PATIENTS AT RISK FOR SUICIDE- PSYCHIATRIC UNITS

PURPOSE: To outline the nursing management of the patient in a psychiatric in-patient care setting who has been screened at risk for suicide.

SUPPORTIVE DATA: A suicide threat/attempt is a method of communication, a cry for help, and a sign that the patient wishes to escape a perceived intolerable situation and sees no positive alternatives. Patients experiencing delusions, and/or hallucinations as well as those patients with a history of violent behavior (reactive aggression) are at high risk. All suicide threats should be considered serious, especially if there are specific plans as to methods, ability, place and time. Patients may not leave the unit unescorted.

Follow-up care will be based on the provider assessment.

SCREENING:

1. Perform the following when patient is admitted to a psychiatric unit:
   - Columbia Screening Tool
   - Notify provider for any “yes” responses

NURSING ASSESSMENT/ REASSESSMENT:

2. Implement interventions based on provider order:
   a. Low risk:
      - Patient requires no special nursing precautions (follow the usual Psychiatric inpatient unit protocol)
      - Nursing rounds every 30 minutes on all patients and log on all patients’ activities and whereabouts
      - Licensed nursing staff documents including suicide screening every shift
   b. Medium Risk:
      - Provider will order suicide precautions
      - Patient will be in constant view of staff
      - Nursing rounds on individual patient every 15 minutes and log of patient’s activities and whereabouts on individual flow sheet, which will be scanned into electronic medical record upon patient’s discharge.
      - Licensed nursing staff will assess for suicidal ideation, attempts, or self-harming behaviors and document in the medical record at the end of shift nursing notes.
   c. High Risk:
      - Provider will order suicide precautions.
      - Patient will be under constant observation with full view of staff at arm’s length at all times.
      - Nursing rounds on individual patient every 15 minutes and log of patient’s activities and whereabouts on individual flow sheet, which will be scanned into electronic medical record upon patient’s discharge.
      - Licensed nursing staff will assess for suicidal ideation, attempts, or self-harming behaviors and document in the medical record at the end of shift nursing notes.
      - Licensed nursing staff document the behaviors that are dangerous to self and determine if restraints/ seclusion are required, When patients are placed in restraints/seclusion, they are constantly observed and Restraints and Seclusion policy will be followed (refer to Medical Center policy #903: Restraints and Seclusion).
      - If a high-risk patient requires 1:1 Observation (above and beyond Constant Line of Sight observation), this will be a separate order, placed either by the

Psychiatric Emergency Room provider or the admitting provider

d. If the nurse determines the level of risks for suicidality is higher than that noted in the admission orders, the nurse will notify the providers promptly and request the provider to evaluate if patient's designation of suicide risk should be modified and ordered accordingly.

3. Assess/Reassess the following a minimum of every 8 hours and as indicated:
   - Suicidal ideation
   - Wish to be dead
   - Suicidal thoughts
   - Suicidal thoughts with methods
   - Suicide intent
   - Suicide intent with specific plan
   - Notify the provider for any new "yes" responses

SAFETY:

4. Notify the following if patient elopes from area:
   - Los Angeles County Sheriff (call first, extension 3333)
   - Call Code Green (extension 111)
   - Psychiatric Emergency Services providers
   - Nurse Manager/Supervisor
   - Patient's provider

THERAPEUTIC MANAGEMENT:

5. Assist patient to identify and develop alternative coping mechanisms.
6. Obtain verbal contract from patient agreeing:
   - Not to harm self
   - To inform staff when suicidal feelings occur
7. Utilize interdisciplinary support services as indicated.

PATIENT/FAMILY TEACHING:

8. Explain that safety measures are to prevent patient from harming self (such as "we take your threat to harm yourself seriously and we are making sure you are safe").

9. Instruct patient/family to notify staff when suicidal feelings occur or are verbalized.
10. Teach alternative coping mechanisms such as talking with staff member about feelings.
11. Provide patients with follow-up mental health clinic appointments and/or referral to outpatient mental health facilities as part of discharge planning and emergency telephone numbers.
12. Provide patients and/or family members with emergency telephone numbers.

COLLABORATION:

13. Collaborate with the interdisciplinary team regarding:
    - Effective interventions
    - Increased verbalization of suicide plan or attempts to harm self
    - Suicide risk (make all ancillary staff aware of risks)

ADDITIONAL STANDARDS:

14. Implement the following as indicated:
    - Grieving
    - Restraints

DOCUMENTATION

15. Document in accordance with documentation standards including:
    - Monitoring of the patient observation (15- minute rounding, continuous, or 1:1) in the electronic health record
    - The level of precautions
    - Interventions implemented to reduce risk
    - The patient's response to the intervention
    - The assessment of the continued need for precautions each shift

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Columbia Screening Tool

Ask questions that are in bold and underlined.	Past month	
Ask Questions 1 and 2	**YES**	**NO**
1) ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) ***<u>Have you had any actual thoughts of killing yourself?</u>***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***<u>Have you been thinking about how you might do this?</u>*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***<u>Have you had these thoughts and had some intention of acting on them?</u>*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***<u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>***		
6) ***<u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u>*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
If YES, ask: ***<u>Was this within the past 3 months?</u>***	**Past 3 Months**	