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PATIENT SAFETY NETWORK

Analysis of suicides reported as adverse events in psychiatry resulted in nine quality improvement initiatives.

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Mackenhauer J, Winsløv J-H, Holmskov J, et al. Analysis of suicides reported as adverse events in psychiatry resulted in nine quality improvement initiatives. Crisis. 2021;43(4):307-314. doi:10.1027/0227-5910/a000787.
https://psnet.ahrq.gov/issue/analysis-suicides-reported-adverse-events-psychiatry-resulted-nine-quality-improvement

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Prior research has found that patients who die by suicide often had recent contact with the healthcare setting. Based on a multi-year chart review at one institution, the authors concluded that suicide risk assessment and documentation in the heath record to be insufficient. The authors outline quality improvement recommendations focused on improving documentation, suicide assessment and intervention training, and improving communications with families, caregivers, and other health care providers.