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Delaney M. Kjendal

University of New Hampshire, Durham

Kerry Nolte

University of New Hampshire, Durham

Sara Robinson

University of New Hampshire, Durham

Kimberly Force

LRH

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Implementing Universal Suicidality Screening in a Critical-Access Emergency Department

University of New Hampshire, Department of Nursing

Honors Quality Improvement Capstone

Delaney Kjendal, SN

Kimberly Force, BSN, RN

Kerry Nolte, PhD, FNP

Sara Robinson, DNP, PMHNP-BC

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Abstract

Background: Implementation of a universal suicidality screening is considered best practice as it is associated with improved the detection of occult, or latent, suicide risk and can reduce subsequent risk. This quality improvement (QI) project evaluates the implementation of the Columbia-Suicide Severity Rating Scale (C-SSRS) to screen patients over the age of twelve at a regional healthcare system.

Methods: The QI project was conducted at Littleton Regional Healthcare (LRH) emergency department, a critical-access hospital in Littleton, New Hampshire that serves about 206 patients per week. Implementation of suicidality screening was of interest to LRH to promote mental health in the communities they support. The QI project utilized three plan-do-study-act (PDSA) cycles. PDSA cycle one involved monitoring the current use of suicidality screening from January 2023 – February 2023. PDSA cycle two was the implementation of the screening protocol from February 2023 – March 2023. PDSA cycle three was providing staff education from March 2023 – March 2023.

Results: In PDSA cycle one, 11% of patients ($n=66$) were screened out of 585 total. In cycle two, 17% of patients ($n=111$) patients were screened out of 656 total patients. In cycle three, 28% ($n=170$) patients were screened out of 613 total patients.

Conclusion: The PDSA cycles resulted in an increase in universal suicidality screening from 11% to 28% ($t=4.143$, $p<.001$). This demonstrates an increase in the rate of screening; however, further work needs to be done to determine further barriers to implementing universal screening in the emergency department at a higher rate of success. Short-term impacts include early risk identification and early intervention for patients who might not have been identified as an at-risk

person and long-term impacts can include improved detection of occult suicide risk, reduced subsequent risk, streamlined interventions, and decreased cost to the hospital.

Introduction

In the United States of America (US), there are about 187,000 emergency department visits for self-harm in 2020 (CDC, 2023). In the US, suicide is the 11th leading cause of death responsible for 48,183 mortalities in 2021, or about 14.5 deaths per 100,000 population. Of these 26,328 were firearm suicides, 12,431 were suffocation suicides, and 5,568 were poisoning suicides.

The gold standard is to universally screen all patients over the age of twelve years old for suicidal ideation and self-harm (“Screening for Suicide Risk in Clinical Practice,” n.d.). Patients ages eight to eleven should be screened if clinically indicated and no screening is indicated for patients under the age of eight. Universal suicide screening is more comprehensive than targeted screening, or only screening behavioral health patients. Patients who are presenting with behavioral health concerns are at significantly greater risk for suicide; however, patients presenting with other concerns, such as a femur fracture, may have occult mental health concerns that are not being addressed. Ahmedani et al. (2014) found that 83% of patients who completed suicide received health care within one year prior to death, but only 45% of these patients had a mental health diagnosis. About 36% of these visits were emergency department visits without a mental health diagnosis. Universal screening is an important way to promote mental health care and can address bias in care delivery by ensuring all patients over the age of twelve are screened for suicide risk (“Screening for Suicide Risk in Clinical Practice,” n.d.).

The Columbia-Suicide Severity Rating Scale (C-SSRS) is one tool that is available to universally screen patients but also to quantify the severity of both the suicidal ideation and/or behavior. Posner et al. (2014) found that the C-SSRS had correctly identified with 100%

specificity and sensitivity lifetime [actual] attempts. The C-SSRS has previously been utilized successfully to implement universal screening in emergency departments (Syndergaard et al., 2023).

Literature Review

Joint Commission: National Patient Safety Guidelines for Suicide Prevention

The Joint Commission released new National Patient Safety Guidelines for Suicide Prevention to be implemented in all Joint Commission-accredited critical-access facilities by July 1, 2020 ("The Joint Commission," n.d.). These guidelines were published considering the lack of improvement in the national suicide rate since at the time it was the tenth leading cause of death in the United States. These guidelines released by the Joint Commission are important areas of consideration for policy and guidelines to reduce the rates of suicide and self-harm as they are aimed at improving the safety and quality of care for those who are being treated for behavioral health concerns—listing action items that critical-access hospitals can use to help guide them in creating policies and procedures.

Centers for Medicare and Medicaid Services: Recommendations for Mitigating Risks for Patients with Suicidal Ideation

CMS endorses the use of universal screening in the emergency department ("Regulations & Guidance," 2017). Centers for Medicare and Medicaid Services (CMS) state that safe care for patients at risk for intentional harm to themselves or other hospitals must provide education on identifying safety risks; also stating that staff must be provided with appropriate education about the potential signs, how to screen patients, and how to implement appropriate interventions. They also recommend that non-psychiatric units, such as the emergency department, should utilize

appropriate safety measures including continuous visual observation, removal of sharp objects, and any equipment that could be used as a weapon or could pose harm.

Recommended Standard Care Elements

The emergency department can be responsible for identifying suicide risk, carrying out a short-term safety planning intervention for patients who are at risk, referring to specialized care, and providing two caring contacts ("National Action Alliance for Suicide Prevention," n.d.). A caring contact is an approach to suicide prevention that involves someone who has had an interaction with the recipient sending a brief expression of care. Screening with a validated tool should be conducted and then, if risk is found, the patient can proceed with an active referral, in the meantime, the patient might have to be held in a safe environment or a referral to outpatient care may be appropriate. A brief safety planning intervention should be completed and with consent, this should be discussed with friends or family, provided the appropriate permissions are in place. Arrange and confirm removal or reduction of lethal means, if possible. And an appointment with a mental health professional should be scheduled; in addition, a caring contact should reach out to the patient (via call, email, or text) within forty-eight hours and a second caring contact within seven days.

The Columbia-Suicide Severity Rating Scale stratifies patients into triage levels of severity. One guideline recommends that for a high acute risk, the initial action plan should be to maintain direct, and safe, observation of the patient, limit access to lethal means (safe room), and coordinate admission to urgent psychiatric hospitalization ("Actions and Referrals for Various Levels of Risk," n.d.). For intermediate acute risk, the initial action plan should be to refer to a mental health provider for a complete evaluation and intervention, contact the mental health

provider to determine the acuity of the referral, and limit access to lethal means. For an assessment of low acute risk, the initial action plan should include a consultation with a mental health provider to determine the need for referral and treatment, treatment of presenting problem, addressing safety concerns, and documentation of care and rationale.

Figure 1. Care Pathway for Suicidal Ideation

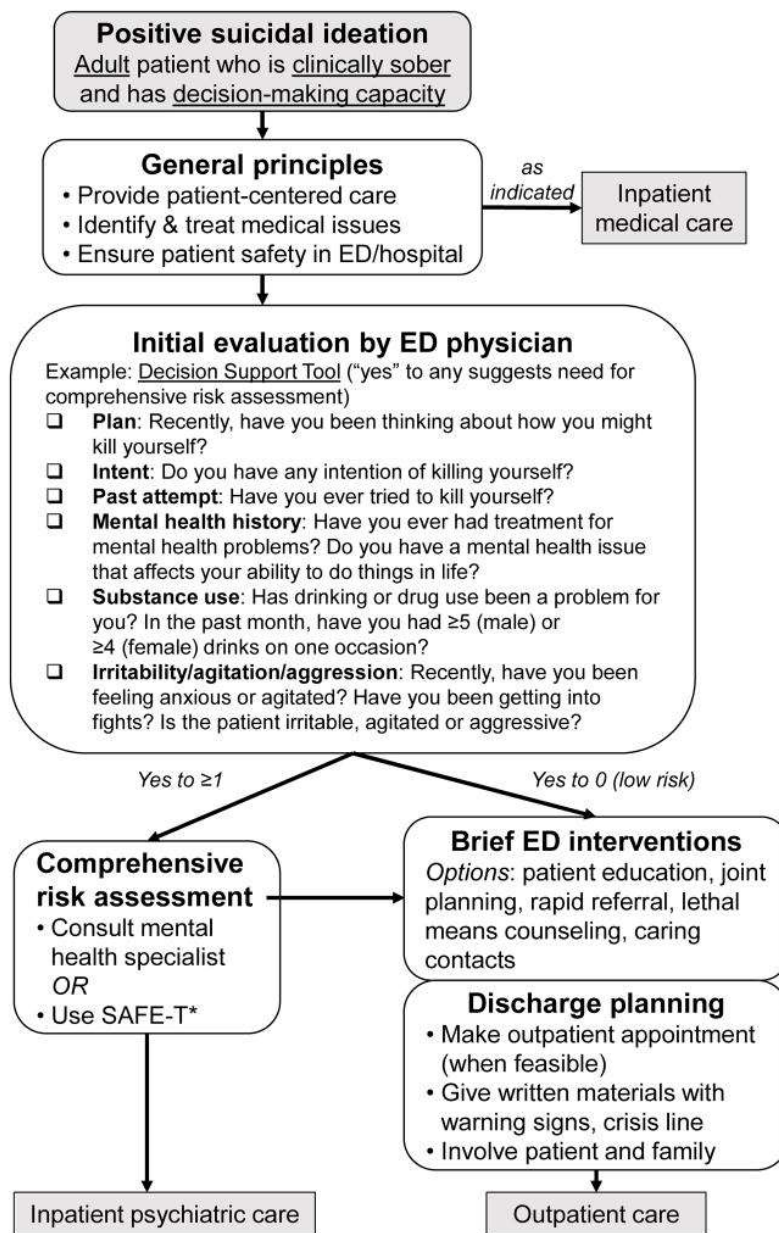


Figure 1. This diagram represents a potential care pathway for the care of patients after suicidal ideation evaluation. This can serve as a general pathway; however, a more detailed and facility-specific policy and procedure should be created for clinical staff to use as a guideline. (Betz & Boudreaux, 2016).

Efficacy of the Columbia-Suicide Severity Rating Scale

A study evaluating the efficacy of the C-SSRS found that it was an appropriate screening tool for the assessment of suicidal ideation and behavior in clinical settings—this was done using three multisite studies (Posner et al., 2014). The results showed good convergent and divergent validity with other multi-informant suicidal ideation and behavior scales, and it demonstrated a high sensitivity and specificity for suicidal behavior and was sensitive to change over time.

Conclusion

Universal suicidality screening for all patients over the age of twelve is the best standard of practice. The Columbia-Suicide Severity Rating Scale is found to be an appropriate screening tool for the assessment of both suicidal ideation and behavior and can quantify the severity and supply appropriate interventions. Thus, focusing on universal suicidality screening for all patients over the age of twelve, using the Columbia-Suicide Severity Rating Scale, is a suitable intervention for critical access hospitals interested in improving screening.

Methods

Design

As a quality improvement (QI) project, this has an implicit study design. Three plan-do-study-act (PDSA) cycles were implemented. The first PDSA cycle (January 25, 2023 to February 14, 2023) was focused on monitoring the current rate of suicidality screening, the second PDSA cycle (February 15, 2023 to March 7, 2023) involved the implementation of the protocol and the effect that it had on the rate of screening (refer to Appendix A), and the third PDSA cycle (March 8, 2023 to March 28, 2023) was the implementation of staff education flyers in the email

and posted on the unit and the effect it had on the rate of screening. After each PDSA cycle, data was collected on the number of patients screened using the protocol and whether they had initially presented for mental health concerns or for other reasons.

Sample and Setting

Littleton Regional Healthcare (LRH) is a critical-access hospital in Littleton, New Hampshire in the White Mountains area which serves about 206 patients per week. The emergency department (ED) is in a unique position to screen patients for mental health concerns which can improve patient outcomes and promote mental health in the populations that the hospital serves. The focus of this quality improvement project is to improve the current rate of universal suicidality screening in the ED at LRH to improve the detection of occult suicide risk and reduce subsequent risk. The sample included any patient twelve or older presenting to the emergency department for any reason.

Data Collection and Analysis

Data was collected using a retrospective chart review collected via the Littleton Regional Healthcare electronic health record by their data expert and was sent over via an encrypted document with identifying data removed. The patients screened presenting with mental health concerns and the patients that were presenting without mental health concerns were initially separated out to account for any discrepancies in the rate of screening as screening is part of the treatment and intervention plan for any patient presenting with mental health concerns in the emergency department.

Descriptive statistics were calculated to review trends and a t-test was conducted to analyze differences between PDSA cycles with a significance level set at $p < .05$.

Results

Table 1 shows descriptive statistics of the number of patients screened, with and without mental health concerns. In PDSA cycle 1, 66 of the 585 patients seen in the emergency department were screened; of the 66 patients screened, 12 presented with mental health (MH) concerns and 54 presented without MH concerns. In cycle 2, 111 of the 656 patients seen in the emergency department were screened; of the 111, 13 presented with MH concerns and 98 presented without MH concerns. In cycle 3, 170 of the 613 patients seen in the emergency department were screened; of the 170 screened, 14 presented with MH concerns and 156 presented without mental health concerns.

Table 1. Number of patients screened with C-SSRS during each PDSA cycle

PDSA CYCLE	Total Patients Screened with C-SSRS n (% of N)	Patients Screened Presenting with MH Concerns n1 (% of n)	Patients Screened Presenting without MH Concerns n2 (% of n)	Total Patients seen in the ED (N)
1	66 (11%)	12 (18.18%)	54 (81.81%)	585
2	111 (17%)	13 (11.71%)	98 (88.29%)	656
3	170 (28%)	14 (8.23%)	156 (91.76%)	613

Figure 2 shows the number of patients screened using the C-SSRS over the three PDSA cycles, while Figure 3 shows the percentage of patients being screened across each PDSA cycle. From PDSA cycle one the baseline rate of screening was determined to be 11%. With the implementation of a screening protocol in PDSA cycle two the rate increased to 17% which shows a 6% increase in the rate of screening. With the implementation of education on how to properly screen patients and the importance of screening patients, that rate further increased to 28% in PDSA cycle three.

Figure 2. Number of Patients Screened Using the C-SSRS over Three PDSA Cycles

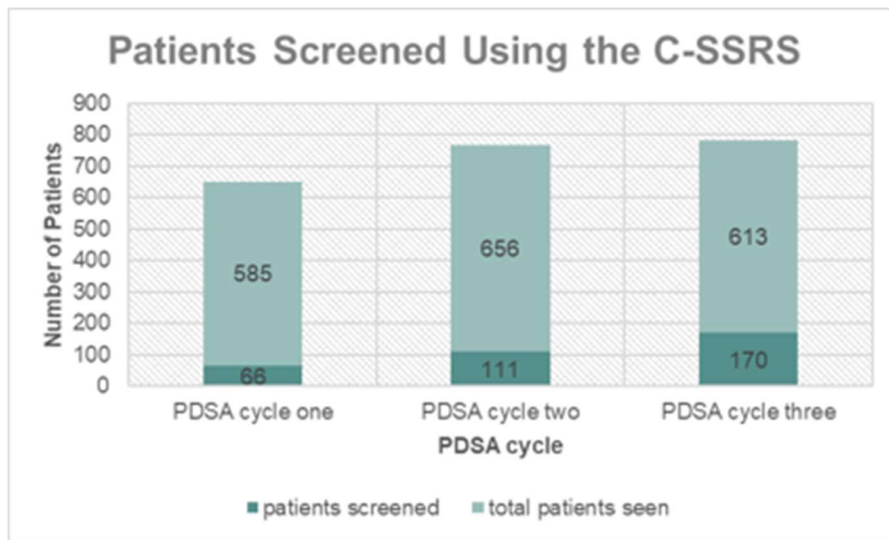
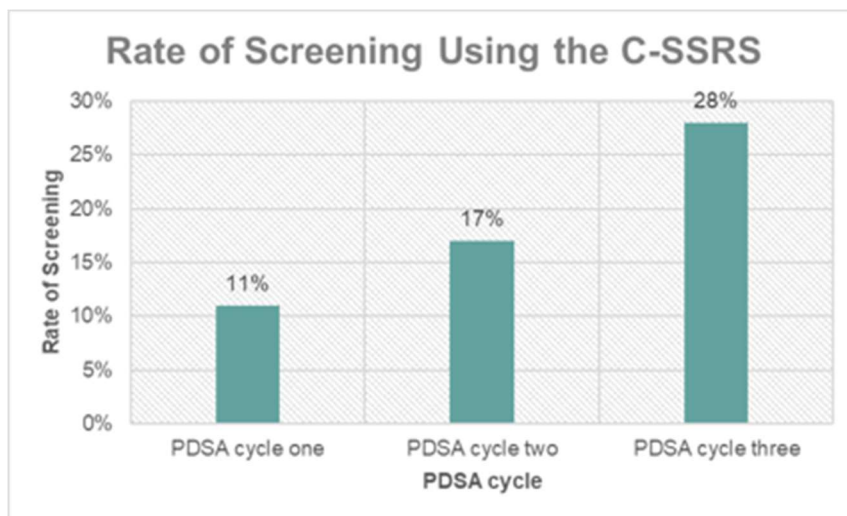


Figure 3. Percentage of Patients Being Screened Across Each PDSA Cycle



The data demonstrated a linear increase in the rate of screening and proved statistically significant ($t = 4.143, p < 0.001$).

Screening patients presenting with mental health concerns for suicide and self-harm in the emergency department is typically part of any assessment and treatment plan. To ensure that

the number of patients presenting with mental health concerns was not resulting in biased results the number of patients screened who presented with mental health concerns and the number of patients screened who did not present with mental health concerns were separated to ensure the data was not disproportionately influenced by this (refer to Figures 4, 5, and 6). However, the number of patients being screened who presented with mental health concerns was relatively stable and only accounted for 18.18% of screenings in the first PDSA cycle, 11.71% of screenings in the second PDSA cycle, and 8.23% of screenings in the third cycle.

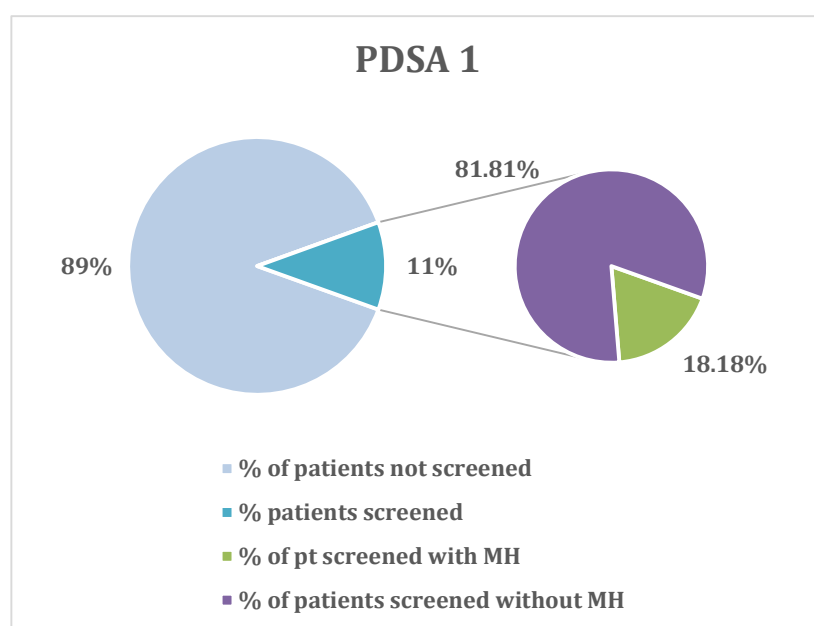
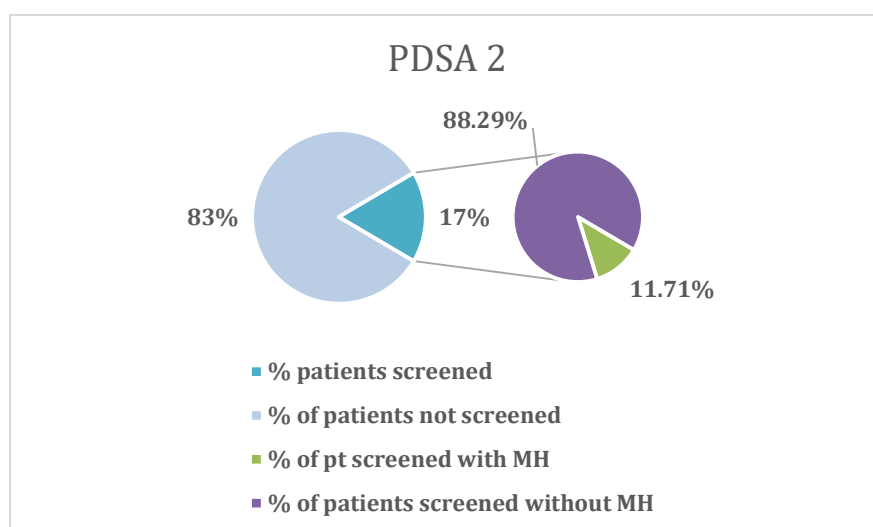


Figure 4. Number of patients screened who presented with mental health concerns versus the number of patients screened who did not present with mental health concerns for PDSA cycle 1

Figure 5. Number of patients screened who presented with mental health concerns versus the number of patients screened who did not present with mental health concerns for PDSA cycle 2



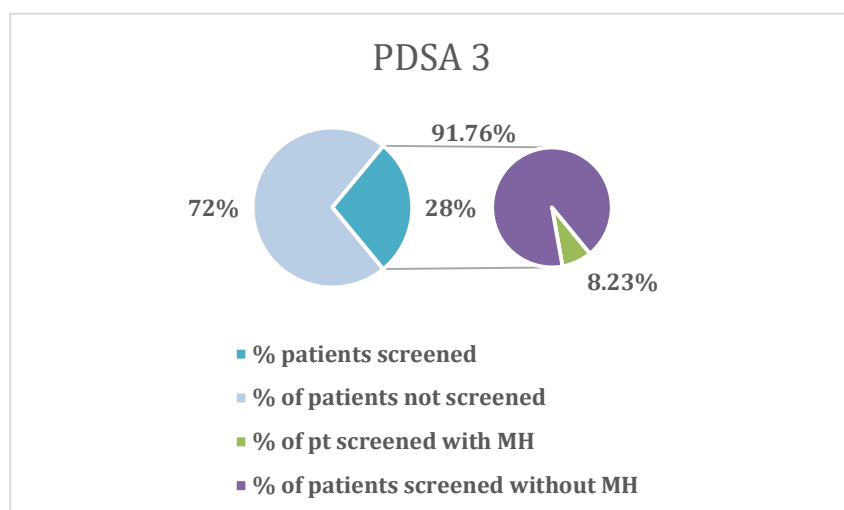


Figure 6. Number of patients screened who presented with mental health concerns versus the number of patients screened who did not present with mental health concerns for PDSA cycle 3

Discussion

The results demonstrate that creating a protocol helped to increase screening rates by 18% from cycle 1 and cycle 3. Providing posted education about the importance of screening and how to effectively use the protocol was helpful as seen by an 11% increase in screening. This promotes patient safety and can allow for early intervention to potentially decrease the risk of self-harm and suicide as well as a reduction in presenting with mental health concerns in the emergency department for the population the Littleton Regional Healthcare serves. Short-term impacts include early risk identification and intervention for patients not previously identified as high-risk. Long-term impacts can include improved detection of occult suicide risk, reduced subsequent risk, streamlined interventions, and decreased cost to the hospital.

This is similar to other studies such as Boudreaux et al. (2016) which evaluated the efficacy of implementing universal suicide screening in the emergency department and implemented three phases—phase one: treatment as usual, phase two: universal screening, and phase three: universal screening and intervention. It showed that documented screenings rose

from 26% to 84% from phase one to phase three and detection of suicidal ideation rose from 2.9% to 5.7% (Boudreaux et al., 2016). Harmston & Reynolds (2022) found a 37% increase in rates of suicidality screening in the emergency department in a rural hospital in Idaho. Although these projects were longer in duration, this project had a lower baseline screening rate at initiation and in three months was able to achieve a 17% increase.

These QI projects involved extensive staff involvement through the formation of quality improvement teams, champions of the project, staff education, and in the case of Boudreaux et al. (2016) on-site trainers. Due to the nature of staffing, a quality improvement team was lacking from this project and it along with proponents on the floor could be implemented in the future.

Limitations

Due to the size of the study, the results from this quality improvement project cannot be generalized to other hospitals. This project only focused on implementing universal suicidality screening in a singular critical-access hospital in New Hampshire for patients over the age of twelve. Thus, providing limitations to be generalized by geographic location, size of the hospital, number of hospitals, and age of patients. An additional limitation was the lack of a quality improvement framework and pre-existing universal suicidality screening protocol.

Some additional factors that might influence the current and future rate of screening might be the percentage of staff members that are contributing to the rate of screening, the percentage of patients presenting with mental health concerns to the emergency department, and the number of patients in the emergency department at any given time combined with the number of incoming traumas and patients in the waiting room.

Future Direction

Further projects on the topic of universal screening in the Littleton Regional Healthcare emergency department can be focused on identifying knowledge gaps in healthcare providers, identifying discontinuities in follow-up care, and identifying barriers to implementing universal screening in the emergency department at a higher rate of success. In addition, studies can be done to look at nurse bias to break down the demographic of patients currently being screened and the number of nurses implementing universal screening. And research needs to be conducted on universal screening in critical-access hospitals, providing resources to these hospitals to do so, and providing follow-up care or providing access to follow-up care.

Conclusion

Implementing universal suicidality screening at Littleton Regional Healthcare required multiple steps. The electronic health record already had a location to chart the results of the Columbia-Suicide Severity Rating Scale. This QI demonstrated a significant increase in the rate of screening; however, further work needs to be done on universal screening in the emergency department and providing resources. Providing resources is something that might be more difficult to achieve; however, to further improve the rate of universal screening an intervention such as a hard-stop pop-up to screen for non-emergent patients could be implemented and a qualitative study on the perceived barriers of the staff could also generate other necessary interventions.

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Appendix A: Protocol for Universal Screening in LHR ED

I. PURPOSE

Implementing universal screening throughout the hospital can improve patient outcomes and promote mental health in the populations that the hospital serves.

II. POLICY

It is the policy of Littleton Regional Healthcare to screen all patients over the age of twelve for suicidal ideation in the emergency department.

III. DEFINITIONS

A. UNIVERSAL SCREENING: Using a brief, standardized, evidence-based tool to screen every patient for suicidal ideation or risk at every encounter whether or not the patient is seeking care based on psychiatric symptoms.

B. SAFETY PRECAUTIONS: Includes interventions such as one-to-one monitoring, removing objects that pose a risk for self-harm if they do not affect the patient's medical care, inspecting objects brought in by visitors to high-risk patients, and using safe transportation.

- (1) If possible ERDA 2 or ED 5.
- (2) Implement one-to-one monitoring.
- (3) Objects that pose a risk for self-harm should be removed if they do not affect patient care.
- (4) Objects

brought in by visitors to high-risk patients should be inspected. (5) Safe transportation should be utilized.

C. THE COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS): A scale used to determine suicidal ideation and behavior and severity rating made by researchers at Columbia University, University of Pennsylvania, University of Pittsburgh, and New York University to evaluate risk.

IV. PROCEDURE

1. All patients over the age of twelve will be screened using the C-SSRS during every emergency department encounter regardless of whether or not they are seeking care for psychiatric symptoms.
2. Clinical judgment can be used for when to implement safety precautions regardless of any answers to the questions.

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Emergency Department Screen Version with Triage Points

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past month	
	YES	NO
Ask questions that are in bold and underlined.		
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? <u><i>Have you wished you were dead or wished you could go to sleep and not wake up?</i></u>		

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past month	
	YES	NO
Ask questions that are in bold and underlined.		
Ask Questions 1 and 2		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, " <i>I've thought about killing myself</i> " without general thoughts of ways to kill oneself/associated methods, intent, or plan." <u>Have you had any actual thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. " <i>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.</i> " <u>Have you been thinking about how you might do this?</u>		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as oppose to " <i>I have the thoughts but I definitely will not do anything about them.</i> " <u>Have you had these thoughts and had some intention of acting on them?</u>		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>		
6) Suicide Behavior Question <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> 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: <u>Was this within the past 3 months?</u>	Lifetime	
		Past 3 Months

Response Protocol to C-SSRS Screening (Linked to last item marked "YES")

Item 1 Behavioral Health Referral at Discharge

Item 2 Behavioral Health Referral at Discharge

Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions

Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions

Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

- Disposition: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
- Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Behavioral Health Referral at Discharge

3. If a patient is a low (or no) risk (yes to questions 1 and 2; no to questions 3, 4, 5, and 6) they should receive a behavioral health referral at discharge.

4. If a patient is a moderate risk (yes to questions 3 and 6 if more than 3 months; no to questions 4 and 5) they should have a behavioral health consult (social worker during the day shift or virtual consult with White Mountain Mental Health during the night shift) and consider safety precautions.

- a. This indicates there is no imminent threat or concern and it is the patient's right to choose care.
- b. However the screening might not be accurate if the patient is an unreliable narrator, the collateral informant's account does not corroborate the patient's account, historical data is available about the patient's state of mind or low reliability, the patient's behavior and observed affect do not match the patient's statements. If this is the case then clinical judgment can be used for what to triage the severity as.

5. If a patient is a high risk (yes to questions 4, 5, and 6 within the last 3 months) then the patient should be considered an involuntary emergency admission

(<https://www.courts.nh.gov/sites/g/files/ehbemt471/files/documents/2021-04/nhjb-2826-d.pdf>),

safety precautions should be implemented, and a full behavioral health assessment/safety evaluation should be conducted.

