US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the VA Boston Healthcare System in Brockton, Massachusetts

Mental Health Inspection | **25-03934-258** | **September 2, 2026**

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To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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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 October 6, 2025, through January 22, 2026, to assess the mental health care delivered in the acute inpatient mental health units (inpatient units) at the Brockton VA Medical Center (facility). The facility is part of the VA Boston Healthcare System in Massachusetts. The OIG completed the on-site portion of the inspection on November 18 and 19, 2025. At the conclusion of the on-site visit, the OIG team provided the acting Healthcare System Director with preliminary findings and observations from the inspection. The OIG published a preliminary results advisory memorandum identifying environmental safety hazards on December 18, 2025.[1] Facility leaders subsequently provided documentation of safety hazard corrections and mitigation plans to the OIG.

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 units. Sixteen recommendations were issued to facility leaders.

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.

For information on the OIG's data collection methods, see appendix A.[2]

Domain	OIG Summary
Leadership and Organizational Culture	The OIG assessed leadership structures and aspects of inpatient unit operations as they related to the delivery of quality care. Executive leaders reported stable inpatient unit staffing and lower nursing turnover compared to other Veterans Integrated Service Network facilities. Mental health leaders noted challenges balancing frequent meetings with direct veteran care and coordinating services across a large system with many clinical programs. The OIG found the Mental Health Executive Council did not have the veteran representation required by Veterans Health Administration (VHA) Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, but leaders addressed this issue following the inspection.[3]

[1] VA OIG, *Environmental Suicide Hazards at the VA Boston Healthcare System in Brockton, Massachusetts*, Report No. 25-03934-33, December 18, 2025.

[2] 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.

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

Domain	OIG Summary
Recovery-Oriented Principles 	To assess the inpatient unit's integration of recovery-oriented principles, the OIG examined aspects of leadership, treatment planning, therapeutic and interdisciplinary programming, and the care environment. The OIG found mental health leaders did not establish a standard operating procedure for staff training and recovery-oriented services on the inpatient unit as required by VHA Directive 1160.06(1), *Inpatient Mental Health Services*.[4] Additionally, staff did not schedule four daily hours of interdisciplinary, recovery-oriented programming on both weekends and weekdays, and did not consistently conduct scheduled groups. Further, the local recovery coordinator did not follow the requirement in VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, to review recovery-focused training materials.[5]
Clinical Care Coordination 	To assess the quality of clinical care coordination, the OIG reviewed access to services, facility procedures for involuntary treatment, medication management, and discharge planning. The facility did not comply with VHA Directive 1160.06(1) expectations for processes to oversee compliance with involuntary commitment state laws.[6] Staff did not consistently complete documentation for medication risks and benefits discussions as required by VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*.[7] Some discharge instructions used language that could confuse veterans and caregivers, and some instructions did not state the reason for prescribed medications.[8]
Suicide Prevention 	To evaluate suicide prevention activity on the inpatient units, the OIG assessed suicide risk screening and evaluation, safety planning, and training. Staff did not consistently complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge, as specified by VA's suicide risk identification strategy.[9] They also did not consistently follow VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06" to complete

[4] 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.

[5] VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 14, 2025.

[6] VHA Directive 1160.06(1).

[7] VHA Directive 1160.01; VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023, amended May 1, 2024.

[8] VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023; VHA Health Information Management, *Health Record Documentation Program Guide Version 1.3*, February 13, 2025; VHA Directive 1345, *Medication Reconciliation*, March 9, 2022.

[9] Department of Veterans Affairs (VA) Suicide Risk Identification Strategy Minimum Requirements by Setting, updated May 10, 2023, February 25, 2025, and October 30, 2025. All three versions contain similar language regarding inpatient mental health requirements; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11), "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (RISK ID Strategy)," memorandum to Veterans Integrated Services Network (VISN) Director, et al., November 23, 2022, was rescinded and replaced by "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum on January 7, 2025.

Domain	OIG Summary
	or review veterans' suicide prevention safety plans prior to discharge.[10] Additionally, inpatient unit staff did not consistently complete suicide risk training as established in "Office of Suicide Prevention Suicide Prevention Mandatory Training Dashboard FAQ [Frequently Asked Questions]."[11]
Safety 	The OIG evaluated aspects of safety, compliance with ongoing assessment of suicide hazards, and completion of mandatory staff training. Interdisciplinary Safety Inspection Team members did not consistently attend inspections or document attendance in Environment of Care Committee minutes, which are required by VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*.[12] Some inpatient and safety inspection team staff did not complete training. Leaders did not follow VHA Office of Mental Health Standard Operating Procedure 1167.2, "Standard Operating Procedure for Submission of MHEOCC [Mental Health Environment of Care Checklist] Attestations Under VHA Directive 1167" instructions to record attestations of training completion.[13] The OIG observed undocumented environmental hazards; facility leaders later provided documentation that all identified hazards had been corrected or had mitigation plans.

[10] VHA Office of Mental Health and Suicide Prevention Standard Operating Procedure 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA Directive 1160.06," September 29, 2023, updated on December 19, 2024. This policy was replaced with Standard Operating Procedure 1160.06.2(1) on February 17, 2026. Unless otherwise specified, the three policies contain similar language regarding safety planning processes.

[11] "Office of Suicide Prevention Suicide Prevention Mandatory Training Dashboard FAQ," VHA Office of Suicide Prevention, accessed April 15, 2026, https://dvagov.sharepoint.com/sites/vhasuicidepreventioncoordinators/SitePages/Education-and-Training.aspx. (This site is not publicly accessible.)

[12] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017, rescinded and replaced with VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, November 4, 2024. The policies contain similar language regarding safety inspection team requirements. The older directive was in place for part of the mental health environment of care checklist and training documentation reviews.

[13] VHA Office of Mental Health Standard Operating Procedure 1167.2, "Standard Operating Procedure for Submission of MHEOCC Attestations Under VHA Directive 1167," November 5, 2024.

VA Comments and OIG Response

The VA Boston Healthcare System and Veterans Integrated Service Network leaders concurred with recommendations 1–16 and implemented multiple corrective actions (see appendixes B and C). Leaders revised the inpatient handbook and updated key mental health policies, including integration of recovery-oriented care expectations. They also improved documentation processes for involuntary commitment and medication informed consent, as well as suicide prevention processes. Discharge templates were corrected to include patient-friendly clinic names and clear medication instructions. Safety oversight was reinforced through improved attendance tracking and training documentation and verification for environmental inspections. Based on information provided, the OIG considers recommendations 2, 4, 10, 13, 14, 15, and 16 closed.

For the remaining recommendations, the OIG will follow up on planned actions until they are completed. See appendix C for the OIG's response.

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Contents

Abbreviations

OIG	Office of Inspector General
SOP	standard operating procedure
STEMS	Skills Training for Evaluation and Management of Suicide
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The mission of the VA Office of Inspector General (OIG) is to conduct independent oversight of VA. The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care through 1,380 healthcare facilities to over nine million enrolled veterans.[14] The OIG established the Mental Health Inspection Program to regularly evaluate VHA's continuum of mental healthcare services. On October 6, 2025, the OIG announced an inspection to evaluate acute inpatient mental health care provided at the Brockton VA Medical Center (facility), part of the VA Boston Healthcare System in Massachusetts. The OIG conducted inspection activities from October 6, 2025, through January 22, 2026, and completed the on-site portion on November 18 and 19, 2025.[15] Following the on-site visit, the OIG team provided the acting Healthcare System Director with preliminary findings and observations from the inspection. The OIG published a preliminary results advisory memorandum identifying environmental safety hazards on December 18, 2025.[16] Facility leaders subsequently provided documentation of safety hazard corrections and mitigation plans to the OIG.

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).[17] Under VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, VHA healthcare system leaders are expected to ensure all veterans who are eligible for care have access to recovery-oriented inpatient, residential, and outpatient mental health programs.[18] All healthcare systems 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.[19]

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[14] "Mission, Vision, and Values," VA OIG, accessed December 15, 2025, https://www.vaoig.gov/about/mission-vision-values; "About VHA," VA, accessed December 15, 2025, https://department.va.gov/vha/about-us/. The OIG considers "VHA" and "VA" interchangeable when referring to a medical facility.

[15] 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. Due to the government shutdown and furlough, the review team ceased work from October 20 through November 12, 2025. The OIG team completed the last interview for this inspection on January 22, 2026.

[16] VA OIG, *Environmental Suicide Hazards at the VA Boston Healthcare System in Brockton, Massachusetts*, Report No. 25-03934-33, December 18, 2025.

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

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

[19] VHA Directive 1160.01. If a healthcare system does not provide required services, those services must be offered through another VA facility or program.

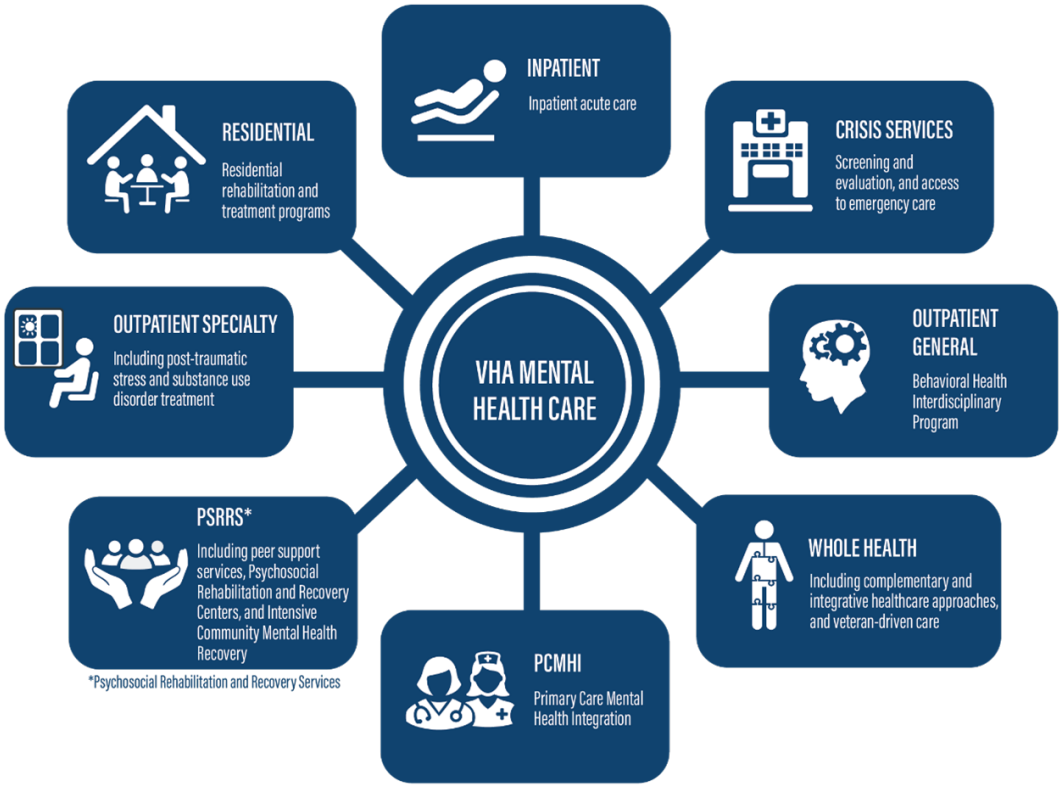

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, August 14, 2025.

In fiscal year 2025, VHA healthcare systems delivered inpatient mental health care for 63,240 veteran stays.

VHA Directive 1160.06(1) requires inpatient mental health unit (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.[20]

To evaluate the quality of inpatient mental health care at the facility, the OIG assessed specific processes across five domains: leadership and organizational culture, recovery-oriented principles, clinical care coordination, suicide prevention, and safety.

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

About VA Boston Healthcare System

The VA Boston Healthcare System, part of Veterans Integrated Service Network (VISN) 1, encompasses three facilities in Brockton, Jamaica Plain, and West Roxbury and four community-based outpatient clinics in Framingham, Lowell, Plymouth, and Quincy, Massachusetts.[21] The Brockton facility has four inpatient units.[22]

From July 1, 2024, through June 30, 2025, the VA Boston Healthcare System provided health care to 62,687 veterans. Of those, 15,042 received outpatient mental health care. Inpatient unit staff cared for 766 veterans and maintained an average daily census of 40.[23] Staff submitted six consults for inpatient mental health care in the community during this period. According to facility data, the four inpatient units had 111 operating mental health beds at the time of the inspection.

[21] In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/.

[22] The OIG inspected all four inpatient units.

[23] "VA Health Systems Research, Corporate Data Warehouse (CDW)," VA, accessed March 24, 2025, https://vaww.virec.research.va.gov/CDW/Overview.htm#FAQs. (This site is not publicly available.); "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."[24] 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.[25]

The OIG assessed leadership structures and aspects of inpatient unit operations as they related to the delivery of quality care.

Leadership Structure

At the time of the OIG's inspection, facility staff reported the healthcare system executive leadership team included the acting Director; acting Deputy Director; Chief of Staff; Deputy Chief of Staff; Associate Director; and Associate Director for Patient Care Services, Nurse Executive. The Chief of Staff and Associate Director for Patient Care Services, Nurse Executive provided oversight for patient care and supervised service directors and program chiefs, including the Chief of Mental Health and Deputy Nurse Executive. The Chief of Mental Health oversaw all mental health programs and served as the facility's mental health lead, a position required under VHA Directive 1160.01.[26]

The VISN Chief Mental Health Officer reported providing consultation and operational support for inpatient units within the network; for example, through monthly meetings in which OIG published reports were shared to identify potential vulnerabilities.

The Chief of Mental Health reported a cohesive and stable healthcare system leadership structure, and inpatient unit leaders described effective interdisciplinary communication. However, mental health leaders noted challenges balancing the number of meetings with direct veteran care responsibilities and care coordination across three facilities with many clinical programs.

According to VHA Directive 1160.01, healthcare systems are required to establish a mental health executive council to ensure quality mental health care is delivered and includes treatment that is responsive to veteran preferences.[27] The facility had a Mental Health Executive Council

[24] Edgar H. Schein, *Organizational Culture and Leadership, 4th ed*, (San Francisco, CA: Jossey-Bass, 2010), https://ia800809.us.archive.org/14/items/EdgarHScheinOrganizationalCultureAndLeadership/Edgar_H_Schein_Organizational_culture_and_leadership.pdf.

[25] VA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, July 2024.

[26] VHA Directive 1160.01.

[27] VHA Directive 1160.01.

that was chaired by the Chief of Mental Health and included a representative from inpatient unit staff, as well as local recovery and suicide prevention coordinators.[28] However, the council did not meet the requirement for a veteran representative.[29] The Chief of Mental Health reported that, following prolonged recruitment efforts, a veteran representative had been selected. As of April 27, 2026, the veteran had started attending the council's meetings. The OIG will monitor to ensure continued veteran involvement.

Inpatient Unit Operations

VHA Directive 1160.06(1) requires facilities to have an inpatient mental health program manager (program manager) to coordinate and promote consistent, sustained, high-quality therapeutic programming on the inpatient unit.[30] The inpatient mental health program manager is responsible for oversight of all inpatient unit clinical services.[31]

Facility staff reported that the inpatient units had a program manager.[32] The program manager oversaw inpatient unit operations and supervised psychiatrists and other inpatient unit staff. Four inpatient mental health nurse managers (nurse managers) supervised nursing staff.

Healthcare system executive leaders described stable inpatient unit staffing and less nursing turnover compared to other healthcare systems in the VISN, despite some nursing vacancies. Leaders cited challenges related to staff coverage during leave, the need for one-on-one observation of high-risk veterans, and delays in human resources processing of new staff. However, mental health and executive leaders reported using overtime when needed and did not identify any veteran safety concerns due to inpatient unit staffing levels.

Leaders described using tools to recruit and retain staff, such as an education debt reduction program, competitive salary adjustment, various residency and training programs, and staff referral and performance awards. Mental health leaders reported collecting staff's input on inpatient unit needs through informal and formal meetings, huddles (brief discipline-specific meetings on patient care), and leadership rounding.[33]

VHA Directive 1160.01 requires facilities to have mechanisms for collecting feedback from veterans who obtain mental health services. Mental health leaders used a patient experience survey, a veteran committee, interaction with staff during group programming, and leadership

[28] VHA Directive 1160.01.

[29] VHA Directive 1160.01.

[30] VHA Directive 1160.06(1).

[31] VHA Directive 1160.06(1).

[32] VHA Directive 1160.06(1).

[33] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

rounding to meet this requirement.[34] Mental health leaders reported implementing suggestions to improve the inpatient unit experience, such as increasing veterans' access to fresh air (discussed further in the Physical Environment section).

Recommendation

1. The Healthcare System Director ensures the Mental Health Executive Council includes veteran representation, in accordance with Veterans Health Administration Directive 1160.01, *Uniform Mental Health Services in VHA [Veterans Health Administration] Medical Points of Service*.

For a detailed action plan, see appendix C.

[34] VHA Directive 1160.01.

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on an individual's "strengths, talents, coping abilities, resources, and inherent value."[35] 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.[36]

The OIG examined aspects of leadership, programming, and the physical environment to evaluate the facility's integration of recovery-oriented principles on the inpatient units.

Leadership

Local recovery coordinators play an important role in VA healthcare systems. They are considered collaborative mental health leaders who ensure recovery-oriented principles are integrated into care delivery. Their role is primarily nonclinical in nature, which allows them to dedicate most of their time to activities such as training, consultation, and education.[37]

To support veterans' recovery, VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, requires healthcare systems to have a full-time local recovery coordinator and a plan across the mental health care continuum for continued transformation and implementation of recovery-oriented services.[38] Additionally, VHA Directive 1160.06(1) requires the local recovery coordinator, in collaboration with the program manager, to establish a standard operating procedure (SOP) that includes processes for "the education, staff training, and implementation of recovery-oriented care" on the inpatient unit.[39]

At the time of the inspection, the OIG determined the local recovery coordinator was not dedicated to the position full-time. The coordinator served as a manager for other mental health programs and provided clinical coverage, which limited time for local recovery coordinator responsibilities.

Prior to the OIG inspection, mental health leaders submitted a waiver requesting temporary exemption from the requirement to maintain a dedicated full-time local recovery coordinator due to staffing challenges. The waiver was approved with the condition of meeting the requirement

[35] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *SAMHSA's Working Definition of Recovery, 10 Guiding Principles of Recovery*, 2012.

[36] US Department of Health and Human Services, Publication No. SMA-09-4371, *Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions,* 2011.

[37] VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 14, 2025.

[38] VHA Directive 1163.

[39] VHA Directive 1160.06(1).

by June 1, 2026. The Chief of Mental Health reported plans to advocate for a full-time employee in the role. After the OIG inspection, facility leaders partially reclassified the local recovery coordinator position to more closely align with VHA Directive 1163 and continue to work with the national program office for further resolution.

Facility leaders did not implement an SOP for staff education and training on recovery-oriented care.[40] The OIG found the coordinator did not review inpatient training materials to ensure a recovery-oriented approach.[41] Although the coordinator reported developing a multi-year transformation plan and conducting annual facility-wide training as required by VHA Directive 1163, interaction with inpatient unit staff was limited to informal consultation. Without a full-time local recovery coordinator, recovery-oriented principles and activities may not be implemented on the inpatient units or elsewhere in the facility.

Recovery-Oriented Treatment

VHA's "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06" requires inpatient unit staff to orient veterans to the unit and recovery-oriented care.[42] Additionally, VHA requires the interdisciplinary treatment team to develop, implement, and monitor progress on each veteran's treatment plan.[43]

Inpatient leaders reported that orientation was provided to veterans at admission along with an orientation handbook.[44] Leaders further explained that clinical staff led daily community meetings to reinforce veterans' understanding of recovery concepts.[45] The OIG also learned that the interdisciplinary treatment team met regularly with veterans to develop and review treatment plans, and inpatient unit managers conducted monthly reviews to ensure the plans' quality.[46]

The OIG observed nursing staff consistently engaged with veterans on inpatient units. However, programming schedules for some units did not contain at least four hours of interdisciplinary, recovery-oriented activities on weekends and certain weekdays as required by VHA Directive 1160.06(1).[47] Additionally, the OIG observed that staff did not consistently hold scheduled groups; mental health leaders attributed these gaps to staffing shortages.[48] Insufficient access to

[40] VHA Directive 1160.06(1).

[41] VHA Directive 1163.

[42] VHA Office of Mental Health and Suicide Prevention SOP 1160.06.3, "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06," September 29, 2023.

[43] VHA Directive 1160.06(1).

[44] VHA SOP 1160.06.3.

[45] VHA SOP 1160.06.3.

[46] VHA Directive 1160.06(1).

[47] VHA Directive 1160.06(1).

[48] VHA Directive 1160.06(1).

structured therapeutic programing, which is a core component of recovery-oriented care, can limit veterans' opportunities to develop skills, participate meaningfully in their treatment, and work toward recovery goals while hospitalized.

According to VHA Directive 1160.06(1), "Veterans should be encouraged to dress in personal clothes during the day unless there is an individualized, documented reason for the Veteran to be in hospital pajamas."[49] During the inspection, the OIG observed that all veterans on inpatient units were wearing hospital garb rather than their own clothing. The facility's inpatient handbook outlines a standard practice of delaying veterans' access to personal clothing until the fourth day of hospitalization. The program manager explained that the practice was implemented to address safety concerns following incidents of hazardous substances being brought into the inpatient units.

The inconsistency between VHA Directive 1160.06(1) and the facility's inpatient handbook regarding individualized veteran access to personal clothing indicates a potential misalignment with the intent of the VHA policy.[50] Restricting veterans from accessing personal clothing can negatively affect their dignity, autonomy, and engagement in recovery-oriented care.

Physical Environment

VHA recognizes the inpatient unit's physical environment as an element of recovery-oriented mental health care. The *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities* provides standards for healthcare systems to create hopeful and healing environments while maintaining safety.[51]

The OIG found the inpatient units had aspects of a recovery-oriented environment.[52] Inpatient leaders reported actively improving the inpatient unit environment through ongoing renovations such as the addition of sensory modulation rooms, which are therapeutic spaces to help users engage in self-directed emotional regulation, and separate sections for women veterans on mixed gender units.[53]

The OIG observed that inpatient unit bedrooms had natural light and common area windows had adjustable blinds within the windowpane. The units had warm paint colors and artwork integrated in most patient areas.

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[49] VHA Directive 1160.06(1).

[50] VHA Directive 1160.06(1).

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

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

[53] Stephanie Haig and Nutmeg Hallett, "Use of Sensory Rooms in Adult Psychiatric Inpatient Settings: A Systematic Review and Narrative Synthesis," *International Journal of Mental Health Nursing* 32 (2023): 54-75, https://doi.org/10.1111/inm.13065.

Figure 2. *Shared dining room (with displayed artwork), recreation room, and secured outdoor space. Source: Photos of the facility's inpatient units taken by OIG staff, November 18, 2025.*

Furniture was generally in good repair. Each unit had a computer station in the dayroom available for veterans' use; however, none of the computers had privacy screens to protect sensitive information.

In alignment with VHA Directive 1160.01, the Chief of Mental Health reported facility staff gathered feedback from veterans receiving inpatient mental health care, and their suggestions led to increased access to a recreation center with outdoor space.[54] The assistant nurse manager reported some veterans were taken to the mental health recreation center, which included an outdoor area, two to three times every other day. According to a nursing leader, a policy regarding safe use of outdoor activities was finalized on November 17, 2025, with plans to train staff on the new policy. Following the OIG's on-site visit, mental health leaders provided documentation confirming that inpatient unit staff completed the required training.

Recommendations

2. The Chief of Mental Health ensures staff develop and implement a local standard operating procedure for staff education and training on recovery-oriented care, consistent with Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*.
3. The Chief of Mental Health ensures the local recovery coordinator conducts reviews of inpatient training material to maintain a recovery-oriented approach, in accordance with Veterans Health Administration Directive 1163, *Psychosocial Rehabilitation and Recovery Services*.
4. The Chief of Mental Health considers consultation with the Office of Mental Health to ensure facility policy aligns with Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*, on veterans' access to personal clothing on the inpatient units.

[54] VHA Directive 1160.01.

5. The Chief of Mental Health ensures a minimum of four daily hours of recovery-oriented, interdisciplinary programming on the inpatient mental health units, consistent with Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*, and develops a plan to monitor for sustained compliance.

For detailed action plans, see appendix C.

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.[55] For veterans with "complex health and social needs, care coordination is crucial for improving their access to [services], clinical outcomes, [and] care experiences."[56] VHA's inpatient mental health services use a recovery-oriented approach with a goal of expediting the transition to a lower level of care.[57]

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 hospitalization and treatment, medication management, and discharge planning.

Access to Care

Successful coordination of mental health care requires well-defined screening and admissions processes that ensure veterans are evaluated and receive clinically appropriate treatment.[58] Facility leaders established standard operating procedures for inpatient unit admission and transfer processes, per VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."[59]

Staff identified two units where all veterans in need of acute inpatient mental health care were initially admitted. Veterans were transferred to a non-admitting unit once they were no longer considered at high risk for harm to self or others but more time was needed for stabilization before discharge. Staff reported that the lengths of stay on the two non-admitting units were notably longer due to veterans requiring further stabilization or awaiting placement to a lower

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

[56] 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*, no. 3 (August 15, 2023), https://www.doi.org/10.3389/frhs.2023.1211577.

[57] VHA Directive 1160.06(1).

[58] VHA Directive 1160.01.

[59] VHA Office of Mental Health and Suicide Prevention Standard Operating Procedure 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023, was replaced with Standard Operating Procedure 1160.06.2 on December 19, 2024, and 1160.06.2(1) on February 17, 2026. Unless otherwise specified, the updated SOP contains similar language related to inpatient mental health unit requirements; VA Boston Healthcare System Medical Center Policy 116A-008-MH, "Admission, Discharge and Transfer Criteria for Mental Health Inpatient Services," February 23, 2024.

level of care. Mental health leaders did not report any barriers to veterans' admission to the inpatient units.

Involuntary Hospitalization and Treatment

> 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."[60]
>
> Standards and procedures for civil commitment are provided by state law and vary by state.[61] VHA requires that leaders consult with the Office of General Counsel, as necessary, to ensure that processes are consistent with applicable laws.[62]

The facility policy, "Conditional Voluntary Admission and Commitment of Mentally Ill Patients" outlined written processes for involuntary hospitalization but did not include guidelines for oversight to ensure compliance with state laws as required in VHA Directive 1160.06(1).[63] Mental health leaders described informal processes such as huddles, team meetings, and documentation of veterans' legal commitment statuses in their electronic health records. The absence of written processes to monitor commitment status can result in staff confusion about veteran's legal statuses and potentially contribute to the illegal hospitalization of veterans.

The facility met requirements under VA's memorandum "For Action: Establishing Veterans Health Administration Facility Involuntary Mental Health Commitment Point of Contacts." A subject matter expert was assigned as a point of contact to consult with facility staff and leaders who oversaw processes related to involuntary commitment.[64]

VHA policy, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care," requires a registered nurse to conduct and record a review of admission documentation, including legal commitment status, prior to veterans' arrival on the

[60] "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, accessed September 10, 2025, https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf.

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

[62] VHA Directive 1160.01.

[63] VHA Directive 1160.06(1); VA Boston Healthcare System MCP-116A-021-MH, "Conditional Voluntary Admission and Commitment of Mentally Ill Patients," October 1, 2020.

[64] Acting Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Establishing Veterans Health Administration Facility Involuntary Mental Health Commitment Point of Contacts," memorandum to Veterans Integrated Services Network Directors (10N1-23), July 30, 2025.

inpatient unit.[65] Ninety-four percent of electronic health records included evidence that nursing staff recorded veterans' legal commitment status in the appropriate note template, which exceeded the 90 percent expected compliance level (see appendix A). When staff have accurate information regarding veterans' legal commitment status, it can ensure that veterans' civil rights are not violated.

Medication Treatment

VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures* requires documentation of an informed consent discussion between prescribers and veterans for newly prescribed central nervous system medications used to treat a wide range of neurologic and psychiatric conditions.[66] The OIG found 78 percent of electronic health records reviewed included documentation of informed consent discussions between prescribers and veterans on risks and benefits of medication use. When providers do not communicate the risks and benefits of medications, veterans may not have sufficient information needed to make informed decisions about their treatment options. A mental health leader conveyed uncertainty as to why informed consent documentation was missing in some records.

Discharge Planning

In alignment with VHA Directive 1160.01, facility leaders established written guidance on care coordination processes for veterans transitioning out of the inpatient units.[67]

All reviewed electronic health records included the required discharge instructions and all had documentation that the veteran was offered a copy of the discharge instructions, as indicated in VHA's *Health Record Documentation Program Guide Version 1.2*.[68]

All reviewed electronic health records reflected documentation of scheduled outpatient mental health follow-up appointments prior to the veteran's discharge.[69] VHA's "Clinic Profile Management Business Rules" specify follow-up outpatient appointment locations and services

[65] VHA Office of Nursing Services VHA-ONS-NUR-22-01, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care" (SOP), September 20, 2022, revised November 2, 2023, and September 10, 2024. Both versions were in effect during the electronic health record review period. Unless otherwise noted, both versions contain similar language related to documentation of voluntary or involuntary legal status.

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

[67] VHA Directive 1160.01; VA Boston Healthcare System MCP 116A-008-MH, "Admission, Discharge and Transfer Criteria for Mental Health Inpatient Services," February 23, 2024.

[68] VHA Health Information Management Office, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023, was updated and replaced with VHA Health Information Management Office, *Health Record Documentation Program Guide Version 1.3,* on February 13, 2025. Unless otherwise specified, the program guides contain similar language related to documentation requirements.

[69] VHA SOP 1160.06.2, replaced with VHA SOP 1160.06.2(1).

should be in easy-to understand language and free from abbreviations and acronyms.[70] The OIG found no records had discharge instructions with easy-to-understand language for follow-up appointment locations and services (see figures 3 and 4).[71] Mental health leaders stated they were unsure how to incorporate easy-to-understand clinic names into discharge instructions. Discharge instructions with abbreviated location information can create barriers for veterans to attend follow-up appointments and receive timely mental health care.

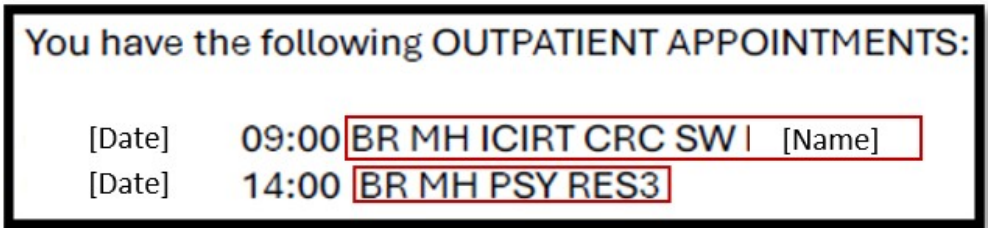

Figure 3. *Example from discharge instructions with abbreviated appointment location information outlined in red.*
Source: OIG review of veterans' electronic health records.
Note: Appointment date and provider name were redacted for privacy purposes.

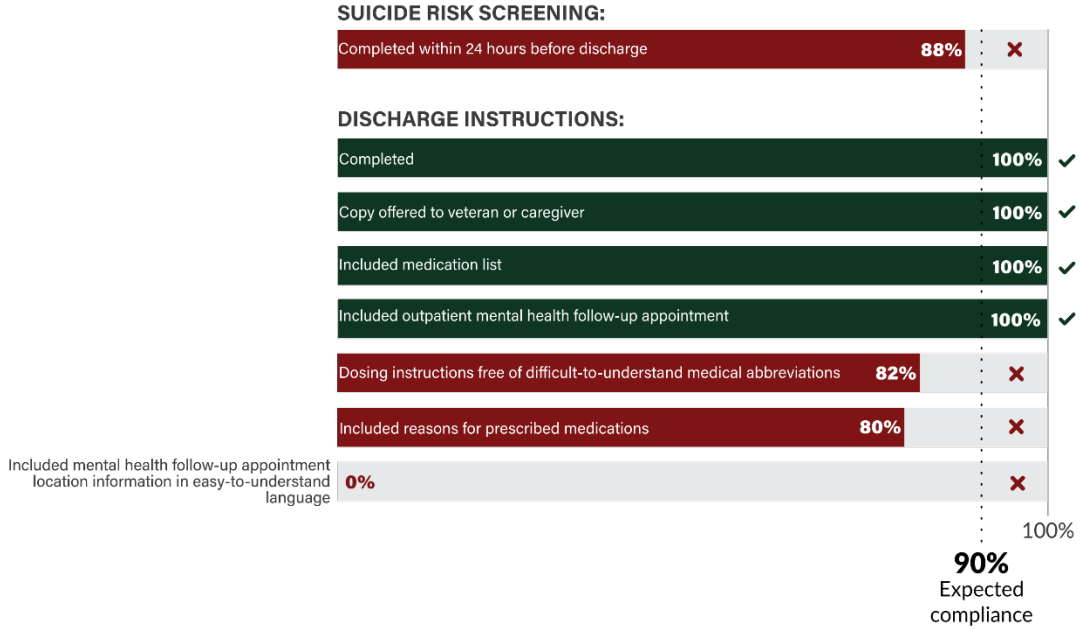

Figure 4. *Discharge-related screening and documentation.*
Source: OIG review of inpatient unit electronic health records.
Note: Based on analysis of 50 electronic health records. Suicide risk screening discussed in Suicide Prevention (below).

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

All reviewed records included documentation that a medication list was provided at discharge; however, not all discharge instruction included the reasons for prescribed medications (see figure 4).[72]

Additionally, many discharge instructions included medical abbreviations that could be difficult for non-medically trained individuals to understand (see figure 5).[73] Accurate and easy-to-understand discharge instructions could prevent medication errors at home following hospitalization.


PRAZOSIN HCL 5MG CAP ACTIVE
SIG: TAKE ONE CAPSULE BY MOUTH AT BEDTIME FOR POSTTRAUMATIC STRESS SYNDROME
PLEASE HOLD IF SBP<100 OR HR<60

Figure 5. *Example of discharge instructions with medical abbreviations outlined in red.*
Note: The medical abbreviation SBP refers to systolic blood pressure and HR refers to heart rate.
Source: OIG review of veterans' electronic health records.

Recommendations

6. The Healthcare System Director develops and implements written processes to ensure compliance with involuntary commitment requirements, in accordance with Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*.
7. The Chief of Staff ensures compliance with Veterans Health Administration Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, requirements related to documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications prior to administration and develops a plan to monitor for sustained compliance.
8. The Chief of Staff ensures veterans' discharge instructions include the appointment location in easy-to-understand language, consistent with Veterans Health Administration's "Clinic Profile Management Business Rules."

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

[73] VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023; VHA Health Information Management, *Health Record Documentation Program Guide Version 1.3*, February 13, 2025.

9. In accordance with Veterans Health Administration Directive 1345, *Medication Reconciliation*, and Veterans Health Administration Health Information Management's *Health Record Documentation Program Guide Version 1.3*, the Chief of Staff ensures discharge instructions include the purpose and dosing information for each listed medication in easy-to-understand language and develops a plan to monitor for sustained compliance.

For detailed action plans, see appendix C.

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.[74]

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."[75] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors.[76]

To evaluate suicide prevention activity on the inpatient units, the OIG assessed suicide risk screening and evaluation, safety planning, and training.

Suicide Risk Screening and Evaluation

The *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy Minimum Requirements by Setting* requires staff to complete the Columbia-Suicide Severity Rating Scale (suicide risk screening) for all veterans within 24 hours prior to discharge from inpatient mental health units.[77] Inpatient unit clinical staff did not consistently complete the suicide risk screening within the required time frame in the reviewed electronic health records (see figure 4, above).[78] According to mental health staff, providers often missed required suicide prevention screening due to time pressures from emergency discharges and the belief that comprehensive assessment templates were sufficient for low-risk veterans, such as those admitted for detoxification. When a suicide risk screening is not completed within the required time frame, staff can be unaware of the veteran's risk level and have an insufficient understanding of discharge readiness and post-discharge care coordination needs.

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

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

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

[77] "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy Minimum Requirements by Setting", updated May 10, 2023, February 25, 2025, and October 30, 2025. All three versions contain similar language regarding inpatient mental health requirements. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11), "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (RISK ID Strategy)," memorandum to Veterans Integrated Services Network (VISN Director, et al., November 23, 2022, was rescinded and replaced by "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum on January 7, 2025.

[78] "VA Suicide Risk Identification Strategy Minimum Requirements by Setting," updated May 10, 2023, February 25, 2025, and October 30, 2025; while VHA requires staff to complete Columbia-Suicide Severity Rating Scales within 24 hours before discharge, the OIG also considered risk screenings compliant if completed on the day of discharge. The OIG used 90 percent as the expected level of compliance for electronic health record reviews.

VHA memorandum "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update" requires facility directors or designees to implement standard operating procedures for suicide risk screening and evaluation and directs executive leaders to identify a champion to ensure staff stay informed of national updates.[79] Facility leaders established a local standard operating procedure and identified a facility champion, per their facility SOP and the memorandum requirements.[80]

Safety Planning

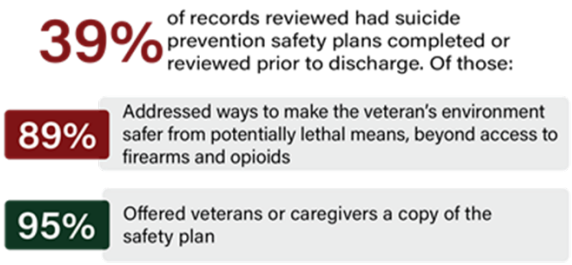

Figure 6. *Facility staff's compliance with VHA safety planning guidance.*
Source: OIG review of veterans' electronic health records.

ASafety 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.[81]

The OIG found that inpatient staff did not consistently complete or review safety plans prior to discharge, which is a requirement in VHA Office of Mental Health and Suicide Prevention SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA Directive 1160.06."[82] An inpatient unit leader reported that staff may have misunderstood the policy and thought only veterans assessed to be at high risk for suicide needed to complete or review a safety plan.

Most reviewed safety plans had documentation that staff provided a copy of the plan to veterans or caregivers.[83] Veterans could be more likely to use coping skills after discharge from the inpatient unit with a copy of the safety plan.

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[79] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11) "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum to Veterans Integrated Services Network Directors (10N1-23), January 7, 2025.

[80] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11) "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum; VA Boston Healthcare System SOP 116A-006-MH, "Provision of Suicide Prevention Screenings and Evaluations in Clinical Care Settings," April 8, 2025.

[81] Barbara Stanley and Gregory K. Brown, "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," *Cognitive and Behavioral Practice* 19, (2012): 256–264, https://doi.org/10.1016/j.cbpra.2011.01.001.

[82] VHA Office of Mental Health and Suicide Prevention SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA Directive 1160.06," September 29, 2023, updated on December 19, 2024. This policy was replaced with SOP 1160.06.2(1) on February 17, 2026. Unless otherwise specified, the three policies contain similar language regarding safety planning processes.

[83] VHA Standard Operating Procedure 1160.06.2, September 29, 2023, updated December 19, 2024.

Some reviewed suicide prevention safety plans did not indicate staff addressed ways to make the environment safer from other potentially lethal means, beyond access to firearms and opioids, as outlined in the *VA Safety Planning Intervention Manual* (see figure 6, above).[84]

In a recent publication, the OIG made the following 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.[85]

Therefore, the OIG does not make any further recommendations on suicide safety plan documentation of lethal means in this report.

The identification of all potential lethal means in the environment, beyond firearms and opioids, can reduce the risk of self-harm.

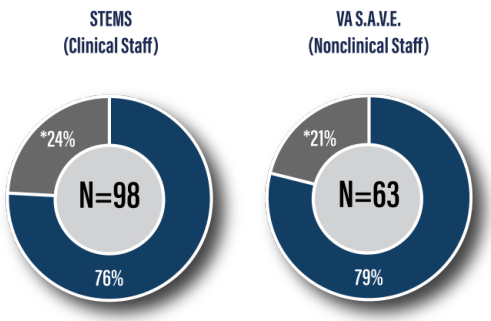

Figure 7. *Inpatient unit staff completion of mandatory suicide prevention training.*
Source: OIG document review of clinical and nonclinical staff training records.
Note: The OIG evaluated completion of STEMS and VA S.A.V.E. training from October 6, 2024, through October 5, 2025.

Training

Skills Training for Evaluation and Management of Suicide (STEMS) and VA S.A.V.E. (Signs of suicide, Asking about suicide, Validating feelings, and Encouraging and supporting next steps) help clinical and nonclinical staff, respectively, identify the warning signs of suicide risk and appropriate interventions.[86]

The OIG determined that inpatient unit staff did not meet the 95 percent completion target for STEMS and VA S.A.V.E. training established in the "Office of Suicide Prevention Suicide Prevention Mandatory Training Dashboard FAQ [Frequently Asked Questions]" (see figure 7).[87] When staff do not complete suicide prevention training, they may not

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

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

[86] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; VA, "VA S.A.V.E. Training: Four Ways You Can Help a Veteran in Crisis" (fact sheet), June 2025.

[87] "Office of Suicide Prevention Suicide Prevention Mandatory Training Dashboard FAQ," VHA Office of Suicide Prevention, accessed April 15, 2026, https://dvagov.sharepoint.com/sites/vhasuicidepreventioncoordinators/SitePages/Education-and-Training.aspx. (This site is not publicly accessible.)

be able to identify suicide risk factors and could lack awareness of resources and interventions to keep veterans safe.

Recommendations

10. The Chief of Staff directs staff to complete the Columbia-Suicide Severity Rating Scale within 24 hours before veterans' discharge, consistent with *Department of Veterans Affairs (VA) Suicide Risk Iden fica on Strategy Minimum Requirements by Se ng*, and develops a plan to monitor for sustained compliance.
11. The Chief of Staff directs staff to complete or review veterans' suicide prevention safety plans prior to discharge from the inpatient mental health units, in accordance with Veterans Health Administration Office of Mental Health Standard Operating Procedure 1160.06.2(1), "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA [Veterans Health Administration] Directive 1160.06," and develops a plan to monitor for sustained compliance.
12. The Healthcare System Director directs staff to complete required suicide prevention training, according to the "Office of Suicide Prevention Suicide Prevention Mandatory Training Dashboard FAQ [Frequently Asked Questions]," and develops a plan to monitor for sustained compliance.

For detailed action plans, see appendix C.

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."[88] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[89]

To assess the inpatient mental health environment, the OIG evaluated ongoing assessments of suicide hazards and completion of staff training.

Mental Health Environment of Care

VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients,* outlines expectations for environment of care inspections.[90] The Interdisciplinary Safety Inspection Team (safety inspection team), is comprised of both mental health and other facility staff, is responsible for conducting environment of care inspections using the Mental Health Environment of Care Checklist.[91] The National Center for Patient Safety continually updates this checklist "based on reports from the field of hazards or adverse events encountered at the local level."[92] Inspection team members are required to use this comprehensive checklist of more than 140 detailed environmental elements to "identify and abate suicide hazards on mental health units and other areas treating patients at high acute risk for suicide."[93]

As outlined in VHA Directive 1167, the safety inspection team should include an inspection lead, inpatient mental health unit program director, inpatient unit nurse manager, suicide prevention coordinator, patient safety manager, representative from engineering or facilities

[88] VHA Directive 1160.06(1).

[89] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017, rescinded and replaced with VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients,* November 4, 2024. Unless otherwise specified, the policies contain similar language related to the inpatient mental health unit Interdisciplinary Safety Inspection Team, mental health environment of care checklist inspections, and training requirements. The older directive was in place for part of the mental health environment of care checklist and training documentation reviews.

[90] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[91] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[92] "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.

[93] VHA Directive 1167, May 12, 2017. The Mental Health Environment of Care Checklist "consists of criteria applicable to all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion rooms, and staff work stations." This policy was replaced with VHA Directive 1167, November 4, 2024; "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, November 18, 2025.

management, and "one additional clinical staff from any discipline or work area."[94] The safety inspection team is required to report to the facility environment of care committee, with team membership, attendance, and findings documented as part of the inspection rounds summary.[95]

The facility had an established safety inspection team and team lead and conducted inspections at the required frequency.[96] However, the suicide prevention coordinator, inpatient mental health program director, and a mental health unit nurse manager did not consistently attend inspections as required.

While inspection findings were included in Environment of Care Committee meeting minutes, inspection attendance was not.[97] The team lead reported being unsure why all required members were not present at inspections and was unaware of the requirement to report the attendance to the Environment of Care Committee. This could have led to missed opportunities to identify potential environmental hazards and for senior leaders to monitor required attendance at inspections.

Figure 8. *Inpatient unit communal toilet (not flush-mounted to the floor, with removeable seat).*
Source: Photo taken by OIG staff, November 18, 2025.

During a physical inspection of the inpatient units, the OIG team found several objects that did not align with inspection standards. This included items that could be used as anchor points for hanging and other high-risk objects such as

- toilets not flush-mounted to the floor, with removeable seats (see figure 8);
- exposed plumbing;
- sink faucets and handles that are not tapered or rounded;
- cabinet door handles that are not sloped, recessed, or concealed;
- medical bed in the restraint and seclusion room; and
- unsecured medical equipment and cords.[98]

Facility staff did not follow VHA processes outlined in VHA Directive 1167 to accurately identify and document safety concerns. Specifically, staff recorded furniture, plumbing, toilets, sinks, and unsecured medical equipment in the Patient Safety

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

[95] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024. The new directive revised the reporting requirements for the inspection team.

[96] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[97] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[98] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," November 18, 2025.

Assessment Tool as meeting requirements, despite the presence of suicide hazards.[99] The facility inspection lead believed that some safety risks met inspection standards because staff were present when patients used these areas. Due to the potential for unpredictable events that could distract staff's attention, correcting the safety concerns in these areas can further decrease veteran risks.

Additionally, the inspection lead believed that because the units were undergoing renovations, not all inspection requirements were applicable. VHA expects that renovations on inpatient units adhere to all inspection requirements outlined in the environment of care checklist.[100] Not accurately identifying safety risk using inspection standards could lead to unmitigated environmental hazards, thereby compromising veteran and staff safety.

OIG staff immediately communicated safety concerns to the acting Director, the Chief of Mental Health, and inpatient unit staff. In response, facility leaders removed some hazardous items from patient care areas and implemented interim risk mitigation measures for the remaining hazards, including 15-minute patient safety checks, staff education on specific environmental hazards, and continual observation in common areas. Additionally, facility leaders conducted an assessment of identified safety concerns to determine the level of risk and developed a corresponding long-term corrective action plan.

Given the seriousness of the issue and similar concerns identified at other facilities, the OIG published a preliminary results advisory memorandum on December 18, 2025, to the Under Secretary for Health to ensure that other VHA facilities are aware of these vulnerabilities and can proactively address similar suicide risks across the enterprise.[101] In May 2026, facility leaders reported to the OIG that they had either mitigated or corrected all identified hazards. For those requiring more involved changes, facility leaders described mitigation plans with corrective actions that will be incorporated into infrastructure updates. When staff do not identify and address environmental hazards, veterans and staff can be placed at risk for harm.

[99] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[100] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," April 30, 2024, October 16, 2024, March 19, 2025, May 29, 2025, June 12, 2025, September 5, 2025, and November 18, 2025. The checklists contain similar language related to units undergoing renovation. VHA requires that units undergoing renovation use criteria that apply to new unit standards.

[101] 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; VA OIG, *Environmental Suicide Hazards at the VA Boston Healthcare System in Brockton, Massachusetts*, Report No. 25-03934-33, December 18, 2025.

Training

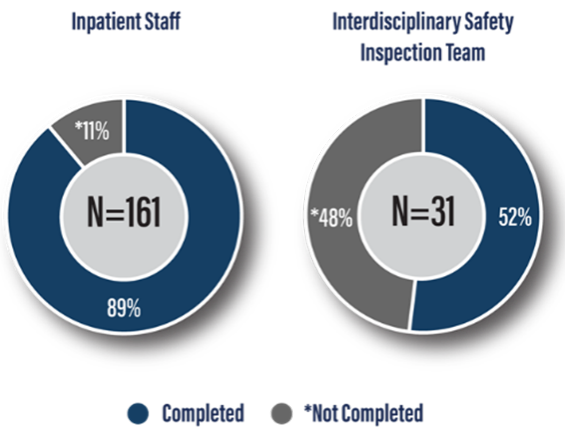

Figure 9. *Mental Health Environment of Care Checklist training completion.*
Source: OIG document review of staff training records for inpatient units and Interdisciplinary Safety Inspection Team staff.
Note: The OIG evaluated completion of Mental Health Environment of Care Checklist training from October 6, 2024, through October 5, 2025. Interdisciplinary Safety Inspection Team staff who were also inpatient unit staff are included in the denominator for both document reviews.

VHA Directive 1167 requires staff to be trained on environmental hazards and oriented to the use of the Mental Health Environment of Care Checklist.[102] Additionally, VA medical facility leaders must attest that required staff have completed the training, per VHA Standard Operating Procedure 1167.2.[103]

Some inpatient unit staff completed the annual training (see figure 9). Many safety inspection team staff did not complete the annual training (see figure 9). Additionally, facility leaders did not include the required attestation of training completion during the time frame of May 4, 2025, through October 5, 2025.[104] The Chief of Mental Health reported being unaware of this requirement. The inspection lead described relying on inspection members to self-report completion of the training.

Completing annual training on environmental hazards and VHA safety requirements can reduce safety risks for veterans and staff on the inpatient units.

Recommendations

13. The Healthcare System Director instructs the Interdisciplinary Safety Inspection Team to adhere to Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients* requirements related to attendance at inspections and record of attendance in meeting minutes, and develops a plan to monitor for sustained compliance.

[102] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.
[103] VHA Office of Mental Health Standard Operating Procedure 1167.2, "Standard Operating Procedure for Submission of MHEOCC Attestations Under VHA Directive 1167," November 5, 2024.
[104] VHA Standard Operating Procedure 1167.2, November 5, 2024; VHA Directive 1167, November 4, 2024. VHA provided a six-month period for facilities to attest to training completion, with implementation due by May 4, 2025.

14. The Healthcare System Director implements processes to ensure Interdisciplinary Safety Inspection Team staff accurately identify and document safety hazards, in accordance with Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*.
15. The Healthcare System Director directs inpatient staff and Interdisciplinary Safety Inspection Team members to complete Mental Health Environment of Care Checklist training requirements, consistent with Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, and develops a plan to monitor for sustained compliance.
16. The Healthcare System Director ensures that Mental Health Environment of Care Checklist training completion is documented in attestations, in accordance with Veterans Health Administration Office of Mental Health Standard Operating Procedure 1167.2, "Standard Operating Procedure for Submission of MHEOCC [Mental Health Environment of Care Checklist] Attestations Under VHA [Veterans Health Administration] Directive 1167," and develops a plan to monitor for sustained compliance.

For detailed action plans, see appendix C.

Conclusion

To support quality of care improvements, the OIG reviewed the facility's acute inpatient mental health care across five domains.

Leaders described a stable executive structure and effective interdisciplinary communication. The facility had a Mental Health Executive Council that met staff participation requirements. The council did not include a veteran; however, following the OIG inspection, a veteran began attending council meetings. Leaders reported collecting veteran feedback and those suggestions led to increased access to a recreation center with outdoor space.

Facility staff followed requirements to provide veterans with orientation materials and interdisciplinary treatment planning. They also implemented recovery-oriented guidance to design therapeutic spaces with natural light and calming elements.

The facility had a recovery coordinator who was not full time. As a result of the OIG inspection, facility leaders partially reclassified the local recovery coordinator position to more closely align with the current VHA directive and are continuing to work with the national program office for further resolution. The coordinator did not review inpatient training materials for a recovery-oriented approach. Daily schedules did not consistently reflect the four-hour daily minimum for recovery-oriented programming, and staff did not always hold scheduled groups. Veterans were also unable to access personal clothing until four days after admission and the local policy appeared to conflict with the VHA directive.

Although facility leaders had standard operating procedure for inpatient unit admission and transfer processes, they did not have formal processes to ensure compliance with state laws on involuntary commitment. Despite this, nearly all health records documented veterans' legal commitment statuses.

Some veteran health records were missing informed consent discussions on medication risks and benefits. Veteran discharge instructions often contained undefined abbreviations and omitted medication purposes.

Inpatient unit staff did not consistently complete required suicide risk assessments before discharge. They also did not consistently complete or review suicide safety plans.

Staff did not meet completion targets for suicide prevention or mental health environment of care checklist trainings. Some required team members did not attend inspections, attendance was not recorded in meeting minutes, and leaders did not document attestations of training completion. The OIG observed ligature risks, unsecured medical equipment, and incorrect documentation of hazards during inspections, and immediately communicated concerns to facility leaders. In response, leaders removed some hazardous items from patient care areas and, following the OIG inspection, corrected the remaining hazards or implemented risk mitigation measures.

The OIG issued 16 recommendations to healthcare system and facility leaders. In response to the OIG's recommendations, leaders revised the inpatient handbook and updated key mental health and suicide prevention policies; enhanced documentation processes for involuntary commitment and medication informed consent; corrected discharge templates; and improved attendance tracking for environmental inspections, as well as training documentation and verification.

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.

Appendix A: Methodology

The Mental Health Inspection Program inspections focused on the quality of care provided by VHA's inpatient mental health services.[105] The OIG randomly selected the VHA healthcare systems included in fiscal year 2026 reviews from all systems with inpatient mental health beds.[106] The OIG conducted a virtual and on-site review at the facility and 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 12 months of healthcare system Mental Health Executive Committee meeting minutes. The OIG reviewed data specific to the facility, prior OIG reports related to the inpatient units, documents, and electronic health records. Additionally, the OIG conducted a physical inspection of the inpatient units and interviewed key staff and leaders.

The OIG reviewed select staff's training records for annual completion of Skills Training for Evaluation and Management of Suicide (STEMS), VA S.A.V.E (Signs of suicide, Asking about suicide, Validating feelings, and Encouraging and supporting next steps), and Mental Health Environment of Care Checklist trainings.[107] 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 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.[108] 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, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and take full responsibility for the content of the publication. All references are for 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

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

[106] The OIG identified healthcare systems with inpatient mental health beds using the Monthly Program Cost Report (MPCR) code of 1310 (High Intensity General Psychiatric Inpatient Unit). For fiscal year 2026, the OIG excluded facilities with inpatient mental health beds that the OIG inspected in fiscal years 2024 and 2025. Allocation Resource Center, "Monthly Program Cost Report (MPCR) Handbook," October 2014, updated March 2017.

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

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

Office of Management and Budget (OMB) Memorandum M-25-21, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust."[109]

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 B and appendix C.

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.[110] 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 electronic health records of veterans discharged from an acute inpatient mental health stay of more than 48 hours at the facility from July 1, 2024, through June 30, 2025.[111] The OIG reviewed for documentation of a risk and benefit discussion specific to veterans who were newly prescribed central nervous system medications (used for treatment of "a wide range of neurologic and psychiatric conditions") during the inpatient stay.[112] 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 units to evaluate if the facility provided a therapeutic, recovery-oriented environment and maintained veteran safety.[113] 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 units for

[109] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

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

[111] The OIG identified the electronic health record 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.

[112] VHA Directive 1004.01(3); John A. Gray, "Introduction to the Pharmacology of CNS [Central Nervous System] Drugs," chap. 21 in *Katzung's Basic & Clinical Pharmacology*, 16th ed., Todd W. Vanderah: (McGraw Hill 2024), https://accesspharmacy.mhmedical.com/content.aspx?sectionid=281750155&bookid=3382&Resultclick=2.

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

cleanliness and veteran access to secure outdoor space.[114] Further, the OIG's physical inspection of areas in the inpatient units focused on selected safety elements specific to this facility.

The OIG reviewed the Mental Health Environment of Care Checklist data documented in the Patient Safety Assessment Tool, the software tool VHA uses to document these types of inspections, and assessed corrective actions taken for deficiencies unresolved for more than six months.[115]

[114] VHA Directive 1160.06, amended to VHA Directive 1160.06(1); VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*; VHA Directive 1850.01(1), *Health Care Environmental Sanitation Program*, March 29, 2023.

[115] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety; VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 10, 2026

From: Director, Department of Veterans Affairs (VA) New England Healthcare System (10N1)

Subj: Office of Inspector General Report, Mental Health Inspection of the VA Boston Healthcare System in Brockton, Massachusetts

To: Director, Office of Healthcare Inspections (54MH00)
Chief Integrity and Compliance Officer (10OIC)

1. I have reviewed and concur with the Office of Inspector General's (OIG's) draft report entitled – Mental Health Inspection of the VA Boston Healthcare System in Brockton, Massachusetts.
2. Furthermore, I have reviewed and concur with the Medical Center Director's actions to the recommendations.
3. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)

Ryan Lilly, MPA
Veterans Integrated Service Network 1 Director, VHA

[OIG comment: The OIG received the above memorandum from VHA on July 10, 2026.]

Appendix C: Healthcare System Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 10, 2026

From: Executive Director, VA Boston Healthcare System (523)

Subj: VA OIG Report, Mental Health Inspection of the VA Boston Healthcare System in Brockton, Massachusetts

To: Director, VA New England Healthcare System (10N1)

1. The VA Boston Healthcare System appreciates the Office of Inspector General's comprehensive Mental Health Inspection of the Brockton Campus and is grateful for the professionalism, diligence, and thoughtful feedback provided throughout the review process. The inspection offered valuable insights into our mental health programs and operations and highlighted opportunities to strengthen processes that support the delivery of safe, high-quality, Veteran-centered care.

2. VA Boston Healthcare System concurs with the recommendations and is fully committed to addressing the recommendations identified in the report and to sustaining improvements through ongoing monitoring, leadership oversight, and accountability at all levels of the organization. As outlined in the enclosed responses, several corrective actions have already been completed, while additional initiatives are underway to further strengthen compliance and performance. We therefore ask for closure of five recommendations.

3. We will continue to collect and provide data, audits, and other evidence demonstrating sustained improvement and the effectiveness of corrective actions. Our leadership team remains steadfast in its commitment to fostering a culture of excellence, transparency, and continuous quality improvement to ensure that every Veteran receives the highest quality, safest, and most compassionate care possible.

(*Original signed by*:)

Leslie Pierson, MS, MT
Executive Director, VA Boston Healthcare System

[OIG comment: The OIG received the above memorandum from VHA on July 10, 2026.]

Healthcare System Director Responses

Recommendation 1

The Healthcare System Director ensures the Mental Health Executive Council includes veteran representation, in accordance with Veterans Health Administration Directive 1160.01, *Uniform Mental Health Services in VHA [Veterans Health Administration] Medical Points of Service*.

__X_ Concur

_____Nonconcur

Target date for completion: November 2026

Director's Comments

On May 14, 2026, the VA Boston Healthcare System submitted April meeting minutes with attendance as evidence of Veteran membership on the Mental Health Executive Committee. The Veteran is a permanent member of the committee and the council continuously recruits additional Veteran membership providing reminders to current members to ensure sustained membership. Monthly minutes for May through October will also be submitted to demonstrate continued attendance; 51% attendance is the minimum acceptable attendance. In accordance with the committee charter, the Mental Health service line Administrative Officer prepares the minutes for review by the chair. The chair is then responsible for the distribution to the members.

Recommendation 2

The Chief of Mental Health ensures staff develop and implement a local standard operating procedure for staff education and training on recovery-oriented care, consistent with Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*.

__X_ Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

The VA Boston Healthcare System edited the Medical Center Policy (MCP) "Acute Psychiatric Inpatient Recovery-Oriented Care, MCP-116A-002_MH" regarding recovery-oriented care to reflect the local standard operating procedures for staff education and training. This policy was amended on June 4, 2026, to incorporate revisions aimed at enhancing recovery-oriented care in acute psychiatric inpatient units.

The Local Recovery Coordinator will monitor compliance. 100% of all Inpatient Mental Health clinicians, nursing staff, and occupational and recreational therapists have been trained on the MCP amendments. We request that this recommendation be closed.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 3

The Chief of Mental Health ensures the local recovery coordinator conducts reviews of inpatient training material to maintain a recovery-oriented approach, in accordance with Veterans Health Administration Directive 1163, *Psychosocial Rehabilitation and Recovery Services*.

__X_ Concur

_____Nonconcur

Target date for completion: February 2027

Director's Comments

The VA Boston Healthcare System has established and implemented a process for the Local Recovery Coordinator to collaborate with the Inpatient Mental Health Services, Associate Chief of Nursing Services for Mental Health, and inpatient discipline managers to routinely assess recovery-oriented principles across all aspects of service delivery that includes recovery-oriented trainings at least annually.

As noted in MCP-116A-002-MH, staff will receive training related to psychosocial rehabilitation and recovery principles at orientation and routinely. All dedicated unit staff complete a minimum of four hours of training annually. Sources of training may include, but are not limited to, VA sponsored grand rounds, TMS [Talent Management System] trainings, in-service presentations, supervisory meetings, and reading of new scientific literature on recovery topics.

The Associate Chief of Nursing and Mental Health Inpatient Director collaborate to compile a list of unit staff to assign recovery-oriented training quarterly. These may be live or TMS trainings.

For example, the recovery coordinator conducted in-person staff training of "Hearing Distressing Voices" (TMS 4686245) on September 17, 2025, March 11, 2026, and May 13, 2026 (attendance sheets attached). The next in-person training is planned for September of 2026. Mental Health leadership will direct all inpatient psychiatry staff to complete the following courses within TMS: "Introduction to the Recovery Model: Understanding the Transformation of Mental Health Service (131012919)" and "Mental Health Recovery and Whole Health (131012944)." All newly hired staff will be assigned this training during onboarding. Supervisors will ensure that at least 90% of all staff attend training.

Recommendation 4

The Chief of Mental Health considers consultation with the Office of Mental Health to ensure facility policy aligns with Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*, on veterans' access to personal clothing on the inpatient units.

__X_ Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

We have verified that there is no local policy referencing a 72-hour delay in providing patients access to their personal clothing and belongings. Specifically, as evidenced in MCP-118-008 Hazardous Items and Maintenance of a Safe and Therapeutic Environment, contains no such language or provision. The VA Boston Healthcare System Acute Mental Health Handbook provided to Veterans on admission was updated to clarify that inpatients may have immediate access to personal clothing and belongings after they are deemed safe. VHA Directive 1160.06(1) Appendix A.2.b requires documentation for Veterans who are restricted from wearing personal clothing, and the facility documents this information in the electronic medical record. This change was communicated to mental health leadership and staff on April 28, 2026, via High reliability Organization Tier 1 and Tier 2 huddles, and clinical practice has been modified to reflect these changes. The VA Boston Healthcare System requests closure of this recommendation.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 5

The Chief of Mental Health ensures a minimum of four daily hours of recovery-oriented, interdisciplinary programming on the inpatient mental health units, consistent with Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*, and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: February 2027

Director's Comments

The VA Boston Healthcare System is ensuring that a minimum of four daily hours of recovery-oriented, interdisciplinary programming is conducted on the inpatient mental health units through

the continued implementation of National Office of Mental Health SOP 1160.06.3 Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements Under VHA Directive 1160.06, as well as local Medical Center Policy, Acute Psychiatric Inpatient Recovery-Oriented Care, MCP-116A-002_MH. In addition, the VA Boston Healthcare System will optimize staffing and operational efficiency by consolidating four inpatient mental units into three by July 13, 2026, creating efficiencies for cross coverage.

The Inpatient Psychology Program Manager, the Inpatient Mental Health Director, and the Local Recovery Coordinator will perform monthly compliance reviews. Monthly compliance data will be tracked for a minimum of six months, after which closure will be requested based on demonstrated and sustained performance of maintaining 90% of a minimum of four daily hours of recovery-oriented, interdisciplinary programming offered to inpatient mental health.

The Inpatient Mental Health Director will report monthly audit findings to the Mental Health Executive Council. The Mental Health Executive Council will report aggregate findings to the Executive Governing Board on a monthly basis. This reporting cycle will continue until the recommendation is closed.

Recommendation 6

The Healthcare System Director develops and implements written processes to ensure compliance with involuntary commitment requirements, in accordance with Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*.

__X_ Concur

_____Nonconcur

Target date for completion: January 2027

Director's Comments

Mental Health Service has updated the "MCP-116A-021-MH, Conditional Voluntary Admission and Commitment of Mentally Ill Patients" to include requirements and processes for the documentation and tracking of patients' involuntary commitment. To ensure compliance with the June 1, 2026 11CS Memo For Action: Implementation of a National Standardized Legal Status Orderable Item for Veterans Treated on Inpatient Mental Health Units (VIEWS 14804498) the legal status order set with implemented starting July 1, 2026. All providers will be educated on utilizing the order set by July 31, 2026 with full implementation by August 1, 2026 in which all inpatient MH Veterans will have a legal status order in place in the medical record.

In addition to the legal status order, the Psychiatrists of the Day (POD) and the inpatient primary psychiatry clinicians will document the legal status for every Veteran admitted to inpatient mental health within the provider note. Each involuntary patient will be reviewed at least daily, or as regularly as clinically indicated, by the primary psychiatry clinician and the patient's

treatment team for appropriateness of continued inpatient stay or readiness for discharge. In addition, patient legal status is captured in a local tracker. Each Psychiatrist of the Day (POD) and the inpatient primary psychiatry clinician who admits or cares for patients on involuntary status will be responsible for entering and updating data in the local tracker. The local tracker will be used to communicate with the interdisciplinary team in daily huddles and aggregate data will be reported at the daily tier 3 huddle.

Monthly compliance data will be tracked for a minimum of six months, after which closure will be requested based on demonstrated and sustained performance of a minimum of 90% of patients having their legal status documented in the electronic medical record and the local tracker.

The Inpatient Mental Health Director will report monthly audit findings to the Mental Health Executive Council. The Mental Health Executive Council will report aggregate findings to the Executive Governing Board on a monthly basis. This reporting cycle will continue until the recommendation is closed.

Recommendation 7

The Chief of Staff ensures compliance with Veterans Health Administration Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, requirements related to documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications prior to administration and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: December 2026

Director's Comments

On June 3, 2026, the note template, "MH Psychiatry, Inpatient Note" was changed to require completion of a field titled "Patient Education/Informed consent documentation regarding new or change in medication".

The Inpatient Mental Health Director is responsible for gathering and monitoring compliance data on a monthly basis. Monthly compliance data will be tracked for a minimum of six months, after which closure will be requested based on demonstrated and sustained performance of a minimum of 90% of audited records reflecting completed documentation of the "Patient Education/Informed consent documentation regarding new or change in medication" field.

The Inpatient Mental Health Director will report monthly audit findings to the Mental Health Executive Council. The Mental Health Executive Council will report aggregate findings to the Executive Governing Board on a monthly basis. This reporting cycle will continue until the recommendation is closed.

Recommendation 8

The Chief of Staff ensures veterans' discharge instructions include the appointment location in easy-to-understand language, consistent with Veterans Health Administration's "Clinic Profile Management Business Rules."

__X_ Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

The VA Boston Healthcare System has changed the template of clinic names to "patient friendly" naming conventions for the discharge instructions within the Mental Health Inpatient field. Upon review of process for this finding, it was discovered that the field the template pulled in was aligned with the incorrect element in the clinic set up. This was fixed in the template and it will always pull in from the patient friendly name field. The unit floor nurses and discharge planning nurses will continue to review all language on the discharge template for understandability as part of their discharge instruction education practice. If further clarification of clinic name is required upon discharge discussion with the Veteran, this will be addressed with a provider correction prior to discharge. The VA Boston Healthcare System requests closure of this recommendation.

OIG Comments

After the facility reported not having sufficient evidence to demonstrate sustained improvement, the OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 9

In accordance with Veterans Health Administration Directive 1345, *Medication Reconciliation*, and *Veterans Health Administration Health Information Management's Health Record Documentation Program Guide Version 1.3*, the Chief of Staff ensures discharge instructions include the purpose and dosing information for each listed medication in easy-to-understand language and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: December 2026

Director's Comments

The pharmacy package in the Computerized Patient Record System (CPRS) was updated in 2023 to require an indication for each medication in both the discharge summary and the discharge instructions provided to the patient. The CPRS note template requires this information to be entered before a provider can proceed with medication orders. Additionally, when dosing information is entered, the system automatically generates a lay language summary of medication instructions for inclusion in the patient's discharge instructions. The facility recognizes that despite these system-level controls, non-lay or clinically technical language may still appear in discharge medication instructions through provider documentation.

To address this risk, Mental Health Service will implement targeted provider education for all inpatient psychiatry clinicians and relevant nursing staff. In addition, floor nurses and discharge planning nurses will confirm that discharge instructions contain medication indications and dosing information written in plain language and will notify Mental Health inpatient provider to resolve any identified issues.

The Inpatient Mental Health Director is responsible for gathering and monitoring compliance data on a monthly basis. Monthly compliance data will be tracked for a minimum of six months, after which closure will be requested based on demonstrated and sustained performance of a minimum of 90% of audited records including discharge instructions with the purpose and dosing information for each listed medication in easy-to-understand language.

The Inpatient Mental Health Director will report monthly audit findings to the Mental Health Executive Council. The Mental Health Executive Council will report aggregate findings to the Executive Governing Board on a monthly basis. This reporting cycle will continue until the recommendation is closed.

Recommendation 10

The Chief of Staff directs staff to complete the Columbia-Suicide Severity Rating Scale within 24 hours before veterans' discharge, consistent with *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy Minimum Requirements by Setting*, and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: May 2026

Director's Comments

The Columbia Suicide Severity Rating Scale (C-SSRS) has been made a mandatory field in the reminder dialogue template for mental health discharge notes. Since December 2025, The VA Boston Healthcare System has exceeded the national average for C-SSRS (96.1% vs 91.3%) and

CSRE [Comprehensive Suicide Risk Evaluation] (100% vs 97.8%) completion within 24 hours of discharge from inpatient mental health care. Quality Management will continue to monitor CSSRS and CSRE compliance rates via the Comprehensive Risk ID Dashboard.

Month	% Adherent to Screening (C-SSRS)	% Timely CSRE
December 2025	96.52%	100%
January 2026	97.03%	100%
February 2026	96.88%	100%
March 2026	99.11%	100%
April 2026	98.10%	100%
May 2026	93.5%	100%

Source: Comprehensive Risk ID Dashboard

OIG Comments

The OIG considers this recommendation closed.

Recommendation 11

The Chief of Staff directs staff to complete or review veterans' suicide prevention safety plans prior to discharge from the inpatient mental health units, in accordance with Veterans Health Administration Office of Mental Health and Suicide Prevention Standard Operating Procedure 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA [Veterans Health Administration] Directive 1160.06," and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: October 2026

Director's Comments

Currently no patients are discharged without safety planning unless the patient declines. Existing training in suicide safety planning includes education for providers in documentation if a Veteran declines to have a safety plan or when an existing safety plan is reviewed. The safety plan is updated prior to discharge if it is completed earlier in the hospitalization. When a patient declines, staff document a declination.

Inpatient MH safety plan compliance for VABHS [VA Boston Healthcare System] is measured and monitored using quarterly and monthly metrics both demonstrating improvements to date. The MHIS [Mental Health Information System] dashboard includes the sp_inpt1 metric integrated in FY25 Q3 providing quarterly oversight. This metric captures the number of MH acute inpatient discharges with timely offer of a suicide prevention safety plan during the MH

acute inpatient stay. In FY25 Q4 sp_inpt1 was at 37.96% and with current focus and efforts showed improvement in FY26 Q2 at 68.14%.

In addition to the quarterly metric, VABHS Mental Health (MH) service established a daily monitoring process to track Suicide Prevention Safety Plan compliance for all inpatient psychiatry admissions. Each weekday assigned leads review the prior day's admissions and add them to a tracking log. Each patient is assigned to a specific staff member to ensure individual staff accountability for safety plan completion prior to discharge. The tracking log is updated daily. As discharges occur, assigned leads verify whether a safety plan was completed or whether the patient formally declined, either of which meet requirements. Monthly compliance is calculated as the number of hospital admissions with a completed or patient-declined safety plan during the inpatient stay. This data is utilized as a current list of all admissions in comparison to safety plan status. Monthly data is captured to monitor the improvements made, as the metric for sp_inpt1 is a rolling 12 months and not reflective of monthly changes. The Inpatient Psychology Program Manager tracks and monitors compliance with completion of all Safety Plans for the service. They also collaborate with the Social Work Supervisor as needed.

Since the monitoring process was implemented, MH has demonstrated consistent monthly compliance above the 90% threshold. From October 2025 through May 2026, monthly compliance ranged from 91.4% to 99%, with an overall rate of 97% across 866 eligible admissions. The Inpatient Mental Health Director will report monthly audit findings to the Mental Health Executive Council. The Mental Health Executive Council will report aggregate findings to the Executive Governing Board on a monthly basis. This reporting cycle will continue until the recommendation is closed.

Recommendation 12

The Healthcare System Director directs staff to complete required suicide prevention training, according to the “Office of Suicide Prevention Suicide Prevention Mandatory Training Dashboard FAQ [Frequently Asked Questions],” and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: June 2026

Director’s Comments

The facility has implemented a process to ensure hospital wide compliance with suicide prevention training meets or exceeds the compliance target rate of 95%. An automated email from executive leadership is sent to staff and supervisors as a reminder ten days prior to the due date. Suicide training compliance has significantly improved. At the beginning of the fiscal year, STEMS training hospital-wide compliance was 54%. Now, twelve-month STEMS training

hospital-wide compliance exceeds 95% and mental health inpatient clinical staff are at 100% compliance. At the beginning of the fiscal year, the hospital-wide initial SAVE training compliance rate was 93% and refresher was 76%. Now, that rate exceeds 95%, and non-clinical mental health inpatient unit staff S.A.V.E. training compliance for initial and refresher training is 99%. Training compliance is monitored by Education and Learning Resources and the Suicide Prevention Program Manager. If staff are found to not be compliant, the issue is escalated through their manager, then to service line chief, Quad leaders, and the Director.

Recommendation 13

The Healthcare System Director instructs the Interdisciplinary Safety Inspection Team to adhere to Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, requirements related to attendance at inspections and record of attendance in meeting minutes, and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

The Mental Health Environment of Care (MHEOC) sign-in attendance process was enhanced to track roles required to participate as outlined in VHA Directive 1167 and Interdisciplinary Safety Inspection Team (ISIT) members sign by their designated role. This allows for more readily tracked assessment of compliance for required attendees. In the absence of a required attendee, a designee participates and is noted in the record of attendance. The ISIT lead reviews the attendance sheet for attendee compliance, and any deficiency in attendance is reported at Environment of Care Committee and Mental Health Executive Council, ultimately up to the Governing Board. Action plan(s) are developed as appropriate and tracked to completion. All required core team members (see below) must be present to conduct MHEOCC rounds; the compliant rate of attendance is 100%. In the event that a required team member and their designated alternate are unexpectedly unavailable, rounds will proceed as scheduled. The ISIT Team Lead (PSM) will subsequently coordinate an *ad hoc* MHEOCC session to ensure all members complete rounds prior to the established due date.

Per the requirements outlined in VHA Directive 1167, the Facility Interdisciplinary Safety Inspection Team (ISIT) is comprised of the following core team members.

(1) VA medical facility PSM

(2) VA medical facility Inpatient Mental Health nurse manager.

(3) VA medical facility Inpatient Mental Health program director.

(4) VA medical facility Engineering/Facilities Management representative.

(5) VA medical facility Suicide Prevention Coordinator.

(6) One additional clinical staff from any discipline or work area (e.g., ED [emergency department] or UC [urgent care], Inpatient Medicine, Inpatient Mental Health, Outpatient Mental Health). Review of two consecutive MHEOCC Rounds, January and July 2026, attendance showed that all required members have attended and their training was up to date reflecting 100% compliance. The VA Boston Healthcare System requests this recommendation be closed.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 14

The Healthcare System Director implements processes to ensure Interdisciplinary Safety Inspection Team staff accurately identify and document safety hazards, in accordance with Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*.

__X_ Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

The Interdisciplinary Safety Inspection Team staff at VA Boston has and will continue to accurately report compliance or non-compliance with MHEOC standards as they are written. Page 28 of this report states that toilets in the inpatient mental health units are not flush mounted to the floor and additionally have removable seats. The Interdisciplinary Safety Inspection Team staff followed MHEOC standard 13.00-19.00-9.00, which states: "For new units, toilets are floor-mounted with no exposed piping that could serve as an anchor point for hanging, and free of removable toilet seat covers (only new units)." Our units are not new and were built prior to 2012. Standard 13.00-19.00-9.00 further states, "For existing units, are all pipes and plumbing that could be used as an anchor point enclosed, and do toilet partitions have no cross-connections that could be used for hanging?" Our units are existing, and therefore, the portion pertaining to new mental health units does not apply. Additionally, in 2019, The VA Boston Healthcare System consulted with the National Center for Patient Safety (NCPS) regarding removable toilet seats. The response received from NCPS indicated our toilet seats posed minimal risk. NCPS referenced a 2018 article from the Joint Commission entitled Special Report: Suicide Prevention in Health Care Settings (2018)." For these reasons, our interpretation is that our units are compliant with MHEOC standard 13.00-19.00-9.00 as written in the July 2025 update. In an

abundance of precaution, The VA Boston Healthcare System has planned upgrades to our toilets and plumbing to further mitigate risk.

Page 28 of this report references exposed plumbing, sink faucets and handles that are not tapered or rounded, and cabinet door handles that are not sloped, recessed or concealed. These findings are limited to our patient dining rooms. MHEOC standard 13.00-30.00-38.02 states, "Are doors that contain suicide hazards such as chemicals or anchor points self-locking and self-closing? If a suicide hazard is not under continuous observation by staff, it must be in a room that has a self-locking and self-closing door." The doors to our dining rooms are both self-closing and self-locking, and veterans are not permitted in the dining rooms unless they are observed by staff. Based on the above-mentioned standard, our units are compliant. However, on the recommendation of the OIG inspectors, we submitted an appeal (LEAF Request # 3736) to the Mental Health Review Board for our exposed plumbing, sink faucets and handles, and cabinet door handles in the patient dining room. After reviewing our appeal, the Mental Health Review Board deemed our request unnecessary, stating that the doors in our dining areas meet MHEOC standard 13.00-30.00-38.02 because: "these rooms have self-closing/self-locking doors and when used, staff are always present. Thus, this appeal is not necessary."

As a standard of practice, the latest MHEOC standards are shared with staff prior to rounds and any changes, updates and removed standards are evaluated by the ISIT. During rounds, standards are reviewed by the team for compliance, and any deviations are discussed at each round's conclusion. The concerns raised are documented by the Interdisciplinary Safety Inspection Team lead. The findings are entered into and tracked via Patient Safety Assessment Tool by the Patient Safety Manager and reported to the Environment of Care Committee and Mental Health Executive Council to completion. Immediate safety issues have an interim risk mitigation measure put in place while the long-term plan timeline is established. An appropriate appeal is submitted to the MHEOCC Review Board as applicable. The VA Boston Healthcare System requests this recommendation be closed.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 15

The Healthcare System Director directs inpatient staff and Interdisciplinary Safety Inspection Team members to complete Mental Health Environment of Care Checklist training requirements, consistent with Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

The Patient Safety team was given TMS administrator access, which allows them to generate and evaluate compliance reports biannually and to ensure that mental health staff and non-mental health staff who perform work on inpatient mental health units complete Mental Health Environment of Care Checklist (MHEOCC) training requirements. In accordance with the MHEOCC TMS Training Verification standardized work process (see document attached below), the Patient Safety Manager generates compliance reports from TMS to ensure that staff participating in MHEOC rounds and all members of the Interdisciplinary Safety Inspection Team are compliant with Mental Health Environment of Care Checklist training requirements prior to the bi-annual MHEOCC survey.

If staff have not completed required training, their supervisor will be notified for follow-up and appropriate action. The VA Boston Healthcare System reports this monthly compliance to our VISN leaders via our monthly manager meeting as a standing reporting item.

Training is up to date for all applicable staff. The VA Boston Healthcare System requests this recommendation be closed.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 16

The Healthcare System Director ensures that Mental Health Environment of Care Checklist training completion is documented in attestations, in accordance with Veterans Health Administration Office of Mental Health Standard Operating Procedure 1167.2, "Standard Operating Procedure for Submission of MHEOCC [Mental Health Environment of Care Checklist] Attestations Under VHA Directive 1167," and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

The VA Boston Healthcare System follows the guidance from SOP 1167.2 Standard Operating Procedure for Submission of MHEOCC attestations as outlined in VHA Directive 1167. Facility Director attestations are submitted via the MH EoCC LEAF Portal. Attestation 3 states: "All applicable facility staff, including non-clinical VA staff, contractors who have completed work on inpatient mental health units, and ED providers have completed required MHEOCC training."

The Patient Safety Team was given TMS administrator access and, in accordance with the MHEOCC TMS Training Verification standardized work process, generates compliance reports bi-annually from TMS to ensure all applicable staff have completed MHEOC training. The most recent attestation, request #4029, dated February 9, 2026, reflects that all applicable facility staff have completed required MHEOC training.

The VA Boston Healthcare System reports this monthly compliance to VISN leaders as a standing reporting item in the monthly manager meeting. The VA Boston Healthcare System requests this recommendation be closed.

OIG Comments

The OIG considers this recommendation closed.

OIG Contact and Staff Acknowledgments

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