



Zero Suicide at Cincinnati Children's

Lessons From One Year of Systems Work

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PEDIATRIC GRAND ROUNDS · SEPTEMBER 29, 2026

Who We Are

Zero Suicide is a core program within the Mental and Behavioral Health Institute (MBHI), bringing together an interprofessional team representing care settings across Cincinnati Children's and the Greater Cincinnati region.



Our mission is to eliminate youth and young adult suicide in the Greater Cincinnati region.

What You Will Take Away

01

Discuss lessons learned from a year of patient safety and quality improvement work in pediatric suicide prevention.

02

Describe system-level strategies for suicide-safer care across settings and roles.

03

Identify the infrastructure, partnerships, and workforce investments needed to sustain suicide prevention.

We See You



Thank you for this work,
and for the care you bring
to it every day.

Suicide-Safer Care is Interprofessional

One profession cannot create suicide-safer care alone.



MEDICAL CARE

Primary care • Emergency department • Developmental and Behavioral Pediatrics • Medical and surgical specialties • Advanced practice nurses



BEHAVIORAL HEALTH

Psychiatry and psychology • Counselors and therapists • Social work • Psychiatric Intake Response Center (PIRC) and crisis teams



NURSING AND COORDINATION

Bedside and triage nursing • Care managers and coordinators • Family navigators • Intake, access, and scheduling



ALLIED HEALTH AND FAMILY SUPPORT

Social Services • Child Life and Integrative Care • Rehabilitation therapies • Spiritual and Grief Care



PARTNERS ACROSS SETTINGS

Inpatient, outpatient, and school-based teams • Mobile crisis and first responders • Community and crisis-line partners • Patients, caregivers, and trusted adults

Youth Suicide and Health Care Contacts



YEAR BEFORE DEATH

88%

One or more health care visits in the year before death.



MONTH BEFORE DEATH

42%

A health care visit within 30 days of death.

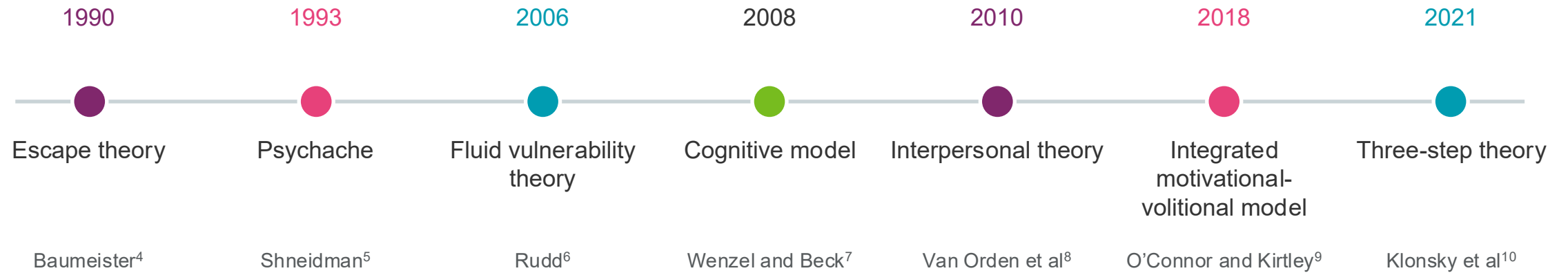


MENTAL HEALTH DIAGNOSIS

60%

No documented mental health diagnosis.

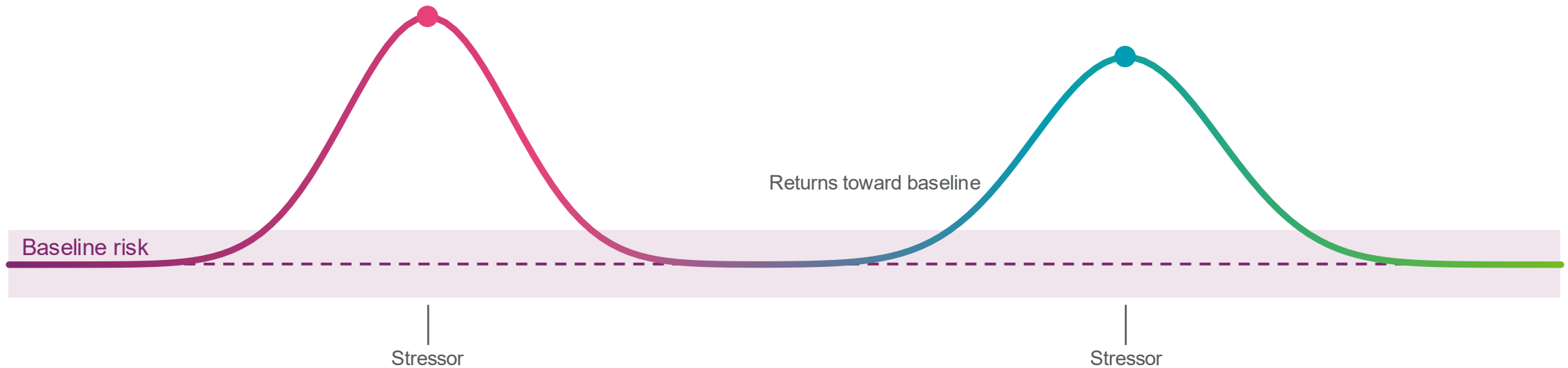
Conceptual Models of Suicide



4. Baumeister RF. Psychol Rev. 1990. 5. Shneidman ES. J Nerv Ment Dis. 1993. 6. Rudd MD. Cognition and Suicide. 2006. 7. Wenzel A, Beck AT. Appl Prev Psychol. 2008. 8. Van Orden KA, et al. Psychol Rev. 2010. 9. O'Connor RC, Kirtley OJ. Philos Trans R Soc Lond B Biol Sci. 2018. 10. Klonsky ED, et al. Prev Med. 2021.

Suicide Is Dynamic, Not Linear

Acute risk



Baseline risk: relatively stable and shaped by predisposing factors, history, and prior suicidal behavior; higher after multiple prior attempts.^{6,11}

Acute risk: time-limited escalation after a stressor that rises quickly and returns toward baseline; more easily triggered when baseline is high.^{6,11}

6. Rudd MD. Cognition and Suicide. 2006. 11. Bryan CJ, et al. New Ideas Psychol. 2020.

Five Lessons We Learned This Past Year

1. The goal is prevention, not prediction.
 2. Training is necessary but not sufficient.
 3. Psychological safety is not about being nice.
 4. Suicide prevention is patient safety.
 5. Expertise requires infrastructure.
- 
- A decorative graphic consisting of three curved lines that start near the bottom left and sweep upwards towards the top right. The top line is a vibrant purple, the middle line is a teal color, and the bottom line is a bright green. They all follow a similar upward-curving path, creating a sense of movement and growth.

How do we move from identifying suicide risk to reliably delivering suicide-safer care in every setting where youth and families enter our system?



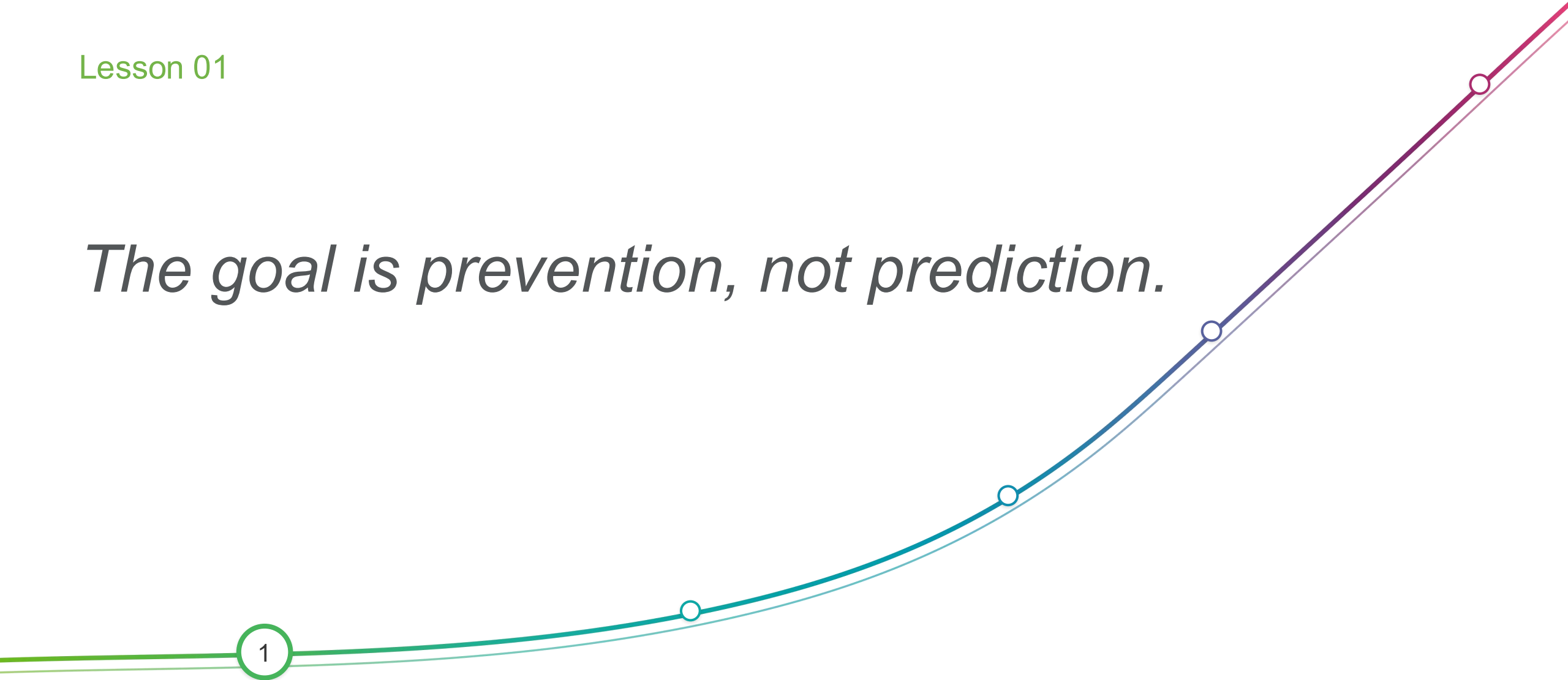
Identifying risk



Suicide-safer care in every setting

Lesson 01

The goal is prevention, not prediction.



The Clinical Reality

Sometimes we already know someone is at risk for suicide...



Risk cannot be predicted with certainty¹²

Suicide risk assessment has shifted from trying to predict who will attempt suicide toward ongoing, collaborative formulation and management.



Hospitalization is not always indicated¹³

Psychiatric hospitalization can carry real risks and costs and is not automatically the safest or most helpful response to suicide risk.



Discharge does not mean risk is absent¹⁴

Suicide risk rises sharply in the weeks after discharge from a psychiatric facility, even when a patient appears stable at the time of release.



A risk label alone does not tell us what to do^{12,15}

A "high risk" label does not specify a plan; formulation has to translate the label into specific resources, supports, and next steps.

The Limits of Prediction

365 studies

Fifty years of research did not improve prediction

365 studies and 3,428 risk-factor effect sizes; prediction stayed only slightly better than chance.¹⁶

$\leq 1\%$

Models that classify well still miss most suicides

Most models reach 1% or less positive predictive value, and 25% to 50% of suicides are still missed.¹⁷

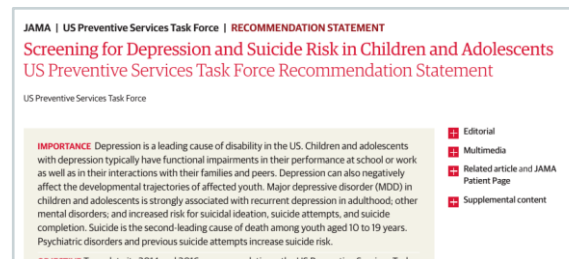
5.5% vs 0.9%

Most high-risk patients did not die by suicide

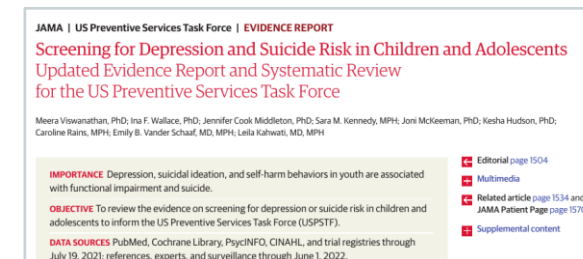
5.5% of high-risk and 0.9% of lower-risk patients died by suicide over 63 months.¹⁸

16. Franklin JC, et al. Psychol Bull. 2017. 17. Belsher BE, et al. JAMA Psychiatry. 2019. 18. Large MM, et al. BMJ. 2017.

Suicide Screening



19



20

B

RECOMMENDED

Adolescents 12–18 · major depressive disorder (MDD)

Screening has a moderate net benefit.

Tools identify MDD accurately in primary care and treatment improves symptoms; harms of screening and psychotherapy are no greater than small.

7

accuracy studies, n = 3,316

13

treatment trials, n = 2,156

0.94

PHQ-A specificity (sensitivity 0.73)

I

INSUFFICIENT EVIDENCE

Children 11 and younger · MDD

The studies were not done in this age group.

Benefits and harms cannot be determined, and early onset is linked to worse outcomes, so the gap matters.

0

accuracy studies in children only

3 of 13

treatment trials included youth 12 or younger

1

treatment-harms study enrolled children under 12

I

INSUFFICIENT EVIDENCE

Children and adolescents · suicide risk

No study has tested screening against no screening.

Screening added no distress in 2 trials (n = 2,675), but treatment trials were too small to show health outcomes.

1

accuracy study, n = 580

0

screened-vs-unscreened trials

12 of 16

treatment trials underpowered

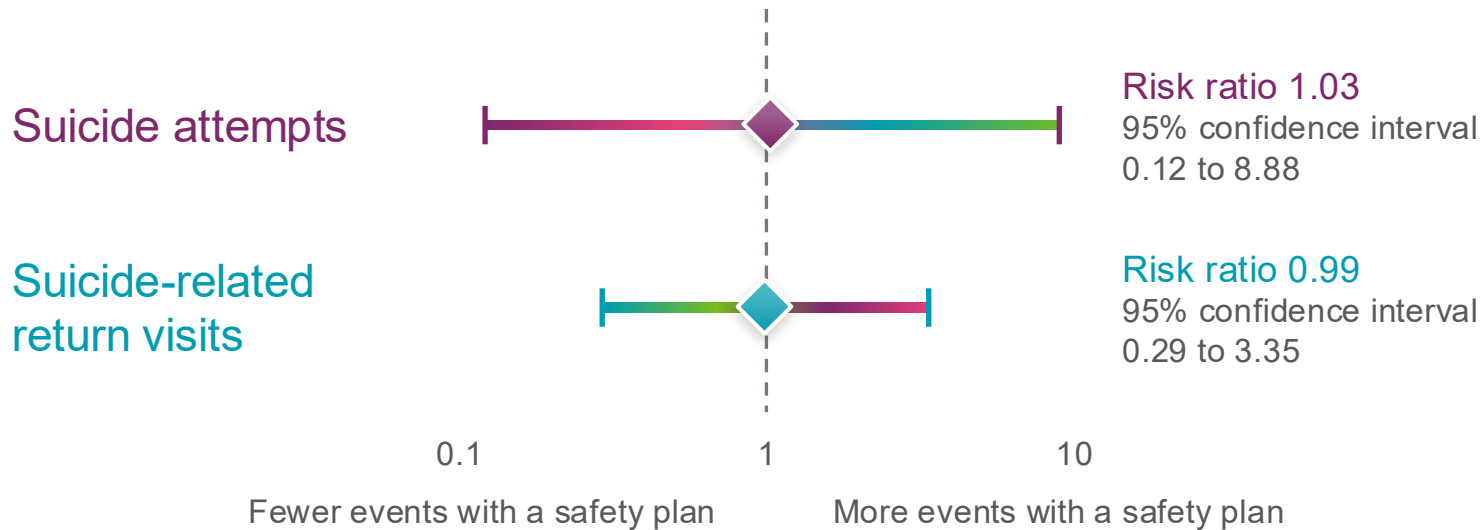
The AAP/AFSP Blueprint still recommends universal suicide risk screening from age 12, and The Joint Commission recommends screening all patients with a validated tool.¹⁹

19. US Preventive Services Task Force. JAMA. 2022. 20. Viswanathan M, et al. JAMA. 2022.

Safety Planning

Standalone safety planning showed no clear effect on attempts or return visits in adolescents.^{21,22}

Systematic review of 10 studies (1,002 adolescents); meta-analysis of 5 studies (619 adolescents)²¹



JAMA Pediatrics | Original Investigation | ADOLESCENT MENTAL HEALTH

Safety Planning Interventions for Suicide Prevention in Children and Adolescents A Systematic Review and Meta-Analysis

Carly Albaum, PhD; Samantha H. Irwin, MSc; Jessica Muha, MSc; Anett Schumacher, PhD; Sherinne Clarissa, BSc; Yaron Finkelstein, MD; Jeffrey A. Bridge, PhD; Daphne J. Korczak, MD

IMPORTANCE Suicide ideation and suicide-related behavior (eg, suicide attempts) are increasingly prevalent among adolescents. Evidence supports safety planning interventions for adults at risk for suicide; the effectiveness for adolescents is unknown.

OBJECTIVE To evaluate the effectiveness of safety planning as a standalone intervention for adolescents with suicide ideation and/or suicide-related behavior.

DATA SOURCES Ovid MEDLINE, OVID PsycINFO, EBSCO CINAHL, and Scopus (Elsevier) from January 1, 2008, to March 26, 2024.

STUDY SELECTION Included were all studies that examined safety planning as a standalone treatment for adolescents and assessed suicide ideation, suicide-related behavior including suicide attempts, and/or re-presentations to health care settings. Included were peer-reviewed studies evaluating intervention effectiveness or efficacy, with or without a control condition. Nonempirical studies, gray literature, and studies not available in English were excluded.

DATA EXTRACTION AND SYNTHESIS Two reviewers performed data extraction and quality assessment independently. Meta-analytic random-effects models were used to calculate effect size estimates. Risk of bias was assessed using Joanna Briggs Institute Critical Appraisal tools.

MAIN OUTCOMES AND MEASURES The outcomes planned for extraction were suicide ideation, suicide-related behavior (eg, attempts; planning with intent to act), and re-presentation to health care settings (ie, emergency department visit; inpatient admission) during the follow-up period.

RESULTS Ten studies including 1002 adolescents (mean [SD] age, 15.0 [0.4] years; 76.0% female) met inclusion criteria; 5 were included (n = 619) in the meta-analysis. There was no significant association between safety planning interventions and suicide ideation (Hedges $g = 0.11$; 95% CI, 0.01-0.21), behavior (Hedges $g = -0.09$; 95% CI, -0.20 to 0.02), attempts (risk ratio [RR], 1.03; 95% CI, 0.12-8.88) or suicide-related re-presentation (RR, 0.99; 95% CI, 0.29-3.35) at follow-up. Risk of bias for the majority of studies was moderate to high.

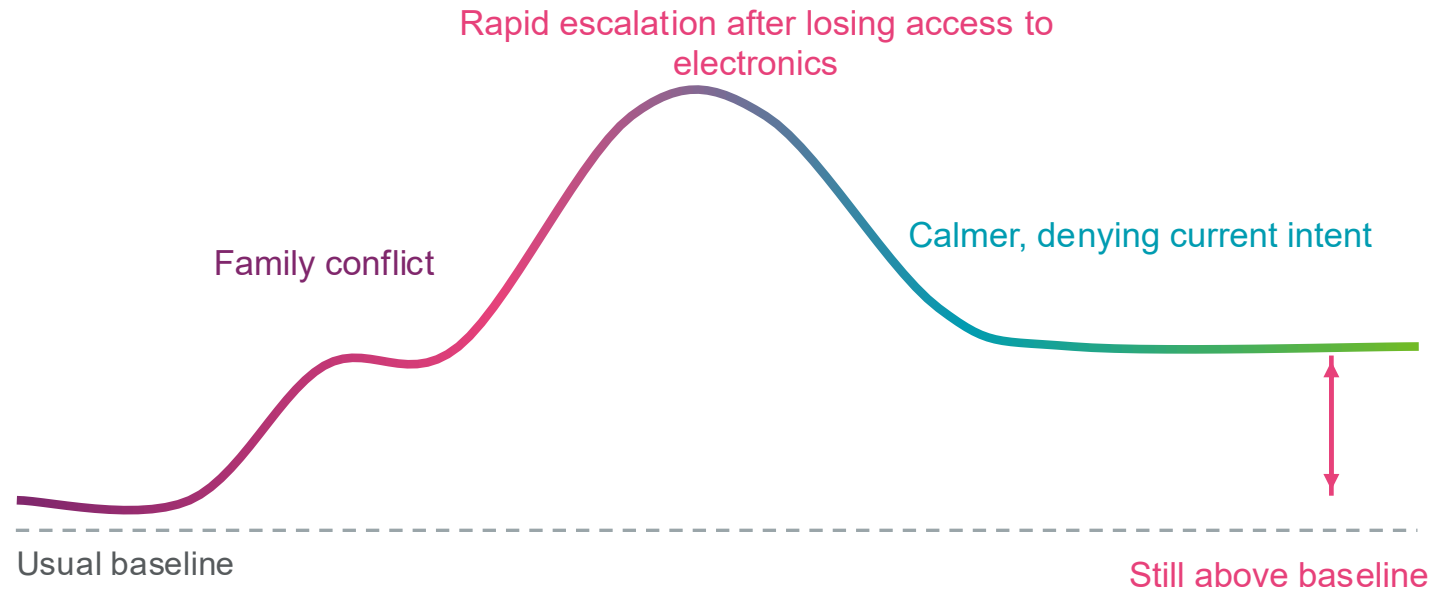
CONCLUSIONS AND RELEVANCE This systematic review and meta-analysis found limited research evaluating safety planning with adolescents. Although available data do not support safety planning as a standalone treatment for reducing suicide-related outcomes among children and adolescents, well-powered studies are needed to address this common intervention for suicide prevention in adolescents.

Meet Jordan

Fictional Composite Case

Jordan, age 14

- Diagnoses of attention-deficit/hyperactivity disorder (ADHD) and depression, with recurrent emotional dysregulation
- History of suicidal ideation, no history of a suicide attempt
- An engaged caregiver and established outpatient treatment



Where Can Initial Stabilization Occur?

LEAST
RESTRICTIVE

01 Outpatient care^{18,23}

- Risk state has not escalated sharply from baseline
- Structured follow-up can be scheduled promptly

- Safety planning, including lethal means counseling, in clinic
- A caregiver can support means safety and supervision

02 Emergency department^{18,23}

- The immediate crisis has eased enough to collaborate
- A feasible plan can support the transition home

- Jordan and the caregiver can take part in safety work
- Rapid follow-up and reassessment are available

03 Inpatient psychiatric setting^{18,23}

- Safety-promoting conditions cannot yet be established
- Caregiver participation or home safety is unclear

- Jordan needs additional containment or observation
- Further stabilization or treatment is needed

▼
MOST
RESTRICTIVE

Can We Create the Conditions for Safety?

1 Jordan can participate²⁴

- Identify warning signs of a developing crisis
- Name people and settings that provide distraction
- Anticipate foreseeable changes that could reactivate risk
- Identify internal coping strategies
- Identify people to contact for help

2 Caregiver and environment²³

- A caregiver is available to participate
- The home plan is feasible
- The caregiver knows when to seek reassessment
- Lethal means counseling can occur
- Supervision and support can be provided

3 Care system²³

- Timely follow-up can be arranged
- Clinical contacts and backup options are understood
- A clear crisis response is available
- Rapid reassessment is possible if the plan begins to fail

If these conditions cannot be established, additional stabilization may be necessary. But...

Prevention Not Prediction

Prediction-focused

How likely is
Jordan to attempt
suicide?



Prevention-focused¹⁸

- 1 What does Jordan need now?
- 2 How is today different from baseline?
- 3 Which resources can be used?
- 4 What may foreseeably increase risk?
- 5 How can we prepare?

From Prediction to Prevention

1 Risk Status

ENDURING · HISTORICAL

How does this patient's risk compare to others in a reference group?
Psychiatric history, prior attempts, family history.

2 Risk State

DYNAMIC · CURRENT

How does this moment compare to the patient's baseline? Recent stressors, events, and acute symptoms elevating risk now.

3 Available Resources

PROTECTIVE

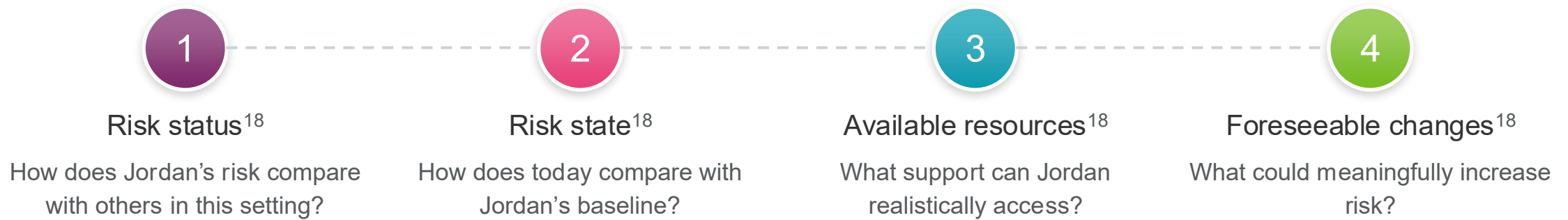
What can the patient draw on if risk escalates? What could prevent them from accessing those resources in a crisis?

4 Foreseeable Changes

ANTICIPATED

What upcoming events, losses, or stressors could rapidly shift the patient's risk state — for better or worse?

Prevention-Oriented Risk Formulation



18. Pisani AR, et al. Acad Psychiatry. 2016.

What Formulation Changes

A collection of tasks

“Moderate risk”

Safety plan completed

988 Suicide & Crisis Lifeline
provided²⁷

Lethal means counseling provided

Outpatient follow-up recommended



A coordinated prevention plan^{15,18}

● Risk state interpreted relative to baseline

● Specific adults and roles clarified

● 988 practiced as well as listed

● Means safety steps assigned

● Follow-up matched to current needs

The SafeSide Framework¹⁸

1 Connect

Ask the question, commit to a plan.

Ask the question

Collaborate with the person and family on a plan we commit to carrying out

2 Assess

Status, state, resources, changes.

Risk status

Relative to others in a given setting

Available resources

Internal and external strengths that support safety and treatment planning

Risk state

Relative to the person's own baseline or other time periods

Foreseeable changes

Changes that could quickly increase risk state

3 Respond

Care aimed at targeting suicide.

Treatments and interventions

Contingency and safety planning

Frequency of contact and check-ins

Team discussion and consultation

4 Extend

Support through every handoff.

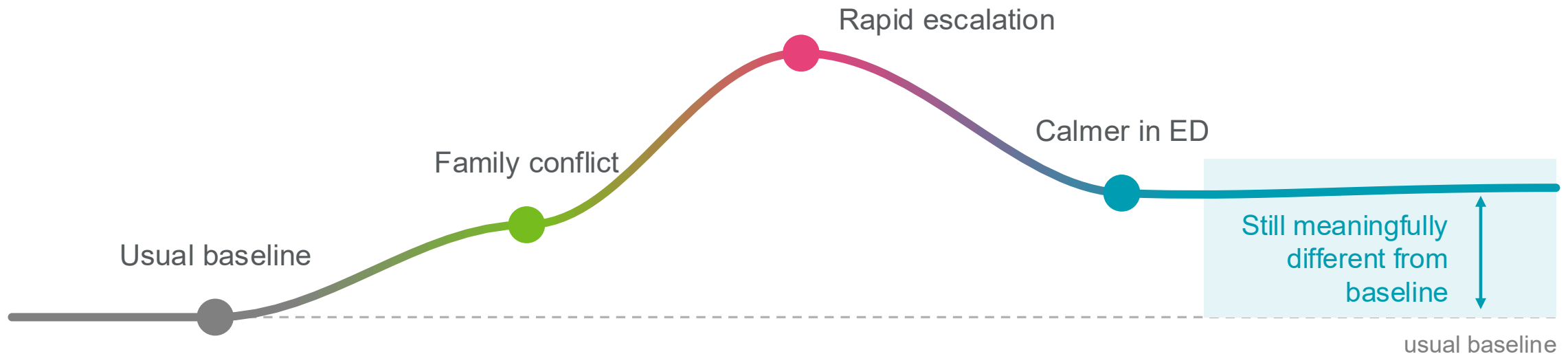
Caring contacts that sustain connection

Shared plans and clear roles for supports

Proactive follow-up after transitions

Warm handoffs across settings

Jordan's Risk State



This informs:

Timing of follow-up

Caregiver involvement

Immediate supervision

Thresholds for reassessment

Available Resources

A resource must be usable¹⁸

LISTED

"Talk to an adult"

"Call 988"

"Use the safety plan"

"Contact the therapist"

USABLE

Identify who,
when, and how

Practice the
call together

Rehearse the
first steps

Clarify
availability and
backup options

18. Pisani AR, et al. Acad Psychiatry. 2016.

Practice Calling or Texting 988

988

Call · Text · Chat

01

Make a practice call together

02

Learn what happens during the call

03

Rehearse how Jordan might begin

04

Clarify when Jordan or the caregiver would call

05

Plan for what happens if Jordan cannot initiate the call

Foreseeable Changes

What could change Jordan's risk state?^{11,18}

Increasing agitation or inability to disengage

Sudden loss of a highly valued activity

Another intense family conflict

Withdrawal from usual supports

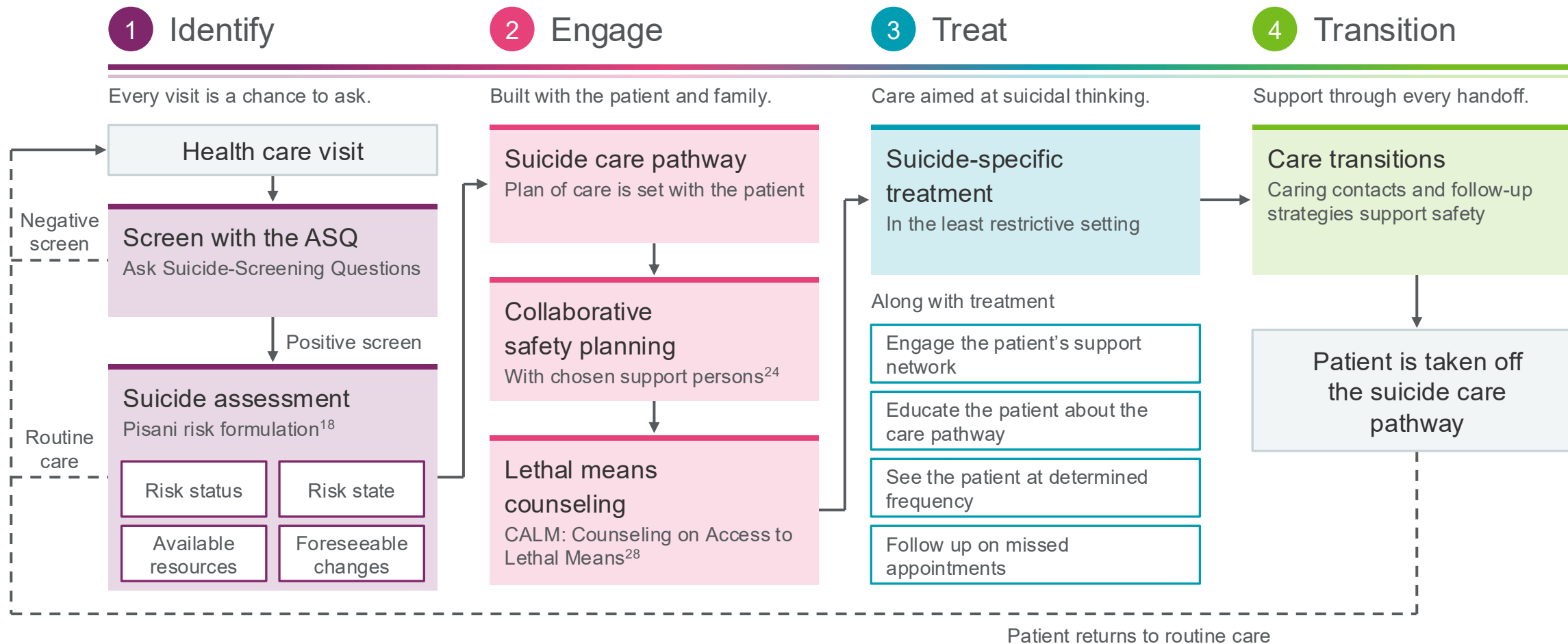
Caregiver unavailability



Build the response before it happens^{18,23}

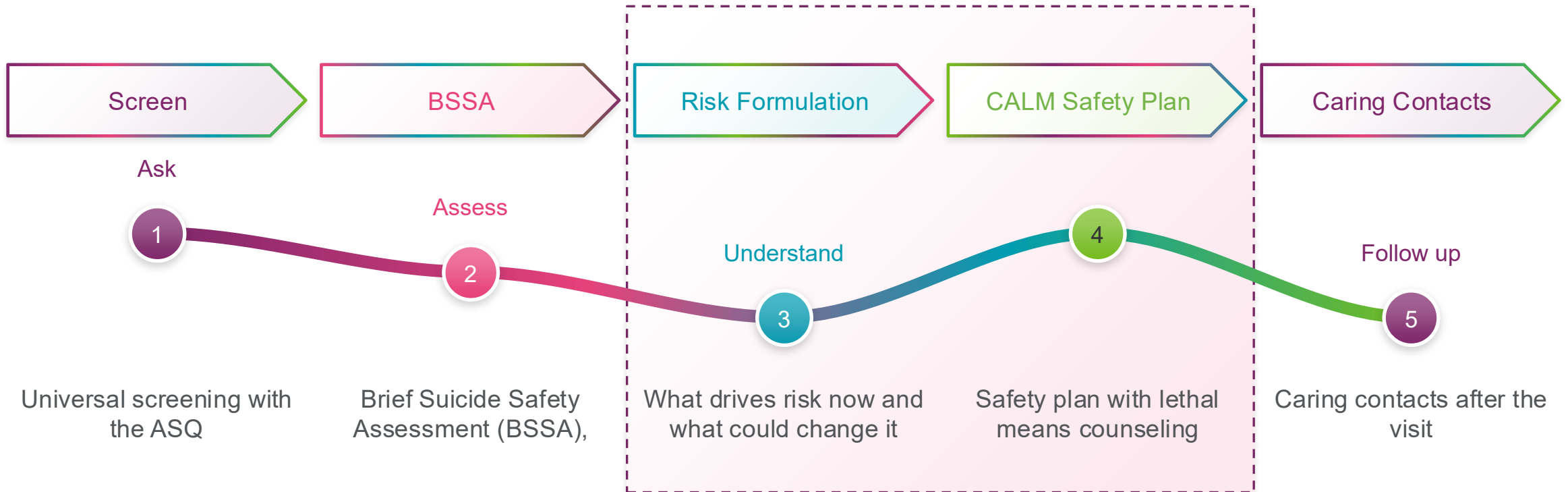
- 1 What will Jordan notice?
- 2 What will the caregiver notice?
- 3 What is the first response?
- 4 Which resource becomes active?
- 5 When is emergency reassessment needed?

Suicide Care Pathway

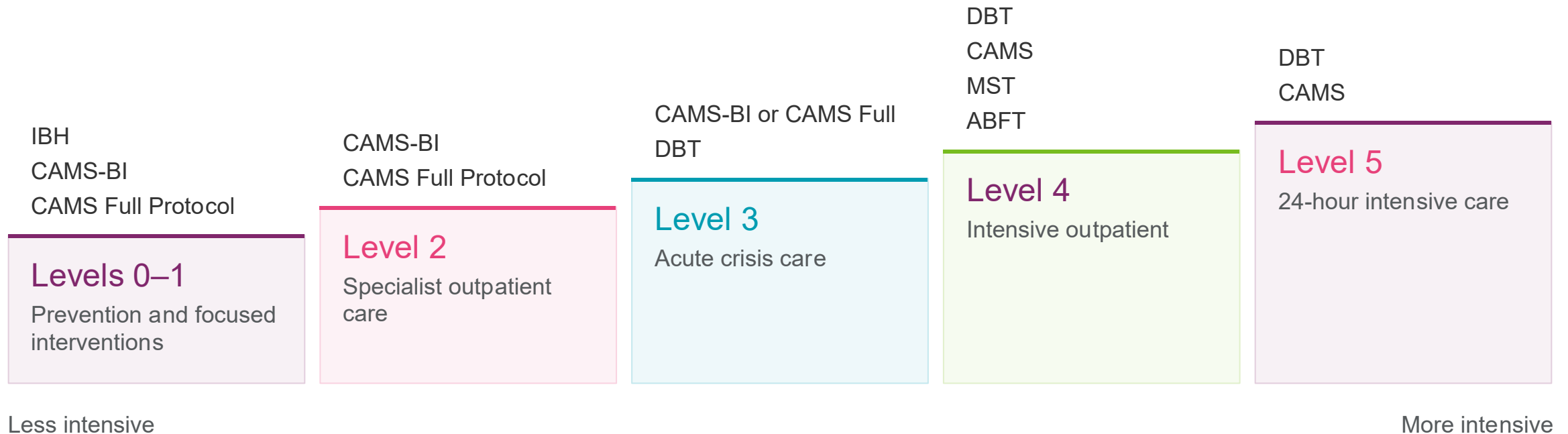


28. Bryan CJ, Stone SL, Rudd MD. Prof Psychol Res Pract. 2011. 29. Adapted from the Zero Suicide Care Pathway.²⁹

Suicide Care Pathway



Levels of Suicide-Focused Care



Across all levels of care

Suicide screening (ASQ), assessment, risk formulation, caring contacts, the Stanley-Brown Safety Plan, and CALM (secure storage devices)²⁴

Regulatory

National Performance Goal 8 (NPG 8)³⁰

Training and education

Treatment and transitions

Suicide-focused treatment (MST and ABFT) and transitions of care across the continuum

IBH, integrated behavioral health; CAMS, Collaborative Assessment and Management of Suicidality; CAMS-BI, CAMS brief intervention; DBT, dialectical behavior therapy; MST, multisystemic therapy; ABFT, attachment-based family therapy.

24. Stanley B, Brown GK. Cogn Behav Pract. 2012. 30. The Joint Commission. R3 Report, Issue 18. 2025.

How does a suicide-focused care pathway change Jordan's care?

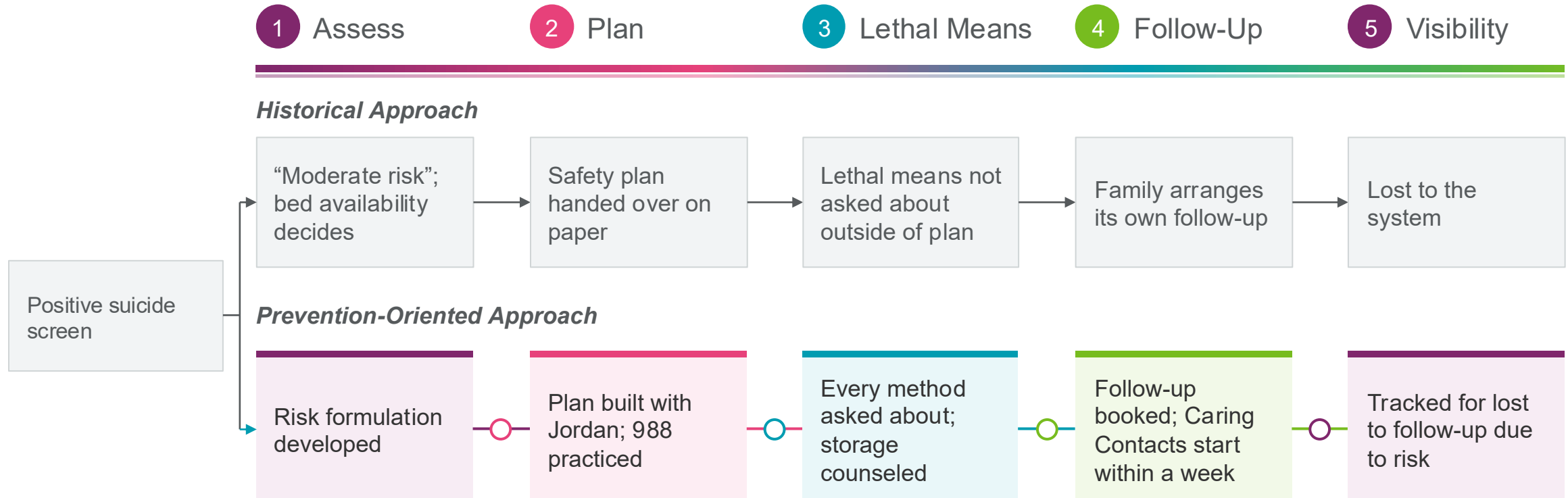


Identifying risk



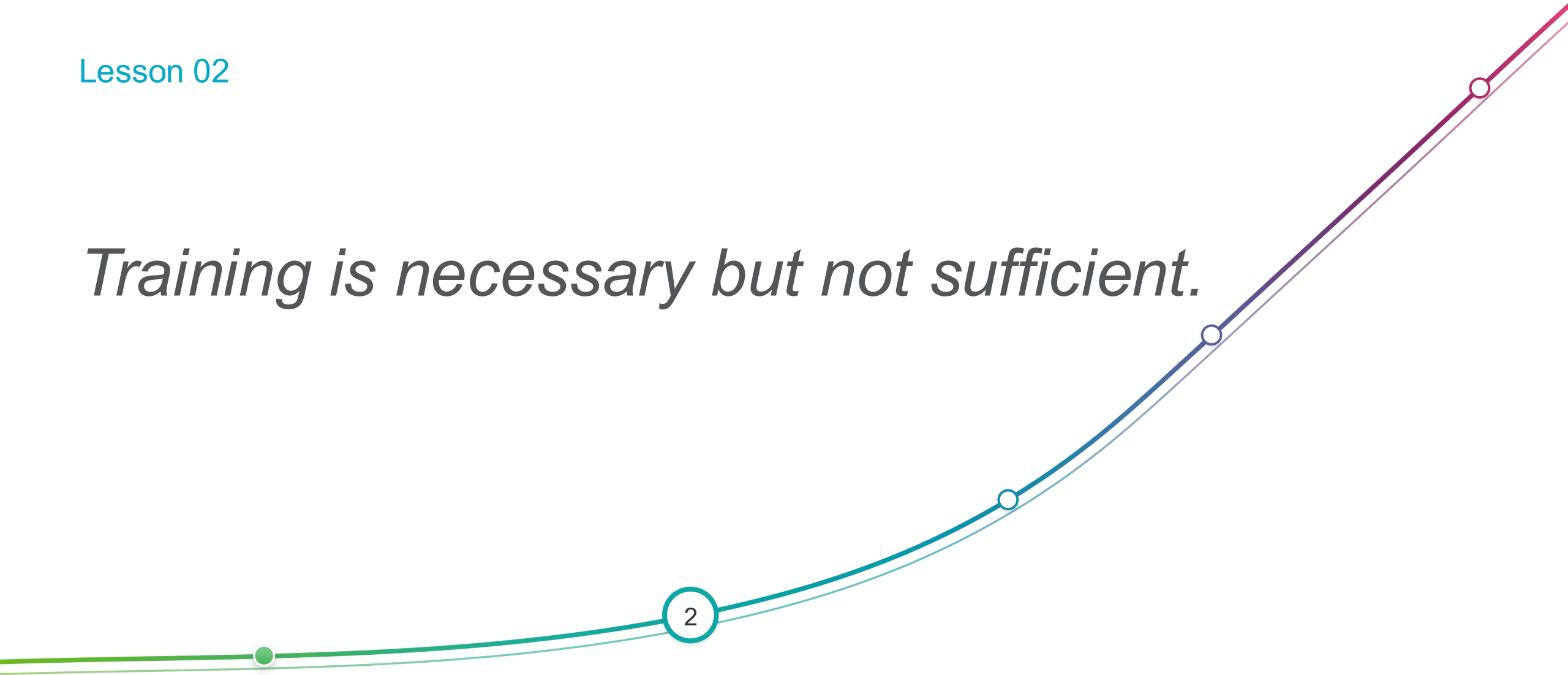
Suicide-safer care in every setting

What changes for Jordan...



Lesson 02

Training is necessary but not sufficient.



CALM Study Design

Register

Select a CALM session

Participants choose a session based on their availability.

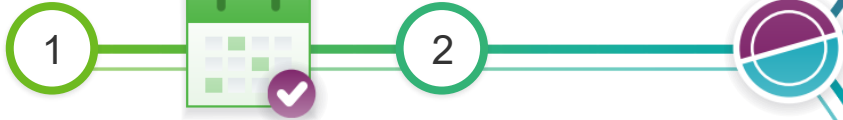


Randomize

Randomize by session

Each session, not each person, is randomized in advance.

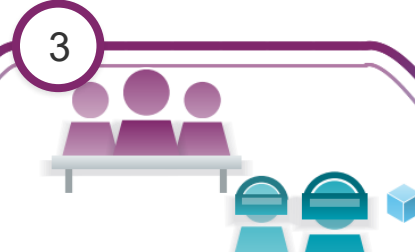
Participants inherit their session's condition.



Complete training

Standard CALM

Workshop without the virtual reality (VR) component



CALM-VR

Workshop with the VR curriculum



Enroll and assess

Post-training enrollment

Review the study sheet and complete the REDCap survey.



Survey records who wants follow-up.

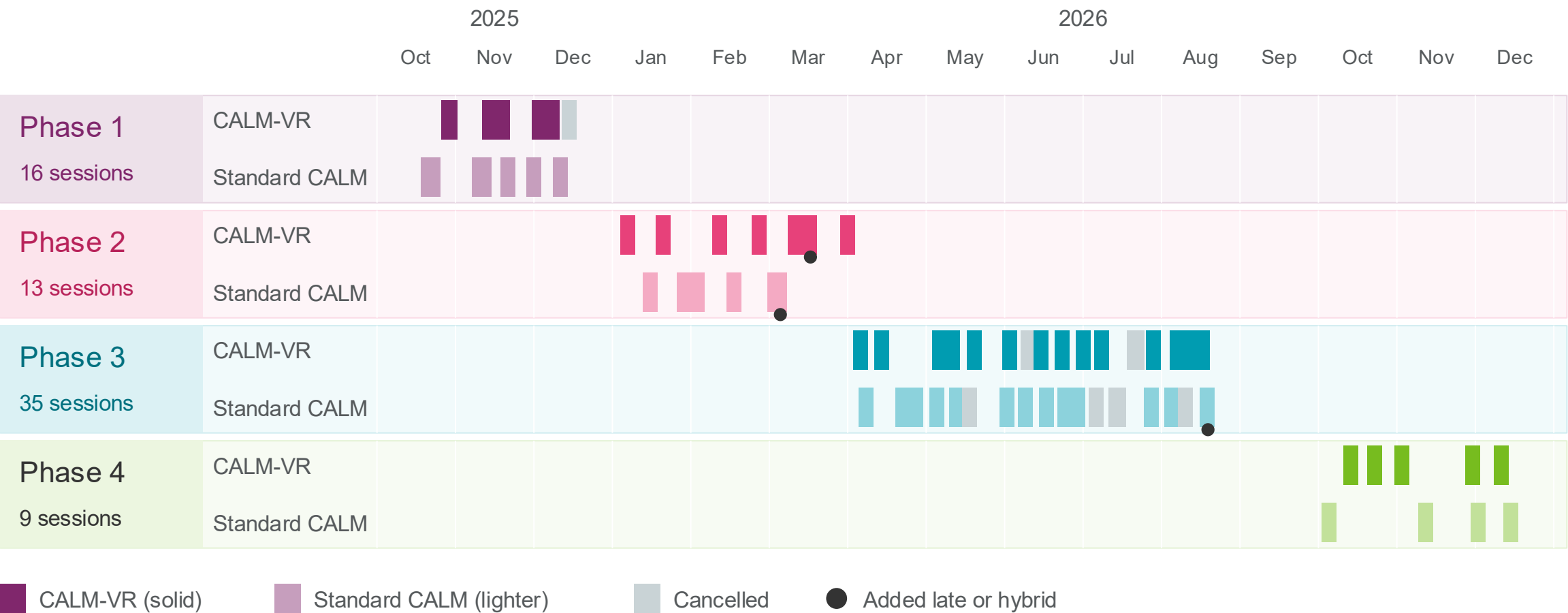
Follow up

2-month survey
Everyone enrolled
REDCap

Patient encounter
Interested + eligible
2 to 4 months

Implementation interview
Interested + eligible
About 2 months

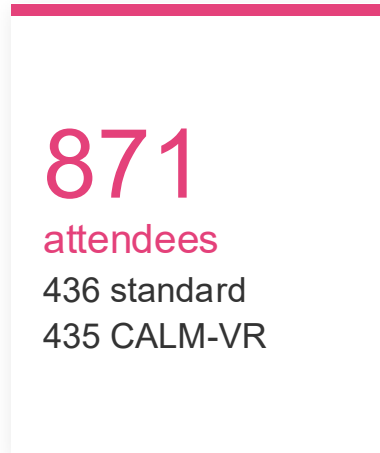
CALM Roll-Out



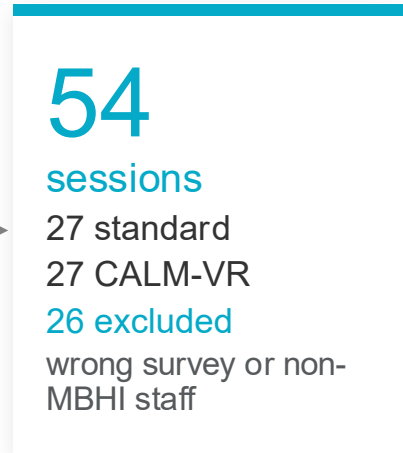
Enrollment

685 of 871 attendees (79%) enrolled across 54 sessions; 65 patient encounters completed and 16 more scheduled.³¹

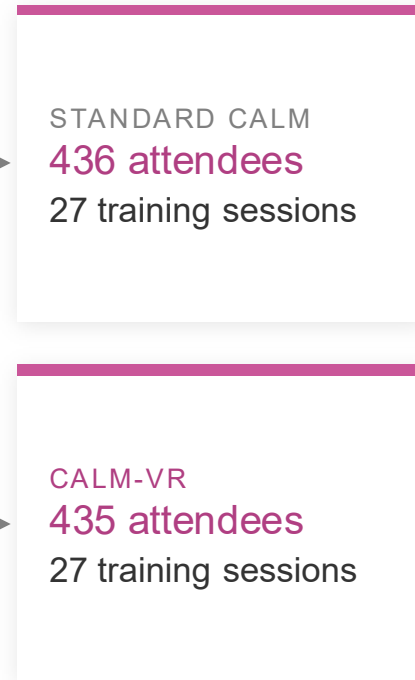
1 REGISTER



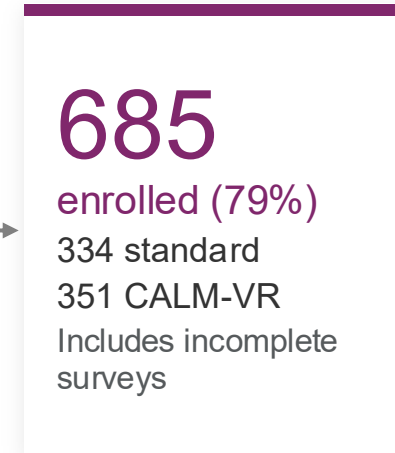
2 RANDOMIZE



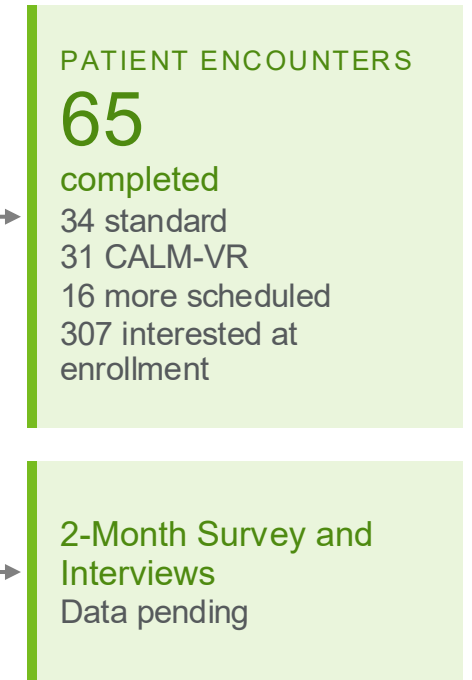
3 COMPLETE TRAINING



4 ENROLL AND ASSESS

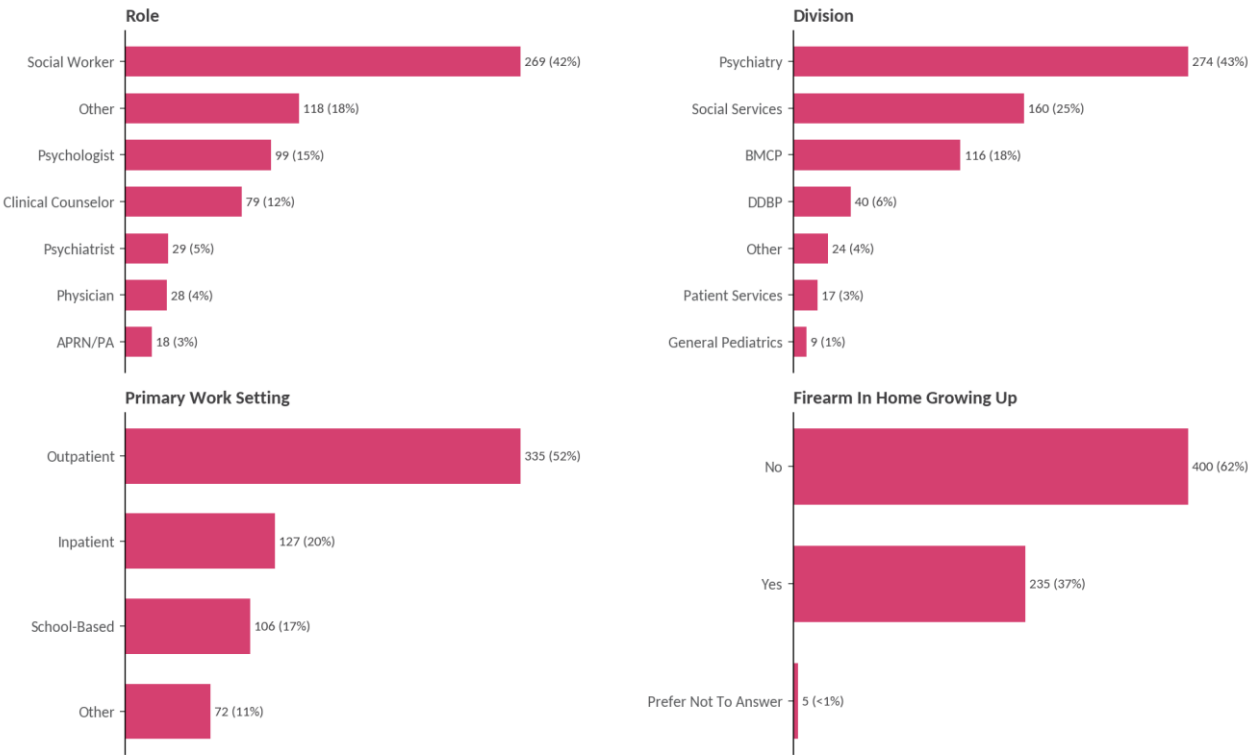


5 FOLLOW UP



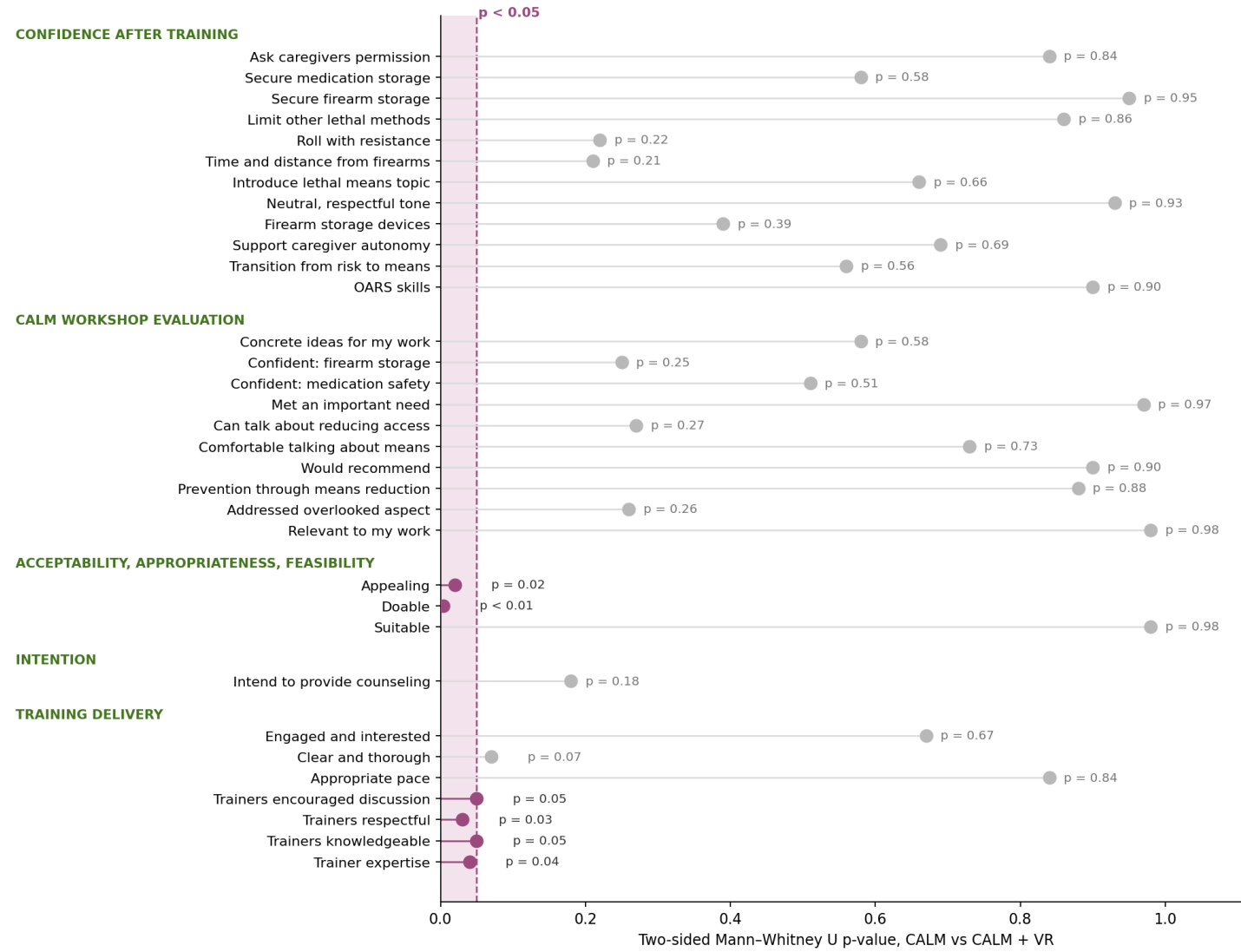
Respondents were mostly outpatient social workers, psychiatry and social services staff (N = 640).³¹

Respondents Were Mostly Outpatient Social Workers, Psychiatry And Social Services Staff (N = 640)



Counts And Percentages Of 640 Respondents. CALM N = 301; CALM + VR N = 340, As Reported In The Source File.

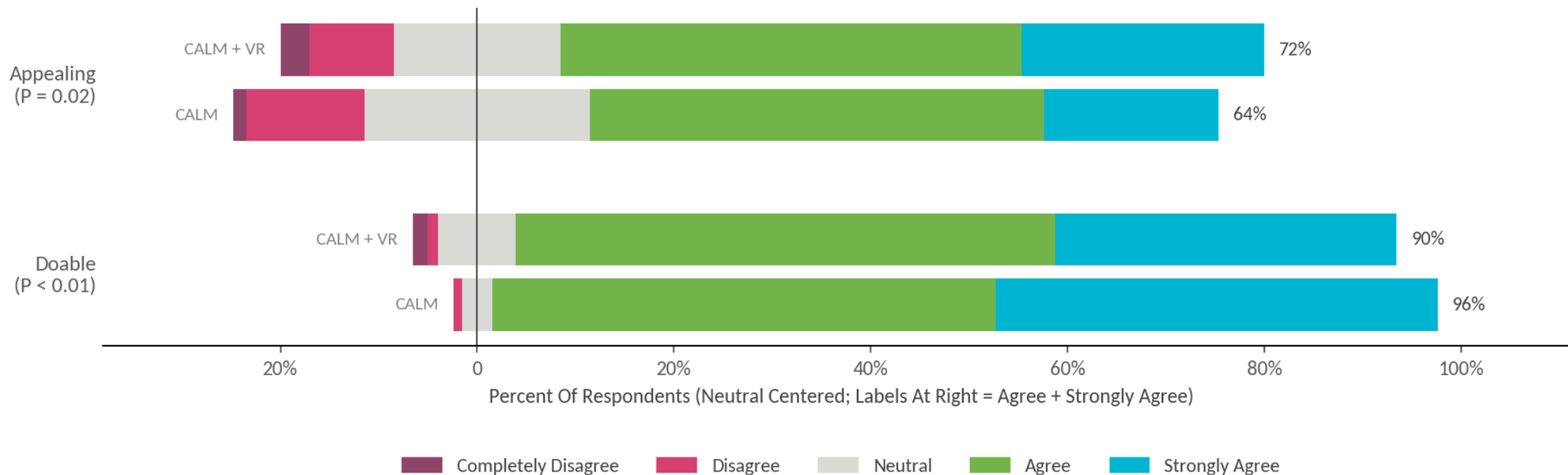
CALM and CALM + VR responses differ on 6 of 33 items: appeal, feasibility and trainer ratings



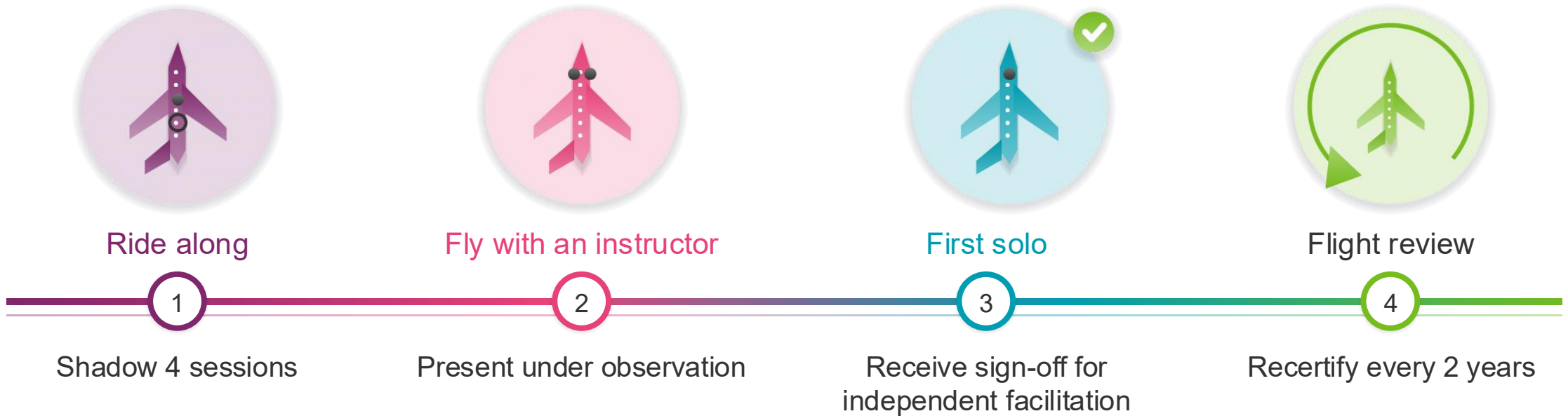
(n = 640)

Standard CALM vs. CALM-VR

CALM + VR Was More Appealing But Less Doable Than CALM



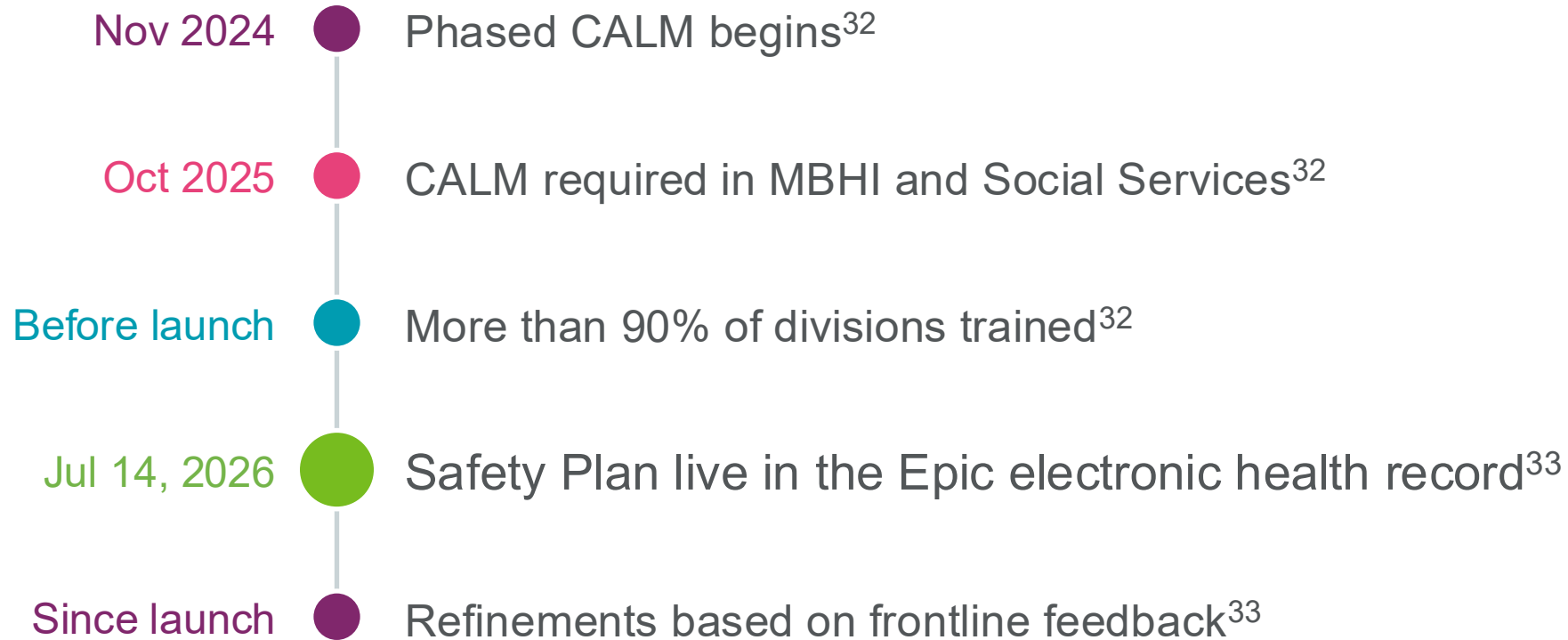
CALM Trainers



Onboarding CALM Trainers



Safety Plan Launch Alongside CALM



Lesson 03

Psychological safety is not about being nice.



“

Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes, and that the team is safe for interpersonal risk-taking.”

Amy C. Edmondson

Professor of Leadership, Harvard Business School

Edmondson's Study of Medical Teams

1

The question

Do better-performing teams make fewer medication errors?

2

The surprise

Units rated as more effective reported more errors, not fewer.³⁵

3

The explanation

Better teams were not making more mistakes. They were more willing to report and discuss them.³⁵

4

The construct

Her 1999 study of 51 work teams introduced team psychological safety: a shared belief that the team is safe for interpersonal risk taking.³⁴

Edmondson's Framework

Safety alone produces comfort; paired with high standards, it produces learning.³⁶

Comfort zone

People speak freely, but the bar is low and the team coasts on consensus.

Learning and high performance

Candor meets ambition: people raise hard questions and test new ideas, and the team delivers.

Apathy zone

People show up but hold back and disengage, so there is little learning and little performance.

Anxiety zone

People feel pressure to perform but have no room to speak, so problems stay hidden and mistakes repeat.

PSYCHOLOGICAL SAFETY ↑

ACCOUNTABILITY AND STANDARDS →

36. Edmondson AC. The Fearless Organization. John Wiley & Sons; 2019.

Korean Air Flight 801

August 6, 1997 · Nimitz Hill, Guam

NATIONAL
TRANSPORTATION
SAFETY
BOARD

WASHINGTON, D.C. 20594

AIRCRAFT ACCIDENT REPORT

CONTROLLED FLIGHT INTO TERRAIN
KOREAN AIR FLIGHT 801
BOEING 747-300, HL7468
NIMITZ HILL, GUAM
AUGUST 6, 1997

PB00-810401
NTSB/AAR-00/01
DCA97MA058

228
of 254
lives lost

The crew saw the danger. No one spoke.

Junior crew members were expected to defer completely to the captain. Questioning him was seen as disrespectful — even as the aircraft descended toward a hillside.

Psychological safety determines whether knowledge becomes action.

Can team members raise concerns, flag errors, and stop unsafe actions — without fear of humiliation or retribution?

Culture change works. Zero fatal crashes since 2000.

Korean Air rebuilt its culture so any crew member can stop the flight. The same principle governs every safe care team.

AFTER THE CULTURE REBUILD

Zero fatal crashes since 2000.

Korean Air rebuilt its culture so that any crew member can stop the flight. The same principle governs every safe care team.

[Link to report](#)

#1

STRONGEST PREDICTOR OF TEAM EFFECTIVENESS

Psychological Safety

“Can we take risks on this team without being embarrassed, rejected, or punished for speaking up, asking questions, admitting mistakes, or taking risks?”

Psychological safety

The foundation on which the other dynamics rest.

Dependability

Can we count on each other to do high-quality work on time?

Structure and clarity

Are goals, roles, and execution plans clear to everyone?

Meaning

Is the work personally important to each of us?

Impact

Do we believe our work matters and makes a difference?

Timothy Clark's Stages of Psychological Safety

INCREASING INCLUSION & CANDOR ↑

1

Inclusion safety

Safe to belong — accepted and included as a member of the team.

2

Learner safety

Safe to learn — ask questions, give and get feedback, make mistakes.

3

Contributor safety

Safe to contribute — use your skills and judgment to make a difference.

4

Challenger safety

Safe to challenge — question the status quo to make things better.

39. Clark TR. The 4 Stages of Psychological Safety. Berrett-Koehler; 2020.

Impact on Patient Safety

01

Reporting dries up

Near-misses never surface. Safety data understates the real danger. The system becomes blind to its own risks.



02

Learning stops

The same failures repeat. You can't fix what no one will name. The organization learns nothing from its own experience.



03

People disengage

Burnout and turnover rise. The staff who spot risk most clearly are the ones who leave first.



04

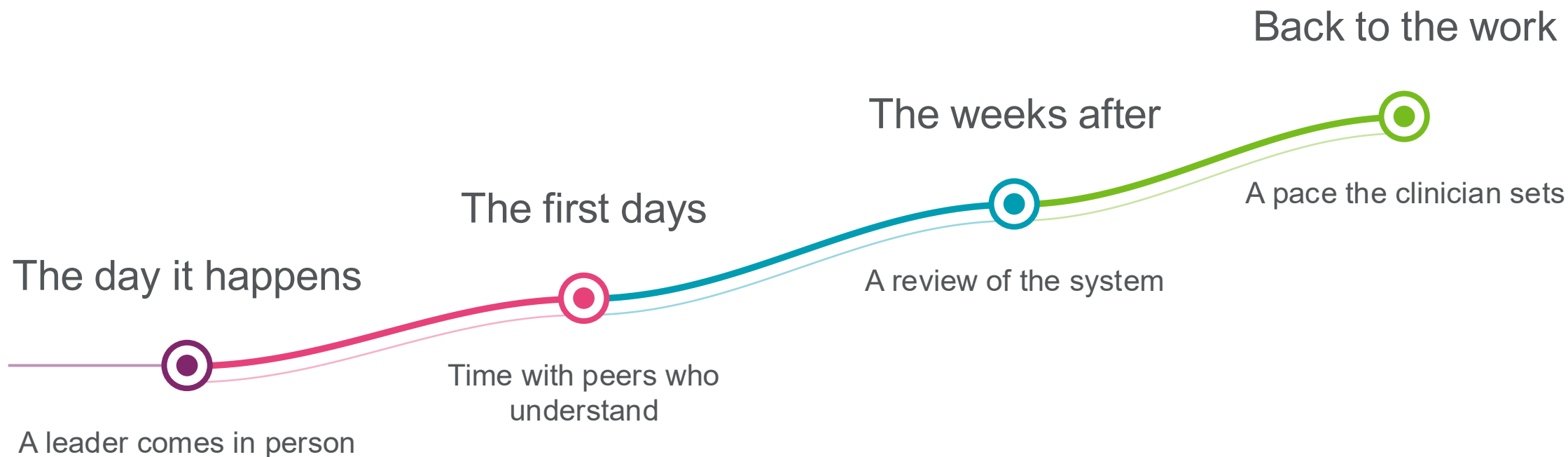
Patients are harmed

Preventable events reach the bedside. Family trust erodes. The organization reacts instead of learns.

*Without psychological safety, we cannot care for
our colleagues.*

Care After a Patient Death

When a young person dies by suicide, the care team grieves too.^{40,41}



Our aim is that clinicians who are cared for after a loss can keep caring for the next young person.

Elements of Postvention

Following a Patient Death by Suicide

1

Timely notification of the whole team

In a survey of mental health clinicians, those who heard about a death second-hand or by accident described added distress.⁴³

2

A senior suicidologist and leader

Clinicians in both United Kingdom surveys wanted confidential advice from a senior suicide lead, a role the Royal College of Psychiatrists recommends.⁴²⁻⁴⁴

3

Support kept separate from case review

A Delphi consensus panel rated this support as essential, and Veterans Affairs (VA) clinicians linked retrospective case reviews to feeling blamed.^{46,48}

4

A choice of supports

A one-size-fits-all approach was named a serious barrier, and residents most valued support from an attending who had been through a similar experience.^{45,46}

5

Preparation before a death

Written policies were rated essential, and Zero Suicide calls for a plan for staff support. One curriculum left residents feeling more prepared.^{46,49,50}

Who Reaches Out and What Gets in the Way

1

Manager

Notifies the senior suicide lead and lists everyone involved, including non-clinical staff.

BARRIER

Waiting to be asked

Leaders assuming clinicians will ask for help.

2

Suicidologist Leader

Starts outreach for every patient death and oversees the process.

BARRIER

Blame

A culture of blame, and punitive or pathologizing reactions.

3

Outreach colleague

Has no review role, has a named person supporting them, and asks each clinician what they need.

BARRIER

A referral instead of a person

Defaulting to an Employee Assistance Program referral, which the Delphi panel did not rate as important.⁴⁶

4

Clinician

Chooses the support, such as a peer who has lost a patient, a facilitated group, therapy, or none for now.

BARRIER

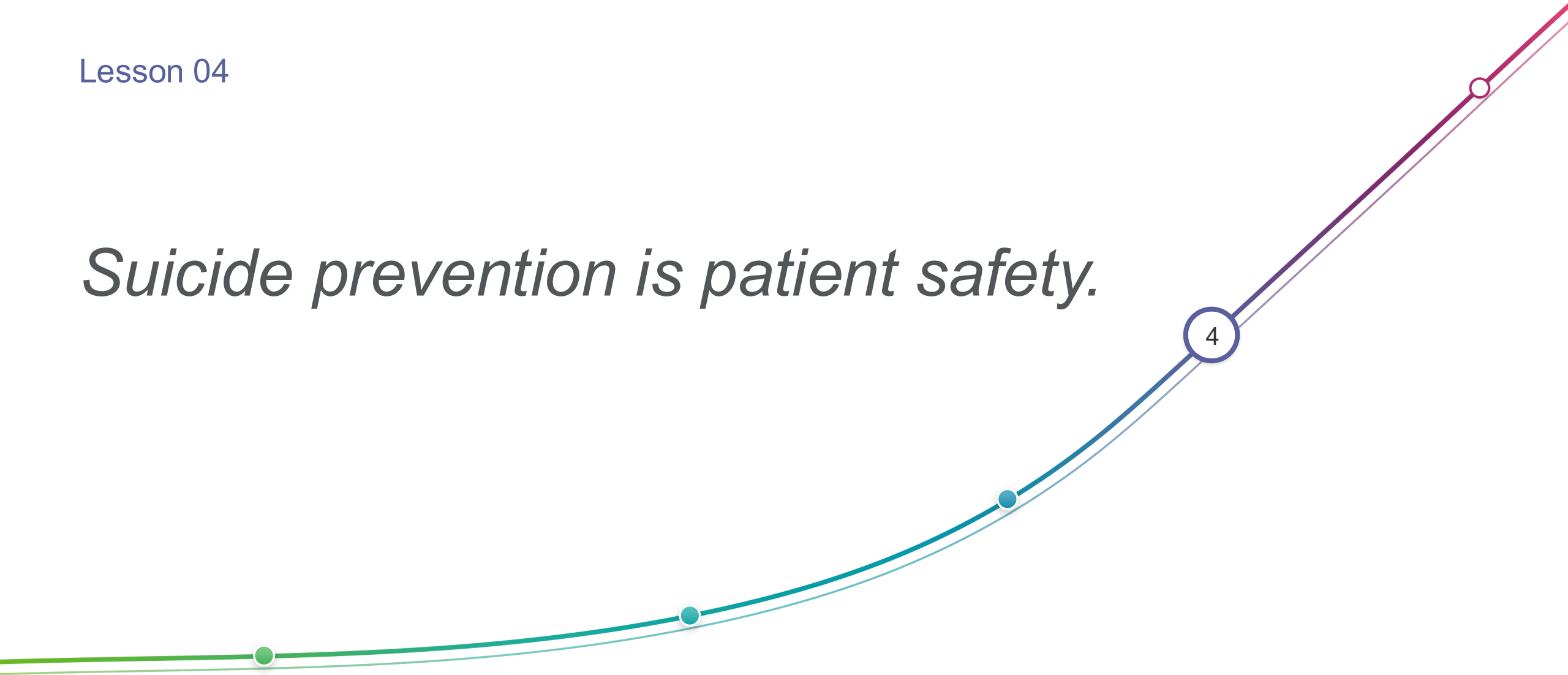
“Every suicide is preventable”

Messaging that clinicians linked to blame.

46. Cummings CM. Omega (Westport). Published online 2026.

Lesson 04

Suicide prevention is patient safety.



The Same Standard

Central line infections

- 1 A bundle for every line
- 2 Every infection reviewed
- 3 Rates tracked



Suicide prevention

- 1 A pathway after every positive screen
- 2 Every event reviewed as a safety event
- 3 Process measures tracked

Suicide Prevention is Patient Safety

TRADITIONAL VIEW

A behavioral-health problem



THE REFRAME

A patient-safety problem

TRADITIONAL VIEW

A risk-prediction problem



THE REFRAME

A systems problem

TRADITIONAL VIEW

The individual clinician's responsibility



THE REFRAME

An organizational responsibility

Foundations of Patient Safety

01 Humans are fallible.

Error is a normal feature of human performance, not a moral failing. The system must account for this and not punish it.⁵⁴

02 Systems shape outcomes.

The design of the system makes errors more or less likely. The same person performs differently in different systems.⁵⁴

03 Harm is multifactorial.

Adverse events arise from many aligned conditions, rarely from a single cause or a single person's failure.⁵⁴

04 Learning improves safety.

Systems that study their own failures get safer over time.⁵⁵

High Reliability Organizations

Five principles of high reliability organizations apply to suicide prevention.⁵⁵

Organizations in high-risk, complex environments that achieve near-zero catastrophic failure rates, by design and not by chance.

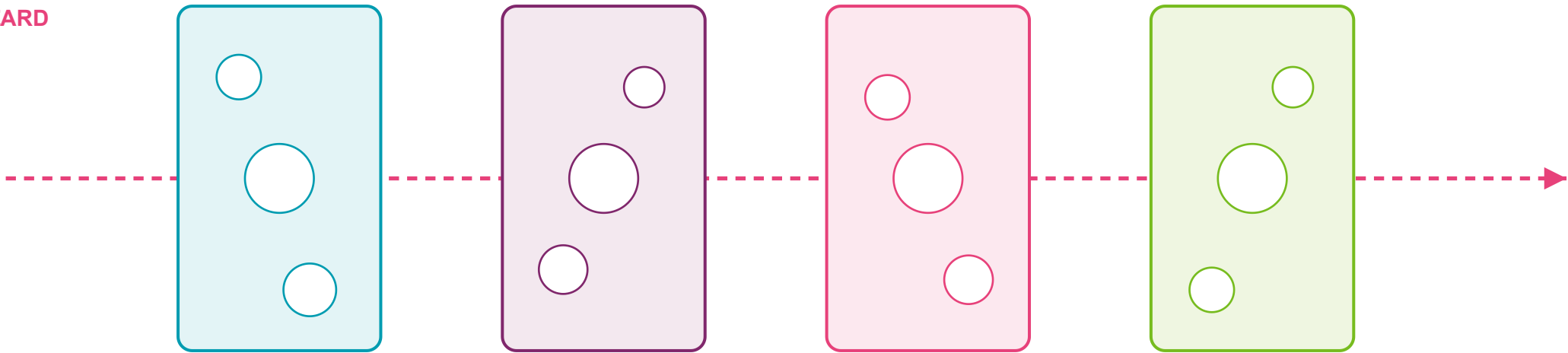
- 1 Preoccupation with failure**
Actively look for what could go wrong before it does.
- 2 Reluctance to simplify**
Resist easy answers; look for true root causes.
- 3 Sensitivity to operations**
Stay attuned to what is happening where care is delivered.
- 4 Commitment to resilience**
Detect and contain errors and recover from them quickly.
- 5 Deference to expertise**
Decisions move toward those with the most relevant knowledge.

55. Weick KE, Sutcliffe KM. Managing the Unexpected. John Wiley & Sons; 2015.

Harm Passes Through Many Failures

Layered defenses protect patients, but each has gaps, and harm reaches the patient only when the holes momentarily align.⁵⁴

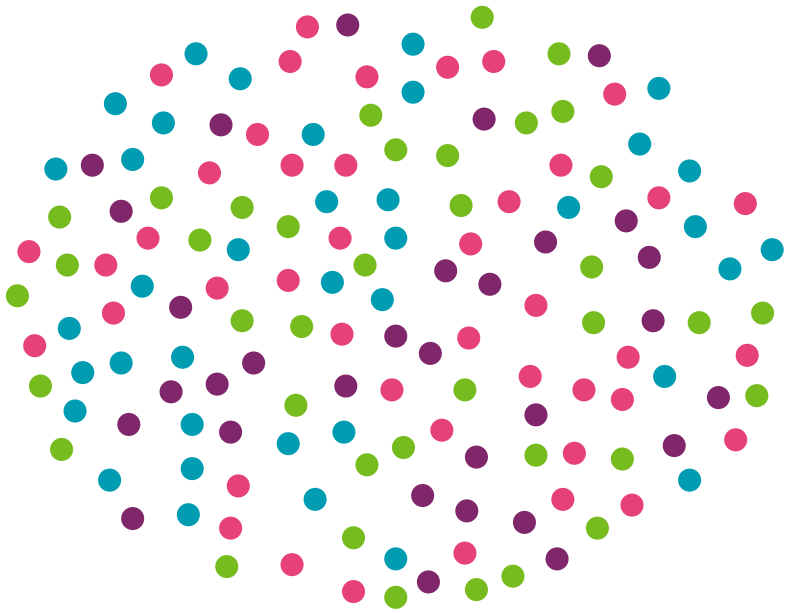
HAZARD



When a defense layer fails, the question is what to change in the system, not who to blame.

54. Wiegmann DA, et al. J Patient Saf. 2022.

Our Safety Work



More than 150 proposed interventions

sFMEA

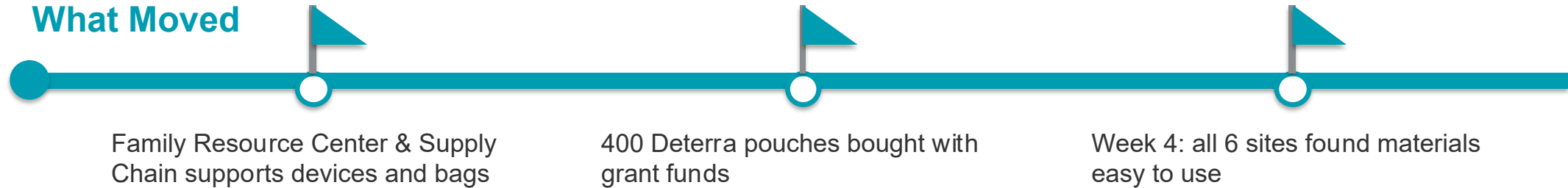
1 Suicide Risk Identification and Clinical Response

2 Lethal Means Safety and 988 Awareness Campaign

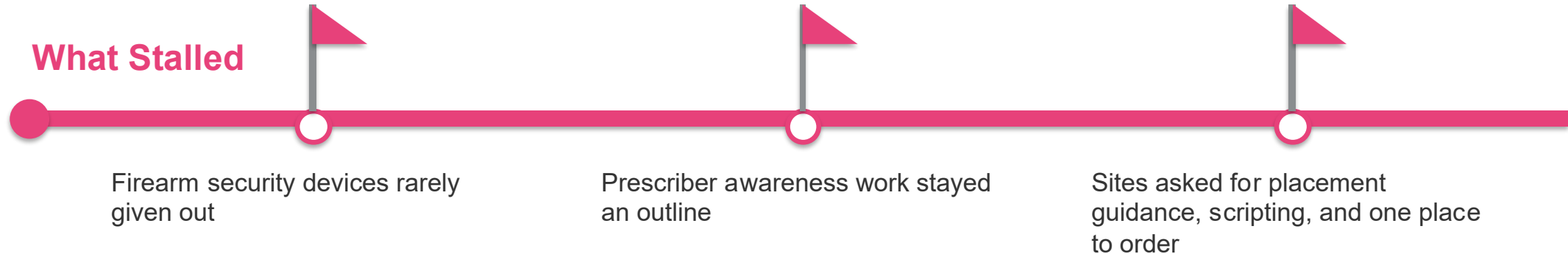
3 Co-production with Youth, Caregivers, and Families

What Moved... And What Stalled...

What Moved



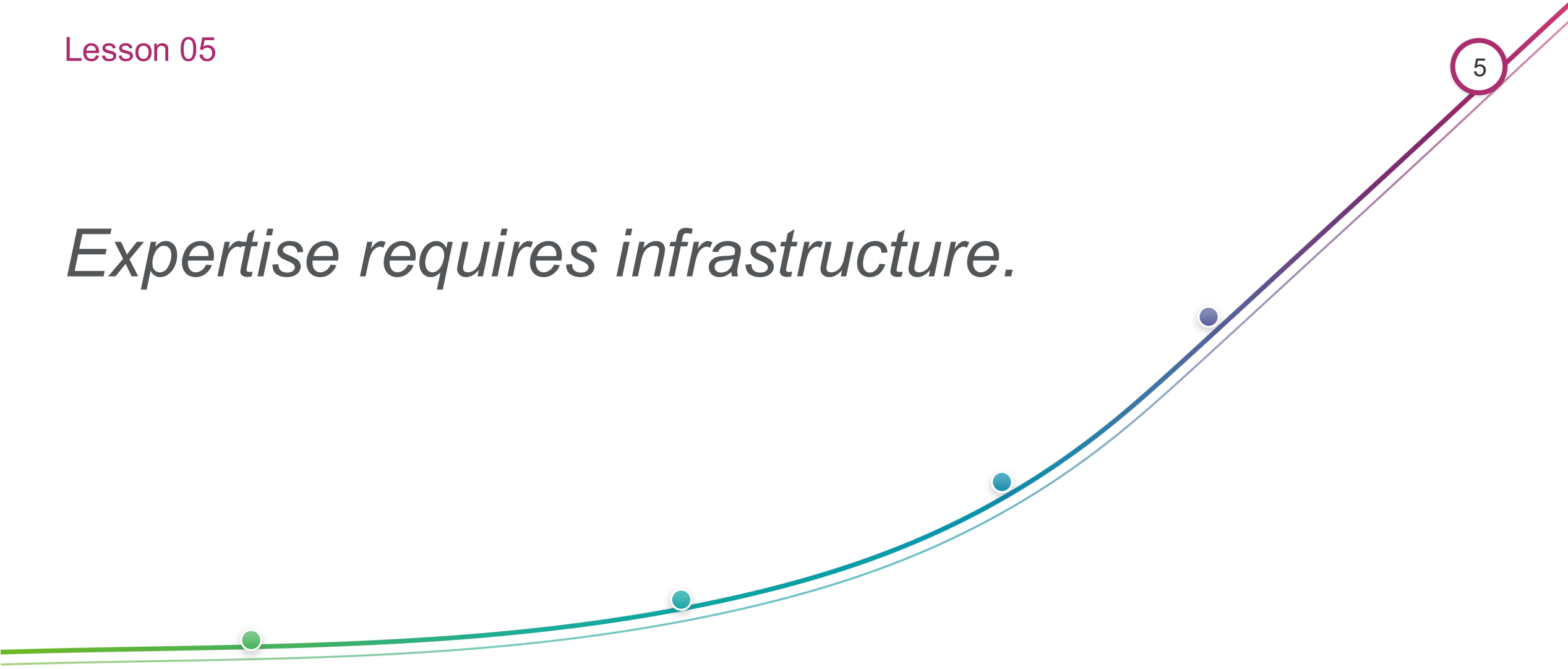
What Stalled



Lesson 05

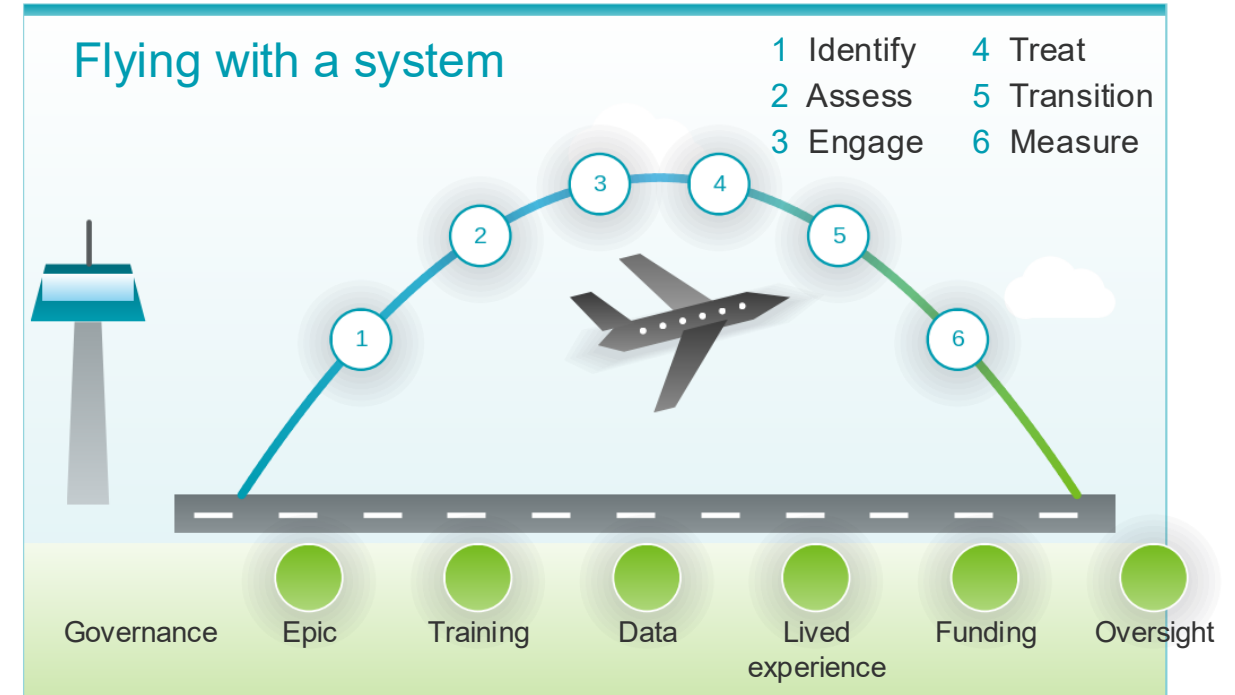
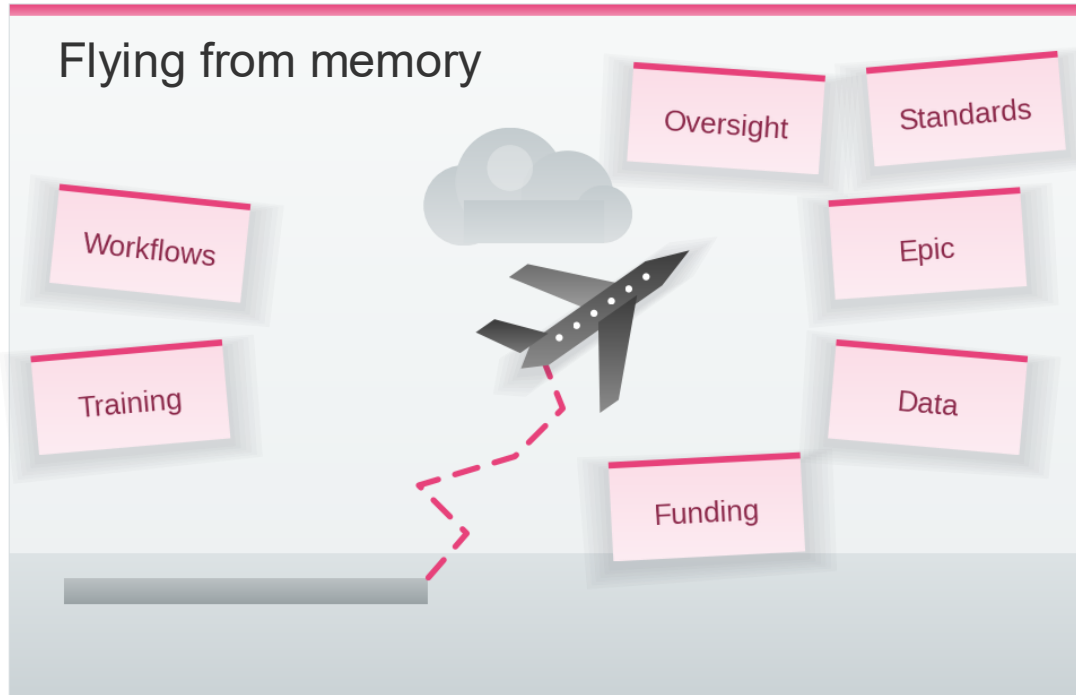
Expertise requires infrastructure.

5

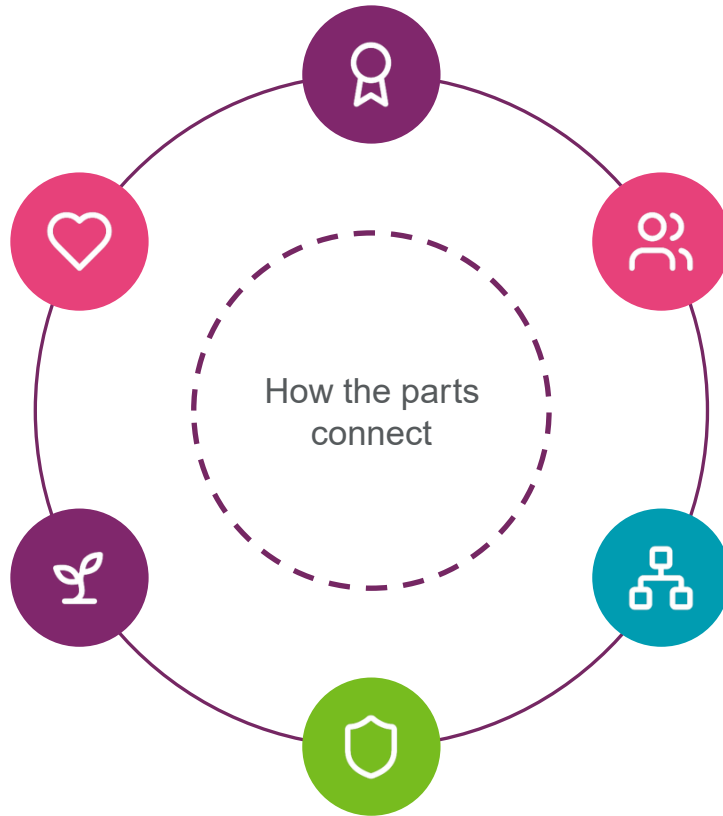


Point	Color
1	Green
2	Teal
3	Teal
4	Teal
5	Dark Blue

Systems Shape Outcomes



Distributed Expertise



- Clinical leaders
- Operations
- Epic and Information Services
- Regulatory and patient safety
- Educators
- Families and lived experience

What It Will Take



Infrastructure

One accountable home
Dedicated leadership
Sustainable operating funds



Partnerships

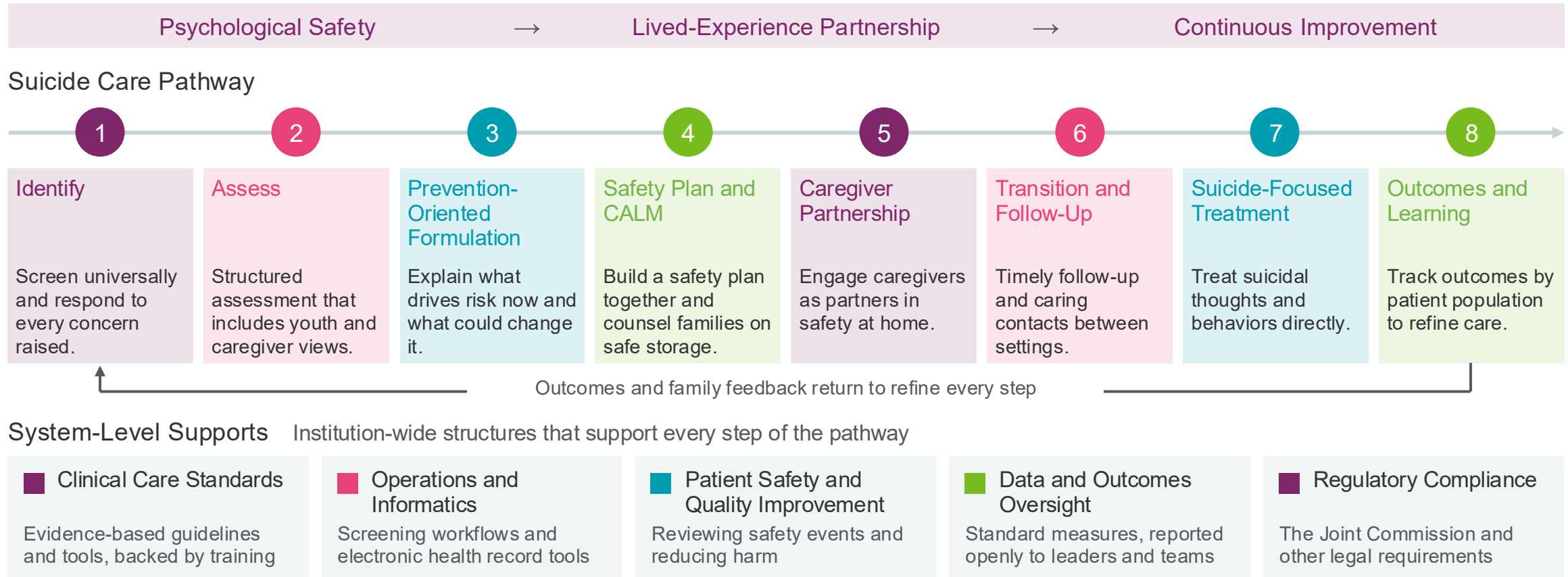
Families and lived experience partners
Coroners and public health
Community clinicians and schools



Workforce

Training with practice and reinforcement
Care after a patient's death
Teams where it is safe to speak up

A Learning System for Suicide-Safer Care



Dedicated Leadership and Suicide Prevention Expertise: Designated leaders with the protected time and authority to guide and sustain this work



Cincinnati Children's is committed to improving the lives of the patients and families we serve. Our team is committed to eliminating youth and young adult suicide in the Greater Cincinnati region.





Thank You!

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