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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of a Patient's Discharge from the Central Virginia VA Health Care System in Richmond

Healthcare Inspection | **25-04450-218** | **August 14, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection on November 24, 2025, to evaluate allegations that staff at the Central Virginia VA Health Care System (system) in Richmond did not arrange a patient's safe discharge from the inpatient mental health unit (unit). The inspection team conducted virtual follow-up interviews from December 3, 2025, through March 25, 2026. Prior to initiating the inspection, the OIG also identified concerns with the patient's post-discharge care.

The OIG substantiated that a psychiatrist and a unit social worker did not facilitate a safe discharge as the patient's needs exceeded what the caregiver could reasonably manage. The treatment team initially determined the patient required a higher level of care than the spouse could provide, however, multiple nursing homes declined admission due to behavior concerns. The psychiatrist subsequently revised the discharge plan to home with services. Despite the spouse's concerns, neither the social worker nor the psychiatrist evaluated whether the patient's discharge plan was safe, or considered an ethics consultation, to address safety concerns.

The OIG also found the patient advocate did not follow required procedures when addressing the spouse's concerns. If the dissatisfaction pertains to a clinical decision, such as a discharge plan, the patient advocate must inform the patient or surrogate about the clinical appeals process.[1] The spouse reported multiple concerns about the discharge plan to the patient advocate; however, the patient advocate did not fully document these concerns, involve the designated service line advocate, or inform the spouse of the clinical appeals process as Veterans Health Administration (VHA) Directive 1003.04, *VHA Patient Advocacy*, requires.[2] System leaders were unaware of concerns reported to the patient advocate, contributing to a missed opportunity to review the discharge decision.

Additionally, the OIG found that the psychiatrist and pharmacist did not ensure all required components of medication reconciliation identified in VHA Directive 1345, *Medication Reconciliation,* were completed at discharge, and despite the patient's dementia diagnosis, the spouse was not included in the discharge medication reconciliation process.[3]

Following discharge, the OIG found that outpatient mental health and primary care staff did not address concerns of potential abuse during post-discharge calls as VHA Directive 1199, *Reporting Cases of Abuse and Neglect,* and system policy 011-047, *Identification, Management,*

[1] VHA Directive 1003.04, *VHA Patient Advocacy*, November 9, 2023; VHA Directive 1041, *Appeal of Veterans Health Administration Clinical Decisions*, September 28, 2020, amended March 3, 2025.

[2] VHA Directive 1003.04.

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

and Reporting of Abuse, requires.[4] The OIG also found that the spirit of VHA Directive 1199 for timely reporting of suspected abuse may not have been met because the Veterans Crisis Line Standard Operating Procedure VCL-S-ACT-404-2405, "Reporting Non-Imminent Abuse, Neglect, and Exploitation," provides only one pathway (routine referral) for a responder to escalate concerns of non-imminent abuse to a suicide prevention coordinator (a mandated reporter) for review the next business day.[5] The spouse reported previous violent encounters that had occurred in the home during a Friday call to the Veterans Crisis Line. Although the Veterans Crisis Line responder followed policy by entering a routine referral to the facility suicide prevention coordinator, communication between the suicide prevention coordinator and the spouse occurred on the following Monday, at which time the suicide prevention coordinator documented that the patient physically assaulted a home health aide over the weekend and was subsequently incarcerated.

As with the patient's discharge, the OIG found that components of medication reconciliation were not completed during post-discharge calls. The OIG also learned the patient's 14-day haloperidol supply was gone after 7 days. In addition to VHA medication reconciliation requirements, VHA and system training materials state that post-discharge phone calls should include a review of medications. During post-discharge calls, nursing staff did not correctly document medication changes that had occurred during hospitalization, preventing further discussion with the spouse. In addition, the spouse's concerns about medication effectiveness did not prompt further education. The OIG identified multiple missed opportunities for staff to evaluate how the spouse was managing the patient's complex haloperidol regimen.

The OIG made one recommendation to the Under Secretary for Health to consider establishing a process, to be used on non-business days, that enables Veterans Crisis Line responders to timely escalate concerns of non-imminent abuse to a mandated reporter.[6]

There are five recommendations to the System Director addressing the evaluation of discharge practices and assessments of caregiver's post-discharge capabilities; compliance with patient advocacy policy; completion of medication reconciliation at discharge and during follow-up encounters; establishment of abuse-reporting requirements; and completion of a comprehensive review of the patient's hospitalization and post-discharge encounters.[7]

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[4] VHA Directive 1199, *Reporting Cases of Abuse and Neglect*, September 3, 2024; Central Virginia VA Health Care System, Medical Center Policy 011-047, *Identification, Management, and Reporting of Abuse*, May 9, 2022.

[5] VHA Directive 1199; Veterans Crisis Line Standard Operating Procedure VCL-S-ACT-404-2405, "Reporting Non-Imminent Abuse, Neglect, and Exploitation," May 2024; Underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[6] The recommendation addressed to the Under Secretary for Health is directed to anyone in an acting status or performing the delegable duties of the position.

[7] VHA Directive 1199.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

The Under Secretary for Health nonconcurred with recommendation 6 (see appendix A). Given that the recommendation asked for the consideration of a new process and VHA demonstrated thorough consideration as detailed in their response, the OIG considers the recommendation closed.

The Veterans Integrated Service Network and System Directors concurred with recommendations 1–5 and developed a new Interdisciplinary Team template that meets all of the required elements; implemented an immediate standdown with the Patient Advocate team to reinforce VHA requirements; trained all providers involved in the medication reconciliation process on documentation expectations; planned to convert system policy to a standard operating procedure to align with VHA requirements and provide guidance on the reporting process for suspected abuse, neglect, or exploitation; and completed a comprehensive review of the patient's hospitalization and post-discharge encounters (see appendixes B and C).[8] Based on information provided, the OIG considers recommendations 5 and 6 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until compliance is met.

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[8] In December 2025, VA announced plans to reorganize and consolidate its Veterans Integrated Service Networks (VISNs) from 18 networks to 5, with the new structure taking effect on June 1, 2026. All VISN references in this report reflect the organizational structure in place at the time of the OIG's review. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/.

Contents

Abbreviations

EHR	electronic health record
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on November 24, 2025, to assess allegations that staff at the Central Virginia VA Health Care System (system) in Richmond were "failing to act in [the patient's] best interest" and did not arrange a safe discharge following admission to the inpatient mental health unit (unit). The OIG conducted virtual interviews from December 3, 2025, through March 25, 2026.

Background

The system is part of Veterans Integrated Service Network (VISN) 6—VA Mid-Atlantic Health Care Network—and consists of the Richmond VA Medical Center and four outpatient clinics.[1] The Veterans Health Administration (VHA) classifies the system as a level 1a, highest complexity.[2] The system provides acute medical, surgical, and psychiatric inpatient care. From October 1, 2024, through September 30, 2025, the system served 93,611 patients and had 402 authorized hospital beds with 22 beds on the unit.

Allegations and Related Concerns

On September 18, 2025, the OIG reviewed a complaint alleging system staff failed to "act in [the patient's] best interest" and did not arrange a safe discharge. During a review of the patient's electronic health record (EHR), the OIG identified further concerns with the patient's post-discharge care. On October 9, 2025, the OIG contacted the system acting Chief of Staff to discuss the patient's outpatient care coordination to ensure ongoing support was provided to the patient.[3] The OIG team opened a hotline inspection on November 24, 2025, to examine the safety of the patient's discharge and post-discharge care coordination.

Scope and Methodology

The OIG conducted virtual interviews from December 3, 2025, through March 25, 2026. The OIG made several attempts to discuss the allegations with the complainant but was unsuccessful. The OIG team interviewed the System Director, Associate Director for Patient Care Services, Chief of Staff, and additional VHA and system leaders and staff familiar with the patient's care

[1] In December 2025, VA announced plans to reorganize and consolidate its Veterans Integrated Service Networks (VISNs) from 18 networks to 5, with the new structure taking effect on June 1, 2026. All VISN references in this report reflect the organizational structure in place at the time of the OIG's review. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/.

[2] VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model OPES Report Data Definitions," October 1, 2023.

[3] The Deputy Chief of Staff was acting as the Chief of Staff.

and related processes. The OIG reviewed the patient's spring 2025 EHR entries and relevant VHA and system policies, quality reviews, electronic communication, organizational charts, incident reports, and reported complaints.

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 issue(s).

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.[4] 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 took full responsibility for the content of the publication. All references are from original source material, not artificial intelligence (AI)-generated content. 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.*"[5]

The OIG substantiates an allegation when the available evidence shows it is more likely than not that the event or action occurred. Conversely, the OIG does not substantiate an allegation when the available evidence shows it is more likely than not that the event or action did not occur. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

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

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

[4] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[5] Executive Office of the President, Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," Memorandum for the Heads of Executive Departments and Agencies, M-25-21: § 4(a), April 3, 2025.

Patient Case Summary

The patient, who was in their seventies and had a 100 percent service-connected disability rating, had a history of metastatic rectal cancer treated with chemotherapy, post-traumatic stress disorder, traumatic brain injury, and recent fall with head trauma. In spring 2025, after an incident at the patient's home, the police transported the patient to a community hospital emergency department due to changes in mental status and behaviors. A community hospital representative alerted system staff of the patient's emergency department admission and the patient was transferred to the system for admission and evaluation.

As no medical conditions causing the change in mental status were found, the patient was transferred (day 1) to the inpatient mental health unit (unit) with a plan to clarify the diagnosis, further evaluate and manage the patient's paranoia and agitation, and complete discharge planning to address safety and placement needs.

An attending psychiatrist (psychiatrist) completed the patient's psychiatric assessment on day 2 and made a diagnosis of dementia with behavioral disturbances, to include irritability, agitation, and aggression, such as verbal and physical abuse and throwing a wheelchair. That afternoon, the patient became increasingly agitated and aggressive. The following day, nurses administered several doses of haloperidol, as ordered, to treat the patient's aggressive behaviors.[6] Additionally, nurses completed multiple disruptive behavior reports. A psychiatry resident documented a conversation on day 4 during which the patient's spouse and children revealed aggressive behaviors had been occurring prior to admission, and if these behaviors continued, the patient could not be managed at home.

During days 5–11, the psychiatrist and another attending psychiatrist determined the patient lacked capacity to make discharge and long-term housing decisions. The patient continued to experience behavioral episodes necessitating medication changes and placement in therapeutic confinement, and a psychiatry resident documented the patient needed an increased level of care and structured support. The spouse agreed with the plan for an increased level of care and made multiple requests for the patient to be placed in long-term care, expressing the inability to care for the patient at home.

During days 12–18, psychiatry residents, the psychiatrist, and nurses documented the patient had further behavioral disturbances, including yelling profanities, spitting at staff, and throwing objects, such as a phone, which required medication and placement in therapeutic confinement. Nurses completed disruptive behavior reports. At times, the patient was found wandering, restless, confused, and moving aimlessly within the unit and the hallways. The patient was also sleeping one hour or less per night. Psychiatry residents, the psychiatrist, and a unit social worker

[6] Underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

also documented conversations with the spouse, who stressed the patient's care and behaviors could not be managed at home, and staff supported the spouse's request for the patient to be discharged to a long-term care or memory care facility. A unit social worker made referrals to community nursing homes but was unsuccessful in finding placement for the patient due to concerns about the patient's behavior. As a result, the psychiatrist recommended the patient be discharged home with home health services in place.

During days 19–25, a psychiatry resident, an attending psychiatrist, and nurses documented the patient continued to demonstrate agitated and aggressive behaviors, prompting staff to enter multiple disruptive behavior reports. Psychiatry residents, an attending psychiatrist, a primary care social worker, and the unit social worker documented conversations with the spouse regarding discharge planning, and acknowledged while the patient would benefit from inpatient memory care, the patient had been declined admission. The psychiatrist noted the patient was psychiatrically stable to go home, and a psychiatry resident indicated receiving home health services after returning home be the most beneficial for the patient. On day 23, a psychiatry resident documented a conversation, including the psychiatrist and the unit social worker, informing the spouse that if the patient was not picked up within "the next 48 hours" that "legal proceedings may need to occur for abandoment [*sic*] of patient." The next day, the same staff informed the spouse the system had no other nursing home options to provide, the patient needed to be discharged, and outlined the abandonment process.

While the psychiatrist documented the patient was psychiatrically stable, nurses documented the patient wandered, experienced behavioral outbursts requiring redirection, and was sleeping 30 minutes to 3 hours per night. On day 26, the spouse asked for an extension of the discharge date to which a psychiatry resident, the psychiatrist, and unit social worker responded there was no psychiatric reason for extension, and if the patient was not discharged as planned, the abandonment process would begin the next business day. The psychiatrist documented the patient did not have capacity to refuse psychiatric treatment and educated the spouse about the patient's severe dementia causing "agitated outbursts" and how to manage the behaviors, including administration of haloperidol and accessing emergency services. The psychiatrist also documented the diagnosis of dementia would put the patient at a "chronically elevated risk for inadvertent self harm [*sic*]" and "… inadvertent violence." The patient was discharged home on day 27 with a 14-day supply of haloperidol and 30 hours of home health aide support per week.

On days 4 and 5 after discharge, nurses completed post-discharge phone calls with the spouse and provided medication education. During the second call, the nurse documented hearing the patient's agitated behaviors and provided the spouse with an "emergency telephone number." The next day, the patient and spouse completed a mental health transition clinic phone appointment in which the nurse practitioner and social worker documented the patient's agitated and aggressive behaviors. The nurse practitioner confirmed medication refills would be mailed and provided instructions to call 911 or the Veterans Crisis Line in an emergency.

On day 7 after discharge, a "friend" of the spouse contacted the Veterans Crisis Line with concerns for the spouse's safety, and a responder called and spoke with the spouse and patient. The spouse described the patient's episodes of aggression and violence at home, and the responder made a referral to a system suicide prevention coordinator. The next day the spouse contacted a clinical triage nurse stating the patient was completely out of haloperidol and was directed to a community emergency department to obtain refills. Ten days after discharge, a system staff member received a community notification that the patient physically assaulted a home health aide and was incarcerated.

Inspection Results

1. The Patient's Discharge

The OIG substantiated that the psychiatrist and the unit social worker did not facilitate a safe discharge as the patient's needs exceeded what the caregiver could reasonably manage. System leaders, the psychiatrist, and unit social worker did not address the spouse's safety concerns regarding the discharge plan or use available resources, such as consulting the ethics team, to obtain further guidance. Further, a patient advocate mismanaged the spouse's complaints related to the discharge plan, and the psychiatrist, a pharmacist, and a nurse did not complete components of medication reconciliation prior to discharge.[7]

Clinical research indicates "approximately 20% of patients experience adverse events in the first 3 weeks after hospital discharge, with 61% of those events regarded as preventable."[8] VHA Directive 1160.06(1), *Inpatient Mental Health Services,* outlines that inpatient mental health team members responsible for a patient's discharge must ensure the plan is "feasible based on available resources."[9] Additionally, the Joint Commission *Standards Manual (PC.04.01.03)* requires that a discharge plan be based on a patient's assessed needs to ensure a safe discharge.[10] The "NASW [National Association of Social Work] Standards for Social Work Practice with Family Caregivers of Older Adults" stresses that assessing caregiver concerns and their capability to fulfill caregiving responsibilities assists in developing a safe discharge.[11]

[7] VHA Directive 1003.04, *VHA Patient Advocacy*, November 9, 2023.

[8] Eric Alper and Katherine Liang, "Patient Safety During Hospital Discharge," Agency for Healthcare Research and Quality, (April 1, 2018), https://psnet.ahrq.gov/perspective/patient-safety-during-hospital-discharge.

[9] VHA Directive 1160.06(1), *Inpatient Mental Health Services*, September 27, 2023, amended December 27, 2024.

[10] The Joint Commission, *Standards Manual,* PC.04.01.03, March 30, 2025. "Provision of Care, Treatment, and Services."

[11] "NASW Standards for Social Work Practice with Family Caregivers of Older Adults." National Association of Social Workers, accessed January 27, 2026, https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/NASW-Standards-for-Social-Work-Practice-with-Family-Caregivers-of-Older-Adults.

The assessment typically begins when a social worker meets with a hospitalized patient and caregiver to gather information about the patient's "health, living situation, family and other support systems."[12] Discharge planning occurs when a multidisciplinary treatment team works with the patient and the patient's support system to develop an individualized plan to manage the patient's health concerns, coordinates services for future needs, and guides the transition to the next level of care.[13]

According to VHA's *Rights and Responsibilities* for patients and family members, a patient or a health care decision maker fully participates in treatment decisions and is "encouraged and expected to seek help" from the medical team or a patient advocate when an issue arises.[14] VHA Directive 1004, *VHA Health Care Ethics,* outlines that all patients, surrogates, and staff should be informed about, and have access to request an ethics consultation as "the discipline of health care ethics is critical … it establishes appropriate standards and addresses actions to take in the face of uncertainty or conflict about values in health care delivery."[15]

The OIG reviewed the quality of care provided and found the medical team documented repeated episodes of aggressive behavior, determined the patient lacked the capacity to participate in discharge planning, and initially concluded the patient needed a higher level of care than the spouse, the patient's surrogate, could provide at home. However, after the unit social worker's referrals to community nursing homes were denied due to behavioral concerns, the psychiatrist updated the discharge plan and documented the patient was appropriate for discharge to either a memory care unit or home with home health services.

During the patient's hospitalization, unit staff documented seven times in the EHR that the spouse expressed concerns about safely managing the patient at home. In the 10 days before discharge, staff documented the patient's repeated disruptive behaviors, with one incident requiring staff to give as-needed haloperidol to manage the behavior. Eight days before discharge, the unit social worker facilitated the order for home health aide services to assist with the patient's nonmedical needs at home such as bathing, dressing, and grooming.

The OIG found that despite the spouse's repeated concerns and the patient's aggressive behaviors, neither the psychiatrist nor the unit social worker assessed whether discharging the patient home with 30 hours of home health aide support per week was a safe, realistic, and manageable plan for the spouse.

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[12] "National Social Work Program: What VA Social Workers Do," VHA Social Work, accessed February 11, 2026, https://www.socialwork.va.gov/socialworkers.asp.

[13] Daniela C. Goncalves-Bradley et al., "Discharge Planning from Hospital (Review)," *Cochrane Database of Systemic Reviews* 2, no. CD000313 (February 24, 2022), https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000313.pub6/full#0.

[14] "Patient rights," Veterans Health Administration, accessed June 25, 2026, https://www.va.gov/health/rights/familyrights.asp.

[15] VHA Directive 1004, *VHA Health Care Ethics*, February 12, 2024.

The psychiatrist and the unit social worker also did not consider an ethics consultation to address the spouse's concerns. Further, four days prior to discharge, the unit treatment team informed the spouse that if the patient was not picked up, "legal proceedings" for abandonment would occur. By not addressing the spouse's concerns about the discharge plan and informing the spouse that abandonment was the alternative option to discharge to home, the treatment team did not uphold the spouse's rights as outlined in VHA's *Rights and Responsibilities*.[16]

The day before discharge, the psychiatrist emailed the deputy chief and chief of mental health explaining the patient's family was "very disgruntled that [unit staff were] not able to place this veteran with severe dementia with behavioral disturbances in a nursing home/memory care unit." The psychiatrist asked for feedback on the plan to discharge the patient home and whether alternative options were available. The deputy chief of mental health responded by asking about potential safety risks in the discharge plan, including whether 30 hours of home health services was enough to manage wandering and elopement concerns, and suggested the exploration of additional family involvement. In response, the psychiatrist wrote "there is always a risk for elopement in patients with dementia, which is why we tried … memory care unit [placement]," and asked for additional recommendations. The deputy chief of mental health provided no additional guidance and the discharge plan remained the same.

The unit social worker told the OIG the discharge plan "wasn't ideal," acknowledged the spouse could not manage the patient alone, and recognized that the spouse wanted more support. The psychiatrist also described the discharge as "not ideal" and that the only option available was sending the patient home with home health services. Additionally, both stated they did not assess the spouse's ability to care for the patient. When asked why, the unit social worker explained being unfamiliar with how to assess caregivers and the psychiatrist remarked that the spouse was "not my patient."

The OIG further questioned the unit social worker and psychiatrist on the use of available resources, such as ethics consultation, to obtain additional guidance. The unit social worker reported being unaware of whether an ethics consultation was considered or who was permitted to request one, and the psychiatrist said an ethics consultation was not warranted. The deputy chief of mental health stated the ethics team could be consulted but was unaware of additional system resources that could have helped staff address the spouse's disagreement with the discharge plan. The chief of mental health reported an awareness of the spouse's concerns and believed the psychiatrist had addressed them by educating the spouse on how to manage the patient's aggressive behavior.

The Chief of Staff reported being unaware of the spouse's concerns during the patient's hospitalization but stated the patient could have remained if unit staff determined the discharge was unsafe. The System Director told the OIG of an expectation that the treatment team should

[16] "Patient rights," Veterans Health Administration.

assess the feasibility of the patient's discharge plan, and consult with ethics if needed, particularly given the spouse's safety concerns.

The OIG concluded that the psychiatrist and the unit social worker did not evaluate whether the patient's discharge plan was safe, given the spouse's concerns about being able to manage the patient at home. Further system leaders and unit staff did not consider consulting with the ethics team to help address those concerns.

Patient Advocate Response

According to VHA Directive 1003.04, *VHA Patient Advocacy*, the patient advocate process is essential for ensuring patient satisfaction, access to quality care, and providing a structured way to resolve healthcare delivery concerns.[17] The process is managed through the Patient Advocate Tracking System, where patient advocates must document issues clearly, concisely, and with enough detail to fully explain the concern, including the complainant's desired resolution.[18] Patient advocates must resolve complaints within seven business days.

VHA Directive 1003.04 also requires patient advocates to coordinate the resolution of complaints with the designated service line advocate to address concerns at the point of service.[19] If the dissatisfaction pertains to a clinical decision, such as a discharge plan, the patient advocate must inform the patient or surrogate about the clinical appeals process.[20] This process allows the chief of staff to review the decision, include additional interdisciplinary staff or subject matter experts if needed, and render a final decision.[21]

Four days before the patient's discharge, the spouse submitted a complaint about the discharge plan to the patient advocate office. The patient advocate documented in the Patient Advocate Tracking System, that the spouse was told "if [the spouse] does not pick up [the patient] within 48 hours it would be consider[ed] [*sic*] abandonment." That same day, the spouse also emailed the patient advocate and the chief of social work to object to the patient's discharge home, stating, "I have my own serious health conditions and have communicated that I cannot provide 24/7 skilled care" and reported feeling intimidated by the psychiatrist. Over the next three days, the spouse sent two more emails to the patient advocate expressing concerns about the discharge plan and about unit staff not allowing additional family members to participate in discharge planning.

[17] VHA Directive 1003.04.

[18] VHA Directive 1003.04.

[19] VHA Directive 1003.04.

[20] VHA Directive 1003.04; VHA Directive 1041(2), *Appeal of Veterans Health Administration Clinical Decisions*, September 28, 2020, amended March 3, 2025.

[21] VHA Directive 1003.04; VHA Directive 1041(2).

The OIG learned the patient advocate contacted the unit social worker for information about the patient's discharge plan, documented a discussion with the spouse, and closed the complaint within seven business days. The documentation showed that the patient advocate explained to the spouse that the unit staff's actions were "correct" and that the patient could not remain on the unit because the patient was medically cleared for discharge, had been admitted for "almost 24 days," and had been denied admission to nursing home facilities.

The OIG determined the patient advocate did not follow VHA Directive 1003.04 when responding to the spouse's concerns.[22] The patient advocate entered the first complaint in the Patient Advocate Tracking System, but did not document the spouse's additional concerns, ensure accurate and comprehensive documentation, consult with the mental health administrative officer (who was also the designated service line advocate), or inform the spouse of the clinical appeals process.

When asked about these discrepancies, the patient advocate acknowledged that emails and conversations with both the spouse and the unit social worker were not thoroughly documented in the Patient Advocate Tracking System. The patient advocate believed the unit social worker had provided enough information to address the complaint, and did not contact additional staff, such as the service line advocate. The patient advocate was unable to explain why the spouse was not informed of the clinical appeals process.

The associate chief of staff, mental health explained that patient advocate complaint management process should involve the service line advocate to ensure the appropriate staff are included in the response. System leaders added that when the patient advocate notifies the service line advocate, service line leaders can review the issue and provide feedback in the Patient Advocate Tracking System. The System Director and Chief of Staff reported being unaware of the complaint. The Chief of Staff told the OIG that if made aware of the complaint, the patient's care would have been reviewed and a different approach may have been recommended to unit staff.

The OIG concluded that the mismanagement of the complaint led to incomplete documentation, prevented escalation of the complaint to system leaders through the clinical appeals process, and resulted in a missed opportunity to address the spouse's concerns.

Medication Reconciliation

VHA Directive 1345, *Medication Reconciliation,* outlines practices that promote the delivery of "accurate, timely, and complete medication information" to patients and caregivers.[23] Providers (a physician, clinical pharmacist, advanced practice registered nurse, physician assistant, or other health care professional who can prescribe medications) are responsible for completing

[22] VHA Directive 1003.04.

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

medication reconciliation at discharge with patients and caregivers, which includes providing a printed medication list; reviewing medication information, including proactive guidance; and assessing the patient's or caregiver's understanding.[24] Medical Center Policy, MCP-119-010, *Therapeutic Order and Drug Use Control*, states that nurses or pharmacists can counsel patients and caregivers on the discharge medications listed in the discharge instructions.[25] Further, caregivers of individuals living with dementia need clear guidance at discharge to ensure proper medication management at home.[26]

The OIG found that despite the patient's dementia diagnosis, the spouse was not included in the medication reconciliation process at discharge. Over the course of the patient's hospitalization, three of the patient's prior home medications were stopped or changed and seven medications were started, including haloperidol to manage agitation and aggressive behavior.

EHR documentation reflected the spouse was unable to be present at discharge; therefore, the unit social worker arranged for a transport company to take the patient home. A pharmacist documented completion of the medication reconciliation, noting the "medical team provided education" but did not specify to whom. The psychiatrist also documented providing education to the spouse over the phone; however, it was limited to the patient's as-needed haloperidol dose. Just before discharge, a nurse documented that the patient received medications and understood discharge instructions, which included the medication list. The medications included a 14-day supply of haloperidol with different doses for daytime, nighttime, and as-needed for behavioral escalation at home, including one dose that required cutting a tablet in half.

When asked about the medication reconciliation process, the pharmacist and the psychiatrist told the OIG that nurses review the medication list with patients at discharge, with the psychiatrist noting that pharmacists can also complete this task. The discharging nurse reported not calling the spouse to review the discharge instructions, including the medication list, stating "I'm not allowed to do that. It's either [a] doctors [*sic*] needs to speak to them or a social worker" and believed transport staff would provide the information. The System Director, Chief of Staff, and Associate Director of Patient Care Services stated that the spouse should have been included in the guidance provided at discharge. The Associate Director for Patient Care Services confirmed

[24] VHA Directive 1345.

[25] Central Virginia VA Health Care System, Medical Center Policy 119-010, *Therapeutic Order and Drug Use Control*, March 20, 2025. This policy was updated and reissued as Central Virginia VA Health Care System, Medical Center Policy 119-010, *Medication Use Process and Pharmaceutical Care*, August 1, 2025. The original policy states that nurses and pharmacists can provide medication education at discharge, whereas the updated policy assigns this responsibility exclusively to nurses.

[26] Mouna J. Sawan et al., "Interventions at Hospital Discharge to Guide Caregivers in Medication Management for People Living with Dementia: a Systematic Review," *Journal of General Internal Medicine* 36, no. 5 (February 3, 2021): 1371–79, https://doi.org/10.1007/s11606-020-06442-5.

nurses are expected to provide medication counseling at discharge and can call caregivers who are not present to review the information via telephone.

The OIG concluded that the psychiatrist and pharmacist did not ensure all components of medication reconciliation were completed. Further the nurse should have contacted the spouse directly to review discharge instructions and provide medication education given the patient's dementia diagnosis and the complexity of the haloperidol regimen.

2. The Patient's Post-Discharge Phone Calls

The OIG determined outpatient staff did not address concerns of abuse during post-discharge phone calls, or complete components of medication reconciliation post-discharge.

VHA recognizes that post-discharge engagement following an inpatient mental health admission promotes continuity of care, safety, and well-being.[27] System leaders confirmed that outpatient mental health and primary care staff conduct post-discharge engagement with a patient or caregiver through phone calls and a transition clinic appointment, which can also be conducted via phone. The adjustment period from acute psychiatric care to home environments is considered a time of increased risk for patients.[28] The chief of mental health explained the purpose of the transition clinic is to provide psychiatric support and medication management services.

Safety Concerns

VHA Directive 1199, *Reporting Cases of Abuse and Neglect*, requires healthcare staff who are mandated reporters to timely report suspected incidents of abuse to appropriate authorities, such as law enforcement or state agencies.[29] Medical Center Policy 011-047, *Identification, Management, and Reporting of Abuse,* further directs employees who suspect abuse to immediately report concerns to the patient's provider or escalate the concern to a supervisor or service chief.[30]

Shortly following the patient's discharge, outpatient mental health staff conducted two phone calls, a post-discharge phone call and a transition clinic phone appointment with the spouse. EHR documentation reflected the patient was exhibiting outbursts during both calls and was

[27] "Post Discharge Engagement (PDE1) Dashboard," Program Evaluation and Resource Center, https://dvagov.sharepoint.com/sites/VHAPERC/Reports/SitePages/PDE_Home.aspx. (This site is not publicly accessible.)

[28] Kelsey S. Dickson et al., "Characterization of multilevel influences of mental health care transitions: a comparative case study analysis," *BMC Health Services Research* 22, no. 437 (April 2, 2022), https://doi.org/10.1186/s12913-022-07748-2.

[29] VHA Directive 1199, *Reporting Cases of Abuse and Neglect*, September 3, 2024.

[30] Central Virginia VA Health Care System, Medical Center Policy 011-047, *Identification, Management, and Reporting of Abuse*, May 9, 2022.

heard yelling at the spouse. The spouse also reported to a nurse practitioner and a social worker, during the transition clinic call, that the patient was experiencing "enraged episodes," pushing the spouse and throwing objects. Additionally, the social worker documented the patient

> was present in the background but unable to participate [due to] behavioral disturbances ... [patient] could be heard … yelling at [the spouse], telling [the spouse] to get off the phone. Phone call abruptly ended two times because [the spouse] needed to tend to [the patient] as [the patient] was escalating.

The OIG determined that although outpatient mental health staff directed the spouse to call 911 or the Veterans Crisis Line in an emergency, staff did not notify the patient's care team nor escalate concerns of abuse to a supervisor or service chief.[31]

Staff told the OIG of not reporting or elevating concerns of abuse as the spouse did not sound distressed and that the patient "wasn't physically aggressive" during the phone calls. In retrospect, one staff member acknowledged that more questions about safety should have been addressed. When asked, system leaders confirmed and reiterated the expectation that staff should elevate and address concerns of abuse as outlined in policy.

The OIG concluded outpatient mental health staff did not address concerns of abuse. Reporting the patient's aggressive behaviors to appropriate parties may have prevented poor outcomes for the patient, spouse, and home health agency staff.

Veterans Crisis Line Contact

VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center,* requires that a 24/7 toll-free hotline is available to veterans and their families (customers) to provide crisis intervention services.[32] Veterans Crisis Line responders triage customer concerns as emergent, urgent, or routine and initiate appropriate services or referrals.[33] Responders are not mandated reporters.

When customers disclose non-imminent abuse, responders initiate a routine referral, with the customer's consent, to a medical center's suicide prevention coordinator (a mandated reporter) as required by Veterans Crisis Line Standard Operating Procedure VCL-S-ACT-404-2405, "Reporting Non-Imminent Abuse, Neglect, and Exploitation."[34] The suicide prevention

[31] VHA Directive 1199; Central Virginia VA Health Care System Medical Center Policy 011-047.

[32] VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, May 26, 2020, amended December 8, 2022.

[33] VHA Directive 1503(2).

[34] Veterans Crisis Line Standard Operating Procedure VCL-S-ACT-404-2405, "Reporting Non-Imminent Abuse, Neglect, and Exploitation," May 2024.

coordinator must review the referral within one business day and contact appropriate authorities according to state mandated reporting requirements.[35]

The OIG learned that staff gave the spouse the Veterans Crisis Line phone number on multiple occasions as well as instructions on when to call for help, including during a mental health emergency or concerns about harm. The day after the transition clinic appointment, a "friend" of the spouse contacted the Veterans Crisis Line with concerns for the spouse's safety, and a responder called and spoke with the spouse and the patient.

During the call, the spouse reported prior violent encounters that had occurred in the home, including instances where both the patient and the spouse had hit one another. The responder obtained consent from the spouse and the patient to make a routine referral to a system suicide prevention coordinator for "Anger issues, mental health." As the Veterans Crisis Line call occurred on a Friday, the suicide prevention coordinator contacted the spouse the following Monday and documented that over the weekend the patient assaulted a home health aide and was subsequently incarcerated.

The suicide prevention coordinator responded to the referral within one business day as required; however, a three-day gap existed between the report of abuse and the mandated reporter's awareness. The OIG found the spirit of VHA Directive 1199's requirement to timely report suspected incidents of abuse to appropriate authorities may not have been met because the Veterans Crisis Line Standard Operating Procedure VCL-S-ACT-404-2405 provides only one pathway (routine referral) for a responder to escalate concerns of non-imminent abuse to a mandated reporter for review the next business day.[36] The Executive Director of the Veterans Crisis Line reported being aware of responders' limited ability to escalate abuse concerns timely and noted potential solutions, such as a partnership with VISN clinical contact centers (24-7 virtual support services for veterans' health concerns), were considered but not yet implemented.

Timely verification and reporting of suspected abuse as VHA requires may have expedited the spouse's and patient's access to safety and support services.[37] This delay also may have placed the spouse, patient, and home health agency staff at increased risk.

Medication Reconciliation

VHA Directive 1345, requires that medication reconciliation is completed "at every episode or transition in care where medications will be administered, prescribed, modified or may influence the care given."[38] Medication counseling is a component of medication reconciliation whereby

[35] Veterans Crisis Line Standard Operating Procedure VCL-S-ACT-404-2405.

[36] Veterans Crisis Line Standard Operating Procedure VCL-S-ACT-404-2405; VHA Directive 1199.

[37] VHA Directive 1199.

[38] VHA Directive 1345.

the medication's purpose and proactive education is provided.[39] VHA and system training materials state that post-discharge phone calls should include a review of medications. System leaders confirmed to the OIG that medication management is a focus of the calls.

Over the course of the patient's hospitalization, three of the patient's prior home medications were stopped or changed, and seven medications were started. The primary care nurse who conducted the first post-discharge phone call documented that no medication changes had been made, therefore, missing an opportunity to discuss medication management with the spouse. The next day a mental health nurse conducted another call, noted the spouse's concerns about the patient's aggressive behavior and that medications were "not working," and provided education on "medication adherence."

Six days after discharge, during the transition clinic appointment, the spouse reported to the nurse practitioner that the patient was experiencing behavioral outbursts and sleep issues. The nurse practitioner performed medication reconciliation with the spouse and ordered medication refills to be mailed to the patient's home.

The next day (a week after discharge), the spouse called the unit requesting medication refills. Unit staff notified the psychiatrist, who documented the 14-day supply of medications provided at discharge was sufficient and refills were placed at the transition clinic appointment the previous day. At the psychiatrist's request, the outpatient nurse practitioner called and reminded the spouse that refills had been mailed. The following day, the spouse called the VISN clinical contact center reporting that the patient was "completely out of" haloperidol.

The OIG determined that despite multiple opportunities for staff to evaluate how the spouse was managing the patient's complex haloperidol regimen, and to provide proactive education, the patient's 14-day haloperidol supply was gone after 7 days. Further, staff did not recognize that the patient's medications may not have been effective in managing behaviors, nor perform further assessment to determine whether additional interventions were needed.

The primary care nurse told the OIG of normally reviewing discharge summaries, including medication changes, before post-discharge phone calls, but in this case likely reviewed an unrelated note that lacked medication updates. The mental health nurse did not assess the spouse's concerns about medication effectiveness or the patient's aggression as the spouse had no questions and reported feeling safe.

The mental health nurse told the OIG of not being concerned about the spouse's ability to administer the haloperidol as prescribed or its effectiveness and therefore did not notify the care team. The nurse practitioner reported that the spouse confirmed giving the haloperidol as prescribed but could not verify the remaining supply, which the practitioner did not view as an issue because a 14-day supply had been provided at discharge. System leaders told the OIG that

[39] VHA Directive 1345.

the patient running out of a two-week supply in one week was concerning and should have prompted further evaluation, and that inaccuracies in the post-discharge call documentation did not meet expectations.

The OIG concluded that outpatient primary care and mental health staff did not perform medication reconciliation as required in VHA Directive 1345.[40] Thorough medication reconciliation could have provided medication counseling and anticipatory guidance that may have (1) triggered additional assessment of medication effectiveness in managing behaviors, and (2) prevented the patient's 14-day haloperidol supply from being depleted after 7 days.

Conclusion

The OIG found that the psychiatrist and unit social worker did not ensure a safe discharge for the patient, as they did not assess the spouse's ability to manage the patient at home and did not address the spouse's repeated safety concerns or consider consultation with the ethics team. The OIG also found that the patient advocate did not follow required processes for documenting and escalating the spouse's complaints and that the psychiatrist and pharmacist did not ensure all components of medication reconciliation were completed. After discharge, outpatient primary care and mental health staff did not escalate concerns of abuse documented during post-discharge calls as required and did not complete medication reconciliation despite multiple opportunities to identify issues with the patient's complex haloperidol regimen. The OIG found that timely reporting of suspected non-imminent abuse may not have occurred in this circumstance because the Veterans Crisis Line standard operating procedure only allows a routine referral, which may delay review until the next business day.

The OIG made one recommendation to the Under Secretary for Health to consider establishing a process, to be used on non-business days, that enables Veterans Crisis Line responders to timely escalate concerns of non-imminent abuse to a mandated reporter.[41] Although the Under Secretary for Health nonconcurred with the recommendation, the OIG considers the recommendation closed given VHA's demonstrated consideration, as detailed in their response.

The System Director concurred with the remaining five recommendations and developed a new Interdisciplinary Team template that meets all of the required elements; implemented an immediate standdown with the Patient Advocate team to reinforce VHA requirements; trained all providers involved in the medication reconciliation process on documentation expectations; planned to convert system policy to a standard operating procedure to align with VHA requirements and provide guidance on the reporting process for suspected abuse, neglect, or

[40] VHA Directive 1345.

[41] The recommendation addressed to the Under Secretary for Health is directed to anyone in an acting status or performing the delegable duties of the position.

exploitation; and completed a comprehensive review of the patient's hospitalization and post-discharge encounters. The OIG will follow up on the planned actions until compliance is met.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–6

1. The Central Virginia VA Health Care System Director evaluates inpatient mental health unit discharge practices and develops processes to assess a caregiver's capability to ensure a safe discharge.

2. The Central Virginia VA Health Care System Director ensures complaints to the patient advocate are reviewed and addressed in accordance with Veterans Health Administration Directive 1003.04, *VHA Patient Advocacy*.

3. The Central Virginia VA Health Care System Director ensures medication reconciliation is completed at discharge and during post-discharge encounters according to Veterans Health Administration Directive 1345, *Medication Reconciliation*.

4. The Central Virginia VA Health Care System Director ensures compliance with Veterans Health Administration Directive 1199, *Reporting Cases of Abuse and Neglect*, requirements related to clinical staff escalating encounters involving potential abuse and neglect.

5. The Central Virginia VA Health Care System Director conducts a comprehensive review of the patient's hospitalization and post-discharge encounters and takes action as indicated, including quality management improvement processes.

6. The Under Secretary for Health considers establishing a process, to be used on non-business days, that enables Veterans Crisis Line responders to timely escalate concerns of non-imminent abuse to a mandated reporter.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: July 22, 2026

From: Acting Under Secretary for Health (10)

Subj: Healthcare Inspection—Review of a Patient's Discharge from the Central Virginia VA Health Care System in Richmond

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the OIG's draft report on Report, Review of a Patient's Discharge from the Central Virginia VA Health Care System in Richmond. The Veterans Health Administration (VHA) non-concurs with the recommendation 6 made to the Under Secretary for Health. Current VCL protocols, developed in consultation with OGC and Privacy, ensures safety through law enforcement referral for imminent risk and Suicide Prevention Coordinator outreach for non-imminent concerns, which successfully addresses the intent of mandated reporting to ensure Veteran safety.
2. VHA is committed to continually improving our processes and tools to support the optimal performance of community care staff, ensuring that we provide the best possible care to our Veterans.
3. Comments regarding contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office.

(Original signed by:)

John Figueroa
Acting Under Secretary for Health

[OIG comment: The OIG received the above memorandum from VHA on July 22, 2026.]

Office of the Under Secretary for Health Response

Recommendation 6

The Under Secretary for Health considers establishing a process, to be used on non-business days, that enables Veterans Crisis Line responders to timely escalate concerns of non-imminent abuse to a mandated reporter.

____Concur

__X__Nonconcur

Under Secretary for Health Comments

The Office of Suicide Prevention (OSP) Veterans Crisis Line (VCL) appreciates the Office of Inspector General's (OIG) attention to the timeliness of abuse referrals and shares the underlying concern for Veteran and caregiver safety that motivates Recommendation 6. VCL respectfully offers the following considerations for the OIG's review in finalizing the report and recommendation:

VHA Directive 1199 is not applicable to VCL, a part of the OSP, which is a National Program Office, according to definitive guidance from the Veterans Health Administration (VHA) Central Office Privacy Office, as shown in the Mandated Reporting email in Adult Protective Services (APS) Abuse Reporting Guidance September 2019.

As such, internal processes were developed in consultation with Office of General Counsel (OGC) and VHA Central Office Privacy, to ensure safety of children and vulnerable adults that creates a path for reporting imminent risk to law enforcement and submitting a Suicide Prevention Coordinator (SPC) referral for possible mandated reporting. Of note, in the Veterans Crisis Line Standard Operating Procedure (SOP) VCL-S-ACT-404-2405, "Reporting Non-Imminent Abuse, Neglect, and Exploitation," effective May 2024, references VHA Directive 1199. The intent was to state compliance with the spirit of VHA Directive 1199 as alternative national guidance was unavailable. However, based on recent guidance from the OGC, VCL SOPs will be restructured and will no longer reference VHA directives that are not applicable.

While the SPC referral represents the documented pathway for non-imminent abuse concerns regarding a vulnerable adult, it does not represent the totality of available Crisis Responder (CR) actions. In circumstances where a CR identifies an imminent safety concern during an interaction, existing VCL protocols provide for direct contact with law enforcement on a 24/7/365 basis. In the instance outlined in OIG's "Review of a Patient's Discharge from the Central Virginia VA Health Care System in Richmond," the CR followed applicable VCL protocols, and no information presented during the contact met the threshold for law enforcement escalation.

VCL internal process directs CRs to initiate a law enforcement emergency dispatch in situations when the Customer describes a pattern/history of abusive, neglectful, or exploitive behaviors toward a child/vulnerable adult that is likely to persist if there is no intervention. The information provided to the CR did not indicate an imminent safety risk or that a vulnerable, protected population was under the threat of abuse. Specifically, the caregiver disclosed that abuse had occurred at times in the past and Veteran was documented as "fine" at the time of the contact. No active, ongoing, or imminent threat of harm was disclosed. The CR's assessment that this did not constitute an imminent safety risk was consistent with VCL training standards and internal processes and did not constitute a situation requiring escalation to law enforcement or mandated reporting.

VCL notes the CR spoke with both the caregiver (the spouse) and the Veteran. The violent incident involving the home health aide occurred after and independently of VCL contact and was not reported to or known by the CR at the time of the call. This incident therefore could not have been anticipated, prevented, or reported by the CR based on the information available during the contact.

VCL's established recourse for reporting concerns and connecting Veterans to care is referral to SPC, with the expectation of SPC outreach within one business day. This pathway applies to all non-imminent risk situations, including Veterans assessed to be at non-imminent risk of suicide. VCL operates under the principle of least invasive intervention, prioritizing connection to care and crisis support over law enforcement contact when the situation safely permits. Escalation to law enforcement and mandated reporting each carry defined thresholds; neither was met in this contact. VCL notes that safety concerns, including reports of abuse, were communicated by the caregiver directly to the treatment facility. As a crisis line, VCL operates independently of the facility and was not party to those disclosures.

For these reasons, VCL respectfully requests that OIG remove Recommendation 6 from the report.

OIG Response

The OIG acknowledges the Veteran's Crisis Line process to report concerns of non-imminent abuse and agrees that the crisis responder complied with the required process. This report highlighted a specific circumstance when timely reporting did not occur due to the concerns being reported to the crisis responder on a Friday. This resulted in a three-day gap between the report of abuse and the mandated reporter's awareness.

The recommendation asked for the consideration of a new process to be used on non-business days that would enable Veterans Crisis Line responders to escalate concerns of non-imminent abuse to a mandated reporter in a more timely manner, thereby reducing the risk of an event similar to the one detailed in this report. Because VHA's response details this consideration, the OIG considers the recommendation closed.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 18, 2026

From: Interim VA Mid-Atlantic Health Care Network Director, VISN 6 (10N06)

Subj: Healthcare Inspection—Review of a Patient's Discharge from the Central Virginia VA Health Care System in Richmond (VIEWS # 14881704)

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54HL06)
Director, GAO/OIG Accountability Liaison Office (VHA 10OICGOALAction)

1. Thank you for the opportunity to review the draft report. I reviewed the action plan provided by the facility and concur with the response.
2. Should you need further information, please contact the Veterans Integrated Service Network Quality Management Officer

(*Original signed by:*)

Kevin P. Amick, MHRM (SES)
Interim Network Director

[OIG comment: The OIG received the above memorandum from VHA on July 22, 2026.]

Appendix C: System Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 10, 2026

From: Director, Central Virginia VA Health Care System (652)

Subj: Healthcare Inspection—Review of a Patient's Discharge from the Central Virginia VA Health Care System in Richmond (VIEWS #14881704)

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

1. We appreciate the opportunity to review and comment on the VA Office of Inspector General's (OIG) draft report, Review of a Patient's Discharge from Central Virginia VA Health Care System in Richmond. The Central Virginia VA Health Care System leadership team concurs with Recommendations 1 through 5 and is committed to implementing corrective actions to address the identified findings and strengthen processes related to discharge planning, patient advocacy, medication reconciliation, reporting of abuse and neglect concerns, and quality management review activities.
2. Leadership has initiated a review of the circumstances outlined in the report and will ensure appropriate actions are taken to improve compliance with Veterans Health Administration directives and local policy requirements. Planned corrective actions and target completion dates are outlined in the attached recommendation responses.
3. Should you need further information, please contact the Chief of Quality Management and Patient Safety.

(*Original signed by*:)

J. Ronald Johnson, FACHE
Director

[OIG comment: The OIG received the above memorandum from VHA on July 22, 2026.]

System Director Response

Recommendation 1

The Central Virginia VA Health Care System Director evaluates inpatient mental health unit discharge practices and develops processes to assess a caregiver's capability to ensure a safe discharge.

_X__Concur

____Nonconcur

Target date for completion: January 2027

Director Comments

Mental Health and Social Work collaborated to develop and implement a new Interdisciplinary Team (IDT) template in CPRS that meets all required elements for informed consent, treatment planning, and safe discharge. The template includes:

Documentation of informed consent for treatment and discharge planning, including an assessment of the patient's or decision maker's capacity to understand the discharge plan. It also captures attempts to engage the patient or caregiver when direct engagement is not possible. It includes a detailed treatment plan outlining specific interventions, frequency, and responsible staff. The template captures documentation of how treatment progress will be monitored. It includes a clear discharge planning criteria. Lastly, it includes an enhanced tentative discharge plan addressing mental health follow-up, family and caregiver engagement and needs, medical follow-up, and community resources.

Additionally, the National Social Work Clinical Intervention Framework has been fully implemented across Central Virginia VA Health Care System (CVHCS), including inpatient psychiatry. This framework includes a comprehensive psychosocial assessment with an expanded discharge planning section and evaluation of social supports and caregiver stress. This structured approach helps identify discharge barriers, including caregiver capability.

Expectations for use of the new IDT template have been shared at monthly Mental Health staff meetings. Training has already been completed through in-service sessions covering comprehensive clinical documentation, mandated reporting, medical legal considerations, recovery-oriented language, welfare checks, treatment planning, discharge planning, and safety planning. All initial training has been documented through meeting agendas, recorded sessions, and Teams attendance logs.

Compliance will be measured by confirming that at least 90 percent of patients discharged from the acute psychiatric unit have documentation using the new IDT template for six consecutive

months. Compliance results will be reported monthly to the Chief of Mental Health and quarterly to the Medical Executive Council.

Recommendation 2

The Central Virginia VA Health Care System Director ensures complaints to the patient advocate are reviewed and addressed in accordance with Veterans Health Administration Directive 1003.04, *VHA Patient Advocacy*.

__X__Concur

____Nonconcur

Target date for completion: January 2027

Director Comments

Leadership implemented an immediate standdown with the Patient Advocate team on June 10, 2026, to reinforce requirements in VHA Directive 1003.04, VHA Patient Advocacy. During this session, expectations for informing Veterans of their clinical appeal rights were reviewed with the entire Patient Advocacy team. A written reminder, including VHA Directive 1003.04 and VHA Directive 1041 (Appeal of Veterans Health Administration Clinical Decisions), was subsequently distributed to ensure consistent understanding across the service.

To strengthen system reliability, the Customer Service Manager has implemented a monitoring process that includes randomly auditing 10 percent of Inpatient Patient Advocate Tracking System (PATS) submissions each month, or 20 records, whichever is greater, to ensure compliance with the Directive. Monitoring will continue until compliance reaches 90 percent compliance for six consecutive months, with results reported quarterly to the Medical Executive Council.

Recommendation 3

The Central Virginia VA Health Care System Director ensures medication reconciliation is completed at discharge and during post-discharge encounters according to Veterans Health Administration Directive 1345, *Medication Reconciliation*.

__X__Concur

____Nonconcur

Target date for completion: January 2027

Director Comments

In this case, the practitioner noted that the psychiatrist would provide medication education. Following the review, all providers involved in the medication reconciliation process have been

instructed to clearly document which team member (psychiatrist or resident) provides medication education and to whom. Providers have also been directed to add the appropriate team members as additional signers to the medication reconciliation note to ensure acknowledgment of the completed process and verification of the accurate medication list.

All providers have been trained on these documentation expectations, including proper use of the national medication reconciliation template at discharge and during post-discharge encounters. Monitoring is underway and includes reviewing 100% of all discharges to verify template use at both points of care. Ongoing monitoring will continue until the facility achieves 90 percent compliance for six consecutive months, with results reported quarterly to the Medical Executive Council.

Recommendation 4

The Central Virginia VA Health Care System Director ensures compliance with Veterans Health Administration Directive 1199, *Reporting Cases of Abuse and Neglect*, requirements related to clinical staff escalating encounters involving potential abuse and neglect.

__X__Concur

____Nonconcur

Target date for completion: January 2027

Director Comments

While VHA Directive 1199 does not require clinical staff to escalate encounters involving potential abuse or neglect, local medical center policy 011-047 requires all CVHCS employees who suspect abuse, neglect, or exploitation to immediately report concerns to the patient's responsible health care provider and/or their supervisor or service chief. The intent is to ensure prompt and appropriate reporting of suspected abuse, neglect, or exploitation of vulnerable adults or children.

The local policy will be converted to a standard operating procedure (SOP) to ensure alignment with the Directive and provide clear guidance on the reporting process. Compliance with the Directive and the SOP will be monitored through monthly chart reviews of "Reporting Concerns for Suspected Abuse and Neglect" notes, beginning May 1, 2026. Ten charts will be reviewed each month; if fewer than ten notes exist, all available notes will be reviewed. Compliance will be measured by confirming that 90 percent compliance for six consecutive months, with results reported quarterly to the Medical Executive Council.

Recommendation 5

The Central Virginia VA Health Care System Director conducts a comprehensive review of the patient's hospitalization and post-discharge encounters and takes action as indicated, including quality management improvement processes.

__X__Concur

____Nonconcur

Target date for completion: June 2026

Director Comments

A comprehensive review of the patient's hospitalization and post discharge encounters was completed by the Chief of Mental Health and Chief of Staff. This review showed no criteria to indicate higher level quality management improvement processes such as a Peer Review or Root Cause Analysis. To address challenges associated with complex discharges, educational materials were developed to guide transition clinic providers in assessing post-discharge safety. These materials emphasize evaluating whether the discharge plan remains appropriate, confirming that the patient or caregiver has sufficient medication, and ensuring they understand correct medication administration. All transition clinic providers have signed an attestation confirming they reviewed these materials.

OIG Response

The OIG considers this recommendation closed.

Glossary

To go back, press "alt" and "left arrow" keys.

capacity. A person's ability "to make a specific decision or perform a specific task."[1]

haloperidol. A medication used to treat certain emotional and mental health conditions, including aggressive behaviors.[2]

mandated reporter. A licensed healthcare professional obligated by state law to report suspected abuse to appropriate authorities.[3]

memory care. Specialized long-term care for individuals with dementia.[4]

therapeutic confinement. A type of seclusion where a patient is physically prevented from leaving a room or area in order to maintain safety.[5]

[1] VHA Employee Education System, "Capacity 101," December 2021.

[2] Mayo Clinic, "Haloperidol (oral route)," accessed February 24, 2026, https://www.mayoclinic.org/drugs-supplements/haloperidol-oral-route/description/drg-20064173.

[3] VHA Directive 1199, *Reporting Cases of Abuse and Neglect*, September 3, 2024.

[4] VA, "When More Care is Needed," chap. 11 in *Dementia Resource Guide*, accessed April 9, 2026, https://www.va.gov/files/2025-07/Dementia%20Resource%20Guide%202024%209.pdf.

[5] VHA Directive 1160.06(1), *Inpatient Mental Health Services*, September 27, 2023.

OIG Contact and Staff Acknowledgments

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