

## CONNECTICUT VALLEY HOSPITAL OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 2:</b>	Assessment
<b>PROCEDURE 2.8:</b>	<b>Evaluating and Managing Suicide Risk</b>
<b>REVISED:</b>	09/27/07; 08/30/12; 3/14/16; Reviewed 02/18
<b>Governing Body Approval:</b>	10/04/12; 3/31/16; 04/18

**PURPOSE:** To describe the process for assessing patient's risk of suicide and providing immediate safety interventions when a patient presents or has a change in his/her risk of suicide. To describe the process for integrating identified suicide risk issues through a Focused Treatment Plan Review (FTPR) of the Integrated Treatment Plan.

**SCOPE:** All clinical staff

### **POLICY:**

In order to ensure the safety and well being of patients entrusted to the care of Connecticut Valley Hospital, (CVH) the hospital has instituted processes to initiate emergency safety precautions in the event that a patient is at risk of suicide. The process *begins on admission* and is initiated when the patient indicates or staff becomes aware that a patient may be a risk for suicide. In this event, the Registered Nurse will initiate a Suicide Risk Assessment, institute immediate safety measures, and contacts the Attending or On-Call Physician whenever there is evidence of patient suicidality throughout the course of hospitalization.

### ***Definitions:***

*Suicide Risk Assessment* - The assessment of a patient who expresses suicidal ideation or presents evidence to suggest suicidal potential. The assessment occurs at admission or any time during hospitalization.

### **PROCEDURE:**

1. At the time of admission the physician will complete a suicide risk assessment as a part of the Admission Psychiatric Assessment. Based on their findings of suicide ideation or intent, the physician may order certain immediate safety measures including levels of supervision in order to keep the patient safe. (See [Operational Procedure 2.11 Special Observation](#)).
2. Whenever a patient expresses or demonstrates evidence suggesting suicide risk, the Registered Nurse (RN) will institute safety measures which include placing the patient on continuous observation or one-to-one observation if indicated. The nurse also considers the need for room alterations and/or environmental controls. Patient specific safety requirements will be ordered by the Physician including review of permitted personal and electronic items.
3. The RN will engage the patient in a discussion regarding their feeling state, including psychological pain, suicidal intent, plans and behavior through the course of completing the Suicide Risk Assessment Form ([CVH-632](#)). After completing the RN section of the assessment the RN notifies the Attending Psychiatrist/On-Call Physician regarding positive indications of suicide risk. (Refer to the [HIM Policy 2.21 Suicide Risk Assessment](#)).

4. Based on the assessment, the RN documents immediate actions taken to ensure the patient's safety noting the date, time and name of the physician contacted.
5. The RN also notifies the Nursing Supervisor of the patient's change in condition, suicide risk status and actions taken.
6. The Nursing staff member assigned to supervise the patient will be provided necessary information about the patient's safety needs, risks, triggers and de-escalation strategies to assist in the patient's care.
7. The Attending Psychiatrist or On-Call Physician evaluates the degree of suicide risk to determine the type and frequency of supervision the patient requires, room alterations, any environmental controls, permitted personal/electronic items and other prescribed treatments.
  - a. At the time suicide risk is identified the physician on duty and the charge RN will, collaboratively, fully assess the issue and discuss a revised plan of care; this will be documented in detail by both the physician and RN in the Integrated Progress Notes, including any follow-up issues to be addressed. A very detailed immediate plan of care along with any follow-up issues that need to be addressed. Any required orders corresponding to the revised plan of care will be written by the physician on a Physician Order Sheet. The treatment changes will be communicated to all unit staff through the inter-shift report process.
8. The treatment team will convene on the next business day, to do a FTPR, which includes a review of the suicide risk looking at predisposing, precipitating, and perpetuating factors, any changes in the treatment plan in response to the risk, or the rationale for not making changes. The individual in recovery is included in the process unless he/she is unable or unwilling to participate. If the individual does not participate, the treatment plan revisions should be reviewed with the individual, by the treatment team, at the earliest possible opportunity.
9. The FTPR is documented in the Recovery Management System (RMS), printed, signed and filed in the Treatment Plan section of the medical record that day. Any modifications to the plan are communicated to the staff through inter-shift report, the extracted Nursing Plan of Care and are incorporated in the patient care assignment process. (See related [Nursing Policy & Procedure 7.3 Nursing Care Assignments](#)).