ORIGINAL DATE: 12/15
REVISION DATE: 02/18

Merrimack Valley Hospice, Inc.

SUBJECT: SUICIDE AND SUICIDE RISK ASSESSMENT

PURPOSE: To describe the assessment of suicide risk, the response to threatened or attempted suicide, and follow-up services to caregivers and staff in the event of a successful suicide.

POLICY

All members of the Interdisciplinary Team (IDT) are responsible for the identification of risk factors that place a patient "at risk" for suicide. The IDT will develop an individualized plan for any patient assessed to be at risk. All direct care staff will receive education in the appropriate response to a threatened or attempted suicide.

DEFINITION

Suicidal ideation is a common medical term for thoughts about suicide that may be as detailed as a formulated plan. Although most people who undergo suicidal ideation do not commit suicide, some do go on to make a suicide attempt or take their own life.

Euthanasia is an act that intentionally and directly causes a patient's death. This definition of euthanasia encompasses active euthanasia, voluntary euthanasia, and in some settings physician assisted suicide. The term "assisted suicide" is most commonly used to represent an act in which a patient is given the means and specific instructions to take his or her own life. Withholding or withdrawing life sustaining therapies or unintentionally affecting the dying process through treatments aimed at controlling symptoms does not constitute either euthanasia or assisted suicide. The purpose of these acts is comfort of the patient, not ending the patient's life. Thus, neither is an act that intentionally and indirectly causes a patient's death.

PROCEDURE

1. Any member of the IDT may identify a patient as being "at risk" for suicide. "At risk" includes suicidal ideation, either overtly or implied.

2. IDENTIFICATION OF SUICIDAL IDEATION (GESTURE) ATTEMPT
   Valid ideation which requires further intervention is the active consideration of suicide as an option for a patient or family member (i.e., not just the thought of suicide). Phrases like "I would never do it" or "I would be afraid to attempt it" do not indicate ideation requiring intervention beyond routine clinical exploration.

3. REPORTING OF SUICIDE IDEATION
    a. The team member who identifies the suicidal ideation will immediately notify the Clinical Director or designee who will contact the Social Worker (SW). The suicidal ideation and notification will be documented in the patient's medical record by the reporting team member.

    b. As soon as it is feasible to do so, staff will notify their supervisor that the patient has exhibited suicidal ideation, and provide detailed information of the intent and the patient's statements and plan.
        i. If this occurs "after-hours," staff will notify the administrator on-call.
        ii. The administrator on-call will develop an immediate plan to ensure patient safety as detailed below.

    c. Assessment of Suicidal Risk
    The SW will conduct an assessment of the suicidal ideation as soon as possible. The suicidal assessment requires assessing the risk of actual suicide.
        i. There are five factors to assess first:
            1. Is there a viable plan including time, place and action?
            2. Are there means at hand (with special attention given to the presence of firearms in the house)?
            3. Is there intent?
            4. Is there an attempt history?
            5. Is the individual abusing alcohol or drugs?
        ii. Factors to be included in the assessment are:
            1. Is the family a viable resource and can they intervene?
            2. Is there a history of suicide in the family?
            3. Is there a diagnosable mental illness? If so, is it being treated?
            4. Demographic risk factors include being male, over 65 and living alone.
            5. Is the individual experiencing chronic pain?
            6. What is their life expectancy without possible successful suicide attempt?
        iii. The SW will document this assessment in the patient's medical record.

    d. A suicide prevention plan will be developed and incorporated in the Plan of Treatment.

    e. All staff involved with the care of the patient will be oriented to the suicide prevention plan.

    f. IDT staff will continue to visit the patient and follow the suicide prevention plan and document observations, interventions and recommendations in the clinical record.

4. ACTION BASED ON LEVEL OF RISK
    a. **Low Risk:** The team members will further assess the underlying reasons for the suicidal ideation and initiate a plan of care to address them appropriately. The following steps will be taken and team members, including on-call providers, will be notified:
        i. A referral will be made to the individual's spiritual mentor if there is a spiritual connection identified.

ii. Medications will be monitored and secured
iii. Available Resources:
1. National Suicide Hotline (24/7) at (800) 273-8255

b. **High Risk:** After implementing the low risk strategies the following steps will be taken and team members, including on-call providers, will be notified:
i. A request will be made to remove guns from the home if present. This request will be documented in the patient's medical record.
ii. The SW may consult with a mental health consultant and other SWs
iii. The SW or HPHPC RN Case Manager will notify the individual's attending physician.
iv. The SW will explore voluntary interventions. These may include transferring the individual to the hospital, 24 hour care, using support of family to protect the individual, removing means, etc.
v. If no contract or voluntary interventions are accepted and there is risk for physical harm to self or others in the home, aggressive intervention will be initiated by the contacting the appropriate responder in the community such as the mental health hotline mobile crisis team, police, etc. to explore possible hospitalization or 24-hour care in the home to prevent suicide attempt. The team member assessing the immediate risk will contact the mental health hotline and/or the police.
- MA (877) 382-1609
- NH (866) 444-4211
- ME (800) 464-5767

vi. A case conference will be convened no later than the next business day. The attending physician and other care providers (e.g., therapist, psychiatrist) will be invited as appropriate.
1. As appropriate, additional consultation will be sought, i.e., VNA Psycho-Social Program or resources in the community
2. Deliberations and recommendations from the case conference will be documented in the patient's clinical record by the Clinical Manager or designee.

5. ACTION IF SUICIDE OCCURS, THE FOLLOWING STEPS WILL BE TAKEN
a. The first staff person who is aware of the suicide will call the police. If staff are present at the location of the presumed suicide, the scene is treated as a "crime scene" and nothing should be disturbed until cleared by the police and medical examiner.
b. The Case Manager RN and/or SW will make a visit to the family. If the family is out of the area, the RN and /or SW will contact them as soon as possible.
c. The clinical manager or administrator on-call will also notify the following list of the suspected suicide.
i. The attending physician and
ii. The Merrimack Valley Hospice/YHH Vice President
iii. The Chief Nursing Officer
iv. The VP of Quality, Compliance and Risk
v. The Department of Health for the appropriate state with assistance from the VP of Quality, Compliance and Risk
d. The SW in coordination with the Clinical Director will arrange for debriefing/processing with team members

e. In the event of a suicide attempt while Merrimack Valley Hospice/YHH staff is present, staff will attempt to stabilize the situation.
   i. If a weapon is present (knife, gun) staff should not attempt to disarm the patient.
   ii. Staff should leave the immediate area and report the situation to their clinical manager or the administrator on-call during off-hours.
   iii. The clinical manager/administrator on-call will provide direction to staff regarding further actions/interventions.
   iv. The clinical manager/administrator on-call will notify the police.

6. EDUCATION OF STAFF AND VOLUNTEERS

In-service education for all staff and volunteers will be provided by the SWs. This will include:

a. Educational class for all current staff and volunteers
b. Follow-up support meeting availability
c. Orientation for all new staff and volunteers
d. Additional support for involved staff will be provided, either by Merrimack Valley Hospice/YHH SW staff or through the Employee Assistance Program

7. SUICIDE PRECAUTIONS AT THE HOSPICE HOUSE

a. A patient who has been determined to be at risk for suicide will be placed in a room that allows direct observation from the Care Station.
b. Upon admission to the Hospice House, a clothing and property review will be conducted to identify and remove items that could be used for self- harm. This includes items such as shoelaces, belts, razors and drawstrings, weapons, glass, sharps, toiletry items, matches, etc. A list will be made of the items removed and the items will be given to the family to take home, or will be stored in a secure area of the Hospice House.
c. Hospice House furnishings or items that could be used for self-harm will be removed from the room. This includes items such as wastebaskets, plastic bags, sharps containers, and alcohol hand sanitizer. Remove call bell from wall and use hand-held bell.
d. Depending on the level of risk, as assessed by the Interdisciplinary Team, the patient may be placed on one-to-one observation.
e. Patients on Suicide Precautions must be observed at least every 15 minutes, and the observation documented in the clinical record.
f. A nursing assessment for suicide risk will be performed every shift and documented in the clinical record.
g. Meals will be served on paper/plastic dinnerware.
h. Hospice Medical Director will evaluate patient and document assessment. A physician order is required before suicide precautions can be stopped.

Related Policy: HHF Weapons Policy #1021

Responsibility: IDT
Distribution: Leadership, YHH Manual

Nature of Change	Updated in entirety.
CCO Signature	_____ ____/____/____
CEO Signature	_____ ____/____/____ Date