Agenda

Learning Outcomes

1. Describe the phenomenology of suicide and how you build your assessment from it.
2. Perform a risk assessment for suicide using the AIDE algorithm identifying risk factors, protective factors, warning signs related to suicide
3. Demonstrate how to document the risk assessment to include the environment, warning signs, interventions, shared safety plan and who this is communicated to.

Statistics
Suicidal Behavior Among Adults in the United States, 2012 (≥18 years of age)

Number (and ratio) of persons affected by suicidal behavior among adults aged ≥ 18 years, United States, 2012

- 30,426 (1) Deaths
- 129,205 (3.3) Hospitalizations
- 405,000 (10.3) Emergency Department Visits
- 1,129,000 (32.7) Suicide Attempts

Source: Personal communication, Alex Crosby, CDC, 2016
Ideation, Attempts, and Medically Treated Attempts by Sex, United States, 2014

Number of Individuals

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal ideation</td>
<td>4,437,000</td>
<td>4,599,000</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>445,000</td>
<td>676,000</td>
</tr>
<tr>
<td>Medically treated suicide attempts</td>
<td>261,000</td>
<td>357,000</td>
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</tbody>
</table>

Source: National Survey on Drug Use and Health, 2014

Ideation and Attempts Among Adults by Age, United States, 2014 (≥18 years of age)

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Suicidal ideation</th>
<th>Suicide attempts</th>
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</thead>
<tbody>
<tr>
<td>18-25</td>
<td>7.4%</td>
<td>0.5%</td>
</tr>
<tr>
<td>26-49</td>
<td>4.0%</td>
<td>2.7%</td>
</tr>
<tr>
<td>50 or older</td>
<td>0.2%</td>
<td>0.2%</td>
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</table>

Source: National Survey on Drug Use and Health, 2014
Acute Care Suicide Competency Education

Phenomenology of Suicide (Competency 1)

1. Identify basic terms related to suicidal thoughts and behaviors.
2. Summarize statistics and epidemiology related to suicide.
3. Discriminate risk and protective factors and warning signs related to suicide.
5. Explain the suicide phenomenon from the consumer perspective.

Describe what the need is for Competency Based training?
Suicide Fact Sheet / Medical-Surgical In-Patient

Suicide: According to the CDC, suicide is when people direct violence at themselves with the intent to end their lives, and they die as a result of their actions. It is a conscious decision to end one’s life as a result of self-directed violence.

Suicide Attempt: Self-directed violence with the intent to die, however, the person lives; however, they often suffer serious injuries. People who survive suicide attempts may also suffer from a mental illness.

- Suicide is the 10th leading cause of death in the United States of America (1) CDC
- Suicide affects every age group (1)
  - Women attempt suicide more than men
  - Men die by suicide more than women
  - The highest suicide rates are for those >85 yo, second highest group are individuals who are between 45 – 65 years old
  - The prevalence of thinking about, making plans or attempting suicide is higher among adults aged 18-29
  - Some ethnicities are at higher risk for suicide (American Indian, Alaska Natives, rural populations, and active or retired military personnel).
- Over 494,000 people with self-inflicted injuries were treated in U.S. emergency departments in 2013 (1)
- Many people at risk for suicide however having a risk factor does not always mean a suicide will occur (1)

Does Suicide Occur on a Medical / Surgical / ICU Unit?

- Suicide occurs 1.8 per 100,000 admissions or 2% in international general hospitals (2)
- In a large VA cohort, inpatient suicide rate per million was 0.6% with most common methods being overdose, hanging, and gunshot. Cutting with a sharp object was most common method for suicide attempt which did not result in death. (Mills)
- In a study involving 8 Mental Health Research Network health systems, nearly all individuals who died by suicide received health care in the year prior to death (83%), but half did not have a mental health diagnosis. 2.9% had been hospitalized on non-psych / non-ER, 4 weeks prior to suicide. (Ahmedani)
- Risk factors for suicide in a general hospital are: 2, 3, 5 (Martielli, Mills, Sakinofsky)
  - The degree of chronicity and severity of the disease (chronic pain, chest pain or non-myocardial infarction).
  - Previous / recent attempted suicide, hopelessness, social stressors
  - The existence of psychiatric co-morbidity or “known at risk for suicide” (substance misuse, alcohol detoxification, depression, agitation, personality).
  - Note that suicides occur with persons “unknown at risk” 5 (Sakinofsky)
- Persons that have a physical illness are at higher risk for suicide
  - There is an increased suicide risk in the elderly with diagnoses of CHF, COPD, Seizures, and Urinary Incontinence. 6 (Juurink)
  - The incidence of suicide in patients with cancer in the U.S.A. is approximately twice that of the general U.S. population. A higher incidence was associated with male sex, white race, being unmarried and with advanced disease at diagnosis. 7 (Misono)
- Factors that can increase suicide risk while hospitalized 3 (Mills)
  - Underestimation of risk of suicide by team, inadequate assessment and supervision.
  - Poor communication within teams (problems communicating suicide risk).
  - Lack of knowledge on how to prevent in-patient suicide.
  - Low rate of psychiatric consultation. 2 (Martielli)

Preventing Suicide is a vision we can all share.
- Screen for suicide risk
- Assess further (intent)
- Treat suicidality and mental illness directly
- Restrict lethal means and ensure safe environment
- Collaborate with patient in safety planning
- Provide and plan for continuous support
- Leadership that stresses safety – oriented culture
- Competent & caring workforce
- Document

Joint Commission: Practice Alert #56 (Feb 2016)
Psychiatric-Mental Health Nurse Essential Competencies for Assessment and Management of Individuals at Risk for Suicide

(Adapted from Suicide Prevention Resource Center (SPRC) & American Association of Suicidality (AAS) (2008). Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals.)

Preamble

Competencies have been developed for mental health clinicians in assessing and managing suicide risk; however, there are no standard competencies for psychiatric nurses. Widely accepted nursing practices do not meet suicide-specific standards of care or evidence-based criteria. Therefore we propose the following essential competencies for psychiatric nurses working in hospital settings as a guide for practice. These competencies are based on a comprehensive review of the extant research literature (both qualitative and quantitative) relevant to assessment and management of hospitalized patients admitted to a psychiatric setting.

The role of the nurse specific to suicide prevention includes both systems and patient level interventions. At the systems level the nurse assesses and maintains environmental safety, develops protocols, policies, and practices consistent with zero suicide, and participates in training for all milieu staff. At the patient level, the nurse assesses risk for suicide, provides suicide-specific psychotherapeutic interventions, monitors and supervises at-risk patients, and assesses outcomes of all interventions. The expectation is that these essential competencies will serve to provide the foundation for training curricula and in measuring the knowledge, skills, and attitudes necessary for expert care.

Essential Competencies

1. The psychiatric nurse understands the phenomenon of suicide.
   - Defines basic terms related to suicidality.
   - Reviews suicide-related statistics and epidemiology.
   - Describes risk and protective factors related to suicide.
• Discusses nursing and best practice/evidence-based literature related to inpatient suicide prevention.

2. The psychiatric nurse manages personal reactions, attitudes, and beliefs.

• Demonstrates self-awareness of emotional reactions, attitudes, and beliefs related to previous experiences with suicide.
• Examines the impact on the patient of nurse’s emotional reactions, attitudes, and beliefs.
• Accepts and regulates one’s emotional reactions to suicide.
• Discusses nurses’ reactions to patients who express suicidal ideation, attempt or die by suicide.
• Participates in a root cause analysis (RCA) or failure mode and effect analysis (FMEA) when a suicide attempt or suicide death occurs on the inpatient unit.
• Participates in staff debriefing following a suicide attempt or suicide death.
• Obtains and maintains professional assistance/supervision for ongoing support.
• Attends to one’s own emotional safety/wellbeing.

3. The psychiatric nurse develops and maintains a collaborative, therapeutic relationship with the patient.

• Maintains a nonjudgmental and supportive stance in relating to the patient and family.
• Provides a therapeutic milieu in which the patient feels emotionally safe and supported.
• Voices authentic intent to help.
  o Uses evidence to educate the patient about the suicidal mind, symptoms of illness, and effectiveness of intervention.
  o Conveys hope and connection while recognizing the patient’s state of mind and need for hopefulness.
• Reconciles the difference and potential conflict between the nurse’s goal to prevent suicide and the patient’s goal to eliminate psychological pain via suicidal behavior.
  o Explains factors and motivation for suicidal thoughts and behaviors.
  o Understands suicidal motivation, thinking, and beliefs of the individual who is experiencing these thoughts and feelings.
  o Recognizes the importance of validating psychological pain.
  o Demonstrates interpersonal skill in validating patients’ pain and emotional state.
  o Accepts that a patient may be suicidal and validates the depth of the patient’s strong feelings and desire to be free of pain.
Understands that most suicidal individuals experience psychological pain and possibly a loss of self-respect/shame.

Views each patient as an individual with his or her own unique set of issues, circumstances, and mini-culture, rather than as a stereotypic “suicidal patient.”

- Makes realistic assessments to assess and care for the suicidal patient within the limitations of the service setting.
  - Assesses, plans, outcomes, and intervenes accordingly based on the assessment data.
  - Maintains the safety of the patient.
  - Provides a thorough and concise handoff to other clinicians including (SBARR):
    - Situation: The immediate relevant events related to the patient, including subjective and objective observations, what was communicated and to whom.
    - Background: Pertinent history about the patient.
    - Assessment: The nurse’s current assessment including labs and current risk assessment.
    - Recommendations: What the reporting person believes needs to happen at this point.
    - Response feedback: “Do you have any questions?” to verify the understanding of the handoff.
  - Uses specific definitions and universal language for observation levels.

- Follows the standards of care appropriate for providing safety and evidence based care.

- Uses clinical reasoning to determine the priority of care including reporting and documenting.

4. The psychiatric nurse collects accurate assessment information and communicates the risk to the treatment team and appropriate persons (i.e. nursing supervisor, on duty M.D., etc.).

- Performs an independent risk assessment for self-directed violence (non-suicidal and suicidal) upon admission and on an ongoing basis throughout the patient’s hospitalization even in the absence of expressed suicidality.
  - Risk factors (distinguish between modifiable and non-modifiable).
  - Protective factors.
  - Full suicidal inquiry.
  - Mental Status Exam.
  - History of physical and/or psychological trauma.
  - Current triggers that activate feeling of distress.
o Patient’s minimization or exaggeration of symptoms.
o Collateral personal sources as appropriate.
o Warning signs of acute risk.
o History of self-directed violence (SDV) and interventions.

- Communicates the assessment of risk to the treatment team and appropriate persons (i.e. nursing supervisor, on duty M.D., etc.).

5. The psychiatric nurse formulates a risk assessment.

- Makes a clinical judgment of the risk that a patient will attempt suicide or die as a result of suicide in the short and long term.
  o Participates as a member of the interprofessional team in ongoing formulation of risk based on changing assessment data.
  o Continues to integrate and prioritize all the information on an ongoing basis.
  o Applies constructs, theories, studies and systematic reviews to understand changes in risk.
  o Determines level of risk of suicide as acute or chronic.
- Assesses the patient’s motivation to minimize risk and to exaggerate risk, including psychological, environmental and contextual influences.
- Distinguishes between acute and chronic suicidal ideation and behavior.
- Distinguishes between self-directed violence with the intent to die vs. without the intent to die.
- Considers developmental, cultural, and gender related issues related to suicide.

6. The psychiatric nurse develops an ongoing nursing plan of care based on continuous assessment.

- Provides the least restrictive form of care to address the patient’s variable need for safety.
- Develops a written plan of care collaboratively with the interprofessional team, patient, family members, and/or significant others with a focus on maintaining safety.
  o Addresses a wide range of individualized nursing interventions that consider the patient and the levels of care related to immediate, acute and continuing suicidal thoughts and behaviors in the plan.
  o Develops a collaborative safety plan with the patient/family if possible.
  o Coordinates and works collaboratively with other treatment and service providers in an interprofessional interdisciplinary team approach.
• Assesses, manages, and maintains patient safety as a focus in the milieu.
• Prepares for active rescue process and related tools.

• Engages in collaborative problem solving with the patient to address internal and external barriers in adhering to the treatment plan, revising the plan as necessary throughout the hospitalization.
  
  o Motivates and supports patients in engaging in all elements of treatment.
  o Engages patient, family, significant others and other care providers in developing, supporting, and reinforcing the agreed plan of care in compliance with HIPAA.
  o Involves the outpatient therapist and family/significant other in the discharge planning.
  o Recognizes and reinforces the boundaries of relationships between the inpatient and outpatient providers.
  o Throughout hospitalization and prior to discharge, engages the patient in understanding feelings related to discharge and potential difficult situations that might arise after discharge to assure those situations are addressed in the treatment plan.
  o Prior to discharge, reviews the treatment plan with the outpatient provider for clarity and feasibility.
  o Prior to discharge, schedules outpatient therapist appointment to ensure continuity with the treatment plan.
  o Assures that the family and significant others have contact information of the outpatient provider.
  o Provides resources, such 1-800-273-TALK.

• Reviews the state and national standards and requirements for practice and understands the institutional policies and procedures related to suicide.
  
  o Participates with the interprofessional team in a root cause analysis for suicide death or serious suicide attempts to identify opportunities for learning at all levels of service delivery.
  o Documents in the medical record in accordance with the standards of nursing practice and institutional policy.
  o Assures that nursing policy and procedures are in place for systematic suicide risk assessments.

• Implements evidence based and best practice problem solving intervention to modify risk factors and enhance the use of protective measures to assist the patient to prevent suicide.
7. The psychiatric nurse performs an ongoing assessment of the environment in determining the level of safety and modifies the environment accordingly.

- Identifies environmental hazards at the unit level (ligature points and lanyards).
- Identifies environmental hazards at the personal level (belts, shoelaces, sharp items, etc.).
- Identifies environment conditions that would indicate higher risk of patient suicide – example of items not accounted for (knives, forks, CD, hording of towels, linen, etc.).
- Removes potentially harmful items if patient is at risk of utilizing items to harm self (remove or modify access to means of suicide).
- Determines level of supervision needed for the patient.

8. The psychiatric nurse understands legal and ethical issues related to suicide.

- Knows state laws pertaining to suicide including civil commitment, patient rights, seclusion, and advance directives for psychiatric treatment.
- Knows essential components of chart documentation of suicide risk assessment, monitoring, and interventions.
- Maintains patient records and rights to privacy and confidentiality within HIPAA regulations.
- Applies ethical principles of autonomy, beneficence, nonmaleficence, fidelity, and justice in relating to patients who are (or may be) suicidal.

9. The psychiatric nurse accurately and thoroughly documents suicide risk.

- Documents suicidal risk assessment and intervention(s) during hospitalization at key times.
- Documents the initial assessment.
- Documents risk level during hospitalization on an inpatient psychiatric unit.
- Documents risk level at discharge.
Suicidal Behavior (CDC, 2014)

- 10th leading cause of death in the USA in 2014
- About 42,773 suicides per year in the USA
- Annual suicide rate of 13.4 per 100,000
- 1,069,325 suicide attempts per year in the USA this means 1 suicide attempt every 30 seconds.
- Males 33,113 vs Females 9,660 Suicided
- Whites 38,675 vs Non-whites 4,098 Suicided
- Attempt Suicide: Females attempt suicide 3 times for each male attempt, but males die 3.4 more times
- AGE and GENDER: Reminder! Age and gender as risk factors tells nothing about risk of suicide without the presence and interaction of other potentiating risk factors.

Suicide Methods (CDC & AAS, 2014)

- Firearms (49%)
- Suffocating and Hanging (26.7 %)
- Poisoning (15.9%)
- Cutting/Piercing (1.7%)
- Drowning (0.9%)

Risk Factors (Competency 1 & 4)
How do you remember the Warning Signs of Suicide?

Here's an Easy-to-Remember Mnemonic:

**IS PATH WARM?**

<table>
<thead>
<tr>
<th>I</th>
<th>S</th>
<th>P</th>
<th>A</th>
<th>T</th>
<th>H</th>
<th>W</th>
<th>A</th>
<th>R</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideation</td>
<td>Substance Abuse</td>
<td>Purposelessness</td>
<td>Anxiety</td>
<td>Trapped</td>
<td>Hopelessness</td>
<td>Withdrawal</td>
<td>Anger</td>
<td>Recklessness</td>
<td>Mood Change</td>
</tr>
</tbody>
</table>

A person in acute risk for suicidal behavior most often will show:

**Warning Signs of Acute Risk:**
- Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself; and/or,
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary.

These might be remembered as expressed or communicated **IDEATION.** If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

Additional Warning Signs:
- Increased **SUBSTANCE** (alcohol or drug) use
- No reason for living; no sense of **PURPOSE** in life **ANXIETY,** agitation, unable to sleep or sleeping all the time Feeling **TRAPPED** - like there’s no way out
  **HOPELESSNESS**
- **WITHDRAWING** from friends, family and society
- Rage, uncontrolled **ANGER,** seeking revenge
- Acting **RECKLESS** or engaging in risky activities, seemingly without thinking
- Dramatic **MOOD change**

These warning signs were compiled by a task force of expert clinical-researchers and ‘translated’ for the general public.

If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.
Protective Measures
1. What are they?
2. Name 2 internal protective factors
3. Name 2 external protective factors

Legal and Ethical Issues in Suicide Prevention (Competency 8 & 9)

What is your professional duty?
- What does a duty to warn mean______________________________
- What does a duty to protect mean______________________________

State laws pertaining to suicide include civil commitment and patient rights
- What are you state laws regarding involuntary hold for Danger to Self?

State Commitment Law varies by state. Look up your state laws at http://tinyurl.com/nq6o9cm and be aware of your responsibility.

Definitions (CDC, 2011) (Competency 1)
- Self-Directed Violence
  - Non-suicidal
  - Suicidal
- Suicide Attempt
  - A non-fatal self-directed potentially injurious behavior with an intent to die as a result of the behavior. May or may not result in injury.
- Predicament Suicide may occur in the absence of diagnosed mental illness (Pridemore, 2009)
- Chronic Suicidal Thoughts: Thinking about suicide with varying intensity and persistence daily over long periods of time

Unacceptable Terms Related To Suicide (Competency 1)
- Completed Suicide
- Failed Attempt
- Nonfatal suicide
- Parasuicide
- Successful suicide
- Suicidality
- Suicide gesture / Manipulative act / Suicide threat
Self-Awareness and the Therapeutic Relationship (Competency 2 & 3)

Monitors self-awareness of emotional reactions, attitudes, and beliefs related to suicide.

- Attitudes toward suicide
- Cultural beliefs
- Religious beliefs
- Personal friend or relative who suicided

AIDE – an acute care algorithm for suicide risk assessment

Assessment
Intervention
Documentation
Environment
IS YOUR PATIENT SUICIDAL?

Conduct a risk assessment:
Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things
- Feeling down, depressed, or hopeless

If patient answers no to all of the assessment questions:
Reassess with change in patient condition, e.g., change in diagnosis, behavior, or emotional expression.

If YES to hopelessness, Consider increasing observation, then ask:
Are you thinking about killing yourself now?

If patient answers yes to any of the assessment questions:
Assign staff member to stay with the patient until psychiatric assessment is completed.

1. Ensure safe environment (remove contraband)
2. Consult Psychiatric Services or attending physician or clinician.
3. Document—the Patient’s response to the questions in quotations and any interventions we (the nurse) performed such as:
   - Assigning patient to one to one observation
   - Who was notified, date, and time, the patients warning signs, risk factors, and protective factors
   - What hazards were removed to ensure a safe environment
4. Contact supervisor to discuss nurses’ feelings about patient’s response.

If Patient answers YES
Assign staff member to stay with the patient until psychiatric assessment is completed.

1. Ensure safe environment (remove contraband)
2. Consult Psychiatric Services or attending physician or clinician.
3. Document—the Patient’s response to the questions in quotations and any interventions we (the nurse) performed such as:
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   - Who was notified, date, and time, the patients warning signs, risk factors, and protective factors
   - What hazards were removed to ensure a safe environment
4. Contact supervisor to discuss nurses’ feelings about patient’s response.

Warning Signs?
- Talking about suicide
- Seeking Lethal Means
- Hopelessness
- Anxiety
- Insomnia

Risk factors?
- Firearms
- Triggering Events
- History of Suicide Attempt
- History of Family Member Suicide Attempt

Protective Factors?
- Coping Style (non-violent or self-destructive)
- Relationships
- Reasons for Living
- Spiritual Connections
ASSESSMENT AND DETERMINATION OF RISK
» Identify warning signs for suicide
» Assess for suicidal ideation, intent, and behavior
» Assess risk and protective factors affecting suicide risk
» Assess the environment for potential hazards.

Definitions:
Suicide—Self directed violence with the intent to end one’s life, and they die as a result of his/her actions.
Hopelessness—Expresses feeling that nothing can be done to improve the situation. Ie: “Not wanting to get out of the bed in the morning”

INITIAL MANAGEMENT OF PATIENT AT RISK FOR SUICIDE
» Determine level of risk for suicide attempt
» Determine appropriate care setting (ensure safe environment by removing contraband)
» Educate patient and family on risk and treatment options
» Limit access to lethal means (ensure safe environment)
» Establish a Safety Plan

» Document using what the patient says in quotes, what you did, and who you communicated the risk and interventions to. Also document the preparation of the environment.
» Document the ongoing safety plan and any updates at discharge.

Assessment

IS YOUR PATIENT SUICIDAL?

ASSESSMENT AND DETERMINATION OF RISK

Definition:
Suicide—Self directed violence with the intent to end one’s life, and they die as a result of his/her actions.

Hopelessness—Expresses feeling that nothing can be done to improve the situation. Ie: “Not wanting to get out of the bed in the morning”

ATTITUDE AND EXTERNALIZATION

» Attitude—Consists of beliefs, values, and behaviors
» Externalization—Consists of thoughts, behaviors, and symptoms

ATTITUDE

Internal
» Suicidal ideation
» Hopelessness
» Risk factors

External

Social factors
» Psychological factors
» Financial factors

Environmental factors

Risk factors

Externalization

Internal
» Suicidal ideation
» Hopelessness
» Risk factors

External

Social factors
» Psychological factors
» Financial factors

Environmental factors

Psychological Factors

» Suicide of relative, someone famous, or a peer (suicide bereavement)
» Threatened loss or Loss of loved one (grief)
» Threatened loss or Loss of relationship (divorce, separation)
» Loss of status/respect/rank (public humiliation, being bullied or abused, failure work/task)

Social Factors

» Stressful Life Events (acute experiences)
» Breakups and other threats to prized relationships
» Other events (e.g., fired, arrested, evicted, assaulted)
» Chronic Stressors (ongoing difficulties)

Financial Problems

» Unemployment, underemployment
» Unstable housing, homeless
» Excessive debt, poor finances (foreclosure, alimony, child support)

Social Support

» Lack of supportive interpersonal relationship (partner, parents, children)
» Geographic isolation from support
» Recent change in level of care (discharge from inpatient psychiatry)

Legal Problems/Difficulties

» DUI/DWI
» Lawsuit
» Criminal offense and incarceration (or threat thereof)
Assessment Questions:
RN Scripting questions and answers for real world use
Ask questions about suicide risk in a clear, straightforward manner:

- **Have you been feeling sad or unhappy?**
  - Men, for example, may not identify with depression, but may be able to tell you they've been feeling sad, unhappy, etc.

- **Do you ever feel hopeless? Does it seem as if things can never get better? Do you sometimes have trouble getting out of bed because you feel like it’s just not worth it?**
  - Feelings of hopelessness are often associated with suicidal thoughts.

- **Have you had thoughts of death or of killing yourself? If so, what were/are they?**
  - A “yes” response indicates suicidal wishes, but not necessarily suicidal plans. Many people who are depressed say they think they’d be better off dead and wish they’d die in their sleep or get killed in an accident. However, most say they have no intention of actually killing themselves.

- **Do you ever have any actual suicidal impulses? Do you have any urge to kill yourself?**
  - A “yes” indicates an active desire to die. This is a more serious situation.

- **Are you currently thinking about killing yourself? Do you have any actual plans to do so?**
  - If the answer is “yes,” ask about their specific plans.

- **What did you think about doing to yourself? What method have you chosen?**
  - Hanging? Jumping? Pills? A gun? Have they actually obtained the rope? What building do they plan to jump from? Although these questions may sound grotesque, they may save a life. The danger is greatest when the plans are clear and specific, when they have made actual preparations, and when the method they have chosen is clearly lethal and available.

- **What are your thoughts on how, when and where you would do this?**
  - If the suicide attempt is a long way off—say, in five years—danger is clearly not imminent. If they plan to kill themselves soon, the danger is grave.

- **Is there anything that would hold you back, such as your family or your religious convictions?**
  - If the person says that people would be better off without them, and if they have no deterrents, suicide is much more likely.

- **Have you tried to hurt yourself? If so, how? Have you attempted suicide in the past? If so, what did you do?**
  - Previous suicide attempts indicate that future attempts are more likely. Even if a previous attempt did not seem serious, the next attempt may be fatal. All suicide attempts should be taken seriously. However, suicidal “gestures” can be more dangerous than they seem, since many people do kill themselves.

- **Has a close friend or anyone in the family died by suicide?**
  - Ask about anniversary dates of these events, as risk may be elevated at these anniversary points.

- **Has anyone in the family ever been treated for depression or emotional illness?**
  - People with depression or other behavioral health issues may be at higher risk for suicide.
For your review: Case Study: Mr. Hary

Assessment:

List 3 Risk Factors:

1. __________________________________________
2. __________________________________________
3. __________________________________________

List 2 Warning Signs:

1. __________________________________________
2. __________________________________________

Protective Factors

What are two internal factors?

1. __________________________________________
2. __________________________________________

What are two external factors?

1. __________________________________________
2. __________________________________________

Interventions:

List 4 interventions you would implement immediately to decrease risk of suicide for Mr. Hary?

1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________
Components of a Safety Plan

(Need to come from the client, we help and facilitate with the client). The more client can assume the responsibility the better. This is their safety plan.

1. Warning Signs

2. Personal Coping Strategies to Calm or Comfort Myself

3. Reasons for Living

4. Activities for Distraction (Social Settings / or Persons to contact)

5. Professional Contacts and phone numbers

6. Step to make the my environment safe

7. Where to go if I still need help-hospital address, phone number, contact

Sources:
Please assess and locate in 2 minutes as many Environmental hazards you can find in following hospital rooms.
**Preparation of a room for persons at risk for suicide**

You are caring for a patient who is on suicide precautions. Please consider the following in helping to keep your patient safe:

- Stay at arm’s reach of patient at all times, even when the patient is using the bathroom. It is important to say, “For your safety, we need to see you at all times. This must be terribly uncomfortable for you. How can I make this better for you?”
- Remove patient belongings and store them in a secure area.
- Common methods historically used to suicide in hospitals are hanging, jumping and suffocation.
- Prep the patient’s room prior to arrival to the floor by removing the following items:
  - Phone (cables)
  - Replace call light with cords to a bell, or other device or show the patient the call bell on the bed rail.
  - Clear room of all plastic medication cups and replace if needed with paper medication cups
  - Place computer on wheels out of reach of the patient
  - Remove tacks from the patient’s bulletin board
  - Do not store dressing change supplies or any extra materials in the room
  - Think before you enter the room, “Do I need this item to provide care?” If not, leave it out.
  - Perform a brief safety sweep with hourly rounding

There are items that are in **most medical/surgical rooms** that are not able to be removed since they are needed to take care of patients. Below is a list of items that could cause harm if used improperly:

- **Be aware of:**
  - Computer on wheels (cables)
  - There are blind cords on the windows
  - Shower curtains
  - Pull cords in bathroom
  - Pulse ox cables
  - Telemetry boxes as they contain wires
    - Is telemetry truly necessary?
  - IV tubing
  - SCD’s as they have tubing
  - Plastic utensils can be sharp
  - Can the patient agree to hand over to companion as soon as he/she is finished?

  - Blood pressure cuffs
  - Ties on patient gowns
  - Toothbrushes can be swallowed
  - Garbage bags
  - Linen bags/linen
  - Hand sanitizer and/or body wash
  - Mirrors that are attached to the wall
  - Sharps container
  - Any chemical or cleaner
  - Ambu bags within plastic bags
Documentation (Competency 9)
  • Why document?
  • Who reads your documentation?
  • Documentation substantiate use of standards of care
  • Critical times to document are:
    o On admission
    o Per policy, usually q shift
    o When going on or off a 1 to 1 observation
    o Psychosocial stressors (person finds out his husband is going to divorce her, patient may be losing job, threat of incarceration or poor diagnosis).
    o Noted or drastic change in mood (worse or better quickly, or increased sadness – hopelessness)
    o Change in physical condition (increased pain, getting news of poor prognosis or treatment failure, medication side effects).
  
  • Critical Content for documentation is:
    o Risk factors & level
    o Detailed assessment of suicidal ideation
    o Avoid vague terms
    o Use direct quotes
    o Presence/absence of firearms
    o Avoid use of “safety contract” in practice or documentation
    o Collaborative agreements
    o Consultations
    o Create a crisis plan
    o Describe and explain the formulation of safety plan
Detecting and treating suicide ideation in all settings

The rate of suicide is increasing in America. The 10th leading cause of death, suicide claims more lives than traffic accidents and more than twice as many as homicides. At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death, usually for reasons unrelated to suicide or mental health. Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings. The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility and continues to be high especially within the first year and through the first four years after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention. The “Perfect Depression Care Initiative” of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force’s suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Bærum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital’s multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred. Dallas’ Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.
Who is at risk for suicide?  
Much of what we know about the profile of individuals who have died by suicide and those who have attempted suicide comes from looking in the rearview mirror – at data compiled about suicide victims and attempts. Suicide may affect certain demographics – such as military veterans and men over age 45 – more than others. It’s important to identify the risk factors, rather than membership in a group, when considering suicide risk. Paying attention to risk factors matters because patients may not disclose suicide ideation voluntarily. Risk factors for suicide include:

- Mental or emotional disorders, particularly depression and bipolar disorder. Up to 90 percent of suicide victims suffer from a mental or emotional disorder at the time of death.
- Previous suicide attempts or self-inflicted injury; the risk of suicide is twice as high (100 percent higher) than general suicide rates for one year following a suicide attempt and the higher risk continues beyond that. The risk is even higher the first few weeks immediately following a suicide attempt.
- History of trauma or loss, such as abuse as a child, a family history of suicide, bereavement or economic loss.
- Serious illness, or physical or chronic pain or impairment.
- Alcohol and drug abuse.
- Social isolation or a pattern/history of aggressive or antisocial behavior.
- Discharge from inpatient psychiatric care within the first year after discharge. While some depressed patients who attempt or die by suicide after inpatient psychiatric hospitalization express suicide ideation before or during hospitalization, other depressed patients who have received inpatient psychiatric treatment develop suicide ideation after discharge.
- Access to lethal means coupled with suicidal thoughts.

However, there is no typical suicide victim. Most individuals having these risk factors do not attempt suicide, and others without these conditions sometimes do. Therefore, there is a danger in considering only individuals with certain conditions or experiences in certain health care settings as being at risk for suicide. It’s imperative for health care providers in all settings to better detect suicide ideation in patients, and to take appropriate steps for their safety and/or refer these patients to an appropriate provider for screening, risk assessment, and treatment.

Assessing suicide risk remains a challenge  
The Joint Commission’s Sentinel Event database has reports of 1,089 suicides occurring from 2010 to 2014 among patients receiving care, treatment, and services in a staffed, around-the-clock care setting or within 72 hours of discharge, including from a hospital’s emergency department. The most common root cause documented during this time period was shortcomings in assessment, most commonly psychiatric assessment. In addition, 21.4 percent (165) of Joint Commission-accredited behavioral health organizations and 5.14 percent (65) of Joint Commission-accredited hospitals (for which the requirement was applicable) were rated non-compliant in 2014 with National Patient Safety Goal 15.01.01 Element of Performance 1 – Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.

Actions suggested by The Joint Commission  
To accomplish the following suggested actions, The Joint Commission urges all health care organizations to develop clinical environment readiness by identifying, developing and integrating comprehensive behavioral health, primary care and community resources to assure continuity of care for individuals at risk for suicide. Many communities and health care organizations presently do not have adequate suicide prevention resources, leading to the low detection and treatment rate of those at risk. As a result, providers who do identify patients at risk for suicide often must interrupt their workflow and disrupt their schedule for the day to find treatment and assure safety for these patients.

DETECTING SUICIDE IDEATION IN NON-ACUTE OR ACUTE CARE SETTINGS  
Primary, emergency and behavioral health clinicians all play crucial roles in detecting suicide ideation through the following three steps, which can be taken in non-acute or acute care settings:

1. Review each patient’s personal and family medical history for suicide risk factors. These are listed in the “Who is at risk for suicide?” section of this alert.

* The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.
2. Screen all patients for suicide ideation, using a brief, standardized, evidence-based screening tool. A waiting room questionnaire including a question specifically asking if the patient has had thoughts about killing him or herself may help identify individuals at risk for suicide who otherwise may not have been identified. Research shows that a brief screening tool can identify individuals at risk for suicide more reliably than leaving the identification up to a clinician’s personal judgment or by asking about suicidal thoughts using vague or softened language. For example, a study using the Patient Health Questionnaire (PHQ-9) found that those who expressed thoughts of death or self-harm were 10 times more likely to attempt suicide than those who did not report those thoughts. Some practices use a shorter version called the PHQ-2, which asks two questions about depression symptoms, and some add an additional question about suicidal thoughts and feelings. If a patient answers “yes” to any of these questions, the PHQ-9 is administered. Other brief screening tools include the Emergency Medicine Network’s ED-SAFE Patient Safety Screener and the Suicide Behaviors Questionnaire-Revised (SBQ-R).

3. Review screening questionnaires before the patient leaves the appointment or is discharged. To determine the proper immediate course of treatment, conduct or refer for secondary screening and assessment patients determined to be at risk for suicide. Useful secondary screeners include the Suicide Prevention Resources Center’s Decision Support Tool and the Emergency Medicine Network’s ED-SAFE Patient Safety Secondary Screener for emergency departments. The SAFE-T20 Pocket Card and the Columbia-Suicide Severity Rating Scale (C-SSRS) can be used for in-depth screening and assessment.

For patients who screen positive for suicide ideation and deny or minimize suicide risk or decline treatment, obtain corroborating information by requesting the patient’s permission to contact friends, family, or outpatient treatment providers. If the patient declines consent, HIPAA permits a clinician to make these contacts without the patient’s permission when the clinician believes the patient may be a danger to self or others.

TAKING IMMEDIATE ACTION AND SAFETY PLANNING

During the following two steps, behavioral health clinicians are generally added to the care team via consultation or referral. The care team should:

4. Take the following actions, using assessment results to inform the level of safety measures needed.

- Keep patients in acute suicidal crisis in a safe health care environment under one-to-one observation. Do not leave these patients by themselves. Provide immediate access to care through an emergency department, inpatient psychiatric unit, respite center, or crisis resources. Check these patients and their visitors for items that could be used to make a suicide attempt or harm others. Keep these patients away from anchor points for hanging and material that can be used for self-injury. Some specific lethal means that are easily available in general hospitals and that have been used in suicides include: bell cords, bandages, sheets, restraint belts, plastic bags, elastic tubing and oxygen tubing.

- For patients at lower risk of suicide, make personal and direct referrals and linkages to outpatient behavioral health and other providers for follow-up care within one week of initial assessment, rather than leaving it up to the patient to make the appointment.

- For all patients with suicide ideation:
  - Give every patient and his or her family members the number to the National Suicide Prevention Lifeline, 1-800-273-TALK (8255), as well as to local crisis and peer support contacts.
  - Conduct safety planning by collaboratively identifying possible coping strategies with the patient and by providing resources for reducing risks. A safety plan is not a “no-suicide contract” (or “contract for safety”), which is not recommended by experts in the field of suicide prevention. Review and reiterate the patient’s safety plan at every interaction until the patient is no longer at risk for suicide.
  - Restrict access to lethal means. Assess whether the patient has access to firearms or other lethal means, such as prescription medications and chemicals, and discuss ways of removing or locking up firearms and other weapons during crisis periods. Restricting access is important because many suicides occur with little planning during a short-term...
crisis, and both intent and means is required to attempt suicide. The Harvard T.H. Chan School of Public Health’s Means Matter website provides helpful advice on means restriction.

BEHAVIORAL HEALTH TREATMENT AND DISCHARGE
Behavioral health clinicians manage the patient’s evidence-based treatments and discharge plans, as well as coordinate care transitions and follow-up care with the patient’s other providers.

5. Establish a collaborative, ongoing, and systematic assessment and treatment process with the patient involving the patient’s other providers, family and friends as appropriate. Suicide risk, by nature, is very dynamic – changing according to personal events, a person’s level of desperation, and available interventional resources. Treatment of individuals at risk for suicide requires a collaborative approach that acknowledges the ambivalence – the desire to find a solution to their pain versus the innate desire to live – that these patients often feel. A valuable support to traditional risk assessment is to use a risk formulation model – drawn from prevention research and violence assessment – that can help providers to understand a patient’s current thoughts, plans, access to lethal means, and acute risk factors. This understanding can be used to develop personalized care and both short- and long-term safety plans for patients struggling with thoughts of suicide.

6. To improve outcomes for at-risk patients, develop treatment and discharge plans that directly target suicidality. Traditionally, behavioral health clinicians often have treated the underlying depression or other mental health disorders in patients but have not directly addressed suicide risk. Providing direct treatment of suicide risk using evidence-based interventions is vital. Hospitalization is often necessary for a patient’s immediate safety, but hospitalization used solely as a containment strategy may be ineffective or counterproductive and considered by the patient as a disincentive or penalty for expressing suicidal thoughts. Evidence-based clinical approaches that help to reduce suicidal thoughts and behaviors include: 1) Cognitive Therapy for Suicide Prevention (CBT-SP), 2) the Collaborative Assessment and Management of Suicide (CAMS), and 3) Dialectical Behavior Therapy (DBT). In addition, Caring Contacts has a growing body of evidence as a post-discharge suicide prevention strategy. See an overview of these and other evidence-based interventions, which emphasize patient engagement, collaborative assessment and treatment planning, problem-focused clinical intervention to target suicidal “drivers,” skills training, shared service responsibility, and proactive and personal clinician involvement in care transitions and follow-up care, such as:

- Engaging the patient and family members/significant others in collaborative discharge planning to promote effective coping strategies.
- Discussing the treatment and discharge plan with the patient and sharing the plan with other providers having responsibility for the patient’s well-being.
- Determining how often patients will be called and seen.
- Establishing real-time telephone or live contact with at-risk patients who don’t stay in touch or show up for an appointment, rather than having staff or resources just leave reminder messages or emails.
- Directly addressing patients’ thoughts about suicide at every interaction.
- Using motivational enhancement to increase the likelihood of engagement in further treatment.

EDUCATION AND DOCUMENTATION
These recommendations are relevant to all care providers and settings.

7. Educate all staff in patient care settings about how to identify and respond to patients with suicide ideation. Develop a process for how staff can sensitively respond to a patient with suicidal thoughts and feelings in a way that is appropriate to their role and professional training. Education for staff should cover environmental risk factors; finding help in emergencies; and policies for screening, assessment, referral, treatment, safety and support of patients at risk for suicide. The Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention developed “Suicide Prevention and the Clinical Workforce: Guidelines for Training.” “Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments.” The Joint Commission’s Standards BoosterPak™ Suicide Risk for National Patient Safety Goal 15.01.01, the QPR Institute and the VA/DoD Clinical Practice Guideline for Assessment and Management of...
Patients at Risk for Suicide (2013)\(^\text{14}\) also are good resources.

8. **Document decisions regarding the care and referral of patients with suicide risk.**

Thoroughly document every step in the decision-making process and all communication with the patient, his or her family members and significant others, and other caregivers. Document why the patient is at risk for suicide and the care provided to patients with suicide risk in as much detail as possible, including the content of the safety plan and the patient’s reaction to and use of it; discussions and approaches to means reduction; and any follow-up activities taken for missed appointments, including texts, postcards, and calls from crisis centers. Be generous in documentation, as it becomes the main method of communication among providers. For a documentation checklist, see Page 21 of **Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments.**\(^\text{38}\)

**Related Joint Commission requirements**

The advice provided in this alert applies universally to all patients in all settings. In addition, since the risk of suicide increases after discharge from emergency departments and inpatient settings, it’s important for health care organizations to incorporate appropriate transition and follow-up actions in accordance with ** Provision of Care, Treatment, and Services accreditation requirement PC.04.01.01 – The organization has a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.**

**Joint Commission requirements related to detecting and treating patients with suicide ideation**

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See the content of these standards on The Joint Commission website, posted with this alert.

**Resources**

- **Zero Suicide Toolkit**, from the Suicide Prevention Resource Center and the National Action Alliance for Suicide Prevention
- **ED-SAFE Materials**, from the Emergency Medicine Network
- **Caring for Adult Patients with Suicide Risk** – A Consensus Guide for Emergency Departments, and **Quick Guide for Clinicians**, from the Suicide Prevention Resource Center
- **Means Matter website**, from the Harvard T.H. Chan School of Public Health
- **Mental Health Environment of Care Checklist** – For reviewing inpatient mental health units for environmental hazards, from the VA National Center for Patient Safety.
QPR Institute – Suicide prevention courses and training for professionals, institutions, and the public, on site or through a self-study program.

SAFE-T Pocket Card for Clinicians – Five-step evaluation and triage for suicide assessment

Suicide Prevention and the Clinical Workforce: Guidelines for Training, from the Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention

VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, from the Department of Veterans Affairs, Department of Defense, June 2013.

References
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54. Freedenthal S. Will I be committed to a mental hospital if I tell a therapist about my suicidal thoughts? Speaking of Suicide website (accessed July 28, 2015).


Patient Safety Advisory Group

The Patient Safety Advisory Group informs The Joint Commission on patient safety issues and, with other sources, advises on topics and content for Sentinel Event Alert. Members: James P. Bagian, MD, PE (chair); Frank Federico, BS, RPh (vice chair); Jane H. Barnsteiner, RN, PhD, FAAN; James B. Battles, PhD; William H. Beeson, MD; Bona E. Benjamin, BS, Pharm; Patrick J. Brennan, MD; Todd Bridges, RPh; Michael Cohen, RPh, MS, ScD; Cindy Dougherty, RN, BS, CPHQ; Michael El-Shammaa; Marilyn Flack; Steven S. Fountain, MD; Tejal Gandhi, MD, MPH, CPPS; Martin J. Hattie, Esq; Robin R. Hemphill, MD, MPH; Jennifer Jackson, BSN, JD; Paul Kelley, CBET; Heidi B. King, MS, FACHE, BCC, CMC, CPPS; Ellen Makar, MSN, RN-B.C, CCM, CPHIMS, CENP; Jane McCaffrey, MHA, DFASHRM; Mark W. Milner, RN, MBA, MHS; Grena Porto, RN, MS, ARM, CPHRM; Matthew Scanlon, MD; Ronni P. Solomon, JD; Dana Swenson, PE, MBA