Ligature Risks: Compliance with the CMS and TJC Standards
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Introduction into the CMS Hospital CoPs
Suicide Prevention

- Every 12 minutes someone in the United States takes his or her own life
- So during this 2 hour webinar, 10 people have committed suicide
- For every one suicide, there are 25 attempts
- Each year more than 900,000 emergency department visits are made by people thinking of suicide
- It is the 10th leading cause of death in the US
  - SAMHSA/HRSA Center for Integrated Health Solutions
SUICIDE PREVENTION

This webpage, focused on suicide and suicide prevention, is geared toward health, behavioral health, and integrated care leadership, providers, and patients/consumers. The information and resources listed here can be easily adapted to other groups and settings. Suicide, Intimate Partner Violence (IPV), and Trauma are often interrelated. Trauma is highly prevalent and a major risk factor for suicide and IPV. It is, therefore, vital for all staff employed by health, behavioral health, and integrated care organizations to understand the nature and impact of trauma and how to use principles and practices that can promote recovery and healing: Trauma-Informed Approaches. In addition to information and resources on Suicide Prevention, at the CIHS website you will find links to Trauma and Trauma-Informed Approaches webpages, as well as IPV webpages, which we encourage you to explore.

Every 12 minutes, someone in the U.S. takes his or her own life. And for every one suicide, there are 25 attempts. Suicide is the 10th leading cause of death in the U.S., and the number and rate of suicides are rising. Each year, more than 900,000 emergency department (ED) visits are made by people thinking of suicide.

Suicide as a public health issue affects everyone: families, health care providers, school personnel, faith communities, friends, and government. The good news is that suicide is often preventable. Research findings by the Henry Ford Health System clearly make the case that health care providers can play a critically important role in preventing suicides by identifying those at risk and responding appropriately. They found that the mental health conditions of most people who die by suicide remain undiagnosed, even though most visit a primary care provider, ED, or medical specialist within the year before they die. The risk of suicide attempts and death is highest within the first 30 days after a person is discharged from an ED or inpatient psychiatric unit;
CMS survey reveals serious deficiencies at South Dakota hospital

CMS has placed the Indian Health Service hospital on the Rosebud (S.D.) Sioux Indian Reservation on "immediate jeopardy" status and will terminate the hospital's Medicare provider agreement Aug. 30 unless the deficiencies are corrected.

Here are five things to know:

1. CMS discovered the issues during a survey of the hospital in late July. The incidents that led to the "immediate jeopardy" status were detailed in a report released Aug. 17, according to The Wall Street Journal.

2. In one incident, a 12-year-old girl reportedly attempted to strangle herself with a call-light cord and shoe laces after she was left alone in a closed room for 20 minutes. She had previously been asking to see her dead father and was despondent. CMS regulators said hospital staff failed to follow proper procedures.

3. CMS said hospital staff failed to follow proper restraint and emergency procedures when restraining a mentally disturbed man. The 35-year-old patient died of cardiac arrest the day after he was improperly restrained, according to WSJ.

4. In a statement to WSJ, IHS said it had made "measurable improvements" at the Rosebud hospital and presented a correction plan to CMS.

5. This is the second time in recent years CMS has threatened to revoke the hospital's Medicare billing privileges. In...
Introduction Ligature Risk

- CMS issued a 13 page memo on clarification of ligature risk policy for hospitals-
  - Amends tag 144 and 701
  - Added to December 29, 2017 manual
    - Preventing inpatient suicide and creating a safe care setting is important to both TJC and CMS
- CMS wants a safe environment to prevent patients from hanging or strangulating themselves
  - Focuses on the care and safety of behavioral health patient and staff
Center for Clinical Standards and Quality/Survey & Certification Group

DATE: December 08, 2017

TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group

SUBJECT: Clarification of Ligature Risk Policy

Memorandum Summary

• Ligature Risks Compromise Psychiatric Patients’ Right to Receive Care in a Safe Setting: The care and safety of psychiatric patients and the staff that provide that care are our primary concerns. The Centers for Medicare & Medicaid Services (CMS) is in the process of drafting comprehensive ligature risk interpretive guidance to provide direction and clarity for Regional offices (RO), State Survey Agencies (SAs), and accrediting organizations (AOs).

• Definition of a Ligature Risk: A ligature risk (point) is defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes, and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures.

• Focus of Ligature Risks: The focus for a ligature “resistant” or ligature “free” environment is primarily aimed at Psychiatric units/hospitals.

• Interim Guidance: Until CMS’ comprehensive ligature risk interpretive guidance is released, the ROs, SAs and AOs may use their judgment as to the identification of
Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

DATE: July 20, 2018

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group (former Survey and Certification Group)

SUBJECT: CMS Clarification of Psychiatric Environmental Risks

**Memorandum Summary**

- **Proposed Psychiatric Task Force:** The Proposed Psychiatric Task Force to address the environmental risks associated with the care of psychiatric inpatients is not the most appropriate vehicle to foster the changes that are required.

- **Ligature Risks Compromise Psychiatric Patients’ Right to Receive Care in a Safe Setting:** The care and safety of psychiatric patients and the staff that provide that care are our primary concerns. CMS is incorporating the outcomes of the TJC Suicide Panel (in which CMS participated) into comprehensive ligature risk interpretive guidance to provide improved direction and clarity for state survey agencies (SAs) and accrediting organizations (AOs).

- **Interim Guidance:** Until CMS’ comprehensive ligature risk interpretive guidance is released, the SAs and AOs may use their judgment as to the identification of ligature and other safety risk deficiencies, the level of citation for those deficiencies, as well as the approval of the facility’s corrective action and mitigation plans to minimize risk to patient safety and remedy the identified deficiencies.
## Facility Extension Request & Progress Updates

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### FOR CMS USE ONLY:

- **Extension Granted:** Select
- **Length of Extension:**
- **New Expected Date of Completion:**
- **Progress Report # 1 Due:**
- **CMS Comments / Notes:**

December 29, 2017 Changes

- Transmittal issued and updated CMS Manual
- Changes to tag 144 on the rights of the patient to receive care in a safe setting
  - Need to have safe a setting to prevent inpatient suicide or any form of self harm
  - Remember separate CMS memo on ligature risks
  - Patient assessment must be done
- Updates tag 701 on buildings and needs to be constructed and maintained to minimize risk
  - Address age related safety features, security, weather related issues and ligature risks
Ligature Risks Also Called SOM

State Operations Manual
Appendix A - Survey Protocol,
Regulations and Interpretive Guidelines for Hospitals

Table of Contents
(Rev. 176, 12-29-17)

Transmittals for Appendix A

Survey Protocol

Introduction
Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings
Task 5 - Exit Conference
Task 6 - Post-Survey Activities

Psychiatric Hospital Survey Module
Psychiatric Unit Survey Module
Rehabilitation Hospital Survey Module
Inpatient Rehabilitation Unit Survey Module
Hospital Swing-Bed Survey Module

Email questions
hospitalscg@cms.hhs.gov

How to Keep Up with Changes

- Many times hospitals ask how can we keep up with new changes in the future?
- Have one or two people in your hospital who have the following responsibility
  - First, once a month check to see if a new CoP manual has been issued
  - Once a month go out and check the survey and certification website to see if any new memos or transmittals
- Sign up to get the Federal Register
- You can email questions to CMS directly now
Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.

The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.

To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers.


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Also Called the SOM

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

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Transmittals for Appendix A

Survey Protocol

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Hospital Swing-Bed Survey Module

Email questions hospitalscg@cms.hhs.gov

Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Select From The Following Options:

- Show all items

- Show only (select one or more options):
  - Show only items whose is within the past
  - Show only items whose Fiscal Year is
  - Show only items containing the following word

Show Items

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Free Guide After An Attempt for EDs

https://store.samhsa.gov/product/SMA18-4359
CMS Hospital CoP Deficiency Reports
Access to Hospital Complaint Data

- CMS has issued quarterly deficiency reports since March 22, 2013
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
- Hospitals can monitor how many deficiencies in ligature risks and a safe environment
- Names hospitals and their full addresses
Updated Deficiency Data Reports

Hospitals

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules it is possible for ‘one’ hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital’s compliance:

- Components appropriately certified as other kinds of providers or suppliers, i.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Facility, Home Health Agency, Rural Health Clinic, or Hospice; Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act; and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient service departments

Accredited Hospitals - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital’s compliance with the Medicare Conditions of Participation (CoP) for all services, areas and locations covered by the hospital’s provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct
Search for Hospital Inspections

Search hospital inspections

Welcome to hospitalinspections.org, a website run by the Association of Health Care Journalists (AHCJ) that aims to make federal hospital inspection reports easier to access, search and analyze. This site includes details about deficiencies cited during complaint inspections at acute-care, critical access or psychiatric hospitals throughout the United States since Jan. 1, 2011. It does not include results of routine inspections or those of long-term care hospitals. It also does not include hospital responses to deficiencies cited during inspections. Those can be obtained by filling a request with a hospital or the U.S. Centers for Medicare and Medicaid Services (CMS).

This effort follows years of advocacy by AHCJ to encourage federal officials to publish this information electronically. Until now, this information has only been available through Freedom of Information Act requests – and only in paper form. Funding for this project was provided by the Ethics & Excellence in Journalism Foundation.

Because CMS has just begun gathering this data and releasing it in electronic format, it remains incomplete. Some reports are missing narrative details, and those are noted on each hospital's page. Beyond that, CMS acknowledges that other reports that should appear may not. CMS has pledged to work with AHCJ to make future iterations of this data more complete. At this time, this data should not be used to rank hospitals within a state or between states. It can be used to review issues identified at hospitals during recent inspections.

Clicking on a state on the map will retrieve a list of all hospitals with their violations grouped together; choosing a state from the drop down menu will list all inspection reports separately, so a hospital may appear more than once.

Last updated: May 2018
Tag 144 Ligature Risks and Self Harm in Patient Rights Section
Suicide Rate

- Why is CMS and TJC focusing on prevention of suicide?
- Suicide is the 10th leading cause of death
- There were 41,149 suicides in the US
  - Males take their life 4X more than females or 77.9% of all suicides
  - Firearms most common in males (56.9%) and poisoning for females (34.8%)
- This is a rate of 12.6 per 100,000
- Equal to 113 suicides each day
- One suicide every 13 minutes
- 17% of students seriously considered suicide in the past year
What to Do?

- Has your hospital assessed the risks to behavioral health patients on prevention of ligature, suicide, and self-harm?
- What has your hospital done to remove these risks?
- Do you have a policy and procedure?
- Have staff been educated on the policy?
- How do you ensure you have enough staff to support the mitigation risks?
- Do you do an individual suicide assessment on each behavioral health patient?
What to Do?

- Identify the areas that behavioral health (BH) patients are cared for in both dedicated area like the BH unit and non-dedicated such in the ED, medical surgical units, ICU, etc.

- The environmental risk assessment is best performed by a multi-disciplinary team

- Consider short term and long term mitigation strategies based on your risk assessment

- Ensure competency of staff who care for BH patients and don’t forget training of anyone who interacts with patient including radiology, lab or housekeeping (ES)

- Monitor the bathroom of the suicidal patient

- Patients and visitors must be monitored
What is a Ligature Risk?

- Anyone who works with patients at risk of hanging or strangulation and who has a duty of care should have anti-ligature training.

- A ligature risk or point is defined by CMS.

- It includes anything that could be used to attach a cord, rope, or other material for purposes of hanging or strangulation.

- This includes handles, coat hooks, pipes, shower rails, radiators, bedsteads (framework of bed on which mattress is placed), window or door frames, ceiling fittings, hinges, and closures.
Anchor Points

- Anchor points could also include:
  - Gaps between the window or the door and its frame
  - Window or door handles
  - Shower heads and shower controls
  - Sink taps
  - Furniture such as metal bed frames arms and chair or table legs
  - Door hinges
  - Ventilation grills, ceiling vents and ducts
  - Sprinkler heads
What is a Ligature Risk?

- A ligature point is a fixed point which a ligature can be tied to, wedged around or behind or held in place by any means which enables the ligature to bear the weight of the patient either wholly or partially.
  - It is any loop or noose that could be attached to the ligature point to enable the patient to hang or strangulate.

- Anti-ligature fittings are those designed in a way to seriously impede the typing or prevent a ligature to it or is designed to break away.

- Risks include plastic bag, bra straps, torn strips of clothing, phone charger cord, phone cord, rubber strips from door seals, ties, shoe laces, cords and belts.
Psychiatric patients have a right to receive care in a safe setting and ligature risks compromise this right.

CMS said they are drafting a comprehensive ligature risk guidance to provide additional clarity so stay tuned for additional information.

The focus of a ligature free environment or ligature resistant is primarily aimed at psychiatric hospitals and behavioral health units.

- Recommend use the terminology ligature resistant.

However, we still need to keep patients who are suicidal safe no matter what unit they are on.
CMS Ligature Risk

- CMS mentions the CQC ligature point memo
  - 75% of patient in the psych unit kill themselves by hanging or strangulation
  - Risk is greater in a room where patients spend time in private without any supervision
  - Risk is greater if nursing staff cannot easily observe all areas of the unit because of poor design or not enough staff
  - Ligature point is between 0.7 and 4 meters (2.3 to 13 feet) from the ground
  - Need policy and procedure
  - Risk assessment of patient and room assigned accordingly
  - Review the ligature audit
Ligature points

Context

Three-quarters of people who kill themselves while on a psychiatric ward do so by hanging or strangulation. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures.

The risk posed by a ligature point is greater if:
1. It is in a room in which patients spend time in private without direct supervision by staff (e.g. bedroom, toilet, bathroom).
2. It is in a ward/area used by high-risk patients (e.g. acute mental illness; high risk of suicide; challenging or chaotic behaviour; comorbid substance misuse).
3. The ligature point is between 0.7 metres and 4 metres from the ground.
4. Nursing staff cannot easily observe all areas of the ward because of poor ward design or because there are too few nurses on duty.

Evidence required

The activities inspection teams will carry out include, but are not limited to, the following:
1. Request and examine provider ligature risk reduction policy and procedure.
2. When touring the ward area, check for ligature points. Are these high risk ie.:
   - in rooms where patients spend time unsupervised?
   - in areas of the ward that are difficult to observe because of the ward design?
# Assessment and Management of Ligature Care Policy

**Version: 4**

## Summary:
This policy sets out the Trust’s approach to ensuring that ligature points are identified, assessed for level of risk and managed.

This policy is supported by the Assessment and Management of Ligature Points Procedure and Standard Operating Procedure: The Use of Ligature Cutters in Mental Health and Learning Disabilities.

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## Target Audience:
All staff who work in mental health and learning disability divisions.

## Next Review Date:
November 2019
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**Appendices**

A1 Environmental Care Plan
A2 Ligature Information for Induction
A3 Training Needs Analysis (TNA)
**Standard:** The patient has the right to receive care in a safe setting

- In order to provide care in a safe setting, the hospital must identify patients at risk for intentional harm to self or others
- The hospital must identify environmental safety risks for these patients
- The hospital must provide education and training for staff and volunteers
- Patients at risk of suicide are in both inpatient and outpatient locations
CMS Ligature Risk

- As discussed previously, the ligature free or resistant environment is for behavioral health hospitals and psych units of acute care hospitals.

- It does **not** apply to other non-psych departments such as the ED, ICU, and medical-surgical units.

- **However**, CMS says that psych patients may be treated in these units and the hospital must also identify patients at risk for intentional or self harm.

- The hospital must still mitigate environmental safety risks.
  - Will discuss the Design Guild to create safe rooms later.
CMS Ligature Risk

- Patients having suicidal ideations outside the psych units must still be protected.
- This might include:
  - 1:1 monitoring with continuous visual observations
  - Removal of sharp objects from the room
  - Removal of equipment that can be used as a weapon
- Note that some hospitals have created a safe room on each unit or several safe rooms in the ED depending on the number of boarded psych patients.
CMS Ligature Risk

- Hospitals are expected to follow nationally recognized standards of care and guidelines to minimize risk to suicidal patients.
- Need to prevent patients from self-harm or harm to others.
- Potential risks include those from ligatures, sharps, harmful substance, access to medications, breakable windows, accessible light fixtures, plastic bags (suffocation), oxygen tubing, bell cords, etc.
Indentifying Patients at Risk

- There are many patient risk assessment tools available to help identify which patients are at risk.
- There is no one size fits all.
- The risk assessment tool used should be appropriate to the patient population, setting, and staff competency.
  - Such as the emergency department, post-partum or pediatric population.
- The hospital must do an appropriate patient risk assessment.
What Assessment Tool Do You Use?
Environmental Safety Risks

- The hospital must implement an environmental risk assessment strategy
- May not be the same in all hospital or in all units
- Must be specific to the unit and patient population
- This does **not** mean that a unit that generally does not care for suicidal patients has to conduct environmental risk assessments
- But, the unit needs to consider the possibility they may have a patient who is at risk for harm to self or others
Environmental Safety Risks

- However, the hospital may want to consider using the tool to assess risks for patient safety and risk management reasons.

- The hospital should **document** the assessment findings.

- CMS mentions the VA environmental risk assessment tool.

- CMS mentions it is a way for hospitals to **assess** for safety risks in all patient care environments or areas.

- CMS also lists some environmental safety risks.
Environmental Safety Risks

- Environmental safety risks includes:
  - Unattended items in housekeeping carts such as hazardous items
    - Mops, brooms, cleaning agents, hand sanitizer, etc.
  - Unsafe items brought to patients by visitors in locked psych units and psych hospitals
  - Call lights, hand rails, door knobs, door hinges, sheets, towels, shower curtains, wall towel dispensers, shoe laces, handles, power cords, light fixtures, windows that can be broken etc.
  - Inadequate staffing to observe and monitor patients
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### VA EC Checklist for Mental Health Environment

#### Mental Health Environment of Care Checklist for Bathrooms

In addition to the following criteria, bathrooms must also meet all General Criteria.

<table>
<thead>
<tr>
<th>Ques. No.</th>
<th>ePSAT cross reference number</th>
<th>Site / Item</th>
<th>Questions / Criteria</th>
<th>Rationale / Assessment Methods:</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>7.2.13.3.1</td>
<td>Light Fixtures</td>
<td>Are light fixtures securely mounted to the ceiling by inaccessible fasteners or tamper resistant fasteners (or equivalent) with non breakable lenses?</td>
<td>Flush mounted fixtures are recommended, however surface mounted lights are acceptable provided they do not provide an anchor point for hanging. All energized parts must be secured with tamper resistant fasteners. It is required by NFPA 70 to have GFCI circuits in all wet locations.</td>
</tr>
<tr>
<td>45</td>
<td>7.2.13.3.2</td>
<td>Walls/Tiles</td>
<td>Are walls solid (gypsum, plaster/lath, concrete block, etc.) and free of Ceramic Tile? <strong>Note: Only new units need to be free of ceramic tile with the exception of 2 inch by 2 inch tile on the floor.</strong></td>
<td>Ceramic tile may be broken and the shards used for self injury or as a weapon. If gypsum board walls are provided in rooms serving patients in seclusion rooms’ additional protection is needed. These walls should be provided with a backing material such as fire treated plywood, or equivalent, to provide additional structural integrity.</td>
</tr>
<tr>
<td>46</td>
<td>7.2.13.3.3</td>
<td>Grab rails</td>
<td>47.a. Are grab rails installed around the toilet and shower areas the closed type that prevent materials from being wrapped around them?</td>
<td>The grab rail should be of a design that permits them to be easily grasped while preventing materials from being threaded through that meet ABA standards. For example rails with continuous filer that extends down from the bottom of the rail before going to the wall (in...</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>48</td>
<td>7.2.13.3.5</td>
<td>Towel Bars</td>
<td>Have towel bars been removed and replaced with flip-down type hooks designed to support the weight of a bath towel and nothing heavier?</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>7.2.13.3.6</td>
<td>Mirrors</td>
<td>Are mirrors shatter proof or other non breakable material and affixed to the wall using tamper resistant fasteners and unable to be used as an anchor point for hanging? Polished stainless steel mirrors are preferred.</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>7.2.13.3.7</td>
<td>Electrical Receptacles</td>
<td>If electrical receptacles have not been removed and covered by a plate fastened using a tamper resistant fastener, is a Ground Fault Circuit Interrupter (GFCI) receptacle or GFCI circuit breaker provided? Removal of the receptacle is preferred [MET]. If a receptacle must be used, GFCI protection is required to reduce the risk of shocks and electrocutions, and the receptacle cover must be fastened with tamper resistant screws [PARTIALLY MET]. An electrical receptacle requires that an electrical cord be plugged into it to be used. Electrical cords may be used as a lanyard (noose) and must be strictly controlled. Ideally electrical receptacles and the need for cords should be eliminated altogether.</td>
<td></td>
</tr>
</tbody>
</table>
## VA EC Checklist for Mental Health Environment

### Mental Health Environment of Care Checklist for Bathrooms

In addition to the following criteria, bathrooms must also meet all General Criteria.

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</tr>
</thead>
<tbody>
<tr>
<td>51</td>
<td>7.2.13.3.8</td>
<td>Call buttons</td>
<td>If provided, two Emergency Call buttons should be used. One mounted using tamper resistant fasteners and located approximately 1 foot above the floor level and the other should be 38” to 44” above the floor. Pull cords should be of plastic breakaway beads in lieu of cords.</td>
<td>Call buttons (when provided) should be accessible to someone who has fallen on the floor. If plastic break-away beads are used the unit should develop a protocol for quickly and easily replacing the beads as they are removed or pulled off by patients.</td>
</tr>
<tr>
<td>52</td>
<td>7.2.13.3.9</td>
<td>Toilets</td>
<td>53.a. For new units, are toilets floor mounted with no exposed piping that could serve as an anchor point for hanging and free of removable seat covers? (Only New Units)</td>
<td>Plumbing fixtures should be enclosed to minimize risks. All facilities should replace removable toilet seats with integrated seats where feasible. Added March 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>53.b. For existing units, are all pipes and plumbing that could be used as an anchor point enclosed?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>53.c. Do toilet partitions have no cross connections that could be used for hanging?</td>
<td></td>
</tr>
<tr>
<td>Ques. No.</td>
<td>ePSAT cross reference number</td>
<td>Site / Item</td>
<td>Questions / Criteria</td>
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<tr>
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<td>--------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>56</td>
<td>7.2.13.3.13</td>
<td>Showers</td>
<td>Are showers free of anchor points? Shower heads should be institutional type. Soap holders should be recessed. Floor drain plates should have tamper-resistant screws.</td>
<td>Institutional shower head is designed to not provide an anchor point for hanging. The shower head and controls should be free of anchor points. Consider using automatic on/off faucets to eliminate the faucet handles. Push button controls for the shower are also an acceptable alternative. Updated February 2013</td>
</tr>
<tr>
<td>57</td>
<td>7.2.13.3.14</td>
<td>Water Temperature</td>
<td>Is the water temperature limited to a maximum of 110 degrees F?</td>
<td>Check the water by running the faucet in the sink or shower or install temperature control guard for all faucet and set temperature to 105-110 degrees F.</td>
</tr>
<tr>
<td>58</td>
<td>7.2.13.3.15</td>
<td>Shower Curtains</td>
<td>Are shower curtains hung from ceiling mounted tracks with curtains designed to tear away when a static load of 5 pounds or more is applied? Are shower curtains made of breathable material (not plastic or vinyl) so that they cannot be used for suffocation? Tracks in bathrooms should be the flush type and not surface mounted.</td>
<td>Shower Curtains are important for privacy and to keep water from flooding the floor - causing fall hazards. It is vital to check that the mounted tracks cannot be used as an anchor point for hanging. Break away curtain rods may be used as a weapon and are not recommended.</td>
</tr>
</tbody>
</table>
Ligature Resistant

- Toilet paper dispenser ligature resistant
- Rounded covers prevents using as ligature anchor
- ED room has roll down cover that locks
- Pictures compliments of Ernie Allen
Environmental Safety Risks

- Tag 144 makes it clear that the presence of ligature risks for a patient with suicidal ideation is a patient safety risk.

- Patients have the right to receive care in a safe setting.
  - This includes furniture that be easily removed or thrown; sharp objects, areas out of view of staff, plastic bags (suffocation), equipment used for vitals signs, medication, non-tamper proof screws, and IV fluid equipment.

- CMS expects 1:1 monitoring with continuous observations and removal of equipment and objects.
<table>
<thead>
<tr>
<th>Ligatures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clothing</strong></td>
<td></td>
</tr>
<tr>
<td>Belt (dressing gown)</td>
<td>Socks</td>
</tr>
<tr>
<td>Belt (trousers)</td>
<td>Stockings</td>
</tr>
<tr>
<td>Bra (Straps)</td>
<td>Shoe Laces</td>
</tr>
<tr>
<td>Braces</td>
<td>Neck Ties</td>
</tr>
<tr>
<td>Cords (Pyjama)</td>
<td>Elastics (Garments)</td>
</tr>
<tr>
<td><strong>Personal Effects</strong></td>
<td></td>
</tr>
<tr>
<td>Baby Wipes</td>
<td>Towels</td>
</tr>
<tr>
<td>Bandages</td>
<td>Headphone leads</td>
</tr>
<tr>
<td>Cord Wash Bags</td>
<td>Game console leads</td>
</tr>
<tr>
<td>Elastic Bands</td>
<td>Mobile / Electric chargers</td>
</tr>
<tr>
<td>Hand luggage straps</td>
<td>Hair Bands</td>
</tr>
<tr>
<td><strong>Bedrooms</strong></td>
<td></td>
</tr>
<tr>
<td>Pillow cases / Sheets</td>
<td>Electrical extension cables</td>
</tr>
<tr>
<td>Curtain / blinds cord or chain</td>
<td>Plastic bin liners</td>
</tr>
</tbody>
</table>
Education and Training

- Hospital staff must be trained to identify environmental safety risks
- Where the hospital has chosen to implement a risk assessment tool to identify potential or actual risks
- Must be trained to identify patients at risk
- Training includes employees, volunteers, contractors, agency nurses, per diem staff and staff providing services under contract
- Training in orientation and when P&P changes
- Recommends training every 2 years
9 Competencies of the Psych Nurse

PSYCHIATRIC-MENTAL HEALTH NURSE
ESSENTIAL COMPETENCIES FOR ASSESSMENT AND MANAGEMENT OF INDIVIDUALS AT RISK FOR SUICIDE

(Adapted from Suicide Prevention Resource Center (SPRC) & American Association of Suicidality (AAS) (2008). Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals.)

Preamble
Competencies have been developed for mental health clinicians in assessing and managing suicide risk; however, there are no standard competencies for psychiatric registered nurses. Widely accepted nursing practices do not meet suicide-specific standards of care or evidence-based criteria. Therefore we propose the following essential competencies for psychiatric registered nurses working in hospital settings as a guide for practice. These competencies are based on a comprehensive review of the extant research literature (both qualitative and quantitative) relevant to assessment and management of hospitalized patients admitted to a psychiatric setting.

The role of the nurse specific to suicide prevention includes both systems and patient level interventions. At the systems level the nurse assesses and maintains environmental safety, develops protocols, policies, and practices consistent with zero suicide, and participates in training for all milieu staff. At the patient level, the nurse assesses risk for suicide, provides suicide-specific psychotherapeutic interventions, monitors and supervises at-risk patients, and assesses outcomes of all interventions. The expectation is that these essential competencies will serve to provide the foundation for training curricula and in measuring the knowledge, skills, and attitudes necessary for expert care.

Essential Competencies
1. The psychiatric nurse understands the phenomenon of suicide.
   - Defines basic terms related to suicidality.
   - Reviews suicide-related statistics and epidemiology.
   - Describes risk and protective factors related to suicide.
   - Discusses nursing and best practice/evidence-based literature related to inpatient suicide prevention.

www.apna.org/i4a/pages/index.cfm?pageid=5684
Essential Competencies

1. The psychiatric nurse understands the phenomenon of suicide.
   - Defines basic terms related to suicidality.
   - Reviews suicide-related statistics and epidemiology.
   - Describes risk and protective factors related to suicide.
   - Discusses nursing and best practice/evidence-based literature related to inpatient suicide prevention.

2. The psychiatric nurse manages personal reactions, attitudes, and beliefs.
   - Demonstrates self-awareness of emotional reactions, attitudes, and beliefs related to previous experiences with suicide.
   - Examines the impact on the patient of nurse’s emotional reactions, attitudes, and beliefs.
   - Accepts and regulates one’s emotional reactions to suicide.
   - Discusses nurses’ reactions to patients who express suicidal ideation, attempt or die by suicide.
   - Participates in a root cause analysis (RCA) or failure mode and effect analysis (FMEA) when a suicide attempt or suicide death occurs on the inpatient unit.
   - Participates in staff debriefing following a suicide attempt or suicide death.
   - Obtains and maintains professional assistance/supervision for ongoing support.
   - Attends to one’s own emotional safety/wellbeing.

3. The psychiatric nurse develops and maintains a collaborative, therapeutic relationship with the patient.
   - Maintains a nonjudgmental and supportive stance in relating to the patient and family.
   - Provides a therapeutic milieu in which the patient feels emotionally safe and supported.
   - Voices authentic intent to help.
     - Uses evidence to educate the patient about the suicidal mind, symptoms of illness, and effectiveness of intervention.
     - Conveys hope and connection while recognizing the patient’s state of mind and need for hopefulness.
   - Reconciles the difference and potential conflict between the nurse’s goal to prevent suicide and the patient’s goal...
Correction of Environmental Risks

- All deficiencies are expected to be corrected within the time frame set by the CMS regional office, the state agency (like the department of health) or the accreditation organization (AO)
  - AO includes TJC, DNV GL Healthcare, Healthcare Facilities Accreditation Program and CIHQ
- In cases where it is not reasonable to expect compliance within the timeframe, only CMS can grant additional time
- Ligature risk deficiencies do not qualify for LSC waivers and will not be granted
Correction of Environmental Risks

- Deficiencies in the plan of care (PoC) must be corrected within 60 days from receipt of the report.
- Follow up surveys will be done to ensure it is fixed.
- The ability of the hospital to comply has sometimes been shown to be a burden.
  - This is especially true when need board approval, capital budget funding, engage in competitive bids, availability of materials, time for completing repairs and access to the area.
Correction of Environmental Risks

- Cited ligature risks that do not pose an immediate jeopardy situation are to be corrected within the allotted days according to CMS or the AO
  - Including when the hospital has removed the immediate threat to patient health and safety

- Interim patient safety measures are expected to be implemented as part of the plan of correction

- The correction period starts when the hospital is notified of the deficiency
  - The SA and AO can only recommend to CMS that more time be given to correct the deficiency
Correction of Environmental Risks

- Interim patient safety measures to mitigate ligature risks many include sitter such as 1:1 observation
  - Note that having one sitter watch 2 patients in the same room is 2:1 and not 1:1
- This includes while the patient sleeps, toilets, and baths
- Also mentions this and other alternative nursing protocols recommended by the American Psychiatric Nursing Association (APNA)
  - Note interesting research on 1:1, also called continuous special observation (CSO), which can have some adverse consequences especially with paranoid or agitated patients
The American Psychiatric Nurses Association Council for Safe Environments has identified assessment and monitoring as factors that impact the safety of inpatient environments. APNA members were invited to submit brief, annotated summaries of references for inclusion in a ‘toolkit’ of assessment and monitoring resources. The CSE is happy to share these resources with psychiatric-mental health nurses.

**Adverse consequence of continuous special observations.**

**Author/Source:** Appleby, L. Kapur, N., Shaw, J. Windfuhr, K Williams, A. Flynn, S., Tham, S. (2015). *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)*. In-patient Suicide Under Observation. Manchester: University of Manchester

This article describes a 6-year study in the UK of inpatients being monitored on intermittent observations or continuous special observation (CSO). The study revealed the current observation levels are not working. Interventions based on engagement must be incorporated into the treatment of high-risk patients. The study describes the problems associated with CSO. They are intrusive and restrict the patient’s privacy. They increase agitation in the patients watched and place the staff watching them at risk. The study describes the problems with how CSO is implemented. Staff do not always observe the patient. Staff implementing the procedure are often the least trained and unfamiliar with the unit. Staff do not engage the patient, which eliminates the therapeutic value of CSO.
APNA 2 Alternatives to CSO

- 2 alternatives to continuous special observation

- PNA or psychiatric nursing availability emphasizes developing a relationship with the suicidal patient based on engagement and making staff available to discuss impulses or distressing thoughts

- PMI or psychiatric monitoring and intervention is based on engagement and the patient is allowed privacy in their room, in the day room, and staff support with impulse control
  - It includes removing the elements of violence; a target, a trigger, a weapon, and a state of arousal
Requests for Extension

- Requests for an extension of timeframes to correct ligature risk deficiencies must include:
  - Hospital’s accepted PoC (plan of correction)
  - Mitigation plan
  - Rationale about why it is not reasonable to meet the correction timeframe
  - Evaluation of the effectiveness of the mitigation plan and
  - Update on the status of the PoC

- Hospitals submit requests to their AO and if none then to the state agency (like the Department of Health)
Requests for Extension

- AO to copy the RO (regional office) or CO (central office) via email with a recommendation for approval
  - AOs include TJC, DNV, HFAP, and CIHQ
- The CO will respond and copy the AO and the RO within 10 working days
- The hospital must provide electronic progress reports to the SA (state agency) or AO on a monthly basis
- Must include: copies of invoices, receipts, communications with vendors that detail the progress
Survey Procedure

- Surveyor instructed to observe patient care environment for housekeeping carts that contain hazardous items that can pose a risk like disinfectant solutions, mops, brushes, tools, etc.

- Suppose to interview staff to determine if staff trained to identify risks in the care environment

- If so, how do staff report these findings?

- Will review the P&P and interview staff to determine how the hospital defines continuous visual observation (CVO) and how it does a 1:1 observation
Survey Procedure

- Will review the P&P to find out what the hospital does to curtail unwanted visitors, contaminated material, or unsafe items that pose a safety risk to patients and staff.
- Will assess hospital security efforts to protect patients at risk for suicide or self harm.
- Security measures must be based on nationally recognized standards of practice.
- Hospital must be providing appropriate security to protect patients.
Tag 701 Buildings
Tag 701 Buildings Accessibility

- Standard: Buildings- The condition of the physical plant and overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

- The hospital must be constructed and maintained to minimize risk for patients, employees, and visitors.

- Safety features must be addressed in accordance with nationally recognized standards.

- The hospital must make sure it meets State and Federal accessibility standards like the OCR requirements.
Tag 701 Age Related Features

- Hospital must address safety hazards and risks related to age
- Includes neonatal, pediatric, and geriatric patients
- Must be consistent with nationally recognized standards
- Age related risks include:
  - Access to medications, cleaning supplies and other hazardous materials, furniture, medical equipment, security of inpatient and outpatient areas, and increased chance of falls
Furniture in Behavioral Health Units

M. Furniture

1. Furniture used in behavioral health facilities should be easily cleaned, easily reupholstered, very sturdy, and as heavy as possible to minimize the likelihood of patients throwing chairs, tables, etc. As much furniture as practical should be built-in or securely anchored in place to prevent stacking or barricading of doors. Remaining loose items (such as chairs) can vary from high-quality wood- or steel-armed upholstered chairs that resemble typical residential furniture to polyethylene rotationally molded and sand-ballasted seating, which is now available with a less institutional look. The health care organization should select furniture appropriate for the patient population served.

2. Lockable storage cabinets and drawers should be provided, along with the means to lock phones and computers away from patients. Some organizations have a switch installed in a staff area to deactivate patient use phones at times when patients are not allowed to make calls.
Tag 701 Security

- Hospital must have adequate security
  - To prevent elopement or patients from leaving
  - To also prevent unauthorized access to the unit
- Must meet nationally recognized standard
  - International Association for Healthcare Security has Security Guidelines
- This includes prevention of infant abduction, pediatric patients, behavioral health patients and those with diminished capacity (dementia/Alzheimer’s)
- Prevent access to non-clinical rooms such as electrical rooms, ventilation, and HVAC rooms
Tag 701  Ligature Risks

- Presence of unmitigated ligature risks in psych hospital or psych unit is an immediate jeopardy
- This includes locations where patients at risk for suicide are identified
- Ligature risk findings must be referred to the health and safety surveyors
- They will evaluate further and determine if hospital needs to be cited under tag 144 in patient rights
Weather-Related Issues & Power Strips

- Hospital must address weather related issues
  - Includes interior and exterior locations
- Includes driveways, entry points, garages, and walkways
- Any power strips deficiencies must be reported to LSC surveyors for citation
- See tag 701 for detailed discussion of power strips
- Discusses when they can be used both outside and inside the patient care area
The Joint Commission Standards on Ligature Risks
TJC Suicide Prevention

- TJC notes that suicide is the tenth leading cause of death in this country
  - Most occur outside the hospital
  - However, risk is increased for patients shortly after discharge
  - In 5 years, TJC has 85 suicides per year according to the Nov 2017 Perspectives
  - TJC has 13 rules for hospitals and three for residential treatment areas
- TJC has published 3 sentinel event alerts on inpatient suicides and recommendations
- TJC issues NPSG 15 and a FAQ was issued
Citing a Deficiency

- TJC will continue to cite a deficiency under EC.02.06.01 EP 1
  - EC.02.06.01 — The hospital establishes and maintains a safe, functional environment. Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community
    - EP 1: Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

- EP 1: Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.
  - However, since July 1, 2018, will cite ligature or self harm deficiencies under the Patient Rights CoP 482.13 (tag 144) as well and not under physical environment

- This was done after TJC consulted with CMS
Effective July 1, 2018: Change coming in citing ligature/self-harm deficiencies

After consulting with the Centers for Medicare & Medicaid Services (CMS), beginning July 1, 2018, Joint Commission surveyors will start citing ligature/self-harm deficiencies under Patient’s Rights Condition of Participation (CoP) 482.13. Previously, Joint Commission surveyors cited these deficiencies under Physical Environment CoP 482.41, as well as under The Joint Commission’s Environment of Care (EC) standard EC.02.06.01, element of performance (EP) 1.

Joint Commission surveyors will continue to use and cite EC.02.06.01, EP 1, but add the relationship between this requirement and CoP 482.13 in the crosswalk. CoP 482.13 will be cited for ligature/self-harm findings, and CoP 482.41 will now be cited for non-ligature/self-harm findings. The EC requirement covers several areas beyond those that could be considered as a self-harm risk; it states:

EC.02.06.01 — The hospital establishes and maintains a safe, functional environment. Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

• EP 1: Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.
TJC Suicide Prevention Introductions

- Each observation of a ligature or suicide risk will be a requirement for improvement (RFI)
  - There must documentation to show all the required elements

- Findings of non-compliance in dedicated patients for psych patients and non-dedicated spaces will be scored at EC.02.06.01 EP 1

- **EC.02.06.01** requires hospitals to establish a safe and functional environment

- EP1 Interior spaces meet the needs of the patient population and are suitable to care and treatment
Suicide Prevention Introductions

- RFIs of observations will be rated on the SAFER Matrix on dedicated suicidal patients.
- It is rated as high because of the risk of suicide and the number of occurrences:
  - Limited, pattern, or widespread
  - Could be a condition level deficiency based on manner and degree
- RFI of observations is cross walked to the CMS CoPs on ligature risk (Tag 144 and 701)
Introduction

- Surveyor will discuss the observations of ligature or suicide risks to assess the hospital’s awareness.
- Any findings under NPSG 15 will be rated on the SAFER Matrix and may be elevated to a condition level deficiency.
- TJC found that 75% of all suicides were from hanging.
- Deficiencies in the plan of correction must be corrected within 60 days of the receipt of the deficiency report as discussed previously.
Dedicated verses Non-dedicated Space

- **Dedicated space** needs to be ligament resistant as in: a psych hospital, psych unit of a hospital, or another space in a general hospital such as an emergency department
  - Any space in which suicidal patients are preferentially care for such as the ED

- **Non-dedicated space** and try and remove as many ligature risks as possible
  - Will need to mitigate any remaining risk for self-harm
  - Remember not only patients with psych diagnosis commit suicide as patient with metastatic cancer
TJC Suicide Prevention Introduction

- TJC put together a team to look at what constitutes a ligature risk and what mitigation strategies were acceptable
- The expert team had meetings; June 9, August 18, 2017, October 11, 2017, December 2017 and meetings will continue
- Recommended term “ligature resistant” rather than “ligature free”
  - Not possible to remove all potential ligature risk points
- There is a definition of ligature resistant
Suicide Risk Reduction

- Need to protect patient from hanging or strangulation
  - Can compress the airway and interfere with blood flow in the neck depriving the brain of oxygen
  - Can also stimulate the carotid sinus reflex and cause bradycardia and hypotension

- Definition for ligature resistant:
  - Without points where a cord, rope, bed sheet, or other fabric or material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life
November 2017 Perspectives Preview: Special Report: Suicide Prevention in Health Care Settings

Recommendations Regarding Environmental Hazards for Providers and Surveyors

Suicide is now the 10th leading cause of death in the United States. Although the vast majority of suicides occur outside of health care facilities, many suicides occur every year within health care facilities, including psychiatric hospitals, psychiatric units within general hospitals, general medical/surgical wards, and emergency departments. Most experts think that far more suicides occur shortly after hospital discharge, although conclusive national data are not available.

Since publishing Sentinel Event Alert Issue 7, “Inpatient Suicides: Recommendations for Prevention” in 1998, The Joint Commission has worked with health care organizations on conducting rigorous risk assessments to help make their health care environment safer and prevent suicides. National Patient Safety Goal NPSG.15.01.01 was introduced in 2007 to further focus preventive efforts. However, suicides continue to occur within health care settings. Over the last five years, approximately 85 suicides per year were reported as sentinel events to The Joint Commission, leading to calls to redouble preventive efforts.

As health care organizations and accrediting bodies intensify efforts to make the health care environment safer, it is critical...
3 More Rules

Quality and safety
January 10, 2018

New recommendations from third expert panel on suicide prevention in health care settings

The Joint Commission has assembled four expert panels to provide guidance to customers and surveyors on safeguards to prevent suicide. The Oct. 25, 2017 issue of Joint Commission Online detailed 13 recommendations that were developed after the first two panels were held. Those recommendations were specific to inpatient units in both psychiatric and general acute care hospitals, as well as emergency rooms.

The third expert panel, held in October 2017, resulted in three more recommendations on the prevention of suicide in other behavioral health care settings, such as residential treatment, partial hospitalization, intensive outpatient and outpatient treatment programs. They are:

• No. 14. These settings are not required to be ligature resistant. For the purpose of this recommendation, ligature resistant is defined as: “Without points where a cord, rope, bedsheets, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life.”

• No. 15. These organizations should conduct a risk assessment to identify elements in the environment that residents could use to harm themselves, visitors, and/or staff. Those items that
Recommendations for Inpatient Psych Unit
Suicide Risk Reduction

- Recommended that the following four inpatient psych units areas be ligature resistant
  - Patient rooms, patient bathrooms, corridors, and common patient care areas
- This includes inpatient psych unit, in both psych hospitals, but also psych units in general/acute care settings
- Nursing stations with an unobstructed view do not need to be ligature resistant since nurse could see a patient if an attempt was made to self harm
  - Also includes self-closing or self-locking doors
Suicide Risk Reduction

- Patient rooms and patient bathrooms must have a solid ceiling and cannot contain a drop ceiling.

- However, they may be a drop ceiling in the hallway or common area as long as the following exist:
  - There is no furniture in the hallway that the patient could climb up on to remove a panel and use as a ligature point.
  - The hall must also be clearly visible.
  - Drop ceilings should be listed on the risk assessment.
  - There should be an appropriate mitigation plan.
Suicide Risk Reduction

2. In the inpatient psych unit of a general/acute care setting or psych hospital, and:

- The doors between the patient rooms and hallways
- Must contain ligature resistant hardware
- Including but not limited to hinges, handles, and locking mechanisms
F. Hardware

1. **Hinges** – Geared-type continuous hinges are preferred for all patient-accessible areas because they minimize possible attachment points. These hinges are available with a closed-sloped top and continuous gears that resist ligature attachment.\(^{111}\)

2. **Closers** – Closers are generally not required for patient room doors in most jurisdictions, but may be required for other doors. Where installed, it is suggested that track closers\(^ {100}\) be mounted on the corridor side of the door, away from rooms where patients will be alone or in groups.

3. **Locksets** – Use of some type of ligature-resistant lockset is recommended for all doors in patient-accessible areas. A lockset can be used for ligature attachment in three ways: pulling down, pulling up and over the top of the door, and tying something around the latch edge of the door using both the inside and outside handles (transverse). The latchbolt itself has even been used successfully as an attachment point as has the opening behind the strike plate; for this reason, a box should always be provided behind the strike plate. In our opinion, the perfect solution for this dilemma does not exist at this time. Several of the better options are discussed below.

   a. Locksets with a Lever Handle\(^ {130}\) – These effectively deal with up and down pressure, but are susceptible
Suicide Risk Reduction

3. In the inpatient psych unit, in both psych hospital, and general/acute care setting:
   - The hospital is **NOT** required to have a risk mitigation device installed to decrease the chance that top of the corridor door will be used as a ligature attachment point
   - Several panelist reported that a patient slipped a ligature between the corridor door and the door frame and/or hinges and committed suicide
Suicide Risk Reduction

- There are several devices to decrease the top of the door being used to fix a ligature
- Like laser beams, pressure-sensing plates, and monitoring cameras that may help prevent this
- Can cause false alarms and could distract staff
  - However, no real world studies so TJC is not requiring
- Make sure the doors are on your environmental risk assessment
- Describe your risk mitigation strategy such as rounding, monitoring by staff, leaving doors open during the day, etc.
Suicide Risk Reduction

4. In the inpatient psych unit, in both psych hospitals and general/acute care settings:

- The area (transition zone) between the patient room and bathroom must be ligature-resistant
- This makes sense since we want a safe environment in an area where the patient resides
  - Can take the door off, place an alarm on the door, or use a special door that has an angled upper door or breakaway magnetic hinges
Sentinel Event Reduction Door

- An example is a sentinel event reduction door (also called saloon doors)
- It is a door designed to prevent inpatient suicides
- There are no anchoring or hanging points on any of the four sides of the door
- ¾ inch extruded polymer resin which does not crack or splinter
- Has universal continuous hinge that can be attached to the doorframe to eliminate gaps used as anchoring points
Suicide Risk Reduction

- Staff may deny access to the bathroom unless staff is present.
- Note some states do not allow modification or removal of the door due to privacy concerns.
  - Such as Virginia, Florida, and Massachusetts.
- Surveyors will survey to the specific state law.
- Another example is soft suicide prevention door.
- It eliminates door anchor points and looks great.
- Has calming artwork.
Soft Suicide Prevention Door (SSPD)

- It was developed by the VA
- It is sold by Kennon
- It has double saloon style panels
- The door hinges consist of magnets which break away
- The door hinges will pull off after 20 pounds of vertical pressure
- It has tamper resistant hardware
- Shatter proof and cleanable
Privacy Curtains

- Privacy or shower curtains should be ligature safe
- Company makes one with velcro tabs that pull away from the curtain
- The track the curtain is on also pulls off with vertical pressure
- They are non-flammable
- Can be cleaned to hospital standards
- Be careful about vinyl/plastic shower curtains to prevent suffocation
Behavioral Health Shower Curtains

Whether you are involved in designing a new building, renovating space, or maintaining an existing behavioral healthcare program, this breakaway track and shower curtain system is an excellent choice for “sensitive” areas of psychiatric, pediatric or correctional facilities where patients are not constantly supervised and patient safety is paramount.

Breakaway Track—This system provides an attractive suspension device while maintaining a safe environment since curtains easily detach from track.

Hook and Loop Fastener System—This is an easy, attractive and safe method to hang curtains. Curtains hang from safety tabs—4" long and ¾" wide strips that are inserted in the track. The safety tab or “hook” engages into the “loop” sewn into the top of the curtains to provide the closure mechanism in which the curtain hangs from the track, along with a breakaway feature for added safety.

Wide Variety of Fabrics—The system can use most any fabric featured in this brochure since curtains are custom made for each order. The Sure-Chek collection (see page 5) is the most commonly used fabric for behavioral health curtains because of the following safety properties:

- Made from an extra heavy-duty vinyl
- Exceptionally durable and fluid proof
- Flame-resistant
- Tear-resistant
- Antimicrobial-treated to protect the product
Shower Curtains or Not?

- Note one surveyor told a hospital they could not have any shower curtains.
- One piece floor units that drain the shower to a central location would not need a curtain anymore.
- New guideline says no shower curtains or their tracks of any kind are recommended in new construction:
  - Even though that say safe or break away.
- In existing hospital, a soft suicide prevention door or sentinel event reduction shower door may be provided.
Ceilings and Beds

In the inpatient psych unit, in both psych hospital, and general/acute care setting:

5. As discussed previously, the patient rooms and bathrooms must have a solid ceiling

6. Other areas, such as common patient areas and hallways can have a drop ceiling with previously mentioned precautions

7. Medical and psych needs of the patients must be assessed and balanced to determine the type of bed
Beds and Toilets

- If patient requires medical bed without ligature points then need mitigation plan and safety precautions

8. Standard toilet seats with a hinged seat and lid are not a significant risk for suicide attempt or self harm

- They are not to cited during the survey and do NOT need to be noted on the risk assessment

- Only one known case of a patient trying to use a toilet seat as a ligature point and no harm occurred
### Mental Health Environment of Care Checklist for Sleeping Rooms

In addition to the following criteria, sleeping rooms must also meet all General Criteria.

<table>
<thead>
<tr>
<th>ePSAT cross reference number</th>
<th>Site / Item</th>
<th>Questions / Criteria</th>
<th>Rationale / Assessment Methods</th>
<th>Met</th>
<th>Partially Met</th>
<th>Not Met</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>41.3</td>
<td>7.2.13.2.3.03</td>
<td>Sheets</td>
<td>Are all fitted bed sheets (with elastic) removed from the units and replaced with either non-elastic fitted sheets or standard flat bed sheets?</td>
<td></td>
<td></td>
<td></td>
<td>While bed sheets themselves can be used as ligatures, bed sheets with elastic are potentially more dangerous as ligatures than bed sheets without elastic. Elastic wrapped tightly around a neck may continue to remain tight and strangle the patient, even after the patient has passed out and stopped applying tension.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NOTE: This is specific to fitted sheets and is not intended to suggest that other items which generally do not have non-elastic alternatives (e.g. pajama pants, underwear, brassieres) be removed from the units. However strong consideration should be given to</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Recommendations for the General Acute Inpatient Setting
9. The general medical/surgical inpatient unit does **not** need to meet the same standards as in the inpatient psych unit or psych hospital as far as the requirement to have a ligature resistant environment

- Fixed ligature risks will not be cited such as bathroom fixtures and doors
- Author’s note: Some hospitals have a safe room on each unit for patients who are suicidal
General Acute Inpatient Setting

- Patients may have equipment to monitor their medical conditions and not possible to make the environment ligature-resistant
  - IV tubing, blood tubing, cardiac monitor leads, etc.
- However, the hospital must still make sure it is a safe environment
- This is discussed under the next section

10. If the patient has suicidal ideations then need to remove any objects that pose a risk for harm that aren’t need for medical care
General Acute Inpatient Setting

- In addition, need to have mitigating strategies such as sitter with **1:1 monitoring**
- The mitigation strategies must be documented
- Need to include to carefully assess objects brought into the room by visitors
- Look at your protocol or process for transporting patients to other areas of the hospital like radiology or physical therapy
- Need P&P on how to monitor the patient and training
General Acute Inpatient Setting

- TJC will cite ligature risk if all of the following are **not** routinely done:
  - Educate and train staff and make sure they are competent on how to care for a suicidal patient
  - Have 1:1 monitoring of patients with serious suicidal ideation
  - Do a risk assessment to determine if any objects that could pose a risk for self harm and remove
    - Most hospitals remove all personal belongings of suicidal patients and put them in a locked bin or locker
  - Monitor the visitors
General Acute Inpatient Setting

- TJC will cite ligature risk if all of the following are **not** routinely done (continued):
  - Monitor bathroom use for patient with serious suicidal thoughts
    - Many hospitals lock the bathroom when not in use
    - Staff monitor the patient when using the bathroom
  - Make sure qualified staff accompany the serious suicidal ideation patient if the patient leaves the unit
11. The ED also does not need to have a ligature resistant environment as far as fixed ligature risks including bathroom fixtures and doors

12. There are 2 main ways to keep suicidal patients in the ED safe

- Place them in a safe room that is ligature resistant and equipment that can be used as a ligature point is removed
- Keep the patient in the ED with a 1:1 sitter and removed any objects that can be used for safe harm
  - As long as equipment is not needed for patient care
Emergency Department (ED)

- A safe room is not required although many EDs have them

- If no safe room then need to do the following:
  - Screen all patients to determine if they have suicidal ideation
    - See toolkit for doing this under the tools system
    - Usually these are preliminary questions
    - Will discuss NPSG 15.01.01
  - Do a secondary screening to assess the risk if the patient has suicidal ideation
  - Do a risk assessment to remove any objects that pose a risk
Emergency Department (ED)

- If no safe room then need to do the following (continued):
  - Have a protocol for removing all items that could pose a risk for self-harm
    - Most remove all personal belongings and clothing and lock them up
    - Patients may be in a different color gown to readily identify them as suicidal
  - Have a protocol for how you are going to monitor the patient
  - Train staff and make sure they are competent
13. Need to have 1:1 continuous monitoring with **serious** suicidal patients

- Need to allow for 360-degree viewing so can see patient anywhere in the room
- Must do continuous monitored video
  - CMS says if doing audio or video recording must be close by
- The monitoring must allow immediate intervention by a staff member if the patient is about to do self-harm
The TJC expert panel had another meeting (3rd) and made the following recommendations for behavioral health settings such as residential treatment, partial hospitalization, or intensive outpatient treatment:

14. These settings are not required to be ligature resistant.

15. These settings should conduct a risk assessment to identify elements in that residents could use to hurt themselves or others.

- Items with high potential to harm should be removed and placed in secure location.
New recommendations from third expert panel on suicide prevention in health care settings

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- **No. 15. These organizations should conduct a risk assessment to identify elements in the environment that residents could use to harm themselves, visitors, and/or staff.** Those items that have high potential to be used to harm oneself or others should be removed and placed in a secure location (for example, putting sharp cooking utensils in a locked drawer) when possible. Staff should be trained to be aware of the elements of the environment that may pose a serious risk to a resident.
Rules 14-16 Residential Treatment

- Recommendations for behavioral health settings such as residential treatment, partial hospitalization, or intensive outpatient treatment:
  - Example: Sharp cooking utensils can be in locked drawer
  - Staff need to be trained on things in the environment that can cause harm to a resident who has serious suicidal ideations
    - Keep resident safe until can be transferred to higher level of care
  - Rule 16: Need P&Ps to address how to manage a patient who experiences increase in S&S that could result in harm to themselves or others
The fourth expert panel meeting was held in December of 2017

Focused on suicide risk assessment

Also looked at key components on how to safely monitor high risk patients

Recommendations will be added to the list

March 14, 2018 JC Online reported that the panel is looking to see if NPSG 15 should be revised

Proposed revisions published March 26, 2018
Zero Suicide Campaign
Zero Suicide Campaign

- Zero suicide is a proposition that suicide deaths in patient within the healthcare setting are preventable
  - It is an aspirational challenge to improve care and outcomes for patients at risk

- There are 10 steps to beginning a zero suicide initiative

- Want to make healthcare suicide safe

- Free video that summarized the campaign

- Need to focus on patients who are suicidal

- 40,000 die every year from suicide
WHAT IS ZERO SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems and is also a specific set of strategies and tools.

FOR CHAMPIONS

Zero Suicide Champions believe that anything short of zero suicides in health care is unacceptable.
10 Steps to Zero Suicide

Welcome to the Zero Suicide Toolkit

Watch Mike Hogan, co-lead of the Zero Suicide Advisory Group, describe Zero Suicide. And read the Quick Guide, in the Tools below, for 10 steps to beginning a Zero Suicide initiative.

http://zerosuicide.sprc.org/toolkit

Learn more about the fundamentals of Zero Suicide implementation
Zero Suicide Campaign

- We fail to ask patients if they are suicidal especially in mental health facilities
- We don’t follow up when they are in transition and the patient sometimes falls between the cracks
- Half of those who die from suicide saw a primary care physician within the last 30 days
- Introduce psych nurse and social workers in primary care offices
- It is both a concept and a practice
Zero Suicide Campaign

- It is a framework for systematic, clinical suicide prevention
- Includes a set of best practices
- www.zerosuicide.com has many resources and tools
Joint Commission FAQs on Ligature Risks
Ligature Risk FAQ

- TJC has many frequently asked question on ligature risks
- One talks about how to assess and mitigate risk for suicide and self harm
- Pertains to psych hospitals, the behavioral health department of a hospital, and patients who are suicidal on a non-behavioral health unit such as the ED or medical units
- All TJC hospitals should be aware of this

Available at
www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=1525&StandardsFAQChapterId=64&ProgramId=0&ChapterId=0&IsFeatured=False&IsNew=False&Keyword=ligature
Ligature Risk FAQ

- References EC.02.06.01 that requires hospitals to establish and maintain a safe environment
- Interior spaces need to meet the needs of the patients and have to be safe
- Therefore, ligature risks need to be identified and eliminated
- Need to implement policies
- Need to mitigate risks identified
- Leadership and staff need to be aware of the current risks
Environment of Care (EC) (Hospital and Hospital Clinics / Hospitals)

Ligature Risks - Assessing and Mitigating Risk For Suicide and Self-Harm

What are the Joint Commission expectations for identifying and managing ligature risks in the hospital setting?

For inpatient psychiatric hospitals, inpatient psychiatric units in general acute care hospitals, and non-behavioral health units DESIGNATED for the treatment of psychiatric patients (i.e. special rooms/safe rooms in Emergency Departments or Medical Units):

The requirements found in the Environment of Care (EC) chapter of the accreditation manual at EC.02.06.01 require hospitals to establish and maintain a safe, functional environment. Element of Performance # 1 states “Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided”. Therefore, ligature and self-harm risks must be identified and eliminated. While risks are in the process of being eliminated, policies and procedures must be developed and implemented to mitigate the harm posed by such risks. Mitigation plans must include, at a minimum the following:

• Ensuring that leadership and staff are aware of the current environmental risks
• Identifying patients’ risk for suicide or self-harm, then implement appropriate interventions based upon risk.
• Ongoing assessments and reassessments of at-risk behavior as defined by the organization.
• Ensuring the proper training of staff to properly identify patients’ level of risk and implement appropriate interventions
• Incorporating suicide risk and self-harm reduction strategies into the overall Quality Assessment/Performance Improvement (QAPI) program - see LD.01.03.01 EP 21.
• If equipment poses a risk but is necessary for the safe treatment of psychiatric patients (i.e. medical beds with side rails on a geriatric unit), the organization must consider these risks in patients’ overall suicide/self-harm risk assessments, then implement appropriate interventions to diminish those risks.
Ligature Risk FAQ

- Need to do an assessment so you know what patients are at risk
- Need to reassess at-risk patients
- Need to make sure staff are trained and educated to identify who is at risk and to implement safety precautions
- Suicide risk and self harm should be part of the QAPI program
  - See LD.01.03.01 EP 21
TJC FAQs Ligatures and Suicide Reduction

- TJC has many other FAQs on ligature and suicide risk reduction:
- These will **not** be covered in this webinar and are included as a reference
  - Assessing and Mitigating Risk for Suicide and Self Harm
  - Assessing Suicidal Risk
  - Ligature Resistant Requirements
  - Ligature Risks that Cannot be Removed
  - Monitoring Patients
  - Safe Rooms
FAQs include the following (continued):
- Assessing Serious Risk
- ED in Accredited Ambulatory Care Organizations
- Requirements for Substance Abuse Units
- Unlocked or Open Psychiatric Units
- The following are for inpatient psychiatric units:
  - Curtains on Bathroom Doors
  - Door Alarms
FAQs include the following for inpatient psychiatric units (continued):

- Drop Ceilings in Common Patient Care Area
- Height Requirements
- Ligature Resistant Medical Beds
- Patient Transports
- Shower Curtains
- Unobstructed View
| Ligature Risks - Assessing and Mitigating Risk For Suicide and Self-Harm |
| Ligatures and Suicide Risk Reduction - Emergency Department - Assessing Suicide Risk |
| Ligatures and Suicide Risk Reduction - Emergency Department - Ligature-resistant Requirements |
| Ligatures and Suicide Risk Reduction - Emergency Department - Ligatures Risks That Cannot Be Removed |
| Ligatures and Suicide Risk Reduction - Emergency Department - Monitoring Patients |
| Ligatures and Suicide Risk Reduction - Emergency Department - Safe Rooms |
| Ligatures and Suicide Risk Reduction - General - Assessing 'Serious Risk' |
| Ligatures and Suicide Risk Reduction - General - Emergency Departments in Accredited Ambulatory Care Organizations |
| Ligatures and Suicide Risk Reduction - General - Requirements for Substance Abuse Units |
| Ligatures and Suicide Risk Reduction - General - Unlocked or Open Psychiatric Units |
| Ligatures and Suicide Risk Reduction - Inpatient Psychiatric Units - Curtains on Bathroom Doors |
| Ligatures and Suicide Risk Reduction - Inpatient Psychiatric Units - Door Alarms |
| Ligatures and Suicide Risk Reduction - Inpatient Psychiatric Units - Drop Ceilings in Common Patient Care Areas |
| Ligatures and Suicide Risk Reduction - Inpatient Psychiatric Units - Height Requirements |
| Ligatures and Suicide Risk Reduction - Inpatient Psychiatric Units - Ligature Resistant Medical Beds |
| Ligatures and Suicide Risk Reduction - Inpatient Psychiatric Units - Patient Transport |
| Ligatures and Suicide Risk Reduction - Inpatient Psychiatric Units - Shower Curtains |
| Ligatures and Suicide Risk Reduction - Inpatient Psychiatric Units - Unobstructed View |
Do not have to assess every patient who comes into the ED for suicide risk

- Only if it is their primary reason for care
- Note many do ask all patients

Environment of Care (EC) (Hospital and Hospital Clinics / Hospitals)

**Ligatures and Suicide Risk Reduction - Emergency Department - Assessing Suicide Risk**

*Do we have to assess every patient for suicide risk who comes into the emergency department?*

No. Only patients being evaluated or treated for behavioral health conditions as their primary reason for care must be screened for suicide risk. Please reference National Patient Safety Goal NPSG 15.01.01.01 found in the Hospital Accreditation Manual for additional detail in addition to Joint Commission standards and requirements regarding screening protocols.

This FAQ was also published in the Perspectives® Newsletter, July 2018, Volume 38, Issue 7 - The Official Newsletter of The Joint Commission.
All EDs do not need to be ligature resistant as in the psych unit
- However, must implement safeguards

Safe rooms are not mandated for the ED

Serious suicide means that the when a suicide assessment was done the patient screened positive
- The assessment should ask about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors
- References NPSG 15
In the ED remove all items that can be removed and provide an appropriate level of monitoring based on the patient’s risk

- Must have a P&P to direct staff on this and provide education
- If ED has a safe room it must be ligature resistant
- Note that most ED which are often referred to as a designated room or safe room but the room is not ligature resistant so just need to understand the terminology
Hospitals with a SUD detox unit should follow the same requirements as general acute care inpatient settings

- So don’t need to be ligature resistant
- Need to screen patient and provide appropriate level of care

Ligature resistant environment requirement applies to inpatient psych unit that is locked

- Do not apply to psych unit that is unlocked and in which patients can enter and exit on their own accord
TJC FAQs Ligatures and Suicide Reduction

- Drop ceilings can be used in the hallway in psych if visible at all times and no objects that the patient can use to climb to the ceiling
- Over the door alarms are not required and TJC neither discourages or promotes its use
- There are no height requirements for a ligature risk in psych
  - Had many reports in which patients used a low pipe to fix a ligature
  - Low to ground piping, as near toilets, or under sinks is a risk
TJC FAQs Ligatures and Suicide Reduction

- If curtains are used in place of a bathroom door in inpatient psych unit this risk should be assessed in the environmental risk assessment
  - Must have a mitigation plan to monitor high risk patients near the curtain area

- No specific requirements for how many ligature resistant beds a unit must have
  - Depends on the need of the patient population
  - Depends on patient’s risk of suicide
  - Could lock an unoccupied room where a medical bed is
TJC FAQs Ligatures and Suicide Reduction

- TJC will not advise or recommend any type of shower curtain in psych
  - Shower curtains are considered a risk
  - Must be on environmental risk assessment and have a mitigation plan and monitor high risk patient near curtain area
- Unobstructed view of nursing station means you can see everything in the nursing station so patient can’t attempt self harm
- Patients at high risk should remain in ligature resistant environment and if transported to another area must protect the patient
TJC Issues SEA 56 on Detecting and Treating Suicidal Ideation
TJC Sentinel Event Alert on Suicide

- TJC has actually published 3 SEAs on suicide
- SEA 56 was issued February 24, 2016
  - It replaces the two previous ones; issues 7 and 46
  - Is 7 pages long
- TJC notes that suicide is the 10th leading cause of death
- Most of those who died had received healthcare within 1 year but providers did not identify suicidal ideation
- Clinicians and staff have a role in detecting if the patient is suicidal in the ED, primary care and BH care
Detecting and treating suicide ideation in all settings

The rate of suicide is increasing in America.¹ Now the 10th leading cause of death,² suicide claims more lives than traffic accidents³ and more than twice as many as homicides.⁴ At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,⁵ usually for reasons unrelated to suicide or mental health.⁶⁻⁷ Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.⁸

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.⁹ The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility¹⁰ and continues to be high especially within the first year¹⁰,¹¹ and through the first four years¹¹ after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The
TJC Sentinel Event Alert on Suicide

- Risk of suicide is 200% higher the first week after discharge from a BH facility

- Continues to be high the first year and for 4 years after

- One hospital does universal screening of all patients and found 1.5% at high suicidal risk and 4.5% at moderate risk

- Who is at risk for suicide
  - Men over 45, vets, mental or emotional disorders (especially bipolar and depression), previous suicide attempts, self inflicted injury, history of trauma or loss
Who is at risk for suicide (continued)

- Serious illness, chronic pain or impairment, alcohol or drug abuse (now called substance use disorder), social isolation, history of aggressive or antisocial behavior, and access to lethal means along with suicidal thoughts

RCA shows that most common problem was the assessment

- Need to conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide

- A suicide lethality scale can measure the degree of lethality of suicide attempts such as a 11 point scale
TJC Sentinel Event Alert on Suicide

- Healthcare facilities should identify, develop and integrate comprehensive behavioral health, primary care and community resources for patients at risk for suicide.

- Review all patient’s medical history for suicidal risk factors.

- Use an evidenced based, brief screening tool to screen all patients for suicidal ideation.
  - Mentions PHQ-9, PHQ-2, ED-SAFE Patient Safety Screener and Suicide Behaviors Questionnaire-Revised ((SBQ-R)) which are discussed later.
TJC Sentinel Event Alert on Suicide

- Review the questionnaire before the patient leaves or is discharged
  - Patient may need to be referred for secondary screening to get additional information
  - Mentions ED-Safe Secondary Screener, Columbia-Suicide Severity Rating Scale (C-SSRS) and the Suicide Prevention Resources Center’s Decision Support Tool
  - Discussed below

- Take immediate action so don’t leave suicidal patient sit in the ED lobby unattended-keep patients in safe environment under 1:1 observation
TJC Sentinel Event Alert on Suicide

- Check patients and visitors in acute suicidal crisis to make sure nothing can be used to harm them
- Patients at low risk of suicide can have outpatient visit within one week
- All patients with suicidal ideation should be given phone number for National Suicide Prevention Lifeline at 800 273-8255
- Conduct safety planning
- Restrict access to lethal means
- Develop discharge plans to target suicidality
TJC Sentinel Event Alert on Suicide

- Engage family and significant others in discharge planning to promote effective coping strategies
- Educate staff on how to identify and respond to suicidal patient
- TJC mentions a number of resources in education and make sure it covers environmental risk factors
  - See next 3 slides for recommendations
- Document decision regarding the care and referral of the patient
Suicide Prevention and the Clinical Workforce: Guidelines for Training


Prepared by the Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention October 2014
Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments

This guide is designed to assist Emergency Department (ED) health care professionals with decisions about the care and discharge of patients with suicide risk. Its main goal is to improve patient outcomes after discharge. The guide helps ED caregivers answer these questions:

- How can I effectively intervene while this patient is in the ED?
- Can this patient be discharged or is further evaluation needed?
- What will make this patient safer after leaving the ED?
Suicide Prevention Resource Center

We all have a role to play. Together, we can save lives.

Effective prevention starts with you.

- Make a plan to prevent suicide
- Find a suicide prevention program
- Measure your program’s success
- Improve suicide care for your patients
- Take action after a suicide

Featured Resources
Zero Suicide

WHAT IS ZERO SUICIDE?
Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/What%20is%20Zero%20Suicide.pdf

LEAD
TRAIN
IDENTIFY
ENGAGE
TREAT

Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health
Joint Commission National Patient Safety Goal (NPSG) on Patient Suicide Risk
Goal 15 States the hospital identifies safety risks inherent in its patient population

The hospital needs to identify patients at risk for suicide

Only 1 left of 2 standards and has 3 EPs

Remember TJC Sentinel Event issued

This section only applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.
Patient Suicide Risk

1. Risk assessment must be conducted that includes factors that increase or decrease the risk for suicide

2. Need to address the immediate safety needs of a suicidal patient and the most appropriate setting

3. Must provide information to patient and family at risk for suicide when they leave the hospital such as a crisis prevention hotline
Booster Pak for Accredited Hospitals

- 27 pages
- Includes standards rationale and suggestions
- Includes evidence and supporting documentation
- Discusses how to comply
Proposed Changes NPSG 15

- TJC proposed changes to NPSG 15 for hospitals and behavioral health units on March 26, 2018

- EP 1 Applies to all hospitals (separate one for BH hospitals)
  - Identify and take action to minimize things in the hospital environment that could be used to attempt suicide as part of the hospital’s environmental risk assessment

- EP 2-8 Applies only to patients in psych hospitals and patients whose primary diagnosis is for a behavioral health condition
  - EP 2 Screen all patients for suicidal ideation who are being treated when evaluated for a behavioral health issue
Proposed Revisions to the National Patient Safety Goal on Reducing the Risk for Suicide for Hospitals

Start Date: March 26, 2018  
End Date: May 7, 2018

The Joint Commission is revising the current National Patient Safety Goal (NPSG) on identifying individuals at risk for suicide based on research and feedback from experts and customers. This NPSG is intended to assist health care organizations to better identify and treat individuals with behavioral health diagnoses, who are potentially at risk for suicide.

Step 1: Read the Proposed Requirement

Note: We are providing you the following documents to assist in your response to the survey.

*This document requires Adobe Reader.

Proposed Revisions to the NPSG on Reducing the Risk for Suicide for Hospitals

Prior to submitting your comments, download and print a copy of the above documents.

Step 2: Provide Your Comments

Tell us what you think. You can submit your comments in one of the following ways:
Proposed Changes NPSG 15

- EP 2 (continued) Must use a validated screening tool
- EP3 If the patient is positive for suicidal ideation during the initial screen, then use an evidenced based process to conduct a suicidal assessment
- EP4 The patient’s overall risk for suicide must be documented
  - Document the plan to mitigate the risk for suicide
- EP5 Need to follow P&Ps that contain, at a minimum the following three things:
Proposed Changes NPSG 15

- EP 5 (continued) P&P on the following:
  - Training and competence of staff who care for suicidal patients
  - Guidelines for reassessment
  - Monitoring patients who are at high risk for suicide
- EP 6 Need to have P&P and follow them for counseling and follow up care
  - This is when patients at risk for suicide are discharged
- EP 7 P&Ps for screening, assessment and management of suicidal patients need to be monitored for implementation and effectiveness
Suicide Risk

- Suicide ranks as the 10th 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 has been the #2 most frequently reported type of sentinel event

  - For data through July 19, 2017 there were 13,346 reports which is about 10.0% of all reports
Suicide is the 10\textsuperscript{th} leading cause of death in the United States and continues to be consistently among the most frequently reviewed Sentinel Events reviewed by The Joint Commission.
Patient Suicide  NPSG 15

- Identification of individuals at risk for suicide while under the care of or following discharge from a facility is an important first step in protecting and planning the care of these at-risk individuals.
- Applies to all patients in the behavioral health unit.
- Applies to any patient in the hospital if their primary diagnosis or primary complaint (DSM diagnosis) is of an emotional or behavioral disorder.
- Gives a number of examples since initially gave contradictory information on scope of this NPSG.
General Hospitals

- Identify patients at risk,

- Patient seen in ED for fracture sustained in act of attempting suicide, admission risk assessment not required by TJC because you know the patient is suicidal but as recovers would need to assess degree of ongoing risk for suicide,

- Patient admitted ICU for detoxification, but again as patient recovers may determine underlying problem,

- Patient admitted to OB in active labor and has history of severe post partum depression after last child, same,
Patient Suicide

- Assess patients at triage and admission and ask if patient has any thoughts about injuring himself or others
- Use sitters for patients at risk
- Have safe room for suicidal patients, especially those admitted outside the behavioral health unit
- Do a FMEA on suicidal patients
- Do assessment of the facility for safety as above
- Don’t have to have own crisis hotline just information on how to access one
Patient Suicide

- Be sure to do an assessment of the environment to ensure there are safe rooms
- Education for nurse on risk of suicidal patients
- Policy on same
Behavioral Health Design Guide

February 2018

Edition 7.3

www.fgiguadelines.org/resource/design-guide-built-environment-behavioral-health-facilities/

BEHAVIORAL HEALTH DESIGN GUIDE

Formerly:
Design Guide for the Built Environment
of Behavioral Health Facilities

James M. Hunt, AIA
David M. Sine, DrBE, CSP, ARM, CPHRM

Includes REVISED
Patient Safety Risk Assessment Tool
to align with The Joint Commission’s
November 2017 Recommendations
Tools of the Trade
Design Guide for BH Facilities

- This is an important resource
- It is 120 pages long
- Updated frequently
- Includes a helpful patient safety risk assessment tool
  - To facilitate conversation between clinical staff and the designers regarding patient safety
- Tool helps to comply with CMS tag number 701 and the TJC EC standards
BH Design Guide

- Explain how to create safe rooms to prevent ligature risk and suicide
- Hospital is at risk for receiving a deficiency from CMS or a requirement for improvement (RFI) if the surveyors observes ligature or self-harm risks
- First published by NAPHS (National Association of Psychiatric Health Systems) in 2003
  - Questions contact David Sine at dsine9@gmail.com
- Document to help hospitals and other facilities to think about how physical design affects patient and staff safety
10. **Lavatory and Sink Faucets and Valves** – Faucets and valves can provide attachment points for ligatures. A lavatory valve unit is now available that uses a shower valve fitted with a ligature-resistant handle\(^5\) to allow patients to control the temperature (thermostatically limited to prevent scalding) and duration of the water flow. This valve can be used to replace the motion sensor activation of some faucets. Faucets are available in a variety of materials and configurations that range from push-button to motion sensor-activated.\(^6\)

11. **Lavatory Waste and Supply Piping** – All piping of this type must be enclosed so it is not accessible to patients.\(^4\) Extreme care should be taken to trim the enclosing material so it fits tightly to the underside of the lavatory fixture to prevent the patient from using this space to hide contraband.
Level V-b. Seclusion Rooms

Seclusion rooms are required by the FGI Guidelines to be no less than 7 feet wide and no greater than 11 feet long to avoid providing enough space for a patient to get a running start at the opposite wall. They should be designed to minimize blind spots where patients cannot be observed by staff without entering the room. A minimum ceiling height of 9 feet is preferred. The distance of the seclusion room from the nurse station needs to be considered. The goal is to avoid excessive distance so staff can be readily available as needed. The seclusion room door should open directly into an anteroom to separate these activities from other patients and give the patient access to a toilet without entering the corridor.

A. Floor – Continuous sheet vinyl with foam backing and heat-welded seams or padded flooring to match wall padding, if used
This is a patient depression questionnaire

PHQ-9 used in primary care practices and asks 9 things

Some use a shorter version, the PHQ-2, and if yes to either question then go to the PHQ-9

Used for quick depression assessment

- Score of 1-4 minimal depression
- Score 5-9 mild depression
- Score 10-14 moderate depression
- Score 15-19 moderately severe depression
- Score 20-27 severe depression

## Patient Health Questionnaire PHQ-9

### Patient Health Questionnaire-9 (PHQ-9)

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

(Use "✓" to indicate your answer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
ED-SAFE Screener

- Patient Safety Screener (PSS-3) is a 2 page tool
- Used by the nursing during the primary nursing assessment and in the ED
- A positive screen is a yes to either SI (suicidal ideation) in the past 2 weeks or life time history of SA (lifetime attempts)
  - Available at http://www.emnet-usa.org/ED-SAFE/materials/K_PtSafetyScreen.pdf

References


ED-SAFE Screener  PHQ-2

Patient Safety Screener

To be administered by primary nurse during primary nursing assessment.

Introductory script: Now I’m going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital’s policy and it helps us to make sure we are not missing anything important.

<table>
<thead>
<tr>
<th>PHQ-2: Over the past 2 weeks.</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. . . . have you felt down,</td>
<td>Depressed mood</td>
</tr>
<tr>
<td>depressed, or hopeless?</td>
<td></td>
</tr>
<tr>
<td>□ Yes  □ No</td>
<td></td>
</tr>
<tr>
<td>2. . . . have you felt little</td>
<td>Anhedonia</td>
</tr>
<tr>
<td>interest or pleasure in</td>
<td></td>
</tr>
<tr>
<td>doing things?</td>
<td></td>
</tr>
<tr>
<td>□ Yes  □ No</td>
<td></td>
</tr>
</tbody>
</table>

| C-SSRS, Ideation: Over the   | Passive ideation,            |
|   past 2 weeks,             |                              |
| 1. . . . have you wished     | At least active ideation,    |
|    you were dead or wished   |    general thoughts without  |
|    you could go to sleep     |    thoughts of ways, intent, |
|    and not wake up?          |    or plan                   |
|   □ Yes  □ No                |                              |

| C-SSRS, Behavior: In your    | Lifetime attempt             |
|   lifetime,                  |                              |
| 1. . . . have you ever       | If within the last 6 months  |
|    attempted to kill        |    considered recent attempt |
|    yourself?                |                              |
|   □ Yes  □ No               |                              |

|                                |                              |
| 2. . . . When did this happen?|                              |
|   □ Today                      |                              |
|   □ Within the last 30 days   |                              |
|     (but not today)            |                              |
### Scoring and interpretation

<table>
<thead>
<tr>
<th>Over the past 2 weeks,</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ...have you felt down, depressed, or hopeless?</td>
<td>Depressed mood</td>
</tr>
<tr>
<td>2. ...have you had thoughts of killing yourself?</td>
<td>Active suicidal ideation (SI)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In your lifetime,</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. ...have you ever attempted to kill yourself?</td>
<td>Lifetime attempt (SA)</td>
</tr>
<tr>
<td>When did this happen?</td>
<td>If within the last 6 months,</td>
</tr>
<tr>
<td></td>
<td>considered recent attempt</td>
</tr>
</tbody>
</table>
Patient Safety Secondary Screener

- This ED-SAFE Patient Safety Secondary Screener tool is used to determine what should be done when the patient has a positive screen on the Patient Safety Screener
  - Should that patient be seen by a mental health professional?
- The patient has active suicidal ideation or a recent suicide attempt within 6 months
- If yes on the items then the physician should get a mental health consult
- There are 6 questions
A “Yes” on any of the items below means the treating physician should consider consulting a mental health professional.

1. Did the patient screen positive on both PSS items – active ideation with a past attempt?
   Source: PSS screener completed by primary nurse, documented on chart.
   - □ Yes  □ No  □ Refused  □ Patient unable to complete

2. Has the individual begun a suicide plan?
   Source: Use patient self report, collateral information
   *Suggested wording: Have you been thinking about how you might kill yourself?*
   - □ Yes  □ No  □ Refused  □ Patient unable to complete

3. Has the individual recently had intent to act on his/her ideation?
   Source: Use patient self report, collateral information
   *Suggested wording: Have you had some intention of acting on your thoughts?*
   - □ Yes  □ No  □ Refused  □ Patient unable to complete

4. Has the patient ever had a psychiatric hospitalization?
   Source: Use patient self report, collateral information, medical records review
   *Suggested wording: Have you ever been hospitalized for a mental health or substance use problem?*
   - □ Yes  □ No  □ Refused  □ Patient unable to complete

5. Does the patient have a pattern of excessive substance use?
   Source: Use patient self report, collateral information, medical records review
   *Suggested wording: Has drinking or drug abuse ever been a problem for you? Or administer CAGE or other standardized substance use screener.*
   - □ Yes  □ No  □ Refused  □ Patient unable to complete

6. Is the patient irritable, agitated, or aggressive?
   Source: Use current observations, collateral information, medical records review
   - □ Yes  □ No  □ Refused  □ Patient unable to complete
ED: Suicide Behaviors Questionnaire SBQ-R

- This is a psychology self-report questionnaire that is designed to identify risk factors for suicide in children and adolescents.
- Between the ages of 13 and 18.
- The 4 question test is filled out by the child and takes about 5 minutes.
- It asks about future anticipation of suicidal thoughts.
  - Each of the 4 questions address a specific risk factor; suicidal thoughts and attempts, frequency of suicidal thoughts, threat level of suicidal attempts, and likelihood of future suicidal attempts.
The Suicide Behaviors Questionnaire-Revised (SBQ-R) - Overview

The SBQ-R has 4 items, each tapping a different dimension of suicidality:¹
- Item 1 taps into lifetime suicide ideation and/or suicide attempt.
- Item 2 assesses the frequency of suicidal ideation over the past twelve months.
- Item 3 assesses the threat of suicide attempt.
- Item 4 evaluates self-reported likelihood of suicidal behavior in the future.

Clinical Utility
Due to the wording of the four SBQ-R items, a broad range of information is obtained in a very brief administration. Responses can be used to identify at-risk individuals and specific risk behaviors.

Scoring
See scoring guideline on following page.

Psychometric Properties¹

<table>
<thead>
<tr>
<th></th>
<th>Cutoff score</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult General Population</td>
<td>≥7</td>
<td>93%</td>
<td>95%</td>
</tr>
<tr>
<td>Adult Psychiatric Inpatients</td>
<td>≥8</td>
<td>80%</td>
<td>91%</td>
</tr>
</tbody>
</table>

## SBQ-R - Scoring

### Item 1: taps into *lifetime* suicide ideation and/or suicide attempts

<table>
<thead>
<tr>
<th>Selected response 1</th>
<th>Non-Suicidal subgroup</th>
<th>1 point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selected response 2</td>
<td>Suicide Risk Ideation subgroup</td>
<td>2 points</td>
</tr>
<tr>
<td>Selected response 3a or 3b</td>
<td>Suicide Plan subgroup</td>
<td>3 points</td>
</tr>
<tr>
<td>Selected response 4a or 4b</td>
<td>Suicide Attempt subgroup</td>
<td>4 points</td>
</tr>
</tbody>
</table>

**Total Points**

### Item 2: assesses the *frequency* of suicidal *ideation* over the past 12 months

<table>
<thead>
<tr>
<th>Selected Response:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>1 point</td>
</tr>
<tr>
<td>Rarely (1 time)</td>
<td>2 points</td>
</tr>
<tr>
<td>Sometimes (2 times)</td>
<td>3 points</td>
</tr>
<tr>
<td>Often (3-4 times)</td>
<td>4 points</td>
</tr>
<tr>
<td>Very Often (5 or more times)</td>
<td>5 points</td>
</tr>
</tbody>
</table>

**Total Points**

### Item 3: taps into the *threat of suicide attempt*

<table>
<thead>
<tr>
<th>Selected response 1</th>
<th>1 point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selected response 2a or 2b</td>
<td>2 points</td>
</tr>
<tr>
<td>Selected response 3a or 3b</td>
<td>3 points</td>
</tr>
</tbody>
</table>

**Total Points**

### Item 4: evaluates *self-reported likelihood* of suicidal behavior in the future

<table>
<thead>
<tr>
<th>Selected Response:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0 points</td>
</tr>
<tr>
<td>No chance at all</td>
<td>1 point</td>
</tr>
<tr>
<td>Rather unlikely</td>
<td>2 points</td>
</tr>
<tr>
<td>Unlikely</td>
<td>3 points</td>
</tr>
<tr>
<td>Likely</td>
<td>4 points</td>
</tr>
<tr>
<td>Rather Likely</td>
<td>5 points</td>
</tr>
<tr>
<td>Very Likely</td>
<td>6 points</td>
</tr>
</tbody>
</table>

**Total Points**

---

Sum all the scores circled/checked by the respondents. The total score should range from 3-18.

**Total Score**
## Environmental Assessment

<table>
<thead>
<tr>
<th>Life Safety Bldgs</th>
<th>Interior Spaces - Pt. Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay-in acoustical type ceiling tiles</td>
<td>Protection of patient room windows with a security screen, with security device</td>
</tr>
<tr>
<td>Recessed fire sprinkler heads</td>
<td>Window openings limited so that person cannot pass through (architectural standard is 4-6 inches)</td>
</tr>
<tr>
<td>Recessed or non-weight bearing smoke detectors</td>
<td>Metal outlet covers with shatter-proof non-conductive covers</td>
</tr>
<tr>
<td>Fire extinguisher boxes secured</td>
<td>Shatter-proof and tamper-resistant glass used in night lights and other lighting fixtures</td>
</tr>
<tr>
<td>Fire alarm pull stations secured</td>
<td>Light fixtures secured to restrict patient access to bulbs and sockets</td>
</tr>
<tr>
<td>Appropriate staff access to BH space (keys, card-reader, elevator, etc.)</td>
<td>Lavatory faucets tamper-resistant</td>
</tr>
<tr>
<td>Electrical outlets GFCI (ground fault circuit interrupter) and tamper resistant</td>
<td>Grab bars been removed in the bathroom or wall “gaps” filled in</td>
</tr>
<tr>
<td>Metal outlet covers been replaced with shatter-proof non-conductive covers</td>
<td>Coat hooks, towel bars, cubicle curtain tracks, and closet poles eliminated to reduce potential ligature</td>
</tr>
<tr>
<td></td>
<td>Piping for the toilet and lavatory protected</td>
</tr>
<tr>
<td></td>
<td>Tamper-resistant, anti-ligature door knob for the patient’s room, patient bathroom</td>
</tr>
<tr>
<td></td>
<td>Tamper-resistant shower controls and shower heads</td>
</tr>
<tr>
<td></td>
<td>Cords on window treatments or blinds removed to decrease ligature or strangulation potential</td>
</tr>
<tr>
<td></td>
<td>HVAC (heating, air, vents) grills tamper-resistant</td>
</tr>
<tr>
<td></td>
<td>All room door hinges and handles assessed with regard to potential barricade situations</td>
</tr>
<tr>
<td></td>
<td>Mirror and picture glazing material considered shatter-proof</td>
</tr>
<tr>
<td></td>
<td>Clothing, including belts &amp; shoes with laces secured</td>
</tr>
</tbody>
</table>
There are a number of environmental summary tools that are available

A nice summary of what to do and look for

Looks at common areas

- Grab bars removed, faucets and shower controls are tamper resistant, no towel bars or coat hooks, no plastic trash bags, etc.

Looks at life safety issues of the building and how the patient room is designed

- No cords on blind, assessment of door hinges, no belts, no shoe laces, tamper resistant, anti-ligature door knob, shatter proof mirrors,
SAD PERSONS Scale

- It was first developed as an assessment tool to determine suicide risk
- There is also an adapted or modified SAD PERSON scale
- Score is calculated from ten yes or no questions
- It is an acronym to be used as a mnemonic device
- Has been widely implemented in clinical settings

- Study in 2017 done since said it had limited supporting evidence and found their findings do not support the use of the SPS and Modified SPS to predict suicide in adults seen by psych services in the ED

  - Predicting Suicide with the SADS PERSONS scale at http://onlinelibrary.wiley.com/doi/10.1002/da.22632/abstract
SAD PERSONS

- **S**: Male sex
- **A**: Age (<19 or >45 years)
- **D**: Depression
- **P**: Previous attempt
- **E**: Excess alcohol or substance use
- **R**: Rational thinking loss
- **S**: Social supports lacking
- **O**: Organized plan
- **N**: No spouse
- **S**: Sickness

This score is then mapped onto a risk assessment scale as follows:

- 0–4: Low
- 5–6: Medium
- 7–10: High
Modified SAD PERSON Scale

- S: Male sex → 1
- A: Age 15-25 or 59+ years → 1
- D: Depression or hopelessness → 2
- P: Previous suicidal attempts or psychiatric care → 1
- E: Excessive ethanol or drug use → 1
- R: Rational thinking loss (psychotic or organic illness) → 2
- S: Single, widowed or divorced → 1
- O: Organized or serious attempt → 2
- N: No social support → 1
- S: Stated future intent (determined to repeat or ambivalent) → 2

This score is then mapped onto a risk assessment scale as follows:

- 0–5: May be safe to discharge (depending upon circumstances)
- 6-8: Probably requires psychiatric consultation
- >8: Probably requires hospital admission
The Columbia Suicide Severity Rating Scale is a tool used in the outpatient behavioral health setting.

It looks at identifiable suicide attempts.

It assesses full range of evidence-based ideation and behavior.

There are 3 versions of the tool:

- Lifetime/Recent version allows practitioners to gather lifetime history of suicidality as well as any recent suicidal ideation and/or behavior.
- Since the last visit and screener version is shortened form of the full version.
Columbia Suicide Severity Rating Scale

- Referred to as the gold standard as identified by the FDA for clinical trials
  - Asks five questions
- The SAMSHA SAFE-T risk assessment tool with C-SSRS questions are embedded
- Obtains a past psychiatric history and family history of suicide
  - Asks about stressor such as legal problems
  - Asks about things like impulsivity, hopelessness, insomnia, and anhedonia (lost interest in things they use to enjoy and decreased ability to feel pleasure)
Columbia Suicide Severity Rating Scale

http://cssrs.columbia.edu/
## SAFE-T Protocol with C-SSRS - Recent

### Step 1: Identify Risk Factors

<table>
<thead>
<tr>
<th>C-SSRS Suicidal Ideation Severity</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Wish to be dead</td>
<td></td>
</tr>
<tr>
<td><em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td></td>
</tr>
<tr>
<td>2) Current suicidal thoughts</td>
<td></td>
</tr>
<tr>
<td><em>Have you actually had any thoughts of killing yourself?</em></td>
<td></td>
</tr>
<tr>
<td>3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act)</td>
<td></td>
</tr>
<tr>
<td><em>Have you been thinking about how you might do this?</em></td>
<td></td>
</tr>
<tr>
<td>4) Suicidal Intent without Specific Plan</td>
<td></td>
</tr>
<tr>
<td><em>Have you had these thoughts and had some intention of acting on them?</em></td>
<td></td>
</tr>
<tr>
<td>5) Intent with Plan</td>
<td></td>
</tr>
<tr>
<td><em>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</em></td>
<td></td>
</tr>
</tbody>
</table>

### C-SSRS Suicidal Behavior: "Have you ever done anything, started to do anything, or prepared to do anything to end your life?"

Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

If "YES" Was it within the past 3 months?

### Current and Past Psychiatric Dx:
- [ ] Mood Disorder
- [ ] Psychotic disorder

### Family History:
- [ ] Suicide
- [ ] Suicidal behavior
## Risk Stratification

### High Suicide Risk
- Suicidal ideation with intent or intent with plan in past month (C-SSRS Suicidal Ideation #4 or #5)
- Or
- Suicidal behavior within past 3 months (C-SSRS Suicidal Behavior)

### Moderate Suicide Risk
- Suicidal ideation with method, WITHOUT plan, intent or behavior in past month (C-SSRS Suicidal Ideation #3)
- Or
- Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime)
- Or
- Multiple risk factors and few protective factors

### Low Suicide Risk
- Wish to die or Suicidal Ideation WITHOUT method, intent, plan or behavior (C-SSRS Suicidal Ideation #1 or #2)
- Or
- Modifiable risk factors and strong protective factors
- Or
- No reported history of Suicidal Ideation or Behavior

### Triage
- Initiate local psychiatric admission process
- Stay with patient until transfer to higher level of care is complete
- Follow-up and document outcome of emergency psychiatric evaluation
- Directly address suicide risk, implementing suicide prevention strategies
- Develop Safety Plan
- Discretionary Outpatient Referral
SAFE-T

- The Suicide Assessment Five Step Evaluation and Triage was developed with the Suicide Prevention Resource Center
- Also with the Screening for Mental Health
  - Used by mental health professionals
  - Information on the SAMSHA website
- Looks at risk factors; suicidal behavior (history, aborted attempts or self-injurious behavior), access to firearms, family history of suicide, key symptoms (hopelessness, anhedonia, impulsiveness, anxiety/panic, insomnia, and command hallucinations)
- Has 3 risk levels; high, moderate, or low
SAFE-T Assessment

SAFE-T
Suicide Assessment Five-step Evaluation and Triage
for Mental Health Professionals

1. IDENTIFY RISK FACTORS
   Note those that can be modified to reduce risk

2. IDENTIFY PROTECTIVE FACTORS
   Note those that can be enhanced

3. CONDUCT SUICIDE INQUIRY
   Suicidal thoughts, plans, behavior and intent

4. DETERMINE RISK LEVEL/INTERVENTION
   Determine risk. Choose appropriate intervention to address and reduce risk

5. DOCUMENT
   Assessment of risk, rationale, intervention and follow up

NATIONAL SUICIDE PREVENTION LIFELINE
1.800.273.TALK (8255)
Pocket Card or Mobile App Available

SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians

Suicide Safe mobile app based on the SAFE-T is available on the app stores now!

Average Rating: 4 out of 70 ratings.

Price: FREE (shipping charges may apply)

This resource gives a brief overview on conducting a suicide assessment using a five-step evaluation and triage plan. The five-step plan involves identifying risk factors and protective factors, conducting a suicide inquiry, determining risk level and interventions, and documenting a treatment plan. Download SAMHSA's Suicide Safe mobile app on your mobile device.

https://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-Pocket-Card-for-Clinicians/SMA09-4432

Pub id: SMA09-4432
Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

### 1. RISK FACTORS

- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- **Family history:** of suicide, attempts, or Axis I psychiatric disorders requiring hospitalization
- **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- **Access to firearms**

### 2. PROTECTIVE FACTORS

Protective factors, even if present, may not counteract significant acute risk

- **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

### 3. SUICIDE INQUIRY

Specific questioning about thoughts, plans, behaviors, intent

- **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- **Plan:** timing, location, lethality, availability, preparatory acts
- **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self-injurious actions
- **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious. Explore ambivalence: reasons to die vs. reasons to live
  
  *For YOUTHS:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition
  
  *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

### 4. RISK LEVEL/INTERVENTION

- **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- **Reassess** as patient or environmental circumstances change

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>RISK/PROTECTIVE FACTOR</th>
<th>SUICIDALITY</th>
<th>POSSIBLE INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant</td>
<td>Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal</td>
<td>Admission generally indicated unless a significant change reduces risk. Suicide precautions</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multiple risk factors, few protective factors</td>
<td>Suicidal ideation with plan, but no intent or behavior</td>
<td>Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers</td>
</tr>
<tr>
<td>Low</td>
<td>Modifiable risk factors, strong protective factors</td>
<td>Thoughts of death, no plan, intent, or behavior</td>
<td>Outpatient referral, symptom reduction. Give emergency/crisis numbers</td>
</tr>
</tbody>
</table>

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

### 5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For YOUTHS, treatment plan should include roles for parent/guardian.
Suicide Prevention Decision Support Tool

- The Suicide Prevention Resources Center’s Decision Support Tool was also mentioned in the TJC SEA

- It is for EDs in the care of adult patients with suicide risk

- Discusses scheduling an outpatient appointment within 7 days

- Ask if access to firearms or other lethal means (prescriptions)

- Brief patient education on follow up recommendations
Suicide Prevention Decision Support Tool

- Follow up with all discharged patients such as emails, letters, phone calls, or text messages
- Provide information on when patient needs to return to the ED
- Give crisis center phone number
- Asks 6 transitional questions: thought of carrying out a plan, suicide intent, significant mental health condition, substance use disorder, or irritability/agitation/aggression
**Brief Suicide Prevention Interventions**

For all patients with suicidal ideation who are being discharged: (1) Provide at least one of the following brief suicide prevention interventions prior to discharge. (2) Include crisis center/hotline information with every brief intervention provided. (3) Involve significant other(s) in the intervention if present.

- **Brief Patient Education:** Discuss the condition, risk and protective factors, type of treatment and treatment options, medication instructions, home care, lethal means restriction, follow-up recommendations, and signs of a worsening condition and how to respond. Provide verbal and written information on the nearest crisis hotline.

- **Safety Planning:** Work with the patient to develop a list of coping strategies and resources that he or she can use during or before suicidal crises. Use the Safety Planning resources (paper version or mobile app) provided in the full guide.

- **Lethal Means Counseling:** Assess whether the patient has access to firearms or other lethal means (e.g., prescription medications), and discuss ways to limit access until the patient is no longer feeling suicidal. Follow the Lethal Means Counseling Recommendations for Clinicians sheet available from Means Matter.

- **Rapid Referral:** During the ED visit, schedule an outpatient mental health appointment for the patient within seven days of discharge. If no appointments are available, review additional suggestions in the full guide and/or refer the patient for a follow-up with a primary care provider.

- **Caring Contacts:** Follow up with discharged patients via postcards, letters, e-mail or text messages, or phone calls. See sample messages in the full guide. These communications can be automated.

**Discharge Planning Checklist**

- Patient involved in planning
- Follow-up appointment scheduled for a date within one week of discharge
- Discharge plan reviewed verbally and understood by patient
- Educational materials provided

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**Caring for Adult Patients with Suicide Risk**

A Consensus Guide for Emergency Departments

This guide assists Emergency Department (ED) health care professionals with decisions about the care and discharge of patients with suicide risk with a focus on improving patient outcomes after discharge. It is a companion resource to the full guide, Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments.

Questions answered by Quick Guide:
- Can this patient be discharged or is further evaluation needed?
- How can I intervene while this patient is in the ED?
- What will make this patient safer after leaving the ED?
An excellent resource is put out by the NY Office of Mental Health patient safety guidelines

- 205 pages and shows companies that supply ligature resistant products
- The purpose is to provide hospitals with a selection of materials, fixtures, and hardware to use in areas with patients at risk for self-harm
- Goal is to reduce risk of suicide and self-harm for patients when admitted to hospitals
- Products represent style and properties to reduce risk
- Does not endorse any product like the VA or TJC
Patient Safety Standards, Materials and Systems Guidelines
Recommended by the
New York State Office of Mental Health

With respect to NYS-OMH operated facilities, these Guidelines apply solely to new construction and major renovation projects. Existing facilities should use these Guidelines as a reference document whenever they make improvements.
NY Patient Safety Standards Guidelines

- Need a multi-directed approach to reduce risk and it included the following:
  - Completion of patient risk assessments.
  - Completion of physical plant risk assessments.
  - Ongoing staff training to ensure their awareness of potential risks on the unit.
  - Installation of risk reduction products in patient bathrooms, bedrooms and other high risk areas.
  - Routine inspections of psychiatric units to ensure safety levels are maintained.
ASQ Ask Screening Questions

- National Institute of Mental Health came up with simple 4 question survey for identify at-risk youths
- The Ask Suicide-Screening Question Toolkit is free
- Can be used in a variety of settings including the ED, outpatient clinics, primary care offices
- Available in many languages
- Easy to use
- Must have follow up plan in place in the event the patient answers yes to any of the questions
Ask Suicide-Screening Questions (ASQ) Toolkit

Quick Links
- Download ASQ Tool (PDF)
- Download Info Sheet (PDF)
- Download Summary (PDF)
- Using the ASQ Toolkit
- Suicide Prevention
- Resources
- References

Medical Settings
- Emergency Department (ED/ER)
- Inpatient Medical/Surgical Unit
- Outpatient Primary Care/Specialty Clinics
Ask the patient:

1. In the past few weeks, have you wished you were dead?  
   - Yes   - No

2. In the past few weeks, have you felt that you or your family would be better off if you were dead?  
   - Yes   - No

3. In the past week, have you been having thoughts about killing yourself?  
   - Yes   - No

4. Have you ever tried to kill yourself?  
   If yes, how?  

   ____________________________________________________________  
   ____________________________________________________________  
   ____________________________________________________________  
   ____________________________________________________________  
   ____________________________________________________________  
   When?  

   ____________________________________________________________  
   ____________________________________________________________  
   ____________________________________________________________  

If the patient answers Yes to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now?  
   - Yes   - No

   If yes, please describe:  

   ____________________________________________________________  
   ____________________________________________________________  
   ____________________________________________________________  
   ____________________________________________________________
Next Steps

Next steps:

- If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).

- If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:
  - “Yes” to question #5 = acute positive screen (imminent risk identified)
    - Patient requires a STAT safety/full mental health evaluation.
    - Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.
  
  - “No” to question #5 = non-acute positive screen (potential risk identified)
    - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient’s care.

Provide resources to all patients:

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741
Resources
National Suicide Prevention Lifeline

https://suicidepreventionlifeline.org/

SPECIAL ANNOUNCEMENT

You can #BeThe1To help someone in crisis.
You don’t have to be a mental health professional to help someone in your life that may be struggling. Learn the Lifeline’s 5 steps that you can use to help a loved one that may be in crisis.

LEARN MORE’
CDC Resources on Suicide

Publications & Resources

- Understanding Suicide: Fact Sheet [PDF 254KB]
- Suicide: At a Glance [PDF 139KB]
- Uniform Definitions for Self-Directed Violence [PDF 1.31MB]
- Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence [PDF 2.51MB]
- Actionable Knowledge series
- The Relationship Between Bullying and Suicide: What We Know and What it Means for Schools [PDF 4.7MB]
- Recommendations for Media Reporting on Suicide [PDF 979KB]
- Preventing Suicide: A Global Imperative

CDC Research Activities

- Evaluating Innovative and Promising Strategies to Prevent Suicide among Middle-Aged Men
- Prevention of Suicidal Behavior Through the Enhancement of Connectedness
- Injury Center Funding Opportunity Announcements (FOAs)
- Extramural Research Resources
Has Section on Risk Factors for Suicide

**UNDER 30 (adolescents and young adults)**
1. Family history of suicide
2. Males > females
3. History of previous attempts
4. Native American
5. Psychiatric diagnosis: mood disorders and substance abuse
6. White > black
7. Mini-epidemic in community
8. History of delinquent or semi-delinquent behavior even without depression in current mental state.
9. Presence of firearms *(when other factors are present)*

**OVER 30**
1. Family history of suicide
2. Males > females
3. History of previous attempts
4. Native American
5. Psychiatric diagnosis: mood disorder, schizophrenia, alcoholism
6. Single: especially separated, widowed, or divorced
7. Lack of social supports
8. Concurrent medical illness(es)
9. Unemployment
10. Decline in socioeconomic status
11. Psychological turmoil
The End  Questions??

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