STOCKPORT SAFEGUARDING ADULTS BOARD

01 Background

Mrs Grant was a 93 year old who lived in a Nursing home. She was diagnosed with dementia and was very frail. She had a do not attempt cardio pulmonary resuscitation (DNACPR) in place. Her health had deteriorated in the weeks before her death and she required assistance to eat and drink.

On the day she died, Mrs Grant was being fed by a health care assistant (HCA). The HCA noticed she was choking and having difficulty breathing. The HCA raised the alarm and the registered nurse (RN) attended the scene and an ambulance was called.

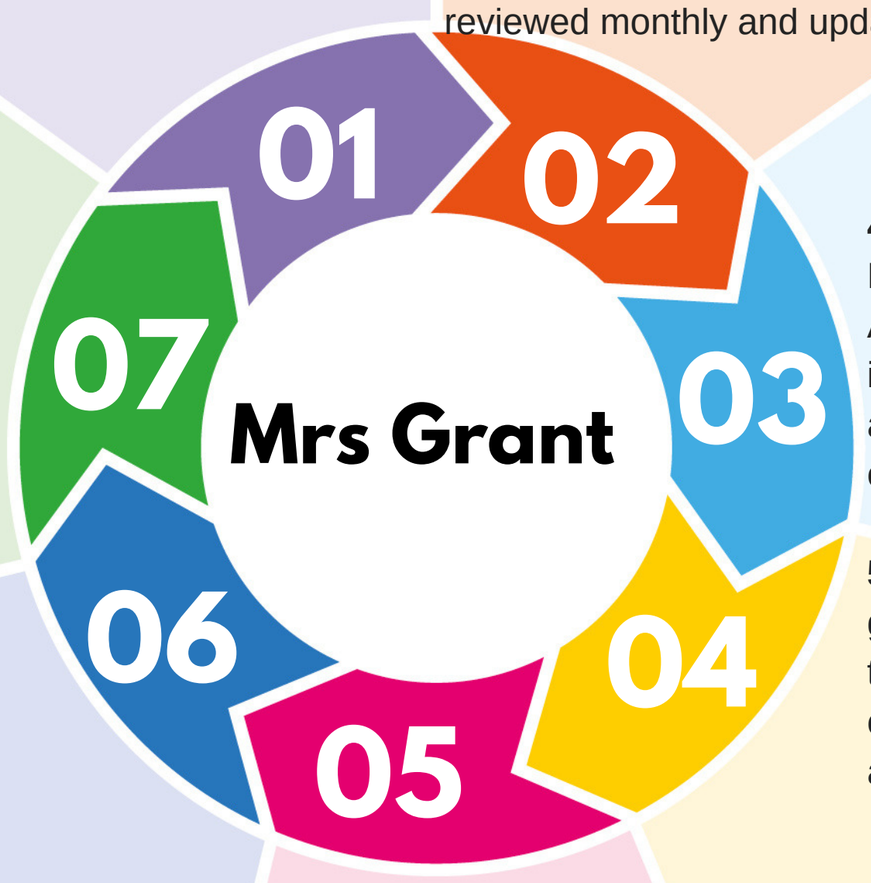
The cause of death was hypoxia, otherwise known as a deficiency of oxygen, followed by aspiration of food.

02 Concerns 1, 2 & 3

1. Communication – The RN did not respond appropriately and left the HCA alone with Mrs Grant who was choking. This was because they went to speak to the operator in another room as the phone was fixed in the office. The RN also did not identify at the time that she was a nurse.

2. Paramedics arrived and found Mrs Grant struggling to breathe, she subsequently went into respiratory arrest. The paramedic sought immediate advice by radio from an advanced paramedic. The on scene Paramedic did not share that Mrs Grant was choking, hence advice was given to cease resuscitation.

3. Risk Assessments - On admission Mrs Grant was assessed for choking and the assessment states she preferred not to wear dentures whilst eating. The risk assessment scored low. However, they were not reviewed monthly and updated accordingly, which left her at risk.



07 Whats next?

Nursing and care homes need to have excellent induction programmes so that new staff are competent, and feel confident, in dealing with emergencies.

Nursing homes also need to be assured that RNs have relevant training, registration and revalidation requirements are in place.

Concerns 4 & 5

4. Risk Assessments - On the day she died Mrs Grant struggled to swallow medication. Although this was not the cause of the choking incident staff did not review or update the risk assessment to assess whether the risk of choking had altered.

5. DNACPR and MCA - While GP followed the guidance and unified policy relating to DNACPR, the GP made the best interest decision based on conversations with the son via email, and without a face to face visit with Mrs Grant.

06 Learning 4 - 8

4. A review of risk assessment should be immediately undertaken in the event of a change of circumstance/health.

5. GPs who make a DNACPR decision should see the person prior, in order to assess their physical health and mental capacity in relation to the decision.

6. All equipment in care and nursing homes should have a written maintenance and testing policy, and an audit log of the test results.

7. Emergency staff need to be aware that under some circumstances, oxygen cylinders may be inadvertently discharged which will lead to an empty cylinder.

8. Nursing and care homes need to have excellent induction programmes so that new staff are competent, and feel confident, in dealing with emergencies. Nursing homes also need to be assured that RNs have relevant training, registration and revalidation requirements are in place.

05 Learning 1 - 3

1. Communication -The person making any 999 call should ideally be in the same room as the resident who needs help. This avoids messages having to be relayed and shortens the line of communication. RNs are required to act with professional standards within the nursing code of conducts.

2. Paramedics seeking advice from other professionals should ensure they provide all the relevant information to enable the relevant advice to be provided.

3. Risk Assessments - All nursing and residential homes need to ensure that all risk assessments are completed, reviewed and updated as indicated within the risk assessments.

Concerns 6 - 8

6. Equipment - When Mrs Grant started to choke the paramedic tried to use two of the home's suction machines to clear an obstruction in her airway. Neither machine was working. This meant there was a delay while the paramedic fetched a suction machine from their vehicle.

7. Equipment -The oxygen cylinder from the ambulance was empty. It appears the reason the cylinder discharged was because a valve may have become caught on the bag it was contained in.

8. Staff Training – Induction training had not been fully completed by the HCA or RN, which included first aid training. The RN did not adhere to basic life support training which include responding to choking.

STOCKPORT METROPOLITAN BOROUGH COUNCIL

Safeguarding Adults in Stockport