WEISMAN CHILDREN'S REHABILITATION HOSPITAL (WCRH)

Administrative Manual

SUBJECT: Suicide Screening and Precautions **No: AM 6.49**

EFFECTIVE DATE: 5/03 **Page: 1 of 5**

REVISED/REVIEWED: 2/04, 1/05, 1/06; 04/07, 1/08; 1/09; 1/10; 1/11; 1/12; 1/13; 1/14, 2/15, 5/16, 12/17; 1/18; 1/21; 9/21; 1/24, 10/25, 2/26

Attached Forms: Suicide Precaution Observation Checklist; Columbia-Suicide Severity Rating Scale (C-SSRS)

National Performance Goal #8, *The hospital reduces the risk for suicide*

Definition: Per National Performance Goals (#8) The hospital reduces the risk for suicide

Purpose: To provide guidelines to assist the interdisciplinary team in identification, care, and documentation for patients who are at risk for suicide. Patient safety is paramount in identifying and treating the patient at risk for suicide.

Policy: All staff members are educated on suicidal risk assessment guidelines.

A) SUICIDE SCREENING

1. Initial Screening and Notifications

    a. Any patient age 12 years or older will have a suicide screening completed at time of admission by a nurse using Columbia-Suicide Severity Rating Scale (C-SSRS)

        i. If the patient answers yes to any of the 6 questions on the C-SSRS, the nurse must immediately communicate results to the physician and initiate suicide precautions.

    b. If any new onset of symptoms of suicidal ideation, or if a history of suicidal ideation is discovered after upon/after admission, a nurse will complete suicide screening using C-SSRS as soon as is practicable at any time of the patient stay.

        i. NOTE: A nurse will not be required to complete the suicide screening if already immediately completed by a physician, psychologist, or psychiatrist

    c. For the purpose of this policy, "at risk for suicide" is defined by:

        i. Positive Suicide Screening

        ii. Suicidal Ideation

iii. History of Suicide Attempt

iv. Recent self-harm behavior: within the previous three (3) months or based on an assessment by the physician/psychologist/psychiatrist

v. Acute psychiatric symptoms with impaired judgement

d. Any patient who exhibits signs of suicidal ideation to any staff member or family member at any point in their hospital stay will immediately be placed on suicide precautions.

e. Nursing staff may initiate suicide precautions until a physician's order can be obtained.

2. Medical and Psychology

a. A physician's assessment and order for suicide precautions must be completed within 24 hours of the first report of suicidal ideation.

b. Based on the results of the physician's assessment, the physician will make a referral to Psychology (or Psychiatrist).

3. Duration of Precautions

a. The physician will determine the extent and duration of observation required, the level of care required, and if a transfer is warranted.

b. If suicide precautions are needed for more than 24 hours, the patient will be transferred out for evaluation

c. After physician handoff is completed and the patient is deemed medically stable to return, the medical team will meet with psychology to determine the treatment plan going forward.

B) SUICIDE PRECAUTIONS*: If patient has a positive suicide screen the following must be performed:*

1. Place patient on direct one-to-one observation immediately

a. See Policy AM 6.47, *Restraints: Care of the Patient at Risk for Physical Harm, RAP, One to One, Continuous Observation*

b. Patient should be placed in hospital-provided attire.

c. All therapies will take place in the patient room.

d. One to one observer is to accompany patient at all times

e. One to one observer should be within arms' reach and maintain unobstructed direct line of sight to the patient's full body at all times

f. Documentation on the **Suicide Precaution Observation Checklist** (see attached) should occur every 15 minutes.

2. Perform Room Check

   a. Upon placement of Suicide Precautions, Q shift, and after any visitation.

      i. Check room and private belongings for harmful items and remove immediately, then at least every shift and after any visitation.

         1. list of items to be removed that are considered harmful is located on the checklist

   b. Notify The Food Service Department of Suicide Precautions. Meals will be provided as below:

      i. Foods will be served in disposable foam, plastic or paper.

      ii. Plastic ware will be provided.

      iii. A knife is NOT provided to patients in suicide precautions and foods served need to be eaten without the use of a knife or cut into bite size pieces.

      iv. Any beverage whose original container is not plastic, paper or foam (such as glass or aluminum) must be poured into a disposable cup.

      v. Meals are served on a standard tray for suicide precautions.

   c. Staff performing the room check must complete the Suicide Precaution Room Checklist, which must be co-signed by a second staff member, and must maintain a log of any personal items removed.

3. Patient Placement

   a. If possible, move the patient to a room near the nurse's station and a private room.

   b. Keep the door to the patient's room open at all times.

4. Caregiver Notification

   a. See policy AM 6.12, *Informing Patient/Family About Outcomes/Unanticipated Outcomes of Care, Treatment and Services*

   b. Notification will be provided to the caregiver(s) as soon as is practicable, followed by a letter (attached to this policy) to the patient/family to explain Suicide Precautions

5. Visitors

    a. Visitors will be restricted to Parent/Guardian (maximum of 2 identified, 2 at a time)

    b. Visitors must check in with nursing prior to entering the patient's room.

        i. A sign will be posted at the door alerting visitors of this.

    c. Visitors must abide by the precautions in place and should not bring any restricted items into the room.

    d. Any items brought in must be evaluated for appropriateness by the nurse.

    e. Patient belongings will be kept safe in a locked location

C) DOCUMENTATION

1. Suicide Screening Tool: Columbia-Suicide Severity Rating Scale (C-SSRS)

    a. To be completed by nursing upon admission for patients ages 12 and older and if any new onset of symptoms of suicidal ideation, or if a history of suicidal ideation is discovered after upon/after admission.

2. Physician's order for Suicide Precautions and One to One Observation

    a. A patient may be placed on suicide precautions by a nurse in emergent situations prior to obtaining an order. The physician must then be immediately notified and give orders to continue suicide precautions.

3. Progress notes

    a. Must include patient’s statements or behaviors that warrant suicide precaution implementation with date and time of initiation.

    b. A progress note should be written once per shift indicating patient's behavior/mood while maintaining suicide precautions. Refer to page 5 under Nursing Responsibilities.

4. Suicide Precaution Observation Checklist

    a. Assigned staff providing one to one observation will document behavioral observations on the Suicide Precaution Observation Checklist.

5. Suicide Precaution Room Checklist

    a. Upon placement of Suicide Precautions, Q shift, and after any visitation.

    b. Must be co-signed by a second staff member

6. Scanning

    a. All Paper documents to be placed in “To Be Scanned Bin” for HIM to scan into Patient’s EHR.

7. Social Work Responsibilities

    a. Social Work will provide information for the Suicide & Crisis Lifeline in the discharge instructions/discharge summary.

8. Nursing Responsibilities

    a. The RN/LPN will review the suicide precaution observation checklist and complete a focused behavioral assessment at least once per 12-hour shift and with any change in the patient’s condition or behavior.

    b. Focused behavioral assessment includes review of behavioral observation trends, patient verbalizations, mood and affect, engagement with staff, and evaluation for any escalation requiring provider notification or change in interventions.

_____

Administrator

Weisman Children's

Patient Label

COLUMBIA-SUICIDE SEVERITY RATING SCALE **SUICIDE IDEATION DEFINITIONS AND PROMPTS**	Past month	
Ask questions that are bolded and <u>underlined</u>.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***<u>Have you actually had any thoughts of killing yourself?</u>***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***<u>Have you been thinking about how you might do this?</u>***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u>, as opposed to "*I have the thoughts but I definitely will not do anything about them*." ***<u>Have you had these thoughts and had some intention of acting on them?</u>***		

COLUMBIA-SUICIDE SEVERITY RATING SCALE **SUICIDE IDEATION DEFINITIONS AND PROMPTS**	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *How long ago did you do any of these?*** □ Over a year ago □ Between three months and a year ago □ Within the last three months	**YES**	**NO**

For inquiries and training information contact: Kelly Posner, Ph.D.New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

Complete by: (Sign and Print) _____

Date: _____

Time: _____

Patient Label

SUICIDE PRECAUTION: ROOM SAFETY & BELONGINGS CHECKLIST

Date/Time: _____

Completed by: _____ **Witnessed by:** _____

Room Placement & Observation:

- ☐ Room near nurses' station (if possible)
- ☐ Sign posted on door for all visitors to check with Nurse prior to entering
- ☐ Door to room remains open

Room Checklist:

- ☐ Curtains removed
- ☐ IV pole removed unless medically necessary
- ☐ Gloves removed
- ☐ Hand sanitizer and soap removed
- ☐ Disinfectant wipes removed
- ☐ Phones removed
- ☐ Trash cans removed
- ☐ No extra or unused furniture in room (i.e. high/low table, extra chairs, bedside cabinet and drawer)
- ☐ Paper towels removed
- ☐ Over-bed light cord secured and shortest length possible
- ☐ No glass items
- ☐ No metal utensils
- ☐ No razors, nail clippers, or tweezers
- ☐ No phone chargers or electrical cords accessible
- ☐ No belts, strings, ribbons, or drawstrings
- ☐ No lanyards or ID badge cords

Bathroom:

- ☐ Shower curtain removed / breakaway
- ☐ Toilet paper limited/controlled
- ☐ No plastic bags in room
- ☐ Toiletries limited to safe, supervised items (cart outside of room?)
- ☐ No aerosol cans

Medical/Rehab Equipment:

- ☐ Oxygen tubing minimized to necessary length
- ☐ IV lines secured and not excessively long
- ☐ Monitor cables organized and out of reach when not in use
- ☐ Emergency equipment not within reach
- ☐ No needles, syringes, or sharps left in room

Patient Clothing and Personal Belongings:

- ☐ No drawstrings in pants/hoodies
- ☐ No belts
- ☐ No scarves
- ☐ Shoes assessed (no long laces — remove/replace if needed)
- ☐ No underwire bras (if applicable and per policy)
- ☐ Backpack/purse searched and secured
- ☐ Electronics reviewed (no charging cords left)
- ☐ Jewelry removed if poses risk (chains, long necklaces)

☐ Belongings confiscated logged & secured in locked location

☐ Room rechecked this shift

Please list all items confiscated and placed in locked location listed below:

Location of Items Confiscated_____

1.	**13.**
2.	**14.**
3.	**15.**
4.	**16.**
5.	**17.**
6.	**18.**
7.	**19.**
8.	**20.**
9.	**21.**
10.	**22.**
11.	**23.**
12.	**24.**

Sign and Print: _____ Date/Time:_____

Witness Sign and Print:_____ _____ Date/Time: _____

Patient Label

DATE:

Suicide Precaution Observation Checklist

Use NUMBER(S) that best describe observed behavior Q15 minutes

1 = Calm/relaxed
2 = Quiet/awake, minimal movement
3 = Sleeping
4 = Talking appropriately with staff/visitor
5 = Watching TV/reading/resting in bed
6 = Eating/drinking
7 = Tearful/crying
8 = Anxious/worried
9 = Restless/fidgeting
10 = Pacing
11 = Withdrawn/avoiding interaction
12 = Irritable
15 = Confused/disoriented
13 = Agitated
14 = Yelling/verbally escalated
16 = Pulling at lines/tubes
17 = Tampering with equipment/room items
18 = Covering head/face or hiding hands
19 = Attempting to get out of bed/chair
20 = Self-harm talk
21 = Talking about death/dying
22 = Hopeless or "burden" statements
23 = Refusing redirection
24 = Requires frequent redirection
25 = Visitor present/support interaction

Code/Initials	Code/Initials	Code/Initials	Code/Initials	Code/Initials	Code/Initials
0700	1100	1500	1900	2300	0300
0715	1115	1515	1915	2315	0315
0730	1130	1530	1930	2330	0330
0745	1145	1545	1945	2345	0345
0800	1200	1600	2000	0000	0400
0815	1215	1615	2015	0015	0415
0830	1230	1630	2030	0030	0430
0845	1245	1645	2045	0045	0445
0900	1300	1700	2100	0100	0500
0915	1315	1715	2115	0115	0515
0930	1330	1730	2130	0130	0530
0945	1345	1745	2145	0145	0545
1000	1400	1800	2200	0200	0600
1015	1415	1815	2215	0215	0615
1030	1430	1830	2230	0230	0630

1045	1445	1845	2245	0245	0645

Initials	Sign AND Print

Weisman Children's

92 Brick Rd Marlton, NJ 08053

Main Phone (856) 489-4520
Administration Fax (856) 489-1169
Business Office Fax (856) 489-4541

Dear Patient and Family,

You are receiving this letter as a part of our patient safety notification due to your child exhibiting behaviors or comments that indicate suicidal ideation (SI). Patient safety is paramount in identifying and treating the patient at risk for suicide.

Weisman Children's Rehabilitation Hospital would like you to be aware of what to expect if you have been made aware that your child is at risk for suicide.

Any patient who exhibits signs of suicidal ideation to any staff member or family member at any point in their hospital stay will immediately be placed on suicide precautions.

Suicide precautions include:

- The patient's room will be made safe and any item deemed harmful will be removed.
- The patient will be placed in hospital-provided attire.
- All therapies will take place in the patient's room.
- A one-to-one observer will accompany the patient at all times
- Only parents and or guardians will be permitted to visit while the patient is on suicidal precautions.
- Visitors are to keep all personal belongings in their vehicle.
- If you would like to bring something in for the patient, it must be checked by the Nursing department prior to you taking it into the patient's room.
- Further assessment will be completed by a Weisman Physician and or Psychologist/Psychiatrist
- If your child's status remains unchanged after 24 hours, the next step is referral to the nearest crisis center for a more comprehensive evaluation to ensure their safety and the appropriate level of care.
- A Weisman physician will be in contact with the parent/ guardian to discuss the treatment plan going forward.

If you have any questions related to this process or need to discuss anything further, please contact the Social Work Department.

Sincerely,

Weisman Children's Rehabilitation Hospital