Manitoba
Health, Seniors and Active Living

Manitoba Health, Seniors and Active Living (MHSAL) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Patient Fall

Summary:

An elderly patient with multiple underlying health conditions, including cognitive impairment, had an unwitnessed fall resulting in a significant head/facial trauma (brain bleed) contributing to his/her death.

Keywords: Fall

This review is based on a single event.

Findings of the Review:

The patient's underlying health conditions, cognitive impairment, level of physical activity and prescribed medication (anticoagulant) coupled by an unfamiliar environment, timing of the change of shift for staff, and a partially implemented Falls Prevention Program increased the likelihood that a fall may occur resulting in significant injury (brain bleed).

It is unknown if the patient had tried to use the nurse call bell system, however it was confirmed during the review process that the bed alarm was turned off when the patient had gone for a diagnostic test. Upon return to the unit the bed alarm had not been turned back on as reported by staff interviewees' that no alarms were sounding upon patient discovery post fall. If the bed alarm was on at the time of the event it potentially may or may not have prevented the patient fall.

There are limited staffing resources currently available to provide 1:1 care/observation for patients at a high risk for falls. Staffing shortages are a global concern in healthcare.

System Learning:

Re-educate 80% of nursing/healthcare aides on the medical unit on the *"Falls Prevention-Acute Care"* CLI.4510.PL.001 policy and procedure to explore/exhaust all mitigation strategies for patients that are deemed a high risk for falls. i.e.) calling family to sit with patient, volunteers, advising family of options re: hiring private care (when not in contravention with current public health orders).

Re-evaluate the use of whiteboards as a communication tool as part of the *"Falls Prevention"* program in acute care. Include in the review placement of the whiteboards in patient rooms with input from the end users to identify corrective measures i.e.) easy access to boards and wipeable crayons instead of markers.

Develop a process that triggers staff to complete a safety check of all devices in use for patients deemed a high risk for falls immediately upon return from diagnostic testing &/or other leaves of absence. E.g.) Put up all siderails and flag bed with a poster (Safety Check Required upon return) &/or use whiteboard. (Gone for tests, requires safety check upon return) Discuss best option with staff input to ensure all safety devices are on and in working order.

Continue with recruitment and retention efforts to fill all vacant positions on the medical unit.

Date of Posting: