Patient Safety Alert

Veterans Health Administration Warning System
Published by VA Central Office

AL07-04 February 16, 2007

Item: **Privacy curtains and privacy curtain support structures (e.g., track and track supports) in locked mental health units**

Specific Incident: A VAMC reported that a patient used a privacy curtain (and its support) in a sleeping room located in a locked mental health unit to commit suicide by hanging. The patient used the privacy curtain as a noose - knotting it to make it more rope-like while it remained attached to the curtain support structure. The entire system supported the full weight of the patient.

General Information: Locked mental health unit sleeping rooms - provided with privacy curtains to meet patient privacy needs - conflict with the need to keep patients safe from self harm. Patient privacy is important; however, patient safety must come first. Privacy curtains and their components are not appropriate in this protected environment.

A review of inpatient suicide and parasuicide events in VHA over the past 5 years reveals that approximately 54% of the reported suicide/parasuicide events have occurred in locked inpatient psychiatric and detox units. 70% of the reported events involved hanging, drug overdose, or cutting with a sharp object. The majority of items used for nooses for suicides include bedding or clothing (including belts and shoelaces). Various items have been used for anchors in the suicide and parasuicides including, but not limited to, doors, wardrobe cabinets, bed rails, shower fixtures, bathroom stalls, handrails, and window latches.

Actions: 1. By close of business (COB) Friday, February 23, 2007 identify every location accessible to patients in your locked mental health units that have privacy curtains and/or support systems for the curtains and remove the curtains.

2. By COB Friday, March 9, 2007 remove any privacy curtain supportive structures (e.g. tracks and track supports) that could be used as an anchor for suicide by hanging.

Addl Information: Two previously issued Patient Safety Alerts address suicide prevention in locked mental health units. One involved a patient using an article of clothing to hang from a louvered heating, ventilating, and air conditioning (HVAC) grille (http://www.patientsafety.gov/alerts/LouveredHVACGrilleFeb28.pdf), and the other involved a patient placing a thin plastic cover from a wheelchair cushion (for incontinence protection) over their head resulting in suffocation. (http://www.patientsafety.gov/alerts/SoftskinAlert.doc).

The Under Secretary for Health's Information Letter, dated December 11, 2006, (see Attachment 1) provides medical centers with guidance in implementing strategies to comply with the new Joint Commission on the Accreditation of

Healthcare Organizations (JCAHO) National Patient Safety Goal regarding mitigating the risk of suicide through screening and action. In addition, a previously issued Patient Safety Advisory (http://www.patientsafety.gov/alerts/DepressionScreeningAdvisoryJan05.pdf) provides tools and resources that providers can use for screening recently separated (from active military duty) patients for depression, which may increase early identification of suicidal patients.

Source: A VA Medical Center

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