PATIENTS AT RISK FOR SUICIDE

PURPOSE: To outline the nursing management of the patient who has been screened as a 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 must be always in view of staff members. Patients located in non-psychiatric settings require a 1:1 observer. Patients may not leave the unit unescorted. Any patient on suicide precautions wanting or needing to leave the unit/service must first be evaluated by the provider and an order must be written to leave the unit, unless a situation arises that is deemed an emergency.

ASSESSMENT:

1. Suicide screening is done for the following:
   - For all patients on admission
   - When there is a change in risk for suicide, for example, when there is a change in status, or change in diagnosis
   - Prior to discharge if previously identified as being at risk for suicide during current hospitalization

2. Complete the Orchid pre-screen section in the Electronic Healthcare Record (EHR). A "yes" answer to any question will require:
   - Provider notification
   - Implementation of this Patients at Risk for Suicide Nursing Clinical Standard
   - Modification of patient care plan
   - Completion of "Suicide Risk Assessment"

3. Perform the following at the time suicide risk is identified, a minimum of every 8 hours and as indicated:
   - Complete "Suicide Risk Assessment" form in the EHR
   - Behaviors that require the use of restraints (if applicable)
   - Environmental Safety implemented: Potentially harmful objects have been removed

SAFETY:

4. Remove the patient's belongings and store them according to unit policy.
5. Ensure patient is always in view of a staff member.
6. Ensure safety measures as outlined on the attached "How to Manage a Patient on Suicide Risk." (The checklist must be completed in non-psychiatric settings).
7. Notify the following if patient elopes from area:
   - Los Angeles County Sheriff (call first, extension 3333)
   - Call Code Green (extension 111)
   - Psychiatric Consultation and Liaison Services (Psychiatric Emergency Physician during off business hours)
   - Nurse Manager/Supervisor
   - Patient's Provider

THERAPEUTIC MANAGEMENT:

8. Assist patient to identify and develop alternative coping mechanisms.
9. Obtain verbal contract from patient agreeing:
   - Not to harm self
   - To inform staff when suicidal feelings occur

- Not to leave the unit unescorted/without permission

10. Utilize interdisciplinary support services as indicated.

PATIENT/CAREGIVER EDUCATION

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

COLLABORATION:

16. 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:

17. Implement the following as indicated:
    - Restraints

DOCUMENTATION

18. Document in accordance with documentation standards.
19. Document continuons observation in the EHR.

Initial date approved: 08/93	Reviewed and approved by: Professional Practice Committee Nurse Executive Council	Revision Date: 11/94, 07/96, 11/00, 03/05, 04/09, 07/12, 8/13, 5/19, 9/23

How to Manage a Patient on Suicide Risk Checklist (Non-Psychiatric Setting)

Note: Please ensure to comply with Suicidal Patient Nursing Clinical Standard, Suicide Risk Screening, Assessment, and Prevention Plan and any other related policies.

To Do

☐ Initiate one-to-one observation by assigning an appropriately trained patient care companion/observer

☐ Ensure patient is kept in view at all times

☐ Place patient in hospital gown

☐ Supervise patient bathroom visits and use of razors

☐ Ensure observer has relief to cover for breaks and before relinquishing care

☐ Observe and ensure that patient swallows medications at time of administration

☐ Inspect patient's belongings and remove any potentially harmful objects, examples:

- Medications
- Aerosolized sprays
- Knife, keys, Matches/lighters
- Belts, straps, shoe laces

☐ Inspect patient's room and remove any potentially harmful objects that are not ordered by the physician or in use by the patient, examples:

- Plastic trash bag
- I.V./oxygen tubing, needles
- Dressing supplies, tape, suture removal scissors
- Removable power cords, phone cords, SCD/BP equipment cables,

☐ Instruct patient not to leave the ward

☐ Escort patient for off-ward diagnostic tests/treatments and clinic appointments

☐ Do not engage in activities that would prevent observation of patient (using cell phone/computer, watching TV, reading newspaper/magazine, etc.)

☐ Reassess patient for self-harm risk every shift

☐ Other_____