Safeguarding Adult Review (SAR) 'Josephine' 7 Minute Briefing

Who was Josephine?

Josephine was a 90-year-old White British woman who live alone. She was registered blind, bedbound and unable to mobilise independently, requiring full support with care. She had previously been independent and valued her autonomy. Josephine had two sons, grandchildren and extended family. Josephine died in April 2024, with causes including acute kidney injury, infection, and frailty.

Josephine's Experiences

Josephine was admitted to hospital following a fall and experienced multiple transfers between hospital and rehabilitation settings. Prior to discharge, she was assessed as having capacity and chose to return home with a package of care, despite family concerns. She was discharged from hospital with complex care needs, including double-handed care, equipment and medication. Josephine experienced 48 hours without care due to agencies being unable to access her home.

Key Findings

Poor discharge planning and coordination across hospital and community services.

Breakdown in communication between agencies, including inaccurate or incomplete information sharing.

Failure to ensure access to the property resulting in missed care visits.

Lack of clarity about roles and responsibilities in the discharge process.

Information gaps including End-of-life status not clearly communicated and medication details not shared with GP.

Missed opportunities for escalation including delayed safeguarding responses and inconsistent triage.

Lack of multi-agency working around high-risk discharge cases.

Learning and Implementation

Discharge planning must be person-centred, coordinated and fully risk-assessed, especially in complex cases.

Accurate and timely information sharing is critical across all professionals including care plans and medication.

Practical arrangements (e.g. access to property) are essential for safe discharge.

Agencies must ensure clear escalation pathways and professional curiosity when care is not delivered as expected.

Cross-agency understanding of roles is vital to avoid assumptions and gaps in care.

Early, proactive multi-agency collaboration and multi disciplinary team working is key to safe discharge.

Systems must support visibility of key information, including key safe codes and referrals.

Recommendations

Strengthen adherence to discharge policies across all partner agencies.

Undertake multi-agency audits of discharge practice to ensure compliance and identify learning.

Improve documentation, recording and communication of property access details, including key safe codes.

Deliver a multi-agency workshops for learning and reflection.

Establish stronger governance and assurance arrangements for discharge processes.

Challenges

Complex multi-agency involvement and inconsistent understanding of discharge processes across organisations.

System and documentation issues leading to fragmented information sharing. Communication issues between hospital, social care and care providers.

Difficulty ensuring timely escalation of risk and safeguarding concerns.

Challenges in ensuring property access and practical discharge arrangements.

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