Shared learning

Theme of the week

Safeguarding Incident - Bruising Sustained During Home Leave

Date

23/12/2024

Background and context

A patient with challenging behaviors was admitted to a neuro-behavioral ward with 1-to-1 care. As part of his rehabilitation and discharge planning, he goes on home leave every Friday to spend the weekend with his family, returning on Sunday evening or early Monday morning.

What happened?

During one of his home leave, the patient returned with bruises on various parts of his body. When asked how he sustained the bruises, his wife was unable to provide an explanation, stating that there was nothing that could have caused the injuries. Since the patient does not have 1-to-1 care during home leave, the only potential witnesses to the incident were the wife and their son. As the cause was unknown, a Safeguarding referral was raised. On further investigation, it was found out that the property had several hazards including their pet dog, the use of a not suitable commode and a bath seat.

What should have happened?

A body map prior to home leave would be very beneficial for the investigation as this could be compared to the current bruise pictures. A robust risk assessment should have been in place and a physical visit to the patient's home could have been conducted prior to allowing the patient to go home on weekends with family. This could help identify possible hazards and actions could be shared with the wife and family prior to the home visit.

What we will do differently next time

A home visit or community trip checklist, along with a comprehensive risk assessment, must be completed to ensure all necessary steps are taken for the patient ' s safety while outside the hospital. This should be shared with everyone involved, including family members, with all parties agreeing to the control measures in place. A pre- and post-visit body map is essential for all trips outside the ward or home visits and should be clearly documented in the EPR. Additionally, the bruise algorithm must be promptly completed to better understand the injury timeline.

What have we learned?

Staff must be proactive in identifying risks and potential hazards for our patients, as early detection can significantly reduce the likelihood of injury. Concealing lapses will only cause further harm, while being open and honest about mistakes allows for the development of more effective strategies to prevent future harm. Ensuring patient safety requires transparency and accountability. Incidents like these should be openly shared for learning purposes, benefiting not only staff but also the family and relatives of our patients

☑ I have read this

Name	Job role	Signature