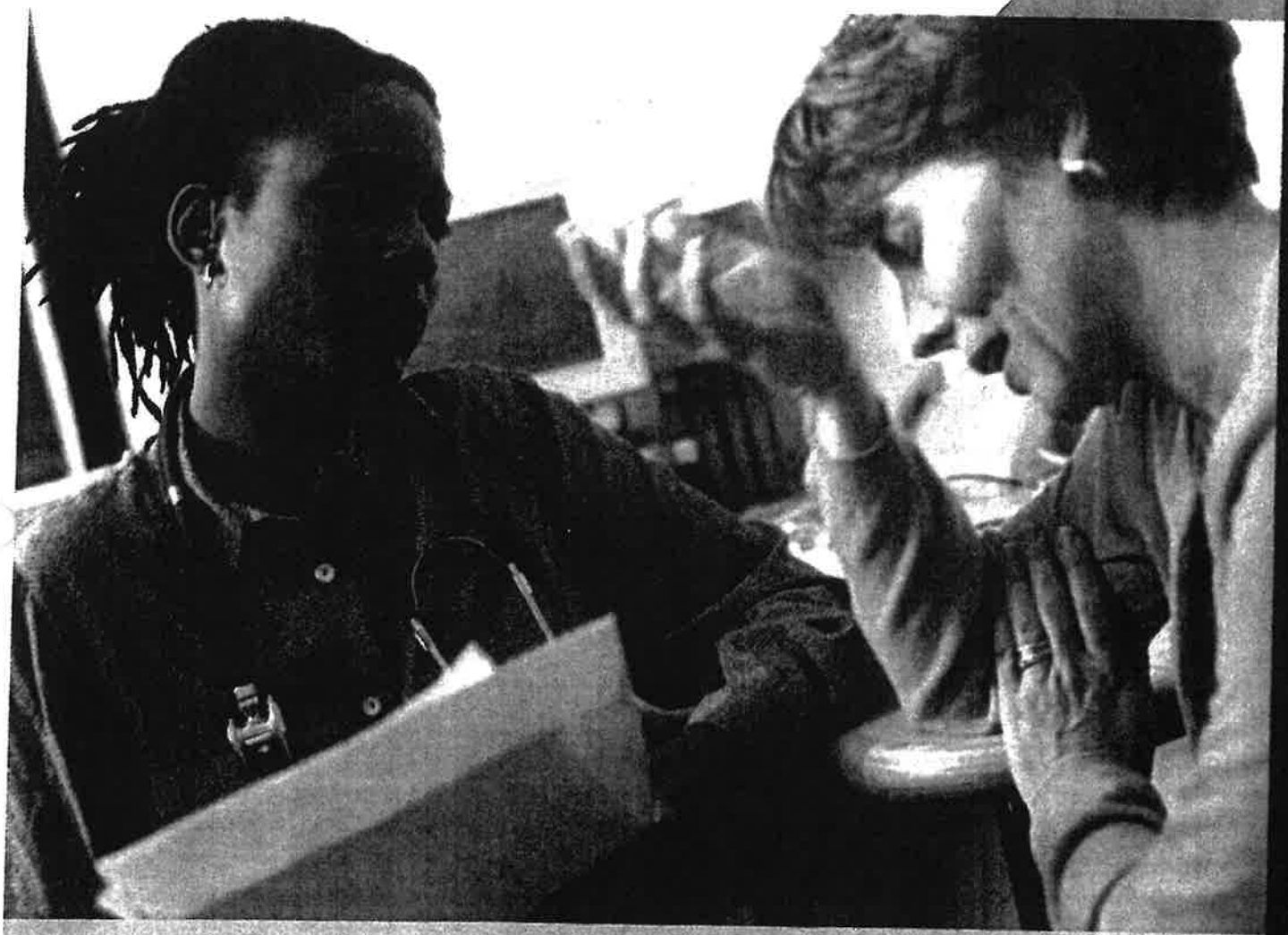
Standards BoosterPak™ for Suicide Risk (NPSG.15.01.01)



The Joint Commission

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A. Description of NPSG and Implementation Expectations

Section A1: Standard Rationale, Elements of Performance (EPs), Scoring Categories, Implementation Suggestions

Program: Hospital and Behavioral Health Care
Chapter: National Patient Safety Goals
Standard Number: NPSG.15.01.01
Standard Text:

Comprehensive Accreditation Manual for Hospitals: Identify patients at risk for suicide.
Note: this requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

Comprehensive Accreditation Manual for Behavioral Health Care: Identify individuals at risk for suicide.
Note: All settings, programs, and services.

Rationale:

Comprehensive Accreditation Manual for Hospitals: Suicide of a patient while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

Comprehensive Accreditation Manual for Behavioral Health Care: Suicide of an individual served while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

Element of Performance 1:

Comprehensive Accreditation Manual for Hospitals: Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.

Comprehensive Accreditation Manual for Behavioral Health Care: Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.

Scoring Categories:
Criticality level: Direct
Documentation required: Yes
Scoring category (A or C): C

Suicide Risk Assessment for Patients/Individuals Served:

- Health care organizations should consider adopting a standardized tool/screening for assessing risk of suicide and consider the use of the tool organizationwide.
  - Standardized tools may be those commonly accepted by the field or standardized locally.
  - Ideally, the tool will produce a rating of suicide risk, either numerical or some other form of rating.
  - The tool should be based on current evidence and leading practice.

- Assess for passive thoughts ("The world would be better off without me.") versus active thoughts ("I am going to take that bottle of pills when I get out of here.")
- Don't be afraid to ask the questions. It is important to directly ask the patient/individual served if he or she is suicidal and/or has a plan. Often patients/individuals served who are suicidal will be relieved that someone asked.
- Remember that patients/individuals served will not normally volunteer the information that they are feeling suicidal, therefore it is important to ask.
- Avoid using statements such as "Patient did not voice any suicidal thoughts." Be sure to reflect that you queried the patient/individual served (for example, "He denied having any suicidal thoughts.").
- Anxiety and agitation are key indicators of suicide risk, as are high energy levels, impulsivity, and sleep deprivation.
- Suicide risk assessments should be conducted on a regular basis—not just on admission. Other times to consider reassessment include change of status, change of diagnosis, prior to a home visit, and prior to discharge.
- Other risk factors can include recent loss, new chronic or terminal diagnosis, divorce, job loss, death of a family member or friend, legal issues, substance abuse, and prior history of suicide attempts.
- There needs to be consistent follow-through for each shift when discussing all patients/individuals served.
- Handoff communication (**PC.02.02.01, EPs 1 and 2 for Hospital [HAP]**) is important when discussing all of the patients/individuals served. All information needs to be shared, even information that staff do not think is significant to share. (For example, "The patient was smiling and participated in activities all day, but cried all evening. He refused to talk to staff. He was in his room all night. Refused to participate in any activities.")
    - **PC.02.02.01:** The hospital coordinates the patient's care, treatment, and services based on the patient's needs. (HAP)
        - **EP 1:** The hospital has a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services (A EP)
        - **EP 2:** The hospital's process for handoff communication provides for the opportunity for discussion between the giver and receiver of patient information. (C EP with Measure of Success [MOS])
- Assess if the patient/individual served is experiencing hallucinations and/or delusions and may harm himself or herself or others.
- Are there multicultural issues or a special population issue that may increase or decrease the risk of suicide?

Environmental Risk Assessments (Institutional Risk Factors):
A recognition that environmental risks are important factors to consider on an organizationwide basis for risk reduction—not just on the mental health programs/services but on all units or patient/individual served care areas.

Comprehensive Accreditation Manual for Hospitals: EC.02.06.01: The hospital establishes and maintains a safe, functional environment.

Comprehensive Accreditation Manual for Behavioral Health Care: EC.02.06.01: The organization establishes and maintains a safe, functional environment.

- Aggregate and document the review results.
- Analysis of the data by leadership to determine risk points and need for action
- Sharing results of the aggregation, analysis, and planned actions with clinical staff
- Mitigation of defined risk areas.

Note: The description of the proactive risk assessment process in the "Leadership" chapter of the Comprehensive Accreditation Manual for Hospitals *and the* Comprehensive Accreditation Manual for Behavioral Health Care *can be a very useful guideline. Please* see ***section B3 of this BoosterPak.***

  - Wanting to be alone in order to follow through with plans of suicide
- It is important that staff assess the potential for elopement.
  - Place the patient/individual served in a room that is away from exits but close to the area where staff are present.
  - Increase frequency of observation of patient/individual served.
- If the patient/individual served needs constant or close observation, be sure this is done by a trained staff member. It is not sufficient to assign this task to a family member.
  - Family members should never be assigned to observe a suicidal patient/individual served while in a 24-hour care setting.
- Observe the patient/individual served closely during medication administration to ensure that he or she swallows all oral medications.

Implementation Suggestions:

- Use the preliminary treatment plan/treatment plan for its intended purpose of identifying and addressing immediate treatment and safety needs.
- For patients/individuals served who are clinically assessed as possessing one or more risk factors for suicide, those factors with **individualized interventions** should be identified and reflected on the preliminary treatment Plan.
- Counteracting heightened patient/individual served vulnerabilities regardless of cause requires good communication among the clinical and unit staff when changes of functional or mental health status occur during treatment.
  - If the patient/individual served receives an upsetting phone call or experiences a disappointing event, constant communication with the patient/individual served and staff is important.
  - Elevated awareness, increased engagement, and closer supervision are good tools to employ when patients/individuals served experience disturbing news or experience a disappointing event while in treatment.
- Completing a suicide risk assessment for all patients/individuals served at the time of consideration for discharge is a good practice and should include assessment for access to weapons.
- Implement an educational program for all staff regarding "Assessment of Patient/Individual Served Risk Factors for Suicide."

Tips:

- Staff should consider the suicide risks in multicultural and special populations.
- Conduct psychiatric environmental risk assessments. Develop a plan of action for those areas that have risks for self-harm.
  - When the environment cannot be easily corrected, consider creating one safe area in which to place patients/individuals served or utilize clinical interventions such as close monitoring.
- Emergency rooms can use an aluminum roller door over counters, in-wall gases, and cupboards that can be quickly locked down to make a the room of a patient/individual served safe.
- Review procedures for contraband detection and engaging family and friends in the process.
- Implement professional practice/evidence-based guidelines for patients/individuals served at risk for suicide.
- Develop educational programs for staff in working with suicide risks for multicultural and special populations.

Section A2: Assessing Compliance During the On-Site Survey

The surveyor will do the following:

- Evaluate the effectiveness of your organization's suicide prevention strategy
- Identify processes and system-level issues that could contribute to suicide attempts

The surveyor begins by reviewing the record of a patient/individual served to attain an understanding of services provided and patient/individual served specific issues. The surveyor interviews the clinical staff working with the patient/individual served about the following issues:

- Crisis process
- Initial screening/assessment process
- Reassessment process, including the triggers for frequency
- Planning process of care, treatment, and services
- Continuum of care, treatment, and services (for example, crisis hotline referrals)
- Education provided to the patient/individual served and family
- Orientation, training, and competency of clinicians and other staff
- Staffing
- Information management

The surveyor does the following:

- Traces the care, treatment and services process from entry of the patient/individual served into the organization
- Interviews other staff, (for example, security, counselors) inquiring about their training and processes relative to caring for and protecting suicidal patients/individuals served.
- Assesses the environment for the presence, or absence, of items that would prevent suicide, (for example, breakaway bars, no locks on doors). This includes tracing the suicide prevention features currently in use back through the organization's environmental risk/safety assessment to determine if such a need was identified. They may ask the organization to provide the risk assessment and to also discuss any related adverse outcomes.
    - Identified risks can be mitigated through changes in the physical environment and/or through staff interventions like more frequent monitoring and using only "safe" areas for those at risk for suicide.
- Assess the organization's policy and procedure on suicide risk assessment, as indicated which should include a copy of the screening instrument, procedures for conducing the assessment and any competency-related issues of the staff conducting the assessments. Has the policy been reviewed and approved by the organization's clinical leadership?
- May also interview patients/individuals served (with their permission) who have been identified at risk but who are no longer displaying acute at-risk behavior/thoughts. The purpose of the interview is to learn more about the perception of safety of the patient/individual served and the helpfulness of the assessment and intervention process.
- Interviews the clinical staff working with the patient/individual served about the following issues:
    - Crisis process
    - Initial screening/assessment process
    - Reassessment process, including the triggers for frequency
    - Care, treatment, and services implementation and planning process
    - Continuum of care, treatment, and services (for example, discharge plan, crisis hotline referrals)
    - Education provided to the patient/individual served and family

B. Frequently Asked Questions, Definitions, and Additional Information About Specific Topics

Section B1: Frequently Asked Questions (FAQs)

(Adapted from the Joint Commission Web site)

Suicide Risk Reduction

Applicability to general hospitals

Q: In our hospital, we do not have a psychiatric unit, but we do admit patients who have psychiatric disorders along with their medical conditions. Does this requirement apply to us?

A. NPSG.15.01.01 applies to all patients/individuals served in organizations surveyed under the BHC (Behavioral Health Care) standards, all patients in psychiatric hospitals, and to any patient in a general hospital with a primary diagnosis or primary complaint of an emotional or behavioral disorder. At this time, suicide risk assessment of patients/individuals served with secondary diagnoses or secondary complaints of emotional or behavioral disorders is encouraged but not required.

For purposes of this requirement, the phrase "emotional or behavioral disorders" refers to any DSM diagnosis or condition, including those related to substance abuse.

The phrase "being treated" is interpreted in terms of the diagnosis or presenting "complaint." of the patient/individual served

The nature of the treatment is really not the issue.

Outpatients

Q. With respect to general hospitals, is this just an inpatient requirement?

A. No. NPSG.15.01.01 applies to all hospital services that is, it applies to any facility, location, or practice setting that is included in a survey conducted under these standards, but only with respect to patients/individuals served as defined above. So an emergency department or hospital-based ambulatory care facility or even hospital-based office practices, if they are part of the hospital survey, will be within the scope of this requirement.

Emergency departments (EDs)

Q. What is the expectation for a patient brought to our general hospital ED for a psychiatric-related condition when the patient will most likely be transferred to a psychiatric facility?

A. The requirement under this safety goal is that a suicide risk assessment will be done in the receiving ED, and appropriate precautions will be taken. There are several cases in The Joint Commission's Sentinel Event Database of suicides in emergency departments while the patients/individuals served were awaiting transfer.

Applicability-sample scenarios

Q. For each of the following general hospital scenarios, would a suicide risk assessment be required?

1. A patient seen in the ED for a fracture sustained in the act of attempting suicide
    - This patient has already identified himself or herself as "at risk" by virtue of the suicide attempt.

Section B2: Definitions of Key Terms

Glossary of Suicide Prevention Terms
From the *National Strategy for Suicide Prevention: Goals and Objectives for Action.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001
https://store.samhsa.gov/shin/content/SMA01-3517/SMA01-3517.pdf

Suicidal act (also referred to as suicide attempt): a potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries

Suicidal behavior: a spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide

Suicidal ideation: self-reported thoughts of engaging in suicide-related behavior

Suicidality: a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide

Suicide: death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death

Suicide attempt: a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries

Suicide attempt survivors: individuals who have survived a prior suicide attempt

Suicide survivors: family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors

Section C: Supporting Documentation, Evidence, Value, Historical Information, and Additional References and Links

Section C1: Supporting Documentation and Evidence

Suicide ranks as the 11th 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 or within 72 hours of discharge has remained in the top 5 most frequently reported sentinel events to The Joint Commission since 1995. Identification of individuals at risk for suicide while under the care of, or following discharge from, a behavioral health care organization or a hospital psychiatric inpatient setting, is an important first step in protecting and planning the care of these at-risk individuals.

Evidence base and consensus process used during development
Staff proposed the topic of suicide risk assessment and prevention for consideration as a National Patient Safety Goal for 2007.

The Sentinel Event Advisory Group (now called the Patient Safety Advisory Group) approved making this goal applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals in 2006 for a 2007 implementation.

Expert panel, task forces
None convened. Topic brought to the Sentinel Event Advisory Group for consideration, followed by the Standards and Survey Procedures Committee approval in April 2006.

Field review process and results
The Joint Commission conducted a field review of the potential 2007 National Patient Safety Goals and Implementation Expectations. The National Patient Safety Goals were widely disseminated for comment to organizations and individuals with an interest and expertise in health care. More than 1,400 responses to the field survey were received.

The health care field's feedback was sought by asking questions specific to potential goals and requirements. The field was asked if the requirement should be added as a goal in 2007. Options were "yes," "yes with modification" or "no." Respondents who answered "yes with modification" were asked to elaborate on their responses. Respondents who answered "no" were asked to indicate why they did not support the goal. Response options included relevancy to quality and safety, priority, practicality, lack of staff required for implementation and lack of equipment needed for implementation.

A little more than half of the hospital respondents agreed with the requirement as written or with modification. As a result of the responses, it was clarified that this goal applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals and organizations accredited under the *Comprehensive Accreditation Manual for Behavioral Health Care.*

Feasibility testing results (setting-specific)
None performed at the time of development

Suicide and Self Injurious Behavior

Recognizing Risks/Warning Signs/Intervention

Mental Health Risk Factors/Suicide

- Major Depressive Disorder
- Mood Disorders
- Anxiety Disorders
- Substance Abuse
- Conduct Disorder
- Impulse Disorder
- Previous Suicide Attempt

Depression

- The most common mental health disorder among adults who have committed suicide.
- Early detection/intervention/treatment can save live.

Recognizing Signs Of Depression

- Low Self-esteem
- Risk-taking
- Withdrawal
- Physical Complaints
- Aggression
- Trouble With Sleep
- Eating Disorders

Recognizing Signs of Bipolar Disorder

- Rapid Mood Swings
- Sleep Difficulties
- Temper Tantrums
- Irritability
- Reckless Behavior
- Sexually Promiscuous
- Racing Thoughts
- Symptoms of Depression

Adult Suicide: Risk Factor

- Feeling Isolated
- Ineffective Coping Skills
- School/Family Crisis
- Loss
- Feeling Disappointed Or Rejected
- Harassment/Bullying
- Sexual Identity Crisis
- Exposure To Violence/Abuse
- Past Suicide Attempts

Suicide: Recognizing Warning

- Making Suicidal Threats
- Plan
- Sudden Changes in Behavior/Habits/Friends/Appearance/Mood
- Increased Trouble With Concentration/Thinking
- Feelings of Hopelessness
- Anger
- Anxiety/Agitation
- Changes In Sleep/Insomnia
- Loss of Interest In Things They Usually Enjoy
- Alcohol/Drug Use or Abuse

Suicidal Adult: Crisis Intervention

- Find A Way To Connect With The Adult
- Know The Warning Signs
- Supervise Closely
- Take Threats Seriously
- Offer Support
- Encourage Positive Coping Skills
- Contract For Safety
- Encourage Following Treatment Plan
- Individual/Family Therapy
- Hospitalization/Medication If Indicated
- The Best Way To Prevent Suicide is Early Intervention.

Self Injurious Behavior: "HELP"

- Self Injury has a dangerous connection to suicide.
- Adults who report SIB without the intent of suicide are still more likely than other adults to report having considered or attempted suicide.

Types Of SIB

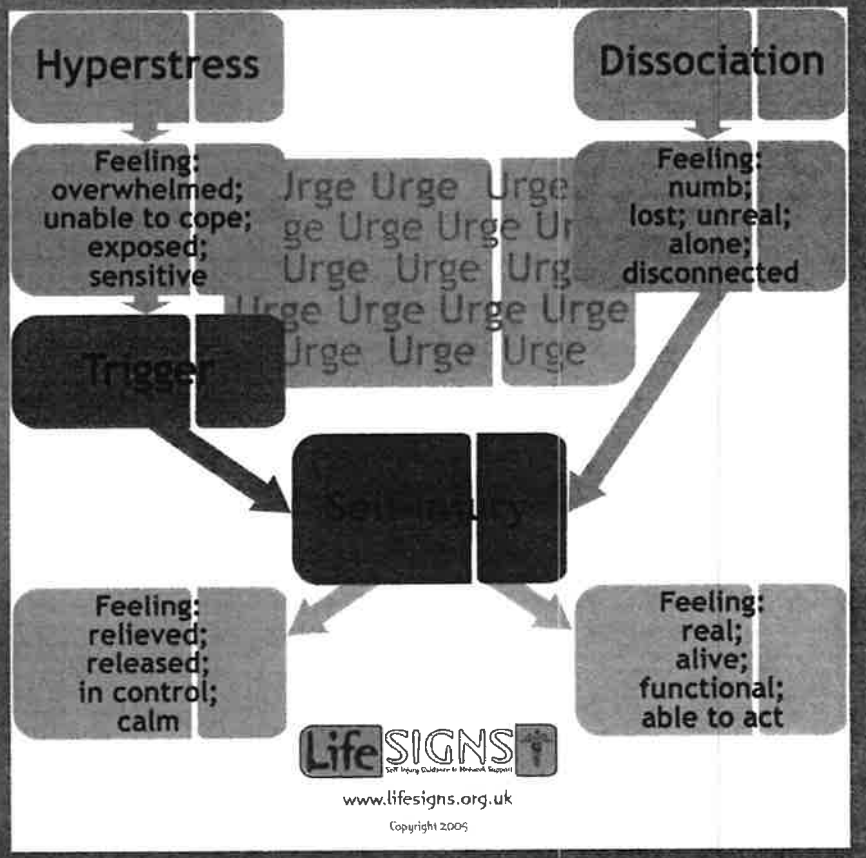
- Cutting
- Burning
- Hair Pulling
- Hitting Self
- Picking Or Scratching Wounds
- Breaking Bones

SIB: WHY?

- Reduces Uncomfortable Emotional Pain
- A Way To Remain In Control
- Release Anger
- Anxiety
- Energy Rush/Feels Good
- Communicate Needs
- Express Feelings
- To reenact a trauma in an attempt to resolve it or to protect other from their emotional pain.
- Lack Of Coping Skills
- Self Punishment
- Inability To Express Emotions

Facts About Adults Who Self Injure

- Above Average In School
- Creative
- Sensitive
- Helpful To Others



Warning Signs Of SIB

- Frequent Complaints Of Accidental Injury
- Defensive When Asked About Possibility Of SIB
- Wearing Concealing Clothing
- Presence Of Objects Such As Knives, Razor Blades, Or Lighters With No Explanation For Them
- Presence Of Wounds/Scars

Intervention/Response For SIB

- Connect
- Encourage Verbalization Of Feelings
- Recognize Strengths/Weaknesses
- Encourage Positive Coping Skills
- Develop a plan to include taking responsibility for behavior, reduce harm inflicted by the behavior, identify positive reactions to triggers, identify safe people and places to seek when the urge arises, and avoidance of objects that could be used for self harm.
- Appropriate Level Of Treatment (Therapist, Psychologist, Psychiatrist, Medication, Hospitalization.)

CRENSHAW COMMUNITY HOSPITAL

Suicide Leveling System Assessment

Assessment Parameters	No Risk	Low Risk/ Level 3	Moderate Risk/Level2	High Risk/Level 1
1. Current Ideation, Plan and Intent (Admission assessment includes suicidal criteria within a 2 week time frame)				
A. Suicidal Thoughts	_____ None Present (0)	_____ Infrequent or passive thoughts without plan or intent (3)	_____ Frequent or Passive with vague plan with no intent (4)	_____ Continuous and/or contain specific plan and/or stated intent (6)
B. Suicidal Plan	_____ None Present (0)	_____ Unrealistic low lethality with an intent; unavailable means (3)	_____Vague but realistic plan; available means (4)	_____Specific realistic plan with available means (6) *
C. Suicidal Intent	_____ None Present (0)	_____Passive desire to die without self-injuries actions or intent (3)	_____Expresses vague intent without consideration of plan (4)	_____Active intent to develop and/or carry out plan (6)
D. Contract for Safety	_____ Able & Willing (0)		_____Ambivalent (3)	_____Unable/Refused (5)*
2. History of Suicidal Behavior				
A. History of Suicide Attempts	_____No previous history (0)	_____1-2 low lethality attempts or non-suicidal self-injuries acts in the past two years (2)	_____One or more serious attempts more than 12 months ago >2 low lethality attempts or non suicidal self-injurious acts in the past year (3)	_____History of suicide of family/close friend (4) _____One or more serious attempts within past 12 months (5)
B. Lethality of past self-injurious behavior (If more than one, score most severe).	_____ None Present (0)	_____Superficial or non suicidal self injurious act without injury requiring treatment (1)	_____Non suicidal self injury or serious attempt with non life-threatening injury requiring treatment (3)	_____Serious attempts with actual or potential life threatening injury (5)
3. Psychological Factors				
A. Depression	_____ None Present (0)	_____mild; feels "slightly down" (2)	_____Moderate; moody, sad (3)	_____Overwhelmed; hopeless; sudden change in demeanor (5)
B. Anxiety	_____Little or None (0)	_____Low; denies episodes of intense anxiety (3)	_____Moderate; Infrequent episodes of intense anxiety (4)	_____High; frequent episodes of intense anxiety; PTSD or panic symptoms (5)
C. Psychosis	_____ None (0)	_____Some mild delusions but reality testing intact (3)	_____Paranoid delusions or ideas of reference, with poor reality testing (4)	_____Command hallucinations for self-harm, severe unremitting delusions (6)
D. Alcohol/Drug Use	_____ None (0)	_____Infrequent or past use only, no excessive use (1)	_____Frequent use, not excessive or occasional use (3)	_____Frequent, excessive or indiscriminate use, or recent increase (4)
E. Anger/Impulsivity	_____ None (0)	_____Low; rare outbursts, few impulsive acts (2)	_____Moderate; occasional outbursts, occasional impulsive acts (3)	_____High; frequent or severe outburst, frequent or aggressive impulsive acts (5)
4. Medical Factors	_____ None (0)	_____Acute but short term no disruption in ADL (1)	_____Chronic or acute, with mild disruption of ADL (2)	_____Chronic, or severely debilitation (3)
5. Resources or Support	_____Adequate family/social resources (0)	_____Limited family/social resources (1)	_____Marginal family/social resources (2)	_____Absent or hostile family/social resources (3)
6. Situational	_____Non-contributory (0)	_____1-2 Stressors (2)	_____3 Stressors (3)	_____4+ Stressors (4)

No risk: **0-7** Low Risk/Level 3: **8-20** Moderate Risk/Level 2: **21-36** High Risk/Level 1: **37+, or any with indicator ***

Patient Score and Risk _____ Observation Level: _____ Q15min checks _____ 1:1 LOS _____1:1 WAL

Nurse's Signature _____Date/Time_____