Preventing suicides in emergency departments and inpatient psychiatric units: Standards of care.pdf

Mona Shattell, PhD, RN, FAAN

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Suicides in emergency departments (EDs) and inpatient psychiatric units are rare, although they do happen. Patients in emotional distress, however, should not die while under our care. When a patient attempts or completes a suicide under our watch, who is at fault? Is someone, usually a health care provider, such as a nurse or physician, always to blame? What is the standard of care for a reasonable and prudent health care provider to prevent patients from killing themselves?

I will use a case to examine these questions. An individual in an ED is placed on close observation for suicidal ideation and psychotic thought processes. The psychiatric nurse practitioner meets with the patient and conducts a suicide risk assessment, and then meets with the ED RN and physician. The psychiatric nurse practitioner and physician decide that the patient needs to be admitted to an inpatient psychiatric unit for crisis stabilization.

As in many locales, there are no inpatient psychiatric unit beds available, so the patient must be “boarded” in the ED. The psychiatric nurse practitioner orders close observation for risk of self-harm. While waiting for a bed to become available on an inpatient psychiatric unit, the patient asked the ED nurse if he could go to the bathroom, which she allowed him to do, unescorted. He was found several minutes later on the floor of the bathroom, after having stuffed 12 rubber gloves down his throat and trachea.

He survives but has anoxic brain injury. He lives out his days in a persistent vegetative state, requiring round-the-clock nursing care. He leaves a young wife and infant child without the active presence of a husband and father.

This case is, in my opinion, a case of failure to provide the standard of care. The nurse who allowed the patient to go to the bathroom unattended did not provide adequate supervision to ensure that he did not act on his suicidal impulses. There was an order for close observation. The order was based on the psychiatric nurse practitioner’s suicide risk assessment, which deemed the patient at risk. The patient was at risk for suicide and the nurse who cared for him did not consider “safety first” when allowing him out of her sight.

What was going on at the time? Was the nurse overburdened by a heavy patient load that was too much, too acute for one person? Was she ill-equipped to continuously monitor and assess a patient with suicidal ideation? Was she unfamiliar with the hospital policies regarding close observation?

Of course, bad things can happen, even when everyone does what he/she is supposed to do, meeting the standard of care. Nurses and physicians are not always to blame. Each incident should be reviewed. Preventable incidents would be prevented, if at all possible.

In the case presented above, the nurse who allowed the patient, who was on close observation, to go to the bathroom unattended was at fault. At the very minimum, we need to prevent patients from hurting themselves, but this might be seen as a pretty low bar. As psychiatric–mental health nurses, we need to do more than simply assess and monitor. According to Polacek et al. (2015), we need to engage and intervene.

REFERENCE

Mona Shattell, PhD, RN, FAAN
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