

Patient Safety Tip of the Week

January 29, 2019

National Patient Safety Goal for Suicide Prevention

In our December 12, 2017 Patient Safety Tip of the Week “[Joint Commission on Suicide Prevention](#)” we highlighted The Joint Commission’s recommendations on suicide prevention ([TJC 2017](#)).

Those have now been incorporated into a new National Patient Safety Goal **NPSG.15.01.01: Reduce the risk for suicide** ([Lyons 2018](#)). Effective July 1, 2019, there will be seven new and revised elements of performance (EPs) supporting this NPSG ([TJC 2018](#)). These are listed below for both the behavioral health care (BHC) and hospital (HAP) accreditation programs. There are also some elements important for non-psychiatric units in general hospitals.

NPSG.15.01.01.EP1: **Environmental Risk Assessment**

BHC: The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the organization takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).

HAP: 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).

As we noted in our December 12, 2017 Patient Safety Tip of the Week “[Joint Commission on Suicide Prevention](#)”, non-psychiatric units in general hospitals are not expected to be ligature-resistant. But that does not mean they are exempt from taking steps to reduce the risk of patient suicide. They are expected to implement procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient’s medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital. (See also below for our own comments on areas, such as your

radiology suite bathrooms, where you probably should make sure they are ligature-resistant). The Joint Commission elements do stress that each organization needs to assess how it will identify objects that could be used for self-harm and use this information in staff training.

We refer you back to our December 12, 2017 Patient Safety Tip of the Week “[Joint Commission on Suicide Prevention](#)” for details of The Joint Commission’s recommendations on the environmental risk assessment ([TJC 2017](#)), most of which rely heavily on many of the points from the VA’s [Mental Health Environment of Care Checklist](#), which we’ve discussed in so many columns (most recently in our August 29, 2017 Patient Safety Tip of the Week “[Suicide in the Bathroom](#)”). In our February 14, 2017 Patient Safety Tip of the Week “[Yet More Jumps from Hospital Windows](#)” we mentioned 2 publications ([Watts 2016](#), [Mills 2016](#)) showing sustained results from implementation of the Mental Health Environment of Care Checklist (MHEOCC). The checklist and program became mandated at all VA hospitals in 2007. Inpatient suicide rates in VA hospitals dropped from 4.2 per 100,000 admissions to 0.74 per 100,000 admissions from 2000 to 2015. The reduction in suicides coincided with introduction of the MHEOCC and has been sustained since implementation in 2007. The authors stress that the physical changes brought about by the MHEOCC likely have a bigger impact on inpatient suicide reduction than the numerous other interventions used.

Again, see our comments below regarding special issues for non-psychiatric units in general hospitals.

NPSG.15.01.01.EP 2: Use of a validated screening tool to assess patients at risk

BHC: Screen all individuals served for suicidal ideation using a validated screening tool.
HAP: 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.

TJC provides examples of validated screening tools: the [ED Safe Secondary Screener](#), the [PHQ-9](#), the [Patient Safety Screener](#), the [TASR Adolescent Screener](#), and the [ASQ Suicide Risk Screening Tool](#). The [Columbia-Suicide Severity Rating Scale](#) can be used for both screening and more in-depth assessment of patients who screen positive for suicidal ideation using another tool. There is more information on the use of the Columbia-Suicide Severity Rating Scale in the [NPSG.15.01.01 Suicide Prevention Resources document](#). (We also discussed it in our December 2011 What’s New in the Patient Safety World column “[Columbia Suicide Severity Rating Scale](#)”).

TJC also provides a link to an article “Development and Implementation of a Universal Suicide Risk Screening Program in a Safety-Net Hospital System” ([Roaten 2018](#)).

NPSG.15.01.01.EP 3: Evidence-based process for conducting suicide risk assessments of patients screened positive for suicidal ideation

BHC: Use an evidence-based process to conduct a suicide risk assessment of individuals served 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. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens individuals served for suicidal ideation and assesses the severity of suicidal ideation.

HAP: Use an evidence-based process to conduct a suicide risk 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.

Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation.

Here they again note that the [Columbia-Suicide Severity Rating Scale](#) can be used for both screening and more in-depth assessment of patients who screen positive for suicidal ideation using another tool. Another tool is SAMHSA's [SAFE-T Pocket Card](#): Suicide Assessment Five-Step Evaluation and Triage for Clinicians, which is now also available for download as an app on your mobile devices.

NPSG.15.01.01.EP 4: Documentation of patients' risk and the plan to mitigate

BHC: Document individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide.

HAP: Document patients' overall level of risk for suicide and the plan to mitigate the risk for suicide.

Here they stress the importance that all clinicians who might come in contact with a patient at risk for suicide be aware of the level of risk and the mitigation plans to reduce that risk. Such information should be explicitly documented in the patient's record.

NPSG.15.01.01.EP 5: Written policies and procedures addressing care of at-risk patients, and evidence they are followed

BHC: Follow written policies and procedures addressing the care of individuals served identified as at risk for suicide. At a minimum, these should include the following: - Training and competence assessment of staff who care for individuals served at risk for suicide - Guidelines for reassessment - Monitoring individuals served who are at high risk for suicide

HAP: 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

Those written policies and procedures should include specifics about training and competence assessment of staff.

NPSG.15.01.01.EP 6: Policies and procedures for counseling and follow-up care for at-risk patients at discharge

BHC: Follow written policies and procedures for counseling and follow-up care at discharge for individuals served identified as at risk for suicide.

HAP: Follow written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide.

A patient's risk for suicide is high after discharge from the psychiatric inpatient or emergency department settings. Developing a safety plan with the patient and providing the number of crisis call centers can decrease suicidal behavior after the patient leaves the care of the organization. We would also stress the importance of scheduling the patient's first followup visit and checking to see that the patient is compliant with such visit.

NPSG.15.01.01.EP 7: Monitoring of implementation and effectiveness, with action taken as needed to improve compliance

BHC: Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of individuals served at risk for suicide and take action as needed to improve compliance.

HAP: 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.

Your quality improvement program should monitor how often screening was done, the level of severity of risk assessed, how often specific items in the mitigation plan (eg. 1:1 monitoring) were followed, discharge arrangements made, and that all staff have had both initial training and reorientation as specified in your written policies.

There are a few points of our own we would like to stress about issues outside of behavioral health units. If you are a general hospital that has a behavioral health unit, there undoubtedly will be patients at risk for suicide in areas other than your behavioral health unit. One particularly important area is your radiology suite. In our August 25, 2015 Patient Safety Tip of the Week "[Checklist for Intrahospital Transport](#)" we stressed that **suicide risk** should be considered when patients are transported to Radiology (or

other sites) whether the patient is on a behavioral health unit or medical unit (see our prior columns January 6, 2009 “[Preventing Inpatient Suicides](#)”, February 9, 2010 “[More on Preventing Inpatient Suicides](#)” and December 2010 “[Joint Commission Sentinel Event Alert on Suicide Risk Outside Psych Units](#)”). We’ve inspected bathrooms in radiology departments in several hospitals and uniformly found that not only do those bathrooms have numerous “loopable” items that could be used for hanging but also that they can be locked from the inside and there is typically no one readily available with a key to get in. In fact, that is one of the items we added to our patient safety scavenger hunt list (see our March 16, 2010 Patient Safety Tip of the Week “[A Patient Safety Scavenger Hunt](#)”). Bathrooms and other rooms in the radiology department also have many other tools and implements that could be used for suicide. So observation protocols for potentially suicidal patients on such units should ensure that doors are not locked (or, if they can be locked, that the “observer” has keys to access the bathroom). Having observers of the same gender as the patient also is recommended.

The other vulnerable area for patients at high risk for suicide is any of your acute care units in which you house psychiatric patients while their acute medical problems need attention. We’ve now done several columns on patients attempting or committing suicide by jumping from hospital windows. You should become familiar with the patient profile we’ve described for such patients (see, for example, our July 10, 2018 Patient Safety Tip of the Week “[Another Jump from a Hospital Window](#)”).

For those of you who frequently have such patients on your acute medical or surgical units, we suggest you actually consider making one or two rooms safer to be used for such patients. You could change the windows in such rooms to the type of windows used in behavioral health units. You could also minimize the number of “loopable” items in such rooms though, being realistic since you’ll more often be using these rooms for patients not at risk for suicide, some potentially loopable items will be needed in the rooms.

But there is much more than the physical environment that needs attention. In many, if not most, suicide incidents on med/surg units or ICU’s the staff have been inadequately trained to deal with behavioral health patients. Often, hospitals designate “sitters” to observe such at-risk patients but fail to ensure those “sitters” have adequate training for that task. The need training and testing for competency on how they would address the situation of a patient with serious suicidal ideation and 1:1 monitoring of patients with serious suicidal ideation. It would also include de-escalation techniques, conducting risk assessments for objects that could pose a risk for self-harm, identifying those objects that should be routinely removed from the immediate vicinity of patients with suicidal ideation, and plans for monitoring visitors (including what items visitors are allowed to bring with them). We also recommend you become familiar with the issue of bed positioning and furniture positioning we’ve discussed in our columns on jumps from windows.

Some of our prior columns on preventing hospital suicides:

- January 6, 2009 “[Preventing Inpatient Suicides](#)”
- February 9, 2010 “[More on Preventing Inpatient Suicides](#)”
- March 16, 2010 “[A Patient Safety Scavenger Hunt](#)”
- December 2010 “[Joint Commission Sentinel Event Alert on Suicide Risk Outside Psych Units](#)”
- September 27, 2011 “[The Canadian Suicide Risk Assessment Guide](#)”
- December 2011 “[Columbia Suicide Severity Rating Scale](#)”
- July 2012 “[VA Checklist Reduces Suicide Risk](#)”
- August 2013 “[Suicide Attempts on Med/Surg Units](#)”
- August 25, 2015 “[Checklist for Intrahospital Transport](#)”
- October 6, 2015 “[Suicide and Other Violent Inpatient Deaths](#)”
- March 2016 “[TJC Sentinel Event Alert on Preventing Suicide](#)”
- April 12, 2016 “[Falls from Hospital Windows](#)”
- February 14, 2017 “[Yet More Jumps from Hospital Windows](#)”
- August 29, 2017 “[Suicide in the Bathroom](#)”
- December 12, 2017 “[Joint Commission on Suicide Prevention](#)”
- July 10, 2018 “[Another Jump from a Hospital Window](#)”
- September 18, 2018 “[More on Hospital Suicides](#)”

References:

TJC (The Joint Commission). November 2017 Perspectives Preview: Special Report: Suicide Prevention in Health Care Settings. Recommendations Regarding Environmental Hazards for Providers and Surveyors. Joint Commission Online 2017; October 25, 2017 <https://www.jointcommission.org/issues/article.aspx?Article=GtNpk0ErgGF%2b7J9WO TTkXANZSEPXa1%2bKH0%2f4kGHCiio%3d>

Lyons M. Joint Commission announces new National Patient Safety Goal to prevent suicide and improve at-risk patient care. Revisions effective July 1, 2019, for accredited hospitals and behavioral health programs. The Joint Commission 2018; December 5, 2018 https://www.jointcommission.org/joint_commission_announces_new_national_patient_safety_goal_to_prevent_suicide_and_improve_at-risk_patient_care/

TJC (The Joint Commission). R³ Report. National Patient Safety Goal for suicide prevention. The Joint Commission 2018; Issue 18: Nov. 27, 2018 https://www.jointcommission.org/assets/1/18/R3_18_Suicide_prevention_HAP_BHC_1_2_18_Rev2_FINAL.pdf

Mental Health Environment of Care Checklist (VA)

<http://www.patientsafety.va.gov/docs/MHEOCCed092016508.xlsx>

<http://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp>

Watts BV, Shiner B, Young-Xu Y, Mills PD. Sustained Effectiveness of the Mental Health Environment of Care Checklist to Decrease Inpatient Suicide. *Psychiatric Services* 2016; Published Online Ahead of Print: November 15, 2016

<http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201600080>

Mills PD. Use of the Mental Health Environment of Care Checklist to Reduce the Rate of Inpatient Suicide in VHA. *TIPS (Topics in Patient Safety)* 2016; 16(3): 3-4
July/August/September 2016

<http://www.patientsafety.va.gov/professionals/publications/newsletter.asp>

Suicide Prevention Resource Center, The Patient Safety Screener (PSS-3): A Brief Tool to Detect Suicide Risk in Acute Care Settings.

<http://www.sprc.org/micro-learnings/patientsafetyscreener>

PHQ-9, (Patient Health Care Questionnaire – 9).

https://www.phqscreeners.com/sites/g/files/g10049256/f/201412/PHQ-9_English.pdf

TASR Adolescent Screener, The Tool for Assessment of Suicide Risk for Adolescents (TASR-A): How to use the TASR – A.

http://teenmentalhealth.org/wp-content/uploads/2015/12/TASR-A_Package.pdf

ASQ Suicide Risk Screening Tool.

<https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials/index.shtml>

Columbia-Suicide Severity Rating Scale

<http://cssrs.columbia.edu/>

TJC (The Joint Commission). NPSG.15.01.01 Suicide Prevention Resources document. November 15, 2018

https://www.jointcommission.org/npsg_150101_suicide_prevention_resources/

Roaten K, Johnson C, Genzel R, et al. Development and Implementation of a Universal Suicide Risk Screening Program in a Safety-Net Hospital System. Joint Commission Journal of Quality and Patient Safety, 2018; 44(1): 4-11

<https://www.sciencedirect.com/science/article/abs/pii/S1553725017303343?via%3Dihub>

SAMHSA (Substance Abuse and Mental Health Services Administration). SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians.

<https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432>



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