Analysis of Inpatient Suicides in Health Care Institutions from Taiwan Patient Safety Reporting System

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Objectives:
From the data of Taiwan Patient Safety Reporting System, we try to understand the situation of inpatient suicide and offer recommendations for medical practice according to the analyzed results.

Methods:
Since 2003 Taiwan Joint Commission on Hospital Accreditation (TJCHA) had began planning to establish Taiwan Patient Safety Reporting System (TPR), the system formally launched in 2005, which was an anonymous, voluntary and learning purposed reporting system, the medical care provider from the institutions that accepted to take the system informing any seen and heard unusual patient safety incidents, including near miss events. Data were collected from year 2005 to 2010 and 134,190 cases in total, which included 916 inpatient suicides. In this study, analysis of the place, time, and behavior characteristics on the cases to understand the status of patient suicides, and according to the analysis results to offer proposals to provide health care institutions.

Results:
In the 916 cases, inpatient suicide occurred mostly in general hospitals, a total of 623 (68.0%) cases, 229 (25.0%) cases in psychiatric hospital, 15 (1.6%) cases in nursing home, 7 (0.8%) cases in psychiatric rehabilitation institutions, 5 (0.5%) cases in other health care institutions, and 37 cases were not filled by reporters (Figure 1). In these patient suicide cases, 62 (6.8%) resulted in death, 140 (15.3%) resulted in very severe and severe harm, 395 (43.1%) resulted in moderate and minor harm, 205 (22.4%) resulted with no harm, 75 (8.2%) were near miss, 31 (3.4%) were with a degree of injury that was not able to determine, 8 (0.9%) cases were unknown. The cases were further differentiated between the division unit where the suicidal patient stayed and the severity, and the results showed as Figure 2 and the table below. Further analysis of 46 suicidal deaths in non-psychiatric units, 37 were inpatients, 3 were outpatient, 3 were emergency patients, and 3 were unknown; in suicidal death of inpatients, 22 were internal medicine patients, which took the biggest proportion, followed by 7 surgical patients, and the other 3 were oncology patients.

Conclusions:
According to the analysis on patient suicides from Taiwan Patient Safety Reporting system, the proportion on reported cases and deaths of non-psychiatric unit in general hospitals is higher than that in psychiatric units and psychiatric hospitals. Relative comparison with psychiatric unit on the strict access, goods and environmental control, the prevention of patient commit suicides in general care unit was more difficult, showing that systematic conducts, such as working processes and training were required for the general care providers to strengthen the ability of assessing the tendency of suicidal patients and be able to transfer the patients.