RISK CASE STUDY

Case: Patient Deterioration – Mental Health – Understaffing

Abstract:

An at-risk patient died by suicide while in hospital. Experts were critical of the lack of monitoring of this patient, noting staffing levels were insufficient.

Key Words:

Psychiatry

Inpatient Suicide

Monitoring

Process Improvement

Documentation

Patient Deterioration

Staffing

Anecdotal Notes

Case summary:

Admitted to a psychiatric unit on an involuntary Form 1, a patient with a history of depression and self-harm was found hanging from the closed door of his room.

Medical legal findings:

The internal critical incident review revealed that prior to the patient's death, the patient had repeatedly expressed suicidal thoughts and had engaged in worrisome and self-harming behavior. The review determined that the patient had utilized a cord taken from his sweatpants to hang himself.

Following a review of the patient's health record, it was determined that the nurse involved in the patient's care had failed to monitor the patient regularly, taken no documented steps to address the patient's concerning behavior and failed to ensure that the patient was clothed appropriately to minimize self-harm.

Experts noted that video footage obtained confirmed that prior to the discovery of the patient's body, the patient had not been monitored for a period of over one hour. In addition, experts confirmed that the patient's state of dress was in direct violation to established organizational policies, which required that all patients at risk for self-harm be attired in hospital-issued garments. The review identified that unit was critically unstaffed, with one staff member responsible for monitoring all patients admitted to the unit.

Reflections:

Reflecting on your practice as well as your facility's/program's policies, procedures and processes:

1. A critical incident review was conducted following this patient incident. Reflecting your organization's policies and ministry requirements (where in place), discuss types of events meet the definition of a critical incident?
2. Discuss the differences between an internal 'system'/critical incident review, performance accountability review and medical legal review? Are the subjective findings/opinions identified during system/critical incident reviews shared with the patient/family as well as the recommendations?
3. Discuss your program's protocol for clothing for patients at risk for self-harm/suicide, including who is responsible for ensuring the appropriate attire for patients and whether a physician's order is required to allow at-risk patients to wear less restrictive/street clothing.
4. Experts described the unit as being critically understaffed given the patient population and acuity levels. Discuss whether understaffing is an example of a 'system' issue. Discuss your local practices, and their effectiveness, to address shortages.

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5. The terms 'constant', 'continuous', and 'one to one' observation/monitoring are often used interchangeably. Describe and define these terms, including whether they are interchangeable. Reflecting on your local policies/practices, what steps should a healthcare provider and unit/program leadership take if a healthcare provider is unable to provide the level of observation required or ordered due to staffing issues?
6. Healthcare providers may feel it necessary to make personal anecdotal notes of situations that have 'not gone well' or where legal or regulatory body involvement is suspected. Discuss the use of personal notes, including whether such notes are private and legally protected from discovery during legal and regulatory body investigations. Why could personal notes cause more harm than good for the healthcare provider?

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