CF OPERATING PROCEDURE
NO. 155-53

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, February 15, 2019

Mental Health/Substance Abuse

SUICIDE AND SELF-INJURY PREVENTION

1. Purpose. This operating procedure establishes minimal standards for the prevention of suicide and self-injury in the mental health treatment facilities.

2. Scope. This operating procedure applies to:

a. Residents hospitalized in state mental health treatment facilities, whether operated by the Department of Children and Families or private entities; and,

b. At the Florida Civil Commitment Center:

(1) Those residents housed on the Residential Mental Health Units;

(2) Any resident evaluated by a psychiatrist as meeting criteria for Residential Mental Health but not yet housed on the unit; and,

(3) Any resident who has been evaluated by a psychiatrist as being an imminent danger to self or others and the behavior is secondary to a mental health disorder/mental health crisis.

3. References.

a. CFOP 155-26, Safe and Supportive Observations of Residents.

b. CFOP 155-41, Environmental Risk Management in State Mental Health Treatment Facilities.

c. The Columbia-Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings from Three Multisite Studies with Adolescents and Adults (Posner, K., et al., American Journal of Psychiatry 2011; 168: 1266-1277).

d. The Joint Commission, Sentinel Event Alert 56: Detecting and treating suicide ideation in all settings, located at https://www.jointcommission.org/sentinel_event.aspx.

e. PHQ-9 Patient Depression Questionnaire, Pfizer Incorporated, 1999. This brief questionnaire may be employed to supplement findings of the Columbia scale.

4. Definitions.

a. Clinician. For the purposes of this operating procedure, a Physician licensed pursuant to Chapter 458 or Chapter 459, Florida Statutes (F.S.), an Advanced Practice Registered Nurse (APRN) licensed pursuant to Chapter 464, F.S., a Physician Assistant licensed pursuant to Chapter 458, or a Clinical Psychologist licensed pursuant to Chapter 490, F.S.

b. Columbia-Suicide Severity Rating Scale (C-SSRS). An assessment instrument to differentiate the domains of suicidal ideation and suicidal behavior. The instrument measures four

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constructs: severity of ideation; intensity of ideation subscale; behavior subscale; and lethality subscale.

c. PHQ-9 Patient Depression Questionnaire. Brief assessment instrument related to depression.

d. Pro Re Nata (PRN) Medical Order. An individualized order for the care of a resident which is written after the resident has been seen by a physician/Advanced Registered Nurse Practitioner (ARNP)/Physician's Assistant (PA) which sets parameters for attending staff to implement according to the circumstances set out in the order.

e. Recovery Team. An assigned group of individuals with specific responsibilities identified on the recovery plan including the resident, psychiatrist, guardian/guardian advocate (if resident has a guardian/guardian advocate), community case manager, family member and other treatment professionals commensurate with the resident's needs, goals, and preferences. At the Florida Civil Commitment Center, the term used is Multidisciplinary Team.

f. Registered Nurse (RN). Per section 464.002(22), F.S., any person licensed in Florida to practice professional nursing. This does not include a Licensed Practical Nurse (LPN). In the absence of a clinician being available to perform the C-SSRS, an RN who is trained in administering the C-SSRS is permitted to complete the C-SSRS assessment (nights and weekends included).

g. Self-Injury. Term which describes the act of deliberately harming one's body through aggressive behavior which is self-directed and could cause self-inflicted injury. Deliberate self-harm behaviors can result in severe injury or death.

h. Suicide Attempt. An act by a resident with the intent to cause his or her own death. For the purposes of this operating procedure, determination of a suicide attempt may include, but is not required to include, a harmful and potentially lethal act by the resident.

5. Preventing Suicide and Self-Injury.

a. Individuals 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 symptoms, standing alone, that can be treated solely by environmental management or prescribed medications.

b. Self-injury without suicidal 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 in the initial step of planning effective services.

c. Suicide 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.

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 a collaborative effort to 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. Facilities will maintain a safe environment through educating 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.

6. Assessment of Risk.

a.. Assessment of each resident's suicide risk shall occur within 24 hours of admission, transfer to new unit, annually, and when indicated using the latest version of the Columbia-Suicide Severity Rating Scale (C-SSRS). The C-SSRS shall be administered by a clinician as defined in this operating procedure, or Psychology Intern/Resident under the direct supervision of a licensed Psychologist or Registered Nurse. Results shall be documented in a progress note, or a facility approved summary and recommendations form, and included in the resident's recovery plan if clinical concerns are present. If the clinician has knowledge of the results of a previous C-SSRS, the clinician may administer versions related to "Since Last Visit" and "Frequent Screener." The Pediatric/Cognitively Impaired Lifetime Recent Clinical version may be used if indicated. Any staff administering the C-SSRS must complete C-SSRS training which is offered by Columbia University and is available on their website at http://cssrs.columbia.edu/training/training-options/. Staff who administer this assessment shall complete training annually. Facility administrators or designees are responsible for tracking participation in training.

b. Residents may become dangerous to themselves without displaying signs of impending crisis. Residents must be assessed by facility staff, as appropriate for their skill level, for suicide and self-injury risk at every interaction and observation.

c. Special attention should be paid to residents displaying signs which may be indicative of increased risk for suicide or intentional self-injury. Dynamic conditions are subject to change and potential therapeutic interventions may be indicated. Static conditions may be historical and/or cannot change but may also warrant some type of intervention because of an ongoing significant and negative impact. Signs include, but are not limited to:

(1) Verbalizing intent to self-harm or suicidal ideation (dynamic);

(2) Verbalizations or behaviors indicating the resident perceives him or herself to be a burden to others (dynamic);

(3) Minimal impulse control (dynamic);

(4) Expressing suicidal plans, particularly plans the resident is physically capable of acting upon (dynamic);

(5) Obsessive ideation with death or afterlife related hallucinations or ideas (dynamic);

(6) Statements of hopelessness, especially with delusional features (dynamic);

(7) Expressions of feeling of worthless or perceiving him or herself to be a burden to others (dynamic);

(8) Indications of fear of being alone, or frustration with a sense of not belonging (dynamic);

(9) Expressions of guilt, especially when accompanied by need for or fear of punishment (dynamic);

(10) Using self-injurious behaviors as a means to obtain attention or to go to off-unit medical services for treatment of self-inflicted injuries (dynamic);

(11) Depressive paranoid ideas (dynamic);

(12) Reporting hallucinations advising suicide or heavenly bound ideas (dynamic);

(13) Command hallucinations to hurt or kill self or others (dynamic);

(14) Increased problems in self-control (dynamic);

(15) No identified support (static but may be dynamic depending on situation);

(16) Self-isolation (dynamic);

(17) Irritability with other residents which are more intense and frequent (dynamic);

(18) Increased hostility during interviews with staff (dynamic);

(19) Increased agitation and anxiety, particularly with insomnia (dynamic);

(20) Prescribed medications being refused (dynamic);

(21) Permanent loss of or permanent rejection by a relative or friend (static);

(22) Temporary loss of or temporary rejection by a relative or friend (dynamic)'

(23) Feeling "trapped" (dynamic);

(24) Increased energy level or sudden recovery from a depressed state (dynamic);

(25) Mania;

(26) Past suicide attempt (static);

(27) History of severe self-injurious behavior (static);

(28) History of childhood abuse (static);

(29) Family history of suicide (static);

(30) Recent onset of mental illness (static);

(31) Recent admission to hospital (static);

(32) Gave away or lost possessions (static);

(33) Sudden extreme religiosity or loss of interest in religion (dynamic); and,

(34) Within the past 30 days, the resident has disagreed with known upcoming change of status such as pending discharge, transfer, conditional release, or return to court as competent to proceed (static).

7. Special Observations and Precautions. Refer to CFOP-155-26 for levels of observation and precautions.

8. Orders for Precautions.

a. Clinicians as defined in this operating procedure may authorize observation and precautions for individuals who are assessed to be at increased levels of risk for suicidality and/or self-injury. Authorizations for precautions are generally provided after a clinical assessment, and to the extent possible, assessment should involve members of the recovery team. In some cases, other staff may be authorized to provide authorization under particular circumstances (these situations will be explained later in this operating procedure). Whether ordered by a clinician or other authorized staff, orders for Suicide Precautions or Self-Injury Precautions will meet the requirements of paragraph 8b of this operating procedure.

b. All written orders for Suicide Precautions, or Self-Injury Precautions, at a minimum, shall include the following procedures.

(1) Identify and describe the indicator(s) of suicidality or self-injury.

(2) Delineate the type of observation and precautions needed to maintain safety.

(3) List evaluation or treatment goals to downgrade observation and precautions.

(4) Indicate whether specialized safety clothing is authorized for 1:1 or 2:1 levels of observation only.

(5) Include the time limit of the order.

(6) All clinicians' orders shall be signed either on paper or electronically. The last page of a paper order shall have a clearly printed or stamped signature line with the authorizing clinician's name, license type (MD, ARNP, PA, Ph.D., Psy.D., or Ed.D.), and the date and time of the order. Each page before the last page shall be initialed by the clinician. The order, if the first, shall be stamped on the first page as "Original Order." Facilities shall maintain signature logs with the names, titles, and sample signatures of clinicians. Facilities with electronic records shall comply with this requirement in the electronic system.

(7) When the authorizing clinician is not on-site, proposed orders shall be prepared by the attending RN and securely faxed or emailed with encryption to the authorizing clinician on a standard form or written order sheet. The authorizing clinician shall return the order via a secure fax or encrypted email immediately following signature. The order, if the first, shall be stamped as "Original Order" on the first page. For facilities with electronic health records, if the authorizing clinician has remote access to the records, it is acceptable to process orders electronically. If the authorizing clinician does not have remote access to the EMR, the RN will contact the on-call provider by telephone to request a verbal order. If the on-call provider is in agreement, he/she will give a verbal order for the special precautions and is responsible for verifying the order in the EMR within 48 hours.

c. Residents for whom written orders for Suicide Precautions or Self-Injury Precautions have been issued should be given the opportunity to engage in activities, unless clinically contraindicated.

d. Unless otherwise clinically indicated, residents assigned to precautions against suicide and self-harm should be gradually downgraded, e.g., 1:1 to Continuous Visual Observation, Group Observation, 15 minute checks, etcetera. In addition, residents should be allowed to access fresh air and sunshine at least one-half hour daily.

9. Emergency Precautions for Suicidality or Self-Injury.

a. Paragraph 9 of this operating procedure applies when immediate action is needed to protect a resident and a clinician is not on-site to evaluate suicidality or self-injury. This situation is likely to occur during holidays, weekends, and other off duty hours for attending clinicians.

b. All staff members may determine based on state of behavior, verbal status, etc., at any time, that a resident shows potential increased risk for suicide or self-injury. Staff will immediately intervene in such a way as to reduce the likelihood that a resident will be able to harm him or herself. Staff will describe precautions taken and the rationale for these precautions in a progress note which will be filed in the medical record. If manual or mechanical restraint is a requirement, such responses must be applied in accordance with Children and Families Operating Procedure 155-21, Use of Restraint in Mental Health Treatment Facilities, and facility-based policy for restraint. Staff will contact a Registered Nurse as soon as possible after addressing the emergent situation.

c. Facilities will ensure that a line of communication occurs which notifies the ward/unit or area supervisor, shift supervisor, and a registered nurse regarding concerns related to suicidality or self-injury. A registered nurse may write the initial order for suicide precautions. The order may not exceed 24 hours. Continuation of suicide precautions must be ordered by an attending clinician as defined in this operating procedure, or by the Medical Executive Director, or designee, or Assistant Hospital Administrator/ Administrator on Call outside work hours. Only a clinician completing a face-to-face evaluation may downgrade suicide precautions.

d. The registered nurse will assess the situation, document the situation in a progress note, and if needed, write an order for Emergency Suicide Precautions on the facility's form for treatment orders. Such emergency responses will always include at least Group Observation precautions until replaced by a further order from a clinician.

e. Immediately upon the initiation of Emergency Suicide Precautions, a registered nurse shall observe and interact with the resident within 30 minutes and document his or her observations.

(1) If the nurse determines that the resident presents immediate behavior or threat of using clothing for self-injury, use of facility approved specialized safety clothing is permitted. Facility approved safety clothing may be used in a manner that respects the resident's basic needs, sense of autonomy, and right to the least restrictive intervention.

(2) Decision to use safety clothing must be clearly documented in the medical record. 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 considered when authorizing safety clothing.

(3) Outside of regular work hours, authorization will be obtained as follows: the nurse will obtain and document verbal authorization from the On Call Clinician, the Medical Executive Director or designee.

f. If the registered nurse deems that a medical or psychiatric evaluation of the resident is immediately indicated, the registered nurse shall immediately contact the clinician on duty and the nursing supervisor.

10. Recovery Team Responsibilities.

a. Whenever staff determine that a resident is an increased risk for suicide or self-harm, the resident shall be assessed using the C-SSRS for overall risk including suicide potential by a clinician or trained R.N. if a clinician is unavailable and the assessment documented in the ward/unit chart. Staff

may address various other aspects of suicidality or self-injury using additional assessment tools which they deem relevant.

b. During all resident's regularly scheduled recovery team review, the resident's potential for suicide and intentional self-injury shall be evaluated and documented in the progress note by the team. 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 next working day. The attending psychiatrist or psychiatric APRN shall participate in this review process. The resident will be reviewed each working day by the attending psychiatrist or psychiatric APRN and recovery team while under observations related to suicidality or self-injury.

d. The decision to continue or discontinue suicide precautions should reflect the consensus of the recovery team. The designated team members shall write orders related to those decisions at this time. The designated team member must be a clinician as defined in this operating procedure. A Suicide Precautions Order will be written on the physician's order form, or on a form for treatment orders, denoting the level of suicide precautions. A corresponding progress note shall be written by a clinician.

e. If the recovery team is unable to reach a consensus regarding the resident's suicide status, the Medical Service Director, or Medical Executive Director, or designees in their absence, will be asked to review the case and render a decision by order to resolve the difference of opinion. In all instances, these decisions shall be binding upon the team. The clinician will ensure that any required orders and progress notes related to suicide precautions are written.

f. The recovery team will identify the issue of increased suicide risk and will develop a formal recovery plan or Integrated Care Plan as referred to at the Florida Civil Commitment Center.

g. The team facilitator or coordinator or designee will document fully in the progress notes the team's decision. Any changes in suicide risk must also be reflected on the C-SSRS.

h. When a resident is determined not to require suicide precautions, this will be so noted in a clinician's order and with justification documented in the progress notes, and to the extent appropriate, the resident will be allowed to resume therapeutic activities.

i. The Nursing Supervisor/Nurse Manager or designee 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/unit chart.

j. Pro Re Nata orders for special precautions are not permissible.

k. When or before the recovery team meets to address a resident's apparent attempted suicide or self-injury, a licensed psychologist shall classify for the team whether the event of focus is either an attempted suicide or is only related to self-injury. Results of the C-SSRS protocol used pursuant to this operating procedure shall be a guide for the psychologist to report and document the various suicidal behavioral subtypes which apply, i.e., Actual Attempt, Interrupted Attempt, Aborted or Self-Interrupted Attempt, and Preparatory Acts or Behavior. All C-SSRS results shall be documented in the resident's medical record. Attempted suicides shall be reported with details to the current prescriber for that resident, the Medical Executive Director, or designee, for review and response to the recovery team and other pertinent staff who can respond to assist with the resident's recovery.

11. Staff Procedures.

a. Unless otherwise directed by a psychiatrist or psychiatric Advanced Practice Registered Nurse (ARPN), as soon as a resident is placed on suicide precautions, assigned ward/unit staff will conduct a pat search, bedroom search, and personal belongings search, removing any potentially harmful objects (e.g., shoelaces, glass objects, scarves, belts, pens, pencils, jewelry, etc.). After the initial search, if staff have reason to believe that safety may have been breached, staff will conduct additional searches while suicide precautions continue. Searches will be conducted in a respectful professional manner. Documentation of each search shall be entered in the resident's medical record.

b. Nurse supervisors will inspect the setting each time a ward/unit has a person on observation status for prevention of suicide or self-injury.

(1) The purpose of the inspection is to assess, remove, and secure environmental hazards including, but not limited to:

(a) Paperclips;

(b) Staples;

(c) Unattended pencils and pens;

(d) Thumbtacks;

(e) Plastic bags;

(f) Protruding nails;

(g) Screws and bolts;

(h) Unattended maintenance or housekeeping carts; and,

(i) Sturdy environmental features that might be used to facilitate a suicide by hanging.

(2) 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 also be paid to the books and literature in the resident's possession, to ensure that staples or wires are removed.

(a) 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.

(b) Work orders will be submitted to correct environmental hazards. The Nurse Supervisor or designee will monitor timely completion of work orders that affect resident safety.

(c) The Nurse Supervisor or designee will ensure that proposed repairs or solutions are appropriate and safe for a psychiatric care setting.

c. Observers will make entries on the Special Observation Flow Sheet or the Clinical Observation Progress note, as determined by the facility, and referenced in CFOP 155-26, Safe and Secure Observations of Residents.

d. Specialized safety clothing may be authorized by order of the attending clinician, Medical Executive Director, or designee, or applicable Assistant Facility Administrator (or designee) during work hours, or the On-Call Administrator.

(1) The use of specialized safety clothing is usually authorized when a person presents such imminent risk of self-harm that use of regular garments poses a specific and documented risk. Use of safety clothing is not permitted based on historical risk factors alone.

(2) 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.

(3) 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.

(4) 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.

(5) Any safety clothing that meets the definition of restraint must be treated as such and the requirements will apply which are stated in Children and Families Operating Procedure 155-21, Use of Restraint in Mental Health Treatment Facilities.

e. Specific dorm/ward/unit staff members on each shift will 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 an outside facility for an extended period of time, no ward/unit staff members will be assigned 1:1 or 2:1 observation more than four (4) consecutive hours during any shift or period of consecutive shifts. The Nurse Supervisor or designee must approve exceptions to this.

f. A registered nurse will place a suicide precaution sticker on the chart of any resident assigned to suicide precautions. Facilities using electronic medical records will have a warning displayed to all users accessing the record that suicide precautions are active. The names of residents on suicide precautions will be placed on any daily clinical management report completed by the facility.

g. If it is determined necessary, the resident will be assigned to 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.

h. Residents on suicide precautions may be required to use special dining utensils as needed to reduce risk of self-injury from cutlery. These precautions must be outlined in the clinical order.

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

j. Toileting and Bathing. Individuals who are on One-to-One (1:1), Two-to-One (2:1), CVO, or GO, must be maintained on observation 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, dorm/ward/unit staff will be mentored and trained by their supervisors, to ensure that continuous, vigilant observation is carried out with dignity and respect.

k. Training. All employees upon initial orientation shall receive training in treating and managing residents who are suicidal or self-injurious. Health care practitioners and other disciplines or staff attending to the needs of residents shall participate in annual training which should be updated when indicated.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

WENDY SCOTT
Director, State Mental Health Treatment Facilities, Policy and Programs

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

Revised paragraph 2 to include selected residents at the Florida Civil Commitment Center; revised paragraphs 4a to replace the professional title of Advanced Registered Nurse Practitioner (ARNP) with the professional title of Advanced Practical Registered Nurse (APRN), and throughout the operating procedure; deleted the definition of Clinical Risk Assessment Guide (CRAG); added paragraph 4c defining PHQ-9 Patient Depression Questionnaire; added paragraph 4e defining Recovery Team; added paragraph 4f defining Registered Nurse (RN) and noted RN's ability to administered Columbia scale in the absence of a clinician; added paragraph 4h defining Suicide Attempt; combined paragraphs 6a and 6b and made wording changes; renumbered paragraph 6c to 6b, and renumbered paragraph 6d to 6c; added two signs of increased risk to paragraph 6c, and noted which signs are dynamic and which are static; deleted details on levels of observation in paragraph 7, and referenced CFOP 150-26 for specifics on observations; added paragraph 8b(6) establishing procedures for signing and labeling orders; added paragraph 8b(7) providing procedures for processing orders when the clinician is not on-site; revised paragraph 9e(3) regarding obtaining authorization outside of regular work hours; added wording to paragraph 9f; changed paragraph 10a to allow trained RN to administer the C-SSRS in the absence of a clinician; added paragraph 10k; and, added paragraph 11k.