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NURSING CARE FOR PATIENTS AT RISK OF SUICIDE

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ABSTRACT
This study aimed to identify actions of nursing care to patients at risk of suicide hospitalized in a Psychiatric Internment Unit of the South of Brazil. This is a qualitative, descriptive study. Data were collected between October 2013 and March 2014, through interviews with 20 nursing professionals at the Unit. In the analysis of the interviews, it was observed that the nursing care for patients at risk of suicide is basically centered on the formation of bonds, the establishment of therapeutic contract with the patient and the organization of the staff's care routines. Linking and establishing a therapeutic contract are part of the more unique care, carried out by both technicians and nurses, in order to better understand patients' life experiences and to help them in dealing with the risk of suicide. Regarding the organization of routines, the nurse is responsible for this process, so that the bond and the therapeutic contract become effective in the daily hospitalization. It is concluded that assistance to patients at risk of suicide has specificities. It should be emphasized that the data obtained allowed the construction of an institutional protocol for the evaluation of suicide risk, which is being used by the nursing team of the hospitalization unit studied.

Keywords: Psychiatric Nursing. Mental health. Suicide. Hospitalization. Nursing team.

INTRODUCTION

Suicide has been considered a serious public health problem because over the past 45 years the worldwide suicide rate has increased by 60%. The World Health Organization (WHO) has estimated that every day a contingent of more than 2,000 people end their life, so suicide is the second most frequent cause of death among people between the ages of 19 and 25[1]. Among the risk factors for suicide we may include psychiatric illness, substance misuse, poor socioeconomic conditions, residence in rural areas and single marital status[2].

In relation to Brazil, there is a significant increase in suicide rates in the North and South regions of Brazil, and the Rio Grande do Sul index is almost double the national average. In some localities within the state and in some population groups, such as farmers, the coefficients far exceed the national average, ranging from 15 to 30 cases per 100,000 inhabitants[3]. Despite this, data on suicide attempts are inconsistent, estimated to be 10 to 40 times greater than suicide deaths[4].

In 2013, the World Health Organization developed a Plan of Action on Mental Health, with targets to be implemented by 2020. Among the actions advocated in the plan are those specific to suicide prevention. It's highlighted the strengthening of leadership and governance in the context of mental health, greater provision of community services, both social assistance and specific mental health services, with the respective offer of actions articulated to them and strengthening the Health information systems[5].

It is considered, in this context, the importance of the worker in mental health, both in the provision of specific actions aimed at the prevention of suicide and in the possibility of organizing the care according to the demands presented by the users of the services. In this sense, nursing plays a fundamental role in the construction of concrete proposals for actions aimed at improving the quality of life of the individual who thinks about suicide, avoiding that the suffering caused by the issues of life leads the subject to commit the act itself.

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Within the actions of nursing in mental health, it is possible to mention the use of the nursing process, as an instrument of qualification of the nurse's clinical practice. Regarding the nursing diagnosis of "suicide risk", aspects such as psychiatric illness, family history of suicide, gender, age, among others, are fundamental in the classification of the risk presented by the patient and in the installation of preventive measures[6].

However, it is important to consider that the care actions developed by the nursing team to the patient at risk of suicide also involve a daily life surrounded by the professional's personal questions, which can also cause difficulties in the process of identification and classification of patients. In this sense, self-knowledge about emotions may contribute to the management of patients with this risk[7].

In view of the above, the present study aims to identify nursing care actions implemented to patients at risk of suicide hospitalized in a Psychiatric Hospitalization Unit. Through the knowledge of the care actions that the nursing team develops there will be the possibility of improving the clinical practice, in order to qualify the care provided in the hospitalization unit.

METHODOLOGY

This study is a cut-off of the development project "Risk Assessment of Suicide in Patients of the Psychiatric Inpatient Unit of the HCPA", which culminated in the elaboration of an institutional protocol focused on the training of the nursing team towards the patient with risk of suicide, making possible the improvements in care through knowledge about the issue of "suicide".

This is a qualitative, descriptive study developed in a Psychiatric Hospitalization Unit of a municipality in the South of Brazil which is a reference in the city and state and receives patients with acute psychic suffering. It is composed of 36 beds, 26 of them are accredited to the Unified Health System and 10 destined to Supplemental Health Plans and private hospitalizations.

For a characterization of the sociodemographic profile of hospitalized patients, a medical records survey of adult patients admitted to the Psychiatric Inpatient Unit was carried out over a period of six months. From that point on, the presence of the Nursing Diagnosis "Risk of Suicide" was found in 61 medical records.

The access to medical records was done with authorization from the Medical File Service (SAME) of the Hospital. In the specification of the authorization request, there is the title of the project, period (01/10/2013 to 03/31/2014), the filter "Psychiatric Internment Unit" and the columns to be retrieved: Name; Number of records; Age; Sex; Civil Status and Nursing Diagnosis. These data enabled the characterization of patients with a nursing diagnosis of "suicide risk".

From the 61 charts analyzed, 34 were female (55.7%), 35 were single, followed by married (19 patients) and the mean age was 42 years-old. The mean length of hospital stay was 28.67 days.

For this study, we used data collected through interviews with 20 of the 35 nursing professionals who work in the Psychiatric Internment Unit. As inclusion criterion, it was used as a professional of the nursing team of the Psychiatric Inpatient Unit for more than a year, time required for the professional to know the institutional routines and to acquire technical experience in the management of psychiatric patients. Nursing staff professionals who were certified for more than 15 days or who were on special leave or vacations during the period of data collection were excluded.

The interviews were carried out from October 2013 to March 2014, in a place reserved at the unit. They were recorded, with the subsequent transcription in full of the discursive content. They were previously scheduled with the professionals and collected by one of the researchers who are members of the project. During the interviews, the following guiding question was applied: What care actions do you perform when you are under the responsibility of a patient at risk of suicide?

The transcribed data were submitted to the analysis by categories, while one of the techniques of the content analysis that works by operations of dismembrane of the text in units. There are three phases of content analysis: pre-analysis, material exploration and treatment of results, with inference and interpretation[8]. The results of the application of these phases generated three categories of qualitative data: the formation of links, the establishment of a therapeutic contract with the patient and the organization of the team's care routines.

In the development of the study, ethical aspects regarding research involving human beings were observed, in accordance with Resolution 466/2012 of the National Health Council and its project was approved by the Research Ethics Committee of the Hospital de Clínicas of Porto Alegre (Opinion No.

353,995, CAAE 16546213.4.0000.5327). All participants signed the Free and Informed Consent Term to guarantee their anonymity. They are identified only with the letter "E", followed by a number corresponding to the order of the interview, for example: E3.

RESULTS AND DISCUSSION

From the 20 professionals under study, eight were nurses and 12 nursing technicians, and who are ranging from 28 to 67 years-old.

In the analysis of the data, it was possible to visualize important questions about nursing care actions against patients at risk of suicide hospitalized in a Psychiatric Hospitalization Unit, which gave rise to the three categories identified: bond formation, establishment of therapeutic contract with the patient and organization of the team's care routines.

It is worth remembering that the establishment of therapeutic bonds and contracts are independent of the degree of professional formation, since they are closely related to knowledge of life and oneself as subject. They are more singular, relational elements of the care process, while the organization of practices is a private activity of the nurse, as supervisor of the process of nursing care. In this sense, in the first two categories, testimonies of nurses and nursing technicians are presented; in the last, only testimonies of nurses.

Bond Formation

In the area of health, more specifically mental health, the link is the result of the quality of the encounter between the professional and the worker, so it is one of the most powerful care technologies in health work. At the moment of establishing links, it is possible to obtain broader understandings about the health / illness process and the actual health needs of the subject. If the link can, on the one hand, rebuild relationships, sometimes verticalized from a biomedical model perspective, on the other hand it also presents challenges in the organization of services and practices, once it is definitively incorporated into the work process of the teams[9-10].

It is understood that in the course of the nursing care process, the bond becomes the best possibility to deepen aspects related to the life history of people in mental suffering (the functioning of the patient, family, circle of relationships, what he likes or not to do, etc.). This means that the power of the meeting not only highlights the professional's willingness to take better care, but also qualifies the clinical practice of the nursing team.

During the interviews, at a first moment, nursing professionals understand that in regard to patients at risk of suicide, it is necessary to show interest and willingness to listen to them, using the link as a fundamental strategy to consolidate affective bonds. For this, it is necessary to be together, to know their anguishes and feelings, to insert them more in the individual and group activities of the unit:

> We take them out of isolation, they have to stay in our place, they have to stay with us, and they have to participate in everything [...]. I try to leave them nearby to create a link. (E1)

> The bond is very important to let them to talk to us, to start unburdening. We let them to tell us [...] all feelings, and other more individualized care. (E4)

> [...] we call them closer, [...] to be always careful about the situation [...]. I try to bring them into the environment. (E7)

It is observed that the formation of links, regardless the technical level of the training, is capable of producing health at the moment of deepening aspects related to the patients' life context. It is in the link that the act of caring materializes, as E4 affirms, even more in the case of patients at risk of suicide, who, with chronic clinical conditions and previous suicide attempts[11-12], have, in the same way, life stories marked by isolation, social rejection and exclusion.

From the link, nursing professionals also understand the importance of investing in the quality of the interpersonal relationship, as a way of improving clinical practice, which also facilitates patient adherence to treatment. This is what is observed in the following reports:

> The staff is very attentive [...]. We try as much as they can verbalize their ideas so that they can expose what they are really feeling. (E17)

> [...] I always try to ask how he is, if he is sad [...]. It moves me to always try to keep watching. (E2)

> [...] I ask him to come closer and [...] do agreement with the patient so that we can pay more attention. (E10)

For the mental health care of the patient at risk of suicide, the creation of an atmosphere that favors the establishment of the bond is a fundamental requirement that will determine the quality of the bond. E2 and E10, for example, always ask that the patient at risk of suicide to be closer, while it is

possible to reflect that only the approximation is not enough to produce care, since it needs to invest in stimulating the patient's expression, as affirmed E17.

It is well known that in the face of the coexistence of divergent desires and attitudes that capture this patient's stalemate about his life, the bond is an attempt to establish a connection with a subject who already feels disconnected from our world. Challenges that intend the teams to rethink their work processes, towards a practice increasingly focused on the subject and his history.

Establishment of therapeutic contract with the patient

In the perspective of contemporary mental health, focusing on the exercise of citizenship and the autonomy of psychiatric patients, it is necessary to restore the social relationship lost through centuries of exclusionary treatments and segregators, typical of traditional institutions. In this case, the process of recovery of the psychiatric patient starts from the reestablishment of contractual power, that is, from the effective valuation of their desires and needs as members of therapeutic projects focused on social insertion[13].

The development of a therapeutic contract is a continuation and consolidation of the formation of bonds with the patient, in which the reciprocal intention of understanding the life histories is maintained. Thus, it is possible to design and delimit care, always focused on the needs presented by the patient and on the productions of subsequent encounters[14]. This means that the therapeutic contracts are configured as pathways through which the patient, as well as the mental health team and the social support network are involved and committed[15].

Nursing professionals report the actions of caring for patients at risk of suicide, presenting the therapeutic contract as a strategy to establish care commitments that involve not only active listening, but also the first concrete clinical practices to deal with the desire of suicide by the patient:

> I talk to him, I see how he's feeling, to understand his sadness, to understand his suicidal ideation, and I try to make a verbal contract. It's really cool because it works. (E20)

> [...] To do agreements, for him to ask for help when he is feeling sad, distressed, or out of control, with guilt. (E1)

> To observe better, their conduct [...] You have to stay alert, to listen, to talk, because sometimes he speaks more with the nursing team [...]. You come and be able to build together with the patient. (E13)

The reports show that the therapeutic contract, even from the verbal point of view, helps in systematizing the care and clarity of the patient in relation to his anguish and experiences that lead him to desire for suicide. By means of combinations constructed with the person at risk of suicide, nursing professionals institute actions permeated by active listening and observation, as components of a care process focused on the individual's understandings and singularities.

In this context, the nursing team is constantly confronted with the process of death and dying and lives with patients suffering, pain, fear, helplessness, hopelessness and loss of various kinds. This contact is an excellent opportunity for professionals to identify the seriousness of the risk of suicide and, at the same time, to minimize it, as observed in the reports:

> The first care is to stay calm [...], stay close, and agree with the patient. (E8)

> [...] by seeing if he can ask us for help [...]. Watching, staying close, and seeing if he can divert those thoughts. (E16)

> Put him near the window (post) or at the door, which we see or be in the hall where we can see all the time. (E12)

Each professional seems to realize the importance of team-patient conciliation as a therapeutic strategy in mental health for the reduction of suicidal ideation. Investing in the continent place, but welcoming, can strengthen flexible relationships, based on a more open dialogue about the patient's feelings and about the problem that involves the interest in suicide[16]. In this context, it is understood that the therapeutic relationship is an essential tool that forms bonds, but to become a therapeutic project in which the patient is a protagonist, must incorporate systematic combinations on behaviors, limits and observation of patients' actions.

Thus, the care of these patients demands the preparation of nursing professionals, insofar as the care in mental health runs through the drug administration and the enforcement of rules, being recognized as an individual and collective process that covers contexts, stimulates the protagonism and produces subjectivity. Thus, it is also necessary that the nursing team is sensitive to the organization of their practices, necessary to allow the approach and

sensitive listening of patient.

Organization of the team's care routines

In the mental health care network, the complexity of mental health demands suggests that there is a link between the care devices in order to build practices focused on the needs presented by the patient. In such cases, it is necessary that health teams are organized to receive the various demands related to suffering[17].

Psychiatric hospital admission units in a general hospital, within the service network, are strategic units for dealing with psychiatric emergency situations, such as suicide risk. Once there is an imminent risk of death, health teams, and especially nursing teams, should consider the importance of physical space and direct actions with the patient within the care routines [17].

The testimonies mention the importance of the team's organization as a mental health care action for patients at risk of suicide:

> [...] we have a unit routine of removing objects around the patient that can cause (suicide). No patient enters with a belt, [...] with a blanket, a scarf. When there is a patient at greater risk, we remove shoelaces from sneakers. (E4)

> [...] It is necessary to have more attention, any detail already signals. We also take care of the patient when he goes to the refectory; takes a knife, a fork, a razor, everything that is a sharp thing [...], we stay close, take care, observe ..., ask how is the thought today, how he slept. (E9)

> We watch over more, take care more, take some objects he can get hurt, try to leave the environment cleaner. We look at him more closely, try to bring him closer to the team, talk to him more, we have to take care. (E14)

> Constant vigilance, we get medical duty, we see where they are, always know where the patient is, what he is doing, if he is more isolated, if he is more in the environment. (E15)

In front of the reports, we can observe the organization of the team in the care of patients at risk of suicide, which involves the establishment of routines, relaying on periodic observation, as well as the care in the use of particular utensils in the psychiatric hospitalization environment. It is in this sense that the organizational dimension is connected as a caring tool, which must be aligned with the nursing work process and the other professionals that make up the multidisciplinary team. This is what the E3 report seems to point out:

> [...] to clarify for the team the severity of the risk so that we can do this supervision. (E3)

Within the organizational dimension of the nursing team, nurses emphasize the importance, in the first place, of understanding the severity of the risk, which involves prior knowledge of the patient's previous history and which will accompany the treatment lines during hospitalization.

In addition, nurses mention other actions within the hospitalization environment, such as constant surveillance, withdrawal of potentially dangerous objects and the systematic supervision of nursing work, in order to follow the quality of meetings and contracts with patients. This is a challenge to the nursing team, in the sense that it is important to consider care as the centrality of nursing work and the multiple dimensions that involve it[18].

Given this, nurses play a fundamental role in the organization of the nursing team, since ties and contracts are not established if we do not maintain a minimal routine of care organization. In this way, it becomes possible for nurses to have a more global clarity about their work process and for their team, providing a better quality of patient care.

In these cases, the shift on duty becomes the propitious environment to build a safe care by the nursing team. E15, for example, cites the need to know the patients at risk to keep them closer to the team. It is understood that, in this way, the patient is not lost within the different work routines, besides being a more structured moment of transferring important technical information about the health status of the patients.

The professionals' accounts lead us to believe that there must have an agreement between the patient's mental health needs and the organization of care routines and practices so that it is possible to offer a differentiated and safe care within the limits of psychiatric hospitalization. Even though it is an environment full of rules and very precise routines, without great flexibilities, it is possible to do different. For this, formation of links, establishment of therapeutic contracts, all based on active listening and direct contact with the patient and his/her world, are fundamental actions for the patient to feel welcome and participant in their therapy.

Therefore, it should be noted that the organization of the team as well as the formation of a link and the therapeutic contract are characterized as care actions for patients at risk of suicide within

the psychiatric unit, since they facilitate the production of an environment in which the patient can express themselves, participate in their treatment and develop autonomy. Faced with this, these characteristics of care actions show how important the understanding becomes of what this patient needs; the investment in the interpersonal relationship between the professionals, and the patients throughout the therapy; and the use of the Psychosocial Attention Network (RAPS) to conceive a care in mental health unrestricted to psychiatric hospitalization, in which the arousal of the social context invigorates actions in health tied to the anxieties of each patient.

FINAL CONSIDERATIONS

From the categories that emerged from the analysis of the data, care actions of nursing professionals were identified to patients at risk of suicide in the investigated context. In the midst of the speeches of these professionals, three main axes characterize the bulge of these care actions: 1) bond formation; 2) establishment of therapeutic contract with the patient; 3) organization of the team's assistance routines.

The adoption of the results of this research in the nursing care of a psychiatric hospitalization unit promoted, in this scenario, the production of an institutional protocol for suicide risk, which is being used by the hospital where the research was carried out. The aforementioned protocol, appropriate to the contributions of the nursing team (technicians and nurses) and materialized in this study, made it possible to systematize the process of suicide risk assessment to hospitalized patients, as well as being a tool for rapid nursing application.

However, the limitations of this study regarding the characteristics of the participants and the scenario investigated should be considered, although it is understood that the results point to some contributions to rethink the daily practice of nursing care in mental health, in the context of psychiatric hospitalization.

CUIDADOS DE ENFERMAGEM A PACIENTES COM RISCO DE SUICÍDIO

RESUMO

Este estudo teve como objetivo identificar ações de cuidado de enfermagem ao paciente com risco de suicídio internado em uma Unidade de Internação Psiquiátrica do Sul do Brasil. Trata-se de um estudo qualitativo, descritivo. Os dados foram coletados entre outubro de 2013 e março de 2014, por meio de entrevistas com 20 profissionais de enfermagem na referida Unidade. Na análise das entrevistas, observou-se que os cuidados de enfermagem a pacientes com risco de suicídio são centrados basicamente na formação de vínculos, no estabelecimento de contrato terapêutico com o paciente e na organização das rotinas assistenciais da equipe. Formação de vínculos e estabelecimento de contrato terapêutico fazem parte do cuidado mais singular, exercido tanto por técnicos como por enfermeiros, no sentido de conhecer melhor as experiências de vida dos pacientes e ajudá-los a lidar com o risco de suicídio. Em relação à organização das rotinas, cabe ao enfermeiro esse processo, de forma a oportunizar que o vínculo e o contrato terapêutico se efetivem no cotidiano da internação. Conclui-se que a assistência aos pacientes com risco de suicídio possui especificidades. Ressalta-se que os dados obtidos possibilitaram a construção de um protocolo institucional para avaliação do risco de suicídio, que está sendo utilizado pela equipe de enfermagem da Unidade de Internação estudada.

Palavras-chave: Enfermagem Psiquiátrica. Saúde Mental. Suicídio. Hospitalização. Equipe de Enfermagem.

CUIDADOS DE ENFERMERÍA A PACIENTES CON RIESGO AL SUICIDIO

RESUMEN

Este estudio tuvo como objetivo identificar acciones de cuidado de enfermería al paciente con riesgo al suicidio ingresado en una Unidad de Internación Psiquiátrica del sur de Brasil. Se trata de un estudio cualitativo, descriptivo. Los datos fueron recolectados entre octubre de 2013 y marzo de 2014, por medio de entrevistas con 20 profesionales de enfermería en la referida Unidad. En el análisis de las entrevistas, se observó que los cuidados de enfermería a pacientes con riesgo al suicidio son centrados básicamente en la formación de vínculos, en el establecimiento de contrato terapéutico con el paciente y en la organización de las rutinas asistenciales del equipo. Formación de vínculos y establecimiento de contrato terapéutico hacen parte del cuidado más singular, ejercido tanto por técnicos como por enfermeros, en el sentido de conocer mejor las experiencias de vida de los pacientes y ayudarlos a lidiar con el riesgo al suicidio. Con relación a la organización de las rutinas, cabe al enfermero este proceso, a fin de llevar a cabo que el vínculo y el contrato terapéutico se efectúen en el cotidiano de la internación. Se concluye que la asistencia a los pacientes con riesgo al suicidio posee especificidades. Se destaca que los datos obtenidos posibilitaron la construcción de un protocolo institucional para evaluación del riesgo al suicidio, que está siendo utilizado por el equipo de enfermería de la Unidad de Internación estudiada.

Palabras clave: Enfermería Psiquiátrica. Salud Mental. Suicidio. Hospitalización. Equipo de Enfermería.

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