

PROCTOCOL FOR: Violence, Risk: Self-Directed: Care of the Patient

POLICY: All patients admitted to inpatient psychiatric units will be evaluated on admission and at least every 8 hours (while patient is awake) for risk to self.

DESIRED PATIENT

- OUTCOMES:**
1. The safety of the patient will be maintained.
 2. The patient will verbalize feelings in place of acting upon impulses.
 3. The patient will begin to use more appropriate coping skills.
 4. The patient will identify stressors or triggers leading to self-harm.

**CLINICAL
ASSESSMENT AND**

- CARE:**
1. The following criteria will be considered when assessing patient for self-destructive behavior:
 - a. self-destructive ideation/behavior
 - b. plan, means of carrying out plan, lethality
 - c. intent
 - d. prior history of self-destructive behavior
 - e. level of impulsivity
 - f. ability to utilize alternative coping strategies
 2. Based on the outcome of the risk assessment, an appropriate status level will be assigned and the RN will review the status level with the admitting MD.
 3. Assessment of self-destructive behavior will be conducted a minimum of every shift or more frequently according to patient need.
 4. Assess patient's ability to approach staff when experiencing self-destructive thoughts or prior to acting upon them.
 5. Evaluate need for staff member to remain with patient while other interventions are being considered.
 6. Place on 15-minute checks or higher status if clinically indicated.
 7. Notify physician.
 8. Institute appropriate safety measures as indicated, based upon patient's level of self-destructive thoughts and behaviors:
 - a. Sharp restrictions (must be supervised by staff when utilizing sharps and/or sharps allowed).
 - b. Confiscate potentially harmful items from patient's possession.

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- c. Restriction to center circle.
 - d. Place patient in hospital attire.
 - e. Private room.
 - f. Constant observation.
 - g. One-to-one.
 - h. Locked door seclusion.
 - i. Restraints.
9. Less restrictive interventions will be utilized as patient demonstrates improvement in symptoms.

**PATIENT
TEACHING:**

1. Educate patient to approach and utilize staff when experiencing self-destructive impulses.
2. Educate patient to rationale for use of more supportive interventions: (1. center circle, 2. time out, 3. private room, 4. seclusion, and 5. restraints.)
3. Educate patient to expected behaviors to progress to less restrictive interventions.
4. Initiate education of more appropriate coping skills:
 - a. verbalizing feelings
 - b. journaling
 - c. distraction
 - d. relaxation

DOCUMENTATION:

1. Complete initial assessment of self-destructive ideation/behavior on interdisciplinary database and High Risk Assessment Form.
2. Document as indicated, in the progress note, any change in the severity of self-destructive behavior.
3. Document any safety interventions initiated and patient's response to interventions.
4. Document on 15-minute checklist as indicated.
5. Document use of 1. center circle, 2. time out, 3. private room, 4. Constant Observation, 5. One-to-One, 6. Seclusion, and 7. Restraints in Progress Notes and Flow Sheet.
6. Document behavior each shift in Progress Notes and on Flow Sheet.

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7. Document any patient/family education on Patient and Family Teaching Record and/or in Progress Notes and on Flow Sheet.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 4/90

REVISION DATES: 2/92, 12/96, 6/99, 10/00, 10/03, 6/06, 8/08