

IMPLEMENTING UNIVERSAL SCREENING FOR SUICIDE

Screening universally for suicide risk in the acute care setting can help to detect patients at risk, while also satisfying the recommendations of accrediting organizations. The strategies outlined here can help organizations to implement screening sustainably and to a high standard.

BACKGROUND

Most of those who die by suicide have interacted with health care services in the year before their death, often for non-psychiatric reasons.¹ Up to one in 10 emergency department patients presenting with medical issues have experienced recent suicidal ideation or suicide attempts.^{2,3} Universal screening allows providers to detect this hidden risk.⁴ The Joint Commission recommends universal screening for suicide risk in acute care settings⁵ and mandates suicide screening in behavioral health settings.⁶ Implementing universal screening for suicide risk in your organization can help to detect suicide risk, meet Joint Commission recommendations, and reduce health care service costs by delivering timely intervention with at-risk patients.

UNIVERSAL SCREENING IN ACUTE CARE SETTINGS

To date, universal screening for suicide risk in acute care settings has tended to focus on the emergency department (ED). EDs represent a risk-enriched environment and may be the only care setting visited by at-risk patients. There is a growing acceptance of screening in the ED, which can serve as an entry point to more intervention services for those at risk of suicide. Universal suicide screening is mandated by the Joint Commission for inpatient psychiatric units.

More recently, suicide screening efforts have expanded to inpatient medical settings. Screening during inpatient admission helps to serve as a safety net, given the significant challenges in obtaining adequate fidelity to screening in the ED. Re-screening on medical admission also reflects the fluctuating nature of suicidal ideation over time, especially as a patient's medical situation or intoxication level changes. Finally, a patient who is reluctant to disclose suicidal ideation or behavior in the ED may be more willing to disclose in a less hectic, more private, inpatient setting. In the UMass Memorial Health Care System and a growing number of health care systems across the country, universal suicide screening has been implemented in EDs **and** inpatient units.

Primary screening for suicide risk is most often completed by a nurse, either during triage or primary nursing assessment. A tool for primary suicide screening should have high sensitivity and should be followed by a secondary risk assessment with higher specificity, often delivered by a physician.⁷ If a patient screens positive, there should be an established protocol for nurses to document, communicate, and respond to suicide risk.

SUICIDE CARE MANAGEMENT PROTOCOLS

Screening alone, in the absence of intervention, will not prevent suicide.⁴ Before implementing universal screening, it is essential that organizations develop clinically acceptable and effective protocols for managing

patients who screen positive. Important components of such a protocol usually include processes for communicating and documenting a positive screen, applying safety precautions, secondary screening, brief intervention, and care transitions. Suicide care management is covered in more detail in the Suicide Care Management Plans handout.

SCREENING TOOLS

In selecting a screening tool to implement, it is important to consider fit with existing workflow, culture, and resources, as well as supporting evidence. Outlined below are three primary screening tools that are widely used for detecting suicide risk in acute care settings.

The **Patient Safety Screener (PSS-3)** consists of three items and is simple to use in a busy health care environment. The PSS-3 assesses depressed mood and active suicidal ideation in the past two weeks and lifetime suicide attempt, which are based on items from the Patient Health Questionnaire and the CSSRS. The screener was validated in ED patients ages 18 and older,⁸ and has since been implemented in dozens of EDs and inpatient medical settings with patients ages 12 years and older. When implemented universally, the PSS-3 was shown to increase the detection of patients at risk of suicide from 2.9% to 5.7%.⁴ The PSS-3 was implemented in eight EDs across the country as part of the ED-SAFE⁴ program and is currently being implemented in EDs, and inpatient and outpatient units across the UMass Memorial Health Care system as part of the System of Safety study.

The **CSSRS Clinical Practice Screener - Recent** is an abbreviated version of the Columbia Suicide Severity Rating Scale.⁹ It assesses passive ideation, active ideation, presence of method, intent and plan in the past month, and history of suicidal behavior. The tool has been used successfully to implement universal suicide screening across a large safety-net health care system,¹⁰ resulting in positive detection of suicide risk of 6.3% of ED patients and 2.1% of hospital inpatient units.

The **ASQ Suicide Risk Screening Tool**¹¹ is designed for screening youth ages 10-24 years. It consists of four items: assessing thoughts of being better off dead, wish to die, and suicidal ideation over the past few weeks, and lifetime history of suicide attempt. The tool was derived from a longer set of items and has been validated in pediatric ED patients.

SAMPLE STRATEGIES FOR IMPLEMENTATION

Successful implementation of universal suicide screening requires a thoughtful, multi-level approach and significant buy-in from key stakeholders. Below, we outline the steps taken by the UMass Memorial Health Care system to implement universal suicide screening in the ED and inpatient settings.

Stakeholder engagement: Before attempting to implement suicide screening, the team met with high-level leadership to ensure buy-in. This engagement facilitated access to several important gatekeepers, including those responsible for clinical operations, the electronic health record, and clinician education. We made sure

to align our effort with the priorities of these stakeholders, demonstrate flexibility in our approach to enhance fit with existing workflow, and identify implementation goals that were specific, measurable, achievable, relevant, and time-bound. Notwithstanding their time constraints, frontline providers gave invaluable insight into units' culture and workflow, as well as acceptability of the proposed screening.

Continuous Quality Improvement: Universal screening efforts at UMMHC were integrated into units' existing continuous quality improvement practices. "Lean" practices provided a framework for mapping the current state of workflow, resources, and stakeholders; conducting root cause analyses; and experimenting with small cycle improvements. Data were regularly posted to results boards in the units and communicated to clinicians.

Electronic health record (EHR) integration: Integrating a suicide risk screening instrument into the EHR required significant engagement with clinical leadership and achieved several important aims. It made the wording of the screener items easily available to the provider administering it. It provided a way of documenting and communicating the outcome of screening, as well as flagging when screening had not been done. With some extra effort, it was also possible to program additional features, such as best practice advisories, positive flags on dashboards, and automated discharge instructions contingent on a positive screen. These increased the likelihood that a positive screen would be acted on. Integrating the screener into the EHR also allowed us to retrieve data about system-, unit-, or provider-level screening performance to inform continuous quality improvement efforts. However, simply integrating a suicide risk screener into the EHR will **not** in itself achieve successful implementation, even if it is programmed as a "hard stop." Clinicians may still skip screening questions, ask the items in a disengaged way, or ignore positive screens. EHR integration is an important implementation strategy, but it is unlikely to change behavior if implemented in isolation.

Training: At UMMHC, several components were used to train frontline nurses on how to deliver primary screening. First, nurse educators were assigned a brief, mandatory e-learning module, which was about 30 minutes in duration and covered the rationale for screening, the PSS-3 items, and screening techniques. The accompanying video that was developed with SPRC covers much of the same material, and the attached slides can be used to deliver this training in person. Second, research staff and nurse educators visited the units to conduct "at-the-elbow" coaching to nurses, with the help of a job aid that was sized to fit in a provider's pocket. This coaching covered the rationale for screening and how to document screening in the EHR. Because coaching was done individually and in the frontline work setting, it allowed nurses to ask questions and receive personalized feedback. Finally, nurse managers were apprised of the screening performance of their nursing

Myths and Facts of Universal Screening

"Universal suicide screening will break our system."

Fact: Universal suicide screening has been implemented in numerous EDs around the country without adversely affecting patient care or leading to a cascade of evaluations.

"Universal screening will increase our liability."

Fact: Providers are more likely to be sued for what they don't assess. Screening does not trigger suicidal thoughts.¹²

"Patients won't answer questions about suicide honestly."

Fact: It is quite rare that a patient will conceal suicidality during screening and go on to attempt.

staff (as measured by fidelity interviews and EHR data) over time and encouraged to reinforce screening education with their staff. As well as the initial training, we took steps to ensure that the training was sustainable by integrating it into onboarding procedures and annual competencies.

SUMMARY: TIPS FOR IMPLEMENTATION

- ✓ **Meaningfully engage top leadership and frontline clinicians**
- ✓ **Collaboratively choose a screening tool that fits with your setting**
- ✓ **Integrate the screening tool into your electronic health record**
- ✓ **Train providers on screening and suicide care management protocols**
- ✓ **Sustain training by integrating it into onboarding and yearly competencies**
- ✓ **Ensure sustainability by integrating screening into site continuous quality improvement activities**

References

1. Ahmedani BK, Simon GE, Stewart C, Beck A, Waitzfelder BE, Rossom R, Lynch F, Owen-Smith A, Hunkeler EM, Whiteside U, Operskalski BH. Health care contacts in the year before suicide death. *Journal of General Internal Medicine*. 2014 Jun 1;29(6):870-7.
2. Claassen CA, Larkin GL. Occult suicidality in an emergency department population. *The British Journal of Psychiatry*. 2005 Apr 1;186(4):352-3.
3. Ilgen MA, Walton MA, Cunningham RM, Barry KL, Chermack ST, De Chavez P, Blow FC. Recent suicidal ideation among patients in an inner city emergency department. *Suicide and Life-Threatening Behavior*. 2009 Oct 1;39(5):508-17.
4. Boudreaux ED, Camargo CA, Arias SA, Sullivan AF, Allen MH, Goldstein AB, Manton AP, Espinola JA, Miller MW. Improving suicide risk screening and detection in the emergency department. *American Journal of Preventive Medicine*. 2016 Apr 1;50(4):445-53.
5. Joint Commission. Sentinel Event Alert 56: detecting and treating suicide ideation in all settings. The Joint Commission. 2016
6. Joint Commission. November 2017 Perspectives Preview: Special Report: Suicide Prevention in Health Care Settings.
7. Boudreaux ED, Horowitz LM. Suicide risk screening and assessment: designing instruments with dissemination in mind. *American Journal of Preventive Medicine*. 2014 Sep;47(3 Suppl 2):S163-9.
8. Boudreaux ED, Jaques ML, Brady KM, Matson A, Allen MH. The patient safety screener: validation of a brief suicide risk screener for emergency department settings. *Archives of suicide research*. 2015 Apr 3;19(2): 151-60.
9. Posner K, Brown GK, Stanley B, Brent DA, Yershova KV, Oquendo MA, Currier GW, Melvin GA, Greenhill L, Shen S, Mann JJ. The Columbia–Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry*. 2011 Dec;168(12):1266-77.
10. Roaten K, Johnson C, Genzel R, Khan F, North CS. Development and implementation of a universal suicide risk screening program in a safety-net hospital system. *Joint Commission journal on quality and patient safety*. 2018 Jan 1;44(1):4-11.

11. Horowitz LM, Bridge JA, Teach SJ, Ballard E, Klima J, Rosenstein DL, Wharff EA, Ginnis K, Cannon E, Joshi P. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Archives of pediatrics & adolescent medicine. 2012 Dec 1;166(12):1170-6.
12. Dazzi T, Gribble R, Wessely S, Fear NT. Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? Psychological Medicine. 2014 Dec;44(16):3361-3.

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