CE 1.0 CONTACT HOUR

Suicide risk assessment and prevention

By Erin Murphy Smith, MSN, RN

Patient safety remains a central concern of nurse managers in every healthcare setting. Although the welfare of patients encompasses a broad range of concerns, the increasing prevalence of suicide in our society compels nurse managers to ensure a safe healthcare environment for patients with suicidal ideation. These efforts include the elimination or, at least, the mitigation of physical setting characteristics that enable suicide attempts. Equally, nurse managers need to ensure that the nursing team is adequately trained to assess patient suicide risk and take appropriate follow-up prevention steps.

This article reviews the statistical impact of suicide, as well as concrete steps that nurse managers and nurses can take to diminish the risk of patient suicide attempts.

A growing concern

As a nurse manager, your duties include, but aren't limited to, interviewing and hiring nursing staff, collaborating with medical staff, developing budgets, interacting with patients and families, scheduling, professional development, and staff evaluation. Although you may have included the possibility of patient suicide within these concerns, the scope of nursing's responsibility to prevent suicide attempts has ballooned commensurate with the increasing prevalence of such events.

Suicide is the 10th-leading cause of death in the US; suicide rates have increased approximately 30% since 1999.[1,2] The CDC reported that 45,000 individuals died by suicide in the US in 2016.[2] Beyond the financial and staffing ramifications posed by

escalating suicide rates, the complexity of the contributing factors of suicidal ideation make the nurse manager's job all the more essential to the mitigation of patient suicide attempts. In recognition of the growing magnitude and difficulty of this problem, the National Action Alliance for Suicide Prevention and the American Foundation for Suicide Prevention established a goal of reducing the annual suicide rate by 20% by 2025.[2]

The American Psychiatric Association estimate that 1,500 suicides take place on inpatient hospital units in the US each year.[3] In 2007, The Joint Commission established the National Patient Safety Goal (NPSG) 15.01.01 to focus healthcare organizations on averting suicide. However, in view of the 85 suicides reported as sentinel events over the last 5 years, The Joint Commission is seeking to further enhance preventive efforts.[1]

Scenarios reflecting the nature of suicide in the healthcare setting highlight the relevance of these statistics to nurse managers and clinicians. In one case, a 50-year-old critical care nurse with 24 years' experience committed suicide after she was fired for a self-reported medication error that may have contributed to the death of a baby with severe heart problems.[4] (See *At risk: Nurses.*) In another hospital, personnel brought a 40-year-old ED patient who was admitted for suicidal ideation to the radiology unit for tests. The patient found his way to the roof of the building and jumped after being left alone in the radiology waiting area. In yet another facility, a patient asked to be voluntarily admitted after a suicide attempt and changed into a hospital gown. After she waited alone in an exam room for more than an hour, the patient walked past the ED charge and triage nurses' stations, as well as multiple other hospital personnel, and eloped. She walked to a nearby highway where she was killed by a passing vehicle.

These cases represent a small sampling of a complex and growing healthcare crisis that nurse managers must be ready to contend with on any given day. Moreover, this isn't just a behavioral health unit problem. Suicide is an issue that cuts across all clinical practice settings, so nurses working on every unit in a hospital must be ready to assess for suicide risk and know what to do if a patient exhibits suicidal ideation.

The American Psychiatric Nurses Association (APNA) indicates that the role of the nurse in preventing suicide includes both system- and patient-level interventions. In essence, a nurse manager "maintains environmental safety; develops protocols, policies, and practices consistent with zero suicide; and participates in training for all milieu staff."[5] Nurse managers must also ensure that staff

At risk: Nurses

Nursing is a caring profession but, all too often, we don't adequately care for our fellow professionals or ourselves. We all deal with the stress of insufficient staffing and shift work, and the emotional rollercoaster associated with patient care. On top of this, researchers have confirmed what most of us know all too well: Nurses at all levels of the profession are often subject to bullying, harassment, and incivility on the job.[1] These stress factors can take a toll. Specifically, nurses may encounter the devastating impact of suicide in both their work and personal lives. One study found that following a patient suicide, nurses experienced shock, condemnation, and fear of reprisal. So, it isn't surprising that nurses are at an elevated risk for suicide. In particular, female nurses are four times more likely to commit suicide than the average woman.[2]

Researchers examining suicide rates among the large, long-term cohort of the Nurses' Health Study found an almost five-fold increase in suicide risk among female nurses in the high stress category. As for those nurses reporting minimal stress, researchers concluded that their excess risk of suicide may reflect denial, undiagnosed depression, or an association with other unmeasured risk factors.[3] Another study found that nurses of both sexes had higher rates of suicide than other educated professionals.[4]

Simply put, we must do a better job of caring for each other and ourselves. In particular, nurses understand the stress of their coworkers and are well situated to assess when everyday workplace pressure may interact with extraordinary personal or professional trauma or grief to elevate that nurse's risk of suicide. Moreover, nurses can serve as models for coworkers and patients by obtaining help when we feel about to "go over the edge." Open discussion of these pressures and constructive means to alleviate them is one way to diminish a sense of false shame, which may account for the failure to obtain timely help.

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members demonstrate an understanding of the statistics, epidemiology, risk factors, and protective factors related to suicide as an essential nursing competency for suicide risk assessment and prevention. In this sense, one study observed, "risk management is the cornerstone of nursing care."[6]

It can happen on your shift

Globally, one suicide occurs every 40 seconds, according to the World Health Organization.[7] In the US, suicide exceeds motor vehicle fatalities and claims more than twice the number of lives from homicides. Although American suicide rates had been stable or falling in the second half of the 20th century, the CDC determined that suicide was the second-leading cause of death for individuals between ages 10 and 34 in 2014.[8]

Amplifying the impact of these distressing statistics, there were 20 attempted suicides for each completed suicide. Experts have concluded that these data demonstrate a pervasive sense of desperation coursing through American society, making it all the more important that we understand this societal trend and sharpen our skills to contend with its manifestations in the healthcare setting.[9]

Additionally, nurses should be aware that the surge in suicides, although widespread, may place different demographic groups within divergent risk categories. For instance, the CDC has reported that:

- Although the age-adjusted suicide rate for men (20.7) was three times greater than women (5.8), the percentage increase in suicide rates from 1999 to 2014 was greater for women (45%) than for men (16%).
- The highest increase in suicide rates was girls age 10 to 14 (200%).
- Suicide rates for women age 46 to 64 increased 63%, whereas the rates for men of the same age group increased by 43%.
- American Indians experienced the steepest rise in suicide among all racial and ethnic categories (89% for women and 38% for men).
- Suicide rates for Black men declined by 8%.[8]

Just as nurses consider demographic data in their patient assessments, these data must be weighed as part of a suicide risk assessment.

Key risk factors

Suicide is a complex phenomenon. In addition to demography, risk factors may include an intricate amalgam of psychological, social, biological, cultural, and environmental circumstances. Nurse managers should ensure that their nurses are knowledgeable about the variety of risk factors that may come to light in a patient history. Specifically, recent research demonstrates that nurses should note and assess patient histories that reveal the following risk factors for suicide:[10]

- mental or emotional disorders
- past suicide attempts or self-inflicted injury
- physical pain or impairment
- substance abuse
- impulsivity following a life crisis
- conflict-related stress
- victim of violence or abuse
- grief
- isolation
- discrimination based on race, ethnicity, gender identity, or sexual orientation
- pattern of aggressive or antisocial behavior
- imprisonment.

Although no single method can significantly diminish the risk of suicide, we can implement a broad spectrum of tactics to help alleviate this growing problem.

Nurses should be cognizant of the potential methods of suicide. In particular, a patient's ready access to weapons or other means of self-violence, together with suicidal thoughts, may raise the suicide risk assessment for that patient. For instance, the CDC indicated that men use firearms in 55.4% of suicides, whereas women most often used poisoning

(34.1%).[8] Certain state laws may impose a legal duty on medical personnel to inform designated authorities that a mental health patient may have weapons in the home.[11] Another study found that suicide via suffocation in the US increased by 45.7% from 2005 to 2014. Many objects commonly found in the healthcare environment may be employed in this suicide method.

Although easy availability of weapons, poisons, and so on should be factored into the nursing assessment, the lack of any apparent access isn't reason to discount the patient's risk of suicide.

Nurses should also be aware that patients' culture and spirituality are relevant components of a patient assessment. In particular, research demonstrates that religious faith may be relevant when assessing for suicide risk. Studies on the association between religious observance and suicide reflect the complexities of assessment and prevention. Many cross-sectional studies have demonstrated that religion provides a protective factor against completed suicide. The Nurses' Health Study found that religious attendance once or more per week was associated with an approximately fivefold lower rate of suicide compared with never attending religious services. However, at the clinical level, confounding factors may make the usefulness of religious observance as a factor in assessing patients for suicide risk more problematic. For example, although the condemnation of suicide by most organized religions may help protect against suicide (among other reasons), other religious doctrines, such as condemnation of lesbian, gay, bisexual, and transgender (LGBT) individuals, may nullify that benefit for certain patients.[13] (See *At risk: LGBT individuals*.)

At risk: LGBT individuals

Family and societal stigma and harassment may contribute to suicide risk factors among LGBT patients. For instance, a recent CDC study found that the prevalence of seriously considering suicide was substantially higher among LGBT high school students (42.8%) and those unsure of their sexual orientation (31.9%) than among heterosexual students (14.8%). In fact, 38.2% of LGBT students and 27.9% of unsure students went so far as to make a plan to attempt suicide as compared with 11.9% of heterosexual students. Further, 29.4% of LGBT and 13.7% of unsure students attempted suicide at least once as compared with 6.4% of heterosexual students who participated in this study.[1] Moreover, a recent survey demonstrated that transgender and gender nonconforming adults across all demographic categories exhibited a high prevalence of lifetime suicide attempts (41%). This far exceeds the 4.6% rate for the overall US population.[2]

Although it would be a mistake to merely assume that LGBT patients and coworkers are at an elevated risk for suicide, these studies show that gender identity and sexual orientation are important factors to keep in mind when assessing for experiences, such as bullying, harassment, violence, and discrimination, that may lead to suicidal ideation.[3]

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Nursing skills needed

Failure to maintain nursing competence in suicide assessment can have devastating effects not only for our patients and their families, but also for the care providers who become secondary victims.[4] According to The Joint Commission, 14.25% of suicides occur within a hospital but outside of its behavioral health unit. The Joint Commission also found that over 1,000 suicides from 2010 to 2014 occurred within 72 of hours of discharge from an around-the-clock healthcare setting such as the ED.[14] Any nurse involved in patient care must be attentive to suicide risk factors and stay informed on the most effective prevention strategies.

Unfortunately, nursing scholarship and clinical training in this area have lagged behind other healthcare providers. For example, one study determined that nursing suicide assessments relied on important but incomplete factors of intuition, experience, and the assessments of others.[10] Another researcher identified that nurses' psychological factors, such as emotions and unresolved grief, complicated their assessment and treatment of suicidal patients. This study also found that nurses sometimes exhibited confusion and misconceptions about suicide, such as expressing that it was a "coward's way out." Most important, the study highlighted nurses'

ambivalence about their qualifications to interact with patients at risk for suicide.[15]

A more recent comprehensive review of the literature on nursing suicide assessments found that most RNs lack the skills to effectively evaluate, treat, or refer a suicidal patient. The authors called for improved research, education, and the implementation of evidence-based clinical care practices and standards.[16]

Both The Joint Commission and the APNA have proposed such evidence-based standards.[5,17] The following is a summary of these guidelines.

• ***Review each patient's personal and family history for suicide risk factors.*** Employ effective therapeutic communication techniques. This includes direct questioning during the assessment. For instance, nurses should ask:[18]
—"Have you ever thought of hurting yourself?"
—"Have you ever tried to hurt yourself in the past?"
—"Have you ever contemplated suicide?"
—"Do you have a plan about how to end your life or hurt yourself?"

The severity of suicidal ideation may be assessed with questions such as:
—"How often do you have thoughts of suicide?"
—"Have these thoughts become more frequent?"

• ***Screen all patients for suicide ideation upon admission using a brief, standardized questionnaire.***[18] Review and assess the questionnaire before discharge.

• ***Begin 1:1 observation of patients at acute risk for suicide.*** Once 1:1 monitoring is initiated, the nurse should explain to the patient that constant observation is for his or her safety and isn't in any way punitive. The staff member must face and be within arms-length of the patient at all times. Although it may seem self-evident that the patient must never be left alone, even while using the bathroom or shower, this still must be stressed to the staff member. The nurse responsible for this patient must remain vigilant and ensure that the staff member maintains the patient's safety at all times. As a matter of standard practice, the nurse will apprise the nurse manager of the patient's risk of suicide and the steps commenced to mitigate the risk. The psychiatrist is responsible for discontinuance of constant observation.

• ***Obtain an immediate psychiatric consult for acute risk patients.*** Arrange for such a consult within 1 week of discharge for lower risk patients. Patients at low risk for suicide demonstrate no intent to act on their thoughts of self-harm. The psychiatrist will determine if the patient is at low risk for suicide based on all relevant and available evidence.

• ***Give every patient with suicidal ideation the National Suicide Prevention Lifeline phone number: 1-800-273-TALK (8255).*** This organization also has online chat access at suicidepreventionlifeline.org. Additionally, the National Institute of Mental Health has concluded that online and social media interventions can safely enhance feelings of interconnectedness in young people at risk for suicide, but also notes the need for further studies to substantiate the effectiveness of these interventions. One example of such an online resource is the Trevor Project at www.thetrevorproject.org, which specializes in at risk LGBT youth.

• ***Identify coping strategies with the patient.*** Some of these strategies include:
—suggest distractions, such as talking on the phone, reading a book, or going to the movies
—encourage the formulation of a crisis management plan
—instill hope
—draw on coping experiences successfully employed in the patient's past.

• ***Discuss ways of restricting access to lethal means.*** Understand any state or local legal requirements regarding access to firearms if it's determined that the patient may be a risk for self-harm or harm to others.

• ***Maintain a collaborative relationship with the patient.*** Constantly strive to establish a relationship of trust. Without trust, there can be no effective communication. Without communication, there can be no effective care.

• ***Accurately communicate the patient's risk to the treatment team and other appropriate personnel.*** Specifically, the APNA calls for nurses to assess patients for risk and protective factors and report that information and evaluation to the healthcare team.

• ***Assess and modify the environment to maximize patient safety.*** For instance, lanyards, call bell cords, I.V. tubing, plastic bags, razors, belts, shoelaces, and sharps should be removed from

the patient's environment to a degree appropriate for the risk.

• ***Accurately document risks and actions taken in response.*** Documentation is essential for transitioning the patient from one unit or shift to another.[19]

The Joint Commission recommendations

The Joint Commission convened two meetings of suicide prevention experts in the summer of 2017. This panel developed recommendations for the prevention of suicide within inpatient psychiatric units, as well as general acute inpatient settings. These recommendations focus on the steps that hospitals need to take to eliminate or mitigate serious environmental hazards.[1]

The Joint Commission concentrated on the presence of ligatures that may be employed for self-harm. Ligatures in the healthcare setting include I.V. lines, call bell cords, and window treatment cords. In addition, ligature anchor points must be considered as a potential risk for a patient with suicidal ideation. Ligature points are anchors that may be used to bear weight, including:[1]

- doorknobs
- hinges
- handles
- door locking mechanisms
- dropped ceiling structures
- shower and other bathroom fixtures
- exposed pipes
- coat hooks
- wall-mounted items such as soap dispensers
- I.V. poles and monitors
- patient clothing.

The Joint Commission recommends that the following areas in general acute care settings be ligature resistant:[1]

- patient rooms
- patient bathrooms
- transition zones between patient rooms and patient bathrooms
- corridors
- common patient areas.

Patient medical needs and suicide prevention must be balanced to determine optimal bed assignment. The Joint Commission recommends that if a patient with serious suicidal ideation is admitted, all objects that pose a risk for self-harm that can be removed without adverse events should be removed. There must be mitigation plans and safety precautions in place for patients who require beds with ligature points, such as 1:1 monitoring, assessment of objects brought into the patient's room by visitors, and protocols for patient transport to other part of the hospital.[1]

Hospitals must demonstrate that the following are done "routinely and rigorously" for patients with serious suicidal ideations:[1]

- training and testing staff on suicide
- implementing 1:1 monitoring
- assessing objects that pose a risk
- removing items that pose a risk
- monitoring visitors
- monitoring bathroom use
- implementing transport protocols.

In the ED, The Joint Commission recommends one of two strategies for suicidal patients: Place the patient in a "safe room" that's ligature resistant or can be made ligature resistant or keep the patient in the main area of the ED while initiating 1:1 monitoring and removing objects that pose a risk for self-harm that can be removed without adverse medical consequences.[1]

At risk: Veterans

Studies of suicide rates among veterans demonstrate how this is a complex phenomenon that transcends racial, ethnic, and gender categories. A study of active duty veterans who served during the Iraq and Afghanistan wars indicated these findings:

- Both deployed and nondeployed veterans had a higher risk of suicide for 3 years after leaving the service.
- Deployed veterans had a lower risk of suicide compared with nondeployed veterans (41% versus 61%); 21.3% of deployed veteran deaths (1,650) were caused by suicide as of 2009, whereas 19.7% of nondeployed veteran deaths (7,703) were a result of suicide.
- Suicide rates for female veterans were about a third of that for male veterans.[1]

In recognition of the difficulties that VA clinical staff members encounter in identifying patients at risk for suicide, a suicide risk algorithm was developed by studying veterans' clinical records. Researchers found that this model more accurately identified those at risk than clinical evaluation. The traditional methodology identified less than one third of high-risk patients.[2] These data drive home the need for us to increase our awareness of this growing problem and respond to it by improving our risk assessment skills.

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The Joint Commission states that healthcare organizations should do the following to protect patients in the ED:[1]

- screen for suicidal ideation
- assess risk of a suicide attempt
- assess risk of objects in patient vicinity
- remove objects that pose a risk
- initiate protocols for monitoring and patient transport
- train and test staff on suicide.

Veterans Affairs checklist

Studies demonstrate that regular active duty military service members and veterans diagnosed with some mental disorders are at a higher risk for suicide than the population at large.[20] (See *At risk: Veterans*.) In 2006, the US Department of Veterans Affairs (VA) developed a checklist to identify environmental hazards on acute mental health units treating suicidal patients. The VA implemented the Mental Health Environment of Care Checklist in 2007.[21]

The multidisciplinary inspection team that performed quarterly reviews of each hospital's mental health unit under this program included both psychiatric and nonpsychiatric unit nurse managers. The team used the checklist to assess patient safety by identifying the types and location of each hazard. Nationwide, VA facilities identified 7,642 hazards. Analysis of the findings identified a positive correlation between the facility's age and the number of hazards identified. Ligature anchor points were the most common and dangerous hazard identified. However, suffocation risks from plastic trashcan liners and poisoning risks from cleaning products were also significant findings. The program also identified materials that could be used as weapons and called for careful review of dresser drawers, moldings, flatware, chairs, artwork, and small objects. Security issues such as elopement constituted an additional common hazard. Researchers who reviewed the findings of this program noted the importance of ongoing staff training to eliminate hazards.[21]

Investigators noted that the checklist has limited usefulness for general medical units because it's nearly impossible to eliminate the hazards identified and continue to treat patients. In this regard, they recommended the use of 1:1 observation for patients with suicidal ideation. A follow-up study determined that the checklist resulted in an 82% drop in suicides in VA facilities (4.2 out of 100,000 admissions to 0.74 out of 100,000 admissions).[22]

Connect, communicate, care

Nurse managers play a valuable role in reducing suicide and suicide attempts in the healthcare setting. We can accomplish this not only by ensuring adequate training of the nursing team, but also contributing to changes to the patient environment. Although no single method can be expected to significantly diminish the risk of suicide or suicide attempts, we can implement a broad spectrum of tactics to help alleviate this growing problem.[23]

Advances in research will be essential in the development of effective treatment strategies. To this end, the National Institute of Mental Health has launched a 5-year study to test treatments intended to prevent suicide.[24] In addition, the continuing education of experienced nurses in the healthcare setting, as well as the curricula for nursing students, must ensure that nurses are equipped with the skills needed to effectively assess and care for patients who may be at risk for suicide. As the International Association for Suicide Prevention advises, we must "connect, communicate, and care" for our at-risk patients to curtail this societal crisis.[7] NM

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