Table

Failure modes and recommended actions

Subprocess	Failure Mode	Potential Cause	Scoring			Recommended Action
			Severity	Probability	Hazard Score	
2a	1. Screening unfinished	Not performed	3	3	9	Establishment of integrated electronic medical system
		Not finished within 24 hours	2	3	6	Establishment of integrated electronic medical system
2b	2. Data not analyzed correctly	Wrong calculation of the total score	3	2	6	Staff continuing education
2c	3. Process not performed according to results	In-charge team not being informed	4	2	8	Establishment of integrated electronic medical system
		Results not being recorded	3	2	6	Establishment of integrated electronic medical system
2d	4. Results not presented during duty shifts	No handover to on-duty staffs appropriately	4	2	8	Establishment of integrated electronic medical system
2e	5. Inpatient safety and	Environment not being	3	4	12	Survey our ward setting

	environment	inspected				and avoid access for suicide
		At-risk patients' room not being adjusted	2	2	4	Special alert during shift changes and close monitor
3a	6. Psychiatric consultation not decided	Incompatible opinion about suicide risk from in-charge team	4	3	12	Establishment of integrated electronic medical system
		Patients or their family refuse	2	3	6	Establishment of integrated electronic medical system
3b	7. Consultation unfinished	No formal consultation record including suicide assessment and suggestion	2	3	6	Establishment of integrated electronic medical system
5a	8. Follow-up not administered	Lack of case management	2	4	8	A full-time clinical psychologist to assist social worker
5b	9. Case not	Lack of case	2	4	8	A full-time

	concluded	**management**				**clinical psychologist to assist social worker**

Fig. Inpatient suicide prevention process and sub-processes at E-Da hospital.

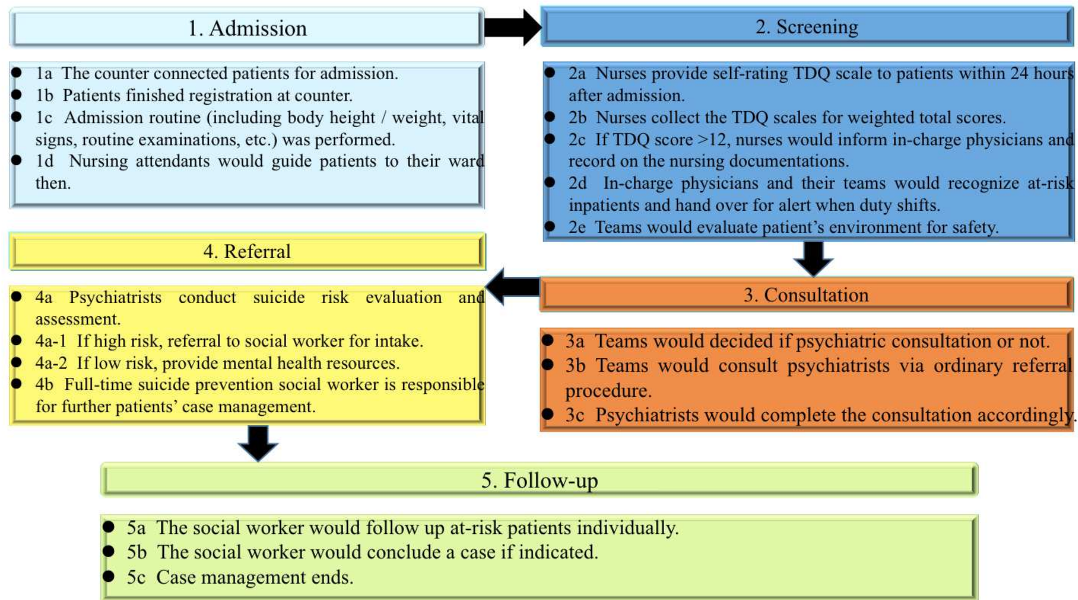
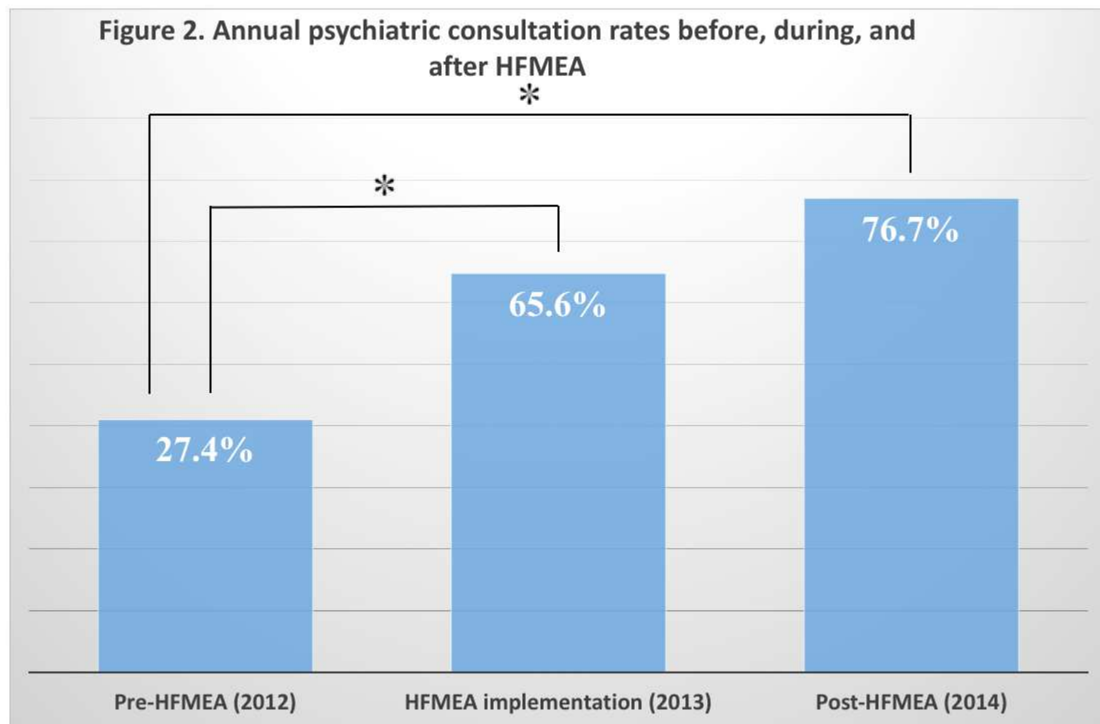


Fig. Annual psychiatric consultation rates before, during, and after HFMEA.



*p<0.0001