Manitoba Health

Manitoba Health supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Suicide Attempt

Summary: A patient with a history of alcohol and drug abuse presented twice within 24 hours to an emergency department (E.D.) with overdoses from illicit drug use and voiced suicidal ideation. He/she was discharged in the middle of the night at 03:00am with no plan in place and was left unobserved while he/she was waiting for his/her next of kin to pick him/her up. The patient was discovered in a quiet room at the health care facility approximately 4 hours later. The patient was in respiratory arrest from an overdose and a Code Blue was initiated. The patient was resuscitated and transferred via STARS to a higher level of care.

Keywords: Overdose, suicide attempt.

This review is based on a single event.

Findings of the Review:

The “Quiet room” that is frequently utilized for mental health (MH) patients is un-monitored.

There is confusion surrounding mental health processes/resources in the service delivery organization’s (SDO’s) emergency departments.

Patient with multiple overdose/suicide attempts was discharged at 3:00am, but remained in the facility waiting for his/her ride. It was discovered 4 hours later that the patient was found in a quiet room in respiratory arrest from an overdose.

Suicide screening, risk assessment, care planning and relevant pertinent charting was incomplete on an acutely suicidal patient that presented to the E.D. twice within 24 hours.

There is insufficient mental health liason nurses (MHLN) scheduled in a 24 hour period to meet increasing mental health (MH) demands within the SDO.

Recommendation:

Explore the feasibility to add video surveillance in the quiet room to enhance patient safety.

If above is feasible, install video surveillance in the quiet room at the site to enhance patient safety.

Educate E.D. health care providers on the following available resources when a MH patient presents to an E.D.:

- Shared Health “Telepsychiatry”.
- In-person MH “crisis team” can be contacted to do an assessment if no MHLN available pending their availability.
- Potential for future virtual care options from MH “Crisis team”.
- MHLN support.

Implement a process for stable MH patients in the E.D. that includes and is not limited to the following:

- keeping patients on EDIS/white board in “alternate level of care” status until physically discharged from facility with comment “ride pending”.

Persue a collective/collaborative approach/process between Community Mental Health program and acute SH-SS facilities for assessing, monitoring and charting those patients/clients who have suicidal ideation.

Add mental health representation as a permanent committee member at the E.D. Council/Critical Care Medical Team (CCMT).

Expand MHLN practice hours based on the following data:

- Number of patients currently in E.D.’s waiting for a psychiatric bed in the SDO.
- Number of people presenting to E.D.’s with MH/addictions concerns.

Suggestions:

Provide laptops for MHLN’s as a tool to access virtual care in all E.D.’s.

Submit a request to the service desk to add TEAMS as a platform for virtual care on the laptops for the MHLN’s.

Provide education to the MHLN’s on conducting a virtual MH assessment via TEAMS platform.

***NOTE SUGGESTIONS DO NOT GET REPORTED TO MHSAL**