Suicide Risk Management

Designated Living Options (DLO)

Covenant Health

Seniors Health & Continuing Care

Policy, Practice, Access & Case Management

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Purpose

To support regulated health care providers in identifying resident suicide risk in DLO

Not intended:

- for residents wishing to pursue *Medical Assistance in Dying* (MAID)
- to provide guidance for Emergency Medical Services and other health care providers providing initial time sensitive emergency response; refer to *Goals of Care Designation Orders and Personal Directives During Response to Apparent Suicide Attempt*.

Objectives

- Be more familiar with suicide risk
- Understand the approach to suicide risk management in DLO
- Know how to perform suicide risk screening and assessment using the revised tool
- Learn helpful interventions/strategies for resident care
- Be able to locate additional resources
- Complete a knowledge check

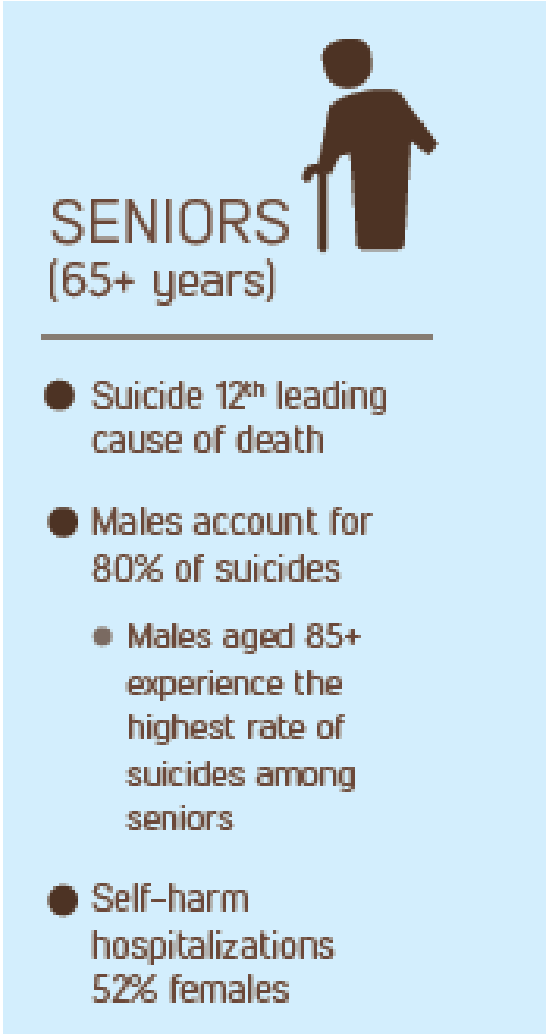
Suicide ideation, attempts and deaths affect us all.

Yet it is often difficult to talk about due to feelings of fear, shame and guilt.

Let’s talk about it.

Suicide in Older Adults

- High risk of suicide
- AHS Reporting & Learning System (2014-2020):
  - 3 client deaths
  - 51 safety incidents related to intended self-harm/suicide
- Deaths can be prevented with early recognition and intervention



Source: https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-infographic.html

Stigma can be reduced by changing the way we talk about suicide.

Avoid…	Try…	Why?
"committed" "completed" or "successful"	"died by suicide"	Non-judgmental language helps reduce stigma
suggesting suicide is inevitable	emphasizing that help is available	We can help prevent suicide by removing barriers to getting help
using words that reinforce stigma, stereotypes and myths	emphasize that recovery is possible	We can help prevent suicide by providing hope & support

Together, we can prevent suicide.

R Recognize warning signs and risk factors.

E Engage in conversation and listen with empathy.

A Ask about suicidal thoughts and feelings.

C Connect to supports and resources.

H Heal ourselves by taking care of our own mental health.

Preventing Suicide
https://www.albertahealthservices.ca/injprev/Page4875.aspx

Recognize

People who are thinking of suicide can often show signs.

Warning signs for suicide can include:

- Talking about death or suicide
- Losing interest in activities
- Acting out of character
- Giving away possessions
- Talking about being a burden

Recognize

Some challenging or traumatic life events can be considered risk factors for suicide.

Risk factors for suicide can include:

- Loss of job
- Death of a loved one
- Knowing someone who died by suicide
- Serious or chronic health conditions
- Previous suicide attempt

Engage

Listen to someone's story with empathy.

- Make time to have an important conversation
- Go to a quiet place or remove distractions
- Show you are listening by giving your full attention
- Show empathy and validate their feelings

Ask

The only way to know if someone is thinking of suicide is to ask.

- It is important to ask about suicide
- Be clear and direct
- Give reasons for why you are asking
- Name warning signs and risk factors you are concerned about

"I've noticed you seem really down lately and you talk about being done with life. Are you thinking of suicide?"

Ask

If someone says yes (or no), let them know you can help connect to supports.

- Thank them for sharing
- Acknowledge their strength in sharing
- You can help by connecting to supports or resources

"Thank you for sharing with me. This takes courage to talk about. I want to support you and connect you with someone that can help. Is that okay?"

Connect

Help is available.

- Call **811** to find out what services are in your area
- Call your nearest distress line together
- In the case of immediate risk, follow established process for accessing emergency care (e.g., call 911)

Thoughts of suicide are serious. Work with your resident to determine the best support for them.

Mental Health Help Line at 1-877-303-2642
First Nations and Inuit Hope for Wellness Help Line
1-855-242-3310

Heal

- Know your boundaries
- Recognize when you are not coping well
- Engage in healthy coping strategies
- Reach out for support when you need it

Take time to consider your needs and reach out for support if you need to.

Help in Tough Times
https://www.albertahealthservices.ca/amh/Page16759.aspx

Points of Emphasis

- Suicide is not predictable
- Preventing suicide depends on our clinical judgement to recognize key factors, accurately identify warning signs, successfully manage care and effectively treat underlying illness
- People often want the pain to go away rather that to end their life.
- We cannot prevent every death by suicide.
- Suicide can cause intense emotions in staff

Busch, K., et al., 2003; Gould et al. 2013

Required Organizational Practice

Residents are assessed and monitored for risk of suicide.

- Identify residents at risk
- Assess at regular intervals
- Address immediate safety needs
- Treatment and monitoring for those at risk
- Strategies are documented

ACCREDITATION AGRÉMENT CANADA

Suicide Prevention

Designated Living Option (DLO) Suicide Risk Management Algorithm

Includes Designated Supportive Living and Long Term Care

Regulated health care provider completes **Section A: Suicide Risk Screening** of the Designated Living Option (DLO) Suicide Risk Screening/Assessment:

- within 36 hours of admission;
- with interRAI assessment/reassessment; and
- PRN when indicated by clinical judgment

Clinical judgment, combined with resident history, observations and information from resident interactions determines the need for a full assessment of the resident s risk of suicide.

Any yes response to screening questions indicates suicide risk assessment is required.

Suicide risk identified

No

Complete interRAI assessment/ reassessment within established timelines

Yes

Complete all sections of the Designated Living Option (DLO) Suicide Risk Screening/Assessment

*In a collaborative care model where the resident resides in DSL and has an AHS Case Manager there is a need for timely and open communication about resident care needs.

This process is solely for the purpose of identifying suicide risk and is not intended for residents wishing to pursue Medical Assistance in Dying.

Evaluation/Review:

- Resident assessment/reassessment as per established frequency on the care plan, PRN and with interRAI assessment - every three (3) months for residents at moderate or high/imminent suicide risk
- Review and revise interventions based on available information, including assessments, regular reviews and case conferences.
- Use interRAI Outcome Scales report to track changes
- Communicate changes to health care team members for awareness*

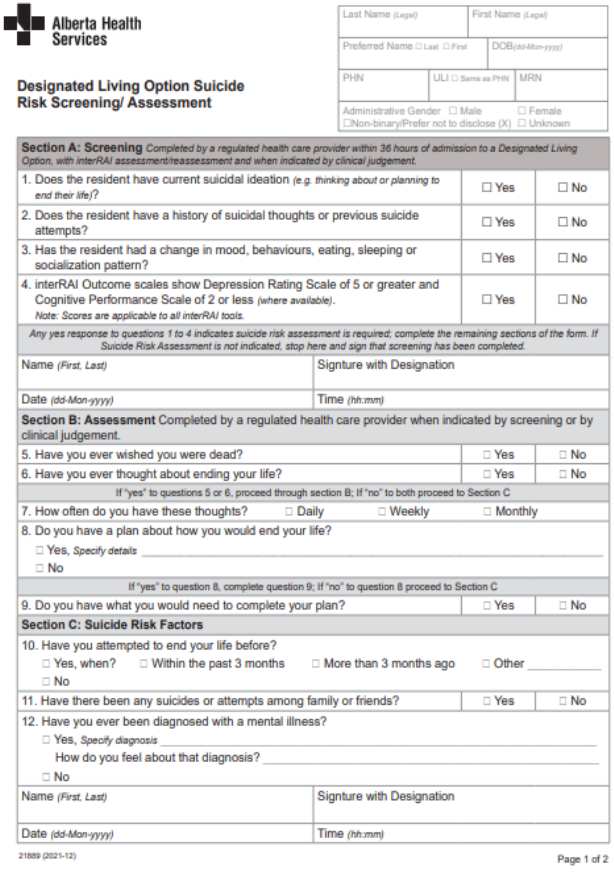
Action Items (Refer to Resource Guide for Details):

- Communicate risk to health care team members (including Most Responsible Health Provider [MRHP], Case Manager and family, as appropriate): - immediately and no longer than 24 hours for residents at moderate or high/imminent suicide risk; and - based on clinical judgement for residents at low risk for suicide.
- Document assessment findings and interventions in the care plan to support resident assessed unmet needs - establish a frequency for evaluation/re-assessment in the care plan
- Consult/ referral for assessment or intervention as clinically indicated: - Gerontologist - Geriatric Psychiatry/psychiatry - Senior s Mental Health - Social Worker - Spiritual Care Practitioner - Others (e.g., Addiction & Mental Health, Occupational Therapy, etc.)

Urgent consult/referral or transfer to higher level of care may be required

- Monitor resident – at a frequency to meet client care needs. Establish monitoring frequency on the care plan for: - Suicidal ideation - Mood and behaviour changes - Changes in eating, sleeping or socialization pattern - Other indicators identified on the care plan

Suicide Risk Screening/Assessment



Alberta Health Services

Designated Living Option Suicide Risk Screening/ Assessment

Last Name (Legal)	First Name (Legal)
Preferred Name ☐ Last ☐ First	DOB (dd-Mon-yyyy)
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

Section A: Screening *Completed by a regulated health care provider within 36 hours of admission to a Designated Living Option, with interRAI assessment/reassessment and when indicated by clinical judgement.*

1. Does the resident have current suicidal ideation *(e.g. thinking about or planning to end their life)*?	☐ Yes	☐ No
2. Does the resident have a history of suicidal thoughts or previous suicide attempts?	☐ Yes	☐ No
3. Has the resident had a change in mood, behaviours, eating, sleeping or socialization pattern?	☐ Yes	☐ No
4. interRAI Outcome scales show Depression Rating Scale of 5 or greater and Cognitive Performance Scale of 2 or less *(where available)*. *Note: Scores are applicable to all interRAI tools.*	☐ Yes	☐ No

Any yes response to questions 1 to 4 indicates suicide risk assessment is required; complete the remaining sections of the form. If Suicide Risk Assessment is not indicated, stop here and sign that screening has been completed.

Name *(First, Last)*	Signture with Designation
Date *(dd-Mon-yyyy)*	Time *(hh:mm)*

Section B: Assessment Completed by a regulated health care provider when indicated by screening or by clinical judgement.

5. Have you ever wished you were dead?	☐ Yes	☐ No
6. Have you ever thought about ending your life?	☐ Yes	☐ No

If "yes" to questions 5 or 6, proceed through section B; If "no" to both proceed to Section C

7. How often do you have these thoughts? ☐ Daily ☐ Weekly ☐ Monthly

8. Do you have a plan about how you would end your life?
☐ Yes, *Specify details* _____
☐ No

If "yes" to question 8, complete question 9; If "no" to question 8 proceed to Section C

9. Do you have what you would need to complete your plan?	☐ Yes	☐ No

Section C: Suicide Risk Factors

10. Have you attempted to end your life before?
☐ Yes, when? ☐ Within the past 3 months ☐ More than 3 months ago ☐ Other _____
☐ No

11. Have there been any suicides or attempts among family or friends?	☐ Yes	☐ No

12. Have you ever been diagnosed with a mental illness?
☐ Yes, *Specify diagnosis* _____
How do you feel about that diagnosis? _____
☐ No

Name *(First, Last)*	Signture with Designation
Date *(dd-Mon-yyyy)*	Time *(hh:mm)*

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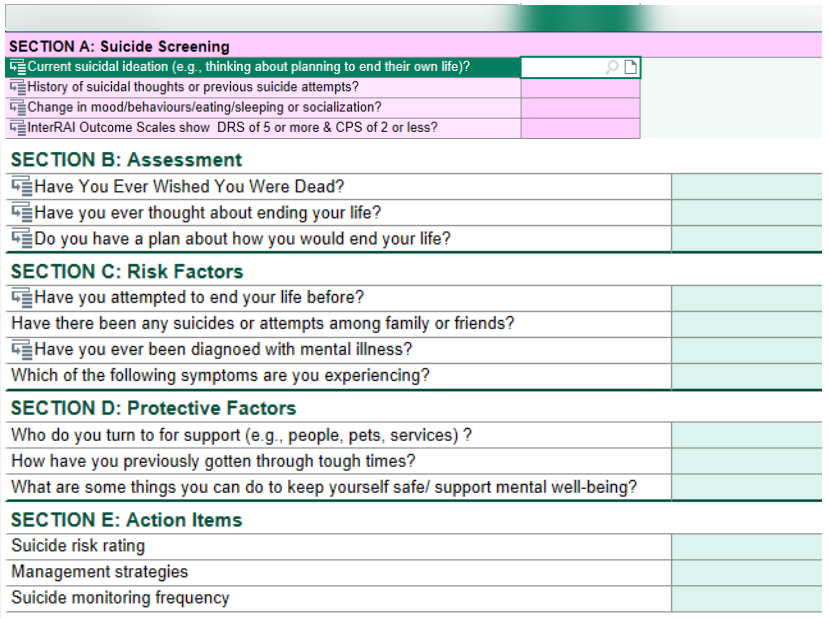


SECTION A: Suicide Screening	
Current suicidal ideation (e.g., thinking about planning to end their own life)?	
History of suicidal thoughts or previous suicide attempts?	
Change in mood/behaviours/eating/sleeping or socialization?	
InterRAI Outcome Scales show DRS of 5 or more & CPS of 2 or less?	

SECTION B: Assessment	
Have You Ever Wished You Were Dead?	
Have you ever thought about ending your life?	
Do you have a plan about how you would end your life?	

SECTION C: Risk Factors	
Have you attempted to end your life before?	
Have there been any suicides or attempts among family or friends?	
Have you ever been diagnoed with mental illness?	
Which of the following symptoms are you experiencing?	

SECTION D: Protective Factors	
Who do you turn to for support (e.g., people, pets, services) ?	
How have you previously gotten through tough times?	
What are some things you can do to keep yourself safe/ support mental well-being?	

SECTION E: Action Items	
Suicide risk rating	
Management strategies	
Suicide monitoring frequency	

Suicide Risk Screening/ Assessment may be completed in other electronic documentation systems (e.g., Meditech, PARIS, Point ClickCare).

Section A: Suicide Risk Screening

Screening completed:

- at time of admission (within 36 hours)
- with interRAI assessment or reassessment
- when indicated by clinical judgement

Information sources:

- preadmission documentation
- interactions
- observation
- information/ reports from others

Section A: Suicide Risk Screening

A "yes" response to any element indicates suicide risk assessment is required.

1. Does the resident have current **suicidal ideation** (e.g. thinking about or planning to end their life)?
2. Does the resident have a history of **suicidal thoughts** or previous suicide attempts?
3. Has the resident had a change in mood, behaviours, eating, sleeping or socialization pattern?
4. interRAI Outcome scales* show Depression Rating Scale of 5 or greater and Cognitive Performance Scale of 2 or less (where available).

If the response to all elements is "no", the screening is completed. However, the regulated health care provider may choose to complete a suicide risk assessment, based on clinical judgement.

Form available here: https://www.albertahealthservices.ca/frm-21889.pdf

interRAI Outcome Scales

- Depression Rating Scale (DRS) is a scale of 0-14. A score of 3 or more may indicate a potential or actual problem with depression.
- Cognitive Performance Scale (CPS) is a scale of 0-6. A higher score indicates more severe cognitive impairment

Interpretation: A resident with a DRS of 5 or greater and a CPS of 2 or less may indicate depression and cognitive ability to plan suicide

Section B: Assessment

5. Have you ever wished you were dead?
   Tip: A person who wishes they were dead could be considered low risk for suicide, however this could progress to suicidal thoughts at a later time.

6. Have you ever thought about ending your life?
   Tip: A "yes" response may indicate someone who is preparing to end their life.

If "yes" to either question 5 or 6, proceed through this section. If "no" to both questions, proceed to the next section (Section C: Risk Factors), skipping questions 7, 8 and 9.

7. How often do you have these thoughts?
   Tip: This can be challenging to measure so these descriptions explain what daily, weekly and monthly mean:
   - Daily = thoughts occur frequently, may be intense (strong) and impossible to dispel/get rid of
   - Weekly = thoughts occur regularly, may vary in strength and may be difficult to dispel/get rid of
   - Monthly = thoughts occur periodically or occasionally, may be of low **intensity** and last a short time

Section B: Assessment

8. Do you have a plan about how you would end your life?
   Tip: A "yes" response means more details about the resident's plan for suicide must be obtained by the regulated health care provider.

If "no" to this question, proceed to the next section (Section C: Risk Factors), skipping question 9.

9. Do you have what you need to complete your plan?
   Tip: A "yes" response is important when considering the resident's suicide risk level and care planning interventions for safety.

All information is considered when determining suicide risk level and care planning interventions. Complete Sections C & D.

Section C: Risk Factors

10. Have you attempted to end your life before?
    Tip: A **suicide attempt** within the past three (3) months is associated with an increased risk of suicide.

11. Have there been any suicides or attempts among family or friends?
    Tip: any exposure to suicide is a risk; the impact appears to be higher within the first year of the event but can vary based on other risk factors present.

12. Have you ever been diagnosed with a mental illness?
    Tip: This may be a challenging question for some residents to answer. An example of mental illness is depression.

13. Are you feeling any of the following: multiple selections
    Tip: residents experiencing multiple challenges, losses, or difficult feelings may be at increased risk of suicide. Select all that apply and others the resident may identify that are not listed.

Risk factors are consider when determining suicide risk level and care planning interventions.

Section D: Protective Factors

14. Who do you turn to for support?
    Tip: This may include past or present supports such as friends, family, pets or services such as counselling or support groups.

15. How have you gotten through tough times previously?
    Tip: This information can be helpful for identifying care planning interventions.

16. What are some things you can do to help keep yourself safe or support mental well-being?
    Tip: This information can be helpful for identifying care planning intervention such as a personal safety plan.

Protective Factors are positive aspects of someone's life that can protect against suicide

Section E: Action Items

Note: Action items may be completed simultaneously and involve other members of the health care team.

Suicide Risk Level is based on:

- resident presentation
- information gathered
- clinical judgement of the regulated health care provider in the context of the situation

Suicide Risk Management in DLO

Suicide Risk Level Definitions *The criteria below is only a guide. The documented level of risk should be based on clinical judgement and does not require the resident to match all risk indications.*		
Low Risk	**Moderate Risk**	**High/Imminent Risk**
• no apparent suicidal ideation • suicidal ideation of limited frequency, intensity, and duration • no identifiable plan(s) • no apparent suicidal intent • few risk factors • multiple protective factors	• frequent suicidal ideation with limited intensity and duration • suicide attempt(s) more than 3 months ago • limited or vague plan(s) • no apparent suicidal intent • limited access to lethal means • some risk factors • some protective factors	• frequent, intense and enduring suicidal ideation • current and/or suicide attempt(s) within the last 3 month • specific plan(s) • intent to act • rehearsal behaviour or prepatory behaviour • access to lethal means • severe distress • acute precipitating event • multiple risk factors • few, if any, protective factors

For additional information: Suicide Risk Level Criteria

Communication

Communicate resident's suicide risk to other members of the health care team:

- immediately and no longer than 24 hours when the resident has been assessed as moderate or high/imminent risk of suicide
- based on clinical judgement for residents assessed as low risk for suicide

Notify AHS Case Manager if resident is at any risk of suicide.

Follow established guidance when sharing information with family.

Section E: Action Items

Management Strategies are:

- individualized for the resident
- documented in the health record such as care plan, notes, consultations, etc.
- reviewed at a frequency established by the health care team

Care strategies for residents at moderate or high/imminent risk of suicide should be reviewed every 3 (three) months at minimum, and more frequently based on the resident care needs and the context of the situation.

Suicide Risk Management in DLO

Examples of care plan interventions/safety strategies for residents at risk for suicide	
Support the resident to develop a *Personal Safety Plan** with strategies to promote the resident's own safety. (Materials located on Insite and CCC)	Contact MRHP to discuss resident care needs, need for consult/referral and discuss treatment plan to maintain resident safety.
Reinforce resident use of positive coping strategies.	Relocate resident to a care space near a highly visible location, if possible.
Encourage resident participation in activities (diversional, recreational, therapeutic).	Keep door to resident room open and/or curtain around bed drawn back.
Engage family/friends to support care/safety as appropriate (e.g., with resident consent or when involved as alternate decision-maker)	Check for any unsafe articles in the resident's environment (e.g., lethal means of suicide) and determine best approach for securing such item(s), considering resident needs, culture, established policy, procedure and/or process in the care setting
Encourage resident to verbalize thoughts, feelings and identify concerns	Ensure resident is accompanied when off unit/site
Implement care for assessed unmet needs (e.g., pain, sleep, functional abilities, etc.)	Consultation/ referral for assessment or intervention as clinically indicated: - Gerontologist - Geriatric psychiatry/psychiatry - Senior's Mental Health - Social Worker - Spiritual Care Practitioner - Others (e.g., Addiction & Mental Health Recreation Therapy, Occupational Therapy, etc.)
Monitor resident for new or change in symptoms, including but not limited to: - mood changes - lack of interest - anxiety/ agitation - anger - health concerns - pain - sleep/ appetite disruption - hopelessness - withdrawal from activities - suicidal ideation	

Additional Care Plan Considerations

- Personal Safety Plan and Companion Guide
- Be aware of unanticipated harms
- Consultation timelines
  - Urgent consult/referral may be indicated for resident at moderate or high/imminent risk of suicide
  - Urgency of consult/referral for resident at low risk of suicide based on clinical judgement

Each situation is different. It is better to communicate a concern than leave a resident at risk.

Section E: Action Items

Resident Monitoring Frequency

- determined by resident's care needs
- identified on the care plan
- communicated to the health care team
- documentation of monitoring

A resident may need to be transferred to a higher level of care, or require constant or 1:1 care.
Prescriber order may be required.
Note: 1:1 care should be provided while awaiting a prescriber order

Monitoring

Monitor the resident for:

- suicidal ideation
- mood and behaviour changes such as:
  - changes in sleeping, eating or socialization patterns
- other indicators on the care plan such as:
  - pacing, expressing fear, crying

Members of the health care team need to be aware of who to report observations/concerns to.

Evaluation/Review

Frequency is determined by the health care team and established in the care plan

Reassess/review residents at moderate or high/imminent risk of suicide every 3 months

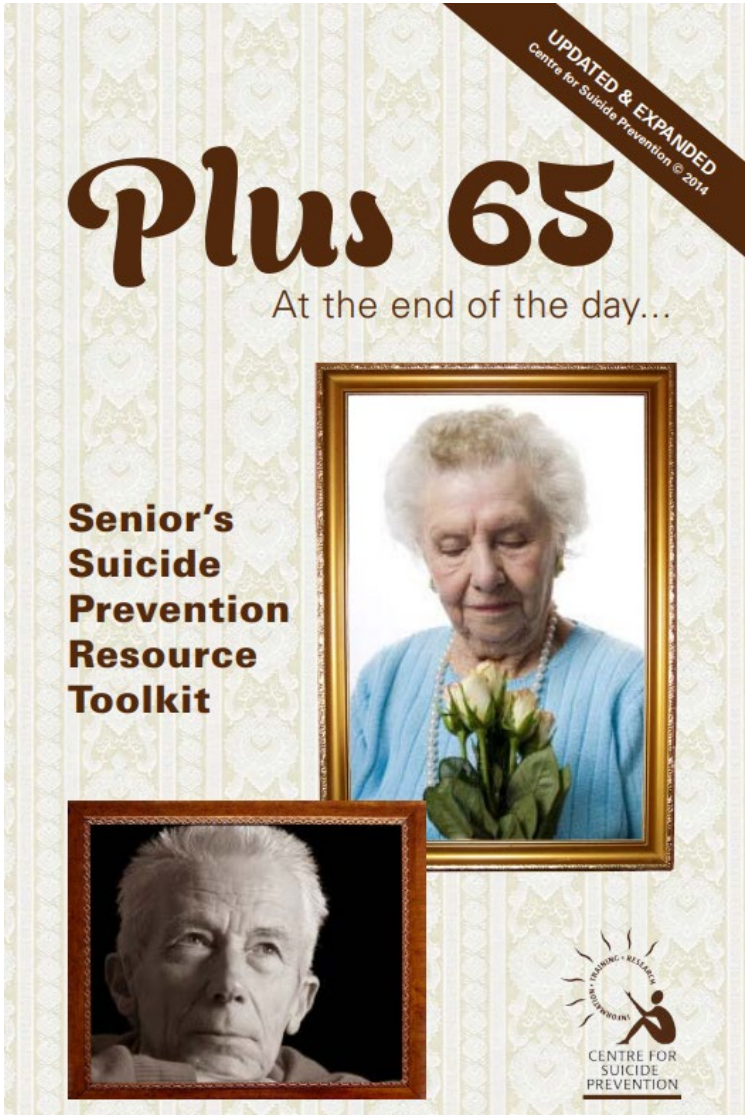
Evaluation/review includes:

- resident assessment/reassessment
- update/ review of interventions
- use of outcome scales to track changes
- communication of changes to the health care team

Canadian Coalition for Seniors Mental Health

https://ccsmh.ca/

Suicide Assessment & Prevention for Older Adults (Brochure):
https://ccsmh.ca/wp-content/uploads/2016/03/CCSMH_suicideBrochure.pdf



Centre for Suicide Prevention

https://www.suicideinfo.ca/

How to Talk to Someone About Suicide (Video)
https://www.suicideinfo.ca/resource/talk-to-someone-about-suicide

Continuing Care Resources

Pain & Mood Toolkit

Continuing Care, Information for Health Professionals

- eLearning Modules
- Supporting Resources
  - Behaviour Mapping
  - Care Planning
  - Guidelines
  - Tip sheets and more

https://www.albertahealthservices.ca/info/Page17547.aspx

Available on Insite (Home>Teams>Seniors Health) and coming soon to CCC!

AHS Education Resources

- Natural Allies Suicide Prevention Training
  - Further explore the REACH pathway
  - 6 hour training, 2 sessions delivered virtually
  - Individuals can register on MyLearningLink
  - Teams and contracted service providers can request sessions by contacting SPEAKS@ahs.ca
- Suicide Prevention, Risk Assessment & Management (SPRAM)
  - Self directed online modules
  - Modules 1-3 recommended to supplement Natural Allies
  - https://www.albertahealthservices.ca/info/Page14579.aspx

Mental Health Commission of Canada | Commission de la santé mentale du Canada

Mental Health First Aid Canada

Mental Health First Aid – Supporting Older Adults

Visit https://mhfa.ca/ and search for courses (virtual options available)

Supports for Health Care Providers

- Please refer to organizational resources in your care setting for:
  - Employee and Family Assistance Program (EFAP)
  - Health and Wellness Resources
- AHS external webpage:
  - Help in Tough Times: https://www.albertahealthservices.ca/amh/Page16759.aspx

Mrs. Jones in Designated Supportive Living (DSL)

- Admitted four (4) months ago requiring health and personal care
- Suicide Risk Screening and RAI Outcome scores did not indicate suicide risk
- Changes noted in the last 30 days:
  - Refuses to engage in group activities
  - Doesn't socially engage with others
  - Lack of eye contact or conversation with daughter
  - States "I just want to sleep forever" or "What's the point?"
  - Little appetite and weight loss

Attribution: https://www.hippopx.com/en/dependent-dementia-woman-old-age-alzheimer-s-retirement-home-186351; no author; CC0

Knowledge Check – Mrs. Jones

Q 1: What "red flags" or warning signs do you recognize in Mrs. Jones? *choose all that apply

- Giving away possessions
- Chronic or increased pain
- Feeling trapped
- Change in eating pattern
- Talking about death
- Talking about being a burden
- Anger, anxiety or agitation
- Lack of purpose
- Death of a loved one
- Previous suicide attempt
- Losing interest in activities
- Serious or chronic health condition
- Substance use
- Withdrawal from friends, family, society
- Sleep disturbance

Q 2: What are the next steps to take in this situation? *choose one

a) Call Mrs. Jones' daughter immediately

b) Implement close observation

c) Complete all sections of the Suicide Risk Screening/Assessment

d) Consult Psychiatry

Knowledge Check – Mrs. Jones

Suicide Risk Screening/Assessment revealed:

- No history of suicidal thoughts or attempts
- No current plan to end her life
- Wishes to “go asleep and not wake up”
- No diagnosis of mental illness
- Feels sad, lack of interest or energy, memory changes make her feel hopeless/helpless
- Several protective factors

Q3: What level of suicide risk is Mrs. Jones?

Low Risk

Moderate Risk

High/Imminent Risk

Knowledge Check – Mrs. Jones

Q 4: What care plan interventions (including consultations) would you consider?*check all that apply

✓	Encourage participation in recreation activities	?	Relocate resident care space near a highly visible location
✓	Engage friends/family to visit resident	?	Keep the door to the resident's room open all the time
✓	Encourage resident to verbalize thoughts and feelings	✓	Check for unsafe articles in the resident's environment
✓	Monitor resident every shift for new or change in symptoms	✓	Accompany resident when off unit/site
✓	Consult Recreation Therapy	✓	Check on resident every 2 hours
✓	Consult Gerontologist	✓	Reassess in 3 months

Knowledge Check – Mrs. Jones

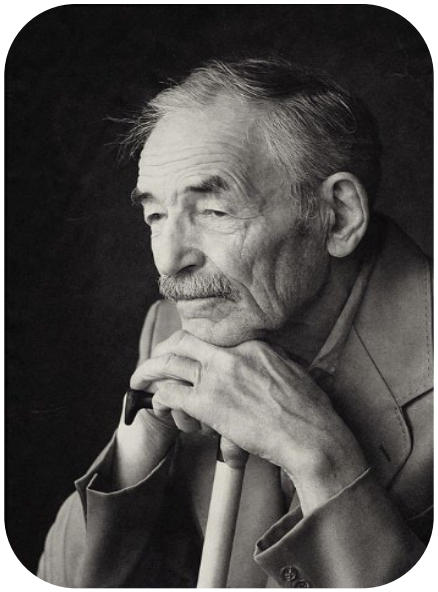
Q 5: Who will you communicate/consult with? * select all that apply

- ☑ Most Responsible Health Provider (MRHP)
- ☑ Daughter (with resident consent)
- ☑ Unit Manager and staff
- ☑ Social Worker
- ☑ Occupational Therapy
- ☑ Spiritual Care Practitioner
- ☑ Dietician

Q6: What is the time frame to communicate risk? Based on clinical judgment

Mr. Blackwood in Long Term Care (LTC)

- Admitted yesterday with increased care needs
- RAI-HC done prior to admission show DRS=5 and CPS=1
- Notes from Designated Supportive Living:
  - Offering to give away hockey card collection
  - No interest in favourite activities (e.g., watching hockey)
  - Doesn't socially engage with others
  - Lies in bed; declines to participate in activities



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Q 1: Would you screen Mr. Blackwood as needing a suicide risk assessment?

Section A: Screening *Completed by a regulated health care provider within 36 hours of admission to a Designated Living Option, with interRAI assessment/reassessment and when indicated by clinical judgement.*		
1. Does the resident have current suicidal ideation *(e.g. thinking about or planning to end their life)*?	☐ Yes	☐ No
2. Does the resident have a history of suicidal thoughts or previous suicide attempts?	☐ Yes	☐ No
3. Has the resident had a change in mood, behaviours, eating, sleeping or socialization pattern?	☐ Yes	☐ No
4. interRAI Outcome scales show Depression Rating Scale of 5 or greater and Cognitive Performance Scale of 2 or less *(where available)*. *Note: Scores are applicable to all interRAI tools.*	☐ Yes	☐ No
Any yes response to questions 1 to 4 indicates suicide risk assessment is required; complete the remaining sections of the form. If Suicide Risk Assessment is not indicated, stop here and sign that screening has been completed.		

Knowledge Check – Mr. Blackwood

Suicide Risk Screening/Assessment:

- No history of suicidal thoughts or attempts
- No current plan to end his life but wishes he were dead so he could “be with his wife”
- No diagnosis of mental illness
- Feels sad, lacks interest or energy, loss of independence and health changes make him feel frustrated, overwhelmed and hopeless/helpless
- Unable to identify protective factors

Q2: What level of suicide risk is Mr. Blackwood?

Low Risk

Moderate Risk

High/Imminent Risk

Q 3: What care plan interventions (including consultations) would you consider?*check all that apply

✓	Encourage participation in recreation activities	?	Relocate resident care space near a highly visible location
✓	Engage friends/family to visit resident	?	Keep the door to the resident's room open all the time
✓	Encourage resident to verbalize thoughts and feelings	✓	Check for unsafe articles in the resident's environment
✓	Monitor resident every shift for new or change in symptoms	✓	Accompany resident when off unit/site
✓	Consult Physical Therapy	✓	Check on resident every 2 hours
✓	Consult Gerontologist	✓	Reassess in 3 months

Q 4: Who will you communicate/consult with? * select all that apply

- ☑ Most Responsible Health Provider (MRHP)
- ☑ Family and/or friends (with resident consent)
- ☑ Unit Manager and staff
- ☑ Social Worker
- ☑ Occupational Therapy
- ☑ Physical Therapy
- ☑ Gerontologist
- ☑ Recreation Therapist
- ☑ Senior's Mental Health

Q5: What is the time frame to communicate risk?
Within 24 hours

Evaluation

Click on this survey link to complete an evaluation of this education.

Thank you!

References

- Accreditation Canada. Suicide Prevention (2018).
- AHS *Collaborative Practice Principles Supporting Patient and Family Centred Care* (2016).
- AHS *Goals of Care Designation Orders and Personal Directives During Response to Apparent Suicide Attempt* (2021) https://www.albertahealthservices.ca/assets/info/acp/if-acp-guidance-document-on-gcd-orders-and-pds-during-response-to-an-apparent-suicide-attempt.pdf
- AHS *Guidelines for Disclosure of Health Information* (2021). https://www.albertahealthservices.ca/assets/info/lp/if-lp-ip-guidelines-for-disclosure-of-health-information.pdf
- AHS *Personal Safety Plan* form (2021) https://www.albertahealthservices.ca/frm-18600.pdf
- AHS *Preventing Suicide.* Injury Prevention & Safety, Information for Health Professionals. https://www.albertahealthservices.ca/injprev/Page4875.aspx
- AHS Provincial Clinical Knowledge Topic: *Suicide Risk Assessment, Adult – Inpatient* (*Non-Psychiatric*) Version 1.0. https://extranet.ahsnet.ca/teams/policydocuments/1/klink/et-klink-ckv-suicide-risk-assessment-adult-inpatient-non-psychiatric.pdf
- AHS Safety Planning with People at Risk for Suicide – Companion Guide (2022). https://www.albertahealthservices.ca/assets/info/amh/if-amh-safety-planning-for-suicide-risk-companion-guide.pdf
- AHS Suicide Risk Level Criteria (2022). https://www.albertahealthservices.ca/assets/info/amh/if-amh-suicide-risk-level-criteria.pdf
- AHS *Trauma Informed Practice* (2013). Information and Evaluation Services.
- Canadian Coalition for Seniors Mental Health (CCSMH) (2006). *National guidelines for seniors' mental health: the assessment of suicide risk and prevention of suicide.*
- Canadian Coalition for Seniors Mental Health (CCSMH) (2009). Suicide prevention among older adults: a guide for family members.
- Centre for Suicide Prevention (2014). *Seniors' Suicide Prevention Resource Toolkit.*
- Mental Health Commission of Canada (MHCC) (n.d.). Older adults and suicide fact sheet.
- Public Health Agency of Canada (2016). Suicide in Canada: infographic. https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-infographic.html
- Public Health Agency of Canada (2020). Suicide in Canada: Key statistics (infographic). https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-key-statistics-infographic.html
- The Ontario Hospital Association & the Canadian Patient Safety Institute (CPSI) (2011) Suicide risk assessment guide: a resource for health care organizations. https://www.patientsafetyinstitute.ca/en/toolsResources/SuicideRisk/Documents/Suicide%20Risk%20Assessment%20Guide.pdf

Questions?

Please contact your zone or program practice lead for more information

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Seniors Health & Continuing Care

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