HACKETTSTOWN REGIONAL MEDICAL CENTER
ADMINISTRATIVE POLICIES
SUICIDAL/HOMICIDAL RISK ASSESSMENT AND PRECAUTIONS

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Effective Date: 9/4/2002	**Procedure No: PC14**
Cross Referenced: former policy 8620.202b	**Origin: Nursing**
Reviewed Date: 3/16/2005	**Authority: Chief Nursing Officer**
Revised Date: 11/14/2014	**Page: 1 of 7**

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SCOPE

All hospital staff members and Physicians

PURPOSE

To provide and outline of specific care guidelines for the risk assessment and management of patients with the potential to harm themselves or others.

DEFINITIONS

I. **Constant Observation** – Observation at all times with a one on one sitter at the bedside. The patient who requires a one to one observation has verbalized thoughts of suicide and a plan. The patient is not to be allowed to go into the bathroom unsupervised or close the door.

II. **Behavioral or Emotional Disorder:** Any DSM (psychiatric) diagnosis or condition, including those related to substance abuse.

III. **SAD PERSONS Scale:** A 10-point scale used to screen patients for risk of suicide based on presence of specific factors (see Page 6)

IV. **1:1 Continuous Observation Form:** A tool to record patients' behavior under a suicide order every 15 minutes by the sitter (see page 7)

POLICY

All patients presenting to the organization with potential or actual behavioral or emotional disorders will be assessed using the SAD PERSONS scale.

A provider order for Suicide Precautions is required when it is determined the patient is at risk to harm him/herself or others. A provider order for Suicide precautions will mean that a patient will be placed on constant observation with a 1:1 sitter at the bedside. The sitter must record patient behavior every 15 minutes until the order is lifted by the provider.

In an emergency, an RN may institute suicide precautions for a patient determined to be at risk of injury to self or others. A 1:1 sitter must be placed at the bedside and an order must be obtained from the provider.

A consult for social services must be provided within 24 hours of patient being medically cleared.

If applicable, follow AHC Restraint policy.

Hospital staff members that can use the SAD PERSONS scale include, but not limited to, Emergency Department nurses, social workers, psychiatric liaisons, continued care coordinators. Hospital staff must be trained and competent in use of SAD PERSONS scale.

Patient Safety Attendants (PSA) or Qualified sitters for suicidal observation must be HRMC staff members who have been educated on the responsibilities related to suicide precautions and constant observations.

Under the direction of the Registered Nurse, PSAs/Sitters are expected to perform the duties as described in their job description and as outlined on the Suicide Watch Observation form.

Family members may stay with the patient but cannot serve as the sitter.

The patient will be removed from suicide precautions by order of the provider.

Patients on suicide precautions not requiring intensive care monitoring may be placed on a nursing unit with constant observation unless suicide precautions were already removed by the provider prior to placement on the unit.

The order for suicide precautions must be renewed every 24 hours by the physician.

PROCEDURE

I. ORDER FOR SUICIDE PRECAUTIONS:

A. Obtain written order from the physician for suicide precautions which will indicate constant observation with a 1:1 sitter.-
B. Notify Social Services Department.
   1. If the patient is under psychiatric care, the attending physician will contact the patient's psychiatrist. If the patient is not under the care of a psychiatrist, a request for a psychiatric consult/tele-psychiatry can be requested.
   2. If the patient refuses the psychiatric consult, determine necessity or need for involuntary certification. Document the patient's refusal in the medical record.

II. RISK ASSESSMENT FOR SUICIDE PRECAUTIONS:

A. All patients presenting to the organization with potential or actual behavioral or emotional disorders will be assessed for suicide risk during the initial assessment.
   1. ED completes assessment and uses the SAD PERSONS scale.
   2. Inpatient units refer to Social Services to complete the SAD PERSONS scale, if questions on Initial Data Base trigger the SAD PERSONS scale.
B. Patients presenting to the organization and not immediately capable of participating in the SAD PERSONS scale will be assessed for suicide risk as soon as possible based on their medical condition.
C. If at any time during the course of inpatient treatment a patient expresses suicide intent or a significant behavioral health complaint, a referral will be made to the social

worker/psychiatric liaison for a SAD PERSONS assessment.

D. The plan of care and interventions of will be based on the outcome of the SAD person assessment.
E. The screener will document the result of SAD PERSONS scale and the corresponding guidelines will be considered during the development of the Plan of Care.
F. The need for suicide precaution is to be reviewed by the attending physician or his/her designee on a daily basis. The attending physician or psychiatrist may discontinue suicide precautions or change a suicide precaution to a lesser degree of observation after an evaluation of the patient.
G. Suicide precautions must not be in place at the time of discharge unless the patient is being transferred to another care facility.

III. OBSERVATION FOR A PATIENT ON SUICIDE PRECAUTIONS:

A. Initiate patient observation as per the provider's physician's order.
B. The Primary care nurse or charge nurse will assign a staff member to stay with the patient and review PSA/sitter responsibilities with assigned staff member, including the recording of behavior on the 1:1 Continuous Observation Form.
C. The primary care nurse will be responsible for visually checks on the patient every hour and documenting those checks on the 1:1 Continuous Observation Form by placing their initials next to the sitter on the hour.

IV. INFORMED CONSENT FOR A PATIENT ON SUICIDE PRECAUTIONS:

A. Inform the patient of the procedures to be followed.
B. Discuss procedure with the family/significant other.
C. Notify Nutritional Care that patient needs Plastic Utensils.
D. Inform the patient of the need to search for potentially harmful objects. Remove belongings from room, which includes personal clothing

V. SUICIDE PRECAUTIONS/SAFE ENVIRONMENT:

A. Examine the patient, patient's belongings and assigned room for potential harmful objects. Remove from the patient and document in the nurse's notes (e.g. scissors, razors, matches, belt).
B. Give objects to family or next-of-kin to take home and document in the nurse's notes those objects given to the family member/significant other. If no family available, lock up in HRMC safe, use HRMC belonging envelope.
C. Remove sharp objects, cords and the telephone from the room.
D. Inform patient's visitors that potentially harmful items are not to be given to the patient, but are to be examined first by the RN to determine they are safe.
E. Assure the presence of a locked window.
F. Notify Nutritional Care that patient needs plastic utensils.

G. Patients are never to be out of continuous visual observation. The door to the patient's room must be left open at all times. They are not allowed to go the bathroom unsupervised or close the door, or curtain around commode.
H. PSA/sitter must maintain continuous visualization of the patient and cannot read text or leave until coverage/relief arrives. The PSA/sitter should not be further than the doorway.
I. Staff members should not wear jewelry such as dangling earrings or a necktie that the patient may pull. The staff members ID badge must be breakaway.

VI. DISCONTINUTATION OF SUICIDE PRECAUTIONS:

A. The physician will write the order to discontinue suicide precaution when the patient is no longer at risk.

VII. ONGOING ASSESSMENTS FOR SUICIDE PRECAUTIONS:

A. When the patient continues to need psychiatric support and is medically stable, facility for transfer will be determined.
B. If patient refuses to be transferred, determine if involuntary certification is necessary. Contact Warren County Crisis Intervention for all involuntary screening assessments.
C. The Registered Nurse will continue to assess the patient hourly, for risk factors after precautions are discontinued, for the next 24 hours.

VIII. DOCUMENTATION FOR SUICIDE PRECAUTIONS:

A. The ED nurse will record SAD PERSONS assessment scale in the EHR.
B. The inpatient nurse will record initial behaviors on admission data base.
C. Social worker/Care coordinator will record the SAD PERSONS assessment scale on the paper tool and place in the paper chart.
D. Ongoing observations of the patient behavior is recorded on 1:1 Continuous Observation form and as appropriate in the nursing physical assessment band of the electronic record.
E. Document the initiation of suicide watch and upon termination of suicide precautions, document the discontinuation and patient's behavior at the time of discontinuation.
F. Continuous monitoring will capture patient's behavior every 15 minutes by recording finding on the 1:1 Continuous Observation form.
G. Complete the 1:1 Continuous Observation form while patient is on suicide precautions, noted each change by sitter and primary care nurse.
H. Complete transfer form if necessary and EMTALA form per policy.

SPECIAL CONSIDERATIONS

I. Any patient who does not communicate adequately in the English language will be assessed through use of Language Line.

II. Patients who present with alcohol intoxication and/or drug overdose/abuse will be monitored until sober. At that time, they will be reassessed for suicidal ideation and refer to either the Counseling and Addiction Center or Social Services based on patient needs.

REFERENCES:

Robie, D., Edgemon-Hill, E., Phelps, B., et. Al. Suicide Prevention Protocol. American Journal of Nursing. Vol. 99 (12), December 1999. p. 53, 55, 57.

Mitchell, A.J. And Dennis, M. Self-harm and attempted Suicide in Adults; 10 Practical Questions and Answers for Emergency Department Staff. Emergency Medicine Journal. Online:emj.bmj.com. 2006; 23; p.251-255.

Patterson, W., Dohn, H. Bird, j, et.al. Evaluation of suicidal patients: The SAD PERSONS score. Psychomatics. 1983; 24; 343-5.

Miller BP and Giordano R. "Creating a Suicide Risk Assessment Tool for Use in the Emergency Department." Abstract NR391, presented May 2007 APA Annual meeting.

ATTACHMENTS
SAD PERSONS Assessment Tool

SAD PERSONS SCALE

SAD PERSONS Scale

Patient at suicide risk because:

☐ S = Sex (male)

☐ A = Age (<19 years or > 45 years)

☐ D = Depression: decreased concentration, appetite, sleep or libido

☐ P = Previous suicide attempt or psych. care

☐ E = Excessive alcohol or drug use

☐ R = Rational thinking loss; organic brain syndrome or psychosis

☐ S = Separated, divorced or widowed

☐ O = Organized plan or serious attempt or stated future attempt

☐ N = No social supports, close family, friend, job or active religious affiliation

☐ S = Sickness (chronic debilitating disease)

Intervention Key:

Interventions:
One point for each of the 10 criteria
☐ 0-2 points = low risk
☐ 3-4 points = mild risk
☐ 5-6 points = moderate risk
☐ 7-10 points = high risk

Risk	Intervention
Low Risk:	Patient will continue to be assessed by screening staff while on inpatient unit.
Mild Risk:	Patient will continue to be assessed by screening staff while on inpatient unit. Outpatient referrals for psychiatric treatment/substance abuse will be given upon discharge.
Moderate Risk:	Patient will continue to be assessed by screening staff while on inpatient unit. Consultation with a psychiatrist may be arranged if necessary for treatment, intervention and disposition.
High Risk	Patient will continue to be assessed by screening staff while on inpatient unit. Consultation with a psychiatrist and/or Warren County Crisis Service will be arranged for treatment, intervention and disposition. Consider 1:1 monitoring.

Guidelines for Action According to the Scale

Total Points	Proposed Clinical Action
0 to 2	Send home with follow up.
3 to 4	Close follow up; consider psychiatric hospitalization or intensive outpatient treatment.
5 to 6	Strongly consider psychiatric hospitalization, depending on confidence in the follow-up arrangement.
7 to 10	Voluntary or involuntary psychiatric hospitalization.

Approved at November 10, 2014 President's Council Meeting
month / year Committee Name

1:1 Continuous Observation Form

Date: ____________________

Please record patient observations every 15 minutes by Sitter

Patient Code Key:	1-Agitated 2-Asleep 3-Calm 4-Combative 5-Confused 6-Cooperative 7-Eating 8-Pacing 9-Visitor **Note: Write-in all codes that apply to patient at the given time.**

Time:	Code:	Initials	Time:	Code:	Initials	Time:	Code:	Initials	Time:	Code:	Initials
0:00			6:00			12:00			18:00		
0:15			6:15			12:15			18:15		
0:30			6:30			12:30			18:30		
0:45			6:45			12:45			18:45		
1:00			7:00			13:00			19:00		
1:15			7:15			13:15			19:15		
1:30			7:30			13:30			19:30		
1:45			7:45			13:45			19:45		
2:00			8:00			14:00			20:00		
2:15			8:15			14:15			20:15		
2:30			8:30			14:30			20:30		
2:45			8:45			14:45			20:45		
3:00			9:00			15:00			21:00		
3:15			9:15			15:15			21:15		
3:30			9:30			15:30			21:30		
3:45			9:45			15:45			21:45		
4:00			10:00			16:00			22:00		
4:15			10:15			16:15			22:15		
4:30			10:30			16:30			22:30		
4:45			10:45			16:45			22:45		
5:00			11:00			17:00			23:00		
5:15			11:15			17:15			23:15		
5:30			11:30			17:30			23:30		
5:45			11:45			17:45			23:45		

Sitter Responsibilities

- Introduce themselves to the patient and let him/her know they are there for a specific time.
- When talking to the patient, maintain a calm manner, avoid talking about his/her personal life and will not give advice.
- The patient will remain in their view at all times. This includes toileting of the patient in the bathroom. If a physician asks sitter to leave the room during an examination, they will wait outside the door and return immediately to the patient when the physician leaves.
- Refer questions regarding the patient's condition to the RN.
- Be alert to changes or potential changes in behavior or condition and reports changes to the RN.
- Never leave for breaks or meals until relieved by a designated replacement or the RN.
- The sitter will maintain a safe environment. If any sharp or potentially dangerous objects are found, remove them and notify the nurse.

RN Responsibilities

- Review the need for constant observation and inform sitter of any special precautions to be taken.
- Will introduce the sitter to the patient and orient the sitter to room and equipment if needed(i.e. Bed functions).
- Determine time and coverage for the sitter's breaks and meals.
- Review patient's plan of care and let the sitter know if they will be participating in any of the activities (based upon job role of sitter).
- Perform an environmental check for safety and review safe environment with sitter according to policies and procedures.
- Verify the sitter knows how to call for help or assistance.
- Check on the sitter hourly to share information and note changes observed by the sitter by initialing in the time box that it is done.

Initials	Print Name	Title	Initials	Print Name	Title

Patient Label	Hackettstown Regional Medical Center Sitter 1:1 Observation Form 22023 (3/2015)	* H 0 0 2 2 0 2 3 *

Approved at November 10, 2014 President's Council Meeting
month / year Committee Name