

Manitoba Health, Healthy Living & Seniors (MHLS) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Fall from Radiation Treatment Table

Summary:

A patient was transferred by paramedics to an ambulatory cancer care facility to receive palliative radiation therapy.

The patient, who had other comorbidities, needed to be moved from the ambulance stretcher to the radiation treatment table (couch). Once moved, safety straps were required to hold the patient in the appropriate position during treatment. The safety strap that was available was not adequate for this purpose. Staff went to look for an additional strap to secure the patient. While the patient was left unattended, the patient rolled off the treatment table landing face down.

The patient was taken to the Emergency Department. They were found to have suffered a fractured nose as a result of the fall.

Keywords:

Falls, Ambulatory, Radiation Treatment, Safety Straps

Device Name (if applicable):

Drug/Name/Fluid Name: (if applicable):

Type of Analysis: single event

Topic: Falls

Findings of the Review:

The patient, who was unable to weight bear, was transported for palliative radiation treatment to address pain management issues. The decision to provide radiotherapy was jointly made by the referring physician and the radiation oncologist.

For both patient comfort and ease of transfer from the stretcher to the radiation treatment table, the patient remained on the stretcher mattress. The patient was slid onto the treatment table using safe patient handling techniques. The stretcher mattress however, is noted to be wider than the treatment table.

A safety strap was to be used to ensure the patient did not move during treatment. When placed, the strap was not long enough requiring the use of an additional extension strap. Both staff members went to the storage area within the room to get an extension strap. While their backs were turned to the patient, they heard the patient fall to the floor.

One staff member went to attend to the patient while the other went to call a "Code 25" (medical emergency).

The Code Team arrived immediately. They assessed, stabilized and transported the patient to a nearby Emergency Department for further evaluation.

The CT scan performed while in the Emergency Department showed bilateral nasal bone fractures.

System Learning:

A new provincial Initiative is planned that includes improvements in communication between care facilities regarding patient transfer information. The intent is to ensure that accurate, clear information is provided about the patient's transfer abilities prior to transfer and upon receipt of the patient.

"Cut to size" treatment mattresses are now being used on the radiation treatment tables. Stretcher mattresses are no longer used unless pre-approved under specific conditions. Newly designed and fabricated safety straps of different sizes are now available for use. Furthermore, the safety straps are now located on the wall closest to the treatment beds for easy access.

A falls prevention plan is being finalized for the area and will soon be implemented.

Policies and procedures require modifications to address the issues identified; in addition, staff training and awareness regarding these items is needed.

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