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Deficiencies in Emergency Department Care for a Patient Who Died by Suicide at the John Cochran Division of the VA St. Louis Health Care System in Missouri.

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https://psnet.ahrq.gov/issue/deficiencies-emergency-department-care-patient-who-died-suicide-john-cochran-division-va-st

This report analyzed a patient suicide at an emergency department and determined factors in the delay of care that contributed to patient harm. This report shares recommendations to address leadership failures and other deficiencies including poor screening and patient monitoring. Post-event gaps identified include poor root cause analysis, disclosure, and reporting activities.