Our D-H teams made the difference maintaining patient care during event
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The Aftermath of Suicide: Lessons Learned from Litigation

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Objectives

- Discuss factors related to identifying individuals at risk for suicide
- Examine liability risks when treating patients who are suicidal - whether inpatient or outpatient
- Describe risk management strategies to lessen the liability exposure
Definitions

- Suicide = death caused by self-directed, injurious behavior with intent to die as a result of that behavior

- Suicide attempt = non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior

- Suicidal ideation = thinking about, considering, or planning suicide

Suicide Statistics (2017)

- 10th leading cause of death
- 2nd leading cause of death ages 10-34
- 4th leading cause of death ages 35-54
- Rate greatest in females 45-54
- Rate greatest in males > 65
- Males use firearms (56.6%)
- Females use poisoning (33%) or firearms (32%)

Source: SAMHSA, 2018 NSDUH
Suicidal Thoughts/Behavior - Adults Aged > 18: 2017

10.6 Million Adults Had Serious Thoughts of Committing Suicide

- 3.2 Million Made Suicide Plans
- 1.2 Million Made Plans and Attempted Suicide
- 1.4 Million Attempted Suicide
- 0.2 Million Made No Plans and Attempted Suicide

Signs - Youth at Risk

- Signs of being bullied
- Preoccupation with weapons or violent video games
- Negative social media postings
- Recent loss of status or loss of a relationship
- Personal failure/poor coping skills
- Suicidal thoughts or attempt
- Thoughts of revenge
- Access to firearms/weapons
- Changes in or unstable home life
- Prior history of violence/cruelty to animals
- Drug, alcohol or tobacco use
Media and Suicide

- High profile suicides recently
  - Kate Spade
  - Anthony Bourdain
  - Margo Kidder
  - Robin Williams

- Television programs
  - Netflix - “13 Reasons Why”
  - 60 Minutes - “Suicide and Violence”
  - ABC - “A Million Little Things”

- Mobile Health Apps
Case Study #1 - New Psych Unit

- Middle-aged adult male with bipolar disorder and depression
- Known to break windows at home secondary to paranoid delusions
- Admitted to locked behavioral health unit
- No bars on windows
- Patient broke window
- Staff felt threatened - did not intervene
- Patient jumped
Risk Reduction Strategies: Environment of Care

- “Safe rooms”
- Safe bathrooms/doors
- Wardrobes without doors
- Safe windows
- No plastic bags
- Light fixtures, door knobs, sprinkler heads
- Hand rails
- Remove dangerous clothing
- Monitoring/observation
- Sitters
- Train all staff in de-escalation techniques
- Educate visitors re: prohibited items
Case Study #2: Schizophrenia

- Patient with known mental health issues
- Brought to acute care hospital by EMS
- Summoned by wife
- Paranoid delusions
- Suicidal ideations
- Scheduled transfer-vulnerable time
- Unless 1 on 1 monitoring, 15 minute checks
- Inadequate given scenario #1
Location

- Bathrooms are a “private” area = MYTH
- Locking doors
  - No locks on doors
  - Door knobs disabled
  - Mechanism altered by toilet tissue obstruction
- Sources for suffocation
  - Toilet paper
  - Rubber gloves
  - Bedsheets
- Privacy component
  - Ideally same sex staff member to monitor
Case Study #3: "See Ya"

- Admitted because of seizures
- Underlying substance use issues
- Repeated admissions
- Incomplete history
- Family attentive and present
- Earlier, patient was placed in restraints
- Financial stress
- Was this foreseeable?
Documentation: Suicide Prevention Contracts

- Suicide Prevention Contracts:
  - Overvalued as clinical/risk management technique
  - Not a legal document - cannot be used as exculpatory evidence
  - Studies have not shown effectiveness in reducing suicide
  - Should not take place of suicide assessment
  - Ensure a safety plan is implemented
Case Study #4: “Make Her Pay”

- Bipolar
- Previous suicide attempts
- Marital, family and job stressors
- Patient blogged extensively
- Maintained a website devoted to medication issues and failing to take prescribed meds
- Refills limited by physician because of failures to attend office visits
Case Study #5: Heightened awareness

- Adolescent
- Transferred from home state
- Older sister first contact
- New to facility
- Family conflict telephonically
- Field trip with facility
- Unanticipated exit from vehicle
- Jumped off overpass
Risk Factors by Location

- Inpatient Room
  - Anchor points
  - Windows
- Egress to outside
- Off-site facility sponsored event
- Transportation
Common Allegations

- Failure to adequately assess suicide risk
- Failure to monitor, supervise, protect
- Failure to take a complete history
- Failure to medicate properly
- Failure to remove dangerous objects
Risk Exposures

- Staff attitudes
- Risk assessments
- Environmental safety
- Patient monitoring
- Staff competency
- Delayed/inappropriate transfers
Systems Risk Factors
“Not in my hospital/not on my watch”

- Inadequate screening/assessments
- Poor staff communication
- Inadequate staff training re: suicide
- Lack of Policies & Procedures re: high risk patients
- Inadequate observation/supervision
Means of Suicide

- Suffocation
- Hanging
- Jumping
- Overdose
- Guns
Reasons Patients Commit Suicide

- Burden to family
- Altered thinking - mental illness
- Revenge
- Pain too great
Response Time CRITICAL

- Time element
  - 15 minute checks is too long
  - A determined patient plans for that interval
  - 4-6 minutes for brain damage to occur
What Courts Consider

- Voluntary admission?
- Preventable?
- Foreseeable?
- Treatable?
- Successful?
- Skill set of Healthcare Practitioner?
- Communication?
- Negligence?
Damages

- Economic damages for failed attempt
  - Medical expenses for failed attempts
  - Lost wages
- Non-economics
  - Pain and suffering
  - Loss of ability to enjoy life
  - Loss of consortium
Considerations with Patient Care

Vulnerable Times:
- Before transfer
- After family conflict
- Medication change

Monitoring:
- Sitter
- 1 on 1
- 15 minute checks
High Risk Transitions: Discharge from the Emergency Department (ED) or Inpatient Unit

- Determine that patient is Stable for discharge
- Transfer from ED to another facility via healthcare/law enforcement vehicle, NOT family, NOT self
- Timely follow up care
- Review suicide risk screening questionnaires before the patient is discharged

Source: All Patients at Risk for Suicide After Psychiatric Facility Discharge, Study Finds
Published Online: 6 Jul 2017 https://doi.org/10.1176/appi.pn.2017.7a17
High Risk Transitions: Discharge from the Emergency Department (ED) or Inpatient Unit

- Give every patient and their family members the number to the National Suicide Prevention Lifeline, **1-800-273-TALK (8255)**, as well as to local crisis and peer support contacts
- Document: assessments, interventions, treatment plan, referral, patient status **AT** discharge

Source: All Patients at Risk for Suicide After Psychiatric Facility Discharge, Study Finds
Published Online: 6 Jul 2017 [https://doi.org/10.1176/appi.pn.2017.7a17](https://doi.org/10.1176/appi.pn.2017.7a17)
Risk Reduction Strategies: Environment of Care

- Consistent process for summoning assistance to control violence
- Panic buttons on psychiatric units/ED
- Sufficient staffing
- Eliminate structures and materials that could be used for hanging
- Use alarms to prevent injuries, falls, elopement, and wandering
- Safety glass and locks for windows and screens
- Paper trash liners
General Risk Reduction Strategies

- Use of assessment tools
- Obtaining psychiatric consult
- Regular security rounds
- Address escalating behavior proactively
- Monitoring and staffing guidelines
- Medication management
General Risk Reduction Strategies

- Patient searches
- Crisis Prevention/Nonviolent Intervention Training
- Behavioral Health Rapid Response Team
- Emergency drills
- Facility assessment
WE can be the change we want to see in OUR world ... and our patients/clients will be the better for our work.

“Be the change you want to see in the world.

- Mahatma Gandhi
Discussion / Questions
Name Card

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