Protecting our most vulnerable patients -

Preventing Patient Suicides
COURSE DESCRIPTION:

- This course is designed to educate staff about the risk factors for suicide, the warning signs that may indicate imminent action, and how to be alert to changes in behaviors or routines of persons at risk.
OBJECTIVES:
- Describe risk factors for suicide.
- Discuss signs that may indicate imminent action.
- Describe actions to take if changes in routines or behaviors of persons at risk are noted.
- Describe common myths related to mental illness.
Ensuring the safety and security of our patients is also very important. Some of our most vulnerable patients are those at risk for suicide.
National Patient Safety Goal 15.01.01

- National Patient Safety Goal 15.01.01 requires hospitals to identify individuals at risk for suicide. The elements of performance for this goal include:
  - Conducting a risk assessment that identified specific individual and environmental factors that increase suicide risk.
  - Address the individual’s immediate safety needs and determine the most appropriate setting for treatment.
  - Upon discharge provides appropriate follow-up information to the patient/family.
Which patients are “at risk” for suicide?

According to a The Joint Commission (TJC) Sentinel Event Alert focusing on preventing patient suicides, all patients in a general hospital setting should be screens for suicide.

- Known risk for suicide
  - Individuals admitted to general hospitals immediately following suicide attempts or individuals seeking help in the emergency department when they are most desperate.

- Unknown risk for suicide
  - Many patients who kill themselves while hospitalized do not have a psychiatric history or a history of suicide attempts.
The TJC Sentinel Event Database includes 827 report of inpatient suicides.

- 14.5% occurred in non-behavioral health units of general hospitals.
- 8.02% occurred in the emergency department.
- 2.45% occurred in other non-psychiatric settings (home health, long term care facilities, and rehab hospitals).
According to TJC locations where patient suicides have occurred include:

- Bathrooms
- Closets
- Showers

Many have occurred after the patients were discharged or were leaving against medical advice.
Methods of Patient Suicides Reported to TJC

- Hanging
- Asphyxiation by other than hanging
- Gunshot
- Jumping from a height
- Overdoses or ingesting poisons
- Cutting or stabbing
- Other
Objects used by patients in the healthcare environment to attempt suicide:

- Call light cords
- Sheets
- Bandages
- Plastic bags
- IV or oxygen tubing
- Restraints
Contributing Factors

- Other factors that may contribute to inpatient suicides include:
  - Ineffective staff education or training
  - Staffing levels
  - Communication issues
  - Misconceptions about mental illness among care providers
  - Inadequate patient screening and care planning
  - Inadequate observation of patients at risk
  - Lack of information about suicide resources
The statistics on suicide are surprising
- Men take their lives at four times the rate of women
- Men age 75 and older have the highest suicide rate
- The highest rate of suicide attempts occurs in the 18 – 25 age group.
Risk Factors for Patient Suicide

- Previous suicide attempt
- Recent suicide attempt
- Verbalizing suicidal thoughts or exhibit suicidal behaviors
- Family history of suicide or psychiatric illness
- Being on antidepressants
- Physical health issues
- Diagnosis of delirium or dementia
- Chronic pain or intense acute pain
- Social stressors – financial pressure, family problems, unemployment
- Substance abuse
- Loneliness
- Recent bereavement
Warning Signs for Patient Suicide

- Irritability
- Increased anxiety
- Agitation
- Impulsivity
- Decreased emotional reactivity
- Complaints of unrelenting pain
- Crying spells
- Declining offers of medication
- Requesting early discharge
Medications associated with increased risk of suicidal thoughts and behaviors:

- Antidepressants
- Antiepileptic medications
- Anticonvulsants
- Antipsychotic agents

Medications associated with suicide:

- Some smoking cessations medications
- Anti-infectives (interferons, mefloquine)
To protect patients, it is important to identify patients at risk of suicide and intervene to prevent harm for those identified as being at risk.

It is important to recognize both long-term risk factors and “red flags” which might indicate imminent risks.
Screening Factors to Consider

- Signs of imminent risk
  - Acute signs of depression, anxiety, agitation, delirium or dementia
  - Intoxication with drugs or alcohol
  - Medical or psychological problems which would impact judgment
  - Terminal conditions, debilitating illness
  - Uncontrolled pain
  - Verbalizing desire to end life
Screening Factors to Consider

- Other factors to consider
  - History of suicide attempts
  - History of mental illness/depression
  - Medications
  - Patient age and gender
  - Living situation
  - Recent loss of loved one
  - Recent loss of job or financial status
  - Family history of mental illness or suicide
The proper identification of patients at risk and prompt intervention is the key to suicide prevention!
Interventions to Prevent Suicide in High Risk Patients

- Partner with medical staff to address concerns related to patient safety.
- Ensure the patient at risk is monitored continuously by sitter.
- Check room for contraband or items that could be used for patient to harm self.
- Ensure that to the extent possible, the patient is involved in determining the plan of care.
- Incorporate population specific approaches are included in care.
- Include suicide risk factors and intervention in patient handovers and handoffs.
One of the most important things you can do is to help our patient’s is to learn more about mental illness. It’s important that you be able to understand mental illness and separate myth from fact.
Myth: There's no hope for people with mental illnesses.
Fact: There are more treatments, strategies, and community supports than ever before, and even more are on the horizon. People with mental illnesses lead active, productive lives.
**Myth:** I can't do anything for someone with mental health needs.  
**Fact:** You can do a lot, starting with the way you act and how you speak. You can nurture an environment that builds on people's strengths and promotes good mental health. For example:

- Avoid labeling people with words like "crazy," "wacko," "loony," or by their diagnosis. Instead of saying someone is a "schizophrenic" say "a person with schizophrenia."
- Learn the facts about mental health and share them with others, especially if you hear something that is untrue.
- Treat people with mental illnesses with respect and dignity, as you would anybody else.
- Respect the rights of people with mental illnesses and don't discriminate against them when it comes to housing, employment, or education. Like other people with disabilities, people with mental health needs are protected under Federal and State laws.
Myth: People with mental illnesses are violent and unpredictable.
Fact: In reality, the vast majority of people who have mental health needs are no more violent than anyone else. You probably know someone with a mental illness and don't even realize it.
Myths and Facts from:
Substance Abuse & Mental Health Services Administration Center for Mental Health Services

- **Myth:** Mental illnesses cannot affect me.
  **Fact:** Mental illnesses are surprisingly common; they affect almost every family in America. Mental illnesses do not discriminate—they can affect anyone.

**Myth:** Mental illness is the same as mental retardation.
**Fact:** The two are distinct disorders. A mental retardation diagnosis is characterized by limitations in intellectual functioning and difficulties with certain daily living skills. In contrast, people with mental illnesses—health conditions that cause changes in a person's thinking, mood, and behavior—have varied intellectual functioning, just like the general population.
Myth: Mental illnesses are brought on by a weakness of character.
Fact: Mental illnesses are a product of the interaction of biological, psychological, and social factors. Research has shown genetic and biological factors are associated with schizophrenia, depression, and alcoholism. Social influences, such as loss of a loved one or a job, can also contribute to the development of various disorders.
Myth: Once people develop mental illnesses, they will never recover.
Fact: Studies show that most people with mental illnesses get better, and many recover completely. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.
**Myth:** Therapy and self-help are wastes of time. Why bother when you can just take one of those pills you hear about on TV?

**Fact:** Treatment varies depending on the individual. A lot of people work with therapists, counselors, their peers, psychologists, psychiatrists, nurses, and social workers in their recovery process. They also use self-help strategies and community supports. Often these methods are combined with some of the most advanced medications available.
Be empowered – save a life. Use your chain of command to ensure your at risk patient gets the treatment he/she needs!

It’s important that you are aware of your role in preventing patient suicides. Please review the following OUMC Policy 11-71: Suicide Precautions: Patient Management.
Subject: Suicide Precautions: Patient Management

Section: 11-71

Coverage: All OUMC personnel & members of the Medical Staff

Purpose: To ensure the screening of patients for the risk of suicide; to provide appropriate supervision minimizing the opportunity for self-harm to a patient that has made a suicide attempt and/or who is expressing suicidal ideation.

Policy:

A. Patients in the Emergency Department and those who are admitted for ongoing care/observation are screened for the potential risk of suicide; appropriate interventions are taken when the screening indicates that there is a risk.

B. Based upon the results of the screen/assessment, suicide precautions may be initiated by physician’s order. The RN may initiate precautions based on clinical indications on any patient who has made a suicide attempt or is expressing suicidal ideation.

C. Hospitalized patients on suicide precautions must have 1:1 direct observation when admitted to a medical/surgical unit. Patients on suicide precautions and located in critical care areas are not required to have 1:1 direct observation due to the higher level of direct care commensurate with staffing patterns in those units. The Mental Health Units will follow unit-specific Suicide Precaution Policy.

D. Suicide precautions are prescribed and direct observation is provided by hospital staff based on the risk level determined by the physician and assessment screens.

1. **High Suicide Risk:**
   - **Indications:** Verbalizes clear intent to harm self or has concrete/specific plan; or medically stabilized patient following suicide attempt.

2. **Moderate Suicide Risk:**
   - **Indications:** Patients admitted for medical stabilization following suicide attempt and active suicide ideation without suicidal plan.

3. **Low Suicide Risk:**
   - **Indications:** Expressed vague suicidal ideation without a plan or suicidal ideation without a plan or self-destructive behavior. These patients may have chronic suicidal thoughts and/or exhibits poor impulse control. No self-destructive behavior.

E. An assessment of environmental features is conducted upon identification of suicide risk; items or objects that have the potential for self-harm are removed/secured and the environment is modified for enhanced safety.
F. Patients determined to be at risk of suicide are further evaluated by a Psychiatrist, Psychiatric Resident and/or a mental health assessment is conducted by a Licensed Mental Health Professional (LMHP).

Procedure:

**Responsible Party:** Emergency Department nursing personnel and Physicians

**Action:**

**Suicidal Precautions – the Hospitalized Patient**

1. Conducts a suicide/harm risk screening to determine if patients are at risk for suicide
2. An RN may initiate Suicide Precautions when clinically indicated.
   a. On initiation of Suicide Precautions, the patient’s room and/or immediate environment is examined for and cleared of any potentially dangerous objects.
   b. A patient on Suicide Precautions is accompanied by at least one staff member or a police officer, if the patient is under Emergency Detention (EOD) and in the Emergency Department (ED).
   c. Follow up assessment of patients’ suicide risk continues per discretion of the attending physician.
      i. Assessment includes current suicidal/homicidal thoughts, intents, past history, and family history.
3. Requests a consult for a mental health assessment and/or psychiatric evaluation for patients as needed
4. ED Physician writes orders as applicable:
   a. Specific for “suicide precaution”.
   b. For admission to the ICU or other location as appropriate if patient is to be hospitalized.
   c. For 1:1 observation or a sitter as applicable.
   d. To obtain Behavioral Health consultation from psychiatrist, psychiatric resident or LMHP.
   e. Makes referrals as applicable to community and/or other providers when patient does not require inpatient treatment.

**Social Services**

1. Completes Mental Health Assessment, when applicable.
2. Evaluates and makes recommendations for referrals to an appropriate facility.
3. During discharge planning, community resources and treatment options are identified and are provided to the patient and family members as they leave the organization.
4. When a patient at risk for suicide leaves the care of the
### Responsible Party: Action:

- hospital, the Social Worker/Social Services personnel provides suicide prevention information such as a Crisis Hotline to the patient and his or her family.

### Consultation Liaison Team – Psychiatry

1. Completes the consultation and evaluation on the patient

### Attending or Consulting Physician

1. Writes an order in patient’s medical record to implement “suicide precautions”.
2. Writes order for transfer to appropriate unit/care center when applicable.
3. Reevaluates and documents the need for continued precautions every 24 hours.
4. Whenever possible, discusses the implementation of suicide precautions with the family.
5. Obtains a psychiatric consult / mental health evaluation for patient to be completed as soon as possible during hospital stay,
6. Writes a specific order for any activity or procedure that requires the patient to leave the unit.
7. Orders oral medications to be given in liquid form whenever available through the pharmacy.
8. Orders dietary precautions to include “finger foods” whenever possible; specify “proper set up” to include paper products only (trays/plates); if utensils are necessary, plastic utensils are required (metal utensils are prohibited).

### Attending or Consulting Psychiatrist / Psychiatry Resident

1. Completes the consultation and evaluation on the patient.
2. Admits the patient who meet admission criteria (e.g., suicidal ideation) if beds are available.
3. Assumes treatment and direction with respect to suicide precautions and/or interventions.

### Charge Nurse

1. The Charge Nurse, Clinical Manager, or Director may initiate suicide precautions in a crisis situation until collaboration with the attending physician can occur.
2. Assigns a hospital designee to stay with patient until arrangements for a sitter are made or, if patient is
Responsible Party:

Action:

under an Emergency Order of Detention, a law enforcement official is available. Contact staffing office for assistance as needed. A family member may not be utilized as the person providing for constant observation.

RN assigned to patient

1. Registered Nurse completes a psychosocial assessment which includes screening patient’s risk of suicide on all admissions.
   a. The admission assessment determines the patient’s risk of suicide based on assessment findings, patient responses, and patient history.
   b. If the patient assessment determines that the patient is at risk of suicide:
      i. Nurse notifies the attending physician of findings including the risk level determined by the assessment.
      ii. Documents the physician notification under the physician notification intervention screen.

2. Implements suicide precaution and other orders as applicable.

3. A psychiatric consult is initiated and/or a referral notification for Mental Health Assessment is sent to Social Services/Case Management for acute inpatients identified as suicide risk.

4. Ensures patient safety:
   a. Remove potentially harmful objects or contraband from patient and environment. Examples include but are not limited to: sharp objects, scissors, razors, glass items/bottles, belts, straps, ties, drugs, hair dryer, curling iron, purse, cosmetics in glass containers; telephone w/ cords, medical devices, monitor cables not in use; clothing items such as belts, ties, shoelaces; medications and antimicrobial/alcohol hygiene solutions; plastic bags, cigarettes and lighters.
   b. Itemize items removed and give valuable items to family as soon as possible. If family is not available, secure valuables in a locked area or send to police/security if appropriate.
   c. Contact Police/Security to dispose of contraband.
   d. Search any object or package brought to
Responsibility Party: Action:

patient by visitors.

e. Respond to patient with active listening; demonstrate concern.

5. Explains “Suicide Precaution” during Patient and Family Education:

a. Risk level, associated restrictions, and rationale to patient and family. Inform family/visitors that potentially harmful items (glass, scissors, home medications, etc.) are not to be given to the patient.

b. Provide and review Crisis Center/Suicide Hotline information.

6. Orders meals with “proper set-up” and “finger foods” whenever possible. Ensure that meals are served on disposable items, i.e. trays, plates, paper/plastic containers; if utensils are necessary, utilize spoons or forks.

7. Notifies Director/Clinical Coordinator of order.

8. Assure that all sitters are aware that at no time is the patient left unattended. This includes:

a. Accompanying the patient whenever he/she leaves the unit for procedures, scheduled appointments, or other activity.

b. Having patient in direct sight while patient is in the bathroom and/or shower.

9. Documents in patient’s medical record any change in assignment of the individual responsible for constant observation.

10. Ensures proper documentation takes place, i.e. suicide precautions maintained; level of precautions, observation intervals,

a. Effectiveness of interventions

b. Physician Notification if appropriate
c. Items removed from patient or environment upon admission
d. Patient/family teaching and response to education.

11. Places sign on patient’s door stating, “All visitors must check in at nurse’s station.”

12. Ensures that individuals wishing to visit on Mental Health Units are approved to do so and that activities of visitors are appropriate while on campuses, i.e. in accordance w/ hospital and suicide policy.

13. Notifies designee assigned to monitor patient of
Responsible Party: Action:
visitors approval.

Hospital Designee Assigned to Monitor Patients

1. Maintains observation of patient at all times. This includes:
   a. Accompanying the patient whenever he/she leaves the unit for procedures, scheduled appointments, or other activity.
   b. Having patient in direct sight while patient is in the bathroom and/or shower.
2. Documents observation of patient status at least every 15 minutes.
3. Ensures all visitors have checked in with nursing staff, monitors visitation to ensure that no contraband of any kind is exchanged.
4. Documents names of all visitors in patient’s medical record.
5. Ensures that no objects are brought into the room that create the potential for self-harm by patient.

Food & Nutrition Personnel

1. Ensures that all meals are served with “proper set-up” i.e. Disposable/ paper products only; plastic utensils only when necessary. Finger Foods are served whenever appropriate.

Pharmacy personnel

1. Makes medications available in liquid form when possible.

Environmental Services

1. Ensures that plastic trash bags are removed from room and are replaced with paper bags only or the liner is left out of the trash receptacle.

Charge Nurse, Registered Nurse, Security, and other authorized care providers

1. Provides resuscitation and care to patient as needed.
2. Notifies physician. Obtains order for suicide precautions, if not already in place.
3. Notifies Nursing Director/House Supervisor.
4. If attempt was successful, notifies OUHSC Police Services/security personnel. OUHSC Police Services/security personnel will notify the local Police Department as necessary.
5. If attempt was successful and/or patient was significantly harmed, leaves room undisturbed as
Responsible Party: Director/House Supervisor

Action:
1. Notifies Administrative Officer, Risk Manager, and ensures that a patient notification is appropriately completed.
2. Much as possible.
6. Notifies Medical Examiner – if attempt was successful.
7. Completes a patient notifications form and forwards to Director.
8. Documents entire incident in patient’s medical record.

See Addendum: Suicide Precautions Flowsheet

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