

Patient Safety Tip of the Week

July 10, 2018

Another Jump from a Hospital Window

Jumps and/or falls from hospital windows are rare events. Unfortunately, we do continue to see fatalities due to such jumps/falls and there are several themes and patterns common to such incidents. We've emphasized in several previous columns that there are important lessons learned from prior incidents. We discussed many of these in our Patient Safety Tips of the Week for April 12, 2016 "[Falls from Hospital Windows](#)" and February 14, 2017 "[Yet More Jumps from Hospital Windows](#)".

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. Many such incidents occur when patients are housed on non-psychiatric units or general medical floors. Hospital beds are often used as "launch pads".

A recent fatal jump from a hospital window illustrates many of these themes ([Meehan 2018](#), [WBAL 2018](#)). The patient, a 47-year old man, apparently was on a "suicide watch" but was housed on a 10th floor general medical unit because of a high heart rate. He "refused to take his medicine and became aggressive." He attempted to strike a staff member with a computer, according to a police report. He "then began to scoot his body closer to the end of the bed then [he] lunged toward the window." He broke the window with his elbow and jumped out the opening, landing on the third-floor ledge of the hospital, according to police.

One obvious question always raised in such incidents is "why don't you have windows that are not easily broken?" The hospital spokesperson in the above case said that the windows were within code for that type of room. But 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.

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**. In our February 14, 2017 Patient Safety Tip of the Week “[Yet More Jumps from Hospital Windows](#)” we said 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. For example, if you have a high-risk patient in a typical double patient room, it may make sense to remove one bed and move the remaining bed to a more central position where it cannot be used to launch at the window.

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. That applies not only to the second bed but also to any **object in the room that might be used to break the window, such as a chair or piece of medical equipment**. In another recent case, a 70-year old man with a history of mental illness, drug and alcohol abuse, and was being evaluated when he picked up a chair and smashed the window in an 8th floor hospital room and jumped to his death ([AP 2017](#), [Valenzuela 2017](#)). 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 their chair should be removed. In the case above, the patient apparently attempted to strike the observer with a computer.

But at a minimum, every room that is to be used for at-risk 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 a case discussed in our February 14, 2017 Patient Safety Tip of the Week “[Yet More Jumps from Hospital Windows](#)” 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 previous 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.)

And one extremely important factor we've also discussed, not only in preventing falls/jumps from windows but also in preventing hospital suicides in general, is 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**.

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.

Lastly, 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](#)").

See also our December 12, 2017 Patient Safety Tip of the Week "[Joint Commission on Suicide Prevention](#)" for the Joint Commission's recommendations for suicide prevention in general acute inpatient settings and emergency department settings.

So if we were doing the RCA (root cause analysis) on the above case, here are some of the questions we'd be asking:

- Was housing of the patient on a general medical unit the most appropriate location?
- Were the staff doing the observation appropriately trained to deal with potentially violent or suicidal patients?
- Were they trained in de-escalation techniques?
- What actions were taken when the patient became aggressive?
- Why was the hospital bed positioned near a window?
- What unnecessary equipment was in the room?

- Were there other beds in the room?
- Were there other items in the room that could be used to break windows?
- Could we have a room that had windows which are unbreakable or cannot be tampered with?
- Have we done an environmental assessment, such as the VA's [Mental Health Environment of Care Checklist](#), on the rooms we use that we use on non-psychiatric floors for patients at risk for suicide?
- Are there nearby structures/spaces that could also be a suicide risk (eg. bathroom, stairwell)?
- Do we include provisions on our "Ticket to Ride" checklist for intrahospital transports to deal with patients at risk for suicide or wandering?

Some of our prior columns on preventing hospital suicides:

- January 6, 2009 "[Preventing Inpatient Suicides](#)"
- February 9, 2010 "[More on Preventing Inpatient Suicides](#)"
- March 16, 2010 "[A Patient Safety Scavenger Hunt](#)"
- December 2010 "[Joint Commission Sentinel Event Alert on Suicide Risk Outside Psych Units](#)"
- September 27, 2011 "[The Canadian Suicide Risk Assessment Guide](#)"
- December 2011 "[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](#)"
- February 14, 2017 "[Yet More Jumps from Hospital Windows](#)"
- August 29, 2017 "[Suicide in the Bathroom](#)"
- December 12, 2017 "[Joint Commission on Suicide Prevention](#)"

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



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