Improving confidence in suicide risk assessment

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- Components of effective suicide risk assessment
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Authors
Sue McLaughlin is nurse consultant and Daren Bailey is ward manager, both at Prospect Park Hospital, Reading; Gwen Bonner is interim clinical director, Berkshire Health Care, Reading; Catriona Canning is acting ward manager, Oxford Health Foundation Trust.

Abstract
McLaughlin S et al (2014) Improving confidence in suicide risk assessment. Nursing Times; 110: 27, 16-18. Suicide risk assessment is a complex task for mental health professionals. Attendance at mandatory training programmes designed to equip staff with the skills to undertake suicide risk assessments can be helpful in ensuring staff understand theoretical aspects. In reality, more support in practice is also required. To address this, we introduced a system of reflective peer review. This has helped staff to reflect on their risk assessments, consider the knowledge and information that has informed their risk management plans and discuss this with their peers in a supportive environment. This process has improved staff skills, confidence and documentation.

Suicide risk assessment is a core function for mental health nurses and other professionals but it is also one of the most complex and stressful duties undertaken in practice. The clinician must weigh the relative risk of an individual engaging in suicidal behaviours within the context of their current clinical and psychosocial presentation.

People differ in terms of the degree to which risk and protective factors affect the likelihood that they will end their life. No one risk factor, or set of risk factors, determines increased suicidal risk. In the same way, no one protective factor, or set of protective factors, guarantees against a completed suicide. Thus, as well as uncovering this information as a backdrop, the clinician needs to sensitively enquire about the individual’s reasons for living and reasons for dying, and synthesise all of this past and present knowledge to better evaluate current risk for suicide. To obtain this information successfully, it is also crucial for the clinician to feel confident and comfortable asking relevant questions as part of a genuine dialogue (Rudd et al, 2006). It has been suggested that how assessors understand and interact with an individual after a suicide attempt can make a difference and either strengthen their hope for life or increase their wish to die (Vatne and Nåden, 2014).

Equipping staff with the skills, confidence and correct manner to be able to undertake this task is of paramount importance and requires practice. However, within healthcare generally we do not tap into the whole range of strategies available to us for this complex learning. This can result in staff not having sufficient skills and confidence when it comes to completing risk assessments and the necessary documentation, which may, in turn, lead to a negative experience for the patient and subsequently increase hopelessness (Vatne and Nåden, 2014). In a worst case scenario it may result in crucial information being withheld and opportunities to prevent suicide being thwarted.

This article explains the content of suicide risk training and discusses an extra component we feel is required to help staff build skills and confidence in suicide risk assessment and clinical documentation.

Keywords: Mental health/Suicide/Risk assessment/Peer review

- This article has been double-blind peer reviewed
Suicide risk training
Over the past year we have been delivering clinical risk training for preventing suicide as part of a mandatory training programme. The content of the training was devised in collaboration with service users and carers (Box 1). It incorporates themes from Serious Incidents Requiring Investigation reports and complaints. The training also focuses on other important areas that have been highlighted in the literature and best-practice guidance (Christensen et al, 2013, Hawton et al, 2013, Appleby et al, 2012; HM Government and Department of Health, 2012; Van Orden et al, 2010; Joiner, 2005).

We have found the theory proposed by Joiner (2005) particularly useful. His theory rests on three factors:

- Perceived burdensomeness – having no sense of purpose or usefulness to others. When people believe they are incompetent and this incompetence has a negative effect on others, they may come to the conclusion they are worth more dead than alive. Joiner highlights the importance of needing to understand that, although this is a perception and not the reality, it is part of a psychological process that can lead to intense shame.

- Thwarted belongingness – an unmet need to belong, which contributes to the development of a desire for death. The feelings of being a burden and a lack of belonging can work together to create a desire for death as an end to pain. Joiner suggests that, alone, neither of these states is enough to move a person to act on the desire for death; together with an acquired ability/capacity (or fearlessness), however, they result in a high-risk state for suicide.

- Acquired ability (or acquired capacity) – a series of painful and provocative experiences over the course of a lifetime that can disinhibit a person from the fear of pain and death that is associated with suicide.

The theory suggests that, for someone to die by suicide, he or she must have all three factors in motion at the same time. Staff find the model useful to guide their thinking, questioning and formulation of the problem.

The training has been well evaluated but staff requested extra support to improve confidence – especially in terms of engaging with the suicidal person – and with documenting the decision-making process and triangulating the assessment, management plan and progress notes within the electronic recording system. In response to this, we devised a peer-review process to address these needs at an individual and team level.

Reflective peer-review process
Peer review is often used in teaching and business and is seen as a way to reinvigorate staff as well as being beneficial to skill acquisition and competence (Baskerville and Goldblatt, 2009). Benefits include:

- Ongoing development via self-reflection;
- Providing a support system and networks; and
- Creating a cycle of continuous improvement in practice (Foulger, 2010).

All members of the staff team are invited to take part in peer review and it can be undertaken at an individual level within clinical supervision or as a team training session. We facilitate the peer review along with the head of patient safety (all have been trained in the peer-review process). The emphasis is on support and reflection so the team or individual can recognise areas that require more thought, detail, explanation or improved documentation.

The session commences with an explanation of the process (the model for peer review is demonstrated in Fig 1). After this a member of the team presents a case, together with their suicide risk assessment and decision making about how the risk has been rated using the following format:

- Historical factors;
- Clinical factors;
- Situational factors;
- Triggers to risk incidents;
- Intent;
- Protective factors; and
- Rationale for rating the risk, based on the above and gut feelings.

Discussion centres around the risk assessment and care plan that has been devised for a patient who is currently on the ward and the patient is invited to attend if possible.

The presenter outlines actions that are being taken by the team to minimise risk along with a rationale for these. The impact of all interventions and actions are considered, and reflections on alternatives and possibilities are encouraged. Following this, documentation is examined to determine whether the full process and decision making has been captured accurately and with sufficient detail. Any gaps in documentation are updated as these are live documents for people on the ward; alternative interventions are incorporated. The patient and carer(s) are also invited to comment on the findings from the peer review.

As mentioned earlier, in practice the peer review can be undertaken within supervision or as part of a larger multidisciplinary team discussion. We have also had feedback that staff have used the process in handover when struggling with differences in opinions about level of risk and observations of a particular patient. The process we have developed aims to embrace the expertise of our peers, and to be a practical approach to building staff skill,
competence and confidence in relation to suicide risk assessment, risk management and documentation. This is achieved by using the process outlined above to:

» Understand past and present risk factors;

» Explore the rationale for decisions made;

» Examine interventions and the impact of these; and

» Link all of this to theory and practice.

The peer review is an opportunity to reflect and explore alternatives.

Our preliminary work demonstrates it is extremely useful to set this up and we have been able to work with colleagues in our neighbouring trust; this provides a wider view and promotes collaborative working. Staff also valued feedback from colleagues who are not involved in the ward.

We found that the process described in Fig 1 can also give teams an understanding of each other’s thinking around risk; this, in turn, can reduce some of the tensions found in referring patients between teams and the decision-making process around patient care plans. Staff report increased confidence and in future we intend to measure this pre- and post-session with the Risk Assessment and Management Self-Efficacy Scale (Delgadillo et al, 2014).

Improvement in clinical documentation

The peer-review process is being robustly audited and results are encouraging. In the three months after its introduction, there was a marked improvement in clinical documentation. The audit measured the quality of risk assessment, risk management plans and progress notes against locally devised standards of practice, including rating the risk based on historical factors, clinical factors, situational and protective factors. In December 2013, 40% of clinical documentation was compliant with these standards; by March 2014, 74% was compliant.

Barriers

Barriers to the implementation of reflective peer review can include:

» Time factors;

» Workload pressures;

» Lack of suitable peers; and

» A resistance to change.

These can be overcome with determination, clarity around the aims of the process and seeking director-level support. Taking these factors into account and working around the barriers, we aim to continue with the process, collecting data on confidence levels, and extend this to community teams.

Conclusion

Engaging with and assessing those who are at risk of suicide is an important and complex task for healthcare workers. Staff need to have skills and courage to listen and elicit information from the person at risk, and synthesise this information to inform the treatment plan.

Reflective peer review is effective alongside training because it taps into the feelings and thinking that can impact on assessment and drive the decision-making process. It provides an opportunity for reflection on alternatives to care using current clinical examples from the practitioner’s workload, as well as exploring staff members’ attitudes to the patient, self-harm and suicide while encouraging reflection on how this may be impacting in a positive or negative way on the care provided. This approach builds on staff members’ existing skills and provides an opportunity for skill acquisition via direct feedback from peers. During the process there is an opportunity to examine and add to the clinical documentation.

An audit of case notes after peer review has highlighted an improvement in documentation in relation to rating risk based on historical, clinical, situational and protective factors. Staff have reported an increased understanding of risk assessment and increased confidence; we have also seen an improvement in record-keeping requirements.

Further work will involve using validated scales to measure confidence and its impact on professional behaviour in terms of risk-management plans that match clinical and best-practice guidelines.

References


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