15 September 2022

Complaint reference:
21 009 745

Complaint against:
Nottinghamshire County Council
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Local Government & Social Care OMBUDSMAN

Parliamentary and Health Service Ombudsman

The Ombudsmen's final decision

Summary: We uphold Mrs J's complaint about the care and treatment provided to her husband by the Council and the Trust. We found fault with the handling of Mr J's discharge, the management of his care and needs and consideration of Mrs J's needs as a carer. This fault caused Mr and Mrs J significant distress. The Council and Trust will apologise to Mr and Mrs J and pay a financial remedy. They will also take action to prevent similar problems occurring in the future.

The complaint

1. Mrs J complains about the care and treatment her husband, Mr J, received from Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (the Trust) while admitted to hospital in February 2021. Specifically, she complains about inadequate management of his fluids, constipation and pressure sores while he was an inpatient.
2. Mrs J is also unhappy with the handling of her husband's discharge by the Trust and Nottinghamshire County Council (the Council) between February and March 2021. Mrs J complains that the Trust failed to ensure Mr J was medically fit for discharge. She also complains that the Council and Trust did not properly consult her or Mr J about the discharge arrangements. She says the Trust and Council did not properly assess Mr J's capacity to make decisions about his care. Further, Mrs J says the Council and Trust did not properly consider her own health problems and ability to care for Mr J.
3. Mrs J is dissatisfied with the handling of her complaint by both organisations, which she says was inaccurate, dismissive and did not properly address the concerns she raised.
4. Mrs J says that the handling of Mr J's inpatient care and his discharge caused his health to deteriorate significantly, to the point he had to move into a care home permanently. She says if the discharge had been handled differently, and more support put in place, Mr J could have returned home for longer and enjoyed a better quality of life.
5. Mrs J would like the Trust and Council to make systemic improvements to ensure discharge procedures are followed correctly and adequate assessment of patient and family needs take place as part of discharge planning.

The Ombudsmen's role and powers

6. The Ombudsmen have the power to jointly consider complaints about health and social care. Since April 2015, these complaints have been considered by a single team acting on behalf of both Ombudsmen. ***(Local Government Act 1974, section 33ZA, as amended, and Health Service Commissioners Act 1993, section 18ZA)***

7. The Ombudsmen investigate complaints about 'maladministration' and 'service failure'. We use the word 'fault' to refer to these. If there has been fault, the Ombudsmen consider whether it has caused injustice or hardship ***(Health Service Commissioners Act 1993, section 3(1) and Local Government Act 1974, sections 26(1) and 26A (1), as amended)***.

8. If it has, they may suggest a remedy. Our recommendations might include asking the organisation to apologise or to pay a financial remedy, for example, for inconvenience or worry caused. We might also recommend the organisation takes action to stop the same mistakes happening again.

9. If the Ombudsmen are satisfied with the actions or proposed actions of the bodies that are the subject of the complaint, they can complete their investigation and issue a decision statement. ***(Health Service Commissioners Act 1993, section 18ZA and Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

10. I discussed the complaint with Mrs J and considered the information she provided. I reviewed information provided by the Council and the Trust, including Mr J's clinical records, his care assessments and his Community Care Officer's notes. In addition, I took account of relevant guidance and legislation. I have carefully considered all the written and oral evidence submitted to us, even if we do not mention specific pieces of evidence within the decision statement.

11. I shared this draft decision with Mrs J, the Council and the Trust and they had an opportunity to comment. I have carefully considered the comments I received.

What I found

Key legislation and guidance

NHS Quick Guide: Discharge to Assess

12. Definition of 'Discharge to Assess – '*Where people who are clinically optimised and do not require an acute bed, but may still require care services, are provided with short term funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support is then undertaken in the most appropriate setting and at the right time for the person.*

13. Principles for Discharge to Assess model include:

- *'Supporting people to go home should be the default pathway, with alternate pathways for people who cannot go straight home.*
- *Putting people and their families at the centre of decisions, respecting their knowledge and opinions and working alongside them to get the best possible outcome.*
- *Take steps to understand both the perspectives of the patient and their carers… [and] their needs…'*

Hospital Discharge

14. Department of Health guidance: *Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care (March 2010)* (the 'Ready to go guidance') is the core guidance around hospital discharge. It contains ten key steps for staff to follow during discharge planning, including:

- start planning for discharge or transfer before or on admission;
- identify whether the patient has simple or complex discharge and transfer planning needs and involve the patient and carer in your decision;
- involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.
- Review the clinical management plan with the patient each day, take any necessary action and update the progress towards the discharge or transfer date.
- Use a discharge checklist 24-48 hours prior to transfer.'

15. Chapter 3: Involving patients and carers notes '*Recognise the role of the carer from the start of the discharge or transfer process to ensure that all states of the care pathway are well managed… Patients and their carers may have different needs, so do not assume that a carer will necessarily be able or willing to continue in a caring role…Carers have a right to an assessment…the results of this assessment may mean more care for the person they are caring for, care delivered in a different way or services just for the carer themselves*.'

Medically fit for discharge

16. Department of Health guidance: Definitions – *Medical Stability and 'Safe to Transfer'* (2003) (the 'Safe to transfer guidance') gives guidance on when a patient can be safely considered to be 'medically fit for discharge'. This lists three key criteria for making this decision and stresses professionals should address them at the same time, if possible. According to the protocol, a person is considered to be safe for discharge when:

- a clinical decision has been made that the patient is ready for transfer;
- a multidisciplinary team decision has been made that the patient is ready for transfer; and,
- the patient is safe to discharge/transfer.

17. A patient can be defined as clinically or medically stable if tests (such as blood tests and observations) are considered to be within the normal range for the patient. A patient is 'fit for discharge' when all relevant physiological, social, functional, and psychological factors have been taken into account. This can require a multidisciplinary assessment.

Mental Capacity Act

18. The Mental Capacity Act 2005 (the MCA) applies to people who may lack mental capacity to make certain decisions. Section 42 of the MCA provides for a Code of Practice (the Code) which sets out steps organisations should take when considering whether someone lacks mental capacity.

19. Both the MCA and the Code start by presuming individuals have capacity unless there is proof to the contrary. The Code says all practicable steps should be taken to support individuals to make their own decisions before concluding someone

lacks capacity. The Code says people who make unwise decisions should not automatically be treated as not being able to make decisions. Someone can have capacity and still make unwise decisions.

Care and Support Statutory Guidance - Care Act 2014

20. Department of Health guidance for the Care Act 2014: *'Care and Support Statutory Guidance 2014'* says that where an individual provides or intends to provide care for another adult and it appears the carer may need support, councils must carry out a carer's assessment. Carers' assessments must seek to find out not only the carer's needs for support, but also the sustainability of the caring role itself. Factored into this must be a consideration of whether the carer is, and will continue to be, able and willing to care for the adult needing care.

What happened

21. Mr J was living at home with Mrs J. He was able to move around his home with the aid of a walking frame and was independent with toileting, dressing and personal hygiene.

22. On 19 February 2021, Mr J tripped over at home. He was admitted to Bassetlaw Hospital with a fractured shoulder.

23. The treating doctors placed Mr J's arm in a collar and cuff. This reduced Mr J's mobility and meant he required assistance from nurses for his personal hygiene needs, to reposition himself and for transfers.

24. The clinical team assessed Mr J as being 'Amber' risk for pressure ulcers. This meant that Mr J needed to be repositioned at least every four hours throughout the day and night.

25. On 22 February, the Trust completed a referral to the Integrated Discharge Team, a multi-disciplinary team consisting of health and social care professionals. The referral documented Mr J's wish to be discharged home.

26. On 23 February, the clinical team decided Mr J was medically fit for discharge. He was allocated to a Community Care Officer (the Officer) for discharge planning. The Officer planned to discharge Mr J home with visits from two care workers, four times a day, while he recovered.

27. Over the next few days, the Officer spoke with Mrs J about the discharge arrangements. Mrs J raised multiple concerns about managing Mr J's needs at home. This included concerns about his mobility and toileting capabilities.

28. An Occupational Therapist (OT) assessed Mr J on 25 February 2021. The OT identified that Mr J required a Rotunda support frame for transfers and felt further assessments were required.

29. On 26 February, the OT visited Mr and Mrs J's home to assess it. Mrs J raised further concerns and asked about the possibility of a short-term rehabilitation placement. The OT explained that rehabilitation was not an option until Mr J's arm healed sufficiently for him to use it.

30. Following Mrs J's concerns, both the OT and the Integrated Discharge Team spoke to the ward. The records suggest there was some confusion as to Mr J's continence needs. The OT noted that a member of ward staff told her Mr J could be incontinent at night. However, the Integrated Discharge Team recorded being told that Mr J asked for the toilet. At the OT's request, the Officer referred Mr J to the Discharge to Assess pathway so he could be considered for therapy once he was fit enough.

31. From 27 February onwards, Mr J started to have more frequent incidents of urinary incontinence, including overnight. Mr J had been constipated and was prescribed laxatives, following which he began to have some faecal incontinence episodes too.

32. Mr J's sacrum, the skin area at base of his spine, had been becoming increasingly red and sore. The area was already vulnerable from a previous pressure ulcer. On 28 February, this developed into an open moisture lesion. Mr J was increased from 'Amber' to 'Red' risk. This meant he needed to be repositioned every two hours throughout the day and night. Mr J's discharge was then briefly delayed due to a raised temperature.

33. On 3 March 2021, Mr J was discharged home. Mrs J, who had been unable to visit him in hospital due to COVID-19 restrictions, was alarmed by his deterioration. She says he arrived home with faeces running down his legs and an open ulcer on his sacrum.

34. As planned, Mr J received visits from two care workers four times a day, with Mrs J supporting him between visits and overnight. Mr J's incontinence continued, both daytime and overnight, and by 8 March, his moisture lesion had significantly deteriorated.

35. The Officer spoke with Mrs J on three occasions between 8 and 16 March 2021. His notes record that he intended to arrange a visit with an OT to review Mr J's care package, however this was not successfully arranged.

36. On 22 March, Mrs J became unwell and was admitted to hospital. The Council found an urgent short-term care in a care home for Mr J, while Mrs J was in hospital.

37. On 24 March 2021, the Officer visited Mr J in the care home to assess his mental capacity. He felt Mr J understood where he was and why he was there. As the Officer was satisfied Mr J had the capacity to consent to his short-term placement in the care home, he did not complete a formal capacity assessment.

38. On 29 March 2021, following Mrs J's discharge from hospital, the Officer phoned her to discuss Mr J's proposed return home on 31 March. Mrs J said she still felt very unwell. She said she was concerned she would not be able to cope with Mr J's night-time care needs and ongoing incontinence. The Officer suggested a 24-hour response service as an option.

39. The Officer phoned the care home to ask about Mr J's current needs. The manager confirmed that Mr J needed repositioning every two hours as he had moisture damage. The manager also explained that Mr J was doubly incontinent and regularly needed checking and changing overnight.

40. On 31 March 2021, the Officer visited Mr J to discuss his care needs. Mr J confirmed he had been experiencing regular incontinence overnight which required the Care Home staff to change his bed sheets. Mr J also confirmed that he had been regularly incontinent, including overnight, when he was at home. Mr J understood his needs could be better met in the care home and agreed to remain in the care home for a longer period.

41. In early April 2021, Mr J's shoulder had healed enough to start physiotherapy. His mobility and continence also began to improve. By mid-May, discussions were taking place about steps for Mr J to return home. In June 2021, Mr J had a fall. Following this, his mobility and health deteriorated again and he had further falls.

Mr J's needs increased again, including overnight care, continence care and regular repositioning due to his recurring sacrum sore.

42. On 23 September 2021, a social worker visited Mr and Mrs J at the care home to discuss his long-term care. She recommended that remaining in the care home long term was the best option. Mr J still wished to return home and was upset, however he understood the reasons and agree to stay in residential care permanently.

Analysis

Mr J's inpatient care

Fluid management

43. Mrs J complains the Trust did not manage Mr J's fluid intake properly when he was an inpatient. She says Mr J was not drinking enough and she was not allowed to drop off Mr J's preferred energy drink due to COVID-19 restrictions. She believes Mr J became constipated as a result.

44. The clinical records document Mr J as having either 'normal' or 'small' food and fluid intake, which varied each day. There were some days where he needed encouragement to eat and drink more. He consistently passed urine at least every six hours.

45. A fluid balance chart of Mr J's intake and output was only recorded on 20 February 2021. Therefore, there are no detailed records of Mr J's daily fluid intake available for review. However, it is only necessary to record a patient's fluid balance if they are at considered to be at risk of malnutrition or dehydration. Given that Mr J was taking fluids, albeit sometimes on the low side, and passing urine regularly, it would not have been necessary for the Trust to monitor Mr J's fluid intake in detail.

46. On 28 February 2021, Mr J's clinical records contain the note of a conversation between Mrs J and the hospital ward. Mrs J told the ward that Mr J does not like tea and prefers an energy drink or orange. The nurse replied that the hospital did not have any energy drink to offer Mr J, but the family could bring him some in.

47. As part of my enquiries, I asked the Trust to clarify the COVID-19 visiting restrictions in place at the time. The Trust said although visiting restrictions were in place at the time, family could leave items at the ward doors and this option was offered to Mrs J. I acknowledge Mrs J did not think this was allowed and it seems likely there a misunderstanding developed surrounding this. However, I am satisfied from the records that there was an option for Mr J's preferred energy drink to be supplied by Mr J's family. Overall, I have not found any fault with the way Mr J's fluid intake was managed.

Constipation management

48. Linked to Mrs J's concerns about fluid management are her further concerns about the handling of Mr J's constipation. Mrs J considers that a lack of fluids caused Mr J to become constipated. In turn, she says this was treated too aggressively with laxatives, causing faecal incontinence and loss of dignity.

49. The clinical records show that, following his admission to hospital, Mr J did not open his bowels for almost a week. His constipation only began to resolve when the clinical team prescribed laxatives. Even then, Mr J remained constipated on discharge. I have not seen any evidence to confirm that Mr J's constipation was caused solely by a reduced fluid intake. While lack of fluids can contribute to

constipation, Mr J was also mostly immobile and on opioid-based pain relief medication. These can also cause constipation. Mr J's clinical records suggest his pain medication was a primary cause of his constipation. Laxatives were required to help counteract this side effect.

50. Long-term constipation can have serious complications if left untreated. Mr J was constipated, and the Trust treated this with laxatives in line with the NICE Guidance for Constipation in Adults (September 2021). The guidance states that short-term constipation in adults who have opioid-induced constipation should be offered osmotic (stool softening) and stimulant laxatives. The Trust prescribed Mr J the appropriate laxatives. Mr J did suffer some episodes of faecal incontinence and the laxatives likely contributed to this. While this would have been unpleasant for Mr J, the use of laxatives was an important part of the treatment for managing Mr J's constipation. I have not found any fault with the way Mr J's constipation was managed. I have addressed Mrs J's concerns about Mr J's arrival home below.

Pressure area management

51. Mrs J complains that the hospital left Mr J in bed for long periods, which led to him developing an open ulcer at the base of his spine.

52. While admitted to hospital, Mr J developed a moisture lesion on his sacral area. Moisture lesions are the breakdown of the skin where an area has prolonged exposure to moisture, for example from urinary and/or faecal incontinence. Areas, such as the patient's sacrum, are particularly vulnerable to moisture damage. Moisture lesions can be very painful.

53. The clinical records show Trust staff assessed Mr J's pressure areas when he was admitted and found his skin intact. The Trust assessed Mr J via its Pressure Ulcer Prevention and Management Care Plan. He was assessed as being 'Amber' risk of pressure ulcers due to his significantly reduced mobility and need for assistance to move and reposition. Therefore, according to the Trust's records, Mr J required a minimum of four-hourly repositioning while in bed and two-hourly while seated in a chair. Mr J's pressure areas should also have been checked three times a day.

54. On 25 February 2021, Mr J's clinical records show redness was starting to form on his buttocks. A barrier cream was appropriately applied multiple times throughout his admission. Despite this, Mr J's skin continued to deteriorate and his sacral area ultimately broke open into a moisture lesion on 28 February. While action can and should be taken to reduce the risk of pressure ulcers, the NHS guidance for pressure ulcers explains that it can be difficult to completely prevent them.

55. At this point, Mr J was appropriately increased to 'Red' risk of pressure ulcers. This was in line with the Trust's criteria for patients '*spending all or majority of time in bed or chair with moisture lesions in sacral area*', Mr J now required minimum two-hourly repositioning while in bed.

56. Overall, Mr J was repositioned as per the schedule for his risk rating. The records show that he regularly moved from his bed to a chair most days. He also had three visits from a physiotherapist to assess his mobility, which involved helping him move around. Skin checks were also completed three times a day. For the majority of Mr J's admission, his pressure area management and treatment was appropriate.

57. However, I note two incidents where Mr J was not moved for significant periods of time. On 25 February 2021, only one daily skin check is recorded. There is also no record of him being repositioned overnight between midnight and 8am. Mr J was 'Amber' risk at this point and should have been repositioned at least every four hours while in bed. This placed Mr J at a greater risk of developing a pressure ulcer.

58. Further, on 2 March 2021, the records show that Mr J was only repositioned once between 9/10am and 6pm, which was to use the toilet. At this point, Mr J had an open moisture lesion and was 'Red' risk, meaning he should have been repositioning every two hours at the minimum while in bed. He was sat in a chair for this period. The seating repositioning regime is not completed for this day but, again, would have been two hourly repositioning as a minimum. The next day's records placed Mr J on to one hourly repositioning in a chair. This is fault. The failure to reposition Mr J regularly increased the risk of his moisture lesion deteriorating further.

Discharge process

Discharge - Medical fitness for discharge

59. Mrs J complains that the Trust failed to ensure that Mr J was medically fit for discharge. She says he arrived home with an untreated urinary tract infection (UTI), an open ulcer at the base of his spine and faeces running down his legs.

60. The Trust tested Mr J's urine while he was admitted to hospital and prescribed a course of oral antibiotics to treat his UTI. I have found no evidence to suggest that he was discharged with an untreated UTI.

61. As I have discussed above, Mr J's overall pressure care was adequate, aside from two occasions. Mr J had multiple factors increasing his risk of developing a pressure area. He had previous skin damage to the area, reduced mobility due to his fracture and had become frequently incontinent. While it would have been unpleasant for Mr J, it is not always possible to avoid moisture lesions forming. The evidence shows that Mr J had previously developed an ulcer in this area and this has continued to be an ongoing issue for him.

62. Mr J was assessed as medically fit for discharge as he no longer required treatment in hospital and his conditions could be managed in the community. I have not found fault with this decision.

63. However, while Mr J was medically ready to leave hospital, I do not consider that he was discharged home with adequate care in place to meet his needs. I will address this point in further detail below.

64. Turning to Mr J's arrival home, Mr J was continent, independent with his personal hygiene and mobile with a walker prior to his fall. Mrs J was unable to visit Mr J during his admission to hospital due to COVID-19 visiting restrictions. Therefore, it is understandable that Mrs J was shocked by the rapid change in Mr J's condition when he arrived home. However, I have not seen any evidence to suggest that Mr J's condition deteriorated directly as a result of poor inpatient care. Instead, the impact of his shoulder injury and UTI appears to have been the main reasons.

65. I have reviewed Mr J's clinical records regarding his personal care, which are not detailed on this point. However, Mr J is recorded as receiving support with his personal hygiene multiple times a day, due to his reduced mobility and sometimes

incontinence. On 3 March 2021, the day of Mr J's discharge, he is recorded as having received personal hygiene support in the morning and afternoon.

66. Mrs J was understandably upset to see Mr J arrive home this way. However, I am satisfied, on the balance of probabilities, that Mr J was supported with his personal hygiene prior to transfer and he likely suffered faecal incontinence enroute. Therefore, I have not found fault on this point.

Discharge - Consultation prior to discharge

67. Mrs J complains she was not properly consulted about Mr J's discharge. She says the Officer was dismissive of her concerns and instead told her what was going to happen without taking her views into account. Mrs J said she felt '*bullied'* into accepting a situation she was unhappy with.

68. Mrs J also feels that Mr J was simply asked if he wished to return home but says there was no proper discussion with him about other options and the implications of returning home with his current level of care needs.

69. Mrs J asked several times about whether Mr J could go to a short-term rehabilitation placement instead of returning straight home. The term '*rehabilitation*' is sometimes used to describe a particular type of service designed to help a person regain or re-learn some capabilities where these capabilities have been lost due to illness or disease. Rehabilitation services can include provisions that help people attain independence and remain or return to their home.

70. As the OT explained to Mrs J during the home visit, Mr J was unable to participate in rehabilitation therapy at the point of discharge as he was unable to use his arm. Therapy was not an option for around six weeks, until the fracture had started to heal, and Mr J's pain had decreased.

71. However, while it is correct that Mr J would not have been suitable for a rehabilitation placement at the time, other short term residential care placements (such as respite care) would have been available as an option.

72. According to the OT's notes, Mrs J asked the OT about Mr J's continence overnight. The OT spoke to the ward, who confirmed Mr J could be incontinent at night. It is recorded that the ward sister agreed to phone Mrs J to discuss this with her. There is no record to confirm this call happened.

73. The Council's electronic case notes contain multiple records of the Officer responding to Mrs J's concerns by simply saying that Mr J wished to return home and he could not go against Mr J's wishes as he had the capacity to decide.

74. It is correct that Mr J's wishes needed to be considered and respected. However, Mrs J's views, as a family member and a carer, also needed to be taken into account. Mrs J would be caring for Mr J between care visits and overnight. The Discharge to Assess guidance and the '*Ready to go?*' guidance, as quoted above, both state that the patient *and their family/carers* need to be full involved in the process. There is no evidence of the Officer having any meaningful conversation about Mr and Mrs J's conflicting views. I have found that Mrs J's concerns about discharge were not given adequate weight by the Officer. This would have been frustrating and worrying for Mrs J.

75. Further, I am not satisfied that Mr J was properly consulted about his discharge options. On 22 February 2021, the Trust completed a referral to the Integrated Discharge Team (IDT). The content of this document was then used by the Officer as the primary grounds for planning Mr J's discharge. The IDT referral

simply stated that Mr J wished to go home. No further detail is given. I have reviewed the Trust's records and the Council's records, including the electronic case notes and I can see no evidence of further discussion, by anyone, with Mr J about his discharge.

76. On 23 February 2021, the Officer spoke to Mrs J on the phone about the discharge arrangements. Mrs J was concerned about Mr J's reduced mobility. She asked whether Mr J could be discharged to a rehabilitation centre instead, for a few weeks, to recover his mobility before returning home. According to the case notes, the Officer replied that Mr J had capacity to decide to return home and he could not go against Mr J's wishes. Mrs J raised concerns about Mr J's capacity to decide to return home and asked whether other options and implications of returning home in his current state had been properly discussed with him. The notes record the Officer's reply that he would be '*more than happy to visit* [Mr J] *on the ward and ask him where he would like to be discharged to*'. There is no evidence this happened. I have seen nothing to suggest the Officer had any direct contact, in person or by telephone, with Mr J prior to his discharge.

77. I have seen no evidence of a discussion with Mr J about what care options may be available, what his care needs when returning home may be and the potential implications of returning home, for example, without overnight care. Further, I have found nothing to suggest Mr J was asked for his views on Mrs J's concerns.

78. Mr J's care needs changed significantly between the referral being completed and his discharge. By his discharge on 3 March 2021, Mr J had developed an open moisture lesion which required frequent repositioning and became increasingly incontinent. I have seen no evidence that the increase in Mr J's care needs and the implications of this on his discharge planning was discussed with him.

79. In response to Mrs J's complaint, the Council's position has consistently been that Mr J had capacity to make decisions about his discharge and wished to return home, therefore it was following his wishes. However, I am not satisfied that Mr J was properly consulted about his discharge arrangements. This is fault. This is not inline with the '*Ready to go?*' guidance which includes involving *'patients and carers so that they can make informed decision and choices…*' The failure to provide Mr J with adequate information would have impacted on his ability to make an informed decision about his discharge arrangements.

Discharge - Mr J's mental capacity

80. Linked to the above complaint, Mrs J felt that Mr J did not have the mental capacity to make decisions about his discharge arrangements. She complains that Mr J's capacity was not properly assessed when she raised concerns.

81. Mr J's medical records stated that he had 'mild cognitive impairment' at the time although he did not have a formal diagnosis of dementia. The records suggest that Mr J sometimes needed extra time to understand information, was occasionally confused and sometimes struggled to properly express himself, which was frustrating for him. However, this does not necessarily mean that Mr J lacked capacity to make decisions about his care.

82. Mr J's capacity was considered by multiple professionals at various stages of his discharge planning and after discharge. Every professional concluded that Mr J had capacity to make decisions about his care. As Mr J was considered to have capacity, it was not necessary for a formal mental capacity assessment to be completed.

83. As above, the Mental Capacity Act 2005 states that individuals should be presumed to have capacity unless there is proof otherwise. Further, a person with capacity still has the right to make unwise decisions.

84. Mr J was able to follow instructions as an inpatient, such as to not attempt to move without assistance. When he moved into a care home on 24 March 2021, he was able to tell the Officer why he was there. On 31 March, Mr J was able to discuss his care needs with the Officer and agree to lengthen his stay in the care home so his needs could be better met.

85. While Mrs J felt it was unwise for Mr J to return straight home, Mr J was deemed able to make this decision. I have not found fault with the way Mr J's capacity was considered. However, he should have been provided with the relevant information about his care to weigh up the pros and cons then reach an informed decision. As mentioned above, this did not happen.

Discharge - Failed discharge

86. Mrs J complains that Mr J's discharge broke down as he was not provided adequate support at home and this put too much pressure.

87. I note Mr J was initially due to be discharged with no equipment or further assessments until Mrs J raised concerns about his continence and mobility. It was only following this that OT input was requested, which resulted in multiple pieces of equipment being provided.

88. The Council says Mrs J did not raise any concerns with the Officer that Mr J's home care package was inadequate. It also says when the Officer tried to arrange a visit, Mrs J suggested it be delayed until after various appointments.

89. Mrs J disputes the Officer's records of their telephone conversations between 8 and 16 March 2021. She says she has no recollection of the Officer asking to visit to check Mr J's care package. Rather, she says he only called to ask for details about the property. She denies asking for any visits to be delayed and said she would have been able to accommodate a visit around the appointments.

90. Presented with two conflicting accounts of these phone calls, and no independent record such as an audio recording, I am unable to make a finding about why the Officer's planned visit did not occur.

91. Mrs J accepts that she did not complain to the Officer about the inadequate care package. She felt it would not make any difference due to the Officer's previous reaction towards her concerns. She says she was exhausted too unwell at the time to address it when she did not think she would be listened to. I appreciate Mrs J's point of view, particularly given that she was admitted to hospital shortly after.

92. In its complaint response of 23 June 2021, the Council accepts that, under the Discharge to Assess model, contact should have been made within 72 hours to check whether Mr J's care package was meeting his needs. This did not happen. This was fault. This was a missed opportunity to identify that the care package was not meeting Mr J's overnight needs and significantly impacting on Mrs J's welfare.

93. In the Council's complaint response of 6 August 2021, the Council states it was unaware of Mr J's overnight needs until 29 March 2021, and therefore unable to act before that. However, as above, it was apparent prior to discharge that Mr J had overnight needs.

94. The IDT discharge document dated 22 February 2021, recorded Mr J's pressure areas as intact, which was correct at the time. It also noted that he was using urine bottles for toileting. However, Mr J later developed a moisture lesion and was rated as 'Red' risk for pressure ulcers. He was placed on a two-hourly repositioning schedule. He was also regularly incontinent, including overnight, which would have exacerbated his moisture lesion. Given this, it is difficult to see how a care package of four daily care visits and no overnight care could meet his needs.

95. I asked the Trust to comment on why it felt the domiciliary care package was suitable in these circumstances. The Trust replied that four daily visits was the maximum care package available at home and Mr J's incontinence had improved prior to discharge. This in inaccurate. The clinical records show Mr J was becoming increasingly incontinent prior to discharge. There is evidence that, on discharge, Mr J had repositioning and overnight needs which could not be met by four daily visits. The fact that this was the maximum number of home care visits available does not mean the care package was suitable for Mr J. Nor is it justification for implementing an unsuitable home care package. Instead, a further conversation should have been held with Mr J and Mrs J to explore whether there was a better way to meet his needs.

96. The evidence suggests the home care package was planned based on out-of-date information obtained shortly after Mr J was admitted. There is no evidence that the discharge planning was updated to reflect Mr J's changed needs of increasing double incontinence and an open moisture lesion, which developed from 28 February onwards. Again, this is not in line with the above '*Ready to Go?*' guidance which includes reviewing '*the clinical management plan with the patient each day, take any necessary action and update the progress towards the discharge or transfer date*' and also that '*a discharge checklist should be completed 24-48 hours prior to transfer*.'

97. Had these needs been properly identified during discharge planning, then the Trust and the Council could have properly considered them when planning Mr J's discharge. The failure of the Council and Trust to review Mr J's needs prior to discharge, identify that his needs had increased and discuss this with Mr J and Mrs J is fault. As a result, there was a missed opportunity to consider more appropriate care options and Mr J was discharged with an unsuitable care package which did not meet his needs.

98. Following Mr J's discharge, there was a continued collective failure to identify that his needs were not being met. I have reviewed the domiciliary care records in relation to the care Mr J received at home between 3 and 23 March 2021 by visiting care workers. Mr J's overnight needs continued once he returned home. These records clearly show that Mr J's moisture lesion was significantly worse by 8 March. Further, there are multiple records of Mr J being incontinent both during the day and frequently overnight, involving regular changing and washing of his bedding. His incontinence was present when he returned home and throughout this period. Mrs J is also recorded as telling the carers she was tired after Mr J had been calling out for help in the night. There is no evidence that the care workers raised concerns that Mr J's care package was inadequate, despite frequently finding he had been incontinent overnight.

99. Further, there were missed opportunities by the Officer to obtain meaningful updates about Mr J's care package during his phone calls with Mrs J. The records of these conversations are brief and the only discussion about Mr J's current

wellbeing related to his pain level. There is nothing in the records to suggest the Officer sought to obtain useful information about Mr J's care package, particularly given the ongoing delayed visit. Mr J was home for 20 days without a proper review of his care, either in person or by telephone.

100. Mr J's clinical records demonstrates that he had known overnight needs on discharge. The domiciliary care records along with information given to the Officer by Mrs J, Mr J and the care home shows that these needs were present on his arrival home and continued to be present throughout, with his moisture lesion deteriorating further.

101. There were multiple failures by both the Trust and the Council to identify at an earlier stage that Mr J had unmet overnight needs. As a result, Mr J did not receive adequate care following discharge and would have encountered avoidable distress and discomfort. These failures also cause a great deal of unnecessary stress and upset for Mrs J.

102. On balance of probabilities, I consider Mr J's discharge would not have failed if his needs had been properly identified and met on discharge. Mr J's needs were apparent prior to discharge. The discharge did not fail due to his needs changing once he returned home. Although Mr J had expressed a preference to return home, he was not given all the relevant information about his care needs and care options to make an informed decision.

103. We cannot say whether Mr J would have chosen different discharge arrangements, had the matter been discussed properly with him. He did have a clear preference to ultimately return home. However, the evidence also shows that he was also able to recognise that his care needs could not easily be met at home. Indeed, Mr J later freely consented to remain in the care home, once this had been discussed with him. As a result, Mrs J has been left with significant uncertainty about how the discharge arrangements impacted on Mr J's long-term recovery.

Discharge – Failure to complete a needs assessment for Mr J

104. Mrs J complains that the Council failed to visit Mr J at home to complete a care assessment. She says the Council incorrectly told her an assessment had been completed.

105. The Council records contain a Care and Support Assessment for Mr J dated 10 March 2021. This was completed by the Officer before a home visit had been arranged to assess him and review his care package. The assessment does not refer to Mr J's incontinence or his moisture lesion.

106. Mrs J is noted on the assessment as providing support to Mr J with preparing meals and drinks, washing and drying laundry, emptying urine bottles and dressing him. I will later address Mrs J's right to a carer's assessment.

107. The assessment is updated on 24 and 29 March 2021, following Mr J's move into a care home. The update notes Mr J's overnight needs for frequent repositioning and hygiene care due to moisture damage and double incontinence.

108. The Officer records in both the needs assessment and the electronic case notes that that Mr J had recently developed overnight needs. This is incorrect. The clinical records show Mr J's needs had begun to change before he left hospital. He developed the moisture lesion prior to discharge and his incontinence had been increasing too. I have already addressed the Officer's failure to obtain meaningful updates about Mr J's home care above.

109. Although the Officer completed a care and needs assessment for Mr J, it was based on out-of-date information. Therefore, the needs assessment initially failed to identify Mr J's overnight needs and the need for frequent repositioning round the clock due to his moisture lesion. As a result, the full extent of Mr J's needs, and the impact of this on Mrs J and his care package, was not properly considered until after 29 March 2021. This was a further missed opportunity to identify earlier that the care package was not suitable to meet Mr J's needs. This contributed to Mr J returning home without adequate care in place. This placed pressure on Mrs J, who was struggling to fill the gaps in the care package herself.

Consideration of Mrs J's needs as a carer

110. Mrs J is an elderly lady with chronic health problems. At the time of Mr J's discharge, she quickly became unwell with an illness which developed into a serious complication. On 22 March 2021, Mrs J was admitted to hospital. This condition causes extreme fatigue and takes several weeks to recover from.

111. Following Mrs J's discharge, the Officer phoned her to discuss Mr J's return home. Mrs J shared her concerns that she was still very unwell and was unable to support Mr J, particularly overnight. She felt his return home so soon would significantly impact on her own ability to recover.

112. Mrs J informed the Officer that Mr J was regularly incontinent and calling out overnight. The Officer suggested a 24-hour response service as an option to manage Mr J's overnight needs at home. This service is intended for occasional emergency issues and can provide assistance with toileting. However, it is not intended to be used on a regular basis.

113. In hospital and then at home Mr J was incontinent on multiple nights. This service states that it is for occasional use only and therefore would have been inappropriate for Mr J's needs. The 24-hour response also would not have addressed Mr J's need for regular overnight positioning. Further, Mrs J would still have been disturbed from her sleep every time Mr J called out for help and been required to wait for the arrival and duration of the care workers attendance. This would have impacted on her own recovery.

114. I have not seen any evidence that the Officer took Mrs J's concerns seriously during this phone call. Instead, he maintained that Mr J's needs could be met at home although he had not visited Mr J, reviewed his care package or obtained further information from the care agency or the care home about Mr J's current care needs at the time. I am also of the view that the Officer did not adequately listen to Mrs J's concerns about the impact Mr J's care was having on her own personal health and wellbeing. There is no evidence that the Officer considered her needs as a carer.

115. Where an individual provides or intends to provide care for another adult and it appears the carer may have any needs for support, local authorities *must* carry out a carer's assessment. Carers' assessments must seek to find out not only the carer's needs for support, but also the sustainability of the caring role itself. This includes the practical and emotional support the carer provides to the adult.

116. Where the local authority is carrying out a carer's assessment, it must include in its assessment a consideration of the carer's potential future needs for support. Factored into this must be a consideration of whether the carer is, and will continue to be, able and willing to care for the adult needing care. *(Care and Support Statutory Guidance 2014).*

117. During my enquiries, the Council confirmed Mrs J was not offered a carer's assessment. This is fault. As a result, the impact of the situation on Mr and Mrs J was not considered. The Council's records of Mrs J's phone calls demonstrates that the lack of consideration of her needs as a carer caused her significant distress, worry and frustration.

Complaint handling

118. The complaint handling by both the Trust and the Council was inadequate. The responses did not address all of Mrs J's concerns and failed to identify that Mr J's discharge was fundamentally mismanaged. This is fault. The complaint handling has caused frustration for Mrs J.

Agreed actions

Council

119. Within one month of my final decision statement, the Council will:

- apologise to Mr and Mrs J for the failures surrounding Mr J's discharge. This left Mr J without sufficient care and caused distress and frustration for Mrs J.
- apologise to Mrs J for failing to offer her a carer assessment; and
- pay Mr and Mrs J £250 each in recognition of the impact of this fault on them.

Trust

120. Within one month of my final decision statement, the Trust will:

- apologise to Mr and Mrs J for the failures surrounding Mr J's discharge. This left Mr J without sufficient care and caused distress and frustration for Mrs J; and
- pay Mr and Mrs J £250 each in recognition of the impact of this fault on them.

121. Within one month of my final decision statement, the Trust will:

- review its pressure area management to ensure that patients are being repositioned as required.

Trust and Council

122. Within one month the Trust and the Council will write to the Ombudsmen to explain what action they will take to ensure the Integrated Discharge Team has:

- a robust procedure to ensure that a person's needs are regularly reviewed throughout their admission and care planning is updated as needed;
- procedures to ensure a person's care needs and options are fully discussed the person and their family/carers prior to discharge; and
- ensured staff are aware of the need to involve family members/carers in the process, including properly considering their views and any arising carer needs.

Final decision

123. I found fault with the Trust's failure to ensure than Mr J was always repositioned when required.

124. I found fault by the Trust and the Council with regards to Mr J's discharge planning and the suitability of the care package provided. I also found fault with the way the Trust and the Council consulted Mr and Mrs J about the discharge.

125. I found fault by the Council due to its failure to complete an up-to-date needs assessment for Mr J. Further, the Council failed to consider Mrs J's needs as a carer.

126. The complaint handling by the Trust and the Council was also inadequate.

127. I am satisfied the actions the Council and the Trust have agreed to take represent a reasonable and proportionate remedy for the injustice caused to Mr and Mrs J by the fault I have identified. I have now completed by investigation on this basis.

Investigator's decision on behalf of the Ombudsmen