Rancho Los Amigos National Rehabilitation Center

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT:	**SUICIDE RISK ASSESSMENT AND PREVENTION PLAN**	**Policy No.:**	**B806**
		Supersedes:	**May 20, 2021**
		Reviewed:	**June 21, 2022**
		Page:	**1 of 8**

PURPOSE

Rancho is committed to providing quality and safe care for those patients identified as high-risk for suicide. The purpose in this policy is to create an effective, multidisciplinary approach to proactively screen and respond to a patient with expressed suicidal ideations, gestures or behavior in order to reduce the risk of patient suicide. This policy will:

1. Establish guidelines for the identification of patients at elevated risk for suicide and the prevention of patient suicides within Rancho
2. Improve patient safety by identifying risk factors that may contribute to patient suicide
3. Promote practices that assist in the identification and classification of patients at elevated risk for suicide and suicidal behaviors
4. Educate on how to implement practices and interventions to reduce the risk of suicide
5. Specify resources to be contacted to support the management of a patient in crisis
6. Provide guidance on how to document the evaluation, findings, suicide precautions taken, interventions implemented and patient response
7. Ensure Rancho leadership and staff demonstrate a consistent effort to evaluate, monitor, improve and document suicide risk screening and assessment for all patients at Rancho.
8. Ensure compliance with the patient safety standards as recommended by The Joint Commission National Patient Safety Goals (15.01.01)

POLICY

The policy of Rancho Los Amigos National Rehabilitation Center is to promote a therapeutic environment that is as safe as reasonably possible for those patients who present a potential for suicide or intentional self-injury.

GOAL

The goal is to assist staff in identifying patients who demonstrate suicidal ideation or behavior and to initiate the appropriate intervention.

SCOPE OF SERVICE

Each clinical discipline or service will be responsible for coordinating educational training in suicide risk screening for all staff within the department and will maintain record keeping of all employee training and updates to ensure competency and compliance in suicide risk screening skills.

DEFINITION OF TERMS: (The following terms are intended to clarify the levels of suicidal behavior and are included in each of the risk categories.) All documentation should include when the person had the thoughts, ideation or intent (e.g., whether current at the time of the examination, weeks ago, months ago or years ago).

A. **SUICIDAL HISTORY** - Documented or verified history of suicide attempts.

B. **EXPRESSED THOUGHTS OF DEATH AND DYING** - Patient's expression of a desire for death, but there is no expressed statement of acting upon the thought; e.g. "I wish I were dead", "I wish they would put me out of my misery," or "I wish I would go to sleep and not wake up."

C. **SUICIDAL IDEATION** - Patient's expression of desire to take own life but there is no defined statement of will to take his/her own life, e.g., "I wish I had the courage to kill myself."

D. **SUICIDAL INTENT** - Patient verbalizes a definite desire/intent/plan/threat to take his/her own life, e.g., "I am going to kill myself," "I figured out how to end this misery." Patient is able to state a plan and is able to carry out the action.

E. **SUICIDAL GESTURE** - Any action taken by the patient towards self with the apparent or expressed intent of bringing about self-injury or death, e.g., cutting wrists or stockpiling medications and taking an overdose.

F. **LETHALITY** - Extent to which patient has the capability and intent to cause own death, e.g., (the patient has a higher lethality based on how easily death can be accomplished via the gesture) ... loaded gun has a higher lethality than 100 aspirin tablets.

G. **5150 –** References WIC 5150. When any person, as a result of a mental disorder, is a danger to others, or to himself or herself, or gravely disabled, an Lanterman–Petris–Short (LPS) authorized person may upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the County approved by State Department of Mental Health as a facility for evaluation.

H. **LIGATURE** – Defined by CMS as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation.

I. **MENTAL HEALTH PROFESSIONAL (MHP)** – may include Psychologist, Psychiatrist, Social Worker, Psychiatric Nurses and other licensed mental health professionals.

PROCEDURE /MATERIAL AND METHOD:

The following will provide guidance on the screening process, the interventions to occur for high-risk patients, appropriate documentation and the environmental assessment to ensure the safety of our patients.

1. **Screening**: a Suicide Risk Screening will be performed on all Rancho patients, both in the inpatient and outpatient settings.

   A. Frequency of Screening
      (1) Inpatient Setting
      Screening will be performed by a Registered Nurse (RN)
      a. All patients on admission

      b. When there is a change in risk for suicide, due to change in clinical status or change in diagnosis. A list of risk factors for suicide are provided in Attachment C.

      c. Prior to discharge, if previously identified as being at risk for suicide during current admission.

      (2) Outpatient Setting
      a. On initial visit with Primary Care Provider (PCP), with initial screening administered by nursing staff.

      b. Annually, thereafter initial visit with PCP.

      c. All providers (Primary Care and Outpatient Specialty Clinics) will review the Health Maintenance Checklist to determine if the annual screening is due and conduct as appropriate.

      d. When there is elevated risk, based on screening or on patient verbalizations or behavior. For example, if patient is stating that they do not want to live. Other reasons for more frequent screening include recent suicide attempt, patient report of recent traumatic events, etc. Attachment C provides more information on risk factors for suicide.

   B. Method of Screening
      (1) Inpatient
      a. Questionnaire administered:
         1. Depression Screening (Patient Health Questionnaire-9, PHQ-9)
         2. Columbia Suicide Risk Assessment

      (2) Outpatient (See Attachment A, "Outpatient Protocol – Depression and Suicide Risk Screening Tools")
      a. Questionnaire administered by nursing in Electronic Health Record unless downtime procedures necessary.

b. Nursing will administer Depression Screening (Patient Health Questionnaire-2, PHQ-2) at initial visit and annually thereafter, unless patient shows signs of at risk behavior. When the Depression Screening (PHQ-2) results in a score of 3 or above, the Patient Health Questionnaire-9 (PHQ-9) will be administered to the patient, which includes a question about thoughts of self-harm.

c. If patient has elevated score on PHQ-9, question 9 (having thoughts of not wanting to live or of harming self), nursing will administer Columbia Suicide Risk Assessment in the Electronic Health Record.

d. The primary care physician and nurse manager will be notified at all times of the staff's concern about patient's suicidal behavior and/or comments. **Social Work, Psychology or Psychiatry (licensed Mental Health Provider) will be notified if there is a question of suicidal ideation, intent or gesture.**

(3) Hospital staff or volunteers who do not typically provide direct patient care or who are not expected to document in a patient chart, should contact Psychology or Social Work departments directly if they become aware of a patient's intent to harm themselves or suspect suicidal ideation/behavior.

2. **Intervention:** appropriate measures will be taken to ensure the safety of patients identified at high-risk for suicide via screening.

A. Inpatient Setting: based upon assessment, evaluate for appropriate risk classification and take suicide precautionary measures as indicated.

a. **Low Risk**: Suicidal ideation (includes expressed thoughts)
(i) Report to RN immediately

(ii) RN will notify physician.
(iii) Suicide precautions: Nursing will frequently observe and reassess patient for suicidal behavior, gestures, and responses to care. This will be documented as it occurs and a minimum of one time each shift. Documentation of patient discussions related to suicidal thoughts will also be entered.

(iv) The first person hearing the threat will document (in the progress notes) the patient's initial suicidal statement in the patient's exact words and will document any subsequent relevant statements/behavior in the medical record.

b. **Moderate Risk:** Verbalized Suicidal intent (includes threat)
(i) Report to RN immediately
(ii) RN will notify the physician.

(iii) Search the patient and room for hazardous personal and environmental items immediately and then on an as-needed basis.

(iv) The nursing staff or therapy department staff will make 15 minute observational checks for the first 2 hours after identifying suicide risk (or as necessary), then hourly, monitoring the patient's behavior, location and verbal responses. These findings must be documented in the patient's medical record.

(v) The first person hearing the threat will document the patient's initial suicidal statement in the patient's exact words and will document any subsequent relevant statements/behavior in the medical record.

c. **High Risk** – Actual Suicidal Gesture/behavior (includes intent/lethality)
(i) Search the patient and the room for hazardous personal and environmental items immediately, then daily and/or as needed.

(ii) Constant monitoring is to be done one to one with the curtains open, until the patient's condition changes.

(iii) The nursing staff or therapy department staff will monitor the patient's behavior and verbal responses.

(iv) When documenting, describe the patient's mental status, affect, behavior, and statement(s), in the patient's exact words. This behavior is to be reported immediately to the physician by the staff nurse/manager. Documentation is to include actions taken to provide a safe environment and reduce immediate danger and the interventions which has been implemented.

(v) Staff must accompany patients with serious suicidal ideation from one area of the hospital to another.

B. Outpatient Setting: based upon assessment as indicated in the "Outpatient Protocol: Depression and Suicide Risk Screening Tools" (Attachment A) and the "Management of a Suicidal Patient Under 1:1 Observation" (Attachment B), take suicide precautions as indicated.

(1) If patient is reporting depression or distress, but does not appear to be at risk, contact Social Work, provide outpatient mental health resource information and crisis line information.

(2) If patient is reporting suicidal ideation and/or endorses thoughts of wanting to die or harm self on PHQ-9, nursing staff should perform the Columbia Suicide Risk Assessment, then follow up:

a. Refer to psychology for further screening. Staff member is to encourage the patient/visitor to stay to discuss the situation with a mental health professional.

(i) If patient/visitor refuses to stay and pose a serious risk for harming themselves (i.e. demonstrated suicidal gestures or states that he/she wants to harm themselves), contact 911 for immediate assistance.

Staff member who first notices patient/visitor exhibiting suicidal behavior and/or comments is to have another employee immediately notify the physician and the area nurse manager or designee. All documentation should include when the person had the thoughts, ideation or intent (e.g., whether current at the time of the examination, weeks ago, months ago or years ago).

b. If the employee is alone, he/she should remain with the patient/visitor until the physician or the area nurse manager arrives and informs the staff member to do otherwise. "Management of a Suicidal Patient under 1:1 Observation" (Attachment B) checklist should be implemented.

c. Remove all possibly harmful items from within reach of the person and attempt to calm the patient/visitor if needed.

C. Intervention should be appropriate to risk of harming self, including:

(1) *None to minimal risk* - Providing mental health resource information about local clinics, urgent mental health care centers, and crisis numbers, with encouragement to go to use emergency resources if at risk of harming self. Encourage use of coping strategies.

(2) *Minimal to moderate risk* – Patient encouraged to contract for safety, provided with mental health resources, and possible safety check by police ordered, if appropriate.

(3) Severe or immediate risk or harming self

a. If patient does <u>not</u> meet 5150 criteria:
   (i) Encourage patient and/or family to go to local emergency or urgent mental health care center to obtain immediate treatment.

b. If patient meets 5150 criteria (WIC 5150), and is at immediate risk of harming self:
   (i) Initiate "Management of a Suicidal Patient Under 1:1 Observation" Checklist (Attachment B), which includes:
      1. Communicate with patient and family members/caregivers of concern for patient's well-being and intent to notify Psychology and obtain immediate assistance.
      2. Notify on-call Psychologist and/or call the Psychology Department.
      3. Initiate one-to-one observation by assigning an appropriately trained patient observer.
      4. Call Department of Mental Health ACCESS line at 1(800) 854-7771 to initiate Psychiatric Emergency Team (PET) response or other appropriate county resource to initiate a 5150 hold, if patient is at immediate risk of harming self.
      5. Contact campus Sheriff and request standby assistance and support while awaiting arrival of the PET ambulance/transportation.
      6. Patients who meet 5150 hold criteria must be transferred to an appropriate facility with a Psychiatric Emergency Department for follow on care and observation.

c. **<u>If, at any point, personnel involved in the management of the patient are concerned for their immediate safety or the safety of the patient, call 911 for rapid assistance.</u>**

3. **Documentation**

A. Inpatient Setting
   (1) When documenting, describe the patient's mental status, affect, behavior, and statement(s), in the patient's exact words. This behavior is to be reported immediately to the physician by the staff nurse/manager.

   (2) Documentation is to include actions taken to provide a safe environment and reduce immediate danger and the level of intervention which has been implemented

   (3) Nurse Manager or designee to contact the Area Administrator

B. Outpatient Setting
   (1) Document discussion of concern with provider.

   (2) Document steps taken to provide intervention (e.g., provide resource information, referral to psychology, social work, or Administrator on Duty)

   (3) Document resources provided, including:
      a. Patient education information on depression, anxiety, or suicidality from patient education tab in Electronic Health Record, if appropriate.

      b. Mental health resources given.

      c. Nurse Manager or designee to contact the Area Administrator

4. **Environmental Assessment:** a physical inspection of the surrounding area should be conducted to identify ligature risks and other potential hazards.

   A. Ligature Risk Assessment: when a patient has been identified as high risk for suicide, a ligature risk assessment of the patient's room and belongings will be performed. See "Management of a Suicidal Patient under 1:1 Observation" attached for more details of how to conduct the assessment (Attachment B). Additionally, the overall physical environment will be assessed for ligature risk during Environment of Care rounds.

      (1) Examples of risks include power cords on medical equipment, call bell cords, hand rails, doors, door knobs, door hinges and hardware, shower heads and curtains, exposed plumbing/pipes, paper towel and soap dispensers on walls, electrical switches/receptacles, lighting fixtures and projections from ceilings.

      (2) All objects that pose a risk for self-harm that can be removed without adversely affecting the ability to deliver medical care, should be removed. Patient access to certain areas may need to be restricted to prevent patients from reaching items they could use for self-harm. Objects brought into the room by visitors should also be carefully assessed.

REFERENCES

1. Joint Commission, National Patient Safety Goals, Standard 15.01.01, EP 1-7, Rev. Jul 1, 2019.
2. The Joint Commission. TJC Perspectives: Special Report – Suicide Prevention in Healthcare Settings, Vol 37, No. 11, November 2017.
3. S&C Memo: 18-06-Hospitals, Clarification of Ligature Risk Policy, Dec 8, 2017. CMS.
4. The Joint Commission. Requirement, Rationale, Reference - R3 Report: National Patient Safety Goal for Suicide Prevention, Issue 18, Nov. 27, 2018.
5. Sentinel Event Alert 56: Detecting and treating suicide ideation in all settings. Joint Commission. (2016) https://www.jointcommission.org/jointcommission.org/sea_issue_56/
6. California Welfare and Institution Code - WIC 5150. (Amended by Stats. 2018, Ch. 258, and Sec. 1. (AB 2099) Effective January 1, 2019.)
7. Western Interstate Commission for Higher Education Mental Health Program. (2009) *Suicide prevention toolkit for primary care practices: A guide for primary care providers and medical practice managers.* Boulder, CO WiCHE MHP
8. AHRQ Ligature Risk Assessment.
9. Mental Health Environment of Care Checklist Veteran's Administration.
10. Patient Health Questionnaire-2 (PHQ-2) and Patient Health Questionnaire-9 (PHQ-9).
11. Columbia Suicide Risk Assessment

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