View as "PDF version"

Patient Safety Tip of the Week

September 3, 2019

Lessons from an Inpatient Suicide

Our focus on preventing suicides in the hospital has dealt most often with events occurring on non-behavioral health units. But suicides occur more often on locked behavioral health units.

We just recently did a column on lessons from hospital suicide attempts (see our July 30, 2019 Patient Safety Tip of the Week "Lessons from Hospital Suicide Attempts"). But a recent suicide on a locked behavioral health unit has some additional lessons worth disseminating (OIG 2019). This case was particularly ironic, because it occurred at a VA hospital. The VA system has produced so many valuable resources on suicide prevention that we now use in hospitals world-wide. This unfortunate case had a variety of contributory factors that we know currently exist at many hospitals.

The Case

A patient was brought by police to a hospital emergency department for an involuntary examination under state law after his spouse believed he was suicidal. He was placed on 1:1 observation and noted to be "visibly agitated and angry". He was admitted to the locked inpatient behavioral health unit and was placed on "close" observation status and remained on that level of safety observation throughout the hospital stay. After a full suicide risk assessment the following morning, he was deemed to be at "high risk" of suicide. Throughout the course of the hospital stay, the patient was cooperative with staff and increasingly social with select unit peers. The patient engaged in most unit activities, was sleeping well, and had a good appetite. On the third hospital day he accepted initiation of antidepressant medication. He now denied suicidal thoughts and discharge was planned for the morning of the fourth hospital day. On the morning of day 4, his suicide risk assessment resulted in lowering his risk status to "low". However, discharge was delayed when contacts and arrangements for safe discharge were unsuccessful. Immediately upon learning of the delayed discharge, the patient became significantly agitated and began screaming and hitting the wall and his chest. After an hour he was calmer and resting in the room and told the nursing staff, "I will be all right, I just wanted to be discharged today." He denied suicidal ideation and was hopeful for discharge the following day.

A nursing assistant documented seeing the patient in his room around 5:45 p.m., when the patient also reportedly declined dinner due to not being hungry. The nursing assistant reportedly did not actually enter the patient's room. At approximately 6:00 p.m., a peer patient went to the patient's room to tell the patient there was a call on the public telephone in the day room. On reaching the room, the peer found the patient's door was closed and noted resistance on the door when trying to open it. A nursing assistant went to the room and pushed the door to gain access. The nursing assistant found the patient, unresponsive, on the ground with a garment tied around his neck that was attached to another garment tied in a knot and wedged over the top of the door. A code was called and cardiopulmonary resuscitation was initiated but was unsuccessful.

The OIG Investigation

The case was reported to the Joint Commission as a sentinel event and facility leaders completed an institutional disclosure with members of the patient's family. The VA Office of the Inspector General (OIG 2019) was called to formally investigate the case.

The OIG report did not find any significant problems with the patient's assessments, treatment plans, or discharge plans. The report also did not find fault with the suicide risk status not being upgraded after the decision to delay discharge, given that he had become calm and denied suicidal ideation. However, the OIG found numerous problems related to the environment of care and the oversight of the unit and the process for assessing environment of care.

We've discussed the VA's Mental Health Environment of Care Checklist (MHEOCC) in many columns (most recently in our January 29, 2019 "National Patient Safety Goal for Suicide Prevention"). We've also previously 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. Those 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.

The hospital in the current case did apparently conduct MHEOCC risk assessment rounds on this behavioral health unit every 6 months in accord with the VHA policy. However, the Interdisciplinary Safety Inspection Team (ISIT) that conducts such assessment was found deficient in many respects. The OIG found that the hospital's Facility Director failed to designate an ISIT to include the appropriate staff disciplines. The OIG team was told that neither an ISIT team nor a subcommittee had ever existed at the facility, and no minutes with the required elements had been recorded. While the facility did have an inspection team, the team was not comprised of the full range of appropriate disciplines and did not keep minutes.

VHA requires that MHEOCC training on environmental hazards should occur upon staff orientation and annually thereafter. Staff members who are both permanently assigned to the mental health unit or who have periodic responsibilities on the unit must be trained, including housekeepers, chaplains, outpatient providers, police officers, and members of the ISIT team. But the OIG found that **only 44 percent of employees required to have the MHEOCC training completed the training** in compliance with VHA Directive.

Responsible managers and staff who conducted Mental Health EOC rounds over the past three years either did not identify that bedroom doors (into the corridors) presented risks because they could be used as anchor points for hanging or that actions were required to mitigate those risks.

In our December 12, 2017 Patient Safety Tip of the Week "Joint Commission on Suicide Prevention" we noted that, in inpatient psychiatric units in both psychiatric hospitals and general/acute care settings, the **doors between patient rooms and hallways must contain ligature-resistant hardware** which includes, but may not be limited to, hinges, handles, and locking mechanisms. But **other aspects of corridor doors** on behavioral health units remain problematic. In our December 12, 2017 Patient Safety Tip of the Week "Joint Commission on Suicide Prevention" we noted that several panelists involved in The Joint Commission's development of its suicide prevention standards reported that they were aware of cases in which a patient slipped a ligature between the corridor door and the door frame and/or hinges and committed suicide. And though there are several mechanical devices available to decrease the risk of the top of a door being used to fix a ligature (eg. laser beams, pressure-sensing plates, and monitoring cameras) they the efficacy of such devices is unproven. So, the panel did not recommend mandatory installation of such devices. Rather, they recommended organizations should note such doors on their environmental risk assessments and describe their mitigation strategies, such as appropriate rounding and monitoring by staff, requiring that doors be left open during certain hours, and so on. A previous VHA memorandum stated, "It continues to be important to monitor for environmental hazards and be aware that any sheet, piece of clothing, towel, or similar item can be used for hanging or strangulation and that many permanent fixtures do provide anchor points despite our efforts to eliminate them. Please consider the use of door alarms if you are not already using them." Also, NCPS (VA National Center for Patient Safety) did not require the use of door top alarms, but suggested they be considered as a risk mitigation option (and these were included in slides developed by the VA in 2012). **Over-the-door alarms** use door top sensors to trigger an alarm in the nursing station when increased pressure (such as a ligature) is identified on the top of the door.

Security cameras had been installed several years earlier in response to a patient incident but had been rendered inoperative after they crashed the hospital's network. They had never been re-deployed on a separate network and were, in effect, **inoperative for several years**. The facility's Chief of Police told the OIG that cameras on this unit were "not required;" that "people rely too much on cameras;" and that "no camera in the world would have given a view" of the patient's room. In fact, policy had required these cameras for several years following that previous incident.

The hospital's routine protocol called for **15-minutes monitoring** of patients. But the OIG report found **several issues** with compliance with that protocol. While unit staffing was sufficient on the day of the patient's suicide, one of the nursing assistants assigned to conduct 15-minute safety rounds also performed other duties during that time contrary to protocol (nursing assistant drew blood on two patients and took vital signs while doing the 15-minute safety rounds). The nursing assistant also did not physically enter the patient's room, instead communicating with the patient verbally through the door. The OIG report also found that observation could be done any time during the 15-minute interval, making it possible that patients could go as long as 25 minutes between checks.

Lastly, the OIG report came down heavily on **leadership failures**. The report notes that various facility leaders and managers knew, or should have known, about on-going lapses related to the unit physical environment, MHEOCC inspection rounds, staff training, the inoperative security cameras, etc.

The OIG report also noted that there had been a patient elopement from this unit just a few months earlier. The patient reportedly followed a housekeeper who exited the rear door of the unit. The facility's review of that event identified several contributory factors, including the non-functional security cameras and the rear door's distant location from the nursing station, as well as a lack of training for clinical and non-clinical staff that work on the unit. Sound familiar? Our July 30, 2019 Patient Safety Tip of the Week "Lessons from Hospital Suicide Attempts" described a similar case where a patient followed an administrative staff person and reached an exit door as it closed but before it fully closed and locked. He was observed peering through the door window and then entering the outer corridor. He subsequently jumped 30 feet to a concrete patio, suffering multiple traumatic injuries. The administrative staff person had never been oriented to the behavioral health unit and never received specific training on making sure the unit locked doors were secured when going in and out and there was no formal policy for such orientation.

There were 50 suicides reported to The Joint Commission as sentinel events in 2018 (TJC 2019a) The Joint Commission (TJC) noted that approximately 425 suicides within healthcare settings had been reported as sentinel events over the previous five years (TJC 2017). In 2019, the Joint Commission has split out suicides occurring on inpatient units, emergency departments, and off-site within 72 hours of discharge (including discharge from the ED). There have been 21 inpatient suicides reported as sentinel events in the first half of 2019 (TJC 2019b). VA facilities reported 37 inpatient suicides from 2012 through 2017, including two on locked mental health units, to the VHA National Center for Patient Safety (NCPS). (OIG 2019).

Hanging is the method used in more than 70 percent of inpatient suicides, as independently reported by the Centers for Disease Control and Prevention's National Violent Death Reporting System, TJC's Sentinel Event Database, and VHA's NCPS. Using the VA's Mental Health Environment of Care Checklist (MHEOCC) is critical for finding hazards for suicide in the environment, but obviously you need to use it

religiously and follow up promptly on deficiencies you identify. See also our Patient Safety Tips of the Week for December 12, 2017 "Joint Commission on Suicide Prevention" and January 29, 2019 "National Patient Safety Goal for Suicide Prevention" for all the Joint Commission standards and expectations. The current case, though, should make you strongly consider whether you need to install over-the-door alarms (or equivalent devices) on the corridor doors on your inpatient behavioral health units.

To review lessons learned here:

- Use a tool like the MHEOCC to guide your environment of care rounds on your behavioral health units.
- Make sure all relevant staff are appropriately trained on the MHEOCC.
- Strongly consider use of over-the-door alarms on your corridor doors on behavioral health units.
- Make sure your responsible staff understand their role in your 15-minute (or other designated interval) observations and the they are not multi-tasking during those responsibilities. Audit compliance with these protocols.
- When your security cameras malfunction for any reason, make sure the reasons for such malfunctions are promptly addressed and corrected.
- Your leadership needs to take an active role in oversight of your inpatient behavioral health units.

And though our focus here has been on prevention of inpatient suicides, we'd be remiss if we did not mention two extremely valuable contributions to the outpatient assessment and management of patients at risk for suicide, just published in the Annals of Internal Medicine (Sall 2019, D'Anci 2019).

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"
- January 22, 2019 "Wandering Patients"
- January 29, 2019 "National Patient Safety Goal for Suicide Prevention"
- July 30, 2019 "Lessons from Hospital Suicide Attempts"

Some of our past columns on issues related to behavioral health:

- January 6, 2009 "Preventing Inpatient Suicides"
- September 22, 2009 "Psychotropic Drugs and Falls in the SNF"
- 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"
- January 15, 2013 "Falls on Inpatient Psychiatry"
- April 2, 2013 "Absconding from Behavioral Health Services"
- 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"
- March 14, 2017 "More on Falls on Inpatient Psychiatry"
- August 29, 2017 "Suicide in the Bathroom"
- December 12, 2017 "Joint Commission on Suicide Prevention"
- February 6, 2018 "Adverse Events in Inpatient Psychiatry"
- July 10, 2018 "Another Jump from a Hospital Window"
- September 18, 2018 "More on Hospital Suicides"
- January 22, 2019 "Wandering Patients"
- January 29, 2019 "National Patient Safety Goal for Suicide Prevention"
- July 30, 2019 "Lessons from Hospital Suicide Attempts"

References:

OIG (Office of Inspector General). Department of Veterans Affairs. VHA (Veterans Health Administration). Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center Florida. Healthcare Inspection Report #19-07429-195; August 22, 2019

https://www.va.gov/oig/pubs/VAOIG-19-07429-195.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

TJC (The Joint Commission). Sentinel event statistics released for 2018. TJC Online 2019; March 13, 2019
https://www.jointcommission.org/issues/article.aspx?Article=AVw4k9l0%2FHrWYnT7qVs9NrWBCgOfdlZemMC0iyFsJUc%3D

TJC (The Joint Commission). Sentinel event statistics released for first 6 months of 2019 with new suicide categories. TJC Online 2019; August 14, 2019
https://www.jointcommission.org/issues/article.aspx?Article=j9D9If0uTZpN%2bDbAexKoEEnrWb2821VUkArk6l3gC94%3d

VA National Suicide Data Report 2005-2016; Office of Mental Health and Suicide Prevention, September 2018
https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP_National_Suicide_Data_Report_2005-2016_508.pdf

TJC (The Joint Commission). Special Report: Suicide Prevention in Health Care Settings. Joint Commission Perspectives 2017 Nov; 37(11): 1, 3-7
https://www.jointcommission.org/assets/1/6/November_Perspectives_Suicide_Risk_Reduction.pdf

Sall J, Brenner L, Bell AMM, Colston MJ. Assessment and Management of Patients at Risk for Suicide: Synopsis of the 2019 U.S. Department of Veterans Affairs and U.S.

Department of Defense Clinical Practice Guidelines. Ann Intern Med 2019; [Epub ahead of print 27 August 2019]
https://annals.org/aim/fullarticle/2748922/assessment-management-patients-risk-suicide-synopsis-2019-u-s-department

D'Anci KE, Uhl S, Giradi G, Martin C. Treatments for the Prevention and Management of Suicide: A Systematic Review. Ann Intern Med 2019; [Epub ahead of print 27 August 2019]
https://annals.org/aim/fullarticle/2748923/treatments-prevention-management-suicide-systematic-review