RISK CASE STUDY

Case: Patient Deterioration – Mental Health

Abstract:

An at-risk patient committed suicide in hospital. The failure to use non-weight bearing hooks was viewed by experts as a contributing factor.

Key Words:

Emergency Room

Inpatient Suicide

Physical/ Environmental Design

Acute Care

Mental Health

Monitoring

Case summary:

After presenting to the Emergency Department (ED) at a large community hospital as a result of concerns related to depression, a patient with a documented history of suicide attempts was admitted to the mental health unit on a Form 1. Following the patient's admission to the unit, the attending physician placed the patient on Q1/2 hour surveillance.

Less than twenty-four hours after the patient's initial admission, the patient was found hanging behind the door of his room, with his nightgown tied in a noose around his neck and his legs free from the floor. The patient was pronounced dead following failed resuscitative efforts.

Medical legal findings:

A review of the patient's health record revealed that in the hours prior to the patient's death, all nurses involved in the patient's care had complied with orders, monitoring the patient at half-hour intervals. As a result, expert opinion was supportive of the care provided by the organization's nursing staff. However, expert review was critical of the environmental design of the patient's room, noting the absence of well-established standards with regard to the use of non-weight bearing hooks within the in-patient mental health care settings.

During the course of an internal critical incident review, it was acknowledged that the physical design equipment on the unit did not meet accepted design standards, with the use of load-bearing non-break-away door hooks ultimately significantly contributing to the patient's death.

Reflections:

Reflecting on your own practices as well as your hospital's policies, procedures and processes:

1. What is your program's documentation expectations for scheduled and PRN checks/rounds for at-risk patients? For example, are the checks/rounds to be consistently recorded in the patient's health record? In the absence of documented checks/rounds, can healthcare providers safely rely on their 'normal practice' during legal/regulatory body investigations as evidence that the check/rounds took place?
2. Does your program/unit have a protocol for clothing for patients at risk for self-harm/suicide? Who is responsible for ensuring the appropriate attire for patients? Is a physician's order required to allow at-risk patients to wear less restrictive/street clothing?
3. This case refers to physical/environmental design 'standards' (e.g. use of breakaway hooks and bars) for mental health programs/units. Are these standards applicable to all hospitals and facilities caring for mental health patients? For example, would the use of non-weight bearing hooks be expected in small/rural hospitals without a designated mental program?
4. Describe some of the differences between an internal 'system' review (quality of care review), performance/accountability review, and medical legal review.

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