Shared health
Soins communs
Manitoba

PSLA 2425006

Patient Safety Learning Advisory

Patient Safety Event:

Fall from Bed Causing Fracture

Why was this a Critical Incident?

A preventable fall from a bed resulted in a fracture.

What happened in the incident?

A patient was found on the floor. A fracture was confirmed, requiring surgical repair.

There was limited documentation of patient specific actions to reduce the risk of falls for the patient.

What is the Health Care System learning?

There was limited documentation on the admission history or care plan about the patient's activities of daily living, assessment of the patient's risk for falls, or specific actions that could be taken to prevent falls for this patient.

Fall mats were unavailable for use at this facility.

What are the recommendations?

Ensure staff review falls prevention policy and education and applicable training for the safe handling of clients.

Complete a chart audit to determine staff compliance of documenting falls prevention interventions and safe handling practices.

Develop a process to communicate care plans during shift handover.

Keywords: fall, fracture, documentation, shift handover, communication, fall mat

Glossary:

Shift handover- the transfer of responsibility of some or all care for a patient to another responsible healthcare provider, including the process of communication that ensures safety and continuity of care.

Fall mat - Padded mat that is placed on the floor alongside the bed. They are designed to prevent injury from potential falls.

Your privacy is important to us, so in this summary we have removed any details which would help identify the subject of this event. It's important that we can learn from safety events and make changes to improve the care we provide.