Clinical Policy & Procedure
Suicide Risk Screening, Assessment and Safety Interventions

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Title	Suicide Risk Screening, Assessment and Safety Interventions
Policy Owner and Contact Information	John Dempsey Hospital Administration 860-679-2422
Scope	UConn Health John Dempsey Hospital Emergency Department and Inpatient Units
Effective Date	March 17, 2022

PURPOSE:
To reduce the risk for suicide.

DEFINITIONS:
None

POLICY STATEMENTS:

1. All patients ages 12 and older who are being evaluated or treated for behavioral health conditions as their primary reason for care are screened for suicide risk using the Columbia Suicide Severity Rating Scale (C-SSRS).

2. For patients who screen as a moderate or high risk for suicide on the C-SSRS, an evidenced-based suicide risk assessment is completed by a practitioner. The assessment asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. In some cases, patients are screened for suicide risk and assessed for the severity of suicidal ideation simultaneously.

3. If the patient's chronic and/or acute condition precludes a suicide risk screening and/or assessment, safety interventions are individualized to each patient depending on clinical status and reason for care, until the screening and/or assessment are able to be completed. Collateral information may be utilized in completing the suicide screening and/or assessment if information is unable to be obtained from the patient.

PROCEDURES

Emergency Department Settings:

1. Patients evaluated or treated for behavioral health conditions as their primary reason for care are screened for suicide risk using the C-SSRS by the Registered Nurse (RN).
2. Patients who have screened as a no or low risk for suicide are rescreened for suicide risk using the C-SSRS by the RN with a new occurrence of suicidal behavior, ideation, statement, or other noteworthy clinical change.
3. Safety interventions are initiated on patients screened to be at moderate or high risk for suicide on the C-SSRS. These interventions may be modified as a result of a rescreening, assessment, reassessment, transfer to a different level of care, or discharge.
    a. 1:1 level of observation is initiated until an evidence-based suicide risk assessment is conducted by the practitioner and an order is placed for the clinically appropriate level of observation based on the practitioner's suicide risk assessment and corresponding documentation in the medical record.
    b. An environmental risk assessment is completed in order to identify features in the physical environment that could be used to attempt suicide or otherwise impose harm. The room/environment is modified by removing objects that pose a risk, if they can be removed without adversely affecting the patient's care.
4. For patients who screen as a moderate or high suicide risk on the C-SSRS, an evidence-based suicide risk assessment is completed by a practitioner. In some cases, patients are screened for suicide risk and assessed simultaneously. The evidenced-based suicide risk assessment by the practitioner determines the risk mitigation strategies, including the level of observation required for the patient.
5. The patient's assessment informs the frequency of reassessment. Interventions may be modified as a result of a re-screening, reassessment, transfer to ligature-resistant setting, or discharge.

Inpatient Non-Behavioral Health Unit:

1. Patients evaluated or treated for behavioral health conditions as their primary reason for care are screened for suicide risk by the RN using the C-SSRS in the non-behavioral health setting if screening was not completed prior to arrival on the inpatient non-behavioral health unit.
2. Patients are rescreened for suicide risk using the C-SSRS by the RN with a new occurrence of suicidal behavior, ideation, statement, or other noteworthy clinical change.
3. Patients who do not present with a behavioral health condition as their primary reason for care are screened for suicide risk using the C-SSRS with an occurrence of suicidal behavior, ideation, statement, or other noteworthy clinical change.
4. Safety interventions are initiated on patients screened to be at moderate or high suicide risk on the C-SSRS. These interventions may be modified as a result of a rescreening, assessment, reassessment, transfer to a different level of care, or discharge.
    a. 1:1 level of observation is initiated until an evidence-based suicide risk assessment is conducted by the practitioner and an order is placed for the clinically appropriate level of observation based on the practitioner's suicide risk assessment and corresponding documentation in the medical record.
    b. An environmental risk assessment is completed in order to identify features in the physical environment that could be used to attempt suicide or otherwise impose harm. The room/environment is modified by removing objects that pose a risk, if they can be removed without adversely affecting the patient's care.

5. For patients who screen as a moderate or high risk for suicide on the C-SSRS, an evidence-based suicide risk assessment is completed by a practitioner. In some cases, patients are screened for risk for suicide and assessed simultaneously. The evidenced-based suicide risk assessment by the practitioner determines the risk mitigation strategies, including the level of observation required for the patient.
6. The patient's assessment informs the frequency of reassessment.

Inpatient Behavioral Health Settings:

1. Patients admitted to the inpatient behavioral health setting directly from the emergency department or inpatient unit are screened for suicide risk and receive an evidence-based suicide risk assessment. The evidence-based suicide risk assessment determines the risk mitigation strategies, including the level of observation required for the patient and is completed by the admitting practitioner prior to the patient's arrival on the inpatient behavioral health unit.
2. Patients admitted to inpatient behavioral health units from a location other than the emergency department or inpatient unit, are screened for suicide risk and receive an evidenced-based suicide risk assessment. The evidence-based suicide risk assessment is completed by the admitting practitioner and determines the risk mitigation strategies, including the level of observation required for the patient.
3. Suicide risk screening, suicide risk assessment, and behavioral health assessments are completed by the RN upon admission to the inpatient behavioral health setting.
4. Patients are rescreened for risk for suicide using the C-SSRS Daily/Shift Screen by the RN daily and with a new occurrence of suicidal behavior, ideation, statement, or other noteworthy clinical change.
5. A behavioral health assessment is completed by the RN, at a minimum, every shift.
6. Subsequent suicide risk reassessments are completed by the practitioner daily.
7. An environmental risk assessment is completed in order to identify features in the physical environment that could be used to attempt suicide or otherwise impose harm. The room/environment is modified by removing objects that pose a risk, if they can be removed without adversely affecting the patient's care.

All Settings:

1. The expectations outlined in the policy and procedure are documented within the Electronic Medical Record (EMR), if possible.
2. Suicide prevention information is provided to patients who are found to be at risk for suicide upon discharge.
3. An RN may place the patient on increased level of observation based on the suicide screening or clinical judgement, and the provider is notified for an order.
4. UCONN Health provides education regarding the screening of patients at risk of harm to self or others, the identification of environmental patient safety risk factors, and mitigation strategies to all direct patient care employees upon hire and prior to providing patient care independently.
5. UCONN Health monitors implementation and effectiveness of policies and procedures for screening, assessment, reassessment and management of patients at risk for suicide and takes action as needed to improve compliance.

REFERENCES:

The Joint Commission. (2017). Perspectives preview: Special report: Suicide prevention in health care settings. Joint Commission 2017 Perspectives Preview

The Joint Commission. (2022). National Patient Safety Goals Effective January 2022 for the Hospital Program. Joint Commission 2022 National Patient Safety Goals

PROCEDURES:

See Suicide Risk Assessment and Intervention Clinical Procedure

SEARCH WORDS:

Suicide, 1:1, Observation, Risk, Sitter, Screening

RELATED POLICIES:

1:1 Observation/Constant Observation Policy and Procedure

ENFORCEMENT:

Violations of this policy or associated procedures may result in appropriate disciplinary measures in accordance with University By-Laws, General Rules of Conduct for All University Employees, applicable collective bargaining agreements, the University of Connecticut Student Code, other applicable University Policies, or as outlined in any procedures document related to this policy.

APPROVAL:

1. Bruce T. Liang, MD (Signed) 03/18/2022
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   Dean, School of Medicine

2. Anne Horbatuck (Signed) 03/17/2022
   Anne D. Horbatuck, RN, BSN, MBA Date
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3. Scott Allen, MD (Signed) 03/18/2022
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4. Caryl Ryan (Signed) 03/18/2022
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   Interim Chief Operating Officer, JDH
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POLICY HISTORY:
Date Issued: 11/31/2019
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Date Reviewed: