Guideline: Suicide Risk Screening

Responsible Department: Ambulatory Services

Effective Date: 09/2025

Scope: University of Toledo Medical Center

Purpose: To establish a standardized approach for identifying and responding to suicide risk in patients.

Procedure:
The clinic environment will be evaluated annually and after any changes to identify and mitigate potential self-harm risks (e.g., ligature points, access to harmful items) in areas where patients may be left unattended.

A. Indications for Suicide Risk Screening

1. During new patient visits or at a patient's annual visit (yearly).
2. When the primary reason for the visit is a behavioral health diagnosis or symptoms (e.g., depression, anxiety, PTSD, psychosis).
3. When the patient expresses suicidal ideation or thoughts/behavior of self-harm during the visit.
4. When screening is recommended based on provider discretion.

B. Screening Tool and Process

1. Completion of one of the below universal, evidence-based screening tools:
    - Columbia–Suicide Severity Rating Scale (C-SSRS)
    - Ask Suicide–Screening Questions (ASQ)
    - Patient Health Questionnaire–9 (PHQ-9)
2. A designated trained clinical staff member (e.g., RN, LPN, MA, provider) will conduct screening.

C. Documentation:

1. Screening results must be documented in the EHR (flowsheets, progress notes, or designated suicide screening section).
2. If positive, record screening score, patient responses, and immediate interventions taken.
3. Time-stamp provider notification and recipient of the notification.

IV. Risk Assessment & Intervention

1. When the patient screens positive for suicide risk during a visit, an evidence-based
   assessment will be conducted by an onsite behavioral health professional (BHP) or

   external consulting service. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.

   a. If the patient is identified as imminent risk, the provider/onsite BHP/external resource will assess the need for hospitalization and discuss potential options available to the patient. If safety remains a concern and the patient is unwilling for further evaluation, 911 will be contacted.
      a. For clinics without onsite BHP resources, or where the provider is uncomfortable performing the assessment, contact external resources such as the ZEPF Center for onsite consultation (419-904-2273). Please note that response time may vary as the team operates on a request schedule; an ETA will be provided.

   b. If the patient is at moderate risk, a referral to behavioral health services will be initiated, and the referring provider will be notified.
      a. A personalized safety plan must be created for all moderate or high-risk patients, including coping strategies and crisis resources such as the 988 Suicide & Crisis Lifeline.

   c. If minimal risk is identified, no further action is needed beyond standard documentation.
      a. Patients identified at risk must receive follow-up contact within 24–72 hours to ensure safety, confirm appointments, and reinforce crisis resources.

V. Training & Compliance

1. All ambulatory employees will receive annual training on suicide risk screening and response protocols.
2. Annual competency validation for all employees conducting screenings must be documented in addition to required training.

3. Compliance with this policy will be monitored through quarterly audits and staff feedback.
4. This guideline and the selected suicide screening tools must be reviewed and approved annually by the hospital's medical staff and governing body to ensure ongoing compliance.

Reviewed by:

/s/

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Marci Cancic -Frey
Chief Administrative Officer

9/1/2025

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Date

Review/Revision Completed by: Accreditation Manager, Administrative Director, Clinical Operations, Chief Administrative Officer

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Review/Revision Date: 9/2025

Next Review Date: 09/2028