN 1 and the facility, including reporting authority and delineation of direct or indirect oversight responsibilities.

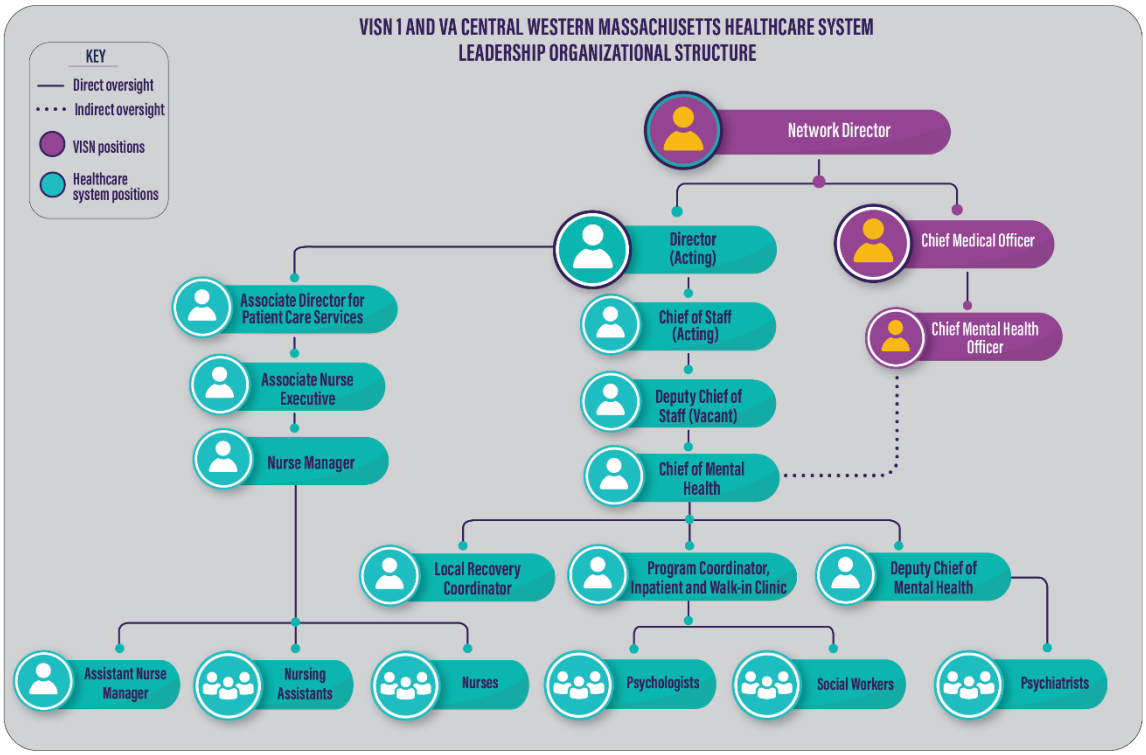

Figure C.1. *VISN 1 and facility organizational structure.*
Source: OIG analysis of interviews and facility documents (received May 20, 2024, through November 22, 2024); OIG analysis of VHA Directive 1160.06 and VHA Directive 1160.01.
Note: The OIG considers the direct supervisor of each position to be the equivalent of "direct oversight."

The OIG examined the facility's inpatient unit staffing, which reflected an interdisciplinary team approach.

Table C.1. Inpatient Unit Staffing

Discipline	FTEE	Percent Dedicated Per FTEE
Nurses*	16	100
Nursing Assistants‡	8	100
Psychiatrists	2	100
Psychologists§	2	5–100
Social Workers	2	100

Source: OIG Review of the facility's Mental Health Inpatient Unit Staffing Spreadsheet (received May 21, 2024).
Note: FTEE stands for full-time equivalent employee.
**Nursing staff include a nurse manager, an assistant nurse manager, 13 registered nurses, and a licensed practical nurse.*
‡Nursing assistant staff include eight psychiatric nursing assistants.
§Psychology staff include the local recovery coordinator, who dedicates 5 percent of time to the inpatient unit.

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 17, 2024

From: Director, VA New England Healthcare System (10N01)

Subj: Mental Health Inspection of the VA Central Western Massachusetts Healthcare System

To: Director, Office of Healthcare Inspections (54MH00)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. Thank you for the opportunity to review and comment on the draft report regarding the healthcare inspection report at the VA Central Western Massachusetts Healthcare System in Leeds. The VA New England Healthcare System is committed to providing exceptional healthcare to Veterans. This includes building a Just Culture that supports the prevention of patient harm and continuous process improvement as a High Reliability Organization.
2. I thank the OIG team for their recommendations which identified areas for improvement.
3. The leadership teams at VA Central Western Massachusetts Healthcare System and the Veterans Integrated Network Office are committed to implementing corrective actions and will diligently pursue all measures to ensure safe, high-quality care for the Veterans that we serve.

(*Original signed by*:)

Ryan Lilly, MPA
VISN 1 Network Director
VA New England Healthcare System

[OIG comment: The OIG received the above memorandum from VHA on January 6, 2025.]

Appendix E: Healthcare System Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 13, 2024

From: Director, VA Central Western Massachusetts Healthcare System (631/00)

Subj: Office of Inspector General (OIG) Draft Report: Mental Health Inspection of the VA Central Western Massachusetts VA

To: Veterans Integrated Service Network (VISN) 1 Director, VA New England Healthcare System (10N01)

1. Thank you for the opportunity to review and comment on the draft report regarding the Mental Health Inspection that was conducted at the VA Central Western Massachusetts Healthcare System in Leeds, MA in June of 2024.
2. I have reviewed and concurred with 15 recommendations, concurred in principle with 1 recommendation, and will ensure the corrective actions are completed and sustained, as described in the attachment.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans. We will continue to partner with the OIG, VISN, and CWM VA HCS Leadership to implement corrective actions to demonstrate our dedication to providing exceptional service to the Veterans we serve.
4. Comments or questions regarding the contents of this memorandum may be directed to the Chief of Quality Management for the VA Central Western Massachusetts Healthcare System.

(*Original signed by*:)

Jonathan Kerr
Interim Executive Director

[OIG comment: The OIG received the above memorandum from VHA on January 6, 2025.]

Healthcare System Director Responses

Recommendation 1

The VA Central Western Massachusetts Healthcare System Director establishes a mental health executive council that operates in accordance with VHA requirements.

_X __Concur in Principle

_____Nonconcur

Target date for completion: December 2024

Director Comments

The facility agrees with the finding because, at the time of the inspection, the Mental Health Executive Council (MHEC) had not met quarterly during the 12-month review period. The MHEC has been in effect since October 11, 2023, with a signed Charter enacted on December 13, 2023.

The VA Central Western Massachusetts Healthcare System (CWM) has a Mental Health Executive Committee (MHEC) that meets on a quarterly basis. The MHEC met in October 2023, January 2024, April 2024, July 2024, and October 2024. Requesting closure on publication based on the supporting evidence provided.

OIG Comments

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

Recommendation 2

The VA Central Western Massachusetts Healthcare System Director ensures staff consistently solicit and incorporate veteran feedback into process improvements.

__X _Concur

_____Nonconcur

Target date for completion: June 2025

Director Comments

The facility has written an Inpatient Recovery Care standard operating procedure (SOP) that incorporates the sustained recovery framework for the inpatient mental health unit. The SOP addresses soliciting Veteran feedback at a weekly recovery group led by the Local Mental Health Recovery Coordinator (LRC). The Mental Health Executive Committee (MHEC) will review and approve a patient survey which will be utilized to obtain additional Veteran feedback. The

patient survey will be distributed prior to discharge so Veterans can complete it on day of discharge. The Mental Health Program Manager or designee will review survey results. All Veteran feedback will be discussed at the Acute Engaged Work Team (EWT), and responses will be incorporated into unit process improvement initiatives as appropriate. The EWT will report Veteran feedback data, decisions, and process improvements to the MHEC.

Recommendation 3

The VA Central Western Massachusetts Healthcare System Chief of Mental Health develops written guidance to ensure staff and veteran safety during outdoor breaks.

__X _Concur

_____Nonconcur

Target date for completion: March 2025

Director Comments

The facility SOP 116-53, Supervised Outdoor Activities (Fresh Air-Breaks) For Acute Mental Health Inpatient Areas dated 11/29/2023, is being reviewed for alignment with the VHA Office of Mental Health SOP 1160.06.1: Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units under VHA Directive 1160.06 published on 10/11/2024 and revised as necessary. The SOP will be routed and published to the facility's Document Control SharePoint (DCS). Staff education will occur once the SOP is published to the DCS. A review of unit-specific SOPs will also be incorporated into onboarding for new employees.

Recommendation 4

The VA Central Western Massachusetts Healthcare System Director ensures the development of written processes for the admission of veterans on an involuntary hold and monitors and tracks compliance with involuntary commitment requirements.

__X _Concur

_____Nonconcur

Target date for completion: June 2025

Director Comments

The Chief of Mental Health is collaborating with the Deputy Chief of Mental Health to develop an SOP that establishes procedures relative to the involuntary commitment of mentally ill patients to the medical center and the formal, periodic review of patient status. Training on this SOP will be conducted once implemented. A review of unit-specific SOPs will also be incorporated into onboarding for new employees. The Utilization Manager, part of the Quality

Management (QM) office will monitor the compliance for the process of involuntary psychiatric patient status as outlined in the SOP for compliance. The results of the monitor will be reported up through the Quality, Safety, and Value Council (QSVC) monthly until 90% compliance achieved for 3 months and then quarterly. Reports will be shared with Mental Health Leadership.

Recommendation 5

The VA Central Western Massachusetts Healthcare System Chief of Staff ensures timely documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: June 2025

Director Comments

The Deputy Chief of Mental Health will collaborate with the Clinical Applications Coordinator (CAC) to develop a new required medication prompt within the electronic medical record. This prompt will include questions to help guide the provider's review of the medications and prompt for discussion points on risks and benefits, which will be included in prescriber's progress notes anytime a medication is started or changed. Quality Management will compile a list of charts to be reviewed by Mental Health Leadership regarding compliance. Mental Health Leadership will then report reviews to the Mental Health Executive Committee and will monitor for consecutive compliance of 90% for 3 months, and then quarterly.

Recommendation 6

The VA Central Western Massachusetts Healthcare System Chief of Staff ensures discharge instructions for veterans include the follow-up appointment location and contact information in easy-to-understand language.

__X _Concur

_____Nonconcur

Target date for completion: June 2025

Director Comments

The Group Practice Manager (GPM) will review the facility's compliance with the Clinic Profile Manager Guidebook for patient-friendly clinic names and update any clinic name that falls outside this naming convention. The Chief of Mental Health will collaborate with the Clinical Application Coordinator (CAC) team to update inpatient mental health discharge progress notes with this naming convention. A report will be provided to the Mental Health Executive Council

(MHEC) with an update of all changes. A Clinic Profile Manager position has been approved for the facility and is being recruited to ensure sustained compliance with VA clinic naming conventions. Sustained compliance will be accomplished through annual GPM clinic name reviews, with reporting annually to Health Care Delivery Council.

Recommendation 7

The VA Central Western Massachusetts Healthcare System Chief of Staff ensures that discharge instructions include the purpose for each medication listed and are written in easy-to-understand language.

__X _Concur

_____Nonconcur

Target date for completion: June 2025

Director Comments

The Chief of Mental Health and Deputy Chief of Mental Health will collaborate with the CAC team to update the discharge instructions note template in CPRS [Computerized Patient Record System] to ensure that the medication list includes the purpose for each medication listed in simple verbiage. The Mental Health Administration, or designee, will conduct periodic reviews of discharge summaries with medication lists, reviewing instructions for each medication's documented purpose and use of easy-to-understand language. Reviews on the use of the template will occur monthly until 90% or greater compliance for three consecutive months and reported to Health Care Delivery Council. After three consecutive months of compliance is reached reports will be provided quarterly to the Mental Health Executive Council.

Recommendation 8

The VA Central Western Massachusetts Healthcare System Chief of Staff ensures staff complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: January 2025

Director Comments

The facility’s SOP 116-57, Discharge Planning from Acute Psychiatric Unit, effective May 23, 2024, describes specific steps to ensure staff complete the Columbia-Suicide Severity Rating (CSSR) Scale within 24 hours before discharge. The SOP was in effect at the time of the

inspection but not in place during the 12-month review period. To ensure compliance with this recommendation, a chart review will be conducted retrospectively by Quality Management to review all discharges from the inpatient mental health unit since the time this process was implemented. If there is not a 90% compliance for the past three months, then additional monthly reviews will be completed. Reviews will be reported to Quality, Safety, and Value Council (QSVC) to ensure compliance, and action taken as warranted.

Recommendation 9

The VA Central Western Massachusetts Healthcare System Chief of Staff ensures that staff address ways to make veterans' environments safer from potentially lethal means in safety plans and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: April 2025

Director Comments

Since the OIG Mental Health Inspection, the facility has hired and trained two licensed independent clinical social workers in the inpatient mental health unit who are able to complete lethal means safety plans. The Inpatient Mental Health Program Manager (IMHPM) will complete a review of safety plans monthly until a rate of 90% or greater compliance for three consecutive months. For sustainability the IMHPM will review safety plans to monitor compliance with lethal means safety plans and results will be reported to the Mental Health Executive Council, quarterly and action taken as warranted.

Recommendation 10

The VA Central Western Massachusetts Healthcare System Director ensures staff comply with Skills Training for Evaluation and Management of Suicide requirements and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: July 2025

Director Comments

The Chief of Quality Management (QM) will collaborate with Education to obtain a monthly Talent Management System (TMS) report of STEMS training and the STEMS refresher courses. A formula will be applied to the report which will show who is due to complete training within 60-days. This information will be provided to corresponding managers by the Education

department. This will also accurately determine compliance and ensure that training completion dates align with the annual requirement. QM will then collaborate with the facility's Suicide Prevention Coordinator (SPC) to track completion rates of the STEMS training with a target benchmark of 90%. Suicide Prevention Coordinator will provide a monthly compliance report to the Quality, Safety, and Value Council (QSVC), this will not include employee names but rates of compliance.

Recommendation 11

The VA Central Western Massachusetts Healthcare System Director establishes an interdisciplinary safety inspection team that meets VHA requirements and ensures ongoing compliance.

__X _Concur

_____Nonconcur

Target date for completion: June 2025

Director Comments

The facility has drafted an Interdisciplinary Safety Inspection Team (ISIT) Committee Charter based on the updates in VHA Directive 1167 dated November 4, 2024. Currently, the Charter is being routed for review and signature. As an initial step, ISIT committee members will review VHA Directive 1167 for understanding and to ensure facility compliance with outlined requirements. The ISIT Committee will report to the facility’s Comprehensive Environment of Care Committee (CEOC). The ISIT will meet quarterly. Attendance of ISIT members and the date of the last Mental Health Environment of Care Committee (MHEOCC) training will be documented in the ISIT minutes and reported to the CEOC Committee every quarter by the ISIT Chair.

Recommendation 12

The VA Central Western Massachusetts Healthcare System Chief of Staff ensures that the sally port inpatient unit doors are synchronized and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: March 2025

Director Comments

In September 2024, funding was secured to address responding to this finding and recommendation. The project started in November 2024 and is being tracked by the Capital

Asset and Execution Committee. Preliminary work to remove old access control hardware and preparation of cabling and electrical is underway. The facility is waiting on hardware from the manufacturer to complete the installation. The estimated time of arrival for the materials is February 2025. Once the materials arrive, installation is estimated to take a month. Currently, staff use manual keys, ensuring one door in the sally port remains locked before the other is opened. Additionally, unit rounding includes checks on entrance and exit doors. The door synchronization will remove the manual key entry in and out of the sally port and transition to card scanners. Staff training will be provided once the project is completed.

Recommendation 13

The VA Central Western Massachusetts Healthcare System Director uses VHA guidelines to develop facility-specific policy for the use of restraint chairs.

__X _Concur

_____Nonconcur

Target date for completion: March 2025

Director Comments

The facility's SOP 116-52, Use of Restraints, will be updated to include specific language for using restraint chairs. The SOP will be reviewed at a minimum at recertification, when there are changes to the governing document, or when there is a regulatory requirement for a more frequent review. Appropriate staff will be trained on the updated SOP. A review of unit-specific SOPs will also be incorporated into onboarding for new employees as part of a competency checklist. The Utilization Management (UM) staff will review clinical care activities, including the use of physical restraint practices, during chart reviews for the acute inpatient mental health unit to ensure ongoing compliance with SOP 116-52. The nurse manager or designee will review the use of restraints on the unit and communicate concerns to mental health and nursing leadership when appropriate. Any non-compliance with SOP 116-52 will be identified and discussed with the mental health nurse manager or designee. In addition to unit tracking, the use of restraints is reported quarterly to the Healthcare Delivery Council (HDC).

Recommendation 14

The VA Central Western Massachusetts Healthcare System Director ensures alignment between use of physical restraint policies and practices.

__X _Concur

_____Nonconcur

Target date for completion: March 2025

Director Comments

The facility's SOP 116-52, Use of Restraints, is being updated and expected to be published to the facility document control center within FY25Q2. Appropriate staff will be trained on the updated SOP. A review of unit-specific SOPs will also be incorporated into onboarding for new employees as part of a competency checklist. The Utilization Management (UM) staff will review clinical care activities, including the use of physical restraint practices, during chart reviews for the acute inpatient mental health unit to ensure ongoing compliance with SOP 116-52. The nurse manager or designee will review the use of restraints on the unit and communicate concerns to mental health and nursing leadership when appropriate. Any non-compliance with SOP 116-52 will be identified and discussed with the mental health nurse manager or designee. In addition to unit tracking, the use of restraints is reported quarterly to the Healthcare Delivery Council (HDC).

Recommendation 15

The VA Central Western Massachusetts Healthcare System Chief of Staff ensures mental health leaders update inpatient unit furniture to meet safety requirements and implements processes to reduce associated safety risks.

__X _Concur

_____Nonconcur

Target date for completion: June 2025

Director Comments

New weighted chairs were ordered and delivered. The chairs were placed in the inpatient unit. The Patient Safety Manager (PSM) and the Unit Nurse Manager re-evaluated the group room and interview room and determined that both rooms fully comply with the Mental Health Environment of Care Checklist (MHEOCC) standards and requirements outlined in VHA Directive 1167. The Interdisciplinary Safety Inspection Team (ISIT) Committee will follow the guidance outlined in VHA Directive 1167, dated November 4, 2024, to monitor for safety risks, including conducting twice-annual MHEOCC inspections. The ISIT will monitor and track MHEOCC compliance and report to the CEOC Committee every quarter.

Recommendation 16

The VA Central Western Massachusetts Healthcare System Chief of Staff ensures compliance with VHA requirements for Mental Health Environment of Care Checklist training completion.

__X _Concur

_____Nonconcur

Target date for completion: July 2025

Director Comments

The Chief of Quality Management (QM) will collaborate with Education, the Inpatient Mental Health Nurse Manager, the Patient Safety Manager, and the Administrative Officer to Mental Health Service Line to ensure that the VHA required MHEOCC training is assigned to all applicable staff in accordance with VHA Directive 1167. Education will then use the list of applicable facility staff to review course completion report from TMS and provide the report to the Patient Safety Officer. The Patient Safety Officer will work with corresponding supervisors to ensure compliance with training. The monthly compliance report will be reported to the Quality, Safety, and Value Council (QSVC).

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