

LOS ANGELES GENERAL MEDICAL CENTER PLAN

		Page 1	Of 5
Subject: SUICIDE RISK SCREENING, ASSESSMENT, AND PREVENTION PLAN		Supersedes: 11/2/22	Effective Date: 2/10/24
		Reviewed & approved by: Attending Staff Association Executive Committee Senior Executive Officer	
Plan Owner(s): Chief of Psychiatric Services Senior Executive Sponsor(s): Chief Medical Officer			
Departments Consulted: Medical Administration Patient Safety Committee Environmental Safety Office Office of Regulatory Affairs Nursing Services	Reviewed & approved by: Attending Staff Association Executive Committee Senior Executive Officer	Approved by: Chief Medical Officer	
		Approved by: Chief Executive Officer	

A. PURPOSE:

The Suicide Risk Assessment Plan (hereafter referred to as “the Plan”) is intended to protect patients at risk for suicide in designated and non-designated areas of the hospital by defining a suicide prevention protocol that follows all elements of performance, as stated in National Patient Safety Goals (NPSG.15.01.01) and CMS memorandum. Both sources attempt to develop expert guidelines in screening, assessing, and preventing suicides within a healthcare environment. This information pertains to all employees within a hospital and/or ambulatory setting.

The plan incorporates the following components of care:

- Identification of patients at risk for suicide or serious self-harm while in the hospital;
- Initial and on-going suicide risk assessment;
- One-to-one observation for patients who express intent, plan or means while in the hospital;
- Management of medical and psychiatric conditions contributing to suicide risk;
- Maintaining a safe patient care environment;
- Educating patients and family regarding suicide risk and prevention.

B. PROCEDURE:

Emergency Department

Each patient admitted through the Los Angeles General Medical Center Department of Emergency Medicine will be screened and assessed for suicide risk by the ED nurse using a 2-question suicide screen which is based on the Columbia Suicide Severity Rating Scale. If the patient answers yes to

SUICIDE RISK SCREENING, ASSESSMENT, AND PREVENTION PLAN

either of the 2 screening questions and there are no medical/surgical problems, the patient will be assigned a care companion, environmental risk reduced, and a Psychiatric Provider will be notified. If the patient answers yes to either of the 2 screening questions and there are medical/surgical problems, the patient will be assigned a care companion, environmental risk reduced, and the ED providers will be notified. If determined by ED provider that pt is at high risk, immediate efforts must be made to further reduce environmental risk and initiate one to one observation. These findings and observations will be clearly noted in the medical record and a request for a psychiatric consultation will be made.

Patients who do not require admission or monitoring for an acute medical or surgical problem but are identified to be at imminent risk for suicide and require immediate psychiatric intervention as determined by psychiatry consultant will be transferred from the Emergency Room Medical side to the Psychiatric Emergency Services for higher level monitoring and care.

- a. In the Psych ER, all patients will be observed continuously in full view. Nursing document patient's activities and whereabouts at least every 15 minutes regardless of level of suicidality.
- b. Licensed nursing staff assess upon admission, re-assess and document every 4 hours of specific symptoms / behaviors that are part of the assessment and risk reduction interventions.
- c. If a high-risk patient requires 1:1 observation (above and beyond constant line of sight observation), it will be a separate order placed by the Psychiatric ER provider

Patients who do require admission or monitoring for an acute medical or surgical problem and are identified to be at risk for suicide will be monitored in the environment of care deemed best to meet their medical and psychiatric needs.

Inpatient Setting

Non-Psychiatric inpatient units:

For patients who are on LPS hold for danger to self and admitted to a non-Psychiatric Inpatient unit, the admission provider will order a sitter at bedside and contact Psychiatry for consultation.

For patients who are not on LPS hold and admitted to a non-Psychiatric Inpatient unit, upon admission to the unit, a registered nurse will assess suicide using a 2-question suicide screen which is based on the Columbia Suicide Severity Rating Scale. If the patient answers yes to either of the 2 screening questions, the nurse will promptly contact the primary provider and maintain vigilance until a one-to-one sitter is assigned. Once notified of suicide risk, the primary provider will order a sitter to bedside and contact Psychiatry for consultation.

SUICIDE RISK SCREENING, ASSESSMENT, AND PREVENTION PLAN

Psychiatric Consultation and Liaison Services (or Psychiatry Emergency Services depending upon time of request) will complete a psychiatric consultation that will include a clinically appropriate suicide risk assessment and recommendations.

Psychiatric Inpatient Units:

Risk levels and corresponding nursing interventions:

1. Low risk:
 - a. Patient requires no special nursing precautions (follow the usual Psychiatric inpatient unit protocol).
 - b. Nursing rounds every 30 minutes on all patients and log on all patients' activities and whereabouts
 - c. Licensed nursing staff documents including suicide screening every shift
2. Medium Risk:
 - a. Provider will order suicide precautions.
 - b. Patient will be in constant view of staff.
 - c. 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.
 - d. 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.
3. High Risk:
 - a. Provider will order suicide precautions.
 - b. Patient will be under constant observation with full view of staff at arm's length at all times.
 - c. 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.
 - d. 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.
 - e. Licensed nursing staff document the behaviors that are dangerous to self and determine if restraints / seclusion is required, when patients are placed in restraints/seclusion, they are constantly observed, and Restraints and Seclusion policy will be followed (see policy #903: Restraints and Seclusion).
 - f. 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.

Prior to admission to an Inpatient Psychiatric unit, the Psychiatric Emergency Room provider will evaluate patient's suicide severity and assign the level of observation (suicide precaution, and 1:1 sitter if clinically warranted) corresponding to that risk, this will be placed in the admission order

SUICIDE RISK SCREENING, ASSESSMENT, AND PREVENTION PLAN

- a. Upon admission to the Inpatient Psychiatric unit, the suicide risk assessment will be completed by a registered nurse. 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. The provider will evaluate if patient's designation of suicide risk should be modified and order accordingly.
- b. Once a patient is placed on a level of observation, it may not be reduced or discontinued without a provider order.
- c. In Inpatient Psychiatric unit, the provider will re-evaluate patient's level of suicidality at least every 24 hours and with any changes in patient's status that warrant re-assessment clinically. The provider will update the suicide precaution order as needed. The provider will document the suicide risk assessment in the daily progress note.
- d. The licensed nursing staff will document risk assessment, provider notification, suicide precaution status and effectiveness of interventions.
- e. Prior to discharging a patient with risk for suicide at admission, crisis hotline information shall be provided to the patient and their family members by the license nursing staff discharging the patient.

Ambulatory Setting

Patients seen through ambulatory care services and identified to be at risk for suicide will be escorted by security and appropriate clinical staff to the Psychiatric Emergency Services for further evaluation. A complete hand-off will be made between providers.

Notification of Sheriff if elopement of patients with suicide thoughts / ideation

The Sheriff Department will be notified immediately if a patient who has been assessed for suicidal thoughts/ideation elopes from the designated unit or from the Psychiatric Emergency Room or Inpatient Psychiatric unit.

Training and Education

All employees will receive education at the time of employment and annual re-orientation on suicide prevention. Nursing competency will include education/training on identification of individuals at risk for suicide, implementation of suicide prevention treatment, and proper discharge education.

Environmental Assessment for Ligature Risk

Hospitals are expected to demonstrate how they identify patients at risk and steps to minimize those risks in accordance with nationally recognized standards and guidelines. For LPS designated areas of our hospital, (Hawkins) Los Angeles General will risk assess all units through the VA Mental Health Environment of Care Checklists regularly and during all construction planning.

For all non-designated areas with a higher-than-normal volume of behavioral patient's (Medical Behavioral unit, Jail, ED, and adult/child outpatient), the American Society for Healthcare Engineering (ASHE), Patient Safety and Ligature Risk Checklist will be used to risk assess and implement mitigating actions to prevent patient suicides. The risk assessment audit will be done on

SUICIDE RISK SCREENING, ASSESSMENT, AND PREVENTION PLAN

an ongoing basis.

The results of these audits will be collected by the Safety Office and presented to the Environment of Care Committee.

Monitoring of Plan

Risk Management and Office of Regulatory Affairs will be notified of all patient suicides and suicide attempts.

Los Angeles General Medical Center employees are required to report events through the Network's web-based Safety Intelligence (SI) system.

The Patient Safety Committee should receive the total number of inpatient and outpatient suicides on a monthly basis, from the Risk Management Office.

All inpatient/outpatient suicide cases will undergo peer review, and when necessary, redesign process associated with the Plan.

Root Cause Analyses (RCAs) will be conducted for sentinel events, as defined by The Joint Commission, and opportunities for improvement identified in the RCAs will be incorporated into the Plan.

REFERENCES:

1. Joint Commission, National Patient Safety Goals, 2019
2. CMS, S&C Memo 18-06, Clarification of Ligature Risk Policy, December 8, 2017
3. Joint Commission, Special Report: Suicide Prevention in Health Care Settings, 2019
<https://www.jointcommission.org/resources/patient-safety-topics/suicide-prevention/>
4. VA, Mental Health Environment of Care Checklist, 2016
5. American Society for Healthcare Engineering (ASHE), Patient Safety and Ligature Risk Checklist, 2017
6. SAMHSA, SAFE-T (Suicide Assessment Five Step Evaluation and Triage)
7. Los Angeles General Medical Center, Clinical Protocol, Suicidal Patient