ENSURING THE QUALITY OF SUICIDE SCREENING

Here we review a series of steps to apply continuous quality improvement principles to measure and improve screening fidelity.

OVERVIEW

In applying continuous quality improvement to improve screening fidelity, there are three main steps:

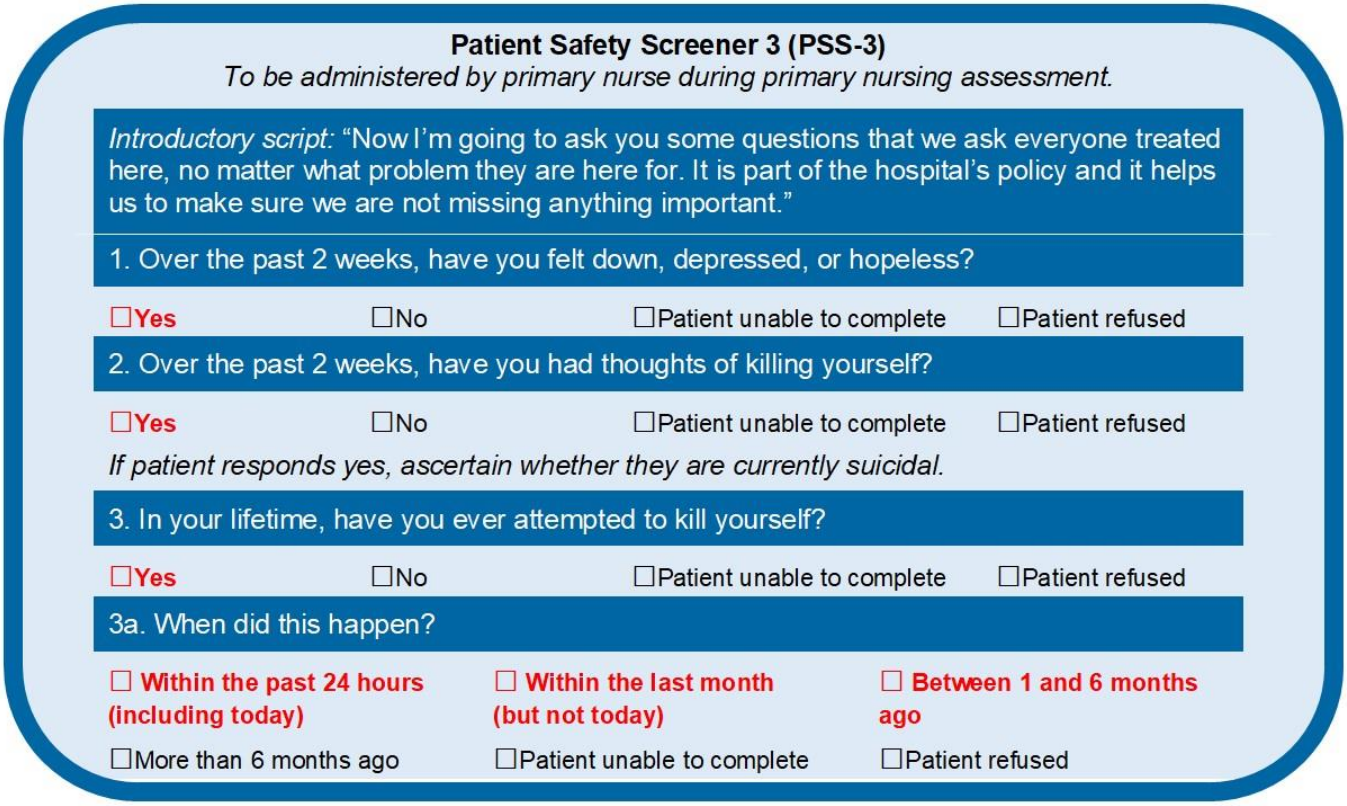
1. Establish Standard Work

2. Create a process for observation

3. Provide feedback and elicit ideas

1. ESTABLISH STANDARD WORK

In order to assess the quality of screening, there needs to be a yardstick to measure against, an agreement of what "good" looks like. "Standard Work" is used to define expectations and measure quality: in an acute care setting where the Patient Safety Screener (PSS-3) is implemented, the tool itself is the Standard Work. The screening tool informs the nurse on how to do screening properly, how to introduce the screening, to ask all three items exactly as worded, and how to interpret a positive screen. By defining our expectations with this Standard Work, we know what to look for when we observe the screening being done.



Patient Safety Screener 3 (PSS-3)

To be administered by primary nurse during primary nursing assessment.

Introductory script: "Now I'm going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital's policy and it helps us to make sure we are not missing anything important."

1. Over the past 2 weeks, have you felt down, depressed, or hopeless?

☐**Yes** ☐No ☐Patient unable to complete ☐Patient refused

2. Over the past 2 weeks, have you had thoughts of killing yourself?

☐**Yes** ☐No ☐Patient unable to complete ☐Patient refused

If patient responds yes, ascertain whether they are currently suicidal.

3. In your lifetime, have you ever attempted to kill yourself?

☐**Yes** ☐No ☐Patient unable to complete ☐Patient refused

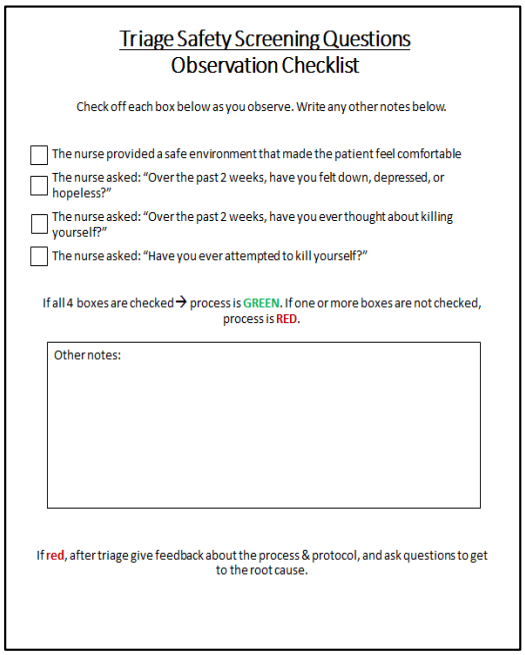
3a. When did this happen?

☐ **Within the past 24 hours (including today)** ☐ **Within the last month (but not today)** ☐ **Between 1 and 6 months ago**

☐More than 6 months ago ☐Patient unable to complete ☐Patient refused

2. CREATE A PROCESS FOR OBSERVATION

Because we want to observe screening where it is happening, it is necessary to directly observe the nurses conducting screening. This assessment will help determine whether Standard Work is being followed. On the left is a template to document screening observation. It can be used when observing a screening to decide if the screening was complete and the quality was good (green), or if it was incomplete and the quality was poor (red). The notes box on the screening template is a space for the observer to bring ideas for improvement back to the project team.



Triage Safety Screening Questions
Observation Checklist

Check off each box below as you observe. Write any other notes below.

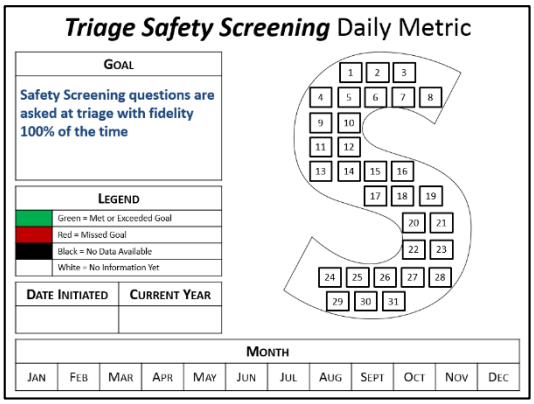
- ☐ The nurse provided a safe environment that made the patient feel comfortable
- ☐ The nurse asked: "Over the past 2 weeks, have you felt down, depressed, or hopeless?"
- ☐ The nurse asked: "Over the past 2 weeks, have you ever thought about killing yourself?"
- ☐ The nurse asked: "Have you ever attempted to kill yourself?"

If all 4 boxes are checked → process is GREEN. If one or more boxes are not checked, process is RED.

Other notes:

If red, after triage give feedback about the process & protocol, and ask questions to get to the root cause.

Below is an example of a template that could be used to visualize and communicate the metrics that are being generated over time. One observation could be done each day and deemed green or red depending on the quality of the screening. Staff would be able to see at a glance if screening is being scored mostly green or red. If there is a lot of red on the board, that indicates a need for improvement.



3. PROVIDE FEEDBACK AND ELICIT IDEAS

After an observation, document notes, give feedback, and ask nurses for ideas to improve. Create a collaborative, not a punitive, environment in doing this. Role plays can be a helpful way to practice giving feedback. Scenarios can be found in the appendix at the end of this document. For each role play, observers should watch the role play and document their observations using the Observation Checklist above. In pairs:

- Partner A: Practice how you would give feedback to the "triage nurse"
- Partner B: Give feedback to Partner A on how their feedback made you feel

SUMMARY

To sustain screening, we need to agree on what constitutes our Standard Work for a given practice, continually and directly observe the practice, identify barriers if screening is not being done with high fidelity, and find ways to address those barriers.

Appendix 1: Role plays to practice observation and rating

Case: Mary, 66 YO woman presenting with foot wound, stepped on nail while gardening previous day

- Type 2 DM, HTN, hyperlipidemia, depression
- No overt distress; alert and fully oriented
- Denies tobacco, alcohol, drugs
- 1-year anniversary of husband's death

"Clinician" role

1. Role play #1

- Adopt dismissive demeanor
- Do not use introductory script
- Ask: "You been depressed?"
- When patient says "no," do not ask about ideation or attempt

2. Role play #2

- Adopt neutral demeanor
- Use introductory script: "Now I'm going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital's policy, and it helps us to make sure we are not missing anything important."
- Ask:
  - "Over the past 2 weeks, have you been depressed?" Answer will be "yes"
  - Ask: "Have you recently thought about or attempted suicide?" Answer will be "yes"

3. Role play #3

- Use appropriate, empathic, and understanding demeanor, be non-judgmental; show you care with compassion, tone, and rate of speech
- Use introductory script: "Now I'm going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital's policy, and it helps us to make sure we are not missing anything important."
- Ask:
  a. "Over the past 2 weeks, have you been depressed?" Answer will be "yes"
  b. "Over the past 2 weeks, have you had thoughts of killing yourself? Answer will be "yes"
     i. Follow up with "When did you have these thoughts?" Answer will be "Today… I thought about getting in a car accident"
  c. "In your lifetime, have you ever attempted to kill yourself?" Answer will be "yes."
     i. "When did this happen?" Answer will be "5 months ago, I took all my pills but it didn't do anything"

“Patient” role

1. Role play #1

- Be guarded/quiet in response to dismissive demeanor
- When asked “You been depressed?”, say “no” defensively; do not volunteer information about ideation or attempt

2. Role play #2

- Neutral attitude
- Agree with introductory script – “Fine”
- Responses
    - Depressed?” Answer will be “yes”
    - Thought about or attempted suicide?” Hesitant “yes.” If further probed, “I guess it crossed my mind”

3. Role play #3

- Engaged attitude
- Agree with introductory script – “That sounds ok”
- Responses
    a. Depressed- Answer will be “yes”
    b. Thoughts of killing yourself- Answer will be “yes”
        i. When- Answer will be hesitant “Today… I thought about getting in a car accident”
    c. Attempted to kill yourself- Answer will be “yes”
        i. When- Answer will be “5 months ago, I took all my pills but it didn’t do anything”

Appendix 2: Observation checklist for screening quality assurance

Triage Safety Screening Questions
Observation Checklist

Check off each box below as you observe. Write any other notes below.

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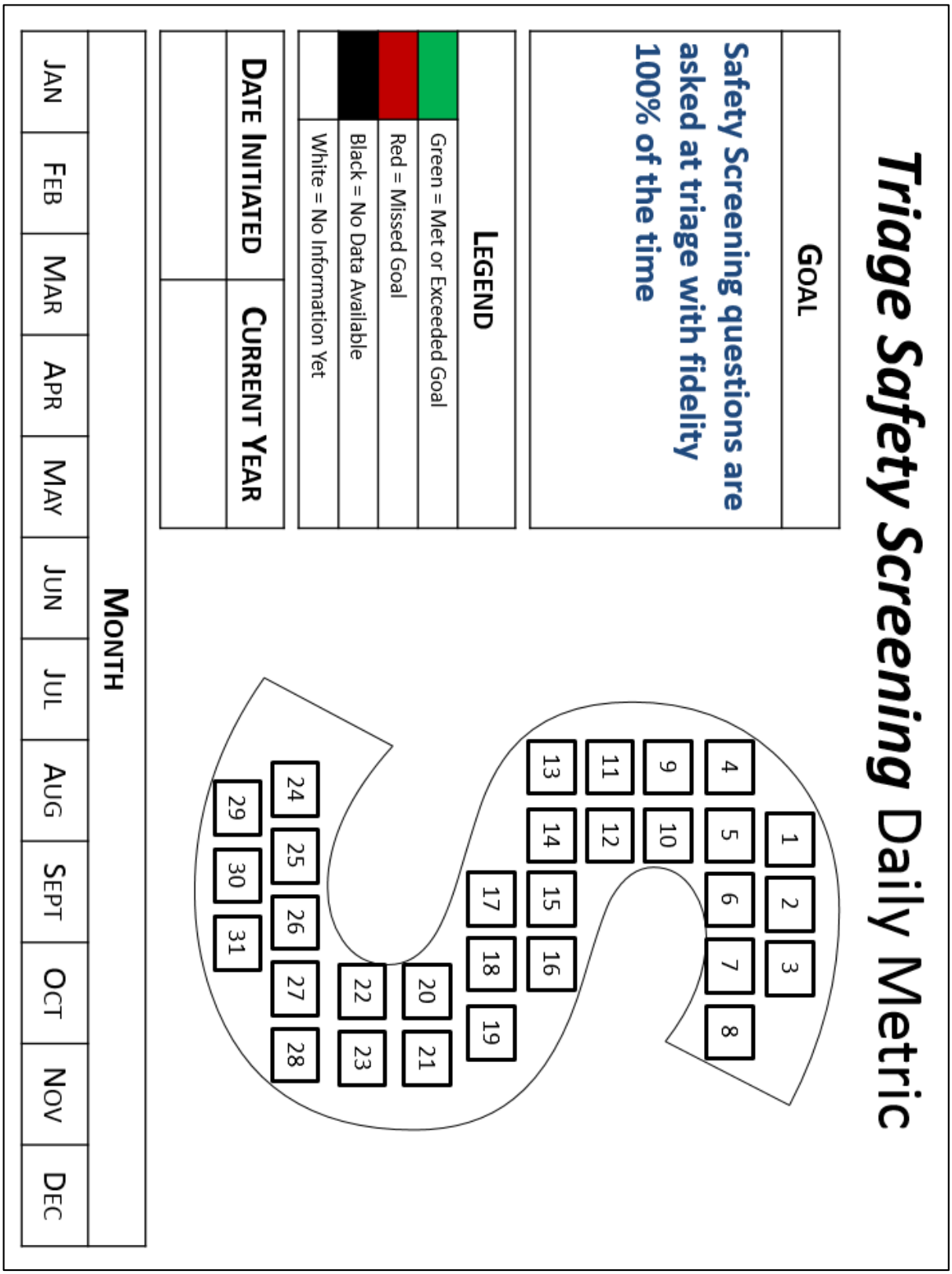

Visit the Suicide Prevention Resource Center's website at http://www.sprc.org/micro-learnings/patientsafetyscreener to view additional resources.