Current Psychiatry

Failing the 15-minute suicide watch: Guidelines to monitor inpatients

Patient commits suicide after 15-minute checks are stopped

Honolulu County (HI) Circuit Court

A patient was brought to a hospital and interviewed by a psychiatrist. She was found to be at moderate risk for suicide, was admitted, and ordered to be monitored every 15 minutes. The patient attempted suicide 2 days later by closing a drawer on her neck. She died from the injuries the following day.

The patient's family claimed that a hospital nurse misread the psychiatrist's instructions and stopped the 15-minute checks on the morning of the incident, believing that the order was limited to 15-minute checks for the first 24 hours, even though they had been done for almost 2 days. The patient refused medication on the first day of admission, and the psychiatrist had started the procedure to obtain a court order committing the patient and allowing injection of necessary medication. The claims against the hospital were settled for a confidential amount.

The patient's family claimed the psychiatrist diagnosed the patient with major depression with recurrent suicide ideation but failed to properly assess her for suicide monitoring. The family also said the patient should have been determined to be at least at high risk and required to be within sight of staff.

The psychiatrist claimed to be unaware the 15-minute monitoring had ceased. The psychiatrist saw the patient 30 minutes before she was found collapsed with her head in the drawer. The hospital staff checked the patient approximately 15 to 30 minutes before she was found.

> **A defense verdict was returned**

Reduced observation blamed for suicide by hanging

Kings County (NY) Supreme Court

A 45-year-old police lieutenant who suffered from alcohol abuse and depression was admitted to a psychiatric care facility. He was classified "Q15," a category assigned to patients who must be visually inspected every 15 minutes, cannot have access to sharp objects or any other material or object they can use to inflict bodily harm, and must request permission to use restrooms. The next day the psychiatrist examined the patient and moved him to a "Q30" status, which halved the frequency of visual inspections, gave him unrestricted access to restrooms, and allowed him to have a bathrobe with a belt. The patient hanged himself the next day, using a restroom door to support a noose he made from the bathrobe belt.

The patient's family faulted the hospital and psychiatrist for prematurely advancing the patient to "Q30" status. The hospital and psychiatrist claimed the suicide could not have been predicted and argued that given

Jon E. Grant, JD, MD, MPH

Dr. Grant's observations
Page 42

Cases are selected by Current Psychiatry from *Medical Malpractice Verdicts, Settlements & Experts*, with permission of its editor, Lewis Laska of Nashville, TN (www.verdictslaska.com). Information may be incomplete in some instances, but these cases represent clinical situations that typically result in litigation.

Dr. Grant is associate professor of psychiatry, University of Minnesota Medical Center, Minneapolis.

his background as a police lieutenant, the patient would have interpreted more stringent restrictions as incarceration. The psychiatrist argued that such a perception would have impeded the patient's progress.

> **A $71,989 verdict was returned, apportioning fault 65% to the hospital and 35% to the psychiatrist**

Dr. Grant's observations

Constant patient observation—such as one-to-one staffing or 15-minute checks—is used to protect patients from harming themselves or others. One study of a psychiatric hospital[1] reported that 13% of psychiatric inpatients required constant observation.

Although one-to-one staffing and 15-minute checks help protect patients, they do not always prevent suicide. In fact, one-third of the approximately 1,500 inpatient suicides in the United States each year occur during one-to-one observation or 15-minute checks.[2,3]

Even 15 minutes is sufficient time to complete a suicide.[3] Common methods of inpatient suicide include hanging, overdosing, and jumping from high places.[4,5] One study found that 73% of inpatient suicides in a psychiatric ward occurred after 28 days of admission.[5]

The cost of constant observation may account for as much as 20% of the total nursing budget at a psychiatric hospital and up to 10% at a long-term care facility or general hospital.[6] The annual cost of constant observation can exceed $500,000, depending on the hospital's size and monitoring frequency.[6]

Determining responsibility

The outcomes of these 2 cases may appear inconsistent. In the first, the psychiatrist who assessed the patient as a moderate suicide risk was not negligent, even though the family claimed the patient was at high risk. In the second case, the psychiatrist was found partly liable for not maintaining a higher vigilance of suicide risk assessment.

Physicians cannot put every patient on one-to-one monitoring or 15-minute checks because of fear of suicide and malpractice litigation. These 2 cases demonstrate that if a suicide occurs, the courts will look for clinical reasons for the level of observation. The level of suicide precautions—one-to-one vs 15-minute checks—should be based on the patient's clinical presentation and supported by clinical rationale.[7]

Risk analysis

The courts look to see if the suicide assessment was "clinically reasonable".[8] To meet this standard, perform a "suicide risk-benefit analysis" each time you make a significant clinical decision, such as ordering 15-minute checks. The record should include information sources you used (such as family members or previous medical records), factors that entered the clinical decision, and how you balanced these factors in a risk-benefit assessment (***Box***).[9]

Risk factors. There are no documented suicide risk factors specific to an inpatient setting.[4] Suicidal ideation at the time of admission has been associated with greater chance for inpatient suicide,[5] but other research has found less than one-half of patients who committed suicide in a hospital were admitted with suicidal ideation.[2,7] Of those who were admitted with suicidal ideation and then committed suicide in the hospital, 78% denied these thoughts during their last communication with hospital staff.[2] Therefore, denial of suicidal ideation alone is not a reliable basis to determine suicide risk.

Document decisions. Mistakes in clinical judgment do not necessarily constitute negligence,[8] but deviations in the standard of care cannot be adequately determined

Clinical Point

78% of patients who were admitted with suicidal ideation and then committed suicide in the hospital denied these thoughts during their last communication with hospital staff

Box

Suicide risk factors to consider in the risk-benefit analysis

- **Suicidal thoughts or behaviors**—ideas, plans, attempts
- **Psychiatric diagnoses**—depression, bipolar disorder, schizophrenia, substance use, Cluster B personality disorders
- **Physical illnesses**—HIV, malignant cancers, pain syndromes
- **Psychosocial features**—lack of support, unemployment
- **Childhood traumas**
- **Genetic and familial effects**—family history of suicide
- **Psychological features**—hopelessness, agitation, impulsiveness
- **Cognitive features**—polarized thinking
- **Demographic features**—adolescents, young adults, and elderly patients
- **Other factors**—access to firearms, intoxication.

Source: Reference 7

in a court of law unless the clinician had documented his or her thought processes at the time of the decision.

Predicting which patients will re-experience or deny suicidal ideation is impossible,[7] but if the patient is determined to be at high risk for suicide, then implement and document a plan to address this risk. In addition, communicate information regarding the risk-benefit assessment to staff responsible for implementing these precautions.

When is this assessment made? The waxing and waning nature of suicidality requires that assessments be repeated over time.[7] Conduct a suicide risk assessment when:

- a patient is admitted for inpatient treatment
- observation status changes
- a patient's clinical condition changes substantially
- acute psychosocial stressors are discovered during the hospitalization.[7]

In the patient's chart, document this risk assessment, your decision-making process, changes in treatment, and communication with family members when you change the level of observation.[7]

Clinical Point

The court cannot adequately determine deviations in the standard of care unless the clinician documents his or her thought processes

References

1. Shugar G, Rehaluk R. Continuous observation for psychiatric inpatients. *Compr Psychiatry* 1990;30:48-55.
2. Busch KA, Fawcett J, Jacobs DG. Clinical correlates of inpatient suicide. *J Clin Psychiatry* 2003;64:14-9.
3. Bowers L, Gournay K, Dufy D. Suicide and self-harm in inpatient psychiatric units: a national survey of observation policies. *J Adv Nursing* 2000;32:437-44.
4. Proulx F, Lesage AD, Grunberg F. One hundred in-patient suicides. *Br J Psychiatry* 1997;171:247-50.
5. Shah AK, Ganesvaran T. Inpatient suicides in an Australian mental hospital. *Aust NZ J Psychiatr* 1997;31:291-8.
6. Moore P, Berman K, Knight M, Devine J. Constant observation: implications for nursing practice. *J Psychosoc Nurs Ment Health Serv* 1995;33:46–50.
7. American Psychiatric Association. Practice guideline for the assessment and treatment of patients with suicidal behaviors. Available at: http://www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05-15-06.pdf. Accessed April 19, 2007.
8. Simon RI. The suicidal patient. In: Lifson LE, Simon RI, eds. *The mental health practitioner and the law*. Cambridge, MA: Harvard University Press; 1998:166-86.
9. *Abille v United States*, 482 F Supp 703 (ND Cal 1980).