

# Safety: A Priority in the Inpatient Mental Health Setting



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## INTRODUCTION

The inpatient mental health setting is challenged with providing safe hospitalization for patients and a safe work environment for staff. Research reveals that the incidence of deliberate self-harm or deliberate violent acts exist within the inpatient psychiatric setting. Approximately 1,500 suicides take place annually in inpatient hospital facilities throughout the United States. This is one of the most closeted and preventable mental health issues. After reviewing the literature and increased incidents of patient self-harm throughout the nation, a 38-bed psychiatric inpatient unit at Catawba Valley Medical Center is taking a proactive approach in providing a safe hospitalization for mentally ill patients.



Push/Pull Door Latches

## OBJECTIVE: Improving Safety in the Psychiatric Inpatient Setting

### Providing a Safe Physical Environment

- Limited number of trash cans, all cans placed in open areas, only one liner per can - Implementation 7/04
- Removal of closet doors, clothes hanging racks, and cabinet doors in patient rooms - Implementation 7/05
- Shower curtain hooks replaced with breakaway hooks - Implementation 7/05
- Replacement of door hinges with piano type hinges in patient care areas - Implementation 12/05
- Replacement of door knobs in patient care areas with push/pull door latches - Implementation 12/05
- Removal of horizontal bathroom handrails, replaced with vertical railing - Implementation 12/05
- Bathroom doors removed in patient rooms, replaced with anti-suicide doors - Implementation 2/07
- Concealed toilet plumbing
- Kevlar gloves provided for staff use when searching patient belongings - Implementation 1/07
- Minimum of 2 staff members completing belongings search on admission - Implementation 2/07

### Comprehensive Suicide Risk Assessment

- Patients placed in hospital gowns on admission prior to physical assessment - Implementation 7/05
- Belts are prohibited on the unit - Implementation 11/06
- Shoe strings removed from shoes, replaced with velcro closures during hospitalization - Implementation 2/07

### Improvement of Patient Observation Structure

- High risk patients placed close to the nursing station or on a high risk unit - Implementation 7/04
- Non-Violent Crisis Intervention recertification required every 6 months for all patient care providers - Implementation 7/04
- Restraint avoidance documentation - Implementation 7/04
- Closed caption cameras in open and common areas - Implementation 12/05
- Safety rounds documented per shift - Implementation 7/05
- Hiring of safety technicians on the evening shifts - Implementation 2/06

### CONTACT INFORMATION

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Anti-Suicide Door

## GOALS for 2007

- Replacement of manual unit door keys with proximal card security system



Vertical Hand Railing

- Concealed sink plumbing in patient rooms

- Visual patient monitoring other than scheduled observation times

- Creating a psychiatric standard of care for suicidal patients admitted to critical care areas



Concealed Toilet Plumbing