Suicide Prevention in Health Care Settings

Recommendations Regarding Environmental Hazards for Providers and Surveyors

The Joint Commission has assembled an expert panel to provide guidance to customers and surveyors on safeguards to prevent suicide. Following are recommendations from the panel’s ongoing discussion of issues related to prevention of suicide in health care settings.

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

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

As health care organizations and accrediting bodies intensify efforts to make the health care environment safer, it is critical to use available data and expert opinion to have clear guidelines on what constitutes serious environmental hazards that must be corrected and what mitigation strategies are acceptable in those situations when all potential hazards cannot be removed. Over the last year there have been several specific situations where surveyors for The Joint Commission and/or state agencies have disagreed on what constitutes a ligature risk and what mitigation strategies are acceptable. There needs to be consensus on these issues so that health care organizations will know what changes they need to make to keep patients safe and so surveyors can reliably assess organizations’ compliance with standards.

To provide guidance to customers and surveyors on what constitutes adequate safeguards to prevent suicide, The Joint Commission assembled an expert panel with representatives from provider organizations, experts in suicide prevention and design of behavioral health care facilities, Joint Commission surveyors and staff, and representatives from the Centers for Medicare & Medicaid Services (CMS). Two meetings were held at The Joint Commission on June 9 and August 18, 2017. The participants are listed in Appendix A. Health care organizations were asked to provide data on suicides that had occurred within their facilities, where possible, to help inform the panel’s decisions on the risk posed by specific potential ligature risk points. A formal consensus process was used to develop the recommendations, which are presented on the following pages. These recommendations address only the most debated and contentious issues related to environmental hazards; excellent articles and books are available about the design of behavioral health care facilities and how to conduct full environmental risk assessments. In addition, although it was not a focus of discussion, the expert panelists all emphasized the critical importance of well-trained, vigilant, compassionate staff who rigorously follow procedures for protecting patients. Health care organizations should focus as much on staff training and monitoring compliance with protocols as they do on detecting and correcting specific environmental hazards.

The expert panel will continue to meet to discuss issues related to prevention of suicide in health care settings and the period immediately after discharge from inpatient care. The Joint Commission convened a third Suicide Expert Panel on October 11, 2017, to discuss other behavioral health care settings, such as residential treatment, partial hospitalization, and outpatient settings. The recommendations from that panel will be added to the recommendations in this document as soon as they are finalized. The Joint Commission is also organizing a fourth meeting to discuss mitigation plans, including recommendations for monitoring patients with serious suicidal ideation in settings that are not ligature-resistant. The Joint Commission believes the ongoing work of the panel will be an important resource for our country in trying to reach national consensus on the many challenging issues involved in caring for suicidal patients.
**Recommendations for Inpatient Psychiatric Units**

1. **Inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, must be ligature-resistant in the following areas:**
   - Patient rooms
   - Patient bathrooms
   - Corridors*
   - Common patient care areas*

   **Nursing stations with an unobstructed view** (so that a patient attempt at self-harm at the nursing station would be easily seen and interrupted) and areas behind self-closing/self-locking doors do not need to be ligature-resistant and will not be cited for ligature risks.

   *Note that patient rooms and bathrooms (recommendation 5) differ from corridors and common patient care areas (recommendation 6) in the type of ceiling required to be considered ligature-resistant.

   The panel recommended the term “ligature-resistant” rather than the term “ligature-free” because they did not think it possible to remove all the potential ligature risk points that have even a remote chance of being successfully used in a suicide attempt. With respect to elements in the physical environment, the panel adopted this definition of ligature resistant: “Without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create a sustain-able point of attachment that may result in self-harm or loss of life.”

2. **In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, the doors between patient rooms and hallways must contain ligature-resistant hardware which includes, but may not be limited to, hinges, handles, and locking mechanisms.**

3. **In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, health care organizations should not be required to have risk-mitigation devices installed to decrease the chance that the top of a corridor door will be used as a ligature attachment point.**

   Although exact rates are not available, several panelists reported that they were aware of cases in which a patient slipped a ligature between the corridor door and the door frame and/or hinges and committed suicide. Please see Appendix B for supporting data related to suicides by corridor doors. There are several mechanical devices available to decrease the risk of the top of a door being used to fix a ligature, including laser beams, pressure-sensing plates, and monitoring cameras. However, all of these have limitations, including false alarms that could distract staff and increase the risk that a patient will attempt suicide. Moreover, there is little data available on the real-world effectiveness of these devices. Instead of mandatory use of these unproven devices, organizations should note such doors on their environmental risk assessments and describe their mitigation strategies, such as appropriate rounding and monitoring by staff, requiring that doors be left open during certain hours, and so on.

4. **In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, the transition zone between patient rooms and patient bathrooms must be ligature-free or ligature-resistant.**

   This may be accomplished with mechanical or behavioral solutions. Examples of mechanical solutions include removing the bathroom door, placing an alarm on the door to prevent inappropriate use, and using a special door designed to prevent using the top to support a ligature (for example, an angled upper edge or breakaway magnetic hinges). The most common behavioral solution is denying access to the bathroom unless staff is present; this still requires having the profile of the door be ligature-resistant in the closed arrangement. Note that some states do not allow modifications or removal of doors due to privacy concerns, including the state of Virginia’s Human Rights Office, the Agency for Health-Care Administration in Florida, and the Department of Mental Health in Massachusetts. In such instances, surveyors must survey to state regulations.

5. **In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, patient rooms and bathrooms must have a solid ceiling.**

   In these areas, a drop ceiling is not an acceptable alternative. Please see Appendix B for supporting data related to suicides by drop ceiling.

6. **In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, drop ceilings can be used in hallways and common patient care areas as long as all aspects of the hallway are fully visible to
staff and there are no objects that patients could easily use to climb up to the drop ceiling, remove a panel, and gain access to ligature risk points in the space above the drop ceiling.

Drop ceilings in areas that are not fully visible to staff (for example, a right-angle curve of a corridor) or for which it is possible that patients could easily move objects to access the area above the drop ceiling should be noted on the risk assessment and have an appropriate mitigation plan. Mitigation strategies for existing drop ceilings in these areas may include gluing the tiles in place, using tile retention clips, installing motion sensors above the ceiling to sense tampering, or using another comparable harm-resistive arrangement. The acceptability of these strategies depends upon the physical capabilities of the patient population.

Data from panelists on the risks posed from drop ceilings are shown in Appendix B.

7. In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, medical needs and the patients’ risk for suicide should be carefully assessed and balanced to determine the optimal type of patient bed utilized to meet both medical and psychiatric needs. For patients who require medical beds with ligature points, there must be appropriate mitigation plans and safety precautions in place.

8. Standard toilet seats with a hinged seat and lid are not a significant risk for suicide attempts or self-harm; they should not be cited during surveys and do not need to be noted on a risk assessment.

There needs to be consensus on these issues so that health care organizations will know what changes they need to make to keep patients safe and so surveyors can reliably assess organizations’ compliance with standards.

No panelist was able to recall a suicide in which a patient used or attempted to use a toilet seat as a ligature attachment point. After the meeting, several panelists examined data from their own health care organizations (see Appendix B). In the large number of patients included in these analyses, there was only one case where a patient attempted suicide by using a toilet seat as a ligature attachment point. No harm occurred in this incident. Therefore, the panel concluded that traditional toilet seats are as safe as toilets without movable seats and covers (that is, the type used in prisons), offer patients more comfort, and are less stigmatizing.

Recommendations for General Acute Inpatient Settings

9. The general medical/surgical inpatient setting does not need to meet the same standards as an inpatient psychiatric unit to be a ligature-resistant environment. Fixed ligature risks, including bathroom fixtures and doors, will not be cited on survey in these areas. Patients with serious suicidal ideation who are admitted to medical/surgical inpatient settings often require equipment to monitor and treat their medical conditions, so it is impossible to make their environment truly ligature-resistant. (See Recommendation 10 for essential actions to protect patients with serious suicidal ideation).

10. If a patient requiring admission to a general acute inpatient setting has serious suicidal ideation, all objects that pose a risk for self-harm that can be removed without adversely affecting the ability to deliver medical care should be removed. In addition, mitigating strategies must be put into place and documented, including one-to-one (1:1) monitoring, careful assessment of objects brought into the room by visitors, and protocols for transporting patients to other parts of the hospital (such as radiology). Organizations should have policies, procedures, training, and monitoring systems in place to ensure these are done reliably.

The Joint Commission will cite ligature risk in a general/acute care inpatient setting if the organization cannot demonstrate that all of the following are routinely and rigorously done:
- Training staff and testing them for competency on how they would address the situation of a patient with serious suicidal ideation
- 1:1 monitoring of patients with serious suicidal ideation
- Conducting risk assessments for objects that pose a risk for self-harm and identifying those objects that should be routinely removed from the immediate vicinity of patients with suicidal ideation who are cared for in the main area of the emergency department
- Removing any items that a suicidal patient could use for self-harm
- Monitoring of visitors
- Monitoring of bathroom use for a patient with serious suicidal ideation
Implementing protocols to have qualified staff accompany patients with serious suicidal ideation from one area of the hospital to another

**Recommendations for Emergency Departments**

**II. Emergency departments do not need to meet the same standards as an inpatient psychiatric unit to be a ligature-resistant environment.** Fixed ligature risks, including bathroom fixtures and doors, will not be cited on survey in these areas.

Patients cared for in emergency departments often require equipment to monitor and treat their medical conditions, so it is impossible to make their environment truly ligature-resistant. (See Recommendation 12 for essential actions to protect patients with serious suicidal ideation).

**12. There are two main strategies to keep patients with serious suicide ideation safe in emergency departments:**

1) Place the patient in a “safe room” that is ligature-resistant or that can be made ligature-resistant by having a system that allows fixed equipment that could serve as a ligature point to be excluded from the patient care area (for example, a locking cabinet), and 2) keep the suicidal patient in the main area of the emergency department, initiate continuous 1:1 monitoring, and remove all objects that pose a risk for self-harm that can be easily removed without adversely affecting the ability to deliver medical care. Organizations should have policies, procedures, training, and monitoring systems in place to ensure these are done reliably.

The Joint Commission does not mandate the use of “safe rooms” within the emergency department. Organizations should do all of the following to protect patients:

- Screen all patients presenting with psychiatric disorders for suicidal ideation (NPSG 15.01.01).
- Formally assess the risk of a suicide attempt among patients with suicidal ideation (“secondary screening”).
- Conduct a risk assessment for objects that pose a risk for self-harm and identify those objects that should be routinely removed from the immediate vicinity of patients with suicidal ideation who are cared for in the main area of the emergency department.
- Have a protocol for removing all movable items that could be used for self-harm from within reach of a patient with suicidal ideation.
- Have protocols for monitoring patients with suicidal ideation, including the use of the bathroom, and how to ensure that visitors do not bring objects that the patient could use for self-harm.
- Have a protocol to have qualified staff accompany a patient with serious suicidal ideation from one area of the hospital to another.
- Train staff and test them for competency on how they would address a situation with a patient with serious suicidal ideation.

**13. Patients with serious suicidal ideation must be placed under demonstrably reliable monitoring (1:1 continuous monitoring, observations allowing for 360-degree viewing, continuously monitored video). The monitoring must be linked to the provision of immediate intervention by a qualified staff member when called for. The organization has a defined policy that includes this detail.**
Appendix A: Suicide Expert Panel Participants

**Expert Panel Members: June 9, 2017, Expert Panel**

Brian Ahmedani, PhD, LMSW (Henry Ford Health System) Kristen Baumann, PhD (NYC Health + Hospitals) Pat Chmielewski, RN, MS (Centers for Medicare & Medicaid Services) Mike Hogan, PhD (Hogan Health Solutions) Jim Hunt, AIA (Behavioral Health Facility Consulting, LLC) Stephanie Hursey, RN, MSN, MHA, CCM (Centers for Medicare & Medicaid Services) Karen Johnson, MSW (Universal Health Services) Ira Katz, MD, PhD (Department of Veterans Affairs) Anne Kelly, MA, BSN (Acadia Healthcare) Mary Jane Krebs, APRN, BC, FACHE (Spring Harbor Hospital) Richard McKeon, PhD (Substance Abuse and Mental Health Administration [SAMHSA]) Peter Mills, PhD, MS (VA National Center for Patient Safety Field Office) Mary Ellen Palowitch, MHA, RN (Centers for Medicare & Medicaid Services) Robert Roca, MD, MPH, MBA (Sheppard Pratt Health System) Michael Sherburn, PhD, RN, MHA (Signature Healthcare Services) David Sine, DrBE, CSP, ARM, CPHRM (Veterans Health Administration) Marie Vasbinder, JD, MBA, RN, CHC, NEA-BC (Centers for Medicare & Medicaid Services) Kim Walton, Community Health Network DD White, RN, MSN (HCA Healthcare)

**Joint Commission panel members:**

David Baker, MD, MPH, FACP (Executive Vice President, Division of Healthcare Quality Evaluation) Ana McKee, MD (Executive Vice President & Chief Medical Officer) Mark Pelletier, RN, MS (Chief Operating Officer) Lisa Vandesaveye, JD, MPA, FACHE (General Counsel) Sue Boylan-Murray, MBA (Senior Director of Field Operations) Stephen Kramer, MD (Physician Surveyor) Tim Markijohn, MBA, MHA, CHFM, CHE (Life Safety Code Field Director) Kathryn Petrovic, MSN, RN-BC (Senior Associate Director, Standards Interpretation SIG) Sandy Rahe, MBA, RN (Nurse Surveyor) Nina Smith, RN (Hospital Field Director) Peter Vance, LPCC, CPHQ (Behavioral Health Care Field Director) James Woodson, PE, CHRM (Engineer, Standards Interpretation SIG)

**Expert Panel Members: August 18, 2017, Expert Panel**

Kristen Baumann, PhD (NYC Health + Hospitals) Wade Ebersole, MHA (Denver Health) Nancy Foster, MA (American Hospital Association) Kate Gagliardi, MSN, RN (Office of Quality, Safety, and Value, VACO) Jim Hunt, AIA (Behavioral Health Facility Consulting, LLC) Karen Johnson, MSW (Universal Health Services) Anne Kelly, MA, BSN (Acadia Healthcare) Mary Jane Krebs, APRN, BC, FACHE (Spring Harbor Hospital) Peter Mills, PhD, MS (VA National Center for Patient Safety Field Office) Rebecca Parker, MD, FACEP (President, American College of Emergency Physicians) Robert Roca, MD, MPH, MBA (Sheppard Pratt Health System) Michael Sherburn, PhD, MHA, RN (Signature Healthcare Services) David Sine, DrBE, CSP, ARM, CPHRM (Veterans Health Administration) Joseph Weinstein, (Steward Group) DD White, RN, MSN (HCA Healthcare)

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Appendix B: Data on Specific Potential Ligature Risk Points

Data collection was initiated after both expert panels to inform potential ligature-related risks within health care organizations. Data collection centered on the use of toilet seats, drop ceilings, and corridor doors as ligature points.

**Data on use of corridor doors as a ligature point:**
Several provider panel members provided numerator and denominator data for attempts or successful suicides in calendar year 2016 related to ligature via corridor doors. The denominators were reported in different terms:
- 934,533 acute inpatient days
- 2 million inpatients
- 838,972 bed days of care
- 11 acute care hospitals representing 1,413 beds
- 44,337 patient days
- 4,347 census days for adolescents and 13,321 for adults

The total numerator was 13 suicide attempts.

**Data on use of drop ceilings as a ligature point:**
Several provider panel members provided numerator and denominator data for attempts or successful suicides in calendar year 2016 related to ligature via drop ceilings. The denominators were reported in different terms:
- 934,533 acute inpatient days
- 2 million inpatients
- 838,972 bed days of care
- 11 acute care hospitals representing 1,413 beds
- 44,337 patient days
- 4,347 census days for adolescents and 13,321 for adults

The total numerator was 2 suicide attempts. Both incidents involved locking ceiling tiles in bedrooms. No cases were reported of suicide attempts involving drop ceilings in corridors or common areas.

**Data on use of toilet seats as a ligature point:**
We received responses from 4 health care provider systems that were represented on the June 9th panel. The denominators were reported in different terms:
- 934,533 acute inpatient days
- 2 million inpatients
- 838,972 bed days of care
- 11 acute care hospitals representing 1,413 beds

The total numerator was 1 attempt (no harm reported as it was not useable as a ligature point).