Objectives

The objectives for this presentation are for you to learn:

- The prevalence of suicide in the United States and North Carolina,
- Who is at increased risk for suicide,
- Cape Fear Valley’s procedure for providing safe care of the suicidal patient,
- When to initiate the Behavioral Disorder Checklist,
- Role of the Resource Nurse, Charge Nurse, Safety Attendant, Security, and all Cape Fear Valley Employees; and
- The significance of “Pink Arm Band” and “Eye Sign”.
Care of Suicidal Patients on Non-Psychiatric Nursing Units

CFV has guidelines to ensure that once a patient has been assessed as a danger to themselves or others, a safe environment is provided for the patient, visitors, and staff.

Suicidal thoughts come at a point where a person can no longer handle the pain he or she feels. A suicidal person is not “crazy.”

All suicide attempts and threats should always be taken seriously.
Why is this so Important?

Suicide is the 8th leading cause of death in the United States. In North Carolina, 12 people out of every 100,000 die from a suicide attempt.

The rate for white, non-hispanic males aged 60 and over in North Carolina is 37 per 100,000.
Since January 1995, patient suicide has been the #2 Sentinel Event reviewed by the Joint Commission.

12.4% of all Sentinel Events have been patient suicide. (The #1 Sentinel Event was wrong-site surgery, accounting for 13.2%)
“The Organization identifies patients at risk for suicide.”

(NPSG 15, 15a)
Increased Suicide Risk

People are at a higher risk for suicide when they:

- Are male
- Are under 19 or over 45
- Have a history of psychiatric disorder or suicide attempt
- Feel helpless or hopeless
- Hear voices or see things others don’t
- Have experienced a recent loss
- Have legal issues pending
- Have increased use of alcohol or other drugs
- Have no social support
- Have chronic pain/health problems
A physician must write the order for suicide precautions, but a nurse can initiate precautions and procedure until the order is received.

"Initiating precautions" means starting the Behavior Disorder Checklist. This is a form that lists specific things to do, in order, and requires initials and time that it is completed.

The Behavior Disorder Checklist is a permanent part of the patient’s medical record.
The Administrative Policy and Procedure “Suicidal Patients Care, Non Psychiatric Nursing Units” can be found on the InfoWeb.
**Procedure for Suicidal Patients**

The unit Resource Nurse or Charge Nurse is responsible for:

- Accepting the patient and his/her belongings in a face-to-face handoff
- Initiating the Behavior Disorder Checklist
- Scanning the room for safety and removing all harmful items
- Ensuring the patient has trained staff with him/her at all times
Procedure for Suicidal Patients

The unit Resource Nurse or Charge Nurse is also responsible for:

- Informing unit secretary of suicide precautions to make sure orders are entered correctly
- Completing the Suicide Risk Assessment to include behavioral disorder diet
Procedure for Suicidal Patients

The Unit Secretary is responsible for requesting a Safety Attendant from Supplemental Staffing and Faxing the following to SST:

- Licensed Independent Practitioner (LIP) order for a Safety Attendant
- Unit and Room Number
- Patient behavior indicating the need for 1:1 Safety Attendant (medical or behavioral.)
  i. Involuntary Commit
  ii. Suicide Precautions
  iii. 4-Point Restraints
  iv. Psychosis/Hostile behavior
SAFETY ASSESSMENT

Do you currently have thoughts to harm yourself (suicide) or have you in the past 5 days? ☐ Yes ☐ No

If Yes:
1. Remove any items from room, to include personal belongings, which can be used as a weapon/means for self-harm.
2. Initiate Suicide Precautions (1:1 Safety Attendant)
3. Conduct Suicide Risk Assessment (below) at initiation of suicide precautions or upon arrival to unit and as patient’s condition changes.
4. Notify Attending/On-Call MD: _____________________________ (Name of MD)
5. Initiate Behavioral Disorder Checklist if not previously initiated.
6. Psychiatric consult per Attending/On-Call: ___________________________ (Consulting MD)
   (Attending physician must contact psychiatrist directly.)

If No:
If the patient is presently on suicide precautions, conduct Suicide Risk Assessment (below) upon arrival to unit and as condition changes, and contact the attending physician to report the change in status.

Risk Assessment: Score both Risk Factors and Risk Reduction Factors

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Points</th>
<th>Patient’s Score</th>
<th>Risk Reduction Factors</th>
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<td>Admission for suicide attempt</td>
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<td>Strong social support</td>
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<td>Current plan</td>
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<td>Employment</td>
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<td>History of suicide attempt</td>
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<td>Strong religiosity</td>
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Total Risk Factor Score ☐ ☐ Minus Total Risk Reduction Factor Score ☐ ☐ = Total Score ☐ ☐

Please place a check mark in the corresponding box to indicate patient’s risk:

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<td>Primary MD notified of need for psychiatric consult</td>
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Assessment Completed by: ___________________________

Printed Name: ___________________________
Date: ___________________________
Time: ___________________________

Cape Fear Valley Health System
P.O. Box 2000
Non-Psychiatric Nursing Unit
Suicide Risk Assessment
Page 1 of 1
TABLE #
NN9520
A Pink armband is placed on the patient who is on Suicide Precautions.
Symbol for Suicide Precautions

An “eye” sign is placed outside the room to alert staff and other departments to watch the patient carefully.

Make sure the sign is up!
Clothing and Belongings

A security officer and a nurse or tech will inventory all of the patient’s clothing and belongings.

Please see Administrative Policy “Handling Patient Valuables” for guidance.

Patients are not to have access to electrical equipment, glass, medications, or any items with cords that are not medically necessary unless under the constant supervision of a staff member.
Other Staff Responsibilities

The Safety Attendant:

– Will document on the Special Observation Record and report to nursing any changes in status, any concerns, or any requests for assistance.

– Will not leave the patient alone for any reason and will remain with the patient until relief or assistance arrives. (See Nursing Policy, “Safety Attendant Protocol”)

– In the case of an “off-unit” procedure/treatment, safety attendant will inform the person performing the procedure/treatment that the patient is not to be left alone.
Ancillary Staff:

- All Ancillary staff must be made aware that the patient is on suicide precautions. This is done by noting the pink armband on the patient and the “eye” symbol just outside the patient’s room.
- Dietary must ensure plastic dinnerware and utensils are used. **No glass or metal silverware.** No soda cans.
- All utensils are to be counted going in and out of the room.
- Environmental Services must be careful not to leave chemicals or cart in patient’s room.
Other Staff Responsibilities

Ancillary Staff:

- Transportation must not transport the patient with the patient’s belongings bag on the stretcher, in the patient’s reach.
- Do not leave the patient unattended!
- Maintenance must not to leave tools unattended.
- Unit Secretary enters a “behavioral disorder diet” in ValleyLink as a part of the patient’s diet order.
- Lab must not leave equipment unattended.
  - Must account for all vials, syringes, tourniquets, etc prior to leaving the room.
Other Staff Responsibilities

Ancillary Staff:

- Therapists (RT, PT, OT) are not to leave equipment or supplies unattended in the patient’s room.
- Radiology is not to leave the patient unattended. The Safety Attendant is to remain with the patient when the Radiology Tech is not in the room.
- All healthcare providers must not leave pens/pencils in the patient’s room.
Communicate the patient’s status

Make sure you communicate the patient’s status to other health professionals who come in contact with the patient.

- Use the “Eye symbol” in the plastic holder outside patient’s room, pink armband on patient, and the handoff reports.
- Note the patient's precaution status on the staff assignment sheet and unit report.
Nursing Assessment and Documentation

The patient’s nurse re-assesses the patient for suicide risk any time patient’s condition changes.

Document any suicidal ideations in the nurse’s notes.

Ensure that the care plan has suicide precautions care and interventions added.
The Safety Attendant documents the patient’s status, behaviors, etc. on the Special Observation Record every 15 minutes.

Any changes in status or behavior are to be immediately communicated to the Lead Charge Nurse or Charge Nurse.
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**CARE & OBSERVATION**

- **Procedural**
  1. 1:1 With Staff
  2. Direct Observation
  3. Meal Served
  4. Fluids Served
  5. Toilet/Hydrea

- **Behavioral**
  6. Calm
  7. Cooperative
  8. Appears Sleeping
  9. Agitated
  10. Confused when awake
  11. Pulling at lines/tubes
  12. Attempts out of bed/chair
  13. Threatening
  14. Combative
  15. Yelling
  16. Restless
  17. Aggressive

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**Room Safety Check**
(every shift)

- □ No belongings in room

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**Attending Personnel**

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Cape Fear Valley Health System
P.O. Box 2000 \ Fayetteville NC 28302-2000

SPECIAL OBSERVATION RECORD
TAB 8

FF0442, Rev: 1/99, 7/25/12

NN0338
Observe Patient at ALL Times!

The suicidal patient is not to be left alone at any time!

Be especially alert while observing patient during toileting, visiting hours and at the change of shift.
**Observe Patient at ALL Times!**

The suicidal patient is **NOT** to leave the nursing unit for **any reason** without staff escort.

If an off-unit procedure is required (e.g. x-ray) the staff must go with the patient to the procedure and keep the patient under observation.
Breaks for Safety Attendants

A Staff nurse/nursing assistant provides relief when a break is needed:

- 15 minute break
- Meal
- Bathroom

**Do not** leave the patient with a visitor or family member!
If...

If the patient becomes agitated:

– Explain that “There are some things we can't allow. I’m sorry you want to (yell, leave, etc.) but we can’t allow that.”

– Ask the patient “How can I help you to feel better?”

– If necessary, call the patient's nurse and dial “22” and announce “Code White”.

If...
To ensure the patients safety all items brought in by visitors are to be checked before allowing the patients to have them.

**Remember:** Plastic bags are dangerous!

Sometimes family members upset patients. Don’t hesitate to ask the visitor to leave the room for the patient’s safety.
Talk with the patient

- Calm them if they are agitated
- Provide reassurance they will be safe
- Play games, cards, provide music
- Assist them with bathing, eating, ambulation
- Maintain restraints if applicable
- Check the room each shift for patient safety
An Involuntary Commitment with an emergency certificate may be initiated on a voluntary patient at the discretion of the physician and in accordance with state law.

Nursing staff are to immediately notify the security officer who takes custody of the patient per security instructions.

See the “Involuntary Commitment” online presentation for more.
When a patient has been identified as a risk for suicide, we are all responsible for providing a safe environment with constant observation.