Suicide Assessment/ Precautions Documentation in Cerner

Firstnet: Patient is first screened upon triage

ED Triage Adult/Pediatric: Under General information section assess for Suicidal Ideation if answer is History of, Intermittent, Constant or Plan these selections will open up additional form. Documentation item is yellow (required). User is unable to complete form without completing this section.

Signs Of Suicide form (Can be completed as ADHOC form also)
Suicide Assessment/ Precautions Documentation in Cerner

ED Adult and Pediatric Systems Assessment:

<table>
<thead>
<tr>
<th>Suicide Risk Assessment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal Ideation</td>
<td>None</td>
</tr>
<tr>
<td>Suicide Plan Formulated</td>
<td>Denies</td>
</tr>
<tr>
<td>Suicide Method</td>
<td>Denies</td>
</tr>
<tr>
<td>Suicide Plan Includes Harm to Others</td>
<td>Yes</td>
</tr>
<tr>
<td>Individual Named</td>
<td>No</td>
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Reference text linked to **Suicidal Ideation**

Suicidal Ideation

<table>
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<td>(Note: Information, Chat guide, Nurse preparation, Patient education, Policy and procedures, Scheduling information)</td>
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Knowledge-Based Nursing Initiative (KBNI)

Suicidal Ideation

- Patients who requested yes to the depressive symptoms screening question related to suicidal thoughts (PEG1 or short G2), had evidence of self-injurious behavior, or made unsolicited assertions that imply a wish to die or should be assessed for suicide risk using a direct, nonjudgmental asking approach.

- Assessing for Suicidal Ideation:
  - Do you feel like it's not worth living and that people would be better off without you? (yes/no)
  - Have you had thoughts about death or about killing yourself? (yes/no)

- Assessing for Suicide Risk in Patients with Suicidal Thoughts:
  - Do you plan to hurt yourself? (yes/no)
  - If yes, plan, what method? (IF method of harm can be identified)

Rationale:
- Depression is a major and strong risk factor for suicide. Patients diagnosed with major depression have a 10-fold greater risk for suicide (Ludgate & Barber, 2004; Yee et al., 2008).
- Risk factors for suicide are depression, lack of social support or loneliness in isolation, recent stressful life events, social isolation, and psychiatric disorders, and previous attempts at suicide. Even though patients who have made a suicide attempt are at increased risk for future attempts, they may not be able to express this knowledge. A patient may be expressing a need for help or intervention.
- Patients who report a history of depression and high levels of stress are at increased risk for suicide.
- It is important to note that patients with affective disorders are at increased risk for suicide.
- Assessing for suicide risk in patients with a history of depression is important.
- Patients who report a history of depression and high levels of stress are at increased risk for suicide.
- It is important to note that patients with affective disorders are at increased risk for suicide.
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- Patients who report a history of depression and high levels of stress are at increased risk for suicide.
- It is important to note that patients with affective disorders are at increased risk for suicide.

January 2017
Suicide Precaution (Added 2016)

- Continuous 1:1 Observation: X
- Sitter at Bedside: X

Suicide Precaution Safety Check
Done

Reference text linked to Suicide Precaution Safety Check (Also serves as a Care Plan)

Plan of Care Suicide Precaution Patient Safety Check and Interventions verifies all of the following have been completed and are within expectations unless otherwise noted:

- Constant attendance by patient safety attendant who will remain in constant view of the patient and observe the behavior and emotion
- Removal of all personal items which may be dangerous
- Continuous observation of at risk patients including during use of bathroom
- Search for potential harmful objects on each shift
- Patients will be informed that staff will remove any potentially harmful objects
- Violation occurs only with the permission, and with a monitor present
- Visitors are informed that nothing is to be given to the patient without the staff approval

****Goal****
To maintain Patient safety and prevent injury
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PowerChart:

ADHOC form Signs of Suicide form (S.O.S.)

Tasked Daily as part of On going assessment:

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Suicidal Ideation: X
Unable to obtain: None
History of Intermittent Constant Plan: None
Suicide Plan Formulated: X
Denies: None
Verbalizes Other: None
Suicide Method:
- Other: X
- Cut wrist: No
- Gun: No
- Hanging: No
- Jumping: No
- Pills/Overdose: No
- Other: X
Suicide Plan Includes Harm to Others: X
Yes: No

January 2017
Suicide Assessment/ Precautions Documentation in Cerner

Suicidal Ideation

Suicide Precaution (Added 2016)

Suicide Precaution Safety Check (Also serves as a Care Plan)

January 2017