



CORRECTIONAL HEALTH SERVICES
Policy and Procedure J-G-05

SUICIDE PREVENTION PROGRAM

References: NCCHC Standard J-G-05 (Essential); MCSO policies CP-11 Safe Bed Intervention, DA-5 Inmate Suicide Prevention, DS-1 Safe Cell Placement, EA-17 Death Investigations.

Applicability: CHS Staff

Supersedes: J-E-02-01-SS-ITK-01 Safe Cell Procedure.

Last Review Date: 01/03/13

Revision Date: 06/07/13

Statement: CHS identifies suicidal patients and intervenes appropriately.

Procedure:

1. Identification of patients at risk occurs through *Receiving screening*, patient self-referral, CHS staff and Maricopa County Sheriff's Office (MCSO) referrals, and CHS Clinical and/or Legal Liaison from external referral sources (e.g., advocates, family members, attorneys).
2. **4th AVE PRE-INTAKE and INTAKE:**
 - a) Arresting officer provides information that patient has demonstrated suicidal behavior or verbally indicated suicidal ideation.
 - b) The *Receiving screening* process includes:
 - i. Questions related to potential suicide risk.
 - ii. Observations by Correctional Health Technician/Licensed Practical Nurse (LPN).
 - iii. Assessment by licensed nurse (LPN/Registered Nurse [RN]), if positive responses to potential suicide risk.
 - c) *Safe cell* placement in 4th Ave Intake is for patients newly booked into the 4th Ave Pre-Intake area or existing patients housed in 4th Ave Outpatient (OP) with urgent mental health problems:
 - i. 4th Ave Intake clinic licensed nurse is contacted by Pre-Intake licensed nurse, 4th Ave OP licensed nurse, or MCSO Detention staff to inquire about *safe cell* availability and *safe cell* placement. CHS staff indicates *potentially suicidal* or actively suicidal watch status and gives a report of relevant patient history.
 - ii. MHP (Mental Health Professional) staff can initiate and discontinue active/potential suicide watch status and consult with Providers, as needed.
 - iii. MHP or clinic licensed nurse may initiate *safe cell* placement:
 - MHP initiating *safe cell* placement writes order for *safe cell* and notifies Intake clinic licensed nurse to initiate *safe cell* checks.
 - If a licensed nurse initiates placement, order for *safe cell* from Medical Provider, Psychiatric Provider, or Psychologist is required within one hour.
 - iv. If patient does not arrive at *safe cell* within 30 minutes, Intake clinic licensed nurse contacts MCSO Intake Sergeant on Duty at 876-8036 or 876-8034 to inquire about patient transfer status. This includes patients from Pre-Intake and 4th Ave OP.
 - v. Intake clinic MHP is responsible for writing *safe cell* renewal order:
 - MHP writing renewal order notifies licensed nurse to continue *safe cell* checks.
 - If no MHP, Medical Provider, Psychiatric Provider, or Psychologist is on-site, the licensed nurse contacts the on-call Psychiatric Provider or Psychologist for renewal order.

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- Licensed nurse obtains full set of vital signs prior to obtaining renewal order.
- *Safe cell* order must be renewed at least every six hours, but can be renewed at any time for a time period not to exceed six hours.
- vi. At time of patient's placement in *safe cell*, the Intake clinic licensed nurse:
 - Completes a brief assessment of patient's general condition and documents findings on a Progress Note.
 - Reviews Intake *Receiving Screening* form for any significant medical or psychiatric findings and obtains any further orders, if needed.
 - Assigns a *Safe Cell Monitor Observer*, if patient is actively suicidal:
 - Any CHS staff can function as Observer.
 - Observer must keep patient under constant monitor observation until patient is removed from active suicide watch or is transferred to the Mental Health Housing Unit (MHU).
 - Observer documents in 15 minute intervals on the Suicide Watch Log.
 - Observer notifies *Mental Health (MH) staff* or Intake clinic licensed nurse immediately, if assaultive, self-injurious, or destructive behavior is observed.
 - Initiates Suicide Watch/Safe Cell/Restraint Flow Sheet.
- vii. Licensed nurse:
 - Conducts direct observation welfare checks on the patient hourly, on the half hour.
 - Documents responses of welfare checks on Suicide Watch/Safe Cell/Restraint Flow Sheet.
 - Offers fluids on the hourly checks and documents on the Suicide Watch/Safe Cell/Restraint Flow Sheet.
- viii. Removal from *safe cell* requires an order:
 - MHP writing removal order notifies licensed nurse.
 - If no MHP, Psychiatric Provider, or Psychologist is on-site, the licensed nurse contacts the on-call Psychiatric Provider or Psychologist, or on-site Medical Provider for removal order and notifies *MH staff*, if on-site, before patient is removed from *safe cell*.
 - Licensed nurse obtains full set of vital signs at time of patient's removal from *safe cell*.
 - Licensed nurse completes brief assessment of patient's general condition and documents findings on Progress Note.

3. GENERAL POPULATION (GP), INFIRMARY, MENTAL HEALTH HOUSING UNIT (MHU):

- a) CHS staff observing patient with suicidal behavior or verbalizing intent to harm self, immediately notifies Detention to ensure patient is not left alone until evaluation for suicide risk category is completed by *MH staff*.
- b) CHS Clinical and/or Legal Liaison staff receiving notification of patient suicidal concerns from outside sources, ensures the appropriate clinic staff is notified of patient's suicidal ideation. Clinical staff assesses patient and if patient is at risk for suicidal behavior, immediately notifies Detention to ensure patient is not left alone until evaluation for suicide risk category is completed by *MH staff*.
- c) Referral to clinical staff by Detention: Urgent concerns are communicated verbally (face-to-face, phone, or radio). Less urgent concerns are communicated via written Referral of Psychiatric Services (form #2600-039 2/5/09).

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4. EVALUATION:

- a) *MH staff* evaluates patients who demonstrate suicidal behavior verbally, in writing, or by gesture, as soon as possible, by completing a comprehensive suicide risk assessment to assist in determining suicide risk category.
- b) *MH staff* coordinates with nursing staff to contact the Psychiatric Provider within 1 hour after patient safety is ensured.
- c) If *MH staff* is not available, licensed nurse follows applicable Nursing Assessment Protocol.
- d) Psychiatric Provider:
 - i. Assesses the patient's risk level based on observed or reported subjective and objective criteria.
 - ii. Determines whether emergency medication and/or clinically-ordered restraints are warranted to ensure the patient's safety.
 - iii. Determines appropriate housing location.
 - iv. If indicated, initiates orders for risk category, watch status, intervention, and transfer to appropriate housing area.
 - v. After orders obtained, CHS staff notifies Detention of watch status and associated housing requirements.

5. MONITORING: Risk categories (watch status) are used to ensure the safety of patients. CHS has two risk categories, Active or *Potentially Suicidal Watch*. The following is required for either risk category and differences between Actively or *Potentially Suicidal Watch* requirements are bolded:

- a) Licensed nurse assesses patient condition and documents patient's behavior upon initiation of suicide watch.
- b) **Patient can be provided with a safety blanket or smock (or can remain clothed for *Potentially Suicidal*), depending on Provider order.** Can be given a smock during transport to designated housing location. **Can have regular mattress and bedding for *Potentially Suicidal*, if ordered by Provider.**
- c) Meals are limited to paper sacks (no plastic bags), without utensils, unless otherwise ordered by Provider.
- d) **Monitoring is continuous for Actively Suicidal. Monitoring is at staggered intervals not to exceed every 15 minutes by Detention for *Potentially Suicidal*.** Closed circuit television can be used as part of monitoring at Intake and MHU provided that CHS licensed staff are onsite and immediately available to respond.
- e) Documentation of patient behavior and staff intervention is completed every 1 hour by licensed staff on the Suicide Watch/Safe Cell/Restraint Flow Sheet.
- f) Nursing/*MH staff* reassess patient every shift for change in patient condition and documents findings on Suicide Watch/Safe Cell/Restraint Flow Sheet.
- g) Significant changes in patient's status are documented on progress note and reported to Psychiatric Provider.
- h) Psychiatric Provider or Psychologist can change or discontinue Suicidal Watch status after evaluating the patient face-to-face or phone report from nursing or *MH staff*.
- i) Nursing/*MH staff* write progress note to document the assessment for patient safety and removal or change of watch status.
- j) Patients discharged from Suicide Watch are scheduled to be seen daily for three consecutive days by *MH staff* to ensure patient safety and to determine frequency of contact post-watch status and receive regularly-scheduled follow-up assessments by *MH staff* based on evaluation and *Treatment Plan* (form #2603-028 04-12), until released from custody.

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6. **TREATMENT:** *MH staff* develop *Treatment Plans* addressing suicidal ideation and behavior that include goals for immediate stabilization and ongoing follow-up to reduce self-harming behavior and suicidal ideation.
7. **HOUSING:** Suicidal patient can be temporarily housed in a *safe cell* to provide for safety while the assessment and evaluation is completed. When determined that patient is actively or *potentially suicidal*, patient is transferred to either MHU or *Infirmary*.
8. **COMMUNICATION:**
 - a) CHS communicates verbally with Detention regarding changes in patient's risk that require increased monitoring or transfer to another facility.
 - b) Detention communicates with CHS verbally (face-to-face, phone, or radio) regarding any observations of patient behavior perceived as high-risk.
9. **INTERVENTION:**
 - a) If patient engages in behaviors that are dangerous to self or others as a result of medical or mental illness while on Actively or *Potentially Suicidal Watch*, Psychiatric Provider can order the use of restraints.
 - b) Detention can be first responder to a suicide or suicide attempt:
 - i. If suicide attempt, Detention secures the scene, provides for patient safety, and initiates first aid measures.
 - ii. Detention notifies CHS staff via Mandown procedure.
 - iii. CHS staff enters scene after it has been secured by Detention. CHS clinical staff continues with Cardiopulmonary Resuscitation and first aid measures, if indicated.
 - iv. If life-threatening emergency, CHS advises Detention staff to activate emergency medical system.
 - v. When situation is stable, CHS staff obtains orders from Psychiatric Provider and advises Detention regarding monitoring and housing plans, as indicated.
10. **NOTIFICATION:**
 - a) CHS clinical staff contacts Nurse Supervisor for suicide attempts requiring Emergency Room run and enters information into the Clinic Event Log database accessed in <C:\Documents and Settings\All Users\Desktop\CHS Clinical Web.lnk>.
 - b) Detention notifies family members of event resulting in death, per MCSO policy.
11. **DOCUMENTATION:**
 - a) Progress notes using Subjective, Objective, Assessment, Plan and Education (SOAPE) format. If Mandown, document on applicable Emergency Response Order (ERO) form U:\Forms\MEDICAL RECORDS_Forms for Patient Charts\ERO Progress Notes or the Mandown form U:\Forms\MEDICAL RECORDS_Forms for Patient Charts_Print in Clinic_Health Record Forms\Man-down Response Note 11062012.pdf instead of the progress notes.
 - b) *MH staff* completes <U:\Forms\Psych Forms\SUICIDE ATTEMPT INFORMATION.doc> report that includes a statement of the method of the attempt; mental health status before and after the attempt, including suicidal intent; current medications; and psychiatric diagnosis for all suicide attempts that result in transfer to the hospital and submits it to CHS Mental Health Director to maintain.
 - c) Special Needs *Treatment Plans* (SNTP) are updated for patients who have engaged in suicidal behavior.
12. **DEBRIEFING and REVIEW:**
 - a) Nursing Supervisor, as soon as possible after event, assesses need for staff debriefing and coordinates debriefing, if indicated, and can refer staff to Employee Assistance Program, if indicated.

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- b) *MH staff* assesses needs for debriefing/ongoing support of cellmates or other affected patients.
- c) Quality Management coordinates Critical Incident Review with mental health, medical, and administrative staff for suicide or serious suicide attempt.

13. **TRAINING:** New Employee Orientation and Annual In-Service Training addresses:

- a) General information about suicide (updated annually).
- b) Signs and symptoms of predisposing factors of *potentially suicidal* patients.
- c) Risk factors in the evaluation of suicide potential.
- d) Management of suicidal patients.
- e) Review of institutional procedures regarding suicide prevention.

14. The *responsible health authority* approves the suicide prevention policy, training curriculum for staff, and intake screening process for suicide potential.

Definitions:

Infirmary is an area in the facility accommodating patients for a period of 24 hours or more, expressly set up and operated for the purpose of caring for patients who need skilled nursing care but do not need hospitalization or placement in a licensed nursing facility, and whose care cannot be managed safely in an outpatient setting. It is not the area itself but the scope of care provided that makes the bed an infirmary bed. (NCCHC)

Mental Health Staff include qualified health care professionals who have received instruction and supervision in identifying and interacting with individuals in need of mental health services. (NCCHC)

Mental Health Staff: Any member of the CHS Mental Health treatment team (Mental Health Associate [MHA], MHP, Psychologist). (CHS)

Potentially Suicidal inmates are not actively suicidal but express suicidal ideation and/or have a recent history of self-destructive behavior. (NCCHC)

Receiving Screening is a process of structured inquiry and observation of all inmates being admitted, designed to obtain immediate treatment for inmates who are in need of emergency health care, identify and meet ongoing current health needs, and isolate those with communicable diseases. (NCCHC)

Responsible Health Authority (RHA) is responsible for the facility's health care services, and arranges for all levels of health care and assures quality, accessible, and timely health services for inmates. The RHA may be a physician, health administrator, or agency. (NCCHC)

Safe Cell is a cell which has been specifically designed to provide the maximum level of safety and security for inmates who are currently exhibiting destructive or self-injurious behavior. These cells are completely padded and contain no fixtures. (MCSO)

Treatment Plan is a series of written statements specifying a patient's particular course of therapy and the roles of qualified health care professionals in carrying it out. (NCCHC)