Memo for Inpatient Providers:
Management of Patient at Risk for Suicide

SHC policy "Screening and Safe Management of Patients at Risk for Suicide in Non-psychiatric Settings" has been updated and a relevant summary for Physicians/APPs is provided here. These guidelines are in alignment with Joint Commission's National Patient Safety Goal #15 requirements. For inpatient settings, risk level is based on the Columbia Suicide Severity Rating Scale (C-SSRS). Screening is required upon admission for primary psychiatric diagnosis and as needed when there is a concern about a patient's safety; initial screening done by RN, although any clinician (RN, SW, Physician, APP) may screen when there is a safety concern.

LOW RISK :

- ☐ RN will notify unit SW for further assessment

MODERATE RISK :

- ☐ RN will notify unit SW and Primary Physician/APP for further assessments
- ☐ **Psychiatry Consult is recommended; Primary Physician/APP to order**
- ☐ Nursing staff will ensure the safest possible environment for patient by removing any room items that are not essential to providing care and that could pose a safety risk (eg cords, tubing, cables; sharps; toxic liquids; unused equipment)

HIGH RISK :

- ☐ RN will initiate 1:1 with NA sitter immediately (may order sitter per protocol)
- ☐ RN will notify unit SW and Primary Physician/APP for further assessments
- ☐ **Psychiatry Consult is required; Primary Physician/APP to perform urgent assessment and order psychiatry consult**
- ☐ **If Primary Physician/APP does not deem psych consult necessary, provider must document their assessment of patient, justification for not ordering consult, and outline safety interventions for patient**
- ☐ Nursing staff will ensure the safest possible environment for patient by removing any room items that are not essential to providing care and that could pose a safety risk (eg cords, tubing, cables; sharps; toxic liquids; unused equipment). 1:1 is within arm's length of patient and maintains direct observation of patient at all times, including bathroom and for off-unit procedures.

- **Upon assessment by Psychiatry, their recommendations should be followed as the most appropriate safety interventions. Primary Physician/APP is responsible for keeping orders up-to-date in Epic**
- If Psychiatry places the patient on 5150 for Danger to Self (DTS), Primary Physician/APP to order **Suicide Precautions** and **5150** status in Epic

If patient is maintained on Suicide Precautions, RN will implement these additional interventions:

- ☐ Place teal colored Safety Precautions sign on room door (to ensure staff awareness of safety concerns)
- ☐ Contact Food Services to ensure patient receives "Safe Tray" meal option only (no metal sharps)
- ☐ Additional room modifications to ensure safety (unit-dependent)
- ☐ 5150 only: Remove patient belongings from room (to ensure patient does not have access to potentially unsafe items)