Suicide Assessment

Epidemiology of Suicide

About 31,000 people complete the act of suicide each year, an average of one person every 16 to 18 minutes. Suicide is the eleventh leading cause of death in the United States. The actual number of suicides may be two to three times higher because of the underreporting that occurs. Worldwide, at least 1000 suicides occur each day, and it is the leading cause of death, outnumbering homicide or war-related deaths. The United States now has one of the highest suicide rates for young men in the world, surpassing Japan and Sweden, countries long identified with high rates of suicide. The overwhelming majority of completed suicides are committed by males. Well over half of these males shoot themselves, and the use of guns in suicide is increasing rapidly. Women attempt suicide twice as often as men. They use potentially less lethal means.

Concern

Suicide of a care recipient while in a staffed, round-the-clock care setting has been the number one most frequently reported type of sentinel event since the inception of the Joint Commission’s Sentinel Event Policy in 1996. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important first step in protecting and planning the care of these at-risk individuals.

Are Health Care Professionals missing suicidal behavior in their patients? It has been reported that 8 of 10 patients who commit suicide talked about it with someone before completing the act. Often the person they talk with is a health care professional. The problem is that health care providers often miss the signs and symptoms of depression and the subtle indicators of self-destructive intentions.

There is evidence, for example, that 45% of people who complete suicide visit primary care providers within 1 month before their attempt, and 20% had contact with mental health services within 1 month before their suicide. Among the elderly, more than 80% give clues of their intent. Of the elderly who commit suicide, 75% are known to have visited their personal physician in the month before they took their life.

Health care professionals report a surprisingly small amount of probing for depressive or suicidal symptoms, even when they are mentioned by the patient. It thus appears that much work needs to be done to alert health care providers to the severity and extent of this problem and to help them better evaluate patients for potential self-destructive responses. When health care professionals identify patients at risk for suicide, we need to provide tangible ways (such as a crisis hotline number) for the individuals and their families to get the help they need in crisis situations.

Suicidal/Self-Harm Assessment

Suicidal Behavior

Suicidal behavior is usually divided into the categories of suicide ideation, suicide threats, suicide attempts, and completed suicide. Suicide ideation is the thought of self-inflicted death, either self-reported or reported to others. Suicidal ideation may vary in seriousness. It can be passive, when there are only thoughts of suicide with
no intent to act; or active, when there are plans or thoughts of causing one’s own death. All suicide behavior is serious, whatever the intent, and thus any suicidal ideation deserves the nurse’s highest priority care.

A suicide threat is a warning, direct or indirect, verbal or nonverbal, that a person is planning to take one’s own life. It may be veiled but usually occurs before overt suicidal activity takes place. The suicidal person may make a statement such as "Will you remember me when I’m gone?" or "Take care of my family for me." In the context of recent stressors and the person’s life situation, statements such as these may be ominous. Nonverbal communication often reveals the suicide threat. The person may give away prized possessions, make a will or funeral arrangements, or withdraw from friendships and social activities. The threat is an indication of the ambivalence that is usually present in suicidal behavior. It represents the hope that someone will recognize the danger and rescue the person from self-destructive impulses. It also may be an effort to discover whether anyone cares enough to prevent the person from harming himself or herself.

A suicide attempt is any self-directed action taken by a person that will lead to death if not stopped. In the assessment of suicidal behavior, much emphasis is placed on the lethality of the method threatened or used. Although all suicide threats and attempts must be taken seriously, vigilant attention is indicated when the person is planning or tries a highly lethal method. Such methods include gunshot, hanging, or jumping. Less lethal means include carbon monoxide and drug overdose, which allow time for discovery once the suicidal action has begun.

Assessment of the suicidal person also includes whether the person has made a specific plan and whether the means to carry out the plan are available. The most suicidal person is one who plans a violent death, has a specific plan, and has the means readily available. This person is exhibiting little ambivalence about a suicide plan. Another aspect to assess includes whether the individual has a suicide attempt history. Additionally the nurse assesses the patient for symptoms such as hopelessness, helplessness, anger/hostility, impulsivity and impaired problem solving.

Clinical Example

Mr. Y was a 52-year-old black man employed in the foundry of a large steel mill. He had worked for the company for 20 years. He lived in a rented room in a blue-collar neighborhood near the mill. Most of his neighbors were Appalachian white and southern black families who had moved to the community to work at the mill. The neighborhood had an undercurrent of racial tension, but Mr. Y was not involved in conflicts with his neighbors. He had separated from his wife before moving to the community and had no close friends or family. The separation resulted from his violent behavior related to drinking binges.

Mr. Y was seen by the occupational health nurse, Ms. G, when he came to the employee health clinic following a 6-week absence from work. He had been hospitalized for broken ribs and a concussion after he had been beaten and robbed by a gang of adolescents in an alley behind his home. Ms. G was familiar with this patient because he had participated in the company’s employee assistance program for alcoholics. When she saw him in the clinic, she immediately noted that he appeared depressed. His face was expressionless, his posture was slumped, and he had lost weight. He appeared disheveled, which was a change from his usual neat appearance. His speech was slow and halting and so soft that he could barely be heard.

He told Ms. G that he had a request to make of her. He knew from past conversations that she was an animal lover. He wanted her to take his pet dog because he did not feel able to care for it adequately, and the neighbors who kept it while he was in the hospital had neglected it. Ms. G was very concerned about Mr. Y and asked him how he was spending his time. He said he kept the television on and he thought a lot. When asked, he said he felt “too shaky” to go outside unless he absolutely had to. He thought the boys who attacked him were still in the neighborhood.

Ms. G asked if he had thought about harming himself. Mr. Y looked startled, then admitted that he saw not
other solution to his problem. "It makes sense. I don't have anybody. If you take Rover, I can go." With further questioning he admitted that he had a loaded revolver at home and planned to use it after he left the clinic. Ms. G realized that Mr. Y needed help immediately and initiated plans for hospitalization and took steps to ensure his safety.

Completed suicide, or simply suicide, is death from self-inflicted injury, poisoning, or suffocation where there is evidence that the decedent intended to kill himself or herself. Completed suicide may take place after warning signs have been missed or ignored. Some people do not give any easily recognizable warning signs.

Summary

The suicidal patient may have many different clinical behaviors. Mood disturbances are often present, as are somatic complaints. Feelings of hopelessness and helplessness are important in explaining suicidal ideation. Nurses should take a careful medical and mental health history and evaluate the patient for recent losses, life stresses, and substance use and abuse. Contrary to common opinion, directly questioning the patient about suicidal thought and plans will not cause the patient to take suicidal action. Rather, most people want to be prevented from carrying out their self-destruction. Most patients are relieved to be asked about these feelings. One of the most important questions to ask of suicidal patients is whether they think they can control their behavior and refrain from acting on their impulses. If patients cannot do this, the nurse would implement suicide precautions (see policy/procedure on Suicide Precautions).

Finally, the nurse should have some systematic way of evaluating a patient for the risk of suicide. The nursing care plan for the person with self-destructive behavior must focus first and foremost on protecting the patient from harm.


Huntsville Hospital's Policies and Procedures>>
The patient care guidelines contained in this document are not intended to be an inflexible, mandatory plan of treatment and are not substitutes for independent clinical judgment with respect to the care and treatment of any individual. It is understood by the hospital that all care is individualized based upon the patient’s current condition, assessment, and the clinical judgment of the health care provider responsible for the patient care.

Title: Suicide Precautions
Department: Housewide
Area: Nursing
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Scope
Patient Care Personnel

Guideline
Screen: All Emergency Department and Inpatients over the age of six are assessed for risk of suicide. All Outpatient Departments assess for suicide on patients being treated or present with emotional or behavioral disorders. If on admission there is a risk for suicide identified, the nurse proceeds to evaluation of thoughts, plan, means and ability.

Additional data to be considered:
- History of suicidal ideas or previous attempt(s), to include plan, lethality of method used, family history of suicide.
- Current suicidal ideas, to include plan, lethality of method, any steps taken to achieve suicide.
- Recent losses or stressors that might cause thoughts of self-harm.
- Statements of hopelessness, helplessness, and futility.

Suicide precautions are initiated when a patient is admitted and has suicidal tendencies. When the patient’s medical condition necessitates admission, a trained staff member remains with the patient at all times. Transfer to an appropriate setting is made as soon as the patient is medically stable. The decision for discontinuation of suicide precautions is made by the attending physician or by the consulting psychiatrist.

Inpatient Procedure
1. A physician’s order for a psychiatric consultation, if warranted, is obtained.
2. On admission, and at initiation of Suicide Precautions, the patient is asked to remove personal clothing and dress in a hospital gown, while a search is done for any unsafe items. This search results in the removal of jewelry, eyeglasses, cigarette lighters, matches, medications, shoe laces, belts, plastic bags, bathrobe belts, or any other personal item, which may be a safety risk while the patient remains on suicide precautions. (advisable to have another staff member present as a witness). Give personal items to Security to be locked up.
3. Assess and remove from patient's room any other instruments that may be used for self-harm. (Soda cans and pop tops, vases with flower spikes, coat hangers, phone cord, and sharp items, etc.).
4. Patients may use electric razors only with cord removed.
5. Instruct family/visitors that potentially harmful items (i.e., glass, scissors, and matches) are not to be given to the patient.
6. Reassess patients on suicide precautions looking for above-mentioned items during bedside shift report.
7. Place blue "suicide precaution" armband on patient.
Patient Care Guidelines

8. When a sitter is needed:
   a. Nurse notifies Manager/Charge Nurse when a patient is assessed as a suicide risk or when a physician has ordered a sitter for suicide precautions.
   b. Staff remains with the patient at all times.
   c. Call the staffing office at 5-8889 to request a sitter and when the sitter is discontinued.

9. Place the patient as close to the nursing station as possible. ICU patients are in direct line of sight.
10. The door to the patient’s room is left open for close observation.
11. The medication nurse pays special attention to patients while administering medications that patients are swallowing their pills and are not collecting them.

Outpatient Procedure

Clinic:
1. If patient identified at risk, remove environmental safety hazards.
2. Remain with patient.
3. Notify physician, counselor, and/or Nurse Practitioner to complete face to face evaluation.
4. Give crisis intervention numbers (see below).

Documentation
1. Removal of harmful objects (as listed) from room and to whom given or where stored, i.e., locked drawer safe.
2. “Suicide precaution” armband placed on patient.
3. Patient's behavior/comments verbatim during each shift (Observation sheet documentation every 15 minutes by sitter).
4. Who is staying with the patient at all times.
5. Safety monitoring of the patient is documented on each shift in iCare and on SBAR.
6. Patient education in iCare
7. “Suicide precautions” on Ticket to Ride.
8. Careplan (depression)

Keypoint
Throughout the admission, hospitalization and/or treatment process the ultimate goal is to provide a safe environment for the patient, even if that means protecting him/her from himself/herself.

If patient is not being admitted to BHS or referred to a mental health professional, nurses are expected to share the Crisis Hotline numbers with patients and families.
Call 1-800-273-TALK (8255) (Suicide Prevention Hotline) or HELPLINE at 256-716-1000 or 1-800-691-8426.