2425-059

Patient Safety Learning Advisory

Patient Safety Event: *Fall from standing*

Why was this a Critical Incident?

An inpatient fell experiencing a fracture. Not all risk reduction measures were in place at the time of the fall.

What happened in the incident?

An older adult was re-admitted with concerns about anemia and low blood pressure. This patient had recent hospital admission for a similar event. They received a blood transfusion and were being monitored.

The first page of the Falls Risk Assessment and Interventions for Inpatients was completed within the first 24 hours of admission. The falls risk assessment scored the patient as high risk. The second page, which identifies which high-risk precautions were implemented, was blank. The Patient Assessment Flowsheets document several interventions were in place but it was unclear if they were all in place at the time of the fall.

The Transfer and Mobility Assessment was completed in a timely manner on the day of the patient's admission and indicated the patient required one assist to mobilize with a walker.

During the admission, the patient demonstrated symptoms of confusion/delirium.

On the day of the fall, the health record indicated the patient was found on the floor during the night. The roommate rang the bell to alert the team. The patient stated they had been trying to walk to the bathroom when they fell on the floor by their bed. A computed tomography (CT) scan that day showed a pelvic fracture.

What is the Health Care System learning?

The patient was very confused/anxious and made attempts to get out of bed. They could not follow directions such as using a call bell for assist.

What are the recommendations?

No formal recommendations were made as there were patient related findings that were not preventable or predictable.

The information and suggestions that follow were brought forward during the Critical Incident review. These factors did not contribute to the critical incident; however, the suggestions are being shared as opportunities for system improvement. This information will not be included in the Shared Health Patient Safety Learning Advisory but will be shared with the respective Senior Leaders. These suggestions are not intended for follow up reporting to Manitoba

Health.

During the review it was noted that the Regional Clinical Orientation information for falls risk reduction is based on 2017 policy, rather than the 2023 policy updates. In addition, it was noted that staff on the unit would benefit from refresher education based on the 2023 policy updates. A suggestion was made to update the Regional Clinical Orientation information and to provide refresher education to unit staff.

Keywords: fall, fracture

Glossary:

Anemia: not having enough red blood cells to carry oxygen

CT scan: a computerized x-ray

Your privacy is important to us, so in this summary we have removed any details which would help identify the subject of this event. It's important that we can learn from safety events and make changes to improve the care we provide.