Managing Ligature Risks and Preventing Patient Self-Harm

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Conflict of Interest Disclosure

Christopher Allman and Claudia Gering do not have any real or apparent conflict(s) of interests or vested interest(s) that may have a direct bearing on the subject matter of the continuing education activity.
Learning Objectives

This presentation will enable participants to:

• Identify the ligature risks in behavioral health, emergency department and inpatient settings and the expectations of healthcare organizations from a regulatory and accreditation perspective.

• Develop an understanding of the most prudent strategies for preventing self-harm in behavioral health, emergency department and inpatient settings.

• Learn the importance of a ligature risk assessment and the mitigation of ligature risks.
Background – Why is there a Seemingly “Sudden” Focus On Ligature Risks?

• Suicide is the 10th most common cause of death in the U.S.
• Inpatient suicide was identified as a “never event” in 2006 by CMS.
• The suicide rate has increased more than 25% from 1999 to 2016 (CDC).
• In 2015, 83 suicides occurred in medical facilities (National Violent death Reporting System); 89 suicides were reported in Joint Commission accredited hospitals alone in 2016-17 (AHRQ).
• In general, accrediting bodies are intensifying efforts to make health care environment safer.
Some Issues Still Exist, Though...

- Ligature and Suicide Risk Reduction – Video Monitoring of Patients at High Risk for Suicide: Can video monitoring/electronic-sitters be used to monitor patients at high risk for suicide? The use of video monitoring or “electronic-sitters” would not be acceptable in this situation because staff would not be immediately available to intervene. The use of video monitoring would only be acceptable as a compliment to the 1:1 monitoring, and not acceptable as a stand-alone intervention. *HFM* (5/15/19)

- Chicago’s Rush University Medical Center Temporarily Closes Mental Health Units Over Patient Safety Concerns: “Rush University Medical Center has temporarily closed its three inpatient mental health units following concerns from the state about patient safety.” Rush “closed the units in late March after the Illinois Department of Public Health found deficiencies in how the hospital protects its psychiatric patients from harming themselves through hanging or strangulation, according to a department report done on behalf of the federal government.” *The Chicago Tribune* (5/31, Schencker)
Some Issues Still Exist, Though…

• TJC and/or state agencies have disagreed on what constitutes a ligature risk and what mitigation strategies are acceptable.

• There needs to be consensus: TJC, CMS, VA, leading Hospital systems, Mental Health Administrators, Medicaid.

• The Joint Commission believes the ongoing work of the panel will be an important resource for our country in trying to reach national consensus on the many challenging issues involved in caring for suicidal patients.
Definition – For our Purposes, anyway...

- Definition of a Ligature Risk: A ligature risk (point) is defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. (CMS)

- Ligature points could include shower rails, coat hooks, pipes, and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures.
“Ligature-Resistant” vs. “Ligature-Free”

• Is it realistic to remove all the potential ligature risk points to be “ligature-free”?
• “Ligature-resistant” is the preferred term.
• Definition of ligature-resistant: “Without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life.”
• In 7/2019 guidance, TJC uses the term “ligature-resistant”
New CMS Regulations

• CMS has issued recent directives (S&C 18-06 and updated 4/19/2019 CMS Draft Memo) for ensuring the safety of psychiatric patients whether
  – housed in a designated psychiatric unit,
  – the ED,
  – on a medical/surgical unit, or
  – where risk is identified by the hospital.

• Hospital Administrators need to be aware of the financial impact associated with ensuring a safe environment.

• Per CMS, deficiencies addressed in a Plan of Correction (PoC) are required to be corrected within 60 days from the last day of survey. (Not new.) 42 CFR §488.28
  – Per 4/19/2019 Draft Memo, POC can be filed after 60 days, upon good cause shown
Ligature Risk deficiencies should be removed prior to an accreditation survey as citations for ligature risks are NOT ELIGIBLE for Life Safety Code waivers (LSC) or equivalencies.

Unique requirements for:
- Psychiatric Hospitals
- Psychiatric Units of an acute care hospital
- Patient rooms/adjoining bathrooms in areas above

Different requirements for:
- Non-psychiatric units in acute care hospitals

Application to Critical Access Hospitals is effective July 1, 2020.
What Do the Regulations Require?
TJC General Requirements and Revised NPSG as of July 1, 2019

• Performance of an environmental risk assessment that identifies features in the physical environment presenting a suicide risk and taking steps to minimize such risk;
• Use of a validated suicidal ideation screening tool for all patients who are being evaluated or treated for behavioral health conditions as their primary reason for care;
• Use of an evidence-based suicide risk assessment for individuals who have screened positive for suicidal ideation;
• Documentation of each individuals’ overall level of risk for suicide and the plan to mitigate the risk for suicide;
• Implementation of written policies and procedures addressing the care of patients identified as at risk for suicide, including staff training and competence assessment, guidelines for reassessment and monitoring of high risk patients;
• Implementation of written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide; and
• Monitoring implementation and effectiveness of policies and procedures for screening, assessment and management of patients at risk for suicide and taking action as needed to improve compliance.
Suicide Prevention

Recommendations for Inpatient Psychiatric Units

• Must be ligature-resistant in the following areas:
  – Patient rooms
  – Patient bathrooms
  – Corridors
  – Common patient care areas

• Nursing stations with an unobstructed view (so that a patient attempt at self-harm at the nursing station would be easily seen and interrupted) and areas behind self-closing/self-locking doors do not need to be ligature-resistant and will not be cited for ligature risks
Recommendations for Inpatient Psychiatric Units

• Doors
  – between patient rooms → hallways ligature-resistant hardware which includes, but may not be limited to, hinges, handles, and locking mechanisms.
  – Instead of mandatory use of these unproven devices, organizations should note such doors on their environmental risk assessments and describe their mitigation strategies, such as appropriate rounding and monitoring by staff, requiring that doors be left open during certain hours, and so on.

• Transition zone (patient rooms → patient bathrooms) must be ligature-resistant
  – Mechanical solutions: Examples: removing BR door, alarm on the door, and using a special door designed to prevent using the top to support a ligature (for example, an angled upper edge or breakaway magnetic hinges).
  – Behavioral solution: denying BR access unless w/staff; this still requires having the profile of the door be ligature-resistant. Note that some states do not allow modifications or removal of doors due to privacy concerns.
Suicide Prevention

- **Recommendations for Inpatient Psychiatric Units**
- **Ceiling**- patient rooms and bathrooms be solid, drop ceiling is not acceptable alternative.
  - drop ceilings can be used in hallways and common patient care areas if all aspects hallway fully visible to staff and there are no objects that patients could easily use to climb up to the drop ceiling, remove a panel, and gain access to ligature risk points above drop ceiling.
- **Beds**- to meet both medical and psychiatric needs
  - For patients who require medical beds with ligature points, there must be appropriate mitigation plans and safety precautions in place
- **Standard toilet seats** with hinged seat/lid are not a significant risk, should not be cited during surveys, no need to note on risk assessment
Suicide Prevention

Recommendations for General Acute Inpatient Settings

• does not need to meet the same standards as an inpatient psychiatric unit
• Fixed ligature risks, including bathroom fixtures and doors, will not be cited on survey in these areas

• **Serious suicidal ideation**-remove potential risk objects of self-harm; mitigating strategies in place and documented, including:
  - 1:1 monitoring, assess items brought by visitors, and transporting protocols to areas of the hospital (such as radiology)

• Organizations should have policies, procedures, training, and monitoring systems in place to ensure these are done reliably.
Suicide Prevention

**General Acute Inpatient Settings**

- TJC cites ligature if the organization cannot demonstrate that all of the following are routinely and rigorously done:
  - Training & testing staff competency re: serious suicidal ideation situation
  - 1:1 monitoring of patients with serious suicidal ideation
  - Conducting risk assessments for objects that pose a risk for self-harm and identifying those objects that should be routinely removed
  - Monitoring of visitors
  - Monitoring of bathroom use for a patient with serious suicidal ideation
  - Implementing protocols to have qualified staff accompany patients with serious suicidal ideation from one area of the hospital to another
Suicide Prevention

Recommendations for Emergency Departments

• Do not need to meet the same standards as IP psychiatric unit
• Fixed ligature risks, including bathroom fixtures and doors, will not be cited on survey in these areas
• Two main strategies:
  – Place the patient in a “safe room” that is ligature-resistant or that can be made ligature-resistant (for example, a locking cabinet), and
  – keep the suicidal patient in the main area of the emergency department, initiate continuous 1:1 monitoring, and remove all objects that pose a risk for self-harm that can be easily removed without adversely affecting the ability to deliver medical care.
• They do state that continuous 360-degree video monitoring of these patients is permitted, however the person monitoring the video must be continuously observing and be close enough to immediately intervene if needed. Thus, remote telemonitoring would not be permitted.
Suicide Prevention

Recommendations for Emergency Departments
“Safe Rooms” -- TJC does not mandate use in ED

• Organizations should do all of the following to protect patients:
  – Screen all patients presenting with psychiatric disorders for suicidal ideation
  – Formally assess the risk of a suicide attempt among patients with suicidal ideation (“secondary screening”)
  – Conduct a risk assessment for objects that pose a risk for self-harm and routinely removed
  – Have a protocol for removing all movable items that could be used for self-harm from within reach of a patient with suicidal ideation
  – Have protocols for monitoring patients with suicidal ideation, including the use of the bathroom, and how to ensure that visitors to not bring objects that could use for self-harm.
  – Have a protocol to have qualified staff accompany a patient with serious suicidal ideation from one area of the hospital to another.
  – Train staff and test them for competency on how they would address a situation with a patient with serious suicidal ideation.
Ligature Risk Assessment

• Unless you are willing to spend significant sums of money, you will likely not be able to fix all of the problems at once.

• From our experience, what the accreditation bodies want to see is that a proper risk assessment has been done, and there is a solid plan to mitigate your facility’s ligature risks in:
  – Behavioral Health Setting
  – General Acute Care Setting
  – Emergency Room
Inpatient Behavioral Health

Risk Assessment
BH Key Area Assessment: Doors

• Doors between patient rooms and hallways must contain ligature-resistant hardware.
• Doors components to assess include, but are not limited to:
  – Door hinges
  – Door handles
  – Door locking mechanisms
  – Door closers / magnets
• Can any hardware be used to attach a ligature?
BH Key Area Assessment: Doors

• Note such doors on environmental risk assessments – AND

• Describe your mitigation strategies, such as:
  – Appropriate rounding & monitoring by staff,
  – Require doors be left open during certain hours, and so on.

• **NOTE: Surveyors will enter a finding if this risk assessment and mitigation strategy is not done.**
BH Key Area Assessment: Transition Zones

- The transition zone between patient rooms and patient bathrooms must be ligature-free or ligature-resistant.
- This may be accomplished with mechanical or behavioral solutions. Examples of mechanical solutions include:
  - Remove the bathroom door (may not be allowed in some states due to privacy concerns)**.
  - Place an alarm on door to prevent inappropriate use.
  - Use a special door designed to prevent using the top to support a ligature (for example, an angled upper edge or breakaway magnetic hinges).

**Note: Surveyors must survey in accordance with the state regulations. Please be prepared to explain these additional requirements to the surveyor.
BH Key Area Assessment: Transition Zones

• The most common behavioral solution:
  – Deny access to the bathroom unless staff is present
  • This still requires having the profile of the door be ligature-resistant in the closed arrangement.
BH Key Area Assessment: Ceilings

• *Patient rooms and bathrooms must have a solid ceiling.*
  
  – In these areas, a drop ceiling is **NOT** an acceptable alternative.

**NOTE: Surveyors will enter a finding if hard ceilings are not provided at patient rooms and adjoining bathrooms.**

• 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 – **AND**
  
  – There are no objects that patients could easily use to climb up to the drop ceiling, remove a panel, and gain access to ligature risk points in the space above the drop ceiling.
BH Key Area Assessment: Ceilings

• Drop ceilings in corridors or monitored rooms that are not fully visible to staff:
  – Note on the risk assessment.
  – Have an appropriate mitigation plan. Mitigation strategies for existing drop ceilings may include:
    • Glue the tiles in place,
    • Use tile retention clips,
    • Install motion sensors above the ceiling to sense tampering,
    • Use another comparable harm-resistive arrangement.
• The acceptability of these strategies depends upon the physical capabilities of the patient population. (Geriatric vs. adolescent units.)
• **NOTE: Surveyors will enter a finding if this risk assessment and mitigation strategy is not done.**
BH Key Area Assessment: Toilets

• Standard toilet seats with a hinged seat and lid are NOT a significant risk for suicide attempts or self-harm; commercial style open seats should be provided.

• Generally, facilities should not be cited during surveys and do not need to be noted on a risk assessment.

• Toilet Seats Risks:
  – Only one case where a patient attempted suicide by using a toilet seat
  – No harm occurred in this incident.
  – Statistically, traditional toilet seats are as safe as toilets without movable seats and covers
Patient assessment is also critical to your risk assessment
Your should have documented:
  – Medical needs and risk for suicide (Clinical)
  – Determination of the optimal type of patient bed utilized to meet both medical care and psychiatric needs.
  – For medical beds with ligature points, you should have an appropriate mitigation plan and safety precautions in place.
General Inpatient Population

GMF, Acute, Non-BH
IP Key Area Assessment

• These spaces do NOT need to meet the same standards as an inpatient psychiatric unit to be a ligature-resistant environment.
• These areas can contain fixed ligature risks, including bathroom fixtures and doors. These will generally not be cited on survey within these areas when risk-assessed.
• Inpatients admitted to or treated in medical/surgical settings may:
  – Be patients with serious suicidal ideation
  – Require equipment to monitor and treat their medical conditions
  – Be put in a space or environment that is impossible to make fully ligature-resistant but require mitigation
IP Key Area Assessment - General

• Patients admitted with serious suicidal ideation:
  – Remove objects that pose risk – and –
  – Mitigating strategies must be put into place and documented including:
    • 1:1 patient monitoring
    • Stopping & assessing objects brought by visitors prior to visitors entering a room
    • Establish protocols for transporting patients and providing treatment while in other areas
IP Key Area Assessment - General

• Hospitals must:
  – Have policies and procedures
  – Provide staff training; test for competency
  – Routine implementation of strategies:
    • 1:1 patient monitoring
    • Remove objects with potential for harm
    • Assess objects prior to persons entering room
    • Monitor bathroom/commode use
    • Protocols include staff accompany patients when transported to other areas
Emergency Department Key Assessment Areas
Yet another set of standards
ED Key Area Assessment - General

• Emergency Department differences:
• Preparation of the environment does not need to meet the same standards as an inpatient psychiatric unit. Specific areas may need to be capable of becoming a ligature-resistant environment.
• Fixed ligature risks, including bathroom fixtures and doors, will not be cited on survey in these areas when listed on the risk assessment for the area.
• Patients in the ED may require equipment to monitor and treat their medical conditions.
• It is impossible to make the at-risk patient environment fully ligature-resistant in the ED.
ED Key Area Assessment - General

• Keeping patients safe in the ED...

• “Safe Room”:
  – Option: Place suicidal patient in a room that is ligature-resistant / capability to make ligature-resistant.
  – If a locked door is provided, the room must be dedicated to only psychiatric patients at-risk of self harm.

• “Other” rooms for patients with serious suicidal ideation should provide ALL of the following:
  – Stay in main area of the ED close to nurse’s station – AND –
  – Continuous 1:1 monitoring – AND –
  – Remove all objects that are a risk for self-harm
ED Key Area Assessment - General

• Follow your protocol/policies for keeping patients safe in the ED.
• ED screening to identify patients with psychiatric disorders for suicidal ideation (clinical) and the level of risk
• Assess environment and remove objects that are a risk of harm / self-harm (cross-coordinate all physical environment assessment with facilities)
• Written protocol for patient monitoring, e.g.,
  – Bathroom use
  – Ensure visitors do not bring objects with potential for harm
• Written policy and procedure for:
  – Qualified staff accompany patients with psychiatric disorders for suicidal ideation when transported throughout the facility
  – Staff training and competency: Situations with a patient with suicidal ideation
ED Key Area Assessment - General

• For patients with suicidal ideation – Hospital policy addresses when to have:
  – Patient under 1:1 continuous monitoring
  – 360 degree observation of patients
  – Continuous video monitoring
  – Link the monitoring to the provision of immediate intervention by a qualified staff member.
• Remember the recent ruling on video monitoring...
Mitigation plans must include, at a minimum the following:

- Ensuring that leadership and staff are aware of the current environmental risks.
- Identifying patients’ risk for suicide or self-harm, then implement appropriate interventions based upon risk.
- Ongoing assessments and reassessments of at-risk behavior as defined by the organization.
- Ensuring the proper training of staff to properly identify patients’ level of risk and implement appropriate interventions.
- Incorporating suicide risk and self-harm reduction strategies into the overall Quality Assessment/Performance Improvement (QAPI) program.
- If equipment poses a risk but is necessary for the safe treatment of psychiatric patients (i.e. medical beds with side rails on a geriatric unit), the organization must consider these risks in patients’ overall suicide/self-harm risk assessments, then implement appropriate interventions to diminish those risks.
Questions?
Thank you!

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