

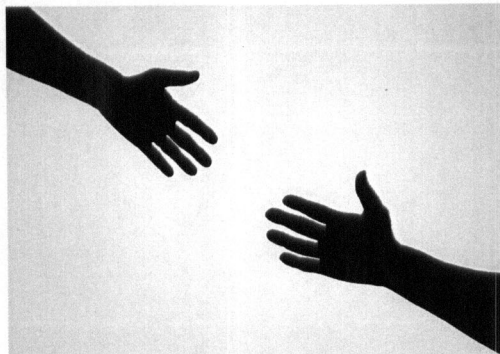
BATES COUNTY MEMORIAL HOSPITAL
Butler, Missouri

TRAINING MODULE

**Identify
patients at
risk for
suicide**



SUICIDE IN THE UNITED STATES



- Suicide is the 10th leading cause of death in the United States claiming more lives than traffic accidents and more than twice as many as homicide
- Suicide is the 2nd leading cause of death in 15-24 year olds
- More than 100 Americans die by suicide per day
- Attempted suicides average 1 per every 25 seconds

RISK FACTORS FOR SUICIDE

- Mental or emotional disorders
- Previous suicide attempts or self-inflicted injury
- History of trauma or loss (such as abused as a child, family history of suicide, economic loss)
- Serious illness/physical impairment
- Chronic pain
- Alcohol and drug abuse
- Social isolation
- Aggressive or anti-social behavior
- Recent discharge from inpatient psychiatric care
- Access to lethal means coupled with suicidal ideation

ADDRESSING SUICIDE RISK IS A CHALLENGE

- There is no “typical” suicide victim
- Providers often do not detect the suicidal thoughts of individuals.
- 45% of people who die by suicide had contact with PCP in the month before death
- The number is higher at 78% of the older population having had contact with PCP in the month before death
- The most common root cause of suicide in a staffed, round the clock health care setting (including 72 hours post discharge) is an inadequate assessment.

DETECTING AND TREATING SUICIDAL IDEATION IN ALL HEALTHCARE SETTINGS

* **Identifying** those at risk is the key. We must be willing to ask people whether they are having thoughts about suicide. Many will tell us if we ask. Inquiring about suicide risk needs to be done so in a straightforward manner. “ Are you having thoughts of hurting yourself?” Avoid using indirect questioning such as “ you aren’t thinking of hurting yourself are you?”

Hospital: Pre-screening & suicidal assessment SBQ-R

* **Engaging** the person we want to help in their own care is vitally important. No longer in use is the “No-suicide contract”. The focus is on safety planning- a collaborative effort to focus on what the patient should and can do to keep them safe rather than what they should not do.

- **Treating** – Behavioral Health Referrals, keeping patient in safe environment under appropriate observation levels
- **Transition** – Period after Inpatient treatment or ED discharge is one of high risk, particularly the first 30 days. Rates of follow up care are poor. Intervention during this time has been shown to save lives and reduce suicidal behavior.

* National Suicide Prevention Lifeline

1-800-273-TALK/ 1-800-273-8255

HOSPITAL SUICIDE RISK MONITORING

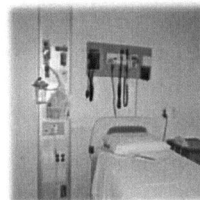
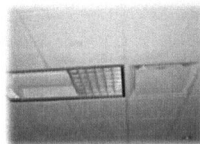
- Notify Physician
- Complete patient room safety checklist on admission and every shift
- **1:1 monitoring with constant visual observation, including restroom**
- Sign on door for all visitors to check-in with nurse
- Only a physician can discontinue suicide risk observation
- Consult Social Services
- Document on patient behavior/ environment checklist

KEY POINTS FOR HOSPITAL PATIENT

- Visual Control – 1:1 continuous observation or video monitoring
- Environmental Risk Checklist
- Ligature Risk – (anything which could be used to attach a cord , rope, or other material for the purpose of hanging or strangulation.

COMMON LIGATURE POINTS

- Doors
- Hooks/handles,
- Windows
- Shower rails
- Hooks
- Pipes
- Ceiling fittings
- Hinges/closures
- Hanging pictures
- Artwork
- Bedrails



LIGATURES (SOMETHING USED FOR TYING OR BINDING TIGHTLY)

- Belts
- Sheets
- Towels
- Shoelaces
- Oxygen tubing
- IV tubing
- Tourniquets
- Nurse call cords
- Clothes hangers
- Electric cords

EXAMPLES OF SUICIDAL ATTEMPTS IN HOSPITAL

- Young person acquired light bulb fixture and hid it under bed covers. Broke bulb, slashed wrists.
- Broke out a window with a chair and jumped off a roof
- Ran out exit doors and attempted to throw self in front of a moving car.
- Tried to drown self in pond
- Slit wrist with a screw
- Took overdose of pain medication brought in by friend
- Attempted to hang self by tying a sheet around his neck and a ceiling pipe while standing on trash can. He then knocked the trashcan out from under himself.

OTHER SAFETY RISK



- Access to medications
- Light fixtures
- Non-tamper proof screws
- Access to Plastic bags
- Sharp objects
- Light weight furniture that can be picked up and thrown
- Areas out of view of staff
- Breakable windows

ITEMS THAT MAY BE USED AS WEAPONS

- Scissors
- Stethoscope (strangulation)
- Lanyards
- Pens/pencils
- Light fixtures
- Loose equipment/bed rails
- Art work
- Light weight furniture
- Vital sign machine
- Breakable mirrors
- Silverware

FOR MORE INFORMATION:

- Resource List located on eConnect