**CARE PLAN 26**

Suicidal Behavior



**Nursing Diagnosis**

**Risk for Suicide**

At risk for self-inflicted, life-threatening injury.

**RISK FACTORS**

• Suicidal ideas, feelings, ideation, plans, gestures, or attempts

• Lack of impulse control

• Lack of future orientation

• Self-destructive tendencies

• Feelings of anger or hostility

• Agitation

• Aggressive behavior

• Feelings of worthlessness, hopelessness, or despair

• Guilt

• Anxiety

• Sleep disturbance

• Substance use

• Perceived or observable loss

• Social isolation

• Problems of depression, withdrawn behavior, eating disorders, psychotic behavior, personality disorder, manipulative behavior, post-traumatic stress, or other psychiatric problems

**EXPECTED OUTCOMES**

***Immediate***

The client will

• Be safe and free from injury throughout hospitalization

• Refrain from harming others throughout hospitalization

• Identify alternative ways of dealing with stress and emotional problems, for example, talking with staff or significant others, within 48 to 72 hours

***Stabilization***

The client will

• Demonstrate use of alternative ways of dealing with stress and emotional problems, for example, initiating interaction with staff when feeling stressed

• Verbalize knowledge of self-destructive behavior(s), other psychiatric problems, and safe use of medication, if any

***Community***

The client will

• Develop a plan of community support to use if crisis situations arise in the future, for example, make a written list of resources or contacts

**IMPLEMENTATION**

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| Nursing Interventions  *\* denotes collaborative interventions* | Rationale |
| Determine the appropriate level of suicide precautions for the client. Institute these precautions immediately on admission by nursing or physician order. Some suggested levels of precautions follow: | Physical safety of the client is a priority. |
| 1. A staff member provides one-to-one supervision of the client at all times, even when in the bathroom and sleeping. The client is restricted to the unit and is permitted to use nothing that may cause harm to him or her (e.g., sharp objects, a belt). | 1. A client who is at high risk for suicidal behavior needs constant supervision and strict limitation of opportunities to harm himself or herself. |
| 2. A staff member provides one-to-one supervision of the client at all times, but the client may attend activities off the unit (maintaining one-to-one contact). | 2. A client at a somewhat lower risk of suicide may join in activities and use potentially harmful objects (such as sharp objects) but still must have close supervision. |
| 3. Special attention—the client must be accompanied by a staff member while off the unit but may be in a staff–client group on the unit, though the client’s whereabouts and activities on the unit should be known at all time. | 3. A client with a lower level of suicide risk still requires observation, though one-to-one contact may not be necessary at all times when the client is on the unit. |
| Assess the client’s suicidal potential, and evaluate the level of suicide precautions at least daily. | The client’s suicidal potential varies; the risk may increase or decrease at any time. |
| In your initial assessment, note any previous suicide attempts and methods, as well as family history of mental illness or suicide. Obtain this information in a matter-of-fact manner; do not discuss at length or dwell on details. | Information on past suicide attempts, ideation, and family history is important in assessing suicide risk. The client may be using suicidal behavior as a manipulation or to obtain secondary gain. It is important to minimize reinforcement given to these behaviors. |
| Ask the client if he or she has a plan for suicide. Attempt to ascertain how detailed and feasible the plan is. | Suicide risk increases when the client has a plan, especially one that is feasible or lethal. |
| Explain suicide precautions to the client. | The client is a participant in his or her care. Suicide precautions demonstrate your caring and concern for the client. |
| Know the whereabouts of the client at all times. Designate a specific staff person to be responsible for the client at all times. If this person must leave the unit for any reason, information and responsibility regarding supervision of the client must be transferred to another staff person. | The client at high risk for suicidal behavior needs close supervision. Designating responsibility for observation of the client to a specific person minimizes the possibility that the client will have inadequate supervision. |
| Be especially alert to sharp objects and other potentially dangerous items (e.g., glass containers, vases, and matches); items like these should not be in the client’s possession. | The client’s determination to commit suicide may lead him or her to use even common objects in self-destructive ways. Many seemingly innocuous items can be used, some lethally. |
| The client’s room should be near the nurses’ station and within view of the staff, not at the end of a hallway or near an exit, elevator, or stairwell. | The client at high risk for suicidal behavior requires close observation. |
| Make sure that the client cannot open windows. (The maintenance department may have to seal or otherwise secure the windows.) | The client may attempt to open and jump out of a window or throw himself or herself through a window if it is locked. |
| If the client needs to use a sharp object, sign out the object to the client, and stay with the client during its use. | The client may use a sharp object to harm himself or herself or may conceal it for later use. |
| Have the client use an electric shaver if possible. | Even disposable razors can be quickly disassembled and the blades used in a self-destructive manner. |
| If the client is attempting to harm himself or herself, it may be necessary to restrain the client or to place him or her in seclusion with no objects that can be used to self-inflict injury (electric outlets, silverware, and even bed clothing). | Physical safety of the client is a priority. |
| Stay with the client when he or she is meeting hygienic needs such as bathing, shaving, and cutting nails. | Your presence and supervision may prevent self-destructive activity, or you can immediately intervene to protect the client. |
| Check the client at frequent, irregular intervals during the night to ascertain the client’s safety and whereabouts. | Checking at irregular intervals will minimize the client’s ability to predict when he or she will (or will not) be observed. |
| Maintain especially close supervision of the client at any time there is a decrease in the number of staff, the amount of structure, or the level of stimulation (nursing report at the change of shift, mealtime, weekends, nights). Also, be especially aware of the client during any period of distraction and when clients are going to and from activities. | Risk of suicide increases when there is a decrease in the number of staff, the amount of structure, or the level of stimulation. The client may use times of turmoil or distraction to slip away or to engage in self-destructive behavior. |
| Be alert to the possibility of the client saving up his or her medications or obtaining medications or dangerous objects from other clients or visitors. You may need to check the client’s mouth after medication administration or use liquid medications to ensure that they are ingested. | The client may accumulate medication to use in a suicide attempt. The client may manipulate or otherwise use other clients or visitors to obtain medications or other dangerous items. |
| Observe, record, and report any changes in the client’s mood (elation, withdrawal, sudden resignation). | Risk of suicide increases when mood or behavior suddenly changes. Remember: As depression decreases, the client may have the energy to carry out a plan for suicide. |
| Observe the client and note when the client is more animated or withdrawn with regard to the time of day, structured versus unstructured time, interactions with others, activities, and attention span. Use this information to plan nursing care and the client’s activities. | Assessment of the client’s behavior can help to determine unusual behavior and may help to identify times of increased risk for suicidal behavior. |
| Be alert to the client’s behaviors, especially decreased communication, conversations about death or the futility of life, disorientation, low frustration tolerance, dependency, dissatisfaction with dependence, disinterest in surroundings, and concealing articles that could be used to harm self. | These behaviors may indicate the client’s decision to commit suicide. |
| Be aware of the relationships the client is forming with other clients and be alert to any manipulative or attention-seeking behavior. Note who may become his or her confidant. See Care Plan 48: Passive–Aggressive Behavior. | The client may warn another client about a suicide attempt or may use other clients to elicit secondary gain. |
| Note: The client may ask you not to tell anyone something he or she tells you. Avoid promising to keep secrets in this way; make it clear to the client that you must share all information with the other staff members on the treatment team, but assure the client of confidentiality with regard to anyone outside the treatment team. | The client may attempt to manipulate you or may seek attention for having a “secret” that may be a suicide plan. You must not assume responsibility for keeping secret a suicide plan the client may announce to you. If the client hints at but will not reveal a plan, it is important to minimize attention given to this behavior, but suicide precautions may need to be used. |
| Tell the client that although you are willing to discuss emotions or other topics, you will not discuss details of prior suicide attempts repeatedly; discourage such conversations with other clients also. Encourage the client to talk about his or her feelings, relationships, or life situation. | Reinforcement given to suicidal ideas and rumination must be minimized. However, the client needs to identify and express the feelings that underlie the suicidal behavior. |
| Convey that you care about the client and that you believe the client is a worthwhile human being. | The client is acceptable as a person regardless of his other behaviors, which may or may not be acceptable. |
| Do not joke about death, belittle the client’s wishes or feelings, or make insensitive remarks, such as “Everybody really wants to live.” | The client’s ability to understand and use abstractions such as humor is impaired. The client’s feelings are real to him or her. The client may indeed not want to live; remarks like this may further alienate the client or contribute to his or her low self-esteem. |
| Do not belittle the client’s prior suicide attempts, which other people may deem “only” attention-seeking gestures. | People who make suicidal gestures are gambling with death and need help. |
| Convey your interest in the client and approach him or her for interaction at least once per shift. If the client says, “I don’t feel like talking,” or “Leave me alone,” remain with him or her in silence or state that you will be back later and then withdraw. You may tell the client that you will return at a specific time. | Your presence demonstrates interest and caring. The client may be testing your interest or pushing you away to isolate himself or herself. Telling the client you will return conveys your continued caring. |
| Give the client support for efforts to remain out of his or her room, to interact with other clients, or to attend activities. | The client’s ability to interact with others is impaired. Positive feedback gives the client recognition for his or her efforts. |
| Encourage and support the client’s expression of anger. (Remember: Do not take the anger personally.) Help the client deal with the fear of expressing anger and related feelings. | Self-destructive behavior can be seen as the result of anger turned inward. Verbal expression of anger can help to externalize these feelings. |
| Do not make moral judgments about suicide or reinforce the client’s feelings of guilt or sin. | Feelings such as guilt may underlie the client’s suicidal behavior. |
| \*Referral to the facility chaplain, clergy, or other spiritual resource person may be indicated. | Discussing spiritual issues with an advisor who shares his or her belief system may be more comfortable for the client and may enhance trust and alleviate guilt. |
| Remain aware of your own feelings about suicide. Talk with other staff members to deal with your feelings if necessary. | Many people have strong feelings about taking one’s own life, such as disapproval, fear, seeing suicide as a sin, and so forth. Being aware of and working through your feelings will diminish the possibility that you will inadvertently convey these feelings to the client. |
| Involve the client as much as possible in planning his or her own treatment. | Participation in planning his or her care can help to increase the client’s sense of responsibility and control. |
| \*Examine with the client his or her home environment and relationships outside the hospital. What changes are indicated to decrease the likelihood of future suicidal behavior? Include the client’s family or significant others in teaching, skill development, and therapy, if indicated. | The client’s significant others may be reinforcing the client’s suicidal behavior, or the suicidal behavior may be a symptom of a problem involving others in the client’s life. |
| \*Plan with the client how he or she will recognize and deal with feelings and situations that have precipitated suicidal feelings or behavior. Include whom the client will contact (ideally, someone in the home environment) and what to do in order to alleviate suicidal feelings (identify what has worked in the past). | Concrete plans may be helpful in averting suicidal behavior. Recognizing feelings that lead to suicidal behavior may help the client seek help before reaching a critical point. |



**Nursing Diagnosis**

**Ineffective Coping**

Inability to form a valid appraisal of the stressors, inadequate choices of practiced responses, and/or inability to use available resources.

**ASSESSMENT DATA**

• Dysfunctional grieving

• Feelings of worthlessness or hopelessness

• Inability to solve problems

• Feelings of anger or hostility

• Difficulty identifying and expressing emotions

• Guilt

• Self-destructive behavior

• Anxiety

• Lack of trust

• Lack of future orientation

• Depression

• Withdrawn behavior

• Low self-esteem

• Perceived crisis in life, situation, or relationships

**EXPECTED OUTCOMES**

***Immediate***

The client will

• Participate in the treatment program within 24 to 48 hours

• Express feelings in a non–self-destructive manner, for example, talk with staff or write about feelings, within 24 to 48 hours

• Identify alternative ways of dealing with stress and emotional problems, within 48 to 72 hours

***Stabilization***

The client will

• Demonstrate use of the problem-solving process

• Verbalize plans for using alternative ways of dealing with stress and emotional problems when they occur after discharge

• Verbalize plans for continued therapy after discharge if appropriate, for example, identify a therapist, make an initial appointment

***Community***

The client will

• Maintain satisfying relationships in the community

**IMPLEMENTATION**

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| Nursing Interventions  *\* denotes collaborative interventions* | Rationale |
| Encourage the client to express his or her feelings; convey your acceptance of the client’s feelings. | Expressing feelings can help the client to identify, accept, and work through feelings, even if these are painful or otherwise uncomfortable. Feelings are not inherently bad or good. You must remain nonjudgmental about the client’s feelings and express this attitude to the client. |
| Help the client identify situations in which he or she would feel more comfortable expressing feelings; use role-playing to practice expressing emotions. | The client may not have experienced a safe environment in which to express emotions and may benefit from practicing with staff members and other clients. Role playing allows the client to try out new behaviors in a supportive environment. |
| Convey your interest in the client and approach him or her for interaction at least once per shift. If the client says, “I don’t feel like talking,” or “Leave me alone,” remain with him or her in silence or state that you will be back later and then withdraw. You may tell the client that you will return at a specific time. | Your presence demonstrates interest and caring. The client may be testing your interest or pushing you away to isolate himself or herself. Telling the client you will return conveys your continued caring. |
| Give the client support for efforts to remain out of his or her room, to interact with other clients, or to attend activities. | The client’s ability to interact with others is impaired. Positive feedback gives the client recognition for his or her efforts. |
| Encourage the client to express fears, anxieties, and concerns. | The client’s behavior may be related to fear or anxieties that he or she has not expressed or is unaware of, or that seem overpowering. Identifying and expressing these emotions can help the client learn how to deal with them in a non–self-destructive way. |
| Provide opportunities for the client to express emotions and release tension in non–self-destructive ways such as discussions, activities, and physical exercise. | The client needs to develop skills with which to replace self-destructive behavior. |
| Involve the client as much as possible in planning his or her own treatment. | Participating in his or her plan of care can help increase the client’s sense of responsibility and control. |
| Teach the client about depression, self-destructive behavior, or other psychiatric problems (see other care plans as appropriate). | The client may have very little knowledge of or insight into his or her behavior and emotions. |
| Teach the client about the problem-solving process: identify a problem, identify and evaluate alternative solutions, choose and implement a solution, and evaluate its success. | The client may never have learned a logical, step-by-step approach to problem resolution. |
| Teach the client social skills, such as approaching another person for an interaction, appropriate conversation topics, and active listening. Encourage him or her to practice with staff members and other clients. Give the client feedback regarding social interactions. | The client may lack skills and confidence in social interactions; this may contribute to the client’s anxiety, depression, or social isolation. |
| \*Encourage the client to pursue personal interests, hobbies, and recreational activities. Consultation with a recreational therapist may be indicated. | Recreational activities can help increase the client’s social interaction and provide enjoyment. |
| Discuss the future with the client; consider hypothetical situations, emotional concerns, significant relationships, and future plans. Use role-playing and ask the client about plans for time outside the hospital, on a trial basis and for discharge. | Anticipatory guidance can help the client prepare for future stress, crises, and so forth. Remember: Although the client may not be suicidal, he or she may not yet be ready for discharge. The client may have increased anxiety when outside of the therapeutic milieu or may be planning self-destructive behavior when no longer being supervised. |
| \*Encourage the client to identify and develop relationships with supportive people outside the hospital environment. See Care Plan 2: Discharge Planning. | Increasing the client’s support system may help decrease future suicidal behavior. The risk of suicide is increased when the client is socially isolated. |



**Nursing Diagnosis**

**Chronic Low Self-Esteem**

Longstanding negative self-evaluating/feelings about self or self-capabilities.

**ASSESSMENT DATA**

• Verbalization of low self-esteem, negative self-characteristics, or low opinion of self

• Verbalization of guilt or shame

• Feelings of worthlessness, hopelessness, or rejection

**EXPECTED OUTCOMES**

***Immediate***

The client will

• Express feelings related to self-esteem and self-worth issues within 2 to 5 days

• Identify personal strengths with nursing assistance within 2 to 4 days

***Stabilization***

The client will

• Demonstrate behavior congruent with increased self-esteem, for example, approach staff or other clients for interactions, maintain eye contact, verbalize personal strengths

• Assess own strengths and weaknesses realistically

• Verbalize plans to continue therapy regarding self-esteem issues, if needed

***Community***

The client will

• Participate in follow-up care or community support groups

• Express satisfaction with self and personal qualities

**IMPLEMENTATION**

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| --- | --- |
| Nursing Interventions  *\* denotes collaborative interventions* | Rationale |
| Convey that you care about the client and that you believe the client is a worthwhile human being. | The client is acceptable as a person regardless of his or her behaviors, which may or may not be acceptable. |
| Encourage the client to express his or her feelings; convey your acceptance of the client’s feelings. | The client’s self-evaluation may be related to feelings that he or she finds unacceptable. The client’s expression and your acceptance of these feelings can help him or her separate the feelings from his or her self-image and learn that feelings are not inherently bad (or good). |
| Initially, provide opportunities for the client to succeed at activities that are easily accomplished and give positive feedback. Note: The client’s self-esteem may be so low that he or she may feel able to make things only for others at first, not for his or her own use. | Positive feedback provides reinforcement for the client’s growth and can enhance self-esteem. The client’s ability to concentrate, complete tasks, and interact with others may be impaired. |
| Encourage the client to take on progressively more challenging activities. Give the client positive support for participating in activities or interacting with others. | As the client’s abilities increase, he or she may be able to feel increasing self-esteem related to his or her accomplishments. Your verbal feedback can help the client recognize his or her role in accomplishments and take credit for them. |
| Acknowledge and support the client for efforts to interact with others, participate in the treatment program, and express emotions. | Regardless of the level of “success” of a given activity, the client can benefit from acknowledgement of his or her efforts. |
| Help the client identify positive aspects about himself or herself. You may point out these aspects, behaviors, or activities as observations, without arguing with the client about his or her feelings. | The client may see only his or her negative self-evaluation and not recognize positive aspects. While the client’s feelings are real to him or her, your positive observations present a different viewpoint that the client can examine and begin to integrate. |
| Do not flatter the client or be otherwise dishonest. Give honest, genuine, positive feedback to the client whenever possible. | The client will not benefit from insincerity; dishonesty undermines trust and the therapeutic relationship. |
| \*Encourage the client to pursue personal interests, hobbies, and recreational activities. Consultation with a recreational therapist may be indicated. | Recreational activities can help increase the client’s social interaction and provide enjoyment. |
| \*Referral to a clergy member or spiritual advisor of the client’s own faith may be indicated. | The client may have feelings of shame or guilt related to his or her religious beliefs. |
| \*Encourage the client to pursue long-term therapy for self-esteem issues, if indicated. | Self-esteem problems can be deeply rooted and require long-term therapy. |