6.15.07

S.O.A.P. - Suicidal Older Adult Protocol (Ages 65-85)

Name_____ Age___ Gender M / F Date_____ Rater_____

A. Demographic Factors

1. Gender/Race/Age
Female/Non-white/65 + = L
Female/White/65+ = L
Male/Non-white/65+ =L
Male/White/65-80 = M
Male/White/80 + = H

2. Marital Status
Married = L, S/D/W = M

L	M	H	E

B. Historical Factors

3. Prior Suicide Attempts
None = L 1 = H 2+ = E
Date_____
Means_____
Tx_____

Recent, Planned, Serious Attempt(s) (3 mo)
No = L Yes = E

L	M	H	E

C. Clinical Factors - Stable

5. Axis I Diagnosis
None = L
Dementia, Anx, Schiz = L
Sub. Abuse = M
Mood Disorders (MDD, BP) = E

6. Phys. Illness*
None = L
Female (COPD, Cancer, Neuro) = L
Males (COPD, Cancer, Neuro) = M

7. Functional Impairment of ADL*
None = L, Moderate = M
High = H

L	M	H	E

Total Factors: ____ ____ ____ ____
L (18) M (17) H (9) E (4)

* As mediated by Depression

D. Contextual Factors

8. Recent Loss/Stressors
None = L
Bereavement (<4yrs) = M
Family Discord,
Financial, Caregiving = M or H

9. Lethal Means Access
9a. Firearms
None = L Yes = M
Recent Purchase = H
9b. Pills/Poisons
No = L Yes = M
Stockpiled = H

10. Social Isolation
No = L
Live Alone Without
Confidants = M

L	M	H	E

E. Clinical Factors - Acute – To be rated by client

11. Do you experience psychic pain, misery or distress?
(L) No **(L)** A little **(M)** Some **(H)** A lot

12. Do you feel hopeless regarding your life (life will not get better)?
(L) No **(L)** A little **(M)** Some **(H)** A lot

13. Do you feel that you are a burden to others?
(L) No **(L)** A little **(M)** Some **(H)** A lot

14. Do you have a plan and or method to commit suicide?
(L) No **(L)** General idea, no specific plans
(M) Specific plan **(E)** Specific plan with method available and scheduled

F. Protective Factors

15. Moral Objections
Yes = L No = M

16. Family Related Concerns
Yes = L No = M

17. Mental Health Treatment For Mood Disorder
NA or Yes = L No = M

18. Other reasons for living: _____

L	M	H	E

OTHER CONSIDERATIONS:

RISK APPRAISAL: (Check one)	Low ☐	Medium ☐	**High** ☐

ACTIONS TAKEN (Check all that apply):

1. Continue monitoring risk factors _____
2. Notify/consult with supervisor _____
3. Recommend/refer increased outpatient treatment _____
4. Recommend/refer to psychiatric consult/med evaluation _____
5. Contract for NO HARMFUL behaviors _____
6. Recommend elimination of access to firearms _____
7. Notify legal authorities of risk to self or others (if applicable) _____
8. Notify family (if applicable) _____
9. Recommend/refer to day treatment _____
10. Recommend/refer to crisis unit/voluntary hospitalization _____
11. Initiate involuntary hospitalization _____
12. Other:_____ _____

_____ _____

Interviewer Supervisor

Suicide Protocol Instructions
When a resident threatens to harm him/herself, start at the top of the flow chart and follow each step.

Take threat seriously. Immediately provide one-on-one supervision.

Notify charge nurse in house. Nurse will assess patient using the S.O.A.P.

Notify Social Worker on call with S.O.A.P. score.

Take the following steps, based on S.O.A.P. score…

Remember:

DOCUMENT ALL ACTIONS TAKEN!!

Low Risk

Refer to psychology and psychiatry for further assessment.

If someone who is at low risk is repeatedly threatening suicide, develop individualized care plan to address behavior.

Document action taken.

Medium Risk

Provide one-on-one supervision until emergency care plan meeting can be arranged.

Remove potentially dangerous items (belts, electrical cords, glass, etc.) from resident's room.

Limit the resident to finger foods (resident should not have access to silverware or plasticware).

Nurse should notify resident's physician, and psychiatrist. **Social work** should notify psychology and resident's guardian/family.

Hold emergency care plan meeting to develop individualized plan ASAP.

Document all actions taken.

High Risk

Provide one-on-one supervision until resident is transferred to a safer environment.

Remove potentially dangerous items (belts, electrical cords, glass, etc.) from resident's room.

Social work should arrange to have resident transferred to a more restrictive environment ASAP.

Nurse should notify resident's physician, and psychiatrist. **Social work** should notify psychology and resident's guardian/family.

Document all actions taken.