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Aftermath of Suicide in the Hospital: Institutional Response

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Abstract

Background—A suicide can be a devastating event in the hospital, and few guidelines exist to aid an institution's response

Method—The authors describe a framework of immediate, short-term and long-term responses in the event of an in-hospital suicide.

Conclusion—Implications for administration, communication, assessment, physical environment, and standards of care throughout the hospital are discussed that are relevant to both general-medical and psychiatric settings. Suggestions for the successful management of the aftermath of a suicide, such as the formation of a multidisciplinary leadership team, are included.

Hospitals are meant to be safe places. A completed suicide in a hospital is an affront to a shared expectation of safety, and it presents unique challenges to patients, clinicians, administrators, and visitors. Since 1995, more than 600 in-hospital suicides have been reported to the Joint Commission.¹ Most of the published literature on the aftermath of suicide in the hospital focuses on the emotional reactions of the survivors, such as family, friends, and healthcare providers.^{2–7} In contrast, little has been written regarding the institutional response to in-hospital suicide. This review provides a framework for clinical and administrative responses in the aftermath of an in-hospital suicide, and we identify immediate actions, short-term tasks, and long-term goals to address the sequelae of such an event, the subsequent provision of care, and the assurance of a safe hospital environment.

This guide is intended for clinicians and administrators responding to an in-hospital suicide; these include consultation–liaison psychiatrists, the attending clinicians on in-patient units, and both clinical and nonclinical hospital administrators. Although the epidemiology of in-hospital suicide is not well-characterized, a substantial minority of in-hospital suicides occur in general-medical or surgical settings.^{8,9} (Joint Commission, personal communication). A suicide on a medical or surgical ward, as opposed to a psychiatric unit, may lead to different clinical and administrative responses and potential legal ramifications. Moreover, the Joint Commission has different standards for psychiatric and medical settings with respect to suicide assessment, ward safety, and other clinical-care procedures. To some extent, these differences in patient safety protocols between the two settings are appropriate because of disparate patient diagnoses and characteristics and the disproportionate frequency with which the risk of suicide emerges as a clinical concern. However, despite these important

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clinical distinctions, the institutional response to an in-hospital suicide demands a coherent and comprehensive approach that is relevant to any hospital setting.

Therefore, the following discussion highlights critical components of institutional responses in the aftermath of an in-hospital suicide that are relevant to both psychiatric and medical settings. Contextual factors, such as the emotional reactions of patients, visitors, and staff to the event, will also influence the institutional response. Accordingly, a highly public and violent suicide will elicit a different institutional reaction than the discovery of a terminally ill patient found dead in a hospital bed after a suspected overdose. The history and institutional culture of the hospital will also determine the emotional and administrative reactions to the suicide. For example, was the suicide an unprecedented event in a hospital with a superb safety record, or was this one of several, recent sentinel events? Also, the method, timing, foreseeability (and perceived preventability), and location of the suicide, as well as the patient's characteristics (e.g., age and diagnosis), will shape the reactions of institutional officials, clinicians, and the community. The critical institutional responses to an in-hospital suicide can be divided into immediate, short-term, and long-term actions (see Table 1).

IMMEDIATE ACTIONS

Immediate Administrative Responses and Communications

An immediate (within the first few to 24 hours) and coordinated response after an in-hospital suicide is crucial, both for safety considerations and crisis-management. Key stakeholders should be identified as soon as possible, with the understanding that the senior hospital administrators, departmental (especially psychiatry) leaders, hospital staff, patients, police, hospital lawyer, and patient's family all play an important role in the aftermath. Rapidly designating a team leader is critical, because this crisis demands immediate leadership, guidance, and structure. The leader (e.g., Department Chair, senior hospital administrator, or CEO) should be someone who is well-respected within the organization and whose stature underscores the gravity of the circumstances. Also, the leader should have the skills necessary to respond appropriately and effectively in clinical, administrative, and political tasks, given the potential for conflicting and competing agendas in all phases of the response to the event.

In general, the leader's immediate tasks include the coordination of communication, clinical assessment, and safety concerns surrounding the suicide. Specifically, the first task of the team leader is to assemble a working group with clinical and administrative representation from both the particular unit in which the suicide occurred and from the hospital at large. In a general-medical setting, this working group will likely include a consultation-liaison psychiatrist. This group will manage and coordinate the organization's response to the suicide and formulate a preliminary account of the circumstances surrounding the event. Ideally, the organization will have anticipated the possibility of such an event and developed an "emergency response" checklist to guide assignment of tasks (see Table 2), similar to the hospital incident command structure used during disaster responses.

The overall plan of action should encompass several domains, including patient safety enhancements, staff responses, communication (within and outside the hospital), assessment of the environment of care, and legal considerations. A master grid outlining the action-plan items for each domain may be useful for a first meeting of this working group. The primary purpose of this early meeting is not to process emotional reactions (which also require timely and sensitive attention), but rather to assign specific, concrete tasks. The authors recognize that, from the earliest moments after an in-hospital suicide, attention to the profound emotional reactions of hospital staff and patients is critical to a compassionate

organizational response. Another immediate action for the team leader is the notification of appropriate individuals. First, a clinician needs to be designated to contact the family. Ideally, this individual would have had a meaningful relationship with the patient and the family and would also possess the clinical expertise to communicate catastrophic news. This notification will be the beginning of a series of conversations with the family, so it is important to begin with as much clarity and empathy as possible.

Second, a skilled clinician needs to provide a simple, accurate description of the event to the other patients on the unit, particularly if the unit patients had significant previous contact with the deceased patient. This description may vary according to unit (particularly long-term versus short stays) and requires sensitivity with respect to the privacy of the patient and the patient's family. This notification is both an expression of respect for the patients and a preemptive measure against rumors and gossip that may ensue in the absence of timely and accurate details. Hospital administrators (including the head of the hospital, chief medical officer, head of nursing, chief safety officer, nurse-manager, head of the department, risk-manager, and public relations coordinator) and legal counsel should also be notified immediately. If the patient was enrolled in a research protocol, this sentinel event will need to be reported to other oversight entities such as the Institutional Review Board, Food and Drug Administration, and Office for Human Research Protections, in accordance with regulatory requirements. A final clinical note should be entered into the patient's medical chart, detailing the events leading up to and including the suicide. This entry should be objective, detailed, and complete, because this chart will likely be sequestered by hospital administrators and legal counsel in anticipation of further investigation or possible litigation. Also, an incident report (also referred to as an adverse-event report or occurrence report in some institutions) should be filed in accordance with hospital policy.

Depending on the nature of the suicide and hospital environment, the leadership may determine that media notification is appropriate. When a suicide becomes public, contagion (i.e., subsequent clustering of suicides) is a concern.^{10,11} Consequently, many media outlets have policies against publishing information about suicides.¹² In some cases, the media will already have been notified through other channels; therefore, the leadership should draft an institutional statement to dispel rumors and to identify resources for counseling and treatment for hospital staff and visitors. Several individuals from the hospital leadership, including a mental-health clinician, legal counsel, and the hospital CEO or designee, should be involved in drafting such a statement. Staff members should be instructed to refrain from public discussions of the suicide in order to respect the privacy of the patient and patient's family, to control contagion effects, and to minimize potential litigation concerns.

Immediate Clinical Assessment and Management

Clinical staff should identify individuals in need of immediate psychological attention, with the understanding that these needs and required resources may vary by patient-care setting. Vulnerable individuals may include patient-, visitor-, or staff-witnesses to the event, patients previously known to be at risk for suicide, patients close to the individual who committed suicide, and staff who cared for the patient.

Consultation-liaison psychiatrists or inpatient mental health clinicians are best positioned to collaborate with the departments of social work and nursing and the employee-assistance program to create and staff emergency counseling services for these vulnerable individuals. Witnesses and individuals affected by the event, regardless of patient status, can be offered immediate brief counseling and referred to other hospital- or community-based resources for follow-up. Helpful guides to counseling emotional reactions after a suicide

have been published,⁷ and these may be distributed to the staff participating in the immediate clinical assessment.

Another decision of the lead administrator concerns the controversial practice of debriefing. Debriefing was originally designed to provide a structured environment for first-responders to a disaster or other emergency event, in which to share their thoughts, experiences, and emotions elicited by the event. The goal of debriefing is to reduce stress and prevent later psychiatric sequelae such as acute stress disorder or posttraumatic stress disorder (PTSD).^{13,14} A contrasting literature argues that psychological debriefing does not prevent PTSD or distress and may, instead, be associated with worsening symptoms when used as a therapeutic intervention.^{15–17} Since the literature does not provide a consensus recommendation about the benefits or timing of debriefing for patients, staff, or visitors, each hospital organization will have to determine its stance regarding the merits of this intervention, which may depend on the contextual circumstances of the suicide. If debriefing is to be used by a hospital as a standard practice, the institution should clearly delineate a debriefing process and designate members of a debriefing team charged with the responsibility for addressing adverse hospital events. Regardless of the presence of an actual debriefing team or program, staff qualified to handle mental health concerns should be on-hand to allow hospital staff and patients to discuss the event, as clinically indicated.

Immediate Changes to the Environment of Care

In the immediate response, the staff need to decide whether interim changes to ward rules are warranted. For example, restriction of patients to the unit until further notice is neither indicated nor possible in most medical settings but often occurs in psychiatric settings. Rooms of individuals determined to be at higher suicide risk can be inspected, when possible, for access to means of suicide, such as unsecured windows, sharp objects, or non-break-away bars. A conservative, but calm approach in the immediate aftermath of a suicide may reassure patients: restricting psychiatric patients to their units while providing counseling may foster an atmosphere that defuses the crisis.

By this stage of the immediate response, the police or appropriate law enforcement officers will have been notified. If it is not possible to rule out other causes of death, such as natural causes or an accident, the site of the apparent suicide will be designated a potential crime scene by the police. The requirement of considering the site a potential crime scene can have the unintended effect of prolonging the distress of patients and staff because of delays in restoring the area and the continued presence of law enforcement and the medical examiner who have overlapping, but different priorities from hospital staff. A clinician who worked with the patient can provide a detailed description of the patient's clinical course to the medical examiner and the police to facilitate determination of the cause of death.

SHORT-TERM TASKS

Short-Term Communication and Administrative Decisions

Throughout the weeks after the suicide, contact should be maintained with the patient's family in order to address their concerns. As family members recover from their initial reactions, they will likely have more questions and may express anger that the staff did not initially observe. Depending on the circumstances, distinctions between a medical error and the tragic consequence of an illness (i.e., suicide) can be discussed at this time. If the suicide may have been due, in part, to an error or staff negligence, full disclosure and an apology are imperative;^{18–19} however, such information must be delivered with sensitivity to both the family and involved staff and after discussion with hospital legal counsel. At this point in the grief process, family members still will likely be formulating their "suicide narratives," or personal reconstructions of how and why the suicide occurred.^{20–22} Hospital staff should

recognize that these narratives often undergo revision and may differ in important ways from their own understanding of the suicide. The patient's family may appreciate the presence of clinicians (and administrators) at the funeral,^{23,24} depending on the specific circumstances of the suicide. Staff may decide that they would like to organize a memorial service in the hospital in remembrance of the patient. Again, involving the patient's family in the planning of such an event is respectful. Another issue that will arise in interactions with the family is whether the hospital will reimburse travel costs and funeral arrangements. This delicate issue should be discussed with the hospital administration and/or hospital legal counsel. Ideally, an existing hospital policy characterizing institutional commitments for travel and funeral cost reimbursement in the event of an unexpected death would avoid both the potential for inconsistent practice as well as an awkward discussion at an emotional time.

Hospital leadership will need to decide whether and how to communicate the event to the entire hospital. In doing so, special care and sensitivity about privacy issues are necessary out of respect for the patient and the patient's family. For example, the use of the patient's name, diagnosis, or details of the suicide should be carefully considered with respect to any public communication. A hospital-wide e-mail may be appropriate in certain institutions. For a highly public suicide, one or more "town meetings," led by senior hospital leaders, and to which all hospital staff are invited, can foster a sense of community and give voice to shared experiences of hospital personnel. Moreover, it may help staff to discuss systems issues and possibly serve as an educational session concerning suicide and mental illness. Identifying suicide risk and strategies to prevent suicide may be an excellent topic for a hospital "Grand Rounds" presentation.

Continued Clinical Assessment and Management

Clinical staff should remain vigilant about the possibility of psychiatric destabilization among other patients on the unit through careful reassessment and monitoring for suicidal ideation and behaviors. The leader should anticipate that patients may exhibit anger and blame toward staff, underscoring the importance of both clarity and empathy in the initial notification process. The consultation-liaison psychiatrist is likely to play a critical role in maintaining a constant presence of mental health professionals throughout the hospital. In addition to the patients, staff can be counseled through both formal sessions and informal conversations while concurrently being observed for evidence of distress. Staff reactions will differ, depending on experience with mental illness and suicide. The difficulty of predicting suicide as well as the rarity of the event further complicates the emotional reactions of staff.

Root-Cause Analysis (RCA) and The Joint Commission

An inpatient suicide is considered a "reviewable sentinel event" by the Joint Commission. Whereas sentinel events are not required to be reported to the Joint Commission, the public reporting of hospital-based suicides to the Joint Commission's Sentinel Event database is desirable, both as a way to foster open discussion of the event without fear of being "found out" and as a way to benefit from the Joint Commission's expertise on the management of in-hospital suicide.²⁵ Regardless of whether an institution decides to report the suicide to the Joint Commission, the organization is required to conduct a "thorough and credible" Root-Cause Analysis (RCA) within 45 days of the event.²⁵ Conducting an RCA requires special training, and details may be found at the Joint Commission website. ²⁵ An RCA, similar to a critical-incident review or psychological autopsy, is a tool for systematically identifying the possible causes or underlying factors that led to the sentinel event. The RCA method guides the organization in assessing the institutional processes that may have contributed to the risk for a suicide, rather than attempting to lay blame or to identify an individual as "responsible" for the event. Based on the results of the RCA, an action plan

(including concise recommendations for improvements and measurable outcomes) is developed to guide the organization in addressing identified risk-points and, ultimately, to obviate the occurrence of a similar sentinel event.

The authors would, nevertheless, underscore the fact that, although the RCA process has been widely embraced by hospitals, to-date there have been no studies evaluating the RCA for effectiveness and utility.²⁶ Nonetheless, some kind of post-event review process is needed in order to identify potential areas of improvement in the hospital's systems and processes. This review should involve both the clinical team involved in caring for the patient at the time of the suicide and the hospital leadership. The establishment of a multidisciplinary leadership team in the aftermath of an inpatient suicide is of paramount importance. This team, which should include representation from the hospital administration, clinical divisions, and hospital patient safety and quality officers, will not only aid in managing the aftermath of the suicide, but will create a mechanism for further enhancing existing processes (e.g., Performance Improvement Committee, Patient Safety Committee) for effectively reviewing other adverse events that may arise in the future. This team also assists stakeholders in avoiding scapegoating of either caregivers or administrators; ideally, it will provide a constructive forum for frank discussion of identified problems and potential interventions.

LONG-TERM GOALS

Administrative Management

Beyond the first 2 weeks after an in-hospital suicide, administrators and clinicians must work closely together in a sustained fashion to accomplish the goals articulated in the Action Plan developed from the RCA. The authors strongly suggest charging a taskforce with responsibility for data monitoring and analysis to inform quality-improvement projects. Data collection required for responses to the Joint Commission and other regulatory agencies will provide the hospital with an opportunity to identify additional ways to improve patient safety. Long-term goals may include more comprehensive mental health clinical training for all hospital staff, as well as additional in-depth training in the assessment of danger and suicide risk. Hospital policy may be revised to improve the ongoing monitoring and documentation of the assessment of mental health and suicide risk in patients, particularly in light of legal or policy considerations that may arise in the aftermath of a suicide and current Joint Commission patient-safety goals.²⁷ Future design and construction modifications to the hospital's environment of care may need to be considered, if they are identified as potentially contributory factors in the RCA.

When implementing changes to existing policy and clinical practice, the leadership team must be conscious of the current hospital culture. An adverse event can magnify preexisting organizational "fault-lines," particularly, the divisive feelings of "us" (clinicians) versus "them" (administrators). Polarization will not aid in the prevention of future adverse events; indeed, such animosity may only impede communication and trust, making adverse events more likely. After a suicide, the acknowledgment that institutional needs may not dovetail with the unit's needs is essential in negotiating the aftermath, highlighting the importance of the multidisciplinary leadership team in the immediate management of the event. The implicit assignment of blame can be palpable and destructive when it persists well beyond the immediate aftermath of a suicide. Both clinicians and administrators should be aware that resentment can resurface for some time, in the face of other, seemingly unrelated events in the ongoing work of caring for patients.

Implementing New Clinical Assessments and Procedures

A common danger in the aftermath of a catastrophic event such as suicide is an overreaction to the event, resulting in the implementation of excessive clinical and administrative requirements. For example, requiring repeated suicide assessments of all patients may lead to desensitization on the part of patients and result in a learned automatic patient response to frequent questioning (e.g., “No, I’m not suicidal.”), thereby negating any improvements in screening. A flood of new documentation requirements may further limit staff time with patients and become demoralizing. The ability of patients and staff to communicate freely and openly is essential for sensitive and accurate identification of suicide risk. Furthermore, staff may perceive the requirement for clinical-process changes in the immediate aftermath of a suicide as an assignment of blame. We suggest that interventions be implemented with caution and sensitivity, with the full knowledge and participation of the involved clinical and administrative staff. An additional long-term goal may include working with the family and the involved staff in creating some type of memorial. For example, a memorial service or planting a tree on hospital grounds may be a respectful and thoughtful way to remember the patient. Family and acquaintances of the patient could be invited to the hospital to participate in such an event.

Regulatory Agencies

A sentinel event inevitably triggers a surge of regulatory agency reviews and requirements, including inquiries and visits from the Joint Commission, Department of Public Health, the Centers for Medicare and Medicaid Services, and other agencies. Information from multiple hospital systems may be requested, and staff may feel burdened and express frustration. Whereas these systems promote and ensure patient safety, they can be experienced as excessive and punitive by staff at all levels of the hospital. Although regulatory intervention is necessary in the review process, the burden brought about by the inquiry should be acknowledged.

Legal Concerns

The possibility of litigation is a concern in the aftermath of any suicide, and legal counsel should be involved early and throughout the aftermath response. Liability arises as the result of a breach of the standard of care or treatment that is viewed as resulting in harm to the patient. Whereas safety considerations, rather than the threat of litigation, should dictate the provision of medical care and the formulation of hospital policy, lawsuits related to suicide demonstrate several common themes relevant to the prevention of future inpatient suicides. Two major issues associated with claimed legal liability for suicide, as summarized from case law, are 1) foreseeability; and 2) causation.^{28–30} “Foreseeability” addresses whether a comprehensive and realistic assessment of suicide risk was obtained for the patient. “Causation” relates to whether the suicide could have been prevented if adequate treatment had been ordered by the clinician and/or carried out by others. Unfortunately, what constitutes adequate assessment and treatment of suicidal individuals is difficult to define and even more difficult to prove without supporting written documentation. Generally, whether the institutions and/or practitioners acted reasonably in a particular case depends on the circumstances, the patient’s condition, and whether the level of care or treatment fell below what is expected of a reasonable institution or professional.

Claims of malpractice can be directed at either a psychiatric or medical institution and/or staff after an inpatient suicide, and these claims underscore the importance of comprehensive suicide assessment, ongoing patient-monitoring, and documentation. An additional possibility is that the organizational liability of the hospital may be seen as distinct from the liability of individual practitioners in the event of an inpatient suicide,³¹ with the result that many individuals (and entire organizations) may be named in a lawsuit.

Whereas litigation considerations will depend critically on the details of the individual case, a growing body of evidence suggests that the expression of empathy, as well as clear and honest disclosure and communication in the aftermath of a catastrophic hospital outcome, may decrease the risk of litigation.^{32,33} The most consistent message from legal resources to prevent a lawsuit related to suicide is to assure careful and contemporaneous documentation in the patient's medical record, which includes the following information: diagnostic considerations, thorough suicide assessments conducted with appropriate frequency, and clear rationale for treatment recommendations.²⁸⁻³³ The quality of documentation (i.e., detail, accuracy, clarity, timeliness, legibility) in medical records should be maintained at the highest possible level.

Suggestions for the Future

To minimize the likelihood of future attempted and completed suicides, hospitals should consider integrating certain practices from the psychiatric setting (such as routine staff education about suicide) into the medical setting for high-risk medical inpatients. For example, patients who have received a life-threatening diagnosis and who appear particularly agitated, despondent, or withdrawn, or patients who have severe, intractable pain are likely candidates for suicide screening. Several training and procedural considerations need to be addressed in order to implement suicide screening in the general-medical setting; these include: improving the knowledge-base of staff with respect to suicide screening and assessment; increasing the comfort level of nonpsychiatric staff by familiarizing them with mental health symptomatology; selection of adequate screening tools for use by general-medical staff; and availability of psychiatric consultation services for follow-up of positive screening responses.

We suggest that, whereas suicide screening in general hospital populations would represent a significant change from current practice, this topic should be included in discussions of in-hospital suicide prevention. In fact, the literature supports this suggestion, because it indicates that a substantial fraction of in-hospital suicides involve medical/surgical patients.⁸ Improving the quality of care in the hospital may involve examining models of improvement from outside the healthcare sector. Failure Mode and Effects Analysis (FMEA) is a quality-improvement strategy that has been adapted from industry.^{34,35} The model involves the assessment of potential failures within a system before an actual adverse event occurs. When adapted for the hospital, this process is used to identify critical risks and vulnerabilities associated with provision of care.³⁴ Examples of FMEA used in hospitals around the country can be found at the Institute for Healthcare Improvement website.³⁴ FMEA can be used prospectively as an exercise to identify risk of inpatient suicide by anticipating possible administrative and clinical failures that would allow such an event to occur. This modeling would then suggest specific safeguards against these possible points of failure in the future.

CONCLUSION

Clinical and administrative knowledge gained from the aftermath of an in-hospital suicide should result in a hospital-wide systems-review of the institution's environment of care, communication practices, and policy development for patients at risk for suicide. In the aftermath of an in-hospital suicide, the creation and maintenance of a multidisciplinary leadership team facilitates the discussion of institutional risk and promotes a culture of safety within both psychiatric and medical settings. The importance of a coordinated, uniform clinical and administrative leadership response cannot be overemphasized. Both the RCA and the closely-related process of FMEA can be embraced as part of the hospital's culture and may influence responses in the aftermath of other adverse events, such as violence, natural disasters, or terrorism. Further exploration of the utility and effectiveness of these models may be aided by a national database of hospital-based suicides and

responses. Modifying longstanding hospital practices can be likened to “turning a large freighter in a small harbor;” such a process requires substantial time, energy, and persistence. Yet, the improvement of safety and the prevention of inpatient suicide, however rare, are critical goals central to the mission of all hospitals. Importantly, more extensive training and supervision of hospital clinicians in the assessment of suicide risk is warranted. Finally, systematic and detailed data-collection about inpatient suicides is essential to inform the development of evidence-based recommendations and optimal policy development for the prevention of, and response to suicide in hospital settings.

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TABLE 1

Immediate, Short-Term, and Long-Term Responses After an Inpatient Suicide

	Communication and Administration	Clinical Assessment and Management	Environment of Care	Policy and Procedures
Immediate Actions	<ul style="list-style-type: none"> • Designate team leader. • Create working group to respond to event. • Notify family, staff, patients, administrators, legal, and regulatory bodies. • Decide on possible media notification. 	<ul style="list-style-type: none"> • Identify individuals at risk for suicide. • Assess staff, patients, and witnesses at risk for trauma reaction. • Decide on possible debriefing of staff. 	<ul style="list-style-type: none"> • Identify changes to the ward (e.g. lock unit, check for windows and cords). • Interact with police and medical examiner (if necessary). 	<ul style="list-style-type: none"> • Create Emergency Response checklist with items such as inpatient safety, staff response, communication, and environment. • Assess existing policies and procedures for immediate safety. • Consider implementing short-term unit restrictions.
Short-Term Tasks	<ul style="list-style-type: none"> • Encourage open communication between patients and staff. • Continue conversations with family. 	<ul style="list-style-type: none"> • Provide counseling to patients and staff for emotional reactions. • Maintain mental-health presence on all hospital units. • Continue monitoring patients for suicide risk. 	<ul style="list-style-type: none"> • Identify and reduce access to lethal means (e.g. temporary netting in atrium, barred windows). 	<ul style="list-style-type: none"> • Conduct Root-Cause Analysis and create Action Plan. • Evaluate patient passes and assessment policies. • Decide on policy for travel costs for family members.
Long-Term Goals	<ul style="list-style-type: none"> • Complete changes to policies in Action Plan. • Avoid excessive clinical and administrative reactions. • Create multidisciplinary team to review adverse events. 	<ul style="list-style-type: none"> • Assure adequacy of staff training in depression and suicide. • Avoid undue assessment of patients. 	<ul style="list-style-type: none"> • Institute environmental modifications as outlined in Action Plan. • Incorporate design modifications and changes for new construction. 	<ul style="list-style-type: none"> • Continue interactions with regulatory agencies. • Identify legal concerns. • Institute Failure Modes and Effects Analysis.

TABLE 2**Checklist for the Immediate Aftermath of an In-Hospital Suicide**

<ul style="list-style-type: none"> • Identify team leader to oversee all components of institutional response. • Conduct immediate meeting with all involved personnel for short-term planning. • Identify individuals in need of clinical attention: <ul style="list-style-type: none"> – Witnesses to the event, including family and visitors – Other patients at risk for suicide – Other patients close to the individual – Staff who cared for the patient • Evaluate need for interim changes in ward procedures and staffing.
<p>Notification:</p> <ul style="list-style-type: none"> • Family • Staff • Patients • Police • Medical Examiner • Hospital administrators • Legal Counsel • Regulatory bodies (e.g. Department of Public Health, FDA, Joint Commission, Institutional Review Board) • Enter final clinical note and sequester chart. • Meet with police and medical examiner. • Decide on whether staff debriefing is necessary and, if so, how it will be carried out. • Decide on media notification and possible creation of a press release. • Counsel staff and patients for emotional reactions. • Continue communication and consider an apology to family (when appropriate). • Decide on clinician presence at funeral. • Schedule Root-Cause Analysis (RCA) or other formal review. <ul style="list-style-type: none"> – Decide on who will lead RCA. – Include all persons involved in the care of the patient. • Consider an announcement to entire hospital.