

Cerner Flash

Columbia Suicide Severity Rating Scale (CSSRS) Nursing and Patient Care Areas

Please see the recent changes to the CSSRS form. The changes were made due to Joint Commission findings regarding documentation of the screened risk level based off the CSSRS documentation. The update now allows for nursing to document the screened risk level of the patient directly on the form based off the responses documented. Questions 1-5 have the appropriate risk level displayed based on each of the "Yes" answers. Question 6b has the appropriate risk level based off the responses in that section. The screened risk level will be associated to last question answered "Yes" for questions 1-5. For question 6b, the screened risk level is associated with the selection answered for that question.

*Performed on: 12/13/2022 1302 EST By: Cerner

CSSRS Screen

Risk Assessment

Safety Plan

Columbia Suicide Severity Rating Scale - Screen

1. Have you wished you were dead or wished you could go to sleep and not wake up? (ref)

If question is answered "Past month, yes", please right-click the documentation box to review reference text for policy guidelines regarding further action.

No
 Yes (Low Risk)

2. Have you actually had any thoughts of killing yourself? (ref)

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

No
 Yes (Low Risk)

3. Have you been thinking about how you might kill yourself? (ref)

If question is answered "Past month, yes", please right-click the documentation box to review reference text for policy guidelines regarding further action.

No
 Yes (Mod Risk)

4. Have you had these thoughts and had some intention of acting on them? (ref)

If question is answered "Past month, yes", please right-click the documentation box to review reference text for policy guidelines regarding further action.

No
 Yes (High Risk)

5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? (ref)

If question is answered "Past month, yes", please right-click the documentation box to review reference text for policy guidelines regarding further action.

No
 Yes (High Risk)

6a. Have you ever done anything, started to do anything, or prepared to do anything to end your life? (ref)

Yes
 No

6b. How long ago did you do any of these? (ref)

Please right-click the documentation box to review reference text for policy guidelines regarding further action based on each response.

Within the last four weeks (High Risk)
 Between one and twelve months ago (Mod Risk)
 Over a year ago (Low Risk)

For question 1-5, the Screened Risk Level is associated with the last question marked "Yes". For question 6b, the Screened Risk Level is associated with the selection made.

Screened Risk

Low risk
Moderate risk
High risk

In acute care areas: documentation of High or Moderate suicide risk will place the appropriate orders/tasks as defined per policy. Depending on score these may include a safety sitter, suicide precautions, safety meal tray, case management/social work consult, provider notification, and additional assessments.