

ROP Fact Sheet: Suicide Prevention

Accreditation Canada defines a Required Organizational Practice (ROP) as an essential practice that organizations must have in place to enhance patient/client/resident safety and reduce risk.



ROP Definition:

Clients are assessed and monitored for risk of suicide.

Tests for Compliance:

1. Clients at risk of suicide are identified.
2. The risk of suicide for each client is assessed at regular intervals or as needs change.
3. The immediate safety needs of clients identified as being at risk of suicide are addressed.
4. Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.
5. Implementation of the treatment and monitoring strategies is documented in the client record.

This ROP is a requirement in all mental health & addictions settings throughout the continuum.

Meeting this ROP: what compliance looks like:

1. We do a comprehensive assessment with all our patients at admission.

- Suicide risk is always assessed as part of the mental health assessment
- Screening for risk follows 5 standard themes:
 - Is the patient feeling unsafe?
 - Do they have a plan to commit suicide or harm themselves?
 - Do they have the means to carry it out?
 - Have they attempted in past?
 - Is there a family history of suicide?
- Includes assessment of triggers and protective factors to inform a safety plan
- Examples of team processes, [guidelines](#) and [procedures](#)

2. We reassess our patients regularly and as their status changes.

- We document suicide risk reassessment in PARIS at each shift change
- The assessment is discussed as part of shift handover

Working with the Suicidal Patient

A Guide for Health Care Professionals

Summary

- assess suicide rather
- ask support - to balance reward/ risk, risk, your goals
- assess current suicidal ideation
- obtain details on current attempts if applicable
- obtain history
- communicate with family/ friends
- connect with relevant healthcare providers
- address patient - build hope, obtain information on existing supports, provide safety plan
- involve relevant at time of discharge
- follow up post discharge

* refer to mental health professionals if high risk *

Task One: ASSESS

1. Assess current suicidal ideation

Is suicidal ideation present now?
How you gotten to the point where you did not want to go on? How you had thoughts of not wanting to be alive? What about right now?

Passive Ideation: The patient would rather not be alive, but does not indicate a plan that involves an act of initiation
→ **LOWER RISK** (e.g., I'd rather not wake up in the morning, I wouldn't mind if a car hit me when I was crossing the road)

Active Ideation: The patient has active thoughts of completing suicide → **HIGHER RISK** (e.g., I do think about killing myself, I feel like throwing myself into traffic)

Intensity, continuous ideation → HIGHER RISK

Is there a plan?
Do you have a plan as to how you would end your life?
Detailed, carefully thought-out plan → **HIGHER RISK**

Is there intent?
You felt about wanting to die, and how even considered (thinking of it) but are you intending to do this?

Low intent: Suicidal thoughts and fantasies about plans, with absolutely no intent to put these plans into action. Fantasizing about suicide can provide some comfort to those in distress to know there is always a way out
→ **LOWER RISK** (e.g., Oh no, I could never do that, I have children)

High intent: Expression of specific intent to end life
→ **HIGHER RISK** (e.g., I intend to do this at work as my daughter's graduation is over)

Ambivalent or Unclear intent: Ask about what has helped in past
What has stopped you from ending your life in the past?
What has helped in the past when you've had these thoughts?

2. Obtain details if there is a suicide plan

How lethal is the plan?
How lethal does the patient believe the methodology to be?

Is there access to means?
Obtain specific details.
What pills do you have or would you take to overdose?
Exactly where would you get a gun from?

Has patient chosen a time and/or place?
How lethal is the patient? What preparations have been made (e.g., buying ropes)?

Has patient made final arrangements?
Has patient prepared a suicide note, settled their affairs or communicated to others?

Higher lethality, access to means, preparations and arrangements → HIGHER RISK

Note: This document is intended to be a guide for working with the suicidal adult, and should not replace a psychiatric consultation. When suicide risk rises, an expert opinion should be sought to determine the need for hospitalization and clarification of diagnosis.
Dr. David B. E. Taylor, and Dr. Ian S. Taylor, B. Psych., 3rd Edition, 2017, Commission for Organizational Medical Health (COMH), www.comh.ca/ Faculty of Health Sciences, Simon Fraser University, Vancouver, BC. Inquiries may be directed to: info@comh.ca

3. We address immediate safety needs with evidence-based interventions and care plans.

- We refer to standard [levels of observations](#) based on risk level
- Goal is to stabilize the client so that a safety plan can be developed to address all the risk factors

4. We partner with our patients and their families to develop a comprehensive safety plan.

- We collaboratively develop mutually agreed-upon safety plans that address the risk and triggers, and build on protective factors (find the [Safety Plan template](#) here)
- We encourage patients to involve family and other support people, and communicate clearly the responsibilities that come with accepting their role in the safety plan

5. We continuously monitor the patients, review their safety plan and document changes.

- We review the safety plan with patients before each pass and to prepare for discharge/transition



What You May Be Working On:

- Improving consistency of practice** – making sure your team processes are used consistently to assess and communicate patients' suicide risk. You may also be participating in the development of regional suicide prevention tools and guidelines, i.e. CST: a common screener between ED and Inpatient Psychiatry.
- Partnering with patients/families** – documented, up-to-date safety plans are an effective, [evidence-based](#) intervention for addressing risk in an empowering, collaborative way.
- Knowing how we're doing** – random spot-audits of documentation, such as how consistently charts contain reassessment checklists completed every shift. You may also track other safety metrics such as use of seclusion, and episodes of violence, as well as functional outcome measures of patient progress.

Surveyors could ask:

- Tell me about how you assess suicide risk in your patients
- How do you communicate suicide risk with the Emergency Department when receiving a patient?
- How do you keep the patient safe from immediate harm?
- How do you work with the interdisciplinary care team, patient and family to develop a plan of care that addresses all the risks identified?
- Where are the assessment and the plan of care documented?
- How do you engage patients and their support people to develop a mutually agreed-upon safety plan/contract?
- How do you monitor the patient for changes and/or progress and share that information with the rest of the care team?
- How do you communicate suicide risk information to the next provider of care at transitions?

Accreditation on VCH Connect: <http://vch-connect/programs/qps/accreditation/Pages/default.aspx>