Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Your ref/eich cyf:
Our ref/ein cyf: [redacted]
Date/Dyddiad: 15 February 2022
Tel/ffôn: [redacted]
Email/ebost: [redacted]
Dept/adran: Chair and Chief Executive

Private and Confidential
Ms Rachel Knight
Her Majesty's Assistant Coroner
Coroner's Office
The Old Courthouse
Courthouse Street
Pontypridd
CF37 1JW

Dear Ms Knight

Regulation 28 – Eva Eileen Wheeler

Thank you for the correspondence in relation to the above Regulation 28 which was received by the Health Board on 23rd December 2021.

Please be assured that the Health Board has taken this matter extremely seriously and action is being taken to address the matters highlighted during the inquest and those raised by yourself and the Regulation 28 report.

We sincerely apologise to Mrs Wheeler's family and would like to confirm that we have acted as directed by your findings. The details provided below align with the numerical order in which you presented your concerns.

The communication error between staff led to a failure to contact an emergency ambulance to transfer a critically ill patient to a major hospital. Since this incident, computerisation has largely replaced written notes in this Trust, and evidence from staff did not satisfy me that any changes were embedded on the ground. I am concerned that there is not a clear and robust process in place for documenting, requesting and chasing-up emergency ambulances throughout YCC.

With regards to the first matter, the existing process for the "Transfer of an Acutely Unwell Patient" has been reviewed and revised with a view to:-

- Making explicit the role and responsibilities of both nursing and medical staff.
- Providing further clarification regarding the separate stages of the process.
- Reinforcing the need for verbal instructions and discussions to be recorded in the medical records and digital nursing records.

Additionally, a programme of re-education is in the process of being taken forward to ensure that all Registered Nursing staff and Medical staff are fully conversant with the revised process. Paper copies of the revised process will also be laminated and displayed by the nurses station for ease of reference at all times.

Furthermore, staff knowledge and understanding of the process will be monitored by undertaking an audit following completion of the re-education process. This will be undertaken by the Senior Nurse with responsibility for the wards within Ysbyty Cwm Cynon.

A consequence of the communication error (above) was that Mrs Wheeler was given lunch, rather than being kept nil by mouth prior to proposed surgical assessment. There should be a protocol to inform relevant staff when an emergency ambulance is awaited, so that where appropriate, the patient is kept nil by mouth.

With regards to the second matter, the existing process has been reviewed and revised with a view to making explicit:-

- the need to communicate verbal medical instructions clearly and in a timely manner to the Registered Nurse with responsibility for the patient.
- the need to record a "nil by mouth" instruction within the medical records. This should be completed by the Doctor in keeping with best practice.
- the need for the Registered Nurse with responsibility for the patient to record the medical instruction "nil by mouth" within the digital nursing records in keeping with best practice.
- the need for the Registered Nurse with responsibility for the patient to notify all relevant staff of the need to maintain the patient nil by mouth in a timely manner.

The on-call Medical Registrar at Prince Charles Hospital was contacted for advice, since doctors do not work at YCC overnight. Had the on-call Surgical Registrar been consulted, there may have been an earlier diagnosis of suspected sigmoid volvulus. Bowel obstructions are relatively common in an elderly patient cohort, so I question whether provision for joint discussion between the registrars should be built into a protocol.

Nursing, Medical and Patient Safety Lead Officers met on the 14th January 2022 to discuss and explore the requirement for joint discussions as advised above. The existing process for reviewing and monitoring an acutely unwell patient is embedded across all four wards, this being the National Early Warning Score (NEWS). Where a patient's observations are outside of normal parameters or

where there are signs of physiological deterioration, Registered Nursing staff take appropriate action by seeking advice and support from medical staff.

Additionally, there is an ongoing monthly NEWS audit in place to ensure compliance with the NEWS documentation, the results of which are reported and acted upon by the site based Advanced Nurse Practitioner in partnership with the Senior Nurse and Ward Managers. This includes the provision of one to one practice development sessions to aid learning and strengthen clinical competencies.

During out of hours, this process continues and where it is identified that a patient is deteriorating, the escalation process is initiated. Again this processed is embedded across all four wards with all Registered Nurses being fully conversant with the action they are required to undertake, namely refer to the on call medical teams for further advice. In this case, the Registered Nurse with responsibility for the patient followed due process by referring to the medical team on call. The decision as to whether discussion or referral to another specialty is required is a clinical decision made by the on call team taking the call. Having reviewed the process which currently exists between the on call teams, there have been no reported incidents in relation this well-established process and it is therefore concluded that there is no requirement for an "on call shared discussion protocol" to be developed.

Yours sincerely

[redacted]
Prif Weithredwr/Chief Executive