Partnership for Patient Care Safety Forum Webinar

Preventing Suicide:
Assessment, Environment and Risk Mitigation

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11:00 a.m. – 12:00 p.m.
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Preventing Suicide: Assessment, Environment and Risk Mitigation

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Objectives

- Recognize the types of distractors that may prevent suicide risk assessment from being completed;

- Compare and contrast the differences between suicide screening and suicide risk assessment;

- Discuss evidence-based suicide prevention strategies and treatment modalities;

- Learn about the important role sitters can play in suicide prevention;

- Understand the components of a successful discharge plan for behavioral health patients with risk factors;

- Address the toll the COVID-19 pandemic is having on mental health wellbeing and its effects on suicide risk.
Death by Suicide: More than a Mental Health Concern

47,000 DEATHS
In 2017, over 47,000 lives were lost to suicide

1,300,000 ATTEMPTS
In 2017, over 1,300,000 people attempted to commit suicide

LEADING CAUSE OF DEATH
Suicide is the second leading cause of death among people ages 10 to 14 years old worldwide and 10 to 34 in the United States

GROWING PROBLEM
Between 2000 and 2017, the national suicide rate increased by 33 percent among all Americans and 50 percent among girls and women*

*Data from the American Psychological Association
Thoughts

— For every one person who dies by suicide, 280 people think seriously about it but don’t act, according to the National Suicide Prevention Lifeline

— Statistics state that “9 out of 10 people who attempt suicide and survive, will not go on to die by suicide later”

— Previous attempts, however, are a suicide risk factor
COVID-19 and Suicide

What happens when an international pandemic aligns with a national suicide crisis?

— Secondary outcomes of the COVID-19 pandemic are inevitable

— Multiple stressors such as PTSD, financial, environmental, and limited access to mental health treatment, will co-exist with a rising suicide rate to further accelerate the crisis

— Suicide rates increased 35% between 1999 and 2018, according to recent CDC data

— Rates were elevated among medical professionals compared to other professions before the outbreak began

— Mental health experts say that it's time to normalize conversations about suicide.
Suicide As a Patient Safety Problem

Don’t Just Check the Box

— Suicide screening is indicated for patients who receive medical care in EDs and medical hospitals

— Patients who present with possible suicide attempts from medication overdose, alcohol intoxication, or repeated ED visits associated with suicidal ideation, gestures, or attempts should all receive a comprehensive suicide risk assessment.

— Even if they deny suicidal thoughts, a more in-depth suicide risk assessment is required
In no other field of medicine is a person's prognosis for an illness so determined by the availability of healthcare services.

Jeffrey A. Lieberman, MD
Suicide Risk Reduction

Assessing Risk Factors

— NPSG.15.01.01 EP 3 requires that the suicide risk assessment include 'risk factors'.
— What are examples of these risk factors?
— Risk factors may be described as a combination of the following factors or characteristics that contribute to the risk of suicide:
  • Individual
  • Biological
  • Psychological
  • Familial
  • Community
  • Cultural
— Societal
Suicide Risk Factors

Risk factors are characteristics of a person or his or her environment that increases the likelihood that he or she will die by suicide (i.e., suicide risk)

Major risk factors for suicide:
- Prior suicide attempt
- Misuse/abuse of alcohol or drugs
- Mental disorders
- Feelings of hopelessness
- Access to lethal means
- Knowing someone who died by suicide
- Social isolation
- Chronic disease/disability
- Cultural and religious beliefs
- Childhood maltreatment
Contributing Factors

Suicide Risk

- Relationship problem (42%)
- Physical health problem (22%)
- Use of Substance (28%)
- Job/Financial problem (16%)
- Loss of housing (4%)
- Crisis (29%)
- Criminal legal problem (9%)

Substance Abuse and Mental Health Services Administration (SAMHSA)
The Center for Disease Control (CDC)
Reality

- We cannot predict suicide
- There are no completely valid and reliable tools to assess or prevent suicidality
- 10th leading cause of death in US
- Military/Veterans (less than 1% of the population) represent 20% of suicides (22/day)
- 31% of the clinical population and 24% of the general population attempted suicide
- Don’t be afraid to ask the questions and use the real language (“Suicide, kill yourself”)
The Joint Commission Requirements

— Thoughtful *evaluation* of the environment

— A *plan*, and

— Available *resources* to guide staff when housing patients at risk for suicide in a patient room in a non-designated space
The Joint Commission

NPSG 15. Key Additions in 2019

— Adds prevention programs and targets medical hospitals and behavioral health organizations

— 4 Key additions (July 2019) NPSG-15:
  • Environmental assessment
  • Suicide assessment of patients who screen positive
  • Staff training for assessing and monitoring patients at risk
  • Discharge Planning and Follow-up care
The Joint Commission Suggestions

- Checklists identifying the self-harm objects to be removed
- Electronic flags (e.g. the patient you are placing in a medical/surgical room is high risk and you should sweep the room for items not essential for patient care which may pose a self-harm risk)
- Competency/training for all sitters who will be with high risk patients to do the environmental assessments
- Visual reminders (e.g., posters) of the most common items that are significant risks on the unit
- On-site psychiatric professional who is available to complete an environmental risk assessment in areas where staff do not have the training to do this independently.
By the Numbers

$1.7 MILLION PER YEAR
One hospital saved $1.7 million per year by adding behavioral health providers to its inpatient medical teams

68% of adults with mental disorders have physical health conditions

29% of adults with physical health conditions have mental disorders

42% of inpatient stays for a physical condition involve a co-occurring mental/substance use disorder

Source: NIMH. Source: Druss and Walker.
Source: Owens et al. * Nonfatal workplace violence involving days away from work Source: U.S. GAO.
Source: Nicks and Manthey. Source: Muskin et al.
Suicide Risk Screening vs. Assessment

Screening:

— Is a brief question tool to see if an assessment is necessary.

— Can be completed as part of a health questionnaire.

— Does the patient have risk factors or overall symptoms that need further evaluation?

Assessment:

— Suicide assessment usually refers to a more comprehensive evaluation done by a clinician to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a course of treatment.

— Is a comprehensive evaluation based on a synthesis of multiple acute, chronic, static, and modifiable risk factors.

— Evidence-based suicide prevention strategies include restricting access to firearms, lethal medications, and hot-spots for suicide by jumping.

— Transitions of treatment for suicidal ideation or attempt may include a continuum of services offered through outpatient clinics, partial hospitalization, crisis residential programs, and/or acute psychiatric hospitals.
Comprehensive Assessments

— Behavioral Health History
  • On admission

— Depression Scale
  • Hamilton Depression Rating Scale
  • PHQ-2,9-(last two weeks)

— Suicide Assessments
  • Columbia Suicide Severity Rating Scale

— Assessment for Violence Tools

  • Triage Tool: to assess a patient's potential danger from others or to him/herself, which may spill over to become an issue in the healthcare setting.
  • Indicator for Violent Behavior: a quick list of five observable behaviors that indicate danger to others.
  • Danger Assessment Tool: to assess the risk to nurses and other healthcare personnel of an individual who is exhibiting signs of potentially dangerous behavior. National Institute for Occupational Safety and Health
Columbia Suicide Severity Rating Scale

Branching Logic of the Columbia-Suicide Severity Rating Scale (C-SSRS), Clinical Practice Screener–Recent

Q1. Have you wished you were dead or wished you could go to sleep and not wake up?

Q2. Have you actually had thoughts of killing yourself?

YES

Q3. Have you been thinking about how you might kill yourself?

Q4. Have you had these thoughts and had some intention of acting on them?

Q5. Have you started to work out or worked out the details of how to kill yourself?

Q6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?

YES

Q6B. How long ago did you do any of these?

STOP

NO
ICAR2E Assessment Tool

— **Identify** suicide risk

— **Communicate** across disciplines and service

— **Assess** for life threats (and ensure safety especially from firearms and dangerous medications)

— **Risk assessment** for suicide based on a synthesis of multiple risk factors,

— **Reduce** suicide risks by treating modifiable risk factors

— **Extend** care beyond the ED by using a continuum of behavioral health and community services

Full Guide is available for download at [https://www.sprc.org/sites/default/files/EDGuide_full.pdf](https://www.sprc.org/sites/default/files/EDGuide_full.pdf)
Hospital Room Risks
Acute Care Patient Room Safety

Consider the following environmental recommendations:

— Identify 2 rooms as ligature resistant rooms that are designed with suicide safety in mind but can be used for all patients

— Adding break away curtains to the treatment spaces

— Have the designated rooms closer to the nursing stations

— Removing the affixed hook in the room which holds the ambu bag and replace with a break away hook to hold the ambu bag.

— Removing curtain rods and curtain strings/chains.

— Evaluating all furniture in the room, consider rounded edges

— Ensuring that bedside stands are either removable or permanently affixed. Remove after use.
Acute Care Patient Room Safety

- Adding flush mounts for the TV.
- Securing the clock to the walls
- Adding locks to the closet space and casework.
- Replacing all screws with tamper resistant screws.
- Verifying that outlets are tamper proof.
- Installing doorways that swing both in and out of the room to prevent patient and staff entrapment or barricade.
- Ensuring that windows that do open are not able to open wide enough for egress.
- Installing secure plated handrails in all of the bathrooms in the designated ligature resistant rooms
- All patients on self harm or suicidal risk should have disposable dinnerware and utensils and preferably finger foods. Also, all dinnerware and utensils should be counted at start and at the end of meal
Safe Environment Checklist Recommendations
Remove:

- O2 tanks stored under beds
- Thermometer
- Sequential compression devices and tubing
- Nurse Call Pendant (when available on bed rail)
- Bed Trapeze (if applicable)
- Examination gloves
- Wire hangers
- Device poles not in use
- BP cuff-locked until needed
- Trash cans - paper bag inserts and away from patient bed
- Cleaning products - chemical solutions
- Hand sanitizer
- Alcohol swabs or peroxide or any other treatment products not in use.
- Activities items used to interact with patient
Patient Care

The PA Patient Safety Authority recommends the following strategies to prevent patients at high risk of suicide from eloping (Patient Safety Authority):

— “Assigning the patient to a room in a location that allows easy observation and access for staff yet is away from exits.”

— “Monitoring and observation of the patient by staff educated in observation of at-risk patients.”

— “Using a team-participation approach, with scheduled, documented monitoring of the patient or, through intensive, one-to-one staffing when indicated.”

— “Keeping the patient’s attire limited to a patient gown.”
Case Studies

— Acute Care Medical Unit

• Patient was on suicide precautions with 1:1 by bedside. The 1:1 was sitting sideways next to the bed so full visibility of the patient was not achievable. The patient asked for a blanket “I’m cold”. After given the blanket, patient began to roll up his top sheet until he was able to wrap it around his neck and tie it to the side of the bed and began choking. The 1:1 had no idea this was occurring. Rapid response called.

— Psychiatric Inpatient Unit

• Patient was admitted for suicidal intent by hanging with a plan- on suicidal precautions for 2 days- she expressed feeling positive overnight and plan to move out of state and get a job. 2 days later when scheduled for discharge, an ex-boyfriend called the unit staff stating that the patient kept texting him that she was going to commit suicide as soon as she got out. They asked the patient about this- she said the boyfriend is cheating on me and wants me to stay away. They reassessed- Psychiatrist, PA, RN’s-patient denied SI, staff felt patient showed hope for future but kept patient one more day. The next day, patient was discharged and committed suicide within 5 hours of being released-by hanging.
Protective Factors

— Protective factors include, but are not limited to:

• Safe, secure, monitored environment (e.g., inpatient hospitalization)
• Receiving clinical care for mental, physical, and substance abuse disorders
• Easy access to a variety of clinical interventions and support for help seeking suicide risk
• Family and community support (connectedness)
• Support from ongoing medical and mental healthcare relationships
• Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
• Cultural and religious beliefs that discourage suicide and support instincts for self preservation
Sitters

Sitters are the #1 treatment option for suicidal patients. BUT............,

Are they competent in knowing what they are monitoring?

Policies and procedures should be evaluated to ensure that the following is included:

— Detailed information and criteria regarding the use of sitters and discontinuation of sitters

— Process for requesting sitters

— Sitter job description, including detailed expectations for sitter behavior and responsibilities and training

— Description of and delineation of the nurse’s role compared to the sitter’s role in caring for the patient

— Consider appointing someone to the role of managing the sitter program to ensure compliance and identify any unmet needs
Success for Sitters

There will be some patients who will definitively require supervision, especially those who express suicidal or homicidal ideation. Some ways in which sitter programs can be more successful include the following:

— Consider requiring the use of different interventions before requesting a sitter.

— Consider training sitters on the specific patient population they are likely to work with.

— De-escalation training and situational awareness are critical skills.

— Ensure that communication between the sitter and nurse is open and that the sitter understands why the patient needs supervision and what risks the patient poses.

— Likewise, all healthcare providers involved in the care of patients who require sitters must be aware of the patient’s conditions and needs, especially as they relate to suicidal tendencies.
Suicide Rate

- The rate of suicide after discharge from psychiatric hospitals and wards (post discharge suicide) is very high
- 178 per 100,000 person/year in the first 3 months after discharge
- It is approximately 15 times the US national suicide rate
- Suicide rates after discharge from Psychiatric Hospitals
Discharge Planning Checklist

— Patient involved in planning

— Patient Crisis safety Plan created days before discharge

— Follow-up appointment scheduled for a date as soon as possible but within one week of discharge

— Discharge plan reviewed verbally and understood by patient

— Barriers and solutions discussed

— Crisis center and Suicide Lifeline phone number provided
Discharge Planning

— Access to lethal means reviewed and discussed

— Written instructions and education materials provided, including what to do if the patient’s condition worsens and when to return to the ED

— Patient confirms his or her understanding of the patient care plan

— Relevant health information transmitted to referral providers

— Patient senses the provider’s care and concern

Safe Transitions

— Warm Handoff

• Rather than simply providing the name and phone number of a provider, as happens frequently, a warm hand-off connects the patient with the new provider before the first appointment.

— Rapid Referral

• To facilitate rapid referral, it may be helpful to establish agreements with outpatient providers to accept rapid follow-up referrals.
Safe Transitions

— Brief patient education

— Assistance with understanding and navigating the system of potential supports, preferably from a peer.

— Onsite counseling by staff from a community-based organization who can then see the patient for follow-up care after discharge- peer supports

— Providing the patient with a copy of his or her safety plan

— Mental health experts say it's time to normalize conversations about suicide.


https://theactionalliance.org/healthcare/caretransitions
Takeaways

— Suicide is the 10th leading cause of death and even more frequent patient safety problem

— Suicide *screening* is indicated for any patient who receives medical care in EDs and medical hospitals

— Patients who present with possible suicide attempts from medication or any drug overdose, alcohol intoxication, or frequent repeated ED visits associated with suicidal ideation, gestures or attempts should all receive a comprehensive suicide risk assessment

— Even if they deny suicidal thoughts, a more in-depth suicide risk assessment is recommended. Denial alone does not reduce risk.

— Re-assessments and risk communication is often missed in transitions of care; follow-up

— Aftercare appointments and warm handoffs are critical for discharge planning of anyone who was assessed and in need of further mental health treatment
Questions
Assessment Tools

— SAFE T

— Columbia Suicide Severity Risk Assessment
  • http://cssrs.columbia.edu/

— Suicide Prevention Resource Center
  • http://www.sprc.org/settings/primary-care/toolkit

— ICAR2E  Suicide prevention tool for ED providers
  • https://www.sprc.org/sites/default/files/EDGuide_full.pdf
National Suicide Prevention Lifeline

We can all help prevent suicide. The Lifeline provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals.

1-800-273-8255
ECRI Resources

- ECRI Healthcare Risk Quality and Safety Guidance
  - Essentials: Behavioral Health
    - [https://www.ecri.org/components/HRC/Pages/Essentials_Behavioral-Health.aspx](https://www.ecri.org/components/HRC/Pages/Essentials_Behavioral-Health.aspx)
  - Suicide Risk Recommendations: FAQs from Joint Commission
    - [https://www.ecri.org/components/HRCAlerts/Pages/HRCAlerts100318_Suicide.aspx](https://www.ecri.org/components/HRCAlerts/Pages/HRCAlerts100318_Suicide.aspx)
  - Do Sitters Make a Difference?
    - [https://www.ecri.org/components/HRC/Pages/RMRep0212_Focus.aspx?tab=2](https://www.ecri.org/components/HRC/Pages/RMRep0212_Focus.aspx?tab=2)
  - Guidance: Suicide Risk Assessment and Prevention in the Acute Care Hospital
ECRI Resources

— 2018 PSO Deep Dive: Meeting Patients' Behavioral Health Needs in Acute Care

— Ask HRC: Training One-to-One Sitters for Patient Suicide Prevention

— Tool: Continuous Observation Responsibilities


— HRC Alerts, November 1, 2017: How Can Providers Reduce Risk for Suicide in Healthcare Settings?

— HRC Alerts, July 13, 2016: Suicide Prevention: Are Some Strategies More Effective Than Others?
The Joint Commission Resources


- Suicide Prevention Resources to Support Joint Commission-Accredited Organizations Implementation of NPSG.15.01.01, Revised November 2018

- “Inadequate hand-off communication,” Sentinel Event Alert, Issue 58, September 12, 2017