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TOPIC: **PREVENTABLE SUICIDES**

Scenario

A 42 year old woman was rushed to the hospital by her husband due to confusion and odd behavior that raised concern for her husband. After some blood test were ran, the Dr. Was able to identify an imbalance of electrolytes including some of the main ones that can cause confusion such as low sodium. The husband stayed with his wife during the treatment of electrolyte imbalance. The patient seemed to be doing ok and back to herself according to the husband and there were no more concerns for the patient's mental status. Next thing you know, while the husband was in the restroom of the patient room, the patient pried the window open in her room and proceeded to attempt jumping. According to the husband, he heard a loud noise outside the restroom and hurried out to see what was going on in the room and seen his wife half way out the window. The husband rushed to her rescue missing her by seconds as she fell and landed on the roof of a few floors down. Fortunately, the patient survived and was rushed to surgery for repair of broken ribs and legs. After surgery and electrolyte imbalance correction the patient was assigned to a room with a medical personnel sitter for 1 on 1 watch 24/7 during the rest of her hospital stay. This patient had a history of depression with prescribed depression medications as well as a previous diagnosis of systemic Lupus.

In what way did the patient care or environment lack? Is this a common occurrence?

In this scenario, the environmental lacking involves a window without adequate safety features. Patient care lacked in this situation as a whole team considering this patient's care was in the hands of nurses, Physicians, OT, and other care team members involved with this patients care plan. This patient not only had obvious confusion with low sodium to prove it, but this patient also had a history of depression and systemic lupus which also causes various mental changes including but not limited to; mental status change, mood swings, personality changes, suicidal ideation including attempts and even death, confusion, seizures, stress, pain, and more. Suicide attempts in the hospital is not necessarily a common occurrence, yet it does happen. According to the Joint Commission Journal, the estimated numbers of in-patient hospital suicide deaths each year in the US is 45.5 to 64.9, which is considerably lower than the wide cited 15,000 per year. (JCJ, 2018). Considering this patients history and all the team members involved there should have been reports given several times. Important information about the patient is passed between members which is similar to the double checks in certain protocols that help the team members work together to prevent

adverse events due to multiple eyes and ears for hopes of someone catching a possible error/or lack of vital information such as the patients history so that all questions, brain storming, and possible problems can be identified and potential risks prevented, as we are only human and unfortunately, do make mistakes or miss important information on occasions.

What circumstances led to the occurrence?

The circumstances that led to this occurrence was the patient care team not considering the patients history or continuing an investigation of the all possible root causes of this patients condition on admission rather than settling with the first line of Evidence found that can cause confusion such as her blood work that showed the obvious electrolytes imbalance of low sodium that can cause confusion and personality changes. Any patient with confusion needs to have a tight eye on them for safety considering the unpredictable nature of confusion. Another leading cause would be the lack of risk identification and applying risk preventing measures for confusion and suicide ideation with her history showing high risks.

In what way could you measure the frequency of the occurrence? (interviewing nurses, examining charts, patient surveys, observation, etc)

Some ways this unfortunate event's frequency of occurrence can be measured is by collecting and analyzing the reported sentinel events of the hospitals involving any association of suicidal events. Other ways include peer reviews, malpractice litigations that also involve suicidal events within hospital care, Patient surveys consisting of questions pertaining to suicidal ideation while hospitalized, and hospital staff interviews of experiences/observations of patients ideation or attempts to commit suicide while in hospital care. Also measuring the times 1 on 1 sitters are understaffed and unavailable in order to correct this shortage.

What Evidence based ideas do you have for implementing interventions to address the problem?

Ways to prevent an environment of possibility for hospital inpatients are room safety measures such as no shower curtains or other items that can be used in hanging considering the number one strategy used for such an attempt is hanging oneself in the hospital restroom (Scott et al. 2018). Installing safety constructed windows such as ones that only open slightly for venting purposes rather than possibilities of falls or in this case, suicide attempts. Maybe even new technology with special locking devices to keep patients from accessing the operational mechanisms of windows in the patient rooms. Another idea may be covering of windows for high risk patients including confused, dementia, and many more.
Ways to intervene with patient care would be to have daily before shift huddles to remind nurses of their duty to advocate for their patients and that includes knowing the patients chart and while creating the patient care plan, analyzing the patients situation

and utilizing the nursing diagnosis and recommendation phases to not just care for the patient with following orders but, fighting for the patient in the way we would for our own loved ones and search for all the possible things that could be the cause of the patients obvious signs. Another intervention would be to hold staff accountable with new set consequences pertaining to events that hold evidence of staff not following safety protocols and basics of nursing such as utilizing the SBAR when doing report of any kind and following the prefilled guided topics cardex that helps with organizing and remembering the most Important details of a patient that need be known by all involved in patient care during report hand off. Also, educating staff on how to accurately identify high risk patients for suicide and accurately conduct a mental screening tool, provided by the hospital for these high risk patients. Clearly stated protocols posted in staffing areas and on electronically used devices easily accessible with notifications engaging staff to learn evidence based guidelines to recognize and conduct high risk patients of suicide. Making sure management of equipment and staffing allows for enough tele-sitters and adequate staff numbers to accommodate in person sitters for 1 on 1 monitoring.

How will you measure the efficacy of the interventions?

Measurements to confirm efficacy can include annual maintenance safety checks of window securement and condition, Risk management involved in room checks for items installed in rooms that create potential risks as well as proper functionality. One way to measure the outcome of implemented strategies and education for high risk for suicide could be a monthly review of informatics that show the breakdown of floors and hospitals occurrences of suicidal situations if there is any, along with surveys to measure patients opinion on if there was prompt recognition of need for that conversation on their mental health and providing information for help as well as offered help while in the hospital. According to the Indian Journal of Psychological Medicine, environmental changes to provide room safety and education of staff with high risk, seems to be the most promising implementations to lower suicide mortalities within hospitals in-patients.

References

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