CONSIDERATIONS:

1. Home health patients have a higher risk for suicide than the general population. The purpose of this procedure is to help clinicians intervene appropriately when patients have been identified as being at risk for suicide.
2. For information for how to assess for suicide risk, see procedure *Assessment: Suicide Risk*.
3. The Weill Cornell Suicide Risk Spectrum (see *Addendum E*) is a tool that helps the clinician determine:
    a. Severity of suicide risk
    b. Interventions that should be taken for each severity level
4. Severity levels on the Weill Cornell Suicide Risk Spectrum include:
    a. Very Low Risk: No suicide ideation:
        i. Normal focus on end of life issues due to advanced age, medical illness or dwindling social networks
        ii. May have occasional thoughts about own mortality
        iii. Is not preoccupied with death; thoughts that life is not worth living or that would be better off dead
    b. Mild Risk: Recurrent thoughts of death: Passive suicide ideation:
        i. Morbid preoccupation with death; thoughts that life is not worth living, or would be better off dead
        ii. Has not considered a method to harm self
    c. Moderate Risk: Thoughts of suicide: Active suicide ideation:
        i. Has considered a method to harm self
        ii. Does not report a specific detailed plan or current intention to harm self
        iii. Demonstrates reasons for living and good impulse control
    d. High Risk: Specific suicide plan or intent:
        i. Reports a specific detailed plan and/or current intention to harm self
        ii. Does not have good impulse control

EQUIPMENT:

Weill Cornell Suicide Risk Spectrum (Addendum E)

PROCEDURE:

1. Assess patient's thoughts about death and plans about harming him/herself.
2. Compare assessment data to the Weill Cornell Suicide Risk Spectrum.
3. Determine where on the spectrum the patient falls:
    a. Very Low Risk
    b. Mild Risk
    c. Moderate Risk
    d. High Risk
4. Very Low Risk:
    a. Discuss with patient that occasional thoughts about mortality are normal
    b. Advise that if these thoughts and feelings become distressing to call home health agency or physician
    c. Ask if the patient would like to discuss concerns with "another person who has more time to discuss these issues"
    d. Alert physician, recommending MSW or community mental health service program referral
5. Mild Risk:
    a. Advise patient that morbid preoccupation with death is serious and patient needs increased support
    b. Ask patient if MSW/psychiatric nurse could visit to discuss thoughts and feelings
    c. Ask patient's consent to notify the caregiver or someone close to the patient
    d. Notify physician and provide following information:
        i. Symptoms of depression
        ii. Patient expresses recurrent thoughts of death
        iii. Patient has not considered a method of harming self
        iv. Obtain orders for psychiatric nurse/MSW referral if patient has agreed
    e. Call office and make MSW/psychiatric nurse referral indicating depression as reason for referral
    f. MSW to make initial visit ideally within 24 - 48 hours
6. Moderate Risk:
    a. Advise patient that thoughts of suicide indicate extreme emotional distress
    b. Provide support for patient's reasons for living and maintaining good impulse control
    c. Instruct patient that he/she requires professional evaluation and support
    d. Discuss referral to MSW/psychiatric nurse
    e. Ask patient's consent to notify the caregiver or someone close to the patient
    f. Notify the physician and provide the following information:
        i. Symptoms of depression
        ii. Patient expresses recurrent thoughts of death

   iii. Patient has considered a method of harming self, but has no current intention to act on method
   iv. Obtain orders for a MSW/psychiatric nurse referral if the patient has agreed
g. Call office and request referral for MSW/psychiatric nurse, indicating reason for referral
h. Notify team members of patient's status
i. MSW/psychiatric nurse initial visit should ideally be within same day, 24 hours

7. High Risk:
   a. Instruct patient that thoughts of suicide and a specific plan with intent are extremely dangerous and that immediate mental health intervention is necessary. Contact supervisor.
   b. If immediate visit by MSW/psychiatric nurse is not possible, or if patient refuses intervention, call 911
   c. Stay with patient until intervention services arrive. However, if nurse feels that personal safety is in danger, nurse should secure own safety
   d. Alert caregiver or contact person
   e. Notify the physician and provide the following information:
      i. Patient has a specific plan and intention to harm self
      ii. Actions taken by the clinician
   f. Notify team members of actions taken

AFTER CARE:

1. Document in patient medical record all of interventions taken including:
   a. Reasons for identifying the severity/urgency of situation
   b. Discussion with patient/caregiver
   c. Communication with physician and supervisor
   d. Referrals to psychiatric nurse, MSW, community mental health program

REFERENCE:

American Psychiatric Association (2004). Quick Reference to the American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders, *Compendium 2004*. Arlington: Author.

Bruce, M., Sheeran, T., Raue, P., Reilly, C., Greenberg, R., Pomerantz, J., Meyers, B., Weinberger, M., & Johnston, C. (2011). Depression Care for Patients at Home (Depression CAREPATH): Intervention Development and Implementation, Part 1. *Home Healthcare Nurse*, 85(3), 416–426.

Veterans Administration/Department of Defense (n.d.). Essentials for Depression Screening and Assessment in Primary Care. Retrieved June 12, 2012 from http://www.healthquality.va.gov/mdd/MDDTool1VADoDEssentialsQuadFoldFinalHiRes.pdf

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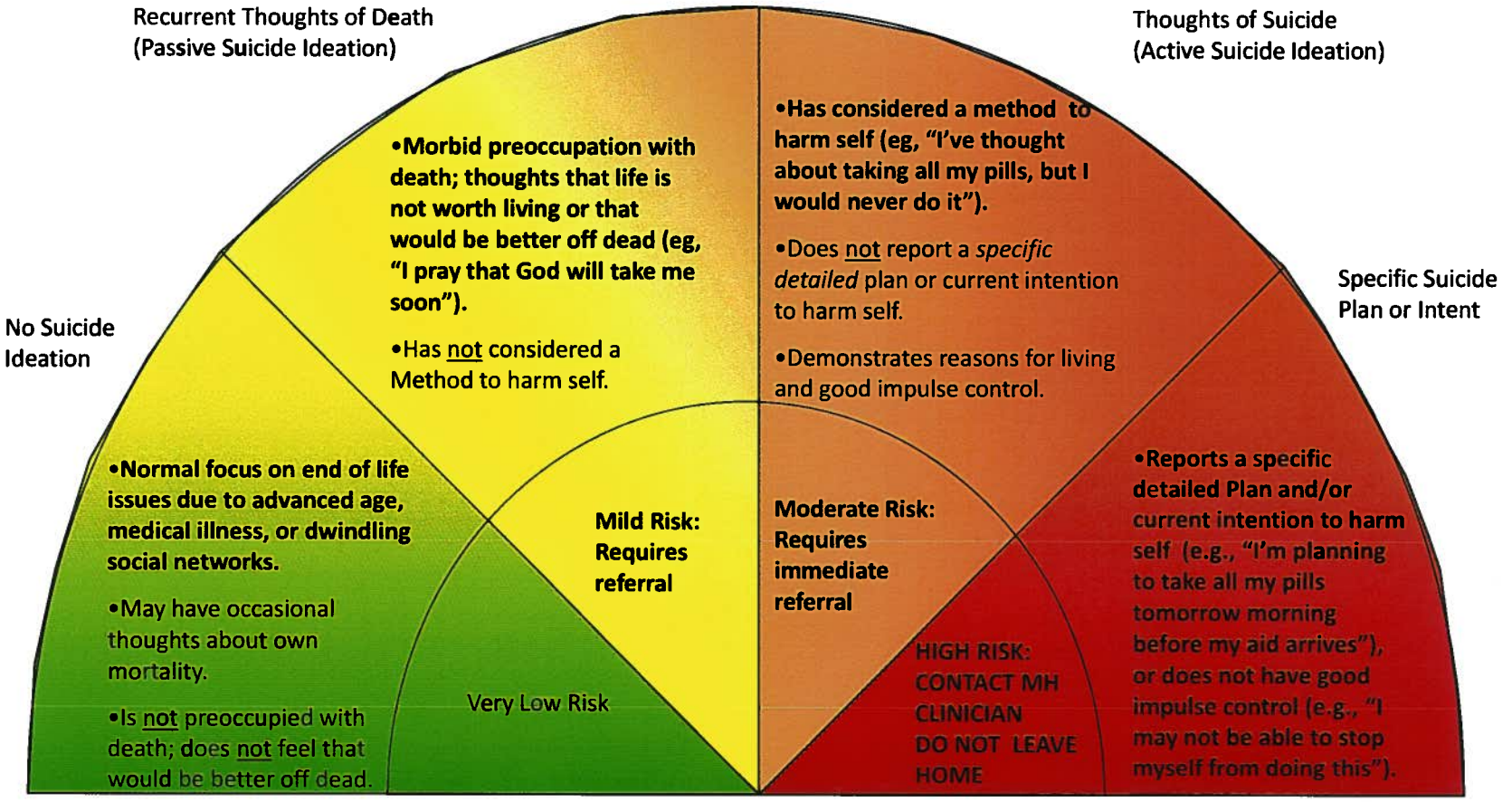
ASSESSING SUICIDE RISK AS A SPECTRUM*



*Always follow individual agency procedures for suicidal patients

Training & Resources for Care Providers
in geriatric mental health

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