BATES COUNTY MEMORIAL HOSPITAL
Butler, Missouri

TRAINING MODULE: SUICIDE RISK AND PRECAUTIONS

PURPOSE:

To provide a guideline to ensure safety of patients who present as a suicide risk, in an acute care setting.

STANDARD:

Patients with identified risk of suicide will have precautions in place to minimize the risk of completed suicide. Staff will assess the patient for ongoing signs and symptoms of suicidal risk. The environment in which the patient is placed will be assessed for ligature risks. Items that are not necessary for the care of the patient will be removed. Education will be completed for all nursing staff consistent with delivering safe care to the suicidal risk patient population at Bates County Memorial Hospital.

Definition: Suicide is defined as intentional, self-inflicted death. Ligature Risk is defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation.

PROCEDURE (GUIDELINES):

Suicide results from a complicated array of factors. There are no standards for the prediction of suicide. The more risk factors and/or warning signs the patient exhibits, the greater the risk of suicide becomes.

Some of the factors that increase the patient's risk of suicide include:

- Isolation
- Recent loss
- Lack of social support
- Unemployment
- Critical life events
- Family history of depression or suicide
- Alcohol or drug abuse
- Lack of impulse control
- Unexplained changes in behavior
- Unstable lifestyles.
- Psychiatric disorders such as schizophrenia, bipolar disorder, borderline personality disorder, mood disorders, panic disorder
- Post traumatic stress disorder
- Chronic medical illness such as cancer, HIV, diabetes, cerebrovascular disease, or head and spinal cord injury
- Prior suicide attempts

Some of the warning signs of impending suicide include:

- Withdrawal
- Social isolation
- Signs of depression, which may include constipation, crying, fatigue, helplessness, hopelessness, poor concentration, reduced interest in sex and other activities, sadness, and weight loss
- Farewells to friends and family
- Putting affairs in order
- Giving away prized possessions
- Expression of covert suicide messages and death wishes
- Obvious suicide messages such as “I’d be better off dead.”

Nursing staff will observe and document factors that increase the patient’s risk for suicide as well as warning signs of impending suicide during the admission assessment and on an ongoing basis.

This will be accomplished by completing a suicide risk screening in the Electronic Health Record concurrent with the Admission Assessment and as needed.

This tool can be used at any point during the hospitalization to reassess and document mental status variance of the patient due to alteration in their social/family support systems, medication regime, physical symptoms or psychological behavior/s related to being at suicidal risk.

If the nurse identifies a concern or significant variance regarding the patients’ risk for suicide, the nurse should contact the patient’s physician for further assessment and orders.

If a patient is admitted to the hospital from the Emergency Department, the verbal handoff report from the ED staff to the Med/Surg/CCU/Tele staff should include the personal belongings brought with the patient, if not sent home with family.

When a patient is admitted with a diagnosis related to suicide or intention to harm self AND is placed on Suicide Precautions, the patient’s belongings will be locked in a secure area, to be given to the patient on discharge from the hospital.

Remove medications from the patient’s room; including any brought to the hospital by patient. These need to be entered into the EHR under the Medication Reconciliation section, then locked up in the locked cabinet until the patient is discharged from the facility. If given to family/friends, instruct them to not return the items to the patient.

If the patient is transferred to another healthcare facility, the belongings will be handed over to the accompanying transportation personnel.

Based on physician assessment and orders, suicide precautions may be initiated. An order for Suicide Precautions must be obtained from the physician. The nurse should document the suicide precautions implemented in the Electronic Health Record

Suicide precautions include:

- Place patient in private room near Nurse's Station if at all possible.
- Keep door of room open unless staff member is in room.
- The patient should be accompanied by hospital personnel at all times, including when off the floor for procedures or tests.
- Patients should be under observation and activities monitored. Continuous observation by nursing or other qualified staff member. When Suicide Precautions are ordered by the physician an order need NOT be obtained for a 1:1 sitter. This will be assumed when the order is received for the Suicide Precautions.
- As a 1:1 sitter, the "Patient Behavior and Environment Checklist", included in this guideline, will be completed every 24 hours while the patient has a 1:1 sitter and then sent with the paper record to HIM for scanning into the permanent EHR.
- The 1:1 sitter must dedicate their time to observing the patient, they may not leave the patient's room without replacement or speaking to the primary nurse.
- Remove dangerous objects from room such as, but not limited to: belts, razors, suspenders, glass, knives, scissors, nail files, clippers, metal coat hangers, soft drink cans, chemicals, clothing, drawstrings, and alcohol-based products. Remove cords, including the phone from the room, unused monitoring cables and equipment that is not necessary for providing care to the patient.
- Patient will be provided a set of paper scrubs to wear and personal clothing will be locked up with patient belongings and returned upon discharge.
- Plastic utensils and disposable dinnerware should be used at mealtimes. Staff to notify dietary of this request. Staff should check that every piece is returned with the food tray.
- The staff can ask the family/friends to reveal any item/s they plan to give the patient, and those items may be rejected if they are able to use them for harm. Explain to family/friends that our intention is to help keep the patient safe.
- When a patient is placed on suicide precautions or a risk of suicide is identified, the nurse should notify the Staffing Coordinator/Nursing Supervisor on duty so that staffing can be adjusted.

Education and Training:

Nursing staff will be provided education in observing, assessing and documenting behaviors of patients who are at suicidal risk at Bates County Memorial Hospital on the acute care unit. This education will be provided during orientation upon hire, as needed, and as yearly mandated education.