Open Book
Learning from close calls and adverse events

Reviewing patient falls: What can we learn?

Falls are one of the most common causes of injury to patients in hospital. This Open Book was written in collaboration with the Health Quality & Safety Commission's Reducing Harm from Falls programme. It summarises four falls events, local review findings and recommendations or actions resulting from review. The comments in the shaded boxes are from the Commission's Reducing Harm from Falls programme clinical lead, Sandy Blake.

Incident 1 – Individual and environmental factors

A man in his 80s was leaving a medical centre after his appointment. On leaving, he fell down some steps, fracturing his pelvis.

Findings

Many environmental controls were already in place for falls prevention: there were handrails and ramps; the step design met specifications; and the edges of the steps were in high-visibility colours. The patient used the steps without using the handrails, was briefly distracted by seeing another patient, lost his balance and fell.

Recommendations/actions

Temporary signs were put in place advising patients to use the available handrails and ramps. The centre is considering replacing steps with ramps.

Comments

This story is reminder of the need to have regular conversations with older people about the risk of falling. These conversations reinforce our desire to keep older people safe, and make them more aware of the potential dangers of the immediate environment. A key aspect of this incident is the finding that the individual 'lost his balance'. This presents an opportunity for all health workers to engage in early conversations and recommend appropriate preventative activities, such as strength and balance exercise programmes for older people who may be at increased risk of falling.

Incident 2 – Patient with delirium

A man in his 80s was recovering after hip surgery. He developed confusion and agitation, and was assessed as suffering from constipation, delirium and withdrawal from alcohol. He was receiving diazepam as per the alcohol withdrawal procedure and was refusing pain relief. He was under high-frequency observation as it was recognised he was at risk of falling. Bedrails were used. In his confused state, the patient climbed over the end of the bed trying to get out and fell. This resulted in a re-fracture of his repaired hip.

Findings

The ward was exceptionally busy, with high-acuity patients and staff shortages. A dedicated 'watch' was not provided. It was determined that the cause of confusion was delirium triggered by constipation, pain and the frequency of diazepam administration rather than alcohol withdrawal. Bedrails were used when the patient was in a confused state. There was also a lack of alarm system equipment (ie, falls mats, sensor beams) available in the ward.

Recommendations/actions

- Secure a stock of falls mats for use next to patient beds.
- Review use of bedrails with a focus on avoiding use for confused patients.
- Review bowel management so appropriate action is taken when patients are constipated.

Cont. over

Comments

Alarms are only effective if they are responded to immediately. In this situation, in a busy ward, an alarm may not have made a difference. Close, responsive care has the greatest chance of keeping safe those with cognitive impairment. Consider partnering with families/whanau to help with this strategy. Avoid using bedrails with a confused patient and consider other preventative falls strategies.

Incident 3 – Changes in patient condition

A woman in her 80s was admitted to hospital with injuries as a result of falling at home. She had a significant history of falls and injury from falls. She suffered from osteoporosis, osteoarthritis and osteosarcoma, and had difficulty swallowing. She had had a prolonged stay in hospital, but was nearing discharge when there was a sudden change in her condition, with confusion, disorientation and slurred speech.

During the process of investigating these new symptoms and preparing for the patient to be transferred, the patient was found on the floor. A CT scan of the patient's head showed subcutaneous haematoma on her forehead. In the following days, she also complained of neck pain. A CT scan of her neck showed a fractured C2 vertebra.

Findings

The patient was admitted with a fall, and a history of falls with harm. The falls prevention strategies were well documented until the onset of acute confusion. There was no re-assessment of falls risk with this change in condition and no changes made to the patient's falls prevention plan. The acute onset of delirium was considered most likely to have contributed to her falling.

Recommendations/actions

- The senior nursing team to develop and implement a training package of scenarios of problems and recognition of changes in patients' condition, including cognition, confusion and delirium with resulting actions.
- A timeline to be developed for the implementation of the training package, assigned responsibilities, plus a plan for documentation and audit of compliance and discussion at staff meetings.
- Following initial implementation and review of training, potential to spread initiative to other clinical areas to be discussed.

Comments

A reassessment of falls risk is needed when a patient's condition deteriorates. This helps health workers focus on what will help keep the patient safe. Discuss patient risks at handover to keep the individual's care needs front of mind.

Incident 4 – Changes in patient condition

A woman in her 80s was admitted to hospital with suspected transient stroke. She was diagnosed with an intracranial haemorrhage. Her symptoms included confusion and inability to follow direction, and she was unsteady on her feet. She was assessed to be at risk of falling and needing close supervision when mobilising. She fell in the bathroom, fracturing her hip.

Findings

Acuity, workload prioritisation and a reduced understanding that the woman should not be left alone in the bathroom led to the patient (with known cognitive and mobility impairment) being left unsupervised in a bathroom and falling, resulting in a fractured hip.

Recommendations/actions

Clearly identify and understand which patients have been assessed as requiring continual supervision (orange wristband/falls monitor). Implement an audit of falls plans.

Comments

While wristbands may be considered helpful, there is little evidence to support them making a consistent difference. Many patients who fall are heading to or returning from the bathroom. Providers should consider adopting the 'signalling system', which provides a suite of visual prompts and reminders to all. Falls prevention is everyone's business.

Cont. over

Closing commentary from the Health Quality & Safety Commission's Reducing Harm from Falls Programme Team

- Engage in conversations about falls risk at every opportunity with patients and their families/whānau, especially to support those with cognitive impairment.
- Always use a human factors approach to understand the contributing factors of an incident, and to identify system improvements.
- Identify risks unique to the individual, and addressed those risks in the care plan.
- Re-assess risks as a patient's condition changes.
- Adopt a consistent approach across the sector by using the signalling system to identify the level of assistance a patient requires for safe mobilising.
- Where recommendations are made, they should be evidence-informed.
- For more information on the signalling system, falls prevention and other resources available to support the sector, please visit: www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls.