TIPS
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"The Best Way to Make Your Dreams Come True is to Wake Up" — Muhammad Ali

By Caryl Lee, RN, program manager, Carol Samples, program analyst, Kathleen Dropp, BS, program analyst, and Scott McKnight, PhD, MS, biostatistician.

I love slogans. They make big things simple. Grandma gave me one on control: "You can't hold what's not in your hand." She gave me another one on timing: "Make hay while the sun shines." When I need a nudge in the right direction, there's always, "Nothing will change until you change it."[1] Just for fun, take a moment and recall your favorites.

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This article features three things that are closely related and tie into the slogans above:

- What your suicide-related RCAs say about patients who try to kill themselves
- Answers to the questions: Why is it hard to do suicide-related RCAs? What would prevent suicide at your facility?
- A brief description of Suicide Prevention Work Group projects that grew out of your RCAs

You Can't Hold What's Not in Your Hand

Thanks to the analyses of many suicide and parasuicide events and close calls, a small team at NCPS was able to categorize a convenience sample of 400 suicide-related RCAs from across the country in FY02. Now we have many facts in hand about the characteristics of patients who hurt themselves and a clear idea about some system-level vulnerabilities (e.g., contraband control, pain management, continuity of care/follow-up, etc.).

NCPS has chosen to share information derived from these 400 RCAs to further the VA's understanding about some of the features involved in suicidal events, and possible strategies for prevention. Of note, these data come from voluntary reports, and they have not been used to calculate rates. To provide a larger context for these numbers: globally there are about 1 million suicides per year, with an estimated 30,000 in the US (ranging from 10.7:100,000 to a high of 65:100,000 for white males >85 years old), and it is estimated that the national cost burden for lost productivity is around $11.8 billion.[2]

Types of Events — There were 10 inpatient and 293 outpatient suicides, along with 47 inpatient and 45 outpatient suicide attempts. Five events could not be classified.

How — The most frequent methods overall were: gunshot (35%); overdose on prescription and/or over-the-counter medications (24%); and hanging (12%). Inpatient suicides resulted from gunshot, hanging, jumping and medication overdose or other poisoning. The vast majority of the inpatient attempts came from three categories: medication overdose (36%); cutting or stabbing (23%); and hanging (21%).

Age and Gender — Two-thirds of the RCAs mentioned age, establishing a range from 20-87, with a median of 51 years. While 94% of the events involved men, it is important to consider that about 30% (7) of all parasuicide and suicide events involving women were inpatient suicide attempts.

Diagnoses — The two most common diagnoses were depressive disorders and alcohol and/or substance abuse. One hundred and thirty-seven RCAs noted that the patients had one or more previous suicide attempts. The three most common physical conditions mentioned were: musculoskeletal (20%), circulatory (19%), and nervous (13%). While the majority of RCAs (68%) did not mention pain or the need for pain management, 14% (56) noted that the patient had treated but unrelieved pain. Of these 56 patients, 85% (48) were outpatient suicides.

Stressors — About three-fourths of the RCAs mentioned current multiple life stressors, including: non-marital conflict (31%), multiple medical problems (28%), marital conflicts (25%), legal issues (20%), and finances (20%).

Last Facility Contact — *Location*: 42% (168) of the reports indicated that the patient's most recent contact was Outpatient Mental Health, followed by Inpatient Mental Health treatment (25%) and Outpatient Primary Care (25%). *Recentness*: About 18% (71) of the events occurred within 24 hours of last contact with the facility; another 50% occurred within a month of last contact. Of the 293 outpatient suicides, 78% (228) had facility contact within a month of their death.

Make Hay While the Sun Shines

During advanced Patient Safety Training 202, February 2003, more than 100 participants provided thoughtful written answers to two questions about RCAs and suicide prevention. The timing couldn't have been more perfect to gather opinions and observations. Here's the condensed version:

Why is it hard to do suicide-related RCAs?

- Individual emotions and facility culture: fear of blame, frustration, futility (suicide is viewed as unpredictable, uncontrollable, and unpreventable), guilt, grief, professional defensiveness, and staff resistance ("It's a waste of time.")
- Difficulty finding root causes/contributing factors
- Limited resources: not enough staff participation, few actions to choose from (lack of valid, benchmarked tools for screening, assessment, treatment)
- Lack of information: limited details about a patient's life experiences, difficulty getting facts from coroners and other providers, and opinions from family or significant others

What would prevent suicide at your facility?

- Continuity of Care: institute formal case management for at-risk patients; require CPRS warnings for at-risk patients; "no-show" follow-up within 24 hours; intensive discharge planning and follow-up (site visits); improve access and

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Reducing Falls and Fall-Related Injuries in the VA System

A One-Year Follow-Up after a Breakthrough Series

By Julie Neily, RN, MS, and Peter D. Mills, PhD, MS, VAM&ROC, White River Junction, Vt.

Falls are a leading cause of adverse events in the Veterans Health Administration.[1] From 2001 to 2002, we conducted a Breakthrough Series to address this issue.[2] The project included two face-to-face meetings with participants, as well as ongoing coaching and support. The participating change teams reduced their overall reported major injury rate by 62%.

One year after project completion, we interviewed team contacts to determine if the teams had stayed together and were continuing to collect data. Other questions concerned whether or not they had been able to hold to the gains made and spread changes to new locations. We also asked what new interventions might have been implemented.

In conjunction with the interviewing process, the team contacts answered a 20-item questionnaire. The same questionnaire had been given to them at the first and second face-to-face meeting of the Breakthrough Series. We used this information to analyze differences in team characteristics between the final face-to-face meeting of the breakthrough series and the one-year follow-up.

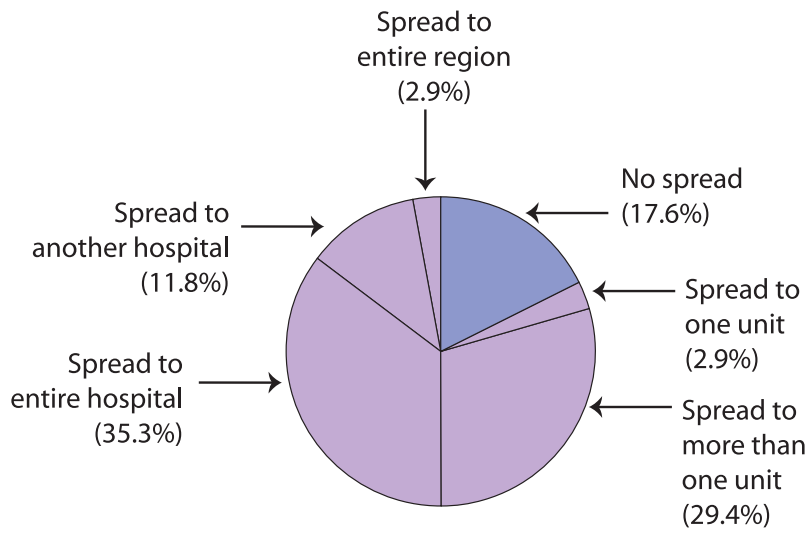
Added to this, a performance score was calculated for the teams to analyze the team characteristics associated with successful performance in the Breakthrough Series.

Thirty-four (91.9%) of the original teams were interviewed at the one-year follow-up. Of those interviewed:

- 82.4% reported they had stayed together as a team
- 97.1% reported they continued to collect data
- 93.9% reported they had been able to maintain their gains
- 82.4% reported that they had spread the changes to new locations (see Figure 1)
- 79.4% reported that they had begun to work on new topics they had not worked on during the Breakthrough Series (see Figure 2).

At the one-year follow-up, teams also reported that they had more resources to accomplish their aims, more time to do so, and more front-line staff support than when the project ended the year before.

Figure 1

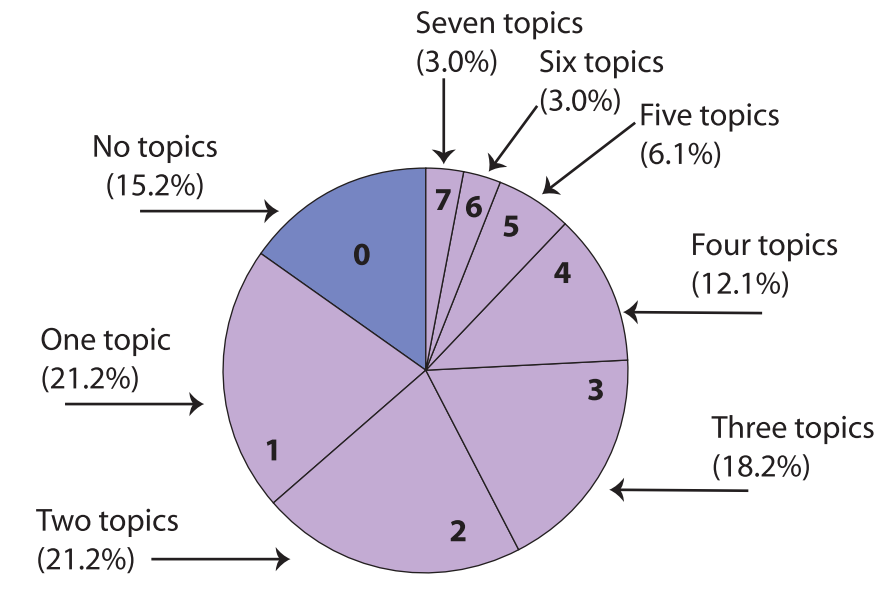


Percentage of teams that were able to spread changes made to other areas of their hospital or region.

Team characteristics in the first face-to-face meeting that correlated with high team performance at the one-year mark include:

- The falls project was part of their organizations' "key strategic goals"
- The teams had "good front-line staff support"
- They had "strong team leadership"
- They had worked as a team before the project, viewing problems as "everyone's responsibility, rather than someone's fault," a cornerstone of a "culture of safety"
- The teams had a plan to spread change (see Figure 3)

Figure 2



The number of new topics that teams were able to implement during the one year follow-up period.

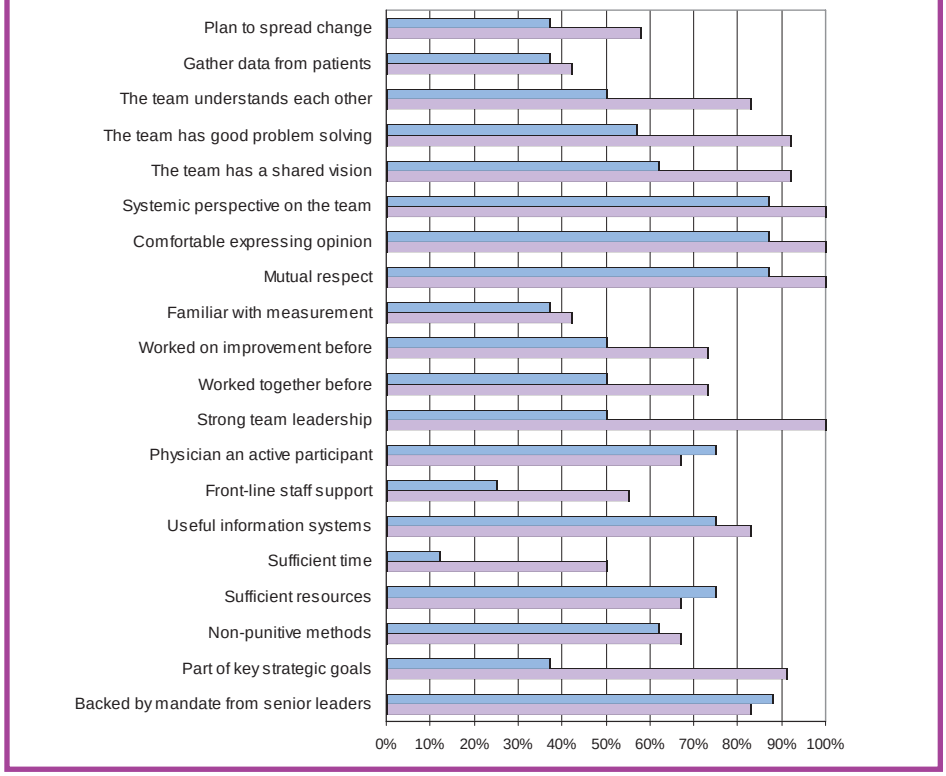
In conclusion, the majority of the teams stayed together, continued to collect data and maintained their gains. They also had spread changes made during the Breakthrough Series to new locations and have implemented new interventions since the end of the project.

Successful performance after the one-year period was associated with support from those in senior leadership and in front-line positions, good team skills, strong systemic thinking and a specific plan to spread change. In addition, the study provides evidence that the Breakthrough Series model can continue to help participating teams one year after the program has formally ended.

[1] Office of the Medical Inspector VHA. VA Patient Safety Event Registry: First Nineteen Months of Reported Cases Summary and Analysis. Washington, DC: Veterans Health Administration, 1999.

[2] Mills P, Waldron J, Quigley P, Stalhandske E, Weeks W. Reducing falls and fall related injuries in the VA system. Journal of Healthcare Safety 2003; 1:25-33.

Figure 3



Differences between high and low performers in the first face-to-face meeting.

Represents the low performer (0 or 1 on our scale)
Represents the high performing teams at the one-year follow-up (3 or 4 on our scale)

The scale is the percentage of teams responding "Agree" or "Strongly Agree" to the team questionnaire.

National Patient Safety Awareness Week: March 7 - March 13, 2004

By Joe Murphy, NCPS PAO

Patient Safety Awareness Week provides an excellent opportunity to promote facility-wide patient safety initiatives, but why stop on March 13?

Consider using the Joint Committee on Hospital Accreditation's annual patient safety goals as a point of departure when deciding how to best frame an ongoing patient safety awareness campaign.

For instance, Goal 7a discusses reducing the risk of health care-acquired infections by complying with current CDC hand hygiene guidelines. We're working on a series of posters that will help alert staff and patients to the importance of this goal.

As indicated in a study conducted in 2002, the use of alcohol-based hand rubs can reduce hospital-acquired infections by 30% when compared to the use of soap.[1]

The first two posters are now available as part of a special section on the NCPS Intranet devoted to providing a better understanding of the 2004 JCAHO Patient Safety Goals: *http://vaww.ncps.med.va.gov/Hand_Hygiene/index.html*

JCAHO Goal 1, improve the accuracy of patient identification, is a potential source for providing veterans firsthand knowledge about our patient safety efforts.

Speaking about the identification process as it occurs, when applicable, can help alert the veteran to the importance of it and of other patient safety measures. A healthcare provider might say: "You know Mr. Smith, when we administer medications like yours, we always use two patient identifiers, not including your room number, to make sure the right medication goes to the right patient." Further, if a patient should ask why a room number isn't used, the answer could easily become a platform to discuss this and other patient safety measures.

For more information on these and other JCAHO goals, review the above mentioned edition of TIPS by clicking to the appropriate page on the NCPS Web site: *http://www.patientsafety/tips.html*

Some of the suggestions available on the National Foundation for Patient Safety's site that propose activities during Patient Safety Awareness Week, *http://www*.npsf.org/html/psaw.html, might be applicable for use at your facility.

1. Fendler et al, AJIC, June 2002

transition to community support programs (food, housing, vocation); increase involvement and reward families/significant others for participation in treatment
- Resources: decrease physician panel size and increase allotted time for outpatient appointments; provide 24/7 psychiatric coverage; increase psychiatric nurse staffing; increase inpatient length of stay; provide intensive outpatient mental health services at every community-based outpatient clinic; create more in- and outpatient mental health treatment options; comprehensive pain management; prescription control/tracking
- Education: train all staff, particularly Primary Care and Emergency Room staff, on signs/symptoms of at-risk behavior and suicide prevention techniques
- Contraband control: protocol for searching belongings and safe storage (e.g., standardized procedures)
- Physical plant: make it safer with constant review and updates of the environment (e.g., breakaway fixtures)

Nothing Will Change Until You Change It[1]

In FY03, the Suicide Prevention Work Group was charged to review the data NCPS pulled from RCAs — demographic characteristics and actions developed in response to the events — and based on that review, pilot test one or more suicide prevention approaches in FY03. (The final work group report, recommendations, details about the projects and point of contact information are on the NCPS Intranet Web site: http://vaww.ncps.med.va.gov/Suicide_Prevention_Wrkgrp_Final_Report.doc).

Here's a brief description of the 11 projects:
- Cleveland – Increase provider awareness that lithium reduces suicide risk (CPRS order menu "headline")
- Detroit – Management of contraband on inpatient units
- VA Greater LA HCS – A tool/approach for developing thoughtful pre-discharge risk assessment notes
- North Chicago – A suicide risk assessment tool useful for both medical and psychiatric patients
- Phoenix – An interactive Web-based suicide prevention training package
- VA Northern California HCS and Reno – A computerized algorithm — Suicide Watch Index (SWI) – for conducting targeted outreach
- San Diego – Electronic Suicide Risk Assessment (ESRA) template which prompts providers to create a health summary report
- VISN 3, Mental Health Care Line and Mental Illness Research, Education and Clinical Center (MIRECC) – Network-wide evidence-based CPRS-linked risk assessment and Suicide Assessment and Prevention Conference
- VISN 4, Butler and MIRECC – A suicide assessment approach and tool applicable to mental health and medical settings
- VISN 5, Suicide Steering Committee – Several prevention strategies (e.g., medical record alert, assessment and screening tools, training programs)
- VISN 21, Palo Alto and MIRECC – A suicide prevention education proposal

The Best Way to Make Your Dreams Come True is to Wake Up

What's next? There's still plenty to do, for example:
- Check out the full Suicide Prevention Work Group report on the NCPS Intranet Web site
- Check out the extensive American Psychiatric Association "Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors" at *www.psych.org/psych_pract/treatg/pg/pg_suicidalbehaviors.pdf*
- Help RCA teams get to root causes/contributing factors more often by getting outside their comfort zone: interview patients who survive, talk with families and significant others. Ask them something like, "Why do you think this happened? What would prevent it from happening to someone else?" Have a focus group with inpatients to develop a broad range of ideas about what they see as dangerous on the unit and how to fix the problems.
- Whenever possible, select human factors-oriented actions (standardization, forcing functions, cognitive aids, etc.). Go for permanent over temporary fixes (e.g., built-in CPRS Reminders vs. memos) and physical over procedural fixes (e.g., breakaway fixtures vs. shift rounds/head counts).
- Speak up about system-level vulnerabilities even if you think they are unpopular. For example, defend the request for more or different staffing with a business case (bolster the RCA team's passion and intuition with facts).

And take heart from these ideas the next time it's suggested that suicide RCAs are a "waste of time":

> "Lessons can be learned from approaches to the prevention of life-threatening conditions such as ischaemic heart disease. A significant reduction in mortality from ischaemic heart disease has been achieved only by addressing a wide range of factors: knowledge of family predisposition, exercise, dieting, smoking cessation, cholesterol level control, sophisticated diagnostic techniques that allow early intervention, treatment in highly specialised intensive care units, bypass and angioplastic surgery, and personalised rehabilitation programmes have all contributed to substantial improvements in survival rates and mortality reduction. Suicide is a much more complex phenomenon than myocardial infarction, so it seems illogical that strategies to fight suicide have to be simpler or less integrated than the struggle against coronary artery disease."[3]

1 Bridge Medical, Inc. "Beyond Blame" (video), Solana Beach, CA, 1998.
2 Institute of Medicine, Reducing Suicide: A National Imperative, The National Academies Press, Washington DC, 2002
3 De Leo, Diego. "Why are we not getting any closer to preventing suicide?" British Journal of Psychiatry (2002), 181, p. 372.
Title quote: Muhammad Ali (interview with Cal Fussman), "[What I've Learned] The Heavyweights", Esquire, January 2004, p. 88.

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