**BASIC RESPONSIBILITY**

Licensed Nurses, Nursing Assistants and All Staff that come in contact with residents

**PURPOSE**

1. To recognize signs of depression in residents and take action to evaluate for the danger of suicide
2. To protect residents that are high risk for self-endangerment
3. Assess for life events commonly associated with suicide:
   1. Physical illness
   2. Uncontrollable pain
   3. Fear of dying a prolonged death that damages family members emotionally and economically
   4. Social isolation and loneliness
   5. Major changes in social roles, such as retirement
   6. Widowed, divorced, and recently bereaved
   7. Depressed individuals
   8. Those who abuse alcohol or drugs
   9. Warning signs of suicide
      1. Change in behavior eating, sleeping habits, withdrawal, anxiety, increased risk taking
      2. Suicide threats
      3. ANY statement revealing a desire to die or indicating "everyone would be better off without me"
      4. Increased use of alcohol and/or drugs
      5. Making final arrangements
      6. Saying goodbye, giving away prized possessions, notes, making a will
      7. Signs and symptoms of depression
      8. Previous suicide attempts especially if they did not get help the first time
      9. Family history of suicide persons who have had a family member die by suicide
      10. Recent losses persons who have suffered a recent loss such as death, breakup of a relationship, loss of a job, or recent loss of physical health
      11. Lack of support persons who are isolated and have limited or no access to family, friends, caregivers, etc.
4. Routine Resident Assessment Responsibilities
   1. In all levels of care, all staff should be able to recognize signs of depression and report these signs to team members trained to evaluate mood problems
   2. The Social Worker in the Health Center will assess resident's mood on admission, and at least quarterly, documenting this on the MDS
   3. The Social Worker will complete a Geriatric Depression Scale assessment to assist in the identification and measurement of those residents with possible depression
   4. The Interdisciplinary Care Plan Team and the Independent Living Committee will address residents with depression and address plans or referrals for adequate medical and psychosocial treatment
   5. The Social worker and/or teams will refer residents with signs of depression to their medical doctors for antidepressant treatment.
   6. All staff must immediately inform their supervisor of all verbal comments of worthlessness, hopelessness, or possible suicidal threats-this includes comments, such as, "I'm no good anymore." “I don't understand why I'm still living." "I hope God will take me."
      1. Immediate (same day) evaluation of this type of comment will be done by Social Worker or licensed nurse
5. Suicidal Evaluation by Social Worker or Licensed Nurse will be done by:
   1. Talking with the resident and validating their feelings
   2. Be direct
   3. Talk openly and matter-of- fact about suicide
   4. Be willing to listen
   5. Allow expressions of feelings
   6. Accept the feelings
   7. Be non-judgmental
   8. Don't debate whether suicide is right or wrong, or feelings good or bad
   9. Don't lecture on the value of life
   10. Don't dare him/her to do it
   11. Don't act shocked. This will put distance between you
   12. Don't be sworn to secrecy
6. Offer hope that alternatives are available Ask the resident directly if they are considering suicide
   1. Examples of questions to ask include:
      1. Do you ever feel life is not worth living?
      2. Do you feel that your situation is hopeless?
      3. Have you ever thought of really hurting yourself?
      4. Have you been thinking about killing yourself?
      5. Have you planned how you would do that?
      6. What do you think you would do?
      7. Do you have the (pills, weapon, etc.) available now
7. Risk Evaluation and Management
   1. No signs of depression, no suicide ideas, no suicide plan
      1. Document assessment in records
   2. Signs of depression, no suicide ideas, no suicide plan
      1. Document assessment in record
      2. Notify physician for consideration of antidepressant medication or increase in dosage
      3. Social Worker to follow up with regular visits, progress notes
      4. Notify family
   3. Signs of depression and/or other warning signs, has suicide ideas, no plan
      1. Notify physician for further orders
         1. Physician may:
            1. Send resident for immediate mental health evaluation
            2. Consider addition of antidepressant medication or increase in current dosage.
      2. Notify family
      3. Remove potentially harmful items from room, such as scissors, belts, plastic bags
      4. Document hourly observation checks, keep in a supervised area as much as possible
      5. Discontinue if and when approved by Crisis Intervention Center or physician.
      6. Social Worker to follow up with regular visits, progress notes
      7. Discuss plans at interdisciplinary team meeting
      8. Document assessment, care, and notifications in record
   4. Signs of depression and/or other warning signs, has suicide plan, but does not have the means to do so
      1. Same as 7c plus the following
      2. Do not leave the resident alone
      3. Strongly encourage a psychiatric or psychological evaluation and treatment in specialized facility
   5. Signs of depression and/or other warning signs, has suicide plan and means to carry it out
      1. Same as 7c plus the following
      2. Do not leave the resident alone
      3. Strongly encourage a psychiatric or psychological evaluation and treatment in specialized facility
      4. Take action, remove the means if possible