NHS
East Suffolk and North Essex
NHS Foundation Trust

Useful Numbers 07

Colchester Hospital
Safeguarding Adults - 07768 560533
Safeguarding Children
Dementia - 07932 662598
Learning Disabilities -07774 889067
Complex Health - 07394 401150

Ipswich Hospital
Safeguarding Adults -07506 056963
Safeguarding Children -
Dementia - 07864 970725
Learning Disabilities - 07539 323041
Complex Health - 07394 401150

Suffolk Community
Safeguarding Adults - 07940 472222

Partnership Review 01

Suffolk Safeguarding Partnership have conducted a partnership review for TL a 63 year old gentleman who was discharged from ESNEFT in January 2019. The partnership review highlighted a gap in discharge planning. Staff were aware that TL lived in sheltered accommodation however, this had not been meeting his needs since the wardens were withdrawn from the accommodation.

Safeguarding and Discharge 02

Discharge from hospital can become a safeguarding issue if a patient who has care and support needs suffers harm form a lack of robust discharge planning. A thematic review of Safeguarding Adult Reviews (SAR's) (2017-19) showed 16% of SAR's featured poor discharge.

What do we need to consider? 03

Making safeguarding personal is key. It is important to establish what the patient wants to happen on discharge.
You may need to consider a mental capacity assessment around decisions relating to discharge. If the patient does not have capacity to make decisions around their discharge you will need to follow the best interest decision making process.

Questions to ask yourself? 04

- If a safeguarding referral has been submitted do we know the outcome?
- Is the patient able to manage at home in their current condition? If not what additional support do they need?
- What sort of accommodation is the patient returning too? Ask them about it don't make assumptions it may not be what you think.
- What other agencies are working with the patient? Do they know the patient is returning home? Are they able to provide the level of support to meet the patients current need?
- Does the patient have a social network who need to be involved in discharge planning ?

Communication in safe discharge 05

The thematic review of SAR's highlighted an over reliance on discharge summaries for communicating to other health partners however, they only usually contain details of the patients medical condition and do not tend to provide a social context such as care needs, presentation, support networks, isolation status etc.
Speak to those who will be looking after patient. Think about who needs to know what and what is the best way of sharing this information.

A multiagency approach to discharge planning 06

Transitions in care are often risky, particularly for people with care and support needs. Shorter hospital stays mean that patients can go home with ongoing care needs. When patients have complex discharge needs or when there are complex safeguarding concerns such as self negelct or hoarding we should consider if a multiagency discharge planning meeting would aide a safe discharge.

Discharge planning meeting can be quick and effective ways of establishing a safety plan for safe discharge. If you have a discharge planning meeting invite the patient, all key agencies and those who provide informal support. Remember to write up the safety plan from the meeting and share this to all those invited, even if they are unable to attend.

Mr TL Case Study – Self-Neglect

Mr. TL had one brother and one sister and is described by his family as preferring to keep his own company and going about his own business. He was not a person inclined to seek out friendships, however when minded to, Mr. TL would happily converse on topics of interest and was a keen motorbike and car enthusiast.

As a young man Mr. TL lived with his parents and worked at a garden centre as a Nurseryman. Whilst employed he was quite outgoing and sociable; however, this came to an abrupt end following a serious motorbike accident which left him with life-long injuries, combined with the loss of his mother Mr. TL rapidly became withdrawn and solitary.

Following the death of his father, over a period of years Mr. TL had difficulties looking after himself and often neglected his personal care and general physical health. He maintained his interest in motorbikes and cars and would purchase topical magazines and other general information on the subject. This interest often extended to Mr. TL purchasing cars and motorbikes through loans which was unrealistic given his physical disability and financial status. The family home became neglected and unkempt which often required a 'deep clean' and 'sort out' with help from his brother and sister-in law who lived close by.

Despite their efforts Mr. TL continued to assert intentions to keep his home clean, supported by his efforts in buying multiple cleaning products, including a new hoover and rental of a new washing machine; however, all remained untouched and unused as his home became more unsanitary. Over the years Mr. TL purchased a number of cars and motorbikes, other electrical goods and IT equipment, all of which remained unused.

Mr. TL's 'low mood' continued to be a concern as his physical health deteriorated further, combined with financial debt including bankruptcy his living conditions became very difficult, therefore with his agreement the family worked with Mr. TL to find a residential home where he was supported by staff, made friends and his health was notably improved, with family believing he was happy there.

Mr. TL later moved from the residential home to independent living at his own choice. Whilst living in independently Mr. TL's personal hygiene deteriorated, displaying previous intentional shopping habits of buying cleaning products and such like. In addition, Mr. TL had entered into a number of financial agreements including a rental of a garage with ambition to buy a motorbike. Although the family were always respectful of Mr. TL's liberty to live an independent and private life, it was of great sadness and frustration that key information about Mr. TL was not passed on to his family, nor in a timely way (including when he was taken into hospital when he broke his arm and importantly that he had moved from the residential home to independent living).

Following Mr. TL's sad death, the family feel this may have been prevented had statutory services been in place to better support Mr. TL.

What is the learning from this case?

- Enough professional curiosity was not shown around Mr. TL's lack of support networks
- When support was withdrawn, there was no follow up to ensure Mr. TL's care needs could effectively be met in a way that he wanted
- Finance forms became a barrier to Mr. TL accessing services
- Options for mental health support not explored with Mr. TL
- Lack of professional join up and co-ordination between agencies involved in Mr.TL's life
- Hospital discharge care planning not effective (following broken arm)