DEPARTMENT OF VETERANS AFFAIRS (VA)
SALT LAKE CITY HEALTH CARE SYSTEM
Salt Lake City, Utah

MEMORANDUM 116.05 September 29, 2017

PREVENTION AND MANAGEMENT OF SUICIDAL AND SELF-HARM BEHAVIORS

1. PURPOSE:

To establish policy and procedures for the safety and care of patients and the management of suicidal and self-harm behavior within the VA Salt Lake City Health Care System (VASLCHCS).

2. POLICY:

Providing a safe and therapeutic environment for patients is the mandated standard of practice for all VA health care providers and employees. Therefore, healthcare providers and non-clinical employees within the VASLCHCS will follow a standardized protocol of assessment, intervention, and reporting of patients exhibiting suicidal or self-harm behaviors as outlined in this policy. Collaboration between care teams, service centers, and sections is required to ensure policy compliance.

3. DEFINITIONS:

See Attachment A.

4. RESOURCES FOR THE PREVENTION OF SUICIDE:

a. Suicide Prevention Team (SPT) is available 0730 – 1630 Monday through Friday. The Suicide Prevention Team (SPT) tracks and monitors patients for a 90 day period after they are placed on the high risk list and receive a Category I Patient Record Flag (CATI PRF) in CPRS. Additionally, the SPT members provide case management for patients, and suicide prevention training and consultation for employees. Contact SPT by calling 801-582-1565, ext. 6310 or immediate needs 385-414-1110.

b. Access Crisis Team (ACT) is available 24 hours daily. Contact ACT by paging 801-241-2579. ACT provides evaluation and assistance with the management of suicidal patients in the ED and outpatient areas of the SLC VAMC with the exception of the Blue Clinic, which is covered by the Behavioral Health Service (described below). ACT is also available by phone to assist CBOC clinicians.

c. Dialectical Behavior Therapy (DBT) Team is available 0800 – 1600 weekdays for triage and assessment purposes. In addition, the DBT is available 24 hours daily for crisis management of veterans with chronic suicidal ideation who are enrolled in the program. The DBT Team provides evidence-based assessment and treatment for veterans with ongoing, passive suicidal ideation and/or Borderline Personality Disorder-spectrum disorders. The DBT Team Leader can be contacted for evaluation of potential patients for the program at ext.2786.

d. Behavioral Health Service is available from 0800 – 1630 Monday through Friday to provide evaluation and assistance with the management of suicidal patients in the Blue Clinic. This service can be reached by paging 801-339-9895.

e. Psychiatry Consult Service is available 24 hours daily. This service provides evaluation and assistance with the management of suicidal patients on inpatient medical or surgical units. To contact, page between the hours of 0800 to 1700, at 801-339-6275; and enter a consultation request in CPRS. If immediate consultation is needed after hours or during the weekend, call the hospital operator and ask for the Psychiatry Resident on-call, be paged.

f. Mental Illness Research Education Clinical Centers (MIRECC) Suicide Prevention Consult Service is available 0800 – 1630 Monday through Friday. This service provides a second opinion on the management of patients at high risk of suicide. This is not an in-person, or immediate consultation. The MIRECC service will provide a comprehensive record and diagnostic review with anticipated turn-around of 7-14 days, depending on the length of the medical records. Contact by completing a consultation request in CPRS

g. National Crisis Hotline is available 24 hours daily at 1-800-273-8255.

5. GENERAL POLICIES AND PROCEDURES:

a. Reporting suicide completions and suicide/self-harm attempts:

(1) All Veterans who die by suicide or when self-harm is determined by a clinician to be a suicide attempt with a plan and intent must be reported to the Suicide Prevention Coordinator and the Patient Safety Manager within 24-hours. This requirement is to be met by completing the Suicide Behavior Report (SBR) note in CPRS. Completion of the SBR generates an order in CPRS to alert facility and Mental Health Service leadership. This order must be signed immediately after completing the SBR.

(2) SBR is required to be entered for:

(a) Behaviors:

All suicide attempts within the past 12 months.

(b) Thoughts:

Suicidal ideation with plan and intent.

(3) The first clinician to become aware of a self-harm behavior or completed suicide (whether in an inpatient or outpatient setting) meeting the criteria listed above, is responsible to complete the SBR.

(4) Additional requirement to notify the Pentad.

(a) A member of the Pentad must be verbally notified if one or more of the following criteria are met:

1 All Veterans, who die by suicide and those who cause self-harm, which is determined by a clinician to be a suicide attempt due to plan and intent that occurs on VA property.

2 There is potential media involvement related to such events.

3 If, in the clinician's judgment, there are unique or high-profile elements that would warrant Pentad involvement.

(b) Notification of the Pentad must be done by the staff member completing the Suicide Behavior Report. In some instances, the clinician may opt to defer Pentad notification until business hours.

(c) During regular business hours, call x1500 and ask to speak with a member of the Pentad.

(d) After regular business hours, The Pentad members may be contacted by calling the numbers listed in the Suicide Behavior Report instructions in CPRS.

b. Protocols for prevention of suicide among high risk patients: When a patient is determined to be at high risk by a clinician and/or an SBR has been completed, the Suicide Prevention Team will initiate the following protocols:

(1) Place on high-risk list.

(2) Initiate the Category I, Patient Record Flag (CATI PRF)

(3) Assign a Suicide Prevention Team Case Manager

(4) Begin intensive 90-day follow-up with weekly contact for the first 30 days; and monthly contact for 60- and 90-day period.

c. Outpatient Suicide Safety Plan:

(1) Completion of a Suicide Behavior Report always requires immediate completion of an outpatient Suicide Safety Plan, unless:

(a) The patient is currently inpatient or will be directly admitted to a hospital.

(b) The report is of a remote event (occurred at least 90 days prior to event being reported) and the clinician determines the patient is no longer at risk.

(c) A qualified clinician evaluates and determines the patient is not currently at risk of self-harm.

(d) The patient is deceased.

(2) Completion of the safety plan is the responsibility of the clinician who first determines the patient is at high risk and this must be done before the patient leaves the facility. If appropriate, safety planning may be "handed off" to a mental health or ACT staff member, but only if immediately available to meet with the patient.

(3) The patient must receive a hard copy of the safety plan.

6. SPECIFIC RESPONSIBILITIES AND PROCEDURES FOR ALL FACILITY EMPLOYEES:

a. Any VASLCHCS employee who becomes aware of a veteran at risk of self-harm or suicide, has the responsibility to take immediate action to ensure patient safety and appropriate reporting of the incident.

b. The procedures outlined below must be followed and pertain to the following situations:

(1) A veteran who attempts suicide or engages in intentional self-harm behaviors (observed or reported).

(2) A veteran who reports suicidal ideation with either plan or intent of self-harm.

c. The following procedures are divided into two general categories: (1) situations when the patient is present (face-to-face encounters) and (2) telephone procedures.

d. Procedures for face-to-face encounters:

(1) Outpatient procedures (non-emergency department):

(a) Non-clinical staff

1 Remain with the veteran, within direct line of sight, at all times until relieved by a clinical staff member, Access Crisis Team (ACT) member, VA police or community police or Emergency Medical Service (EMS). Direct line of sight is defined as: always within direct line of sight to include while patient is sleeping or toileting.

2 Immediately seek assistance from a clinical staff member (if available onsite).

3 If clinical backup is not immediately available onsite, page ACT (pager: 801-241-2579) for assistance.

4 If appropriate, ask another non-clinical staff person for assistance.

5 If the veteran appears to be in imminent danger or has already completed a self-harm act, immediately call VA police (ext. 4444) if on main campus or 911 if at a CBOC or in the community.

6 If requested, assist clinical staff to resolve situation.

7 If appropriate, attempt to engage the patient verbally in a calm manner to de-escalate him/her until assistance arrives.

(b) Clinical staff

1 Remain with the veteran, within direct line of sight, at all times until relieved by another VA or community clinician, ACT, VA or community police or until a clinician has determined the patient is not currently a danger to self.

2 If appropriate, ask another clinical or non-clinical staff person for assistance.

3 If the veteran appears to be in imminent danger or has already completed a self-harm act, immediately call both the VA police (ext. 4444) and ACT (pager: 801-241-2579) if on main campus or 911 if at a CBOC or in the community.

4 All patients who have attempted suicide or engaged in self-harm behaviors (either reported or observed) or who are expressing suicidal ideation with plan or intent must be evaluated by a qualified licensed clinician prior to returning to the community. This evaluation must include a risk assessment and a determination of whether inpatient treatment is indicated. This evaluation may be completed by the clinician who first becomes aware of the self-harm behavior/ideation or by a clinician with specialized training in mental health. If assistance from a mental health clinician is required:

a If the veteran is located in a primary care outpatient clinic, contact Behavioral Health Service (801-339-9895).

b patients located in all other areas (including CBOCs), contact any in-house behavioral health staff or ACT (pager: 801-241-2579).

c In some cases, additional evaluation/treatment in the VA or a community emergency department (ED) may be warranted. With the exception of situations of imminent risk of self-harm, the decision to escort/transport the patient to an emergency department can be made in consultation with ACT.

d If further evaluation/treatment in an emergency department is indicated:

(1) On the main campus, a clinician or staff personnel should walk with veteran to the ED. When indicated, more than one staff member should accompany the patient to the ED. If the patient is unwilling to be escorted to the ED, then ACT will assess the patient where he/she is located and then contact the VA Police (4444) for transport to the ED. If the patient is in imminent danger and/or at risk of fleeing, contact the VA police first for immediate assistance, then call ACT to complete appropriate assessment and paperwork.

(2) If at a CBOC, dial 911 to contact local police and/or EMS directly for transport to an appropriate emergency room. ACT may be contacted for consultation/assistance if needed.

5 If patient is determined to be at risk of self-harm but does not require hospitalization, then a formal outpatient Suicide Safety Plan must be completed and a hard copy given to the patient before the patient leaves the facility.

6 Completion of the safety plan is the responsibility of the clinician who first determines the patient is at high risk and this must be done before the patient leaves the facility, or document why it wasn't able to be completed at that time. If appropriate, safety planning may be "handed off" to a mental health or ACT staff member.

7 Complete the Suicide Behavior Report.

(c) Outpatient follow-up and monitoring

1 Available quantities of prescribed medications should be limited to the extent possible to prevent overdose during the time a patient is on the high-risk list.

2 Informal review of the outpatient safety plan should occur at each visit or phone call throughout the time patients are on the high-risk list. If necessary, the plan should be updated. If updated, a new hard copy must be given to the patient.

(2) Emergency department procedures: Refer to Memorandum 118.19, "Care of the Emergency Care Unit Patient with Suicide Ideation." for procedures.

(3) Inpatient procedures (medical or surgical units): Please refer to Memorandum 00Q.77, "One to One Observation" for procedures.

(4) Inpatient procedures (psychiatry units):

(a) Refer veteran to clinical team for further assessment. Contact Clinical Provider if urgent assessment is needed.

(b) Suicide Precautions:

1 Suicide precautions are indicated for a patient admitted to an inpatient ward who is identified as suicidal, potentially suicidal, or at imminent risk of physical self-harm. Suicide precautions must be ordered by a health care provider with authority to do so. Established suicide precaution levels are:

a Suicide Precaution 1 (SP1 High Risk): SP1 precaution requires one-to-one care. A staff member will be assigned to the patient at all times. When SP1 precautions are initiated, the patient's personal belongings are searched and potentially dangerous objects are removed. The patient will always be within the patient room and at arm's length of the staff member assigned, to include times while the patient is sleeping or toileting. UNDER NO CIRCUMSTANCES IS THE

PATIENT TO BE LEFT ALONE. A staff member assigned to one-to-one special care of a patient will have no other assignment during that specified period of time. Staff assigned to this duty should be alert at all times to prevent patient access to dangerous articles that could be used to inflict self-injury. The patient is restricted to the unit and all visitors are screened. Exceptions are indicated for clinical exams, diagnostic tests, etc., but staff coverage must be sufficient to prevent any self-injurious behavior by the patient while off the unit.

b Suicide Precaution 2 (SP2 Moderately High Risk): SP2 is initiated when the patient is acutely suicidal or self-destructive but not determined to be at high risk of imminently acting on suicidal or self-destructive impulses. These patients will be maintained on Close Observation status. Close Observation requires that the assigned staff member maintain the patient in line of sight at all times. At the beginning of each shift the patient will be discreetly searched for harmful objects. The patient will be restricted to the unit except for the exceptions noted in (a) above and staff coverage will be sufficient to prevent any self-injurious behavior by the patient. Up to two patients on close observation may be watched by one staff member, but both must be within line of sight at all times. A staff member assigned to Close Observation will have no other assignments during that period of special patient supervision.

c Suicide Precaution 3 (SP3 Moderate to Low Risk): SP3 is for Mental Health use only. The patient will be checked every 15 minutes during the 24-hour period but checks should be random to avoid establishing a routine during both waking and sleeping hours. The patient will be discreetly searched at the beginning of each shift to ensure they do not possess any harmful objects. The patient is restricted to the unit with the same exceptions noted in (a) and (b) above.

2 A licensed health care provider must assess patients requiring any type of suicide precautions at least once each day. Provider documentation of the daily assessment of the mental status of a patient on special surveillance status is required. An R.N. will chart on the status of all patients on suicide precaution at least once each shift.

3 Removal from or change in surveillance status: The provider and at least one other treatment team member or consultant will interview the patient to assess current suicide risk. Findings will be documented in the chart, and appropriate orders written. No harm contracts with the patient are insufficient justification for removal from special surveillance status. A patient is never to be removed from suicide precaution status for the convenience of staff or staffing patterns.

(c) Psychiatry Discharge Assessment: When a patient has expressed suicidal ideation, or has made a suicide attempt, and is clinically determined appropriate for discharge, the discharging physician will document suicide risk

assessment at the time of discharge in the discharge summary. In addition, the nursing staff will conduct a suicide risk assessment, which is included on the nursing discharge note. A formal outpatient Suicide Safety Plan must be completed by an inpatient clinician prior to discharge. The patient must participate in the development of the plan. A hard copy of the plan must be given to the patient prior to discharge. The hospital copy of the safety plan must be placed in the treatment plan folder of CPRS.

(d) Patient Passes and Transfers: A patient may be granted a pass or transfer from an acute psychiatry setting to another ward within the facility, to a community based facility, or an out of state VA facility. In such cases, patient safety must be ensured. Patient transfers must include hand-off communication between providers if the patient's in-patient stay included suicidal ideation and/or suicide attempts. The attending health care provider is ultimately the person responsible for ensuring that efforts, to make the discharge environment safe, have been established and are well documented.

e. Procedures for telephone encounters (crisis calls):

(1) Hospital operators and other non-clinical staff.

The caller should be instructed to call the Veterans Crisis Line. Available 24/7 at 1-800-273-8255. Alternatively, the call can be forwarded to the hotline by dialing 9-1-800-273-8255.

(2) Clinical staff.

(a) Telephone encounters with a patient known to the clinician:

1 If there is evidence that the veteran is in imminent danger or has already completed a self-harm act, immediately call 911 and request a police and EMS response.

2 All patients who have attempted suicide or engaged in self-harm behaviors (either reported or observed) or who are expressing suicidal ideation with plan or intent must be evaluated by a qualified licensed clinician. This evaluation must include a risk assessment and a determination of whether inpatient treatment is indicated. This evaluation may be completed either face-to-face or by telephone at clinician discretion.

3 If patient is determined to be at risk of self-harm but hospitalization is not required, then an outpatient safety plan must be completed. If appropriate this may be completed by phone. In that situation, ask the patient to take notes and make a copy of the plan and also mail a copy to patient.

4 Appropriate face-to-face and/or telephone follow-up should be arranged prior to ending the call.

5 If an adequate safety evaluation cannot be conducted by phone and the patient cannot or will not come to the facility or a community ED, then a wellness check by community police may be appropriate. The clinician can contact community police directly, or if the clinician would like consultation, ACT (pager 801-241-2579). Refer to Privacy Office Policy for requirements if police are contacted.

6 Complete the Suicide Behavior Report if indicated.

(b) Telephone encounters with a patient unknown to the clinician:

1 Attempt to identify the patient and determine his/her location. Look at caller ID, if available, to get the phone number the call is placed from and make a note of it.

2 Avoid a transfer of the call or placing the person on hold unless the patient has given their exact location. Transferring the call limits ability to trace the call.

3 All patients who have attempted suicide or engaged in self-harm behaviors (either reported or observed) or who are expressing suicidal ideation with plan or intent must be evaluated by a qualified clinician. This evaluation must include a risk assessment and a determination of whether inpatient treatment is indicated. For patients who are not currently in treatment with the clinician taking the call, this evaluation should ideally occur face to face, however the clinician should use clinical judgment to determine the most appropriate course of action. ACT (pager 801-241-2579) can be consulted as needed.

4 If a face-to-face evaluation is indicated, this should occur at the nearest (VA or community) ED. Patients at risk of self-harm should not transport themselves to an ED. Transportation should occur either by EMS (call 911) or a reliable friend/family member.

5 If the caller will not provide name or location, contact VA police for assistance tracing the call. As soon as the patient is identified and/or location determined – then call 911 and request both police and EMS response to the location.

6 Complete the Suicide Behavior Report if indicated.

7. SUICIDE PREVENTION EDUCATION FOR STAFF:

a. Suicide Prevention Education will be provided to all new VASLCHCS staff via the face-to-face National S.A.V.E. training. S.A.V.E. is the acronym used to remember the important steps involved in suicide prevention:

Signs of suicide thinking
Ask if they have suicidal ideations
Validate the Veterans' experience
Encourage treatment and **E**xpedite getting help.

SAVE is National mandate for all new employees within 90 days of start date. The VHASLCHCS Human Resource Department is responsible for compliance with this mandate. S.A.V.E. Training dates and times can be obtained by calling ext. 6306 or ext. 1460. The training is provided by the Suicide Prevention Team.

b. VASLCHCS Center for Learning will provide optional additional training on the recognition, management of and reporting of suicidal behavior/events, through TMS for all employees.

c. All Clinical Service Chiefs are responsible to ensure that their staff is educated on this policy on an annual basis, and that new employees attend suicide prevention training within 90 days of hire.

8. SUICIDE PREVENTION OVERSIGHT COMMITTEE: Committee Functions:

a. Assist the suicide prevention coordinator with planning and support of National Suicide Prevention activities for the VASLCHCS.

b. Assist the suicide prevention coordinator with the design, implementation, and reporting aggregate Root Cause Analysis (RCA) of suicide attempts and completions as mandated.

c. Oversight of development and implementation of VHASLCHCS suicide prevention policies.

d. Monitoring compliance with and effectiveness of VHASLCHCS suicide prevention policies.

e. Quarterly reports and recommendations will be provided to the CEB and Mental Health Service leadership.

f. Peer review of all confirmed and suspected suicides as determined by the Office of Medical Examiners (OME).

9. REFERENCES:

Center Policy Memorandum 118.02, “Seclusion and Restraint”
Center Policy Memorandum 118.19, “Care of the Emergency Care Unit Patient with Suicide Ideation”
HCSM 116A-05-4, “Supervision of Psychiatric Patients”
OIG Recommendations, 2017
Center Policy Memorandum 00Q.63, “Patient Safety Program”
Center Policy Memorandum 00Q.77, “One to One Observation”
VHA Handbook 1050.1
VHA National Patient Safety Improvement Handbook, March 4, 2011
VHA National Suicide Prevention Coordinator’s Handbook

10. RECERTIFICATION DATE: This policy is scheduled for recertification on or before the last working day of September 2020.

11. RESCISSION: Center Policy Memorandum 116.05, “Prevention and Management of Suicidal and Self-Harm Behaviors,” dated July 23, 2014.

12. FOLLOW-UP RESPONSIBILITY: Suicide Prevention Coordinator, Mental Health Services (116OP) and Access Crisis Team Leader (116OP).

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SHELLA STOVAL, MNA, RN
Director

Attachment: A. Definitions

ATTACHMENT A: DEFINITIONS

a. Suicide Prevention: Efforts to prevent suicide and suicide attempts that encompasses two general processes. The first includes efforts to prevent veterans who are at high-risk from attempting suicide or self-harm behaviors. The second is making every reasonable effort to provide a safe environment of care free of hazards that could result in self-harm.

b. Self-Directed Violence: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

c. Suicidal intent: There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and in the absence of suicidal behavior.

d. Physical Injury: A (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical, or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance. In some cases an injury results from an insufficiency of vital elements, such as oxygen. Acute poisonings and toxic effects, including overdoses of substances and wrong substances given or taken in error are included, as are adverse effects and complications of therapeutic, surgical and medical care. Psychological injury is excluded in this context.

e. Interrupted by Self or Other: A person takes steps to injure self but is stopped by self/another person prior to fatal injury. The interruption may occur at any point.

f. Suicide attempt: A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior.

g. Suicide: Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.

h. Non-Suicidal Self-Directed Violence Ideation: Self-reported thoughts regarding a person’s desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent.

i. Suicide Ideation: Thoughts of engaging in suicide-related behavior.

j. Self-Directed Violence, Preparatory: Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can

include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).

k. Non-Suicidal Self-Directed Violence: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent.

l. Undetermined Self-Directed Violence: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based upon the available evidence.

m. Suicidal Self-Directed Violence: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.

n. Suicide Screen in PHQ9: Four-question initial suicide screening tool in the PHQ9. Comes up if the depression reminder is positive.

o. Suicide Risk Assessment: A formal in-depth assessment completed by a licensed clinical professional. Use of this assessment is the preferred method for establishing suicide risk.

p. Suicide Behavior Report (SBR): The nationally mandated form for reporting any completed suicides, suicide attempts, self-harm behaviors and suicidal ideations with plan and intent.

q. Outpatient Suicide Safety Plan: A formal suicide/self-harm prevention plan developed by a clinician and patient working together. The plan must include the following elements:

(1) Triggers or signs that may lead to suicidal ideations or self-harm behavior;

(2) Ways of preventing self-harm without help from others;

(3) Reaching out to friends or family for help;

(4) Contacting professionals for help.

(5) Making the environment safe.

The formal plan is the only acceptable safety plan for outpatients. A copy of the plan must always be given to patients immediately upon completion.

r. Inpatient Suicide Safety Plan: The inpatient unit policies and processes designed to keep patients safe from self-harm. This may include a specific plan developed with the patient, when appropriate. The inpatient safety plan must be replaced with an outpatient safety plan prior to discharge from the hospital.

s. Direct Line of Sight: Direct line of sight is always in the same room and within view line of sight, to include while patient is sleeping or toileting. Observer must not be reading, watching television, doing homework, or using a telephone while on duty.

For additional information about specific definitions and modifiers of self-directed violence please refer to http://www.mirecc.va.gov/visn19/education/nomenclature.asp.