County of Los Angeles **Department of Health Services**

VALLEYCARE
OLIVE VIEW-UCLA MEDICAL CENTER/HEALTH CENTERS
POLICY & PROCEDURE

NUMBER: 247
VERSION: 3

SUBJECT/TITLE: SUICIDE RISK ASSESSMENT AND PREVENTION – HOSPITAL BASED AMBULATORY CARE CLINICS

POLICY: A risk assessment will be completed whenever a patient presents with a primary diagnosis or primary complaint of an emotional or behavioral disorder or expressing suicidal thoughts/ideation or is on LPS hold in the ambulatory care clinics. The risk assessment includes identification of specific factors that may increase or decrease risk for suicide.
Steps will be taken to reduce the risk for suicide by ensuring the patient receives appropriate care in the most appropriate setting.

Crisis hotline information will be provided to patient and family/caregivers.

PURPOSE: To provide guidelines for staff to use in identifying patients at risk for suicide and in developing a plan of care and interventions.

DEPARTMENTS: All

DEFINITIONS: **Emotional or behavioral disorder:** Refers to any DSM (Diagnostic and Statistical Manual of Mental Disorders) diagnosis or condition, including those related to substance abuse.

Mental Health Hold or LPS Hold: An involuntary detainment under the Lanterman Petris Short Act.

Suicidal Ideation: Thoughts a person has regarding killing himself or herself.

Suicide: Refers to self- inflicted harm or endangerment that results in death.

Chief complaint: Refers to patient's main reason for seeking treatment that day.

PROCEDURE:

I. A Registered Nurse conducts an assessment of the following risk factors that may increase or decrease risk for suicide for every patient who presents in the clinic with a chief complaint/primary diagnosis of an emotional or behavioral disorder or is expressing suicidal thoughts.

A. Suicide Risk Factors

- family history of suicide
- has made an attempt to harm himself/herself or others including all cases of overdose, alcohol poisoning and ingestion of toxic materials)
- reports suicidal thoughts or intent or the patient's family is concerned about the person being suicidal or reports feelings of hopelessness
- has a psychiatric diagnosis of mood disorder, impulsive behavior, panic disorder, substance abuse, schizophrenia, alcoholism, depression
- single (especially separated) widowed or divorced
- lacks social support
- has concurrent medical illness
- unemployed
- currently facing a real or imagined loss or failure
- has feelings of hopelessness
- presence of depression or despair
- acutely intoxicated
- history of self- mutilating behavior
- access of firearms

B. Protective Factors (can serve to decrease a patient's suicide risk especially when several factors are present.)

- has ongoing care for mental, physical and substance abuse disorders
- has access to clinical interventions and support
- has support from family and community
- has on-going supportive medical and mental health care relationships
- has ability to solve problems, resolve conflicts, handle disputes in a non-violent way
- has cultural and religious beliefs that discourage suicide

II. If any of the above suicide risk factors are identified, the Registered Nurse will immediately escort the patient to an exam room for further evaluation by a Licensed Independent Practitioner. The Licensed Independent Practitioner will evaluate the patient's risk for suicide and determines the disposition or further referral to a Psychiatrist or Psychologist or transfer to the Psychiatric Emergency Room.

III. The Registered Nurse will ensure that a staff stays with the patient and is not left alone unless another staff assumes responsibility for observing the patient until the patient is transferred to an appropriate care setting.

IV. The Registered Nurse will document risk assessment, physician notification, suicide precautions maintained and effectiveness of interventions.

V. Prior to discharging a patient with risk for suicide, crisis hotline information is provided to the patient and their family members for crisis situations by the RN/LIP discharging the patient or Clinical Social Worker.

VI. Notify Sheriff Department immediately if a patient who has been triaged and/or assessed for suicidal thoughts/ideation, elopes prior to being evaluated by a physician/LIP.

Note: Refer to Emergency Room Nursing Triage Assessment Policies and Procedures for the Suicide Risk Assessment and Prevention Procedures specific to the Emergency Room.

Refer to the Mental Health Nursing Policies and Procedures for the Suicide Risk Assessment and Prevention Procedures specific to the Psychiatric Emergency Room.

References:
Joint Commission Extranet. FAQ for The Joint Commission's 2007 National Patient Safety Goals (Update 1/07). Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations.

Postgraduate Medicine Online. Principles of Suicide Risk Assessment, Volume 112. Number 3. September 2002.

Joint Commission. Joint Commission Perspectives on Patient Safety August 2006; Page 5.

Approved by: VEC-2011Jan	Date: 11/13/2012
Review Date: 10/16/2018, 3/2/2011	Revision Date:
Distribution: Olive View Hospital-Wide Policies	
Original Date: 8/07	