Suicide: A Permanent Solution to an Often Temporary Situation

Pamela Stacy

Suicide is an uncomfortable topic, avoided by even the most seasoned nurses. This article examines many myths about suicide, current treatment modalities for depression and suicide, and suggestions of how to approach this sensitive topic.

Suicide. The very word brings chills to a person’s heart. It is such a terrifying, abhorrent idea that in most cultures suicide is a taboo subject. People would rather sweep the topic under the rug than think about it, talk about it, or face it. As health care professionals, our attitude toward suicide is important. The majority of people who die by suicide make contact with a health professional within a relatively short time before death (Jones, 2010). Negative relationships with health professionals have also been cited as a key factor precipitating death by suicide.

The National Institute of Mental Health (NIMH) reported over 34,000 deaths by suicide in the United States and approximately 11 suicide attempts per every death from suicide in 2007 (NIMH, 2010). Males are more likely to die from suicide attempts because of their use of more lethal methods, such as firearms. However, females are two to three times more likely to make a suicide attempt (Sobczak, 2009).

In this article, myths about suicide will be discussed, as well as how to broach the subject with someone in great distress or anguish, current treatment modalities, and how to be of support to someone contemplating suicide. The purpose of this article is to prepare the medical-surgical nurse to take on the challenge of suicidal clients. When the subject of suicide does come up, or needs to come up, the medical-surgical nurse will be better equipped to provide support with compassion and dignity.

Common Myths

There are many common myths about suicide pervasive in our culture today. These myths stereotype people contemplating suicide and alienate them from the help they desperately need. These myths also serve to increase the stress level of the health care professional so that the medical-surgical nurse approaches the subject with tentative fear and trembling or avoids the subject altogether.

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A Time for Reflection and Growth

Much of the work done by the AMSN Board of Directors (BOD) is accomplished electronically or by phone. However, three times a year, we come together to address work of the association. The BOD held a face-to-face meeting in March.

Each year, the BOD takes time to review its role as a board and participates in learning activities specifically related to the leadership of the association using resources from the American Society of Association Executives (ASAE). The board recently reviewed its role in strategic planning, working as a group, and its fiduciary responsibilities. The role of the Nominating Committee was also reviewed and discussed, which was valuable as the board prepared for the report of the Nominations Process task force later in the meeting.

Along with this annual process of board development, the BOD spent time considering the methods by which we communicate the mission and message of AMSN. Recently, the board allocated funds to a consultant to assist in the development of the AMSN brand. Executive Director Cyndee Hnatiuk shared the background information and recommendations of the consultant with the BOD. The work of the consultant was very enlightening. Simple changes were suggested regarding how AMSN presents materials and the need for a consistent brand was addressed. The association management team will implement strategies recommended by the consultant. As a result, you will likely notice some changes in format and layout of some of the materials you receive from AMSN.

Leading AMSN into the Future

In the last issue, I mentioned the Institute of Medicine (IOM) Future of Nursing initiative as a focus of the board’s work at the winter board meeting. The board discussed current and future activities of AMSN that correlate with the recommendations. The board’s work is still in progress and will continue through the next face-to-face meeting in June. What we do know is AMSN and its members have an important role to play related to this initiative in upcoming years.

The strategic plan has brought many opportunities to initiate a number of task forces. The BOD heard three reports at the meeting and those task forces have finished the tasks assigned. The first was a task force to evaluate AMSN affiliations and relationships with other organizations. The task force, headed by Linda Yoder, developed a tool for evaluation, conducted evaluations, and made recommendations to the board. The decision was to continue our current relationships which include: 1) Medical-Surgical Nursing Certification Board (MSNCB); 2) Organizational Affiliate, the American Nurses Association (ANA); 3) ANA Congress on Nursing Practice and Economics (Kathleen Reeves, AMSN representative); 4) National Quality Forum, member (Cynthia Barrere, AMSN representative); 5) The Nursing Community and Americans for Nursing Shortage Relief (ANSR) (Robin Hertel, AMSN representative); 6) Nursing Organizations Alliance (The Alliance); 7) Hartford Institute for Geriatric Nursing; and 8) Nursing Symposium and Nursing2011. This work was important as the board considers how it can best use resources to make AMSN visible within the nursing community.

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A Healthy Collaboration with the American Nurses Association

“AMSN believes the unified voice of professional nurses strengthens when medical-surgical nurses strategically collaborate with others. AMSN is committed to working with other organizations that share our patient care issues, values, and priorities” (AMSN, 2010).

One of the organizations AMSN collaborates with is the American Nurses Association (ANA). AMSN has been an ANA Organizational Affiliate since 2008. As an organizational affiliate, AMSN has a voting seat at ANA’s House of Delegates and ANA’s Congress on Nursing Practice and Economics (CNPE). AMSN maintains autonomy as a specialty organization but collaborates with ANA as well as other organizations to provide a unified voice in matters that impact the nursing profession as a whole.

I was privileged to represent AMSN at the ANA House of Delegates in 2010. Although not every topic discussed was relevant to AMSN, many were. Items such as mentoring, social media guidelines, and staffing were discussed and the CNPE is expected to address these items over the next two years.

As the AMSN representative, I am also serving as a member of the CNPE until September 2012. The CNPE is a diverse 60-member group comprised of elected members, organizational liaisons, and Organizational Affiliate representatives. We are tasked with multiple responsibilities including the development of standards, policy alternatives, and programs, as well as addressing key nursing issues and emerging trends within the health care industry.

The CNPE recently discussed guidelines for the responsible and professional use of social media such as Facebook and Twitter. Policies are already in place in many work settings; however, nurses in any work setting can use these guidelines. The guidelines should be available later this year through a new ANA position statement.

In addition, the CNPE discussed nurses’ involvement with the electronic health record (EHR). Principles have been developed to emphasize the importance of nurses’ and end-users’ active participation in the selection, implementation, and evaluation of the EHR.

Prior to the publication of the social media guidelines and EHR guidelines, public opinion will be sought. This will offer AMSN members an opportunity to provide input into the final documents.

One of the other items the CNPE will be working on this year is revision of the ANA Principles of Nurse Staffing. As you know, “AMSN believes the medical-surgical patient receives better care in an environment that integrates evidence-based care, and determines staffing reflective of the intensity of patient care needs rather than predetermined staffing or using fixed staffing ratios” (AMSN, 2010). ANA will be seeking public comment related to the Principles of Nurse Staffing. Once again, this will be an opportunity for AMSN members to provide input and share concerns and comments about the document. Please look for an announcement about this opportunity later this year.

The collaboration between AMSN and ANA benefits both organizations. ANA benefits from the expertise and experiences of medical-surgical nurses. AMSN benefits from the sharing of ideas and concerns, the additional learning opportunities, and the ability to strengthen the voice of nursing with issues relevant to the entire profession.

Reference
Academy of Medical-Surgical Nurses (AMSN). (2010). Priority agenda. Retrieved from http://www.amsn.org/cgi-bin/WebObjects/AMSNMain.woa/1/wa/viewSection?s_id=1073744083&ss_id=536873948&wosid=gRHj1sJsmxy82CV4Rm96Gm4f0RR

Kathleen Reeves, MSN, RN, CMSRN, CNE
AMSN Past President

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Strategies for Nurse Educators

Development of a Teaching/Learning Assessment Tool: Bedside Nursing Assessment

The Bedside Nursing Assessment Tool was developed to facilitate the assessment, documentation, and organizational skills of students. Using the tool enables learners to ask themselves the questions of assessment, to guide their examination of patients, and in subsequent oral report and documentation.

One of the courses I teach is Fundamentals of Nursing. Students face many hurdles and “firsts;” so many are hesitant and some are just plain frightened to enter a patient’s room during the first clinical experience. As educators, we expect them to not only enter patients’ rooms, but also to engage in conversation, assist with patient hygiene (or give a complete bed bath), and conduct a physical examination. All of these skills are new to the students. My words of wisdom to them are, “It’s OK. You have the outfit [white uniform] and stethoscope. Go on in. It’s OK.”

I developed the Bedside Nursing Assessment Tool (see Table 1) to ease entry into a patient’s room. With this tool quickly in hand or pocket, students report feeling more at ease as the tool gives them focus and purpose. The tool guides student nurses through the assessment process and assists them in remembering the questions to ask themselves and what to do next as they examine patients.

Another hurdle the novice student faces is, “How do I give a report to the nurse in a succinct manner and make sure I include all pertinent data?” Many students are nervous and intimidated to give a verbal report to the nurses. Using the Bedside Nursing Assessment Tool as a guide, student nurses feel more comfortable and competent in the handoff to the patient’s primary nurse. The tool assists students in giving report in an orderly fashion and ensures all pertinent patient data for each body system is included. Similarly, this tool helps students learn to document by systems. Students can review their assessment and determine what is necessary to include in documentation.

Students in other clinical courses have found the tool to be equally useful in helping organize patient assessment. In reviewing the literature (Green & Watson, 2006; Myers, 2003; Zwakhalen, Hamers, Abu-Saad, & Berger, 2006), the use of tools and instruments such as the Bedside Nursing Assessment Tool are effective and evidence-based. Expert nurses use assessment tools for evaluating pain, nutrition, falls, and more in daily practice. The use of such tools assists novice student nurses in their journey to becoming experts.

**Table 1.** Bedside Nursing Assessment Tool

<table>
<thead>
<tr>
<th>This assessment tool can be used in the clinical setting.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neuro</strong></td>
</tr>
<tr>
<td>Is the patient awake, alert, oriented (x3)? Can he/she move all extremities? How strong is the patient?</td>
</tr>
<tr>
<td>5 = normal strength</td>
</tr>
<tr>
<td>4 = weaker</td>
</tr>
<tr>
<td>3 = can move against gravity</td>
</tr>
<tr>
<td>2 = can move, but not against gravity (e.g., able to move an arm across stomach, but not lift it up)</td>
</tr>
<tr>
<td>1 = minimal movement (e.g., flicker of fingers). Is the patient’s speech clear and comprehensible?</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
</tr>
<tr>
<td>Respiratory rate (RR) and rhythm, pulse ox? Lung sounds? Is the patient on oxygen? Is the patient getting any respiratory treatments? If so, are they effective? What are the lung sounds pre- and post-treatment? Does the patient have a fever?</td>
</tr>
<tr>
<td><strong>Cardiac</strong></td>
</tr>
<tr>
<td>Heart rate (HR) and rhythm? Are the pedal pulses obtainable, weak, or 1-2+? Capillary refill, is it brisk? Does the patient have any pedal edema? Is it pitting or 1-2+?</td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
</tr>
<tr>
<td>Is the abdomen soft, non-tender (NT), non-distended (ND)? Are the bowel sounds (BS) positive? Is the patient eating? If so, how much? Nasogastric tube (NGT) feedings or percutaneous (PEG) tube feedings? When was the last bowel movement (BM)? Also note the color, consistency, and amount of BM. Does the patient have any nausea or vomiting?</td>
</tr>
<tr>
<td><strong>Genitourinary</strong></td>
</tr>
<tr>
<td>Does the patient void on his/her own? Is there any dysuria or hesitancy? Is the urine clear or cloudy? What is the color of the urine? Does the patient have a Foley or a Texas catheter? Note the amount of urine.</td>
</tr>
<tr>
<td><strong>Skin</strong></td>
</tr>
<tr>
<td>Is the skin warm, dry, and intact? Is there sun damage? Are there suspicious lesions? Are there any areas of skin breakdown? If so, observe and document any wound (size, depth, color, odor, drainage, tender, warmth). If a dressing was done, describe and document.</td>
</tr>
<tr>
<td><strong>Psychiatric</strong></td>
</tr>
<tr>
<td>Evaluate the patient’s mood and anxiety level. Are they congruent? Is the patient’s behavior appropriate?</td>
</tr>
</tbody>
</table>

References


© Victoria Siegel

Victoria Siegel, RN, MSN, CNS, EdD, is an Associate Professor of Nursing, Suffolk County Community College, Brentwood, NY.
Healthy Work Environments

The Manager’s Role in a Healthy Work Environment

The medical-surgical nurse manager’s role in providing a healthy work environment is vital. The manager’s leadership style has a direct impact on making this successful. The authentic leader is emerging as the one necessary in today’s nursing world to establish a healthy work environment.

What does a medical-surgical nursing staff need from a nurse leader? What type of leadership is required to successfully position the medical-surgical nursing unit as a healthy work environment for staff? How can a nurse manager support nursing staff? Although a distinction can be made between the terms leadership and management, for the purpose of this article, these titles will be used interchangeably.

A healthy work environment is one that supports and fosters excellence in patient care. Increasing evidence shows that unhealthy work environments contribute to medical errors, ineffective care delivery, and conflict and stress among health professionals (American Association of Critical Care Nurses [AACN], 2005). The medical-surgical nurse manager is a critical component in promoting a healthy work environment.

Nurse managers who are strong advocates for developing a healthy work environment may be viewed as risk-takers. The workplace is an important setting for the nursing leader to address the mental, physical, social, and economic welfare of employees (Tomey, 2009). One of a nurse manager’s responsibilities is to create a positive work environment for employees, one where nursing staff are excited to come to work.

Geedey (2006) suggests the following tips to assist a nurse manager in setting the tone for a positive work environment:

- Create an environment where humor is encouraged.
- Create a true open door policy.
- Ensure unit values and expectations are clear.
- Keep the environment simple and the work area orderly and uncluttered.
- Recognize volunteerism.

Part of providing a healthy work environment includes appropriate staffing levels. This not only includes nurse-to-patient ratios, but also matching patient acuity with the medical-surgical nurses’ competencies (AACN, 2005).

AACN (2005) identified authentic leadership as one of the six standards for creating and sustaining a healthy work environment. Shirey (2006) described authentic leaders as people who understand their own purpose and remain true to their core values. Authentic leaders set the example and then role model ethical behavior. Authentic leaders value staff involvement in decision making, whether in work design and flow or creating trust.

The nurse manager’s support in creating fair and just cultures of safety is central to promoting and sustaining a healthy work environment. Cultures that allow for human error in correcting system problems also hold people responsible for reckless behavior. Quality outcomes which are desired by managers are measured by monitoring medication errors, fall prevention practices, and system processes. Supporting the front line medical-surgical nursing staff will ensure quality outcomes in a healthy work environment. If the work culture is viewed as fair and just, nursing staff are more likely to report errors and near-misses. However, if the staff view the reporting of errors in processes as people-focused and/or associated with blame or punishment, employees are less likely to report events. Unreported events may contribute to continued process failures of the same nature and serve as a missed opportunity to create an atmosphere for the staff to contribute to a safe and healthy workplace (Marx, 2001).

The most important element to a healing environment for patients is medical-surgical nurses who have a positive work environment (Stichler, 2009). Nurse managers must set the standard for healthy work environments for staff, which in turn, provides for quality outcomes for the institution. As pay-for-performance looms on the horizon, these same quality outcomes will become the institutions’ bottom line. Thus, if a healthy work environment prevails, everyone will benefit.

References


Patient falls are a serious issue and can be very costly to the health care system. It is estimated the annual direct and indirect cost of fall injuries will reach $54.9 billion by the year 2020 as the population ages (Centers for Disease Control and Prevention, 2009). Multifactorial approaches, including identification of high-risk patients, communication among staff and family members about the risk of falls, and both case-specific and universal interventions, are usually employed for fall prevention (McCarter-Bayer, Bayer, & Hall, 2005). Family involvement has been implicated as being vital to a fall prevention program; however, it remains undetermined whether and how family involvement can contribute to fall prevention in the acute care setting. Therefore, this article will examine the effectiveness of family involvement and set evidence-based guidelines for incorporating family involvement in fall prevention.

Literature Review

Tzeng Yin, Tsai, Lin, and Yin (2007) administered a cross-sectional survey in a medical center in Taiwan to address whether family/aides/companions could help prevent patient falls in acute care settings. This is one of few published studies focusing on the impact of family involvement on fall prevention. In this study, 61.8% of falls occurred when patients were accompanied by at least one family member/aide. Of these falls, 45.5% were due to the families’ lack of engaging and 35.5% were due to improper handling. Based on the observed results, the researchers suggested having family members/aides with the patients might not be an effective way to prevent falls. The weaknesses of this study (non-random patient selection, incomplete data source, and lack of consideration of important factors) prevent it from being useful to nursing. For example, it is usual in Taiwan for nurses to delegate some work to the accompanying family members/aides. Therefore, it is important to take into account any differences in nursing care activities when comparing the fall incidences.

Giles and colleagues (2006) evaluated the effect of volunteers on preventing falls in patients at high risk for falling. The study was conducted in two safety bays located in two hospitals. No falls occurred when the volunteers were present in the safety bays, though the overall rate was not affected significantly. The study also confirmed there was no significant difference in the distribution of falls over time and in the profile of patients who fell in terms of age, gender, or length of hospital stay. In addition, qualitative data were collected to evaluate the experiences of the volunteers, patients’ families, and hospital staff. Similar to another study on volunteer programs in fall prevention (Donoghue, Graham, Mitten-Lewis, Murphy, & Gibbs, 2005), this study supports the implementation of a volunteer companion program to prevent falls. One weakness in the Giles study lies in the lack of controls, such as a safety bay in the same hospital without implementing the volunteer program in the same period.

A study by Ryu, Roche, and Brunton (2009) was conducted on a neuroscience unit in an acute care hospital. Implementation of patient and family education on fall prevention was done in one-on-one sessions. During the study period, no falls were reported among patients who received the education, while two falls occurred among patients who did not receive the education. Although this study shows support for patient education regarding fall prevention, the study is weak due to the lack of randomization of a small sample size. The outcomes were also influenced by the other interventions present at the study time.

In 2009, Dykes, Carroll, Hurley, Benoit, and Middleton conducted a study focused on the views of nurses and nurse assistants regarding the reasons patients fall and how to prevent falls in hospitals. Their conclusions stressed the importance of involving all stakeholders, including the patients’ families, in carrying out a patient care plan in preventing falls. This is one of few studies focusing on insight from nurses and nurse assistant bedside caregivers. However, the participants were not a randomized sample and the size was small.

Fonda, Cook, Sandler, and Bailey (2006) studied the impact of a multistrategy fall prevention approach over a three-year period. The multistrategy intervention included increasing surveillance by engaging families and volunteers. The fall prevention implementation period revealed a significant decrease in both the total number of falls and the number with serious injuries while there was little difference in patient demographics.
The five articles reviewed indicated the involvement of patients’ families or volunteers can be a valid strategy in preventing patient falls when effectively implemented. Family involvement is mainly applied in two ways: educating families/volunteers about fall prevention and engaging them in patient surveillance. It is important to make sure the education is actually effective; otherwise, the families won’t contribute much to fall prevention (Tzeng et al., 2007). Repetitive education sessions and distribution of pamphlets would help improve effectiveness. It is equally important to have families monitor patients because the majority of patient falls happen when they are not being observed (Fonda et al., 2006; Tzeng et al., 2007). The nursing staff is often a limited source; hence, employing families to increase surveillance may be a practical way to attain the goal of fall prevention.

Summary

There are few studies addressing the effect of family involvement in patient fall prevention. Most often family involvement is integrated into a multifactorial approach to prevent patient falls, making it hard to assess its individual impact on fall prevention. However, based on the limited published resources that are relevant, this article concludes family involvement should be encouraged and incorporated into any fall prevention plan.

References


Lixian Luo, BSN, MBA, RN-III, CVRN-II, BC, is a Charge Nurse, The Methodist Hospital, DeBakey Heart Center, Texas Medical Center, Pearland, TX.
Chapter #317

Chicago Chapter #317 had a grand celebration during the holidays for their volunteers. The chapter demonstrated a commitment to acknowledge the volunteers who showed outstanding efforts in community outreach activities. A recognition dinner was held in December and surprise guests stopped by to help celebrate. The chapter also made connections with new members of AMSN.

Members networked, discussed how to work together, and relaxed. Nurses were pampered with laughter (the Little People stopped by), massages, and manicures. Speaker Deb Desario wore a superhero suit to emphasize how nurses can do it all—family, work, and volunteer efforts. The chapter also planned the “hot seat,” where a lucky nurse had to answer fast facts to win a gift basket.

The event attendees represented 5 hospitals in the Chicago area. As President of Chicago Chapter #317, I hope to encourage all chapters to collaborate with nurses from many hospitals. For more information on this chapter, contact me at cpalmer@nmh.org.

Cora J. Palmer, BSN, RN-BC, CMSRN
Chapter #317 President
cpalmer@nmh.org

NC Triangle Chapter #234

The NC Triangle Chapter #234 met at Duke Raleigh Hospital on January 27. Mary Edmondson, MD, presented “Psychiatric Management of the Medical-Surgical Patient in the Acute Care Setting.”

Duke Bookstore donated a gift certificate for the event; it was won by Vicky Overby. Engraved pens and flashlight keychains were available for sale as a chapter fundraising effort. The chapter also used this opportunity to collect blankets and coats for the Raleigh Rescue Mission.

The next meeting will be held July 28, 2011, at 7 p.m. at Duke Raleigh Hospital. Peggy Gleason, RN, MS, NHD, IHC, will present “Shift: A Day at Work or a Day at the Beach—A Matter of Perspective.” For more information, contact me at kathy.chiulli@duke.edu.

Kathy Chiulli, MSN, RN, CNS, CMSRN
Chapter #234 President
kathy.chiulli@duke.edu

Chapter Reports Due June 30

Chapters, this is the time of year your chapter gets to brag about its recent achievements. Every chapter needs to send in the Chapter Achievement Report by June 30. Your reports will be used to determine six Annual Chapter Achievement Awards. The report also keeps the National Office abreast of basic chapter information and how successful each chapter has been in the activities of Collaboration, Community Services, Education, Political/Legislative, and Recruitment and Retention. If your chapter has proven outstanding in an area, it could win a Chapter Award that includes a certificate of recognition, $50 check, and two complimentary 1-year AMSN memberships. The Chapter of the Year will also receive two complimentary AMSN Annual Convention registrations and a $100 check.

For the Chapter Achievement Report and instructions, go to Chapters on www.amsn.org and select Chapter Resources.
Citing Material Obtained on Facebook and Twitter

Does the thought of assembling an APA citation for material found online make you shudder? Never fear! You're not alone. Researchers have been relying more and more heavily on social media as a source of newsworthy information, and nurses are no exception to this trend. Considering this, the number of Web addresses in manuscript reference lists is rapidly increasing, as well as the number of questions surrounding how to properly format them in APA style. Most confusing of all seems to be sites like Facebook and Twitter. While this specific subject wasn't addressed in the 6th edition of the APA Style Manual (2010), the issue is discussed at length on the APA Style Blog (http://blog.apa.org/apa/style/social-media/).

In a nutshell, if you've learned how to structure an online article citation in APA format (which is now fairly commonplace), citing Facebook posts and Twitter tweets is just as easy. If you need a refresher on citing Internet-only electronic sources, read our April 2009 column on this topic.

For social media citations, include all the same information you normally would for an electronic resource: author, date, title, and Web address. The only addition you'll need to note is what the source is (i.e. a tweet or post). This information should appear in brackets following the title (when applicable), before the period.

For example, this is how we could cite a tweet from AMSN:


Note there is no title here, as tweets share only a condensed amount of information (usually linking elsewhere to elaborate). You also don't need to include a date of retrieval for a tweet because the URL is static and the information found there will remain the same regardless of when it is accessed.

If you want to reference something from the AMSN Facebook page, it would appear like this:


Again, this post doesn't have a title attached to it. Examples of sources that would contain a title include blog posts, YouTube videos, and Wikipedia articles. It's also helpful to know direct URLs for Twitter and Facebook posts are available in your address bar after clicking the date/time of the post underneath it. The Web address provided in a reference list should lead you directly to the source, not the user's main profile page or Wall. Be as specific as possible; your readers will thank you.

Katie R. Brownlow, ELS, is Managing Editor, MedSurg Matters!, Pitman, NJ. She may be contacted via email at katie@ajj.com.

Look for more tips on proper APA format in future issues of MedSurg Matters!

Frequently Asked Questions about MSNCB

CMSRN (Certified Medical-Surgical Registered Nurse) certification is a rewarding endeavor that reflects expert knowledge in the medical-surgical specialty. Here are some of the most common questions about certification and their answers.

Certification

Q: Will the CMSRN certification be recognized by the Magnet Hospital Program?
A: The Magnet Hospital Program, which expects a percentage of certified nurses as part of its requirements, recognizes the CMSRN credential. It recognizes all certification credentials provided by nationally recognized nursing certification programs. You may contact Magnet directly at magnet@ana.org or 1-800-284-2378.

Recertification

Q: When do I need to send in my recertification application?
A: You have until your certification expiration date to have your recertification application postmarked in the mail. You can send it in up to one year prior to your certification expiration date, and your renewal will still be extended from the expiration date. If you do not recertify by the expiration date, MSNCB offers a one-year grace period, but a late fee will be assessed at the time of renewal.

Contact MSNCB at msncb@ajj.com or 866-877-2676 with your questions.
Suicide

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One common misconception is that people who talk about suicide are just trying to get attention or manipulate others and will not try to kill themselves. In reality, people who die by suicide have usually talked about it first or sent out subtle messages of despair. The suicidal person is in physical and emotional anguish and oftentimes reaches out for help because he or she does not know what else to do when experiencing such hopelessness. When a person talks about suicide, it indicates that something is terribly wrong, and the subject must be dealt with compassionately, taken seriously, and managed with appropriate assessment and intervention (Videbeck, 2011).

Some believe death by suicide occurs without warning signs. On the contrary, there are almost always warning signs. Verbal warning signs may include statements indicating the individual “can’t take it anymore,” giving away prized possessions to friends or family members, or claiming people will be “better off without me.” Non-verbal cues may be fluctuations in mood, such as a change from being extremely anxious to extremely calm or from being hostile to passive (Videbeck, 2011). Many medical-surgical nurses believe only a trained professional can identify a person who is contemplating suicide. However, family members, friends, teachers, and clergy are often the first to notice signs of suicidal ideation and are usually the first ones confided in during times of great distress (Horowitz, 2009).

Another misconception is that once people decide to die by suicide, there is nothing anyone can do to stop them. In fact, death by suicide can be prevented. Most people who are suicidal do not want to die; they just want to stop their pain (Caruso, 2011). This should give the medical-surgical nurse great hope and encouragement to broach the subject and take the opportunity to make a significant difference in the suicidal person’s life with appropriate intervention (Videbeck, 2011).

Yet another falsehood is that people who want to die by suicide feel that way all the time. While depression is a leading cause of death by suicide, it is a very cyclical illness. According to Dr. Michael Welling, psychiatrist (personal communication, 2005), people generally have personal baselines, where the normal ups and downs of life cause some variation, but return to their usual level of homeostasis (see Figure 1). Then something transpires, whether situational or biochemical, and the person starts down a slope of depression. Part way down that slope is often a phase of higher energy reactions and emotions such as anxiety, anger, insomnia, and irritability. Some people remain at that level; some continue into the lower energy reactions of somnolence, dysphoria, and anergy. There are few people who are deeply depressed all the time. For most people, the depression begins to lift, sometimes because of changed circumstances, getting help and support, starting antidepressant therapy, or biochemical changes. The depressed person once again often passes through the higher energy phase back to his or her usual level of equilibrium.

There is a commonly held belief that people only die by suicide in the lowest depths of depression. In truth, the very depths of depression are often a time of lowest energy. The tremendous strength of will to complete suicide often does not come until after the person begins to come out of the depths of depression. Suicide rates are higher in April, when the spring’s sunshine increases people’s natural energy levels. The rest of a weekend often gives an individual energy to commit suicide on Monday morning. Research indicates the reason there is an increase in suicides after a person starts an antidepressant is due to the increased energy level experienced from the effect of the antidepressant (Videbeck, 2011).

Some people believe you should never ask a person if he or she is suicidal, because just talking about it will give the individual the idea of suicide (Videbeck, 2011). However, asking about suicidal ideation will not make a non-suicidal person become suicidal. Broaching the subject in a kind, compassionate manner gives the person contemplating suicide permission to talk about his or her pain and get the help needed to find less drastic ways to deal with life. Like an abscess in the body, lancing or opening that abscess releases the great pressure and enables deep healing to begin.

The subject of suicide is an even greater taboo in India than in the United States. In the author’s work at a suicide helpline in India, the only tool used was active listening. “You mean all you do is LISTEN? What good does that do?” was the frequent query. A great deal! This author found that genuine listening is rarely done, but is one of the most loving things that can be done for someone. As a call to the helpline would draw to a close, this author often asked how the person felt after talking. “Better!” was almost invariably the response. Releasing that pain very often gives a person new vitality and strength to deal less destructively with the situation at hand. “Sometimes only words are left. When all else fails, when effort comes up short and reason can’t be found,
just talking it out can get you through,” said Sandy Diaz, psychologist at the Connecting Trust Helpline (personal communication, January 2, 2009).

Asking the Question

Although there seems no good way to say it, there are better ways to ask questions about suicide ideation. A medical-surgical nurse’s tone of voice and body language can make a huge difference in the patient’s response. A calm, accepting manner, open posture, and warm, compassionate tone are essential. “You’re not thinking about KILLING yourself are you?” delivered in an aghast tone typically predicates a “No!” answer, whether or not that is the real case. The better way to assess a person at risk may be the use of a question such as one of those listed in Table 1. The suggested questions are not an exhaustive list, but ones the medical-surgical nurse might find helpful to use as a way of approaching this difficult subject.

This writer has found during such conversation, using the client’s own terms or words yields a much more natural transition to the topic of suicide. Shea (2002) advocated for the medical-surgical nurse to assume an attitude of unconditional positive regard toward the suicidal person in order to unobtrusively inquire about the suicidal person’s thoughts and intent which otherwise might not be shared because of shame and guilt.

Medical-surgical nurses should be cautious of euphemisms. “Do you sometimes wish you were in a better place?” might seem as if you are clearly pointing to thoughts of suicide, but the other person may be thinking, “Yes, Aruba!”

Some people do not assess for suicidality because they fear offending the other person. Generally, the responses this author has received when asking the tough questions have been the acknowledgement that the questions indicate concern for the individual being questioned and that the cry for help has been heard. Perhaps the individual is not suicidal right now, but sometime down the road when having a really difficult time, thoughts of suicide intrude. This person will remember that this is a subject one person was not afraid to discuss. And word gets around; he or she may be talking to someone who is really down (teens do this a lot) and he or she may say, “You really need to talk to Pam. Her shoulders are broad; she can handle it.”

What Do I Do with the Answer?

“Yes.” (Oh dear, I was so hoping the answer was “no!”) Horrifying as it is, this person has just given you, the medical-surgical nurse, a great gift – trust. Handle this trust gently and respectfully. Take the time needed to explore those feelings with the person, and then do everything in your power to assist him or her in formulating a plan to get the help and support needed. This should include immediate mental health care or at least placing the person in a safe environment. The medical-surgical nurse should help the person identify and activate the informal support network already available, such as family, friends, and clergy. Once a person acknowledges thoughts of suicide, the medical-surgical nurse must assess more deeply the person’s “death wish.” Table 2 includes further assessment questions regarding the person’s intent for life (Videbeck, 2011).

Table 1.
Suggested Questions For Assessing a Person’s Risk for Suicide

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<th>Question</th>
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<td>Does it feel like you can’t go on without them?</td>
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<td>Have you reached the point of feeling suicidal?</td>
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<tr>
<td>Do you feel like you’ve had enough?</td>
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<tr>
<td>Does it feel pointless to carry on?</td>
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<tr>
<td>Is it all too much?</td>
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<tr>
<td>Has it been so bad you’ve thought about hurting yourself?</td>
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<tr>
<td>Some people that are in such a difficult circumstance as you consider suicide. Have you thought about it?</td>
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People contemplating death by suicide might plead with the medical-surgical nurse not to tell anyone. This is a promise the medical-surgical nurse cannot afford to make. You must assure the patient you will maintain his or her confidence but will also need to provide a safe environment for him or her, which may mean informing others of the individual’s state of mind (Videbeck, 2011). Let the person know as lovingly and warmly as possible that he or she is valued and you can assist in finding alternatives to suicide.

When is a “no” not really a no? Some of the cues that a “no” hides a “yes” are body language, such as looking anywhere but your eyes or a closed posture. When there is hesitancy in the answer, a long pause, “Noooo, not really,” or an

continued on page 12
Why is suicide of concern to the medical-surgical nurse? Patient death by suicide in a staffed 24/7 care setting has been the number one reported sentinel event (Anderson, Ridge, & Latimer, 2007). Individuals contemplating suicide often seek help due to the urging of family and friends. Once a person attempts suicide, he or she is admitted to a general hospital (often on medical-surgical units) for observation and stabilization (The Joint Commission, 2010). The medical-surgical nurse will follow the facility’s policy and procedures for the care of patients who have attempted suicide.

More and more patients are turning to primary care providers for mental health care. Depression is treated with pharmacotherapy, psychotherapy, or a combination of both. It is important to take into consideration the patient’s preferences and what may have helped in the past. An antidepressant medication trial may require between 4 and 8 weeks for the medication to reach a therapeutic level (Sobczak, 2009). Response to psychotropic drugs is highly individual, and some trial and error is often needed. Despite recent press to the contrary, antidepressant treatment is associated with a significant reduction in suicidal ideation and suicide deaths (Mulder, Joyce, Frampton, & Luty, 2008). One must remember the antidepressant may give an individual the energy to commit suicide before the medication is effective in reducing the suicidal ideation (Videbeck, 2011).

Cognitive behavioral therapy (CBT) has also been effective, particularly with adolescents and young adults (Eskin, Ertekin, & Demir, 2008). CBT teaches patients to recognize and overcome ingrained patterns of negative thoughts and behaviors (Harvard Mental Health Letter, 2008). This intervention is primarily implemented by nurses and therapists trained in mental health care.

Suicide Survivors

Suicide survivors are people left behind when someone close to them dies by suicide. It is a painful and terrible place to be. Time alone is not the only healing modality for suicide survivors. Time plus allowing survivors to share their feelings is necessary for growth and healing. Survivors of suicide are consumed with thoughts of “if only…” and “I wish I had known.” Support groups, such as www.survivorsofsuicide.org, have been formed to assist survivors of suicide with healing.

Conclusion

There are many myths that keep thoughts of suicide taboo and hidden behind closed doors. Medical-surgical nurses have the opportunity to be part of the solution by willingly and compassionately exploring thoughts of suicide with those at risk and assisting them in finding alternatives to suicide.

References


Pamela Stacy, RN, BSN, LCSW, is a Nursing Instructor, Ivy Tech Community College, Columbus, IN. She was also an instructor, mentor, and volunteer for Connecting Trust, a suicide helpline in Pune, India.

Editor’s Note: May is National Mental Health Awareness Month. Please see page 14 for a personal story from an AMSN member regarding mental health, depression, and thoughts of suicide. Thank you to Sheila Hill for sharing her experience with fellow medical-surgical nurses.

A related article on the topic of suicide entitled, “After an Attempt: Caring for the Suicidal Patient on the Medical-Surgical Unit,” will appear in the August 2011 issue of MEDSURG Nursing, the official journal of the Academy of Medical-Surgical Nurses.
Instructions For Continuing Nursing Education Contact Hours

Suicide: A Permanent Solution to An Often Temporary Situation

Deadline for Submission: June 30, 2013

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1. For those wishing to obtain CNE contact hours, you must read the article and complete the evaluation through the AMSN Online Library. Complete your evaluation online at www.amsn.org/library
2. Upon completion of the evaluation, a certificate for 1.1 contact hour(s) may be printed immediately or later.

Fees

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Objectives

The purpose of this continuing nursing education article is to increase the awareness of treatment modalities for and myths surrounding suicide in nurses and other health care professionals. After studying the information presented in this article, you will be able to:

1. Define suicide and indicate its affect on health care and nursing.
2. Identify several myths surrounding the topic of suicide and explain why these theories are inaccurate.
3. Discuss ways in which nurses can approach the topic of suicide with patients in a sensitive way.
4. Explain treatment modalities available to patients considering suicide.

Note: The author, editor, and education director reported no actual or potential conflict of interest in relation to this continuing nursing education article.

This educational activity has been co-provided by AMSN and Anthony J. Jannetti, Inc. Anthony J. Jannetti, Inc. is a provider approved by the California Board of Registered Nurses, provider number CEP 5387. Licensees in the state of CA must retain this certificate for four years after the CNE activity is completed.

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Flex Your Benefits: Get Picky!

One of the valuable benefits of being an AMSN member is involvement in your local chapter. Many members have been rewarded through the educational programs, networking, and leadership opportunities they experience with their local chapters.

When there is more than one chapter in your area, you are given the flexibility to belong to the chapter of your choosing. You can opt to move to one that is closer, more familiar, or just starting. Simply make changes in your online profile at www.amsn.org or send an email to amsn@ajj.com.
I have been a nurse for 28 years and nursing has been such a blessing in my life. What a lot of my colleagues do not know is that I suffered from a major depressive disorder most of my life. Nurses, as well as the public, often misunderstand the severity of mental health illness.

For many years, I lived in a dark world which only those who suffer from the same illness would understand. I had been on almost every medication possible and was in therapy on and off for years. My depressive disorder made me feel like I was walking around with a pair of sunglasses on 24 hours a day. Do you know what it feels like to live in darkness every day? It takes over your brain to the point that you truly want to take your own life. Your mind is in a constant battle between good and evil. One part says, “It’s OK to take your own life,” and the other part says, “Don’t even think about it.” The pain was taking control of me.

As a nurse, imagine for a moment what a person who is suicidal could be feeling. You can have everything you could ever ask for; but to live in the dark every day is more painful than you may imagine. It takes everything to get out of bed. You have so many feelings of despair, hopelessness, worthlessness, sadness, and numbness. It is truly a battle of the mind to stay alive.

So what kept me from ending it all and taking a bunch of pills, buying a gun, or pulling out in front of a tractor trailer? How did I go from darkness to living life? It was a spring evening and I was driving down the road on one of my worst days, and I was ready to end my life. What stopped me? God! It was then I knew I needed to make a life or death choice. I chose life! Here I was...a Christian, a mom, a wife, a sister; a daughter; an aunt, a friend, a nurse, and many other things. I had a great job, a beautiful home, a new car, and I was loved by so many. Why would I want to take my own life?

I went to see my physicians and went through something I thought I would never submit to – a series of treatments called electroconvulsive therapy (ECT). I was so afraid undergoing this treatment would ruin my career. It was one of the most difficult months of my life but also one of the best. After my first treatment, the suicidal thoughts were gone. After the second treatment, my depression began to lift.

When I completed my ECT treatment, the recovery was an overwhelming experience for me and my family. I had periods of confusion and short-term memory loss. My mind felt like it was in a fog for a couple of weeks, but when the fog was lifted, it was the first time in years I hadn’t felt depressed. After years of medication and therapy, ECT was what worked best for me.

I see things differently now: the flowers, trees, clouds, sunrise, and sunset – such lightness and beauty. I have been given a second chance in life. I am beginning to see so many things as I have never seen them before. Life is beautiful!

As a nurse, I want to thank my colleagues and my family for being by my side and for their love and support. Because of them, I am living proof that it is possible to move from the darkness and into the light.

Sheila Hill, RN, CMSRN
Stephens City, VA
Winchester Medical Center

Editor’s Note: Visit http://www.nimh.nih.gov/health/topics/brain-stimulation-therapies/brain-stimulation-therapies.shtml to learn more about ECT. Treatment options and results vary, so speak to your doctor about what’s best for you.
For a number of years, Nurses Nurturing Nurses (N3) has been an important program offered by AMSN. Over the past few years, it has been more of a challenge to maintain the mentoring dyads. The board asked a task force, chaired by Cece Gatson Grindel, to evaluate the N3 program and make recommendations for future activities. The task force affirmed the importance of the mentoring relationship. This is consistent with some of the Future of Nursing recommendations. The form that mentoring will take in this work is yet to be determined. While the mentoring relationship is valuable, the task force recommended the current N3 program be phased out. This was not an easy decision by the task force or the board; however, it seems to be the best decision at this time. The materials used within the N3 program continue to have value, but are in need of updating. The board will convene a group to do this work in the near future. The task force made a number of other recommendations related to clinical leadership, mentoring, and residency programming. The BOD will consider these as the work regarding the Future of Nursing continues.

The Nominations Process Task Force, chaired by Kathleen Singleton, convened to consider the methods used to assess and evaluate potential candidates for the AMSN BOD. Through the ongoing development of the board, we’ve learned the importance of selecting the best candidates for positions on the board. The board also wanted clarity and transparency in the process used. Much of the work regarding the selection process was used in the current election cycle. The task force made additional recommendations that are under consideration by the board.

A Call to Members

The two days of the winter board meeting were packed with many other topics and discussions. There is much ahead for AMSN which will require many volunteers to complete the work; we will be asking you to join us in these endeavors. Additional task forces will be formed in the spring and summer. Task force work is short-term and the majority of the work is done through email or conference calls. In our calls for volunteers, we are working to identify the skill set needed for the task force to most efficiently and effectively accomplish the parameters of its work. Please review our future calls for volunteers and carefully consider how you best fit with the skills required.

Approaching the winter BOD meeting, I knew the work would require a lot of mental and physical energy from the board. They were up to the challenge and much work was accomplished in leading AMSN into the future. I am proud to have the opportunity to work and lead this group.

Sandra D. Fights, MS, RN, CMSRN, CNE
AMSN President
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