ZERO SUICIDE INPATIENT ORGANIZATIONAL SELF-STUDY

Name of Organization

City

State

Date Study Completed

Team members completing study:

Name	Role
Name	Role
Name	Role
Name	Role
Name	Role

Background:

The Inpatient Organizational Self-Study is designed to allow you to assess what components of the comprehensive Zero Suicide approach your organization currently has in place. The Self-Study can be used early in the launch of a Zero Suicide initiative to assess organizational strengths and weaknesses and to develop a work plan. Later in your implementation efforts, the self-study can be used as a fidelity check to determine how closely the components of the Zero Suicide model are being followed and as an opportunity to identify areas for improvement. We recommend taking the self-study at launch and then at 12-month intervals.

Staff involved in the policymaking for and care of patients at risk for suicide should complete the self-study as part of an implementation team. The team should complete this tool together during one of their initial meetings. (Information about putting together a Zero Suicide implementation team can be found on our website.) While the self-study is not exhaustive with regard to all issues that can affect patient care and outcomes, it does reflect components that define the Zero Suicide approach. For more information or clarification regarding any of the items in this self-study, please visit zerosuicide.com.

Each component of the Zero Suicide model is measured on a rating scale from 1 to 5, described below. The scale is intended to balance minimal reporting burden with measuring implementation for the most essential parts of the model. This tool should be completed by members of the implementation team who are responsible for developing and implementing the organization's Zero Suicide initiative.

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General guide to rating:

Anchors, or specific expectations, are included for most components following this guide.

Rating	Description
1	Routine care or care as usual for this item. The organization has not yet focused specifically on developing or embedding a suicide care approach for this activity.
2	Initial actions toward improvement taken for this item. The organization has taken some preliminary or early steps to focus on improving suicide care.
3	Several steps towards improvement made for this item. The organization has made several steps towards advancing an improved suicide approach.
4	Near comprehensive practices in place for this item. The organization has significantly advanced its suicide care approach.
5	Comprehensive practices in place for this item. The organization has embedded suicide care in its approach and now relies on monitoring and maintenance to ensure sustainability and continuous quality improvement.

1. Create a leadership-driven, safety-oriented culture:

What type of commitment has leadership made to reduce suicide and provide safer suicide care?

This item refers to the development of formal policies, processes, or guidelines in one or more of the following areas:

- Workforce training
- Suicide screening
- Suicide risk assessment and risk formulation
- Suicide care management plan
- Safety planning
- Lethal means reduction
- Evidence-based treatment
- Contact with patients with known suicide risk who don't show for initial outpatient appointments or programs
- Follow-up with patients with known suicide risk during care transitions or following discharge
- Environment of care risk assessment

» Please select the number where your organization falls on a scale of 1–5.		
	1	The organization has no processes specific to suicide prevention and care, other than what to do when someone mentions suicide during intake, at admission, or in a crisis or emergency room setting.
	2	The organization has 1–2 formal processes specific to suicide care.
	3	The organization has written processes specific to suicide care. They have been developed for at least 3 different components listed above.
	4	The organization has processes and protocols specific to suicide care. They address at least 5 different components listed above. Staff receive training on processes as part of their orientation or when new processes are developed. Processes are reviewed and modified at least annually.
	5	Processes address all components listed above. Staff receives annual training on processes and when new ones are introduced. Processes are reviewed and modified annually and as needed.

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

As the Zero Suicide approach relies on the formalization of several policies intended to establish guidelines and promote the adoption of safer suicide care, please consider whether you have established, written policies as well as staff training in the following areas:

(Numbering below follows from previous page to align with online version)*	Do you have a written agency protocol specific to this component of suicide care? (yes/no)	Is this component embedded in your electronic health record or easily identifiable in your written documentation? (yes/no)	Do you provide staff training specific to this component of suicide care? (yes/no)	Additional Comments (Character limit: 126)
2. Screening				
3. Assessment				
4. Lethal means restriction				
5. Safety planning				
6. Suicide care management plan				
7. Transition of care planning				
8. Environment of care		(Not Applicable)		

9. Create a leadership-driven, safety-oriented culture:

What type of formal commitment has leadership made to reduce suicide and provide safer suicide care?

» Please select the number where your organization falls on a scale of 1–5.		
	1	The organization does not have dedicated staff to build and manage suicide care processes.
	2	The organization has one leadership or supervisory individual who is responsible for developing suicide-related processes and care expectations. Responsibilities are diffuse. Individual does not have the authority to change policies.
	3	The organization has assembled an implementation team that meets on an as-needed basis to discuss suicide care. The team has authority to identify and recommend changes to suicide care practices.
	4	The organization has a formal Zero Suicide implementation team that meets regularly. The team is responsible for developing guidelines and sharing with staff.
	5	The Zero Suicide implementation team meets regularly and is multidisciplinary. Staff members serve on the team for terms of one to two years. The team modifies processes based on data review and staff input.

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

10. Create a leadership-driven, safety-oriented culture:

What is the role of suicide attempt and loss survivors in the organization's design, implementation, and improvement of suicide care policies and activities?

» Please select the number where your organization falls on a scale of 1–5.		
	1	Suicide attempt or loss survivors are not explicitly involved in the development of suicide prevention activities within the organization.
	2	Suicide attempt or loss survivors have ad hoc or informal roles within the organization, such as serving as volunteers or peer supports.
	3	Suicide attempt or loss survivors are specifically and formally included in the organization's general approach to suicide care, but involvement is limited to one specific activity, such as leading a support group or staffing a crisis hotline. Survivors informally provide input into the organization's suicide care policies.
	4	Suicide attempt and loss survivors participate as active members of decision-making teams, such as the Zero Suicide implementation team.
	5	Suicide attempt and loss survivors participate in a variety of suicide prevention activities within the organization, such as sitting on decision-making teams or boards, participating in policy decisions, assisting with employee hiring and training, and participating in evaluation and quality improvement.

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

11. Develop a competent, confident, and caring workforce:

How does the organization formally **assess staff** on their perception of their confidence, skills, and perceived support to care for individuals at risk for suicide?

» Please select the number where your organization falls on a scale of 1–5.		
	1	There is no formal assessment of staff on their perception of confidence and skills in providing suicide care.
	2	Clinicians who provide direct patient care are routinely asked to provide suggestions for training.
	3	Clinical staff complete a formal assessment of skills, needs, and supports regarding suicide care. Training is tied to the results of this assessment.
	4	A formal assessment of the perception of confidence and skills in providing suicide care is completed by all staff (clinical and non-clinical). Comprehensive organizational training plans are tied to the results.
	5	A formal assessment of the perception of confidence and skills in providing suicide care is completed by all staff and reassessed at least **every two years**. Organizational training and policies are developed and enhanced in response to perceived staff weaknesses.

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

12. Develop a competent, confident, and caring workforce:

What **basic** training on identifying people at risk for suicide or providing suicide care has been provided to NON-CLINICAL staff?

» Please select the number where your organization falls on a scale of 1–5.		
	1	There is no organization-supported training on suicide care and no requirement for staff to complete training on suicide risk identification.
	2	Training is available on suicide risk identification and care through the organization but not required of staff.
	3	Training is required of select staff (e.g., crisis staff) and is available throughout the organization.
	4	Training on suicide risk identification and care is required of *all* organization staff. The training used is considered a best practice and was not internally developed.
	5	Training on suicide risk identification and care is required of *all* organization staff. The training used is considered a best practice. Staff repeat training at regular intervals.

Please indicate the training approach or curriculum the organization uses to train all non-clinical staff on suicide risk identification and care:

- ☐ ASIST (Applied Suicide Intervention Skills Training) - for direct care staff
- ☐ AMSR (Assessing and Managing Suicide Risk) – for direct care staff
- ☐ CALM (Counseling on Access to Lethal Means)
- ☐ Kognito At-Risk in Primary Care
- ☐ Kognito At-Risk in the ED
- ☐ QPR (Question, Persuade, and Refer)
- ☐ Connect Suicide Prevention/Intervention Training
- ☐ QPR for Nurses
- ☐ QPR for Physicians, Physician Assistants, Nurse Practitioners and Other Advanced Practice Providers
- ☐ safeTALK
- ☐ Other (please name): _____

____ Please indicate the minimum number of hours of training required annually for non-clinical staff in suicide risk identification and care.

If you wish to describe or elaborate on any item, please do so. Space is provided on the online version.

13. Develop a competent, confident, and caring workforce:

What **advanced** training on identifying people at risk for suicide, suicide assessment, risk formulation, and ongoing management has been provided to CLINICAL staff?

» Please select the number where your organization falls on a scale of 1–5.		
	1	There is no organization-supported training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management, and no requirement for clinical staff to complete training on suicide.
	2	Training is available on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management through the organization, but it is not required of clinical staff.
	3	Training is required of select clinical staff (e.g., psychiatrists, therapists/clinicians, nurses) and is available throughout the organization.
	4	Training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management is required of *all* clinical staff. The training used is considered a best practice and was not internally developed.
	5	Training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management is required of *all* clinical staff. The training used is considered a best practice. Staff repeat training at regularly defined intervals.

Please indicate the training approach or curriculum the organization uses to train clinical staff on advanced suicide prevention skills:

- ☐ AMSR (Assessing and Managing Suicide Risk) - Outpatient
- ☐ AMSR (Assessing and Managing Suicide Risk) - Inpatient
- ☐ CALM (Counseling on Access to Lethal Means)
- ☐ CASE Approach (Chronological Assessment of Suicide Events)
- ☐ Commitment to Living
- ☐ C-SSRS (Columbia- Suicide Severity Rating Scale)
- ☐ QPRT Suicide Risk Assessment and Management Training
- ☐ RRSR (Recognizing and Responding to Suicide Risk)
- ☐ RRSR-Primary Care
- ☐ SuicideCare
- ☐ Other (please name): _____

____ Please indicate the minimum number of hours of training required annually for non-clinical staff in suicide risk identification and care.

If you wish to describe or elaborate on any item, please do so. Space is provided on the online version.

14. Systematically identify and assess suicide risk:

What are the organization's policies for **screening** for suicide risk?

» Please select the number where your organization falls on a scale of 1–5.		
	1	There is no systematic screening for suicide risk.
	2	Individuals in designated higher-risk programs or settings (such as crisis and access, Intensive Outpatient Programs, Partial Hospitalization Programs) are screened.
	3	Individuals in designated higher risk programs or settings (such as crisis and access, Intensive Outpatient Programs, Partial Hospitalization Programs) are screened AND *all* individuals are screened at admission to behavioral health inpatient or intensive treatment levels of care.
	4	Suicide risk is screened at admission for *all* individuals in intensive care settings and is reassessed at least every waking shift for those identified at risk (daily for those in Intensive Outpatient Programs, Partial Hospitalization Programs).
	5	Suicide risk is screened admission for *all* individuals receiving health or behavioral health inpatient care and is reassessed at least every waking shift for those at risk. Suicide risk is also screened when a patient has a change in status: transition in care level, change in setting, or potential new risk factors (e.g., change in life circumstances, such as divorce, unemployment, or a diagnosed illness).

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

15. Systematically identify and assess suicide risk:

How does the organization **screen** for suicide risk in the people it serves?

» Please select the number where your organization falls on a scale of 1–5.		
	1	The organization relies on the clinical judgment of its staff regarding suicide risk.
	2	The organization developed its own suicide screening tool but not all staff are required to use it.
	3	The organization developed its own suicide screening tool that all staff are required to use.
	4	The organization uses a validated screening tool that all staff are required to use.
	5	The organization uses a validated screening tool and staff receive training on its use and are required to use it.

If a suicidality screening tool is used, the screener used is:

☐ PHQ-9 ☐ PHQ-3 ☐ Columbia Suicide Severity Rating-Scale (C-SSRS)

☐ National Suicide Prevention Lifeline Risk Assessment Standards

☐ Other tool (please name): _____

If you wish to describe or elaborate on any item, please do so. Space is provided on the online version.

16. Systematically identify and assess suicide risk:

How does the organization **assess** suicide risk among those who screened positive?

» Please select the number where your organization falls on a scale of 1–5.		
	1	There is no routine procedure for risk assessments that follow the use of a suicide screen.
	2	Risk assessment is required after screening, but the process or tool used is up to the judgment of individual clinicians AND/OR only psychiatrists can do risk assessments.
	3	Providers conducting risk assessments use a standardized risk assessment tool, which may have been developed in-house. All patients who screen positive for suicide have a risk assessment. Suicide risk assessments are documented in the medical records.
	4	All individuals with risk identified, either at admission or at any other point during care, are assessed by clinicians who use validated instruments or established protocols and who have received training. Assessment includes both risk and protective factors.
	5	A suicide risk assessment is completed using a validated instrument and/or established protocol that includes assessment of both risk and protective factors and risk formulation. Staff receive training on the risk assessment tool and approach. Risk is reassessed and integrated into a suicide care management plan or individualized treatment plan for each person identified with risk..

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

17. Ensure every person has a suicide care management plan (pathway to care):

Which best describes the organization's approach to caring for and tracking people at risk for suicide?

A suicide care management plan should include the following:

- Screening
- Assessment and risk formulation
- Safety planning
- Lethal means restriction
- Evidence-based treatment
- Supportive contacts with patients who don't show for initial appointments and during care transitions
- Real time communication between teams and caregivers about patient needs

» Please select the number where your organization falls on a scale of 1–5.		
	1	All inpatient caregivers use best judgment in the care of individuals with suicidal thoughts or behaviors and seek consultation if needed. There is no formal guidance related to care for individuals at risk for suicide.
	2	When suicide risk is detected, the care plan is limited to screening and does not include the suicide care management plan components listed above.
	3	All inpatient caregivers are expected to provide care to those at risk for suicide. The organization has written guidance for care management of individuals at different risk levels, including observation expectations, frequency of contact, care planning, and safety planning.
	4	Electronic or paper health records are enhanced to embed all suicide care management components listed above. Inpatient caregivers have clear guidelines or policies for care management for individuals with suicidal thoughts or behaviors, and real time information sharing and collaboration among all relevant caregivers are documented. Staff receive guidance on and clearly understand the organization's suicide care management approach.
	5	Individuals at risk for suicide are placed on a suicide care management plan (care pathway). The organization has a consistent approach to suicide care management, which is embedded in the electronic health record and reflects all components of suicide care management listed above. Guidelines for putting someone on and taking someone off a care management plan are clear. Staff in intensive levels of care hold regular case conferences or treatment rounds about patients who remain on suicide care management plans beyond a certain defined time frame, which is established by the implementation team.

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

18. Collaborative safety planning:

What is the organization's approach to collaborative safety planning when an individual is at risk for suicide?

» Please select the number where your organization falls on a scale of 1–5.		
	1	Safety planning is neither systematically used by nor expected of staff.
	2	Safety plans are expected for all individuals with elevated risk whether admitted to inpatient care or to a less restrictive level of care. There is no formal guidance or policy around content. There is no standardized safety plan or documentation template. Plan quality varies across inpatient caregivers.
	3	Safety plans are developed for all individuals at elevated risk whether admitted to inpatient care or a less restrictive intensive level of care. Safety plans rely on formal supports or contacts (e.g., call provider, call helpline). Safety plans do not incorporate individualization, such as an individual's strengths and natural supports. Plan quality varies across inpatient caregivers.
	4	Safety plans are collaboratively developed for all individuals at elevated risk whether admitted to inpatient care or a less restrictive intensive level of care and must include risks and triggers and concrete coping strategies. The safety plan is shared with the individual's partner or family members (with consent). All staff use the same safety plan template and receive training in how to create a collaborative safety plan.
	5	A safety plan is collaboratively developed on the same day as the patient is assessed positive for suicide risk. The safety plan is shared with the individual's partner or family members (with consent). The safety plan identifies risks and triggers and provides concrete coping strategies, prioritized from most natural to most formal or restrictive. Other clinicians involved in care or transitions are aware of the safety plan. Safety plans are reviewed and modified at times of transition of care and every contact as needed.

Please indicate whether or not the organization uses the Stanley/Brown collaborative safety plan template:

☐ YES ☐ NO

If no, identify the safety planning tool or approach the organization uses:

_____

How frequently is the safety plan reviewed with the individual? _____

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

19. Collaborative restriction of access to lethal means:

What is the organization's approach to lethal means reduction?

» Please select the number where your organization falls on a scale of 1–5.		
	1	Means restriction discussions and who to ask about lethal means are up to individual clinician's clinical judgment. Means restriction counseling is rarely documented.
	2	Means restriction is expected to be included on collaborative safety plans for all patients identified as at risk for suicide. Steps to restrict means are up to the individual clinician's judgment. The organization does not provide any training on counseling on access to lethal means.
	3	Means restriction is expected to be included on all collaborative safety plans. The organization provides training on counseling on access to lethal means. Steps to restrict means are up to the individual clinician's judgment. Family or support people may or may not be involved in reducing access to lethal means.
	4	Means restriction is expected to be included on all collaborative safety plans, and families or support people are included in means restriction planning. The organization provides training on counseling on access to lethal means. The organization sets policies regarding the minimum actions for restriction of access to means.
	5	Means restriction is expected to be included on all collaborative safety plans. Contacting family or support people to confirm that lethal means have been removed is the required, standard practice. The organization provides training on counseling on access to lethal means. Policies support these practices. Means restriction recommendations and plans are reviewed at times of transition of care and regularly while the individual is at an elevated risk.

Counseling on Access to Lethal Means	Plans included in collaborative safety planning document	Training for staff on means restriction on both logistics and counseling skills	Process includes confirmation of removal of means	Policies identify minimum actions required to document and ensure means restriction	Policy includes plans for review of means restriction with individual in care
Score Yes or No	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

20. Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors:

What is the organization's approach to **treatment** of suicidal thoughts and behaviors?

» Please select the number where your organization falls on a scale of 1–5.		
	1	Clinicians rely on experience and best judgment in risk management and treatment for all mental health disorders. The organization does not use a formal model of treatment for those at risk for suicide.
	2	The organization may use evidence-based treatments for some psychological disorders, but it does not use evidence-based treatments that specifically target suicide.
	3	Some clinical staff have received specific training in treating suicidal thoughts and behaviors and may use this in their practices.
	4	Individuals with suicide risk receive empirically-supported treatment and/or brief interventions specifically for suicide (e.g. CAMS, CBT-SP, BCBT, DBT) in addition to evidence-based treatments for other mental health and substance use issues. The organization regularly provides all clinical staff with access to competency-based training in empirically supported treatments targeting suicidal thoughts.
	5	The organization has invested in evidence-based treatments for suicide care (e.g. CAMS, CBT-SP, BCBT or DBT), with designated clinical staff receiving training in these models. The organization has a model for sustaining staff training. The organization offers or collaborates with outpatient providers to offer additional treatment modalities for those chronically or continuously screening at high risk for suicide, such as DBT groups or attempt survivor groups.

Please indicate if clinicians receive formal training in a specific suicide treatment or brief intervention model:

- ☐ CAMS (Collaborative Assessment and Management of Suicidality)
- ☐ CBT-SP (Cognitive Behavioral Therapy for Suicide Prevention)
- ☐ DBT (Dialectical Behavior Therapy)
- ☐ BCBT(Brief Cognitive Behavioral Therapy)
- ☐ ASSIP (Attempted Suicide Short Intervention Program)
- ☐ MI-SI (Motivational Interviewing to Address Suicidal Ideation)
- ☐ TMBI (Teachable Moment Brief Intervention)

If you wish to describe or elaborate on any item, please do so. Space is provided on the online version.

21. Ensure a suicide safer environment of care for all patients receiving inpatient care:

What is the organization's approach to management of risks in the physical environment that could be used to attempt suicide?

» Please select the number where your organization falls on a scale of 1–5.		
	1	The organization has not yet focused specifically on developing a suicide safer environment of care and currently maintains routine or care as usual processes for this item.
	2	The organization completes regular environmental risk assessments and identifies potential hazards to minimize risk to individuals served but there is no defined process for implementing identified change needs.
	3	Based upon a defined and regularly implemented organizational risk assessment, the organization has made specific changes to the physical environment (such as removal of anchor points, door hinges, and hooks that could be used for hanging). Organization adheres to written policies specific to contraband and patient belongings (such as belts, shoelaces, ties).
	4	The organization has made specific changes to the physical environment (such as removal of anchor points, door hinges and hooks) and has written policies for keeping patients in suicidal crisis in a safe environment under the appropriate level of direct supervision. These policies include provision for one to one monitoring, safe storage of patient's and visitors' belongings that may be used for self-harm, and removal of objects from the room such as bell cords, bandages, gowns with strings, plastic bags, cleaning supplies.
	5	The organization has made specific changes to the physical environment (such as removal of anchor points, door hinges and hooks) and has written policies for keeping patients in suicidal crisis in a safe environment under the appropriate level of direct supervision. These policies include provision for one to one monitoring, safe storage of patient's belongings that may be used for self-harm, and removal of objects from the room such as bell cords, bandages, gowns with strings, plastic bags, cleaning supplies. Education for all staff caring for suicidal patients includes review of policies and safety procedures to ensure a suicide safer environment of care. Staff are comfortable speaking about safety concerns.

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

22. Provide continuous contact and support:

What is the organization's approach to following up on patients who have recently been discharged from acute care settings?

» Please select the number where your organization falls on a scale of 1–5.		
○	**1**	There are no specific guidelines for contact of those at elevated suicide risk following discharge from acute care settings.
○	**2**	The organization ensures that those at elevated suicide risk have a documented scheduled (within 7 days) follow up or transition appointment at the time of discharge from inpatient care, but the parameters and methods for ensuring follow up are not defined by policy.
○	**3**	Organizational guidelines are directed to the individual's level of risk and address one or more of the following: follow-up after crisis contact, transition from an emergency department, or transition from psychiatric inpatient hospitalization.
○	**4**	The organization has a comprehensive transition practice in place to provide a non-demand caring contact within 24–48 hours post-discharge from inpatient care and at 7 days post-discharge and/or until individual has attended one or more outpatient appointments. Organizational protocols are in place that address these expectations following transition from inpatient care. Training for staff supports improving engagement efforts.
○	**5**	The organization has a comprehensive transition practice in place to provide a non-demand caring contact within 24–48 hours post-discharge from inpatient care and at 7 days post-discharge and/or until individual has attended one outpatient appointment. Organizational protocols stipulate that at any post-discharge (phone or in-person) contact, screen and as needed conduct assessment for suicide risk and check in regarding safety plan and access to lethal means. Written policies or guidelines define structured expectations for follow up (such as providing a caring card, letter or text at least at 30, 60 and 90 days post-discharge). Training for staff supports improving engagement efforts.

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

23. Apply a data-driven quality improvement approach:

What is the organization's approach to reviewing deaths for those who received inpatient care? (For other intensive care settings, translate the criteria below to your setting and rate your approach.)

» Please select the number where your organization falls on a scale of 1–5.		
	1	When a suicide or adverse event (suicide attempt or interrupted attempt) happens while the patient is in inpatient treatment, a team meets to discuss the case.
	2	Root cause analysis is conducted on all suicide deaths or near misses of people in inpatient care.
	3	Root cause analysis is conducted on all suicide deaths or near misses of people in inpatient care and data from all root cause analyses are routinely examined to look at trends and to make changes to policies.
	4	Root cause analysis is conducted on all suicide deaths of people in inpatient care as well as for those up to 30 days post-discharge. Policies and training are updated as a result.
	5	Root cause analysis is conducted on all suicide deaths of people in inpatient care as well as for those up to 6 months post-discharge, and on all suicide attempts requiring medical attention. Policies and training are updated as a result.

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

24. Apply a data-driven quality improvement approach:

What is the organization's approach to measuring suicide deaths? (For other intensive care settings, translate the criteria below to your setting and rate your approach.)

» Please select the number where your organization falls on a scale of 1–5.		
	1	The organization has no policy or process to measure suicide deaths for those who received inpatient care.
	2	The organization measures the number of deaths for those who received inpatient care based primarily on family report.
	3	The organization has specific internal approaches to measuring and reporting on all suicide deaths for people in inpatient care as well as for those up to 30 days post-discharge. Deaths are confirmed through coroner or medical examiner reports.
	4	The organization annually crosswalks inpatient admissions (e.g., from a claims database) against state vital statistics data or other federal data to determine the number of deaths for those admitted for inpatient care up to 30 days post-discharge.
	5	The organization annually crosswalks inpatient admissions (e.g., from a claims database) against state vital statistics data to determine the number of deaths for those admitted for inpatient care. The organization tracks suicide deaths among inpatient admissions for up to 6 months post-discharge.

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

25. Apply a data-driven quality improvement approach:

What is the organization's approach to quality improvement activities related to suicide prevention?

» Please select the number where your organization falls on a scale of 1–5.		
	1	The organization has no specific policies related to suicide prevention and care, and it does not focus on suicide care other than care as usual. Care is left to the judgment of the clinical staff.
	2	Suicide care is discussed as part of employee training and by those in supervision in clinical settings.
	3	Early discussions about using technology and/or enhanced record keeping to track and chart suicide care are underway. Suicide care management is partially embedded in an her or paper record.
	4	Suicide care management plan is partially embedded in an electronic health record (EHR) or paper record. Data from suicide care management plans (using EHRs or chart reviews) are examined for fidelity to organizational policies, and discussed by a team responsible for quality improvement.
	5	Suicide care is entirely embedded in the electronic health record (EHR) or paper record. Data from EHR or chart reviews are routinely examined (at least every two months) by a designated team to determine that staff are adhering to suicide care policies and to assess for reductions in suicide. EHR clinical workflows or paper records are updated regularly as the team reviews data and makes changes.

If you wish to describe or elaborate on this item, please do so. Space is provided on the online version.

Once your implementation team has completed this organizational self-study using this document, the results can be entered online at http://zerosuicide.sprc.org/what-organizational-self-study.

Should you have additional questions, please email **zerosuicide@edc.org**.