Manitoba
Health, Seniors and Active Living

Patient Safety Learning Advisory

Death by Suicide in Facility

Summary:

A personal care home (PCH) resident completed suicide by hanging in the facility.

This resident was admitted from acute care six weeks prior to death. Suicide assessment completed at the acute care site and the information related to chronic suicidal ideation was relayed to the PCH.

Keywords: suicide, personal care home, mental health

This review is based on a single event.

Findings of the Review:

Information transfer occurred from the acute care site to the PCH and included all pertinent information related to a history of depression and suicidal ideation. Documentation on the PCH admission assessment indicated previous mental health involvement but past suicidal ideation was indicated as “no”.

The suicide risk assessment in the acute care site did not indicate an active risk for suicide. It was reported after admission to the PCH that the resident’s mood and behavior had improved.

There is a lack of knowledge of suicide assessment in facilities. This is a new Accreditation Canada Required Organizational Practice (ROP). A process has been implemented to audit compliance of this ROP.

The resident was cognitively aware and orientated to time/place/person. The resident typically kept the door to their room open with the light on. The resident valued their independence and preferred privacy in their room. During rounds, the door was noted to be closed. The ward was noisy that night with call bells ringing and it was assumed that the door was closed due to noise.

The resident was found deceased after having been last seen three hours prior.

System Learning:

Facilitate and support enhanced education related to the Accreditation Canada Suicide Assessment Required Organizational Practice (ROP).

Finalize and implement a policy related to observation checks of PCH residents.

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