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After a Suicide: The Zero Suicide Approach to Postvention in Health and Behavioral Healthcare Settings

| December 8, 2016



Moderator

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Julie Goldstein Grumet, PhD

Director of Health and Behavioral Health Initiatives
Suicide Prevention Resource Center



Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention



The nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention*.



#zerosuicide

@SPRCtweets

@ZSInstitute

WHAT IS ZERO SUICIDE?



Zero Suicide is...

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- Embedded in the National Strategy for Suicide Prevention.
- A priority of the National Action Alliance for Suicide Prevention and a project of the Suicide Prevention Resource Center.
- A focus on error reduction and safety in healthcare.
- A framework for systematic, clinical suicide prevention in behavioral health and healthcare systems.
- A set of best practices and tools including www.zerosuicide.com.

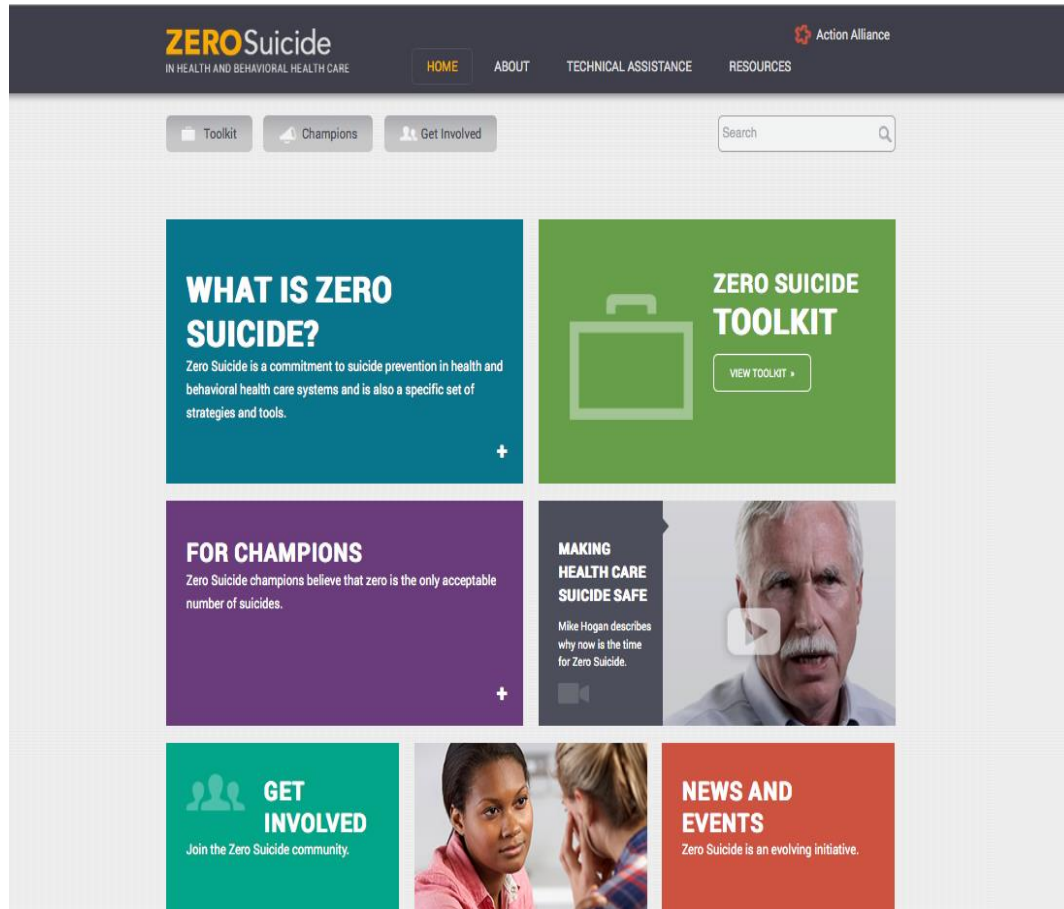
Elements of Zero Suicide

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ZeroSuicide.com

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Contact

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Zero Suicide

Suicide Prevention Resource Center

Education Development Center

zerosuicide@edc.org

202-572-5361

Learning Objectives

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By the end of this webinar, participants will be able to:

- 1) Explain how a health and behavioral health organization's response to a suicide death can support improvements in suicide care practices
- 2) Describe the role of Root Cause Analysis in a postvention response
- 3) Identify steps that can be taken by organizations to support staff, other patients, and the family following a patient death by suicide

Speakers

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Ken Norton



**Candace
Landmark**



**Eliza Jacob-
Dolan**



Becky Stoll

Presenter

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Ken Norton

Postvention as Part of Comprehensive Suicide Prevention in Health and Behavioral Health Care

Components of a comprehensive approach to suicide

- Prevention: education about early recognition
- Intervention: skills for responding to attempts and threats
- Postvention: appropriate response after a suicide

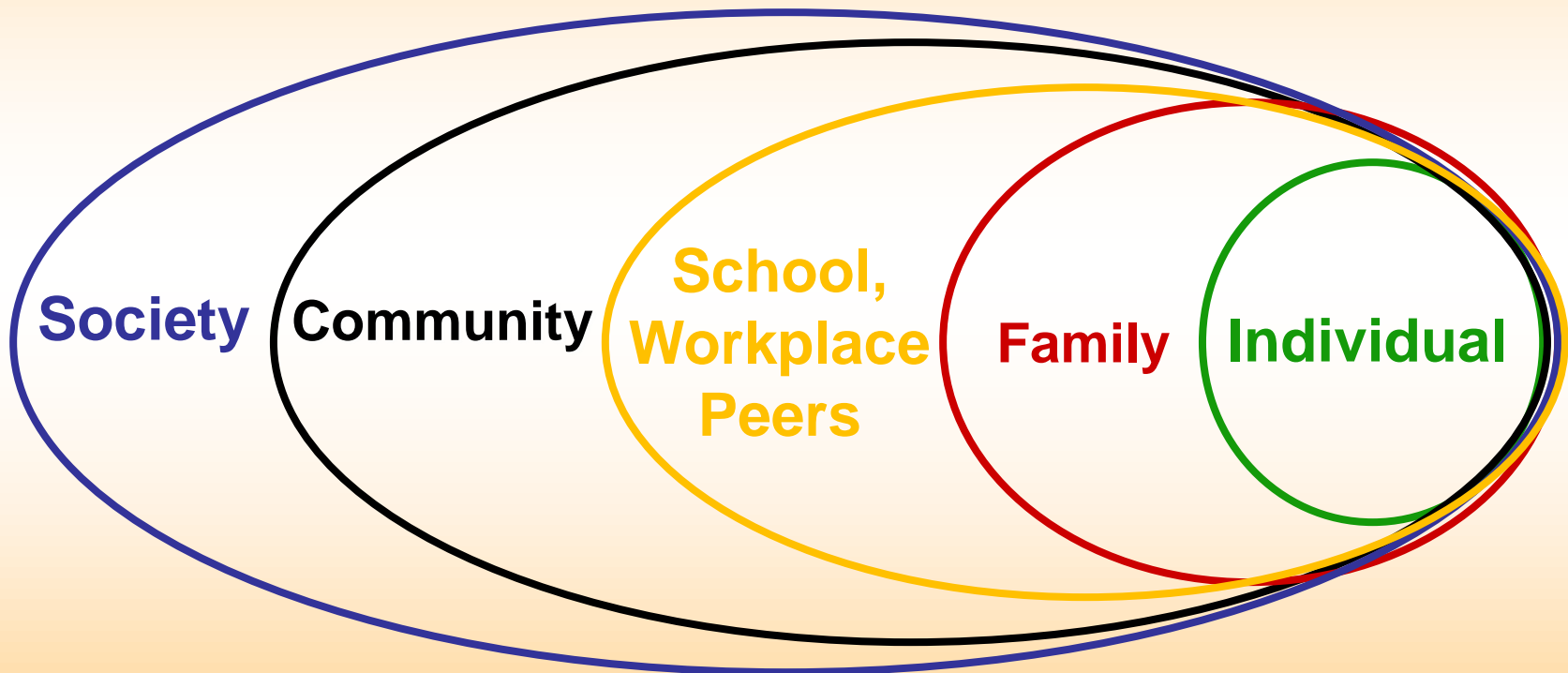


Postvention

Prevention

A circular diagram with the word "Postvention" in red at the top and "Prevention" in green at the bottom. Two light blue curved arrows connect them, one on the left pointing from Postvention down to Prevention, and one on the right pointing from Prevention up to Postvention, forming a continuous loop.

Ecological model



Inadequate training

A national survey of social workers on suicide prevention/intervention found:

- Training in how to respond to a suicide (postvention) is even less common.
- Fewer than half of U.S. psychiatry residency programs provide any instruction in handling the loss of a patient to suicide.

Postvention

- Activities and response following a suicide death
- Activities should be planned in advance
- Goals of postvention response

Frequency

- As many as 1 in 5 people who die by suicide were in treatment at time of their deaths (Luoma et al., 2000)
- Estimates are:
 - 51% of psychiatrists will lose a client to suicide
 - 22% of psychologists will lose a client to suicide (Chemtob & Hamada et al., 1988)
 - Nurses who treat patients at risk are likely to have a patient suicide during their careers (Collins, 2003)
 - 15,000 clinician survivors (Weiner, 2005)



**How might a health care
system/organization be impacted by
suicide?**



Training Professionals & Communities in
Suicide Prevention & Response



NAMI

New Hampshire

What role does a mental health agency provide following a suicide?



Training Professionals & Communities in
Suicide Prevention & Response



NAMI

New Hampshire

Impact of suicide death on a health care provider

- Impact may rise to level of post traumatic response
- May be career changing



One clinician's experience

*Quote from a clinician who lost a client to
suicide*



Postvention planning



Postvention protocols

- Without protocols, emotional turmoil and confusion can impair decision-making.
- Protocols guide people on what to expect and do.
- NAMI NH's Connect Program has developed specific postvention protocols for key service providers



Professional/legal implications



Training Professionals & Communities in
Suicide Prevention & Response



NAMI

New Hampshire

Family perception of clinicians



Training Professionals & Communities in
Suicide Prevention & Response



NAMI

New Hampshire

Attending the service and other professional concerns



Post-traumatic growth

- Research demonstrates that working through traumatic experiences can produce growth
- Post traumatic growth can occur both personally and professionally following a suicide death
- Must be open to change and willing to discuss stressful event



Example of a comprehensive postvention program



www.theconnectprogram.org



Key points to remember if a suicide occurs

- We all grieve differently.
- Stress importance of self care skills/asking for help – promote warning signs for suicide
- Watch out for who is not doing well and get the additional support needed.
- Take any threat of suicide seriously.
- Help others understand how to prevent contagion.
- Pay attention to anniversary dates



Audience:

Using the chat box please tell us what was most meaningful or poignant to you about this presentation.

Presenter

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Candace Landmark, RN, BSN, MBA
Cause Analysis at Community Health Network

Our challenge

“The single greatest impediment to error prevention in the medical industry is that ‘ we punish people for making mistakes’”

Lucian Leape, MD

Professor, Harvard School of Public Health

Testimony before congress on Healthcare Quality Improvement

SafetyFirst

But to understand failure:

- Questions are not:
 - Where did they screw up
 - Why didn't they notice what we find important now?
- Question is:
 - Why did it make sense for them to do what they did?

Why did it make sense?

- To understand why people did what they did, reconstruct the world in which they found themselves at the time

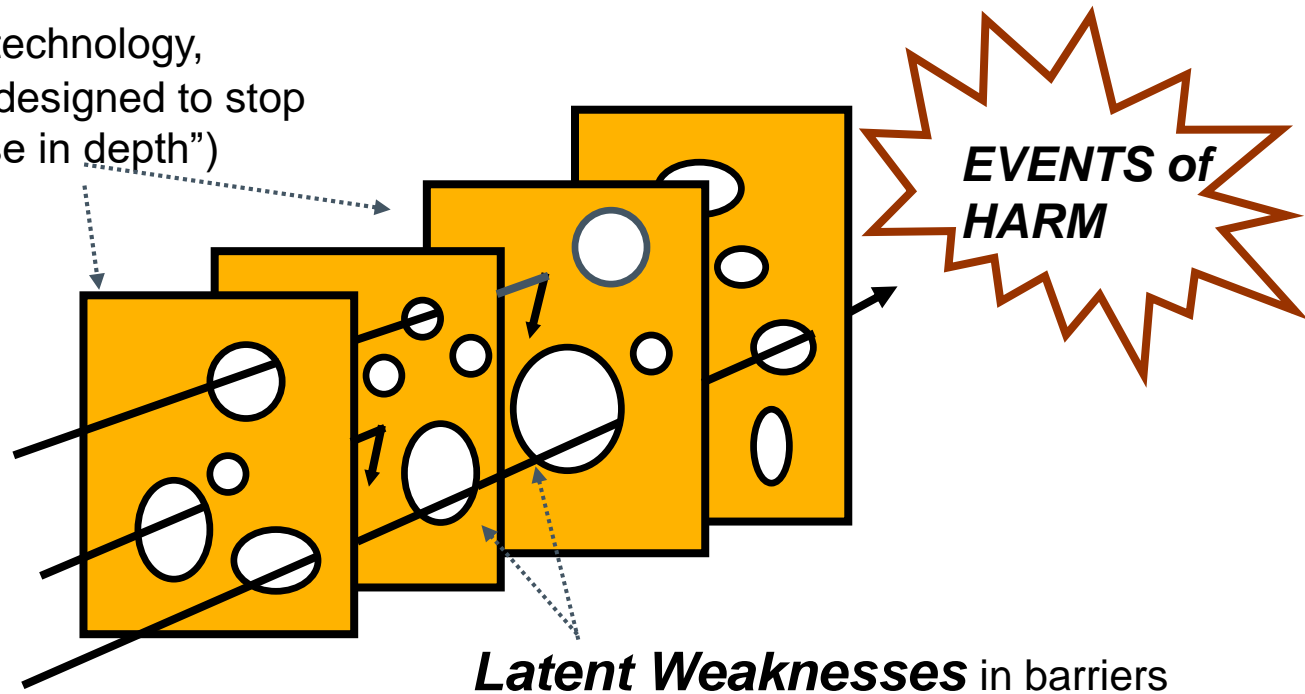


Sidney Dekker
Associate Professor
Centre for Human Factors in
Aviation
Linköping Institute of Technology
Sweden

SafetyFirst

Comprehensive Approach to Event Prevention

Multiple Barriers - technology, processes, and people - designed to stop active errors (our “defense in depth”)



Active Errors
by individuals result
in initiating action(s)

Latent Weaknesses in barriers

PREVENT
The Errors =

DETECT
System Weaknesses

CORRECT
Root Causes of Events

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Root Cause Analysis (RCA)

- A structured problem-solving technique that results in one or more corrective actions to prevent recurrence of an event.
- The goal of a Root Cause Analysis is a *Root Solution*.

Apparent Cause Analysis (ACA)

- A limited investigation of an event that is performed instead of RCA for less-significant (e.g. Precursor or Near-Miss) events.
- The goals of an Apparent Cause Analysis are to:
 - Remediate conditions adverse to quality
 - Support future trending and monitoring efforts (e.g. Common Cause Analysis)

RCA at a glance

- Event Occurs: Stabilize the situation first and foremost
- Consider the need for the RISE team? (Resiliency In Stressful Events)
- Risk Management notification
- Initial investigation
- Develop the SBAR documentation for the RCA advisors
- RCA huddle
- Lead analyst completes investigation
- Development of Events and Causal Factors chart
- Three meeting model
- Meeting with executive sponsor to prepare them for their responsibilities
- Identify root cause(s) and significant proximate causes, that require action plans

Initial notification and investigation

- Event occurs: stabilize the situation
- Risk Manager is notified
- Assure appropriate site leadership is notified
- Assure event is entered in Midas (incident reporting system)
- Risk Manager investigates and develops SBAR for the RCA advisor team.

SBAR: Keep it concise!

- Situation
- Background
- Assessment
- Recommendation/Request for RCA Advisors

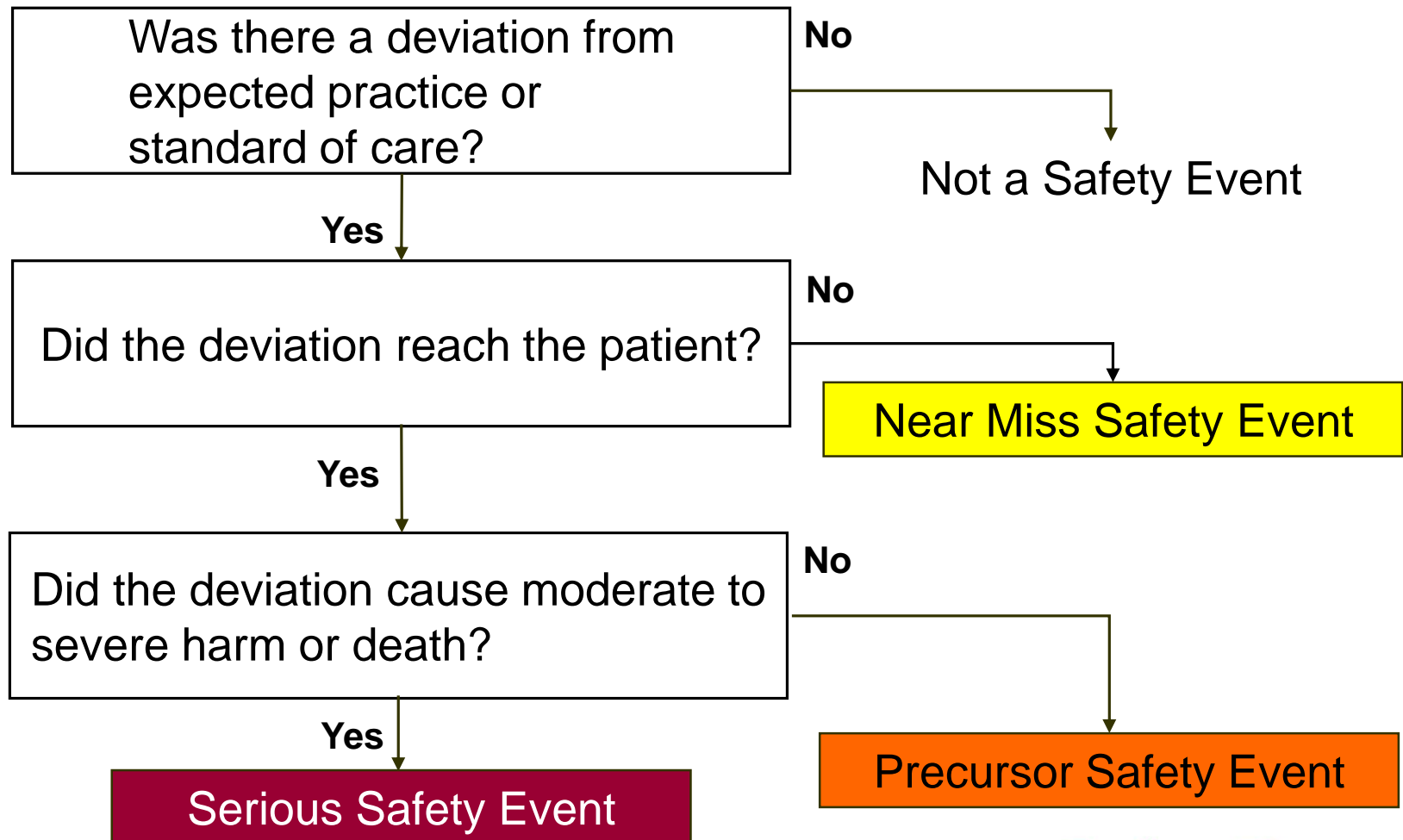
RCA huddle

- RCA advisors team meet ASAP after event becomes known
- Classification of the Event: Serious vs. precursor vs. near miss
- Determination of the level of analysis: RCA vs. ACA vs. Barrier Analysis
- Disclosure discussion: within 24 hours
- **Goal: Get to the root cause(s) within 45 days**

RCA huddle

- Additional decisions:
 - Identification of the executive sponsor
 - Lead analyst assignment
 - Support of staff/physicians discussed (RISE)
- What should NOT happen in the huddle:
 - Fix the problem
 - Get into too much detail
 - Jump to conclusions: Trust the RCA process!!!

Safety Event Decision Algorithm



Joint Commission Sentinel Event Definitions

- **Sentinel Event:** a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition), that reaches a patient and results in death, permanent harm or severe temporary harm*
- **For suicide:** suicide of any patient receiving care, treatment and services in a staffed around the clock care setting, or within 72 hours of discharge, including from the hospital's emergency department.

*Severe temporary harm is critical, potentially life-threatening harm, lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, additional major surgery

Investigation

Review of records, literature and equipment

Includes:

- patient record
- equipment records
- schedules
- assignments
- contact maintenance or clinical engineering

Literature review or consultation with an expert is expected with each RCA!

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Investigation

The Interviews:

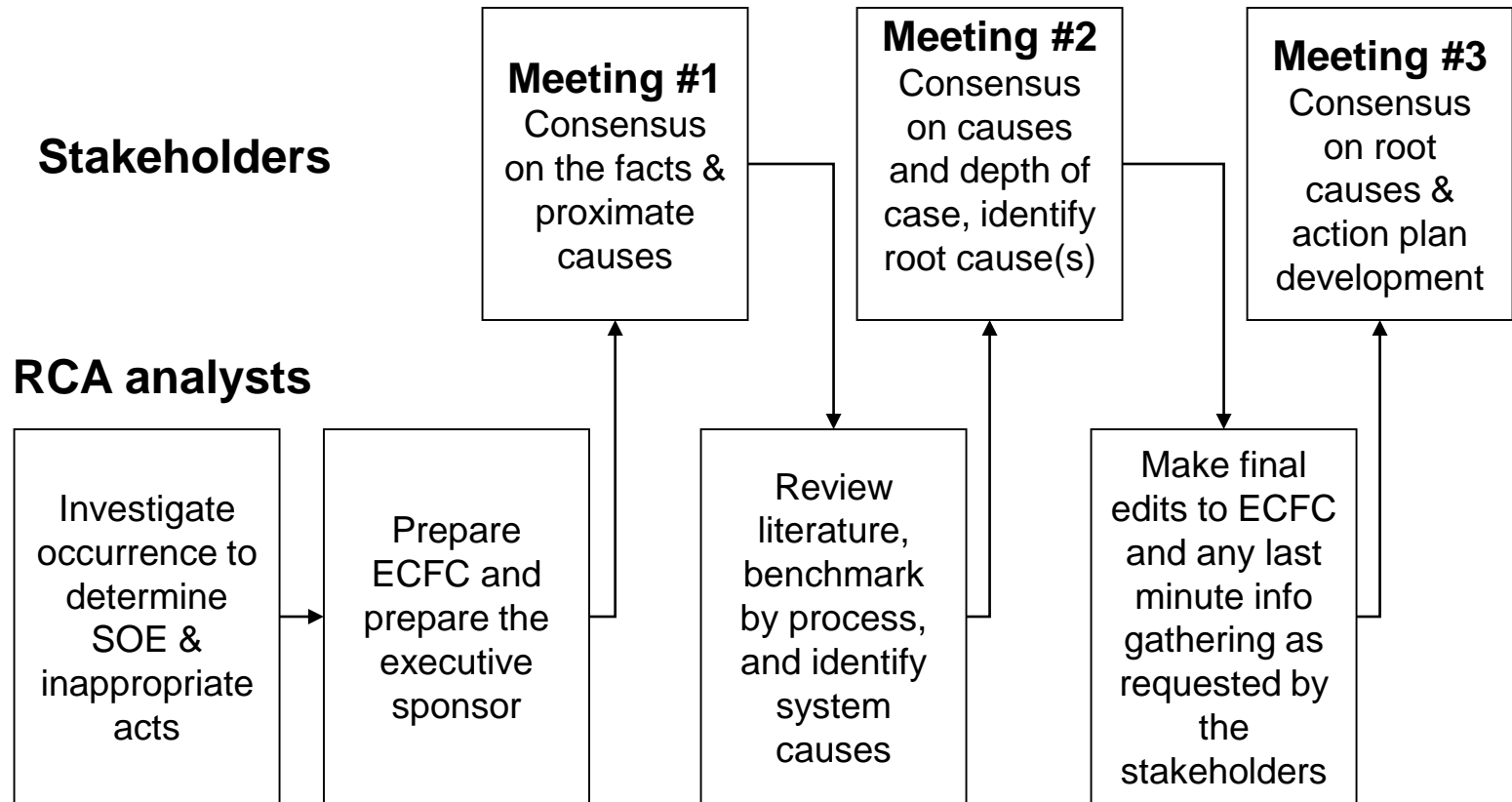
- Sequence interviews from least involved to most involved (to assure what the process is supposed to be before comparing to what actually happened)
- Key issues are addressed and interview stays on track
- Start the interview by explaining the RCA process and this is about PROCESS improvement, not about finding blame
- Start with open, more broad questions, then get more detailed
- Be very aware of your non-verbal communication and take detailed notes

Early on: Meet with executive sponsor

The executive sponsor:

- A senior leader who “is responsible” the root cause analysis quality
- VP level or above, can be executive director level
- **Is ultimately responsible for the root solution and implementation of corrective actions**

Three meeting model



SOE = Sequence of Events

ECFC = Events & Causal Factors Chart

CAPTR = Corrective Actions to Prevent Recurrence

Getting to the Root Cause

Testing for Comprehensiveness:

- Taguchi Method: Ask **Why** five times
- Keep asking **Why** as long as the answer is more significant - stop when the answer is less significant
- Stop when actions to prevent recurrence don't change

Finding the Root Cause(s)

A root cause must meet the following criteria:

- Proven cause and effect relationship – if corrected, recurrence of the event is prevented
- Is under the control of management
- Can be prevented cost effectively

A confirming check...

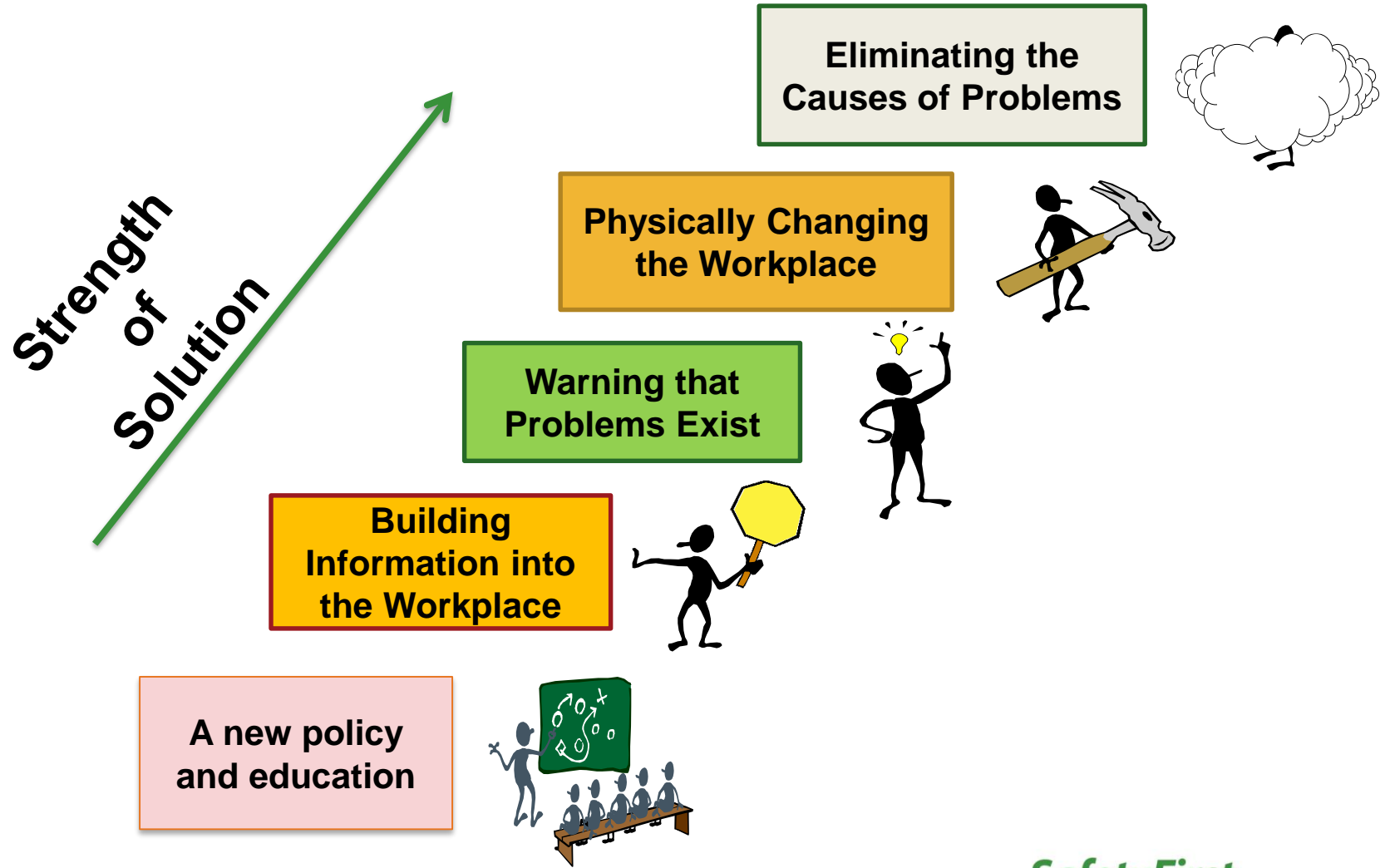
- Is sub-standard if it is a **system** causal factor (not individual failure)

Developing a CATPR

Corrective Actions to Prevent Recurrence (CATPR):

- At a minimum address each root cause(s)
- May include actions to address other causal factors
- Beware of fixing “World Hunger”
- Single person responsibility for each action
- Set due dates for each action step
- Check Step Questions: Confirmation of effective implementation

Strength of Solution



Develop a spread and sustain plan

- Spread and Sustain plan is part of the action plan!
- Stakeholder team to discuss and decide transportability of the root cause(s) and action plan
 - Where does this problem exist?
 - What information needs to be shared and how?
 - Some actions apply across the network, others do not
 - Executive sponsor to help determine extent of the spread and sustain plan

Audience:

Using the chat box please tell us what was most meaningful or poignant to you about this presentation.

Interview

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**Julie Goldstein
Grumet, PhD**



**Eliza Jacob-
Dolan, LICSW**

Audience:

Using the chat box please tell us what was most meaningful or poignant to you about this presentation.

Discussant

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**Becky Stoll,
LCSW**

TYPE IN THE Q & A BOX

What questions do you have for any of our presenters?



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Continuing the Discussion: Answers to Frequently Asked Questions

It is often hard for us to find out that the individuals death was determined a suicide. Can the speakers address stigma and reporting?

It is important to develop close working relationships with your Coroner/Medical Examiner as well as local law enforcement which can be key to confirming a suicide death. New Hampshire has established a daily link between our Medical Examiner and Bureau of Behavioral Health in which information about suicide deaths are shared and passed on to the community mental health centers, schools and other key providers for postvention response. This evolved from the work the Connect Program did in establishing best practice protocols for Medical Examiners and law enforcement which include confirmation and notification. The protocols are included as part of the Connect Postvention training process, which in taking a community approach results in shared language, understanding and more cooperation among those who will be deployed during a postvention response.

In some situations it may not be possible to confirm that the death was a suicide. For instance when toxicology reports are required it may be a 4-6 week lag time before the cause/manner of death is confirmed. A modified postvention response may still be indicated in these situations. Sudden deaths can occur in many forms beside suicide including: homicide, drug overdose deaths, accidents, medical conditions or as noted above may be under review and or undetermined. Each of these can be traumatic to family, friends, workplaces, communities and/or organizations and though they lack the aspect of potential for contagion, they may benefit from a coordinated postvention response to promote understanding, healing, support, and help seeking.

What kind of training do your Peer Support Clinicians receive?

New Hampshire has peer support people working in a variety of settings and organizations. Their training depends on the roles they serve in and the organizations they work for. The state is in the process of developing a peer support certification program which includes suicide prevention training but not (as of yet) postvention training.

Are there any studies or outcomes studied on providers who do attend funeral services?

I am not aware of any studies specific to attending funeral services. There are studies which indicate having contact with family may lower the risk of litigation, but this must be considered in relation to confidentiality, releases of information (if any) and deceased patient's wishes as well as organizational policies and procedures.