Southern Health Santé Sud

ADDRESSOGRAPH OR LABEL

RISK ASSESSMENT FOR SUICIDE TOOL (RAST)

Information sources (*check all that apply*)

☐ Resident ☐ Substitute decision maker ☐ Family member
☐ Health record ☐ Application/Assessment ☐ Other:

Risk Factors for Suicide (*check all that apply for the resident*)

☐ Reports suicidal ideation	☐ History of domestic violence	☐ Feelings of loneliness
☐ Has written about his/her suicide or death	☐ History of torture or violence	☐ Chronic conditions and/or pain
☐ Previous self-harm	☐ Childhood adversity (e.g. losing a parent, sexual abuse)	☐ Hopelessness
☐ Previous suicide attempt(s)	☐ History of substance abuse/misuse/gambling	☐ Access to means
☐ Family history of suicide/attempts, suicide ideation or mental illness	☐ Medication side effects (e.g. antidepressants, mood stabilizers, anticonvulsants, antipsychotics)	☐ Male and 80+ years of age
☐ History of mental illness (e.g. major depression, other mood disorders, psychotic disorders)	☐ Recent (past 3 months) social, physical and financial losses or negative events, and other transitional events	

Protective Factors Mitigating Suicide Risk (*check all the apply for the resident*)

☐ Strong connections with staff, family, friends and community support	☐ Skills in problem solving, coping and conflict resolution	☐ Sense of belonging, sense of identity, and good self esteem
☐ Monitoring for medication side effects and review at quarterly medication reviews	☐ Management of chronic conditions and/or pain	☐ Engagement in purposeful activities that nurture hope, self-esteem, resilience & spirituality
☐ Support through ongoing medical and mental health care relationships	☐ Effective treatment for depression and other mental health issues, physical and substance use disorders	☐ Easy access to a variety of clinical interventions and support for seeking help
☐ Restricted access to lethal means of suicide		

Management of Immediate Safety Needs (*if applicable*) (*use Integrated Progress Note if more space needed*)

Action	Responsibility	Timeframe

Communication with the healthcare team:

☐ Prescriber ☐ Pharmacist ☐ Substitute Decision Maker ☐ Other:

Consults to:

☐ Social Work/Designate ☐ Spiritual Health ☐ Seniors Consultation Team ☐ Other:

☐ Care plan developed and document (refer to the Suicide Risk Assessment Resource Guide)

Completed by (name, signature and designation):

Date and time:

Suicide risk assessment to occur at quarterly care plan reviews using depression screening tools.

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Instructions for Use:

1. This is an assessment form used to assist the healthcare team in Personal Care Homes to make informed judgments about suicide risk by providing a framework to gather, organize, analyze and document information about the resident.

   The assessment form assists in the provision of appropriate clinical care and management of suicide risk.

   The form is completed for all residents identified at risk for suicide on the Suicide Risk Screening Tool or if suicide risk is identified at the quarterly care plan review using either the Geriatric Depressing Scale (GDS) – Short Form (CLI.6410.PL.021.FORM.03) or the SIG E CAPS - Screening for Depression tool (CLI.6410.PL.021.FORM.04).
2. Check all the applicable boxes in the section labeled “Information Source”.
3. Complete the “Risk Factors for Suicide” section. Put a check mark in the appropriate box for each of the suicide risk factors. A check mark indicates the risk factor is present. Absence of a check mark indicates the risk factor is not present.
4. Complete the “Protective Factors Mitigating Suicide Risk” section. Put a check mark in the appropriate box for each of the protective factors. A check mark indicates the resident experiences and perceives the protective factor. Absence of a check mark indicates the resident does not experience or perceive the protective factor.
5. Complete the “Management of Immediate Safety Needs” section. Use the space provided to detail the actions taken or to be taken to support the safety of the resident. Specify the specific action, who has responsibility for completing the action, and the timeframe in which the action must be completed.
6. Complete the “Communication with the Healthcare Team” section. Put a check mark beside the appropriate selection(s).
7. Complete the “Consults to” section. Put a check mark beside the appropriate selection(s).
8. Check the box for Care Plan developed and documented if one has been completed for the resident.
9. File the document in the resident’s health record.