

Name of Policy: Suicide Assessment and Prevention		 Effective date: Original effective date: June 1, 2014	
Policy Number: 3364-120-66			
Approving Officer: Chief Executive Officer Chief Nursing Officer Service Chief			
Responsible Agent: Chief Nursing Officer Service Chief			
Scope: The University of Toledo Medical Center			
Key words: risk, behavior, severity, reassessment, precautions			
	New policy proposal		Minor/technical revision of existing policy
	Major revision of existing policy	X	Reaffirmation of existing policy

(A) Policy statement

It is the policy of inpatient behavioral health to create an environment of care that will foster the accurate identification and successful management of patients who are at an increased risk for suicide or self-destructive behaviors. Patients at risk for suicide require intensive support, close observation, frequent re-assessment, and application of protective measures for their emotional and physical well-being at all times. The scope of this plan begins at admission and continues through the patient’s discharge.

(B) Purpose

- (1) The purpose of this policy is to ensure an effective method for suicide assessment, monitoring, and treatment of patients at risk for suicide.
- (2) To assess a patient’s current potential to engage in suicidal behavior using versions of the Columbia Suicide Severity Rating Scale.
- (3) To develop an understanding of the factors in the individual’s past and current life situation which have resulted in considering and/or attempting suicide as a maladaptive means of coping with existing stressors.
- (4) To arrive at:

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- (a) A clinical decision as to the current level of risk that an individual represents for suicidal behavior.
- (b) Recommendations for appropriate suicide precautions, if any.

(C) Procedure

- (1) A suicide risk assessment will be completed on all admissions by the registered nurse (RN) by completing the Columbia Suicide Severity Rating Scale (CSSR) as part of the nursing admission assessment in the patient's medical record.
- (2) A psychiatric evaluation is completed within 24 hours of admission.
- (3) A psychosocial assessment is completed as soon as possible, but not later than within 72 hours of admission.
- (4) All assessments shall be considered by the treatment team and incorporated into the patient's individualized treatment plan.

(D) Assessment of suicide risk

- (1) Admission nursing assessment. As part of the admission process, the admitting registered nurse must complete the CSSR for the patient being admitted. When the admitting registered nurse recommends a higher level of observation than previously ordered, the physician will be notified.
- (2) Psychiatric evaluation. As part of a comprehensive psychiatric evaluation, the physician will assess the risk of suicide for each new patient.
- (3) Psychosocial assessment. The psychosocial assessment is completed by a qualified therapist as soon as possible, but not later than within 24 hours of admission.

(E) Reassessment of suicide risk

- (1) Reassessment of suicide risk by the registered nurse will occur no less than every shift for any patient on suicide precautions or who exhibits a sudden or significant change in mental status.
- (2) All other patients will be reassessed as clinically indicated.
- (3) At a minimum of every 24 hours, the nurse or the on-call/attending physician or psychiatrist will review the patient's status and modify suicide precautions as

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clinically indicated. Other disciplines may be involved in the determination when available.

- (4) All patients who are being discharged shall be reassessed for suicide risk prior to discharge. Any positive findings of risk at this time are to be communicated to the physician for evaluation of the appropriateness of discharge.
- (5) No patient may be discharged until suicide precautions have been discontinued for at least 24 hours.
- (6) All reassessments shall be considered by the treatment team and incorporated into the patient's individualized treatment plan.

(F) Patient monitoring

- (1) All patients will be monitored at least every 15 minutes.
- (2) Patients who are assessed to be at moderate or high risk or when clinically indicated for suicide may be placed online of sight observation or on a one-to-one (1:1) observation status as outlined in [policy 3364-120-67 Observation Levels, Standard, Line of sight 1:1](#).
- (3) An observation level can only be decreased with a physician's order.
- (4) An increased observation level may be initiated by a registered nurse in an emergency.

(G) Suicide monitoring

- (1) Suicide precautions may be ordered by the admitting or attending physician.
- (2) Staff will closely observe and make rounds on the patient at least every 15 minutes, or more often if heightened observations have been ordered.
- (3) Suicide precautions are to be clearly indicated and communicated during every transition of care through thorough hand-off communication process.
- (4) Staff assigned to observe patients on suicide precautions shall be vigilant for, immediately communicate to the charge nurse, and carefully document, any concerning changes in behavior.

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- (5) Staff are to maintain a safe and therapeutic environment for all patients. Additional safety interventions are implemented for patients on suicide precautions. These interventions include, but may not be limited to:
- Perform a thorough search of the patient's clothing, personal articles, room, and belongings to ensure that any items which might be used in a self-harmful way are confiscated.
 - The patient's room may be searched as needed, at the discretion of nursing personnel, and in compliance with patient's rights.
 - Remove all potential ligatures and sharps from the environment.
- (6) All items brought in by visitors are to be thoroughly searched for dangerous items upon entry into the milieu.
- (7) RN will stay with the patient during medication administration to ensure patient has taken all medication.

	15 minute checks	Line-of-sight	1:1
Razors, sharps, or personal items with electrical cords	Under staff observation only. Collected immediately after use.	Under staff observation only. Collected immediately after use.	Prohibited
Sharp utensils at meals/snacks	Collect and inventory at end of meal	Staff with continuous visual monitoring.	Staff must be continuously present with patient.
Toileting, Sleeping & Showering	Maintain 15-minute check and verify safety.	Staff posted outside bathroom door with continuous visual monitoring.	Staff must be continuously present with patient.
Activities Outdoors	Staff must be continuously present with patient.	Prohibited	Prohibited
Art Activities	Under staff observation only.	Under staff observation only.	Staff must be continuously present with patient.

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(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.

<p>Approved by:</p> <p>_____</p> <p>Daniel Barbee, MBA, BSN, RN, FACHE Chief Executive Officer</p> <p>_____</p> <p>Date</p> <p>_____</p> <p>Kurt Kless, MSN, MBA, RN, NE-BC Chief Nursing Officer</p> <p>_____</p> <p>Date</p> <p>_____</p> <p>Tanvir Singh, MD Service Chief</p> <p>_____</p> <p>Date</p>	<p>Policies superseded by this policy</p> <ul style="list-style-type: none"> • <i>None</i> <p>Initial effective date: June 1, 2014</p> <p>Review/Revision Date:</p> <p><i>6/2017</i></p> <p><i>6/2020</i></p> <p><i>4/1/2023</i></p> <p><i>2/2/2024</i></p> <p>Next review date:</p>
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<p><i>Review/Revision Completed by: Psychiatry – Inpatient Administration</i></p>	
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