UConn Health Suicide Assessment Algorithm

All patients will be screened for suicide using the Columbia Suicide Severity Rating Scale (C-SSRS) by a Registered Nurse (RN).

Instructions: Questions 1, 2 & 6 are required of all patients.
Questions 3, 4 & 5 are required if a patient answers "yes" to question 2.

ASK Question 1 (YES = Low)
Have you wished you were dead or wish you could go to sleep and not wake up?

Yes or No

ASK Question 2 (YES = Low)
Have you actually had any thoughts of killing yourself?

Yes

ASK Question 3
Have you been thinking about how you might kill yourself? (Yes = Moderate)

ASK Question 4
Have you had these thoughts and had some intention of acting on them? (Yes = High)

ASK Question 5
Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? (Yes = High)

ASK Question 6
Have you ever done anything, started to do anything, or prepared to do anything to end your life?

Yes

- <4 weeks (Yes = High)
- 1-12 months ago (Yes = Moderate)
- ≥ 1 year ago (YES = Low)

C-SSRS completed, calculate risk.

No

ASK Question 6
Have you ever done anything, started to do anything, or prepared to do anything to end your life?

Yes

- < 4 weeks (Yes = High)
- 1-12 months ago (Yes = Moderate)
- ≥ 1 year ago (YES = Low)

C-SSRS completed, calculate risk.

No

C-SSRS completed, calculate risk.

The suicide severity risk is based on the highest level of risk amongst all answers:
Any answer in

- Red = High
- Orange = Moderate
- Yellow = Low

No to all questions = the patient is not considered at risk for suicide at this time, rescreen with any noteworthy clinical change.

UConn Health Suicide Precautions
RN Room Assessment Supplement

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Any answer in

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Orange = Moderate

Yellow = Low

No to all questions = the patient is not considered at risk for suicide at this time, rescreen with any noteworthy clinical change.

All areas below will be addressed by the RN and documented within the EMR:

- Level of Observation: If the patient is on 1:1 Observation or Constant Observation all aspects of the *1:1 Observation/Constant Observation Monitoring of Acute Medical/Surgical and/or Behavioral Health Patients* Policy will be followed.
- Covering Provider aware.
- Nursing Supervision aware (Charge Nurse, Assistant Nurse Manager, Nurse Manager, Nursing Supervisor).
- A psychiatric consultation in place, if applicable.
- An environmental risk assessment will be conducted, focusing especially on areas of ligature risk. A safe environment will be established at all times for the patient at risk for suicide.
    - All supplies and equipment will be removed from the room except that which is essential to the patient's care.
    - The patient's belongings (including jewelry, socks, undergarments and other clothing) will be removed from the room and secured in a designated location on the unit. The patient will be changed into a hospital approved gown with snaps, no strings.
    - A "Diet – Finger Foods" order will be placed by the covering practitioner, along with the specification that the tray be delivered to the nurse, rather than the patient directly. Trays will be inspected by the RN before presenting to the patient.
    - The door to the room will be kept open at all times.
    - All visitors and visitors' belongings will be monitored. Education will be provided to all visitors in regards to patient safety and items that may compromise the patient's safety.
- Suicide risk/interventions documented in the Care Plan.
- Suicide risk/interventions documented in the Education section of the EMR.
- Counseling and follow-up care upon discharge.
- Suicide prevention education upon discharge.