Case Summary

Mrs. K (aged 77 at the time of her death) lived with her daughter and grandson who was in his early 20's in a flat. Mrs. K's daughter was the main carer and her grandson would provide care and support during the day when his mother was at work. There is little else known by agencies about Mrs. K's interests or lifestyle. Her medical history includes a recorded diagnosis of vascular dementia although this has not been confirmed), bi-polar disorder, paranoid psychosis and delusional symptoms, Parkinson's disease, hypothyroidism, poor balance and difficulty mobilising outside (and at times inside) the home.

During December 2016 Mrs K had a short stay in hospital following a fall at home and was discharged on 23 December 2016. Mrs K did not receive the community nursing and pressure relieving equipment (bed, mattress and cushion) she needed. In mid-January 2017, Mrs. K was readmitted to hospital on due to a deterioration in her health, including multiple pressure ulcers, and she died in hospital in mid-February 2017.

Lessons

- The importance of responding swiftly and effectively to known ***IT and other system glitches*** to avoid peoples care needs being missed.
- The importance of *better joint working* and between agencies and full ***engagement of people and their families*** in all aspects of care planning.
- ***Hospital discharges***, particularly over bank holidays, need to be carefully managed with engagement of both community and acute professionals.
- The importance of a shared understanding of the effective management ***of pressure ulcers*** across agencies.

Richmond and Wandsworth
Safeguarding Adults Board

7-minute Learning Summary

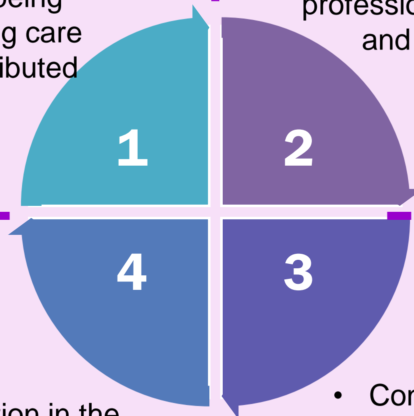
Safeguarding Adults Review Mrs K

Referral to Community Nursing Services

- The referral pathway involved a referral from the hospital to the Single Point of Access (SPA). The referral would then be forwarded to the Community Nursing services via an agency which should then notify the SPA of any district nursing matters using a bespoke software package and make a follow up call.
- There were known issues about the compatibility of the IT systems resulting in non-delivery of emails.
- A back up email was therefore also required. This was sent to a nurse as opposed to a joint inbox. However, the relevant nurse on annual leave at the time, and the referral was therefore not received by the nursing team.
- Failures in this system led to Mrs K's referral for community nursing and equipment not to be actioned leading to equipment not being delivered and for wound and nursing care not being provided, ultimately contributed to a deterioration in Mrs K's health.

Consideration of Mental Capacity

- Throughout Mrs K's engagement with services, there was a presumption of her having capacity to make decision about her care and treatment.
- During her hospital admission, Mrs K was unwell and had an infection. It is possible that her mental capacity was at least temporarily impaired.
- This was not considered by any of the professionals involved with Mrs K's treatment and support.



Consideration of Mental Capacity

- Contact with Mrs K herself was limited with most of the discussions taking place between professionals and her family members.
- Mrs K was under the care of a Neurologist and none of the involved professionals had information on whether she was living with ongoing mental health concerns and whether there was a regular review and monitoring of her prescribed anti-psychotic and anti-depressant medication.
- Mrs K had complex care needs and required input from a range of professionals who each engaged with her family support on an individual basis.
- There was a lack of professional appreciation that the support required from the family was considerable and complex for lay people to understand.

Discharge planning

- There was a lack of co-ordination in the discharge planning and a lack of understanding by the referring ward that the equipment would not be delivered until the next day.
- Coupled with the non-receipt of the District Nursing referral this led to Mrs K being left without support.
- There was no comprehensive assessment or carers assessment and a lack of checking if Mrs K and her family understood her needs and how she should be supported
- Mrs K's daughter was offered limited support and it is unclear whether she fully understood the complexity of her mother's support needs.