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

Patient Suicide

Summary:

A patient was brought to an emergency department (E.D.) following a sudden onset of mental health concens noted by his/her family and community. After initial assessments the patient was further transferred to an acute mental health care facility for ongoing treatment.

The patient was started on medication and was undergoing assessment and intervention for social issues/manic behavior. The patient had shown significant improvement in mood and affect, and was moved from a controlled observation area to a regular in-patient room at the facility. While doing a routine observation check, a psychiatric nursing assistant (PNA) discovered the patient unresponsive in his/her room, with a ligature around the neck which was secured to the bedframe. The patient was pronounced deceased.

Keywords: Suicide

This review is based on a single event.

Findings of the Review:

The patient was very dysregulated (inability to control one’s emotional responses) upon admission which had improved very quickly. The admitting differential diagnosis was manic psychosis. Following assessment and treatment it became more apparent that the diagnosis was more of a personality disorder related to stress combined with societal issues.

The patient displayed competency in decision making throughout the hospitalization.

The patient had criminal charges pending that escalated his/her emotional distress.

The patient completed the act of suicide to control how/when he/she died.

System Learning:

Recommendations:

There are no critical incident recommendations following the review as all findings were patient related and were not predictable/preventable. However, there are two suggestions to enhance patient safety.

***SUGGESTIONS TO ENHANCE PATIENT SAFETY**

The information and suggestion that follow were brought forward during the Critical Incident review. These factors did not contribute to the critical incident; however, the suggestions are being shared as opportunities for system improvement. This information will not be included in the Manitoba Health Patient Safety Learning Advisory but will be shared with the respective Senior Leaders. These suggestions are not intended for follow up reporting to Manitoba Health.

Inform healthcare providers at the site to document all details of patient death.

Add to admission/discharge check-list to assess room safety measures.

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