POLICY:	**Suicide Risk Assessment in Personal Care Homes**
Program Area:	**Personal Care Home**
Section:	**General**
Reference Number:	**CLI.6410.PL.021**
Approved by:	**Regional Lead – Community & Continuing Care**
Date:	Issued 2019/Apr/17 Revised 2024/Jul/3

PURPOSE:
To establish and maintain a process to assess for suicide risk in Personal Care Homes.

BOARD POLICY REFERENCE:
Executive Limitation (EL-02): Treatment of Clients

POLICY:
- All residents who move into a personal care home are assessed for suicide risk.
- All residents in personal care homes are screened for depression quarterly.
- Screening may be done for any resident at any time as needed, based on the clinical judgment of health care providers.
- Suicide risk is addressed through individualized care plans and follows established guidelines.

DEFINITIONS:
See the Regional Personal Care Home Suicide Risk Assessment Resource Guide (CLI.6410.PL.021.SD.01).

IMPORTANT POINTS TO CONSIDER:
- The Regional Personal Care Home Suicide Risk Assessment Resource Guide is available to all staff and provides more information about suicide risk, protective factors, screening, care planning and interventions.

PROCEDURE:
The following procedure is summarized from the Regional Personal Care Home Suicide Risk Assessment Resource Guide.

Screening
1. The nurse (Registered Nurse, Licensed Practical Nurse, Registered Psychiatric Nurse) or designate assesses the risk of suicide for residents within 24-48 hours of admission to the Personal Care Home(PCH) using the Suicide Risk Screening Tool (CLI.6410.PL.021.FORM.01).
2. The Risk Assessment for Suicide Tool (RAST) (CLI.6410.PL.021.FORM.02) is completed with all residents identified at risk for suicide on the Suicide Risk Screening Tool.

Care Planning

1. Immediate safety needs of residents at risk of suicide are addressed. This may include:
    - Removing items which may be used to harm self;
    - Increasing monitoring of the resident;
    - Contacting mental health crisis services.
2. The care plan is developed with the healthcare team, including the prescriber, resident and/or substitute decision-maker (SDM) when risk for suicide has been identified. Initiate a goal of care for the resident regarding depression/altered well- being/suicidal risk on the interdisciplinary care plan. Communicate the care plan to the healthcare team.

Interventions & Documentation

1. The plan of care and interventions are documented in the Integrated Care Plan (CLI.6410.PL.003.FORM.01) and communicated to the healthcare team.

Reassessment

1. Complete the Quarterly Care Plan Review Form (CLI.6410.PL.003.FORM.08) or Annual Care Conference Review Form (CLI.6410.PL.003.FORM.07).
2. Screen for depression using:
    - No cognitive impairment to mild dementia: Use the Geriatric Depression Scale – Short Form (GDS) (CLI.6410.PL.021.FORM.03); or
    - Moderate to severe dementia: use the SIG E CAPS – Screening for Depression (CLI.6410.PL.021.FORM.04).
3. If the resident's depression screening is not suggestive of depression, note this on the correct review form (i.e. quarterly or annual) and file the screening tool in the health record.
4. If the resident's depressing screening is suggestive of depression, the nurse or designate shares this finding with the prescriber.
5. If the resident's depression screening is suggestive of depression, ask the resident:
    - Do you ever think about hurting or harming yourself? If yes, what would you do?
6. If the resident is cognitively impaired and unable to answer the question, ask the SDM:
    - Has the resident ever communicated to you thoughts of hurting or harming him/herself? If yes, what would he/she do?
7. If the resident/SDM answers "no", document this discussion in the Integrated Progress Notes (CLI.6410.PL.003.FORM.06).
8. If the resident/SDM answers "yes", complete the RAST.
9. Update the Integrated Care Plan accordingly and document the implementation of treatment, intervention and monitoring strategies.
10. Monitor the resident's response to interventions and involve the resident in evaluating his/her progress.

11. Any resident may be screened at any time by any nurse or social worker if clinical presentation warrants the screening. This may be to help rule out other conditions, such as delirium, or to help understand symptoms a resident may be experiencing.

Policy Audits

1. A Suicide Risk Assessment chart audit is conducted in the PCH every two (2) years.
2. The audit is conducted utilizing the Suicide Risk Assessment in Personal Care Homes Policy Implementation Audit (CLI.6410.PL.021.FORM.05).
3. Results from the audits are summarized using the Suicide Risk Assessment in Personal Care Homes Policy Implementation Audit Summary Form (CLI.6410.PL.021.FORM.06)
4. 10% of the total PCH population or a minimum of five (5) residents, whichever is greater, will be audited.
5. Each facility determines the staff member that completes the Suicide Risk Assessment in Personal Care Home Policy Implementation Audit.
6. Information from the Suicide Risk Assessment in Personal Care Homes Policy Implementation Audit Summary Form is inputted into the MS Teams spreadsheet the identified date.

SUPPORTING DOCUMENTS:

CLI.6410.PL.021.SD.01	Regional Personal Care Home Suicide Risk Assessment Resource Guide
CLI.6410.PL.021.FORM.01	Suicide Risk Screening Tool
CLI.6410.PL.021.FORM.02	Risk Assessment for Suicide Tool (RAST)
CLI.6410.PL.021.FORM.03	Geriatric Depression Scale (GDS) – Short Form
CLI.6410.PL.021.FORM.04	SIG E CAPS – Screening For Depression
CLI.6410.PL.021.FORM.05	Suicide Risk Assessment in Personal Care Homes Policy Implementation Audit
CLI.6410.PL.021.FORM.06	Suicide Risk Assessment in Personal Care Homes Policy Implementation Audit Summary Form

REFERENCES:

Winnipeg Regional Health Authority (2017). *Suicide Risk Assessment: Long Term Care Program Resource Guide.*