Institutional Handbook of Operating Procedures Policy 09.13.38	
Section: Clinical Policies	Responsible Vice President: Senior Vice President, Chief Medical & Clinical Innovation Officer
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 in both the inpatient and outpatient setting. Identification of individuals at risk for suicide while under our care and following discharge is an important step in protecting those individuals at imminent risk.

Patients who are 12 years old or older who are being evaluated or treated for a behavioral health condition as their primary reason for care, or exhibiting emotional or behavioral disturbances, will be screened using a validated screening tool. If the screen is positive for suicide risk, suicide precautions will be implemented. The provider must perform a suicide risk assessment using an evidence-based tool to determine level of risk, appropriate plan of care, and safest disposition. If the provider determines suicide precautions are not needed as part of the plan of care, the provider must write an order to discontinue suicide precautions. Suicide risk reassessments will be performed as outlined in the procedures.

This policy does not apply to psychiatric clinics. Psychiatric clinics screen all patients for suicide with validated screening tools as appropriate to the patient.

III. Procedures

A. Behavioral Health Screening

1. *Qualified designated staff members will do the following:*

    a. Pre-screen all patients who are 12 years old or older to determine if the patient is being evaluated or treated for a behavioral health condition as their primary reason for care or exhibiting emotional or behavioral disturbances.

    b. Consider whether one of the following primary diagnoses or primary complaints is applicable:

        - Mood disorder (for example, depression, mania, anxiety)
        - Attention deficit hyperactivity disorder

- Psychotic disorder
- Violent or disruptive disorder
- Eating disorder
- Postpartum depression
- Substance abuse

B. Suicide Risk Screening

1. *Qualified designated staff members will do the following:*

Perform a suicide risk screen on patients who are being evaluated or treated for a behavioral health condition as their primary reason for care, or are exhibiting emotional or behavioral disturbances, using the validated screening tool. If the screen is positive for suicide risk, implement suicide precautions. The provider will be notified to conduct a Suicide Risk Assessment.[See Appendix 1: Patient Safety Screener (PSS-3)]

C. Suicide Risk Assessment

1. *Licensed practitioners will do the following:*

   a. Complete and document a risk assessment using the evidenced-based risk assessment tool within the appropriate time frame. [See Appendix 2: SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) – Recent]

      Alternatively, if psychiatry completes the initial assessment within the appropriate time frame, psychiatry shall use an evidence-based process.

      i. For ED: Within 2 hours of arrival for chief complaint of suicidal ideation or suicide attempt, or PSS-3 screen positive for suicide risk, or initial report of suicidal ideation; whichever is applicable to the encounter.

      ii. For inpatients: Within 4 hours of arrival for direct admit patients with chief complaint of suicidal ideation or suicide attempt, or PSS-3 screen positive for suicide risk, or initial report of suicidal ideation; whichever is applicable to the encounter.

      iii. For outpatients: During encounter visit.

   b. Determine appropriate plan of care and disposition based on level of risk and clinical judgment.

      i. For patients whose suicide risk assessment indicates the individual is at imminent/high risk for suicide, or when deemed necessary based on clinical judgment, place order to continue suicide precautions. Continuous observation is included as part of the order for suicide precautions. (Refer to Policy 3.56 – Continuous Observation of a Patient with Suicide Precautions or Behavioral Restraints)

ii. For patients whose suicide risk assessment indicates the individual is at no, low, or moderate risk for suicide, and deemed appropriate based on clinical judgment, place order to discontinue suicide precautions.

D. Suicide Precautions Monitoring and Observation

1. *Qualified designated staff members will do the following:*

a. Ensure the patient's immediate safety needs are met.

b. Modify the patient's environment to increase safety by using the appropriate Guidelines for Suicide Risk Safety. (Refer to Guidelines for Suicide Risk Safety- ED and Inpatient or Guidelines for Suicide Risk Safety- Ambulatory)

i. If possible, encourage the patient to give their belongings to a family member or other designee to keep off premises. If the patient is unable or unwilling to give belongings to a family member or other designee, two staff members will perform a search in the presence of the patient to check for hidden weapons, medications, or other dangerous items. Prior to the search, inform the patient this action is for their safety and ask if their belongings contain any weapons, medications, or other dangerous items.

I. For any weapons reported or found, notify University Police Department. (Refer to IHOP – 08.02.04 – Possession of Weapons and IHOP – 08.02.09 – Concealed Handguns on UTMB's Campus)

II. For any illegal substances reported or found, notify the University Police Department.

III. For any personal medications reported or found, return them to the family or store them in accordance with UTMB policy. (Refer to Policy 07.07 Medications Brought from Home)

IV. For any valuables, such as jewelry, electronic devices, cash, and credit/debit cards, return them to the family or store them in accordance with UTMB policy. (Refer to IHOP – 09.01.02 – Management of Patient Belongings)

V. Collect and store all other personal belongings in the designated areas on the unit.

VI. Document all items collected and storage location in the patient's chart.

VII. If the patient refuses to relinquish belongings, notify the charge nurse and Clinical Operations Administrator (COA). For imminent safety concerns, notify the University Police Department.

c. If the patient has a cell phone:

i. Upon initiation of suicide precautions, collect the patient's cell phone.

ii. After the provider completes the risk assessment, the provider will use clinical judgment to determine if the patient can safely have their cell phone while on

suicide precautions. If deemed safe, the provider must write an order to allow the patient to have their cell phone.

iii. Before the patient may have their cell phone, all accessories and attachments must be removed and stored with patient belongings. The device will also be inspected for any other physical items that may pose a safety risk. If the device is unable to be modified for safety, the device must be stored with the patient's valuable belongings (refer to process for collecting and storing valuables above).

iv. The patient will not be provided with a charging cord while on suicide precautions. Devices must be charged outside of the patient's room in a secure location.

v. Evaluation of cell phone safety will be ongoing. If at any point the care team deems the cell phone to be a safety risk, the device must be collected and stored utilizing the process for collecting valuables. Safety risks to consider include physical safety and emotional distress.

d. Immediately begin to monitor the patient with continuous 1:1 observation, ensuring a full and unobstructed view of the patient and environment. Document patient observations and continuous environment monitoring every 15 minutes (or more frequently as needed). (Refer to Policy 3.56 Continuous Observation of a Patient)

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

ii. 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)]

iii. If a patient is in isolation, the 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)

e. Ensure patients must use an electric razor for shaving or, if necessary, a safety razor only under continual qualified staff supervision.

f. 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. Sharp items should only be used with continual trained staff supervision.

2. *Qualified nurses will do the following:*
    a. Explain to the patient and, if applicable and appropriate, their family or visitors that the patient is on suicide precautions for their safety.
    b. Document the patient's observed behavior at the initiation of observation and every 2 hours.
    c. Notify provider of any pertinent clinical changes, change in behavior, or reports of increased suicidal ideation.
    d. Ensure patient's environment remains safe. Document attestation of safe environment every shift.
    e. Ensure the qualified designated staff member is providing constant observation according to established standards. (Refer to Policy 3.56 Continuous Observation of a Patient)
    f. Inspect the patient's mouth after administering oral medications to ensure patient has swallowed it. Liquid concentrates are preferred.

3. *Licensed Practitioners will do the following:*
    a. Place an order for any personal belongings the patient is safely allowed to keep while on suicide precautions. The order must be a detailed list of each item.

4. Suicide precautions can only be discontinued by a licensed practitioner's order.

E. Reassessment

1. *Licensed practitioners will do the following:*
    a. Reassess at minimum:
        i. Any subsequent suicidal behavior
        ii. Increased suicidal ideation
        iii. Pertinent clinical change or behavioral change
        iv. For ED:
            I. At time of departure if the disposition changes from transfer to inpatient mental health facility to discharge home.
            II. If patient is identified as being at moderate or high risk of suicide, and remains moderate or high risk, local behavioral health resources or psychiatry or mental health consultation shall be considered for further evaluation and recommendations.

v. For inpatients:

I. Prior to discontinuing suicide precautions.

II. At time of departure, unless transferred to a mental health facility.

2. Psychiatry assesses patients using an evidence-based process. Non-psychiatry providers assess using the SAFE-T Protocol with C-SSRS.

F. 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 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)

G. Training, Education, and Monitoring

1. 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.

2. Monitoring

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

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

IV. Definitions

Licensed Practitioner (LP)- Any individual permitted by law and UTMB to provide care and services within the scope of the individual's license.

Qualified Designated Staff Members- Staff members who have completed the required suicide precautions training module and competency assessment. Completion of the module is required annually.

Qualified Nurse- A registered nurse who has completed the required suicide precautions training module and competency assessment. Completion of the module is required annually.

Suicidal- Used to describe a person who intends to purposefully end their life and/or has threatened self-harm with the intention of taking their life, has made a self-destructive gesture, or has been described by a physician as suicidal.

Suicidal ideation- 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 attempt- Intentional self-harm with lethal intent.

Suicide precautions- Continuous interventions aimed at providing a safe environment for individuals identified as exhibiting suicidal behavior and/or ideations. Suicide precautions include continuous observation and a safe environment.

Suicide risk assessment- The process for obtaining clinically relevant information about each individual seeking behavioral health care, treatment, or services. The information is used to match an individual's need with the appropriate setting, service/program, and intervention.

Suicide risk screening- A method to separate individuals who are at risk for suicide from those who have low or no risk of suicide. Screening consists of a series of questions and observations used to determine if an individual needs a suicide risk assessment.

V. Related UTMB Policies, Procedures, and Resources

Patient Safety Screener (PSS-3)

SAFE-T Protocol with Columbia-Suicide Severity Rating Scale (C-SSRS)

Guidelines for Suicide Risk Safety in the ED and Inpatient Settings

Guidelines for Suicide Risk Safety in the Ambulatory Care Setting

Mental Health Resource List

Nursing Service Policy 3.56 Continuous Observation of a Patient

Nursing Service Policy 4.3.1 Competency Assessment, Evaluation and Education

Nursing Service Policy 7.13.10 ED Transfer of a Patient to a Psychiatric Hospital

Pharmacy Service Policy 07.07 Medications Brought from Home

IHOP – 08.02.04 – Possession of Weapons

IHOP – 08.02.09 – Concealed Handguns on UTMB's Campus

IHOP – 09.01.02 – Management of Patient Belongings

IHOP – 09.01.14 – Patient Discharge

IHOP – 09.01.13 – Discharge Planning

Healthcare Epidemiology 01.19 – Isolation

Healthcare Epidemiology 01.19.02 – Isolation Precautions in Clinics

VI. References

Substance Abuse and Mental Health Services Administration. (2009, September). *Safe-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians.*
Safe-T Pocket Card

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

The Joint Comission. *Suicide Prevention*.
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*.
Suicide Prevention Resources

The Joint Commission. (2019). *R³ Report: Requirement, Rationale, Reference.*
R3 Report- Requirement, Rationale, Reference

UpToDate. (2024). *Sedative-analgesia in ventilated adults: Management strategies, agent selection, monitoring, and withdrawal*. Last updated 2024, February 6.
Richmond Agitation-Sedation Scale (RASS)

UpToDate. (2023). *Suicidal ideation and behavior in adults*. Last updated 2023, June 28.
Suicidal Ideation and Behavior in Adults

VII. Dates Approved or Amended

Originated: 03/28/1998	
Reviewed with Changes	*Reviewed without Changes*
08/01/2013	
02/19/2016	
08/19/2018	
06/17/2019	

04/07/2020	
10/20/2020	
6/28/2022	
07/12/2022	
09/10/24	

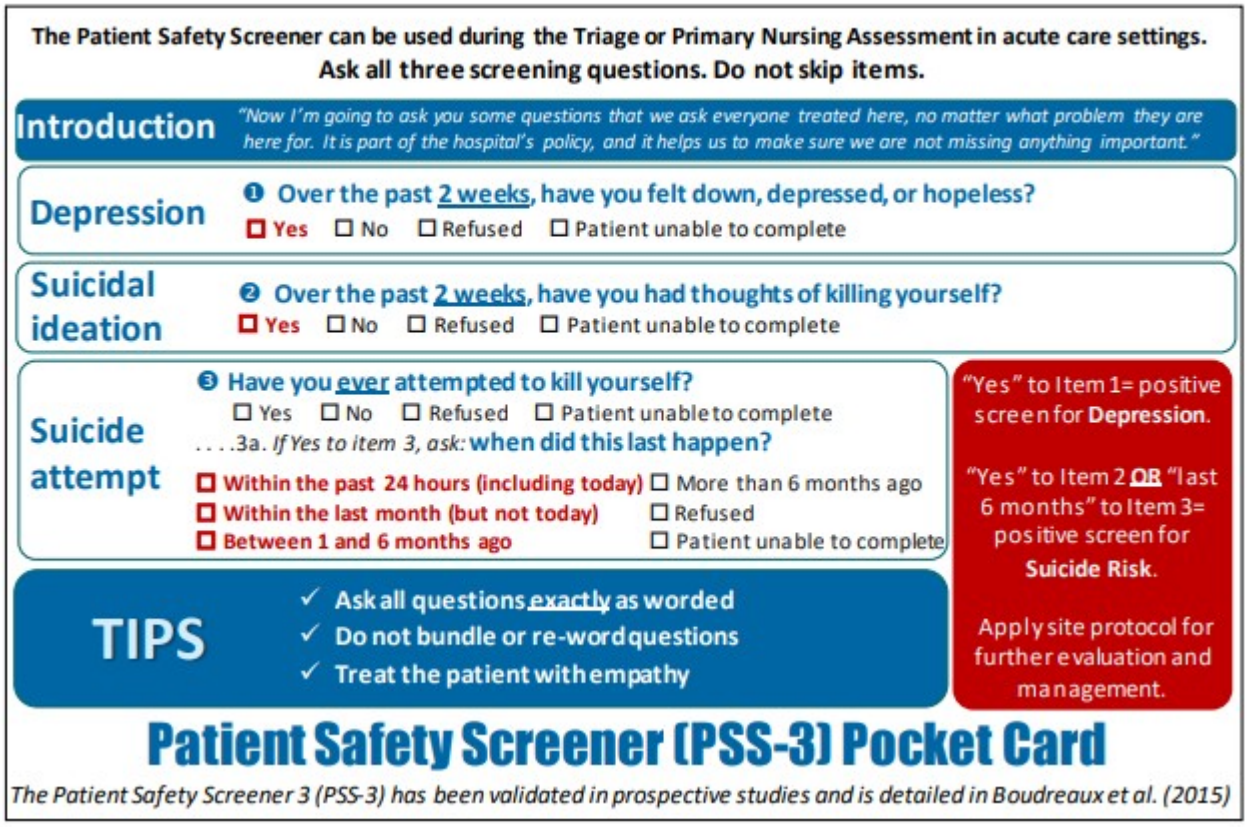
VIII. Contact Information

Department of Quality and Healthcare Safety

409-747-2151

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

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

Suicide attempt
❸ 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)

Appendix 2

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

Step 1: Identify Risk Factors	
C-SSRS Suicidal Ideation Severity (If question 2 is "no" you may skip 3, 4 and 5)	**Month**
1) Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*	
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*	
5) Intent with Plan *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*	
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?	**Lifetime** **Past 3 Months**

Activating Events:	**Clinical Status:**
□ 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:** □ _____ □ _____ □ _____	□ 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 <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)	
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

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior – skip if questions 1-5 are all no)

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 (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (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 (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop 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 (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (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

High Suicide Risk □ 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)	½ **Initiate local psychiatric admission process** ½ **Stay with patient until transfer to higher level of care is complete** ½ **Follow-up and document outcome of emergency psychiatric evaluation**
Moderate Suicide Risk □ 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	½ **Use clinical judgement to determine if further evaluation is necessary** ½ **Outpatient Referral**
Low Suicide Risk □ 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	½ **Outpatient Referral**

Step 5: Documentation

Risk Level :

[ ] High Suicide Risk
[ ] Moderate Suicide Risk
[ ] Low Suicide Risk

Clinical Note:

- ½ Your Clinical Observation
- ½ Relevant Mental Status Information
- ½ Methods of Suicide Risk Evaluation
- ½ Brief Evaluation Summary
  - ½ Warning Signs
  - ½ Risk Indicators
  - ½ Protective Factors
  - ½ Access to Lethal Means
  - ½ Collateral Sources Used and Relevant Information Obtained
  - ½ Specific Assessment Data to Support Risk Determination
  - ½ Rationale for Actions Taken and Not Taken
- ½ Provision of Crisis Line 1-800-273-TALK(8255)
- ½ Implementation of Safety Plan (If Applicable)