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Owner:	*Louise Dyjur: Dir Medical Service Line*
Policy Area:	*Patient Care Services*
References:	
Applicability:	*WA - Providence St. Mary MC*

Suicide Awareness, Prevention and Precautions

POLICY

The purpose of this policy is to outline practices for the identification, assessment and prevention of self harm or attempted suicide by at risk patients during hospitalization.

There will be consistent procedures for evaluating patients at risk for suicide and for protecting patients with potential for self-harm. Patients admitted for medical or surgical stabilization following a behavioral crisis or suicide attempt will be subject to procedures designed to lessen the potential for self-harm.

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PROCEDURE

Safety Screening

A. Upon admission to the adult inpatient units, a Patient Health Questionnaire-4 (PHQ-4) mood disorder questionnaire is completed on all alert patients. The mood disorder questionnaire helps to screen patients who may be at risk for self-harm.

B. For pediatric patients aged 10 and older, the pediatric suicide risk screen is completed.

C. If a score less than 3 is achieved on the PHQ-4, the patient is deemed **low risk**. If a score of 3 or greater is achieved on the PHQ-4, the Columbia Suicide Severity Rating Scale (C-SSRS) is completed. The C-SSRS is an assessment tool that evaluates suicidal ideation and behavior.

   1. There are two main categories on the C-SSRS assessment tool: suicidal ideation and suicidal behavior
   2. Patients are deemed **moderate risk** in the following circumstances:
      a. suicidal ideation - wish to be dead
      b. non-specific active suicidal thoughts
      c. active suicidal ideation without intent to act
   3. Patients are deemed **high risk** in the following circumstances:
      a. active suicidal ideation with some intent to act
      b. active suicidal ideation with specific plan and intent
      c. actual suicide attempt
      d. engaged in non-suicidal injurious behavior

e. aborted suicide attempt

f. preparatory suicide acts or behavior

D. The suicide screen is repeated during hospitalization if the patient exhibits suicidal behaviors, suicidal ideation, despondency, hopelessness, changes in mood, emotions or behavior.

Level of Monitoring

Determine the level of monitoring that is required, based on the results of the suicide screen and assessment. Document the risk level and interventions initiated.

- **Low risk**: Patients who are identified as low risk for suicide or other safety concerns will be monitored as all patients are monitored. A staff member visually and verbally checks in with the patient at least every hour during waking hours, or more frequently, depending on the patient needs.
- **Moderate Risk**: Immediately notify provider, provide suicide education and crisis hotline number, initiate the room clearance protocol, and consider using a 1:1 continuous observer. The nurse, in consultation with the provider and other staff involved in the care of the patient, may determine that although the patient presents with suicidal ideation or a minor suicide attempt, the supervision and structure of the hospital setting is enough to help maintain the patient's safety and a continuous observer is not necessary.
- **High Risk**: Immediately notify provider, provide suicide education and crisis hotline number, initiate the room clearance protocol, and immediately implement the following suicide precaution protocol.

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Suicide Precaution Protocol

1. Notify the House Administrative Supervisor and attending physician immediately.
2. Based on the suicide risk severity, discuss the need for a psychiatric consult
3. Consider admission/transfer to the ICU for visual and auditory monitoring based on patient acuity.
4. If restraints are necessary during the transfer from ER to inpatient units, restraints may preclude the removal of clothing until released in a secured area. In this case clothing should be inspected for any items that may be in pockets, etc., which may be used in a harmful manner. The patient's shoes are to be removed prior to transfer to the Nursing Unit.
5. Maintain continuous visual and auditory observation of the patient, by providing 1:1 continuous observation by trained staff. This includes any time the patient is transported from one area of the hospital to another. (See the attached guidelines).
6. Identify safety concerns and potential safety concerns when report is passed from shift to shift
7. Inform the patient that he/she is being placed on Suicide Precautions. Provide rationale and explain procedure of Suicide Precaution monitoring.
8. Educate and discuss with the patient that they need to let the nurse or staff in attendance know if they are feeling increasingly depressed, hopeless, overwhelmed or have thoughts of suicidal ideation.
9. Staff assigned to continually observe a patient at risk for self harm will immediately communicate any change in affect, behavior or compliance to the assigned registered nurse.
10. Assign or reassign the patient on suicide precautions to a room as close as possible to the nursing station.
11. Remove unsafe items from patient's clothing and belongings including any item that has the potential to

cause bodily harm: i.e. glass, sharps, medication, cords, belts, matches, and lighters. Call Security to assist with the search and removal of patient belongings. All belongings are to be inventoried by two people and labeled prior ro being placed in safekeeping.

12. All clothing, shoes, and unsafe belongings are to be removed and locked away for the patient's safety. This is to decrease the possibility of patient elopement.
13. Remove unsafe items from the patient's room, while maintaining the ability to provide quality care and treatment. Items of concern might include cords, oxygen tubing, other tubing, curtain cords, plastic bags, etc. Utilize the “Room Clearance” protocol to ensure that all unsafe items have been removed.
14. Identify that the patient is on suicide precautions when ordering dietary meals and snacks. Patients will then receive plastic utensils and paper cups. Check all meal trays to remove unsafe items before distributing meals to the patient.
15. Brief all staff that provide escort for the patients receiving tests or procedures off the unit on the patient's safety status needs.
16. Authorized visitors are screened and concerns of safety conveyed to them about any objects the patient could use for self-harm. (Call Security to complete screening).
17. New belongings brought in for the patient are searched to maintain safety.
18. When the family is informed of the patient's safety risk status, educate and instruct them to let the nurse or staff in attendance know if they notice an increased sense of depression, hopelessness, sadness, over-relief or sudden uplift in mood or any unusual behavior that is of concern to them that might show an increase in suicidal thoughts.
19. Observe all medication administration and monitor for pocketing/cheeking of medications. Do not leave medications at the bedside or in the medication locked boxes in the room.
20. Referral shall be made to Social Services/case Management.
21. Nursing staff may consult with Social Services/Case Management regarding the specific care needs of patient/family.
22. If patient exhibits behavior that is a danger to self or others, see policy #8720.7003 Restraints and #8720.5740 Evaluation and Stabilization of Psychiatric Patient
23. 1:1 continuous observation may be discontinued upon the recommendation of the multidisciplinary team involved in the care of the patient. The team may determine that the patient no longer requires continuous observation and that the supervision and structure of the hospital setting is enough to help maintain the patient's safety. Suicide awareness precautions will continue to be utilized

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Attachments:

Continuous Visual Observation Guidelines
Room Clearance Checklist

Approval Signatures

Approver	Date
Yvonne Strader: CNO St Mary Med Ctr	06/2019
Louise Dyjur: Dir Medical Service Line	06/2019

Applicability

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