# Adult Practice Review Report

# Cardiff and the Vale Safeguarding Adults Board
# Extended Adult Practice Review

# APR 02/2017

## Brief outline of circumstances resulting in the Review

*To include here: -*

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

**Legal context**

An Extended Adult Practice review was commissioned by Cardiff and the Vale Regional Safeguarding Board on the recommendation of the Adult and Child Practice Review Sub-Group in accordance with the Guidance for Multi Agency Adult Practice Reviews. The criteria for this review are met under Section 139 of the Social Services and Wellbeing (Wales) Act 2014:

*'A board must commission an extended adult practice review where an adult at risk who has, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:*
*Died, or*
*Sustained potentially life threatening injury or*
*Sustained serious and permanent impairment of health.'*

In accordance with the guidance, the criteria for an Extended Adult Practice Review was met; abuse was suspected as a potential associated factor, and during the six months preceding their death the adult subject of this review was subject to adult safeguarding enquiries following a referral from a commissioned care provider.

**Circumstances resulting in the review**

The adult subject of this review, who we shall refer to as Adult A, died in 2017 from a hospital acquired infection. The rationale behind the decision to commission this Extended Adult Practice Review was that Adult A was an adult at risk who had care

and support needs of a high level of dependency (she had been bed bound for ten years due to ill health) and was therefore unable to protect herself from abuse.

Prior to her admission to hospital, Adult A was living in her own home, with a family member who was identified as her carer. She was supported at home by a commissioned care provider that visited four times a day to provide personal care and assistance with meals.

There was a family history of alcohol and substance misuse, allegations of domestic abuse and a history of volatile relationships between family members at Adult A's home. There had been a number of adult safeguarding concerns raised by the care provider in the months prior to her last hospital admission but there was no multi-agency response to the concerns. The unresolved concerns about her home circumstances delayed her discharge from hospital where she remained and succumbed to a hospital acquired infection.

The time period reviewed was from 1 October 2016 to 30 April 2017, the date of Adult A's death. Adult A had been known to adult social services for over 10 years, but in the 18 months leading up to the review period there had been limited contact with some agencies with nothing of significance being reported by adult services.

## Practice and organisational learning

*Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances*

(Relevant circumstances supporting each learning point may be informed by what was learned from the family's contact with different services, the perspective of practitioners and their assessments and action taken, family members' perspectives, evidence about practice and its impact, contextual factors and challenges)

Representatives from South Wales Police, Probation Services, Welsh Ambulance Services NHS Trust, Adult Social Services, Adult Safeguarding Team, Housing, District Nursing Team, Home Care Provider and the Cardiff & Vale University Health Board were invited to the Learning Event. This takes into account the complexity of agencies that have had contact with Adult A and family over the last ten years and in particular during the review period.

**Communication and information sharing**

Practitioners at the learning event recognised they had worked in isolation from each other. They did not always liaise with other agencies or even with other staff within their own agency on a regular basis or at times of concern. If they had been aware of concerns held by other agencies it would have added weight to their own concerns and may have resulted in a multi-agency response to investigate the concerns and protect Adult A.

Practitioners felt that relevant agencies needed to be invited to contribute to adult services reviews of care packages to share relevant information that may impact on the health and safety of an individual. They acknowledged that district nurses, home care providers and social services could not attend every care package review, but when a concern has been raised there should be an expectation that all agencies involved will attend or otherwise contribute to the review. Such an expectation should result in clearer communication and earlier identification of safeguarding concerns.

**Assessment**

Agencies need to be mindful that when assessing/reviewing the suitability of care packages it is sometimes tempting to concentrate on the risks associated with more tangible activities, such as lifting of individuals or trip hazards, rather than focussing meaningfully on whether the adult at risk is safe from abuse in their own home. It is of particular importance that during the assessment review, the adult at risk is given the time and opportunity to engage in the process and be spoken to alone to avoid any undue influence from others.

It appeared to the reviewers that unhelpful barriers to communication existed between the care providers, the social services review team and the social services safeguarding team. Concerns about Adult A's wellbeing got lost in that triangle of teams. Local authorities should keep in mind the fact that commissioned care providers have more frequent contact with clients and witness their home circumstances on a daily basis. The views of commissioned care providers, about for example the package of care in place or another family members' behaviour, should be respected and given due weight and consideration when assessing risk.

**Adult Safeguarding and consent**

Practitioners recognised they had sometimes not followed the correct procedure when reporting safeguarding concerns. Submitting a VA1 form does not safeguard someone, but rather the safeguarding actions taken as a result of the concerns being identified and shared do. On two occasions the home care provider completed a safeguarding referral following an allegation of physical abuse by Adult A perpetrated by her carer but they did not report this to the police. The reviewers are of the opinion that too much faith was placed in the VA1 referral as a safeguarding measure, rather than agencies following up on the action taken as a result of their referral and when necessary escalating their concerns to safeguard Adult A.

A strategy discussion/meeting, including all relevant agencies, was not held in response to the alleged assault. The social worker thought that Adult A's consent to follow safeguarding procedures was required, and had not been given, so no further action was taken. At the learning event there was significant confusion amongst practitioners about consent and safeguarding issues.

Adults have a right to independence, choice and self-determination, including control over information about themselves. If a person has mental capacity and requests that information is not shared or that reports are not made to police, their wishes should be respected. However, in the context of adult safeguarding and where there are

justifiable reasons to act contrary to their wishes in order to safeguard a person or persons, information may be shared without consent, for example;

- where the person is subject to coercion or undue influence to the extent that they are unable to give consent
- where there is an overriding public interest, for example, risk to others
- to prevent serious abuse or distress or in life-threatening situations
- where a Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment indicates a high risk of serious harm or homicide

Practitioners at the learning event were able to reflect on the issue of consent and safeguarding and accept that consent is not required from an adult at risk to have a strategy discussion/meeting about their wellbeing. The myth around consent remains a barrier to safeguarding people.

**Domestic Abuse and Disability**

The WAST Practitioner (Welsh Ambulance Services NHS Trust) shared that its staff had missed an opportunity to ask Adult A, when she was alone with them, questions about her general wellbeing and domestic abuse victimisation in particular.

In 2015 Public Health England published a report named Disability and Domestic Violence, Risk, Impact and Response. The report reviewed the published evidence and statistical information about domestic abuse affecting disabled people. It highlighted that disabled people experience disproportionately higher rates of domestic abuse. They also experience domestic abuse for longer, and suffer more severe and frequent abuse than non-disabled people.

Practitioners at the learning event spoke positively about the discontinued Safer Wales Butterfly Project which offered information, advice and assistance to older people, around issues relating to domestic abuse. They would welcome re-investment in a similar service.

Adult Social Care should be a core agency at the Domestic Violence Multi-Agency Risk Assessment Conference (DV MARAC). They will often hold vital information about the individual's care and support needs, care packages and capacity concerns in addition to being able to offer actions including assessments.

**Training**

Practitioners reported that current adult safeguarding training offered by the Safeguarding Board was generally inadequate and needs improvement to include more about topics such as disguised compliance by carers (a term that is often used about carers of children but not often for carers of adults), safeguarding and consent, safeguarding and mental capacity and information sharing.
Some practitioners may also benefit from attending DV MARAC training to enhance their knowledge of high risk domestic violence situations to better protect all vulnerable people in a household where domestic violence is prevalent.

**Police Public Protection Notifications (PPN)**

Adult A was not always included on the PPNs that were submitted due to incidents of aggression between other relatives at the family home which meant that information about these incidents was not shared with adult services. On one occasion, although Adult A was included on the PPN, the document was not shared with Adult Services as she was not listed as the main subject; a locally agreed process meant that the form would therefore not be accepted by health or social services. When this process was identified, as a consequence of this review, it was stopped and is no longer in place.

During the learning event, police officers showed a better awareness about the need to include any vulnerable adult present at an altercation between others on the PPN. Wales Community Rehabilitation Company also reflected that they would in future think more holistically about vulnerable adults caught up in conflict situations, rather than focussing solely on family members directly involved in the conflict.

**Home standards and respite care**

It was felt that there was an inconsistent level of acceptance of Adult A's poor home conditions by some practitioners; for example no light bulb in Adult A's room and on occasion no electricity, no hot water and dog fouling of the property. While it is accepted that people can choose how they want to live, practitioners felt that there should be guidance on acceptable levels of home conditions when people are not able to take responsibility for the conditions of their own accommodation, for reasons of ill-health or disability. Such guidance could help to safeguard people within their own homes and provide a safe environment for visiting professionals.

There had been allegations of abuse and concerns about unsuitable adults frequenting the property, poor home conditions, lack of social contact and a lack of personalised opportunities for Adult A. Adult services had agreed that respite care should be sought just a couple of weeks before Adult A's hospital admission, but this was out of concern about her carer's stress levels and ability to cope, rather than out of concern for Adult A's well-being.

There was a delay in finding respite for Adult A. There were communication difficulties between the adult social care review team and the district nursing service in part due to a faxed referral. The faxing of referrals is unreliable and outdated practice. It is difficult to audit the receipt of faxed referrals and in this case a 'stray' referral contributed to the delay in sourcing a suitable respite option for Adult A.

Practitioners at the learning event reported that due to a shortage of respite options available to the local authority, timely respite care was generally available only in emergency situations.

**Hospital admission**

The events leading to Adult A's hospital admission included a safeguarding referral by the commissioned care provider. A strategy meeting should have happened within seven days but this did not take place.

At the learning event, practitioners from the hospital said they were not fully briefed on the reasons that Adult A required a respite placement on discharge rather than being able to return to her family home. If they had known, the responsibility that was given to some family members whilst Adult A was in hospital may not have been deemed appropriate.

Adult A was considered medically fit for discharge two days following her admission to hospital. A safe discharge meeting was not arranged until four weeks after her admission to hospital. Adult A sadly died of a hospital acquired infection before the safe discharge meeting could take place.

It is desirable that, once patients are medically fit for discharge, they return to the community as expeditiously as possible in order to avoid an outcome such as this.

## Improving Systems and Practice

*In order to promote the learning from this case the review identified the following actions for the SAB and its member agencies and anticipated improvement outcomes*:-

The focus of this section of the report are actions that could "bring about improvements in systems and practice, and should be specific, workable and affordable and have clearly defined anticipated outcomes" as indicated in the Social Services and Wellbeing (Wales) Act 2014, Working Together to Safeguard People, Volume 3, Adult Practice Reviews.

**Agency Improvements in Practice**

Agencies have already taken some action to improve practice during the time that has elapsed since Adult A's death;

1. There has been a change in practice in relation to cases referred to the MASH that present with elements of domestic abuse and where the adult meets the definition of an adult at risk. These changes should now result in a strategy discussion taking place in the MASH about an adult at risk like Adult A who was in a volatile and potentially harmful home situation.

2. There has also been a change in practice with regards to the faxing of requests for nursing respite assessments. Faxes are no longer sent and information is now submitted via email.

3. The WAST Practitioner at the learning event reported that they missed an opportunity to undertake routine enquiry into potential domestic abuse whilst alone with Adult A. WAST are currently providing “Ask And Act” training on undertaking a “targeted enquiry” in line with the statutory obligations of the National Training Framework under the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015.

4. The locally agreed process which restricted the sharing of PPNs where adults at risk were not the main subject of the incident has been removed.

## Recommended Actions for the Regional Safeguarding Board

The learning points identified through this review have resulted in further recommended actions for the board.

1. Cardiff and Vale Safeguarding Board will review the adult safeguarding and domestic abuse training currently available to staff to ensure that it provides clarity about immediate safeguarding action expected when allegations of abuse are made, and the issues of capacity, consent, disguised compliance and when to follow adult safeguarding procedures. This training should also specifically include a reminder to practitioners that even if someone is in receipt of a care package, there can still be safeguarding concerns which require multi agency discussion. This improved training should result in a better informed and more confident workforce, better equipped to safeguard adults.

2. All constituent local authority partners of Cardiff and Vale Safeguarding Board will ensure that all agencies, having involvement with an adult in receipt of care, make a meaningful contribution to the care package review process and identify safeguarding issues at an earlier stage

3. Cardiff and Vale Safeguarding Board will audit adult safeguarding referrals to the Vale Adult Safeguarding Team and Cardiff MASH involving domestic abuse, to determine whether a strategy discussion/meeting takes place, and if there is none what action has been taken. This will provide assurance to the Board that the MASH is improving safeguarding practice through improved multiagency information sharing and decision making.

4. Cardiff and Vale Safeguarding Board will require that Adult Social Care is included as a core member of the DV MARAC and that relevant staff from all agencies access the DV MARAC multi-agency training

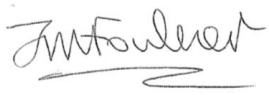
   Vale of Glamorgan Adult Services routinely have a representative on DV MARAC.

5. South Wales Police will remind staff that details of any adult at risk involved in or affected by an incident must be included on the PPN.

6. Cardiff and Vale Safeguarding Board should develop guidance for practitioners on acceptable levels of home conditions when people are not able to take responsibility for the conditions of their own accommodation.

   It is further recommended that this guidance gains policy status in its own right rather than being a subsection of a wide self-neglect policy.

7. Cardiff and Vale Regional Safeguarding Board should develop a protocol for the sharing of relevant information concerning people with prior care and support needs that is likely to impact on treatment and discharge planning in order to facilitate expeditious discharge of medically fit patients to the community.

| Statement by Reviewer(s) | | | |
|---|---|---|---|
| **REVIEWER 1** | Jane Foulner | **REVIEWER 2 *(as appropriate)*** | Dr Lorna Price |
| **Statement of independence from the case**<br>*Quality Assurance statement of qualification* | | **Statement of independence from the case**<br>*Quality Assurance statement of qualification* | |
| I make the following statement that prior to my involvement with this learning review:-<br>• I have not been directly concerned with the individual or family, or have given professional advice on the case<br>• I have had no immediate line management of the practitioner(s) involved.<br>• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review<br>• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference | | I make the following statement that prior to my involvement with this learning review:-<br>• I have not been directly concerned with the individual or family, or have given professional advice on the case<br>• I have had no immediate line management of the practitioner(s) involved.<br>• I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review<br>• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference | |
| **Reviewer 1** *(Signature)*  | | **Reviewer 2** *(Signature)*  | |
| **Name** *(Print)* | Jane Foulner…… | **Name** *(Print)* | Lorna Price…… |
| **Date** | June 2019 | **Date** | June 2019 |

| | |
|---|---|
| *Chair of Review Panel (Signature)*  | |
| **Name** *(Print)* | Andrew Cole……. |
| **Date** | June 2019 |

**Appendix 1**: Terms of reference
**Appendix 2:** Summary timeline

| **Adult Practice Review process**<br><br>*To include here in brief:*<br>• *The process followed by the SAB and the services represented on the Review Panel*<br>• *A learning event was held and the services that attended*<br>• *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.* |
|---|
| An Adult Practice Review Panel was established on 25/05/2018, chaired by Andy Cole, Operational Manager at the Vale of Glamorgan County Council. The reviewers were Dr Lorna Price, Designated Doctor, National Safeguarding Team, NHS Wales (Public Health Wales) and Jane Foulner, Senior Probation Officer, Cardiff.<br><br>The Panel consisted of representatives from South Wales Police, Welsh Ambulance Services NHS Trust, Adult Social Services, Adult Safeguarding, Cardiff and Vale University Health Board, Cardiff Council Occupational Therapy, Community Rehabilitation Company, Cardiff Housing and Commissioned Care Service.<br><br>A Learning Event was held on 24th October, 2018 and was attended by members of staff from South Wales Police, Welsh Ambulance Services, Adult Social Services, Adult Safeguarding, Cardiff and Vale University Health Board, Cardiff Council Occupational Therapy, Community Rehabilitation Company, Cardiff Housing and Commissioned Care Service. Unfortunately, the home care providers were not able to attend for the whole learning event and one of the social workers with key involvement in the case was unavailable. The practitioners who attended the learning event are commended for their open and honest contributions.<br><br>The reviewers did not meet with family members as one did not respond to a proposed meeting and another declined the invitation. |
| x☐ Family declined involvement |

**For Welsh Government use only**

Date information received ……..

Date acknowledgment letter sent to SAB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

| Agencies | Yes | No | Reason |
|---|---|---|---|
| CSSIW | ☐ | ☐ | |
| Estyn | ☐ | ☐ | |
| HIW | ☐ | ☐ | |
| HMI Constabulary | ☐ | ☐ | |
| HMI Probation | ☐ | ☐ | |

**Appendix 1**

**Cardiff & Vale of Glamorgan Regional Safeguarding Board**

# Terms of Reference for an Adult Practice Review (Extended) Exemplar

# Re: APR 2/2017

## Introduction

An extended adult practice review will be commissioned by the Regional Safeguarding Adults Board (RSAB) in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 3. An extended adult practice review will be commissioned where an adult at risk has, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health.

## Terms of Reference

The terms of reference agreed for this review are:

- The timeframe for the review will be **1st October 2016 – 30th April 2017.**

- The following services will produce a timeline of significant events of its involvement with the Adult, for the timeframe above. A merged timeline will then be produced.

  - South Wales Police
  - Cardiff Adult Services
  - Cardiff Adult Safeguarding
  - Cardiff & Vale University Health Board (*District Nursing/GP/GP Out-of-hours)*
  - Welsh Ambulance Service NHS Trust
  - Cardiff Occupational Therapy
  - Commissioned Care Service
  - Community Rehabilitation Company (Wales)
  - Cardiff Housing

**Core Tasks (for a concise/extended adult practice review *(delete as appropriate)***

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.

- Examine inter-agency working and service provision for the individual and family.

- Determine the extent to which decisions and actions were individual focused.

- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.

- Take account of any parallel investigations or proceedings related to the case.

- Hold a learning event for practitioners and identify required resources.

**For Extended review ONLY. In addition to the review process, to have particular regard to the following:**

- Whether previous relevant information or history about the adult at risk and/or family members was known and taken into account in professionals' assessment, planning and decision-making in respect of the adult at risk, the family and their circumstances. How that knowledge contributed to the outcome for the adult at risk.

- Whether the actions identified to safeguard the adult at risk were robust, and appropriate for that adult and their circumstances.

- Whether the actions were implemented effectively, monitored and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.

- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the adult at risk. Whether the protocol for professional disagreement was invoked.

- Whether the respective statutory duties of agencies working with the adult at risk and family were fulfilled.

- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

**Specific tasks of the Review Panel**

- Identify and commission a reviewer/s to work with the *Review Panel* in accordance with guidance for concise and extended reviews.

- Agree the time frame.

- Identify agencies, relevant services and professionals to contribute to the review not already requested by the CPR/APR Sub Group, produce a timeline and an initial case summary and identify any immediate action already taken.

- Produce a merged timeline, initial analysis and hypotheses.

- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.

- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.

- Receive and consider the draft adult practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.

- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to RSAB for consideration and agreement.

- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

**Tasks of the Regional Safeguarding Adults Board (RSAB)**

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.

- *Review panel* completes the report and action plan.

- RSAB send Report and Action Plan to relevant agencies for final comment before sign-off and submission to Welsh Government.

- Confirm arrangements for the management of the multi-agency action plan by the CPR/APR Sub-Group, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on RSAB website.

- Agree dissemination to agencies, relevant services and professionals.

- The Chair of the RSAB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

**Appendix 2**

## APR 02/2017 Summary Timeline

| Date | October 2016 | November 2016 | December 2016 | |
|---|---|---|---|---|
| **Event** | Commissioned Care Provider informed Adult Social Care that the carer was not administering medication to Adult A at the prescribed time. | Commissioned Care Provider contacted Adult Social Care requesting feedback. | Commissioned Care Provider made a referral to Adult Social Care with concerns about poor home conditions, electricity regularly being off (so no light or hot water to wash Adult A), large groups of men using drugs at the property and aggressive behaviour from the carer and another family member. | One week later Commissioned Care Provider made an Adult Safeguarding referral following a disclosure by Adult A that her carer had assaulted her by slapping her face. Red mark visible. |

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| **Outcome** | | A Social Worker was allocated and made a home visit to resolve the medication issues. | Social Worker visited Adult A who said there were no issues. Since Adult A was deemed to have capacity no further action was taken at this time. | Social Worker met with carer and Commissioned Care Provider at the property 2 days later. Adult A retracted the disclosure. She was deemed to have full capacity and no further action was taken. |

| Date | January 2017 | February 2017 | | March 2017 | | |
|---|---|---|---|---|---|---|
| **Event** | Police called to Adult A's home as there was an altercation between her carer and a female family member who alleged that the carer had grabbed her by the throat. | Further police call out to Adult A's home following an argument between her carer and the same female family member. | Eleven days later there was a further police call out to Adult A's home following a violent argument between her carer and the same female family member. | Telephone call from Commissioned Care Provider to Adult Social Care to express concerns about Adult A's wellbeing. Her carer is not coping and respite care is needed. | Police were again called out to an argument between Adult A's carer and the same female family member. | Adult A's carer called 999 requesting an ambulance. He was concerned that she was not eating and drinking and that she had become delirious. |
| **Outcome** | Enquiries by police revealed the incident was not as first reported. A PPN was submitted which made reference to Adult A but did not include her full details. | A PPN was submitted which made reference to Adult A but did not include her full details. | PPN submitted but no mention of Adult A was included. | One week later the social worker arranged a joint visit with the care provider. Adult A and her carer agreed to respite care. | Adult A's full details were included on the PPN but the PPN was not shared with adult services. | Adult A was assessed by a paramedic. Decision made by the paramedic for Adult A to remain at home |

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| | | | | | | after a discussion with the GP working at the GP Out-of-Hours. GP advised that the family should contact their own GP. |

| Date | 6 April 2017 | 8 April 2017 | 10 April 2017 | 24 April 2017 |
|---|---|---|---|---|
| **Event** | Carers attend Adult A and note some unexplained injuries; bruising to right side of face, left wrist and right arm/shoulder. She is in significant pain. GP visit requested. Adult safeguarding referral sent regarding suspected abuse. | Adult A is deemed medically fit for discharge from hospital. | Adult Safeguarding ask Hospital Social Work team to 'make enquiries' regarding alleged abuse i.e. to establish Adult A's views and wishes and her capacity to understand risk and make a complaint to police. Safeguarding referral deferred for 7 days pending the | Adult A becomes unwell. She has a chest infection and antibiotics are commenced. |

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| | | | outcome of these enquiries. Two days later the Hospital Social Worker visited Adult A and found her reluctant to discuss how she sustained her injuries. | |
| **Outcome** | GP visits and arranges transfer to hospital by ambulance with a possible broken hip. Adult A appeared dehydrated, and was reported to be losing weight and not eating or drinking. She was becoming increasingly confused. Adult A is assessed in the Emergency Department and admitted to the ward. | Two days earlier Adult Social Care had requested that the ward facilitate safe discharge to a respite placement. | Two weeks later it is recorded that the Hospital Social Worker is to arrange a safe discharge planning meeting to include the commissioned care provider and the GP. | Adult A develops a hospital acquired pneumonia and dies six days later (three days after the decision to hold a safe discharge planning meeting). |