Suicide Risk Assessment

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Any positive response to:
"Thoughts that you would be better off dead, or of hurting yourself in some way?"

Social Work Counselor: provide counseling and appropriate resources

Nursing:
- Initiate measures to maintain continuous observation of patient; evaluate and secure immediate physical environment as indicated
- Document information in patient’s medical record (see Appendix B)
- Notify attending provider

Moderate or High Risk for Suicide, see Page 2

Social Work Counselor to assess for active suicidal ideation

Yes

Social Work assessment indicates moderate or high risk for suicide?

Off-campus phone call received

Via face to face conversation

Nursing:
- Maintain continuous observation of patient and secures immediate physical environment by removing hazardous items (Patient should not be left alone)

Social Work Counselor:
- Notify Attending Physician and Nurse Manager/Center Administrative Director (CAD) or designee
- Provide counseling and appropriate referrals

Via PNS

Workforce Member identifies patient with trigger for suicide risk

Page High Risk pager to notify Social Work
(During clinic hours/daytime work hours, notify Social Work Counselor assigned to the area; for off hours and holidays, use High Risk pager for Social Work counselor on call
High Risk pager: 713-404-6556)

Any positive response to:
"Thoughts that you would be better off dead, or of hurting yourself in some way?"

Workforce member:
- Initiate measures to maintain continuous observation of patient; evaluate and secure immediate physical environment as indicated
- Contact Social Work Counselor for an immediate assessment (if Social Work Counselor not available use High Risk pager: 713-404-6556 for on-call Social Work Counselor)
- Document information in patient’s medical record (see Appendix B)
- Notify attending provider

See Appendix A for Risk Indicators Triggers

Questions from PN S (Patient Needs Screening) regarding feelings over the last two weeks:
- Little interest or pleasure in doing things
- Feeling down, depressed or hopeless

Hazardous items to be removed from immediate area: sharp objects, potential weapons, other implements that could be used to cause harm (scissors, other sharps, medication, silverware, belts, glass, liquids, and dining trays). Include patient personal items.

If face to face conversation is with a qualified mental health professional, that mental health professional may assess for active suicidal ideation.

Expect a response from Social Work within 30 minutes

See Appendix C for Suicidal Assessment checklist

See Appendix D for Available Resources

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Department of Clinical Effectiveness V3

1 See Appendix A for Risk Indicators Triggers

2 Questions from PNS (Patient Needs Screening) regarding feelings over the last two weeks:
   - Little interest or pleasure in doing things
   - Feeling down, depressed or hopeless

3 Hazardous items to be removed from immediate area: sharp objects, potential weapons, other implements that could be used to cause harm (scissors, other sharps, medication, silverware, belts, glass, liquids, and dining trays). Include patient personal items.

4 If face to face conversation is with a qualified mental health professional, that mental health professional may assess for active suicidal ideation.

5 Expect a response from Social Work within 30 minutes

6 See Appendix C for Suicidal Assessment checklist

7 See Appendix D for Available Resources
Consult with Emergency Center (EC) physician and transfer patient to EC for evaluation, triage, and sitter services as applicable, and place order for Psychiatric consultation, if needed

If at Houston Area Location (HAL) refer to appropriate medical facility or local Emergency Center

Patient should always be accompanied by the designated nursing personnel

Physician to assess the patient and place orders for Psychiatry consultation, if needed

Patient should always be accompanied by the designated nursing personnel

Area suitable for patient to wait?

Yes

No

Social Work assessment indicates moderate or high risk for suicide

Inpatient

Outpatient

Provider:
- Assess the patient
- Confirm suicide precaution orders
- Place orders for psychiatric consultation if needed, with re-consultation as indicated

Physician available?

Yes

No

Social Work assessment questions: see Appendix D

See Appendix B for Documentation and Discharge

Continued from Page 1
OFF-CAMPUS PROCEDURE

Off-campus phone call received

Direct call to clinical staff member

Any positive response to: “Thoughts that you would be better off dead, or of hurting yourself in some way?”

Nursing:
- Contact Social Work Counselor for an immediate assessment2 (if Social Work Counselor not available use High Risk pager: 713-404-6556 for on call Social Work Counselor)

Social Work Counselor: assess for active suicidal ideation3

Social Work assessment indicates moderate or high risk for suicide?

Yes

Social Work Counselor will provide counseling and appropriate resources4

No

Call or direct caller to contact Emergency Medical Services (911) or proceed to their nearest Emergency Center, as appropriate and applicable or

- Notify local law enforcement to initiate a welfare and safety check at the caller’s location as appropriate and applicable or

- Call for an ambulance to pick the patient up and take the patient to the nearest emergency room as applicable and appropriate

Nursing: document information in patient’s medical record (see Appendix B)

See Appendix B for Documentation and Discharge

1 Stay on line with patient until clinical staff member picks up the line, no cold transfer. Do not place the caller on hold. Obtain as much information as possible in order to inform 911 operator if needed.
2 Expect a response from Social Work within 30 minutes
3 Social Work assessment questions: see Appendix D
4 See Appendix C for some available resources

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APPENDIX A: Risk Indicator Triggers (Alone or in combination)

- Verbalizing of suicidal gestures or ideations with plan
- History of past suicidal attempts
- Recent treatment for the presence of psychiatric illness
- A family history of suicide
- Major depression
- Verbalizing no hope for the future
- Major depression followed by a sudden elevation in mood
- Giving away personal possessions if not imminently terminal
- Reports of command auditory hallucinations to harm self or others
- Evidence of persecutory delusions
- Recent significant actual or perceived loss of job, relationship, physical abilities, limbs, etc.
- Decreased social support
- Evidence of alcohol or substance abuse
- Perception of increased burdensomeness
- Intractable symptoms causing distress
- Unmanaged pain

APPENDIX B: Documentation and Discharge

Staff involved with patient to complete documentation of the following in the patient’s medical record:

- Suicidal remarks, gestures, or self-destructive comments/behaviors
- Assessment, reassessment
- Date and time suicide precautions initiated and discontinued (nursing)
- Maintenance of suicide precautions every shift (nursing)

At discharge:

- Provide suicide patient education document
- Provide crisis hotline number
- Provide counseling or psychiatric referral as appropriate
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APPENDIX C: Suicidal Assessment Checklist

Below is the information asked on the Social Work Suicide Assessment Checklist by the Social Work Counselor.

Suicide Risk Assessment – questions to ask:
Are you feeling hopeless about the present/future? _____ yes _____ no
Have you had thoughts about taking your life? _____ yes _____ no
When did you have these thoughts and do you have a plan to take your life? If so, what is your plan? Have you rehearsed this plan?
Have you ever had a suicide attempt in the past? When? What happened?
How long have you been thinking about this?
If you were to kill yourself, when would it be?
Do you have the means? (guns, pills, etc.)
What has been stopping you/Where are you finding your hope, etc.?

Risk Factors
— Past Attempts
— Current ideation/intent/plan/access to means
— Substance Abuse
— Psychiatric diagnosis
— Impulsiveness and poor self-control
— Hopelessness-presence, duration, severity
— Recent losses-physical, financial, personal
— Recent discharge from an inpatient unit
— Burdensomeness
— Isolation
— Trapped
— Command Hallucinations
— Change in Treatment
— Physical Pain
— Other

Protective Factors
— Positive social support
— Spirituality
— Sense of responsibility
— Children in home/pregnancy
— Life satisfaction
— Positive problem solving skills
— Positive coping skills
— Positive relationship with medical team
— Access/willingness for mental health care
— Other

Level of Risk
— Low
— Moderate
— High

Collateral Information
Name:
Telephone Number:
How often are they able to see patient?

Follow-up Plan
Did patient agree to limit access to means? _____ yes_____ no
Did patient agree to follow-up treatment? _____ yes_____ no
Does patient have a crisis hotline number and emergency numbers to call? _____ yes_____ no

Comments:
APPENDIX D: Resources

- National Suicide Prevention Hotline: 1-800-273-TALK (8255)
- Emergency number: 911
- Internal numbers for questions about safety for MD Anderson patients at risk for suicide:
  - The Department of Social Work: 713-792-6195
  - The Department of Psychiatry: 713-792-7546

- Reference documents:
  - The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) (n.d.) Suicide Warning Signs. National Suicide Prevention Hotline.
  - United States Department of Veterans Affairs. (n.d.) ACE: Suicide Prevention for Veterans and Their Families and Friends. [Brochure].

- Education Center computer based training:
  - “Suicide Awareness” course number NPDE 4418
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SUGGESTED READINGS


This practice consensus algorithm is based on majority expert opinion of the Suicide Risk Assessment Workgroup at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following faculty and caregivers:

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