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Original Research

The Role of Suicide Risk Assessment Screening in the Pediatric Orthopaedic Clinic

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ABSTRACT

Background: Suicide is the second leading cause of death for youth 12–18 years of age. Identification of adolescents with suicidal ideation can help facilitate early interventions. This study evaluates the use of a PSS-3 Suicide Risk Screener (SRA), given to patients presenting to a specialty pediatric orthopaedic clinic (SCC), to identify suicide risk and interventions performed for these patients.

Methods: We conducted a retrospective cohort study of the 1920 patients that presented to the SCC in 2022. Every patient that entered the clinic was given a SRA to complete. We determined the frequency of positive screens, negative screens, and incomplete screens and the demographics of the patients in the positive group. We also determined the frequencies of the interventions performed for patients that did have a positive screen.

Results: Of the 1920 patients that presented in the SCC in 2022, 319 patients had an incomplete screen and were excluded from the analysis. One patient was incorrectly coded to have a positive screen in the SCC clinic and was excluded. Of the 1600 patients that had a complete screen, 3% (48) had a positive SRA screen. Of the patients with a positive screen, the mean age was 13.6 years (1.27), 54.2% (26) female, and 89.8% (43) had public insurance. Of note, 23% (11) of those with a positive screen met with a social worker and were admitted to an inpatient facility.

Conclusions: The addition of the PSS-3 Suicide Risk Screener in this pediatric orthopaedic clinic screened 83% of patients presenting to the clinic and found a 3% positivity rate for patients that completed the screen. In 2022, 1 in every 180 patients who visited the SCC were admitted to an inpatient facility for suicidality. The implementation of a suicide risk assessment helped us to identify a need for intervention in patients originally presenting for musculoskeletal complaints. There is a role for suicide risk screening in pediatric orthopaedic clinics.

Key Concepts:
(1) Utility of suicide screening questionnaires in orthopaedic clinics is poorly understood.
(2) This study sought to investigate the risk of suicidality in pediatric orthopaedic patients.
(3) Suicide risk screening in pediatric populations can identify patients at risk.
(4) Early intervention to address suicide risk in pediatric orthopaedic patients can significantly improve outcome.
(5) Suicide risk screening in pediatric orthopaedic clinics has a strong role in better promoting overall health.

Level of Evidence: Level III

Introduction

Suicide in preadolescent and adolescent populations has become an increasingly widespread public health concern in the United States (U.S.) and globally. In 2020, suicide was the second leading cause of death in ages 10 to 14, and the third leading cause of death in ages 15 to 19 in the U.S [1]. When comparing suicide rates globally, the U.S. ranked seventh in suicide rates in ages 10 to 19 [2]. Suicidality in preadolescent and adolescent populations is highly complex. Janiri et al. described a number of risk and protective factors for suicide in adolescent populations [3]. Of the risk factors listed, physical health conditions were highly associated with increased suicidal tendencies [3]. A study published in 2024 found that of the 306,800 suicides studied, more than a third had physical problems and no documented psychological illness [4].

In pediatric orthopaedic practice, suicide screening is often an overlooked component of comprehensive medical care. Many orthopaedic

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conditions, especially those that are debilitating, can profoundly affect a child's mental health [5]. One study found a moderate to severe risk of depression in roughly 1.3–3.5% of pediatric orthopaedic patients [5], this further highlights the utility of suicide screening. Integrating routine suicide screening is a useful tool to identify high-risk youth that may otherwise go undetected. Boudreaux et al. found a nearly two-fold increase in suicide risk detection when universal screening was implemented [6]. Additionally, many studies have detailed the importance of timely intervention when preventing suicidality. Data released in 2022 detail the dynamic nature of the suicide process and how timely management can dramatically change the outcome [7]. Thus, suicide risk screenings are beneficial in all settings, including orthopaedics, to assist with timely intervention and suicide prevention.

Despite the growing evidence supporting the relationship between physical health and mental well-being, there remains a significant gap in knowledge and understanding of the relationship. This study aims to investigate the use of a PSS-3 Suicide Risk Assessment in a Specialty Pediatric Orthopaedic Clinic to better identify the risk of suicide in specific orthopaedic conditions and interventions employed once risk assessed. Additionally, this study seeks to provide further context to the highly dynamic interplay between physical health and mental well-being.

Materials and Methods

Participants

The study was approved by the University of Texas at Austin Institutional Review Board. Patients aged 11–18 years who presented for musculoskeletal complaints to the orthopaedic clinic at an urban acute care hospital with a level 1 pediatric trauma center were retrospectively identified. The Specialty Care Clinic (SCC) universally screened patients for suicide risk using the PSS-3 between January 1st and December 31st, 2022. All data was sourced from the electronic medical record (EMR) and extracted manually or queried from existing hospital-based databases.

Instrumentation

PSS-3 is a brief screening tool to identify suicide risk and further screening in the ED setting. The hospital system adapted this screening tool into the suicide risk assessment (SRA) and it is administered in the hospital orthopaedic clinic (Fig. 1). Each of the PSS-3's items evaluates a different aspect of suicide risk: depressed mood, active ideation, and lifetime attempt. In the clinic, one response of "yes" initiated a protocol for a social worker to visit with the patient to determine the need for further intervention. Patients were not told prior to completing the screening tool that a social worker would visit them if positive. This was an attempt to get the most honest answer from parents. If the SRA was negative, then no further screening was completed.

A social worker visited with the patient and family in the clinic after a positive result was determined. Social Workers are always present in this clinic and are always available for immediate consultation following a positive result. They gathered more information about the patient's current state, history, and access to resources. They also completed safety plans with patients and families and determined the need for psychiatric hospitalization.

The compliance rate, or the percentage of encounters that correctly followed the suicide screening procedures (appropriate administration of SRA followed by a social worker visit for those positive on SRA), was calculated to understand screening procedure adherence. Approximately 63% (n = 31) of SRA-positive screens who were evaluated by a social worker resulted in either additional resources or hospitalization.

Data collection

Patients meeting study inclusion who visited the pediatric orthopaedic clinic in 2022 were identified (N = 1920) by querying hospital EMR databases. A manual EMR review was conducted to validate the patient had an encounter in the clinic and completed an SRA. EMR review found 1 patient incorrectly coded as visiting the clinic and was excluded from further analysis. Of the remaining 1919 patients, 319 did not complete a SRA and these patients were also excluded. 1600 patients were included in the analysis of suicide risk.

The variables queried from hospital databases included the date of the clinic visit; age; sex (male and female); residential zip code; insurance status (private, public, and uninsured); visit diagnosis; result of SRA; and interventions after a positive SRA result.

Data analysis

Frequencies and percentages were used to investigate the rate of positivity among the study cohort and to determine the rate of those who were admitted to inpatient psychiatric facilities. A chi-square test of independence was performed for each of the categorical variables of interest and a *P* value was obtained to determine whether there was a statistically significant difference in the factor among positive and negative patients. A standard 2-tailed *t*-test was used to test the association of the patient's age at the time of the encounter with the outcome. A chi-square test was also run for the presenting diagnoses in the clinic, and a Bonferroni correction was also used to adjust the significance level. For

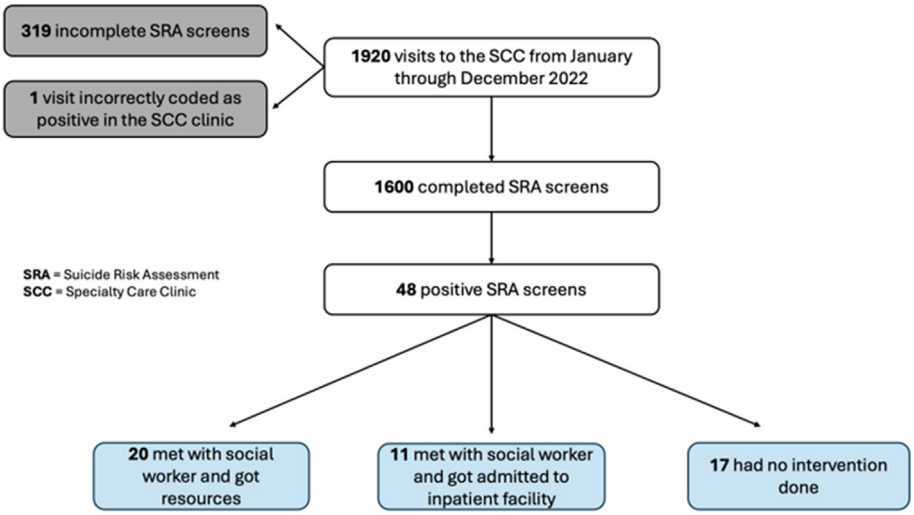


Figure 1. Summary of universal screening outcomes.

all tests, the *P*-value was set to .05. Additionally, further statistical analysis was conducted to determine effect size by condition to quantify the power of any potential association between suicidal ideation and specific diagnoses.

Results

Demographic characterization

Of the 1600 who completed the SRA screening tool, 48 positive screens were identified. 54% of the patients that screened positive were female and had a mean age of 13.6 years (Table 1). When the study population was characterized based on insurance status, 6.1% were privately insured, 89.8% were publicly insured, and 4.1% were uninsured.

The demographics of the 1552 patients who screened negative on the SRA during their visit to clinic is presented in Table 1. Characteristics of the study population were nearly identical to those of patients who screened positive on the SRA, although they had a larger percentage of males than females.

Summary of universal screening outcomes

Of the 1920 patient visits to the pediatric orthopaedic clinic in 2022, 1600 patients were screened for suicidality using the SRA tool. Of those 1600 patients, 48 patients screened positive for suicide risk. 20 patients met with a social worker and received mental health resources and counseling referrals, 11 met with the social worker and were admitted directly to an inpatient psychiatric facility, and 17 had no documented intervention performed (Fig. 1).

Characterization of positive results by condition

A total of 48 positive results were found from patients presenting with many types of musculoskeletal diseases and conditions. In addition to the positive screening result for suicidality, 11 unique conditions were present, including scoliosis, fracture, herniated disk, ligament sprain, avulsion, foot pain, joint dislocation, fibroma, coccygeal pain, contracture, and hip pain. Studies of the prevalence of different conditions vary widely. Patients with disc herniation were found to have a 100% occurrence of suicidality, although the sample size was small, N = 2 (Table 2). In contrast, the two conditions with the largest sample sizes—fractures and scoliosis—had the lowest screening-positive rates of 4.1% and 4.4%, respectively. Additionally, an in-depth statistical analysis was performed detailing Chi-square, Chi-square *P*-value, odds ratio, Fisher's exact *P*-value, Cohen's W, and Power for each condition to determine true correlation (Table 3). Based on our data, all patients screening positive showed small to negligible effect size and insufficient power to support a genuine association with individual diagnosis.

Table 1
Demographics of all patients that completed SRA screening.

Metric	Positive screening	Negative screening
Screening result	(N = 48)	(N = 1552)
Gender	Male: 45.8% Female: 54.2%	Male: 62.6% Female: 37.4%
Insurance status	Private: 6.1% Public: 89.8% Uninsured: 4.1%	Private: 5.5% Public: 89.0% Uninsured: 5.5%
Average age	13.61 years	13.98 years
Age Range	10–12: N = 10 (20%) 13–14: N = 30 (61%) 15–16: N = 7 (14%) 17+: N = 2 (4%)	10–12: N = 380 (24%) 13–14: N = 616 (40%) 15–16: N = 402 (26%) 17+: N = 150 (10%)

Table 2
Result by presenting positive conditions.

Diagnoses	Positive test (n = 48)	Negative test (n = 704)	% of completed screens
Scoliosis	10	215	4.4%
Fracture	17	394	4.1%
Herniated disc	2	0	100.0%
Sprain	3	13	18.8%
Avulsion injury	3	3	50.0%
Foot pain	5	25	16.7%
Dislocation	1	22	4.3%
Fibroma/Fibrous dysplasia/cyst	3	5	37.5%
Coccyx pain	2	2	50.0%
Contracture	1	3	25.0%
Hip pain	1	22	4.3%

Table 3
Statistical analysis of conditions with positive results.

Condition	Chi-square	Chi-square *P*-value*	Odds ratio	Fisher's exact *P*-value*	Cohen's W†	Power‡
Scoliosis	1.55	.21259	0.60	.1927	0.05	0.06
Fracture	6.74	.00945	0.43	.0069	0.09	0.40
Herniated disk	6.54	.01055	15.30	.0219	0.09	0.39
Sprain	2.35	.12520	3.55	.0755	0.06	0.10
Avulsion	12.64	.00038	15.62	.0042	0.13	0.76
Foot pain	3.91	.04808	3.17	.0360	0.07	0.19
Dislocation	0.00	1.00000	0.66	1.0000	0.00	0.00
Fibroma	8.40	.00375	9.35	.0108	0.11	0.52
Coccyx pain	6.54	.01055	15.30	.0219	0.09	0.39
Contracture	0.25	.61439	4.99	.2318	0.02	0.01
Hip	0.00	1.00000	0.66	1.0000	0.00	0.00

Interpretation:
* Applying Bonferroni *P*-value correction for 11 conditions ($\alpha' = 0.05/11 \approx 0.0045$) $P < .0045$.
† Cohen's W effect size, where small effect: W = 0.1; medium effect: W = 0.3; large effect: W = 0.5.
‡ Power (1-β) - The probability of correctly rejecting the null hypothesis >0.8.

T-test analysis of age

T-test analysis was performed on the ages of positive and negative screening. The average age of participants with a positive screen result was 13.61 ± 1.27 years, while the average age of participants with a negative screen result was 13.98 ± 1.72 years. Statistical analysis of the relationship between age and screening results revealed no significant correlation between age and screening results ($P = .0526$). Significance was determined at a value of $P < .05$ (Table 4).

Table 4
Analysis of respondents by age.

T-test for age	
P-value	.0526
Average positive age	13.61±1.27
Average negative age	13.98±1.72
Median positive age	14
Mode positive age	14

Discussion

The results of this study highlight the importance of integrating suicide risk screening within pediatric orthopaedic clinics. With the successful screening of 83% of patients and a 3% positivity rate among those who completed the screening, it is evident that the implementation of the PSS-3 Suicide Risk Screener was effective in identifying at-risk individuals. This aligns with more recent research that demonstrates the effectiveness of brief screening tools, such as the Ask Suicide-Screening Questions (ASQ), in detecting suicide risk across various clinical settings. Recent studies suggest that such tools are effective even in non-mental health environments, including pediatric emergency departments and outpatient clinics, where mental health symptoms may be indirectly presented [7].

The patient's demographics with a positive screen revealed that the mean age was 13.6 years, with 54.2% being female, and almost 90% had public insurance. This provides insight and clarity into the proposed utility of targeted support and intervention strategies. These findings are somewhat consistent with newer studies that continue to show that females and adolescents from lower socioeconomic backgrounds, particularly those with public insurance, are at heightened risk for suicidality [8]. This demographic's vulnerability suggests a need for more targeted interventions in specialty care settings where at-risk youth may not typically receive mental health screening.

The findings also demonstrate the significance of the interventions performed for patients with a positive screen. A notable 23% of these patients met with a social worker and were subsequently admitted to an inpatient facility for further evaluation and treatment. This underscores the critical role of early identification and timely interventions in addressing suicidality among pediatric orthopaedic patients. Recent research emphasizes the importance of immediate referral to mental health services post-screening, including safety planning interventions that can reduce suicidal behavior. While the study results are promising in identifying at-risk individuals and providing interventions, several potential drawbacks remain. Firstly, the use of a suicide risk screener in a pediatric orthopaedic clinic may not be the most effective or feasible method of identifying at-risk individuals. Musculoskeletal complaints may not always be directly linked to mental health concerns, and relying solely on this setting for suicide risk screening may lead to missed opportunities for identifying individuals in other clinical settings, such as primary care or emergency departments, where suicide risk screening may be more appropriate [9,10]. Additionally, this study was based on patients in a specialty care hospital clinic where social workers are readily available to consult patients. In private practice, it might be difficult to replicate the social work team that is available in a hospital setting.

Moreover, the reliance on a brief screening tool like the PSS-3 may not capture the full complexity of suicide risk and mental health concerns in adolescent patients. The tool's focus on depressed mood, active ideation, and lifetime attempts may overlook other important factors such as underlying mental health disorders, past trauma, or ongoing stressors in the patients' lives [9,11]. Recent reviews have highlighted the limitations of these screeners in addressing the full scope of suicide risk and have recommended that they be used as part of a more comprehensive assessment strategy, especially in non-mental health settings [9]. Additionally, the high rate of patients with public insurance who completed the screening raises questions about potential disparities in access to mental health care. Recent studies continue to document disparities in mental health service access based on insurance status, with individuals on public insurance more likely to be screened but potentially receiving fewer follow-up resources [9,12]. It's possible that patients with private insurance or those who are uninsured may not have been equally represented in the study, which could skew the results and limit the generalizability of the findings [9]. clinical time to complete the screening is a highly variable and a relevant consideration. Once Social Workers were consulted, additional clinical time and resources were provided in order to ensure the entirety of the patient's orthopaedic and mental health needs were addressed.

This study is limited by the length of the questionnaire implemented for suicide risk assessment. Suicidality is a multifactoral, evolving phenomenon that cannot be fully captured in one screening assessment. Thus, providing the possibility of false negatives and/or positives being present. Additionally, parents may not fully understand the unique expression of depression and suicidality in pediatric populations, providing an additional avenue for false negatives when completing shorter screening assessments. Although only studies filled out by patients were included, parent-patient interaction and parent-social work may have had some influence. Due to limited availability, we were unable to identify the long-term outcome and diagnosis following social work intervention. Additionally, although our study detailed a number of demographic data on both groups, previous psychiatric history, family history, and other social factors leave out an important context. Despite this, our study highlights the importance of further discussions of suicide screening in orthopaedic practice for pediatric populations. With the right social work tools in place, suicide risk screening can be a valuable reference in guiding clinicians in the future.

Conclusion

In conclusion, the incorporation of suicide risk assessment within the pediatric orthopaedic clinic not only identified individuals at risk who will need access to care and support. This study underscores the potential for early detection and intervention in a population that may not have been otherwise referred for mental health treatment. While the study emphasizes the potential benefits of integrating suicide risk assessment within pediatric orthopaedic clinics, it's essential to critically evaluate the limitations and potential unintended consequences of such practices. A more comprehensive and nuanced approach to mental health screening and intervention may be necessary to ensure the well-being of at-risk pediatric patients.

Additional links

- **JPOSNA®:** Diagnosis and Management of Nerve Injuries Caused by Pediatric Upper Extremity Fractures
- **JPOSNA®:** Use of a “Fast, Feed, and Wrap” Technique with Local Anesthesia for In-Office Surgical Correction of Postaxial Polydactyly Type B in Infants

Author contributions

Cortney Matthews: Writing – original draft, Formal analysis. **Trayce Gray:** Writing – review & editing, Writing – original draft, Methodology, Data curation. **Jordan Tanyi:** Writing – review & editing, Writing – original draft. **Niamh McMahon:** Writing – review & editing, Supervision, Resources, Project administration. **Hilton Gottschalk:** Supervision, Resources, Project administration, Investigation.

Informed patient consent

Complete written informed consent was obtained from the patient, their guardian or legal representative for the publication of this study and accompanying images.

Ethics

This study was approved by the University of Texas at Austin IRB committee. IRB documentation is available upon request.

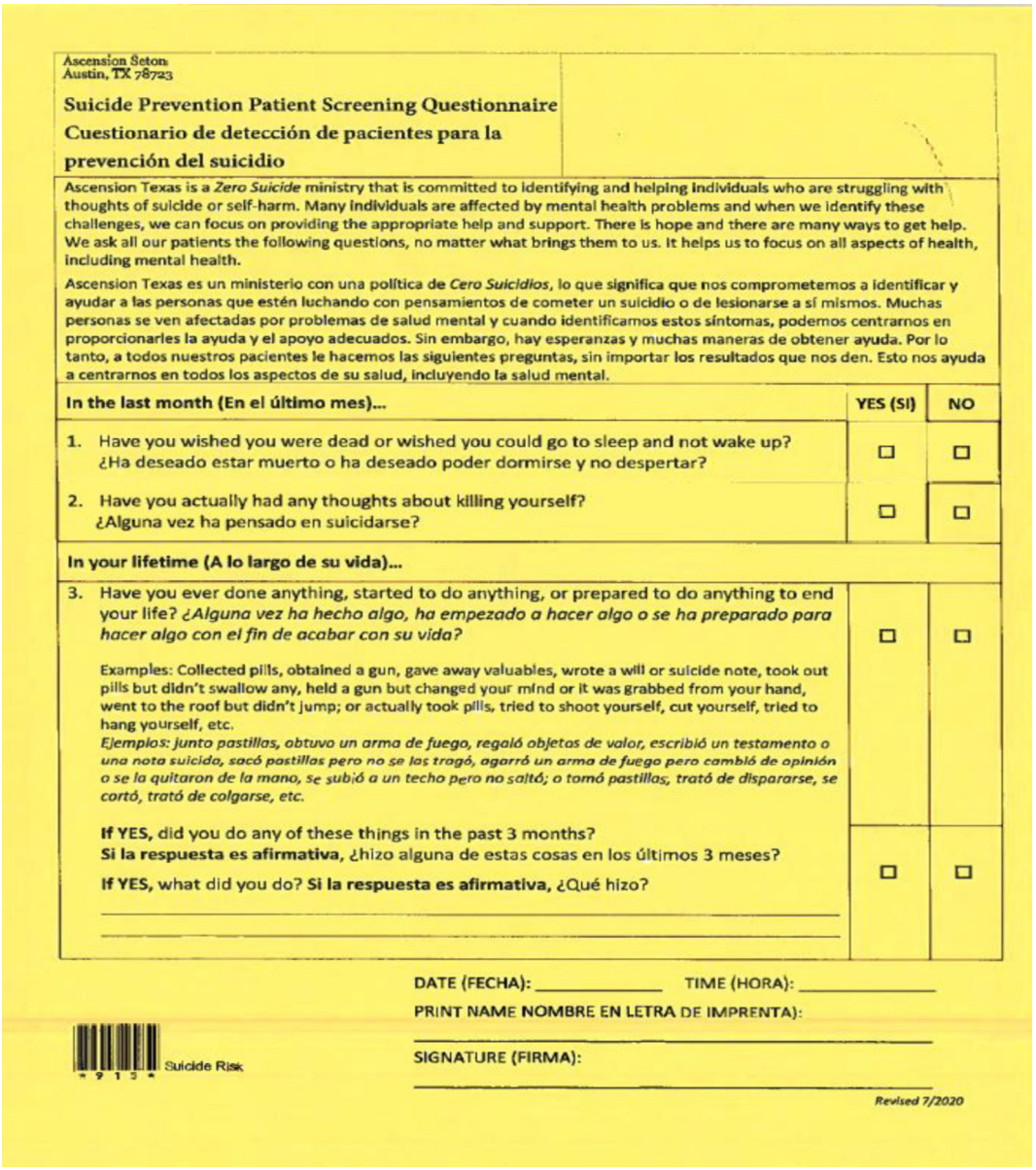
Funding

This study received no external funding.

Declaration of competing interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix 1. SRA Tool



Ascension Seton
Austin, TX 78723

Suicide Prevention Patient Screening Questionnaire
Cuestionario de detección de pacientes para la prevención del suicidio

Ascension Texas is a *Zero Suicide* ministry that is committed to identifying and helping individuals who are struggling with thoughts of suicide or self-harm. Many individuals are affected by mental health problems and when we identify these challenges, we can focus on providing the appropriate help and support. There is hope and there are many ways to get help. We ask all our patients the following questions, no matter what brings them to us. It helps us to focus on all aspects of health, including mental health.

Ascension Texas es un ministerio con una política de *Cero Suicidios*, lo que significa que nos comprometemos a identificar y ayudar a las personas que estén luchando con pensamientos de cometer un suicidio o de lesionarse a sí mismos. Muchas personas se ven afectadas por problemas de salud mental y cuando identificamos estos síntomas, podemos centrarnos en proporcionarles la ayuda y el apoyo adecuados. Sin embargo, hay esperanzas y muchas maneras de obtener ayuda. Por lo tanto, a todos nuestros pacientes le hacemos las siguientes preguntas, sin importar los resultados que nos den. Esto nos ayuda a centrarnos en todos los aspectos de su salud, incluyendo la salud mental.

In the last month (En el último mes)...	**YES (SI)**	**NO**
1. Have you wished you were dead or wished you could go to sleep and not wake up? ¿Ha deseado estar muerto o ha deseado poder dormirse y no despertar?	☐	☐
2. Have you actually had any thoughts about killing yourself? ¿Alguna vez ha pensado en suicidarse?	☐	☐
In your lifetime (A lo largo de su vida)...		
3. Have you ever done anything, started to do anything, or prepared to do anything to end your life? *¿Alguna vez ha hecho algo, ha empezado a hacer algo o se ha preparado para hacer algo con el fin de acabar con su vida?*	☐	☐
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. *Ejemplos: juntó pastillas, obtuvo un arma de fuego, regaló objetos de valor, escribió un testamento o una nota suicida, sacó pastillas pero no se las tragó, agarró un arma de fuego pero cambió de opinión o se la quitaron de la mano, se subió a un techo pero no saltó; o tomó pastillas, trató de dispararse, se cortó, trató de colgarse, etc.*		
If YES, did you do any of these things in the past 3 months? **Si la respuesta es afirmativa,** ¿hizo alguna de estas cosas en los últimos 3 meses? **If YES,** what did you do? **Si la respuesta es afirmativa,** ¿Qué hizo? _____ _____	☐	☐

DATE (FECHA): _____ TIME (HORA): _____

PRINT NAME NOMBRE EN LETRA DE IMPRENTA): _____

SIGNATURE (FIRMA): _____

Suicide Risk

Revised 7/2020

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Suicide Risk Assessment (C-SSRS)

For INITIAL ASSESSMENT, begin questions with "In the past month..."
For REASSESSMENT, begin questions with "Since I last asked..."

Ask questions 1 and 2 (questions are **bolded & underlined**). If asking caregiver, reframe question.	NO	YES
1. Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore or wish to fall asleep and not wake up. **Patients 12 and up:** Have you wished you were dead or wished you could go to sleep and not wake up? **Patients 10-11/Cognitively Impaired:** Do you ever wish you weren't alive anymore?	☐	☐
2. Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. **Patients 12 and up:** Have you actually had any thoughts of killing yourself? **Patients 10-11/Cognitively Impaired:** Have you thought about doing something to make yourself not alive anymore?	☐	☐
If YES to 2, ask questions 3, 4, 5, and 6. **If NO to 2,** go directly to question 6.	**NO**	**YES**
3. Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it." **Patients 12 and up:** Have you been thinking about how you might do this? **Patients 10-11/Cognitively Impaired:** Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)?	☐	☐
4. Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts, but I definitely will not do anything about them." This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it. **Patients 12 and up:** Have you had these thoughts and had some intention of acting on them? **Patients 10-11/Cognitively Impaired:** When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?	☐	☐
5. Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. **Patients 12 and up:** Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? **Patients 10-11/Cognitively Impaired:** Have you ever decided how or when you would make yourself not alive anymore? Have you ever planned out (worked out the details of) how you would do it? When you made this plan (or worked out these details), was any part of you thinking about actually doing it?	☐	☐
6. Suicide Behavior Question: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **Patients 12 and up:** Have you ever done anything, started to do anything, or prepared to do anything to end your life? **Patients 10-11/Cognitively Impaired:** Did you ever do anything to try to kill yourself or make yourself not alive? **IF YES, ask:** How long ago did you do any of these?	☐	☐ >1 year ☐ >3mo <1yr ☐ within 3mo

DATE: _____ TIME: _____
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Suicide Risk Assessment

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Ascension Seton
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Suicide Risk Stratification & Interventions

✓	Assessment	Patient/Caregiver Responses	Interventions
☐	**HIGH**	**Yes to #4** and/or **Yes to #5** and/or **Yes to #6, within last 3 months** and/or **Guided by Clinical Judgement/Situational Context***	Initiate **HIGH** Suicide Risk Interventions
☐	**MODERATE**	**Yes to #3** and/or **Yes to #6, > 3 months < 1 year ago**	Initiate **MODERATE** Suicide Risk Interventions
☐	**LOW**	**Yes to #1** and/or **Yes to #2** and/or **Yes to #6, > 1 year ago**	Initiate **LOW** Suicide Risk Interventions

***Clinical judgement & situational context should be considered along with patient responses when determining risk level**
(i.e. a patient denying ideation upon admission/initial SRA immediately following a known attempt > consider HIGH suicide risk)

✓	Assessment	Patient/Caregiver Responses	Clinical Interventions
☐	**NO RISK**	**No to #1 & #2 and #6**	• **RN** to consider situational context to determine risk level* • No suicide precautions required at this time
☐	**Unable to Assess***	**Document** current reason Unable to Assess *(use this space for downtime)*:	• **RN** to consider situational context to determine risk level* • **RN** to notify Provider if suicidality is indicated as part of admission • **RN** documents Reason Unable to Asses in medical record • **RN** to document safety precautions as determined/ taken by care team • **RN** to assess patient/caregiver when able/ available to respond
☐	**Patient Refusal to Discuss SRA***	**Document** to explain refusal & actions taken *(use this space for downtime)*:	• **RN** to consider situational context to determine risk level* • **RN** to notify Provider • **RN** to document as "Clinician Notification" – include actions taken • **RN** to document safety precautions as determined/ taken by care team

DATE: _____ TIME: _____
PRINT NAME: _____
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