



SUICIDE PREVENTION



OVERVIEW

- Suicide is the 11th leading cause of death in the United States
- Suicide is the third leading cause of death among persons aged 10-14, the second among persons aged 15-34 years, the fourth among persons aged 35-44 years, the fifth among persons aged 45-54 years, the eighth among person 55-64 years, and the seventeenth among persons 65 years and older

IDENTIFICATION

- Identification of individuals at risk for suicide while under the care of or following discharge from a healthcare organization is an important first step in protecting and planning the care of these at risk individuals.

SUICIDE AND HOSPITALS

- Patients in general hospitals who are suicidal attempt suicide after admission more rapidly and with fewer threats or warnings than suicidal psychiatric inpatients.
- Studies have shown that suicide attempts within general hospital environments are more violent (hanging, jumping, or gunshot) than those on psychiatric units



RISK FACTORS FOR SUICIDE

- Recent suicide attempt
- Suicidal thoughts or behaviors
- Family history of suicide or psychiatric illness
- Taking antidepressants
- Physical health problems; poor prognosis
- Diagnosis of delirium or dementia
- Chronic pain or intense acute pain
- Social stressors (financial, disability, relationship problems)
- Substance abuse



WARNING SIGNS AND IMMINENT RISK

- Irritability
- Increased anxiety (in addition to panic)
- Agitation
- Impulsivity
- Decreased emotional reactivity
- Complaining of unrelenting pain
- Refusing visitors
- Crying spells
- Declining medications
- Requesting early discharge

CONTRIBUTING FACTORS IN HOSPITALS

- Specific means easily available in hospitals that have been used in suicide attempts:
 - Bell cords
 - Bandages
 - Sheets
 - Restraint belts
 - Plastic bags
 - Elastic tubing
 - Oxygen tubing

SYSTEMIC CARE SHORTCOMINGS

- Inadequate screening and assessment
- Care planning and observation
- Insufficient staff orientation and training
- Poor staff communication
- Lack of information on suicide prevention and referral resources



RISK REDUCTION STRATEGIES

- Watch for behaviors, mental status, or conditions that may indicate a risk of suicide
- Screen patients who demonstrate these behaviors, mental status characteristics, or conditions for suicide risk
- Immediately communicate to the attending MD, any evidence of suicidal ideation, suicidal intent, suicidal plans, or other serious self harm risk factors identified



RISK REDUCTION

- All patients on admission, ED patients, and Physician Practice outpatient clinic patients ages 9 and above are screened for suicide risk utilizing the Columbia-Suicide Severity Rating Scale.
- Northern Pediatrics will utilize PSC17(Pediatric Symptom Checklist) and PHQ-9 (Patient Health Questionnaire).
- Any evidence of suicidal ideation, suicidal plans, or other serious self-harm factors identified by staff is immediately communicated to the attending physician.



COLUMBIA SUICIDE SEVERITY SCALE- HOSPITAL

Columbia-Suicide Severity Rating Scale (C-SSRS)-Hospital

Ask questions that are in bold and underlined		Past Month	
Ask Questions 1 and 2		YES	NO
1	<u>Wish to be dead</u> - Have you wished you were dead or wished you could go to sleep and not wake up?		
2	<u>Suicidal Thoughts</u> - Have you actually had any thoughts of killing yourself?		
If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6			
3	<u>Suicidal thoughts w/Method</u> - Have you been thinking about how you might do this?		
4	<u>Suicidal Intent (without Specific Plan)</u> - Have you had these thoughts and had some intention of action on them?		
5	<u>Suicidal Intent (with Specific Plan)</u> - Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
		Lifetime	
6	<u>Suicide Behavior</u> - Have you ever done anything, started to do anything, or prepared to do anything to end your life?		
If "YES" - Was it within the past 3 months?		Past 3 months	
High Risk	If Yes #4 relative to 30 days #5 relative to 30 days #6 relative to 90 days	Notify physician immediately to initiate IVC if not already; psychiatric consult. 1:1 Observation by qualified staff member; (Camera may only be used in addition to sitter). 15 min documentation; Revise diet order to safe tray; complete behavioral risk assessment every shift	
Moderate Risk	If Yes #3 #6 relative to >90 days	Notify physician for further assessment; consider psychiatric consult; implement patient safety monitors; camera surveillance; outpatient mental health referral on discharge	
Low Risk	If Yes #1 or #2 Remaining NO	Sitter not required; discretionary outpatient mental health referral	
No Risk	No #1 or #2		

COLUMBIA SUICIDE SEVERITY SCALE- CLINICS

Columbia-Suicide Severity Rating Scale (C-SSRS)-CLINICS

Ask questions that are in bold and underlined		Past Month	
Ask Questions 1 and 2		YES	NO
1	<u>Wish to be dead</u> - Have you wished you were dead or wished you could go to sleep and not wake up?		
2	<u>Suicidal Thoughts</u> - Have you actually had any thoughts of killing yourself?		
If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6			
3	<u>Suicidal thoughts w/Method</u> - Have you been thinking about how you might do this?		
4	<u>Suicidal Intent (without Specific Plan)</u> - Have you had these thoughts and had some intention of action on them?		
5	<u>Suicidal Intent (with Specific Plan)</u> - Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
		Lifetime	
6	<u>Suicide Behavior</u> - Have you ever done anything, started to do anything, or prepared to do anything to end your life?		
If "YES" - Was it within the past 3 months?		Past 3 months	
High Risk	If Yes #4 relative to 30 days #5 relative to 30 days #6 relative to 90 days	Notify physician immediately. Staff to remain with the patient at all times, one on one observation. Consult Mobile Crisis through Daymark. Provider may initiate IVC if needed.	
Moderate Risk	If Yes #3 #6 relative to >90 days	Notify physician for further assessment; implement patient safety monitors; consult Mobile Crisis with Daymark. Initiate IVC if necessary.	
Low Risk	If Yes #1 or #2 Remaining NO	Consider outpatient mental health referral	
No Risk	No #1 or #2		



RISK REDUCTION STRATEGIES CONTINUED

- Once a patient is deemed high risk, do not leave the patient; provide constant observation. Alert someone to notify the physician.
- Refer to the *Suicidal or Personal Harm Risk Assessment and Management* policy
- Relocate the patient to an environmentally safe room if possible by removing all mobile items that could be used to harm self or others



HIGH RISK PATIENTS

- Staff will make visual contact with the patient every 15 min and will document same
- Initiate involuntary commitment procedures if not already under commitment
- Remove all patient clothing and place the patient in a gown (notify Security for assistance) and document an inventory of all items removed from the patient and room. Remove potentially harmful items such as equipment cords, IV tubing, telephone cords, television cords, and electronic bed cords. All plastic bags should be removed from the room and paper bags placed in the trash cans, or the trash cans should be completely removed from the room. No ingestible toxins should be in the room (e.g., mouthwash, shampoo, aftershave, colognes, hand sanitizer, or perfumes).




HIGH RISK PATIENTS

- Secure any patient medications according to the patient valuable policy
- Any weapons found will be secured by Security staff
- Relocate the patient to the observation room if ED patient.
- If the patient is admitted, the patient will be placed in ICU in 416, 408, or 410 if possible. Place camera in the room with surveillance available from multiple computers. Cameras may only be used in conjunction with 1:1 staff observation. Bed alarms should be activated.
- Any meals provided to the patient will be finger foods in disposable paper/Styrofoam products. The requisition to dietary should indicate Safety Diet
- Tray order. Canned drinks should not be provided to the patient and should be poured into a Styrofoam cup





HIGH RISK PATIENTS


- Once a patient is no longer considered high risk, the physician may write an order to reduce the level of observation
- To maintain the patient's safety, a reassessment of the patient's psychological and emotional well-being, should occur EVERY SHIFT or per unit-specific reassessment guidelines while the patient is on suicide precautions
- Safety checks will be completed based on the level of monitoring ordered.



- The physician is the only person who may discontinue suicide precautions.
- If staff observe any behavior indicating the patient is at a high risk for suicide or self harm, the staff member will remain with the patient under constant observation while alerting other staff or the MD via the nurse call system (or any other means without leaving the patient), to come and reevaluate the patient
- Provide the crisis hotline number for behavioral healthcare services to suicidal risk patients on discharge. 1-888-235-4673 (1-888-235-HOPE), TTY (1-800-749-6099)



PLEASE COMPLETE POST TEST



QUESTIONS



1. Patients in general hospitals who are suicidal attempt suicide after admission more rapidly and with fewer warnings than suicidal psychiatric inpatients.

True False

2. Risk Factors for Suicide are

- a) Recent suicide attempt
- b) Family history of suicide
- c) Physical health problems
- d) Social stressors
- e) All of the above

QUESTIONS



3. Warning signs of imminent risk are

- a) Irritability and increased anxiety
- b) Agitation and impulsivity
- c) Refusing visitors
- d) Crying spells
- e) All of the above

4. Patients demonstrating suicidal behaviors or mental status characteristics should be screened for suicidal risk.

True False

5. Patients deemed high risk for suicide should be placed on constant observation and not be left alone.

True False