CLINICAL PATHWAY

Behavioral Health

Suicide Prevention

CHRISTIANA CARE
HEALTH SYSTEM

Suicide Prevention

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INTRODUCTION

Suicide in the United States has surged to the highest levels in nearly 30 years, a federal data analysis found, with increases in every age group except older adults. Increases were so widespread that they lifted the nation's suicide rate to 13 per 100,000 people, the highest since 1986.

The Joint Commission reported that during 2010-2014 there were 1,089 suicides reported with shortcomings in the assessment as the root cause.

The Suicide Prevention Pathway seeks to come in line with Joint Commission standards to reduce the variation of our current suicide screening assessment by developing a standardized screening process throughout CCHS to identify and treat individuals with suicide ideation or at risk for suicide.

Scope of this Pathway

The Columbia – Suicide Severity Rating Scale (C-SSRS) tool will be adopted system-wide. Current active areas include, all three emergency departments and acute medicine units. Excluded units include: Women's and Children, Inpatient Psychiatry, Joint Replacement, Rehab., and Same-Day & 23 hour Observation Surgical units.

Pathway Contacts

The content of this pathway is developed and maintained by the Behavioral Health Service Line of Christiana Care Health System. Questions or feedback about the content may be directed to:

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CLINICAL PATHWAY

TABLE 1: RISK STRATIFICATION AFTER C-SSRS IN EMERGENCY DEPARTMENT

RISK LEVEL	CRITERIA	ACTIONS
Low	Yes to Q1 and/or Q2 AND No or > 1 year ago to Q6 OR No to Q1 and/or Q2 AND > 1 year ago to Q6	Patient education Safety plan Outpatient referrals
Moderate	Yes to Q3 AND No to Q4 and Q5 OR Yes to Q1, Q2, or Q3 AND 1-12 months ago to Q6	Place in room quickly Constable's screening Patient education Safety plan Suicide History Screen and Risk Assessment Treatment referral Daily Re-screen Notify DFES, consider: Elopement precautions Psychiatric consult Safety Companion
High	Yes to Q4 or Q5 OR Yes to Q1, Q2, or Q3 AND	Place in room quickly Constable's screening Prompt to assign ESI 2 Safety Companion Elopement precautions Suicide precautions

RISK LEVEL	CRITERIA	ACTIONS
	In past 4 weeks to Q6	Patient education Safety plan Treatment referral Psychiatric consult Suicide History Screen and Risk Assessment (optional) Daily Re-screen Notify DFES

TABLE 2: RISK STRATIFICATION AFTER C-SSRS FOR ADMITTED PATIENTS

RISK LEVEL	CRITERIA	ACTIONS
Low	Yes to Q1 and/or Q2 AND No or > 1 year ago to Q6 OR No to Q1 and/or Q2 AND > 1 year ago to Q6 ago to Q6	Patient education Safety plan Outpatient referrals
Moderate	Yes to Q3 AND No to Q4 and Q5 OR Yes to Q1, Q2, or Q3 AND 1-12 months ago to Q6	Patient education Treatment referral Elopement precautions Safety plan Notify Attending and consider: Psychiatric consult Suicide precautions Safety companion Daily re-screen
High	Yes to Q4 or Q5 OR Yes to Q1, Q2, or Q3 AND In past 4 weeks to Q6	Patient education Safety plan Treatment referral Elopement precautions Suicide precautions Psychiatric consult Safety Companion Notify Attending Daily re-screen

PATHWAY ALGORITHMS

ALGORITHM 1: SUICIDE PREVENTION FOR EMERGENCY DEPARTMENT PATIENTS

START

Exclusions
ESI 1
Trauma Codes
Obtunded
<12 y.o.

Patient enters the Emergency Room and completes Quick Reg at window

Patient waits for call to Triage and then Triage RN begins Columbia Suicide Severity Rating Scale: Questions 1, 2, & 6 **MUST** be asked of all.

Ask Question 1: *Have you wished you were dead or wished you could go to sleep and not wake up?*

YES or NO

Ask Question 2: *Have you actually had any thoughts of killing yourself?*

YES → Patient Enters the Pathway and **MUST** be asked questions 3 thru 6

NO → Ask Question 6

Ask Question 3: *Have you been thinking about how you might kill yourself?*

NEXT

Ask Question 4: *Have you had these thoughts and had some intention on acting on them?*

NEXT

Ask Question 5: *Have you started to work out or worked out details on how to kill yourself? Do you intend to carry out this plan?*

NEXT

Ask Question 6: *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*

No to Question 1, 2, and 6 → **No Risk**

YES (Question 3) →

Moderate Risk Protocol
Place in room quickly
Security Screen
Pt. Education & Referral
Safety Plan
Suicide Hx Screen
Rescreen Daily
Pathway Designator in Problem List (d/c + 30day)

Notify DFES, consider . . .
Elopement Precautions
Psych Consult
Safety Companion

YES (Questions 4 and 5) →

High Risk Protocol
ESI 2
Place in room quickly
Security Screen
Elopement Precautions
Suicide Precautions
Psych Consult
Suicide Hx Screen (optional)
Safety Companion
Pt. Education & Referral
Safety Plan
Rescreen Daily
Pathway Designator in Problem List (d/c + 30day)

Rescreen q 24 hours

Rescreen Q 24 hours

YES (Question 6) →

If In the past 4 weeks: **High Risk** Protocol

If in 1-12 months ago: **Moderate Risk** Protocol

If ≥1 year ago: **Low Risk** Protocol

NO →

Low Risk Protocol
OutPt Referrals
Safety Plan
Pt. Education

Patient assigned highest level of risk as indicated by responses.

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ALGORITHM 2: SUICIDE PREVENTION FOR ADMITTED PATIENTS

START

Exclusions
Obtunded
<12 y.o.

Patient admitted to floor with no prior C-SSRS completed
OR
Admitted patient indicates suicidal ideation.

Nurse begins Columbia Suicide Severity Rating Scale: Questions 1 & 2 **MUST** be asked.

Ask Question 1: *Have you wished you were dead or wished you could go to sleep and not wake up?*

YES or NO

Ask Question 2: *Have you actually had any thoughts of killing yourself?*

YES

Patient Enters the Pathway and **MUST** be asked questions 3 thru 6

NO

Ask Question 3: *Have you been thinking about how you might kill yourself?*

NEXT

Ask Question 4: *Have you had these thoughts and had some intention on acting on them?*

NEXT

Ask Question 5: *Have you started to work out or worked out details on how to kill yourself? Do you intend to carry out this plan?*

NEXT

Ask Question 6: *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*

No to Question 1, 2, and 6

No Risk

YES

Moderate Risk Protocol
Pt. Education & Referral
Safety Plan
Elopement Precautions
Pathway Designator in Problem List (d/c + 30day)
Rescreen Daily

Notify Attending, *consider:*
Safety Companion
Psychiatric Consult
Suicide Precautions

YES

YES

High Risk Protocol
Pt. Education & Referral
Safety Plan
Elopement Precautions
Suicide Precautions
Safety Companion*
Psychiatric Consult
Notify Attending
Pathway Designator in Problem List (d/c + 30day)
Rescreen Daily

Rescreen
q 24 hours

Rescreen
Q 24 hours

YES

If In the past 4 weeks: **High Risk** Protocol

If in 1-12 months ago: **Moderate Risk** Protocol

If ≥1 year ago: **Low Risk Protocol**

NO

Low Risk Protocol
OutPt Referrals
Safety Plan
Pt. Education

Patient assigned highest level of risk as indicated by responses.

*For Perioperative Service, order for 1:1 will contain language to assess for appropiateness post-surgery.

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ALGORITHM 3: Q24 HOUR SCREENING FOR EMERGENCY AND ADMITTED PATIENTS

Rescreen Q 24 hours → Nurse begins Columbia Suicide Severity Rating Scale Daily Screen

YES or NO → Ask Question 2: *Since you were last asked, have you actually had thoughts about killing yourself?*

- YES → Patient **MUST** be asked questions 3 thru 6
- NO → Ask Question 6

Ask Question 3: *Have you been thinking about how you might do this?*
- YES → Moderate Risk Protocol
- NEXT → Ask Question 4

Ask Question 4: *Have you had these thoughts and had some intention on acting on them?*
- YES → High Risk Protocol
- NEXT → Ask Question 5

Ask Question 5: *Have you started to work out or worked out details on how to kill yourself? Do you intend to carry out this plan?*
- YES → High Risk Protocol
- NEXT → Ask Question 6

Ask Question 6: *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*
- YES → High Risk Protocol
- NO → Low Risk Protocol

Moderate Risk Protocol
Pt. Education & Referral
Safety Plan
Elopement Precautions
Pathway Designator in Problem List (d/c + 30day)
Rescreen Daily

Notify Attending, *consider:*
Safety Companion
Psychiatric Consult
Suicide Precautions

High Risk Protocol
Pt. Education & Referral
Safety Plan
Elopement Precautions
Suicide Precautions
Safety Companion
Psychiatric Consult
Notify Attending
Pathway Designator in Problem List (d/c + 30day)
Rescreen Daily

Low Risk Protocol
OutPt Referrals
Safety Plan
Pt. Education

Moderate Risk Protocol / High Risk Protocol → Rescreen q 24 hours → (return to Ask Question 2)

PATIENT EDUCATION MATERIALS

Helping Someone Who Is Suicidal

Suicide: Caring for Yourself

Mental Health Referral List

My Safety Plan

CLINICAL EDUCATION MATERIALS

LINKS FOR STAFF EDUCATION

Inpatient Physician Education (in Learning Center)

Inpatient Physician Education

Inpatient Nursing Education: Summary

Inpatient Nursing Education

Emergency Physician Education

FREQUENTLY ASKED QUESTIONS

Can asking these questions make someone more suicidal?

No. Asking someone about suicidal thoughts or ideas does not make them suicidal. Asking these questions gives an opportunity for the person to express thoughts or ideas that are already there.

I am not behavioral health staff; why must I ask these questions?

Suicidal thoughts and feelings occur in every type of patient who are here for many different medical reasons. Clinical staff needs to be able to ask these sensitive questions that could save a person's life. This can then help you alert the behavioral health staff to address this need for our patient.

My patients often feel these questions are offensive. How do I navigate these questions in this situation?

Explain that these are questions that we ask everyone. It's okay to validate their feelings in agreeing that these can be uncomfortable to answer.

I don't like how the questions are phrased; can I ask them in my own words? Do I have to ask the questions verbatim?

The questions must be asked verbatim as they are written on the Columbia Suicide Severity Rating Scale. This is a well-researched and valid tool. Changing the wording will change the validity of the results.

The patient is unable to provide answers; can a family member provide responses for the patient?

Yes. On the right side of the Columbia Suicide Severity Rating Scale, you can document who is providing the responses and what their relationship is to the

patient. The Columbia Suicide Severity Rating Scale is also a valid tool when information is gathered by someone close to the patient.

The patient is refusing to complete the screening? What do I do?

Check the box for “unable to respond” and document that patient refused.

I don’t feel triage provides enough privacy to ask these questions. What can I do?

If there are no other options for space to ask these questions, you can talk in a lower voice or move closer to the patient. This is a JCAHO requirement and we all must do the best that we can.

My patient has been deemed “moderate risk”, medical issues are fully addressed, and behavioral health staff has not yet cleared them, can they leave? What do I do?

No, they cannot leave. Please alert the behavioral health department to inform them of the patient’s status. For the Emergency department, call the Psychiatric Emergency Services staff: 733-2881 in Christiana; 320-2118 in Wilmington; Behavioral Health IPad in Middletown. For an inpatient unit, please go through the consult service.

The patient is moderate risk and the computer suggests that the patient does not need a safety companion but I think they do. What should I do?

The interventions suggest to “consider” a safety companion. As the clinical staff actually treating this person, you have the authority to advocate for what you believe is the safest option for your patient. Discuss your concern with DFES or their attending doctor.

The Columbia Suicide Severity Rating Scale does not replace or override in-person assessment.

The patient answers “no” to the questions, but I sense that is not the truth? What can I do?

Discuss your concerns with DFES or the patient’s doctor. The Columbia Suicide Severity Rating Scale does not replace your in-person contact and the information you gather from that.

What do I do with patient belongings?

Secure the patient’s belongings per your units’ policy. Patients may keep their cell phones unless you deem that unsafe.

How do I reach a psychiatrist to talk to the patient?

Put in an order for a psychiatric consult and use the psychiatric consult paging service or ask the Psychiatric Emergency Services staff to talk with the patient.

My patient answered yes to 1 and 2 and then refused to answer any more questions. What do I do?

First try to explain that these are questions that we must ask all patients. Also reassure the patient that you are aware they can be uncomfortable and that we want to make sure that if they need any emotional support, that we can help them get that. If there is a family member or friend there, you may ask these questions of them as well. If they still refuse, notify DFES or attending doctor. At this point, you will have to change the status of the Scale to “unable to respond” and state why in your note. Indicate their answers that you were able to get and share with their doctor.

Do I have to complete the Columbia Suicide Rating Scale with children?

Yes, with adolescents 12 years old and older. For younger children, you should check the box for "child under 12" that is on the form. This will allow you to skip the form.

There is a Safety Plan that prints out with patient education. What should I be doing with it?

On an inpatient floor, the safety plan should be given to the patient at admission if the Columbia Screen identifies them as being on the pathway. All patients reporting any level of risk should receive one. The goal is for the patient to complete the safety plan while they are in the hospital. They should be encouraged to share it with the psychiatrist here, or with their outpatient providers and anyone they list as their supports.

In the emergency department, they should be given the safety plan as soon as possible. If this is a person being discharged home, they should be encouraged to share it with their outpatient providers and anyone they list as their supports.

Do all hospital patients receive this?

No. There are several units that are not covered by the Suicide Prevention Pathway. These include: Same-Day and Observation Surgery; Women's and Children, Joint Replacement, Inpatient Psychiatry, and Rehab.

The patient is high risk and a psychiatric consult was automatically ordered. When will the psychiatrist come?

You will need to treat that order like any other consult order and place the call to the psychiatric consult service yourself. The consult service does not get automatically notified when a patient is high risk.

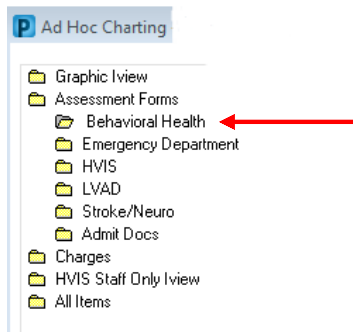
My patient originally scored high or moderately at risk of suicide. What is this daily screen in my task list? Must I do it or will a behavioral health staff do it?

The daily screen must be done by the nursing staff on the unit. Behavioral health staff will not come by to complete it. It is designed to prompt when the patient is at low risk and may be appropriate to come off a safety companion.

If a patient comes in moderate risk but then on the daily rescreen scores high risk, the high risk interventions will automatically fire in the computer, including safety companion, psychiatric consult, and precautions.

My patient is expressing suicidal thoughts, but had not previously reported suicidality. What can I do?

You can complete an ad hoc CSSRS Short Form, found under ad hoc, Assessment Forms, Behavioral Health folder



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The Christiana Care Way

We serve our neighbors as respectful, expert, caring partners in their health. We do this by creating innovative, effective, affordable systems of care that our neighbors value.

CHRISTIANA CARE
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