# IS YOUR PATIENT SUICIDAL?

***Research question: What is the best practice for patients presenting in emergency departments with suicidality?***

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## INTRODUCTION

New Zealand suicide rates are on the rise and is now a National crisis, with reports that one New Zealander dies every 15 hours by suicide (MacDonald, 2017). Emergency departments (ED's) often deal with people at risk of suicide and although the tools available are useful in the clinical setting, the confidence and training of the staff assessing the patients plays a major role. Staff attitudes towards suicide often impact on the quality of care given to patients (Mitchell, Garand, Dean, Panzak, & Taylor, 2005). Suicide assessment is time critical and if not done accurately the possibility of identifying suicide risk diminishes (Bolster, Holliday, Oneal, & Shaw, 2005).

## EVIDENCE

New Zealand's ED triage system has been put in place to categorise and prioritise patients on arrival and into one of five triage categories which allow staff to know a safe time for that patient to wait for assessment (Ministry of Health [MOH], 2016). MOH (2016) indicate that there are current risk assessment guidelines and procedures available in ED's, but time constraints, poor mental health literacy, stigma and lack of psychiatric training are major barriers to these assessments being done accurately or being done at all (Health Central, 2018). Inevitably mentally ill patients are being discharged without the correct supports and/or treatments (Health Central, 2018).

The flowchart (opposite) shows current best practice of suicide risk assessment in to support ED staff (MOH, 2016 & BMJ Publishing Group Ltd, 2017).

## RECOMMENDATIONS

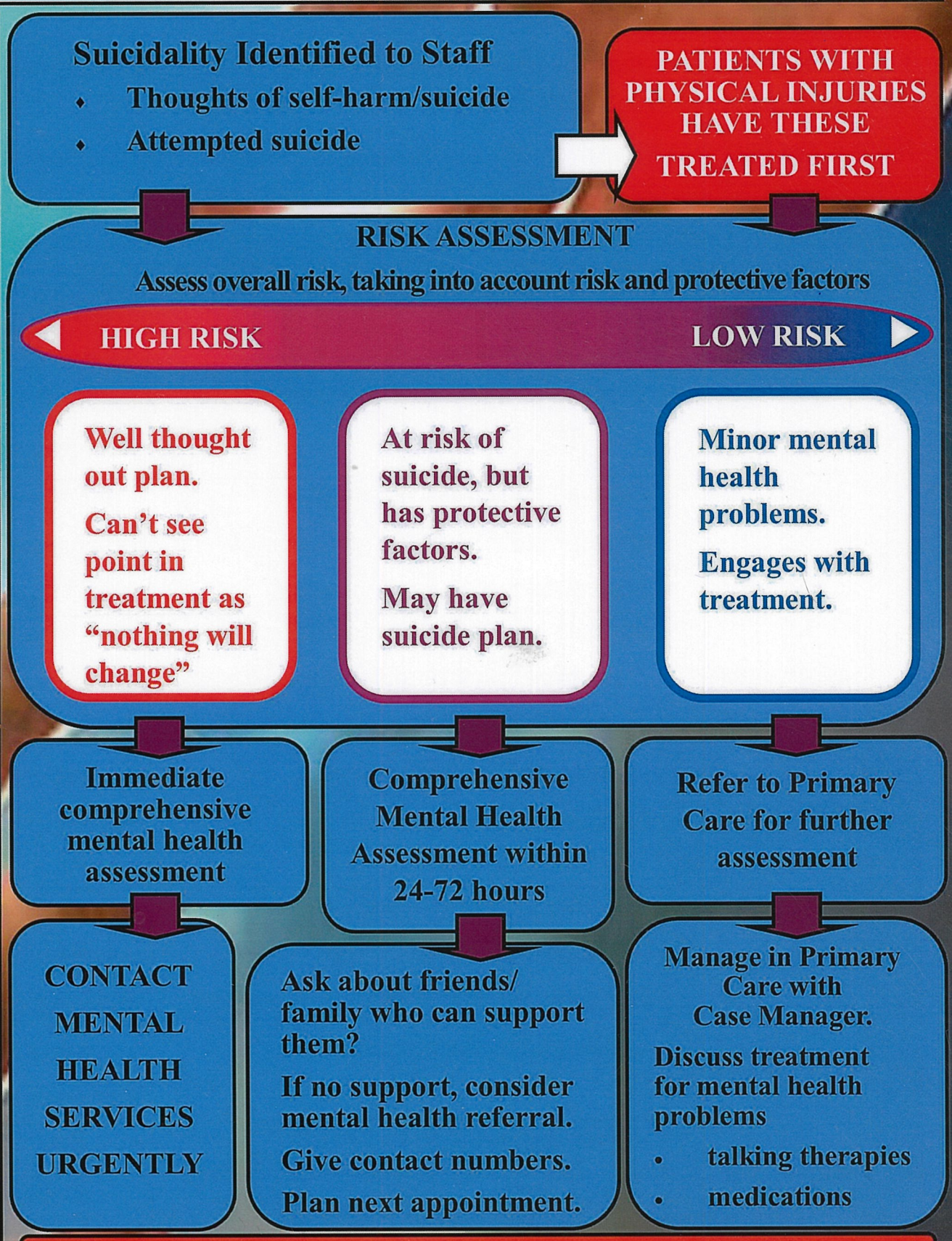
⇒ Treat all patients presenting with suicidality as if their next thought or attempt to take their life will result in suicide death. This aims to reduce patient assessments being missed.

⇒ Extend suicide assessment time frames when needed and if the most accurate assessment cannot be undertaken in the ED, encourage hospitalisation until such assessments are complete. This will ensure that these necessary assessments are being done.

⇒ On discharge ensure all referrals are under way and follow ups with the patient are scheduled. This ensures a plan is in place for patients to receive the help needed as soon as possible.

## CONCLUSION

Comprehensive, accurate and precise suicide risk assessments in ED's are imperative to help combat New Zealand's national crisis. Suicidality is rising and suggests that while there are current risk assessment guidelines and procedures available in ED's, work needs to be done to further educate staff and make sure assessments are done accurately to improve quality of care and outcomes for patients.




This flow chart has been adapted from MOH (2016) & BMJ Publishing Group Ltd ( 2017).

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Background Image: 2-hands-reaching-out. Retrieved from http://lifelettercafe.com/wp-content/uploads/2016/08/2-hands-reaching-out.jpg

## RATIONALE

With suicide ideation on the rise and at crisis point in New Zealand, I wanted to pursue the issue of risk assessments in emergency departments (ED's) being brief, not following guidelines or missed altogether.

I have chosen to create this poster as a visual guide for ED staff. A poster summarises key elements of a topic and can apply the best practice and evidence to clinical practice. A poster is a less threatening type of education and allows the reader to take the information in at their own pace (Taggart & Arslanian, 2000). The poster supports the assessment process according to current best practice for suicidality presentation in ED's throughout New Zealand, with the aim to be an effective, quick guide for ED staff to visualise current best practice of suicide risk assessment.

The research question that has been formulated using the PECOT framework model (Schneider, Whitehead, LoBiondo-Wood, & Haber, 2013) is:

*What is the best practice for patients presenting in emergency departments with suicidality?*

| PECOT CATEGORY | Information relating to Question | Explanation |
|---|---|---|
| **Population** | Patients presenting with suicidal ideation or attempted suicide in ED's. | This is a critical time for these patients to be assessed correctly and support, treatment or planning for treatment to commence. |
| **Exposure (Intervention)** | Patients presenting as suicidal who were appropriately assessed, and support and/ or treatment plan implemented. | I will focus on literature that discusses best practice in ED's for assessment and treatment of suicidal patients. |
| **Comparison/Control** | Patients presenting as suicidal who were discharged back to the community without appropriate assessment and no support and/or treatment plan implemented. | As I wish to investigate why some clinical assessments are not undertaken before discharge for some patients at risk of suicide, I will focus on best practice guidelines and where the links are being broken because of stigma and poor health literacy. |
| **Outcome** | To apply best practice assessments and treatments before discharge.<br>Planning initial and continued support if discharged to the community. | I am interested in whether current best practice is consistent and is of an acceptable standard, allowing all patients at risk of suicide proper assessment and support/treatment implementation before discharge. |
| **Time** | Before discharge from the ED | • Appropriate assessments and planning for treatment.<br>• Implementing suitable supports and family consultation.<br>If these are *not* done during this critical time, before discharge to the community, relapse increases, and the likelihood of a quick recover lessens. |


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