GMHA
Nursing Services Department

Guidelines for Care:

Suicide Precautions: a Two-Tiered Approach

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Objectives:

1. Discuss suicide precautions for GMHA patients.
2. Understand warning signs and risk factors for the at risk patient.
5. Discuss the role of the Interdisciplinary Team for patient safety.
6. Recall Nursing staff responsibilities for patient care.
7. Define 2 Levels of Suicide Precautions in the GMHA Patient.
8. Review guidelines for the care of Suicide Precaution patients.
9. List the different types of forms for GMHA patients.
10. Understand the use of Patient Observation Sheet.
11. Discuss the Patient Sitter Program.
12. Discuss how to safely discharge patients from inpatient care or from the ER.

Suicide Precautions

- To ensure and establish the immediate and continual safety of the client as well as the clinical staff.
- All patients are assessed for suicidal potential (out-patient or in-patient)
- 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.
- Interventions based on 2 Suicide Levels

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'

Major Risk Factors for Suicide

- Hopelessness/Depression
- Substance Abuse
- Life Changing Event with Poor Coping Skills
- Access to Means
- Psychosis/Behavioral Health Conditions
- Terminal Illness
- Previous Attempts of Suicide

Warning Signs of Suicide

- 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

An Interdisciplinary Approach:

- The GMHA Interdisciplinary Team Includes
  - Attending Physician
  - Licensed Nursing Staff
  - Non-Licensed Nursing Staff
  - Security Officer
  - Facilities Maintenance

Physician Responsibilities

- Give Suicide Precaution orders and specific interventions (using Suicide Precautions Order Form)
- Determine the initial and continued need of suicidal precautions and will determine the level of suicidal precautions to be taken with a client; conduct daily reassessments
- Will initiate the psychiatric consult to be taken and will complete the medical clearing process for the patient to receive an out-sourced psychiatric evaluation.

Referral for Psychiatric Screening

- Referrals happen after medical clearance obtained
- Referral made to Guam Behavioral Health and Wellness Center (GBHWC)
- Private psychiatric consults possible after MD to Psychiatric practitioner endorsement and acceptance of care

Discontinuation of Suicide Precautions

- Will only be done by a FACE-TO-FACE evaluation by attending physician
- In consultation with the proper psychiatric personnel, if applicable

Nursing Staff Responsibilities

- Licensed Nursing Staff
  - Conduct Patient Assessment (Initial & Continued assessments)
  - Ensure immediate safety of client and staff
  - Inform MD of specific safety needs
  - Maintain communication between the care team
  - Address need for behavioral health consult with MD
  - Properly Document
    - Patient Assessments and Nursing Care

Nursing Staff Documentation:

- Suicide Risk Screening Tool
- Behavioral and Activity Assessment
- Patient Observation Sheet
- Suicidal Patient Safety Needs to Consider in the Physical Environment
- Emergency Department Unit Specific Environmental Checklist
- Discharge Instructions- Suicide Risk

Nursing Staff Responsibilities

- Non-Licensed Nursing Staff
  - Assist with keeping patient safe
  - One to One Observation
    - Patient Sitter

Security Officer

- Will contribute to the safe maintenance of the environment of the patient
- Will complete environmental assessment
- Includes searching belongings of visitors - if allowed by the physician and nursing staff
- Directly control visitors under the management of the primary and charge nurse

Facilities Maintenance

- 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.

2 Levels of Suicide Precautions:

- Level I
- Minimal Suicide Precautions
- Has active thoughts, no plan,
- assessed as having significant risk for suicidal attempt or self-harm.

- Level II
- Strict Suicide Precautions
- Has active thoughts, with plans, has presented with an existing suicidal attempt or attempted self-harm.

Suicide Precautions Level I:

- MD will conduct a face-to-face assessment and evaluation for continuation and discontinuation of precautions measures.
- 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.**
- **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.
- 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.
- 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.

Suicide Precautions Level I:

- 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 judgment or upon physician orders.
- 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 non-operating hours to address the environmental and facilities needs of the client under suicidal precautions.

Suicide Precautions Level II:

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

Suicide Precautions Level II:

- 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.
- 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 judgment or upon physician orders.
- 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 non-operating hours to address the environmental and facilities needs of the client under suicidal precautions.

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.

Special Considerations

- Frequency in monitoring and Behavioral Assessment for clients who present to the in-patient/out-patient unit meeting criteria requiring suicidal precautions but with considerations due to clinical status
- such as: 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
- this must be explicitly documented and ordered by the clinical practitioner after a face-to-face evaluation.

Documentation

- Patient Observation Sheet: time and assessments
- Progress Notes: 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.
- Behavioral Activity Assessment: on admission and as indicated based on suicide precaution level
- Environmental Checklist: by interdisciplinary team

Patient Observation Flowsheet:

- **Suicide Precaution Level**
  - **Level I (visual every15 mins)**
  - **Level II (visual every 30 mins)**
- **Patient Visually Observed As:**
  - **Calm, Non-anxious, Other**
- **Is 1:1 Observer Present?**
- **Does the patient Require Further Assessment?**
- **Staff Initial**

For ER Patients

- May require suicidal precautions although not for admission
- Psychiatric evaluation will be done after medical interventions
- Transfer to consulting facility will require specific escort
- Level I:Licensed clinical staff assigned to patient in clear view
- Level II: 1:1 Observer with escorting out of ER or to restroom
- Unit and facility transfer requires licensed staff and patient sitter

Patient Sitter Program

- "one-to-one" or "constant observers",
- staff assigned to provide direct observation for patients at risk to harm themselves or others.
- Used for Patients on Suicide Precautions Level II, Risk for Fall, Risk for self harm, or patient with confusion/delirium/agitation
- Ordered by MD
- Must complete orientation program
- Will communicate individual patient needs

Who can be a Patient Sitter?

- Security personnel
- Patient Couriers
- Certified Nurse Assistants
- CMT, ERT, other Non-Licensed Nsg staff
- can be a patient sitter upon completion of the *"Patient Sitter Orientation"*.
- must be a current Basic Life Support Provider and be CPI certified. (Crisis Prevention Intervention)
- Assigned by Nursing Supervisor II

Patient Sitter Responsibilities

- Stay awake and alert, NO CELL PHONES!
- Never leave patient alone, visual contact 4-6ft away from patient, use call light for help
- Refer all visitors to nurse, screen all items
- Convey attitudes of compassion, empathy and understanding
- Report to nurse/next sitter observations about mood (sad, joyful, or angry), behavior (withdrawn, talkative, or friendly), and anything the patient said about feelings, thoughts, and plans concerning suicide

Suicide Precautions: Patient & Family Education

- Provide education on GMHA policy and proper channels for psychiatric evaluation referral
- Education on warning signs and risk factors to suicidal attempts and acts of self-harm
- Provide information on safety measures and community resources

Education-Keeping Safe at Home:

- 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)

Discharge Planning

- From ER: transfer patient directly to GBHWC or for psychiatric evaluation with escort
- From ER or Inpatient: Provide patient and family teaching on suicide prevention, provide hand-outs in policy
- Emphasize removal or reduction of access (i.e. guns, pills, rope)
- Social work may be consulted

5 Key Take Away Points

- Patient Safety is Our Responsibility! Immediate patient safety takes precedence over MD evaluation.
- 2 Suicide Precaution Levels
  - Level I- active thoughts, ideation, no plan
  - Level II-with thoughts, plan, and attempt
- Assessment and Proper Documentation is important.
- Educate Patient & Family on how to stay safe!
- The interdisciplinary team approach is key to keeping patients safe!

REFERENCES:

- GMHA Policy: Suicide Precautions

  (Policy No. 6301-II-A-8)- updated Dec 2017
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- 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.

Thank you!

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