

Suicide Monitoring/Precautions

Risk Assessment and Intervention

NCONL

Nursing Care Interventions

Psychiatric Care in an Acute Care Setting

- I. Policy
Psychiatric care is available for patients with psychiatric related illnesses or patients with emotional needs.
- II. Performed By
Registered Nurse, Licensed Practical Nurse, Nurse Aide, Mid Level Provider, Physician
- III. Assessment
 - A. Assessment by RN of patient's physical, social and psychological status upon admission ensuring that Mental Health Advance Directive is addressed.
 - B. Assessment by nurse of patient's physical, social and psychological status at periodical intervals i.e. every twelve hours or with each change in caregiver or change in patient status.
 - C. Observe for and identify potentially harmful behaviors with each patient assessment.
 1. Presence of suicidal ideation
Suicide risk will be considered as follows:
At Risk: Patient currently expresses thoughts of harming self and acknowledges a plan to do so and/or patient admission is directly related to a suicide attempt. Patients at risk for suicide are placed on Suicide Precautions. Patients admitted as a result of suicide attempt shall be placed on Suicide Precautions. Suicide Precautions may be initiated by a registered nurse or physician. If initiated by a registered nurse the registered nurse will notify the physician of the rationale for this level of intervention.
 2. Presence of definitive suicidal plan
 3. Presence of observed or reported agitation or severe anxiety
 4. Ambivalence about refraining from self injury
 5. Withdrawal symptoms
 6. Aggression- verbal or physical
 - D. Assess environmental factors and accommodate to provide a safe environment for patients and caregivers. Environmental safety factors include but are not limited to
 1. Cleanliness and orderliness of patient rooms
 2. Proper functioning of equipment
 3. Removal of any safety hazard when applicable, such as, broken furniture, torn linens, etc...

4. Cleaning spills as soon as they occur
5. be aware of potential safety hazards that cannot be eliminated and monitor area closely for patient safety. These considerations may include but are not limited to: locks on doors; doors that open in rather than open out; windows without stops to prevent opening more than 4-6 inches; light fixtures; ceiling grids; unanchored furniture; towel racks; window treatments; closets with clothing pole; sprinklers; television; call bell cords; pulse oximetry cords.
6. Patient belongings that might be considered a potential safety hazard, e.g. belts; ties; razors; charger cords for cell phones, computers, etc...

IV. Interventions

- A. Identify plan of care – Address psychosocial/emotional care needs i.e. Alteration in Coping & Anxiety, Mental Status, Psychosocial/Spiritual, and/or Death Anxiety.
- B. Discuss need for psychiatric consultation with the attending physician.
- C. Watch for escalating behaviors and notify physician if prescribed treatment is not effective.
- D. Discuss need for additional safety measures with the physician and healthcare team as appropriate to the patient's condition.
- E. Encourage participation in self-care activities and provide activities such as board games, playing cards, coloring, and puzzles when appropriate.
- F. Discuss plan of care with patients, and their families when applicable, allowing for boundaries that may be necessary to provide appropriate care.
- G. Monitor patient location both on and off the unit.

V. At Risk Patient and Patient Admitted with Suicide Attempt and/or Involuntarily Committed

- A. Initiate Suicide Precautions when it is determined the patient is at risk.
 - a. Initiate an order on the medical record for Suicide Precautions and a plan of care to promote the safety/welfare of the patient.
- B. Notify Supervisor when patient is admitted for suicide attempt or when a patient at risk is identified.
 - a. The Supervisor is to assess the patient situation to determine if an appropriate plan of care has been initiated.
- C. Suicide Precautions require close observation of patient. Patient should be placed in room as close to nurse's station as possible.
 - a. The patient and their belongings should be searched for contraband and weapons. This includes home medications brought in by the patient. These items should be removed and placed in a secure location. Contraband includes any items that may be used by the patient to harm or injure self such

as shoestrings, belts, fingernail files, mirrors, all types of razors...

- b. Suicide precautions include paper / plastic utensils (remove knife), locked windows or application of screens, removal of sharp objects, glass or potentially dangerous equipment or other items with exception of medically necessary equipment.
 - c. Observe patient while administering all medications. Do not leave medications with the patient to be taken unsupervised.
- D. Assign a qualified Sitter to remain in constant attendance with the patient at all times if the patient is suicidal or involuntarily committed.
- 1. Maintain continuous observation/visualization of the patient at all times.
 - 2. Accompany patient to bathroom and shower.
 - 3. Sitter is to remain with the patient while visitors are in attendance.
 - a. Sitter will utilize Sitter Observation and Documentation Form to document observations and activities and submit to the patient care nurse at the end of each shift.
 - 4. Door to patient room should be left open for patient and staff safety.
- E. Undress the patient and place in a hospital gown or personal sleepwear.
- F. Search patient, patient belongings and room for contraband, potentially dangerous items, and weapons. This includes medications brought in by the patient.
- 1. Examples of contraband (not all inclusive) include: razors, any items containing glass, matches and lighters, aerosols, toiletries, nail clippers/files, scissors, tweezers, eyebrow pencil sharpeners, shoestrings, belts, electrical appliances.
 - a. These items are to be removed and placed in a secure location on the unit.
 - 1) Personal items such as razors and toiletries may be used for patient care only under strict supervision and authorization by the registered nurse. These items are returned to the secured location following use.
 - b. Identify medications brought into the hospital by the patient and family. Follow Medication Reconciliation policy.
 - 2. Search for contraband is to be performed for all patients who are deemed suicidal, homicidal, or are involuntarily committed and admitted through the Emergency Department, while the patient is in the Emergency Department, and repeated upon admission to the nursing unit, and each time a patient is transferred during the visit.

a. The physical search of patient, patient belongings and room may be repeated as patient condition indicates.

1) The registered nurse and/or physician may authorize periodic searches as clinically indicated.

3. Contact Security to be present during the patient search.

- G. Nursing is responsible to complete the physical search of the patient, belongings and patient room.
- H. Sleepwear and non-contraband personal items may be kept in the patient's room.
 - 1. Follow hospital policy to account for valuables. Send home with family members or document and secure valuables in a safe location.
- I. Notify Security to increase patrols to the nursing unit if patients are involuntarily committed. J. Notify Supervisor of patients under involuntary commitment.
 - 1. Supervisor will verify the status of commitment with the nursing staff, care interventions and appropriateness of the plan of care.
- K. Supervised visitation of involuntarily committed patients may be allowed if this does not interfere with the care of the patient.
 - 1. Sitter is to remain with the patient during periods of visitation.

VI. Expected Outcome

- A. Patient/family is involved with the development of the plan for care and understands treatment goals.
- B. Patient is informed he/ she cannot leave the facility voluntarily if they are involuntarily committed.
- C. Patient is informed of the arrangements for psychiatric care following discharge from the hospital.
- D. A safe and therapeutic environment throughout patient's hospitalization is maintained.

VII. Documentation

- A. Document assessment and patient care on the respective documentation forms i.e. Admission History Record, Nursing Flowsheet, Interdisciplinary Plan of Care, and Education Teaching Record, Sitter Observation and Documentation Form
- B. Removal of personal clothing and placement in hospital gown.
- C. Document physical search and removal of personal items and where item are secured when appropriate to do so.

VIII. References

“Diligence and Design in Behavioral Health Impact Patient Safety”. *PA-PSRS Patient Safety Advisory*. September 2007. Vol 4, No.3.

Vedebeck, S, Psychiatric Mental Health Nursing, 2nd edition, 2003, June. Boyd, M, Psychiatric Nursing Contemporary Practice, June 2004.

Joint Commission National Patient Safety Goals 2009, Goal 15.

The Joint Commission FAQ. Suicide Risk Reduction. NPSG 15.01.01, December 2008.

Violence Risk Screening

Date:	Time:	Patient Name:
Referred from:		DOB:
Staff Assessor:		Female <input type="checkbox"/> Male <input type="checkbox"/>

Scoring Instructions:

Collect information about each of the risk factors, referring to scoring information as described under each item. Put a check in the box to indicate the degree of risk potential for the prospective patient.

The scoring is as follows:

- No: 0 Does not apply to this patient
- Maybe/moderate: 1 Maybe applies/present to a moderately severe degree
- Yes: 2 Definitely applies to a severe degree
- Do not know: - Too little information to answer

<p>1. Previous and/or current violence: Yes: Severe violence refers to physical attack (including use of weapons) towards another individual with intent to inflict severe physical harm. Maybe/moderate: Less severe aggressive acts such as kicks, blows, and shoving that does not cause severe harm to another individual. No (0) <input type="checkbox"/> Maybe/Moderate (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> Do not know <input type="checkbox"/></p>
<p>2. Previous and/or current threats (verbal/physical): Verbal: Statements, yelling, that involve threat of inflicting other individuals physical harm Physical: Movements and gestures that warn physical attack No (0) <input type="checkbox"/> Maybe/Moderate (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> Do not know <input type="checkbox"/></p>
<p>3. Personality disorder history: Eccentric (schizoid, paranoid) and impulsive, uninhibited (emotionally unstable, antisocial) types No (0) <input type="checkbox"/> Maybe/Moderate (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> Do not know <input type="checkbox"/></p>
<p>4. Shows lack of insight into illness and/or behavior: This refers to the degree to which the patient lacks insight in his/her mental illness, for example, with regard to need of medication, social consequences, or behavior related to illness or personality disorder. No (0) <input type="checkbox"/> Maybe/Moderate (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> Do not know <input type="checkbox"/></p>
<p>5. Expresses suspicion: The patient expresses suspicion towards other individuals either verbally or nonverbally. The person appears to be “on guard” towards the environment. No (0) <input type="checkbox"/> Maybe/Moderate (1) <input type="checkbox"/> Yes (2) <input type="checkbox"/> Do not know <input type="checkbox"/></p>
<p>Total Score:</p>

Security Risk Assessment Tool

- ü Law Enforcement CANNOT be released before initiation of Medical Screening Exam
- ü Reassessment at least q4 hours and prn

Date/Time	/	/	/	/	/	/	/	/	/	/	/	/	
		INITIAL Assessment			Reassessment			Reassessment			Reassessment		
		0 pts	1 pt	2 pts	0 pts	1 pt	2 pts	0 pts	1 pt	2 pts	0 pts	1 pt	2 pts
1. Previous history of violence to others?													
2. Previous history of harm to self?													
3. Evidence of substance misuse?													
4. Evidence of poor compliance with treatment or medication?													
5. Presence of recent severe stress, loss?													
6. Presence of specific threats to self or others?													
7. Access to potential victims?													
8. Degree of immediacy of risk?													
9. Symptoms exacerbated by custodian interactions													
TOTAL POINTS													
Initials													
Signatures													

RISK ASSESSMENT SCORE:

Security Assessment Item	Definition
1. Is there a history of documented evidence of actual violent behavior directed towards other people, animals or property?	0 points if absent 1 point if cruelty to animals or serious damage to property 2 points if actual physical assault on another person
2. Is there a history of documented evidence of self-harming behavior such as cutting, taking overdoses, etc.? This does not have to show evidence of specific suicidal intent, exclude nonspecific self-damaging behavior such as excess alcohol consumption or substance abuse	0 points if absent 1 point if present
3. Is there history of documented evidence of substance misuse	0 points if absent 1 point if present
4. Is there a history of poor compliance with treatment or disengagement with psychiatric services	0 points if absent or no previous psych history 1 point if present
5. Is there any evidence of severe stress, loss, threatened loss or significant life event within the last week (immediate) or over past year (recent)? This excludes criminal justice consequences of offenses such as imprisonment but includes losses as a result of the offense	0 points if absent 1 point for recent 2 points for immediate
6. Have there been any specific or current threats made by the individual?	0 points if absent 1 point if threat made about a general group of victims 2 points if threats made about a named victim
7. Does the individual have access to potential victims?	0 points if no access 1 point if access to a general group (i.e. women, health care workers, community) 2 points if access to specifically identified or named victim
8. Are potential victims in a position of immediate risk from the individual under the current conditions?	0 points if no 1 point if yes
9. Are there signs that the guardian/custodian may be negatively impacting the behavior or the patient?	0 points if absent 1 point if yes

Points = 10 – 13 High Security Risk Recommend Law Enforcement stay with patient
 Points = 8 – 9 Medium Security Risk Trial release prior to releasing law Enforcement
 Points = 1 – 7 Low Security Risk Recommend releasing Law Enforcement

Patient Label

Suicide Precautions/Risk Level

POLICY:

_____ seeks to provide a safe environment for all patients. While on suicidal precautions, a patient must be monitored on psychiatry or in the critical care unit, if the patient's condition warrants CCU treatment and observation. All patient belongings brought into the patient care environment will be examined by a nursing staff member to determine if the contents are potential for injury to the patient. Patients, family members, and visitors will be educated as to the purpose of this inspection and be requested to be present when possible. In an effort to provide optimum protection, any patient deemed to be at risk for suicidal behaviors will be placed on suicide precautions. If suicide precautions are recommended by the nursing staff and/or the attending physician a psychiatric consult will be requested to determine the appropriate suicide level.

Suicidal/Sisk Levels:

1. Routine Precautions:

Patients who are not presently voicing suicidal ideations or not presently exhibiting clinical symptoms that suggest intent or plan to inflict self harm will receive routine precautionary care.

Precautions:

- A. An assessment will be performed by a Registered Nurse on admission, with documentation of suicidal precautions.
- B. The RN will notify the physician immediately of any suicidal attempt or any changes in the patient's condition/behavior that indicates a plan or intent for self-harm.
- C. Routine unit precautions will be observed:
- D. Patient rooms, day rooms, and dining room will be assessed daily for harmful objects.
- E. The patient, room, and belongings, will be assessed on admission and any sharps or substances that could be harmful to the patient will be removed. The patient will be informed prior to the inspection and the reason for the inspection. The patient's environment will be reassessed on a daily basis by the staff.
- F. The physician will evaluate the patient's condition/behavior and indicate the appropriate level of precautions.
- G. Documentation of routine observations will be made in the progress notes for psychiatric patients. Observations of the critical care patient will be done in the critical care flow sheet.

2. Level III :

Patients with suicidal ideations, who after an assessment by a physician, present clinical symptoms that suggest a possible intent for self harm but no plan for acting on that intent.

Example of Patient Symptoms: The patient who has made threats of self harm but has no plan and is willing to make a no suicide contract.

Precautions:

Routine precautions will be taken in addition to the following;

- A. The RN may place the patient on Level III suicide precautions until receiving a physician's order.
- B. The RN will document in the patient progress notes the date and time that precautions were initiated.
- C. Observation of the psychiatric patient will be documented every hour on the Observation Record. An assessment of suicidal ideations and/or intent will be made and documented at least Q 8 hours. Observation of the critical care patient will be documented every hour on the critical care flow sheet.
- D. The patient will have constant supervision by staff during meal times. The patient will receive disposable utensils.
- E. A physician's order is required to decrease or change the level.

3. Level II

Patients with suicidal ideations, who after an assessment by a physician, present clinical symptoms that suggest a clear intent for self harm, but a vague plan for acting on the intent.

Example of Patient Symptoms: The patient who is ambivalent about making a no-suicide contract and continues to talk about self harm.

Precautions:

Level III precautions will be taken in addition to the following;

- A. The Registered Nurse may place the patient on Level II until receiving a physician's order indicating level.
- B. Observation of the psychiatric patient will be documented every 30 minutes on the Observation Record. Observation of the critical care patient will be documented every 30 minutes on the critical care flow sheet.

4. Level I

Patients with suicidal ideations or delusions of self mutilation, who after assessment by a physician, present clinical symptoms that suggest a clear intent to follow through with a plan or delusion. Patients that make a suicidal gesture while hospitalized will be placed on level I precautions.

5. Example of Patient Symptoms: The patient is currently verbalizing a clear intent to do self harm, has a concrete plan to commit suicide or has attempted suicide in the recent past by a

particularly lethal method (i.e., hanging, guns, carbon monoxide, a potentially lethal overdose confirmed).

Precautions:

Level II precautions will be taken in addition to the following;

- A. The RN may immediately place the patient on Level I suicidal precautions until receiving a physician order indicating the level. The RN will immediately notify the attending physician when placing a patient on Level I precautions.
- B. If necessary, the nursing staff will provide first aid measures when appropriate.
- C. Observation of the psychiatric patient will be documented every 15 minutes on the Observation Record. Observation of the critical care patient will be documented every 15 minutes on the critical care flow sheet.
- D. The patient will have 1:1 observation during meal times.
- E. A 1:1 order may be obtained for constant observation of the patient.
- F. While on level 1 precautions the patient's absence from the department will be limited to medically necessitated escorts to other areas of the hospital.

Forced Medications/Treatments

Purpose

To provide appropriate care and maintain a safe environment while ensuring patient's rights to the extent allowed by law.

Policy

A voluntarily admitted patient and/or their legal representative has the right to refuse any treatment offered by the hospital. If treatment is refused, the attending physician or designee will determine whether an alternative treatment is possible. Appropriate medication and treatment, consistent with accepted medical standards, may be administered to an involuntarily admitted patient by their attending physician or designee. A physician's order is required prior to the administration of the intervention and rationale documented in the medical record. Medication and treatments may be forced in special circumstances as described in the following procedures.

Policy Detail

- A. In the event of an emergency situation in which there is significant possibility that the patient may harm self or others, treatment or medication (except electroconvulsive therapy or other treatments that require specific expressed written consent or experimental interventions) may be administered despite refusal of the voluntarily admitted patient and/or their legal representative.
- B. Patients admitted under the involuntary commitment process may be administered medications and/or treatments despite refusal of the patient and/or legal representative, in the following circumstances:
 - 4. In the event of an emergency situation in which there is significant

possibility that the patient may harm self or others; or

5. Whenever the attending physician and a second physician (clinical medical director or designee) at the hospital have considered the side effects of the treatment and determined that, without the treatment:
 - a. The patient is unable to participate in any available treatment plan which will provide a realistic opportunity to improve the patient's condition; or
 - b. There is a significant possibility that the patient may harm self or others before improvement in their condition occurs.

The rationale for administration of medication and /or treatment despite the patient's objection must be clearly documented in the medical record.

Mental Health Care Coordination Communication Tool

Presentation Date: _____ Time: _____ am/pm Arrived from home facility _____ other _____

Admitting Dx _____ Attending Physician _____

Past Mental Health History _____

Family Present Yes No Accompanied by _____ Phone # _____

Precaution: Suicide Homicidal Combative Involuntary Commitment 1:1 Sitter Other _____

Initiated Psychiatric Management Orders: Yes No

Nursing Plan of Care:

Problem / Focus – Problem can be actual or potential

- Altered cognitive status Suicide attempt Aggressive behavior Seizures Non-suicidal self-mutilation
- Victimization Predatory Behavior Polydypsia Psychotic signs Fire Setting
- Sexual acting out Elopement Behavior; at risk for harm to self or others
- Other _____

Primary Support identified: _____ Contact #: _____

Action in patient care Legal Guardian POA

Other contacts: Name _____ Phone #: _____ Relationship: _____

Name _____ Phone #: _____ Relationship: _____

Patient/Family Comments:

Voiced by: _____ Date: _____ Time: _____ To: _____

Date: _____ Time: _____ RN Signature: _____

Diagnostic Impression: _____

Recommended Treatment Plan:

Date: _____ Time: _____ MD Signature: _____

Patient's Deficits/Stressors include: *check all that apply*

Date Time	Initial		Date Time	Initial		Date Time	Initial	
		Education			Financial Stressors			Health Concerns
		Lacks Insight			Treatment Non-Compliance			Occupational /Educational Concerns
		Losses			Traumatic Events			Impaired Intellectual Functioning
		Substances			Lack of Support System			Unable to Meet Basic Needs
		Poor Judgment			Marital Family Conflicts			Ineffective Communication Skills
		Legal Issues			Lack Motivation			Other:
		Peer Issues			Other:			Other

Involuntary Commitment Date/ Renewals: _____ Anticipated Discharge Date: _____

Discharge Readiness Treatment Assessment

Date Time	Initial	Discharge Criteria	Date Time	Initial	Primary Discharge Plan
		No longer a danger to self or others			Return to previous living arrangement
		Basic life and health needs met			Arrange alternate living arrangement/placement
		Adequate post-discharge living arrangements			Attend 12 step Recovery Program
		Mood thinking and/or behavior stabilized			Outpatient treatment
		Withdrawal symptoms are absent or sub-acute			Arrange medical follow-up for health concerns
		Verbal commitment to treatment compliance			Other:
		Other:			Other:

Final Discharge Disposition:

Discharge to: Home Facility/ Other: _____

Outpatient follow-up: _____

Treatment Plan has been presented to and reviewed with patient, family member / significant other

Family / S.O. Name: _____ Comments: None Yes

Complete for discharge / transfer	Signature	Date	Time
Nursing:			
Social Work:			

Complete for discharge / transfer to another facility
 When patient stable for discharge / transfer Signature Date Time

Nursing:		
Social Work:		

Signature / Initials for Patient Deficits / Stressors and Treatment Team Assessment

Signature _____ Initial _____

Signature _____ Initial _____

Signature _____ Initial _____

Signature _____ Initial _____

Signature _____ Initial _____

Signature _____ Initial _____

Signature _____ Initial _____

Signature _____ Initial _____

ONGOING COMMUNICATIONS DURING PATIENT

DATE	TIME	DISCIPLINE	NOTES / SIGNATURE

Patient Identifier

Suicide Prevention Bundle – ED

Purpose: To reduce the risk of suicide while receiving care outside the psychiatric unit.

Since the inception of The Joint Commission’s Sentinel Event Policy in 1996, patient suicide, while in a staffed, round-the-clock care setting has been the most frequently reported type of sentinel event. . Safe passage from the emergency department to CCU, then to the psychiatric unit, must be managed appropriately for these at-risk patients.

Bundle Protocols:

- Any patient who poses an immediate threat to self or others will be placed in an area that allows direct observation.
- Patients, assessed as medically unstable and physically unable to act on suicidal intent (i.e. patient on a ventilator), will be placed on **Routine Suicide Precautions:** Patients who are not presently voicing suicidal ideations or are unable to act on suicidal intentions.
 1. Assessment for suicidal ideations, plans/gestures, every 12 hours and PRN. This assessment will be completed and documented by the psychiatric patient care coordinator (PCC) or resource nurse. Documentation of observations will be in progress notes as per clinical documentation.
- Patients assessed as a threat, or with a history of suicidal attempts or intentions, will be placed on **Level I Precautions:** Patient with suicidal ideation or history/evidence of self-mutilating behavior with **CLEAR** intent to follow through with plan, or patients who have recently attempted suicide by particularly lethal method (examples include, but are not limited to: hanging and potentially lethal overdose).

The implementation of the suicide prevention bundle will not be delayed for any reason.

1. The PCC from psychiatry or resource nurse must be notified ASAP from triage to assess the patient. These psychiatric resources will reassess the patient, in the ED, at least every 12 hours and PRN until the patient is discharged or transferred.
2. Observations are documented at least **every 15 minutes** in progress notes as per clinical documentation.

Bundle Components Environmental Safety

- Dress the patient in a hospital gown and remove ALL belongings from the room.
- RN will assess patient, and belongings, for objects that could be used to cause self-harm or injury to others. Search patient’s clothing and belongings with the patient, and a second staff member present. An itemized list of these belongings is to be compiled and the items stored as appropriate. Contraband can include:
 1. Sharps: Scissors, glass bottles, nail files, razors, safety pins, mirrors, etc.
 2. Dangerous Items and Flammable Liquids: plastic bags, gloves, matches, cigarette lighters, perfume, shoe laces, belts, sashes, telephone cords, etc.
 3. No food or drinks from outside hospital are allowed.

Environmental Safety

- Store patient belongings in secure area or send home with a family member. Document which takes place.
- Send a dietary message via Meditech: Deliver all meals on disposable tray including plastic utensils. No cans or glass allowed.
- Patient may use a hospital approved cordless telephone as appropriate.
- Privacy curtains must remain open at all times unless a staff member is present in the room.
- Items/supplies/equipment taken into the room for procedures should be kept in the control of staff at all times and immediately removed from room after procedure.
- Monitor patient when administering medications ensuring that medications are swallowed completely.
- Visitors permitted in the patient's room at the discretion of the primary or charge nurse.

Consults/Collaboration

- Upon placement in an examination room, the ED nurse will consult the ED PCC and/or charge nurse to assist in the assessment of the patient, environmental safety, and the coordination of care.
- The ED triage nurse will consult the psychiatric PCC and/or psychiatric resource nurse immediately at presentation to assist in assessment/recommendations related to environmental safety and patient care by calling # _____. The psychiatric resource nurse will round in the ED at least every 12 hours and PRN.
- During walking rounds, and at hand-off, and when the psychiatric resource nurse rounds, a discussion regarding safety strategies and care planning will occur. Documentation of the plan of care is made in the nursing notes via clinical documentation.

Assessments

An ED charge nurse, PCC &/or the psychiatric resource nurse will be responsible for:

- Suicide risk assessment upon placement into examination room, increased level of consciousness and/or when the patient is able to act on suicidal intentions.
- Perform routine precaution assessment and re-assessments at least **every 12 hours** and PRN and complete assessment documented.
- Level I precaution assessment and documentation in clinical documentation.

ED staff nurse will be responsible for:

- Contacting one of the above resources when/if patient conditions change.
- Routine or Level I Precautions implementation and documentation of observations in clinical documentation.
- Monitoring the patient when giving medications ensuring that medications are swallowed completely.
- Assuring that a NURSE accompanies patient to any location outside of patient's examination room (radiology, etc).

Education (Patient, Family, Visitor)

- The ED nurse, ED PCC, or Psychiatric Resource Nurse will provide education and instructions to the patient and family regarding safety measures described in environmental safety bundle components. An educational brochure will be provided to the family. All other appropriate ED education will be provided.
- The psychiatric PCC or resource nurse will provide education and instructions to the patient and family regarding the patient's transfer to the psychiatric unit.
- In the event a patient is discharged from the ED, the psychiatric PCC or resource nurse will provide patient and/or family with psychiatric discharge instruction. This education will include a crisis resources contact card.

References

HCPPro, Inc., 03/29/2007. Suicide Risk Assessment: Save Lives and Comply with The Joint Commission (audioconference).

Litch, Bonnie. (2007). How The Use Of Bundles Improves Reliability, Quality and Safety. *Healthcare Executive*. Mar/Apr., 13-18.

Temkin, Ted M. and Crotty, Margaret. (2004). Suicide and Other Monitoring in Inpatient Psychiatry. *Journal of the American Psychiatric Nurses Association*, Vol. 10, No. 2.

Ball, Lauren R. Suicide Risk Assessment – Practical Strategies and Tools for Joint Commission Compliance. Marblehead, MA. HCPPro, Inc., 2007. Suicide Bundle Temporary Action Group: 07/11/07

Suicide Prevention Bundle - Critical Care

Purpose: To reduce the risk of suicide while the patient is receiving care outside the psychiatric unit.

Suicide of a care recipient while in a staffed, round-the-clock care setting has been the most frequently reported type of sentinel event since the inception of The Joint Commission’s Sentinel Event Policy in 1996. Safe passage from the

Bundle Protocols:

- All suicide attempt patients not admitted directly to psychiatry department will be admitted to a CCU video-monitored room regardless of medical stability status.
- Patients assessed as medically unstable and physically unable to act on suicidal intent will be placed on **Routine Suicide Precautions:** Patients who are not presently voicing suicidal ideations or unable to act on suicidal intents.
 1. An assessment will be completed and documented by the psychiatric patient care coordinator (PCC) or resource nurse every 12 hours and PRN.
- Patients assessed as medically stable and physically able to act on suicidal intent will be placed on **Level I Precautions:** Patients with suicidal ideations or delusions of self-mutilation with **CLEAR** intent to follow through with plan or delusion, or patient has recently attempted suicide by particularly lethal method, (examples include but are not limited to: hanging and potential lethal overdoses).

The implementation of the suicide prevention bundle will not be delayed while waiting on psychiatric resources to assess the patient.

3. The psychiatric PCC or resource nurse, CCU PCC or charge nurse must be notified **ASAP** to assess the patient upon endotracheal extubation, awakening or with increased level of consciousness and having the ability to act on suicidal intent. These psychiatric resources will reassess the patient at least every 12 hours and PRN until the patient is discharged or transferred and document assessments on the psychiatric assessment intervention.
4. The CCU nurse or nurse aide will observe patient’s behavior at least **every 15 minutes** and document observations on the suicide assessment form (intervention).
5. A psychiatrist or the psychiatric nurse practitioner will perform a psychiatric assessment through the consult process (order entry & telephone notification) as ordered by the attending physician. The CCU PCC or charge nurse will communicate with the psychiatric resource person to expedite the consult.

Bundle Components

Environmental Safety

- Remove all potentially harmful items from patient room (remove drawers, empty cabinets, telephone with cord, respiratory supplies, any unnecessary equipment including cables and medical supplies).
- Dress the patient in a hospital gown with second staff member present. Use a hospital gown without strings.
- The bed exit alarm must be on at all times while the patient is in bed.
- Search patient's clothing and belongings with a second staff member present.
- Remove all potentially harmful objects that may have been brought into hospital.
 1. Sharps: Scissors, glass bottles, flower vases, nail files, razors, safety pins, wire hangers, mirrors, etc.
 2. Dangerous Items and Flammable Liquids: plastic bags, gloves, matches, cigarette lighters, perfume, shoe laces, belts, sashes, telephone cords, etc.
 3. No food or drinks from outside hospital are allowed.

Environmental Safety

- Store items in secure area or send them home with a family member.
- Send a dietary message via order entry: Deliver all meals on disposable trays including plastic utensils. No cans or glass allowed.
- Patients may use a hospital approved cordless telephone.
- Privacy curtains must remain open at all times unless a staff member is present in the room.
- Video camera monitor must be on and viewed by monitor tech and/or nursing staff.
- Items/supplies/equipment taken into the room for procedures should be kept in the control of staff at all times and immediately removed from room after procedure.
- Place visitors' purses, coats, hats, bags, medications, tobacco products, etc in a locker located in the staff lounge. Instruct the visitor to ask staff upon leaving unit to retrieve personal belongings.

Consults/Collaboration

- The CCU nurse will consult the psychiatric PCC and/or psychiatric resource nurse upon admission by calling # _____ to assist in assessment and recommendations related to environmental safety and patient care.
- During walking rounds, at hand-off of care, in multidisciplinary team meetings, and on psychiatric resource nurse rounds, a discussion regarding safety strategies and care planning will occur.
- Documentation of the plan of care is made in the nursing notes via electronic clinical documentation.

Assessments

CCU &/or Psychiatric PCC, CCU Charge Nurse, or Psychiatric Resource nurse will be responsible for:

- Suicide risk assessment upon admission into the patient room, upon extubation, with increased level of consciousness and/or when the patient is able to act on suicidal intentions. **CCU Nurse should notify one of these resources when this occurs.**
- An assessment will be completed and documented by the psychiatric PCC or resource nurse every 12 hours and PRN. The CCU nurse accesses clinical documentation (add intervention select SUI then pick suicide precautions routine and intervention suicide assessment) for the psychiatric nurse to document. This process applies for both routine and level 1 precautions assessment and documentation.

CCU staff nurse will be responsible for:

- Contacting one of the above resources when a patient condition change occurs.
- Implementing routine or level I precautions based on patient's status as noted in the bundle protocols.
- Monitoring the patient when giving medications ensuring that medications are swallowed completely.
- Assuring that a nurse accompanies patient to any location outside of patient's room (radiology, etc).

Education (Patient, Family, Visitor)

- The CCU nurse, CCU PCC, or psychiatric resource nurse will provide education and instructions to the patient and family regarding safety measures described in environmental safety bundle components. The CCU nurse will provide an educational brochure to the family. All other routine CCU education will be provided by the CCU nurse (examples: ID process, call bells, visiting hours, etc.)
- The psychiatric PCC or resource nurse will provide education and instructions to the patient and family regarding transfer of care to the psychiatric unit.
- The psychiatric PCC or resource nurse will provide patient and/or family with psychiatric discharge instruction in the event a patient is discharged from the CCU. This education will include a crisis resources contact card.

References

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