INPATIENT PRACTICE

Preventing Suicide Is All-Staff Effort

The Joint Commission on Accreditation of Healthcare Organizations has issued its new Hospital/Critical Access Hospital National Patient Safety Goals, which go into effect next year. One of those goals is identifying patients at risk for suicide. This goal applies to psychiatric hospitals and inpatient psychiatric units in general hospitals.

In this month's column, Darlene Galashaw, R.N., M.S.N., of Lutheran Medical Center, New York, discusses the new safety goals.

Ms. Galashaw, who is responsible for seeing that Lutheran Medical Center meets those goals, has conducted a study of suicide on psychiatric units and spearheaded her unit's implementation of goals aimed at suicide prevention.

BY DARLENE GALASHAW, R.N., M.S.N.

CLINICAL PSYCHIATRY NEWS: How did JCAHO's focus on preventing patient suicide come about?

MS. GALASHAW: The commission has been interested in suicide prevention and has been collecting data on inpatient suicide since 1996, when it classified suicide as a sentinel event under its voluntary reporting guidelines. In 2003, the American Psychiatric Association addressed suicide prevention and assessment in a task force report on patient safety. So these new mandates have been coming for some time.

CPN: What did the commission find?

MS. GALASHAW: Some of the data that have been collected suggest that 50% of individuals who commit suicide are in psychiatric treatment at the time of their suicide, that 10% are inpatients, and that another 5%-10% are patients relatively recently discharged from the hospital. The most common suicide methods in the hospital are hanging (about 70% of successful suicides) and jumping from a window (about 20%).

The commission's review of hospital suicides identified numerous factors associated with suicide, including unsafe environmental factors, such as shower heads and towel racks that can bear weight. Most attempts on psychiatric units obviously occur in private areas, such as in bathrooms and closets. But it is also clear that the most crucial element of suicide prevention is the relationship between caregivers and the patient. Caregivers can foster a relationship in which they are told things and can observe the patient's state and behaviors.

CPN: What will the new goals require?

MS. GALASHAW: The new goals will require units to continue to monitor the safety of the environment. And—as with the previous patient safety goals—units will need to document and respond to sentinel events. The new part is that units will have to have a process for comprehensively assessing suicide risk in all patients, both at admission and with continued monitoring.

At our institution we are going to implement those assessments because it is not just patients with depression and schizophrenia who are at risk, but also manic patients, substance abusers, and patients with borderline personality disorder, who have a myriad of psychiatric conditions in which anxiety may cloud the senses and self-destructive behaviors may follow.

CPN: How will you implement this new mandate?

MS. GALASHAW: At our facility, we are going to assess all psychiatric patients admitted during their admission triage. In my research, I found that some of the best work on institutional suicide assessment actually comes from the penal system. So I adapted some of the tools and screening questions from a manual developed by the New York State Department of Corrections.

We had suicide risk questions before, but now they will be much more comprehensive. We will be asking about family history of suicide, recent changes in employment and family structures, substance abuse, and the many triggers and stressors that we as mental health care workers realize can precipitate irrational thinking leading to suicide.

The main point is that we will be making sure that our unlicensed staff members, who spend a great deal of time with patients, are adequately trained and understand suicide assessments.

CPN: Why the focus on unlicensed staff?

MS. GALASHAW: They are critical because they have a great deal of patient contact. Their ongoing assessments are vitally important because patients not deemed a risk at admission may experience a change in their lives while under our care. We have had patients attempt suicide when they learned that their children were going to be taken away, for example.

CPN: What other steps are you taking to make sure that JCAHO's suicide requirements are met?

MS. GALASHAW: We have also put together a task force that will review the environmental safety of the unit quarterly. The task force will include not just a physician and nurse, but the building engineer as well. Bringing in people from outside the unit who were not previously involved but play a role is an important part of these efforts.

I know of another hospital that is including the purchasing department in its safety assessments now, because the staff realized that the patient admission kits came in a large plastic bag that could be a hazard.

Patients will think of ways of hurting themselves that we wouldn't dream of. We need to be ready. ■

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Staff Education Program Leads to Decrease in Use of Seclusion, Restraint

BY NANCY WALSH
New York Bureau

NEW YORK — The use of seclusion and restraint among psychiatric inpatients was successfully reduced by a program involving staff education, changes in policy and practice, and improved communication with patients, Dr. David J. Hellerstein said in a poster presentation at the American Psychiatric Association's Institute on Psychiatric Services.

Although a standard of care has evolved that generally limits the use of the "last resort" measures of seclusion and restraint to instances of imminent harm to the patient or others, the actual use of these practices varies widely, he wrote.

The 58-bed New York State Psychiatric Institute (NYSPI) in upper Manhattan has a large research population as well as the typical state hospital population of patients with schizophrenia and other severe mental illnesses.

Before the program began in 2000, the rates of seclusion and restraint at NYSPI were the highest among the New York Office of Mental Health hospitals, according to Dr. Hellerstein, who is medical director of the psychiatry clinical trials program at Columbia University Medical Center, New York.

This high use was attributed to NYSPI's status as an acute-care hospital that is also a research facility where clinical trials are conducted and patients may be taken off medication at times.

The program includes several components:

- ▶ Decrease in time of initial restraint or seclusion order from 4 to 2 hours.
- ▶ Staff education and in-service training.
- ▶ Relaxation of no-smoking policy.

Some other studies have reported increased rates of injury with reductions in use of restraint and seclusion. In this study, emphasis was also placed on helping staff members manage patients' agitation, psychosis, and potential for violence.

After the program was implemented, there were statistically significant reductions in the mean number of patients secluded—3.18 to 1.13 patients per month—and in length of seclusion—1.28 to 0.09 hours per 1,000 patient-hours, he reported.

The reduction in restraint and seclusion has been maintained through 5 years of follow-up, suggesting that a "culture change" has occurred at NYSPI, he said. Culture change in this context has been described as emphasizing staff sensitivity and training in noncoercive methods of de-escalating possible violence (J. Psychiatr. Pract. 2003;9:7-15).

No increase has been seen in rates of injury to the staff, Dr. Hellerstein said.

Future steps to be taken include the implementation of patient involvement in coping plans and the eventual elimination of the use of restraint, he wrote. ■

Care Management Unit Reduces ED Crowding

SAN FRANCISCO — A seven-bed care management unit in an emergency department reduced overcrowding by trimming the number of patients admitted to the hospital or waiting for telemetry beds, a pilot study of 1,325 patients found.

One factor in the national crisis of emergency department overcrowding is the slow transit of patients being admitted to the hospital. They often spend more than 24 hours in the emergency department, Dr. Varnada A. Karriem-Norwood said in a poster presentation at the annual meeting of the Society for Academic Emergency Medicine.

Dr. Karriem-Norwood and associates at Emory University, Atlanta, conducted a prospective study of patients admitted from the emergency department to a care management unit for asthma, chest pain, heart failure, or hyperglycemia between August 2003 and April 2004. Four case managers available in the unit 24 hours each day coordinated a care plan with a physician, educated patients, filled prescriptions, entered patient information into a database, arranged follow-up, and maintained phone contact with patients.

The care management unit successfully discharged about 87% of patients, admitted 13% to the hospital, and transferred three patients (less than 1%) back to the emergency department. The concept could be introduced at other hospitals, the investigators said.

—Sherry Boschert