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

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28 April 2022

Caroline Saunders
Senior Coroner for the area of Gwent
Via Email: gwent.coroner@newport.gov.uk

Dear Ms Saunders

I am writing to provide you with the Health Board's response to the Regulation 28: Report to Prevent Future Deaths, following the inquest into the death of Mr Marvin Rue following a fatal fall in hospital on 2nd February 2021.

As requested, the information presented below is intended to describe the action taken / being taken to mitigate the risk of future deaths.

1. Action that will be taken to address the reason why staff are failing to follow the policies as indicated by their training.

The Health Board's Policy to Reduce and Manage Adult Inpatient Falls, was updated and published in July 2021, to strengthen and make clearer the multidisciplinary responsibilities, for both registered and non-registered staff, about the action required to reduce the incidence of falls in hospital and ensure appropriate care following a fall. Many of the changes to the policy were made in direct response to previous serious incidents involving a fall in hospital, including the fall and subsequent death of Mr A Jones (the subject of a Regulation 28: Report to Prevent Future Deaths received by the Health Board 19th February 2021). Considerable effort has been made by the Health Board to support the implementation and compliance of this policy, including additional staff training to both refresh existing learning but also reinforce the requirements that are new and specific to the Health Board.

As a result of these actions, the Health Board has seen marked reduction in hospital falls, evident since February 2021 and which has been maintained since. Whilst the data is an encouraging indicator of the positive impact of the action taken, there remains the risk of harm from any fall that does occur. Whilst international evidence tells us that it is not possible to eliminate all hospital falls without either depriving patients of their liberty, or stopping

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active rehabilitation, we know that reducing the number of falls overall has a real impact on reducing harm. The Health Board is clear that there is much more that we can do to reduce harm from hospital falls, including deaths and we are determined to achieve this.

The Health Board recognises that despite appropriate policies being in place, practical improvements to assessment documentation, and staff having received the required training (core training and refresher training), there are occasions when staff fail to follow the policy i.e. undertake the required person specific assessments and put in place care plans that have the best opportunity of protecting patients whilst in the hospital environment; which is the specific concern that you raise in this PFD report. The Health Board's primary focus on reducing harm from hospital falls is very much in response to this concern, which we share. It is critical that we gain a better and detailed understanding of why staff are failing to follow the policy so that we can directly address the reasons, which we know will ultimately reduce the incidence of hospital falls further.

The Health Board's approach to answering the 'why question' will look to identify all occasions when non-compliance happens, not only when incidents happen, but also when they don't. Ward level audits are our most effective tool in identifying non-compliance but we will need to undertake them extensively and consistently. Our learning from the investigation of Mr Rue's death is that these audits were not happening in a way that would have alerted us to non-compliance and this is what we need to put right, across the Health Board.

Our Health Board action plan details the approach to audit at ward level, specifically the routine '1 Patient 1 Day', Dignity and Essential Care (DECI) audits (action 3.a) as well as the establishment of a Health Board wide cycle of audits (action 2.c), which will actively monitor agreed metrics such as completion of the MFRA and associated care plans.

These audits will allow us to firstly identify non-compliance and then undertake a deeper analysis of the reasons why staff did not follow the policy; this will allow ward areas to take specific remedial action, whether it be additional support for staff (on an individual or team basis) and / or practical changes in the operational running of the ward. The Health Board will also be expecting that local, ward level learning from these audits is shared and applied wider in the Health Board.

In addition to the ward level and Health Board wide audits, the routine monitoring of falls incidence data, at a hospital and ward level, provides the Health Board with an additional early warning of areas of concern. The Health Board has an established data dashboard for hospital falls, which presents the data at this granular level (hospital and ward level). The dashboard is updated monthly and shared extensively across the Health Board. We use this information to inform us about areas of concern for targeted action, including a deeper analysis about what might be happening at ward level such as non-compliance with the policy.

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The Health Board is not complacent in its drive to reduce hospital falls and related harm, such that we are actively exploring action taken in other health and care organisations to reduce falls and challenging ourselves about whether we can do more. The Health Board participates in both the National Inpatient Falls Network and the Four Nations Falls Collective, which provides an important means of comparing practice and benchmarking performance and outcomes, both within Wales and across the four nations of the UK. The Health Board continues to seek assurance that the action it is taking is effective but also whether there is more it can do, such that it is working with the Four Nations Falls Collective in exploring opportunities for establishing external peer reviews.

2. Reassurance that Senior Management within the Health Board is fully aware of the risks posed to patients through regular monitoring of adherence to the Falls Policy.

I can reassure you that the Health Board receives regular briefings and updates about the risks of falling in our hospitals. The Health Board is regularly briefed on the falls related incidents, including trends from the dashboard data but also about individual serious incidents when they happen, and importantly action being taken in response. Regular briefings are received by the Executive Team (weekly) and the Patient Quality, Safety and Outcomes Committee, which is a formal committee of the Board (bi-monthly).

The Health Board recently commissioned Internal Audit to undertake an audit seeking to provide assurance that the Falls Policy was being adhered to by staff and monitored appropriately. This audit was completed in March 2022 and issued overall reasonable assurance.

Within the audit two areas received substantial assurance, which were the falls policy and the oversight and monitoring. One area received reasonable assurance which was policy application and adherence. One area received limited assurance which was MFRA completion. Related to the latter area, a management action plan has been agreed that responds to recommendations from the audit. I have enclosed for your information the full audit report, which includes the management action plan.

3. **A revised action plan which takes points (1) and (2) into account**

The revised, corporate falls action plan is enclosed with this response. Whilst the action plan provides a comprehensive overview of the wide range of action that will collectively help to reduce hospital falls, please note that action points 2.c and 3.a are specific to the concerns that you have raised, to use ongoing ward level audits to monitor the adherence to the policy and use them to understand and address the reason why staff are failing to follow the policies as indicated by their training. Further detail about these aspects, specifically responding to non-compliance of the policy and the expectation of action required, is also included in the agreed management action plan within the enclosed Internal Audit report.

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The Health Board would like to note that the action plan is deliberately multi-faceted and diverse in the range of action identified to achieve the intended reduction in hospital falls and associated harm, but we know that no single action in isolation will make a difference. In the past a lot of emphasis has been placed on completing risk assessments and care plans, which are very important, especially related to decisions to provide enhanced care for patients at risk of falling. This can however be misleading, as enhanced care provided for a patient at risk of falling will not in itself prevent them from falling, as so many other multi-factoral risks also need to be addressed.

An important change in emphasis and focus for the Health Board in its work to reduce hospital falls is in challenging the clinical decision to admit somebody at risk of falling into a hospital environment, which considerably increases their risk, equally the decision not to discharge back to their safer, home environment. Whilst a hospital admission can be necessary to deal with an acute medical episode, once that is achieved then a continued hospital stay is unnecessarily exposing patients to risk. The Health Board is actively challenging decisions around admission and discharge and holding to account where patients are being unnecessarily exposed to risk; this has had an increased emphasis in our investigation of falls related incidents and we feel has the biggest potential to reduce hospital falls.

Delivery of the action plans will be overseen and monitored by the Executive led Falls & Bone Health Committee and reported to the Executive Team and the Patient Quality, Safety and Outcomes Committee.

It should be noted that the action that the Health Board has taken and described in this response, and set out in the enclosed action plans, some of which is in direct response to the PFD report received on 19th Feb 2021, has been implemented after the Mr Rue's fatal fall on 2nd February 2021. The Health Board is fully committed and determined to reduce harm and death from hospital falls by implementing these action plans, which sadly will not change the outcome for Mr Rue.

I trust that this information addresses the concerns that you have raised.

Yours sincerely

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Prif Weithredwr dros dro/Interim Chief Executive

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