Depression Screening and Suicide Precautions POLICY NUMBER: CSC0029

Highlights from the above policy: please read policy for DETAIL.

PHQ9 Assessment:

Based on the assessment the following interventions maybe implemented:
• Below 5: No Action Required
• *5-9 Mild* o Notify attending provider

• *10-14 Moderate* o Notify attending provider
o Consider therapeutic treatment
o Refer to Pharmacy for Psychiatric Pharmacy recommendations
o Consider referral to Social Work

• *15 and above Severe* o Notify attending provider immediately
o Consider therapeutic treatment
o Refer to Pharmacy for Psychiatric Pharmacy recommendations
o Refer to Social Work
o Psychiatry Consult

REGARDLESS of TOTAL SCORE:

If the patient scores **1 or greater on question number 9** they will be considered at risk for suicide. **Suicide precautions should be implemented** for these patients
[Q 9: Thoughts that You Would be Better Off Dead or of Hurting Yourself in Some Way:]

1. A provider's (attending or consulting psychiatrist) **order is required** to initiate or discontinue suicide precautions which includes direct observation. An RN can place a patient who expresses suicidal thoughts into suicide precautions without a provider order in an emergent situation. The order then must be obtained within 2 hours. The **attending or ED provider, after assessment** of the patient **may order or discontinue** suicide precautions, this assessment must be documented

2. When suicide precautions are ordered, obtain a **psychiatric** service **consult within 24 hours.**

3. A provider's (attending or consulting psychiatrist) **must re-evaluate** and document the need for continued precautions every 24 hours.