Walsall Safeguarding Partnership

Safeguarding Adult Review – SAR13

Review in Rapid Time Report

'Eric' (pseudonym)

1. Details of initial referral

Eric was an 85-year-old White British male who had been a resident at a local Nursing Home for two days following discharge from Walsall Manor Hospital. Eric had complex care needs and a number of medical conditions. On 23rd August 2023 the lifeless body of Eric was found in his room by staff. Cardiopulmonary resuscitation (CPR) was not performed.

2. Review in Rapid Time

Reporting agency: West Midlands Police
Date submitted to WSP: 25 August 2023

Short summary of rationale for referral:

Eric was found deceased in his room by staff. CPR was not performed by staff and an ambulance was called. When West Midlands Ambulance Service personnel arrived, they confirmed that Eric had died and asked if a 'RESPECT/Do Not Resuscitate' form was in place. This could not be confirmed at that time and West Midlands Ambulance Service notified West Midlands Police of their concerns that CPR had not been administered.

An investigation by West Midlands Police found that there was a 'Respect/Do Not Resuscitate' form in place for Eric, and no criminal offences had occurred.

West Midlands Police subsequently made a referral for consideration of a Safeguarding Adult Review due to concerns as to whether correct protocols had been followed in the process of transferring Eric from hospital to the nursing home. Concerns had also been expressed in the initial referral as to a delay of one hour in the ambulance service being called and how Eric presented on arrival of West Midlands Ambulance Service.

3. Family context

At the time of his death Eric had been a resident of the nursing home for two days, having been discharged from Walsall Manor Hospital where he had been an in-patient for several weeks. His wife had died the year before and whilst he could eat and drink independently, he was suffering from a number of medical conditions and had care and support needs.

Eric's next-of-kin is recorded as being his niece (no further details known).

4. Initial scoping discussion

The initial referral had been submitted by West Midlands Police due to concerns that proper procedures had not been followed with regards to the administration of CPR.

A fact-finding investigation by West Midlands Police had shown that initial concerns of a possibly negligent omission in not administering CPR, was not borne out. There was a 'Respect/Do Not Resuscitate' form in place for Eric but concerns remained that this had not been properly communicated between partner agencies.

The 'Respect/Do Not Resuscitate' forms had been completed on 2nd August 2023 whilst Eric was an in-patient at Walsall Manor Hospital but had not accompanied him at the point of discharge, transfer and admission to the nursing home.

It was agreed on 15 September 2023 that the criteria for Safeguarding Adult Review as laid down in Section 44 of the Care Act 2014 were met:

Eric had died, procedures had not been adhered to which may amount to neglect, and this was indicative of partner agencies not working together effectively.

5. Review in Rapid Time

Attendees:

- West Midlands Police
- Black Country ICB Safeguarding
- Black Country ICB Care Homes Quality and Safety
- Black Country Healthcare NHS Foundation Trust
- Walsall Council – Adults Social Care
- Walsall Healthcare Trust
- West Midlands Ambulance Service
- Walsall Safeguarding Partnership Case Review Coordinator
- Walsall Safeguarding Partnership (Adults) Chair

The Chair of the Walsall Safeguarding Partnership Safeguarding Adult Board chaired the meeting and began by explaining the process.

It was confirmed that Eric:

- had care and support needs,
- there was reasonable concern how partnership agencies had worked together to safeguard him,
- condition 1 was met as Eric had died,
- there were unresolved concerns as to whether his death resulted from neglect.

It was further noted that there are a range of Safeguarding Adult Review methodologies available, and that a Review in Rapid Time was one option. At the conclusion of the meeting, it would be determined whether all relevant learning had been identified via the Review in Rapid Time process or an alternative form of review was required, and this could include a traditional Safeguarding Adult Review methodology.

It was agreed to work through what had happened chronologically, from Eric's discharge from hospital, the transfer process and his admission to the nursing home.

Hospital:

It was explained that at the point of discharge, whether via the Discharge Lounge or directly from a ward, there is a discharge checklist, which includes the Respect Status of any patient, in use across the hospital. Enquiries at Walsall Manor Hospital found no evidence this had been used when Eric was discharged.

There was discussion as to what led to the failing; human error, staffing levels or newly qualified staff were raised as possible contributory factors. The review by Walsall HealthCare Trust had not identified a definitive conclusion.

The merits of verbal and written handovers were discussed and it was acknowledged that unless there is a documented record, there would not be an auditable account of the information shared.

The hospital ward where Eric had been an in-patient has since implemented an improvement plan, to ensure discharge checklists are completed, and there was further acknowledgement that protocols need to be equitable not only across the hospital but across the Black Country Integrated Care Board.

There is now a Discharge Co-ordinator who takes responsibility for all patient discharges on the ward the patient was discharged from.

It was confirmed that the issues highlighted via this Safeguarding Adult Review have been raised with the Director of Nursing and the safeguarding team at Walsall Healthcare Trust.

It was noted that there will be an audit of the use of Electronic Discharge Summary forms (this is separate to the discharge checklist referenced above) as there is the potential for the form to be incomplete, as was the case in this situation. Further work is being undertaken regarding RESPECT/Do Not Resuscitate notices and the Electronic Discharge Summary. There is also to be a 'quality assurance' visit by the Black Country Integrated Care Board.

The Trusted Assessor Form was completed at the hospital on 17th August 2023 and this was shared with the nursing home prior to Eric being admitted there. The Trusted Assessor Form for Eric did state he was Do Not Resuscitate but the necessary RESPECT/Do Not Resuscitate paperwork did not accompany him when transferred. This indicated that the nursing home may have been aware that Eric was Do Not Resuscitate but proper procedures had not been adhered to, although a key part of the admission process to any home should be to check the Respect Status and clarify this.

The Do Not Resuscitate form is deliberately printed on coloured paper (purple) so that it stands out. This is good practice.

Transfer by West Midlands Ambulance Service:

Eric was transferred from Walsall Manor Hospital to the nursing home by the non-emergency arm of West Midlands Ambulance Service.

Whilst there is an expectation that the required paperwork will accompany the patient, there is no robust check and verification for this.

It was agreed that a more robust process needs to be in place that includes a checklist for non-emergency staff carrying out the transfer process.

This was recognised as being of particular significance' as staff who work on the non-emergency service are not trained to the same level as paramedics and therefore an accessible checklist is to be considered.

Nursing home:

There is a checklist that should be completed when receiving a patient for admission. There is no evidence that this was done when Eric arrived.

A root cause analysis investigation was completed by the nursing home supported by the Black Country Integrated Care Board and the learning was shared and improvements implemented with the care home staff. The care home also improved communication with staff by establishing a WhatsApp group.

Since this incident the induction process for staff, including agency staff, has been reviewed, updated and shared with the agency and their staff.

It was further noted that a communication message has been circulated to all care homes in Walsall with a reminder as to the importance of the admission checklist, and the homes to ensure they have the correct Do Not Resuscitate/Respect paperwork present in place. A WhatsApp group has been set up to improve ease of communication, mainly in respect of staff rostering with separate electronic devices for patient information.

The learning identified through this Safeguarding Adult Review will be shared at the Managers' Forum once completed.

The care home manager is undergoing a 'train the trainer' course on CPR.

Other agency/partner involvement:

GP:

Eric was seen by his GP at the nursing home on 22nd August 2023 at the request of staff due to clinical concerns. This was during a routine weekly visit and Eric would have been reviewed as he was a new admission. All residents are reviewed by a GP within seven days of admission.

It is understood that with such 'ward-round' visits by a GP, the nursing home staff would have access to the nursing home electronic records for each resident. The record for Eric had not been updated to show he was Do Not Resuscitate.

The issue of 'Do Not Resuscitate' was not discussed at that visit and the submission from the GP practice notes that it would not have been 'clinically appropriate' at that time. The issue of Eric's

chronic diarrhoea was noted, as this had been the reason for his admission to hospital. Best practice would be to clarify and check the respect status of each patient at first contact.
A further visit was planned and this would have taken place within two weeks, at which time the issue of 'Do Not Resuscitate' may have been discussed.

The GP practice had received the 'Electronic Discharge Summary' form, and noted in their submission that it did not identify 'Do Not Resuscitate'.

Other issues:

A question was raised as to whether the nursing home staff were aware of police procedures when there is an unexpected death. This was acknowledged as not being a safeguarding issue and as such was outside of the remit of the Safeguarding Adult Review process.

However, it may be worthy of further discussion as to whether care and nursing home managers might benefit from input on police procedures.

Learning identified:

- When submitting a referral for consideration of commissioning of a Safeguarding Adult Review, partner agencies should ensure information is accurate.
- There are protocols in place for when a patient is discharged from hospital, which have been reviewed in light of this Safeguarding Adult Review. These protocols must be adhered to and the checklist completed at the point of handover.
- There are also protocols in place for when a patient is admitted to a nursing home. These protocols must be adhered to and the checklist completed by the receiving setting.
- There appears to be a gap in terms of an auditable record at the point where West Midlands Ambulance Service non-emergency service assumes responsibility for a patient they are transferring from hospital to another setting.

Recommendations:

Walsall Healthcare Trust to:

- provide assurance to Walsall Safeguarding Partnership of a 'review and refresh' of their discharge policy.
- provide an update on their review of the Electronic Discharge Summary form.

Black Country Integrated Care Board to:

- to update Walsall Safeguarding Partnership following a review of discharge policy and procedures at Walsall Healthcare Trust.
- Liaise with Primary Care to seek assurance when reviewing patients in care homes, there is a personalised support plan that includes escalation and resuscitation status.

West Midlands Ambulance Service to:

- update Walsall Safeguarding Partnership as to what action they are taking regarding receipt and handover protocols for their non-emergency service when transferring patients from hospital to other settings.

The Black Country Integrated Care Board Quality and Safety Team to:

- provide assurance to Walsall Safeguarding Partnership that on quality assurance visits admission processes are reviewed at nursing homes for which it has responsibility.

Conclusion

In summarising the discussions, it was the consensus view that the criteria for a Safeguarding Adult Review had been met and that the Review in Rapid Time process had identified all the likely relevant learning and that it was not necessary to commission a 'traditional' Safeguarding Adult Review.

An Action Plan to address the learning points will be produced in line with the recommendations above.