



Universal Health Services, Inc., Behavioral Health Division

Inpatient Suicide Care Management Plan Template

To be adapted by each facility if needed.

Beginning at Intake:

- Use an evidence-informed assessment approach and evidence-based screening tools
 - E.g. the Assessing and Managing Suicide Risk assessment forms and the Columbia Suicide Severity Rating Scale screener and since last visit versions
- Formulate a judgment of clinical risk using both risk status and risk state to determine appropriate level of care
 - If individual at risk is assessed to be appropriate for treatment in outpatient care:
 - Create a collaborative crisis safety plan using an evidence-based tool such as the Safety Planning Intervention or Crisis Response Planning
 - Provide counseling to reduce or restrict access to lethal means of suicide
 - Confirm with a support person such as the family that lethal means have been secured
 - Ensure outpatient treatment referral is completed with an appointment in a clinically appropriate time frame based on the risk formulation
 - For continuity of care, communicate disposition, risk formulation, crisis safety plan, and counseling on access to lethal means to receiving provider and system
 - Follow-up to regarding treatment engagement and with caring contacts
 - If the individual at risk is admitted to inpatient care:
 - Decide on appropriate unit
 - Communicate suicide risk assessment and risk formulation including any specific warning signs, risk factors, protective factors, suicidality, and cultural and individual factors to the unit as appropriate
 - Communicate specific suicidal thoughts, behaviors, or plans that the unit needs to consider regarding environmental safety and patient observations specific to the inpatient unit
 - Complete all necessary documentation
 - Use clinical skills and best practices to begin engaging the individual at risk in care, specifically trauma-informed skills

Suicide Care Management Plan on the inpatient unit:

- Use evidence-informed approach for risk assessment, such as the Assessing and Managing Suicide Risk forms and risk formulation, to determine if the person is placed on the suicide care management plan for inpatient stay and treatment
 - Additional tools, which may include a standardized screening and assessment tool such as the Columbia - Suicide Severity Rating Scale, can be used to identify risk and triage which patients to place on the suicide care management plan during inpatient stay

- General guidelines for AMSR tools and risk formulation – patients who meet the following criteria would be recommended for the suicide care management plan:
 - Risk State higher than baseline
 - Risk Status higher than comparison group (such as other patients on the inpatient unit or other males with depression in the community)
 - Recent suicide attempt
 - Recent suicidal behavior
 - Current or recent suicidal ideation with intent or plan
 - High risk factors with limited protective factors
 - Clinical judgment indicates placement on the suicide care management plan is appropriate to manage risk and support recovery
- **For patients not placed on the suicide care management plan:**
 - Engage the patient in creating a collaborative, individual crisis safety plan using the Safety Planning Intervention or Crisis Response Planning
 - Identify any specific lethal means and take appropriate steps to restrict access to lethal means both on the unit and at home
 - Use appropriate precautions and continually assess level of precautions
 - Continue to screen and assess for suicide risk daily
 - If patient’s risk state changes to meet criteria for placement on the suicide care management plan at any point during the inpatient stay, place on suicide care management plan and follow appropriate procedures, including documentation and communication, related to this.
 - For unclear situations, consult with the treatment team
- **For patients placed on the Suicide Care Management Plan on the inpatient unit:**
 - At every waking shift: Re-screen and assess for suicide risk using evidence-informed skills and tool such as Assessing and Managing Suicide Risk skills, risk formulation, and AMSR forms
 - Each specific unit should outline the workflow for this screening and assessment to define clear roles and prevent duplicative screening and assessment
 - If new stressors, changes in clinical presentation, and/or changes in suicidal ideation/planning/intent are found by the CSSRS re-screener or through informal screening and assessment, conduct a re-assessment and adjust your risk formulation, making changes to treatment, support, and/or patient-specific actions as needed.
 - Educate patient and appropriate support persons in the suicide care management plan, treatment plan, and restricting access to lethal means
 - Within 24-48 hours of admission, engage patient in collaborative, individualized crisis safety plan using the Safety Planning Intervention or Crisis Response Planning, which are evidence-based interventions
 - Through crisis safety planning, if any specific means are identified, take necessary steps to eliminate, and, if elimination is not possible, reduce access to lethal means on the unit and begin lethal means restriction at home

- Provide patient with a copy of or way to access and review their crisis safety plan
- Document crisis safety plan in the appropriate place in the health record
 - This documentation should be easily accessible, in addition to documentation in the progress, therapy, or nursing note.
- Through patient observations and interactions in the milieu, staff check in with patient regarding their use of their crisis safety plan
- Staff assist the patient in identifying and bringing awareness to warning signs and triggers as they occur during treatment
- Staff use appropriate therapeutic interventions, specifically those related to evidence-based treatments for suicide as a part of the patient’s care plan, and teach coping skills, distraction, and distress tolerance skills when warning signs and triggers are observed
- Staff provide appropriate support and assist patient in accessing support as outlined in the patient’s crisis safety plan
- Staff assist patient in accessing therapy, nursing, and/or psychiatric care as needed
- Provide evidence-based treatment directly targeting suicidal ideation and behaviors
 - Group and expressive therapies as outlined in unit schedule
 - As possible, group and expressive therapies are tailored to directly target suicidal thinking and behaviors
 - Example: suicide attempt survivors group
 - Example: Dialectical Behavioral Therapy group specific to suicidality
 - Psychiatric medication management and interventions daily
 - Family therapy (with appropriate identified support persons)
 - If the patient has no identified support systems, work to engage them through therapeutic interventions to identify at least 3 supports. These can be formal and informal supports
 - Formal supports may include a shelter, community center, elderly or aging center
 - Informal supports may include friends, family members, co-workers, neighbors
 - Individual therapy as indicated
 - Develop and practice contingency plans for two potential triggers for suicidal crisis
 - Follow-up and use therapeutic engagement strategies if patient is resistant to or misses group, individual, or others therapies
- Use evidence-informed assessment skills & tools, such as Assessing and Managing Suicide Risk, to determine individualized patient interventions throughout stay and to help determine discharge date.
- **Discharge:**
 - Review and update crisis safety plan using the Safety Planning Intervention or Crisis Response Planning prior to and at discharge

- Provide counseling on access to lethal means
 - Restrict access to lethal means and confirm with support persons that, when possible, lethal means have been secured
 - If necessary, follow procedures to secure lethal means through law enforcement or other resources- such as blister packaging with medications.
- Engage key support person(s) in discharge planning process and educate regarding risk post-discharge
- Provide education regarding outpatient care, medications, treatment recommendations, crisis supports, and other resources available such as bridge groups
- Provide a caring contact within 24-48 hours post-discharge and at 7 days post-discharge and/or until has attended 1 outpatient appointment, then provide caring card or letter (or text, with HIPAA-compliant protocol) at least at 30 days, 60 days, and 90 days post-discharge
- At any phone (or in-person) contact with patient post-discharge, screen and as needed, conduct assessment for suicide risk; check in regarding crisis safety plan and access to lethal means
 - If patient has higher risk state than discharge, consider readmission
 - If necessary, use skills to counsel on access to lethal means
 - Engage the client and their support system to restrict or reduce access to means
 - When determined necessary, follow hospital and local procedures for using law enforcement or other resources such as changes in prescription amount to reduce or restrict access to means.
- Confirm patient has gotten any prescribed medications
 - Review barriers to getting medications and outline possible ways to overcome these barriers
- (For calls at 7 days and beyond) Confirm patient has followed through with outpatient treatment for at least one appointment
 - Review barriers to follow-up and outline possible ways to overcome these barriers
 - If possible, provide a warm hand-off to receiving provider(s) and/or organization
- Ensure communication is completed with receiving provider(s) including all documentation including crisis safety plan, recommendations and steps to restrict or reduce access to lethal means, discharge plan, treatment plan, medications, and risk assessment.