

# Assessing *the* Risk

*Suicidal Behavior in the  
Hospital Environment of Care*

**SHARON CHAPUT, RN, CSHA**  
**KIRK WOODRING, LICSW, CGP**

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HCPro

*Assessing the Risk: Suicidal Behavior in the Hospital Environment of Care* is published by HCPro, Inc.

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ISBN: 978-1-60146-894-9

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Rev. 10/2012  
21927

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# Dedication

This book is dedicated to the memory of Kyle Woodring, who reached the world through his music and kindness, but whose depression ultimately ended his life.

Where there was music, now there is only silence

But the energy remains

Produced by your rhythm

Fueling the lives of all who knew you

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Sincerely,

Jaclyn Zagami

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# Foreword

Psychiatric patients in the acute care medical setting are often viewed by nonpsychiatric medical caregivers with much of the same aloofness and anxiety that exists outside the medical setting. There is nothing more disconcerting to a person than being confronted with an individual who is contemplating the taking of his or her own life; so robust is our normal will to live. This is no different for the medical clinician and caregiver. The idea that a person would take his or her own life can, and often does, raise many primal feelings, including fear, panic, anxiety, helplessness, anger, and more. And yet, as in other areas of medicine, there is a body of literature and clinical protocols that can assist the clinician in gaining perspective and skill in treating individuals who are brought to acute care settings for evaluation and treatment of life-threatening, self-destructive behaviors.

Given that 90% of suicidal patients have a preexisting mental illness, it is important for nonpsychiatric caregivers to understand that just as other organs get sick and need treatment, so does the brain. Mental illness is a complex process involving genetics, biology, and behavior. One in five people will develop a mental illness at some point in their lives, and for those that do, the contemplation of suicide and other self-destructive behavior is a common side effect of these mental illnesses. Mental illness itself is shrouded in stigma, which further compounds the tendency of the person with mental illness to have increased low self-esteem, social isolation, and hopelessness. The stigma of having a mental illness (and depression is the most common mental illness) leads over half of the people with a mental illness to conceal symptoms and never seek treatment due to shame. People with mental illness often hold the same beliefs as society at large and blame themselves for their illness, often not realizing that their brain is ill and needs treatment, just as in other areas of medicine.

The cultures that patients come from shape their response to mental illness and affect the kinds of mental health services they use. Likewise, the cultures of the clinicians and the service system that they work in affect diagnosis, treatment, and the organization and financing of services. A person with a mental illness is

often stigmatized by language such as “psycho,” “nut,” “wacko,” or “crazy person.” And a psychiatric hospital is often referred to as a “loony bin,” “funny farm,” or “insane asylum.” We would never refer to the cardiac or cancer unit in a hospital in similar language.

This is an important book, because it addresses directly the stigma that impedes patients with psychiatric disorders and suicidal tendencies from receiving adequate care in the acute medical setting. This book, by focusing on skill development in the assessment and treatment of suicidal patients, helps take the fear and anxiety out of the caregiver. This focus on the science of psychiatric intervention for the nonpsychiatric acute care medical caregiver lets you know that there is something that you can do and that you can be very effective at it.

Chaput and Woodring are very knowledgeable clinical administrators with more than 40 years of combined experience in providing emergency evaluation and acute care treatment of psychiatric patients who are either a danger to themselves or others. They have specifically designed and implemented safety protocols and tools to ensure that clinicians have a robust road map to enhance their competence and skill in suicide risk assessment. The tools provided can build confidence in clinicians, which translates to alliance building with complex patients who are at high risk of self-harm or other injurious behavior. Once integrated into clinical practice, these skill sets can also assist the clinician in reducing stigmatized, knee-jerk responses to patients given by other care givers in the immediate environment, a response which puts patients at higher risk.

Additionally, the nonpsychiatric clinician who adopts these robust models of intervention and nonstigmatic ways of conceptualizing high-risk patients will build credibility among other caregivers in the immediate environment (emergency room or medical unit). This guidance in skill enhancement and protocols leads to an increased comfort on the part of the provider in dealing with one of the greatest challenges in acute care medicine—the patient bent on self-destruction. Providers become experts at assessment and de-escalation, increasing their capacity for leadership in the care environment. And leadership saves lives.

In summary, this jewel of a book will allow all healthcare providers to learn skills that will save lives and build a more sophisticated patient care environment. What better feeling is there in healthcare and medicine than that?

*Robert E. Simpson, Jr., DSW, MPH  
President & Chief Executive Officer  
Brattleboro Retreat*

# Introduction

In 2008 there were nearly 125 million emergency department visits to U.S. hospitals. Of those, 666,000 were classified as intentional self-injuries, and nearly two million involved alcohol and drug use. In 2007, suicides were the fourth leading cause of death in the United States for adults ages 18 to 65. Internationally, suicide ranks as the third most frequent cause of death.

It has been reported that 90% of people who commit suicide have a diagnosable psychiatric disorder at the time of their death. It is critical that assessment of both mental illness and suicide risk occur during any interview for patients presenting to hospital emergency departments, medical/surgical units, inpatient psychiatric units, and outpatient psychiatric settings.

As medical professionals it is crucial that we have tools for rapidly assessing and evaluating risk in these fast-paced environments and settings. We often have to rely only on what our patients are willing to tell us; however, we believe the recommended tools in this book can help remind us of the demographic, psychosocial, historical, and individual risk and protective factors when clinically evaluating patients and considering treatment options.

In this book we will discuss the Joint Commission Sentinel Event Alert that was issued in November 2010, and the implications for assessment and treatment in the previously noted settings. We will assist the reader in understanding The Joint Commission's National Patient Safety Goal (NPSG) 15.01.01, related Joint Commission standards in the Environment of Care (EC) chapter, as well as the corresponding Centers for Medicare & Medicaid Services (CMS) *Conditions of Participation (CoP)*.



## ■ INTRODUCTION

We have included a description of suicide risk and protective factors to assist the reader understanding of the various tools that are provided. These tools include sample suicide assessment screens, documentation samples, EC suicide risk checklists, and examples of EC safety enhancements. We have also included interviews with high-risk patients, some of whom have attempted suicide, in order to gain insight into the depth of pain and struggle these individuals face on a daily basis, as well as interventions they found helpful or detrimental to their recovery.

The sample case studies will take you through clinical scenarios in a variety of settings where opportunities for suicide risk assessment were missed and the outcome was devastating. We have provided case studies in which medical professionals accurately assessed suicide risk and protective factors and intervened appropriately and in which the clinical outcomes were positive.

The discussion of suicide cannot begin without an acknowledgment that the topic is evocative of strong emotions and debate. Many people believe that self-determinism allows an individual the right to take his or her own life. Many others believe that, for religious or cultural reasons, suicide under any circumstances is never an option. Still others believe that suicide or assisted suicide is acceptable within certain parameters in order to preserve an individual's dignity (such as progressive terminal illness in which no hope for treatment exists). This book will not consider the philosophical or ethical dialectics of suicide; its focus is on understanding the risk factors that lead to suicide and self-injurious behavior and on providing tools to assist individuals in getting the necessary help that may avert a suicidal crisis.

The authors recognize that when suicidal crises are averted, lives can be saved. We also believe that suicide is at times the very unfortunate outcome of a terminal and treatment refractory mental illness, such as depression, bipolar disorder, psychosis, or chemical dependency. There are times in the lives of every health-care provider where we face the fact that no matter what the intensity and frequency of the intervention, the patient cannot be saved. We hope only that this book assists the reader in the process of trying.

The following figure provides a brief primer on demographics related to suicides.

**Figure 1****Suicide Statistics**

A brief primer on demographics related to suicides may help frame the remaining chapters and assist in understanding the scope and magnitude of this serious public health issue.

- There are an estimated 18 attempted suicides for every suicide death, and there are four male suicides for every female suicide, but three times as many females as males attempt suicide.
- Suicide is the fifth leading cause of death for children between the ages of five and 14 and the third leading cause of death for those between 15 and 24.
- Among Native Americans ages 15–34, suicide is the second highest cause of death, and this rate is 2.2 times higher than the national average for this age group.
- Female Hispanic teens report feeling suicidal 14.4% of the time, compared to their African-American (9.9%) and non-Hispanic white peers (7.7%)
- Between 1980 and 1996, the suicide rate for African-American males ages 15–19 has doubled.
- Among young adults there is one completed suicide for every 150 attempts. For adults over age 65, there is one completed suicide for every four attempts.
- Major depression rates in the elderly (over 65) who have seen their primary care clinician in the prior six months are nearly 10%.
- Over 60% of all people who die by suicide suffer from major depression. If a co-occurring alcohol diagnosis is included, this figure rises to more than 75%.
- Thirty percent of all clinically depressed patients attempt suicide; half of them ultimately die by suicide.
- Depression is among the most treatable mental illnesses. Nearly 90% of people with depression respond positively to pharmacologic treatment when combined with psychotherapeutic/cognitive behavioral intervention.
- Alcoholism is a factor in about 30% of all completed suicides, and approximately 7% of individuals with alcohol dependence will die by suicide.
- Patients who desire an early death during a serious or terminal illness are usually suffering from a treatable depressive condition.
- Firearms account for 50% of all suicides. Firearms are used in more suicides than homicides.

Source: American Foundation for Suicide Prevention, "Facts and Figures." [www.afsp.org/index.cfm?fuseaction=home.viewpage&page\\_id=050fea9f-b064-4092-b1135c3a70de1fda](http://www.afsp.org/index.cfm?fuseaction=home.viewpage&page_id=050fea9f-b064-4092-b1135c3a70de1fda) (accessed August 4, 2011).



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## Chapter 1

# Overview and Rationale for NPSG 15.01.01

## LEARNING OBJECTIVES

After reading this chapter, you will be able to:

1. Understand and explain the rationale for NPSG 15.01.01
2. Demonstrate an understanding of Sentinel Event Alert suicide risk assessment and reduction recommendations

## Introduction

In this chapter we will provide an overview of National Patient Safety Goal (NPSG) 15.01.01; its Elements of Performance (EP) and rationale; and an analysis of Sentinel Event Alert, Issue 46, and its recommendations for hospital medical units and emergency departments (ED). It is very important to note that NPSG 15.01.01 has not changed despite the release of the Sentinel Event Alert, Issue 46, titled “A follow-up report on preventing suicide: Focus on medical/surgical units and the emergency department,” released in November 2010.

Whether The Joint Commission will revise this safety goal in the future and require hospitals to screen for suicide risk, conduct a risk assessment in the Environment of Care (EC), and comply with treatment and discharge requirements for all inpatients admitted to nonbehavioral health settings remains to be seen. However, the release of this alert certainly moves hospitals further in that direction.

There are Joint Commission EC standards and Centers for Medicare & Medicaid Services (CMS) *Conditions of*

*Participation (CoP)* that currently do require hospitals to conduct an environmental risk assessment for patient safety risks in all areas of the hospital, including nonbehavioral health areas. Some hospitals have been surprised by this and typically think the EC and suicide risk pertains only to patients admitted to inpatient psychiatric units and those treated in the ED or admitted to a medical unit post suicide attempt. However, based on statistics alone, it is just as important for all hospital units to invest in proper resources and training for both EC and clinical suicide risk assessment. The Executive Summary from the *Healthcare Risk Management* March 2011 issue states the following statistics:

- ✦ Patients commit suicide in hospitals at an alarming rate, and most healthcare providers do not adequately screen for patients at risk
- ✦ The ED is one of the most common sites of patient suicides
- ✦ Research suggests 8% to 10% of ED patients are at risk of suicide
- ✦ Providers are reluctant to talk about patient suicides because of the stigma and negative publicity, as well as the legal liability
- ✦ Universal screening of all ED patients for suicide risk may be the best

## **NPSG 15.01.01 and EP**

At this time, NPSG 15.01.01 still applies only to organizations surveyed under behavioral health standards, psychiatric hospitals surveyed under hospital accreditation standards, and patients treated in an acute care medical hospital with a primary psychiatric diagnosis or who are being treated for a suicide attempt.


It is also important to be aware that each of the EPs for NPSG 15.01.01 carries a direct impact designation, as denoted by the symbol . The “C” designation means that three instances of noncompliance observed by a surveyor results in a recommendation for improvement (RFI)—the “three strikes you’re out” concept.

Figure 1.1 is a summary of the NPSG 15.01.01 standards and rationale, and the EP.

**Figure**  
**1.1**

## NPSG 15.01.01 Rationale and EP

**Rationale:** Suicide of a patient while in a staffed, round-the-clock care setting is a frequently reported sentinel event. Identification of individuals at risk for suicide while under the care of or immediately after discharge from a healthcare facility is an important step in protecting these at-risk individuals.

**Elements of Performance:**

EP1—Risk assessments should include identification of detailed patient and environmental factors that may increase or decrease the risk for suicide

EP2—Hospitals should address the patient’s direct safety needs and maintain a suitable environment or setting for treatment

EP3—Hospitals should make information available (such as a crisis hotline) to patients at risk for suicide and their family members

*Source: The Joint Commission, 2011.*

## Analysis of Sentinel Event Alert, Issue 46

The goal of this Sentinel Event Alert issued by The Joint Commission in November 2010 is to encourage hospitals to look at two distinct populations of patients to ensure that they are assessed and treated appropriately. These two populations are:

1. Patients who are treated in general hospital ED and medical/surgical units that do not present with a primary mental health diagnosis and are an unknown risk
2. Patients who are admitted after a suicide attempt or who are a known risk

In contrast to inpatient locked psychiatric units or psychiatric hospitals, medical/surgical units and most EDs do not routinely assess every patient who comes in the door for suicide risk and are not environmentally designed or equipped to care for suicidal patients. This alert discusses other issues that may contribute to an

increased risk of suicide of a patient in a nonbehavioral health hospital setting. According to the Sentinel Alert, contributing factors include:

- ✦ No inclusion of suicide risk assessment or risk factors
- ✦ Lack of education in the initial orientation of new staff
- ✦ Lack of refresher education for all staff
- ✦ No ongoing competency assessment for suicide risk assessment
- ✦ Poor handoff communication between the ED and medical units
- ✦ Poor discharge planning due to staff members not having information about suicide prevention and referral resources at their fingertips

The Joint Commission Sentinel Event Database states that since 1995, suicide has ranked in the top five most frequently reported events, and it includes 827 reports of inpatient suicides. Of the 827 reports:

- ✦ 14.25% occurred in the nonbehavioral health units of general hospitals (e.g., medical or surgical units, ICU, oncology, telemetry)
- ✦ 8.02% occurred in the ED of general hospitals
- ✦ 2.45% occurred in other nonpsychiatric settings (e.g., homecare, critical access hospitals, long-term care hospitals, and physical rehabilitation hospitals)

We can see that roughly 25% of suicides reported to The Joint Commission as a Sentinel Event occur in a nonpsychiatric setting. Also, because the majority of these events are voluntarily reported, the Sentinel Event database does not include all actual Sentinel Events. This makes it difficult to ascertain the number of actual events. These statistics, however, were alarming enough for The Joint Commission and did lead in part to the release of Sentinel Event Alert, Issue 46.

Other statistics on suicide taken directly from the Sentinel Event Alert are as follows:

- ✦ Men take their lives at nearly four times the rate of women, and men age 75 and older have the highest rate of suicide (35.7 per 100,000).
- ✦ The highest incidence of reported suicide attempts occurs in the 18- to 24-year age group, and suicide is the third leading cause of death among 15- to 24-year-olds.
- ✦ Of the adults who attempted suicide in 2008, 62.3% (678,000) received medical attention for their suicide attempts and 46% (500,000) stayed overnight or longer in a hospital for their suicide attempts.
- ✦ In addition, general hospital patients who attempt suicide after admission more rapidly and with fewer threats or warnings than suicidal psychiatric inpatients.
- ✦ Two studies showed that suicide attempts within the general hospital environment were more violent (hanging, jumping, or gunshot) than those on psychiatric units.

### ***Recommendations for reducing suicide risk***

The Joint Commission recommends that the following interventions be used universally for all patients presenting for treatment in an acute care nonbehavioral health setting regardless of diagnosis or presenting problem:

- ✦ Conduct suicide screening on all patients presenting to the ED.
- ✦ Screen all inpatients for depression.
- ✦ Educate staff on what medications are associated with increased suicide risk, either as a side effect of the medication itself or an exacerbation of an underlying illness, like epilepsy or bipolar disorder. Examples include some smoking-cessation drugs, mefloquine, interferons, amantadine, isotretinoin, and SSRIs.
- ✦ Routinely order psychiatric consults for patients admitted for medical treatment following a suicide attempt.
- ✦ Screen the hospital environment for suicide risk.



### ***Recommendations for assessing patients with a known suicide risk***

The Joint Commission also suggests that once you've done an initial assessment of your facility and all inpatients, it's important to take an even closer look at patients that do show signs of suicide risk. Recommendations by The Joint Commission to prevent suicide in those patients assessed and identified to be at a high or increased risk of suicide include:

- ✦ Factoring in age and cultural considerations during your assessment and treatment decisions.
- ✦ Consider using a volunteer or peer support specialist for 1:1 staffing who can alert staff to any warning signs that may indicate imminent action.
- ✦ In the absence of 1:1 staffing, check the patient for and remove items that could be used to commit suicide. (Remove belts, shoelaces, undergarments, pillowcases, and sheets from the rooms of high-risk patients. Even if the treatment room or area the patient is in has been equipped with environmental suicide-resistant safety features, patients can use these items to choke themselves by tying the item tightly around their neck. There are suicide-resistant hospital gowns, pillowcases, and bedding that can be purchased.)
- ✦ Involve the patient and, if applicable, the family in any planning and decision-making for further inpatient treatment, and if outpatient treatment is recommended, ensure that the patient and family are involved in the discharge planning process and aftercare recommendations.
- ✦ Ensure hand-off communication. (This includes MD to MD, nurse to nurse, shift to shift, and unit to unit. It cannot be stressed enough how crucial handoff communication and documenting is in preventing suicide, as we shall see in one of the case studies later in the book.)

Although not part of the Sentinel Event Alert, it is also important to assess the EC, particularly in areas not highly visible to staff, for items patients could use as tools to commit suicide. Tools and recommendations for assessing the EC can be seen in Chapter 5.

### ***Assessing patients with no psychiatric history (the unknown risk)***

The most concerning aspect of this Sentinel Event Alert is that a majority of patients who commit suicide in general hospital inpatient units do not have a history of suicide attempt or even a psychiatric history or

diagnosis. Those who work in EDs, ICUs, critical care units, and general medical units are accustomed to doing suicide risk assessments or screens on patients who have a primary psychiatric diagnosis and/or who have recently attempted suicide. The main difference between this Sentinel Event Alert and NPSG 15.01.01 is the recommendation to assess for suicide risk in those patients who are not clearly presenting as suicidal and who do not have a primary psychiatric diagnosis in addition to those patients who are already considered a known risk.

It may seem overwhelming to assess every single patient for suicide risk who presents to a “controlled chaotic,” fast-paced ED or busy medical unit, but it is important to remember in the ED and medical unit settings that a brief evidence-based suicide risk screen is appropriate and helpful. In fact, the screen should be what triggers the need for a more in-depth assessment, interview, or consult with a mental health professional.

Many professionals, including triage nurses that work in nonbehavioral health settings, may have had limited training or education on how to assess for suicide risk and may often feel uncomfortable or unsure how to interview beyond asking questions such as, “Are you or have you ever been suicidal?”

In an article released by AHC Media, Edwin Boudreaux, PhD, a professor in the Department of Emergency Medicine and Psychiatry at the University of Massachusetts Medical School in Worcester, MA, states that reluctance to discuss the risk of suicide oftentimes stands in the way of prevention efforts. “The waiting room in the ED is a nightmare, and you don’t want to throw someone who is suicidal into that,” Boudreaux says in the article. “Patients have killed themselves after waiting hours in the ED, so it doesn’t help you much to wait until they are in the exam room to start asking about suicide risk.”

Boudreaux, who is currently in the process of studying suicides in acute care settings such as the ED, goes on to describe a hospital that had a suicide in the ED. The changes implemented after a root-cause analysis (RCA) was conducted, included screening all patients universally for suicide risk during the triage process and handing off the patient directly to the next caregiver.

The following chapters in this book will give tools that can assist you in more rapidly identifying patients who are a known risk and patients who are an unknown risk. These tools will also aid you in proper assessment, documentation, and handoff communication in your facility to provide the best patient care possible.

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# Assessing *the* Risk

*Suicidal Behavior in the  
Hospital Environment of Care*

**SHARON CHAPUT, RN, CSHA • KIRK WOODRING, LICSW, CGP**

Suicide of a care recipient while in a staffed, round-the-clock care setting or within 72 hours of discharge has remained in the top five most frequently reported sentinel events to The Joint Commission since 1995. Perform thorough suicide risk assessments and comply with The Joint Commission's Sentinel Event Alert through strategies provided in the HCPro book *Assessing the Risk: Suicidal Behavior in the Hospital Environment of Care*.

Authors Sharon Chaput, RN, CSHA, and Kirk Woodring, LICSW, CGP, provide efficient and effective ways to address environment of care issues, improve documentation and patient handoffs, and utilize rapid assessment to reduce suicide risk at your facility.

- Gain a better understanding of NPSG 15.01.01 and implement the necessary processes to ensure compliance with this goal
- Help your staff identify and assess at-risk patients quicker and more effectively by using the ready-made screening and assessment tools
- Ensure proper documentation of suicide risk assessments by staff in high-risk units such as the emergency room
- Learn from your peers through several case studies and results of recent CMS and Joint Commission surveys
- View sample interviews with high-risk patients to understand motives and recognize components of the interview that elucidate risk

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ISBN: 978-1-60146-894-9

