Suicide Ideations

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Giving people the freedom to remain at home

ADDUS SM HOMECARE

Introductions

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- Senior Quality Manager JourneyCare
- 30 years in Home Health & Hospice
- 10 years in Quality

Nicole Dappert BSN, RN, WCC, CHPN

- Clinical Informatic Director JourneyCare
- 15 years in Hospice
- 5 years in Informatics

Joshua Kaplan-Lyman MSW

- Social Worker at Promedica
- 4 years in Hospice
- 10 years as SW

ADDUS HOMECARE

JourneyCare

Serving 13 counties
Chicago & Northern Illinois
Hospice
Palliative Care

Conflict of Interest

As required, we would like to inform you that we have no bias or conflict(s) of interest

Session Objectives

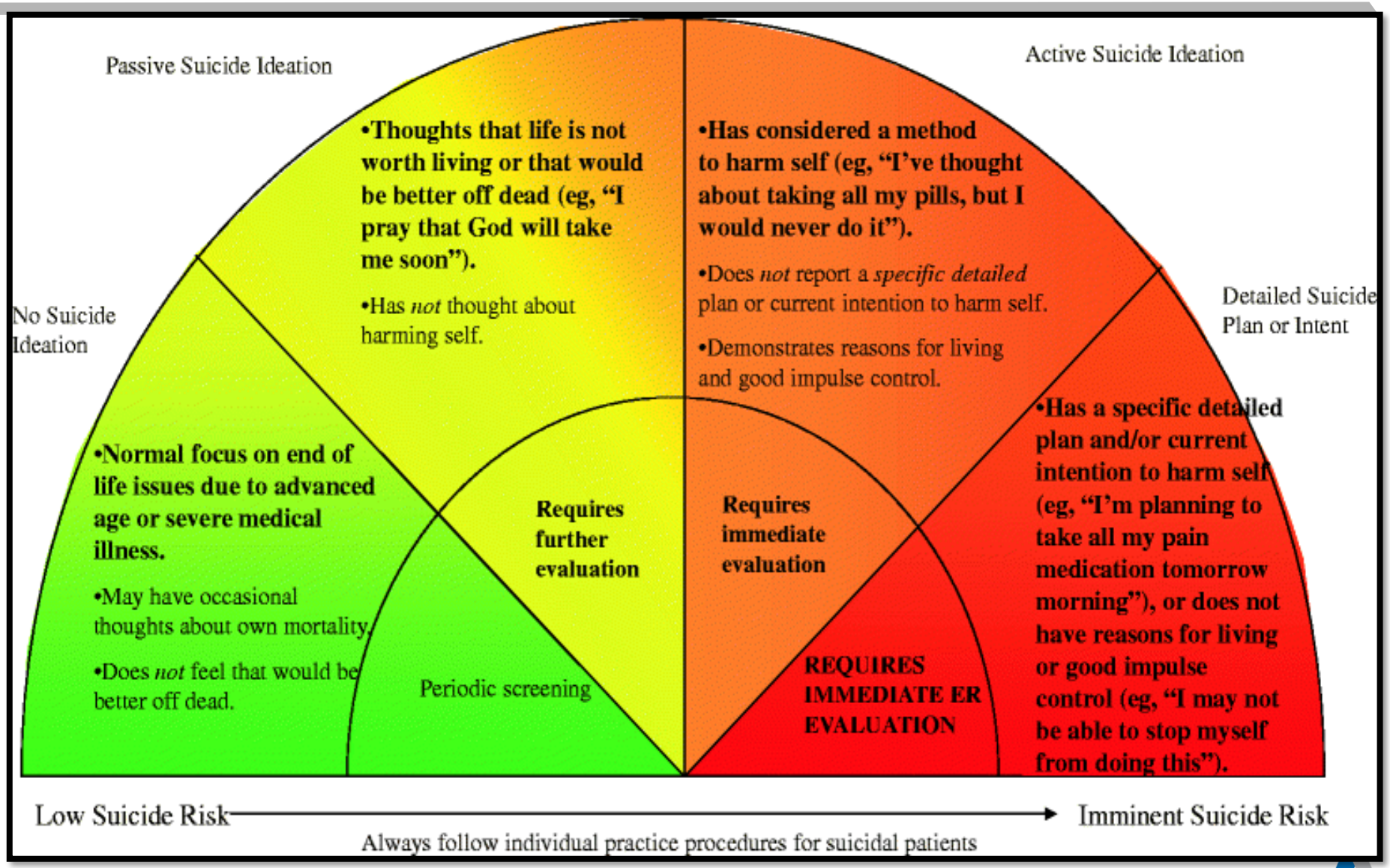
Recognize suicide risk factors and the suicide spectrum

Follow the Lean Process approach utilized to build and update Suicide Ideations process

Discover technological & paper tools to assist staff in identifying risk and developing suicide ideations interventions and plan of care

Suicide Risk Factors
&
Suicide Spectrum

Suicide Risk Spectrum



Passive Vs. Active

Suicidal Ideation

This is the psychiatric term used for thoughts about suicide

Passive suicidal ideation

- feeling like you'd be better off dead
- not thinking about doing anything to speed that along

Active suicidal ideation

- thinking about specifics of how to kill yourself, e.g. how, when, and where
- intending to follow through

GET HELP

mentalhealthathome.org

Warning Signs and Risk Factors

Warning sign are indications that someone may be thinking about or planning a suicide attempt	Risk factors are conditions or characteristics that one holds that correlate with higher likelihood of suicidality
Require immediate intervention	Risk Factors are not determinative but may indicate increased monitoring of warning signs

WARNING SIGNS OF SUICIDE:

The behaviors listed below may be some of the signs that someone is thinking about suicide.

TALKING ABOUT:

- Wanting to die
- Great guilt or shame
- Being a burden to others

FEELING:

- Empty, hopeless, trapped, or having no reason to live
- Extremely sad, more anxious, agitated, or full of rage
- Unbearable emotional or physical pain

CHANGING BEHAVIOR, SUCH AS:

- Making a plan or researching ways to die
- Withdrawing from friends, saying good bye, giving away important items, or making a will
- Taking dangerous risks such as driving extremely fast
- Displaying extreme mood swings
- Eating or sleeping more or less
- Using drugs or alcohol more often

If these warning signs apply to you or someone you know, get help as soon as possible, particularly if the behavior is new or has increased recently.

National Suicide Prevention Lifeline
1-800-273-TALK

Crisis Text Line
Text "HELLO" to 741741

National Institute of Mental Health

www.nimh.nih.gov/suicideprevention

NIMH Identifier No. OM 19-4316

Risk Factors

More common with men

Social Isolation

Chronic Illness

Higher in veterans, LGTBQ+, attempt survivors, loss survivors, and disaster survivors.

Pre-existing mental health history

Family history of suicide

Hospice patients

Financial Distress

Lean Process approach utilized to build and update Suicide Ideations process

What is Lean/A3 Methodology?

A3 Process Improvement Methodology		
1. Reason for Action • *What is the issue?* • *Why is it important?* • *Scope*	**4. Gap Analysis** • *Understand and define the problem* • *What is the root cause?*	**7. Completion Plans** • *Actions defined with owners and dates* • *Track progress*
2. Initial State • *Understand current process & data* • *Understand waste and variation*	**5. Solution Approach** • *What needs to be put in place to address the root causes?* • *Develop hypothesis*	**8. Confirmed State** • *Evaluating success and sustainability* • *Have we achieved our target state (box 3)?*
3. Target State • *Improved process goal & Barriers* • *Data goals*	**6. Rapid Experiments** • *Testing the hypothesis* • *Short tests of ideas* • *Okay to fail*	**9. Insights** • *Lessons learned* • *Reflections* • *Other applications?*

Ground Rules Example

Team Member Roles Tool






Sponsor (Not on team)	Champion	Process Owner	Team Members	Quality Advisors (Sensi)	Facilitator	Recorder	Adjunct Members
Identifies Oversight Understands the project well Removes barriers & allocates resources Rewards & recognizes	Ensures changes are sustainable after project closure Has courage to ask the hard questions	Owns testing & implementing Ensures timely tasks completion Reports to process leaders Implements corrective actions to address negative performance trends	Ambassadors "Real" work expert Brings info to and from co-workers Runs tests & collects data	Supports & advises Reports successes Helps leaders interpret data	Coordinate meetings Project Process Owner Monitors present & plans next steps Challenges thought processes	Scribe Takes attendance Documents discussion, action plan	Ad hoc consultants Knowledge experts Observers

Suicide Ideations Reason for Action & initial State

1 ✓ **Reason for Action**
2 ✓ **Initial State**
3 **Target State**

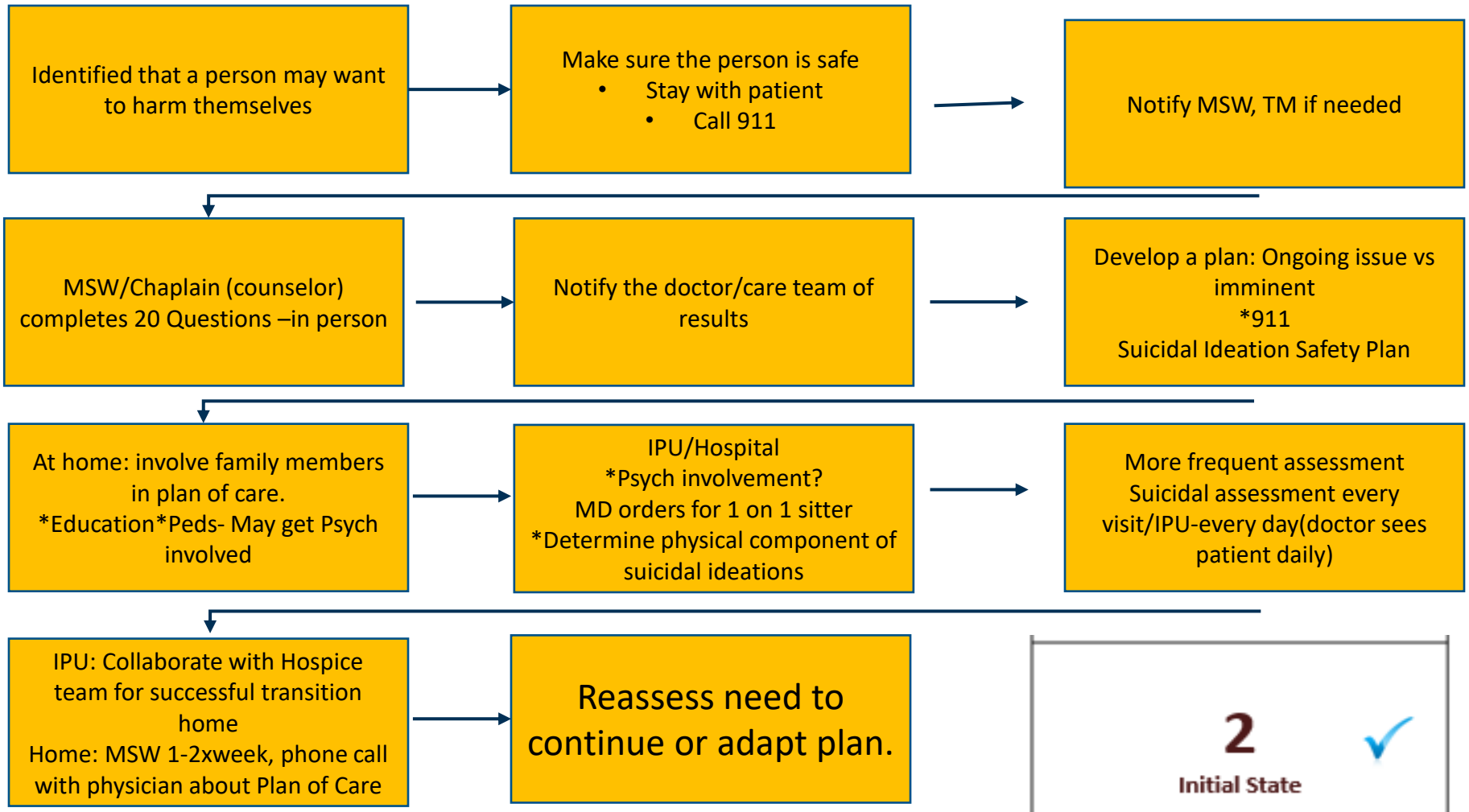
Reason for Action:
- 2 known suicide ideation events in one year
- 1 Suicide attempt

Aim Statement: We want patients with suicide ideations to feel safe, supported, and feel there is an avenue to get the care they need so they do not feel suicide is an option.

Initial Internal Data-CAHPS
- Would You Recommend
- Excellent Rating
- Help for anxiety/sadness
- Training to Care for patients

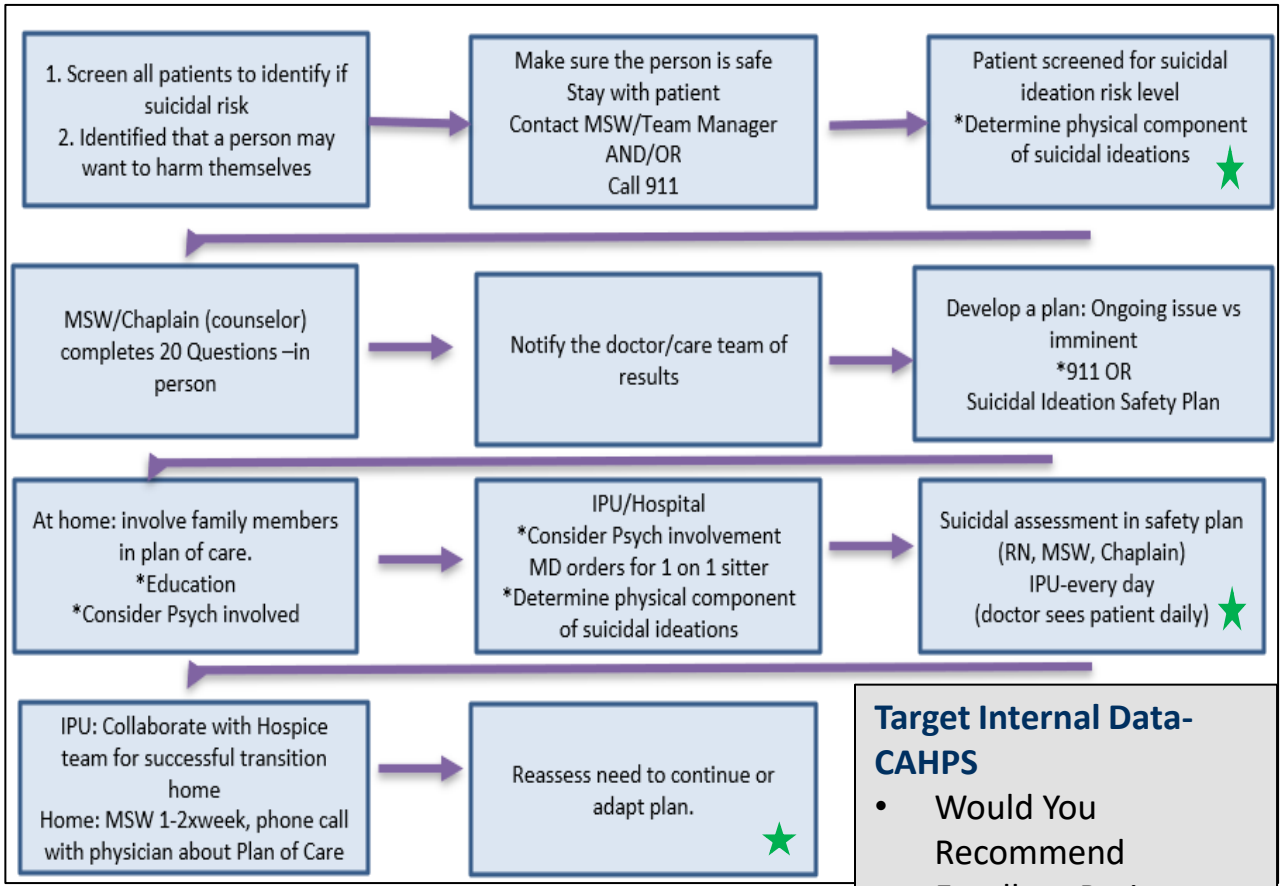
Initial External Data
- Suicide #10 leading cause of death nationally
- Hospice & chronic illness patients more prone to suicide than general public

Suicide Ideations Initial State



Suicide Ideations Target State

1 **Reason for Action**
2 **Initial State**
3 **Target State** ✓



Target Internal Data- CAHPS

- Would You Recommend
- Excellent Rating
- Help for anxiety/sadness
- Training to Care for patients
- Process Measures

Barriers

Method	Mother Nature	Material	Machine	Measure	Man
Policies, procedures, protocols	Factors outside our control	Supplies, information	Equipment or technology	Metrics for process or outcome	Human factors, training

Suicide Ideations Gap Analysis

4

Gap Analysis

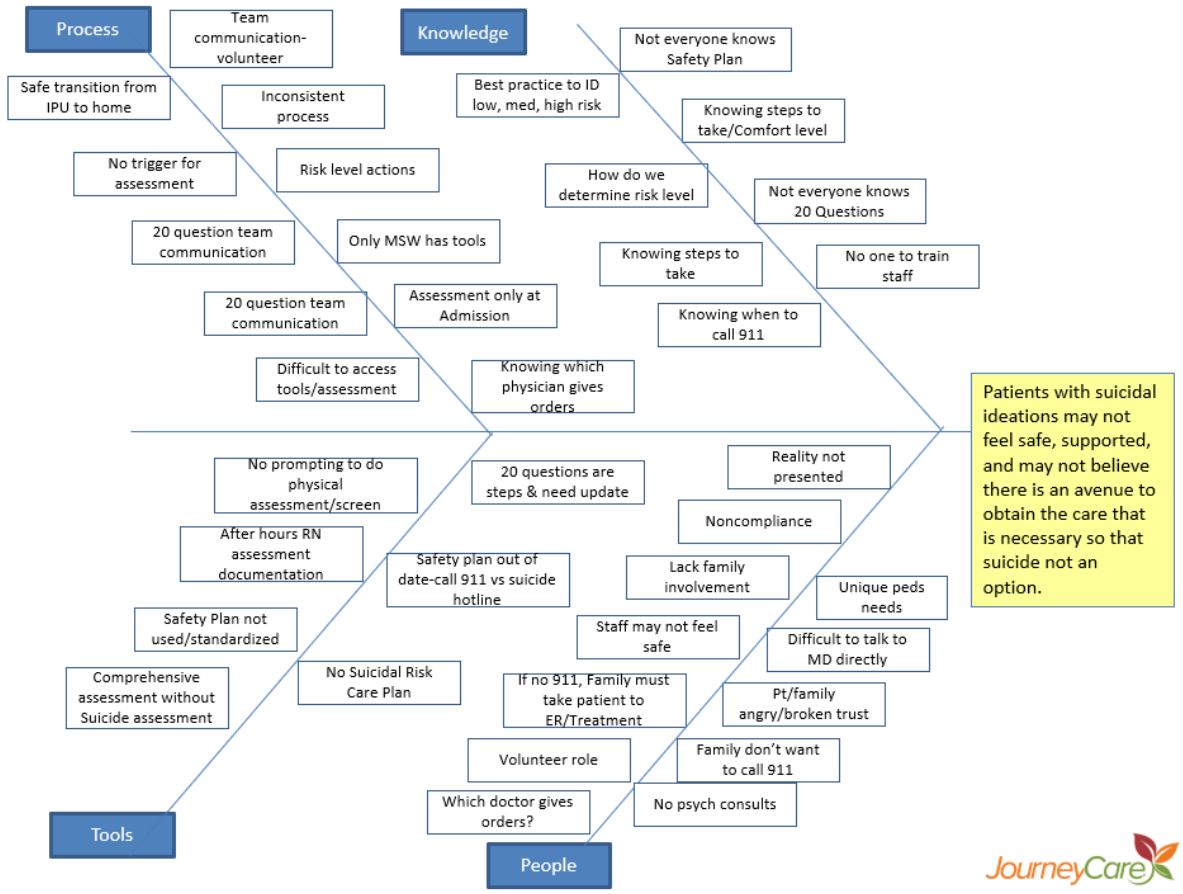
5

Solution Approach

6

Rapid Experiments

Direct Causes



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Box 4: Gap Analysis
Direct Cause vs Root Cause Information

What gets in the way of us achieving the target state?

Direct Cause: the initial reason, what you can see. It is often mistaken for the root cause.

- Identifying just the Direct Cause can lead to problem → solution thinking

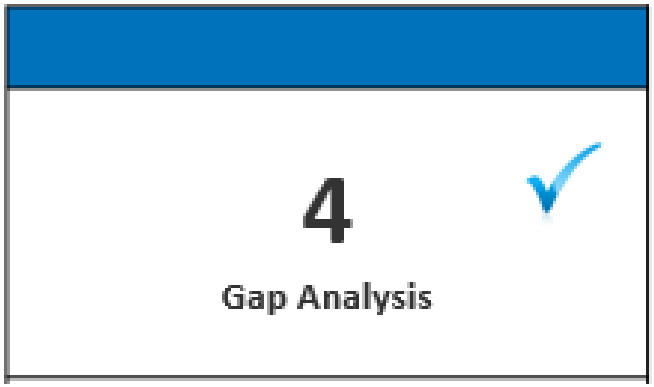
Root Cause: the underlying cause of the problem, not usually understood without deeper investigation.

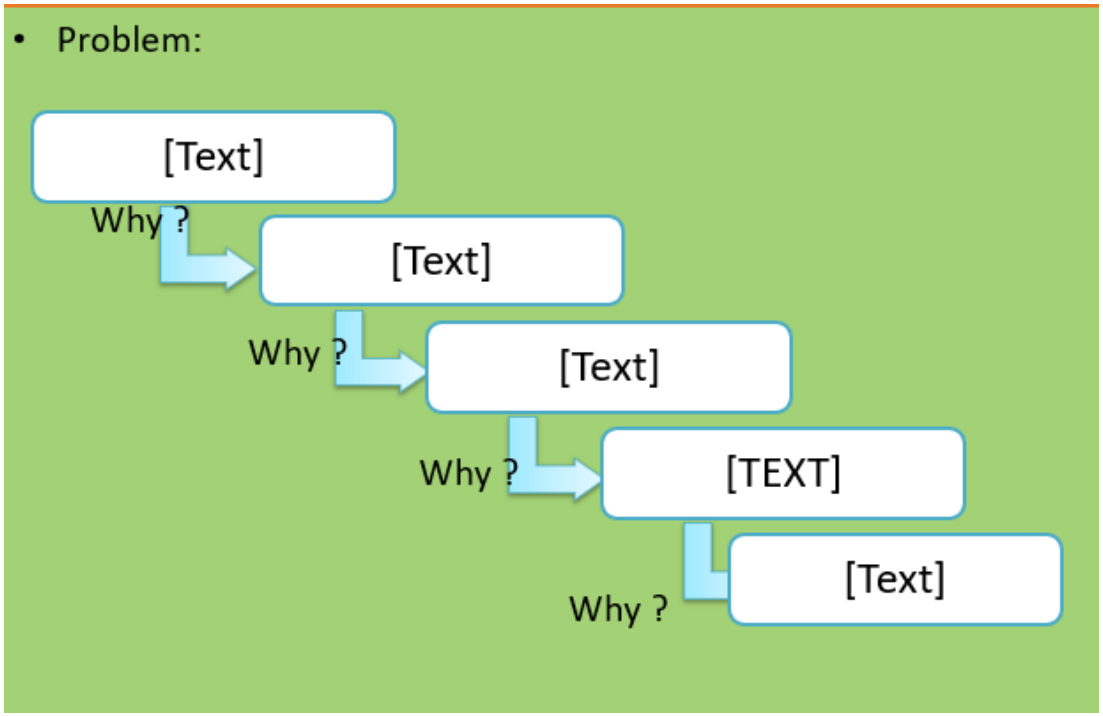
- Only when the root cause is identified can the "real" problem be solved for.

Root Cause Tool: Asking "why" 5 times usually reveals the root cause

Improvements often fail because
we solve direct cause rather than root cause

Suicide Ideations Root Causes





Root Causes

1. How do we determine risk level

>Outdated tools

2. Comprehensive assessment missing suicide risk assessment

>Technology assessments

3. Knowing steps to take

>Outdated/Missing processes

Suicide Ideations Solutions & Experiments

SOLUTIONS
PHQ-2 Scale for nurses
Build risk levels into assessment tools
Care plans correlate with risk level
Update internal process
Suicide risk contract
Patient education

4 **Gap Analysis**
5 **Solution Approach**
6 **Rapid Experiments**

Suicide Ideations Completion Plans & Confirmed State

COMPLETION PLANS
Internal process updated
Suicide risk contract
Online training module
Newsletter notification of process
Team Manager & IDT Training
CONFIRMED STATE
Internal process updated
Suicide risk contract
Online training module
Validated tool in EHR (PHQ-9 & SLAP) ✗
Case studies to measure success
INSIGHTS
Needed to address anxiety/sadness
Update process guide

7 ✓ **Completion Plans**
8 ✓ **Confirmed State**
9 ✓ **Insights**

Technological & paper tools to assist staff in identifying risk and developing suicide ideations interventions and plan of care

Suicide Ideations Technology Barriers

Assessments

- SW assessment access only
- SW document assessment in the initial comprehensive only
- Multiple clicks with logic to display
- No prompting/guidance of what are the next step

Care Plans/Interventions

- No Suicide Care Plans

PHQ-2

Hand off/Alert other staff

- Where is the risk level?
- Are there staff resources?
- What are the next steps?

SLAP

PHQ-9

Suicide Ideations Agency Barriers

Assessments

- Validated tools
- Accessible to nursing and social workers with guidance

PHQ-2

PHQ-9

SLAP

SN-PHQ-2 Depression Assessment

The Patient Health Questionnaire-2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Nursing Comprehensive Assessment
Notify SW if positive Depressions Screening.

Utilized the "additional" customizable tabs in the assessment to add the PHQ-2 questions

Feedback from the nurses regarding non-verbal patients

- Unable to assess reason

Adapted

Assessment Changes

Social Work (SW)

Modified the existing Mental/Emotional assessment.

Hid many areas to keep the SW assessment focused

Suicide/SLAP/PHQ9 assessments all in one area

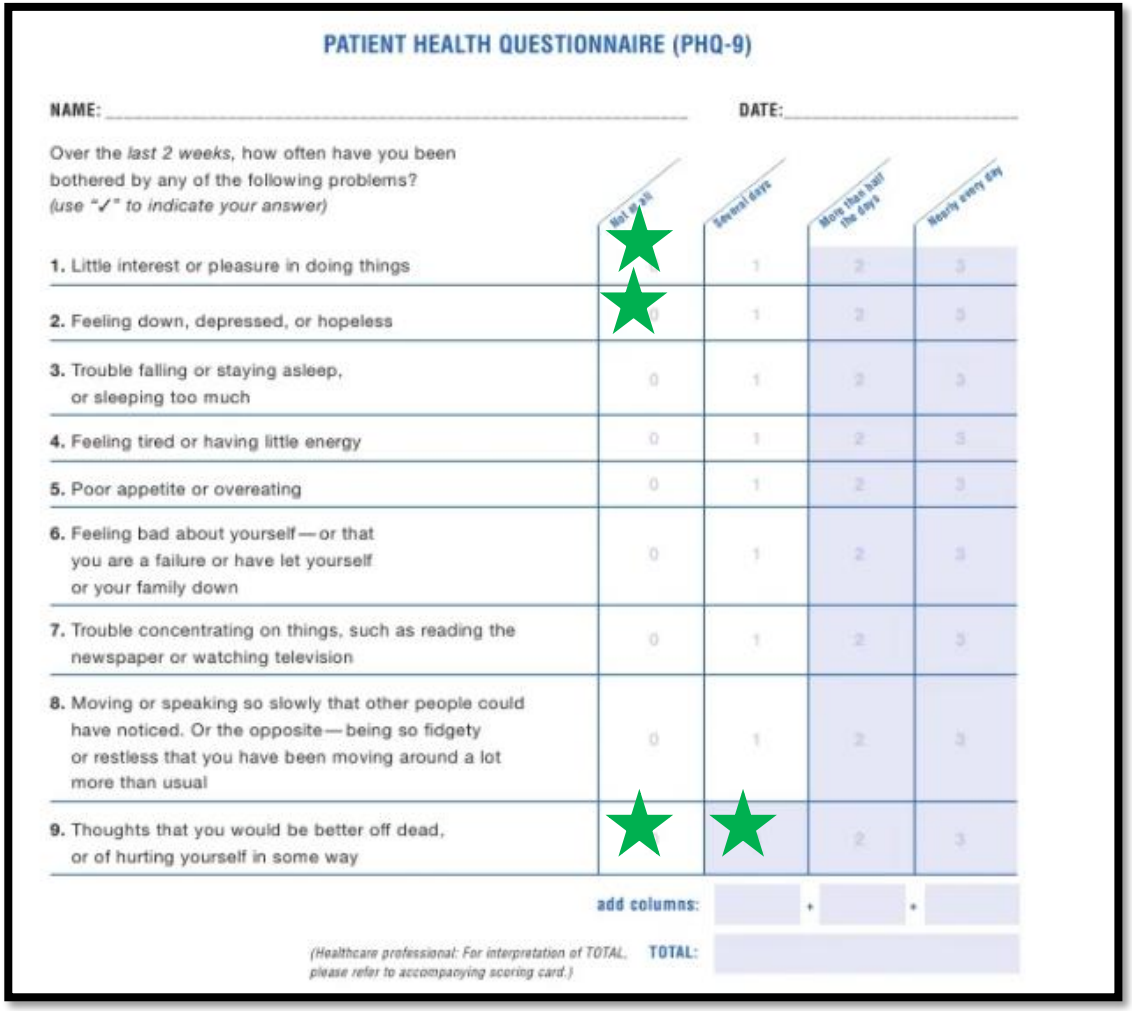
Able to add the definition of the different risks for both the SLAP and the scores on the PHQ-9 to prompt clinicians for next steps

Social Work Suicide Assessment

SYMPTOMS	SUPPORTS	STRESSES
• Sleep changes • Weight changes • Hopelessness • Depression • Agitation • Impulsivity	• Housing issues • Community resources • Financial problems	• Loved one's loss • Loss of job • Legal problems • Physical problems

Cross reference to suicidal risk factors
**Would like to include missing risks*

SW Suicide Risk Assessment



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	★	1	2	3
2. Feeling down, depressed, or hopeless	★	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	★	★	2	3
add columns:		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL:

PHQ-9

★ *Depression Questions*

★★ *Suicide Ideation Question*

SW Suicide Assessments-SLAP

S How **SPECIFIC** is the plan of attack? The more specific the details relate, the higher the degree of present risk.

L How **LETHAL** is the proposed method? How quickly could the person die if the plan is implemented? The greater the level of lethality, the greater the risk.

A How **AVAILABLE** is the proposed method? If the tool to be used is readily available, the level of suicide risk is greater.

P What is the **PROXIMITY** of helping resources? Generally, the greater the distance the person is from helping resources, –if the plan were implemented, the greater the degree of risk.

Determine immediate suicide risk and next steps

Suicide Care Plans

SUICIDE INTERVENTIONS
Assess for suicide ideations and negative behaviors
Assess for suicidal risk and collaborate with IDT
Review medications
Assess/train patient/caregiver to identify suicide risks
Assess/train patient/caregiver on risk of patient remaining at home
Notify physician(s) care team, manager, and quality of suicide risk
Screen for uncontrolled symptoms contributing to risk
Initiate verbal no harm agreement
Help patient identify one thing worth living for
Train caregiver on high-risk actions
Train on 24-hour supervision

Social Work
Nurse
Chaplain
C.N.A.

Interventions correspond to risk categories identified within assessment. Goals and Interventions overlap between disciplines

Care Plans

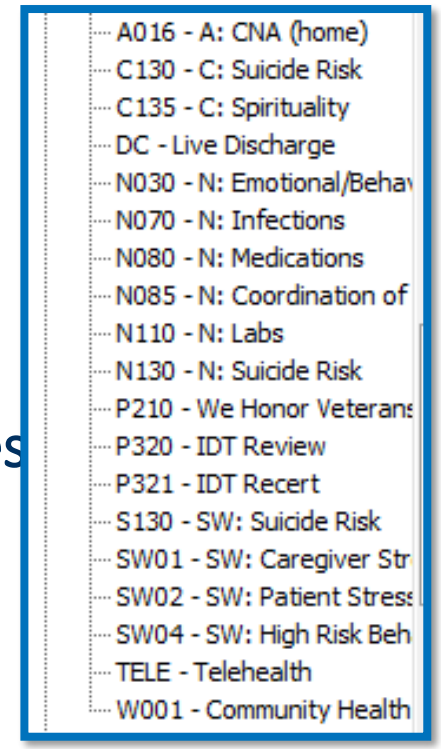
Added a care plan for each discipline regarding suicide

Each discipline has Risk Category

No way to flag the chart in EMR

- Utilize Basic Screen -> Staff Information with a 130+

Is care plan effective for hand off? Enhancement reques made to the EMR vendor to add customizable flags – under consideration with the vendor



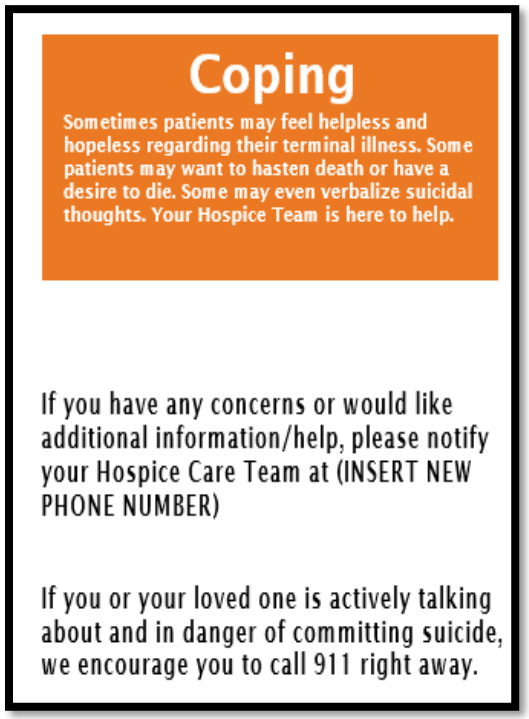
Adapted

Supplemental patient education, tools, and evaluation processes

Suicide Idea Patient Education & Tools

Resources for Patients

- *Coping and Anxiety patient education*
- *Suicide ideation safety plan & contract*

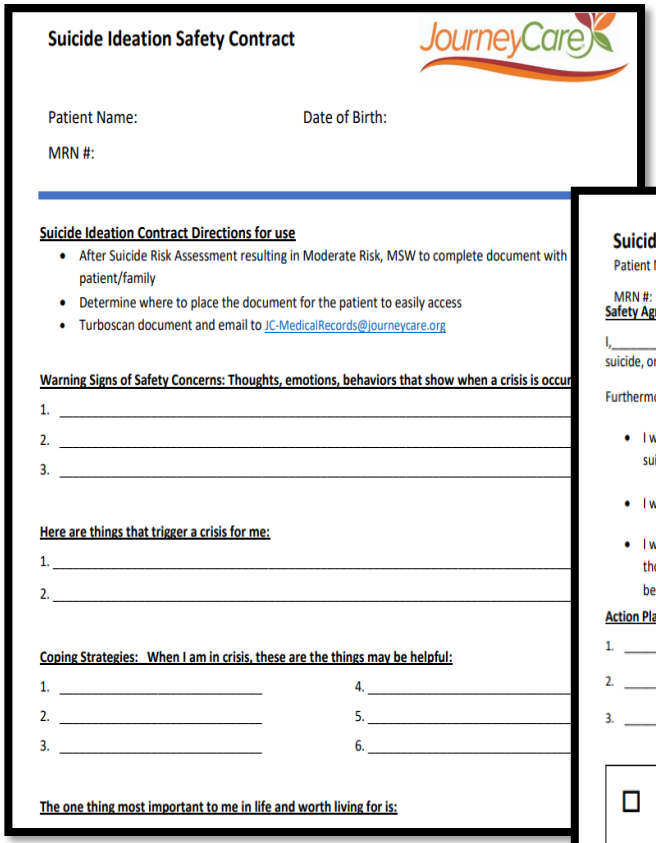


Coping

Sometimes patients may feel helpless and hopeless regarding their terminal illness. Some patients may want to hasten death or have a desire to die. Some may even verbalize suicidal thoughts. Your Hospice Team is here to help.

If you have any concerns or would like additional information/help, please notify your Hospice Care Team at (INSERT NEW PHONE NUMBER)

If you or your loved one is actively talking about and in danger of committing suicide, we encourage you to call 911 right away.



Suicide Ideation Safety Contract

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Patient Name: Date of Birth:

MRN #:

Suicide Ideation Contract Directions for use

- After Suicide Risk Assessment resulting in Moderate Risk, MSW to complete document with patient/family
- Determine where to place the document for the patient to easily access
- Turboscan document and email to JC-MedicalRecords@journeycare.org

Warning Signs of Safety Concerns: Thoughts, emotions, behaviors that show when a crisis is occu

1. _____
2. _____
3. _____

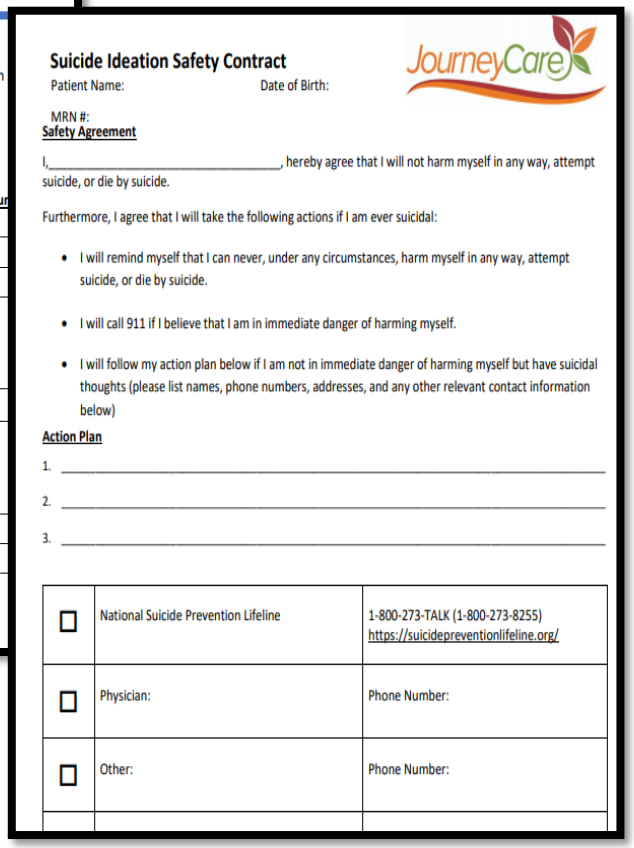
Here are things that trigger a crisis for me:

1. _____
2. _____

Coping Strategies: When I am in crisis, these are the things may be helpful:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

The one thing most important to me in life and worth living for is:



Suicide Ideation Safety Contract

JourneyCare

Patient Name: Date of Birth:

MRN #:

Safety Agreement

I,_____, hereby agree that I will not harm myself in any way, attempt suicide, or die by suicide.

Furthermore, I agree that I will take the following actions if I am ever suicidal:

- I will remind myself that I can never, under any circumstances, harm myself in any way, attempt suicide, or die by suicide.
- I will call 911 if I believe that I am in immediate danger of harming myself.
- I will follow my action plan below if I am not in immediate danger of harming myself but have suicidal thoughts (please list names, phone numbers, addresses, and any other relevant contact information below)

Action Plan

1. _____
2. _____
3. _____

☐	National Suicide Prevention Lifeline	1-800-273-TALK (1-800-273-8255) https://suicidepreventionlifeline.org/
☐	Physician:	Phone Number:
☐	Other:	Phone Number:

Clinician Tools

Suicide Ideation Questionnaire, Checklist & SLAP Screening Tool (Formerly 20 Questions)

1. Patient Name
2. Diagnosis
3. **Screening (Any Nurse, Chaplain)**
   a. Any new event that prompted this?
   b. What is the underlying cause?
   c. Patient's fears and concerns
   d. Any fears regarding death that are prompting this feeling
   e. If removal of unsafe objects from home is needed
   f. Can patient physically complete the act?
   g. Evaluate spirituality or right to die
   h. Does patient have a plan for suicide?
   i. Is this Suicide Ideation or a wish to die (very different)?
   j. Complete PH-Q2 (Nurses)
   k. Need for supervision/sitter
4. **Assessment (MSW)**
   a. Depression history, previous attempts, and/or any psych history?
   b. Has a family member previously committed suicide?
   c. Consult with nurse regarding medications relating to underlying causes or resolution of depression or symptom management
   d. Complete Suicide assessment including PHQ-9, SLAP assessment
   e. Does patient have a plan for suicide?
   f. Is there existential pain/lack of purpose that leaves them feeling hopeless
   g. What are the uncontrolled symptoms that may be contributing to this? Does CHIMBOP* need to be evaluated? 5Ps?
5. **Notify (Any Discipline)**
   a. Family and address safety concerns
   b. Notify Hospice Medical Director and Primary Care Physician
   c. Team Manager and Care team/ Interdisciplinary team
   d. For any suicide attempts or high risks for attempts, notify Team Manager and Regional Director
6. **Interventions (Any Discipline)**
   a. Develop Suicide Ideation Safety Contract **(MSW)**
   b. Notify 24/7 if immediate MSW consult needed for suicide assessment
   c. Assess need to increase visit frequency
   d. Recommend Supervision for patient/ Care Center order sitter
   e. Nurse to evaluate recent medication changes for cause or symptom management
   f. Transfer to a higher level of care
   g. Documentation review per Team Manager
   h. Update POC to address fears and concerns

Intranet Clinician Resources: Suicide Assessment Tools
Steps for Assessing Suicidality, PHQ2, SLAP, PHQ9
Suicide ideation questionnaire, checklist & SLAP screening tool
PHQ-2
PHQ-9

SLAP Screen	Depression Severity	PHQ-9 Score	Treatment Actions	JourneyCare Interventions
Low: Person has vague thoughts of suicide but no specific plan or intent. "I wish I could die."	None - Minimal	0 – 4	None	
	Mild	5 – 9	Watchful waiting; repeat PHQ 9 at follow-up	• Contact physician for new/changed medications • Consider need to transfer to higher level of Care-especially for uncontrolled physical or emotional symptom management • Repeat PHQ-9/SLAP at follow up
Moderate: Suicidal intent expressed but is vague about timing OR plan is based on future event. Immediacy high, but lethality/availability is low.	**Moderate**	10 – 14	Treatment plan, consider counseling, follow up and/or pharmacotherapy	• Initiate Suicide Ideation Contract • Contact physician for new/changed medications • Consider need to transfer to higher level of Care • Repeat PHQ-9/SLAP at follow up
	Moderately Severe	15 – 19	Active treatment with pharmacotherapy and/or psychotherapy	• Initiate Suicide Ideation Contract • Contact physician for new/changed medications • Consider need to transfer to higher level of Care • Repeat PHQ-9/SLAP at follow up
High: there is a specific plan, highly lethal method available, and is ready to implement	**Severe**	20 - 27	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management	• Call 911 • Transfer to IPU or hospital • Initiate Suicide Ideation Contract • Contact physician for new/changed medications • Consider need to transfer to higher level of Care • Repeat PHQ-9/SLAP at follow up

Adapted

Updating Suicide Ideations Process Case Study 1

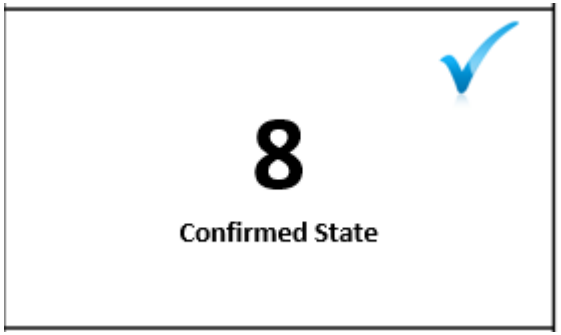
Measuring Success

Process measures

- Hard to identify

Outcome measures

- Actual incidents
- Scheduled Case Studies



Case Study 1 Details

78-year-old man with cancer

Living with spouse

Upon admission, patient related to Nurse, Social Worker & Chaplain

- Saw loved ones die painful deaths without the support of friends and family
- Detailed plans to commit suicide in the future
- Spouse dispelled the plans as the patient just talking
- The Final Exit seen in room

Documented, but negative PHQ-2 for depression, no PHQ-9, no SLAP.

No Suicide Care Plan, follow up discussions, or IDT notes

Patient attempted plan exactly as described

Quality notified of event and case study scheduled

Disclaimer: Patient information & story have been changed. Similar situation presented

Evaluation Process: Case Studies

MRN:

Patient Name: _____
Terminal Dx: _____ Admit Date: _____
Team: _____

Team Members involved in Event:	Name	Role

Reason for Review:
Xxx

Chart Review Findings
Pertinent History:
Clinical Notes:
Assessments:
Care Plans:
Medications Ordered:

Participants

- *Care Team*
- *Quality*
- *Compliance*
- *Physician*
- *Administrators*

Process

- *Pre-review*
- *Timeline*
- *Highlights*
- *Documentation Review*

Case Study 1 Findings

CASE STUDY DISCUSSION

What went well?

Patient trusted us enough to tell us her plans

What could have gone better?

Completing the screening tools
Identification of suicide risk
Communicating plans to team, even though spouse denied them
Completing a suicide contract
Addressing patient's fears

Any barriers?

Availability of tools
Spouse's denial
Afraid to overstep boundaries
Ease of identifying suicide risk in electronic medical record
Staff: Staffing, working in silos, emotional/profession resources

Was the suicide ideation process followed?

No. Most were not acutely aware of process

Revisions Plan

Focus group formed with subject matter experts

Previous process was focused mainly on social workers intervening

- Identifying suicidal risk and ideation should be the responsibility of all IDT team members.

Providing increased support to clinicians who are assessing for suicidal ideation

- Suicide Confidential email group
- Peer supervision for clinicians to discuss ethical issues and vicarious trauma

Case Studies and Ethical Consults

- To review patients who may have high risk factors or warning signs and to review any suicidal attempts to understand ways to improve.

Technological Revisions

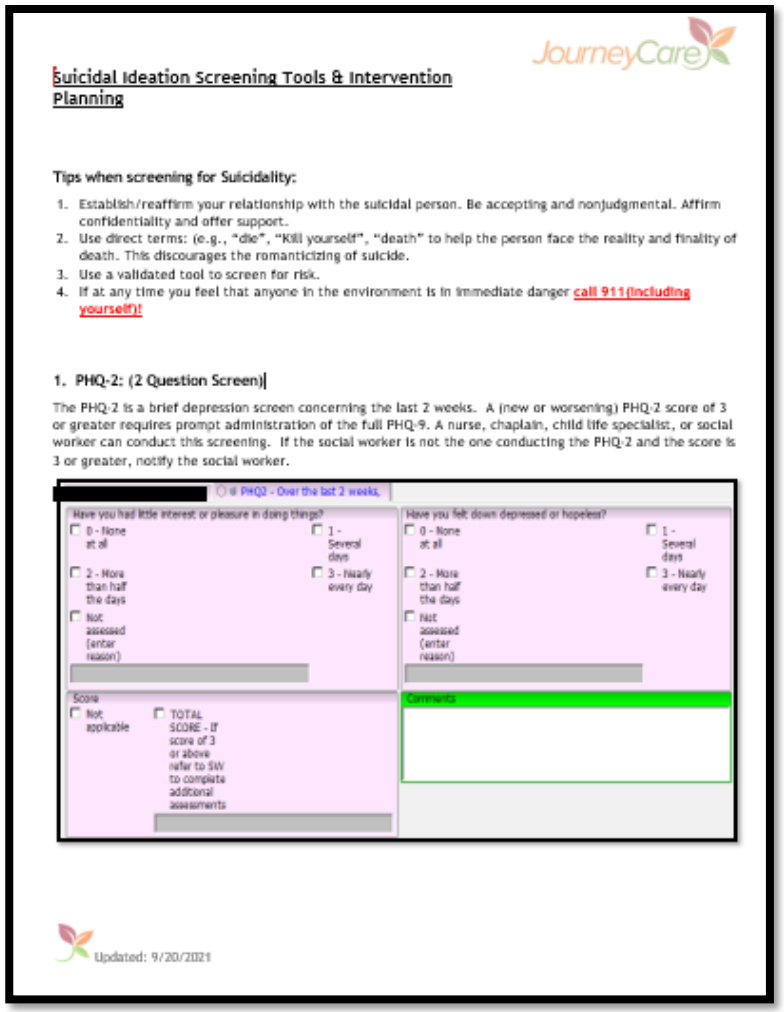
ICD-10 Code: R45.851 Suicidal Ideations

Nurse & Chaplain standalone suicide screening: PHQ-2+

- PHQ-2 Depression questions
- PHQ-9 Suicide question

SOURCE	QUESTION
PHQ-2 Question 1	Little interest or pleasure in doing things?
PHQ-2 Question 2	Feeling down, depressed, or hopeless?
PHQ-9 Question 9	Thoughts you would be better off dead or hurting yourself in some way?

Process Revisions



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Suicidal Ideation Screening Tools & Intervention Planning

Tips when screening for Suicidality:

1. Establish/reaffirm your relationship with the suicidal person. Be accepting and nonjudgmental. Affirm confidentiality and offer support.
2. Use direct terms: (e.g., "die", "Kill yourself", "death" to help the person face the reality and finality of death. This discourages the romanticizing of suicide.
3. Use a validated tool to screen for risk.
4. If at any time you feel that anyone in the environment is in immediate danger call 911(including yourself)!

1. PHQ-2: (2 Question Screen)

The PHQ-2 is a brief depression screen concerning the last 2 weeks. A (new or worsening) PHQ-2 score of 3 or greater requires prompt administration of the full PHQ-9. A nurse, chaplain, child life specialist, or social worker can conduct this screening. If the social worker is not the one conducting the PHQ-2 and the score is 3 or greater, notify the social worker.

[redacted] ○ If PHQ2 - Over the last 2 weeks,

Have you had little interest or pleasure in doing things?
- ☐ 0 - None at all
- ☐ 1 - Several days
- ☐ 2 - More than half the days
- ☐ 3 - Nearly every day
- ☐ Not assessed (enter reason)

Have you felt down depressed or hopeless?
- ☐ 0 - None at all
- ☐ 1 - Several days
- ☐ 2 - More than half the days
- ☐ 3 - Nearly every day
- ☐ Not assessed (enter reason)

Score
- ☐ Not applicable
- ☐ TOTAL SCORE - If score of 3 or above refer to SW to complete additional assessments

Comments

Updated: 9/20/2021

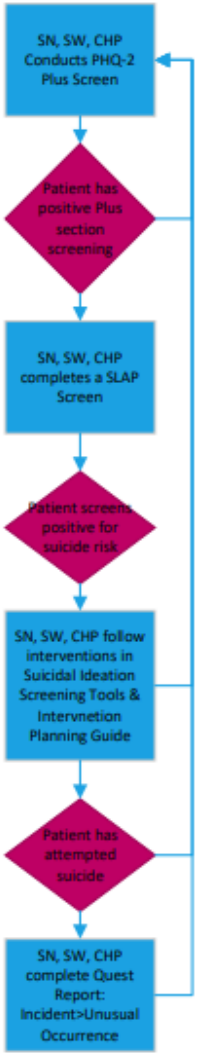
Suicidal Ideation Patient Process Guide

Process Category:	[redacted]	Reviewer:	
Purpose:	assist and guide in planning interventions for patients with suicidal ideation	Review/Revision Date:	
Original Author:	[redacted]	Committee Approval Date:	
Original Date:	[redacted]	Total Process Time (Minutes):	22
Process Owner Role:	Nurse, Social Worker, Chaplain	Process Flow:	
Abbreviation(s):	SW, Social worker, SN, Skilled nurse, CHP, Chaplain		
Regulation(s):			

Responsible Party	Step	Task(s) to Complete	Time in Minutes	Key Points (Provides the "How to" Includes "Tips / Tricks)	Why is this Step Important (Expected outcome from patient and clinical perspective)
SN, SW, CHP	1	Conduct PHQ-2 Plus screen	2		Screen patients for suicide risk and identify patient needs
SN, SW, CHP	2	A positive indicator in the Plus section requires a Staff Screening	5	If a SW is completing the PHQ-2 Plus Screen, a score of 3 or greater in the PHQ-2 portion or a positive indicator in the Plus section requires PHQ-9 Screen	Complete more thorough screening to further assess patient needs
SN, SW, CHP	3	Complete Staff screen	10		Complete more thorough screening to further assess patient needs
SN, SW, CHP	4	For patients with a low, Moderate, or High suicidal risk follow interventions in Suicide Ideation Screening Tools & Intervention Planning Guide	2	[redacted]	Develop individualized plan of care that acknowledges suicide risk and concerning need for further interventions
SN, SW, CHP	5	Complete Guest event / Incident / unusual occurrence	3		

Revised process to new format with links

Workflow Revisions



Suicidal Ideations Patient Process

2021.12

Abbreviations: SN-Skilled Nurse, SW-Social Worker, CHP-Chaplain

Link to RESOURCE_Suicidal Ideation Screening Tools & Intervention Planning

Easy visual guide for process

Training Revisions

Online Learning

Improve dissemination of process

- Multiple interactive CEU presentations to educate on process and demystify assessment and interventions.

Case Study 2

Case Study 2 Details Part 1

78-year-old male with cancer, living with wife

Upon admission, patient stated he believed in right to die; wife agreed

Patient stated he did not want to die with unmanaged pain

Suicide risk screenings completed. Comprehensive pain assessments every visit

Patient screened as low suicide risk

Suicide Care Plans initiated

Interdisciplinary Team notified and developed plan

Disclaimer: Patient information & story have been changed. Similar situation presented

Case Study 2 Details Part 2

Quality notified and Ethics Consult requested and completed

Patient & spouse notified that

- Illinois is not a right to die state
- Hospice will keep symptoms managed to decrease patient's and spouse's fears

Outcome

- As patient started experiencing symptoms, pain was managed, and patient denied suicidal ideations
- Multidisciplinary approach to manage symptoms
- No suicide ideations
- Patient died peacefully at home

Disclaimer: Patient information & story have been changed. Similar situation presented

Case Study 1 Findings

CASE STUDY DISCUSSION
What went well?
Patient trusted us enough to tell us his beliefs Screening tools completed upon admission and during length of stay Suicide risk identified in chart and communicated to team Ethics consult requested immediately Patient's fears acknowledged and managed Pain symptoms assessed regularly and managed
What could have gone better?
Completing a suicide contract (although patient never scored high on risk)
Any barriers?
Pulling together Ethics Consult quickly
Was the suicide ideation process followed?
Yes. The team went beyond reporting and actively requested an ethics review

Final Thoughts

Final Thoughts

Staff hesitancy

Impact of Case Studies

Willingness to revise process

Training vs interactive exercises

Nurses and Aide training

Understanding expectations

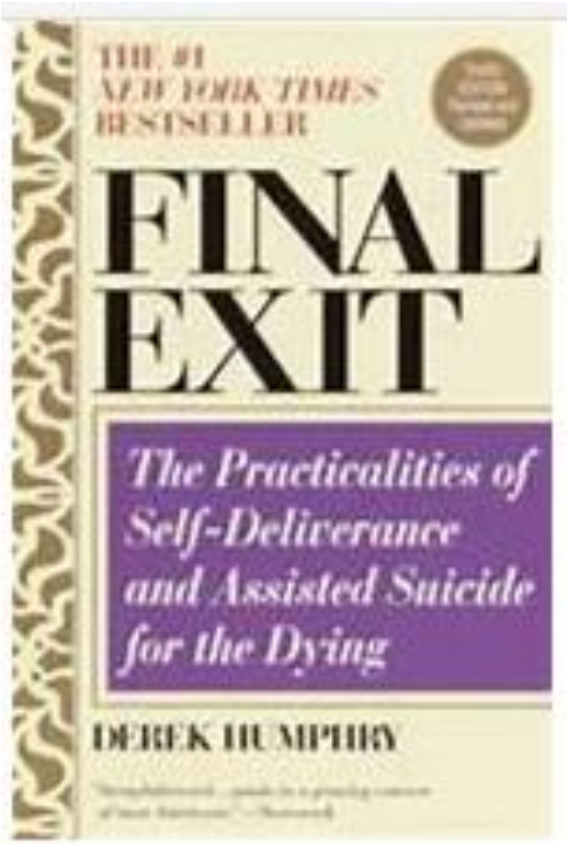
Impact of support throughout process

Seeing the difference when the process was followed

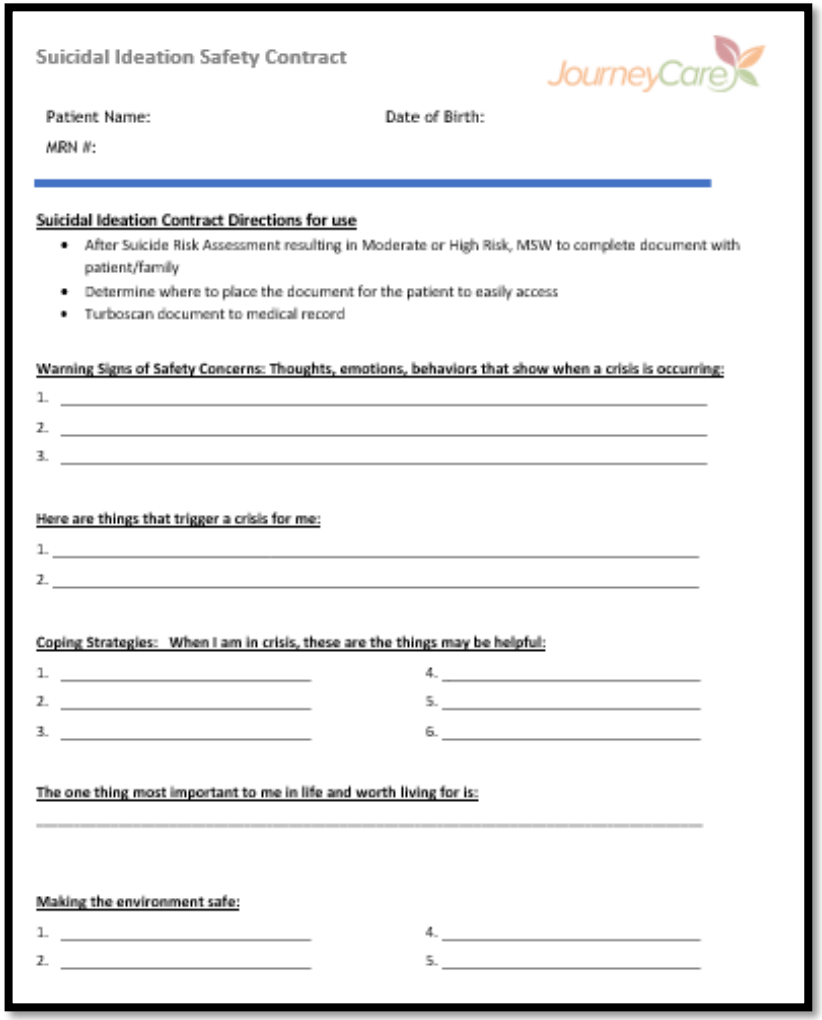
Session Objectives

- ✓ Recognize suicide risk factors and the suicide spectrum
- ✓ Follow the Lean Process approach utilized to build and update Suicide Ideations process
- ✓ Discover technological & paper tools to assist staff in identifying risk and developing suicide ideations interventions and plan of care

Resources


THE #1
NEW YORK TIMES
BESTSELLER
FINAL
EXIT
The Practicalities of
Self-Deliverance
and Assisted Suicide
for the Dying
DEREK HUMPHRY

Suicide Ideation Safety Contract



Suicidal Ideation Safety Contract

JourneyCare

Patient Name: Date of Birth:

MRN #:

Suicidal Ideation Contract Directions for use

- After Suicide Risk Assessment resulting in Moderate or High Risk, MSW to complete document with patient/family
- Determine where to place the document for the patient to easily access
- Turboscan document to medical record

Warning Signs of Safety Concerns: Thoughts, emotions, behaviors that show when a crisis is occurring:

1. _____
2. _____
3. _____

Here are things that trigger a crisis for me:

1. _____
2. _____

Coping Strategies: When I am in crisis, these are the things may be helpful:

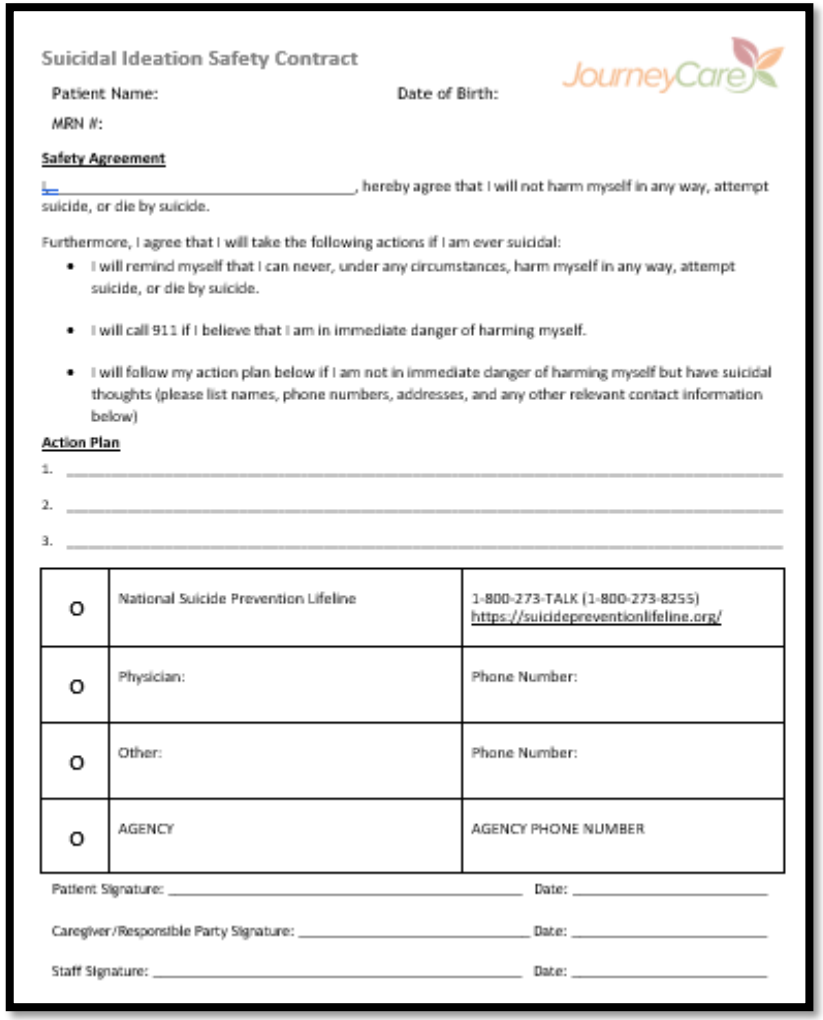
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

The one thing most important to me in life and worth living for is:

_____

Making the environment safe:

1. _____ 4. _____
2. _____ 5. _____



Suicidal Ideation Safety Contract

JourneyCare

Patient Name: Date of Birth:

MRN #:

Safety Agreement

I_____, hereby agree that I will not harm myself in any way, attempt suicide, or die by suicide.

Furthermore, I agree that I will take the following actions if I am ever suicidal:

- I will remind myself that I can never, under any circumstances, harm myself in any way, attempt suicide, or die by suicide.
- I will call 911 if I believe that I am in immediate danger of harming myself.
- I will follow my action plan below if I am not in immediate danger of harming myself but have suicidal thoughts (please list names, phone numbers, addresses, and any other relevant contact information below)

Action Plan

1. _____
2. _____
3. _____

O	National Suicide Prevention Lifeline	1-800-273-TALK (1-800-273-8255) https://suicidepreventionlifeline.org/
O	Physician:	Phone Number:
O	Other:	Phone Number:
O	AGENCY	AGENCY PHONE NUMBER

Patient Signature: _____ Date: _____

Caregiver/Responsible Party Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Questions & Discussion

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