Universal Suicide Screening

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What is a Clinical Pathway?

An evidence-based guideline that decreases unnecessary variation and helps promote safe, effective, and consistent patient care.

Objectives of Pathway

- Identify youth at risk for suicide within our pediatric emergency department
- Improve the safety of youth at risk for suicide
- Connect patients to care if screening positive for suicide risk

Why is Pathway Necessary?

- Suicide is a leading cause of death for youth between 10 and 24 years of age in the United States

- Many youth who later die by suicide had a health care visit within months of their death, which led to the release of the Joint Commission's National Patient Safety Goal (NPSG) 15.01.01.
  - The goal of the NPSG 15.01.01 is to improve the identification of youth at risk for suicide, assess risk level, and improve the quality and safety of care while in healthcare settings

- Expert consensus pathways were created and utilized suicide screening tools appropriate for pediatric settings.

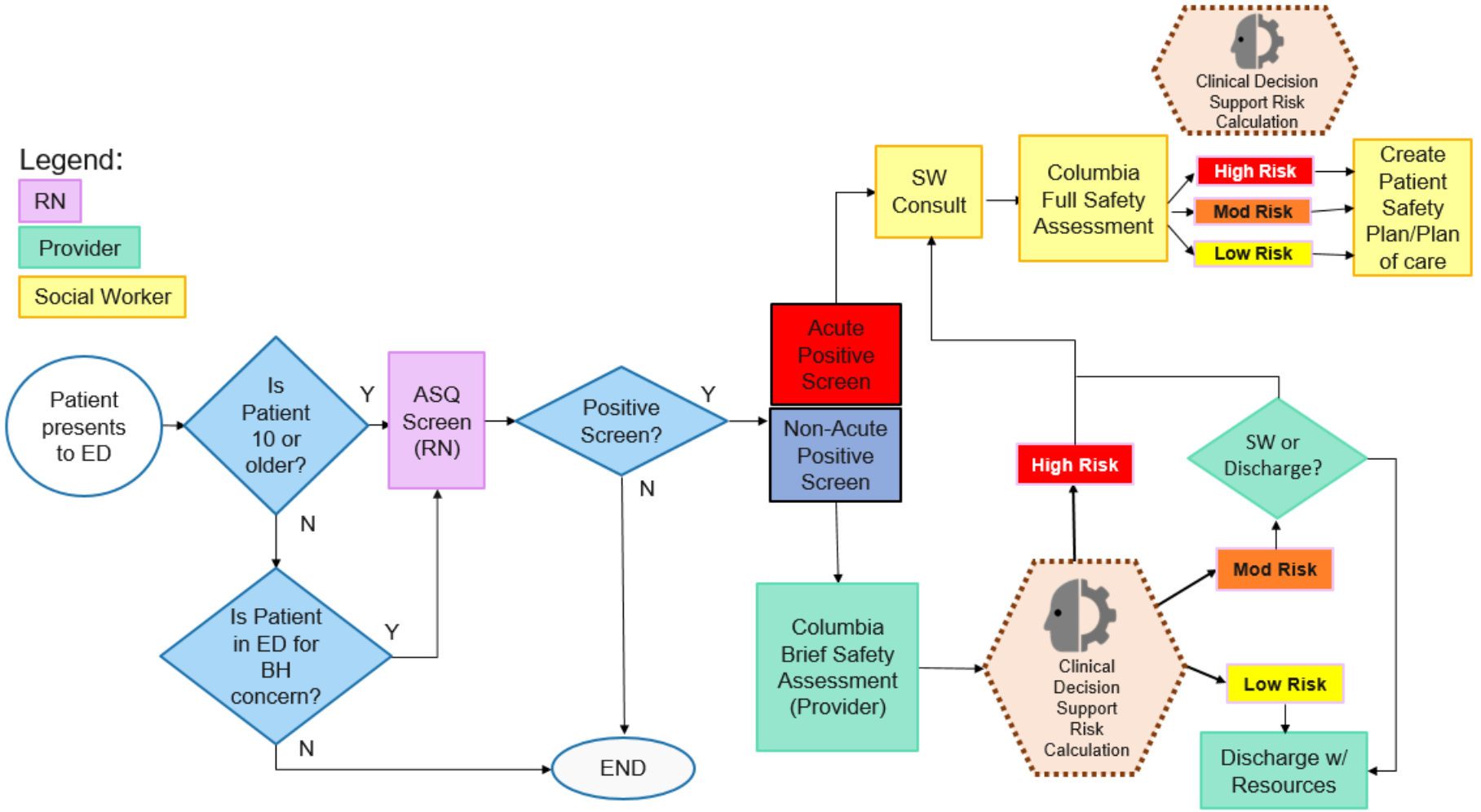
Background

- This standardized pathway was first developed in 2019 in CT Children's ED and utilizes a validated tool, the Ask Suicide-Screening Questions (ASQ)

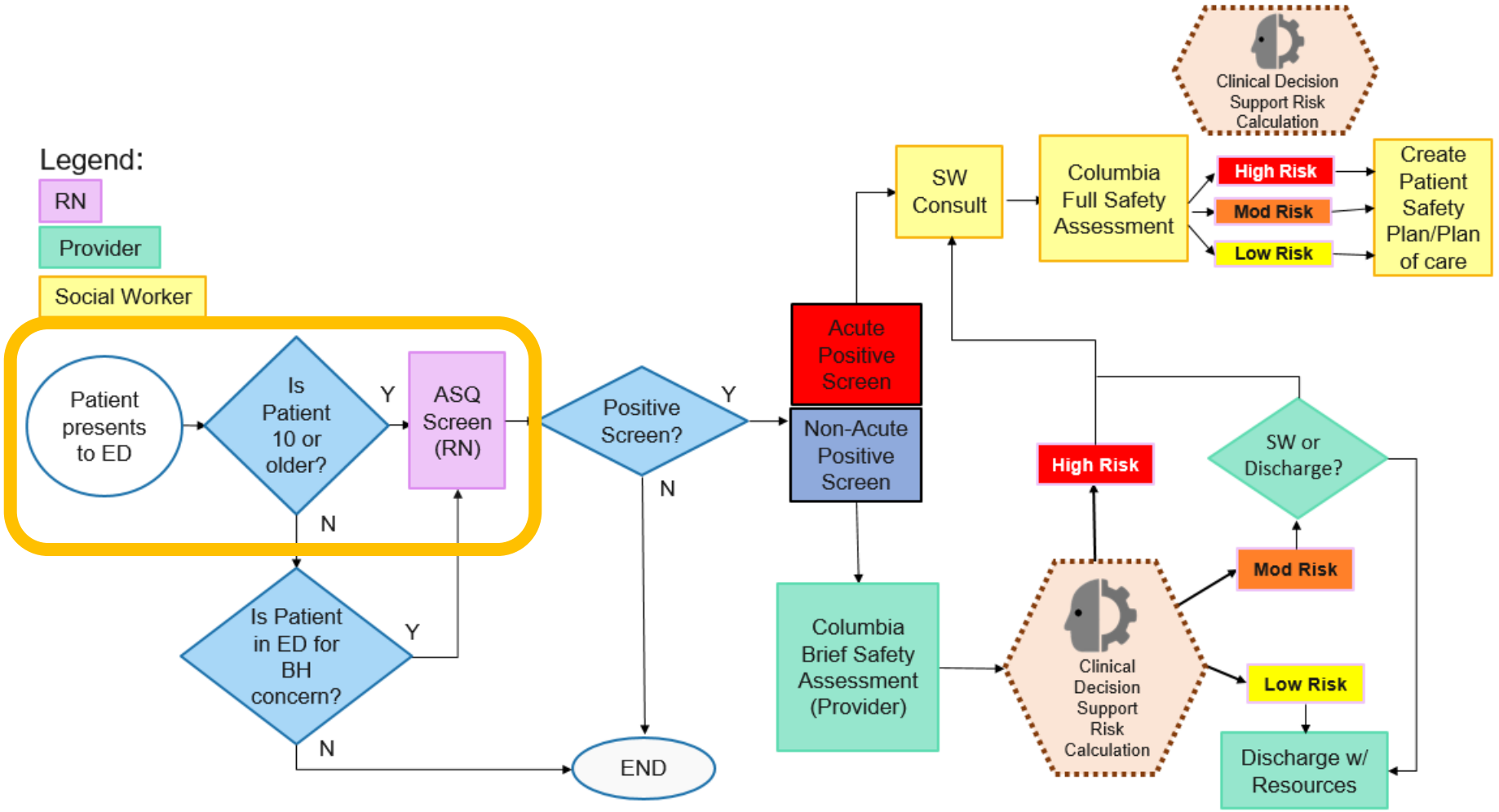
- After undergoing many revisions over the years and in reviewing over 90,000 visits where this screening was utilized, this pathway has identified that approximately 1 in 5 patients who visit our Emergency Department screen positive for risk of suicide

This is the Universal Suicide Screening Clinical Pathway.

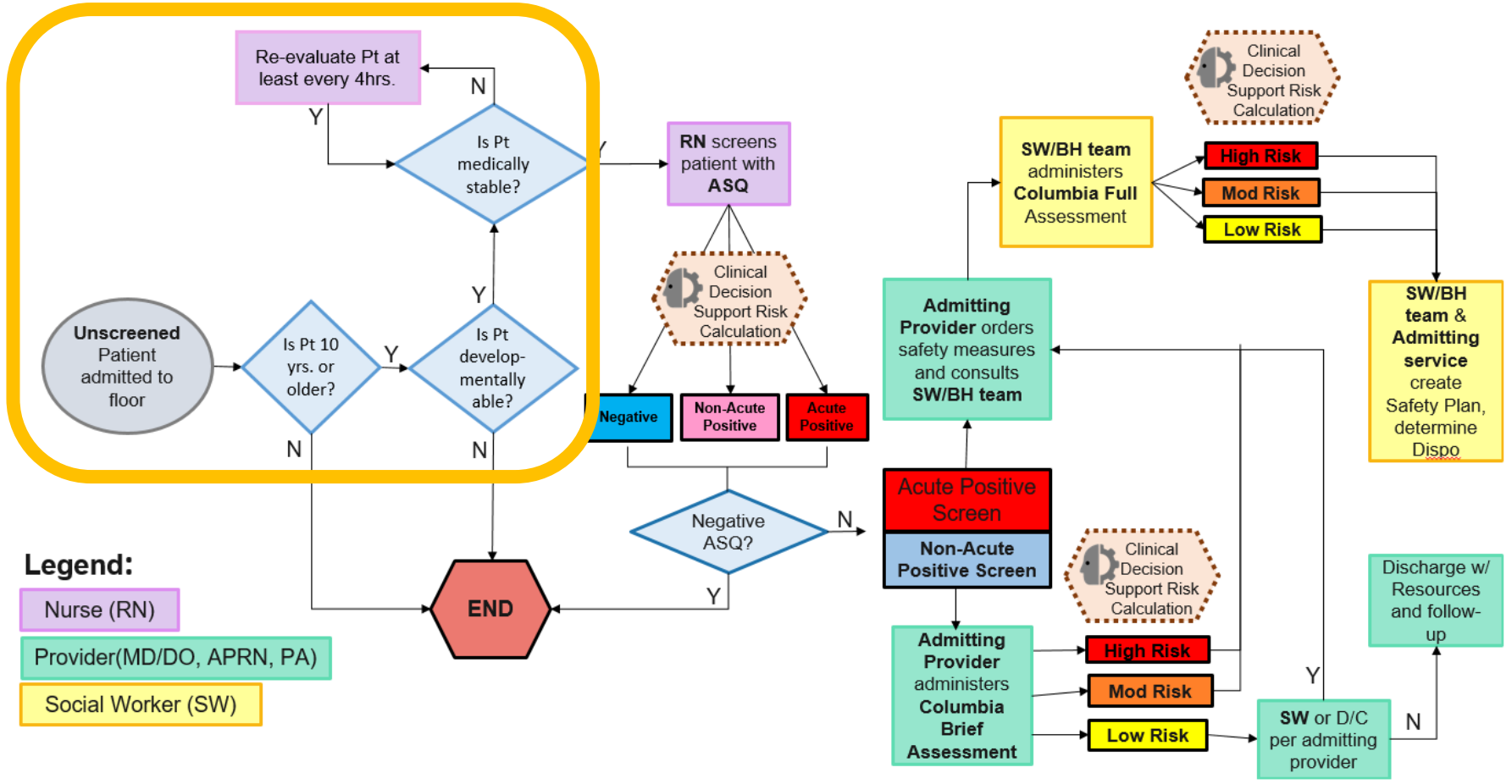
We will be reviewing each component in the following slides.



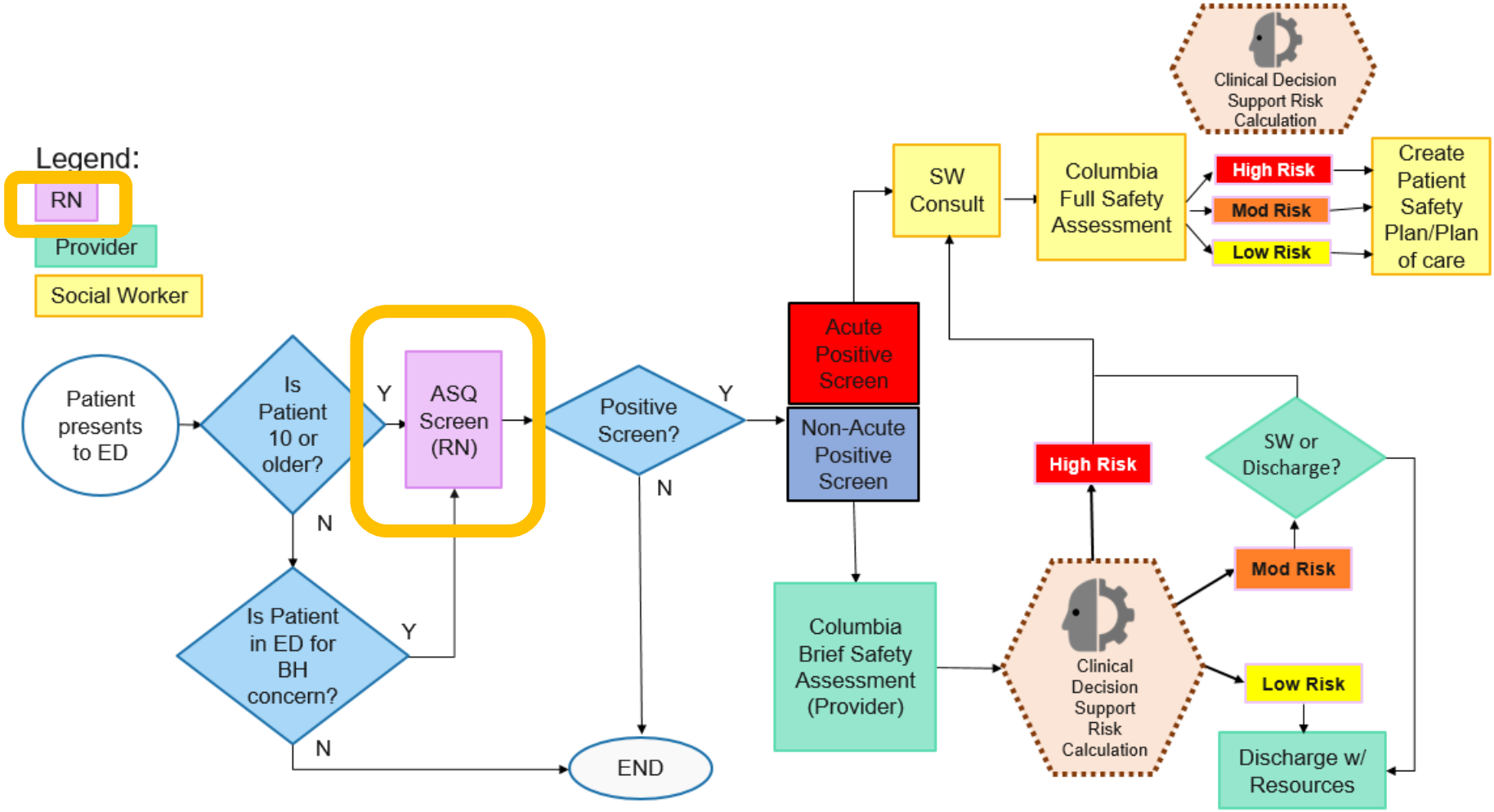
- There are 2 pathways available: emergency department, and med surg floors 6/7.
- For the emergency department, patients are eligible to be screened using the Ask Suicide-Screening Questions (ASQ), if they are age 10 or older, developmentally appropriate and medically stable to answer questions.
    - If the child is medically unstable, re-screen if they become stable.
- Kids under 10 presenting with a behavioral or mental health concern should also be screened if they are developmentally appropriate for the questions.
- Patients that don't fit the criteria are not screened.



- For Med Surg floors 6 and 7, inclusion criteria is slightly different for those patients who are eligible to be screened using the Ask Suicide-Screening Questions (ASQ).
  - If they are age 10 or older, developmentally appropriate and <u>medically stable.</u>
  - If the child is medically unstable, re-evaluate every 4 hrs until they become stable to answer the questions.
- Patients that don't fit the criteria are not screened.



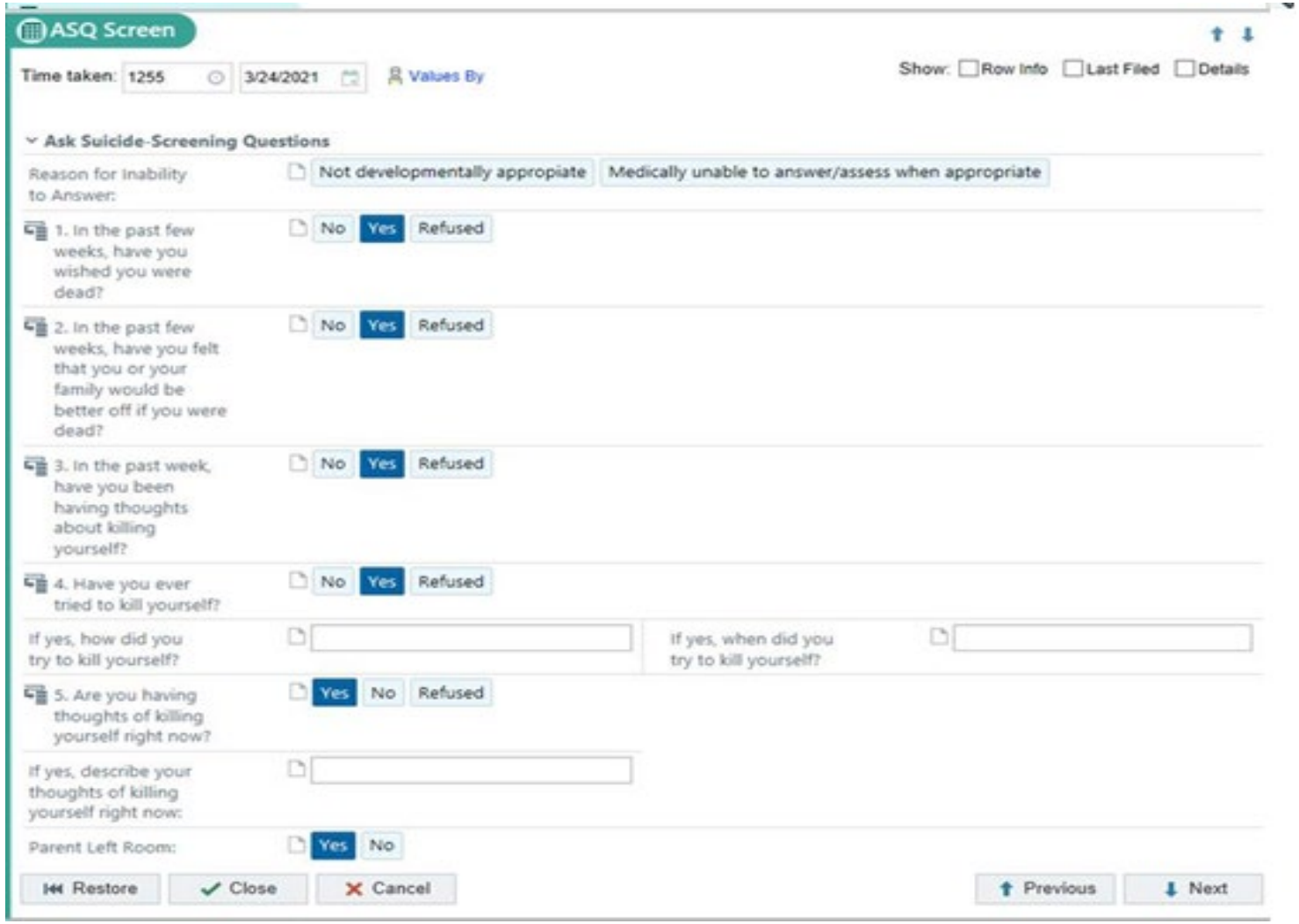
- The ASQ should be asked during the nurse's initial assessment.
- Each question should be read verbatim because the tool has been validated. Some people may find the questions to be unsettling due to their directness. Therefore, it is important to become familiar and comfortable with the questions prior to screening patients.
- *Read each question*



- The ASQ should be asked during the nurse's initial assessment and should happen immediately, while in the patient's room.
  - If the patient answers "**no**" to questions 1 through 4, screening is complete and their result is NEGATIVE. It is not necessary to ask question number 5 and no intervention is necessary.

  - If the patient answers "**yes**" to **any** of questions #1-4, or **refuses to answer** any one of the questions, their result is a positive screen for suicide risk. At this point, the nurse should ask question #5, "Are you having thoughts of killing yourself right now?" This is done in order to assess clinical acuity in the ED. There are two ways to screen positive for suicide risk: **non-acute positive** and **acute positive**.

- Note: If the child answers in a way that, in the clinical judgement of the screener, suggests there is reason for concern, the screener can override a negative screen and request positive screen protocol be followed.

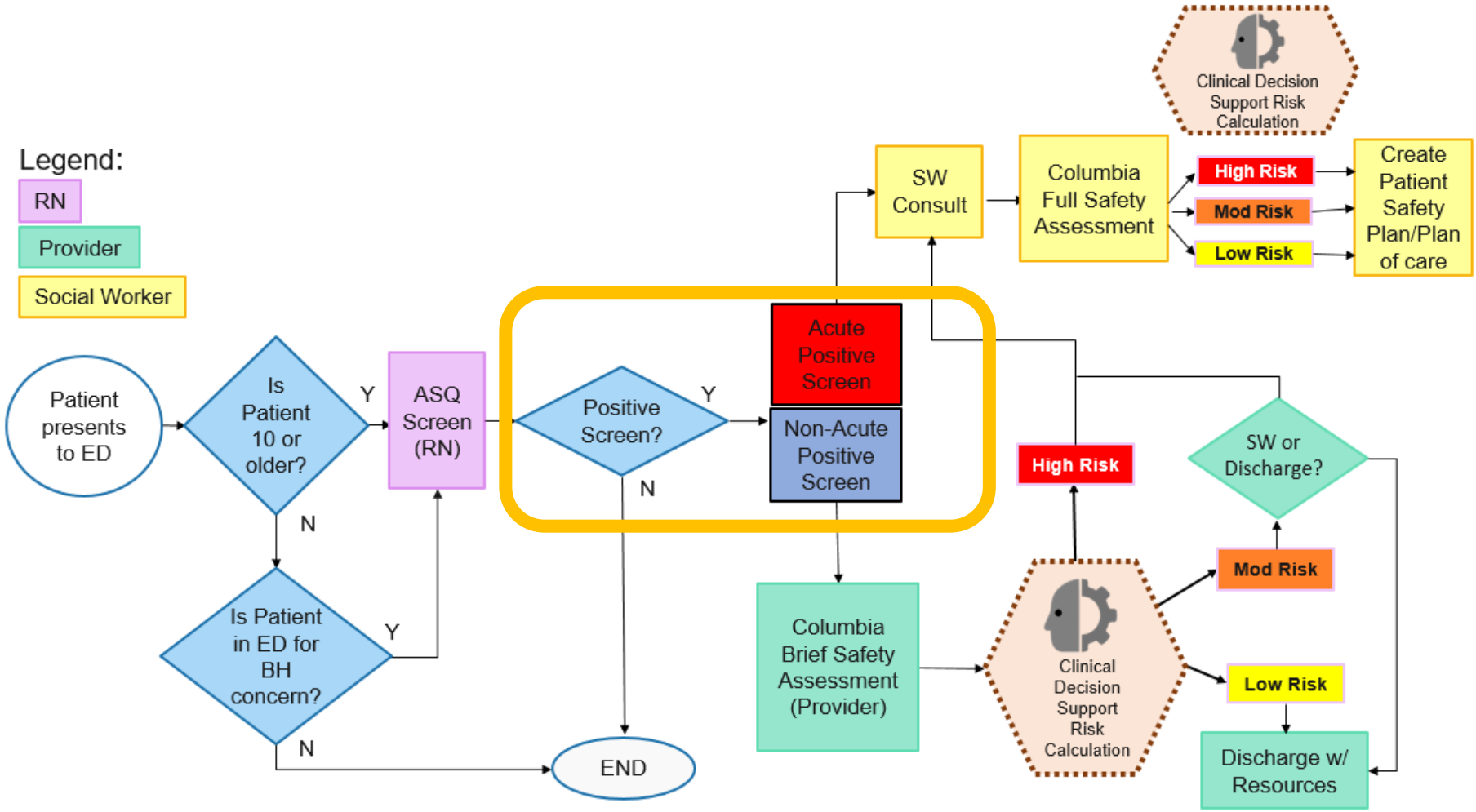


- **Non Acute positive screen**

Medical provider will administer the Columbia **Brief** assessment and determine their level of risk (low, moderate or high). Depending on risk level, the patient may be discharged or may be directed to Social Work for a **Full** Columbia assessment.

- **Acute positive screen**

Ensure patient has 1:1 or constant observation and place consult order for Social Work to administer the **Full** Columbia assessment and evaluate the patient. Patients are having active suicidal thoughts and are considered high risk; therefore, a Columbia **Brief** assessment is **NOT** needed.



Non-Acute positive screen

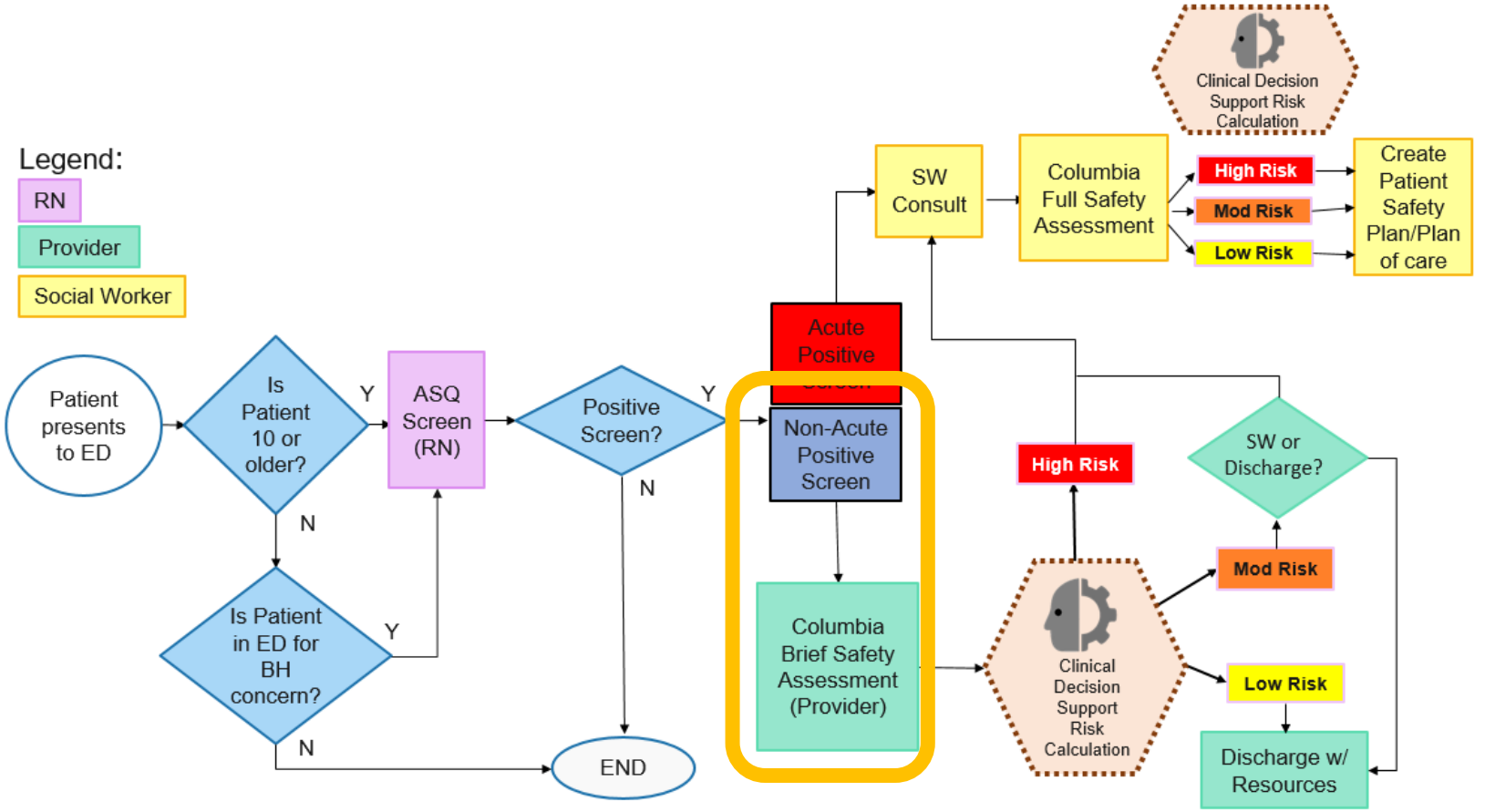
If the patient answers “yes” to any of the questions #1-4, but answers “no” to question #5, they are considered a non-acute positive screen, meaning that *potential* suicide risk has been identified and requires further evaluation.

A **Columbia Brief** safety assessment needs to be conducted by a provider in order to determine whether or not a Social Worker should administer the **Columbia Full** suicide safety assessment.

Nursing will assess what level of observation the patient needs, ranging from 15 minute checks for low risk/acuity to 1:1 observation for high risk/acuity. In rare occasions, 2 sitters are needed to observe 1 patient.

The patient cannot leave the ED until evaluated for safety. If a parent denies or declines further evaluation of safety after screening positive, the attending and medically responsible physicians should be alerted. This matter should be treated according to the same rules of the institution as when a parent/guardian declines what is considered urgent medical care for other life threatening conditions.

Outcomes will never be positive or negative. They indicate a level of risk – low, moderate or high.



Non-Acute Positive/Columbia Brief Outcomes & Actions Needed

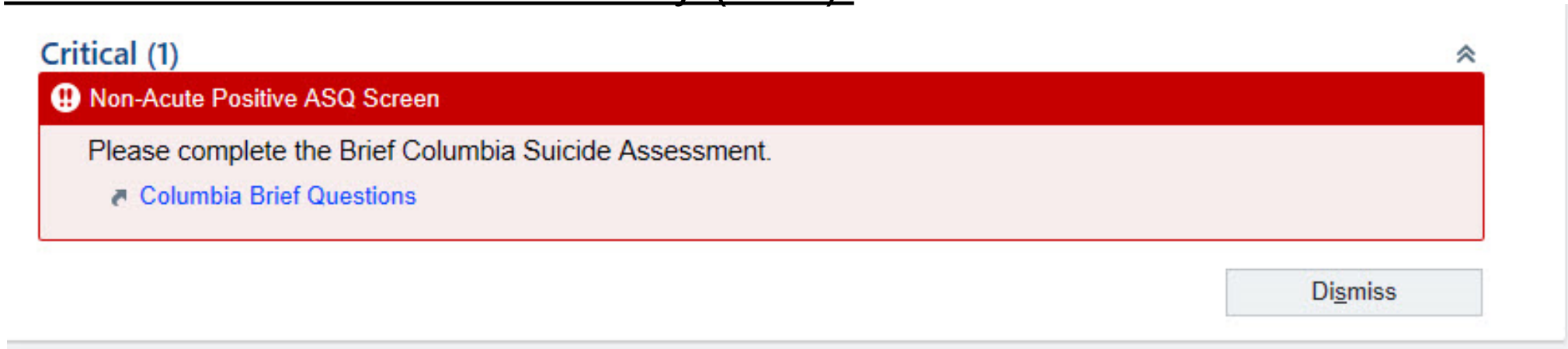
Low Risk: If the provider agrees with the low risk score, it is safe to discharge them home from the ED with appropriate safety planning and referrals. The provider may always request further evaluation if they are unsure of the patient's risk level.

Moderate Risk: Depending on patient acuity, the provider may decide to discharge the patient OR place a consult order for Social Work to administer the Full Columbia suicide assessment for further evaluation.

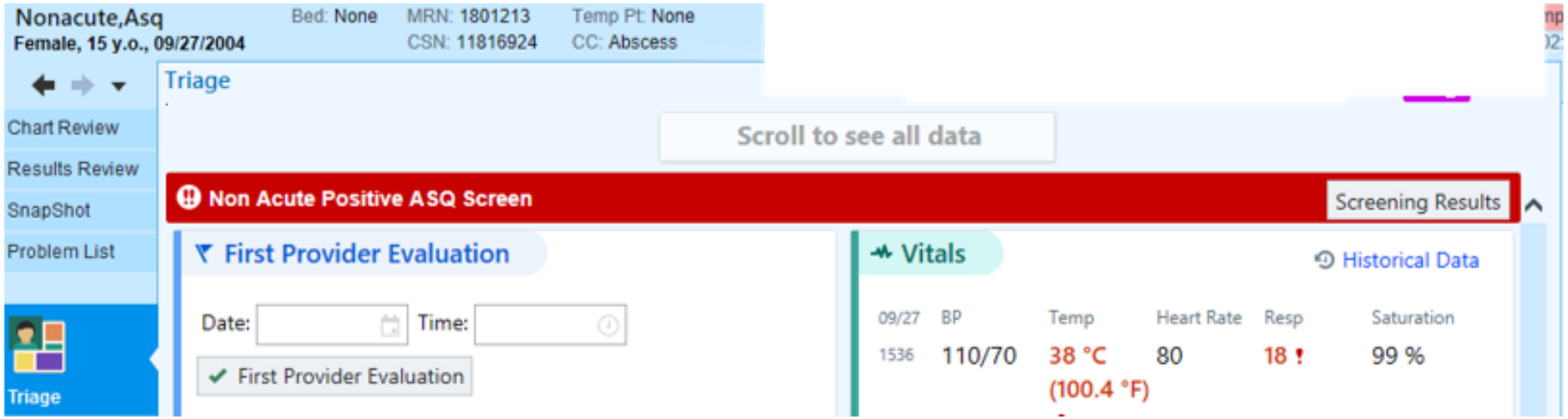
High Risk: The provider will place a consult order for Social Work to administer the Full Columbia suicide assessment.

Non-Acute Positive ASQ Screen - Provider

Provider Best Practice Advisory (BPA):



Provider Banner:

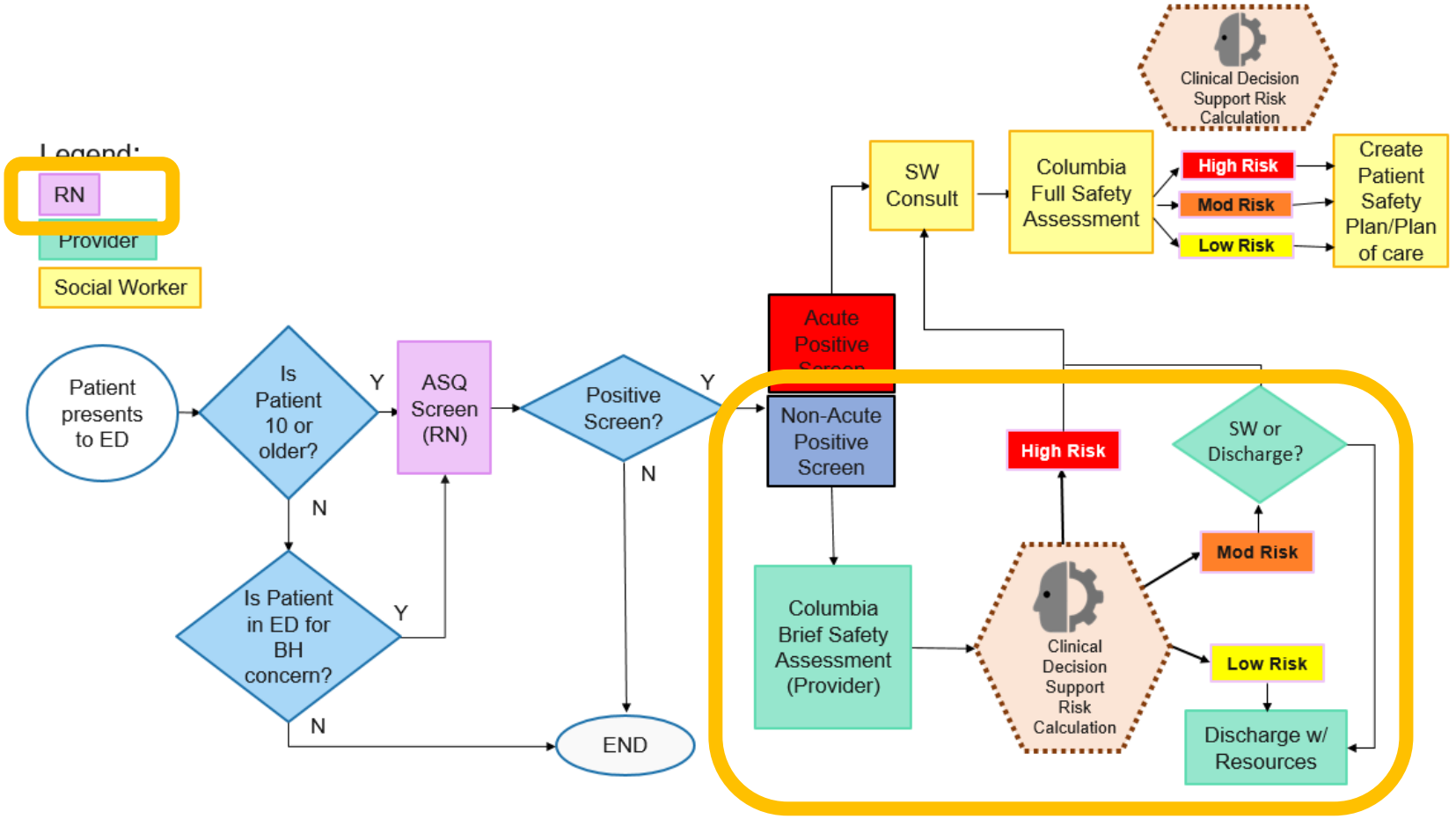


Columbia Brief Suicide Safety Assessment

- The medical provider will explain their role and praise patient for discussing their thoughts will explain to the patient (separate from parent(s)/guardian(s) if possible).
- Details of the information they share are confidential, though you will share any concerns about their safety with their parent(s) or guardian(s).
- Inform them that you will be speaking with the parents separately.

- The medical provider will complete the 6 question Columbia Brief Suicide Assessment which should typically take 10 minutes or less. This is officially referred to as the Columbia Suicide Severity Risk Score or C-SSRS.

- Outcomes will never be positive or negative. They indicate a level of risk.



Columbia Brief Suicide Safety Assessment

- Confirm presence of suicidal ideation by asking Q1 & Q2.
- Preface each question with “in the past month”.
- If patient responds “yes” to either Q1 or Q2, ask questions 3 through 6. If they respond “no” to both Q1 & Q2, ask question 6 next.

Ask questions that are bolded and <u>underlined</u>.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) ***<u>Have you actually had any thoughts of killing yourself?</u>***		

Columbia Brief Suicide Safety Assessment

Assess for suicidal methods, intent, and plan by asking questions 3 through 5. They all assess for active suicidal ideation AND…

- Question 3 reviews methods.
  - Ask the patient, *"In the past month have you been thinking about how you might do this?"*
- Question 4 reviews intent to act.
  - Ask the patient, *"In the past month, have you had these thoughts and had some intention of acting on them?"*
- Question 5 reviews having a specific plan.
  - Ask the patient, *"In the past month, have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?"*

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

Columbia Brief Suicide Safety Assessment

Question 6 assesses for past suicidal behavior.

Suicidal behavior includes:

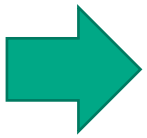
- **Actual attempts**
- **Aborted or self-interrupted attempts**
- **Interrupted attempts**
- **Preparatory acts**

Ask the patient, "*Have you ever done anything, started to do anything, or prepared to do anything to end your life*?" If they answer "yes", ask, "*Was this within the past three months?*"

If they respond "YES" within the past 3 months, the patient scored high risk and will require a full suicide safety evaluation by a mental health professional (LCSW). If the patient is having active thoughts of killing themselves they will also need safety precautions in place.

If they respond "NO" or if behaviors have been longer than 3 months, the patient scored moderate risk and may be safe to discharge home from the ED with appropriate safety planning and referrals or may require or benefit from a full suicide safety evaluation by a mental health professional (LCSW).

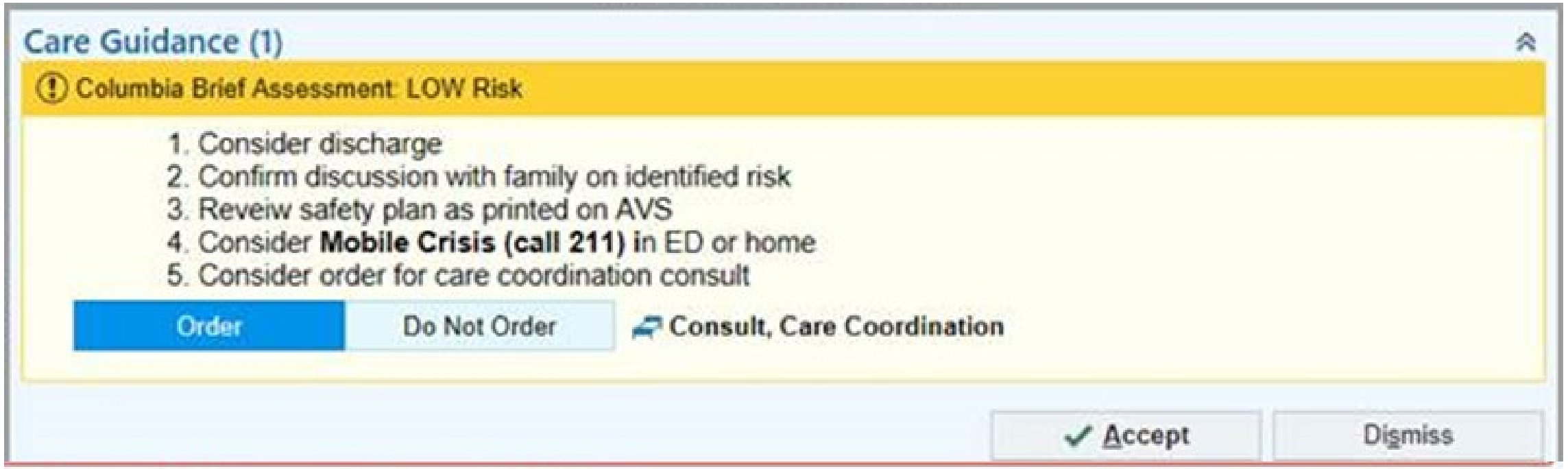
Thank the patient for answering the questions.



6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past three months?***	**Lifetime** **Past 3 Months**

Columbia Brief Suicide Safety Assessment – Low Risk (Provider)

Provider Best Practice Advisory (BPA):



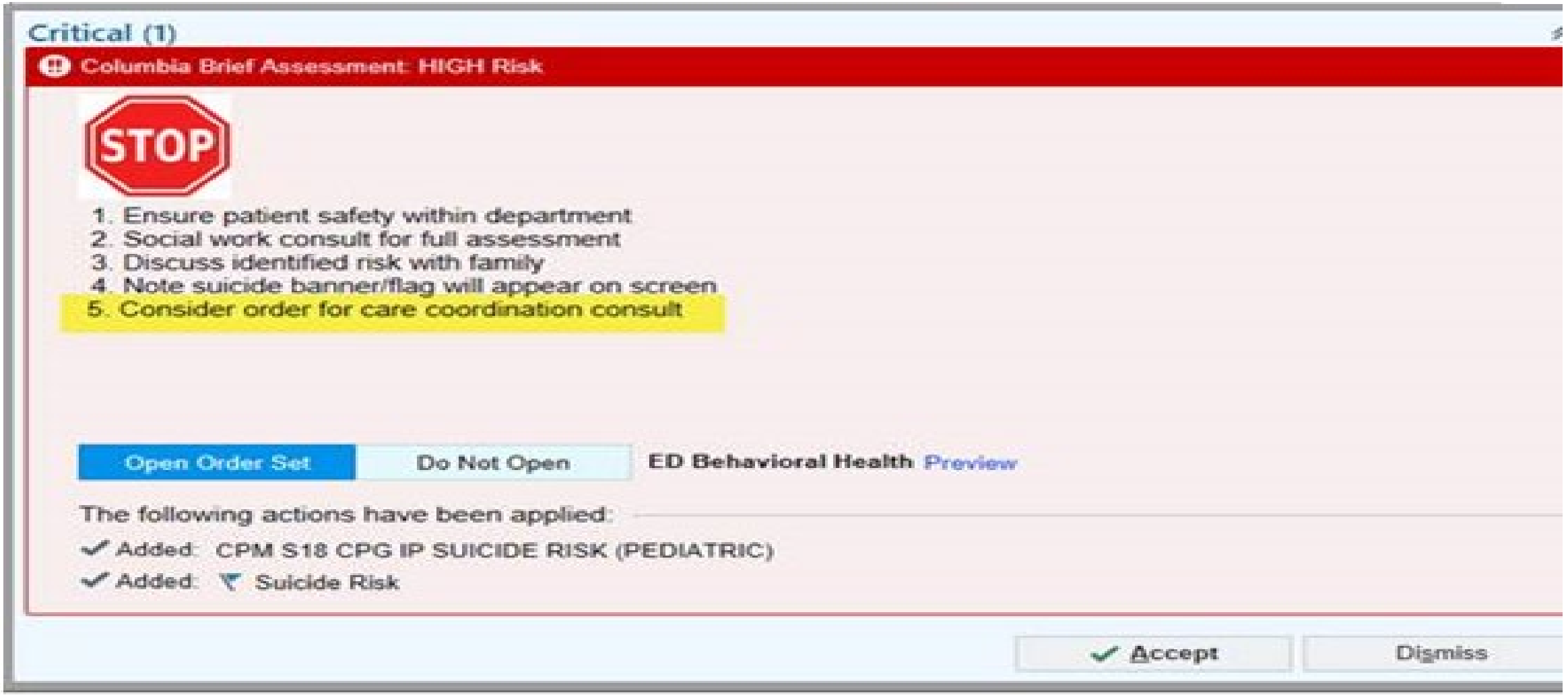
Columbia Brief Assessment – Moderate Risk (Provider)

Provider Best Practice Advisory (BPA):

Columbia Brief Assessment – High Risk (Provider)

Connecticut Children's

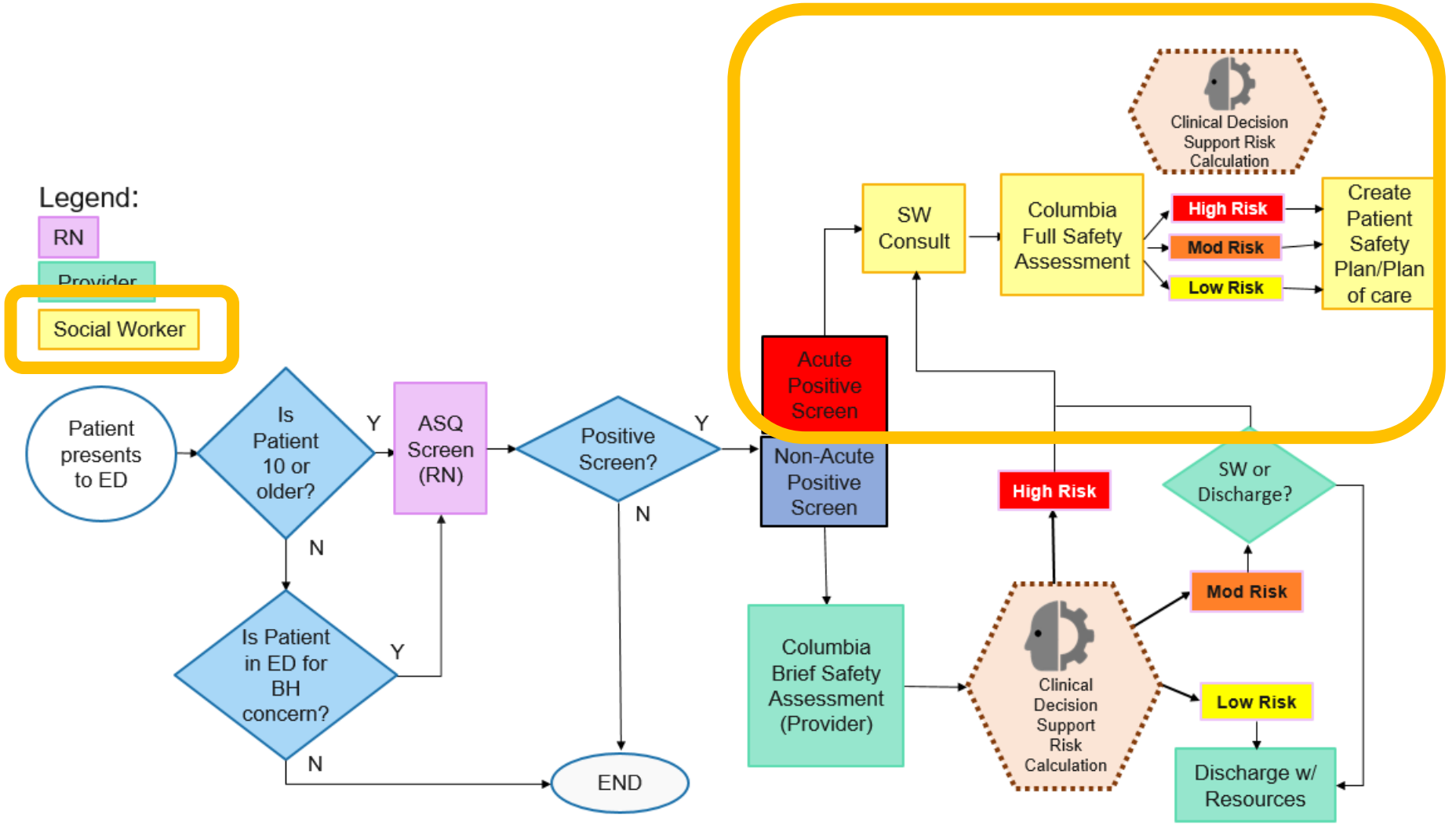
Provider Best Practice Advisory (BPA):



Acute Positive ASQ Screen

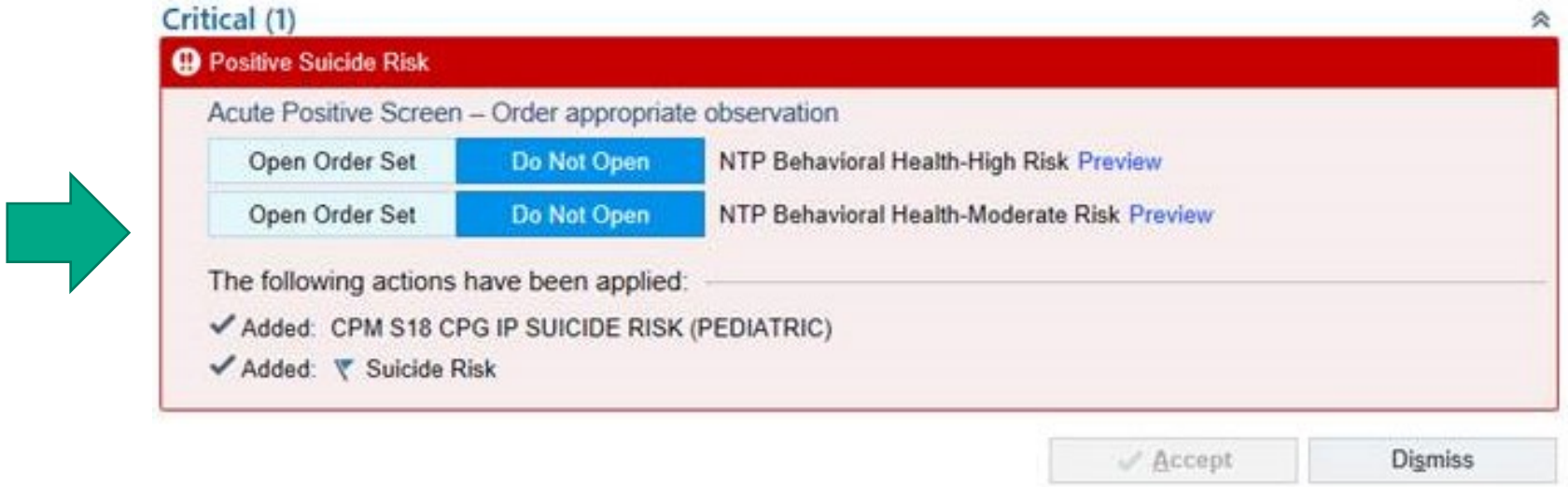
- Patients screening acute positive are currently having *active* thoughts of suicide in the ED and are at high risk for suicide.
- When a patient answers "yes" to question 5 on the ASQ, they are considered to be actively suicidal:

    1) The nurse will receive a BPA with links to observation order sets to ensure proper safety in the ED.
    2) The provider will receive a BPA with a link to place a social work consult that they will select.
    3) Social work will complete a mental health evaluation, including a Columbia Full suicide safety risk assessment.
- Once social work completes the Columbia Full assessment questions in EPIC, a suicide severity risk score will auto populate. Social work will then create a safety plan and a plan of care for the patient.



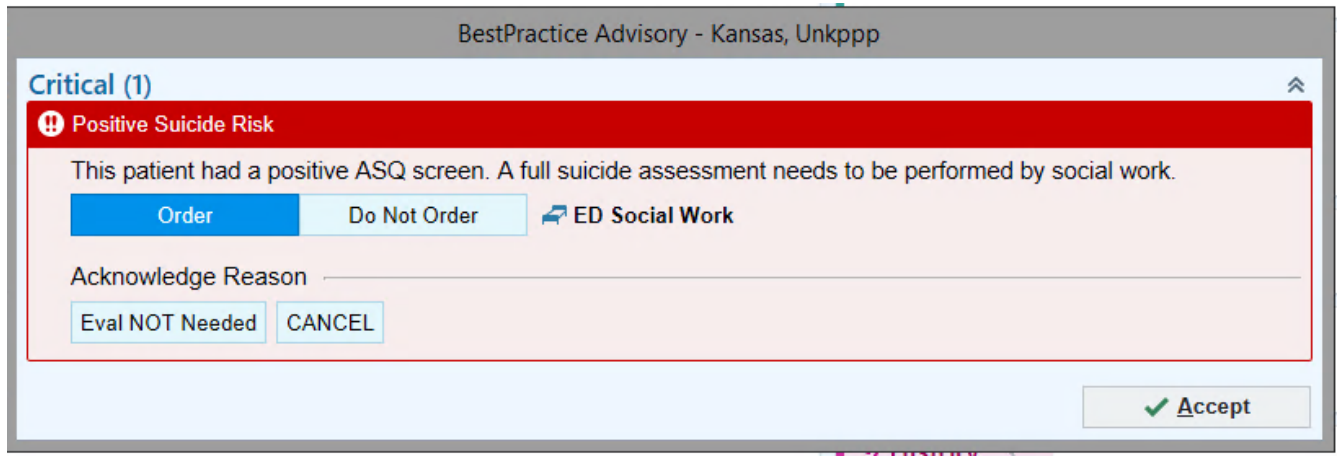
Acute Positive ASQ Screen – NURSING

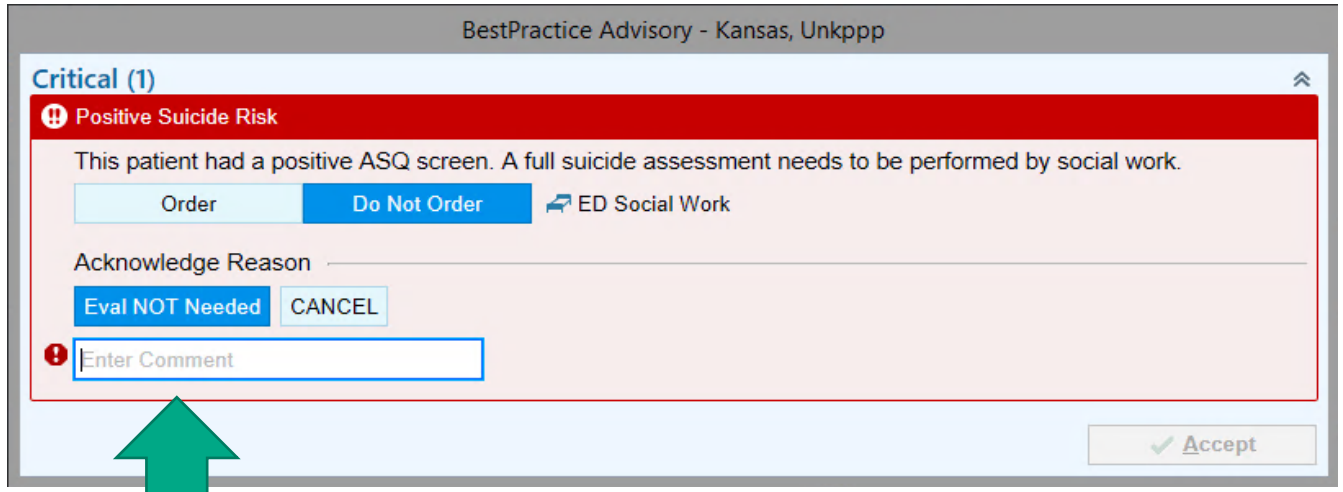
- RN Best Practice Advisory (BPA)
- The nurse will see this BPA with links for observation order sets.



Acute Positive ASQ Screen – PROVIDER
Provider Best Practice Advisory (BPA)

- The medical Provider will see this BPA with a link to place an order for a social work consult.
- As a reminder**, the Columbia brief assessment should not be completed for acute positive ASQ screens.** Inadvertently administering the Columbia Brief could result in downgrading the patient's risk level from high to moderate or low if the child changes their answers. This could prevent us from intervening with a patient that needs support and could potentially result in patient harm.
- **If there is a reason that the provider feels the social work consult is not needed, the provider must provide an explanation in the "acknowledge reason" box.** (Example: patient is arriving from an inpatient psychiatric unit for a medical issue, a consult is not needed if patient returning to an inpatient psychiatric facility.
- **Any deviation** in a mental health evaluation **requires very clear documentation** of why your clinical judgement overrides the workflow.





If **Eval NOT Needed** is selected, a reason must be recorded

Acute Positive ASQ Screen – Social Work

Social Work Best Practice Advisory (BPA)

The mental health professional (Social Worker) will see this BPA and complete a full suicide safety assessment when a patient either has an Acute Positive ASQ screen OR has a High Risk score after answering the Columbia Brief questions asked by the medical provider.

All high risk patients require a full suicide safety assessment to be conducted by a mental health professional (Social Worker).

Full Columbia C-SSRS Interventions (completed by Social Work)

Risk level interventions as a result of calculated risk score

• Low Risk	• Moderate Risk	High Risk
• Consider discharge • Consider referral order for Care Coordination consult • Contact any current providers for handoff • Consider mobile crisis (call 211) for in ED or in Home • Consider Transitions Clinic	• Ensure patient safety within department • Discuss identified safety concerns with family • Consider consultation with Psychiatry vs. Medical Provider • Consider ordering “OBS” in ED or Inpatient • Consider Transitions Clinic • Consider Mobile Crisis (call 211) for in ED or in Home • Consider referral order for care coordination or consult • Dispo. as appropriate	• Ensure patient safety within department • Discuss identified safety concerns with family • Consultation with Psychiatry REQUIRED • Consider ordering “OBS” in ED or Inpatient • Consider Transitions Clinic • Consider Mobile Crisis (call 211) for in ED or in Home • Consider referral order for care coordination or consult • Dispo. as appropriate

After Visit Summary Safety Information

During your visit to the emergency department it was determined that your child may be at increased risk for suicide. To ensure your child's safety the care team at Connecticut Children's would like you and your family to review the following information and/or contact community resources:

1. Keep all sharps, medications (prescription and over the counter), weapons and other lethal means locked and away from the patient at all times. Sharps includes items such as box cutters, exacto knives, razors, etc. Over the Counter medications include items such as cough medicine, Tylenol, ibuprofen and any other item that your child can eat or drink.
2. If your child becomes upset or talks about being unsafe to themselves and/or others contact Mobile Crisis by dialing 211. Option 1 then option 1 again and wait for a crisis worker to help you.
3. If your child is in immediate harm to hurting themselves and/or anyone else, please contact 911 or go to your nearest emergency room.
4. You or your child can contact the suicide text line by texting 741741.
5. You or your child can contact the Suicide Prevention Hotline 1-800-273-TALK (8255).
6. You can contact Connecticut Childrens Care Coordination services for ongoing help with connecting to resources in your community at 860-837-6200. They are open M-F 8am to 4:30pm, closed evenings, weekends and holidays.
7. Below are resources that you can connect with for ongoing support.

Community Health Resources (CHR)
Multiple locations in multiple towns
Intake line 877-884-3571

St Francis Behavioral Health Group
Multiple locations
Hartford and Glastonbury
860-714-2750

Institute of Living
Enhanced Care Clinic (ECC) at 200 Retreat Ave
Hartford CT, 06106
By appointment only
860-545-7239

Team Member Crisis Resources

- National Suicide Prevention Crisis Hotline: 988
- Team member Psychologist
  - TeamPsychologists@connecticutchildrens.org
- Well-Being and Work-Life Program Partner: KGA
  a) Phone: 800-648-9557
  b) Visit my.kgalifeservices.com using company code “ctchildrens”
- The Ears for Peers helpline (1:1 support): 860-837-PEER

Review of Key Points

- Suicide is leading cause of death
- Screening is a feasible way to identify youth at risk for suicide
- Providing at risk youth with mental/behavioral health resources may reduce their risk of dying by suicide and improve their chances of connecting to appropriate therapeutic resources to reduce suffering from thoughts of suicide

Quality Metrics

- Number of patients that require screening
- Percentage of positive ASQs (medical vs mental/behavioral health)
- ASQ screening compliance (medical vs mental/behavioral health)
- Columbia Brief Compliance
- High risk/acute positive seen by Social Work/Psychology

Pathway Contacts

- Steven Rogers, MD, MS → Emergency Department (PEM)
- Kristen Volz-Spessard, MS → Youth Suicide Prevention Center
- Heather Boudle, RN→ Emergency Department (Nurse Team Lead)
- Sarah Orlando, APRN/PA → Emergency Department (PA)
- Isabella LeSage → Acute Care Systems (IS)
- Erin Chandanathil , RN→ Emergency Department (Nurse Manager)
- Erin Boyle, RN→ Behavioral Health, Emergency Department (Nurse Manager)

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Thank You!

About Connecticut Children's Pathways Program

Clinical pathways guide the management of patients to optimize consistent use of evidence-based practice. Clinical pathways have been shown to improve guideline adherence and quality outcomes, while decreasing length of stay and cost. Here at Connecticut Children's, our Clinical Pathways Program aims to deliver evidence-based, high value care to the greatest number of children in a diversity of patient settings. These pathways serve as a guide for providers and do not replace clinical judgment.