St. Luke's University Health Network

2026 HAP Achievement Award

Optimal Operations Award—Large Division

Standardization of Suicide Risk Assessment and Interventions

The Goal

Across the network's emergency departments and inpatient units, inconsistent suicide risk practices raised regulatory concerns and contributed to unnecessary continual 1:1 observation. Baseline data showed that 50 percent of suicide-related 1:1 observation orders did not meet high-risk criteria. The team set out to establish a more reliable process that matched each patient's level of support to their documented risk while reducing unnecessary observation.

The Intervention

A multidisciplinary suicide prevention committee guided the work, creating a more consistent approach to screening, documentation, and observation across the network. The team implemented universal suicide risk screening in emergency department and inpatient settings, updated related policies, and created role-specific checklists to help staff connect each patient's risk level with the right observation plan.

The work also focused on reducing unnecessary continual 1:1 observation while keeping patients safe. Electronic health record workflows and order sets were updated to make documentation clearer, secure hold rooms were expanded for high-risk patients, and virtual observation was used more consistently for low- and moderate-risk patients. Ongoing audits

and dashboards helped departments see where practices were aligned with policy and where additional follow-up was needed.

Results

The work led to safer, more consistent use of observation across the network. Non-compliant continual 1:1 observation orders dropped from 50 percent to 28 percent, exceeding the team's original goal. Secure hold rooms and virtual observation were used more appropriately based on each patient's risk level, helping reduce reliance on continual 1:1 observation. The changes resulted in $2.93 million in cost avoidance without an increase in self-harm events or suicide attempts.