

Provider Suicide Assessment & Orders

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Provider Suicide Assessment & Orders

BJC/Washu has implemented a new suicide provider assessment and orders that will go into affect Aug. 15th for the ED and non-psychiatric inpatient areas. See below for new information pertaining to the Provider Suicide Assessment and Suicide Orders.

Suicide Assessment using SAFE-T

The RN will complete a screening upon patient arrival or admission and notify if the patient is to be found at risk for suicide. If the screening determined the patient to be at a moderate- high risk or high- risk for suicide, the patient must be evaluated by a provider or Qualified Mental Health Professional (QMHP) to determine the overall risk level for suicide and to determine an appropriate plan of care to mitigate the risk.

Patients that screen and low or moderate- low risk for suicide may need provider level intervention, but do not require the suicide assessment below.

1. In **Notes** activity, select Progress and click **New Note**.
2. In the **Insert SmartText** field, type Suicide, CSSRS or Safe T.
3. Select **BW IP SAFE-T CSSRS Provider Assessment** and click **Accept**.

SmartText Lookup

safe t

Matches

- ☆ ED PROVIDER SUICIDE...
- ☆ BW IP SAFE-T CSSRS P...

Preview

SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) - Recent

Step 1: Identify Risk Factors:

Columbia Suicide Severity Rating Scale (Recent Screener)	Initial Screening:	Reassessment (as needed):
Is this encounter related to a suicidal attempt/behavior?	No	{encounter related (Optional):37835}
Information obtained from:		{info obtained from (Optional):37836}

Favorites Only

4. The note opens and the provider completes their documentation. *Press F2 on your keyboard to navigate through the note.*

Before you start, let's go over a few sections:

Identify Risk Factors:

- The information noted in the Initial Screening comes from data compiled from the nursing flowsheet documentation. The second column allows the provider to do a reassessment if needed.

SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) - Recent

Step 1: Identify Risk Factors:

<u>Columbia Suicide Severity Rating Scale (Recent Screener)</u>	Initial Screening:	Reassessment (as needed):
Is this encounter related to a suicidal attempt/behavior?	No	{encounter related (Optional):37835}
Information obtained from:		{info obtained from (Optional):37836}
1. In the past month, have you wished you were dead or that you could go to sleep and not wake up?	Yes	{wished you were dead (Optional):37837}
2. In the past month, have you actually had any thoughts of killing yourself?	Yes	{thoughts of killing yourself (Optional):37838}
3. In the past month, have you been thinking about how you might kill yourself?	No	{how you might kill yourself (Optional):37839}
4. In the past month, have you had these thoughts and had some intention of acting on them?	No	{intention of acting (Optional):37840}
5. In the past month, have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?	Yes	{worked out details (Optional):37841}
6. In the past month, have you ever done anything, started to do anything, or prepared to do anything to end your life?	No	{done anything (Optional):37842}
6b. Was this within the past three months?		{past 3 months (Optional):37843}
Suicide Risk Level:	High	N/A

Activating Events: {activating events:37728}

Specific Questioning about Thoughts, Plans, and Suicidal Intent:

- This section contains numbered SmartList options. Once you have completed this assessment, tally the numbers and type in the total in the last row titled: **Total Suicidal Ideation Intensity Score**.

Step 3: Specific Questioning about Thoughts, Plans, and Suicidal Intent (see Step 1 for Ideation Severity and Behavior):	
C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	Month
Frequency <i>In the past month, how many times have you had these thoughts?</i>	{frequency:37748}
Duration <i>When you have the thoughts how long do they last?</i>	{duration:37749}
Controllability <i>Could/can you stop thinking about killing yourself or wanting to die if you want to?</i>	{controllability:37750}
Deterrents <i>Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?</i>	{deterrents:37751}
Reasons for Ideation <i>What sort of reasons did you have for thinking about wanting to die or killing yourself?</i> <i>Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?</i>	{reasons:37752}
Total Suicidal Ideation Intensity Score* (add values of selected answers above) *Score can range from 2- 25: -Low: 2-5 -Moderate: 6-10 -Moderately Severe: 11-15 -Severe: 16-20 -Very Severe: 21-25	***

Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level:

- Use this chart to determine risk level and interventions to lower risk level.

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level:

Assessment of risk level is based on **clinical judgment** after completing steps 1-3.

The Suicide Ideation Intensity Score does not directly correlate to Suicide Risk.

The Suicide Ideation Intensity score must be used in conjunction with clinical judgment to determine risk stratification.

Initial Risk Stratification	Suggested Interventions
<p style="text-align: center;"><u>High Suicide Risk</u></p> <p>Suicidal ideation with intent or intent with plan <u>in past month</u> (C-SSRS Suicidal Ideation #4 or #5)</p> <p style="text-align: center;">OR</p> <p>Suicidal behavior <u>within past 3 months</u> (C-SSRS Suicidal Behavior)</p>	<p>High Suicide Precautions</p> <ul style="list-style-type: none"> • 1:1 observation • All belongings secured • Hospital attire • Elopement precautions • Minimize environment risk in room
<p style="text-align: center;"><u>Moderate-High Suicide Risk</u></p> <p>Suicidal ideation with method <u>WITHOUT plan, intent or behavior in past month</u> (C-SSRS Suicidal Ideation #3)</p> <p style="text-align: center;">OR</p> <p>Multiple risk factors and few protective factors</p>	<p>Moderate-High Suicide Precautions</p> <ul style="list-style-type: none"> • Patient sitter not required • May keep items evaluated as safe, other belongings secured • Hospital attire • Minimize environment risk in room
<p style="text-align: center;"><u>Moderate-Low Suicide Risk</u></p> <p>Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime)</p> <p style="text-align: center;">OR</p> <p>Multiple risk factors and few protective factors</p>	<p>Moderate-Low Suicide Precautions</p> <ul style="list-style-type: none"> • Resources given to patient • Nursing handoff precautions
<p style="text-align: center;"><u>Low Suicide Risk</u></p> <p>Wish to die or Suicidal Ideation <u>WITHOUT method, intent, plan or behavior</u> (C-SSRS Suicidal Ideation #1 or #2)</p> <p style="text-align: center;">OR</p> <p>Modifiable risk factors and strong protective factors</p> <p style="text-align: center;">OR</p> <p>No reported history of Suicidal Ideation or Behavior</p>	<p>Low Suicide Precautions</p> <ul style="list-style-type: none"> • Resources given to patient

Assessment and Plan:

- Agree or update the Risk Level based on the completed assessment.

Step 5: Assessment and Plan:

Updated Risk Level: {risk level:37753}

Rationale for risk level decision and actions taken: ***

If the selected updated risk level does not match the current risk level, A BPA will trigger to instruct the provider to place a new suicide precaution order as seen below:

Suicide Orders

!
Please complete the suicide assessment prior to placing the suicide orders

There are four types of suicide orders to choose from:

- Low
- Moderate-Low
- Moderate-High
- High

The RN may have already entered a suicide precautions order upon screening. They have been instructed that only a provider may modify or discontinue those orders.

1. In **Orders** activity, search **Suicide**.
2. Select **Suicide Precaution Orders – Low, Moderate-low, Moderate-High, and High** Order Set and click **Accept**.

Order and Order Set Search

SUICIDE

Order Sets & Panels

Name	User Version Name	Type
SUICIDE PRECAUTION		Order Panel
Suicide Precaution Orders - Low, Moderate-low, Moderate-High, and High		Order Set
Toxicology - Inpatient		Order Set

Medications (No results found)

Procedures (Click to expand)

Select And Stay **Accept** Cancel

The orderset opens:

Order Sets

Orders

Suicide Precaution Orders - Low, Moderate-low, Moderate-High, and High

Please select the appropriate level of suicide precautions from this order set, and any additional orders that are necessary with that level of precaution.

BJC Core Suicide & Non-Suicide Self-Injurious Minimal Interventions included in stratified risk level precautions

	Low Suicide Precautions	Moderate-Low	Moderate-High Suicide Precautions	High Risk Suicide Precautions	Low Risk Non-Suicidal Self-Injurious Precautions	High-Risk Non-Suicidal Self-Injurious Precautions
Provider Notification	X	X	X	X	X	X
Patients/ caregiver education	X	X	X	X	X	X
As needed, consult/ referrals/ resources	x	X	x	x	x	x
Nursing Care Plan*			X	X	X	X
1:1 Observation +				X		X
Environment Risk Checklist			+	X		X
Belongings secured			+	X		X
Hospital attire			+	X		X
Lifesaver sign			X	X		X
Hand-off includes precautions		x	X	X		X
Blowup				X		
Provider QMHP Suicide Assessment			X	X		
Non-Suicidal Self-Injurious Safety Plan +						X

*Nursing Care Plans are not required in the Emergency Department.

*1:1 Observation for highly contagious or violent patients at high risk for suicide or high- risk non-suicidal self-injurious behaviors may be completed with audio-visual monitoring with ratio of an assigned 1:1 staff member that is immediately able to intervene. BJH ED BH Pod may only include High risk suicide patients.

*Environment Checklist for Mod-High patients, all risks in non-ligature resistant environment will not be possible to be removed/ mitigated; remove what is appropriate clinically; consider 1:1, "Within Line of Sight", or audio-visual monitoring per clinical judgement

*Removing belongings & Hospital attire for moderate risk patients is as appropriate; work with Public Safety to secure potentially hazardous belongings; Risk Management on alternate plan if patient refuses to change into hospital attire

*Non-Suicidal Self-Injurious Safety Plans (paper form) are completed by inpatient providers only; patients in the ED will have a documented conversation with the provider.

Precaution Orders

- Suicide Precautions - Low Click for more
- Suicide Precautions - Moderate Low Click for more
- Suicide Precautions - Moderate High Click for more
- Suicide Precautions - High Click for more

Suicide Precautions – Low & Suicide Precautions - Moderate Low orders:

▼ **Precaution Orders**

▼ **Suicide Precautions - Low**

- Suicide Precautions - Low
- Suicide precautions - low Routine
- Consult to Social Work
- Consult to Spiritual Care
- Consult to Psychiatry

▼ **Suicide Precautions - Moderate Low**

- Suicide Precautions - Moderate Low
- Suicide precautions - moderate low Routine
- Consult to Social Work
- Consult to Spiritual Care
- Consult to Psychiatry

Suicide Precautions – Moderate High orders:

- Moderate-high risk does not include 1:1 Observation or Elopement Precautions, if clinically indicated, must be ordered separately.

▼ **Suicide Precautions - Moderate High**

- Suicide Precautions - Moderate High

Non- Psych Inpatient & ED: The BJC core suicide policy requires that for patients on moderate- high suicide precautions have the lifesaver sign posted, diet modified, environment assessed for potential risks, and belongings inventoried. Items/ equipment that pose risk that are not clinically needed and are able to be physically be removed will be. Patient may keep belongings unless concern for illicit items. Will request that patient wear hospital attire.

Dietary Orders
(From admission, onward)

Start	Ordered
05/12/21 0929	Adult Diet Regular Diet effective now Question: (AMH) Diet Type Answer: Regular

- Suicide precautions - moderate high STAT
- Elopement precautions STAT
- Adult Diet with Suicide Precautions
- Consult to Social Work
- Consult to Behavioral Health QMHP
- Consult to Spiritual Care
- Consult to Psychiatry

Suicide Precautions – High orders:

- High-risk suicide precautions include 1:1 observation (unless policy exclusions met), this does not need to be ordered separately. If varying from the precautions in policy, order clarification will be needed.

▼ Suicide Precautions - High

Suicide precautions - high

Non-Psych Inpatient & ED: The BJC core suicide policy requires that for patients on high suicide precautions continuous 1:1 observation, elopement precautions (including hospital/ elopement attire), environmental assessment, belongings inventory and securement, lifesaver sign posted, and diet modification are required. All potential risk in the patient's environment must be removed; those that are needed clinically or physically unable to be removed will be mitigated by 1:1 continuous observation. If special circumstance allows patient to keep additional item at bedside, an order must be placed and the item will be monitored by the 1:1 continuous observation. **Exclusions to 1:1 Observation only allowed for critical care patients that are mechanically ventilated, sedated, and/ or in restraints that are not alert enough to participate in self-injurious acts or patients in any department that are unarousable. Patients that are violent and/ or have a highly contagious infection in which a staff member at bedside would be unsafe may be continuously monitored 1:1 via audio-visual monitor (all other requirements for 1:1 in policy apply) at the provider & nursing leadership digression.

Dietary Orders
(From admission, onward)

Start	Ordered
05/12/21 0929	05/12/21 0928
Adult Diet Regular Diet effective now Question: (AMH) Diet Type Answer: Regular	

Suicide precautions - high
STAT

Elopement precautions
STAT

Adult Diet with Suicide Precautions

Nursing communication - allowed belongings at bedside
Continuous, Patient may keep *** at bedside. PSA/ sitter will monitor usage.

Consult to Behavioral Health QMHP

Consult to Social Work

Consult to Spiritual Care

Consult to Psychiatry



Please Note: The high- risk suicide precaution order must be discontinued prior to discharge.

- Once the new suicide order is placed, the corresponding banner will update on the summary report.

Summary

General Adult Overview | Overview | Meds History | TPN | Intake/Output

High Self-Injurious Risk

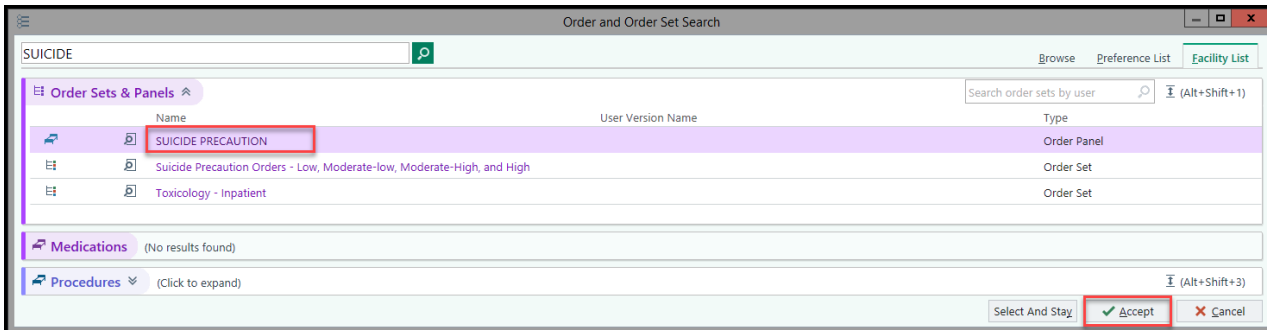
Moderate-Low Suicide Risk

Patient has a Legal Guardian-please review health care agent for more information

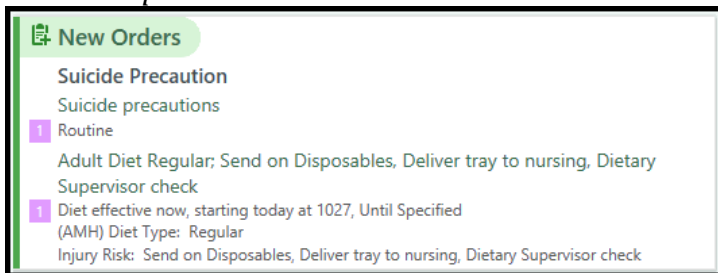
Suicide Precaution Order Panel

If you need to place Suicide precaution and diet order, follow these steps:

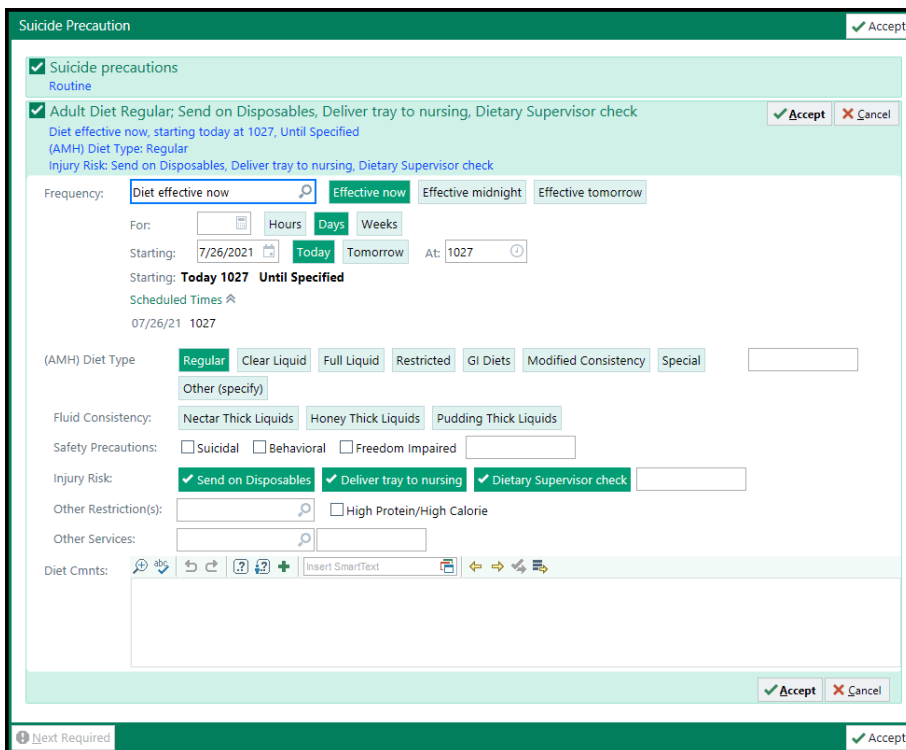
1. In **Orders** activity, search **Suicide**.
2. Select **Suicide Precaution** Order Panel and click **Accept**.



This order panel will be added to the Orders sidebar:



3. Click on the order details to review, add, or modify orders:



Key point: If a patient is already on diet, the diet will default back to Regular diet.

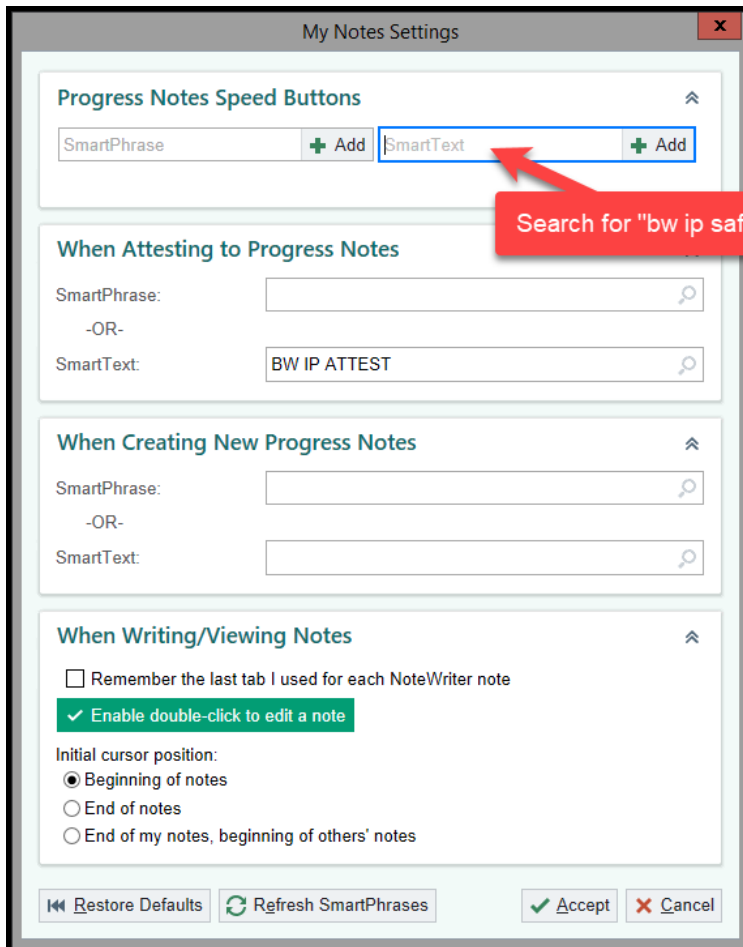
Adding a Speed Button

To add a speed button to the Progress Note Activity of the Rounding Navigator, follow these steps below.

1. In the **Rounding Navigator**, select Progress Note.
2. Select the wrench.



3. In the **SmartText** field, search for **"BW IP Safe T"**



4. Select **BW IP SAFE-T CSSRS Provider Assessment** and click **Accept**.

SmartText Lookup

bw ip safe T

Matches

- ☆ BW IP SAFE-T CSSRS PROVIDER ASSESSME...

Preview

SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) - Recent

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4. In the past month, have you had these thoughts and had some intention of acting on them?	No	{intention of acting (Optional):37840}
5. In the past month, have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?	Yes	{worked out details (Optional):37841}
6. In the past month, have you ever done anything, started to do anything, or prepared to do anything to end your life?	No	{done anything (Optional):37842}

Favorites Only

Accept Cancel

5. Review your settings and click **Accept** again.

My Notes Settings

Progress Notes Speed Buttons

SmartPhrase: + Add SmartText: + Add

BW IP SAFE-T CSSRS PROVIDER ASSESSMENT

Caption: BW IP SAFE-T CSSRS PROVIDER A...

When Attesting to Progress Notes

SmartPhrase: -OR- SmartText: BW IP ATTEST

When Creating New Progress Notes

SmartPhrase: -OR- SmartText:

When Writing/Viewing Notes

Remember the last tab I used for each NoteWriter note

Enable double-click to edit a note

Initial cursor position:

- Beginning of notes
- End of notes
- End of my notes, beginning of others' notes

Accept Cancel

The **“Safe-T CSSRS Provider Assessment”** speed button has now been added.

Rounding

REVIEW

BestPractice

Expected Discha...

Problem List

Progress Note

1 BW IP SAFE-T CSSRS PROVIDER ASSESSMENT

You have no filed Progress Notes for this patient within the last 24 hours.

For additional information, please refer to your organizations policy & procedure manual