## 7 Learning Points

1. A decision to suspend a care package for an adult at risk must be made on facts not assumptions.
2. All parties to a contract *[including the third-party client]* can benefit from agreed specific expectations in the contract.
3. Clear policy can empower staff to ensure that risks are managed appropriately for clients who attend the Emergency department who are known to have care and support needs within the context of the Care Act 2014.
4. The periods of transference of both care and responsibility between agencies are high risk.
5. Failure to investigate and record the outcomes of high-risk incidents means that the risks remain and can recur.

**Next Steps:**

1. Circulate and discuss the issues of this briefing within your team.
2. Review your personal and collective practice in the areas identified.
3. Attend the workshops that SSAB will be delivering in relation to the learning from this and other Learning Reviews.
4. Find the Full Overview Report here.
5. Look at the recommendations to the SAB - all partner agencies will progress actions and present assurances to the SAB on impact made from the learning.

## 6 Repeated Incident

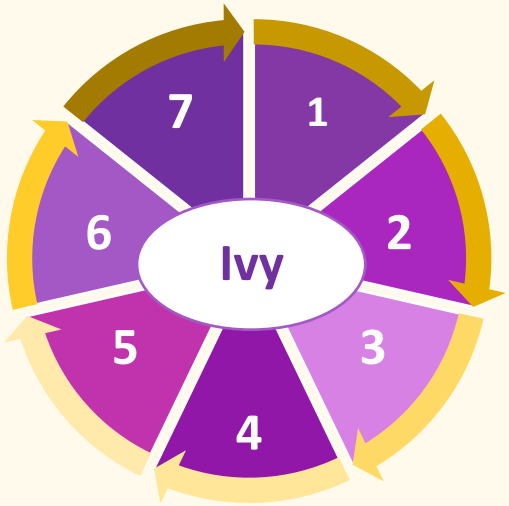
There had been a previous incident that had happened to Ivy in 2017. After a hospital admission, a different care provider was not informed that Ivy had been discharged. She was again left in a soiled bed, unfed for 24 hours. Learning was not embedded in to practice sufficiently.

## 5 Transferring of Care

Ivy's circumstances fell outside normal hospital discharge procedures as she was not actually admitted to hospital. Both hospital and ambulance staff were assured by Ivy that her care was in place when in fact it had been cancelled. This was not challenged or checked as Ivy was believed to have the capacity to make her own decisions and express her wishes and feelings. Conversations between professionals and service users, should be recorded, when discussions take place on how an individual's care and support needs will be met upon their return home. This includes, what outcomes have been discussed and agreed, and what actions professionals will take to notify care providers or other agencies.

## 1 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, whilst Ivy had limited mobility and was bed bound.




## 4 Communication

Ivy's care provider suspended her care package in the belief that she had been admitted to hospital. In fact, Ivy was 'assessed' but not 'admitted' to the hospital. It has become clear that this terminology can be interpreted ambiguously, and that further work is required between agencies to ensure a clear understanding of terminology and language is used across all agencies.

Adult Social Care contracts with care providers contains a general expectation that the care agency will keep in touch with clients who are admitted to hospital. Ivy's claim to the hospital staff that she had spoken to the provider by phone should not be considered adequate assurance. As such this expectation was not met in Ivy's case.

## 2 Incident -

In the four months before her death Ivy was engaging with multiple agencies including Adult Social Care who were aiming to get her mobile and out of her house with the use of a wheelchair. Ambulance Services were responsible for transferring Ivy to and from hospital appointments with the aid of a bariatric ambulance to ensure her safety, dignity and comfort. Ivy also had a commissioned package of care consisting of four calls per day.

In April 2019, Ivy's GP attended her home following concerns raised by her care provider. An ambulance delivered Ivy to hospital where she was assessed in the Emergency Department but not formally admitted to the hospital. If Ivy had of been formally admitted into hospital, then the expectation would be for the hospital to activate the standard discharge protocols.

Whilst Ivy was in ED, she was placed in a side ward where she was being cared for by hospital staff until a suitable vehicle was available to take her home. 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.

A suitable ambulance had become available, Ivy was returned home to bed, she was not seen by her care provider, friends or family until 13 days later, when she was being collected by her ambulance crew to attend an outpatient's hospital appointment. Ivy died several days later in hospital.

## 3 Cause of Death -

Ivy's causes of death was identified as a combination of Sepsis, Pneumonia, Pyelonephritis (kidney inflammation due to bacteria), limb ischaemia (sudden lack of blood flow to a limb), pressure ulcers and epithelial damage due to prolonged contact with urine, Obesity and type II diabetes. These conditions reached a deadly status because she was stranded in her bed without care. Ivy's single call during the 13 days unattended was made to Ivy by a nurse to discuss her diabetes. She did not answer the phone and the GP's records from this time show Ivy was incorrectly labelled as 'admitted' to hospital.

The conditions that caused Ivy's death can to some extent be attributed to inadequate communication between agencies, and some were triggered by inadequate care.

7 Minute Briefing

Safeguarding Adults in Stockport