SUBJECT:  CLOSE WATCH

PURPOSE: To establish precaution guidelines while providing care for the adult and pediatric patient with acute psychosis, suicidal or homicidal ideations, self-inflicted injuries, overdose, and/or statements of self-harm intentions.

POLICY STATEMENT(S): Patients considered at high risk are placed on close safety watch (constant observation) until the staff and physician are reasonably assured the danger is reduced and the physician discontinues the close watch order. Close Watch is defined as maintaining constant observation of the patient.

Adult patients requiring close watch for suicidal/homicidal ideation/attempts are admitted/transfered to LifeSpring if they are medically stable. All adult inpatients being transferred to LifeSpring must be discharged and then admitted to LifeSpring.

PROCEDURE:

All Areas:

1. Patients verbalizing suicidal or homicidal ideation or determined to be at risk for self-harm are placed on close watch.

   KEYPOINT: A physician’s order is obtained prior to or immediately following the initiation of close watch.

2. The patient is received/registered as a Secured patient, if applicable.

   KEYPOINT: Patient may be placed in room closer to nursing station when beds are available.

3. The patient’s room is cleared of equipment or objects that he/she could use to harm themselves such as trash cans, trash bags, chairs, bedside tables (with mirrors), etc. prior to placing the patient in the room.

   KEYPOINT: See contraband list on back of Close Watch Log (M0281). One chair may remain in the room for close watch staff use.

4. The patient’s belongings are collected and secured, either with a Security Officer or in the ED, following the Administrative Policy 0070-0068 Patient’s Valuables. A Patient’s Belongings Checklist is documented in Meditech per Administrative Policy 0070-0068 Patient’s Valuables.

   KEYPOINT: Items brought by family/friends are to be checked by nursing staff for safety before items are given to patient.

5. Assess the patient’s suicide potential at least every shift and prn and document.

6. Psychiatric consultation as ordered by physician.
7. A physician’s order is required to discontinue close watch.

Emergency Department:

1. A Registered Nurse performs and documents an appropriate triage upon patient arrival to the Emergency Department.

2. The patient is assigned an Emergency Severity Index (ESI) Triage Level of 2 due to the high-risk nature of the patient.

   KEYPOINT: Signs and symptoms to evaluate a patient for suicidal, homicidal or psychiatric concerns include verbal statements, family/visitor statements and non-verbal assessments such as pacing, mounting agitation, insomnia, paranoia – voiced or non-verbal, intellectual/neurological deficits, altered nutritional deficits, inability to concentrate, increased voice volume, substance withdrawal, psychosis – auditory or visual hallucinations. (Reference from LifeSpring Departmental Policy 6400-LS25 Series 60 Assaultive or Violent Behavior)

3. The patient is placed in the paper scrubs.

4. The ED RN completes the ED Psychiatric Assessment in EDM. The ED RN collaborates with the ED Physician to plan the care and treatment of the patient.

   KEYPOINT: For additional assistance, the ED RN may collaborate with the RN from the Inpatient LifeSpring Unit.

Inpatient Areas:

1. Upon arrival, or immediately after the patient verbalizes suicidal/homicidal ideation or plans, the nurse assesses the patient’s suicidal/homicidal potential, risk for self-harm.

   KEYPOINT:
   The nurse asks the patient:
   a. Are you having thoughts of killing yourself or others?
   b. What is your plan for doing this?

   Suicide Risk Factors to evaluate:
   a. Past attempt/family history of suicide
   b. Psychiatric disorder/illness
      • Disturbed thinking
      • Disorganized thinking
      • Depression (sleep, appetite, mood)
      • Anxiety
   c. Drug/Alcohol use
   d. Lack of support (social isolation)
      • Divorced
      • Separated
      • Lives alone
   e. Unemployed
   f. Chronic physical illness
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g. Losses-Recent bereavement
h. Feels hopeless
i. Uncommunicative
j. Declines to contract for safety
   KEYPOINT:  Contract For Safety:  Patient will verbally state they will not harm self.

2. Patients verbalizing suicidal/homicidal ideation or determined to be at risk for self harm or unintentional injury are placed on close/patient safety watch. The door to the patient’s room must remain open at all times. An orange magnet with a magnifying glass symbol is placed on the outside door frame to alert staff there is a patient in close watch in that room.
   • Contact the House Manager to arrange for staffing needs.
   • Family cannot be responsible for providing close watch observation.
   • Intubated patients who are not conscious do not require close watch. When the patient is conscious and responsive, the nurse assesses for suicide potential and consults with the physician.

3. The nurse contacts the physician with assessment information and requests the adult suicidal/homicidal patient be admitted to LifeSpring after medical clearance.
   • Nurse calls admitting to provide information.
   KEYPOINT:  Adult patients who are suicidal and are medically stable are admitted to LifeSpring on a voluntary or involuntary basis (See LifeSpring Policies: 6400-LS14 & 6400-LS13). Any staff physician can order a 72-hour hold. Within 24 hours of the hold, the physician must document that in his/her opinion the individual should be involuntarily hospitalized. If the admitting physician is not a psychiatrist, the admission is cleared with the medical director of Psychiatry or the on-call Psychiatrist.

4. Patients who are suicidal with medical care needs:
   • Notify LifeSpring staff for any order written for a 72-hour hold on adult patients only.
   • RN performs suicidal assessment once a shift and consult with physicians with contract for safety or potential for non-suicidal ideations.
   • Secure all home medications and send to Pharmacy.
   • Document patient’s behavior on close watch log every 15 minutes
     KEYPOINT:  RN verifies and initials close watch activity every 2 hours.
   • Observe patient constantly.
   • Be alert to sharp objects or any other potentially dangerous items and remove from room or patient.
   KEYPOINT:  Patients are only allowed ink pens while signing documents. Non-toxic crayons should be utilized if requested for other writing or drawing needs.
   • A room safety check (check room, bed, tables, etc. for contraband and other unsafe items) is performed and documented by close watch staff at 7 AM and 7 PM and upon return to the room if the patient was out of the room for testing.
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- Inform Dietary to deliver all meals on paper plates with plastic utensils.

5. Provide education on the following to the patient and family member and document in medical record.
   - The purpose and method of close watch
   - Removal of contraband
   - Leaving personal items in vehicle when visiting patient

6. If patient requires tests in another department the close watch staff accompanies patient and remains with patient at all times continuing close/patient safety watch.

**KEYPOINT:** Close watch patients cannot leave the unit to go to the gift shop or the cafeteria.

7. Close watch staff are not assigned more than two patients at one time.

**KEYPOINT:** Unit PCA will have to perform PCA duties if close watch staff observing two patients.

8. If the close watch staff is assigned two patients to observe at the same time, they must call for assistance as needed if one of the patient’s leaves the bedside.

9. Utilize Ticket to Ride form (F0051) and the Close Watch Log (M0281) for hand-off communication at shift change.

**KEYPOINT:** One Ticket to Ride is to remain in the chart, and one Ticket to Ride stays with the close watch. The Ticket to Ride is updated every shift as needed.

10. Close watch staff must complete initial training and yearly CBT’s.
   - Close watch staff may not bring personal diversional activities or items including cellular phones.
   - Close watch staff coordinates breaks with the nursing staff.

**REFERENCES:**

- KRS 202A.031
- Suicide and Documentation, Psychosocial Nursing, July 2006
- Joint Commission Solutions, Recognizing the Issues Behind Patient Suicide, Nursing Management, May 2007

**ATTACHMENTS:**

- M0281 Close Watch Log (Contraband list on page 2)
- F0051 Ticket to Ride
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APPROVE(S):  
Clinical Practice Committee .............................. 02/14  
Director, Cardiovascular Services Line .............. 01/14  
Director, Medical/Surgical Services ................. 01/14  
Director, Emergency Department ......................... 02/14  
Medical Executive Committee............................. 03/14  
Vice President/CNO......................................... 02/14