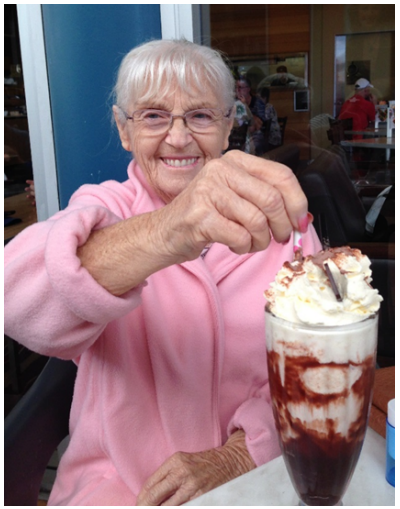
Mrs Dean's story



16th December 2014
ED admission following fall
In ED for 7 hrs and discharged home

17th December @ 3.45am
admitted to HDU following second fall at home

18th December following a fall in the corridor

Mrs Dean had been moved to 3 patient rooms in the first 24 hours of admission, further exacerbating her confusion, suffered another fall, sustained significant injury and was diagnosed with a delirium.

January – April 2015

May 2015

The lessons we have learnt from Mrs Deans admission are this:

- A falls screen and assessment on admission is crucial, particularly when a patient is admitted following a fall at home. This process should start in the Emergency Department.
- Handing over this information to ward staff is paramount.
- The information gained from the falls assessment must be translated into a management plan
- Delirium screening and development of a management plan will significantly reduce a patients risk. Patients, particularly those with a delirium should not be moved around the ward (particularly in the late evening/night) unless absolutely necessary
- Wherever possible a patients with a delirium should be in a high observation room, be nursed with a patient special and a communication plan should be established with the family.
- Families are often willing to stay with a patient if they are educated about falls and delirium and the risks associated with both.

- The good news is, data up until August 2018, identifies that there was not a fall with serious injury at Batemans Bay Hospital for 3 years
- Across the board, falls are trending downward at Batemans Bay
- To date, 90% of staff have completed all three state approved falls prevention education modules

Mrs Deans Story on VIDEO can be found on the NSW Falls Prevention Network website/Resources/videos and patient stories

http://fallsnetwork.neura.edu.au/wp-content/uploads/2017/11/05%20niccola%20follett.mp4