Evidence of Impact from SAR 6 (Ivy)

Safeguarding Adults in Stockport

Background

Ivy was 62 years old who had complex medical needs, she was morbidly obese and had recently been diagnosed with cancer. She lived at home and was visited by a care provider four times a day to assist Ivy with her needs.

1

In April 2019, Ivy's GP attended her home following concerns raised by her care provider. An ambulance escorted Ivy to hospital where she was assessed in the Emergency Department but not formally admitted to the hospital. During this time, Ivy is recorded to have contacted her care provider to inform them she was returning home. However, there was no mental capacity information recorded for Ivy at this time, and it cannot be substantiated if this happened.

Ivy was discharged from hospital and the ambulance team had taken her home. She was placed in bed at approximately 1pm, the crew were under the impression carers would arrive soon that day. The crew left and closed the front door and replaced the key in its key safe.

12 days later, the ambulance crew went to collect Ivy for a routine appointment and discovered she was at her home address, it appears that she had been at home, without food, water or insulin. She was saturated with urine and covered in faeces, with severe pressure sores on her back, buttocks and legs and had severe urine burns to the inside of her legs.

Ivy was taken to hospital where she later died.

2

Assessment at panel

The SAB received a Safeguarding Adult Review (SAR) referral from Greater Manchester Police and a SAR screening panel convened. After screening it was decided to undertake a SAR under Section 44 of the Care Act 2014.

3

What was discussed and decided?

This was a difficult case as criminal investigations were ongoing around the actions of some agencies within the partnership. There were considerable conversations around this, and it was clear the facts around her death were clear and the circumstances had met the criteria for a SAR.

Further detailed discussions took place to ensure this situation would not be repeated. A group was set up to review the protocols around discharge from hospital back to a home setting. The care agency had also introduced a wrist band for all their residents which contains emergency contact details. The panel agreed the wrist band project was an example of good practice that should be shared quickly, and wider within the provider market.

4

Voice of the adult and family members

Ivy had a niece whom she was in contact with who visited Ivy weekly. The SAB wrote to the family to offer their condolences and to inform them about the commission of a SAR, which was supplemented with a leaflet to the family explaining the SAR process.

The Independent authors had taken knowledge of the contact that had already been made with family and friends during the SAR process and determined that further contact was not appropriate for the purposes of the review.

5

Impact

Stockport council manage the independent market and ensure good quality care is commissioned on behalf of people in need of care and support. In this case, the improvements required the formalising of their expectation among providers with an inclusion within the contract about hospital admission.

Ivy's care provider attended the Provider-led Domiciliary Care Forum to discuss the Wristband Project with all other provider managers.

The Wristband project was included in the newsletter sent to all providers.

The Process for hospital admissions was also included within the newsletter with direct contact details for the hospital team.

Contractual agreement between the council and providers was revised to request that providers keep in touch and retain some responsibly for those they work with on admission to hospital. The revised contract was issued to all providers.

Quality Assurance Officers now check with providers that they are complying with the process of regular contact with individuals during periods in hospital at quality monitoring visits. They also monitor how providers are adhering to this element of the contract and evidencing how they have done so.

6

What we learnt?

There had been a similar incident previously that had happened to Ivy in 2017. After a hospital admission, a different care provider was not informed that Ivy had been discharged. She was again left in a soiled bed, unfed for 24 hours. Learning was not embedded in to practice sufficiently.

7

How we shared learning?

A programme of work has been ongoing to address the recommendations. This has included producing and sharing the learning via a 7-minute briefing. A Safeguarding and MCA Forum was also established for champions to have an opportunity to reflect on the review and share the learning within their respective agencies.

The final Overview report was published on the SAB website and sited on the National SAR library for other local areas to access to enhance learning based on complex medical needs.