COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE			POLICY
Care and Treatment of the Psychiatric Patient			**EMD-008**
MANUAL	EFFECTIVE DATE	REVIEW DATE	
Emergency Department			
DEPARTMENT	REFERENCE		
Emergency Department/Nursing Services			

I. SCOPE

This policy applies to Mangum Regional Medical Center for the assessment and management of patients with suicidal/homicidal/self-harm/harm of others ideations, psychiatric disorders and/or substance abuse.

II. PURPOSE

The intent of this policy is to describe the procedures for identifying individuals at risk, provision of a safe environment for the patient's emotional and physical health with appropriate interventions, and development of a plan or care for patients with suicidal/homicidal/self-harm/harm of others ideations, psychiatric disorders and/or substance abuse.

Risk Factors for suicide include but are not limited:

A. Psychosocial Factors include: previous suicide attempt, self-harm behaviors, alcohol and/or substance abuse disorders, current and/or previous psychiatric disorders (especially mood disorders, schizophrenia, anxiety and personality disorders), previous trauma/physical/sexual abuse, major physical illness, chronic pain, family history of suicide, and/or history of violent/aggressive behavior.

B. Environmental Factors include: a triggering event that may lead to feelings of humiliation, despair, loss (job, financial, relational, social), and/or easy access to lethal means (i.e. firearms).

Mangum Regional Medical Center's goal is to accurately recognize, rapidly triage using the Emergency Severity Index (ESI) and Algorithm (See EMD-006A Form), assess for suicide risk using the ASQ Suicide Risk Screening Tool (See Attachment A), provision of an appropriate medical screening examination with any necessary stabilizing treatment, and initiate appropriate

transfer or discharge with safety plan for patients with suicidal/homicidal ideations, self-harming behaviors, other psychiatric disorders and substance abuse disorders.
Performing a suicide risk assessment screening and providing appropriate interventions should not be considered a “one size fits all” process and will be completed through the use of procedures that are specific to the patient setting and circumstances while meeting the elements of this policy.

III. DEFINITIONS

A. **Suicidal Ideations** (suicidal thoughts) means thinking about death considering and/or planning to take their own life, with or without a specific plan. Suicidal ideations can range from fleeting thoughts to a detailed plan.

B. **Homicidal Ideations** means thoughts about homicide that can range from vague ideas to detailed and formulated plans to commit homicide.

C. **Suicide** means death caused by injuring oneself with the intent to die.

D. **Suicide Attempt** means when someone harms themselves with the intent to end their life but did not die as the result of their actions.

E. **Suicidal Behavior** means intentional injury to self-associated with some level of intent, development of a plan or strategy for suicide, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end their life.

F. **Self-Harming Behaviors** means behavior that is self-directed and deliberately results in injury or the potential for injury to self or others. Self-harming behaviors may or may not be categorized as suicidal.

G. **Suicide Statement** means any statement made by a patient that suggests that the patient is contemplating suicide. This includes but not limited to, non-verbal statements such as written statements, photos, text messages, etc.

H. **“One to One Observation”** means one competent observer to one patient within “arm’s reach”, in close proximity with no physical barriers in the same room/area with the patient.

I. **“Line of Sight Observation”** means one competent observer in direct line of sight (LOS) with one or more patients.

J. **Competent Staff** are those who have completed a facility-based competency assessment initially and ongoing basis related to core elements required to monitor a patient under suicidal/self-harm precautions.

K. **“Qualified Medical Professional”** means A Practitioner or AHP who is or who will be providing clinical services pursuant to a contract with the Hospital must meet the same

basic qualifications for appointment to the Staff, must be evaluated for appointment, reappointment, and clinical privileges in the same manner as all other Practitioners or AHP's.

IV. POLICY

The approach to the care of suicidal/homicidal ideations, self-harming behaviors, other psychiatric disorders and substance abuse disorders is multidisciplinary. At a minimum all patients who present to the Emergency Department with a psychiatric related complaint or show signs/symptoms of being a self-harm risk will be screened using the ASQ Suicide Risk Screening Tool. An "acute positive screen" requires an immediate safety/comprehensive risk assessment. Nursing staff will place the patient under one to one observation at all times by a **competent** health care provider who is monitoring the patient. Nursing staff will use the Environmental Patient Safety Checklist to ensure that the patient has been provided a safe environment. The hospital will provide a prompt medical and psychiatric assessment with appropriate stabilizing treatment by the qualified medical provider as recognized in the Hospital Medical Staff Bylaws/Rules, Regulations and Policies. The Hospital will arrange and expedite an appropriate transfer to a mental health facility or discharge with a safety plan and discharge instructions.

V. CARE OF SUICIDAL, SUICIDAL/HOMICIDAL IDEATION, SELF-HARMING BEHAVIORS OR OTHER PSYCHIATRIC COMPLAINTS

A. Assessment

1. Upon presentation to the hospital all patients with a psychiatric complaint or who exhibit signs/symptoms of suicidal/homicidal ideation, attempt or self-harming behaviors will be triaged using the Emergency Severity Index Scale.
2. During triage all patients with a psychiatric related primary complaint, suicidal/homicidal ideation, or self-harming behaviors will be screened for the risk of suicide using the ASQ Suicide Risk Screening Tool.
   a. If the patient answers "no" to questions #1 through #4 screening is complete and no additional intervention is necessary (clinical judgment can always override a negative screen).
   b. If the patient answers "yes" to any of the questions #1 through #4 it is considered a **positive screen**. Question #5 should be asked to assess acuity.
   c. If the patient answers "yes" to question #5 it is considered an **acute positive screen** and an "imminent risk" identified.
   d. If the patient answers "no" to question #5 it is considered a **non-acute positive screen** and a "potential risk" identified.

B. Evaluation

The hospital has two options in which to evaluate the patient presenting with a psychiatric complaint or who exhibits signs/symptoms of suicidal/homicidal ideations, attempt or self-harming behaviors:

1. Licensed Mental Health Provider.

   a. If the patient has an **acute positive screen** hospital staff will contact a participating behavioral health center with telehealth capabilities to obtain a Licensed Mental Health Professional (LMHP) evaluation.
      i. Place patient under one to one observation
      ii. Staff nurse to complete and document the Columbia Suicide Severity Scale (CSSS)(Attachment C) in the patient's medical record.
      iii. Complete the Environmental Patient Safety Checklist (See Attachment D) and ensure all dangerous objects are removed from the patient's room.
   b. The LMHP will complete a full mental health evaluation to determine the need for in-patient psychiatric treatment.
      i. Ensure the LMHP Statement is placed in the patient's medical record.
   c. If the LMHP determines the patient does not meet criteria for in-patient psychiatric treatment and should be discharged home for out-patient psychiatric follow-up, the LMHP should complete a discharge safety plan with the patient and family (if present).
      i. If the LMHP does not complete the discharge safety plan with the patient and family (if present), hospital staff will complete a discharge safety plan prior to discharge.
2. Emergency Department Provider
   a. If the patient answers "yes" to question #5 it is considered an **acute positive screen** and an "imminent risk" identified. Patient requires an immediate Brief Suicide Safety Assessment (BSSA) (See Attachment B) and the ED physician/mid-level provider will obtain/initiate a mental health evaluation for purposes of transfer to an acute psychiatric facility. Patient cannot be transferred until the evaluation for safety has been completed and documented in the patient's medical record.
      i. Place patient under one to one observation
      ii. Staff nurse to complete and document the Columbia Suicide Severity Scale (CSSS)(Attachment C) in the patient's medical record.
      iii. Complete the Environmental Patient Safety Checklist (See Attachment D) and ensure all dangerous objects are removed from the patient's room.
      iv. Alert physician or mid-level provider responsible for patient's care.
   b. If the patient answers "no" to question #5 it is considered a **non-acute positive screen** and a "potential risk" identified. Perform the BSSA to determine the need for completion of the CSSS and full mental health evaluation. Patient cannot be transferred or discharged until the BSSA has been completed and documented in the patient's medical record.
3. If the patient cannot be screened at triage due to the patient's medical status (i.e. unconscious, intubated, intoxicated or mentally unstable) screening may be postponed until the patient has been stabilized and can be assessed. The screening should be performed as soon as possible as the patient's condition permits.
4. On admission to the ED the patient will be asked to remove personal clothing and dress in a hospital gown, while a search is performed for any unsafe items (i.e. weapons, sharp objects, drugs/medications, etc.). This search should result in the removal of jewelry, cigarette lighters, matches, medications, shoelaces, belts, plastic bags, or any other item which may be a safety risk while the patient remains a suicide

risk. The search should be performed with another staff member present, or per patient preference. All clothing and personnel belongings/items should be removed from the patient's room, inventoried and placed securely in the Emergency Department until time of transfer or discharge.

5. The physician/mid-level provider responsible for the patient's care will perform an appropriate MSE including any tests (i.e. labs, etc.), to rule out a medical illness as the cause for or contributing to the patient's mental condition.
6. If medical causes are ruled out for patient's mental condition and has been determined to be at risk for suicide/self-harm, a comprehensive risk assessment should be completed by physician/mid-level provider.

C. Observation and Monitoring

1. All patients who screen "**acute-positive** for suicide/self-harming behaviors will be placed under one to one observation with a patient attendant. Those patients who screen "**non-acute positive**" for suicide/self-harming behaviors will have level of observation and monitoring determined by physician/mid-level provider based on BSSA/comprehensive risk assessment.
2. If a patient has any concerning/contributing history, circumstances or signs/symptoms that might indicate an increased risk of suicide the patient should be placed on one to one observation with a patient attendant until a full evaluation has been completed by the physician/mid-level provider. Physician/mid-level provider based on full evaluation of the patient will place an order for the appropriate level of observation and monitoring.
3. If a patient presents with a psychiatric complaint has a negative ASQ Suicide Risk Screening and has no concerning/contributing history, circumstances or signs/symptoms that might indicate an increased risk for suicide the physician/mid-level provider based on full evaluation of the patient may order the appropriate level of observation and monitoring based on the patient's clinical presentation.

D. Documentation

1. The ASQ Suicide Risk Screening should be documented as part of the triage process in the Emergency Department by the triage nurse.
2. Nursing staff must complete the Environmental Patient Safety Checklist for a patient at risk for suicide or self-harming behaviors at the time of admission and at the beginning of each shift. If risks are identified on the checklist that cannot be removed, staff should mitigate risk to the patient.
3. If patient is one to one, line of sight (LOS) or close observation as determined by physician/mid-level provider, environmental assessment, the required observation will be recorded on the Psychiatric Flow Sheet (See Attachment E) by the assigned patient attendant.
4. Nursing staff should perform and document a focused nursing assessment to rule out any medical conditions that may be contributing to the patient's mental condition. Assessment should include a psychosocial assessment of the patient.
5. Hospital staff assigned as a patient attendant to monitored suicidal/self-harming patients will document observations every 30 minutes on the Psychiatric Flow Sheet.
6. The Environmental Patient Safety Checklist should be completed and documented by the assigned patient attendant on admission, each shift change, any change in staff and any changes in behavior.

7. Physician/mid-level provider will document in the patient's medical record the MSE including any tests performed, any stabilizing treatment provided, and disposition of patient. If the patient has sign/symptoms and/or concerning/contributing history or circumstances that might indicate increased risk of suicide and ASQ Suicide Risk Screen negative, physician/mid-level provider should document the rationale for appropriate level of observation and monitoring in the patient's medical record.

E. Any threat to the security and safety of patients, visitors, staff and/or the hospital environment will be reported promptly to the Mangum Police Department. Complete incident report for all involvement by law enforcement and forward to the Risk Manager.

F. Two critical assessments should be performed as soon as possible and documented in the patient's medical record:

VI. ENVIRONMENTAL RISK ASSESSMENT (Safety Check)

A. Prior to admission to patient room:

1. Remove all sharp objects
2. Remove unnecessary monitor cables, cords and equipment
3. Remove telephone
4. Remove call light unless necessary to use to call for assistance. If needed to call for assistance, ensure call light cord is shortened so as not useful to cause harm.
5. Remove any bottles/containers that contain solutions
6. Limit linen available in the room
7. Remove all plastic trash liners. Use only paper trash liners
8. Visitors are not permitted to take anything into room; this includes what may be in their pockets which could be used to cause harm. All handbags, cell phone chargers and other bags should be secured in the visitor's personal vehicle until visitors are ready to leave. The physician may order "No Visitors" if appropriate and necessary for patient safety.
9. Patient belongings are searched upon arrival for potential self-harm items or contraband.
    a. If any potential self-harm items are found on patient, items should be inventoried and secured in a designated area in the ED until the patient is transferred or discharged.
    b. If staff discovers any contraband or illegal substances, the item(s) should be confiscated from the patient and local law enforcement notified. The item(s) should be inventoried and secured until arrival of local law enforcement.

B. On admission to room:

1. Explain to patient and family that the patient is on suicide/self-harm precautions for their safety.
2. Immediately place the patient on constant one to one observation
    a. Hospital staff assigned to monitor patient should be of same gender as patient whenever possible, or per patient preference.
    b. Family members are not permitted to provide one to one observation.
    c. Law enforcement/correction officers are not allowed to provide monitoring of patients. Law enforcement staff may be allowed to provide the one to one observation, but hospital staff must still perform ongoing monitoring every 30 minutes and document observations on the Psychiatric Flowsheet.

3. Assist patient into hospital gown.
4. Search all belonging, including pockets in clothing, purse/bags:
   a. This must be completed by two hospital staff in the patient's presence
   b. Items which could be used for self-injurious behavior include but are not limited to:
      i. Belts
      ii. Shoelaces
      iii. Cellphones/phones
      iv. Ties/necklaces/jewelry
      v. Medications brought by the patient (OTC and prescription)
      vi. Other dangerous items (i.e. glass, scissors, knives, razors, nail files, electrical cords, lighters, cleaning chemicals, ink pens, alcohol foam, compact with mirror, phone charger/cord or any other items which could be used to harm self/staff).
   c. Contraband will be turned over to law enforcement.
   d. Explain to the patient/family we are doing this for their safety and according to policy.
   e. If the patient's physical person is searched, a hospital staff member of the same gender (or per patient preference) as the patient must assist in carrying out the search.
5. Document all patient belongings, removed from the room and secure them **[designate area]** or return to a family member to be taken from the hospital (this includes cell phones).

C. Assessment:
   1. Patient's environmental safety must be assessed and documented by nursing staff on admission, each shift, change in hospital staff member and with any reported change in behavior using the Environmental Patient Safety Checklist.

VII. DISCHARGE WITH A SAFETY PLAN

A. A Discharge Safety Plan (See Attachment F) is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in **the patient's own words**, and is **easy** to read.

B. After medical evaluation and risk assessment screening either the LMHP or the ED provider will determine if the patient can safely be discharged home. If it is determined the patient can return home safely a safety plan will be completed with the patient and family (if present) prior to discharge by either the LMHP or hospital staff.
   a. If the discharge safety plan is completed by the LMHP nursing staff will document the completion of the safety plan with the patient and family (if present) in the patient's medical record, and ensure patient and/or family have no additional questions or concerns prior to discharge.

C. Safety planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.
   1. There are six (6) steps to completing the Safety Plan with the patient using the Discharge Safety Plan. Identify Warning Signs

   a. Ask: ***"How will you know when the safety plan should be used?"***
   b. Ask: ***"What do you experience when you start to think about suicide or feel extremely depressed"***
   c. List warning signs (thoughts, images, thinking process, mood, and/or behaviors) using the patient's **own words**.
2. Identify Internal Coping Strategies
   a. Ask: ***"What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"***
   b. Assess likelihood of use: Ask: ***"How likely do you think you would be able to do this step during a time of crisis?"***
   c. If doubt about use is expressed, ask: ***"What might stand in the way of you thinking of these activities or doing them if you think of them?"***
   d. Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.
3. Identify Social Contacts Who May Distract from the Crisis
   a. Instruct patients to use Step 3 if Step 2 does not resolve crisis or lower risk.
   b. Ask: ***"Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"***
   c. Ask for safe places they can go to be around people (i.e. coffee shop).
   d. Ask patient to list several people and social settings in case the first option is unavailable.
   e. Remember, in this step the goal is distraction from suicidal thoughts and feelings.
4. Identify Family Members or Friends Who May Offer Help
   a. Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
   b. Ask: ***"Among your family or friends, who do you think you could contact for help during a crisis?"*** or ***"Who is supportive of you and who do you feel that you can talk with when you're under stress?"***
   c. Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
5. Identify Professionals and Agencies to Contact for Help
   a. Instruct the patient to use Step 5 if Step 4 does not resolve crisis or lower risk.
   b. Ask: ***"Who are the mental health professionals that we should identify to be on your safety plan?"*** and ***"Are there other health care providers?"***
   c. List names, numbers and/or locations of clinicians, local urgent care services.
6. Identify How to Make the Environment Safe
   a. Ask patients which means they would consider using during a suicidal crisis.
   b. Ask: ***"Do you own a firearm, such as a gun or rifle?"*** and ***"What other means do you have access to and may use to attempt to kill yourself?"***
   c. Collaboratively identify ways to secure or limit access to lethal means: Ask: ***"How can we go about developing a plan to limit your access to these means?"***

D. Assess likelihood patient will engage during each step; ID potential obstacles, and problem solve.

E. The Discharge Safety Plan should be completed collaboratively with the patient and family (if present) by nursing staff prior to discharge. The original should be provided to the patient and a copy placed in the patient's medical record.
F. Upon discharge the patient will be provided with the appropriate discharge instructions and information and a list of mental health resources (See Attachment G).

VIII. EMERGENCY ORDER OF DETENTION

A. Patients who meets the definition of a "person requiring treatment" may be subject to an Emergency Order of Detention.
B. A "person requiring treatment" means a person who because of his or her mental illness or substance abuse dependency:
   1. poses a substantial risk of immediate physical harm to self as manifested by evidence of serious threats of or attempts at suicide or other significant self-inflicted bodily harm,
   2. poses a substantial risk of immediate physical harm to another person or persons as manifested by evidence of violent behavior directed toward another person or persons,
   3. has placed another person or persons in a reasonable fear of violent behavior directed towards such person or persons or serious physical harm to them as manifested by serious and immediate threats,
   4. is in a condition of severe deterioration such that, without immediate intervention, there exists a substantial risk that severe impairment or injury will result to that person, or
   5. poses a substantial risk of immediate serious physical injury to self or death as manifested by evidence that person is unable to provide for and is not providing for his or her basic physical needs.
C. History of mental illness or substance abuse may be used as part of the evaluation to determine whether a person requires treatment but shall not be the sole basis for determination.
D. Homelessness, dementia, developmental disability or mentally retarded, seizure disorder, or traumatic brain injury alone is not enough to have a person placed in Emergency Detention. He/she must also meet one of the criteria of a person requiring treatment.
E. If the patient meets the criteria for a person requiring treatment a Third-Party Statement (See Attachment H) should be completed by the person who personally observed the concerning behavior.
F. Once a third party statement has been completed and LMHP or BSSA by provider has determined the patient is a "person requiring treatment", law enforcement should be notified (if not already present) to take the patient into protective custody for transport to a psychiatric facility.
G. A LMHP examination must be completed within twelve (12) hours of being placed into protective custody for the purpose of determining whether emergency detention of the patient is necessary.

IX. AGITATION AND DE-ESCALATION

A. Types of Aggression

1. Instrumental Aggression: used by those who have found they can get what they want by violence or threats of violence. This type of aggression can be handled by using counter offers to the aggressor's threats.
2. Fear Driven Aggression: patient wants to avoid being hurt and may attack to prevent someone from hurting them. This type of aggression can be handled by giving the patient plenty of space. Do not have a show of force or in any way intimidate the patient. Provide ongoing reassurance to the patient they are safe.
3. Aggression: This type of aggression comes in two forms:
   a. Person who has had boundaries violated; someone has cheated, humiliated, or otherwise emotionally wounded them. This type of aggression can be handled by setting conditions for the patient to be heard.
   b. Persons who are chronically angry at the world and are looking for an excuse to "go off". This type of aggression can be handled by giving the patient choices, let them know you will work with them but only if they are willing to be cooperative. Set firm limits to protect staff, patients, and others.

B. De-escalation of the agitated patient.

1. History is critically important in determining whether the source of agitation is likely related to a general medical condition such as hypoglycemia, hypoxia, or neurological problem versus an exacerbation of a psychiatric illness.
2. Identifying the underlying etiology is key to treating agitation in the ED setting.
3. When working with an agitated patient there are four (4) main objectives:
   a. Ensure the safety of the patient, staff, and others in the area.
   b. Help the patient manage their emotions and distress and maintain or regain control of their behavior.
   c. Avoid the use of restraints (mechanical, chemical and/or physical hold) when at all possible.
4. Avoid coercive interventions that escalate agitation.
5. Methods of de-escalation may include, but are not limited to the following interventions:
   a. Respect the patient's personal space.
   b. Maintain calm speech, demeanor, and facial expression.
   c. Establish verbal contact (designate one staff member to directly communicate and interact with the patient whenever possible).
   d. Listen closely to what the patient is saying.
   e. Be concise.
   f. Identify wants and feelings.
   g. Find a way to respond that agrees with or validates the patient's position.
   h. Explain to the patient what you want them to do.
   i. Clearly inform the patient of acceptable behaviors.
   j. Set clear limits.
   k. Offer choices and optimism.
   l. Show kindness (offer blankets, magazines, food, beverage if not contraindicated by environmental safety check).
   m. Never promise the patient something that cannot be delivered.
   n. Stand at an angle from the patient, hands should be visible.

i. Physical Environment
   a. The physical environment is important for the safe management of the agitated patient.
   b. The ability to remove furniture from the area can expedite the creation of a safe environment.
   c. There should be adequate exits (except in the case of suicidal/self-harm patients), and extremes in sound, wall color and temperature of environment should be avoided to minimize abrasive secondary stimulation.
   d. Hospital staff must remain aware of the potential for an agitated patient throwing objects that may cause injuries to others. Any sharp objects such as pens, sharp objects, table lamps, etc. that may be used as weapons should be removed or secured.

X. FOLLOW-UP CARE

For those patients that require further mental health services, the medical provider or LIP will make the appropriate referrals. A list of community resources will be made available to patients and or family if needed or required.

XI. RESPONSIBLE PARTIES/QUALITY ASSURANCE

Hospital leadership including but not limited to, the Nursing Department Director are responsible for ensuring that all individuals adhere to the requirements of this policy, procedures are implemented and followed at the Hospital and instances of non-compliance with the policy are reported to the Chief Nursing Officer and an incident report completed.

All patient and visitor reports of law enforcement involvement or security risk events will require the completion of an incident report.

All incident reports will be forwarded to the Quality Risk Manager and reported to the Safety/EOC, QAPI, MEC, and Governing Board.

VII. ATTACHMENTS

See EMD-006A: Emergency Severity Index Algorithm
Attachment A: ASQ Suicide Risk Screening Tool
Attachment B: Brief Suicide Safety Assessment
Attachment C: Columbia Suicide Severity Scale
Attachment D: Environmental Patient Safety Checklist
Attachment E: Psychiatric Flowsheet
Attachment F: Discharge Safety Plan
Attachment G: Local Mental Health & Substance Abuse Resources
Attachment H: Third Party Statement
Attachment I: Psychiatric Flowsheet Algorithm
Attachment J: Psychiatric Patient Outcome Review

VIII. REFERENCES

Wolf, Lisa A., PhD, RN, CEN FAEN; Perhats, Cydne, MPH, et al. (2018) *Assessing for occult suicidality at triage: Experiences of emergency nurses.* Journal of Emergency Nursing [Electronic version retrieved 04/26/19).

Mills, Peter D., PhD., MS (2018). Suicide Risk in the Hospital. Agency for Healthcare Research and Quality [Electronic version 04/26/18] at http://psnet.ahrq.gov/webmm/case/445/suicidde-risk-in-the-hospital

McCoy, Elizabeth M., RN, CEN (2010). Development of Emergency Care Psychiatric Clinical Framework. Emergency Nursing Association Position Statement [Electronic version retrieved 04/26/19].

Smith, Erin Murphy, MSN RN (2018). Suicide risk assessment and prevention. Nursing Management [Electronic version retrieved 04/26/19].

American College of Emergency Physicians (2018). Pediatric mental health emergencies in the emergency department. American College of Emergency Physicians Position Statement [Electronic version retrieved 04/26/19].

Dzubak, Jessica L. RN (2017). Managing mental health emergencies in the ED. American Nurse Today. [Electronic version retrieved 04/26/19).

Beebe, Chad AIA, CHFM, CFPS, CBO, FASHE (2018). Ligature-risk requirements: Separating fact from fiction in suicide prevention. HF Magazine. [Electronic version retrieved 04/26/19).

American College of Emergency Physician Sub-committee, et.al. (2017). Clinical Policy: Critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department. Annals of Emergency Medicine. [Electronic version retrieved 04/26/19).

Joint Commission (2018). National Patient Safety Goal for suicide prevention. [Electronic version retrieved 04/26/18)

Emergency Nurses Association (2018). Clinical Practice Guideline: Suicide risk assessment. [Electronic version retrieved 04/26/19)

Emergency Nurses Association (2013). Care of the psychiatric patient in the emergency 2018department. White Paper. [Electronic version retrieved 04/26/19).

Centers for Disease Control and Prevention (2019). Risk factors for suicide. Retrieved 05/09/19 from https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

Emergency Nurses Association (undated). Safe discharge from the emergency setting. Position Statement. [Electronic version retrieved on 04/26/19].

Joint Commission (2018). Ligature risks: Assessing and mitigating risks for suicide and self-harm. [Electronic version retrieved on 04/26/19].

Suicide Prevention Resource Center (2008). Safety planning guide: A quick guide for clinicians. [Electronic version retrieved 05/10/19].

Joint Commission (2017). Patient Safety Tip of the Week: Joint Commission on Suicide Prevention. [Electronic version retrieved on 05/10/19].

Joint Commission (2018). Suicide prevention resources to support Joint Commission accredited organizations implementation of NPSG 15.01.01 revised November 2018 [Electronic version 05/10/19).

2018 Oklahoma Statutes Title 43A. Mental Health §43A-1-103. Definitions

2018 Oklahoma Statutes Title 43A. Mental Health §43A-5-207. Local Law Enforcement Mental Health Manpower Act

2018 Oklahoma Statutes Title 43A. Mental Health §43A-5-208. Initial assessments – Emergency detention – Release.

American Association of Emergency Psychiatric Project BETA De-escalation Workgroup (2012). Verbal de-escalation of the agitated patient: Consensus statement of the American Association of Emergency Psychiatry Project BETA De-escalation Workgroup, West EM.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change