Reducing Inpatient Suicide Risk
In The Hospital Setting

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Suicide is the 10th leading cause of death in the United States, taking the lives of 37,793 people in 2010.1 In 2003, the American Psychiatric Association reported that 1,500 suicides take place in inpatient hospital units in the United States each year.2

Suicide has ranked in the top five most frequently reported events to The Joint Commission (TJC) since 1995. From 1995 through the first quarter of 2012, TJC Sentinel Event Database includes 1007 reports of inpatient suicides.

In 1998, TJC issued a Sentinel Event Alert on inpatient suicides with recommendations for prevention.3 This alert dealt broadly with inpatient suicides with most of those occurring in psychiatric hospitals. When it became apparent that 14% of the suicides were occurring in medical/surgical units and 8% occurred in the emergency department, a follow-up Sentinel Event Alert urging greater attention was issued on November 17, 2010.4

In an effort to address the issue of suicide risk, TJC implemented NPSG.15.01.01, a National Patient Safety Goal (NPSG) starting in 2007 requiring all accredited behavioral health care organizations, psychiatric hospitals and general hospitals treating individuals for emotional or behavioral disorders to identify individuals at risk for suicide.

Implementation expectations include the following:

- Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk of suicide.
- Address the immediate safety needs and most appropriate setting for treatment of the individual served.
- When an individual at risk for suicide leaves the care of the organization, provide suicide prevention information (such as a crisis hotline) to the individual and his or her family.

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Locations
Data from recent studies in Veterans Health Association hospitals indicate that about 50% of completed suicides and serious suicide attempts occur on mental health units, and 50% occur in other areas of the hospital. The Emergency Department (ED) and acute care or medical units are the second and third most common location. While psychiatric providers and staff are well aware of the risk of suicide among their patients, other hospital departments are not designed to prevent suicides and their staff may not have received education about suicide risks and prevention. It is important that staff training supports the notion of suicide detection and having a high index of suspicion.

Methods
The most common methods of inpatient suicide and suicide attempts involved hanging or jumping from a roof or window.

Root Causes
The most common root causes of suicides on medical units include problems with communication of suicidal risk, the need for staff education on suicide assessment and treatment, the need for improved suicide assessment, and a poor system for managing suicidal patients. Common root causes for the EDs were poor communication of suicide risk, lack of available staff, poor contraband search, and problems with the physical layout of the ED.

Assessing Suicide Risk
Many patients who commit suicide in general hospital settings do not have a psychiatric history or a history of suicide attempts. According to TJC, the top five groups at high risk for suicide include the young, medically ill, specific populations groups (such as Native Americans, Alaskan Natives, and African American males ages 15-19), persons with mental and substance abuse disorders, and the elderly.5

A critical first step in any suicide prevention effort is an effective risk assessment that identifies specific individual characteristics and environmental features that may increase or decrease the risk for suicide. Assessment of patients for suicide risk is a process, rather than an isolated event. Because the ED may serve as the entry point for patients at risk for suicide, initial risk assessment should begin in the emergency care unit. All patients should be screened for depression as part of the inpatient admission process. Emphasis should be placed on the need for ongoing evaluation particularly at clinically significant points during inpatient care including transitions between units, levels of care, and before discharge.

If it is determined that a patient is at risk for suicide, findings from the suicide risk assessment will drive the elements of the patient's treatment plan including the setting for treatment, therapeutic interventions, and necessary measures to ensure patient safety.

Environment of Care Controls
An important component of any suicide prevention program is environmental assessment and risk mitigation. Patient rooms should be designed to eliminate possible environmental elements that could facilitate suicide attempts. Reasonable steps should be taken to ensure the environment of care is designed to enhance patient safety including the removal of weight-supporting fixtures and rods, shoelaces and belts, razors, electrical appliances, plastic trash can liners, and unsecured windows.
Staff Education

All staff should be educated about the risk factors for inpatient suicide and the organization’s prevention efforts and protocols. Training should include how to be alert to changes in behavior or routines of the patient at risk and warning signs that may indicate the need for immediate action. Training should begin at new staff orientation and include hospital and agency staff assigned to non-behavioral health units since inpatient suicide may occur anywhere within your organization. Thereafter, provide for annual staff training with competency requirements appropriate for their assignment. The ED staff should be educated on the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements and their implications for screening and treating suicidal patients in the ED.

Communication among Caregivers

Patient information including the treatment plan should be communicated to all healthcare providers involved in the patient’s care.

Patient Safety Strategies to minimize suicide-related exposure

- Review TJC accreditation standards and patient safety goals as well as federal and state requirements related to organizational suicide prevention efforts.
- Conduct an assessment of your current organizational practices for suicide prevention to identify strengths and weaknesses. Begin by reviewing any root cause analyses completed as a result of sentinel event reporting to TJC.
- Develop a standardized process to assess patients for suicide risk.
- Educate staff about inpatient suicide and the organization’s prevention efforts and treatment protocols.
- Ensure a mechanism for staff to communicate with each other and implement a standardized approach to hand-off procedures including practitioner to practitioner, unit to unit, facility to facility or home.
- Conduct regular environmental assessments to evaluate every patient care area for hazards.

Inpatient suicide represents a significant risk for all hospitals, and is one of the most devastating events that can occur in a healthcare setting. While there is no way to predict which patients will attempt suicide in the in-patient setting, Risk Managers must ensure that an appropriate patient safety strategy is in place for suicide assessment and prevention.

Additional Resources


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Suicide Risk Guide for ED Evaluation & Triage

A two-page summary guide to suicide risks from hospital patients is available from the Suicide Prevention Resource Center.

One in 10 suicides are by people seen in an emergency department within 2 months of dying, according to government statistics. The guide notes: “Many were never assessed for suicide risk. Look for evidence of risk in all patients.”

For patients showing signs of acute suicide risk, the guide suggests asking six (6) questions —
1. Have you ever thought about death or dying?
2. Have you ever thought that life was not worth living?
3. Have you ever thought about ending your life?
4. Have you ever attempted suicide?
5. Are you currently thinking about ending your life?
6. What are your reasons for wanting to die and your reasons for wanting to live?

“These questions ease the patient into talking about a very difficult subject. Patients who respond “no” to the first question may be ‘faking good’ to avoid talking about death or suicide. Always continue with subsequent questions.”

The guide offers a matrix for quickly separating patients into high-risk, moderate-risk and low-risk categories with corresponding recommended interventions and actions to consider.

For additional information, contact Sandra McBroom of McNeary at (704) 367-7101, or you can download the guide from http://www.sprc.org.

Suicide Risk: A Guide for ED Evaluation and Triage

1 in 10 suicides are by people seen in an ED within 2 months of dying. Many were never assessed for suicide risk. Look for evidence of risk in all patients.

**Signs of acute suicide risk**
- Talking about suicide or thoughts of suicide
- Seeking lethal means to kill oneself
- Purposeness—no reason for living
- Anxiety or agitation
- Insomnia
- Substance abuse—excessive or increased

**Other factors:**
- Past suicide attempt increases risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk.
- Triggering events leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status—real or anticipated.
- Firearms accessible to a person in acute risk magnifies that risk, inquire and act to reduce access.

Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others. Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.

Ask if you see signs or suspect acute risk—regardless of chief complaint
1. Have you ever thought about death or dying?
2. Have you ever thought that life was not worth living?
3. Have you ever thought about ending your life?
4. Have you ever attempted suicide?
5. Are you currently thinking about ending your life?
6. What are your reasons for wanting to die and your reasons for wanting to live?

These questions ease the patient into talking about a very difficult subject.
- Patients who respond “no” to the first question may be “faking good” to avoid talking about death or suicide. Always continue with subsequent questions.
- When suicidal ideation is present clinicians should ask about:
  - the frequency, intensity, and duration of thoughts;
  - the existence of a plan and whether preparatory steps have been taken; and
  - intent (e.g., “How much do you really want to hurt” and “How likely are you to carry out your thoughts/plans?”)

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

10% of all ED patients are thinking of suicide, but most don’t tell you. Ask questions—save a life.

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Reducing Inpatient Suicide Risk In The Hospital

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**End Notes**