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A Patient's Suicidal Ideations and a Clinical Nurse Leader's Responsibility

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Nurses caring for patients at end of life are faced with many ethical dilemmas. A patient's desire to commit suicide affects not only the person who commits suicide but also the patient's family, friends, and health care professionals. This fictional case study demonstrates an ethical dilemma when Beth, a novice hospice clinical nurse leader, is at a home care visit for Joan, a patient with end-stage ovarian cancer, and Joan expresses her wish to commit suicide. The case raises issues about patient autonomy, patient confidentiality, nursing professional code of ethics, beneficence, and whether the nurse's actions were enough to prevent the death.

KEY WORDS

depression, desire to die, ethics, hospice care, nursing, nursing responsibilities, patient confidentiality, suicidal ideations

Clinical nurse leaders caring for patients diagnosed with cancer who are nearing end of life can face many ethical dilemmas. One ethical dilemma is suicide. Globally, nearly 1 million people die each year by suicide.[1] In the United States alone, more than 30 000 people commit suicide annually.[1] Suicide leaves family members, caregivers, friends, and health professionals feeling inadequate, helpless, and responsible.

A REVIEW OF THE LITERATURE

A systematic literature review was completed using the following key words: suicidal ideations, nursing, patient confidentiality, desire to die, ethics, depression, and hospice care. The most pertinent articles were reviewed to understand some of the reasons why a person decides to commit rational suicide, the nurse's responsibility in terms of confidentiality, and patient autonomy.

Despite the low incidence of suicide in patients with terminal-stage illness, nurses still have an obligation to assess and intervene when patients verbalize suicidal ideation. Nurses have an ethical responsibility to assess patients for suicide risk and address their requests for assisted suicide and euthanasia. This can be challenging for both novice and expert nurses. The American Nurses Association prohibits nurses' participation in assisted suicide and euthanasia and requires the nurse to provide supportive care to the dying.[2] The Code of Ethics for Nurses With Interpretive Statements states, "The worth of the person is not affected by death, disability, functional status, or proximity to death. This respect extends to all who require the services of the nurse for the promotion of health, the prevention of illness, the restoration of health, the alleviation of suffering, and the provision of supportive care to those who are dying."[2] Nurses are obligated to assess and intervene to keep patients safe and without undue suffering. Assessing for suicide risk can be an awkward conversation, especially for the novice nurse. The American Psychiatric Nurses Association has established competencies for assessment and management of patients at risk of suicide. The key roles nurses play is found both at the system level and the patient level.[3] The system level involves establishing policies and procedures for assessing and maintaining a safe environment.[3] At the patient level, the nursing process should be followed, thereby assessing, intervening, monitoring, and assessing the outcomes of the intervention.[3]

According to the 2013 *Core Curriculum for the Advanced Practice Hospice and Palliative Care Registered Nurse*,[4] suicidal ideations should be considered an emergency. Helpful assessment questions include the following:

i. Do you find yourself wishing that death would come soon?
ii. Have you thought about killing yourself?
iii. If answer to above question is yes, ask, "Have you thought of the method you would use?" to further assess plan and intent.

Patient safety should be the priority, including immediate psychiatric referral, especially if the patient has an actual plan to carry out his/her thoughts.[4] The interdisciplinary team is key in determining the best plan for the patient.[4]

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The authors have no conflicts of interest to disclose.

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DOI: 10.1097/NJH.0000000000000501

There are different ways to keep the patient safe in the short term, from 24-hour supervision to sending the patient to the emergency department for urgent psychiatric care.[4] The interdisciplinary team should also be called in for patients with passive thoughts, without a plan to carry out their thoughts.[4] For example, the patient states he/she wishes this was over with already. The interdisciplinary team can provide a whole patient assessment to determine the reasons for his/her suicidal ideation and establish a plan to address the patient's fears. If any doubt exists, a referral to psychiatry or crisis intervention is appropiate.[4]

The Hospice and Palliative Nurses Association has created a position statement addressing the nurse's role when a hastened death is requested. The topic of aid in dying and physician-assisted death is important to discuss as more states legalize this option for patients with terminal-stage illness. The primary premise of the position statement is that "All patients are entitled to expert and compassionate palliative care."[5] This article does not address aid in dying or physician-assisted death, but rather focuses on suicidal ideations and how to assess patients for risk. Competency in suicide risk assessment should be a vital part of all patient assessments in hospice and palliative care. It is not uncommon for patients with serious illness to make statements about "getting it over with," "I can't go on like this," or "Can't you just give me something to get this over with?" It is important that nurses take a step back and talk with the patient about what is meant by these statements and the reasons for the statements. A thorough physical assessment and psychological assessment, including a comprehensive depression assessment, should be completed at the start of care and ongoing care thereafter for all patients. Once the assessment is complete, the interventions can be determined. The interdisciplinary team plays a key role in determining the appropriate intervention and evaluation of the patient's mental state.

Patients expressing suicidal ideation and a nurse's role in confidentiality are distressing and difficult situations for a nurse to encounter. If the nurse informs the patient's health care team, the patient's autonomy and confidentiality are violated. If the nurse maintains confidentiality, the patient's safety may be at risk. In these situations, the ethical principles of autonomy and beneficence cannot be chosen without one violating the other.[6] Beauchamp and Childress[7] define autonomy as an agreement to respect another's right to self-determine a course of action: support of independent decision making. However, autonomy can be overridden in order to avoid a suicide attempt and maintain patient safety. Beauchamp and Childress[7] define beneficence as compassion, taking a positive action to help others, and desire to do good: a core principle of patient advocacy. Nonmaleficence is the core principle of the medical oath and nursing ethics and is defined as the avoidance of harm or hurt, which requires the nurse to take action to ensure patients will not harm themselves.[7] A nurse is required to do no harm, help others, and give quality nursing care to all patients. But when faced with this ethical dilemma, the nurse may be unsure of the best way to respond.

Nurses have an obligation to respond professionally and compassionately to a patient's desire to commit suicide. According to the Hospice and Palliative Nurses Association, the palliative and hospice nurse responsibilities are as follows: recognize personal and professional values of nursing, understand respect for person, allow a capable person to decide his/her course of action and not abandon the patient, respect patient decisions, continue palliative and hospice care, maintain a nonjudgmental attitude but if necessary may defer involvement and transfer the patient to another provider, respect colleagues' opinions on the matter, and acknowledge the patient's right to refuse or stop life-sustaining therapies.[5]

A wish to die (WTD) in patients with terminal-stage illness has 3 components: reasons, meanings, and functions.[8] Reasons are the factors that patients understand as causing them to have a WTD, such as burdensome events, pain, fear, finances, social circumstances, or lack of a care network.[8] Meanings reflect their personal values and moral understandings.[8] Function or functional effect is either within their internal emotional world such as to reestablish a sense of autonomy or regarding other people and relationships such as to prompt a more serious conversation with caregivers.[8] Without detailed understanding of the specific intention of a WTD and without insight into its specific meanings, reasons, and functions, it is difficult to understand what a patient wants and why wishing to die is important to him/her.[8]

When responding to a patient's request to die, the nurse must formulate a plan of care. In planning to meet the patient's needs, the nurse must make an overall assessment, including the patient's mental condition and social supports, as well as physical condition and prognosis.[9] In addition,nurses must be careful to consider the patient's cultural background and spiritual beliefs because faith traditions may consider the passage of life to death a critically meaningful process.[9] A wish to hasten one's death does not always mean a patient has depression, but in some cases, the request may prompt further assessment for depression, and if present, treat it appropriately.[9] Depression can often be hard to distinguish from grief and is common in patients with terminal-stage illness, and its treatment can improve their quality of life.[9] Awareness of this fact is reflected in the requirement in Oregon's Death with Dignity Act to make a referral to a mental health professional if the clinician suspects that the person's judgment is affected by mental disorder.[9] Nurses should attempt to assess what the patient hopes to accomplish with death, which can help nurses explore with the patient alternative methods

for achieving the patient's goals.[9] Nurses must be careful to explore psychosocial and relational motivations, in addition to the more apparent ones such as pain relief, for potential alternative ways to intervene.[9] Counseling patients regarding options and helping patients explore how those options fit their values and situation are within the accepted bounds of ethical nursing practice.

A collaborative care approach strives to provide optimal care for patients.[10] While a multidisciplinary approach to suicide risk assessment and management has been identified as important for reducing suicide, standard clinical guidelines for such an approach do not exist. Proposed is the adoption of the therapeutic risk management of the suicidal patient (TRMSP) to improve suicide risk assessment and management within multidisciplinary systems of care.[10] The TRMSP involves augmenting clinical risk assessment with structured instruments, stratifying risk in terms of both severity and temporality, and developing and documenting a safety plan.[10] When structured instruments are combined with clinical risk assessment, the incorporation of suicide-specific structured instruments offers an approach to suicide risk assessment, with risk assessment as a process as opposed to an event.[10] Patients who present with risk will require additional suicide risk assessments. Therapeutic risk assessment of the suicidal patient requires moving beyond the 1-dimensional stratification of suicide risk that has traditionally been predicted on low, moderate, or high.[10] A multidisciplinary approach to TRMSP requires a standardization nomenclature that facilitates consistent documentation and communication between providers and creates a cohesive medical record.[10]

The third component involves the safety planning intervention (SPI). The SPI is an alternative approach to the no-suicide contracts.[10] The SPI consists of 6 steps: warning signs, internal coping strategies, people and social settings that provide distraction, contact family or friends to help resolve a crisis, contact professionals or agencies to help with crisis, and reduce the potential for use of lethal means.[10] The SPI along with the suicide risk assessment is ongoing. Safety plans are the property of the patient but should be visible to all the providers. In creating the multidisciplinary approach to the TRMSP for systems of care, the goal will be to surround suicidal patients with a network of providers who cooperatively optimize care and mitigate risk.[10]

There have been tensions between patients' rights, society's overarching desire to prevent suicide, and clarifying the relationship between mental disorders, mental capacity, and rational suicide.[11] Claims arising from suicide are one of the most frequent types of malpractice suits. There are increased risks of lawsuits against clinicians treating outpatients. Many malpractice claims focus on issues relating to negligence, such as foreseeability and causality, based on a premise that most suicides are preventable if foreseeable and if appropriate steps are taken to prevent suicide.[11] While legal statutes facilitate involuntary hospitalization for those who are at serious risk of harm to themselves due to a mental illness, little was said about managing cases of suicidality in people with intact mental capacity making a rational decision.[11] Rational suicide is made by those with mental capacity and seen as a means of protecting others from suffering. This could be viewed as altruistic, rather than irrational because it can be justified by achieving a higher-order goal, which is reducing the suffering of those left behind.[11] There remains much debate about whether suicide can ever be rational. While upholding patient rights of autonomy, cases of suicidality warrant a delicate consideration of clinical judgment, duty of care, and legal obligations for the clinicians and nurses.[11] Current guidelines and legal statutes do not adequately consider the complexity of suicidality, including the potential for suicidality made under free will, uninfluenced by an identified psychiatric disorder. The impact on care provided to patients comes with potential risks that cannot be taken lightly. These risks are to the patient's rights and responsibilities, as well as to the clinicians' and nurses' attitudes and approaches to managing suicidality.[11]

In 2004, a nursing theory was developed to guide the care given to people with suicidal ideas and those with a previous suicide attempt of safe and compassionate care via the channel of the therapeutic relationship.[12] It includes holistic assessments, protection, basic care, and promoting healing through advanced care.[12] Nurses could use the theory as a guide as they initiate and maintain therapeutic relationships with patients who are at risk of suicide. The theory could advance the quality of care provided by nurses. In addition, it holds potential for instilling hope in patients who lost their ability to cope with life events and perhaps life itself.[12] Research should be done to determine if the theory remains relevant more than a decade later.

A summary of literature concludes depression and suicide are difficult subjects to breach and often are not discussed until a nurse has established positive therapeutic communication. Position statements should guide our ethical practice when caring for patients with suicidal ideation. It is difficult to determine why a patient decides to commit rational suicide without understanding the patient's rationale. Suicidal thoughts are most common in cancer patients with pain and emotional distress. The nurse's responsibility in terms of patient confidentiality and patient autonomy comes with the risk of having to violate the patient's rights, but it is not considered a violation if it is in the best interest of the patient's safety. Utilizing therapeutic relationship from the nursing theory can help nurses with the quality of care given to suicidal patients.

THE CASE OF JOAN

The last home care visit of the day for Beth, a novice hospice clinical nurse leader (CNL), was to Joan's home to monitor her blood sugar levels due to the steroid therapy and to provide further education. Beth reviewed Joan's medical history prior to the visit. Joan, a 72-year-old woman, has a 2-year history with ovarian cancer, which has metastasized to her spleen and liver. All curative treatment had been unsuccessful. She has continuous pelvic and abdominal pain, persistent bloating, nausea, and loss of appetite. She has been taking oral morphine for pain, an appetite stimulant, and a bowel regimen and recently began taking a steroid for her nausea. Despite taking her medications, Joan was steadily losing weight. Joan lives alone since her husband died last year. She has been previously deemed mentally capable of making all her own decisions. She has an advanced directive, which states she wants to be home to die and have adequate pain management. Joan is financially stable and has a trust fund set up for her daughter, Meg, and grandchildren. The oncologist and hospice team are following her care. Beth utilized the nursing process, which is a process to plan the care for her visit.[13]

Assessment: Joan has reported that the pain was getting increasingly worse despite an increase in her morphine dose a few weeks ago. She states she is in so much pain she could no longer do the things she used to enjoy. She has distanced herself from her friends and wants to spend the rest of her time with her family. Joan told Beth she was ready to be with her deceased husband. She told Beth she was tired and knew she was dying anyway so why suffer in pain and wait for it to happen naturally. Beth asked her if she was feeling depressed, and she stated she was not. At this time, Beth performed a comprehensive physical assessment focusing on a comprehensive pain assessment. A depression screen and suicidal ideation screen would be appropriate. Being new to hospice care, Beth felt Joan's feelings were normal in a patient with terminal-stage illness and deferred a formal depression screen.

Diagnosis: Based on Beth's assessment, Joan was in need of better pain control. Joan did not want to make any changes in her regimen until she sees her case manager the next day. She is exhibiting signs of depression when stating she wants to be with her husband, but without a depression screen depression cannot be confirmed. Beth has also noticed Joan has decreased her connection with friends and is allowing only her family to visit.

Planning: Beth suggested Joan be admitted to the hospital under hospice care to obtain better pain relief, but she refused, stating "I can wait for an adjustment until tomorrow." She was adamant about wanting to be at home when she died because all her fond memories were at home. Joan had begun laughing when she mentioned to Beth that she had enough morphine in the house to go and be with her husband, which made Beth very concerned. Beth encouraged Joan to talk about her feelings and her WTD, but she refused to engage in any further conversation at that point. Beth asked if she had informed her daughter about her feelings in an attempt to keep the conversation going. At that point, Joan had become very upset and told Beth that her daughter was very busy and that she was not to inform her. Joan's tone changed, and she told Beth not to worry. She stated she was just feeling sorry for herself and not really serious about taking her life. She just wanted more time with her daughter and grandchildren. Joan then asked Beth to leave because she was tired and wanted to rest.

Implementing: Beth had an uneasy feeling when she left the house, and based on her intuition and assessment of the situation, she called the hospice agency to inform them of Joan's present state of mind. The hospice case manager informed Beth she would call Joan. Beth then called the oncologist to update him. He informed Beth that he would call Joan and have her make an appointment to come to his office tomorrow. He reassured Beth that people who say they want to commit suicide were not usually serious, which put Beth's mind at ease. Beth documented all the calls and conversations. Beth felt comfortable with how she handled the situation and that she notified the provider regarding Joan's comments.

Evaluation: The next day Beth was informed by her manager that Joan had died, and her daughter had been the one that found her. Next to Joan were empty bottles of morphine, her antiemetic medication, and a bottle of wine. Meg was furious that her mother was left with enough medication needed to commit suicide and was inquiring if anyone was aware of her mother's suicidal intentions. Beth later found out that the hospice case manager and the oncologist all left a message for Joan, but no one has spoken with her. The hospice case manager was scheduled to come the next day but left an emergency contact phone number for Joan to utilize if she needed to talk during the night before their next visit. After receiving this information, Beth began to wonder if she acted with enough urgency and felt uncomfortable as the novice hospice CNL on the case.

ADVANCED PRACTICE ROLE OF A CNL

The core competencies of a CNL are clinician, outcomes manager, patient advocate, educator, information manager, risk anticipator, leader, member of a profession, and a lifelong learner.[14] Clinical nurse leaders also contribute to research through the study of advanced practice with a focus on specific disease and care settings, outcome evaluation based on best practice in patient care, and the systematic evaluation of evidence-based research. Clinical nurse leaders can provide the coordination and comprehensive

care management that is often lacking for the patient and the patient's family when faced with a serious or life-limiting illness. They can also identify and manage the multidimensional needs of the patient and patient's family, collaborate with other providers, and engage the patient and family in meaningful conversations that include care options and modifications in advanced care planning.[14]

In Joan's case, Beth did notify the care team of her concerns about Joan but failed to take that "gut feeling" into account and urgently pull in the team. Beth did not inform Joan's daughter, so patient confidentiality was maintained on the family level. Since a team managed Joan's medical treatment, it was Beth's responsibility to use her leadership and risk anticipator role to inform the team about a change in patient status that would cause harm to the patient. The CNL must utilize the entire interdisciplinary team for the best outcome of patient care, which in Joan's case would have identified the need for immediate intervention. Although Joan stated she was not depressed, Beth was uneasy and concerned, that "gut feeling." Patients with terminal illnesses often say things they do not intend on carrying out. All patients who make statements around suicide need to be assessed further. As a CNL, there is a need to promote active listening, offer verbal support, provide information to assist the patient in coping with the situation, identify past strengths, and support previously successful ways of coping.[14] These techniques could have helped Beth further assess Joan, but Beth being a novice CNL has not mastered these competencies. A novice advanced practice palliative nurse is inconsistently eliciting a patient's health history for directed therapies, cure, or palliative care.[15] On the other hand, an expert advanced practice palliative nurse manages complex pain and symptoms utilizing evidence-based tools and can evaluate patient's responses to palliative care and the effectiveness of the care to optimize quality of life of patients and families.[15] An expert CNL would have pressed the need for Joan to talk about her feelings to try to lessen the burden that Joan must have been feeling, as well as be more in touch with her own intuition about the situation.

Support System: Joan lived alone, and her daughter did not visit often, her husband had died, and she socially isolated herself. She did not have a reliable support system in place to be with her at this difficult stage of illness. Spiritual care would be contacted to come and speak with Joan and see if she had any unresolved issues they could help with. A conversation about what gives Joan purpose and hope could have encouraged her to open up about what mattered most to her and show that she had a tie to humanity. The spiritual care team could have connected Joan with community services to take her mind off of her illness, even if only for a short time. Beth being a novice CNL incorporated the core scientific and ethical principles in identifying ethical issues arising with patients but lacked the skills of an expert CNL who would have realized to engage Joan more and include family in quality-of-life and end-of-life decisions.[14] An expert CNL would also have realized that patient safety would have come before confidentiality and autonomy in this situation and made the proper emergency referrals.

Pain Management Communication: Joan's pain should have been addressed with a comprehensive pain assessment and medications adjusted appropriately and in a timely manner. Joan had laughed about having enough morphine in the house to commit suicide, which showed Joan not only was speaking of having suicidal thoughts but also had a plan as to how she would carry it out. These issues justified immediate and definitive action by Beth. The appropriate team members were notified, but there was no follow-up or urgency conveyed. An expert CNL would have realized the acuity of the issue and ensured a visit be made that day, especially when Joan was not answering the calls from multiple providers. The acuity of the matter was not clear, and there was no appropriate follow-up from any member of the team, physician, or nurse.

Mental Capacity: Joan appeared to have mental capacity per her history and physical from the oncology office. She was making a decision based on the lack of treatment options and felt that suicide was her best option. Suicide would prevent her from being a burden on her family and causing suffering to her family. In Joan's case, she felt suicide was the best option, and Beth informing other team members would be harmful to her plan. An expert CNL would have carried out a mental health assessment at the visit to ensure that Joan had the mental capacity to make her own decisions and made an appropriate referral if needed.

Patient Confidentiality: Joan wished to protect her daughter, Meg, but in the end, it left Meg powerless. Joan asked Beth not to tell her daughter because she did not want to further burden her daughter. She felt her quality of life had diminished to the point that she no longer wanted to live. She had the right to end her life. Because of confidentiality, Meg's grief and anger were deflected to the professionals and not her mother. An expert CNL that is trained in therapeutic responses would have been able to explore Joan's wishes and possibly pull Meg in to help her understand her mother's wishes.

Meg was upset that Joan was left with enough medication to commit suicide, and no one contacted her about her mother's suicidal ideations. Patients often have many different medications in the home when they are on hospice. Safety of having those medications in the house should always be discussed, along with disposal, misuse, and diversion. In this scenario, Joan appeared to be using her medications appropriately, and there was no justification to remove the medications. She had escalating pain and required adequate pain control. However, if an appropriate

depression and suicide screen assessment was done, the risk may have been identified and plans in place to give Joan only a certain number of pills.

Suicidal Ideations: Joan was just waiting for Beth to leave so she could join her husband. She refused an in-patient admission to hospice to better maintain her pain because she did not want to leave her home. She wanted to die in her own bed. The option to commit suicide was thought about, a decision was made, and a competent person carried out the plan. Beth would not be able to stop this without the assistance from others on the interdisciplinary team. An expert CNL possibly would have been able to prevent it by utilizing her additional educational skills of assessment, intervention, and evaluation.

Therapeutic Communication: Exploring with Joan what gives her life purpose and her life accomplishments could have been very therapeutic and perhaps even helped her to identify how she can regain purpose back in her life. Beth did her best to listen to Joan, not allow her own beliefs to influence or deter any aspect of Joan's care, and maintain her presence until Joan asked her to leave. Beth was as compassionate as Joan would allow her to be.

An expert CNL could have had a positive influence on this case, leading to a positive outcome. But as always, looking back there are always more things that a nurse feels could have been done differently with a patient. The hope is this experience will bring new insight that can be applied to the next patient.

SUMMARY OF THE ISSUE

Nurses may struggle to determine whether a patient who is verbally expressing the thought of committing suicide is requesting hastened death, a sign of psychosocial distress, or merely a passing comment that is not intended to be heard literally as a death wish.[10] When a patient tells the nurse about thoughts of committing suicide, it creates an ethical dilemma for the nurse because the nurse must make a morally correct choice, which causes concern and confusion for many nurses, even those who have many years of experience, as they try to determine the basis of the statement and the appropriate response. Guidance is needed for nurses in regard to what is an appropriate therapeutic response that will not compromise the patient's quality of care or the nurse's ethical obligations. Despite warning messages preceding 80% of suicides, these messages are commonly ignored or discounted.[8] There is no evidence that talking about suicidal thoughts will elicit suicidal behavior in someone who has not previously considered the possibility of suicide.[8] According to the American Nurses Association, discussion of suicidal thoughts does not increase the risk of suicide and may actually be therapeutic in decreasing the likelihood.[2]

In summary, all nurses whether novice or expert should be able to recognize when a situation is above their competency and what team members to refer to next so the urgency of the situation is acknowledged. Nurses have a responsibility to the patient to protect their confidentiality and maintain patient autonomy but at the same time maintain safety and provide them with the best possible care.[16] At times, this means the nurse may need to violate her oath to patient confidentiality and patient autonomy to protect the patient from harm. Appropriate assessment, intervention, and evaluation of depression and suicide risk should be assessed on all patients upon hospice admission and periodically thereafter. Team members need to be informed if a patient's status had changed, especially if the nurse feels it is beyond the nurse's competency level.[16] Knowing the patient is competent, understanding the nursing code of ethics statement, and ethical principles can help the nurse make his/her ethical decision.

Nurses should receive guidance in discerning the appropriate response to hospice patients expressing suicidal thoughts and what their roles and responsibilities are. Beth had to fulfill her duty and respect Joan's wish of confidentiality in regard to Joan's daughter, but that duty does not apply when it came to Joan harming herself. In the end, Beth did collaborate with the team members in an attempt to keep Joan safe, thus upholding the nursing code of conduct.

References

1. World Health Organization. Preventing suicide: a global imperative. http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/. Accessed March 28, 2018.
2. American Nurses Association. Euthanasia, assisted suicide, and aid in dying. http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Euthanasia-Assisted-Suicide-and-Aid-in-Dying.pdf. 2013. Accessed June 1, 2016.
3. Psychiatric-Mental Health Nurse Essential Competencies for Assessment and Management of Individuals at Risk for Suicide. February 2015. https://www.apna.org/files/public/Resources/Suicide%20Competencies%20for%20Psychiatric-Mental%20Health%20Nurses(1).pdf. Accessed June 6, 2018.
4. HPNA *Core Curriculum for the Advanced Practice Hospice and Palliative Care Registered Nurse*. 2nd ed. Pittsburgh, PA; 2013.
5. Hospice and Palliative Nurses Association. Guidelines for the role of the registered nurse and advanced practice registered nurse when hastened death is requested. 2017. http://advancingexpertcare.org/wp-content/uploads/2017/07/Guidelines-for-RN-and-APRN-When-Hastened-Death-Requested.pdf.2017. Accessed August 22, 2017.
6. Jie L. The patient suicide attempt—an ethical dilemma case study. *Int J Nurs Sci*. 2015:408-413.
7. Beauchamp T, Childress J. *Principles of Bioethics*. New York, NY: Oxford; 2016.
8. Ohnsorge K, Gudat H, Rehmann-Sutter C. What a wish to die can mean: reasons, meanings and functions of wishes to die, reported from 30 qualitative case studies of terminally ill cancer patients in palliative care. *BMC Palliat Care*. 2014;13:38.
9. Olsen D. Ethical nursing care when the terminally ill patient seeks death. *Am J Nurs*. 2017;117(7):50-55.

10. Grant C, Lusk J. A multidisciplinary approach to therapeutic risk management of the suicidal patient. *J Multidiscip Healthc*. 2015;8:291-298.
11. Onkay A. Suicide: rationality and responsibility for life. *Can J Psychiatry*. 2014;59(3):141-147.
12. Sun F, Long A, Boore J, Tsao L. A theory for the nursing care of patients at risk of suicide. *J Adv Nurs*. 2004;53(6):680-690.
13. Nursing Process Organization. Nursing Process Steps. 2018. https://www.nursingprocess.org/Nursing-Process-Steps.html. Accessed March 27, 2018.
14. American Association of Colleges of Nursing. Competencies and curricular expectations for clinical nurse leader education and practice. 2013. http://www.aacnnursing.org/Portals/42/AcademicNursing/CurriculumGuidelines/CNL-Competencies-October-2013.pdf. Accessed August 13, 2016.
15. Reville B, Foxwell A. Competency milestones: guidelines for advanced practice palliative nurses. *J Hosp Palliat Nurs*. 2017;19(4):339.
16. Wittenberg E, Ferrell B, Goldsmith J, et al. *Textbook of Palliative Care Communication*. New York, NY: Oxford; 2016.

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