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Cardiff and Vale University Health Board

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[redacted]
Interim Chief Executive

24 January 2017

PRIVATE & CONFIDENTIAL

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

Dear Mr Barkley

Regulation 28 report – Mr M I (Died 14.06.2016)

Thank you for your letter dated 7 November 2016. The letter was issued to the University Health Board (UHB) on 11 November 2016, but unfortunately there is no record of this being officially received. Please accept our sincere apologies for the fact that this has led to a delay in responding to you. You have very kindly agreed to extend the deadline for 14 days, which we are very grateful for.

I have reviewed the points raised within the Regulation 28 report which relates to the very sad death of Mr I. My response has been informed by key clinical and managerial colleagues within the Medicine Clinical Board, who work within the clinical environment in which the care was provided to Mr I.

I recognise that this will have been a difficult time for Mr I's family and would wish to offer my sincere condolences on behalf of the University Hospital Board.

You will be aware that the UHB undertook an internal investigation which was reported to Welsh Government in 2016. The report detailed numerous recommendations for the Directorate and Clinical Board and an action plan was subsequently developed and completed.

For ease of reference, I will respond to each of the matters of concern you have raised in turn:

- **The investigation revealed shortcomings in the way in which Mr I's risk of falls was assessed and recorded, e.g. no clear care plan was introduced until after the fourth fall. Although there were**

some occasions when Mr I was given 1:1 care it was not consistent and despite the increasing number of falls he was not given true 1:1 supervision/observation. This was recommended within the medical notes and that this should have been in place at the time of Mr I's final fall. The reality on the ward was that he was being observed by a nurse on a 1:4 basis. Despite the ward being staffed to "agreed staffing levels" the evidence showed that on the ground, on occasions, there was simply not enough staff to manage the demands of the ward.

Mr I's condition was so variable and unpredictable, and against a background of so many falls, 1:1 care was indicated. The evidence showed that whilst there was a review of his situation after each fall, a more 'holistic' approach, recognising the dangers posed by his unpredictable behaviour, and the causes of that, might have prevented so many falls.

The Medicine Clinical Board, in conjunction with all Directorates, have put in place the following key changes to identify how risk is assessed and the level of specialling that a patient requires to support a more holistic approach. When completing the falls risk assessment, all patients identified as at risk have a falls care plan commenced. This care plan is reviewed weekly, or more frequently as the patient's health and requirements change. Since the tragic incident involving Mr I, the Clinical Board recognises the need for more robust discussion of the risk assessment outcome and the need for 1:1 specialling with families/carers. Families and carers are now actively encouraged to share their opinions if they feel 1:1 specialling is not appropriate for their relative or if they may respond poorly to this type of enhanced monitoring. Environmental consideration and the assessment for quiet areas are also considered. Families and carers are encouraged to visit and stay as long as they deem necessary if they feel that it would benefit their relative.

All patients with known cognitive impairment have documentation completed by themselves or by a relative or carer in order to help healthcare staff learn about the patient as a person. We recognise that in the case of Mr I, regrettably, the 'Reach Out To Me' document had not been completed. All staff have been reminded of this and it will form part of regular documentation audits. Behaviour charts are maintained to identify any triggers for falls and wandering behaviour. Tools such as Intentional Rounding, which ensures that patients are reviewed every two hours in order to ensure that patients have a drink, and are offered toileting in a timely manner are well embedded within all Directorates. Medication reviews are undertaken weekly by the medical team and Pharmacy colleagues to minimise medication interactions and use of sedative medication. Daily Board Rounds supported by a multi-disciplinary team approach are completed to provide a patient centred holistic review.

In addition, the Board and Directorate have engaged in Sensor Mat trials which can be an alert mechanism to nursing staff to identify when patients are moving and are at risk of a potential fall.

Nursing staff that have been identified to provide specialling have been informed that they are not to participate in care that would take them away from their role of providing specialling. The Clinical Board are currently undertaking benchmarking of enhanced observational care within other organisations across Wales and England.

The Health Board has a formal and well embedded process for the management and escalation of issues in relation to safe staffing levels. Ward establishments are set and approved on an annual basis; these are signed off by the Director of Nursing in the Clinical Board and the Executive Nurse Director. There is a 6 weekly off duty in place which is subject to weekly review and requests for staff are placed/managed where there are gaps in covering shifts.

Unfortunately, we know that some ward staff in Mr I's case were unclear on what to do with regards to documentation to support safe staffing levels. All staff have since been reminded of how to access and use 'specialling' documentation which is available on the intranet and this was reinforced with staff at a ward meeting held on 12/09/2016 where the appropriate documentation was made available for all to read.

On a daily basis, staffing levels are operationally managed by the Senior Nurses at ward/departmental level. They liaise with ward sisters and charge nurses and staff are moved to provide the best cover possible, based on patient need on a daily basis. Sometimes, Clinical Nurse Specialists and Senior Nurses are also asked to work clinically in wards and often other additional support staff e.g. physiotherapist etc are approached to support wards. If there are difficulties covering a ward/department, the Senior Nurse will approach the Directorate Lead Nurse to see whether it is possible to release capacity from other areas of the directorate. If this does not provide a solution, the matter is then escalated to the Clinical Board Director of Nursing to identify staff who can be released from across the wider Clinical Board. Every opportunity is undertaken to support safe staffing with the utilisation of Temporary Staffing and Agency, and on-going recruitment drives. Deficits in staffing levels, reported by staff through the patient safety incident reporting system, are reviewed by Executive Directors at the Management Executive meeting on a weekly basis.

The UHB is currently carrying out a project on the 'Specialling of patients' which we hope to have in place in the Medicine Clinical Board ward areas in February 2017.

- **After the first fall, shortcomings were identified in the way that the standard Neurological Observations were carried out. They were not carried out in line with UHB policy. They were conducted by a Health Care Assistant, who had not been trained and who failed to conduct one part of the test for a period of six hours. The omission was not identified by the qualified nurse whose duty it was to oversee the work of the Health Care Assistant.**

The Medicine Clinical Board has undertaken a review of the delegated tasks that are completed by non-registered nursing staff. At this point in time, the Medicine Clinical Board has taken a decision that responsibility for the

completion of neurological observations will be undertaken by registered nurses only. The UHB is currently reviewing the clinical skills of Health Care Support Workers and this issue which has arisen in Medicine, will be considered as part of that review. All registered nurses are aware of their UHB and NMC requirements to ensure that neurological observations are undertaken as per UHB policy, and make a clinical decision on the need to escalate to the relevant clinician, dependant on the results of these observations.

Arrangements are in place to share learning from this incident for the Clinical Gerontology Directorate and for the Medicine Clinical Board in February 2017.

The UHB has now also established a Falls Delivery Group, which will be chaired by an Assistant Director with Executive support from the Director of Therapies and Health Sciences. The group is multi-disciplinary and has representation from medicine, nursing, pharmacists and therapists. The aim of the group is to work with key internal and external stakeholders and partners to provide expertise, review and monitor practice and promote the prevention and management of falls resulting in fractures and other significant injuries across the health community of Cardiff and the Vale of Glamorgan. The first meeting of this group took place on 20 January 2017.

Your findings at Mr I's inquest are of relevance to all Clinical Boards in the University Health Board. A copy of your Regulation 28 report and my response will be shared with all Clinical Boards with the intention that all clinical areas will review the actions undertaken to date and assess areas of clinical risk in their Directorates to minimise risk of reoccurrence of the matters of concern.

I hope that the information set out in this letter provides you with the assurance that the Health Board has fully considered the issues raised as a consequence of the inquest into Mr I's death, and has taken appropriate action in response.

Yours sincerely

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Interim Chief Executive