Suicide Risk*

Teaching Points for Inpatient/Ambulatory/Clinic RN, LVN, UAP, MA, AHP

- Suicide within a hospital/clinic is considered a sentinel event

Inpatient Screening

- Nurses do basic screening when admitting a patient:
  - Expression of suicidal/self-harm thoughts without intent? Yes/No
    - If yes, is there a plan?; if yes, describe plan
    - Is there a means to complete the plan? If yes, describe means to complete plan
  - Prior suicide attempts? Yes/No
    - If yes, when? If yes, what prior method?

Patient Safety

The immediate focus of the assessment should be on the safety of the patient and the level of observation necessary to maintain their safety.

- Examples of precautions taken to ensure the patient’s safety include:
  - Sitters, removal of potentially harmful objects not being used for clinical care, and removal of potentially harmful objects in patient’s belongings
- Notify the provider who will evaluate the specific psychiatric needs of the patient; the patient’s attending will order a psychiatric consult as needed
- An orange checkered armband is ONLY used for patients at risk for suicide in the Emergency Department – the armband are to be removed prior to the patient leaving the ED
- “Additional Health Resources” on discharge documents (AVS) include: National Suicide Prevention Lifeline number and San Diego Access & Crisis Line to ensure any patient and his/her family at risk for suicide is provided suicide prevention information
- Some suicidal patients may be placed on a “5150”: Danger to self: The person must be an immediate threat to him/herself due to mental disorder; person is held involuntarily in the hospital for up to 72 hrs
- If a suicidal patient elopes, notify security immediately

Communicating with Patients & Families

- Explain to the patient and family that we are taking every precaution to ensure their safety; document the education in the teaching plan

Suicide Risk Monitoring

- The inpatient RN will document every 2 hours in the electronic medical record. Documentation should include safety and behavioral issues (MCP 381.3). Document within the Flowsheet activity by wrenching in the Restraint/Suicide activity.

Orange and White Checkered Arm Bands

- Orange and white checkered arm band are used to identify patients at risk for suicide in Emergency Department (ED) only
• If you see a patient with an **orange and white checkered arm band** not in the ED, they need to be returned to the ED; do not let the patient out of your sight
• If needed, request help; notify security and the ED

**Factors that Increase Risk for Suicide include:**
- Previous suicide attempt, family history of suicide
- History of depression, mood disorder, substance abuse
- Anxiety, hopelessness (such as having no reason for living), impulsivity (such as acting reckless or engaging in risky activities seemingly without thinking), insomnia
- Recent significant loss, trauma, or life crisis
- Chronic illness or chronic pain
- Sudden change in behavior or attitude
- Social isolation

**Role of Clinic Staff**
- Be aware of the factors above that may increase the risk for suicide
- Notify RN and/or Provider of any behavior or verbalization by patient or family that indicates the patient may want to hurt themselves

**Safety Measures**
- Increase observation level – don’t leave the patient unattended
- Communicate to other caregivers
- Be direct and talk openly
- Be willing to listen
- Be non-judgmental and don’t lecture about the value of life
- Don’t give advice
- Don’t act shocked
- Don’t be sworn to secrecy – seek support
- Remove means such as sharp objects, etc.
- In clinics call 911 as needed

**Source:** Annual Judith Pfeiffer Director of Psychiatric Services; MCP 381.3
The Joint Commission -National Patient Safety Goal 15A: “The organization identifies patients at risk for suicide”.