PSNet
PATIENT SAFETY NETWORK

Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died.

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Incomplete assessment of patient needs can miss opportunities to prevent patient harm. This report analyzes an incident where an intoxicated patient called a dedicated crisis support line yet preventive measures weren't activated to avert an accidental overdose resulting in patient death. Recommendations for improvement include enhanced training for weekend and holiday staff, standardized safety plan development, and systemized internal review processes.