



Emergency Department Management of the Suicidal Patient

PA-PSRS has received several reports of patient suicide attempts, failed searches of suicidal patients' possessions, and elopements of suicidal patients from emergency departments (ED). Although suicides, suicide attempts, and patient self-harm should be reported as Infrastructure Failures, facilities have reported them and their near-miss counterparts to the Patient Safety Authority (PSA). Suicidal patients are evaluated and often held for observation in the ED. Keeping an at-risk patient safe is a challenge for an ED, as the following cases indicate:

Patient took 100 Klonopin while on suicide watch in the ED.

Intoxicated, suicidal patient was brought to the ED by the police for observation overnight. Six hours later, the patient was not there, and the bed was made. Security had checked the room and thought the patient was discharged.

Patient came to the ED with suicidal ideations. The patient's purse was not removed from the room. The patient was admitted to the ICU. Family members found the purse with medications in it. The purse was removed from the care area.

Heightened vigilance is warranted during the holiday season, when depression can be exacerbated and substance abuse may be more likely. To optimize the safety of suicidal patients, consider the strategies below when reviewing policies and procedures for patients at risk of suicide.¹

Emergent care begins with expeditious triage of the suicidal or at-risk patient, followed by a patient search. Search practices to consider include:

- Disrobing the patient and providing a hospital gown.
- Searching the patient's possessions for weapons, medications, and any other items that can be used for self-harm.

- Placing the patient's clothing and possessions in a secure location outside the room and not giving these items to family or friends.²

Often, aspects of the search are witnessed by or delegated to other staff. For example, security personnel may be assigned to examine the patient's possessions (e.g., wallet, purse). The individual performing the search looks for items that could cause harm. Any potentially harmful items, including medications, are documented and secured away from the patient.²

Providing a safe physical environment for suicidal patients often necessitates modification of the facility's structural features, as well as furnishings and equipment, in patient areas. Suggestions for review of the environment, specifically the exam room, include the following:

- Assessing the area for items that might increase the risk of suicide by hanging, such as door hinges, plumbing fixtures, privacy partitions, clothing hooks, and closet and curtain rods.
- Eliminating, to the extent possible, all means of hanging such as sheets, pants, belts, shoelaces, any cords (e.g., the call-bell, electronic equipment, and curtains or blinds). Even something as seemingly benign as a stethoscope, if left behind by a clinician, can become a strangulation device.
- Using plastic utensils and disposable dishes for meals.
- Minimizing access to glass by using Plexiglas for windows and any framed artwork.³

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Emergency Departmental Management of the Suicidal Patient (Continued)

- Eliminating materials that present a smothering hazard, such as plastic shower curtains, trash liners, and disposable gloves.⁴

Rooms that are designated for behavioral health patients but may be used for any patient when demand is high—brings with it risk. Housekeeping, contracted services, and clinical staff may unwittingly leave items in the room that can enable determined patients to inflict self-harm.³ Before placing an at-risk patient in an exam room, scan the room to ensure safety.

Elopement is another risk among suicidal patients. Agitated, frightened, and often angry, suicidal patients are likely to run away if the chance arises. Considerations to minimize escape opportunities include:

- Assigning the patient to a room in a location that allows easy observation and access for staff yet is away from exits.
- Monitoring and observation of the patient by staff educated in observation of at-risk patients.
- Using a team-participation approach, with scheduled, documented monitoring of the patient or, through intensive, one-to-one staffing when indicated.
- Keeping the patient's attire limited to a patient gown.

Frequently, after a suicide attempt, patients are evaluated and then transferred to other settings in the chain of care. Structured collaboration is necessary between facilities during institutional transfers and between teams during intrahospital transfers (e.g., from the ED to the medical/surgical or psychiatric unit).⁵

In an effort to provide the at-risk suicidal patient the safest care possible, be systematic about the patient search process, the environment of care, and the risk of elopement.

Notes

1. Drew BL. Self-harm behavior and no suicide contracting in psychiatric inpatient settings. *Arch Psychiatr Nurs* 2001 Jun;15(3):99-106.

2. Initial management of potential suicidal/homicidal or potentially violent patients. *ED Manag* 2003 Jul;15(7 Suppl):1-3.

3. Yeager K, Saveanu R, Roberts A, et al. Measured response to identified suicide risk and violence: what you need to know about psychiatric patient safety. *Brief Treat Crisis Interv* 2005 May;5(2):121-41.

4. Nestor C. Suicide watch. Design your facility to protect troubled patients from self-harm. *Health Facil Manage* 2000 Oct;13(10):24-6.

5. Mann JJ, Apter A, Bertoltoe J, et al. Suicide prevention strategies: a systematic review. *JAMA* 2005 Oct 26;294(16):2064-74.



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The Patient Safety Authority is an independent state agency created by Act 13 of 2002, the Medical Care Availability and Reduction of Error ("Mcare") Act. Consistent with Act 13, ECRI, as contractor for the PA-PSRS program, is issuing this newsletter to advise medical facilities of immediate changes that can be instituted to reduce serious events and incidents. For more information about the PA-PSRS program or the Patient Safety Authority, see the Authority's website at www.psa.state.pa.us.



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