

Emergency Departmental Management of the Suicidal Patient (Continued)

- 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, Bertolote J, et al. Suicide prevention strategies: a systematic review. *JAMA* 2005 Oct 26;294(16):2064-74.

The Highly Reliable Operating Team

At the most recent Clinical Congress of the American College of Surgeons, I had the honor of moderating a panel on the topic of "The Highly Reliable Operating Team." The panelists were Benjamin Sachs, M.B.B.S., discussing "Improving Team Performance," Michael Leonard, M.D., discussing "Improving Communication," and Forrest Calland, M.D., discussing "Standardization and Checklists."

From my notes of the discussion, I will convey the following suggestions about how surgeons can help make the operating team safer:

1. Be a good role model. Participate in the pre-operative time out; pay attention to incorrect sponge counts; honor other safety practices.
2. Introduce yourself and everyone else on the team. It has been shown that people who know each other by their first names are more likely to speak up if they see a problem.
3. Specifically ask people to speak up if they have concerns or questions.
4. Include contingency planning in your pre-operative time out.
5. Double check that equipment works and supplies are available before you start the case.
6. Bring all information you might need to make intra-operative decisions to the operating room.
7. Help people understand your goals by saying *why* you want something as well as *what* you want.
8. Make confirmation feedback a habit for your operating team.
9. Don't be afraid to ask for help.
10. Adhere to best practice standards, when they exist.
11. If you find yourself doing a "work-around," ask yourself "What can I do to keep this from occurring again?"
12. Have a short debriefing after the case.

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