

# Standards BoosterPak™ for Suicide Risk (NPSG.15.01.01)



The Joint Commission

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## Contents

### A. Description of NPSG and Implementation Expectations

- Section A1: Standard Rationale, Elements of Performance (EPs), Scoring Categories, Implementation Suggestions
- Section A2: Assessing Compliance During the On-Site Survey

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

- Section B1: Frequently Asked Questions (FAQs)
- Section B2: Definitions of Key Terms
- Section B3: Additional Information About Specific Topics

### C. Supporting Documentation, Evidence, Value, Historical Information, and Additional References and Links

- Section C1: Supporting Documentation and Evidence
- Section C2: Additional References and Links

### Index

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The purpose of this document is to provide all the information needed to understand and correctly interpret a standard in a single source. New standard-specific documents would be created as needed according to prespecified criteria when problematic standards are identified through existing measurement systems.

## **A. Description of NPSG and Implementation Expectations**

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

**Program:** Hospital and Behavioral Health Care

**Chapter:** National Patient Safety Goals

**Standard Number:** NPSG.15.01.01

**Standard Text:**

**Comprehensive Accreditation Manual for Hospitals:** Identify patients at risk for suicide.

*Note: this requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.*

**Comprehensive Accreditation Manual for Behavioral Health Care:** Identify individuals at risk for suicide.

**Rationale:**

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

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

**Element of Performance 1:**

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

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

**Scoring Categories:**

Criticality level: Direct

Documentation required: Yes

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: Yes

**Suicide Risk Assessment for Patients/Individuals Served:**

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

- Risk for suicide is typically not a simple (yes or no) finding. Usually, there are levels or gradations of suicide risk or lethality depending on current life situation, mental status, or periods of crisis.
- The required risk assessment will determine staff response to the patient/individual served. The assessment should evaluate the following four variables:
  1. Thoughts
  2. Plan
  3. Means
  4. Ability
- Many patients/individuals served may have suicidal thoughts, but no specific plan. As the thoughts firm up with the progression of the four variables, the response moves increasingly toward determining the level of care that is needed to ensure the safety of the patients/individuals served.
- Organizations should develop a risk assessment that identifies specific characteristics of patients/individuals served and environmental features that may increase or decrease the risk of suicide.
- Your organization should review this risk assessment with your multidisciplinary clinical team (if applicable) in order to develop a comprehensive assessment and to ensure acceptance. If your organization is a single service, then the screening/assessment process is reviewed by the clinician.
- In 24-hour care settings (for example, inpatient, residential, group home), after the suicide risk is assessed, the clinical staff should determine the following:
  - o The level of supervision needed in order for the patient/individual served to be safe; and the level of documentation for the observations.
  - o Often, the level of supervision and documentation parallels the risk of suicide. The immediate safety needs of the patient/individual served and the most appropriate setting for treatment would be based on the risk assessment.

With the permission of the patient/individual served, you may be able to use information provided by family members (or other pertinent information) as you determine the risk of suicide.

### **Implementation Suggestions:**

#### *Identifying specific patient/individual served characteristics:*

- A structured patient/individual served screening process for emergency departments (EDs), outpatient/clinics, and 24-hour care settings must be developed and implemented and be based on current evidence and leading practice.
- Focused open-ended questions should be used by trained staff to screen for the potential for self-harm/suicide, with consistent implementation of the screening process by clinical staff.
- Develop and implement an observation/supervision process to evaluate the effective use of the screening process by clinical staff.
- Develop and implement suicide risk assessment criteria/factors that must be evaluated, with resulting practice/safety recommendations by the clinician performing the screening/assessment.
- Provide effective training/supervision/support for the clinical staff conducting the screening/assessment.

### **Tips:**

- Inquiry about suicide risk needs to be communicated in a clear and straightforward manner (“Are you having thoughts of harming yourself?”)
- Avoid the use of indirect questioning such as “You aren’t suicidal are you?” or “You aren’t having thoughts of harming yourself are you?”

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

**Environmental Risk Assessments (Institutional Risk Factors):**

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

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

*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.*

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

EC.02.06.01, Element of Performance 1:

**Comprehensive Accreditation Manual for Hospitals:** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

**Comprehensive Accreditation Manual for Behavioral Health Care:** Interior spaces meet the needs of the individuals served for safety and suitability for the care, treatment, or services provided.

**Scoring Categories:**

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

- For environmental assessments, administrative, clinical, and medical staff should be involved in conducting the assessments.
- For environmental assessments, the organization should also obtain a second opinion (for example, staff from other programs/services or outside assistance) on the environmental risks. Often, internal staff see the same risks over and over without identifying them as environmental risk factors for patient/individual served self-injury or suicide. Environmental and maintenance staff may be a good source of suggestions and observations.
- For environmental risk factors such as bedding, materials, equipment or furnishings, the clinical and medical staff should be involved with the selection of and purchasing because they have first-hand knowledge of equipment and material risks associated with self-injury and suicide risk.
- Regular environmental rounds to detect unsafe conditions on the behavioral health programs/services where patients/individuals served are placed should include different scenarios, such as the following:
  - Use staff from other programs/services who are cross trained to help assess the environment for potential hazards (a second set of “eyes” often detect vulnerabilities that the assigned staff do not observe).
  - Use a standardized environmental risk assessment tool that is organizationwide because self-injury behavior and suicide occur in many locations of the 24-hour care settings.
  - Continuous assessment and surveillance of environmental vulnerabilities should be included in a risk assessment of the patient/individual served care areas. It is important to have consistency in the environmental rounds as organizations assess potential suicide risk factors in the environment.

*An environmental risk assessment should include the following:*

- Outpatient and ED care settings (organizations can evaluate the frequency and severity of recent and remote self-harm/suicide attempts and characteristics of patients/individuals served in these care settings to determine the criteria for the review of the environmental review process).
- A structured review guideline to provide staff with prompts/criteria regarding what to evaluate in the physical environment
- Evaluation of the unit or area in which the patient/individual served will reside, sleeping room, bathroom, group rooms, and open areas

- Staff training in effective use of the structured risk assessment guideline
- A schedule for implementation of the environmental review process, or criteria/triggers for implementation of the review process
- Inclusion of clinical AND administrative/supervisory staff in the walk-through review process (do not rely on one person to complete the structured review process).
- Aggregate and document the review results.
- Analysis of the data by leadership to determine risk points and need for action
- Sharing results of the aggregation, analysis, and planned actions with clinical staff
- Mitigation of defined risk areas.

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

**Element of Performance 2:**

**Comprehensive Accreditation Manual for Hospitals:** Address the patient's immediate safety needs and most appropriate setting for treatment.

**Comprehensive Accreditation Manual for Behavioral Health Care:** Address the immediate safety needs and most appropriate setting for treatment of the individual served.

**Scoring Categories:**

Criticality level: Direct

Documentation required: Yes

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: Yes

**Addressing Immediate Safety Needs and Most Appropriate Setting:**

1. When a patient/individual served has been identified as a suicide risk based on the assessment criteria develop and implement a treatment plan (identified needs, indices for progress, and interventions) to address safety needs.
  2. Define the levels of observation, such as 1:1, close observation.
  3. Monitor consistency of the implementation of observation procedures.
    - o Trained clinical staff should provide leadership and supervision when implementing the treatment plan.
    - o Monitor and assess the response of the patient/individual served and evaluate the need to revise the treatment plan at regularly scheduled intervals with needed supervision.
    - o Provide effective training, supervision, and support for clinical/direct care staff in use of treatment plans/interventions for patients/individuals served at risk for suicide.
    - o Evaluate the physical environment/treatment area in close proximity to where the patient/individual served at risk for suicide will be living/receiving treatment/sleeping for risk factors.
    - o Regularly assess the competence of clinical staff who are responsible for screening/assessing/intervening with patients/individuals served at risk for suicide.
    - o Develop and implement an effective discharge plan for the patient/individual served at risk for suicide that integrates, to the extent possible, involved family/significant others.
- Be sure to assess accessibility of items with which the patient/individual served may harm himself or herself.
    - o Have the patient/individual served use plastic eating utensils, and have staff responsible for counting each piece after the patient/individual served finishes a meal, no matter what level of observation he or she has been placed on.
    - o Review the contraband policy of the organization.
    - o Develop a standardized list of contraband items.
    - o Develop standardized monitoring requirements for specific items (for example, "Hair dryer use requires staff supervision.")
    - o Visitors have all gifts and personal items for the patient/individual served verified by staff prior to giving.

- Suicidal patients/individuals served may be at a higher risk of elopement. This risk for elopement may be based on one of several factors:
  - Not wanting to be admitted to a behavioral health care unit/program
  - Wanting to be alone in order to follow through with plans of suicide
- It is important that staff assess the potential for elopement.
  - Place the patient/individual served in a room that is away from exits but close to the area where staff are present.
  - Increase frequency of observation of patient/individual served.
- If the patient/individual served needs constant or close observation, be sure this is done by a trained staff member. It is not sufficient to assign this task to a family member.
  - Family members should never be assigned to observe a suicidal patient/individual served while in a 24-hour care setting.
- Observe the patient/individual served closely during medication administration to ensure that he or she swallows all oral medications.

#### **Implementation Suggestions:**

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

#### **Tips:**

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

**Element of Performance 3:**

**Comprehensive Accreditation Manual for Hospitals:** When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

**Comprehensive Accreditation Manual for Behavioral Health Care:** o When an individual at risk for suicide leaves the care of the organization, provide suicide prevention information (such as a crisis hotline) to the individual and his or her family.

**Scoring Categories:**

Criticality level: Direct

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: Yes

**Implementation Suggestions:**

- Provide patient/individual served/family with National Hotline number: 1-800-273-TALK (8255).
- Discharge instructions need to be clear and concise as to medications and follow-up appointments.
- Assist the patient/individual served in understanding follow-up clinic visits, their location, and their importance.
- Important to provide the patient/individual served not only with crisis numbers but also with an appointment for follow up
  - o Before developing your handout with local crisis numbers, be sure to call to verify that they are still current and active crisis numbers.
  - o It is a good idea to include their hours of operation (not all are 24/7), along with fees charged, acceptability of insurance by other entities, directions, and public transportation information
- When a patient/individual served is being discharged, suggest a discharge or reentry meeting with him or her and appropriate family members.
  - o Use the meeting to reaffirm the posthospital care plan, posthospital continuing needs, next provider plans, and community resources for any emergency or crisis needs.
  - o The continuing care meeting with family or significant others is a good way to recap or “hand off” critical information to others at the point of discharge.

**Tips:**

- Staff should be aware of organizations in the area that provide mental health services.
- Implement education for family/friends regarding suicide risk factors.
- Become involved in presenting programs to schools and community groups regarding suicide prevention.
- Consider providing a hotline number or staff contact number to patient/individual served/family when the individual leaves the facility for a home visit.

## Section A2: Assessing Compliance During the On-Site Survey

The surveyor will do the following:

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

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

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

The surveyor does the following:

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

- o Orientation, training, and competency of clinicians and other staff
- o Staffing
- Observes (to the extent possible) the implementation of the care plan with the patient/individual served

Surveyors may select multiple patients/individuals served to trace, focusing on the topic of suicide prevention.

- Interview emergency room staff on how they identify patients/individuals served with an emotional or behavioral health disorder that would trigger a suicide assessment.
- Interview various staff members as to how they determine the level of observation for an individual after they complete the suicide assessment.

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

### **Section B1: Frequently Asked Questions (FAQs)**

*(Adapted from the Joint Commission Web site)*

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#### **Suicide Risk Reduction**

##### *Applicability to general hospitals*

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

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

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

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

The nature of the treatment is really not the issue.

##### *Outpatients*

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

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

##### *Emergency departments (EDs)*

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

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

##### *Applicability-sample scenarios*

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

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

A risk assessment is not necessary. Treatment of the fracture and the emotional condition is needed. As the patient recovers, an assessment of the degree of ongoing risk for suicide is required in order to plan the appropriate continuing care.

2. A patient admitted to the ICU for detoxification

- Detoxification is a medical treatment. At the time of the patient's admission to the ICU, the primary diagnosis is medical. However, as the patient recovers, the primary diagnosis will shift to the underlying psychiatric or substance abuse problem. When the patient is able a suicide risk assessment will be required.

3. A patient admitted to OB in active labor, has history of severe postpartum depression after a previous childbirth

- The decision to do a suicide risk assessment and when to do it would be left to the responsible practitioner. It would not be required under NPSG.15.01.01; however, this type of patient represents a high risk.

*Screening vs. comprehensive assessment*

**Q. For psychiatric hospitals and residential treatment facilities, are we required to screen all individuals admitted and to conduct a more detailed risk assessment, as appropriate, or to conduct a thorough suicide risk assessment for every individual who presents for admission?**

- A. The details of the risk assessment process, when required, are left to the individual organization to decide. A two-stage process—for example, screening followed by a comprehensive assessment, as appropriate—is acceptable.

*Crisis hotline*

**Q. NPSG.15.01.01, EP 3, says, “The hospital provides information such as a crisis hotline to individuals at risk for suicide and their family members.” Does this mean we have to provide our own crisis hotline?**

- A. No. Actually, it means that organizations must provide information about the availability of a crisis hotline (not necessarily its own) or other resources, and how to access them if needed. This would be required for any patients/individuals served identified as “at risk” based on the assessment process as you have conducted it.

## Section B2: Definitions of Key Terms

### Glossary of Suicide Prevention Terms

From the *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD:

U.S. Department of Health and Human Services, Public Health Service, 2001

<https://store.samhsa.gov/shin/content/SMA01-3517/SMA01-3517.pdf>

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

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

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

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

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

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

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

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

### **Section B3: Additional Information About Specific Topics**

#### **Proactive Risk Assessment (From the “Leadership Chapter Overview” in the *2011 Comprehensive Accreditation Manual[s] for Hospitals and Behavioral Health Care*)**

By undertaking a proactive risk assessment, an organization can correct process problems and reduce the likelihood of experiencing adverse events. A health care organization can use a proactive risk assessment to evaluate a process to see how it could fail, to understand the consequences of such a failure, and to identify parts of the process that need improvement. The term *process* applies broadly to clinical procedures.

The processes that have the greatest potential for affecting safety of patients/individuals served should be the primary focus for risk assessments. Proactive risk assessments are also useful for analyzing new processes before they are implemented. Processes need to be designed with a focus on quality and reliability to achieve desired outcomes and protect patients/individuals served. An organization’s choice of which process it will assess may be based in part on information published periodically by The Joint Commission about frequently occurring sentinel events and processes that pose high risk to patients/individuals served.

A proactive risk assessment increases understanding within the organization about the complexities of process design and management and what could happen if the process fails. If an adverse event occurs, the organization may be able to use the information gained from the prior risk assessment to minimize the consequences of the event—and to avoid simply reacting to them.

Although there are several methods that could be used to conduct a proactive risk assessment, the following steps make up one approach:

1. Describe the chosen process (for example, through the use of a flowchart).
2. Identify ways in which the process could break down or fail to perform its desired function, which are often referred to as “failure modes.”
3. Identify the possible effects that a breakdown or failure of the process could have on patients/individuals served and the seriousness of the possible effects.
4. Prioritize the potential process breakdowns or failures.
5. Determine why the prioritized breakdowns or failures could occur, which may involve performing a hypothetical root cause analysis.
6. Design or redesign the process and/or underlying systems to minimize the risk of the effects on patients/individuals served.
7. Test and implement the newly designed or redesigned process.
8. Monitor the effectiveness of the newly designed or redesigned process.

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

### **Section C1: Supporting Documentation and Evidence**

Suicide ranks as the 11th most frequent cause of death (3rd most frequent in young people) in the United States, with one person dying from suicide every 16.6 minutes.

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

#### **Evidence base and consensus process used during development**

Staff proposed the topic of suicide risk assessment and prevention for consideration as a National Patient Safety Goal for 2007.

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

#### **Expert panel, task forces**

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

#### **Field review process and results**

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

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

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

#### **Feasibility testing results (setting-specific)**

None performed at the time of development

## Section C2: Additional References and Links

- American Psychiatric Association: Practice Guideline for the assessment and treatment of patients with suicidal behaviors. *Am J Psychiatry* 160(suppl.):1–60, Nov. 2003.
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## Books, Newsletters, and Education Programs

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Additional information and case study examples can be found in the following publications from Joint Commission Resources:

- The Joint Commission: *Meeting The Joint Commission's 2011 National Patient Safety Goals*. Oak Brook, IL: Joint Commission Resources, 2010.
- The Joint Commission: *Suicide Prevention: Toolkit for Implementing National Patient Safety Goal 15A*. Oak Brook, IL: Joint Commission Resources, 2008.

The following JCR periodicals address standards compliance issues and best practices related to suicide prevention:

- *The Joint Commission Journal on Quality and Patient Safety*
- *The Joint Commission Perspectives*
- *The Joint Commission Perspectives on Patient Safety*

The following are articles on suicide prevention that appeared in JCR periodicals between 2006 and 2011:

- Ballard, E., et. al.: Suicide in the medical setting. *Jt Comm J Qual Patient Saf* 34:474–481, Aug. 2008.
- Coffey C.: Building a system of perfect depression care in behavioral health. *Jt Comm J Qual Patient Saf* 33:193–199, Apr. 2007.
- Cullen S., Marcus S.: Suicide in inpatient settings: Are our hospitals safe enough? *Jt Comm J Qual Patient Saf* 34:472–473, Aug. 2008.
- Joint Commission Resources: *Sentinel Event Alert*: A follow-up report on preventing suicide. *Jt Comm Perspect* 31:15, Jan. 2011.
- Joint Commission Resources: Systematic screenings crucial in preventing patient suicides. *Joint Commission Perspectives on Patient Safety* 10:8–10, Apr. 2010.
- Joint Commission Resources: Tracer methodology 101: The suicide prevention tracer. *Joint Commission: The Source* 7:6–7, Dec. 2009.
- Joint Commission Resources: Assessing patients' potential suicide risk. *Joint Commission Perspectives on Patient Safety* 9:8–9, Apr. 2009.
- Joint Commission Resources: Patient suicide: Complying with National Patient Safety Goal 15A. *Joint Commission Perspectives on Patient Safety* 8:7–11, Feb. 2008.
- Joint Commission Resources: Creating a suicide risk management program: Teaching all staff members to assess for suicide risk. *Joint Commission Perspectives on Patient Safety* 6:9–14, Nov. 2006.
- Mills P., et. al.: Checklist to identify inpatient suicide hazards in Veterans Affairs hospitals. *Jt Comm J Qual Patient Saf* 36:87–93, Feb. 2010.
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JCR offers several educational products and services to fit the needs of any health care organization. Offerings include the following:

- Custom education designed specifically on any topic of interest to an organization, including National Patient Safety Goals, based on your educational needs assessment
- Face-to-face learning events, including Accreditation Essentials programs, which cover the specific National Patient Safety Goals in greater detail.

To view all JCR education products, please visit <http://www.jcrinc.com/View-All-Products/>

## Links

### Sentinel Event Alert:

Sentinel Event Alert, *Issue 46: A follow-up report on preventing suicide: Focus on medical/surgical units and the emergency department* (Nov. 17, 2010)

[http://www.jointcommission.org/sentinel\\_event\\_alert\\_issue\\_46\\_a\\_follow-up\\_report\\_on\\_preventing\\_suicide\\_focus\\_on\\_medicalsurgical\\_units\\_and\\_the\\_emergency\\_department/](http://www.jointcommission.org/sentinel_event_alert_issue_46_a_follow-up_report_on_preventing_suicide_focus_on_medicalsurgical_units_and_the_emergency_department/) (2010)

Sentinel Event Alert, *Issue 7: Inpatient Suicides: Recommendations for Prevention* (Nov. 6, 1998)

[http://www.jointcommission.org/sentinel\\_event\\_alert\\_issue\\_7\\_inpatient\\_suicides\\_recommendations\\_for\\_prevention/](http://www.jointcommission.org/sentinel_event_alert_issue_7_inpatient_suicides_recommendations_for_prevention/)

### Frequently Asked Questions for NPSG.15.01.01:

[http://www.jointcommission.org/standards\\_information/jcfaqdetails.aspx?StandardsFAQId=166&StandardsFAQChapterId=77](http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=166&StandardsFAQChapterId=77)

### *The Joint Commission Journal on Quality and Patient Safety* Blog:

<http://www.jcinc.com/Blog/2010/11/23/Preventing-Suicide-Outside-Mental-Health-Units/>

To access the Joint Commission's Leading Practice Library to search for leading practices for suicide risk, click the following link:

<https://leadingpractices.jointcommissionconnect.org/sites/extranet/default.aspx>

This will bring you to the sign-in page for the Leading Practice Library on *Joint Commission Connect™* using your extranet log-in ID and password:

The screenshot shows the login interface for the Joint Commission Connect™ Leading Practice Library. At the top, there is a blue header with the text "The Joint Commission Connect™". Below this is a light blue banner with the text "Sign In". The main content area is titled "Leading Practice Library" and includes the instruction: "Please use your Joint Commission Connect extranet login id (e-mail address) and password to access the Leading Practice Library. If you experience any login problems, please send an e-mail to [LeadingPracticeSupport@Jointcommission.org](mailto:LeadingPracticeSupport@Jointcommission.org)". There are two input fields: "User name:" and "Password:". Below the fields is a "Sign In" button. At the bottom, there is a checkbox labeled "Sign me in automatically" and a note: "Note: Sign me in automatically will remember your Username and Password on subsequent visits to this site".

**American Association of Suicidology and Suicide Prevention Resource Center (2011). Continuity of Care for Suicide Prevention and Research**

<http://www.sprc.org/library/continuityofcare.pdf> or <http://www.suicidology.org>

**Access your state mental health Web site**

**The National Association of Psychiatric Health Systems**

“Design Guide for the Built Environment of Behavioral Health Facilities”: <http://www.naphs.org>

**National Institute of Mental Health**

<http://www.mentalhealth.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml>

**Centers for Disease Control and Prevention**

<http://www.cdc.gov/ViolencePrevention/suicide/riskprotectivefactors.html>

[http://www.cdc.gov/injury/features/peer\\_victimization.html](http://www.cdc.gov/injury/features/peer_victimization.html)

<http://www2c.cdc.gov/podcasts/player.asp?f=7242>

<http://www.cdc.gov/Features/PreventingSuicide/>

<http://www.cdc.gov/ViolencePrevention/suicide/>

**Substance Abuse and Mental Health Services Administration**

<http://www.samhsa.gov/prevention/suicide.aspx>

**National Action Alliance for Suicide Prevention**

<http://actionallianceforsuicideprevention.org/>

**American Association of Suicidology**

<http://www.suicidology.org>

<http://www.suicidology.org/web/guest/stats-and-tools/fact-sheets>

**American Foundation for Suicide Prevention**

<http://www.afsp.org/>

**American Psychiatric Association**

<http://www.psych.org/>

**National Adolescent Health Information Center**

<http://nahic.ucsf.edu/>

**National Association of Social Workers**

<http://www.socialworkers.org/>

**National Youth Violence Prevention Resource Center**

<http://www.safeyouth.gov>

**Suicide Prevention Resource Center**

<http://www.sprc.org>

**Suicide Prevention Resource Center/Cultural competence**

<http://www.sprc.org/grantees/campus/2011/PDF/Penary%20%20Rutz%20Developing%20Cultural%20Competent%20Programs.pdf>

<http://www2.sprc.org/sites/sprc.org/files/SuicidePreventionMulticulturalCompetenceKit.pdf>

[http://www.sprc.org/grantees/statetribe/desc/showStateTribe.asp?st\\_trID=18](http://www.sprc.org/grantees/statetribe/desc/showStateTribe.asp?st_trID=18)

**The Guide: School-Based Youth Suicide Prevention**

<http://theguide.fmhi.usf.edu>

**University of Michigan Depression Center**

<http://www.depressioncenter.org/>

## Index

### A

Ambulatory care facilities, applicability of goal, 12  
Appointments for follow-up care, 9  
Assessment/screening of patients/individuals served  
    documentation of, 3, 4  
    in EDs, 3, 12–13  
    four variables to evaluate, 3  
    frequency of, 4  
    handoff communication and, 4  
    implementation suggestions, 3  
    level of supervision and safety needs based on, 3  
    requirement for, 2–4, 12–13  
    screening vs. comprehensive assessment, 13  
    tips for, 3–4  
    tool for, 2, 3

### B

Behavioral health care (BHC) organizations, applicability of goal, 2, 12  
Books, 17

### C

Communication  
    after upsetting phone calls or disappointing events, 8  
    handoff communication (PC.02.02.01), 4  
    during risk assessment, 3–4  
Continuing care meeting, 9  
Contraband policy, 7, 8  
Crisis hotlines, 9, 13

### D

Definition of terms, 14  
Detoxification, 13  
Discharge instructions, 9  
Discharge planning, 7

### E

Education and training  
    assessment of during surveys, 10–11  
    educational products, 18  
    of family and friends, 9, 10  
    of patients/individuals, 10  
    programs in schools and community about suicide prevention, 9  
    of staff, 7, 8, 10  
Elopement risk, 7–8  
Emergency departments (EDs)  
    applicability of goal, 12  
    assessment of compliance during surveys, 11  
    assessment/screening of patients/individuals served, 3, 12–13  
    environmental risk assessment, 5

items with which patients/individuals may harm themselves, accessibility to, 8  
suicides in, 12

Emotional or behavioral disorders, 12

Environmental risks

assessment of during surveys, 10

assessment of risk, 5–6, 8

documentation of assessment, 6

frequency of assessment of, 5

interior spaces, safe and suitable (EC.02.06.01), 5

safe, functional environment (EC.02.06.01), 4–6

tool for, 5

Environmental rounds, 5

## **F**

Failure modes, 15

Family and friends

education and training of, 9, 10

observation, assignment to, 8

suicide prevention information to, 9

## **G**

Glossary, 14

## **H**

Handoff communication (PC.02.02.01), 4

Hospitals, applicability of goal, 2, 12

Hotline number, 9, 13

## **I**

ICU admission, suicide risk assessment and, 13

Implementation suggestions and tips, 3–4, 8

Individualized interventions, 8

Institutional risk factors, 4–6

Interior spaces, safe and suitable (EC.02.06.01), 5

## **L**

Links, 19–21

## **M**

Medication administration, observation during, 8

Meeting, discharge or reentry, 9

Multicultural populations, 8

## **N**

National Hotline number, 9, 13

National Patient Safety Goal. *See also* Suicide risk, identifying patients at risk for (NPSG.15.01.01)

applicability of goal, 2, 12, 16

development of, 16

field review process and results, 16

Newsletters and periodicals, 17, 18

## O

- OB admission, suicide risk assessment and, 13
- Observation
  - consistency of implementation of procedures, 7
  - elopement risk and, 8
  - family members, assignment of to, 8
  - levels of, 7, 11
  - during medication administration, 8
- Office practices, applicability of goal, 12
- Outpatient settings
  - applicability of goal, 5, 12
  - assessment/screening of patients/individuals served, 3
  - environmental risk assessment, 5

## P

- Patient Safety Advisory Group (Sentinel Event Advisory Group), 16
- Periodicals and newsletters, 17, 18
- Postpartum depression, 13
- Proactive risk assessment, 6, 15
- Processes, proactive risk assessment of, 15

## R

- References and links, 17–21
- Risk. *See also* Suicide risk
  - environmental risks, assessment of, 5–6, 8
  - proactive risk assessment, 6, 15

## S

- Safe, functional environment (EC.02.06.01), 4–6
- Sentinel Event Advisory Group (Patient Safety Advisory Group), 16
- Sentinel events
  - Sentinel Event Database, 12
  - suicides as, 16
- Special populations, 8
- Staff
  - education and training of, 7, 8, 10
  - interviews with during on-site surveys, 10–11
- Suicidal act, 14
- Suicidal behavior, 14
- Suicidal ideation, 14
- Suicidality, 14
- Suicide
  - definition of, 14
  - frequency of, 16
  - as sentinel events, 16
- Suicide attempt, 14
- Suicide attempt survivors, 14
- Suicide prevention
  - assessment of compliance during surveys, 10–11
  - hotline number, 9
  - information to patient and family about, 9
  - programs in schools and community about, 9
  - references and links, 17–21

- Suicide risk
  - environmental risks, 4–6
  - factors that increase, 4
  - items with which patients/individuals may harm themselves, accessibility to, 7
  - levels or gradations of, 3
  - references and links, 17–21
- Suicide risk, identifying patients at risk for (NPSG.15.01.01)
  - applicability of goal, 2, 12, 16
  - assessment of compliance during surveys, 10–11
  - development of Goal, 16
  - implementation suggestions and tips, 3–4, 8
  - rationale, 2
  - risk assessment for patients/individuals served, 2–4, 12–13
  - suicide prevention information to patient and family, 9
  - treatment plan to address safety needs of patients/individuals, 7–8
- Suicide survivors, 14
- Surveys, on-site
  - assessment of compliance during, 10–11
  - tracer activities during, 10, 11

## **T**

- Treatment
  - “being treated,” 12
  - treatment plan to address safety needs of patients/individuals, 7–8