McLaren
CARO REGION

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Patient Name:_____ DOB:_____

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	PAST MONTH	
Ask questions that are in bold and underlined.	**Yes**	**No**
Ask questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, *"I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.* ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place, or method details worked out *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it."* ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
	Yes	**No**
If yes, ask: Was it in the past 4 weeks?		
Was this 1-12 months ago?		
Was this > 1 year ago?		

RN Signature: _____ ***Date/Time:*** _____

STICKER

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INTERVENTIONS

☐ **Low**

- May wait in in lobby if with family/caregiver; otherwise, should be taken to room as soon as available.
- Potential Behavioral Health screen for education if outpatient referral.
- Provide educational and discharge instructions for the mental health patient.
- National Suicide Prevention Lifeline-1-800-273-TALK (8255).
- Provide patient with McLaren Caro Region Behavioral Health Community Resources.
- Provide Suicide Prevention and Adult Safety Plan

☐ **Moderate-Chart observations every 30 minutes**

- Complete all low-risk interventions and the below interventions.
- Patient should be put into appropriate room near nurses' station.
- No curtains or doors are to be closed unless staff is in the patient's room.
- Complete the Environment Checklist every shift or delegate to sitter. Monitor and maintain patient safety by:
    - Visitors/family will not act as a substitute for continuous observation.
    - Accompany to bathroom and maintain continuous direct one to one observation.
    - Patients must be disrobed and placed in appropriate safety gown with sensitivity to survivors of abuse, which may require further explanation of procedure
    - Remove from the environment anything the patient may use to inflict injury and check belongings for any secretive, unsafe items.
    - Flight risk precaution added precautions.
    - Notify security.
    - Patients must have their personal belongings searched, removed to be stored at ED Nursing Station and a list of belongings must be completed by staff. Contraband shall be removed and placed in labeled storage bags to be sent home with family or placed in locked storage.
    - Verification by RN during medication administration to ensure patient has taken meds and is not keeping medications to stockpile.
- Notify ED Physician patient was placed on precautions. Request consult for psychiatric evaluation once patient medically cleared. Obtain order for active suicide precautions.
- Conduct assessment every shift and re-assessment at least every shift and according to the patient's identified needs.
- Patients should receive disposable plates, plastic cups and plastic silverware for meals. Staff monitoring the patient will check the contents of the meal tray on arrival and removal. Staff will remove contraband to ensure contents are safe and to prevent items from being left in the patient's room.
- Complete Environment Checklist/Suicide Precautions Assessment every shift
- Provide patient with McLaren Caro Region Behavioral Health Community Resources, if patient discharged from emergency department.
- Provide Suicide Prevention and Adult Safety Plan

☐ **High-Chart observations every 15 minutes**

- **Complete all low and moderate risk interventions including continuous direct one to one observation of the patient and the below interventions.**
- Put directly into a room if imminent harm to others or flight risk, then security presence shall be utilized, if available.
- Consider restraint to prevent serious injury to self or others as appropriate.
- Assess patient's need for medication to assist with controlling suicidal ideation.
- Obtain an order from the physician if you are required to hold a patient for safety of medication administration and record the patient's response to the medication.
- Consider petitioning the patient.
- Staff will chart observations every 15 minutes. Constant observation will be maintained.
- Seclude as necessary and/or restrain as necessary to prevent serious injury to self as appropriate. Assess patient's need for medication to assist with controlling suicidal ideation.
- Provide educational and discharge instructions for the mental health patient
- Complete Patient Safety Checklist/Suicide Precautions
- Provide patient and family Active Suicide Precautions education sheet.

RN Signature _____ Date/Time _____