Care/Residential Home Case Study.

Mrs Y, aged 80, had always lived independently until she suffered a fall in 2018. She was admitted to hospital and later discharged to Residential Home as it was advised that this would be the safest option for her and that she now required professional care and assistance.

Mrs Y's medical history included arthritis, memory impairment, hallucinations, confusion, falls and Dementia. The Residential Home assessed her regularly as being high risk to falls.

Approximately one year and several falls later since her admission to the Residential Home, Mrs Y was found wondering in a confused state out of her room by a member of staff. She was taken back to her room and the member of staff left her to go on a break.

Five minutes later, Mrs Y had come out of her room again, and fell down a flight of eleven stairs. This resulted in multiple face and neck fractures and bruising to her brain.

Sadly, Mrs Y passed away one week later in hospital as a result of her fall injuries.

Unfortunately, the residential home did not take adequate steps in their care for Mrs Y or have any monitoring in place to prevent Mrs Y falling. Had they had pressure mats, door alarms, stair gates in place, or had a member of staff monitored Mrs Y when she was in a confused state and a high risk to falls, Mrs Y's fall, which resulted in her death, could have been prevented.