If there are any risk concerns at the end of a patient’s day -
The RN must evaluate in a private setting, meet with the patient first
Then meet with parent alone, then patient and parent together.

RISK ASSESSMENT

1. Is the patient communicating with you appropriately?
   0 = good,
   5 = Communicating / but not consistent or reliable
   10 = poor communication – minimal

2. Are they making eye contact?
   0 = yes
   5 = intermittent
   10 = no

3. Do they have a plan?**
   0 = no
   15= vague
   30 = yes, they have a plan: Specify:

4. Are they using skills to cope?
   0 = yes, able to demonstrate and use specific skills
   5 = able to use skills with support
   10 = poor skill use / no use

5. How are they communicating right now with their parent?
   (or person they would be going home with)
   0 = good communication
   5 = not consistent / reliable
   10 = poor communication

6. How do they usually get along with this person?
   0 = good supportive relationship
   5 = varies
   10 = high conflict relationship

7. Severity of conflict at that moment with their support person
   0 = no conflict
   5 = moderate conflict
   10 = severe conflict

SCORE:
0-24 – may be able to go home, proceed with safety plan
25 or higher – Needs to be evaluated by PES in the Emergency Room
   Escort to ER.
IF they need to go to the ER – Call PES and send them down immediately.
If you want to try to page the treatment team for the patient, Do this AFTER you send
them to the ER. IF you don’t reach the EDU therapist / doc, leave a voice mail for them.
Additional Questions if the patient might be going home. The answers to these questions might change the decision about going home Versus to the ER for further assessment.

What made you think about hurting yourself (or not wanting to be alive)?

How can you cope with this differently?

How long have you been feeling this way?

SUPPORT SYSTEM:
Who are they going home with?

Who will be at home tonight?

Where are they sleeping / distance from parents?

What is their sleep quality? Sleeping thru the night, falling asleep?

REVIEW SAFETY PLAN if they have one, add to it if necessary.

IF there is not a written safety plan, Have the parent and patient work together to create one for tonight (use template)
Review it with them, and have them sign it.
Copy for the chart

IF they go home, call to follow up at 9:30 PM
SUDS Interpretation Key for Milieu Staff:

**SUDS:**
For numbers 1-6, help patient to determine what skills will be useful in minimizing distress and help patient come up with a safety plan.

For numbers 7 and above, part of the 1:1 check-in will include a more detailed safety (suicidal/self harm) assessment please use the SIB and SI scales and notify RN immediately of the intervention. This is to determine level of urge.

RN notify therapist and MD for any further assessment needed.

**SIB scale:**
1 more focused 1:1 check-in to help patient to determine what skills will be useful in minimizing distress and help patient come up with a safety plan

2 or higher
Take patient to RN immediately RN initiate support zone; Q15 minute checks; notify therapist and MD for further assessment and orders. RN to complete body check if not already completed that shift.

**SI scale:**
0 No further intervention
1 Take patient to RN; initiate Notification of therapist and MD if not previously done (weekends compare ratings for week notify PES with any safety concerns)
2 As above, plus initiate support zone Q 15 minute checks
3 As above, plus initiate unit based support zone, not to leave unit
4 Emergency level: 1-1 supervision until assessment by therapist/MD or PES
5 As above

**Weekend Management of Patients:** Initiate wrap around for any patients with SI or SIB scores above zero

**For all patients 12 and younger:** Administer Distress Scale only and consult with therapist about plan for any scores greater than 4. Therapist will determine if SI/SIB scales will be utilized.
Distress Scale

10 = Extremely desperate and overwhelmed; Highest distress ever felt; Must do something to get out of unbearable feelings; highly avoidant of others

9 = Feeling desperate; feeling out of control; feeling and/or acting impulsive; avoiding eye contact, and/or refuses to talk.

8 = Withdrawn and irritable; Will not discuss feelings or use skills; Avoiding eye contact; High conflict with others.

7 = Very anxious and irritable; not able to use skills; avoiding others and conversations.

6 = Anxious; More overwhelmed; Feelings are less manageable alone; Difficulty identifying and using skills; Beginning to think you have to do something about feelings.

5 = Moderately upset, Uncomfortably distressing feelings; Feelings are only manageable with greater effort. Unable to use skills on your own. Need support to use skills

4 = Somewhat upset; Unsure if you can easily ignore distressing emotions/thoughts; Feelings are still manageable with some effort. Can use some skills on own, better skill use with support.

3 = Mildly upset; Worried; Bothered by a few thoughts/emotions; Skills are helping.

2 = A little upset, can notice some distressing thoughts/emotions.

1 = No acute distress and feeling basically good. If you took special effort you might find distressing things.

0 = Peaceful; calm; no anxiety.

Name______________________________ Date ____________

Update 6-7-2010 MS/MAK
Suicide Ideation Scale:

Sometimes people think about ending their lives. This is called "suicide ideation."

Where would you rank yourself with regard to your suicide ideation?

5 = I would like to kill myself, and I have a plan for what I would do, I know how I will get access, or already have access to what I need.

4 = I would like to kill myself, and I have a plan for what I would do, but I don’t know how I will get access to what I need.

3 = I would like to kill myself, and I have thought about what I could do, but don’t intend to kill myself.

2 = I am thinking about killing myself but I have not thought about what I would do.

1 = I have passively thought about what it would be like to not be here, but I would not do anything about it.

0 = I don’t have any thoughts of killing myself.

Name ___________________________________________ Date _____________

Updated MS/MAK 6-7-2010
Wrap Around Home Support Program Suggestions

**Must Haves**
Call EDU at 9 p.m. to do evening check in with nursing staff. (720-777-6289)
- Parent and Patient
- How are things going so far tonight

Clear home of loose sharps
Either get rid of or secure items they could use to harm themselves with
- Kitchen knives, hunting knives, pocket knives, razors (all types), box cutters, exacto knives, packing supplies, scissors and other art supplies with blades.
- Check Garage for tools and other items that could be used

Assess Sleeping Arrangements
- Occasionally it is necessary to have them sleep in the same room as parent in order to make sure they are safe throughout the night.

If on Meds in the evening
- Mouth checks- occasionally patients have cheeked and saved meds

Lock up all medications in the home
- Prescription and over the counter
- If no locking cabinet can purchase a locking fire box, small portable safe

Bathroom Door to remain cracked or open when occupied.

Be aware of where they are at all times
- In sight of responsible family member not alone in their room or roaming neighborhood

⭐ Review Safety Contract prior to going home for the evening ⭐

**Suggested Items**
No outings
- This could add stress to current situation

Backpack check by parents
- Have they brought anything home that they could hurt themselves with?

All Car Keys should be temporarily held by parents
- Secured by parents where they can not be retrieved by impulsive teen / young adult.

If at any time behaviors are escalating or out of control call EDU. If unable to reach EDU go to the nearest Emergency Department.
There are now 2 levels of support zone. **Low level support zone & High level of support zone**. There are also now new Epic changes (dot phrase orders) that correlate for orders and sign off.

**Dot phrase orders:**

.edulowlevelsupportzone

.eduhighlevelsupportzone

**Smart Text:**

**EDU SUPPORT ZONE**

--> sign off lower level

--> sign off higher level
SAFETY PLAN

I, ______________________ agree to be safe and not do anything that will be potentially self or other injurious, including running from the unit/staff. If at any point I am feeling unsafe, I agree to do the following in order to help myself remain safe:

FIVE WARNING SIGNS THAT I AM FEELING OVERWHELMED, ANXIOUS AND AM AT RISK OF BEING UNSAFE:

1.
2.
3.
4.
5.

FIVE THINGS I CAN DO TO HELP MYSELF:

1.
2.
3.
4.
5.

FIVE PEOPLE THAT CAN HELP ME STAY SAFE:

1.
2.
3.