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Screening for Suicide in Veterans with Cancer

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Executive Summary

Introduction to the Problem

Veterans are at elevated risk of suicide. The U.S. Department of Veterans Affairs (VA) historically made many changes to policy and procedure to readily identify veterans at risk for suicide. Veterans must be screened annually and referred to appropriate resources based on the results for suicide mitigation measures. There are currently no department-level policies or procedures in place to screen veterans presenting to the oncology department for cancer care, who require more frequent screening. Education of suicide risk factors, use of the current, VA-mandated suicide screening tool, and review of the process of referring positive screens to the proper organizational resources are paramount for patient safety. Annual requirements currently exist with required training and supported the sustainability of screening more frequently for veterans with cancer. The benefits are easily evaluated by the analytics team and result in prompt suicide interventions for this high-risk population. A Cancer Care Navigation Team provides case management to the highest risk veterans, requiring minimal additional time investment for frequent screening and the team best suited to note danger signs.

Literature Review

The purpose of the literature review was to establish a need for screening for suicide in veterans with cancer, as the data reflects that this is a high-risk population, finding the most appropriate suicide risk assessment tool for the oncology setting, and to investigate barriers to completion of suicide risk assessments by clinicians. The current tools used to assess behavioral health and the effectiveness of determination of suicide risks were evaluated, as well as other tools available within the VHA system, that are not the mandated tools per local protocol.

Veterans have been identified as having a 47% increased risk of suicide than the general population, with those with a cancer diagnosis being at even higher risk. Veterans with a diagnosis of esophageal, head and neck, lung, and late-stage cancer are at the highest risk. The initial three months present the highest risk, persisting through the first-year post-diagnosis. Clinician fear and anxiety were identified as barriers to screening, with education leading to self-efficacy in performing suicide assessments. The C-SSRS is a validated tool currently used at the VA.

Project Methods

The purpose of the project was to educate on the importance of performing routine suicide screenings of veterans with cancer, by providing education on population risk factors, review of the standardized VA-approved C-SSRS tool, and patient resources available when clinicians encounter a positive screen, and a review of local policy and procedures. The goal of the education was to implement screening within the Oncology department, increase the number of veterans screened, and to promote self-efficacy for clinicians performing the screenings. The project took place in a tertiary Veterans Health Administration oncology department in Washington, within the outpatient setting. The project was reviewed jointly by the IRB review board of academic institution, the Research Protection Program, and Quality, Safety and Value service line at the VA facility where the work was conducted and determined that this quality improvement (QI) project does not constitute human subject research.

Evaluation

The evaluation of the project's objectives was to be performed using data obtained from the VA C-SSRS Dashboard. Upon requesting the data from the Analytics team, it was determined that the data must be saved every two weeks. The two-week data capture was not

performed. This posed a barrier to obtaining the number of C-SSRS surveys completed within the sixty-day pre- and post-education period. Additionally, the Analytics team was unable to determine which providers had completed the C-SSRS surveys, as they could only identify the clinic name.

This resulted in the sixty-day pre-education and sixty-day post-education documentation to be pulled manually and each chart reviewed for the presence of completion of the C-SSRS survey. The findings were significant in that none of the educated providers performed any C-SSRS surveys during the pre-education period (n=0) or during the post-education period (n=0). The Analytics team remained unable to drill down the data specific to the educated oncology staff.

The Analytics team was able to later access the number of total surveys performed during the pre-education period (n=38) and post-education period (n=31). Staff names were pulled in the data search. The findings were that all the surveys were completed as part of the annual VA requirement for annual screening and tied to oncology clinics staffed by specialty nursing clinical staff (non-oncology). The combination of this data confirmed that none of the trained oncology staff performed suicide screenings at each visit. Missed opportunities for screenings were also determined not to show a meaningful change pre-screening (n=6) and post-screening (n=5).

The most profound finding from the data was that the minimum VA requirement of annual screenings was not being performed within staff population pulled in the reports. All clinicians know how to perform the screening, as they must complete and attest to annual yearly training yet was still missed when the reminder populated that the screening is due (annually). The data was presented to the stakeholder, who agreed that this requirement must be addressed

before implementing more frequent screenings. Making the requirement a Commission on Cancer (CoC) standard through the local Cancer Committee would also be an avenue for accountability.

The limitations of this project were the small sample size of clinicians (n=29) and the lack of readily available data to determine if clinicians are completing not only a minimum of annual surveys, but also at regular oncology visits. Time was expressed as an issue during the training sessions, especially by nursing and social work staff, as they stated their current duties present a time burden and that a positive screen would take up valuable time that cannot be recouped during the workday. This resulted in missed opportunities for each veteran served by these staff members. The inability of the electronic health record (EHR) to populate an alert at each Oncology visit was also a noted limitation.

Impact on Practice

The immediate impact at the clinical site was that current policies and procedures that provide for annual suicide screening for all Veterans were not being met. The oncology team is a small percentage of providers, calling for facility-wide data to be explored and re-training to occur. Calling for accountability for screening would result in all veterans receiving a minimum of the annual required screening before making any significant changes to the frequency that the screening is to be performed within the oncology department. The predicted long-term impact of not completing the C-SSRS could be catastrophic to veterans who are contemplating suicide, especially within the high-risk cancer population. Immediate accountability for the importance of annual screens opens the door for more frequent screenings in veterans with cancer.

Recommendations for changes for implementation are to start with veterans at the highest risk of suicide, veterans with head and neck cancers. This population is followed by the Cancer

Care Navigation Team, which consists of an advanced practice nurse, a registered nurse, and a social worker, all of whom routinely perform cancer distress screenings and refer to appropriate resources based on the screening results. There is a Cancer Care Navigation intake process that would be the most opportune time to implement the C-SSRS, with the team being able to reassess during each contact and refer to resources as appropriate as the veterans progress through treatment, or experience complications that may affect their mental health. This is a change that could be immediate and impactful, addressing those at highest risk for suicide.

Conclusion

The outcomes of educating the oncology staff about suicide risk factors associated with cancer, and reviewing the mandated tool, policies, and resources for positive screenings did not result in increased clinician self-efficacy, as evidenced by an increase in suicide screens.

Although the outcomes were not as expected, a larger issue was discovered, showing that minimum screening requirements were not being met, having facility-wide implications for veteran safety. Assigning the task to the Cancer Care Navigation Team will enhance compliance with screenings in the highest-risk veterans with cancer, as this team is already tasked with evaluating and addressing psychosocial issues. This data should prompt executive leadership to look at this data facility-wide and retrain and address accountability as necessary for the safety of our veterans.

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