Status Active PolicyStat ID 14501175

Suicide Risk Assessments and Treatment Guidelines

PURPOSE:

To provide protection and a safe environment for the patient at risk for suicide.

RESPONSIBLE STAFF:

Registered Nurses (RN), Certified Nursing Assistant (CNA), ED Tech, Licensed Independent Practitioner (LIP), Behavioral Health Clinicians (County Designated Mental Health Provider)(BHC)

DEFINITIONS:

- Behavioral Health Clinician – a licensed psychiatrist, a licensed psychologist, a certified nurse practitioner with a specialty in psychiatric mental health, or any clinician whose authorized scope of practice includes mental health diagnosis and treatment
- Behavioral Health Assessment – an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.
- Qualified Observer - a designated Good Shepherd Staff Member who has received training on safety interventions for patients at risk for suicide and the role of the observer.

PRACTICE GUIDELINE:

A. SCREENING FOR SUICIDE RISK

1. Upon arrival to the emergency department (ED) and/or inpatient unit, all patients 10 years of

age and older will be screened by a RN for suicide risk using the Columbia Suicide Severity Rating Scale (C-SSRS). (See Appendix A&B).

2. The RN will document findings in the electronic health record and notify the LIP if patient is screened to be at moderate or high risk for suicide. The LIP on duty is responsible for assessing and directing the patients care while in the ED. The LIP will work with the multidisciplinary team to ensure all patients receive appropriate treatment and disposition.
    a. Patients will not be re-screened using the C-SSRS upon transition of care to a new department. i.e. transfer from ED to an acute care unit unless there is a change in clinical status that warrants re-screening.
3. Interventions are initiated based on C-SSRS risk stratification.
    a. Consider initiating high risk suicide precautions based on clinical presentation, behaviors, and/or timing of suicidal thoughts or actions regardless of screening score.
    b. Patients screening may be deferred or not performed if the patient is unable to respond due to alteration in level of consciousness or impaired cognition. Reason for deferments must be documented.
    c. All patients will be offered a copy of the Treatment Rights (Policy T-100).
    d. All patients age >/10 will be encouraged to identify a lay caregiver to assist in the patients care plan and discharge planning. Identification of a lay caregiver will be documented in the electronic health record (EHR).

INTERVENTIONS FOR PATIENTS AT LOW SUICIDE RISK

1. If the patient is screened to be at low risk, information about resources for suicide will be provided. A referral to behavior health or their primary provider considered. Additionally, a BH assessment may be warranted and will be ordered by the LIP.
2. Education on recognizing suicide warning signs will be provided.
3. Information about resources for suicide prevention will be provided.
4. Consider an outpatient referral to behavioral health or the patient's primary provider.

INTERVENTIONS FOR PATIENTS AT MODERATE SUICIDE RISK

1. Initiate hourly rounding.
    a. A brief check-in with the patient, performed by any member of the clinical team completed approximately every 60 minutes to ensure safety and location of the patient on the unit.
    b. Observe the patient for activities of self-harm. If any behaviors are observed, initiate high suicide risk interventions and notify the provider.
2. Initiate a request for a behavioral health assessment for all patients at moderate risk.
    a. A behavioral health assessment is completed by a behavioral health clinician using an evidenced-based process which includes information about suicide ideation, plan, intent, suicidal, self-harm behaviors, risk factors, and/or protective factors.
    b. Once a behavioral health assessment is complete, the results will be communicated

with the care team with recommendations both hospital and discharge suicide risk management plan.

c. Orders for ongoing suicide risk management will be modified, discontinued, or maintained based on assessment and plan.

d. A LIP/PA may complete a focused assessment to determine the imminent risk for suicide while awaiting behavioral health assessment. (See Appendix C). A LIP/PA order is required to decrease or discontinue the suicide risk interventions.

3. Ongoing assessments for all patients at moderate risk will be completed by the RN.
    a. The RN will assess the patient for ongoing suicidal thoughts or actions and safety each shift and will communicate any changes to the care team.
    b. The LIP/PA or behavioral health clinician will perform an ongoing assessment of the patient and may modify the patients risk status if they feel that the patient's in-hospital risk has changed.
    c. Prepare for safe discharge
        a. Education on recognizing suicide warning signs will be provided.
        b. Information about resources for suicide prevention will be provided.
        c. Consider an outpatient referral to behavioral health or the patient's primary provider.

INTERVENTIONS FOR PATIENTS AT HIGH SUICIDE RISK

1. Place the patient in a safe location
    a. Immediately room the patient
    b. Room 8 will be utilized whenever possible for ER patients.
    c. If room 8 is not available, consider the location of patient room to allow for constant observation and limited access to exits as able.
2. Assess and remove at risk items that will not adversely affect the patient's medical care.
3. Address all items on the room safety checklist: remove any items that could be used as a weapon. (See Appendix D).
4. Replace sharps containers if more than 3/4 full.
5. Only the medical equipment that a patient needs constantly should remain in the room. Close observation of the patient will allow for observation of potentially unsafe equipment that is necessary. Other equipment should be in the room only when in use.
6. The room safety checklist should be reviewed every shift and kept outside the room for review. Documentation of initial completion in the EHR and updated anytime there is a room change.

    KEY POINT: *A bell or alternative should be used in place of a call light cord for moderate and high suicide risk patients.*

7. Assess and remove

a. If patient's clothing has not previously been removed:
    i. Explain the purpose for clothing and personal belongings check.
    ii. Request patient to remove all layers of clothing, including socks and shoes.
    iii. Place patient in hospital paper scrubs.
    iv. Assist with clothing removal when the patient is unable to follow directions or refuses to cooperate.
    v. Safe items may be returned to the patient after inspection. All other belongings should be kept secure until a behavioral health assessment is performed and it is determined that items can be returned to the patient.
    vi. Documentation of the patients belongings should be completed in the Patient Belongings Flowsheet and stored in a secure area.

KEY POINT: *Assistance by Security may be needed during involuntary clothing removal. At least one member of the hospital staff of the same gender as the patient should be present in the room during involuntary clothing removal.*

KEY POINT: *Be careful when examining patient clothing for items that are potentially harmful (for example, knives, needles, or toxic substances).*

8. Initiate one to one observation with a qualified observer.
    a. Close observation order will be obtained and ordered by the physician in the EHR.
    b. Describe and explain the reason for one to one observation to patient. Emphasize that staff are there to help the patient maintain personal safety.
    c. Observation will continue until discontinued by the LIP/PA.
    d. **Family or visitors may not be used as observers for patients at HIGH risk for suicide.**
    e. The observer must be close enough to intervene at all times and maintain line of sight. If the patient is actively engaging in self-harm activities, then the observer will remain within arm's reach of the patient and be ready to intervene.

    KEY POINT: *The only exception to being outside of the required distances is when it is unsafe for a staff member to be that close to a patient because the patient's current behavior is threatening the safety of staff. In these instances, the 1:1 observer will remain at a safe distance from the patient while still maintaining direct line of sight at all times. Clear documentation must be present to demonstrate the violent behavior.*
    f. Supervise patient's bathroom use:
        i. Accompany the patient to bathroom and provide the appropriate level of surveillance/observation to maintain staff and patient safety.
        ii. As possible, when the bathroom is not in use, keep bathroom door locked from the outside to ensure that patient does not have access until observed.

KEY POINT: *Remain facing the patient and avoid letting the patient get between you and the door.*

g. One-to-one observation should be continued by a qualified observer during transport to another unit (e.g. nursing unit, imaging, or procedural area).

h. Observe patient for manipulation of medications, IVs, and treatments:

    i. Observe medication ingestion to ensure that the patient swallows' medication. Consider giving medication in liquid form rather than tablets, which may be saved or concealed by the patient.

i. If the patient actively engages in self-harm, call for help and intervene as able to prevent harm.

    i. Notify provider

    ii. Assess the ability to further mitigate environmental risk or situation to prevent further self-harm

    iii. Document and review during hand-off

9. Initiate a request for a behavioral health assessment for all patients at high risk.
    a. A behavioral health assessment is completed by a behavioral health clinician using an evidenced-based process which includes information about suicide ideation, plan, intent, suicidal, self-harm behaviors, risk factors, and/or protective factors.
    b. Once a behavioral health assessment is complete, the results will be communicated with the care team with recommendations for ongoing suicide risk management plan
    c. Orders for ongoing suicide risk management modified, discontinued, or maintained based on assessment.

10. A LIP/PA may complete a focused assessment to determine imminent risk for suicide while awaiting behavioral health assessment (See Appendix C). An LIP/PA order is required to decrease or discontinue suicide risk intervention.

11. Monitor visitors
    a. Visitors will be limited to ensure that the safe environment can be maintained.
    b. Visitors may be asked to leave unsafe items outside of the room prior to visiting. Instruct visitors not to leave personal items.
    c. The observer will also watch the visitors to ensure the safe environment is maintained.

12. Maintain other safety precautions as necessary:
    a. Be alert to the possibility of patient obtaining or concealing medications or dangerous objects from other patients, visitors, or environment that could be used for self-harm.
    b. Safety utensils should be used. This request can be included in the patient's diet order.

c. Avoid leaving portable equipment in and around the area.

13. Ongoing assessments
    a. The RN will assess the patient for ongoing suicidal thoughts or actions and safety each shift and communicate any changes to the care team.
    b. The LIP/PA or behavioral health clinician will perform ongoing assessments of the patient and may modify the patients at risk status if they feel that the patient in-hospital risk has changed.
    c. Communicate any changes in the patient's condition during hand-off procedures.

B. DOCUMENTATION

1. **High Risk:**
    a. Document psychosocial assessment on suicidal thoughts and behaviors every shift in EHR.
    b. Document patient behaviors, interventions, and safety every hour in EHR (RN or Tech)
    c. Document in the room safety checklist flowsheet section every shift in EHR (RN or Tech).
2. **Moderate Risk:**
    a. Document psychosocial assessment on suicidal thoughts and behaviors every shift in EHR.
    b. Complete documentation on hourly rounding approximately every hour-activity, room check, patient observation and suicide precautions (RN or Tech).
3. A LIP/PA may complete a focused assessment to determine imminent risk for suicide while awaiting behavioral health assessment.
4. Record objective and subjective measurements.
5. Record communications with attending LIP, behavioral health clinician, and psychiatric liaison consult in progress notes of EHR.
6. Document completion of room preparation and ongoing safety checks in the EHR.

C. Discharge Requirements

1. Refer to Discharge Planning for Mental/Behavioral Health Patients

References:

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Simon, G., Rutter, C., Peterson, D., Oliver, M. Whiteside, U. Operskalski, B. Ludman, E. (2013) Does response on the PHQ-0 depression questionnaire predict subsequent suicide attempt or suicide death? Published Online:1 Dec 2013https://doi.org/10.1176/appi.ps.201200587
The Joint Commission November 2017 perspectives preview: special report: suicide prevention in health care settings, October 25th, 2017.

APPENDICES:

A. Columbia Suicide Severity Rating Scale (C-SSRS) for adults
B. Columbia Suicide Severity Rating Scale (C-SSRS) for pediatrics
C. Provider risk assessment
D. Room Safety Checklist