Learning from Safeguarding Adults Review

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This short briefing summarises the key themes and lessons to be learned following a Safeguarding Adults Review (SAR) undertaken by Surrey Safeguarding Adults Board (SSAB). The SAR commissioned by SSAB and relates to a man referred to as Aulia, who was originally from Indonesia.

Aulia's Story

Aulia was 81 years old at the time of his death; he lived with his wife, who he was married to for 12 years and they did not have any children.

Aulia reported to have received contact from his local council regarding housing benefits which was said to have caused him some anxiety. Historically Aulia had experienced acute psychotic episodes triggered by financial concerns.

On 21 March 2017 Aulia was brought to the Accident and Emergency (A&E) department at St Peters Hospital (ASPH) following an acute episode of confusion and aggression at home. The initial assessment found that he was at risk of unintentional harm due to his confused state, and he remained in (A&E) to be assessed by the Elderly Psychiatric Consultant from the Psychiatric Liaison Team the following morning.

Following the assessment by the Psychiatric Consultant on 22 March 2017, Aulia, was given medication and discharged home with a follow up with the community mental health team. Aulia's wife was happy to have him home and understood that he should not be out alone.

On 23 March 2017 following a 999 call from his home, Aulia was reported to have been threatening to kill himself, Police and Ambulance attended. Aulia was taken to ASPH by ambulance.
Aulia was again referred to the Psychiatric Liaison Team, he was seen, and it was planned for a Mental Health Act assessment to be undertaken. Aulia did not consent to an informal admission. At 4pm it was noted that Aulia was missing, he was found later that day in the lake of a nearby business park, resuscitation was unsuccessful and Aulia was declared deceased upon return to ASPH.

Key Themes Highlighted from the Review

- **Recording systems** for Mental Health Trust employees and the Hospital trust staff have separate recording systems; neither could access the other trusts system.
- **Mental Health staff were not based within the A&E department** – therefore they had to leave the area to record on their system.
- **Poor mobile phone reception in A&E**, Mental Health Trust employees struggled

to contact colleagues whilst they were in A&E.

- A breakdown in **communication** resulted in the staff in A&E not being made aware of the outcome of the psychiatrist assessment, which identified Aulia being at risk of accidental risk to himself and others. As a result, the level of observation was based on the initial risk assessment and was not reassessed following the updated mental health review.
- Improve **communication** when a patients first language is not English.
- **Missing persons protocol** was not easily accessible or useable, which may have led to delay in contacting police.
- **Mental Health Crisis Care did not cover over 65s out of hours**, contributing factor to Mr A presenting at A&E.
- **Mental capacity Act** not considered.
- **Communication** - Use of and accessibility of interpreters and Advanced Mental Health Practitioners (AMPHS)

Learning Themes

Recording Systems

Mental Health Trust and Acute Trust to explore with their respective IT departments the feasibility of SystmOne being accessible in the Emergency Department.

All relevant staff groups should be reminded of record keeping requirements and audits should be undertaken to assure compliance.

What we will do

- SystmOne to be installed on all Emergency Department computers subject to appropriate license checks.
- Mental Health Trust Information Governance Team to look at A&E staff having access to read only access of SystmOne.
- Surrey and Borders partnership NHS trust (SABP) to participate in current monthly documentation audit alongside ASPH staff.
- SABP to provide ASPH with documentation standards for audit which will be incorporated as a psych liaison/mental health section within a joint ASPH/SABP audit tool.
- Audit results to be reviewed at monthly Psych liaison meeting.

Crisis Care Pathway

Mental Health Trust to develop a crisis care pathway for patients of all ages which will prevent patients being taken to A&E inappropriately.

What we will do

- Work together and in partnership with partners and the crisis concordat group hold a workshop to review existing pathways.

Mental Health staff not based within the A&E department

Mental Health Trust to explore the support that they can provide to A&E Department when there is a patient in the department who has been identified as being significantly mentally unwell.

What we will do

- Mental Health Trust staff will complete a high-risk care plan for individuals at the point of assessment (where necessary) for people with significant risk factors who are admitted to the inpatient wards at ASPH and waiting in A&E.
- High-risk care plan training to be included within the competency framework that liaison nurses will undertake.
- All staff will receive training around high-risk care plans as part of their local induction.
- Discussions to be started around the possibility of staff members having the opportunity to experience each other's roles i.e. A&E staff to shadow liaison and vice versa. This will improve relationships and parity of esteem.
- SABP to explore access to the Primary Care Record as part of the shared access record project

Designated mental health area

SABP and ASPH to explore the provision of a designated mental health area within the Emergency Department which is set up with access to SystmOne so that mental health staff can work effectively within the Emergency Department without having to leave to access the SABPFT clinical record system.

What we will do

- Medical Team room will be interim designated area until point B is concluded.
- Explore possibility of including office space in the planned expansion of UCC into neurology to free up a dedicated office space in ED 24/7 for Psych liaison.
- As an interim measure the night member of staff within Liaison to be based in Emergency Department. This will allow increased clinical interface and collaboration. 1:1 observation, would not be the liaison's role, however it would improve access to advise and discussion around patients.

Poor mobile phone reception in A&E

SABP to explore solutions to the current problems associated with phone signal coverage or exploring alternatives such as pagers or Wi-Fi enabled mobiles which can connect to the ASPH network

What we will do

- SABP liaise with ASPH IT to identify appropriate phone replacement. SABP has ordered a team iPhone - awaiting confirmation from Information Governance around use of WhatsApp.

Missing persons protocol

The current 'Missing from Care' protocol is not easily accessible or usable. There is some confusion over the risk assessment required and the actions to be carried out prior to notifying police that a person is not where they are expected to be.

What we will do

- There will be a task and finish group arranged to re-write the Missing from Care policy. This will be managed via the SSAB Delivery Group.

Actions Completed

Crisis Care Pathway

- Single point of access is live in East and West Surrey for all ages.

Recording Systems

- All computers in A&E have had SystmOne installed for SABP staff to access in the department instead of having to leave the department.
- Monthly audits of record keeping by the Liaison Manager in the written record of the A&E department continue to take place at ASPH.

Mental Health staff not based within the A&E department

- Training has been carried out for ASPH and SABP staff around high-risk care plans.
- SABP/ASPH A&E are looking at adding the high-risk care plan to the risk assessment to avoid additional paperwork.
- SABP keep a record of all training and use real life scenarios and target A&E staff first thing in the morning.
- New staff working in ASPH are invited to shadow members of staff in A&E and Psych Liaison as part of induction and this is working well.
- ASPH has access to the patient summary care record but not SABP care record

Designated mental health area

- ASPH new dedicated room has helped improve communication and better working relationships. Both ASPH and RSCH have Core 24 in place which enables a more proactive rather than reactive level of care/services.

Poor mobile phone reception in A&E

- WIFI calling has been implemented at ASPH and has improved communication but noted were still some black spots. Psych Liaison has set up a secure WhatsApp group to ensure that somebody will always pick up the message and can escalate as appropriate.

Missing persons protocol

- Missing from Care protocol updated and published on the SSAB website.

Communication

- All acute trusts have a 24/7 interpreter service.

This summary is one of the ways in which the Safeguarding Adults Board aims to share learning as widely as possible to support practice across Surrey. The briefing aims to pull together key messages from the review and the lessons learnt to enable you and your organisation to reflect and challenge the ways in which we work to safeguard adults from abuse and neglect.

Thank you for taking the time to read this learning summary. If you would like to provide any feedback or have any questions, please email: surreysafeguarding.adultsboard@surreycc.gov.uk