

**Title:** CARE OF THE PATIENT AT RISK FOR SELF HARM (ACUTE CARE)

**Responsibility:** RN, LPN, NA's, MHT's and other trained personnel

**Purpose:**

1. To provide a safe environment for the patient.
2. To prevent harm to a patient.
3. To promote supportive and protective factors with the patient.

**Equipment:** Special Report Sheet [Form NU091]  
Suicide Lethality Scale [Form KB066] for Kobacker patients only  
Pink colored patient identification door card

<u>Procedure</u>	<u>Point of Emphasis</u>
<ol style="list-style-type: none"> <li>1. Assess patient's suicidal potential on admission by obtaining information in a matter of fact manner:               <ol style="list-style-type: none"> <li>a. history of attempted suicide</li> <li>b. feelings of hopelessness</li> <li>c. has a suicide plan</li> </ol> </li> <li>2. Complete Suicide Lethality Scale when patient answers yes to any of the above questions.</li> </ol>	<p>Openness and honesty are the basis for a positive supportive relationship. Patient characteristics such as expressions of hopelessness, depression, irrational thinking, and environmental features such as assaults, substance abuse or domestic violence may contribute to an increased risk for suicidal ideation.</p> <p>As a result of the RN's assessment the patient can be placed on suicide precautions based on the score of the Suicide Lethality Scale (Form KB066). Report and document any suicidal ideation/plan to the physician immediately.</p>

**Levels of Risk and Interventions**  
On Suicide Lethality Scale score is 0-20

**None**

The patient is not verbalizing or suggesting suicidal ideation but may only present with signs of mild depression.

On Suicide Lethality Scale 21-39.

**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.

On Suicide lethality Scale 40-79

**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)

On Suicide Lethality Scale 80-125

Procedure

Point of Emphasis

**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: (Erin, Parks, & Wilcox, 2007):**

- Monitor by direct observations every 15 minutes and document safety checks on the Special Report Sheet (Form NU091).
- 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.
- Use of plastic dinnerware (no serrated plastic knives and dietary department will cut meat.)
- Signage will be placed outside of the patients room.
- Patient will be admitted to a room where direct visual observation is enhanced, with documented safety checks of at least every 15 minutes are completed on Special Report Sheet (NU091).
- Room checks are conducted 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.
- All sharp objects shall be confiscated

This education reinforces caring and our efforts to help keep the patient safe. The physician may order close observation if the patient continues to exhibit self harm, or is actively threatening harm. The patient and the order need to be re-evaluated every 24 hours, per the physician.

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| <p>3. Explain suicide precautions to the patient.</p>  | <p>This education reinforces caring and keeping our patients safe.</p>  |
| <p>4. Belongings will be checked for safety on admission, as well as if the family brings additional belongings. Examples of hazardous items may include but is not limited to:</p> <ul style="list-style-type: none"> <li>• Razorblades, straight razors, safety razors, electrical razors</li> <li>• Knives, or any item that can be used as a knife</li> <li>• Firearms and ammunition</li> <li>• Medicines brought from home [prescription and over-the-counter meds]</li> <li>• Nail files, clippers, and tweezers</li> <li>• Scissors</li> <li>• Glass items [exception corrective lenses eyeglasses]. No glass vases allowed.</li> <li>• Mirrors including those in compacts</li> <li>• Needles, hooks, pins, pin-on-jewelry, safety pins</li> <li>• Shaving lotion, polish remover, personal care items containing alcohol or other caustic liquids</li> <li>• Aerosol cans</li> <li>• Rope, shoelaces, belts</li> <li>• Valuables, including personal clothing</li> </ul> | <p>Room checks are ongoingly conducted to ensure unsafe objects are removed from the patient's room and secured.</p> <p>May use sharps with close observation.</p> <p>Dietary trays are sent only with plastic fork and spoon, paper plates and cups. Dietary is to pre-cut the meat. No plastic knives with serrated edges.</p> <p>The nurse is to make sure the patient swallowed the ordered medication. No meds to be left in the room.</p> <p>ADL's and toileting need to be closely monitored.</p> <p>All excess linen will be removed from the patient's room.</p> <p>Unused IV, oxygen tubing, and unnecessary bed control cords will be removed. Necessary Bed cords will be secured by maintenance in a</p> |

<u>Procedure</u>	<u>Point of Emphasis</u>
<ul style="list-style-type: none"><li>• Car keys</li><li>• Cigarette lighters</li><li>• Paraphernalia pertaining to chemical use</li><li>• Plastic liners for garbage cans</li><li>• Coins</li></ul>	small loop [so at minimum length].
5. Communication: establish a positive, therapeutic alliance with the patient.	Remain calm, caring, supportive, accepting and Nonjudgmental. Use active listening skills, encourage the patient to talk about his/her feelings. Help the patient identify, accept, and work through these emotions even if they are uncomfortable or painful.
6. Identify protective factors with the patient: <ul style="list-style-type: none"><li>• Support system/spouse/significant other/children/relatives</li><li>• Social Connectedness/friends</li><li>• Religious/spiritual coping</li><li>• Ability to problem solve</li><li>• Mental Health Literacy</li><li>• Reductions in Depressive Signs/Symptoms</li><li>• Instillation of Hope/Forward Thinking</li></ul>	Discuss with the patient protective factors he/she already has. Explore that these protective factors can be very helpful in recovery.
7. Prepare patient for discharge by providing suicide prevention information	Crisis planning at discharge emphasizes how and where to obtain help. Crisis hotline number should be provided on discharge instructions as applicable.

Reviewed by: Greg Shannon, MSN, RN, Staff Development Coordinator  
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References: Wenzel, A., Berchick, E. R., Tenhave, T., Halberstadt, S., Brown, G. K., & Beck, A. T. (2011). Predictors of suicide relative to other deaths in patients with suicide attempts and suicide ideation: A 30-year prospective study. *Journal of Affective Disorders, 132*(3), 375-382.  
Wong, W. C. (2013). A pilot study of a collaborative education program between psychogeriatric ward and community psychiatric service for caregivers of suicidal elderly. *European Psychiatry, 28*(1), 1.