TRANSCRIPTION

cpsi Canadian Patient Safety Institute
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[0:00:09] My father was a tough guy. He immigrated to Canada in 1952. He survived the Second World War. My father worked as a welder at IPSCO. It was a steel pipe company. He was content to just be with his family, friends. He liked to talk to people. I would say he was a very humble man. 2008 Father's Day was probably the last normal day of life my father had. I'm so thankful that we had such a good day with my dad.

[0:00:51] I had my mother and father over at my house. I made lemon pie, which was my dad's favourite, and we just had a really good day. They went home, and then the next morning, I received a phone call by my mother at seven in the morning that my father was quite ill. He was complaining of abdominal pain. And I went to see my dad. And being a nurse, I knew he needed to be seen by a surgeon. So I knew that my dad couldn't wait all day to see a doctor. So I decided to take him to the local hospital that I worked at.

[0:01:31] Probably by 8:00, after eight, we were at the hospital. By 9:00 in the morning, he had been examined and we waited all day for a surgeon to see my dad. By 9:10 in the morning, my dad was diagnosed with a bowel obstruction. So in reality, what happened was my dad had an ischemic gut, I guess I'd call it. It wasn't just a bowel obstruction, it was an ischemic bowel. So the bowel was starting to die. And what happens with that is you need early diagnosis, prompt treatment for a possible good outcome.

[0:02:11] So what happened was my dad – and I was with him all day. We waited all day for the surgeon to come see my dad. The surgeon on call was booked in elective surgery all day. My dad went in shock at about 6:00 in the evening before even being seen by a surgeon. So I had said, "My dad's crashing." So all of a sudden, the surgeon arrived and he ended up in the operating room. And of course, they did everything they could to save his life. And he did survive the surgery. But of course, with the delays and treatment and the surgery, it seriously compromised his life.

[0:02:57] The whole intent of being the surgeon on call is so that someone is available for an emergency case. I had asked the one nurse, I said, "Please do not get my dad out of bed while I'm not there," because he was in a weakened state and he would fall asleep sitting in the chair. And I was concerned about a fall. Being a nurse, nurses are always aware of the potential things that can happen. But anyways, whoever made the decision, they got my father out of bed and left him in a broda chair.

[0:03:36] Now, I didn't even know what a broda chair was. It's a type of a restraining chair, I take it. But my father was placed in a broda chair and he was left unattended in the room. And my mother and I came in to see my dad. And immediately we were told, “We don't know what happened, but your father had a fall. He doesn't seem to have any apparent injuries.” But of course, as the day went on, my father was complaining of pain in his chest. And the doctor did come in and I think he wanted to do some CAT scan or something of his chest. But by that point, my father basically refused anything more. I think the fall was kind of the ultimate thing that happened to him, that he just kind of resigned himself to that nothing was going to improve. And he died five days after that fall.

[0:04:39] But about a year after my dad's fall – and I mean, he had died – I decided to make a request to ask for the incident report that was filled out on my father. I was shocked because the incident report was just a tick box kind of a report. The manager of the unit was away on vacation during that time my father had been on a unit and had died. So the incident report was filled out well after he had already been dead and buried. And basically, from what I could make out on the report is it really gave no indication as to really what happened to my dad, except he was in a broda chair, some passerby happened to notice he was on the floor, and that the broda chair had tipped over. But in essence, there really was no investigation as to how could a broda chair tip over or how can someone fall out of the broda chair?

[0:05:51] What I do know is that the manager did not interview the staff that was involved in his care that day because there were no comments made. The manager ticked off on the box at the bottom of the page, “Problem solved.” And I found that very offensive because there was really no investigation as to how this happened, therefore no learning as to, was it an equipment failure. There was no learning from the event itself. There wasn't even a comment on the paper on the incident report that my father died five days after that fall.

[0:06:33] I think, first of all, the failure of the actual incident reporting system, it's flawed. If the people filling out the incident report maybe are lacking the education to do it or they're lacking insight as to the value of filling out the incident report, or if the manager doesn't see the value in processing it, then there's a failure there. And then when it goes to the next step, risk management won't identify it either as an adverse event because the information isn't there. So basically, I would say the whole process was flawed in my dad's case.

[0:07:22] I would like to suggest that anyone who works in health care that when you're looking after patients, put that patient in perspective, that that could be your mother or your father laying there, and that they're the one waiting for a doctor all day, or they're the one that has a fall in the hospital. Because I think in terms of the way you will react to that will be much different.

[0:07:48] The whole intent of me telling my dad's story today is not to point fingers at anybody. The point is to learn that something happened. There's a flaw in the way, first of all, that the fall happened, and secondly, the process, that basically no real investigation took place as to what happened to my dad.

[0:08:13] He liked to laugh. He'd actually have a very booming laugh. He loved a good joke. His big source of humour came from the *Reader's Digest*. He would read the jokes and he would laugh before he could even get to the punchline to tell us what the punchline was. So he was just a very humble, just a down-to-earth guy. As I head into my retirement, I plan on becoming more involved with Patients for Patient Safety Canada and my local health region. And I'm already involved with a few different connections and projects that are coming up. So I'm very hopeful.

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