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Patient Safety Tip of the Week

July 30, 2019

Lessons from Hospital Suicide Attempts

Suicide in the hospital is a "never event". Yet this remains a problem, both for behavioral health hospitals and general hospitals. A couple incidents from the most recent release of California Department of Public Health hospital incidents reinforce some lessons we have focused on in the past.

Many of our columns on hospital suicides have highlighted the problem of patients attempting suicide while in bathrooms in areas other than behavioral health units. The radiology suite is one area we have always talked about because behavioral health patients may need to go there for imaging studies and bathrooms there may not be ligature-proof and may be capable of being locked from the inside. The first CDPH case (CDPH 2019a) illustrates the same vulnerability – but this time in the emergency department. The patient was admitted to the ED from the facility's chemical dependency unit because of attempted suicide and was placed on 72-hour involuntary hold. He was assigned a 1:1 sitter but the sitter allowed the patient to go to the ED restroom alone, where he closed and locked the door. A registered nurse later found the patient kneeling on the restroom floor with the call light cord around his neck. The patient was assisted back to his room and was subsequently admitted to the General Acute Care Hospital psychiatric unit.

The sitter was a "float" who usually worked on a transitional care unit rather than the ED. She was also not used to working with suicidal patients. The sitter did not have a key to the bathroom and did not know where the key was kept. A nurse and the sitter responded to the nurse call light (presumably triggered when the patient attempted to hang himself by the call light cord).

The house nursing supervisor noted that, when the ED requests a sitter, she pulls one from one of the floors in the hospital. The sitter receives an orientation once they arrive in the unit. They receive basic training and are given "additional instructions", but it was not clear what training they were given for dealing with psychiatric or suicidal patients.

The facility's plan of correction involved multiple educational interventions aimed at ensuring sitters understood their roles and responsibilities. The facility also replaced the

nurse call light cord in the ED bathroom with a psychiatric safe breakaway cord to reduce the chance it could be used as a ligature.

Lessons from this case:

- bathrooms in high risk areas (ED, Radiology, etc.) need to be made suicide-resistant
- sitters in non-behavioral health areas must be properly trained (in advance) for dealing with such patients
- all staff working in the ED need to know where the bathroom keys are located
- gender issue? We've questioned previously whether patients and/or sitters are reluctant to follow the patient into the bathroom when the patient and sitter are of opposite gender.

Are you required by The Joint Commission to have ligature-resistant standards in the emergency department? The answer is probably no. Their standards FAQ's state "Emergency departments do not need to meet the same standards as an inpatient psychiatric unit to be a ligature-resistant environment" (TJC 2018a). However, if you provide a "safe room" in your ED for patients at high risk for suicide TJC states: "The organization should remove all items that can be removed from the room and provide an appropriate level of monitoring based upon patient's suicide risk and the ligature/self-harm items that remain in the environment to ensure patient care is provided in a safe environment. The organization is expected to develop and implement a policy/procedure to direct staff, provide education to staff as to the procedure, and ensure demonstrated competence and compliance. If the organization has a designated "safe room," The Joint Commission expects this room to be ligature resistant." (TJC 2018b).

Regarding the role of the sitter, The Joint Commission requires the staff member to immediately intervene should the patient attempt self-harm. Their standards FAQ's (TJC 2019) states "…monitoring of patients at high risk for suicide, the monitoring should be constant 1:1 (at all times, including while the patient sleeps, toilets, bathes, etc.) and the monitoring must be linked to the provision of immediate intervention by a qualified staff member when required."

The second CDPH case (CDPH 2019b) involved a patient who jumped or fell 30 feet to a concrete patio after escaping from a behavioral health unit. The patient was admitted to a Mental Health Unit on a 14-day hold order after he had attempted to hang himself at home. However, he managed to get out of the locked MHU, go outside and jump down to a concrete patio, which caused multiple traumatic injuries. The CDPH investigation and video tapes revealed that the patient had been behind an administrative staff person who left the MHU via a door that is usually locked. The patient followed the staff person and reached the door as it closed but before it fully closed and locked. He was observed peering through the door window and then entering the outer corridor. The video then showed him walking to a lobby and entering an elevator. When another patient alerted staff that the patient was missing, an immediate search was undertaken. The MHU RN Supervisor found the patient lying on the patio covered in blood, trying to move, moaning

and stating, "Just let me die." It was later determined he had jumped or fallen about 30 feet to that concrete patio.

The administrative staff person had never been oriented to the MHU and never received specific training on making sure the MHU locked doors were secured when going in and out and there was no formal policy for such orientation to the MHU.

Lessons from this case:

- Patients are very clever when it comes to finding ways to escape from locked units
- Areas adjacent to such locked units need to be assessed for environmental issues that might present a suicide risk
- All staff who might enter and exit a behavioral health unit need orientation about safety measures and especially about the need to ensure doors lock

In our October 6, 2015 Patient Safety Tip of the Week "Suicide and Other Violent Inpatient Deaths" we noted that another potential vulnerability has to do with **fire alarms**. In one case a patient pulled a fire alarm which automatically unlocked doors on a behavioral health unit, allowing him to escape and jump to his death from a rooftop (Pfeiffer 2010). After we heard about that case, we began to include inspection of stairwells and rooftop access points adjacent to behavioral health units in our patient safety walk rounds or environmental walk rounds.

In our September 18, 2018 Patient Safety Tip of the Week "More on Hospital Suicides" we noted another case which did not involve an actual suicide but serves as a reminder of how patients may use fire alarms to facilitate elopement (Fettes 2018). A patient on a behavioral health unit set his mattress and bedding on fire, triggering the facility's fire alarm. The alarm automatically disarmed the facility's fire doors and the patient left the unit. Fortunately, he was later found and returned to the unit. But the case illustrates a problem we've seen before. The behavioral health unit involved did not have a specific policy for "a combined fire and security incident". You'll recall we have recommended that facilities consider **combining safety drills** to account for such incidents. For example, you could do a fire drill and then immediately do a drill for a missing patient (or an abducted child).

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"
- July 10, 2018 "Another Jump from a Hospital Window"
- September 18, 2018 "More on Hospital Suicides"
- January 22, 2019 "Wandering Patients"
- January 29, 2019 "National Patient Safety Goal for Suicide Prevention"

Some of our past columns on issues related to behavioral health:

- January 6, 2009 "Preventing Inpatient Suicides"
- September 22, 2009 "Psychotropic Drugs and Falls in the SNF"
- 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"
- January 15, 2013 "Falls on Inpatient Psychiatry"
- April 2, 2013 "Absconding from Behavioral Health Services"
- 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"
- March 14, 2017 "More on Falls on Inpatient Psychiatry"
- August 29, 2017 "Suicide in the Bathroom"
- December 12, 2017 "Joint Commission on Suicide Prevention"
- February 6, 2018 "Adverse Events in Inpatient Psychiatry"
- July 10, 2018 "Another Jump from a Hospital Window"
- September 18, 2018 "More on Hospital Suicides"
- January 22, 2019 "Wandering Patients"
- January 29, 2019 "National Patient Safety Goal for Suicide Prevention"

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