PRINCE ALBERT PARKLAND
HEALTH REGION

Healthy Living in Healthy Communities

The Story of Maggie

Maggie had found herself after 70 plus years without her partner and requiring some help in daily living. She couldn't get around as well as she had in earlier times and by and large had the comfort of her wheelchair to assist her in moving from place to place. She loved the town where she had spent years as a teacher raising her children to be contributing part of the community and it was here where she wanted to live out her remaining years. Spending time with old friends at the nursing home was not so bad and she did have her family who visited often and helped her with trips to the doctor and occasional outings and shopping trips. A real bonus were the days when she could talk her way into an extended card game with either one of the staff, one of the family or one of the other residents. Maggie loved cards and loved to win.

Maggie had just returned from Prince Albert with her daughter Florence. It was her turn to have a bath, a process that Maggie had endured once a week if she needed it or not. No one ever asked but I guess these were the rules and everyone had to comply. Maggie was tired, she wasn't used to all the activities that the trip entailed. As soon as she got back to the home and before she could even say a proper goodbye to her daughter, two of the staff members came to her room and were impatiently waiting to get her ready for the bath. Florence getting the message left and suggested that she'd come back later in the evening and maybe they could play some cards.

Maggie tried her best to assist in the process, she had had many baths at the home, it always meant some discomfort as they took off all her clothes, gave her a bit of a robe to cover her while she rode down the hallway in the bath chair. The bath chair was made of molded plastic and stuck to her and felt cold against her skin. She was hoping that the bath water would be just right but the old tub didn't have temperature control and it really was up to the staff to determine what the temperature would be. Maggie didn't like too hot but most times the staff never asked about this preference. Maggie would just be dunked into the tub sitting on the formed plastic chair. It was just the same old routine except that something was different but she didn't know what. The staff helped her do her scrub, the water this time was a little warm but after a while it was fine. Everything was going as it always had until it was time to be lifted out of the tub in the tub chair. Maggie was now at the top of the world about 4 feet from the floor, the staff was doing some work on her toe nails, staff had just turned for just a second to get some extra towels and Maggie slipped, she just meant to reach over but nothing held her in, the safety belt had not been done up and she lost her balance.

The staff member turned and attempted to catch Maggie and break her fall but it was too late, she was landing head first and it hurt.

Maggie found herself at the centre of intense activity. Other staff came to her side and gave her something to rest her head on, the nurse came and gave her a bit of a physical examination, she could move everything and respond even though it was somewhat in a haze and it did hurt. Maggie had a bruise on the back of her head and a pain in her side. She was helped back to her chair and her room and laid down a little while before dinner. She knew she was hurt but didn't want to complain. It was good to see Florence after dinner and they played cards until about 9:30 and then was taken back to bed. Maggie spent a restless night but didn't ring for help. The doctor came in the morning and checked her out again. She still had the bruise on her head and the pain in her side but that would likely go away. There was no sense in making a fuss and everyone around the place felt badly about her fall. She would be okay.

Maggie died later that evening. The coroner was called and determined the cause of death and the events leading to Maggie's death. The pathologist's report clearly linked the death with Maggie's fall the previous day. Criminal charges against the staff were considered and not proceeded with in this case.

Our district's own internal review concluded that an accident had occurred and that the accident was a result of omission. Someone had not fastened the safety belt or had undone the safety belt during the bathing process and there was only one staff in the bath room and involved with the bath.

Review of the staff's work record revealed a history of "hurrying to get things done quickly" and a number of situations that showed little respect for the residents or their families. The staff member's sixteen-year career in long term care came to an end.

Since Maggie's death, we have all had time to search our hearts and to put things in place to insure that we don't get so caught up in the pressure to get things done.

These are the things we have done:

- we have an orientation checklist and our nursing unit manager makes sure that everyone knows the proper use of our bath chair and bath tub. They have to demonstrate its use. All current staff also went through the process to attempt to eliminate some bad habits that might have crept into their daily routines.
- we now reinforce a procedure which sees two people present for every lift which includes the bath chair. Although we do not require two persons in the tub room at all times, we do ask that two people be present for each lift into and out of the tub, and proper positioning to observe the resident in the chair.
- we have taken our discussion and our learning from this accident to the district's care team in long term care, and our sister programs across the district have reviewed and reinforced their own bathing processes.
- we spend more time talking to our residents about their preferences and focus less on staying on schedule at all costs.
- we have developed this case study to be used as a factual depiction of how we need to remain vigilant of working safe and not allow our response to the daily routine to put our residents at risk.

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note: The Prince Albert Parkland Health Region has submitted this story and requested it be used as a case study in the Transferring Lifting Repositioning (TLR®) program©. The information is shared with the full cooperation and support of the family; they encourage health care workers to ensure that bathing procedures and other lifting procedures are completed with the utmost attention. (August 2006)