



Suicide Risk Prevention Best Practice Recommendations on The Joint Commission Standards 15.01.01

November 5, 2021

NPSG - National Patient Safety Goal
EP - Element of Performance

REQUIREMENTS	RECOMMENDATIONS
NPSG 15.01.01, EP 1	
<p>The hospital conducts an environmental risk assessment</p> <ul style="list-style-type: none"> Implements procedures to mitigate the risk of suicide for patients at high risk for suicide 	<ul style="list-style-type: none"> Use of a standardized tool for assessment of ligature points and safety risk items in the environment <ul style="list-style-type: none"> Conduct initial assessment Conduct an annual assessment Conduct an annual assessment when there is change in population served and/or alteration in the environment Documentation of risk mitigation or correction Staff education and training includes identified risks and mitigations in place An environmental safety checklist is helpful tool
NPSG 15.01.01, EP 2	
<p>Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool.</p> <ul style="list-style-type: none"> <i>Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.</i> 	<ul style="list-style-type: none"> Universal screening as best practice for 10 years old and above Use of The Columbia-Suicide Severity Rating Scale (C-SSRS) as an evidence-based, validated tool

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REQUIREMENTS	RECOMMENDATIONS
NPSG 15.01.01, EP 3	
<p>Use an evidence-based process to conduct a suicide risk assessment of patients who have screened positive for suicidal ideation.</p> <ul style="list-style-type: none"> The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. <i>Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation.</i> 	<ul style="list-style-type: none"> The goal is to identify high risk patients and provide appropriate level of care Patients who “screen” high risk on C-SSRS will be “assessed” by <ul style="list-style-type: none"> *Behavioral health consultants/team using an evidence-based tool or process (Use an assessment tool that corresponds to the screening tool) Patients who “screen” moderate risk on C-SSRS will be “assessed”, per discretion of provider, by behavioral health consultants/team using an evidence-based process <ul style="list-style-type: none"> *Behavioral health consultants may include psychiatrists, psychologists, social workers, tele-psychiatry etc. per hospital policy.
NPSG 15.01.01, EP 4	
<p>Document patients’ overall level of risk for suicide and the plan to mitigate the risk for suicide</p>	<ul style="list-style-type: none"> Overall risk is determined by the assessment (risk and protective factors are critical) Mitigation as follows and documented: <ul style="list-style-type: none"> High Risk <ul style="list-style-type: none"> 1:1 continuous observation Removal of potentially harmful objects to the extent possible (use environmental safety checklist) Moderate Risk <ul style="list-style-type: none"> Behavioral health consultation per provider discretion Note: line of sight is not automatically required; follow hospital policy on addressing patient safety and observation levels.
NPSG 15.01.01, EP 5	
<p>Follow written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following:</p> <ul style="list-style-type: none"> Training and competence assessment of staff who care for patients at risk for suicide Guidelines for reassessment Monitoring patients who are at high risk for suicide <p><i>CMS: Hospitals must provide the appropriate level of education and training to staff regarding the identification of patients at risk of harm to self or others, the identification of environmental patient safety risk factors and mitigation strategies. CMS recommends initial training and then ongoing training at least every two years thereafter.</i></p>	<ul style="list-style-type: none"> Policy to address <ul style="list-style-type: none"> Training and competence assessment of staff who care for patients at risk for suicide Guidelines for reassessment Monitoring patients who are at high risk for suicide Training frequency done during initial orientation, when there is a change in the policy and no less than every 2 years Training content is addressed outside of the policy <i>Examples of content:</i> Environmental risk and mitigation, 1:1 continuous observation training for sitters, screening, and assessment (training/competency varies depending on role, licensure etc.)

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NPSG 15.01.01, EP 6	
<p>Follow written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide</p>	<ul style="list-style-type: none"> • Include National Suicide Prevention Lifeline and/or other resources on the after-visit summary (AVS) for all patients • High Risk
NPSG 15.01.01, EP 7	
<p>Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and take action as needed to improve compliance.</p>	<ul style="list-style-type: none"> • Partner with quality/risk department on process to monitor effectiveness of the policy • Includes data/metrics being monitored • Develop improvement plan where indicated • <i>Examples:</i> % of high, moderate, low risk, compliance rate, 1:1 utilization, patient events, suicide, action taken