

# The Joint Commission Perspectives®

## FAQs: Suicide Risk Recommendations

The Joint Commission has received questions related to the Suicide Risk Recommendations published in various *Perspectives* articles over recent months.<sup>1-4</sup> The following set of Frequently Asked Questions (FAQs) is intended to address these questions and provide clarification to the field.

*For questions related to the FAQs or the suicide risk recommendations, please contact the Standards and Interpretation Group (SIG) via the [Standards Online Submission Form](#).*

### Inpatient Psychiatric Units

**Question:** Can you please clarify the first recommendation as it relates to the nurses station?

**Answer:** *The recommendation states: “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.”<sup>1</sup> This refers to what can be seen within the nurses station, not what is being seen from the nurses station. If there is an unobstructed view of everything within a nurses station, then patients should not be able to attempt self-harm at the nurses station since this would be easily seen and interrupted.*

**Question:** How many ligature-resistant medical beds does my unit have to have?

**Answer:** *The Joint Commission has not specified a requirement for the number of ligature-resistant beds on any given unit. This will depend on the needs of the patient population. The type of medical bed should be balanced based on the medical needs and the patients’ risk for suicide. For patients who require medical beds that have ligature points, there must be appropriate mitigation plans and safety precautions in place. This information should be documented within the patient’s medical record. In addition, The Joint Commission will not advise on the type of medical beds or ligature-resistant bed that should be purchased for patients. These decisions should be balanced based on patient needs.*

***If these medical beds are being used within an inpatient psychiatric unit, safety provisions must be considered for all patients who could be at risk for suicide. Provisions may include locking the patient room door where a medical bed is being used when unoccupied, removing a medical bed from the unit if not in use, and/or any intervention that restricts access to the medical bed by other patients.***

**Question:** Can drop ceilings be used in hallways and common patient care areas? **Answer:**

*Yes. 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 at all times and there are no objects that patients could easily use to climb up to the drop ceiling.*

**Question:** Are over-the-door alarms required to be used on patient bedroom doors from the corridor?

**Answer:** *We neither discourage nor promote the use of these devices.*

**Question:** If patients are transported to another location (such as another building for programming), does that building/space need to be ligature resistant?

**Answer:** *Patients who are currently at high risk for suicide should remain in a ligature-resistant environment. Monitoring of patients leaving the unit for a period of time must protect patients from self-harm.*

**Question:** Is there a height requirement in order to consider something a “ligature risk”?

**Answer:** *There is no height requirement for a ligature risk. Information from various sources notes that suicides as a result of asphyxiation can occur at any height. Specifically, we have had multiple reports of suicides or suicide attempts during which patients fixed a ligature to a low pipe and around their neck and then spun their body (“alligator roll”) to twist the ligature until it asphyxiated them. Thus, low-to-the-ground exposed piping (such as piping near toilets or under the sink, for example) or any other apparatus protruding from the wall or another structure is still considered a ligature risk if the patient is able to create a sustainable point of attachment with another material in order to inflict self-harm or cause loss of life.*

**Question:** What type of shower curtains are allowable in an inpatient psychiatric unit? **Answer:**

*The Joint Commission will not advise or recommend any particular type of shower curtain, but shower curtains are considered a risk. The expectation is that shower curtains should be noted on an environmental risk assessment and the organization must have a mitigation plan for monitoring any high-risk patients near the curtain or area where this risk is present.*

**Question:** Can curtains be used in place of a bathroom door in an inpatient psychiatric unit?

**Answer:** *If curtains are used in place of a bathroom door, analysis of this risk should be noted on the environmental risk assessment, and the organization must have a mitigation plan for monitoring any high-risk patients near the curtain or area where the risk is present.*

## **Emergency Departments**

**Question:** Do emergency departments need to be ligature resistant?

**Answer:** *No. Emergency departments do not need to meet the same standards as an inpatient psychiatric unit to be a ligature-resistant environment. Patients in emergency departments often require equipment to monitor and treat their medical conditions, so it is impossible to make their environment truly ligature resistant. However, organizations must implement safeguards to keep patients with active suicidality safe during the course of treat-*

ment in that setting (see Recommendation #12<sup>1</sup>). In designing the emergency department environment, the organization must first consider state rules and regulations (typically the state health department).

**Question:** Does every emergency department need to have a “safe room”?

**Answer:** No, The Joint Commission does not mandate “safe rooms” in emergency departments. Please see Recommendation #12 to understand how patients can be protected during treatment in the emergency department.<sup>1</sup>

**Question:** Do we have to have 1:1 monitoring for every psychiatric patient who comes in through the emergency department?

**Answer:** No. Only patients with serious suicidal ideation (that is, those with a plan and intent) must be placed under demonstrably reliable monitoring. Most importantly, the monitoring must be linked to immediate intervention by a qualified staff member when called for.

**Question:** Do we have to assess every patient for suicide risk who comes into the emergency department?

**Answer:** No. Only patients being evaluated or treated for behavioral health conditions as their primary reason for care must be screened for suicide risk. Please reference National Patient Safety Goal NPSG 15.01.01.01 for additional detail in addition to Joint Commission standards and requirements regarding screening protocols.

**Question:** What if all objects posing a ligature risk cannot be removed from the area where high-risk patients are being treated or triaged?

**Answer:** Please refer to the [second Emergency Department FAQ above](#) and Recommendation #12.<sup>1</sup> The organization should remove all items that can be removed from the room and provide an appropriate level of monitoring based upon patient’s suicide risk and the ligature/self-harm items that remain in the environment to ensure patient care is provided in a safe environment. The organization is expected to develop and implement a policy/procedure to direct staff, provide education to staff as to the procedure, and ensure demonstrated competence and compliance.

**If the organization has a designated “safe room,” The Joint Commission expects this room to be ligature resistant.**

### Miscellaneous Questions

**Question:** What are the requirements for an inpatient substance abuse detox unit? **Answer:**

Organizations providing inpatient substance abuse detox treatment (as the primary focus of treatment) should follow the recommendations applicable to general acute care inpatient settings, given the complexity of physical health care required to care for these patients. These units do not need to meet the same recommendations as psychiatric inpatient units.<sup>1</sup>

**As with any patient receiving treatment for mental health, screening, assessment, and reassessment are critical when determining the appropriate level of care.**

**Question:** What does “serious” risk for suicide mean?

**Answer:** Organizations should use an evidence-based process to conduct a suicide assessment of patients who exhibit suicidal behavior or who have screened positive for suicidal ideation. The assessment should directly ask about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. After this assessment, patients should be classified as high, medium, or low risk of suicide. The Joint Commission considers “serious” as equivalent to “high risk.” (Please refer to NPSG 15.01.01 for information relevant to screening and assessment of patients at risk for suicide).

**Question:** Are the recommendations the same for open and/or unlocked psychiatric units?

**Answer:** The recommendations for a ligature-resistant environment<sup>1</sup> for inpatient psychiatric units (in both a psychiatric hospital and a general acute care hospital) apply to closed or secure/locked psychiatric units in which entrance to and exit from the unit are controlled by unit staff and a patient could not independently leave the unit without supervision. The recommendations would not apply to an open or unlocked psychiatric unit in which patients are able to enter and exit of their own accord.

**Question:** Do emergency departments in Joint Commission–accredited ambulatory care organizations need to comply with the “Recommendations for Emergency Departments” in the November 2017 *Perspectives* article?

**Answer:** Yes. These freestanding emergency departments accredited under the Ambulatory Care Accreditation Program must comply with the emergency department recommendations.<sup>1</sup>

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## References

1. Joint Commission Resources. Special report: Suicide prevention in health care settings. *Jt Comm Perspect.* 2017 Nov;37(11):1 and 3–7.
2. Joint Commission Resources. Special report: Suicide prevention in health care settings. *Jt Comm Perspect.* 2018 Jan;38(1):1–3.
3. Joint Commission Resources. Notes on suicide prevention panel recommendations published in November. *Jt Comm Perspect.* 2018 Feb;38(2):12.
4. Joint Commission Resources. Update: Recommendations from fourth meeting of suicide expert panel. *Jt Comm Perspect.* 2018 Mar;38(3):1 and 2.