

National Patient Safety Goal – Suicide Prevention

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Objectives

1. Identify suicide risks as reflected in Joint Commission sentinel event data
2. Review Joint Commission survey findings specific to suicide risk including ligatures
3. Discuss NPSG 15 requirements - effective July 1, 2019
4. Develop a plan for evaluating organization risk according to NPSG 15 requirements

Mission and Vision of The Joint Commission

VISION AND MISSION OF THE JOINT COMMISSION

Vision

All people always experience the safest, highest quality, best-value health care across all settings.

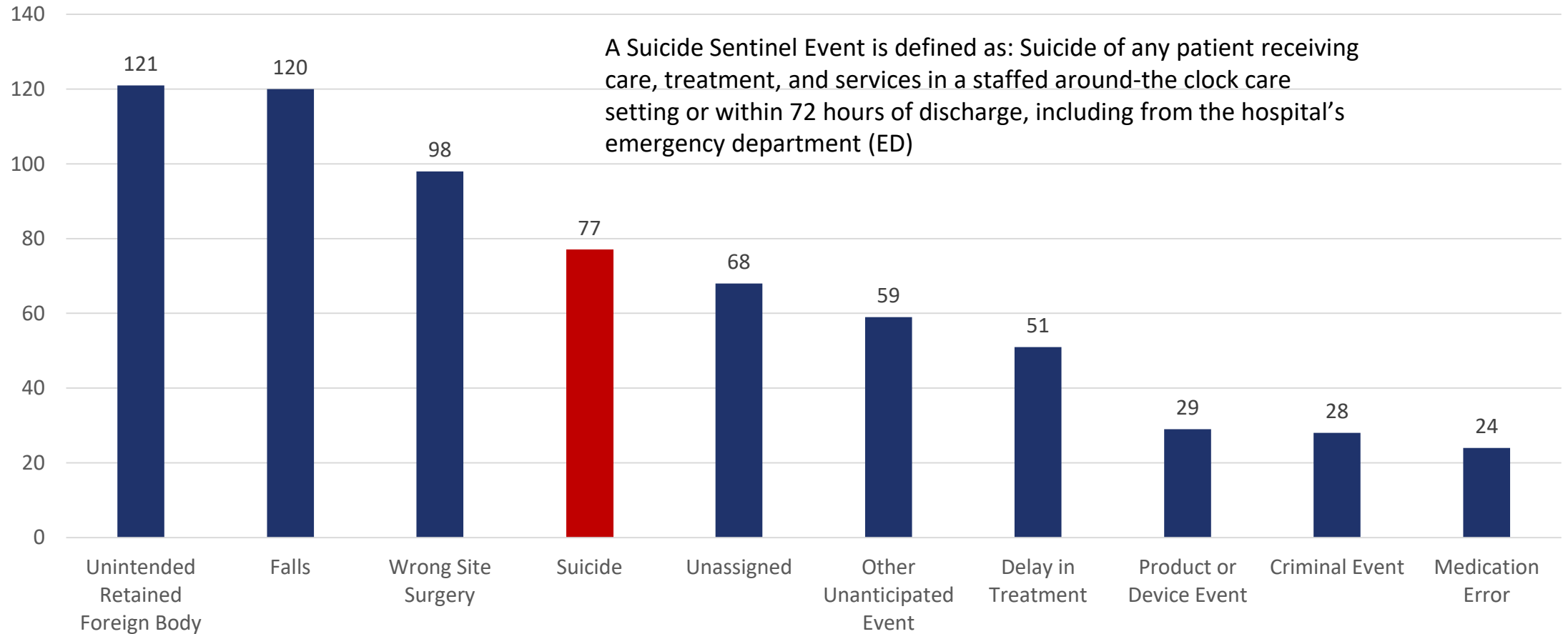
Mission

To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

Levers Addressing Issues

- **Accreditation Activities**
 - Standards and Survey Processes
 - R3 Reports
 - Booster Paks
 - SIG/FAQs
 - Continuous Customer Engagement
- **Risk Reduction**
 - Sentinel Event Alerts
 - Sentinel Event Review Process
 - Complaint Analysis
 - Topic specific portals
- **Education and Publication**
 - Published Books and Journals
 - Seminars/Webinars/Conferences
- **Communication**
 - Joint Commission Online
 - Website postings and news releases
 - Quick Safety/Advisories
- **Center for Transforming Healthcare**
 - Targeted Solutions Tools
 - Center projects
- **Performance Measurement**
 - Pioneers in Quality Portal
 - Quality Check
- **Government Advocacy**
 - Washington, DC office
- **Collaboration with Agencies and Professional Organizations**
 - Advisory Groups and Expert Panels

Sentinel Events - 2018



Sentinel Events – January-June, 2019

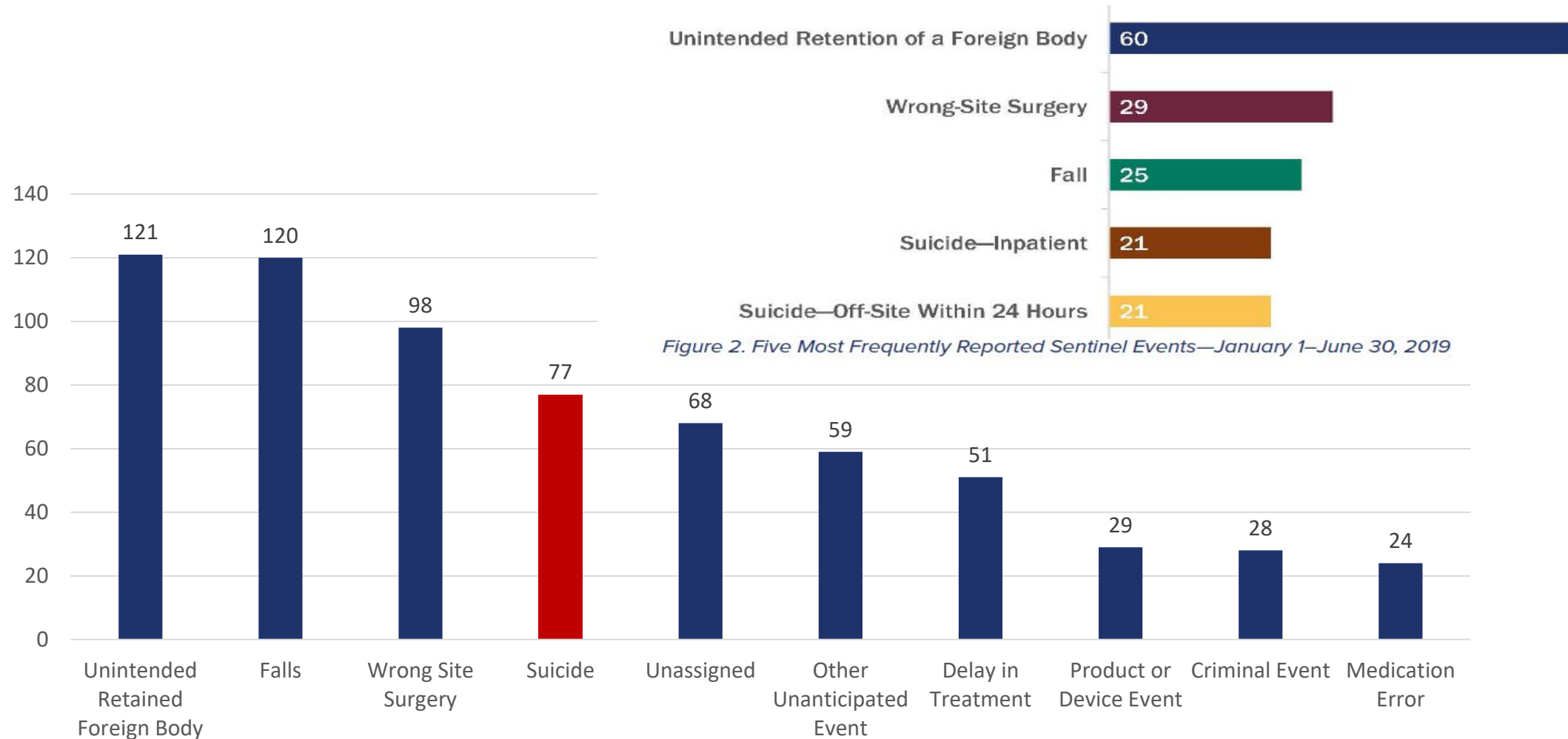


Figure 2. Five Most Frequently Reported Sentinel Events—January 1–June 30, 2019

Inpatient Suicides

- Estimates are that between 48 and 65 inpatient deaths occur in United States hospitals each year*
 - 74% occur while receiving inpatient psychiatric care
 - 3.2 per 100,000 psychiatric inpatient admissions
 - 0.03 per 100,000 non psychiatric inpatient admissions
 - 72% by hanging

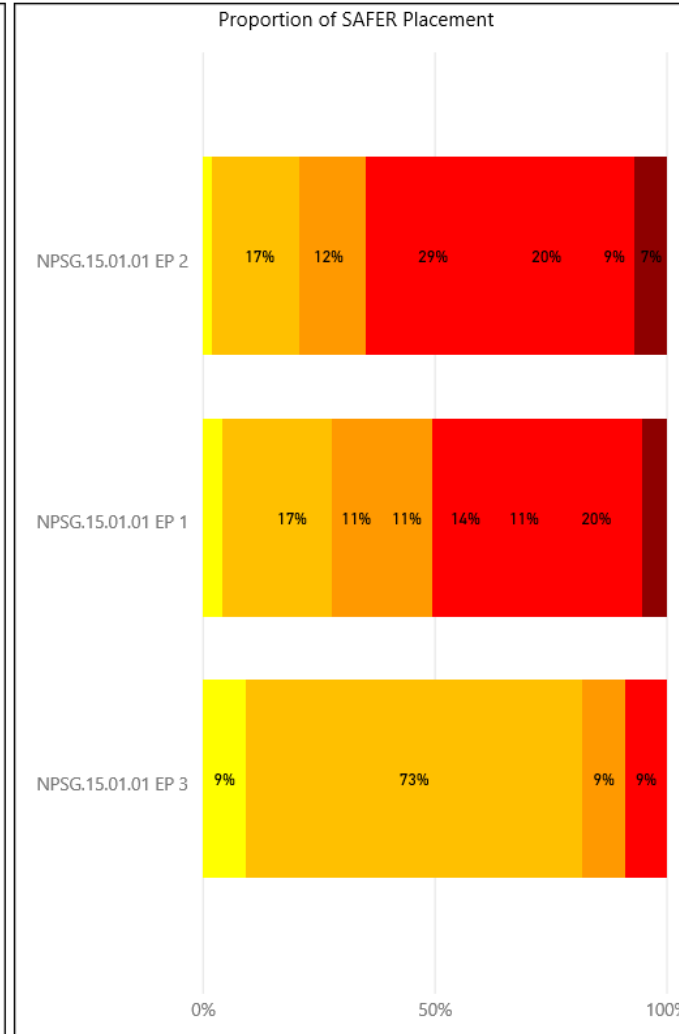
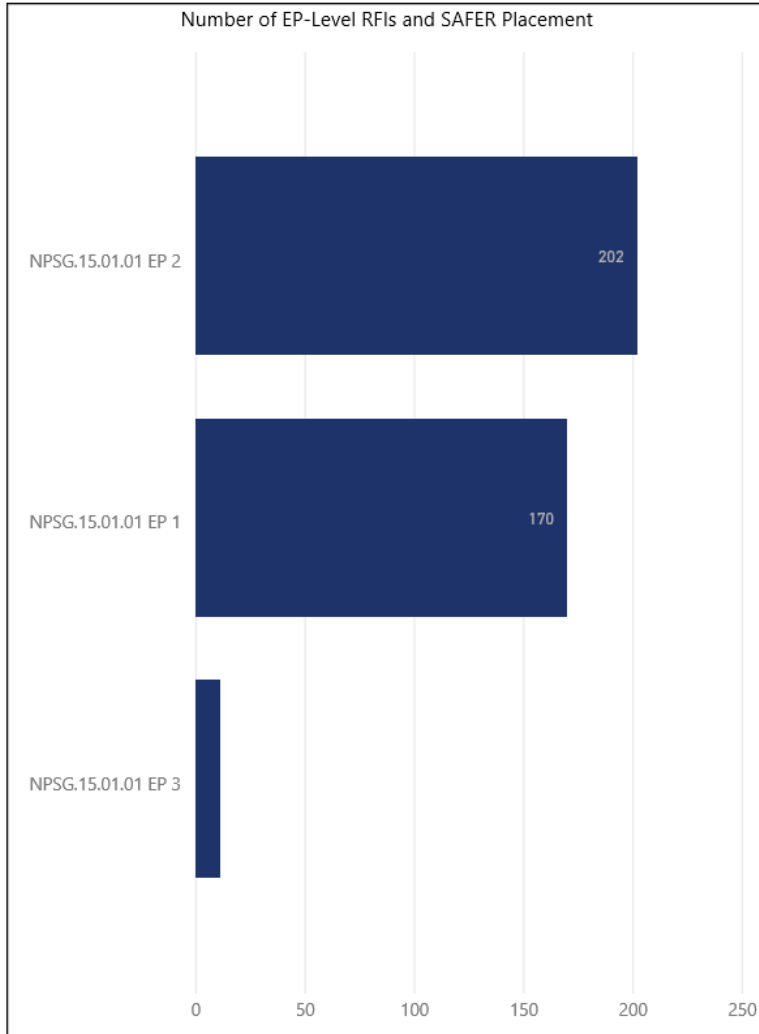
*Source: Williams, Schmaltz, Castro, & Baker (2018). Incidence and Method of Suicide in Hospitals in the United States. Joint Commission Journal on Quality and Patient Safety, 44:643-650.

[https://www.jointcommissionjournal.com/article/S1553-7250\(18\)30253-8/fulltext](https://www.jointcommissionjournal.com/article/S1553-7250(18)30253-8/fulltext)

Sentinel Events – Root Causes

SE - Top 10 contributing factors	2016	2017	2018	Total
Human Factors	950	885	650	2485
Leadership	806	741	580	2127
Communication	645	658	575	1878
Assessment	431	379	240	1050
Physical Environment	144	176	127	447
Health information technology-related	56	72	60	188
Information Management	58	52	44	154
No Root Cause Identified	37	48	42	127
Medication Use	54	44	28	126
Care Planning	46	24	35	105
Total	3227	3079	2381	8687

Survey Findings – January 2018 to June, 2019



Total For Time Period and Program

Number of Surveys	Number of EP-Level RFIs	Avg EP-Level RFIs per Event
1,736	58,160	33.5

Statistics for Selected Standards

Number of Surveys	Number of EP-Level RFIs	Avg EP-Level RFIs per Event
305	383	1.2

SAFER Matrix Distribution of EP-Level RFIs

Likelihood	Limited	Pattern	WideSpread	ITL	Total
ITL				6.01%	6.01%
High	21.67%	15.67%	13.58%		50.91%
Moderate	18.80%	11.49%	6.01%		36.29%
Low	3.13%	2.35%	1.31%		6.79%
Total	43.60%	29.50%	20.89%	6.01%	100.00%

NPSG 15 Requirements

- NPSG 15.01.01.01 – Identify patients at risk for suicide
 - EP 2 (N=202) – Address the patient’s immediate safety needs and most appropriate setting for treatment.
 - Example Finding: Video surveillance was used to provide continuous monitoring of patients at high risk for suicide. Staffing consisted of a registered nurse and a security officer for four at risk patients. At the time of the observation, the registered nurse was on the telephone receiving information for a new admission. The security officer was viewing an adjacent computer not related to video surveillance. The registered nurse then left the monitoring area leaving the security officer alone without a second person to monitor the remaining patients if intervention required.

NPSG 15 Requirements

- NPSG 15.01.01.01 – Identify patients at risk for suicide
 - EP 2 (N=202) – Address the patient’s immediate safety needs and most appropriate setting for treatment.
 - Example Finding: Patients at high risk for suicide were not placed on 1:1 observation. All patients are monitored via every 15-minute observation regardless of level of suicide risk.

NPSG 15 Requirements

- NPSG 15.01.01.01 – Identify patients at risk for suicide
 - EP 2 (N=202) – Address the patient’s immediate safety needs and most appropriate setting for treatment.
 - Example Finding: A patient was identified as low risk for suicide according to the initial risk screen occurring in the emergency department. Upon arrival on the nursing unit, the nurse placed the patient in medium risk precautions. However, the physician documented the patient was at high risk for suicide without implementation of high risk precautions.

NPSG 15 Requirements

- NPSG 15.01.01.01 – Identify patients at risk for suicide
 - EP 1 (N=170) – Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
 - Example Finding: A patient was admitted through the emergency department (ED) to the inpatient psychiatric unit and designated a high risk for suicide. However, there was no documented suicide risk assessment or 1:1 observation while in the ED as required by hospital policy.

NPSG 15 Requirements

- NPSG 15.01.01.01 – Identify patients at risk for suicide
 - EP 1 (N=170) – Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
 - Example Finding: The organization reported that it had not conducted an environmental risk assessment within the emergency department to identify specific risks that may increase or decrease the risk for suicide. There were environmental risks (ligature) present in the room of a patient reported to be at high suicide risk. However, an assessment was not documented and there was no risk mitigation plan for environmental factors in the room. The patient assessment tool did not include a delineation of risk levels or specifications in care; all patients received every 15 minute monitoring.

NPSG 15 Requirements

- EC.02.06.01 –The hospital establishes and maintains a safe, functional environment.
 - EP 1 - Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.
 - Example Finding - The following ligature points were identified in each patient's bathroom on the inpatient behavioral health unit: bathroom door three-hinge closure systems, exposed toilet plumbing, sink faucets, and under sink plumbing

NPSG 15 Requirements

- NPSG 15.01.01.01 – Identify patients at risk for suicide.
 - EP 3 (N=11) – When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.
 - Example Finding: In 2 of 10 patient records reviewed, it was noted that patients who had been assessed and treated for suicide risk were not given specific suicide prevention contact information at the time of discharge. Neither the patient discharge instruction sheet, nurses discharge notes, or the physician discharge summary addressed this requirement.

NPSG 15 Requirements – Effective July 1, 2019

R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 18, Nov. 27, 2018

UPDATED May 6, 2019

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for [email](#) delivery.

National Patient Safety Goal for suicide prevention

Effective July 1, 2019, seven new and revised elements of performance (EPs) will be applicable to all Joint Commission-accredited hospitals and behavioral health care organizations. These new requirements are at National Patient Safety Goal (NPSG) 15.01.01 and are designed to improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide. Because there has been no improvement in suicide rates in the U.S., and since suicide is the 10th leading cause of death in the country, The Joint Commission re-evaluated the NPSG in light of current practices relative to suicide prevention.

NPSG 15 Requirements – Effective July 1, 2019

- NPSG 15.01.01.01 – Reduce the risk of suicide
 - EP 1 - For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk/s (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).

NPSG 15 Requirements – Effective July 1, 2019

- NPSG 15.01.01.01 – Reduce the risk of suicide
 - EP 2 - Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool.
 - EP 3 - Use an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.
 - EP 4 - Document patients' overall level of risk for suicide and the plan to mitigate the risk for suicide.

NPSG 15 Requirements – Effective July 1, 2019

- NPSG 15.01.01.01 – Reduce the risk of suicide
 - EP 5 - Follow written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following:
 - Training and competence assessment of staff who care for patients at risk for suicide
 - Guidelines for reassessment
 - Monitoring patients who are at high risk for suicide

NPSG 15 Requirements – Effective July 1, 2019

- NPSG 15.01.01.01 – Reduce the risk of suicide
 - EP 6 - Follow written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide.
 - EP 7 - Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and take action as needed to improve compliance.

Develop a Plan



The screenshot shows the Suicide Prevention Portal on The Joint Commission website. The page features a navigation menu with 'Topics' selected, a search bar, and social media sharing options. The main content area is titled 'Suicide Prevention Portal' and includes a central message about NPSG 15.01.01 compliance. It is organized into three columns: 'Information on NPSG.15.01.01' with links to December 2018 Perspectives and R3 Report; 'Compliance with NPSG 15.01.01' with links to Environmental Risk Assessment, Validated/Evidence Based Screening Tools, Validated/Evidence Based Suicide Risk Assessment Tools, and Safety Planning Upon Discharge; and 'Compliance with Suicide Recommendations' with links to May 2019 Perspectives, January 2019 FAQ Perspectives, July 2018 FAQ Perspectives, March 2018 Perspectives, January 2018 Perspectives, and November 2017 Perspectives. A 'Resources' section on the right lists 'General Suicide Reduction Tools' and 'Resource Compendium'. At the bottom right, there is a circular graphic with four quadrants: 'high-level direction and coordination', 'suicide prevention', 'patient medication competency', and 'heredity/genetics', with a caption '4-1-1 on Survey Enhancements'.

The Suicide Prevention Portal

The Suicide Prevention Portal is a resource for organizations seeking to be in compliance with NPSG 15.01.01 (changes effective July 1, 2019) and the Suicide Risk Recommendations from the Suicide Risk Reduction Expert Panel:

- Information on NPSG.15.01.01
 - December 2018 Perspectives
 - R3 Report
- Compliance with NPSG 15.01.01
 - EP 1: Environmental Risk Assessment
 - EP 2: Validated/Evidence Based Screening Tools
 - EP 3 & 4: Validated/ Evidence Based Suicide Risk Assessment Tools
 - EP 6: Safety Planning Upon Discharge
- Compliance with Suicide Recommendations
 - May 2019 Perspectives
 - January 2019 FAQ Perspectives
 - July 2018 FAQ Perspectives
 - March 2018 Perspectives
 - January 2018 Perspectives
 - November 2017 Perspectives
- Resources
 - General Suicide Reduction Tools
 - Resource Compendium

4-1-1 on Survey Enhancements

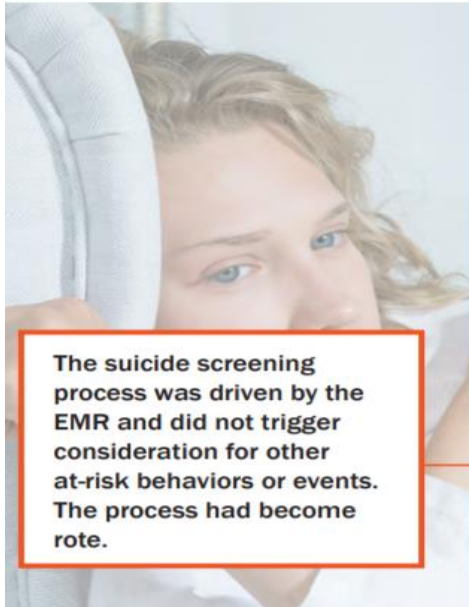
Develop a Plan



Case Example #3 – Part 1 Suicidal patient slips through the cracks

UPDATED:
See added safety strategies on page 2

CASE EXAMPLE

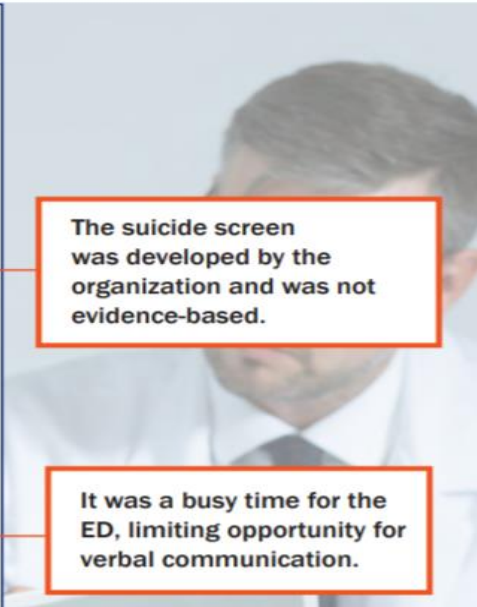


The suicide screening process was driven by the EMR and did not trigger consideration for other at-risk behaviors or events. The process had become rote.

A patient was brought to the emergency department (ED) via ambulance after being found unresponsive at home from an alcohol and drug overdose. The patient was given Narcan by the EMS prior to arrival and was able to participate during triage.

Upon the patient's arrival to the ED, a nurse performed a suicide screening using questions adapted for the organization's electronic medical record (EMR). Though the patient shared that he had recently lost his job and was having relationship issues, he assured the nurse that the overdose was an attempt to relax and sleep, and he denied suicidal ideation. The suicide screening was determined to be negative. While the patient's social stressors were documented in the nursing notes, they were not directly communicated to the ED physician.

The ED physician assessed the patient, noting a decrease



The suicide screen was developed by the organization and was not evidence-based.

It was a busy time for the ED, limiting opportunity for verbal communication.

https://www.jointcommission.org/assets/1/6/Case_Example_3.pdf

Questions



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