

ASQ: Suicide Screening and Environment Checklist for Nurses, Paramedics and Clinical Staff

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The Ask Suicide Questions (ASQ) Screening Tool

The ASQ (Ask Suicide-Screening Questions) is a brief validated suicide risk screening tool used by MHC to assess risk for suicide in patients 8-11 years of age. The Suicide Risk level obtained from the ASQ determines safety precautions to be implemented.

Documentation of the ASQ

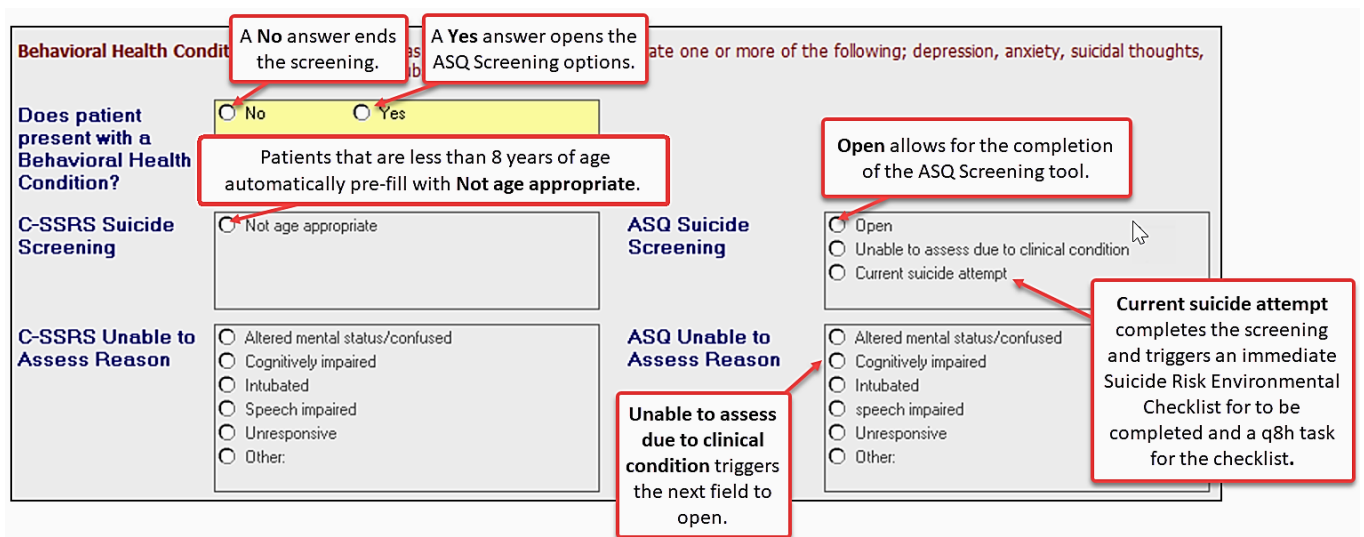
The ASQ Suicide Screening can be accessed from the Triage Form-Peds ED /Urgent Care Intake PowerForm, a task, or AdHoc to use per clinical staff discretion for any patient at any point of their stay.

ASQ Screening as a task is generated:

- Upon arrival to the ED (via the Triage-Peds ED PowerForm).
- If the Triage Form-Peds ED /Urgent Care Intake PowerForm is not documented (including when the patient is a direct admit to an inpatient unit).
- Upon the selection of Unable to assess due to clinical condition.
- Every 12 hours following an ASQ Screening risk of Moderate during the current visit.

ASQ suicide screening is tasked for patients aged 8-11 years who present with a **Behavioral Health Condition**.

1. Complete the Suicide Risk Screening within the Triage Form-Peds ED /Urgent Care Intake PowerForm:



The screenshot shows the ASQ Suicide Screening form with several sections and annotations:

- Behavioral Health Condition:** A red box highlights the question "Does patient present with a Behavioral Health Condition?" with radio buttons for "No" and "Yes". Annotations state: "A No answer ends the screening." and "A Yes answer opens the ASQ Screening options."
- C-SSRS Suicide Screening:** A red box highlights the "Not age appropriate" option. An annotation states: "Patients that are less than 8 years of age automatically pre-fill with Not age appropriate."
- C-SSRS Unable to Assess Reason:** A list of reasons including "Altered mental status/confused", "Cognitively impaired", "Intubated", "Speech impaired", "Unresponsive", and "Other".
- ASQ Suicide Screening:** Radio buttons for "Open", "Unable to assess due to clinical condition", and "Current suicide attempt". An annotation states: "Open allows for the completion of the ASQ Screening tool."
- ASQ Unable to Assess Reason:** A list of reasons including "Altered mental status/confused", "Cognitively impaired", "Intubated", "Speech impaired", "Unresponsive", and "Other". An annotation states: "Unable to assess due to clinical condition triggers the next field to open."
- Current suicide attempt:** A red box highlights the "Current suicide attempt" option. An annotation states: "Current suicide attempt completes the screening and triggers an immediate Suicide Risk Environmental Checklist for to be completed and a q8h task for the checklist."

If Unable to assess due to clinical condition is documented, an **ASQ Screening Unable to Assess Task** is:

- Tasked in 12 hours.
- Retasked every 24 hours until screening completed.

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2. Complete the ASQ:

Ask questions 1 through 4. Additional questions will become required based on documented answers.

Suicide Risk is determined based on documented answers to the required screening questions.

A High or Moderate Suicide Risk Interpretation opens the Suicide Risk Environment Checklist.

If a patient is interpreted as Moderate or High Risk, the Provider Notification field is required.

Note: If a patient's Moderate risk level increases to High risk, the provider must be notified of the increase. The patient will remain at High risk from that point on, and staff will no longer receive any reassessment tasks.

ASQ Ask Suicide-Screening Questions

1. In the past few weeks, have you wished you were dead?

2. In the past few weeks, have you felt that you or your family would be better off if you were dead?

3. In the past week, have you been having thoughts about killing yourself?

4. Have you ever tried to kill yourself?

Describe How? and When? below

5. Are you having thoughts of killing yourself now?

Describe below

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

Suicide Risk Interpretation

☐ No indication of suicidal ideation or behavior at this time

☐ Moderate risk

☒ High risk

Provider Notified of Moderate/High Risk of Suicide

Interventions

Right click in box below to view Self Harm Risk Interventions

3. Complete the Suicide Risk Environment Checklist:

A No selection opens the checklist area for charting.

Selecting Yes opens the Precautions area. Make a precautions selection i.e., behavior health 1:1 monitoring or suicide precautions.

The top section of the checklist will show for Emergency Departments and Urgent Cares only.

Suicide Risk Environment Checklist

Patient located in ED/UC Waiting area?

☐ No ☒ Yes

Precautions

<input type="checkbox"/> None	<input type="checkbox"/> behavioral health close observation	<input type="checkbox"/> limb alert LUE	<input type="checkbox"/> radium implant
<input type="checkbox"/> Guard at bedside	<input type="checkbox"/> behavioral health general	<input type="checkbox"/> limb alert RLE	<input type="checkbox"/> restraint
<input type="checkbox"/> latex sensitive	<input type="checkbox"/> Elopement	<input type="checkbox"/> limb alert RUE	<input type="checkbox"/> security risk
<input type="checkbox"/> odor sensitive	<input type="checkbox"/> fall risk	<input type="checkbox"/> neutropenic precautions	<input type="checkbox"/> seizure precautions
<input type="checkbox"/> aspiration precautions	<input type="checkbox"/> insulin pump	<input type="checkbox"/> no heparin/heparin products	<input type="checkbox"/> suicide precautions
<input type="checkbox"/> behavioral health 1:1 monitoring	<input type="checkbox"/> limb alert LLE	<input type="checkbox"/> Pain pump	<input type="checkbox"/> swallowing precautions

This list is not inclusive. If you are in doubt about an item, please discuss with PCC/Manager

Unsafe Items Removed	Strategy Applied
Room cleared of all unsafe items (unless clinically necessary) that can be USED AS A STRANGULATION DEVICE e.g. phone cords, call light cord, respiratory supplies/tubing, IV tubing, monitoring cords (telemetry, pulse oximeter, BP cuff, etc.), suction tubing, unnecessary linens, strings in clothes or bags, extra linen, hand held shower head	If No, explain/mitigation strategy
<input type="radio"/> Yes <input type="radio"/> No	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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LaunchPoint, Care Compass, Tracking Board, and Grease Board Alerts

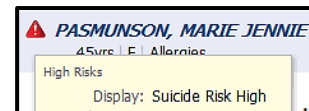
LaunchPoint

1. The first column of the organizer displays a red alert indicating high suicide risk.
2. In the second column the head icon indicates a moderate suicide risk.





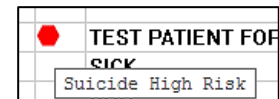
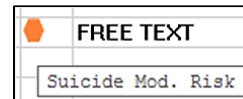
Care Compass

1. Hover over the red alert triangle to read the alert type.



ED/UC Tracking Board ASQ column icons: Grease Board, Ancillary Department tracking boards i.e., radiology, lab, etc. will display all patients at risk for Self-Harm in the Suicide Risk column.

1. Patients identified as a moderate risk for self-harm. 
2. Patients identified as a high risk for self-harm. 



Orders and Consults

A CAC (Centralized Access Center) Consult will be placed for all MMC patients with a Moderate or High Risk of Suicide, or current suicide attempt.

Consults/Referrals				
<input checked="" type="checkbox"/>	12/12/2022 9:53 PM EST	CAC Consult	Ordered	Routine, 12/12/22 21:53:41 EST SYSTEM GENERATED for Suicide Risk Assessment based on documentation

One of the following Orders will be placed by the System based on screening results.

1. Precautions – Patient at Moderate Risk for Self Harm.

Patient Care				
<input checked="" type="checkbox"/>	3/10/2023 11:55 AM EST	Precautions - Patient at Moderate Risk for Self Harm	Ordered	03/10/23 11:55:32 EST, ONCE, 03/10/23 11:55:32 EST Documentation indicates that patient is at Moderate Risk of Self-Harm

2. Precautions – Patient at High Risk for Self Harm.

Patient Care				
<input checked="" type="checkbox"/>		Precautions - Patient at High Risk for Self Harm	Ordered	03/13/23 16:14:10 EDT, ONCE, 03/13/23 16:14:10 EDT Documentation indicates that patient is at High Risk of Self-Ha...