Case Study Three: Mr N – Move to care home with no consultation

Summary
Mr N, who has been newly diagnosed with dementia, had been living at home before being admitted to hospital. The hospital wanted to discharge him into a care home as it felt he wouldn't be able to cope alone. Mr N had not been consulted in the decision-making process, however, and, after meeting with an IMCA it was decided that he did in fact have the capacity to decide where he wanted to live and was returned home with an appropriate care package.

Background
Mr N had a new diagnosis of dementia and required discharge into a care home as his medical team did not feel that he would be able to manage at home. The aim was for him to be discharged from hospital into a Discharge to Assess bed. Therefore Health were leading as they would be funding the placement until the Decision Support Tool (DST) for Continuing Health Care (CHC) assessment had been undertaken in a nursing home. Mr N was previously living at home with a package of care before his recent admission to hospital and although he has had several admissions to hospital in the past, his last admission was in 2011. It was also noted that Mr N was well known to his GP, and he had a social worker.

IMCA report
'I accessed Mr N's records in the first instance which highlighted that he had communication difficulties as he was very hard of hearing. I noted that previously a communicator had been used several years ago. It was documented in Mr N's medical notes that his social worker was of the view that he had capacity regarding decisions in his life, that she believed the package of care was working well and had no concerns about him being discharged home and was not planning for an admission into residential care. This was also confirmed over the phone when I spoke to her. In addition, it was noted that no capacity assessment specific to the decision at hand (hospital discharge) had taken place, and if it had, this was not documented in his medical notes. I then met with Mr N on the ward. Although communication was difficult at times, with time and a clear voice using simple questions, he was able to appropriately respond to my questions asked. He was able to express his wishes about where he wanted to go and live and had an awareness of the care package he was previously in receipt of.
Following information gathered on the ward I contacted the CHC assessor who was responsible for facilitating discharge and expressed my concerns regarding this case. This included:

- *that no capacity assessment had been completed*
- *2) that there are differing views regarding capacity between health and Mr N's social worker*
- *that if Mr N is discharged into a Discharge to Assess bed, and the decision-maker becomes the local authority, what impact this will have on him if the local authority believes that he should continue to reside at home. The fact that there is a risk he will become institutionalised or experience multiple moves*

- *that best interests and least restrictive options also need to be considered alongside the eligibility of funding.*

These concerns and information regarding the best interests process were then faxed to the ward for the attention of Mr N's consultant and discharge coordinator.'

Barriers which were overcome

The Discharge to Assess process is apparently currently being used in the hospitals as a means of managing the bed crisis. It means that discharge can take place more quickly and patients are not sitting in hospital beds waiting for assessments to be completed and decisions to be made regarding their discharge. Although Mr N no longer needed to be in hospital and the fact that his wider and longer-term best interests were not being considered as part of that process was concerning. In addition, if it was determined that Mr N did have capacity then he would have been moved against his wishes.

Outcome

The DST for CHC was undertaken in hospital whilst Mr N remained there and so he was not discharged into a Discharge to Assess bed. The outcome was mainstream funding so the local authority became responsible for facilitating discharge. His social worker became more involved in these decisions having previously been advised that he was a self-funder and had turned down the request from the ward asking her to come and visit him so they could ascertain if he was back to his baseline, or if in fact he had deteriorated. This led to her being involved in Mr N's capacity assessment on the ward. Following the DST Mr N was deemed to have capacity and was being supported to return home with a package of care.