Case Study: Scenario # 1

Post Fall Case Study: Scenario “Alert Patient walking with Nurse”

On June 20, at 09:00am, Mr. Ambulatory, was ambulating down the hallway with the nurse for the first time, after undergoing a post-surgical procedure the day before, when he suddenly became weak in the knees and started to fall. The RN attempted to stop the fall by leaning Mr. Ambulatory against her chest and allowing him to slide down her legs in a gentle manner to the floor, breaking the fall. The RN immediately yelled for help and started to assess the patient. Mr Ambulatory was alert and oriented to person, place, time, and situation but stated he had started feeling dizzy, and did not want to fall, but could not seem to be able to communicate this to the RN.

After another staff member arrived, and Mr. Ambulatory’s vital signs were taken. The heart rate was 120, respiratory rate 16, temperature 98.6F, and his blood pressure 90/60 while lying on the floor. The staff asked Mr Ambulatory if he could stand long enough to conduct orthostatics, but he stated that he was still dizzy. He felt that he could get up into the wheel chair in order to go back his bed.

The staff successfully moved the Veteran to the bed without incident and the provider was contacted to see him. The patient sustained no injury and was discharged two days later.

Steps

Based on this case study, let’s work through the “8 steps for a post fall huddle”:

1. Announcement of an immediate huddle when a patient experiences a fall: Announcement of an immediate huddle occurred within 20 minutes of the fall event.
2. Staff critical discussion of the fall including all staff present, the provider, ancillary services, the patient, and any visitors present at the time of the fall: The huddle included the RN walking the patient, the certified nursing assistant, the nursing coordinator/nurse house supervisor, and the shift charge nurse. A visitor in the hallway at the time of the fall was seen leaving the ward, but the staff was unable to stop them to include them in the huddle. The physician was with another patient and could not participate.
3. Analysis of scenario and factors leading to the fall, determining root / immediate cause and type of fall: The RN who had been assigned to the Veteran stated that this was the Veteran’s first time up on the ward despite his surgery having been done the day before. The Veteran had arrived back to the unit late in the evening due to having his surgery delayed. The RN discussed that the Veteran had not been out of bed due to the concern for postoperative bleeding and being symptomatic upon sitting on the side of the bed. The H/H was low and there had been

1 Catalano, K. (2009). Legal Department: Hand-Off Communication Does Affect Patient Safety. Plastic Surgical Nursing, 29(4), 266–270.

some concerns post operatively that he might require blood, thus he had been receiving serial laboratory draws. The RN stated he had tried to set the Veteran up a couple of times and each time, the Veteran had felt nauseated and had refused to walk.

The hemoglobin had just been called back to the RN who was assigned to the Veteran and he had been in the process of calling the provider to initiate a blood transfusion on the Veteran when the event occurred and had been unaware of his peer walking the Veteran.

The RN, who was walking the Veteran at the time of the fall, had thought she would help out her peer and walk Mr. Ambulatory, as he expressed that he wanted to get out of bed and try to walk. She had sat the Veteran up on the side of the bed, and then began to assist the patient with ambulation.

The type of fall was Anticipated Physiological Fall, due to low hemoglobin and hematocrit (H&H), or likely hypovolemia exacerbated by low H&H, resulting in Orthostasis.

1. Summarize information gleaned from post fall huddle (PFH) and intervention for prevention of repeat fall based on the same immediate/root cause: Hand-off communication is essential between care providers. Information included in any hand--off must be up-to-date and takes into account the patient’s current condition, care and treatment plan, and any recent or anticipated changes to the patient’s condition (Catalano, 2009). The RN who was walking the patient was re-educated on the importance in obtaining hand-off communication on any patient that they may be working with who they had not been directly assigned to prior to assisting the Veteran. Even though the RN walking the Veteran had heard morning report, she may not be privy to the most up-to-date information and thus should be communicating the Veteran’s request for ambulation.
2. Completion of the Post-Fall Huddle Form and process within your medical center based on your policy: The hospital’s policy is to conduct the post fall huddle as soon as possible within 15 minutes. While the post fall huddle could not be conducted that quickly, due to the multiple activities currently on the ward, the huddle was completed within 20 minutes.
3. Implementation of patients’ care plan changed plan: Changes in the plan of care included the requirement for blood transfusion; assessing for orthostatic vital signs upon standing and symptoms of dizziness.
4. Updated patient’s plan of care is communicated in patient hand-off reports. The RN reported the fall event, patient assessment, post fall huddle results, change in care plan to oncoming RN.
5. Fall documentation and documentation of huddle with recommendations in electronic medical record (EMR) by the patient’s team nurse: The incident report and the Post Fall Huddle form were completed. The Post Fall Huddle form should take approximately 5 minutes of your time and remember the more information you include in the occurrence report and to make recommendations from the post fall huddle, the better the Fall Aggregate RCA Team can look at patterns and opportunities to prevent future falls.