



OHSU HEALTHCARE

Policy # HC-PC-450-POL	Title: Suicide Risk Screening and Safety Interventions in Non-Psychiatric Clinical Settings	
Effective Date: 12/18/2019	Category: Provision of Care	
Origination Date: 9/2007	Next Review Date: 12/18/2022	Pages 1 of 4

PURPOSE:

This policy describes the processes used by OHSU Healthcare to conduct a risk screen, further behavioral health assessment and basic safety interventions for patients identified at increased risk for suicidal behaviors.

POLICY:

Any patient greater than 10 years old who presents to the OHSU Emergency Department or is admitted as an inpatient will have a suicide risk screen. Patients in primary ambulatory settings will be given an annual depression risk screening and/or will be screened for suicide risk in any ambulatory setting if they present with a chief complaint of an emotional or behavioral concern. Patients who screen positive must have further clinical assessment and be provided safety interventions, including further behavioral health assessment.

DEFINITIONS:

1. Behavioral Health Assessment: an evaluation by a behavioral health clinician to determine a patient's need for immediate crisis stabilization.
2. Behavioral Health Clinician: A licensed psychiatrist, psychologist, nurse practitioner with a specialty in psychiatric mental health, clinical social worker, counselor or therapist, intern or resident working under a board-approved supervisory contract in a clinical mental health field.
3. ASQ: Ask Suicide Questions: suicide risk screen (validated for ages 10-24) utilized in pediatric ambulatory, Emergency Department and inpatient settings not to be confused with the ASQ-3: the Ages & Stages Questionnaire used as a developmental screening tool in ambulatory pediatric settings.
4. Caring Contact: Contact (in-person, telemedicine, or by phone) between a patient who has experienced a recent behavioral health crisis and a qualified mental health practitioner that occurs within 48 hours of release from the ED or inpatient hospital setting.
5. C-SSCRS: Columbia Suicide Severity Rating Scale Screen of suicide risk (valid ages 18+) utilized in adult ambulatory, Emergency Department and inpatient settings.
6. Lethal Means Counseling: Counseling strategies designed to reduce the access by a patient who is at risk for suicide to lethal means, including but not limited to firearms.
7. Ligature risk: points where a cord, rope, bedsheet, or fabric/material can be looped or tied to create a point of attachment that may result in self-harm or loss of life.
8. PHQ-9: Patient Health Questionnaire (self-administered depression screen) utilized in adult ambulatory, settings.
9. PHQ-2: Short form of Patient Health Questionnaire utilized in adult Emergency Department and inpatient settings.
10. Safety Plan: A standardized template used to develop and individualized safety plan to mitigate risk of suicide in patients identified at increased risk of suicide.
11. Screening: Codified method to determine the potential presence of suicidal ideation.

12. Standard nursing suicide precautions for ED/inpatient settings:

- a. Notify the patient's medical team to develop a plan of care for further assessment.
 - i. Place Social work order/referral for further assessment and discharge planning.
- b. Institute Environmental Safety Precautions: (See attached Environmental Check List)
 - i. Notify dietary to provide paper tray with plastic utensils and no glass or cans.
 - ii. Consider double room, if appropriate.
- c. Perform safety search of patient and belongings inventory (See Safety Search Policy HC-PC-137-RR)
 - i. Move unsafe items to a secure location.
- d. Institute 1:1 Patient Safety Attendant until further assessment regarding risk can be obtained. Utilize the pediatric or adult PSA algorithm (attached).
 - i. In Adult ED, interview room 20, 21, or 22 may replace 1:1 if clinical assessment indicates.
 - ii. Keep bathroom door ajar when in use. High risk patient is not to be alone in bathroom due to ligature risk.
 - iii. Ensure that patient swallows all medications. Never leave medication at bedside.
- e. Have visitors report to nursing station to ensure items brought to the patient are clinically safe.
- f. Patients remain on unit and are escorted by staff when leaving unit for diagnostic testing or procedures only.
- g. If patient is assessed as an elopement risk, patient shall remain in hospital clothing without access to personal outer clothing/shoes. (ED: consider paper scrubs.)

RESPONSIBILITIES:

It is the responsibility of any OHSU Healthcare workforce member who provides direct patient care to understand and to comply with this policy.

PROCEDURES:

1. Ambulatory Clinical Practice

- a. If patient expresses suicidal ideation on telephone, do not attempt to screen further. Connect patient to the National Suicide Prevention Lifeline 1 800 273-8255 who will in turn assist, assess and connect them with local mental health crisis resources.
- b. As a rolling annual health maintenance modifier, administer the age appropriate screening tool as the first step of assessing the patient's risk for depression and suicidal ideation.
- c. If adult patient scores ≥ 3 on the PHQ-2 and/or answers "yes" to question 9 of PHQ-9 as part of routine screening or expresses thoughts of suicide or the pediatric patient scores positive on the ASQ, notify the provider or behavioral health clinician to conduct a further suicide risk assessment.
- d. Do not leave the patient alone until an assessment has been completed and has determined that the current suicide risk is low or plan has been developed by team and patient/family to mitigate risk with agreed upon outpatient level of follow-up care (see 1e below).
- e. If patient is determined to be at imminent risk
 - i. On Marquam Hill campus: The patient requires further acute evaluation by either the Emergency Department or, if an adult, Psychiatric Emergency Services (PES) at Unity Hospital.
 1. Clinic may call 9-1-1 and request Emergency Medical Transport or
 2. LIP may contact the Emergency Department Communication Center 4-7551 and request to speak to appropriate ED personnel for report (charge RN, attending LIP, or LCSW).
 3. Patient must be escorted by staff (RN, MA, or manager) to ED triage and report is to be given to ED triage RN upon arrival.
 4. Clinic staff remains with patient until ED staff is able to take over supervision of the patient.
 5. If patient refuses to be transported, request assistance from Public Safety who will determine if the patient meets their criteria for placing a Peace Officer hold for transport purposes.

- ii. Off-site clinics will notify local emergency services (9-1-1) or the local county mental health crisis line. The responding officer or crisis team will determine where the patient is transported (Unity PES, or nearest emergency department).
 - iii. If patient leaves clinical site, notify Public Safety or local police.
 - f. If imminent risk is not assessed and outpatient referral is indicated:
 - i. Provide suicide crisis intervention hotline information in writing.
 - ii. Create and document a safety plan.
 - iii. Identify and include a family member/person of patient's choice in safety planning.
 - iv. Provide lethal means counseling.
 - v. Ensure mental health follow-up within 7 days or document reason this is not possible.
- 2. Pre-operative day patient environment: Follow ambulatory practice guidelines. No need to screen unless primary diagnosis or primary complaint of an emotional or behavioral disorder or symptom is present.
- 3. Emergency Department and Inpatient Settings:
 - a. **RN**:
 - i. If patient admitted for suicide attempt, institute standard nursing suicide precautions (definition #12 above).
 - ii. All other patients screen using the age appropriate and location appropriate screening tool in electronic medical record.
 - iii. If positive screen, institute standard nursing suicide precautions (definition #12 above) or previously agreed upon documented individualized safety care plan.
 - iv. If positive screen, nursing documentation will reflect plan for managing risk.
 - 1. Inpatient setting: Add Suicide Risk CPG in electronic medical record, document interventions.
 - b. **LIP, PMHNP, LCSW**:
 - i. Perform mental health assessment
 - ii. Based on assessment, develop plan to mitigate risk, which may include psychiatric consultation for safety evaluation and treatment recommendations including need for a psychiatric hold (see Hospital Hold for Treatment of Mental Illness) or Pediatric Behavioral Health Safety Protocol.
 - iii. Refer to appropriate inpatient or outpatient treatment as indicated by assessment.
 - 1. If outpatient care is indicated:
 - a. Provide suicide crisis intervention hotline information in writing upon discharge.
 - b. Create and document a safety plan.
 - c. Identify and include a family member/person of patient's choice in safety planning.
 - d. Provide lethal means counseling.
 - e. Ensure mental health follow-up within 7 days of discharge or document reason this is not possible.
 - f. Ensure a Caring Contact within 48 hours of discharge.

RELEVANT REFERENCES:

- Horowitz, L.M. et al. (2014) Screening Youth for Suicide Risk in Medical Settings. *American Journal of Preventive Medicine*, Elsevier Inc. 2014: 47 (3S2): S170-175.
- Simon, G.E. et al. (2013, Sept 16). Does Response on the PHQ-9 Depression Questionnaire Predict Subsequent Suicide Attempt or Suicide Death? *Psychiatric Services in Advance*. Doi:10.1176/appi.ps.201200587
- Quinnet, P. (2018, October 30). The Role of Clinician Fear in Interviewing Suicidal Patients. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. Advance online publication. <http://dx.doi.org/10.1027/0227-5910/a000555>.

RELATED DOCUMENTS/EXTERNAL LINKS:

- OAR 333-520-0070
- House Bill #3090, 3091.

- Extreme Risk Protection Order (ERPO): 2017, SB719.
- <https://zerosuicide.sprc.org/toolkit>
- ASQ Tool Kit:
- Columbia Suicide Severity Rating Scale
- PSA decisional Algorithm
- ED Psychiatry Triage Stability Grid Assessment Tool
- Patient Safety Attendant Policy
- Safety Search Policy
- Hospital Hold for Mental Illness Policy
- Video Monitoring Attendant Policy

TITLE, POLICY OWNER:

Cognitive Behavioral Care Committee

APPROVING COMMITTEE(S):

- Nursing Practice Council
- Patient Care Operations Council

FINAL APPROVAL:

Policy Steering Committee

Supersedes: policy originally titled “Precautions on Adult Non-Psychiatric Units,” 9/24/2007 (revised with title changed to “Suicide Risk Screening in Non-Psychiatric Clinical Settings”) 2/5/2009; 5/27/2015; 1/2018; 3/2019 updated based on new regulatory requirements defined in House bill 3090, 3091; updated 12/2019;