

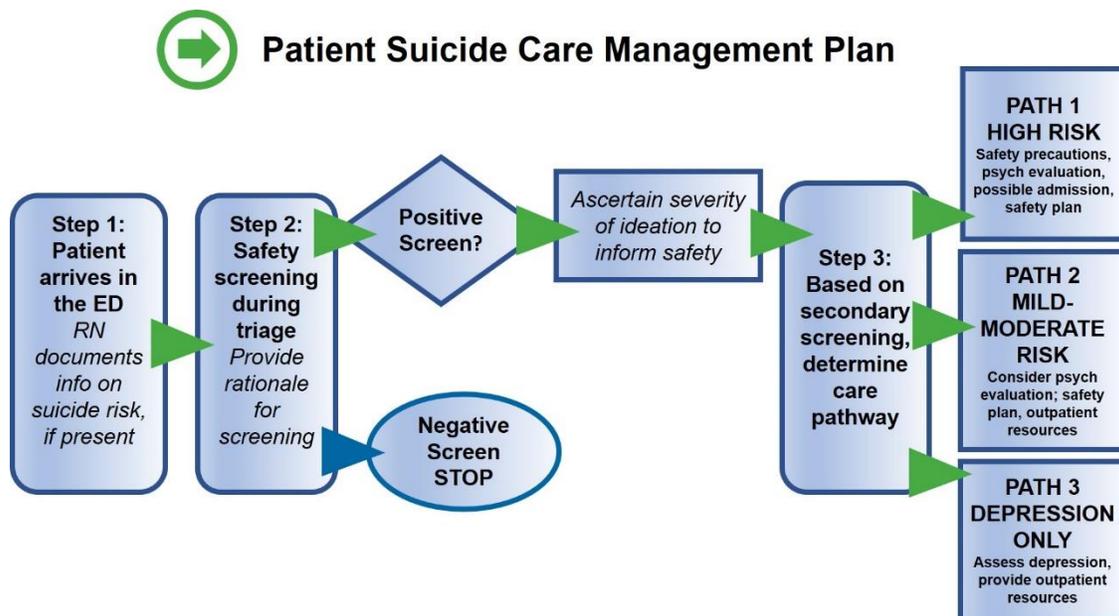
# SUICIDE CARE MANAGEMENT PLANS

What should acute care providers do when a patient screens positive on a primary suicide screening tool? This is a question that should be resolved before universal screening is implemented. Policies, procedures, training, and monitoring systems should be put in place to support clinicians.

## INTRODUCTION

When universal screening is implemented in a health care system, there will be an increase in the number of patients detected as being at risk of suicide.<sup>1</sup> These “incidentally detected” patients do not always need the kind of intensive intervention that is commonly used for patients making suicide-specific presentations, like safety precautions, psychiatric evaluations, and psychiatric hospitalization. This document describes options for organizing the care of patients who screen positive for suicide risk in acute care settings, presented in order from the positive screen through to post-discharge.

Figure 1: Sample suicide care management plan



## IMMEDIATELY AFTER A POSITIVE SUICIDE SCREEN

Upon detecting suicide risk, the nurse must decide whether to apply immediate safety precautions, such as one-to-one observation and accommodating the patient in a safe room. This decision can be informed in part by assessing the severity of the patient’s current ideation. For example, if the Patient Safety Screener (PSS-3)<sup>2</sup> is being used and a patient endorsed suicidal ideation in the past two weeks, they should be asked about the severity of that ideation (for example, whether it includes method, intent, and plan) and whether they have current suicidal ideation, for example “Are you having thoughts of killing yourself right now?” or “Are you having thoughts of suicide right now?” The nurse should then document the screening results in the patient record and

communicate with the treatment team. Some patients will screen positive for depression only and will not need suicide-specific intervention.

When a patient screens positive for suicide risk, nurses should:

- ✓ **Thank the patient for disclosing their risk and tell them you will make the treatment team aware**
- ✓ **Obtain more detail on the intensity of the patient’s ideation and immediacy of their risk**
- ✓ **Decide whether to enact safety precautions**
- ✓ **Document the screening results and additional details that support decision-making**
- ✓ **Communicate the patient’s risk to the treatment team**

## **SAFETY PRECAUTIONS**

According to the Joint Commission, emergency department patients with “serious suicide ideation” should receive safety precautions.<sup>3</sup> Not all patients who screen positive during primary screening have “serious” ideation. In the UMMHC system, ideation is considered severe if it includes intent or plan or if it is current at the time of screening. Before enacting safety precautions, the patient should be informed in an empathic way that the staff are concerned for the patient’s safety and may ask a staff member to keep them company and help make sure that they are safe. Joint Commission recommended strategies are to:

- 1) Place the patient in a “safe room” that is ligature-resistant or that can be made ligature-resistant by having a system that allows fixed equipment that could serve as a ligature point to be excluded from the patient care area (for example, a locking cabinet).
- 2) Keep the suicidal patient in the main area of the emergency department, initiate continuous 1:1 monitoring, and remove all objects that pose a risk for self-harm that can be easily removed without adversely affecting the ability to deliver medical care.<sup>3</sup>

It is good practice to have an environmental safety checklist that is shared between the nurse and the 1:1 observer, conduct safety checks at every shift change, and document the safety check in the patient record.

## **SECONDARY SCREENING**

After the nurse has responded to the positive screen and enacted safety precautions where necessary, the attending physician can take the lead on assessing whether a psychiatric evaluation is needed. In inpatient medical settings where positive screens for suicide risk are infrequent, the protocol might be to consult liaison psychiatry for every positive screen. In the busier, resource-limited ED, physicians may need to be more stringent about ordering a psychiatric evaluation. In deciding about whether to consult psychiatry, the attending physician should consider broader risk factors beyond the current ideation or recent attempt. The ED-SAFE secondary screener suggests a psychiatric evaluation may be required if the answer is “Yes” to any of the following:

1. **Did the patient screen positive on both PSS items 2 and 3, active ideation with a past attempt?**
2. **Has the individual begun a suicide plan?**
3. **Has the individual recently had intent to act on his/her ideation?**

4. Has the patient ever had a psychiatric hospitalization?
5. Does the patient have a pattern of excessive substance use?
6. Is the patient irritable, agitated, or aggressive?

*Sources of information for secondary screening: PSS screener completed by primary nurse, patient self-report, collateral information, medical records review, direct observation*

## PSYCHIATRIC EVALUATION AND HOSPITALIZATION

If the physician orders a psychiatric evaluation, it is likely to address the following domains:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Reason for the evaluation      | <input type="checkbox"/> General medical history         | <input type="checkbox"/> Review of systems         |
| <input type="checkbox"/> History of the present illness | <input type="checkbox"/> Occupational & military history | <input type="checkbox"/> Mental status examination |
| <input type="checkbox"/> Past psychiatric history       | <input type="checkbox"/> Legal history                   | <input type="checkbox"/> Impression and plan       |
| <input type="checkbox"/> History of substance use       | <input type="checkbox"/> Family history                  |  |

The results and recommendations of the evaluation are shared with the treatment team and documented in the patient record. Inpatient psychiatric admission may be recommended by the evaluation team. If so, the suicide risk of the patient should be communicated clearly across care settings through psychiatric admission.

## BRIEF INTERVENTIONS

There are several evidence-based brief interventions for suicide risk in acute care settings.

The **Safety Planning Intervention**<sup>4</sup> is an evidence-based brief intervention that involves working collaboratively with patients at risk for suicide to create a prioritized written list of coping strategies and sources of support. The written safety plan can be printed out and given to the patient, integrated into the EHR, facilitated by mobile apps like My3, and revised with the patient over time. This intervention can be used even if a patient’s suicidal ideation or attempt occurred in the months before hospitalization.

**Lethal means counseling**<sup>5</sup> is a recommended brief intervention in the acute care setting. Restricting access to lethal means for suicide can prevent suicide. This approach involves assessing whether a patient at risk of suicide has access to a firearm or other lethal means, and then working collaboratively with the patient and their social supports to limit access until they are no longer at elevated risk.

Further details on these and other brief interventions are reviewed in the SPRC video [“How Emergency Departments Can Help Prevent Suicide among At-Risk Patients: Five Brief Interventions.”](#)

## CARING CONTACTS AND CARE TRANSITIONS

Every patient who screens positive for depression or suicidality should receive at least a mental health referral list and psychoeducational material. Outpatient appointments should ideally be scheduled while the patient is still in the acute care setting, and information about the patient’s risk and treatment should be shared with their outpatient providers. There is evidence for the effectiveness of no-demand caring contacts, such as postcards, as a cost-effective means of suicide prevention post discharge.<sup>6</sup> Directly providing (or collaborating with crisis

call centers to provide) follow-up phone calls to assess patients' well-being, conducting safety planning, and ensuring outpatient engagement post discharge can help to prevent further suicidal behavior.<sup>7</sup>

## References

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Visit the Suicide Prevention Resource Center's website at <http://www.sprc.org/micro-learnings/patientsafetyscreener> to view additional resources.