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2425-079

Patient Safety Learning Advisory

Patient Safety Event: Patient death following Left Without Being Seen from Emergency Department (ED).

Why was this a Critical Incident?

According to Manitoba Critical Incident Reporting Guidelines, patient death or serious disability associated with patient disappearance is a reportable event.

What happened in the incident?

A patient was brought to the ED by Royal Canadian Mounted Police with a laceration to their wrist from self-harm. The patient had a history of suicide attempts and substance misuse. The patient had been drinking alcohol throughout the day. The patient was triaged as a CTAS level 4, and directed to the waiting room. No suicide screening was performed.

The patient left the ED without being seen, and was brought back by Emergency Response Services (ERS) after being involved in a vehicle/pedestrian collision. The patient was pronounced deceased.

What is the Health Care System learning?

The ED was experiencing a significant influx of patients and all available rooms were occupied.

The patient was triaged at a CTAS level 4 for a laceration (self-inflicted) and placed in the waiting room.

Secondary modifiers of CTAS (suicide ideation, flight risk, intoxication) indicate a CTAS level 2 which would have led to more frequent monitoring in the ED (15 minute versus 60-minute re-assessments).

No suicide assessment documents were completed for an intoxicated patient who presented to the ED with self-inflicted lacerations to the wrist and a history of suicide attempts and mental health concerns.

The patient left the ED un-noticed and was struck by a vehicle on the highway. It cannot be determined if this was intentional or accidental.

What are the recommendations?

Implement “Institutional Safety Officers (ISO’s)” in regional ED’s.

Implement further training on CTAS for mental health/substance concerns for ED presentations.

Implement a “Suicide Prevention Program ROP Implementation” working group to develop a suicide tool kit for improved suicide risk screening and interventions.

Keywords: Suicide, Emergency Department Death

Your privacy is important to us, so in this summary we have removed any details which would help identify the subject of this event. It’s important that we can learn from safety events and make changes to improve the care we provide.