

## **Suicide watch**

### **Design your facility to protect troubled patients from self-harm**

By Constance Nestor

Patient suicides do happen--more frequently than people realize. Of all sentinel events reported by hospitals, suicide accounts for 21 percent, according to 1999 statistics from the Joint Commission on Accreditation of Healthcare Organizations. And the reported incidents are a fraction of the true volume of sentinel events that occur in hospitals. Further, of the 65 inpatient suicide cases reviewed by the JCAHO between 1996 and November 1998, 34 occurred in psychiatric hospitals. That's why health care facilities should apply the principles of safe design--starting now.

#### Building an ideal environment -

Because the majority of suicide victims suffer from depression, personality disorder, and schizophrenia, behavioral health patients considered at risk for suicide should be cared for in environments that minimize risks while providing a habitat that is as natural, humane, and therapeutic as is practical. Patients have proven to be more receptive to treatment and better able to function in such a therapeutic environment.

#### Unlikely hazards -

What is safe for a low-risk patient might not be for a chronic or suicidal patient. For example, a planter or piece of artwork may be appropriate in a low-risk or partial hospital unit, while such objects may be perceived as potential hazards (or even potential weapons) on a high-risk unit. Regardless of severity, any accident causes an interruption that can interfere with patient care. Behavioral health organizations should adopt protocols for identifying and eradicating potential safety risks, keeping patient care disruptions down to a minimum.

The extent to which any facility includes or excludes therapeutic elements (for example, aquariums, writing materials, craft materials) must depend on the physician's diagnosis, the degree of supervision and patient privileges.

#### Facility parameters -

Depending on the level of patient privileges, inpatients maybe granted free access to many areas of the facility. Other areas, such as staff offices and storage rooms, are generally kept locked.

Other rooms could be equipped and used as restraint and/or seclusion rooms with cameras for increased monitoring. Consults, therapy sessions, and outpatient programs are typically conducted during the day and evening hours.

ECT procedures may also be performed onsite.

Go the extra mile -

Many behavioral health facilities have been constructed or have been adapted to include a variety of patient safety features.

Depending on the judgment and discretion of the physicians, providers, university officials and other experts, additional safety precautions may or may not be needed (though some of them will alter the therapeutic quality of the patient environment), depending on their advantages or disadvantages.

But you may be limited by cost and functionality considerations.

How do you spot possible hazards? Loose equipment, furniture or fixtures may become weapons for confused or hostile patients. HVAC grills and other wall-mounted or recessed facility elements could be pried loose and used by patients to hurt themselves, other patients or staff.

Eliminate such risks around patients considered high-risks for suicide or as a possible threat to others. It has been tested and proven that if a hazardous opportunity exists, patients will seize that opportunity to harm themselves or someone else.

Hanging risks -

According to the 1998 JCAHO inpatient suicide study, 75 percent of patients committed suicide by hanging themselves in a bathroom, bedroom or closet.

The integrity of the ceiling system in high-risk areas is critical to protecting patients from access to potentially hazardous infrastructure located within the space above. And any plumbing, piping, ductwork or other potentially hazardous elements concealed within the space above the dropped ceiling system could be accessed and used as a hanging device.

Some ceiling applications/solutions:

Rivet a metal lay-in ceiling system into place.

Install a poured-in-place concrete or other homogenous ceiling.

If the existing ceiling system poses a hazard, such as an acoustical lay-in system, make sure that housekeeping or other staff inspects it daily (or more often, depending on the patient population) and repairs any conditions immediately.

Sprinkler heads and sturdy curtain rods that are designed so that rope or some other fabric can be tied to them are serious risks. Eliminate them, and also remove venetian blinds and drapery cords.

Other precautions: Remove all unnecessary door-closing hardware with the exception of fire egress doors, which ideally will be located in view of the nurse stations or staff workstations.

Mount towel racks low enough on the toilet partitions so that patients cannot hang themselves. Mount grab bars low and on a steep slope so they can't be

used as hanging devices.

Remove most showerheads, and mount spigot control knobs very low. Push-button shower controls are recommended. Patient closets should be constructed using a coat rod detail that precludes the tying of any material to the rod for the intention of hanging, as should toilet partitioning for group toilets.

Don't use coat hooks on partitions or on the backs of room or toilet staff doors. Replace high-mounted continuous handles and hinges on tall cabinetry with those that cannot support hanging materials.

Staff members should supervise occupational therapy, ADA-compliant, and other patient toilets that must include grab bars.

#### Smothering risks -

Ensure that shower curtains are made of a non-sealworthy plastic substance, and eliminate plastic trash can liners and plastic disposable sterile glove dispensers. Gloves should not be disposed of in a manner that allows patients the opportunity to retrieve them.

Where privileged patients have access to basement areas, lock-away waste carts and containers in service areas rather than leaving them in corridors.

#### Other areas of risk -

Door assemblies. Seclusion room door construction sometimes includes welded and bolted steel elements. Thin-edged metal window frames have proven vulnerable and dangerous. Explore alternative door construction to eliminate risks.

Equip seclusion and restraint room doors with lock sets that are operable from the exterior by staff. Mount slide bars on the exterior to prevent jamming of the lock sets by kicking. Observation windows on seclusion room doors are typically welded in place on the interior and bolted onto the door frames from the exterior.

Ideally doors to patient rooms in high-risk areas should open out. If the doors open in, use hardware such that when the strike is depressed from the exterior side, the door will open out, thereby providing staff access to any barricaded patient. Lock sets must not be provided on patient room or patient toilet doors.

Mechanical/electrical devices. A patient could tamper with electrical and telephone outlets depending on the installation. Secure or inspect/repair outlets on a daily basis.

Take the following (or equal) measures: Enclose exposed radiators in built-in casework; affix return air ducts using safety screws; rivet vents into place; and affix thermostats with safety head or allen-head screws.

Plumbing fixtures. Patients could harm themselves on the exposed hardware of toilet bowls, sinks and drinking fountains. Better-designed fixtures are available in the market where replacement is warranted. Also, wall-mounted soap, paper towel and toilet dispensers, depending on their design, can pose a threat--especially those fabricated from a sheet metal-style design.

**Safety first -**

More behavioral health institutions are seeking assistance and funding to render their facilities "suicide proof. "Behavioral health facilities should be constructed and/or adapted with such safeguards in mind.

Facility leaders must make the final decision to protect their patients from self-harm.

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