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Eich cyf/Your ref:
Ein cyf/Our ref: AC-jb-05-4793
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Professor Adam Cairns
Chief Executive

12 May 2015

Mr A Barkley
Senior Coroner
Coroner's Court
Central Police Station
Cathays Park
Cardiff
CF10 3NN

Dear Mr Barkley

Regulation 28 Report, Elsie May Hayward (died 10 January 2015)

Thank you for your letter dated 19 March 2015 which was received by my office on 26 March 2015.

I have reviewed the points raised within the Regulation 28 report following the inquest regarding the death of Mrs Elsie May Hayward. My response has been informed by senior clinicians responsible for the clinical care provided to Mrs Hayward.

I would of course wish to extend my sincere condolences to the family on behalf of the University Health Board (UHB).

You will be aware that the University Health Board undertook and internal investigation conducted by [redacted] Falls & Bone Health Programme Manager and [redacted] Consultant Nurse for Older Vulnerable Adults prior to the inquest. The report detailed a series o f recommendations for the UHB and a continuous improvement plan was subsequently developed. A summary of the actions being taken forward include:

- At Ward level:
    - Board rounds, safety briefings and MDT meetings are held to discuss risks, actions and raise awareness of the risks of Falls for patients on anti-coagulation.
    - A Disciplinary investigation in to the practice of an individual nurse is to commence due to repeated failures to follow UHB policies and procedures following a patient fall
    - General staff in this clinical area are being retrained

- Local compliance audits are to be maintained
- A Training strategy has been developed and implemented
- Medical staff (including medical students) induction will be revised to include the practical aspects of ward based falls assessment tools/use of bedrails.

This incident, the findings of the investigating and the areas of concern within the Regulation 28 report have been discussed at the UHB Quality, Safety and Experience Committee on 21 April 2015 and also at the Public Board meeting last week on 5 May 2015.

In addition to the measures being taken forward by the Medicine Clinical Board to address the local issues identified, the Executive Nurse Director and Medical Director have issued a Situation, Background, Assessment and Recommendation (SBAR) report across all Clinical Boards within the UHB to ensure that the learning from this case is shared and leads to improvements across the whole organisation.

An Internal Audit of the processes in place for the management of falls within the UHB was carried out during 2014 and was reported to the Audit Committee in April 2014. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risk associated with Prevention & Management of Falls within the UHB was assessed as **Substantial Assurance**. The UHB will now give further consideration to the need for a further Internal Audit over the coming months.

For ease of reference I have set out below the UHB's response to the points you have raised in the Regulation 28 report:

1 **On 7 January 2015 medical staff were having to care for 50% more patients over what is generally considered to be a safe staff to patient ratio. The evidence showed that the team was significantly overstretched and as a result were not able to oversee the care of this lady. Because of the pressures on the team it is likely that there were deficiencies in the care afforded to her which may have contributed to her repeated falls.**

The pressures on staff that were caring for Mrs Hayward during her stay in hospital have been recognised as significant. There were several factors that contributed to this. Over the Christmas period the acuity of in-patients coupled with the level of admissions led to a situation where a number of medical patients were admitted to outlying beds in other specialties. This meant that the medical staff had to care for more than their usual number of patients. We recognise that this is unacceptable and that a safe staff to patient ratio is absolutely paramount to maintain the safety of our patients. Currently there are no national recognised standards for medical staffing levels although this is currently being considered by the Royal College of Physicians (RCP) and the UHB will work with the RCP to agree staff requirements and standards for the medical management of patients who are outliers.

To avoid this situation in the future the UHB is taking forward a number of actions:

- The Clinical Director for Internal Medicine has worked with the junior doctors, led by the Chief Resident (SpR) to agree a process for covering vacancies due to short term sickness/absence to ensure that staffing is not compromised.
- Annual winter planning incorporates the need for additional medical beds over the winter months to accommodate the anticipated additional demand. Planning for Winter 2015 will incorporate the lessons learned from last year to ensure that there are sufficient beds on each hospital site and ensure that as far as reasonably possible there are no medical outliers.
- In times of extreme pressure, the Medical Director makes representation to all Clinical Boards to make sure that as many medical staff are undertaking generic medical duties as possible to increase capacity in areas which are under more pressure.

Additionally the UHB continues to prioritise issues of patient flow and monitors workload pressures for the multi-disciplinary team and recognises associated risks. The Medicine Clinical Board (MCB) will continue to work with the UHB patient flow work stream in order to safely manage patient flow through the organisation. Risks identified will be managed via the Risk Register and acted upon accordingly.

2 **Despite clear guidance and directive the neuro observations on the deceased following her head injury were not undertaken in accordance with the Health Boards procedure and the NICE national guidance.**

As previously described, the case has been discussed at various senior and executive committees including the UHB Board and UHB Quality, Safety and Patient Experience Committee. It has also been discussed at the Medicine Nursing and Midwifery Board with particular reference to neurological observations.

More recently, Welsh Government has issued Patient Safety Notice PSN/009/April 2015 - Awareness of NICE Clinical Guidelines on head injuries - and this has been issued to all Clinical Boards to remind them of the importance of this particular guidance. Within the medicine Clinical Board, Lead and senior nurses will ensure further dissemination of this information to ward sisters by the end of May 2015.

There will be a planned audit by the end of July 2015 of any known patient fallers with a head injury to give assurance that staff are complying with the requirements of the NICE Guidance and relevant UHB policies for the management of patients following falls.

The nurse responsible for Mrs Hayward's care is currently under investigation in line with UHB policy. This issue is also highlighted in the SBAR circulated on behalf of the Executive Nurse Director and the Medical Director.

3 **There were extensive omissions in the note taking and a clear inconsistency between nursing notes and clinical notes resulting in confusion and a breakdown in communication between the nursing staff and the medical team.**

The omissions and inconsistencies in notetaking has been recognised and immediate action has been taken to remove the "core-care plan" and staff will now write individualised care plans for all patients. Further checks have been made in all other areas within Medicine to ensure the core care plan is not being used. The "real time" documentation has also been removed so that only one clinical note is in use.

The Medicine Clinical Board representatives at the Vulnerable Adult Risk Management Group (VARMG) will support the development and dissemination of a new care plan to the clinical areas, utilising champions from the newly formed Falls Focus Group as required.

The Ward Sister has been reminded of the need to ensure safety briefings are undertaken with multidisciplinary staff to ensure that issues in relation to safety are communicated.

The revised nursing establishments will facilitate a clinical nurse being present at Board rounds, ward rounds and Multi-disciplinary Team meetings so that communication can be improved. There is a recognition that this will not be fully effective until all the nurse recruitment has been completed but is imminent.

The UHB, in line with all other Health Boards in Wales does not have a single electronic patient record in place but will continue with all Wales work to progress this agenda which would inevitably bring significant patient safety benefits.
The continuous improvement plan has been presented and discussed at the Medicine Clinical Board formal Board meeting and has also been shared at the UHB Quality, Safety and Patient Experience Committee meeting. The Directorate is required to regularly review the improvement plan and provide assurance to the various quality and safety monitoring mechanisms. An update on progress will be presented at the September 2015 Quality, Safety and Experience Committee.

I hope that the information set out in this letter and the attached continuous improvement plan provides you with assurance that the Health Board has fully considered the issues raised both as a consequence of the internal investigation into this incident and also of your Regulation 28 report of 19 March 2015 and has taken action in response.

If you require any further information please do not hesitate to contact me.

Yours sincerely

[redacted]

Professor Adam Cairns
Chief Executive