Case Study – Fall

Event description
62 year old female with history of CHF was admitted from the Emergency Department with Left Lower Lobe Pneumonia. She has been living independently at home with no assistance needed with cares. She was complaining of pain with inspiration, vital signs were normal, oxygen saturation was 90% on room air. On hospital day 2, she was found on the floor at 2345 in severe pain. X-rays revealed a hip fracture. The next day she was taken to surgery for repair. During surgery she had an AMI and expired while on the table.

This is a reportable event due to fall with serious injury. The death in the OR will be examined through peer review and is not an issue for the RCA.

RCA discussion
The nurse came on at 2300 that evening and got report which indicated the patient was pleasant and cooperative, asking for help as needed, didn’t attempt to get up on her own, used the call light. Looking at the medical record found the patient had been given a sleeping pill and pain medication at 10pm, the same as the previous night and the sleeping pill is the same as she takes at home.

At 2330, the nurse checked the patient to do vital signs, found her dozing but easily arousable although a little confused when first awakened. The unit became busy as they just received a fresh surgical patient post operatively.

At 2345, a nurse walking by the room heard a noise and went to investigate. She found the patient on the floor and called for help. The patient had been incontinent of bed and gown, the floor was dry. They had to move furniture in the room to get at patient as there were extra chairs in the room after her family visited that evening. Her oxygen tubing was wrapped around her IV pump. The physician came immediately and assessed the patient. X-rays were ordered and the patient was taken to x-ray. The x-rays revealed a hip fracture. Orthopedics saw the patient and scheduled her for surgery the next day. She was prepared for surgery and sent the next day.

There was the usual staffing levels and mix. The unit was busy but not chaotic.

The staff knew there was a policy on risk assessment of falls. They indicated they had been educated and had their skills validated, however they didn’t think it was helpful and stated they would like more direction than what the policy provides.

Risk of falls was assessed and documented on admission. The patient was found to be at very low risk with no issues. No reassessment was documented. Report communicated the patient was pleasant and cooperative, asking for help as needed, didn’t attempt to get up on her own. RT had seen the patient at 2200 and placed the patient on O2 at 2L for wheezing. He gave her extra long tubing as she liked to sit up in a chair. RT had documented their adding oxygen, but not the long tubing and did not verbally pass this information on to the nurse.
The patient had an IV pump for antibiotic administration. She was in a single room. There were extra chairs in the room from a family visit making it difficult to move around. The patient had been given extra long oxygen tubing so she could sit up in a chair.

The event occurred in the evening. The room was dark, but the patient had a night light in the bathroom. She had been given a pain medication and sleeping pill at 2200, she had been given this the night before and the sleeping pill was one she also took at home. The unit had just received a post operative surgical admit and staff were busy.

There was a policy for assessment of risk of falls which stated on admission and as needed. Staff did not find the procedure helpful as it did not give enough direction.

The patient had been incontinent soiling the bed and gown, but not floor.

RCA Exercise

- Review the case study information
- Using the information provided, identify root cause statements for this event
- Refer to the RCA Resources in the Resource Guide including:
  - Root Cause Categories
- For any human factors or deviation from expected process, provide the preceding cause(s) as part of the root cause finding.

Identify the possible RCA Statements for this event:
**CAP Exercise**

- Review root cause findings
- Develop corrective actions and measurement strategy
- Refer to the Corrective Action Plan intervention categories under Tab 4 in the Resource Guide as you develop your interventions
- Determine whether the corrective action proposed is a stronger action, an intermediate/moderate action or a weaker action.
- Determine the process and outcome measures for the action plan.

**Develop the Corrective Action Plan for this event:**

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