	Policy Name: ED Suicide Screening, Risk Assessment and Interventions	
	Department/Service Line: Emergency Services	Policy Identifier: BUMC.NUR.S.ED.17.P
Location: BUMC-Dallas	Origination Date: 10-24-12	Date of Last Review: 10-13-2014
Approved By: Claudia Wilder, RN, DNP		

SCOPE

This policy applies to Emergency Department (ED) staff caring for patients with behavioral health emergencies and substance abuse who come to the ED at Baylor University Medical Center seeking care

PURPOSE

To provide guidelines for ED staff caring for patients when there is a reasonable risk the patient may endanger themselves.

POLICY

1. Baylor EDs implement suicide screening, risk assessment and special procedures/interventions for patients at risk of harm to self or others.

2. Each patient presenting to the ED with psychiatric symptoms must have an appropriate medical screening examination (MSE) suitable for the symptoms presented.(See policy –Medical Screening Exam in the ED)

3. Situations involving patients at risk of self harm and high risk for medical deterioration are to be addressed based on clinical assessment and existing medical/nursing procedures applicable to the patient's condition.

4. An individual presenting to the ED is screened initially by a Registered Nurse (RN) for imminent risk of harm to self or others.

5. The RN completes a Suicide Risk Assessment (see Attachment 1) on patients who screen positive for risk of self harm.

6. Based on the Suicide Risk Assessment, the RN indicates high, moderate or low risk for suicide or self harm. Nursing staff environment initiate the Safe Environment Checklist for patients at moderate or high risk of self harm.

7. The assessment findings of the initial and ongoing assessments for suicide risk are communicated to the ED provider or admitting physician and treatment team and are documented in the patient's health record.
   a. Documentation includes statements, behaviors, and circumstances that prompted the clinician to perceive the patient to be at risk, as well as clinical assessment findings.

8. All patients assessed by the nurse to be at moderate or high risk for suicide or risk of harm to self or others will have continuous observation by a sitter
    a. It is the responsibility of the nurse caring for the patient to ensure the patient is under observation at all times.
    b. Staff members designated to provide observation will be instructed as to their role responsibilities.
    c. If resources are not available for observation, inform nursing chain of command immediately to request additional resources.
    d. Visitors may be restricted for patients under involuntary detention (APOWW) and patients assessed as moderate or high risk for suicide or risk of harm to self or others. The RN will document the reason visitors were restricted, as well as the time the restriction began and ended, based on the patient's assessment. (See Patient Rights and Visitation Policies). Family will not to be utilized for observation of patients at risk for suicide or self harm.
    e. It is the responsibility of the nurse caring for the patient to notify Baylor Public Safety and document the date and time this notification occurred in the patients chart.
    f. It is the responsibility of the nurse caring for an APOWW patient to document that a law enforcement officer was present at the patient's bedside.
9. Monitoring is continued according to the patient's needs until stabilized, admitted or appropriately transferred.

10. Behavioral restraints may be utilized during observation only if less restrictive interventions have failed to manage risk of self harm. Restraints may be applied in accordance with Baylor policy. (See Restraint Management Policy).

11. The ED provider or admitting physician will review the Suicide Risk Assessment and evaluate the patient to determine the need for a Mental Health Specialist. If a need is determined, the provider will write an order to consult a Mental Health Specialist.

12. If the patient has received Medical Clearance from the ED provider and the patient requires continuing care at a psychiatric facility, a transfer will be initiated. (See Transfer Process Policy).

13. If the patient agrees to a Voluntary Commitment and then later wants to leave the ED prior to transfer, Baylor Public Safety is notified for assistance.

14. If the decision to admit the patient is made, ED leadership and Nursing Administration will make the necessary determination(s) regarding location of the patient and type of sitter assigned responsibility for providing appropriate observation of the patient.

15. If an involuntary detention order (APOWW) is in place, the patient is not to leave the ED/hospital under any circumstances except as a transfer to an inpatient psychiatric facility. Law Enforcement will be asked to remain with the patient. Baylor Public Safety may be called for assistance. A sitter will also be provided.

16. If the decision to discharge home from the ED is made, home care instructions with appropriate referrals and Suicide Hotline information will be provided.

DEFINITIONS

When used in this Policy these terms have the following meaning:

Observation: The provision of a member of the hospital's staff to be in constant attendance in the patient's room and in close proximity to the patient, even during bathroom use (patient will be accompanied by appropriate staff). The staff member must have a clear and unobstructed view of the patient at all times.

Involuntary Detention Order - Also known as Apprehension by Peace Officer without Warrant (APOWW) from (TEX HS. CODE ANN. § 573.001: Texas Statutes - Section 573.001): The practice of using legal means as part of the Texas law to commit a person to a psychiatric facility or the like against their will or over their protests for observed behavior constituting a clear and present danger to the individual and/or others. This may include actual or attempted substantial self-injury, attempted or inflicted serious bodily harm to another, acting in a manner that indicates that the person may not be able to care for him/her self without assistance, attempting suicide or showing high risk of suicide. Such behavior must have occurred in the past 30 days. An on-duty licensed Peace Officer for the State of Texas makes the determination to enact an APOWW.

Medical Clearance: The process required to reach the point, with reasonable clinical confidence, at which any remaining medical problems can be treated on an outpatient, non-emergent basis. This is the point at which it is medically appropriate to discharge the patient from either the ED or transfer to a psychiatric facility.

Mental Health Specialist: A specially trained clinician who evaluates the patient in order to recommend appropriate mental health treatment and/or disposition.

Suicidal Behavior/Thoughts: A spectrum of activities related to self reported thoughts and behaviors that include suicidal thinking, suicide attempts, and successful suicide.

Voluntary Commitment: The act or practice of a person going into a psychiatric facility or the like voluntarily and without the process of Involuntary Commitment. Admission is based on the determination of a psychiatrist that this level of care is needed.

PROCEDURES

These Procedures are to be followed, however, they are not meant to be a substitute for professional judgment when assessing and treating patients.

1) Suicide Screen:
   a) ED RN screens all patients >14 years old for imminent risk of harm to self or others by asking the following questions:
      Q1 - In the past two weeks, have you felt hopeless or depressed?

Q2 - Are you thinking of harming yourself now?

b) ED RN screens all patients ≤14 years old for imminent risk of harm to self or others by asking the child and/or parent the following questions:
Q1 - Have you or your child experienced bullying?
Q2a - Do you or your child feel sad most of the time?
Q2b - If yes, have you or your child felt this way for two weeks or more?
Q3 - Are you concerned that you or your child is at risk to harm yourself/ himself/ herself or others?

2) Suicide Risk Assessment (Attachment 1):
   a) A patient who presents to the ED with a suicidal gesture with intent to harm self or others will automatically be assessed as HIGH risk.
   b) A Suicide Risk Assessment will be conducted for any patient >14 years old with YES answer to Screening question 1 or 2 (Q1 or Q2).
   c) A Suicide Risk Assessment will be conducted for any patient ≤14 years old with YES answer to Screening question 2a, 2b, or 3 (Q2a, Q2b, or Q3).

3) Safety of environment and patient:
   a) Nursing staff will oversee the preparation of a safe environment for the patient using the Safe Environment Checklist (See Attachment 2).
   b) Medical equipment/supplies needed for patient monitoring or care may remain in the patient room based on specific patient medical needs. The reason for equipment and supplies remaining in the room is documented in the medical record.
   c) Observations and assessments including changes in the patient's behavior, are communicated to nurse and provider and are documented in the patient's health record.
   d) Sitters and other hospital staff will have documented education on role and expectations.

4) Admission:
   a) Handoff communication to the receiving nurse will include Suicide Risk Assessment findings and precautions in place.

5) The RN will document the following:
   a) Suicide risk screening for all patients
   b) Suicide risk assessment for patients who screen positive for risk
   c) Measures provided for patient and environmental safety
   d) Presence of sitter with patient
   e) Presence of law enforcement officer with patient
   f) Level of observation for moderate and high risk patients
   g) Presence of APOWW
   h) Notification to Baylor Public Safety for any patient with APOWW who leaves treatment area while in custody
   i) Provision of suicide prevention home care instructions, appropriate referrals, and Suicide Hotline information for patients discharged as LOW risk.

6) Compliance with policy

a) ED nursing leadership will monitor compliance with this policy and enact appropriate measures for improvement as needed.

REFERENCES

Texas Health and Safety Code - TEX HS. CODE ANN. § 573.001: Texas Statutes - Section 573.001 – (Definition of APOWW)

RELATED INTERNAL DOCUMENTS

Document Identifier	Document Name
BUMC.NUR.S.GEN.02.P	Restraint Application for Non-Violent and Violent/Self Destructive Behavior
BUMC.NUR.S.ED.12.P	Medical Screening Exam (MSE) in the ED policy

ATTACHMENTS

Document Identifier	Document Name
BUMC.NUR.S.ED.17.A1	Suicide Risk Assessment Tool
BUMC.NUR.S.ED.17.A2	Safe Environment Checklist

Attachment Name:
Suicide Risk Assessment Tool
Attachment Identifier: BUMC.NUR.S.ED.17.A1
Date of Last Review: 10-13-2014

SUICIDE RISK ASSESSMENT		
Ask questions that are bolded and underlined. The remaining information is for staff only.	YES	NO
Ask questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***In the past week, have you wished you were dead, or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent or plan. ***In the past week, have you had any actual thoughts of killing yourself?***		
If YES to 2 Ask Question 3.		
3) Suicidal Thoughts with method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period This is different than a specific plan with time, place, or method details worked out *"I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it and I would never go through with it "* ***In the past week, have you been thinking about how you might do this?***		
If NO to 2 or NO to 3, skip to Question 6 and stop there If YES to Question 3, ask Question 4 and 5, Do NOT ask Question 6		
4) Suicidal Intent (without specific plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***In the past week, have you had these thoughts and had some intention of acting on them?***		
5) Suicidal Intent With Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out, and person has some intent to carry it out. ***In the past week, have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything with any intent to die?*** Examples: Attempt. Took pills, shot self, cut self, jumped from a tall place; Preparation: Collecting pills, getting a gun, giving valuables away, writing a suicide or goodbye note, etc.) **If YES, ask:** ***How long ago did you do any of these?*** **( ) More than a year ago? ( ) Between a week and a year ago? ( ) Within the last week?**		

Baylor University Medical Center

II. Response Protocol to C-SSRS Screening (Linked to last item answered YES)
Item 1 –Low risk - Mental Health Referral at Discharge, Provider notification
Item 2 –Low risk - Mental Health Referral at Discharge, Provider notification
Item 3 –Moderate risk - Psychiatric Consultation and Patient Safety Monitor/Procedures
Item 4 –Moderate/High risk - Psychiatric Consultation and Patient Safety Monitor/Procedures
Item 5 - Moderate/High risk - Psychiatric Consultation and Patient Safety Monitor/Procedures
Item 6 –Low risk - If more than a year ago, Mental Health Referral at discharge, Provider notification
If between 1 week -1 year ago –Moderate risk - Psychiatric Consultation and Patient Safety Monitor
If one week ago or less –High risk - Psychiatric Consultation and Patient Safety Monitor

Nurse signature_______________________ Date__________ Time __________

Attachment Name:
Safe Environment Check List

Attachment Identifier: BUMC.NUR.S.ED.17.A2

Date of Last Review: 10-13-2014

Date.					
Time·					
Hospital Staff / Sitter / Close Observation	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Law Enforcement Personnel Custody / Close Observation	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Minimize proximity of room assignment from department exits	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Staff must be aware and have the means to unlock bathroom doors	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
ROOM PREPARATION / MONITORING:	**Document location of items removed**				
Check if cupboards/drawers are locked or empty	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Remove oxygen tubing/ flow meter	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Remove suction tubing/ vacuum control	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Remove phone from room	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Remove all plastic trashcan or biohazard liners and portable sharps containers, remove plastic bags of any kind	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Remove any other items that might be used to cause self-inflicted harm (be sure to check closets, cabinet/cupboards and drawers)	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Place sign on door for family/sitters/staff to check with nurse prior to entry	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
PATIENT PREPARATION / MONITORING:					
Inform patient of need to remove identified potentially harmful, personal items for patient's safety (may include shoe laces, pants with drawstring, belts etc)	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Patient belongings documented and removed for safety, document on patient valuables list.	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Disposable tray for meals (order radiation tray)	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
VISITOR EDUCATION					
Discuss need to restrict any items into the room that might be potentially harmful to the patient	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Visitors are not utilized as observers	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Initials of RN/Sitter/UAP completing document					

Printed Name	RN/Sitter/UAP Signature and Title	Initials

This document is part of the permanent record

Last revised 10 2014

Baylor University Medical Center at Dallas

Attachment Name:
Suicide Risk Assessment Tool

Attachment Identifier:
BUMC.Nurs.SED.17.A1

Date of Last Review:
Oct, 2014

SUICIDE RISK ASSESSMENT		
Ask questions that are bolded and underlined. The remaining information is for staff only.	YES	NO
Ask questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***In the past week, have you wished you were dead, or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts. General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent or plan. ***In the past week, have you had any actual thoughts of killing yourself?***		
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Item 6 –Low risk - If more than a year ago, Mental Health Referral at discharge, Provider notification
If between 1 week -1 year ago –Moderate risk - Psychiatric Consultation and Patient Safety Monitor
If one week ago or less --High risk - Psychiatric Consultation and Patient Safety Monitor

Nurse signature______________________________________ Date__________ Time __________

BAYLOR
University Medical Center
at Dallas

Attachment Name:
Safe Environment Check List

Attachment Identifier:
BUMC.Nurs.SED.17.A2

Date of Last Review:
Oct, 2014

Date.					
Time.					
Hospital Staff / Sitter / Close Observation	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Law Enforcement Personnel. Custody / Close Observation	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Minimize proximity of room assignment from department exits	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Staff must be aware and have the means to unlock bathroom doors	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
ROOM PREPARATION / MONITORING:	**Document location of items removed**				
Check if cupboards/drawers are locked or empty	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
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Remove suction tubing/ vacuum control	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Remove phone from room	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Remove all plastic trashcan or biohazard liners and portable sharps containers, remove plastic bags of any kind	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Remove any other items that might be used to cause self-inflicted harm (be sure to check closets, cabinet/cupboards and drawers)	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Place sign on door for family/sitters/staff to check with nurse prior to entry	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
PATIENT PREPARATION / MONITORING:					
Inform patient of need to remove identified potentially harmful, personal items for patient's safety (may include shoe laces, pants with drawstring, belts etc).	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Patient belongings documented and removed for safety, document on patient valuables list.	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Disposable tray for meals (order radiation tray)	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
VISITOR EDUCATION					
Discuss need to restrict any items into the room that might be potentially harmful to the patient.	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Visitors are not utilized as observers	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Initials of RN/Sitter/UAP completing document					

Printed Name	RN/Sitter/UAP Signature and Title	Initials

This document is part of the permanent record

Last revised 10 2014

Date of Review: 10/17/2014

Patient Name:	
Account No:	
Date of Service:	
ED RN:	
ED Providers:	
ED Supe/CHG RN (at arrival):	

Quality Flag:

☑ Suicide Screen Positive

☐ APOWW

☐ Review Requested by: ____________

Timeline:

Arrival	______			
Bed Placement	______			
Suicide Screen Positive?	☑ Yes	☐ No		
Suicide Risk Assessment Done?	☐ Yes	☐ No		
Suicide Risk Assessment	☐ Low	☐ Mod	☐ Mod/High	☐ High
Time of Risk Assessment	______			
Time Provider Notified	______			
Name of Provider	______	Arrival to Bed:	0:00	
Time Sup/CHG RN Notified	______	Arrival to Risk Assessed:	0:00	
Name of Supe/CHG RN	______	Length of Stay:	hrs	
Time of Sup/CHG RN Rounding	______			
Time Safe Env. Checklist Complete	______			
Time Sitter Present	______			
ne of APOWW	______			
e BPD Notified if APOWW	______			
Time Law Enf. Present if APOWW	______			

Dispo Location ☐ ADM ☐ DC ☐ Transfer ☐ LWBS ☐ Eloped

Outpt. Referrals Given for DC ☐ Yes ☐ No ☐ NA

Psych DX included in ADM DX ☐ Yes ☐ No ☐ NA

Opportunities for Improvement:

RN follow up: ____

ED RN Signature: Date: ED Supervisor Signature: Date:

Provider follow up: ____

ED Provider Signature: Date: ED QI MD Signature: Date:

PHYSICIAN REVIEW:

☐ Refer to ED Peer Review Committee

☐ SOC Met

ED Q RN: M. Early, RN

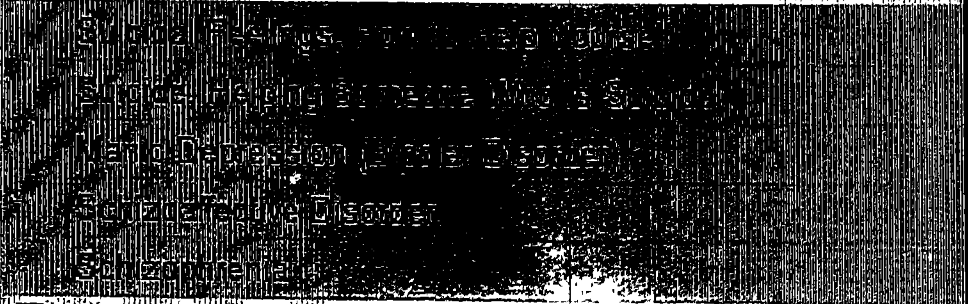
20 7_me

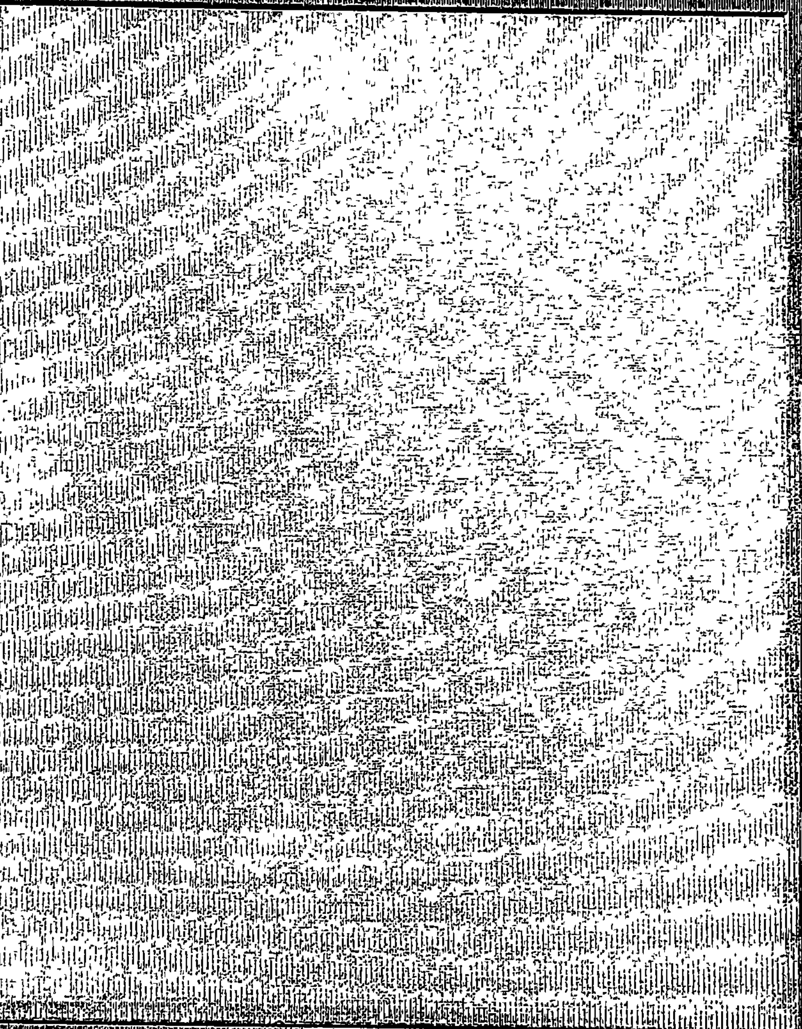
A message from Bradley T. Lembcke, MD, MBA
Chief Medical Officer, Baylor University Medical Center
October 10, 2014

..plying with the Medicare Conditions of Participation, Joint Commission Standards, BUMC Bylaws and Rules and Regulations, and Hospital Policies related to the Medical Staff is not optional. It is mandatory. Our upcoming CMS surveys will be looking to confirm this compliance. To assure continual readiness for these upcoming CMS surveys, we will be focusing on several areas where the Medical Staff at times is deficient. Areas of focus are as follows:

- **All Verbal orders must be signed with 48 hours.**
- **All Restraint orders must be signed within 24 hours.**
- **H&P's must be documented within 24 hours of admission.**
- **H&Ps must have specific components:**
  - Chief complaint
  - Details of present illness
  - Allergies
  - Medications
  - Relevant past, social and family histories (appropriate to the patient's age)
  - Inventory of body systems
  - Physical examination, including pertinent laboratory tests and imaging studies
  - Impression
  - Plan
- **Current H&Ps or updates must be complete and on the chart prior to going into the OR:**
  If a history and physical has been documented within the last thirty (30) days, it may be used in conjunction with an admission note which updates the history and physical. Both documents shall be recorded and signed in the patient's medical record no later than twenty-four (24) hours after admission or prior to procedure, whichever comes first.
- **All documents need to be co-signed within 48 hours**
- **Immediate Post Op notes must be documented prior to the patient moving to the next level of care unless the complete Operative report is documented in Allscripts.**
  Post Op Note Components
    a. The name(s) of the primary surgeon(s) and his or her assistant(s)
    b. Procedure performed
    c. Findings of the procedure
    d. Estimated blood loss
    e. Specimens removed
    f. Postoperative Diagnosis
- **Operative Reports must be dictated within 24 hours of procedure/operative episode.**
  Operative Report Components
  - The name of the licensed independent Practitioner who performed the procedure and his/her assistant
  - The name of the procedure performed
  - Findings of the procedure
  - Any estimated blood loss
  - Any specimen removed
  - Postoperative diagnosis
  - Detailed description of the procedure
- **Consents must be complete prior to going into the OR**
- **Do NOT Use abbreviations**
- **Wash your hands before you enter a patient room and when you leave**
- **Participate in the procedural Time Outs**
  When physicians log in to Signature Manager in Allscripts they need to use the following criteria to ensure they sign everything:
  - Start Date: Earliest Available, Stop Date: Latest Available
  - Item Type Filter: Orders and Documents
  - Item Status Filter: Active and Incomplete

Disposition
Search
Suggested
All Documents
Prescriptions
Search


Language: English
Discharge Instructions
Discharge Summary Sheet
Resources
Substance Abuse
Mental Health Resources
Counseling Resources
Notes
Preview
Fax
Pharmacy
OK
Cancel



Policy Name:
Restraint Application for Non-Violent and Violent/Self Destructive Behavior

Department/Service Line:
Nursing

Policy Identifier:
BUMC.Nur.SGen.02.P

Location:
Dallas-BUMC

Origination Date:
05/2010

Date of Last Review:
8-15-14

Approved By:
BHCS CNO Council; Claudia Wilder, DNP, RN, VP-CNO

SCOPE

This policy applies to Baylor clinical staff caring for patients who may require the use of restraints during their care. This policy does not address seclusion as a means of restraint.

PURPOSE

To guide clinician use and management of restraints, protect patient rights and promote patient safety during restraint use.

POLICY

1. Baylor policy is to create an environment that protects the patient's right to be free from restraint, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff and as such adheres to the following guidelines:

   A. Decision to use a restraint is not driven by diagnosis, but by a comprehensive individual patient assessment.

   B. Use of restraint is specific to patient behavior that restraint is being used to address:
      1) Non-Violent Behavior – preventing or disrupting planned treatment or care (example-patient is pulling tubes and trying to disconnect from a ventilator)
      2) Violent/Self-Destructive Behavior (example-patient is violent, hitting staff or peers, and is a danger to self or others)

   C. Restraints are initiated in accordance with an order from the physician responsible for the care of the patient.

   D. Restraints are initiated by trained staff to ensure immediate physical safety of the patient or others and are discontinued at the earliest possible time.

   E. The type of restraint is the least restrictive intervention that will be effective.

   F. Alternatives to restraint will be considered first.

G. Patient's right, dignity, physical and psychological well-being is preserved at all times during restraint use.

H. Leadership is responsible for creating a culture that supports a patient's right to be free from restraint and ensures systems and processes are developed, implemented, and evaluated to support patient rights and eliminate inappropriate restraint use.

2. Physician Order Guidelines

A. Non-Violent and Violent/Self-Destructive Behavior Restraint Orders:
- Order must be obtained prior to application of restraint or obtained immediately afterwards (within minutes) in emergency situation
- Specify maximum length of time (time limited) order is valid (see table below)
- Specify restraint type
- Include clinical justification/reason
- Signed, dated, and timed by ordering physician. If telephone order obtained, the order must be dated, timed and signed within 48 hours by ordering physician.

Non-Violent Behavior	**Violent/Self Destructive Behavior**
• Order is in effect for up to 48 hours	• Order is in effect for up to : o 4 hours for adults age 18 and older o 2 hours for children and adolescents ages 9 to 17 o 1 hour for patients under age 9 • If patient remains in restraint 24 hours, physician must see patient and conduct a face-to-face re-evaluation (see Special Assessment Requirement below) before writing a new order for continued restraint use.

1. Non–Violent and Violent/Self-Destructive Behavior Restraint orders are not:
   - Written as needed (PRN), standing or protocol orders
   - Discontinued if the restraint is released temporarily for the purpose of patient care needs; such as toileting, feeding and range of motion exercises.
2. Special Considerations
   - If restraint is discontinued prior to original order expiration, a new order must be obtained prior to restarting restraint use.
   - Attending physician or covering physician must be consulted as soon as possible if attending physician did not order restraint

B. Violent/Self-Destructive Behavior Patients (Face-To-Face Evaluation) Special Assessment Requirement

1) Physician or Advance Practice Registered Nurse (APRN) will conduct a face-to-face patient evaluation in person within 1 hour after restraint initiated. A telephone call or telemedicine method is not permitted.

2) If patient's violent or self-destructive behavior resolves and restraint is discontinued before physician or APRN arrives to perform face-to-face evaluation, physician or APRN is still required to see patient face-to-face and conduct evaluation within 1 hour after restraint initiated.

3) This face-to-face evaluation requirement applies when a medication is used as a restraint to manage violent or self-destructive behavior.

3. Monitoring and Assessment of Patient in Non-Violent and Violent/Self-Destructive Behavior Restraint(s)

Non-Violent Behavior
• Each patient is assessed to evaluate initial need for restraint, on-going need for restraint, readiness to discontinue restraint, and that restraint type is safe and appropriate.
• Each patient will receive a comprehensive initial assessment prior to restraint application.
Visual Checks: Every 1 hour
Monitoring will be completed every two (2) hours or based on patient's condition or cognitive status to include: a) Hygiene/toileting b) Skin/circulation c) Repositioning d) Hydration/feeding e) Range of motion/removal of restraint, one at a time
Reassessment will be done every four (4) hours or based on patient's condition or cognitive status. Reassessments include patient's behavior; need to continue restraint use and significant changes in patient's condition.

Violent/Self Destructive Behavior
• Each patient is assessed to evaluate initial need for restraint, on-going need for restraint, readiness to discontinue restraint, and that restraint type is safe and appropriate.
• Each patient will receive a comprehensive initial assessment prior to restraint application.
Visual Checks: Every 15 minutes
Monitoring will be completed every two (2) hours or based on patient's condition or cognitive status to include: a) Hygiene/toileting b) Skin/circulation c) Repositioning d) Hydration/feeding e) Range of motion/removal of restraint, one at a time

Reassessment will be done every four (4) hours or based on patient's condition or cognitive status.

Reassessments include patient's behavior, the need to continue restraint use and when there are significant changes in patient's condition.

4. Restraint Documentation for Non-Violent and Violent/Self Destructive Behavior in patient's health record
    a. Individual patient assessment and reassessment
    b. Any alternatives or other less restrictive interventions attempted
    c. Orders for restraint
    d. Notification of physician regarding restraint use
    e. Patient's condition, symptom(s) that warranted restraint use and intervention used
    f. Patient's response to intervention(s) used, including rationale for continued use of intervention
    g. Monitoring every 2 hours
    h. Modifications to patient's plan of care
    i. Injuries to patient
    j. Death associated with restraint use
    k. Criteria met for discontinuation of restraint
    l. Education provided to patient and family

Violent/Self Destructive Behavior Face to Face Assessment Documentation would include at a minimum, but not limited to, the following:

- History
- Behavioral Assessment
- Review of systems assessment
- Medications
- Recent test results

5. Discontinuation of Restraint

    A. Discontinue at earliest possible time, regardless of time length identified in order.
    B. Document discontinuation criteria met.
    C. RNs involved in patient's care are authorized by this policy to determine whether or not restraint(s) should be discontinued.

6. Training and Education Requirements

    A. Baylor staff, including contract or agency personnel, who provide direct care for patients who may be restrained will demonstrate competency in restraint application, monitoring, assessment, and providing care for a patient in restraints. This training and education will be documented and consistent with the scope of the individual's care delivery role.
        1. Before performing any action described in this policy
        2. As part of orientation; and

3. On a periodic basis thereafter based on: new/revised procedures, policies, equipment, technologies, initiatives, or new data (e.g. quality improvement, event reports, surveys)

B. Physician and APRN Education and Training on restraint use will include, at a minimum, a working knowledge of this policy. This training may include, but not necessarily be limited to, the following:
1. Patient's rights regarding restraint use
2. Prohibitions on restraint use
3. Ordering requirements
4. Documentation requirements; and
5. Time frames for patient assessment

7. Reporting Death Requirements

A. Baylor will report the following information to the Centers for Medicare and Medicaid Services (CMS) Regional Office by telephone, facsimile, or electronically by close of business on the next business day following knowledge of the patient's death for:
1. Each death that occurs while a patient is in restraint
2. Each death that occurs within twenty-four (24) hours after the patient has been removed from restraint
3. Each death that occurs within 1 week after the use of restraints, where it is reasonable to assume that restraint use contributed directly or indirectly to the patient's death. "Reasonable to assume" in this context includes, but is not limited to deaths related to:
a. Restrictions of movement for prolonged periods of time
b. Chest compression
c. Restriction of breathing or asphyxiation

Exception: When the only restraint used on the patient is 2-point, soft, cloth- like non rigid wrist restraints, the death does not need to be reported to CMS.

B. CNO will maintain an internal log on:
1. Any death that occurs while a patient is in 2-point, soft, cloth-like non rigid wrist restraints
2. Any death that occurs within twenty-four (24) hours after the patient has been removed from 2-point, soft, cloth-like non rigid wrist restraints

C. The internal log will meet the following requirements:
1. Each entry must be made no later than seven days after the date of death of the patient
2. Each entry must include the patient's name, date of birth, date of death, name of attending physician, medical record number and primary diagnosis
3. The information must be made available in either written or electronic form to CMS immediately upon request

D. The following will be documented in patient's medical record:

1. Date and time death was reported to CMS
2. Time and date death was recorded in the internal log

8. Audit and Monitoring Requirements:

Organizational quality assurance and improvement will include a program that audits and monitors restraint use.

DEFINITIONS

When used in this Policy these terms have the following meaning:

Physical Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

Chemical Restraint: A medication when used to manage patient behavior or restrict patient freedom of movement and is not a standard treatment or dosage for patient's medical condition.

a. Medications that comprise a patient's medical regimen including PRN medications are not considered chemical restraints if:
   i. Approved by United States Food and Drug Administration (USFDA) and used in accordance with approved indications and label instructions, including listed dosage parameters
   ii. Use follows national practice standards established or recognized by medical community and/or professional medical association or organization; and
   iii. Used to treat patient's specific clinical condition and is based on that patient's symptoms, overall clinical situation, and on physician's knowledge of that patient's expected and actual response

PROCEDURES

1. The Registered nurse completes the "Report of Hospital Death Associated with Restraint" form for deaths specified in policy statement 7 A and 7B of this policy.
2. Give the completed form to the Chaplain who will take the form to nursing administration.
3. Nursing administration records the name, date and time of the form and maintains an internal log and/or reports the death to the Centers for Medicare and Medicaid Services (CMS) as appropriate.
4. Nursing administration faxes all completed forms to Health Information Management for documentation in the electronic health record.

REFERENCES

Centers for Medicare and Medicaid Service's (CMS) State Operations Manual
Appendix A: Conditions of Participation & Interpretive Guidelines
§482.13 – Condition of Participation: Patient Rights
§482.13(e) - §482.13(g) - Standard: Restraint or seclusion

The Joint Commission Comprehensive Accreditation Manual for Hospitals
Provision of Care, Treatment and Services Chapter
PC.03.05.01 – PC.03.05.19

RELATED INTERNAL DOCUMENTS

Document Number	Document Name
BHCS.PubSafe.500-01.P	Forensic Patients and Orientation of Forensic Staff (Law Enforcement)

ATTACHMENTS

Attachment Number	Attachment Name
BUMC.NUR.SGen.02.A	Examples of Restraints and Non Restraints

IS a Restraint if it deliberately restricts freedom of movement	**Is NOT a Restraint** if it does not intentionally restrict voluntary movement
Manufacturer products designed to restrain a patient	Mechanical Support: When used to achieve proper body position, balance, or alignment to allow greater freedom of mobility than would be possible without its use
Vest, Wrist or Ankle Restraints, Belt that cannot easily be removed by the patient	Positioning or Securing Device: a. When a medically necessary device is used to maintain position, limit mobility, or temporarily immobilize patient during medical, dental, diagnostic, or surgical procedures b. Recovery from Anesthesia: Devices used while patient is recovering from anesthesia in a critical care or post anesthesia care unit are considered part of the surgical procedure. c. Law Enforcement: Law enforcement officers who act to maintain control and/or custody of any individual outside this policy's scope and through law enforcement application are governed by Federal, State, and Department of Public Safety policies, rules and regulations. Use of such law enforcement application is considered a law enforcement action, not a healthcare intervention. Law enforcement officers may assist during application of appropriate healthcare restraint intervention when that assistance is at the direction of the medical staff. [see Forensic Patients and Orientation of Forensic Staff (Law Enforcement) policy]
Enclosure beds Chair with locking tray	Age or Developmentally Appropriate Protective Safety Interventions: Devices such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails
Four raised Side rails used to restrict the	Raised Side rails

IS a Restraint if it deliberately restricts freedom of movement	**Is NOT a Restraint** if it does not intentionally restrict voluntary movement
patients freedom to exit the bed	a. Used to protect patient from falling out of bed when on a stretcher, during transport, recovering from anesthesia or sedation, experiencing involuntary movement, or on certain types of therapeutic beds b. When side rails are segmented and all but one segment is raised so that patient can still freely exit bed c. When patient not physically able to get out of bed regardless of whether side rails are up.
Hand Mittens that are • pinned or attached to the bed frame or bedding • applied so tightly that the patient's hand or fingers are immobilized • so bulky that the patient's ability to use their hands is significantly reduced.	Hand Mittens that • do not meet the definition of a restraint • are easily removed by the patient
Tucking in sheets so tightly that patient cannot move	Wheelchair seat belt –when used during transport

Last/Org Name: psych   First Name:

Suggested | On Duty | Physician | On Call | Search

Name	Specialty
BUMC Psych Nurse-Meredith	Psychiatry

Consulting Physician:

Name

Registration | Chart | Orders | Disposition | Documents | Attachments | Events

Search: PSYCH

Common | RN Protocols | MD Workups | Search

Psych Workup

Psych/Tox Evaluation

Psych/Tox Treatment

Psychiatric Consult

Miscellaneous Medication - Non Formulary

Order	Status	Time
DAU (Drug Abuse - Urine) Screen	In Process Unspecified	1[illegible]6
CMP (Comprehensive Metabolic Panel)	Returned	14:46
ETOH (Alcohol Level)	Returned	14:46
EKG/Clerk	Completed	14:47
EKG/Tech	Completed	14:47
Salicylate (Aspirin) Blood Level	Reviewed	14:47
Acetaminophen (Tylenol) Blood Level	Returned	14:47
Monitor - NIBP (Non-Invasive Blood Pressure)	Completed	15:29
Monitor - Place On Cardiac Monitor	Completed	15:29
Monitor - Place On Pulse Ox	Completed	15:29
Oxygen - Protocol	Completed	15:29
Suicide Precautions	Completed	15:29

elv...
Pelv...
/Pelv...
ttack
T 2 Labs
RT Radiolog...

Key elements for physicians:

1) Review of suicide risk screen (low, medium or high)
2) Acknowledgement of risk assessment
3) Agreement or further assessment of risk after medical screening exam
4) For low risk discharges they must receive a behavior diagnosis at discharge AND community resources list
5) For admissions we must include a behavioral diagnosis, in addition to the medical diagnosis for admission

Signing verbal orders and completing medical records.

Hospital bylaws require that physicians:

a. Co-sign all orders within 48 hours
b. complete history and physical exam within 24 hours of admission
c. NOT use unapproved abbreviations
d. For admissions, when using residents or APPs, all admissions must have full attestation

We must adhere to each of these.

Please make all reasonable efforts to complete your charts and sign all orders prior to leaving shift. Or complete them within required time frames.

Any unsigned orders in Medhost "roll over" to Allscripts when the Medhost chart "locks" at 18 hours. These can only be signed off by logging into Allscripts

Fortunately Medhost and Allscripts can be accessed from anywhere via myBayloremr.com

To access Medhost, and Allscripts through myBayloremr.com: At top right side bar log into MyApps. The Medhost remote and Allscripts gateway links are both there

Questions & Answers:

1) **what and where are diagnosis and community resources?**

In discharge documents search for behavioral diagnosis (depression, schizophrenia, bipolar, drug abuse etc)
For resources search for substance abuse, mental health resources, concealing resources as appropriate
As you use this Medhost should begin to populate your preferences

2) **to whom shall we refer?**

Referral is to "private doctor", follow up is "as needed"

3) **do we need to include discharge behavioral discharge diagnosis and give community resources if this is not the primary diagnosis?**

Yes: Reviewers will be looking for overall care of ALL behavioral patients, not only transfers and primary behavioral complaints

Reminders:

A) Medication reconciliation must be completed

B) When sending to psychiatric facility IT MUST BE A TRANSFER. Do not discharge to inpatient setting (i.e. "go to Timberlawn/Green Oaks/PMH and check yourself in")

For transfers the MOT (memorandum of transfer), nurse to nurse, and doc to doc (except for Northstar inpatient-I believe) must be complete and documented.
If doc to doc was not required for transfer, as directed by psychiatric assessor, document it was not required

C) Each shift there must be documentation of transition of care and examination by physicians. Use safer sign out technique to review case, plan of care, diagnostics, planned disposition and complete face-to-face hand of while examining patient.

D) Treat patient appropriately for chronic medical conditions (DM, HTN, asthma, COPD, etc) while they are in department.

E) Consider re-starting or initiating appropriate psychiatric medications while in ED while we seek placement.

Report of Person Requesting Warrantless Apprehension
By Peace Officer

Physician Completes.

1. Person for whom warrantless apprehension is sought:

   Last Name______________________ First Name______________________

2. Do you believe the person is mentally ill? Yes☐ No☐

3. Why do you believe that the person's mental illness creates a substantial risk of serious harm to himself/herself or others if the person is not immediately apprehended? (√ all applicable boxes)
   - ☐ The person threatened or attempted suicide
   - ☐ The person threatened, attempted to seriously harm, or did seriously harm himself/herself
   - ☐ The person threatened, attempted to seriously harm, or did seriously harm another person
   - ☐ Evidence of severe emotional distress and deterioration in the person's mental condition to the extent that the person cannot remain at liberty
   - ☐ Other ____

4. Why do you believe the risk of harm is imminent (i.e., there is not sufficient time to obtain a warrant) unless the person is immediately transported to an appropriate mental health facility? (√ all applicable boxes)
   - ☐ Recent behavior of the person
   - ☐ Overt acts of the person
   - ☐ Attempts to harm himself/herself or another person
   - ☐ Threats to harm himself/herself or another person
   - ☐ Other ____

I personally witnessed or confirm these facts in writing and attest to these facts by my signature below.

Reporting Person (information below is required by Texas Health & Safety Code §573.001 or §573.002)

Last Name______________________ First Name______________________

Address: 3500 Gaston Avenue City: Dallas State: Texas Zip Code: 75246

Relationship to the person for whom warrantless apprehension is sought:______________________

Signature______________________ Date____________ Time__________

The responding peace officer may use the information on this form to fulfill some or all of the requirements for a warrantless apprehension. However, the responding peace officer must also complete a Peace Officer's Notification Of Emergency Detention form as part of the warrantless apprehension process.

PEACE OFFICER APPLICATION FOR EMERGENCY DETENTION WITHOUT WARRANT

(Pursuant to Texas Health and Safety Code: Title 7, Subtitle C, Chapter 573, Subchapter A)

OFFICERS PLEASE PRINT ALL INFORMATION

Pursuant to the Texas State Mental Health Code, the applicant ______________________________,
(OFC NAME & ID NUMBER)

a Peace Officer with the ____ makes this
(NAME OF DEPARTMENT)

application for the emergency detention of

____
(LAST NAME) (FIRST NAME) (RACE) (SEX) (DOB)

who was apprehended on the _____ day of ________________, 20_____ at _____ am/pm

at ____.
(ADDRESS/LOCATION OF APPREHENSION)

Emergency detention is sought for the following reasons:

(1) I believe there is not sufficient time to obtain a warrant before taking the person into custody;
(2) I have reason to believe and do believe that the person evidences mental illness;
(3) I have reason to believe and do believe that the person evidences a substantial risk of serious harm to him/herself or others;
(4) I have reason to believe that the risk of harm is imminent unless the person is immediately restrained;

(5) My above stated beliefs are based on the following specific recent behavior, overt acts, attempts or threats (*describe the person's behavior and the risk of harm the person presents*):

____

____

____

____

____

____

which were observed by me and/or reliably reported to me by ______________________________
(NAME OF REPORTING PERSON)

who is □ related □ unrelated to the person as follows______________________________________.
(REPORTING PERSON'S RELATIONSHIP/AFFILIATION)

Executed on this the ____day of ________,20___,at______________,___________,Texas
(City) (County)

____
SIGNATURE OF PEACE OFFICER

____

FOR FACILITY USE ONLY

·cepted for preliminary examination for emergency detention on the ____ day of _____________, 20____, at ______am/pm.

____
(Signature of Mental Health Facility Employee)

Revised 08/2009 White-MI Court Yellow- Mental Health Facility Pink- Applying Department