NURSING SERVICE GUIDELINES
OUTPATIENT BEHAVIORAL HEALTH

Guideline: **Suicide risk screen**

Policy Number Superseded:

Responsibility: It is the clinical team's responsibility to conduct suicide risk screens and implement plans of treatment under guidance of a licensed provider, based on the clinical needs of the patient.

Related Polices:
3364-100-45-23 Involuntary Civil Commitment; Patients Lacking Decision Making Capacity
3364-100-60-60 Adult Patients Requiring Psychiatric Interventions
3364-101-02-01 Ambulatory Medical Record
3364-160-CR-110 Suicide Risk Screening and Assessment

Purpose of Guideline: This guideline outlines the procedures and documentation for suicide risk screen for patients ages 12 years and older.

Effective Date:
September 18, 2023

Initial Effective Date:
September 18, 2017

Procedure:

(A) As part of each **pharmacological management appointment**, the medical assistant (MA) will ask the patient suicide screening questions and document responses in the clinical record.

(1) If patient answers "No," no further action is required.

(2) If patient answers "Yes":

(a) To assist in determining if this is an acute suicidal crisis requiring immediate intervention, the MA will ask a follow up question "Do you have plans and want to commit suicide now?"

(i) If the answer is "No," MA will document this information in the medical record and notify the provider via text page that the patient answered "Yes" to the suicide screening question(s) and "No" to the acutely suicidal question and return patient to the waiting room area.

(ii) If the answer is "Yes," MA will document this information in the medical record, notify the provider that the patient answered yes to the ACUTE suicide screen. Patient will be staffed 1:1* until provider retrieves the patient and will complete documentation on the suicide precaution checklist.

(iii) When patient is with the clinician, the clinician will:

(a) Conduct a suicide risk assessment;

(b) Determine appropriate level of care based on assessment;

(c) Add an objective on the treatment plan that will address suicidal ideation for on-going monitoring as part of the session and delivery of care;

(d) Provide patient information to available resources such as the National Suicide Prevention Lifeline or other local resources;

(e) Ensure the patient is staffed 1:1* until safety planning is complete and disposition determined;

(f) Conduct safety planning in collaboration with the patient and guardian if applicable, to include coping skills and resources for reducing risks.

(B) As part of the **initial therapy appointment**, the provider will conduct the suicide screen and document responses in the clinical record.

(1) If patient answers "No," no further assessment is required.

(2) If patient answers "Yes" the clinical provider will:

(a) Conduct a suicide risk assessment;

(b) Determine appropriate level of care based on assessment;

(c) Add an objective on the treatment plan that will address suicidal ideation for on-going monitoring as part of the session and delivery of care;

(d) Provide patient information to available resources such as the National Suicide Prevention Lifeline or other local resources such as Rescue Crisis, UTMC ER, etc.;
(e) Ensure the patient is staffed 1:1* until safety planning is complete and disposition determined;
(f) Conduct safety planning in collaboration with the patient and guardian, if applicable, to include coping skills and resources for reducing risks.

(C) In the case where the patient is not agreeable for inpatient treatment and does not meet criteria for involuntary civil commitment, requests will be made of the patient to contact friends, family, or other outpatient treatment providers. (If necessary, HIPAA permits providers to make these contacts when the provider believes the patient may be a danger to self or others.)

* Staffed 1:1 means one individual assigned to one patient who will maintain visual contact and be located in the same room of the assigned individual at all times.

(D) Telehealth considerations

(1) When performing a telehealth appointment with a patient, the staff member should confirm:

(a) The patient's physical location.
(b) A telephone to contact should they lose connection.
(c) An emergency contact and their phone number should the staff member need to contact to assist in maintaining patient safety (e.g., while waiting for emergency services/911 to arrive).

(2) If a patient expresses a psychiatric emergency during a telehealth appointment:

(a) The staff member is to attempt to remain on the phone with the patient.
(b) The staff member is to contact 911/emergency services to request a well check.
(c) Document the disclosure on the PHI disclosure log.

(E) Resources

Screening for Depression and Adolescents: U.S. Preventive Services Task Force Recommendation Statement Annals of Internal Medicine Vol 164 No. 5 1 March 2016

Child Suicide Screening Methods: Are We Asking the Right Questions? A review of the Literature and Recommendations for Practice The Journal for Nurse Practitioner – JNP Volume 12, Issue 6, June 2016

Practice Parameter for the Assessment and Treatment of Child and Adolescents with Suicidal Behavior Child and Adolescent Psychiatry 40:7 July 2001

The Suicidal Behaviors Questionnaire – Revised (SBQ-R): Validation With Clinical and Non-Clinical Samples Psychological Assessment 2001 Volume 8, Number 4 443-454

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Review/Revision Completed by:
Outpatient Behavioral Health Administration

Initial effective date:
September 18, 2017

Review/Revision Date:
June 5, 2019
January 10, 2020
August 31, 2020
September 18, 2023

Next review date:
September 18, 2026