

Patient Safety Alert

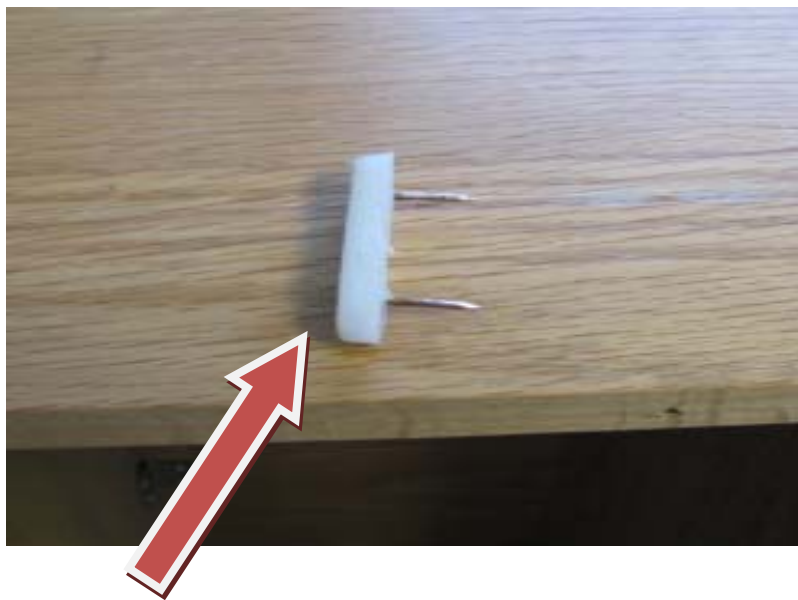
Veterans Health Administration Warning System
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Item: Furniture floor guards in mental health units treating actively suicidal patients and other areas treating or holding suicidal patients that are not on 1:1 observation (e.g., psychiatric holding areas in emergency departments)

Specific Incident: A VA medical center reported that a patient in a locked inpatient mental health unit removed a hard plastic floor guard from the bottom of his platform bed and refused to give it to staff. The floor guard had protruding nails (see the picture below) that were used to attach it to the platform bed, making it a potential weapon. While no injuries were reported, this event could have resulted in injury to staff, the patient, or other patients on the unit had the plastic floor guard been used as a weapon.



The floor guard, showing protruding nails



Floor guard similar to the one pulled off by the patient – originally located on the bottom of the platform bed (note that the bed frame is turned on its side)

General Information:

Floor guards (also called furniture glides or floor protectors) can be found on almost any piece of furniture (e.g., chairs, beds, tables, desks, etc.). They are generally made out of plastic and serve to protect both the furniture and the floor, and some designs may aid in leveling the furniture. While some floor guards look like that shown in this Patient Safety Alert, others may look much different.

Actions:

1. By Close of Business (COB) June 30, 2011, the **Medical Center Director (or designee)** must ensure all staff working on 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 August 1, 2011, the **Unit Manager (or designee) on all 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)** must ensure that floor guards on all furniture in the unit or holding area are either a) attached to the furniture using tamper-resistant fasteners or b) removed from the furniture.

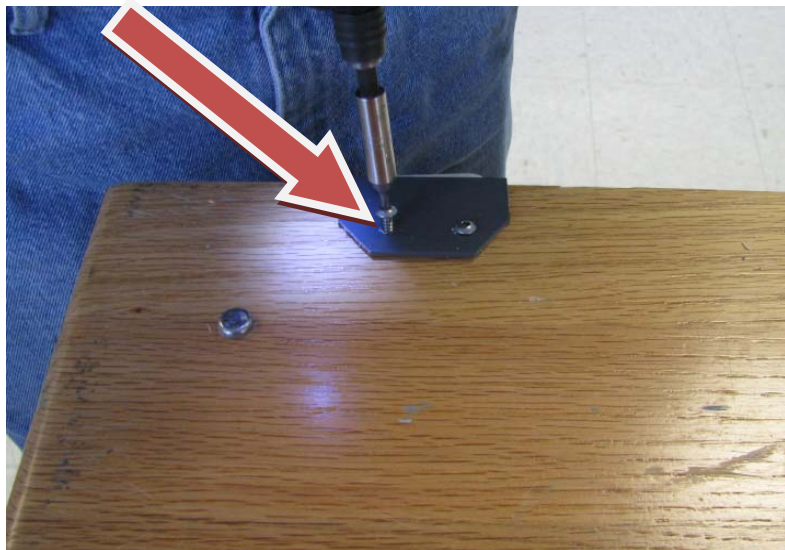
NOTE: Regardless of the choice of correction (i.e., removing the floor guards or attaching them with tamper-resistant fasteners), this must be done for all furniture in the unit or holding area, not just beds. In addition, this must be done throughout the unit for areas treating currently suicidal patients since furniture can easily migrate from fairly public

rooms (e.g., day rooms) to private/less-observed areas (e.g., sleeping rooms). Further, all new purchases for the units and holding areas will need to be evaluated for this vulnerability and the floor guards must be either a) attached to the furniture using tamper-resistant fasteners or b) removed from the furniture.

Should you decide to use tamper-resistant fasteners, consult with your Facilities Engineering Department for best practices. An example of what the reporting facility constructed is shown below.



Recessed, tamper-resistant screws in the floor guard and tamper-resistant screws in the supporting frame for the floor guard



3. By COB August 8, 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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