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PATIENT SAFETY NETWORK

Comprehensive Healthcare Inspection Summary Report: Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2020.

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https://psnet.ahrq.gov/issue/comprehensive-healthcare-inspection-summary-report-evaluation-mental-health-veterans-health

Patient suicide is a reoccurring sentinel event that is a challenge for the veteran's health care community. This report shares the results of 36 unplanned inspections at United States Veterans Affairs facilities. While the inspections found general guidance compliance to be in place, weaknesses in required patient follow-up, staff training and outreach activities were flagged as areas in need of targeted improvement to enhance patient safety.