

# Patient Safety Advisory

Veterans Health Administration Warning System  
Published by VA Central Office

AD 11-02

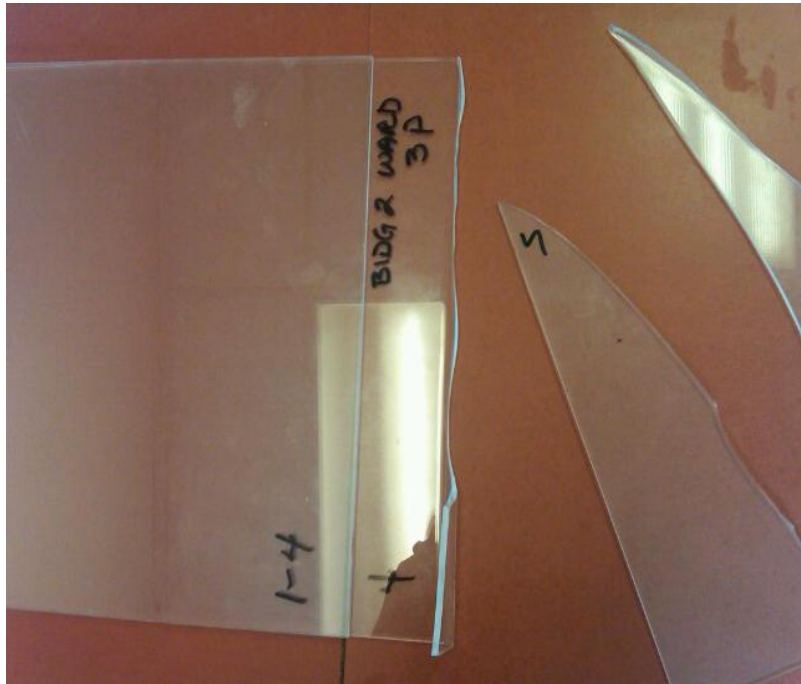
September 22, 2011

**Item:** Some plastic items can cause harm in mental health units treating actively suicidal patients and other areas treating or holding suicidal patients who are not on 1:1 observation

**Specific Incidents:** A VA medical center reported that a patient in a locked inpatient mental health unit tore the corner off a plastic dish (shown below), that is part of a wash basin, leaving a jagged edge exposed, which he used to cut himself.



In another incident, a patient was able to obtain an acrylic document holder that was in the nurse's station behind a Lexan screen. The patient was able to reach through openings in the screen and grab the document holder. The patient then broke the plastic document holder into at least two sharp pieces that could easily have been used as a weapon (see below). The pieces were found on the unit under the patient's mattress.



**General Information:** Plastic items seem safe to have on mental health units treating actively suicidal patients and other areas treating or holding suicidal patients who are not on 1:1 observation; however, some plastics, when broken or torn, create sharp-edged pieces that can be used for self-harm or harm to others.

In testing other plastic items, mental health staff were able to tear (with some effort) the lips off of the wash basin and also off of emesis basins (available on most wards), exposing jagged edges.

**Recommendations:** Review and complete the following recommendations or implement other measures to achieve an equivalent or increased level of safety by close of business December 6, 2011:

1. Staff working on mental health units treating actively suicidal patients and other areas treating or holding suicidal patients who are not on 1:1 observation should be made aware of this Patient Safety Advisory.
2. Staff on mental health units treating actively suicidal patients and other areas treating or holding suicidal patients who are not on 1:1

observation should periodically assess hard plastic items in areas where patients have access to or can potentially gain access to for their ability to be torn or broken and subsequently created into sharp objects that could be used for self-harm or to harm others. Plastic items that are assessed as hazardous should be removed or, if appropriate, reinforced. Plastic items that are removed that have specific functional, aesthetic, or other specific value should be replaced, when possible, with similar items deemed safe so as not to prevent these items from being available to patients and staff.

3. The Patient Safety Manager will document on the VHA Hazard Alerts and Recalls Web site, that top management reviewed and implemented these recommendations or implemented equivalent safety measures.

**Additional Information:** The Mental Health Environment of Care Checklist has been developed for locked inpatient mental health units in VHA facilities and has recommendations for reducing suicide hazards. The checklist has been revised to reflect the vulnerability described in this Patient Safety Advisory:  
<http://www.patientsafety.gov/SafetyTopics.html#mheocc>

**Source:** Two VA medical centers

**Contact:** Dr. Peter Mills, VA National Center for Patient Safety, (802) 295-9363, x6567, [Peter.Mills@va.gov](mailto:Peter.Mills@va.gov), or  
Ms. Lori King, VA National Center for Patient Safety, (734) 930-5890, [lori.king2@va.gov](mailto:lori.king2@va.gov).