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PATIENT SAFETY NETWORK

A checklist to identify inpatient suicide hazards in Veterans Affairs hospitals.

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Mills PD, Watts V, Miller S, et al. A checklist to identify inpatient suicide hazards in veterans affairs hospitals. Jt Comm J Qual Patient Saf. 2010;36(2):87-93.
https://psnet.ahrq.gov/issue/checklist-identify-inpatient-suicide-hazards-veterans-affairs-hospitals

Suicide in a hospitalized patient is considered a never event. The majority of inpatient suicide attempts occur in patients hospitalized on psychiatric units, and a prior study conducted in Veterans Affairs hospitals used root cause analysis to identify predisposing factors for suicide attempts. Based on those findings, in this study, the authors report on the development of a checklist to identify and minimize suicide hazards in mental health facilities. The checklist primarily focused on eliminating environmental hazards, such as anchor points for hanging attempts and materials that could be used as weapons. After implementation of the checklist, over three-quarters of potential hazards were removed. A case of a suicide attempt on a medical unit is discussed in an AHRQ WebM&M commentary.