






# Unexpected adverse events in healthcare settings: a case report

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**KEYWORDS:** adverse events, patient safety, healthcare quality.

**CITATION:** *Cardiol Croat.* 2024;19(11-12):595. | <https://doi.org/10.15836/ccar2024.595>

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**Introduction:** Unexpected adverse events occurring in healthcare settings, especially those affecting patients, are often directly linked to treatment or nursing care. Among such events, patient falls represent approximately 70% of all adverse incidents within hospitals. Patient falls are considered adverse events and must be reported, analyzed, and monitored according to the Regulations of Healthcare Quality Standards and the Accreditation Standards for Hospital Healthcare Institutions.<sup>1</sup> These procedures involve continuous patient monitoring, root cause analysis, and corrective and preventive measures aimed at improving patient safety. Hospitals operate with clear quality management systems that provide guidelines for timely reporting and documentation of adverse events through Standard Operating Procedures and mandatory forms, in accordance with Croatian healthcare laws. Patient falls as adverse events often result in negative outcomes such as injuries, complications requiring further medical interventions, extended hospitalization, surgery, or in severe cases, death. Timely reporting of these adverse events is essential for preventing their recurrence, improving healthcare professionals' experiences, and ensuring enhanced patient safety through improved nursing practices. Providing high-quality healthcare and maintaining patient safety are core principles of healthcare ethics and serve as a benchmark for nursing care quality.<sup>2</sup>

**Case report:** 68-year-old patient with multiple comorbidities, including end-stage heart failure and an implanted left ventricular assist device was undergoing regular cardiology check-ups at the outpatient clinic. During one of these routine evaluations, the patient, while being assisted by medical personnel, fell in a hospital hallway after a dressing change. The patient did not lose consciousness and clearly remembered the event, attributing the fall to improper gait and foot problems. The ground-level fall resulted in a blow to the right side of the forehead, causing a visible hematoma. Given the patient's use of anticoagulant therapy, a head MSCT was performed, revealing a subarachnoid hemorrhage, leading to hospitalization. Despite emergency surgery and all measures of intensive care, the patient tragically passed away 13 days after the unexpected adverse event.

**Conclusion:** Reporting adverse events is essential for preventing and avoiding repeat incidents, improving healthcare professionals' experience by ensuring patient safety through the provision of safe care and achieving a high level of safety in healthcare institutions. Providing quality healthcare and ensuring patient safety are integral to the professional ethics of healthcare professionals and represent the most reliable measure of quality in nursing.

**RECEIVED:**  
October 11, 2024

**ACCEPTED:**  
October 31, 2024



## LITERATURE

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