Ligature and Self-Harm Risks

October 2, 2018

Welcome

Robyn Thomason
California Hospital Association
Continuing Education

Continuing education will be offered for this program for behavioral/social work, compliance, health care executives and nursing.

Full attendance and completion of the online evaluation and attestation of attendance are required to receive CEs for this webinar. CEs are complimentary and available for the registrant only.

Faculty

**Kathryn Petrovic**, MSN, RN-BC, is a field director in the department of Surveyor Management and Development for the Behavioral Health Care and Psychiatric Hospital programs at TJC. She is responsible for hiring, training and providing direction to surveyors. Certified in psychiatric-mental health nursing by the ANCC, Ms. Petrovic has more than 17 years of behavioral health nursing experience.

**Herman McKenzie**, MBA, CHSP, is an engineer in the Standards Interpretation Group of TJC. He provides standards interpretation, reviews survey reports, conducts Intracycle Monitoring conference calls, and serves as faculty for educational programs. He has more than 25 years of health care experience having held managerial and director level roles in clinical engineering, plant operations and facilities services throughout the Chicago area.

**Nicolette Pacheco** is manager of quality improvement, risk management & infection prevention for College Hospital Costa Mesa (CHCM), a 122-bed acute care hospital offering medical/surgical services and a full spectrum of psychiatric services to treat adults and adolescent patients. Ms. Pacheco is primarily responsible for regulatory compliance, ensuring CHCM meets the standards of performance set by The Joint Commission, CMS and other regulatory agencies.

**Anthony Gonzalez** is director of engineering at CHCM and is responsible for the maintenance of nearly 67,000 sq. ft. of acute care hospital space with 122 beds in secure units. Mr. Gonzalez maintains CHCM’s fire life safety compliance to TJC and CMS standards, which includes documentation, inspections and testing, and also manages their preventative maintenance program.
David Perrott, MD, DDS, MBA, FACS is senior vice president and chief medical officer of the California Hospital Association. Dr. Perrott's responsibilities include clinical issue areas, including the Center for Hospital Medical Executives, and California Alliance of Hospital-Physician Organizations. Dr. Perrott is also board chair of the Hospital Quality Institute, vice chair of The Joint Commission (TJC) Board of Commissioners and a board member of Joint Commission Resources.
MEMORANDUM

Sender: Director
Recipients: Survey and Certification Group

Date: December 06, 2017

Subject: Clarification of Ligature Risk Policy

Memorandum Summary

- Ligature Risks Compromise Psychiatric Patients’ Rights to Receive Care in a Safe Setting: The care and safety of psychiatric patients and the staff that provide that care are our primary concerns. The Centers for Medicare & Medicaid Services (CMS) is in the process of drafting comprehensive ligature risk interpretive guidance to provide direction and clarity for Regional Offices (ROs), State Survey Agencies (SSAs), and accrediting organizations (AOs).
- Definition of a Ligature Risk: A ligature risk spot is defined as anything which could be used to attach or tie up, or other material for the purpose of binding or strangulation. Ligature spots include shower rails, sink hooks, pipes, and railings, ventilators, windows, and other fixtures, and ligature points, heroicons, hinges, straps and locks.
- Focus of Ligature Risks: Focusing for a ligature “risk spot” or ligature “free” environment is primarily around a three-prong approach:
  1. Immediate Action: Until CMS’ comprehensive ligature risk interpretive guidance is released, SSAs and AOs may use their judgment as to the identification of ligature and other safety risk deficiencies, the level of citations for those deficiencies, as well as the approval of the facility’s corrective action and mitigation plans to remediate those deficiencies.
  2. Timeliness of Correction: All citations are expected to be corrected within the timelines designated by the CMS RO, SA or AO. In cases where it is determined that it is not reasonable to expect compliance within the designated timelines, CMS may grant additional time for correction.
  3. Ligature Risk Deficiencies Do Not Qualify for Life Safety Code (LSC) Waivers: Ligature risks are not LSC deficiencies. Therefore, a LSC waiver may not be granted.
- Monitoring of Progress: When additional time for correction is granted, the hospital is required to provide monthly electronic progress reports to the SA or AO, including substantiating evidence of progress toward compliance. The SA or AO will update the RO or Central Office (CO) monthly, as required.

DATE: July 20, 2018
TO: State Survey Agency Directors
FROM: Director
SUBJECT: CMS Clarification of Psychiatric Environmental Risks

Memorandum Summary

- Proposed Psychiatric Task Force: The Proposed Psychiatric Task Force to address the environmental risks associated with the care of psychiatric inpatients is not the most appropriate vehicle to foster the changes that are required.
- Ligature Risks Compromise Psychiatric Patients’ Rights to Receive Care in a Safe Setting: The care and safety of psychiatric patients and the staff that provide that care are our primary concerns. CMS is incorporating the outcomes of the JCAHO Process (in which CMS participated) into comprehensive ligature risk interpretive guidance to provide improved direction and clarity for state survey agencies (SSAs) and accrediting organizations (AOs).
- Interim Guidance: Until CMS’ comprehensive ligature risk interpretive guidance is released, the SSAs and AOs may use their judgment as to the identification of ligature and other safety risk deficiencies, the level of citation for those deficiencies, as well as the approval of the facility’s corrective action and mitigation plans to minimize risk to patient safety and remedy the identified deficiencies.
Incidence and Method of Suicide in Hospitals in the United States

Scott C. Williams, PsyD; Stephen E. Schmaltz, PhD; Gerard M. Careau, PhD; MPH; David W. Baker, MD, MPH

Background: There are no reliable estimates of hospital inpatient suicides in the United States. Understanding the rate and the methods used is crucial to guide prevention efforts. This study analyzed two national data sets to establish an evidence-based estimate of hospital inpatient suicides and the methods used.

Methods: The study is designed as a cross-sectional analysis of data from 27 states reporting to the National Violent Death Reporting System (NVDRS) for 2014–2015, and from hospitals reporting to The Joint Commission’s Sentiment Event (SE) Database from 2010 to 2017. Categorical variables and qualitative reviews of event narratives were used to identify and code suicide events occurring during hospital inpatient treatment.

Results: Based on the hospital inpatient suicides reported in the NVDRS during 2014–2015, 72.9% of which occurred during psychiatric treatment, it is estimated that between 48.5 and 64.9 hospital inpatient suicides occur per year in the United States. Of these, 31.0 to 51.7 are expected to involve psychiatric inpatients. Hanging was the most common method of inpatient suicide in both the NVDRS and SE databases (71.7% and 75.3%, respectively).

Conclusion: The estimated number of hospital inpatient suicides per year in the United States ranges from 48.5 to 64.9, which is far below the widely cited figure of 1,500 per year. Analysis of inpatient suicide methods suggests that hospital prevention efforts should be primarily focused on mitigating risks associated with hanging, and additional suicide prevention efforts may be best directed toward reducing the risk of suicide immediately following discharge.

Ligature & Suicide Risk Reduction

Herman A. McKenzie, MBA, CHSP, Engineer, Standards Interpretation Group, The Joint Commission

Kathryn Petrovic MSN, RN-BC, Field Director, Surveyor Management & Development Accreditation & Certification Operations, The Joint Commission

California Hospital Association
LIGATURE & SUICIDE RISK REDUCTION

CALIFORNIA HOSPITAL ASSOCIATION

OCTOBER 2018

Herman A. McKenzie, MBA, CHSP
Engineer, Standards Interpretation Group

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Field Director, Surveyor Management & Development
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PROGRAM OVERVIEW
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- Review updates to suicide risk
- Recommendation work
- Review of FAQs
- Survey Evaluation
- Questions

SUICIDE PREVENTION: MEETING THE CHALLENGE
TO ADDRESS THE PHYSICAL AND CLINICAL COMPONENTS ...

- The Joint Commission assembled Expert Panel
  - Including CMS, accredited organizations, national alliances, clinicians, The Joint Commission staff, other accrediting organizations, etc.
- Convened 5 expert panel meetings in 9 months
  - 16 recommendations
  - FAQs to provide further clarification
  - NPSG 15.01.01

EXPERT PANEL SUCCESSES

- Achieved consensus on terminology of “ligature-resistant” vs “ligature-free”
- Evaluated different environments for applicability
- Increased alignment with CMS

Must be ligature resistant:
Inpatient psychiatric units, in both psychiatric and general/acute care hospitals, dedicated spaces in the

Not required to be ligature resistant:
But are required to have conducted an environmental risk assessment, steps, protocols, safeguards, etc. in place to protect suicidal patients:
EDs, general med/surg inpatient units, residential, partial hospitalization, day treatment, intensive outpatient programming
DESIGN

- Designated behavioral health
- Preferred behavioral health
  - Emergency Department
- Non-designated behavioral health
- Understanding the hierarchy
  - State rules and regulations
  - Guidelines for design and construction of health care facilities, 2014 edition
  - When the above rules, regulations, and guidelines do not meet specific design needs, use of other reputable standards and guidelines that provide equivalent design criteria

SURVEY EVALUATION
SURVEY EVALUATION

Patient Room
- Solid ceiling
- Bed
- Light fixtures
- HVAC vents
- Tamper proof screws
- Sprinkler heads
- Bathroom fixtures (plumbing, toilet paper dispensers, paper towel dispensers, etc.)
- Grab rails*
- Full-size doors and hardware
- Curtains (privacy, window treatment, and shower**)
- Medical gases
- Medical devices

SURVEY EVALUATION (CONT.)

Corridor
- Ceiling – drop ceiling in corridors permitted when visible to staff, otherwise it should be solid ceiling as required in patient room and patient bathroom
- Grab rails*
- Corridor doors* and hardware
- Fire/smoke barrier doors and hardware*
- Security doors and hardware
- Light fixtures
- HVAC vents
- Tamper proof screws
- Sprinkler heads
- Life safety devices: exit signs, audio/visual devices, medical gas shut-off, etc.
SURVEY EVALUATION (CONT.)

- **Common Areas**
  - Therapy room
  - Day room
  - Restrooms/bathroom
  - Laundry room

- **Non-designated [i.e. Emergency department (not all), medical units, etc.]**
  - Risk assessment
  - Policy/procedure – guidance for staff
  - Mitigate based on risk of patient

**EXPERT PANEL RECOMMENDED EXCEPTION**

Not required to be ligature resistant if all of the following are met:
1. Self-closing door*
2. Self-locking door
3. When occupied by patients is directly observed by staff from within the room

Still identify on risk assessment

RISK ASSESSMENT

- Conducting a risk assessment takes a proactive approach to problem resolution, evaluating issues before an event happens
- A proactive risk assessment evaluates a process to identify the “weak link” and adjust to improve reliability
- Complete documentation
**RISK ASSESSMENT CYCLE**

1. Identify Issue
2. Advantages
3. Disadvantages
4. Objectively evaluate
5. Reach a conclusion
6. Document
7. Monitor & Re-assess

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**RISK ASSESSMENT**

1. Identify Safety & Security Risks
2. Established Process?
   - Yes
   - No
     1. Identify Risk?
       - Yes
       - No
         1. Resolved?
            - Yes
            - No

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EC.02.01.01

Unsafe conditions? Consider EC.02.06.01 EP 1

EP 3
## INPATIENT PSYCHIATRIC UNITS

*BOTH IN PSYCHIATRIC HOSPITAL AND GENERAL MEDICAL HOSPITAL*
INPATIENT PSYCHIATRIC UNITS

Can you please clarify the first recommendation as it relates to the Nurses station?

A: Nurses stations do not need to be ligature-resistant. This refers to what can be seen WITHIN the nurses station, not what is being seen FROM the nurses station. If there is an unobstructed view of everything within a nurses station then patients should not be able to attempt self-harm AT the nurses station since this would be easily seen and interrupted.

INPATIENT PSYCHIATRIC UNITS (CONT.)

How many ligature resistant medical beds does my unit have to have?

A: Depends on the needs of the patient population. The type of medical bed should be balanced based on the medical needs and the patients’ risk for suicide. For patients who require medical beds, that have ligature points, due to documented medical need, there must be appropriate mitigation plans and safety precautions in place.

Safety provisions must be considered for all patients who could be at risk for suicide.
INPATIENT PSYCHIATRIC UNITS (CONT.)

Can drop ceilings be used in hallways and common patient care areas?

A: Yes. 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 at all times and there are no objects that patients could easily use to climb up to the drop ceiling.

Reviewing the use of clips, glue as permanent solution at next Expert Panel to not require continuous observation of staff.

INPATIENT PSYCHIATRIC UNITS (CONT.)

Are over-the-door alarms required to be used on patient bedroom doors from the corridor?

A: *We neither discourage nor promote the use of these devices.*
**INPATIENT PSYCHIATRIC UNITS (CONT.)**

- If patients are transported to another location (such as another building for programming), does that building/space need to be ligature resistant?

- **A:** Patients who are currently at high risk for suicide should remain in a ligature resistant environment. Monitoring of patients leaving the unit for a period of time must protect the patient from self-harm.

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**INPATIENT PSYCHIATRIC UNITS (CONT.)**

- Is there a height requirement in order to consider something a “ligature risk”?

- **There is no height requirement for a ligature risk.**
INPATIENT PSYCHIATRIC UNITS (CONT.)

Q: What type of shower curtains are allowable in an inpatient psychiatric unit?

A: No recommendation for particular shower curtain used

Shower curtains are considered a risk
- Include on Environmental Risk Assessment
- Protect high risk patients

EMERGENCY DEPARTMENTS
**EMERGENCY DEPARTMENTS**

- Non-designated areas/rooms in ED:
  - Not needed to be ligature-resistant
  - Need policy/procedures guiding clinical mitigation
    - Identify risks
    - Remove what can be removed
    - 1:1 monitoring for patient at high risk for suicide
      - Qualified staff
      - Uninterrupted, continuous monitoring
      - Ability to immediately intervene

**EMERGENCY DEPARTMENTS (CONT.)**

- Does every Emergency Department need to have a “safe room”?
  - A: No, The Joint Commission is not mandating the use of “safe rooms” within Emergency Departments.
EMERGENCY DEPARTMENTS (CONT.)

- Do we have to do a suicide assessment on every patient that comes into the ER?
- A: No. Only patients being evaluated or treated for behavioral health conditions as their primary reason for care are required to be screened for suicide risk.
What are the requirements for an inpatient substance abuse detox unit?

A: Follow the recommendations applicable to general medical inpatient settings given the complexity of physical health care required to care for these patients.

No ligature-resistant requirement

Important of ongoing suicide risk assessments

What does “serious” risk for suicide mean?

We consider “serious” as equivalent to “high risk.”
MISC. (CONT.)

Are the recommendations the same for open and/or unlocked psychiatric units?

A: The recommendations would not apply to an open or unlocked psychiatric unit in which patients are able to enter and exit on their own accord.

MISC. (CONT.)

Do Emergency Departments under the “Ambulatory Healthcare” program need to comply with the “Recommendations for Emergency Departments” in the November 2017 Perspectives article?

A: Yes. These freestanding Emergency Departments accredited under the Ambulatory Healthcare Accreditation program would be required to comply with the Emergency Department recommendations.
SURVEY REPORT DATA
1331 HOSPITAL SURVEY REPORT REVIEWED

PREVENTATIVE ANALYSIS: CAUSES

- Environment
  - Lack of understanding risks
  - Responsibility of one individual versus organizational commitment

- Leadership
  - Lack of oversight
    - Policies
  - Lack of financial support
  - Lack of organization-wide suicide risk reduction program

- Human Resources
  - Complacency with environment/patients
  - Lack of training/competency
  - High turnover
  - Ineffective handoff

- Documentation
  - Disjointed with change from paper to EMR
  - Lack of timely chart audits
CORRECTIVE ACTIONS

- Environment of Care
  - Initial or revised environmental risk assessment
  - EOC rounds by leadership

- Policy/procedures
  - Suicide Risk Assessment
    - Who completes it?
    - When?
    - How? What tool?
    - Interventions?
  - Monitoring/precaution procedures
CORRECTIVE ACTIONS (CONT.)

- Human Resources
  - Staff training
    - Policies/procedures
  - Demonstrated staff competency
    - Suicide risk assessment
    - Determining interventions
    - Monitoring procedures

CALL TO ACTION
IMPORTANT REVISIONS

NPSG.15.01.01

IMPORTANT COMMUNICATIONS

Perspectives articles
- November 2017
- January 2018
- March 2018
- July 2018
CONTINUING CHALLENGES

- Established ongoing, internal workgroup; staff-led process for addressing issues that arise, for example:
  - Video monitoring
  - Other settings not specifically discussed with panel (e.g., substance abuse detox units, eating disorder units, “free-standing”/affiliated EDs)
  - Patient populations not specifically discussed with panel (e.g., adolescents [height requirements/drop ceilings], geri-psych [mobility])

QUESTIONS?
Thank You

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Identifying Environmental Risks for Patients at Risk Of Harm to Self or Others

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Anthony Gonzalez, Director of Engineering, College Hospital Costa Mesa
OBJECTIVES

- Identify key requirements by CMS for protecting patients from harm to self or others.

- Identify environmental risks in care areas for patients at risk of harm to self or others.

- Identify ways to mitigate identified risks.
Applicable CMS Standards

- §482.13(c)(2) The patient has the right to receive care in a safe setting.

- §482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well being of patients are assured.

  Hospital staff should follow current standards of practice for patient environmental safety, infection control, and security. Standards have not changed, but the interpretive guidance under Appendix A of the State Operations Manual has.

Areas of Focus

- Focus is on patients at risk of suicide (or other forms of self-harm) or exhibit violent behaviors toward others in both inpatient and outpatient locations of hospitals.

- Focus for a ligature “resistant” or ligature “free” environment is that of psychiatric units of acute care hospitals and psychiatric hospitals.

Does not apply to non-psychiatric units of acute care hospitals that provide care to those at risk of harm to self or others, e.g. emergency departments, intensive care units, medical-surgical units, and other inpatient and outpatient locations.
Key Terms

Risk Correction
- The risk is removed and no longer tangibly exists.

Risk Mitigation
- The risk still exists, but measures have been put in place to prevent the risk from occurring.

Identifying Environmental Risk
- All hospitals must implement an environmental risk assessment strategy.
- Purpose is to identify ligature and other types of risk to patients.
- Assessments should be appropriate to the specific care environment and patient populations.
  - This does not mean that a unit which does not typically care for patients with psychiatric conditions is not expected to conduct environmental risk assessments.
  - The risk assessment must be appropriate to the unit and should consider the possibility that the unit may sometimes care for patients at risk for harm to self or others.
What is a Ligature Risk?

Anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation.

Ligature risks include:
- hand rails
- door knobs
- door hinges
- shower curtains
- exposed plumbing/pipes
- soap and paper towel dispensers on walls
- power cords on medical equipment or call bell cords
- light fixtures or projections from ceilings

Ligature points include:
- shower rails
- coat hooks
- pipes
- radiators
- bedsteads
- window
- door frames
- door frames
- ceiling fittings
- handles
- hinges and closures
- belts or sheets/towels
- shoelaces

Other Environmental Risk

In addition to ligature risks, there are other potential environmental hazards that can pose a risk to patients:

- Access by patients to hazardous materials, objects
- Unsafe items brought to patients by visitors
- Furniture that can be easily moved or be thrown
- Access to plastic bags (for suffocation)
- Breakable windows and unprotected light fixtures
- Staffing levels to provide appropriate patient observation and monitoring
Non-Psychiatric Care Areas

- Must identify patients with psychiatric conditions at risk for intentional harm to self or others and mitigate environmental safety risks.
- Psychiatric patients requiring medical care in a non-psychiatric setting (medical inpatient units, ED, ICU, etc.) must be protected when demonstrating suicidal ideation or harm to others.
- The protection would be that of utilizing safety measures such as 1:1 monitoring with continuous visual observation, removal of sharp objects from the room/area, or removal of equipment that can be used as a weapon.

Staff Responsibilities

- If you are caring for a patient at risk of harm to self or others, do the following:
  - Be aware of the environment in which the patient is receiving care.
  - Be on the look-out for possible ligature or other issues that can pose a risk to the patient in the care environment.
  - If a risk issue is identified, take immediate action to protect the patient.
    * Remove the risk if you are able
    * Report the risk to your supervisor
    * Place the patient under 1:1 continuous observation per policy
References

- Medicare Conditions of Participation for Acute Care Hospitals §482.13(c)(2) & §482.41(a)
- Veteran’s Administration Environmental Risk Assessment Tool
- FGI Design Guideline for the Built Environment for Behavioral Health Facilities
| Room No. | Sink Handles | Handwash | Faucet | Soap Dispenser | Shelves | Toilet | Hinges | COST $ / ROOM | 1st Audit | 1st Audit | 2nd Audit | 2nd Audit | Audit | Audit | Audit | Audit | Audit | Audit | Audit | Audit | Audit | Audit |
|---------|--------------|----------|--------|--------------|---------|--------|--------|-------------|----------|----------|-----------|-----------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| RM 108 | Y            | Y        | Y      | Y            | Y       | Y      | Y      | $397        | $521     | $513     | $1,479    | $1,479    | N     | N     | N     | N     | N     | N     | N     | N     | N     |
| RM 106 | Y            | Y        | Y      | Y            | Y       | Y      | Y      | $397        | $521     | $513     | $1,479    | $1,479    | N     | N     | N     | N     | N     | N     | N     | N     | N     |
| RM 103 | Y            | Y        | Y      | Y            | Y       | Y      | Y      | $397        | $521     | $513     | $1,479    | $1,479    | N     | N     | N     | N     | N     | N     | N     | N     | N     |
| RM 101 | Y            | Y        | Y      | Y            | Y       | Y      | Y      | $397        | $521     | $513     | $1,479    | $1,479    | N     | N     | N     | N     | N     | N     | N     | N     | N     |
| RM 123 | Y            | Y        | Y      | Y            | Y       | Y      | Y      | $397        | $521     | $513     | $1,479    | $1,479    | N     | N     | N     | N     | N     | N     | N     | N     | N     |
| CB     | Y            | Y        | Y      | Y            | Y       | Y      | Y      | $397        | $521     | $513     | $1,479    | $1,479    | N     | N     | N     | N     | N     | N     | N     | N     | N     |

**COST** $0 $0 $0 $0 $8,094 $8,623 $7,823 **$18,540**

**TOTAL** $0

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**Thank You**

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Questions

**Online questions:**
Type your question in the Q & A box, press enter

**Phone questions:**
To ask a question, press *1

Upcoming Programs

**Behavioral Health Care Symposium & Emergency Services Forum**
December 10-12, 2018
Mission Inn Hotel and Spa and Riverside Convention Center

Day 1: Focus is on behavioral health care policy and pressing issues.
Day 2: This blended format is designed for both behavioral health care providers and ED professionals.
Day 3: Emphasis is solely on emergency medical care services issues and innovative practices to create future-focused ED care systems.

Visit the conference webpages for more information:
www.calhospital.org/behavioral-symposium
www.calhospital.org/emergency-services-forum
Thank you for participating in today’s webinar. An online evaluation will be sent to you shortly.

For education questions, contact Robyn Thomason at (916) 552-7514 or rthomason@calhospital.org.