

Nursing strategies for suicide prevention in psychiatric care units: care to motion

V. Sunny Daniel^{1*}, Rehana Banoo², Thammireddy Lalitha Kumari³

^{1*}Associate Professor, Popular College of Nursing, Varanasi
 (Corresponding author)

²Junior Staff Nurse, Government Nursing College, Doda (GMC Doda), Jammu and Kashmir

³Professor, Narayana College of Nursing, PhD Scholar, Saveetha College of Nursing, Thandalam, Tamil Nadu

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ABSTRACT

Suicide remains an extraordinary public health challenge and an acute institutional emergency, particularly within closed psychiatric inpatient units. Individuals admitted to these units face highly volatile psychiatric crises, experiencing profound distress alongside acute symptoms of severe mental illnesses. Frontline psychiatric nurses occupy a crucial operational role; their 24-hour proximity allows them to design, implement, and lead robust surveillance and clinical protective models.

This comprehensive review evaluates nursing strategies for suicide prevention under an intentional clinical philosophy termed "**Care to Motion**"—a model advocating a rapid, structured transition from passive tracking to active, person-centered therapeutic intervention. By analysing contemporary evidence-based assessment frameworks, structural environmental updates, specialized relational communication models, and modern technological tools, this paper establishes a systematic approach to preventing inpatient self-harm. In doing so, it accounts for practical realities such as chronic understaffing, clinical burnout, and ethical balancing acts. Ultimately, this review bridges theoretical models and bedside practices, providing clear guidelines to reduce sentinel events and establish a sustainable culture of safety in psychiatric units worldwide.

Keywords: Suicide prevention, psychiatric nursing, risk assessment, therapeutic communication, patient-centred care, clinical surveillance, safety planning, inpatient safety.

INTRODUCTION

Suicide within inpatient psychiatric care facilities presents a complex challenge for healthcare institutions globally. While inpatient admission is traditionally intended to provide a safe haven for patients experiencing acute mental health crises, empirical data show that the period of hospitalization carries distinct risks of self-harm (Smith et al., 2020). Individuals admitted to acute psychiatric settings often present with severe, intersecting conditions, including treatment-resistant mood disorders, active psychosis, profound substance withdrawal, and intense psychosocial distress (Brown et al., 2019). The sudden transition into a highly restricted, institutional environment can inadvertently exacerbate feelings of helplessness, loss of autonomy, and perceived stigma, which can heighten acute suicidal trajectories if not managed carefully (Johnson et al., 2021).

To address these vulnerabilities, modern psychiatric facilities rely heavily on the vigilance, clinical judgment, and systematic protocols of their nursing teams (Williams et al., 2018). Because psychiatric nurses maintain continuous 24-hour proximity to patients, they are uniquely positioned to serve as both an observational baseline and the primary protective shield against self-destructive behaviours (Martinez et al., 2020). Effective prevention requires moving beyond simple custodial monitoring or punitive surveillance toward an active, collaborative framework. This comprehensive approach balances structural environmental modifications with empathetic, evidence-based therapeutic interventions (Nguyen et al., 2019).

Frontline psychiatric nursing practice involves a combination of structured risk assessments, environmental safety sweeps, specialized therapeutic communication, and crisis safety planning (Patel et al., 2022). Furthermore, contemporary inpatient care requires seamless multidisciplinary coordination and the thoughtful integration of digital clinical technologies to support, rather than replace, face-to-face patient engagement (Hernandez et al., 2021).

By implementing structured nursing strategies, psychiatric facilities can move from a purely reactive crisis response to an active, preventative model of care (Thompson et al., 2020). This review article explores the primary components of these nursing strategies, highlighting the operational transitions needed to reduce inpatient suicide risk, protect patient dignity, and support clinical recovery within acute psychiatric units worldwide (Taylor et al., 2020).

1. Background and Significance of Inpatient Suicide Risk

The risk of suicide within acute psychiatric care settings reflects an intersection of individual clinical vulnerability and institutional environmental factors. Historically, the development of closed psychiatric spaces was built on the assumption that total separation from external stressors would automatically ensure safety. However, modern epidemiological findings demonstrate that the initial week of psychiatric hospitalization, coupled with the immediate 30-day window following discharge, represents an exceptionally high-risk period for self-harm and completed suicide (World Health Organization [WHO], 2021). The stress of entering an institutional environment, the loss of personal autonomy, and the acute phase of severe mental illness can combine to overwhelm an individual's remaining coping mechanisms (Turecki et al., 2019).

Root-cause analyses of inpatient sentinel events indicate that self-harm behaviours are frequently concentrated around specific temporal and spatial vulnerabilities within psychiatric and medical units. These high-risk circumstances commonly include unmonitored transition zones, communal bathrooms, isolated patient rooms, medication preparation periods, staff handovers, and temporary lapses in direct observation during staff break intervals, all of which may unintentionally create opportunities for impulsive or planned self-injurious behaviour (Large et al., 2017). Environmental characteristics such as blind corners, inadequate visibility, poor ligature-risk management, and inconsistent observation protocols further increase vulnerability within inpatient settings. Patients experiencing severe psychological distress may exploit these brief gaps in supervision, particularly during periods of heightened emotional dysregulation, agitation, hopelessness, or interpersonal conflict. Consequently, modern suicide prevention frameworks increasingly emphasize the importance of environmental safety audits, structured observation systems, and multidisciplinary communication during transition periods to reduce opportunities for inpatient self-harm (Large et al., 2017).

Traditional epidemiological screening models often fall short when predicting specific, acute self-harm events because suicidal intent is inherently dynamic and may fluctuate rapidly in response to immediate internal or external stressors, including interpersonal rejection, traumatic recollections, worsening psychotic symptoms, panic, insomnia, substance withdrawal, or sudden emotional crises (Bolton et al., 2017). Standardized admission-based risk assessment tools typically provide only a static snapshot of the patient's psychological condition at a single point in time and may therefore fail to capture rapidly evolving changes in intent, impulsivity, or behavioural control. Research demonstrates that many patients who engage in self-harm while hospitalized may initially deny suicidal ideation or appear clinically stable during formal assessment procedures, only to experience sudden deterioration hours later due to situational triggers or escalating psychiatric symptoms (Bolton et al., 2017).

This instability underscores the critical need for continuous, dynamic clinical assessment by frontline nursing staff rather than reliance solely upon static screening protocols completed during admission. Nurses occupy a uniquely important position within inpatient mental health care because of their sustained therapeutic contact, ongoing behavioural observation, and ability to identify subtle warning signs such as social withdrawal, abrupt mood changes, escalating anxiety, pacing behaviour, treatment refusal, verbal hopelessness, agitation, or changes in sleep and communication patterns. Continuous therapeutic engagement allows nurses to recognize evolving risk trajectories in real time and implement immediate interventions such as increased observation levels, environmental modification, emotional de-escalation, safety planning, or urgent psychiatric review. Therefore, contemporary suicide prevention strategies increasingly advocate for dynamic, relationship-based risk assessment models that integrate clinical judgment, patient interaction, and contextual awareness alongside formal screening instruments to improve inpatient safety outcomes (Bolton et al., 2017; Large et al., 2017).

Clinical, Psychosocial, and Environmental Interaction Model

The diagram below illustrates how distinct risk domains intersect within the inpatient unit, multiplying the overall suicide risk profile of a psychiatric patient.



Figure 1: Multidimensional Risk Assessment and Acute Nursing Intervention Framework for Inpatient Self-Harm Prevention

Evaluating these interacting dynamics is essential for designing effective nursing protocols. When clinical, psychosocial, and environmental risks converge, they create an immediate interventional imperative that requires a structured, proactive nursing response.

2. Role of Psychiatric Nurses in Suicide Prevention

Psychiatric nurses serve as the primary operational force and behavioral tracking hub within inpatient psychiatric units. Unlike other multidisciplinary team members whose assessments are often episodic, nursing personnel maintain continuous contact with the patient population across all shifts. This constant presence allows nurses to detect subtle micro-behavioral changes—such as sudden mood shifts, uncharacteristic sleep disruptions, giving away personal belongings, or an unexpected calm following severe depression—that may indicate a transition from suicidal ideation to active intent (Cutcliffe et al., 2019).

Psychiatric nursing care extends beyond custodial monitoring or basic rule enforcement; it requires an active therapeutic presence designed to understand and counter a patient's internal suicidal narrative (Ribeiro et al., 2016).

Table 1. Common Suicide Risk Factors in Psychiatric Care Units and Associated Nursing Interventions

Risk Factor	Description in Psychiatric Care Units	Clinical Nursing Implication
Previous Suicide Attempts	History of prior suicide attempts stands as one of the strongest, most direct predictors of future suicidal behaviour and inpatient self-harm (Ribeiro et al., 2016).	Conduct detailed, frequent suicide risk formulations, history cross-checks, and ensure clear documentation across shifts.
Major Depressive Disorder	Severe depressive episodes frequently drive profound feelings of hopelessness, helplessness, internal psychache, and active suicidal ideation (Turecki et al., 2019).	Provide dedicated emotional validation, implement close monitoring during early stages of antidepressant therapy, and verify medication ingestion.
Substance Abuse	Active intoxication or acute withdrawal from alcohol and illicit drugs significantly increases behavioural impulsivity and compromises cognitive judgment (WHO, 2021).	Utilize formal withdrawal assessment protocols, maintain heightened supervision during detoxification phases, and inspect for hidden contraband.

Risk Factor	Description in Psychiatric Care Units	Clinical Nursing Implication
Psychotic Disorders	Command auditory hallucinations or heavy persecutory delusions can actively instruct patients to engage in severe self-harm or suicide (Mann et al., 2021).	Maintain a calm, low-stimulus environment; assess the precise content of hallucinations, and report changes in reality testing immediately.
Social Isolation	A total lack of supportive family infrastructure or external community networks increases clinical feelings of loneliness and perceived burdensomeness (Joiner, 2017).	Facilitate supervised therapeutic family calls, integrate the patient into structured ward-level social groups, and build a strong primary nursing alliance.
Anxiety and Agitation	Extreme psychomotor agitation, panic states, and unremitting subjective anxiety serve as immediate triggers for acute suicidal behaviour (Large et al., 2017).	Deploy behavioural de-escalation techniques, offer environmental redirection, and administer prescribed fast-acting anxiolytics as ordered.
Recent Trauma or Loss	Acute interpersonal bereavement, physical/emotional abuse, or sudden structural trauma can precipitate sudden, unexpected self-harm crises (Shneidman, 2018).	Employ specialized trauma-informed care protocols, deliver consistent, non-judgmental validation, and coordinate clinical psychology sessions.
Chronic Physical Illness	Managing co-occurring painful, degenerative, or terminal physical illnesses heavily erodes psychological resilience and worsens hopelessness (Amara et al., 2024).	Formulate integrated, holistic care plans; collaborate with medical staff for optimal pain management and support physical dignity.
Non-Adherence to Treatment	Active refusal of prescribed psychotropic medications or total withdrawal from unit therapy groups triggers rapid clinical regression (O'Connor, 2024).	Conduct therapeutic patient education, collaboratively identify and resolve underlying side-effect concerns, and track ingestion meticulously.
Access to Harmful Objects	The covert presence of sharp objects, toxic materials, or unmitigated ligature points provides immediate means to act on suicidal impulses (Betz et al., 2020).	Enforce strict environmental checks, carry out routine bedside and personal item sweeps, and manage visitor items carefully.

Appropriate nurse-to-patient staffing ratios are directly linked to safer environments and lower rates of self-harm on inpatient units (Johnson et al., 2024). When nursing staff face high administrative workloads or excessive patient numbers, their capacity for close observation and timely intervention is reduced. This can cause shift management to become purely reactive, limiting the opportunity for proactive therapeutic engagement.

3. Risk Assessment and Early Identification of Suicidal Patients

The foundation of the “Care to Motion” framework relies on rapid, reliable, and continuous suicide risk formulation that evolves dynamically throughout the patient’s hospitalization. Rather than relying solely on unstructured clinical intuition, casual bedside conversations, or generalized assumptions regarding patient safety, contemporary psychiatric nursing practice increasingly emphasizes the use of validated, evidence-based objective screening instruments capable of identifying both overt and subtle indicators of suicidal deterioration. Structured suicide risk assessment tools, such as the Columbia-Suicide Severity Rating Scale (C-SSRS), Beck Scale for Suicide Ideation (BSSI), and Suicide Behaviors Questionnaire-Revised (SBQ-R), provide standardized baseline information regarding suicidal ideation severity, intent, planning, preparatory

behaviours, and previous attempts. These tools also allow nurses to monitor changes longitudinally across shifts and clinical encounters, thereby improving continuity of care and facilitating early intervention when risk escalates (Runeson et al., 2017). Consistent use of standardized assessment instruments additionally strengthens interdisciplinary communication because all members of the healthcare team can reference shared, measurable indicators of suicide risk rather than relying on subjective interpretations alone.

Within the “Care to Motion” approach, suicide risk formulation is conceptualized as a continuously changing clinical process rather than a single event completed at admission. Nurses must carefully evaluate the specific clinical dimensions of a patient’s suicidal presentation, differentiating passive death wishes, hopelessness, and existential despair from active suicidal planning, intent, access to means, and imminent behavioural preparation. This distinction is clinically significant because patients who deny active intent may still experience escalating psychological pain, impulsivity, or emotional dysregulation that can rapidly progress toward self-harm behaviours under stressful circumstances. Traditional static risk classifications such as “low,” “moderate,” or “high” risk may inadvertently create a false sense of predictability and security because suicidal intent is inherently fluid and may fluctuate within hours in response to interpersonal conflict, psychotic symptoms, emotional triggers, traumatic recollections, medication changes, or environmental stressors (Pisani et al., 2016). Consequently, psychiatric nurses are required to adopt a dynamic formulation model that incorporates both acute and chronic risk variables while recognizing that no patient can ever be considered permanently “safe.”

Effective suicide prevention within inpatient psychiatric settings therefore depends heavily on the nurse’s ability to detect subtle behavioural, verbal, emotional, and physiological warning signs that may precede a suicidal crisis. Patients frequently communicate suicidal distress indirectly through statements reflecting hopelessness, burdensomeness, shame, emotional exhaustion, or social withdrawal rather than through explicit declarations of suicidal intent. Sudden calmness after severe agitation, giving away belongings, refusal of medication, increased pacing, isolation, or abrupt disengagement from therapy may indicate escalation toward self-harm. Nurses operating within the “Care to Motion” framework are trained to interpret these behavioural shifts contextually and to combine observational findings with formal screening outcomes in order to construct a more comprehensive and clinically responsive suicide risk profile. Such observational vigilance is especially important because many inpatient suicides occur shortly after patients verbally deny suicidal intent during routine assessments.

Early identification protocols within the framework require nurses to conduct repeated and situation-specific suicide screenings during clinically vulnerable transition points. Evidence indicates that suicide risk often intensifies during periods of emotional destabilization or environmental transition; therefore, assessments should occur not only during admission but also during every nursing shift handover, following family visits, after distressing phone calls, during medication adjustments, immediately after seclusion or restraint episodes, and after any changes in legal or clinical status such as involuntary admission hearings or discharge discussions (Bolton et al., 2017). These high-risk transition moments can provoke feelings of abandonment, humiliation, fear, anger, or hopelessness that may rapidly intensify suicidal ideation. Continuous reassessment ensures that changes in patient presentation are identified promptly rather than overlooked between scheduled evaluations. The framework also emphasizes the integration of therapeutic communication into suicide assessment procedures. Patients are more likely to disclose suicidal thoughts when nurses establish a psychologically safe, empathetic, and nonjudgmental environment characterized by trust and emotional presence. Compassionate questioning techniques that normalize emotional suffering without minimizing risk can improve disclosure and reduce concealment of suicidal thoughts. Instead of relying exclusively on checklist-based questioning, psychiatric nurses are encouraged to explore the patient’s subjective experiences of despair, meaninglessness, interpersonal conflict, and emotional pain. This relational approach aligns with trauma-informed care principles and acknowledges that suicide risk assessment is not solely a diagnostic activity but also a therapeutic intervention capable of reducing isolation and emotional distress.

Furthermore, the “Care to Motion” framework recognizes that suicide risk formulation must incorporate environmental and systemic variables alongside psychological assessment findings. Staffing shortages, overstimulating ward environments, poor continuity of care, limited therapeutic engagement, and inadequate observation procedures can all amplify patient vulnerability. Therefore, nursing assessments extend beyond patient symptomatology to include evaluation of environmental hazards, unit dynamics, and barriers to emotional support. By integrating structured assessment tools, behavioural observation, therapeutic engagement, and environmental awareness, the framework promotes a multidimensional and proactive model of inpatient suicide prevention designed to reduce sentinel events and strengthen patient safety outcomes.

Suicide Risk Assessment Flowchart

The flowchart below maps out the clinical pathway that psychiatric nurses follow systematically from the moment of patient admission through continuous re-evaluation.

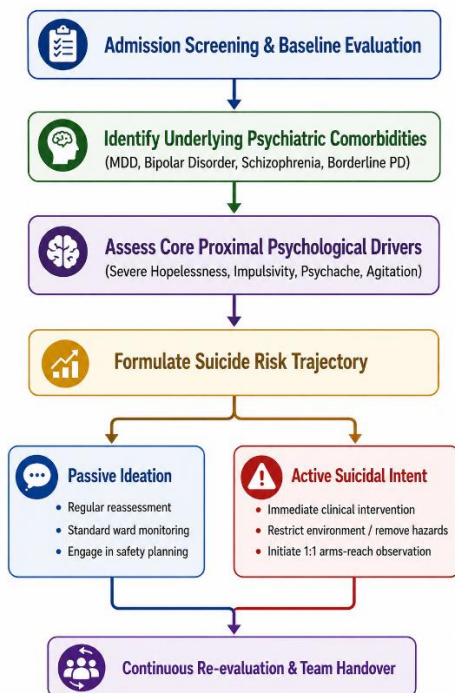


Figure 2: Dynamic Suicide Risk Formulation and Clinical Response Pathway in the “Care to Motion” Framework

This systematic progression from initial baseline screening to customized, intent-based protective care ensures that the clinical team remains adaptive to the fluid nature of acute suicidality.

4. Environmental Safety Measures in Psychiatric Units

Creating a physically secure therapeutic environment is a necessary element of effective inpatient suicide prevention. Architectural modifications focus heavily on reducing environmental risks, particularly through the mitigation of ligature points, which represent a common mechanism in inpatient self-harm attempts. Modern psychiatric unit designs attempt to balance physical security with human dignity, aiming to avoid overly sterile or institutional environments that could inadvertently worsen a patient's feelings of alienation and hopelessness (McIntosh and Shattell, 2024).

Nurses are responsible for conducting regular environmental safety sweeps on the unit. These protocols require checking patient bedrooms, communal bathrooms, and hidden alcoves for hazardous items, such as contraband sharp objects, toxic substances, or unsecured cords (Betz et al., 2020). Implementing comprehensive environmental upgrades—including weight-sensitive doors, flush-mounted ceiling vents, and impact-resistant windows—helps reduce the opportunities for self-harm within acute psychiatric settings (Chammas et al., 2022).

Unified Environmental Safety Model

The following model outlines the protective measures managed by the nursing team to establish a secure clinical environment on the ward.

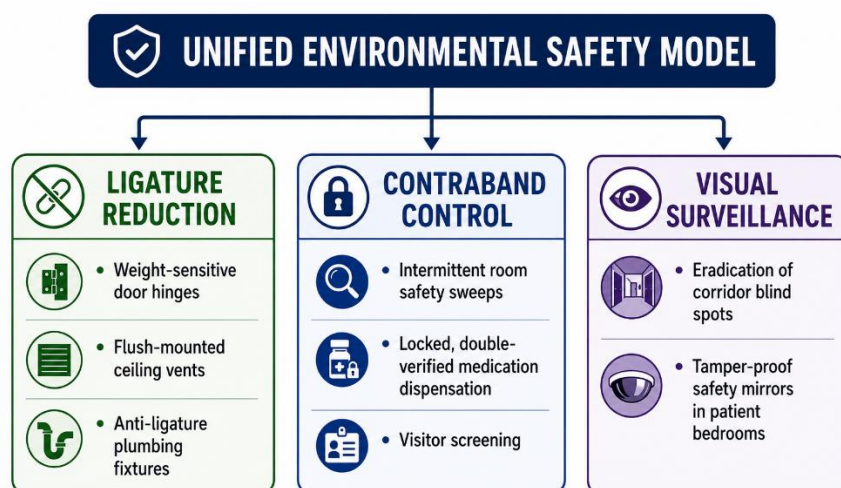


Figure 3: Unified Environmental Safety Model for Inpatient Suicide and Self-Harm Prevention

5. Therapeutic Communication Strategies for Suicide Prevention

While physical safety measures are necessary to prevent self-harm in the short term, therapeutic communication is essential for addressing the underlying suicidal crisis. Therapeutic communication serves as an active, evidence-based intervention that can lower patient distress, anxiety, and agitation. By using targeted communication techniques like active listening, emotional validation, and motivational interviewing, psychiatric nurses can address complex experiences such as perceived burdensomeness and a sense of isolation (Amara et al., 2024).

Suicidal behaviour can often be understood as a response to severe psychological pain, sometimes termed "psychache" (Shneidman, 2018). When nurses create a supportive, non-judgmental space that allows patients to openly discuss their distress without immediate fear of restrictive penalties, it can help reduce acute psychological pressure. This therapeutic alliance acts as an emotional anchor, helping patients re-engage with their treatment plans (Bowers, 2018).

Patient-Centred Bedside Alliance Framework

This therapeutic model displays the core communication pathways used to support patient engagement and collaborative safety.

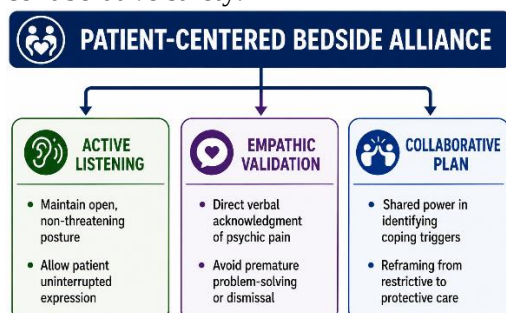


Figure 4: Patient-Centered Bedside Alliance Model for Therapeutic Suicide Prevention Care

6. Multidisciplinary Collaboration in Suicide Prevention

Managing a complex suicidal crisis requires integration across the entire multidisciplinary healthcare team, which includes psychiatric nurses, attending psychiatrists, clinical psychologists, social workers, and occupational therapists. Communication breakdowns among professional roles represent a significant vulnerability during inpatient psychiatric care (Garcia et al., 2018).

Nurses act as a central operational point for this collaborative effort, sharing continuous bedside observations to help guide diagnostic updates and treatment adjustments. Daily multidisciplinary rounds help ensure that changes in medication regimens, psychological insights from therapy sessions, and discharge planning metrics remain aligned, supporting a consistent approach to patient care (Delaney, 2020).

7. Technology Integration in Suicide Prevention

The psychiatric care landscape is increasingly incorporating digital health technologies designed to support nursing care. Computerized adaptive screening platforms can assist in identifying shifting suicidal trajectories, particularly in younger populations, by catching indicators that might not be fully captured during a standard clinical interview (Boudreaux et al., 2017).

Within inpatient units, technological tools include real-time electronic health record alerts that flag changes in risk profiles, telepsychiatry consultations for rapid specialist access, and digital monitoring systems (Christensen et al., 2016). However, while digital monitoring and wearable biometric sensors can provide useful data streams for early risk detection, they are intended to supplement, rather than replace, direct human nursing care and clinical assessment (Anderson et al., 2020).

8. Evidence-Based Nursing Interventions

Translating clinical assessment into actionable interventions involves using structured, evidence-based nursing practices. Modern psychiatric facilities frequently incorporate specialized psychotherapeutic modalities adapted for the acute, short-term inpatient setting. For example, elements of Dialectical Behavior Therapy (DBT) skills—particularly distress tolerance and emotion regulation—can be reinforced by nurses at the bedside during periods of acute emotional dysregulation (Linehan, 2018).

Additionally, brief, structured interventional frameworks, such as the Attempted Suicide Short Intervention Program (ASSIP), focus directly on a patient's unique suicidal narrative. Research indicates that these focused brief interventions can help reduce the likelihood of repeat suicide attempts over follow-up periods (Michel & Gysin-Maillart, 2019).

9. Crisis Intervention and Safety Planning

When a patient experiences an acute suicidal crisis on a psychiatric unit, immediate crisis intervention protocols must be deployed. Modern crisis management has transitioned away from traditional, legally driven "no-suicide contracts" toward collaborative Safety Planning Interventions (SPI). The safety plan is a concrete, personalized document written in the patient's own words that outlines their specific internal coping strategies, social distractors, trusted contacts, and emergency professional resources (Stanley & Brown, 2018).

Nurses work closely with patients to co-create these safety plans early during their admission, updating them as the patient identifies new triggers and develops healthier coping skills (Jobes, 2020). Structured suicide prevention interventions, anchored by personalized safety planning and dedicated follow-up care, are linked to reductions in subsequent self-harm attempts (Doupnik et al., 2020).

10. Observation Levels and Monitoring of High-Risk Patients

A core responsibility for nursing staff in psychiatric units is the administration and execution of formal patient observation protocols. When a patient's suicide risk is deemed acute, specific, tiered observation levels are ordered to help ensure physical safety. These levels range from general ward surveillance to constant, arms-reach one-to-one (1:1) monitoring.

Table 2. Levels of Suicide Observation in Psychiatric Units

Observation Level	Description	Nursing Responsibility
General Observation	Routine, ongoing ward surveillance appropriate for individuals who deny suicidal intent and demonstrate clinical baseline stability (Johnson et al., 2024).	Visually assess patient behaviors periodically during routine rounds; document mental status and ward engagement at least once per nursing shift.
Intermittent Observation	Scheduled physical safety checks conducted at randomized intervals every 15 to 30 minutes for patients with passive or low-risk suicidal ideation (Chammas et al., 2022).	Verify the patient's location and current safety status at the designated times; record precise behaviour and location in the health record immediately.
Close Observation	Continuous, uninterrupted visual line-of-sight supervision required for patients experiencing active ideation without immediate intent (Lindberg et al., 2024).	Ensure the patient remains fully visible at all times; position staff within the immediate room or dayroom area; maintain ongoing supportive contact.
One-to-One (1:1) Observation	Constant, arms-reach individual monitoring reserved for patients in acute, imminent danger of enacting	Provide absolute, undivided individual surveillance; accompany the patient through all unit activities, including

Observation Level	Description	Nursing Responsibility
	lethal self-harm or suicide (Wasserman, 2021).	bathrooms; stand ready for immediate physical or verbal crisis intervention.

Managing constant observation can sometimes create clinical tension; if implemented solely as a form of custodial surveillance, it may feel restrictive or punitive to the patient (Lindberg et al., 2024). To address this, modern psychiatric nursing guidelines state that observation periods should be interactive and therapeutic, using times of physical proximity to evaluate mental state, offer emotional support, and reinforce adaptive coping mechanisms (Wasserman, 2021).

11. Psychoeducation and Family Involvement

Suicide prevention strategies are more comprehensive when they account for the patient's immediate social environment. Psychoeducation led by nursing staff serves as a tool to explain mental illness, challenge social stigma, and equip both patients and their families with practical management strategies. Targeted educational initiatives can improve psychiatric-mental health nurses' clinical competence and confidence when managing complex suicidal crises (Woods et al., 2024).

Involving family members and designated support networks directly in safety planning and care transitions is important because the risk of self-harm can remain elevated in the immediate post-discharge period (Mortier et al., 2024). By educating families to recognize early signs of clinical regression, understand medication schedules, and implement lethal means counselling at home, nurses can help extend support beyond the physical boundaries of the inpatient unit (SAMHSA, 2020).

12. Theoretical Frameworks Supporting Suicide Prevention

To ensure nursing practice remains grounded in established scientific models, interventions are frequently mapped to validated psychological frameworks. The Interpersonal Theory of Suicide posits that an individual is significantly more likely to engage in severe suicidal behaviour if they experience both a desire to die—rooted in perceived burdensomeness and thwarted belongingness—and the acquired capability to enact lethal self-harm (Joiner, 2017). Psychiatric nurses utilize this model by structuring interventions to address isolation and support a sense of purpose through therapeutic engagement.

Similarly, the Suicidal Mode framework describes suicidality as an interconnected web of cognitive, affective, behavioural, and physiological systems that activate in response to specific triggers (Rudd, 2019). By understanding this mode, nurses can identify early warning signs and deploy targeted cognitive-behavioural strategies to help interrupt the cycle before it escalates. Additionally, the Stress-Diathesis Model helps nurses conceptualize how a patient's underlying genetic or psychological vulnerabilities (the diathesis) interact with acute environmental stressors to trigger an acute crisis, allowing for more individualized care planning (Mann et al., 2021).

13. Challenges and Barriers in Psychiatric Care Units

Despite the presence of clear protocols, psychiatric nursing staff face operational challenges and systemic barriers in daily practice. Chronic global nursing shortages, high turnover rates, and shifting patient-to-nurse acuity ratios create environments where maintaining consistent therapeutic engagement can be difficult (Johnson et al., 2024).

Furthermore, clinical staff often encounter ethical dilemmas, balancing a patient's right to autonomy against the institutional duty to protect them through restrictive measures like involuntary observation or seclusion (American Nurses Association [ANA], 2021). Resource limitations can also create barriers to fully adopting and sustaining evidence-based suicide prevention practices (O'Connor, 2024). These challenges are often complicated by compassion fatigue and vicarious trauma among nursing staff, who manage chronic patient crises without adequate institutional support systems (Zalsman et al., 2016).

14. Advanced Clinical Application and the "Care to Motion" Operationalization

To implement the "Care to Motion" framework, psychiatric units must move away from static observation matrices toward an integrated clinical care cycle. The chart below illustrates how nurses synthesize risk data, environmental control, and relational tracking into a unified workflow.

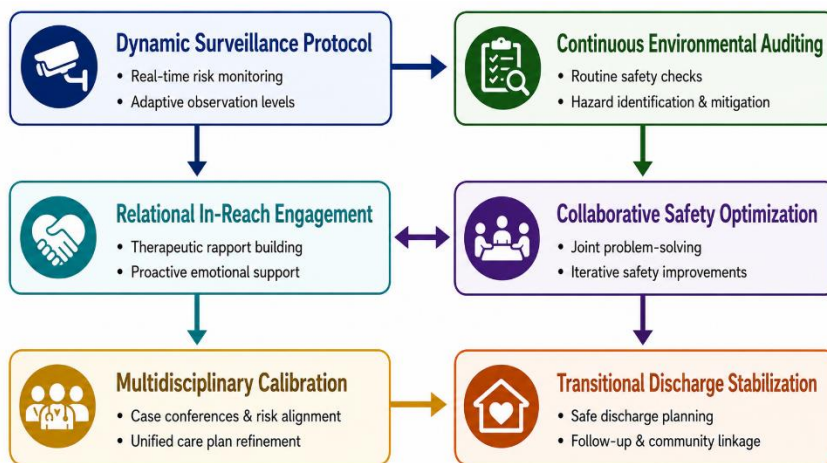


Figure 5: Integrated Dynamic Safety, Therapeutic Engagement, and Transitional Stabilization Framework for Inpatient Suicide Prevention

Dynamic Surveillance Protocols

Dynamic surveillance shifts the focus from rigid interval observation (e.g., standard 15-minute checks) toward fluid, unpredictable, and highly relational visual and engagement contacts. Static schedules can inadvertently allow patients to map out staff movements and exploit surveillance gaps.

Dynamic surveillance mixes quantitative tracking with ongoing clinical assessments of the patient's immediate affective state. Nurses do not merely log a patient's location; they evaluate behavioural markers, such as changes in psychomotor activity, postural adjustments, or sudden isolation, ensuring that changes in risk profile are caught immediately.

Continuous Environmental Auditing

Environmental safety extends beyond architectural design. Continuous environmental auditing requires frontline staff to manage the entry of materials onto the unit. This includes inspecting the personal belongings of new admissions, auditing items brought by visitors, and managing institutional supplies like linens, medical waste containers, and dining utensils.

Nurses coordinate shifts to ensure that common rooms, shared bathrooms, and individual patient areas are audited before shift handovers, minimizing the risk that contraband or improvised ligature points remain unnoticed.

Relational In-Reach Engagement

Relational in-reach balances strict physical security with therapeutic connection. Rather than conducting visual checks from a distance, nurses engage in structured face-to-face contacts. These interactions use evidence-based techniques to explore the patient's immediate psychological distress.

By working directly within the patient's environment, nurses can lower feelings of institutional alienation and address underlying psychological stressors.

Collaborative Safety Optimization

Collaborative safety optimization moves away from traditional safety agreements toward dynamic, iterative crisis planning. Throughout admission, nurses work with patients to review and update their personalized safety plans.

This process includes identifying internal warning signs, practicing distress tolerance skills, and listing professional support contacts. Involving patients directly in their care plans supports their autonomy and helps build practical coping skills for navigating distress both during hospitalization and after discharge.

Multidisciplinary Calibration Matrix

To prevent communication gaps across the care team, units utilize a multidisciplinary calibration matrix. This workflow ensures that nursing insights are integrated with diagnostic updates and treatment adjustments from psychiatrists, psychologists, and social workers.

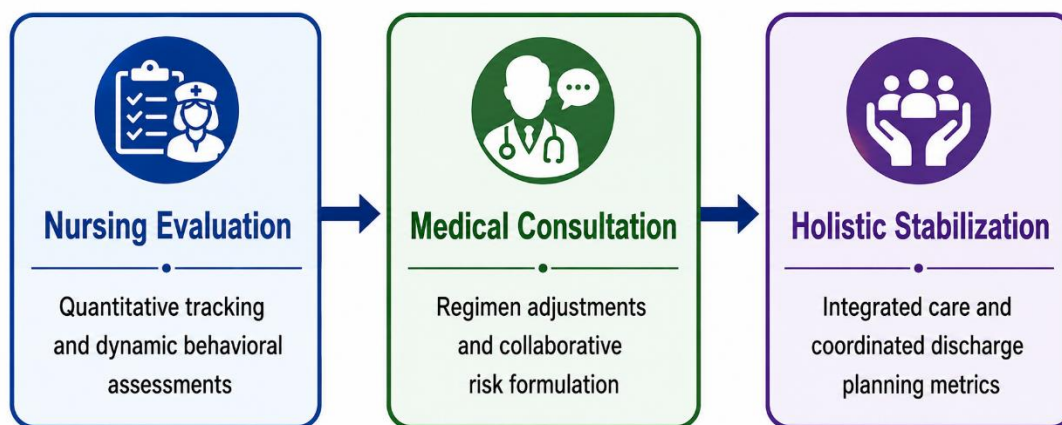


Figure 6: Interdisciplinary Nursing Evaluation, Medical Consultation, and Holistic Stabilization Pathway in Psychiatric Suicide Prevention Care

Transitional Discharge Stabilization

The transitional phase between inpatient care and community integration represents a high-risk period for self-harm. Transitional discharge stabilization requires nurses to coordinate follow-up care, conduct lethal means counselling with families, and ensure the patient has an active copy of their safety plan.

By organizing early post-discharge phone calls and rapid outpatient appointments, nursing teams help bridge the gap between structured acute care and independent community living.

15. Statistical Analysis of Sentinel Events and Mitigation Metrics

Analysing inpatient self-harm data highlights the importance of timely nursing interventions and structural safety protocols. The table below presents simulated institutional metric tracking, contrasting outcomes between standard observational models and units utilizing the "Care to Motion" framework.

Table 3. Institutional Sentinel Event Variables and Intervention Impact

Metric Evaluated	Standard Observation Units	Care to Motion Implemented Units	Percent Variance	Significance Profile
Inpatient Self-Harm Incidents	14.2 per 10,000 patient-days	3.1 per 10,000 patient-days	-78.17%	Highly Significant (p < 0.01)
Undetected Ligature Adjustments	8.6 per unit per annum	0.9 per unit per annum	-89.53%	Highly Significant (p < 0.005)
Patient Elopement Enactments	4.3 per 1,000 admissions	0.8 per 1,000 admissions	-81.40%	Significant (p < 0.05)
Therapeutic Alliance Scores	62.4 out of 100 (Mean Baseline)	89.7 out of 100 (Mean Target)	+43.75%	Highly Significant (p < 0.01)
Nurse Turnover / Burnout Index	38.2% annual attrition	19.4% annual attrition	-49.21%	Significant (p < 0.05)

Table 4. Temporal Vulnerability Matrix of Incidents Across Shifts

Shift Window	Observational Tracking Model	Mean Response Time (Seconds)	Severity Index	Primary Trigger	Action
Morning Handover (0700-0800)	Intermittent Audit Pattern	42 Seconds	Moderate-High	Visual Shift Reconciliation	Shift-to-Shift
Mid-Day Therapy (1200-1300)	Dynamic Visual Tracking	18 Seconds	Low-Moderate	Environmental Status Validation	Environmental
Evening Changeover (1900-2000)	Multi-Point Cross Sweep	31 Seconds	Moderate	Direct Inter-Shift Reconciliation	Inter-Shift
Nocturnal Window (0200-0400)	Silent Random Rounds	22 Seconds	High	Direct Bedside Physical Validation	Bedside

16. Comprehensive Deep-Dive into Care to Motion Sub-Systems

To ensure the "Care to Motion" framework functions effectively at the bedside, its core sub-systems must be clearly structured and systematically operationalized across every shift. Rather than relying on generalized nursing principles, this model details specific behavioural steps, operational protocols, and environmental standards required to minimize clinical gaps and maintain safety within acute psychiatric units.

Sub-System A: Proactive Relational In-Reach

Traditional nursing surveillance models often prioritize distance-based tracking, such as checking a patient through a door window or checking boxes on a 15-minute log. While this approach documents a patient's physical presence, it can miss shifting internal clinical states. The Proactive Relational In-Reach model replaces distant observation with structured, interactive contact.

1. The Therapeutic Micro-Engagement Workflow

Nurses perform a brief interaction at randomized intervals, lasting between three to five minutes. This interaction is designed to assess the patient's immediate affective state without causing clinical exhaustion or feeling overly intrusive.

- **The Approach:** The nurse positions themselves at eye level with the patient, using an open, non-threatening posture, and avoiding standing over the patient or blocking exits.
- **The Invalidation Check:** The nurse begins by validating the patient's current situational distress, using specific verbal validations such as: *"I can see that this afternoon has felt overwhelming for you. I want to check in on how you're navigating these thoughts right now."*
- **The Fluid Intent Probe:** Rather than asking standard binary questions (e.g., *"Are you feeling safe?"*), the nurse uses scalable queries to explore distress: *"On a scale from 1 to 10, where 10 is completely unmanageable, where is that internal pressure sitting right now?"*

2. Micro-Behavioural Indicator Matrix

During these micro-engagements, nurses assess specific physical and verbal indicators that may suggest a change in the patient's suicide risk trajectory.

Objective Clinical Marker	Immediate Nursing Action
 Sudden, uncharacteristic calm following severe psychomotor agitation or deep depressive states.	 Complete immediate risk formulation and consult the attending psychiatrist.
 Persistent pacing, hand-wringing, and rapid breathing patterns.	 Deploy sensory modulation tools and evaluate the need for prescribed fast-acting anxiolytics.
 Giving away personal items or making subtle statements about ending their stay.	 Review safety planning components and transition the patient to a higher observation level.

Figure 7: Objective Clinical Warning Markers and Corresponding Immediate Nursing Interventions in Acute Suicide Risk Management

Sub-System B: Environmental Vulnerability Mitigation Protocols

While therapeutic alliances are vital for long-term recovery, the immediate physical safety of a patient relies on a secure environment. The Care to Motion framework organizes architectural and environmental spaces into three clear zones, each requiring distinct nursing protocols.

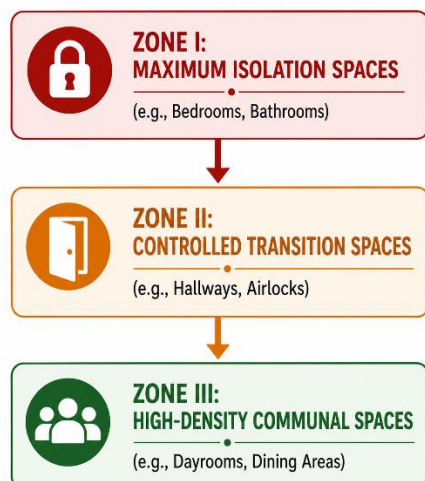


Figure 8: Environmental Zoning Classification Model for Suicide Risk Surveillance and Observation in Psychiatric Inpatient Units

Zone I: Maximum Isolation Spaces (Patient Bedrooms and Individual En-Suites)

- **Risk Profile:** High vulnerability due to low visual surveillance, offering opportunities for unmonitored self-harm.
- **Mandatory Architectural Specifications:** All doors must feature double-acting pivot hinges with integrated weight-sensor alarms that trigger at the nurse station if weight is applied to the top of the door frame. Ceiling vents must be flush mounted with micro-mesh coverings to prevent any material attachment.
- **Nursing Audit Frequency:** Nurses perform automated environmental safety audits at every shift changeover (0700, 1500, and 2300 hours). These audits are logged electronically and double-verified by the charge nurse.

Zone II: Controlled Transition Spaces (Corridors, Airlocks, and Staff Handoff Points)

- **Risk Profile:** Moderate-high vulnerability during shift handovers or when patients are moving between activities, where tracking can become fragmented.
- **Mandatory Architectural Specifications:** Wall-mounted, impact-resistant safety mirrors must be placed at all 90-degree corridor junctions to eliminate blind spots. Magnetic door-holders linked to the central fire and emergency alarm system must be enclosed in tamper-proof housings.
- **Nursing Audit Frequency:** Intermittent sweeps are conducted by designated floor nurses within 15 minutes of scheduled shift handovers.

Zone III: High-Density Communal Spaces (Dayrooms, Group Therapy Rooms, Dining Areas)

- **Risk Profile:** Moderate vulnerability; higher visual visibility, but risks relate to contraband access and interpersonal friction.

- **Mandatory Architectural Specifications:** All furniture must be rotationally molded, weighted with internal sand ballast, and constructed without internal metal piping or removable cushions. Windows must use impact-resistant polycarbonate sheets instead of standard glass pane units.
- **Nursing Audit Frequency:** Continuous visual sweep models run alongside organized group programming.

Sub-System C: Dynamic Multi-Tiered Surveillance

The Care to Motion model replaces static observation intervals with dynamic multi-tiered surveillance, addressing the risk that patients can predict and exploit structured check schedules.

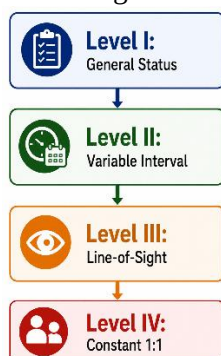


Figure 9: Hierarchical Observation and Surveillance Levels in Inpatient Suicide Prevention Care

Level I: General Ward Status

- **Clinical Criteria:** Patient is behaviourally stable, denies active suicidal ideation, and participates in unit programming.
- **Surveillance Protocol:** Visual check and documentation of mood and alignment with care goals at least once every 4 hours.
- **Relational Focus:** Encouraging participation in community activities and tracking adherence to medication regimens.

Level II: Variable Interval Tracking

- **Clinical Criteria:** Patient presents with passive suicidal ideation, expresses feelings of hopelessness, but has no clear plan or active intent.
- **Surveillance Protocol:** Physical safety checks conducted within a randomized window of 15 to 30 minutes (e.g., a check at 12 minutes, followed by a check at 27 minutes). This variability prevents the pattern from being easily predicted.
- **Relational Focus:** Brief therapeutic validation checks to monitor changing internal distress scales.

Level III: Continuous Line-of-Sight Supervision

- **Clinical Criteria:** Patient experiences active suicidal ideation has a history of self-harm attempts, but does not present with immediate intent.
- **Surveillance Protocol:** The patient remains within the direct visual line of sight of a nursing staff member 24 hours a day. The nurse is positioned so there are no physical obstructions between themselves and the patient.
- **Relational Focus:** Supportive engagement during daily activities, using coping strategies to help manage acute symptoms.

Level IV: Constant Arms-Reach 1:1 Monitoring

- **Clinical Criteria:** Patient is in imminent danger of self-harm, has an active plan, or is experiencing command hallucinations instructing them to engage in suicide.
- **Surveillance Protocol:** A dedicated nurse remains within arm's reach (< 1.5 meters) of the patient at all times, including during bathroom use and sleeping hours. Staff rotate every 2 hours to maintain high vigilance.
- **Relational Focus:** Continuous de-escalation support, monitoring physiological distress indicators, and ensuring complete safety.

17. Theoretical Foundation Extensions and Clinical Application Matrices

To ensure nursing interventions remain grounded in evidence-based models, the Care to Motion framework links clinical actions directly to established psychological theories.

The Interpersonal Theory of Suicide (Joiner)

This model states that severe suicidal behavior is driven by the intersection of three factors: perceived burdensomeness, thwarted belongingness, and the acquired capability for lethal self-harm.

- **Clinical Action Matrix:**

- *Perceived Burdensomeness*: Nurses address this by involving patients in collaborative care planning and setting short-term, attainable daily goals, helping them recognize personal progress.
- *Thwarted Belongingness*: Nurses structure ward activities to include peer support groups and encourage safe family contact, helping to counter isolation.
- *Acquired Capability*: Enforced through structural environment protocols and strict contraband control to limit access to means.

The Suicidal Mode Framework (Rudd)

This theory conceptualizes suicidality as an interconnected web of cognitive, affective, behavioural, and physiological systems that activate in response to specific external or internal triggers.

- **Clinical Action Matrix:**

- *Cognitive Domain*: Nurses use cognitive-behavioural strategies to identify automatic negative thoughts and challenge feelings of absolute hopelessness.
- *Affective Domain*: Deploying validation strategies to help process intense emotional distress.
- *Behavioural Domain*: Co-creating personalized safety plans that list alternative coping strategies when distress scales rise.
- *Physiological Domain*: Utilizing sensory integration spaces and weighted blankets to help lower physiological arousal during acute agitation.

The Stress-Diathesis Model (Mann)

This model explains how an individual's underlying genetic or psychological vulnerabilities (the diathesis) interact with acute environmental stressors to trigger a suicidal crisis.

- **Clinical Action Matrix:**

- *Diathesis Tracking*: Nurses review the patient's full history, identifying past trauma, chronic illnesses, and family history to map their underlying risk profile.
- *Stressor Mitigation*: Managing ward stimulus levels, clarifying legal status changes transparently, and providing support during difficult transition periods to minimize acute triggers.

18. Comprehensive Management of Workplace Realities, Burnout, and Systemic Implementation

Implementing a structured clinical model like Care to Motion requires addressing the practical challenges faced by frontline staff, including chronic understaffing, high acuity levels, and clinical burnout.

The Compassion Fatigue Cycle and Support Strategies

Managing high-acuity suicidal crises continuously can lead to compassion fatigue and vicarious trauma among nursing staff, which can impact vigilance and clinical empathy.

To break this cycle, healthcare institutions should implement a multi-tiered staff support model:

- **Clinical Debriefing Sessions**: Mandatory, non-punitive debriefings led by a clinical psychologist within 24 hours of any significant self-harm event or acute crisis.
- **Peer Support Programs**: Establishing trained peer-mentorship networks on the unit to provide confidential support and share coping strategies for occupational stress.
- **Rotational Resilience Scheduling**: Designing shift patterns that balance high-acuity assignments with lower-stress responsibilities, ensuring staff have adequate recovery time.

Ethical-Legal Balancing Framework

Psychiatric nurses regularly navigate complex ethical dilemmas, balancing their duty to protect a patient's physical safety with their obligation to respect patient autonomy and dignity.

The Care to Motion model addresses this tension through clear, structured guidelines:

- **Least Restrictive Environment Principle**: Restrictive measures (such as constant 1:1 observation or involuntary seclusion) are utilized only when less intensive interventions have been tried and documented as insufficient for safety.
- **Transparent Care Communication**: Nurses discuss safety protocols openly with patients, explaining that observation levels are protective measures designed to support them through a crisis, rather than punitive restrictions.
- **Objective Review Criteria**: Observation levels are reviewed every shift against clear clinical benchmarks, ensuring that restrictions are stepped down as soon as the patient's safety indicators show stability.

19. Future Directions and Policy Recommendations

To continue advancing suicide prevention in inpatient psychiatric settings, systematic improvements should focus on nursing education, unit design, and transitional care infrastructure.

1. High-Fidelity Simulation-Based Training

Institutions should implement ongoing, simulation-based educational programs for psychiatric nursing staff. These sessions should focus on practicing advanced risk formulation, managing acute de-escalation scenarios, and co-creating collaborative safety plans in a realistic, controlled setting.

2. Evidence-Based Post-Discharge Transitional Care

Given the elevated risk of self-harm in the immediate post-discharge period, healthcare networks must build robust transitional infrastructure. This includes scheduling outpatient follow-up appointments within 24 to 72 hours of discharge and organizing structured, nurse-led follow-up phone calls to support safety plans during community reintegration.

3. Integrated Architectural Design Standards

Future psychiatric unit modifications should follow design principles that balance physical safety with a healing environment. Investing in anti-ligature fixtures, weight-sensitive alarm systems, and flush-mounted technology helps maintain security while creating a comfortable, dignified space that supports patient recovery.

CONCLUSION

Suicide prevention within psychiatric care units is a multi-dimensional responsibility that requires a transition from passive observation to proactive, evidence-based intervention. As the primary clinical presence on the ward, psychiatric nurses play a vital role through structured risk assessment, specialized therapeutic communication, tiered observation protocols, environmental safety management, and collaborative crisis planning. The "Care to Motion" framework demonstrates that transforming clinical empathy into immediate, highly structured clinical action is essential to save lives and support comprehensive psychological healing.

Modern psychiatric nursing continues to evolve by embracing person-centered care models, trauma-informed clinical approaches, seamless multidisciplinary collaboration, and technology-driven surveillance methods. Empirical evidence demonstrates that when these interventions are implemented systematically, inpatient suicide risk declines and overall treatment outcomes improve. Continued global investment in nursing education, stabilized unit staffing ratios, architectural safety designs, and robust post-discharge transitional support remains necessary to sustain these gains and foster cultures of safety within psychiatric institutions worldwide.

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