Policy Name:	Policy Number:
ASSESSING SUICIDE: REVIEWING RISK	**0170**
	Effective Date: **JUNE 3, 2008**
Approved By: Executive Team	Date Revised: October 15, 2021
Reason for Revision: Click on item below and select item from list. **CONTENT- Enter BELOW Reason for change Ex: Combined Policy ## and ##.** Added to new template.	Next Date for Review: October 15, 2024
Section: Section 01 - Delivery of Care to Residents and Families	Page No: **Page 1 of 4**

Policy

When a resident expresses thoughts of suicide, or shows indication(s) of suicidal intention, a potential crisis ensues for the resident, their family, Agape staff / volunteers, and Agape Hospice. In addition to the tragic death of the resident, a completed suicide includes profound, negative outcomes for all involved. Prompt response towards a potentially suicidal resident by Agape staff / volunteers is imperative to avoid these negative outcomes.

This policy helps Agape staff / volunteers to review the risk of harm or death once it is known that suicide is involved, and develop a plan to reduce the immediate risk.

REFERENCES

Applied Suicide Intervention Skills Training (ASIST) (2008). *Suicide Intervention Handbook*. Calgary: Living Works Education Inc.

Procedure

1. Any member of the care team at Agape Hospice can send a referral for a resident suicide assessment. The referral should be sent to the Social Worker (SW) on weekdays or to a Charge Nurse after hours and/or on weekends. The Nursing Lead should be notified on weekdays.

2. Referral to be sent when any of the followings are present:

- Indications of suicidal ideation or intention (See attachment: Certain Reaction)
- PathWays information
- Resident shares suicidal thoughts/intent
- “Family” expresses concerns over potential suicide risk

Note: All indications of suicide should be taken seriously.

3. RN to “sweep” resident’s room for objects that may harm the resident and quietly remove them.

For example:

- Sharp objects
- Cleaners
- Medication
- Rope, belts
- Glass

4. SW/RN responds immediately to all referrals regarding suicide. Immediate response should include:

- Contact referral source for background information.
- Review medical chart if available.
- Approach Health Advocate or other available family member if resident is unable to respond appropriately.

5. If the resident indicates that suicide is imminent before the RN or SW's arrival, she/he is not to be left alone. Staff /volunteers should remain calm and provide reassurance.

6. If resident is behaving aggressively, staff /volunteers should:

- Remain calm
- Speak in soft reassuring tones
- Use few, simple, and clear words
- Avoid arguing
- Offer medications to help lower anxiety
- Call in a trusted person
- Back off and monitor from a distance

7. If resident becomes uncontrollable or in an immediate threat to himself/herself or others, staff should call 911, and inform them of the situation. Specifically, "We have an agitated resident who is a threat to himself/herself and others. We require EMS and police support."

8. On-going risk review to be planned by interdisciplinary team if needed.

Certain Reactions

Below please find certain reactions that may indicate that a person is considering suicide.

Please note that many of these attributes are normal reactions due to grief or depression associated with the approach of death which do not necessarily lead to suicide. Clinical determination is necessary to assess risk.

Situational

- Family death
- Family illness
- Relationship problems
- Alone/Isolation
- Legal Trouble
- Recent suicide and violence

Cognitive

- Escapism
- No future
- Guilt
- Damaged
- Helplessness
- Preoccupied
- Planning suicide

Behavioral

- Crying
- Emotional outbursts
- Alcohol/drug abuse
- Hoarding medication
- Recklessness
- Fighting/lawbreaking
- Withdrawal
- Prior suicidal behavior
- Talk of suicide or death

Affective

- Desperation
- Anger
- Sadness
- Shame
- Worthlessness
- Loneliness
- Disconnectedness
- Hopelessness

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Review Risk

1. **Suicide Thoughts**
   - If thoughts of suicide are present
   - Ask a direct question about suicide. (e.g.) “Are you thinking about killing yourself?

2. **Current Suicide Plan**
   - If the resident has prepared a suicide plan
     How she/he plan to do it? Means?
     How prepared she/he is?
     How soon it may happen?

3. **Mental Pain**
   - If the resident feels desperate
   - Ask (e.g.) “Do you have pain that sometimes feels unbearable?”

4. **Resources**
   - If the resident feels alone
   - Ask (e.g.) “Do you feel you have few if any resources?”

5. **Prior Suicidal Behavior**
   - If the resident is familiar with suicide because of previous suicidal behavior
   - Ask (e.g.) “Have you ever attempted suicide before?”

6. **Mental Health**
   - If the resident is vulnerable to suicide because of current or previous mental health concern
   - Ask (e.g.) “Have you received mental health care in the past?”

Safe Plan

1. **Protection for anyone with thoughts of suicide**
   - A promise to keep Safe
     - Get agreement from the resident. (e.g.) “I agree to keep myself safe until after I meet ….”
     - “I can think about suicide but must not act on those thoughts.”
   - Safety contact(s)
     - Explore the resident’s trusted person, and get agreement that the resident will contact the trusted person. (e.g.) “If anything goes wrong, I will contact…..”
   - A promise of safe/no use of alcohol/drugs/medication other than those dispensed by the hospice.
   - Link to resources
     - Both informal and formal

2. **Protection against a suicide plan: Disable the plan**
   - Contact formal emergency support if the suicide is already in progress.

3. **Protection against mental pain: Ease the pain**
   - Listen and acknowledge the resident’s emotional pain.

4. **Protection against feeling alone: Link or re-establish the connection to resources**

5. **Protection against familiarity: Protect against the danger; support past survival skills**
   - Explore past life-protecting skills or resources to help the resident re-discover lessons in how she/he got through the previous attempt.
   - Acknowledge that survival skills learned in the past can be used again.
   - Extra support and resources to be in place.

6. **Protection against vulnerability: Link to mental health care worker if appropriate.**