


<b>Name of Policy:</b>	<u><b>Suicide Assessment and Prevention</b></u>	 <p><b>Effective Date:</b> 7/8/ 2016 Initial Effective Date: August, 1983</p>
<b>Policy Number:</b>	3364-122-12	
<b>Department:</b>	Nursing Service – Kobacker Inpatient Psychiatric Hospital, Partial Hospitalization Program	
<b>Approving Officer:</b>	Director of Nursing/Chief Nursing Officer	
<b>Responsible Agent:</b>	Nursing Director Inpatient Behavioral Health	
<b>Scope:</b>	The University of Toledo Medical Center	
<input type="checkbox"/> New policy proposal <input checked="" type="checkbox"/> Minor/technical revision of existing policy		
<input type="checkbox"/> Major revision of existing policy <input type="checkbox"/> Reaffirmation of existing policy		

### (A) Policy Statement

Inpatient suicide is the most common sentinel event reported to the Joint Commission, with 50 inpatient suicides each year, occurring most often on psychiatric units, or within 72 hours of discharge (MacNeil, 2007). As a result, all child and adolescent patients receiving hospital treatment for emotional or behavioral disorders will be screened for risk of suicide utilizing the attached Suicide Lethality Scale (Smith, Conroy, and Ehler, 1984).

### (B) Purpose of Policy

The purpose of this policy is to ensure an effective method for suicide assessment, monitoring, and treatment of patients at risk for suicide (Dlugacz et. al, 2003). These prevention techniques will be accomplished by a comprehensive approach that identifies and mitigates process and system-level issues contained within the hospital environment that may contribute to suicide attempts.

### (C) Procedure

1. A physician or designee will assess patients for suicide risk for those who are being treated for an emotional or behavioral disorder. The following risk factors for children and adolescents include, but are not limited to (Juhnke, 1996):
  - Gender
  - age
  - presence of mood and/or conduct disorder
  - previous attempts
  - substance abuse
  - irrational thinking loss
  - lack of social supports
  - presence of organized plan
  - negligent parenting
  - significant family stressors
  - suicidal modeling by parents or siblings
  - school problems
  - history of physical and sexual abuse
  - incest
  - domestic violence or other assault
2. The physician or designee will also assess the patient using the results from the Suicide Lethality Scale (used during the initial assessment,) indicating the appropriate level of severity according to the patient's total numerical value.

3. If suicide risk is present, physician orders for suicide precautions will be initiated immediately. Nursing staff can initiate suicide precautions, in the absence of a physician with identified rationale for this decision. The information shall be recorded in the electronic medical record, and the patient's physician shall be notified as soon as possible.
4. All staff need to be aware of the potential for suicide. The medical record will be flagged indicating suicide precautions, including the expiration date.
5. Suicide precautions must be re-evaluated every 24 hours by the physician and nursing staff. The attending physician can make discontinuations or change the level of care at any time via the ordering process. The physician must document current clinical status and reasons for continuing, modifying or discontinuing precautions. Prior to further suicide precaution orders, or discontinuing orders, the physician or designee will complete the Suicide Lethality Scale to determine the next course of action.
6. The nurse will notify the patient's team members of any patients on special precautions each morning ensuring hand off communication.
7. Patients will be initially screened for suicide risk during the admission assessment, through questions contained on the psychosocial admission assessment form, nursing admission assessment form, and the Suicide Lethality Scale. This will determine level of risk and appropriate interventions. Assessment will continue every 24 hours until risk is ameliorated. Furthermore, an additional assessment will be conducted prior to discharge.
8. The patient's treatment plan will contain information regarding the problem, goals, and staff interventions which will include but is not limited to home safety assessment and plan, discharge crisis plan, medication compliance (as appropriate), and outpatient therapy compliance. Both the patient and family will actively participate in the treatment planning process.
9. Comprehensive discharge planning will enhance community connectivity through providing the patient/family with emergency contact phone numbers and outpatient follow-up appointments. This discharge planning will be appropriate to the patient's current level of functioning with recommended ongoing interventions to the accepting outpatient agency.
10. Inpatient unit will be regularly reviewed for safety (Links, 2005). This will be accomplished by daily safety rounding (see Daily Safety Round form). Additionally, a comprehensive safety analysis will be conducted at least annually by administration using the Environmental Rounds form.
11. Staff will establish a therapeutic relationship and instill hope by identifying major problems, generating and exploring alternatives, developing and formulating action plans and follow-up plans with the patient and family (Barrio, 2007).
12. Orders for suicide precautions will be dependent upon the risk-level identified through the completion of the Suicide Lethality Scale. Associated risks and staff interventions are as follows:

### **Levels of Risk and Staff Interventions**

#### **Low Risk Patients**

The patient presents with vague suicidal ideation, but has an absence of a plan, and is able to make a commitment to safety and exhibits insight into existing problems. Staff interventions include, but are not limited to the following for low risk patients (Erin, Parks, & Wilcox, 2007):

- Patients may participate in activities within the building at the discretion of the charge nurse or designee.
- Monitor by direct observations every 15 minutes and document safety checks on Special Report Sheet (Form N-328).
- Frequent verbal contact during waking hours
- Must be accompanied 1: 1 staff for any necessary on campus (out of building) activities
- All sharp objects shall be confiscated. May use sharps only with 1: 1 staff observation.
- Room will be checked daily for potentially harmful items brought in by visitors
- All belongings brought in by visitors will be searched for any harmful items

- RN will stay with the patient during medication administration to ensure patient has taken all medication.
- Use of plastic dinnerware
- The patient may not visit off the unit unless 1: 1 supervision by staff.

#### Moderate Risk Patients:

The patient has been assessed to be more capable of implementing a suicide plan. The patient's behavior has presence of suicidal ideation, verbalizes concrete plan, ambivalence concerning commitment to safety, observed and/or history of poor impulse control, and minimal insight into existing problems. May have medical treatment needs (Erin, Parks, & Wilcox, 2007). Staff interventions include, but are not limited to for medium risk patients:

- Patient will be admitted to a room where direct visual observation is enhanced (when available), with documented safety checks of at least every 15 minutes are completed on Special Report Form (N-328)
- Room checks are concluded to ensure that unsafe objects or items are removed from the patient's room
- Staff will maintain frequent verbal contact during waking hours, reassuring patients that they are in a safe environment
- Patients may participate in activities within the building at the discretion of the charge nurse or designee
- Use of plastic dinnerware
- RN or designee will stay with the patient during medication administration to ensure the patient has taken all medication
- All belongings brought in by visitors will be searched for any harmful items
- Must be accompanied 1: 1 staff for any necessary on campus (out of building) activities
- All sharp objects shall be confiscated. May use sharps only with 1:1 staff observation
- The patient may not visit off the unit unless 1:1 supervision by staff.

#### High Risk Patients:

The patient has attempted suicide and. is in imminent danger of implementing a suicide plan immediately or in the near future. The patient's behavior includes verbalizing clear intent for self-harm, concrete and viable plan with rescue prevention, delusions of self mutilation, command hallucinations, unable to commit to safety, poor impulse control, no insight into existing problems, and includes a past attempt via lethal method (Erin, Parks, & Wilcox, 2007). Staff interventions include, but are not limited to the following for high-risk patients:

- Continuous 1: 1 direct observation, at arm's length
- The patient may not attend out of building activities
- OT, TR, and School activities will take place on the unit for 1: 1 observation by staff. Participation will be at the discretion of the treatment team.
- Monitor on an on-going basis by nursing staff with documented safety checks at least every 15 minutes on the Special Report Sheet (Form N-328)
- II A patient may attend clinic appointments with 1: 1 supervision within the hospital and health center.
- While on suicide precautions, the patient may not have LOA's off campus
- The patient may not visit off the unit unless supervised 1: 1 by nursing staff

#### **Items Considered Hazardous Posing a Risk for Patient Safety**

1. Hazardous items are defined as any implement that can be used in whole, part, or broken to function as weapons, or otherwise pose a threat of injury or jeopardize the patient's therapeutic plan of care.
2. Staff will determine which items patient use most impulsively and lethally and designate these as contraband.

Procedure for handling contraband:

1. Patients on suicide precautions except under direct supervision may not use hazardous items by staff.

2. Medications brought from home may not be left with the patient. Nursing staff will administer medications as ordered by the physician.
3. Alcohol, drug paraphernalia and any non-prescription mood altering drugs are prohibited, and will be removed, and not returned to the patient. Contact Pharmacy and/or Campus Police for proper disposal of non-authorized medications. Document the findings of contraband and disposal in the electronic medical record.

<p><b>Approved by:</b></p> <div style="margin-top: 10px;"> <p><u>Tamara L. Cerrone RN, BSN</u>      <u>7/8/16</u></p> <p>Tamara Cerrone BSN, RN      Date</p> <p>Nursing Director Inpatient Behavioral Health</p> </div> <div style="margin-top: 10px;"> <p><u>Monecca Smith MSN, RN</u>      <u>7-8-2016</u></p> <p>Monecca Smith, MSN, RN      Date</p> <p>Director of Nursing / C N O</p> </div> <p style="margin-top: 10px;"><i>Review/Revision Completed By:</i>  <i>Tamara Cerrone nursing director, Barb Lanzi RN</i></p>	<p><b>Review/Revision Date:</b></p> <p>7/84      7/8/2016</p> <p>1985</p> <p>1986</p> <p>1987</p> <p>1988</p> <p>1989</p> <p>1990</p> <p>6/192</p> <p>1994</p> <p>5/95</p> <p>4/96</p> <p>5/97</p> <p>5/98</p> <p>4/99</p> <p>8/01</p> <p>1/02</p> <p>3/04</p> <p>3/07</p> <p>5/17/2010</p> <p>4/8/2014</p> <hr/> <p><b>Next Review Date:</b> 7/8/2019</p>
<p><b>Policies Superseded by This Policy:</b> 1-M-12</p>	