Name of Policy:	**Suicide Risk Assessment/Precautions**
Policy Number:	3364-110-09-14
Department:	Nursing Service
Approving Officer:	Chief Nursing Officer (CNO)
Responsible Agent:	Chief Nursing Officer (CNO)
Scope:	The University of Toledo Medical Center (UTMC)

Effective Date: 12/16/2022
Initial Effective Date: 3/1981

_____ New policy proposal
_____ Major revision of existing policy
__X__ Minor/technical revision of existing policy
_____ Reaffirmation of existing policy

(A) Policy Statement

All admitted patients age 12 and above will be screened for the risk of suicide utilizing the Columbia Suicide Severity Rating Scale Screen Version (C-SSRS).

(B) Purpose of Policy

The purpose of this policy is to ensure an effective method for suicidal assessment, monitoring and treatment of patients at risk for suicide. These prevention techniques will be accomplished by a comprehensive approach that identifies and mitigates process and system level issues contained within the hospital environment that contribute to suicide attempts.

(C) Procedure

Suicide Risk Assessment

1. A suicide risk assessment will be completed on all patients by a Registered Nurse (RN) using the Columbia-Suicidal Severity Rating Scale (C-SSRS), on admission, presentation to the Emergency Room (ER), and upon any relevant change in condition.

    a. A brief evaluation summary will be documented by the RN. The summary may include warning signs, risk indicators, protective factors, access to lethal mean, collateral sources used and relevant information, specific assessment data that supports risk determination and rationale for actions taken and not taken.

2. All staff needs to be aware of suicidal risks. Suicide precautions will be noted in the medical record. Report and document any suicidal ideation/plan to the physician immediately.

3. Patients may be placed on suicide precautions by a physician's written or verbal order or as a result of a clinical assessment. The RN may place a patient on suicide precautions, inform the physician of the patient's behavior.

4. Once notified of the suicide risk, the physician or designee will evaluate the patient every 24 hours for continuation of suicide precautions.

5. Nursing interventions will be implemented based on the C-SSRS results.

Levels of Risk and Interventions using the C-SSRS

No reported history of Suicidal Ideation or Behavior:

- No action

Low Suicide Risk: Wish to Die or Suicidal Ideation **without** method, intent, plan or behavior (C-SSRS Suicidal Ideation #1 or #2) OR modifiable risk factors and strong protective factors

Interventions:

- assess patient's medical stability
- body/belongings search – remove any potentially harmful objects
- safety plan/move patient as close to nurse's station as possible
- assess physical environment
- warning signage
- frequent verbal contact
- room checked for harmful objects daily and after visitors depart
- social service consult

Moderate Suicide Risk: Suicidal ideation with method, **without** plan, intent or behavior in past month (C-SSRS Suicidal Ideation #3) OR suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) OR multiple risk factors and few protective factors

Interventions:

- assess patient medical stability
- body/belonging search
- safety plan/move patient as close to nurse's station as possible
- assess physical environment
- warning signage
- frequent verbal contact
- room checked for harmful objects daily and after visitors depart
- social service consult
- remove patient belongings
- arrange for plastic dinnerware or finger-food
- confiscate sharp objects
- Assess visitor belongings prior to being taken into patient room
- Psychiatry consult

High Suicide Risk: Suicidal ideation **with** intent or intent with plan in the last month (C-SSRS Suicidal Ideation #4 or #5) OR suicidal behavior within the past 3 months (C-SSRS Suicidal Behavior)

Interventions:

- assess patient's medical stability
- body/belonging search
- safety plan/move patient as close to nurse's station as possible
- assess physical environment
- warning signage
- frequent verbal contact
- room checked for harmful objects daily and after visitors depart
- social service consult
- remove patient belongings
- arrange for plastic dinnerware or finger-food
- confiscate sharp objects
- Assess visitor belongings prior to room entry
- Psychiatry consult
- Direct continuous 1:1 observation with documentation every 15 minutes on a Special Monitoring Special Precautions sheet (Form #NU091)
    - ADL's and toileting are to be closely monitored.
    - Bathroom and shower doors must remain open providing uninterrupted direct observation of patients on suicide precautions.
    - A staff member will accompany each high suicide risk patient when medical treatment requires the patient to leave the unit.

(D) Procedure for Belongings and Safety Checks

Procedure	Point of Emphasis
4. If the patient is assessed as a moderate or high risk, visitor belongings will be assessed, and hazardous items will not be allowed in patient room. Examples of hazardous items to be confiscated may include but are not limited to: • Razorblades, straight razors, safety razors, electrical razors • Knives, or any item that can be used as a knife • Firearms and ammunition • Medicines brought from home [prescription and over-the-counter meds] • Nail files, clippers, and tweezers	Room checks are ongoing and conducted to ensure unsafe objects are removed from the patient's room and secured. Dietary trays are sent only with plastic fork and spoon, paper plates and cups. Dietary is to pre-cut the meat. No plastic knives with serrated edges. Finger-foods may also be used as an alternative. The nurse is to make sure the patient swallowed the ordered medication. No meds to be left in the

- Scissors
- Glass items [exception corrective lenses eyeglasses]. No glass vases allowed.
- Mirrors including those in compacts
- Needles, hooks, pins, pin-on-jewelry, safety pins
- Shaving lotion, polish remover, personal care items containing alcohol or other caustic liquids
- Aerosol cans
- Rope, shoelaces, belts
- Valuables, including personal clothing
- Car keys
- Cigarette lighters
- Paraphernalia pertaining to chemical use
- Plastic liners for garbage cans
- Coins
- Cell phones at RN discretion

room.

Unused IV, oxygen tubing, and unnecessary bed control cords will be removed. Necessary Bed cords will be secured by maintenance in a small loop [so at minimum length].

(E) Goal of Communication

To establish a positive, therapeutic alliance with the patient.

- Remain calm, caring, supportive, accepting and nonjudgmental
- Use active listening skills
- Encourage the patient to talk about his/her feelings
- Help the patient identify, accept, and work through these emotions even if they are uncomfortable or painful

(F) Protective Factors

Discuss with the patient protective factors he/she has available**.**

- Support system/spouse/significant other/children/relatives
- Social Connectedness/friends
- Religious/spiritual coping
- Ability to problem solve
- Mental Health Literacy
- Reductions in Depressive Signs/Symptoms
- Instillation of Hope/Forward Thinking

(G) Preparing for Discharge

Prepare patient for discharge by providing suicide prevention information.

Crisis planning at discharge emphasizes how and where to obtain help.

- The National Suicide Prevention Lifeline 1-800-273-TALK (8255);
- Rescue Crisis 419-255-9585

(H) Training and Competence

All staff members who screen, assess, provide care for, monitor, transport, and/or have contact with patients at high risk for suicide do the following:

1. Achieve and maintain appropriate licensing, certification, credentialing, and/or privileging.
2. Demonstrate competency in performing job-related tasks associated with screening, assessing, providing care for, and/or monitoring patients at high risk for suicide.
3. Participate in all relevant ongoing education and training opportunities.

(I) Other

1. If a suicide is attempted, the need for medical treatment will be assessed and procedures for treatment will be initiated. The nurse will notify the attending physician, resident, Nursing Director (ND), and House Supervisor (HS). The HS will notify the administrator on call.

2. If a patient on suicide precautions elopes from the unit, staff is to immediately initiate a Code Brown. Further notification is then to be made to the attending physician and the ND. Campus police will notify the Toledo Police Department and the HS will notify the administrator on call.

References:
Tomb, David [2008 Seventh edition, Lippincott Williams & Wilkins] Psychiatry
Donald, M., J Dower, et al. [2006 "Risk and Protective Factors for Medically Serious Suicide Attempts: A Comparison of Hospital Based Sample of Young Adults". Australian & New Zealand Journal of Psychiatry 40[1]:8796
Hodson, D. (2011). Nurses concerned about rise in suicides at home. *Mental Health Practice, 17*(1), 6.
Research Foundation for Mental Hygiene (2008), C-SSR-Lifetime Recent-Clinical (Version 1/14/09). _

Approved by:	**Review/Revision Date:**
/s/ Kurt Kless, MSN, MBA, RN, NE-BC — Date *Review:* Policy & Standard Committee, 8/2010, 7/11, 12/13, 6/15, 7/17, 2/2020, 6/2020, 12/2022 *Revision Completed By: Kurt Kless, MSN, MBA, RN, NE-BC and Nancy Gauger, MSN, RN*	1982 9/90 8/2007 1983 7/93 11/2008 1984 6/94 8/31/2010 1986 5/96 6/10/2011 1987 2/99 7/22/11 1988 7/02 12.20.13 1989 6/05 6.26.15 10/05 07/17/217 2/20/2020 6/23/2020 12/6/2022 12/16/2022 **Next Review Date:** 12/2023
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