Practitioner Learning Brief Safeguarding Adults Review (SAR): LUCY

February 2020

Lucy was admitted to Hospital on of 22nd February 2020 following a fall at home the previous evening. Lucy advised the ambulance crew on their arrival that she was experiencing pain in her left leg and hip area. On arrival at the A&E Department, Lucy was examined by a doctor and an x-ray taken of her left hip, which demonstrated that she had sustained a fractured neck of femur (#NOF). On 24th February, Lucy had surgery to repair her fracture (insertion of a dynamic hip screw).

March 2020

On 11th March, Lucy was transferred to an Intermediate Care Centre for rehabilitation (plan was for her to follow a 21-day pathway to improve her physical mobility, enabling her to return home). During her admission, Lucy participated in physiotherapy sessions, and was improving physically and engaging well with staff. However, Lucy was reported to be sad at times and requested to talk to a priest (her family reported this to have always lifted her mood). Following a weekly multidisciplinary meeting, a provisional date for her planned discharge was agreed for 1st April.

6th - 9th April 2020

On 6th April, Lucy was discharged from hospital after expressing a desire to go home (despite no agreement from Lucy's family and no review by a Senior Doctor). Lucy was taken home by ambulance around 6pm and provided with 'sufficient medication' to last until the next day (no indication how she would obtain further medications or instructions for carers to administer that evening). A care package was arranged to visit her four times daily, commencing on the evening of her discharge.

On her arrival home, Lucy called her daughter saying she did not have any money to pay for her taxi home, which caused her daughter(s) concern around Lucy's confusion. At 9pm, a carer arrived to find Lucy on the floor complaining of pain in her hip. An ambulance was called, but the carer was advised there was a delay of approx. 4 - 6 hours, so sought advice from the care agency. A 2nd Carer arrived, and Lucy was assisted from the floor to a commode, where she remained until the arrival of an ambulance. Lucy arrived at hospital at 11.45pm and was found to have fractured her right neck of femur.

Background

- 87-year-old female, an Irish immigrant and one of eight children.
- A widow and mother of two daughters, one of whom lived in Essex and one who lived in Devon.
- Lived independently in her own home, with support from her daughter, a neighbour, and a befriending service.
- Described by her daughter as being stubborn and fiercely independent since the death of her husband (6-7 years earlier) from dementia.
- Unable to drive and had not left her home very often during the 2 years prior to her death in April 2020.

1st - 6th April 2020

On 1st April, Lucy was unwell, anxious, and confused. She was diagnosed with a chest infection and prescribed oral antibiotics, hence was not discharged home as planned.

On 3rd April, Lucy was more confused, wheezy, complaining of pain when passing urine (possible urinary tract infection causing pain and confusion) and in 'low mood' (a telephone conversation took place with her daughter, after which she improved).

On the same day, Lucy's daughter spoke to the Continuing Health Care Team who confirmed the discharge had been delayed; she expressed concern that her mother was not safe to manage at home independently, and she herself was unable to provide support due to isolating (COVID-19). In response to her concern, it was agreed that admission to a residential care home may be a safer option for Lucy.

Also at this time, in response to the increasing pressure of the COVID-19 pandemic, a system decision was taken to close the intermediate care centre and on 4th April, Lucy was moved to a hospital. A verbal handover took place, and a transfer handover sheet was completed (mobility and infection were mentioned, however not the confusion). Unfortunately, the speed of the decision to close the care centre (24 hours) and transfer patients meant Lucy's daughter was not advised of her transfer until it had taken place.

9th - 28th April 2020

On 9th April, Lucy underwent further surgery to repair her fracture (of insertion of a dynamic hip screw). Following surgery, she was still confused, refused to take her oral medications, complained of difficulty in swallowing (appears to have been partly why she was refusing her medication) and was hardy eating and drinking. No referral was made to a dietician and/or speech and language therapist (to assess her swallowing).

On 20th April, Lucy refused any input from staff, developed a cough, and was subdued, so medication to treat depression/anxiety was agreed and plans were made to transfer her to a rehabilitation centre; however, no beds were available at this time. On 25th April, Lucy was transferred to another hospital but on arrival appeared to be unwell and was coughing. A CT scan was carried out which demonstrated signs of possible COVID-19, so on 26th April, Lucy was transferred back to the previous hospital, where she continued to decline her medication and therapy. Lucy subsequently died on 28th April 2020.

2 significant falls experienced within a period of 3 months.

2 safeguarding concerns raised.

9 agencies involved with Lucy's care.

9 areas for improvement that were identified:

1. Share the findings of this review with hospital and continuing care nurses who were redeployed to facilitate discharges from the community hospitals to ensure learning from this incident (NELFT & ICB).
2. Review of Business Continuity plans to take place, to ensure there are clear lines of accountability regarding discharge planning, including appropriate senior managerial oversight (all organisations)
3. Review discharge policy in circumstances where patients experiencing episodes of confusion are expressing a wish to be discharged from hospital. A formal mental capacity assessment must be undertaken to ensure consequences and potential risks are understood (NELFT).
4. Ensure that where a patient lacks capacity, a best interest assessment should be undertaken, and this must include the views of family members (NELFT).
5. Ensure that all documented plans are reviewed on the day of discharge (to confirm they are up to date/remain relevant) and that the patient is assessed by a registered health professional immediately prior to leaving the ward to ensure that they are fit for discharge (NELFT).
6. Update Business Continuity plans to ensure arrangements are in place to enable prompt access to IT clinical systems (all health organisations).
7. Ensure that all staff are provided with further training in respect of a) manual handling procedures and b) actions to be taken on discovery of a patient on the floor with a possible hip fracture (MercyLink)
8. Consider arrangements in place in discharge hubs to a) monitor discharges and b) provide an urgent response in the event of failed discharges (ICB's & Local Authority).
9. Submit all future Individual Management Reviews (IMRs) using the Essex County Council Standard format, ensuring organisation's recommendations are set out within the IMR (all organisations).

Good Practice

It is acknowledged that there have been significant changes to the way discharges are planned since this incident and there is a greater focus on Home First – Discharge to Assess models which involve better interagency collaboration through establishing transfer of care hubs, with dedicated care co-ordination and clear lines of accountability.

Essex Safeguarding Adults Board