

Safety Companion Ligature/Suicide Precautions

Revised : 11/18, 6/19, 7/30/19 CK/ML

Use of a Safety Companion for Safety for At-Risk Patients

Policy CM S13



- Define the role of the Safety Companion
- Define levels of Safety Companion
- Differentiate between RN and Safety Companion responsibilities
- Discuss proper documentation for Safety Companion
- Differentiate between Non-suicidal and Suicidal Precautions

What is a Safety Companion?

Specially trained clinical staff, designated to provide observation of a patient at risk for safety due to:

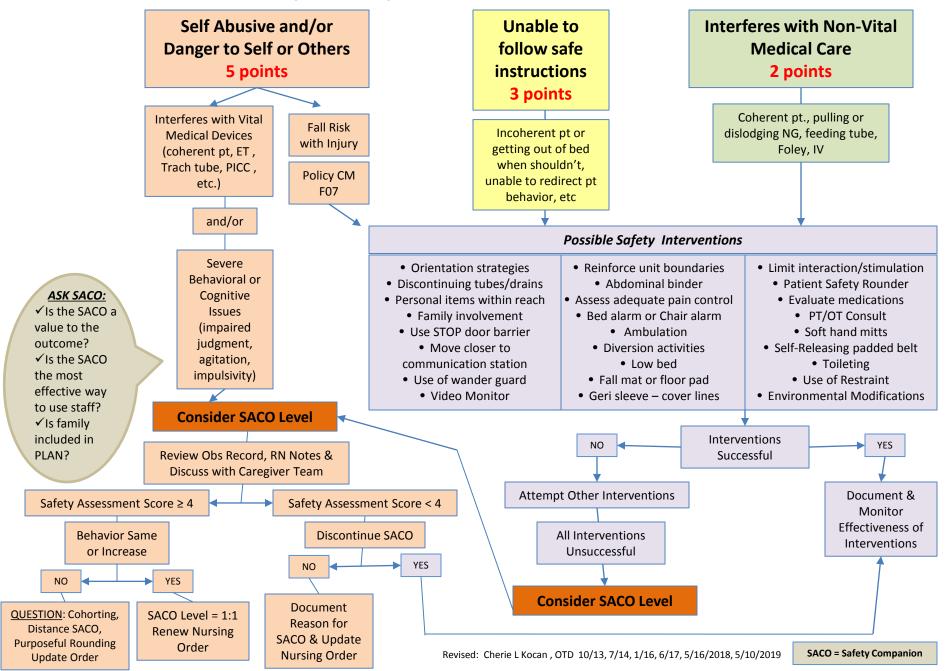
- Suicide ideations or attempts
- >Self-Abusive/Danger to Others
- Unable to follow safe instructions
- >Interferes w/ non-vital medical care
- **SACO**=Safety Companion

LPN, HCT, SCA, HA/UST, MHTA, MOA (In-pt)

RN Safety Assessment & Evaluation Plan

- If the RN determines a patient is at "at risk" (safety concern), they will complete a "Safety Assessment" every 8 hours and PRN to determine a NEED & LEVEL of SACO using the Safety Companion Decision Tree
- The score total will help to objectively determine if a nursing order for a SACO is recommended
- The assessment and level will be documented in the Electronic Medical Record (EMR)
- The SACO Level is also documented on the Observation Record F81973

Safety Companion Decision Tree



Possible Safety Interventions: Patient Safety Rounder

The Clinical Leader/ Charge Nurse/Shift Coordinator

- Will determine at the beginning of each shift the need for a Patient Safety Rounder and communicate need with the staffing office.
- The Patient Safety Rounder will attend unit safety huddles each shift to understand the safety needs of each patient.
- The Patient Safety Rounder will round continuously on up to 12 patients attending to their IMMEDIATE SAFTY needs.

Possible Safety Interventions : Patient Safety Rounder (cont.)

 Have no other assignment other than "Patient Safety Rounder"

 Document in EMR – your start and end times as a Patient Safety Rounder and any time that additional help was needed by staff.

Report any concerns immediately to the unit Clinical Leader/Charge Nurse/Shift Coordinator.

Safety Companion Scoring

3

2

Self Abusive/Danger to Self or Others 5 points

Unable to follow safe instructions points

Interferes with non-vital med. care points

Total =

If total points ≥ 4: Consider use of a Safety Companion

RN determines the level of SACO needed 1.1:1

2. Cohorting (2:1)

3. Distance Safety Companion

4. Purposeful Rounding Companion

1:1

HIGH RISK patient requires 1:1 constant visual, arms reach observation for immediate or impulsive behavior that may be harmful to self or others

>Assaultive/Aggressive behavior

Interferes with Vital medical Devices (ET, Trach or PICC)

>Actively psychotic experiencing visual, auditory and/or command hallucinations

>Acute detox with seizures or delirium tremors

>3 or 4 point restraint or Twice-As-Tough Cuff Stretcher/Quick Release

> Fall risk with injury when other interventions are not effective

Cohorting (2:1)

 Two patients who do <u>NOT</u> require constant visual observation but require a SACO in the room

> Remain with both patients in the same room

Both patients:

>may have similar conditions and/or symptoms

>must be responsive to verbal directions

cannot be agitated, suicidal or require a great deal of physical care, etc.

SACO must communicate to the RN if one patient needs extended periods of time (toileting, bathing, walking, etc)

Another staff member will observe one patient while the SACO addresses the other patient needs.

Cohorting (2:1) ED ONLY

 Two patients who do not require constant visual observation but require a safety companion.

SACO is within 10 to 15 feet from both patients (approximately the length of 1 stretcher) so they are able to respond to immediate patient needs

Remains with both patients in a designated area

Distance Safety Companion

 Direct observation of the patient at all times within 20 feet of patient (approximately length of 2 stretchers)

For patients that might have had 1:1 SC Level and now trying to decrease SACO Level to promote more freedom

Direct observation but does not have to be constant

Provides the patient with a little sense of privacy/independence

Safety Companion Purposeful Rounding

 Frequent (more than hourly) rounding on Purposeful Rounding patients ONLY as determined by the needs of the patient and RN

- Clinical Leader/Charge Nurse/Shift Coordinator determines the minimal rounding time for each patient.
- The SACO will be assigned NO more than three (3) patients and will have NO other unit assignments other than "Purposeful Rounding"..
- Inquire about the 5P's (Pain, Positioning, Personal Needs, Possessions & P.O.)
- At the same time: Respond to Questions, Reassure that they are there to help and will return frequently (the 2R's)

Once the RN determines a SACO is needed

• RN

Notifies the Clinical Leader/Charge Nurse/Shift Coordinator

Together they review alternatives attempted

Clinical Leader/Charge Nurse/Shift Coordinator

Notifies the Nursing Unit Manager and, Nursing Unit Director or Administrative Supervisor of the order.

Upon agreement

➢Write <u>nursing order</u> for SACO

>SACO Nursing Order expires in 8 hours

RN Responsibility

Continue to assess need for SACO every 8 hours and w/ changes

D/C as soon as no longer indicated

>Use lower level of SACO when possible ("weaning")

Family may serve as alternative to a SACO

> Determined by the RN and family members

Patient/family/care givers education on expectations

>Only intervals of time

 Nursing supervisors and/or Nurse Managers are encouraged to rotate SACO assignments on the same unit every 4 hours.

RN Responsibility (cont.)

Gives verbal report to SACO within 30 minutes of assignment

> Be specific about behaviors, interventions

Check in on SACO periodically

Ensures SACO is relieved for Meals & Breaks

Unit Clinical Leader/Charge Nurse/Shift Coordinator schedules coverage minimally every 4 hours

SACO Responsibility

SACO receives report and reviews Electronic Medical Record WORKLIST w/RN within 30 minutes of beginning assignment.

Communicates observations to RN every shift and with any change in patient condition, behavior, affect, interactions or visitors or any concerns that may affect SACO need or level.

Gives/receives verbal report using Observation Record (F81973)

SACO Responsibility (cont.)

- Be alert & aware of all patient activity and avoid any distraction
- No eating or drinking at the bedside
- Do not bring personal items or activities in the patient's room (backpack, purse, coats, etc.) (personal reading and/or studying, cell phone use {calls or texts} or use of other electronic devices)
- No Sleeping or "resting your eyes"
- Use Vocera conference feature to join unit
- Follow SACO LEVEL that is assigned as a Nursing Order via nurse

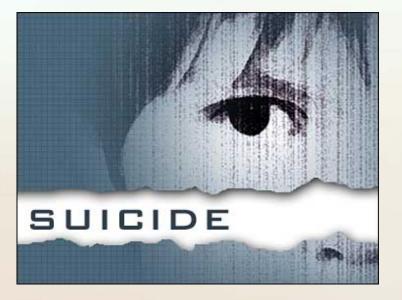
SACO Activities w/ Patient

- Engage patient in activities according to plan of care in collaboration w/ RN
- **Activity Cart**
 - Community: Administrative Hallway 1st Floor
 - Downtown: 1328B hallway
- Provide competent physical/therapeutic care and ADL's consistent with job title/role
- Offer diversion activities with direction of RN
- Walk patient around unit if stable "Get up & Go Program"
- Redirecting patient





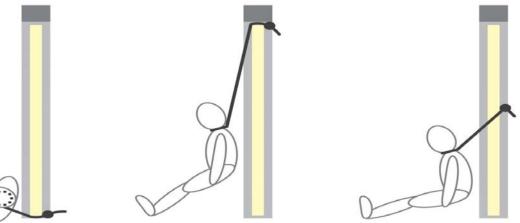
Ligature & Suicidal Risk Policy CM S-09, Suicide Precautions



Suicide Precaution – Ligature Risk

 Ligature risk points are anything that could be used to create a attachment point, such as a cord, rope or other material, for hanging or strangulation.
 Common points include doors, hooks, handles, window frames, belts, sheets, towels, and

sheets, towels, and shoelaces.



Schweich, Emily, (2019, April 29) CMS Revisions Ligature Risk Guidance. Retired from https://essentialhospitals.org/policy/cms-revises-ligature-risk-guidance/

Placing Patient on Suicide Precautions

 RN can write an RN Suicide Precaution order for patients who exhibits active suicide thoughts and/or behavior, or who are admitted for attempted suicide. (valid 1hr)

Charge Nurse notifies Administrative Supervisor of 1:1 Suicide Watcher (SUWA)

 Covering MD will evaluate & determine need within 1 hour of implementation = order via EMR

>MD order is required to discontinue

Psychiatric consult is ordered by MD to determine continued need

Psychiatric Consultation Service – see patient daily

STAT Psychiatric Consultation Service – for elopement/AMA

Room Preparation

- The RN and SUWA will observe the room for possible environmental risks that can be removed without negatively impacting the ability to deliver medical care.
- Confirm window latches are secured and locked
- Place sign on door indicating visitors need to report to nurse's station prior to entering room (F87612) via Duplicating
 - Excluding In-Patient Psych
 - Limit 1 plastic liner to 1 trash can





? Environmental Risk Items:

- 1. BP Cuff
- 2. Stethoscope
- 3. SCD Tubing
- 4. Extra Dirty Linen
- 5. Chair
- 6. Bed Frame
- 7. Telephone
- 8. Call Bell
- 9. IV Pump
- **10. Privacy Curtain**
- **11. Suction Gauge**
- 12. Over-bed Table
- 13. Bed-Side Stand
- 14. Air Conditioner 15. Blinds
- 16. Extra Telephone 17. Wire Basket
- 18. Track Hooks

1:1 Suicide Watcher (SUWA) responsibilities:

• Is the SAME as a 1:1 High Risk Safety Companion but adds:

- Visual observation of hands at all times (including but not limited to: bathing/showering, toileting, sleeping, test/treatment)
- Patient MUST wear hospital SAFETY gowns, pants & socks (EXCEPTION: 2N DT and 4East CC)
 - DT = Medical Equipment Request via ZenWorks via linen services
 & CC = Environmental Services

SUWA responsibilities (cont.)

- Patient is NOT aloud personal belongings except for quality of life items (glasses, dentures, hearing aides, etc.)
- Patient is restricted to room unless medical team gives the "OK" (PEDS = stoplight)
 - Report to RN when patient is leaving the unit for medical reasons
 - May step out of room, remaining just outside, at physician request ONLY (examining patient)
 - If patient transfer communicate precautions

SUWA Responsibilities (cont.)

Disposable Precautions: account for ALL plastic utensils

No outside food allowed (PEDS = stoplight)

 Visitor belongings to be placed in room lockers/cupboards – nothing at bedside

When possible SUWA & patient = same gender

SUWA Responsibilities (cont.)

<u>Continuously</u> monitor RISK ITEMS in room (Appendix A)

O2 meter/tubing	Toxic Substances	Thermometers	Soda Cans				
Cords Of Any Kind	Otoscope	Linen	Pens/Pencils				
Wire baskets	Ophthalmoscope	Plastic Bags	Mirrors				
Suction Gauge	BP Cuffs	Glass/Sharp Items	Bed/Stretcher				
Blinds/Curtains	Stethoscope	Clothes Hangers	Chair/Sofa				

Document q15min via Observation Record (F81973 is medical record)

RN Responsibilities

- Perform an Environmental Risk assessment and document on the Observation Record (F81973)
- Provide patient & family education about safety precautions (aka Suicide Precautions)
 - Food, dress code, room restriction, visitors belongings locked
- Give verbal report to SUWA within 30 min of assignment
 - Review Environmental Risk Assessment (ERA) & other risk items <u>NOT</u> removed from room (F81973) with SUWA

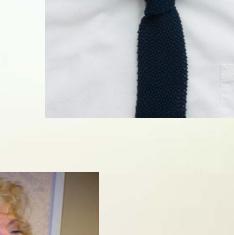


For your own Safety...

- Keep yourself between the patient and an exit
- May need to obtain help a neutral person may be able to diffuse the situation
- Staff abuse is unacceptable (physical or verbal)
 - Take steps to protect your safety
 - Notify your supervisor
 - Contact University Police as needed and complete the required injury/occurrence forms as needed
 - Refer to Workplace Violence Prevention Policy Statement (Policy W-04)

For your own safety...

- Remove items from around your neck
- Tuck in shirt ties, no hooded sweatshirts
- No hanging jewelry, cloth handbands
- Don't discuss personal information
- Keep track of utensils, etc.
- Back off, wait it out







EXCEPTIONS

- Psychiatric Inpatient Unit (4B and 5 West): Refer to unit specific policy PSY S-05 Suicide Precautions.
- Patients who are intubated and on a continuous sedative drip will require a 1:1 SUWA during any period of holding or weaning the continuous sedative drip. The Observation Record must be completed. (F81973)
- Pediatric ICU: An RN or unlicensed personnel will act as the 1:1 SUWA while the patient is intubated and sedated. The Observation Record must be completed. (F81973)

Correction Officers (State & County) (Excluding In-Pt Psych)

- May assume responsibility for 1:1 SUWA constant observation (no nursing staff required).
- Required to document every 15-minute observations in the DOCCS log book or the County Jail log book on admitted patients including admitted inmates in the ED awaiting placement.
- A copy of the log will be obtained by the nurse caring for the patient every 8 hours & attach to Observation Record Form (F81973).
- Nursing will place a patient sticker on the copy of the log and document "Constant Observation by DOCCS/County Jail Officer".



Overview of Changes

Changes have been made in Epic for charting on Safety Companion needs and use in the Daily Cares/Safety flowsheets so that documentation will reflect policy. In addition, there is a change to the icon seen on the Unit Manager for those patients that have a safety companion.

Wha

Hourly Rounding

Precautions

Is Video Monitoring being used?

Video Monitoring Start Time

Video Monitoring Stop Time

Patient Safety Rounder

Patient Safety Rounder Start

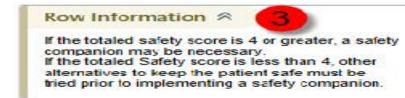
Patient Safety Rounder Stop

Precautions Maintained?

Safe Environment

Farm Bands On	
Bedside Safety Equipment	
Room Safety Measures	
Bed In Lowest Position	
Bed Wheels Locked	
Side Rails/Bed Type	
NonSkid Footwear	
Safety Companion	2
Self Abusive and/or Danger to	5
Unable to follow safe instructions	3
Interferes with Non-Vital Medical	2
Safety Companion Score	10
Safety Companion	Initiated
Level of Safety Companion	
Indications for Safety Companion	

- New row in the Precautions group for documenting on the Patient Safety Rounder.
- Combined Safety Companion charting into one group.
- See the Row Information in the Details Report to determine whether or not a Safety Companion may be warranted based on the auto-calculated score.



4. If Initiated is chosen for the Safety Companion cascading row, 2 more rows populate to docum ent what level of safety companion is in place, and what are the indications for having one.

SACO Documentation

Observation Record (F81973)

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F81973 - Observation Record 4/2019.1

SACO/SUWA

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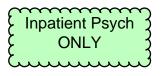
F81973 - Observation Record 4/2019.1

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F81973 -	Observatio	n Record 4/	2019							Page	1 of 2								М	ir F	

Inpatient Psych ONLY

Patient Name: Sally Safety	Account#:ABC0	09		3456	_Date: / - / - / 9
Observation (Obs) Level: (Safety Companion-RN Only-assessed 1:1=High Risk, 2:1=Cohorting, D=Distance Safety Companion, R=R	l every 8 hours) Purposeful Bounding, F=Family	/Friends 1.1 SU	WA-Suicide Watch DC-	-Discontinue Safety Compani	ion/Suicido Watchor
0/0=One to One (IP Psych) 15=15 minute Observation (IP Psych	h) 30=30 minute Observatio	n (IP Psych)	CO=Constant Observation	on (IP Psych)	
Environmental Risk Assessment (ERA): These items will be reme A. 02 flow meter/tubing C. Suction gauge E. Otoscope, or	oved from the patients room o phthalmoscope G. Stethosc	nce medically c			ssessed every 8 hours)
A. 02 flow meter/tubing C. Suction gauge E. Otoscope, or B. Monitors & Cords D. BP cuff F. Wire basket	H. Thermon		I. Phone J. Other:	K. Other: L. Other:	
Please be aware of items in the room that are not removed and	pose a risk to the patient incl			· · · · · · · · · · · · · · · · · · ·	·····
☐ Curtains and blinds ☐ Shower curtain ☐ C-loc ☐ Chairs ☐ Sleeper sofa ☐ Liner	cker 🗌 Call bell n and gown 🗗 Mirror		□ Lamp shade □ Extra linen	Cords of any kind	Bed frame/Stretcher
Activity Code:					
1. TV/Movie 5. On the telephone 9. Shower, 2. Therapeutic Play 6. Approved visitor visiting 10. Ambulat			16. Puzzles/book mind 17. Restina	game 19. Urinal/bedpan 20. Off unit for test/	21. Other (Describe):
3. Eating 7. Physician present 11. Story Te	elling/Reminisce 15. Activity		18. Playing cards/board	d procedure	22. Other (Describe):
4. Drinking 8. Toileting 12. Sleeping	g acivity		games		
Behavior Code: a. Crying d. Yelling/screaming f. Restles	i. Cooperat	tive	k. Responds to verbal	m.Risk Behavior: (hitting,	hiting colf injund
b. Quiet/reclusive e. Unable to follow g, Sleepy	j. Follows o	lirections	cueing	n. Other:	bidiig,sen-injuiy)
c. Impulsive directions h. Disorie	inted		I. Calm	•	
Location Code: (IP Psych only) R = Room Awake K = Kitchen D = Davro	oom QR = Quiet	Room	P. Bathroom	H. Helliner	
SW - Social Worker S = Asleep T = Treatr	ment Room GR = Group	Therapy	B = Bathroom SH = Shower	H = Hallway CR = Conference	
L = Laundry OU = Off Unit P = Privile	ege/Pass 0 = Doctor	Office	MR = Music Room	C = Classroom	
Date Time Initial On-coming SACO/SUWA Signature	Print Name/Title	Date Time	Initial Off-going SACO/	/SUWA Signature	Print Name/Title
11/19 0200 CL Chic Little Chic	- Little, MOA	11/19 0600	Ci Chie La	the Chie	Little, MOA
1/19 0600 DD David Duck Dar	10 DUCK, HCT	1/19 0700	DD David	Duck David	Duck, HCT
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Date Time Initial RN Order RN - Signature	Print Name	Date Time	Initial RN Order	RN - Signature	Print Name
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F81973 - Observation Record 4/2019



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Patient Name: Sally Safety Observation (Obs) Level: (Safety Companion-RN O	Account #: ABC	189	MR#:O1_	23456	Date:	RN ONLY - q8h/prn,
1:1=High Risk, 2:1=Cohorting, D=Distance Safety Co 0/0=One to One (IP Psych) 15=15 minute Observa	npanion, R=Purposeful Rounding, F tion (IP Psych) 30=30 minute Obs	ervation (IP Psych) CO=Constant Observa	ation (IP Psych)		must communicate to SACO/SUWA
	Otoscope, ophthalmoscope 🛛 G. Si	room once medica tethoscope hermometer	ally cleared: (Environmen I. Phone J. Wither:	tal Risk Assessment-RN Onl K. Other: L. Other:	y-assessed every 8 hours)	Suicide Precautions
Please be aware of items in the room that are not r Curtains and blinds Shower curtain Chairs Sleeper sofa	□ Ç-locker □ Ç	e nt including, but n all bell Tirror	not limited to: Lamp shade Extra linen	Cords of any kind	Bed frame/Stretcher	\dots
Activity Code:1. TV/Movie5. On the telephone2. Therapeutic Play6. Approved visitor visiting3. Eating7. Physician present4. Drinking8. Toileting	10. Ambulating14. R11. Story Telling/Reminisce15. A	RN present 📃 🔨	ablet 16. Puzzles/book min 17. Resting etitive 18. Playing cards/bo games	20. Off unit for tes		Suicide Precautions ONLY: SUWA constantly aware of items remaining in room
Behavior Code:a. Cryingd. Yelling/screamingb. Quiet/reclusivee. Unable to followc. Impulsivedirections		ooperative bllows directions	k. Responds to verbal cueing I. Calm	n Other	ng, biting,self-injury) My ROCK STAR RN s	
Location Code:(IP Psych only)R = Room AwakeK = KitchenSW - Social WorkerS = AsleepL = LaundryOU = Off Unit	T = Treatment Room GR =	= Quiet Room = Group Therapy Doctor Office	B = Bathroom SH = Shower MR = Music Room		5 items in the ERA sec EMAIN in the Pt room not be mitigated	and that } tion will and can }
Date Time Initial On-coming SACO/SUWA Sign 1/1/19 0200 CL Chic Little 1/1/19 0600 DD David Divek 1/1/19 0730 LK Lettle King 1/1/19 1100 PP Viettig Rick	David Duck, H David Duck, H Little King, H Pretty Ping, H	0A 11/190 HCT 11/190 HCT 11/191 HCT 11/191	1600 CL Chie &	CO/SUWA Signature Lick Chi Lick Dav Lick Da	id Duck, HC	
1/1/19 1500 mm Mukey Moos	e Michey Moosé ; i	moA				— · · · · · · · · · · · · · · · · · · ·
Date Time Initial RN Order RN - Signatur 1/1/19 0136 5W Image: Signatur Image: Signatur 1/1/19 0136 5W Image: Signatur Image: Signatur 1/1/19 0136 5W Image: Signatur Image: Signatur 1/1/19 1015 5B V Image: Signatur 1/1/19 1015 5B V Image: Signatur 1/1/19 1515 CB V Image: Signatur 1/1/19 1600 CB V Image: Signatur	Le Snowy White, ue Sleeping Blue, Le Speping Blue, whice Brown	RN RN RN	Checking box indicates assessment to start/char Safety Companion order has to start Suicide Pre assessment. Documen column on reverse side Record & Ef	nge/discontinue or when the RN cautions due to it in Obs Level of Observation	Print Name	- - - -

F81973 - Observation Record 4/2019

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STEP BY STEP Directions for OBSERVATION RECORD F81973

1. <u>Safety Companion (SACO) ~ Non-Suicide</u>

a. Using the Activity Codes on page 2 - place a NUMBER in the Activity Code Column on page 1 EVERY HOUR and/or

Activity Code:

1.	TV/Movie	5.	On the telephone	9. Shower/bathing	13. Book/Magazines/Tablet	16. Puzzles/book mind game	19. Urinal/bedpan	21. Other (
2.	Therapeutic Play	6.	Approved visitor visiting	10. Ambulating	14. RN present	17. Resting	20. Off unit for test/	-
3.	Eating	7.	Physician present	11. Story Telling/Reminisce	15. Activity Apron/repetitive	18. Playing cards/board	procedure	22. Other (
4.	Drinking	8.	Toileting	12. Sleeping	acivity	games		990000 - 10000 89 0890

Time	Activity Code	Behavior Code	Location Code	ERA	Init
2400		5			
15					
30					
45					

b. Using the Behavior Codes on page 2 – place a lower case LETTER in the Behavior Code Column on page 1 EVERY HOUR

Behavior Code:

- a. Crying d. Y b. Quiet/reclusive e. U c. Impulsive d
 - d. Yelling/screaming f. Restless e. Unable to follow g. Sleepy directions h. Disoriented
 - ess V
- i. Cooperative j. Follows directions
- k. Responds to verbal
- cueing I. Calm
- m.Risk Behavior: (hitting, biting,self-inj n. Other: _____

- TimeActivity
CodeBehavior
CodeObs
LevelLocation
CodeERAInit.240015111111301111111451111111
 - **c.** Place your initials in the Initial (Int.) Column on page 1 every time you write in EITHER the Activity or Behavior Columns on page 1

Time	Activity Code	Behavior Code	Obs Level	ERA	Init
2400				8	
15					
30					
45					

d. Place your signature on page 2

- On-coming = arriving SACO to patient room
- Off-going = leaving SACO from patient room
- ✓ Keep in mind that a RN/LPN can be in the SACO role during breaks they would sign their signature in the On-coming or Off-coming SACO area on page 2

Date	Time	Initial	On-coming SACO/SUWA Signature	Print Name/Title	Date	Time	Initial	Off-going SACO/SUWA Signature	Print Name/Title
									·

2. Suicide Watcher (SUWA) ~ Suicide Precautions

- a. Using the Activity Codes on page 2 place a NUMBER in the Activity Column on page 1 EVERY 15 MINUTES and/or
- Using the Behavior Codes on page 2 place a lower case LETTER in the Behavior Column on page 1 EVERY 15 MINUTES
- c. Place your initials in the Initial (Int.) Column on page 1 every time you write in EITHER the Activity or Behavior Columns on page 1
- d. SUWA and/or RN can place check marks next to any of the items in the room that are NOT removed from the patient room

Please be aware of items in the room that are not removed and pose a risk to the patient including, but not limited to:

Curtains and blinds	□ Shower curtain	🗆 C-locker	🗆 Call bell	🗆 Lamp shade	□ Cords of any kind	□Bed frame/Stretcher
🗆 Chairs	🗆 Sleeper sofa	🗆 Linen and gown	🗆 Mirror	🗆 Extra linen	8	

e. Pace your signature on page 2

- On-coming = arriving SUWA to patient room
- ✓ Off-going = leaving SUWA from patient room
- ✓ Keep in mind that a RN/LPN can be in the SUWA role during breaks they would sign their signature in the On-coming or Off-coming SUWA area on page 2

1. <u>Registered Nurse ~ Non-Suicide Patient</u>

- a. Using the Observation (obs.) Level Codes on page 2 place the code in the Obs Level column on page 1
 - ✓ When RN writes a NEW Safety Companion Order
 - ✓ When the RN CHANGES the Level of Safety Companion Order
 - ✓ When a NEW SACO is reporting, the code will validate previous RN order if less than 8 hours ago and confirms SACO/RN verbal report
 - ✓ At least EVERY 8 HOURS

Observation (Obs) Level: (Safety Companion-RN Only-assessed every 8 hours)

1:1=High Risk, 2:1=Cohorting, D=Distance Safety Companion, R=Purposeful Rounding, F=Family/Friends, 1:1 SUWA=Suicide Watch, DC=Discontinue Safety Companion/Suicide Watcher 0/0=One to One (IP Psych) 15=15 minute Observation (IP Psych) 30=30 minute Observation (IP Psych) C0=Constant Observation (IP Psych)

Time	Activity Code	Behavior Code	Location Code	ERA	Init.
2400					
15					
30					
45					

- b. Place your initials in the Initial (Int.) Column on page 1 ONLY when you write in the Obs Level column on page 1, which is at least every 8 hours
- c. Place a CHECK MARK on the RN Order column on the bottom of page 2 ONLY when you write a RN order

Date	Time	Initial	RN Order	RN - Signature	Print Name	Date	Time	Initial	RN Order	RN - Signature	Print Name

- d. Place RN Signature on page 2
 - ONLY when you sign your initials in the (Int.) column of page 1
- 2. <u>Registered Nurse ~ Suicide Precautions</u>

 \checkmark

- a. Using the Observation (obs.) Level Codes on page 2 place the SUWA code in the Obs Level column on page 1
 - When RN has assessed the patient and feels that should be place on Suicide Precautions
 MD evaluation in 1 hour
 - When a NEW Suicide Watcher is reporting, the SUWA code will validate the continued MD Suicide Precaution order at least EVERY 8 HOURS and confirms SACO/RN verbal report
- b. Place your initials in the Initial (Int.) Column on page 1 ONLY when you write in the Obs Level column on page 1, which is at least every 8 hours
- c. Using the Environmental Risk Assessment (ERA) Codes on page 2 place capital LETTERS in the ERA column on page 1 of all items in the patients room that REMAIN in patient room EVERY 8 HOURS. Once they are no longer needed for treatment they would be removed and no longer need to be documented

Environmental Risk Assessment (ERA): These items will be removed from the patients room once medically cleared: (Environmental Risk Assessment-RN Only-assessed every 8 hours)

A. O2 flow meter/tubing	C. Suction gauge	E. Otoscope, ophthalmoscope	G. Stethoscope	I. Phone	K. Other:
B. Monitors & Cords	D. BP cuff	F. Wire basket	H. Thermometer	J. Other:	L. Other:

Time	Activity Code	Behavior Code	Obs Level	ERA	Init.
2400					
15					
30					
45					

d. RN and/or SUWA can place check marks next to any of the items in the room that are NOT removed from the patient room

Please be aware of items in the room that are not removed and pose a risk to the patient including, but not limited to:

Curtains and blinds	🗆 Shower curtain	C-locker	🗆 Call bell	🗆 Lamp shade	Cords of any kind	□Bed frame/Stretcher
□ Chairs	🗆 Sleeper sofa	🗆 Linen and gown	🗆 Mirror	🗆 Extra linen		74 F

e. RN and SUWA review the items that remain in the room – suggestion – count the High Risk items.

f. Place a CHECK MARK on the RN Order column on the bottom of page 2 ONLY when you write a RN order

✓ RN can write an initial Suicide Precaution Order if assessment indicates

✓ NO check mark is indicated if your just validating MD order

Date	Time	Initial	RN Order	RN - Signature	Print Name	Date	Time	Initial	RN Order	RN - Signature	Print Name
8			5				0	5			

g. Place RN Signature on page 2

✓ ONLY when you sign your initials in the (Int.) column

