

NURSING SERVICES GUIDELINE INPATIENT BEHAVIORAL HEALTH

Guideline: Care of the patient at risk for self-harm



Policy Number Superseded:

Responsibility: RN, MHT, trained PCAs or other trained personnel

Effective Date:
May 30, 2024

Purpose of Guideline: Suicidal patient care

Initial Effective Date:
April 1996

Equipment:

- (1) Special report sheet
- (2) Private lockable inpatient room
- (3) Extremity restraints

PROCEDURE	POINTS OF EMPHASIS
<p>(A) Assess patient's suicidal potential via suicide lethality scale upon admission, during medication changes, mood improvement or worsening, and the attempted suicide or successful suicide of a fellow patient, along with evaluations on an ongoing basis.</p> <p>The patient will remain on suicide precautions for a minimum of a 24-hour period as ordered by the physician. Continued suicide precautions past the 24-hour period will depend on the results of the suicide lethality scale. If the completed scale determines that the patient is not at risk for suicide, then they can be taken off of precautions after the first 24-hours.</p>	<p>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 Suicide Lethality Scales (Smith, Conroy, and Ehler, 1984).</p> <p>Research shows that suicide is likely after patients are placed on new medications and report an increase in energy; the patient may have been suffering from depression and lack of energy previously and will now have the energy to carry out the suicide</p>

<p>As long as the patient has any risk of suicide per lethality scale, the patient will remain on suicide precautions.</p> <ol style="list-style-type: none"> (1) Ask on admission. (2) Previous attempts. (3) Hx of suicide in family. (4) Recent losses. (5) Plan – assess. (6) Specifics of plan . (7) Ask when, where, how, and with what tools. (8) Evaluate suicidal patient daily, or more often if necessary. Assessment should be performed, particularly upon sudden improvement or worsening of symptoms. An increase in energy and improved mental state are risk factors and suicide prevention measures should be taken. (9) Complete suicide lethality scale tool on admission/discharge, and more often if indicated. 	<p>because of the new medication (Vicarolis, Carson, & Shoemaker, 2006, p. 482).</p> <p>“Most suicides occur during the first week after admission into a psychiatric hospital, and that the suicide of one patient serves as a model for another” (Lloyd, 1995, p. 346).</p> <p>“The patient’s mental state may also appear to improve prior to suicide” (Lloyd, 1995, p.345). Focus should be on recognizing an increase in energy and an improved mental state as a risk factor for suicide, and measures can be taken to prevent suicide” (Vicarolis, Carson, & Shoemaker, 2006, p.481).</p> <p>Patients’ suicidal potential varies; the risk may increase or decrease at any time. Strongest risk factors are depression, alcohol abuse, drug abuse, aggressive or disruptive behavior.</p> <p>Past attempts, ideation, family history of mental disorders or co-occurring mental and alcohol or substance abuse disorders, stressful life event or loss, identification with a suicide victim are important in assessing suicide risk.</p> <p>Plans are more lethal when they are specific. Is there easy access to lethal methods, especially guns.</p> <p>Increased lethality is higher risk if patients have available means, specific plans with date, time, and place.</p>
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	<p>Increased risk for harm: gun and hanging.</p> <p>Look for sudden changes:</p> <ul style="list-style-type: none"> • Energy lifting. • Giving away of prized possessions. • Signs of stress; headaches, muscle aches, problems sleeping. • Hopelessness, helplessness. • Other risk factors for suicide in children and adolescents include but are not limited to (Juhnke, 1996): <ul style="list-style-type: none"> • Previous attempts. • Lack of social supports. • Presence of organized plan. • Negligent parents. • Significant family stressors. • Suicidal modeling by parents or siblings. • School problems. • History of physical and sexual abuse. • Incest. • Domestic violence and assault.
<p>(B) Obtain information in a matter-of-fact manner; do not discuss in length or dwell on details. Ask directly if patient is experiencing thoughts of suicide.</p>	<p>Patient may be using suicidal behavior as a manipulation or to obtain secondary gain.</p>
<p>(C) Explain suicide precautions to the patient, including the assigned risk level.</p>	<p>Demonstrates caring and concern for the patient.</p> <p>Minimizes the possibility that the patient will have inadequate observation.</p> <p>Observation level depends on identified level of risk.</p>

<p>(D) Designate responsibility for observation of the patient to a specific person and maintain close observation. Document on special report sheet.</p>	<p>Minimizes the possibility that the patient will have inadequate observation. Observation level depends on identified risk level.</p>
<p>(E) Assume responsibility for safety of the patient.</p> <p>(1) Inspect patient's room and day area, on an ongoing basis, for potentially hazardous items. Document checks on special report sheet each shift. Suicide precautions should be documented every 15 minutes at a minimum.</p> <p>Examples of hazardous items which can include, but not be limited to, the following:</p> <ul style="list-style-type: none"> • Razor blades, straight razors, safety razors, electrical razors. • Knives or any item that may be used as a knife. • Firearms and ammunition. • Medicines brought from home (prescription, over-the-counter). • Nail files, clippers and tweezers. • Scissors. • Glass items (exception: corrective lenses, glasses). Check any items brought from floral shops – no glass vases allowed. • Mirrors, including those in compacts. 	<ul style="list-style-type: none"> • Protects patient from self-destructive acts and maintains a safe acute care environment. <p style="text-align: center;">Levels of risk and interventions Low risk patients</p> <ul style="list-style-type: none"> • 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.

<ul style="list-style-type: none"> • Needles, hooks, pins, pin-on-jewelry, safety pins. • Shaving lotion, polish remover, and personal care items containing alcohol or caustic liquids. • Aerosol cans. • Rope, shoelaces, belts. • Valuables, including personal clothing. • Car keys. • Paraphernalia pertaining to chemical use. • Plastic liners for garbage cans. • Coins. <p>(2) Place patient in centrally located room, away from exits and near nurse's work area.</p> <p>(3) Insure that sharp objects are not accessible to patient.</p>	<ul style="list-style-type: none"> • 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. <p style="text-align: center;">Moderate risk patients</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 form (N-328). • 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
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	<p>that they are in a safe environment.</p> <ul style="list-style-type: none">• 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. <p style="text-align: center;">High Risk Patients</p> <ul style="list-style-type: none">• 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).
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	<ul style="list-style-type: none">• Staff interventions include, but are not limited to, the following for high-risk patients:<ul style="list-style-type: none">• Continuous 1:1 direct observation, at arms-length.• The patient may not attend out of building activities.• OT, TR, and school activities will be 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).• 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.• Place in private room if necessary, one close to nursing station if possible.• Monitor closely in activity areas.• If able to attend OT/TR activities, inform the staff of suicide precautions.
(F) If patient's behavior becomes self-abusive or aggressive, when necessary restrain patient, see	Physical safety of the patient is a priority.

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<p>Restraints, Seclusion and Physical Hold Guideline, or place him/ her in seclusion with no objects that can be used to inflict injury.</p>	<p>Goal is to minimize use of seclusion/restraints.</p> <p>Utilize least restrictive interventions as possible.</p>
<p>(G) Observe, record, and report to physicians, any changes in patient's mood (elation, withdrawal, sudden resignation).</p>	<p>Risk of suicide increases when mood or behavior suddenly changes. As depression decreases, client may have the energy to carry out a plan for suicide.</p>
<p>(H) Establish positive relationship with patient.</p>	<p>Remain calm, listen carefully, ask questions, encourage problem-solving.</p>
<p>(I) Encourage patient to ventilate feelings.</p> <p>(1) Convey acceptance of these feelings.</p> <p>(2) Remain non-judgmental about patient feelings and express this attitude to the client.</p>	<p>Ventilation of feelings can help patient identify, accept, and work through his/her feelings, even if these are painful or uncomfortable to patient.</p>
<p>(J) Assist patient in developing positive alternatives.</p> <p>Teach child appropriate expression of feelings through use of writing in journal, labeling and discussing feelings, venting anger by screaming into pillow, throwing ball, shredding paper, etc. Utilization of related nursing groups: management, social skills & problem solving. Reaffirm hope.</p>	<p>Positive feedback provides reinforcement for patient's growth and can enhance self-esteem.</p> <p>Continue to support, educate, monitor and assess parameters to ensure patient compliance and safety.</p> <p>Develop crisis plan for patient upon discharge, emphasizing how and where to obtain help. Discuss with family how to keep home safe.</p>

(A) Documentation

Document the following:

- (1) Initial assessment as outlined in Practice Guidelines.
- (2) Complete suicide lethality scale.
- (3) Add problem(s) and goal(s) to the treatment plan.
- (4) Whereabouts of child every 15 minutes; use special report sheet.

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- (5) Any changes in client's mood.
- (6) Any verbalization of suicidal thought.
- (7) Any gestures, attempts to harm self, when, where, precipitating events, outcome, patient reaction to situation.
- (8) Patient teaching: journal, feelings bag, angry time, specific patient assignments.
- (9) Document 1:1, if monitored 1:1 by staff.
- (10) Document patient's room and day area has been inspected for hazardous items on special report sheet each shift

(B) References

Boardman, J., & Roberts, G. (2014). Risk, safety and recovery. ImROC Briefing Paper. London: Centre for Mental Health and Mental Health Network.

Glenn, C. R., Franklin, J. C., & Nock, M. K. (2015). Evidence-based psychosocial treatments for self-injurious thoughts and behaviors in youth. *Journal of Clinical Child & Adolescent Psychology*, 44(1), 1-29.

Johnson, D. R., Ferguson, K., & Copley, J. (2017). Residential staff responses to adolescent self-harm: The helpful and unhelpful. *Clinical Child Psychology and Psychiatry*, 1359104516689378.

Approved by:

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