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Perinatal Mood Anxiety Disorder and Suicide Risk Screening in the Family Birth Center

PURPOSE/EXPECTED OUTCOME

To outline a protocol to identify patients at risk for perinatal mood and anxiety disorders, suicide, or self-injury while admitted to the Family Birth Center, through screening and identified interventions.

POLICY STATEMENT

All patients who present for care at the Family Birth Center will be screened for mood disorders and suicide risk during their admission. Pregnancy is associated with a high rate of mental health disorders, including depression. Maternal mental health conditions are the most common complication of pregnancy and birth, affecting 1 in 5 birthing people in the US (Maternal Mental Health Leadership Alliance, 2020). Depression during or after pregnancy can have profound effects on the mother and her family. Left untreated, perinatal mood and anxiety disorders can impact a mother's ability to care for her child and can lead to suicidal ideation, self-harm, or suicide. Maternal mental health is also a leading cause for maternal mortality, with suicide and drug overdoses, and other causes related to mental health and substance use issues accounting for 22% of pregnancy-related deaths in the United States (CDC, 2022).

Although suicide and suicide attempts occur at a lower rate during pregnancy and postpartum than in the general population, the prevalence of suicidal thoughts in the perinatal period may be as high as 14 percent. Suicide and homicide account for more pregnancy-associated deaths than any other cause of maternal mortality, including hemorrhage, preeclampsia, or anaphylactic syndrome of pregnancy. Of the pregnant and postpartum women who do complete a suicide, research indicates that as many as 40

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percent did not have a known mental health problem at the time of their death suggesting that it is possible to have suicidal ideation without depression.

DEFINITIONS

EMR Electronic medical record

EPDS: Edinburgh Postpartum Depression Scale

C-SSRS: Columbia Suicide Severity Rating Scale

Constant 1:1 visual observation in which a trained observer is assigned to continuously observe (in-person) only one patient . This allows the trained observer to immediately intervene should the patient attempt self-harm. The constant 1:1 observations are maintained while the patient sleeps, toilets, bathes, transfers off the unit, etc.

Trained Observer: Clinical team member trained and assessed to be competent to care for patients at risk for suicide or self-injury. The training and competence assessments are documented.

Direct Line of Sight A dedicated, trained clinical team member who has unobstructed sight of the patient. May be watching more than one patient but no more than 4.

MHP: Mental Health Professional. A provider trained to assess for suicide risk including Psychiatrist, Psychologist, MSW, LMHC, Psychiatric ARNP or CNS, and Psychiatric RN.

Risk Mitigation Precautions These are dependent on the patient condition, their need for medical monitoring, provider orders, and risk level. Precautions may include the search or removal of personal belongings, phone restrictions, observation, visitor screening, meal orders limited to finger foods or plastic utensils, and the removal of all ligature risks not required for safe patient care,.

SUPPORTIVE DATA

- Screening of patient and belongings policy
- Code Gray (Out of Control Behavior) Policy
- Elopement/Missing patient protocol
- Discharge safety/crisis plan guidelines
- Restraint and Seclusion Policy, 964.00
- Sitter Monitoring Protocol
- PMADs EPDS Algorithm
- SuicideSafetyPlanTemplate

PROCEDURE

A. A suicide risk assessment will be performed on all patients when they present for care at the Family Birth Center.

B. The nurse should make every attempt to obtain a valid response to the screening questions

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and delay the screen until the patient can fully understand the questions. This includes, but is not limited to, not conducting the screen during active labor, removing family/support that may influence the patient to answer falsely, or obtaining a medical translator.

C. The patient who is unable/unwilling to respond because of self-inflicted injury or suspicious harm, or exhibits psychotic behavior indicating imminent risk of self-injury will be considered high risk and will be placed on continuous in-person observation until he/she can be assessed by a provider or MHP.

D. All measures should be undertaken to reassess the safety of the patient demanding to leave who has screened as a high risk for suicide.

Mood Disorders Screening

A. All patients will be screened for mood disorders before discharge and approximately 12-hours after delivery using the Edinburgh Postpartum Depression Scale (EPDS).

B. If the total score is 10-12, the patient will be considered to be at risk for depression and/or anxiety and the nurse will notify the HCP and request a social worker referral, or appropriate referral based on facility practice, prior to patient discharge.

C. If the total score is 13 or higher, the patient will be considered to be likely suffering from depression and/or anxiety. The nurse will notify the HCP and request a social worker referral, or appropriate referral based on facility practice. The patient should not be discharged until that evaluation is completed.

D. If the score on question 10 is 1 or higher, the patient will be considered to be in a maternal crisis and at risk of harm to others or self. An immediate notification of the HCP and referral for a social worker evaluation is required, or appropriate evaluation based on facility practice. The patient should not be discharged until that evaluation is completed.

Suicide Risk Screening

A. All patients presenting for care shall be screened and assessed for suicide risk using the Columbia Suicide Severity Rating Scale (C-SSRS). The RN is responsible to conduct an initial screen, to determine the level of risk for the patient.

B. If the patient screens as low, moderate, or high risk for suicide, the nurse should immediately notify the provider and institute appropriate suicide risk mitigations. Patients who screen as high risk of suicide at admit will not be discharged until an evaluation by a social worker, or appropriate referral based on facility practice, is completed.

Mental Health Evaluations, Re-screening, and Reassessment

A. Patients who are assessed at any level of suicide risk will not be downgraded without a provider order. Risk mitigation precautions will not be removed without provider order.

B. Patients who screen as low, moderate, or high for suicide should have a mental health evaluation by a social worker, or appropriate referral based on facility practice, as soon as possible. The level of risk mitigation precautions following the mental health evaluation will be

based on the results of the mental health evaluation and provider judgment.

C. Patients who do not require risk mitigation precautions as determined by the mental health evaluation should have them discontinued as soon as ordered to provide for patient privacy, dignity, and autonomy.

D. Patients who remain on risk mitigation precautions following an mental health evaluation require re-screening with every shift change and change in patient condition.

E. Patients who give indication of potential self-harm or suicide risk at any point in their stay or who have concerning changes in their mental health condition will be re-screened and assessed appropriately, with interventions placed based on results of the re-screen and reassessment.

Suicide Risk Mitigation

Negative screen (no risk of suicide)

- Continue appropriate care

Low Risk of Suicide

- No observation required
- Communicate risk level to provider
- Suicide hot line (1-800-273-8255) and behavioral health discharge instructions provided
- Consider mental health evaluation by social worker, or appropriate referral based on facility practice, .

Moderate Risk of Suicide due to past attempt only but with no current indication of risk

- No observation required
- Communicate risk level to provider
- Suicide hot line(1-800-273-8255) and behavioral health discharge instructions provided
- Consider mental health evaluation by social worker, or appropriate referral based on facility practice,
- Complete safety planning form (attached) prior to discharge

Moderate Risk of Suicide with current indications of risk

- Direct line of sight monitoring with no more than 1:4 ratio
- Communicate risk level to provider
- Implement risk mitigation precautions
- Provide mental health evaluation by social worker, or appropriate referral based on facility practice,
- Complete safety planning form (attached) prior to discharge
- Suicide hot line(1-800-273-8255) and behavioral health discharge instructions provided

High Risk of Suicide

- Constant 1:1 visual observation implemented in which a trained observer is observed to one patient at all times
- Communicate risk level to provider
- Implement risk mitigation precautions
- Provide mental health evaluation by social worker, or appropriate referral based on facility practice,
- Complete safety planning form (attached) prior to discharge
- Suicide hot line (1-800-273-8255) and behavioral health discharge instructions provided

1:1 and Line of Sight Monitoring

A. Maintain continuous monitoring and document observations every 15-minutes in EMR.

B. Maintain continuous monitoring and not be distracted by any other activity such as reading, use of phone, etc.

C. Maintain continuous monitoring while patient is toileting/showering, eating, and during visitations.

D. Maintain continuous monitoring when patient is transported of the unit for procedures or tests

E. Conduct hand-off to relief observer when on breaks

F. Consult or inform assigned RN or charge RN if patient condition/bheavior changes or when difficulties arise while maintaining level of suicide precautions.

G. Call for assistance if needed for immediate intervention.

Communication/Hand-Off Procedures

A. Verbal reports and hand-off information from RN to observer must be completed within the first hour of shift or when placed on precautions.

B. Admission hand-offs from the emergency department, shift report and any other hand-offs occurring during hospitalizations will include a review of suicide risk-level and interventions.

C. The charge nurse will be made aware of any patient placed on or removed from suicide precautions on their floor or unit.

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REQUIRED REVIEW

Attachments

PMADs EPDS Algorithm.pdf

SuicideSafetyPlanTemplate.pdf

Approval Signatures

Step Description	Approver	Date

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Formatting and posting	[redacted] Document Control Coord	12/19/2024
FBC Standards Committee	[redacted] Administrative Assistant II	12/16/2024
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