

# Preventing Suicide in Non-Behavioral Health Care Units

## *Strategies for the Emergency Department and Medical/Surgical Units*



*Suicides can happen in general hospitals—not just psychiatric ones.*

A patient with an acute heart condition is on suicide watch in a hospital medical/surgical unit. A nurse checks on him every 15 minutes. But during one of these checks, the nurse discovers the worst: The patient has hanged himself with a power cord. The cord was connected to a piece of medical equipment housed in the room.

Incidents like this might be expected to occur only in behavioral health care settings, unfortunately, such incidents occur far too often in general hospital settings. More than 14% of suicides

reported to The Joint Commission Sentinel Event Database occur in non-behavioral health care units. These include medical/surgical units, intensive care units (ICUs), oncology units, and telemetry units. In addition, 8% of reported suicides occur in emergency departments (EDs).<sup>1</sup>

### **Suicide Risks in the ED, Medical/Surgical Units**

Although psychiatric settings are designed to be safe for suicidal individuals

*Continued on page 2*

## **Preventing Suicide Outside Behavioral Health Units**

(continued from page 1)

and are staffed with people specially trained to deal with these individuals, hospital medical/surgical units and EDs are typically not designed to mitigate suicide risk and do not have staff with such training, even though potentially suicidal patients are often present in these settings. Individuals are frequently admitted to general hospitals immediately following suicide attempts. Some seek help in a hospital ED—often at the urging of family or friends—when they are feeling most desperate.<sup>2</sup> Lack of adequate health insurance for mental health services also leads many individuals to seek initial treatment for mental disorders in the ED, again at a point when they may be desperate and at increased risk of suicide.<sup>3</sup>

Access to potentially dangerous items is a contributing factor. Compared to a psychiatric hospital or unit, a general hospital presents more access to items that can be used to attempt suicide. These items are either already in the setting—such as equipment and supplies—or may be brought into the facility in the form of contraband. Some specific means of suicide that are readily available in the general hospital setting include bell cords, bandages, sheets, restraint belts, plastic bags, elastic tubing, and oxygen tubing.<sup>4</sup>

Compounding the presence of potential means for suicide is the reality of staff distraction during their urgent business of providing care in the ED and on medical/surgical units. There are many instances when a suicidal patient is alone in these settings, which can create opportunities for the patient to attempt or re-attempt suicide.

## **Mitigating Suicide Risks**

To help hospitals improve the safety of their patients, The Joint Commission recently released a *Sentinel Event Alert*

that focuses on preventing suicide in the ED and medical/surgical units. (Go to [http://www.jointcommission.org/assets/1/18/SEA\\_46.pdf](http://www.jointcommission.org/assets/1/18/SEA_46.pdf) for a complete copy of *Sentinel Event Alert* 46.) This *Alert* is a follow-up to one released in 1998. The Joint Commission reexamined this issue because of ongoing concerns regarding patient safety in these vulnerable settings.

One of the primary recommendations of the *Alert* involves consistently screening and assessing patients for suicide risk when they enter the ED and medical/surgical areas. This screening and assessment process will vary, depending on the organization, but should involve watching for behaviors, mental status, and conditions that may indicate risk of imminent suicide.

These include the following:

- Acute signs of depression, anxiety, agitation, delirium, and dementia
- Medical or psychological problems that significantly impact judgment, including intoxication with alcohol or drugs
- Chronic pain or other debilitating problems, including chronic illness and terminal cancer

When designing a suicide screening process, some organizations choose to use a form or tool to help with the assessment. In fact, there are many such tools in use in hospitals throughout the country. Screening and assessment tools should be appropriate for a person's age and characteristics. Furthermore, as David M. Sine, A.R.M., C.S.P., C.P.H.R.M., co-author of *Design Guide for the Built Environment of Behavioral Health Facilities*, distributed by the National Association for Psychiatric Health Systems, explains, "While a tool can help identify patients at risk, it should not be considered the only way to identify these patients." He adds, "Sometimes patients who eventually

commit suicide have gone through an organization's screening process and do not screen positive for suicide risk at the time of the screening. A form or tool can be a helpful guide, but staff members must also be aware of the signs and symptoms so they can recognize escalating behavior as it occurs."

## Facility and EC Strategies

In addition to thoroughly screening patients for suicide risk, some strategies related to the environment of care (EC) can help mitigate risk. Several of these strategies are discussed here:

- *Assess the room.* Several engineering controls can minimize the risks of patient suicide in the ED and medical/surgical unit. To determine the need for these engineering controls, an organization should perform a comprehensive room assessment to identify potential risks and determine possible mitigation strategies. For example, if the room has a window, the window should have a limited portion that is operational to prevent patient elopement or leaping. Any covers on lights should be replaced with shatter-proof and tamper-resistant material. If the

room houses a shower, it should be equipped with a ligature-resistant shower head, tamper-resistant shower curtains, and so forth. "Some organizations have a roll-down door that covers the medical gas outlets in the treatment room," says Sine. "If the patient does not require medical gas for treatment, the door can lock out the area and prevent access."

When assessing a room for suicide risks, organizations should look at the entire room, as the risks for suicide can be found in some seemingly unlikely places. For example, patients have been known to "hang" themselves from objects as close to the floor as 18 inches, and one study found that 50% of hangings were from heights below the waist of the victim.<sup>5</sup> (See "Checklist for Assessing Environmental Risks for Suicide," page 10, for a tool to help with the assessment process.)

- *Minimize medical equipment in the room.* Although many risks can be addressed as a result of a room assessment, ED and medical/surgical rooms will still contain a host of equipment and supplies to ensure comprehensive medical care. These can also present hazards. "Not every

patient will require all the equipment and supplies housed in these rooms," says Sine. "When treating patients at risk for suicide, an organization should minimize the equipment in the room and include only that which is absolutely necessary for the patient. To do this effectively, an organization should have a policy in place that addresses what can be removed from the room and what can't. Although an organization certainly can't remove all the equipment and supplies, limiting these to only those that are necessary for a particular patient can reduce risk."


- *Check for contraband.* In addition to equipment and supplies found in the room, patients can bring into a hospital items that can be used in a suicide attempt, such as knives, needles, and weapons. For this reason, it is critical that an organization engage in a reasonable search of person and property when a patient is screened for possible suicide risks. "To prevent confusion about this, organizations should have an explicit policy that covers what a reasonable search entails, when it should occur, and who should perform it," says Sine.

*Continued on page 10*

## Preventing Suicide Outside Behavioral Health Units

(continued from page 3)

### One-to-One Observation

Even if an organization implements comprehensive policies for assessing the patient room, limiting medical equipment, and checking for contraband, there is still a possibility that a patient could commit suicide in the ED or on medical/surgical units. “You simply cannot remove every possible risk,” says Sine. “So, it is imperative for organizations to have a policy and procedure for one-to-one observation of those patients deemed at risk for suicide.” One-to-one observation means having a trained person sitting with the patient around the clock. “In an observation policy, organizations should think about the qualifications of the sitter and when such a sitter is warranted,” says Sine. “At the very least, organizations want someone who can identify when the patient’s behavior is escalating and know how and when to seek help.” 

### References

1. The Joint Commission: A follow-up report on preventing suicide: Focus on medical/surgical units and the emergency department. *Sentinel Event Alert* 46, Nov. 17, 2010.
2. Spence J.M., et al.: Experiences of substance-using suicidal males who present frequently to the emergency department. *CJEM* 10:339–346, Jul. 2008.
3. U.S. Surgeon General: *Mental Health: A Report of the Surgeon General*, 1999. <http://www.surgeongeneral.gov/library/mentalhealth/home.html> (accessed Feb. 12, 2011).
4. Bostwick J.M., Rackley S.J.: Completed suicide in medical/surgical patients: Who is at risk? *Curr Psychiatry Rep* 9:242–246, 2007.
5. Gunnell D., et al.: The epidemiology and prevention of suicide: A systematic review. *Int J Epidemiol* 34:433–442, 2005.

## Checklist for Assessing Environmental Risks for Suicide

Following is a brief checklist to help hospitals assess and address suicide risks in their ED and medical/surgical units.

- ☐ Avoid “lay-in” ceilings. These can make it easier for the patient to hide contraband, can provide a convenient place to secure a ligature for self-harm, or may allow the patient access to above-the-ceiling interstitial spaces.
- ☐ If the outside window of the room is operable, limit the opening so a person could not pass through (4–6 inches is considered the architectural standard of care). Alternatively, consider protecting a window with a security screen that is secured by a device that can be removed from the inside only with a special tool (such as a non-common screw head).
- ☐ Make window glazing shatter-proof.
- ☐ Use a tamper-resistant, anti-ligature door knob for the patient’s room.
- ☐ If a hospital bed is in use, secure the electrical power cord on the bed. Consider replacing the bed cord with a “jumper cord” that can be removed by staff, kept in a secure place, and used only when the bed needs to be adjusted. (Check the bed design to ensure that the bed can be mechanically lowered to a “CPR” position.)
- ☐ Use tamper-resistant screws throughout the room.
- ☐ Secure the power cord on the TV. A mounting bracket can be an attachment point for a ligature.
- ☐ Replace cork bulletin boards with dry-mark boards, thus eliminating inadvertent use of thumbtacks.
- ☐ Use shatter-proof and tamper-resistant glass in night lights and other lighting fixtures.
- ☐ Secure light fixtures to restrict patient access to bulbs and sockets.
- ☐ Remove grab bars in the bathroom or fill in the wall “gap.”
- ☐ Eliminate coat hooks, towel bars, cubicle curtain tracks, and closet poles.
- ☐ Ensure that all electrical outlets are GFCI (ground fault circuit interrupter) and tamper resistant.
- ☐ Replace metal outlet covers with shatter-proof non-conductive covers.
- ☐ Protect the piping for the toilet and lavatory.
- ☐ Use tamper-resistant lavatory faucets.
- ☐ Ensure that HVAC (heating, ventilating, and air conditioning) grills are tamper resistant.
- ☐ Use tamper-resistant shower controls and shower heads.
- ☐ Ensure that mirror and picture glazing material are shatter-proof.

*Source:* Adapted from Sine D.M.: Latent risks in the built environment for the behavioral health patient: Concerns for the healthcare risk manager. In *The American Society for Healthcare Risk Management Handbook*, 6th ed. Chicago: American Hospital Association, 2010.