If the hospital has consistently initiated advanced life support in fewer than 5 minutes, quality data should be reviewed to determine how this time could be even shorter. An interdisciplinary committee can be formed to complete resuscitation services reviews. These reviews include resuscitation cases and data to identify and suggest practice and system improvements in resuscitation performance.

Measurable Elements of COP.04.00

1. Resuscitation services are available and provided to all patients 24 hours a day, every day, throughout all areas of the hospital.
2. Medical equipment for resuscitation and medications for basic and advanced life support are standardized and available for use based on the populations served. (*See also* MMU.03.01, ME 4)
3. In all areas of the hospital, basic life support is initiated immediately upon recognition of cardiac or respiratory arrest, and advanced life support is initiated in fewer than 5 minutes.
4. Ⓓ The hospital performs an internal review of all resuscitation events for effectiveness and makes efforts to improve identified areas for improvement, including the following at minimum:
   - How often early warning signs of clinical deterioration were present prior to in-hospital cardiac arrest in patients in unmonitored or noncritical care units
   - Timeliness of staff's response to a cardiac arrest
   - Timeliness of initiation of advanced cardiovascular life support (ACLS) to the shortest time possible
   - The quality of cardiopulmonary resuscitation (CPR)
   - Post–cardiac arrest care processes
   - Outcomes following cardiac arrest

Management of Patients at Risk of Suicide or Self-Harm

Standard COP.05.00

The hospital has a process to identify and protect patients at risk for suicide and self-harm.

Intent of COP.05.00

Suicide is considered a sentinel event. Patients being evaluated or treated for behavioral health conditions often have suicidal ideation. The hospital must implement screenings and assessments to identify patients at risk for suicide and self-harm to minimize the likelihood of a suicide or self-harm attempt.

Screening identifies those at risk or potentially in need of a further, more specialized assessment. An assessment is a systemic process done to evaluate needs that can then be fulfilled, or a plan made around them on how to meet those needs, thus the individual conducting the assessment should have an expertise or specialty in the field being assessed.

Validated screening tools are an effective way to identify individuals who require further assessment to determine risk for suicide. A validated screening tool is one that has been scientifically tested for reliability (the ability of the instrument to provide consistent results), validity (the degree to which the instrument is measuring the condition that it is designed to measure), sensitivity (the ability of the instrument to correctly identify individuals with the condition), and specificity (the ability of the instrument to correctly identify individuals without the condition). In addition, the hospital must select validated screening tools that are appropriate for the population (for example, age-appropriate).

When using validated screening tools, organizations should not change the wording of the questions because small changes can affect the accuracy of the tools.

It is important that organizations ensure that the chosen screening tool(s) is implemented and completed as directed by the creators of the tool(s). For example, the Columbia–Suicide Severity Rating Scale (C-SSRS) is a validated screening tool that contains six questions. Depending on the answer to the first two questions, additional questions apply. One or more questions may get missed if the tool is not implemented or completed as directed. Another example, the Ask Suicide-Screening Questions (ASQ) Suicide Risk Screen Tool, is a four-question validated screening tool, which also contains a fifth question to assess acuity. This question may get missed if the tool is not implemented or completed as directed. Therefore, if not completed as instructed, the validity of the tool to identify individuals who may be at risk for suicide is compromised. Ultimately, it is the responsibility of each organization to ensure that validated tools are implemented and completed accurately.

Hospitals that care for patients at risk for suicide and self-harm need to assess risks in the physical environment to identify areas and features that could be used to attempt suicide. Psychiatric hospitals and hospitals with psychiatric wards and units design, build, and maintain the environment in a manner that minimizes or eliminates risks identified in the environmental risk assessment. Nonpsychiatric units in hospitals assess clinical areas to identify objects that could be used for self-harm so they can be removed, or the risk posed by those items mitigated when needed, from the area around a patient who has been identified as high risk for suicide (for example, in psychiatric hospitals, securing windows that can be opened and removing anchor points, door hinges, and hooks that can be used for hanging; in nonpsychiatric hospitals, removing items such as blood pressure cuffs, phone cords, call light cords, and monitor wires when not needed for clinical care of the patient). In addition, the hospital should have a process to handle patient clothing and belongings to mitigate risks, such as removing and securing shoes with shoelaces and other patient items that could be used for self-harm. The hospital's environmental risk assessment process should be the starting point and should also include a plan for risk mitigation such as one-to-one observation when indicated.

Measurable Elements of COP.05.00

1. Ⓓ The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide or self-harm; the hospital takes necessary action to minimize the risk(s). (*See also* FMS.03.00, ME 1; FMS.04.00, ME 2)
2. Using a validated screening tool, the hospital screens all patients for suicidal ideation who are being evaluated or treated for behavioral conditions as their primary reason for care.
3. The hospital uses an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.
4. Suicide screenings and assessments are documented in the patient's medical record or in accordance with laws and regulations when applicable.
5. Ⓓ The hospital follows written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, the polices should include the following:
   - Training and competence assessment of staff who care for patients at risk for suicide
   - Guidelines for reassessment of patients who are at risk for suicide and self-harm
   - Monitoring patients who are at high risk for suicide and self-harm
6. Ⓓ The hospital follows written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide and self-harm.
7. Ⓓ The hospital monitors implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and self-harm, and takes action as needed to improve compliance.