

# Patient Safety Tip of the Week

February 14, 2017

## Yet More Jumps from Hospital Windows

A patient jumps to his or her death from a hospital window. Think that could never happen at your non-psychiatric hospital? Think again. Last year we described 2 such cases (see our April 12, 2016 Patient Safety Tip of the Week “[Falls from Hospital Windows](#)”) and we’ve come across several additional cases since then. We wouldn’t be surprised if there are other cases that we simply have not heard about. There are also many news headlines about patients who have jumped from hospital windows that provide no details.

Suicide on non-behavioral health units has been a topic of several of our columns and also one of Joint Commission’s sentinel event alerts (see our December 2010 What’s New in the Patient Safety World column “[Joint Commission Sentinel Event Alert on Suicide Risk Outside Psych Units](#)”). But not all jumps from windows are suicide attempts. In many cases it is a confused patient trying to escape from the hospital. The two cases we described in our April 12, 2016 Patient Safety Tip of the Week “[Falls from Hospital Windows](#)” had traumatic brain injuries.

In one of the cases we’ve subsequently come across ([Pearson 2016](#)) a 25 y.o. man who had attempted an overdose with aspirin and multivitamins was on a “crisis stabilization” unit on the third floor (that hospital’s main behavioral health unit is on first floor). The patient “launched” himself off the bed and through the window, even while he was under direct observation. When found, he had “medical wires still connected”.

In another case ([Bay Bulletin 2016](#)) a man, age 29, had been admitted to hospital for alcohol-related issues on a Saturday before the incident the next morning, Christmas Day. He ran away from a doctor, broke the window and fell from the fifth floor to the ground.” Both his legs were fractured in the fall and he suffered a serious head injury and subsequently died.

In another ([Hutton 2014](#)) a 39 y.o. man suffering from alcohol withdrawal threw himself out of a fourth-floor window after he became disorientated and confused while waiting for a psychiatric review. His condition had stabilized over three days but his state of mind went from “jovial and chirpy” to “confused” until the night of his death when he began wandering around the ward incoherently before running away from the two nurses monitoring him, locking himself in a room, breaking the security locks on windows and throwing himself out.

Even the elderly may be at risk. An 80 y.o. man admitted for elderly care was left unattended in day room and broke window with a chair, crawled onto a ledge and fell to his death from second floor ([Jolly 2016](#)).

And not all victims are males. A female patient in her 40's on acute medical unit jumped to death from window ([Yorkshire Evening Post 2014](#)). No other details were provided. An older case ([Associated Press 2002](#)) again involved a head-injured patient but the patient was female. She was located in the hospital's head trauma unit on the 11<sup>th</sup> floor. She apparently was in some sort of restraints. A hospital worker heard a scuffling sound as he tended to the other patient in the room but events transpired so quickly that "by the time he heard the noise and went over, the person had already broken from the restraints" and squeezed through the 18-inch high opening of the large window in her room and fell fatally seven stories before hitting the roof of another building.

And the most recent case, which led to today's column, comes from another statement of deficiencies/plan of correction from the California Department of Public Health ([CDPH 2016](#)). A patient with auditory hallucinations attempted suicide by stabbing himself in the chest and neck, resulting in hospital admission as a trauma patient. He had a hemothorax and needed chest tube insertion. He was under 1:1 observation in a trauma/medical/surgical unit on the hospital's 10<sup>th</sup> floor. He suddenly "launched himself" up off his bed and out the window, breaking the window pane and falling 60 feet to his death on a 4<sup>th</sup> floor roof top. As we usually find with the reports from the CDPH, this case had numerous lessons learned. While several communication issues contributed, there were important lessons about the dangers in the environment that contributed or were otherwise hazardous (discussed below).

Even though we lack details on many of these cases, there clearly is **a pattern**. Moreover, there are some surprisingly simple issues that are actually very good lessons learned. The typical patient is a young or middle-aged male, but occasionally elderly patients or females have also jumped through or out of windows. The patient is often admitted for an attempted suicide but, again, not always. Typically he/she is confused or hallucinating. It's not just patients with known psychiatric disorders or a history of suicide attempt that are at risk. Patients with brain injuries or delirium are at risk, particularly those who have demonstrated a tendency to wander or have verbalized their **intent to "get out of here" or "go home"**. And the incidents have commonly occurred while patients are already on 1:1 continuous observation and the observer is actually in the room.

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 many of these cases.

Most general acute care hospitals have not installed the **type of window** used on behavioral health units that is **not breakable or subject to manipulation**. But perhaps it

might be reasonable to designate one or two rooms on acute care floors for housing such patients deemed at risk and install such windows in those rooms. And, given that many such victims have been head trauma patients, perhaps it would be wise to install such windows on any acute head trauma units or other units dealing with TBI patients. But be wary that even windows you may consider “safe” may not be. At one hospital a male patient (no further details) removed a metal grill from a third floor window and fell out ([Malloy 2016](#)). The hospital subsequently checked the “safety restrictors” on all their windows.

But at a minimum, every room that is to be used for such patients needs a **thorough environmental assessment** such as the VA’s [Mental Health Environment of Care Checklist](#). Particularly in a room where medical equipment is being used there will be special dangers. For example, in the CDPH case discussed above the patient’s oxygen had been discontinued but the mask, tubing, etc. were still in the room. These are objects that can be used by a patient to hang himself or otherwise injure himself. So **make sure that medical equipment and supplies that are no longer needed are promptly removed from the room**. The environmental assessment should also evaluate the immediate surroundings. For example, in that CDPH case there was a **stairway** exit 15 feet from the patient’s room with a **door that was unlocked**. (Note that we’ve discussed the VA’s [Mental Health Environment of Care Checklist](#) in several columns and will probably do another soon. Recent studies ([Watts 2016](#), [Mills 2016](#)) have shown that it has been very successful in reducing suicides, perhaps more important than any other interventions.)

So what are the more subtle lessons learned? First is that several patients were able to stand up on the bed and “launch themselves” through the window from the bed. That implies a **proximity of the bed to the window**. So one key lesson is to position the patient’s bed in the room at a reasonable distance away from the window so such “launches” are not possible.

Second, **positioning of the observer** may be important. The observer is usually positioned in the room on the side away from the window and near the door. We suspect that is intentional and may be a consideration for the safety of the observer plus it would allow the observer to easily yell for help if necessary. But that obviously needs to be rethought.

And some other less obvious equipment needs to be removed: the **second bed in a 2-bed room should probably be temporarily moved**. That can only hinder someone from attempting to rescue a patient who is trying to jump out of a window.

And since the patient often uses an **object in the room to break the window, such as a chair or piece of medical equipment**, care must be taken to make sure such objects are not in reach for a patient even for a very brief time. For example, if the observer needs to briefly leave the room perhaps the chair should be removed.

We've also discussed before the importance of **adequate training for the personnel designated as observers**. Most people assigned as observers on med/surg floors have never worked in behavioral health units or even worked with behavioral health patients. Often they are not even healthcare personnel (some hospitals have utilized security personnel as observers) and may not have been adequately trained to recognize red flags or trained in de-escalation techniques.

And don't forget that **intra-hospital 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. We also hope that you've checked those bathrooms in radiology for loopables and other implements that might be used in a suicide attempt (see our March 16, 2010 Patient Safety Tip of the Week "[A Patient Safety Scavenger Hunt](#)").

Staff on med/surg units, ICU's and rehab units need to be aware of risk factors for wandering, elopement, suicide or other impulsive behavior just as much as staff on behavioral health units do. 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 and appropriate environmental assessments done to minimize the chance a patient may harm him/herself.

#### **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](#)”
- April 12, 2016 “[Falls from Hospital Windows](#)”

**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](#)”
- April 7, 2015 “[Missing Patients and Death](#)”
- October 6, 2015 “[Suicide and Other Violent Inpatient Deaths](#)”
- April 12, 2016 “[Falls from Hospital Windows](#)”

**References:**

Pearson K. Investigation continues into man's death by jumping from Winter Haven hospital window. Girlfriend talked to him hours before, said he showed no signs of self-harm. The Ledger 2016; Published: Monday, April 25, 2016  
<http://www.theledger.com/article/20160425/news/160429648>

Bay Bulletin. Port Elizabeth - Patient Dies After Jumping From Livingstone Hospital Window. Bay Bulletin 2016; December 28, 2016  
<https://thebaybulletin.blogspot.com/2016/12/port-elizabeth-patient-dies-after.html>

Hutton A. Patient died after jumping from hospital window, inquest hears. Camden New Journal (UK) 2014; 14 February 2014  
<http://www.camdennewjournal.com/news/2014/feb/patient-died-after-jumping-hospital-window-inquest-hears>

Jolly L. Vulnerable man, aged 80, dies after jumping through third-floor window at Paisley's Royal Alexandra Hospital. Daily Record (UK) 2016; 20 June 2016  
<http://www.dailyrecord.co.uk/news/local-news/vulnerable-man-aged-80-dies-8235725>

Yorkshire Evening Post. Changes ordered following patient's jump from Leeds hospital window. Yorkshire Evening Post (UK) 2016; 2 June 2014

<http://www.yorkshireeveningpost.co.uk/news/health/changes-ordered-following-patient-s-jump-from-leeds-hospital-window-1-6646904>

Associated Press. Patient jumps to her death from 11th story of Miami hospital. StAugustine.com. April 8, 2002

[http://staugustine.com/stories/040802/sta\\_627753.shtml#.WI4L1X\\_g884](http://staugustine.com/stories/040802/sta_627753.shtml#.WI4L1X_g884)

CDPH (California Department of Public Health). Complaint Intake Number CA00397967; 2016

[http://www.cdph.ca.gov/certlic/facilities/Documents/2567\\_ScrippsMercyHospital\\_IJAP\\_SanDiego.pdf](http://www.cdph.ca.gov/certlic/facilities/Documents/2567_ScrippsMercyHospital_IJAP_SanDiego.pdf)

(suicidal patient in acute care setting)

Malloy T. Patient falls from window at Weston General Hospital after removing safety grill. SomersetLive 2016; August 12, 2016

<http://www.somersetlive.co.uk/patient-falls-from-window-at-weston-general-hospital-after-removing-safety-grill/story-29613744-detail/story.html>

VA Mental Health Environment of Care Checklist (MHEOCC).

<http://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp>

Watts BV, Shiner B, Young-Xu Y, Mills PD. Sustained Effectiveness of the Mental Health Environment of Care Checklist to Decrease Inpatient Suicide. *Psychiatric Services* 2016; Published Online Ahead of Print: November 15, 2016

<http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201600080>

Mills PD. Use of the Mental Health Environment of Care Checklist to Reduce the Rate of Inpatient Suicide in VHA. *TIPS (Topics in Patient Safety)* 2016; 16(3): 3-4 July/August/September 2016

<http://www.patientsafety.va.gov/professionals/publications/newsletter.asp>



The  
Truax  
Group  
Healthcare Consulting  
[www.patientsafetysolutions.com](http://www.patientsafetysolutions.com)

<http://www.patientsafetysolutions.com/>

[Home](#)

[Tip of the Week Archive](#)

[What's New in the Patient Safety World Archive](#)