

Maddison Bushell

CSON IM8

11/28/22

### **Quality Improvement Activity: Fall Accidents**

An 87 year old female patient was admitted to the palliative unit as a medical/surgical overflow patient with the diagnosis of a delirium as a result of a urinary tract infection. The patient was coming from a nursing home/assisted living center as a direct admission per the onsite clinician at the nursing home. During report the nurse receiving the patient on the palliative unit was informed the patient was very confused and only oriented to self, not place, time, or situation. It was also reported that the patient normally walks well at the facility with a walker but has been experiencing generalized weakness and lethargy prior to the onset of confusion. Once the patient arrived to the unit fall precautions were put in place. She had on a yellow gown, grip socks, bed alarm, and was placed in a room near the nurses station with the door left open. There were already orders to administer antibiotics to treat the urinary tract infection so our main concern was keeping her safe. She had orders for a telesitter to be in the room but we were still waiting on it to be brought to the room and set up. There were two nurses on staff at the time. Nurse A had one palliative patient that was coherent, admitted for pain control, and expected to discharge back home with hospice. Nurse A also had two med/surg patients that were being monitored after minor procedures done the previous day before they could be discharged. Nurse B had two palliative patients that were actively dying and one med/surg patient with suspected sepsis. Nurse B was to take the 87 year old admission. The unit was also staffed with a charge nurse, secretary, and nurse aide. Upon the patients arrival Nurse B immediately hung the first antibiotic that was due and set to run over the next few hours. While waiting on the telesitter to be delivered and set up one of Nurse B's palliative patients passed away and the family was very distraught. Nurse B and the secretary were in

the room getting the deceased patient straightened up and made decent for the family's last visit before the patient was to be taken to the morgue. Nurse B stayed in the room to console the family while waiting on the chaplain to arrive. At that time the nurse aide was giving a bed bath and the charge nurse was on the phone with a doctor. During that time the new admission was able to get out of bed. The bed alarm was going off but by the time someone was able to get into the room she had already fallen on the floor. It looked like she had tried to grab the IV pole to catch herself but she took the pole down with her and it fell on top of her. After lab work and imaging was processed we were informed the new patient now had a broken hip and a concussion.

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

In this scenario an elderly patient was admitted with delirium due to a urinary tract infection. Although the patient walked with a walker normally, the patient was put on fall precautions. We know that urinary tract infections in the elderly often cause great confusion. The patient care environment lacked in the fact that the nurse's patient acuity was not carefully considered before assigning the admission. We knew the patient did not have a telesitter in the room yet and even though we put all of the other fall precautions in place someone should have sat with the patient until it arrived. Even though it was a very busy shift we should have figured out a way to have someone in the room with the patient until the telesitter arrived.

**What circumstances led to the occurrence?**

The circumstances that led to this occurrence were the diagnosis of urinary tract infection, age of the patient, diagnosis of delirium, nurse to patient acuity ratio and the unavailability of staff.

**In what way could you measure the frequency of the occurrence?**

We already keep track of falls very well but a way to measure this type of occurrence is to look for telesitter status in the patients chart and the nurse to patient acuity ratio for the shift the incident happened on.

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

Zero tolerance for falls and fall education should be included in new employee training (even non-clinical staff) and annual patient safety trainings (maybe even more often than annually). The unit huddles at the beginning/end of each shift and an emphasis on fall prevention and education should be emphasized at every huddle. It would also be a good idea to go over which patients are at high risk for falls and if they have a telesitter or not during huddle so that other staff can help keep an eye out on those patients. There should also be extensive training and education for the charge nurses on patient-nurse assignments in regards to patient acuity level. On the palliative unit the charge nurses should have even more education on acuity and assignments because having a palliative patient is very different than a med/surg patient.

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

Measuring the efficacy of these interventions can be accomplished by extensive chart review, debriefing after each incident, and review of the scheduled staff on the date of the incident. We already have extensive fall precautions in place for high fall risk patients and we already carefully audit patient charts in regards to falls, but we need to dig a little deeper and make sure each high fall risk patient has a telesitter. If the patient did not have a telesitter we need to investigate why they did not have one.

Lastly we can review the staff on schedule for that specific shift and look at the nurse to patient acuity ratio to determine if that is the main concern for the reason of that fall.