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During one of our clinical rotations, we were told a scenario in which a patient within the Emergency department, who was admitted for a possible UTI, as well of a past medical history of dementia. It was very evident that this patient was experiencing an altered mental status due to a combination of both conditions. They had arrived via EMS, and the patient suddenly went from being alert and oriented, to opening their eyes very wide, in a terrifying manner stating, "Who are all of you people?" The patient was transferred to the bed, in which the nurse conducted her assessment as well as hooking the patient up to the vitals machine and obtained her labs before placing 2 side rails up and exiting the room. The patient was next to be seen by the present physician in order to receive a second assessment. The physician lowered one side rail and quickly conducted their assessment and was off to see their next patient. However, in this instance, the physician failed to return the siderail, that had been lowered down, back to its original position and the nurse who had conducted the first assessment also failed to give the patient a call light in case they needed any assistance. Unfortunately, the patient needed to use the bathroom, but had no call light and because the side rail was left down, they attempted to go to the bathroom with no help. This led the confused elderly patient to sustain a fall in which they obtained a fractured hip.

**Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?**

In the above scenario, a patient who was known to have an altered mental status was appropriately assessed, but while focusing on patient care, both the physician and nurse failed to also focus on patient safety. I believe an underlying problem found when the occurrence of patient falls is looked at, is an inability of staff to take the time to ensure that patients are safe. Often, we are so rushed that we don't take small measures that could lead to the avoidance of these incidents. The patient's environment lacked standard fall precautions that are typically seen within the hospital setting. Falls are a common occurrence that happen within many different hospitals.

**What circumstances led to the occurrence?**

This happened when the physician failed to place the side rail back up, and the nurse failed to hand the patient their call light. Within Covenant hospital, its protocol that before leaving a patient's room, they have their possessions (including their call light), have been assessed for pain, have been asked about their need to use the bathroom, and if they are in a comfortable

position (including both side rails being up). Because these things weren't done, it resulted in the patient experiencing a fall and a fracture to their right hip.

**In what way could you measure the frequency of the occurrence? (interviewing nurses, examining charts, patient surveys, observations, etc.)**

One technique that I have seen utilized within hospitals settings, in order to observe/measure the frequency of the occurrence of falls, is a chart placed onto the wall of the unit that states, "x number of days without a patient fall" This method greatly helps to encourage nurses to keep that number at "0," as well as helping to assure patients that they are in safe hands. This is a method that is able to hold those apart of the healthcare team accountable.

**What ideas do you have for implementing interventions to address the problem?**

Implementation of measures that are consistently used on a daily basis during all patient encounters can greatly help reduce the occurrence of patient falls. These measures would include:

- Placing the patient in a yellow fall precaution gown as well as yellow non-skid socks
- Placing patients with a high incident of falls on a bed alarm
- Checking on patients at least every two hours to see if they need to use the restroom as well as routine checks throughout the shift
- Turning on a bathroom light at night so the room is dimly lit
- Label patient room as a fall risk
- Bed in the lowest position
- At least 2 side rails to remain up besides when patient is receiving care

**How will you measure the efficacy of the interventions?**

Standards of care should reflect an optimal goal and be evidence based. Measuring efficacy of the intervention could be done by doing an audit to see if the change is working or not. This would consist of a constant evaluation of the problem. If a unit was to utilize a system that recorded the number of falls per day, staff would be able to see if there is an increase or decrease in the number of falls recorded since the interventions were put into place.