Protecting Suicidal Patients

Clinical Quality Insights

Thursday, September 15, 2022

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MONTHLY CLINICAL QUALITY INSIGHTS

Webinar Schedule & Topics

The 3rd Thursday of Every Month:
10AM Pacific, 1PM Eastern

SEPTEMBER

Protecting Suicidal Patients

OCTOBER

Responding Effectively to Adverse Findings

NOVEMBER

Preventing Infection-Related Survey Disasters

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SOLUTIONS INSIGHTS

Insights

Article

Case Study

Infographic

Webinar

Helping Providers Deliver on the Essential Promise of Healthcare

Helping people at their most vulnerable demands sustained, top-tier clinical performance. Chartis Clinical Quality Solutions—formerly The Greeley Company—works with clients to improve clinical quality performance through its High Reliability Care Solutions, Medical Staff Services Optimization, Education Solutions, and Workforce Solutions.

Responding Effectively to Adverse CMS, State, and Accreditation Findings

Uncover practical approaches for how to work with regulators and implement meaningful, sustainable, and efficient corrective action.

Protecting Suicidal Patients

Suicide prevention is at the top of The Joint Commission's list of frequently cited issues. Our panelists will break down the complexities into a streamlined process for clinicians and regulators.

EMTALA Made Simple

Learn practical approaches to achieve sustained compliance through simple, satisfying, and safe solutions.

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We are a partner to healthcare organizations nationwide, helping to advance patient safety and clinical quality for the past 30+ years. We help healthcare providers achieve top-tier clinical performance through our four lines of business:

- High Reliability Care Solutions
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- ✓ Rapid Response to Regulatory Emergencies
- ✓ Resolving CMS and TJC Adverse Actions
- ✓ CMS and Accreditation Survey Readiness
- ✓ Environment of Care, Life Safety, and Emergency Preparedness
- ✓ Hospital-CMS Systems Improvement Agreements … the National Leader
- ✓ Emergency Department/EMTALA
- ✓ Behavioral Health
- ✓ Infection Prevention
- ✓ Patient Safety
- ✓ Process/Policy Simplification
- ✓ Streamlined Health Records
- ✓ Process Implementation
- ✓ Quality Monitoring and Improvement

Integration with other best-in-class consulting services offered by The Chartis Group

Simplify & Comply

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What sort of

ORGANIZATION DO YOU REPRESENT?

a. Hospital or Critical Access Hospital

b. Psychiatric Hospital or Unit

c. Health System

d. Other Provider of Healthcare Services

e. Consulting Group

f. Other

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Today's Discussion

Why are suicide prevention requirements so difficult for hospitals to master?

What can you do to create a sustainable, practical, safe, and compliant program at your institution?

Cherilyn Ashlock
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Bud Pate

Vice President, Content & Learning, Clinical Compliance and High Reliability

"Don't make promises you can't keep

"Say what you do and do what you say

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Objectives

Dispel the many myths about suicide prevention requirements

Learn or reinforce what is actually required to comply with the various standards and regulations

Convert regulatory mandates into common sense, patient-focused solutions

Program slides are shared as a PDF in the Chat function.

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What is your

ACCREDITING ORGANIZATION?

a. The Joint Commission

b. DNV GL

c. The Center for Improvement in Healthcare Quality (CIHQ)

d. The Accreditation Commission for Health Care (ACHC … Formerly HFAP)

e. Commission on Accreditation of Rehabilitation Facilities (CARF)

f. Other Accreditor

g. Not Accredited

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Agenda

01

Facts about suicide prevention requirements

02

Discussing common failure points and the strategies to avoid them

03

10 tips to avoid regulatory survey mishaps and better protect patients

Questions should be posted in the webinar interface throughout the presentation.

We will respond to any unanswered questions in writing following the webinar.

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CMS (State Survey Agency) Findings Related to Suicidal Patients

~100% of CMS citations related to suicide prevention arise from an adverse event (e.g., suicide attempt, elopement).*

80% of suicide-related surveys result in the threat of loss of Medicare certification.*

30% of suicide-related investigations result in "Immediate Jeopardy" status.*

Conditions of Participation Cited*
- Patients' Rights (80%)
- Emergency Services (20%)
- Nursing (10%)
- Discharge Planning (20%)

Risk Points
- Unnecessary complexity
- Basic safety
- Addressing the underlying cause significant adverse events

There seems to be a dramatic increase in the number of
- State Agency (CMS) surveys
- Patients with behavioral health issues

Primary Issues

- Overcommitment and under performance
- Environmental safety
- Failure to protect at-risk patients
- Appropriateness of discharge
- Screening vs. assessment/plan
- Role of "Crisis Teams"
- Ligature-resistance
- Competency of observers

** Source … CMS statements of deficiencies entered into the CQOR database between January and June 2021*

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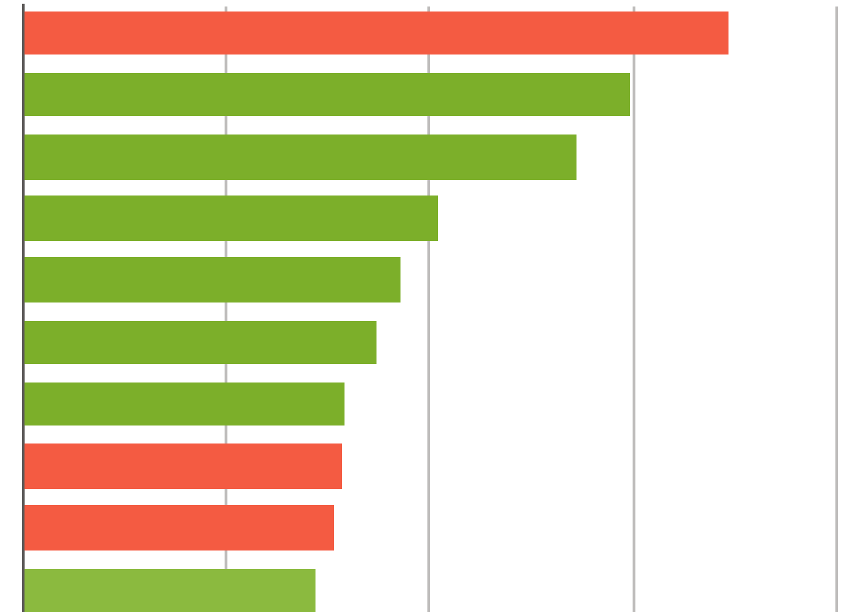
Top 10 “Higher Importance” Joint Commission Requirements for Improvement: 2020

		Moderate Risk	High Risk	Immediate Threat	Total	% of Highest
NPSG. 15.01.01 EPO1	Suicide	107	99	1	207	17%
IC.02.02.01 EP02	Infections	73	120	1	194	16%
IC.02.01.01 EP01	Infections	110	33	0	143	12%
MM.06.01.01 EP03	Medications	68	70	0	138	12%
EC.02.05.01 EP15	Infections	54	53	0	107	9%
EC.02.06.01 EP01	Infections	72	29	0	101	9%
EC.02.02.01 EP05	Infections	24	57	0	81	7%
NPSG 15.01.01 EP05	Suicide	39	34	1	74	6%
NPSG 15.01.01 EP04	Suicide	20	52	1	73	6%
IC.02.02.01 EPO4	Infections	48	18	0	66	6%
Total		615	565	4	1184	100%
Percent		52%	48%	0%	100%	



Source: Joint Commission Perspectives, May 2021: 1,104 Hospital Surveys Conducted in 2020

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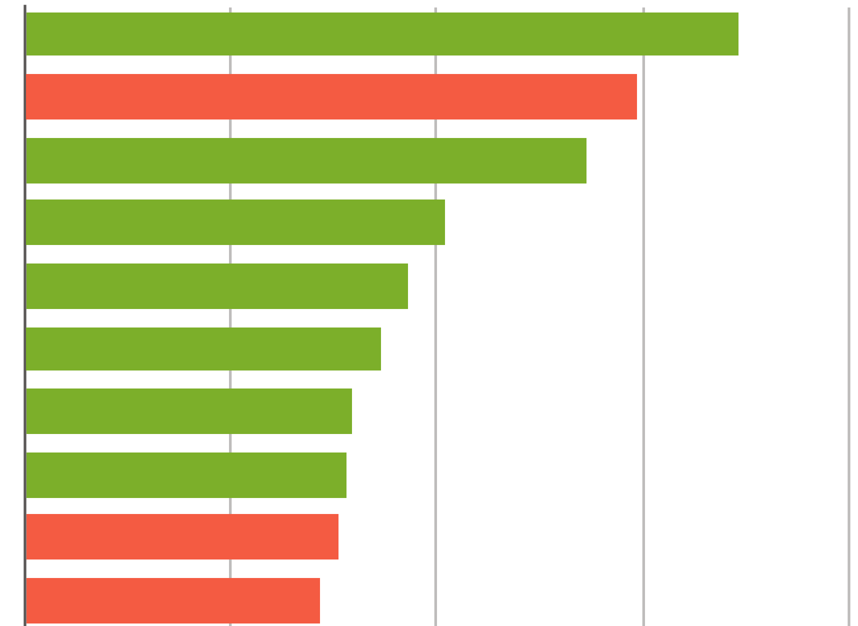
Top 10 “Higher Importance” Joint Commission Requirements for Improvement: 2021

		Moderate Risk	High Risk	Immediate Threat	Total	% of Highest
IC.02.02.01 EP02	Infections	136	277	20	433	17%
NPSG. 15.01.01 EP01	Suicide	167	204	1	372	14%
MM.06.01.01 EP03	Medications	107	233		340	13%
EC.02.06.01 EP01	Infections	204	51		255	10%
EC.02.05.01 EP15	Infections	101	131		232	9%
EC.02.02.01 EP05	Infections	68	149		217	8%
IC.02.01.01 EP01	Infections	133	64	1	198	8%
IC.02.02.01 EP04	Infections	142	54		196	8%
NPSG 15.01.01 EP05	Suicide	80	110	1	191	7%
NPSG 15.01.01 EP04	Suicide	44	135		179	7%
Total		1182	1408	23	2613	100%
Percent		45%	54%	1%	100%	

Source: Joint Commission Perspectives, May 2022: 1,363 Hospital Surveys Conducted in 2020



2020: 354 Suicide Findings in 1104 Surveys (32%)*
2021: 742 Suicide Findings in 1363 Surveys (54%)

*Ratio of findings to the number of full surveys. NOT a percent of surveys with side-related findings.

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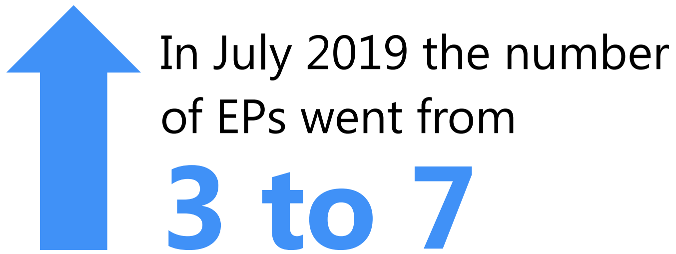
Facts About The Joint Commission's Suicide Prevention Requirements

The suicide prevention **safety goal** has been in place for

~15 years.



In July 2019 the number of EPs went from

3 to 7

- The old standard was not decreasing suicide.
- The jury is still out about the clinical impact of the reworded and more detailed standards.

There are about

45,000

suicides in the US each year. Between **49 and 65** of these suicides take place in the institutional setting.

There are more than

30 FAQs

on TJCs web site addressing suicide prevention and ligature resistance.

Many ***Perspectives*** articles are written in an attempt to clarify suicide prevention requirements.

The Joint Commission Perspectives®

Contents

High Risk:

- Environmental Safety (EP01)
- Patient Monitoring (EP05)
- Risk Level/ Precautions (EP04)

Contributing

- Screening (EP02)
- Assessment (EP03)

Other Issues

- Follow up Care at Discharge (EP06)
- Quality Monitoring (EP07)

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Please participate in the discussion by using the “questions” or “raised hands” functions in the Zoom interface.

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Which of the following

REQUIRE A FORMAL SCREENING FOR THEIR RISK OF SUICIDE?

(Pick all that apply)

a. All patients presenting to the emergency department

b. All inpatients

c. Patients being treated for a suicide attempt

d. Patients with a behavioral health presenting complaint

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Screening
The Facts

Although EP02 is not highly cited, over-interpretation of this requirement leads directly to citations under EP04 (plan/ precautions) and EP05 (patient monitoring and competencies)

[What is the difference between suicide *screening* and a suicide *assessment*]

[Is re-screening using an evidence-based tool required?]

[Is screening required if an assessment is promptly conducted for patients presenting with a behavioral health complaint/condition?]

[Is re-screening using an evidence-based tool a good idea?]

[Do nurses ***really*** ask all patients if they are having suicidal thoughts? Really?]

[What are the unintended consequences of over screening?]

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Assessment

Our Opinion

Confusion over the assessment vs. screening requirements is a significant contributor to gaps in safe patient care practices (not to mention compliance with the regulation/standard and your hospital's policy).

Who may perform suicide *assessment*?

What role does a psychosocial assessment play in protecting the patient?

What role does a psychosocial assessment play in meeting the suicide prevention requirement?

What are the required elements of a suicide assessment?

Must the suicide *assessment* also use an evidence-based tool?

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Plan, Precautions, & Competencies

The Facts

High risk of suicide patients require
EITHER

1:1 observation by a trained individual
OR
other precautions if the patient is in a ligature-resistant environment.

What impact has the pandemic had on the implementation of suicide precautions?

When are arms-length precautions required (or indicated)?

Do all patients at high risk for suicide require 1:1 observation?

What are the common vulnerabilities you see with respect to sitters?

Should sitters document every-5-minute checks?

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Safe Environment

The Facts

Ligature resistance and environmental safety for suicidal patients has remained **the #1 or #2 highest cited of all TJC requirements** since the Ligature Resistance Taskforce issued its report in November 2017.

Before the new EP for NPSG was created (July 2019), this issue was cited under the Environment of Care chapter.

The **frequency** of citations for this issue is **going up.**

[What are the main causes of citations for ligature-resistant environments?]

[What are the main causes of citations in other hospital settings?]

[What type of environment draws the most TJC citations?]

[Does TJC require 1:1 observation for high-risk patients in ligature-resistant environments?]

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to Align Practice with Regulatory Expectations and Safe Patient Care

1. Understand the underlying causes of *any* adverse events (incidents) relating to self harm, assaults, and elopements of patients requiring the hospital's protection.
2. Streamline policy and documentation expectations. Avoid pencil whipping for sitters.
3. Document the implementation of precautions for high-risk patients (but make it easy).
4. Perform initial and ongoing psychosocial assessments for **all** patients and protect at risk patients when indicated.
5. **Do not** use an evidence-based suicide screening tool for ALL patients, just those with behavioral health complaints.
6. **Do not** "re-screen" patients once a qualified health professional has developed a plan for the patient's suicidality.
7. Perform concurrent (not just retrospective) quality monitoring of your processes. Reinforce appropriate actions and documentation in real time. Correct vulnerabilities before they reach the patient.
8. Develop three suicide risk levels: High, Moderate, and None. Deploy precautions accordingly: 1:1, general staff awareness, and none.
9. Ensure that "sitters" are competent to protect patients and understand the behaviors to identify and the corresponding interventions.
10. Say what you do. Do what you say … Simplify and comply.

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