

Institutional Handbook of Operating Procedures
Policy 09.13.38

Section: Clinical Policies	Responsible Vice President: Executive Vice President UTMB Health System
Subject: General	Responsible Entity: Quality Management

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.

****The department of psychiatry screens all patients for suicide with validated screening tools as appropriate to the patient.****

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, Patient Safety Screener–3 (PSS-3), and the provider will be notified of positive results. If the screening result is positive, suicide precautions will be implemented. (See Appendix: [Patient Safety Screener \(PSS-3\)](#))

Suicide Risk Assessment/Reassessment:

A suicide risk assessment will be conducted by a provider using an evidenced-based risk assessment tool, Columbia–Suicide Severity Rating Scale (SSRS), on any patient who screened positive for suicidal ideation. 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 Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#))

A reassessment will be conducted by the provider using an evidenced-based risk assessment tool, Columbia-SSRS, 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 Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#))

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 a validated screening tool, PSS-3. If the screen is positive, implement suicide precautions. The provider will automatically be notified. (See Appendix 1: [Patient Safety Screener \(PSS-3\)](#))

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

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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. Provider will automatically be notified when a patient has a positive screen for suicidal ideation. (See Appendix 1: [Patient Safety Screener \(PSS-3\)](#))
2. A provider must complete a risk assessment using the evidenced-based risk assessment tool, Columbia-SSRS, within four (4) hours of implementation of suicide precautions. (See Appendix 2: [SAFE-T Protocol with Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#))
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 providers 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 evidenced-based risk assessment tool, 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

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the medical record. The education will include suicide prevention information such as a crisis 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 Safety Screener \(PSS-3\)](#)

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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 Screening Process.pdf](#)
12. [Provider Suicide Risk Assessment and Reassessment Process](#)
13. [Suicide Risk Safety Checklist and Guidelines](#)
14. [Suicide Risk Safety Checklist and Guidelines - Ambulatory](#)
15. [Mental Health Resource List](#)
16. [Healthcare Epidemiology 01.19 – Isolation](#)
17. [Healthcare Epidemiology 01.19.02 – Isolation Precautions in Clinics](#)

VII. References

Suicide Prevention Resource Center. *The Patient Safety Screener: A Brief Tool to Detect Suicide Risk*. [The Patient Safety Screener: A Brief Tool to Detect Suicide Risk | Suicide Prevention Resource Center \(sprc.org\)](#)

Richmond Agitation-Sedation Scale (RASS) graphic obtained from [www.icudelirium.org/docs/RASS.pdf](#) on 8/17/2015.

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 https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/suicide-prevention/suicide_prevention_compendium_5_11_20_updated-july2020.pdf

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The Joint Commission. (2019). *R³ Report: Requirement, Rationale, Reference*. Received from https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf

VIII. Dates Approved or Amended

<i>Originated:</i> 03/28/1998	
<i>Reviewed with Changes</i>	<i>Reviewed without Changes</i>
08/01/2013	
02/19/2016	
08/19/2018	
06/17/2019	
04/07/2020	
10/20/2020	
6/28/2022	
07/12/2022	

IX. Contact Information

Nursing Services
409-772-4104

Appendix 1

Use this pocket card as a job aid or training tool when implementing universal suicide screening in acute care settings.

The Patient Safety Screener can be used during the Triage or Primary Nursing Assessment in acute care settings.
Ask all three screening questions. Do not skip items.

Introduction *"Now I'm going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital's policy, and it helps us to make sure we are not missing anything important."*

Depression ① **Over the past 2 weeks, have you felt down, depressed, or hopeless?**
 Yes No Refused Patient unable to complete

Suicidal ideation ② **Over the past 2 weeks, have you had thoughts of killing yourself?**
 Yes No Refused Patient unable to complete

Suicide attempt ③ **Have you ever attempted to kill yourself?**
 Yes No Refused Patient unable to complete
 ...3a. *If Yes to item 3, ask: when did this last happen?*
 Within the past 24 hours (including today) More than 6 months ago
 Within the last month (but not today) Refused
 Between 1 and 6 months ago Patient unable to complete

TIPS

- ✓ Ask all questions exactly as worded
- ✓ Do not bundle or re-word questions
- ✓ Treat the patient with empathy

“Yes” to Item 1= positive screen for Depression.

“Yes” to Item 2 OR “last 6 months” to Item 3= positive screen for Suicide Risk.

Apply site protocol for further evaluation and management.

Patient Safety Screener (PSS-3) Pocket Card

The Patient Safety Screener 3 (PSS-3) has been validated in prospective studies and is detailed in Boudreaux et al. (2015)

SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) - Recent

Step 1: Identify Risk Factors				
C-SSRS Suicidal Ideation Severity	Month			
1) Wish to be dead <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i>				
2) Current suicidal thoughts <i>Have you actually had any thoughts of killing yourself?</i>				
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) <i>Have you been thinking about how you might do this?</i>				
4) Suicidal Intent without Specific Plan <i>Have you had these thoughts and had some intention of acting on them?</i>				
5) Intent with Plan <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i>				
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?	<table border="1"> <tr> <td style="background-color: yellow; text-align: center;">Lifetime</td> </tr> <tr> <td style="background-color: orange;"></td> </tr> <tr> <td style="background-color: red; text-align: center;">Past 3 Months</td> </tr> </table>	Lifetime		Past 3 Months
Lifetime				
Past 3 Months				
<p>Activating Events:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Recent losses or other significant negative event(s) (legal, financial, relationship, etc.) <input type="checkbox"/> Pending incarceration or homelessness <input type="checkbox"/> Current or pending isolation or feeling alone <p>Treatment History:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous psychiatric diagnosis and treatments <input type="checkbox"/> Hopeless or dissatisfied with treatment <input type="checkbox"/> Non-compliant with treatment <input type="checkbox"/> Not receiving treatment <input type="checkbox"/> Insomnia <p>Other:</p> <ul style="list-style-type: none"> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ 	<p>Clinical Status:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hopelessness <input type="checkbox"/> Major depressive episode <input type="checkbox"/> Mixed affect episode (e.g. Bipolar) <input type="checkbox"/> Command Hallucinations to hurt self <input type="checkbox"/> Chronic physical pain or other acute medical problem (e.g. CNS disorders) <input type="checkbox"/> Highly impulsive behavior <input type="checkbox"/> Substance abuse or dependence <input type="checkbox"/> Agitation or severe anxiety <input type="checkbox"/> Perceived burden on family or others <input type="checkbox"/> Homicidal Ideation <input type="checkbox"/> Aggressive behavior towards others <input type="checkbox"/> Refuses or feels unable to agree to safety plan <input type="checkbox"/> Sexual abuse (lifetime) <input type="checkbox"/> Family history of suicide 			
<input type="checkbox"/> Access to lethal methods: Ask <u>specifically</u> 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)				
<p>Internal:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fear of death or dying due to pain and suffering <input type="checkbox"/> Identifies reasons for living <input type="checkbox"/> _____ <input type="checkbox"/> _____ 	<p>External:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Belief that suicide is immoral; high spirituality <input type="checkbox"/> Responsibility to family or others; living with family <input type="checkbox"/> Supportive social network of family or friends <input type="checkbox"/> 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)	
C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	Month
Frequency How many times have you had these thoughts? (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	
Duration When you have the thoughts how long do they last? (1) Fleeting - few seconds or minutes (4) 4-8 hours/most of day (2) Less than 1 hour/some of the time (5) More than 8 hours/persistent or continuous (3) 1-4 hours/a lot of time	
Controllability Could/can you stop thinking about killing yourself or wanting to die if you want to? (1) Easily able to control thoughts (4) Can control thoughts with a lot of difficulty (2) Can control thoughts with little difficulty (5) Unable to control thoughts (3) Can control thoughts with some difficulty (0) Does not attempt to control thoughts	
Deterrents 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? (1) Deterrents definitely stopped you from attempting suicide (4) Deterrents most likely did not stop you (2) Deterrents probably stopped you (5) Deterrents definitely did not stop you (3) Uncertain that deterrents stopped you (0) Does not apply	
Reasons for Ideation 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? (1) Completely to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (2) Mostly to get attention, revenge or a reaction from others (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (0) Does not apply	
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.

RISK STRATIFICATION	TRIAGE
<p style="text-align: center;">High Suicide Risk</p> <p><input type="checkbox"/> Suicidal ideation with intent or intent with plan in past month (C-SSRS Suicidal Ideation #4 or #5)</p> <p style="text-align: center;">Or</p> <p><input type="checkbox"/> Suicidal behavior within past 3 months (C-SSRS Suicidal Behavior)</p>	<p>$\frac{1}{2\pi}$ Initiate local psychiatric admission process</p> <p>$\frac{1}{2\pi}$ Stay with patient until transfer to higher level of care is complete</p> <p>$\frac{1}{2\pi}$ Follow-up and document outcome of emergency psychiatric evaluation</p>
<p style="text-align: center;">Moderate Suicide Risk</p> <p><input type="checkbox"/> Suicidal ideation with method, WITHOUT plan, intent or behavior in past month (C-SSRS Suicidal Ideation #3)</p> <p style="text-align: center;">Or</p> <p><input type="checkbox"/> Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime)</p> <p style="text-align: center;">Or</p> <p><input type="checkbox"/> Multiple risk factors and few protective factors</p>	<p>$\frac{1}{2\pi}$ Directly address suicide risk, implementing suicide prevention strategies</p> <p>$\frac{1}{2\pi}$ Develop Safety Plan</p>
<p style="text-align: center;">Low Suicide Risk</p> <p><input type="checkbox"/> Wish to die or Suicidal Ideation WITHOUT method, intent, plan or behavior (C-SSRS Suicidal Ideation #1 or #2)</p> <p style="text-align: center;">Or</p> <p><input type="checkbox"/> Modifiable risk factors and strong protective factors</p> <p style="text-align: center;">Or</p> <p><input type="checkbox"/> No reported history of Suicidal Ideation or Behavior</p>	<p>$\frac{1}{2\pi}$ Discretionary Outpatient Referral</p>

Step 5: Documentation

Risk Level :

- High Suicide Risk
- Moderate Suicide Risk
- Low Suicide Risk

Clinical Note:

- $\frac{1}{2\pi}$ Your Clinical Observation
- $\frac{1}{2\pi}$ Relevant Mental Status Information
- $\frac{1}{2\pi}$ Methods of Suicide Risk Evaluation
- $\frac{1}{2\pi}$ Brief Evaluation Summary
 - $\frac{1}{2\pi}$ Warning Signs
 - $\frac{1}{2\pi}$ Risk Indicators
 - $\frac{1}{2\pi}$ Protective Factors
 - $\frac{1}{2\pi}$ Access to Lethal Means
 - $\frac{1}{2\pi}$ Collateral Sources Used and Relevant Information Obtained
 - $\frac{1}{2\pi}$ Specific Assessment Data to Support Risk Determination
 - $\frac{1}{2\pi}$ Rationale for Actions Taken and Not Taken
- $\frac{1}{2\pi}$ Provision of Crisis Line 1-800-273-TALK (8255)
- $\frac{1}{2\pi}$ Implementation of Safety Plan (If Applicable)