Case Example #3
Suicidal patient slips through the cracks

CASE EXAMPLE

A patient was brought to the emergency department (ED) via ambulance after being found unresponsive at home from an alcohol and drug overdose. The patient was given Narcan by the EMS prior to arrival and was able to participate during triage.

Upon the patient's arrival to the ED, a nurse performed a suicide screening using questions adapted for the organization's electronic medical record (EMR). Though the patient shared that he had recently lost his job and was having relationship issues, he assured the nurse that the overdose was an attempt to relax and sleep, and he denied suicide ideation. The suicide screening was determined to be negative. While the patient's social stressors were documented in the nursing notes, they were not directly communicated to the ED physician.
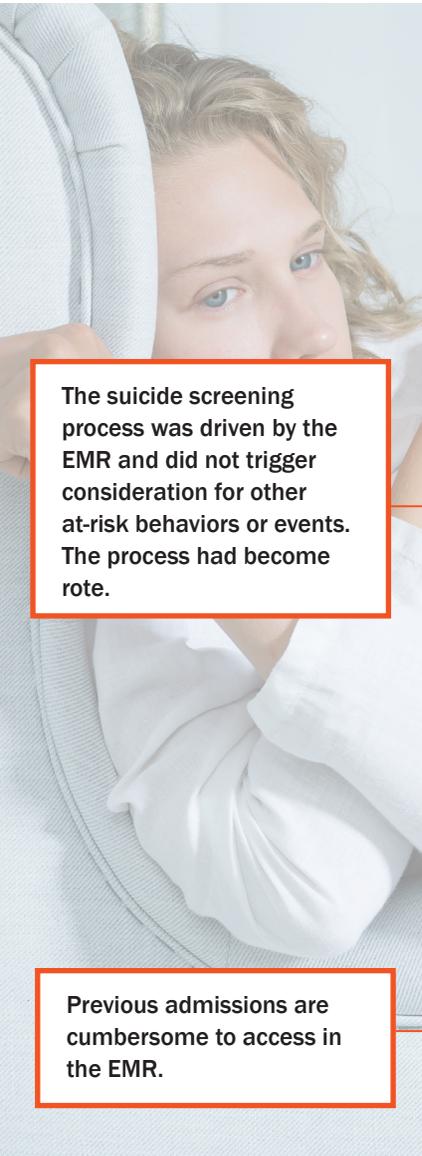
The ED physician assessed the patient, noting a decrease in oxygen saturation, and consulted with the hospitalist. They decided to admit the patient to the medical floor for suspicion of aspiration pneumonia. This was the third overdose patient that shift for the ED physician, and after seeing the suicide screen as negative and hearing the patient's explanation, the physician believed the patient to have accidentally overdosed, so the physician focused on the medical aspects. Psychosocial factors were not communicated to the admitting hospitalist. Later, it was found that eight months prior, the patient had been admitted to a sister hospital for an overdose after a suicide attempt. This information was not accessed by either physician.

The patient was transferred to the medical-surgical unit. A hand-off between the ED and the receiving unit did not occur. An admission assessment and history/physical was conducted by the medical-surgical nurse. Although a repeat suicide risk screening and assessment was required per policy, it was not performed.
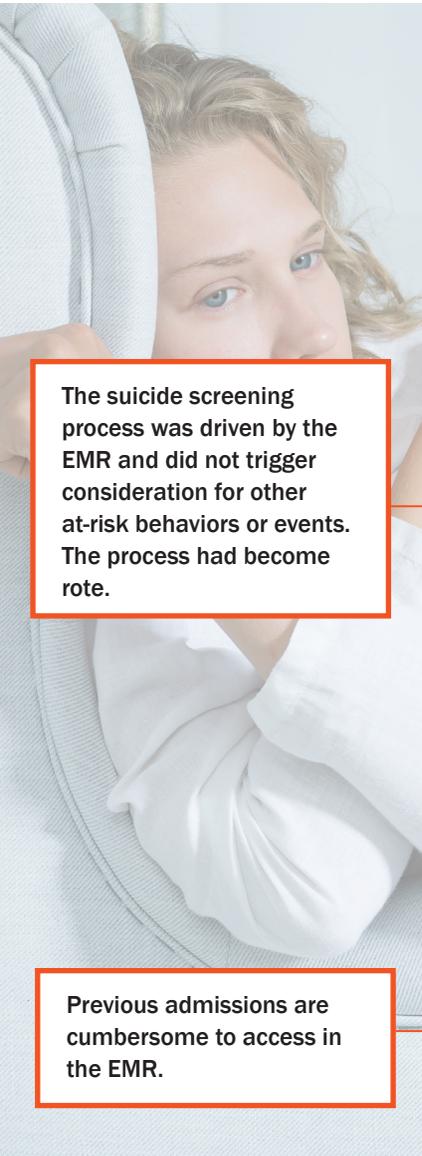
The patient improved medically throughout the day with more energy and positive presentation, though he continued to casually verbalize stress over the loss of his job and relationship issues to various staff (nursing, substance abuse services consult), remarking that he was "tired of dealing with it all" and wished he could "just sleep and it'll be over." The comments were documented in the EMR, but were not communciated to anyone

Later in the afternoon, the patient had a visitor. Some time after, a nurse performing hourly rounds entered the patient's room to find the patient hanging from his belt, which was wrapped around his neck and tied to the bed. A code blue was called, and the code team arrived to revive the patient, but he was unable to be resuscitated.
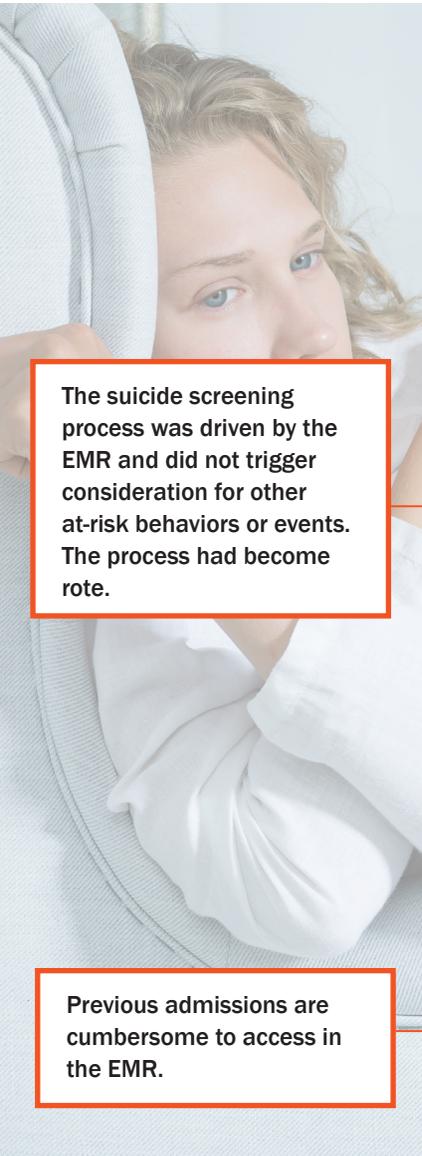
Disclaimer: This case example is aggregated and is not representative of a single report or incident. Any likeness to an actual event is purely coincidental.
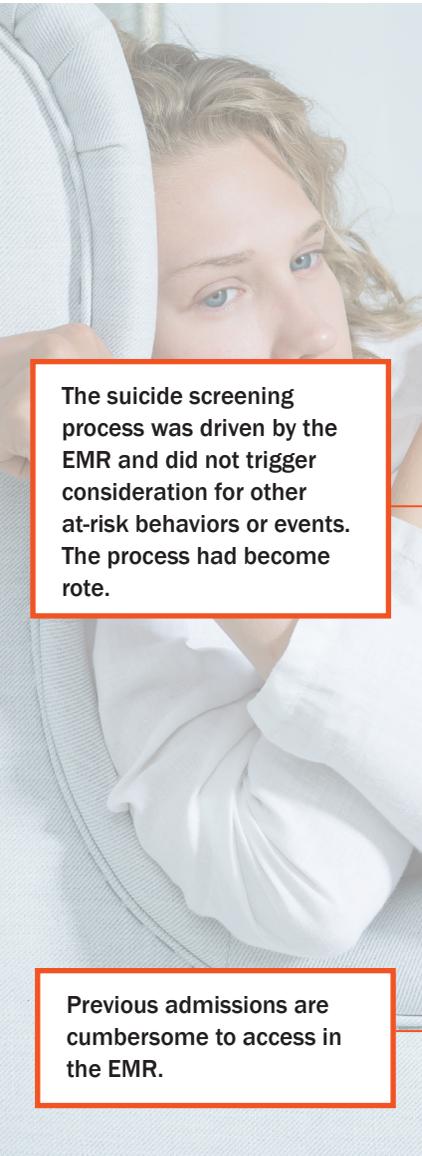
Annotations:

The suicide screening process was driven by the EMR and did not trigger consideration for other at-risk behaviors or events. The process had become rote.
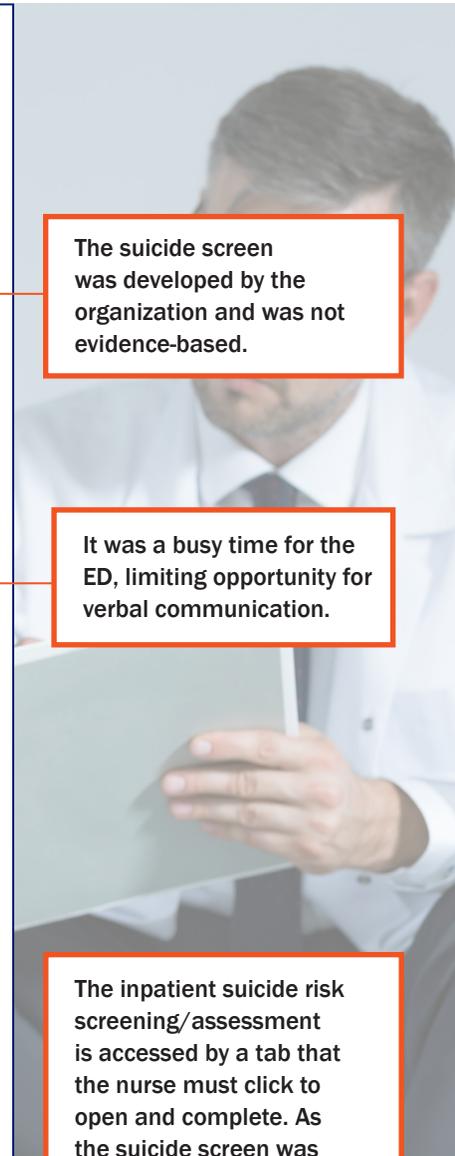
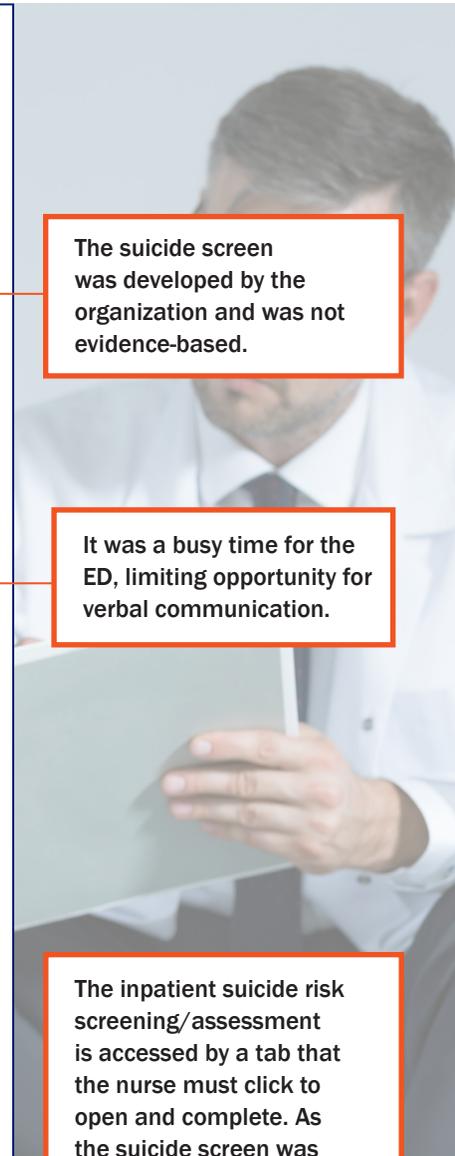Previous admissions are cumbersome to access in the EMR.

The verbal report/hand-off with the receiving med-surg nurse was not conducted because of a high-volume of cases in the ED.
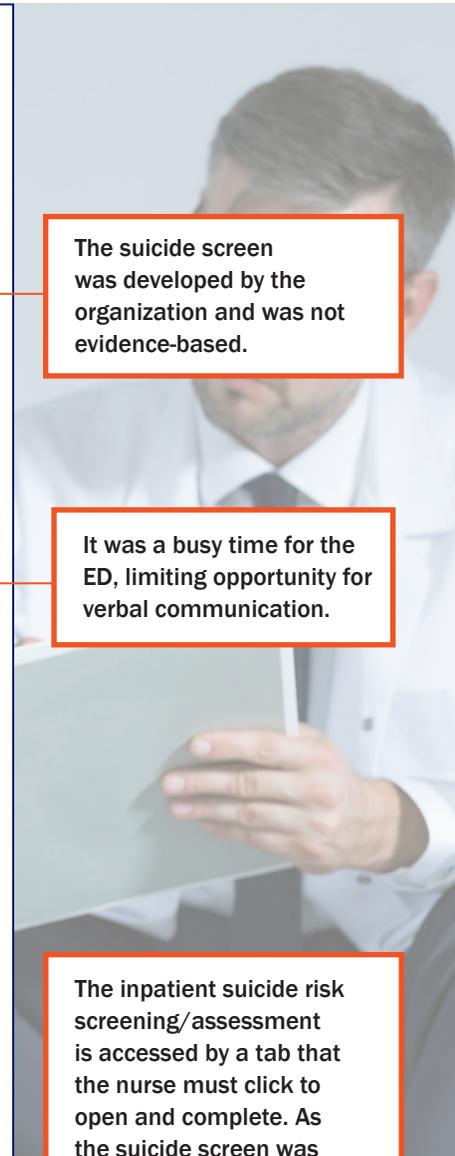
Concerned statements by the patient were not followed up on or interrogated further, as there was no education as to high-risk triggers or actions to take to mitigate risk.
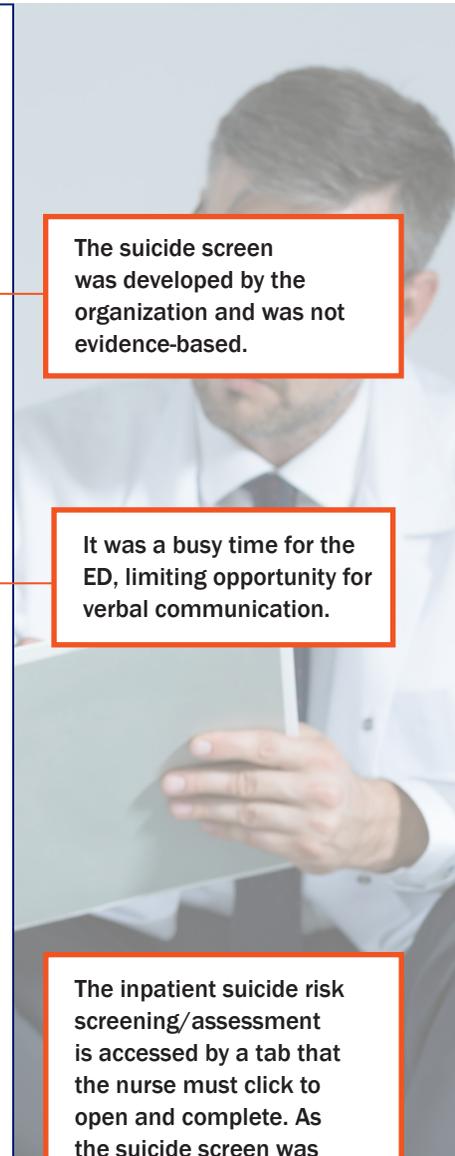
The suicide screen was developed by the organization and was not evidence-based.

It was a busy time for the ED, limiting opportunity for verbal communication.

The inpatient suicide risk screening/assessment is accessed by a tab that the nurse must click to open and complete. As the suicide screen was negative in the ED, there was no other apparent information or prompt, so the additional suicide screening/ assessment was overlooked.

Each discipline's notes are separate, and there is no efficient means to see the "big picture" for each patient. To do that, staff must go in and out of each discipline's notes.