The Sentinel Events program captures two categories of reportable events related to suicide:

- Suicide within 48 hours of discharge
- Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a healthcare setting

The Joint Commission (TJC) released Sentinel Event Alert 56 in February 2016; it highlighted the detection and treatment of suicidal patients. TJC found that 21.4% of accredited behavioral health facilities and 5.14% of accredited hospitals are non-compliant with National Patient Safety Goal 15.01.01 that focuses on suicide prevention. Facilities were encouraged to establish suicide screening programs to identify at risk patients and improve suicide prevention. The Sentinel Event Alert offers many resources, including assessment tool links and is found at: https://www.jointcommission.org/sea_issue_56/.

In January 2017, the Agency for Healthcare Research and Quality published information gleaned from the Healthcare Cost and Utilization Project (HCUP) Statistical Brief on ED visits related to suicidal ideation among adults aged 18 years or older in 2006, 2010, and 2013. It found the following:

- Throughout the 7-year time period, the percentage of ED visits related to suicidal ideation that resulted in admission to the same hospital or transfer to another hospital or facility was 3–4 times greater than the percentage of other ED visits that resulted in admission or transfer. In 2013, 71.8 percent of ED visits related to suicidal ideation resulted in admission or transfer compared with 19.4 percent of all other ED visits.
- From 2006 to 2013, the rate of ED visits related to suicidal ideation among adults increased by 12 percent on average annually. By 2013, 1 percent of all adult ED visits involved suicidal ideation.
- Three-quarters of ED visits with suicidal ideation had an associated diagnosis of mood disorders, 43 percent had a substance-related disorder, and 30 percent had an alcohol-related disorder.

In 2013, compared with other ED visits, those related to suicidal ideation were more likely to be among patients who were male, aged 18–64 years and uninsured or covered by Medicaid.

From 2006 to 2013, aggregate ED plus inpatient costs of ED visits related to suicidal ideation that resulted in admission to the same hospital increased from $600 million to $2.2 billion—an average annual increase of 20.4 percent.

Suicide screening and assessment are often used interchangeably, yet have slightly differing purposes and are conducted differently. Experts in suicide prevention generally use the term suicide screening to refer to a procedure in which a standardized instrument or tool is used to identify individuals who may be at risk for suicide. Suicide screening can be done independently, or as part of a more comprehensive health or behavioral health screening. Screening may be done in several ways: with the screener asking questions, or the patient completing the assessment with pencil and paper, or using a computer.

In comparison, suicide assessment refers to a more comprehensive evaluation done by a clinician to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a course of treatment. Although assessments can involve structured questionnaires, they may also include a more open-ended conversation with a patient and/or friends and family to gain insight into the patient’s thoughts and behavior, risk factors (e.g., access to lethal means or a history of suicide attempts), protective factors (e.g., immediate family support), and medical and mental health history.
SUICIDE RISK SCREENING TOOLS CONT.

Utilization of an effective suicide risk tool is imperative as facilities are challenged with adequately and accurately assessing patient suicide risk. According to the Suicide Risk Prevention Center, an instrument should be chosen based on the following:

a. The evidence showing it will be effective with the population you are planning to screen or assess
b. The resources you have available to devote to this activity

Questions to ask when choosing an instrument or approach include:

- Has the instrument been evaluated and found effective?
- Is there a cost associated with using the instrument?
- For what age group was the instrument developed?
- How long does it take to screen or assess an individual?
- Who will conduct the screening or assessment? Paraprofessionals? Health care professionals? Mental health professionals?
- Does using the instrument require training? If so, how expensive is this training, and how many people will you need to train?
- If you are planning to implement screening, are you planning to screen universally or selectively?

Using an effective screening tool for suicide risk is important and it is essential that there are resources in place, and available, for those patients identified as needing services.

POWER OF TRANSPARENCY

Institute for Healthcare Improvement writer Derek Feely shared his thoughts on transparency in healthcare with the article “Facing the Fear of Transparency” (http://www.ihi.org/communities/blogs/_layouts/15/ihi/community/blog/itemview.aspx?List=7d1126ec-8f63-4a3b-9926-c44ea3036813&id=315). Feely wrote, “More than a century ago, pioneering Boston surgeon Dr. Ernest Codman came up with what was then a revolutionary idea. He argued that clinicians should follow patients long enough to evaluate whether the care they received had the desired impact. And, crucially, he argued that health care should share the results of these evaluations with the public.”

The idea, and need for, transparency was propagated over a hundred years ago, yet providers and facilities still find it a challenge to embrace and incorporate this openness. Feely continues by stating that fear prohibits individuals and organizations to be transparent and emphasizes that this fear must be overcome.

IHI’s High-Impact Leadership Framework White Paper (Swensen S, Pugh M, McMullan C, Kabcenell A. “High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs”. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2013. Available at ihi.org) asserts that transparency is one of the five high-impact leadership behaviors, referring to all levels of leadership, not just senior leaders. Furthermore, “Transparency is a powerful catalyst for organizational change and learning. It entails sharing data that demonstrates both positive results and defects, and helps reveal opportunities for improvement. Leaders need to be open and firm about the organization’s commitment to — and expectation for — transparency and a path to action for eliminating defects.”

The IHI White Paper reviews three interdependent parts of leadership that, when combined, define high-impact leadership in health care. These dimensions are:

- New Mental Models-how leaders think about challenges and solutions;
- High-Impact Leadership Behaviors-what leaders do to make a difference;
- IHI High-Impact Leadership Framework-where leaders need to focus efforts.

IHI recommends utilizing the five High-Impact Leadership Behaviors, which are aligned with the above three dimensions, to accelerate changing culture. Transparency is one of those leadership behaviors, and encompasses behaviors that promote:

- Being candid with stakeholders;
- Acknowledging major issues and maintaining motivation to solve them;
- Accountability and trust while promoting learning and self-study; and
- Sharing data that reveals organizational strengths and weaknesses and opportunities for improvement.

Furthermore, leaders at all levels need to be resolute that the organization expects and is committed to transparency. This allows for multiple leaders to be accountable for creating and authentically demonstrating transparency in their decision making and daily interactions.

Transparency across the organization is broad and involves collection and assessment of data in health outcomes, use of services, and care costs. Organizations must have information systems in place that provide the data required for identification of gaps so those gaps can be addressed.
An article by Sadler and Stewart, “Leading in a crisis: the power of transparency” (The Health Foundation, December 2015), further discusses transparency, including what inhibits it. They found there are five specific factors that inhibit healthcare transparency:

- **Fear of litigation**—may cause clinicians to say less instead of more when something goes wrong;
- **Insufficient training for clinicians and managers**—there is a lack of communication skills impeding the ability to engage in difficult conversations with patients;
- **Negative media coverage**—many organizations fear negative publicity and should instead learn how to deal with it honestly and transparently through use of developing a collaborative and positive relationship with the media;
- **Lack of transparent and effective leadership**—effective and courageous leadership is essential in a crisis, but frequently organizations have not been clear with leaders about expectations. Do leaders know how to respond and will they be supported; and
- **Unrecognized second victim effects**—when a patient suffers an adverse event, the clinician may also suffer adverse effects professionally and personally. These effects are mitigated with a collaborative and supportive work environment instead of a punitive approach that erodes transparency.

The following recommendations are offered by Sadler and Stewart to create an organization that supports transparency: embrace and model an organizational culture of transparency; develop and implement adequate training programs for effective communication; commit to learning from failings; actively support compassionate patient, family, and employee communication; recruit, develop, and support leaders who act with courage and transparency; and design, disseminate and regularly test a crisis management plan. When a crisis event does occur there are several recommendations offered for leaders including the most basic, “Commit to a culture of transparency. It is the platform on which everything else rests.”
UPDATES FROM THE SENTINEL EVENT TEAM

The SET on-site review at O.A. Center for Orthopaedics identified ‘best practices’ in two areas. The resources available through the pharmacy consultant were comprehensive and included a newsletter, new medication lists, quarterly reports, internal reviews that included benchmarking and follow up on items from prior visits, and competency tests. Additionally, the use of a hand-off communication tool between the pre-op, OR, and PACU nurses and anesthesiology, as well as the use of the WHO surgical safety checklist were found to be contributing factors to promoting patient safety.

The SET is planning an educational session on May 8, 2017 in Augusta on Systems Analysis and RCAs with Jeff Brown and Angela Gibbs. This will be an all-day training. This is intended for those working in quality/risk/safety. Additional details will be forthcoming.

The 8th annual Maine Patient Safety Academy will be held on September 29, 2017. Registration for the Patient Safety Academy will open later this spring.

FYI-Medication events are currently the third most reported Sentinel Event in 2017.