



INTERNAL MANAGEMENT POLICY & PROCEDURE

Applicability: ☐ ADULT Operations Only ☐ JUVENILE Operations Only ☒ DEPARTMENT-WIDE

IMPP #: 10-105D

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PROGRAM AND SERVICES: Facility Suicide Prevention Programs

Original Date Issued: 02-23-16 **Replaces IMPP Issued:** 01-10-19 **CURRENT EFFECTIVE DATE:** 06-25-24

Approved By: , Secretary **Next Scheduled Review:** 03/2027

POLICY

All facilities shall have a written suicide prevention and intervention program, which has been reviewed and approved by qualified medical and behavioral health professionals. The program shall be established by the Regional Psychiatric Director and Regional Medical Director and approved by the Director of Health Care Compliance. The program components shall include methods for the identification, monitoring, and housing of potentially suicidal residents; referrals to behavioral health providers; communication between health care and facility staff; intervention/response techniques; notification procedures; and reporting and review procedures. (NCCHC P-B-05)

To ensure the implementation of such programs, all facility staff with responsibility for resident supervision shall be trained to recognize behavioral and verbal signs, which might indicate suicide potential. The training curriculum shall be developed with input from facility staff and approved by the Regional Psychiatric Director, Regional Medical Director, Health Services Administrator, Behavioral Health Coordinator/Director (BHC/BHD) and the warden/superintendent.

DEFINITIONS

Director of Health Care Compliance: Acts as the administrative health authority for the Department. This position manages health care systems, directs the health care services model, and has final approval on all policies and procedures in the health care system.

Facility Psychiatric Director: Responsible to the Regional Psychiatric Director clinically and the facility Health Services Administrator administratively.

Observation: The resident and the resident's movement are observed as prescribed by a written plan outlined by the Facility Psychiatric Director. Observation of potentially suicidal residents shall include irregular, unpredictable documented checks according to the prescribed crisis level, but no greater than 15 minutes apart. Residents who are actively suicidal are placed on constant observation. Supervision aids such as closed-circuit television can be used as a supplement to, but never as a substitute for, direct staff monitoring.

Qualified Health Care Professionals: Includes physicians, physician assistants, nurses, nurse practitioners, dentists, behavioral health professionals, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the health needs of the patient.

Regional Medical Director: The physician Medical Director of the contracted agency or organization responsible for the provision of health care services for the KDOC resident population. This position has full clinical autonomy and responsibility for the provision of clinical services within the KDOC.

Regional Psychiatric Director: Responsible for the clinical supervision of all facility psychiatrists. The Regional

Psychiatrist is supervised clinically by the Regional Medical Director and administratively by the Regional Vice President and/or designee.

Resident Companions: Residents who have specialized training to perform suicide observation of other residents in accordance with IMPP 10-144A.

Standard Precautions: An approach to infection control based on the concept that all human blood and certain human body fluids are treated as if known to be infectious for Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), and other blood borne pathogens.

PROCEDURES

I. Establishment of a Suicide Prevention Program (ACI 3-4364 NCCHC P-B-05 NCCHC MH-G-04)

- A. The Regional Psychiatric Director and the Regional Medical Director shall develop a written program approved by the Director of Health Care Compliance for identifying and responding to suicidal individuals. Such programs shall include the following elements:
 - 1. Identification: Screening of newly received residents shall be completed upon arrival and include observation and interview items related to the resident's potential suicide risk, per IMPP 10-117D.
 - a. If emergent issues are identified in the screen, a follow up assessment must be completed within one hour. For other identified issues, a follow up review must be completed by behavioral health staff within 24 hours.
 - 2. Training: Procedure for training staff members in verbal and behavioral cues that indicate potential suicide, per IMPP 03-104D. (NCCHC P-B-05)
 - 3. Assessment/Evaluation: Procedures whereby qualified behavioral health professionals designate the resident's status with regard to suicidal activity.
 - 4. Treatment: Strategies and services to address the underlying reasons for the resident's suicidal ideation are to be considered.
 - 5. Monitoring: Procedures for monitoring a resident who has been identified as potentially suicidal.
 - 6. Housing: Procedures for housing residents in accordance with the degree of risk and available staff, per IMPP 10-117D.
 - 7. Referral: Procedures for referring potentially suicidal residents and attempted suicides to behavioral health care providers or facilities.
 - 8. Communications: Procedures for communicating between health care and correctional personnel regarding the status of the resident.
 - 9. Intervention/Response: Procedures for handling a suicide in progress, including how to cut down a hanging victim, administering other first aid measures, and use of universal precautions.
 - 10. Notification: Procedures for notifying appropriate staff, outside authorities, and family members of completed suicides or attempted suicides which shall be in accordance with IMPP 01-114D.
 - 11. Reporting: Procedures for documenting the identification and monitoring of potential or attempted suicides.
 - 12. Incident Review: Procedures for medical and administrative review should a completed suicide occur.

13. Critical Incident Debriefing: Procedures for offering critical incident debriefing to all affected personnel and residents involved in responding to and/or observing a suicide in progress. (NCCHC P-B-05)

II. Training of Staff Responsible for the Implementation of Suicide Prevention and Intervention Program

- A. The warden/superintendent shall identify those staff positions requiring training in the suicide prevention program, in accordance with IMPP 03-104D.
 1. Such training shall be completed within 90 days of the employee's appointment.
- B. Tentative identification of a potentially suicidal resident may be made by any staff member of the facility.

III. Intervention Referral of Potentially Suicidal Resident

- A. Staff shall immediately refer any resident who exhibits behavior, which is suggestive of potential suicide to qualified health care professionals.
 1. Staff shall arrange for an immediate evaluation by a qualified health care professional.
 2. Pending the immediate evaluation by the qualified health care professional, the resident shall be kept under continuous observation.
- B. A resident who has attempted suicide shall receive immediate medical attention.
 1. After emergency medical treatment is completed, a behavioral health professional shall perform an immediate evaluation.
 2. Pending evaluation, the health care staff shall be contacted to obtain directives with regard to the level of behavioral health monitoring required.
 3. Behavioral health care staff shall manage the resident as potentially suicidal (see Section V.).

IV. Assessment of Potentially Suicidal Resident and Follow-up Procedures (NCCHC P-B-05)

- A. If a resident is referred to a behavioral health professional for suicide assessment and the examiner(s) determines that the resident is not potentially suicidal:
 1. Such determination shall be documented, in writing.
 2. The housing/supervision of such residents shall be determined by the warden/superintendent or designee.
- B. If a resident is referred to a behavioral health professional for suicide assessment and the examiner is unable to make a judgment regarding suicide potential, the resident shall be managed as potentially suicidal.

V. Housing/Placement and Supervision of Potentially Suicidal Residents (NCCHC P-B-05)

- A. Residents assessed as potentially suicidal shall be:
 1. Placed on behavioral health monitoring as approved by the behavioral health professional and/or psychiatrist and kept under observation;
 - a. The frequency and type of observation shall be as prescribed in a written plan of

care as outlined by the qualified health care professionals.

- (1) Actively suicidal residents will be placed on continuous suicide observation.
 - (2) Potentially suicidal residents will be monitored on an unpredictable (staggered) schedule according to the prescribed plan with no more than 15 minutes between checks.
 - (3) Residents who are no longer potentially suicidal but are still in need of ongoing monitoring, or those whose mental health status requires closer monitoring, will be monitored on an unpredictable (staggered) schedule according to the prescribed plan with no more than 30 minutes between checks.
 - (4) The checks shall be documented on a monitoring form, approved by the Regional Medical Director and the Director of Health Care Compliance (example provided in Attachment A [adult] and Attachment B [juvenile]), for behavioral health monitoring, intermittent suicide observation, continuous suicide observation, clinical restraints, and emergency psychotropic medication administration.
- b. Resident Companions may be used (when ordered by psychiatry staff) to provide supplemental, continuous observation of residents who have been placed on behavioral health monitoring or intermittent suicide observation in accordance with IMPP 10-144A.
2. Evaluated daily by behavioral health (or medical) staff; and,
 - a. Facilities not able to provide for daily evaluation by behavioral health or medical staff, shall arrange for the immediate transfer of potentially suicidal residents to a facility where such services are available.
 - b. Resident's medical assessments by medical staff are in accordance with procedures established by the psychiatrist.
 - c. Staff, including program staff, shall be informed of the resident's status.
3. **ADULT:** Considered for transfer to El Dorado Correctional Facility (EDCF) (for male residents) or Topeka Correctional Facility Behavioral Health Unit (TCF-BHU) (for female residents) for further evaluation and/or for intensive mental health supervision and counseling. (NCCHC P-B-05)
 - a. After a female resident is transferred to TCF Behavioral Health Unit, if staff at that facility determine it to be necessary and appropriate, transfer to Larned State Security Hospital shall be considered in accordance with IMPP 11-103A and IMPP 16-114D. (NCCHC P-B-05)
 - (1) All residents must be medically stable and cleared medically by the site medical director they are transferred to EDCF, TCF, or the Larned State Security Hospital.

VI. This IMPP must serve as final policy in all departmental facilities, and no General Orders shall be developed or implemented on this subject.

NOTE: The policy and procedures set forth herein are intended to establish directives and guidelines for staff and residents and those entities that are contractually bound to adhere to them. They are not intended to establish State created liberty interests for employees or residents, or an independent duty owed by the Department of Corrections to employees, residents, or third parties. Similarly, those references to the standards of various

accrediting entities as may be contained within this document are included solely to manifest the commonality of purpose and direction as shared by the content of the document and the content of the referenced standards. Any such references within this document neither imply accredited status by a Departmental facility or organizational unit, nor indicate compliance with the standards so cited. The policy and procedures contained within this document are intended to be compliant with all applicable statutes and/or regulatory requirements of the Federal Government and the state of Kansas. This policy and procedure is not intended to establish or create new constitutional rights or to enlarge or expand upon existing constitutional rights or duties.

REPORTS REQUIRED

None.

REFERENCES

IMPP 01-114D, 03-104D, 10-117D, 11-103A, 16-114D
ACI 5-ACI-6A-30, 5-ACI-6A-35
NCCHC P-C-04, P-B-05 ; MH-G-04

HISTORY

02-23-16 Original
01-10-19 Revision 1
06-25-24 Revision 2

ATTACHMENTS

Attachment	Title of Attachment	Page Total
A	Monitoring Sheet for Behavioral Health Monitoring, Intermittent Suicide Observation, Continuous Suicide Observation, Clinical Restraints, Emergency Psychotropic Medication	1 page
B	Juvenile Services Monitoring Sheet for Behavioral Health Monitoring, Continuous Suicide Observation, Clinical Restraints, Emergency Psychotropic Medication	1 page

Resident Name (Last, Middle, First)	DOC#	DOB	Race/Sex	Facility
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Completed logs shall be submitted to the Shift Manager, who shall save all logs for documentation purposes.