Suicide Prevention in Emergency Departments

An Implementation Toolkit Informed by Vermont's Experience

December 2025

Vermont Program for Quality in Health Care

VPQHC
Vermont Program for Quality in Health Care, Inc.

Acknowledgements

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This toolkit is a living document.

As VPQHC and our partners continue to advance this work, the tools, guidance, and examples included here will evolve to reflect emerging evidence, regulatory guidance, and on-the-ground learning from implementation.

Who This Toolkit is For

This toolkit is intended for:

- Emergency Department leadership and managers
- Quality improvement and patient safety teams
- Clinical leaders and frontline staff involved in suicide care
- Hospital implementation teams and project leads
- External partners supporting ED suicide care work

How to Use This Toolkit

This toolkit is designed as a step-by-step implementation guide. The steps reflect a recommended sequence. Teams may adapt timing, order, or depth based on local readiness, resources, and scope.

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Introduction

Since 2022, the Vermont Program for Quality in Health Care (VPQHC) has partnered with Vermont Emergency Departments (EDs) to implement and continuously improve suicide care pathways for individuals presenting to the ED.

This work focuses on:

- Evidence-informed clinical workflows
- Workforce training and readiness
- Continuous quality improvement
- Long-term sustainability of suicide care best practices

Implementing reliable, high-quality suicide care in the ED is not a one-time effort. It requires deliberate sequencing, testing, refinement, and reinforcement over time. For many organizations, full implementation and sustainment of best practices may unfold over multiple years, as systems mature, staff turn over, workflows evolve, and data are used to guide ongoing improvement.

Improving suicide care at scale is most successful when situated within a deliberate improvement system, including clear standards, performance measurement, coaching, and shared learning across teams. External partnerships can enhance this work by providing specialized expertise and facilitation, but the core components can also be built within organizations. Vermont's Emergency Departments have advanced along this continuum with support from VPQHC, progressing from initial assessment to implementation and long-term sustainment.

This toolkit reflects that longitudinal, learning-based approach and is designed to support teams wherever they are in their implementation journey.

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Before You Begin: How to Get Started

Insights from Edwin Boudreaux, PhD

Emergency Departments (EDs) can help prevent suicide. There are well-established best-practices for doing so. But, many EDs are simply not taking advantage of these best-practices, and the care they provide falls short. The reason this is true is because, while best-practices exist, they are not easy to implement. It requires more than simply training clinicians to perform a specific task; it requires a substantial organizational commitment to change the way the system provides care from start to finish. And, this commitment needs to stay strong for months or even years.

Why should a health system invest the time and resources to do this? The first and most important reason is because it leads to reduced suicide attempts and reduced suicide. This not only helps suicidal individuals directly, it has a ripple effect. Preventing one suicide prevents suffering and anguish of the individual's friends, family, coworkers, and community members. But, there are other reasons. Improving care can reduce ED re-use, which can help healthcare organizations and payors save money. And, if done well, it can improve clinician satisfaction. When clinicians feel more confident and capable of helping suicidal individuals, they feel pride and satisfaction.

We have distilled the process of transforming ED care into a 10-step approach, described below.

VPQHC maintains all of the listed tools in the 10-step approach in multiple editable formats (e.g., Word, Excel). For access or more information, please contact info@vpqhc.org.

The 10-Step Implementation Path for Hospital Implementation Teams

1. Orient to the Work & Engage Leadership

Create shared understanding of purpose, scope, and expectations. Secure leadership alignment and commitment. Leadership support should include resources for staffing, quality improvement (QI) expertise, information technology (IT) support, protected time, and policy or workflow updates.

2. Form the Implementation Team

A multidisciplinary implementation team is critical. At minimum, this typically includes the ED Director, ED Nurse Manager, and mental health clinicians who support patients at risk for suicide in the ED (whether in-house or contracted), along with QI, data/analytics, and IT/EHR staff as relevant.

3. Assess Organizational Current State & Gaps Against Best Practice

Document how current suicide care practices align with evidence-based and leading practice. This step focuses on what is happening now, not readiness or capacity.
It identifies alignment, gaps, and variation across leadership, policies, workforce training, clinical practices, safety processes, and quality systems. Findings establish a shared understanding of the current state and inform prioritization.

Tool 1: Suicide Care in the ED Organizational Assessment

The 10-Step Implementation Path for Hospital Implementation Teams

4. Anchor to Best Practice

Define the expectations for suicide care in the ED. The Elements guide defines what “good” care looks like and serves as the reference point for pathway design, auditing, training, and performance monitoring. It distinguishes minimum regulatory expectations from best and leading practices. This guide functions as the north star for all pathway design, improvement, and sustainment work.

Tool 2: Elements of a Suicide Care Pathway

5. Address Environmental Safety & Establish Baseline Performance

Before designing or updating the clinical pathway, complete the Suicide Care in the ED Mock Survey Tool to assess current suicide care practices. Environmental safety should also be reviewed early given its foundational role in reliable suicide care. At the same time, conduct a baseline chart audit to understand how suicide care is currently documented and delivered. Baseline findings surface gaps in process execution and documentation of essential elements and help ground pathway design in real-world conditions.

Tool 3: Suicide Care in the ED Mock Survey Tool

Tool 4: Chart Audit Tool

The 10-Step Implementation Path for Hospital Implementation Teams

6. Map Current Practice & Identify Gaps

Map the current state of suicide care workflows in the Emergency Department. Use the workflow mapping tool to document how care is delivered today, and apply the audit tool to assess alignment with the Essential Elements of a Suicide Care Pathway Guide. Together, these tools help identify gaps, variation, and areas of misalignment between current practice and best practice across roles, documentation, handoffs, and clinical processes.

Tool 5: Suicide Care in the ED Clinical Pathway Mapping Tool

Tool 6: Suicide Care in the ED Clinical Pathway - Audit Tool

7. Design the Ideal Future-State Pathway

Design a future-state suicide care pathway that addresses identified gaps and incorporates all essential elements of evidence-based and leading practice. The future-state pathway should define clear roles, reliable workflows, and documentation expectations across the ED visit and transitions of care. This pathway becomes the foundation for training, improvement testing, auditing, and long-term sustainment.

The 10-Step Implementation Path for Hospital Implementation Teams

8. Launch Improvement Work

Use Plan-Do-Study-Act (PDSA) cycles to define improvement aims, select meaningful measures, test changes, and establish feedback loops at the clinical microsystem level. This tool serves as the formal record of improvement work and learning over time.

Tool 7: Suicide Care in the ED QI PDSA Tracking Tool

9. Prepare the Workforce

Plan and sequence training by role and pathway. Integrate into onboarding, annual education, and competency checks to build shared understanding, strengthen confidence, and ensure staff know what to do, when, and how.

Tool 8: Suicide Care in the ED Training Scaffolding

10. Monitor Fidelity & Performance

Monitor documentation and performance over time. Ongoing review reinforces standards, supports compliance, and sustains reliability.

Tool 4: Chart Audit Tool (Ongoing)

Additional Information

Adaptation and Local Customization

All tools in this toolkit are intended to be:

- Adapted to local staffing models and workflows
- Integrated with each site's electronic health record
- Aligned with regulatory, accreditation, and internal quality structures

Organizations should preserve the core intent and structure of each tool while tailoring operational details to local context.

Data Use, Confidentiality & Learning Culture

Information generated through use of these tools is intended to support quality improvement and learning. Results should be shared internally in a non-punitive manner and, when shared externally, aggregated unless explicit permission is provided. The toolkit is designed to promote transparency, psychological safety, and continuous improvement.

Questions, Support & Technical Assistance

VPQHC welcomes questions and is available to provide clarification related to the use of these tools. Organizations seeking to replicate this work at a regional or statewide level are encouraged to connect for shared learning at info@vpqhc.org.

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TOOLS

- **Tool 1: Suicide Care in the ED Organizational Assessment**
- **Tool 2: Elements of a Suicide Care Pathway**
- **Tool 3: Suicide Care in the ED Mock Survey Tool**
- **Tool 4: Chart Audit Tool**
- **Tool 5: Suicide Care in the ED Clinical Pathway - Mapping Tool**
- **Tool 6: Suicide Care in the ED Clinical Pathway - Audit Tool**
- **Tool 7: Suicide Care in the ED QI PDSA Tracking Tool**
- **Tool 8: Suicide Care in the ED Training Scaffolding**

Tool 1: Suicide Care in the ED Organizational Assessment

Introduction

The purpose of this reassessment is to evaluate progress and identify ongoing strengths and opportunities for improvement related to suicide prevention practices in the ED setting. While not exhaustive of all factors that influence patient care and outcomes, the assessment reflects key components of a comprehensive suicide prevention approach. Please note that this tool is based largely on the ZeroSuicide Inpatient Organizational Assessment and has been adapted specifically for use in ED settings. There are 25 questions in this assessment. Thank you for your continued commitment to this important work.

Who should complete the assessment?
While it is recommended that one person coordinate the responses for each hospital, it is important that multiple perspectives are included. As such, we recommend completing the assessment collaboratively, perhaps during a team meeting. Please include at least the following in that meeting: ED nurse manager, ED Director, Quality Director, Risk Management, a frontline ED nurse, ED physician, and medical technician (or other representative that may be engaged on 1:1 observation with a suicidal patient in the ED).

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Tool 1: Organizational Assessment

Technical Notes: You are welcome to work on this survey over time, meaning that the settings are such that you should be able to make updates, close out, and return to complete as your schedule allows.

Deadline: Kindly submit this assessment by [INSERT YOUR DEADLINE]. Should you have any questions, please reach out to [INSERT YOUR CONTACT PERSON].

Please provide information on the lead coordinator for this assessment:

Name	
Position Title	
Organization	
Email Address	
Phone Number	

Please list other people that contributed to this assessment below. As a reminder, while it is recommended that one person coordinate the responses for each hospital, it is important that multiple perspectives are included. As such, we recommend completing the assessment collaboratively during a team meeting. Please include at least the following in that meeting: ED nurse manager, ED Director, Quality Director, Risk Management, a frontline ED nurse, ED physician, and medical technician (or other representative that may be engaged on 1:1 observation with a suicidal patient in the ED).

Name, Position, Title, Email	
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Tool 1: Organizational Assessment

ZERO SUICIDE ELEMENT ONE: LEAD

A comprehensive suicide-prevention approach relies on the creation of several policies intended to establish guidelines and promote the adoption of safer suicide care. Please consider whether you have established written policies, as well as staff training, in the following areas (yes/no responses):

	Do you have a written ED protocol/policy specific to this component of suicide care?	Is this component embedded in your EHR or easily identifiable in your written documentation?	Do you provide staff training specific to this component of suicide care?
Suicide-specific screening	**YES/NO**	**YES/NO**	**YES/NO**
Suicide risk assessment and formulation	**YES/NO**	**YES/NO**	**YES/NO**
Lethal means safety and counseling	**YES/NO**	**YES/NO**	**YES/NO**
Safety planning	**YES/NO**	**YES/NO**	**YES/NO**
Transition of care planning (discharge and follow-up)	**YES/NO**	**YES/NO**	**YES/NO**
Environment of care (psychical hospital environment)	**YES/NO**	**YES/NO**	**YES/NO**

Tool 1: Organizational Assessment

Has leadership made a formal commitment to reduce suicide and provide safer suicide care through a dedicated suicide prevention implementation team? **(yes/no responses)**

Are suicide attempt or suicide loss survivors involved in the development of suicide prevention activities in your ED? **(yes/no responses)**

Please indicate activities in which suicide attempt and suicide loss survivors are involved (select all that apply):

☐ Ad hoc informal advisory role
☐ Lead support groups
☐ Staff crisis hotline
☐ Review and advise on policies and procedures
☐ Assist with employee hiring and training
☐ Participate in evaluation and quality improvement activities
☐ Play an active role in decision-making teams
☐ Other, please specify:

Tool 1: Organizational Assessment

ZERO SUICIDE ELEMENT TWO: TRAIN

How does your ED formally assess staff on their perception of their confidence, skills, and support to care for individuals at risk for suicide?

☐ There is no formal assessment of staff on their perception of confidence and skills in providing suicide care.

☐ Clinicians who provide direct patient care are routinely asked to provide suggestions for training.

☐ Clinical staff complete a formal assessment of skills, needs, and supports regarding suicide care. Training is tied to the results of this assessment.

☐ A formal assessment of the perception of confidence and skills in providing suicide care is completed by all staff (clinical and non-clinical). Comprehensive ED training plans are tied to the results.

☐ A formal assessment of the perception of confidence and skills in providing suicide care is completed by all staff and reassessed at least annually. ED training and policies are developed and enhanced in response to perceived staff weaknesses.

Additional comments:

Tool 1: Organizational Assessment

What advanced training on identifying people at risk for suicide, suicide assessment, risk formulation, and ongoing management has been provided to ED clinical staff?

☐ There is no ED-supported training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management, and no requirement for clinical staff to complete training on suicide.

☐ Training is available on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management through the ED, but it is not required of clinical staff.

☐ Training is required of select staff (e.g., psychiatrists, therapists/clinicians, nurses) and is available throughout the ED.

☐ Training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management is required of all clinical staff. The training used is considered a best practice and was not internally developed.

☐ Training on identification of people at risk for suicide, suicide assessment, risk formulation, and ongoing management is required of all clinical staff. The training used is considered a best practice. Staff repeat training at regularly defined intervals.

Additional comments:

Tool 1: Organizational Assessment

Please indicate the training approach or curriculum the ED uses to train clinical staff on advanced suicide prevention skills (select all that apply):

☐Assessing and Managing Suicide Risk (AMSR)
☐Chronological Assessment of Suicide Events (CASE Approach)
☐Commitment to Living
☐Counseling on Access to Lethal Means (CALM)
☐Columbia-Suicide Severity Rating Scale (C-SSRS)
☐Recognizing and Responding to Suicide Risk (RRSR)
☐SuicideCare
☐QPRT Suicide Risk Assessment and Management Training
☐Collaborative Assessment and Management of Suicidality (CAMS)
☐Safety planning

Additional comments:

Please indicate the minimum number of hours of training required annually for non-clinical staff in suicide risk identification and care.

Tool 1: Organizational Assessment

ZERO SUICIDE ELEMENT THREE: IDENTIFY

What are the ED's policies for screening for suicide risk?

☐ There is no systematic screening for suicide risk.

☐ Individuals in designated higher-risk programs or categories are screened.

☐ Suicide risk is screened at intake for all individuals presenting with mental health primary needs.

☐ Suicide risk is screened at intake for all individuals receiving either psychical health or mental health care.

☐ Suicide risk is screened at intake for all individuals receiving either psychical health or mental health care; suicide risk is reassessed at least every waking shift for those identified at risk.

Additional comments:

Please indicate the screening tool(s) your ED uses to screen for suicide risk (select all that apply):
☐ PHQ-3
☐ Columbia Suicide Severity Rating-Scale (C-SSRS) Screener
☐ Columbia Suicide Severity Rating-Scale (C-SSRS) Triage Version
☐ National Suicide Prevention Lifeline Risk Assessment Standards
☐ The Patient Safety Screener
☐ ASQ Suicide Risk Screening Tool
☐ Other (please specify):

Tool 1: Organizational Assessment

How does the ED assess suicide risk among those who screened positive?

☐ There is no routine procedure for risk assessments that follow the use of a suicide screen.

☐ Risk assessment is required after screening, but the process or tool used is up to the judgment of individual clinicians and/or only psychiatrists can do risk assessments.

☐ Providers conducting risk assessments use a standardized risk assessment tool, which may have been developed in-house. All patients who screen positive for suicide have a risk assessment. Suicide risk assessments are documented in the medical records.

☐ All individuals with risk identified, either at intake screening or at any other point during care, are assessed by clinicians who use validated instruments or established protocols and who have received training. Assessment includes both risk and protective factors.

☐ A suicide risk assessment is completed using a validated instrument and/or established protocol that includes assessment of both risk and protective factors and risk formulation. Staff receive training on risk assessment tool and approach.

Additional comments:

What instrument(s) do you use to conduct the risk assessment? Select all that apply.

☐ SAFE-T
☐ CSSR-S Risk Assessment Version
☐ Scale for Suicide Ideation - Worst (SSI-W; Beck et al., 1997)
☐ Beck Scale for Suicide Ideation (BSI; Beck & Steer, 1991)
☐ Other (please specify):

Tool 1: Organizational Assessment

ZERO SUICIDE ELEMENT FIVE: TRANSITIONS OF CARE

When answering the next question, please consider the following as components of a comprehensive suicide care management plan.

- Screening
- Assessment and risk formulation
- Safety planning
- Lethal means safety
- Evidence-based treatment
- Supportive contacts with patients who don't show for appointments and during care transitions
- Real-time communication between teams and caregivers about patient needs

Please select the statement that most closely aligns with your ED's practices related to suicide care management plans:

☐ Caregivers use best judgment in the care of individuals with suicidal thoughts or behaviors and seek consultation if needed. There is no formal guidance related to care for individuals at risk for suicide.

☐ When suicide risk is detected, the care plan is limited to screening and does not include the suicide care management plan components listed above.

☐ All caregivers are expected to provide care to those at risk for suicide. The ED has written guidance for care management for individuals at different risk levels, including observation expectations, frequency of contact, care planning, and safety planning.

continue to next page for additional options

Tool 1: Organizational Assessment

☐ Electronic or paper health records are enhanced to embed all suicide care management components listed above. Caregivers have clear guidelines or policies for care management for individuals with suicidal thoughts or behaviors, and real time information sharing and collaboration among all relevant providers are documented. Staff receive guidance on and clearly understand the ED's suicide care management approach.

☐ Individuals at risk for suicide are placed on a suicide care management plan (care pathway). The ED has a consistent approach to suicide care management, which is embedded in the electronic health records and reflects all of the suicide care management components listed above. Guidelines for putting someone on and taking someone off a care management plan are clear.

Additional comments:

Tool 1: Organizational Assessment

What is the ED's approach to collaborative safety planning when an individual is at risk for suicide?

☐ Safety planning is neither systematically used by nor expected of staff.

☐ Safety plans are expected for all individuals with elevated risk, but there is no formal guidance or policy around content. There is no standardized safety plan or documentation template. Plan quality varies across providers.

☐ Safety plans are developed for all individuals at elevated risk. Safety plans rely on formal supports or contact (e.g., call provider, call helpline). Safety plans do not incorporate individualization, such as an individual's strengths and natural supports. Plan quality varies across providers.

☐ Safety plans are collaboratively developed for all individuals at elevated risk and must include risks and triggers and concrete coping strategies. The safety plan is shared with the individual's partner or family members (with consent). All staff use the same safety plan template and receive training in how to create a collaborative safety plan.

☐ A safety plan is collaboratively developed on the same day as the patient is assessed positive for suicide risk. The safety plan is shared with the individual's partner or family members (with consent). The safety plan identifies risks and triggers and provides concrete coping strategies, prioritized from most natural to most formal or restrictive. Other clinicians involved in care or transitions are aware of the safety plan.

Tool 1: Organizational Assessment

Additional comments:

Does your ED use the Stanley/Brown safety plan template?
☐ Yes
☐ No
☐ Unsure

What safety planning tool or approach does your ED use?

Tool 1: Organizational Assessment

What is your ED's approach to lethal means safety and counseling?

☐ Means safety discussions and who to ask about lethal means are up to individual clinician's clinical judgment. Means safety counseling is rarely documented.

☐ Means safety is expected to be included on collaborative safety plans for all patients identified as at risk for suicide. Steps for means safety planning are up to the individual clinician's judgment. The ED does not provide any training on counseling on lethal means safety.

☐ Means safety is expected to be included on all collaborative safety plans. The ED provides training on counseling on access to lethal means. Steps for means safety planning are up to the individual clinician's judgment. Family or significant others may or may not be involved in reducing access to lethal means.

☐ Means safety is expected to be included on all collaborative safety plans, and families are included in means safety planning. The ED provides training on counseling on access to lethal means. The ED sets policies regarding the minimum actions for restriction of access to means.

☐ Means safety is expected to be included on all collaborative safety plans. Contacting family to confirm removal of lethal means is the required, standard practice. The ED provides training on counseling on access to lethal means. Policies support these practices. Means safety recommendations and plans are reviewed at times of transition of care and regularly while the individual is at an elevated risk.

Additional comments:

Tool 1: Organizational Assessment

Please include additional information on your ED's approach to lethal means safety and counseling.

☐ Plans included in collaborative safety planning document.
☐ Training for staff on means restriction on both logistics and counseling skills
☐ Process includes confirmation of removal of means.
☐ Policies identify minimum actions required to document and ensure means restriction.
☐ Policy includes plans for review of means restriction with individual in care.

Additional comments:

What is the ED's approach to transitions of care for patients who are at elevated suicide risk and have recently been discharged?

☐ There are no specific guidelines for contact of those at elevated suicide risk following discharge from the ED.

☐ The ED ensures that those at elevated suicide risk have a documented scheduled (within 7 days) follow-up or transition appointment at the time of discharge from the ED, but the parameters and methods for ensuring follow up are not defined by policy or the individual's level of risk.

☐ The ED has as comprehensive transition practice in place to provide a caring contact within 24-48 hours post-discharge from the ED. ED protocols are in place that address those expectations following transition from the ED. Training for staff supports improving engagement efforts.

Additional comments:

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Tool 1: Organizational Assessment

Please briefly describe the current practices in your ED for reaching out to patients after discharge for a mental health concern or suicidality.

Thinking about implementing a system for caring post-discharge contacts with patients who were identified with suicidality, what are some barriers you can foresee, or already encountered?

What are possible facilitating factors that might make it easier to implement post- discharge caring contacts?

What are other systems for communicating with patients following discharge, not related to mental health crisis or suicidality, that might serve as a model for doing follow-up with these patients?

Tool 1: Organizational Assessment

ZERO SUICIDE ELEMENT SIX: IMPROVE

What is your ED's approach for reviewing identified deaths by suicide in the ED?

☐ When a suicide or adverse event (including suicide attempt or interrupted attempt) happens while the patient is in the ED, a team meets to discuss the case.

☐ Root cause analysis is conducted on all suicide deaths or near misses of people in the ED.

☐ Root cause analysis is conducted on all suicide deaths or near misses of people in the ED and data from all root cause analyses are routinely examined to look at trends and to make changes to policies.

☐ Root cause analysis is conducted on all suicide deaths of people in inpatient care as well as for those up to 30 days post-discharge. Policies and training are updated as a result.

☐ Root cause analysis is conducted on all suicide deaths of people in the ED as well as for those up to six months post-discharge, and on all suicide attempts requiring medical attention. Policies and training are updated as a result.

Additional comments:

Tool 1: Organizational Assessment

What is your ED's approach to measuring suicide deaths?

☐ The ED has no policy or process to measure suicide deaths for those who received care in the ED.

☐ The ED measures the number of deaths for those who received care in the ED primarily based on family report.

☐ The ED has specific internal approaches to measuring and reporting on all suicide deaths for those who received care in the ED up to 30 days post-discharge. Deaths are confirmed through coroner or medical examiner reports.

Additional comments:

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Tool 1: Organizational Assessment

What is the ED's approach to quality improvement activities related to suicide prevention?

☐ The ED has no specific policies related to suicide prevention and care, and it does not focus on suicide care other than care as usual. Care is left to the judgment of the clinical provider.

☐ Suicide care is discussed as part of employee training.

☐ Early discussions about using technology and/or enhanced record keeping to track and chart suicide care are underway. Suicide care management is partially embedded in an EHR or paper record.

☐ Suicide care is partially embedded in an EHR or paper record. Data from suicide care management plans (using EHRs or chart reviews) are examined for fidelity to ED policies, and discussed by a team responsible for this.

☐ Suicide care is entirely embedded in EHR. Data from EHR or chart reviews are routinely examined (at least every two months) by a designated team to determine that staff are adhering to suicide care policies. EHR clinical workflows or paper records are updated regularly as the team reviews data and makes changes.

Additional comments:

Tool 1: Organizational Assessment

HOSPITAL ENVIRONMENT OF CARE

What is your ED's approach to management of risks in the physical environment that could be used to attempt suicide?

☐ The ED has not yet focused specifically on developing a suicide safer environment of care and currently maintains routine or care as usual processes for this item.

☐ The ED completes regular environmental risk assessment and identifies potential hazards to minimize risk to individuals served but there is no defined process for implementing identified change needs.

☐ Based upon a defined and regularly implemented ED risk assessment, the ED has made specific changes to the physical environment (such as removal of anchor points, door hinges, and hooks that could be used for hanging). The ED adheres to written policies specific to contraband and patient belongings (such as belts, shoelaces, ties).

☐ The ED has made specific changes to the physical environment (such as removal of anchor points, door hinges, and hooks) and has written policies for keeping patients in suicidal crisis in a safe environment under the appropriate level of direct supervision. These policies include provision for one to one monitoring, safe storage of patient's and visitor's belongings that may be used for self-harm, and removal of objects from the room such as bell cords, bandages, gowns with strings, plastic bags, and cleaning supplies.

continue to next page for additional options

Tool 1: Organizational Assessment

☐ The ED has made specific changes to the physical environment (such as removal of anchor points, door hinges, and hooks) and has written policies for keeping patients in a suicidal crisis in a safe environment under the appropriate level of direct supervision. These policies included provision for one to one monitoring, safe storage of patient's belongings that may be used for self-harm, and removal of objects from the room such as bell cords, bandages, gowns with strings, plastic bags, cleaning supplies. Education for all staff caring for suicidal patients includes review of policies and safety procedures to ensure a suicide safer environment of care. Staff are comfortable speaking about safety concerns.

Additional comments:

Tool 2: Elements of a Suicide Care Pathway

INTRODUCTION

A suicide care pathway is a formalized, structured sequence of processes designed to identify, assess, mitigate, treat, and transition care for individuals with suicide risk. It helps to ensure that every patient receives consistent, comprehensive support. It is often presented using a process diagram or map that shows the step-by-step care elements involved. This map generally corresponds to written narratives that describe each care elements, which can be incorporated into policies and protocols.

When constructing a suicide care pathway in acute care settings, a site should consider the universe of care elements that can produce the best possible outcome for the patient. This often starts with the minimum standards or essential elements, such as those outlined in the Joint Commission's Patient Safety Goal 15. It can then be expanded by adding in best-practices, when and where possible, based on a site's population and resources.

A typical pathway in acute care must be specific about who (what role?) completes and documents each care element. Care pathways should be informed by people with lived experience; should be flexible to allow patient-centered, compassionate care; and should enhance, not over-ride, clinician judgement. Alterations to the care pathway for an individual patient, when they occur, should be justified and documented as part of care decision making.
This document defines the different care pathway elements that can be chosen. We indicate whether the element is required by the Joint Commission and whether it is a best-practice.

Tool 2: Elements of a Suicide Care Pathway

When available, we provide a reference to an authoritative organization that recommends this best-practice. The first three elements are general approaches that typically occur at the organization or setting level, while the remaining elements apply to steps when treating individual patients.

1. Environmental safety assessment. Technically, an environmental safety assessment is not part of a care pathway, as the care pathway typically refers to caring for an individual patient. It is included here, because it is a foundation of suicide prevention in acute care, is required by The Joint Commission, and care pathways may differ based on the type of settings, such as whether the unit is ligature resistant. The environmental safety assessment is completed at the organization level using a process whereby a team evaluates the environment of care to determine if it is safe, such as whether there are ligature points. Such risks are then addressed, when possible, such as installation of ligature resistant doors and furniture. When they are not remediable by permanent or structural means, the specifics associated with removing hazards should be made clear, such as whether medical equipment needs to be removed from the room or the level of observation that should be used, such as 1:1 continuous observation.

In general, medical areas are not ligature resistant and have other safety hazards, and, therefore, require a combination of approaches to reduce access to lethal means, including removing equipment and use of constant observation for those at high risk. Behavioral health treatment areas are typically safer and may require less removal of items and less intensive observation, such as 15-minute frequent checks, except for those judged to be at imminent risk.

Tool 2: Elements of a Suicide Care Pathway

Status: Required by The Joint Commission (Element of Performance 1)1 and Centers for Medicare and Medicaid Services (CMS)2 is a best practice endorsed by the Zero Suicide Institute3 and the National Action Alliance for Suicide Prevention (NAASP).4

2. Person-centered care. This is an over-arching element that pertains to the entire visit, from initial presentation through transfer out of the ED, and is applicable for all care roles. Broadly, it refers to treating individuals in a humane, respectful, compassionate manner. This includes the use of patient-centered communication approaches, collaborative decision making, addressing implicit and explicit bias, use of least restrictive approaches, and trauma informed care approaches.

Status: Not required by The Joint Commission1 but is a best practice endorsed by the Zero Suicide Institute,3 NAASP,4 the American Association of Colleges of Nursing (AACN),5 and the Substance Abuse and Mental Health Services Administration (SAMHSA).6

3. Continuous quality improvement (CQI). This is not a specific are element but refers to how the care pathway is implemented in practice to ensure that actual care being delivered consistent with the pathway. First, sites have written policies and procedures that address care of patients that include a description of the training and establishment of staff competence on the care elements they are expected to deliver, guidelines for reassessment of risk, and monitoring patients at high risk. Second, implementation, monitoring, and improving upon the care pathways using a CQI approach should be used.

Tool 2: Elements of a Suicide Care Pathway

Status: Required by The Joint Commission (Element of Performance 5 and 7)1 and is a best practice endorsed by the Zero Suicide Institute3 and the Agency for Healthcare Research and Quality (AHRQ).7

4. Evidence-based screening. At the individual care level, initial screening using an evidence-based screening tool should be completed. The care pathway should:

1. Clearly identify which patients are to be screened, including if it is clinically indicated (those with mental health presenting complaints) or universal (all comers);
2. Who (what role) will do the initial screening;
3. When the screening will be done, e.g., triage vs initial assessment;
4. The instrument to be used, including whether different instruments will be used for different age groups and settings; and
5. How and where the screening should be documented in the record.

Ideally, the initial screening will lead to risk stratification, such as negligible, mild, moderate, or high risk. This initial screening is primarily for triage purposes and is conservative. Secondary screening or brief assessment by a trained clinician, such as the emergency physician, social worker, or mental health professional, can also happen to help further define or modify the individual's risk strata in situ.

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Tool 2: Elements of a Suicide Care Pathway

Examples of evidence-based screening tools include:

Measure	Ages 8-11	Ages 12-17	Ages 18+
ASQ Suicide Risk Screening Tool	☑	☑	☑ *to 24
C-SSRS Triage Version (C-SSRS Screener)	☑	☑	☑
Patient Safety and Secondary Screener		☑	☑
Computerized Adaptive Test for Suicide		☑	☑
Suicide Behavior Questionnaire – Revised		☑	☑
Suicidal Thoughts and Behaviors Inventory (SITBI)		☑	☑

Status: Required by The Joint Commission (Element of Performance 2)1 and is a best practice endorsed by the Zero Suicide Institute3 and NAASP.4

Tool 2: Elements of a Suicide Care Pathway

5. Brief suicide safety assessment. A brief suicide safety assessment (BSSA), sometimes referred to as secondary screening, is a process of gathering more information about the individual's risk, but it is not a comprehensive suicide risk assessment. It is typically performed by a trained clinician, such as the emergency physician, social worker, or mental health professional, and is used to further define or modify the individual's risk strata in situ and to determine additional care that is required, such as a full psychiatric evaluation. It is commonly used with the Ask Suicide Questions (ASQ) as a recommended step.

Status: Not required by The Joint Commission1 but is a best practice endorsed by the Zero Suicide Institute3 and Lisa Horowitz, PhD, a prominent suicide prevention researcher.8

6. Mitigation. Safety precautions for those who screen positive should be deployed, tailored to the individual's risk level, with a primary focus on those who are designated "high" risk. This includes, when appropriate, making the environment (treatment location) safe, observation, and restricting access to lethal means (e.g., clothing that could be used as a ligature). There may be separate approaches for medical versus behavioral health areas of the ED.

Status: Required by The Joint Commission (Element of Performance 1, 4, and 5)1 and CMS2 and is a best practice endorsed by the Zero Suicide Institute3 and the NAASP.4

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Tool 2: Elements of a Suicide Care Pathway

7. Suicide risk assessment and formulation. The suicide care pathway should define who gets a comprehensive suicide risk assessment by a trained professional. This assessment should lead to risk formulation and can be used to change the risk strata and mitigation procedures. It should consider acute vs. chronic risk and in situ risk within treatment locations, such as EDs and medical units vs. in the community.

Examples of evidence-based risk assessment tools include:

Measure	Ages 8-11	Ages 12-17	Ages 18+
SAFE-T		☑	☑
C-SSRS Risk Assessment Version	☑	☑	☑
Beck Scale for Suicide Ideation (BSI)		☑ *17 only	☑
Assessment and Management of Suicide Risk (AMSR)	☑	☑	☑

Status: Required by The Joint Commission (Element of Performance 3)1 and CMS2 and is a best practice endorsed by the Zero Suicide Institute3 and the NAASP.4

Tool 2: Elements of a Suicide Care Pathway

8. Discharge care planning. Discharge care planning should include consideration of resources to further mitigate suicide, including outpatient mental health services, crisis resources, and suicide prevention resources, like 988. To the greatest extent possible, the discharge plan should be specific, and delivered in a format that is understandable and health-literacy appropriate. Medical (primary care), mental health, and social service follow-up should be considered. Appointments for follow-up should be scheduled before discharge when possible.

Status: Required by The Joint Commission (Element of Performance 6)1 and is a best practice endorsed by the Zero Suicide Institute3 and the NAASP.4

9. Interventions. Brief interventions can help decrease suicide risk, help patients manage suicide-related symptoms after discharge, and promote continued engagement with treatment. These interventions include safety planning, Counseling on Access to Lethal Means (CALM), and other emerging interventions, like JASPR. Pathways should stipulate who should get the intervention, who delivers the intervention, and how interventions are documented.

When feasible safety planning should include family or other caregivers that might be helping to support the individual, such as group home personnel. Collaborative safety planning should occur prior to discharge from any acute care setting (ED, medical inpatient unit, mental health inpatient unit).

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Tool 2: Elements of a Suicide Care Pathway

Examples of evidence-based interventions:

Intervention	Ages 8-11	Ages 12-17	Ages 18+
Stanley-Brown Safety Plan		☑	☑
Counseling on Access to Lethal Means (CALM)	☑ *10+	☑	☑
Crisis Response Planning			☑

In addition, a site should consider if additional evidence-based interventions will be provided, such as Collaborative Assessment and Management of Suicidality or Cognitive Behavioral Therapy for Suicidal Ideation. This is primarily relevant to inpatient mental health units.

Examples of evidence-based treatments specific for suicide (Inpatient):

Treatment	Ages 8-11	Ages 12-17	Ages 18+
Collaborative Assessment and Management of Suicidality		☑	☑
Cognitive Behavioral Therapy for Suicide Prevention		☑ *13+	☑
Dialectical Behavior Therapy	☑	☑	☑

Tool 2: Elements of a Suicide Care Pathway

Status: Not required by The Joint Commission1 but is a best practice endorsed by the Zero Suicide Institute3 and the NAASP.4

10. Facilitate care transitions. Communication of risk across settings and locations of care should be defined in the pathway, including when moving from the ED to medical units, within medical units (ICU to acute care), from medical units to inpatient psychiatric units, and from acute care settings to outpatient settings.

Status: Not specifically required by The Joint Commission1 but is related to Element of Performance 4 (mitigation) and is a best practice endorsed by the Zero Suicide Institute3 and the NAASP.4

11. Post-discharge follow-up. Post-discharge follow-up contact should be carefully considered. Caring contact post cards and post-visit telephone follow-up calls are options. The care pathway should identify who is responsible for the cards/calls, content of the cards/calls, frequency, and time window(s).

Status: Not required by The Joint Commission1 but is a best practice endorsed by the Zero Suicide Institute,3 the NAASP4, and AHRQ.7

Tool 2: Elements of a Suicide Care Pathway

References

1. https://www.jointcommission.org/en-us/knowledge-library/suicide-prevention
2. https://www.cms.gov/files/document/r216soma.pdf
3. https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf
4. https://www.aacnnursing.org/essentials/tool-kit/domains-concepts/person-centered-care
5. https://www.aacnnursing.org/essentials/tool-kit/domains-concepts/person-centered-care
6. https://www.tandfonline.com/doi/pdf/10.1080/10872981.2023.2178366
7. https://psnet.ahrq.gov/innovation/suicide-prevention-emergency-department-population-ed-safe
8. https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

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Tool 3: Suicide Care in the ED Mock Survey – Audit Tool

Organization Name:

Date of Survey:

Surveyor:

Survey Participants:

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
Complete environmental risk assessment tool and identify actions to minimize suicide risk. **Tour ED and conduct staff interviews.**		Aim for ligature resistance - no environment can be completely free of all possible ligature points. The Joint Commission defines ligature resistant as follows: Without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life. Solid ceilings in patient rooms and bathrooms. Drop ceilings are allowed in corridors and common areas where staff are regularly present. Standard toilet seats with a hinged seat and lid are not a significant risk for suicide attempts or self-harm and not cited.	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
		Fixed ligature risks, including bathroom fixtures and doors, will not be cited in the ED on survey unless the space is a designated or dedicated behavioral health care area or room. Patients with serious suicidal ideation must be placed under demonstrably reliable monitoring (1:1 continuous monitoring, observations allowing for full viewing). For patients at high risk of suicide, video monitoring should only be used in place of direct line-of-sight monitoring when it is unsafe for a staff member to be physically located in the patient's room. In addition, for both direct line-of-sight and video monitoring of patients at high risk for suicide, the monitoring should be constant 1:1 (at all times, including while the patient sleeps, uses the toilet, bathes, and so on), and the monitoring must be linked to the provision of immediate intervention by a qualified staff member when required. Examples of mechanical solutions include removing the bathroom door, placing an alarm on the door to prevent inappropriate use, and using a special door designed to	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
		prevent using the top to support a ligature (for example, an angled upper edge or breakaway magnetic hinges). Safety precautions for those who screen positive should be deployed, tailored to the individual's risk level, with a primary focus on those who are designated "high" risk. This includes, when appropriate, making the environment (treatment location) safe, observation, and restricting access to lethal means (e.g., clothing that could be used as a ligature). A well-educated, well-trained, vigilant, and compassionate staff is the key to environmental safety.	
Evaluate use of an evidence-based screening tool to identify individuals at risk for suicide **Chart review alignment including those with primary discharge diagnosis being suicidal**		Screen all patients for suicidal ideation who are being evaluated or treated for mental health conditions as their primary reason for care using a validated screening tool. (12 and above). Screening tools commonly used in suicide care include the ASQ Suicide Risk Screening Tool, typically used up to age 24; the C-SSRS Triage Version (C-SSRS Screener); the Patient Safety and Secondary Screener; the Computerized	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
ideation/self-injury/self-harm		Adaptive Test for Suicide; the Suicide Behavior Questionnaire–Revised; and the Suicidal Thoughts and Behaviors Inventory (SITBI). Assessment tools used to evaluate suicide risk across the care pathway include the SAFE-T and the C-SSRS Risk Assessment Version, both of which are used across adolescent and adult populations. The Beck Scale for Suicide Ideation (BSI) is typically used beginning in late adolescence, with many sites using it specifically at age 17. The Assessment and Management of Suicide Risk (AMSR) framework is designed for clinicians working with individuals 18 and older. Define: • which patients are to be screened (behavioral health presenting conditions or universal) • who and what role will do the initial screening, when the screening will be done (i.e. triage vs initial assessment) • the instrument to be used including whether different instruments will	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
		be used for different age groups and settings • How and where the screening should be documented in the record.	
Evaluate use of evidence-based processes for conducting suicide risk assessments of individuals screened positive for suicidal ideation. **Evaluate documentation of individuals' level of risk and the plan to mitigate their risk for suicide.** **Evaluate uniform interventions at each level of risk.**		Use an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, previous suicide attempt and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation. Document patients' overall level of risk for suicide and the plan to mitigate the risk for suicide. Staff should conduct assessments regularly. Although The Joint Commission doesn't specify when these assessments must be conducted, some suicide	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
Chart review alignment including those with primary discharge diagnosis being suicidal ideation/self-injury/self-harm. Include low risk SI patients (follow up for mental health reasons).		prevention organizations recommend doing so at intake, before care transitions and handoffs, prior to any decision about a change in monitoring levels, prior to discharge, and during any follow-up contact after discharge. Patient assessment should provide information concerning the patient's suicide risk factors, protective factors, and any warning signs of impending suicide attempts. It should also provide information about the nature of the patient's suicidal ideation, including planning, suicidal behaviors, and intent. Finally, the timing of assessment should allow for clinical formulation of risk for each patient, which can inform clinical interventions and decisions about where and how to care for the patient. The identification of a patient as high risk, moderate risk, or some risk, or similar classification, should bring with it a set of measures and precautions that are documented and uniform, so staff know exactly what is expected for each level of risk	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
		Secondary screening or brief assessment by a trained clinician, such as the emergency physician, social worker, or mental health professional, can also happen to help further define or modify the individual's risk strata in situ. The suicide care pathway should define who gets a comprehensive suicide risk assessment by a trained professional. This assessment should lead to a risk formulation and can be used to change the risk strata and mitigation procedures. It should consider acute vs. chronic risk and in situ risk within treatment locations, such as EDs and medical units vs. in the community. This should be a process that can be clearly linked to an evidence-base, often using a tool that is designed for this, such as the Columbia Suicide Severity Rating Scale Baseline or Risk Assessment versions.	
Evaluate written policies and monitoring		The policies need to address protocols for the following:	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
tools related to the care of the patient at risk of suicide **Chart review alignment including those with primary discharge diagnosis being suicidal ideation/self-injury/self-harm. Check any SRE or RCA for suicide attempts CAP.**		• Where individuals will be treated • Who will treat them • What level of monitoring will be required • Who will do the monitoring • What special precautions must be taken, including what items must be removed from the treatment area • What procedures should be followed for eating and use of the toilet • Any other interventions that may be required to safely treat both the individual's suicidal ideation and any medical issues It is up to the organization to determine monitoring requirements for patients determined to be at high risk of suicide and define such requirements in their policy. Follow written policies and procedures addressing the care of patients identified as at risk of suicide. At a minimum, these should include the following: • Training and competence assessment of staff who care for patients at risk for suicide • Guidelines for reassessment • Monitoring patients who are at high risk for suicide	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
Evaluate written policies and procedures for counseling and follow-up care at discharge for individuals identified as at risk for suicide **Chart review alignment including those with primary discharge diagnosis being suicidal ideation/self-injury/self-harm**		Follow written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide. A suicide safety plan is a concrete plan designed to help at-risk individuals recognize the onset of a crisis and take concrete steps to ensure their own safety. It should include tools for understanding how and when an individual is likely to experience suicidal acts, as well as contact information for friends, family, and providers of care who can intervene to help the person deal with the crisis. Clearly, good discharge planning is critical to reducing the patient's risk of post discharge suicide. It is important to continue to address the patient's potential suicidality, which may remain present despite treatment for underlying mental and behavioral issues. Includes: patient and family involvement, crisis line, follow up appointments, support network, lethal means counseling, known triggers, warning signs, internal coping strategies, social determinants.	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
		All individuals with suicide risk should be offered a collaborative safety plan that includes lethal means restriction counseling. When feasible, this should include family or other caregivers that might be helping to support the individual, such as group home personnel. Collaborative safety planning should occur prior to discharge from any acute care setting (ED, medical inpatient unit, behavioral health inpatient unit). Pathways should stipulate who should get the offer, who does the safety plan, and how it is documented. Evidence-based procedures should be used, such as the Stanley-Brown safety plan.	
Evaluate Care Transitions		Communication of risk across settings and locations of care should be defined in the pathway, including when moving from the ED to medical units, within medical units (ICU to acute care), from medical units to inpatient psychiatric units, and from acute care settings to outpatient settings.	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
Evaluate Discharge Planning		Discharge planning should include consideration of resources to further mitigate suicide, including outpatient behavioral health services, crisis resources, and suicide prevention resources, like 988. To the greatest extent possible, the discharge plan should be specific and delivered in a format that is understandable and health-literacy appropriate. Medical (primary care), mental health, and social service follow-up should be considered. Appointments for follow-up should be scheduled before discharge when possible. The Joint Commission requires that, as a crucial part of the discharge process, clinical staff must provide resources for continuity when the patient leaves the hospital. It is a good practice to assist patients in making an appointment with a specific mental health care provider before discharge. Patients who have survived a suicide attempt may benefit from participating in peer support groups, counseling, or	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
		networks for suicide survivors. Organizations should provide contact information and facilitate first contact between the patient and someone in the group. TELE-HEALTH OPTIONS, Wallet card When a patient makes the transition from one provider to another, both providers need to work together to complete the transition successfully.	
Evaluate Post Discharge Follow Up		Post-discharge follow-up contact should be carefully considered. Caring contact post cards and post-visit telephone follow-up calls are best practice. The care pathway should identify who is responsible for the cards/calls, content of the cards/calls, frequency, and time window(s).	
Assess staff competency process **Training documentation/tracking review**		Organizations should address how staff are trained and how competency is assessed for the identification and removal of environmental risks, demonstrated understanding of policy and oversight. The protocol should be explicit, written, and presented as part of the training for all staff likely to encounter at-risk individuals. Train staff and test them for competency on how	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
		they would address a situation with a patient with serious suicidal ideation. **Best Practice Tips for Monitors** The following is a list of tips for monitors, nursing assistants, or other staff charged with 1:1 monitoring of suicidal patients. Although good practices, these tips are not required by The Joint Commission. 1. Because patients on suicide precautions are under constant observation, they must not be left alone at any time, even when using the restroom and showering. Use your discretion to respectfully keep the patient in view but also to give some privacy. 2. Notify the RN of the following: • Escalating behavior (for example, increase in activity or agitation, tearfulness, loud talking, using obscenities, threatening you or others) • Changes in level of consciousness • Attempts at or successful elopement • Abnormal vital signs 3. All patient belongings must be stored away from the patient in a predetermined safe place.	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
		4. The Joint Commission does not specify what items are permitted in inpatient units but leaves this up to the organization to determine. Compliance with such safety measures is based on organization policies/procedures, individual care plans, and applicable state rules or regulations. Organizations may consider whether to require that all eating utensils must be paper and plastic and to prohibit metal, glassware, and cans. Counting utensils before and after use is a good practice; then, if there are any utensils missing from the tray after the patient has eaten, the patient and the immediate area can be searched until the missing item is found. 5. Refer all visitors to the RN before visiting. Any items brought in by family or friends must be examined for safety and appropriateness (no sharp objects, medications, ties, belts, and so on). 6. The monitor should accompany the patient to all procedures off the unit. The patient is not to leave the unit for any other reason. If the patient is considered an acute elopement risk, it is recommended that two	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
		people accompany the patient off the unit (this is not a Joint Commission requirement, however). 7. The monitor will receive a thorough report from the RN about any circumstances and concerns regarding the patient. The monitor, likewise, needs to give the RN and next monitor a thorough report about the patient's behavior. This would include observations about mood (for example, sad, joyful, angry), behavior (for example, withdrawn, talkative, friendly), and anything the patient said about feelings, thoughts, and plans concerning suicide. 8. Documentation is the RN's responsibility. Monitoring documentation is extremely important.	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
Evaluate employee support system as "second victims" after witnessing a suicide or suicide attempt **Staff Interview**		The term second victims was coined to describe health care providers and others who witness adverse events and who may need support and/or interventions to help them process the trauma. Patient suicide is one of the most traumatic events health care professionals encounter.	
Evaluate monitoring of implementation and effectiveness of policies and procedures, then taking action as needed to improve compliance **Discuss PI and reporting process with Quality Department staff**		Monitoring compliance with the essential elements of suicide prevention is necessary to sustain adherence to regulations and support high reliability tenets of patient safety.	

Essential Element	Compliance Y/N/Partial	Rationale	Strengths/Recommendations
Qualitative question for staff: How can we improve the patient experience? **Staff interview**	**N/A**	Include frequent re-assessment of suicide risk and monitoring to achieve compassionate care.	

The Joint Commission Resources, *Preventing Patient Suicide*, April, 2022

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Tool 4: Chart Audit Template

Reviewer(s):

Patient #:

*** Disclaimer:** This tool is designed for quality improvement purposes only. It is not intended for regulatory compliance, accreditation, peer review, legal documentation, external reporting, or performance evaluation of individual clinicians or staff. Sites should adapt sampling approaches based on their volume, operational capacity, and QI goals. The aim is to support learning, identify system-level improvement opportunities, and promote safer and more consistent care. VPQHC conducted up to 10 chart audits per mock survey.

Measure	Y/N	Comments	Recommendation
Documentation of evidence-based screening (type)			
Evidence of secondary screening or brief assessment			
Evidence of a comprehensive suicide risk assessment by a trained professional for patients screening positive (Columbia Suicide Severity Rating Scale Baseline or Risk Assessment versions).			
Evidence of overall level of risk			

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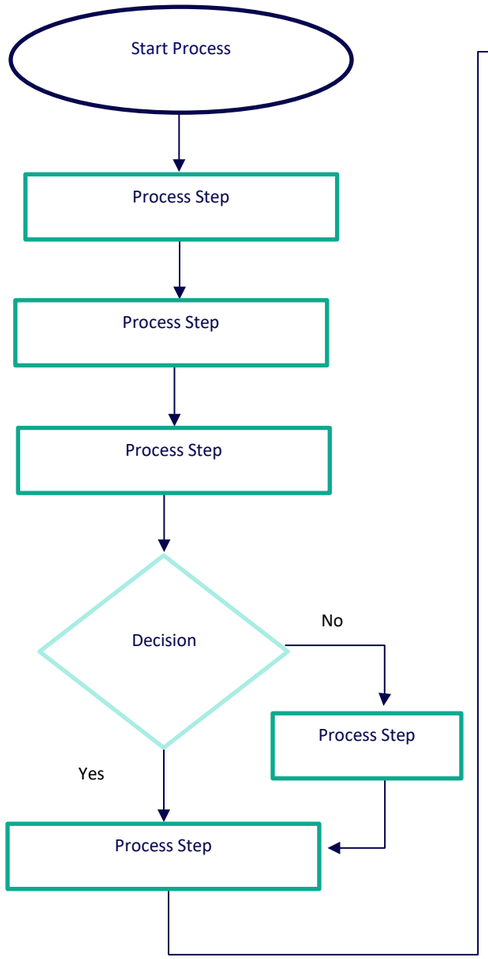
Measure	Y/N	Comments	Recommendation
Evidence of interventions to mitigate risk (This may include making the environment or treatment location safe, observation, and restricting access to lethal means (e.g., clothing that could be used as a ligature).			
Evidence of uniform interventions at each level of risk			
Evidence of a suicide safety plan including documentation and response to availability of lethal means and medications Is the Collaborative Assessment and Management or Cognitive Behavioral Therapy for Suicidal Ideation used or appropriate to provide additional suicide – related interventions?			
Care Transitions: Evidence of communication of risk across settings and locations of care including when moving from the ED to medical units, within medical units (ICU to acute care), from medical units to			

Measure	Y/N	Comments	Recommendation
inpatient psychiatric units, and from acute care settings to outpatient settings.			
Evidence of resources provided for continued care			
Evidence of follow-up appointment arrangements			
Post Discharge Follow Up: Evidence that the patient was contacted after discharge (Caring contact post cards and post-visit telephone follow-up calls are options)			

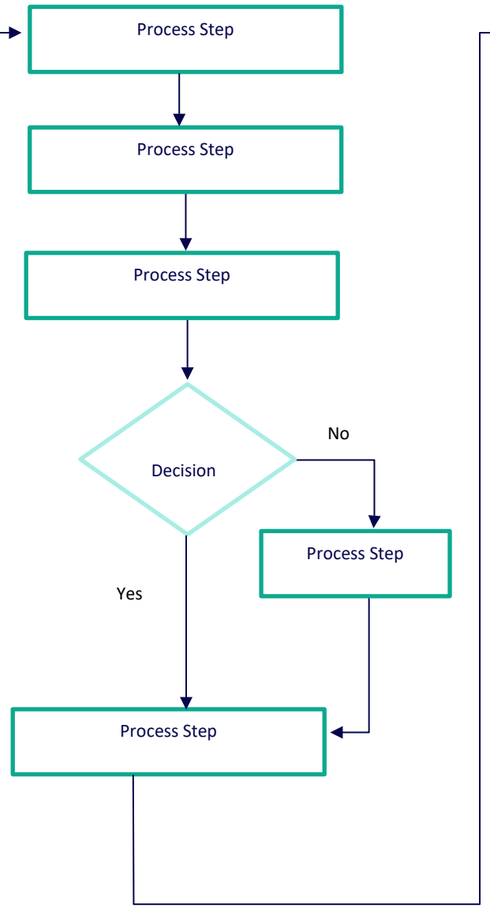
Tool 5: Suicide Care in the ED Clinical Pathway Mapping Tool

Your Organization HERE

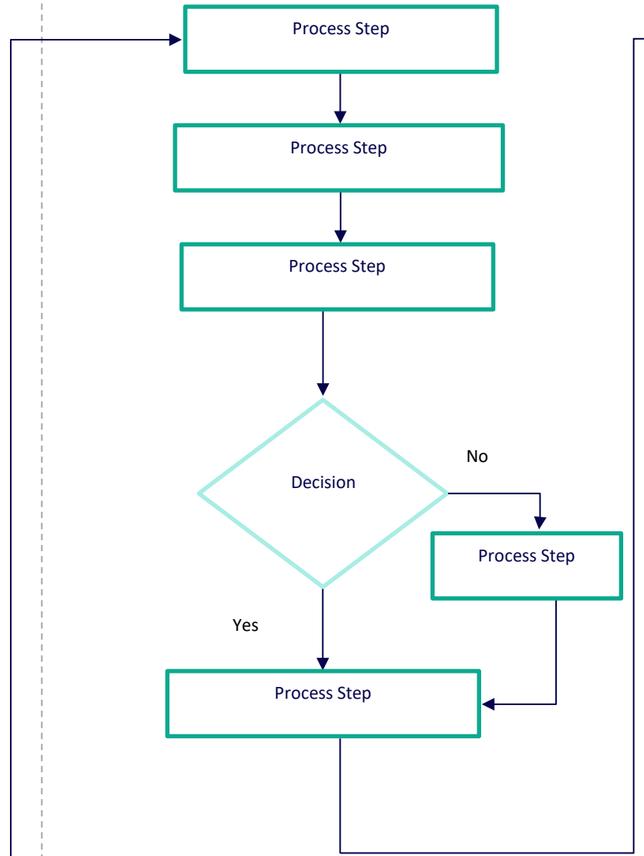
Screening (Mitigation)



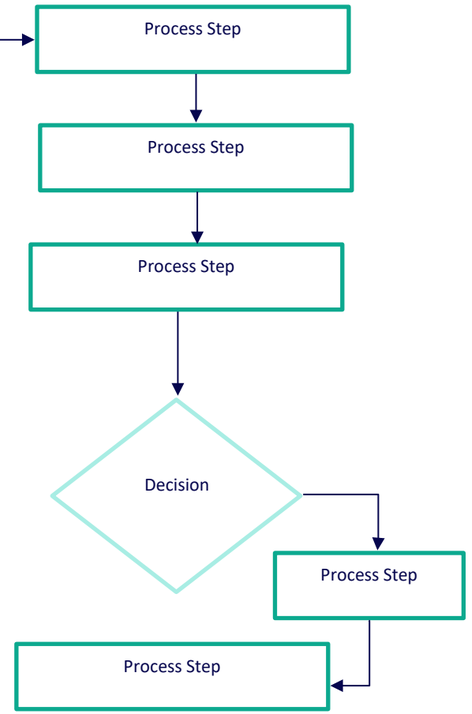
Assessment



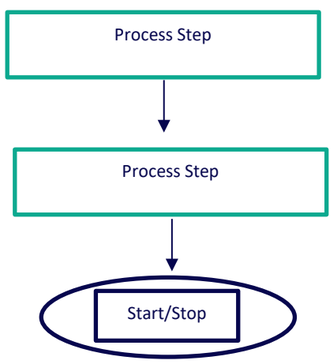
Interventions



Care Transitions *(Discharge vs Admit)*



Post Discharge Follow Up



Resources on Creating Workflow Diagrams

Flowchart | IHI - Institute for Healthcare Improvement

How to Video IHI

https://youtu.be/tq7dQVaTbcc

How to Video 2 IHI

https://youtu.be/yFtV0-gm9nk

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Tool 6: Suicide Care in the ED Clinical Pathway - Audit Tool

Hospital Name:

Date:

Reviewer(s):

Audit Tool Table Legend:

- **Care Pathway Element:** Guidance as outlined in the Essential Elements guide.
- **Element Present Y/N/Partial:** Reviewer states whether the care pathway element is included – or partially included - in the ideal state pathway.
- **Role**: Reviewer identifies whether who is carrying out each element (role) is identified in the ideal state pathway.
- **Rationale**: Reviewer provides justification for findings.
- **Recommendations**: Reviewer outlines recommendations for improvement to ensure ideal state pathway aligns with recommended best practice as outlined in the Essential Elements guide.
- **Commentary**: Review(ers) provide comments for consideration.

Care Pathway Element	Element Present Y/N/Partial	Role	Rationale	Recommendations	Commentary
Evidence-based screening. Initial screening using an evidence-based screening tool					

Care Pathway Element	Element Present Y/N/Partial	Role	Rationale	Recommendations	Commentary
should be completed. The care pathway should: 1. Clearly identify which patients are to be screened, including if it is clinically indicated (those with behavioral health presenting complaints) or universal (all comers); 2. Who (what role) will do the initial screening; 3. When the screening will be done, e.g., triage vs initial assessment; 4. The instrument to be used, including whether different instruments will be used for different age groups and settings; and 5. How and where the screening should be documented in the record. Ideally, the initial screening will lead to risk stratification, such as negligible, mild, moderate, or high risk. This					

Care Pathway Element	Element Present Y/N/Partial	Role	Rationale	Recommendations	Commentary
initial screening is primarily for triage purposes and is conservative. Secondary screening or brief assessment by a trained clinician, such as the emergency physician, social worker, or mental health professional, can also help further define or modify the individual's risk strata in situ.					
Mitigation Safety precautions for those who screen positive should be deployed, tailored to the individual's risk level, with a primary focus on those who are designated "high" risk. This includes, when appropriate, making the environment (treatment location) safe, observation, and restricting access to lethal means (e.g.,					

Care Pathway Element	Element Present Y/N/Partial	Role	Rationale	Recommendations	Commentary
clothing that could be used as a ligature).					
Suicide risk assessment and reassessment The suicide care pathway should define who gets a comprehensive suicide risk assessment by a trained professional. This assessment should lead to risk formulation and can be used to change the risk strata and mitigation procedures. It should consider acute vs. chronic risk and in situ risk within treatment locations, such as EDs and medical units vs. in the community. This should be a process that can be					

Care Pathway Element	Element Present Y/N/Partial	Role	Rationale	Recommendations	Commentary
clearly linked to an evidence-base, often using a tool that is designed for this, such as the Columbia Suicide Severity Rating Scale Baseline or Risk Assessment versions.					
Interventions **Safety planning**. All individuals with suicide risk should be offered a collaborative safety plan that includes **lethal means restriction** counseling. When feasible, this should include family or other caregivers that might be helping to support the individual, such as group home personnel. Collaborative safety planning should occur prior to discharge from any acute care setting (ED, medical inpatient unit, behavioral health inpatient unit). Pathways should stipulate who should get the					

Care Pathway Element	Element Present Y/N/Partial	Role	Rationale	Recommendations	Commentary
offer, who does the safety plan, and how it is documented. **Evidence-based procedures should be used, such as the Stanley-Brown safety plan.**					
Care Transitions. Communication of risk across settings and locations of care should be defined in the pathway, including when moving from the ED to medical units, within medical units (ICU to acute care), from medical units to inpatient psychiatric units, and from acute care settings to outpatient settings.					

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Care Pathway Element	Element Present Y/N/Partial	Role	Rationale	Recommendations	Commentary
Discharge Planning Discharge planning should include consideration of resources to further mitigate suicide, including outpatient behavioral health services, crisis resources, and suicide prevention resources, like 988. To the greatest extent possible, the discharge plan should be specific and delivered in a format that is understandable and health-literacy appropriate. Medical (primary care), mental health, and social service follow-up should be considered. Appointments for follow-up should be scheduled before discharge when possible.					
Post-discharge follow-up Post-discharge follow-up contact should be carefully considered. Caring contact post cards and					

Care Pathway Element	Element Present Y/N/Partial	Role	Rationale	Recommendations	Commentary
post-visit telephone follow-up calls are options. The care pathway should identify who is responsible for the cards/calls, content of the cards/calls, frequency, and time window(s).					

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SECTION I: OVERVIEW

This template is a resource to support sites with documenting the steps for implementing the ideal state suicide care clinical pathway in their Emergency Departments. Throughout the document, the font in *italics* indicates instructions or additional prompts to guide completion for sites.

SECTION II: The Model for Improvement

What are we trying to accomplish?

What is your hospital trying to accomplish with this project? What are the implications?

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How will we know that change is an improvement?

How will your hospital know that the changes made are an improvement? This should address what you will be measuring.

Measure	Goal	Baseline	Notes

SECTION III: Plan

What will your hospital do that will result in an improvement?

For the purposes of the suicide prevention in the ED Ideal State Implementation plan, this serves as a high-level work list of activities detailing what you intend to do to execute the implementation plan. Consider things such as staff engagement activities, education, collaboration with your Designated Agency, internal meetings, and chart audits, etc. Be as specific as possible about who is responsible for what and when you intend to do things. Your plan may change throughout the grant year. ***Document changes below as you progress to completion and capture explanations for changes in the Do section.***

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Milestones	Responsible Person (s)	Progress to Completion Status and Notes	Target Date	Completion Date

SECTION IV: Do

As you implement the ideal state clinical pathway, capture notes regarding the intervention, here.

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What happened as your ideal suicide care pathway was implemented?

Was each aspect of the project implemented as expected? Note any deviations from the plan and why they were made

What surprises or challenges came up along the way?

How did this impact the implementation plan? What changes did you make as a result?

We recommend tracking measures on, at least, a monthly basis to monitor impact:

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Measure	Goal	Baseline	Monthly update (insert more columns as needed)	Notes

SECTION V: Study

What were the results?

After collecting and documenting all final outcome information in the Plan section, analyze the results and summarize and reflect on what you learned from this project.

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Measure	Goal	Baseline	Monthly update (insert more columns as needed)	Outcome/Result	Notes

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SECTION VI: Act

Adapt, Adopt, or Abandon

This is an opportunity to consider how to incorporate what you learned from the Study section. Will you:

☐ Adapt – Modify the approach(es)

☐ Adopt – Use the same approach(es)

What modifications to the implementation plan (if any) will be made to assure sustainability of the ideal state suicide care pathway?

Describe any changes you will make.

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Tool 8: Suicide Care in the ED Training Scaffolding

Overview

Training should be incorporated into ED workforce development at multiple levels, including onboarding, annual training and competency validation, and continuing education. A coordinated training approach creates shared knowledge across the different roles in the ED suicide care pathway and improves the expertise and confidence needed to reliably execute each essential element relative to role.

Training exists for non-clinical roles that support ED operations (e.g., registration, administrators, security staff, scribes), medical roles (e.g., nurses, physicians), and mental health roles (e.g., crisis evaluators, psychologists, psychiatrists). In typical ED workflows, role expectations within medical personnel often differ between nurses and physicians with regard to suicide care; however, it is strongly encouraged that both groups receive training in common core content areas. Aligning foundational training across roles helps establish a shared understanding of the patient experience, facilitates handoffs, and supports cross-coverage.

Existing training for the ED setting is provided in the table below. Training should be assigned based on role and function within the care pathway, and specific training should be selected based on the tools implemented and resources available to each ED. For each role, baseline (basic) training is recommended, with optional advanced training available to deepen specialized competencies and support high-reliability execution of the clinical pathway. Continuing education options should be used to reinforce skills, maintain competency, and support workforce sustainability.

Training Plan

To create shared knowledge across roles, it is encouraged that all roles complete the "Preventing Suicide in Emergency Departments" training offered by the Zero Suicide Institute as a foundational training. Additional training should then be assigned to increase expertise and confidence in completing each essential element aligning with that role. Below are suggested training plans based on role.

Non-Clinical Staff

1. **Foundation**: Preventing Suicide in Emergency Departments
2. **Intervention**: Counseling on Access to Lethal Means (CALM) or Crisis Response Planning for the Public or Stanely Brown Safety Planning Intervention (Fundamentals)
3. **Discharge Planning:** Overview of the Include, Discuss, Educate, Assess, and Listen framework for discharge planning
4. **Care Transitions**: Overview of the NAASP Best Practices for Reducing Suicide with Improved Care Transitions
5. **Post-Discharge Follow-Up**: Overview of Caring Contacts

Medical Personnel

1. **Foundation**: Preventing Suicide in Emergency Departments
2. **Screening, Risk Assessment and Formulation:** Ask Suicide Screening Questionnaire (ASQ), Columbia Suicide Severity Rating Scale, or Patient Safety Screener and ED SAFE Secondary Screener
3. **Intervention**: Counseling on Access to Lethal Means (CALM) Clinical, Crisis Response Planning for Healthcare Professionals, and/or or Stanely Brown Safety Planning Intervention (Fundamentals)
4. **Discharge Planning**: Overview of the Include, Discuss, Educate, Assess, and Listen framework for discharge planning
5. **Care Transitions:** Overview of the NAASP Best Practices for Reducing Suicide with Improved Care Transitions, and Navigating Collaboration with Differing Levels of Risk Tolerance around Suicidality
6. **Post-Discharge Follow-Up:** Overview of Caring Contacts or Caring Contacts if nurses are expected to complete Caring Contacts Online Training

Mental Health Clinicians

1. **Foundation:** Preventing Suicide in Emergency Departments
2. **Screening:** Ask Suicide Screening Questionnaire (ASQ), or Columbia Suicide Severity Rating Scale
3. **Risk Assessment and Formulation:** Basic- Suicide Risk Detection, Assessment, and Management, Collaborative Assessment and Management of Suicidality (CAMS), Columbia Suicide Severity Rating Scale; Advanced- Suicide Risk Assessment, Suicide Risk Detection, Assessment, and Management, or Collaborative Assessment and Management of Suicidality Brief Intervention (CAMS-BI)
4. **Intervention:** Basic- Counseling on Access to Lethal Means (CALM), Clinical or Crisis Response Planning for Healthcare Professionals or Stanely Brown Safety Planning Intervention (Fundamentals) or CAMS; Advanced- Stanely Brown Safety Planning Intervention (Intermediate), and/or Collaborative Assessment and Management of Suicidality Brief Intervention (CAMS-BI)
5. **Discharge Planning:** Overview of the Include, Discuss, Educate, Assess, and Listen framework for discharge planning
6. **Care Transitions:** Overview of the NAASP Best Practices for Reducing Suicide with Improved Care Transitions; Navigating Collaboration with Differing Levels of Risk Tolerance around Suicidality
7. **Post-Discharge Follow-up:** Caring Contacts Online Training, or Overview of the CLASP-ED follow-up call protocol and modifications (if doing more than caring contacts for follow-up)

Training Title	Essential Element(s) Covered	Roles	Level	Type	Source
Preventing Suicide in Emergency Departments	Screening, Risk Assessment and Formulation, Risk Mitigation, Intervention, Discharge Planning	Non-clinical, Medical, Mental Health	Basic	Online	EDC Zero Suicide https://zerosuicide.edc.org/resources/trainings-courses/ED-course
Suicide Risk Detection, Assessment,	Screening, Risk Assessment and	Medical, Mental Health	Basic	Online	Question, Persuade, Refer https://www.qprinstitute.com/qpr-qprt

Training Title	Essential Element(s) Covered	Roles	Level	Type	Source
and Management	Formulation, Intervention				
Ask Suicide Screening Questionnaire (ASQ)	Screening	Medical, Mental Health	Basic	Live	SME *VPQHC has partnered with Lisa Horowitz to offer these trainings*
Columbia Suicide Severity Rating Scale	Screening, Risk Assessment and Formulation, Intervention	Medical, Mental Health	Basic	Online, Live	Columbia Lighthouse Project https://cssrs.columbia.edu/training/training-options/ *VPQHC has partnered with Adam Lesser to offer these trainings*
Patient Safety Screener	Screening	Medical	Basic	Live	SME
ED SAFE Secondary Screener	Screening, Risk Assessment and Formulation	Medical	Basic	Live	SME
Suicide Risk Assessment	Risk Assessment and Formulation	Mental Health	Advanced	Live	Suicide Prevention Therapy https://suicidepreventiontherapy.com/training
Counseling on Access to Lethal Means (CALM)	Intervention	Non-clinical, Medical, Mental health	Basic	Online	EDC Zero Suicide https://zerosuicidetraining.edc.org/
Counseling on Access to Lethal Means (CALM) Clinical	Intervention	Medical, Mental Health	Basic	Live	SME *VPQHC has partnered with Mark Margolis to offer these trainings*
Crisis Response Planning for the Public	Intervention	Non-clinical, Medical	Basic	Live	Suicide Prevention Therapy https://suicidepreventiontherapy.com/training
Crisis Response Planning for Healthcare Professionals	Intervention	Medical, Mental Health	Basic	Live	Suicide Prevention Therapy https://suicidepreventiontherapy.com/training

Training Title	Essential Element(s) Covered	Roles	Level	Type	Source
Stanely Brown Safety Planning Intervention (Fundamentals)	Intervention	Non-clinical, Medical, Mental health	Basic	Live	SME *VPQHC has partnered with Mark Margolis to offer these trainings*
Stanely Brown Safety Planning Intervention (Intermediate)	Intervention	Mental health	Advanced	Live	SME *VPQHC has partnered with Rachel Davis-Martin to offer these trainings*
Collaborative Assessment and Management of Suicidality (CAMS)	Risk Assessment and Formulation, Intervention	Mental health	Basic	Live	CAMS-care https://cams-care.com/training-certification/cams-trained/
Collaborative Assessment and Management of Suicidality Brief Intervention (CAMS-BI)	Risk Assessment and Formulation, Intervention	Mental health	Advanced	Live	CAMS-care https://cams-care.com/training-certification/cams-bi/
Overview of the Include, Discuss, Educate, Assess, and Listen framework for discharge planning	Discharge Planning	Non-clinical, Medical, Mental Health	Basic	Live	SME
Navigating Collaboration with Differing Levels of Risk Tolerance around Suicidality	Care Transitions	Medical, Mental Health	Basic	Live	SME
Overview of the NAASP	Care Transitions	Non-clinical,	Basic	Live	SME

Training Title	Essential Element(s) Covered	Roles	Level	Type	Source
Best Practices for Reducing Suicide with Improved Care Transitions		Medical, Mental health			
Overview of the CLASP-ED follow-up call protocol and modifications	Post-Discharge Follow-up	Mental Health	Basic	Live	SME
Caring Contacts	Post-Discharge Follow-up	Medical, Mental Health	Basic	Online	CSPAR https://uwcspar.org/self-guided-training/caring-contacts-online-training/
Overview of Caring Contacts	Post-Discharge Follow-up	Non-clinical, Medical	Basic	Live	SME