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FUNCTIONAL AREA/ROOM: Patient Safety	**POLICY DESCRIPTION:** Suicide Prevention Policy – Non-Behavioral Health Settings
PAGE: 1 of 7	**POLICY NUMBER:** PCS189
EFFECTIVE DATE: January 2023	**REPLACES POLICY DATED:** June 2022
OWNER & TITLE:	**APPROVED BY:**

PURPOSE:

To provide guidance to assist with the identification of patients in non-Behavioral Health (BH) settings who are at risk for suicide, ensuring a safe environment for the provision of care.

DEFINITIONS:

Columbia Suicide Severity Rating Scale (C-SSRS): Initial screening tool utilized by the nurse. It will provide an auto-calculated level of no risk, low, moderate or high risk.

Suicide Detailed Risk Assessment (suicide DRA): Subsequent assessment completed by the Provider/Practitioner. *The suicide DRA must be completed for any patient with a positive C-SSRS screen.*

Overall Risk Level (ORL): Determined by the provider/practitioner's clinical judgement and suicide DRA. The provider/practitioner will assign a level of no risk, low, moderate, or high risk. *This will take precedence over the C-SSRS, if the risk level differs.*

One to one observation may be implemented as virtual/line of sight or physical in-person based on the patient ORL. This is initiated by nursing based on the C-SSRS score and facility protocol. The level of observation may be adjusted by the provider after the patient has been assessed and ORL has been determined.

POLICY:

It is the policy of Medical City Arlington to create an environment of care that will foster the assessment, identification, and management of patients who are at increased risk for suicide or self-harming behaviors. Patients who are at an increased risk for suicide or self-harming behaviors require intensive support, close observation, and frequent reassessment for their emotional and physical well-being. The scope of this plan begins at triage, prior to admission to the hospital, and continues until the patient is discharged.

Minimum requirement: Patients in non-psychiatric areas (e.g., Emergency Room (ER) and non-BH inpatient units), ages 12 years and older, who are being evaluated or treated for BH conditions as their primary reason for care should be screened using the C-SSRS. Screening all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care supports the Joint Commission's National Patient Safety Goal 15.01.01. The Provider/Practitioner will be notified of positive screens (i.e., at risk patients). The at-risk patient's (low, moderate, or high) environment will be made safe by implementing the checklist and observation precautions. *The at-risk patient will be monitored and reassessed, with accompanying documentation, daily, when a change in condition occurs, and prior to discharge.* Documentation of an ORL and personal safety plan must also be documented prior to discharge. Suicide prevention information and resource phone numbers will be included in the discharge planning instructions.

Staff education and training requirements: All staff members providing care for patients at risk for suicide are to complete education and have demonstrated competency prior to providing such care. Such education and competency should be reflective of the staff member's specific role, including at a minimum:

1) Suicide risk screening,
2) Recognition of environmental risks, and
3) Appropriate mitigation strategies based upon the patient's suicide risk.

PROCEDURE:

1. The nursing assessment will include current, recent, and past thoughts of suicide, plans, means and/or intent, as well as recent or past history of suicide attempts within their lifetime for patients age twelve and above being admitted to ERs, and inpatient non-BH areas who are being evaluated or treated for behavioral health (BH) conditions. The C-SSRS is the **initial screening** tool utilized by the nurse. Although it will provide an auto-calculated level risk (i.e., no risk, low, moderate or high risk), it is intended to differentiate "at-risk" patients from patients without identified risk.

2. Any patient with a positive, "at-risk" C-SSRS screening (i.e., low, moderate or high risk) require a secondary level suicide DRA to identify activating events, protective factors, and contributing clinical factors to risk of suicide. This should be completed by a licensed or credentialed physician/practitioner, or available licensed BH provider resources (Licensed BH Specialist, social worker, or community assessor).

3. The Provider/Practitioner will use the information collected from the suicide DRA paired with clinical judgement to determine (estimate) the patient's ORL.
    a. Note: The ORL may not match the auto-calculated score from the initial C-SSRS. The ORL is considered the standard of care for assigning suicide risk level as it is based on consideration of modifiable and protective risk factors.

4. The Provider/Practitioner will reassess at-risk patients at least every calendar day AND as needed with a change in patient condition. The Provider/Practitioner will coordinate care with the patient's nurse to ensure the appropriate environment of care and suicide risk mitigation strategies are implemented according to the overall risk level.

5. The no-risk patients will be reassessed as needed with a change in patient condition. The nurse will coordinate care with the Provider/Practitioner if changes in condition occur.

6. If the suicide risk screen cannot be completed upon presentation to the ER or upon admission to an inpatient unit because of the patient's condition, the screening will be completed once the patient's condition improves (i.e. extubation). Then the patient care team will take next steps to implement the appropriate safety precautions and risk mitigation strategies as determined by patient's level of risk.

7. The patient's care plan will be updated, ensuring patient-centered care by engaging the person at risk in care planning and decision making.

8. Patients, who are determined no longer at risk for suicide, will be evaluated for a decrease in protective measures or precautions by a nurse who will coordinate care with a Provider/Practitioner.

9. C-SSRS risk score calculations are outlined below:

C-SSRS Scoring rules **Positive response (yes) to the following query**	**Results in the following calculated risk level**
Wish to be dead or to not wake up in the past month?	Low
Wish to be dead or to not wake up in your lifetime?	Low
Non-specific active suicidal thoughts in the past month?	Low
Non-specific active suicidal thoughts in your lifetime?	Low
Active ideation without method, plan, or intent in the past month?	Moderate
Active ideation without method, plan, or intent in your lifetime?	Low
Active ideation with some intent and without a plan in the past month?	High
Active ideation with some intent and without a plan in a lifetime?	Low
Active suicidal ideation with plan and intent in the past month?	High
Active suicidal ideation with plan and intent in a lifetime?	Low
Attempted, plan to attempt, or prepared to end life in a lifetime?	Moderate
Attempted, plan to attempt, or prepared to end life in the past 3 months?	High

10. RN will determine the appropriate interventions based on the initial C-SSRS. **Once the subsequent suicide DRA is completed and ORL is assigned, the ORL is used as the source of truth to determine appropriate interventions are determined**:

INTERVENTIONS	No Risk	Low Risk	Moderate Risk	High Risk
Provider/Practitioner Notified		X	X	X
Physical Patient Safety Attendant (PSA) in Place **(1:1)**				X
Line of Sight/Virtual PSA (if available; if not, escalate to sitter)			X *Only if the ideation is without method/ plan/ intent within the past month.* *<u>Not</u> required if the ideation is within a lifetime only.*	
Reassessment daily, with a change in patient condition, and prior to discharge		X	X	X
Suicide Safe Environmental Documentation: Room, Dietary and Nursing Environment (all 3 areas required). Every Shift and as needed with a Change in Patient Condition			X Only for moderate risk past month. For moderate risk lifetime, complete once upon admission to determine individual environmental risk.	X
Suicide Interventions Implemented			X (see bullet 11 below)	X (see bullet 11 below)

11. Additional suicide interventions for moderate and high-risk patients:

SUICIDE INTERVENTIONS	MODERATE RISK (LIFETIME)	MODERATE RISK (PAST MONTH)	HIGH RISK
Suicide Safe Environment Checklist initiated	X (once upon admission only)	X	X
Paper scrubs or scrubs without ties		X	X
Remove ligature risks that are not essential to patient care (e.g., unnecessary cords removed, gloves removed, nurse call cords secured)		X	X
Remove/secure sharp items		X	X
Remove extra bed linens and towels that are not in use		X	X
Remove plastic liners in trash cans and obtain paper liners		X	X
Curtains removed/secured		X	X
Remove/secure patient belongings from the room		X	X
Electric beds disabled / unplugged		X	X
Implement dietary safe environment orders (as appropriate)		X	X
Observation precautions implemented (as appropriate for patient see below)		X	X
Request behavioral health consult		X	X
Referral to outpatient behavioral health upon discharge		X	X

12. 1:1 Patient Safety Attendant (PSA) Process:
    a. All patients identified as high risk for suicide in an outpatient or inpatient non-BH setting are required to have a process in place to provide 1:1 PSA observation.
    b. Provider/Practitioner order is not required; this is a policy driven-process. Initiate internal PSA request process.

13. Virtual PSA/Line-of-Sight Process:
    a. All patients identified as moderate risk for suicide due to active ideation without method/plan/intent within the last month should have a virtual PSA or be in continuous line-of-sight observation.
    b. Provider/Practitioner order is not required; this is a policy-driven process. Initiate internal request process for obtaining virtual sitters or accommodating continuous line-of-sight.

14. Discontinuation or de-escalation of increased observation measures (e.g. 1:1 PSA, virtual PSA or line-of-sight supervision) should be determined by an improvement in patient condition and reflected by a decreased ORL upon reassessment.
    a. An escalation or increase in suicide safety precautions can occur at any time based on a change in patient condition, precipitating a reassessment of the overall risk level indicating a higher overall risk level.

15. If a patient is determined to be low, moderate, or high risk for suicide and refuses to remain in the hospital for a psychiatric evaluation, an Emergency Detention may be requested and executed, if applicable.

16. Discharge Planning:
    a. Pre-Discharge Suicide Assessment:
    Patients who were assessed low, moderate, or high risk upon admission will be reassessed for suicide risk prior to discharge. If the patient is low, moderate, or high risk at this time, then the patient will be evaluated for the appropriateness of discharge.
    b. Suicide Prevention / Discharge Patient Education will include the personal safety plan (PSP): The treatment team will provide and review "The Patient Discharge Education Suicide Risk Prevention" printout with the patient/family. It will be included as part of the written discharge instructions. "The Patient/Family Suicide Risk Prevention/Warning Signs Discharge Education" form is provided, which includes two crisis hot-line numbers (a national and a local number) and the Substance Abuse Mental Health Services Administration. Patients and family members, or others identified as support systems by the patient, will be invited to participate in the education.
    c. Elements of the education will include, but are not limited to:
        i. Names and numbers of key contacts (outpatient providers, next level of care providers, crisis hot-lines and community and peer support groups
        ii. Instructions regarding lethal weapons/firearms that the patient may have access to upon discharge.
        iii. Safe storage and management of all medications
        iv. Warnings to abstain from the use of alcohol or other illicit substances
        v. Warning/risk signs of returning suicidal risk

17. The contents of the Discharge Patient Education form are to be clearly communicated to the patient, family members, the next level of care, and others that the patient identifies prior to or upon discharge. A copy of the Discharge Patient Education form will be given to the patient/family at discharge, and the original will be placed in the patient's medical record. Education on suicide prevention will be provided to clinical staff upon hire and annually.

ATTACHMENTS

1. Attachment A- Suicide Safe Environment Checklist – ER
2. Attachment B- Suicide Safe Environmental Checklist – Inpatient Non-BH Unit
3. Attachment C- "At Risk" Suicide Sitter Hand-off Checklist
4. Attachment D- PSA Observation Log
   https://connect.medcity.net/web/nursingcorner/psa-strategy

REFERENCES

The Joint Commission National Patient Safety Goal 15.01.01.

Grant, C.L. and Lusk, J.L. (2015). A Multidisciplinary Approach to Therapeutic Risk Management of the Suicidal Patient. Journal of Multidisciplinary Healthcare. (8): 291-298.

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The Columbia Lighthouse Project. (2016). *Clinical Triage and Workflow Guidelines for the C-SSRS*

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