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

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

NUMBER: 5527
VERSION: 2

SUBJECT/TITLE: **SUICIDE RISK ASSESSMENT AND PREVENTION – PSYCHIATRIC EMERGENCY ROOM**

MD ORDER: **YES [ ] NO [ ]**

POLICY: A suicide risk assessment will be completed on any patient who presents in the Psychiatric Emergency Room with a primary complaint of an emotional or behavioral disorder or expressing suicidal thoughts/ideation or is on Lanterman-Petris-Short (LPS) hold.
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: **MENTAL HEALTH NURSING**

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.

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

PROCEDURE:

1. A Registered Nurse (RN) conducts an assessment of the following risk factors that may increase or decrease risk for suicide for every patient who presents in the Psychiatric Emergency Room 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

2. The Registered Nurse further assesses for presence of suicidal intent, plan and a means to carry out the plan and initiate the following suicide precautions.

    a. If patient has suicidal thoughts, assign one staff to be with patient while in the waiting area until patient is admitted in the locked holding room.
    b. Closely observe patient in the holding room in full view.
    c. Provide for patient safety by removing potentially harmful objects or contraband from patient and environment (e.g., sharp objects, belts, straps, ties, drugs, hair dryer, curling iron, purse, cosmetics in glass containers, plastic bags

including any plastic liners for trash cans). Refer to list of contraband items.

f. Search any object(s) or package(s) brought to patient by visitors.

g. Monitor bed linens to avoid patients having access to multiple sheets at one time.

h. Inspect the physical environment for presence of hazards, e.g., loose screws, sharp edges, broken furniture, tacks or bulletin board pins, glass vases, exposed wires, opened electrical outlets.

i. Observe patient when using shower/bathroom and during visiting hours. However, allow the patient some privacy by sitting off to the side.

j. Notify dietary to bring disposable tray, plastic or paper and no sharp utensils for patient's use for meals. Allow patient only blunted eating utensils. Staff must check that all utensils are returned.

k. Inform all staff of patient's status by indicating suicide precaution and specific level of observation in the assignment sheet, and patient's chart.

l. Inform family/visitors that potentially harmful items (glass scissors, etc.) are not to be given to patient.

m. Communicate patient's suicide risk precaution to all staff and during shift-to-shift hand-off communication and other staff/shift changes.

n. Communicate and monitor maintenance (facilities) workers to ensure that their carts and tools are monitored and are not accessible to any patient when in and around the Psych ER areas.

o. Communicate and monitor housekeeping staff to ensure that they keep their work carts in view and hazardous items are secured and not accessible to any patient when in and around PER areas.

p. Follow oral medication administration with careful mouth checks to ensure that medication is ingested. Obtain order to give medication in liquid form if necessary.

q. Encourage patient to verbalize his/her feelings towards hospitalization or any issue that may be relevant to the behavior. Respond with active listening and demonstrate concern.

r. Assist patient to structure their time, e.g., selecting TV shows, providing reading material, conversation or other activities, such as games or art projects, if available.

s. Observe change in patient's behavior such as isolation, manic phase, and giving away possessions.

3. The Registered Nurse evaluates and reports to physician/other care team members the effectiveness of interventions, any patient's behavioral/mood changes, increase or decrease in suicidal ideation and or verbalization of positive self/future planning.
4. The Registered Nurse will document assessment findings, physician notification, suicide precautions maintained and effectiveness of interventions.
5. 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 (Licensed Independent Practitioner) discharging the patient or Clinical Social Worker.

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

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.

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