Provider Suicide Assessment & Orders

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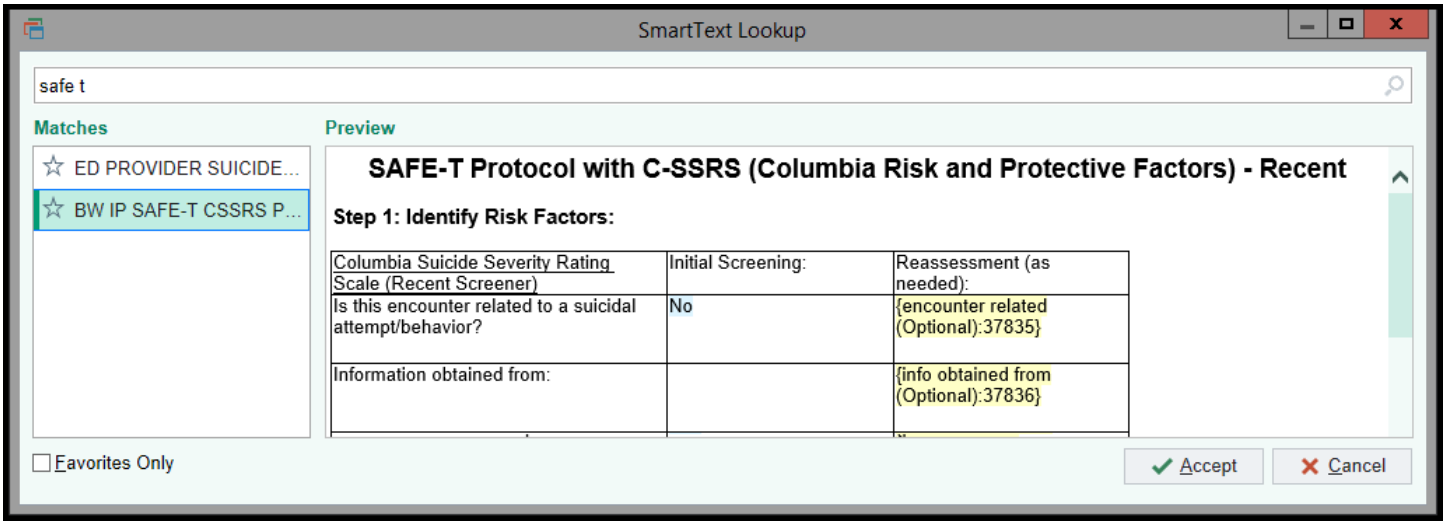
BJC/Washu has implemented a new suicide provider assessment and orders that will go into affect Aug. 15th for the ED and non-psychiatric inpatient areas. See below for new information pertaining to the Provider Suicide Assessment and Suicide Orders.

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.**



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:

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}
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 *In the past month, how many times have you had these thoughts?*	{frequency:37748}
Duration *When you have the thoughts how long do they last?*	{duration:37749}
Controllability *Could/can you stop thinking about killing yourself or wanting to die if you want to?*	{controllability:37750}
Deterrents *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?*	{deterrents:37751}
Reasons for Ideation *What sort of reasons did you have for thinking about wanting to die or killing yourself?* *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?*	{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.

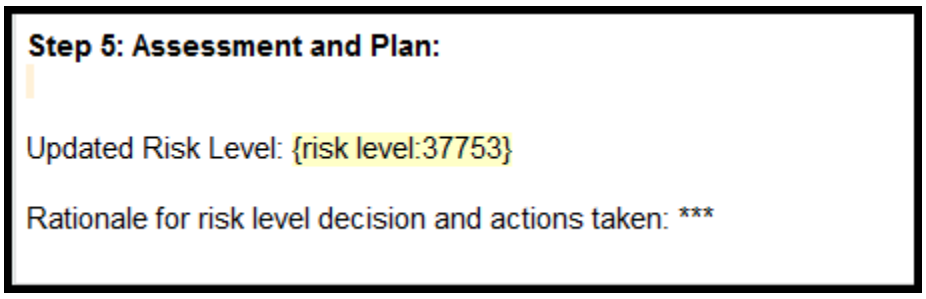
The Suicide Ideation Intensity Score does not directly correlate to Suicide Risk.

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

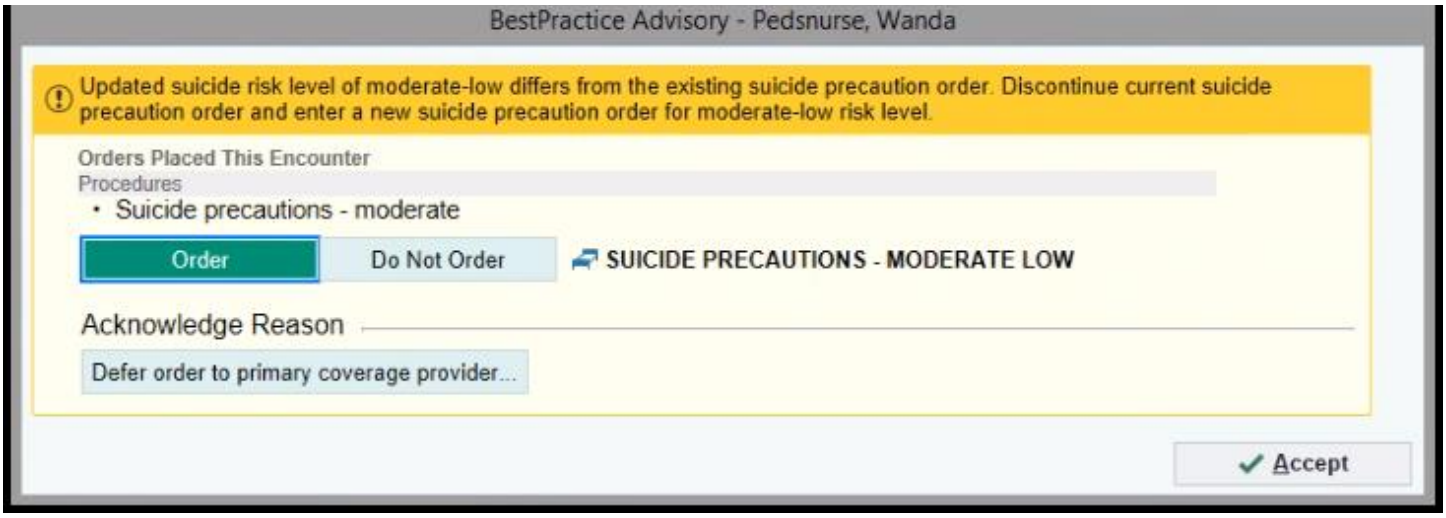
Initial Risk Stratification	Suggested Interventions
High Suicide Risk Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **OR** Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	**High Suicide Precautions** • 1:1 observation • All belongings secured • Hospital attire • Elopement precautions • Minimize environment risk in room
Moderate-High Suicide Risk Suicidal ideation with method **WITHOUT plan, intent or behavior in past month** (C-SSRS Suicidal Ideation #3) **OR** Multiple risk factors and few protective factors	**Moderate-High Suicide Precautions** • Patient sitter not required • May keep items evaluated as safe, other belongings secured • Hospital attire • Minimize environment risk in room
Moderate-Low Suicide Risk Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) **OR** Multiple risk factors and few protective factors	**Moderate-Low Suicide Precautions** • Resources given to patient • Nursing handoff precautions
Low Suicide Risk Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) **OR** Modifiable risk factors and strong protective factors **OR** No reported history of Suicidal Ideation or Behavior	**Low Suicide Precautions** • Resources given to patient

Assessment and Plan:

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



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

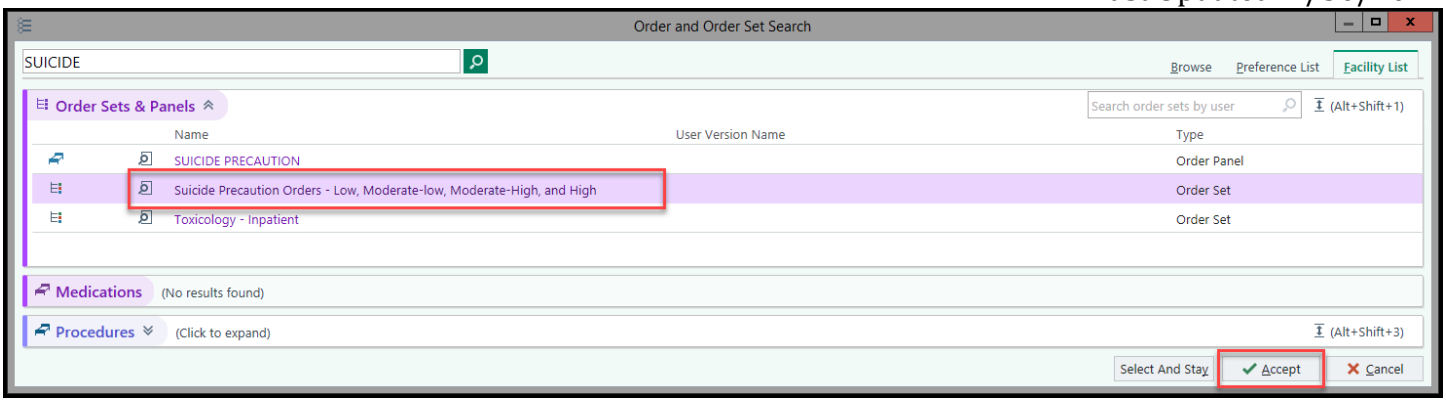
!	***Please complete the suicide assessment prior to placing the suicide orders***

There are four types of suicide orders to choose from:

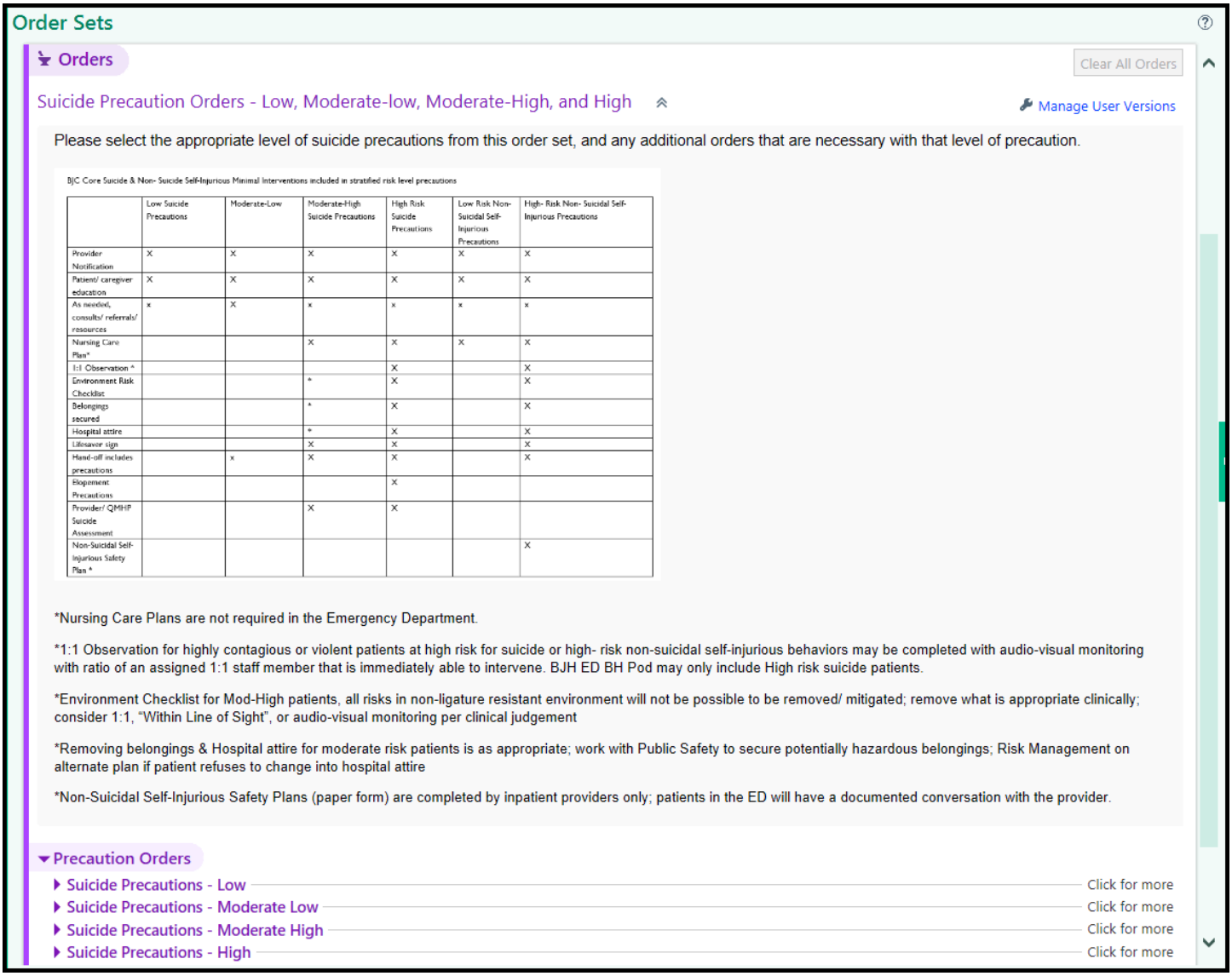
- Low
- Moderate-Low
- Moderate-High
- High

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.

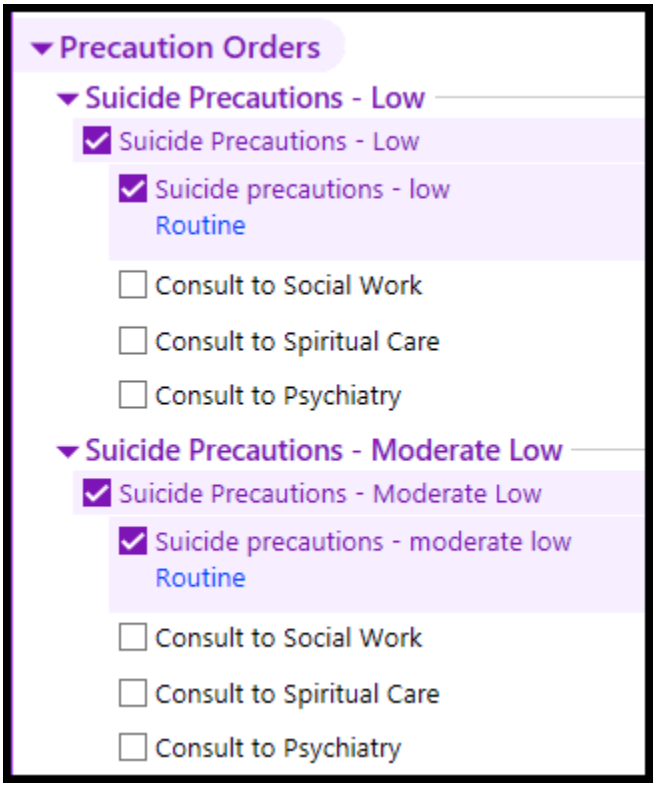
1. In **Orders** activity, search ***Suicide***.
2. Select ***Suicide Precaution Orders – Low, Moderate-low, Moderate-High, and High*** Order Set and click **Accept**.



The orderset opens:

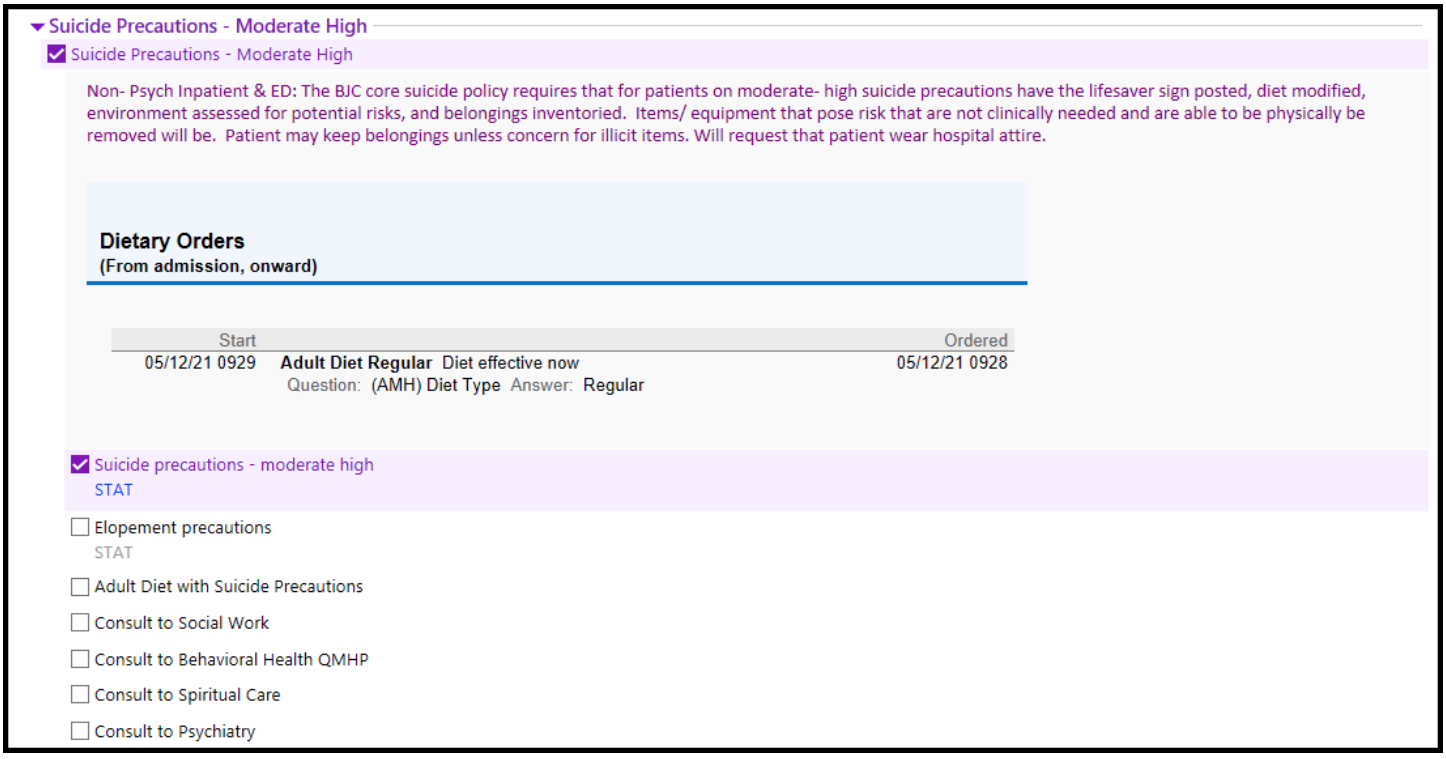


Suicide Precautions – Low & Suicide Precautions - Moderate Low orders:



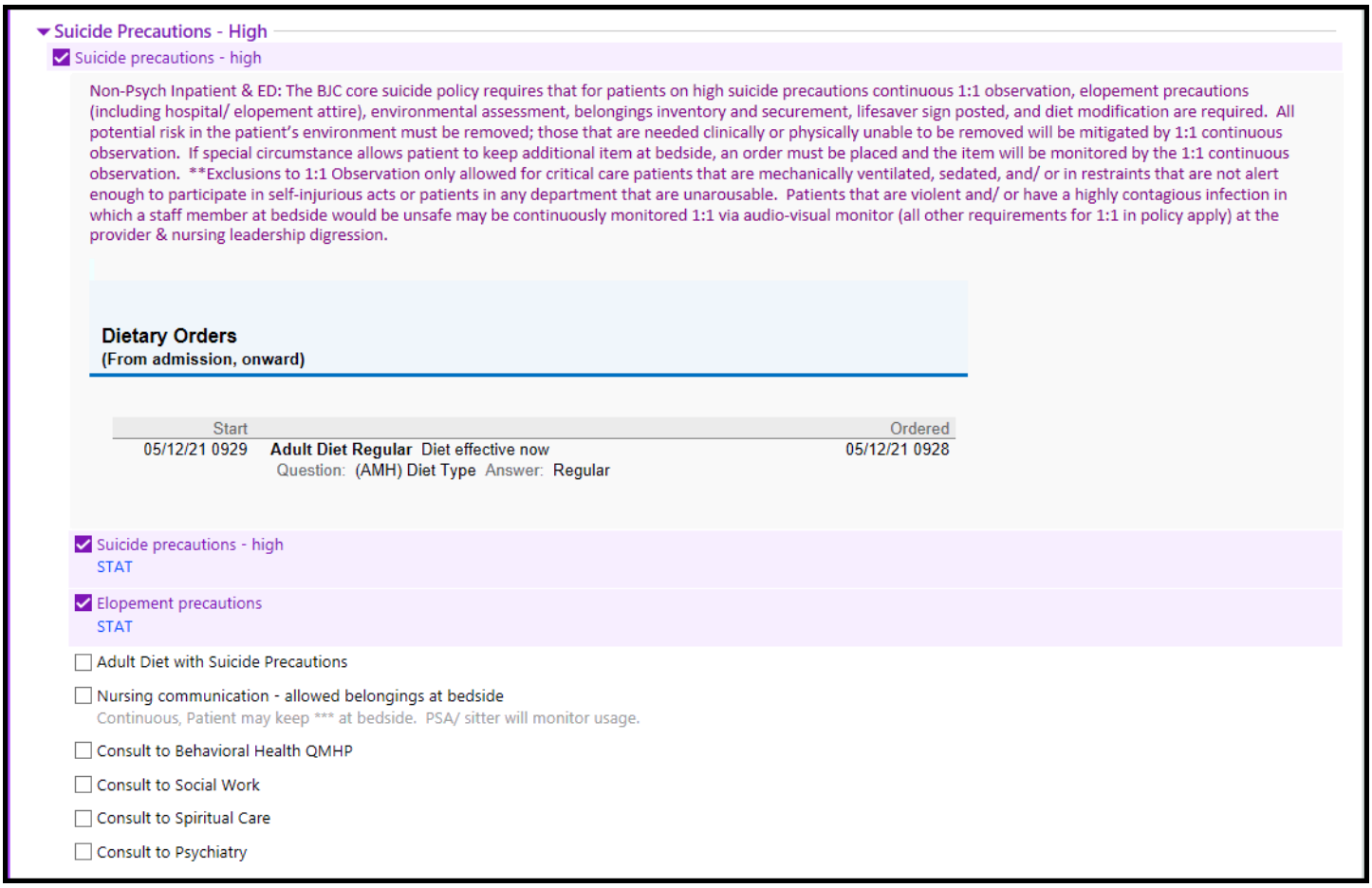
Suicide Precautions – Moderate High orders:

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



Suicide Precautions – 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.



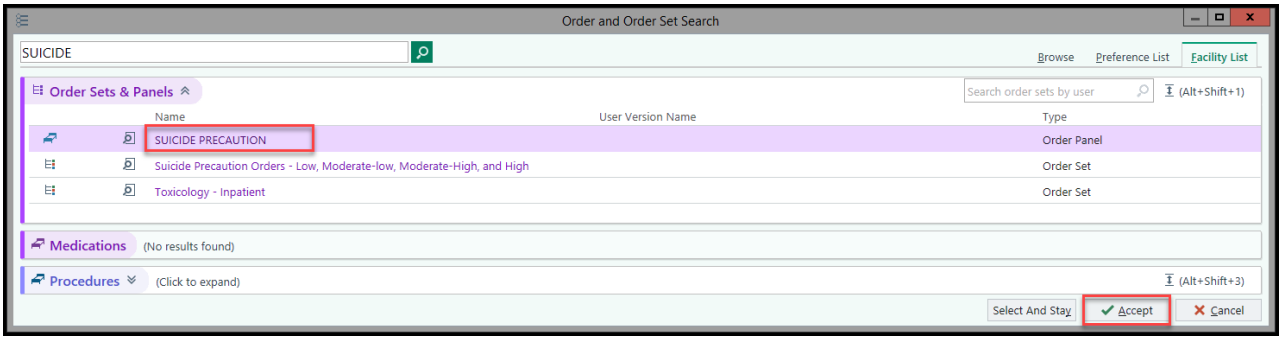
!	Please Note: The high- risk suicide precaution order must be discontinued prior to discharge.

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

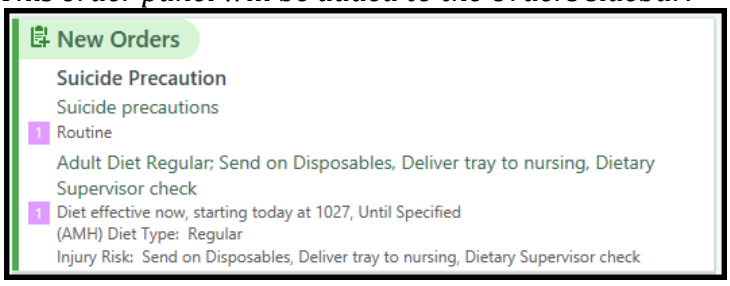
Suicide Precaution Order Panel

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

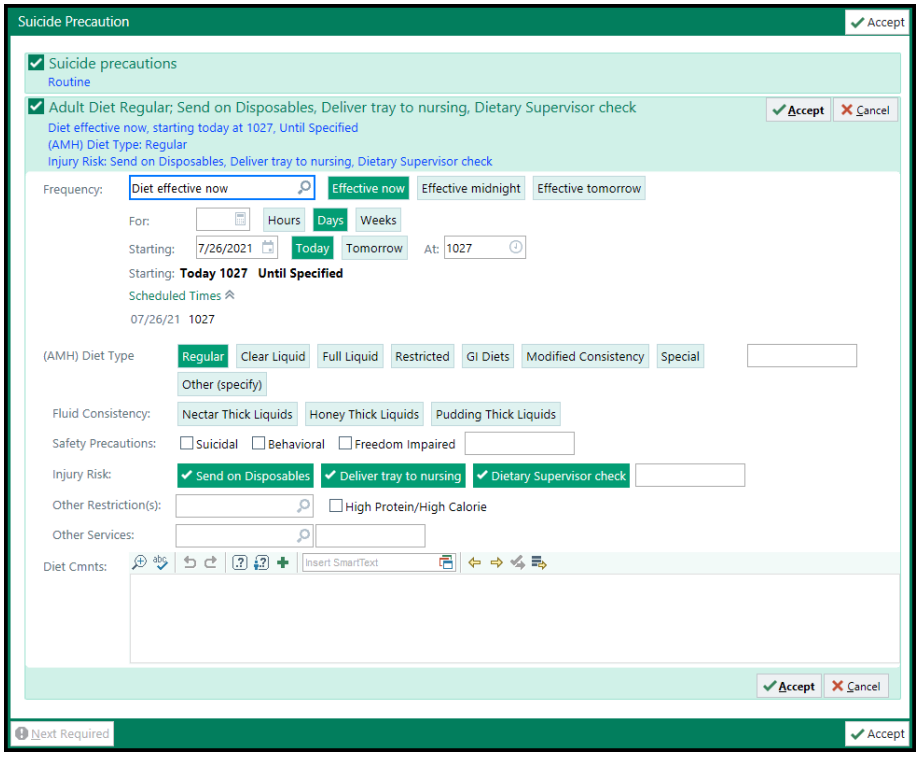
1. In **Orders** activity, search ***Suicide***.
2. Select ***Suicide Precaution*** Order Panel and click **Accept**.



This order panel will be added to the Orders sidebar:



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

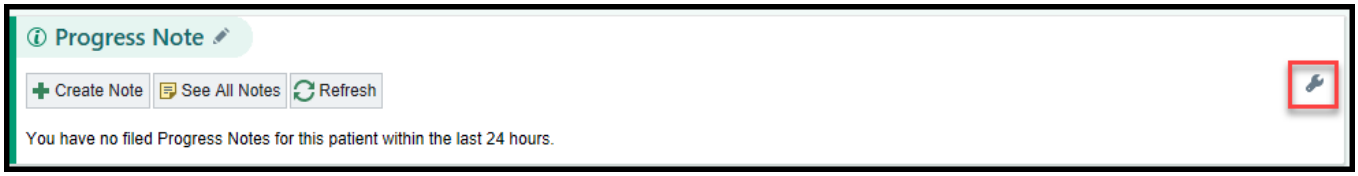


!	Key point: If a patient is already on diet, the diet will default back to Regular diet.

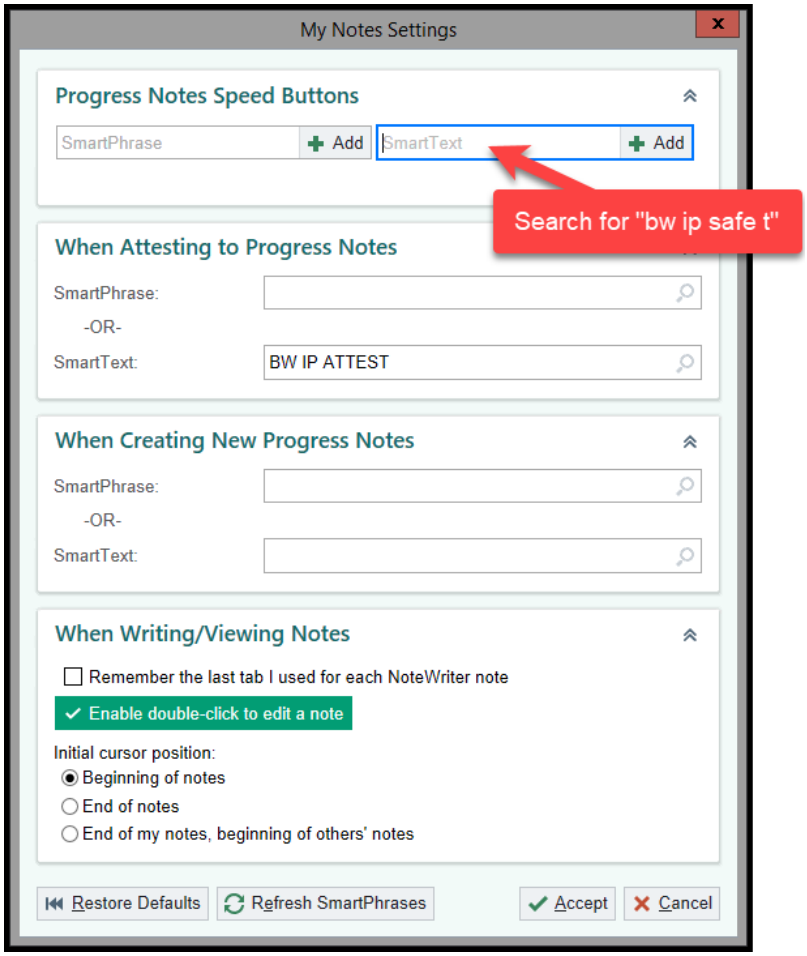
Adding a Speed Button

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

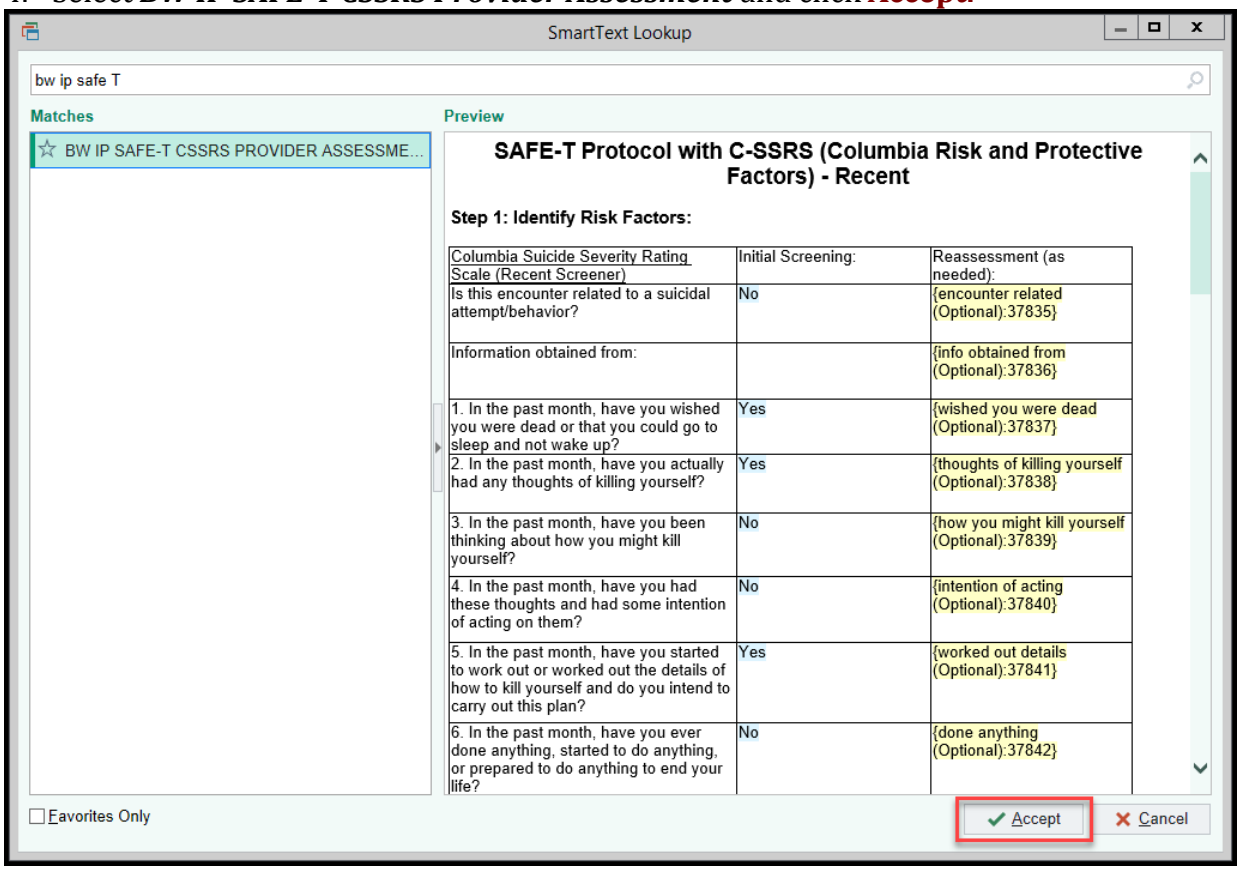
1. In the **Rounding Navigator**, select Progress Note.
2. Select the wrench.



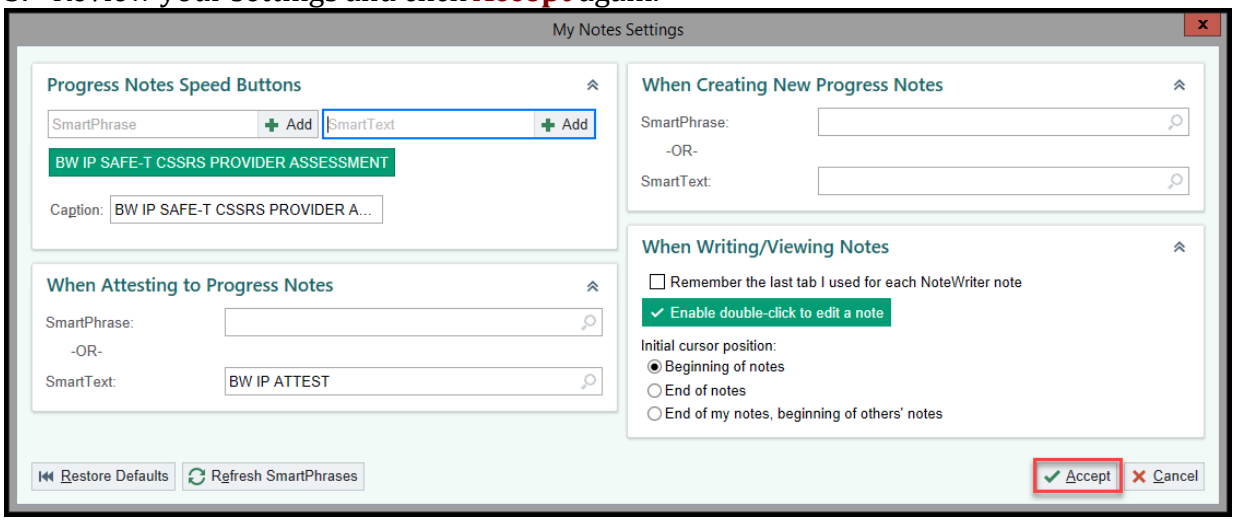
3. In the **SmartText** field, search for **"BW IP Safe T"**



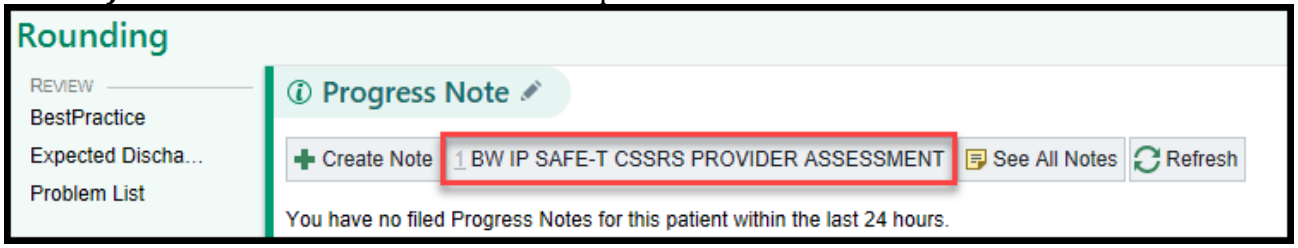
4. Select ***BW IP SAFE-T CSSRS Provider Assessment*** and click **Accept.**



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



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



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