Patient Safety Alert

Veterans Health Administration Warning System
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Item: **Potential anchor points for hanging 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 Incidents:

- In the first event, a patient was found by staff to have attached a ligature tightly around the convex portion of a shower head that protruded at a downward angle from the wall (approx. 6 1/2 feet from the floor). See Attachment 1. The ligature was constructed from a torn sheet and fashioned into a noose from which the patient may have attempted to hang himself by standing on a chair (staff did not witness the attempt). The event occurred on a weekend on a sustained (non-acute) bed unit. No patient injury occurred.

- The second event involved a wooden platform bed which had been on the inpatient mental health unit since 1974 and weighed 165 pounds. Staff felt this bed was safe, based on its weight. A patient however lifted the bed up on its end by opening the drawers for a space to grasp it. The bed had a metal frame underneath and small holes near the footboard; the patient inserted a sheet into the holes and made a sling shot type device which the patient then used to attempt suicide by hanging. No patient injury occurred. See Attachment 2.

Actions:

1. By Close of Business (COB) July 5, 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 Close of Business August 1, 2011, staff shall check 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) for beds that can be stood on end to be used as anchor points for hanging and for shower faucets that can be used as anchor points and remove these hazards if they exist.

3. By close of business August 8, 2011, the **Patient Safety Manager** will document on the VHA Hazard Alerts and Recalls website that facility management has reviewed and implemented these actions.

The Mental Health Environment of Care Checklist has been developed for locked inpatient mental health units treating currently suicidal patients in VHA facilities and has recommendations for reducing suicide hazards. The Checklist has recommendations regarding the vulnerabilities described in this Patient Safety Alert: http://www.patientsafety.gov/SafetyTopics.html#mheocc

Attachments: 1) Shower head that can be used as an anchor point for hanging
2) Platform bed standing up on its end that can be used as an anchor point for hanging

Source: VA Medical Centers

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ATTACHMENT 1: Shower head that can be used as an anchor point for hanging

ATTACHMENT 2: Platform bed standing up on its end that can be used as an anchor point for hanging