Patient Safety Tip of the Week

April 12, 2016 Falls from Hospital Windows

The patient names were different and the hospital names were different but the two cases were otherwise almost identical. Last month a 43-year-old man died after falling from the window of his sixth-floor hospital room at a Maine hospital. The patient was recovering from a motorcycle accident earlier in the month in which he suffered a traumatic brain injury. He apparently had been in a medically-induced coma for a period but was recovering and getting ready for rehab. The patient's daughter believes her father was not suicidal, but was disoriented and trying to get home to his family (Byrne 2016). "He wanted nothing more in the world than to come home with the family, but with the extent of his brain injuries he needed more hospital time and rehab before that could happen." "All he could focus on was getting home, and due to his state of mind he was willing to try anything to get out of that hospital. He was able to open his hospital window enough to get out," she wrote.

This case sounds eerily similar to one we described in our October 6, 2015 Patient Safety Tip of the Week "Suicide and Other Violent Inpatient Deaths". That case involved a 26-year old male patient in Pennsylvania who had suffered a head injury in a motorcycle accident (Darragh 2014a). He was said to have an "impulse control disorder" following the head trauma and was on continuous observation by a hospital security guard in an ICU when he entered the bathroom and locked the door. He then smashed double-paned locked windows and jumped to his death from the sixth floor. The guard had not received the same training that nurses who usually provide continuous observation would have had. Such would have required continued observation of the patient in the bathroom at least via a partially open door.

According to the Portland (Maine) Press Herald report (Byrne 2016), newly constructed hospital facilities in Maine must meet the American Institute of Architects 2006 general guidelines for hospitals, which doesn't require windows in patient rooms to be openable. However, if windows in patient rooms are able to be opened, "operation of such windows shall be restricted to inhibit possible escape or suicide," the standards state. Those new standards may not have applied to the hospital section in which the patient in this case was housed.

Another critical factor we see over and over is that there may be **inadequate training for those charged with close monitoring or observation of patients**. This is especially the case on med/surg floors when patients are identified as being at high risk for suicide, other self-harm, or wandering and elopement.

In the Pennsylvania case the patient had been hospitalized and four times tried to leave the hospital against medical advice (Darragh 2014b). He was successful twice and was picked up by police and returned to the hospital. Previous attempts at elopement are a risk factor for subsequent elopements (see our July 28, 2009 Patient Safety Tip of the Week "Wandering, Elopements, and Missing Patients").

In patients committing suicide, we often see that a period of greater vulnerability when their depression is improving. The same probably applies to the patient with traumatic brain injury (TBI) and staff need to be aware that the **impulsivity** often seen after TBI accompanied by the desire to go home can lead to the sort of disastrous consequences unfortunately seen in these two cases.

Most of you are familiar with patients having dementia or Alzheimer's disease who may be prone to wandering and elopement. But any patient with impaired cognition may be at risk. This includes patients with psychiatric disorders, developmental disabilities, and acquired neurological disorders such as traumatic brain injury (TBI).

Some standardized questions that appear on most wandering assessment tools are:

- Is there a history of dementia?
- Is there a prior history of wandering or elopement?
- Has the patient been legally committed?
- Do they have a court-appointed legal guardian?
- Are they a danger to self or others?
- Do they lack cognitive ability to make decisions?
- Do they have physical or mental impairments that increase risk of harm?
- Do they walk round aimlessly?
- Do they often get agitated doing simple tasks?
- Do they ask the same question over and over?
- Do they frequently ask where they are?

A prior history of wandering or elopement (eg. at a long-term care facility prior to admission) should be a red flag.

Others have emphasized "**exit-seeking behavior**" such as **talking about going home** or asking about things not available on the unit (typically something such as candy bars). But there are other risk factors or contributing factors as well. Many of the drugs we've talked about under delirium (particularly sedating agents) may contribute.

Just as with fall risk assessments or delirium risk assessments or even DVT risk assessments, things change during a hospitalization. Therefore, a single assessment for elopement or wandering risk on admission is not sufficient. That risk assessment must be repeated after surgery, at internal transfers of care, and any time there has been a significant change in the patient's mental status or overall medical status.

We've also often discussed that intrahospital patient transports may also be vulnerable events. You've heard us talk on several occasions about the "**Ticket to Ride**" concept in

which a formal checklist is completed for all transports (eg. to radiology). Such checklists typically contain information related to adequacy of any oxygen supplies and medications needed but should also include information about things like suicide risk and wandering/elopement risk. These all need to be conveyed to the caregiver who may be accepting the patient in the new area. Just as we've talked about cases where a patient may attempt suicide in a bathroom in the radiology suite that is not suicide-proofed, a patient at risk for wandering or elopement may wander off easily while waiting in the radiology suite if not appropriately supervised.

Behavioral health units and staff are usually attuned to the risk of patients eloping or attempting suicide. But these cases illustrate that staff on med/surg units or ICU's or rehab units also need to be aware of risk factors for wandering, elopement, suicide or other impulsive behavior. Doing risk assessments and ensuring that staff caring for at-risk patients are adequately trained in dealing with such patients is important. When high-risk patients are identified it is also important to ensure they are not left alone in rooms with windows that can be opened (or broken) by patients.

Some of our prior columns on preventing hospital suicides:

- January 6, 2009 Patient Safety Tip of the Week "Preventing Inpatient Suicides"
- February 9, 2010 Patient Safety Tip of the Week "More on Preventing Inpatient Suicides"
- March 16, 2010 Patient Safety Tip of the Week "A Patient Safety Scavenger Hunt"
- December 2010 What's New in the Patient Safety World column "Joint Commission Sentinel Event Alert on Suicide Risk Outside Psych Units"
- September 27, 2011 Patient Safety Tip of the Week "The Canadian Suicide Risk Assessment Guide"
- December 2011 What's New in the Patient Safety World column "Columbia Suicide Severity Rating Scale"
- July 2012 "VA Checklist Reduces Suicide Risk"
- August 2013 "Suicide Attempts on Med/Surg Units"
- August 25, 2015 "Checklist for Intrahospital Transport"
- October 6, 2015 "Suicide and Other Violent Inpatient Deaths"
- March 2016 "TJC Sentinel Event Alert on Preventing Suicide"

See our previous columns on wandering, eloping, and missing patients:

- July 28, 2009 "Wandering, Elopements, and Missing Patients"
- December 2012 "Just Went to Have a Smoke"
- April 2, 2013 "Absconding from Behavioral Health Services"
- October 15, 2013 "Missing Patients"
- December 2013 "Lessons from the SFGH Missing Patient Incident"

References:

Byrne M. Daughter: Fall victim at Maine Medical Center wasn't suicidal, was probably disoriented. Portland Press Herald 2016; March 31, 2016
http://www.pressherald.com/2016/03/30/police-identify-patient-who-fell-or-jumped-from-maine-med-window/

Darragh T. State: St. Luke's staff not properly trained to monitor man who jumped to death from hospital window. The Morning Call (Allentown, PA) August 6, 2014
http://articles.mcall.com/2014-08-06/news/mc-stlukes-patient-escape-investigation-20140806_1_hospital-window-jonathan-hanchick-carol-kuplen

Darragh T. Death at Pa. facility highlights security challenge for hospitals. The Morning Call (Allentown, Pa.) June 21, 2014
http://articles.mcall.com/2014-06-21/news/mc-stlukes-hanchick-elopement-20140621_1_luke-jonathan-hanchick-head-injury

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