US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the Martinsburg VA Medical Center in West 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. The OIG conducted this inspection from January 21 through April 3, 2025, to address the mental health care delivered in the acute inpatient mental health unit (inpatient unit) at the Martinsburg VA Medical Center (facility) in West Virginia.

The OIG evaluated acute inpatient mental health care across five domains. The OIG assessed processes in each of the domains and identified successes and challenges that affected the quality of care provided on the inpatient unit. The OIG issued 16 recommendations to facility and Veterans Integrated Service Network (VISN) 5 leaders.

For information on the background of 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 evaluated reporting channels, committee structures, staffing practices, and oversight and monitoring provided by leaders. At the time of the inspection, the facility's executive leadership team consisted of the Facility Director, Associate Director, Chief of Staff, and Associate Director for Patient Care Services. The Chief of Staff and the Associate Director for Patient Care Services supervised program chiefs, including the Chief of Mental Health and the Chief Nurse, Mental Health, respectively. The Chief of Mental Health served as the required mental health lead and oversaw all mental health programs, including the inpatient unit. Discipline leads supervised their respective inpatient unit staff. The Chief of Mental Health identified communication challenges in the reporting structure with leaders outside the mental health service supervising nursing staff on the inpatient unit. The OIG also observed ongoing communication issues between facility executive and mental health leaders, including executive leaders being unaware of pertinent information related to mental health staffing and processes. The Chief of Mental Health chaired the facility's Mental Health Executive Council, which also included inpatient unit staff. However, the council did not meet the requirement for veteran representation, which could provide critical stakeholder input. OIG recommendations: • The Facility Director ensures regular communication between mental health and executive leaders regarding staffing needs and mental health processes.

[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
	• The Facility Director ensures the Mental Health Executive Council operates in accordance with Veterans Health Administration requirements.
Recovery-Oriented Principles 	Recovery-oriented mental health treatment is personalized to a veteran's abilities, resources, preferences, and values, and empowers the veteran to make decisions and meet treatment goals. To assess the inpatient unit's integration of recovery-oriented principles, the OIG examined aspects of leadership, interdisciplinary programming, treatment planning, and the care environment. The facility did not meet the Veterans Health Administration requirement to have a full-time, dedicated local recovery coordinator. Mental health leaders had a recovery transformation plan but not a standard operating procedure for education and implementation of recovery-oriented services on the inpatient unit. Mental health leaders solicited input from veterans who used inpatient mental health services and implemented their suggestions, including increasing group programming and veteran involvement in treatment planning. Inpatient unit staff offered veterans at least four hours of recovery-oriented, interdisciplinary programming on weekdays and weekends. However, the programming did not consistently occur as scheduled and there was no formal process to ensure coverage when group facilitators were unavailable. Nurses educated veterans on recovery principles by reviewing the group programming schedule and orientation packet. The interdisciplinary team met with veterans to set individualized treatment goals and coordinated with outpatient services to assist with continuity of care. The inpatient unit had some elements of a hopeful and healing environment, such as a dayroom and bedrooms with natural light and artwork. Staff also had written guidance for safely accompanying veterans outdoors. However, the OIG found communal shower room monitoring practices could compromise veterans' privacy and dignity. OIG recommendations: • The Chief of Mental Health ensures a full-time, dedicated local recovery coordinator is integrated into the inpatient mental health unit to support recovery-oriented care. • The Chief of Mental Health ensures mental health leaders develop and implement written processes for staff training, education, and recovery-oriented services. • The Chief of Mental Health ensures staff provide a minimum of four hours of recovery-oriented, interdisciplinary mental health programming on weekdays and weekends. • The Facility Director ensures veterans' privacy in the communal shower room on the inpatient mental health unit.

Domain	OIG Summary
Clinical Care Coordination 	Care coordination, which involves intentionally sharing a veteran's information and organizing healthcare activities, is crucial for those with complex health and social needs. To assess the quality of clinical care coordination, the OIG reviewed access to services, facility processes for involuntary treatment, interdisciplinary treatment planning, medication management, and discharge planning. Facility leaders established a policy for admission to the inpatient unit for mental health treatment, but facility staff did not document veterans' capacity to consent to admission. Additionally, staff did not perform involuntary holds or admissions due to leaders' incorrect interpretation of West Virginia state law. The facility lacked formal processes to monitor compliance with involuntary commitment requirements and communication with non-VA facilities at patient discharge. The VISN also did not identify that the facility's involuntary hospitalization policy did not align with state laws. The facility had written guidance for inpatient unit treatment planning processes and the transition of care following discharge. However, staff did not consistently document medication risk and benefit discussions. Most discharge instructions included abbreviations and acronyms that could be difficult for veterans and caregivers to understand. Not all instructions included the reasons for prescribed medications; many documented both trade and generic names with no explanation that the medications were the same. OIG recommendations: • The Facility Director ensures clinicians document veterans' capacity to consent to admission to the inpatient mental health unit. • The Veterans Integrated Service Network Director ensures facilities' involuntary hold and hospitalization processes align with applicable state laws and develops processes for ongoing oversight. • The Facility Director consults with District Counsel to establish written involuntary hold and hospitalization processes that align with West Virginia State laws and monitors compliance. • The Facility Director develops and implements written care coordination processes for veterans involuntarily admitted to non-VA healthcare facilities. • The Chief of Staff ensures providers document discussions with veterans on the risks and benefits of newly prescribed medications and monitors for compliance. • The Chief of Staff ensures veterans' discharge instructions are written in easy-to-understand language and include the follow-up appointment location, the purpose of each medication, and an explanation when both trade and generic names are used for the same medication.

Domain	OIG Summary
Suicide Prevention 	The underlying causes of suicide can be complex and multifactorial, and suicide prevention may require coordinated systems, services, and resources to effectively support veterans at risk of suicide. To evaluate suicide prevention activities on the inpatient unit, the OIG reviewed compliance with required suicide risk screening and evaluation, safety planning, and training. The OIG found that staff consistently completed the Columbia-Suicide Severity Rating Scale, a suicide risk assessment tool, within 24 hours before discharge. However, the safety plans reviewed did not consistently address ways to make the veteran's environment safer from potentially lethal means. The OIG made related recommendations in a recently published report. Clinical staff completed Skills Training for Evaluation and Management of Suicide, but nonclinical staff did not consistently complete VA S.A.V.E. (signs of suicidal thinking, ask questions, validate the person's experience, and encourage treatment and expedite getting help) training. OIG recommendations: • The Facility Director ensures staff comply with suicide prevention training requirements and monitors for compliance.
Safety 	The primary goal of inpatient mental health services is to stabilize veterans who are experiencing acute distress by providing a safe, secure environment with staff trained to recognize and mitigate 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 the Interdisciplinary Safety Inspection Team (ISIT) conducted Mental Health Environment of Care Checklist inspections at the required frequency, meeting minutes lacked required membership and attendance details. The OIG observed safety hazards such as unapproved window coverings in most bedrooms and potentially unsafe equipment in a communal shower room. Further, during multiple Mental Health Environment of Care Checklist (MHEOCC) inspections, the ISIT did not identify the window coverings as a safety hazard in the Patient Safety Assessment Tool and did not follow the required process for correcting this issue. Additionally, inpatient unit staff and the ISIT did not consistently complete Veterans Health Administration-required MHEOCC annual training nor follow processes for reporting training completion. OIG recommendations: • The Facility Director ensures Interdisciplinary Safety Inspection Team members participate in Mental Health Environment of Care Checklist inspections and document membership and attendance. • The Facility Director ensures the Interdisciplinary Safety Inspection Team accurately identifies, documents, and addresses safety hazards within the Patient Safety Assessment Tool and monitors for compliance. • 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

The Veterans Integrated Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes D and E). The VISN Director concurred with recommendation 8 and reported initiating the development of involuntary hold procedures and directing comprehensive reviews of all cases to ensure practices align with state law. The Facility Director concurred with recommendations 1–7 and 9–16 and reported instituting initiatives to enhance oversight of mental health services through monthly leadership meetings, monitoring key performance indicators, and appointing a veteran representative to serve on leadership committees. In addition, the Facility Director reported plans to expand staff training, improve care coordination between VA and non-VA facilities, and standardize documentation and discharge procedures to promote recovery-oriented care. The OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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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
S.A.V.E.	signs of suicidal thinking, ask questions, validate the person's experience, and encourage treatment and expedite getting help
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The mission of the VA Office of Inspector General (OIG) is to conduct independent oversight of VA. The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care through 1,380 healthcare facilities to more than 9.1 million enrolled veterans.[1] The OIG established the Mental Health Inspection Program to regularly evaluate VHA's continuum of mental healthcare services.[2] The OIG conducted an inspection from January 21 through April 3, 2025, to evaluate acute inpatient mental health services provided at the Martinsburg VA Medical Center (facility) in West Virginia.[3]

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).[4] 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.[5]

All HCSs must provide diagnosis, evaluation, and treatment for the full spectrum of mental health conditions. Required services include psychological and neuropsychological evaluation, evidence-based individual and group psychotherapy, pharmacotherapy, peer support, and vocational rehabilitation counseling.[6]

[1] "Mission, Vision, Values," OIG, accessed June 10, 2024, https://www.vaoig.gov/about/mission-vision-values; "About VHA," VA, accessed January 8, 2025, 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] "About us," VA, accessed March 10, 2025, https://www.va.gov/martinsburg-health-care/about-us/.

[4] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.

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

[6] VHA Directive 1160.01. If an HCS does not provide required services, those services must be offered through another VA facility or program.

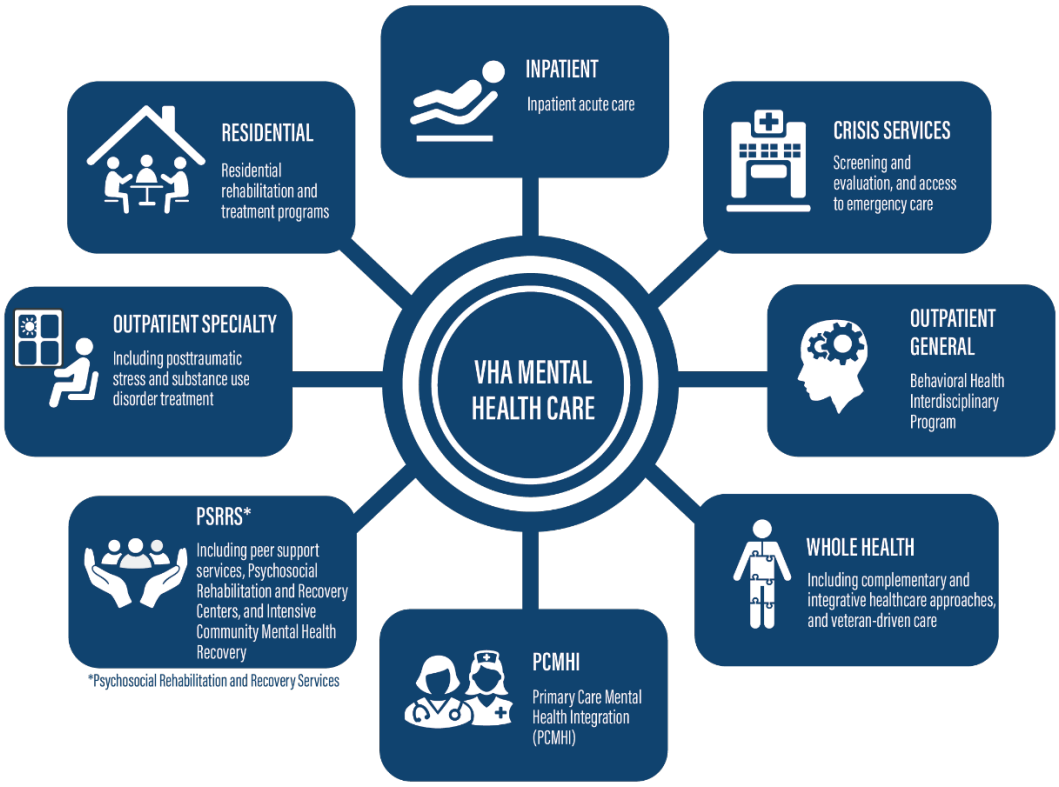

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services*, August 13, 2019, amended to VHA Directive 1163(1) on March 7, 2025. This directive was rescinded and replaced with VHA Directive 1163,* Psychosocial Rehabilitation and Recovery Services*, on August 14, 2025. For the purpose of this inspection, the directives contain the same or similar language related to psychosocial rehabilitation and recovery services.*

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.[7] In fiscal year (FY) 2024, VHA HCSs delivered inpatient mental health care for 64,298 veteran stays.[8]

[7] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023, amended to VHA Directive 1160.06(1), December 27, 2024. Unless otherwise specified, the amended directive contains similar language related to inpatient mental health unit requirements. 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.

[8] 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. "Admissions, Discharges, & Transfers (ADT) by Nursing Unit Type - National Summary," VHA Support Service Center, accessed April 30, 2024, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fNursing%2fADT%2fADT_UnitTypeSummary_Ntl&rs:Command=Render&rc:Toolbar=True. (This site is not publicly accessible.)

To evaluate the quality of inpatient mental health care at the HCS, the OIG assessed specific processes across five domains: leadership and organizational culture, recovery-oriented principles, clinical care coordination, suicide prevention, and safety. For background information and related requirements, refer to appendix A. For information on the OIG's data collection methods, see appendix B.

About the Martinsburg VA Medical Center

The facility, part of Veterans Integrated Service Network (VISN) 5, provides acute inpatient mental health care and operates seven community-based outpatient clinics located in Maryland, West Virginia, and Virginia.[9]

In FY 2024, the facility provided health care to 37,674 veterans, with 12,525 receiving outpatient mental health care. The facility's acute inpatient mental health unit (inpatient unit) maintained an average daily census of 10, with staff caring for 331 veterans. Facility staff submitted one consult for inpatient mental health care in the community. At the time of this inspection, the inpatient unit had 23 authorized beds.[10]

[9] The seven community-based outpatient clinics are in the cities of Cumberland, Hagerstown, and Fort Detrick, Maryland; Petersburg and Franklin, West Virginia; and Winchester and Harrisonburg, Virginia.

[10] "Corporate Data Warehouse (CDW)," VA Health Systems Research, accessed April 8, 2020, https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm; VHA Support Service Center Capital Assets (VSSC), VA, accessed July 18, 2025, https://www.data.va.gov/dataset/VHA-Support-Service-Center-Capital-Assets-VSSC-/2fr5-sktm/about_data.

Leadership and Organizational Culture

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

The OIG reviewed the facility's leadership structure, inpatient unit staffing practices, and VISN oversight, while evaluating 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 Facility Director, Associate Director, Chief of Staff, and Associate Director for Patient Care Services. The Chief of Staff and the Associate Director for Patient Care Services supervised program chiefs, including the Chief of Mental Health and the Chief Nurse, Mental Health, respectively. The Chief of Mental Health served as the required mental health lead and oversaw all mental health programs, including the inpatient unit (see figure 2).[13]

Discipline leads supervised their respective inpatient unit staff. For example, the chief of psychiatry provided direct oversight of inpatient unit psychiatrists, and the inpatient mental health nurse manager (nurse manager) supervised nursing staff (see appendix C for information on current staffing levels). The Chief of Mental Health identified communication challenges in the reporting structure, with leaders outside the mental health service supervising nursing staff on the inpatient unit.

The OIG observed ongoing communication challenges between facility executive and mental health leaders, including executive leaders being unaware of pertinent information related to mental health staffing and processes. During an OIG discussion with VISN and facility leaders, the Chief of Staff requested information reported by mental health leadership regarding

[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*, July 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] VHA Directive 1160.01.

important state requirements and local practices related to involuntary holds, such as previously undisclosed guidance on these practices (discussed further in the Involuntary Hospitalization and Treatment section). Additionally, executive leaders reported instances in which challenges affecting mental health were not clearly communicated, such as the need for more suicide prevention staff.

The Chief of Mental Health stated a staff member was hired to be the local recovery coordinator (LRC) but the individual continued to serve in a prior suicide prevention role until executive leaders approved the position to be backfilled. Executive leaders stated if the need had been communicated, they would have been supportive of hiring for the suicide prevention position. Lapses in communication between facility leaders may negatively affect veteran care.

VHA requires HCSs to establish a mental health executive council (MHEC) to ensure quality mental health care that is responsive to veteran preferences.[14] The facility MHEC was chaired by the Chief of Mental Health, as required. The MHEC included the acting LRC and inpatient unit staff but did not meet the requirement for veteran representation.[15] The Chief of Mental Health reported the lack of veteran representation was an oversight, and acknowledged prior difficulty recruiting veterans to serve on the MHEC. Without the required representation, the facility's MHEC missed opportunities to ensure input from key stakeholders to identify and address inpatient unit quality of care concerns.

Inpatient Unit Staffing

The facility had an inpatient mental health program manager (program manager), as required by VHA.[16]

At the time of the inspection, mental health leaders reported adequate nursing staff to accommodate 15 operating beds. Executive leaders also reported sufficient staff to support the average daily census and being unaware of any staffing issues affecting the inpatient unit.

Mental health leaders reported collecting inpatient unit staff's input through a suggestion box, multiple unit committees, and regular meetings to discuss improvements. The nurse manager provided an example of process improvement from staff input: inpatient unit staff meet veterans while in the emergency department to assist in admission procedures to the inpatient unit.

[14] VHA Directive 1160.01.

[15] VHA Directive 1160.01; The OIG reviewed meeting minutes provided by the facility from October 1, 2023, through September 30, 2024. The facility refers to its MHEC as the Mental Health Executive Council/Integrated Clinical Community.

[16] VHA Directive 1160.06; VHA Directive 1160.06(1). The program manager is defined as a leadership position and can be filled by "the full range of core mental health disciplines." The amended directive does not include this specification although notes the position title may vary based on "the discipline selected." The program manager was supervised by nursing.

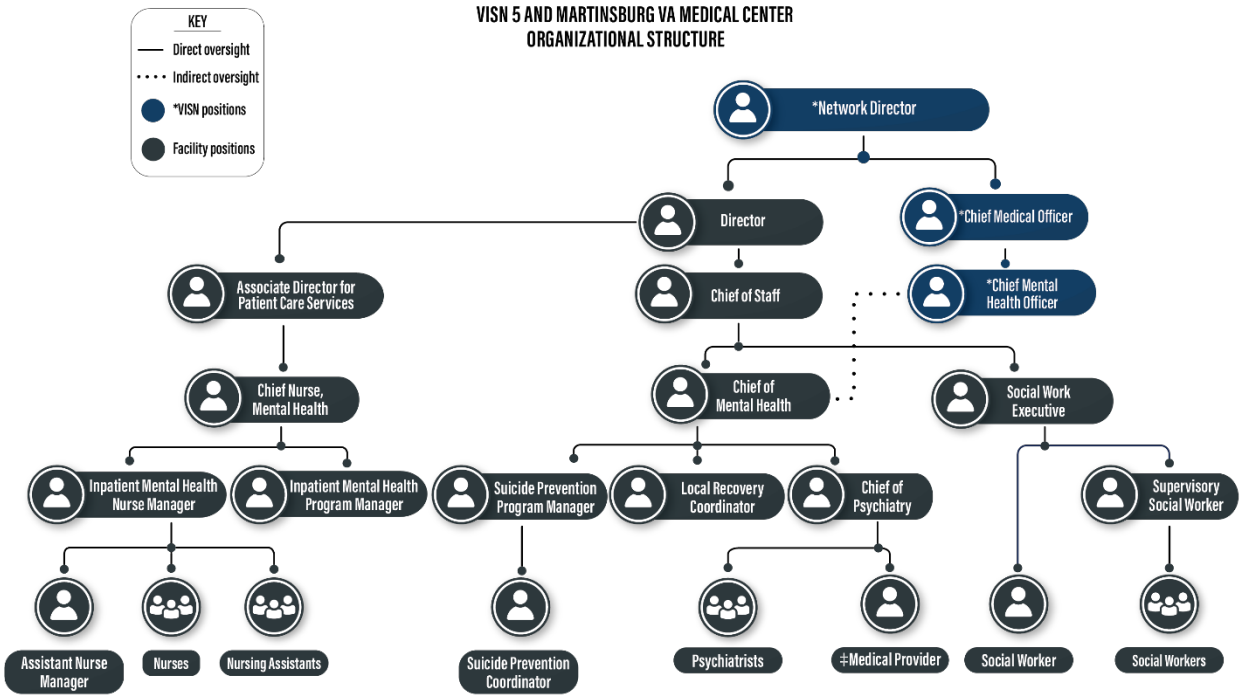

Figure 2. *VISN 5 and facility organizational structure.*
Source: OIG analysis of interviews and facility documents (received January 21 through March 7, 2025); VHA Directive 1160.06; VHA Directive 1160.06(1); VHA Directive 1160.01.
Note: The OIG considers the direct supervisor of each position to be the equivalent of "direct oversight," and programmatic oversight of identified positions as the equivalent of "indirect oversight." In addition to the inpatient mental health program and nurse manager, staff disciplines identified in the bottom row were assigned to the inpatient unit; however, the figure does not represent all inpatient unit staff. The suicide prevention coordinator and the local recovery coordinator were designated as acting in the positions.
‡ *The medical provider role was filled by a physician's assistant at the time of the inspection.*

Recommendations

1. The Facility Director ensures regular communication between mental health and executive leaders regarding staffing needs and mental health processes.
2. The Facility Director ensures the Mental Health Executive Council operates in accordance with Veterans Health Administration requirements.

For detailed action plans, see appendix E.

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on an individual's "strengths, talents, coping abilities, resources, and inherent values."[17] 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.[18]

The OIG examined aspects of leadership, programming, and the physical care environment to evaluate the facility's integration of recovery-oriented principles, as required, on the inpatient unit.[19]

Leadership

VHA expects the program manager to "coordinate and promote consistent, sustained, high-quality therapeutic programming" on the inpatient unit.[20] The program manager described responsibilities including coordination of group programming, staff training, clinical coverage, communication with outpatient providers, and management of post-discharge follow-up.

The facility did not meet the VHA requirement to have a full-time, dedicated LRC.[21] The acting LRC, who was balancing suicide prevention position responsibilities, described conducting recovery-oriented activities on the inpatient unit such as staff education and group programming. The acting LRC anticipated having the bandwidth to attend treatment team meetings, conduct environment of care rounding, and participate in other recovery-oriented activities once in the position full time.

Mental health leaders had not established a standard operating procedure (SOP) with processes for staff training, education, and implementation of recovery-oriented services on the inpatient unit, as required.[22] The program manager reported being unaware of this requirement, and the acting LRC described not having the dedicated time, due to collateral duties, to develop an SOP.

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[17] "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.

[18] "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.

[19] VHA Directive 1160.06; VHA Directive 1160.06(1).

[20] VHA Directive 1160.06. The inpatient mental health program manager is responsible for oversight of all inpatient unit clinical services; VHA Directive 1160.06(1).

[21] VHA Directive 1163, 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.)

[22] VHA Directive 1160.06; VHA Directive 1160.06(1).

As of 2019, VHA has required mental health leaders and LRCs to develop a recovery transformation plan.[23] However, the acting LRC noted that the transformation plan was developed in January of 2025 with support of Chief of Mental Health. Facility mental health leaders and staff attributed this delay to the LRC position previously being vacant.

Full-time staffing of the LRC position and an SOP may strengthen the implementation of recovery-oriented principles and activities on the inpatient unit.

Mental health leaders reported soliciting input from veterans who used inpatient mental health services through a patient experience survey, groups, and post-discharge follow-up phone calls. Mental health leaders reported implementing suggestions such as additional group programming and increased veteran and family involvement in treatment team meetings.

Recovery-Oriented Programming

The inpatient unit staff scheduled at least four hours of interdisciplinary, recovery-oriented programming on weekdays and weekends, as required.[24] However, the OIG observed programming did not consistently occur as scheduled. The program manager noted there were no formal processes in place to ensure coverage when group facilitators were unavailable. Inconsistent programming may limit opportunities for veterans to work on recovery goals while receiving inpatient unit care.

Inpatient unit staff reported that veterans were educated to recovery principles on the unit, as required, with nurses reviewing the group programming schedule and orientation packet during admission.[25] Additionally, inpatient unit staff shared that the interdisciplinary team met with veterans to set individualized treatment goals and coordinated with outpatient services to assist with continuity of care.

Physical Environment

The OIG found the inpatient unit had some aspects of a recovery-oriented environment that met VHA standards.[26]

[23] VHA Directive 1163, August 13, 2019.

[24] VHA Directive 1160.06; VHA Directive 1160.06(1).

[25] 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.

[26] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*, January 2021.

Figure 3. *Veteran bedroom (artwork on bathroom door) and dayroom (natural lighting and veteran artwork).*
Source: Photos of the facility's inpatient unit taken by OIG staff, February 4 and 5, 2025.

The inpatient unit had natural light in the dayroom and bedrooms, warm paint colors, clean furniture, and artwork displayed in the bedrooms, hallways, and dayroom (see figure 3). Additionally, staff placed cushioned rocking chairs in front of the television, contributing to a home-like environment.

Staff reported that veterans who used the communal shower were monitored from outside the room, off the main hallway, through a slightly open door to maintain safety. This could allow individuals in the hallway or an adjacent bedroom to view inside the room, compromising veterans' privacy and dignity.[27]

Despite not having a dedicated outdoor space, the OIG found that mental health leaders established written guidance to promote the safe practice of accompanying veterans outdoors.[28]

The Chief of Mental Health shared that facility leaders planned to move the unit but did not have a specific time frame. The acting LRC reported not currently being involved in design plans for the future unit. The OIG would expect an LRC, who is responsible for "sustaining the integration of recovery principles," to assist the facility in environmental design plans.[29]

Recommendations

3. The Chief of Mental Health ensures a full-time, dedicated local recovery coordinator is integrated into the inpatient mental health unit to support recovery-oriented care.
4. The Chief of Mental Health ensures mental health leaders develop and implement written processes for staff training, education, and recovery-oriented services.

[27] Veterans have the "right to be treated with dignity in a humane environment that affords them both reasonable protection from harm and appropriate privacy." Patients' Rights, 38 C.F.R. § 17.33 (2005).

[28] VHA Directive 1160.06; VHA Directive 1160.06(1); Martinsburg VA Medical Center (VAMC) SOP VHA-V05-613-NUR-SOP-INPTMH-0007, "Off Unit/Fresh Air Breaks 6A," July 6, 2023.

[29] VHA Directive 1163, August 13, 2019; VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

5. The Chief of Mental Health ensures staff provide a minimum of four hours of recovery-oriented, interdisciplinary mental health programming on weekdays and weekends.
6. The Facility Director ensures veterans' privacy in the communal shower room on the inpatient mental health unit.

For detailed action plans, see appendix E.

Clinical Care Coordination

"Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective" treatment.[30] For veterans with "complex health and social needs, care coordination is crucial for improving their access to [services], clinical outcomes, [and] care experiences."[31] 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.[32]

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.

Access to Care

Successful coordination of mental health care requires well-defined admissions processes that ensure veterans have timely "access to … evaluation and clinically appropriate treatment provided in a safe and secure environment."[33] Providers are required to ensure "well-coordinated, safe, documented and appropriate" care for veterans who are treated outside of VA facilities.[34]

The OIG found facility leaders established SOPs, as required, for inpatient admission and transfer processes.[35] However, facility staff did not track when veterans were transferred to the state hospital for involuntary mental health treatment.[36] The absence of written processes to track

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

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

[32] VHA Directive 1160.06; VHA Directive 1160.06(1).

[33] VHA Directive 1160.01; VHA Directive 1160.06; VHA Directive 1160.06(1).

[34] VHA Directive 1310(1), *Medical Management of Enrolled Veterans Receiving Self-Directed Care from External Health Care Providers*, October 4, 2021, amended April 13, 2022.

[35] VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023. The SOP updated the requirement to include procedures and processes for facility staff responsible for admission of veterans to the inpatient units; Martinsburg VAMC SOP VHA-VO5-613-MH-SOP-INPT-0003, "6A Inpatient Mental Health Admission Criteria," January 5, 2023; Martinsburg VAMC SOP VHA-VO5-613-NUR-SOP-INPTHM-0002, "Admission and Transfer to 6A Acute Inpatient Mental Health Unit," February 18, 2020.

[36] VHA Directive 1160.06; VHA Directive 1160.06(1).

and monitor care coordination with non-VA facilities may impede coordination of veterans' post-discharge care.

The facility admissions SOP outlined expectations for veterans to sign a consent form for admission to the inpatient unit.[41] Mental health leaders acknowledged issues such as intoxication or cognitive impairment may limit veterans' ability to provide consent for treatment. Staff reported assessing veterans for decision-making capacity but not documenting the assessment, so there was no way to verify consent for voluntary admission.[42]

Involuntary Hospitalization and Treatment

The facility had written processes for both involuntary holds and hospitalizations, as required.[43] However, the OIG found local policy did not align with West Virginia State law.[44]

Facility policy and mental health leaders stated that in facility settings other than the inpatient unit, such as the emergency department, staff were prohibited from involuntarily holding veterans at imminent risk of harm for further assessment.[45] As such, staff released veterans from the facility and contacted local police to obtain a warrant to take veterans into

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" hospitalization.[37]

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."[38]

Standards and procedures for civil commitment are provided by state law and vary by state.[39] VHA requires that HCS leaders consult with legal counsel, as necessary, to ensure that processes are consistent with applicable laws.[40]

[37] Leslie C. Hedman et al., "State Laws on Emergency Holds for Mental Health Stabilization," *Psychiatric Services* 67, no. 5 (February 29, 2016): 529–535, https://doi.org/10.1176/appi.ps.201500205.

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

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

[40] VHA Directive 1160.01.

[41] Martinsburg VAMC SOP VHA-VO5-613-MH-SOP-INPT-0003.

[42] VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023, amended May 1, 2024.

[43] VHA Directive 1160.06; VHA Directive 1160.06(1). The amended directive added the word applicable to the requirement that "each VA medical facility must develop clear guidelines for involuntary hospitalization in accordance with applicable state and local civil commitment laws." Martinsburg VAMC VHA-V05-613-MH-SOP-0004, "Detaining and Involuntary Commitment of Psychiatric Patients," May 2, 2023.

[44] West Virginia Code § 27-5-4, Chapter 27, *Mentally Ill Persons*, 2024 Regular Session. West Virginia Code § 27-1-9, *Mental Health Facility*, 2024 Regular Session.

[45] Martinsburg VAMC VHA-V05-613-MH-SOP-0004.

custody for a court hearing.[46] Additionally, mental health leaders operated under the misconception that if the court determined the veteran needed to be involuntarily hospitalized, VA staff were prohibited from admitting the veteran to the facility's inpatient unit. According to interviews with leaders, veterans on the inpatient unit who transitioned from voluntary to involuntary status were discharged and taken by the sheriff in handcuffs for transfer to a state hospital.[47]

West Virginia State law outlines criteria and processes for involuntary commitment, including the roles of mental health professionals, law enforcement, and the courts. The law identifies VA facilities as an appropriate setting for individuals in need of involuntary mental health hospitalization. [48]

When policy and practices do not align with state law, veterans at risk of imminent harm to themselves or others may not be properly assessed and treated, potentially leading to unnecessary stress and trauma.

At the request of the OIG, facility leaders developed an action plan to begin using involuntary holds and hospitalizations at the facility when clinically appropriate and provided a target of October 2025 to establish related processes. The OIG determined safety concerns remain until facility leaders implement the action plan and expect policy and practices to fully align with state laws, as required.[49]

VHA requires the VISN director to ensure inpatient mental health units "comply with relevant state laws governing inpatient mental health care."[50] The VISN Chief Mental Health Officer (CMHO) reported relying on facility mental health leaders' description of involuntary hospitalization processes. The OIG found the VISN did not identify the lack of alignment between state laws and the facility policy on involuntary hospitalization. The absence of VISN oversight may lead to inadequate governance and implementation of erroneous clinical practices at facilities across the network.

[46] Martinsburg VAMC VHA-V05-613-MH-SOP-0004.

[47] Martinsburg VAMC VHA-V05-613-MH-SOP-0004. The facility policy denotes the use of handcuffs when a warrant is issued outside the inpatient unit but does not provide the process of discharging and transferring veterans on the inpatient unit to state facilities.

[48] West Virginia Code § 27-5-4, Chapter 27, *Mentally Ill Persons*. West Virginia Code § 27-1-9, Chapter 27, *Mental Health Facility*.

[49] VHA Directive 1160.06; VHA Directive 1160.06(1).

[50] VHA Directive 1160.06; VHA Directive 1160.06(1).

Facility staff generally completed admission screens using the required template and documented legal status in reviewed electronic health records (EHRs).[51]

Treatment Planning

In alignment with VHA requirements, the facility's SOP outlined inpatient unit treatment planning processes, including recovery-oriented elements such as veterans' involvement in setting individualized goals.[52] Mental health leaders described processes to oversee the quality of treatment planning documentation through EHR reviews by quality management staff and peers. Inpatient unit staff stated providers and nurses met daily with veterans and communicated any treatment planning concerns to the interdisciplinary team. Inpatient unit staff also reported the interdisciplinary treatment team met daily to discuss veterans' treatment plans, with veterans attending at least once during their hospitalization.[53]

Medication Treatment

The OIG found that some of the reviewed EHRs lacked the required documentation of informed consent discussions between prescribers and veterans on the risks and benefits of medication treatment.[54] The chief of psychiatry stated that providers did not use the standard EHR note template correctly, and also acknowledged the template needed further revisions for clarity and addition of missing elements. When veterans are not given the opportunity to discuss the risks and benefits of medication use, they may be deprived of the ability to make informed decisions.

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[51] VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care" (SOP), revised April 5, 2023, November 2, 2023, and September 10, 2024. All three versions were in effect during the EHR review period. Unless otherwise noted, all versions contain similar language related to documentation of legal status; VA Form 10-0114J (3), Medical Record Supplement to Progress Note for Specialized Disciplines-Vertical, revised May 2023 and December 2023. Both VA forms include the same language related to voluntary or involuntary documentation.

[52] Acting Deputy Under Secretary for Health for Operations and Management, "Mental Health Treatment Planning and Software Tools," memorandum to Veterans Integrated Service Network (VISN) Director (10N1-23) et al., May 3, 2019; Martinsburg VAMC SOP, "Mental Health Treatment Planning," March 1, 2021.

[53] VHA Directive 1160.06; VHA Directive 1160.06(1).

[54] VHA Directive 1108.07(1), *General Pharmacy Service Requirements*, November 28, 2022, amended October 4, 2023. 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 Directive 1004.01, *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023; VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, amended May 1, 2024; 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 *Katzung's Basic & Clinical Pharmacology*, 16th edition, ed. Todd W. Vanderah (McGraw-Hill Education, 2024), https://accesspharmacy.mhmedical.com/content.aspx?sectionid=281750155&bookid=3382&Resultclick=2.

Discharge Planning

Facility leaders established required written guidance on coordination of care processes for veterans transitioning out of inpatient care.[55] The guidance outlined processes for pre- and post-discharge planning, including documentation requirements, veteran involvement in continuity of care, and nursing follow-up phone calls.

Of the records reviewed, none had discharge instructions that included veterans' follow-up appointments in easy-to-understand language (see figures 4 and 5).[56] Inpatient unit leaders did not implement national guidance on clinic naming conventions. Lack of clarity in discharge instructions may create barriers for veterans to attend follow-up appointments and receive timely mental health care.

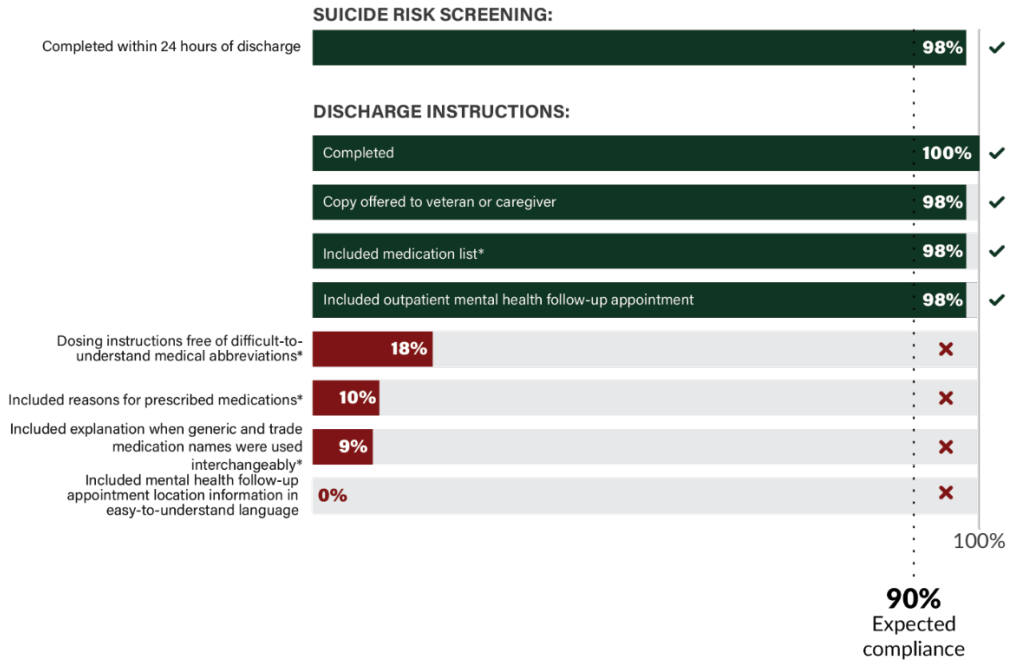


Figure 4. *Discharge-related screening and documentation.*
Source: OIG review of inpatient unit EHRs.
Note: Based on analysis of 50 EHRs. Suicide risk screening discussed in Suicide Prevention (below).
**Corresponds to a subset of records with a completed medication list (n=49).*

[55] VHA Directive 1160.01; Martinsburg VAMC SOP, "6A Discharge Phone Calls," March 20, 2020; Martinsburg VAMC SOP, "Care Coordination Review Team (CCRT)," June 21, 2022; Martinsburg VAMC SOP, "Continuity of Care," August 1, 2021; Martinsburg VAMC Medical Center Policy, "Authentication and Timeliness of Health Records," May 1, 2021.

[56] VHA Directive 1160.06; VHA Directive 1160.06(1); VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06"; VHA Handbook 1160.06, *Inpatient Mental Health Services,* September 16, 2013. The handbook was in place during the episode(s) of care in FY 2024; VHA Office of Integrated Veteran Care*, Clinic Profile Management Business Rules,* updated May 24, 2023.

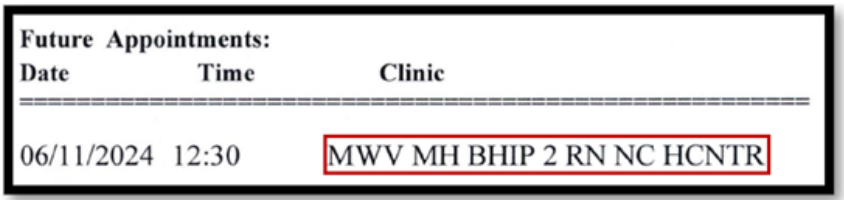


Figure 5. *Example from discharge instructions with difficult-to-understand appointment information (outlined in red).*
Source: OIG review of veterans' EHRs.

Most discharge instructions did not include the reason for prescribing the medication (see figures 4 and 6).[57] The chief of psychiatry reported being unaware why staff did not consistently use the facility's template for discharge instructions and stated having a plan to identify and address barriers. Consistent with recovery-oriented principles, providing the reason a medication is prescribed supports veterans' understanding of their treatment and may help them participate more actively in their care.

Additionally, most EHRs had discharge instructions with medical abbreviations that could be difficult for nonmedically trained individuals to understand (see figures 4 and 6).[58]

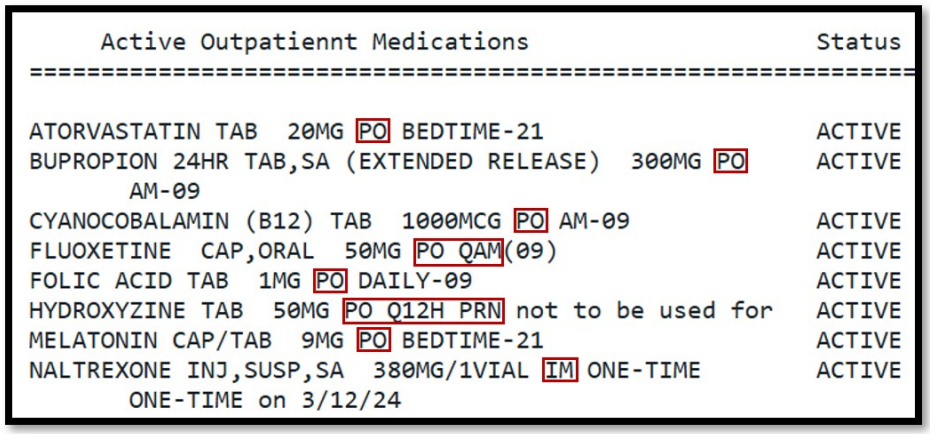
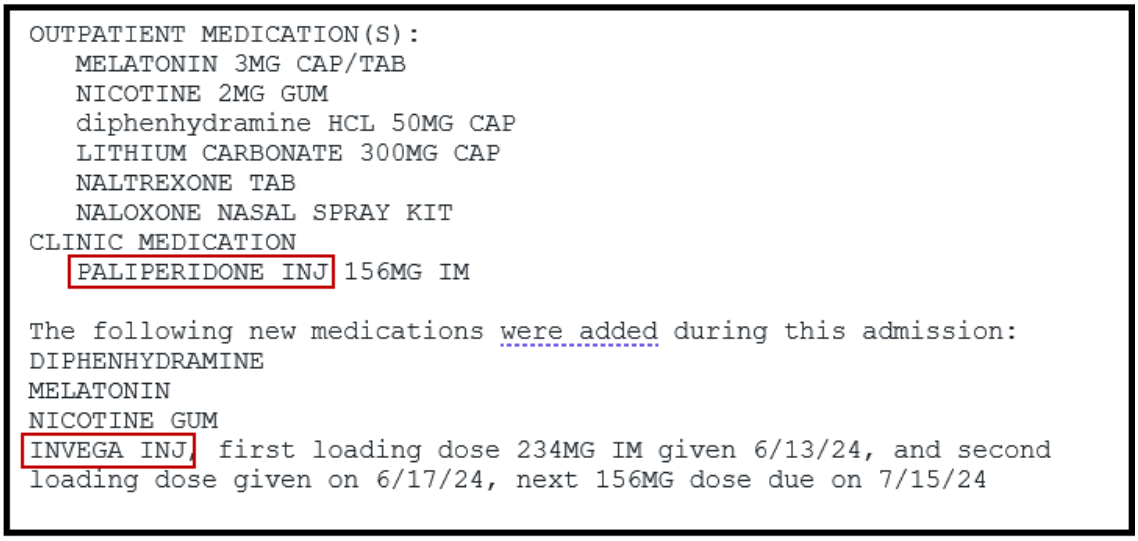


Figure 6. *Example of discharge instructions, including Latin abbreviations (outlined in red) for listed medications and not including the reasons for prescribed medications, provided to a veteran.*
Source: OIG review of veterans' EHRs.
Note: The Latin terms IM, PO, PRN, QAM, and Q12H (outlined in red) describe how and when medications should be taken.

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

[58] VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023; Randa Hilal-Dandan and Laurence L. Brunton, "Appendix I: Principles of Prescription Order Writing and Patient Compliance," in *Goodman and Gilman's Manual of Pharmacology and Therapeutics, 2e* (McGraw-Hill Education, 2016), https://accesspharmacy.mhmedical.com/content.aspx?bookid=1810&sectionid=124489535; VHA Directive 1160.06; VHA Directive 1160.06(1).

The majority of records included both trade and generic names of medications in the discharge instructions without an explanation that the medications were the same (see figures 4 and 7).


OUTPATIENT MEDICATION(S):
MELATONIN 3MG CAP/TAB
NICOTINE 2MG GUM
diphenhydramine HCL 50MG CAP
LITHIUM CARBONATE 300MG CAP
NALTREXONE TAB
NALOXONE NASAL SPRAY KIT
CLINIC MEDICATION
PALIPERIDONE INJ 156MG IM

The following new medications were added during this admission:
DIPHENHYDRAMINE
MELATONIN
NICOTINE GUM
INVEGA INJ, first loading dose 234MG IM given 6/13/24, and second loading dose given on 6/17/24, next 156MG dose due on 7/15/24

Figure 7. *Example of discharge instructions with both generic and trade names used for the same medication (outlined in red).*
Source: OIG review of veterans' EHRs.
Note: Paliperidone is an injectable antipsychotic medication with a trade name of Invega.

Inpatient unit leaders stated these problems could be avoided by correctly using the discharge template. Accurate and easy-to-understand discharge instructions could prevent medication errors, such as taking double the prescribed dose at home following hospitalization.[59]

Recommendations

7. The Facility Director ensures clinicians document veterans' capacity to consent to admission to the inpatient mental health unit.
8. The Veterans Integrated Service Network Director ensures facilities' involuntary hold and hospitalization processes align with applicable state laws and develops processes for ongoing oversight.
9. The Facility Director consults with District Counsel to establish written involuntary hold and hospitalization processes that align with West Virginia State laws and monitors compliance.
10. The Facility Director develops and implements written care coordination processes for veterans involuntarily admitted to non-VA healthcare facilities.

[59] VHA Directive 1345.

11. The Chief of Staff ensures providers document discussions with veterans on the risks and benefits of newly prescribed medications and monitors for compliance.
12. The Chief of Staff ensures veterans' discharge instructions are written in easy-to-understand language and include the follow-up appointment location, the purpose of each medication, and an explanation when both trade and generic names are used for the same medication.

For detailed action plans, see appendix E.

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.[60]

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."[61] Per VA national strategy, providers play a critical role in identifying veterans at-risk of suicide and helping manage at-risk behaviors.[62]

To evaluate suicide prevention activity on the inpatient unit, the OIG assessed compliance with required suicide risk screening and evaluation, safety planning, and training.

Suicide Risk Screening and Evaluation

VHA requires staff to complete the Columbia-Suicide Severity Rating Scale (C-SSRS) for all veterans within 24 hours prior to discharge from inpatient mental health units. The OIG found most of the reviewed EHRs included evidence of a completed C-SSRS within the required time frame.[63]

Safety Planning

Some of the reviewed safety plans did not address ways to make the environment safer from potentially lethal means, including safety considerations beyond access to firearms and opioids (see figures 8 and 9).[64] Mental health leaders stated clinicians did not comprehensively address ways to make the environment safer due to confusion about template documentation expectations.

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

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

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

[63] VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting," updated May 10, 2023; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum to Veterans Integrated Service Network Director (10N1-23) et al., January 7, 2025. While VHA requires staff to complete C-SSRSs within 24 hours before discharge, the OIG also considered C-SSRSs compliant if completed on the day of discharge.

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

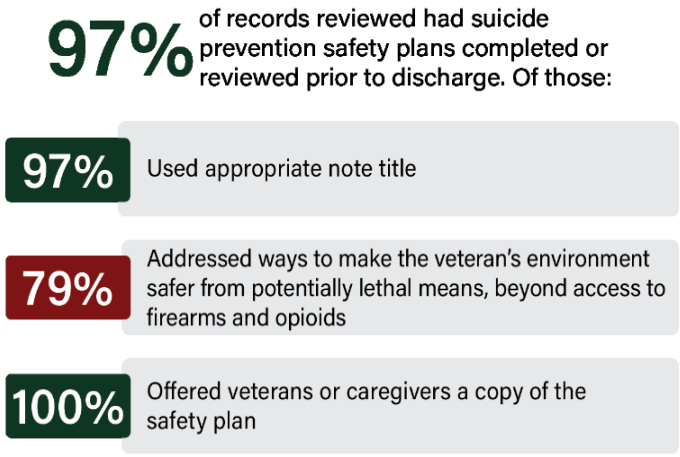


Figure 8. *Facility staff's compliance with VHA safety planning guidance.*
Source: OIG review of veterans' EHRs.

The OIG has found inaccurate use of the national Suicide Prevention Safety Plan to be a consistent finding in multiple inspections.[65] In a recent publication, the OIG made a recommendation related to suicide safety plan completion:

The Under Secretary for Health identifies barriers to, and ensures documentation of, discussions specific to making the environment safer from identified lethal means in veterans' safety plans.[66]

The OIG does not make any further recommendations on suicide safety plan documentation in this report.

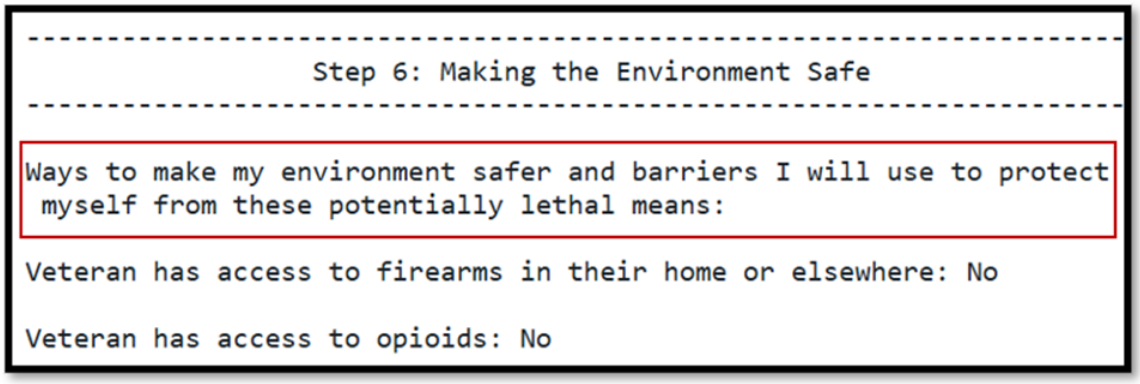


Figure 9. *Example from a safety plan that did not address ways to make the environment safer from potentially lethal means beyond firearms and opioids (outlined in red).*
Source: OIG review of veterans' EHRs.[1]

[65] VA OIG, *Mental Health Inspection of the VA Augusta Health Care System in Georgia*, Report No. 24-00675-259, September 26, 2024; VA OIG, *Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds*, Report No. 24-01859-62, March 5, 2025; VA OIG, *Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania*, Report No. 24-01862-151, June 26, 2025; VA OIG, *Mental Health Inspection of the VA Salem Healthcare System in Virginia*, Report No. 24-01861-144, June 26, 2025.

[66] VA OIG, *Mental Health Inspection of the NY Harbor Healthcare System in New York*, Report No. 25-00729-23, December 18, 2025.

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.[67] VHA targets at least 95 percent compliance for mandatory suicide prevention trainings. Clinical staff were compliant with required STEMS training; however, nonclinical staff were noncompliant with completion of mandatory VA S.A.V.E. training (see figure 10).[68]

The OIG found facility leaders lacked a clear process and person responsible for monitoring compliance. Staff not completing required training may contribute to deficiencies in identifying suicide risk factors and unawareness of resources and interventions to enhance veterans' safety.

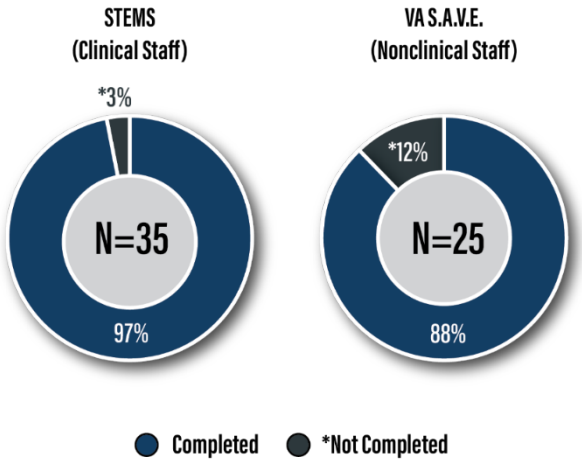


Figure 10. *Inpatient unit staff's completion of mandatory suicide prevention training.*
Source: OIG document review of clinical and nonclinical staff training certificates.
Note: The OIG evaluated completion of STEMS and VA S.A.V.E. trainings during the time frame of January 21, 2024, through January 21, 2025.

Recommendation

13. The Facility Director ensures staff comply with suicide prevention training requirements and monitors for compliance.

For detailed action plans, see appendix E.

[67] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; The acronym "S.A.V.E" summarizes the steps needed to take in recognizing and responding to a veteran in suicidal crisis: signs of suicidal thinking, ask questions, validate the person's experience, encourage treatment, and expedite getting help. VA, "VA S.A.V.E. Training: Four Ways You Can Help a Veteran in Crisis" (fact sheet), June 2025.

[68] VHA Directive 1071(1); Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., June 9, 2022.

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."[69] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[70]

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.

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.[71] The National Center for Patient Safety continually updates the Mental Health Environment of Care Checklist (MHEOCC) "based on reports from the field of hazards or adverse events encountered at the local level."[72] ISIT members are required to use this comprehensive checklist of over 150 detailed environmental elements to "identify and abate suicide hazards on mental health units and other areas treating patients at high acute risk for suicide."[73]

The facility had an established ISIT responsible for using the MHEOCC to "identify and address environmental risks for suicide" on inpatient mental health units.[74] ISIT staff conducted MHEOCC inspections at the required frequency; however, not all required members participated and summaries did not include the required ISIT membership or attendance.[75] The patient safety manager reported taking attendance during MHEOCC inspections, but was unaware of the requirement to report ISIT membership and attendance. Facility leaders not ensuring the ISIT meets all requirements may result in an inability to identify and correct environmental hazards.

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[69] VHA Directive 1160.06; VHA Directive 1160.06(1).

[70] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017; VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, November 4, 2024. The policies contain similar language related to the design of the inpatient unit and staff training requirements.

[71] VHA Directive 1167.

[72] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, accessed June 5, 2025, https://www.patientsafety.va.gov/features/Mental_Health_Environment_of_Care_Checklist.asp.

[73] VHA Directive 1167, May 12, 2017. The MHEOCC "consists of criteria applicable to all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion rooms, and staff workstations."

[74] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

[75] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to ISIT and MHEOCC inspections requirement frequency; however, the new directive changes the required ISIT membership.

In a physical inspection of randomized MHEOCC safety elements, the OIG found general compliance.[76] However, the OIG found multiple hazards that may have been present but not identified by the ISIT during the most recent MHEOCC inspection, such as unsafe furniture and items protruding from walls.

The OIG observed additional safety risks for veterans, including unapproved window coverings in most bedrooms and equipment in a communal shower room that could obstruct staff access in an emergency.[77] Additionally, during multiple MHEOCC inspections, the ISIT did not identify the window coverings as a safety hazard in the Patient Safety Assessment Tool or follow the required process for correcting this issue.[78] The patient safety manager reported a plan from two years prior to install replacement window coverings; however, the replacements had not been installed at the time of the inspection. Staff not accurately identifying and mitigating environmental risks could place veterans and staff at risk of harm.

At the OIG's request, facility leaders developed corrective action and risk mitigation plans, and processes for monitoring compliance to address safety deficiencies identified during the inspection.

Training

VHA requires staff to be trained on environmental hazards and oriented to the "content and proper use" of the MHEOCC. Each of the inpatient MHEOCC categories listed multiple individual items that staff must evaluate during semiannual inspections.[79]

Some ISIT and inpatient unit staff were noncompliant with annual MHEOCC training requirements (see figure 11). The OIG found discrepancies among facility leaders and the patient safety manager regarding oversight processes for MHEOCC training completion. Completing

[76] The OIG reviewed the inpatient unit for randomized safety elements such as anchor free doors, ligature free window coverings, and secured under-sink storage.

[77] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety; Katie Byrne et al., "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."

[78] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Electronic Mental Health Environment of Care Checklist (MHEOCC) Waiver Request and Attestation Process," memorandum to Veterans Integrated Service Network (VISN) Director (10N1-23) et al., December 1, 2021; VHA Office of Mental Health, "Standard Operating Procedure for Submission of MHEOCC Inspections and Appeals Under VHA Directive 1167," November 5, 2024. Both the memorandum and SOP were in effect during the review period and contain similar language related to the Patient Safety Assessment Tool.

[79] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to MHEOCC training requirements. Staff assigned to the inpatient unit and staff conducting MHEOCC inspections are required to complete the training. The OIG used 90 percent as the expected level of compliance.

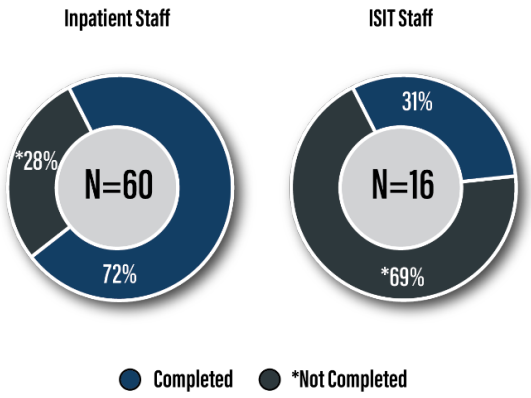

Figure 11. *MHEOCC training completion, January 21, 2024, through January 21, 2025. Source: OIG document review of staff training certificates.*

annual training on environmental hazards and VHA safety requirements may reduce risks for veterans and staff on the inpatient unit.

Recommendations

14. The Facility Director ensures Interdisciplinary Safety Inspection Team members participate in Mental Health Environment of Care Checklist inspections and document membership and attendance.
15. The Facility Director ensures the Interdisciplinary Safety Inspection Team accurately identifies, documents, and addresses safety hazards within the Patient Safety Assessment Tool and monitors for compliance.
16. 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

To assist facility leaders in meaningful quality of care improvements, the OIG conducted a review across five domains of inpatient mental health care. The OIG found communication challenges between facility executive and mental health leaders, in addition to issues with application and oversight of involuntary holds and admissions.

Executive leaders were sometimes unaware of key information about mental health processes and staffing needs. The facility did not have a full-time LRC due to the acting LRC's additional duties in other programs, which contributed to lack of support in implementing recovery-oriented care on the inpatient unit. Executive leaders acknowledged a delay in learning key information and reported relying on communication from mental health leaders to make staffing decisions.

Facility staff believed West Virginia State laws prohibited involuntary hospitalizations at VA facilities and required admission to state hospitals; therefore, veterans on the inpatient unit who transitioned from voluntary to involuntary status were discharged and taken by the sheriff for transfer to a state hospital. However, the OIG determined veterans may be involuntarily hospitalized at VA facilities when deemed necessary due to imminent risk.

At the request of the OIG, facility leaders developed an action plan to begin using involuntary holds and hospitalizations at the facility when clinically appropriate. During an OIG discussion with VISN and facility leaders, the Chief of Staff requested previously undisclosed information reported by mental health leaders regarding involuntary holds. The OIG determined safety concerns remain until facility leaders implement the action plan and expects policy and practices to fully align with state laws.

Further, the OIG found VISN leaders did not directly oversee involuntary hospitalization processes. Without alignment to state law and proper oversight, veterans at imminent risk of harm may not be appropriately held or hospitalized across the facilities in the network. Additional findings included noncompliance with development of facility policies, EHR documentation, completion of staff trainings, and environment of care requirements.

The OIG provided 16 recommendations to the Facility Director, Chief of Staff, Chief of Mental Health, and VISN 5 Director. In response, the VISN Director concurred with recommendation 8 and committed to ensuring that each VISN 5 Mental Health Director collaborates with district counsel to establish state-compliant involuntary hold procedures and will direct the Chief Mental Health Officer to conduct comprehensive reviews to verify adherence. The Facility Director concurred with recommendations 1–7 and 9–16 and committed to implementing a range of corrective actions, including enhanced leadership oversight, expanded veteran engagement, strengthened staff training, and improved coordination and documentation practices to support safe, recovery-oriented mental health care.

Appendix A: Background

Inpatient Mental Health Services

VHA offers acute inpatient mental health services as a "high-intensity" treatment option for veterans experiencing "acute and severe emotional or behavioral symptoms" that pose a safety risk or result in compromised mental function. When a healthcare provider determines that inpatient mental health care is appropriate, the veteran should be immediately admitted to ensure safety and stabilization.[80]

VHA requires inpatient unit staff use a veteran-centered, "evidence-based, recovery-oriented approach" that incorporates evaluation and monitoring, interdisciplinary treatment, discharge planning, sufficient staffing, privacy, and dignity.[81] To evaluate the quality of recovery-oriented care provided at the HCS, the OIG assessed compliance with VHA requirements in the five 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.[82]

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 sufficient staff to form interdisciplinary teams, ensure veterans' access to mental health care, and fully implement program requirements.[83]

Each HCS must have a dedicated chief 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.[84] Each MHEC must include "at least one Veteran, and ideally one who is receiving mental health services" and not employed at the local HCS.[85] The MHEC is required to

[80] VHA Directive 1160.06; VHA Directive 1160.06(1).
[81] VHA Directive 1160.06; VHA Directive 1160.06(1).
[82] VA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*.
[83] VHA Directive 1160.06; VHA Directive 1160.06(1).
[84] VHA Directive 1160.01.
[85] VHA Directive 1160.01.

meet quarterly and "record minutes that are accessible to all mental health clinical staff."[86] The HCS mental health lead must assign an inpatient mental health program manager "to coordinate and promote consistent, sustained, high quality therapeutic programming" in the inpatient unit setting.[87]

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."[88] 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."[89]

Recovery-Oriented Principles

The President's *New Freedom Commission on Mental Health* report, published in 2003, outlined a vision for the delivery of recovery-oriented mental health care.[90] 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."[91]

To support veterans' recovery, VHA requires HCSs to have a plan across the mental health care continuum for continued transformation and implementation of recovery-oriented services.[92] Additionally, VHA requires the local recovery coordinator, in collaboration with the inpatient mental health program manager, to establish a standard operating procedure that includes processes for staff training, education, and implementation of recovery-oriented services on the inpatient unit.[93]

[86] VHA Directive 1160.01.

[87] VHA Directive 1160.06; VHA Directive 1160.06(1).

[88] VHA Directive 1160.06; VHA Directive 1160.06(1).

[89] "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.)

[90] "Achieving the Promise: Transforming Mental Health Care in America," President's New Freedom Commission on Mental Health, accessed June 11, 2024, https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/InsideCover.htm.

[91] "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#.

[92] VHA Directive 1163, August 13, 2019.

[93] VHA Directive 1160.06; VHA Directive 1160.06(1).

VHA requires adherence to principles of veteran-centered, recovery-oriented mental health care and ongoing evaluation of services provided on the inpatient unit.[94]

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.[95] For VA medical facilities with a MHEOCC-compliant secure outdoor space, daily programming should include dedicated time for veterans to be outdoors.[96]

Clinical Care Coordination

Care coordination poses a major challenge to healthcare safety for chronically ill individuals who receive services from multiple providers in a variety of settings.[97] VHA requires inpatient units to have an interdisciplinary treatment team composed of individuals who are responsible for the veteran's care. An interdisciplinary approach is critical to ensure "comprehensive, coordinated, and holistic care."[98]

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.[99] 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.[100]

There are no federal civil commitment laws; therefore, HCS leaders are required to have clear guidelines that align with state and local laws for civil commitment.[101] 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.[102]

The interdisciplinary treatment team must ensure the recovery-oriented treatment plan includes the veterans personally identified goals and is completed in collaboration with the veteran. The

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[94] VHA Directive 1160.06; VHA Directive 1160.06(1); VHA Directive 1163, August 13, 2019; VHA Directive 1160.01.

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

[96] VHA Directive 1160.06; VHA Directive 1160.06(1). For VA medical facilities with a MHEOCC-compliant outdoor space, "designated time for Veterans to be outdoors should be incorporated into the daily programming as permitted by staffing, individual Veteran interest, safety observation level of the Veteran, weather and as determined by the patient's [Interdisciplinary Treatment Team], clinical condition, and any other relevant contingency factors."

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

[98] VHA Directive 1160.06; VHA Directive 1160.06(1).

[99] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06"; VHA Directive 1160.06; VHA Directive 1160.06(1).

[100] VHA Directive 1160.06; VHA Directive 1160.06(1).

[101] VHA Directive 1160.06; VHA Directive 1160.06(1).

[102] VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," revised September 10, 2024.

interdisciplinary treatment team must also ensure outpatient mental health care is coordinated with the veteran prior to discharge, including follow-up appointment information.[103]

VHA requires that veterans receive a copy of the written discharge plan and a copy of the safety plan, as applicable, at discharge.[104] The written discharge plan must include the provider's name if available, as well as follow-up appointment information.[105]

Suicide Prevention

According to the *2024 National Veteran Suicide Prevention Annual Report*, "suicide was the 12th-leading cause of death for Veterans in 2022" and the second-leading cause of death for Veterans under age 45.[106] Suicide risk is elevated after a suicide attempt, including the period following discharge from an inpatient psychiatric setting.[107] 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.[108]

Inpatient unit clinical staff are to complete the C-SSRS, a risk assessment tool, for veterans within 24 hours prior to discharge.[109] A positive C-SSRS then requires the "timely completion of the Comprehensive Suicide Risk Evaluation (CSRE)."[110] Staff may complete the CSRE in lieu of the suicide risk screening prior to discharge.[111]

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

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

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

[106] VA Office of Suicide Prevention, *2024 National Veteran Suicide Prevention Annual Report Part 2 of 2: Report Findings*, December 2024.

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

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

[109] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting," updated May 10, 2023.

[110] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum. 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.

[111] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Frequently Asked Questions (FAQ)," updated December 13, 2022.

When veterans are determined to be at risk for suicide, providers are expected to engage them in safety planning.[112] Safety planning is an intervention in which "patients are given tools that enable them to resist or decrease suicidal urges for brief periods of time" and "involves eliminating or limiting access to any potential lethal means in the environment."[113] According to VHA, all patients in a VHA inpatient mental health setting "must be offered the opportunity to create or update a Safety Plan as part of the discharge plan. This should be documented in the patient's medical record."[114]

In 2018, VA published its 10-year strategic plan for preventing veteran suicide, which outlines the objective of reducing access to lethal means. The document discusses provider education for veterans on safe storage and access to firearms, as well as "storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons."[115] The *VA Safety Planning Intervention Manual*, a guide to help VHA providers develop safety plans with veterans, further emphasizes identification of access to potentially lethal means such as firearms, opioids, medications, ropes, and household toxins.[116]

VHA requires healthcare providers complete STEMS and nonclinical staff complete VA S.A.V.E. training annually.[117] In June 2022, VHA issued a memorandum indicating a target of at least 95 percent completion for mandatory suicide prevention trainings.[118]

Safety

In VHA HCSs, inpatient mental health units must be designed to ensure veteran safety while still integrating recovery-oriented principles into the environment.[119] ISIT members and all inpatient unit staff are responsible for ensuring a safe environment.[120] Additionally, an ISIT is required to assess the inpatient unit twice annually for suicide hazards using the MHEOCC and the patient

[112] VA, VA Safety Planning Intervention Manual.

[113] Barbara Stanley and Gregory K. Brown, "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," *Cognitive and Behavioral Practice* 19, no. 2 (May 2012): 256-264, https://doi.org/10.1016/j.cbpra.2011.01.001.

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

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

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

[117] VHA Directive 1071(1).

[118] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification."

[119] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to the incorporate recovery and ensure safety on the inpatient unit.

[120] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to all staff members' responsibility to ensure safety on the inpatient unit.

safety manager or other designated mental health staff track corrective actions taken for identified environmental risks.[121]

An ISIT is a mandatory subcommittee of the HCS environment of care committee, with team membership documented as part of MHEOCC inspection rounds summary. The ISIT should include an inpatient mental health unit program director and inpatient unit nurse manager, the suicide prevention coordinator, a patient safety manager, a representative from engineering/facilities management, and an "additional clinical staff from any discipline or work area."[122]

[121] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to ISIT and use of MHEOCC. VHA Directive 1160.06; VHA Directive 1160.06(1). The MHEOCC is a "checklist designed to help identify and abate suicide hazards on mental health units and other areas treating Veterans 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/physical restraint rooms, and staff workstations."

[122] VHA Directive 1167, November 4, 2024.

Appendix B: Methodology

The Mental Health Inspection Program inspections focused on the quality of care provided by VHA's inpatient mental health services.[123] The OIG randomly selected the VHA HCSs included in FY 2025 reviews from all HCSs with inpatient mental health beds.[124]

The OIG conducted a virtual and on-site review at the facility from January 21, 2025, through April 3, 2025. The OIG did not receive any complaints beyond the scope of this review that required referral to the OIG hotline.

The OIG reviewed VHA and facility policies, standard operating procedures, and guidance documents in effect at the time of the inspection. Additionally, the OIG reviewed HCS Mental Health Executive Committee meeting minutes from FY 2024. The OIG reviewed data specific to the facility, prior OIG reports related to the inpatient unit, documents, and EHRs.

The OIG reviewed select staff's certificates for annual completion of STEMS, VA S.A.V.E, and MHEOCC trainings.[125] Staff were excluded from analysis of STEMS and VA S.A.V.E trainings if identified as being employed in their position less than 90 days. Except for a 95 percent threshold for mandatory suicide prevention training completion, the OIG used 90 percent as the expected level of compliance for record review.

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards. During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and assumes full responsibility for the content of the publication. All references are for original source material, not artificial intelligence (AI)-generated content. The Office of Healthcare Inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust."

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

[124] 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 2025, the OIG excluded facilities with inpatient mental health beds that the OIG inspected in FY 2024. Allocation Resource Center, "Monthly Program Cost Report (MPCR) Handbook," October 2014, updated March 2017.

[125] VHA Directive 1071(1); VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

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 review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[126] 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.

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, 2023, through September 30, 2024.[127] As previously discussed, the OIG used 90 percent as the expected level of compliance for record review.

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.[128] The OIG team visually assessed the inpatient unit environment for warm and inviting design elements such as natural lighting, artwork, and calming paint colors. The OIG also observed the unit for general cleanliness and veteran access to secure outdoor space.[129] Further, the OIG's physical inspection of areas in the inpatient unit focused on additional selected safety elements specific to this facility.

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

[127] 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.

[128] VHA Directive 1160.06; VHA Directive 1160.06(1). A unit is an "area in a medical facility and especially a hospital that is specially staffed and equipped to provide a particular type of care." *Merriam-Webster.com Dictionary*, "unit," accessed August 10, 2022, https://www.merriam-webster.com/dictionary/unit.

[129] VHA Directive 1160.06; VHA Directive 1160.06(1); VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

The OIG reviewed the MHEOCC data documented in the Patient Safety Assessment Tool for inspections completed in FY 2024 and FY 2025, and assessed corrective actions taken for deficiencies unresolved for more than six months.

Appendix C: Inpatient Unit Staffing

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
Acting Suicide Prevention Coordinator	1	10
Assistant Nurse Manager	1	30
Chaplain	1	30
Dietitian	1	10
Medical Provider	1	100
Medical Support Assistant	1	100
Nurse*	23	100
Nursing Assistant	11	100
Peer Support Specialist	2	10
Pharmacist	1	100
Psychiatrist	4	20–100
Recreation Specialist/Assistant‡	3	10
Social Worker	5	10–50
Vocational Rehabilitation Specialist	1	10

Source: OIG review of the Martinsburg VA Medical Center's mental health inpatient unit staffing spreadsheet and facility correspondence (received from January 23, 2025, through March 11, 2025).

Note: FTEE indicates full-time equivalent employee.

**Includes one charge nurse, 20 staff nurses, one licensed practical nurse, and one unit-based educator.*

‡*Includes two recreation specialists and one recreation assistant.*

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 30, 2025

From: Director, VA Capitol Health Care Network (10N05)

Subj: Mental Health Inspection of the Martinsburg VA Medical Center in West Virginia

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

1. This memorandum is in response to the Office of the Inspector General's draft report entitled Mental Health Inspection of the Martinsburg VA Medical Center in West Virginia.

2. I have reviewed the comments provided by the Medical Center Director, Martinsburg, W.V., VAMC, and concur with the responses and actions to recommendations. Facility recommendations 1–7, 9–12, and 14–16 will remain open and in progress. Recommendation 13 is requested for closure.

3. Recommendation 8 is assigned to the VISN, corrective actions remain open and in progress.

4. Should you require any additional information, please contact the Quality Management office.

(*Original signed by:*)

Robert M. Walton, FACHE

[OIG comment: The OIG received the above memorandum from VHA on October 14, 2025.]

VISN Director Response

Recommendation 8

The Veterans Integrated Service Network Director ensures facilities' involuntary hold and hospitalization processes align with applicable state laws and develops processes for ongoing oversight.

__X_ Concur

_____Nonconcur

Target date for completion: August 2026

Director's Comments

Each VISN 5 facility Mental Health Director will consult with District Counsel to establish written involuntary hold and hospitalization processes that align with state laws. The VISN 5 Chief Mental Health Officer will conduct a quality review on 100% of involuntary holds and hospitalizations for 6 consecutive months at each VISN 5 site to ensure relevant state laws and facility processes were followed. The level of compliance for closure will be 90% or greater with the numerator being the number of involuntary holds and hospitalizations VISN-wide that followed the written facility process and the denominator the total number of VISN-wide involuntary holds and hospitalizations. Leadership will report the data through the VISN 5 Mental Health Integrated Clinical Community (ICC) to the VISN Healthcare Delivery Committee (HDC) to monitor compliance.

Appendix E: Medical Center Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 17, 2025

From: Director, Martinsburg VA Medical Center (613/00)

Subj: Mental Health Inspection of the Martinsburg VA Medical Center in West Virginia

To: Director, VA Capitol Health Care Network (10N05)

1. Attached please find the Medical Center Director's response (action plan) regarding the OIG Site Visit conducted from January 21 through April 3, 2025, at the Martinsburg VA Medical Center's acute inpatient mental health unit.

2. The Medical Center Director (MCD) concurs with recommendations 1–7 and 9–16. Recommendation 8 will be answered by the VISN 5 Network Director (ND).

3. If you have any questions, please contact my office.

(*Original signed by*:)

Kenneth W. Allensworth, FACHE
Medical Center Director/CEO

[OIG comment: The OIG received the above memorandum from VHA on October 14, 2025.]

Medical Center Director Responses

Recommendation 1

The Facility Director ensures regular communication between mental health and executive leaders regarding staffing needs and mental health processes.

__X_ Concur

_____Nonconcur

Target date for completion: March 2026

Director's Comments

Currently, the Mental Health Leadership team meets with the Chief of Staff at least monthly to discuss Mental Health processes and staffing needs. The meetings began May 2, 2025. Effective October 1, 2025, leadership will track attendance for the monthly meetings on the Mental Health Service Performance Improvement Data Tool and report this information to the Quality and Patient Safety Council (QPSC). Numerator is number of staff in attendance. Denominator is number of staff required to be in attendance (5 – Martinsburg VA Medical Center's Chief of Staff (COS), Chief of Mental Health, Deputy Chief of Mental Health, Chief of Mental Health Nursing Service, and Mental Health Business Manager, or designee). Leadership will monitor compliance until 90% is met for 6 consecutive months.

Recommendation 2

The Facility Director ensures the Mental Health Executive Council operates in accordance with Veterans Health Administration requirements.

__X_ Concur

_____Nonconcur

Target date for completion: July 2026

Director's Comments

The Mental Health Advocacy Council will appoint a Veteran representative to be a voting member of Mental Health Executive Council/Integrated Clinical Communities Committee (MHEC/ICC). Effective September 2025, a Veteran representative will be invited to attend MHEC/ICC meetings which are held every other month. Veteran member attendance will be recorded in meeting minutes. Attendance will be tracked on the Mental Health Performance Improvement tool and reported to the QPSC. The numerator is the number of meetings the Veteran member was invited to; denominator is the total number of meetings. Leadership willl monitor compliance until 90% is met for 6 consecutive months.

Recommendation 3

The Chief of Mental Health ensures a full-time, dedicated local recovery coordinator is integrated into the inpatient mental health unit to support recovery-oriented care.

__X_ Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

A full time Local Recovery Coordinator (LRC) has been selected; however the LRC remains at 0.5 FTE for Suicide Prevention due to current program vacancy and associated risk. The LRC will be dedicated 1.0 FTE by June 2026 and will have initiated Directive-prescribed responsibilities to the unit. The status of this position will be tracked on the Mental Health Performance Improvement Data tool, reported to the QPSC, and monitored until the LRC is released to be 1.0 FTE to LRC duties.

Recommendation 4

The Chief of Mental Health ensures mental health leaders develop and implement written processes for staff training, education, and recovery-oriented services.

__X_ Concur

_____Nonconcur

Target date for completion: March 2026

Director's Comments

The Chief of Mental Health, in collaboration with mental health leaders, is developing a Standard Operating Procedure (SOP) to address staff training, education, and recovery-oriented services. Once the new SOP is developed and approved, the Local Recovery Coordinator will provide initial face-to-face Recovery Training with all inpatient staff; and all staff will complete Talent Management System (TMS) Training VA 33942 "Mental Health Recovery: How to Transform Principles into Practice" within 90 days of the SOP effective date. Approval of the SOP and staff training completion rate will be tracked on the Mental Health Performance Improvement Data Tool and reported to the QPSC. Leadership will monitor compliance until the SOP is completed and staff training is at 90%.

Recommendation 5

The Chief of Mental Health ensures staff provide a minimum of four hours of recovery-oriented, interdisciplinary mental health programming on weekdays and weekends.

__X_ Concur

_____Nonconcur

Target date for completion: March 2026

Director's Comments

The Chief of Mental Health, in collaboration with the mental health team, is currently working on an SOP to address staff training. Once the new staff training SOP has been approved, guidelines will be developed to more closely monitor daily group activities. Effective October 1, 2025, a detailed audit report will be submitted bi-monthly to MHEC/ICC for oversight. Leadership will track the data for this metric on the Mental Health Performance Improvement Data Tool and report this information to the QPSC. The numerator will be the number of days compliant with four hour programming; the denominator will be the total number of days in the month. Leadership will monitor compliance until 90% is met for 6 consecutive months.

Recommendation 6

The Facility Director ensures veterans' privacy in the communal shower room on the inpatient mental health unit.

__X_ Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

The Chief of Mental Health Nursing Service, in collaboration with the Mental Health Environment of Care Committee (MHEOCC), will complete a Risk Assessment to ensure Veteran privacy in the communal shower room while still maintaining safety. Follow-up actions determined by the Risk Assessment analysis will be implemented. Leadership will track Action plan completion resulting from the Risk Assessment analysis on the Mental Health Performance Improvement Data Tool and report this information to the QPSC. Leadership will monitor compliance until all actions are complete.

Recommendation 7

The Facility Director ensures clinicians document veterans' capacity to consent to admission to the inpatient mental health unit.

__X_ Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

The Social Work Executive will ensure compliance with documentation of capacity of each Veteran admitted to the inpatient mental health unit by reviewing 100% of Veteran charts. Leadership will track the data on the Mental Health Performance Improvement Data Tool and report this information to the QPSC. Numerator will be the number of admissions with capacity to consent to admission documented; the denominator is the total number of admissions for the month. Leadership will monitor compliance until 90% is met for 6 consecutive months.

Recommendation 9

The Facility Director consults with District Counsel to establish written involuntary hold and hospitalization processes that align with West Virginia State laws and monitors compliance.

__X_ Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

Medical Center leadership consulted with District Counsel on March 5, 2025, to obtain guidance to develop a local process in compliance with West Virginia State law. As a result of that meeting, a Standard Work and a Standard Operating Procedure were developed and approved. Staff training is ongoing with an expected completion date of January 1, 2026. All episodes of involuntary holds/hospitalization between January 2025 and June 2026 will be reviewed by the Chief of Mental Health for compliance with the policy. Leadership will track the data for this metric on the Mental Health Performance Improvement tool and report this information to the QPSC. The numerator will be the number of involuntary hold/hospitalizations which are compliant with new process; the denominator will be the total number of involuntary hold/hospitalizations. Leadership will monitor compliance until 90% is met for 6 consecutive months.

Recommendation 10

The Facility Director develops and implements written care coordination processes for veterans involuntarily admitted to non-VA healthcare facilities.

__X_ Concur

_____Nonconcur

Target date for completion: March 2026

Director's Comments

Internal processes have been put in place that are associated with VA as payor source (Care in the Community related) for Veterans involuntarily admitted to non-VA healthcare facilities. The Social Work Executive will develop a Standard of Work process for care coordination between VA and non-VA sites regarding continuum of care post discharge from the state facility upon notification that a Veteran has been involuntarily committed to a non-VA state facility. Leadership will track compliance on the Mental Health Performance Improvement Data Tool and report this information to the QPSC. The numerator will be the number of Veterans involuntarily admitted to non-VA facilities who received care coordination with Martinsburg VA; the denominator will be the number of Veterans involuntarily admitted to non-VA facilities for whom notification was made to Martinsburg VA. Leadership will monitor compliance until 90% is met for 6 consecutive months.

Recommendation 11

The Chief of Staff ensures providers document discussions with veterans on the risks and benefits of newly prescribed medications and monitors for compliance.

__X_ Concur

_____Nonconcur

Target date for completion: March 2026

Director's Comments

The Chief of Pharmacy Service will ensure providers on the Inpatient Mental Health Unit document discussions with Veterans on the risks and benefits of newly prescribed medications and verification of understanding. The Chief of Pharmacy will audit 100% of admissions each month to determine that the discussion and patient understanding are documented. Leadership will track the data for this metric on the Mental Health Performance Improvement Tool and report this information to the QPSC. Leadership will monitor compliance until 90% is met for 6 consecutive months. The numerator will be the number of charts reviewed which document the discussion of risks/benefits of newly prescribed medications; the denominator will be the total number of Inpatient Mental Health unit admissions each month.

Recommendation 12

The Chief of Staff ensures veterans' discharge instructions are written in easy-to-understand language and include the follow-up appointment location, the purpose of each medication, and an explanation when both trade and generic names are used for the same medication.

__X_ Concur

_____Nonconcur

Target date for completion: March 2026

Director's Comments

The Chief of Mental Health Nursing Service will implement a process to ensure Veterans receive discharge instructions that are presented in a clear, simple, and accessible way for all Veterans. Once the process is in place, the Chief of Mental Health Nursing Service will monitor 100% of the charts monthly to ensure compliance with the new process. Leadership will track progress on the Mental Health Performance Improvement Tool and report this information to the QPSC. The numerator will be the number of charts in compliance with the process; the denominator will be the total number of discharges reviewed each month by Chief of Mental Health Nursing Service.

Recommendation 13

The Facility Director ensures staff comply with suicide prevention training requirements and monitors for compliance.

__X_ Concur

_____Nonconcur

Target date for completion: September 2025

Director's Comments

The Suicide Prevention Program Manager prepares and submits a monthly report outlining deficient and coming due in the next 30 days suicide prevention training. The TMS report is sent to the Medical Center and VISN leadership monthly for review. Supervisors use the TMS report to identify and address unmet training requirements with employees. The facility **has demonstrated completion through use of TMS reports for required trainings**, Skills Training for Evaluation and Management of Suicide (STEMS) and Refresher (TMS 39351/43820), Suicide Prevention Guide Training (VA S.A.V.E.), Refresher, and Enduring (TMS 66979/30535/33770), and Lethal Means Safety (TMS 34560). The Suicide Prevention Program Manager will work with facility leadership to improve the process for the sustainment of the completion rate and increase the compliance rate. Request closure of this recommendation.

OIG Comments

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

Recommendation 14

The Facility Director ensures Interdisciplinary Safety Inspection Team members participate in Mental Health Environment of Care Checklist inspections and document membership and attendance.

__X_ Concur

_____Nonconcur

Target date for completion: August 2026

Director's Comments

The Interdisciplinary Safety Inspection Team (ISIT) established required membership in March 2025. The Chief of Safety will track attendance at bi-annual Mental Health Environment of Care (MHEOC) inspections. Leadership will track data for this metric on the Mental Health Performance Improvement Data Tool and report information to the Environment of Care Council (EOCC). The numerator will be the number of staff in attendance at bi-annual MHEOC inspections; the denominator will be the number of staff required per directive for the inspection. Leadership will monitor compliance until 90% is met for 2 consecutive inspections.

Recommendation 15

The Facility Director ensures the Interdisciplinary Safety Inspection Team accurately identifies, documents, and addresses safety hazards within the Patient Safety Assessment Tool and monitors for compliance.

__X_ Concur

_____Nonconcur

Target date for completion: March 2026

Director's Comments

The Mental Health Environment of Care (MHEOC) inspection was completed by the Interdisciplinary Safety Inspection Team (ISIT) team on June 16, 2025. The Chief of Safety ensured all variances that could not be addressed within six months had an appeal submitted with a risk mitigation plan that was approved. The VISN MH Chief and VISN PSO will be invited to participate in the December 2025 MHEOC inspection to ensure ISIT accurately identifies and records safety hazards. Leadership will track the action plan on the Mental Health Performance Improvement Data Tool and report the information to the EOCC. Numerator will be the number of hazards identified which required an appeal; the denominator will be the number of hazards not addressed within six months. Leadership will monitor compliance until 90% is met for 6 consecutive months.

Recommendation 16

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: February 2026

Director's Comments

The Chief of Mental Health and Chief of Safety will evaluate completion of required training for participants prior to each bi-annual Mental Health Environment of Care Checklist (MHEOCC) inspection. Unit staff training deficiency reports will be reported to the EOCC and disseminated to supervisors for action. Leadership will track the data for this metric on the Mental Health Performance Improvement Data Tool and report this information to the EOCC. The numerator will be the number of staff who completed the required training; the denominator will be the number of staff required to complete the training. Leadership will monitor compliance until 90% is met for 6 consecutive months.

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