



*Promoting wellness and recovery*

Mike DeWine, *Governor*  
Lori Criss, *Director*

# **Appalachian Behavioral Healthcare's Zero Suicide Initiative**

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# Learning Objectives

## Participants will:

1. Increase understanding of the clinical and environmental risks related to inpatient suicides.
2. Increase awareness of tools/procedures to reduce risk of inpatient suicide.
3. Learn how one psychiatric hospital is addressing suicide risk from admission through the post-discharge period.

# Appalachian Behavioral Healthcare

- One of six OhioMHAS inpatient psychiatric hospitals
- 92 beds
- 520 admissions/discharges in fiscal year 2019
- Rural service area; challenges include: poverty, transportation issues, gun culture, substance abuse.



# Overall Prevalence

- Suicide is the 10<sup>th</sup> leading cause of death in the U.S.
- Suicide is the 2<sup>nd</sup> leading cause of death for people between the ages of 10-34.
- There are more than twice as many suicides (47,173) in the United States as there were homicides (19,510).



# Ohio Suicide Statistics

- The state's suicide rate per 100,000 people increased by 24% from 2008 to 2017.
- Males are at much greater risk with an average 10-year rate of 21.4; the rate of suicide death for females was 5.4.
- Suicide rates were highest among people between the ages of 50-59, followed by 40-49, during the 10-year study period.
- In 2017, young adults (20-29) exhibited the highest suicide rate per age group.



# SE Ohio Suicide Statistics

- Three Appalachian counties: Meigs (21.5), Jackson (19.9); and Hocking (19.7) had the highest average suicide death rates per 100,000 population.
- Appalachian Ohio reported higher suicide rates per 100,000 population than the remainder of Ohio.





# Prevalence in Hospitals

- 75-80% of inpatient suicides were completed by psychiatric patients.
- Hanging accounted for over 70% of suicides.
- Nearly half occurred in hospital bathrooms and a third occurred in bedrooms.
- Most commonly used ligature point was a door, door handle, or door hinge.



# ABH's Zero Suicide Story

- The Zero Suicide initiative is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies.
- Staff's initial reaction to it...really? This is part of ABH's journey of high reliability/zero harm.
- Not a finished product; ongoing interdisciplinary PI team dedicated to preventing suicide.
- <http://zerosuicide.sprc.org/>



# The Joint Commission & CMS

- Heightened focus on suicide prevention as a result of the Suicide Risk Reduction Expert Panel.
- TJC released Sentinel Event Alert 56 in February 2016 outlining the 8 steps healthcare facilities can take to help prevent suicide.
- National Patient Safety Goal 15.01.01 has 7 new and revised elements of performance effective July 1, 2019.
- TJC has a suicide prevention portal where anyone can access all their resources on suicide prevention in one place.

[https://www.jointcommission.org/topics/suicide\\_prevention\\_portal.aspx](https://www.jointcommission.org/topics/suicide_prevention_portal.aspx)



# Addressing Ligature Risk

- Patient Safety Risk Assessment
  - Entire patient programming area environmental risk assessment and mitigation plan
  - Patient-specific risk assessments for medical equipment (hospital bed, wheelchair, etc.)
    - These are attached to the patient's treatment plan and reviewed/updated.
- Mitigating Factors
  - Clinical interventions
  - Staff training
  - Milieu Monitor
  - Policy Changes (ratio, supervised areas, etc.)



# Patient Safety Risk Assessment

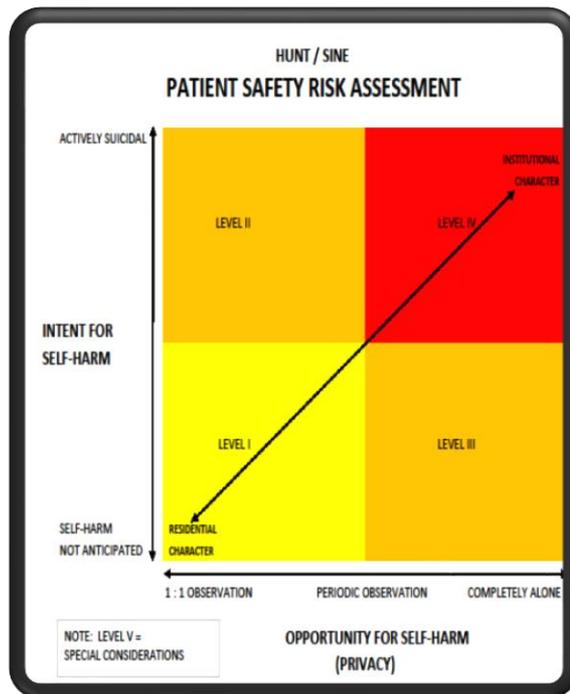
**Level I:** Areas where patients are not allowed or are under constant supervision, such as staff and service areas.

**Level II:** Areas behind self-locking doors where patients are highly supervised and not left alone for periods of time such as treatment team rooms, and laundry rooms.

**Level III:** Areas that are not behind self-locking doors where patients may spend time with minimal supervision such as day areas, dining rooms, and corridors, some of which are not fully visible without cameras.

**Level IV:** Areas where patients spend a great deal of time alone with minimal or no supervision, such as patient rooms (semi-private and private) and patient bathrooms.

**Level V:** Areas where staff interact with newly admitted patients who present potential unknown risks or where patients may be in a highly agitated condition. Due to these conditions, these areas fall outside the parameters of the risk map and require special consideration of patient and staff safety. Such areas include quiet rooms, examination rooms, and rooms where admissions occur (Treatment Team Rooms).



# Ligature Resistant Area



<u>Risk Level</u>	<u>Room/Area</u>	<u>Ligature Points/Ligatures</u>	<u>Additional Mitigating Factor</u>
III	Corridors	<ul style="list-style-type: none"> <li>• Fire Extinguisher Box</li> <li>• Fire Pull Station(s)</li> <li>• Fire Strobes</li> <li>• Sprinkler Heads</li> <li>• Safety Mirrors</li> <li>• HVAC Vents</li> <li>• Drop in Ceiling</li> <li>• Utilities above drop in ceiling</li> <li>• Temperature Control Cover</li> <li>• Lock to Mechanical Room</li> <li>• Exit Signs</li> <li>• Hallway Doors between the units</li> <li>• Magnetic Hold Opens</li> <li>• Door Closures</li> </ul>	<ul style="list-style-type: none"> <li>• Patients identified at high to moderate risk are placed on 1:1 (high) or 15-minute checks (moderate)</li> <li>• Staff awareness of the increase in risk in corridors at night and during report when traffic is reduced.</li> <li>• Counting of items based on patient assessment.</li> <li>• Routine as well as precautionary checks occur.</li> <li>• Staff awareness of possible triggers that individual patients may have and discussion of therapeutic ways to navigate those triggers.</li> <li>• Patients identified as High risk are placed on a 1:1 and/or in corridors that are in direct line of sight from nursing station.</li> </ul>

# Milieu Monitor

- Member of nursing staff designated as the monitor, out in the unit milieu, 24/7.
- Staff are assigned for 1 hour at a time.
- Constantly walking through unit monitoring ligature risks not visible from nurses' station, patient acuity, and any other safety concerns.
- Conducting hourly room checks of patient rooms and treatment rooms for ligature risks, including:
  - Excess towels
  - Privacy doors/curtains intact and correct number of clips accounted for
  - Caulk is intact



# The 2019 Joint Commission Feedback on ABH Ligature Risk Assessments

Surveyors said that all ligatures they identified would be cited, but the findings would not be conditional, if the following conditions were met:

- Every ligature risk must be on risk assessment
- Every ligature risk must have a mitigation plan
- The mitigation plan must be reasonable
- The surveyors must observe mitigation plan being implemented
- *This is based on surveyor comments from our August 2019 Joint Commission Survey*

# ABH Clinical Improvements to Suicide Prevention Process



# Admission Screen

- Admitting practitioners screen 100% of patients at admission using the Columbia Suicide Severity Rating Scale screener and a document that addresses protective factors.
- Based on results of that screen and the practitioner's clinical judgment, patients are identified as low, moderate, or high risk.
- Patients admitted as a result of suicidal ideation or attempt will be identified as moderate or high risk regardless of screen.



# High Risk of Suicide

- Patients identified as high risk will have the following interventions ordered by the practitioner:
  - Suicide Precautions
  - 1:1 Observation
  - Columbia Suicide Severity Rating Scale completed by the RN within 24 hours of the order
  - Patient Suicide Safety Plan completed by patient and social worker prior to discharge



# Moderate Risk of Suicide

- Patients identified as moderate risk must have the following interventions ordered by the practitioner:
  - Suicide Precautions
  - 1:1 Observation or 15 minute checks
  - Columbia Suicide Severity Rating Scale completed within 24 hours of the order
  - Patient Suicide Safety Plan completed prior to discharge



**SUICIDE SEVERITY RATING SCALE-PHYSICIAN FORM**  
*Screen Version - Recent*

<b>SUICIDE IDEATION DEFINITIONS AND PROMPTS</b>	<b>Past month</b>	
Ask questions that are bolded and <u>underlined</u> .	<b>YES</b>	<b>NO</b>
Ask Questions 1 and 2		
1) <b><u>Have you wished you were dead or wished you could go to sleep and not wake up?</u></b>		
2) <b><u>Have you actual ly had any thoughts of killing yourself?</u></b>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) <b><u>Have you been thinking about how you might do this?</u></b>  E.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."		
4) <b><u>Have you had these thoughts and had some intention of acting on them?</u></b>  As opposed to "I have the thoughts but I definitely will not do anything about them."		
5) <b><u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u></b>		
6) <b><u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u></b>  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, ask: <b><u>Was this within the past three months?</u></b>	<b>YES</b>	<b>NO</b>

- Low Risk
- Moderate Risk
- High Risk

**Risk Factors (select all that apply)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Prior attempts  | <input type="checkbox"/> Current lethality        | <input type="checkbox"/> Intent to die  |
| <input type="checkbox"/> Hopelessness    | <input type="checkbox"/> Anxiety/agitation        | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Impulsiveness/Aggression | <input type="checkbox"/> Loss/Trauma    |

**Risk Factors (Comments)**

**Protective Factors (Select all that apply)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Marriage/Family/Social | <input type="checkbox"/> Established relationships | <input type="checkbox"/> Religious/cultural beliefs |
| <input type="checkbox"/> Healthy coping skills  | <input type="checkbox"/> Employment                | <input type="checkbox"/> Other (Explain below)      |
| <input type="checkbox"/> Children in the home   | <input type="checkbox"/> Willing to seek help      |   |

**Protective Factors (Comments)**

**Patient's Overall Acute Suicide Risk:**

- LOW                       MODERATE                       HIGH

High Risk Required Interventions\*                      Additional Interventions\*

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> 1:1 observation                      | <input type="checkbox"/> Private Room  |
| <input checked="" type="checkbox"/> Suicide Precautions                  | <input type="checkbox"/> Other (List): |
| <input checked="" type="checkbox"/> Columbia Suicide Severity Assessment |  |
| <input checked="" type="checkbox"/> Patient Suicide Safety Plan          |  |
| <input checked="" type="checkbox"/> Level 1 movement only                |  |

Moderate Risk Required Interventions\*                      Additional Interventions\*

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Suicide Precautions (select 1:1 OR 15 min checks) | <input type="checkbox"/> 1:1 observation OR |
| <input checked="" type="checkbox"/> Columbia Suicide Severity Assessment              | <input type="checkbox"/> 15-minute checks   |
| <input checked="" type="checkbox"/> Patient Suicide Safety Plan                       | <input type="checkbox"/> Private Room       |
| <input checked="" type="checkbox"/> Level 1 movement only                             | <input type="checkbox"/> Other (List)       |

\*Admitting RN must add interventions to the Initial Individualized Treatment Plan

\_\_\_\_\_  
**Practitioner's Signature**

\_\_\_\_\_  
**Date/Time**

# High and Moderate Risk of Suicide

- The RN will add suicidality as a separate problem on the treatment plan.
- Practitioner will order suicide precautions and specifies monitoring (1:1, 15 minute checks)
- The RN will complete a Columbia Suicide Severity Rating Scale within 24 hours
- The RN will add all practitioner orders as interventions to the treatment plan.



# Suicide Precautions

- Orders can be for 1:1, within arms length; 1:1, within eyesight; 1:1 while awake only and 15 minute checks.
- RN writes note a minimum of every 12 hours and physician assesses patient and writes a note a minimum of daily.
- Monitoring includes observing the patient as well as monitoring the patient's environment for potential ligature risks.



# Treatment Planning

- Suicidality is listed as its own problem on the treatment plan.
- Interventions
  - C-SSRS, Patient Suicide Safety Plan, monitoring, etc.
- Objectives
  - CBT, DBT, medication adherence, safety plan, etc.
- Patient safety risk assessment
  - Individualized risk assessment conducted when a patient is ordered medical equipment.



# Discharge

- Patients admitted at moderate or high suicide risk leave the hospital with a copy of their Patient Suicide Safety Plan.
- PSSP is also faxed with aftercare plan to patient's outpatient provider.
- Prior to discharge, social worker helps patient enter hotline numbers and suicide prevention apps into their cell phone.



# Caring Contact

- Peer Support Specialist reaches out via phone to all patients after discharge.
- Asks patient if they had a PSSP and whether they are using it.
- Assists patients in accessing resources, rescheduling appointments as needed.
- Patients who cannot be reached by phone are sent a letter in the mail.



# Staff Training

- Two psychologists certified in CBT for suicidality
- AMSR (Assessing and Managing Suicide Risk) training provided for all psychiatrists, psychologists and social workers, as well as some other clinical staff.
- CALM (Counseling on Access to Lethal Means) training required for social workers
- Have a staff person newly certified in training QPR (Question, Persuade, Refer) for non-clinical staff



# Pre vs. Post Performance Improvement

## Pre-PI Process

- Clinical judgment
- Environmental risk not part of patient treatment
- No systematic use of PSSP
- Limited training to staff
- No Caring Contacts post-discharge

## Post-PI Process

- Validated screening/assessment tools + clinical judgment
- Environmental risk assessment and monitors
- Procedure of suicide prevention efforts in policy
- Extensive staff training
- Contact post-discharge



# Summary of actions we take to reduce risk of suicide

- Assess the environment for all ligature risks.
- Remove the risks where possible.
- Develop mitigation processes to reduce the risks.
- Complete suicide screenings on all patients.
- Complete a Columbia Suicide Severity Rating Scale on all patients identified as being at high or moderate risk of suicide.
- Work collaboratively with identified patients to develop a Patient Suicide Safety Plan.
- Update treatment plan as appropriate and document steps to reduce suicide risk.
- Continually monitor the environment.
- **Know Your Patients.**



# Questions?



# References

- A Longitudinal Analysis of Ohio Suicide Deaths 2008-2018; The Ohio Alliance for Innovation in Population Health; May 2019
- Incidence and Method of Suicide in Hospitals in the United States. The Joint Commission Journal on Quality and Patient Safety. Volume 44, Issue 11, November 2018.
- [Centers for Disease Control and Prevention \(CDC\) WISQARS Leading Causes of Death Reports](#)

