Patient Safety Learning Advisory

Shared health Soins communs Manitoba

Patient Safety Event: Fall with fracture

Why was this a Critical Incident?

The concern is the patient's mobility aid (cane) was removed from their possession. Another mobility aid was not documented as an alternative. A few days later, the patient experienced a fall with hip fracture.

What happened in the incident?

A patient ("they/their") was taken to an emergency department after a car accident. The next-of-kin (NOK) provided collateral information for the patient who was experiencing new onset confusion. The patient, who mobilized with the use of a cane, lived at home in the community with the support of NOK. The NOK reported the patient had not been themselves for about six weeks, had been falling in the community, and expressed concerns about their well-being.

The patient was admitted to a medical unit for further follow-up. It was determined that the patient had newly diagnosed dementia and demonstrated responsive behaviours (agitation) to their environment while in hospital. When upset, the patient shook their cane at staff. The patient's cane was removed for safety concerns (i.e. shaking cane towards staff). The patient fell and experienced a hip fracture, requiring surgery.

What is the Health Care System learning? What are the recommendations?

There are no recommendations from this review as advanced fall injury reduction interventions were in place at the time of the fall. It cannot be forecasted whether the patient would have used a walker or whether using one would have prevented a fall.

Keywords:
fall; fracture

Glossary:
N/A

YOUR PRIVACY IS IMPORTANT TO US, SO IN THIS SUMMARY WE REMOVED ANY DETAILS THAT WOULD HELP OTHERS IDENTIFY WHO IT HAPPENED TO. IT'S IMPORTANT THAT WE CAN LEARN FROM SAFETY EVENTS AND MAKE CHANGES TO IMPROVE THE CARE WE PROVIDE.

Unique Identification #2324-118