Psychiatric Bulletin (1989), **13**, 561–564

Clinical management

Guidelines on the clinical management of suicidal patients in psychiatric units

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Views differ as to whether it is feasible – or indeed desirable – to agree on a Code of Practice with respect to the clinical management of suicidal patients in psychiatric units (Morgan, 1988). At Fulbourn Hospital (Gardner, 1988) we have developed some guidelines which might, if suitably modified, be used elsewhere; they are appended below.

GUIDELINES ON THE MANAGEMENT OF SUICIDAL PATIENTS IN FULBOURN HOSPITAL

1.0 IDENTIFYING THE SUICIDAL

1.1 Hospital in-patients are most likely to commit suicide:

shortly after admission – especially if a violent method of suicide is being contemplated

at the time of a stressful life-event such as marital separation, bereavement, or loss of a job etc

within days or weeks of a previous suicidal attempt

when a depression is lifting as a result of treatment with ECT or antidepressant medication, or both

weekend leave and the period shortly after discharge from hospital are particularly vulnerable times.

1.2 Staff may sense that a patient is suicidal (despite denial of suicidal thoughts or intentions) because of the patient's increasing tension, agitation or social withdrawal, or because of expressions of hopelessness or refusal of food. They should share these suspicions with other members of the ward team and it is then essential for an individual assessment of the patient to be carried out. In the meantime the patient should be continuously observed.

2.0. NURSES' OBSERVATIONS

2.1 **Continuous observation** ('specialling') means having a nurse with the patient at all times.

2.2 **Close observation** involves ensuring that the patient's whereabouts are known and that he or she is seen at least once in every ten minutes. This is sufficient when the patient is no longer trying to leave the ward and when the risk of a suicidal attempt, perhaps by some violent method such as hanging, drowning, or going to the road or railway, has receded.

2.3 **Observation** means that the patient remains on the ward or leaves only when accompanied by a member of staff, relative, or other responsible adult. This suffices when there is no overt suicidal behaviour such as the patient seeking solitude, being secretive or possessing an object or drugs with which to harm him or herself, and when there is little risk of a suicidal attempt.

2.4 **Continuous** or **close observation** will enable nurses to form a therapeutic relationship with the patient, and should not be regarded merely as a custodial form of care. Staff should try to gain the trust of the patient and to encourage him or her to express their feelings. As the patient may resent the constant company of nurses it is all the more important for them to reinforce their positive caring role.

3.0 ASSESSMENT

3.1 Most suicidal patients admitted to Fulbourn Hospital have already been identified as such by the referring agent, usually their general practitioner or the general hospital.

3.2 While awaiting the ward or duty psychiatrist, the patient should be kept under continuous observation. The nurse should remove any harmful objects in the patient's possession and decline requests by the patient to be left alone – even in the toilet or bathroom. The reasons for this course of action should be explained to the patient.

3.3 The admitting psychiatrist should make a careful record of the history, including information

https://doi.org/10.1192/pb.13.10.561 Published online by Cambridge University Press

obtained by telephone from the referring agent(s), and of the mental state and physical examinations. It is better to note what the patient says and to describe any suicidal behaviour than to use vague terms such as suicidal "ideation" or "gesture", or "trivial" or "minor" overdose.

3.4 On admission every depressed patient – whether or not they have been identified as suicidal – must be asked if they have any suicidal thoughts or intentions and their replies recorded. Most patients are only too relieved to talk openly about these and are not offended or driven into further suicidal behaviour.

3.5 It is essential to interview an informant because the patient may have communicated their suicidal ideas to relatives or friends and not to their general practitioner.

3.6 Good communication between the admitting psychiatrist and nursing staff is crucial and this can be facilitated if a trained nurse is present during the medical interview.

3.7 Sometimes a patient who has not been suicidal before admission to hospital may make an attempt (see paras 6. 1–4) or hint or threaten deliberate self harm. Such a patient also needs an individual assessment.

3.8 A previously suicidal patient may telephone or come to the ward while on weekend leave or after discharge:

In the case of a telephone call give the patient an opportunity to talk; find out their whereabouts; assess the need for another person to be involved, e.g. a relative or neighbour, general practitioner, community psychiatric nurse or the police – and then take the necessary action.

If the patient attends the ward, admission is indicated when either a violent method of suicide or taking a more lethal drug or poison is contemplated; the patient is unaccompanied, lives alone, it is night time or an occasion when usual social contacts are disrupted (e.g. a Bank Holiday) or when the support of a relative or neighbour cannot be arranged.

4.0 TREATMENT PLAN

4.1 After assessment, the psychiatrist and nursing staff should decide on a joint treatment plan; this will include:

(a) **The medication needed.** All suicidal patients require a good night's sleep. If agitated or deluded (or both) a major tranquilliser is indicated.

(b) **The level of nursing observation required.** When a patient is to be continuously or closely observed, the nurse in charge should nominate a specific nurse for this task. In the case of close observation, the designated nurse should coordinate and be responsible for the period of observation. Keeping a suicidal patient under continuous observation is demanding work, and a nurse should not be expected to do this for more than one hour at a time.

(c) **Where the patient is to be nursed.** Only a suicidal patient who is to be "specialled" should be admitted to a single room. Patients who are to be continuously or closely observed should not be too widely separated in the ward, particularly at night when staffing levels are reduced.

(d) **Whether in the case of an informal patient a change of status is necessary.**

4.2 If a decision is required relating to (d) or if there is uncertainty as to the best course of action, the advice of the appropriate consultant or senior registrar or senior psychiatrist on call will have to be sought.

4.3 Staff should explain carefully to the patient and to the patient's relatives what is to be done and the reasons for it.

4.4 The psychiatrist should record in the patient's case notes the decisions reached, in particular the medication prescribed and the levels of nursing observation agreed with the nursing staff. If the patient is initially to be nursed in night clothes, a note should be made to this effect.

4.5 The nurse in charge should draw up rotas for nurses carrying out continuous or close observations and tell all nurses about their duties and responsibilities. The senior nurse on duty, or in his absence the duty nursing officer, should be informed and asked for extra nursing cover if this is needed.

4.6 Nursing staff should write up the agreed management plan in the care plans and on the ward report. Both documents should have "At Risk" written in red as the opening title of the plan report.

5.0 CONTINUING CARE OF THE SUICIDAL

5.1 A psychiatrist should interview the patient as frequently as possible until the risk of suicide has receded and keep a careful record of progress, and of any changes in medication and degree of nursing observation.

5.2 Regular reviews of the patient's mental and physical state should take place at which all staff observations from individual interviews of the

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patient, ward rounds and handovers may be taken into account. This will enable the degree of nursing observation to be varied as necessary.

5.3 Decisions about changes from continuous to close observation should only be made by the ward team after discussion with a consultant psychiatrist or a senior registrar, and only between the hours of 9.00 a.m. and 5.00 p.m.

5.4 Details of any period of nursing observation or changes in it, and of any change in the patient's verbal or non-verbal behaviour should be recorded in the nurse's notes and care plans.

5.5 If a patient is found to be missing while under observation the hospital search procedure should be initiated. Unless found immediately, relatives or friends should be alerted promptly by telephone as the patient may have left hospital with the intention of committing suicide at home.

6.0. IN-PATIENT ATTEMPTED SUICIDE

6.1 If a patient deliberately harms him or herself, staff should:

take any immediate action necessary to preserve the patient's life (see hospital emergency procedure)
call the ward or duty psychiatrist
start relevant nursing observations such as pulse, blood pressure, levels of consciousness
give any emergency medical treatment necessary
if the patient vomits, keep a sample (universal container) for analysis
inform the duty nursing officer.

6.2 When the patient needs to be transferred to Addenbrooke's Hospital, staff should:

dial 999 for an ambulance
discuss the patient's case over the telephone with the medical registrar of the firm "on take"
arrange for a nurse to accompany the patient to the Admissions Unit in the Accident and Emergency Department with a letter from the psychiatrist, the patient's case notes and drug prescription card, any unidentified tablets and, if available, a sample of vomit
notify the relatives.

6.3 If the patient's physical condition is such that he or she can safely be kept on the ward, a fresh psychiatric assessment is indicated. Staff should recognise that the physical risk to the patient does not necessarily indicate the severity of the mental disturbance or the likelihood of repetition and of suicide.

6.4 The ward team should then review the joint treatment plan (see paras 4.1–6).

7.0 LEAVE OR DISCHARGE FROM HOSPITAL

7.1 Care should be taken when deciding whether a patient is to be allowed to leave hospital, go on weekend leave, or be discharged home. At such times an individual assessment of the patient is essential and reliance should not be placed solely on observations made of the patient in group settings.

7.2 Staff should explain to relatives who wish to take the patient out of hospital the need for them to:

stay with the patient or have the patient stay with them
take care of any medication prescribed by the hospital
clear out tablets hoarded at home, and
remove any firearms.

7.3 Relatives or friends should be advised to bring the patient back to the ward, or in the case of a discharged patient to contact their general practitioner, if there is any further hint or threat of deliberate self-harm.

7.4 When the patient is discharged from hospital, good communication with their general practitioner is essential. If appropriate, a community psychiatric nurse may be informed. Before leaving hospital, the patient and their relative(s) should be given the time of any out-patient appointment and a relative asked to accompany the patient to the clinic.

8.0 IN-PATIENT SUICIDE

8.1 Despite every possible precaution being taken some persons may succeed in killing themselves. If this happens staff should:

initiate the hospital emergency procedure, so ensuring the presence of the ward or duty psychiatrist and duty nursing officer
carry out any emergency action considered necessary until the psychiatrist arrives. Only a medical practitioner can certify that a patient is dead.
after death has been confirmed, ensure that the body is covered and screened, and that the surroundings are not altered in any other way.

8.2 The duty psychiatrist should inform:

the responsible medical officer
the patient's general practitioner – the latter may be the best person to break the news to the relatives.

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8.3 The duty nursing officer should notify

the police who will tell the coroner that a sudden death has occurred
the relevant manager of that clinical area
the hospital manager/deputy.

He or she should request nurses on duty to make notes of the circumstances leading to the death which they can use when asked for a statement by the police and hospital managers.

The nursing officer should also ensure that the duty psychiatrist and a senior nurse are available to help the police with their enquiry.

8.4 Whenever possible, relatives should be interviewed in preference to being told about the patient's death over the telephone.

8.5 The nurse in charge, the ward or duty psychiatrist, and the duty nursing officer should review the management of patients requiring close or continuous observation. Extra nursing cover should be provided if needed.

8.6 As soon as it can be arranged, a meeting should be held of staff and patients on the ward to express feelings and to talk through the incident.

8.7 The consultant and ward staff should meet to discuss the circumstances leading up to the suicide.

8.8 It is important that not only the consultant concerned, but also other psychiatrists treating patients on the ward are fully informed and that the circumstances of the suicide are discussed at a staff meeting.

9.0 PREVENTION OF SUICIDE

9.1 Suicide is largely preventable – indeed most suicidal patients admitted to hospital are successfully treated.

9.2 It is therefore of crucial importance for all staff working on a ward to review untoward accidents, such as a patient making a suicide attempt or leaving the ward unaccompanied while being closely observed. Any lessons learnt at the staff meeting may then be applied to improving patient care and ward management.

9.3 Since in-patient suicide is an uncommon event, every effort must be made by both medical and nursing staff and management to learn from such an incident. This is best achieved by an informal inquiry at the time and by regular reviews of hospital suicides as part of the postgraduate educational training programme.

Acknowledgements

My thanks to Dr A. R. K. Mitchell, M. Blank and P. Barker for initial help with the guidelines and to members of a working party: Drs P. Brook & M. Cooper, Ms A. McDonald, Drs G. Petrie & J. Sklar, Ms S. Salkield, M. Topping, Dr T. Webb, J. Wells, Dr J. Werner, Ms S. Whitcher, Dr M. Williams, Ms E. Workman; and co-opted members: A. McEachern & Dr T. K. McLachlan.

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The advice contained in paragraph 5.3 has not been fully implemented (Gardner, 1988).

https://doi.org/10.1192/pb.13.10.561 Published online by Cambridge University Press