SYNOPSIS

KEY POINT SUMMARY

OBJECTIVES

Suicide is a leading cause of death in the United States, and approximately 1,500 suicides occur in inpatient hospital units in the United States each year, This study examines the specific environmental factors involved in suicide attempts and completions in an ED in a large, nationally represented hospital sample (VA).

Suicide Attempts and Completions in the Emergency Department in Veterans Affairs Hospitals

Mills, P. D., Watts, B. V., DeRosier, J. M., Tomolo, A. M., Bagian, J. P.
2012 | Emergency Medicine Journal
Volume 29, Issue 5, Pages 399-403

Key Concepts/Context

The joint commission reports that eight percent of all inpatient suicides that are reported in their database of sentinel events occur in the emergency department. Using its system-wide data for root cause analysis (RCA), the Veterans Administration (VA) was able to conduct this study of suicide attempts and completions. This is the first study in a large national medical system to examine environmental hazards associated with suicide risk in the ED.

Methods

VA medical centers are required to conduct RCAs on all inpatient suicides and report all suicides and serious suicide attempts to the National Center for Patient Safety (NCPS). RCA reports must be completed by the facility with 45 days of the event. The reports are submitted to the NCPS throughout the year and include narrative descriptions of the event, all contributing factors, a final understanding of the event, and a specific action plan for addressing underlying causes.

This is a retrospective review of all RCA reports of suicide attempts or completions in the VA healthcare system for a 10-year period through December 2009. The method, location, anchor point for hanging and implement for cutting, as well as the root causes were categorized.

Findings

The authors found that similar to Joint Commission statistics, 10% of all RCA reports of suicides and suicide attempts that occur within the hospital occur in the Emergency Department (ED), of which 87.1% of the patients were men with an

average age of 52.1 years. The ED suicide attempts and completions number was second to inpatient psychiatric wards. Hanging, cutting, and strangulation were the most common methods patients used to attempt suicides. The most common anchor point for hanging was doors or door handles, and the most common implement for cutting was a razor blade. In eight of 10 cases of cutting, the implement was brought into the ED. While there can be multiple root causes reported, the authors found that 'problems communicating risk' was the most common identified root cause for suicide attempts and completions in the ED. Another important contributing factor identified was not enough staff to provide immediate one-to-one observation for suicidal patients.

Limitations

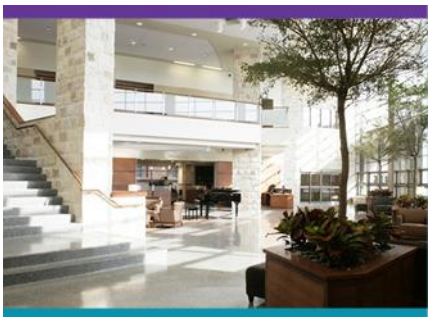
Some of the limitations of this study were:

- The results data only contain suicide attempts and completions that were reported through the VA patient safety system; thus, there could be potential sampling inadequacies, as those that didn't get reported would not be analyzed.
- RCA reports focus on the systemic vulnerabilities in the ED and the hospital that may have contributed to the adverse event rather than the specific characteristics of the patients involved. Any individual characteristic of the patient that may have contributed to the suicide/ attempt was not captured, although these are reported in other studies.
- This study focused more on the environmental hazards for suicide in the ED rather than on the possible effectiveness of staff protocols for reducing suicide attempts.
- Generalization of the study findings should be made with caution, as the data was confined to just one study setting with some unique characteristics.

Design Implications

This study examines the specific environmental factors involved in suicide attempts and completions in an ED in a large, nationally represented hospital sample (VA). The authors note the importance of having no unobserved doors (including lockers and cabinets); no protruding objects that can be used as anchor points; and no sharp edges in areas where suicidal patients are being held. This is especially true in toilet rooms, where the patient may be unattended. Physical layout problems contributed to suicide events, when staff had difficulty monitoring patients because of corners or other blocks to viewing patients. Inadequate holding area was also cited, when the RCA team found that there was not a safe place to hold suicidal patients in their ED.

Based on the study results authors made the following recommendations for helping to reduce suicide attempts in the ED: (1) periodically review environmental



The Center for Health Design: Moving Healthcare Forward

The Center for Health Design advances best practices and empowers healthcare leaders with quality research providing the value of design in improving patient and performance outcomes in healthcare facility planning, design, and construction, optimizing the healthcare experience and contributing to superior patient, staff, and performance outcomes.

Learn more at www.healthdesign.org

hazards using a checklist and systematic protocol; (2) consider continuous observation of suicidal patients when possible; (3) where allowed by law and/or regulations, conduct thorough searches for weapons or other forbidden items with suicidal patients; (4) where possible, designate specialized holding areas for suicidal patients. These should be free of environmental hazards such as sharp edges, anchor points, medications, and equipment and should be remote from exits to reduce elopment risk.