

Screening for Suicidality in the Emergency Department

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st. Joseph healthcare

St. Joseph Hospital

Our Mission

"St. Joseph Healthcare-committed to wellness promotion and holistic healing-provides healthcare services which embody compassion, competence and community."

"These are the words we live by, each and every one of us who comprise the caring community of St. Joseph Healthcare. We take our Mission seriously. Those we serve depend on it."



- **Compassion**

- The St. Joseph Healthcare team demonstrates special sensitivity toward all persons, especially those who are vulnerable and suffering.

Communication · Respect · Open-mindedness

- Competence
- Community

**OUR
VALUES**



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Welcome to our ED

- 18 beds
 - 16 with full cardiac monitoring
 - 3 critical care rooms
 - 2 psychiatric rooms
- 3 bay subacute area
- In 2014, we served 685 suicidal patients (1.8/day)
 - 112 in January and February
- In 2015, we served 503 suicidal patients (1.3/day)
 - 89 in January and February
- In 2016, (January 4-February 26) we have served 64 suicidal patients (1.2/day)
- We partner with Community Health and Counseling Services to care for this vulnerable population.



Why Suicidal Patients?

- In 2011, 224 Maine citizens, 4 each week, died by suicide.
- Maine Suicide Prevention Program Strategic Plan 2012-2017
 - “The purpose of the MSPP Strategic Plan 2012-2017 is to guide Maine’s statewide suicide prevention efforts across the lifespan. The Plan’s implementation **requires the engaged efforts** of state and local agencies, decision-makers, **health care providers, service organizations**, educators, planners, employers, community members, and others to **integrate suicide prevention best practices** within their settings and initiatives. “ (Dr. Sheila Pinette, Director, Maine CDC)



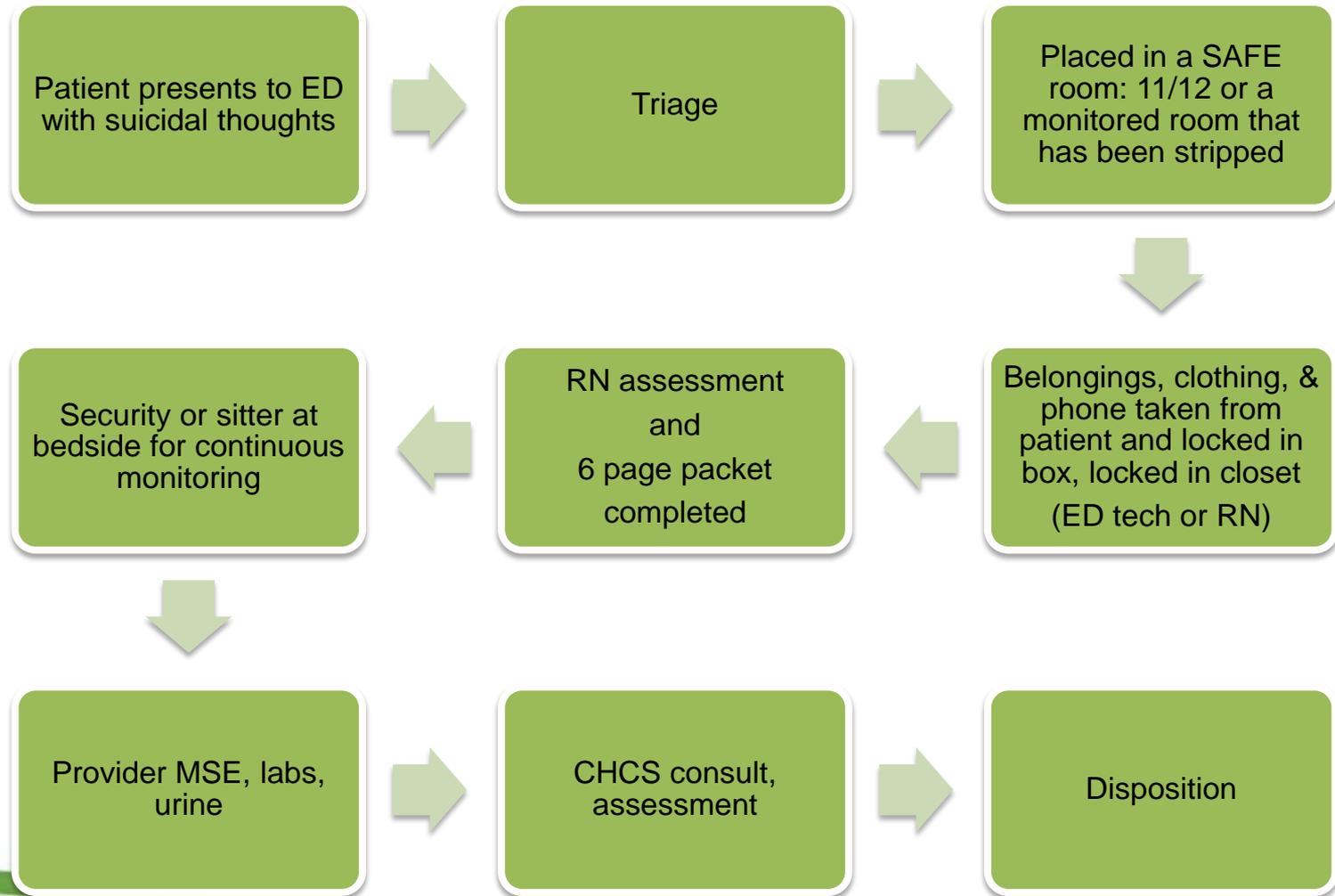
Why Suicidal Patients?

- Because, I saw a chance to make a change in our practices for the better
 - This came from a LEAN measure to review the pathway for the psychiatric patient

..... And I RAN WITH IT!



Previous State

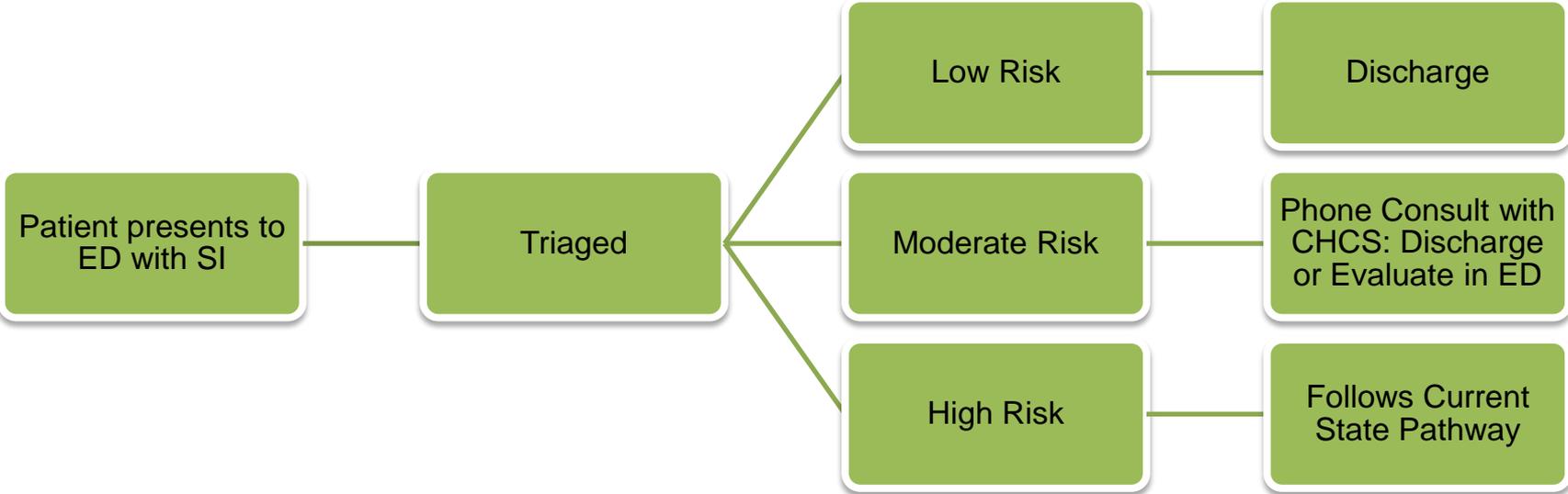


Previous State: Problems

- Increased length of stay for all patients
- Maximum resources utilized
 - Security guard or CNA sitter
 - Security guards missed 2/3 of their time to round on hospital due to patient observation
 - Lab work collection , processing, and reporting
 - Urine collection, processing, and reporting
 - Evaluation in ED by mental health worker
- Increase in escalated events resulting in chemical and/or physical restraints
- Decrease in staff satisfaction
- Decrease in patient satisfaction
- Creates a barrier to therapeutic care



Proposed State



Proposed State: Benefits

- Decrease the amount of resources used
 - Security time
 - » Decrease security time by 49%
 - RN time spent settling patient
 - » (increase therapeutic RN time)
 - CHCS time
- Decrease escalated events
- Increase staff satisfaction
- Decrease LENGTH OF STAY for all patients
 - Increase throughput of waiting room patients
 - Decrease LWBS patients



How Do We Do This?



Columbia-Suicide Severity Rating Scale

- What is it?
 - Structured assessment of suicidal ideation
 - Addressing method, plan, and intent
 - Assessment of suicidal behaviors
- Key Points:
 - Validity, Sensitivity, & Specificity
 - “Demonstrated good convergent and divergent validity with other multi-informant suicidal ideation and behavior scales” (Posner et al, 2011)
 - “had high sensitivity and specificity for suicidal behavior classifications compared with another behavior scale and an independent suicide evaluation board” (Posner et al, 2011)
 - The CDC adopted Columbia definitions of suicidal ideation and behavior.
 - Immediate-use ready
 - Mental health training not required to administer



Columbia-Suicide Severity Rating Scale

- Why **Ideation** and **Behavior**?
 - “Studies of risk factors predicting suicide consistently suggest that suicidal ideation and a history of suicide attempts are among the most salient risk factors for suicide” (Posner et al, 2011)
 - The first three warning signs are:
 1. Threatening to hurt or kill self
 2. Looking for ways to kill self
 3. Talking or writing about death, dying, or suicide(Brown GK, Beck AT, Steer RA, Grisham JR, 2000)
 - The history of a prior suicide attempt is the best known predictor for future suicidal behaviors, including completed suicide (American Psychiatric Association, 2004; Sentinel Event Alert-TJC, 2010)





Columbia –Suicide Severity Rating Scale

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS		
	YES	NO
*Ask questions that are bolded and <u>underlined</u> .		
Ask Questions 1 and 2		
<p>1) Wish to be Dead:</p> <ul style="list-style-type: none"> • Person endorses thoughts about a wish to be dead or not live anymore, or wish to fall asleep and not wake up. <p><u>Have you wished you were dead or wished you could go to sleep and not wake up?</u></p>		
<p>2) Suicidal Thoughts:</p> <ul style="list-style-type: none"> • General non-specific thoughts of wanting to end one’s life/commit suicide, “<i>I’ve thought about killing myself,</i>” without general thoughts of ways to kill oneself/associated methods, intent, or plan. <p><u>Have you actually had any thoughts of killing yourself?</u></p>		



If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):

- Person endorses thoughts of suicide and has thought of a least one method during the assessment period.
- This is different than a specific plan with time, place or method details worked out.
- *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."*

Have you been thinking about how you might kill yourself?

4) Suicidal Intent (without Specific Plan):

- Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."*

Have you had these thoughts and had some intention of acting on them?

5) Suicide Intent with Specific Plan:

- Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.

Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?



SUICIDE IDEATION DEFINITIONS AND PROMPTS			
*Ask questions that are bolded and <u>underlined</u>.		YES	NO
6) Suicide Behavior Question: <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> <ul style="list-style-type: none"> • Preparation: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind, went to the roof but didn't jump • Attempt: took pills, shot yourself, cut yourself, tried to hang yourself, etc. <p>If YES, ask: <u>How long ago did you do any of these?</u> ___ Over 1 year ago? ___ Between 3 mos. & 1 year ago? ___ Within the last 3 mos.?</p>			
Risk Factors		Protective Factors	
<input type="checkbox"/> Command Hallucination <input type="checkbox"/> Personality Disorder <input type="checkbox"/> ETOH/Substance Use <input type="checkbox"/> Impulsivity, aggression, or antisocial behavior <input type="checkbox"/> Recent or anticipated loss <input type="checkbox"/> Legal issues/incarceration <input type="checkbox"/> Access to lethal means <input type="checkbox"/> Non-compliant <input type="checkbox"/> Ongoing medical illness	<input type="checkbox"/> Ability to cope with stress or frustration <input type="checkbox"/> Sense of responsibility to others <input type="checkbox"/> Social support <input type="checkbox"/> Has a reason to live <input type="checkbox"/> Religious beliefs <input type="checkbox"/> Positive relationships <input type="checkbox"/> Engaged in work or school <input type="checkbox"/> Fear of death <input type="checkbox"/> Cultural, spiritual or moral attitudes against suicide		



Response Protocol to C-SSRS: linked to last question patient answered "yes" to	
Suicidal Ideation	
• Question 1 or 2	Low-Risk Suicidal Precautions
• Question 3	Moderate-Risk Suicidal Precautions
• Question 4 or 5	High-Risk Suicidal Precautions
Suicidal Behavior (Question 6)	
• More than 1 year ago	Low-Risk Suicidal Precautions
• Between 3 months and 1 year ago	Moderate-Risk Suicidal Precautions
• Within the last 3 months	High-Risk Suicidal Precautions

Initials

Nurse Signature

time/date

- Low Risk
 - Minimal resources used
 - No seclusion
- Moderate Risk
 - Moderate resources used
 - Assess best practice for patient (evaluation in ED or community)
- High Risk
 - Maximum resources used

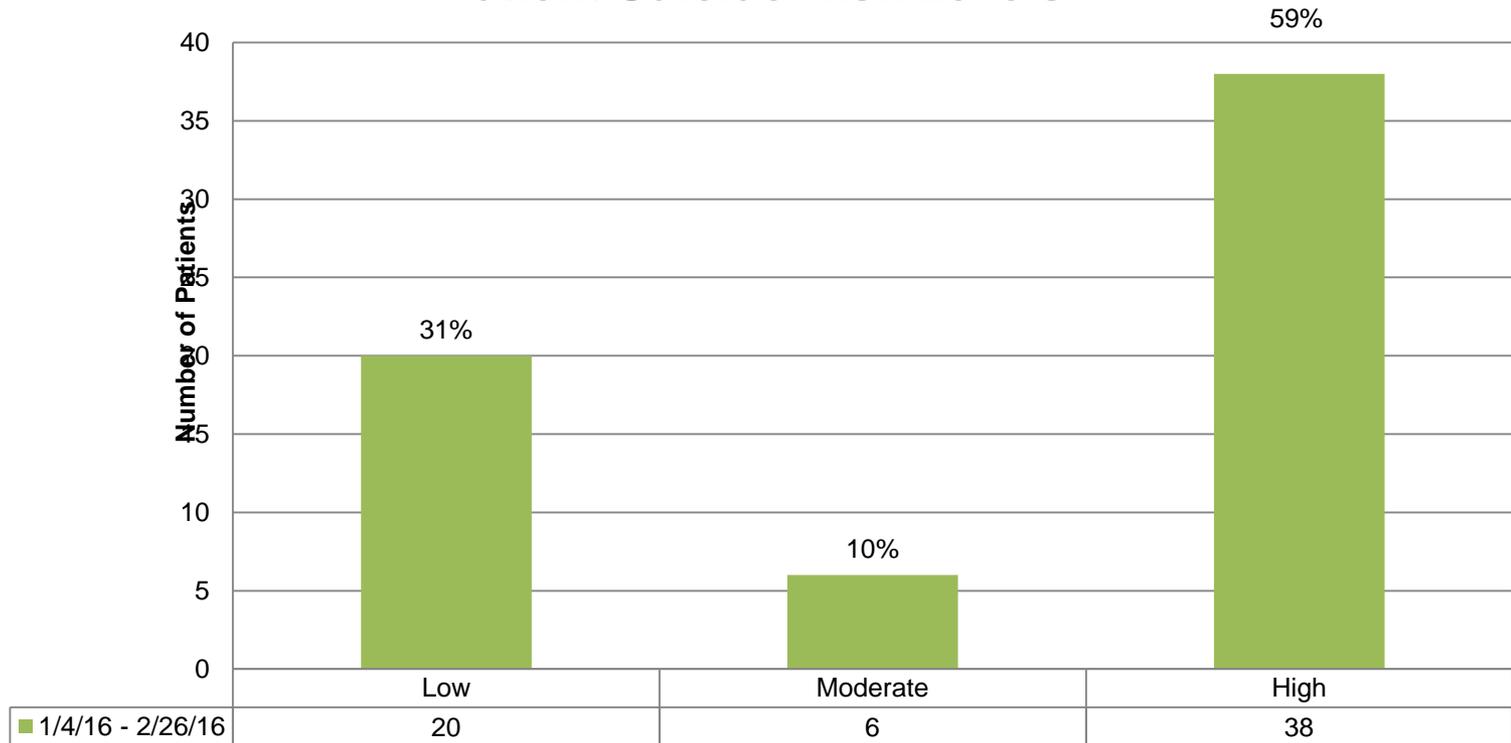


What Did it Take?

- **EDUCATION**- 1 hour of mandatory face-to-face education
- “A qualitative study by Cristine et al, (2007) explored the role of a registered nurse with two years of crisis intervention training to provide care for ED patient with mental health complaints. The benefits attributed to the implementation of the role were decreased wait times, improved discharge and follow up care” (Brim, 4, 2012)
- ED triage nurse and psychiatric nurse consultant “found poor agreement” (Brim, 4, 2012)
 - Multiple studies recommended training to improve the confidence of ED personnel (RN and Provider) in screening patients for suicide risk
 - » More accurate risk assessments
 - » Increased staff satisfaction



Patient Suicide Risk Levels

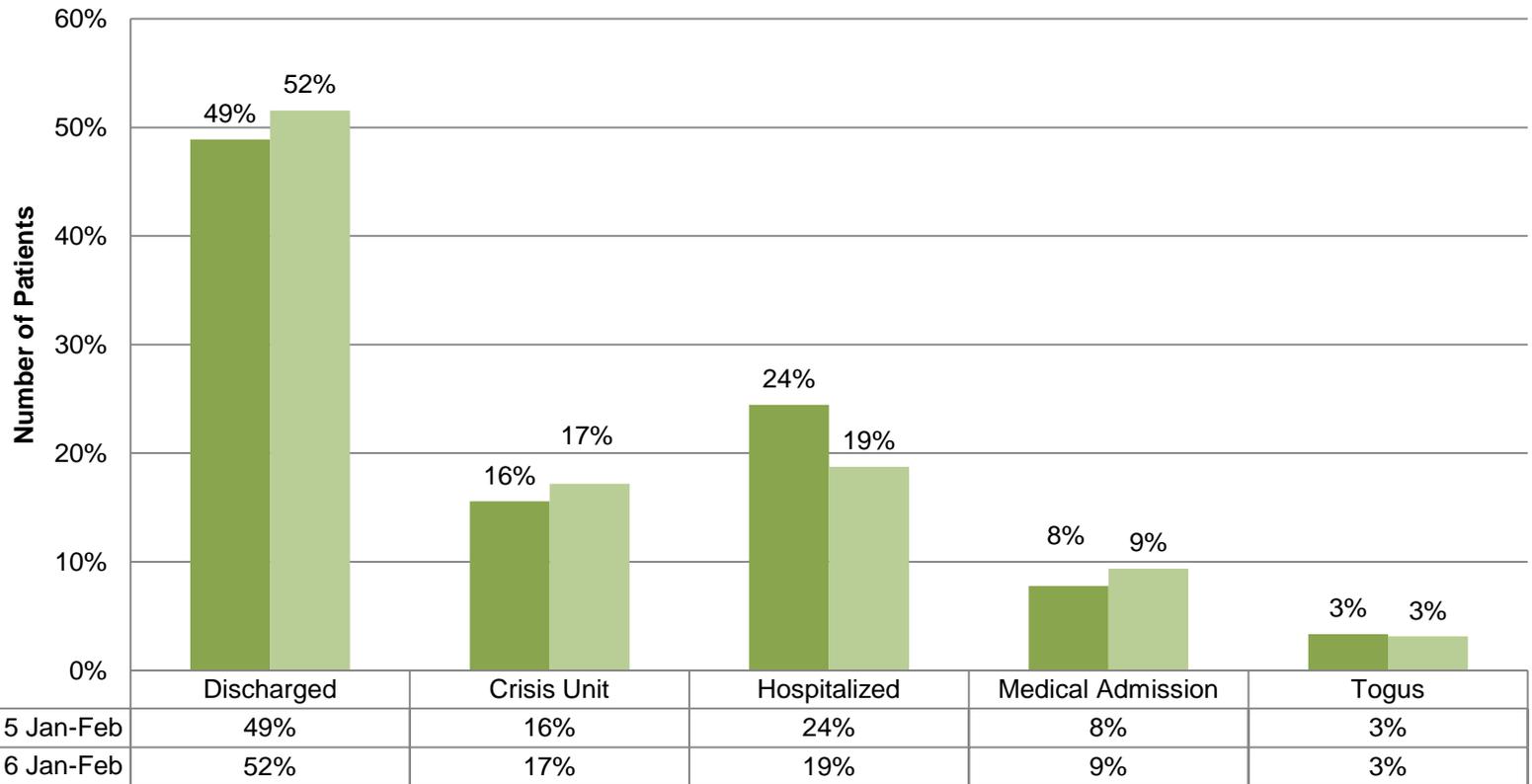


Results

- 41% of SI patients did not need a security guard watching them
- 31% of SI patients did not have belongings removed or get placed in a secluded room



Suicidal Patient Dispositions 2015-2016



Patient Disposition

Results

Disposition has remained the same, patients are still getting the treatment they need without utilizing maximum resources.

Results

- Decreased LOS for Low Risk patients
 - Some discharged within 2 hours
- Decreased escalated events
 - 0 escalated events (for SI patients) requiring chemical or physical restraint
- Increased patient satisfaction
 - Allowing low risk and moderate risk patients to keep own clothing
- Increased staff satisfaction
 - “No problems. Slick as shit. Love it” (St. Joes, ED RN)
- Decreased Security watch hours by 56%!!!



Limitations

- Limited time to collect data
- ETOH patients
- T-system
- Flexibility





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References

- American Psychiatric Association. (2004). Practice guidelines for the assessment and treatment of patients with suicidal behaviors. *Practice Guidelines for the Treatment of Psychiatric Disorders Compendium*, 2nd ed., 835-1027.
- Betz, M., & Boudreaux, E. (2015). Managing suicidal patients in the emergency department. *Annals of Emergency Medicine*. doi:10.1016/j.annemergmed.2015.09.001
- Brim, C., Lindauer, C., Halpern, J., Storer, A., Barnason, S., Young Bradford, J., . . . Williams, J. (2012). Clinical practice guideline: Suicide risk assessment. *Emergency Nurses Association*, 1-15. Retrieved June 8, 2015, from <https://www.ena.org/practice-research/research/CPG/Documents/SuicideRiskAssessmentCPG.pdf>
- Chang, B., & Tan, T. (2015). Suicide screening tools and their association with near-term adverse events in the ED. *The American Journal of Emergency Medicine*, 1680-1683. doi:10.1016/j.ajem.2015.08.013
- Posner, K., Brown, G., Stanley, B., Brent, D., Yershova, K., Oquendo, M., . . . Mann, J. (2011). The Columbia–Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *The American Journal of Psychiatry*, 168, 1266-1277. doi:10.1176/appi.ajp.2011.10111704
- Posner, K. (n.d.). Columbia Suicide Severity Rating Scale (C-SSRS)-general information. Retrieved May 8, 2015, from http://cssrs.columbia.edu/about_cssrs.htm
- Ronquillo, L., Minassian, A., Vilke, G., & Wilson, M. (2012). Literature-based Recommendations for Suicide Assessment in the Emergency Department: A Review. *The Journal Of Emergency Medicine*, 43(5), 836-842. doi:10.1016/j.jemermed.2012.08.015
- Ryan, C., & Large, M. (2015). Preventing suicide in the emergency department. *The Journal Of Emergency Medicine*, 48(3), 335-336. doi:10.1176/appi.ajp.2011.10111704
- Sentinel event alert- A follow-up report on preventing suicide: Focus on medical/surgical units and the emergency department. (2010, November 17). Retrieved May 8, 2015, from http://www.jointcommission.org/sentinel_event_alert_issue_46_a_follow-up_report_on_preventing_suicide_focus_on_medicalsurgical_units_and_the_emergency_department/
- Suicide prevention using the C-SSRS. (2012). Retrieved July 17, 2015, from <http://www.depressioncenter.org/colloquium/2012/downloads/suicide-prevention-using-c-ssrs.pdf>

