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SYSTEM: Hospital Sisters Health System	**MANUAL(S): Executive Manual**
TITLE: Safety Precautions: Suicide and Self Harm (Non-Behavioral Health Units) Policy	**ORIGINATING DEPARTMENT: Quality and Physician Relations**
EFFECTIVE DATE: 07/07/22	**REVISION DATE(S):**
SUPERCEDES: D-27 1/25/18, 12/11/17	

* As required by CMS Regulation §482.12 A-0043 Conditions of Participation: Governing Body, the following hospitals and entities are included as HSHS entities: **ILLINOIS**: (1) HSHS St. John's Hospital – Springfield (2) HSHS St. Mary's Hospital – Decatur, (3) HSHS St. Francis Hospital – Litchfield, (4) HSHS Good Shepherd Hospital – Shelbyville, (5) HSHS St. Anthony's Memorial Hospital – Effingham, (6) HSHS St. Joseph's Hospital – Highland, (7) HSHS St. Joseph's Hospital – Breese, (8) HSHS St. Elizabeth's Hospital – O'Fallon, (9) HSHS Holy Family Hospital – Greenville, (10) HSHS Physician Enterprise (HSHS Medical Group – Illinois, Prairie Cardiovascular Consultants). **WISCONSIN**: (1) HSHS St. Vincent Hospital – Green Bay, (2) HSHS St. Mary's Hospital Medical Center – Green Bay, (3) HSHS St. Clare Memorial Hospital – Oconto Falls, (4) HSHS St. Nicholas Hospital - Sheboygan, (5) HSHS Sacred Heart Hospital – Esau Claire, (6) HSHS St. Joseph's Hospital – Chippewa Falls, (7) HME Home Medical, (8) Libertas Treatment Center – Green Bay and Marinette, (9) HSHS Physician Enterprise (HSHS Medical Group – Wisconsin).

- **POLICY:**

  Any patient in a non-behavioral unit who is being treated or evaluated for a behavioral condition as their primary reason for care, and all patients who express suicidal ideation during the course of care regardless of their registration status will be screened for risk of harm to themselves or others and precautions will be implemented to ensure safe delivery of care

- **PURPOSE**:

  A. To promote patient safety through screening and early identification and detection of patients at risk for self-harm or suicide.
  B. To provide guidelines for the screening, and intervention for patients who are at risk for self-harm or suicide. To maintain a safe environment for the patient and others.

- **SCOPE:**

  This policy is applicable only to patients receiving care outside of a dedicated behavioral health unit. This policy applies to inpatients, and patients presenting to the Emergency Department, Urgent Care, and walk-in clinics. All other outpatients will be referred to the Emergency Department for application of this policy if suicidal ideation is expressed during their visit/treatment. This policy excludes all locations not under an HSHS hospital accreditation number.

- **DEFINITIONS:**
  A. **Against Medical Advice (AMA):** refers to a patient that demands to be discharged from the hospital before the completion of treatment or contrary to the advice of the attending physician.
  B. **Behavioral Health Consult:** Patient assessment by: Psychiatrists; psychologist; another mental health professional/agency provider; or Licensed Independent Practitioners (Provider) who can establish a psychiatric diagnosis, assess suicide risk, initiate commitment procedures for involuntary psychiatric hospitalization or otherwise facilitate the acquisition of mental health services
  C. **Columbia- Suicide Severity Rating Scale:** (C- SSRS) – Validated suicide screening tool approved for use in all setting for ages 7 year and older.

D. **Columbia Suicide Severity Rating Scale (Lifetime/Recent)-**: Validated Suicide assessment tool approved for use with C-SSRS on ages 7 years and older

E. **Danger to Self (DTS):** a patient's behavior that can be expected to result in intentional or unintentional self-harm. This global definition may include any of the following:

a. **Self-harm:**
- i. An intentional and often repetitive behavior that involves the infliction of harm to one's body for purposes not socially condoned (excluding culturally accepted aesthetic modifications such as piercing) and without suicidal intent.
- ii. It may be very difficult to distinguish between self-harm and suicide-related behavior as both are self-directed and dangerous.
- iii. The majority of individuals who engage in self-harm do not wish to die. Rather, they use self-harm as a coping mechanism that provides temporary relief from psychological distress.

b. **Suicide:**
- i. the act of intentionally killing oneself;
- ii. Death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death.

c. **Suicide Attempt/Act:**
- i. The potentially lethal act of trying to kill oneself;
- ii. A potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself/herself;
- iii. A suicidal act may result in death, injuries, or no injuries.

d. **Suicidal Ideation:**
- i. Self-reported thoughts of engaging in suicide related behavior.
- ii. The process of contemplating suicide or the method to be used without acting on these thoughts;
- iii. Thoughts about killing oneself.

e. **Suicide Plan:** The plan that describes the means such as weapons and/or medications, method and intent of committing suicide. The more specific the details or ideas of suicide, the greater the possibility of suicide.

f. **Suicide Intent:** Thoughts of killing oneself with some intent to act on such thoughts.

F. **ED:** Emergency Department

G. **Elopement** – a patient is absent from the care of the unit without notice. (See Elopement policy)

H. **Ligature:** Something which binds or ties. Something that can be used for strangulation.

I. **Ligature Point:** Anything that could be used to attach a ligature, cord, rope or other material or item for the purpose of strangulation.

J. **Non-Behavioral Health Setting:** Applies to all inpatient units (except for Behavioral Health) and Emergency Department where patients are admitted.

K. **Observer Types:**
- Continuous Observer (1:1)
- Close Observation
- Hourly Observation
- Video/camera monitoring

L. **Safety Precautions for Suicide/DTS:** based on the patient response to the screening tool.

- **GUIDELINES**

A. An annual environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and take necessary action to minimize the risk(s) for patients who are at high risk for suicide will be conducted in designated care areas/units.

B. During initial intake to the facility, patients being evaluated or treated for a behavioral health condition as their primary reason for care will be screened for suicidal ideation using an age appropriate validated screening tool.

C. The patient will be assessed and medically cleared by the provider upon initial presentation. The provider may utilize an Advance Practice Professional or Mental Health professional (social worker, counselor, psychologist or appropriate agency staff) to assist him/her in the evaluation and disposition.

D. For patients who screen positive for suicidal ideation, an evidence-based process will be utilized to conduct a suicide risk assessment. The assessment addresses suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.

E. The patients' overall level of risk for suicide and the plan to mitigate the risk for suicide will be documented in the patients' Electronic Medical Record (EMR). The documentation will occur per protocol on the Risk Mitigation Plan.

1. Guidelines for reassessment and disposition
2. Initiate patient monitoring, if indicated
3. Place patient in a safe environment
    a. Secure patient items
    b. Initiate patient environmental risk assessment
    c. Consider department annual environmental risk assessment to ensure patient is placed in a safe environment or as close as medically appropriate
    d. Visitors restrictions as appropriate

F. Discharge protocols for counseling and follow-up care will be based on each patient's individual assessment. Discharge may include a Safety Plan when applicable.

G. Patients who are at high risk for suicide will be monitored according to the protocol outlined below in Assessment section. Monitoring is subject to change during the patient's visit based on reassessments of suicide risk.

H. AMA: A patient's right to leave against medical advice (AMA) is determined by the screening response protocol findings and the provider assessment.

I. Training/Competency for staff who care for patients at risk for suicide will take place during orientation and annually.

J. Compliance to policies and procedures for screening, assessment, and management of patients at risk for suicide will be monitored by the assigned committee (s). Policies and procedures will be re-evaluated bi-annually and improved as indicated.

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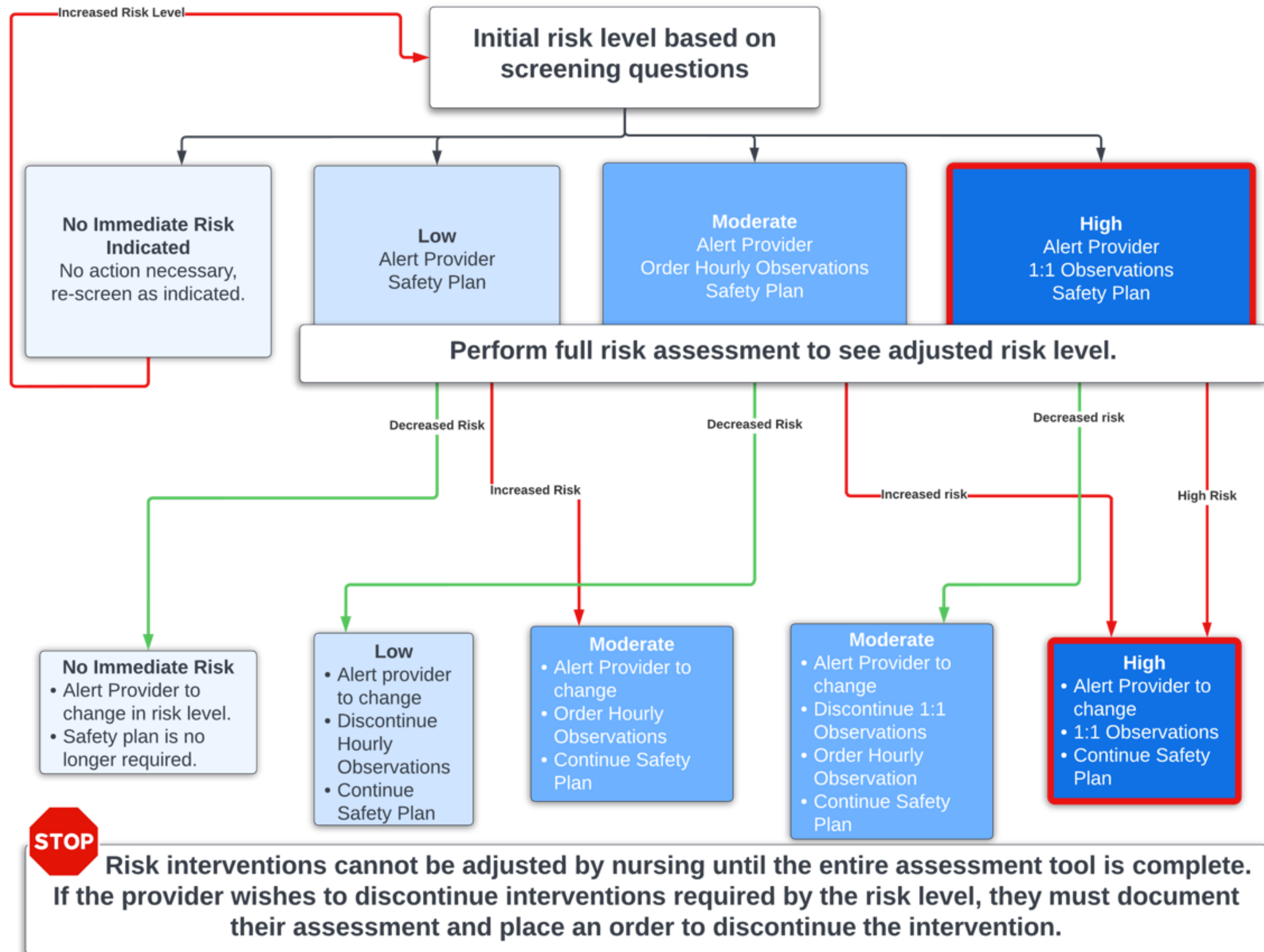

- **PROCEDURE**

A. **Screening:**

1. Can be performed by any trained colleague or agency.
2. Patients who present for evaluation or treatment of a behavioral health condition will be screened for suicidal ideation using age appropriate tool upon arrival to the facility and/or if new risk factors are identified throughout stay.
   a. Outpatient locations include ED, OB triage.
   b. Behavioral health conditions may include anxiety, depression, overdose, psychiatric, and suicide attempt.
   c. Patients may present with other chief complaints that have high risk factors for suicide, staff must use clinical judgement when assessing patient risk in these situations (e.g. GSW, ingestions, stab wound, substance abuse, and unconscious/unknown).
   d. Patient on or changed to hospice respite, re- screening is not required.

3. The suicide screening will be deferred in the following situations, based on clinical condition:
    a. The patient is clinically unstable and performing the screening would delay necessary clinical care.
    b. Patient is unresponsive, ventilated, with altered level of consciousness, in a trauma or cardiac arrest.
4. Suicidal ideation will be reassessed daily for at risk patients or with status change as part of the mental status assessment.

B. **Risk Mitigation:**

- Risk mitigation strategies will be implemented based on the patient's overall risk for suicide and department specific environmental risk assessment.

C. **Assessment:**

1. To be performed by provider or trained colleague/agency.
2. A suicide risk assessment using age appropriate tool will be completed as soon as possible following patient's positive screening.
    - Suicide risk assessment will be repeated with a change in patient status (e.g. taken off a 1:1, transfer from medical to behavioral health unit).

D. **Disposition:**

- The following dispositions will be determined based on the screening, assessment, or provider evaluation.
    a. Discharge to home:
        i. If the patient was positive for suicidal ideation, a safety plan will be released with community resources for behavioral health.
        ii. Patients who are assessed as moderate or high risk for suicide will have communication to patient's community provider/agency, if the patient does not have a community provider a referral and follow up call will be initiated. Patient must be agreeable to having information shared. Patients without a local provider should follow their Safety Plan.
    b. Admitted to the Behavioral Health Unit after consultation with the attending psychiatrist.
        i. The provider will conduct a medical evaluation for the patient, order any diagnostic testing and report any abnormal findings to the psychiatrist on call.
        ii. Admitted patients will be transported to the Behavioral Health Unit with an escort.
    c. Transferred to another health care facility.
        i. The Protocol for Transfer of Patient to Another Acute Health Care Facility policy must be followed, including a physician to physician transfer.
    d. If a court order has been issued, the provider must comply with the order.

E. **Emergency Department Considerations:**

- 1. Adult or pediatric patients being housed in the Emergency Department may have privileges adjusted based on collaborative evaluation by patients care team.

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F. **Pediatric Considerations:**

1. The responsible adult/guardian is encouraged to stay with the patient throughout the patient's visit.
2. There may be occasions when a responsible adult/guardian cannot feasibly stay with the patient. Contact information for the legal guardian must be obtained and documented in the record. The guardian must be available by phone throughout the patient's visit.
3. If the responsible adult/guardian abandons the child, Childrens Services will be notified.
4. The parent cannot substitute a 1:1 staff observation

G. **Elopement Protocol**

1. **Prior to medical screening exam or re-evaluation:**
   a. The patient will be asked to stay for the medical screening exam and strongly encouraged if he or she attempts to leave upon initial presentation or with status change.
   b. Attempts to delay the patient's departure should continue until the provider is able to evaluate the patient.
   c. The provider will see the patient as soon as possible and evaluate the sincerity of the patient's intent to harm him or herself and make a determination on the legal status as defined by law.
2. **Established Patients:**
   a. The staff will continuously assess the patient for elopement risk by observing signs; i.e. pacing, interest in exits, refusal of treatment, paranoia, and verbal threats of leaving.
   b. When a patient demonstrates signs of intent to leave, staff will take steps to help prevent successful elopement.
   c. Once it is discovered that a patient has left the patient care unit without staff's knowledge or permission, staff should immediately alert all other unit staff members to search the immediate patient care area and inquire if the patient has been transported off the unit for a test/procedure. Staff should also immediately notify Security and the nurse manager, house supervisor or designee.
   d. Patients who do not meet criteria for legal holds can be verbally encouraged to return but cannot be physically forced.
   e. It is recommended staff remain on hospital grounds when witnessing a patient leaving hospital grounds.
   f. Staff will document in the patient record the prevention, intervention, and notification actions taken and the results.
   g. If the patient has left the grounds, but returned, staff will conduct a safety and belongings search and assess the need for new physician orders.

- ADDITIONAL REFERENCE POLCIES
  1. **AMA (Against Medical Advice) & Elopement (HSHS IL)**
  2. **D-22 Restraint and Seclusion Policy**

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- **REFERENCES:**

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ORIGINATOR: ______ *Bill Cox*
System Director, Quality

ACCOUNTABLE LEADER: ______ *Bill Cox*
System Director, Quality

ADMINISTRATIVE APPROVAL: ______ *Damond Boatwright*
President & CEO