Preventing Inpatient Suicide

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Inpatient suicides are viewed as the most avoidable and preventable because they occur in close proximity to staff. Early in the admission is a clear high-risk period, but risk declines more slowly for some patients. Included here are factors that may guide the clinician in treating these at-risk patients.

**TIPSHEET: INPATIENT SUICIDE PREVENTION RECOMMENDATIONS**

- More stringent assessment of risk
- More stringent monitoring of patients’ risk
- Better monitoring of behavioral signs and symptoms
- Improve staff communication of signs and risk
- Wait for significant, stable, reliable change before relaxing precautions
- Improve suboptimal staff-patient relationships
- Gather collateral information
- Do not rely solely on patient self-report of no suicidal ideation
- Do not rely on “no suicide” contracts
- Ensure a safe physical environment that is devoid of means to commit suicide, access to hidden areas. Units should be periodically checked to ensure suicide-proof architecture
- Avoid overconfidence in or overreliance on 15-minute checks
- Avoid premature discharge
- Smooth, tight transition to outpatient care
- Base suicide precautions on an adequate risk assessment and clinical rationale
- Document risk assessment and clinical rationale
- Form a suicide prevention committee
- Utilize Failure Mode and Effect Analysis

For more on this topic, see "Inpatient Suicide: Identifying Vulnerability in the Hospital Setting," by James L. Knoll, IV, MD, from which this Tipsheet is adapted.

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