Suicide and Homicide Prevention Policy

Inmind Reference:	CLN22
Category:	Clinical Policies
Version Number:	V1.0
Reviewed on:	October 2018
Next review date:	October 2019
Lead Officer:	Director of Nursing
Equality Impact Assessment completed:	Yes

Applicable Legislation/Regulations:
DH (2011) No Health without Mental Health: a cross-government mental health outcomes strategy for people of all ages DH (2012) Preventing Suicide in England: A cross-government outcomes strategy to save lives NPSA (2009) Preventing Suicide: A toolkit for Mental Health Services Appleby, L. et al (2016) Annual report and 20-year review DH (2009) Best Practice in Managing Risk: Principles and guidance for best practice in the assessment and management of risk to self and others in mental health services DH (2008) Refocusing the Care Programme Approach: Policy and positive practice guidance NICE (2004) Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. CG16 NICE (2013) Quality Standard for Self-harm. QS34 NICE (2015) Violence and Aggression: Short-term management in mental health, health and community settings.
Codes of Practice:
MHA Code of Practice
Purpose:
To protect patients from the risk of suicide and homicide.

Version Control Table		
Date Ratified	**Version Number**	**Status**
October 2019	V1.0	Live

Date	**Key Revision**
October 2018	Reviewed

Please check to ensure this is the most current electronic copy of this document as it is updated and published in electronic format only (hard copies may become out of date).

Equality Impact Assessment for this policy

Protected Characteristic (domain)	Area of conflict	Resolution
Age	Nil	N/A
Disability	Nil	N/A
Gender Reassignment	Nil	N/A
Pregnancy & Maternity	Nil	N/A
Race	Nil	N/A
Religion or Belief	Nil	N/A
Sex	Nil	N/A
Sexual Orientation	Nil	N/A
Marriage and Civil Partnership	Nil	N/A

All relevant persons are required to comply with this policy and must demonstrate sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation. If you feel you are disadvantaged by this policy, please contact the Registered Manager and the service will actively respond to the enquiry.

1 Introduction

1.1 It is known that people who are receiving treatment or who have recently received treatment for mental health problems are at greater risk of suicide than the general population. It is reported that approximately 1700 mental health patients take their own lives annually across the United Kingdom which is approximately 28% of the total rate of suicide (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness).

1.2 Death by suicide in the three months following discharge from inpatient mental health care is more likely than suicide during inpatient treatment. Suicide is most common in the two weeks following discharge.

1.3 In order to identify high risk individuals each potential and current patient will be subject to a thorough risk assessment. Where risks are identified, these will be

managed by detailed care planning, effective communication, observation and timely therapeutic interventions.

1.4 Clinical teams will receive training in risk assessment and will also have their competence to conduct risk assessments reviewed at regular intervals.

1.5 Risk assessment must consider the patient's circumstances. Patients should only be risk assessed using the specific tool for the patient group within which they fall for example risk assessment tools that are highly relevant to people with acute mental illness may give misleading results if applied to patients with learning disabilities or severe cognitive impairment. Where the assessor is uncertain about the validity of a particular tool, he/she should seek advice from someone who has more experience. See CLN24 CPA Section 117 Aftercare Policy.

1.6 It is understood that on rare occasions inpatients will take their own lives despite thorough risk assessment and clinical intervention. In the event of such an incident the incident management, reporting and investigation process should be followed enabling the clinical team and the division as whole to review its practice, to learn valuable lessons and make improvements. An action plan will be put in place in conjunction with and subject to monitoring by the hospital Clinical Governance Committee.

2 Access to Lethal Methods of Self-Harm

2.1 Suicide is often an impulsive act; if the means are not immediately available the risk may be minimised.

2.2 Hanging or strangulation are the most common methods of suicide among the general population and those on mental health wards. Good safety practice requires that regular audits and checks are made of the inpatient environment paying attention to potential ligature points.

2.3 Colleagues should be constantly mindful of the risk posed by the ligatures that are found in the ward and hospital environment; these will include luggage straps, laptop/phone cables and items of clothing such as hoodies and belts. This is not an exhaustive list. Whilst certain ligatures can be removed during periods of high patient acuity and distress this action should be a last resort given that this can impact on a patient's choice and freedom and can cause discomfort and impact negatively on the person's mental health and willingness to engage. Colleagues should in the first instance work towards ensuring a safety culture which involves engagement, openness, risk assessment and observation.

2.4 Careful consideration should be given to self-harm risk when engaging in self-medication regimes and permitting patients to have access to sharp items.

3 Pre-Admission

3.1 The risk assessment process starts at the point at which a patient is referred to Inmind Healthcare Group. The receiving team will whenever possible, from the written evidence and history, assess the risk that person presents for serious self-harm, suicide or other risk behaviours and whether they can be managed within an identified environment.

3.2 They should also establish if he or she has a history of drug or alcohol misuse and note all treatments and interventions used.

3.3 The clinical team need to consider the impact that an admission to Inmind Healthcare Group may have on the individual. They may, for instance, have less contact with family/friends and sever existing links with their support networks and local community.

3.4 For all admissions specific enquiry should be made about any history of violence, suicidal thoughts or self-harm to include the following:
(a) What were the circumstances leading to this?
(b) What method did the patient use?
(c) What was their clinical presentation?
(d) What is their account of events now?
(e) What, if anything, has changed to reduce (or increase) the risk of it reoccurring?

3.5 All the above information will be recorded and discussed by the referral team. If the patient is deemed suitable for the hospital an initial care plan and treatment goals will be drawn up by the clinical team (prior to admission), which will take account of information collated and risks identified.

3.6 The person in charge of the receiving ward will request a current transfer summary and risk assessment for patients who have been on the waiting list for some time. A reassessment of their suitability may be required if there have been significant changes to their presentation.

4 The Admission Assessment

4.1 Risk assessment and management are an integral part of care planning and management. The challenge for clinical team's rests with their collective ability to accurately assess risk in individuals particularly when considering patients on community or home leave.

4.2 Whenever possible, the patient will be involved in the risk assessment and risk management planning process. Their views will be recorded in the written records.

4.3 It is vital that the admitting colleagues try to establish a good rapport with the patient. This will help put them at ease and help enable cooperation with the care and treatment plan. A good rapport is likely to lead to a more open disclosure from the patient when assessing the risk of suicide.

4.4 The patient must be given ample opportunity to discuss any current concerns, past offending behaviour or suicide attempts and factors that may lead to an increased risk of harm to self, such as anniversaries, recent life events or known triggers. There is no evidence that discussing suicide leads to an increased risk of preoccupation with the subject or an increase in actual ideation, intent or attempt but instead offers the opportunity for the person to discuss and relieve themselves of distressing and uncomfortable thoughts.

4.5 The patient should be given the opportunity to explore their individual way of coping with their distress; for instance, withdrawing or seeking someone they trust to discuss concerns with. The patient will also be given the opportunity to identify what events/circumstances may increase their distress and therefore the risk of suicidal thinking.

5 Care Planning

5.1 On admission all patients will have an initial care plan formulated, this will be formulated where possible in partnership with the patient and where appropriate their family. The admitting nurse, in conjunction with the admitting medical officer, will consider the following when planning the patient's care:

(a) The degree of risk the patient presents to himself or herself.
(b) Where a significant risk is identified, ways in which this can be managed will be recorded in a management plan.
(c) The level of observation that the patient will be subject to and at what intervals this will be reviewed.
(d) The option of admitting the patient in a 'safe room', with reduced ligature points.

6 Safer Services Recommendations (1999)

6.1 Safer Services 1999 presented recommendations based upon Inquiry findings, these include:

6.2 The recommendation that ward teams are more vigilant about patient's whereabouts and activities during the evening and night and increase monitoring.

6.3 Additional risk assessments are carried out by the clinical team prior to granting leave to patients recovering from acute illness.

6.4 During the first seven days of admission, patients deemed to be at risk of suicide should be closely monitored.

6.5 Patients subject to non-routine observations will not normally be allowed time off the ward.

6.6 Colleagues responsible for 1:1 observations of vulnerable patients will ensure there are no "gaps" in their observation.

6.7 That hospitals enable clinicians to learn from an inpatient suicide in order to prevent future tragedies and avoid developing a “blame culture”.

6.8 The above will be achieved by conducting transparent inquiries and audits.

6.9 That, in the aftermath of a suicide, the outcome of any inquiry is communicated to the family of the victim if they so wish.

6.1 In the event of the death of a patient, the RC will comply with the requirements of the National Confidential Enquiry into Suicide and Homicide.

7 Discharge

7.1 Suicide is most common in the two weeks following the discharge of the patient. It is essential to have an appropriate plan for post-discharge follow-up.

7.2 It is essential to document where the patient is to be discharged to and what support they will have there. Discharge should not take place until the clinical team are satisfied that the patient’s essential needs will be met at the place they are going to and if applicable a Care Programme Approach Meeting held detailing support that will be in place following discharge.

7.3 There should be a plan for medical follow-up after discharge. This may be a referral and follow-up appointment with their GP, community team or in outpatients.

7.4 The individual or service responsible for the patient upon discharge, should accept and understand their responsibility and be fully appraised of any risk that the patient presents.

7.5 Colleagues who are managing the discharge process should be mindful of the fact that patients identified as being at moderate or high risk of self-harm should be seen within 48 hours of discharge and those who are low risk patients should be seen within seven days. Risk levels should be made clear to the team receiving the patient.

7.6 Patients should have an emergency plan agreed prior to discharge. This may include a ‘phone number for the ward, contact details for the local crisis service or advice to contact their GP.

7.7 Occasionally, patients leave before a discharge plan can be agreed with them. They may discharge themselves against medical advice or abscond. When this happens, the ward colleagues should do everything practicable to arrange appropriate follow-up and put in place an emergency plan. See H02 Admission, Transfer and Discharge policy. Ask lisa

8 Notification

8.1 In all cases of reported or possible suicide policy Incident Management, reporting and Investigation should be referred to. This provides details on the actions to be taken in terms of managing and notifying the incident.

NOTE:
Actuarial & clinical risk assessment tools such as the START, HCR-20 or Beck Suicide Ideation Scale can be used to assist the clinician.

The management of risk can include many types of interventions, such as: counselling/listening; distraction and activity; relaxation and recreation, minimising environmental risks, enhanced observations and the use of medication.

The benefits of maintaining a patient's safety with the use of close observation must be balanced against the "potentially distressing effect on the patient of close observation", Mental Health Act Code of Practice 1983. Any patient subject to close observation will have this addressed in their care plan. Risk should be balanced with least restrictive practice.

A formal and comprehensive risk assessment will be completed by the patient's Multidisciplinary team, within four weeks of admission and then prior to each CPA meeting (if on CPA).

Any patient deemed to be of at least moderate risk of suicide or a potential serious risk to others will have their care plan reviewed at each multi-disciplinary review.

All patients on CPA will be subject to a multi-professional risk assessment at every CPA and Section 117 meeting (except Scotland).

Pre-discharge planning, in conjunction with the locality team is vital for patients about to return to the community and factors that suggest that a patient has been, or might be, assessed as a suicide risk are to be recorded in case summaries and discharge letters. Patients who have recently been discharged from an inpatient environment are at a high risk of suicide (Department of Health 1999).

Discharge planning should be conducted by multidisciplinary teams, including liaison between health and social care service, housing agencies, criminal justice professionals & MAPPA as required.

Referral/ transfer and discharge summaries should be written and sent to relevant professionals and should include information such as diagnosis, medication, results of any assessments, follow up arrangements, risk assessment, risk factors, relapse indicators, contingency and crisis management and plans/ advice for future management, along with a clear plan of action to follow if a patient fails to comply with the conditions of their discharge.

All patients who are deemed to be at immediate risk of suicide or harm towards others will have a nursi relating to this. This will be formulated between the patient and his/her named nurse and will include n the patient finds effective in minimising the risk, for instance, those they turn to for support in times of cr directives etc.

The named or allocated nurse will review the care plan, which relates to an immediate risk, at least twice in every 24 hours.

Where there is evidence that a patient poses a significant and immediate risk of serious self-harm/suicide/harm to others, the care management of that patient will be discussed and documented by the named nurse, RC/Consultant and Ward Manager.

The nurse in charge will report any significant changes to the patient's presentation to the Ward Medical Officer on call (if out of hours).

Serious incident reviews should be open and independent, with adequate support provided to the member of staff and families/carers involved. They should occur without unnecessary delay and recommendations should be acted upon.