

# Patient Safety Alert

Veterans Health Administration Warning System  
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**Item:** Walker used to barricade a sleeping room door on a locked inpatient mental health unit treating currently suicidal patients

**Specific Incident:** A patient on a locked mental health unit treating actively suicidal patients jammed his walker under the door handle of the door to his sleeping room, preventing it from opening. While no injury was reported, this event could have resulted in serious injury or death if a suicidal patient was able to barricade himself in the room in this manner. Although not associated with this event, it is noted that assistive devices, such as walkers, may also be used as an anchor point for hanging or as a weapon.



**General Information:** A review of reports submitted into the VA National Center for Patient Safety RCA database indicates that a renewed emphasis needs to be placed on identifying and eliminating anchor points for hanging and devices that can be used for obstructing doors from being opened by staff on mental health units treating or areas holding suicidal patients that are not on 1:1 observation (e.g., psychiatric holding areas in emergency departments). The Mental Health Environment of Care

Check List (MHEOCC) must be used to complete assessments of the environment of care in inpatient mental health units treating currently suicidal patients.

**Actions:**

1. By Close of Business (COB) July 15, 2011, the **Medical Center Director (or designee)** must ensure all staff working in mental health units treating actively suicidal patients and other areas treating or holding suicidal patients that are not on 1:1 observation (e.g., psychiatric holding areas in emergency departments) are made aware of this Patient Safety Alert.

2. By COB July 29, 2011, the **Medical Center Director (or designee)** must ensure that, upon a patient's admission to the mental health units treating actively suicidal patients and other areas treating or holding suicidal patients that are not on 1:1 observation, practitioners 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. Some examples that could result are listed below; however, note that these are just examples and that assessment (and hence decisions regarding the assistive devices) are to be based on the professional experience and judgment of the treatment team.

- A practitioner may decide that a walker may be used for a particular patient because it has been tested and cannot be used to barricade any doors in the unit and the patient and other patients within the unit do not appear aggressive.
- A practitioner may decide that a walker may be used for a particular patient - even if it can be used to barricade a door - if the patient needs the device for mobility (no other device will suffice), has not been found to be at high risk for suicide, and neither the patient nor other patients on the unit appear to be aggressive. Alternatively, the practitioner may decide that the walker is to be provided to the patient only when needed and secured (i.e., locked away) when not

needed.

- A practitioner may decide that a quad cane is more effective for a particular patient than the walker, after their risk vs. benefit assessment.
- A practitioner may decide that walkers do not need to be removed from a high risk patient, since that patient will be on 1:1 observation.

3. By COB August 6, 2011, the **Patient Safety Manager** will document on the VHA Hazard Alerts and Recalls website that facility leadership has reviewed and implemented these actions.

**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 Alert: <http://www.patientsafety.gov/SafetyTopics.html#mheocc>

**Source:** A VA Medical Center

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