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Sentinel Event Definition of Suicide: How to Apply It

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Disclosure

- I have no actual or potential conflict of interest in relation to this presentation.
- The Joint Commission have agreed that they perceive no conflict of interest regarding TJC's participation in this presentation and that TJC's provision of similar speaking engagements to other organizations does not constitute a conflict of interest.

Old Sentinel Event Suicide Definition

Suicide of any patient receiving care, treatment, and services in a staffed around the clock care setting or within 72 hours of discharge, including from the healthcare organization's emergency department.

Patient was admitted to psych unit.

Patient was assessed as low risk of suicide.

The patient was discharged with a follow up plan.

The family reported that the patient took his own life by gunshot wound six days after discharge.

Patient with long history of mental illness presented to an outpatient appointment.

The patient was in a treatment session and asked to go to the bathroom.

The patient didn't return to complete the treatment session.

They started searching the clinics and found that patient jumped from the roof of the garage and died.

- What would you do?
- Would you report it to TJC?

Please type your answers in the chat box

Goals

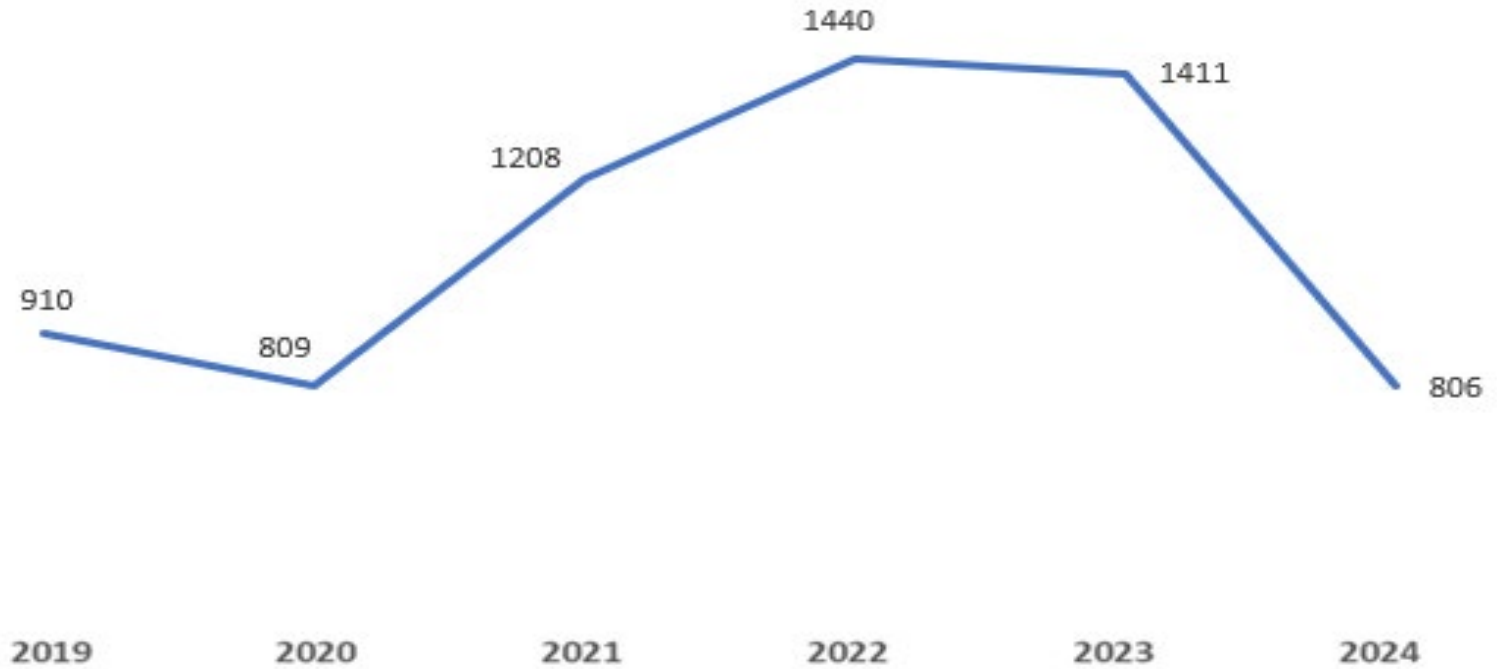
At the end of this presentation, you will be able to:

- Apply the updated Sentinel Event definition to different clinical cases
- Compare the data before and after the change of the definition
- Identify new opportunities for improvement and develop health plans for patients in the newly added services

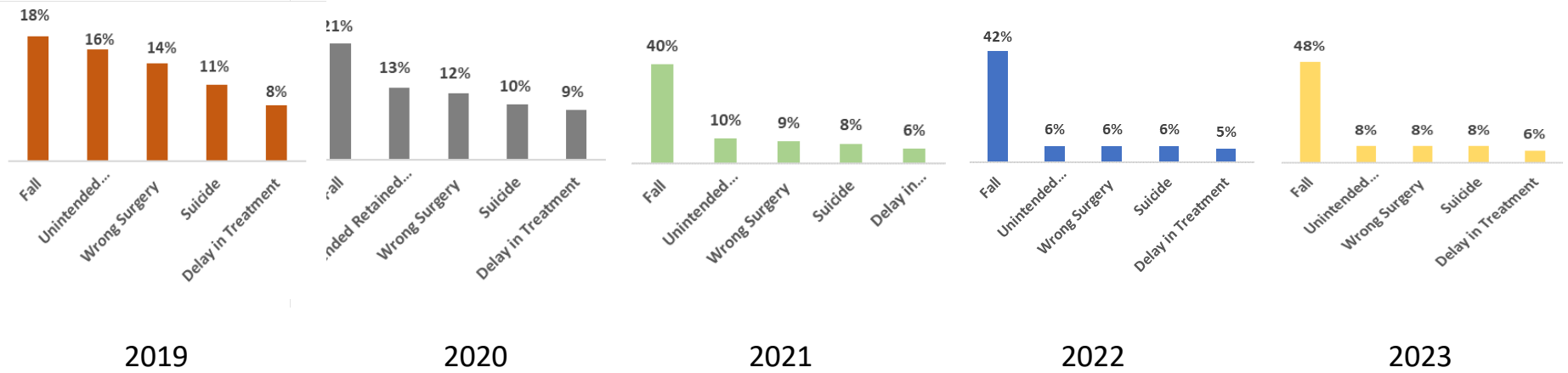
Objectives

- Describe a sentinel event data
- Explain the determination process of the new suicide definition
- Discuss case scenarios
- Questions

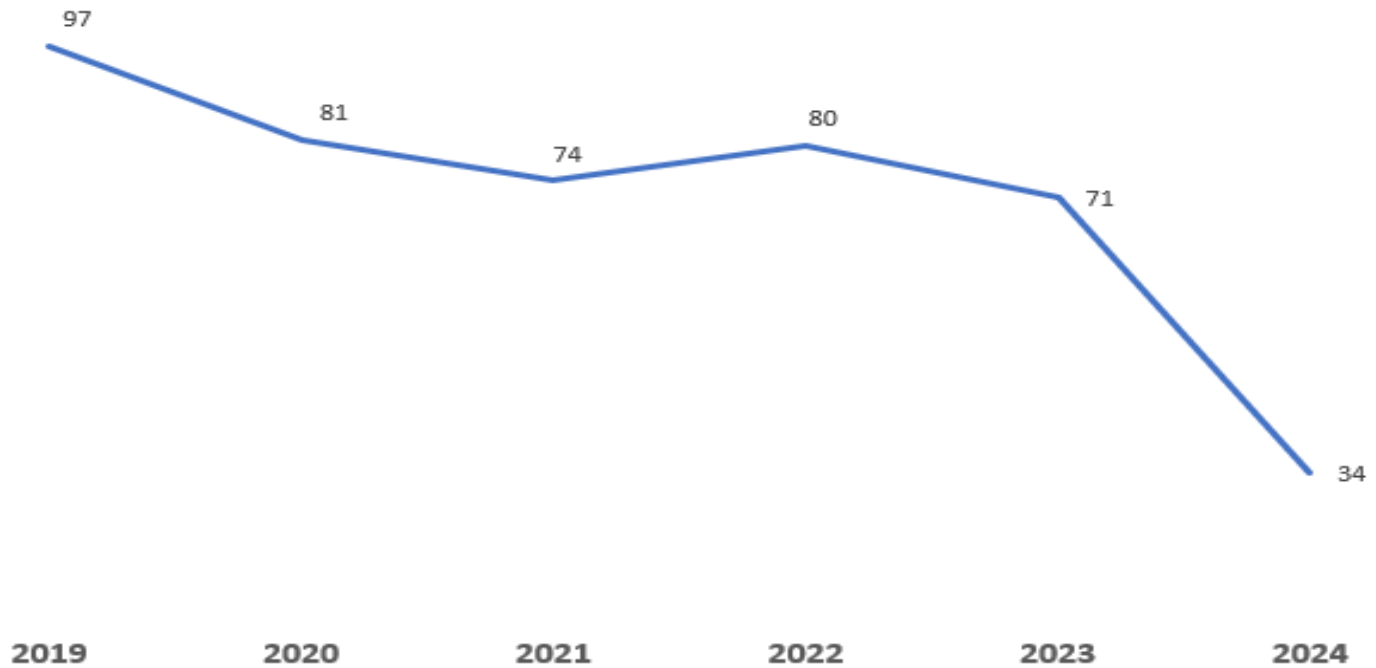
All Sentinel Events by Calendar Year (2019-2024YTD)



Leading Sentinel Events (2019-2024YTD)



Number of Sentinel Events Classified as Patient Suicide (2019-2024YTD)

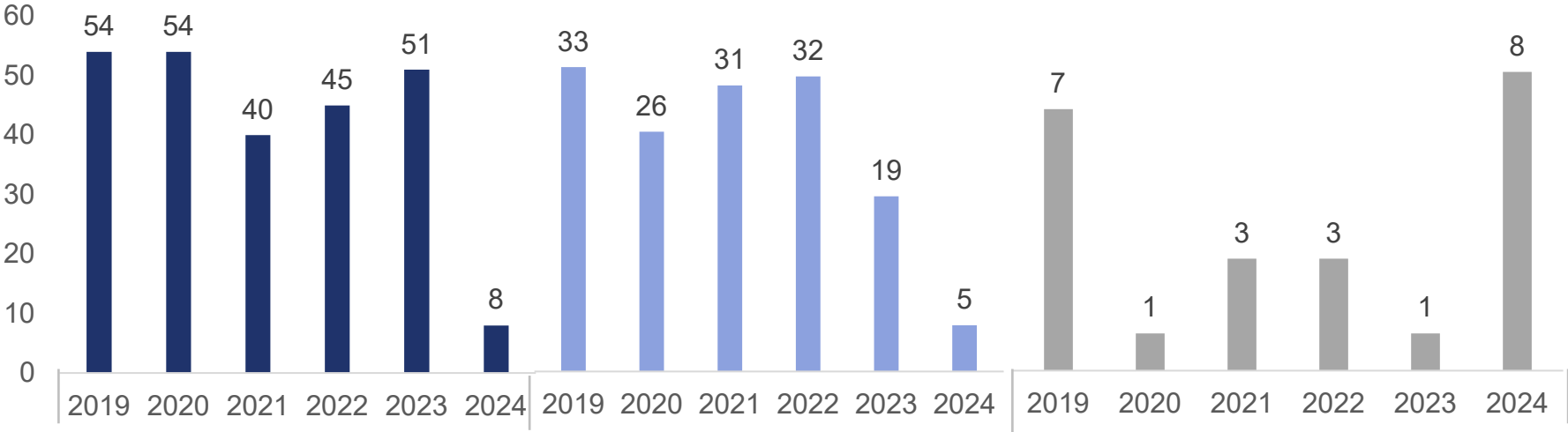


Leading Means of Suicide

- Gunshot 56%
- Hanging 17%
- Drug overdose 12%

Sentinel Events Classified as Patient Suicide by Category Over Time

Past Definition



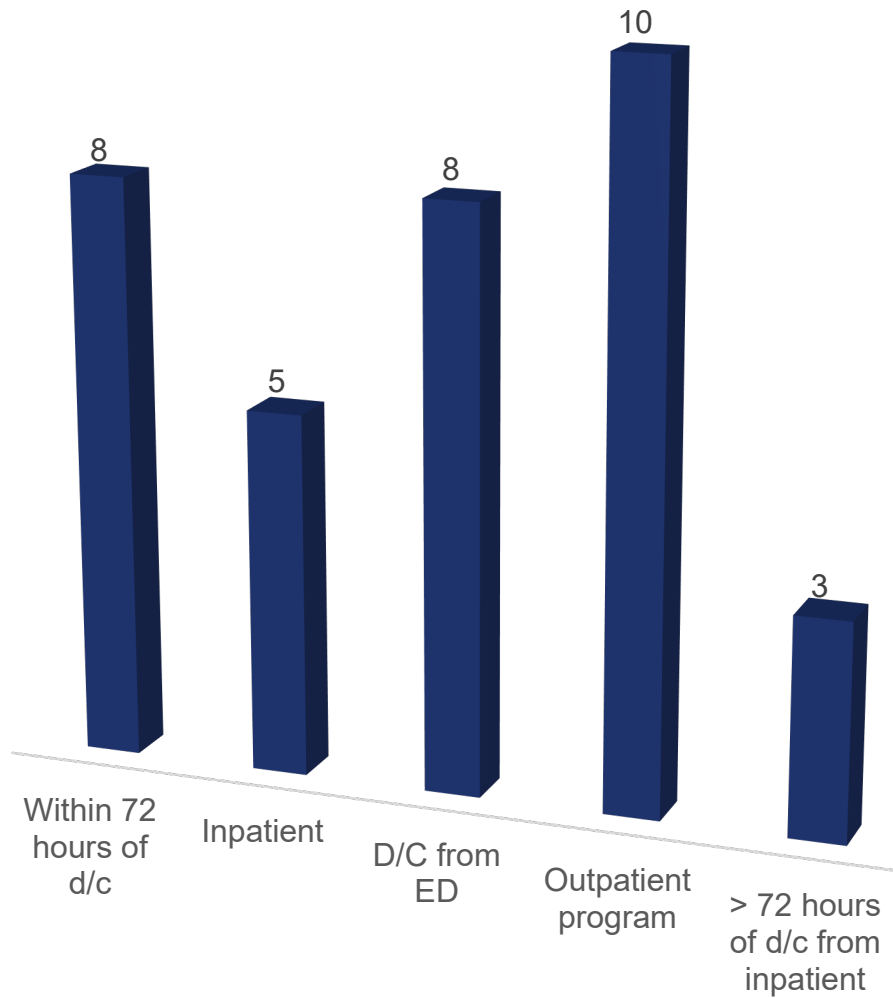
Suicide - offsite w/in 72 hours

Suicide - inpatient

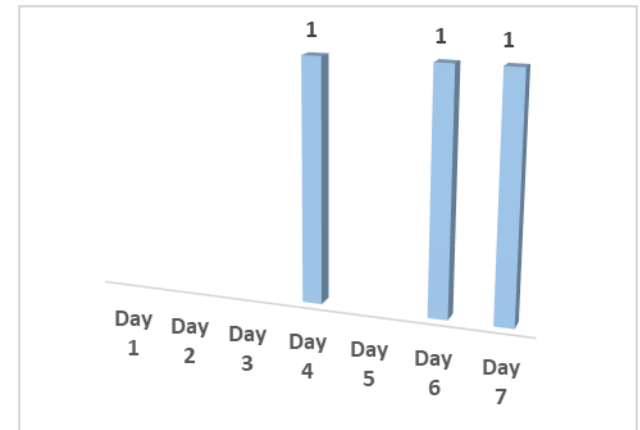
Suicide - emergency department

Sentinel Events Classified as Patient Suicide in 2024

Current Definition



Suicide cases > 72 hours from discharge



Why changing?



More than 13 years.
It was updated to reflect current evidence-based literature.

Healthcare services that were not included in the past definition is included.

Healthcare services that were not included in the past definition is included and is not staffed around 24/7.

Literature search is showing why we have chosen the 7 days vs 72 hour.

Literature Review

Suicide Rates after Discharge from Psychiatric Facilities

Post discharge suicide rate is 100 times the global suicide rate during the **FIRST THREE MONTHS** after discharge. In the United States, psychiatric patients' rate of suicide in the first 3 months after discharge is roughly 15 times the national suicide rate.

Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care

Suicide death rate is 300 times higher in the **FIRST WEEK** and 200 times higher in the **FIRST MONTH** than the general population post discharge from inpatient psychiatric care and it remains higher for up to 3 months after discharge.

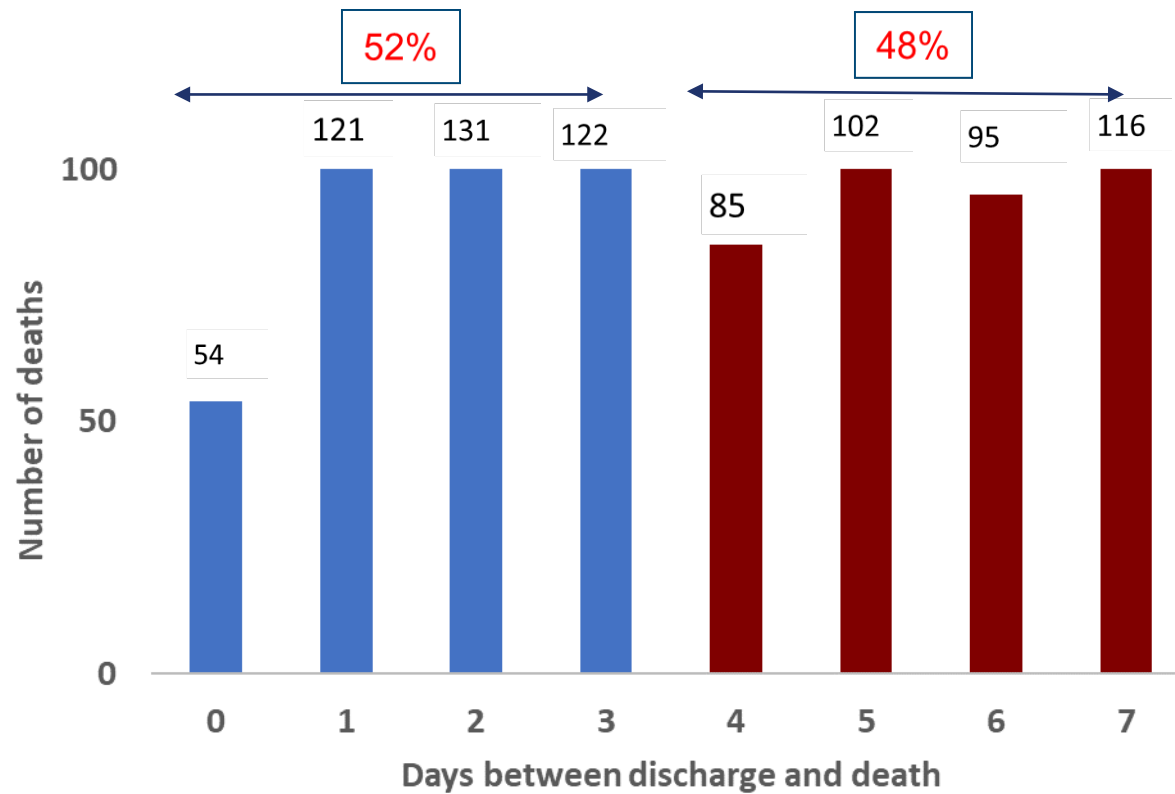
Meta- analysis of Suicide Rates in the First Week and the First Month After Psychiatric Hospitalization

Suicide rates **ONE WEEK** post discharge were 3000 suicides per 10000 person years while **ONE MONTH** rates were 2000 per 10000 person years. Rates from the **SECOND WEEK** to the **FOURTH WEEK** were 1000 per 10000 person years.

Preventing Patient Suicide: Suicide Within Two Weeks of Discharge from Psychiatric Inpatient Care: A Case-control Study

One study in the United Kingdom found that, among psychiatric inpatients who died by suicide after discharge, 55% of suicides occurred within **ONE WEEK** of discharge, 49% of whom died before their first follow up appointment.

Early Post-Discharge Suicide in Mental Health Patients: Findings From a National Clinical Survey



Variation in patterns of health care before suicide: A population case-control study

- Case – Control study to compare variation in patterns of healthcare use by healthcare setting between individuals who died by suicide and the general population
- 2674 individuals who died by suicide between 2000 and 2013. Healthcare use was more common across all healthcare settings for individuals who died by suicide
- 30% had a healthcare visit in the 7 days before suicide (6.5% emergency, 16.3% outpatient specialty, and 9.5% primary care)

PubMed 2019

Current Sentinel Event Suicide Definition

Death caused by self-inflicted injurious behavior if any one of the following apply:

- While in a healthcare setting
- Within seven days of discharge from inpatient services
- Within seven days of discharge from emergency department (ED) services
- While receiving or within seven days of discharge from the following behavioral healthcare services:
 - *Day Treatment/PHP/IOP*
 - *Residential*
 - *Group Home*
 - *Transitional Supportive Living*

FAQs

Is it mandatory to report SE to TJC?

What benefit to our org when we report SE to TJC?

How orgs get to know about patient suicide after discharge?

What about death by drug overdose?

Why did you change the definition?

Is suicide the same as self-inflicted behavior?

Is the organization responsible for the follow up for the 7 days?

What is the expectation if we are not aware if a discharged patient died by suicide?

Case Scenarios

Case 1:

Patient with long history of cancer on chronic pain medication.

Patient went to an outpatient oncology appointment accompanied a family member.

When the patient got in the car, she pulled a gun and shot herself in the head.

Case 2:

Patient presented to ED with accidental overdose.

Patient had a history of drug abuse and was on outpatient group treatment.

Next day after discharge, the family notified the facility of the patient's death by GSW.

Lessons Learned from Suicide Sentinel Events

- Basic suicide risk assessment training and how to identify and respond to patients at risk of suicide.
- The current approach to risk assessment and responding only to those identified as ‘high risk’ is fundamentally flawed.
- Don’t depend only on the risk assessment tool, consider both risk factors/red flag signs and protective factors.
- The absence of risk factors does not mean the absence of any suicide risk; people may conceal their suicide thoughts for a variety of reasons (stigma, shame, or fear).

Questions

