Learning from prevented suicide in psychiatric inpatient care: An analysis of data from the National Patient Safety Agency

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\section*{ABSTRACT}

Background: Inpatient suicide is a tragedy, and removal of the means is only a partially effective strategy.

Objectives: To identify the mechanisms by which attempted inpatient suicides are prevented, so that their use can become more widespread.

Method: Analysis of one year of nationally reported suicide attempts on inpatient psychiatric wards from the National Patient Safety Agency.

Results: Patients are discovered in the act by staff checks (medication rounds, meals, routine activities, and intermittent observation) and by staff being caringly vigilant and inquisitive (noticing the absence of patients, their psychological distress, physical state, responding to unusual noises, etc.).

Conclusions: The use of intermittent observation and other patient checks should be increased, and particularly directed to private areas of the ward. All staff should act on any sense of unease or feeling that something about a patient, their behaviour, or noises on the ward, are not right.

\section*{What is already known about the topic?}

- About 120 psychiatric patients complete suicide every year in England.
- Removal of the means to attempt suicide, most notably ligature points, has been the main preventive strategy.
- Although some inpatient suicides occur after the patient absconds from hospital, it is not clear that locking the ward door is an effective strategy.

\section*{What this paper adds}

- New strategies to reduce inpatient suicide in mental health settings.

1. Introduction

The death of a patient through suicide is a tragedy that psychiatric services strive hard to prevent. Those left behind, relatives, friends and staff, are traumatised. For the staff this can include longstanding impacts on their practice (Bowers et al., 2006), perhaps especially if they have been involved in finding the patient or trying to resuscitate them. The risk of suicide is one of the justifications for compulsory admission to hospital, and the suicide of an inpatient appears much more avoidable because of the continuous presence of staff, mainly nurses.

Yet both prediction and prevention of inpatient suicide are fraught with difficulty. The only known statistical predictors are previous suicidal behaviour and depressive symptoms, both of which apply to large numbers of
inpatients (Bowers et al., 2010). Removal of the means to suicide has been a major policy in England, specifically the removal of potential ligature points and the more widespread use of collapsible curtain and shower rails (Department of Health, 2001). While numbers of inpatient suicides have thankfully declined, it is hard to know for certain this is as a result of the policy, as numbers of admissions have also declined (The NHS Information Centre, 2009b). Anxiety about patient safety has led to England’s acute psychiatric wards locking their doors in the hope that this will prevent patients from absconding and killing themselves (Van Der Merwe et al., 2009). However there are indications that doing so makes patients feel further stigmatised, perhaps deepening their depression, and increasing rates of self harm (Bowers et al., 2008). Meanwhile alternative and equally efficacious means of reducing absconding by inpatients have been developed and are available (Bowers et al., 2003). Additional ways to prevent inpatient suicide are clearly required.

Serious attempted suicides occurring on the ward are usually seen as untoward events, prompting investigation and review as to what went wrong, and what service defects can be remedied. However these events can also be viewed as a success for the staff, as the completion of suicide was prevented. Adopting this point of view allows us to ask how attempted suicides are arrested, and what common staff actions achieve that end result.

Bringing this alternative view to bear upon national records collated by the National Patient Safety Agency (NPSA) provides sufficient numbers of cases, with enough information, to say what these preventive actions are. These actions are already saving lives. With the analysis below we identify and describe them, with a view to sharing them and intensifying their use across psychiatric services.

2. Method

2.1. The data

The NPSA is an arm’s length body of the Department of Health that works to identify and reduce risks to patients receiving NHS care. Through local trust risk management systems the NPSA collects anonymised reports of patient safety incidents from healthcare staff across England and Wales, which are mapped onto the NPSA’s central database: the Reporting and Learning System (RLS; http://www.nrls.npsa.nhs.uk/). For this study, data were extracted from the RLS regarding all attempted suicides occurring between 01st January 2009 and 31st December 2009 in mental health inpatient intensive care units, secure units or wards classified as one of the following specialties: adult mental health, forensic mental health, mental health rehab or older adult mental health. A total of 711 reports of attempted suicide were obtained and included information on the care setting of occurrence, specialty, location (intensive care unit/secure unit/ward), description of what happened, actions preventing reoccurrence, apparent causes, age at time of incident, gender, ethnic category, degree of harm (severity), date of incident, time of incident, and date incident received by NPSA.

2.2. Data analysis

To ensure that the sample only included reports of attempted suicide, reports where the person took their own life (n = 45) or where they expressed suicidal ideation but no act was described (n = 16), were excluded from the analysis. Reports of attempts made outside of the ward (n = 48) were also excluded, unless the suicide was prevented by the actions of ward staff. This left a total of 602 cases for analysis.

The field ‘description of what happened’ was analysed to obtain further information about the suicide attempt. Each report was read, and coded by a researcher into the following categories: the location of the attempt on the ward, the observation status of the patient, the method of suicide attempt, a description of methods of strangulation/suffocation (including ligature points used), the objects used (including ligature materials), and a summary of how the suicide was prevented. In some reports it was evident that a combination of interventions prevented the person from taking their own life. In such cases data was coded into the primary action (e.g. person found by staff) and then any subsequent action, or additional detail (found during checks, staff alerted to suspicious noise, etc.).

In order to distinguish between high risk attempts (where death would be a probable outcome of the act) and low risk attempts (where death would be a highly unlikely outcome of the act), the severity of each attempt was scored using the Lethality of Suicide Attempt Rating Scale (Smith et al., 1984). This is an 11 point scale which takes into consideration the lethality of the method used, and also the circumstances surrounding the attempt (such as the likelihood of someone being discovered). The scale ranges from 0 to 10 with each score expressing the probability that someone could take their own life as a result of the suicidal act. A score of 0 on the scale represents an act where ‘death is an impossible result of the suicidal behaviour’, and a score of 10 where ‘death is almost a certainty regardless of the circumstances or interventions by an outside agent’. In reports where the lethality of the act was unclear we sought guidance from colleagues at the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. In cases of self poisoning we consulted TOXBASE (http://www.toxbase.org/), the clinical toxicology database of the National Poisons Information Service, where we obtained information about the lethal doses of medications and other poisons taken.

The scoring system was adapted to take into account unique circumstances within psychiatric inpatient care, as according to the lethality scale, suicide attempts ‘where he/she is likely to be helped or discovered’ are given a lower score. In psychiatric inpatient care this would potentially include all people attempting suicide, especially those under observation. However, 22% of completed inpatient suicides occur while the patient is under some form of special observation (Appleby et al., 2006), and so patients under observation were not given a lower score. The scoring system was also modified for cases of self
poisoning as the Lethality of Suicide Attempt Rating Scale relies on LD₅₀ values to determine severity scores, which were not available for many of the substances used by people in the sample. It additionally is structured around whether the patient communicates the fact that he or she has taken the overdose. Consequently the following scoring system was applied for cases of self-poisoning: 8 = lethal dose taken and not communicated to others, 3.5 = lethal dose taken and communicated, 2 = non-lethal dose taken and not communicated, 1 = non lethal dose taken and communicated. For self-tied ligatures, where the report stated these were tied ‘tightly’ or in cases where it was evident that it was tight (e.g. patient unconscious, blue in face, use of ligature cutters necessary, etc.), these were scored as 7 or above, where they were described as tied loosely, they were scored as 3.5 or below.

A random sample of 100 reports was extracted from the data, and lethality scored independently by another researcher using the same scoring rules. Agreement between raters was evaluated using the intra class correlation coefficient (ICC). The two sets of scores were strongly correlated (ICC = .93, df = 84, p < .001), indicating the reliability of the adjusted scale.

The distribution of the lethality score was bimodal, which meant that the sample could easily be separated into reports of low severity and high severity suicide attempts (Fig. 1). Of the 602 attempts, 219 were classified as low severity, with scores ranging from 0 to 3.5 (mean 2.1; s.d. 1.01) and 244 were classified as high severity, with scores ranging from 5 to 10 (mean 8.0; s.d. 0.87). The severity of 139 attempts could not be determined from the information provided in the report, for example cases where there was no description of how tightly a ligature was tied (or no indication of such), or no information about the amount of medication taken. These cases were excluded from the analysis. Because we were interested in discovering the actions that prevented someone from taking their own life, only the 244 high severity attempts were analysed and are reported below.

Descriptive statistics were used to describe the basic features of the data (demographic characteristics, time and location of the attempt, method and objects used, and interventions preventing the suicide). Statistical tests (Chi-square, Spearman’s correlation, Mann–Whitney, z test of equality between proportions) were performed to reveal any relationships between these variables.

3. Results

3.1. Characteristics of people attempting suicide

Over two-thirds of the suicide attempts were by women (n = 171, 70%), with 50 attempts (21%) by men. In 9% of reports (n = 23) the gender of the patient was not specified. The majority of patients were from a white ethnic background (n = 139, 57%), 18 patients (7%) were from a minority ethnic background and the ethnicity of 87 (36%) patients was unknown. The average age was 34.4 years (s.d. = 11.70), and ranged from 17 to 77 years old. The vast majority of reports of attempted suicide came from acute psychiatric wards (85%, n = 208), a smaller number of attempts were reported on forensic wards (11%, n = 27) and very few from older adult mental health (3%, n = 8) and mental health rehabilitation (0.4%, n = 1) services. After taking into account the numbers of beds within each service nationally (The NHS Information Centre, 2009a), there were significantly more reports of attempted suicide on acute wards compared to other types of services (z = 6.38, p < .001), and the odds of an acute ward reporting an attempted suicide were over 7 times greater than for other wards (OR = 7.64, 95% CI = 5.36–10.89).

3.2. The suicide attempts

3.2.1. Method

The most commonly used method was strangulation, which was used in 82.4% of attempts (n = 201), followed by suffocation (9.4%, n = 23) and self poisoning (2.9%, n = 7). Less commonly used were exsanguination (1.2%, n = 3), jumping (1.2%, n = 3), collision with automobile (1.2%, n = 3), duplicate methods (1.2%, n = 3), and one person set themselves on fire (0.4%). In cases of strangulation 56.2% (n = 113) of people tied the ligature around their neck, while 40.5% (n = 82) used some kind of ligature point. Over 40 different ligature points were used and windows (5.5%, n = 11), doors (4.5%, n = 9), beds (3.0%, n = 6) and bathroom rails (2.5%, n = 5) were used most frequently. Six reports did not provide enough information to determine the precise method of strangulation.

3.2.2. Objects used

Over 50 different objects featured in suicide attempts, the majority of which were used as some kind of ligature, and were readily available to patients. Most commonly used were items of clothing or underwear (40.6% of attempts, n = 99), plastic bags (7.0%, n = 17), bed linen (6.6%, n = 16), electrical cables from objects such as hair straighteners or phone chargers (4.9%, n = 12) and medica-

![Histogram](image)

Fig. 1. The distribution of lethality scores.
3.2.3. Place

One hundred people attempted suicide while in their bedroom (41.0%), and a number of people attempted suicide in other private areas on the ward such as bathrooms and shower rooms (11.5%, n = 28), and toilets (9.8%, n = 24). A smaller number of attempts took place in ward outside areas (3.7%, n = 9), or outside of the ward itself (4.4%, n = 11). Very few attempts occurred in more public areas such as the living room (0.8%, n = 2), dining room (0.8%, n = 2), laundry room (0.8%, n = 2), corridor (0.4%, n = 1), dormitory (0.4%, n = 1), and quiet room (0.4%, n = 1). The location of 63 attempts (25.2%) was unknown.

3.2.4. Time

Chi square test of goodness of fit was performed to determine if the number of suicides throughout the day was equally distributed. A significantly higher proportion of suicide attempts occurred in the evening ($\chi^2 = 106.71$, $n = 234$, df = 23, $p = < 0.001$) with the highest number of attempts occurring between 18:00 and 21:00. There was also a peak in the number of attempts during the day between 11:00 and 13:00 h (Fig. 2).

There were no significant differences in the number of attempts occurring on each day of the week, however the number of suicide attempts were not equally distributed across each month of the year ($\chi^2 = 28.16$, $n = 244$, df = 11, $p = 0.003$). These differences did not appear to follow a coherent pattern, and were not related to the seasons of the year.

3.2.5. Relationships between patient characteristics and suicide attempts

Statistical tests (Spearman’s correlation, Mann–Whitney, z test of equality between proportions) were conducted to discover any associations between demographic characteristics and the suicide attempts. On average women had significantly higher severity scores than men (mean 8.1; s.d. 0.80 vs mean 7.8; s.d. 0.91, $U = 3511$, $z = 2.13$, $p < 0.05$). There were also significant differences in the proportions of men and women using different methods of strangulation, with a higher proportion of women using self ligatures than men (55% vs 33%, $z = 2.68$, $p = < 0.01$), and a higher proportion of men attaching ligatures to ligature points than women (29% vs 51%, $z = 2.59$, $p < 0.01$). There was no significant correlation between age and severity score ($r = −.063$, $p = 0.36$).

3.2.6. Preventative actions

The circumstances in which patients attempting suicide were discovered could be determined from 95% ($n = 233$) of reports. The vast majority (80%) of suicides were prevented because the patient was found by staff. A small number of people were prevented from jumping off hospital buildings by staff (1.2%), and a number of attempts were stopped because the person was found by a fellow patient (6.6%). Smaller numbers of people were found by domestic or security staff, police, or after a third party such as a friend or relative had alerted staff (3.2%). A few people changed their mind during the attempt and either activated an alarm, or revealed what they were doing (2.8%). Finally, some patients were unable to take their own lives due to a poorly designed method, or the management of the ward environment, such as the installation of collapsible curtain rails or window alarms (1.6%).

We examined reports of patients found by staff in more detail in order to discover more about the actions of staff preventing suicide. This level of detail was provided in 120 (62%) of these reports (Table 1). Some suicides were prevented because patients were under constant or intermittent observation.

Attempted suicides during constant observation were acts the patient concealed while in the presence of the observing nurse. Examples included:

- Ran into her bedroom, locking the door behind her, tying a ligature before access could be gained.
- Tying ligature underneath the bedclothes while in bed ($n = 2$).
wards
activities were conducted on patients. Patient's bedrooms were
physical assessment of
Table
Staff actions preventing suicide.

<table>
<thead>
<tr>
<th>Staff action</th>
<th>Freq.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant observations</td>
<td>7</td>
</tr>
<tr>
<td>Doing observations</td>
<td>1</td>
</tr>
<tr>
<td>Intermittent observations</td>
<td>48</td>
</tr>
<tr>
<td>Meal/drink checks</td>
<td>2</td>
</tr>
<tr>
<td>Meds round</td>
<td>4</td>
</tr>
<tr>
<td>Other normal daily activity</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Other checks</td>
<td>18</td>
</tr>
<tr>
<td>Staff caringly vigilant and inquisitive</td>
<td>32</td>
</tr>
</tbody>
</table>

- Allowed to go to the toilet unobserved while nurse waited outside the door, attempted suicide by suffocation while out of sight ($n = 1$), or by tying ligature ($n = 2$).
- Allowed to go to the toilet with door left open, but nurse stood to one side to give privacy. Ligature tied out of sight.

In two cases there was no explanation as to how the suicide attempt was made in the presence of an observing staff member, suggesting that observation had been incorrectly interrupted or terminated.

Attempted suicides during intermittent observation were discovered when the check took place. Other types of patient checks were also important. For example, some wards were implementing formal, regular checks of all patients. A number of people were found because of daily activities on the ward which meant that nursing staff were present in ward communal areas, or entered patient's bedrooms. These activities included staff offering patients a drink, calling them for dinner, or for their medication. 'Other daily activities' included staff entering patient's bedrooms to discuss an aspect of their care ($n = 2$), to conduct a psychological assessment ($n = 1$), to take their physical observations ($n = 1$), for a fire safety check ($n = 1$), or to ask if they wanted to go for a walk ($n = 1$). 'Other' cases where patients were found by staff were where staff were alerted by a fire alarm ($n = 1$) or noticed the patient's slipper outside the bathroom door ($n = 1$). A large number of patients were found because of staff being 'caringly vigilant and inquisitive'. This term encompassed seven different behaviours outlined in Table 2.

4. Discussion

One year of data on officially reported attempted suicides by psychiatric inpatients, collated by the NPSA, yielded 244 high severity incidents. Most attempts were by women and occurred on acute psychiatric wards. The most common methods used were strangulation and suffocation, and the most common objects utilised were items of clothing (belts and shoelaces predominantly) and plastic bags. Women were more likely to use self-ligatures compared to men, and men more likely to attach a ligature to a fixed point. The most common locations were bedrooms, bathrooms and toilets, and the most common times were the evenings, and during midday and evening nursing shift handovers. The vast majority of attempts were prevented from becoming completed suicides because the patient was found by staff. This was mainly due to staff implementing some form of checks, or because they were being caringly vigilant and inquisitive.

There are a number of limitations regarding the data used in this study. It may be that there are different reporting cultures within different services, and there may be a number of suicide attempts that are not reported. Consequently the data may not be entirely representative of the national picture. Also, patient identity is unknown and is not represented in any way in the sample. It may be that some people attempted suicide several times during their admission and this may make it difficult to interpret.

Table 2
Examples of 'caringly vigilant and inquisitive'.

<table>
<thead>
<tr>
<th>Action</th>
<th>$N$</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Following a patient in distress</td>
<td>2</td>
<td>“Patient was in the garden and came up crying and ran into her bedroom. Staff were close behind and followed her in.” “Patient was coming back from the garden with staff member and she ran off into the toilets. Staff was told to go back and follow her”</td>
</tr>
<tr>
<td>Listening carefully to safety calls</td>
<td>5</td>
<td>“Client was discovered in the toilets. Staff called out to patient but did not feel happy with the response” “I stood outside the bathroom door initially patient spoke to me but stopped communicating”</td>
</tr>
<tr>
<td>Noticing a patient’s absence</td>
<td>2</td>
<td>“Staff became concerned when patient was not in communal areas of ward” “Patient was found to be missing”</td>
</tr>
<tr>
<td>Noticing suspicious actions</td>
<td>8</td>
<td>“Patient was lying on her bed, turned on front and staff saw her elbow moving slightly”. “Patient was lying in bed with her sheet rolled up to her neck, I noticed shaking” “Staff observed patient’s head under the duvet”</td>
</tr>
<tr>
<td>Noticing that a patient appears physically ill</td>
<td>3</td>
<td>“Patient attended the office and was observed to be dazed and pale in colour” “I noticed that patient appeared very drowsy and was staggering”</td>
</tr>
<tr>
<td>Noticing that a patient is taking a long time in the toilet</td>
<td>2</td>
<td>“Patient went to the toilet and appeared to be taking a long time” “Client attended bathroom and was noted to be in the bath for too long”</td>
</tr>
<tr>
<td>Responding to an unusual noise</td>
<td>10</td>
<td>“I heard rustling from patient’s bedspace” “Staff heard a thud to the floor”, “I heard a banging noise from the one of the bedroom corridors” “Patient was heard coughing in his bedroom”</td>
</tr>
</tbody>
</table>
demographic data. There were some missing data in the sample where fields were left incomplete, and some that could not be further analysed because descriptions of what had happened were too brief. Our analysis was based on staff’s description of the event, which may not be the full account of what happened. There was certainly a wide variety in the level of detail provided by staff, with reports ranging from just a few sentences to over 550 words. Despite its limitations this data is the only national data available concerning attempted suicides in inpatient care, and this is the first time it has been systematically analysed in any detail. Some additional caution may be required in generalising our findings to countries other than England.

One of the more striking aspects of our data is the gender imbalance in suicide attempts. While this differential in self-harm rates is well known (Hawton et al., 2002), for inpatient completed suicide no such imbalance is consistently reported (Bowers et al., 2010). When the methods used during attempted suicide are compared to methods used during completed inpatient suicides (Appleby et al., 2006), while strangulation still dominates, all inpatient suicides together include a much higher proportion of ‘jumping/multiple injuries’. As men are more likely to use more violent methods (Ajdacic-Gross et al., 2008) and are also more likely to abscond from hospital (Bowers et al., 2000), it seems highly likely that the gender differential in our sample is partly linked to the location of the act. The only previous study to provide information on gender and location does show the proportion of males to be higher in those inpatients completing suicide outside the hospital (Appleby et al., 2006). The greater tendency of female inpatients to attempt suicide with self-tied ligatures may also contribute to the gender imbalance in our sample. While we only included cases where the ligature was tied tightly, it might be that this method is less likely overall to be effective, or more difficult to implement, in comparison to ligatures tied to a fixed point.

The role of staff supervision in suicide prevention is very clear. Most attempted suicides were discovered and prevented by staff, and those discoveries occurred through the checking of patients, particularly in the more private areas of the ward which were not open to public display. The checking on patients that occurs as part of normal routine (e.g. mealtimes, medication rounds) is an important mechanism by which prevention occurs, as is the use of intermittent observation. Intermittent observation is well tolerated by patients (Whittington et al., 2009), and high usage on a ward has been shown to be associated with low rates of self harm (Bowers et al., 2008). It is possible that for some of the suicide attempts in our dataset that occurred during intermittent observation, the intent may not have been as serious, as the patients may have calculated that they would be found prior to completion. However it is also known that 19% of completed suicides on the ward are under intermittent observation (Appleby et al., 2006). Thus some patients attempting suicide during intermittent observation clearly do have a strong enough intent to succeed and so our data suggests that it is effective in preventing suicide for some. This tallies with the common use of intermittent and constant observation, with constant being initiated when a period of intermittent is seen as too risky (Kettles and Paterson, 2007), and intermittent initiated after constant, as risk is assessed to decline and as a step down mechanism (Pauker and Cooper, 1990).

The use of intermittent observation does have a cost in terms of staff time. The cost in staff time of intermittent observation for one patient during one shift is a third of constant observation. However, because intermittent observation is used more frequently than constant observation, English acute wards have been estimated to spend £45.5 million on intermittent, and £35.5 million on constant observation in 2005 prices (Flood et al., 2008). The modernisation of psychiatric wards and the increase in single person bedrooms seems likely to have increased the workload of psychiatric nurses in order to maintain a similar level of supervision. It is known that environment complexity and various forms of staff observation naturally interact to produce an even level of ‘surveillance’ (Stewart and Bowers, 2011).

Our data does shed a little more light on how patients manage to successfully complete suicide during constant special observation. One previous study has reported this to occur when nurses informally cease to carry out the observation in order to undertake other tasks (Gale et al., 1980). Our data shows this can also happen when patients conceal plastic bags or ligatures under the bedclothes, when they are allowed privacy in the toilet, and when they can run into a private area and lock doors behind them. Nurses therefore need to be alert during constant observation. Observation during urination and defecation is clearly a sensitive issue and nurses are understandably reluctant to enforce this. Yet clearly there are a small number of desperate and unwell patients who are driven to exploit this opportunity.

The importance of general observation and supervision is also highlighted by the timing of the attempts, with most occurring in the evening and night hours, with peaks during the usual times of nursing shift handovers. These are all times during which nursing supervision is at a reduced level, although it is also possible that diurnal mood variation contributes to this pattern. Simple methods to increase staff presence and supervision during handovers and evening hours may aid in suicide prevention or early detection of attempts. The roles and activities of night staff up till midnight may be also usefully reviewed in order to maximise observation and supervision of patients. Low staff to patient ratios during the evening and early night should be avoided.

In addition to the role of supervision and patient checks in preventing suicide, the other significant mechanism is what we have called being ‘caringly vigilant and inquisitive’. This short phrase captures the nursing staff’s thorough knowledge of the patient as a person, together with a constant and consistent attentiveness to their state of mind, whereabouts, and safety. That attentiveness is also global, in that unusual circumstances and noises are noticed and investigated. The capacity to increase the process of being caringly vigilant and inquisitive through education is not known, however it is possible that simply knowledge that this saves lives may motivate nurses to redouble their efforts.
Together, these findings highlight the efficacy of inpatient care as a life preserving measure, and act as a corrective to the negative comments which can sometimes be made about this component of a comprehensive psychiatric service. Moreover, checking on patients and being caringly vigilant and inquisitive are unlikely to be the only way in which psychiatric wards prevent suicides. The identification and effective treatment of depressive symptoms by medical staff will be another (National Institute for Clinical Excellence, 2004), as will impersonal support and encouragement from nurses and other disciplines (Cutcliffe and Stevenson, 2007). Given that we have identified 244 severe attempted suicides in hospital in the course of one year, and that there are approximately 50 completed suicides per year, it seems clear that many more lives are saved during inpatient care than are lost.

5. Conclusions

Inpatient suicide prevention strategies should include the increased use of intermittent observation and other patient checks. These should be particularly employed to check the private areas of the ward (bedrooms, bathrooms and toilets) and during nursing handovers, the evening and night. All staff of whatever discipline should strive to be caringly vigilant and inquisitive, and should act on any sense of unease or feeling that something about a patient, their behaviour, or noises on the ward, is not right. Staff conducting constant observation should be particularly aware of the risks of patients concealing actions under the bedclothes, suddenly running into lockable areas, or acting while unobserved in the toilet. Further research on intermittent observation is required, particularly to address how and when to utilise intermittent or constant observation for maximum preventive efficacy.

Conflict of interest: The views expressed are those of the author(s) and not necessarily those of the NPSA, East London Foundation NHS Trust or the Department of Health.

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Ethical approval: This study was service evaluation, therefore no ethical review was required under UK regulations.

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