Department of Defense
Patient Safety Center

DoD Patient Suicide Data Based on RCAs

2000 – 2009

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DOD Patient Safety Center

Root Cause Analysis (RCA) is mandated by The Joint Commission since 1997 for all accredited facilities for the following :

Sentinel Event

An unexpected occurrence or variation involving death or serious physical or psychological injury, or risk thereof.

DOD Instruction 6025.13

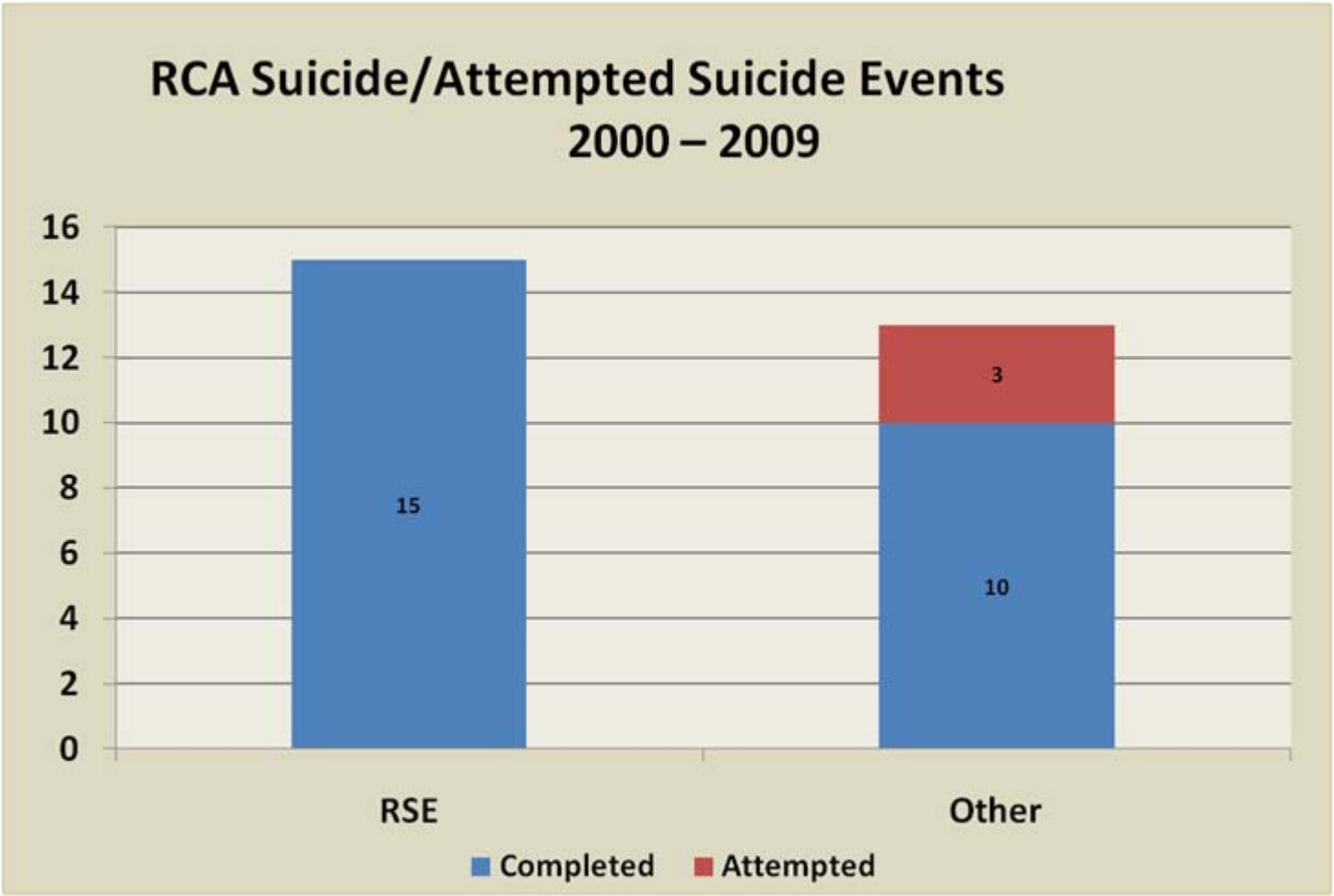
5.2.1: All sentinel events defined by JCAHO, as reportable to JCAHO, shall be reported. The completed RCA and action plan, consistent with JCAHO policy and time limits, shall be made available to JCAHO.

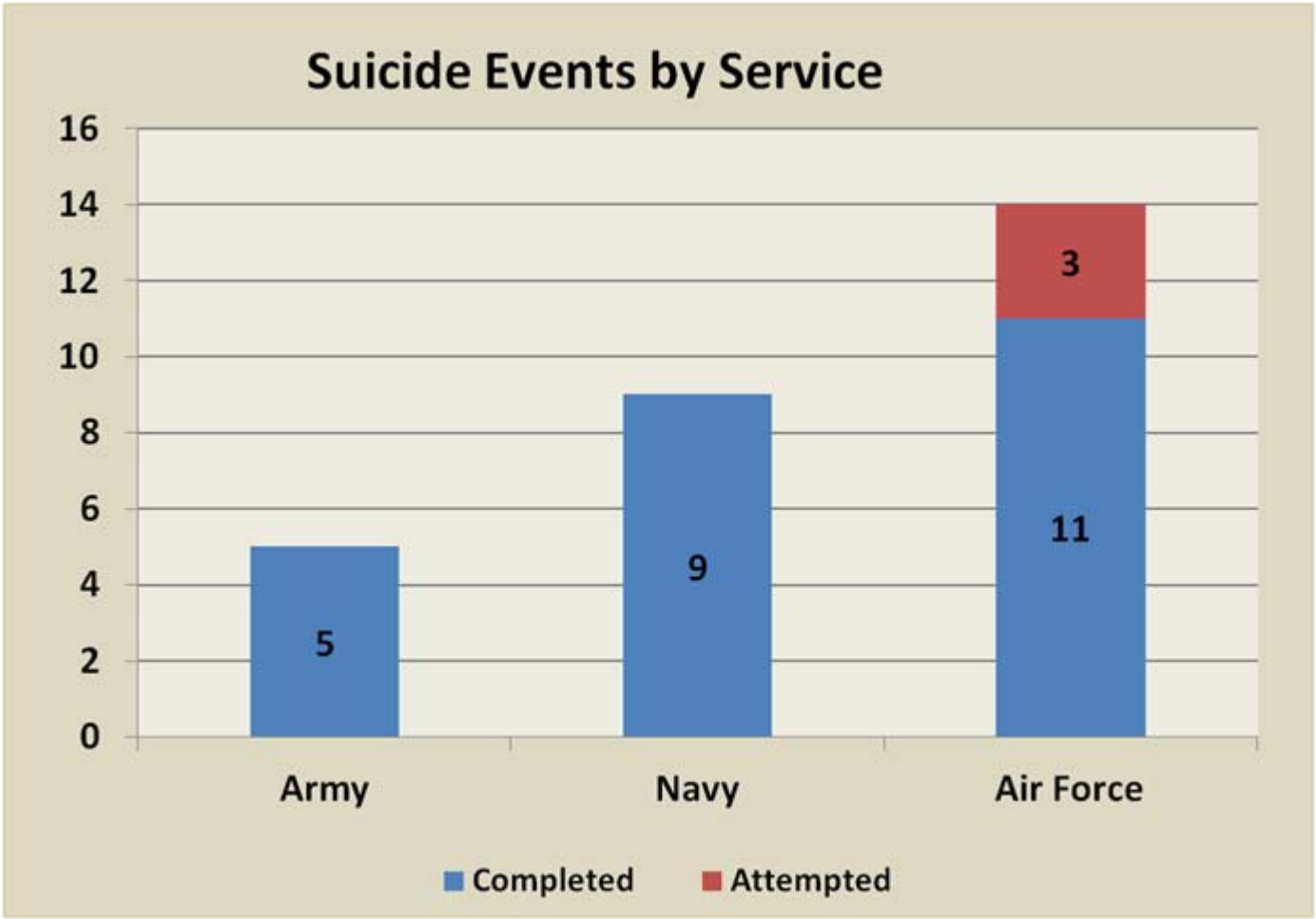
Reviewable Sentinel Event

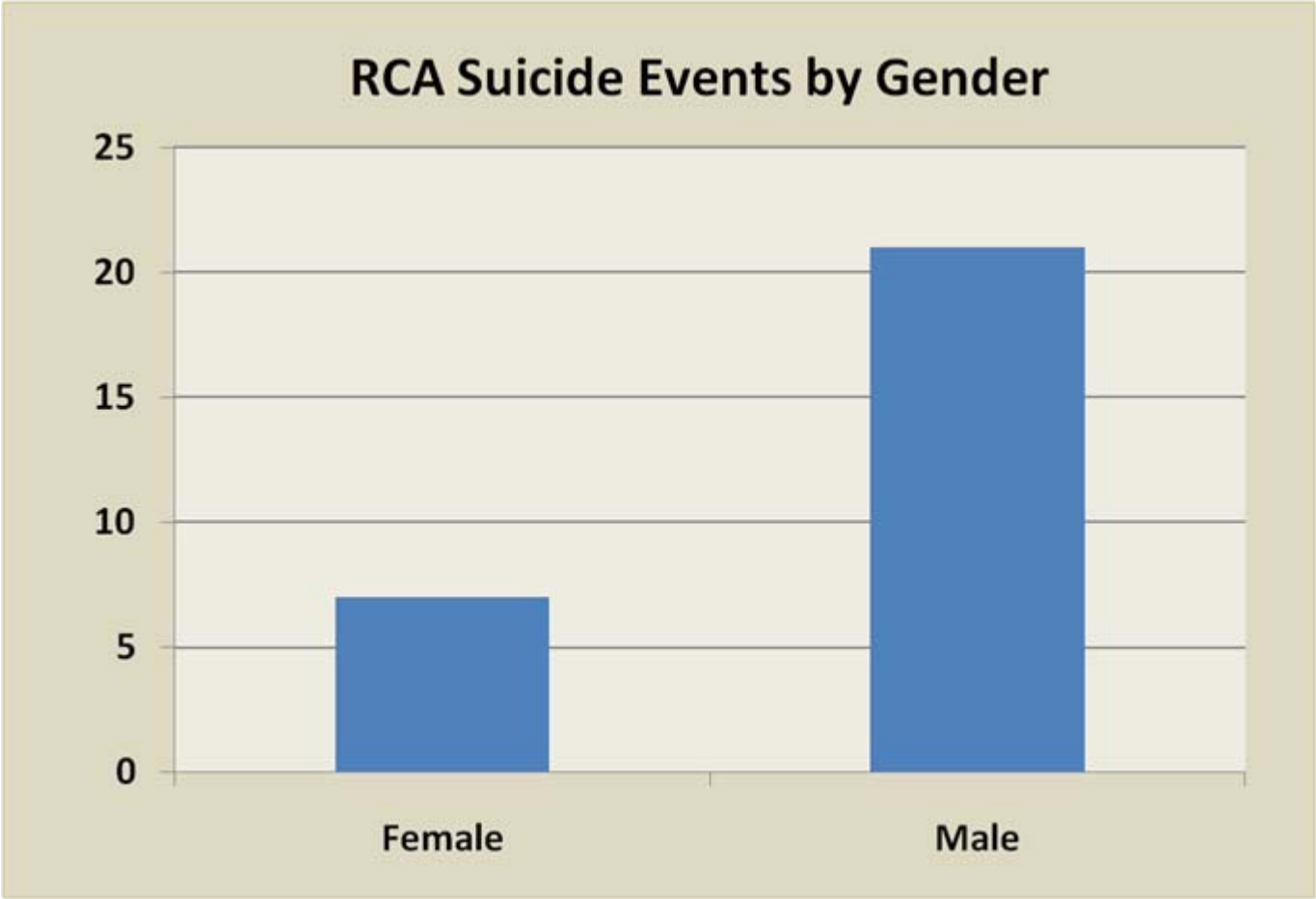
"Suicide of any patient receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of discharge."

(TJC 2009)

*** Excludes most suicides occurring in the ambulatory environment.**


RCA Suicide/Attempted Suicide Events
2000 – 2009
16
14
12
10
8
6
4
2
0
15
3
10
RSE
Other
Completed
Attempted


Suicide Events by Service
16
14
12
10
8
6
4
2
0
5
9
11
3
Army
Navy
Air Force
Completed
Attempted


RCA Suicide Events by Gender
25
20
15
10
5
0
Female
Male

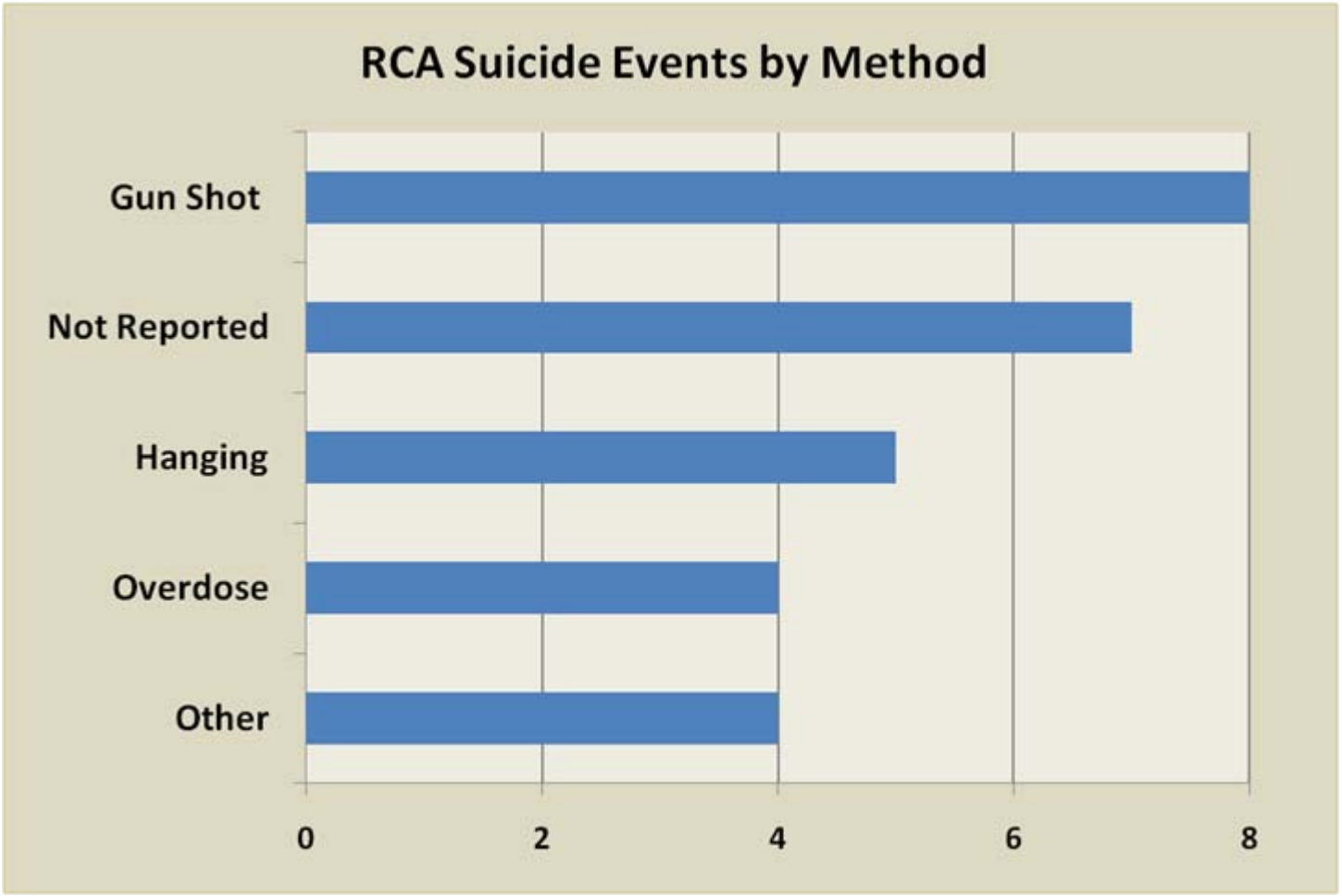
RCA Narrative Observations

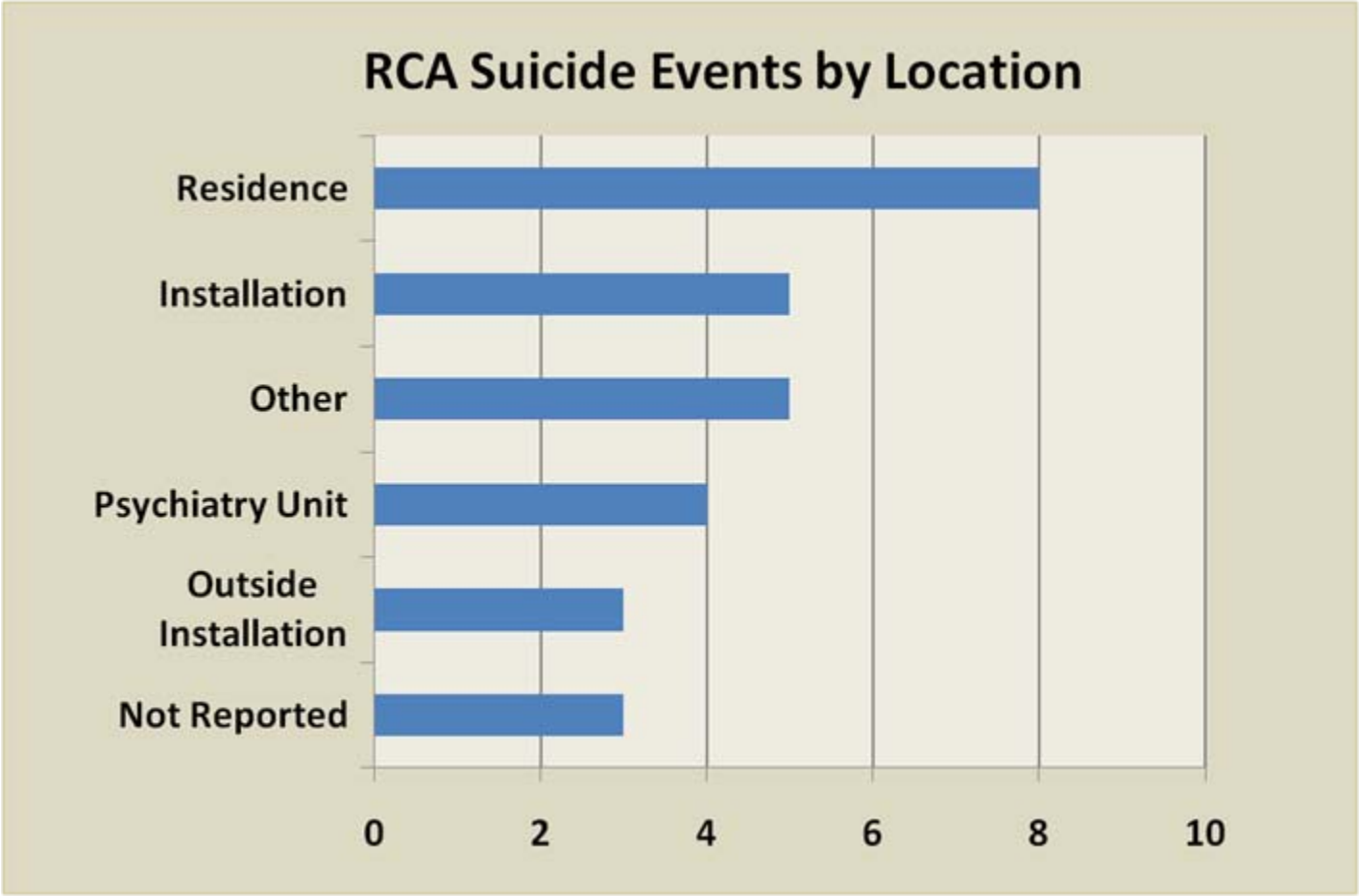
Suicide Profile

- Expressed suicidal ideation before event
- Previous suicidal gesture/attempt
- Depression
- Anxiety
- Pain
- Substance abuse
- Legal
- Relationships
- Job performance
- PTSD

Age Range

- 19 – 52 (median age 31)


RCA Suicide Events by Method
Gun Shot
Not Reported
Hanging
Overdose
Other
0
2
4
6
8


RCA Suicide Events by Location
Residence
Installation
Other
Psychiatry Unit
Outside Installation
Not Reported
0
2
4
6
8
10

JC Minimum Scope of Root Cause Analysis

- Behavioral Assessment Process
- Physical Assessment Process
- Patient Observation Procedures
- Care Planning Process
- Continuum of Care
- Staffing Levels
- Orientation & Training of Staff
- Competency Assessment/Credentialing
- Supervision of Staff
- Communication with Patient/Family
- Communication Among Staff Members
- Availability of Information
- Physical Environment
- Security Systems and Processes

DoD Suicide/Attempted Suicide Contributory Factors

1. Equipment Related

- Architectural hazards (e.g., door knobs, ceiling pipes)
- Pajamas/robes
- Razor
- Doors
- Car lock (e.g., lack of child lock)

DoD Suicide/Attempted Suicide Contributory Factors

2. Knowledge Related

- Accessing locked ward
- When/how to ascertain psych consult
- Search and seizure protocol
- Handling problematic patients
- Personal/environmental inspection

DoD Suicide/Attempted Suicide Contributory Factors

3. Documentation Related

- **Transcription of mental health exam**
- **Entering patient information into the Db/system**
- **Effectiveness of treatment/evaluation**
- **Late consultant entry**
- **Clinical follow-up**
- **Unavailable medical record**
- **Incomplete documentation of all therapeutic interactions staff had with patient**
- **Failure to document significant findings**

DoD Suicide/Attempted Suicide Contributory Factors

4. Delayed Emergency Response

- **Access to unit**
- **Untimely performance**
- **Initiate a code process**

DoD Suicide/Attempted Suicide Contributory Factors

5. Communication Related

- **Coordination of care**
- **Continuum of care issues**
- **Failure to communicate findings**
- **Inadequate evaluation and effectiveness of care**
- **Released to quickly from treatment**
- **Inadequate access to information**
- **Curbside consultation**
- **No multidisciplinary rounding**
- **Unstructured discharge**

DoD Suicide/Attempted Suicide Contributory Factors

6. Standard Operating Procedures/Policies Related

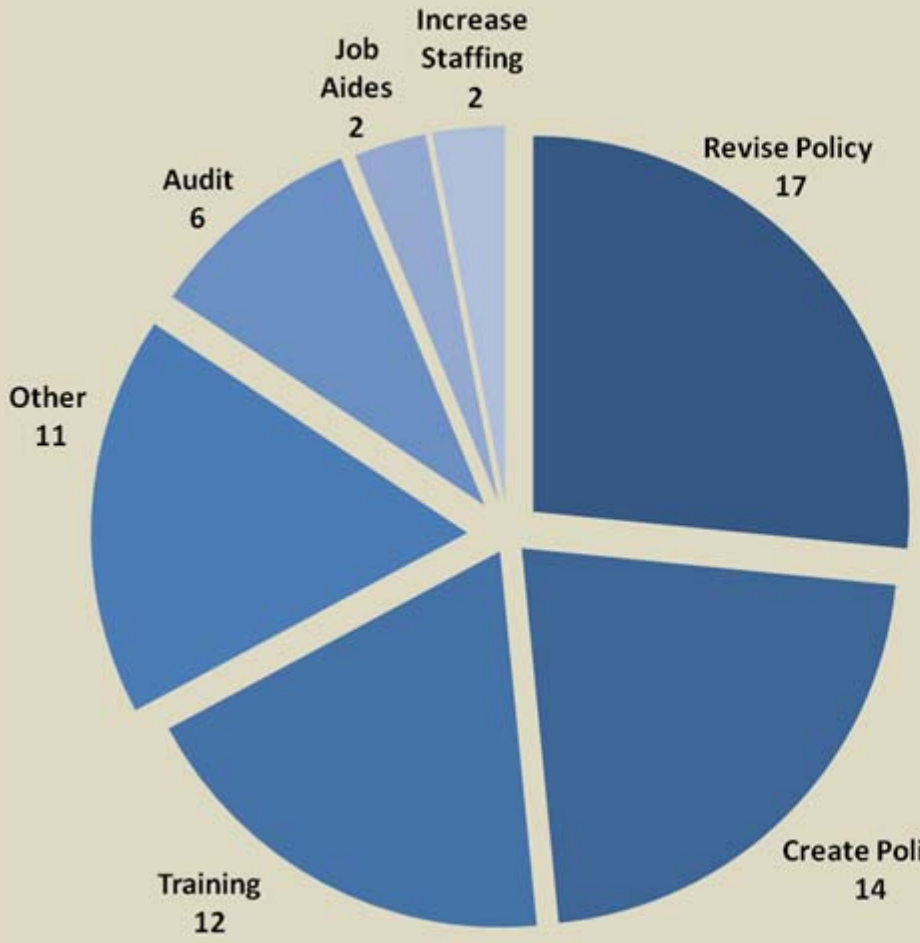
- **Not used/followed**
- **Followed incorrectly**
- **Policy inadequate**
- **No policy**
- **Ambiguous policy**

DoD Suicide/Attempted Suicide Contributory Factors

7. Monitoring Related

- **Eyeballing the patient**
- **Failure to make timely rounds**
- **Not in line of sight**

Actions



Other – One Each

Hazard Analysis
Environmental Analysis
Standardize Turnover Communication
Reinforce Protocol
Tracking System
Revise Protocol
Environmental Inspection
Revise Program
Peer Review
Access to Electronic Medical Record Systems
FMEA

Sharing Lessons Learned

- DoD Patient Safety Program Newsletter
- Focused Review

Current Initiative

NPSGs # 15 and 15a mandate that a hospital:

- **"identify safety risks inherent in it's patient population" and**
- **"identify patients at risk for suicide"**

(TJC, 2008)

How best to accomplish?

Summary

- Inpatient suicide within the MHS is rare
- Risk reduction strategies include: regular environmental rounds; ensure that architectural hazards are identified and corrected formalized search and seizure policies should be implemented wherever patients having psychiatric diagnoses are admitted; better communications and coordination of care must include the medical and mental health teams; continuous suicide reduction education in all areas of the facility.
- Ambulatory mental health services: Ensure protocols are in place and enforced for contacting patients who have missed appointments; real time weapon removal for high risk ambulatory patients; develop reliable and efficient communication between ED discharge and ambulatory treatment.