Barking & Dagenham Safeguarding Adults Board

Safeguarding Adult Review (SAR) 'Josephine'

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Contents

Glossary of Terms

BHRUT	Barking, Havering and Redbridge University Hospitals Trust
CGL	Change, Grow, Live (drug and alcohol services)
CHAT	Community Hospital Assessment Team
GP	General Practitioner
IDH	Integrated Discharge Hub
IRB	Inpatient Rehabilitation Bed
LBBD	London Borough of Barking and Dagenham
NELFT	North East London NHS Foundation Trust
NOK	Next of Kin
POC	Package of Care
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review

1. Introduction

Barking and Dagenham Safeguarding Adults Board (SAB) is publishing this report into the review of Josephine who was 90 years when she sadly died on 23rd April 2024. A Post Mortem examination was undertaken and her cause of death was:

1a) Acute kidney injury
1b) Pyelonephritis
II) Hypertension, pneumonia, frailty of old age.

This report sets out the review, findings and learning for the Safeguarding Adult Review (SAR) Josephine and has been agreed and endorsed by the Barking and Dagenham Safeguarding Adult Board.

Josephine's two sons have been contacted via letter to explain the process of a Safeguarding Adult Review and given the opportunity to be involved and make comment on the review, however they have not been in contact.

Further information about SARs and published reports can be found on the Barking and Dagenham Safeguarding Adult Board (BDSAB) website at this link https://www.lbbd.gov.uk/adult-health-and-social-care/barking-and-dagenham-safeguarding-adults-board/safeguarding-adult

2. Safeguarding Adult Reviews (SARs) and the Care Act 2014

Section 44 of the Care Act 2014 stipulates that Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area with care and support needs dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult with care and support needs, in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The criteria for a Safeguarding Adult Review are met when:

- an adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death, or
- an adult has sustained a potentially life-threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect.

And one of the following:

- Where procedures may have failed and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk.
- Serious or apparently systematic abuse that takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale and may require more time.
- Where circumstances give rise to serious public concern or adverse media interest in relation to an adult at risk.

The purpose of conducting a review is to enable members of the SAB to:

- Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard adults at risk.
- Review the effectiveness of procedures and their application (both multi-agency and those of organisations).
- Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.
- Bring together and analyse the findings of the various reports from agencies in order to make recommendations for future action.

A referral was made to the Barking and Dagenham One Panel and on the 23rd January 2025 the panel agreed that the case of Josephine meets the criteria for a Safeguarding Adult Review due to evidence of neglect, multiple agencies being involved and clear opportunities for learning for partners around hospital discharge. The SAB Independent Chair endorsed this decision.

3. Safeguarding Adult Review Methodology

In 2024, a number of cases were referred to the Havering SAB with hospital discharge as a theme. The Havering SAB, in partnership with NELFT and BHRUT undertook a thematic review which they kindly shared with the Barking and Dagenham SAB. BHRUT and NELFT also shared the work they had undertaken to address the learning. This work has been identified by NHS England as good practice and is being replicated in other regions.

Given the extensive work, analysis and learning developed from this thematic review it was agreed by the Barking and Dagenham SAR Panel that we would build on this work rather than repeat it.

Contributing agencies in this review were:

- Barking, Havering and Redbridge University Hospitals Trust (BHRUT)
- North East London NHS Foundation Trust (NELFT)
- London Borough of Barking and Dagenham (LBBD) Adult Social Care
- The care agency
- Havering Safeguarding Adults Board

Following the Havering thematic SAR, representatives from the Barking and Dagenham SAB were invited to partake in a multi-agency assurance meeting, held on 24th September 2025. At this meeting all agencies, including BHRUT and NELFT shared the learning and changes that have been made within practice, processes and systems to address the issues around hospital discharge. This learning and feedback has been incorporated into this report.

A review learning meeting was held with professionals involved on Tuesday 14th October 2025 to discuss the findings and learning and to gather any further views. A meeting was held with the BHRUT Discharge Working Group Team on Wednesday 20th May 2026 to discuss the finding and recommendations. The final report was shared with the SAR Panel in June and presented and signed off for publishing by the Safeguarding Adults Board on the 22nd July.

4. Historical Multi Agency Learning Identified

The previous learning from various Safeguarding Adult Reviews can be themed under different areas and are relevant to the issues identified in this review and also in relation to hospital discharge in general.

Discharge Themes	Issues Identified	Work Already Undertaken	References
Discharge relating to mental health services	Cared by Psychiatric Liaison Services to be discharged	Review of processes with Queens Hospital, substance misuse services and mental health in-patient services. Audit of NELFT discharges Learning event on supporting people with drug and alcohol use. Drug and Alcohol awareness training for partners CGL use of Alcohol Screening Tool	SAR Kasey (Havering) SAR RW (Havering) SAR Jack (Barking & Dagenham)
Discharges from Hospital	Lack of discharge planning meetings and/or did not include the relevant agencies Lack of communication and referrals to district nurses for insulin management District nursing referrals not received Discharge without evidence of notification to the care agency of the patients discharge	Monthly meetings, with the NELFT and Patient Safety Practitioner Safeguarding Level 3 training updated around pressure ulcers, pressure ulcer e-learning Processes tightened around communication between BHRUT and DN Team (emails) MDTs for complex cases, MDT ward rounds twice daily Discharge alert reports Revised Section 42 review system	SAR William (Barking & Dagenham) SAR SL (Havering) Section 42s analysis Discharge alerts

	Discharge to care homes with a lack of clarity of the patients' needs Lack of equipment to be safely discharged Discharge alerts for the wrong hospital Discharge without or inappropriate medication Discharge communication for key safe Comms with District Nurses around pressure ulcers Self neglect, planning around food, heating, utilities Discharge despite concerns around care provider Sharing of information with care provider around medication Sharing of information with GP around medication	NELFT participate in monthly Integrated Discharge Hub meeting Meeting of senior leaders Feb 2024 to discuss concerns BHRUT, NELFT, Havering ASC, NEL ICB, pharmacies, St Francis Hospice, Havering Housing, care homes. Practitioner event June and follow up September 2024 Joint discharge learning event with NELFT SARs, CSPR & DHRs shared at BHRUT Safeguarding Operations & Strategic Assurance Groups Use of Discharge Medication Service (DMS) by pharmacies to check prescribed medication and that patient understands how to take it	

5. Overview of the Circumstances Leading to the Review

Josephine was 90 years old when she died. She was a White British, female who was born in Hornchurch and married for over 50 years until her husband sadly passed way. She had two sons, five grandchildren and great grandchildren. Prior to her retirement Josephine worked in a factory that made records. Josephine had a sense of independence and like to do things for herself where possible. At the time of her death, she lived on her own, was registered blind, was cared for in bed and unable to mobilise herself. Due to the limited collateral information about Josephine's life, we are unable to provide further details. Family members were invited to contribute to this review but to date, there has been no response.

Timeline

Below is a timeline that sets out the key events leading to Josephine's death. For a full chronology please see appendix 1.

Date	Timeline
8th February 2024	Josephine attended King George Hospital (KGH) Emergency Department following a fall at home.
29th February 2024	Josephine was transferred to Meadow Court Rehabilitation unit where she received treatment.
11th March 2024	Josephine was transferred to King George Hospital Emergency Department from Meadow Court Rehabilitation unit due to shortness of breath, a cough and raised infection markers.
12th March 2024	Josephine was admitted to a hospital ward.
12th March to 15th April 2024	Josephine received medical treatment in hospital.
10/11th April 2024	Preparations had begun for Josephine's discharge from hospital. There was confirmation that furniture has been moved in Josephine's home to allow for the delivery of equipment such as a hospital bed, pressure care mattress, bed rails, bed bumpers and slide sheets. A key safe was also installed.
15th April 2024	Josephine was discharged from hospital with medication and package of care in place starting with a teatime call on the 15th. Carers visited the property for the teatime call. They knocked on the door and waited but no one came to the door. No instruction was provided regarding access or the key safe. The care agency was unable to reach the next of kin on the phone. Carers visited the property to complete the bedtime visit. Carers knocked on the door and had no response. Carers were unable to access the property and were unable to contact the next of kin.

16th April 2024	Carers visited the property three times to complete the morning, lunch and teatime visits. They knocked on door and were unable to access the property and were unable to reach next of kin as the phone number supplied was incorrect. The care agency called the hospital ward but could get no response. They also called the King George Emergency Department and were advised incorrectly, that Josephine was still in hospital. The package of care was put on hold.
17th April 2024	The care agency notified the Intake Team and the allocated social worker that Josephine was still in hospital and the package of care had been placed on hold. The Integrated Therapies department confirmed in an email that Josephine was discharged on 15th. The care agency were asked to send carers urgently and use the key safe to enter property. The care technology company were contacted to see if the emergency alarm system would permit them to talk to Josephine through the device, however this was not possible. Carers arrived and undertook personal care (washing and dressing), meal preparation, medication and ensured that Josephine was comfortable.
18th April 2024	A referral was received from the care agency requesting an assessment as Josephine had been discharged with end of life medication.
19th April 2024	A safeguarding concern was raised by Adult Social Care in respect of the discharge home and missed care and support. The care agency also raised a safeguarding concern with the London Borough of Barking and Dagenham and London Borough of Redbridge Social Services as advised by the Social Worker for London Borough of Barking and Dagenham, due to the reported concerns of bruises. An email was sent to the hospital integrated discharge hub requesting that an updated discharge medication list be sent to the GP.
22nd April 2024	A District Nurse attempted to visit Josephine but could not access the property and managed to speak to her through the window. The carers were not present. The District Nurse left a note for the carer's asking them to share the key safe code. Adult Social Care were informed by the care agency that Josephine was not eating.

	The Intake Team and allocated social worker were notified that the GP contacted the care agency and advised that the teatime carers should call an ambulance to take Josephine back to hospital. Paramedics declined attendance advising that there was no noted emergency. Carers contacted NHS 111 and they sent out a clinician to visit Josephine at home.
23rd April 2024	Josephine was due for blood transfusion at hospital but on the arrival of the ambulance to take her she was found deceased in her home.

Summary of Circumstances Leading to Josephine's Death

On 11th March 2024 Josephine was transferred from Meadow Court Rehabilitation unit, where she had been staying and receiving treatment, to King George Hospital Emergency Department. This was due to shortness of breath, a cough and raised infection markers. On 12th March Josephine was admitted to a ward where she spent a few weeks receiving medical treatment.

Around the 8th April preparations started for Josephine's discharge home from hospital. On the 10th April there was confirmation that furniture has been moved in Josephine's home to allow for the delivery of equipment such as a hospital bed, pressure care mattress, bed rails, bed bumpers and slide sheets. A key safe was also installed.

A referral alert was received from the Integrated Discharge Hub (IDH) via a case note, and documents were uploaded of the occupational therapist recommendations for discharge from the hospital. A referral was made to the Community Hospital Assessment Team (CHAT) for a double handed care plan stating that Josephine was to be cared for in bed. A care plan for four calls of double handed care per day, was initiated.

When Josephine was ready for discharge, the IDH informed the CHAT. Initially, Josephine's son requested consideration for residential care home upon discharge. Josephine was deemed to have mental capacity to make her owns decisions about where she would like to reside and she stated her preference to return to her own home with a care package in place. Josephine had not had carer support prior to this and was previously independent.

The CHAT Team made a referral to the Independent Living Agency (ILA) to assist in moving furniture at Josephine's home ready for her discharge. The hospital arranged the delivery of a hospital bed, pressure care mattress, bed rails, bed bumpers, slide sheets and installation of a key safe.

On the 9th April the CHAT sent an email to the hospital discharge team to confirm that Josephine's furniture at home had been moved to accommodate the equipment and to confirm that the care agency was commissioned to provide the care package. The hospital was to inform CHAT when Josephine was ready for discharge.

On the 15th April Josephine was discharged from hospital. Staff from the hospital ward called the care agency to start the care package. Carers attended for the teatime and bedtime call and knocked but no one answered. They could not enter the property and were not aware of the key safe. They called the next of kin's phone number but got no answer.

On the 16th April carers visited the property three times to complete the morning, lunch and teatime visits. They knocked on the door and no one answered. They were unable to access the property and were unable to reach next of kin as the phone number supplied was wrong. The care agency called the hospital ward but could get no response. They also called the King George Emergency Department and was advised incorrectly, that Josephine was still in hospital. The package of care was put on hold. This meant that Josephine did not receive care for a 48-hour period.

Also, on the 16th April, a Social Work attempted a welfare call to Josephine but could get no answer. The care agency informed the CHAT that they had attended on the evening of 15th and 16th April. It was not made clear at this point that the care agency had failed to access the home. It later transpired on the 17th that they had not entered the property and provide care for Josephine.

On the 17th April the care agency emailed the LBBD Intake Team stating that Josephine was still in hospital and the package of care had been put on hold. The CHAT team checked with the hospital, confirming Josephine's discharge on the 15th. Contact was made with the care agency manager immediately with instruction that the carers use the key safe to enter the property. The care agency were given the key safe code over the phone. The CHAT contacted Josephine's son to discuss the concern, and he stated he had not been informed by the hospital that his mother had been discharged home on the 15th. The CHAT team requested Alcove, who are the care technology provider, to use the telecare system to talk to talk to Josephine, but they were unable to as the equipment could not carry out this function. The care manager confirmed that carers were on site on and ensuring Josephine was dressed and had food and fluids that she was awake and conversational.

On the 19th April a safeguarding concern was raised by LBBD Adult Social Care in respect of Josephine's discharge home and the missed care and support. The threshold for a Section 42 safeguarding enquiry was not met. The care agency also raised a safeguarding concern with the LBBD and London Borough of Redbridge (LBR) Social Services as advised by the Social Worker, due to the reported concerns of bruises.

The care agency said that there were end of life medications in Josephine's hospital prescriptions, but this was not recorded on the discharge information and this information was not communicated to Josephine's GP. An email was sent to the IDH requesting an updated discharge medication list to be sent to the GP.

On the 22nd April the care agency informed the CHAT that Josephine was declining food. It was later learnt from hospital records that Josephine was also not eating or drinking prior to her discharge from hospital. A District Nurse attempted to visit Josephine but could not access the property and managed to speak to her through the window. The carers were not present. The District Nurse left a note for the carer's asking them to share the key safe code. The Intake Team and allocated social worker were notified that the GP contacted the care agency and advised that the teatime carers should call an ambulance to take Josephine back to hospital. Paramedics declined attendance advising that there was no noted emergency. Carers contacted NHS 111 and they sent out a clinician to visit Josephine at home.

On the 23rd April Josephine was due for blood transfusion at hospital but on the arrival of the ambulance to transport her, she was found deceased in her home.

During a meeting with the Coroner and hospital representatives following Josephine death, they discussed that Josephine had had a period in Inpatient Rehabilitation Bed (IRB) but was moved to a ward due to being unwell. The referral that the CHAT received from the hospital did not include information about Josephine's journey through hospital and some key information was missing. The hospital also confirmed that she was discharged with end-of-life medications.

6. Learning Identified and Implemented

The following learning areas have been identified, and work has been implemented across the BHR footprint to address these.

Learning Theme	Actions and Outcomes
Improve Understanding of Cross Agency Discharge Processes	**NELFT** Care agency and next of kin (NOK) details are clearly documented and checked on RIO at the point of triage for communication purpose. If the patient cannot or has difficulty communicating when contacted, nurses would discuss with the NOK. Senior Nurses undertake triage of referrals. The lead patient safety specialist in NELFT facilitates a bi-monthly NELFT & BHRUT peer group, for frontline clinicians. We explore together safety issues relating to discharges/transfers of care and the work is underpinned by the ethos of developing trusted working relationships between clinicians-to know each others' roles and remits more clearly.
	BHRUT BHR wide Discharge Improvement Working Group in place to address active issues chaired by Director of Adult Social Care in Havering and by Integrated Care Board (ICB). Development of a discharge alerts dashboard for discharges where issues are identified, allowing themes and trends to be analysed. At present this is at the early stages of development. The data will be shared with senior nurses for learning. The new Electronic Patient Record System has been rolled out across BHRUT. This means information is more centrally located and staff have access to East London Care Records. Daily multi-agency conference calls with Local Authority, NELFT and ICB partners to address challenges with delays and initiate escalations where required. Hospital length of stay reviews are taking place for patients that have been in hospital over 70 days. Dashboard with trends will be developed and shared with Senior Management Team. Themes are shared with the Discharge Improvement Working Group to look at how blockages can be resolved.

	Discharge assessments are taking place at an earlier stage, including the principles of Making Safeguarding Personal (MSP) ensuring the voice of service users and carers are included in the discharge planning. The BHRUT Hospital Discharge Team support wards by reviewing Discharge to Assess paperwork where referrals have been deferred or declined. Networking opportunities at NELFT and BHRUT have improved joint working to address safeguarding issues and has enabled better communication, pathways and contact points for early escalations.
	LBBD Review of the complex case discharge process has been undertaken to ensure all the necessary requirements for discharge are in place. A review of the care plan format is being undertaken to ensure that all key information relating to the safe delivery of care to the adult is visible and shared with care providers. Additional checks are now being undertaken to ensure the accuracy of key information held on client records i.e. next of kin emergency contact names/numbers.
Key Safe Processes	Additional checks have been introduced to ensure that care providers have property key safe codes. This includes where hospital therapists have arranged for installation of key safes. Key safe provider now provides prompts in their communications to the referrer to remind them to inform care agencies and the Community Hospital Assessment Team (CHAT) if and when the key safe is in place. This is to ensure that this information is communicated to all organisations even if they are not involved in the process prior to the discharge.
System Wide Learning	Patient Safety Summit undertaken on 4th December, hosted by BHRUT with speakers including a NELFT consultant psychologist to share learning and drive cultural and procedural improvements. NELFT follow the PSIRF framework which promotes cross-system learning as part of patient safety improvement. A Swarm Huddle learning review was undertaken which led to an enhanced structured triage process regarding timeliness of visits. BHRUT have presented at the Barking and Dagenham Care Providers Forum to share improvement to discharge processes,
Serious Incident Escalation Processes	Review of serious incident and safeguarding escalation processes within LBBD has taken place to ensure appropriate escalation of cases for discussion and review.

7. Emerging Issues

During discussions around hospital discharge processes the following issues were raised and noted.

- Consider how the Discharge To Assess process currently operates across the Barking, Havering and Redbridge footprint, and how this impacts on a patient's discharge from hospital.
- For BHRUT and NELFT to continue to develop communication points between the hospital and district nursing service to ensure better communication around referrals. For example, in-reach district nurses being accessible and known at the ward level. Where there are issues these will be addressed at the BHRUT and NELFT Group meetings.

8. Recommendations

Theme / Learning Area	SMART Objective	Specific Actions	Lead Organisations	Evidence / Measure of Impact
Information & Guidance: Hospital discharge practice	By July 2026 ensure all professionals involved in hospital discharge across BHRUT, NELFT and LBBD are aware of and adhere to the current BHRUT Discharge Policy and Procedure.	Re-circulate current BHRUT Discharge Policy and Procedure. Confirm receipt and access across teams.	Discharge Improvement Working Group (BHRUT lead)	Evidence of dissemination and confirmation of sharing across all partners and services. Policy accessible on shared systems. Feedback findings and impact to the BDSAB Board or Learning from Practice group.
Information & Guidance: Assurance of adherence	By September 2026 obtain assurance that discharge practice aligns with policy requirements.	Complete a multi-agency sample audit of discharge cases. Identify learning and improvements.	Discharge Improvement Working Group BDSAB	Audit report with learning shared with partners. Feedback findings and impact to the BDSAB Board or Learning from Practice group.
Systems & Documentation: Property accessibility	By September 2026 improve processes to ensure property accessibility information is consistently captured and shared.	Review current discharge documentation and systems to check key safe numbers and key safe location is being communicated clearly.	LBBD, BHRUT, NELFT and Care Agencies BDSAB	Evidence of implementation and compliance. Feedback impact to the BDSAB and Learning from Practice group.
Dissemination of Learning & Assurance	By July 2026 embed learning from this review across partner organisations.	Develop a learning briefing with links to relevant Policies and Procedures by July 2026. Deliver multi-agency reflective learning workshop by October 2026.	BDSAB NELFT & BHRUT BDSAB	Learning briefing created and disseminated to partners. Workshop delivered with attendance recorded. Feedback findings and impact to the BDSAB Board or Learning from Practice group. Review actions and learning via an assurance meeting after one year.

9. Appendix 1 – Combined Chronology of Events

Date	Time	Organisation	Events	Issues/Concerns	Learning points
08/04/2024	13:24	BHRUT and LBBD	Email from Barking and Dagenham Council Team Manager, confirming that someone from ILA (Independent Living Agency) is to attend the ward ard tomorrow (09 April 2024) to collect the keys from the patient so that they can access her property for the micro-environment set up quote.		
09/04/2024		BHRUT	Keys are collected from the ward by ILA		
09/04/2024	12:44	BHRUT and LBBD	Email from Barking and Dagenham Council Consultant Social Worker that ILA are supporting the furniture move today		
09/04/2024	15:58	BHRUT and LBBD	Email from Barking and Dagenham Council Consultant Social Worker confirming that the ILA will complete the furniture move and that they have agreed with the care agency that they have been sourced for care plan provisions. The Consultant Social Worker asked to be informed when the equipment was in place and when the patient was ready for discharge the ward staff were requested to contact the care agency by telephone in 0208 5026660 for discharge confirmation so they can start the care package.		

10/04/2024	12:27	BHRUT and LBBD	Email from Barking and Dagenham Council Equipment and Adaptions Team to Tilbury Contracts (key safe provider) asking to fit a key safe, BHRUT ward staff copied into email. Key safe code stated to be: 1472		
10/04/24		BHRUT to LBBD	Key safe requested by Odessa Sales KGH OT. Sent to Tilbury Contracts for installation.		Process is that once a request is made, when job is sent to contractor the referrer is copied in with key safe number included in email
10/04/2024	12:51	BHRUT and LBBD	Email from Barking and Dagenham Council Consultant Social Worker to the ILA asking if the furniture has been moved and the hospital can send the equipment in.		
10/04/2024	13:25	BHRUT and LBBD	Email from ILA confirming that all furniture had been removed and placed in another room. ILA advised that a picture of the room had been taken and shown to the physio team, and they are happy with the space to accommodate the bed, photo attached.		
10/04/2024	14:06	BHRUT and LBBD	Email from Barking and Dagenham Council Consultant Social Worker to the Trust confirming that the room is ready for the equipment to be delivered, photo attached		
10/04/2024	16:12	BHRUT and LBBD	Confirmation that Key safe has been installed by external company		Confirmation to social care and referrer sent by email
12/04/2024	09:56	BHRUT	Email from BHRUT Occupational Therapist sending OT report for the	Key safe code is NOT confirmed on the OT report	Email states discharge due 15/04/24

			patient to Integrated Discharge Hub (IDH) at NELFT advising that the equipment delivery essential for discharge is pending. Within the discharge report it states that access to the property will be with a key safe.	During an assessment of ADLs (therapies initial assessment) it is documented that prior to admission, Josephine's grandchildren were providing assistance with domestic duties. However, Josephine was preparing her own meals prior to admission. In this assessment, Josephine had disclosed that this has started to become difficult. The care agency was commissioned to provide assistance with personal care and assistance with eating and drinking.	
Weekend		BHRUT	Family members visited the ward over the weekend, however as discharge was not yet confirmed, awaiting equipment delivery, the family were not updated on discharge plans.		
15/04/2024	11:50	BHRUT	Nursing staff on the ward called the care agency to start the package of care with the teatime call today. They contacted them by telephone on 0208 5026660 as requested. This is confirmed by call records, not documentation from the notes.	The key safe number was available on the social services system confirmed on 10 April 2024 and was sent to BHRUT OT as referrer There is no evidence available that the ward informed the care agency of the key safe number. The process of handover of information from BHRUT to the care agency is via telephone. Evidence of this handover of information must	Immediate learning BHRUT, the local authority and the care agency will clarify whose responsibility it is to hand a key safe number to the care agency The council installed the key safe code, and the council commissioned the care agency service

				be documented. However, there is no documented evidence to confirm if the key safe code was shared at this point No calls were made to social care to confirm or request key safe number at this time	
15/04/2024	11:55	BHRUT	Email from the ward, BHRUT to IDH and NELFT chasing for an update as the patient has remained in hospital for 3 further days awaiting discharge arrangements.		This email is from the shared email bhrut.kghintegratedtherapies@nhs.net and the person has not put their job title on the email they are from the Trust's Integrated Therapies Department
15/04/2024	13:23	BHRUT	IDH from NELFT responded an email to ask that BHRUT need to confirm that the equipment has been delivered today, a package of care has been put in but was on hold until the equipment was delivered as it was essential for discharge	There may have been a delay in confirming equipment had been delivered/set up, this is thought to have been due to the weekend.	
15/04/2024	13:53	BHRUT and LBBD	Email from BHRUT Care Pathway Facilitator to IDH and BHRUT Therapists and other senior nursing staff at BHRUT (the" flow" lead nurse and ward manager of the ward) confirming that the equipment had been delivered to the patient's address and the package of care would start today with a teatime call	Due to the level of input required there should have been an MDT for this lady prior to discharge.	Senior Nursing included in the email are the Flow Lead Nurse and Ward Manager of the ward

			Notification of e-mail sent to consultant social worker LBBD.		
15/04/2024	13:54	BHRUT	Email from IDH at NELFT to the IDH and Barking and Dagenham Council forwarded email timed 13:53 above to inform the council that the patient was discharged today.	NELFT and Barking and Dagenham council were informed the patient was being discharged that day.	
15/04/2024	14:02	BHRUT	Transport request received by Transport Team for booking the patient a trip from the ward to patient's home address		There is no record of anyone contacting Jospehine's family to tell them she was being discharged
15/04/2024	14:06	BHRUT	Transport crew allocated		
15/04/2024	14:46		Email from IDH at NELFT to shared email at NELFT confirming that package of care with the care agency for 4 x call daily has been confirmed and that BHRUT is to liaise with agency on 02085026660	This had already been completed by the ward and contact with the care agency was made by telephone	Immediate Learning Not all clinicians in BHRUT and NELFT have a shared understanding of the criteria and discharge the requirements of each other's services. In this instance, the ward didn't send the referral to Community Health and Social Care services (CHSCS) the day Josephine was discharged. We heard that there was an understanding that because Josephine's needs were non-urgent, the referral didn't need to be same day. This is not the case. BHRUT acknowledged that Community Nursing Services (district Nurses) were not alerted to Josephine's discharge (she had non urgent DN needs)

					Patient was not discharged with a valid prescription for the medications for which she was supplied.
15/04/2024	14:48	BHRUT	Email from IDH to BHRUT forwarding the confirmation email regarding care for the ward's attention		
15/04/2024	15:06	BHRUT	Ambulance Crew arrive to the ward to collect patient to take her to her home address		
15/04/2024	15:07	BHRUT	Ambulance Crew leave the ward with the patient	There was no district nurse referral on discharge	Ward Staff verbally reported that they attempted to call multiple family members however there is no call records to support this verbal report – this has been disclosed to the family and an apology given. However, there are no safety concerns and there was an appropriate discharge provision (i.e. confirmed equipment/access/care agency and Josephine had capacity) Immediate Learning: Ward Staff verbally reported that they attempted to call multiple family members however there is no call records to support this verbal report – this has been

					disclosed to the family and an apology given. BHRUT representatives present at the meeting shared that although best practice was to talk to Josephine's family, there were no safety concerns and there was appropriate discharge provision (i.e. confirmed equipment/access/care agency and had capacity) A District Nurse referral should have been completed at this time
15/04/2024	15:30	BHRUT	Ambulance Crew arrive at the patient's home and enter using the key safe		
15/04/2024	15:48	BHRUT	Ambulance Crew had settled the patient at home, and they left the patient's property		
15/04/24	16:00	Care Agency	Josephine was discharged home, according to the hospital. Agency was advised to commence POC visits with the teatime call. Carers visited the property for the teatime call. Carers knocked on the door and waited but no one came to the door. No instruction was provided regarding access; hence carers expected to meet up with the family.	First attempt to access property unsuccessful Key Safe information was not received by the care agency. NOK telephone number was incorrect Assumptions that family were involved as there was no request for the agency to complete shopping	Immediate Learning: The care agency used the circumstances surrounding this incident as a training resource. Agency staff know they must not rely on neighbours for critical information about the whereabout of a resident. Email communication escalation is required, not just verbal.

			The next-door neighbour informed the carers that the client was still in the hospital. Agency was unable to reach the NOK as phone number on Support plan was only 10 digits instead of 11. Carers reported to the agency's office and were advised to maintain visits as per the Support Plan.		Carers must now remain on site until they have confirmation from the discharging ward as to the whereabout of the patient. The care agency will call the discharging ward after the first failed attempt to reach the patient.
15/04/24	16:01	LBBD	Email from consultant social worker to the care agency informing Josephine is being discharged today. *I have been informed that this person is being discharged today, please start the service, thank you*. Notification of e-mail sent to Team manager LBBD.		
15/04/24	20:00	Care agency	Carers visited the property to complete the bed time visit Carers knocked on the door and had no response. The next door neighbour advised that no one was in the property stating that no family member had been sighted for a long time.	Second Attempt - No escalation to the Social workers/hospital at this time that Josephine had not received her planned and scheduled care.	Immediate Learning: The care agency used the circumstances surrounding this incident as a training resource. Agency staff know they must not rely on neighbours for critical information about the whereabout of a resident. Carers must now remain on site until they have confirmation from the discharging ward or duty

			Carers were unable to access the property as there was no key safe number. Neighbour informed the carers that client was still in the hospital. Agency was unable to reach NOK as phone number supplied was wrong. Visits were left open on the assumption that client could come home anytime.		Manager as to the whereabout of the patient. The care agency will call the discharging ward after the first failed attempt to reach the patient. The Care agency will request to be triaged to the duty Manager in the event that it is unable to get through to the discharging ward. The Care agency will email social services on the same day or notify the Out of Hours duty Social Worker when new clients for hospital discharge is not to home or it has been unable to complete a visit.
16/04/2024	08:00	Care Agency	Carers visited the property to complete the morning time visit. Carers knocked on client's door and were unable to access the property. Next-door neighbour informed carers that client was still in hospital. Agency was unable to reach NOK as phone number supplied was wrong. Visits were left open per procedure.	Third Attempt: No escalation to the Social Workers/hospital at this time that Josephine had not received her planned and scheduled care.	

16/04/2024	12:00	Care Agency	Carers visited the property to complete the lunchtime visit. Carers knocked on client's door and were unable to access the property. Next-door neighbour informed carers that client was still in hospital. Agency was unable to reach NOK as phone number supplied was wrong. Visits were left open per procedure.	Fourth attempt: No escalation to the Social Workers/hospital at this time that Josephine had not received her planned and scheduled care.	
16/04/2024	16:00	Care Agency	Carers visited the property to complete the tea-time visit. Carers knocked on client's door and were unable to access the property. Next-door neighbour informed carers that client was still in hospital. Agency was unable to reach NOK as phone number supplied was wrong. Visits were left open per procedure.	Fifth attempt.	

16/04/24	16.28	Care Agency	The agency called the ward and had no response. The agency called the King George A&E and was advised that client was still an inpatient. The carers were advised to suspend visits. The agency contacted the hospital at 1628 hours via the A&E as the ward was not picking up calls. The A&E staff advised that client was still an inpatient. The agency placed the POC visits on hold.	The care agency called the hospital on the 16th after their 5th incomplete visit. They were not able to contact the ward. They called ED. This is not an agreed pathway of escalation and was not reliable. Call records from 16:38 to the hospital indicate a 12 second call was held between ED staff and the ED at KGH. There are no call records of a call between the Care Agency and ward.	Immediate Learning Improvement action required from the care agency regarding escalation processes.
16/04/24	10:51	LBBD	Task assigned to social worker for welfare call, ➢ Check home safe ➢ check care agency attending ➢ check is any ongoing un-addressed concerns / Resolve/advise/refer as required. ➢ Inform as to the 4–6-week review process. ➢ Inform that at review a financial assessment process		

			will be started. Inform of potential financial contributions. ➢ provide intake number: 02082272915. ➢ Post the hospital discharge leaflet to address. Return to CHAT tray when completed all tasks.		
16/04/24	Recorded at 15:23	LBBD	Case note -Phone call attempted to Josephine, no answer. *Phone call to care agency who informed me they started providing care towards Mrs Josephine yesterday evening, I requested for the carer to contact me during Josephine next visit to allow me to speak to her directly.*		Misunderstanding of communication between the care agency and LBBD when it was reported "they started providing care". LBBD assumed this to mean that the care agency had been into the property and attended to Josephine as no report given they had not gained access.
16/04/24	11:58	LBBD	Case note – DISCHARGE CONFIRMED Patient was admitted to KGH on 11/03/2024 with Cough and SOB. ward referred patient for SW input for POC. patient was discharged on 15/04/2024. case reassigned to Social Worker.		
17/04/24	11:47	LBBD	Case note – email from the care agency to Intake team, brokerage worker and CSW Email from the care agency stating below		Immediate Learning: LBBD have reviewed the support plan and there is no mention of the key safe on the support plan. The support plan is written by IDH and that would come via LBBD

			Good Morning Team, *<u>Update FYI:</u>* ➢ *Client's POC was to be restarted with the tea call on 15/04/2024.* ➢ *Carers who visited SU did not meet her at home.* ➢ *POC was left open as client was expected back home yesterday 16/04/2024.* *The POC was placed on hold from today 17/04/2024 until further notice as client is still in hospital.*		brokerage to the care agency. At the time of this event, the support plan from IDH had different pages that go to different agencies. So only parts of the care plan were received by the care agency. Immediate action was taken by LBBD to ensure full documents are shared as appropriate.
17/04/24	11:47	Care Agency	Following their telephone call with KGH ED, the care agency notified the Intake Team and allocated social worker that Josephine was still an inpatient at the hospital Star Agency notified social services that the POC had been placed on hold.	Josephine was not an inpatient and had been discharged on the 15th.	
17/04/24	Recorded 14:26	LBBD	Phone call from care agency advising Josephine is still in hospital. SW advised that she called yesterday and was informed that a carer had visited and questioned why this information was provided if she was in hospital.		
17/04/24	13:11	LBBD	Case note E-mail sent to hospital IDH/ITH to query if Josephine was discharged		

			home as care agency inform, she remains in hospital.		
17/04/24	14:32	LBBD	Case note Integrated Therapies department confirm in email that Josephine was discharged 15.4.24. They have checked with ward who have stated the same.		
17/04/24	14:32	LBBD	Case note E-mail to care agency informing the hospital confirmed she was discharged and requesting “Can you please ensure the carers are using the key safe to enter and check as she is double handed care.”		
17/04/2024	14:31	Care Agency	Email notification received from allocated social worker advising that she has received correspondence from the hospital that client was discharged from hospital on 15.04.2024. Social Worker shared the key safe number with the agency. The agency actioned on restart of the POC. The carers visited and supported client with personal care; fluids and meal intake and medication management.		

17/04/24	15:12	LBBD	Case note T/C (telephone call) to Care agency manager by CSW. Asked him if he could send carers urgently. Care Agency stated they were informed by King George she is still in hospital. CSW informed that bed corrections confirmed she is not in KGH and was discharged. CSW asked him to get the carers to use the key safe to enter. He stated he would send carers urgently now and update us. He asked for next of kins details as the one he has does not connect (Peter). CSW checked the hospital initial assessment details and gave son's contact details.	Contact details were incorrect on the support plan. Learning – to double check in future prior to sending	
17/04/24	15:23	LBBD	Case note T/C to son by CSW expressing concern as have conflicting information about whether Josephine was discharged. He stated the hospital has not informed him his mother has been discharged. Discussion about her care needs, equipment and key safe held. I informed the care agency that I have been requested to attend immediately and use the key safe to enter the property. I informed him I am concerned about his mum as the hospital informed, she was discharged but the care agency stated they were not met by ambulance, he stated he visited her on		

			Sunday in hospital and requested a care home placement to be considered as she is blind and unable to support herself. CSW informed that we were told she was being discharged on Monday 15th home for the bed time call, the carers said no ambulance arrived, the neighbours have stated she is not home yet. However, CSW contacted the hospital, and they still state she is home (though they informed the care agency she was still in hospital). Jospehine's son stated that she was unable to walk and answer the door, I informed him there is a key safe in place, this was used by the cleaning service to organise her home, he stated he did not know if the equipment was there yet. CSW informed that she was told all was ready and the hospital planned to discharge on Monday evening. CSW updated that she has asked the care agency to use the key safe to enter the property and check the home to see if she is there, if she was discharged it has been over a day without carers attending and as such, he was very concerned. He requested we contact him and update him. He stated he will contact the hospital and check also.		

17/04/24	15:38	LBBD	Case note T/C to Alcove (care technology) to see if her emergency alarm system would permit us to talk to her through the device, this was not possible.		
17/04/24	15:47	LBBD	Case note T/C received from the care agency manager informed the carers are there, she is talking and informed them she returned home last night, they will make sure she is clean and dressed and has food provided, he informed the carers have told him she is talking coherently and seems Okay.		
17/04/2024	16:03	Care Agency	Carers arrived to support client with personal care (washing and dressing), meal preparation, medication and ensuring that she was comfortable. The carers accessed the property using the Key safe number provided by social worker Family visited and met up with the carers to support client as needed. The POC visits of x4 visits daily was maintained until client sadly passed away on 23/04/2024.		

18/04/24	10:18	LBBD	Email from CSW to care agency Asking for update on Josephine and if she is safe and well. Also requesting a report of what occurred that prevented care going in at the time of discharge home and what lessons have been learnt to prevent this from occurring again. An additional request that the carers greet her, informing her of the time of day, as she is blind, she may not have a concept of whether it is night or day.		
18/04/2024	12:30	Care Agency	The agency's supervisor, met up with the client's Granddaughter and completed a full risk assessment Noted concerns were escalated to GP, DN and social services per procedure.		
	14:38	Care Agency	Completed a GP referral with an urgent request for medical intervention due to reported concerns of skin discoloration/bruises to both hands and legs. Social worker and Intake Team (Social Services) were copied in the email.		
	14:56	Care Agency	The agency completed District Nurses' Referral as it was noted that client was discharged home with		

			injectable end of life medication; if needed.		
	15:47	Care Agency	The agency informed the social services of noted concerns of skin discoloration/bruises, end of life medication/Client's DNAR status post hospital discharge and actions taken by escalating to relevant team members via email.		
18/04/24	15:56	NELFT	An initial referral was received by the care agency. The referral stated that Josephine had been discharged from hospital with end-of-life medication and required district nursing intervention.		
18/04/24	15:58	NELFT	Referral received from the care agency care coordinator requesting an assessment as Josephine had been "discharged'' (not specified on the referral from where) with end-of-life medication. The Community Health and Social Care Service (CHSCS) scheduled a planned visit for the 22/04/24. The care agency care coordinator had written the key code number, highlighted, on the referral.	CHSCS did not follow their triage process. Josephine was not contacted, and she should have been visited within 24 hours of receipt of referral. Triage health care professionals (HCP) did not add the key code number onto the NELFT EPR RiO	Immediate learning: Revised triage process.
19/04/24		LBBD	Safeguarding concern raised by CSW in respect of the discharge home and missed care and support.		

19/04/24	15:47	LBBD	Email from care agency - New POC / Risk assessment yesterday, 18/04/2024 / Concerns of bruises & end of life medication noted / GP & DN team informed / GP requested for an SVA to be raised / Granddaughter informed *Dear Team,* *Report FYI:* ➢ *Client's POC commenced on 17/04/2024 with the teatime visit.* ➢ *Client is in receipt of bed care.* ➢ *The agency's field supervisor carried out a risk assessment yesterday, 18/04/2024 and noted some concerns.* ➢ *The client presented with skin discoloration and bruises.* ➢ *Please see the attached photos taken with client's consent.* ➢ *Client was discharged home with end-of-life medication which the district nursing team and the GP were not aware of.* ➢ *Client is of DNAR status.* *Action Taken:* ➢ *The agency had notified the GP and the DN team yesterday, 18/04/2024, via emails of the*		

			noted bruises and the end of-life medication. ➢ *The GP, contacted the agency today, 19/04/2024, and requested the agency to raise a safeguarding regarding the noted bruises*. ➢ *Client's granddaughter / emergency contact person notified of the concerns and actions taken*. Pictures received from agency re concerns		
19/04/24	16:07	NELFT	GP sent a MAAR chart to CHSCS, and it was uploaded onto RIO.		
19/04/24	16:07	NELFT	The referral was uploaded onto the medical records system (Care Doc) and updated on RiO.		
	16:14	Care Agency	The agency raised a safeguarding alert with the London Borough of Barking and Dagenham due to the reported concerns of bruises as instructed by the GP. The agency raised a safeguarding alert with London Borough of Redbridge Social Services as advised by Duty Social Worker for London Borough of Barking and Dagenham		
19/04/24	16:30	LBBD	Email to BHR integrated discharge hub requesting updated discharge medication list to be sent to GP, there is no copy of this on our documents,	Lack of information / discussion / awareness re end of life status.	

			care agency reports end of life medications, but this is not detailed on referrals.	LBBD only had confirmation she was end of life from the SAR.	
19/04/24		LBBD	Case note LBBD worker spoke to son, he stated Josephine had multiple bruises in hospital due to fall and treatments, they developed over time, he will check when he is there. He also stated the granddaughter informed him the care agency informed there are pressure areas that look sore and DN assessment for pressure mattress is being referred for as she is currently on regular mattress.		
19/4/24		LBBD	Safeguarding 1 triaged by intake: Safeguarding concern and prior actions: S42 threshold not met. Wilful neglect not identified as concern related to miscommunication.		
19/04/24		LBBD	Secondary Safeguarding concern raised: Client presented with bruises on discharge from the hospital. The GP was notified and she requested for an Safeguarding vulnerable adults to be raised. The district nursing team is aware. Client requires medical intervention from the medical team.		
19/04/24	17:17	LBBD	Case note Safeguarding alert - response to referrer Safeguarding enquiry to be completed by Redbridge (SAE) as the incident		

			happened whilst she was at their hospital-King George Hospital		
22/04/24		NELFT	A second referral was received from the GP, attaching the discharge notification.		
22/04/24	10:36	NELFT	The GP referral was triaged by the District Nursing team.		
22/04/24	08:02	NELFT	HCP attempted to visit Josephine but could not access the property. He managed to speak to Josephine through the window. The carers were not present. The HCP left a note through the mailbox saying "*Dear carers, district nurses are unable to enter Josephine house because we do not have a keycode. Kindly share keycode or son's mobile number for help. Josephine agreed to her keycode shared with us".*	HCP should have considered discussion with NELFT safeguarding team due to care agency not being present at the home.	A discussion may have prompted escalation which may have triggered action sooner. There may have been a delay.
22/04/24	10:38	NELFT	Referral received from the GP stating that a MAAR chart had been sent on the 19/04/2024 and that Josephine had recently been discharged from hospital. The referral cited 'end of life'. The key code was not written on this referral. The referral received on the 18.4.24, with the key code written on it, was closed on the EPR.	The referral on the 18.04.24, with the key code on it, was closed so it was not used/seen The key code had not been written on the NELFT EPR and this was where staff expected to see a key code if there was one.	Good practice – the care agency had clearly documented and highlighted the Key Code to the CHS DN. Learning points: The key safe number was not made clear on the front page of the DN system and therefore was not easily accessible to the visiting clinicians. Second referral did not include the key code and this second referral then cancelled out the first (with the key code). Immediate learning:

					Improvements: a 'Swarm Huddle' learning review led to an enhanced structured triage process regarding timeliness of visit (SOP to be provided). For Josephine's needs – this would mean that she would have been seen within 24 hours of the team receiving the first referral. Swarm Huddle identified that patients are not always telephoned on receipt of a referral which has led to team reflection. New process that ensures that all key safe numbers are added to the 'RIO' system.
22/04/24	14:47	Care Agency	Intake Team and allocated social worker notified of GP request for tea-time carers on Friday, 19/04/2024, to contact the paramedics to take client back into hospital. Carers called out the paramedics as instructed but paramedics had declined attendance advising that there was no noted emergency. 111 team was contacted and it sent out a clinician to visit client at home same day. NOK had updated the agency that the clinician who visited had completed some blood test which		

			had established that client had low haemoglobin.		
22/04/24	15:07	Care Agency	Carers reported that client presented with reduced appetite. The GP was notified via email of the noted concern with a request for medical intervention. The NOK; Intake Team and the Social worker were copied in the email sent to the GP. Intake Team and allocated social worker informed of the concerns noted regarding client's fluids and meal intake on 22/04/2024. The agency notified the GP same day. Client's NOK/Granddaughter informed the agency that client was already scheduled for an appointment at Clover Ward of KGH on 23/04/2024.		
22/04/24	15:47	LBBD	Case note ➢ care agency e-mail reporting The GP contacted the agency on Friday, 19/04/2024 and advised that the teatime carers should call out the paramedics to take client back into hospital.		

			➢ The teatime carers called out the paramedics and the paramedics declined attendance stating that there was no noted emergency. ➢ The paramedics advised the carers to call out the 111 team. ➢ The carers called out the 111 team and were advised that a clinician would be sent out to the client. ➢ Client's NOK later informed the agency that client was visited by a clinician and blood test was carried out. The blood test established that client presented with low haemoglobin.		
22/04/24	16:04	LBBD	Case note – email from care agency ➢ The carers that visited in the morning and at lunchtime today, 22/04/2024, reported that client had declined to eat and drink despite being encouraged. ➢ The agency notified the GP today, 22/04/2024, via an email with a request for medical intervention. The NOK / granddaughter was informed, and she advised that client has got an appointment at Clover ward – King George hospital tomorrow, 23/04/2024.		

22/04/24	16:10	NELFT	The HCP visiting for the planned visit telephoned prior to the visit and spoke to both carers and Josephine. Carers informed HCP that they would inform Josephine's son of the planned visit being made that day. The carers informed the HCP that they would be present at the time of the arranged visit and that they would grant HCP entrance to the home, as the home had a key safe in place.	That no set time was agreed between the staff from NELFT visiting and the care agency.	
22/04/24	16:21	NELFT	A telephone call was made by the nurse to Josephine's home, to inform her that he would be visiting her that day. Josephine answered and asked the carers to take the call. The nurse introduced himself to the carer and explained that he was due to visit that day. He asked the carer to inform Josephine about the visit and gain her consent. Consent was provided via the carer and Josephine stated that she would inform her son that there would be a nurse visiting. The Carer stated that the nurse would find them at the house, so a keycode was not obtained as they would be there to grant access.		
22/04/24	16:30	NELFT	HCP could not gain access to Josephine's property and by this time the carers had gone. The HCP rang the doorbell and called the mobile number on the EPR. The HCP then knocked at a neighbour's house to ask if the	HCP did not check the system and view previous referrals where the key code number was clearly visible.	

			neighbour had access to Josephine's home, which the neighbour did not. The neighbour said that Josephine had been home from hospital for a week. The HCP called the mobile phone number again and Josephine told him to go to the window. She was in but could not open the door. She said she could not remember the keycode number nor her son's telephone number. Josephine asked HCP to leave a note for the carers for them to call HCP back with the keycode number. HCP tried the contact numbers given on the referral form, but unsuccessful.		
22/04/24	16:21	LBBD	Case note – email from care agency Report FYI: ➢ The carers that visited this morning, 22/04/2024, reported that the dressing on the left leg needed changing. ➢ Client is known to the District nursing team. ➢ Action Taken: ➢ The agency has today, 22/04/2024, notified the District nursing team via an email referral with a request for medical intervention. Client's NOK informed.		
22/04/24	16:30	NELFT	The visit was attempted but was unsuccessful as there was no		

			response when the doorbell was rung. An attempt was made to ring Josephine's mobile telephone number but there was no answer. The nurse knocked at the neighbour's door and asked if they had access to Josephine's door, to which they responded no. Josephine's mobile telephone number was called again. She answered and stated that she could not open the door and could not remember the key code. Josephine instructed the nurse to write a note for the carers to come and call her son to share the keycode. A note was left for the cares for them to call Josephine's son to gain permission to share the key code with the District Nurses. The plan was for the District Nurses to await a call from the carers and if no call was received, to call Josephine again.		
	08:48	Care Agency	Carers who visited client for the morning call met the paramedics on arrival. The paramedics informed the carers that they had visited client to take her to hospital appointment and had met client unresponsive. Client's NOK/son was contacted, and he advised that he was on his way.		

			Client's son visited the property and met up with the paramedics.		
23/04/24	09:30	NELFT	HCP managed to reach Josephine's granddaughter on another mobile number. She told the HCP that Josephine was going to the hospital that day due to having a low Hb and she may have a transfusion depending on what transpires, or she could be admitted. The HCP scheduled a planned visit for the 24.04.24. The granddaughter gave HCP the keycode number. Planned visit arranged for the 24/04/2024.		
23/04/24	09:30	NELFT	A telephone call was made to Josephine's granddaughter, to try to gain access to the house for a palliative care assessment. The issues regarding trying to gain access were explained. Josephine's granddaughter seemed angry when palliative care was mentioned and stated that her grandmother had recently been discharged from hospital, and this had not been mentioned. She had just been informed about palliative by the carers after they saw injections in the discharge bag. She also advised that Josephine would be in hospital that day due to her low blood pressure and that she could have a transfusion, or she could be admitted. It was suggested that a visit would be put on		

			the planner for the next day (24 April 2024) and the District Nursers would call her for updates and if Josephine was home, then the team would visit as she needed to be seen as soon as possible. Josphine's granddaughter agreed to the plan and stated that the nurse should call the family after the assessments before performing any intervention. The nurse stated that the team would involve the family and let them decide on what they felt was best for Josephine. The key code was shared by Josephine's granddaughter and updated on the system.		
23/04/24	Recorded 12.12	LBBD	Case note T/C Received (CI) Josephine's son informed that Josephine was due for blood transfusion today at hospital but on the arrival of the ambulance she was found deceased. I informed them that I saw an e-mail from the care agency yesterday that she was declining food and medication and they contacted the GP, who suggested an ambulance; the ambulance stated there was not a medical need to attend and referred to 111. GP arranged blood tests, which indicated low blood sugars, hospital admission was planned for today but sadly she was deceased at the arrival of ambulance transport.		

			Josephine's son informed she was declining food when he visited on the weekend also, she would only take a few sips of water. He informed that the ambulance crew said she has bruises over her body, we discussed the photos taken on her arrival home and that he was going to feed back after the weekend visit whether these were new bruises or witnessed in hospital, he stated she had the bruising he could see, in hospital. Noted he was driving to her home, I advised him to take breaks whenever needed to ensure safety whilst driving and he stated he was going to do this. He thanked me for the communications we have had and informed he plans to contact the hospital and get more information about the discharge.		
23/04/24		LBBD	Case note RIP notice email from care agency *Dear Team,* *Report FYI:* ➢ *The ambulance crew that visited client this morning, 23/04/2024, to take her to King George for her hospital appointment met her unresponsive.*		

			➢ *The ambulance crew called out the Police and the paramedics to certify client dead.* ➢ *Client was of DNAR status and in receipt of end-of-life care.* ➢ *The agency has notified client's NOK-son and the granddaughter.* ➢ *Client's son informed the agency that he was already on his way to his mum's as he had wanted to escort her to the hospital for her appointment.* ➢ *The agency will notify the CQC accordingly.* *May her good gentle soul RIP.*		
23/04/24	17:54	NELFT	A called was received from Josephine's son informing the team that his mother had died.		
24/04/24	08:40	NELFT	DNAR was located by a triage nurse on CareDoc having been uploaded prior to receiving the first referral.	DNAR should have been checked for on receipt of the first referral.	