

UConn HEALTH

Clinical Procedure Suicide Risk Assessment and Intervention

Title	Suicide Risk Assessment and Intervention
Policy Owner and Contact Information	John Dempsey Hospital Administration 860-679-2422
Scope	UConn Health John Dempsey Hospital Emergency Department and Inpatient Units
Effective Date	October 31, 2019

PURPOSE:

To identify and assure safe handling of patients with potential for suicide risk.

POLICY: Suicide Risk Assessment and Intervention

DEFINITIONS:

Suicide:

Death caused by self-directed injurious behavior with an intent to die as a result of the behavior.

Suicide attempt:

A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.

Suicidal ideation:

Thinking about, considering, or planning suicide.

MATERIALS NEEDED:

None

PROCEDURES:

EMERGENCY DEPARTMENT PROCEDURE

The Registered Nurse (RN) in the ED will:

1. Initiate a 1:1 Observation of the patient if the patient's chief complaint is:
 - a. Suicidal Ideation
 - b. Homicidal Ideation
 - c. Self-Injurious Behavior

2. Complete the Columbia Suicide Severity Rating Scale (C-SSRS) on every patient during triage.
 - a. If the patient answers “no” to C-SSRS screening questions 1, 2 and 6, the patient is considered not at risk for suicide at this time.
 - b. If the patient answers “yes” to any of the C-SSRS screening questions the UConn Health Suicide Assessment Algorithm (see Appendix link) will be followed and applicable interventions will be initiated. Determine risk of suicide (low, moderate, high) based on the UConn Health Suicide Assessment Algorithm and Supplement.

If the patient is found to be at no, low or moderate risk, the RN will rescreen a patient using the C-SSRS with a new occurrence of suicidal behavior, ideation, statement, or other noteworthy clinical change.

If the patient is found to be at low risk for suicide the RN in the ED will:

1. Notify the ED Practitioner of both the risk and its level (low). Determine, in collaboration with the physician, the level observation appropriate for the patient.
2. Notify the Charge Nurse, Assistant Nurse Manager and/or Nurse Manager of the positive suicide screening.
3. Conduct an environmental risk assessment (see the UConn Health Suicide Assessment Algorithm and Supplement) that identifies and removes/mitigates features in the physical environment that could potentially be used for harm.
4. Document the plan to mitigate the risk for suicide in the EMR.

If the patient is found to be at moderate or high risk for suicide the RN in the ED will:

1. Initiate a 1:1 level of observation.
2. Notify the ED Practitioner of both the risk for suicide and its level (moderate, high).
3. Notify the Charge Nurse, Assistant Nurse Manager and/or Nurse Manager of the positive suicide screening.
4. Conduct an environmental risk assessment (see the UConn Health Suicide Assessment Algorithm and Supplement) that identifies and removes/mitigates features in the physical environment that could potentially be used for harm.
5. Document the plan to mitigate the risk for suicide in the EMR.

If the patient is found to be at low risk for suicide the ED Practitioner (s) will:

1. Assess the patient and document the following in the EMR:
2. Level of Observation required, including justification.
3. If determined that a CO is sufficient for safety, the justification for a CO and its corresponding order.
4. Directly address suicidality in the treatment and discharge (if applicable) plan.

5. Provide for counseling and follow-up care upon discharge/release from hospital care.
6. Provide suicide prevention information upon discharge/release from hospital care.

If the patient is found to be at moderate or high risk for suicide, the ED Practitioner (s) will:

Assess the patient and document the following in the EMR:

1. An order for 1:1 Observation.
2. An order a ED Psychiatric Consult
3. An order for Suicide Precautions
4. Directly address suicidality in the treatment and discharge plan.
5. Provide for counseling and follow-up care upon discharge.
6. Provide suicide prevention information upon discharge/release from hospital care.

After an ED psychiatric consultation is initiated by the ED Practitioner, the consulting psychiatry practitioner (independently licensed Practitioner and/or resident on service/call) will:

1. Complete and document a complete psychiatric evaluation.
2. Document the level of observation required (1:1 vs. CO) and justification.
3. Review Plan of Care and recommend specific interventions to manage risk of harm to self or others.
4. Specific recommendations to manage risk of harm to self or others will be made. Psychiatry will follow the patient in the Emergency Department.

PROCEDURES

INPATIENT UNITS

The RN will screen the patient for suicide using the C-SSRS if the patient has not already been screened during the current encounter.

1. If the patient answers “no” to C-SSRS screening questions 1, 2 and 6, the patient is considered not at risk for suicide at this time. See above policy statement regarding rescreening.
2. If the patient answers “yes” to any of the C-SSRS screening questions the UConn Health Suicide Assessment Algorithm (see Appendix link) will be followed and applicable interventions will be initiated. Determine the level of suicide (low, moderate, high) based on the UConn Health Suicide Assessment Algorithm and Supplement..

If the patient is found to be at no, low or moderate risk, the RN will rescreen a patient using the C-SSRS with a new occurrence of suicidal behavior, ideation, statement, or other noteworthy clinical change.

If the patient is found to be at low risk for suicide the RN will:

1. Notify the Covering Practitioner of both the risk and its level (low). Determine, in collaboration with the Covering Practitioner, the level observation appropriate for the patient.
2. Notify the Charge Nurse, Assistant Nurse Manager and/or Nurse Manager of the positive suicide screening.
3. Conduct an environmental risk assessment (see the UConn Health Suicide Assessment Algorithm and Supplement) that identifies and removes/mitigates features in the physical environment that could potentially be used for harm.
4. Document the plan to mitigate the risk for suicide in the EMR.

If the patient is found to be at moderate or high risk for suicide the RN will:

1. Initiate a 1:1 level of observation.
2. Notify the Covering Practitioner of both the risk for suicide and its level (moderate, high).
3. Notify the Charge Nurse, Assistant Nurse Manager and/or Nurse Manager of the positive suicide screening.
4. Conduct an environmental risk assessment (see the UConn Health Suicide Assessment Algorithm and Supplement) that identifies and removes/mitigates features in the physical environment that could potentially be used for harm.
5. Document the plan to mitigate the risk for suicide in the EMR.

If the patient is found to be at low risk for suicide the Covering Practitioner will:

Assess the patient and document the following in the EMR:

1. Level of Observation required, including justification.
2. If determined that a CO is sufficient for safety, the justification for a CO and its corresponding order.
3. Directly address suicidality in the treatment and discharge (if applicable) plan.
4. Provide for counseling and follow-up care upon discharge/release from hospital care.
5. Provide suicide prevention information upon discharge/release from hospital care.

If the patient is found to be at moderate or high risk for suicide, the Covering Practitioner will:

Assess the patient and document the following in the EMR:

1. An order for 1:1 Observation.
2. An order a Psychiatric Consult
3. An order for Suicide Precautions
4. Directly address suicidality in the treatment and discharge plan.

5. Provide suicide prevention information upon discharge/release from hospital care.

After a psychiatric consultation is initiated by the Covering Practitioner , the consulting psychiatry practitioner (independently licensed Practitioner and/or resident on service/call) will:

1. Complete and document a complete psychiatric evaluation.
2. Document the level of observation required (1:1 vs. CO) and justification.
3. Review Plan of Care and recommend specific interventions to manage risk of harm to self or others.
4. Specific recommendations to manage risk of harm to self or others will be made. As consultants, Psychiatry will review management plans to mitigate/prevent factors leading to increased risk. Psychiatry may make recommendations to modify the management plan as appropriate.

EDUCATION

All patients who are admitted to the psychiatric service, or are being treated for psychiatric, emotional or behavior disorders/complaints in identified locations will be given the following information and instructions in WRITTEN form upon discharge:

“If you feel unsafe or feel that you might harm yourself or others you can:

1. Call 211 for Mental Health Intervention Services
2. Call 1-800-273-8255 for the National Suicide Prevention Lifeline
3. Call 911 or go to your nearest emergency room.”

The following patient educational sheets may be printed for the patient and added to the discharge information within the EMR. These, as well as other topics relevant to the patient, may be found under the Clinical References Section which is located within the Discharge Navigator/Discharge Education.

1. Helping Someone Who is Suicidal
2. Self-Destructive Behavior
3. Suicidal Feelings: How to Help Yourself

The following patient education sheets may also be provided to the patient and/or family (if appropriate) in order to educate on suicide. They may be found in PDF format on the web.

1. Suicide in America: Frequently Asked Questions – Published by The National Institute of Mental Health (NIMH)

<https://www.nimh.nih.gov/health/publications/suicide-faq/index.shtml>

2. NIMH Answers Questions about Suicide – Published by The National Institute of Mental Health (NIMH)

<https://www.nimh.nih.gov/health/publications/nimh-answers-questions-about-suicide/index.shtml>

3. Understanding Suicide – Published by The Centers for Disease Control

https://www.cdc.gov/violenceprevention/pdf/suicide_factsheet-a.pdf

4. Older Adults and Depression – Published by The National Institute of Mental Health

<https://www.nimh.nih.gov/health/publications/older-adults-and-depression/index.shtml>

All RN Staff will be educated and evaluated for competency on suicide risk assessment and mitigation upon hire, transition to a new role and yearly.

Staff who could be assigned the care of a patient at risk for suicide will be educated and evaluated for competency in suicide risk mitigation **upon hire/transition** to another role. Staff who could be assigned the care of a patient at risk for suicide will be educated and evaluated for competency in suicide risk mitigation **yearly**.

ATTACHMENTS/FORMS

UConn Health Suicide Assessment Algorithm and RN Room Assessment Supplement

REFERENCES:

The Joint Commission. (2017). *Perspectives preview: Special report: Suicide prevention in health care settings*. Retrieved from:

[The Joint Commission Suicide prevention in health care settings](#)

SEARCH WORDS:

Suicide, 1:1, Observation, Risk, Sitter

ENFORCEMENT: Violations of this policy or associated procedures may result in appropriate disciplinary measures in accordance with University By-Laws, General Rules of Conduct for All University Employees, applicable collective bargaining agreements, the University of Connecticut Student Code, other applicable University Policies, or as outlined in any procedures document related to this policy.

Clinical Procedure HISTORY:

Procedure Approved: 10/31/19