Ann & Robert H. Lurie Children's Hospital of Chicago

Suicide Prevention
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INCLUSION & EXCLUSION CRITERIA

Inclusion:
- All patients ≥ 10 years old
- Patients < 10 years old, if there is a clinical concern by any person or are present for psychiatric concerns
- Additional criteria as found on pages of individual care areas (see individual pages for details)

Exclusion:
- Telemedicine visits
- Outpatient Ancillary Services (i.e., phlebotomy, non-sedated medical imaging, rehab services)
- Additional criteria as found on pages of individual care areas (see individual pages for details)

Note:
With any exclusion, if clinically concerned for suicidal ideation, provider is obligated to escalate and report any safety concerns immediately.

OVERALL GOALS

- Standardize suicide prevention workflows and processes
- Support universal screening at Lurie Children's locations for suicidal ideation
- Provide resources for staff, patients, and families

POLICY
Suicide Prevention: Risk Identification and Interventions

Click for Evidence

Any patient entering the Lurie Children's System

All underlined text is hyperlinked

Emergency Department (ED)	• Includes the Emergency Department
Inpatient	• Includes inpatient units [15,16,17,18,19,20,21,22]
Procedural Areas	• Includes Pre/PACU/Post and Imaging at Lurie Main 5, 6, and 7 • Includes Westchester and Northbrook surgical centers
Ambulatory	• Includes Adolescent Medicine • Includes ambulatory/satellite locations that are screening patients for suicide • Includes ambulatory/satellite locations where a Lurie employee has psychiatric concern for a patient
Appendix A CCG Overview and References	• Includes an overview of suicide prevention background, metrics, contributors, and references
Appendix B Staff Education and Resources	• Includes links to resources specific to screening, assessment, and safety plans • Includes links to resources for families in need of additional information on suicide • Includes scripted guidance for staff specific to screening and assessment
Appendix C Environmentally Safe Room	• Includes guidance for how to check that a room is environmentally safe for patients who screen positive
Appendix D Patient Admission Guidance	• Includes guidance for patient cases that may require admission to an inpatient unit from the Emergency Department or Procedural areas

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Suicide Prevention Algorithm
Emergency Department (ED)

Inclusion Criteria:
- Patient admitted to the ED
- All patients ≥ 10 years old
- Patients < 10 years old, if there is a clinical concern by any person or are present for psychiatric concerns

Exclusion Criteria:
- Patient >18 years old, see ED Behavioral Health Disposition Algorithm
- Telemedicine Visits

A. Ask Suicide Questionnaire (ASQ)

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts of killing yourself?
4. Have you ever tried to kill yourself?

IF YES TO 4, ASK:
"When was the attempt?

IF YES TO ANY OF 1-4, ASK 5:
5. Are you having thoughts of killing yourself right now?

B. RISK DETERMINATION REFERENCE
- **Imminent Risk:** Patient presents with severe behavioral symptoms and suicidal ideation with plan, method, and intent. Protective factors are not sufficient to offset risk, psychiatric admission may be required.
- **Intermediate to High:** Patient reports suicidal ideation with/without plan but denies intent or behavior. There are more risk factors than protective factors.
- **Low Risk:** Patient expresses passive thoughts of death, no plan, no intent. Protective factors are strong.

POLICY
Suicide Prevention: Risk Identification and Interventions

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Any patient entering through the Emergency Department

Patient developmentally appropriate to screen and able to answer yes or no questions?
- NO → Ask guardian: Does your child have any self-harming behaviors
  - NO → No Further Action Needed
  - YES → Provider to determine need for psych evaluation
- YES →

Patient medically capable of responding?
- YES →
- NO → Complete ASQ when patient becomes capable.

Guidance if family refuses to complete ASQ

Complete ASQ [A]

Review Answers to ASQ

YES to Q4 ONLY AND attempt was >1 year ago → No Safety Precautions Needed → Provider Reviews ASQ Reponses

All other positive ASQ responses →

RN to Initiate Safety Measures
- *Place Suicide Precautions Order Set*
- Patient placed under 1:1 observation
- Patient's clothes, shoes, personal belongings including electronic devices will be sent home or stored in a secure location
- Safety assessment completed by Security
- Create an environmentally safe room [appendix C]
- For cases of Sexual Assault or suspected Sex Trafficking/Exploitation review the linked algorithms and:
  - Modify the workflow as appropriate to preserve evidence while maintaining safety.
  - Notify ED APP and consider/discuss: wanding with home clothes on, removal of shoelaces & drawstrings, no bubbles or play-doh, NPO, no bath/shower, collection of dirty urine.

NO TO ALL → **Negative Screen:** Continue medical care as needed

Provider Reviews ASQ Reponses →

Review Answer to ASQ #5
- NO → Provider conducts Brief Suicide Safety Assessment (BSSA) and determines risk level

BSSA Script Sample

- YES →

What is the Risk Determination? [B]

IMMINENT RISK
Provider:
- Maintain safety precautions
- Notify nurse and observer

INTERMEDIATE TO HIGH RISK
Provider:
- Maintain safety precautions
- Notify nurse and observer

LOW RISK
Provider:
- Place ED Discontinue Sitter Order
- Notify nurse and observer
- Return belongings and discontinue Suicide Precautions order

Is admission medically indicated?
- YES → Voalte FYI to ED Psych Social Worker (SW); Convey need for inpatient psych consultation to inpatient care team
- NO →
  - Place ED Psych Consult Order
  - Voalte ED Psych Social Worker
  - ED Psych SW to complete Mental Health Evaluation, convey any privileges updates to ED provider and determine disposition
  - Based on psychiatry recommendations, ED provider will modify privileges order as indicated
  - See the ED Behavioral Health Disposition Algorithm for further details

Is psychiatric admission indicated?
- YES → Admit / transfer to Inpatient Psych Unit
- NO →

Is admission medically indicated?
- YES → Continue medical care, convey need for Inpatient team to engage in safety planning prior to discharge.
- NO →

Expected ED Discharge
- Engage in Safety Planning & document in Suicide Risk Toolkit
- Offer gun lock if indicated, stored in Pod 3 breakroom closet
- Add educational handout to AVS titled Teens and Suicide: What Families Should Know
- If outpatient mental health referrals needed, voalte ED Psych SW to add to AVS

Discharge

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Ann & Robert H. Lurie Children's Hospital of Chicago

Suicide Prevention Algorithm
Inpatient Unit

Inclusion Criteria:
- Patients admitted to an inpatient floor
- Patients admitted as outpatient in bed status
- All patients ≥ 10 years old
- Patients < 10 years old if there is a clinical concern by any person or are present for psychiatric concerns

Exclusion Criteria:
- Telemedicine Visits
- Outpatient Ancillary Services (i.e., phlebotomy, non-sedated medical imaging, rehab services)
- Inpatient Psych Unit

A. Ask Suicide Questionnaire (ASQ)

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts of killing yourself?
4. Have you ever tried to kill yourself?

IF YES TO 4, ASK:
"When was the attempt?

IF YES TO ANY OF 1-4, ASK 5:
5. Are you having thoughts of killing yourself right now?

B. RISK DETERMINATION REFERENCE
- **Imminent Risk:** Patient presents with severe behavioral symptoms and suicidal ideation with plan, method, and intent. Protective factors are not sufficient to offset risk, psychiatric admission may be required.
- **Intermediate to High:** Patient reports suicidal ideation with/ without plan but denies intent or behavior. There are more risk factors than protective factors.
- **Low Risk:** Patient expresses passive thoughts of death, no plan, no intent. Protective factors are strong.

POLICY
Suicide Prevention: Risk Identification and Interventions

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Any patient in an Inpatient Unit

Review APPENDIX D for patients being admitted through the Peri-Operative area or ED

Patient developmentally appropriate to screen and able to answer yes or no questions?

NO → Ask guardian: Does your child have any self-harming behaviors

NO → No Further Action Needed

YES → Provider to determine need for psych evaluation

YES

Patient medically capable of responding?

NO → Complete ASQ when patient becomes capable

YES → Complete ASQ [A]

Guidance if family refuses to complete ASQ

Review Answers to ASQ

YES to Q4 ONLY AND attempt was >1 year ago

No safety precautions needed

Provider Reviews ASQ Reponses

All other Positive ASQ responses

RN to Initiate Safety Measures
- *Place Suicide Precautions Order Set*
- Patient placed under 1:1 observation
- Patient's clothes, shoes, personal belongings including electronic devices will be sent home or stored in a secure location
- Create an environmentally safe room [appendix C]
- The Provider is notified of the results of the screening
- The Provider will use the diet modifier "disposable safety tray" when entering the diet order

NO TO ALL

Negative Screen: No further action needed at this time

Recommended to re-screen monthly if patient still admitted

How did patient answer to #5

NO → Provider conducts Brief Suicide Safety Assessment (BSSA) and determines risk level

ED BSSA Script Sample

YES

What is the Risk Determination? [B]

IMMINENT RISK
Provider:
- Maintain safety precautions
- Notify nurse and observer

INTERMEDIATE TO HIGH RISK
Provider:
- Maintain safety precautions
- Notify nurse and observer

LOW RISK
Provider:
- Discontinue 1:1 observation unless indicated for other Behavioral Health reasons
- Modify privileges as indicated
- Notify nurse and observer

Consult Psychiatry
- Psych to complete Mental Health Evaluation, convey any privileges updates to provider and determine disposition
- Provider will modify privileges order as indicated based on psychiatry recommendations

Long term admissions recommended to re-screen monthly

Continue medical care as indicated

Discharge Checklist
- Engage in Safety Planning & document in Suicide Risk Toolkit
- Place Medical Social Work consult to offer gun lock if indicated
- Add educational handout to AVS titled Teens and Suicide: What Families Should Know
- Provide outpatient mental health referrals if indicated

Discharge

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Suicide Prevention Algorithm
Procedural

Inclusion Criteria:
- Procedural or Imaging patients at Lurie Main, Westchester and Northbrook surgical centers
- Patients receiving nursing care
- All patients ≥ 10 years old
- Patients < 10 years old if there is a clinical concern by any person or are present for psychiatric concerns
- New and existing patients who have not been screened within the past 30 days

Exclusion Criteria:
- Telemedicine visits
- Outpatient ancillary services (i.e., phlebotomy, rehab services)

A. Ask Suicide Questionnaire (ASQ)

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts of killing yourself?
4. Have you ever tried to kill yourself?

IF YES TO 4, ASK:
"When was the attempt?

IF YES TO ANY OF 1-4, ASK 5:
5. Are you having thoughts of killing yourself right now?

B. SECONDARY SCREEN

IF YES ONLY TO 4, No to 5, Ask:
6. Has the patient received or is currently in mental health care?
7. Is parent/guardian aware of past suicidal behavior?
8. Is the suicidal behavior not a current, active concern?

C. RISK DETERMINATION REFERENCE
- **Imminent Risk:** Patient presents with severe behavioral symptoms and suicidal ideation with plan, method, and intent. Protective factors are not sufficient to offset risk, psychiatric admission may be required.
- **Intermediate to High:** Patient reports suicidal ideation with/ without plan but denies intent or behavior. There are more risk factors than protective factors.
- **Low Risk:** Patient expresses passive thoughts of death, no plan, no intent. Protective factors are strong.

POLICY:
Suicide Prevention: Risk Identification and Interventions

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Any patient entering through the Procedural or Imaging Area (Lurie Main 5/6/7, Westchester and Northbrook Surgical Center)

Patient developmentally appropriate to screen and able to answer yes or no questions?
- NO → Ask guardian, "Does your child have any self-harming behaviors?"
  - NO → No Further Action Needed
  - YES → Provider to determine need for psych evaluation
- YES

Do not cancel or delay procedure. Clinical judgement should be used to determine if further assessment is needed before procedure.

Patient medically capable of responding?
- YES
- NO → Complete ASQ when patient becomes capable

Complete ASQ[A] ← Guidance if family refuses to complete ASQ

Review Answers to ASQ
- NO TO ALL → **Negative Screen:** Continue procedural care as needed
- YES to Q4 ONLY → Ask Secondary Screen[B]
- ALL OTHER POSITIVE ASQ RESPONSES

Did patient answer **Yes to all and attempt >1 year ago**?
- NO → **RN to Initiate Safety Precautions**
  - *Place Suicide Precautions Order Set*
  - Patient placed under 1:1 observation
  - Patient's clothes, shoes, personal belongings including electronic devices will be sent home or stored in a secure location
  - Create an environmentally safe room [appendix C]
  - Provider notified of screen prior to surgery

  Guided script: how to talk to families about a positive ASQ
- YES → Patient at Low Risk; no further action needed → Continue procedural care as needed

How did patient answer to #5
- NO → **Lurie Main:** Medical Social Worker (SW) completes Brief Suicide Safety Assessment (BSSA) and determines risk level
  WST/NB: Provider completes BSSA and determines risk level
  BSSA Script Sample
- YES

Is patient medically capable to participate in BSSA?
- YES → What is the Risk Determination?[C]
- NO → SW or Provider completes BSSA when patient medically capable of participating in BSSA

What is the Risk Determination?[C]

IMMINENT RISK
- Provider/SW notifies nurse and observer
- RN maintains safety precautions and modifies Suicide Precaution Order set to include Privileges as indicated

INTERMEDIATE TO HIGH RISK
- Provider/SW notifies nurse and observer
- RN maintains safety precautions and modifies Suicide Precaution Order set to include Privileges as indicated

LOW RISK
- Provider/SW notifies nurse and observer
- RN places order to discontinue 1:1 Observation

Is post-op observation/admission indicated?
- YES → Admit Inpatient, convey need for Inpatient team to place psych consult for mental health evaluation
- NO

Is post-op observation/admission indicated?
- YES → Admit Inpatient. Convey need for inpatient team to complete BSSA if patient was not medically able to respond to BSSA while in procedural area
- NO

Transfer Patient to ED

Lurie Main
- Medical Social Worker (SW): Call ED Psych to give handoff (312-274-8677)
- RN: Call ED Charge RN to give handoff (312-274-6951)
- RN or Medical SW: Call Security (7-7777) to request patient transport assistance at time of transport
- See the ED Behavioral Health Disposition Algorithm for further details

WST/NB
- RN: Follow Transfer to Higher Level of Care Policy and send patient to ED

Is psychiatric admission indicated?
- YES → Admit to Inpatient Psych Unit
- NO

Discharge Checklist
- Med SW/Provider to engage in Safety Planning & document in Suicide Risk Toolkit
- Med SW/Provider to offer gun lock if indicated
- Med SW/Provider to provide outpatient mental health referrals if indicated
- Med SW/Provider add educational handout to AVS titled Teens and Suicide: What Families Should Know
- Med SW/ Provider to provide handoff to RN/MA about completion of checklist

Discharge

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Suicide Prevention Algorithm
Ambulatory

Inclusion Criteria:
- Patients at an ambulatory clinic in which psychiatric or suicidal ideation is of concern
- Patients seen in Adolescent Medicine *at Dayton only or*
  - All patients ≥ 10 years old
  - Patients < 10 years old if there is a clinical concern by any person or are present for psychiatric concerns
  - New and existing patients who have not been screened within the past 30 days

Exclusion Criteria:
- Non-medical provider clinics at Dayton
- Telemedicine Visits
- Outpatient Ancillary Services (i.e., phlebotomy, non-sedated medical imaging, rehab services)

A. Ask Suicide Questionnaire (ASQ)

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts of killing yourself?
4. Have you ever tried to kill yourself?

IF YES TO 4, ASK:
"When was the attempt?

IF YES TO ANY OF 1-4, ASK 5:
5. Are you having thoughts of killing yourself right now?

B. SECONDARY SCREEN

IF YES ONLY TO 4, No to 5, Ask:
6. Has the patient received or is currently in mental health care?
7. Is parent/guardian aware of past suicidal behavior?
8. Is the suicidal behavior not a current, active concern?

C. RISK DETERMINATION REFERENCE
- **Imminent Risk:** Patient presents with severe behavioral symptoms and suicidal ideation with plan, method, and intent. Protective factors are not sufficient to offset risk, psychiatric admission may be required.
- **Intermediate to High:** Patient reports suicidal ideation with/ without plan but denies intent or behavior. There are more risk factors than protective factors.
- **Low Risk:** Patient expresses passive thoughts of death, no plan, no intent. Protective factors are strong.

POLICY
Suicide Prevention: Risk Identification and Interventions

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Any patient at an Adolescent Medicine appointment at Dayton or any patient at an ambulatory clinic in which psychiatric or suicidal ideation is of concern

Patient developmentally appropriate to screen and able to answer yes or no questions?

NO → Ask guardian: Does your child have any self-harming behaviors

- **NO** → No Further Action Needed
- **YES** → Notify Provider → Provider to use clinical judgement to determine need for further assessment

YES

Complete ASQ #1-4[A]

Guidance if family refuses to complete ASQ

If psychiatric concern exist, or patient has an ASQ positive screen, and a provider is unable to complete BSSA, follow Transfer to Higher Level of Care Policy

Review Answers to ASQ

- **NO TO ALL** → **Negative Screen:** Continue care as needed
- **YES to Q4 ONLY** → Ask Secondary Screen[B]
- **ALL OTHER POSITIVE ASQ RESPONSES** → How did patient answer to #5

How did patient answer to #5

- **YES** → **MA/ RN to Initiate Safety Measures**
  - Patient placed under 1:1 staff observation; should not be left unattended
  - Create an environmentally safe room [appendix C]
  - The Provider and/or Social Worker (SW)on site, is notified of the results of the screening
  - If a patient is demonstrating violent or self-destructive behavior and does not respond to verbal de-escalation re-direction, call security if on site, or call 911

  → **IMMINENT RISK** → **Patient Transfer to ED via Ambulance**
  - Provider discretion if patient is to transfer to nearest ED or Lurie ED based on proximity and wait time
  - Call 911 or MedEx (773-725-9111) to request transport to Lurie ED
  - If transferring to Lurie ED, Call ED Psych (312-274-8677) and ED Charge RN to give handoff (312-274-6951)

  Ambulatory Lurie Main
  - Call ED Psych to give handoff (312-274-8677)
  - Call ED Charge RN to give handoff (312-274-6951)
  - Call Security (7-7777) to request patient transport assistance at time of transport

  → Disposition determined by the ED
- **NO** → Notify Provider and/or Social Worker (SW) on site

Did patient answer **Yes to all and attempt >1 year ago**?

- **NO** → Notify Provider and/or Social Worker (SW) on site
- **YES** → Notify Provider and/or Social Worker (SW) on site
  - Provider/ SW to use clinical judgement to determine need for further assessment
  - Complete Discharge Checklist

Notify Provider and/or Social Worker (SW) on site

NO

Provider or Medical SW on site completes Brief Suicide Safety Assessment (BSSA) and determines risk level

BSSA Script Sample

What is the Risk Determination?[C]

- **LOW RISK**
- **INTERMEDIATE TO HIGH RISK**
- **IMMINENT RISK**
  - Provider/SW notifies nurse and observer
  - MA/RN maintains safety precautions

Discharge Checklist
- Engage in Safety Planning as determined by provider or if patient is determined to be low to high risk
- Document in Suicide Risk Toolkit, complete safety plan and provide to the family
- Offer gun lock if indicated and available on site
- Print or add educational handout to AVS titled Teens and Suicide: What Families Should Know
- Provide outpatient mental health referrals if indicated

→ Discharge

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Suicide Prevention Algorithm
Appendix A CCG Overview

This guideline is based on the best available evidence and local expert consensus for elements for which evidence are inconclusive.

Suicide Prevention CCG Overview

Background & Problem:
- Lurie Children's instituted a policy to screen all youth 10 years and older for suicide risk with the Ask Suicide-Screening Questions (ASQ) in 2019. Compliance with ASQ screening needs to be sustained. Compliance with recommended follow-up steps requires improvement.

- Baseline Data (2024): Compliance with ASQ screening was 83% across the hospital. Brief Suicide Safety Assessment completion was 60% in the ED and 32% in inpatient/ procedural areas. Safety plan completion was 62% in the ED and 19% in inpatient/ procedural areas. The sitter order rate among patients with a positive suicide risk screen was 43% across the hospital.

Inclusion:
- All youth 10 years and older seen in the ED, inpatient, procedural, and adolescent clinics

Exclusion:
- Other care areas; youth who are developmentally unable to answer yes/no

Outcome Measure:
- Number of ED visits and hospitalizations for suicide attempts per quarter

Process Measures:
- Percent of youth 10 and older screened with the ASQ
- Percent of youth with +ASQ who receive a Brief Suicide Safety Assessment (BSSA)
- Percent of youth with +ASQ who receive a safety plan prior to discharge
- Percent of youth with +ASQ with appropriate sitter utilization

Balancing Measures:
- Percent of patient with imminent positive ASQ who have a Psychiatric consultation completed

Contributors

Clinical Leaders:
- Laura Clarke, MD, (General Medicine)
- Ibeth Clavijo, SW (Family Services)
- Kimberly Denicolo, RN (Emergency Department)
- Laura Finn, APN PA (Practice and Professional Development)
- Monica A. Getz, RN (Nursing Excellence)
- Debrea Griffith, MD (General Medicine/Pulmonary)
- Jennifer Hoffmann, MD (Emergency Department)
- Aron Janssen, (Psychiatry)
- Tierney Lofgren, RN (Nursing Excellence)
- Anna Lund, RN (Nursing Excellence)
- Alba Pergjika, MD (Psychiatry)
- Carolynn Price, MD (General Medicine)
- Anna Ross, Psychologist (Adolescent Medicine)
- Lisa Simons, MD (Adolescent Medicine)

Key Members:
- Christine Adler, RN (Emergency Department)
- Rebecca Barber, LCSW (Emergency Department Psychiatry)
- Christine Bauer (Ambulatory Clinical Applications)
- Moshe Bitterman (Psychiatry)
- John Bowden (Accreditation Readiness)
- Takishma Bryant, RN (Emergency Department)
- Erin Burke, RN (Nursing Excellence)
- Amanda Burnside, Psychologist (Psychiatry)
- Laura Cambruzzi, SW (Family Services)
- Gina Carpinelli, RN (Pre & Post Procedural Care)
- Elizabeth Colla, RN (Cardiology)
- Valerie J. DeMarchi, RN (Nursing Informatics & Innovation)
- Sommer Deselms, RN (Pre & Post Procedural Care)
- Amanda Eichstaedt, RN (Medical Imaging)
- Megan Forby, SW (Family Services)

Key Members (continued):
- Teresa Garcia (Inpatient Clinical Applications)
- Rachel Hersch, RN (Nursing Excellence)
- Mallory Hillard, LCSW (Psychiatry Administrations)
- Vivian T. Ho, SW (Family Services)
- Cally Hutton, RN (Nursing Education & Research)
- Kim Kaczor (Psychiatry Services)
- David Koscinski (Inpatient Clinical Applications)
- Susana Marchan-Rojo, (Inpatient Clinical Applications)
- Emily McGiness, RN (Nursing Excellence)
- Ashely Miller, RN (Cardiology)
- Emily Munro, RN (Pediatric Surgery/Transplant)
- Michael Olsen, RN (Nursing Excellence)
- Caylin Rubino, RN (Pediatric Intensive Care Unit)
- John P. Sarmiento, RN (Nursing Excellence)
- Allison Schroepfer, (Nursing Informatics & Innovation)
- Tara Spears (Nursing Informatics & Innovation)
- Samantha Swiderski, RN (General Medicine/ Pulmonology)
- Jonathan W. Wanta, MD (Psychiatry)
- Natalie Weatherred, APP (Anesthesia Clinical Support)
- Christina M Wilbur, RN (Nursing Education & Research)
- Halley Williams, SW (Family Services)
- Janis Zinanni, APRN (Inpatient)

Improvement Consultants:
- Brian Giblin, MBA
- Fernando Gonzalez III, MBA

Version History

July 2022, March 2026

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Suicide Prevention Algorithm
Appendix B Education and Resources

Ann & Robert H. Lurie Children's Hospital of Chicago

Suicide Prevention Policy | Suicide Prevention Terms and Definitions | Suicide Screening at Lurie Handout | Suicide Screening at Lurie Handout- Spanish

Ask Suicide Screening Questions (ASQ) Resources

For staff: ASQ Screening Tool | ASQ Toolkit Summary

For families: ASQ Refusal Guidance/ Addressing Caregiver Concerns | ASQ Refusal Guidance/ Addressing Caregiver Concerns - Spanish

National Institute of Mental Health Recommended Script	**Say to parent/guardian:** "National safety guidelines recommend that we screen all kids for suicide risk. We ask these questions in private, so I am going to ask you to step out of the room for a few minutes. If we have any concerns about your child's safety, we will let you know." **Once parent steps out, say to patient:** "Now I'm going to ask you a few more questions." *Administer the ASQ and any other questions you want to ask in private* **If patient screens positive, say to patient:** "These are hard things to talk about. Thank you for telling me. I'm going to share your answers with [Provider or SW] and they will come speak with you." **If patient screens positive, say to parent:** "We have some concerns about your child's safety that we would like to further evaluate. It's really important that they spoke up about this. I'm going to talk to [Provider or SW], and they will further evaluate your child for safety.
ASQ Refusal Guidance (Handouts available in For Families section)	**ED/Inpatient/Procedural** 1. Screener will ask the family what it is about the screening they are concerned about. 2. If specifically refusing to have screening questions asked in private, instead ask the questions with the family present. 3. Print and provide ASQ Refusal Guidance handout found above. Scripting for team: I understand you have concerns about screening your child for suicide risk. Explain to the family that the screening is done using a validated tool and screening is a national standard to prevent suicide. "Suicide risk screening does not increase the prevalence of suicidal thoughts in children and adolescents, does not lead to increased psychological distress, and does not lead to increased risk of suicide" (Decou et al 2018, On the Iatrogenic Risk of Assessing Suicidality: A Meta-Analysis). 4. If still refusing, escalate to unit leadership and providers (fellows/attendings). 5. If still refusing and family expresses concern, refer to patient relations. 6. If the frontline provider has a clinical concern about the child's risk of suicide and the parent is refusing to let the provider interview the child to complete the assessment, reference the Emergency Temporary Protective Custody Algorithm to determine if the patient meets inclusion criteria.
	Adolescent Medicine & Ambulatory 1. Screener will ask the family what it is about the screening they are concerned about. 2. If specifically refusing to have screening questions asked in private, instead ask the questions with the family present. 3. If still refusing, notify provider that screening did not take place. 4. If indicated, print and provide ASQ Refusal Guidance handout found above. Scripting for team: I understand you have concerns about screening your child for suicide risk. Explain to the family that the screening is done using a validated tool and screening is a national standard to prevent suicide. "Suicide risk screening does not increase the prevalence of suicidal thoughts in children and adolescents, does not lead to increased psychological distress, and does not lead to increased risk of suicide" (Decou et al 2018, On the Iatrogenic Risk of Assessing Suicidality: A Meta-Analysis).

Brief Suicide Safety Assessment Resources

For staff: BSSA Worksheet | BSSA Guide | Risk Level Determination Examples

Risk Level Determination Reference	• **IMMINENT RISK:** Patient presents with severe behavioral symptoms and suicidal ideation with plan, method, and intent. Protective factors are not sufficient to offset the risk. Emergency psychiatric admission may be required. • **INTERMEDIATE TO HIGH RISK:** Patient reports suicidal ideation with or without plan but denies intent or behavior. There are more risk factors than protective factors. • **LOW RISK:** Patient expresses passive thoughts of death, no plan, no intent. Protective factors are strong. *Note: These examples are intended to serve as an example of a range of risk levels and interventions, not actual determinations. Please click on the RISK LEVEL DETERMINATION EXAMPLES link above for more information*

Safety Planning Resources

For staff: Stanley Brown Safety Plan

For families: Teens and Suicide What Families Need to Know | Teens and Suicide What Families Need to Know- Spanish | Mental Health Resources

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Suicide Prevention Algorithm
Appendix C Environmentally Safe Room

ALL AREAS

When transporting a patient at risk for suicide that is in airborne or droplet precautions, staff must remove the metal nose clips form the patient's surgical mask and discard in a sharp's container.

PROCEDURAL/AMBULATORY: Imminent risk only:

- Remove as many dangerous items from room as possible
- Lock drawers and cabinets if applicable
- Allow patient to stay in clothes but empty pockets and remove items & check for items like belts and other clothing items that could cause harm (i.e., bras with underwires, etc.)

INPATIENT/ED:

The patient's shoes and clothes will be removed, and patient will be placed in hospital attire. Clothes, shoes, and personal belongings including electronic devices will be sent home or stored in a secure location until the Psychiatric Evaluation is completed.

Examples of items to remove from the patient and the room who is at risk for suicide:

Sharp Items

- Aluminum cans
- Clippers
- Compact Discs/ DVD's
- Glass or porcelain dishes
- Jewelry
- Keys
- Metal eating utensils
- Mirrors
- Nail Files
- Needles
- Paper clips
- Pocket knives
- Razors
- Sharps Containers
- Spiral Notebooks
- Toothpicks
- Tweezers

Items that could be used for strangulation

- Balloons
- Belts
- Chains
- Cords (i.e., charging cords for electronic devices, unnecessary electrical cords, corded phones)
- Dental Floss
- Draw strings
- Ribbons
- Scarves
- Shoestrings
- Stockings
- Suspenders
- Ties
- Trash Bags
- Unnecessary tubing (oxygen, pulse ox, etc.)

Ingestible items

- Alcohol based hand sanitizer
- Alcohol based mouthwash
- Batteries
- EVS Cleaning products (such as soaps or detergents)
- Medications (including home medications)
- Shampoos and conditioners
- Small items that would be easy to swallow

Other

- Matches or lighters
- Unnecessary medical supplies
- Unnecessary medical equipment
- Furniture or equipment with parts that can be easily broken off

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Suicide Prevention Algorithm

Appendix D Patient Admission Guidance

Care Area Origin	Care Area Destination	Guidance
Emergency Department	Inpatient Unit	• Patients who are medically unable to participate in the BSSA during their ED visit, may need to have the BSSA completed once medically able to on an inpatient unit. Once a BSSA is completed, continue to re-screen every 30 days to determine need for a new BSSA completion.
Pre/PACU/Post	Inpatient Unit	• Patients in pre-op complete an ASQ and a secondary screen when indicated, to determine need for a BSSA. If the secondary screen is negative, patients are identified at low risk. If admitted to the inpatient unit, a BSSA does not need to be completed on the unit. Continue to re-screen every 30 days to determine need for a new BSSA completion. • If a BSSA was not completed prior to surgery, the patient will likely be unable to participate in the PACU due to recent sedation. The BSSA can be completed once the patient is admitted. Do not delay transfers between care areas.

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