St. Joseph's Healthcare Hamilton Suicide Prevention Work Plan for Implementation of External Review Recommendations

July 14, 2017
UPDATE September, 2018

St. Joseph's Healthcare Hamilton is fully committed to preventing suicide by all possible means in our hospital and for the patients we serve, with the aim of making suicide a never event in our facility. We sought the help of experts to review suicide events, our care approach, our policies and procedures. The recommendations from that review were released in July 2017. In concert with this an Action Committee for the Prevention of Suicide at St. Joseph's Healthcare Hamilton was created to ensure an uncompromising approach to deliver on those recommendations. Below you will find the recommendations, work plan, strategies in place, and an update on actions taken on each recommendation.

We have categorized each action as Complete (green), Mostly Complete (light green), In Progress (yellow), and Incomplete (red). Mostly Complete indicates that the work to accomplish the recommendation has been completed, recognizing there are further steps planned regarding continuing education, expanding the action to other areas, or furthering communication on the action. Subsequent work will focus on sustaining all initiatives and further engagement with our community to address suicide as a public health issue.

The scope of this work is extensive and our efforts toward suicide prevention will require continual work, assessment and improvement. St. Joseph's is committed to devoting the energy and additional resources necessary to ensure this is the safest place possible for our patients in times of crisis and despair.

	Recommendation	Work Plan	Strategies In Place as of July 2017	Status Update as of March 2018	Status Update as of October 2018
Rec #1	**System Improvement and Learning:** *SJHH should continue to take a system improvement approach by learning from every suicide incident and working with families to identify opportunities to improve care.*				
				UPDATE AS OF MARCH 2018	UPDATE AS OF OCTOBER 2018
1.1	Continue to take a quality improvement approach to devise, implement and disseminate system changes that provide the safest care possible to patients at risk of suicide.	• On a daily basis all incidents are investigated and reviewed completely and care is adjusted as needed • Quarterly review of Safety Incident Reports of level 1-4 suicide attempt incidents will be completed by Quality/Risk Departments and provided to Mental Health & Addiction Leadership Team (MHALT) to identify any emerging trends and concerns. • Review and consider expanding mandate of Suicide Prevention Required Organization Practice (ROP) working group. • A standardized communication with families for critical incidents	• SJHH has a strong expertise and commitment to quality improvement. • A process is already in place for assigning Most Responsible Person(s) and tracking and reporting on implementation status for all Critical Incident Review Recommendations, including suicide deaths. Each recommendation is reviewed at 3 and 6 months and implementation status is reported to the Corporate Quality Steering Committee. • Recommendations that apply across all of the Mental Health & Addiction Program (MHAP) are overseen by the Mental Health and Addictions Leadership Team (MHALT).	**COMPLETE** As an organization which is strongly committed to continual quality improvement, SJHH completed this recommendation as per strategies identified in the work plan. These strategies include: • All relevant Safety Incident reports have been identified and analyzed; • Suicide within the institution is a Never Event at SJHH; • We have developed and implemented a standardized strategy to communicate with families following critical incidents.	

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		will be implemented that includes follow-up post the review.			
1.2	Continue to develop greater consistency in the approach to Critical Incident Reviews of suicides.	• A review will be undertaken of peer organizations to establish the criteria for inclusion of discharged patients who have completed suicide in St. Joseph's Healthcare Hamilton critical incident reviews.	• Extensive work has been completed in the last 18 months to develop consistency in the approach to Critical Incident Reviews of suicides across inpatient clinical areas. • This standardized Critical Incident Review Process is in use to facilitate timely reporting, management and follow up of Level 5 and 6 suicide attempt and suicide deaths. All inpatient level 5 and 6 harm incidents follow this standard, which includes a fulsome review of the contributing patient, system and team factors. To strengthen this process we are working to include the perspective of patients and families.	**COMPLETE** • An environmental scan of approaches that our peer organizations utilize in relation to critical incident reviews of suicides has been completed and analyzed; • Based on the results of the environment scan, we are conducting quality reviews for critical incidents involving suicides for those which occur within 30 days of inpatient discharge, Emergency Department visit or mobile response visit.	
1.3	The Critical Incident Reports should specify the patient's voluntary/ involuntary status and observation level at the time of the critical event.	• Starting immediately, both these elements will be standard questions on the 24-hour review checklist. • These elements are being built into the electronic SIR reporting system.	• These fields have been added to the 24-hour review checklist on July 12, 2017.	**COMPLETE** • These fields have been added to the 24-hour review checklist and used since July 12, 2017.	
1.4	Leadership should determine and then communicate whether any further steps can be taken to make the environment safer in the context of previous	• A further review will be undertaken by redevelopment and clinical services to identify if any further opportunities to improve safety are achievable. This will include a review with peer organizations and subsequent published literature on	• Extensive work was completed in the design of the W5th Campus to minimize the risk of suicide attempts secondary to environmental design. • Recommendations from the internal reviews of these cases have already been implemented.	**Mostly Complete** • A thorough environment review was completed. We care for a broad range of patients in the Mental Health and Addiction Program, hence the environmental scan included looking at beds that help to prevent falls, care for patients who need the head of their bed raised due to respiratory conditions,	**COMPLETE** • A thorough environment review has been completed and the opportunities that were identified to improve safety have been implemented. • A new environmental checklist has been developed and implemented to enhance

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	inpatient attempts and deaths by suicide.	best hospital practice to improve environmental safety in suicide prevention. • As environmental safety enhancements are approved implementation will move forward very promptly.	• Co-leads from redevelopment and clinical team appointed to complete this review. • Recommendations to be presented to Mental Health Leadership and Senior Leadership within 60 days.	and patients at risk of self-harm. In all of this work, patient safety and quality of overall care have been major considerations; • An environmental check list was developed to enhance the existing monthly environmental reviews and is based on the work of other mental health facilities locally and internationally and the available literature. The checklist includes daily, monthly and annual reviews for identifying and mitigating any risks for violence or self-harm in the physical environment, and looks at an extensive list including doors, furniture and fixtures. The checklist has been trialed on two inpatient units (Orchard 2 and Orchard 3) and is being amended based on the learnings gathered from those trials. The revised plan was presented to the Mental Health and Addiction Leadership Team (MHALT) on February 23, 2018 and approved. The checklist will be broadly shared with managers and front line staff in March 2018. Each unit will then identify individuals responsible for completing the checklist by no later than May 1, 2018; • The procedure for search of patient belongings (April 2017) has since been revised and adapted as a policy which was approved and posted on January 30, 2018; and is now fully implemented. • The Search of Patient Belongings policy outlines various levels of search procedures and includes a list of items Not Allowed or	the existing reviews. • The Search policy is revised and implemented. The awareness posters have been posted.

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				May Not be Allowed on inpatient areas. These lists are available to patients and visitors for their awareness. Signage and posters for Not Allowed/May Not Be Allowed Items are in progress and will further increase awareness of patients and visitors.	
Rec #2	**Screening Assessment and Formulating Risk:** *All patients should be screened for suicide risk at their first contact with SJH and at every subsequent contact.*				
2.1	Adopt an approach to suicide risk screening, assessment and management that ensures that these actions are "always" events. For example, several suicide prevention groups, including the Suicide Prevention Resource Centre, the National Action Alliance for Suicide Prevention, and the Columbia Lighthouse Project, have recommended universal screening for all patients at every encounter.	• Review of current state across the organization. • Collaborate with Emergency Department to standardize approach to suicide risk screening. • Develop a synthesis of the literature on suicide screening, algorithms and safety plans to ensure risk screening is evidence-based and reflects latest research. • Make decisions for each level of assessment, from universal screening to follow up with more detailed assessment and treatment plans/care pathways. • Implement the standardized approach and revise as new learnings are available. • Using Plan *Do Study Act* (PDSA) framework to optimize algorithm.	• Currently a variety of tools and assessments are used, including but not limited to the Resident Assessment Instrument – Mental Health (RAI-MH), which contains content and quantitative risk scoring. • Outpatient and outreach programs use some standardized tools, but this is service specific. • Some clinics that are using Electronic Health Record have an algorithm in place or planned. • The new electronic health record (EHR) will contain more standardized approaches (i.e. Columbia Suicide Severity Rating Scale) and offers an excellent avenue to improve as outlined in the work plan.	**Mostly Complete** • A standardized approach to suicide risk screening, assessment and management has been developed, utilizing the Columbia Suicide Severity Rating Scale (CSSR-S). This standardized approach maps the patient's journey at transitional points from first contact in the Emergency Department, through Psychiatric Emergency Services and onto inpatient units; • Patients presenting in Emergency Department or Urgent Care with mental health concerns or history of, suicidal ideation, addiction and /or self-harm or who are identified at risk by a team member at any point during their Emergency Department stay is screened using this scale. In addition, given the dynamic nature of suicidal ideation, these assessments are repeated throughout hospitalization; • To ensure consistent management of suicidal risk, suicide risk assessment is now implemented with any change in the level of monitoring for patients considered at risk of suicide; • 91% of nursing staff across the inpatient	**COMPLETE** • A standardized approach to suicide risk screening, assessment and management has been developed, utilizing the Columbia Suicide Severity Rating Scale (CSSR-S). • This approach is fully implemented across the inpatient units and Psychiatric Emergency Services of the Mental Health and Addiction Program.

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				Mental Health and Addiction Program, Emergency Department and Urgent Care unit have completed training related to the use of the Columbia Suicide Severity Rating Scale; • Further staff training to enhance standardization of suicide assessment, safety planning and management has been developed with the implementation timeline by June 2018. This training addresses staff's educational needs as identified by the needs assessment survey administered in October 2017; • All newly recruited nursing staff receive a comprehensive training on suicide risk assessment and management during orientation.	
2.2	Patients with a mental health history should be screened for suicide risk in the Emergency Department (ED).	• Implement a standardized screening and assessment process for suicide risk in ED. • Review the screening process for Urgent Care. • Align the screening process with 2.1 and implement Columbia Suicide Severity Rating Scale built into the new Electronic Health Record. • Ensure that screening is initiated in triage.	• Staff education has begun related to the Columbia Suicide Severity Rating Scale and the process for assessment of suicide risk in the ED. • Standardized screening and assessment process is developed and being implemented.	**COMPLETE** • Each patient presenting in the Emergency Department (ED) or Urgent Care Centre with mental health concerns or history of, suicidal ideation, addiction and /or self-harm or who are identified at risk by a team member at any point during their ED stay is screened using the Columbia Suicide Severity Rating Scale (screening version); • In effort to facilitate a discussion with patients in the Emergency Department and Urgent Care regarding mental health concerns and provide information on resources in the community, a poster has been developed with input from patients and families represented on the Suicide Prevention Action Committee.	

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				This is present in the various waiting rooms in the Emergency Department and Urgent Care Centre.	
2.3	Specific criteria should be developed regarding patients that need to have a psychiatric assessment after presenting to the Emergency Department as being at risk for suicide.	• Specific criteria have been developed to identify patients who require suicide risk assessment upon presentation to the ED. • Based on the suicide risk assessment and clinical presentation, specific interventions have been identified to address immediate safety, psychiatric assessment and follow-up.	• Staff education has begun related to suicide risk assessment and the identified interventions. • Assessment process is developed and being implemented.	**COMPLETE** • We have developed and put in place criteria for patients who present in the Emergency Department or the Urgent Care Centre when further psychiatric assessment is required by the Psychiatric Emergency Services.	
2.4	The Psychiatric Emergency Service (PES) Risk Assessment tool should be revised.	• Continue undertaking a review of the PES Risk Assessment tool and leverage EHR with future enhancements. • Complete an environmental scan of risk assessment practices utilized in other Psychiatric Emergency Services. • Align a standardized approach to risk assessment with 2.1 and 2.2. and implement enhancements.	• Significant work has been completed to date to enhance the current PES Assessment tools in preparation for the EHR implementation, which will enable easier access to past assessments to capture a more accurate historical picture of the patient's story. • A risk assessment tool is currently completed for every patient in PES.	**COMPLETE** • In tandem with recommendation 2.1, Psychiatric Emergency Service has adopted the Columbia Suicide Severity Rating Scale and is now using it as part of a broader assessment of **all** patients who present at risk of suicide.	
2.5	PES Assessment is not saved with the rest of the record and this may explain our concerns about capturing the details of the management plan arising from the PES	• It is already the practice to save the PES assessment. Viewing this assessment will be enhanced with the introduction of the EHR. • Implement a standardized process to ensure PES records chronologically tell the story of the patient's journey.	• Template for crisis/safety plan development has been developed and utilized. • An enhanced and standardized Transfer of Accountability process has been implemented to improve the communication during patient transitions between PES and the	**COMPLETE** • Psychiatric Emergency Services assessment is now part of our Electronic Health Record which provides relevant patient information across the organization and is accessible to inpatient clinical areas.	

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	Assessment. The document includes a crisis plan; however, it could be made more collaborative by indicating that copies are to be given to patient, family physician and family/significant others.	• Receive input from the MHAP Patient and Family Advisory Council regarding how the current crisis/ safety plan can more fully incorporate the voice of the patient and family. This action aligns with 3.3.	receiving unit of an admitted patient.		
2.6	Access to means is included in the PES assessment but should be built into inpatient assessments particularly prior to discharge.	• Complete random chart audits, and an environmental scan to determine how access to means is currently being captured. • Build into the screening/assessment process a reassessment of access to means prior to passes and discharge. • Within the written assessment process include any information provided by the family about access to means.	• Currently within the PES assessment, access to means is assessed and documented. • Enhancements to the inpatient assessments to incorporate the information about access to means are being built as part of Electronic Health Record.	**COMPLETE** • Questions regarding access to means are built into the new Electronic Documentation System both at the time of the initial patient assessment and ongoing care.	
2.7	Processes should be adopted that require a re-assessment of suicide risk be completed and documented with each change in the patient's level of observation.	• Existing practice is to reassess patients when significant changes occur. • Re-assessment of suicide risk will be aligned with and included in processes described in 2.1. It will address ongoing follow-up and "triggers" for re-assessment and putative change in risk level during treatment.	• For inpatient care, the Resident Assessment Instrument is triggered when there is significant change in status, this will revise the various self-harm scales. • Some outpatient services also have methods to update risk assessments and safety plans. • These strategies will be reviewed	**Mostly Complete** • A process that requires re-assessment of suicide risk has been developed and incorporated into the standardized approach to suicide risk screening, assessment and management noted in 2.1; • Additional training on this process is developed with the implementation timeline by June 2018.	**COMPLETE** • A process that requires re-assessment of suicide risk has been developed and incorporated into the standardized approach to suicide risk screening, assessment and management noted in 2.1. Staff education is completed.

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		• The working group addressing the suicide risk/mitigation algorithm will ensure that a standard process for change in status is in place. • With the addition of the Electronic Health Record (EHR) auditing and compliance rates of the processes will be shared at all levels including with point of care staff and with the Patient and Family Advisory Council.	against best practice and applied across Mental Health and Addiction Program.		
Rec #3	**Clinical Services, Care Management and Safety Planning:** *SJHH should take the approach that most suicides are preventable, recognizing that suicide prevention requires a collaborative approach that involves patients, families and care teams.*				
3.1	Complete a needs assessment survey regarding staff's educational needs to ensure that they feel confident and competent to deal with patients at risk for suicide.	• A small group will be formed to formulate comprehensive needs assessment related to suicide risk assessment and treatment. • In parallel, a series of focus groups will be held with patients and families to ascertain their experiences of staffs' interventions and perceived gaps in knowledge, skills and attitude. • The needs assessment will be administered electronically. • Results will be tabulated and analyzed for themes. • Concurrently with the above, the group will review best practice educational offerings and determine the most feasible alternatives. • Staff needs as identified by the assessment will be matched to	• Education on suicide risk assessment and management is provided to new clinical staff as part of clinical orientation. • Various clinics and services have had staff engage in a variety of training opportunities when these have arisen in the past. • Managers and directors have completed some environmental scans and are aware of training opportunities (e.g. ASSIST) that might be scaled up.	**COMPLETE** • We have completed a needs assessment survey, premised on the "Zero Suicide" strategy - publically available and supplemented by custom questions; • This survey was sent out to over 500 clinical staff and physicians working in the inpatient Mental Health and Addiction Program as well as the Emergency Department; • The results of the survey informed an education plan for staff which will be rolled out by June 2018 and will aim at enhancing the standardization of our current practice in suicide risk screening, assessment, safety planning and treatment.	

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		available training opportunities. • Education will be offered to all staff with a view toward sustainability (i.e. onboarding new staff in future)			
3.2	Concurrent Disorders Program should develop and implement an algorithm for decision making and intervention for patients with a specific risk profile related to suicide, e.g. the algorithm should include risk profiles, substance use, care pathways, family engagement, observation levels, an environmental evaluation and rapid responses related to emerging information.	• Develop a synthesis of the literature on Concurrent Disorder and Addictions on specific risk factors for suicide, and evidence-informed interventions. • Complete an environmental scan of practices utilized in similar peer organizations. • Develop, implement and evaluate a compressive algorithm that outlines care pathways, and clear treatment protocols based on identified risk factors. • Engage the MHAP Patient and Family Advisory Council to ensure the patient and family voice is clearly captured throughout the admission process.	• Considerable work has been completed to date to incorporate best practices in the assessment and management of Concurrent Disorders. • Currently, M1 utilizes an electronic battery of validated screening and assessment measures to assess substance use, mental health symptoms and risk factors. • An environmental scanning process titled "Red, Yellow, Green" is completed and in place to identify environmental risks on the unit daily. • An Addiction Counselor meets with each patient to develop an initialized assessment and treatment plan that includes risk. • A monthly family group for families of patients with Concurrent Disorders is facilitated at the West 5th Campus. • Current screening practices include standardized tools for symptoms of substance use and withdrawal, which can impact risk levels.	**COMPLETE** • Current scientific literature on concurrent disorders and addiction has been reviewed to establish if similar algorithms have been developed; • The literature review found no algorithms for Concurrent Disorder population. As a result, we have developed and implemented an algorithm in our inpatient Concurrent Disorders Program based on evidence and with input from the Action for Suicide Prevention Committee. This algorithm includes factors such as risk profiles, care paths, family engagement, levels of monitoring, environmental evaluation and rapid responses related to emerging information.	
3.3	Expand on collaborative approaches that include families and	Therapeutic alliance, collaboration and trust are foundational to care of patients and in the relationship	• MHAP has already identified partnerships with families as one of their strategic directions and multiple	**Mostly Complete** We recognize the importance of clear communication and engaging with families. The	**COMPLETE** • Guidelines for Family and Staff Communication have been developed,

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	significant others in suicide prevention such as: • Fostering collaborative safety planning, • Joint interventions to remove access to means, • Clear procedures to respond to a family's concerns about the patient's risk for suicide	between clinicians and patients and their families. This is already reflected in professional standards, quality and accreditation standards and many policies and procedures. The following will be done to strengthen the importance of therapeutic alliance and collaboration: • Emphasis on the importance of therapeutic alliance in orientation of all clinical staff • Implementation of a consistent safety/crisis tool with consultation from the MHAP Peer Advisory and Family Advisory Councils and thereby engaging families in safety/crisis planning • Guidelines have already been implemented called "*Guidelines for Communicating with Family Members"* and will be amended, in light of these recommendations to emphasize the therapeutic alliance, collaborative safety/crisis planning and will consistently include open discussion of suicide risk.	strategies have been developed and implemented to foster collaborative relationships with families. • "*Guidelines for Communicating with Family Members"* has been developed with training sessions for all clinical staff held in Fall 2016. • Process for consultations with Family Advisory Council and Peer Advisory Council is in place.	following strategies have been developed to advance our strong commitment to partnering with families and significant others in suicide prevention: • Guidelines for Family and Staff Communication regarding Suicide Risk and Prevention Planning are completed; • A comprehensive implementation plan is underway that includes engagement of MHAP Family Advisory Council, Mental Health and Addiction Program (MHAP) Leadership Forum, education to front line staff to be completed by May 2018, and inclusion in MHAP Policy and Procedure; • With the patient's consent, family and significant others are invited to participate in assessment, treatment and discharge planning; • The Family Charter of Rights has been developed and approved, with the input from the Mental Health and Addiction Program Family Advisory council.	implemented and are accessible to staff. • Family Charter has been developed and approved.
3.4	Staff should continue to focus on developing therapeutic alliances and support the patient in telling their story.	• The practice of engaging patients in their plan of care will continue with strong emphasis on the importance of the therapeutic alliance. • This is already reflected in professional standards, quality and accreditation standards and many	• SJHH is deeply committed to a person-centred approach to care which places strong emphasis on therapeutic alliance with patients we serve. • *Key Steps to Discharge* is currently firmly established in the Schizophrenia and Mood Disorders Services.	**COMPLETE** • Extensive work on *Safewards* training and implementation across the Mental Health and Addiction Program proceeded as planned and is on target for completion in March of 2018. The importance of the therapeutic alliance is foundational to *Safewards*;	

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		policies and procedures. • The importance of the therapeutic alliance is foundational to *Safewards*, currently in process of implementation across the Mental Health and Addiction Program; *Key Steps to Discharge* which includes strong elements for patient and family engagement; and other patient-first strategies that are implemented across the Program such as the Comfort Plan. • The Patient Story is integrated into the new electronic health record.	• *Safewards* Modules are in process of being implemented across MHAP inpatient units. • Comfort Plans are in use on all inpatient units. • Clinical Monitoring process is in place and it fosters patient engagement and development of therapeutic alliance.	• To ensure there is education about the elements of *Safewards*, a Knowledge Fair was held in October, featuring how our staff have implemented each of the 10 interventions, and the *Safewards* team hosted the mental health rounds the same month; Information about *Safewards* is posted and updated on the internal St. Joe's website. • The electronic health record system has been implemented, with the Patient Story integral to that system.	
3.5	Policies regarding passes – The program may consider creating a policy about allowing passes to patients on Forms 1, 3 and 4.	• In light of these recommendations, the Mental Health and Addiction Program policy addressing Therapeutic Passes will be reviewed and updated. Upon completion of this, the policy will be distributed and implemented. • Continue ongoing environmental scan of peer organizations' policies and procedures related to passes and integrate improvements into the Mental Health and Addiction Program policy on an ongoing basis. • Review integration of applicable policy elements into the new electronic health record.	• 042-MHA (Mental Health and Addictions) policy is drafted and near completion	**Complete** • Therapeutic passes are a clinical approach that supports various degrees of access to the community for an inpatient, with the ultimate goal of community re-integration; • Many factors are considered when determining the level of therapeutic pass and involve the dynamic interplay of managing risk, personal liberty and community re-integration. • The therapeutic pass policy has been thoroughly reviewed, revised, approved and posted on February 1, 2018 and is now fully implemented. • The focus of policy revisions was to ensure a consistent approach to the determination and ongoing assessment of therapeutic pass levels.	

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3.6	Clinical Monitoring Policy: Within the policy, the section on documentation should specifically indicate that a new assessment of suicide risk should be documented with any change in the level of monitoring for patients considered at risk of suicide.	• Review and amend the Clinical Monitoring Policy (031-MHA) to reflect this recommendation.	• Clinical Monitoring policy was developed in 2015. This policy supports a culture that fosters person-centred care and places greater emphasis on therapeutic engagement, and reduction of emotional distress. • Clinical staff conducts clinical monitoring rounding at least hourly and this intervention contributes to the broader assessment of patient's well-being and plan of care.	**COMPLETE** • The policy has been revised, approved and disseminated in September of 2017. • Policy revision included the recommendation that a new assessment of suicide risk should be documented with any change in the level of monitoring for patients considered at risk of suicide.	
3.7	Suicide Risk Assessment and Monitoring Policy: The Guiding Principles should include that most suicides are preventable; suicide prevention requires a collaborative approach involving patient, family, etc. Although the document is quite complete, the policy should include doing safety planning with each patient at risk and documenting that removing access to means has been addressed.	• The Suicide Risk Assessment and Monitoring Policy (040-MHA) will be revised immediately to include the guiding principles outlined in this recommendation. • Subsequently a much broader revision of this policy will be carried out as work on 2.1 and 2.7 will necessarily change the actions called for in that policy.	• The current policy has been in place since 2011 and is widely known and adhered to.	**Mostly Complete** • Revisions to this policy required completion of several recommendations outlined in this document; • With those recommendations completed, we have drafted necessary revisions, incorporating the process for suicide risk screening, assessment and management, as outlined in 2.1; • The policy has received a preliminary approval and will be brought forward to the Mental Health and Addiction Program Leadership Team early in 2018 to be formally approved.	**COMPLETE** • Policy is revised and implemented in light of recommendation.
3.8	Contracting for safety is not an effective suicide	• The implementation of this recommendation will be aligned	• The lack of evidence for contracting is generally known and accepted by staff.	**Mostly Complete** • Contracting for safety and its lack of efficacy	**COMPLETE**

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	prevention method and focusing primarily on the presence or absence of suicide ideation is not an adequate means to determine suicide risk. Both these approaches should not be used to replace a well-documented suicide risk assessment, management plan and pathway of care.	with needs assessment and education plan described in 3.1 • A component of the education plan will reflect a shift from contracting for safety to more evidence-informed strategies.		and effectiveness is being addressed through a plan for education to be completed by June 2018, based on the process described in 2.1 and policy revisions noted in 3.7.	• All staff and physicians have been educated about the lack of efficacy of contracting for safety and have been provided with an evidence based alternative.
3.9	Patients seen in ED because of the risk of suicide should have follow-up contact.	• Identify and implement specific interventions based on the suicide risk assessment and clinical presentation, to ensure immediate safety, psychiatric assessment, support and follow-up.	• Interventions have been identified and the process is being implemented.	**Complete** • For patients who are under the care of the Emergency Room physician, follow-up arranged with Primary Care and/or psychiatry as required. Criteria for psychiatry follow-up has been developed and an algorithm is available outlining the process.	
3.10	Leadership action should be taken on search and seizure policies to prevent patients from having access to means.	• In light of the recommendations, the Patient Search Procedure including the Contraband/Restricted items list will be reviewed and updated to include risks for self-harm that have arisen from these completed suicides. • Update recently established Patient Search Procedure to include risk for self-harm. Include all relevant	• Considerable work has been completed to date. • All inpatient clinical staff at the W5th campus has reviewed Patient Search Procedure with a consistent Contraband/Restricted list established for all MHAP units. • Training plan for staff is under development and will include an instructional video.	**Complete** • The procedure for search of patient belongings (April 2017) has since been revised and adapted as a policy which was approved and posted on January 30, 2018; and is now fully implemented. • The Search of Patient Belongings policy outlines various levels of search procedures and includes a list of items Not Allowed or May Not be Allowed on inpatient areas.	**Complete** • Signage and posters for Not Allowed/May Not Be Allowed Items have been posted

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		programs (beyond MHAP) where applicable. Include review of Contraband/Restricted items list. • Continue ongoing environmental scan of peer organizations' policies and procedures related to searches and integrate improvements into MHAP as appropriate. • Develop communication, implementation and training plan for all inpatient staff.		These lists are available to patients and visitors for their awareness. • Signage and posters for Not Allowed/May Not Be Allowed Items are in progress and will further increase awareness of patients and visitors.	
Rec #4	**Leadership:** *St. Joes should undertake a review of its leadership structure in the Mental Health and Addiction Program that positions the organization to be a regional leader in suicide prevention and Concurrent Disorders. Leadership should work to encourage increased engagement of psychiatric staff in the leadership of the Concurrent Disorders Program.*				
4.1	Review the medical leadership structure of the "General Psychiatry and Addictions Services" and the Concurrent Disorders Inpatient Program.	• This review will be completed by the Chief of Psychiatry in collaboration with the Chief of Staff.		**COMPLETE** • A search for concurrent disorders medical lead is completed and the lead is appointed.	
4.2	The Medical Leadership structure should encourage more engagement of the psychiatric staff in the operations of the Concurrent Disorders Inpatient Service.	• Increase standardization of psychiatric care for this specialized population • Recruit addictions lead for this program	• Monthly meetings with Head of Service of the General Psychiatry and Addiction Services and the physicians within this service are already in place • Physicians participate in team meetings and safety huddles on the unit • Monthly complex care reviews are established	**COMPLETE** • Individual psychiatrists were involved in the implementation of the recommendations specific to the Concurrent Disorders Inpatient Service. • SJHH senior leadership and staff have been instrumental in developing an inpatient addiction medical service and Rapid Access Addiction Medicine clinic (RAAM). If approved, this will dramatically enhance our ability to bring best practice and support needs of patients in our medical, Emergency	**COMPLETE** • The Rapid Access Addiction Medicine Clinic (RAAM) is operational.

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				Department and Mental Health and Addictions programs.	
4.3	It is suggested that the organization and its healthcare professionals consider sharing relevant issues arising from this review with other psychiatric facilities and professionals in the province and the Ontario Hospital Association (as it relates to the Suicide Prevention Standards Task Force) with the specific goal of creating an appropriate means of collecting data to refine the most effective policies, procedures and practices in order to approach the zero suicide objective.	• A distinct report document will be developed that describes the circumstances that led to the review, recommendations resulting and organizational response. • The report will also contain a lessons learned component to help peers with practices that were effective, feasible, and sustainable. That document will be shared with the Mental Health and Addiction Quality Initiative (MHAQI) members and discussed at regular meetings so as to maximize the opportunity for peer institutions to learn from our experience. (**MHAQI is a group of peer hospitals in Canada who provide mental health services and have agreed to share data and quality initiatives so that the work of one organization can benefit all.)** • The report will serve as a basis for webinar or online learning with executive teams at other Ontario Mental Health Programs	• SJHH has been a longstanding member of the MHAQI, which involves almost 30 mental health facilities in Ontario. • MHAQI already discusses similar issues that arise and can be updated on our work in progress.	**Mostly Complete** • This recommendation represents a final step and culmination of all of the work described in this document. We are committed to disseminating this work to interested peers, and intend to provide a summary of our learnings at the next Mental Health and Addiction Quality Initiative (MHAQI) meeting in 2018; • We also believe there is the potential for national and international interest as the scope of this work is relatively unprecedented.	**COMPLETE** • All significant work products arising from the recommendations have been shared with the Mental Health and Addiction Quality Initiative (MHAQI).