

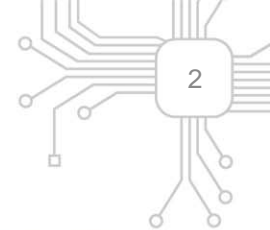
**Improvements in
Suicide Surveillance:
The DoD Suicide
Event Report (DoDSER)**

**Gregory A. Gahm, PhD
&
Mark A. Reger, PhD**

 **DEFENSE CENTERS OF EXCELLENCE**
For Psychological Health & Traumatic Brain Injury



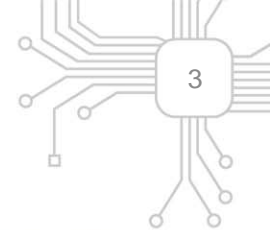
ACKNOWLEDGEMENTS



- Col Robert Ireland, M.D.
- CDR Janet Hawkins, MSW
- CDR Aaron Werbel, Ph.D.
- Lt Col Steven Pflanz, Ph.D.
- LCDR Bonnie Chavez, Ph.D.
- CDR Anthony Doran, Psy.D.
- Mr. Walter Morales
- MAJ Lisa Hull
- Lt Col Catherine Bobenrieth, M.D.
- Lt Col Michael Kindt, Ph.D.
- Lynne Oetjen-Gerdes
- CAPT Joyce Lapa, M.D., MPH
- Debi Harris



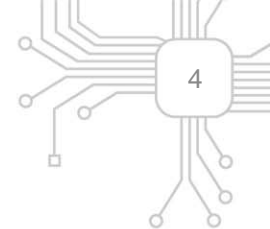
PURPOSE



- To provide an overview of:
 - The DoD Suicide Event Report (DoDSER) surveillance program
 - Findings from the first year of data collection (CY 2008)



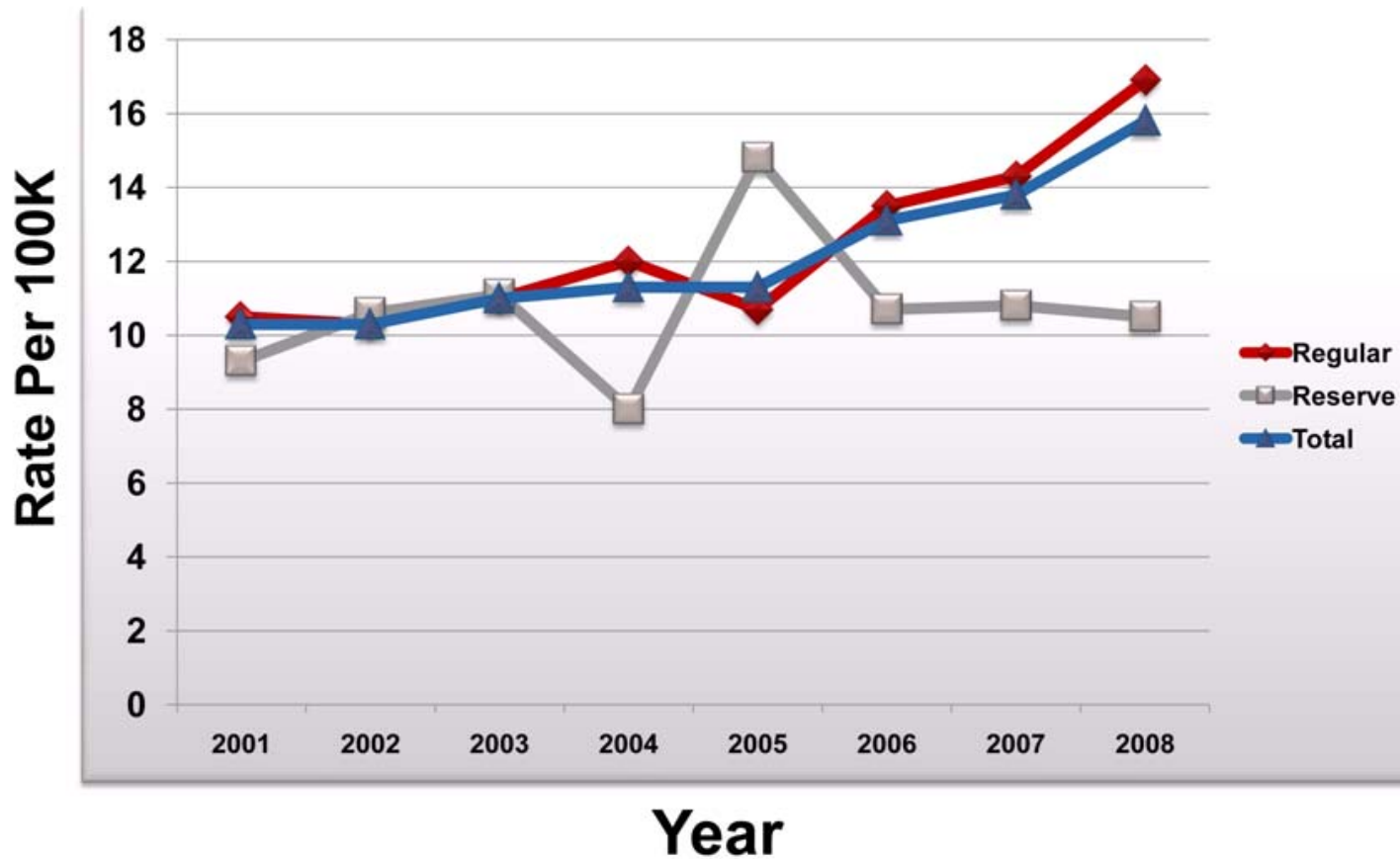
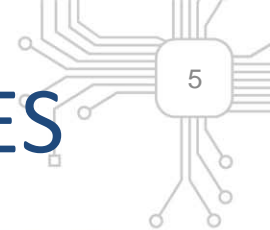
AGENDA



1. DoD SER Purpose, History & Methods
2. Limitations and Future Directions
3. Key Findings
4. Summary

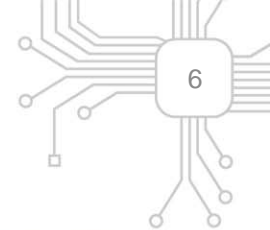


ACTIVE DUTY MILITARY SUICIDE RATES





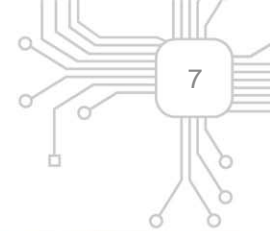
IMPORTANCE OF SUICIDE SURVEILLANCE IN THE MILITARY



- Quality surveillance allows the DoD to:
 - Describe the current status
 - Track trends and identify patterns
 - Within suicides
 - Between those with suicide behaviors and the population
 - Between the military and civilian cases
 - Examine risk factors unique to Warriors
 - Identify possible solutions or interventions
 - Evaluate the effectiveness of programs & policies
 - Provide senior leaders quality data



DoD SUICIDE SURVEILLANCE: PURSUING STANDARDIZATION

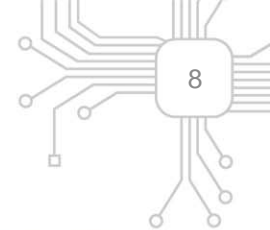


- Historically, U.S. Military Services have utilized separate surveillance systems to collect retrospective data about suicide cases:
 - Air Force: Suicide Event Surveillance System (SESS)
 - Army: Army Suicide Event Report (ASER)
 - Navy/Marines: Department of the Navy Suicide Incident Report (DONSIR)

Problem: Combining data for DoD-level analysis was not possible



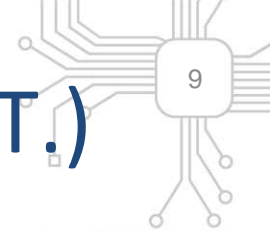
DEVELOPMENT OF THE DoDSER



- The Services' Suicide Prevention Program Managers meet monthly in the Suicide Prevention and Risk Reduction Committee (SPARRC)
- Successful standardization of suicide rates across Services
- Created interest in standardizing idiosyncratic Service-level surveillance systems
- T2 asked to take the lead in collaboration with the Services to develop the DoDSER



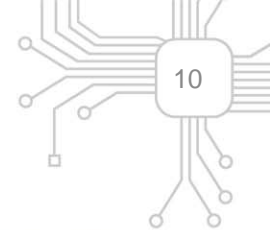
DEVELOPMENT OF THE DoD SER (CONT.)



- Detailed software requirements collaboratively developed with Suicide Prevention Program Managers of all Services (Army, Navy, Air Force and Marines).
- Initial data-collection only website developed and launched 1 January 2008.
- Major software revision deployed August, 2009
 - Common Access Card (CAC) Log-In
 - Account Management Features



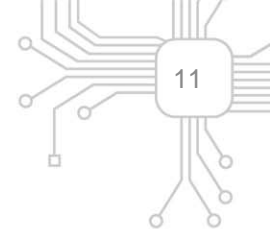
DoDSER ITEM CONTENT



- Objective & Subjective, detailed, standardized information:
 - Comprehensive event data (method, location, fatality)
 - Extensive risk factor data
 - dispositional or personal (e.g. demographics)
 - historical or developmental (e.g. military Hx)
 - contextual or situational (e.g. firearm in home)
 - clinical or symptom factors (e.g. diagnoses)



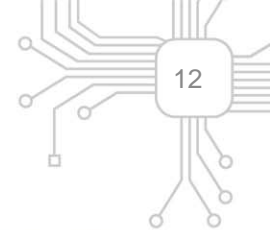
DoDSER RESPONDENTS



- Behavioral Health Provider
- Health Care Providers
- Technicians (under supervision)
- Investigative Agents
- Command Representative



DoDSER DATA SOURCES



Suicides

Review of medical and BH records
Personnel and counseling records
Investigative agency records (e.g. CID)

Records related to manner of death
(casualty reports, toxicology, autopsy,
suicide notes)

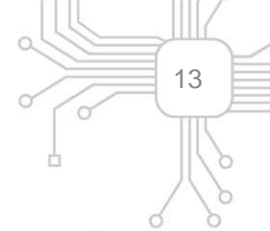
Interview of co-workers/supervisors,
responsible investigative agency officer,
other involved professionals, or family
members when appropriate (some
Services)

Non-Fatal Suicide Behaviors

Interview of patient
Review of medical and BH records
Interview of co-workers and
supervisors as needed



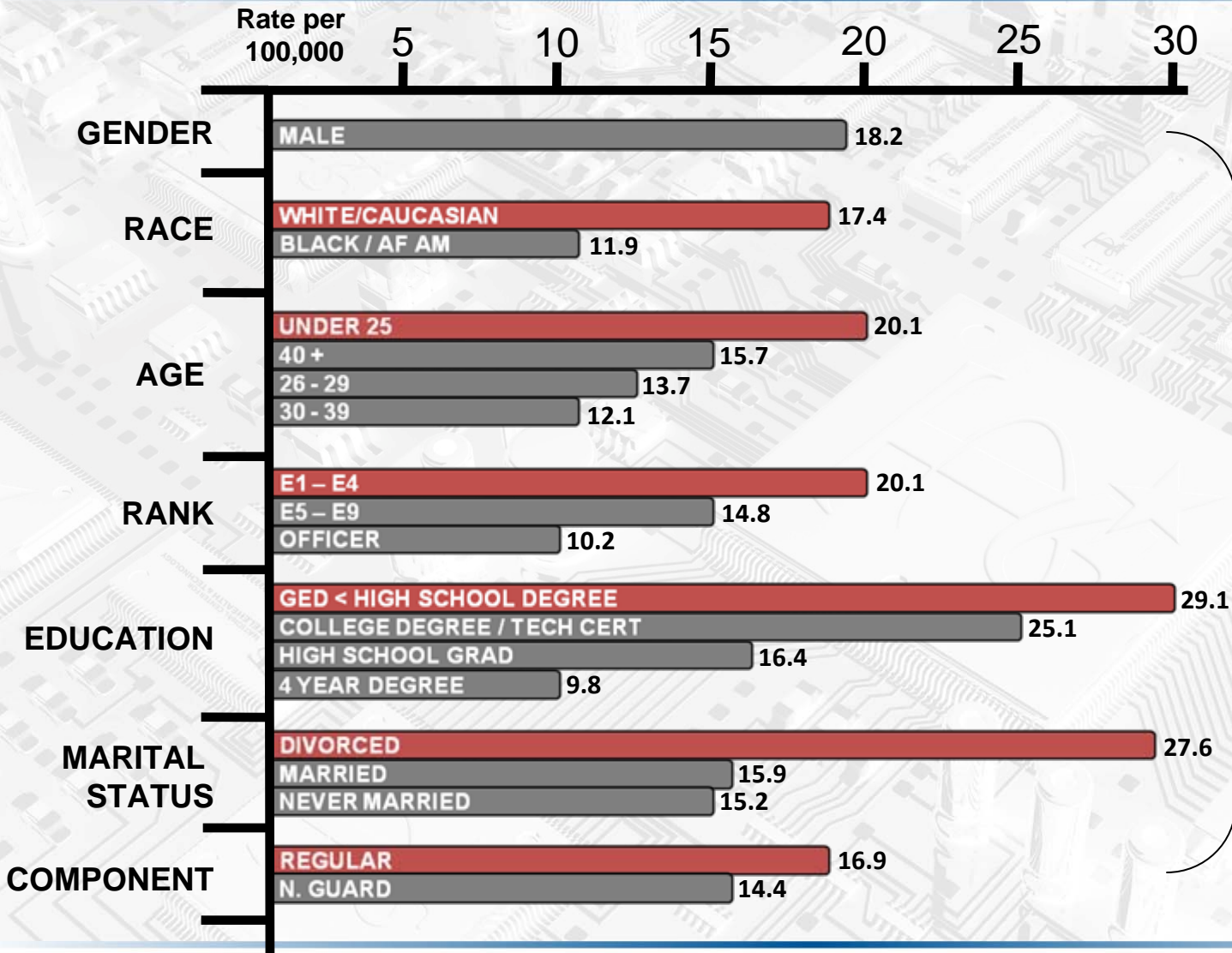
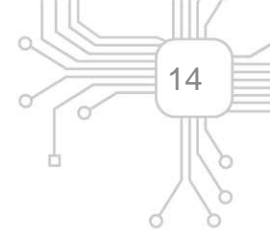
LIMITATIONS AND FUTURE DEVELOPMENTS



Limitation	Future Direction / Mitigation
<ul style="list-style-type: none">Population level data for many DoDSER variables unavailableUnable to statistically determine suicide risk factors	<ul style="list-style-type: none">T2's Suicide Risk Management and Surveillance Office (SRMSO) is currently piloting a DoDSER control sample study at Fort Lewis
<ul style="list-style-type: none">Reliability and validity of DoDSER items is currently unknown	<ul style="list-style-type: none">T2's SRMSO is currently finalizing a more detailed standardized coding manual and plans to test inter-rater reliabilityT2 is developing internet and video-based DoDSER training materials
<ul style="list-style-type: none">There are many DoDSER items to support a wide variety of needs but multiple comparisons are problematic, as differences will be observed by chance	<ul style="list-style-type: none">Clear communication of the probability of spurious results in a minority of cases
<ul style="list-style-type: none">Small sample sizes limit conclusions that can be drawn in some cases	<ul style="list-style-type: none">Future years will capitalize on multiple years of data collection

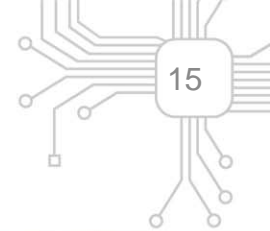


DoDSER 2008 RESULTS

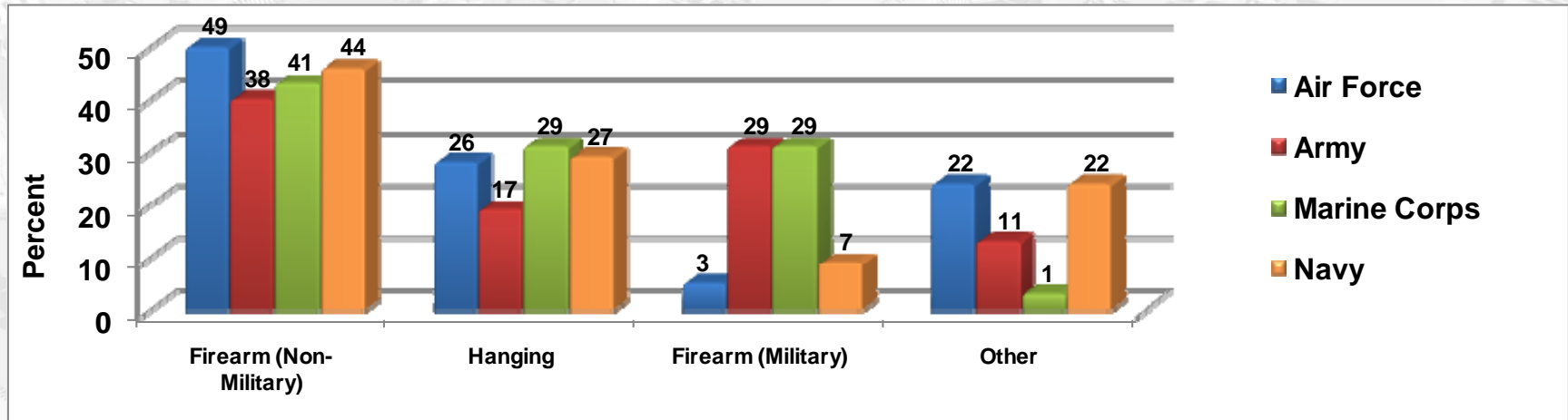


Rates were not calculated for groups $n < 20$

$p < .05$ for red bars compared to respective DoD demographic groups



SUICIDE METHODS

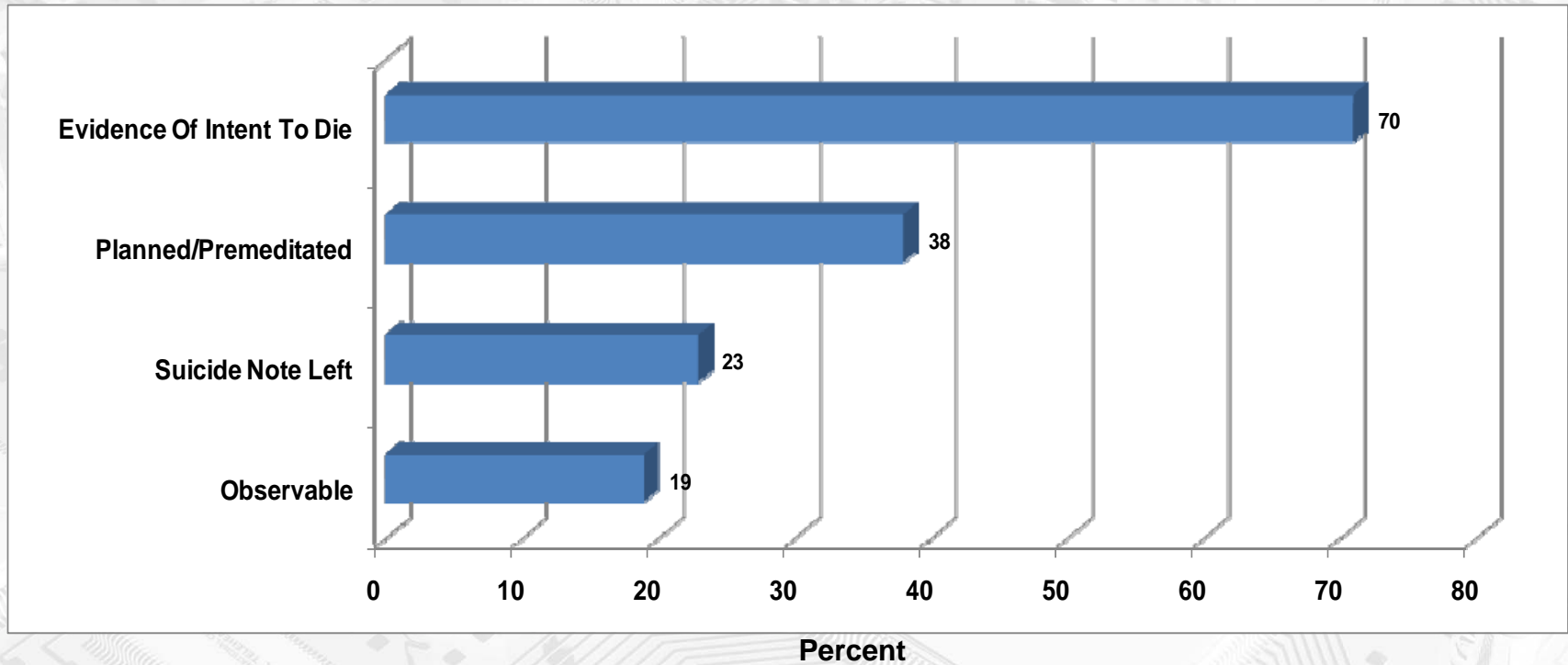
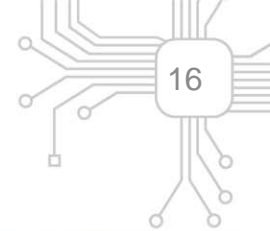


DoD Total 41% 22% 21% 16%

- Across services, non- military firearms were the most frequently utilized method for suicide (41%)
- Military firearms were used in 21% of suicides with higher incidence in the Army and Marine Corps



ADDITIONAL EVENT DETAILS



Additional Details:

- No association between calendar month of the year and suicide
- Evidence of death risk gambling (e.g., Russian Roulette) was rare (2%)



COMMUNICATED POTENTIAL FOR SELF HARM

# of Communications	N	%
0	168	70
1	51	22
2	15	6
3	5	2



SPOUSE
12% (28)

FRIEND
8% (19)

MENTAL HEALTH STAFF
5% (11)

SUPERVISOR
3% (7)

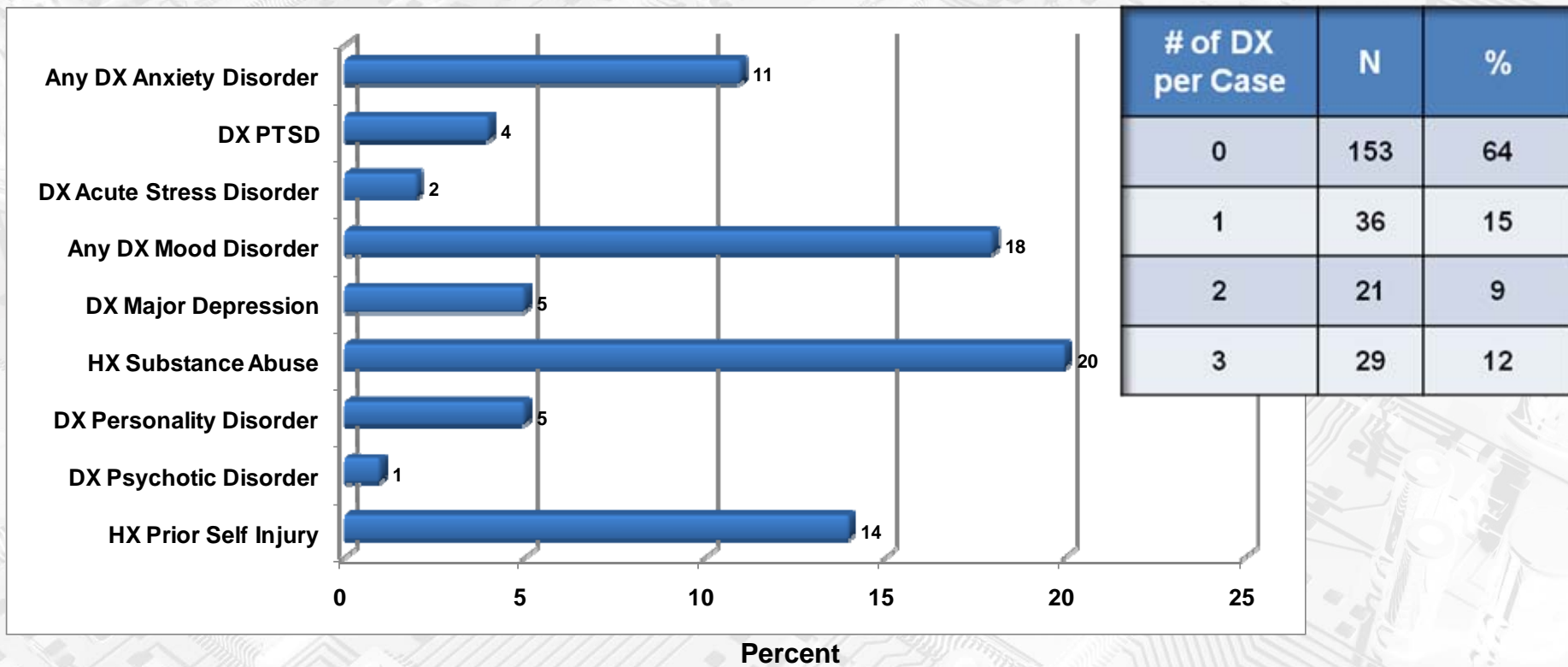
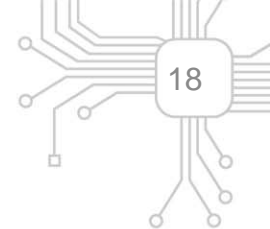
CHAPLAIN
2% (4)

OTHER
11% (26)

30% of individuals who died by suicide were known to communicate their potential for self harm.



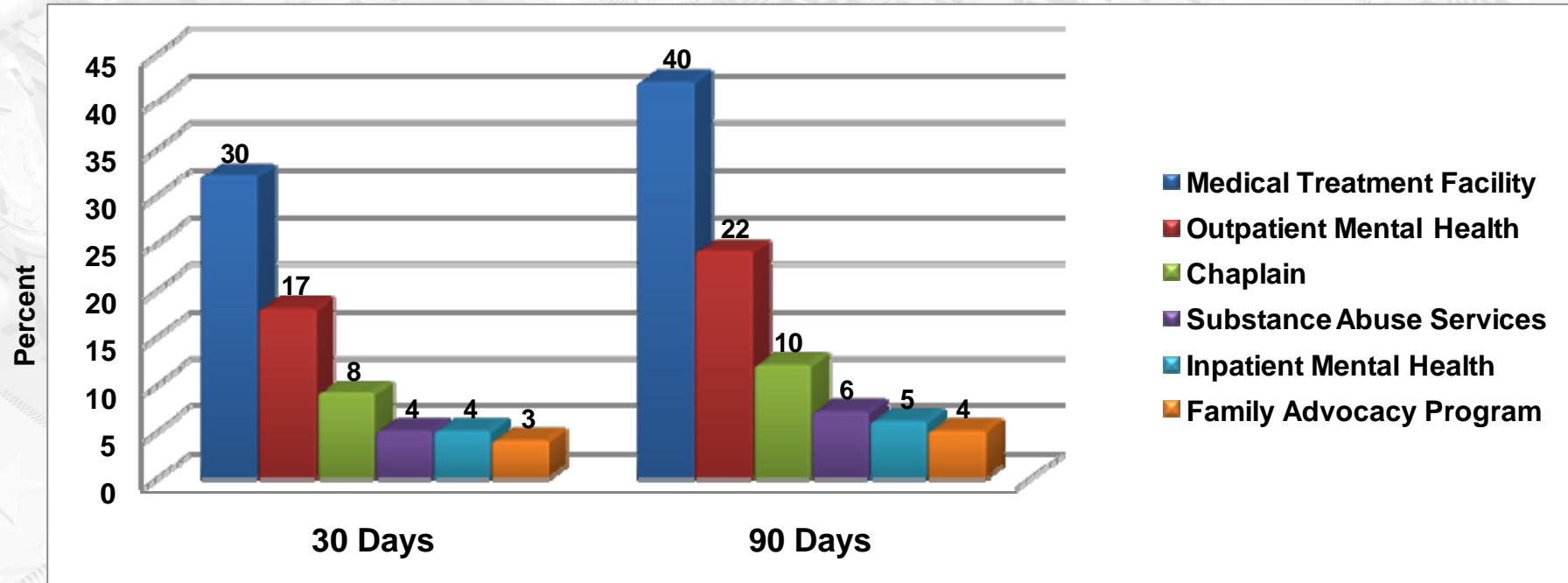
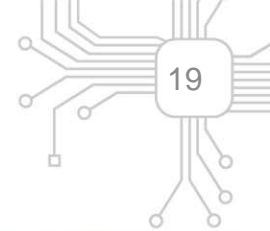
HISTORY OF MENTAL HEALTH DIAGNOSIS



36% of suicide cases had a history of at least one mental disorder



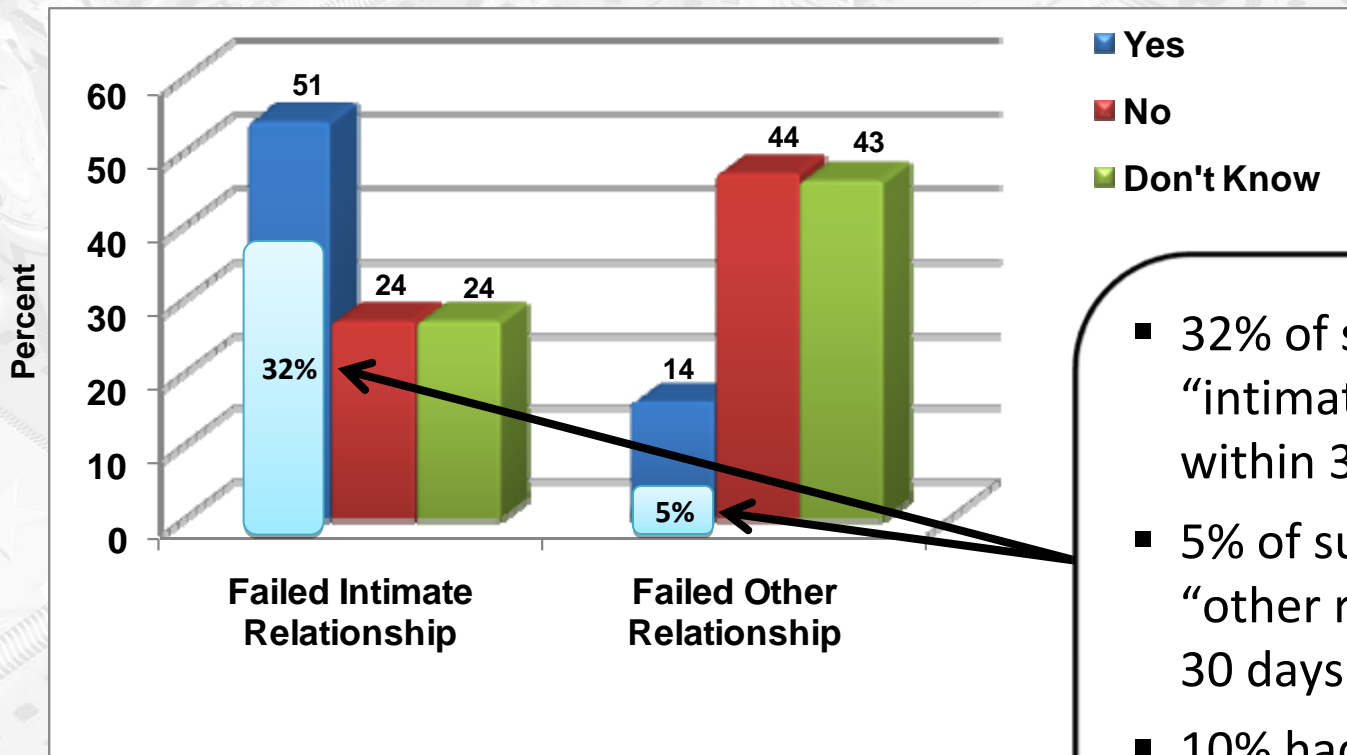
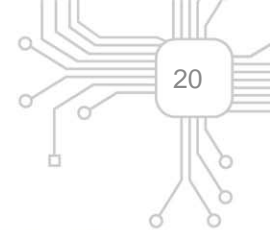
TREATMENT HISTORY



- 49% had been seen in at least one of the programs/clinics within 30 days
- 26% had sought broadly-defined mental health resources



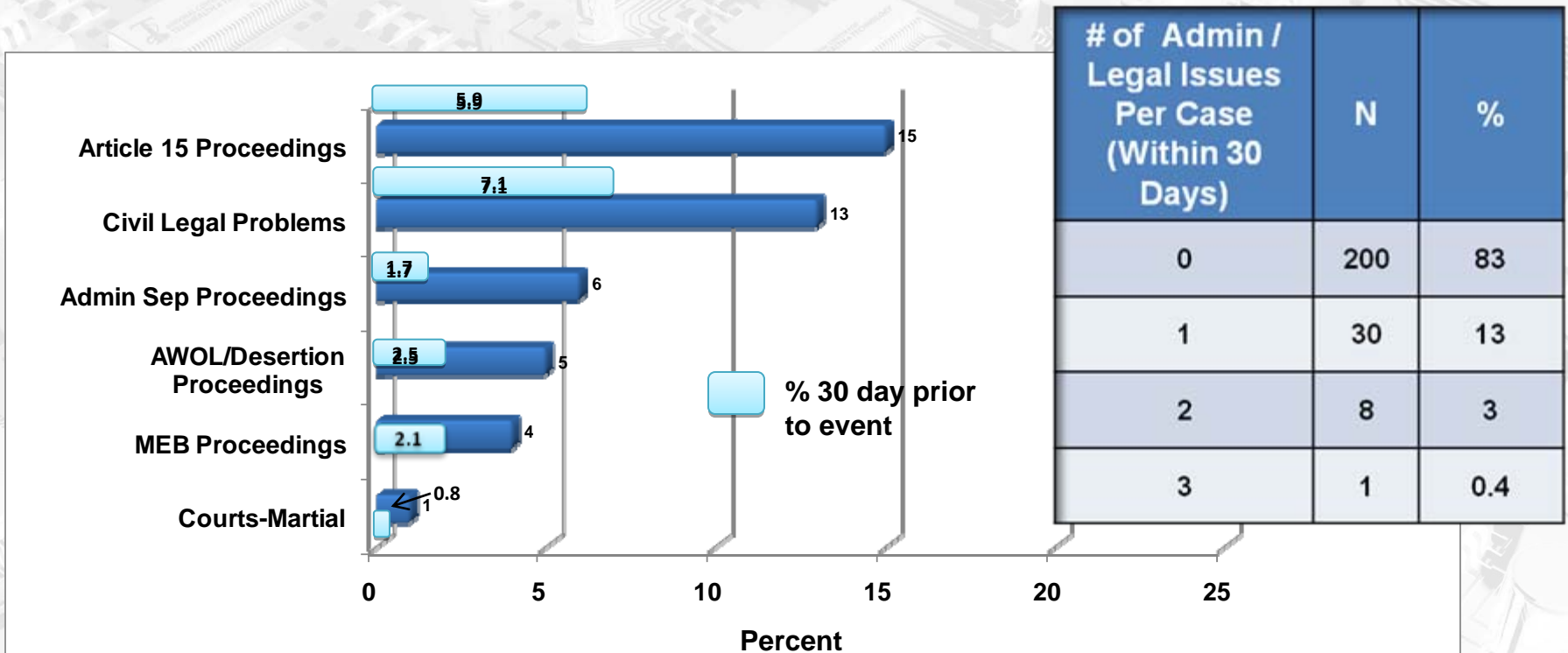
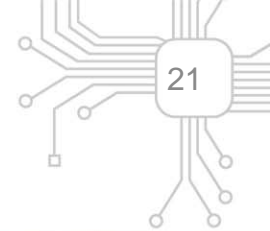
RELATIONSHIP HISTORY



- 32% of suicides had a failed “intimate relationship” within 30 days of the suicide
- 5% of suicides had failed “other relationships” within 30 days of the suicide
- 10% had both a failed intimate and failed other relationship



ADMINISTRATIVE/LEGAL HISTORY



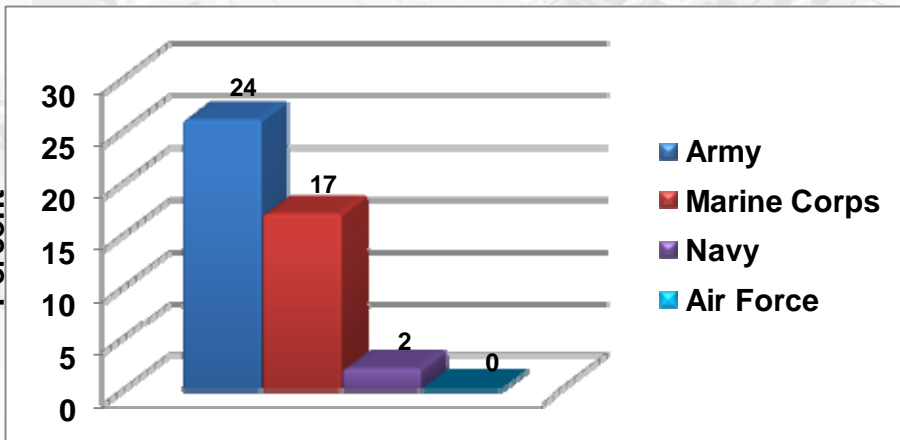
# of Admin / Legal Issues Per Case (Within 30 Days)	N	%
0	200	83
1	30	13
2	8	3
3	1	0.4

- 16% had history of admin/legal problems
- 4% had multiple admin/legal problems
- Civil Legal problems were the most common legal stressors 30 days prior to the suicide



DEPLOYMENTS

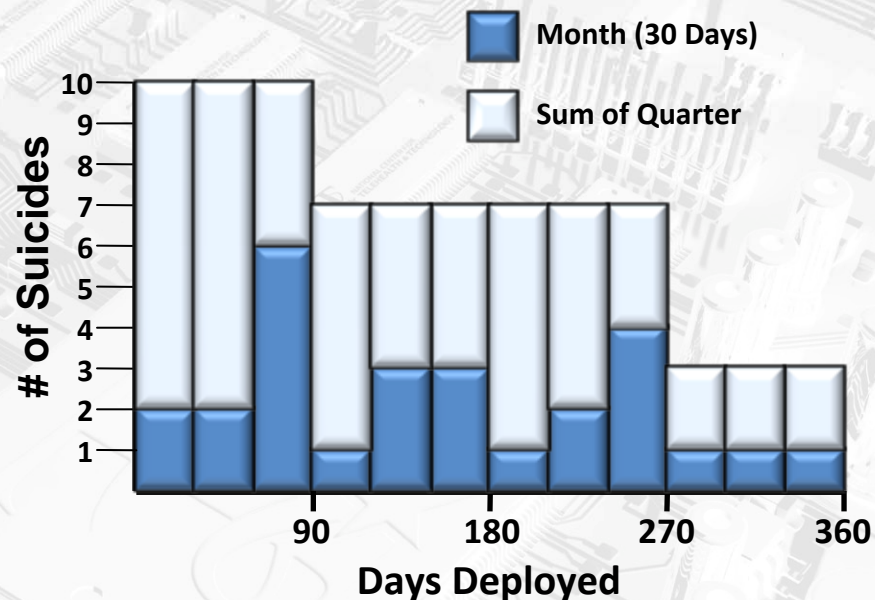
Suicides During OIF-OEF Deployment (DoD N = 268)



- ARMY: 34 / 140 (24%)
- AIR FORCE: 0 / 45 (0%)
- NAVY: 1 / 41 (2%)
- MARINE CORPS: 7 / 42 (17%)

- **DoD: 42 / 268 (16%)**

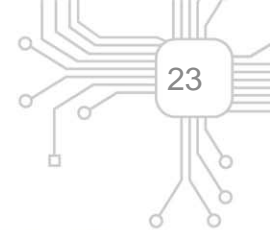
Days Deployed



- No association between number of days deployed and suicide
- Multiple years of data will be used in the future to increase the ability to detect an association



DEPLOYMENT HISTORY FOR THOSE THAT DID NOT DIE IN THEATER



Deployment Location

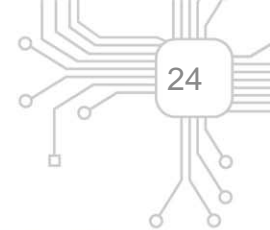
Most Recent Deployment Location	%
Iraq	24.4
Afghanistan	2.5

Number of Deployments

# of Iraq / Afghanistan Deployments	N	%
0	108	53.7
1	66	32.8
2	20	10.0
≥ 3	7	3.5



2008 ARMY DATA:EXAMPLE OF FUTURE DoDSER OPPORTUNITIES



Comparisons of Data across years:

- ASER 2007 items were compared to DoDSER 2008
- In nearly all cases, there were no differences ($p > .05$)

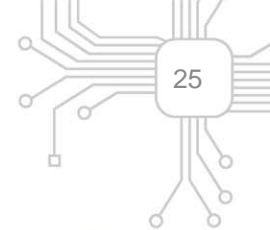


Comparisons of deployed and non-deployed suicide cases:

- Traditional risk factors were lower for OIF-OEF cases (e.g. failed intimate relationships):
 - 56% in non OIF-OEF cases
 - 44% in OIF-OEF cases
- Work problems were higher in OIF-OEF cases compared to non OIF-OEF cases (e.g. 27% vs. 19% respectively)



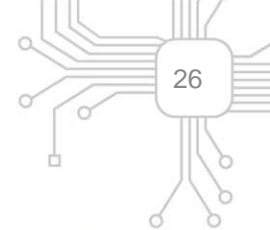
SUMMARY (1 of 3)



- Demographic groups at highest risk for suicide were similar to findings in civilian research (White/Caucasian, young, GED/less than high school education).
- Across the Services, non-military firearms were the most frequently utilized method for suicide (41%). Military Firearms (21% overall) less frequently used by Air Force and Navy decedents
- There is an opportunity to intervene in some cases:
 - 30% of suicide cases were known to communicate their potential for self harm
 - 19% of suicides were performed under circumstances where it would likely be observed and possibly intervened by others
 - 49% had been seen in a medical/support clinic/program within 30 days of suicide



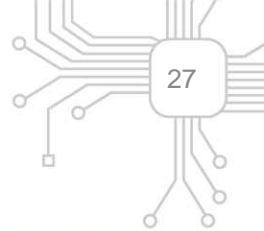
SUMMARY (2 of 3)



- Significant stressors were common prior to the suicide:
 - Failed marital/intimate relationships were reported for 51% of cases
 - Other failed relationships (non-intimate) were reported for 14% of suicide cases
 - History of Article 15 proceedings were reported in 15% of decedents
 - Civil legal problems were reported among 13% of suicides
 - 36% of suicides had been DX with a mental health disorder; PTSD was fairly rare (4%)



SUMMARY (3 of 3)



- Majority of suicides did not occur during deployment
 - 16% of DoD cases occurred during OIF-OEF deployment
 - 24% of Army cases and 17% of Marine Corps suicides died in theater
- For those who did not die in theater, the most recent deployment location was Iraq/Afghanistan for 27%
- 13% of DoD suicide cases had a history of multiple deployments to Iraq or Afghanistan



Use of a VA Root Cause Analysis database to reduce suicide among recently returned veterans

Peter Mills Ph.D. MS

Director, VA National Center for Patient Safety Field Office

Adjunct Associate Professor of Psychiatry

Dartmouth Medical School

Agenda for this talk

- What is a Root Cause Analysis?
- RCA reports of suicide and suicide attempts in VA.
- Mental Health Environment of Care Checklist.
- RCA reports of suicide among OEF/OIF veterans.

The Challenge

- **11th leading cause of death U.S. (>32,000/year)**
 - **2006: 162,359 hospitalized for self-inflicted injuries**
 - **2005: 372,722 treated in ER for Self harm**
- **Primary risk factors are**
 - Suicidal thoughts/behaviors and/or history.
 - Psychiatric diagnoses
 - Physical illnesses
 - Availability of lethal means (meds, weapons)
 - Hopelessness, impulsivity, aggression, anxiety.
 - Elderly white males at high risk (especially when alone).
- **Veterans are twice as likely to die from suicide than non-veterans.**

What is a Root Cause Analysis?

- The focus on the systemic and organizational factors that may have contributed to an adverse event .
- Mandated by JC since 1997.
- Conducted at the local level in VA by Patient Safety Managers using Safety Assessment Code (SAC).
- Produces a detailed narrative report of what happened, why it happened and how to prevent it from happening again.

National Center for Patient Safety 400 Root Cause Analysis Reports

Caryl Lee RN, MSN
National Center for Patient Safety

- National Center for Patient Safety 2002
- Utilize Root Cause Analysis Database
- 400 Root Cause Analyses
 - Suicides and Serious Suicide Attempts
- Define victim demographics and risks

National Center for Patient Safety

400 Root Cause Analysis Reports

- Gender: 94% male
- Age: 20-87 (median 51 years)
- Suicide Location:
 - Inpatient: 10
 - Inpatient suicide attempts: 47
 - Outpatient: 293
 - Outpatient suicide attempts: 45

National Center for Patient Safety 400 Root Cause Analysis Reports

- Method (Overall):
 - Gunshot: 35%
 - Drug overdose: 24%
 - Hanging: 12%
- Method (Inpatient suicides N=10):
 - Hanging: 3
 - Drug overdose: 3
 - Gunshot: 2
 - Jumping: 2
- Method (inpatient suicide attempts N=47):
 - Drug overdose: 17
 - Cutting: 11
 - Hanging: 10

National Center for Patient Safety 400 Root Cause Analysis Reports

- Non-marital family relationships/conflicts (31%)
- Multiple medical problems (28%)
- Marital problems (e.g., separation, divorce) (25%)
- Legal issues/court dates (20%)
- Personal finances/money (20%)
- Physical pain - 14% (N = 56) noted pain that was treated but unrelieved.

National Center for Patient Safety 400 Root Cause Analysis Reports

- Most Common Diagnoses: depression, substance use disorder, musculoskeletal disease, circulatory, nervous system disease
- Previous attempt: 34%
- Last Contact:
 - Outpatient Mental Health: 42%
 - Inpatient Mental Health: 25%
 - Outpatient Primary Care: 25%
 - Outpatient Suicides : 78% within 1 month

Root Cause Analysis Actions

- Train staff and improve awareness
- Standardize assessments and provide tools
- Install new monitoring devices
- Architectural and infrastructure changes
- Improve continuity and case management
- Educate veterans and families

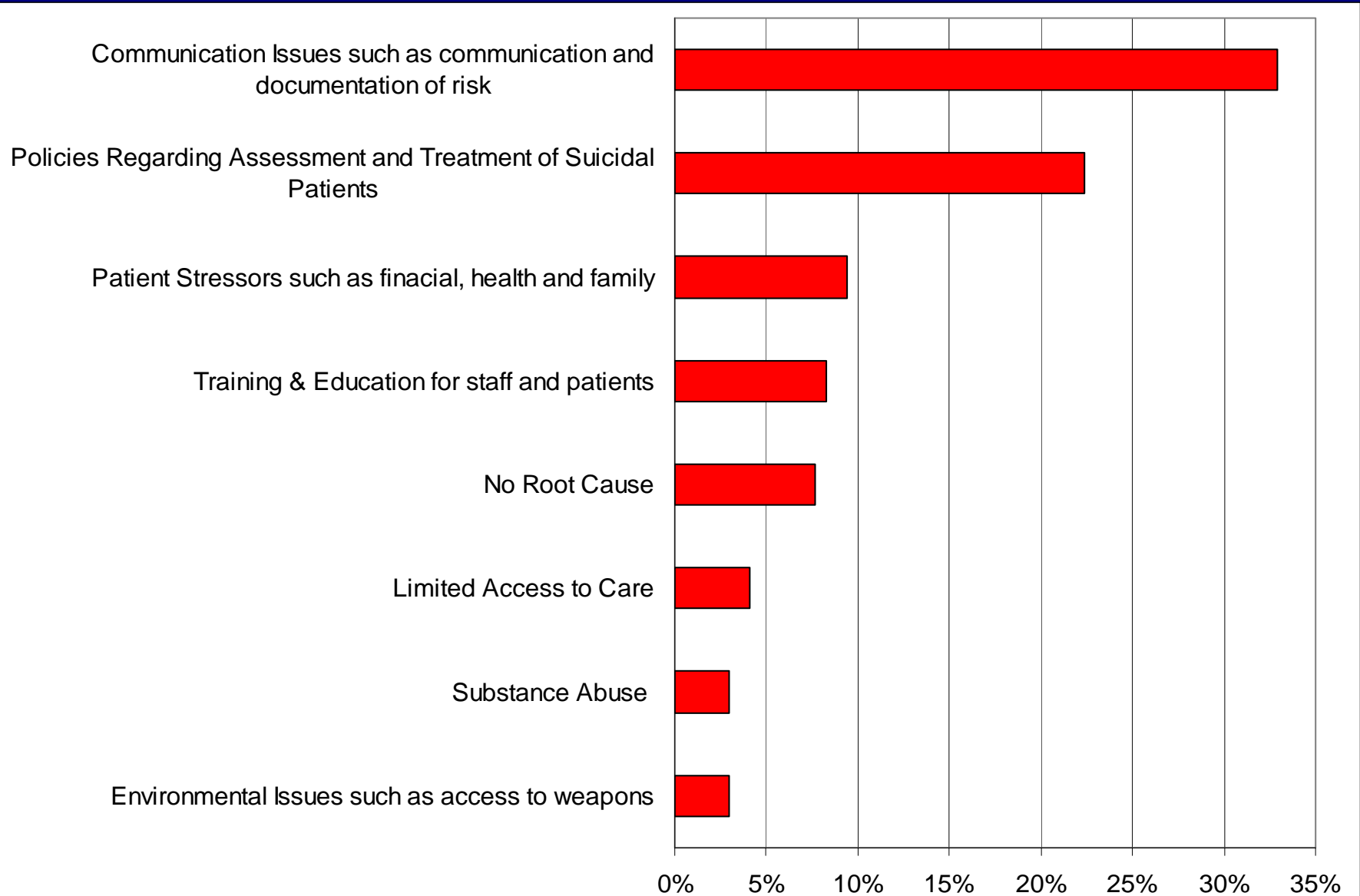
Aggregated RCA Reports Para-Suicide

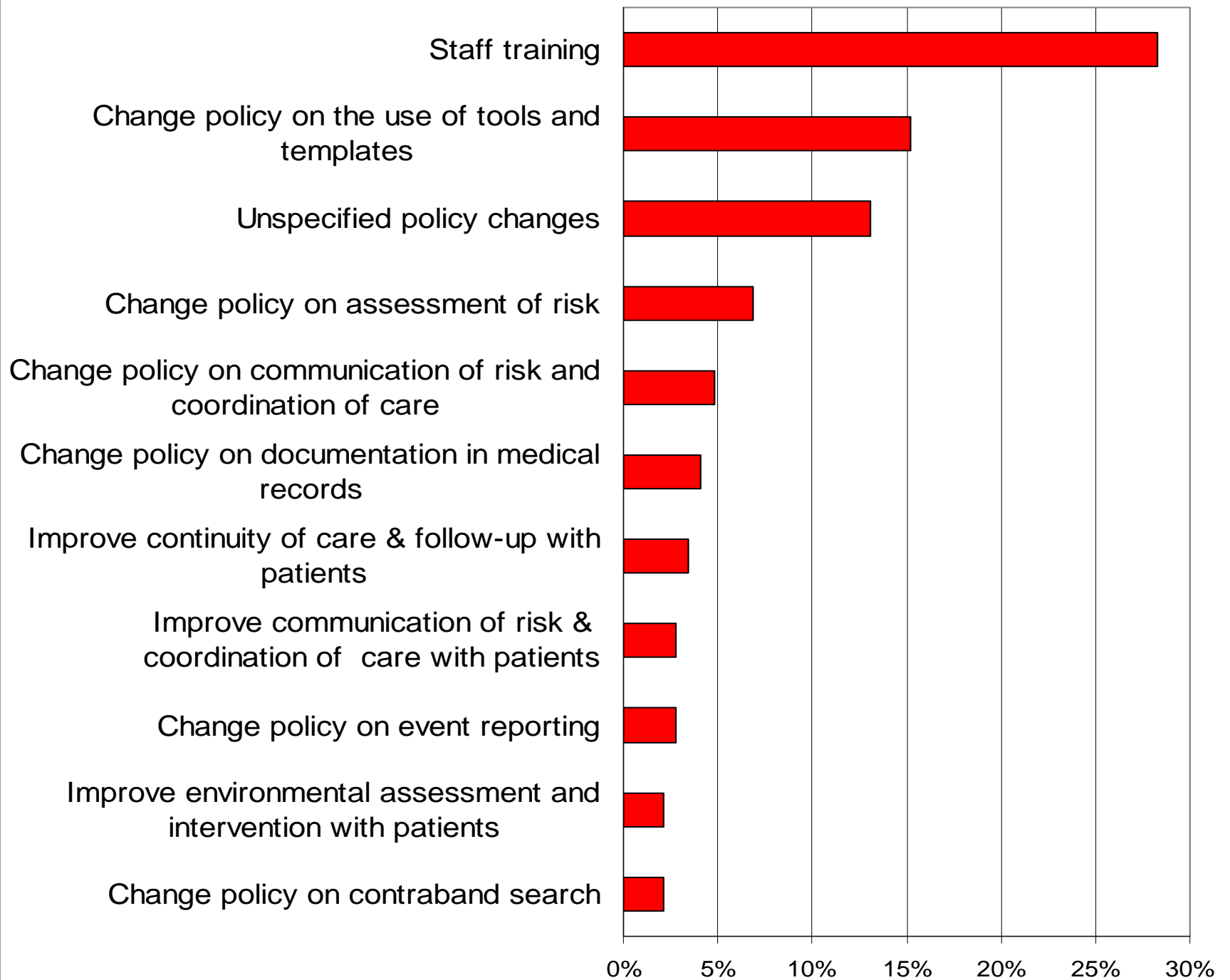
- Examined 94 aggregated root cause analyses submitted from 59 VHA facilities. The aggregated reviews were all those submitted covering the time period of October 1, 2000 through March 31, 2003.
- We conducted a semi-structured telephone interview with each site that submitted either a parasuicidal aggregated review and/or a selected single case RCA.

The Aggregated Reviews

- A total of 775 cases of parasuicidal behavior were reviewed in the 94 aggregate reviews.
- The mean number of cases reviewed per aggregated RCA was 8.5; the median was 5; and the standard deviation was 10.1.
- It took an average of 33.5 person hours (SD = 25.8 hours) to complete an aggregated RCA.

Primary Root Cause/Contributing Factors





Characteristics of the Actions

- 88% (214) of the actions address the root cause.
- Of the 214 actions that addressed the root cause:
 - 68.1% (145) were fully implemented
 - 15.5% (33) were partially implemented
 - 9.9% (21) were not implemented
 - 44.7% of the actions has a specific person responsible for implementation
 - Mental Health was responsible for 34.4% of the actions
 - Nursing for 2.8% of the actions
 - More than one service had responsibility for implementing 56.9% of the actions.

Outcome Measures

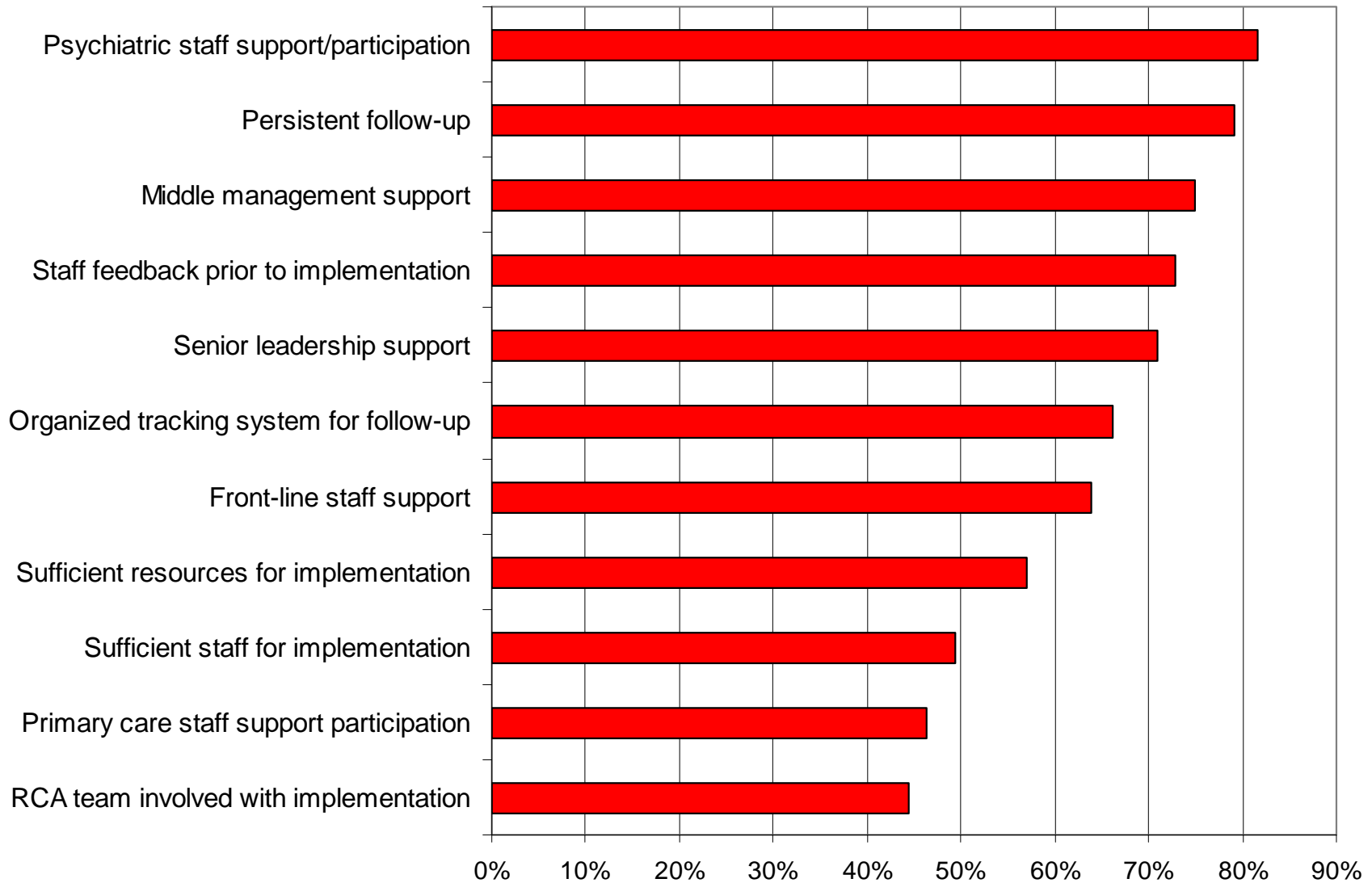
Outcome measure	Not using the measure	Too soon to tell about improvement	Have seen improvement	Have seen no change to date	Have seen an increased number of reports
Reduced reports of parasuicidal events	7%	28.20%	23.90%	32.40%	8.50%
Lengthened time between reported events	44.60%	17.60%	20.30%	17.60%	0%
Reduced reports of suicides	8.50%	18.30%	32.40%	36.60%	4.20%
Fewer reported attempts after discharge from hospital	47.80%	13.40%	22.40%	14.90%	1.50%
Improved discharge planning	29.60%	8.50%	47.90%	14.10%	0%
Fewer suicidal patients lost to follow-up	35.40%	13.80%	35.40%	15.40%	0%

“How are you defining parasuicidal events”?

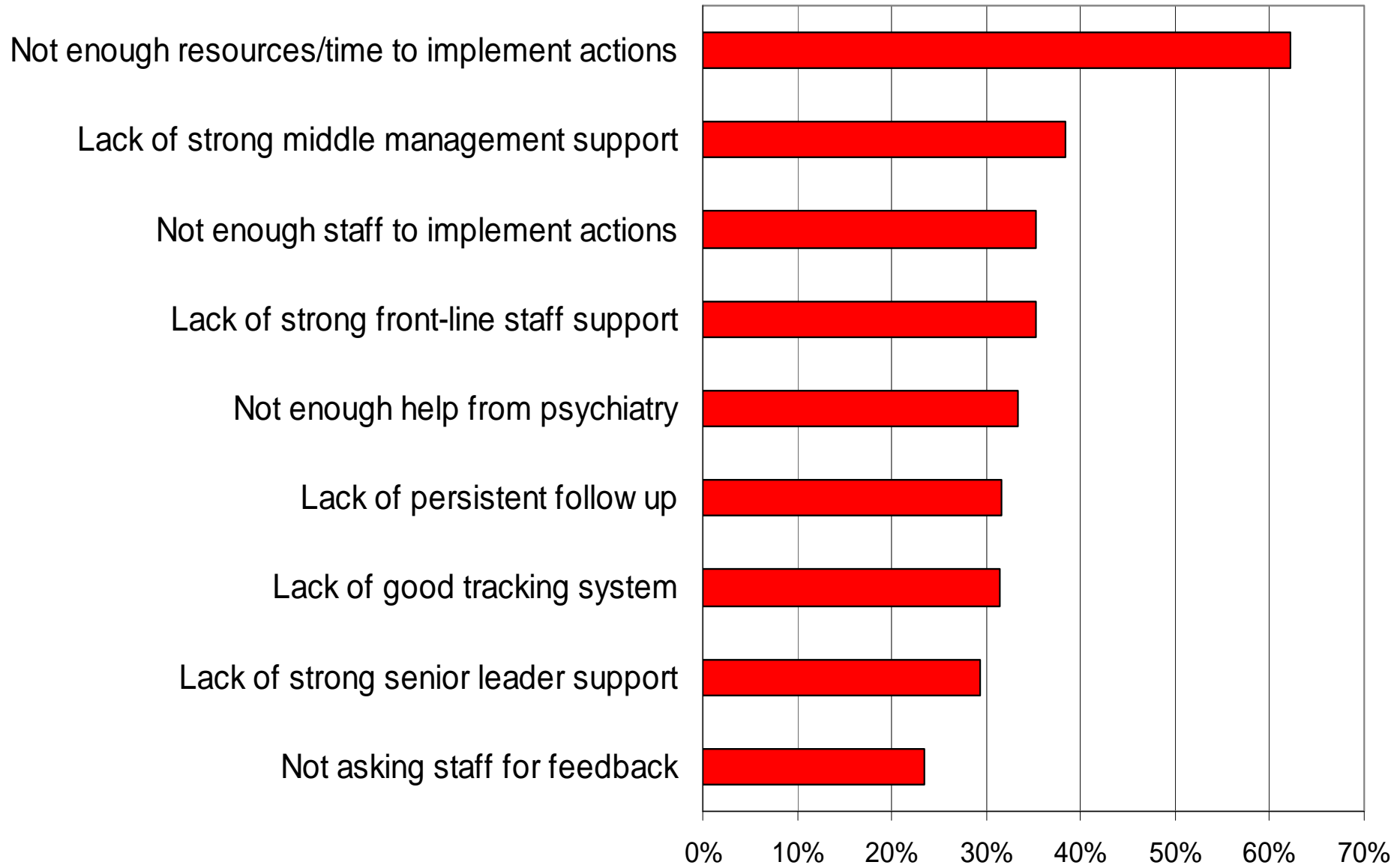
- Parasuicidal definitions were obtained from 67 sites - 73%, fell into one of three categories:
- An attempt or gesture.
- An attempt, gesture, or ideation.
- An attempt, gesture or threat.

Handbook definition: “any suicidal behavior with or without physical injury {i.e. short of death} including the full range of known or reported attempts, gestures and threats”.

Success Factors for Implementation of Actions



Barriers to Implementation



Characteristics Associated with Improved Implementation and/or Clinical Outcome

- “Having a good tracking system for following up on the actions” was significantly correlated with both implementation rate and reports of improved clinical outcomes
- Improved clinical outcome was correlated with strong senior leader support, strong front-line staff support, and enough resources to implement action plans.
- Also, higher implementation rates were associated with strong middle management support and having enough staff to implement action plans.

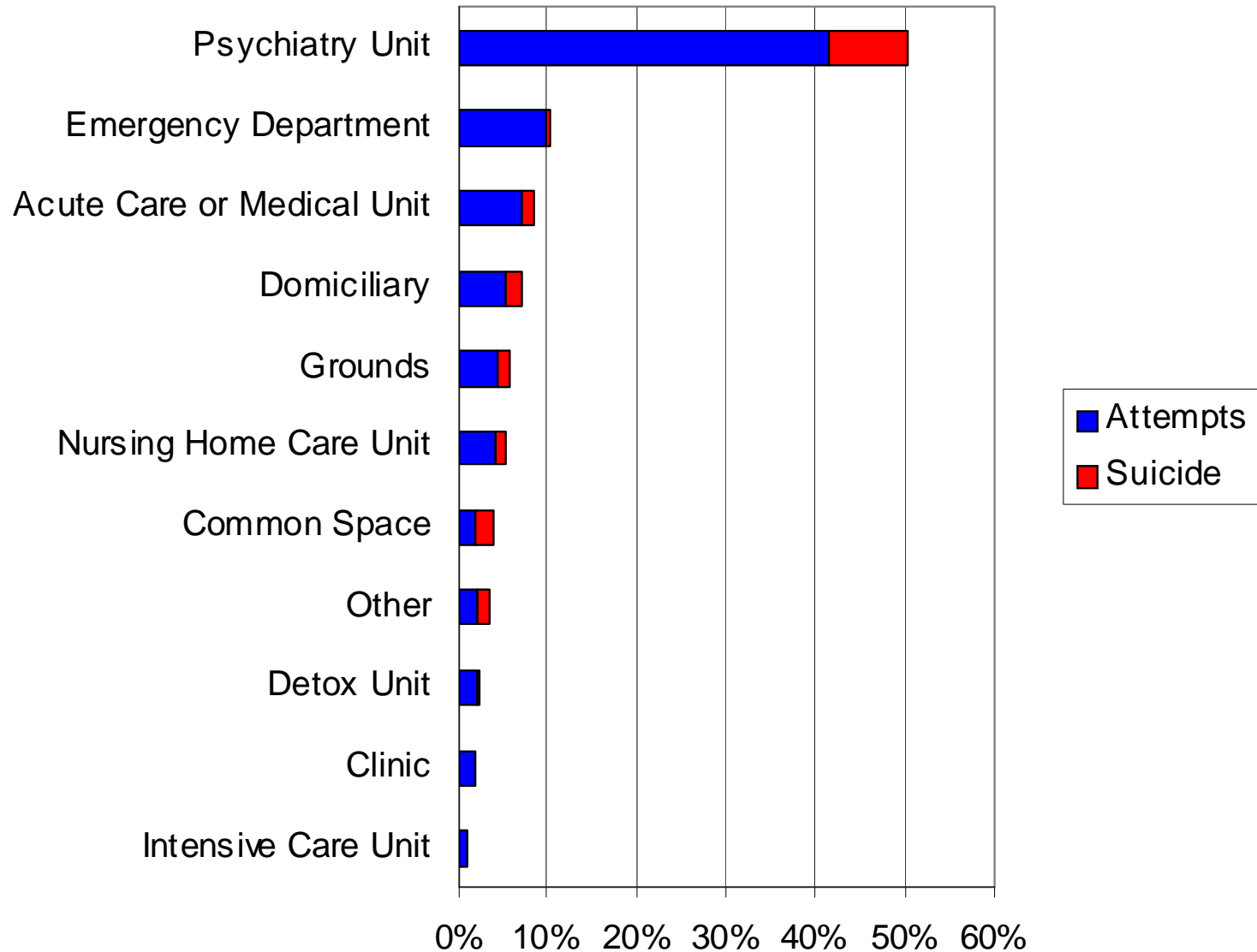
Take Home Points

- Better tools and approaches to aid in the assessment and communication of risk for suicidal behavior.
- Increased reports of parasuicidal events may make it easier to identify trends and root causes. Encourage reports by making it easy and less time-consuming for providers to report events.
- Dealing with “no root cause”
- Use a well-organized tracking system for actions.
- Senior leadership needs to demonstrate that reducing suicidal behavior is a priority by devoting resources and staff to implement actions.

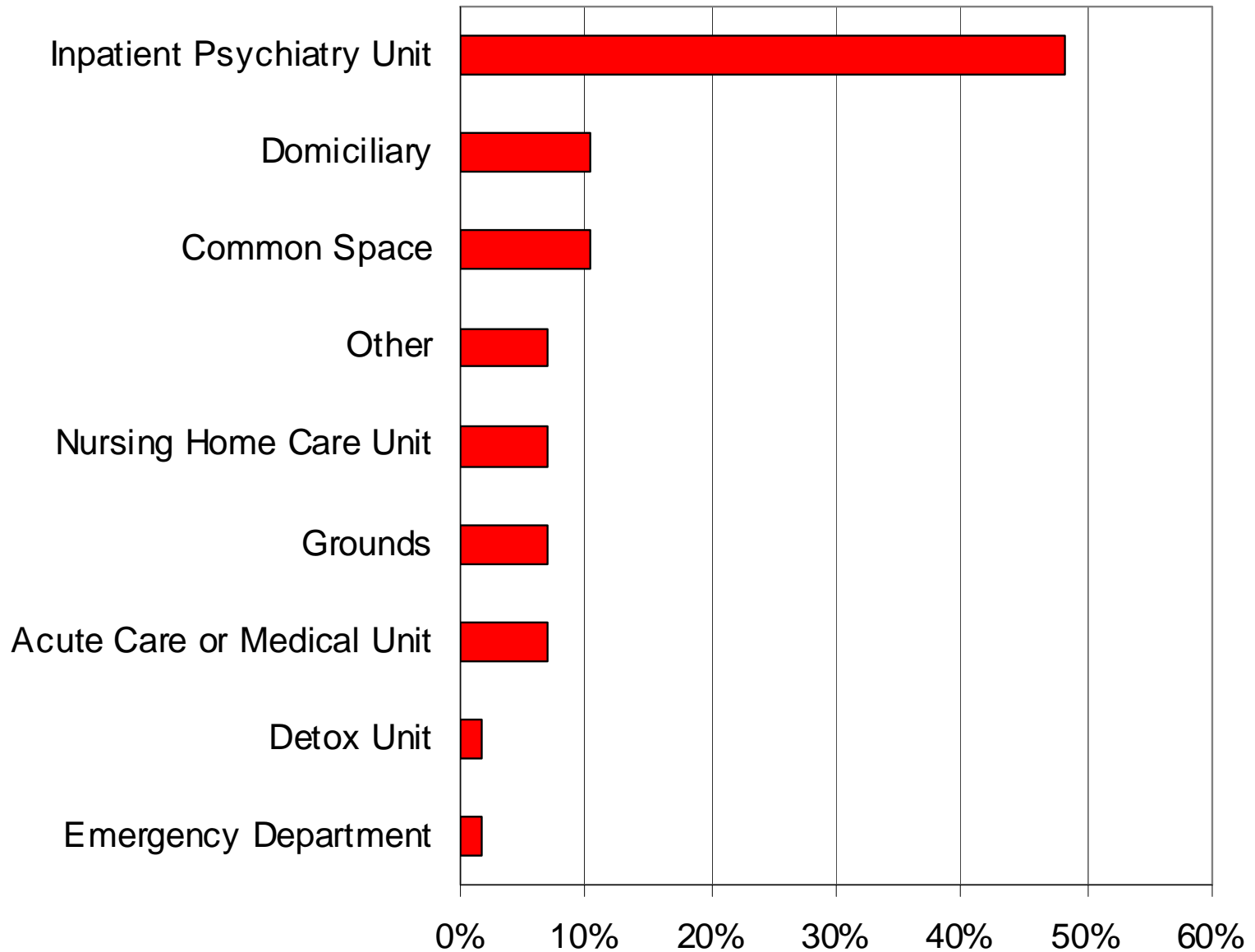
Inpatient Suicide in VA

- Reviewed all RCA reports of suicide, suicide attempts or “para-suicide” on any inpatient unit from December 1999 to December 2008
- Coded the reports for location, method, hanging anchor points and type of lanyard used
- Found 258 RCA reports of inpatient suicide attempts and 58 reports of completed inpatient suicide.

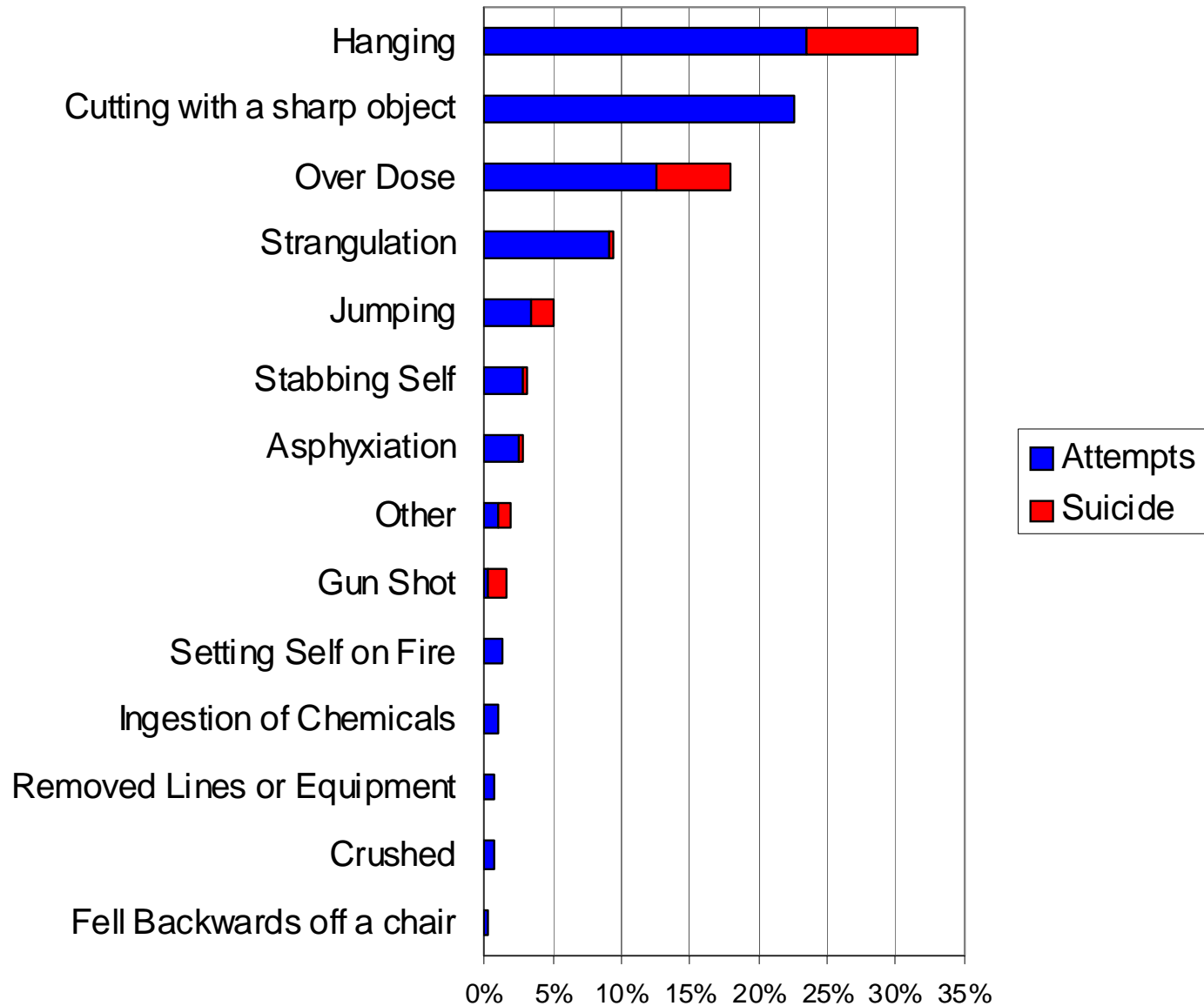
Location of Inpatient Suicide and Suicide Attempts in VA (N = 316)



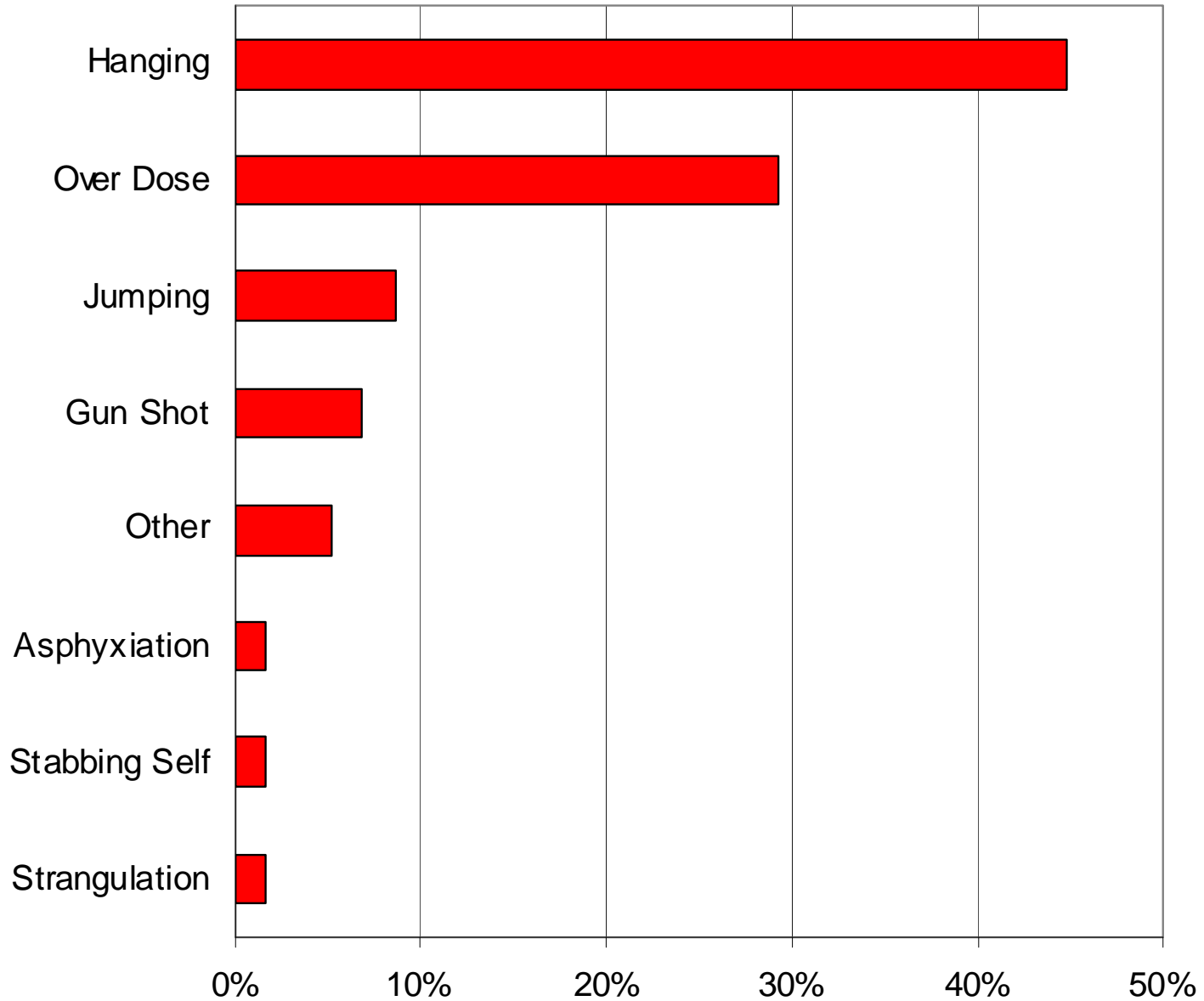
Location for Completed Inpatient Suicides (N=58)



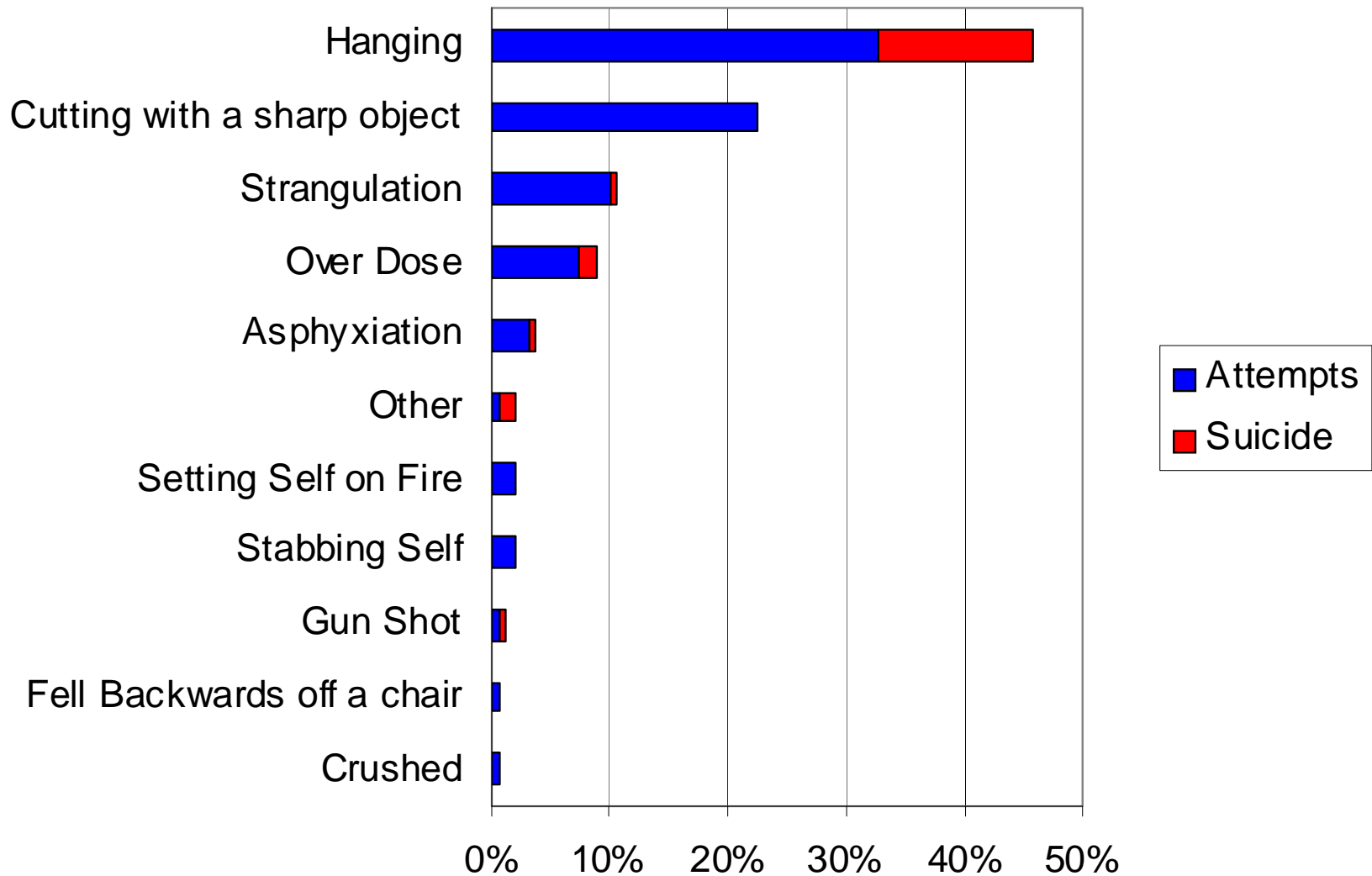
Methods for Inpatient Suicide and Suicide Attempts in VA (N=316)



Method for Completed Inpatient Suicide (N=58)

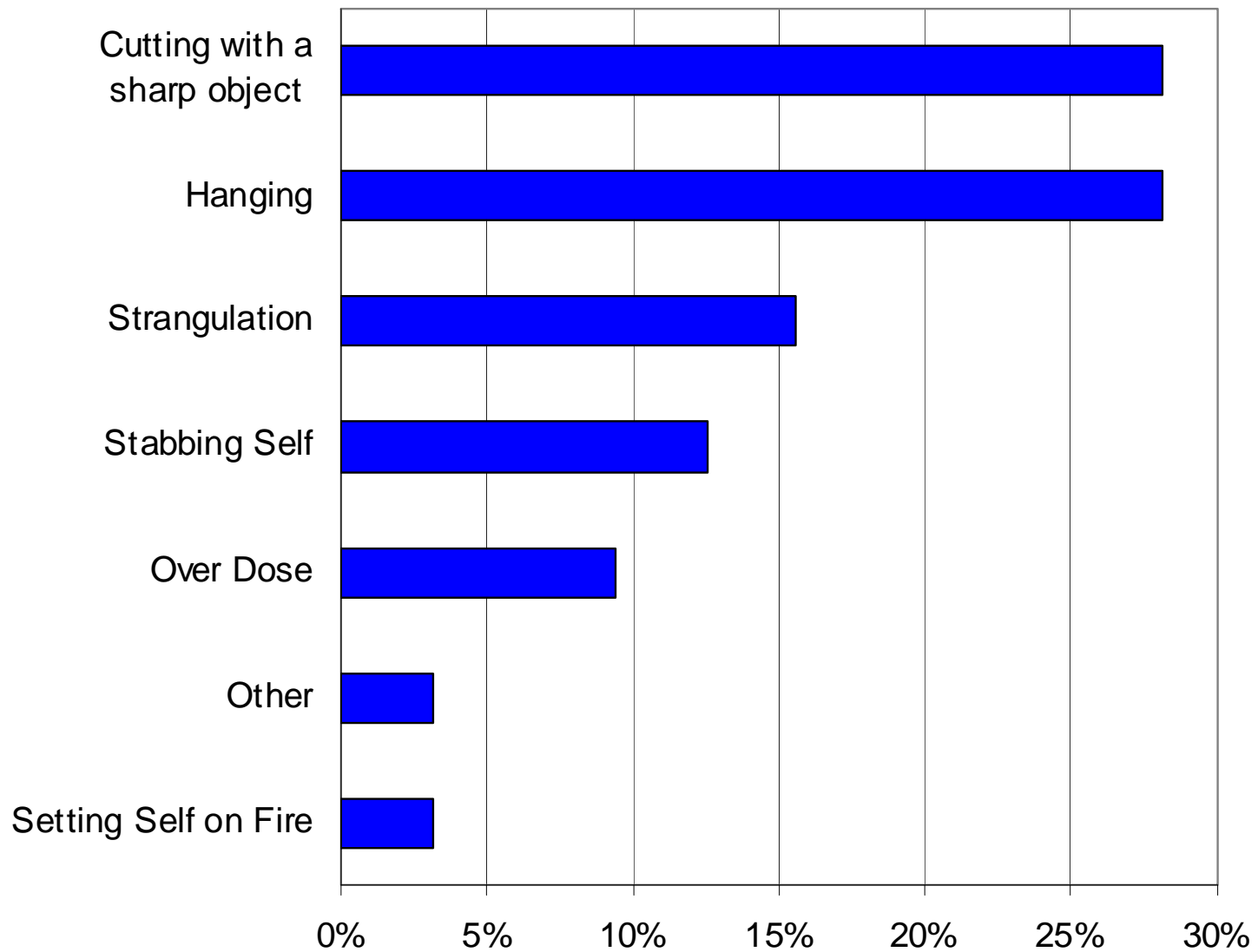


Methods for Inpatient Suicide and Suicide Attempts on Psychiatry units Only (N = 159)

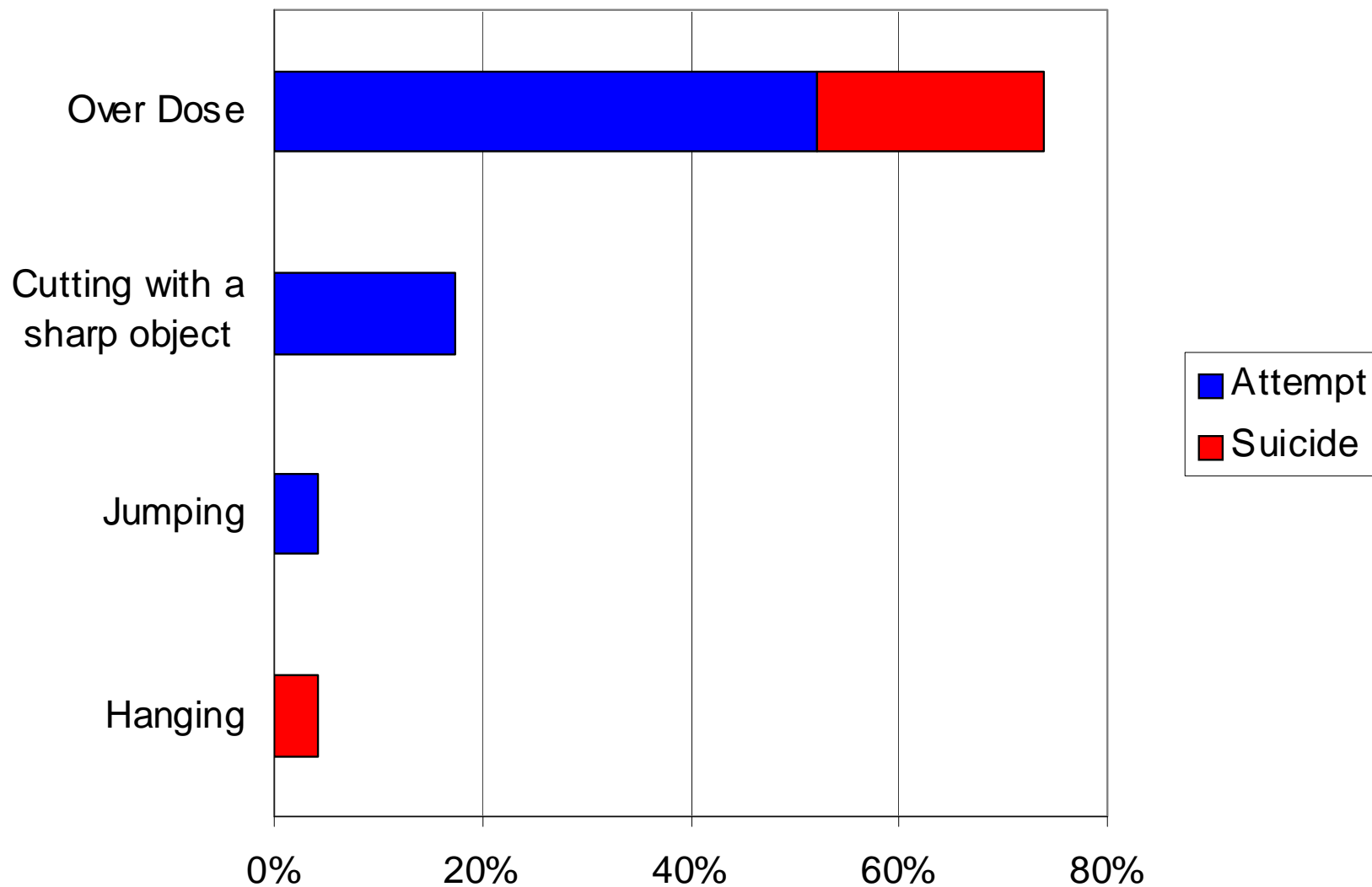


Method of Inpatient Suicide Attempts in ED (N=32)

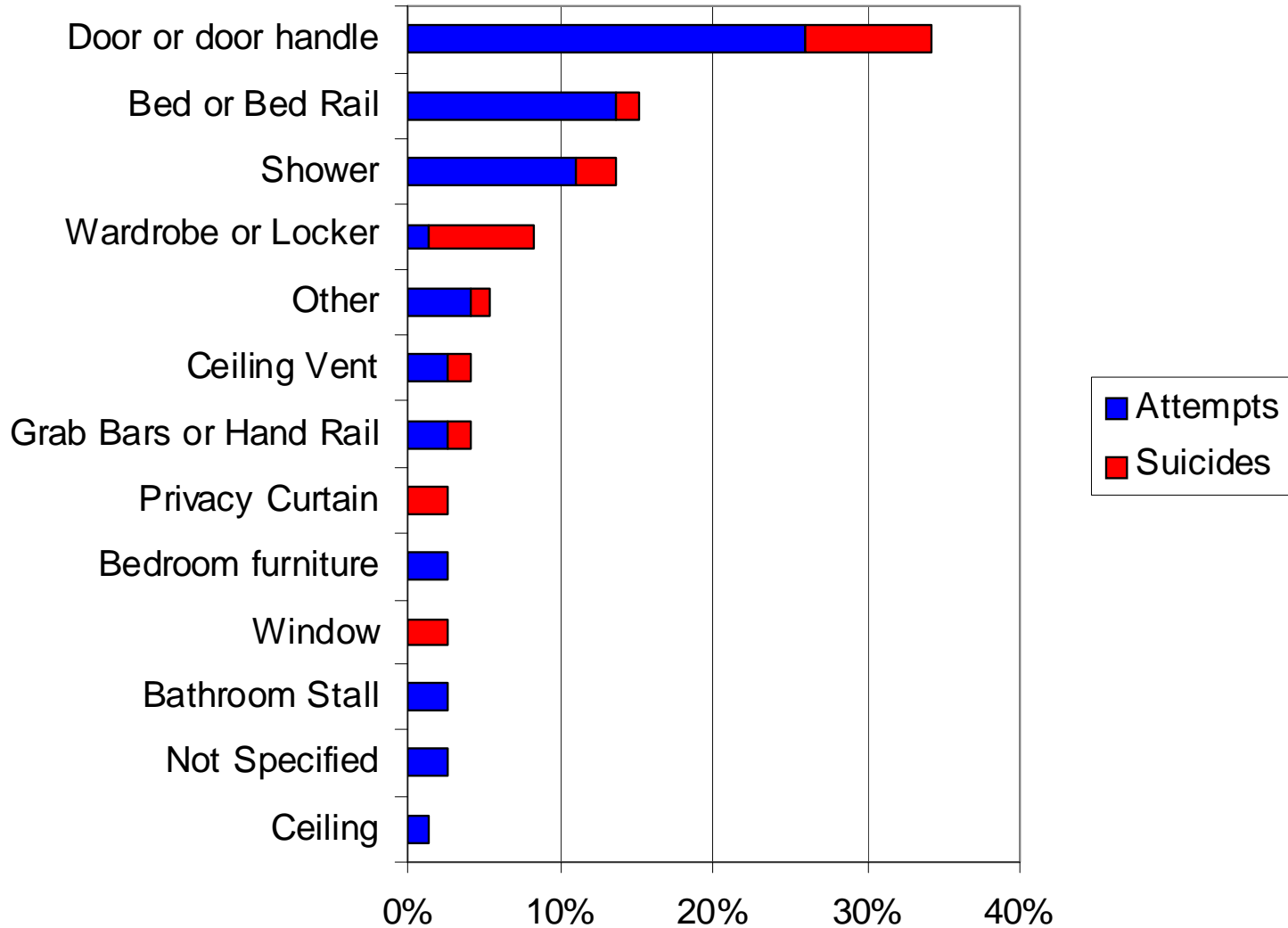
There were no completed suicides



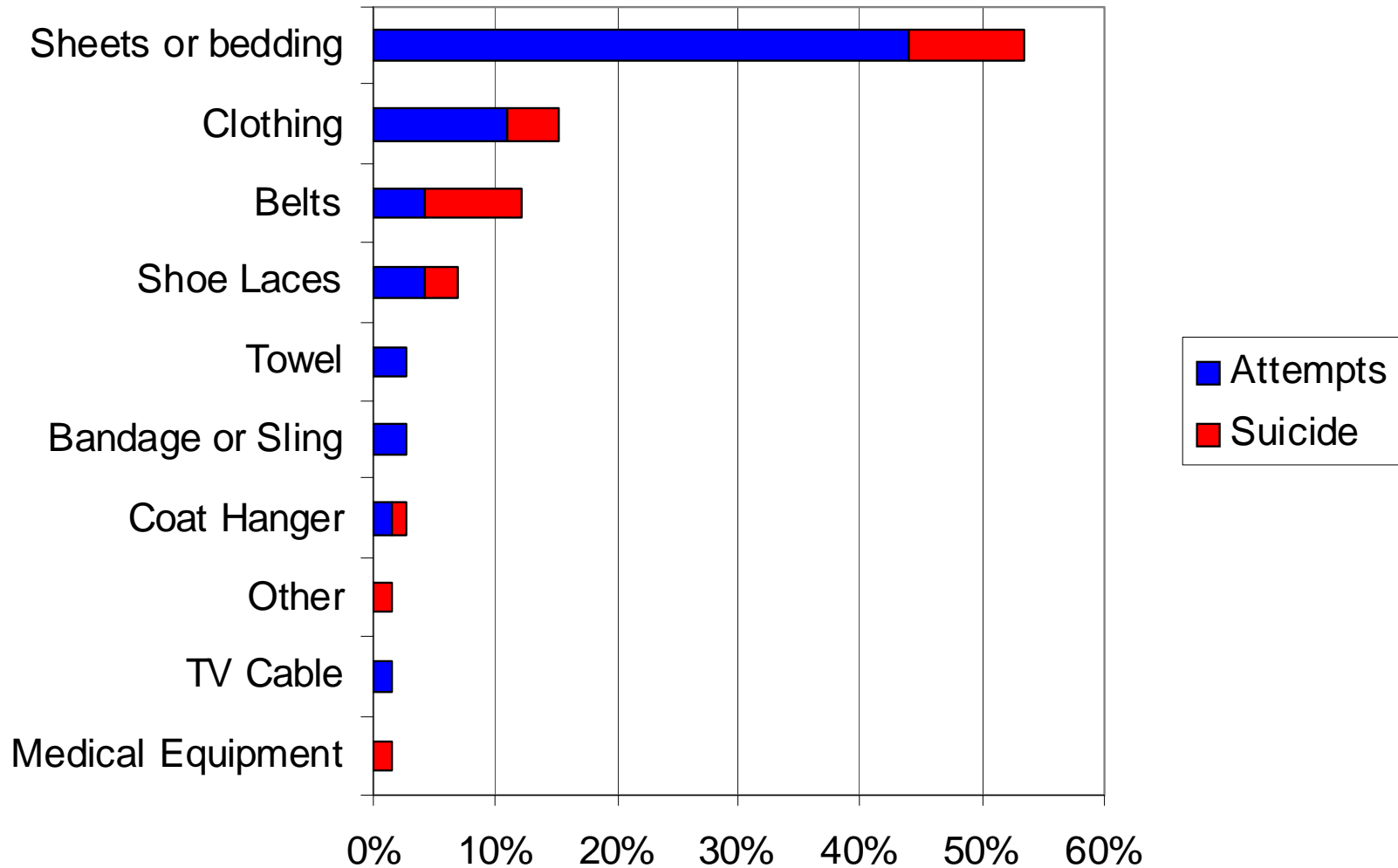
Method of Inpatient Suicide and Suicide Attempts in Domiciliaries (N=23)



Anchor Points for 73 RCA Reports of Inpatient Suicide and Attempted Suicide by Hanging on Psychiatry Units Only

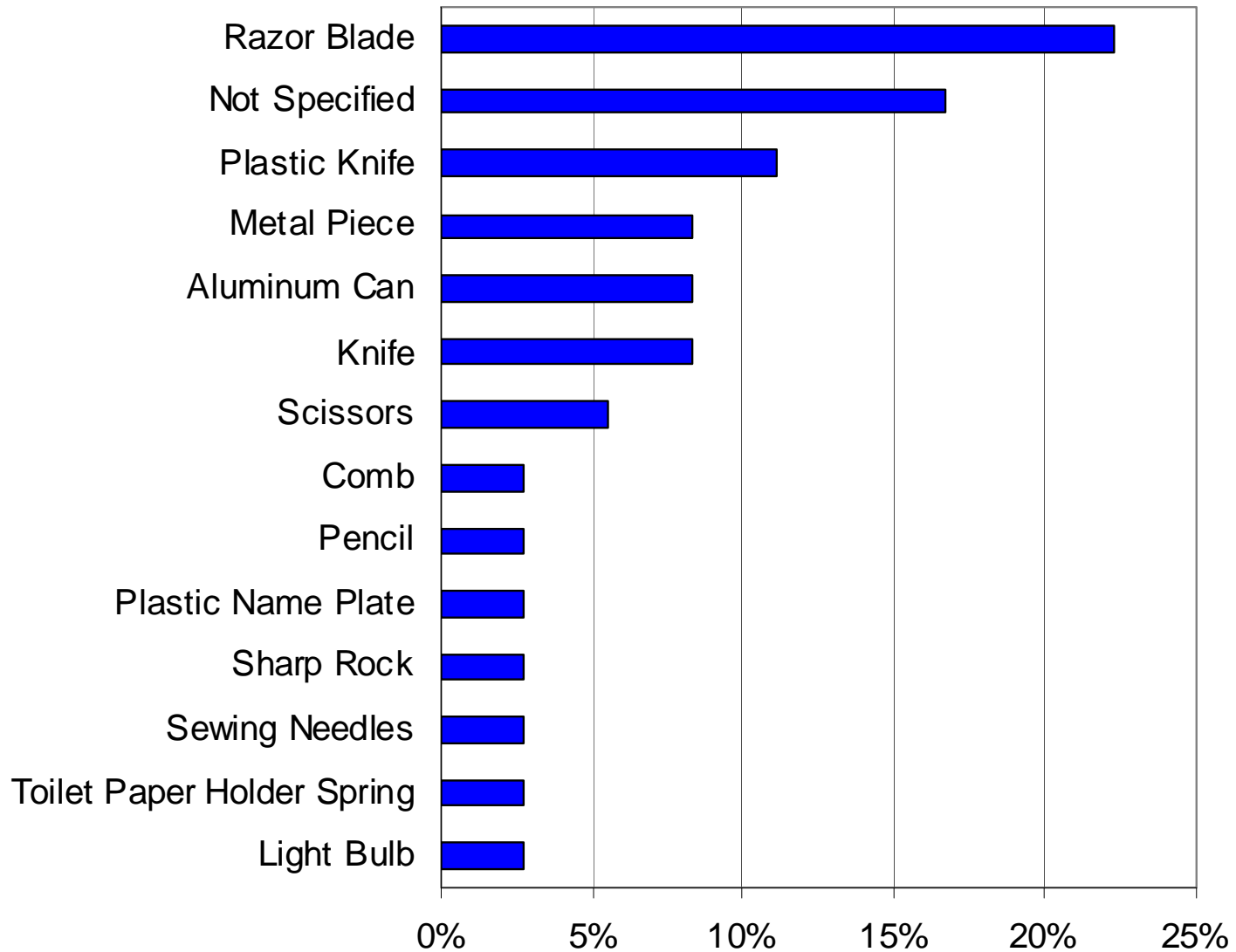


Types of lanyards for the 73 RCA Reports of Inpatient Suicide and Attempted Suicide by Hanging on Psychiatry Units Only

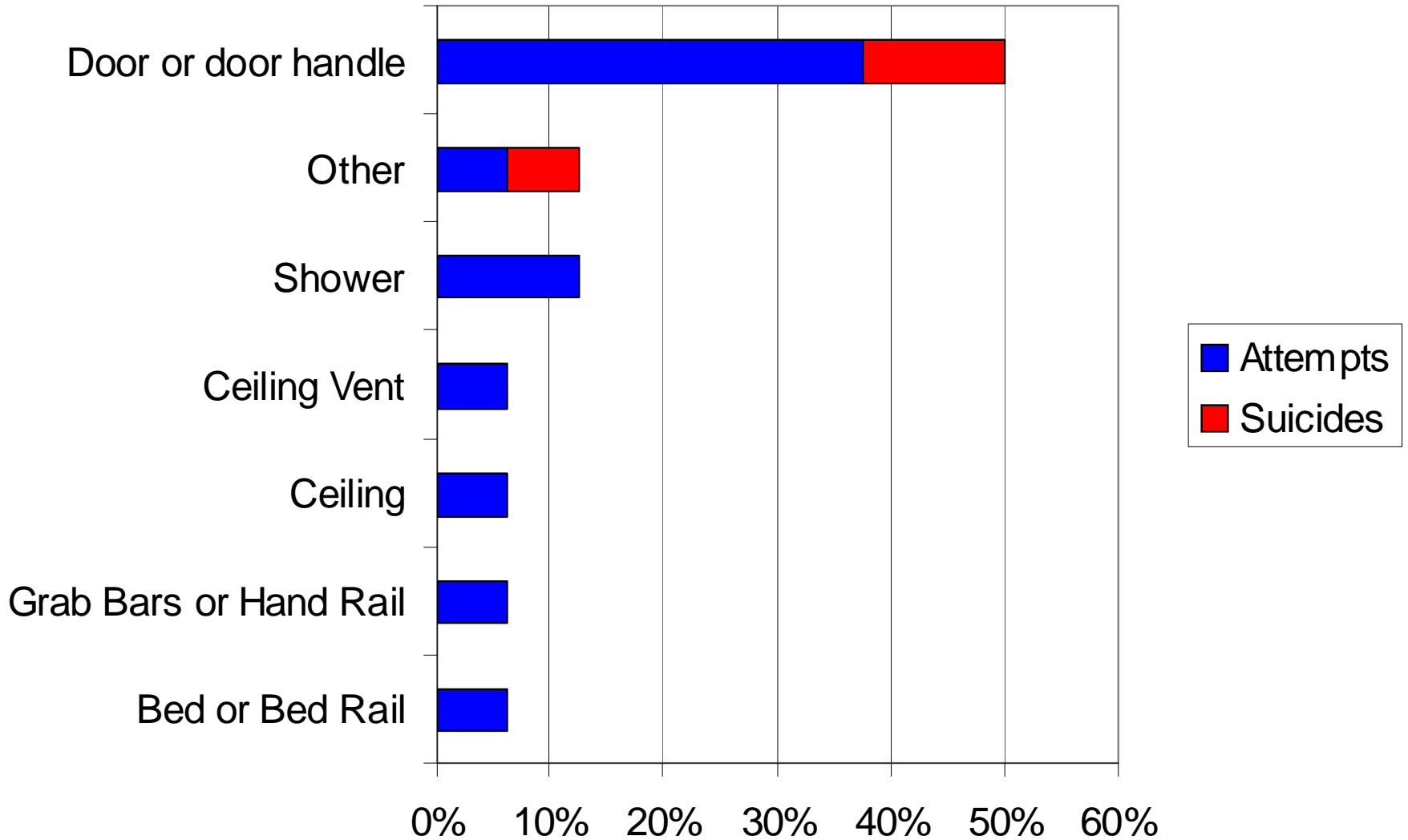


Method for Cutting on Psychiatry Units

There were no Completed Suicides (N=36)



Anchor Points for Hanging on Psychiatry Units in FY 2008 (N = 16)



Conclusions

- Inpatient suicide on psychiatry units in VA continues to be extremely rare – approximately 2.3 completed suicides for every 100,000 psychiatric admissions.
- Hanging continues to be the most common method for inpatient suicide and doors, especially interior doors, are the most common anchor points.
- Sheets and bedding continue to be the most common type of lanyard for hanging.

The Mental Health Environment of Care Checklist for Locked Units

- From Patient Safety Workgroup
- Formed multidisciplinary national committee in Fall 2006
 - Patient safety, psychiatry, psychology, nursing, fire protection, architecture, facilities engineering, quality improvement, senior management
- Focused on specific rooms in locked mental health units
 - General room, bath, bed, seclusion, utility, kitchen, Laundry, OT, dining, staff office, nursing station, entrance to unit, outdoor areas

Protocol for Environmental Rounds

- Form multidisciplinary safety inspection team
 - Include suicide prevention coordinator, patient safety officer, facility safety officer, psych nurse, non-psych nurse, Psychiatrist, reps from engineering and environmental services – get people who are not normally on the unit
- Conduct environmental rounds at least quarterly
- Rate identified safety concerns using a standardized scale taking severity and frequency into account.
- Track progress and report to senior leadership
- First tracking sheet was due October 2007

27.a. Are closets free of clothes rods that could be used as an anchor point for hanging?

27.b. Are closets free of clothes hangers (plastic, wood, and metal)?

28.a. Are shelves in closets secured with tamper resistant fasteners and designed so they cannot be used as an anchor for hanging?

28.b. Are heavy items on shelves placed low to the floor and secured in place to prevent them from being removed?

28.c. Is each shelf layer secured and not removable so that it cannot be pulled apart to be used as a weapon?

Spring-loaded hooks designed for mental health areas should be used in lieu of closet rods and hangers.

If there is a television or other electrical or heavy item on the shelf, it should be secured so that it cannot be pulled off onto someone, and the electrical cord must be short and plugged directly into the electrical receptacle. Sets of shelves should be short or low in height (low profile) to prevent the patient from reaching the ceiling.

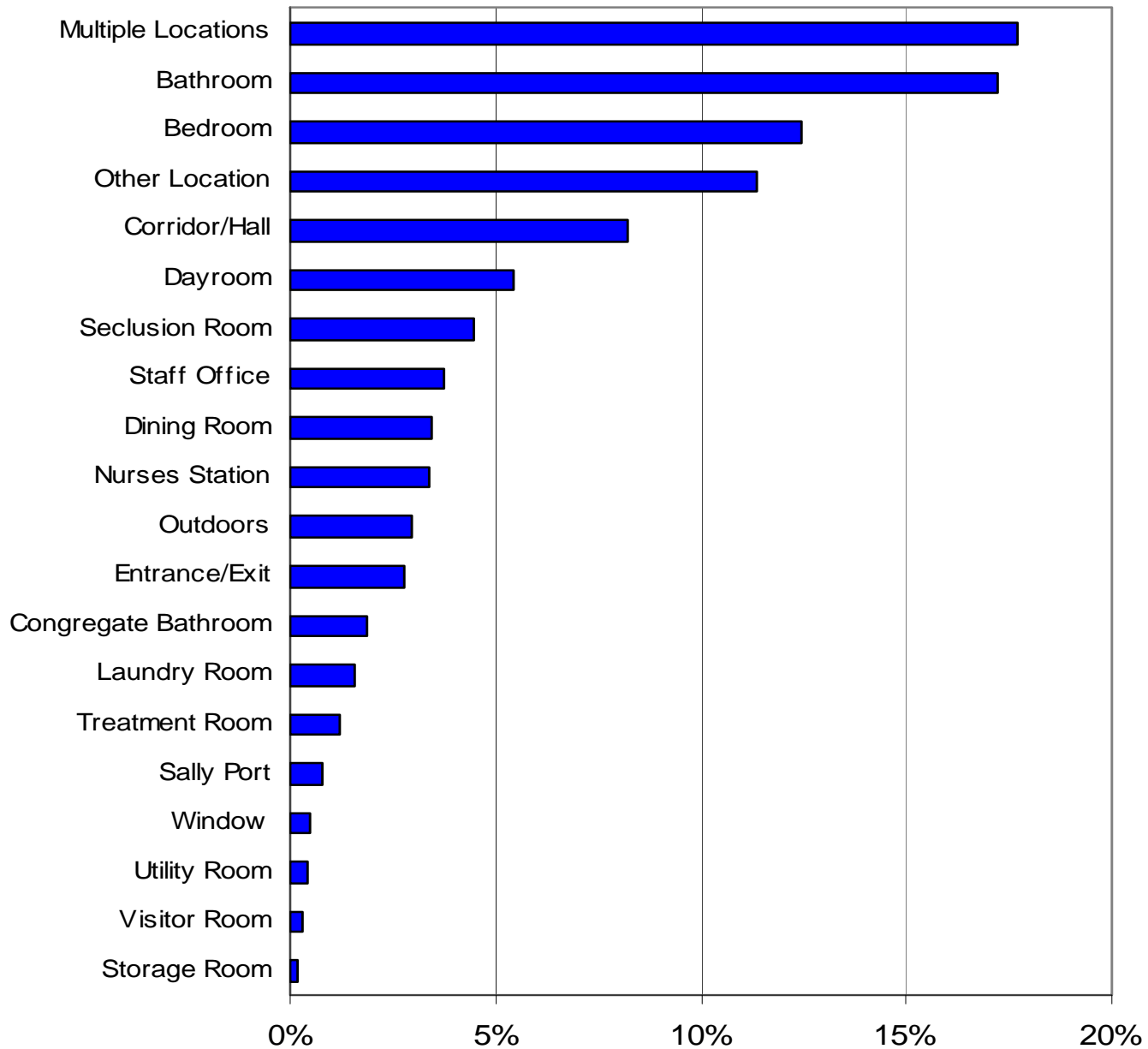
Risk Level Classification Chart

Risk Level Classification Chart				
Mishap Probability	A	B	C	D
Hazard Severity				
I	5	5	4	3
II	5	4	4	3
III	3	2	2	1
IV	2	2	1	1

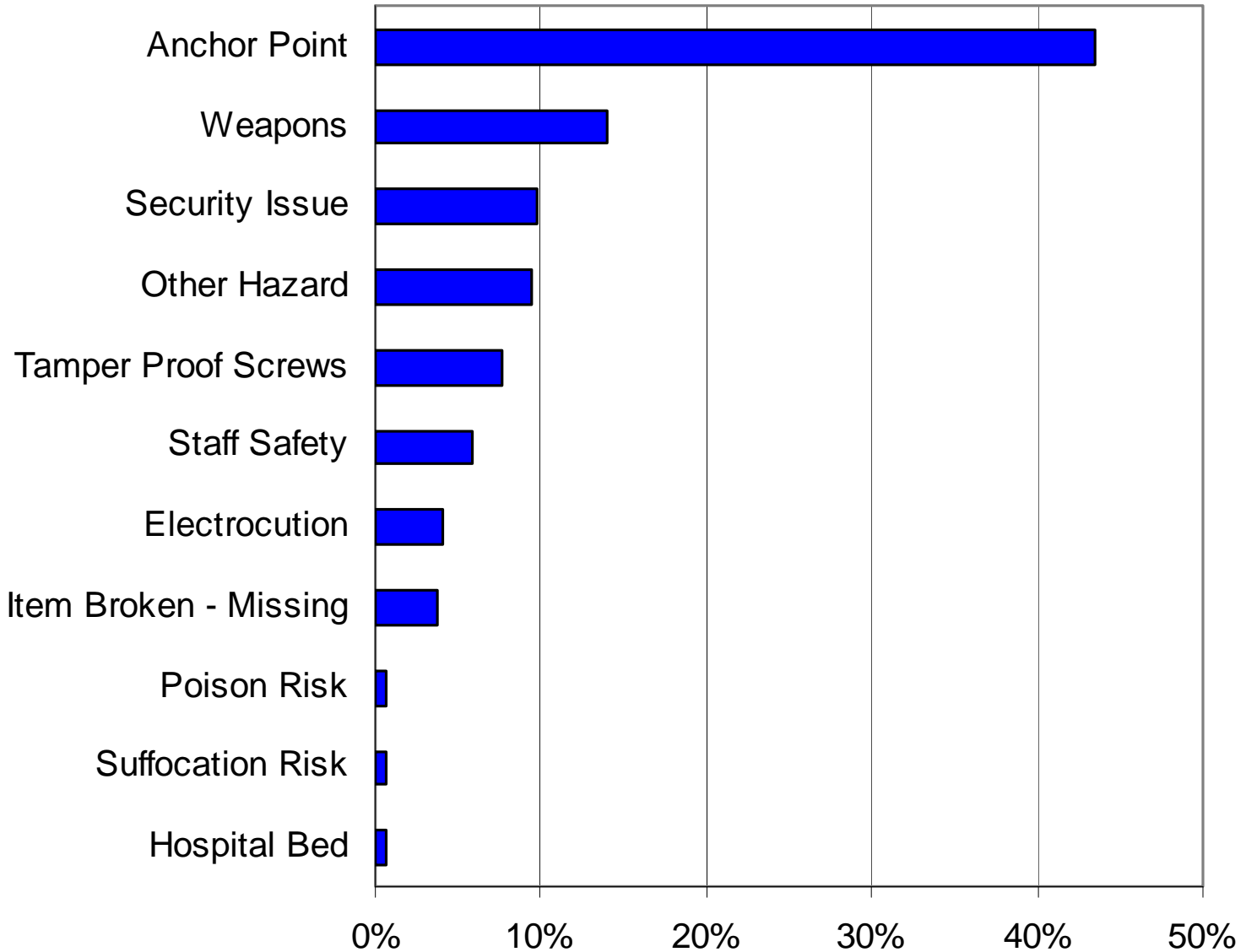
The first 12 months of the MHEOCC

- 113 VA facilities used the checklist to evaluate their mental health units.
- These facilities identified and rated 7642 hazards.
- At the end of the first year of the project, 5834 (76.3%) of these hazards had been abated.
- The next 2 slides show where the hazards were identified and what type of hazards were the most common.

Percent of Total Hazards By Location



Percent of Hazards by Type of Hazard

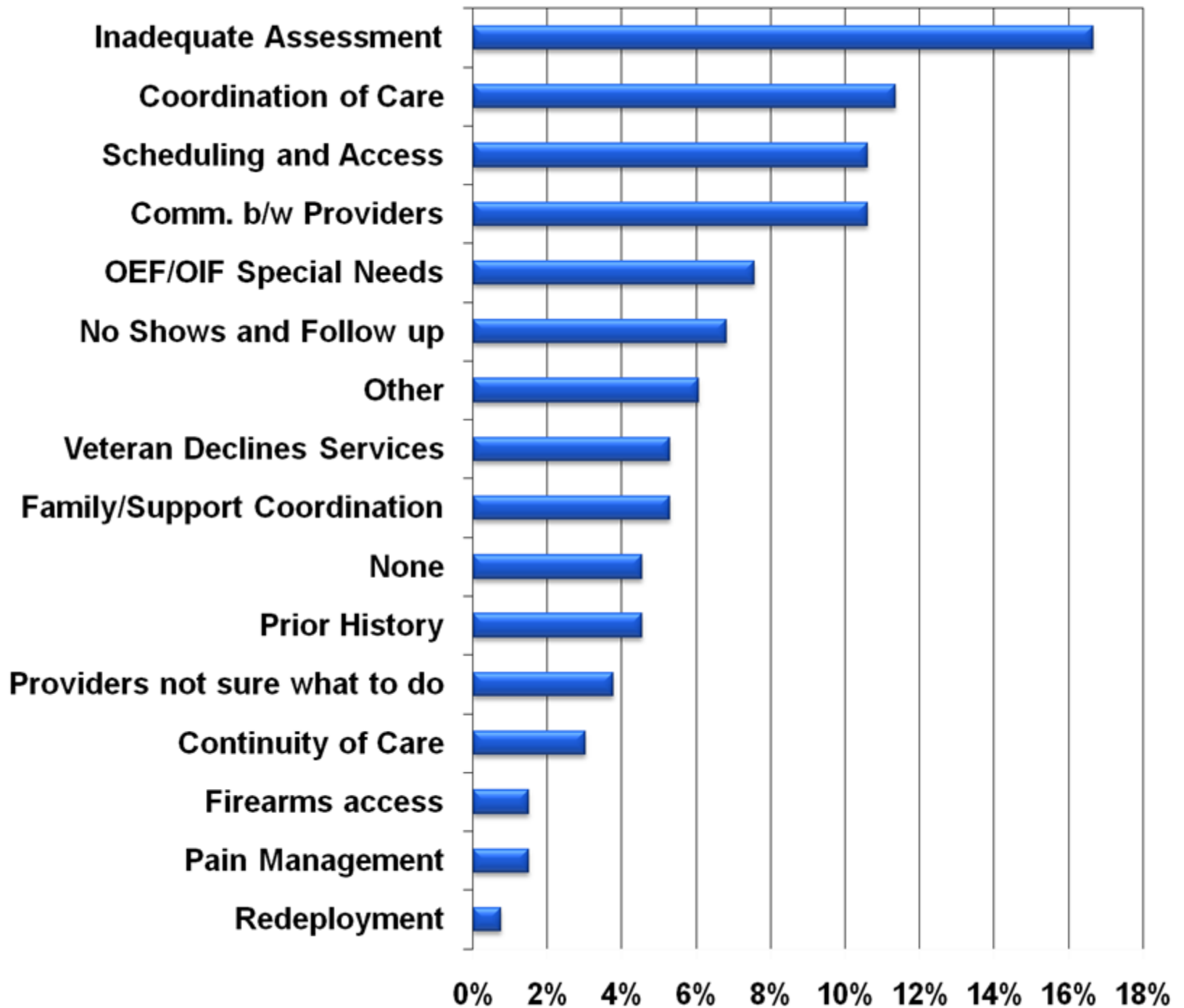


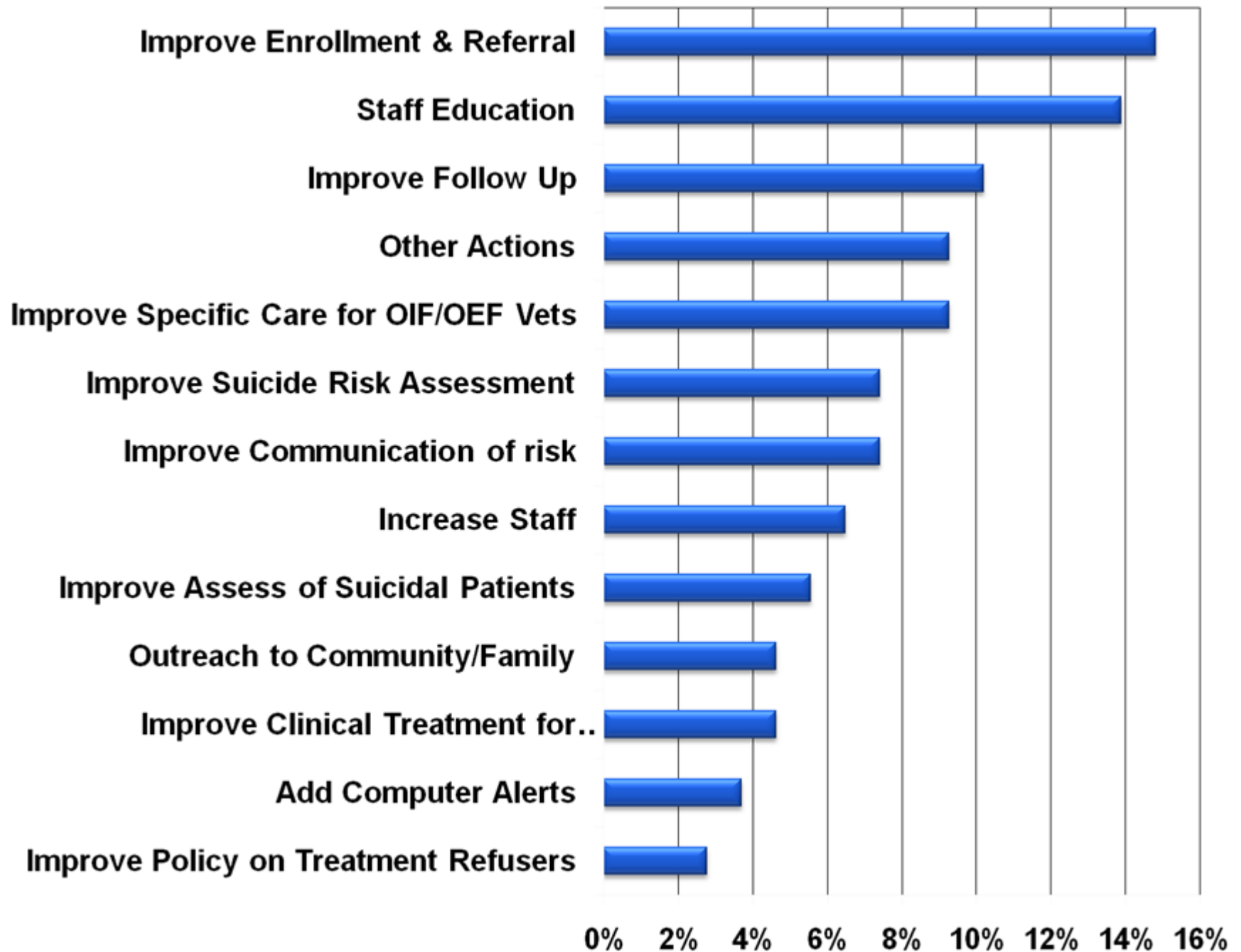
Risk Level of Hazards

- Hazard Type
 - Anchor Points
 - Suffocation Risk
 - Poison Risk
- Room Type
 - Bedrooms had the highest risk level
 - Bathrooms
 - Congregate Bathrooms

Study of Suicide in Recently Returning Veterans

- Fifty-one RCA reports of OIF/OEF suicides were identified between April 2003 (known date of the first RCA done on an OEF/OIF veteran) and July 2008
- 16 common categories among 132 root causes
- 13 categories among 108 recommended actions





Epidemiological Factors

- 63% reported death by firearms, 20% hanging
- TBI most common medical diagnosis
- PTSD most common but not in isolation
 - Depression, Anxiety and Substance Abuse
- Median time after discharge was 15.5 months (range 2-40 months)

Conclusions:

- Review of multiple RCA reports can identify organizational vulnerabilities detected at the local level that may be applicable system-wide. Attention to improving suicide assessment, coordination of care and timely access may have the largest impact on reducing suicide among OIF/OEF veterans.

Questions?



**Department of Defense
Patient Safety Center**

**DoD Patient Suicide Data
Based on RCAs
2000 – 2009**

Pamela Copeland, RN, BSN, JD, ARM

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 The Joint Commission, as reportable to The Joint Commission, shall be reported. The completed RCA and action plan, consistent with The Joint Commission policy and time limits, shall be made available to The Joint Commission.



Reviewable Sentinel Event

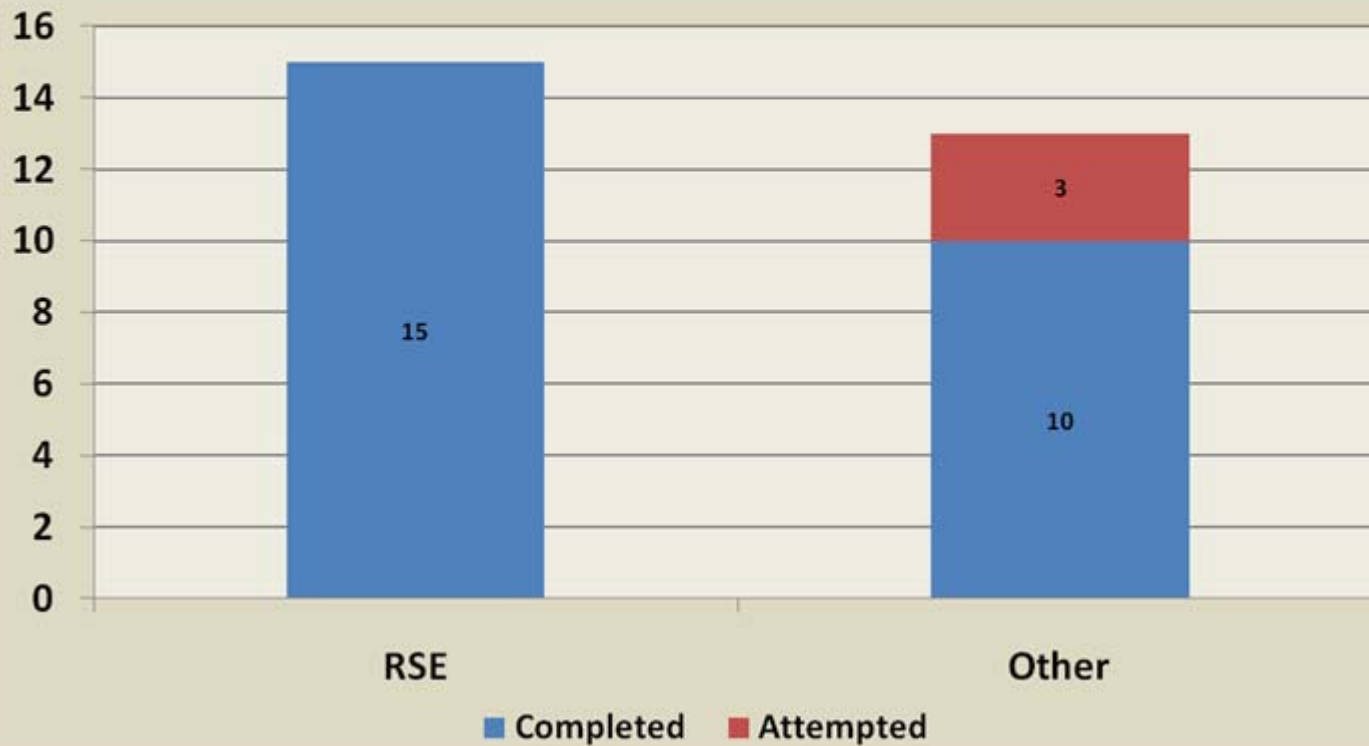
“Suicide of any patient receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of discharge.”

(TJC 2009)

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

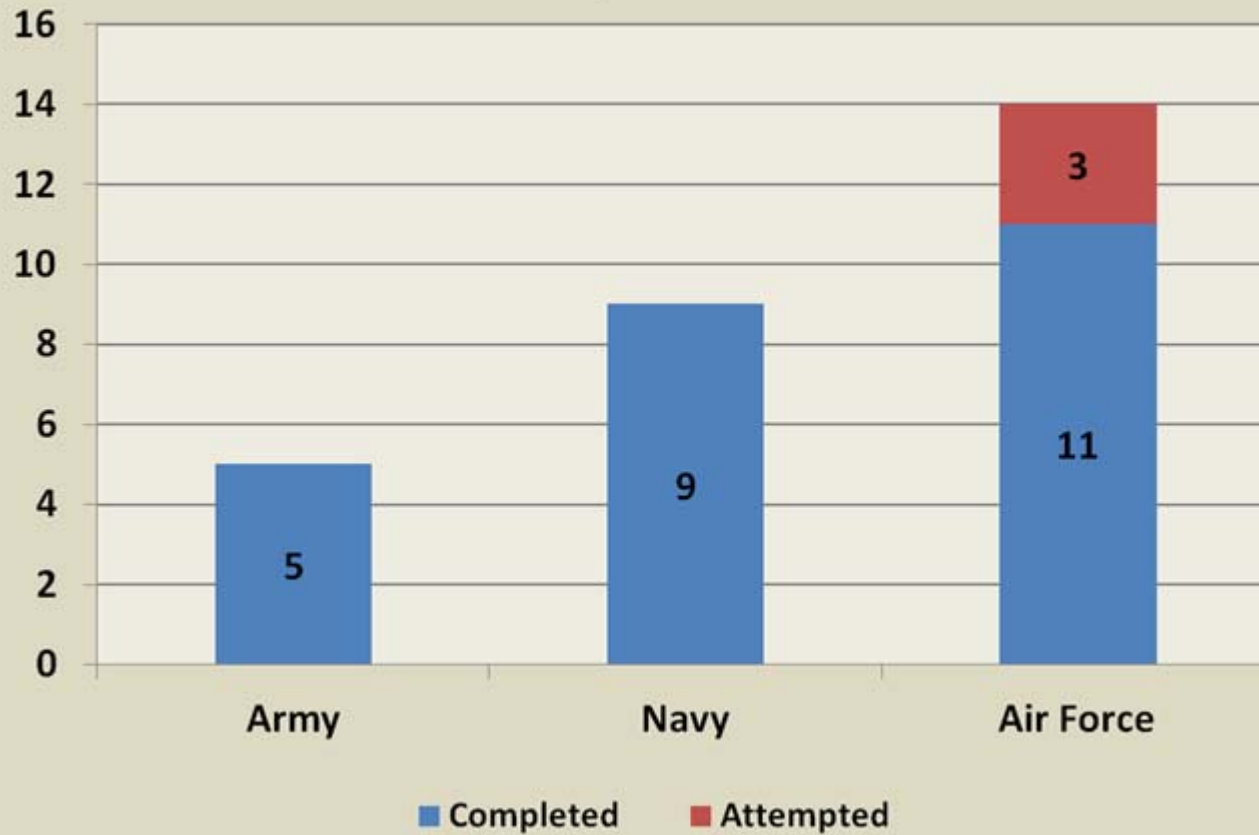


RCA Suicide/Attempted Suicide Events 2000 – 2009



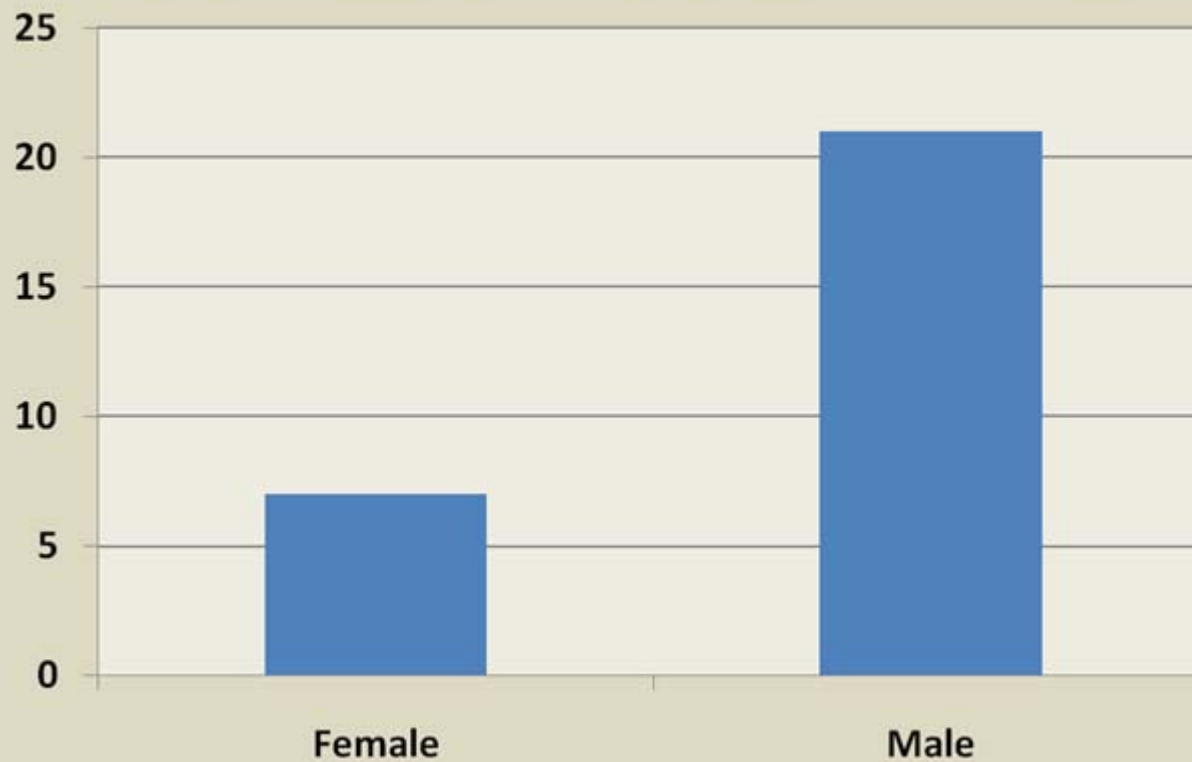


Suicide Events by Service 2000 – 2009





RCA Suicide Events by Gender 2000 – 2009





RCA Narrative Observations

Suicide Profile

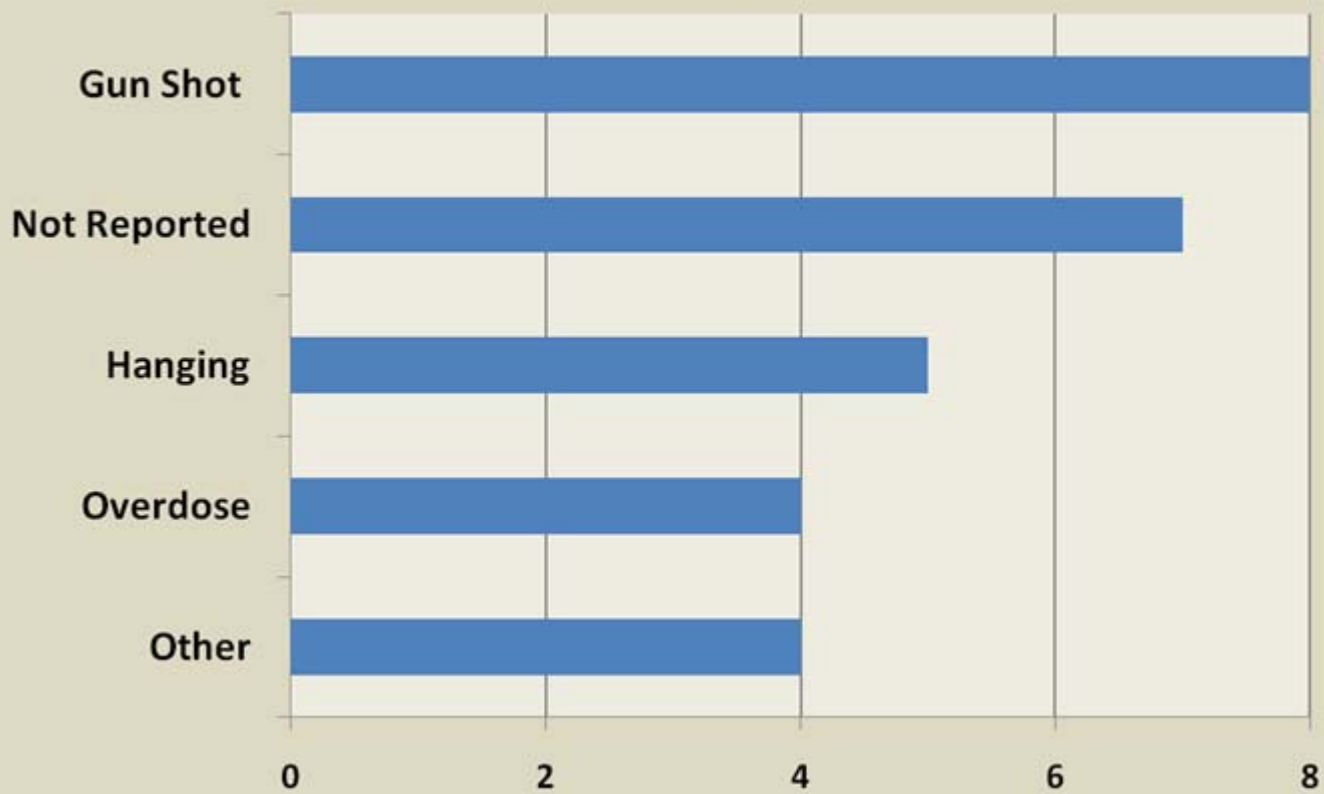
- Expressed suicidal ideation before event
- Previous suicidal gesture/attempt
- Depression
- Anxiety
- Pain
- Substance abuse
- Legal
- Relationships
- Job performance
- PTSD

Age Range

- 19 – 52 (median age 31)

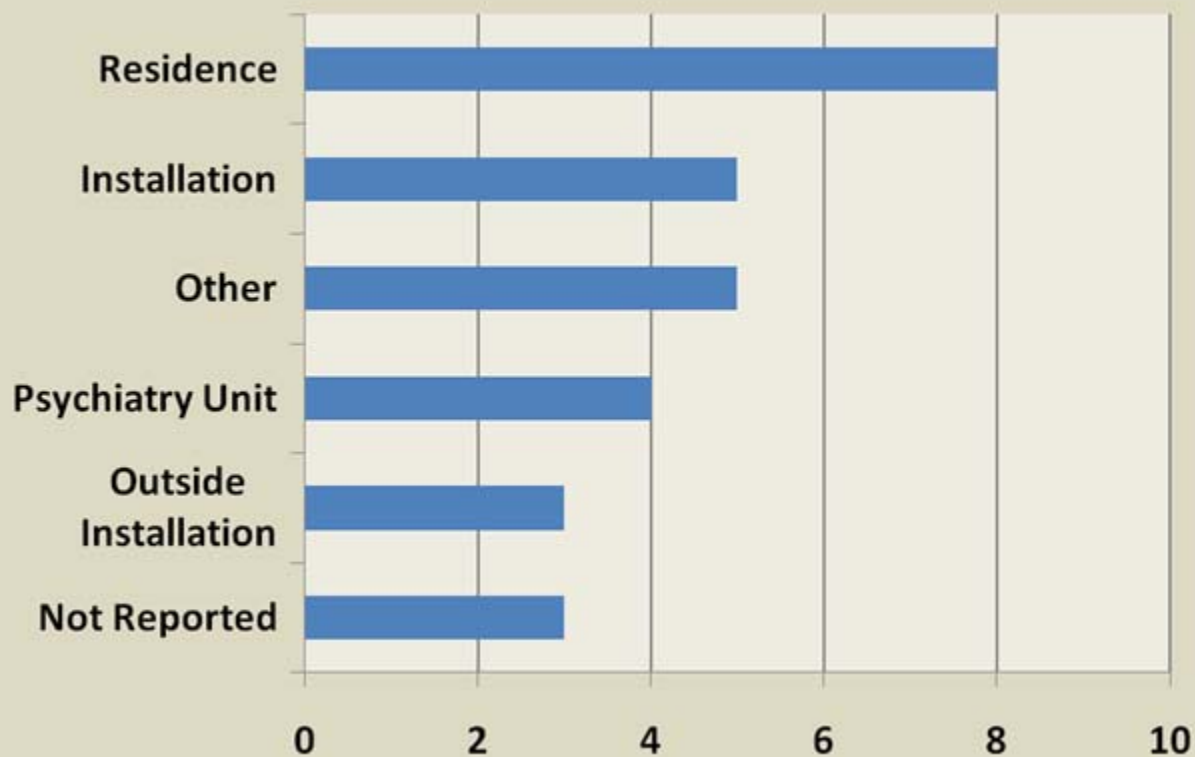


RCA Suicide Events by Method 2000 – 2009





RCA Suicide Events by Location 2000 – 2009





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 too 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**



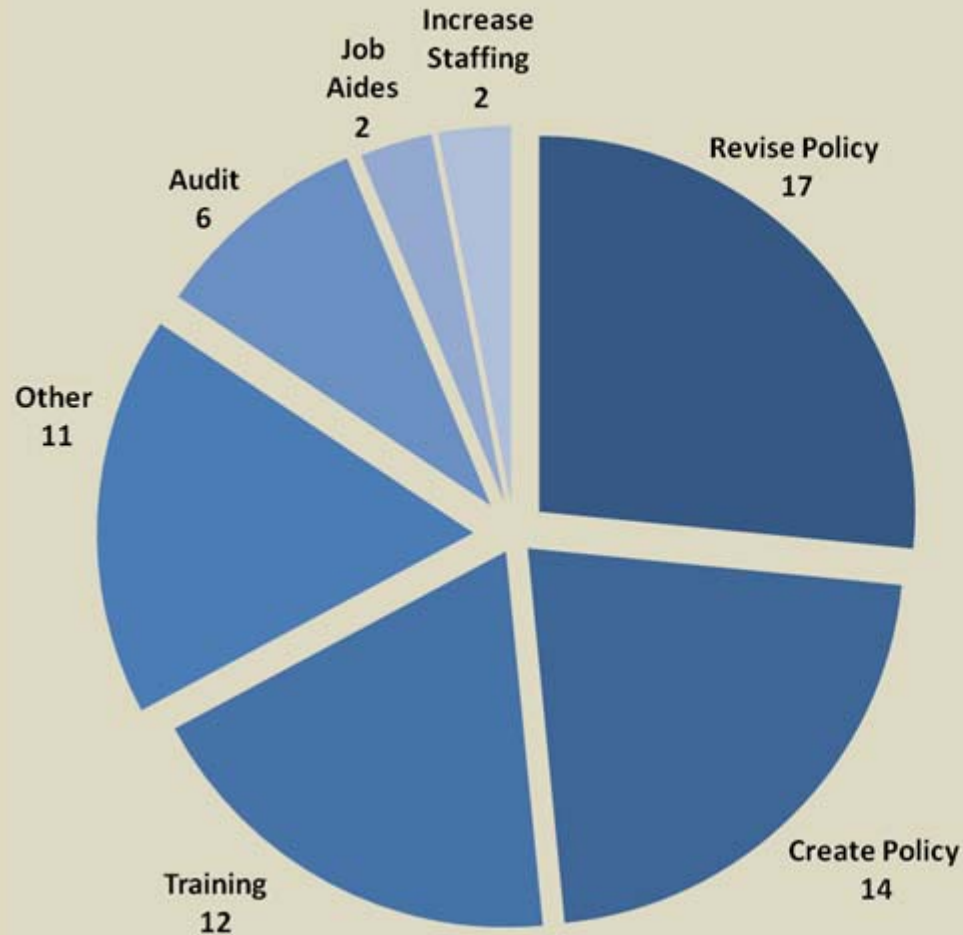
DoD Suicide/Attempted Suicide Contributory Factors

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



Lessons Learned Conveyed

- **DoD Patient Safety Program Newsletter**
- **Planned Focused Review**



Current Initiative

NPSGs # 15 and 15a mandate that a hospital:

- **“identify safety risks inherent in its 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.