1.6: Establishing Safety

Suicidal thoughts are a common symptom of mental health disorders and typically resolve with effective treatment. However, despite a recent increased focus on mental health care, there has been no documented decrease of suicide rates in the United States, and suicide remains the tenth leading cause of death in the country.¹

Warning Signs of Suicide

Everyone can help prevent suicide by recognizing warning signs of suicide and intervening appropriately. Warning signs of suicide include client statements or nurse observations of the following²:

- Feeling like a burden
- Being isolated
- Increasing levels of anxiety
- Feeling trapped
- Being in unbearable pain
- Increasing substance use
- Looking for a way to access lethal means
- Increasing anger or rage
- Exhibiting extreme mood swings
- Expressing hopelessness
- Sleeping too little or too much
- Talking or posting about wanting to die
- Making plans for suicide
See Figure 1.3 for five action steps for anyone to take to prevent suicide in someone experiencing suicidal thoughts or ideations. Nurses can educate others to take the following steps if they believe someone may be in danger of suicide:

- Call 911 if danger for self-harm seems imminent.
- Ask the person if they are thinking about killing themselves. Although asking this question can feel invasive, it is common for individuals with mental health problems to share their thoughts and plans regarding suicide. Asking them about suicide will not “put the idea into their head” or make it more likely that they will attempt suicide. In fact, by responding appropriately, you can help save their life by asking this question.
- Listen without judging and show you care.
- Stay with the person or make sure the person is in a private, secure place with another caring person until you can get further help.
- Remove any objects that could be used in a suicide attempt.
- Call or text 988 to reach the new nationwide Suicide and Crisis Line for a direct connection with compassionate, accessible care and support for anyone experiencing mental health-related distress.

Establishing a Safe Care Environment for Clients

In addition to encouraging these general action steps to prevent suicide, nurses can further prevent suicide by establishing a safe care environment. Establishing a safe care environment is a priority nursing intervention.

Reducing the risk for suicide is one of the National Patient Safety Goals for Behavioral Health Care established by The Joint Commission. New requirements were established in 2020 that apply to patients in psychiatric hospitals, patients being evaluated or treated for behavioral health conditions as their primary reason for care in general hospital units or critical access hospitals, and all patients who express suicidal ideation during their course of care. These requirements include performing an environmental risk assessment, screening for suicidal ideation, assessing suicide risk, documenting risk of suicide, following evidence-based written policies and procedures, providing information on follow-up care on discharge, and monitoring effectiveness of these actions in preventing suicides. These requirements are discussed in further detail in the following subsections.

Read more about suicide prevention at Joint Commission’s Suicide Prevention webpage.
Perform Environmental Risk Assessment

An **environmental risk assessment** identifies physical environment features that could be used by clients to attempt suicide. Nurses implement actions to safeguard individuals identified at a high risk of suicide from environmental risks, such as continuous monitoring, routinely removing objects from rooms that could be used for self-harm, assessing objects brought into a facility by clients and visitors, and using safe transportation procedures when moving clients to other parts of the hospital.

In psychiatric hospitals and on psychiatric units within general hospitals, additional measures are taken to prevent suicide by hanging by removing anchor points, door hinges, and hooks. The Veteran’s Health Administration showed that the use of a Mental Health Environment of Care Checklist to facilitate a thorough, systematic environmental assessment reduced the rate of suicide from 4.2 per 100,000 admissions to 0.74 per 100,000 admissions. [7]

Read more about the VA Mental Health at the [Mental Health Environment of Care Checklist (MHEOCC) webpage](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/01%3A_…)

Screen for Suicidal Ideation With a Validated Tool

Clients being evaluated or treated for mental health conditions often have suicidal ideation (i.e., thoughts of killing themselves). Additionally, clients being treated for medical conditions often have coexisting mental health disorders or psychosocial issues that can cause suicidal ideation. Therefore, all patients aged 12 and older admitted for acute health care should be screened for suicidal ideation with a validated tool. An example of a validated screening tool is the Patient Safety Screener. [9][10] View more information about the Patient Safety Screener tool in the following boxes.

Visit the Suicide Prevention Resource Center’s webpage to read more about the [The Patient Safety Screener: A Brief Tool to Detect Suicide Risk](https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/01%3A_…)

View the following YouTube video on administering the Patient Safety Screener: [12] The Patient Safety Screener 3

Assess Suicide Risk

An evidence-based **suicide risk assessment** should be completed on patients who have screened positive for suicidal ideation. Patients with suicidal ideation vary widely in their risk for a suicide attempt depending upon whether they have a plan, intent, or past history of attempts. An in-depth assessment of patients who screen positive for suicide risk must be completed to determine how to appropriately keep them safe from harm. Assessment for suicide risk includes asking about their suicidal ideation (i.e., thoughts of suicide), if they have a plan for committing suicide, their intent on completing the plan, previous suicidal or self-harm behaviors, risk factors, and protective factors. [13] When assessing for a suicide plan, notice if the plan is specific and the method they plan to use. The risk of acting on suicide thoughts increases with a specific plan. The risk also increases if the plan includes use of a lethal method that is accessible to the client.

An example of an evidence-based suicide risk assessment tool that anyone can use with anyone, anywhere is the Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS). Read more about the C-
SSRS in the following box. The C-SSRS uses a series of simple, plain-language questions that anyone can ask. The answers help identify if a person is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs. Examples of questions include the following\[^{14}\]:

- Have you had thoughts of killing yourself?
- Have you thought about how you might do this?
- Have you done anything, started to do anything, or prepared to do anything to end your life?

**Columbia Suicide Severity Rating Scale (C-SSRS)**\[^{15}\]

Read more about using the C-SSRS at [Columbia Lighthouse Project web site](https://www.lighthousecolumbia.org/).

View the following YouTube video on C-SSRS\[^{16}\] at [Saving Lives Worldwide – A Call to Action – The Columbia Lighthouse Project](https://www.youtube.com/watch?v=).

---

**Develop a Safety Plan**

If a client is assessed as high risk for suicide, a safety plan should be created in collaboration with the client. A safety plan is a prioritized written list of coping strategies and sources of support that clients can use before or during a suicidal crisis. The plan should be brief, in the client’s own words, and easy to read. After the plan is developed, the nurse should problem solve with the client to identify barriers or obstacles to using the plan. It should be discussed where the client will keep the safety plan and how it will be located during a crisis.\[^{17}\]\[^{18}\]

Read the [Safety Planning Guide PDF](https://www.westahe.edu/safety-planning-guide) by the Western Interstate Commission for Higher Education.\[^{19}\]

---

**Document Level of Risk for Suicide**

After suicide screening and suicide risk are assessed, it should be documented and communicated with the treatment team, along with the plan to keep the client safe. It is vital for all health care team members caring for the client to be aware of their level of risk and plans to reduce that risk as they provide care.\[^{20}\] Nurses complete documentation regarding the level of a client’s suicide risk and associated interventions every shift or more frequently as needed, depending upon the client status.

---

**Follow Written Policies and Procedures**

Nurses must strictly follow agency policies and procedures addressing the care of individuals who are identified at risk for suicide to keep them safe. For example, in some suicide cases reported to The Joint Commission, the root cause was a failure of staff to adhere to agency policies, such as a period of time when one-to-one monitoring was in place for a client identified as high risk for suicide.\[^{21}\]

---

[14] https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/01%3A_...
Updated: Sat, 24 Sep 2022 23:53:25 GMT
Powered by
Provide Information for Follow-Up Care on Discharge

Nurses should provide written information at discharge regarding follow-up care to clients identified at risk for suicide and share it with their family members and loved ones as appropriate. Studies have shown that a patient’s risk for suicide is high after discharge from psychiatric inpatient or emergency department settings. Developing a safety plan with the patient and providing the number of crisis call centers can decrease suicidal behavior after the patient leaves the care of the organization.\(^\text{[22]}\)

Monitor Effectiveness of Suicide Prevention Interventions

The effectiveness of policies and protocols regarding suicide prevention should be evaluated on a periodic basis as part of overall quality improvement initiatives of the agency.\(^\text{[23]}\) Research demonstrates implementation of the Zero Suicide Model results in lower suicidal behaviors.

Zero Suicide Toolkit\(^\text{[24]}\)

Read the American Psychiatric Association Psych News Alert, "Zero Suicide’ Practices at Mental Health Clinics Reduce Suicide Among Patients".

Visit the Zero Suicide Toolkit webpage.

View the following WHO video on preventing suicide by health care workers\(^\text{[25]}\):

A YouTube element has been excluded from this version of the text. You can view it online here: https://pb.libretexts.org/hurse234/?p=42
Establishing a Safe Care Environment for Nurses and Other Health Care Team Members

The American Nurses Association states, “No staff nurse should have to deal with violence in the workplace, whether from staff, patients, or visitors.” Workplace violence is the act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty. The impact of workplace violence can range from psychological issues to physical injury or even death. Violence can occur in any workplace and among any type of worker, but the risk for nonfatal violence resulting in days away from work is greatest for health care workers.

Research indicates the rate of physical assaults on nurses is 13.2 per 100 nurses per year, and 25% of psychiatric nurses experienced disabling injuries from client assault. Many experts believe these figures represent only the tip of the iceberg and that most incidents of violence go unreported. See Figure 1.4 for an illustration of safety first.

Figure 1.4 Safety First

Safety strategies for nurses and nursing students providing client care include the following:

- **Dress for Safety**
  - Tuck away long hair so that it can’t be grabbed
  - Avoid earrings or necklaces that can be pulled
  - Avoid overly tight clothing that can restrict movement or overly loose clothing or scarves that can be caught
  - Use breakaway safety lanyards for glasses, keys, or name tags
  - Do not wear your stethoscope around your neck

- **Be Aware of Your Work Environment**
  - When in a room with a client or visitor who is demonstrating warning signs of escalation, position yourself between the door and the client so you can exit quickly if needed
  - Note exits and emergency phone numbers, especially if you float to other areas
  - Recognize that confusion, background noises, and crowding can increase clients’ stress levels
  - Be aware that mealtimes, shift changes, and transporting patients are times of increased disruptive behaviors
• Be Attuned to Patient Behaviors
  ◦ Most violent behavior is preceded by warning signs, including verbal cues and nonverbal cues. The greater the number of cues, the greater the risk for violence. Be aware of these verbal and nonverbal cues indicating a client’s potential escalation to violence:

  • Verbal Cues
    ▪ Speaking loudly or yelling
    ▪ Swearing
    ▪ Using a threatening tone of voice

  • Nonverbal and Behavioral Cues
    ▪ Evidence of confusion or disorientation
    ▪ Irritability or easily angered
    ▪ Boisterous behavior (i.e., overly loud, shouting, slamming doors)
    ▪ Disheveled physical appearance (i.e., neglected hygiene)
    ▪ Holding arms tightly across chest
    ▪ Clenching fists
    ▪ Heavy breathing
    ▪ Pacing or agitated restlessness
    ▪ Looking terrified (signifying fear and high anxiety)
    ▪ Staring with a fixed look
    ▪ Holding oneself in an aggressive or threatening posture
    ▪ Throwing objects
    ▪ Exhibiting sudden changes in behavior or signs of being under the influence of a substance

• Use Violence Risk Assessment Tools
  ◦ Use risk assessment tools to evaluate individuals for potential violence, enabling all health care providers to share a common frame of reference and understanding. This minimizes the possibility that communications regarding a person’s potential for violence will be misinterpreted. These tools can be used as an initial assessment upon admission to determine potential risk for violence and repeated daily to assist in predicting imminent violent behavior within the next 24 hours. See sample risk assessment tools in the box at the end of this section.

• Be Attuned to Your Own Responses
  ◦ Be aware of your own feelings, responses, and sensitivities and pay attention to your instincts. For example, your “fight or flight” response can be an early warning sign of impending danger to get help or get out.
  ◦ Be aware of how you express yourself and how others respond to you. Those who know you well may respond differently than do strangers. Effective therapeutic communication skills are an essential tool in preventing violence.
  ◦ Use self-awareness and acknowledge if you have a personal history of abuse, trauma, or adverse childhood experiences (ACEs) that can affect how you respond to situations.
  ◦ If coworkers are engaging in abusive behaviors, consider if you are exhibiting similar behaviors.
  ◦ Be aware that fatigue can diminish your alertness and your ability to respond appropriately to a challenging situation.
Check Your Cultural Biases

- A key aspect of self-awareness is recognizing how our own particular cultural heritage, values, and belief systems affect how we respond to our clients and coworkers and how they, in turn, respond to us.

Sample Violence Risk Assessment Tools from the CDC:

- Triage Tool PDF
- Indicator for Violent Behavior PDF
- Assault and Homicidal Danger Assessment Tool PDF

If travelling to a home setting as a home health nurse, additional safety strategies are as follows:

- Review agency files to confirm that a background check was done on a patient regarding any history of violence or crime, drug or alcohol abuse, and mental health diagnoses. Also, check to see if a patient’s family member has a record of violence or arrest.
- If entering a situation assessed as potentially dangerous, you should be accompanied by a team member who has training in de-escalation and crisis intervention.
- Always carry a charged cell phone.
- Make sure someone always knows where you are.
- Have a code word to use with your office or coworkers to let them know you’re in trouble if you can’t call the police.

The CDC offers a free, online course called Workplace Violence Prevention for Nurses to better understand the scope and nature of violence in the workplace. Access the free CDC course on workplace violence with nurse videos at the Workplace Violence Prevention for Nurses webpage.

References:

3. "5actionsteps_t.jpg" by unknown author for National Institute of Mental Health is licensed in the Public Domain. Access for free at https://www.nimh.nih.gov/health/topics/suicide-prevention-


