I. Title

*Suicide Risk Screening and Suicide Precautions for Patients*

II. Policy

The University of Texas Medical Branch (UTMB) Health System is committed to providing a safe environment for patients, students, visitors, and employees. Identification of individuals at risk for suicide while under our care and following discharge is an important step in protecting those individuals at risk.

**Determining Need for and Conducting Suicide Risk Screening:**

Clinical staff who perform intake screening on patients 12 years old or older, within the UTMB Health System, will document whether or not a patient is being evaluated or treated for a behavioral health condition as their primary reason for care. Additionally, clinical staff will document if they become concerned by emotional or behavioral disturbances exhibited by any patient at any time during the patient’s clinic visit/admission, regardless of the primary reason for care.

**Screening for Suicidal Ideation:**

Patients determined to have a behavioral health condition as their primary reason for care or who exhibit emotional or behavioral disturbances will be screened for suicidal ideation by utilizing a validated screening tool and the provider will be notified of positive results. If the screening result is positive, suicide precautions will be implemented. (See Appendix 1: PHQ-9).

**Suicide Risk Assessment/Reassessment:**

A suicide risk assessment will be conducted by a provider on any patient who screened positive for suicidal ideation using an evidenced-based risk assessment tool. Interventions for the safety of the patient will be implemented based on the risk level determined by the provider and the patient’s risk assessment. (See Appendix 2: SAFE-T Protocol with C-SSRS).

A reassessment will be conducted by the provider using an evidenced-based risk assessment tool, at a minimum of a change in patient status, patient changes location, and/or at the time of discharge. Reassessment will include the risk level of the patient with suicidal ideation. (See Appendix 2: SAFE-T Protocol with C-SSRS).
III. Procedures

A. Patient Encounter

1. All patients who are 12 years old or older will be pre-screened to determine if patient is being evaluated or treated for a behavioral health condition as their primary reason for care. Any patient exhibiting behaviors that might indicate an intent to harm oneself, regardless of age, will also be pre-screened.

2. For those patients being evaluated or treated for a behavioral health condition as their primary reason for care or are exhibiting behaviors of harming self, screen patient for risk of suicide using the PHQ-9 validated screening by asking the patient question number 9, “Are you having thoughts that you would be better off dead or of hurting yourself?” If the screen is positive, notify the provider and implement suicide precautions. (See Appendix 1. PHQ-9).

B. Implement suicide precautions

1. Modifications of the patient’s environment to increase safety by using the appropriate Suicide Risk Safety Checklist and Guidelines. (Refer to Suicide Risk Safety Checklist and Guidelines, Suicide Risk Safety Checklist and Guidelines - Ambulatory, and IHOP – 08.02.09 – Concealed Handguns on UTMB’s Campus).

a. Remove any personal medications and return them to the family or store them in accordance with UTMB policy. (Refer to Policy 07.07 Medications Brought from Home).

b. An electric razor for shaving or, if necessary, a safety razor only under continual qualified staff supervision.

c. Order food tray in plastic or paper containers with plastic utensils (no knives or aluminum cans) by modifying the diet order in the electronic chart, and sharp items should only be used with continual trained staff supervision.

d. Inspect the patient’s mouth after administering medication in tablet form to ensure patient has swallowed it. Liquid concentrates are preferred.

2. Monitor patients with continuous observations by a trained designated staff with full view of the patient. Document observations every 15 minutes (or more frequently as needed, with no time lapse greater than 15 minutes). (Refer to Policy 3.56 Continuous Observation of a Patient).

a. When a patient is in the bathroom or shower, a qualified staff member will maintain observation. Use of a bedside commode is recommended.

b. Staff may delay implementation of continuous observation and every 15-minute
documentation for ICU level patients with a Richmond Agitation-Sedation Scale (RASS) score of –3 (moderate sedation), –4 (deep sedation), or –5 (un-arousable). Any delayed suicide precautions interventions must be initiated upon any change that could result in a RASS score of –2 (light sedation) or above. (Refer to Richmond Agitation-Sedation Scale [RASS]).

c. If a patient is in isolation, observer must be able to maintain a continuous view of the patient outside of the room with the door closed and be able to intervene without delay when necessary. The observer will don appropriate Personal Protective Equipment (PPE) to ensure entry into the room occurs without delay if necessary. If this is not possible, the observer would have to remain in the room, with the door closed, donned in appropriate PPE while maintaining continuous view of the patient. (Refer to Healthcare Epidemiology 01.19 - Isolation and Healthcare Epidemiology 01.19.02 - Isolation Precautions in Clinics).

3. Licensed clinical staff must document at the initiation of observation and every 2 hours.

C. Provider Risk Assessment

1. Staff to notify provider if patient has a positive screening for suicidal ideation.

2. A provider must complete a risk assessment using the Columbia - Suicide Severity Rating Scale (SSRS) within four (4) hours of implementation of suicide precautions. (See Appendix 2: SAFE-T Protocol with C-SSRS).

3. Once the provider determines the level of risk for suicide, suicide precautions will be implemented or continued on patients at high risk of suicide. Suicide precautions will be considered for those patients having a moderate risk of suicide based on the provider’s assessment. Patients with low risk of suicide will be considered for a referral to behavioral health, psychiatry, a primary care provider, and/or a social worker. Staff should inform the patient that these suicide precautions are being implemented in their best interest.

4. A provider’s order is required for the discontinuation of suicide precautions.

5. A reassessment using the Columbia – SSRS must be completed by the provider at minimum when a change in patient status occurs, when the patient changes location, and/or at time of discharge.

D. Transport, Discharge, and Follow-up

1. If a patient must be transported off the unit, he/she will be accompanied at all times by two persons, one person being a qualified staff who observes the patient and one other person (two-person transport is required at a minimum).

2. Patient/family education regarding suicide will be documented in the appropriate location in the medical record. The education will include suicide prevention information such as a crisis plan.
hotline. Provide counseling and follow-up care instructions to the patient at time of discharge. (Refer to IHOP – 09.01.14 – Patient Discharge and IHOP – 09.01.13 – Discharge Planning).

3. If indicated from an inpatient, Emergency Department or Procedural Area, arrangements for transfer to a psychiatric facility will follow UTMB transportation policies for psychiatric transfers. (Refer to Policy 7.13.10 ED Transfer of a Patient to a Psychiatric Hospital).

4. If from an ambulatory setting, arrangements for transfer to a psychiatric treatment facility or closest emergency department by calling 911. (Refer to Mental Health Resource Contact List).

IV. Training, Education, and Monitoring

A. Training and Education

Competence assessment of staff who care for patients at risk for suicide will be conducted by annual and real-time training and educational opportunities.

B. Monitoring

1. Implementation and effectiveness of policies and procedures for screening, assessment, and management of individuals served at risk for suicide will be monitored for compliance.

2. Actions will be completed as needed to improve noncompliance with policies and procedures.

V. Definitions

*Suicide attempt* is an effort to commit suicide involving definite risk. The outcome frequently depends on circumstances alone and is not under the person’s control.

*Suicidal ideation*, also known as suicidal thoughts, is thinking about or an unusual preoccupation with suicide. The range of suicidal ideation varies greatly from fleeting thoughts, to extensive thoughts, to detailed planning, role-playing (e.g., standing on a chair with a noose), and incomplete attempts.

*Suicide precautions* are continuous interventions aimed at providing a safe environment for patients identified as exhibiting suicidal behavior and/or ideations.

*Suicide risk assessment* is a method to separate patients who are at risk for suicide from those who have moderate, low or no risk of suicide.

*Suicidal threat* is a statement of intent to commit suicide that is accompanied by behavior changes indicative of suicidal tendencies.

VI. Related UTMB Policies, Procedures, and Resources

1. Patient Health Questionnaire (PHQ-9)
2. SAFE-T Protocol with Columbia-Suicide Severity Rating Scale (C-SSRS)
3. Nursing Service Policy 3.56 Continuous Observation of a Patient
4. Nursing Service Policy 7.13.10 ED Transfer of a Patient to a Psychiatric Hospital
5. Nursing Service Policy 4.3.1 Competency Assessment, Evaluation and Education
6. Pharmacy Service Policy 07.07 Medications Brought from Home
7. IHOP – 08.02.09 – Concealed Handguns on UTMB’s Campus
8. IHOP – 09.01.02 – Management of Patient Belongings
9. IHOP – 09.01.14 – Patient Discharge
10. IHOP – 09.01.13 – Discharge Planning
11. Suicide Risk Process Flow-Risk Stratification
12. Provider Suicide Risk Assessment and Reassessment Process
13. Suicide Risk Safety Checklist and Guidelines
15. Mental Health Resource List
16. Healthcare Epidemiology 01.19 – Isolation
17. Healthcare Epidemiology 01.19.02 – Isolation Precautions in Clinics

VII. References

Patient Health Questionnaire (PHQ-9 & PHQ-2) obtained from

Richmond Agitation-Sedation Scale (RASS) graphic obtained from

The Joint Commission. Suicide Prevention. Received from
https://www.jointcommission.org/resources/patient-safety-topics/suicide-prevention/

The Joint Commission. (2020) Suicide Prevention Resources to support Joint Commission Accredited organizations implementation of NPSG 15.01.01, revised July, 2020. Received from

VIII. Dates Approved or Amended

<p>| Originated: 03/28/1998 |</p>
<table>
<thead>
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<th>Reviewed with Changes</th>
<th>Reviewed without Changes</th>
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<td>08/19/2018</td>
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<td>06/17/2019</td>
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<td>04/07/2020</td>
<td></td>
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<tr>
<td>10/21/2020</td>
<td></td>
</tr>
</tbody>
</table>

IX. Contact Information

Nursing Services
409-772-4104
**Patient Health Questionnaire (PHQ-9)**

Name: ___________________________________________________________  Date: __________________________

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

For office coding: Total Score ______ = ______ + ______ + ______

Total Score ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all  ☐ Somewhat difficult  ☐ Very difficult  ☐ Extremely difficult
How to Score the PHQ-9

Major depressive disorder (MDD) is suggested if:
- Of the 9 items, 5 or more are checked as at least ‘more than half the days’
- Either item 1 or 2 is checked as at least ‘more than half the days’

Other depressive syndrome is suggested if:
- Of the 9 items, between 2 to 4 are checked as at least ‘more than half the days’
- Either item 1 or 2 is checked as at least ‘more than half the days’

PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally the numbers of all the checked responses under each heading (not at all=0, several days=1, more than half the days=2, and nearly every day=3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below.

<table>
<thead>
<tr>
<th>Score</th>
<th>Depression Severity</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>None-minimal</td>
<td>Patient may not need depression treatment.</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild</td>
<td>Use clinical judgment about treatment, based on patient’s duration of symptoms and functional impairment.</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate</td>
<td>Use clinical judgment about treatment, based on patient’s duration of symptoms and functional impairment.</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe</td>
<td>Treat using antidepressants, psychotherapy or a combination of treatment.</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe</td>
<td>Treat using antidepressants with or without psychotherapy.</td>
</tr>
</tbody>
</table>

Functional Health Assessment
The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, life at home, or relationships with other people. Patient response of ‘very difficult’ or ‘extremely difficult’ suggest that the patient’s functionality is impaired. After treatment begins, functional status and number score can be measured to assess patient improvement.

Note: Depression should not be diagnosed or excluded solely on the basis of a PHQ-9 score. A PHQ-9 score ≥ 10 has a sensitivity of 88% and a specificity of 88% for major depression. Since the questionnaire relies on patient self-report, the practitioner should verify all responses. A definitive diagnosis is made taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs. Spitzer, Williams, Kroenke and colleagues, with an educational grant from Pfizer Inc. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at www.pfizer.com. Copyright © 1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

## Step 1: Identify Risk Factors

### C-SSRS Suicidal Ideation Severity

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Wish to be dead</td>
<td></td>
</tr>
<tr>
<td><em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td></td>
</tr>
<tr>
<td>2) Current suicidal thoughts</td>
<td></td>
</tr>
<tr>
<td><em>Have you actually had any thoughts of killing yourself?</em></td>
<td></td>
</tr>
<tr>
<td>3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act)</td>
<td></td>
</tr>
<tr>
<td><em>Have you been thinking about how you might do this?</em></td>
<td></td>
</tr>
<tr>
<td>4) Suicidal Intent without Specific Plan</td>
<td></td>
</tr>
<tr>
<td><em>Have you had these thoughts and had some intention of acting on them?</em></td>
<td></td>
</tr>
<tr>
<td>5) Intent with Plan</td>
<td></td>
</tr>
<tr>
<td><em>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</em></td>
<td></td>
</tr>
</tbody>
</table>

### C-SSRS Suicidal Behavior: "Have you ever done anything, started to do anything, or prepared to do anything to end your life?"

Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

If “YES” Was it within the past 3 months?

### Activating Events:
- Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)
- Pending incarceration or homelessness
- Current or pending isolation or feeling alone

### Treatment History:
- Previous psychiatric diagnosis and treatments
- Hopeless or dissatisfied with treatment
- Non-compliant with treatment
- Not receiving treatment
- Insomnia

### Other:
- __________________
- __________________
- __________________

### Clinical Status:
- Hopelessness
- Major depressive episode
- Mixed affect episode (e.g. Bipolar)
- Command Hallucinations to hurt self
- Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- Highly impulsive behavior
- Substance abuse or dependence
- Agitation or severe anxiety
- Perceived burden on family or others
- Homicidal Ideation
- Aggressive behavior towards others
- Refuses or feels unable to agree to safety plan
- Sexual abuse (lifetime)
- Family history of suicide

### Access to lethal methods: Ask specifically about presence or absence of a firearm in the home or ease of accessing

## Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

### Internal:
- Fear of death or dying due to pain and suffering
- Identifies reasons for living
- __________________
- __________________

### External:
- Belief that suicide is immoral; high spirituality
- Responsibility to family or others; living with family
- Supportive social network of family or friends
- Engaged in work or school

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### Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior)

<table>
<thead>
<tr>
<th>C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency</strong>&lt;br&gt;How many times have you had these thoughts?</td>
<td></td>
</tr>
<tr>
<td>(1) Less than once a week</td>
<td>(2) Once a week</td>
</tr>
<tr>
<td><strong>Duration</strong>&lt;br&gt;When have the thoughts how long do they last?</td>
<td></td>
</tr>
<tr>
<td>(1) Fleeting - few seconds or minutes</td>
<td>(4) 4-8 hours/most of day</td>
</tr>
<tr>
<td>(2) Less than 1 hour/some of the time</td>
<td>(5) More than 8 hours/persistent or continuous</td>
</tr>
<tr>
<td>(3) 1-4 hours/a lot of time</td>
<td></td>
</tr>
<tr>
<td><strong>Controllability</strong>&lt;br&gt;Could/can you stop thinking about killing yourself or wanting to die if you want to?</td>
<td></td>
</tr>
<tr>
<td>(1) Easily able to control thoughts</td>
<td>(4) Can control thoughts with a lot of difficulty</td>
</tr>
<tr>
<td>(2) Can control thoughts with little difficulty</td>
<td>(5) Unable to control thoughts</td>
</tr>
<tr>
<td>(3) Can control thoughts with some difficulty</td>
<td>(0) Does not attempt to control thoughts</td>
</tr>
<tr>
<td><strong>Deterrents</strong>&lt;br&gt;Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?</td>
<td></td>
</tr>
<tr>
<td>(1) Deterrents definitely stopped you from attempting suicide</td>
<td>(4) Deterrents most likely did not stop you</td>
</tr>
<tr>
<td>(2) Deterrents probably stopped you</td>
<td>(5) Deterrents definitely did not stop you</td>
</tr>
<tr>
<td>(3) Uncertain that deterrents stopped you</td>
<td>(0) Does not apply</td>
</tr>
<tr>
<td><strong>Reasons for Ideation</strong>&lt;br&gt;What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn’t go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?</td>
<td></td>
</tr>
<tr>
<td>(1) Completely to get attention, revenge or a reaction from others and to end/stop the pain</td>
<td>(4) Mostly to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)</td>
</tr>
<tr>
<td>(2) Mostly to get attention, revenge or a reaction from others and to end/stop the pain</td>
<td>(5) Completely to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)</td>
</tr>
<tr>
<td>(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain</td>
<td>(0) Does not apply</td>
</tr>
</tbody>
</table>

**Total Score**
## Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

“The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential clinical judgment, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior.”

From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

<table>
<thead>
<tr>
<th>RISK STRATIFICATION</th>
<th>TRIAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Suicide Risk</strong></td>
<td>□ Initiate local psychiatric admission process</td>
</tr>
<tr>
<td>□ Suicidal ideation with intent or intent with plan in past month (C-SSRS Suicidal Ideation #4 or #5) Or □ Suicidal behavior within past 3 months (C-SSRS Suicidal Behavior)</td>
<td>□ Stay with patient until transfer to higher level of care is complete □ Follow-up and document outcome of emergency psychiatric evaluation</td>
</tr>
<tr>
<td><strong>Moderate Suicide Risk</strong></td>
<td>□ Directly address suicide risk, implementing suicide prevention strategies □ Develop Safety Plan</td>
</tr>
<tr>
<td>□ Suicidal ideation with method, WITHOUT plan, intent or behavior in past month (C-SSRS Suicidal Ideation #3) Or □ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) Or □ Multiple risk factors and few protective factors</td>
<td></td>
</tr>
<tr>
<td><strong>Low Suicide Risk</strong></td>
<td>□ Discretionary Outpatient Referral</td>
</tr>
<tr>
<td>□ Wish to die or Suicidal Ideation WITHOUT method, intent, plan or behavior (C-SSRS Suicidal Ideation #1 or #2) Or □ Modifiable risk factors and strong protective factors Or □ No reported history of Suicidal Ideation or Behavior</td>
<td></td>
</tr>
</tbody>
</table>

## Step 5: Documentation

**Risk Level:**
- [ ] High Suicide Risk
- [ ] Moderate Suicide Risk
- [ ] Low Suicide Risk

**Clinical Note:**
- □ Your Clinical Observation
- □ Relevant Mental Status Information
- □ Methods of Suicide Risk Evaluation
- □ Brief Evaluation Summary
  - □ Warning Signs
  - □ Risk Indicators
  - □ Protective Factors
  - □ Access to Lethal Means
  - □ Collateral Sources Used and Relevant Information Obtained
  - □ Specific Assessment Data to Support Risk Determination
  - □ Rationale for Actions Taken and Not Taken
- □ Provision of Crisis Line 1-800-273-TALK (8255)
- □ Implementation of Safety Plan (If Applicable)