

CARE OF THE PATIENT WITH SUICIDAL IDEATION /POTENTIAL FOR SELF INJURY

OBJECTIVES:

1. To identify suicidal behaviors.
2. To maintain a safe environment.
3. To promote self esteem.

PROCESS STANDARDS:

1. The patient's suicidal risk will be assessed each shift (when, how, frequency of thoughts), for suicidal ideation and/or behavior.
2. The patient's environment will be assessed at least every shift for potential risk and all potentially dangerous items removed.
3. The patient will be encouraged to express suicidal thoughts.
4. The patient will be observed for decreased communication, disorientation, dependency, concealing articles, and the MD notified of significant changes.
5. The patient will be monitored daily for adequate nutrition, hydration, and elimination.
6. The patient will be encouraged to have a balance of rest, sleep, and activity.
7. The patient will be encouraged to identify positive aspects of self.
8. The patient will be encouraged to identify stressful life situations that may precipitate suicidal thoughts, and to develop alternative coping techniques.
9. The patient will receive medication as ordered and the effectiveness documented.
10. The patient will be advised regarding follow-up care (MD visits and importance of medication regime).

OUTCOME STANDARDS:

1. The patient will demonstrate ability to control self-destructive and suicidal behavior.
2. Adaptive behavior will be present and documented.
3. The patient will be able to express, identify, and plan how to cope with feelings and stress producing situations.
4. The patient will be able to communicate appropriate methods of follow-up mental health care.
5. The patient will exhibit feelings of self worth by expressions of past accomplishments and positive aspects of self.

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HAVE I DOCUMENTED:

- * Expressed Suicidal ideation
- * Environmental risks
- * Nutritional status
- * Activity level
- * Patient Education
 - Warning signs of inability to adapt
 - Insomnia
 - Weight changes
 - Guilt
 - Thoughts of death
 - No future objectives/goals
- * Medication Response

At The Time of Discharge:

- * Adaptive behavior present
- * Medication regime
- * Patient/family has understanding of home and follow-up care
- * Patient/family has knowledge of available Community Resources

Reference:

1. Townsend, M. Nursing Diagnosis in Psychiatric Nursing 7th-ed. (2008). *Risk for Suicide and Low Self Esteem*. Philadelphia: F.A. Davis: [AR, LA, OK Libraries - LSU - Shreveport -- Nursing Diagnoses in Psychiatric Nursing - 7th Ed. \(2008\)](#)
2. Varcaroles, E., Carson, V.B., and Shoemaker, N. Foundations of Psychiatric Mental Health Nursing, 5th ed. (2005). Philadelphia: Mosby/Saunders.