Patient Safety Advisory

Veterans Health Administration Warning System
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Item: **Disassembly of wheelchairs in inpatient mental health and emergency department (ED) settings treating patients who have the potential for unpredictable or unsafe behavior (e.g., violence, suicide, etc.) and are not on 1:1 observation**

Specific Incidents: Two issues have been reported regarding disassembly of wheelchairs in VA inpatient mental health units:

1. A patient was able to remove the screws from his wheelchair and disassemble parts from the wheelchair, removing the legs and arm rest.

2. A patient removed the detachable anti-tipper metal bar from his wheelchair and attempted to pry open a locked closet door with the bar.

While no injury occurred in either of these instances, other patients or staff could have been injured if any of the parts of the wheelchair were used as a weapon. In addition, patient harm can result if parts of the wheelchair are used to enable access to areas that are intended to be off-limits to patients or if the wheelchair is used with missing parts.

General Information: Parts of a wheelchair that can be removed include anti-tipper bars, arm rests, the cushion/seat and foot rests. As such, Question 37 of the Mental Health Environment of Care Checklist (MHEOCC) was edited to reflect this vulnerability (see the attachment).The most current version of the MHEOCC can be found at http://www.patientsafety.gov/SafetyTopics.html#mheocc.

Recommendations: Review and complete the following recommendations or implement other measures to achieve an equivalent or increased level of safety by close of business (COB) June 6, 2012.

1. Disseminate this Patient Safety Advisory discussing vulnerabilities with wheelchairs to staff in inpatient mental health and ED settings treating patients who have the potential for unpredictable or unsafe behavior (e.g., violence, suicide,

etc.) and are not on 1:1 observation and to staff who transport patients to these areas.

2. There should be a policy in place that requires any wheelchairs coming into these vulnerable units – where the wheelchair will be left unattended (i.e., not continuously watched) – to have all removable parts of the wheelchair firmly attached with tamper-resistant hardware. In addition, the wheelchair should be examined for contraband that may be hidden in the cushion/seat or other areas of the wheelchair. Wheelchairs not intended to be continuously watched or that cannot be made to have removable parts firmly attached with tamper-resistant hardware should either be removed from the unit or stored away securely. Access to these units for those that require wheelchairs should not be denied, though the precautions identified above are intended to help to promote safety.

   NOTE: Tamper-resistant wheelchairs will help to minimize the risk to patients and staff in these vulnerable settings. However, wheelchairs typically have anchor points and staff should be educated about the risks these may present. Patient supervision by qualified staff plays a vital role in mitigating risk in these settings, along with appropriate assessment, observation and therapy.

3. Patient transporters should remain in contact with any transport wheelchair brought into inpatient mental health and ED settings treating patients who have the potential for unpredictable or unsafe behavior (e.g., violence, suicide, etc.) and are not on 1:1 observation. This contact must remain in place throughout the transfer and until the transport wheelchair is removed from the setting.

4. The **Patient Safety Manager** will document on the VHA Hazard Alerts and Recalls Web site that medical center leadership has reviewed and implemented these recommendations or equivalent safety measures, or that these recommendations are not applicable to your facility.

Add'l Information: If altering hardware on wheelchairs in these vulnerable settings is not an acceptable or viable option for your facility, or if it is time for new wheelchairs to be purchased for these settings, consider acquiring wheelchairs specifically marketed as tamper-resistant.

Attachment: Excerpt from the Mental Health Environment of Care Checklist – Question 37 (Version 03-01-2012)

Sources: Two Department of Veterans Affairs medical centers

Contacts: Dr. Peter Mills, VA National Center for Patient Safety at (802) 295-9363, x6567, peter.mills@va.gov, or

Ms. Lori King, VA National Center for Patient Safety at (734) 930-5890, lori.king2@va.gov

ATTACHMENT: Excerpt from the Mental Health Environment of Care Checklist – Question 37 (Version 03-01-2012)

Ques. No.	Site / Item	Questions / Criteria	Rationale / Assessment Methods
37	Weapons	37 a. Is the area free of lamps, steel trash cans, and other items that could be used as weapons? --------------------------- 37 b. Have patients with assistive devices been evaluated for their risk for using the device as a weapon or to barricade themselves in a room?	Inspect ward and patient rooms. Also inspect for devices with detachable pieces that could be used to harm themselves or another e.g., wheelchairs with detachable pieces (e.g., arm rests, anti-tip parts, foot rest, etc.) Practitioners should assess a patient's suicide and fall risks, the need for assistive devices and the danger of the assistive device, on a case-by-case basis. The practitioners and the treatment team must weigh the risks vs. benefits for each patient and the environment as a whole. This assessment needs to include, at minimum, the patient's risk for falls, the patient's risk for suicide, aggression or aggressive behaviors on the part of the patient or other patients within the unit, and the ability of the device to barricade a door or be used as a weapon. It is suggested that physical therapy be consulted, as needed, to assist in developing an interdisciplinary plan of care that minimizes risk for injury from falls, self-harm behavior or of harm to others. Less complex options for patient mobility could be found to be more applicable (e.g., don't permit use of a walker if a quad cane is equally effective and safe for the particular patient). Note that reassessment during a patient's stay will be required if the patient's behavior or suicidal status changes (e.g., if the patient become aggressive) or if the environment changes.