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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Quality of Care for Patients Seeking Acute Mental Health Care at the Lexington VA Healthcare System in Kentucky

Healthcare Inspection | **25-00349-10** | **November 20, 2025**

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection at the Lexington VA Healthcare System (system) in Kentucky on October 27, 2024, to determine the validity of an allegation that patients seeking or receiving acute mental health treatment did not receive the care needed.[1] The OIG conducted a virtual site visit January 7 through 9, 2025, and completed additional virtual interviews from December 10, 2024, through March 18, 2025.

The OIG substantiated quality of care deficiencies for two patients seeking acute mental health treatment at the system. Specifically, multiple staff did not recognize Patient 1's personally owned insulin pump as a lethal means, and a psychiatrist (Psychiatrist 2) did not provide a patient (Patient 2) with emergency department discharge instructions or document care consistent with Veterans Health Administration (VHA) policy.[2]

Patient Case Summaries

Patient 1, who had a history of major depressive disorder, suicide attempts, and type 2 diabetes mellitus treated via a personally owned insulin pump, presented to the system emergency department in the fall of 2023, reporting suicidal ideation with a plan to overdose using medication.[3]

Mental health, emergency department, and inpatient medical and nursing staff completed clinical assessments. Two mental health providers completed comprehensive suicide risk evaluations and determined that the patient was at high acute risk for suicide.[4] A psychiatrist (Psychiatrist 1), documented that the patient would be admitted to a medical floor for further care.[5] The patient was admitted to a medical unit. At admission, an inpatient medicine physician evaluated the patient and documented a plan to continue the patient's insulin pump and consult endocrinology for insulin management.[6] The following morning, a different psychiatrist (Psychiatrist 2)

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[1] VHA refers to suicidal ideation as thoughts of engaging in suicide-related behavior. VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021.

[2] VHA Directive 1101.14(1), *Emergency Medicine*, March 20, 2023, amended March 7, 2025. The directives contain the same language regarding emergency department discharge instructions; VHA HIM, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023; VHA Health Information Management, *HIM Practice Brief Monitoring Copy and Paste,* March 2023.

[3] Harvard Health, "Depression," accessed May 2, 2025, https://www.health.harvard.edu/topics/depression; Harvard Health, "Type 2 diabetes mellitus," accessed March 26, 2025 https://www.health.harvard.edu/diseases-and-conditions/type-2-diabetes-mellitus-a-to-z. Type 2 diabetes is "characterized by high levels of sugar in the blood."

[4] VHA Directive 1160.07. A comprehensive suicide risk evaluation is a standard process VHA uses to assess patients who have a positive suicide risk screening.

[5] Patient 1 was admitted to the medical unit due to the patient's medical needs.

[6] Cleveland Clinic, "Endocrinologist," accessed April 18, 2025, https://my.clevelandclinic.org/health/articles/22691-endocrinologist. "Endocrinology is the study of hormones" in the body, including diabetes.

completed a comprehensive suicide risk evaluation and documented that Patient 1 was low acute risk for suicide and had no access to lethal means. Later that day, Patient 1 reported attempting suicide the previous evening using the insulin pump to administer extra insulin (adverse event 1).

Patient 2 presented to the system's emergency department in late summer 2024, one day after being discharged from the system's inpatient mental health unit, reporting psychotic symptoms and stating, "the only way [to] get out of it is to die."[7] Psychiatrist 2 completed a comprehensive suicide risk evaluation, documented that Patient 2 denied intent or a plan of self-harm, and assessed the patient as low acute risk for suicide. Psychiatrist 2 determined the patient did not need to be admitted to the inpatient mental health unit, and recommended outpatient treatment.[8] Later that day, Patient 2 returned to the emergency department via emergency medical services. At the time of arrival, emergency medical services staff reported Patient 2 ingested multiple doses of prescribed medication and aspirin and vomited sixty pills; the patient subsequently died in the system's intensive care unit (adverse event 2).

Recognition of Insulin Pump as a Lethal Means

Patients with diabetes may take a medication called insulin, which regulates blood glucose and can be administered as multiple daily injections or via an insulin pump.[9] Insulin pumps, small wearable medical devices that can fit into a pocket or clip on to clothing, hold a cartridge that allows patients to administer the medication under the skin for up to three days.[10] Patients with and without diabetes have attempted suicide using insulin to overdose.[11]

VHA refers to lethal means as objects, including some medications, that could be used for "suicidal … self-directed violence."[12] VHA requires patients who screened positive for risk of suicide be further assessed for access to lethal means and The Joint Commission requires removal of items that could pose a risk for self-harm.[13]

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[7] Patient 2 was admitted for suicidal ideation.

[8] Treatment included antipsychotic medication.

[9] Cleveland Clinic, "Insulin" accessed March 14, 2025, https://my.clevelandclinic.org/health/body/22601-insulin.

[10] Cleveland Clinic, "Insulin Pumps," accessed March 14, 2025, https://my.clevelandclinic.org/health/articles/insulin-pumps.

[11] Evanthia Gouveri et al., "Intentional Insulin Overdose and Depression in Subjects with and Without Diabetes Mellitus: A Commentary," *Diabetes Therapy* 15, (July 24, 2024): 1845-1854, https://doi.org/10.1007/s13300-024-01623-5.

[12] VHA Directive 1160.07.

[13] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1–23) et al., November 23, 2022; VHA Directive 1160.07; The Joint Commission, *E-dition Standards and Elements of Performance,* NPSG 15.01.01, July 1, 2025.

The OIG found that mental health, emergency department, and inpatient medical and nursing staff completed clinical assessments, and two mental health providers assessed Patient 1 as high risk for suicide. However, none of the staff identified Patient 1's personally owned insulin pump as a potential lethal means. A psychiatrist and an emergency department physician told the OIG of not considering the insulin pump as a possible source for lethal means at the time of the patient's admission. As a result, Patient 1 continued to have access to the insulin pump, subsequently using it to attempt suicide.

Following adverse event 1, leaders failed to implement system-wide actions to mitigate the risk associated with insulin pumps and patients who have suicidal ideation. Nursing leaders acknowledged the need for and provided education to some nurses after adverse event 1. Further a facility insulin policy, which included information identifying an insulin pump as a lethal means for patients with suicidal ideation was drafted. However, other system leaders did not (1) educate the emergency department, mental health, and inpatient medical providers and mental health staff or (2) finalize and implement the insulin pump policy. Although a nursing leader reported the draft policy was undergoing committee approval, the OIG is concerned that without system-wide staff education or a policy, the vulnerability of an insulin pump as a potential lethal means for suicide remains a patient safety risk. Further, in that VHA directives, policies, or guidance do not provide instruction specific to patients with personally owned insulin pumps and suicidal ideation in VHA emergency departments and inpatient units, the OIG concluded that VHA facilities would benefit from national guidance that could decrease the risk of patient harm and improve quality of care.

Discharge and Documentation

The OIG determined that Psychiatrist 2 did not provide Patient 2 with discharge instructions after concluding the patient was appropriate for discharge from the emergency department. Discharge instructions are required by VHA and used as a vital communication tool for staff to review care and follow-up appointments with patients being discharged from an emergency department.[14]

The day before the emergency department visit, a system staff member provided inpatient discharge instructions, including outpatient mental health appointments, for Patient 2. However, in the emergency department, Psychiatrist 2 missed the opportunity to verify Patient 2's understanding of the previously arranged follow-up care. Psychiatrist 2 could not recall giving Patient 2 discharge instructions in the emergency department but believed the patient left abruptly and further explained that Patient 2 had been given appointments when discharged from the system's inpatient mental health unit. Notably, electronic health record (EHR) documentation did not reflect that the patient left the emergency department abruptly.

[14] VHA Directive 1101.14(1).

In addition, Psychiatrist 2's emergency department EHR documentation included copied and pasted information from two previous emergency department visits, a different VHA provider's psychiatric history for the patient without attribution, history of involvement with the justice system, and lengthy excerpts from two journal articles. It also included a derogatory, critical comment about Patient 2, which suggested the patient may return to the emergency department or engage in behavior that should be considered criminal and not psychiatric. Psychiatrist 2 explained the comment was referring to an assessment of Patient 2's disruptive behavior during a previous emergency department visit.[15]

VHA requires that documentation in a patient's EHR is accurate, succinct, clear, and reflects current patient status for continuity of care.[16] VHA also prohibits the use of "[r]epetitive copying and pasting of notes."[17] Additionally, VHA prohibits comments that appear derogatory or critical of a patient.[18]

Although Psychiatrist 2 told the OIG the amount of information was included in the note to be thorough, the OIG is concerned that if an EHR contains obscured information, members of the healthcare team may have difficulty coordinating and providing continuity of mental health care. Further, had Patient 2 accessed the EHR, the critical comment could have negatively affected the patient's engagement in future care.

Deficient Quality Management Processes

The OIG determined the System Director and Chief of Staff did not ensure that quality management processes were conducted in an accurate and complete manner to address system vulnerabilities and patient safety risks for Patients 1 and 2. Specifically, the OIG identified deficiencies with the safety assessment code scoring and the root cause analysis (RCA) and peer review processes.

The system patient safety manager did not correctly apply the safety assessment code when scoring the potential risk for harm for Patient 1's suicide attempt. VHA provides guidance to consider the "reasonable" worst-case outcome when assessing the severity of potential risk.[19] The patient safety manager determined that a suicide attempt via administration of extra insulin

[15] The OIG reviewed documentation that confirmed the patient engaged in physical disruptive behavior that "was related to alcohol or substance abuse," and which "did [not] involve a criminal and purposefully unsafe act.'

[16] VHA HIM, *Health Record Documentation Program Guide Version 1.2*.

[17] VHA Health Information Management, *HIM Practice Brief Monitoring Copy and Paste*.

[18] VHA Health Information Management, *HIM Practice Brief Monitoring Copy and Paste*.

[19] VHA National Center for Patient Safety, *Guidebook for Safety Assessment Code (SAC) Evaluation,* August 2023, replaced by *VHA National Center for Patient Safety, Guidebook for Safety Assessment Code (SAC) Evaluation,* April 2025. The guidebooks contain the same language regarding severity categories. VHA outlines severity in four categories: minor "no injury, nor increased length of stay", moderate "increased length of stay," major "permanent lessening of bodily functioning … not related to the natural course of the patient's illness," catastrophic "death or major permanent loss of function … not related to the natural course of the patient's illness."

was not a potential catastrophic event and therefore assigned adverse event 1 a safety assessment code score that did not require an RCA. However, adverse event 1 involved the potential death of a patient and should have been scored as catastrophic, which would have prompted system leaders to conduct an RCA.

System staff completed an RCA in response to adverse event 2 that did not include a complete and comprehensive review of Patient 2's care on the day of the event. Specifically, the RCA team did not interview staff involved in the patient's care during the first of two emergency department visits on the day of adverse event 2. VHA provides guidance that individuals directly involved in an adverse event be interviewed as part of the RCA process.[20] When staff do not complete a comprehensive review, the underlying system vulnerabilities that put patients at risk may not be identified.

Peer review is a confidential process used to review the clinical care delivered by an individual healthcare provider.[21] The OIG found that the Chief of Staff and deputy chief of staff failed to fulfill VHA's requirement to have a healthcare professional peer present at the Peer Review Committee meeting when the psychiatrist's care was discussed and the peer review finding lowered to a level that did not require any follow-up action.[22] The deputy chief of staff, who served as chairperson that day, incorrectly thought the psychiatrist's external peer review met the requirement to have a psychiatrist present at the meeting and the Chief of Staff did not report concerns with the Peer Review Committee's decision to lower the rating without a peer at the meeting. Without peer representation for Psychiatrist 2, the Peer Review Committee did not ensure the discussion for final peer review level was fair and credible as required.

The OIG made eight recommendations to the System Director related to evaluation and removal of personally owned insulin pumps, finalization of an insulin pump policy, review of system policy approval, compliance with discharge instructions, review of Psychiatrist 2's EHR entries, accuracy of safety assessment code scores, education on RCA processes, and psychiatrist peer representation at the system Peer Review Committee for psychiatry case reviews. The OIG published a separate report with one recommendation to the Under Secretary for Health to consider specific VHA guidance related to personally owned insulin pumps as a lethal means when patients are deemed at risk for suicide.[23]

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[20] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis Version 15*, July 2024.

[21] VHA Directive 1190(1), *Peer Review for Quality Management,* November 18, 2018, amended July 19, 2024. VHA defines a peer as a "health are professional that has comparable education, training, experience, [and] licensure … who can make a fair and credible assessment of the actions taken by the clinician … under review."

[22] VHA 1190(1).

[23] VA OIG, *Management of Personally Owned Insulin Pumps for Patients at Risk for Suicide in Emergency Departments and Inpatient Units*, Report No. 25-03462-12, November 20, 2025.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the OIG findings and eight recommendations. The System Director provided action plans related to personally owned insulin pumps, an insulin pump policy, compliance with discharge instructions, review of a psychiatrist's EHR entries, accuracy of safety assessment code scores, education on root cause analysis processes, and psychiatrist peer representation at the system Peer Review Committee for psychiatry case reviews (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

COS	Chief of Staff
CSRE	comprehensive suicide risk evaluation
EHR	electronic health record
OIG	Office of Inspector General
PRC	Peer Review Committee
RCA	root cause analysis
SAC	safety assessment code
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection in October 2024 and conducted a virtual site visit January 7 through 9, 2025, at the Lexington VA Healthcare System (system) in Kentucky to determine the validity of an allegation that patients seeking or receiving acute mental health treatment did not receive the care needed.

Background

The system, part of Veterans Integrated Service Network 9, provides comprehensive health care through a variety of patient care services including inpatient mental health and medical care, emergency care, and outpatient mental health treatment. The Veterans Health Administration (VHA) classifies the system as a level 1b complexity.[1] From October 1, 2022, through September 30, 2023, the system served 35,581 patients.

Insulin and Insulin Pumps

Patients with diabetes may take a medication called insulin, which regulates blood glucose, and can be administered as multiple daily injections or via an insulin pump.[2] Insulin pumps, small wearable medical devices, about the size of a deck of cards that can fit into a pocket or clip on to clothing, supply patients with insulin underneath their skin (see figure 1).[3] An insulin pump holds a cartridge of insulin that allows for up three days of insulin administration.[4] Patients with and without diabetes have attempted suicide using insulin to overdose.[5] "Insulin overdose may lead to severe and prolonged hypoglycemia, hypoglycemic coma, and death."[6]

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

[2] Cleveland Clinic, "Insulin," accessed March 14, 2025, https://my.clevelandclinic.org/health/body/22601-insulin.

[3] Cleveland Clinic, "Insulin Pumps," accessed March 14, 2025, https://my.clevelandclinic.org/health/articles/insulin-pumps.

[4] Cleveland Clinic, "Insulin Pumps."

[5] Evanthia Gouveri et al., "Intentional Insulin Overdose and Depression in Subjects with and Without Diabetes Mellitus: A Commentary," *Diabetes Therapy* 15, (2024): 1845-1854, https://doi.org/10.1007/s13300-024-01623-5.

[6] Hypoglycemia is low blood sugar or low blood glucose levels that occur due to too much insulin. Severe hypoglycemia can be life-threatening. Cleveland Clinic, "Hypoglycemia (Low Blood Sugar)" accessed May 1, 2025. https://my.clevelandclinic.org/health/diseases/11647-hypoglycemia-low-blood-sugar; A hypoglycemic coma is "a life-threatening complication that can result from … low blood sugar. A coma is a prolonged, deep state of unconsciousness." Cleveland Clinic, "Diabetes-Related Coma" accessed July 28, 2025, https://my.clevelandclinic.org/health/diseases/16628-diabetic-coma; Gouveri, et al., "Intentional Insulin Overdose and Depression in Subjects with and Without Diabetes Mellitus: A Commentary."

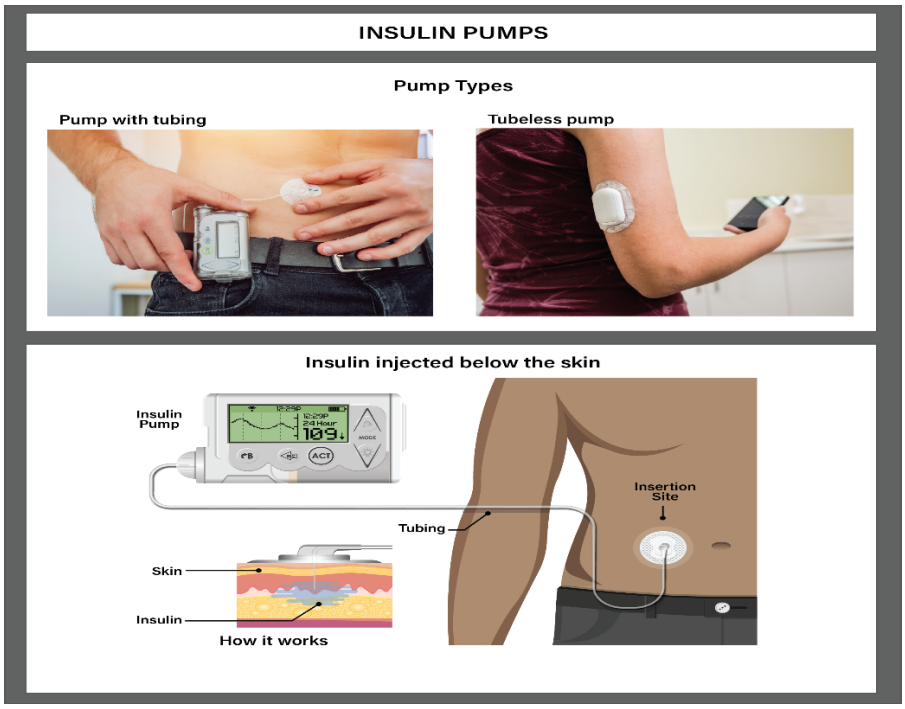

Figure 1. *Insulin Pumps.*
Source. OIG analysis/Adobe Stock.

Allegations and Related Concerns

In August 2024, the OIG received an allegation from a complainant that alleged "patient care issues for patients seeking acute mental health treatment at [the system]."[7] After reviewing the allegation, the OIG opened this inspection to evaluate the quality of care of two patients who had suicidal ideation and sought acute mental health treatment.[8] The OIG identified additional concerns regarding leaders' not ensuring that quality management processes conducted in response to adverse events were accurate and complete.[9]

[7] The complainant provided patient examples.

[8] VHA refers to suicidal ideation as thoughts of engaging in suicide-related behavior. VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021.

[9] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. VHA defines an adverse event as "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm directly associated with care or services delivered by VA providers."

Scope and Methodology

The OIG conducted a virtual site visit January 7 through 9, 2025, and completed additional virtual interviews from December 10, 2024, through March 18, 2025.

The OIG interviewed the complainant, System Director, Chief of Staff (COS), Associate Director for Patient Care Services, deputy chief of staff, and chief nurse operations and specialty care. The OIG also interviewed quality management, emergency department, and mental health leaders and staff, and an inpatient diabetes educator.

The OIG reviewed VHA directives, system policies and standard operating procedures, electronic health records (EHRs) of two patients, emails, Peer Review Committee (PRC) minutes, and quality management reviews, which included a peer review and a root cause analysis (RCA).[10]

In the absence of current 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 issue(s).

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

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

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

[10] VHA Directive 1190 (1), *Peer Review for Quality Management,* November 21, 2018, amended July 19, 2024. A Peer Review for Quality Management is a "review of care performed by a peer conducted in accordance with all applicable laws, regulations, and current VHA policies."; VHA Directive 1050.01(1). An RCA is a "comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events."

Patient Case Summaries

Patient 1

In the fall of 2023, Patient 1 had two inpatient medical unit admissions for depression and suicidal ideation.[11] At the time of these admissions, Patient 1 was in their 70's, with multiple comorbidities that included major depressive disorder, type 2 diabetes mellitus, congestive heart failure, and chronic obstructive pulmonary disease with use of home oxygen.[12] The patient also had a history of suicide attempts and a designation as high risk for suicide.[13]

During the first admission, an inpatient medicine physician requested a diabetes educator consult. The inpatient diabetes educator documented that Patient 1 had suicidal ideation and was admitted with an insulin pump "in use" but shortly after admission the insulin ran out. The inpatient medicine physician placed orders to have inpatient nursing staff monitor Patient 1's blood sugar and administer insulin as indicated for the remainder of the admission.

Six days after discharge, Patient 1 returned to the emergency department and reported suicidal ideation with a plan to overdose using medication. Two mental health providers completed comprehensive suicide risk evaluations (CSREs), which included an assessment of the patient's access to lethal means that noted the patient had medication at home that was "locked up."[14] Both mental health providers determined the patient was at high acute risk for suicide.

An emergency department physician evaluated the patient and documented that the patient reported suicidal ideation with a plan to overdose. The physician also documented the presence of the insulin pump. An emergency department nurse completed an assessment, documented that the patient reported suicidal ideation, and noted the presence of an insulin pump.[15] A psychiatrist (Psychiatrist 1) evaluated the patient and noted reports of suicidal ideation. Psychiatrist 1

[11] Patient 1 was admitted to the medical unit due to the patient's medical needs such as oxygen.

[12] The OIG uses the singular form of they, "their" in this instance, for privacy purposes; Harvard Health, "Depression," accessed May 2, 2025 https://www.health.harvard.edu/topics/depression. Major depressive disorder is a "profound sadness or a sense of despair … lasting at least two weeks."; Harvard Health, "Type 2 diabetes mellitus," accessed March 26, 2025 https://www.health.harvard.edu/diseases-and-conditions/type-2-diabetes-mellitus-a-to-z. Type 2 diabetes is "characterized by high levels of sugar in the blood."; Harvard Health, "Heart failure," accessed May 2, 2025 https://www.health.harvard.edu/a_to_z/heart-failure-a-to-z. Congestive heart failure is "a condition in which the heart cannot pump efficiently enough to meet the body's need for blood."; Harvard Health, "COPD," accessed May 2, 2025, https://www.health.harvard.edu/topics/copd. "Chronic obstructive pulmonary disease is a chronic lung disease that blocks airflow from the lungs … that causes difficulty breathing."

[13] "The primary purpose of the [High Risk for Suicide Patient Record Flag] is to communicate to VA staff members that a patient has been identified as high acute risk for suicide. Individuals identified as high acute risk have elevated risk of dying by suicide for a period of time." VHA Directive 1166, *Patient Record Flags*, November 6, 2023.

[14] VHA Directive 1160.07. CSRE is a standard process VHA uses to assess patients who have a positive suicide risk screening. VHA refers to lethal means as objects, including some medications, that could be used for "suicidal … self-directed violence."

[15] Inpatient providers and an inpatient nurse also documented that Patient 1 had a personally owned insulin pump.

documented that the patient would be admitted to a medical floor for further care and that a medicine consult was needed to manage Patient 1's insulin.

Later that day, an inpatient medicine nurse documented the patient had an insulin pump and noted "medication review to be conducted by provider." The inpatient medicine physician completed an evaluation of Patient 1 that acknowledged the patient's report of suicidal ideation with plan to use medication. The inpatient medicine physician further documented a plan to continue the patient's insulin pump and consult endocrinology for further recommendations on insulin management.[16]

The following morning, a different psychiatrist (Psychiatrist 2) completed a CSRE, to assess Patient 1. Psychiatrist 2 documented that Patient 1 was low acute risk for suicide and had no access to lethal means. Later that day, an endocrinologist addressed the consult placed by the inpatient medicine physician and documented that Patient 1 reported attempting suicide the previous evening by using the insulin pump to administer extra insulin. Endocrinology physicians confirmed that the patient administered extra insulin the previous evening; noted Patient 1's blood glucose was in normal range shortly after administering the insulin; and advised the inpatient medicine physicians that the insulin pump be turned off.[17]

Following the suicide attempt, a mental health social worker assessed Patient 1 daily, documented a CSRE that included Patient 1's suicide attempt, and completed lethal means counseling with management of medication access.

Patient 2

Patient 2 was in their 30's, with past diagnoses of a mood disorder, substance use disorders, psychotic disorder, personality disorder, and other comorbidities. In late summer 2024, one day after being discharged from the system's inpatient mental health unit, the patient presented to the system's emergency department reporting psychotic symptoms and stating, "the only way [to] get out of it is to die." An emergency department physician evaluated Patient 2 and documented the patient admitted to recent substance use and denied suicidal ideation. Psychiatrist 2 evaluated Patient 2 and documented the patient's thoughts of self-harm if psychotic symptoms persisted and denial of intent or plan of self-harm. Psychiatrist 2 completed a mental status exam during which active suicidal ideation was "denied." Psychiatrist 2 completed a CSRE that noted Patient 2 denied intent or a plan of self-harm and assessed Patient 2 low acute risk for suicide. Psychiatrist 2's documentation included having treated Patient 2 during multiple past mental health unit admissions, the most recent ending the day prior and that Patient 2 declined

[16] Cleveland Clinic, "Endocrinologist," accessed April 18, 2025, https://my.clevelandclinic.org/health/articles/22691-endocrinologist. "Endocrinology is the study of hormones" in the body, including diabetes.

[17] The OIG reviewed documentation that indicated staff removed the insulin pump following the patient's suicide attempt. The date and time of the insulin pump removal was not documented in the EHR.

medication management for psychosis.[18] Psychiatrist 2 documented supporting evidence and clinical rational for (1) determining diagnoses of personality disorder and substance use disorder and (2) concluding that Patient 2 was not "suffering from an acute primary psychosis." Psychiatrist 2 determined that Patient 2 did not need to be admitted to the inpatient mental health unit, and recommended outpatient treatment. Psychiatrist 1 documented an addendum concurring with Psychiatrist's 2 assessment. An emergency department nurse documented that Patient 2 left after speaking with Psychiatrist 2 and that the patient was "ok to leave" per the psychiatrist. Later that day, Patient 2 returned to the emergency department via emergency medical services. At the time of arrival, emergency medical staff reported Patient 2 ingested multiple doses of a prescribed medication and aspirin and vomited sixty pills. The patient subsequently died in the system's intensive care unit.

Inspection Results

1. Quality of Care Deficiencies

The OIG substantiated quality of care deficiencies for two patients seeking acute mental health treatment at the system. Specifically, multiple staff did not recognize Patient 1's personally owned insulin pump as a lethal means and Psychiatrist 2 did not provide Patient 2 with emergency department discharge instructions or document care consistent with VHA policy.[19]

Recognition of Insulin Pump as a Lethal Means

The OIG found that providers and staff did not identify Patient 1's insulin pump as a potential lethal means. As a result, Patient 1 continued to have access to the insulin pump—an object that posed a risk of harm—and subsequently used it to attempt suicide (adverse event 1).[20]

VHA requires patients who screened positive for risk of suicide to have a CSRE completed by a licensed independent practitioner.[21] The CSRE includes an assessment of a patient's access to

[18] Patient 2 was admitted due to suicidal ideation.

[19] VHA Directive 1101.14(1), *Emergency Medicine*, March 20, 2023, amended, March 7, 2025. The directives contain the same language regarding emergency department discharge instructions; VHA HIM, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023; VHA Health Information Management, *HIM Practice Brief Monitoring Copy and Paste,* March 2023.

[20] VHA Directive 1050.01(1). VHA defines an adverse event as "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm directly associated with care or services delivered by VA providers."

[21] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to VISN Directors (10N1-23) et al., November 23, 2022; VHA Directive 1160.07; VHA Directive 1100.21(1) *Privileging*, March 2, 2023, amended April 26, 2023; "[A] licensed independent practitioner (LIP) is an individual permitted by law and the VA medical facility, through its Medical Staff Bylaws to provide patient care services independently, without supervision or direction."

lethal means and The Joint Commission requires hospitals to implement procedures to mitigate the risk of suicide including the removal of items that pose a risk for self-harm.[22] Lethal means refers to objects, including some medications, that could be used for "suicidal … self-directed violence."[23]

Providers who are responsible for ordering and managing medication are trained and educated about medication risks and benefits and may discontinue a patient's medication if it is potentially harmful. Further, a registered nurse completes a nursing assessment, which includes medication history. [24]

The OIG reviewed the patient's EHR and found that, during Patient 1's first admission for suicidal ideation, the patient was admitted with the insulin pump. However, shortly after admission the pump ran out of insulin. Nursing staff administered insulin injections for the duration of the admission.

Over the course of Patient 1's second admission for suicidal ideation, mental health, emergency department, inpatient medical, and nursing staff completed clinical assessments but did not identify the patient's personally owned insulin pump as a lethal means.

Two mental health providers completed CSREs and documented that Patient 1 had suicidal ideation with a plan to overdose using pills, but neither recognized the patient had access to medication via a personally owned insulin pump. Psychiatrist 1 documented Patient 1 had suicidal ideation. The emergency department physician and inpatient medicine physicians documented that Patient 1 had suicidal ideation with a plan to overdose and the presence of an insulin pump. The emergency department physician and Psychiatrist 1 deferred the patient's insulin management to the inpatient medicine physicians. The inpatient medicine physicians consulted endocrinology for insulin management. An inpatient nurse identified the insulin pump as a risk factor for a skin injury; however, did not identify the insulin pump as a lethal means.

Both Psychiatrist 1 and the emergency department physician told the OIG of not considering the insulin pump as a possible source for lethal means at the time of Patient 1's admission. The emergency department physician acknowledged appreciation for being alerted to this issue and planned to consider this information in future patient psychiatric admissions.

The inpatient medicine physician, who was responsible for Patient 1's evaluation during the patient's second admission, told the OIG of having considered the insulin pump as a "possible lethal means." However, the inpatient medicine physician explained deferring to and supporting

[22] The Joint Commission, *E-dition Standards and Elements of Performance,* NPSG 15.01.01, July 1, 2025.

[23] VHA Directive 1160.07.

[24] VHA Directive 1345, *Medication Reconciliation,* March 9, 2022; System SOP [Standard Operating Procedure] 118-40, *Emergency Department Nursing Standards of Care*, October 10, 2023.

another inpatient medicine physician's evaluation that the patient could continue using the insulin pump.

The OIG concluded that staff made efforts to medically manage Patient 1's insulin. However, emergency department, mental health, and inpatient staff did not recognize the insulin pump as a lethal means for a patient with suicidal ideation and a plan to overdose with medication. As a result, staff did not remove the insulin pump, which allowed Patient 1 to administer an extra bolus of insulin to attempt suicide.

Failure to Mitigate Risk

The OIG found that leaders failed to implement system-wide actions to mitigate the risk associated with insulin pumps and patients who have suicidal ideation.

Insufficient Response and Education to Patient Safety Concerns

The OIG found that after becoming aware of adverse event 1, Patient 1's attempt to overdose with insulin, nursing leaders took some actions to educate nursing staff to prevent harm and improve processes. However, other system leaders did not take actions to educate emergency department, mental health, and inpatient medical providers and mental health staff, as a result the vulnerability of an insulin pump as a lethal means for suicide remained a patient safety risk.

VHA's high reliability organizational framework is based on three foundational pillars leadership commitment, culture of safety, and continuous process improvement. Culture of safety focuses on quality, safety, and using practices to prevent harm and learn from mistakes. The aim for process improvement is to "use effective tools for continuous learning and improvement."[25]

Following Patient 1's first admission, the inpatient diabetes educator sent an email to inpatient and emergency department nurse managers as well as a physician leader (chief hospitalist) and a physician involved in Patient 1's first admission. The email outlined safety concerns related to the patient's ability to use an insulin pump to overdose and reminded staff, "[that patients] have been successful in the past with using insulin pumps to end their lives." In an OIG interview, the inpatient diabetes educator reported not receiving many responses to this email.

The OIG learned that two days following adverse event 1, the inpatient diabetes educator sent follow-up emails to the original group and included additional system leaders.[26] The emails again addressed patient safety concerns about patients with insulin pumps and suicidal ideation. Nursing leaders responded and acknowledged the need for a policy or process and education

[25] VA, "High Reliability Organization (HRO) Fact Sheet," April 2023. "High reliability in health care means fewer accidents or events of harm, despite operating in a complex, high-risk environment."

[26] The OIG reviewed email communication referenced by the diabetes educator from October 19, 2023, through October 24, 2023. Additional system leaders included the chief of mental health, chief of emergency medicine, chief nurse of operation and specialty, patient safety manager, and risk manager.

regarding insulin pumps. Additionally, the suicide prevention coordinator replied to the diabetes educator, offering support with staff education related to safety and suicide prevention. Other system leaders, (including two service chiefs, patient safety managers, and a risk manager), did not respond to the inpatient diabetes educators' initial or follow-up emails.

In an interview with the OIG, the inpatient diabetes educator described education provided to the inpatient medical unit and emergency department nursing staff, that identified insulin pumps as a contraindication for patients with suicidal ideation and provided guidance for insulin pump removal. The Associate Director for Patient Care Services explained nurses would remove the insulin pump after a licensed independent practitioner entered an order. When asked if providers received education, the inpatient diabetes educator explained the education "was from nursing for nursing."

During interviews, the Associate Director for Patient Care Services, the chief of quality management, chief nurse operations and specialty care, and a staff member reported that following adverse event 1, a change in practice occurred regarding the removal of an insulin pump when patients are admitted for suicidal ideation. The chief of emergency medicine also acknowledged an awareness of the change made when patients with suicidal ideation require inpatient admission with an insulin pump but explained no process changes had occurred within the emergency department.

The OIG is concerned that further actions were not initiated to broadly educate staff, including emergency department, mental health, and inpatient medical providers and mental health staff who evaluate patients' access to medication and risk for suicide. Moreover, without system-wide staff education, the vulnerability of an insulin pump as a potential lethal means for suicide remains a patient safety risk.

System's Insulin Pump Policy Not Finalized

The OIG found that the system initiated drafting an insulin pump policy in 2023 but did not finalize and implement the policy.

VHA does not have a policy that specifically delineates how to manage a hospitalized patient's personally owned insulin pump. The Institute for Safe Medication Practices reports suicidal ideation as a contraindication "to self-management of the pump during hospitalization."[27]

When asked about actions taken following adverse event 1, leaders referred to a draft insulin policy but could not identify when the policy would be finalized. The OIG found the draft policy specified that insulin pumps were contraindicated for patients with suicidal ideation but did not include information for emergency department, mental health, and inpatient medical providers

[27] Institute for Safe Medication Practices, "Managing Hospitalized Patients with Ambulatory Pumps—Part 2: Guidelines for the Use of Insulin Pumps during Hospitalization," *Acute Care ISMP Medication Safety Alert!* 21, no. 21, (October 20, 2016), https://www.ismp.org/sites/default/files/attachments/2018-03/20161020.pdf.

and mental health staff regarding lethal means assessment or determining insulin pump removal. Further, the OIG found that as of March 2025, the draft policy had not been finalized or approved by the System Director.

The COS told the OIG "we … [do not] have a clear and documented policy for management of insulin pumps … [and are] in the final stages of … finalizing an insulin pump policy." The chief nurse operations and specialty care reported that "[the policy] still has to go through committee approval process" and a staff member taking leave had contributed to the delay in policy approval. The OIG opined the procedure to review and approve system policies should not be person dependent, and the system would benefit from a review of the insulin pump policy approval process.

The OIG concluded that leaders failed to ensure finalization of the draft insulin pump policy and did not recognize a sense of urgency to ensure timely approval and implementation. A process outlining system-wide guidance regarding the identification of insulin pumps as a potential lethal means and removal of an insulin pump for a patient with suicidal ideation, may prevent a similar adverse event from occurring.

Lack of National Guidance

The OIG sought input from VHA National Emergency Medicine Office, VA Office of Specialty Care, National Endocrinology and Diabetes Program, Office of Nursing Service, Office of Suicide Prevention, and Pharmacy Benefits Management Services regarding patients using personally owned insulin pumps who present with suicidal ideation in VHA emergency departments and inpatient units. The OIG learned there are no VHA directives policies, or guidance specific to patients with personally owned insulin pumps and suicidal ideation.

The OIG concluded that VHA facilities would benefit from national guidance regarding caring for patients with personally owned insulin pumps who present at risk for suicide in emergency departments and inpatient units. Further guidance could decrease the risk of patient harm and improve quality of care. The OIG has made one recommendation in an Office of Healthcare Inspection separate report; therefore, a recommendation is not included in this report.[28]

Discharge and Documentation

The OIG did not find evidence that Psychiatrist 2 provided Patient 2 with discharge instructions after completing a suicide risk assessment and determining the patient was appropriate for discharge from the emergency department. Prior to Patient 2's suicide behavior and death, an emergency department physician and Psychiatrist 2 completed evaluations that included Patient 2's denial of suicidal ideations. Additionally, Psychiatrist 2, who had a treatment history with

[28] VA OIG, *Management of Personally Owned Insulin Pumps for Patients at Risk for Suicide in Emergency Departments and Inpatient Units*, Report No. 25-03462-12, November 20, 2025.

Patient 2, documented the clinical rationale for diagnoses and recommendation of outpatient treatment. Later that day, the patient engaged in suicide behavior by ingestion of a prescribed medication and aspirin and subsequently died in the system's intensive care unit (adverse event 2). The OIG was unable to determine whether the provision of discharge instructions would have prevented Patient 2's death. The OIG found Psychiatrist 2's documentation did not align with VHA policy. [29]

Lack of Discharge Instructions from the Emergency Department

The OIG determined that Psychiatrist 2 did not provide Patient 2 with discharge instructions after concluding the patient was appropriate for discharge from the emergency department.

VHA requires that "all patients discharged from the [emergency department] are given specific follow-up care instructions" and these instructions must be documented in the EHR.[30] Discharge instructions are a vital communication tool that allow staff to review care, convey follow-up appointment information, and ensure patients understand the next steps to care.

The OIG reviewed the patient's EHR for discharge instructions and determined that the day before adverse event 2, Patient 2 was discharged from a system inpatient unit. Prior to discharge, system staff scheduled outpatient appointments for substance use disorder care, provided Patient 2 with inpatient discharge instructions, and notified the patient's mental health treatment coordinator of the treatment plan.

In an interview, the emergency department physician reported Psychiatrist 2 evaluated and "released" Patient 2. The chief of emergency medicine explained that normally emergency department staff give patients discharge instructions, however "[Psychiatrist 2] … saw and discharged [Patient 2] from the emergency department." During an interview, when asked if Patient 2 received discharge instructions, Psychiatrist 2 stated, "I cannot say for sure but I believe [Patient 2] stormed out." Psychiatrist 2 further explained that the patient had been given appointments when discharged from the inpatient mental health unit the day prior to the emergency department visit. Notably, EHR documentation did not reflect that the patient left the emergency department abruptly. Additionally, a nurse documented that Psychiatrist 2 and a nurse practitioner both said the patient was "ok to leave."

In an interview, the chief of mental health reported that discharge plans including appointments should be reviewed even if a patient was recently discharged and then returned to the system.

The OIG concluded that Psychiatrist 2 did not provide emergency department discharge instructions as required and missed the opportunity to verify Patient 2's understanding of follow-up care and required next steps.

[29] VHA Directive 1101.14(1).

[30] VHA Directive 1101.14(1).

Extensive Use of Copy and Paste

The OIG found that Psychiatrist 2's extensive use of copy and paste, and a derogatory, critical, comment was inconsistent with VHA documentation policy.[31]

VHA requires that documentation in a patient's EHR is accurate, succinct, clear, and reflects current patient status for the provision of continuity of care.[32] VHA provides guidance that "[r]epeating information does not enhance patient care …, but instead makes reading the health record more difficult and time-consuming; copied portions of notes … is overwhelming to the reader."[33] VHA prohibits the use of "[r]epetitive copying and pasting of notes."[34] Further, VHA prohibits comments that are derogatory or critical of a patient.[35]

The OIG found that approximately 77 percent of Psychiatrist 2's *Psychiatry Attending Note* for Patient 2's first emergency department visit included copied and pasted content from previous care. Specifically, content included information from two previous emergency department visits, a different VHA provider's psychiatric history for the patient, history of involvement with the justice system, and lengthy excerpts from two journal articles.

This extensive use of copy and paste could impede another provider's ability to determine which components of the information referred to Patient 2's mental health status during the current episode of care versus previous care.

When asked about EHR documentation, Psychiatrist 2 told the OIG that, "being thorough in [the *Psychiatry Attending Note*] and continuing to provide documentation that supports the rationale for discharge is important because not everyone reads all the notes."

The OIG determined the extensive use of copy and paste could have obscured relevant information regarding Psychiatrist 2's assessment and medical decision-making preceding Patient 2's adverse event. The OIG is concerned that if an EHR contains obscured information, members of the healthcare team may have difficulty coordinating and providing continuity of mental health care.

Documentation Contained a Derogatory, Critical Comment

The OIG found that Psychiatrist 2's EHR notes included a derogatory, critical comment about Patient 2. The OIG is concerned that Psychiatrist 2 copied and pasted a comment that appeared unrelated to Patient 2's clinical presentation and suggested the patient may return to the

[31] VHA Health Information Management, *HIM Practice Brief Monitoring Copy and Paste*; VHA HIM, *Health Record Documentation Program Guide Version 1.2*.

[32] VHA HIM, *Health Record Documentation Program Guide Version 1.2*.

[33] VHA Health Information Management, *HIM Practice Brief Monitoring Copy and Paste*.

[34] VHA Health Information Management, *HIM Practice Brief Monitoring Copy and Paste*.

[35] VHA Health Information Management, *HIM Practice Brief Monitoring Copy and Paste*.

emergency department or engage in behavior that should be considered criminal and not psychiatric.

When the OIG inquired about the derogatory, critical comment in the EHR, Psychiatrist 2 explained the comment was referring to an assessment of Patient 2's disruptive behavior during a previous emergency department visit.[36] Further, Psychiatrist 2 stated "[i]f I thought [Patient 2] was going to do something, I would have admitted [Patient 2] … there was no indication to me that [Patient 2] was … going to engage in [suicidal] behavior." Psychiatrist 2 stated, "I should have been a little bit more clear, because that [EHR documentation] is … confusing."

The OIG concluded that although Psychiatrist 2's critical comment did not affect the medical care Patient 2 received after returning to the emergency department following the ingestion of multiple doses of prescribed medication and aspirin, such documentation had the potential to bias providers responsible for evaluating the patient for continuity of mental health care. Moreover, had Patient 2 accessed the EHR, the critical comment could have negatively affected the patient's engagement in future care.

2. Deficient Quality Management Processes

The OIG determined the System Director and COS did not ensure that quality management processes were conducted in an accurate and complete manner to address system vulnerabilities and patient safety risks for Patients 1 and 2. Specifically, the OIG identified deficiencies with the safety assessment code (SAC) scoring, and the RCA and peer review processes.

Safety Assessment Code

The OIG found the system patient safety manager did not correctly apply VHA guidance when determining the potential risk SAC score. Specifically, Patient 1's suicide attempt was not recognized as a potential catastrophic event and was not assigned a SAC score that required an RCA.[37]

VHA requires patient safety managers review patient safety events to determine the severity of an incident using two scores: an actual risk score for the harm that occurred and a potential risk score for "what could have happened."[38] VHA provides guidance to consider the "reasonable"

[36] The OIG reviewed documentation that confirmed the patient engaged in physical disruptive behavior that "was related to alcohol or substance abuse," and which "did [not] involve criminal and purposefully unsafe act."

[37] VHA National Center for Patient Safety, *Guidebook for Safety Assessment Code (SAC) Evaluation*, August 2023, replaced by VHA National Center for Patient Safety, *Guidebook for Safety Assessment Code (SAC) Evaluation*, April 2025. The guidebooks contain the same language regarding severity categories; VHA Directive 1050.01(1).

[38] VHA National Center for Patient Safety, *Guidebook for Safety Assessment Code (SAC) Evaluation*; VHA Directive 1050.01(1).

worst-case outcome when assessing the severity of potential risk.[39] Further, according to VHA, a RCA is required when the potential risk is scored as catastrophic, which may be "death or major permanent loss of function … not related to the natural course of the patient's illness."[40]

The OIG reviewed documentation and found that a system patient safety manager assessed adverse event 1 but did not assign a potential SAC score of catastrophic; therefore, an RCA was not required. In email communication to the OIG, the patient safety manager, who had recently assumed the role at the time of the event, could not recall the discussion with the quality team about how the score was determined. The patient safety manager explained the potential SAC score should have reflected a potential catastrophic outcome. The OIG opined that adverse event 1 involved the potential for a patient's death and should have been scored catastrophic.

The OIG concluded system patient safety manager's scoring of adverse event 1 did not acknowledge the potential for catastrophic harm and precluded an RCA. Completion of an RCA to evaluate adverse event 1 would have afforded the system the opportunity to review potential process issues and implement mitigation strategies that could help prevent a similar event from reoccurring.

Root Cause Analysis

The OIG found that facility staff completed an RCA in response to adverse event 2 that did not include a complete and comprehensive review of Patient 2's care on the day of the event. Specifically, the RCA team did not interview staff involved in the patient's first of two emergency department visits on the day of adverse event 2.

According to the VHA National Center for Patient Safety, following an adverse event, an RCA looks at system processes "to find out what happened, why it happened, and what must be done to prevent it from happening again." The RCA team works to understand and define "what factual events took place leading to an adverse event" through interviews, document review, and analysis that results in the identification of contributing factors and a plan to address process issues.[41] In addition, VHA provides guidance that individuals directly involved in an adverse event be interviewed as part of the RCA process.[42]

The OIG found the RCA team focused on the care provided to Patient 2 following ingestion of multiple doses of prescribed medication and aspirin. In an interview an RCA team member

[39] VHA National Center for Patient Safety, *Guidebook for Safety Assessment Code (SAC) Evaluation*. VHA outlines severity in four categories: minor "no injury, nor increased length of stay," moderate "increased length of stay," major "permanent lessening of bodily functioning … not related to the natural course of the patient's illness," catastrophic "death or major permanent loss of function … not related to the natural course of the patient's illness."

[40] VHA Directive 1050.01(1); VHA National Center for Patient Safety, *Guidebook for Safety Assessment Code (SAC) Evaluation.*

[41] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis Version 15*, July 2024.

[42] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis Version 15.*

reported the decision to discharge Patient 2 after the first emergency department visit was a clinical decision; therefore, the RCA team did not review the care preceding adverse event 2 for process improvement opportunities.

During OIG interviews both the patient safety manager, who served as the RCA team's adviser, and the chief of quality reported an understanding that the RCA team should have interviewed staff involved in the process or care of the patient prior to adverse event 2. When asked how the decision was made on who should be interviewed for the RCA, the patient safety manager explained the team made the decision; but the patient safety manager was not part of the discussions, and there was no documentation available related to the decision.

The OIG concluded that RCA team members did not interview staff involved in the emergency department visit preceding adverse event 2 to ensure a complete understanding of potential contributing factors to adverse event 2. Therefore, potential process issues and improvement opportunities regarding patient safety may not have been identified and addressed.

Peer Review Oversight

The OIG found that the COS and deputy chief of staff did not ensure peer representation during a PRC meeting to finalize a peer review of Psychiatrist 2.[43]

Peer review is a confidential process used to review the clinical care provided by an individual healthcare provider. VHA defines a peer as a "health care professional that has comparable education, training, experience, [and] licensure … who can make a fair and credible assessment of the actions taken by the clinician … under review."[44] A peer reviewer makes an initial evaluation of the provider under review's care and assigns a level from 1 to 3.[45] The COS is responsible for "arranging for appropriate [peer] representation at PRC meetings."[46] The PRC is responsible for the discussion and review of all initial peer reviews with an initial assigned level of 2 or 3.[47]

The OIG found that the PRC changed the level of an initial peer review. The OIG found the peer review was lowered to a level that did not require any follow-up action. During an interview, the COS explained the expectation was that a VHA psychiatrist be included in the PRC's discussion regarding adverse event 2. However, the COS did not report concerns with the PRC's decision to

[43] VHA Directive 1190(1).

[44] VHA Directive 1190(1).

[45] VHA Directive 1190(1), The levels are based on what the peer reviewer would have done under the same set of circumstances. "Level 1 is the level at which most experienced and competent clinicians would have managed the case in a similar manner." "Level 3 is the level at which experienced and competent clinicians would have managed the case differently."

[46] VHA Directive 1190(1).

[47] VHA Directive 1190(1).

lower the rating without a peer at the PRC meeting. The COS also told the OIG of not being present at the PRC meeting and stated that the deputy chief of staff served as chairperson that day.[48]

When asked about having an expectation to have a peer involved in a review discussion at a PRC meeting, the deputy chief of staff told the OIG of being aware of the requirement. The deputy chief of staff incorrectly thought the psychiatrist's external peer review met the requirement to have a psychiatrist present at the meeting. Further, the deputy chief of staff explained the assistant chief of mental health, who is a psychologist, presented the initial peer review and Psychiatrist 2's response to the PRC.[49] The deputy chief of staff also reported discussing the peer review level change with the COS following the PRC's decision to lower the rating, and stated the COS did not voice any concerns. Following the interview, the deputy chief of staff emailed the OIG and confirmed "a psychiatrist was not present for the peer review."

The OIG concluded that the COS and deputy chief of staff failed to ensure that a healthcare professional peer was present at the PRC meeting when the review of Psychiatrist 2's care was discussed and the peer review level was changed. Without peer representation for Psychiatrist 2, the PRC did not ensure the discussion for final peer review level was fair and credible as required.[50]

Conclusion

The OIG substantiated quality of care deficiencies for two patients seeking acute mental health treatment. Multiple staff did not recognize Patient 1's personally owned insulin pump as a lethal means. As a result, staff did not remove the insulin pump, which allowed Patient 1 to subsequently use it to attempt suicide.

Following the attempted suicide, leaders failed to implement system-wide actions to mitigate the risk associated with insulin pumps and patients who have suicidal ideation. The OIG found that nursing leaders acknowledged the need for and provided education to some nurses after adverse event 1. Further a facility insulin policy, which included information identifying an insulin pump as a lethal means for patients with suicidal ideation was drafted. However, system leaders failed to (1) ensure medical providers and mental health staff were included in the education and (2) finalize the draft insulin pump policy. In addition, VHA directives, policies, and guidance do not provide instruction specific to patients with personally owned insulin pumps and suicidal

[48] VHA Directive 1190(1). VHA requires that a service chief initiate follow-up actions with staff whose peer reviews have a final assignment of level 2 or level 3.

[49] Psychologists do not meet the definition of peer of a psychiatrist as they do not have comparable education, training, licensure, or experience.

[50] VHA Directive 1190(1).

ideation. The OIG concluded that VHA facilities would benefit from national guidance, which could decrease risk of patient harm and improve quality of care.

The OIG determined that Psychiatrist 2 did not provide Patient 2 with discharge instructions after determining the patient was appropriate for discharge from the emergency department. Additionally, the OIG determined that Psychiatrist 2's documentation was inconsistent with VHA policy. Psychiatrist 2's extensive use of copy and paste could obscure relevant information and members of the healthcare team may have difficulty coordinating and providing continuity of mental health care.

The OIG found that Psychiatrist 2 included a derogatory, critical, comment about Patient 2 in EHR notes and although Psychiatrist 2's comment did not affect medical care documentation, the comment had the potential to bias providers responsible for evaluating the patient for continuity of mental health care.

The OIG determined that the System Director and COS did not ensure that quality management processes were conducted accurately and completely to address system vulnerabilities and patient safety risks for Patients 1 and 2. The system patient safety manager's scoring of adverse event 1 did not acknowledge the potential for catastrophic harm and precluded an RCA. Additionally, RCA team members did not interview staff involved in the emergency department visit preceding adverse event 2 to ensure a complete understanding of potential contributing factors to adverse event 2. Last, the OIG found that the COS and deputy chief of staff did not ensure peer representation during a PRC meeting to finalize a peer review of Psychiatrist 2.

The OIG issued eight recommendations. The System Director provided action plans related to personally owned insulin pumps, an insulin pump policy, compliance with discharge instructions, review of a psychiatrist's EHR accuracy of safety assessment code scores, education on root cause analysis processes, and psychiatrist peer representation at the system Peer Review Committee for psychiatry case reviews.

Recommendations 1–8

1. The Lexington VA Healthcare System Director ensures emergency department, mental health, and inpatient medical and nursing staff responsible for suicide risk assessment understand the need to evaluate patients for a personally owned insulin pump and remove the insulin pump prior to inpatient admission, when necessary, and monitors for compliance.
2. The Lexington VA Healthcare System Director verifies the draft insulin pump policy is finalized, and Lexington VA Healthcare System emergency department, mental health, and inpatient medical and nursing staff are educated on the policy.
3. The Lexington VA Healthcare System Director ensures leaders and staff review the Lexington VA Healthcare System policy evaluation and approval procedure.
4. The Lexington VA Healthcare System Director verifies that patients receive discharge instructions, with a follow-up care plan, when discharged from the Lexington VA Healthcare System emergency department.
5. The Lexington VA Healthcare System Director ensures a review of Psychiatrist 2's documentation in Patient 2's electronic health record and makes certain documentation is completed according to Veterans Health Administration policy, including that entries are accurate, succinct, without extensive copy and paste, and devoid of derogatory, critical comments, and takes action as warranted.[51]
6. The Lexington VA Healthcare System Director confirms that the patient safety managers understand and apply Veterans Health Administration guidance to accurately use safety assessment codes when scoring a patient safety event.
7. The Lexington VA Healthcare System Director verifies that root cause analyses are completed according to Veterans Health Administration policy including interviewing individuals knowledgeable about the event.
8. The Lexington VA Healthcare System Director ensures peer representation at the Peer Review Committee for psychiatry case reviews.

[51] During the draft review phase, VHA submitted technical comments that clarified VHA Health Information Management, *HIM Practice Brief Monitoring Copy and Paste*; VHA HIM, *Health Record Documentation Program Guide Version 1.2* policies. Based on these comments, the OIG made changes to this recommendation in the final report.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 29, 2025

From: Acting Network Director, Department of Veterans Affairs (VA) MidSouth Healthcare Network (10N9)

Subj: Office of Inspector General (OIG) Draft Report—Review of Quality of Care for Patients Seeking Acute Mental Health Care at the Lexington VA Healthcare System in Kentucky

To: Director, Office of Healthcare Inspections (54HL04)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the OIG's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. I concur with the report findings and recommendations of OIG's report –Review of Quality of Care for Patients Seeking Acute Mental Health Care at the Lexington VA Healthcare System in Kentucky.

2. I have reviewed the documentation and concur with the action plans as submitted.

3. Should you need further information, contact the Veterans Integrated Network (VISN) 9, Quality Management Officer.

(*Original signed and dated September 30, 2025, by:*)

Anthony M. Stazzone, MD, FACP
Title

[OIG comment: The OIG received the above memorandum from VHA on September 30, 2025.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 29, 2025

From: Director, Lexington Department of Veterans Affairs (VA) Healthcare System (596)

Subj: Office of Inspector General (OIG) Healthcare Inspection—Review of Quality of Care for Patients Seeking Acute Mental Health Care at the Lexington VA Healthcare System in Kentucky

To: Network Director, VA MidSouth Healthcare Network (10N9)

1. The Lexington VA Healthcare System is committed to honoring Veterans by ensuring they receive high-quality health care services. I appreciate the opportunity and always look to improve the care provided by the Lexington VA Healthcare System.

2. Please find the attached response to each recommendation included in the report. The Lexington VA Healthcare System completed, or is in the process of completing, the OIG's recommended actions to strengthen the care we provide.

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

(*Original signed by*:)

Russell W. Armstead, CGFM

[OIG comment: The OIG received the above memorandum from VHA on September 30, 2025.]

Facility Director Response

Recommendation 1

The Lexington VA Healthcare System Director ensures emergency department, mental health, and inpatient medical and nursing staff responsible for suicide risk assessment understand the need to evaluate patients for a personally owned insulin pump and remove the insulin pump prior to inpatient admission, when necessary and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: April 2026

Director Comments

By October 31, 2025, education will be provided to all emergency department, mental health, and inpatient medical and nursing staff responsible for suicide risk assessment to evaluate patients for a personally owned insulin pump and remove the insulin pump prior to admission, when necessary. The Chief, Quality, Performance, and Patient Safety will conduct a chart audit on all patients admitted with an insulin pump to ensure the appropriate suicide risk assessment was completed and insulin pump was removed when applicable. Audit data will be reported by the Chief, Quality, Performance, and Patient Safety in Health Care Delivery Council until 90 percent compliance is sustained for six consecutive months.

Recommendation 2

The Lexington VA Healthcare System Director verifies the draft insulin pump policy is finalized, and Lexington VA Healthcare System emergency department, mental health, and inpatient medical and nursing staff are educated on the policy.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

On May 13, 2025, Medical Center Policy (MCP) 11-39 Insulin Pump Policy was finalized. The emergency department, mental health, and inpatient medical and nursing staff will be educated on MCP 11-39 by October 31, 2025. Finalization of MCP 11-39 and staff training will be reported in Health Care Delivery Council by the Chief, Quality, Performance, and Patient Safety.

Recommendation 3

The Lexington VA Healthcare System Director ensures leaders and staff review the Lexington VA Healthcare System policy evaluation and approval procedure.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The Lexington VA Health Care System will review the facility policy evaluation and approval procedure to identify and address potential time barriers and educational gaps that impact the policy review process. Detailed analysis and educational plan will be reported to Quality and Patient Safety Council (QPSC) by December 1, 2025.

Recommendation 4

The Lexington VA Healthcare System Director verifies that patients receive discharge instructions, with a follow-up care plan when discharged from the Lexington VA Healthcare System emergency department.

_X _Concur

____Nonconcur

Target date for completion: April 2026

Director Comments

Each month, the Chief of Staff (COS) will ensure an audit of 30 patients discharged from the emergency department to ensure discharge instructions and follow-up care plans are completed. Audit data will be reported in the Health Care Delivery Council by COS or designee until 90 percent compliance is sustained for six consecutive months.

Recommendation 5

The Lexington VA Healthcare System Director ensures a review of Psychiatrist 2's documentation in Patient 2's electronic health record and makes certain documentation is completed according to Veteran Health Administration policy, including that entries are accurate, succinct, without extensive copy and paste, and devoid of derogatory, critical, comments, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

By December 1, 2025, a review of Psychiatrist 2's documentation in patient 2's electronic health record will be completed to ensure documentation is compliant with VHA policy that identifies entries are accurate, succinct, without extensive copy and paste, and devoid of derogatory, critical comments. Results of review and appropriate administration action as warranted will be managed by the Chief of Staff.

Recommendation 6

The Lexington VA Healthcare System Director confirms that the patient safety managers understand and apply Veteran Health Administration guidance to accurately use safety assessment codes when scoring a patient safety event.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

On January 9 – 11, 2024, the Patient Safety Managers attended Foundations for Patient Safety face-to-face training. Additional Root Cause Analysis training was completed by Patient Safety Managers on November 11, 2023, and February 19, 2025. These trainings included VHA guidance to accurately use safety assessment codes (SAC) when scoring a patient safety event.

Each month, the Chief, Quality, Performance, and Patient Safety will audit 10 patient safety events to confirm proper SAC scoring. Audit data will be reported to the Quality and Patient Safety Council until 90 percent compliance is sustained for six consecutive months.

Recommendation 7

The Lexington VA Healthcare System Director verifies that root cause analyses are completed according to Veterans Health Administration policy including interviewing individuals knowledgeable about the event.

_X _Concur

____Nonconcur

Target date for completion: August 2025

Director Comments

An audit was completed by the Chief, Quality, Performance, and Patient Safety from March – August 2025 for completed root cause analyses to ensure interviews were conducted by the Root Cause Analysis team and were documented. Greater than 90% compliance was sustained for six consecutive months. Audit data will be reported to the Quality and Patient Safety Council on September 24, 2025.

OIG Comments

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

Recommendation 8

The Lexington VA Healthcare System Director ensures peer representation at the Peer Review Committee for psychiatry case reviews.

_X _Concur

____Nonconcur

Target date for completion: April 2026

Director Comments

The Peer Review Charter will be updated by October 31, 2025, to ensure peer representation at the Peer Review Committee for psychiatric case reviews. The Chief, Quality, Performance, and Patient Safety will review Peer Review meeting attendance roster each month and ensure peer representation was present for psychiatric cases. Audit data will be reported to the Quality and Patient Safety Council until 90 percent compliance is sustained for six consecutive months.

OIG Contact and Staff Acknowledgments

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