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Owner:	Angela Graves: RN Mgr-Prof Prac/Qlty ER Svcs
Policy Area:	Emergency Services
References:	
Applicability:	OR - Oregon Region

ED Practice Guideline: Suicide Screening and Care of Behavioral Health Patients

Note: This practice guideline describes essential components of assessments and intervention. The hospital may incorporate established evidence based practices. The implementation of the guideline is based on the patient's chief complaint and clinical presentation. Implementation of the guideline and removal of the guideline **is acceptable** ONLY upon the providers judgment, and should be reflected in documentation by the provider and/or the patient's primary nurse. (Provider: document in Nurse Communication Order; primary nurse document in the electronic health record (EHR). All discharge policies must be made publicly available.

Guideline Goals:

1. To maintain safe conditions for patients, visitors, and caregivers.

Triage RN Safety Assessment and Interventions

1. Assess and document patient's chief complaint.
2. Assess for possible medical conditions associated with, or independent of a mental health complaint presentation.
3. Refer emergent medical issues for immediate ED Provider evaluation.
4. Assess mental status.
5. Place the patient in an appropriate location, considering safety needs to include:
 - a. Observation needs
 - b. Removal and securing of patient belongings
 - c. Environmental safety and mitigation
 - d. Possible need for restraints or seclusion (Refer to Restraint and Seclusion Policy).

Risk for Violence/Suicide Risk Assessment

1. All patients who present with potential behavioral health concerns (including, but not limited to, complaints of suicidal or homicidal attempt or ideation, depression, and anxiety) must have their suicidal/homicidal risk level assessed. The Columbia Suicide Severity Rating Scale (CSSRS)

Screening Tool in EPIC must be completed as part of the triage screening for patients.

2. If the patient answers "yes" to any of the screening questions, the RN must chart the patient's level of risk for violence/suicide. (see below, Safety Classifications)
3. The patient's immediate safety needs should be addressed and documented, including appropriate setting for treatment and consideration of observation needs . This also includes possible seclusion and/or restraint defined in the Restraint & Seclusion policy.
4. The triage RN should document whom they notified of the patient's safety risk within the Electronic Health Record (EHR)
5. Patient assessment and clinical judgment should be used to determine safety needs throughout the patient's visit.
6. Refer to policy ED Practice Guideline for Triage.

Safety/Suicide Risk Classification

Examples listed under each safety classification are provided as a guide and point of clarification. They do not supersede clinical judgment that a patient's condition may warrant a higher classification.

Judgment should error on the side of increased safety.

It may be helpful to collect information from other collateral sources such as police or law enforcement; to assess patient's most urgent psychiatric and medical needs, while continuously considering confidentiality concerns of the patient. The hospital must not require the disclosure of protected health information without obtaining a patient's consent.

The hospital may incorporate established evidence based practices.

The Regional ED Triage Nurse Behavioral Health Workflow (attached) shall be referenced for patient observational needs.

The ED 2020 BH Environmental Assessment and Mitigation Plan (attached) shall be referenced for room/area safety mitigation.

The policy named "Safety Management Plan" shall be referenced for general safety guidance.

The patient will be asked the CSSRS Screening questions. The patient's responses to questions 1,2, and 6 will trigger the screening tool to ask additional assessment questions if needed. Responses to the screening tool will assign a safety/suicide risk level. The risk level will determine the initial level of observation for the patient until seen by the ED Provider or CIS.

1. **Low safety/suicide risk:** patient answers "no" to all CSSRS screening questions, does not complain of, or appear to be psychotic and is not an elopement risk. Patient can be seen in any room as "General Behavioral Health" status meaning patient does not require enhanced observation. A mitigated room should be used when possible.
2. **Moderate safety/suicide risk:** *Patient requires Q15' close observation until seen by Provider. If Treatment Team (including Provider) agrees close observation is not needed, alternative plan and/or discontinuation of close observation will be decided at that time and written as a Provider's Order.*
3. **High safety/suicide risk:** *Requires 1:1 continuous observation until seen by Provider unless placed in a designated BH secured area such as PSV Red Pod. If Treatment Team (including Provider) agrees 1:1 continuous observation is not needed, alternative plan and/or discontinuation of constant observation will be decided at that time and written as a Provider's order.*

Safety Observation

General Behavioral Health- Patients do not require enhanced observation.

Close Observation -The key element of an adequate close observation is *direct visual observation* of the patient every 15 minutes. Staff must be close enough to the patient to view respirations and observe the head and neck of the patient. Using a flashlight or approaching the side of the bed may be necessary to fully observe the patient. The identity of the patient must also be ensured.

Continuous Observation -Consider continuous observations for patients needing more frequent supervision than **15 minute observations**. Security officers can be utilized to assist *high risk* patients to ensure safety.

Note: *PSV Red Pod and PPMC Team 5 are appropriate for any level of safety observation up to and including continuous 1:1 observation.*

Mitigation Considerations

1. Prior to patient's arrival in the treatment room, the room must be assessed and mitigated for safety. This includes removing ligature risks, sharp objects and other potential dangerous objects from the area when possible. This may be delegated to an Emergency Department Technician (EDT) or Behavioral Health Technician (BHT) by the receiving RN. Preparation of room safety should be charted once performed. *The ED 2020 BH Environmental Assessment and Mitigation Plan (attached) should be referenced for room/area safety mitigation.*
2. The patient must remain in constant observation until a handover to another caregiver has occurred. A handover does not change the level of observation. The level of observation can be changed by the ED Provider when appropriate. The change must be written as an order by the ED Provider if observation level is being downgraded.
3. The hospital must not delay a patient's discharge or transfer to another facility.

Receiving Treatment Team Member

1. Upon arrival of all behavioral health patients to their room, the receiving RN completes (or delegates) and documents the following:
 - a. Removal of all patient belongings.
 - b. Removal of other items in the patient care area that can have the potential to cause injury/harm to patient or staff.
 - c. Placement of patients into safe scrubs while observed by caregiver for safety.
 - d. Documents actions taken to lessen the risk of violence/suicide within the patient's immediate environment.

Primary RN

1. Confirm removal of patient belongings and other items that may be used to induce harm.
 - a. Confirm and document that the patient is in safe scrubs.
 - b. Assess and document patient's level of safety risk.
 - c. Determine and document observation needs of patient.

- d. Ensure and document patient's treatment room has been mitigated for safety.
2. Assess for possible medical conditions associated with, or independent of a behavioral health complaint presentation. Communicate to the Provider and document findings in the EHR.
3. Consider need for seclusion or physical restraint order if patient is at risk to injure self or others.
4. Refer to policy "Regional Nursing Minimum Documentation Reference" for charting guidance.
5. Reassess the patient's safety needs and response to intervention. This includes assessment of the desired or adverse effect of administered medication(s).
6. Add patient to the Safety Behavioral Health Tab in EPIC. This will allow caring contacts be automatically arranged within 48 hours of release from ED.
7. The RN will encourage the patient to designate a lay caregiver and sign authorization form ORC 240A (attached). The patient will be informed that they have the ability to rescind the authorization of the lay caregiver at any time. RN is to document in the Safety Behavioral Health Tab, the name and phone number of the patient's lay caregiver if patient desires their collaboration in discharge planning as part of the initial assessment. This should be completed within 2 hours of patient's admission to the Emergency Department.
 - a. If the patient does not wish to name a Lay Caregiver, click the "decline" box next to Lay Caregiver in the Behavioral Health Tab.
 - b. The RN will educate the patient and lay caregiver (if present) the benefits of involving a lay caregiver in the discharge plan for the patient. The Providence Information sheet should be given to the patient and lay caregiver if present at this time and charted as such in the Safety Behavioral Health Tab.
8. Complete a nursing note, with a complete set of vital signs every 8 hours (and more frequently as appropriate).
9. Complete and document an assessment, with vital signs, every 4 hours, if patient has received sedating medications (more frequently, if indicated).
10. Complete and document an assessment with a complete set of vital signs after any self-harm event. If patient refuses vital signs, document as such. Report the self-harm event to the Provider to determine next steps in patient care. Document the notification to Provider and all updates to treatment and/or discharge safety plan.
11. Complete a focused reassessment upon assuming care of the patient.
12. Complete an initial BARS assessment as a part of the primary nurse assessment. Subsequent BARS assessments should be completed every 4 hours and as needed per changes in the patient's behavior.
13. Complete the Safety Assessment in EPIC every 1 hour and upon patient assignment to a new treatment room to assure room has been mitigated for patient safety and validates a safe environment for the patient.
14. Reflect patient's risk of safety in the Behavioral Health tab.
15. Disposition of patient
 - a. The patient's immediate safety needs and the appropriate setting for treatment should be considered in disposition planning.

- b. Ensure the discharge planning is appropriate to the acuity of the patient, the needs of the patient and the abilities of the lay caregiver.
- c. A plan for ongoing needs should include patient's capacity for self-care and whether the patient can be properly cared for in the place the patient resides at the time patient is in the Emergency Department.
- d. RN must document patient's understanding of discharge instructions.
- e. If a patient:
 - i. declines the safety plan and/or discharge instructions or
 - ii. is unable to understand the safety plan and/or discharge instructions or
 - iii. refuses to sign any documents required by policy or
 - iv. refuses to be given a copy of the safety plan and/or discharge instructions alert the ED physician.

16. All abnormal vital signs should be reevaluated and made aware to ED Provider prior to disposition.

- a. Refer to the following policies in Policy Stat as needed:

Emergency Treatment and Active Labor Act (EMTALA) Patient Transfers Between Facilities
 ED Practice Guideline Discharge Plan of Care and Education of Non- Behavioral Health Patients
 ED Practice Guideline Delayed Admission
 Releasing A Patient Following a Behavioral Health Crisis
 ED Practice Guideline Triage

Risk for Violence/Suicide Risk Interventions

- 1. Agitated but not physically aggressive:
 - a. Reasonable methods of de-escalation and least restrictive measures should be used and documented prior to using physical restraints. Techniques such as reassurance, limit setting and negotiation may be employed, using simple, direct language.
 - b. Use BARS as a tool to help assess the need for PRN medications.
 - c. Consider pharmacological treatment of anxiety, agitation or psychosis after physician and RN assessment.
- 2. Escalation in aggressive behavior :
 - a. Reasonable methods of de-escalation and least restrictive methods should be used and documented prior to using physical restraints. Techniques such as reassurance, limit setting and negotiation may be employed, using simple, direct language.
 - b. Use BARS as a tool to help assess the need for PRN medications.
 - c. Consider pharmacological treatment of anxiety, agitation or psychosis after physician and RN assessment.
 - d. Request assistance from specially trained staff in prevention and management of assaultive behavior (i.e. PMAB). Initiate "Pre-Code Gray" or "Code Gray," as needed.
- 3. Actively violent as evidence by physical aggression toward self or others:
 - a. Reasonable methods of de-escalation and least restrictive methods should be used and

documented prior to using physical restraints, when possible. Techniques such as reassurance, limit setting and negotiation may be employed, using simple, direct language.

- b. Use BARS as a tool to help assess the need for PRN medications.
- c. Consider pharmacological treatment of anxiety, agitation or psychosis after physician and RN assessment. **Note: Treatment without patient consent may only occur in an emergency when a situation presents where patient poses imminent danger to self or others.**
- d. Request assistance from specially staff trained in prevention and management of assaultive behavior (i.e. PMAB). Initiate "Code Gray," as needed
- e. Consider the need to initiate close observation and/or constant 1:1 observation or the use of seclusion or restraints.
- f. Consider calling police for back up if needed for patient or staff safety.

Visitors

1. Provide patient visitors with a sticker identifying them as such. Visitor's belongings are to be secured or cleared by a caregiver. All visitors of behavioral health patients MUST check with the patient's primary nurse prior to entry. (Refer to policy "Visitors to Patients" for additional guidance or clarification)

ED Provider

1. Assessment
 - a. Complete an emergency medical screening examination, including potential medical causes of presentation.
 - b. Assess mental status and consider psychosis and suicidal ideation. The suicide risk assessment should include identification of factors and features that may increase or decrease risk for suicide.
 - c. Continually assess and manage the safety needs and concerns of the patient.
 - d. Assess the patient for the need for a Notice of Mental Illness and/or medication treatment, Director Hold or 12 hour Transport Hold depending on your ministries designation.
2. Interventions
 - a. Proceed with interventions and orders as necessary, including but not limited to initiation of order for seclusion/restraints or Notice of Mental Illness and/or medication treatment, Director Hold or 12 hour Transport Hold depending on your ministries designation.
 - b. In an emergency (situations of imminent danger to self or others), medications/treatment may be given without patient consent with an order from the Emergency Department Provider.
 - c. Do not continue to administer medication or treatment after the emergency has subsided or the patient has regained the ability to consent to the treatment, without obtaining the patient's informed consent.
 - d. Document in the EHR the specific nature of each emergency and the procedure that was used to deal with the emergency. If the patient is unable to give consent, document that fact in the EHR.

3. Disposition

- a. The patient's immediate safety needs and the appropriate setting for treatment should be considered in disposition planning.
- b. Consult with the psychiatric social worker (when available) to discuss plan of care, including disposition.

4. Admission and/or Transfer

- a. Arrange and coordinate admission at a facility capable of providing the appropriate level of care if unable to offer the appropriate level care at your ministry.

5. Discharge

- a. A plan for ongoing needs is developed by considering the patient's risk assessment and long term needs including patient's capacity for self-care and whether the patient can be properly cared for in the place the patient resides at the time patient is in the Emergency Department.
- b. Outpatient treatment should be initiated to help transition the patients care to community-based providers, peer support, lay caregivers or others who can implement the patient's plan of care.
- c. When possible have a follow- up appointment scheduled within 7 calendar days of discharge. If this is not possible, document the reason in the patient's chart if not performed by CIS.
- d. Ensure the discharge planning is appropriate to the acuity and abilities of the patient and the abilities of the lay caregiver.
- e. If a patient:
 - I. declines the safety plan and/or discharge instructions or
 - II. is unable to understand the safety plan and/or discharge instructions or
 - III. refuses to sign any documents required by policy or
 - IV. refuses to be given a copy of the safety plan and/or discharge instructions, pause and reassess patient. Engage the patient and lay caregiver (if available) to explain the clinical rational behind the plan. Ensure that care providers are aware that the patient has declined the safety plan and/or discharge instructions.

6. Reassessment of boarding patients

- a. Reassess the patient at least every 12 hours or with change in patient's condition. Make adjustments to the treatment plan as indicated.

Psychiatric Consultant (when available)

1. Assessment

- a. Conduct a behavioral health assessment using the CSSRS assessment in EPIC, including but not limited to a risk for violence/suicide risk assessment. Include identified factors and features that may increase or decrease risk for suicide and violence.
- b. Communicate safety risk to Treatment Team using safety classification.
- c. Assess the patient's need for Notice of Mental Illness.
- d. Reflect patient's safety risks on the Behavioral Health Safety tab.

2. Interventions

- a. Proceed with interventions and orders as necessary, including but not limited to initiation of seclusion/restraints, Notice of Mental Illness and/or medication treatment.
- b. Consult with the psychiatric social worker (when available) to discuss suicide risk, if applicable, and develop and implement an appropriate disposition plan.

3. Disposition

- a. The patient's immediate safety needs and the appropriate setting for treatment should be considered in disposition planning.

4. Discharge

- a. A plan for ongoing needs is developed by considering the patient's risk assessment and long term needs including patient's capacity for self-care and whether the patient can be properly cared for in the place the patient resides at the time patient is in the Emergency Department.
- b. Outpatient treatment should be initiated to help transition the patients care to community-based providers, peer support, lay caregivers or others who can implement the patient's plan of care (case worker).
- c. The Psychiatric Consultant will make a follow-up appointment for the patient scheduled within 7 days of discharge. If this is not possible, document the reason this is not possible in the EHR.
- d. Ensure the discharge planning is appropriate to the acuity of the patient and the abilities of the lay caregiver.
- e. If a patient declines the safety plan and/or discharge instructions, pause and reassess patient. Engage the patient and lay caregiver (if available) to explain the clinical rationale behind the plan. Ensure that other care providers are aware that the patient has declined the safety plan and/or discharge instructions

5. Admission and/or Transfer

- a. Arrange and coordinate admission at a facility capable of providing the appropriate level of care.

ED Clinical Intervention Specialists (CIS)/ED Social Work

1. Conduct a behavioral health assessment using the CSSRS assessment in EPIC. Include assessment of the patient's medical, functional and psychosocial needs that may include an inventory of resources and supports recommended by a behavioral health clinician, indicated by a behavioral health assessment, and agreed upon by the patient.
2. Include a risk for violence/suicide risk assessment and lethal means counseling. Identify factors and features that may increase or decrease risk for suicide and violence. See BH Crisis Workflow (attached).
 - a. Communicate safety risk to Treatment Team using safety classification.
 - b. Assess the patient's need for Notice of Mental Illness.
 - c. Ensure patient has been added to the Safety BH tab so that caring contact arrangements will

be automatically arranged within 48 hours of release from ED.

d. Reflect patient's risk on Behavioral Health safety tab.

3. Collaborate with care team to determine the observation needs of the patient.

4. Collect collateral information and involve lay caregiver in plan of care.

5. De-escalate agitated patients

6. Assist in Pre-code Grays and Code Grays

7. Perform crisis focused therapy

8. Reassessments:

a. Perform on-going assessment for appropriateness of inpatient hospitalization.

b. Repeat the suicide risk assessment:

i. When there is a change in the patient's mental status (regardless of the previous level of suicide risk)

ii. Every 24 hours if the previous assessment was rated moderate or high.

iii. When the patient is discharged, admitted or transferred if the previous assessment was rated moderate or high.

9. Disposition:

a. The patient's immediate safety needs and the appropriate setting for treatment should be considered in disposition planning.

b. Lethal means counseling is to be documented using the CAF AVS smartphrase and added to the patient's discharge instructions.

10. Discharge:

a. A plan for ongoing needs is developed by considering the patient's risk assessment and long term needs.

b. Outpatient treatment should be obtained to help transition the patient's care to community-based providers, peer support, lay caregivers or others who can implement the patient's plan of care (case worker).

c. A follow-up appointment will be scheduled within 7 calendar days of discharge by the ED CIS/ Social Worker. If this is not possible, document the reason this is not possible in the EHR.

d. Ensure the discharge planning is appropriate to the acuity and abilities of the patient and the abilities of the lay caregiver.

e. If a patient:

I. declines the safety plan and/or discharge instructions or

II. is unable to understand the safety plan and/or discharge instructions or

III. refuses to sign any documents required by policy or

IV. refuses to be given a copy of the safety plan and/or discharge instructions, alert the ED physician.

11. Admission and/or Transfer:

- a. Arrange and coordinate admission at a facility capable of providing the appropriate level of care.
12. If a clinician is not available to perform a behavioral health assessment, the ED caregivers will follow their chain of command.

ED Mental Health Tech/ED Tech

1. Assist with the following activities:
 - a. Monitor and assist behavioral health patients in the department
 - b. Continuous and close observation as applicable
 - c. Assist with activities of daily living as needed
 - d. Removal of patient belongings and placement of patients in safe scrubs.
 - e. Prepare treatment room for patient using the Environmental
 - f. Obtain vital signs
2. Report any change in the patient's behavior or concerns to the primary nurse and primary social worker (if available).

Definitions:

*The following is intended as general resource information which **may not apply to each ED.***

Restraint/Seclusion Documentation: Complete on any violent, restrained patient, whether in seclusion or physical restraints. Restraints/seclusion can be initiated by RN, but needs a physician order immediately and a face to face within one hour.

Mental Status Exam – Assesses, mood, thinking, affect memory, etc.

Notice of Mental Illness (NMI/Hosp. Hold): Completed for a patient who is a danger to self or others AND requires emergent care or treatment for a mental illness. Initiated by ED physician and psychiatric social worker, filed with the court.

Civil Rights Documentation: Completed by the psychiatric social worker or RN who informs patient of Civil Rights when put on a Notice of Mental Illness (NMI) or Transport Hold.

Behavioral Health Emergent Assessment Documentation (BHEA): Used by PSA ED psychiatric social worker to document an assessment on all mental health patients seen in the ED.

Behavioral Activity Rating Scale (BARS)- A scale used for clinical communication and an objective scale to help determine whether PRN intervention is indicated.

Columbia Suicide Severity Rating Scale (CSSRS): suicide risk assessment through a series of simple, plain language questions; answers help identify risk, severity and immediacy of risk.

Close Observation : Documented 15 minute in-person observations of patients by caregivers to ensure patient safety.

Continuous One-To-One Observation- Documented, constant in-person observation by a caregiver with the sole responsibility of keeping the patient safe at all times. Caregiver should be free of all extraneous distractions.

Self-harm Event- The deliberate destruction or alteration to ones body tissue.

Transfer Hold Documentation: Completed by ED physician for patients being held involuntarily awaiting transfer to a psychiatric inpatient hospital. Hold is in effect for 12 hours at facilities certified by The State of Oregon as a Transport Hold Facility (i.e. Providence Willamette Falls and Providence

Medford Medical Center.)

Treatment Team: The group of health care professionals caring for the patient. This may be comprised of the ED Provider, RN, EDT and ED Social Worker.

Adult Informed Consent for Voluntary Admission Behavioral Health Services: Consent signed by patient or legal guardian for voluntary psychiatric admissions

ED Practice Guideline: Triage

ED Practice Guideline: Delayed Admission

Regional Nursing Minimum Documentation Reference

Notification of Mental Illness

Code Gray-Pre-Code Gray

Restraints and Seclusion

Releasing A Patient Following A Behavioral Health Crisis

Safety Management Plan

Regional Nursing Minimum Documentation Reference

Emergency Treatment and Active Labor Act (EMTALA) Patient Transfers Between Facilities

ED Practice Guideline Discharge Plan of Care and Education of Non- Behavioral Health Patients

Missing Endangered Adults

Approved by:

Oregon Regional Emergency Clinical Collaborative September 2020

Reviewed January 28, 2021 by EDCC.

Attachments

[2020 PMH Emergency Services Environmental Risk Assessment.docx](#)

[9.30.20 FINAL-BH Crisis workflow.pdf](#)

[BH Environmental Risk Assessment- PWF.xlsx](#)

[HB 3090 Lay Caregiver Brochure_Patient Handout.pdf](#)

[ORC 240A Release of PHI 2010.pdf](#)

[PHR BH Environmental Risk Assessment and mitigation plan.xlsx](#)

[PMMC BH Environmental Risk Assessment and Mitigation Plan-PMMC ED.xlsx](#)

[PSV ED 2021 BH Environ Risk Assessment and Mitigation Plan.xlsx](#)

[Regional ED Triage BH Workflow with Observation Algorithm - V 12.docx](#)

Approval Signatures

Approver	Date
Angela Graves: Mgr-Ed Prof Prac/Dev/Sys/Qlty	02/2021
Jeremy Lynn	02/2021
Angela Graves: Mgr-Ed Prof Prac/Dev/Sys/Qlty	01/2021

Approver**Date**

Angela Graves: Mgr-Ed Prof Prac/Dev/Sys/Qlty 01/2021

Applicability

OR - Clinical Support Staff (CSS), OR - Connections, OR - Credena Health (CH), OR - Home Health (HH), OR - Home Medical Equipment (HME), OR - Home Services, OR - Home Services Pharmacy (HSRx), OR - Hospice (HO), OR - Providence Ctr for Medically Fragile Children, OR - Providence Hood River Memorial Hospital, OR - Providence Medford MC, OR - Providence Medical Group, OR - Providence Milwaukie Hospital, OR - Providence Newberg MC, OR - Providence Portland MC, OR - Providence Seaside Hospital, OR - Providence St. Vincent MC, OR - Providence Willamette Falls MC

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