Wolverhampton Safeguarding Together (WST) Learning Lessons Briefing – SAR Stan

The Review

This Learning Lessons briefing has been written as a result of the Safeguarding Adult Review (SAR) which was undertaken to review the experiences of Stan, a 90-year-old man, who was diagnosed with Alzheimer's disease. The SAR followed the methodology of the Serious event analysis.

The timescale of information to be reviewed is between 31st October 2020 and 9th December 2020 during the Covid-19 pandemic.

The Safeguarding Adult Review considered the findings and key learning themes arising from the information provided by agencies who had been supporting Stan.

Information was provided by Stan's family, The Hospital Trust, West Midlands Ambulance Service (WMAS), Care Home, Clinical Commissioning Group (CCG) and Adult Social Care (ASC), all of whom had contact or involvement with Stan prior to his death.

The panel reviewed information obtained from the Hospital Trust's Root Cause Analysis (RCA), WMAS and care home which was shared as part of the Multi provider tabletop review held by the CCG. Alongside the responses by each agency to the family's questions which has been fed into this review.

The key lines of enquiry for the review were as follows –

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- What consideration was given by both the care home and the hospital to informing Stan's next of kin of both his admittance to, and discharge from, hospital?
- What led to Stan's discharge (a 90-year-old man with Alzheimer's) to his home in the early hours of a winter's morning?
- What steps did the Patient Transport Service take to ensure that Stan would be warm and safe on his return home?
- Quality of safe discharge plans

Scrutiny of actions taken by professionals and agencies including areas of good practice and key learning themes were considered and reviewed by the SAR panel.

The purpose of this briefing is to share the learning that arose from the review.

How can you make a difference?

Key messages from the learning to ask yourself for your practice are: -

- *Can I make changes to improve my own practice?*
- *Do I need to seek further support, training, or supervision?*

Background Summary

Stan is described by his family as a very private man who did not like to trouble people, he was not particularly interested in socialising and was happy in his own company. For many years Stan lived with his brother, prior to his brothers passing.

Stan took pride in his appearance and was always well dressed and smart, he had a passion for sport; a Wolves football fan and followed cricket. Despite Stan's dementia he enjoyed keeping up to date with current affairs and politics which he enjoyed talking about to his family.

Stan is reported to have enjoyed a warm home environment and was not concerned about energy bills. Stan's nephew described the average temperature in Stan's home to be 25 degrees.

Stan was a 90-year-old man, prior to October 2020 he lived alone and maintained contact with a niece and nephew. He had a diagnosis of Alzheimer's Disease and had previously had a mental capacity assessment in respect of his care and accommodation; the outcome was that he lacked capacity. Stan was deemed to be at risk of falls; he was receiving four calls per day at home from a care agency. Stan suffered a fall in October 2020 and was taken to hospital and admitted. He was discharged to a Care home on 18 November 2020 with a view to further assess whether he could return home safely. Unfortunately, Stan suffered a further fall at the Care home on 4 December 2020 which led to Stan being taken to Hospital by ambulance.

Stan was presented to the Emergency Department (ED) at 16:40 he was assessed by a doctor and following blood tests that were unremarkable and a CT head scan which showed a resolved subdural he was discharged by Patient Transport Service (PTS) transport to his home address at 04.57 hours on 5th December 2020.

Due to the Covid-19 pandemic there were no visitors allowed in the Hospital trust at the time, in normal circumstances patients are often accompanied by carers or relatives who can confirm address details. The Hospital Trust was also trying to keep time spent in Hospital to a minimum to reduce the risk of spreading Covid-19 where safe to do so depending upon medical need and interventions.

Stan's temporary residence (Care home) was contacted by the Dementia Outreach Team on the 9th December 2020 for a review, the nursing home assumed that Stan had been admitted as they had not returned from ED on 5th December 2020 and was not at the nursing home. ED were contacted by the Dementia Team and confirmed that the patient had been discharged to their home address.

A safe and well visit was conducted by the police and next of kin informed. Stan was found on the floor, unresponsive and cold but was breathing and an emergency ambulance was called. Stan was transported to the ED but suffered a cardiac arrest on route, CPR was stopped on arrival to ED as a DNAR was in place.

The SAR panel considered there may have been missed opportunities to safeguard Stan and his death could have been preventable. The SAR panel and family also questioned whether safe discharge processes were followed or effective, these issues are reflected in the SAR findings and recommendations.

Sensitivity: RESTRICTED

Key findings and recommendations arising for WST Safeguarding Partners and Voluntary Organisations to the SAR. They outline the learning which needs to be considered for effective change.

Key Finding 1 – The Hospital Trust, CCG and Care Home to review the current admission and discharge processes to ensure incidents of this nature can be prevented from happening again. This is to include communication and notification of next of kin.

Key Finding 2 -The Hospital Trust, CCG and Care Home to review and improve systems and processes in place to prevent reoccurrence.

GP practice training and education of team concerning correct recording of changes of address. Also, internal care coordinating staff have a process where they notify the relevant teams regarding changes of circumstances regarding temporary addresses

Clarify the process and who is responsible for updating the NHS spine with temporary addresses

Explore the issues of basic checks and safeguarding training for all Patient Transport Service (PTS)

Key Finding 3 – The Hospital Trust, CCG and Care Home to ensure all members of staff have completed professional curiosity training and seek assurance that this is embedded in practice.

Key Finding 4 - To review and establish a process for serious incidents when there are multiple providers involved in any future incident and consider the effectiveness of information flow and exchange between provider and commissioner.

Key Finding 5 – WST is to seek assurance that Commissioners, care agencies and Hospitals agree and document their role in ensuring that there is continuance of care in circumstances where an adult with care and support needs is discharged from ED

Implementation

An action plan has been developed which will be overseen by Wolverhampton Safeguarding Together' s One Panel.

Some of the learning from the review has already been implemented by participating agencies during the SAR process. The Hospital Trust have also taken the following steps –

- Patient Safety Lead for the Trust and other senior staff undertook a process mapping of all current pathways, to ensure safer systems and more robust processes were in place to help reduce human errors from occurring.
- A thematic analysis of previous events was completed, which allowed the Trust to reflect on previous incident and review trends.
- Review of patient documentation within EDto ensure that it was fit for purpose Monthly audit of compliance undertaken, which has demonstrated improved compliance. ED documentation reviewed and amended.
- Audit of the discharge process, both within the ED and Trust wide.
- Discharge training package for qualified Nurses in development.

- Delivery of a bespoke Mental Capacity Act (MCA) training package Trust wide to the multidisciplinary team.
- Additional categories including 'discharged to wrong address' added to the Trust incident reporting system.
- Discharge checklist developed and implemented Trust wide.
- Appropriate discharge to be discussed at all Trust Governance Meetings.
- Discharge Policy under review.