Psychiatric-Mental Health Nurse Essential Competencies for Assessment and Management of Individuals at Risk for Suicide

(Adapted from Suicide Prevention Resource Center (SPRC) & American Association of Suicidality (AAS) (2008). Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals.)

Preamble

Competencies have been developed for mental health clinicians in assessing and managing suicide risk; however, there are no standard competencies for psychiatric nurses. Widely accepted nursing practices do not meet suicide-specific standards of care or evidence-based criteria. Therefore we propose the following essential competencies for psychiatric nurses working in hospital settings as a guide for practice. These competencies are based on a comprehensive review of the extant research literature (both qualitative and quantitative) relevant to assessment and management of hospitalized patients admitted to a psychiatric setting.

The role of the nurse specific to suicide prevention includes both systems and patient level interventions. At the systems level the nurse assesses and maintains environmental safety, develops protocols, policies, and practices consistent with zero suicide, and participates in training for all milieu staff. At the patient level, the nurse assesses risk for suicide, provides suicide-specific psychotherapeutic interventions, monitors and supervises at-risk patients, and assesses outcomes of all interventions. The expectation is that these essential competencies will serve to provide the foundation for training curricula and in measuring the knowledge, skills, and attitudes necessary for expert care.

Essential Competencies

1. The psychiatric nurse understands the phenomenon of suicide.

- Defines basic terms related to suicidality.
- Reviews suicide-related statistics and epidemiology.
- Describes risk and protective factors related to suicide.

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- Discusses nursing and best practice/evidence-based literature related to inpatient suicide prevention.

2. The psychiatric nurse manages personal reactions, attitudes, and beliefs.

- Demonstrates self-awareness of emotional reactions, attitudes, and beliefs related to previous experiences with suicide.
- Examines the impact on the patient of nurse's emotional reactions, attitudes, and beliefs.
- Accepts and regulates one's emotional reactions to suicide.
- Discusses nurses' reactions to patients who express suicidal ideation, attempt or die by suicide.
- Participates in a root cause analysis (RCA) or failure mode and effect analysis (FMEA) when a suicide attempt or suicide death occurs on the inpatient unit.
- Participates in staff debriefing following a suicide attempt or suicide death.
- Obtains and maintains professional assistance/supervision for ongoing support.
- Attends to one's own emotional safety/wellbeing.

3. The psychiatric nurse develops and maintains a collaborative, therapeutic relationship with the patient.

- Maintains a nonjudgmental and supportive stance in relating to the patient and family.
- Provides a therapeutic milieu in which the patient feels emotionally safe and supported.
- Voices authentic intent to help.
    - Uses evidence to educate the patient about the suicidal mind, symptoms of illness, and effectiveness of intervention.
    - Conveys hope and connection while recognizing the patient's state of mind and need for hopefulness.
- Reconciles the difference and potential conflict between the nurse's goal to prevent suicide and the patient's goal to eliminate psychological pain via suicidal behavior.
    - Explains factors and motivation for suicidal thoughts and behaviors.
    - Understands suicidal motivation, thinking, and beliefs of the individual who is experiencing these thoughts and feelings.
    - Recognizes the importance of validating psychological pain.
    - Demonstrates interpersonal skill in validating patients' pain and emotional state.
    - Accepts that a patient may be suicidal and validates the depth of the patient's strong feelings and desire to be free of pain.

    - Understands that most suicidal individuals experience psychological pain and possibly a loss of self-respect/shame.
    - Views each patient as an individual with his or her own unique set of issues, circumstances, and mini-culture, rather than as a stereotypic "suicidal patient."
- Makes realistic assessments to assess and care for the suicidal patient within the limitations of the service setting.
    - Assesses, plans, outcomes, and intervenes accordingly based on the assessment data.
    - Maintains the safety of the patient.
    - Provides a thorough and concise handoff to other clinicians including (SBARR):
        - Situation: The immediate relevant events related to the patient, including subjective and objective observations, what was communicated and to whom.
        - Background: Pertinent history about the patient.
        - Assessment: The nurse's current assessment including labs and current risk assessment.
        - Recommendations: What the reporting person believes needs to happen at this point.
        - Response feedback: "Do you have any questions?" to verify the understanding of the handoff.
    - Uses specific definitions and universal language for observation levels.
- Follows the standards of care appropriate for providing safety and evidence based care.
- Uses clinical reasoning to determine the priority of care including reporting and documenting.

4. The psychiatric nurse collects accurate assessment information and communicates the risk to the treatment team and appropriate persons (i.e. nursing supervisor, on duty M.D., etc.).

- Performs an independent risk assessment for self-directed violence (non-suicidal and suicidal) upon admission and on an ongoing basis throughout the patient's hospitalization even in the absence of expressed suicidality.
    - Risk factors (distinguish between modifiable and non-modifiable).
    - Protective factors.
    - Full suicidal inquiry.
    - Mental Status Exam.
    - History of physical and/or psychological trauma.
    - Current triggers that activate feeling of distress.

    - Patient's minimization or exaggeration of symptoms.
    - Collateral personal sources as appropriate.
    - Warning signs of acute risk.
    - History of self-directed violence (SDV) and interventions.
- Communicates the assessment of risk to the treatment team and appropriate persons (i.e. nursing supervisor, on duty M.D., etc.).

5. The psychiatric nurse formulates a risk assessment.

- Makes a clinical judgment of the risk that a patient will attempt suicide or die as a result of suicide in the short and long term.
    - Participates as a member of the interprofessional team in ongoing formulation of risk based on changing assessment data.
    - Continues to integrate and prioritize all the information on an ongoing basis.
    - Applies constructs, theories, studies and systematic reviews to understand changes in risk.
    - Determines level of risk of suicide as acute or chronic.
- Assesses the patient's motivation to minimize risk and to exaggerate risk, including psychological, environmental and contextual influences.
- Distinguishes between acute and chronic suicidal ideation and behavior.
- Distinguishes between self-directed violence with the intent to die vs. without the intent to die.
- Considers developmental, cultural, and gender related issues related to suicide.

6. The psychiatric nurse develops an ongoing nursing plan of care based on continuous assessment.

- Provides the least restrictive form of care to address the patient's variable need for safety.
- Develops a written plan of care collaboratively with the interprofessional team, patient, family members, and/or significant others with a focus on maintaining safety.
    - Addresses a wide range of individualized nursing interventions that consider the patient and the levels of care related to immediate, acute and continuing suicidal thoughts and behaviors in the plan.
    - Develops a collaborative safety plan with the patient/family if possible.
    - Coordinates and works collaboratively with other treatment and service providers in an interprofessional interdisciplinary team approach.

    - Assesses, manages, and maintains patient safety as a focus in the milieu.
    - Prepares for active rescue process and related tools.
- Engages in collaborative problem solving with the patient to address internal and external barriers in adhering to the treatment plan, revising the plan as necessary throughout the hospitalization.
    - Motivates and supports patients in engaging in all elements of treatment.
    - Engages patient, family, significant others and other care providers in developing, supporting, and reinforcing the agreed plan of care in compliance with HIPAA.
    - Involves the outpatient therapist and family/significant other in the discharge planning.
    - Recognizes and reinforces the boundaries of relationships between the inpatient and outpatient providers.
    - Throughout hospitalization and prior to discharge, engages the patient in understanding feelings related to discharge and potential difficult situations that might arise after discharge to assure those situations are addressed in the treatment plan.
    - Prior to discharge, reviews the treatment plan with the outpatient provider for clarity and feasibility.
    - Prior to discharge, schedules outpatient therapist appointment to ensure continuity with the treatment plan.
    - Assures that the family and significant others have contact information of the outpatient provider.
    - Provides resources, such 1-800-273-TALK.
- Reviews the state and national standards and requirements for practice and understands the institutional policies and procedures related to suicide.
    - Participates with the interprofessional team in a root cause analysis for suicide death or serious suicide attempts to identify opportunities for learning at all levels of service delivery.
    - Documents in the medical record in accordance with the standards of nursing practice and institutional policy.
    - Assures that nursing policy and procedures are in place for systematic suicide risk assessments.
- Implements evidence based and best practice problem solving intervention to modify risk factors and enhance the use of protective measures to assist the patient to prevent suicide.

7. The psychiatric nurse performs an ongoing assessment of the environment in determining the level of safety and modifies the environment accordingly.

- Identifies environmental hazards at the unit level (ligature points and lanyards).
- Identifies environmental hazards at the personal level (belts, shoelaces, sharp items, etc.).
- Identifies environment conditions that would indicate higher risk of patient suicide – example of items not accounted for (knives, forks, CD, hording of towels, linen, etc.).
- Removes potentially harmful items if patient is at risk of utilizing items to harm self (remove or modify access to means of suicide).
- Determines level of supervision needed for the patient.

8. The psychiatric nurse understands legal and ethical issues related to suicide.

- Knows state laws pertaining to suicide including civil commitment, patient rights, seclusion, and advance directives for psychiatric treatment.
- Knows essential components of chart documentation of suicide risk assessment, monitoring, and interventions.
- Maintains patient records and rights to privacy and confidentiality within HIPAA regulations.
- Applies ethical principles of autonomy, beneficence, nonmaleficence, fidelity, and justice in relating to patients who are (or may be) suicidal.

9. The psychiatric nurse accurately and thoroughly documents suicide risk.

- Documents suicidal risk assessment and intervention(s) during hospitalization at key times.
- Documents the initial assessment.
- Documents risk level during hospitalization on an inpatient psychiatric unit.
- Documents risk level at discharge.

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