GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL

APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.:	PAGE:
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TITLE: SUICIDE PRECAUTIONS				
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PURPOSE

To delineate procedures to be undertaken when a suicide precaution order has been given or when a client meets criteria warranting initiation of suicidal precautions and procedures.

Guam Memorial Hospital Authority does not have an in-house psychiatric consult. The goal for clinical staff is to ensure and establish the immediate and continual safety of the client as well as the clinical staff.

POLICY:

- All patients who fall under the responsibility of the clinical/nursing departments of the Guam Memorial Hospital Authority will be assessed suicidal potential. Suicidal screening potential will be completed at the out-patient and in-patient level of care as part of the admission screening and clinical assessment at the initial presentation of the client and as determined upon clinical judgement from the licensed clinical staff.

- As part of the clinical assessment, suicidal assessments will include (1) If the presence of any suicidal disposition is existent in the client, (2) any Suicidal history and tendencies, (3) psychiatric history of the patient, (4) present psychosocial condition of the patient, (5) individual strengths and coping mechanisms.

- Suicide precaution orders will be given by a physician for the patient who meets the specified criteria for suicidal precautions. Additional safety and interventional steps specifically required for each patient will be ordered in addition to the set procedures. It is the responsibility of nursing staff to assess and notify the clinical physician of the specific safety needs. *(Refer to Attachment IV– Suicide Precautions Order).*

- All patient who are ordered suicidal precautions at any level will be referred to proper psychiatric screening and evaluation once the medical clearance of the patient is met while admitted in the hospital inpatient setting or emergency department. Psychiatric evaluation will be completed with a referral to the Guam Behavioral Health and Wellness Center following medical clearance of the patient. Patients with private psychiatric consults may be referred to their psychiatric practitioners after direct medical physician-to-psychiatric practitioner endorsement and acceptance by the consulting psychiatrist.

- Interventions for suicidal precautions will be applied based on the presenting case of the patient and the clinical decision of the evaluating physician based on a two tiered assessment-intervention system to be applied in the in-patient and outpatient unit from initial presentation and assessment to discharge and transfer to an out-patient psychiatric consult.

RESPONSIBILITIES:

Patient Sitter (CNAs, ERTs, Patient Couriers) – Initiate and intervene on the actions that maintain safety for a client's placement under suicidal precautions. Patient Sitter will provide the continued monitoring (1:1) of the patient and will actively communicate the individual needs of the patient to the licensed nursing staff .

Attending Physician – Place the order for suicidal precautions and specific interventions needs of the patient. The physician will determine the initial and continued need of suicidal precautions and will determine the level of suicidal precautions to be taken with a client. Physicians will initiate the psychiatric consult to be taken and to complete the medical clearing process for the patient to receive an out-sources psychiatric evaluation.

Licensed nurse/Licensed clinical staff (Primary and Charge Nurse) – Perform the initial and continued assessment for the patient requiring suicidal precautions. The licensed nurse will maintain communication between the client, clinical staff, security and facilities maintenance personnel, and the physician. The nurse will bring and report the condition of the patient to other clinical staff and to the physician. The nurse will address the need of the patient to have had a behavioral health consult by reporting criteria of the patient that may warrant behavioral health consultation to the attending physician.

Security officer – Will contribute to the safe maintenance of the environment of the patient to include searching belongings of visitors – if allowed by the physician and nursing staff, and to directly control visitors under the management of the primary and charge nurse.

Facilities Maintenance Staff/Boiler Room Staff (After Hours) – Will complete the environment assessment for the client under suicidal precautions. Staff will assist in modifying the environment to fit the safety and medical needs of the patient. The security officer will complete the environmental assessment with Boiler room Staff during afterhours.

DEFINITIONS:

Suicide: Self-inflicted death with either implicit or explicit evidence of the intention of the individual

Self-Harm (deliberate): Willful self-inflicting of painful, destructive or injurious acts without intent to die.

Suicidal Ideation: Thoughts of serving as the agent of one's own death. Suicidal ideation may vary in seriousness depending on the specificity of suicide plans and the degree of suicidal intent.

Suicidal Attempt: Self-injurious behavior with a nonfatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die.

Client: Term to indicate individual receiving clinical care in the GMHA facility – may be used interchangeably with 'patient.'

PROCEDURE:

I. PATIENT MONITORING AND CARE

A. **Procedure**

1. Upon admission/ED triage, licensed personnel will determine the need to implement interventions to decrease and prevent a means of suicide based on the presenting case of the client and the risk for suicidal ideation. *(Refer to Attachment II, Suicide Risk Screening Tool)*

2. When a client is found to need interventions for suicidal precautions, the licensed staff will ensure the immediate safety of the client and clinical personnel and will initiate interventions and level of monitoring based on the criteria of the two-level system. The initiation of the steps to ensure the immediate safety of the client and personnel is the priority before the evaluation of the attending physician.

3. Continuation of suicide precautions in the in-patient unit will be done through a daily re-assessment by the attending physician.

4. Discontinuation of suicide precautions will be done by a face-to-face evaluation by the attending physician in consultation with the proper psychiatric personnel, if applicable.

5. Documentation in the Progress Notes will indicate the assessment findings and the indication for implementing suicidal precautions.

6. Two-Tier/Two Level Suicide Precautions will be used to address the intervention need for the client at risk:

    a. **LEVEL I (Minimal Suicide Precautions)** Implemented for patients with active thoughts/ideation and no plan; assessed by the attending physician as having significant risk for suicidal attempt or self-harm.

        i. Attending Physician will conduct a face-to-face assessment and evaluation for continuation and discontinuation of precautions measures.
        ii. Clinical Licensed Staff will make visual contact with the patient at 15 minute intervals and will document that visual contact was made in the patient observation sheet.
        iii. Behavioral/ Suicide assessment by the licensed clinical staff will be completed once every nursing shift change, upon unit transfer, or upon the assessed need for the client by a licensed clinical staff.
        iv. Client will be placed near the nursing station of the unit or within clear un-obstructed view in the out-patient unit. Client's door will remain open at all times unless situations warrant client privacy (bedside procedures, physician examination) with clinical support/ licensed clinical staff/ clinical practitioner present in the room.
        v. Client will be accompanied out of the monitoring area or will be transported with one clinical support staff until client is returned to the monitoring area or care is transferred to an accepting facility.

vi. Security personnel will conduct searches of all items brought to the patient's room and will not allow items which can be used to facilitate self-harm.

vii. Nursing staff will assess the room for items that may be of facilitative use for self-harm and will arrange for the movement and removal of items. Nursing staff will control the reception of visitors into the patient's room and will inform security personnel of any restrictions to visitation based on clinical judgement or upon physician orders.

viii. Facilities maintenance personnel will work with clinical and security staff to ensure the maintenance of a safe environment and will designate a liaison department during nonoperating hours to address the environmental and facilities needs of the client under suicidal precautions. *(Refer to Attachments V and VI—Suicide Environment Checklist and Emergency Department Unit Specific Suicidal Patient Safety Needs to Consider in the Physical Environment Checklists)*

b. **LEVEL II (Strict Suicide Precautions)** Implemented for clients who have presented with active thoughts and a plan; clients who have presented with an existing suicidal attempt or attempted self-harm.

i. Attending Physician will conduct a face-to-face assessment and evaluation for continuation and discontinuation of precautions measures.

ii. Clients will have a 1:1 observer that will remain in the constant presence of the patient. Observers will be assigned by the unit or by the nursing supervisor based on staff availability and unit patient-to-staff load.

iii. Clinical Licensed Staff will make visual contact with the patient at 30 minute intervals and will document that visual contact was made in the patient observation sheet.

- Behavioral/ Suicide assessment by the licensed clinical staff will be completed once every two hours while the patient is awake, during nursing shift change, upon unit transfer, or upon the assessed need for the client by a licensed clinical staff. If the patient is asleep, the licensed nursing staff will document that the patient is asleep, calm, with maintained safety and under a 1:1 observation instead of the scheduled assessment.

- Client will be placed near the nursing station of the unit or within clear un-obstructed view in the outpatient unit. Client's door will remain open at all times unless situations warrant client privacy

(bedside procedures, physician examination) with clinical support/ licensed clinical staff/ attending physician present in the room.

- Client will be accompanied out of the monitoring area or will be transported with one clinical support staff as the observer and one licensed clinical personnel at minimum until the client is returned to the monitoring area or care is transferred to an accepting facility. Clients who need restroom facilities must be accompanied by clinical support staff and returned immediately to the monitoring area.

vii. Security personnel will conduct searches of all items brought to the patient's room and will not allow items which can be used to facilitate self-harm.

- Nursing staff will assess the room for items that may be of facilitative use for self-harm and will arrange for the movement and removal of items. Nursing staff will control the reception of visitors into the patient's room and will inform security personnel of any restrictions to visitation based on clinical judgement or upon physician orders.

viii. Facilities maintenance personnel will work with clinical and security staff to ensure the maintenance of a safe environment and will designate a liaison department during nonoperating hours to address the environmental and facilities needs of the client under suicidal precautions. *(Refer to Attachment V, Suicide Environment Checklist)*

B. <u>Food Trays</u>

Food trays will be prepared by the dietary department. Nursing units are to order isolation trays for high risk suicidal patients. If outside food is allowed by the physician, security and nursing staff will inspect food items and will not allow items that may increase the risk of suicidal attempt or attempted self-harm.

C. <u>Special Considerations: Frequency in monitoring and Behavioral Assessment</u>

For clients who present to the in-patient/out-patient unit meeting criteria requiring suicidal precautions but with considerations due to clinical status (sustained altered mental status, comatose state, continuous sedation under life support measures), frequency and applicability of consistent patient observation may be determined non-applicable or may be specifically altered and must be explicitly documented and ordered by the clinical practitioner after a face-to-face evaluation.

II. DOCUMENTATION

Documentation for the client under suicidal precautions include the Patient Observation Sheet (R*efer to Attachment I, Patient Observation Sheet*) which will indicate the time a licensed clinical staff member visually observed the patient, that the patient was observed as calm, the presence of a 1:1 observer – if applicable, notation that the patient had required no further assessment other than a routine visual inspection. Progress notes will reflect the patient's need for suicidal precautions at the initial initiation of suicidal precautions, the indications for discontinuing suicide precautions, communication with the physician regarding the care and monitoring of the patient, and additional interventions that were taken.

The Behavioral Activity Assessment will be completed upon admission and evaluation into the clinical patient area, as indicated based on the suicide level of the patient, and upon need based on the clinical judgment of the licensed clinical staff.

An environmental checklist will be completed and endorsed by the security, facilities maintenance staff, and nursing staff upon the initiation of suicide precautions, deeming the environment as appropriate for the patient with ordered. *(Refer to Attachment III, Behavior and Activity Assessment)*

III. OUTPATIENT UNIT GUIDELINES

A. Patients in the Emergency Department who present with a singular or concurrent finding requiring suicidal precautions but are not disposed for admission, will require a psychiatric evaluation following medical interventions. Psychiatric Evaluation may be delayed until all medical clearance and required interventions are met as determined by the Emergency Department Physician.

B. The transfer of patients to the consulting psychiatric facility will require the specified escort personnel as for patients admitted.

C. Patients who require medical clearance prior to acceptance for psychiatric evaluation, but do not require intensive cardio-pulmonary interventions and monitoring, need only be placed in clear view of nursing personnel but must be assigned a licensed clinical staff to comply with patient observation while under the care of the Emergency department. Level II patients will require a 1:1 observer in the Emergency department and may be escorted from the monitoring area to diagnostic study and to restroom facilities and back under constant observation of clinical support staff. Unit and facility transfers require licensed clinical staff in addition to patient sitters.

IV. FAMILY/PATIENT EDUCATION – Family/Patient Education to Include:

A. Knowledge on the process of managing patients under suicidal precautions and the proper channels for psychiatric evaluation referral.

B. Safety measures to be maintained and enforced while the patient is under in-patient care.

C. Warning signs and risk factors to suicidal attempts and acts of self-harm.

V. DISCHARGE PLANNING

A. For Emergency Department patients who do not meet inpatient admission requirement, ensure that patient is transferred directly to the behavioral health/psychiatric evaluation with a staff escort, as specified based on the ordered suicide precaution level. In-patients requiring further psychiatric evaluation may be transported after medical requirement have been met.

B. For all discharged patients (Emergency Department and Inpatient Discharges): Provide patient/family teaching on suicide prevention *(Refer to Attachment VII, Discharge Instructions - Suicide Risk)* which includes the Crisis Hotline and other community resources are provided. If available, provide the patient with "Focus on Life: Stop Suicide on Guam" and "Focus on Life: A Guide on Surviving and Coping from Suicide Loss" *(Refer to Attachments VIII & IX)*.

C. Should there be an identified means of access (i.e. guns, pills, rope), discharge instructions to patient/family members should emphasize the removal or reduction of these access.

D. Social Services may be consulted for in-patient discharge planning.

REFERENCES:

Lewis L.M. No Harm Contracts – A review of what we know. *Suicide Life Threatening Behavior*. 2007 Feb;37(1):50-7

McMyler C. Do No-Suicide Contracts Work. *Journal of Mental Health Nursing*. 2008 Aug;15(6):512-22.

Sakinofsky I. Preventing Suicide Among Inpatients. *Canadian Journal of Psychiatry Revue Canadienne de Psychiatrie*. 2014; 59(3):131-140.

RESCISSIONS:

6301-II A-8, Suicide Precautions, of the Nursing Services Manual made effective October 13, 2013.

ATTACHMENTS:

I. Patient Observation Flowsheet
II. Suicide Risk Screening Tool
III. Behavior and Activity Assessment
IV. Suicide Precautions Order
V. Suicide Environmental Assessment
VI. Emergency Department Unit Specific Suicidal Patient Needs to Consider in the Physical Environment
VII. Discharge Instructions - Suicide Risk
VIII. "Focus on Life: Stop Suicide on Guam"
IX. "Focus on Life: A Guide on Surviving and Coping from Suicide Loss"

ATTACHMENT I

GUAM MEMORIAL HOSPITAL
PATIENT OBSERVATION SHEET

PATIENT OBSERVATION FLOWSHEET						
DATE:						
TIME:						
Suicide Precaution Level	☐ Level I (visual every 15 mins) ☐ Level 2 (visual every 30 mins)	☐ Level I (visual every 15 mins) ☐ Level 2 (visual every 30 mins)	☐ Level I (visual every 15 mins) ☐ Level 2 (visual every 30 mins)	☐ Level I (visual every 15 mins) ☐ Level 2 (visual every 30 mins)	☐ Level I (visual every 15 mins) ☐ Level 2 (visual every 30 mins)	☐ Level I (visual every 15 mins) ☐ Level 2 (visual every 30 mins)
Patient Visually Observed As:	☐ calm ☐ non-anxious ☐ Other: _____	☐ calm ☐ non-anxious ☐ Other: _____	☐ calm ☐ non-anxious ☐ Other: _____	☐ calm ☐ non-anxious ☐ Other: _____	☐ calm ☐ non-anxious ☐ Other: _____	☐ calm ☐ non-anxious ☐ Other: _____
Is 1:1 Observer Present?	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable
Does the patient Require Further Assessment?	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable
Staff Initial						
DATE:						
TIME:						
Suicide Precaution Level	☐ Level I (visual every 15 mins) ☐ Level 2 (visual every 30 mins)	☐ Level I (visual every 15 mins) ☐ Level 2 (visual every 30 mins)	☐ Level I (visual every 15 mins) ☐ Level 2 (visual every 30 mins)	☐ Level I (visual every 15 mins) ☐ Level 2 (visual every 30 mins)	☐ Level I (visual every 15 mins) ☐ Level 2 (visual every 30 mins)	☐ Level I (visual every 15 mins) ☐ Level 2 (visual every 30 mins)
Patient Visually Observed As:	☐ calm ☐ non-anxious ☐ Other: _____	☐ calm ☐ non-anxious ☐ Other: _____	☐ calm ☐ non-anxious ☐ Other: _____	☐ calm ☐ non-anxious ☐ Other: _____	☐ calm ☐ non-anxious ☐ Other: _____	☐ calm ☐ non-anxious ☐ Other: _____
Is 1:1 Observer Present?	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable
Does the patient Require Further Assessment?	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable
Staff Initial						

PATIENT OBSERVATION FLOWSHEET
Guam Memorial Hospital Authority
Approved: NM:_____ HIMC:_____
Form #: iMed

PATIENT ID LABEL

ATTACHMENT II

SUICIDE RISK SCREENING TOOL

Date	Time
QUESTIONS TO ASSESS THOUGHTS OF SUICIDE	
Has the patient had any thoughts of self-harm in the past week?	☐Not Applicable ☐Yes ☐No
If Yes, does the patient have a plan for self-harm? Or has the patient followed through on his/her plan of self-harm?	☐Not Applicable ☐Yes ☐No
MAJOR RISK FACTORS FOR SUICIDE	
Please choose what risk factors apply	☐Hopelessness/Depression ☐Substance Abuse ☐Life Changing Event with Poor Coping Skills ☐Access to Means ☐Psychosis/Behavioral Health Conditions ☐Terminal Illness ☐Previous Attempts of Suicide
ASSESSMENT OF SUICIDE RISK	
Suicide Risk Level: LEVEL 1 (MINIMAL SUICIDE PRECAUTIONS LEVEL 2 (STRICT SUICIDE PRECAUTIONS)	☐None – No current thoughts, no plans, no risk factors ☐LEVEL 1 – Has active thoughts, no plan, assessed as having significant risk for suicidal attempt of self-harm ☐LEVEL 2 – Has active thoughts, with plans, has presented with an existing suicidal attempt or attempted self-harm.
ATTENDING PHYSICIAN NOTIFICATION **IF PATIENT IS ASSESSED TO BE POSITIVE FOR SUICIDE RISK, THE FOLLOWING PHYSICIAN WAS NOTIFIED**	
Physician Name	
NAME AND SIGNATURE	
Licensed Practical Nurse's Name and Signature	
Registered Nurse's Name and Signature	
User's Name and Signature	

ATTACHMENT III

BEHAVIOR AND ACTIVITY ASSESSMENT

Date	Time
Reason for completing assessment:	☐Not Applicable ☐Suicide Risk ☐Restraint Use ☐Hourly Rounds ☐Wound Management (Positioning) ☐Other (Specify)
Suicide Risk Level Level 1: Has active thoughts, no plan, assed as having significant risk for suicidal attempt of self-harm. Level 2: Has active thoughts, with plans, has presented with an existing suicidal attempt or attempted self-harm Any changes in the patient's level must have a detailed assessment documentation in the patient's notes feature.	☐ Not applicable ☐ Level 1: Minimal Suicide Precautions – visual contact every 15 minutes ☐ Level 2: Strict Suicide Precautions – visual contact every 30 minutes
NOTE: SOCIAL SERVICES TO BE CONTACTED FOR SUICIDE RISK LEVEL 1 OR 2	
Has Social Services been notified?	☐Yes ☐No
Call button within reach:	☐Yes ☐No (Indicate corrective actions)
Privacy maintained:	☐Yes ☐No (Indicate corrective actions)
Bed in lowest position:	☐Yes ☐No (Indicate corrective actions)
Level of consciousness:	☐Alert ☐Awake ☐Asleep ☐Sedated ☐Lethargic ☐Comatose ☐Other (Specify)
Behavior	☐Cooperative ☐Calm ☐Communicative ☐ Uncooperative ☐Combative/Destructive ☐Angry ☐Anxious/Agitated ☐Uncommunicative/Flat affect ☐Crying ☐ Laughing ☐Yelling ☐Suicide ideation present ☐Other (Specify)
Patient's behavior for continued restraint use:	

Pain expressed:	☐Yes (Document in Pain Assessment Flowsheet) ☐ No
Hygiene offered (If on suicide precautions, need to be supervised. If assisted, indicate in notes.)	☐Not applicable ☐Oral care ☐Shower ☐Shave ☐Bed bath ☐ Offered, declined
Elimination:	☐Not applicable ☐Urinated ☐Bowel movement ☐Foley catheter ☐Urinary Incontinent ☐ Offered, declined
Repositioning – For patients with limited movement, or bed-bound	☐Not applicable: Patient with Independent activity ☐Supine ☐Right lateral ☐Left lateral
Range of motion done	☐Not applicable: Patient with independent activity ☐Active ROM: Restraint released and reapplied ☐Passive ROM (Specify)
What changes occurred with the restraint use order? Restraint ordered renewed = Restraint Use Justification Assessment New Restraint Order Obtained = Restraint Use Justification Assessment None = Restraint Order is CURRENT Restraint removed, patient met release criteria (ensure that patient's behavior is documented).	☐Not Applicable ☐Renewed, Restraint Order ☐Obtained, New Restraint Order ☐None (Order is Current) ☐Terminated, Restraint Removed
Restraint Use: BM reasons: Assess every 15 minutes. MS reasons: Assess every 2 hours	☐Not Applicable ☐For Behavioral Management Reasons ☐For Medical Surgical Reasons
Extremity on Restraint	☐Not applicable ☐Right Wrist ☐Right Ankle ☐Right Hand ☐Left Wrist ☐Left Ankle ☐Left Hand ☐Chest ☐Pelvic
Restraint Type:	☐Not Applicable ☐Limb Holder ☐Hand Restraint (Twice as Tough) ☐Vest ☐Mitten ☐Belt ☐Pelvic
Restraint Status:	☐Not Applicable ☐Applied ☐Intact ☐Released ☐Released and Reapplied
Circulation:	☐Not Applicable ☐Brisk (<3 seconds) ☐Sluggish (>3 seconds)
Skin Color:	☐Not Applicable ☐Normal ☐Pale ☐Cyanotic ☐Other (Specify)
Sensation:	☐Not Applicable ☐Normal ☐Tingling ☐Numb ☐Other (Specify)
Respiratory Status:	☐Not Applicable ☐Normal ☐Shallow ☐Labored ☐On Ventilator

Skin Integrity – Indicate further assessment in notes for any abnormalities	☐Not Applicable ☐Intact ☐Open Lesion ☐ Abrasion ☐Redness ☐Other (Specify)
Release Criteria (Based on physician order form)	☐Not Applicable ☐Meets Release Criteria ☐Not Met
COMPLETED BY:	
User's Name and Signature	

ATTACHMENT IV

ITEMS WITH BOXES/PARENTHASES MUST BE CHECKED TO BE ORDERED. Orders that have been changed (additions, deletions, or strike outs) must be initialed by the ordering MD for the order to be valid.

PHYSICIAN'S ORDER
(EXCLUDING IV Fluids and MEDICATIONS)

SUICIDE PRECAUTIONS ORDER

Date:_____ **Time:**_____

Patient Risk Suicide Level Diagnosis

- ☐ Level 1 (Minimal Suicide Precautions): Has active thoughts, **no** plan, assessed as having significant risk for suicidal attempt of self- harm.
- ☐ Level 2 (Strict Suicide Precautions): Has active thoughts, **with** plans, has presented with an existing suicidal attempt or attempted self-harm.

Patient Condition

☐ Critical ☐ Stable

Observe Patient/ Initiate ongoing suicide assessment

- ☐ (Level 1) Observe every 15 minutes; assess patient's behavior every shift, or as necessary
- ☐ (Level 2) Observe every 30 minutes; assess patient's behavior every 2 hours, or as necessary

Patient Transfers (staff must remain in constant attendance of the patient during transfers)

- ☐ 1:1 escorts on transfers (Level)
- ☐ 2:1 escort on transfers – RN must escort (Level 2)
- ☐ Psychiatric/ Behavioral Health Consultation
- ☐ Social Services Referral for Suicide Precautions discharge planning
- ☐ Pastoral Care Services for spiritual guidance
- ☐ Diet: Isolation Tray
  Diet Type:_____
- ☐ Restraint Use for Behavioral Management Reasons (use Behavioral Management Restraint Use Order Sheet, verify that preprinted order is signed)
- ☐ Restraint Use for Medical Surgical Reasons (use Medical Surgical Restraint Order Sheet, verify that preprinted order is signed)
- ☐ Provide patient/ family education on suicide precautions

TORB (Nurse Signature)_____

MD Signature _____

IVF and MEDICATION ORDERS ONLY

INTRAVENOUS FLUID and MEDICATION ORDERS

ALLERGY (describe allergic reaction):

PATIENT ID LABEL

- ✓ Summary/Blanket orders are unacceptable.
- ✓ Medication orders must be complete.
- ✓ PRN medication orders must include an indication.
- ✓ Write legibly.
- ✓ Rewrite orders upon transfer and/or post-operatively.
- ✓ Date, time, and sign verbal & telephone orders within 48 hours.

DO NOT USE:

U	MS
IU	MSO_4
Q.D.	$MgSO_4$
Q.O.D.	Trailing zero
Lack of leading zero	

Physician's Initial

SUICIDE PRECAUTIONS ORDER

GMHA FORM#_____ STOCK#_____
APPROVED DATE: NM: _____, PSC: _____, MEC: _____, EMC: _____, HIMC: _____ FORM REVISED:_____

ATTACHMENT V

Date	Time
DIRECTION: This assessment should be conducted with representatives from Nursing, Security, Safety, and Facilities Maintenance prior to the patient's entry into the room.	
ACCESS TO MEANS OF HANGING, SUFFOCATION, AND STRANGULATION	
Are there fixtures from which something heavy can be suspended?	☐Yes (Specify in Notes) ☐No
Types of Fixtures	☐Shower Heads ☐Light Fixtures ☐Curtain Rods ☐Closet Doors ☐Door Knobs
Do showers and closets have break away rods?	☐Yes (Specify in Notes) ☐No
Does the patient's care require any medical equipment such as intravenous lines or oxygen?	☐Yes ☐No ☐Not Applicable
Specify	
Are there any trash cans with liners present in the room?	☐Yes ☐No ☐Not Applicable
Do showers have plastic curtains?	☐Yes ☐No ☐Not Applicable
Is the call light cord longer than 12 inches?	☐Yes ☐No ☐Not Applicable
Is there a bed with sheets in the room?	☐Yes ☐No ☐Not Applicable
ACCESS TO MEANS OF JUMPING	
Is the unit located at higher than ground level?	☐Yes ☐No ☐Not Applicable
Does the patient have access to windows, glass doors, balconies, any places from which he or she could jump?	☐Yes ☐No ☐Not Applicable
Specify	
Is the window(s) and/or glass door able to be opened or broken?	☐Yes ☐No ☐Not Applicable
ACCESS TO MEANS OF JUMPING	
Is the unit locked?	☐Yes ☐No ☐Not Applicable
Are items brought in by visitors searched?	☐Yes ☐No ☐Not Applicable
Are items such as belts, shoelaces, drawstrings, glass, sharps, lighters, etc. taken from patient?	☐Yes ☐No ☐Not Applicable
Are there electrical outlets in the bathroom?	☐Yes ☐No ☐Not Applicable

Are cleaning supplies closely monitored by staff or locked when not in use?	☐Yes ☐No ☐Not Applicable
Are there electrical equipment within the patient's room?	☐Yes ☐No ☐Not Applicable
REMOVE ANY HAZARDS IN THE PATIENT'S ROOM THAT CAN BE REMOVED AND REMAIN AWARE OF EXISTING HAZARDS THAT REMAIN	
BE COGNIZANT OF THESE WHEN CONDUCTING PATIENT OBSERVATIONS	
Please write each individual's names responsible for the completion of this assessment:	
Completed By:	☐Security ☐Safety ☐Facilities Maintenance ☐Nursing
User's Name and Signature	

ATTACHMENT VI

Emergency Department Unit Specific Suicidal Patient Safety Needs to Consider in the Physical Environment

The most common method of suicide in hospitals are hanging, suffocation, and jumping.

This checklist should be conducted with representatives from Nursing, Security/Safety, and Facilities Maintenance/Boiler Room Prior to the patient's entry into the room.

I. Access to means of hanging, suffocation, and strangulation

☐ YES	☐ NO	Are there fixtures (shower heads, light fixtures, curtain rods, closet doors, door knobs) from which something heavy could be suspended?
YES	☐ NO	Does the patient's care require any medical equipment such as intravenous lines or oxygen?
☐ YES	☐ NO	Are there any trash cans with liners present in the room?
☐ YES	☐ NO	Are the medical equipment cords longer than 12 inches?
☐ YES	☐ NO	Is there a bed with sheets in the room?

II. Access to means of jumping

☐ YES	☐ NO	Is the unit located at higher than ground levels?
☐ YES	☐ NO	Does the patient have access to windows, glass doors, balconies, any place from which he/she could jump
☐ YES	☐ NO	Is the window(s) and/or glass door able to be opened or broken?

III. Access to other potential harmful items

☐ YES	☐ NO	Is the unit locked?
☐ YES	☐ NO	Are items brought in by visitors searched
☐ YES	☐ NO	Are items such as belts, shoelaces, drawstrings, glass, sharps, lighters, etc taken from patient?
☐ YES	☐ NO	Are cleaning supplies closely monitored by staff or locked when not in use
☐ YES	☐ NO	Is there electrical equipment within patient's room?
☐ YES	☐ NO	Are hazardous items removed from the patient?
Corrective actions to deficiencies noted:		

Completed By:

_____	_____	_____
RN Name/Title & Signature	Date	Time
_____	_____	_____
Security Dept Staff or Safety Officer Name/Title & Signature	Date	Time
_____	_____	_____
Facilities Maint. /Boiler Rm. Name/Title & Signature	Date	Time

ATTACHMENT VII

Date	Time

DISCHARGE INSTRUCTIONS FOR A SUICIDE RISK PATIENT

As you are discharged from the Guam Memorial Hospital, it is important to learn about how to keep safe from harming yourself.

RECOGNIZE THE WARNING SIGNS

- Abrupt changes in personality
- Giving away possessions
- Use of drugs and/or alcohol
- Change in eating patterns – major weight changes
- Change in sleeping patterns – all the time/unable to
- Unwillingness/inability to communicate
- Depression
- Unusual sadness, discouragement/loneliness
- Talk of wanting to die
- Neglect of personal appearance
- Rebelliousness – reckless behavior
- Withdrawal from people/activities they love
- Confusion – inability to concentrate

IF YOU OR A LOVED ONE OBSERVES ANY OF THESE BEHAVIORS OR HAS CONCERNS ABOUT SELF-HARM, HERE'S WHAT YOU CAN DO

- Talk about your feelings
- Talk about reasons for harming yourself
- Remove any means of hurting yourself (e.g.: Pills, Rope, Extension Cords, Firearm)
- Professional help by the Guam Behavioral Health and Wellness Center, Psychological Counseling, etc.
- Do not be alone, call your safe contact". Someone whom you trust and who will be there for you
- Call your local CRISIS HOTLINE: 647-8833 or call the toll free National Suicide Prevention Hotlines:
    - National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
    - National Hope Line Network: 1-800-SUICIDE (784-2433)

Educational/Teachings Materials provided to the Patient.	☐Yes ☐No ☐Not Applicable
Other Educational/Teachings Materials provided to the Patient	

FOLLOWING THIS DISCHARGE, YOU HAVE AN APPOINTMENT WITH (INDICATE PHYSICIAN NAME, CLINIC NAME, AND CONTACT NUMBER)

Physician Name	Clinic Name	Contact No.

UNDERSTANDING OF DISCHARGE INSTRUCTIONS

I and/or my family member understand the warning signs of suicide	☐Yes ☐No ☐Not Applicable
I and/or my family member understands what to do when thoughts of suicide are present	☐Yes ☐No ☐Not Applicable

I and/or my family member have been given contact numbers to the Crisis Hotline and other toll-free suicide hotlines	☐Yes ☐No ☐Not Applicable
I and/or my family member understand the discharge instructions that were provided to me/the patient	☐Yes ☐No ☐Not Applicable
SIGNATURE(S)	
Signature of Patient/Family Member	
NAME AND SIGNATURE	
Licensed Practical Nurse's Name and Signature	
Registered Nurse's Name and Signature	
User's Name and Signature	

COMMUNITY RESOURCES

Airmen and Family Readiness Center
Phone (671) 366-8136

I'Pinangon
Campus Suicide Prevention Program
Phone (671) 735-2888 / 9
Fax: (671) 734-5255
Email: i_pinangon@uguam.uog.edu

Inafa' Maolek, Inc.
Peer Mediation and Conflict Resolution
Phone: (671) 475-1977

Isa Psychological Services Center
Ofc Hrs: Mon – Fri, 9:00am – 5:00pm
Phone: (671) 735-2883
Email: isa@uguam.uog.edu
Website: www.uog.edu/isa

Island Girl Power
Phone: (671) 637-3011

OASIS
Phone: (671) 646-4601

Salvation Army
Lighthouse Recovery Center
Phone: (671) 477-7671
Fax: (671) 477-4649

Salvation Army
Family Services Center
Phone: (671) 477– 9807

US Department of Veterans Affairs
Phone: (671) 475-5760

Vietnam Veterans Outreach Program
Phone: (671) 472-7160

Youth for Youth LIVE! Guam
Youth helping youth through empowerment and leadership
Phone: (671) 477-8861 / 8863
Facebook: youthforyouthlive.guam

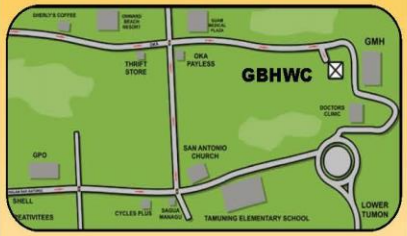
PRIVATE COUNSELING PERSONAL / FAMILY

Guahan Behavioral Clinic
Ariel Ismael, M.D.
Phone: (671) 646-7972

Mary K. Fegurgur, PSY.D
Phone: (671) 649-5910

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER

Main Office
790 Governor Carlos G.
Camacho Rd. Tamuning,
Guam 96913
Phone: (671) 647-5325 or 647-5440
Fax: (671) 647-0250
Website: www.dmhsa.guam.gov



Prevention and Training Branch (PEACE office)
J&G Commercial Bldg.
Chalan Santo Papa St.
Suite 203 & 204 F, Hagatna, Guam
Phone: (671) 477-9079 thru 9083
Fax: (671) 477-9076
Website: www.peaceguam.org
Facebook: "Focus on Life Guam"

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STOP SUICIDE ON GUAM

With Help, there's Hope.

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER
PEACE
FOCUS ON LIFE

CRISIS HOTLINES & SUPPORT GROUPS

All calls are confidential and free of charge

National Suicide Prevention Lifeline
Toll-Free, 24-Hour Hotline
1 (800) 273-TALK (8255)

Guam Behavioral Health and Wellness Center
24-Hour Crisis Hotline
(671) 647-8833

Military One-Source (24/7)
Phone: (800) 342-9467

Navy Fleet Family Support Center
Phone: (671) 333-2056 thru 2059

Sanctuary Inc.
Outreach Crisis Intervention for Youth
24-Hour Hotline: (671) 475-7100

Victims Advocates Reaching Out (VARO)
24-Hour Hotline: (671) 477-5552
Website: www.varoguam.com

Life Works Guam: Suicide Prevention Program and Rainbows for all Children on Guam
Phone: (671) 632-0257

Survivors of Suicide Support Group
Open to youth and adults who have experienced suicide loss. Call for monthly schedule.
Phone: (671) 477-9079 thru 9083

Grief and Loss Monthly Support Group
Open to adults 18 years or older who have experienced the death of a loved one.
Call for monthly schedule.
Phone: (671) 647-5355

The Compassionate Friends Support Group
Supporting Families After a Child's Death
Call for monthly schedule.
Phone: (671) 998-9662
Email: tcfGuam@hotmail.com

Learn to Recognize the Warning Signs

⇒ Abrupt changes in personality

⇒ Giving away possessions

⇒ Use and/or misuse of substances such as alcohol, tobacco and drugs

⇒ Significant weight change

⇒ Change in sleeping pattern—unable to sleep or sleeping all the time

⇒ Unwillingness or inability to communicate

⇒ Clinical depression

⇒ Unusual sadness

⇒ Reckless behavior

⇒ Withdrawal from people or usual activities they love

⇒ Confusion — inability to concentrate

Remember that suicide is the most preventable cause of death among our island people. **Help is always available.**

What You Can Do to Help Someone at Risk for Suicide

ASK

⇒ Express concern by asking what is troubling the person. Ask further questions to get to the root of the problem.

⇒ Ask if he/she has thought about suicide.

⇒ If the individual has thought about suicide, ask if he/she has a plan.

LISTEN

⇒ Be willing to listen. Allow him/her to express their feelings. Listen carefully.

⇒ Be empathetic. Try to imagine what your friend is going through and accept the feelings he or she expresses.

⇒ Be non-judgmental. Avoid lecturing on the value of life or debating whether suicide is right or wrong. Instead, allow the person to talk freely about his/her feelings.

ACT

⇒ Take all threats, gestures and previous attempts seriously.

⇒ Remove any means that might be used to hurt him/herself such as pills, extension cords, wire coat hangers or rope.

⇒ Never agree to keep suicide thoughts or plans a secret.

⇒ Offer hope by letting him/her know that counseling can help.

⇒ Assist him/her in finding professional help and offer to accompany him/her.

How You Can Ensure Your Personal Safety

People who neglect their own needs and forget to nurture themselves are at danger of deeper levels of unhappiness, low self-esteem and feelings of resentment. Also, sometimes people who spend their time only taking care of others can be at risk for getting burned-out on all the giving, which makes it more difficult to care for others and themselves. Taking time for ***self-care*** can start by managing your stress. Here are some tips:

⇒ Learn how to say "NO"

⇒ Avoid people who stress you out

⇒ Express your feelings instead of bottling them up

⇒ Manage your time better

⇒ Learn to relax; try regular meditation.

⇒ Remember the **Four As**

✓ **Avoid the Stressor**
Do something that makes you happy such as joining extra-curricular or sports activities.

✓ **Alter the Stressor**
Focus your time and energy on positive experiences. Practice smart time management.

✓ **Adapt to the Stressor**
Know your limits and be flexible. Accept that things will not always go your way.

✓ **Accept the Stressor**
Accept the things that you cannot change.

GBHWC SERVICES

INTAKE, EMERGENCY SERVICES AND CRISIS HOTLINE
An intake assessment will be conducted by a clinical staff member to those individuals who feel overwhelmed and need immediate help

CHILD AND ADOLESCENT SERVICES
Also known as I Famagu'on-ta (Our Children); provided by a group of dedicated and caring professionals working together as a team with a child, youth and family

PREVENTION AND TRAINING
Aimed at promoting healthier lifestyles by recognizing and preventing suicide, and reducing the demand for alcohol, tobacco and other drugs in our community

CONTACT INFORMATION

Crisis Hotline	**(671) 647-8833**
Adult Inpatient Unit	**or 8834**
Child Inpatient Unit	
Clinical Services Department	
Reception	(671) 647-5325
Adult Counseling	(671) 647-5300
Community Support Services	(671) 647-5405
Day Treatment	(671) 647-5317
Drug and Alcohol Treatment (New Beginnings)	(671) 475-5438 or 5440
Guam GetCare	(671) 475-4646
Healing Hearts Crisis Center	(671) 647-5423
I Famagu'on-ta	(671) 477-5338 or 5339
Medical Records	(671) 647-5343
Medication Clinic	(671) 647-5345
Nursing Services	(671) 647-8837 or 0297
Prevention and Training (PEACE office)	(671) 477-9079 thru 9083
Residential Recovery Program Homes	(671) 647-5474
Serenity Home	(671) 649-0682

MESSAGE FROM SURVIVORS OF SUICIDE

"I do not resent my father for the lost opportunity to bond with him. I am sad that he must have felt alone during that point in his life."

Brandon
Father died by suicide

" Mei fokun weires ai upue etiwa me weweiti poutunon ai ewe uncle are mongean inei ewe, a fokun weires turunon emon aramasen non ai ewe family pokiten ouwa angei am aninis senir meinisn."

"Losing my uncle was hard to accept and understand, but it was through my family's support that help each one of us cope."

Dreama
Uncle died by suicide

"In the beginning, the Survivors Support Group was the place where I can let my pain out. It helped me become stronger. Now, that place of hurt is a place where I find hope."

Clyde
Son died by suicide

TALK TO SOMEONE
Help is Available

Local Emergency
911

24-Hour National Suicide Prevention Lifeline (Toll-Free)
1 (800) 273-TALK (8255)

Guam Behavioral Health and Wellness Center
24-Hour Crisis Hotline
(671) 647-8833

I'Pinangon, University of Guam Campus Suicide Prevention Program
(671) 735-2888 / 9

LifeWorks Guam: Suicide Prevention Program and Rainbows for All Children on Guam
(671) 632-0257

Sanctuary, Inc. of Guam
24HR Crisis Hotline
(671) 475-7100

Like

www.facebook.com/FocusonLifeGuam

SURVIVORS OF SUICIDE SUPPORT GROUP

- Who: Open to youth and adults who have lost a loved one to suicide
- When: Every 2nd and 4th Thursday of the month
- Where: GBHWC - PEACE office in Hagatna

For more information, contact:
Guam Behavioral Health and Wellness Center—Prevention and Training Branch (PEACE office)
(671) 477-9079 thru 9083 • www.peaceguam.org

A Guide on Surviving and Coping from Suicide Loss

Finding Strength and Courage to Live
You are not alone.

FOCUS ON LIFE
www.peaceguam.org

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER

PEACE
www.peaceguam.org

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Surviving After Suicide

We all experience difficult times and there are moments that seem impossible to deal with. If you have lost someone to suicide, it is important to know that you are not alone and that there are services available.

Survivors often experience mixed reactions of grief and disbelief that they cannot move on. Grief is a normal process in life when losing a loved one. Grieving is the first step in the healing process and well-being.

COMMON REACTIONS FROM GRIEF

Shock: The feeling of numbness, confusion and trouble concentrating

Depression: Changes in sleeping and eating patterns, lack of energy, and intense sadness

Anger: Towards self, family, and friends

Stress/Anxiety: Being displeased about daily routines and feeling lonely or sad

Regrets: Feeling guilty and thinking, "If only I had …"

Behavioral Changes: Living conditions and personal appearance becomes poor

Isolation: Withdrawing yourself from family and friends

Coping from Suicide Loss

- Talk with a family member, close friend, or health care provider. Take the initiative to talk about the suicide and tell them how you feel so that they may understand.
- Keep in contact with friends and loved ones and update yourself with what is happening in your environment and community.
- Keep in mind that everyone grieves at their own pace. There is no rush to heal or forget. It takes time.
- Some people find it easer to find the comfort within their religious beliefs or spiritual activities.
- Although anniversaries, birthdays, and holidays may be difficult to cope with, you may want to think about continuing traditions or keeping the spirit of the occasion alive.
- Take care of your own well-being by seeking professional help.
- Remind yourself to take it one day at a time. Be good to yourself; when you are ready to begin the journey of the healing process you will find joy in life again.

Children are also vulnerable and may feel abandoned or guilty. Listen to them and provide them age-appropriate answers. You may seek professional advise on ways to explain suicide to your schildren.

- Tell them as truthfully as possible about the death, while in a comfortable setting.
- Reassure them that the death is not their or anyone else's fault.
- Let them know that you will not abandon them.
- Try to stick to your child's daily routines.
- The most powerful gift that you can give to your child is love and support.

Comforting a Survivor

✓ Be patient. Listen and understand with your heart. *How was your day?*

✓ Familiarize yourself with their grieving process. *Could I be of any assistance to you?*

✓ Mentioned their loved one's name, acknowledging that you have not forgotten about them, especially during holidays, anniversaries and birthdays. *Your loved one is never forgotten.*

✓ Join them in their healing process. Be a part of the support group with them. *I am and will be here for you.*

✓ Provide them reassurance. *It is not your fault.*

✗ Do not push your way in and cutoff the person from talking. *Why can't you just tell me how you are feeling?*

✗ Don't be surprised by the intensity of their feelings. *Don't cry. Time will go by.*

✗ Avoid providing simple solutions *Think about those around you. There are things worth living for.*

✗ Don't judge their spiritual faith *There is a reason for everything. Just pray and everything will get better.*

✗ Don't assume. Listen to them. *I know how you feel.*

GRIEF IS A NORMAL PROCESS IN LIFE, ESPECIALLY AFTER LOSING A LOVED ONE. IT IS THE FIRST STEP IN THE HEALING PROCESS AND WELL-BEING.