RISK CASE STUDY

Case: Patient/Client Falls

Abstract:

A rehabilitation facility client sustained a serious head injury after falling from bed. The transfer technique and communication practices with the family were criticized.

Key Words:

Patient/Client/ Resident Fall

Fall Prevention

Rehabilitation

Transfer

Family Notification/ Disclosure

Communication

Critical Incident

Case summary:

While receiving care at a rehabilitation facility, a client with paralysis and spasticity suffered a head injury after a fall during a routine bed changing procedure. As a result of the head injury, the client sustained a blood blot on the brain, which required emergency surgery.

Medical legal findings:

Internal investigations into the incident revealed that while two nurses were providing care during the bed linen change-out, the client slid out of the bed in a forward motion, subsequently hitting the left side of his temple against the edge of the bed. While the technique used by the involved nurses was not an issue of concern during the course of the investigations, questions were raised with regard to whether the healthcare team could have taken further steps to mitigate the risk of falls, particularly considering the client's ongoing spasticity.

In addition, the healthcare team's communication with the family in the aftermath of the incident was criticized. Review of the incident revealed that following the client's fall, the involved healthcare team members had failed to contact the patient's family promptly, resulting in a two-hour delay between the incident and the time at which the family was informed of the injury sustained by the client. Furthermore, the disclosure of the incident was prompted following concerns raised by the client's family, who observed and noted the physical trauma sustained by the client during a scheduled visit.

Contrary to the internal review, expert opinion was critical of the transfer technique employed by the nurses, as they failed to ensure that necessary adjustments were made to account for the risk of abnormal posturing. Furthermore, the experts felt the nurses failed to reassess the patient during the transfer. It was noted that no person or side rail had been positioned in such a manner as to ensure that the heaviest sections of the client's body were prevented from moving off of the bed during the times that the bed linens were being tucked in or removed.

Reflections:

Reflecting on your practices as well as your facility's policies, procedures and processes:

1. Discuss any additional precautions that may have prevented this fall. Are these precautions reflective of your facility's normal practices?
2. There was a two hour delay notifying the family of the client's fall. Describe what should have taken place after the client's fall, including who should have been notified? Who would be expected to notify the family?

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