US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the VA Salem Healthcare System in Virginia

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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 Salem VA Medical Center (facility), part of the VA Salem Healthcare System in Virginia.

The OIG evaluated acute inpatient mental health care across six domains. The OIG assessed processes in each of the domains and identified successes and challenges that affected the provision of the quality of care provided on the inpatient mental health unit (inpatient unit). The OIG issued 15 recommendations to facility leaders.

For background information on each domain, see appendix A.[1] For 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. The Chief of Staff and Associate Director for Patient Care Services supervised service directors and program chiefs, including the Chief of Mental Health and Chief Nurse of Mental Health, respectively. The Chief of Mental Health oversaw all mental health programs, including the inpatient unit. The OIG found the facility had a local Mental Health Executive Council chaired by the Chief of Mental Health that met within the expected time frames; however, required attendee participation could not be verified through documentation provided by facility staff. The Veterans Integrated Service Network (VISN) Chief Mental Health Officer provided consultation and support for inpatient unit operations within the network. The VISN Chief Mental Health Officer chaired the VISN Mental Health Executive Council, which is responsible for monitoring quality and access across the VISN's continuum of mental health care. OIG recommendation: • The Facility Director ensures the mental health executive council operates in accordance with Veterans Health Administration (VHA) requirements.

[1] 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.

Domain	OIG Summary
High Reliability Principles 	High reliability principles center on empowering workers to find and report issues before they 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. Staff and leaders' questionnaire results regarding psychological safety and performance were generally positive. Mental health leaders solicited staff and veteran input for process improvement, as required. The OIG made no recommendations in this domain.
Recovery-Oriented Principles 	Recovery-oriented mental health treatment is personalized to a veteran's abilities, resources, 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 local recovery coordinator was integrated into recovery-oriented activities on the inpatient unit. Mental health leaders met the requirement to have a plan across the mental health care continuum for continued transformation to recovery-oriented services. The OIG found inpatient unit staff provided a minimum of four hours of recovery-oriented, interdisciplinary programming on weekdays, but gave conflicting reasons for not meeting the required programming hours on weekends. Inpatient unit staff introduced veterans to recovery principles through an orientation handbook and programming. The inpatient unit had several aspects of a recovery-oriented environment that met VHA standards for a safe, hopeful, and healing environment, including designated outdoor spaces for veterans. OIG recommendation: • The Chief of Mental Health identifies barriers and implements processes to provide a minimum of four hours of recovery-oriented, interdisciplinary programming on weekends on the inpatient mental health unit and monitors for compliance.
Clinical Care Coordination 	Care coordination, which involves intentionally sharing a veteran's information among all concerned with their care 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. The facility had a standard operating procedure for admission that included guidance for interfacility transfers of veterans on an involuntary hold to the inpatient unit for mental health treatment. The facility did not have formal processes to monitor and track compliance with involuntary commitment state laws.

Domain	OIG Summary
	The facility's written guidance for the transition of care following inpatient unit discharge met 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 develops and implements processes to monitor and track compliance with involuntary commitment requirements. • The Chief of Staff ensures timely documentation of informed consent 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 are written in easy-to-understand language and include the purpose for each medication.
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 that staff did not consistently complete the Columbia-Suicide Severity Rating Scale within the 24 hours before discharge; review safety plans prior to discharge; and address ways to make the veteran's environment safer from potentially lethal means. Additionally, staff did not complete lethal means safety and suicide risk trainings as required. OIG recommendations: • The Chief of Staff directs staff to complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge and monitors for compliance. • The Chief of Staff directs staff to complete or review safety plans with veterans prior to discharge and monitors for compliance. • The Chief of Staff directs staff to address ways to make the veteran's environment safer from potentially lethal means in safety plans and monitors for compliance. • The Facility Director directs staff to comply with Lethal Means Safety training and monitors for compliance. • The Facility Director directs staff to comply with Skills Training for Evaluation and Management of Suicide training and monitors for compliance.

Domain	OIG Summary
	• The Facility Director directs staff to comply with VA S.A.V.E. training 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 Interdisciplinary Safety Inspection Team meeting minutes were retained, they did not include a record of attendance; therefore, the OIG could not determine whether the required members were present or if they had completed Mental Health Environment of Care Checklist training. The OIG found beds and chairs in the geriatric section, and a bathroom sink in an unavailable veteran bedroom on the inpatient unit, that posed ligature risks. Although the facility had a local policy on the use of restraints, it did not include the use of restraint chairs. OIG recommendations: • The Facility Director ensures Interdisciplinary Safety Inspection Team requirements are met and monitors for compliance. • The Facility Director implements processes to ensure the Interdisciplinary Safety Inspection Team applies Mental Health Environment of Care Checklist standards to all sections on the inpatient mental health unit and monitors for compliance. • The Facility Director uses VHA guidelines to develop a facility-specific policy for the use of restraint chairs. • The Facility Director directs staff to comply with Mental Health Environment of Care Checklist training requirements and monitors for compliance.

VA Comments and OIG Response

During VHA's review of an OIG draft report, it is usual practice for VHA to submit comments for consideration and discussion.[2] For this report, VHA provided the OIG comments in the Facility Director memorandum during the draft phase. The OIG considered and reviewed the comments. Based on the review, minor changes were made to the report for clarification, but no changes were made to OIG recommendations. The Veterans Integrated Service Network and VA Salem Healthcare System Directors concurred with the recommendations and provided acceptable action plans (see appendixes D and E). The OIG will follow up on the planned actions until they are completed.

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in the role of Acting Assistant Inspector General,
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[2] VA OIG Directive 306, *Comments to Draft Reports*, April 10, 2024, amended April 24, 2019.

Contents

Abbreviations

C-SSRS	Columbia-Suicide Severity Rating Scale
CMHO	Chief Mental Health Officer
EHR	electronic health record
FY	fiscal year
HCS	healthcare 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
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 Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care through 1,321 healthcare facilities to over nine million enrolled veterans.[1] The OIG established the Mental Health Inspection Program to regularly evaluate VHA's continuum of mental healthcare services. The OIG conducted an inspection from August 5 through September 13, 2024, to evaluate acute inpatient mental health care provided at the Salem VA Medical Center (facility), part of the VA Salem Healthcare System in Virginia.[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 April 30, 2024, https://www.va.gov/health/aboutvha.asp.

[2] 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.

[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 Directive 1160.01. In this report, the OIG refers to veterans instead of patients to support recovery-oriented language.

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

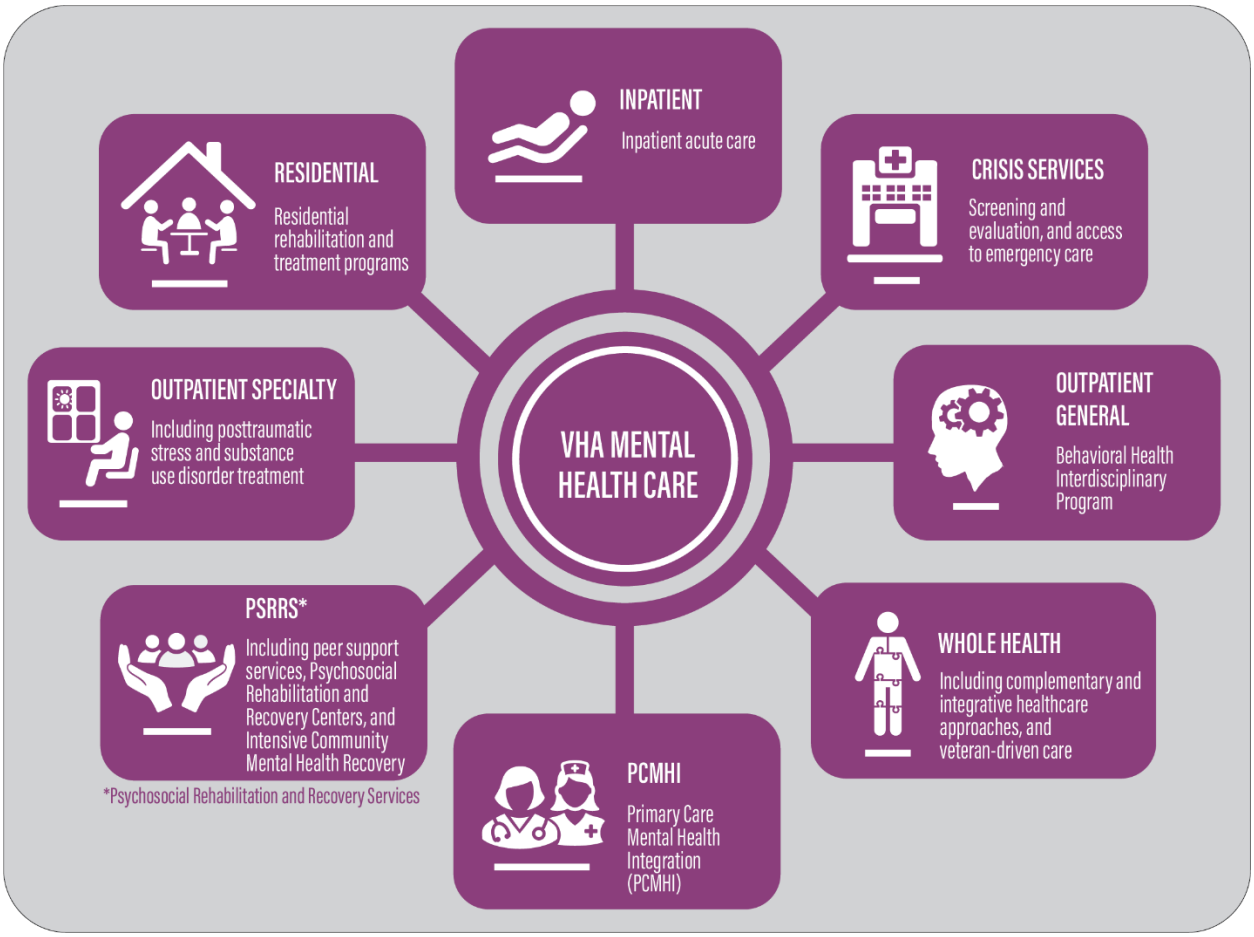

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163.

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.[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 domains: leadership and organizational culture, high reliability principles,

[6] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023.

[7] 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 3, 2024, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf; 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.)

recovery-oriented principles, clinical care coordination, suicide prevention, and safety. For background information and related requirements, refer to appendix A and appendix B.[8]

About the VA Salem HCS

The VA Salem HCS, part of Veterans Integrated Service Network (VISN) 6, provides acute inpatient mental health care at the facility and operates five community-based outpatient clinics in Virginia.[9]

In FY 2023, the facility provided health care to 32,770 veterans, with 10,359 receiving mental health care. During this same time frame, the facility maintained an approximate average daily census of 17 in the acute mental health inpatient unit (inpatient unit), with staff caring for 290 veterans.[10] During the same FY, facility staff submitted one consult for inpatient mental health care in the community.

At the time of the inspection, the inpatient unit was divided into acute, geriatric, women's, and general sections. The unit had 36 authorized beds; however, 13 beds were designated as unavailable since July 2021 as discussed below.

[8] 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.

[9] VA administers healthcare services through a nationwide network of 18 regional systems referred to as VISNs. "Veterans Integrated Services Networks (VISNs)," VHA, accessed November 18, 2024, https://www.va.gov/HEALTH/visns.asp; The five community-based outpatient clinics are in the cities of Danville, Lynchburg, Staunton, Tazewell, and Wytheville.

[10] The average daily census was rounded from 16.8.

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] 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.[12]

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

Leadership Structure

At the time of the OIG's inspection, the facility's executive leadership team consisted of the Executive Director, Assistant Director, Associate Director, Chief of Staff, Deputy Chief of Staff, and Associate Director for Patient and Nursing Services.[13] The Chief of Staff supervised the Chief of Mental Health, and the Associate Director for Patient and Nursing Services supervised the Chief Nurse of Mental Health. The Chief of Mental Health served as the required facility mental health lead and oversaw all mental health programs, including the inpatient unit (see appendix C for relevant organizational structure).[14]

The Chief of Mental Health, who had served in the role since July 1991, supervised the inpatient unit psychiatrists. The inpatient unit nurse manager supervised nursing staff. Social workers and psychologists on the inpatient unit were supervised by their respective discipline leads. The facility had an inpatient mental health program manager (program manager), as required by VHA.[15] The program manager also functioned as the inpatient medical director, with oversight of the inpatient unit operations, but did not have formal supervisory authority over unit staff.

[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] VA, *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 website is not publicly accessible).

[13] "Leadership," VA, accessed November 25, 2024, https://www.va.gov/salem-health-care/about-us/leadership/.

[14] VHA Directive 1160.01.

[15] VHA Directive 1160.06.

VHA requires HCSs to establish a mental health executive council (MHEC) to ensure quality mental health care is delivered and includes treatment that is responsive to veteran preferences.[16] The facility MHEC was chaired by the Chief of Mental Health and met within the expected time frames.[17] The OIG could not determine from the meeting minutes provided whether required attendees, including designated inpatient unit staff and a veteran, were present during the meetings.[18] Without participation from key stakeholders, the facility's MHEC may be less equipped to identify and address inpatient unit care quality concerns.

Inpatient Unit Staffing

The OIG learned that, in July 2021, facility leaders designated 13 beds on the inpatient unit as unavailable due to staff recruitment challenges. At the time of the inspection, the inpatient nurse manager stated that staffing was sufficient to provide care for veterans using the remaining 23 beds. July 2023 documentation described mental health leaders' plan to increase staffing levels and resume use of the 13 beds. At the time of this inspection, the beds remained unavailable and mental health leaders described continued challenges with staffing. (For information on current staffing levels, see table C.1 in appendix C.)

VISN Oversight

Documentation showed the VISN MHEC included participants, such as each of the VISN's HCS chief mental health leads, as required.[19] The VISN Chief Mental Health Officer (CMHO), who chaired the VISN MHEC, provided an indirect consultative role with the facility's mental health staff and operations (see figure 2). The VISN CMHO reported mechanisms of oversight such as monthly MHEC meetings, site visits, and biannual meetings with mental health leads from each HCS.

The VISN CMHO also reported monitoring processes to ensure veterans had timely access to care, such as reviewing inpatient unit data at a monthly operations meeting. Facility leaders and the VISN CMHO described having bidirectional communication that was consultative.

[16] VHA Directive 1160.01.

[17] VHA Directive 1160.01. The facility refers to its MHEC as the Integrated Clinical Community Mental Health Council.

[18] VHA Directive 1160.01.

[19] VHA Directive 1160.01. VISN 6 refers to its MHEC as the Mental Health Integrated Clinical Community Sub-Committee.

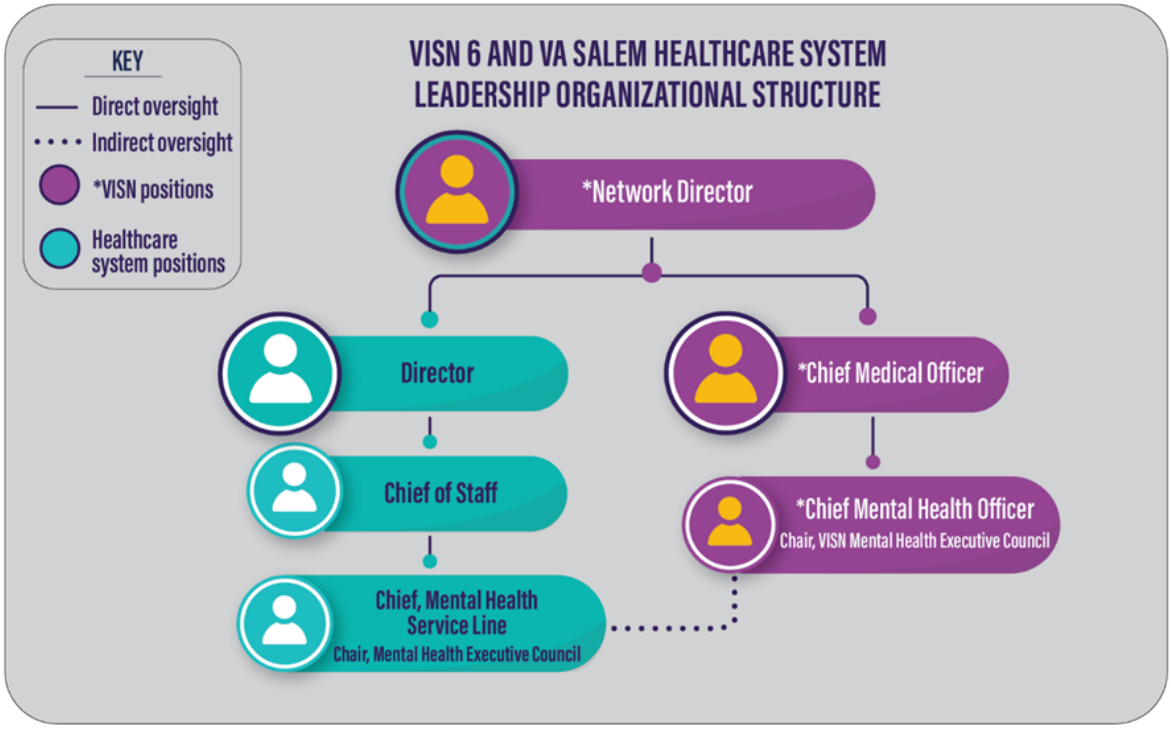

Figure 2. *VISN 6 and facility leadership organizational structure.*
Source: OIG analysis of interviews and facility documents received from August 5, 2024, through March 7, 2025; VHA Directive 1160.06; and VHA Directive 1160.01.
Note: This figure represents the facility and VISN leadership positions relevant to this review.

Recommendation

1. The Facility Director ensures the mental health executive council 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."[20] 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."[21]

The OIG disseminated a questionnaire to evaluate staff's and leaders' 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.[22]

[20] 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/.

[21] "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.

[22] 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 United States. "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

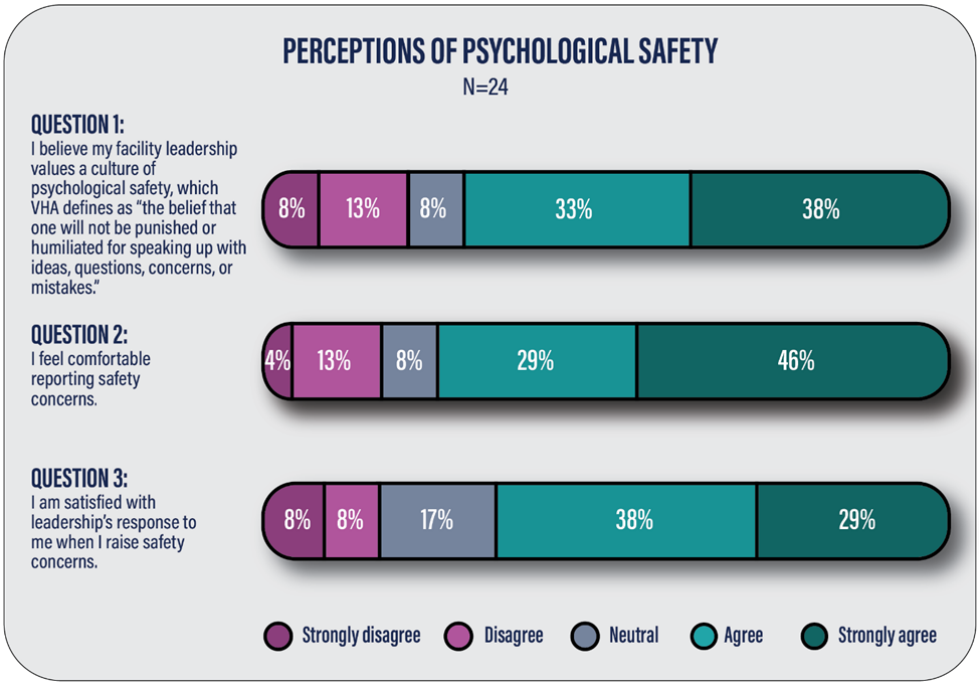

Figure 3. *Mental health staff and leader perceptions of psychological safety.*
Source: OIG analysis of staff questionnaire responses. VA, "VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)," September 2022, updated September 2024.
Note: The order of 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

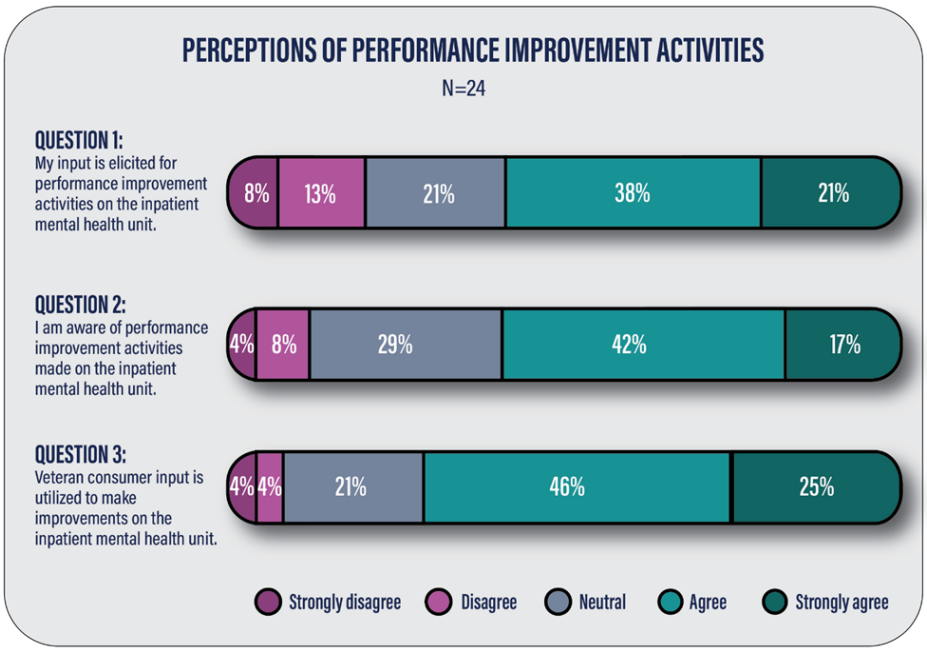

Figure 4. *Mental health staff and leaders' perceptions of performance improvement activities.*
Source: OIG analysis of staff questionnaire responses.
Note: Values may not add to 100 percent due to rounding. The order of the colors in the key corresponds to the order in the scales above.

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).

The inpatient nurse manager described collecting inpatient unit staff input, as required, through huddles, team meetings, and a suggestion box. As required, mental health leaders reported having processes in place to solicit veteran input through the veteran's council, comment cards prior to discharge, and other mechanisms.[23] Mental health leaders described staff collecting comment cards, reviewing veteran input quarterly, and incorporating feedback into process improvements; for example, staff names were highlighted in the inpatient unit handbook for veterans to easily identify treatment team members.

The OIG made no recommendations in this domain.

[23] VHA Directive 1160.01; The Joint Commission, *Standards Manual e-dition*, PI.04.01.01, January 2024; A facility document describes the veteran's council as a group of veterans, family members, and community stakeholders "who come together to provide a consumer point of view on programs, policies, and other matters that affect mental health service delivery." VA Salem Healthcare System, "Veterans Mental Health Council" brochure.

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on an individual's "strengths, talents, coping abilities, resources, and inherent values."[24] 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.[25]

The OIG examined aspects of leadership, programming, and the physical care environment to evaluate the facility's integration of recovery-oriented principles on the inpatient unit, as required (see appendix B for methodology).[26]

Leadership

VHA expects the program manager "to coordinate and promote consistent, sustained, high-quality therapeutic programming" on the inpatient unit.[27] The Chief of Mental Health reported the program manager coordinated with inpatient unit staff to ensure therapeutic programming.

The facility leaders met the VHA requirement to have a full-time local recovery coordinator (LRC) and a plan for continued transformation to recovery-oriented services.[28]

The LRC reported having responsibilities within and beyond the inpatient unit. The LRC described conducting recovery-oriented activities on the inpatient unit such as group facilitation, staff training, and veteran comment card review. The LRC also reported completing an annual observation of the physical environment, the veteran experience, and group programming; then reviewing observations with mental health leaders.

[24] "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.

[25] "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.

[26] VHA Directive 1160.06.

[27] VHA Directive 1160.06. The program manager is a leadership position that can be filled by providers in any of the full range of core mental health disciplines.

[28] 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.)

Recovery-Oriented Programming

The OIG found the inpatient unit staff offered at least four hours of recovery-oriented interdisciplinary programming on weekdays, as required; however, staff reported not having processes in place to ensure coverage during staff absences.[29]

The OIG found inpatient unit staff did not offer at least four hours of programming on weekends, as required.[30] Leaders provided the OIG with conflicting information regarding staffing as a reason for limited weekend programming. The OIG would expect implementation of processes to avoid service disruption and ensure compliance with programming requirements.

Inpatient unit staff provided orientation on recovery-oriented care to veterans at admission, as required; for example, an orientation handbook included recovery-oriented concepts and language.[31]

Physical Environment

The OIG found that the inpatient unit had several aspects of a recovery-oriented environment that met VHA standards for a safe, hopeful, and healing setting.[32] In general, the inpatient unit was clean and had recovery-oriented artwork and warm paint colors. Natural lighting included skylights in two of the day rooms (see figure 5). The facility had outdoor areas designated for inpatient unit veterans.[33] Additionally, the unit had a dedicated visitation room for veterans and visitors.

[29] VHA Directive 1160.06.

[30] VHA Directive 1160.06.

[31] 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 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 into two offices operating independently as the Office of Mental Health and the Office of Suicide Prevention, with staff realigned to the respective offices.

[32] 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.)

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

Figure 5. *Day room (with natural light and recovery-oriented artwork) and secure outdoor space. Source: Photos of the facility's inpatient unit taken by OIG staff, September 3, 2024.*

Recommendation

2. The Chief of Mental Health identifies barriers and implements processes to provide a minimum of four hours of recovery-oriented, interdisciplinary programming on weekends on the inpatient mental health unit and monitors for compliance.

For a detailed action plan, see appendix E.

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.[34] For veterans with "complex health and social needs, care coordination is crucial for improving access to services, clinical outcomes, and care experiences."[35] 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.[36]

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 "access to mental health evaluation and clinically appropriate treatment provided in a safe and secure environment."[37] The OIG found facility leaders established a standard operating procedure for the inpatient unit admission processes including interfacility transfers, as required by VHA.[38]

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

[35] 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 14, 2023), https://www.doi.org/10.3389/frhs.2023.1211577.

[36] VHA Directive 1160.06.

[37] VHA Directive 1160.01; VHA Directive 1160.06.

[38] 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 clarified the requirement to include procedures and processes for facility staff responsible for admission of veterans to the inpatient mental health units; Salem VA Medical Center SOP 658-116-MH-IAP-12, "Standard Operating Procedure for Admission Policy to Acute Inpatient Mental Health," January 9, 2024; 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."

Involuntary Hospitalization and Treatment

The OIG found a facility policy outlined the processes for involuntary hospitalization admissions but did not address monitoring and tracking of ongoing compliance with state laws.[43] Mental health leaders described an informal process for monitoring and tracking veterans' legal (voluntary or involuntary) commitment statuses. The absence of written processes for monitoring compliance with state law may result in staff confusion about veterans' legal statuses and could contribute to illegal hospitalization.

VHA policy requires documentation of voluntary or involuntary legal status within 24 hours of admission to the inpatient unit. The OIG found that facility staff documented legal status within the required time frame in 98 percent of reviewed electronic health records (EHRs).[44]

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.[39]

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."[40]

Standards and procedures for civil commitment are provided by state law and vary by state.[41] VHA requires that leaders consult with the Office of General Counsel, as necessary, to ensure that processes are consistent with applicable laws.[42]

Treatment Planning

In alignment with VHA requirements, the facility's 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

[39] Leslie C. Hedman et al., "State Laws on Emergency Holds for Mental Health Stabilization," *Psychiatric Services* 67, no. 5 (May 2016): 529–535, https://psychiatryonline.org/doi/10.1176/appi.ps.201500205?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed.

[40] "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.

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

[42] VHA Directive 1160.01.

[43] Salem VA Health Care System MCP 658-118-MH-IAP-09, "Detainment and Commitment Procedures," December 1, 2022.

[44] 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.

timelines, the standard operating procedure included guidance to develop an interdisciplinary mental health treatment plan within five days of admission.[45]

The OIG found 96 percent of reviewed EHRs included documentation that staff offered or involved veterans in the development of treatment plans. In addition, 96 percent of EHRs indicated the interdisciplinary treatment team was involved in treatment planning.[46]

Medication Treatment

VHA requires a discussion between prescribers and veterans on the risks and benefits of medication treatment.[47] The OIG found 34 percent of EHRs reviewed included prescriber documentation of the risks and benefits of medication treatment as part of the informed consent discussion. When prescribers do not provide the opportunity to discuss the risks and benefits of medication use, veterans may be deprived of the ability to make informed decisions.

Discharge Planning

The OIG found facility leaders established written guidance on coordination of care processes for veterans transitioning from inpatient care, per VHA requirements.[48] The guidance outlined processes for outpatient follow-up appointments and discharge coordination that involved the veteran, the interdisciplinary treatment team, and relevant outpatient providers.[49]

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[45] 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; Salem VA Health Care System SOP 658-116-03, "Treatment Plans in Mental Health," March 8, 2023.

[46] Acting Deputy Under Secretary for Health for Operations and Management (10N), "Mental Health Treatment Planning and Software Tools," memorandum; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[47] 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.

[48] VHA Directive 1160.01; Salem VA Healthcare System SOP 658-118-MHC-09, "Mental Health Service Line Follow-Up Care and Appointments for Patients Discharged from Acute Psychiatry and Domiciliary Units," August 8, 2023; Salem VA Healthcare System Memorandum 658-11-20, "Discharges From Inpatient Care," August 21, 2019.

[49] Salem VA Healthcare System SOP 658-118-MHC-09, "Mental Health Service Line Follow-Up Care and Appointments for Patients Discharged from Acute Psychiatry and Domiciliary Units"; Salem VA Healthcare System Memorandum 658-11-20, "Discharges From Inpatient Care."

The OIG found 100 percent of reviewed EHRs reflected documentation of scheduled outpatient mental health follow-up appointments prior to the veteran's discharge.[50] Mental health leaders and inpatient unit staff reported coordinating discharges with outpatient mental health providers and mental health treatment coordinators.

Mental health leaders and inpatient unit staff reported challenges with scheduling appointments for veterans receiving post-discharge care at other VA HCSs. However, staff indicated having available resources, such as a traveling veteran coordinator, to assist with discharges to other VA HCSs.[51]

The OIG determined 96 percent of reviewed EHRs included documentation of the discharge summary within two business days of the veteran's discharge and 98 percent included documentation the veteran was offered a copy of the discharge instructions, as required.[52] Additionally, the OIG found 94 percent had discharge instructions that included the veterans' outpatient mental health follow-up appointments in easy-to-understand language (see figure 6).[53]

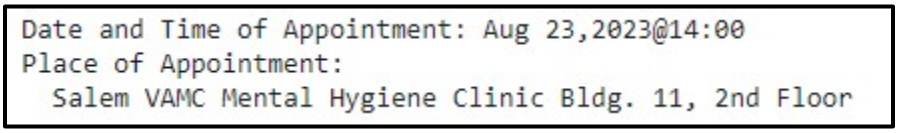

Figure 6. *Example from discharge instructions with appointment information with easy-to-understand language.*
Source: OIG review of veterans' EHRs.

The OIG found that 100 percent of reviewed EHRs included a required medication list in discharge instructions; however, only 49 percent identified the reason for prescribing the medication.[54]

[50] 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 policies contain similar language related to scheduling outpatient mental health follow-up appointments; The handbook was in place during the time frame of the veterans' episode(s) of care in FY 2023.

[51] A traveling veteran coordinator "coordinates necessary or ongoing health care" for veterans at their preferred VA HCS. VHA Handbook 1101.11(4), *Coordinated Care for Traveling Veterans,* April 22, 2015.

[52] VHA Health Information Management Program Office, *Health Record Documentation Program Guide Version 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; 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 handbook was in place during the time frame of the veterans' episode(s) of care in FY 2023.

[53] VHA Handbook 1160.06; VHA Directive 1160.06; The handbook was in place during the time frame of the veterans' episode(s) of care in FY 2023.

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

Additionally, 63 percent of the EHRs had discharge instructions free of medical abbreviations that could be difficult to understand by a nonmedically trained individual (see figure 7).[55] Accurate and easy-to-understand discharge instructions could potentially prevent medication errors at home following veterans' hospitalization.[56]

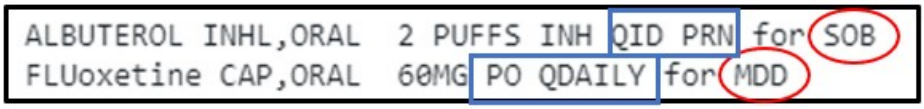

Figure 7. *Example of discharge instructions, including Latin abbreviations (outlined in blue) and medical abbreviations (circled in red), provided to a veteran.*
Source: OIG review of veterans' EHRs.
Note: The Latin terms qid, prn, po, and qdaily are used to describe how and when medications should be taken. The OIG recognizes the medical abbreviations SOB as shortness of breath and MDD as Major Depressive Disorder. Terry L. Schwinghammer et al., "Part 1: Common Medical Abbreviations," Appendix C in Schwinghammer's Pharmacotherapy Casebook: A Patient-Focused Approach*, 12th ed, (McGraw Hill Education, 2023), accessed June 26, 2024, https://accesspharmacy.mhmedical.com/content.aspx?bookid=3312&sectionid=276027121.*

Recommendations

3. The Facility Director develops and implements processes to monitor and track compliance with involuntary commitment requirements.
4. The Chief of Staff ensures timely documentation of informed consent discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications and monitors for compliance.
5. The Chief of Staff ensures discharge instructions for veterans are written in easy-to-understand language and include the purpose for each medication.

For detailed action plans, see appendix E.

[55] 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* (McGraw Hill Education, 2016), https://accesspharmacy.mhmedical.com/content.aspx?bookid=1810&sectionid=124489535.
[56] 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.[57]

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." [58] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors. [59]

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 66 percent of reviewed EHRs included evidence of a completed Columbia-Suicide Severity Rating Scale (C-SSRS).[60] Forty-four percent of the EHRs had evidence that a C-SSRS was completed within the 24 hours before discharge, as required.[61] Failure to complete suicide risk assessments 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.

Safety Planning

The OIG found that inpatient staff did not consistently complete or review safety plans with veterans prior to discharge. Most completed or reviewed safety plans included the required elements the OIG selected for review. The OIG identified staff were deficient in addressing ways to make veterans' environments safer from potentially lethal means, including safety considerations beyond access to firearms and opioids (see figure 8).[62]

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

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

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

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

[61] 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. The OIG considered EHRs compliant if C-SSRS documentation was completed within 24 hours of discharge or on the calendar date of discharge; The OIG used 90 percent as the expected level of compliance for record review.

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

Meeting safety plan requirements prior to discharge, including the identification of all potential lethal means in the environment, may reduce the risk of veteran harm.[63]

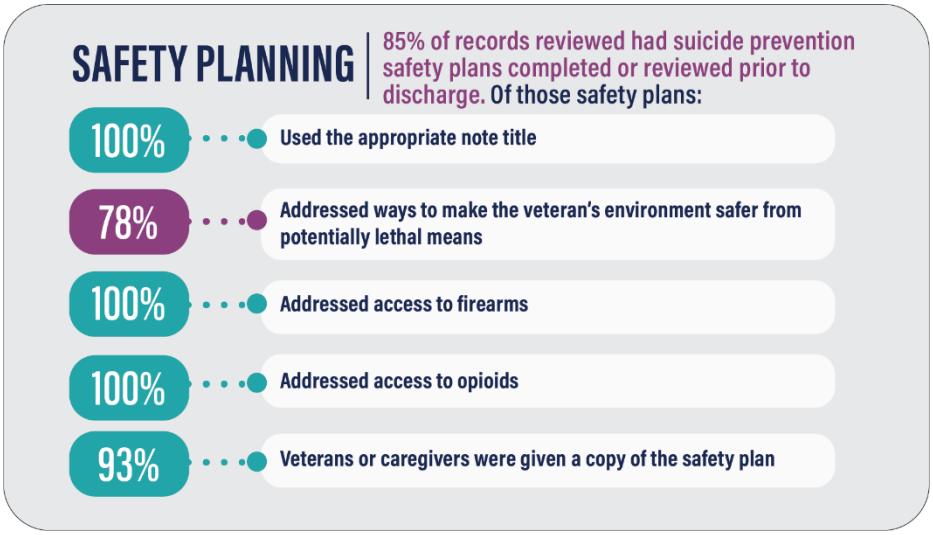

Figure 8. *Facility staff's compliance with VHA safety planning guidance.*
Source: OIG review of veterans' EHRs.
Note: The OIG used a 90 percent compliance rate for elements reviewed.

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.[64] Lethal Means Safety training provides guidance on how to work with veterans and their support systems to reduce suicide risk, which includes "firearm and medication safe storage practices."[65]

[63] VA, *VA Safety Planning Intervention Manual*.

[64] 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 acronym for VA S.A.V.E. acronym as: signs of suicide, asking about suicide, validating feelings, and encouraging help and expediting treatment; Skills Training for Evaluation and Management of Suicide (STEMS) is a suicide risk and intervention training for VHA health care providers.

[65] 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.

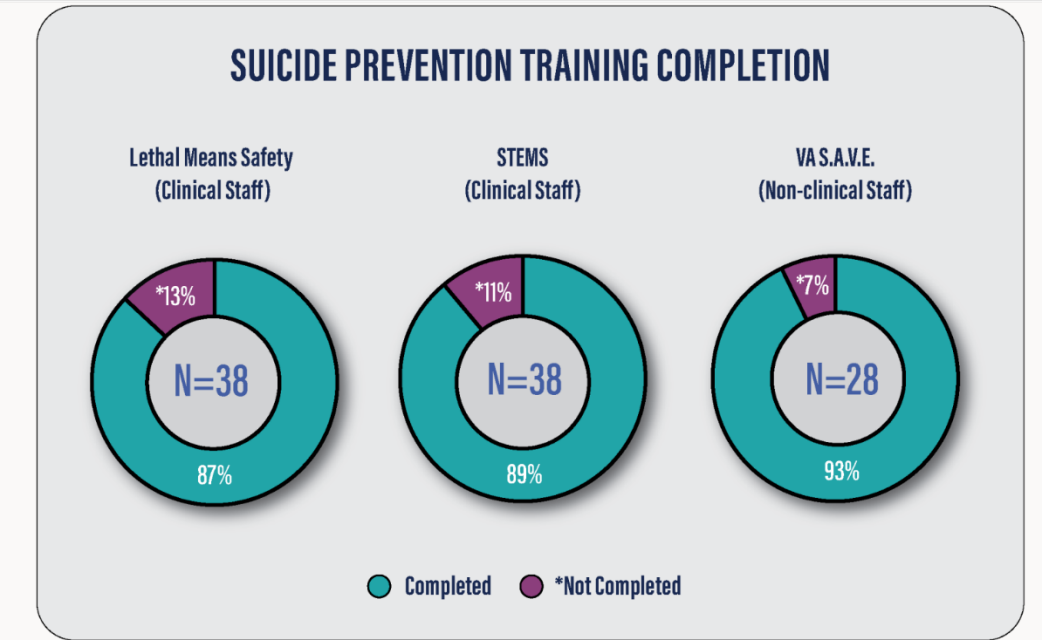

Figure 9. *Inpatient unit staff completion of mandatory suicide prevention training.*
Source: OIG document review of clinical and nonclinical staff training certificates.
Note: The OIG evaluated completion of STEMS and VA S.A.V.E. trainings during the time frame of August 5, 2023, through August 5, 2024. The OIG evaluated whether clinical staff completed Lethal Means Safety training once during the clinical staff's employment.

The OIG found facility staff were noncompliant with the required Lethal Means Safety, STEMS, and VA S.A.V.E trainings (see figure 9).[66] When staff fail to timely complete required suicide risk trainings, they may miss critical signs of suicide risk and be unaware of resources and interventions to assist in keeping veterans safe.

Recommendations

6. The Chief of Staff directs staff to complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge and monitors for compliance.
7. The Chief of Staff directs staff to complete or review safety plans with veterans prior to discharge and monitors for compliance.
8. The Chief of Staff directs staff to address ways to make the veteran's environment safer from potentially lethal means in safety plans and monitors for compliance.

[66] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Lethal Means Safety (LMS) Education and Counseling," memorandum; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Lethal Means Safety (LMS) Education and Counseling," memorandum. Both memoranda have similar language related to Lethal Means Safety Education and Counseling training requirements; VHA Directive 1071(1).

9. The Facility Director directs staff to comply with Lethal Means Safety training and monitors for compliance.
10. The Facility Director directs staff to comply with Skills Training for Evaluation and Management of Suicide training and monitors for compliance.
11. The Facility Director directs staff to comply with VA S.A.V.E. training 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.[67] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[68]

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 Interdisciplinary Safety Inspection Team (ISIT), comprised of both mental health and other facility staff, is responsible for conducting environment of care inspections and monitoring compliance with the Mental Health Environment of Care Checklist (MHEOCC).[69] The MHEOCC is used to "identify and abate suicide hazards" on the inpatient mental health unit (see figure 10).[70]

Although ISIT meeting minutes were retained, they did not include the required record of attendance; therefore, the OIG could not determine whether expected members were present.[71] Failure of facility leaders to ensure the ISIT meets all requirements may result in an inability to identify and correct environmental hazards.

During a physical inspection of randomized MHEOCC safety elements, the OIG found the inpatient unit had ceilings constructed of solid materials, sinks were mounted to the wall or floor, and under-sink storage was secured. Additionally, the OIG observed medical equipment was in direct line of sight of nursing staff and interior bathroom doors were inspected semiannually, per VHA requirements.[72]

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[67] VHA Directive 1160.06.

[68] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017, rescinded and replaced by VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, November 4, 2024. Unless otherwise specified, the two directives contain the same or similar language related to the inpatient mental health environment and inspections.

[69] VHA Directive 1167, May 12, 2017.

[70] VHA Directive 1167, May 12, 2017; 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."

[71] VHA Directive 1167, May 12, 2017.

[72] VHA Directive 1167, May 12, 2017.

The OIG inspected bedrooms that were unavailable for veteran care at the time of the inspection and observed a bathroom sink, located in an unavailable bedroom, which posed a ligature risk.[73] The OIG would expect that facility leaders ensure the bathrooms meet MHEOCC standards prior to the bedrooms becoming available for veteran care.

Figure 10. *MHEOCC categories.*
Source: MHEOCC and VHA Directive 1167.

On the geriatric section of the inpatient unit, which was being used for veteran care at the time of the inspection, the OIG observed hospital beds and chairs with ligature risks. The OIG would expect all sections on an inpatient mental health unit to be in compliance with MHEOCC requirements. At the request of the OIG, facility leaders provided a risk mitigation plan to address the safety risks identified during the OIG's physical inspection of the unit.

Per VHA, inpatient units must have a MHEOCC-compliant room available for physical restraint.[74] The unit met this requirement; however, staff reported primarily using a restraint chair when physical restraint was needed. The OIG assessed for written processes and guidance on the use of restraint chairs. The facility standard operating procedure for seclusion and restraint did not specify processes for use of a restraint chair. The OIG would have expected the facility to have a policy outlining use of restraint chairs, in alignment with expectations expressed by the National Director, Inpatient Mental Health Services.[75]

[73] "Special Report: Suicide Prevention in Health Care Settings," The Joint Commission *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."

[74] VHA Directive 1106.06. The directive specifies the room used for physical restraint must be MHEOCC-compliant.

[75] In August 2024, the National Director, Inpatient Mental Health Services informed the OIG of the expectation for facilities to have a standard operating procedure for the use of restraint chairs. 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. For more information, see VA OIG, *Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds*, Report No. 24-01859-62, March 5, 2025.

The facility standard operating procedure for seclusion and restraint did not specify processes for use of a restraint chair.

Training

VHA requires training on environmental hazards and staff orientation on the "content and proper use" of the MHEOCC and the Patient Safety Assessment Tool to identify and correct risks. Each of the inpatient MHEOCC categories listed above includes multiple individual items that staff must evaluate during semiannual inspections (see figure 10).[76]

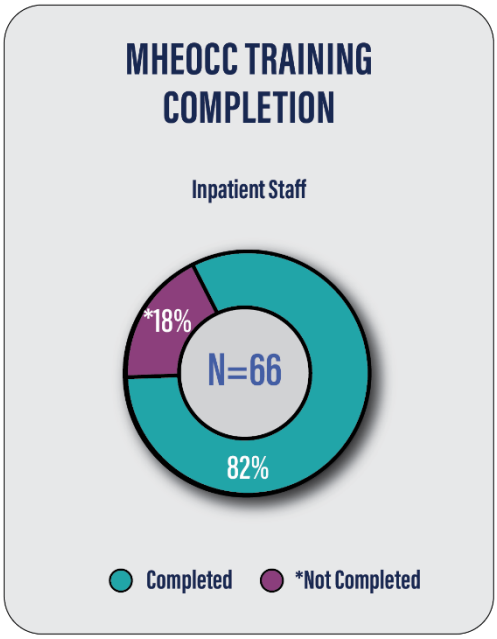

Figure 11. *MHEOCC training completion, August 5, 2023–August 5, 2024. Source: OIG document review of staff training certificates.*

The OIG found inpatient unit staff were noncompliant with VHA required annual MHEOCC training (see figure 11).[77] Additionally, due to the lack of documented attendance in the ISIT meeting minutes, the OIG could not determine whether ISIT members completed the required MHEOCC training.[78] Completing annual training on environmental hazards and VHA safety requirements may reduce safety risks for veterans and staff on the inpatient unit.

[76] VHA Directive 1167, May 12, 2017.

[77] VHA Directive 1167, May 12, 2017; VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, updated December 2022.

[78] VHA Directive 1167, May 12, 2017.

Recommendations

12. The Facility Director ensures Interdisciplinary Safety Inspection Team requirements are met and monitors for compliance.
13. The Facility Director implements processes to ensure the Interdisciplinary Safety Inspection Team applies Mental Health Environment of Care Checklist standards to all sections on the inpatient mental health unit and monitors for compliance.
14. The Facility Director uses VHA guidelines to develop a facility-specific policy for the use of restraint chairs.
15. The Facility Director directs staff to comply with Mental Health Environment of Care Checklist training requirements and monitors for compliance.

For detailed action plans, see appendix E.

Conclusion

The VA Salem Healthcare System demonstrated compliance with some of the VHA inpatient mental health unit requirements reviewed in this inspection. The facility had an MHEC, which is responsible for overseeing the quality of mental health care; however, the OIG could not determine whether required attendees were present during the meetings. The VISN had an MHEC responsible for monitoring quality and access across the VISN's continuum of mental health care.

Most staff and leaders responded positively to questions about psychological safety and continuous process improvement.

The facility had a plan for continued transformation to recovery-oriented services and treatment planning requirements. Staff provided the requisite amount of interdisciplinary programming on weekdays but did not provide required weekend programming. The environment was recovery-oriented and included, for example, skylights, artwork, and multiple outdoor spaces.

Facility leaders established a standard operating procedure for admissions to the inpatient unit that included guidance for interfacility transfers. However, facility leaders did not have formal processes to monitor and track compliance with state involuntary commitment laws.

EHR reviews indicated that most veterans and the interdisciplinary treatment team were involved in treatment planning. Most reviewed EHRs did not have evidence of the required informed consent discussion with veterans on the risks and benefits of prescribed medications. Discharge instructions did not consistently include the reason for prescribed medications; many discharge instructions had medical abbreviations that could be difficult to understand.

Some EHRs did not include evidence of timely suicide risk screening or documentation of completed or reviewed safety plans prior to discharge. Further, some of the reviewed safety plans did not address ways to make the environment safer from potentially lethal means beyond access to firearms and opioids. Multiple staff did not complete MHEOCC or suicide prevention training requirements.

The OIG could not determine whether the ISIT meetings included the required members, or if ISIT staff completed required MHEOCC training. The OIG observed ligature risks on the inpatient unit on some bathroom sinks, hospital beds, and chairs. Facility leaders provided a risk mitigation plan, at the request of the OIG, to address these safety risks.

The OIG issued 15 recommendations to facility leaders. 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 inpatient mental health care is appropriate, the veteran should be immediately admitted to ensure safety and stabilization.[79]

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.[80] 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 associate director of patient care services, should ensure that inpatient units have adequate staffing to establish interdisciplinary teams, provide services, and fully implement program requirements.[81]

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. 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.[82] 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."[83]

[79] VHA Directive 1160.06.
[80] VHA Directive 1160.06.
[81] VHA Directive 1160.06.
[82] VHA Directive 1160.01.
[83] VHA Directive 1160.01.

The VISN Director is responsible for ensuring that 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 state laws governing inpatient mental health care, hospital accreditation regulations, and VISN and facility level procedures."[84]

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."[85] 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.[86]

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.[87] In addition, each HCS is required to have an LRC who spends 75 percent of their time ensuring that 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 recovery transformation plan that must be updated every three years.[88]

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.[89] "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."[90] Peer support staff must be available for veterans when clinically indicated and may serve as members of an interdisciplinary treatment team.[91]

[84] VHA Directive 1160.06.

[85] "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.)

[86] VHA Directive 1160.01.

[87] VHA Directive 1160.06.

[88] VHA Directive 1163.

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

[90] VHA Directive 1163.

[91] 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 process improvement into care delivery.[92] A high reliability organization focuses on patient safety, "zero harm," and continual process improvement.[93] 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.[94]

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."[95]

VHA requires adherence to principles of veteran-centered, recovery-oriented mental health care and ongoing evaluation of services provided on the inpatient unit.[96] 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.[97] 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.[98]

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.[99] VHA requires inpatient units to have an interdisciplinary treatment team composed of individuals who are

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[92] VA, "VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)," September 2022, updated September 2024. Both versions contain similar language related to psychological safety and continuous process improvement.

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

[94] VA, "VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)"; VA, "VHA High Reliability Organization (HRO) Reference Guide," April 2023, updated September 2024. Both versions contain similar language related to continuous process improvement.

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

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

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

[98] VHA Directive 1160.06.

[99] 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."

responsible for the assessment, planning, and implementation of a veteran's care. An interdisciplinary approach is critical to ensure comprehensive, coordinated, and holistic care.[100]

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.[101] When treatment is not available within the HCS, staff may transfer the veteran to another VHA or non-VHA HCS for inpatient mental health care.[102]

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.[103] HCS staff must be aware of the veteran's legal status (voluntary or involuntary admission) to safeguard against potential civil rights violations, including illegal detainment in a locked inpatient unit.[104]

The interdisciplinary treatment team must ensure that the recovery-oriented treatment plan includes the veteran's personally identified goals and is completed in collaboration with the veteran.[105] The interdisciplinary treatment team must also ensure outpatient mental health care is coordinated with the veteran prior to discharge, including follow-up appointment information.[106]

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.[107]

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.[108] Immediately following inpatient hospitalization, there is an

[100] VHA Directive 1160.06.

[101] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."; *Standards Manual e-dition*, PC.01.01.01.

[102] VHA Directive 1160.06.

[103] VHA Directive 1160.06.

[104] 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.

[105] VHA Directive 1160.06.

[106] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[107] 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* when inpatient unit staff must provide the veteran with information regarding the written discharge plans.

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

increased risk for suicide attempt or death by suicide.[109] 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.[110]

Inpatient unit clinical staff are to complete the C-SSRS, an evidence-based risk assessment tool, for veterans within 24 hours before discharge, as required. A positive C-SSRS then requires the "timely completion of the [CSRE]."[111] Staff may complete the CSRE in lieu of the suicide risk screening prior to discharge.[112]

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 a crisis.[113]

These plans must include, but are not limited to, discussion of environmental safety strategies, safety options, access to firearms, opioids, and other potential lethal means, such as medications, ropes, or household toxins.[114]

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.[115] 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.[116] In June 2022, VHA issued a memorandum

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

[110] 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 Veterans Integrated Service Network Directors (10N1-23) et al., June 12, 2017.

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

[112] 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 (CSRE) when the screen is positive; VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Frequently Asked Questions (FAQ)," updated December 13, 2022.

[113] VHA Directive 1160.07.

[114] VA, *VA Safety Planning Intervention Manual*.

[115] VHA Directive 1071(1).

[116] 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.

indicating a target of at least 95 percent completion for mandatory suicide prevention trainings.[117]

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. Additionally, the 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.[118]

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 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."[119]

[117] 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 a 95 percent compliance with mandatory suicide prevention trainings.

[118] VHA Directive 1167, May 12, 2017. 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."

[119] VHA Directive 1167, May 12, 2017.

Appendix B: Methodology

The Mental Health Inspection Program inspection began in FY 2024 and focused on the quality of care provided by VHA's inpatient mental health services.[120] The OIG randomly selected the VHA HCSs included in FY 2024 reviews from all facilities with inpatient mental health beds.[121]

The OIG conducted a virtual and on-site inspection at the facility from August 5 through September 13, 2024. The OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

The OIG reviewed VHA facility level data, 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 in 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.[122] 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.

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

[121] 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.

[122] 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.[123] As previously discussed, the OIG used 90 percent as the expected level of compliance for record review.

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	98
	Inpatient mental health treatment plan	Completed	50	100
		Veteran involved in development or offered opportunity	47	96
		Included interdisciplinary treatment team input	50	96
	New Central Nervous System medication	Risk and benefits discussed with veteran	32	34
	Discharge summary	Completed	50	98
		Completed within two business days of discharge	49	96
	Outpatient mental health follow-up appointment	Scheduled prior to discharge	49	100
	Discharge instructions	Completed	50	100
		Included outpatient mental health appointment	49	100
		Copy offered to veteran	49	98
		Included location of follow-up appointment in easy-to-understand language	49	94
		Included medication list	49	100

[123] 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 the veteran's first admission only.

Domain	Topic	Inspection Element Reviewed	Number of Records Included	Percent Compliant (%)
		Included reasons for prescribed medications	49	49
		Free of medical abbreviations that could be difficult to understand by a nonmedically-trained individual	49	63
Suicide Prevention	Columbia-Suicide Severity Rating Scale	Completed prior to discharge	50	66
		Completed within 24 hours before discharge	50	44
	Suicide Prevention Safety Plan	Completed or reviewed prior to discharge	48	85
		Used appropriate note title	43	100
		Addressed ways to make the veteran's environment safe from potentially lethal means	41	78
		Addressed access to firearms	41	100
		Addressed access to opioids	41	100
		Offered veteran or caregiver a copy	41	93

Source: OIG review of VA Salem 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 69 individuals identified as facility 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 found that 24 of the 69 staff completed the OIG questionnaire (35 percent). For recipients who had not completed the questionnaire after the initial request, the OIG extended the suspense date and provided two additional reminder requests. The OIG acknowledges the responses may not fully represent the views of all individuals who received the survey but maintains that the results offer valuable insight into employee perceptions of psychological safety and performance improvement.

OIG Inspection of the Physical Environment

The OIG inspected selected areas of the inpatient unit to evaluate if the facility provided a therapeutic, recovery-oriented environment and maintained veteran safety.[124] The OIG team visually assessed the inpatient unit environment for warm and inviting design elements such as natural lighting, artwork, and warm paint colors. The OIG also observed the unit for general cleanliness and veteran access to private and outdoor space.[125] Further, the OIG's physical inspection of areas in the inpatient unit focused on selected safety elements specific to this facility.

The OIG reviewed the Patient Safety Assessment Tool for MHEOCC inspections completed in FY 2022, FY 2023, and FY 2024, and assessed corrective actions taken for deficiencies unresolved for more than six months.

[124] VHA Directive 1160.06; 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 9, 2022, https://www.merriam-webster.com/dictionary/unit.

[125] 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 6 and the facility, including reporting authority and delineation of direct or indirect oversight responsibilities.

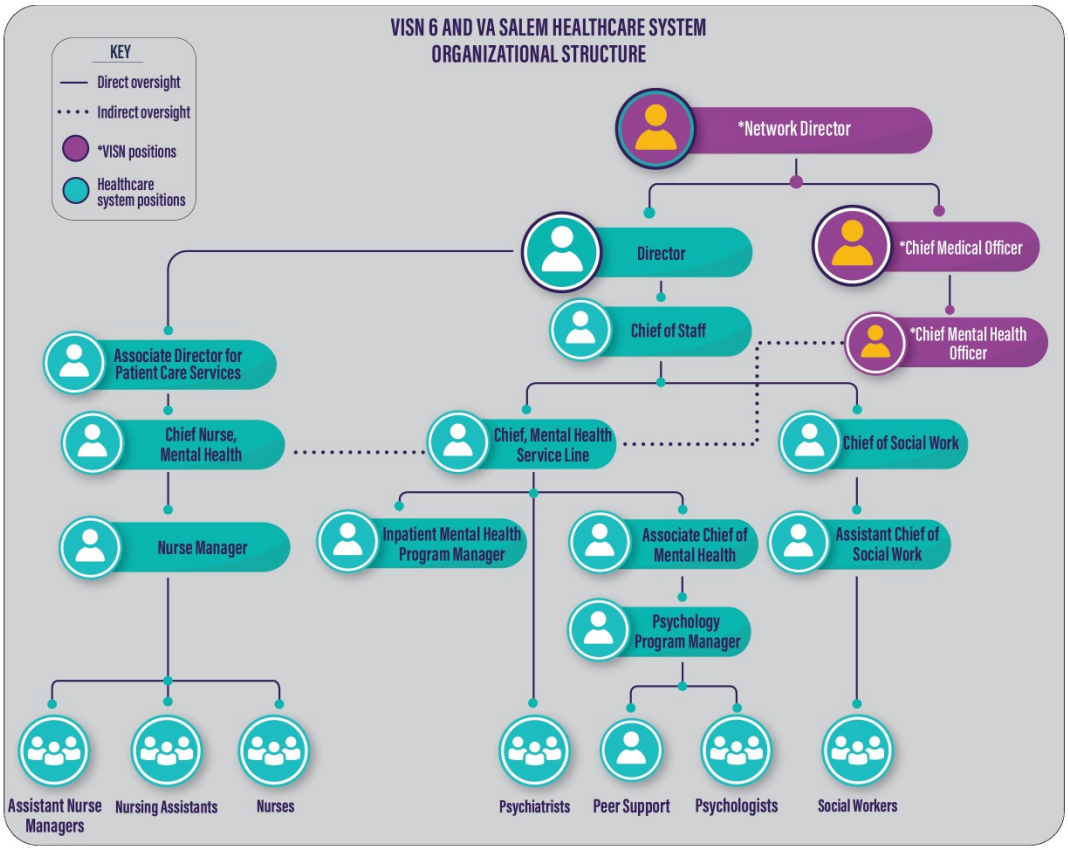

Figure C.1. *VISN 6 and facility organizational structure.*
Source: OIG analysis of facility documents (received August 5, 2024, through March 7, 2025). OIG analysis of VHA Directive 1160.06.
Note: The Chief of Mental Health reported the inpatient unit medical director also served as the inpatient mental health program manager. The OIG considers the direct supervisor of each position to be the equivalent of "direct oversight," and programmatic oversight of identified positions as the equivalent of "indirect oversight." Staff disciplines identified in the last row were assigned to the inpatient unit.

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

Table C.1. Inpatient Unit Staffing

Discipline	FTEE	Percent Dedicated Per FTEE
Advanced Practitioners	2	35–60
Medical Support Assistants	4	10
Nurses*	34	50–100
Nursing Assistants‡	17	100
Peer Specialist	1	88
Psychiatrists§	4	20–100
Psychologists‖	2	28–100
Social Workers	2	100

Source: OIG Review of the facility's Mental Health Inpatient Unit Staffing Spreadsheet (received August 30, 2024, through March 7, 2025).

Note: FTEE stands for full-time equivalent employee.

**Nursing staff includes a nurse manager, two assistant nurse managers, 25 registered nurses, and 6 licensed practical nurses.*

‡Nursing assistant staff include 17 psychiatric nursing assistants.

§Psychiatry staff includes the Chief of Mental Health with 20 percent of time dedicated to the unit.

‖Psychology staff includes the local recovery coordinator with 28 percent of time dedicated to the unit.

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 13, 2025

From: Interim Director, VA Mid-Atlantic Health Care Network (10N06)

Subj: Mental Health Inspection of the VA Salem Healthcare System in Virginia

To: Program Director, Office of Healthcare Inspections (54MH00)
Office of Chief Operating Officer (10C)

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I concur with the report findings and recommendations.

2. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)

Dana Ballard
Quality Management Officer, VISN 6
For
Jonathan S. Benoit, MSHSA

[OIG comment: The OIG received the above memorandum from VHA on May 13, 2025.]

Appendix E: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 12, 2025

From: Director, VA Salem Healthcare System (658)

Subj: Office of Inspector General (OIG) Draft Report, Mental Health Inspection of the VA Salem Healthcare System in Virginia

To: Director, VA Mid-Atlantic Health Care Network (10N06)

1. We appreciate the opportunity to review and comment on the OIG draft report, Mental Health Inspection of the VA Salem Healthcare System in Virginia. The Salem Healthcare System concurs with the recommendations and will take corrective action.

2. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

3. Should you need further information, please contact the Chief of Quality Management.

(*Original signed by*:)

Rebecca J. Stackhouse, DHSc, FACHE, CTRS
Executive Director, SVAHCS

[OIG comment: The OIG received the above memorandum from VHA on May 13, 2025.]

Facility Director Response

Recommendation 1

The Facility Director ensures the mental health executive council operates in accordance with VHA requirements.

_X __Concur

_____Nonconcur

Target date for completion: September 2025

Director's Comments

The Chief of Mental Health completed a review of VHA requirements for the Mental Health Executive Council operation per VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023, and meeting attendance over the past twelve months. Starting with the next quarterly meeting in May 2025, a record of meeting attendance will be embedded within the minutes for each meeting. Compliance will be measured through monitoring attendance recorded in the Mental Health Integrated Clinical Community (MHICC) Council minutes, with a goal of 90% compliance. Data will be reported to the Medical Executive Committee (MEC) monthly to monitor compliance.

Recommendation 2

The Chief of Mental Health identifies barriers and implements processes to provide a minimum of four hours of recovery-oriented, interdisciplinary programming on weekends on the inpatient mental health unit and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

The Chief of Mental Health and Chief Nurse of Mental Health identified additional recovery-oriented programming that can be implemented during weekends. In addition to existing Peer Support and Chaplain groups, mental health nursing will implement a Wrap-Up Group to discuss daily goals, progress and/or barriers to meeting goals, actions to be taken to complete daily goals, and education related to relaxation techniques beginning April 18, 2025. Mental Health nursing will continue the current Psychoeducational Group with a focus on Whole Health. The combination of Peer Support, Chaplain Groups, Wrap Up Group, and the Psychoeducational Group will range from four to six hours daily. Compliance will be measured by a monthly audit

of the health record documentation of weekend interdisciplinary programming completion, with a goal of 90% compliance. Data will be reported to MEC monthly to monitor compliance.

Recommendation 3

The Facility Director develops and implements processes to monitor and track compliance with involuntary commitment requirements.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

The commitment status is present in the electronic health record within intake and progress note documentation. An order will be placed at the time of admission and at any change in status within the electronic health record documenting status and expiration date. The Administrative Officer of the Day will continue documenting the commitment status and expiration date in VISTA [Veterans Health Information Systems and Technology Architecture] and this information will be readily available for staff on the acute Mental Health unit. A discussion related to commitment status will be included in unit daily huddles. Compliance will be measured through monthly monitoring for the presence of commitment status orders and documentation within the electronic health record, with a goal of 90% compliance. Data will be reported to MEC monthly to monitor compliance.

Recommendation 4

The Chief of Staff ensures timely documentation of informed consent 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: August 2025

Director's Comments

The acute psychiatry intake template and inpatient progress notes were revised to include documentation of benefits, alternatives, and risks of newly prescribed medications discussed with the Veteran, and that the Veteran verbalized understanding. Compliance will be measured through monthly monitoring for the presence of documented discussions between the prescriber and Veteran on the risks and benefits of newly prescribed medications in the electronic health

record, with a goal of 90% compliance. Data will be reported to MEC monthly to monitor compliance.

Recommendation 5

The Chief of Staff ensures discharge instructions for veterans are written in easy-to-understand language and include the purpose for each medication.

__X _Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

Education has been provided to inpatient psychiatrists and residents regarding writing discharge instructions with easy-to-use language and including the purpose for each medication. The ED [emergency department] Psychiatrist will be added as an additional signer to electronic health record notes for review of discharge instructions. Compliance will be measured through monthly monitoring to confirm discharge instructions are written in easy-to-understand language and includes the purpose for each medication in the electronic health record, with a goal of 90% compliance. Data will be reported to MEC monthly to monitor compliance.

Recommendation 6

The Chief of Staff directs staff to complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: Completed March 2025

Director's Comments

The practice of completing the Columbia-Suicide Severity Rating Scale within 24 hours before discharge was in place at the time of the inspection, but not during the entire 12-month review period. MH [mental health] Leadership requested a change to the Mental Health Discharge Note in July 2023 to include completion of the CSSRS. To ensure compliance with this recommendation, Quality Management has completed a 100% review of discharges from the inpatient Mental Health unit for the presence of completed Columbia-Suicide Severity Rating Scale within 24 hours before discharge or on the day of discharge for fiscal year (FY) 2024 and FY 2025 to date. This audit demonstrated greater than 90% monthly compliance for January

2025, February 2025, and March 2025. 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 additional documentation to support closure.

Recommendation 7

The Chief of Staff directs staff to complete or review safety plans with veterans prior to discharge and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

Education has been provided to inpatient psychiatrists and residents regarding the completion and review of safety plans with Veterans prior to discharge. A LEAF [technology platform] request was placed to revise the Mental Health Discharge Note to include provider review of the safety plan with the Veteran prior to discharge. Compliance will be measured through monthly monitoring of the electronic health record to confirm the presence of a completed review of the safety plan with Veteran prior to discharge, with a goal of 90% compliance. Data will be reported to MEC monthly to monitor compliance.

Recommendation 8

The Chief of Staff directs staff to address ways to make the veteran's environment safer from potentially lethal means in safety plans and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

Staff provided education in the completion of safety plans to address other lethal means outside of weapons and opiates, but to consider hazards such as household chemicals and cleaning supplies, alcohol, and/or excess medications. Compliance will be measured through monitoring for documentation of addressing potential environmental lethal means within the safety plan, with a goal of 90% compliance. Data will be reported to MEC monthly to monitor compliance.

Recommendation 9

The Facility Director directs staff to comply with Lethal Means Safety training and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: July 2025

Director's Comments

Quality Management (QM) staff and the Talent Management System (TMS) Administrator completed a review to evaluate current compliance with Lethal Means Safety Training TMS modules and to ensure module assignment upon orientation occurs. Compliance will be measured through monitoring of required staff who have received and completed education on Lethal Means Safety Training, with a goal of 90% compliance. Data will be reported to MEC monthly to monitor compliance.

Recommendation 10

The Facility Director directs staff to comply with Skills Training for Evaluation and Management of Suicide training and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: July 2025

Director's Comments

QM staff and the TMS Administrator completed a review to evaluate current compliance with Skills Training for Evaluation and Management of Suicide (STEM) or STEM-Refresher TMS modules. Monthly compliance data for STEM and STEM-Refresher will be reviewed by QM staff. QM will notify staff leadership within a 45-day window prior to the training expiration with a reminder that training is almost due. Compliance will be measured through monitoring of required staff who have received and completed education on STEM, with a goal of 90% compliance. Data will be reported to MEC monthly to monitor compliance.

Recommendation 11

The Facility Director directs staff to comply with VA S.A.V.E. training and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: July 2025

Director's Comments

QM staff and the TMS Administrator completed a review to evaluate current compliance with Signs-Ask-Validate-Encourage S.A.V.E. or S.A.V.E-Refresher TMS modules. Monthly compliance data for S.A.V.E and S.A.V.E-Refresher will be reviewed by QM staff. QM will notify staff leadership within a 45-day window prior to the training expiration with a reminder that training is almost due. Compliance will be measured through monitoring of required staff who have received and completed education on S.A.V.E., with a goal of 90% compliance. Data will be reported to MEC monthly to monitor compliance.

Recommendation 12

The Facility Director ensures Interdisciplinary Safety Inspection Team requirements are met and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

Facility Inpatient Mental Health Leadership, Quality Management Leadership and facility Interdisciplinary Safety Inspection Team (ISIT) Lead met to review VHA Directive 1167, Mental Health Environment of Care Checklist for Units Treating Suicidal Patients, dated November 4, 2024, to ensure compliance with requirements as outlined within the directive. An ISIT workgroup will be established as a subgroup of the facility Environment of Care Committee (EOCC) with quarterly meetings and reporting to the EOCC. Participation of all required members on the ISIT will be captured and maintained as a record of attendance for workgroup meetings and twice annual Mental Health Environment of Care Checklist (MHEOCC) inspections of the mental health unit. Compliance will be measured through monitoring of required staff who have received and completed education about MHEOCC, with a goal of 90% compliance. The ISIT will follow the guidance outlined in VHA Directive 1167 to monitor for safety risks, including conducting twice annual MHEOCC inspections. The ISIT will monitor and track MHEOCC compliance and report to the EOCC at least quarterly.

Recommendation 13

The Facility Director implements processes to ensure the Interdisciplinary Safety Inspection Team applies Mental Health Environment of Care Checklist standards to all sections on the inpatient mental health unit and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

The ISIT workgroup will follow guidance outlined in VHA Directive 1167, Mental Health Environment of Care Checklist for Units Treating Suicidal Patients, dated November 4, 2024, to identify and report safety risks to include required MHEOCC inspections to be completed twice per year. The ISIT will monitor MHEOCC compliance and report to the EOCC quarterly.

Recommendation 14

The Facility Director uses VHA guidelines to develop a facility-specific policy for the use of restraint chairs.

_X __Concur

_____Nonconcur

Target date for completion: July 2025

Director's Comments

Medical Center Policy 658-11-24 Restraint and Seclusion will be updated to reflect the use of restraint chairs in the Acute Mental Health unit only. Appropriate staff will be trained on the updated medical center policy. Compliance will be measured through monitoring of required staff who have received and completed education about the revised policy, with a goal of 90% compliance. Data will be reported to MEC monthly to monitor compliance.

Recommendation 15

The Facility Director directs staff to comply with Mental Health Environment of Care Checklist training requirements and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: July 2025

Director's Comments

QM staff and the TMS Administrator completed a review to evaluate current compliance with MHEOCC TMS training modules. Monthly compliance data for MHEOCC training will be reviewed by QM staff. QM will notify staff leadership within a 45-day window prior to the training expiration with a reminder that training is almost due. Compliance will be measured through monitoring of required staff who have received and completed education, with a goal of 90% compliance. Data will be reported to MEC monthly to monitor compliance.

OIG Contact and Staff Acknowledgments

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