MISSTEPS BEFORE AND AFTER PATIENT FALL

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DESCRIPTION

A 68-year-old inpatient suffered a severe head injury following an unwitnessed fall.

KEY LESSONS

- Identification and reassessment of patient fall risk is critical for recognition of changes in patient status
- Documentation and comprehensive hand off communication is vital for sharing fall risk information
- Implementation of post-fall protocol/policy provides a standardized approach to evaluation and is essential for ongoing patient safety

CLINICAL SEQUENCE

A patient on coumadin for peripheral vascular disease was admitted to the hospital by his cardiologist for symptoms consistent with thrombosis/arterial insufficiency of the foot. The patient was diagnosed with an acute arterial embolism, requiring surgery. The patient required a pre-op cardiac evaluation for bradycardia and remained on anticoagulation therapy. At the time of surgery, the patient was assessed at low risk for falling. Following surgery, he was transferred to telemetry unit.

Five days post-operatively, at approximately 6:00 p.m., the patient's family reported that he fell in the bathroom and hit his head. A nurse found the patient sitting on the bathroom floor. The patient denied any injury but had an abrasion on his right arm. The patient's son and nurse assisted him back to bed and the nurse dressed the wound. Following his fall, the nurse elevated the patient's fall risk. On the same day, physical therapy had documented the patient had difficulty walking due to leg pain and swelling.

The nurse filed an incident report; the fall was not documented in the patient's chart. Because the injury was minor, the physician was not notified, and no treatment was indicated.

At the change of shift, the overnight nurse was not informed of the patient's fall. The night nurse documented the patient was responsive throughout the night. At 5:51 a.m., the nurse found the patient aphasic and called the rapid response team. A stat head CT revealed a large right intraparenchymal hematoma. The patient underwent a hemicraniectomy and hematoma evacuation. He was transferred post-operatively—on a ventilator—to the intensive care unit. The neurosurgeons note stated, per family, the patient lost his balance and fell back into the shower hitting his head.

Two days later, the patient deteriorated. A repeat CT showed ongoing bleeding and new infarcts. The patient's anticoagulants were stopped. The patient's neurological status failed to improve, and a tracheostomy and PEG was placed.

The patient died 15 days later.

ALLEGATION

The patient's family filed a claim alleging a lack of proper fall precautions, failure of the nurse to report the patient's fall to his physician or the oncoming nurse, and failure to monitor the patient post fall.

DISPOSITION

This case was settled in excess of $1M.

DISCUSSION POINTS

Fall Risk Assessment/Re-assessment

The patient's pre-op fall risk is inconsistent with established standards, which would have scored him at a moderate risk of falling due to his diagnoses, medications, and gait. The patient should have been reassessed for fall risk upon transfer from the post-operative care unit to the telemetry unit.

Documentation/Communication

The nurse caring for this patient did not document the patient fall in the chart. This vital information was not conveyed to the patient's physician or the oncoming nurse. Communication of a patient's fall is imperative to ensuring the patient is appropriately monitored and reassessed throughout the post-fall period for indicators of latent head injury.

Post-fall Assessment and Management Policy

Fall-related policies should include post-fall assessment and management. This ensures appropriate steps are taken to safeguard the well-being of a post-fall patient. AHRQ's Post-fall Assessment Tool outlines the post-fall assessment to include notification of the medical provider, clinical assessment of the patient, and interventions based on facts pertaining to the patient's clinical condition and the type of fall. And, as in this case, measures to take due to an unwitnessed fall.

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REFERENCES AND FURTHER READING

- Using a Post Fall Assessment Simulation to Examine Nurse Thought Processes.
- Impact of Post-Fall Huddles on Repeat Fall Rates
- Tool 3H: Morse Fall Scale for Identifying Fall Risk Factors.
- Tool 3N: Postfall Assessment, Clinical Review
- Engaging Patients and Their Families in the Three-Step Fall Prevention Process