GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Our ref: [redacted] Direct Line: [redacted] 13 April 2021

Ms Caroline Saunders
HM Senior Coroner for Gwent
Room 204W
The Civic Centre
Godfrey Road
Newport
NP20 4UR

Dear Ms Saunders

Re: Aneurin Bevan University Health Board response to Regulation 28 Report received following the inquest touching on the death of Mr Alan Jones, DOB 22/06/1926

Thank you for your report dated 16 February 2021, which was received by the Health Board on 19 February 2021. Information has been provided by [redacted] Executive Director Therapies & Health Science and the Executive Director of Nursing.

Further to your report, the information presented below is intended to describe the action taken / being taken by the Aneurin Bevan University Health Board to mitigate the risk of future deaths.

Matter of Concern – Multidisciplinary Care

The Health Board fully accepts that protecting hospital patients from falls and the related harm is the responsibility of the entire multidisciplinary team, both registered and non-registered staff. This is extensively supported by the evidence base and national guidance, which the Health Board both endorses and works to incorporate in its approach to protecting patients whilst in hospital. It is clear from the death of Mr Jones, and other serious incidents where hospital patients have fallen, that the Health Board has scope for improvement and can take further action to strengthen the multidisciplinary approach.

Pencadlys
Ysbyty Sant Cadog
Ffordd Y Lodj
Caerllion
Casnewydd
De Cymru NP18 3XQ
Ffôn: 01633 234234

Headquarters
St Cadoc's Hospital
Lodge Road
Caerleon
Newport
South Wales NP18 3XQ

Tel No: 01633 234234

Bwrdd Iechyd Prifysgol Aneurin Bevan yw enw gweithredol Bwrdd Iechyd Prifysgol Aneurin Bevan
Aneurin Bevan University Health Board is the operational name of Aneurin Bevan University Health Board

Your concerns as set out in the Regulation 28 notice, rightly point to the care planning that follows from the initial multifactorial assessment when a patient arrives on a ward or their circumstances change. To be effective in reducing falls and protecting patients from related harm, the care plan must be multidisciplinary, which the Health Board has recognised in revising its Falls Policy for Hospital Adult Inpatients. The entire policy has been reviewed through this lens, to make clear the responsibilities of all professions and disciplines that can contribute to the care of a hospital patient. The policy makes clear the expectation of joint multidisciplinary assessment and care planning. The policy revisions have been completed and are awaiting ratification by the Health Board's Clinical Standards and Policy Group before publication. It will be ratified by end of April, when the supported implementation will commence. Once ratified, a copy of the policy can be provided.

The Health Board recognises that publishing a revised policy will not in itself enable the required change in emphasis towards multidisciplinary care planning and so a policy implementation plan is being developed. The policy implementation plan will be overseen and monitored by the Falls & Bone Health Steering Group, which is both multidisciplinary in its membership and also diverse in representing all divisions across the Health Board. The Falls & Bone Health Steering Group reports to the Health Board's Quality and Patient Safety Committee (a formal committee of the Board). The implementation plan will largely focus on training, targeting the multidisciplinary team and will be delivered both through online learning but also, importantly, through face to face training on the wards. Informing the training will be learning taken directly from serious incident investigations involving hospital falls, using actual case studies. The training will be evaluated and compliance will be monitored, including multidisciplinary participation.

To further support awareness of the multidisciplinary requirements set out in the revised policy, a Health Board wide communications campaign will be developed and launched to coincide with the publication of the policy.
The Falls & Bone Health Steering Group has also developed an action plan for reducing inpatient falls (enclosed). This action plan includes a wide range of action beyond the revision of the policy. A key action in the plan is introducing 'Falls Prevention Collaboratives', which utilise quality improvement methodologies which support identification of specific areas for focus alongside thematic reviews. The 'Collaboratives' follow a similar approach adopted by the Health Board to successfully reduce pressure damage in hospital; they are delivered at ward level with full multidisciplinary participation. Wards and teams that will participate in the collaborative have already been selected and work is underway.

Learning from incidents is key to ward level improvement and preventing future harm and this needs to happen involving the entire multidisciplinary team. The Health Board has established robust arrangements for investigating injurious falls in hospital. All hospital falls resulting in a long bone fracture,

and classified as severe harm, are investigated and presented to the Falls Review Panel, which is multidisciplinary in membership. Hospital falls classified as catastrophic harm are subject to an Executive led investigation, again involving the entire multidisciplinary team. In response to the need to ensure multidisciplinary participation in patient care planning to prevent falls, then it is essential that accountability sits with the multidisciplinary team and that they are all involved in the incident investigations. It is true that in the recent past that the Health Board investigation of falls and reporting (whether to the falls review panel, to Exec led investigations and even to the Coroner inquests) has fallen largely to nursing colleagues. This deliberate change to engage the multidisciplinary team in the investigations and subsequent reporting of findings is a key change being adopted by the Health Board.

In direct response to the Coroner's concerns about multidisciplinary care, the Falls & Bone Health Steering Group will be actively reviewing and monitoring completion of the actions described, with a clear expectation that multidisciplinary participation and ownership of falls prevention care plans can be evidenced.

Matter of Concern – 1:1 Supervision

Clear processes are in place within the Health Board to escalate any staffing deficits within the planned roster and/or any requests for additional staffing requirements. At the time of Mr Jones' fall the Health Board had in place a Nurse Staffing Escalation Policy which articulates everyone responsibility, from Ward to Board, in maintaining appropriate nurse staffing levels and sets out clear actions if there is a deviation from what is required. In addition, daily site meetings occur to manage nurse staffing levels, consider any deficits, manage and identify any potential risks and escalate any supplementary requirements to the Resource Bank. There is clear evidence, by way of 'Healthroster', to indicate there was a recognition and identified need to increase nurse staffing levels to manage enhanced care on many occasions throughout Mr Jones's admission. This requirement had been escalated and acted upon by the Ward Manager, Senior Nurse and Assistant Divisional Nurse – as per Nurse Staffing Escalation Policy. Additional shifts had been created and sent to the Resource Bank. All reasonable steps had been taken to manage the known staffing deficits (as required by the Nurse Staffing Levels Wales Act). Despite this not all temporary staffing requests were able to be filled.

Ward 4/1 is deemed a Nurse Staffing Levels (Wales) Act 2016 (NSLWA) s25B ward and as such undergoes an in-depth bi-annual review and re-calculation to determine acuity, dependency and nurse staffing requirements following the All Wales Bi-Annual Acuity Audit. A review, assessment and recalculation of ward 4/1 took place in September 2019. All quality metrics aligned to the NSLWA were considered, to include falls. The bi-annual review involved the full engagement and contribution of the Divisional Nurse, Senior Nurse, Ward Sister, finance and Human Resources to ensure the ward establishment was fit for purpose and aligned to patient acuity. It is to be noted that ward 4/1 had

previously identified a need for an increase in Health Care Support Worker's to support enhanced care by night and as a consequence the substantive HCSW workforce was increased to support this requirement.

In 2019, on the backdrop of significant vacancies, circa 350 Whole Time Equivalent (WTE), it was imperative that the Health Board considered new roles and responsibilities for acute wards, promoting the principle of the 'Prudent Registered Nurse' with emphasis on appropriate and safe delegation practices. The core care team model was introduced as a result of a collaborative approach between Divisional and Corporate Nursing together with Workforce and Organisational Development. Ward 4/1 was identified as an ideal ward to embed this new model due to the dependency of the patients cared for, hence the recalculation undertaken in September 2019 incorporated the core care team model. The core care team comprised of several different roles, to include:

- Band 4 Assistant Practitioner
- Roster Creators
- Ward Assistants

The implementation and embedding of this new model has since been evaluated and presented to the Executive Team. The overall evaluation was deemed positive.

By way of assurance the Health Board has in place the following to review and maintain nurse staffing levels:

- Biannual review of nurse staffing levels on all s25B adult medical and surgical acute wards.

- A sequence of nurse staffing reviews in other areas/specialties, which include:

  - Assessment areas: ED, AMU, SAU
  - Coronary Care
  - High Care Respiratory
  - Critical Care
  - Theatres
  - Community Hospitals

- A NSLWA Operating Framework and Staffing Escalation Process, the purpose of which is to standardise and inform staff groups of their responsibilities also of processes and procedures for ensuring appropriate and carefully considered nurse staffing in all areas.

- A weekly reporting and escalation process by means of the Executive Safety Huddle by which nurse staffing deficits are reported. A comprehensive report is shared, which includes any incidents resulting in harm which may have been attributed to nurse staffing levels.

The establishment of Registered Nurse and HCSW pools on each acute site to support deployment of staff – taking all reasonable steps to ensure planned rosters were maintained on a backdrop of significant absenteeism and fluctuation in capacity required to manage the pandemic.

The recruitment strategies deployed within Aneurin Bevan University Health Board to address the vacancy factor has placed the Health Board in a far more positive position than some 18 months ago. March 2021 reports a vacancy factor of 165.45WTE Registered Nurse vacancies – with a projected forecast of 121.32WTE vacancies by August 2021.

In addition to the extensive work on RN recruitment the Health Board has also supported a significant increase in the substantive HCSW workforce across all specialities. An additional 145WTE HCSW's have been employed since July 2020, providing continuity in care and improved patient experience.

Other matters not included in Regulation 28 report

I would like to respond to two other matters that you raised during the Inquest that were not found to have contributed to Mr Jones' death and therefore not contained in your Regulation 28 report but outlined in a separate letter dated 15th February 2021. I will respond to each in turn:

Performance of neurological observations following Mr Jones' seven falls

You have specifically asked that we review the Serious Concerns Report performed after the death of Mr Jones and to confirm (with reference to the records) whether the neurological observations were requested post fall and performed according to the Health Board protocol.

On review of the Serious Incident report there are three falls incidents which make reference to a request for neurological observations, which accords with the Health Board protocol. These specific three falls are detailed below. On all three occasions immediate observations were undertaken by staff at the time of the falls and recorded.

Regarding the fall that occurred on 13th November 2020, the clinical review which forms part of the 'Immediate Assessment following an Inpatient Fall' included a request for neurological observations. From the time of the fall, the required observations were undertaken hourly until 10.04 on the day Mr Jones passed away. This information was recorded in the Care Flow System (a system where observations are recorded).

The falls which occurred on the 29th October and the 9th November also detail a request for neurological observations as part of the post fall clinical review. On both occasions the clinical records on our Care Flow System show no evidence that the required observations were undertaken.
It is clear that, despite the request from the 'Immediate Assessment following an Inpatient Fall' for neurological observations, on two of the occasions, this was not completed fully as required.

I am sorry that the Serious Concerns Report we prepared in response to Mr Jones' seven falls did not make this explicit and clear. To ensure that internal serious incident investigations are both thorough and accurate the Health Board will in future seek additional clarity and documented evidence for statements related to care and treatment, including assessments and observations.

Notification of the Health and Safety Executive

We have reviewed the falls and subsequent death of Mr Jones, referring to the incident record and Serious Concerns Report and conclude that this incident meets the criteria of RIDDOR and therefore should have been reported to the HSE for failings in providing and applying adequate fall prevention measures, including close supervision to a patient in a confused mental state. I can confirm that the death of Mr Jones has been reported to the Health & Safety Executive since the Inquest and your letter.

To enable the Health Board to meet the requirements of RIDDOR a dashboard has been developed within the Datix Incident Reporting system to allow visibility of any falls resulting in significant harm. We have also reviewed the Standard Operating Procedure for RIDDOR and incorporated a new section on reporting patient falls. In addition, our Health Board's Head of Health and Safety will be participating in a newly established All-Wales task and finish group to look at the reporting of patient safety RIDDOR's to ensure that we have a consistent approach across NHS Wales.

I hope that this additional information in relation to these two matters is helpful in terms of clarification but also as an update on how we are improving and strengthening in these specific areas.

I trust that this information addresses the concerns raised in your report, however please do not hesitate to contact me should you require any further information.

Yours sincerely

Chief Executive/Prif Weithredwr

Encs ABUHB Inpatient Falls Action Plan (updated 6th April 2021)