

Suicide Assessment and Precautions - CE

ALERT

Don appropriate personal protective equipment (PPE) based on the patient's signs and symptoms and indications for isolation precautions.

Suicide and suicide attempts are serious acts that devastate families, acquaintances, health care providers, and communities. Assessing and responding to suicide risk is a health care priority. Suicide prevention relies on prudent judgment by responsible health care providers as well as a strong therapeutic alliance with the patient and open communication with the patient and family, significant others, and the health care team.

OVERVIEW

Suicide is a leading cause of death in the United States, particularly among young people.⁵ People who attempt suicide but fail commonly require either acute medical or psychiatric care. Assessing patients with emotional or behavioral issues for a risk of suicide is a national patient safety goal.⁸ A completed suicide by an inpatient is considered a sentinel event. Since suicide presents a significant risk, it is important for the health care team to be aware of comorbid behavioral health issues when treating patients for primary medical conditions because these patients may be at risk for suicide.⁷ Patients with a change in clinical status or a poor prognosis may also be at risk for suicide.⁷ These patients must be properly assessed for suicidal ideation as part of their overall evaluation.⁷

When an assessment determines that a patient is at risk for suicide, standard interventions include increasing supervision and observation of the patient, instituting suicide precautions, and removing access to means of suicide. The primary goals are to maintain patient safety and protect an admitted patient from attempting suicide.

The multidisciplinary team members should collaborate to identify interventions to prevent suicide for an inpatient in a health care organization. Goals are directed toward decreasing suicidal thoughts and plans, supporting and facilitating psychiatric treatment, and teaching the suicidal person coping skills to remain safe. The greater the patient's psychological disorder, whether command hallucinations, schizophrenia, or psychotic features of depression, the more the patient should be stabilized with medication to provide protection, safety, symptom management, structure, and support. Initially, treatment of a suicidal patient requires crisis management using a problem-solving approach and a psychopharmacologic approach. Long-term treatment includes learning long-term coping skills.

Working with a suicidal patient may trigger feelings of anxiety and fear in health care personnel. Health care team members require education and training to assess the patient adequately and determine if a risk of suicide exists.²

EDUCATION

- Provide developmentally and culturally appropriate education based on the desire for knowledge, readiness to learn, and overall neurologic and psychosocial state.
- Obtain the patient's permission to include the family in treatment planning.
- Establish a rapport with the patient and family to foster open communication.
- When interviewing the patient and family members, be aware that perceived stigma and shame may affect disclosure and openness.

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- Collaborate with the patient and family to identify the need for inpatient care.
- Inform the patient and family of the patient's rights and responsibilities while an inpatient.
- Collaborate with the patient and family to set goals for treatment, as appropriate.
- Offer opportunities for self-care and involvement in treatment planning and monitoring (a proven strategy for improving treatment of depression and decreasing suicidal thinking).
- Educate the patient and family about the signs of suicide risk (e.g., impulsivity, agitation, depressed mood, anxiety, suicidal ideation) and suicide precautions.
- Provide emergency contact numbers, suicide hotline numbers, and information about community resources for support.
- Explain to the patient and family the importance of treating associated psychiatric symptoms and illness.
- Inform the patient and family about restricting the means to suicide.
 - All items brought for the patient will be checked for potential hazards.
 - Family members should avoid giving the patient items that could be used for self-harm, including medications and plastic bags.
 - To decrease suicide risk, the family should restrict access to weapons in the home.
- Teach the patient and family about factors that may increase the risk of suicide and factors that may protect the patient from suicide (e.g., married status, extended social network, involvement in religious activities).¹³
- With the patient's permission, discuss the patient's motives and the meaning of a suicide attempt, if appropriate.
- Teach the patient and family coping skills and problem solving.
- Instruct the patient and family to notify a health care team member immediately if he or she indicates any suicidal thoughts, a formulated plan for suicide, or the intent to attempt suicide.
- Encourage questions and answer them as they arise.

ASSESSMENT

1. Perform hand hygiene and don PPE as indicated for needed isolation precautions.
2. Introduce yourself to the patient.
3. Verify the correct patient using two identifiers.
4. Assess the patient's cognitive ability to communicate or comprehend aspects of the evaluation.
5. Assess the patient for a history of mental health concerns (e.g., chronic mental illness or inpatient care for depression), including a detailed history of substance use.
6. Evaluate the patient's current mental health status (e.g., self-harm ideation or increased anxiety).
7. Assess the patient for a family history of mental illness and suicide.

Rationale: A family history of completed suicide is a significant risk factor.

8. Assess the patient for suicidal or homicidal ideation or thoughts of self-harm. Use an organization-approved standardized tool for suicide assessment⁸ (e.g., Columbia-Suicide Severity Rating Scale.¹⁵)
9. Assess the need to implement additional safety precautions (e.g., constant direct observation by health care team members) if the patient is at risk for suicide.
10. Assess the need for a psychiatric practitioner consult and seek a consult as appropriate.

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11. Assess the safety of the immediate environment by paying attention to such items as oxygen and IV tubing, call bell, and telephone cord.
12. Evaluate the patient for medical issues that may increase depression, anxiety, or suicidal ideation (e.g., chronic pain, traumatic injuries, newly diagnosed devastating illness).
13. Assess current stressors that may be contributing to the patient's distress (e.g., caring for an ill parent or spouse).
14. Evaluate the patient's coping strategies, supports, and resources.
15. Consider behaviors of concern reported by family members (e.g., giving away possessions) when assessing risk.
16. Assess the patient's competency and willingness to collaborate with treatment and safety measures.
17. Assess the patient's and family's understandings of suicide precautions.
18. Identify whether the patient is at risk for elopement and whether he or she has a history of not cooperating with recommended treatment.
19. Assess the patient's mental status for increased anxiety, agitation, hopelessness, feelings of guilt, and suicidal thoughts with a plan and intent.
20. Assess the patient for psychosis (hallucinations and delusions) and the patient's ability to follow directions.

STRATEGIES

1. Perform hand hygiene and don appropriate PPE based on the patient's signs and symptoms and indications for isolation precautions.
2. Verify the correct patient using two identifiers.
3. Explain the strategies to the patient and ensure that he or she agrees to treatment.
4. Establish a therapeutic alliance with the patient to promote communication via a nonjudgmental approach and active listening.

Rationale: A lack of knowledge or negative attitudes among health care team members about suicide and suicide attempts directly affects the care a patient receives and can affect team members' ability to keep the patient safe.⁶

Do not assume that a patient who denies suicidal ideation is not at risk. Actively listen to the patient because he or she may not be honest with health care team members who appear detached and uncaring.

5. Assess the patient's strengths and coping mechanisms.
6. To explore the patient's current stressors and risk factors for suicide, ask direct questions about these issues.
 - a. History of suicidal behaviors, including self-injurious behaviors
 - b. Current or past psychiatric disorders
 - c. Symptoms of hopelessness, anxiety, or panic; chronic insomnia; and command hallucinations
 - d. Family history of suicide, suicide attempts, and psychiatric disorders
 - e. Stressors that may have led to the patient feeling humiliation or shame (e.g., being fired from a job or failing at school) or despair (e.g., breakup with significant other, financial issues, health problems, the influence of a substance, family issues, social isolation, a history of abuse)
 - f. Change in psychiatric practitioners or recent discharge from inpatient psychiatric care

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g. Access to a firearm or lethal weapon

Rationale: Asking direct questions helps elicit accurate information.¹⁰ Suicidal behaviors may be associated with most psychiatric disorders. Having more than one disorder or having unresolved medical illnesses increases the risk of suicide.³

7. Determine the patient's current protective factors.

- a. Internal factors, such as religious beliefs that influence the patient's ability to manage stress and frustration
- b. External factors related to the patient's environment, such as family or pets, positive relationships, and a good support system

Rationale: Knowing the patient's protective factors assists with safety planning.⁹

8. Ask direct questions about suicidal thoughts, plans, means, behaviors, and intent.

Rationale: Asking questions does not influence the patient to become suicidal, but it may prevent the patient from becoming suicidal.

9. Ask the patient about thoughts to kill someone else and identify the plan, means, behaviors, and intent if the patient has such thoughts.

10. Remind a patient who is medically ill or injured about the importance of early recognition of depressive symptoms.

Rationale: Patients who are at risk for depression may benefit from early education and intervention. Unrecognized and untreated depression puts the patient at a high risk for suicidal behaviors.

11. Encourage the patient to speak openly about any self-injurious behaviors.

- a. Ask specifically about cutting, burning, and other forms of self-mutilation.
- b. Closely monitor a patient who acknowledges self-injurious behaviors.

Rationale: Some patients with chronic mental illness engage in self-harming behaviors as a way of coping with stress. In other cases, self-injury precipitates a more serious suicide attempt. The health care team member must engage the patient in a discussion about self-harm in a nonjudgmental and compassionate way.

Do not assume that a patient who engages in self-mutilation is doing so to seek attention.

12. Encourage family members to share concerns about the patient's safety with health care team members. Do not reveal information about the patient's treatment without his or her consent unless an imminent risk is present.

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Rationale: Collateral information is helpful to determine suicide risk and can be obtained without revealing confidential information about the patient.

13. Initiate suicide precautions if the patient has suicidal thoughts.

- a. If appropriate, initiate direct, constant observation per the organization's practice.
 - i. The patient may be in a room with others but must remain within view of the health care team at all times.
 - ii. If the patient leaves the room, a team member must accompany him or her.

Follow the organization's practice on staying within a specific distance of the patient at all times.

b. Determine which team member will remain with the patient, maintaining visual contact at all times, even while the patient is in the bathroom.

Never leave the patient alone.

- c. Plan breaks for team members assigned to constant observation to ensure they can maintain close attention to the patient.
- d. Assign the patient to a room close to the nurses' station.
- e. Inform the patient that he or she is being placed on suicide precautions and give the rationale. Allow the patient to ask questions and express thoughts and feelings regarding the level of supervision.

Rationale: The patient's immediate safety needs and the most appropriate treatment setting should be addressed with the patient. An empathetic, caring, yet direct approach should be used to inform the patient of the observation status and the rationale. Many suicidal patients are impulsive; they may feel safe at the present moment but may later act on suicidal impulses.

Do not promise secrecy; the treatment team needs to know the patient's thoughts and intentions.

14. During handoff communication among health care team members, provide information based on direct, constant observation of the suicidal patient.

- a. The reason for direct, constant observation, the patient's behaviors during the observation period, and the health care team's interventions if suicidal behaviors occurred
- b. The patient's care and treatment
- c. The patient's behaviors, feelings, or actions, including the response to suicide precautions
- d. The patient's current thoughts and feelings, pertinent conversations regarding suicidal intent, and his or her response to treatment
- e. Recent or anticipated changes in supervision, changes in the patient's behaviors or actions, and the patient's responses to stressors
- f. The condition of the environment, including the location of items secured and any contraband found
- g. The patient's ability to use the skills identified in the safety plan

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15. Obtain a psychiatric consultation as soon as possible to determine an appropriate plan of care to meet the patient's mental health needs. Meet with other members of the health care team to determine the patient's level of treatment, willingness to receive voluntary inpatient care, or need for involuntary inpatient care.

16. Together with the other members of the health care team, including a behavioral health professional, collaborate with the patient to develop a safety plan.¹¹

Rationale: A safety plan is developed to give the patient a prioritized list of coping skills to use when in crisis to help keep him or her safe. This plan can be developed for an inpatient and can be revised before discharge to list coping skills the patient can use at home.

Do not use a verbal or written no-suicide contract to ensure patient safety because contracting for safety has not been shown to decrease suicide incidence.¹¹

17. Immediately direct a patient who is actively engaging in suicidal behaviors (i.e., in the process of cutting self, attempting a hanging, taking an overdose) to stop.

a. Remove or ask the patient to relinquish any objects that may be used for self-harm.

Rationale: Gaining a patient's cooperation with relinquishing possessions demonstrates a desire to work collaboratively. Maintaining a nonadversarial stance is important.

b. Contact the mental health practitioner as soon as possible and give as-needed medication to assist with reducing anxiety or psychosis.

18. Search the patient for contraband, such as medications, belts, drawstrings, shoes with shoelaces, razors, glass, plastic bags, or mirrored items.

a. Maintain the patient's privacy and dignity during the search.

b. Remove the items and secure them out of the patient's possession per the organization's practice.

Rationale: Patients may try to hide contraband to use for self-harm later. Removing the means of suicide and maintaining a safe environment are effective suicide prevention strategies.

19. Make sure the patient is taking medication as prescribed and not pretending to swallow it or stashing it for a later overdose. Also, make sure to monitor for suicidal ideation or behaviors in children, adolescents and young adult patients who have started on antidepressant medications.

Rationale: Children, adolescent, and young adult patients may have an increase in suicidal ideation or behaviors during the first month of treatment after starting an antidepressant.¹²

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20. Perform frequent assessments if the patient is at risk for developing depression related to a medical illness or injury.

Rationale: Patients who have no previous history of mental illness may be at risk of depression and suicidal ideation after a traumatic injury or diagnosis.

Monitor the patient for the development of symptoms that may indicate an increase in hopelessness, anxiety, and despair.

21. At discharge, identify resources the patient can contact if feeling suicidal, including a psychiatrist, therapist, social worker, suicide hotline, and crisis centers.

- a. Include specific names and telephone numbers for resources in the discharge instructions.
- b. Advise the patient to call the emergency response number in his or her area (e.g., 911) to report feeling imminently suicidal.

22. Remove PPE and perform hand hygiene.

23. Document the strategies in the patient's record.

REASSESSMENT

1. Continually assess and gain a thorough understanding of the patient's ongoing suicide risk as well as his or her response to interventions and the goals of treatment.

Rationale: The risk of suicide can change throughout the patient's stay, and frequent reassessment is crucial to management.

2. Provide information and additional resources for the patient and family.
3. Monitor the patient's response to health care team interventions and involve the patient in evaluating his or her progress.
4. Evaluate whether the patient is responding to treatment for psychiatric symptoms, such as anxiety, agitation, insomnia, depression, delusions, or hallucinations.
5. Assess, treat, and reassess pain.

EXPECTED OUTCOMES

- Patient remains safe and free from harm.
- Health care team members and patient collaborate to create a safe environment.
- Patient and health care team members discuss patient's suicidal ideation, intentions, or plans and assign appropriate interventions and treatments.
- Patient cooperates with level of observation and supervision.
- Patient and family are involved in care and informed of signs of suicide risk and appropriate actions to take.
- Patient returns to a safe environment when discharged.

UNEXPECTED OUTCOMES

- Patient's level of risk increases.
- Patient attempts suicide.
- Patient resists suicide precautions and observation and requires more restrictive measures.
- Health care team member is injured.

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- Patient does not collaborate with treatment.
- Patient completes suicide while in the health care organization or soon after discharge.

DOCUMENTATION

- Suicide risk assessment at admission, during any change in the patient's condition or treatment, and before discharge
- Rationale for suicide risk level, including statements made by the patient indicating suicidal ideation
- Suicidal ideation, intent, plan at admission, status at each shift, and the implementation of treatment plans or changes in plans
- Consent to contact the family or, if no consent, the critical need for information to protect the patient
- Inquiry about the presence and location of weapons and instructions given to the patient and family
- Interventions, treatment, and patient's response
- Evaluation of patient's progress and outcomes of health care team interventions
- Patient's strengths that promote effective coping and recovery, including learned coping skills, such as methods for accessing support, assertiveness, regulation of emotion, and adoption of healthy self-care behaviors
- Support provided to reduce patient's level of distress
- Health care team members collaborative communication, meetings, or methods to facilitate communication
- Education about suicide risk and preventive measures, including, if appropriate, how to take psychotropic medications safely; how to cope with future crises safely; and how to manage future suicidal thoughts, warning signs of suicide, resources, and treatment options
- Provision of emergency contact numbers, hotline numbers, and community resources
- Unexpected outcomes and related interventions

ADOLESCENT CONSIDERATIONS

- Establish a rapport with the adolescent and family because family attitudes may influence the adolescent's attitude toward inpatient care.
- Suicide risk factors in adolescents include risk-taking behaviors; impulsivity; a history of abuse; lesbian, gay, bisexual, or transgender orientation; social isolation; difficult relationships with parents; stressful life situations; firearms in the home; and suicide of friends.³
- Collaborate with the adolescent and family to plan reasonable diversion activities that the adolescent can use while an inpatient.
- Parental consent and adolescent assent are essential for treatment.
- Teach the adolescent and family that self-mutilation is an unhealthy coping skill and not an expected developmental behavior.
- Educate the adolescent and family about the risks of the misuse of substances.
- Educate the adolescent and family about the need for family support of the adolescent^{4,14} and the importance of continual monitoring for suicidal thinking, especially when the adolescent is beginning therapy on an antidepressant.
- Use interventions designed to strengthen self-esteem and increase coping skills.

OLDER ADULT CONSIDERATIONS

- Depression is not a normal response to loss experienced by older adults.¹
- Promote self-care and involvement in purposeful activities to promote a sense of worth.

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- Promote an environment that reduces anxiety and a sense of helplessness (e.g., adequate lighting, easy access to restrooms, and visibility of health care team members).
- Educate the patient and family about the risks of alcohol use.
- Monitor the older adult's cooperation with medication therapy.
- Older patients may deny having suicidal thoughts or deny feeling sad but may admit to wanting to go to sleep and not wake up or verbalize thoughts of being no good to anybody anymore. In these situations, perform a suicide assessment.

SPECIAL CONSIDERATIONS

- Formal training regarding suicide assessment and management of the suicidal patient and identification and promotion of protective factors should occur on a regular basis with all health care team members.
- Implement support for the health care team to promote self-caring behaviors and stress reduction because team members working with patients who are suicidal or have attempted suicide may experience negative attitudes toward the patient.⁶

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*In these skills, a "classic" reference is a widely cited, standard work of established excellence that significantly affects current practice and may also represent the foundational research for practice.

Elsevier Skills Levels of Evidence

- Level I - Systematic review of all relevant randomized controlled trials
- Level II - At least one well-designed randomized controlled trial
- Level III - Well-designed controlled trials without randomization
- Level IV - Well-designed case-controlled or cohort studies
- Level V - Descriptive or qualitative studies
- Level VI - Single descriptive or qualitative study
- Level VII - Authority opinion or expert committee reports

Supplies

- Gloves and PPE, as indicate

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