

Adverse Event Scenario

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.

Reportable or Not Reportable?

Reportable as she died post fall. She would not have gone to surgery had she not fallen. The death in the OR will be examined through peer review and is not an issue for the RCA.

The RCA:

The nurse came on at 11pm 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 11:30, 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 11:45, 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.

Staffing:

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

Education:

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.

Communication:

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.

*Please note - all information contained is fictional, used for example purposes only.

RT had seen the patient at 10pm 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

Equipment:

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.

Environment:

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 10pm, she had been given this the night before and the sleeping pill was one she took at home.

The unit had just received a post operative surgical admit and staff were busy

Policy/Procedure:

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.

Other/Uncontrollable:

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

Root Cause:

Incomplete assessment/re-assessment of risk for falls due to the policy being vague and providing minimal direction resulted in a fractured hip

Obstacles in the room caused a hazard and risk for falling

Action Plan:

1. Implement the Morse Risk Scoring for assessment/re-assessment – Nursing educator – 1 month
2. Revise policy to include addition of Morse Risk Scoring and assessment on admission with re-assessment every shift and change in condition (which includes pain medications/sleeping pills) – Nurse educator – 1 month
3. Educate staff regarding Morse Risk Scoring – Nurse educator – 2 months
4. Create space on admission assessment form for risk scoring – Clinical Director – 1 month
5. Create space on flow sheet for reassessment/scoring every shift and PRN – Clinical Director – 1 month
6. Talk with RT about leaving shorter O2 tubing for patients to be used while they are in bed
7. Staff are to remove all but 1 chair and declutter room with their 10pm rounds

Measurement Plan:

Percent of patients on admission with a Morse Risk Score and reassessment every shift with score

Randomly sample 15 patients to determine if they have been assessed on admission and every shift and given a score. If not 95%, the Clinical Director will work with staff to determine and remove barriers. Re-measure in 30 days.

Ongoing measurement:

Percent of patients with risk of falls assessment on admission and reassessment every shift.