Preventing Ligature Risks: CMS and TJC Guidelines and Requirements

Sue Dill Calloway

RELIAS LEARNING

Speaker

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Objectives

- Describe Tag 144 and 701 as they relate to ligature risks.
- Describe TJC's requirements on preventing patient self-harm.
- Explain CMS' recommendation on educational orientation and policy changes.

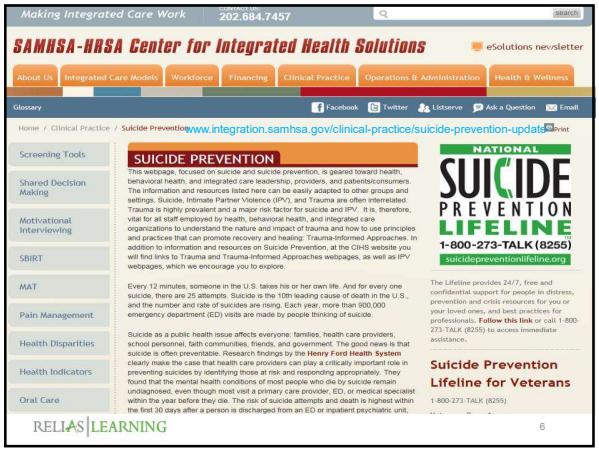
Introduction into the CMS Hospital CoPs

RELIAS LEARNING

Suicide Prevention

- Every 12 minutes someone in the United States takes his or her own life
- So during this 2 hour webinar, 10 people will have committed suicide
- For every one suicide, there are 25 attempts
- Each year more than 900,000 emergency department visits are made by people thinking of suicide
- It is the 10th leading cause of death in the US
  - Source: SAMSHA/HRSA Center for Integrated Health Solutions

RELIAS LEARNING 5



Introduction Ligature Risk

- CMS issued a 13 page memo on clarification of ligature risk policy for hospitals
- Amends tag 144 and 701
- Added to December 29, 2017 manual
  - Preventing inpatient suicide and creating a safe care setting is important to both TJC and CMS
- CMS wants a safe environment to prevent patients from hanging or strangulating themselves
  - Focuses on the care and safety of behavioral health patient and staff

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

S&C Memo: 18-06- Hospitals

DATE: December 08, 2017

TO: State Survey Agency Directors

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

FROM: Director
Survey and Certification Group

SUBJECT: Clarification of Ligature Risk Policy

Memorandum Summary

- **Ligature Risks Compromise Psychiatric Patients' Right to Receive Care in a Safe Setting:** The care and safety of psychiatric patients and the staff that provide that care are our primary concerns. The Centers for Medicare & Medicaid Services (CMS) is in the process of drafting comprehensive ligature risk interpretive guidance to provide direction and clarity for Regional offices (RO), State Survey Agencies (SAs), and accrediting organizations (AOs).
- **Definition of a Ligature Risk:** A ligature risk (point) is defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes, and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures.
- **Focus of Ligature Risks:** The focus for a ligature "resistant" or ligature "free" environment is primarily aimed at Psychiatric units/hospitals.
- **Interim Guidance:** Until CMS' comprehensive ligature risk interpretive guidance is released, the ROs, SAs and AOs may use their judgment as to the identification of

December 29, 2017 Changes

- Transmittal issued and updates CMS Manual
- Changes to **tag 144** on the rights of the patient to receive care in a safe setting
  - Need to have safe setting to prevent inpatient suicide or any form of self harm
  - Remember separate CMS memo on ligature risks
  - Patient assessment is important
- Updates **tag 701** and buildings needs to be constructed and maintained to minimize risk
  - Address age related safety features, security, weather related issues and ligature risks

Ligature Risks - CoPs Also Called SOM

State Operations Manual
Appendix A - Survey Protocol,
Regulations and Interpretive Guidelines for Hospitals

Table of Contents
(Rev. 176, 12-29-17)

Transmittals for Appendix A

Email questions
hospitalscg@cms.hhs.gov

Survey Protocol

Introduction
- Task 1 - Off-Site Survey Preparation
- Task 2 - Entrance Activities
- Task 3 - Information Gathering Investigation
- Task 4 - Preliminary Decision Making and Analysis of Findings
- Task 5 - Exit Conference
- Task 6 – Post-Survey Activities

Psychiatric Hospital Survey Module
Psychiatric Unit Survey Module
Rehabilitation Hospital Survey Module
Inpatient Rehabilitation Unit Survey Module
Hospital Swing-Bed Survey Module

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_Appendixtoc.pdf

How to Keep Up with Changes

- Many times hospitals ask how can we keep up with new changes in the future?
- Have one or two person in your hospital who has the following responsibility
- First, once a month, check to see if a new CoP manual has been issued
- Once a month, go out and check the survey and certification website to see if any new memos or transmittals
- Sign up to get the Federal Register
- You can email questions to CMS directly

Medicare State Operations Manual
Appendix

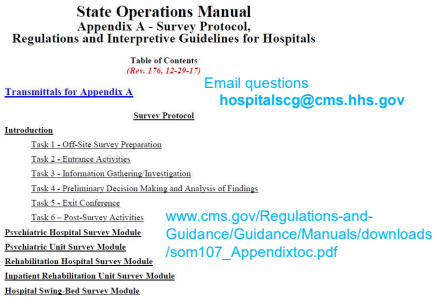
Email questions to CMS hospitalscg@cms.hhs.gov or CAH scg@cms.hhs.gov

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers

Website at www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

App. No.	Description	PDF File
A	Hospitals	2,185 KB
AA	Psychiatric Hospitals	606 KB

Also Called the SOM



State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

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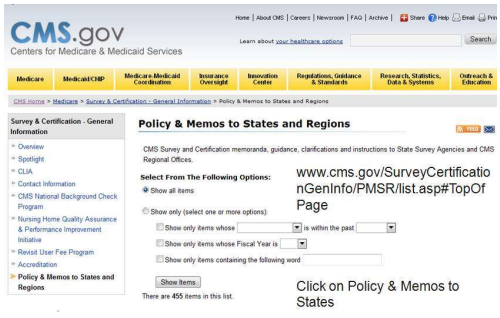
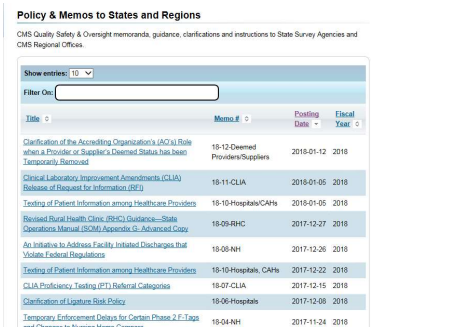
CMS Survey and Certification Website



www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Click on Policy & Memos to States

CMS Survey Memos



Policy & Memos to States and Regions

CMS Quality Safety & Oversight memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Show entries: 10
Filter On:

Title	Memo #	Posting Date	Fiscal Year
Clarification of the Accrediting Organization's (AO's) Role when a Provider or Supplier's Deemed Status has been Temporarily Removed	18-12-Deemed Providers/Suppliers	2018-01-12	2018
Clinical Laboratory Improvement Amendments (CLIA) Release of Request for Information (RFI)	18-11-CLIA	2018-01-05	2018
Texting of Patient Information among Healthcare Providers	18-10-Hospitals/CAHs	2018-01-05	2018
Revised Rural Health Clinic (RHC) Guidance—State Operations Manual (SOM) Appendix G- Advanced Copy	18-09-RHC	2017-12-27	2018
An Initiative to Address Facility Initiated Discharges that Violate Federal Regulations	18-08-NH	2017-12-26	2018
Texting of Patient Information among Healthcare Providers	18-10-Hospitals, CAHs	2017-12-22	2018
CLIA Proficiency Testing (PT) Referral Categories	18-07-CLIA	2017-12-15	2018
Clarification of Ligature Risk Policy	18-06-Hospitals	2017-12-08	2018
Temporary Enforcement Delays for Certain Phase 2 F-Tags	18-04-NH	2017-11-24	2018

Subscribe to the Federal Register

CMS Transmittals

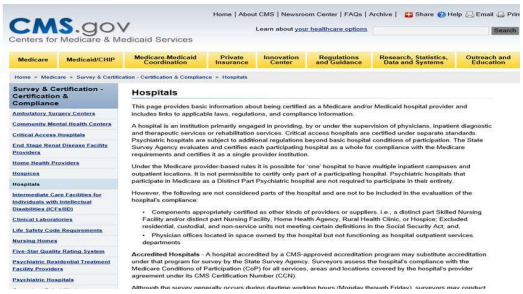
www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018-Transmittals.html

CMS Hospital CoP Deficiency Reports

Access to Hospital Complaint Data

- CMS has issued quarterly deficiency reports since March 22, 2013
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
- Hospitals can monitor how many deficiencies in ligature risks and a safe environment
- Names hospitals and provides their full address

Updated Deficiency Data Reports



www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html

Tag 144 Ligature Risks and Self Harm in Patient Rights Section

Suicide Rate

- Why is CMS and TJC focusing on prevention of suicide?
- Suicide is the 10th leading cause of death
- There were 41,149 suicides in the US
  - Males take their life 4X more than females or 77.9% of all suicides
  - Firearms most common in males (56.9%) and poisoning for females (34.8%)
- This is a rate of 12.6 per 100,000
- Equal to 113 suicides each day
- One suicide every 13 minutes
- 17% of students seriously considered suicide in past year
  - CDC 2015 report accessed February 1, 2018 at www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf

What to Do

- Has your hospital assessed the risks to behavioral health patients on prevention of ligature, suicide, and self-harm for behavioral health patients?
- What has your hospital done to remove these risks?
- Do you have a policy and procedure?
- Has staff been educated on the policy?
- How do you ensure you have enough staff to support the mitigation risks?
- Do you do an individual suicide assessment on each behavioral health patient?

What to Do

- Identify the areas that behavioral health (BH) patients are cared for in both dedicated area like the BH unit and non-dedicated such in the ED, medical surgical units, ICU, etc.
- The environmental risk assessment is best performed by a multi-disciplinary team
- Consider short term and long term mitigation strategies based on your risk assessment
- Ensure competency of staff who care for BH patients
- Monitor the bathroom of the suicidal patient
- Patients and visitors must be monitored

What is a Ligature Risk?

- Anyone who works with patients at risk of hanging or strangulation and who has a duty of care should have anti-ligature training
- A ligature risk or point is defined by CMS
- It includes anything that could be used to attach a cord, rope, or other material for purposes of hanging or strangulation
- This includes handles, coat hooks, pipes, shower rails, radiators, bedsteads (framework of bed on which mattress is placed), window or door frames, ceiling fittings, hinges, and closures

Anchor Points

- Anchor points could also include;
  - Gaps between the window or the door and its frame
  - Window or door handles
  - Shower heads and shower controls
  - Sink taps
  - Furniture such as metal bed frames arms and chair or table legs
  - Door hinges
  - Ventilation grills, ceiling vents and ducts
  - Sprinkler heads

What is a Ligature Risk?

- A ligature point is a fixed point which a ligature can be tied to, wedged around or behind or held in place by any means which enables the ligature to bear the weight of the patient either wholly or partially
  - It is any loop or noose that could be attached to the ligature point to enable the patient to hang or strangulate
- Anti-ligature fittings are those designed in a way to seriously prevent a ligature to it or is designed to break away
- Risks include plastic bag, bra straps, torn strips of clothing, phone charger cord, phone cord, rubber strips from door seals, ties, shoe laces, cords and belts

CMS Ligature Risk

- Psychiatric patients have a right to receive care in a safe setting and ligature risks compromise this right
- CMS is drafting a comprehensive ligature risk guidance to provide additional clarity so stay tuned for additional information
- The focus of a ligature free environment or ligature resistant is primarily aimed at psychiatric hospitals and behavioral health units
  - Better to use the term ligature resistant
- However, we still need to keep patients who are suicidal safe no matter what unit they are on

CMS Ligature Risk

- CMS mentions the CQC ligature point memo
  - 75% of patients in psych ward kill themselves by hanging or strangulation
  - Risk is greater in a room where patients spend time in private without any supervision
  - Risk is greater if nursing staff cannot easily observe all areas of the unit because of poor design or not enough staff
  - Ligature point is between 0.7 and 4 meters (2.3 to 13 feet) from the ground
  - Need a policy and procedure
  - Risk assessment of patient and room assigned accordingly
  - Review the ligature audit

CareQuality Commission — Brief guide for inspection teams

Ligature points

https://www.cqc.org.uk/sites/default/files/20170120_briefguide-ligature-points.pdf

Context

Three-quarters of people who kill themselves while on a psychiatric ward do so by hanging or strangulation.[1] A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures.

The risk posed by a ligature point is greater if:

1. It is in a room in which patients spend time in private without direct supervision by staff (e.g. bedroom, toilet, bathroom).
2. It is in a ward/area used by high-risk patients (e.g. acute mental illness; high risk of suicide; challenging or chaotic behaviour; comorbid substance misuse).
3. The ligature point is between 0.7 metres and 4 metres from the ground.
4. Nursing staff cannot easily observe all areas of the ward because of poor ward design or because there are too few nurses on duty.

Evidence required

The activities inspection teams will carry out include, but are not limited to, the following:

1. Request and examine provider ligature risk reduction policy and procedure.
2. When touring the ward area, check for ligature points. Are these high risk ie.:
   - in rooms where patients spend time unsupervised?
   - in areas of the ward that are difficult to observe because of the ward design?

So What's In Your Policy?

Assessment and Management of Ligature Care Policy

Version: 4

Summary:	This policy sets out the Trust's approach to ensuring that ligature points are identified, assessed for level of risk and managed. This policy is supported by the Assessment and Management of Ligature Points Procedure and Standard Operating Procedure: The Use of Ligature Cutters in Mental Health and Learning Disabilities.
Keywords (minimum of 5): *(To assist policy search engine)*	Ligature, ligatures, ligature policy, ligature point, ligature points, suicide, ligature procedure, attempted suicide, self-harm, hanging.
Target Audience:	All staff who work in mental health and learning disability divisions.
Next Review Date:	November 2019

www.southernhealth.nhs.uk/EasysiteWeb/getresource.axd?AssetID=75591&type=full&servicetype=Inline

CONTENTS

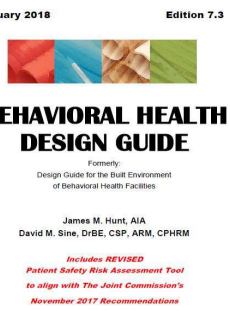
CMS Ligature Risk Tag 144

- **Standard:** The patient has the right to receive care in a safe setting
- In order to provide care in a safe setting, the hospital must identify patients at risk for intentional harm to self or others
- The hospital must identify environmental safety risks for these patients
- The hospital must provide education and training for staff and volunteers
- Patients at risk of suicide are in both inpatient and outpatient locations

CMS Ligature Risk

- As discussed previously, the ligature resistant environment is for behavioral health hospitals and psych units of acute care hospitals
- It does **not** apply to other non-psych departments such as the ED, ICU, and medical-surgical units
- **However,** CMS says that psych patients may be treated in these units and the hospital must also identify patients at risk for intentional or self harm
- The hospital must still mitigate environmental safety risks
  - Will discuss the Behavioral Health Design Guide to create safe rooms later

Behavioral Health Design Guide



www.fgiguidelines.org/resource/design-guide-built-environment-behavioral-health-facilities/

CMS Ligature Risk

- Patients having suicidal ideations outside the psych units must still be protected
- This might include:
  - 1:1 monitoring with continuous visual observations
  - Removal of sharp objects from the room
  - Removal of equipment that can be used a weapon that is not needed on the patient
- Note that some hospitals have created a safe room on each unit or several safe rooms in the ED depending on the number of board psych patients

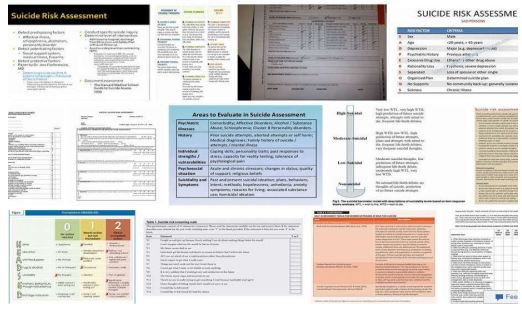
CMS Ligature Risk

- Hospitals are expected to follow nationally recognized standards of care and guidelines to minimize risk to suicidal patients
- Need to prevent patients from self-harm or harm to others
- Potential risks include those from ligatures, sharps, harmful substance, access to medications, breakable windows, accessible light fixtures, plastic bags (suffocation), oxygen tubing, bell cords, etc.

Indentifying Patients at Risk

- There are many patient risk assessment tools available to help identify which patients are at risk
- There is no one size fits all
- The risk assessment tool used should be appropriate to the patient population, setting, and staff competency
  - Such as the emergency department, post-partum or pediatric population
- The hospital must do an appropriate patient risk assessment

What Assessment Tool Do You Use?



Environmental Safety Risks

- The hospital must implement an environmental risk assessment strategy
- May not be the same in all hospital or in all units
- Must be specific to the unit and patient population
- This does **not** mean that a unit that generally does not care for suicidal patients has to conduct a full environmental risk assessment
- But, the unit needs to consider the possibility they may have a patient who is at risk for harm to self or others

Environmental Safety Risks

- However, the hospital may want to consider using a tool to assess risks for patient safety and for risk management reasons
- The hospital should **documen**t the assessment findings
- CMS mentions the VA environmental risk assessment tool
- CMS mentions it is a way for hospitals to **assess** for safety risks in all patient care environments or areas
- CMS also lists some environmental safety risks

Environmental Safety Risks

- **Environmental safety risks includes:**
- Unattended items in housekeeping carts such as hazardous items
  - Mops, brooms, cleaning agents, hand sanitizer, etc.
- Unsafe items brought to patients by visitors in locked psych units and psych hospitals
- Call lights, hand rails, door knobs, door hinges, sheets, towels, shower curtains, wall towel dispensers, shoe laces, handles, power cords, light fixtures, windows that can be broken etc.
- Inadequate staffing to observe and monitor patients

VA Mental Health Guide - 74 pages

VA | U.S. Department of Veterans Affairs

Environmental Programs Service Mental Health Guide

www.patientsafety.va.gov/docs/joe/eps_mental_health_guide.pdf

Table of Contents

VA EC Checklist for Mental Health Environment

Mental Health Environment of Care Checklist for Bathrooms

In addition to the following criteria, bathrooms must also meet all General Criteria

Ques. No.	ePSAT cross reference number	Site / Item	Questions / Criteria	Rationale / Assessment Methods:
44	7.2.13.3.1	Light Fixtures	Are light fixtures securely mounted to the ceiling by inaccessible fasteners or tamper resistant fasteners (or equivalent) with non breakable lenses?	*Flush mounted fixtures are recommended, however surface mounted lights are acceptable provided they do not provide an anchor point for hanging. All energized parts must be secured with tamper resistant fasteners. It is required by NFPA 70 to have GFCI circuits in all wet locations.*
45	7.2.13.3.2	Walls/Tiles	Are walls solid (gypsum, plaster/lath, concrete block, etc.) and free of Ceramic Tile? **Note: Only new units need to be free of ceramic tile with the exception of 2 inch by 2 inch tile on the floor.** 	*Ceramic tile may be broken and the shards used for self injury or as a weapon. If gypsum board walls are provided in rooms serving patients in seclusion rooms' additional protection is needed. These walls should be provided with a backing material such as fire treated plywood, or equivalent, to provide additional structural integrity.*
46	7.2.13.3.3	Grab rails 	47.a. Are grab rails installed around the toilet and shower areas the closed type that prevent materials from being wrapped around them? 47.b. Are all grab rails eliminated where they are not	*The grab rail should be of a design that permits them to be easily grasped while preventing materials from being threaded through that meet ABA standards. For example rails with continuous filer that extends down from the bottom of the rail before going to the wall (in*

48	7.2.13.3.5	Towel Bars	Have towel bars been removed and replaced with flip-down type hooks designed to support the weight of a bath towel and nothing heavier?	
49	7.2.13.3.6	Mirrors	Are mirrors shatter proof or other non breakable material and affixed to the wall using tamper resistant fasteners and unable to be used as an anchor point for hanging?	*Polished stainless steel mirrors are preferred.* 
50	7.2.13.3.7	Electrical Receptacles	If electrical receptacles have not been removed and covered by a plate fastened using a tamper resistant fastener, is a Ground Fault Circuit Interrupter (GFCI) receptacle or GFCI circuit breaker provided?	*Removal of the receptacle is preferred [MET]. If a receptacle must be used, GFCI protection is required to reduce the risk of shocks and electrocutions, and the receptacle cover must be fastened with tamper resistant screws [PARTIALLY MET]. An electrical receptacle requires that an electrical cord be plugged into it to be used. Electrical cords may be used as a lanyard (noose) and must be strictly controlled. Ideally electrical receptacles and the need for cords should be eliminated altogether.*

VA EC Checklist for Mental Health Environment

Mental Health Environment of Care Checklist for Bathrooms

In addition to the following criteria; bathrooms must also meet all General Criteria.

Ques. No.	ePSAT cross reference number	Site / Item	Questions / Criteria	*Rationale / Assessment Methods:*
51	7.2.13.3.8	Call buttons	If provided, two Emergency Call buttons should be used. One mounted using tamper resistant fasteners and located approximately 1 foot above the floor level and the other should be 38" to 44" above the floor. Pull cords should be of plastic breakaway beads in lieu of cords.	*Call buttons (when provided) should be accessible to someone who has fallen on the floor. If plastic break-away beads are used the unit should develop a protocol for quickly and easily replacing the beads as they are removed or pulled off by patients.* 
52	7.2.13.3.9	Toilets	**53.a. For new units, are toilets floor mounted with no exposed piping that could serve as an anchor point for hanging and free of removable seat covers? (Only New Units)** 53.b. For existing units, are all pipes and plumbing that could be used as an anchor point enclosed? 53.c. Do toilet partitions have no cross connections that could be used for hanging?	*Plumbing fixtures should be enclosed to minimize risks. All facilities should replace removable toilet seats with integrated seats where feasible. Added March 2013* 

Ques. No.	ePSAT cross reference number	Site / Item	Questions / Criteria	*Rationale / Assessment Methods:*
56	7.2.13.3.13	Showers	Are showers free of anchor points? Shower heads should be institutional type. Soap holders should be recessed. Floor drain plates should have tamper-resistant screws.	*Institutional shower head is designed to not provide an anchor point for hanging. The shower head and controls should be free of anchor points. Consider using automatic on/off faucets to eliminate the faucet handles. Push button controls for the shower are also an acceptable alternative. Updated February 2013*
57	7.2.13.3.14	Water Temperature	Is the water temperature limited to a maximum of 110 degrees F?	*Check the water by running the faucet in the sink or shower or install temperature control guard for all faucet and set temperature to 105-110 degrees F.*
58	7.2.13.3.15	Shower Curtains	Are shower curtains hung from ceiling mounted tracks with curtains designed to tear away when a static load of 5 pounds or more is applied? Are shower curtains made of breathable material (not plastic or vinyl) so that they cannot be used for suffocation? Tracks in bathrooms should be the flush type and not surface mounted.	*Shower Curtains are important for privacy and to keep water from flooding the floor - causing fall hazards. It is vital to check that the mounted tracks cannot be used as an anchor point for hanging. Break away curtain rods may be used as a weapon and are not recommended.* ***Note: On new construction***

www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp

Watts, B.V., Young-Xu, Y., Mills P.D., DeRosier, J.M., Kemp, J., Shiner, B. & Duncan, W.E. (2012). An Examination of the Effectiveness of a Mental Health Environment of Care Checklist in Reducing Suicide on Inpatient Mental Health Units. Archives of General Psychiatry, 69(6), 588-592.

Ligature Resistant

- Toilet paper dispenser ligature resistant
- Rounded covers prevents using as ligature anchor
- ED room has roll down cover that locks
- Pictures compliments of Ernie Allen

Environmental Safety Risks

- Tag 144 makes it clear that the presence of ligature risks for a patient with suicidal ideation is a patient safety risk
- Patients have the right to care in a safe setting
- This includes furniture that be easily removed or thrown, sharp objects, areas out of view of staff, plastic bags (suffocation), equipment used for vitals signs, medication, non-tamper proof screws, and IV fluid equipment
- CMS expects 1:1 monitoring with continuous observations and removal of equipment and objects

Ligatures		
Clothing		
Belt (dressing gown)		Socks
Belt (trousers)		Stockings
Bra (Straps)		Shoe Laces
Braces		Neck Ties
Cords (Pyjama)		Elastics (Garments)
Personal Effects		
Baby Wipes		Towels
Bandages		Headphone leads
Cord Wash Bags		Game console leads
Elastic Bands		Mobile / Electric chargers
Hand luggage straps		Hair Bands
Bedrooms		
Pillow cases / Sheets		Electrical extension cables
Curtain / blinds cord or chain		Plastic bin liners
Miscellaneous		

Education and Training

- Hospital staff must be trained to identify environmental safety risks
- Where the hospital has chosen to implement a risk assessment tool to identify potential or actual risks
- Must be trained to identify patients at risk
- Training includes employees, volunteers, contractors, agency nurses, per diem staff and staff providing services under contract
- Training in orientation and when P&P changes
- Recommends training every **2 years**

9 Competencies of the Psych Nurse

Nurses: Advocates for Hope

PSYCHIATRIC-MENTAL HEALTH NURSE ESSENTIAL COMPETENCIES FOR ASSESSMENT AND MANAGEMENT OF INDIVIDUALS AT RISK FOR SUICIDE

(Adapted from Suicide Prevention Resource Center (SPRC) & American Association of Suicidality (AAS) (2008). Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals.)*

Preamble

Competencies have been developed for mental health clinicians in assessing and managing suicide risk; however, there are no standard competencies for psychiatric registered nurses. Widely accepted nursing practices do not meet suicide-specific standards of care or evidence-based criteria. Therefore we propose the following essential competencies for psychiatric registered nurses working in hospital settings as a guide for practice. These competencies are based on a comprehensive review of the extant research literature (both qualitative and quantitative) relevant to assessment and management of hospitalized patients admitted to a psychiatric setting.

The role of the nurse specific to suicide prevention includes both systems and patient level interventions. At the systems level the nurse: assesses and maintains environmental safety, develops protocols, policies, and practices consistent with zero suicide, and participates in training for all milieu staff. At the patient level, the nurse assesses risk for suicide, provides suicide-specific psychotherapeutic interventions, monitors and supervises at-risk patients, and assesses outcomes of all interventions. The expectation is that these essential competencies will serve to provide the foundation for training curricula and in measuring the knowledge, skills, and attitudes necessary for expert care.

Essential Competencies

1. **The psychiatric nurse understands the phenomenon of suicide.**
   - Defines basic terms related to suicidality.
   - Reviews suicide-related statistics and epidemiology.
   - Describes risk and protective factors related to suicide.
   - Discusses nursing and best practice/evidence-based literature related to inpatient suicide prevention.

www.apna.org/i4a/pages/index.cfm?pageid=5684

Essential Competencies

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   - Discusses nursing and best practice/evidence-based literature related to inpatient suicide prevention.

2. **The psychiatric nurse manages personal reactions, attitudes, and beliefs.**
   - Demonstrates self-awareness of emotional reactions, attitudes, and beliefs related to previous experiences with suicide.
   - Examines the impact on the patient of nurse's emotional reactions, attitudes, and beliefs.
   - Accepts and regulates one's emotional reactions to suicide.
   - Discusses nurses' reactions to patients who express suicidal ideation, attempt or die by suicide.
   - Participates in a root cause analysis (RCA) or failure mode and effect analysis (FMEA) when a suicide attempt or suicide death occurs on the inpatient unit.
   - Participates in staff debriefing following a suicide attempt or suicide death.
   - Obtains and maintains professional assistance/supervision for ongoing support.
   - Attends to one's own emotional safety/wellbeing.

3. **The psychiatric nurse develops and maintains a collaborative, therapeutic relationship with the patient.**
   - Maintains a nonjudgmental and supportive stance in relating to the patient and family.
   - Provides a therapeutic milieu in which the patient feels emotionally safe and supported.
   - Voices authentic intent to help.
     - Uses evidence to educate the patient about the suicidal mind, symptoms of illness, and effectiveness of intervention.
     - Conveys hope and connection while recognizing the patient's state of mind and need for hopefulness.
   - Reconciles the difference and potential conflict between the nurse's goal to prevent suicide and the patient's goal

Correction of Environmental Risks

- All deficiencies are expected to be corrected within the time frame set by the CMS regional office, the state agency (like the department of health) or the accreditation organization (AO)
  - AO includes TJC, DNV Healthcare, Healthcare Facilities Accreditation Program and CIHQ
- In cases where it is not reasonable to expect compliance within the timeframe, only CMS can grant additional time
- Ligature risk deficiencies do not qualify for LSC waivers and will not be granted

Correction of Environmental Risks

- Deficiencies in the plan of care (PoC) must be corrected within 60 days from receipt of the report
- Follow up surveys will be done to ensure it is fixed
- The ability of the hospital to comply within the required time frame has sometimes shown to be a burden
  - This is especially true when you need board approval, capital budget funding, to engage in competitive bids, availability of materials, time for completing repairs and access to the area

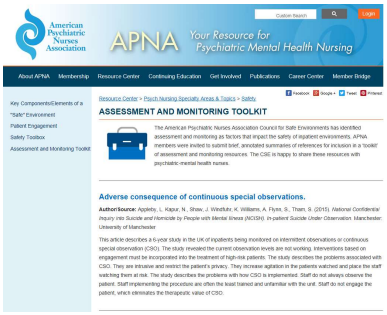
Correction of Environmental Risks

- Cited ligature risks that do not pose an immediate jeopardy situation are to be corrected within the allotted days according to CMS or the AO
  - Including when the hospital has removed the immediate threat to patient health and safety
- Interim patient safety measures are expected to be implemented as part of the plan of correction
- The correction period starts when the hospital is notified of the deficiency
  - The SA and AO can only recommend to CMS that more time be given to correct the deficiency

Correction of Environmental Risks

- Interim patient safety measures to mitigate ligature risks many include sitter such as 1:1 observation
  - Note that having a sitter watch 2 patients in the same room is 2:1 and not 1:1
- This includes while the patient sleeps, toilets, and baths
- Also mentions this and other alternative nursing protocols recommended by the National Psychiatric Nursing Association (NPNA)
  - Note interesting research on 1:1, also called continuous special observation (CSO), which can have some adverse consequences especially with paranoid or agitated patients

American Psychiatric Nurses Association



www.apna.org/i4a/pages/index.cfm?pageID=6271

APNA 2 Alternatives to CSO

- 2 alternatives to continuous special observation
- PNA or psychiatric nursing availability emphasizes developing a relationship with the suicidal patient based on engagement and making staff available to discuss impulses or distressing thoughts
- PMI or psychiatric monitoring and intervention is based on engagement and the patient allowed privacy in their room, in the day room, and staff support with impulse control
  - It includes removing the elements of violence; a target, a trigger, a weapon, and a state of arousal

Requests for Extension

- Requests for an extension of time frames to correct ligature risk deficiencies must include:
  - Hospital's accepted PoC
  - Mitigation plan
  - Rationale about why it is not reasonable to meet the correction timeframe
  - Evaluation of the effectiveness of the mitigation plan and
  - Update on the status of the PoC
- Hospitals submit request to their AO and if none then to the state agency (like the Department of Health)

Requests for Extension

- AO to copy the RO (regional office) or CO (central office) via email with a recommendation for approval
- The CO will respond and copy the AO and the RO within 10 working days
- The hospital must provide electronic progress reports to the SA or AO on a monthly basis
- Must include: copies of invoices, receipts, communications with vendors that detail the progress, etc.

Survey Procedure

- Surveyor instructed to observe patient care environment for housekeeping carts that contain hazardous items that can pose a risk like disinfectant solutions, mops, brushes, tools, etc.
- Suppose to interview staff to determine if staff trained to identify risks in the care environment
- If so, how do staff report these findings?
- Will review the P&P and interview staff to determine how the hospital defines continuous visual observation (CVO) and how it does a 1:1 observation

Survey Procedure

- Will review the P&P to find out what the hospital does to curtail unwanted visitors, contaminated material, or unsafe items that pose a safety risk to patients and staff
- Will assess hospital security efforts to protect patients at risk for suicide or self harm
- Security measures must be based on nationally recognized standards of practice
- Hospital must be providing appropriate security to protect patients

Tag 701 Buildings

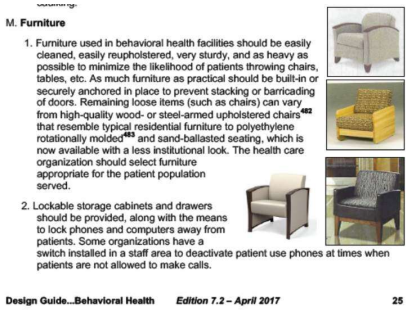
Tag 701 Buildings Accessibility

- Standard: Buildings- The condition of the physical plant and overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured
- The hospital must be constructed and maintained to minimize risk for patients, employees, and visitors
- Safety features must be addressed in accordance with nationally recognized standards
- The hospital must make sure it meets State and Federal accessibility standards like the OCR requirements

Tag 701 Age Related Features

- Hospital must address safety hazards and risks related to age
- Includes neonatal, pediatric, and geriatric patients
- Must be consistent with nationally recognized standards
- Age related risks include:
  - Access to medications, cleaning supplies and other hazardous materials, furniture, medical equipment, security of inpatient and outpatient areas, and increased chance of falls

Furniture in Behavioral Health Units



M. **Furniture**

1. Furniture used in behavioral health facilities should be easily cleaned, easily reupholstered, very sturdy, and as heavy as possible to minimize the likelihood of patients throwing chairs, tables, etc. As much furniture as practical should be built-in or securely anchored in place to prevent stacking or barricading of doors. Remaining loose items (such as chairs) can vary from high-quality wood- or steel-armed upholstered chairs[482] that resemble typical residential furniture to polyethylene rotationally molded[483] and sand-ballasted seating, which is now available with a less institutional look. The health care organization should select furniture appropriate for the patient population served.
2. Lockable storage cabinets and drawers should be provided, along with the means to lock phones and computers away from patients. Some organizations have a switch installed in a staff area to deactivate patient use phones at times when patients are not allowed to make calls.

Design Guide...Behavioral Health ***Edition 7.2 – April 2017*** **25**

Tag 701 Security

- Hospital must have adequate security
  - To prevent elopement or patients from leaving
  - To also prevent unauthorized access to the unit
- Must meet nationally recognized standards
  - International Association for Healthcare Security has Security Guidelines
- This includes prevention of infant abductions, pediatric patients, behavioral health patients and those with diminished capacity (dementia/Alzheimer's)
- Prevent access to non-clinical rooms such as electrical rooms, ventilation, and HVAC rooms

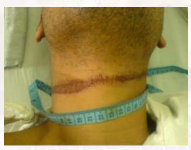
Tag 701 Ligature Risks

- Presence of unmitigated ligature risks in psych hospital or psych unit constitutes immediate jeopardy
- This includes locations where patients at risk for suicide are identified
- Ligature risk findings must be referred to the health and safety surveyors
- They will evaluate further and determine if hospital needs to be cited under tag 144 in patient rights

Weather-Related Issues & Power Strips

- Hospital must address weather related issues
  - Includes interior and exterior locations
- Includes driveways, entry points, garages, and walkways
- Any power strips deficiencies must be reported to LSC surveyors for citation
- See tag 701 for detailed discussion of power strips
- Discusses when they can be used both outside and inside the patient care area

The Joint Commission Standards on Ligature Risks



TJC Suicide Prevention

- TJC notes that suicide is the tenth leading cause of death in this country
  - Most occur outside the hospital
  - However, risk is increased for patients shortly after discharge
  - In 5 years, TJC has 85 suicides per year according to the Nov 2017 Perspectives
  - TJC has 13 rules for hospitals and added 3 for residential treatment facilities
- TJC has published 3 sentinel event alerts on inpatient suicides and recommendations
- TJC issues NPSG 15 and a FAQ

TJC Suicide Prevention Introductions

- Each observation of a ligature or suicide risk will be a requirement for improvement (RFI)
  - There must documentation to show all the required elements
- Findings of non-compliance in dedicated patients for psych patients and non-dedicated spaces will be scored at EC.02.06.01 EP 1
- **EC.02.06.01** requires hospitals to establish a safe and functional environment
- EP1 Interior spaces must meet the needs of the patient population and be suitable to care and treatment of the patients

Suicide Prevention Introductions

- RFIs of observations will be rated on the SAFER Matrix on dedicated suicidal patients
- It is rated as high because of the risk of suicide and number of occurrences
  - Limited, pattern, or widespread
  - Could be a condition level deficiency based on manner and degree
- RFI of observations is cross walked to the CMS CoPs on ligature risk (Tag 144 and 701)

Introduction

- Surveyor will discuss the observation of ligature or suicide risks to assess the hospital's awareness
- Any findings under NPSG 15 will be rated on the SAFER Matrix and may be elevated to a condition level deficiency
- TJC found that 75% of all suicides were from hanging
- Deficiencies in the plan of correction must be corrected within 60 days of the receipt of the deficiency report as discussed previously

Dedicated verses Non-dedicated Space

- **Dedicated space** needs to be ligament resistant as in: a psych hospital, psych unit of a hospital, or another space in a general hospital such as an emergency department
  - Any space in which suicidal patients are preferentially care for such as the ED
- **Non-dedicated space** and try and remove as many ligature risks as possible
  - Will need to mitigate any remaining risk for self-harm
  - Remember not only patients with psych diagnosis commit suicide but also a patient with metastatic cancer

TJC Suicide Prevention Introduction

- TJC put together a team to look at what constitutes a ligature risk and what mitigation strategies were acceptable
- The expert team had meetings; June 9, August 18, 2017, October 11, 2017, December 2017 and meetings will continue
- Recommended term "ligature resistant" rather than "ligature free"
  - Not possible to remove all potential ligature risk points
- There is a definition of ligature resistant

Suicide Risk Reduction

- Need to protect the patient from hanging or strangulation
  - Can compress the airway and interfere with blood flow in the neck depriving the brain of oxygen
  - Can also stimulate the carotid sinus reflex and cause bradycardia and hypotension
- Definition for ligature resistant:
  - Without points where a cord, rope, bed sheet, or other fabric or material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life

The 13 Rules - Perspective Nov 2017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Article

Quality and safety

November 2017 Perspectives Preview: Special Report: Suicide Prevention in Health Care Settings

Recommendations Regarding Environmental Hazards for Providers and Surveyors

Suicide is now the 10th leading cause of death in the United States. Although the vast majority of suicides occur outside of health care facilities, many suicides occur every year within health care facilities, including psychiatric hospitals, psychiatric units within general hospitals, general medical/surgical wards, and emergency departments. Most experts think that far more suicides occur shortly after hospital discharge, although conclusive national data are not available.

Since publishing *Sentinel Event Alert* issue 7, "Inpatient Suicides: Recommendations for Prevention" in 1998, The Joint Commission has worked with health care organizations on conducting rigorous risk assessments to help make their health care environment safer and prevent suicides. National Patient Safety Goal NPSG.15.01.01 was introduced in 2007 to further focus preventive efforts. However, suicides continue to occur within health care settings. Over the last five years, approximately 85 suicides per year were reported as sentinel events to The Joint Commission, leading to calls to redouble preventive efforts.

As health care organizations and accrediting bodies intensify efforts to make the health care environment safer, it is critical

www.jointcommission.org/issues/article.aspx?Article=GtNpk0ErgGF%2b7J9WOTTkXANZSEPXa1%2bKH0%2f4kGHCiio%3d

3 More Rules Residential Treatment Centers

Quality and safety
January 10, 2018

Download This Issue (PDF)

New recommendations from third expert panel on suicide prevention in health care settings

The Joint Commission has assembled four expert panels to provide guidance to customers and surveyors on safeguards to prevent suicide. The Oct. 25, 2017 issue of *Joint Commission Online* detailed 13 recommendations that were developed after the first two panels were held. Those recommendations were specific to inpatient units in both psychiatric and general acute care hospitals, as well as emergency rooms.

The third expert panel, held in October 2017, resulted in three more recommendations on the prevention of suicide in other behavioral health care settings, such as residential treatment, partial hospitalization, intensive outpatient and outpatient treatment programs. They are:

- **No. 14. These settings are not required to be ligature resistant.** For the purpose of this recommendation, ligature resistant is defined as: "Without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life."
- **No. 15. These organizations should conduct a risk assessment to identify elements in the environment that residents could use to harm themselves, visitors, and/or staff. Those items that**

Recommendations for Inpatient Psych Unit

RELIAS LEARNING

Suicide Risk Reduction

- Recommended that the following **four** inpatient psych units areas be ligature resistant
  - Patient rooms, patient bathrooms, corridors, and common patient care areas
- This includes inpatient psych unit, psych hospital, but also general/acute care settings
- Nursing stations with an unobstructed view do not need to be ligature resistant since nurse could see a patient if an attempt was made to self harm
  - Also includes self-closing or self-locking doors

Suicide Risk Reduction

- Patient rooms and patient bathrooms must have a solid ceiling and cannot contain a drop ceiling
- However, they may be a drop ceiling in the hallway or common area as long as the following exist:
  - There is no furniture in the hallway that the patient could climb up on to remove a panel and use as a ligature point
  - The hall must also be clearly visible
  - Drop ceilings should be listed on the risk assessment
  - There should be an appropriate mitigation plan

Suicide Risk Reduction

2. In the inpatient psych unit, psych hospital, and general/acute care setting:
- The doors between the patient rooms and hallways
- Must contain ligature resistant hardware
- Including but not limited to hinges, handles, and locking mechanisms



Hardware: Hinges

F. **Hardware**

1. **Hinges** – Geared-type continuous hinges are preferred for all patient-accessible areas because they minimize possible attachment points. These hinges are available with a closed-sloped top and continuous gears that resist ligature attachment.[111]

2. **Closers** – Closers are generally not required for patient room doors in most jurisdictions, but may be required for other doors. Where installed, it is suggested that track closers[100] be mounted on the corridor side of the door, away from rooms where patients will be alone or in groups.

3. **Locksets** – Use of some type of ligature-resistant lockset is recommended for all doors in patient-accessible areas. A lockset can be used for ligature attachment in three ways: pulling down, pulling up and over the top of the door, and tying something around the latch edge of the door using both the inside and outside handles (transverse). The latchbolt itself has even been used successfully as an attachment point as has the opening behind the strike plate; for this reason, a box should always be provided behind the strike plate. In our opinion, the perfect solution for this dilemma does not exist at this time. Several of the better options are discussed below.

a. Locksets with a Lever Handle[130] – These effectively

Behavioral Health Design Guide

February 2018 **Edition 7.3**

www.fgiguidelines.org/resource/design-guide-built-environment-behavioral-health-facilities/

BEHAVIORAL HEALTH DESIGN GUIDE

Formerly:
Design Guide for the Built Environment
of Behavioral Health Facilities

James M. Hunt, AIA
David M. Sine, DrBE, CSP, ARM, CPHRM

Includes REVISED Patient Safety Risk Assessment Tool to align with The Joint Commission's November 2017 Recommendations

Suicide Risk Reduction

3. In the inpatient psych unit, psych hospital, and general/acute care setting:

- The hospital is **NOT** required to have a risk mitigation device installed to decrease the chance that top of the corridor door will be used as a ligature attachment point
- Several panelist reported that a patient slipped a ligature between the corridor door and the door frame and/or hinges and committed suicide

Suicide Risk Reduction

- There are several devised to decrease the top of the door being used to fix a ligature
- Like laser beams, pressure-sensing plates, and monitoring cameras that may help prevent this
- Can cause false alarms and could distract staff
  - However, no real world studies so TJC is not requiring
- Make sure the doors are on your environmental risk assessment
- Describe your risk mitigation strategy such as rounding, monitoring by staff, leaving doors open during the day, etc.

Suicide Risk Reduction

4. In the inpatient psych unit, psych hospital, and general/acute care setting:

- The area (transition zone) between the patient room and bathroom must be ligature-resistant
- This make sense since we want a safe environment in an area the patient resides
  - Can take the door off, place an alarm on the door, or use a special door that has an angled upper door or breakaway magnetic hinges

Sentinel Event Reduction Door

- An example is a sentinel event reduction door (also called saloon doors)
- It is a door designed to prevent inpatient suicides
- There are no anchoring or hanging points on any of the four sides of the door
- ¾ inch extruded polymer resin which does not crack or splinter
- Has universal continuous hinge that can be attached to the doorframe to eliminate gaps used as anchoring points

Suicide Risk Reduction

- Staff may deny access to the bathroom unless staff is present
- Note some states do not allow modification or removal of the door due to privacy concerns
- Such as Virginia, Florida, and Massachusetts
- Surveyors will survey to their state law
- Another example is soft suicide prevention door
- It eliminates door anchor points and looks great
- Has calming artwork

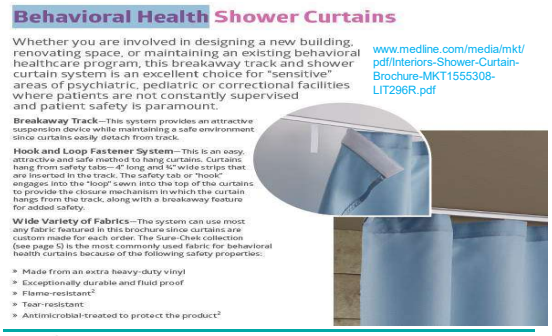
Soft Suicide Prevention Door (SSPD)

- It was developed by the VA
- It is sold by Kennon
- It has double saloon style panels
- The door hinges consist of magnets which break away
- The door hinges will pull off after 20 pounds of vertical pressure
- It has tamper resistant hardware
- Shatter proof and cleanable

Privacy Curtains

- Privacy or shower curtains should be ligature safe
- Company makes one with Velcro tabs that pull away from the curtain
- The track the curtain is on also pulls off with vertical pressure
- They are non-flammable
- Can be cleaned to hospital standards
- Be careful about vinyl/plastic shower curtains to prevent suffocation

Behavioral Health Shower Curtains



www.medline.com/media/mkt/pdf/Interiors-Shower-Curtain-Brochure-MKT1555308-LIT296R.pdf

Shower Curtains or Not?

- Note, one surveyor told a hospital they could not have any shower curtains
- One piece floor units that drain the shower to a central location would not need a curtain anymore
- New guideline says no shower curtains or their tracks of any kind are recommended in **new** construction
  - Even though they say safe or break away
- In existing hospital a soft suicide prevention door or sentinel event reduction shower door may be provided

Ceilings and Beds

In the inpatient psych unit, psych hospital, and general/acute care setting:

5. As discussed previously, the patient rooms and bathrooms must have a solid ceiling
6. Other areas, such as common patient areas and hallways can have a drop ceiling with previously mentioned precautions
7. Medical and psych needs of the patients must be assessed and balanced to determine the type of bed

Beds and Toilets

Ligature Resistant Toilet Seat

- If the patient requires a medical bed with ligature points then need mitigation plan and safety precautions

8. Standard toilet seats with a hinged seat and lid at not a significant risk for suicide attempt or self harm

- They are not to cited during the survey and do NOT need to be noted on the risk assessment
- Only one known case of a patient trying to use a toilet seat as a ligature point and no harm occurred

Fitted Sheets

Mental Health Environment of Care Checklist for Sleeping Rooms

n addition to the following criteria, sleeping rooms must also meet all General Criteria.

ues. No	ePSAT cross reference number	Site / Item	Questions / Criteria	Rationale / Assessment Methods:	Met	Partially Met	Not Met	Comments
41.3	7.2.13.2.3.03	Sheets	Are all fitted bed sheets (with elastic) removed from the units and replaced with either non-elastic fitted sheets or standard flat bed sheets?	While bed sheets themselves can be used as ligatures, bed sheets with elastic are potentially more dangerous as ligatures than bed sheets without elastic. Elastic wrapped tightly around a neck may continue to remain tight and strangle the patient, even after the patient has passed out and stopped applying tension. NOTE: This is specific to fitted sheets and is not intended to suggest that other items which generally do not have non-elastic alternatives (e.g. pajama pants, underwear, brassieres) be removed from the units. However strong consideration should be given to				Updated April 2011 See Use of elastic-hemmed fitted bed sheets in mental health units AL 11-02. http://vaww.ncps.med.va.gov/Guidelines/alerts/Docs/AL11-02Elastic-hemmedFittedBedSheets.pdf

Recommendations for the General Acute Inpatient Setting

RELIAS LEARNING

General Acute Inpatient Setting

Ligature Resistant Sinks

Ligature Resistant Doors

9. The general medical/surgical inpatient unit does **not** need to meet the same standards as in the inpatient psych unit as far as the requirement to have a ligature resistant environment
   - Fixed ligature risks will not be cited such as bathroom fixtures and doors
   - Author's note: some hospitals have a safe room on each unit for patients who are suicidal

General Acute Inpatient Setting

- Patients may have equipment to monitor their medical conditions and it is not possible to make the environment ligature-resistant
  - IV tubing, blood tubing, cardiac monitor leads, etc.
- However, the hospital must still make sure it is a safe environment
- This is discussed under the next section

10. If the patient has suicidal ideations then need to remove any objects that pose a risk for harm that aren't need for medical care

General Acute Inpatient Setting

- In addition, need to have mitigating strategies such as sitter with 1:1 monitoring
- The mitigation strategies must be documented
- Need to include to carefully assess objects brought into the room by visitors
- Look at your protocol or process for transporting patients to other areas of the hospital like radiology or physical therapy
- Need P&P on how to monitor the patient and training

General Acute Inpatient Setting

- TJC will cite ligature risk if all of the following are not routinely done:
  - Educate and train staff and make sure they are competent on how to care for a suicidal patient
  - Have 1:1 monitoring of patients with **serious** suicidal ideation
  - Do a risk assessment to determine if any objects could pose a risk for self harm and remove
    - Most hospitals remove all personal belongings of suicidal patients and put them a locked bin or locker
  - Monitor the visitors

General Acute Inpatient Setting

- TJC will cite ligature risk if all of the following are not routinely done (continued):
  - Monitor bathroom use for patient with serious suicidal thoughts
    - Many hospitals lock the bathroom when not in use
    - Staff monitor the patient when using the bathroom
  - Make sure qualified staff accompany the serious suicidal ideation patient if the patient leaves the unit

Emergency Department (ED)

11. The ED also does not need to have a ligature resistant environment as far as fixed ligature risks including bathroom fixtures and doors
12. There are 2 main ways to keep suicidal patients in the ED safe
    - Place them in a safe room that is ligature resistant and equipment that can be used as a ligature point is removed
    - Keep the patient in the ED with a 1:1 sitter and remove any objects that can be used for safe harm
    - As long as equipment is not needed for patient care

Emergency Department (ED)

- A safe room is not required although many EDs have them
- If no safe room then need to do the following:
  - Screen all patients to determine if they have suicidal ideation
    - See toolkit for doing this under the tools resources
    - Usually these are preliminary questions
    - Will discuss NPSG 15.01.01
  - Do a secondary screening to assess the risk if the patient has suicidal ideation
  - Do a risk assessment to remove any objects that pose a risk

Emergency Department (ED)

- If no safe room then need to do the following (continued):
  - Have a protocol for removing all items that could pose a risk for self-harm
    - Most remove all personal belongings and clothing and lock them up
    - Patients may be in a different color gown to readily identify them as suicidal
  - Have a protocol for how you are going to monitor the patient
  - Train staff and make sure they are competent

Emergency Department (ED)

13. Need to have 1:1 continuous monitoring with suicidal patients
- Need to allow for 360-degree viewing so can see patient anywhere in the room
- Must do continuous monitored video
  - CMS says if doing audio or video recording must be close by
- The monitoring must allow immediate intervention by a staff member if the patient is about to do self-harm

Rules 14-16 From October 25, 2017 Meeting

- The TJC expert panel had another meeting (3rd) and made the following recommendations for behavioral health settings such as residential treatment, partial hospitalization, or intensive outpatient treatment:

14. These settings are not required to be ligature resistant
15. These settings should conduct a risk assessment to identify elements in that residents could use to hurt themselves or others
  - Items with high potential to harm should be removed and placed in secure location

Quality and safety
January 10, 2018

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New recommendations from third expert panel on suicide prevention in health care settings www.jointcommission.org/issues/article.aspx?Article=YbrgRjiwegMhie9YmzI3um9h0tnbX0tYVXsukaAa1Pk=

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- **No. 15. These organizations should conduct a risk assessment to identify elements in the environment that residents could use to harm themselves, visitors, and/or staff. Those items that have high potential to be used to harm oneself or others should be removed and placed in a secure location (for example, putting sharp cooking utensils in a locked drawer) when possible. Staff should be trained to be aware of the elements of the environment that may pose a serious risk to a resident**

Rules 14-16 Residential Treatment

- Recommendations for behavioral health settings such as residential treatment, partial hospitalization, or intensive outpatient treatment:
  - Example: Sharp cooking utensils can be in locked drawer
- Staff need to be trained on things in the environment that can cause hard to a resident who has serious suicidal ideations
  - Keep resident safe until can be transferred to higher level of care
- Rule 16: Need P&Ps to address how to manage a patient who experiences increase in S&S that could result in harm to themselves or others

4th Expert Panel Meeting December 2017

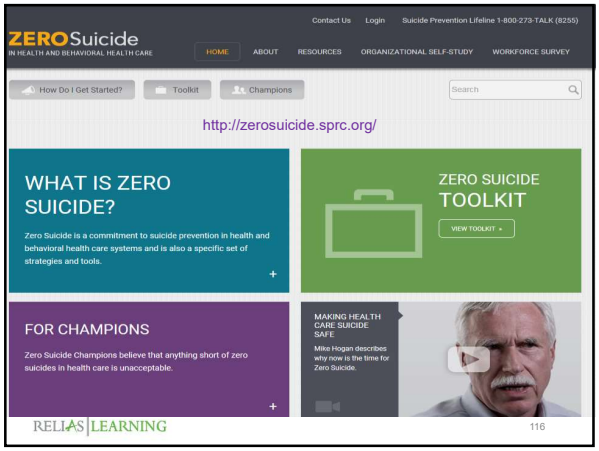
- The fourth expert panel meeting was held in December of 2017
- Focused on suicide risk assessment
- Also looked at key components on how to safely monitor high risk patients
- Recommendations will be added to the list
- March 14, 2018 JC Online reported that the panel is looking to see if NPSG 15 should be revised

Zero Suicide Campaign

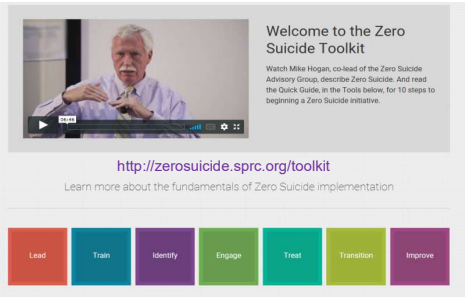
achieving zero suicide

Zero Suicide Campaign

- Zero suicide is a proposition that suicide deaths in patient within the healthcare setting are preventable
  - It is an aspirational challenge to improve care and outcomes for patients at risk
- There are 10 steps to beginning a zero suicide initiative
- Want to make healthcare suicide safe
- Free video that summarized the campaign
- Need to focus on patients who are suicidal
- 40,000 die every year from suicide



10 Steps to Zero Suicide



Zero Suicide Campaign

- We fail to ask patients if they are suicidal especially in mental health facilities
- We don't follow up when they are in transition and the patient sometimes falls between the cracks
- Half of those who die from suicide saw a primary care physician within the last 30 days
- Introduce psych nurse and social workers in primary care offices
- It is both a concept and a practice

Zero Suicide Campaign

- It is a framework for systematic, clinical suicide prevention
- Includes a set of best practices
- www.zerosuicide.com has many resources and tools

TJC Ligature Risk FAQ

Ligature Risk FAQ

- TJC has a frequently asked question on ligature risks
- Talks about how to assess and mitigate risk for suicide and self harm
- Pertains to psych hospitals, the behavioral health department of a hospital, and patients who are suicidal on a non-behavioral health unit such as the ED or medical units
- All TJC hospitals should be aware of this
- Available at www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=1525&StandardsFAQChapterId=64&ProgramId=0&ChapterId=0&IsFeatured=False&IsNew=False&Keyword=ligature

Ligature Risk FAQ

- References EC.02.06.01 that requires hospitals to establish and maintain a safe environment
- Interior spaces need to meet the needs of the patients and have to be safe
- Therefore, ligature risks need to be identified and eliminated
- Need to implement policies
- Need to mitigate risks identified
- Leadership and staff need to be aware of the current risks

Ligature Risk FAQ

Environment of Care (EC) (Hospital and Hospital Clinics / Hospitals)

Ligature Risks - Assessing and Mitigating Risk For Suicide and Self-Harm
What are the Joint Commission expectations for identifying and managing ligature risks in the hospital setting?

For inpatient psychiatric hospitals, inpatient psychiatric units in general acute care hospitals, and non-behavioral health units DESIGNATED for the treatment of psychiatric patients (i.e. special rooms/safe rooms in Emergency Departments or Medical Units):
The requirements found in the Environment of Care (EC) chapter of the accreditation manual at EC.02.06.01 require hospitals to establish and maintain a safe, functional environment. Element of Performance # 1 states "Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided". Therefore, ligature and self-harm risks must be identified and eliminated. While risks are in the process of being eliminated, policies and procedures must be developed and implemented to mitigate the harm posed by such risks. Mitigation plans must include, at a minimum the following:

- Ensuring that leadership and staff are aware of the current environmental risks
- Identifying patients' risk for suicide or self-harm, then implement appropriate interventions based upon risk.
- Ongoing assessments and reassessments of at-risk behavior as defined by the organization.
- Ensuring the proper training of staff to properly identify patients' level of risk and implement appropriate interventions
- Incorporating suicide risk and self-harm reduction strategies into the overall Quality Assessment/Performance Improvement (QAPI) program - see LD.01.03.01 EP 21.
- If equipment poses a risk but is necessary for the safe treatment of psychiatric patients (i.e. medical beds with side rails on a geriatric unit), the organization must consider these risks in patients' overall suicide/self-harm risk assessments, then implement appropriate interventions to diminish those risks

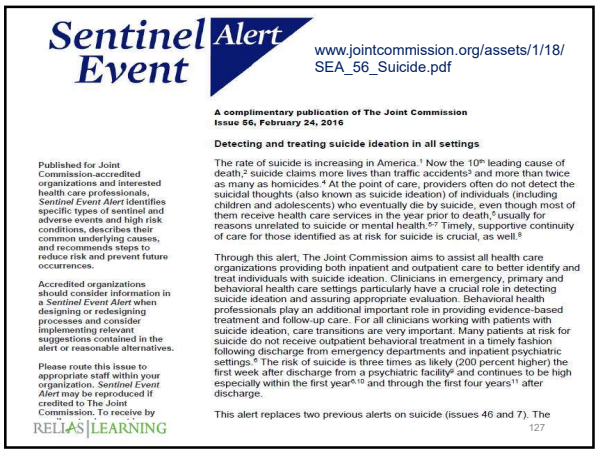
Ligature Risk FAQ

- Need to do an assessment so you know what patients are at risk
- Need to reassess at-risk patients
- Need to make sure staff are trained and educated to identify who is at risk and to implement safety precautions
- Suicide risk and self harm should be part of the QAPI program
  - See LD.01.03.01 EP 21

TJC Issues SEA 56 on Detecting and Treating Suicidal Ideation

TJC Sentinel Event Alert on Suicide

- TJC has actually published 3 SEAs on suicide
- SEA 56 was issued February 24, 2016
  - It replaces the two previous ones; issues 7 and 46
  - Is 7 pages long
- TJC notes that suicide is the 10th leading cause of death
- Most of those who died had received healthcare within 1 year but providers did not identify suicidal ideation
- Clinicians and staff have a role in detecting if the patient is suicidal in the ED, primary care and BH care



Sentinel Event Alert

www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf

A complimentary publication of The Joint Commission
Issue 56, February 24, 2016

Detecting and treating suicide ideation in all settings

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may be reproduced if credited to The Joint Commission. To receive by

The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[6,7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[9] The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility[9] and continues to be high especially within the first year[9,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The

RELIAS | LEARNING

127

TJC Sentinel Event Alert on Suicide

- Risk of suicide is 200% higher the first week after discharge from a BH facility
- Continues to be high the first year and for 4 years after
- One hospital does universal screening of all patients and found 1.5% at high suicidal risk and 4.5% at moderate risk
- Who is at risk for suicide
  - Men over 45, vets, mental or emotional disorders (especially bipolar and depression), previous suicide attempts, self inflicted injury, history of trauma or loss

RELIAS | LEARNING

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TJC Sentinel Event Alert on Suicide

- Who is at risk for suicide (continued)
  - Serious illness, chronic pain or impairment, alcohol or drug abuse (now called substance use disorder), social isolation, history of aggressive or antisocial behavior, and access to lethal means along with suicidal thoughts
- RCA shows that most common problem was the assessment
  - Need to conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide
  - A suicide lethality scale can measure the degree of lethality of suicide attempts such as a 11 point scale

RELIAS | LEARNING

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TJC Sentinel Event Alert on Suicide

- Healthcare facilities should identify, develop and integrate comprehensive behavioral health, primary care and community resources for patients at risk for suicide
- Review all patient's medical history for suicidal risk factors
- Use an evidenced based, brief screening tool to screen all patients for suicidal ideation
  - Mentions PHQ-9, PHQ-2, ED-SAFE Patient Safety Screener and Suicide Behaviors Questionnaire-Revised ((SBQ-R) which are discussed later

TJC Sentinel Event Alert on Suicide

- Review the questionnaire before the patient leaves or is discharged
  - Patient may need to be referred for secondary screening to get additional information
  - Mentions ED-Safe Secondary Screener, Columbia-Suicide Severity Rating Scale (C-SSRS) and the Suicide Prevention Resources Center's Decision Support Tool
  - Discussed below
- Take immediate action so don't leave suicidal patient sit in the ED lobby unattended-keep patients in safe environment under 1:1 observation

TJC Sentinel Event Alert on Suicide

- Check patients and visitors in acute suicidal crisis to make sure nothing can be used to harm them
- Patients at low risk of suicide can have outpatient visit within one week
- All patients with suicidal ideation should be given phone number for National Suicide Prevention Lifeline at 800 273-8255
- Conduct safety planning
- Restrict access to lethal means
- Develop discharge plans to target suicidality

TJC Sentinel Event Alert on Suicide

- Engage family and significant others in discharge planning to promote effective coping strategies
- Education staff on how to identify and respond to suicidal patient
- TJC mentions a number of resources in education and make sure it covers environmental risk factors
  - See next 3 slides for recommendations
- Document decision regarding the care and referral of the patient

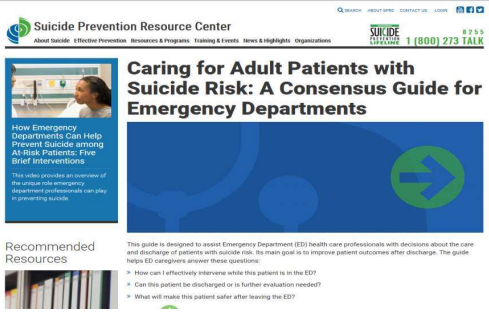
Suicide Prevention - 64 Pages

Suicide Prevention and the Clinical Workforce: Guidelines for Training

http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Guidelines.pdf

Prepared by the
Clinical Workforce Preparedness Task Force
of the National Action Alliance for Suicide Prevention
October 2014

Suicide Prevention Resource Center



www.sprc.org/edguide?sid=48235

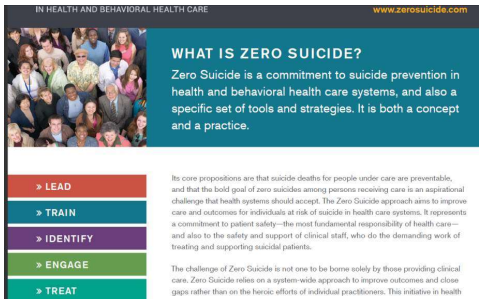
VA/DoD CPG Suicidal Patients

VA/DoD CLINICAL PRACTICE GUIDELINE FOR
ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE

Department of Veterans Affairs
Department of Defense

www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf

Zero Suicide



http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/What%20is%20Zero%20Suicide.pdf

Joint Commission National Patient Safety Goal (NPSG) on Patient Suicide Risk

15. Patient Suicide Risk NPSG.15.01.01

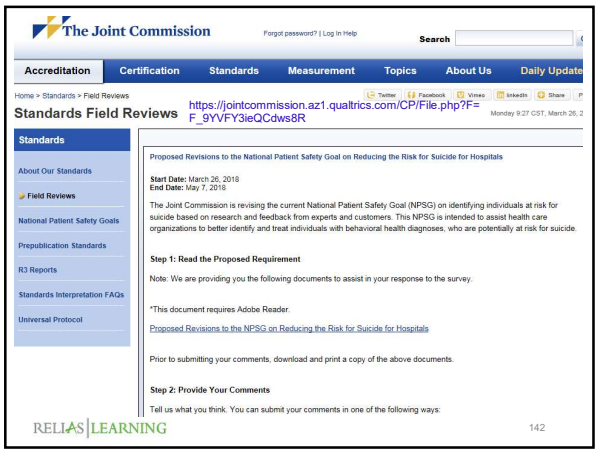
- Goal 15 States the hospital identifies safety risks inherent in its patient population
- The hospital needs to identify patients at risk for suicide
- Only 1 left of 2 standards and has 3 EPs
- Remember TJC Sentinel Event issued
- This section only applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals

Patient Suicide Risk

1. Risk assessment must be conducted that includes factors that increase or decrease the risk for suicide
2. Need to address the immediate safety needs of a suicidal patient and the most appropriate setting
3. Must provide information to patient and family at risk for suicide when they leave the hospital such as a crisis prevention hotline

Proposed Changes NPSG 15

- TJC proposed changes to NPSG 15 for hospitals and behavioral health units on March 26, 2018
- EP 1 Applies to all hospitals
  - Identify and take action to minimize things in the hospital environment that could be used to attempt suicide as part of the hospital's environmental risk assessment
- EP 2-8 Applies only to patients in psych hospitals and patients whose primary diagnosis is for a behavioral health condition
  - EP 2 Screen all patients for suicidal ideation who are being treated when evaluated for a behavioral health issue



Proposed Changes NPSG 15

- EP 2 (continued) Must use a validated screening tool
- EP3 If the patient is positive for suicidal ideation during the initial screen, then use an evidenced based process to conduct a suicidal assessment
- EP4 The patient's overall risk for suicide must be documented
  - Document the plan to mitigate the risk for suicide
- EP5 Need to follow P&Ps that contain, at a minimum the following three things:

Proposed Changes NPSG 15

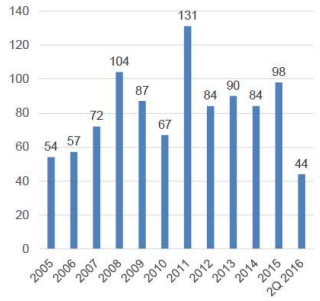
- EP 5 (continued) P&P on the following:
  - Training and competence of staff who care for suicidal patients
  - Guidelines for reassessment
  - Monitoring patients who are at high risk for suicide
- EP 6 Need to have P&P and follow them for counseling and follow up care
  - This is when patients at risk for suicide are discharged
- EP 7 P&Ps for screening, assessment and management of suicidal patients need to be monitored for implementation and effectiveness

Suicide Risk

- Suicide ranks as the 10th most frequent cause of death (3rd most frequent in young people) in the United States
- With one person dying from suicide every 16.6 minutes
- Suicide of a care recipient while in a staffed, round-the-clock care setting has been the #2 most frequently reported type of sentinel event
  - For data through July 19, 2017 there were 13,346 reports which is about 10.0% of all reports

Patient Suicide

Suicide is the 10th leading cause of death in the United States and continues to be consistently among the most frequently reviewed Sentinel Events reviewed by The Joint Commission.



Patient Suicide

- Identification of individuals at risk for suicide while under the care of or following discharge from a facility is an important first step in protecting and planning the care of these at-risk individuals
- Applies to all patients in the behavioral health unit
- Applies to any patient in the hospital if their primary diagnosis or primary complaint (DSM diagnosis) is of an emotional or behavioral disorder
- Gives a number of examples since initially gave contradictory information on scope of this NPSG

General Hospitals

- Identify patients at risk
- Patient seen in ED for fracture sustained in act of attempting suicide, admission risk assessment not required by TJC because you know the patient is suicidal but as recovers would need to assess degree of ongoing risk for suicide
- Patient admitted ICU for detoxification, but again as patient recovers may determine underlying problem
- Patient admitted to OB in active labor and has history of severe post partum depression after last child, same

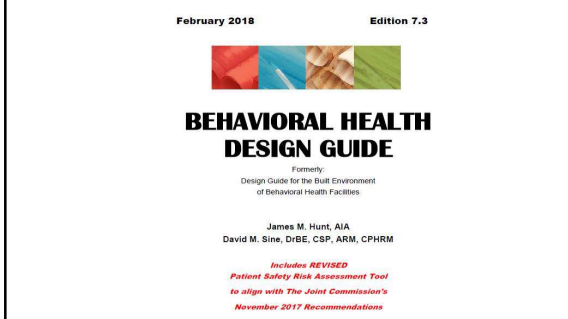
Patient Suicide

- Assess patients at triage and admission and ask if patient has any thoughts about injuring himself or others
- Use sitters for patients at risk
- Have safe room for suicidal patients, especially those admitted outside the behavioral health unit
- Do a FMEA on suicidal patients
- Do assessment of the facility for safety as above
- Don't have to have own crisis hotline just information on how to access one

Patient Suicide

- Guidelines for the Built Environment of Behavioral Health Facilities at http://fgiguidelines.org/beyond.php
  - Now called Behavioral Health Design Guide
- Be sure to do an assessment of the environment to ensure there are safe rooms
- Education for nurse on risk of suicidal patients
- Policy on same

Behavioral Health Design Guide



www.fgiguidelines.org/resource/design-guide-built-environment-behavioral-health-facilities/

Tools of the Trade

Design Guild for BH Facilities

- This is an important resource
- It is 114 pages long
- Updated frequently
- Includes a helpful patient safety risk assessment tool
  - To facilitate conversation between clinical staff and the designers regarding patient safety
- Tool helps to comply with CMS tag number 701 and the TJC EC standards

Behavioral Health Design Guide

February 2018 Edition 7.3

BEHAVIORAL HEALTH DESIGN GUIDE

Formerly:
Design Guide for the Built Environment of Behavioral Health Facilities

James M. Hunt, AIA
David M. Sine, DrBE, CSP, ARM, CPHRM

Includes REVISED Patient Safety Risk Assessment Tool to align with The Joint Commission's November 2017 Recommendations

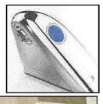
www.fgiguidelines.org/resource/design-guide-built-environment-behavioral-health-facilities/

BH Design Guild

- Explain how to create safe rooms to prevent ligature risk and suicide
- Hospital is at risk for receiving a deficiency from CMS or a requirement for improvement (RFI) if the surveyors observes ligature or self-harm risks
- First published by NAPHS (National Association of Psychiatric Health Systems) in 2003
  - Questions contact David Sine at dsine9@gmail.com
- Document to help hospitals and other facilities to think about how physical design affects patient and staff safety

Design Guild for BH Facilities

10. **Lavatory and Sink Faucets and Valves** – Faucets and valves can provide attachment points for ligatures. A lavatory valve unit is now available that uses a shower valve fitted with a ligature-resistant handle[574] to allow patients to control the temperature (thermostatically limited to prevent scalding) and duration of the water flow. This valve can be used to replace the motion sensor activation of some faucets. Faucets are available in a variety of materials and configurations that range from push-button to motion sensor-activated.[570]



11. **Lavatory Waste and Supply Piping** – All piping of this type must be enclosed so it is not accessible to patients.[410] Extreme care should be taken to trim the enclosing material so it fits tightly to the underside of the lavatory fixture to prevent the patient from using this space to hide contraband.

Design Guild for BH Facilities

Level V-b. Seclusion Rooms

Seclusion rooms are required by the FGI *Guidelines* to be no less than 7 feet wide and no greater than 11 feet long to avoid providing enough space for a patient to get a running start at the opposite wall. They should be designed to minimize blind spots where patients cannot be observed by staff without entering the room. A minimum ceiling height of 9 feet is preferred. The distance of the seclusion room from the nurse station needs to be considered. The goal is to avoid excessive distance so staff can be readily available as needed. The seclusion room door should open directly into an anteroom to separate these activities from other patients and give the patient access to a toilet without entering the corridor.

A. **Floor** – Continuous sheet vinyl with foam backing and heat-welded seams[272] or padded flooring to match wall padding, if used

Patient Health Questionnaire PHQ-9

- This is a patient depression questionnaire
- PHQ-9 used in primary care practices and asks 9 things
- Some use a shorter version, the PHQ-2, and if yes to either question then go to the PHQ-9
- Used for quick depression assessment
  - Score of 1-4 minimal depression
  - Score 5-9 mild depression
  - Score 10-14 moderate depression
  - Score 15-19 moderately severe depression
  - Score 20-27 severe depression
- www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf

Patient Health Questionnaire PHQ-9

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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	0	1	2	3
2. Feeling down, depressed, or hopeless	0	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	0	1	2	3

ED-SAFE Screener

- Patient Safety Screener (PSS-3) is a 2 page tool
- Used by the nursing during the primary nursing assessment and in the ED
- A positive screen is a yes to either SI (suicidal ideation) in the past 2 weeks or life time history of SA (lifetime attempts)
  - Available at http://www.emnet-usa.org/ED-SAFE/materials/K_PtSafetyScreen.pdf

References

Boudreaux, E. D., Jaques, M. L., Brady, K. M., Matson, A., & Allen, M. H. (2015a). The Patient Safety Screener: validation of a brief suicide risk screener for emergency department settings. *Archives of Suicide Research*, *19*(2), 151-160.

Boudreaux, E. D., Camargo, C. A., Arias, S. A., Sullivan, A. F., Allen, M. H., Goldstein, A. B., ... & Miller, I. W. (2015b). Improving suicide risk screening and detection in the emergency department. *American Journal of Preventive Medicine*, *50*(4), 445-453.

ED-SAFE Screener PHQ-2

Patient Safety Screener

To be administered by primary nurse during primary nursing assessment.

Introductory script: Now I'm going to ask you some questions that we ask everyone treated here, no matte what problem they are here for. It is part of the hospital's policy and it helps us to make sure we are not missing anything important.

PHQ-2: Over the past 2 weeks,	Interpretation
1. . . . have you felt down, depressed, or hopeless? ☐ Yes ☐ No	Depressed mood
2. . . . have you felt little interest or pleasure in doing things? ☐ Yes ☐ No	Anhedonia
C-SSRS, Ideation: Over the past 2 weeks,	
1. . . . have you wished you were dead or wished you could go to sleep and not wake up? ☐ Yes ☐ No	Passive ideation,
2. . . . have you had thoughts of killing yourself? ☐ Yes ☐ No	At least active ideation, general thoughts without thoughts of ways, intent, or plan
C-SSRS, Behavior: In your lifetime,	
1. . . . have you ever attempted to kill yourself? ☐ Yes ☐ No	Lifetime attempt
2. . . . When did this happen? ☐ Today ☐ Within the last 30 days (but not today)	If within the last 6 months considered recent attempt

ED-SAFE Screener PHQ-3

Scoring and interpretation

	Interpretation
Over the past 2 weeks,	
1. …have you felt down, depressed, or hopeless?	Depressed mood
2. …have you had thoughts of killing yourself?	Active suicidal ideation (SI)
In your lifetime,	
3. … have you ever attempted to kill yourself? When did this happen?	Lifetime attempt (SA) If within the last 6 months, considered recent attempt

Patient Safety Secondary Screener

- This ED-SAFE Patient Safety Secondary Screener tool is used to determine what should be done when the patient has a positive screen on the Patient Safety Screener
  - Should that patient be seen by a mental health professional?
- The patient has active suicidal ideation or a recent suicide attempt within 6 months
- If yes on the items then the physician should be a mental health consult
- There are 6 questions

A "Yes" on any of the items below means the treating physician should consider consulting a mental health professional.

1. Did the patient screen positive on both PSS items – active ideation with a past attempt?
Source: PSS screener completed by primary nurse, documented on chart.

☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete

2. Has the individual begun a suicide plan?
Source: Use patient self report, collateral information
Suggested wording: Have you been thinking about how you might kill yourself?

☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete

3. Has the individual recently had intent to act on his/her ideation?
Source: Use patient self report, collateral information
Suggested wording: Have you had some intention of acting on your thoughts?

http://emnet-usa.org/ED-SAFE/materials/Patient%20Safety%20Screener_secondary_5-18-12%20FINAL.pdf

☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete

4. Has the patient ever had a psychiatric hospitalization?
Source: Use patient self report, collateral information, medical records review
Suggested wording: Have you ever been hospitalized for a mental health or substance use problem?

☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete

5. Does the patient have a pattern of excessive substance use?
Source: Use patient self report, collateral information, medical records review
Suggested wording: Has drinking or drug abuse ever been a problem for you? Or administer CAGE or other standardized substance use screener.

☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete

6. Is the patient irritable, agitated, or aggressive?
Source: Use current observations, collateral information, medical records review
☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete

ED: Suicide Behaviors Questionnaire SBQ-R

- This is a psychology self-report questionnaire that is designed to identify risk factors for suicide in children and adolescents
- Between the ages of 13 and 18
- The 4 question test is filled out by the child and takes about 5 minutes
- It ask about future anticipation of suicidal thoughts
  - Each of the 4 questions address a specific risk factor; suicidal thoughts and attempts, frequency of suicidal thoughts, threat level of suicidal attempts, and likelihood of future suicidal attempts

ED: Suicide Behaviors Questionnaire SBQ-R

The Suicide Behaviors Questionnaire-Revised (SBQ-R) - Overview

The SBQ-R has 4 items, each tapping a different dimension of suicidality:[1]

- Item 1 taps into lifetime suicide ideation and/or suicide attempt.
- Item 2 assesses the frequency of suicidal ideation over the past twelve months.
- Item 3 assesses the threat of suicide attempt.
- Item 4 evaluates self-reported likelihood of suicidal behavior in the future.

Clinical Utility

Due to the wording of the four SBQ-R items, a broad range of information is obtained in a very brief administration. Responses can be used to identify at-risk individuals and specific risk behaviors.

Scoring

See scoring guideline on following page.

Psychometric Properties[1]

	Cutoff score	Sensitivity	Specificity
Adult General Population	≥7	93%	95%
Adult Psychiatric Inpatients	≥8	80%	91%

https://integration.samhsa.gov/images/res/SBQ.pdf

SBQ-R - Scoring

Item 1: taps into *lifetime* suicide ideation and/or suicide attempts			
Selected response 1	Non-Suicidal subgroup	1 point	
Selected response 2	Suicide Risk Ideation subgroup	2 points	
Selected response 3a or 3b	Suicide Plan subgroup	3 points	_____
Selected response 4a or 4b	Suicide Attempt subgroup	4 points	Total Points

Item 2: assesses the *frequency* of suicidal *ideation* over the past 12 months			
Selected Response:	Never	1 point	
	Rarely (1 time)	2 points	
	Sometimes (2 times)	3 points	
	Often (3-4 times)	4 points	_____
	Very Often (5 or more times)	5 points	Total Points

Item 3: taps into the *threat of* suicide *attempt*		
Selected response 1	1 point	
Selected response 2a or 2b	2 points	
Selected response 3a or 3b	3 points	_____ Total Points

Item 4: evaluates *self-reported likelihood* of suicidal behavior in the future			
Selected Response:	Never	0 points	
	No chance at all	1 point	
	Rather unlikely	2 points	
	Unlikely	3 points	
	Likely	4 points	
	Rather Likely	5 points	_____
	Very Likely	6 points	Total Points

Sum all the scores circled/checked by the respondents.
The total score should range from 3-18.

_____
Total Score

Environmental Assessment

Life Safety Bldgs
Lay-in acoustical type ceiling tiles
Recessed fire sprinkler heads.
Recessed or non-weight bearing smoke detectors
Fire extinguisher boxes secured
Fire alarm pull stations secured
Appropriate staff access to BH space (keys, card-reader, elevator, etc.)
Electrical outlets GFCI (ground fault circuit interrupter) and tamper resistant
Metal outlet covers been replaced with shatter-proof non-conductive covers

Interior Spaces- Pt. Room
Window openings limited so that person cannot pass through (architectural standard is 4-6 inches)
Protection of patient room windows with a security screen, with security device
Metal outlet covers with shatter-proof non-conductive covers
Shatter-proof and tamper-resistant glass used in night lights and other lighting fixtures
Light fixtures secured to restrict patient access to bulbs and sockets
Lavatory faucets tamper-resistant
Grab bars been removed in the bathroom or wall "gaps" filled in

Protection of patient room windows with a security screen, with security device
Metal outlet covers with shatter-proof non-conductive covers
Shatter-proof and tamper-resistant glass used in night lights and other lighting fixtures
Light fixtures secured to restrict patient access to bulbs and sockets
Lavatory faucets tamper-resistant
Grab bars been removed in the bathroom or wall "gaps" filled in
Coat hooks, towel bars, cubicle curtain tracks, and closet poles eliminated to reduce potential ligature
Piping for the toilet and lavatory protected

Interior Spaces- Pt. Room
Tamper-resistant shower controls and shower heads
Cords on window treatments or blinds removed to decrease ligature or strangulation
HVAC (heating, air, vents) grills tamper-resistant
All room door hinges and handles assessed with regard to potential barricade situations
Mirror and picture glazing material considered shatter-proof
Clothing, including belts & shoes with laces secured
Tamper-resistant, anti-ligature door knob for the patient's room, patient bathroom

Environmental Assessment

- There are a number of environmental summary tools that are available
- A nice summary of what to do and look for
- Looks at common areas
  - Grab bars removed, faucets and shower controls are tamper resistant, no towel bars or coat hooks, no plastic trash bags, etc.
- Looks at life safety issues of the building and how the patient room is designed
  - No cords on blind, assessment of door hinges, no belts, no shoe laces, tamper resistant , anti-ligature door knob, shatter proof mirrors,
- www.courtemanche-assocs.com/suicide-prevention-ligature-risks/

SAD PERSONS Scale

- It was first developed as an assessment tool to determine suicide risk
- There is also an adapted or modified SAD PERSON scale
- Score is calculated from ten yes or no questions
- It is an acronym to be used as a mnemonic device
- Has been widely implemented in clinical settings
- Study in 2017 done since said it had **limited** supporting evidence and found their findings do not support the use of the SPS and Modified SPS to predict suicide in adults seen by psych services in the ED
  - Predicting Suicide with the SADS PERSONS scale at http://onlinelibrary.wiley.com/doi/10.1002/da.22632/abstract

SAD PERSONS

- **S**: Male sex
- **A**: Age (<19 or >45 years)
- **D**: Depression
- **P**: Previous attempt
- **E**: Excess alcohol or substance use
- **R**: Rational thinking loss
- **S**: Social supports lacking
- **O**: Organized plan
- **N**: No spouse
- **S**: Sickness

This score is then mapped onto a risk assessment scale as follows:

- 0–4: Low
- 5–6: Medium
- 7–10: High

Modified SAD PERSON Scale

- S: Male sex → 1
- A: Age 15-25 or 59+ years → 1
- D: Depression or hopelessness → 2
- P: Previous suicidal attempts or psychiatric care → 1
- E: Excessive ethanol or drug use → 1
- R: Rational thinking loss (psychotic or organic illness) → 2
- S: Single, widowed or divorced → 1
- O: Organized or serious attempt → 2
- N: No social support → 1
- S: Stated future intent (determined to repeat or ambivalent) → 2

This score is then mapped onto a risk assessment scale as follows:

- 0–5: May be safe to discharge (depending upon circumstances)
- 6-8: Probably requires psychiatric consultation
- >8: Probably requires hospital admission

C-SSRS Columbia Suicide Severity Rating

- The Columbia Suicide Severity Rating Scale is a tool used in the outpatient behavioral health setting
- It looks at identifiable suicide attempts
- It assesses full range of evidence-based ideation and behavior
- There are 3 versions of the tool
  - Lifetime/Recent version allows practitioners to gather lifetime history of suicidality as well as any recent suicidal ideation and/or behavior
  - Since the last visit and screener version is shortened form of the full version

Columbia Suicide Severity Rating Scale

- Referred to as the gold standard as identified by the FDA for clinical trials
  - Asks five questions
- The SAMSHA SAFE-T risk assessment tool with C-SSRS questions are embedded
- Obtains a past psychiatric history and family history of suicide
  - Asks about stressor such as legal problems
  - Asks about things like impulsivity, hopelessness, insomnia, and anhedonia (lost interest in things they use to enjoy and decreased ability to feel pleasure)

Columbia Suicide Severity Rating Scale

SAFE-T Protocol with C-SSRS - Recent

Step 1: Identify Risk Factors	
C-SSRS Suicidal Ideation Severity	**Month**
1) **Wish to be dead** *Have you wished you were dead or wished you could go to sleep and not wake up?*	
2) **Current suicidal thoughts** *Have you actually had any thoughts of killing yourself?*	
3) **Suicidal thoughts w/ Method** (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	
4) **Suicidal Intent without Specific Plan** *Have you had these thoughts and had some intention of acting on them?*	
5) **Intent with Plan** *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*	
C-SSRS Suicidal Behavior: *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If "YES" Was it within the past 3 months?	**Lifetime** **Past 3 Months**
Current and Past Psychiatric Dx: □ Mood Disorder □ Psychotic disorder	**Family History:** □ Suicide □ Suicidal behavior

Risk Stratification

RISK STRATIFICATION	TRIAGE
High Suicide Risk Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **Or** Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	□ **Initiate local psychiatric admission process** □ **Stay with patient until transfer to higher level of care is complete** □ **Follow-up and document outcome of emergency psychiatric evaluation**
Moderate Suicide Risk Suicidal ideation with method, **WITHOUT plan, intent or behavior in past month** (C-SSRS Suicidal Ideation #3) **Or** Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) **Or** Multiple risk factors and few protective factors	□ **Directly address suicide risk, implementing suicide prevention strategies** □ **Develop Safety Plan**
Low Suicide Risk Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) **Or** Modifiable risk factors and strong protective factors **Or** □ No reported history of Suicidal Ideation or Behavior	□ **Discretionary Outpatient Referral**

SAFE-T

- The Suicide Assessment Five Step Evaluation and Triage was developed with the Suicide Prevention Resource Center
- Also with the Screening for Mental Health
  - Used by mental health professionals
  - Information on the SAMSHA website
- Looks at risk factors; suicidal behavior (history, aborted attempts or self-injurious behavior), access to firearms, family history of suicide, key symptoms (hopelessness, anhedonia, impulsiveness, anxiety/panic, insomnia, and command hallucinations)
- Has 3 risk levels; high, moderate, or low
  - www.integration.samhsa.gov/images/res/SAFE_T.pdf

SAFE-T Assessment

Pocket Card or Mobile App Available

SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians

Suicide Safe mobile app based on the SAFE-T is available on the app stores now!

Average Rating: 4 out of 70 ratings.
Rate!
Comments

Price: FREE (shipping charges may apply)

This resource gives a brief overview on conducting a suicide assessment using a five-step evaluation and triage plan. The five-step plan involves identifying risk factors and protective factors, conducting a suicide inquiry, determining risk level and interventions, and documenting a treatment plan. Download SAMHSA's Suicide Safe mobile app on your mobile device.

Like https://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-Pocket-Card-for-Clinicians/SMA09-4432

Pub id: SMA09-4432

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Guidelines or Manual - In Stock

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Download Digital Version

SAFE-T Card (PDF, 162 KB)

Learn about the Suicide Safe Mobile App (HTML)

Suicide Safe mobile app on Google

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and recent onset of illness increase risk
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis I psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g. loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious. Explore ambivalence: reasons to die vs. reasons to live

** For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition

** Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

RELIAS LEARNING 181

Suicide Prevention Decision Support Tool

- The Suicide Prevention Resources Center's Decision Support Tool was also mentioned in the TJC SEA
- It is for EDs in the care of adult patients with suicide risk
- Discusses scheduling an outpatient appointment within 7 days
- Ask if access to **firearms** or other lethal means (prescriptions)
- Brief patient education on follow up recommendations

RELIAS LEARNING 182

Suicide Prevention Decision Support Tool

- Follow up with all discharged patients such as emails, letters, phone calls, or text messages
- Provide information on when patient needs to return to the ED
- Give crisis center phone number
- Has 6 transitional questions: thought of carrying out a plan, suicide intent, significant mental health condition, substance use disorder, or irritability/agitation/ aggression

RELIAS LEARNING 183

NY Patient Safety Standards Guidelines

- An excellent resource is put out by the NY Office of Mental Health patient safety guidelines
  - 205 pages and shows companies that supply ligature resistant products
  - The purpose is to provide hospitals with a selection of materials, fixtures, and hardware to use in areas with patients at risk for self-harm
  - Goal is to reduce risk of suicide and self-harm for patients when admitted to hospitals
  - Products represent style and properties to reduce risk
  - Does not endorse any product like the VA or TJC

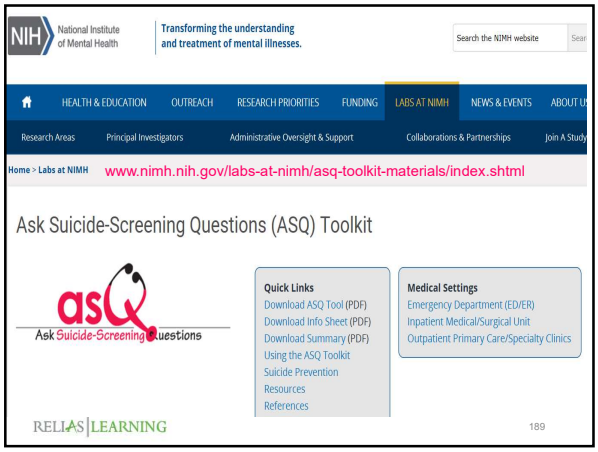
RELIAS LEARNING 185

NY Patient Safety Standards Guidelines

- Need a multi-directed approach to reduce risk and it included the following:
- Completion of patient risk assessments.
- Completion of physical plant risk assessments.
- Ongoing staff training to ensure their awareness of potential risks on the unit.
- Installation of risk reduction products in patient bathrooms, bedrooms and other high risk areas.
- Routine inspections of psychiatric units to ensure safety levels are maintained.

ASQ Ask Screening Questions

- National Institute of Mental Health came up with simple 4 question survey for identify at-risk youths
- The Ask Suicide-Screening Question Toolkit is free
- Can be used in a variety of settings including the ED, outpatient clinics, primary care offices
- Available in many languages
- Easy to use
- Must have follow up plan in place in the event the patient answers yes to any of the questions



NIMH TOOLKIT

asQ Suicide Risk **Screening Tool**

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

RELIAS LEARNING 190

Next Steps

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

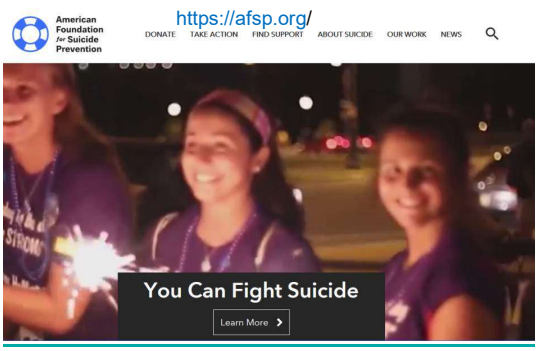
asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 6/13/2017

RELIAS LEARNING 191

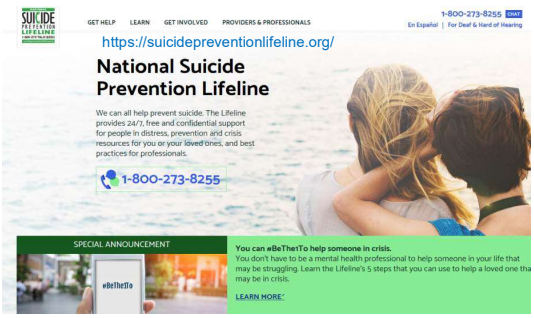
Resources

RELIAS LEARNING

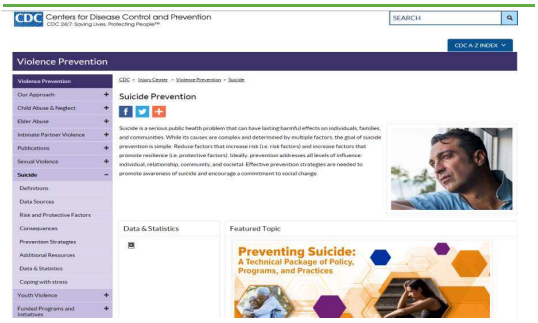
American Foundation for Suicide Prevention



National Suicide Prevention Lifeline

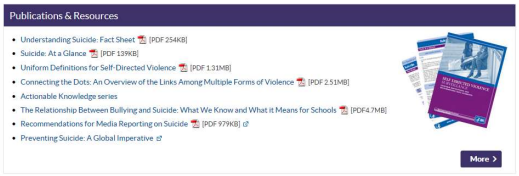


CDC Suicide Prevention Website

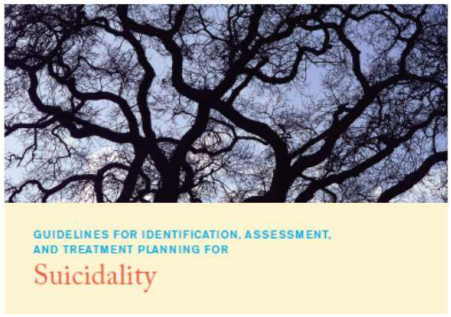


www.cdc.gov/violenceprevention/suicide/index.html

CDC Resources on Suicide



Crico Guidelines and Assessment



Has Section on Risk Factors for Suicide

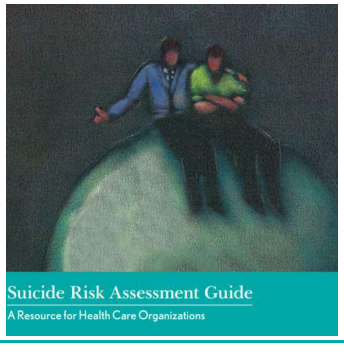
UNDER 30 (ADOLESCENTS AND YOUNG ADULTS)

1. Family history of suicide
2. Males > females
3. History of previous attempts
4. Native American
5. Psychiatric diagnosis: mood disorders and substance abuse
6. White > black
7. Mini-epidemic in community
8. History of delinquent or semi-delinquent behavior even without depression in current mental state.
9. Presence of firearms *(when other factors are present)*

OVER 30

1. Family history of suicide
2. Males > females
3. History of previous attempts
4. Native American
5. Psychiatric diagnosis: mood disorder, schizophrenia, alcoholism
6. Single: especially separated, widowed, or divorced
7. Lack of social supports
8. Concurrent medical illness(es)
9. Unemployment
10. Decline in socioeconomic status
11. Psychological turmoil

Suicide Risk Assessments Guide 132 Pages



The End! Questions???

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THANK YOU