ELSEVIER Clinical Skills

Suicide Assessment and Precautions

CHECKLIST

S = Satisfactory **U** = Unsatisfactory **NP** = Not Performed

Step	S	U	NP	Comments
Performed hand hygiene and donned PPE as indicated for needed isolation precautions.				
Introduced self to the patient.				
Verified the correct patient using two identifiers.				
Assessed the patient's cognitive ability to communicate or comprehend aspects of the evaluation.				
Assessed the patient for a history of mental health concerns, including a detailed history of substance use.				
Evaluated the patient's current mental health status.				
Assessed the patient for a family history of mental illness and suicide.				
Assessed the patient for suicidal or homicidal ideation or thoughts of self-harm. Used an organization-approved standardized tool for suicide assessment.				
Assessed the need to implement additional safety precautions if the patient was at risk for suicide.				
Assessed the need for a psychiatric practitioner consult and sought a consult as appropriate.				
Assessed the safety of the immediate environment by paying attention to such items as oxygen and IV tubing, call bell, and telephone cord.				
Evaluated the patient for medical issues that might increase depression, anxiety, or suicidal ideation.				
Assessed current stressors that might be contributing to the patient's distress.				
Evaluated the patient's coping strategies, supports, and resources.				
Considered behaviors of concern reported by family members when assessing risk.				
Assessed the patient's competency and willingness to collaborate with treatment and safety measures.				
Assessed the patient's and family's understandings of suicide precautions.				
Identified whether the patient was at risk for elopement and whether he or she had a				

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history of not cooperating with recommended treatment.				
Assessed the patient's mental status for increased anxiety, agitation, hopelessness, feelings of guilt, and suicidal thoughts with a plan and intent.				
Assessed the patient for psychosis and the patient's ability to follow directions.				
Performed hand hygiene and donned appropriate PPE based on the patient's signs and symptoms and indications for isolation precautions.				
Explained the strategies to the patient and ensured that he or she agreed to treatment.				
Established a therapeutic alliance with the patient to promote communication via a nonjudgmental approach and active listening. Did not assume that a patient who denied suicidal ideation was not at risk. Actively listened to the patient because he or she may not have been honest with health care team members who appeared detached and uncaring.				
Assessed the patient's strengths and coping mechanisms.				
To explore the patient's current stressors and risk factors for suicide, asked direct questions.				
Determined the patient's current protective factors.				
Asked direct questions about suicidal thoughts, plans, means, behaviors, and intent.				
Asked the patient about thoughts to kill someone else and identified the plan, means, behaviors, and intent if the patient had such thoughts.				
Reminded a patient who was medically ill or injured about the importance of early recognition of depressive symptoms.				
Encouraged the patient to speak openly about any self-injurious behaviors.				
1. Asked specifically about cutting, burning, and other forms of self-mutilation.				

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2. Closely monitored a patient who acknowledged self-injurious behaviors. Did not assume that a patient who engaged in self-mutilation was doing so to seek attention.				
Encouraged family members to share concerns about the patient's safety with health care team members. Did not reveal information about the patient's treatment without his or her consent unless an imminent risk was present.				
Initiated suicide precautions if the patient had suicidal thoughts**.** Followed the organization's practice on staying within a specific distance of the patient at all times. Never left the patient alone.				
1. If appropriate, initiated direct, constant observation per the organization's practice.				
2. Determined which health care team member would remain with the patient, maintaining visual contact at all times, even while the patient was in the bathroom.				
3. Planned breaks for team members assigned to constant observation to ensure they can maintain close attention to the patient.				
4. Assigned the patient to a room close to the nurses' station.				
5. Informed the patient that he or she was being placed on suicide precautions and gave the rationale. Allowed the patient to ask questions and express thoughts and feelings regarding the level of supervision. Did not promise secrecy; the treatment team needs to know the patient's thoughts and intentions.				
During handoff communication among health care team members, provided information based on direct, constant observation of the suicidal patient.				
1. The reason for direct, constant observation, the patient's behaviors				

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during the observation period, and the health care team's interventions if suicidal behaviors occurred				
2. The patient's care and treatment				
3. The patient's behaviors, feelings, or actions, including the response to suicide precautions				
4. The patient's current thoughts and feelings, pertinent conversations regarding suicidal intent, and his or her response to treatment				
5. Recent or anticipated changes in supervision, changes in the patient's behaviors or actions, and the patient's responses to stressors				
6. The condition of the environment, including the location of items secured and any contraband found				
7. The patient's ability to use the skills identified in the safety plan				
Obtained a psychiatric consultation as soon as possible to determine an appropriate plan of care to meet the patient's mental health needs. Met with other members of the health care team to determine the patient's level of treatment, willingness to receive voluntary inpatient care, or need for involuntary inpatient care.				
Together with the other members of the health care team, including a behavioral health professional, collaborated with the patient to develop a safety plan. Did not use a verbal or written no-suicide contract to ensure patient safety because contracting for safety has not been shown to decrease suicide incidence.				
Immediately directed a patient who was actively engaging in suicidal behaviors to stop.				
1. Removed or asked the patient to relinquish any objects that might have been used for self-harm.				
2. Contacted the mental health practitioner as soon as possible and gave as-needed medication to assist with reducing anxiety or psychosis.				

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Searched the patient for contraband, such as medications, belts, drawstrings, shoes with shoelaces, razors, glass, plastic bags, or mirrored items.				
1. Maintained the patient's privacy and dignity during the search.				
2. Removed the items and secured them out of the patient's possession per the organization's practice.				
Made sure the patient was taking medication as prescribed and not pretending to swallow it or stashing it for a later overdose.				
Performed frequent assessments if the patient was at risk for developing depression related to a medical illness or injury**.** Monitored the patient for the development of symptoms that have may indicated an increase in hopelessness, anxiety, and despair.				
At discharge, identified resources the patient could contact if feeling suicidal, including a psychiatrist, therapist, social worker, suicide hotline, and crisis centers.				
Assessed, treated, and reassessed pain.				
Removed PPE and performed hand hygiene.				
Documented the strategies in the patient's record.				

Learner: _____ Signature: _____

Evaluator: _____ Signature: _____

Date: _____