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. References:
   a. Florida Statutes, Chapter 394.459, Florida Mental Health Act, Rights of Patients
   b. Florida Statutes, Chapter 916.107, Mentally Deficient and Mentally Ill Defendants, Rights of Forensic Clients
   c. Children and Families Operating Procedure 155-3, State Mental Health Treatment Facilities Mortality Reporting and Review Procedure
   d. Children and Families Operating Procedure 155-25, Incident Reporting and Processing in State Mental Health Treatment Facilities
   e. Children and Families Operating Procedure 155-26, Safe and Supportive Observations of Residents
   f. Children and Families Operating Procedure 155-41, Environmental Risk Management in State Mental Health Treatment Facilities
   g. Children and Families Operating Procedure 155-53, Suicide and Self-Injury Prevention
   h. Children and Families Operating Procedure 215-1, Loss Prevention
   i. Children and Families Operating Procedure 215-6, Incident Reporting and Analysis System (IRAS)
   j. Florida State Hospital Operating Procedure 10-1, Critical Event / Incident s Reporting
   k. Florida State Hospital Operating Procedure 75-1, Resident Injury/Event Reporting
   l. Florida State Hospital Operating Procedure 151-1, Death of a Florida State Hospital Resident
   m. Florida State Hospital Operating Procedure 155-1, Freedom of Movement of Residents on Hospital Grounds
   n. Florida State Hospital Operating Procedure 155-22, Seclusion and Restraint Use in Psychiatric Crisis Management

This Operating Procedure supersedes: Operating Procedure 150-6 dated December 20, 2017
OFFICE OF PRIMARY RESPONSIBILITY: Psychology
DISTRIBUTION: See Training Requirements Matrix
3. Definitions:

a. Suicidal: A term used to identify the thoughts of a resident 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-Injury: A 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.

c. Specialized safety clothing: Clothing made of non-tear able 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 commercially ordered or fabricated at Florida State Hospital with permission from the applicable Assistant Hospital Administrator and Medical Executive 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.

d. Suicide attempt: A potentially lethal act which reflects an attempt by an individual to cause his or her own death as determined by a licensed mental health professional or other licensed healthcare professional.

e. Clinician: A Physician licensed pursuant to Chapter 458 or Chapter 459, F.S., Advanced Registered Nurse Practitioner (ARNP) licensed pursuant to Chapter 464, F.S., Physician Assistant licensed pursuant to Chapter 458, or Clinical Psychologist licensed pursuant to Chapter 490, F.S. and currently credentialed within the Florida State Hospital Professional Clinical Staff.

f. Colombia-Suicide Severity Rating Scale (C-SSRS). An assessment instrument to differentiate the domains of suicidal ideation and suicidal behavior. The instrument measures four constructs: severity of ideation; intensity of ideation subscale; behavior subscale; and lethality subscale.

g. Clinical Risk Assessment (CRA). An assessment tool that provides areas to consider and report on when assessing a resident’s risk of harm to self or others in the facility. The CRA also includes some items related to medical risks. This assessment tool is an adjunctive tool which may assist clinicians in developing a more broad-based review of a resident’s status. The tool may also assist with tracking issues related to risk which need to be in recovery plans.

h. 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. There shall be no PRN orders for psychotherapeutic medication, seclusion, restraints or special observations.

i. Patient Health Questionnaire (PHQ-9). A brief nine item screener, which has also been proven to be useful in the identification of depression and its response to treatment.

4. 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.
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.

5. Preventing Suicide and Self-Injury (Refer to CFOP 155-53):

   a. 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 through individual behavioral analysis as the initial step in planning effective services. Deliberate self-harm behaviors can result in severe injury or death.

   b. 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. Staff members need to be sensitive to the possibility of an individual's past victimization and the related fear of authority including difficulty relinquishing control.

   c. Executive Nursing Directors, Residential Service 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 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 (refer to CFOP 155-41).

6. Assessment of Risk (Refer to CFOP 155-53):

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

   b. Assessment of each resident's suicide risk shall occur within 24 hours of admission, 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, and included in the resident's recovery plan if clinical concerns are present. 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.

   c. Residents also receive scheduled assessments for risk of suicide and potential self-injury using the Clinical Risk Assessment, 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, every 6 months, and annually.

   d. Additional assessment evaluations may be employed to assess a resident's risk for suicide and self-injury (e.g., PHQ-9). Suicide and self-injury risk are addressed in the Recovery Plan.

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

1. Verbalizing intent to harm self or suicidal ideation;
2. Verbalizations or behaviors indicating perceives him or herself to be a burden to others;
3. Minimal impulse control;
4. Expressing suicidal plans, particularly plans the resident is physically capable of acting upon;
5. Obsessive ideation with death or afterlife related hallucinations or ideas;
6. Statements of hopelessness (especially with delusional features);
7. Expressions of feeling worthless or perceiving him or herself to be a burden to others;
8. Indications of fear of being alone, or frustration with sense of not belonging;
9. Expressions of guilt, especially when accompanied by need for or fear of punishment;
10. 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;
11. Depressive paranoid ideas;
12. Reporting hallucinations advising suicide or heavenly bound ideas;
13. Command hallucinations to hurt or kill self or others;
14. Increased problems in self-control;
15. No identified support or self-isolation;
16. Arguments with other residents which are more intense or frequent;
17. Increased hostility during interviews with staff;
18. Increased agitation and anxiety, particularly with insomnia;
19. Prescribed medications being refused;
20. Recent loss or rejection by a relative or friend;
21. Feeling “trapped;”
22. Increased energy or sudden recovery from a depressed state;
23. Past suicide attempt;
(24) History of severe self-injurious behavior;
(25) History of childhood abuse;
(26) Family history of suicide;
(27) Recent onset of mental illness;
(28) Recent admission to hospital;
(29) Giving away possessions;
(30) Sudden interest or loss of interest in religion, and;
(31) Transfer to another ward, transfer or discharge of a friend
(32) Within the past thirty (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.

7. Special Observations and Precautions. Procedures and criteria to be utilized for preventing suicide
and self-injury through the use of clinical observation.

a. Close Observation (CO): This level of observation should not be used for residents
who have been determined to be at risk for suicide or significant self-injury.

(1) This level of observation requires staff to monitor and document a resident’s
condition, location, and/or behavior at 15 minute intervals. The resident is not continually watched, and
this procedure should be used for issues of a less than serious nature where Routine Observation
would not be frequent enough, and 1:1 observation would be too intensive.

(2) Close Observation will occur in settings residents generally occupy such as
bedrooms, dorms, restrooms, dining rooms, activity rooms, classrooms, and enclosed yards attached to
buildings. Close Observation consists of visual observation which is the result of a special written order
in a resident’s medical record.

(3) Supervisors will ensure that staff members are vigilant and aware of each resident’s
whereabouts and status. Authorization for Close Observation is by clinician order as defined in this
operating procedure.

(4) This level of observation must be reviewed and renewed at least every 96 hours and
include a face-to-face examination by a clinician. The clinician will document whether changes have
occurred, note additional concerns, if any, write a new order and document justification for continuation
or discontinuation of an order.

(5) During state holidays and weekends, orders may be renewed by a clinician on call,
the Medical Executive Director, or Assistant Hospital Administrator/Administrator on Call if he or she is
a clinician as defined in this operating procedure.

b. Group Observation (GO): This level of observation should not be used for residents
who have been determined to be at risk for suicide or significant self-injury.
(1) This level of observation requires a staff member to remain within visual contact and close proximity of up to three (3) designated residents, in order for the physical, medical, emotional, or security needs of the residents to be met.

(2) The assigned staff maintains visual contact of the assigned residents at all times. Should a resident need to separate from the group observation for medical care, the bathroom, or increased signs of suicidality or self-injury, additional staff assistance will be called to maintain appropriate observation.

(3) Documentation of behavior, activity, and location is required every 15 minutes. Authorization for GO is by clinician order as defined in this operating procedure.

(4) This level of observation must be reviewed and renewed at least every 96 hours and include a face-to-face examination by a clinician. The clinician will document whether changes have occurred, note additional concerns, if any, write a new order and document justification for continuation or discontinuation of an order.

(5) During state holidays and weekends, orders may be renewed by a clinician on call, the Medical Executive Director, or Assistant Hospital Administrator/ Administrator on Call if he or she is a clinician as defined in this operating procedure.

c. One-to-One (1:1) Observation or Two-to-One (2:1) Observation: 1:1 observation is the minimum observation level to be used as a suicide precaution.

(1) One-to-One Observation requires one staff member to maintain uninterrupted visual contact of a resident while remaining within arm’s length at all times. Two-to-one Observation requires two staff members to maintain uninterrupted visual contact of a resident while remaining within arm’s length at all times.

(2) If it is determined by a clinician that “within arm’s length” creates a danger to staff members or is not therapeutic for the resident, the clinician may write an order indicating a variance from this requirement. The clinician will document justification for the variance.

(3) Staff assigned this coverage cannot be assigned to more than one resident at a time. Both levels of observation require documentation at least every 15 minutes.

(4) Authorization for 1:1 or 2:1 observation is from a clinician as defined in this operating procedure (exceptions are noted in paragraphs 9c and 9d of this operating procedure).

(5) This level of observation must be reviewed and renewed at least every 24 hours and include a face-to-face examination by a clinician. The clinician will document whether changes have occurred, note additional concerns, if any, write a new order and document justification for continuation or discontinuation of an order.

(6) During state holidays and weekends, orders may be renewed by a clinician on call, the Medical Executive Director, applicable Assistant Hospital Administrator/ Administrator on Call if he or she is a clinician as defined in this operating procedure.

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:

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

(2) Delineate 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 are authorized for 1:1 or 2:1 levels of observation only;

(5) Include the time limit of the order; and,

(6) Include signature, credentials, date, and time.

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 Group Observation, followed by Close Observation. 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 most likely to occur during holidays, weekends, and other off-duty hours for attending clinicians.

b. All staff members may determine based on a resident’s behavior, verbal comments, etc., at any time, that the resident shows potential increased risk for suicide or self-injury. Staff members will immediately intervene in such a way as to reduce the likelihood that a resident will be able to harm him or herself. Staff members will describe in a progress note, the precautions taken and the rationale for these precautions, 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 Family Operating Procedure 155-21, Use of Restraint in Mental Health Treatment Facilities, and facility based policy for restraint. Staff members will contact the dorm Registered Nurse (or if unable to contact, a unit based Registered Nurse) or the Unit’s Executive Nursing Director as soon as possible after addressing the emergent situation.

c. In addition to the notification of the dorm’s Registered Nurse (or if unable to contact, a unit based Registered Nurse) or the Unit’s Executive Nursing Director, the dorm Direct Care Staff supervisor, and the Residential Services Director regarding concerns related to suicidality or self-injury. A registered nurse may write the initial order for suicide precautions. The order may not exceed 4 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 Assistant Hospital Administrator/ Administrator on Call outside work hours if he or she is a clinician as defined in this operating procedure. 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 1:1 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 will be initiated. The hospital’s 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) Authorization will be obtained as follows: the nurse will obtain and document verbal authorization from the Medical Executive Director, applicable Assistant Hospital Administrator/Administrator on Call outside regular work hours.

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 or the Medical Executive Director.

10. Recovery Team Responsibilities (Refer to CFOP 155-53):

   a. Upon admission, each resident shall be assessed for suicide potential by the psychiatrist or psychiatric Advanced Registered Nurse Practitioner and documented in the resident’s desk file, by the resident’s Recovery Team using Form 65, Clinical Risk Assessment, and by the completion of the C-SSRS by a Clinician.

   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 (on Form 52 and Form 147). The assessment will include the use of C-SSRS by a Clinician, and the Clinical Risk Assessment when indicated. Other supplementary procedures to assess suicide risk may be employed as needed (e.g., PHQ-9).

   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, psychiatric Advanced Registered Nurse Practitioner, or Physician's Assistant shall participate in this review process. The resident will be reviewed each working day by the attending psychiatrist or psychiatric ARNP and recovery team while under observations related to suicidality or self-injury.

   d. The decision to continue or discontinue suicide precautions shall reflect the consensus of the Recovery Team. The minimum number of team members to discontinue or reduce the level of precautions is three (3), such that a team quorum is reached. A Clinician shall write orders related to those decisions at this time.

   e. The Suicide Precautions Order shall be written on a physician’s order form, if written by a physician or Advanced Registered Nurse Practitioner, or on a treatment order, if written by a Licensed
Psychologist, nurse, dorm or shift supervisor or other team member, denoting the level of suicide precautions as specified in paragraph 7 of this operating procedure. A corresponding Progress Note shall be written by the Clinician, as well as by a member of the team, if a treatment order is written.

f. If the Recovery Team is unable to reach a consensus regarding the resident's suicide status, the Medical Services Director 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 Clinician shall ensure that any required orders and progress notes related to suicide precautions are written.

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

h. The Recovery Team leader or designee shall document fully the Team Minutes regarding the team’s decision. Any changes in suicide risk must also be reflected on the C-SSRS, the Clinical Risk Assessment Instrument, and any other supplemental procedure used to assess suicide risk.

i. When a resident is determined to not require suicide precautions, this shall also be noted in the Clinician’s order and with justification documented in the progress notes, as well as in the Team Minutes completed by the Recovery Team leader or designee. Further, to the extent appropriate, the resident will be allowed to resume therapeutic activities, with documentation noted of such in the aforementioned Team Minutes and progress notes completed. Suicide precautions shall not be reduced or removed on a Friday or a day preceding a holiday.

j. Standing and Pro Re Nata (PRN) orders for special precautions are not permissible.

11. Staff Procedures:

a. Unless otherwise directed by a psychiatrist or psychiatric Advanced Registered Nurse Practitioner (ARNP), as soon as a resident is placed on suicide precautions, assigned dorm/unit staff shall 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). After the initial search, assigned dorm staff shall conduct intermittent searches as needed while suicide precautions continue. Searches should not interfere with the resident’s sleep. Searches will be conducted in a respectful professional manner. Documentation of each search shall be entered in the resident’s medical record.

b. The Nurse supervisor or designee or the Executive Nursing Director will inspect the setting each time a dorm/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 cards; 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 or the Executive Nursing Director will ensure that proposed repairs or solutions are appropriate and safe for a psychiatric care setting.

c. Observers will make entries on the Clinical Observation Progress note.

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

(1) The use of specialized safety clothing is only permitted when a person presents such imminent risk of self-harm that one to one (1:1) observation or Two-to-One (2:1) 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.

(2) Return to regular garments should be assured as soon as the risk of imminent danger has passed, even when the resident otherwise remains on suicide and self-injury observation status.

(3) Specialized safety clothing will not be used to identify a resident 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/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 the resident is thinking and how he/she is feeling, so that his/her mental status can be tracked. Staff
assigned will ensure that resident’s hands and face are visible at all times sitting or lying down and staff is aware of the resident’s use of these extremities. Except when it is necessary to accompany a resident to an outside facility for an extended period of time, no dorm/unit staff members will be assigned 1:1 or 2:1 observation for more than four (4) consecutive hours during any shift or period of consecutive shifts. The Nurse Supervisor or designee or Executive Nursing Director 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. Additionally, a warning will be visible to all users accessing the resident’s electronic record that suicide precautions are active. The names of residents on suicide precautions will be placed on the Daily Communication Log, as well as any other daily clinical management report.

g. If it is determined necessary, the resident will be assigned to a 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 in order 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 unit or dorm/pod. No resident on suicide precautions is to be granted unescorted movement.

j. Toileting and Bathing. Individuals who are on One-to-One (1:1) Observation or Two-to-One (2:1) Observation, or Group Observation (GO), 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, dorm/pod/unit staff will be mentored and trained by the Nurse Supervisor or designee or Executive Nursing Director, to ensure that intensive, continuous, vigilant observation is carried out with dignity and respect.

12. Discharge Issues:

a. The team leader shall consult in writing with the Medical Executive 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 resident committed per F.S. Chapter 394 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 have a history of self-injury or suicide attempts are determined “not dangerous to self” and are approved for conditional release, leave of absence, or discharge, their suicidal history, and/or self-injury history shall be noted in the Team Minutes and Discharge Summary Form. It is recommended that any established pattern of self-injury behavior and interventions be addressed in a relapse prevention plan and attached to a resident’s Conditional Release Plan. Any contacts with a community living environment regarding a resident’s self-injury behavior, history of suicide attempts, or identified pattern of self-injury behavior (including precursor symptoms) should be documented on the Report of Contact form.

d. Actively suicidal residents on voluntary status who request discharge against medical advice shall be immediately recommended for involuntary commitment.
e. When residents committed per F.S. 916 who have a history of self-injury or suicide attempts are recommended for return to Court as no longer meeting criteria for incompetent to proceed or as dangerous to self or others, their suicidal and/or self-injury history shall be noted in the relevant Clinical Summary, Competency Evaluation, and Discharge Summary. If applicable, documentation on the Report of Contact form should also be made.

13. Training Requirements: A check in the box below indicates which employees within the department are required to read this operating procedure and when they will receive training at Florida State Hospital. Employees within identified departments will also be required to review the policy each time it is updated.

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Signed Original on file in Quality Improvement Program

BOB QUAM
Chief Hospital Administrator

SUMMARY OF REVISED, ADDED OR DELETED MATERIAL

Addition of references and definitions. Addition of sub-items under sections, as well as addition of sections (e.g., Assessment of Risk; Special Observations and Precautions) and titles (e.g., Executive Nursing Director; Residential Services Director), along with deletion of terms (e.g., serious self-injury; Unit Director) and sections (e.g., Termination and Reduction of Suicide Precautions). Change of Chief Hospital Administrator Name.