A 67-year-old male (Mr. B) was brought into the emergency room for pain to left leg and left hip. The injury occurred when the patient had a fall due to him losing his balance after tripping over his dog. The hospital is a 60-bed rural hospital located in Mr. B’s hometown. Mr. B was brought in by his son and neighbor. Upon triage Mr. B was complaining of pain 10/10 on the numerical pain scale and his vitals were found to be stable. Mr. B has a history of impaired glucose tolerance, prostate cancer, and chronic pain which he is on oxycodone. The Patient states he had no known allergies or previous falls. Upon the nursing assessment Nurse J. has noticed that the patient has limited range in motion, his left leg has swelling and appears shortened in comparison to the right.

Nurse J. has informed the ED physician which he came to his bedside for evaluation. Upon evaluation the physician decided that Mr. B needed to have a reduction of his left hip, due to the dislocation and will require a conscious sedation. Mr. B requires multiple doses of medication to achieve the desired sedation affect for the reduction. Once the reduction was successful Mr. B is left with son in the room where a full set of vitals were not continuously monitored and goes into respiratory failure which led to the death of Mr. B. Staffing on this day is the day of the event consisted of a secretary, emergency department physician (Dr. T), and two nurses (one RN and one LPN). A respiratory therapist is in house and available as needed in this six bed ED and sixty bed hospital.

**Events**

At 3:30pm- Mr. B was taken to ED for left leg and left hip pain from a fall. Pain is 10/10 vitals include 120/80 blood pressure (BP), 88 heart rate (HR) and regular, 98.6 temperature, (T), 32 respirations (R), 175 lbs. At 4:05pm- Mr. B was given Diazepam 5mg IVP which had no affect after 5min. At 4:10pm- Dr. T orders 2mg of hydromorphone to be given to Mr. B. At 4:15pm- Mr. B was given 2mg of hydromorphone IVP.

At 4:20pm- Dr. T is not satisfied with level of sedation and orders Mr. B to be given 2mg of hydromorphone, and diazepam 5mg IVP.

At 4:25pm- Mr. B appears to be sedated and reduction of his (L) hip takes place. The patient remains sedated and appears to have tolerated the procedure. The procedures concludes at 4:30pm. No distress is noted, patient is placed on monitor for blood pressure to be taken every 5 minutes along with pulse oximeter, but no supplemental oxygen or ECG leads (monitors cardiac rhythm and respirations) was placed on patient at this time.

At 4:30pm- Nurse J allows Mr. B’s son to remain in the room with him as he is being monitor by blood pressure machine only. Nurse J leaves the room.

At 4:35pm- Mr. B vitals are BP 110/62, O2 sat is 92% still no oxygen or ECG leads are on patient at this time. EMS is transporting a patient in respiratory distress; lobby is beginning to get congested.

LPN and Nurse J. in the process of discharging 2 patients and are checking in the patient that EMS has transported in. LPN enters Mr. B’s room and resets his alarming monitor that was showing a sat of 85% and restarts the B/P to recycle. LPN does not supply oxygen and does not alert Nurse J at this time. Management is not notified that patient acuity and patient load is increasing. Nurse J is now fully engaged with the emergency care of the respiratory distress patient.

At 4:43pm- Mr. B’s son comes out of room and informs the nurse that the monitor is alarming with vitas of B/P 80/58 O2 of 79%. The patient has no palpable pulse and is not breathing. A STAT code is called, and the son is taken to the waiting room.

The code teams arrives places Mr. B on cardiac monitor where he is in ventricular fibrillation and the team begins resuscitative efforts. CPR is started and the patient is intubated. Mr. B is defibrillated and reversal agents, vasopressors and IV were started. At 5:13pm- After 30 min of interventions the ECG returns to a normal sinus rhythm with Mr. B’s B/P being 110/70. The patient is completely dependent on the ventilator, his pupils are fixed and dilated and there is no spontaneous movements. The family as asked for the patient to be transferred out to a tertiary facility for further advanced care.

Seven Days later Mr. B has died. The family had requested that life-support be removed after brain death had been determined by EEG’s. This is a sentinel event.