Suicide and Self-Harm in Inpatient Psychiatric Units: A Study of Nursing Issues in 31 Cases

Gournay, K., Bowers, L.
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Key Concepts/Context
A significant number of incidents of suicide and self-harm occur in in-patient facilities. This study comprises of the review and audit of 31 suicide cases, each case being the subject of legal action brought by patients and/or their families.

Methods
The data on these 31 cases was collected using a systematic review of case records, trust policies, expert reports and, where appropriate, inquest transcriptions. The sample comprised 12 suicides and 19 cases of serious self-harm.

Findings
The main findings associated with the suicide events in the 31 cases include: being male, having a dual diagnosis of mental illness and drug/alcohol abuse, and age between 21 and 30 years. Of the 12 deaths, five occurred in hospital, four by hanging, and one by drowning.

Limitations
As this study deals with just the 31 unique cases of patients with suicide, any generalization of the study findings must be carried out with extreme caution. There was a considerable variation in the content and quality of observation policy and practice.
Design Implications

The audit highlighted environmental factors such as nursing shortages, facility/unit layout which prohibits the staff to observe the patients clearly at all times, and healthcare staff not following observation protocols which were associated with these events. All these factors can be easily addressed.