Suicide PC.S35

Regulatory Citation(s):	None
L-Tag(s):	None

POLICY: Members of the IDG respond to suicidal ideation and/or actual suicide attempts in a proactive and compassionate manner aimed at protecting the safety of all involved parties.

DEFINITIONS:

Suicidal Behavior: *An expressed intent to complete suicide, voicing a specific plan for completing suicide, possessing or having access to lethal means, rehearsing a suicide, or attempting suicide.*

Suicide Attempt: *A non-fatal, self-inflicted, destructive act with the intent to die.*

Suicide Risk: *The foreseeable likelihood of a completed suicide.*

Suicide Risk Factors: *Variables that alone or in combination increase the risk of a suicide attempt.*

PROCEDURE:

1. Suicide risk factors are included in the comprehensive assessment of each patient. Risk factors for hospice patients may include, but are not limited to:
    a. making statements about helplessness, hopelessness, worthlessness, uselessness;
    b. recently attempting suicide or incurring serious self-injury;
    c. threatening suicide or to harm oneself in some way;
    d. rehearsing completion of suicide or visiting a place to complete suicide;
    e. having a well-thought out and do-able plan and access to lethal means; and/or
    f. writing a suicide note.

2. When the IDG determines that a patient is a possible suicide risk, additional screening is conducted by a hospice clinician that includes asking the patient the following questions:
    a. Have thought about killing yourself? Are you thinking about it right now?
    b. Are these thoughts persistent and uncontrollable?
    c. Do you have a plan on how to kill yourself?
    d. Have you the means to carry out this plan?
    e. Do you intend to carry out this plan?

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3. If the patient answers yes to any of the above questions, the patient is considered to be at a high risk for a suicide attempt and further action is warranted.

4. If there appears to be no immediate danger (for example, there is no evidence of available lethal means), the clinician may:
    a. express caring and concern for the patient;
    b. enlist the support of the patient's family, caregivers and significant others to engage the patient and actively listen to his/her expressed concerns;
    c. ensure that the patient is receiving appropriate and adequate pain and symptom management and control; and/or
    d. suggest a suicide watch until the crisis subsides.

5. If there appears to be immediate danger of a suicide attempt the clinician may:
    a. contact the hospice Director of Clinical Operations as soon as feasible for backup support and direction;
    b. assess the safety of all parties (including the patient, family members and others in the home)
    c. if feasible and safe to do so, remove weapons, pills, chemicals, car keys, etc.;
    d. provide a suicide watch until the crisis subsides; and/or
    e. call 911 if necessary and appropriate to maintain the safety of the patient and all others present in the home.

6. The clinician completes an adverse event report and when a patient threatens or attempts suicide.

7. The Director of Clinical Operations completes an adverse event report and a comprehensive investigation, and notifies the department of health if a patient completes suicide.

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