
— BEHAVIORAL HEALTH LITIGATION

Keeping Patients Safe

Suicide Risk in Hospitals and the New Joint Commission Goal

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This is a difficult subject, and we'll keep the focus on systems and records.

Hospitals are supposed to be safe places, and that expectation is strongest for patients who come in because they're at risk of harming themselves. When a patient dies by suicide or is seriously injured in a hospital's care, or soon after discharge, families want to know how it happened and what the hospital knew.

On January 1, 2026, the Joint Commission's new National Performance Goal 8, "The hospital reduces the risk for suicide," replaced National Patient Safety Goal 15.01.01 for hospitals and critical access hospitals. (NPSG 15 still applies to behavioral health and human services organizations.) The expectations will look familiar, but they're now stated more clearly:

- Screen patients 12 and older who are evaluated or treated for behavioral health conditions with a validated tool.
- Give patients who screen positive a structured assessment of ideation, plan, intent, behaviors, risk factors, and protective factors.
- On psychiatric units, identify and remove environmental hazards, particularly ligature points. On general units, use mitigation for high-risk patients, such as one-to-one observation and removing hazardous items.
- Document each patient's risk level and mitigation plan.
- Maintain written policies on training, reassessment, monitoring, and counseling and follow-up at discharge.
- Monitor compliance and correct problems.

Separately, Medicare's Conditions of Participation guarantee patients care in a safe setting (42 C.F.R. § 482.13(c)(2)), and CMS has given surveyors guidance on environmental risks for patients at risk of self-harm.

A FICTIONAL CASE

A 45-year-old man is brought to an ER by his sister after telling her he doesn't see a way forward. A validated screen puts him at high risk. He's placed in a standard ER room, not cleared of equipment, while psych evaluation is arranged. The order says "checks every 15 minutes." The department gets slammed. The observation log shows checks at regular intervals, but security video later shows about 40 minutes when nobody entered or looked into the room. During that gap he seriously injures himself.

DID THE SCREEN DRIVE THE PLAN?

The screen happened and showed high risk. What came next? Was a full assessment done, and by whom? Did the observation level match the risk? Most hospital policies tie observation to risk level, and for high-risk patients many call for continuous observation, someone keeping the patient in view at all times, rather than periodic checks.

THE ROOM

Emergency departments are full of cords, equipment, and supplies, which is why many have designated safe rooms or a checklist for clearing a standard room. Was a safe room available? If not, was the room cleared per the checklist, and is that documented? Were his belongings searched and removed as policy required?

OBSERVATION: THE LOG VERSUS EVERYTHING ELSE

Observation logs are frequently where these cases turn. A log with tidy entries every 15 minutes can look complete. If video, badge access, or staff assignments show nobody was at the door at those times, the log becomes a serious problem, and may reflect entries filled in afterward. Compare the log to every other source: video, assignments, what the assigned staff were doing at the same moments, and sitter records. Video is often overwritten within days or weeks, so request preservation immediately.

STAFFING AND BOARDING

Behavioral health patients often board in the ER for hours or days waiting for a bed, and many hospitals rely on sitters to watch them. Were there enough? Was a sitter requested and unavailable? What did the hospital do when it couldn't provide the observation its own policy required? A hospital that knows it can't staff continuous observation and has no backup plan has a system problem.

WHAT THE FAMILY SAID

His sister brought him in. What did she tell triage? Specific statements, plans, recent losses? Did anyone ask? Family often knows best how serious things are. If she told staff something that should have raised concern and it isn't in the chart, her account becomes key evidence, along with anything she was told about how he'd be watched.

MEDICAL FLOORS

Patients admitted to medical units after an overdose or self-inflicted injury, or medical patients who develop suicidal thoughts, can be at high risk in rooms never designed for it. NPG 8 expects a plan for them: observation and removal of hazards once high risk is identified, and timely psychiatric consultation. Was the risk identified, was a safety plan made, and was it carried out?

WHAT THE HOSPITAL ALREADY KNEW

Accredited hospitals are expected to review serious safety events. If earlier incidents on the same unit identified the same hazards or observation gaps, did anything change? Root cause analyses and quality reviews may be privileged depending on the state, but policies, environmental risk assessments, and physical changes over time often aren't. A hospital that found hazards and didn't fix them is in a very different position from one that did.

DISCHARGE

Many cases involve patients injured or lost soon after discharge. Was risk reassessed before discharge? Was a safety plan developed with the patient? Was there counseling about reducing access to lethal means at home, as many guidelines recommend? Was family involved? Was follow-up scheduled, how soon, and was the next provider told? NPG 8 specifically addresses counseling and follow-up at discharge.

THE RESPONSE

When he was found, how fast was help called, and how long until the emergency team arrived? The code record's timestamps show whether response delays added to the harm.

FAIRNESS

Suicide risk can't be predicted perfectly, and some patients come to harm despite appropriate care. A fair review asks whether the facility did what its policies and the standards required, not whether it was perfect. But when a patient is known to be high risk and in the facility's care, expectations for supervision and environment are high, and the evidence usually shows clearly whether they were met.

RECORDS WORTH REQUESTING

- Complete ED and inpatient records
- All screening and assessment tools and results
- Observation orders and logs; sitter and staffing assignments
- Video footage and badge access data (preserve immediately)
- Policies on suicide risk screening, observation levels, environmental safety, and discharge
- Environmental risk assessments for the unit, with dates
- Code and emergency response records
- Records of prior similar events and the hospital's response, where discoverable

SOURCES

- The Joint Commission, National Performance Goal 8 (effective Jan. 1, 2026), replacing NPSG.15.01.01 for hospitals and critical access hospitals; Perioperative Leader / OR Manager coverage (Sept. 2025)
- The Joint Commission, *R3 Report Issue 18: National Patient Safety Goal for Suicide Prevention* (updated Dec. 3, 2025)
- 42 C.F.R. § 482.13(c)(2)

This newsletter is for education only and isn't medical or legal advice. The case is fictional. If you or someone you know is struggling, call or text 988 (Suicide & Crisis Lifeline) in the U.S.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a case involving self-harm in a healthcare setting and need the identified risk compared carefully with the protection actually provided, we'd welcome the conversation.

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