Mrs C – Safeguarding Adults Review (SAR)

Part I: Significant Event Enquiry

Part II: SAR in Rapid Time

Signed off by SAB:
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Introduction

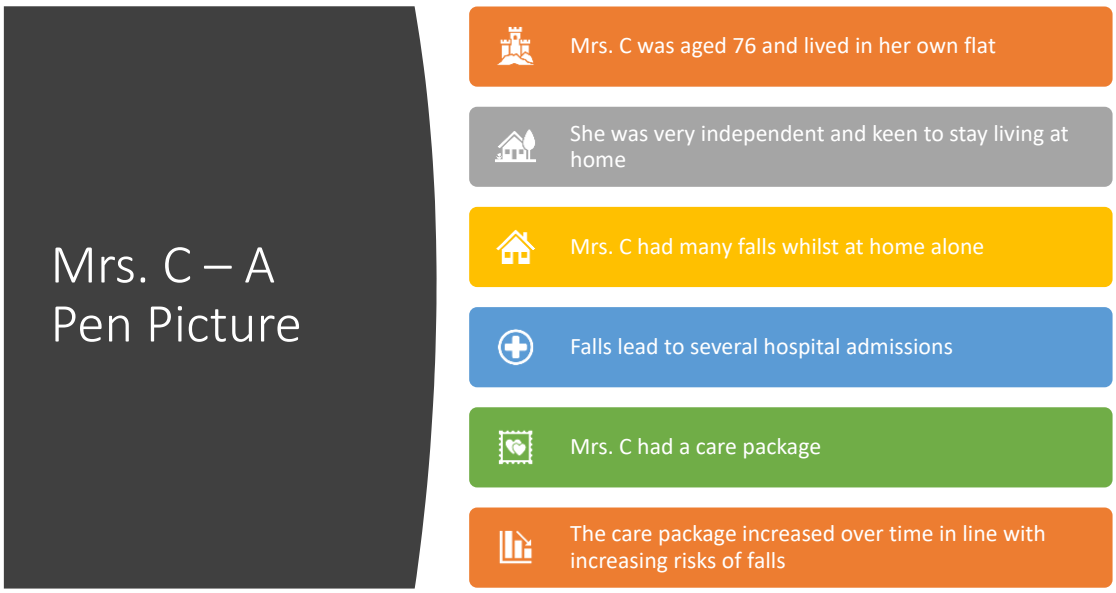
The Safeguarding Adults Board (the board) made the decision to complete a Safeguarding Adults Review under Section 44 of the Care Act 2014 regarding Mrs. C because she was an adult with care and support needs and the board had sufficient concern about the way partners worked together to prevent harm. In order to identify learning the SAB agreed that a multi-agency Significant Event Enquiry (methodology) is appropriate, and this is covered in Part I of this report. This was completed in February 2020 and actions agreed.

In January 2020 the Covid Pandemic hit the country, soon leading to a total lockdown and impacting on hospitals capacity. On 19 March 2020 the government issued the 'Discharge to Assess'[1] Policy and Operating Model. The SAB therefore decided to test how this may have affected Mrs. C's discharge and further undertook a Rapid Review to identify any challenges and enablers regarding this new process and applying Mrs. C's circumstances.

Part I – Significant Event Enquiry and Workshops

David Jones (Interim Chief Officer for Adult Services, Bedford Borough Council) and Nicola Keer (Head of Nursing for Safeguarding, Bedfordshire Hospitals NHS Foundation Trust Bedford Hospital) led on the Significant Event enquiry on behalf of the SAB. Two multi-agency workshops were held December 2019 and February 2020 involving agencies managers and practitioners involved as follows:

- Bedford Borough Council
- Bedford Hospital
- Private Care Agency



1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/962885/Hospital_Discharge_Policy_1.pdf

Summary of Events

21/03/2019	Admitted to hospital falling a fall (1st Admission).
13/04/2019	Discharged from Bedford Hospital to Archer Unit
07/05/2019	Medically optimised for discharge, no sign of infection.
14/05/2019	Mrs C was discharged Home from Archer Unit. The hospital social work team record notes that they had confirmed with Mrs C's son that he would be at her home to let her in and ensure she had what she needed.
14/05/2019	The care agency contacted the hospital social work team to say they had attended their first care call and Mrs C had already had another fall. Carers found Mrs C on the floor. The care agency raised concerns about hospital discharge without proper preparation 'No food in her house and family were not aware of her returning home'. Ambulance called and Mrs C was re-admitted to Bedford Hospital.
15/05/2019	2nd Admission - Brought to A&E by ambulance. Full medical assessment undertaken. Patient noted to have shortness of breath and increased need to urinate. X-ray of shoulder showed no breaks following the fall at home. Antibiotics were given for urine infection and Mrs C was admitted. IV fluids were given and review by clinical navigation team requested. Possible hypoglycaemia as not had breakfast or insulin that morning. Falls and mobility assessments completed on admission showing high risk of falls.
16/05/2019	Family discussed concerns regarding number of falls and small flat which is difficult to manoeuvre around with frame. This is compounded by urinary incontinence and other medical problems that are contributing to the number of falls. Referral made to hospital social work (HSWT) team.
17/05/2019	**Plan:** best interest meeting, to reduce the risk of falls and discharge destination.
18/05/2019	Review by Social Worker (SW) Explained that she fell whilst at home. When asked why she had not waited for the carers, she explained that it was going to be a while as she had got home early. Discussed what she wanted to happen when she left hospital, she explained that she did not want to go to the Archer Unit again, describing the group physio sessions as childish. Discussed how she would feel about going to a care home when she is discharged maybe for a short period of time. Mrs C was not keen on this idea and she reported that she wanted to return home as she liked it there.
19/05/2019	Navigation team review Patient sat out and happy to mobilise, stood up with assistance of one, then mobilised 12 metres using wheeled walking frame and chair behind. SW review Discussed discharge plans and ability to mobilise, as her ability to mobilise has recently deteriorated. She agreed but did not want to return to Archer Unit. She explained that she felt that the staff were

	abrupt, and the exercises were like children's games. Agreed to a care home with a rehab section within. Recommendation: Patient to be considered for inpatient rehabilitation within a care home; if not accepted increase care package to QDS care package (2 carers) and encourage patient to wait for carers to provide support. Discussion between HSWT and son (NOK). Beginning of conversation was an explanation of why his mother moved from living with him and his family and about his mother sometimes not helping herself by not taking part in care home activities or mobilising and at times not acknowledging her current condition or reduced mobility. Concerns raised by son during conversation: Son was concerned that the flat was quite tight making walking around it with a frame difficult. He visited his mother on her return home and explained that her feet were catching each other when she was moving around corners. The patient's son explained that his mother has a fear of care homes, he explained that the bad press they got in the 80's and 90's had stuck with her and she was scared to go into one and he is therefore not surprised that she was not keen to go into one. The patient's son asked that when his mother was discharged that he was informed. He explained that on her discharge from the Archer Unit he was told there was nothing he needed to do, when this was not the case. He needed to do the shopping and other bits for her. He explained that it cannot be expected for him to help at the drop of a hat as he works and lives in Milton Keynes – acknowledged his point agreed and requested that he is kept up to date.
20/05/2019	Occupational therapist assessment of mobility and transfers, lying in bed, needs two to sit on edge of bed. Stood into wheeled walking frame (WWF), mobilised 15 metres with close supervision of 2 with WWF. Safe turn to chair. Would benefit from hospital bed and mattress, will speak to patient and son. Patient has been seen by HSWT and is setting up care four times a day with two carers. Maintain transfers and mobility. OT spoke with patient about hospital bed, patient agreed to this. OT spoke with son who wasn't happy about the idea as will decrease his mum's independence. He is to think about this and will let OT know re bed as existing bed will have to be removed.
21/02/2019	Remains fit for discharge. Navigation team: continue to practice mobilising and transfers. Patient advised to wait for carers before mobilising once home. Plan: Review in the morning and maintain mobility with WWF. Ward visit by Social Worker Follow up ward visit after handover from colleague. Patient wishes to return home with an increase of care from 3 calls to 4 calls with 2 carers rather than one. I have spoken to the son and said I will call once a care agency has been confirmed.
21/05/2019	Documented on SWIFT data base by Hospital Social Work team, that Mrs. C wished to return home with an increased care package,

22/05/2019	Remains fit for discharge. Navigation Team: Patient is now refusing a hospital bed, assessed bed transfers with PT. She was able to transfer on and off with minimal assistance of one. Understands why a hospital bed has been prescribed before but wants to keep her electric bed. Social Worker and son contact: Son advised that previous agency cannot support new package of care so a new agency is being sourced, also advised that a key safe will be required to allow access for carers. Son stated he would fit this himself and would call the office with the details. Son advised by social worker she was away until 27/05/19.
22/05/2019	Son updated and care agency being sourced as original agency was unable to support with increased hours. Worker advised that she was now off until 27/05/19.
23/05/2019	Remains fit for discharge, with continued discharge planning
24/05/2019 11:00	Care Agency Visited the patient on the ward at 11:00 to undertake an assessment. Confirmed they could provide a package of care after 18:00 but that the ward would need to ring to confirm the patient was going home. Navigation Team Patient seen with OT and PT, home today with four times a day package of care starting this evening, transport booked. Navigation Nurse: Phoned son who is aware of discharge plan today; he is travelling to Scotland tonight and will be back on Monday. Patient aware of plans.
24/05/2019 17:30	Care agency called x3 Three calls were made to the agency by ward nurse between 17.30 and 17.35 none of which were answered.
24/05/2019 17:45	Delay in transport arriving due to traffic, patient picked up at 17.45. Checked she had a key and was happy with medication before discharge.
24/05/2019	Mrs C is discharged home.
27/05/2019	Mrs C found deceased by her private cleaner.

Analysis and Findings

Finding 1

Mrs. C was discharged from an escalation area (Victoria Ward). This did not have the benefit of a Discharge Coordinator whose duty it would have been to finalize arrangements with the care agency at the time of discharge. Whilst nurses attempted to inform the new agency of the later than planned discharge, this failed as the agency did not answer the calls. Final confirmation of onward care arrangements was not in place.

Finding 2

The care agency visited at the arranged time, but Mrs. C was not yet at home as her discharge had been delayed and her journey home took significantly longer due to heavy traffic in the area delaying the ambulance.

Finding 3
The discharge took place late on a Friday afternoon/evening at around 18:00 before a bank holiday. There was a slight delay in Mrs. C's discharge caused by traffic. The risks of late and delayed discharges on bank holidays and weekends are well known and again demonstrated in the case of Mrs. C.

Finding 4
It was discovered that Mrs C died of a heart attack at a time that was not able to be precisely determined. Whilst the circumstances of her discharge were clearly not safe and failed to meet the standards expected, it is not possible to say that if things had been different and care arrangements had been confirmed on discharge, that the outcome for Mrs C would have been any different.

Actions resulting from Significant Event Enquiry

All actions were completed as soon as they were identified by February 2020 as follows:

1) A discharge coordinator is allocated to all escalation areas including Victoria ward.
2) The care agency made improvements to their telephone system to ensure that there is 24/7 cover as well as the possibility to leave a message in order for urgent missed calls to be promptly returned.
3) To escalate risks to senior managers for their consideration and reconsider discharge when high risks are indicated following a delay and safe discharge timeslot not being met.

Part II – SAR in RAPID TIME-Covid Changes.

A SAR commissioned by the Central Bedfordshire Council and Bedford Borough Council Safeguarding Adult Board (SAB)

The SAB has conducted a SAR In-Rapid-Time to learn from the response of all partners in the case of Mrs. C. She was discharged from hospital to her own home where the expectation was that a care package would commence. Mrs. C was found to have passed away 72 hours later; her care package had not started. Following a Coroner's inquest, it was concluded that Mrs. C died of a cardiac event. The SAB is conducting the SAR under Section 44(1)(a) of the Care Act 2014. This gives the SAB authority to conduct a SAR if it has reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult. In this case, the SAB is determined to capture and share learning that will enable patients to be safeguarded at the time of discharge from hospital and consider how changes resulting from Covid 19 have impacted on hospital discharge.

The SAB is collaborating with the Social Care Institute for Excellence (SCIE) to test a new methodology to enable learning to be turned around more quickly than usual through a traditional SAR. This new methodology is referred to as a SAR In-Rapid-Time and is based on a model of systems findings.

The difficulties for practitioners and agencies in supporting people throughout the Covid pandemic has to be recognized, including the efforts of all involved in implementing Covid

safe methods and the challenges, having to consider ever changing law and guidance. This SAR provided an opportunity to stress-test the new discharge pathways to enable better delivery.

This document

This document forms the final output of the SAR in Rapid Time. It provides the systems findings that have been identified through the process of the SAR. These findings are future oriented. They focus on social and organisational factors that will make it harder or easier to discharge a patient with care and support needs safely. As such, they are potentially relevant to professional networks more widely. In order to facilitate the sharing of this wider learning the case specific analysis is not included in this systems findings report. Similarly, an overview of the methodology and process is available separately. Each systems finding is first described. Then a short number of questions are posed to aid SABs and partners in deciding appropriate responses.

Contact

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Systems findings

Introduction

The case of Mrs. C offers a window and opportunity to not only review and evaluate the discharge from hospital at the time of Mrs C's death in 2019, pre Covid but also, the SAB agreed that the new discharge pathways introduced during the Covid Pandemic should also be considered as part of the rapid time SAR. It should therefore also reflect current circumstance and make the case applicable post Covid. The introduction of the Discharge to Assess guidance was done at speed changing one discharge pathway to a set of complex pathways. This was constantly updated often introducing additional or new requirements. This meant it was difficult for policy makers and practitioners alike to keep up and be clear of expectations.

The constraints of a SAR in Rapid Time mean that the learning captured in this report cannot be comprehensive. The review recognises that managers and practitioners know of some of the challenges this review identifies that there are ongoing work streams to address these. This includes to improve communications with care providers, family members and patients and mapping activity. All agree that there has been little time to evaluate the outcomes of the new ways of working. The priority given to speed causes a tension with the requirement to take time to consult and communicate.

The policy was introduced to reduce the risk of infection and to maintain capacity in hospital settings. The SAR in Rapid Time has highlighted a number of systems issues that reflect the challenges of the current discharge arrangements from hospital to the community. The findings are designed to support the development of some of these efforts.

The SAB wanted the SAR to focus on what are the barriers and enablers to:

- timely and safe hospital discharge?

- the robust interpretation and embedding locally of the current national policy regarding hospital discharge, to ensure that patients are adequately safeguarded?
- safeguarding patients' rights and freedoms, as part of decision-making regarding discharge arrangements?

Findings – SAR in Rapid Time

1. The best practice guidance developed by ADASS[2] to support implementation of the new hospital discharge to assess policy[3] is not yet been fully embedded locally, evidencing a lack of clarify on the part of practitioners regarding their roles and responsibilities.

The aim of the High Impact Change Model: "This model was developed in 2015 by strategic system partners and was then refreshed in 2019 with input from a range of partners including the Local Government Association, the Association of Directors of Adult Social Services, NHS England and Improvement, the Department of Health and Social Care, the Ministry of Housing, Communities and Local Government and Think Local Act Personal Partnership. It has now been updated in July 2020 to integrate emerging learning from responding to the COVID-19 pandemic."[4] Therefore is the best practice model to aspire to.

In the case of Mrs C practitioners at the time of her discharge were clear about their roles and responsibilities. Mrs C was offered choices and options and the discharge planning took 9 days to finalise. Both the hospital discharge to assess guidance nor the ADASS tools have been translated for local use. This is leading to challenges interpreting and implementing this at the front line. Action cards are strategic and perhaps require further consideration by senior managers to then implement at local level.

Questions for the SAB and partner agencies:

- Recognising the speed at which the changes have been made do practitioners in all agencies know their own and others' roles and responsibilities or do they require further interpretation locally?
- During C19 does the MDT or complex case conference model adequately safeguard people?
- Are the principles of making safeguarding personal adhered to in relation to discharge?

2. There is currently not enough guidance for practitioners as to how to manage the competing imperatives on speed required by the new hospital discharge requirements and time needed to be compliant with

[2] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high/about

[3] https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model

[4] https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high

the MCA, and Human rights legislation as well as keep the patient at the centre of decision making. This risks lessening the patient choice for onward care arrangements.

The rational is to discharge at speed is legitimate and understandable due to the Covid pandemic and risks to vulnerable people. It is recognised that this is likely to cause tension with the time needed to properly consult. This SAR has highlighted this tension and without adequate guidance it has identified system vulnerabilities such as communication with patients and families and due consideration that the rights and freedoms of patients could be compromised.

- How can we enable local agencies and practitioners to manage competing priorities and a speedy process whilst listening to patients and working with existing legislation?
- Is there a further need to incorporate the challenges of doing so into local toolkits for practitioners?
- Does the current policy override what is law (Mental Capacity Act 2005[5] and Human Rights Act 1998[6])?
- How are we assured of practitioners legal literacy and knowledge of legislation underpinning decision making about hospital discharge?
- Is there sufficient evidence of challenge regarding MCA compliance?

3. The lack of Covid specific/safe community resources is recreating a bottle neck in spite of the new hospital discharge guidance increasing the risk of extended hospital stays and leads to deconditioning of patients and risk of contracting Covid 19.

Whilst priority is given to speed it highlights a tension. There is an assumption of available resources in the community and it was highlighted that some of these are not available. This is complicated, as patients may have complex health needs and 'long Covid' and are being discharged earlier and that this can result in a risk of re-admission. Aligning the right person, at the right time to the right resources cannot be achieved.

- The review indicated that there are insufficient RED Covid beds available locally to enable timely discharge. The policy assumes adequate resources. Has the SAB been assured that resources for all pathways are available in sufficient quantity locally?
- Are the SAB assured that assessment following discharge are completed in all pathways following discharge?
- Are the SAB assured that Care Act assessment are completed in the community to fully assess the needs of the individual to properly plan their onward care?

[5] https://www.legislation.gov.uk/ukpga/2005/9/contents

[6] https://www.legislation.gov.uk/ukpga/1998/42/contents