Recognizing and Addressing Suicide Risk in Hospital Patients

By Debra Wood, RN, contributor

December 3, 2010 - Although hardly an everyday occurrence, suicide in emergency departments and medical-surgical units has become a significant concern—one of the five serious events most frequently reported to The Joint Commission, leading the accrediting body to issue a Sentinel Event Alert that calls attention to the problem and issues suggestions for mitigating the risk.

"Nurses serve the most vital role [in preventing suicide], because they spend more time with patients than any other health care worker," said M. Justin Coffey, M.D., physician champion for Perfect Depression Care in Chronic Diseases at Henry Ford Health System in Detroit. "They are afforded the opportunity that allows them to notice behavior that may sound an alarm."

Those observations might allow the health care team to prevent a suicide. Coffey added that there is no doubt that nurses in the general medical hospital setting will be taking care of patients with suicidal ideation.

"We need to be comfortable talking about suicide in the same way we are in talking about chest pain," Coffey said. "We don’t know how common it is, but I will tell you one [death] is too many. Anyone involved in a sentinel event where someone [a patient] killed himself … it’s a life-changing event. It’s common enough, the Joint Commission has placed an emphasis on this work."

Peggy O’Rourke, RN, a nurse manager at Long Island College Hospital in Brooklyn, N.Y., estimates suicide happens in less than 0.4 percent of acute-care patients.

Nearly 25 percent of 827 suicide cases voluntarily reported to The Joint Commission since 1995 have occurred in non-psychiatric settings—14 percent in patient units, 8 percent in the emergency department, and 2 percent in home care, long-term care hospitals, rehabilitation facilities and other non-psychiatric settings.

Those patients killing themselves in general hospital units often do not have a psychiatric history, the organization said. Risk factors include dementia, traumatic brain injury, chronic or intense acute pain, a poor prognosis or terminal diagnosis, divorce or relationship problems, and substance abuse. Declining health, loneliness and recent bereavement can place older adults at greater risk.

"It’s difficult to see risk factors," O’Rourke said. "Even psychiatrists will tell you that there is no fail-safe. You have to go with your gut instinct and tremendous safety precautions—watching, observing."

The Joint Commission’s recent alert outlined the following suicide warning signs, which are associated with increased desperation and imminent risk: irritability, increased anxiety in addition to panic, agitation, impulsivity, decreased emotional reactivity, complaints of unrelenting pain, refusing visitors, crying spells, declining medications, and requesting early discharge.

Antidepressants, antiepileptic or anticonvulsant medicines, and antipsychotic agents also can increase the risk.

"It’s important to recognize that depression is not the only condition that increases risk of suicide," Coffey said. "Nurses may notice the patient is more confused, fearful or suspicious. That person is at risk of harm, even if there may not be a depression."

In addition, The Joint Commission points out that the following are diagnostic criteria for depression: hopelessness or helplessness, decreased interest in treatment or prognosis, feelings of worthlessness, and refusing to eat.

Debbie Bellisario, RN, MSN, a manager of adult services at Chestnut Ridge Center at West Virginia University Hospitals in Morgantown and a lecturer in risk reduction at the WVU School of Nursing, added that hopelessness represents a dangerous warning sign.

Coffey added that warning signs include talking about wanting to give up, not interacting with the
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Sue Penque, Ph.D., NP, RN, senior vice president for patient care at South Nassau Communities Hospital in Oceanside, N.Y., said nurses at her facility assess every patient and determine their risk using standardized tools. If a patient is at risk and has a plan or suicidal tendencies, the nurse will closely observe that patient, create a safe setting on a medical-surgical unit and check for contraband.

“Looking at the environment is critical, making sure there is nothing in the environment that could harm them and that they are getting close observation,” Penque said. “You’re screening the patient and the people who visit the patient. Many times you are treating the family and social network.”

Darrick Cheyno RN, MICN, CEN, manager of emergency services at Providence Saint Joseph Medical Center in Burbank, Calif., reports that nurses in his ED screen every patient, completing a full psychosocial assessment of life stressors, and will try to determine whether a problem is situational or associated with substance abuse. Nurses may involve social services if something important comes to light, and if the patient is deemed a danger to self or others, nurses will call security for one-to-one observation and a clinician who is able to assess whether the person needs to be placed on a mandatory hold.

“We need to be diligent about screening,” Cheyno said. “Not everyone will say they are depressed or suicidal. You need to look at whether they are taking care of themselves or are disheveled. Nurses need to look visually as well as ask questions.”

Bellisario said any nurse can contract with patients for safety after a suicide assessment. Although she cautioned that the nurse’s thoughts about mental illness and suicide affect interactions with patients.

“The more comfortable we can get, the more we will benefit patients,” Bellisario said.

The Joint Commission recommends hospitals empower staff to call a mental health professional or take other action, such a placing a patient under constant observation, if staff members notice suicidal warning signs.

At South Nassau Communities Hospital, nurses can contact a specially trained crisis intervention social worker, without a physician’s order.

The Joint Commission also suggests educating staff about suicide risk factors, such as a family history of suicide, anxiety and the use of antidepressants, and to stay aware of changes to behavior or warning signs that the patient may consider acting on his or her suicidal thoughts. Other recommendations include discharging at-risk patients with suicide prevention information, such as a crisis hotline.

“Nurses are key to behavioral health,” Coffey said. “The strength of nurses is in their skills of empathy, and they should feel comfortable using those skills when they have a patient at risk of suicide. There is no suggestion in the literature that talking about those thoughts will increase the likelihood the patient will act on those thoughts.”

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