Team Name: Critical Care and Medicine Team Team Lead: Regional Director – Acute Care Approved by: Executive Director – Acute & Chief Nursing Officer	Reference Number: CLI.4510.PL.010 Program Area: Across Hospital Units Policy Section: General
Issue Date: June 29, 2020 Review Date: Revision Date:	Subject: Suicide Prevention in Acute Care

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POLICY SUBJECT:
Suicide Prevention in Acute Care

PURPOSE:
To establish and maintain a process for suicide prevention across hospital units.

BOARD POLICY REFERENCE:
Executive Limitation (EL-01) Global Executive Restraint and Risk Management
Executive Limitation (EL-02) Treatment of Clients

POLICY:
Suicide prevention enhances safety and promotes quality of life for at-risk patients through timely screening, risk assessments, care planning, and the provision of appropriate interventions.

DEFINITIONS:
Constant care: Constant, continuous one-on-one supervision.

Close observation for suicide prevention: visual confirmation by a staff member to occur at **irregular i**ntervals not to exceed 15 minutes between checks, consisting of six (6) or more observations per hour.

Mental Competence: in the absence of evidence to the contrary, it shall be presumed
- That a person who is 16 years of age or more is mentally competent to make treatment decisions and to consent; and
- That a person who is under the age of 16 is not mentally competent to make treatment decisions or to consent.
- Determining mental competence to make treatment decisions, consider:

a. Whether the patient understands
    i. Conditions for which the treatment is proposed,
    ii. The nature and purpose of the treatment,
    iii. The risks and benefits involved in undergoing treatment, and
    iv. The risks and benefits involved in not undergoing treatment; and
b. Whether the patient's mental condition affects his/her ability to appreciate the consequences of making a treatment decision.

Mental Disorder: a substantial disorder of thinking, mood, perception, orientation or memory that grossly impair judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life. This excludes mental disability related to vulnerable persons and often excludes persons diagnosed with Fetal Alcohol Syndrome, substance abuse, Alzheimer's disease, or personality disorders (Mental Health Act).

Mental Illness: mental disorders that include major depressive disorder, any mood disorder, psychotic disorders, and substance use.

Pass/Leave of Absence: Any period of time in which a patient is authorized to be absent from the hospital.

- **Accompanied Pass:** A pass in which the patient is supervised by specified individual while away from the facility
- **Unaccompanied Pass:** A pass in which the patient is able to leave the facility without supervision.
- Passes from hospitals may be granted for very short periods of time (e.g. 1-2 hours) or longer but not to exceed 48 hours.

Protective Factors: aspects of a person's life that provide reward, meaning, a sense of purpose and/or a sense of connection with others. These protective factors are associated with a decreased risk of suicidal ideation and behaviour, and can be strengthened to decrease the risk of suicide.

Risk Factors: dynamic (modifiable) or static (unmodifiable) characteristics associated with an increased likelihood of suicide. Modifiable risk factors can inform strategies to decrease the risk of suicide.

Warning signs: observable signs or expressed symptoms indicative of an increased imminent risk of suicide, which may occur in the absence of potentiating risk factors.

Prescriber: a professional whose scope of practice includes prescribing privileges (e.g. medical doctor, nurse practitioner, physician assistant).

Restrain: to place under control when necessary to prevent harm to the patient or to another person by minimal use of force, mechanical means or medication as is reasonable having regard for the patient's physical and mental condition (Mental Health Act).

Restraint: any manual, physical, or mechanical device or material; or pharmaceutical agent, which restricts voluntary movement.

Seclusion: a form of restraint that involves confining a patient in a full protective environment for the purpose of safety or behavioural management.

Self-Injurious Behaviours: Self-inflicted actions with a nonfatal outcome, with an intent to harm self but not necessarily with an intent to die. When the intent of these behaviours is to die, these actions are referred to as suicidal behaviours. However, based on the degree of inflicted self-harm, self-injurious behaviours may result in death.

Suicide: Self-inflicted death with the evidence (either explicit or implicit) that the person intended to die.

Suicidal Behaviours: Self-inflicted actions with a nonfatal outcome, accompanied by explicit or implicit evidence that the person intended to die.

Suicidal Ideation: thoughts that a person has regarding killing him/herself. These can range from being general non-specific thoughts of wanting to end one's life to well defined specific intent and plan.

Suicidal Intent: subjective expectation and desire for a self-destructive act to end life.

Suicide Attempt: a potentially self -injurious act carried out with the wish to die.

IMPORTANT POINTS TO CONSIDER:

If the patient is an involuntary mental health patient (MHP), formed under Mental Health Act (MHA), follow *Transfer of Custody of an Apprehended Involuntary Patient under the Mental Health Act from Law Enforcement/Peace Officer* (CLI.5110.PL.008) policy.

Suicide prevention involves assessment; interventions and monitoring; and documentation and communication of the suicidal risk and safe plan.

Assessment of risk of suicide in the emergency department (ED) is a time sensitive process that involves evaluating the degree of risk of self-harm, mitigating acute risks, and determining appropriate level of care for the person.

"No-suicide contracts" do not guarantee a person's safety and are **NOT** indicated for use in acute care.

Suicide risk assessment tools are only one aspect of the risk assessment process and do not replace clinical judgement. These tools only provide information about the severity or complexity of a person's level of distress.

A patient's mental status can be an indicator of the need for suicide screening and risk assessment. Assessing a person's mental status includes noting their appearance, behavior, speech, perception, mood, affect, intellectual functioning, insight, judgment, memory, thought content, and thought processes. Hanging, cutting and strangulation were the most common method of suicides and suicide attempts within EDs. The most common anchor point for hanging was doors and the most common implement for cutting was a razor blade.

The period following discharge from a psychiatric hospital pose an extraordinarily high risk of suicide, especially during the first week.

Granting passes (leaves of absence) for hospital inpatients assessed as at risk for suicide:

- Passes are therapeutic treatment decisions that should maximize benefits, minimize risk and facilitate therapeutic movement towards discharge of the patient to the community by:
  - Progressively increasing independence, confidence, and enabling the practice of positive coping skills and strategies, and positive healthy lifestyle choices within the community;
  - Providing the opportunity to evaluate patient progress towards reintegration back into the community by identifying challenges, concerns, and anxiety producing situations encountered. This information is used to inform a safe discharge plan.
- Developing a safe plan with the patient and significant support(s) prior to granting a pass is required. However, the extent to which the patient and/or significant support(s) comply with the safe plan is expected to be neither perfect nor within the control of facility staff.
- In collaboration with the patient and significant support person(s), the treatment team weighs the risks and benefits of proceeding with passes/leaves when less than optimal understanding or co-operation exists.

PROCEDURE:

1. **Suicide Screening:**
   1.1. Screen all patients who presented to the emergency department (ED) or are directly admitted to inpatient units with PRIMARY or SECONDARY issues related to (a) **substance use**; (b) **mental health and psychosocial issues** (e.g. depression / suicidal / deliberate self-harm; hallucinations; bizarre behavior); and/or (c) **mental status.**
      - Cues for issues related to mental status are located on page 2 of the *Suicide Screening, Risk Assessment and Care Planning* (CLI.4510.PL.010.FORM.01) form.
      - Further screen each patient who presents or admitted with one or more of the issues identified above by asking:
        - Over the past 2 weeks, have you felt down, depressed or hopeless?
        - Over the past 2 weeks, have you thought of killing yourself?
        - Have you attempted to kill yourself during the last 6 months?
      - Identify if suicide risk assessment is indicated.

   1.2. Screen for violence as per *Violence Prevention Program in Acute Care* (CLI.4510.PL.004) policy.
2. **Risk Assessment:**
   2.1. If a mental health practitioner (e.g. Mental Health Liaison Nurse; Crisis Response Team member) is available to complete a comprehensive suicide prevention assessment,

immediately inform them; indicate date, time, and to whom the request was made to on the *Suicide Screening, Risk Assessment and Care Planning* form.

- Mental Health Practitioner: complete *Suicide Screening, Risk Assessment and Care Planning* form; communicate and document findings/safe plan.

2.2. If a mental health practitioner is not available, use the *Suicide Screening, Risk Assessment and Care Planning* form and assess the risk of suicide.

- Sample questions are provided in *Suicide Prevention, Sample Interview Questions* (CLI.4510.PL.010.SD.01)
- Identify warning signs and risk factors of suicide.
  - Any/all warning signs and risk factors can increase the risk of suicide. If any are present, explore/obtain details about their suicide plan, actual level of intent, and the severity of their suicidal ideations.
    - See *Suicide Prevention, Sample Interview Questions* for possible interpretations of suicide risk associated with warning signs and risk factors.
    - Use the depression-screening tool on page 2 of the *Suicide Screening, Risk Assessment and Care Planning* form to screen for depression if indicated.
- Identify protective factors, which may lower the level of risk of suicide.

2.3. Use the data gathered from the screening criteria and clinical judgement to determine **level of suicide risk** present at time of assessment.

- Key warning signs of a current high/very high risk of suicide are persistent suicidal ideation, a well-defined suicide plan, and the intent is to die.
- In the absence of persistent suicidal ideation, a suicide plan, and the intent to die, the presence of the other warning signs and risk factors can also increase the risk of suicide and are to be considered within the context of the patient's presentation.
- Consider the influence that protective factors may have in mitigating the risk of suicide.
  - Using clinical judgment, the prescriber or mental health practitioner Select **level of suicide risk** as either none; low; moderate; or high/very high.

3. Care Planning – Monitoring, Interventions, and Reassessments:

3.1. Use an interprofessional team approach (if possible) to develop a personalized safe care plan with the patient/significant support(s) to mitigate suicidal risk factors that identifies interventions and monitoring needs.

- Identify, select and implement appropriate interventions based on the level of suicide risk, patient-specific risk profile, and clinical judgment (see items # 3.2., 3.3., and 3.4. below for recommendations).
- Establish frequency of monitoring based on level of supervision identified as appropriate based on level of risk.
- Reassess risk for suicide at regular intervals based on level of suicide risk, interventions implemented, and clinical judgment.

3.2. Recommended interventions for patients screened **very high/high level** of suicidal risk:

- Initiate contraband protocol as defined by the following actions:
  - Remove any items which may be used to harm self and/or others, including wall hooks (for examples, see *Contraband List of Potentially Harmful Items*, on page 2 of the *Suicide Screening, Risk Assessment and Care Planning*; or on the *Review of Contraband Items: Sign-in for Visitors* CLI.4510.PL.010.FORM.02).

- Ensure privacy and have patient disrobe and don hospital gown (without ties/belts).
  - Use anti-piercing gloves and forceps to search clothing and other personal belongings for contraband items.
  - If patient refuses to disrobe, and when safe and with the patient's consent, search clothing.
  - If patient refuses to disrobe and to have their clothing/personal belongings searched, contact police and/or security.
    - Security personnel (if available) search patient belongings for contraband items.
- After a search, place all personal belongings and clothing in a garment bag labelled with patient's name; remove from room and place in a secure location.
- Check the patient's hair, behind the ears, nostrils, mouth (including under the tongue), and other body areas for possible harmful items/substances. For example:
  - For patients with hair and if the patient is able, instruct patient to run his/her hands through their hair (to ensure that there is nothing hidden in the hair, such as a hairpin).
    - If patient is unable to search own hair and with the patient's permission, search hair using gloves and caution.
  - To ensure nothing is tucked behind the ears, ask patient to pull ears forward and turn their head;
  - Within the mouth, look beneath the tongue and between the lips and gums;
  - Other body areas with folds (e.g. axillae, under the breasts).
    - This **excludes** a body cavity search.
- If any personal item found may be an illicit substance, follow the *Handling of Suspected Illicit Substance* (CLI.6010.PL.024) policy.
- Review with and remove any contraband items from visitors (including family members and police).
  - To prevent violation of Personal Health Information Act (PHIA) and Freedom of Information and Protection of Privacy Act (FIPPA):
    - With each presenting visitor, obtain consent from the patient to disclose with the visitor the need to remove contraband items – this may lead to the visitor becoming informed of the reason for the visit/admission.
    - If the patient refuses to give consent to disclose, assess if the visitor's presence would be beneficial to the patient's well-being. If yes, consider discretionary disclosure as per the *Personal Health Information Disclosure Due to Risk of Serious Harm* (CLI.4110.PL.016) policy.
  - Document on *Review of Contraband Items: Sign-in for Visitors* document.

- Create a "care" environment by introducing comforting and therapeutic interventions (e.g. decrease noise; involvement of the same care providers).
- Initiate **constant** care.
  - Maintain this level of supervision for toileting, showering, and bathing.
- Involve significant others/supports.

- If patient refuses to have family/significant support(s) contacted, consider discretionary disclosure (see *Personal Health Information Disclosure Due to Risk of Serious Harm Reference*).
- Complete sign-in procedure (see above).

- Consider use of seclusion room if appropriate and available.
- Assess appropriateness of pharmaceutical therapies.
- Identify and treat underlying causes/conditions.
- Refer to mental health services for a STAT for an in-depth psychosocial assessment.
- Reassess responses to interventions at a minimum every hour.
- Based on reassessment(s) findings, update care plan.
- Develop with and communicate the initial plan of care and updates with patient, significant other(s)/support(s), and other team members.

3.3. Recommended interventions for patients screened at a **moderate level** of suicidal risk:

- Initiate contraband protocol (see above).
  - Remove wall hooks and other items within the environment that may pose a risk to the patient.
- Create a "care" environment (see above).
- Initiate close observation with visual confirmation by a staff member to occur at **irregular i**ntervals not to exceed 15 minutes between checks, consisting of six (6) or more observations per hour.
  - Use one-to-one supervision with an open-door for toileting, showering, and bathing.
- Involve significant other(s)/support(s) if available.
- Assess appropriateness of pharmaceutical therapies.
- Identify and treat underlying causes/conditions.
- Refer to mental health services for an in-depth psychosocial assessment **prior** to discharge.
- In addition to close observation monitoring, reassess responses to interventions at a minimum every hour (e.g. vital signs).
- Update care plan as needed.

3.4. Recommended interventions for patients screened as at a **low level** of suicidal risk:

- Routine hourly observations.
  - Using clinical judgment, consider the use of an open or closed door for toileting, showering, and bathing.
- Involve significant other(s)/support(s) if available.
- Assess appropriateness of pharmaceutical therapies.
- Identify and treat underlying causes/conditions.
- Refer to mental health services (in-depth assessment can occur post discharge).
- Refer to other community supports if indicated (e.g. Crisis Stabilization Unit; Home Care; religious organizations).
- Reassess as per routine ED/inpatient unit practices.

4. Reassess suicide risk based on responses to interventions and clinical judgment.

4.1. For patients admitted from the ED to an inpatient unit, reassess risk of suicide within 24 hours post admission and PRN.

5. Documentation and Communication:

5.1. Complete the *Suicide Screening, Risk Assessment and Care Planning* form.

- Based on the level of monitoring and reassessment required, select the most appropriate medium/form for documentation (e.g. Emergency Department Information System [EDIS] and/or the *Integrated Progress Notes* [IPN; CLI.4510.PR.002.FORM.01) or *Frequent Monitoring Record* CLI.4510.PR.002.FORM.02) and at minimum document:
  - Reason for risk assessment.
  - Summary of risk and protective factors
  - Findings from the assessment, including suicide inquiry related to thoughts, plans, and intent.
  - Safety interventions put in place (e.g. constant care; use of seclusion room).
  - Results from search for contraband items.
  - Monitoring /re-evaluation plans and outcomes.
  - Updates to the care plan.

5.2. Complete *Review of Contraband Items: Sign-in for Visitors* if applicable.

5.3. Communicate initial plan of care and all updates with patient, significant other(s) or support(s), and other team members.

5.4. Provide written and/or verbal reports at care transitions. That is: when transferring care from provider to provider at break relief, shift changes, or with changes in location during admission, transfer, or discharge (follow *Information Transfer at Care Transition - Acute Care* CLI.4510.PL.005 policy).

5.5. Follow *Occurrence Reporting and Managing Critical Incidents, Critical Occurrences, Occurrences and Near Misses* (ORG.1810.PL.001) policy for immediate and internal notifications of all suicide attempts.

6. Discharge planning for inpatients:

6.1. Consider progressive re-integration back into the community with use of passes/leaves from the hospital. A prescriber written order is required.

- This is a recommended strategy.
- Order medications required on the leave from pharmacy 24 hours in advance at regional centres and 48 hours in advance for non-regional centres (follow *Patient/Resident's Leave of Absence Medications* CLI.6010.PL.002 policy).

6.2. In collaboration with the patient and significant support person(s), develop a safe plan for when on a pass/leave. Include in the plan (but not limited to):

- Length of time for the pass/leave of absence;
- Supervised/unsupervised;
- Education related to the plan (e.g. risks of engaging in the use of illicit drugs or alcohol; only to take prescribed medications and how/when);
- When to return (date and time) but, for their safety, stress that the patient can return at any time prior to the designated return date and time.
- Schedule a debrief session with the patient and significant support(s) upon their return.
- Identify what went well and any challenges, concerns, and anxiety producing situations encountered.
- Repeat passes/leaves if indicated.

6.3. Use data from the passes/leaves to develop with the patient and significant support(s) a safe discharge plan.
- The plan must include scheduled follow-up with a mental health practitioner.
- Complete a medication discharge plan (use *Discharge Medication Plan* CLI.6010.PL.009.FORM.02)

7. Evaluation:

7.1. Using the *Suicide Prevention – Chart Audit* (CLI.4510.PL.010.FORM.03), annually complete 10 chart audits at regional centres and 5 at non-regional centres for patients who presented to the ED with a complaint of substance use and/or mental health and psychological issues as per Canadian Triage and Acuity Score (CTAS).

SUPPORTING DOCUMENTS:

CLI.4510.PL.010.FORM.01	Suicide Screening, Risk Assessment and Care Planning
CLI.4510.PL.010.FORM.02	Review of Contraband Items: Sign-in for Visitors
CLI.4510.PL.010.FORM.03	Suicide Prevention – Chart Audit
CLI.4510.PL.010.SD.01	Suicide Prevention, Sample Interview Questions

REFERENCES:

CLI.4510.PR.002.FORM.01 Integrated Progress Notes (IPN)
CLI.4510.PR.002.FORM.02 Frequent Monitoring Record (FMR)
CLI.6010.PL.009.FORM.02 Discharge Medication Plan
CLI.4510.PL.004 Violence Prevention Program in Acute Care
CLI.6010.PL.024 Handling of Suspected Illicit Substance
CLI.5110.PL.008 Transfer of Custody of an Apprehended Involuntary Patient under the Mental Health Act from Law Enforcement/Peace Officer
CLI.4110.PL.016 Personal Health Information Disclosure Due to Risk of Serious Harm
CLI.4510.PL.005 Information Transfer at Care Transition-Acute Care
ORG.1810.PL.001 Occurrence Reporting and Managing Critical Incidents, Critical Occurrences, Occurrences and Near Misses
CLI.6010.PL.002 Patient/Resident's Leave of Absence Medications

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