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Nurses' experiences of inpatients suicide in a general hospital[☆]Mirriam Matandela, Mokgadi C. Matlakala^{*}

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ABSTRACT

When suicide occurs, it is regarded as an adverse event. Often, little attention is given to the nurses who cared for the patients prior to the adverse event. Instead the affected nurses are expected to write statements and incident reports about the adverse event. The aim was to explore the experiences of nurses who cared for patients who successfully committed suicide whilst admitted at a specific general hospital in Gauteng Province, South Africa. A qualitative exploratory research was conducted. Data were collected through in-depth interviews with a purposive sample of six nurses and content analysis was done. Nurses experienced feelings of shock; blame and condemnation; inadequacy and feared reprisal. This study suggests a basis for development of support strategies to assist the nurses to deal with their emotions following experience of adverse events.

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1. Introduction and background

The World Health Organization (WHO)'s global report on violence and health indicates that one person commits suicide every 40 s, and that approximately one million people of all ages die from suicide every year (WHO, 2012). The WHO further estimates that by 2020, these figures may have increased to 1 death every 20 s. A study on the profile of suicide in South Africa indicate that suicide accounted for 7.7% of all non-natural deaths in South Africa (Alberdi-Sudupe et al. 2011). According to Burrows and Schlebusch (2008) 6500

suicides occur annually in South Africa. Gauteng province was dubbed the second leading province in South Africa with regard to high suicide statistics (Uys & Middleton, 2010). However, there is limited literature on general hospital based suicides in Gauteng province, except for incidents reported on the media.

Suicide is described as the act of taking one's own life. It is multi-factorial in nature, with associated risk factors such as demographic factors, psychiatric disorders, terminal or chronic medical conditions and recurrent unresolved psychological stressors (Masango, Rataemane, & Motojesi, 2008). Different methods of committing suicide include amongst

[☆] This study suggests a basis for development of support strategies to assist the nurses to deal with their emotions following patient suicide incidents in a general hospital. The study will contribute knowledge to the importance of designing and strengthening Employee Assistance Programmes for nurses who experience such serious adverse events.

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others, shooting, hanging, poisoning, gassing and burning and jumping from heights. Suicide can be committed anywhere including at home or even in hospitals.

The Joint Commission (2010) indicates that 14.25% of suicides occur in the non-behavioural units of the general hospitals such as medical or surgical units. Knoll (2012) indicates that 'inpatient suicides do occur in the medical settings and are viewed as the most avoidable and preventable because they occur in close proximity to staff. Therefore hospitals are faced with adverse events when patients commit suicide. Some patients sustain serious injuries before or may die instantly. When suicide occurs in general hospitals, it poses challenges to health care workers, including nurses who witness or care for these patients before they die, as well as the patients' families, and hospital administrators (Knoll, 2012). The patients include those who are admitted for conditions such as respiratory, cardio-vascular, endocrine, haematological and renal diseases rather than mental illness. Whilst the cause of suicide is often not known, some conditions may lead to confusion; whilst some patients may not accept their disease status; and therefore resort to suicide. According to Cheng, Hu, and Tseng (2009) inpatient suicides often have devastating effects on survivors and on staff morale. However, there is limited literature on the experiences of nurses who cared for patients who successfully committed suicide in the general hospital units such as medical wards.

When a patient commits suicide in hospital, it is regarded as an adverse event. The National Core Standards for Health Establishments in South Africa indicate that adverse events are sub-domain in the domain of Patient Safety, Clinical Governance and Clinical Care domain which includes support of any affected patient or staff (National Department of Health, 2011). The criteria in this sub-domain requires that the health establishment actively encourages reporting of adverse events. Therefore each health establishment should design a procedure to report the adverse event.

In this specific hospital, management of such adverse events includes in-depth investigation of the incident. A procedure of writing incident reports, often called statements, file analysis by quality assurance coordinators, clinical managers and nurse managers is followed to investigate the incident. The reports are written to assess the clinical status of the patient prior to the incident, to facilitate preliminary investigation. Inpatient suicide is an unnatural death that is reported to the South African Police Services (SAPS) who further request statements from nursing personnel involved. Post-mortem of the deceased, in case of successful suicide is mandatory as part of investigation for confirmation of injuries that led to the death of the patient.

Nurses are the frontline workers in providing nursing care to patients in the hospitals. When adverse events such as patient suicide occur, they raise concerns from hospital authorities, the media, the police, the community as well as the affected family. The nurses that were involved in the care of these patients have to provide full details of any action, care plans and are expected to write reports on the occurrence of the incidents. Following such adverse events, the anecdotal observations of the researchers is that the

affected nurses absent themselves from work or are admitted in hospital with stress. If there is any alleged negligence of the patient who committed suicide, the nurses may be required to appear before disciplinary hearings in their institutions and eventually the South African Nursing Council (SANC) if the incidents are related to nursing omissions.

2. Problem statement

In the specific hospital for this study, four patients committed suicide whilst admitted in the medical unit of the specific hospital during the period 2008–2012. All the patients were males, aged 39–48 years. The patients jumped through the windows from the 3rd floor of the medical ward. During the adverse event, hospital managers focused on getting written statements from the nurses involved, addressing the families of the deceased, and reporting the incident to the relevant authorities. Essentially, (in the nurses perceptions) hospital managers became more concerned about the impact that the adverse event would have on the family, hospital budget, the image of the institution and the perception of the community towards the institution. Very little attention was given to nurses that were involved and affected by the adverse events.

The nurses were very traumatized by the events, had to go through the stress of having to explain what happened, and were in fear of being disciplined and reported to the SANC. Anecdotal information indicates that the reactions such as guilt, anger, self-blame, sadness, fear, and feelings of failure were observed from the affected nurses. Some nurses absented themselves from work; whilst others were admitted in hospital with depression or stress following the suicide incidents.

3. Aim

The aim of this article is to present the experiences of nurses who cared for patients who successfully committed suicide while admitted in a general hospital in Gauteng Province, South Africa.

4. Research design and method

A qualitative design was used (Denzin & Lincoln, 2011), following interpretivism (Creswell, 2009). This design was deemed suitable because the researchers needed a complete understanding of the experiences from the affected nurses (Babbie, 2012; Burns, Gray, Grove, Behan, & Duvall, 2012). The epistemological assumption of this study was that to understand the experiences of nurses following patient suicide, it is important to allow them to narrate their feelings following the incidents.

The study was conducted at an urban general hospital in Gauteng Province, South Africa. The hospital is a five level-storey high rise; and the medical unit is situated on the third floor of the building, is twenty-five bedded with big glass

windows without shatter proofs; and cubicles with glass doors leading to the balcony. The balcony doors were not locked as they were regarded as emergency exit doors. The hospital was chosen based on the four incidents of patient suicides, which happened during the period 2008–2012 (Gauteng Provincial Government, 2013).

The accessible population of this study was nurses licensed to practice by the SANC, who were working at the selected general hospital. Purposive sampling was used to select a sample of the nurses employed in the medical units of the hospital during the period 2008–2012; who were involved in caring for patients who committed suicide whilst admitted in the medical unit, to provide information about their experiences following such adverse events. These nurses were general registered professional nurses and enrolled nurses who did not possess any additional qualification or training in psychiatry or mental health in order to deal with suicidal patients.

5. Data collection

Data were collected through individual in-depth interviews with the nurses who were willing to participate (Burns et al. 2012). The interviews were audio recorded with the permission of the participants. Six interviews took place at mutually acceptable venues and times within the hospital setting, during the period July 2013 until October 2013. The sample size was determined by the number of eligible nurses who were available and willing to participate in the interviews. The sample was small because there is only one medical unit where the incidents occurred.

6. Data analysis

Audio recorded interviews were transcribed verbatim (Creswell, 2012). The transcripts were printed and data analysis was done following a manual generic qualitative content analysis (Polit & Beck, 2008). Each transcript was analysed to identify statements that told each participant's narrative of their experience. A consensus meeting was held by the researchers to develop and verify similar themes from the transcripts. The emerged themes are discussed as the experiences of the participants, supported by narrative extracts.

7. Trustworthiness of the study

The researchers had adequate engagement with the participants in the medical unit. Information was gathered from those nurses that had experience of caring for a patient who successfully committed suicide whilst admitted in medical unit, to ensure that the data was truthful/believable. The transcribed interviews and data analysis process were evaluated by an independent reviewer, to ensure dependability (Krefting, 1991). The possibility of transferability of the findings depended on the comprehensive description of the experiences. However, because people experience incidents in different ways the nurses could apply the findings to their

own situations. On the spot member checking was done with the participants during the interviews to confirm that what was captured was indeed the information intended to share. Peer review was done by constant discussion and feedback between the researchers. An audit trail of the methods was kept to ensure objectivity of the study (Krefting, 1991).

8. Ethical considerations

Ethical approval was obtained from the Department of Health Studies Higher Degrees Committee, UNISA. Permission to conduct the study was sought and obtained from the Gauteng Department of Health and the management of the hospital, through their ethical committees following provision of relevant documentation from the researchers. Written informed consent was obtained from the participants, following provision of adequate information regarding the research aim. Voluntary participation and freedom to decline participation was emphasised to the participants. The rights of the participants were protected through respect, justice and beneficence (Burns et al. 2012). Privacy and confidentiality was maintained in that the names of the participants were not revealed and the audio tapes were identified by the dates on which the interviews were conducted only. Emotional disturbance as a risk was anticipated; as the interviews could expose deep seated fear and anxiety that were previously repressed. Care was taken to prevent emotional harm (in that the participants were explained to that they could withdraw from the interview should they feel so).

9. Results

Five themes were identified. The participants reported their fears and emotional reaction of the aftermath of the suicide incidents.

9.1. Experience of disbelief and helplessness

The nurses expressed feelings of disbelief on the level of the unit as a health hazard that the patients found to be useful as a tool to commit suicide. Discovering the body of the patient who jumped out of the window made the nurses feel shocked as indicated:

'The patient flew down like a bird. That was shocking. I didn't even want to go to lower ground to see that patient the way I was shocked, shivering'.

'One patient just opened that door and went through. Just imagine from third floor to lower ground. It is a shocking, depressing and frustrating experience'.

'That corpse was crushed. I always experience visual hallucinations'.

The experiences of disbelief were accompanied by feelings of helplessness as the participants indicated that they felt the

institution exposed them to risks by not considering the safety of the patients; whilst holding them accountable for the adverse events as stated:

'Doors leading to the balcony are not locked. Suicidal patients can easily jump from the balcony and thereafter we will have to account. Really patient safety is compromised'.

'When these incidents happen, I have to account. The fact that the unit is not safe is not even looked into'.

9.2. Feelings of blame and condemnation

The participants feared the family's reaction to inpatient suicide, and response to the loss of their loved one. The nurses experienced evidence of blame directed to them; and were also condemned for the suicide. The participants felt threatened by the families as indicated:

'The family demanded answers from us as nurses and we didn't even know that the patient was intending to kill himself'.

'I remember this woman who pointed a finger at me and said I will make sure that you will never work again'.

'This woman said you are responsible for my brother's death. Actually your cruelty caused my brother to choose to jump through a window than to be taken care of by you'.

9.3. Feelings of guilt and inadequacy

The participants indicated that they felt inadequate as they could not recognise altered behaviour that could lead to suicide. The participants' descriptions of suicidal patients indicated that the patients' behaviours were very unpredictable and self-destructive, and therefore the patients withheld their suicidal intentions from the nurses.

'Patients who successfully commit suicide appear normal. They never pre-empt what they will do, so no-one predicts'.

'Feelings of guilt and inadequacy overwhelmed me, I started asking myself what could I have done better should I have known that the patient was going to brutally kill herself like that'.

9.4. Emotional reaction

The findings revealed that the nurses were negatively affected by the experiences of patient suicide. The nurses' emotional reactions to suicide included stress, self-blame, emotional trauma and depression. The participants mentioned the following:

'I was stressed, my heart was painful and I could not sleep that day. I was just rolling in my bed seeing the picture of the patient.'

'It was traumatising and depressing. I'm still on anti-depressants now. I even dream about it'.

The participants felt responsible for the suicides and blamed themselves for the occurrence as indicated in the following extracts:

'I blamed myself, I could not sleep, I felt like I have killed the patient. I felt like the observation that I did the whole night was not enough'.

'I felt like I have failed the family because they trusted me with their family member'.

'It feels like whatever was done for the patient was not enough because now the patient has chosen to die than to be taken care of'.

9.5. Fear of reprisal

The participants indicated that they feared to lose their jobs, based on the decision of the employer about the future of the involved personnel.

'I thought of being removed from the South African Nursing Council register'.

10. Discussion

According to [Takahashi et al. \(2011\)](#) patient suicide is an extremely serious incident for medical professionals. [Fang et al. \(2007\)](#) mentioned health care professionals undergo significant levels of psychological stress during suicide events. The findings of this study indicated that inpatient suicide affected the nurses negatively because they became shocked, frustrated, traumatised and depressed. [Shimozono \(2003\)](#) suggests that successful suicide of a patient represents a critical event for a nurse who was in charge of or had some contact with the patient. It is evident that the sight of the deceased bodies after the incidents traumatised the nurses. Some developed visual hallucinations, emotional trauma and depression. The nurses blamed themselves for inpatient suicide, felt incompetent, inadequate, guilty and responsible for the patients' death. They felt that they failed both the patient and the family. [Uys and Middleton \(2010\)](#) indicate that common reactions experienced by caregivers are guilt, anger, self-blame, sadness, fear and feelings of professional failure. On the other hand [Fukuyama \(2004\)](#) indicates that the nurse may blame him/herself and experience feelings of worthlessness associated with inability to prevent the patient's death.

The manner in which patients committed suicide brought shock and disbelief to the participants. A hospital is regarded as a refuge where patients are protected from their own self-destructive tendencies; and where hope for their future is communicated to them ([Ballard et al., 2008](#)). However, in this study the patients used the hospital as a place where they fulfilled their self-destructive behaviour by successfully committing suicide. [Neville \(2013\)](#) recommends that suicidal patients should be nursed in an environment that is free from hazards that might be used as methods of committing suicide. [McGuire \(2011\)](#) revealed that weaknesses in the environmental safety were the root cause of suicides. While patients

in psychiatric units commonly commit suicide by hanging those in the medical wards commonly jump from heights (McGuire, 2011). A safe environment can be created by restricting access to heights, preventing rooftop access, locking doors and closing windows.

Different reactions were demonstrated by families and those reactions caused the nurses to be stressed, as some relatives blamed nurses for the death of their loved ones. The findings of this study revealed that blaming was directed at the nurses who were afraid to talk back. Expressing bitter feelings is often considered by nurses and other medical professionals to be giving in to one's weaknesses and exposing one's helplessness to others. Nurses fear that disclosure of their weaknesses would damage their professional reputation, and this fear could be one of the reasons for not speaking up (Takahashi et al. 2011).

However, it was evident that the nurses did not predict that the patients would commit suicide because no suspicious behaviour was demonstrated by the patients. This may have been also related to the fact that the nurses were not adequately trained to care for suicidal patients. Hence, it was not possible for nurses to prevent the occurrence of inpatient suicide. The nurses' description of suicidal patients included unpredictable patient behaviour. Fukuyama (2004) indicated that nurses who have lost a patient due to suicide are troubled by the thought that they may be responsible for the death. This sense of guilt and self-condemnation can result in depression. The findings of this study could not confirm the reasons for suicide because the patients successfully committed suicide without presenting a suspicious behaviour (Kneisl & Trigoboff, 2013).

The nurses feared loss of their jobs when patients committed suicide. Their concerns were that the Department of Health will apportion blame on them. When suicide incidents occurred, nurses reviewed their reasons for becoming nurses; and thoughts of reconsidering career change are common reactions among nurses (Kneisl & Trigoboff, 2013). However, none of the nurses indicated change of the career except that they were more concerned about the decision that will be taken by the employer (Department of Health) and the regulating body (SANC) about their career. This study showed that nurses understood the functions of the SANC and the Department of Health, hence, their concern was about the decisions that would be taken by the SANC and the employer. Loss of job was their greatest fear as nurses thought of worst decisions such as being de-registered from the SANC. It follows that the nurses had to live with those feelings which resulted in others being treated with anti-depressants. However, the medications only suppressed the feelings. This indicates the need for support for the nurses to cope with their experiences of inpatient suicide.

10.1. Recommendations regarding support for nurses practice and policy making

Develop a debriefing strategy for employees who experience inpatient suicide. The hospital should if not available, revive the employee and wellness assistant programme for nurses within the hospital and refer them following experience of adverse events. The hospital should in consultation with staff ensure to

move risky units to the lower ground and design layouts that will minimise risks. The units should develop support strategies for the nurses and families of patients who committed suicide. Development of continuous in-service training for the nurses on patient risky behaviour is also essential.

10.2. Limitation of the study

The study was conducted in one general hospital in Gauteng, with a small sample of nurses, therefore the findings cannot be generalised to other general hospitals.

11. Conclusion

When suicide occurs it is regarded by the hospital authorities as a adverse event. Often, little attention is given to the nurses who cared for the patients prior to the adverse event. This study suggests a basis for development of support strategies to assist the nurses to deal with their emotions following patient suicide incidents in a general hospital. The study will also help hospital authorities to strengthen Employee Assistance Programmes for nurses who experience such serious adverse events.

Authors' contributions

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