SUICIDE AND SELF-INJURY PREVENTION

1. **Purpose**: This operating procedure establishes guidelines for the initiation, monitoring, and termination of suicide and self-injury precautions while assuring that all Civil and Forensic residents of Florida State Hospital are treated in the least restrictive manner possible.

2. **Policy**: It is the responsibility of all staff in contact with Florida State Hospital residents to be alert to signs of increased risk of suicide or intentional self-injury in residents, and to respond appropriately and immediately when the potential for suicide or self-injury appears to exist. In order to meet this responsibility, employees in positions which bring them into contact with Hospital residents should acquire and maintain skills in the assessment and management of suicide risk and self-injurious behavior through professional education and/or in-service training.

3. **Training Requirement**: All staff will be trained on this operating procedure upon hire during New Employee Education, by their supervisor each time the operating procedure is revised, and annually during Annual Safety and Risk Management Education. Direct care staff in residential units, psychology staff, nurses, psychiatrists, Advanced Registered Nurse Practitioners, Human Service Counselors, rehabilitation therapy staff, and Qualified Mental Health Professionals will also be trained on this operating procedure during Discipline-Specific Education and by their supervisor each time the operating procedure is revised. Medical Unit Supervisors, Unit Directors, and supervisors in Operations and Facilities and Housekeeping will be trained on this operating procedure by their supervisor during worksite education and each time the procedure is updated.

4. **References**:
   b. Children and Families Operating Procedure 155-26, Specialized Therapeutic Observation in State Mental Health Treatment Facilities.
   c. Florida Mental Health Act, Rights of Patients, Florida Statutes 394.459.
   d. Florida State Hospital Operating Procedure 150-56, Assigned Clinical Observation.
   e. Florida State Hospital Operating Procedure 151-1, Administrative Procedure for Resident Death.
   f. Florida State Hospital Operating Procedure 155-1, Access to Grounds.

This Operating Procedure supersedes: Operating Procedure 150-6, dated December 3, 2008
Office of Primary Responsibility: Quality Assessment and Planning
Distribution: Florida State Hospital Computer Network Users
g. Florida State Hospital Operating Procedure 155-22, Psychiatric Crisis Prevention and Management.

h. Florida State Hospital Operating Procedure 155-26, Clinical Risk Assessment for Residents and Management of High Risk Residents.

i. Florida State Hospital Operating Procedure 155-27, De-Escalation Preferences of Residents.

j. Florida State Hospital Operating Procedure 75-1, Resident Injury/Event Reporting.

k. Forensic Services Operating Procedure 155-17, Ward/Pod Rounds.

l. Mentally Deficient and Mentally Ill Defendants, Rights of Forensic Clients, Chapter 916.107, Florida Statutes.

m. Florida State Hospital Operating Procedure 10-1, Critical Event Reporting

n. Florida State Hospital Operating Procedure 215-1, Resident Health and Safety Plan/Committee.

o. Florida State Hospital Operating Procedure 155-10, High Risk Resident Management.

5. Definitions:

   a. **Suicidal**: A suicidal person is one who has been assessed to be at risk for taking his or her own life by his or her own behaviors and actions.

   b. **Self-injurious**: A self-injurious person is one who has been assessed to be at risk for harming himself or herself, without the obvious intent to die or the likelihood of intentional lethal injury.

   c. **Serious self-injury**: Behavior that does not result from an obvious intent to die, but may still be lethal. Behavior that results in injuries that necessitate medical or surgical hospitalization is serious.

   d. **Specialized safety clothing**: Clothing made of non-tearable fabric with few, or no, fasteners or accessories (such as zippers or buttons) which could be used for self-harm. Such clothing can only be ordered with permission from the applicable Assistant Hospital Administrator and Clinical Director (or the On Call Administrator, outside work hours) and must be used within the guidelines of this procedure to prevent self-injury or suicide.

   e. **Suicide attempt**: An act done with intent to die, as determined by a licensed mental health professional, along with injury requiring medical treatment or intentional behavior that could be lethal (e.g., throwing oneself under a moving vehicle).

   f. **Licensed Mental Health Professional**: A person licensed as a medical doctor, psychiatric nurse practitioner, psychologist, licensed clinical social worker, or licensed mental health professional and currently credentialed within the Florida State Hospital Professional Clinical Staff.

6. Preventing Suicide and Self-Injury:
a. Persons who attempt to kill or injure themselves are generally recognized as experiencing symptoms of hopelessness, depression, perception of being a burden to others, and sense of thwarted belongingness, often in the context of negative life events. It is primarily through the relationships that a resident develops with staff that we encourage the development and maintenance of feelings such as hope, self-worth, connectedness, value, and self-control. If suicidal and self-injurious behaviors are part of an enduring personality pattern or maladaptive behavioral repertoire, they are not stand-alone symptoms that can be treated solely by environmental management or prescribed medications.

b. Self-injury without specific lethal intent serves various underlying functions (such as relief of chronic tension and negative affect, response to command hallucinations, attempts to communicate need for help, or attempts to cope), which can be discerned through individual behavioral analysis as the initial step in planning effective services. Deliberate self-harm behaviors can result in severe injury or death.

c. Suicides in the inpatient setting may occur in the context of no voiced suicidal ideation, even in response to specific questions, and often correlate with physical and psychic discomfort expressed through severe to extreme anxiety, agitation, and insomnia which goes unaddressed.

d. Residents identified as actively or potentially suicidal or self-injurious should not be approached with harsh, repressive measures for the sake of prevention. Rather, emphasis should be on positive methods that indicate genuine interest and facilitate establishment of mutual trust. These positive methods may involve assuming full control of the resident when his or her vulnerability deems such control, and then negotiating more freedom to encourage self-control, mutual trust, and self-esteem.

e. Unit Directors, Program Directors, and those responsible for the living areas, program areas, grounds and facilities shall ensure a safe and well-maintained environment through educating their employees about the environmental risks for suicide and self-harm that may be prevented through observation, reporting of safety issues, and taking personal action to alleviate potential hazards.

7. Assessment of Risk:

a. Assessment of each resident’s risk of suicide and intentional self-injury is a continuous process at Florida State Hospital.

b. Residents receive scheduled assessments for risk of suicide and potential self-injury using Florida State Hospital Form 65, Clinical Risk Assessment Instrument, within 120 hours of admission, during the 30 day Recovery Plan meeting, following medical or behavioral events that immediately impact the resident’s health and safety, prior to changing the resident’s freedom of movement status, and annually. Additional assessment evaluations may be employed to assess a resident's risk for suicide and self-injury. Suicide and self-injury risk are addressed in the Recovery Plan.

c. Residents may become dangerous to themselves without displaying signs of impending crisis. As a result, residents should be assessed for suicide and self-injury risk at every interaction with and observation by Hospital staff.

d. Certain history, demographic, and diagnosis variables have a verified statistical association with increased suicide risk. These include but are not limited to:
• History of two (2) or more suicide attempts (incidents of tissue damage with intent to die)
• Caucasian race (however, rate is increasing among black men)
• Male gender
• Age greater than 65
• Diagnosis of depression, and depression plus dysthymia (“double depression”)
• Diagnosis of schizophrenia
• Diagnosis of Body Dysmorphic Disorder
• Diagnosis of Anorexia
• Diagnosis of a “Cluster B” personality disorder

e. Special attention should be paid to residents displaying signs which have been identified as predictive of increased risk of suicide or intentional self-injury. These signs include:

• verbalizing intent to harm self;
• verbalizations or behaviors indicating person perceives self to be a burden to others;
• minimal impulse control;
• expressing suicidal plans the resident is physically capable of acting upon;
• obsessive ideation with death;
• statements of hopelessness, especially with delusional features;
• expressions of feeling worthless;
• indications of fear of being alone, or frustration with sense of not belonging;
• expressions of guilt, especially when accompanied by need for or fear of punishment;
• histories of using self-injurious behaviors as a means to obtain attention or to go to off-unit medical services for treatment of self-inflicted injuries;
• depressive paranoid ideas;
• reporting hallucinated voices advising suicide or "join me in heaven;"
• command hallucinations to hurt or kill self or others;
• increased problems in self-control;
• self-isolation;
• arguments with other residents which are more intense or frequent;
• increased hostility during interviews with staff;
• agitation and anxiety, particularly with insomnia;
• prescribed medications being refused;
• rejection by a relative or friend;
• feeling “trapped;”
• transfer to another ward, transfer or discharge of a friend;
• within the past 30 days, the resident has become aware of a change of status such as pending discharge, transfer, conditional release, or return to court as competent to proceed.

8. **Levels of Suicide Precautions:**

a. Unless otherwise clinically indicated, residents assigned to precautions against suicide and self-harm should be stepped down from one level of precautions through each lower level. In addition, residents should be allowed to access fresh air and sunshine for at least one-half hour daily. Residents should be given the opportunity to engage in therapeutic activities, unless clinically contraindicated. Fluid intake should be encouraged.

9. Emergency Suicide Precautions:

a. All employees who determine at any time that a resident shows potential increased risk for suicide or self-injury shall immediately intervene in such a way as to reduce the likelihood that the resident will be able to harm himself or herself.

b. The employee observing a resident at risk for self-injury or suicide shall provide the resident with the observation and precaution as required by the situation to reduce the risk of the resident harming himself or herself, and contact the ward supervisor, shift supervisor, or professional member of the resident’s Recovery Team. The employee’s observations and conclusions are to be documented in the resident’s progress notes.

c. The ward supervisor, shift supervisor, or professional member of the resident’s Recovery Team will assess the situation, and may write an order for emergency suicide precautions on Form 10, Treatment Orders. Such emergency precautions shall always include 1:1 special until replaced by a further order from a psychiatrist or psychiatric Advanced Registered Nurse Practitioner.

d. Immediately upon initiating emergency suicide precautions, a registered nurse shall be contacted. The registered nurse shall observe and interact with the resident within 30 minutes of contact by the staff, and document his or her observations. If the nurse determines that the resident presents immediate behavior or threat of using clothing for self-injury, use of hospital-approved specialized safety clothing will be initiated. In addition, any request by the resident to use the specialized safety clothing in an effort to maintain his or her own safety will be factored into the determination and the request for authorization. Even if the resident requests or assents to wearing safety clothing, authorization will be obtained as follows: the nurse will obtain and document verbal authorization from the Clinical Director and applicable Assistant Hospital Administrator, or the Administrator On Call outside work hours (see 11c below).

e. If the registered nurse deems that a medical or psychiatric evaluation of the resident is indicated, the registered nurse shall immediately contact the psychiatrist, Advanced Registered Nurse Practitioner, or physician on duty.

f. The psychiatrist, Advanced Registered Nurse Practitioner, or physician will provide assessment and treatment as clinically indicated.

g. No later than the working day following initiation of suicide precautions, the Recovery Team shall review the data and resident’s clinical status. The Clinical Risk Assessment Instrument (Form 65) will be updated to reflect the Suicide Risk Assessment. The team will make any necessary modification of the precaution level.

10. Recovery Team Responsibilities:

a. At the time of admission, each resident shall be assessed for suicide potential by the psychiatrist or psychiatric Advanced Registered Nurse Practitioner and documented in the ward chart, and by the resident’s Recovery Team using Form 65, Clinical Risk Assessment Instrument.
b. During each resident’s regularly scheduled Recovery Team review, the resident’s potential for suicide and intentional self-injury shall be evaluated. When the assessment indicates the resident is at risk for self-harm, this shall be documented in the resident’s Progress Notes. The assessment will employ the Clinical Risk Assessment Instrument when indicated. Other supplementary procedures to assess suicide risk may be employed as needed.

c. The Recovery Team shall review emergency suicide precautions as soon as possible, and in all cases no later than the team’s next working day. The attending psychiatrist or psychiatric Advanced Registered Nurse Practitioner shall participate in this review process.

d. The decision to initiate, continue, or discontinue suicide precautions shall reflect the consensus of the Recovery Team. The designated team member shall write orders related to those decisions at this time. This designated team member must be a clinical professional licensed as such in Florida (psychiatrist, licensed psychologist, or nurse). If the psychology member of the team is not licensed, his or her input and documentation will be reviewed and co-signed within one working day by a licensed psychologist responsible for psychology services to that unit. The Suicide Precautions Order shall be written on Form 150, Physician’s Order, if written by a physician or Advanced Registered Nurse Practitioner, or on a Form 10, Treatment Order, if written by a licensed psychologist or nurse, denoting the level of suicide precautions as specified in paragraph 8 of this operating procedure. A corresponding Progress Note shall be written by the physician or Advanced Registered Nurse Practitioner.

e. If the Recovery Team is unable to reach a consensus regarding the resident’s suicide status, the Medical Service Director of the service shall be asked to review the case and render a decision to resolve the difference of opinion. In all instances, these decisions shall be binding upon the team. The designated psychiatrist or psychiatric Advanced Registered Nurse Practitioner shall ensure that any required orders and Progress Notes related to suicide precautions are written.

f. The Recovery Team shall identify the problem of increased suicide risk and shall develop a plan of treatment within the Recovery Plan.

g. The Recovery Team leader or designee shall document fully in the Progress Notes the team’s decision. Any changes in suicide risk must also be reflected on Form 65, Clinical Risk Assessment Instrument.

h. When a resident is determined to not require suicide precautions, this shall be so noted in the Progress Notes and the resident will be allowed to resume therapeutic activities.

i. The Unit Director shall review the management and progress of residents on suicide precautions with the Recovery Team at least once every seven (7) days, with documentation of this review being noted in the progress notes section of the resident’s ward chart.

j. PRN orders for special precautions are not permissible.

11. Staff Procedures:

a. Unless otherwise directed by a psychiatrist or psychiatric Advanced Registered Nurse Practitioner, as soon as a resident is placed on suicide precautions, assigned ward staff shall conduct a pat search, bedroom search, and personal belongings search, removing any potentially harmful object (e.g., shoelaces, glass objects, scarves, matches, belts, pens, pencils, jewelry). After the initial search, assigned ward staff shall conduct intermittent searches as
needed while suicide precautions continue. Documentation of each search shall be entered in the resident’s progress notes.

b. Ward supervisors will inspect the setting each time a ward has a person on any level of observation status for prevention of suicide or self-injury. The purpose of the inspection is to assess, remove, and secure environmental hazards including but not limited to paperclips, staples, unattended pencils and pens, thumbtacks, plastic bags, protruding nails, screws, bolts, unattended maintenance or housekeeping carts, and sturdy environmental features that might be used to facilitate a suicide attempt by hanging. Attention should be paid to the contents of trashcans that are open and accessible. Attention should be paid to the area where residents have their meals and receive their medication. Attention should be paid to the books and literature in the resident’s possession, to ensure that staples or wires are removed. The purpose is to continuously ensure a safe environment in which the resident can move around to the fullest extent possible based on their clinical condition and the orders for their care, without creating a barren, non-therapeutic environment. Work orders shall be submitted to correct environmental hazards. Medical Unit Supervisors shall monitor timely completion of work orders that affect resident safety. Unit Directors shall ensure that proposed repairs or solutions are appropriate and safe for a psychiatric care setting.

c. If the person is actively using or threatening to use their clothing as a means to self-injure, specialized safety clothing may be authorized by order of the Clinical Director and the applicable Assistant Hospital Administrator (or their designees) during work hours, or the On Call Administrator. The nurse obtains and documents the authorization. The use of specialized safety clothing is only permitted when a person presents such imminent risk of self harm that Level C (one to one observation) is in use and that use of regular garments poses a specific and documented risk. Use of safety clothing is not permitted based on historical risk factors alone. Return to regular garments should be assured as soon as the risk of imminent danger has passed, even when the person otherwise remains on suicide and self-injury observation status. Specialized safety clothing will not be used to identify a person who requires special observation, nor will it substitute for continuous efforts to engage and provide meaningful therapeutic interaction to a person who is acutely hopeless and isolated. Use of the specialized safety clothing will be managed by unit nursing staff in a way to assure the dignity, privacy, cleanliness, safety and health of the person wearing it. Documentation in the progress notes by the registered nurse will address the continued necessity for, and monitoring of, specialized safety clothing.

d. Specific ward staff members on each shift shall be assigned to each resident on suicide precautions to carry out orders and document the resident’s behavior. Staff documentation should include not just physical and behavioral observations, but also quotes from residents to illustrate what they think and how they feel, so that their mental status can be tracked. Except when it is necessary to accompany a resident to a facility outside Florida State Hospital for an extended period of time, no ward staff member shall be assigned to 1:1 suicide precautions for more than four (4) consecutive hours during any shift or period of consecutive shifts. The Unit Director or designee must approve exceptions to this. The Unit Director shall review all such exceptions made during his or her off-duty hours.

e. A registered nurse shall place a suicide precaution sticker on the chart of any resident assigned to suicide precautions. The names of residents on suicide precautions shall be placed on the Daily Clinical Management Report (Form 331) by the ward supervisor.

f. If it is determined necessary, the resident shall be assigned to the sleeping and/or bedroom area that is most visually accessible at all times. The unit is to designate sleeping areas for those on suicide precautions.
g. Residents on suicide precautions may be required to use special dining utensils as needed in order to reduce risk of self-injury from cutlery.

h. Restraints may be utilized for residents on suicide precautions only when less restrictive measures are ineffective or not feasible. A 1:1 suicide precaution shall be ordered for the duration of the restraint. In these cases Hospital restraint and seclusion operating procedures shall be applicable.

i. The resident is to be escorted by staff any time it is necessary to leave the unit or ward. No resident on suicide precautions is to be granted unescorted movement.

j. Toileting and bathing: Individuals who are on Level C (1:1 observation) or Level B (CVO) must be maintained on those levels of supervision during toileting or bathing. Except in extreme emergencies, supervision during such activities will be conducted by a person of the resident’s gender. In all instances, ward staff will be mentored and trained by their supervisors to ensure that intensive, continuous, vigilant observation is carried out with dignity and respect.

12. Termination and Reduction of Suicide Precautions:

a. Removal of residents from suicide precautions shall be done gradually unless rapid discontinuation is specifically indicated and is so documented in the Progress Notes. The minimum team composition for removing suicide precautions is three (3) professionals, one of whom shall be a psychiatrist or psychiatric Advanced Registered Nurse Practitioner.

b. More rapid removal from suicide precautions is appropriate with residents whose expressions of intent to self-injure are transient and impulsive and the resident’s history does not indicate intentional self-injury in the past. More rapid removal from intensive observations is indicated when continued close monitoring is unnecessarily stressing a resident whose risk of intentional self-injury is deemed to be low.

c. When the resident is removed from suicide precautions, the suicide precaution sticker shall be removed from the chart by a registered nurse.

d. Suicide precautions shall not be reduced or removed on a Friday or a day preceding a holiday.

e. When residents who are considered in suicidal remission are approved for Freedom of Movement or Leave of Absence for therapeutic trial, their suicidal history shall be noted in the Progress Notes. There shall be a gradual resumption of privileges unless rapid resumption is specifically indicated and the indications are noted in the resident’s Progress Notes. Form 65, Clinical Risk Assessment Instrument, must also be updated by the Qualified Mental Health Professional.

13. Discharge Issues:

a. The Qualified Mental Health Professional shall consult in writing with the Hospital Clinical Director or designee at the time a resident presently or within the past thirty (30) days on suicide precautions is recommended for discharge.

b. A voluntary resident who has made a serious suicide attempt or produced serious self-inflicted injuries within the past three (3) months and who is absent without leave shall be evaluated by the Recovery Team for possible involuntary commitment upon his/her return to the Hospital.
c. When residents who are considered in suicidal remission are determined “not dangerous to self” and are approved for conditional release, leave of absence, or discharge, their suicidal history shall be noted in the Progress Notes and Discharge Plan/Separation Summary.

d. Actively suicidal residents on voluntary status who request discharge against medical advice shall be immediately recommended for involuntary commitment.

e. When forensic residents who are considered in suicidal remission are recommended for return to court as no longer meeting criteria for incompetent to proceed or dangerous to self or others, their suicidal history shall be noted in the relevant Clinical Summary, Competency Evaluation, and Discharge Plan/Separation Summary.

14. Incident Review Procedure:

a. Incidents of suicide, including those which happen within thirty days of discharge, shall be reviewed through the Hospital’s Mortality Review Process and by any other special review processes designated by the Hospital Administrator.

b. All incidents of suicide attempt and self-injury recorded on Florida State Hospital Form 44, Resident Incident Report, shall be reviewed by the Unit Director or designee the next workday following an incident, preferably in a group format such as the morning meeting, prior to submitting the Form 44, which is due within 72 hours to the Hospital Office of Risk Management. The incident coding (suicide attempt vs. self-injury vs. another category) must be reviewed with a licensed mental health professional on the Recovery Team (see “c” below) to ensure that the Form 44 accurately reflects the nature of the incident. If the incident report has already been sent to Office of Risk Management labeled “suicide attempt,” but the consensus of the Recovery Team is that the incident is better labeled with a different term, the Recovery Team shall provide the Office of Risk Management with a Progress Note (Form 52) or a Recovery Team Meeting Minutes (Form 156) that reflects the consensus of the Team and includes the signature of the licensed mental health professional.

c. Initial unit-level reviews of self-injury, suicide threat, and suicide attempt incidents should identify potential clinical and environmental issues in need of further analysis and action at the unit level. The overall goal is to manage and reduce the frequency and severity of self-harm behaviors at the lowest possible level within the organization.

c. Incidents of verified suicide attempt (defined as “intent to die” as determined by a licensed mental health professional, along with actual injury, or behavior that could have resulted in lethal injury) shall be reviewed in the following sequence.

(1) The unit will convene and document an internal High Risk review of the incident, to include an analysis of the function or motivation of the resident’s behavior.

(2) The Unit Health and Safety Committee, including a clinician representative, will convene to review the environmental aspects of the incident. Most suicide attempt incidents involve residents’ use of objects or conditions in the environment to facilitate their behavior. The Unit Health and Safety Committee will also document the appropriateness and timeliness of environmental repairs or solutions as they are implemented. Minutes of the unit health and safety committee will be forwarded to the Resident Safety Officer in the Office of Risk Management.
(3) The Office of Risk Management will monitor the documentation of unit reviews of the clinical and environmental aspects of suicide attempts and will request review or assistance from Hospital Administration as needed.

d. All incidents of self-injury shall be reviewed at the unit health and safety committee level as well as through the hospital's clinical within-unit and outside-unit review processes (e.g., high risk review process, psychiatry review process) as needed.

(Signed original on file in Central Health Information Services)

DIANE R. JAMES
Hospital Administrator

**SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL**

This operating procedure was revised to: describe the process of and responsibility for event reviews; to update terminology; to update training requirements; to spell out the responsibilities of the unit safety committee; and to add new definitions.