SUICIDE SCREENING, RISK ASSESSMENT and CARE PLANNING Date: _____

A: SUICIDE SCREENING:

Patients who presented to the emergency department (ED) or are directly admitted to inpatient units with PRIMARY or SECONDARY issues within these 3 categories

☐ Substance Use	☐ Mental Health and Psychosocial	☐ Mental Status (cues on page 2)

If yes - ASK these three (3) questions:

1. Over the past 2 weeks, have you felt down, depressed or hopeless ☐ NO ☐ YES	2. Over the past 2 weeks, have you thought of killing yourself? ☐ NO ☐ YES	3. Have you attempted to kill yourself during the last 6 months? ☐ NO ☐ YES

A response of **YES** *to 1 or more of the 3 questions above indicates the need for a* **Suicide Risk Assessment**.

Is a Suicide Risk Assessment indicated? ☐ NO ☐ YES If YES, complete all applicable sections below ☐ Unable at this time

Section A Completed by (Signature and professional designation):

Re-evaluated at (date/time/signature):

Mental Health Services available for comprehensive suicide prevention assessment and planning

☐ NOT available – complete risk assessment

☐ **YES available - INFORMED (date and time)**_____

Mental Health Practitioner (name)_____

B: SUICIDE RISK ASSESSMENT: Select all that apply

Warning Signs and Risk Factors

☐ Access to firearms	☐ Common hallucinations	☐ Conduct disorders
☐ History of abuse	☐ History of prior suicide attempts	☐ Hopelessness
☐ Impulsivity	☐ Limited psychosocial support	☐ Mood disorders
☐ Ongoing medical illness(es)	☐ Post traumatic stress disorder	☐ Personality disorder
☐ Psychotic disorders	☐ Recent mental health hospitalization	☐ Self-injurious behavior(s)
☐ Substance abuse		

☐ Ideation:

☐ Plan:

☐ Behaviour:

☐ Intent:

If response to item # 1 under suicide screening is "YES", complete depression screening (on page 2) Depression Scale Completed: ☐ NO ☐ YES

Depression Score: _____ (If indicated but not done – document why)

Protective factors *(may lower level risk for suicide)*

☐ Coping skills (e.g. problem solving; conflict resolution)	☐ Future oriented plans	☐ Strong social supports
☐ Responsibility to others	☐ Positive therapeutic relationships	☐ Religious/spiritual beliefs

Section B Completed by (Signature and professional designation):

C: LEVEL OF SUICIDE RISK:

Using clinical judgment, rate LEVEL OF SUICIDE RISK (by Prescriber or Mental Health Practitioner)

☐ None	☐ Low	☐ Moderate	☐ High/Very High

Section C Completed by (Signature and professional designation):

D: CARE PLANNING: Monitoring

☐ **N/A** - Care planning related to suicide prevention is not indicated

Level of Supervision	☐ Routine hourly observations	☐ Close observations: visual confirmation at **irregular** intervals not to exceed **15 min. between checks** (**6 times or more per hour**)	☐ Constant care with one-to-one supervision
	☐ Other (describe):		

Section D Completed by (Signature and professional designation):

SUICIDE SCREENING, RISK ASSESSMENT and CARE PLANNING (cont.)

E: CARE PLANNING: Interventions		
Use of seclusion room or other restraints	☐ NO	☐ YES
Potentially harmful items removed (see list of contraband items below)	☐ NO	☐ YES
Visitors to be screened for potentially harmful items (if yes, initiate *Review of Contraband Items: Sign-in for Visitors* CLI.4510.PL.010.FORM.02)	☐ NO	☐ YES
In-depth psychosocial assessment by **Mental Health** (Crises Team/Liaison Nurse) indicated and referral completed (Risk: Very High/High = STAT; Moderate = prior to discharge; Low = can occur post discharge)	☐ NO	☐ YES
Pharmaceutical therapy indicated	☐ NO	☐ YES
Other Diagnosis-specific therapy indicated	☐ NO	☐ YES
Initial Care Plan shared with (list):		
Section E Completed by (Signature and professional designation):		

Assessing Mental Status:

- ☐ Appearance: appropriate, clean, tidy; clothing atypical, unusual; clothing disheveled; physically unkempt, unclean; other
- ☐ Behavior: cooperative; aggressive; atypical; guarded; restless; withdrawn; other
- ☐ Speech: within normal limits; slurring; decreased rate; increased rate; increased volume; decreased volume
- ☐ Perception: no perceptual disturbances; illusions; auditory hallucinations; visual hallucinations; other
- ☐ Predominant mood: typical for patient; anger; depression, sadness; euphoria, elation; fear, anxiety
- ☐ Intellectual functioning: clear; abstract thinking impaired; impaired attention span/concentration; calculation ability impaired; level of consciousness; impaired
- ☐ Memory: no deficits noted; immediate recall impaired; recent memory impaired; remote memory impaired
- ☐ Judgement : able to manage daily living activities; able to participate in decision making; impaired ability to make reasonable decisions; impaired ability to manage daily living activities
- ☐ Thought content: congruent with situational context; delusions; excess worry; homicidal ideation; ideas of reference/influence; obsessions; paranoia; phobias; suicidal ideation
- ☐ Affect: appropriate; blunted; normal range; flat; other
- ☐ Thought process: clear, coherent, organized; tangent; thought flow decreased, slowed; thought flow increased
- ☐ Insight: acknowledges presence of psychological problems; difficulty in acknowledging presence of psychological problems; mostly blames others or circumstances for problems
- ☐ Interview-Patient relationship: appropriate; cooperative; domineering; provocative; suspicious; uncooperative

Depression Screening: *Patient Health Questionnaire*	Not at all	Several days	More than half the days	Nearly every day
ASK: Over the past two (2) weeks, how often have you been bothered by any of the following problems?				
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
Directions for completing assessment: Circle the response and add scores. TOTAL Score				
Interpretation of depression score: 0-4 None/minimal; 5-9 Mild; 10-14 Moderate; 15-19 Moderately severe; 20-27 Severe				
ASK: If you said yes to any of the above items, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult				

Source: Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *J Gen Intern Med*, *16*(9), 606-613.

Contraband List of Potentially Harmful Items

Potentially harmful items that can be used when a patient is at risk of suicide include but are not limited to:

- Personal items: Pens, lighters, nail clippers, knife, scissors, belts, jewelry, razor blades, hair pins, personal medications
- Supplies and equipment: flatware and other small objects; all medical equipment; cleaning agents and other poisons; medications; any sharp object; belts or strings on hospital gown
- Environment: anchor points on wall that could support the weight of a person (e.g. wall hooks); drawers, cords, mouldings, tiles; any/all materials that can be used as weapons
- Exits: risk of potential elopement