LEARNING BRIEFING

Case 6/21
Mrs 'I'

Teeswide Safeguarding Adults Board

1 Background

Mrs I was an 84 year old lady who lived in a care home receiving 24 hour nursing care. The care home identified that Mrs I was agitated, restless and felt unwell. Observations were recorded which indicated low blood pressure, low pulse rate and reduced oxygen saturations. An emergency ambulance was called and Mrs I was transported to hospital. Mrs I had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documents and also had an emergency health care plan (EHCP) in place.

Mrs I attended the Emergency Department (ED) with upper back pain with no history of trauma. On arrival to ED her observations were recorded, which identified a reduced heart rate accompanied by a low blood pressure. Mrs I was examined and the doctor noted that the she had a current DNACPR and EHCP in place. Initially the doctor planned further investigations through an x-ray but following advice from a senior doctor in the department it was decided that this would not provide any benefit. The decision was made to discharge Mrs I back to the care home with instructions for the GP to review her medication in view of low blood pressure and slow pulse.

Mrs I returned to the care home but returned to the ED later that day extremely unwell as her condition had significantly deteriorated since discharge. Following examination and a discussion with the family a decision was made to admit Mrs I to hospital in a side room for end of life care and anticipatory medications only. Unfortunately there was a delay in obtaining an in-patient bed and Mrs I died whilst in the ED causing significant distress to family members.

2 Theme 1: Communication from the care home to the hospital regarding clinical concerns

Whilst it was acknowledged that the care home had escalated care and provided the DNACPR and EHCP, there was no written documentation around Mrs I's current issues and her normal observation ranges.

Prior to Covid-19 a red bag system was in place to improve two way communication between care homes and hospitals for all admissions and discharges, this was stopped due to increased infection control risk. No other system was implemented. Care homes must ensure that the information shared with hospitals on admission includes an up to date SBARD report (Situation, Background, Assessment and Recommendations), and transfer of care to hospital documentation.

3 Theme 2: Communication from the hospital to care home

A telephone call was made to the care home by the ED staff to obtain further information regarding Mrs I's condition, the care home advised that the patient had low blood pressure although there was no confirmation of what the normal ranges were for Mrs I.

Prior to discharge back to the care home, the normal practice is to telephone the care home and provide a verbal update on the decision to discharge and explain any changes to the care plan, or future interventions needed, this call did not happen.

A discharge letter was completed by the ED team, but was not received by the care home. It is uncertain what happened to the discharge letter.

4 Theme 3: Medical management of the patient

Mrs I attended hospital and was unable to give a clear history of the presenting complaint and relevant clinical symptoms, due to her illness. The care home had previously identified that Mrs I had some blood evident in her urine but this information was not given to the ED team.

The medical team did not give consideration to a full range of causes for the back pain as they were unaware of all of the symptoms.

5 Theme 4: Professional Curiosity

Staff did not question or challenge when concerns about Mrs I's health were made, there seemed to be an acceptance of the situation. Staff from the care home did not question the hospital's decision to discharge Mrs I back to the care home. Concerns were not explored, and it appears that professional curiosity was lacking to question decision making.

6 Theme 5: Personalised care

Mrs I's care needs were not assessed and personalised to her own needs. Mrs I's wishes and her family's wishes which were recorded in the EHCP did not appear to be taken into consideration. Staff in both settings were busy at this time which may have led to the breakdown in the personalised approach to care. Care home staff must ensure that when making any decisions regarding changes of placement or admissions to hospital that they consider what the person would have wanted and ensure that decisions remain personalised regardless of how busy the care home is.

7 What to do now and next...

- Reflect on how the themes link with your direct work with adults, families, carers and other professionals.
- Think about how you can adapt your practice based on this learning.
- Discuss within your team meetings and consider any team learning and development needs.
- Share this learning briefing amongst your networks for example:
  - ⇒ Local Authority (LA) Commissioners to share through their Local Authority networks.
  - ⇒ Care providers to share and reflect upon the importance of two way communication when admitting and discharging patients into and out of hospital.
  - ⇒ NHS Foundation Trusts to share with their clinical teams.
  - ⇒ Share with relevant Safeguarding and Partnership Boards.
- Care providers to provide a SBAR (Situation, Background, Assessment and Recommendations) handover approach when handing over care. Care providers to be encouraged to use the existing SBARD documentation which is available through their LA contacts.
- Alternative methods to a red bag system are currently been explored. In the interim it is suggested that the documentation (transfer of care to hospital and SPA/transfer of care and the SBARD documentation) previously used within the red bag is sent with the person to hospital in an envelope. This will be communicated with care homes through the LA networks.
- All care providers to be reminded of the importance of personalised care. LA Contract Compliance Officers to monitor care and support plans in care homes to ensure that they are personalised and that they accurately record the persons wishes, and any wishes for the future.
- Check www.tsab.org.uk for up to date policies, procedures and guidance, including the Professional Curiosity Learning Briefing .

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