

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) is committed to providing a safe environment for patients, students, visitors, and employees. Early identification of patients at risk for suicide is a first step in providing reasonable care and intervention.

Determining Need for and Conducting Suicide Risk Screening:

Clinical staff who perform intake screenings 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. If clinical staff becomes concerned by emotional or behavioral disturbances exhibited by any patient at any time during the patient’s clinic visit/admission, regardless of the results of the patient’s suicide risk screening, the clinical staff will notify the faculty provider to determine appropriate evaluation, referral, and precautions needed.

Screening for Suicidal Ideation:

Patients who are determined to have a behavioral health condition as their primary reason for care will be screened for suicidal ideation by utilizing a validated screening tool.

Suicide Risk Assessment:

The provider will use an evidenced-based process to conduct a suicide risk assessment on those patients who screened positive for suicidal ideation. If the results of the risk assessment indicate that a patient is at high risk of suicide, suicide precautions will be implemented. For moderate risk of suicide, the provider will consider implementing suicide precautions. Patients with low risk of suicide will be considered for a referral to behavioral health, psychiatry, a primary care physician, and/or a social worker.

III. Procedures

- A. Notify provider if patient has a positive screening for suicidal ideation.
- B. If appropriate and with an expectation for a suicide risk assessment by the provider, clinical staff can initiate suicide precautions to mitigate the risk of suicide.
- C. Once the provider determines the level of risk for suicide, suicide precautions will be implemented or continued on patients at high risk of suicide. Consideration for suicide

IHOP Policy 09.13.38

precautions to be made for those patients having a moderate risk of suicide. Staff should inform the patient that these precautions are being taken in their best interest. Patients with low risk of suicide will be considered for a referral to behavioral health, psychiatry, a primary care physician, and/or a social worker.

- D. A physician's written order for suicide precautions will be obtained within four (4) hours of implementation of suicide precautions.
- E. A physician's order is required for the discontinuation of suicide precautions.

IV Implementing Suicide Precautions

- A Modifications of the patient's environment to increase safety (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](#)).
- B Continuous observation by qualified designated staff. The observer must always have full continuous view of the patient and be able to intervene without delay. (Refer to [Policy 3.56 Continuous Observation of a Patient](#)).
- C Documentation of observation every 15 minutes (or more frequently as needed, with no time lapse greater than 15 minutes). Licensed clinical staff must document at the initiation of observation and every 2 hours.
- D 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 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](#)).

Inpatient, Emergency Department, and Procedure Areas

1. 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.
2. If a patient is in isolation, observer must be able to maintain full 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 maintain the appropriate PPE to ensure entry into the room without delay, if necessary. If this is not possible, the observer would have to remain in the room, with the door closed, donning the appropriate PPE with full continuous view of the patient. (Refer to [Isolation Policy](#).)
3. If a patient must be transported off the unit, he/she will be accompanied at all times by a qualified staff and transport personnel (two-person transport is required at a minimum).
4. Remove any personal medications and return them to the family or store them in accordance with UTMB policy.

IHOP Policy 09.13.38

5. When a patient is in the bathroom or shower, a qualified staff member will maintain observation. Use of a bedside commode is recommended.
6. An electric razor for shaving or, if necessary, a safety razor only under continual qualified staff supervision.
7. 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 qualified staff supervision.
8. Inspect the patient's mouth after administering medication in tablet form to ensure patient has swallowed it. Liquid concentrates are preferred.
9. If indicated, 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.](#))

Ambulatory Areas

1. If indicated, arrangements for transfer to a psychiatric treatment facility or closest emergency department by calling 911. (Refer to [Mental Health Resource Contact List.](#))

V. Definitions

Suicidal 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. Nursing Service [Policy 3.56 Continuous Observation of a Patient](#)
2. Nursing Service [Policy 7.13.10 ED Transfer of a Patient to a Psychiatric Hospital](#)
3. Nursing Service [Policy 4.3.1 Competency Assessment, Evaluation and Education](#)
4. Pharmacy Service [Policy 07.07 Medications Brought from Home](#)

IHOP Policy 09.13.38

5. [IHOP – 08.02.09 – Concealed Handguns on UTMB’s Campus](#)
6. [IHOP – 09.01.02 – Management of Patient Belongings](#)
7. [IHOP – 09.01.14 – Patient Discharge](#)
8. [IHOP – 09.01.13 – Discharge Planning](#)
9. [Suicide Risk Process Flow-Risk Stratification](#)
10. [Suicide Risk Safety Checklist and Guidelines](#)
11. [Suicide Risk Safety Checklist and Guidelines - Ambulatory](#)
12. [Mental Health Resource List](#)
13. [Healthcare Epidemiology 01.19 – Isolation](#)
14. [Healthcare Epidemiology 01.19.02 – Isolation Precautions in Clinics](#)

VII. References

Patient Health Questionnaire (PHQ-9 & PHQ-2) obtained from <http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health.aspx> obtained on April 24, 2018 at 10:32 AM.

Mitchell, A., Garand, L., Dean, D., Panzak, G., and Taylor, M. (2005). “Suicide Assessment in Hospital Emergency Departments: Implications for Patient Satisfaction and Compliance.” *Top Emerg Med.* 2005 October; 27 (4): 302-312.

Peate, I., and McGrory, C. “[Performing searches on patients: a practical guide.](#)” *British Journal of Healthcare Assistants*, 2009 Nov., three (11): 556-58.

Puntill, Cheryl. (2018) “Suicide Assessment and Precautions.” https://lms-elsevierperformancemanager-com.libux.utmb.edu/ContentArea/NursingSkills/GetNursingSkillsDetails?skillid=MH_010&skillkeyid=1238&searchTerm=suicide&searchContext=home

The Joint Commission Standards BoosterPak for Suicide Risk (NPSG.15.01.01)

The Joint Commission Sentinel Event Alert – A follow-up report on preventing suicide: Focus on medical/ surgical units and the emergency department. *Issue 46, November 17, 2010.*

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

VIII. Dates Approved or Amended

<i>Originated:</i> 03/28/1998	
<i>Reviewed with Changes</i>	<i>Reviewed without Changes</i>
08/01/2013	

IHOP Policy 09.13.38

02/19/2016	
08/19/2018	
06/17/2019	
04/07/2020	

IX. Contact Information

Nursing Services
409-772-4104