GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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Mr John Gittins
Senior Coroner
North Wales (East and Central)
Coroner's Office
County Hall
Wynnstay Road
Ruthin
LL15 1YN

Ein cyf / Our ref: JW/MJ/DL/3115
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E-bost / Email: [redacted]
Dyddiad / Date: 10th June 2022

Dear Mr Gittins

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Nora Jane Foulkes

I write in response to the Regulation 28 Report to Prevent of Future Deaths issued by yourself to Betsi Cadwaladr University Health Board, following the inquest touching the death of Nora Foulkes.

I would like to begin by offering my deepest condolences to the family and friends of Mrs Foulkes, and I apologise for the concerns identified at the inquest that have given rise to your notice.

In your Notice, you raised concern that although the original failure to restart the deceased's treatment for her hypothyroidism would appear to have been discussed and agreed between the Advance Nurse Practitioners (ANPs) and the care home when a medication review was conducted, the deceased was subsequently seen by ANPs on six more occasions between then and her subsequent admission to hospital and as a result there were multiple opportunities for this error to be spotted and corrected but this did not happen because at those visits there was no consideration being given by the ANPs to the patient's medication regime to ensure that appropriate treatment was being provided.

In response, I can advise that a safeguarding referral has been made and that we have undertaken an internal review of the staff involved. The findings of this review have been shared with the Local Authority Safeguarding Team. They have confirmed to us, on 19 May 2022, they are taking no further action as they are satisfied with the lessons learned and actions taken in relation to staff and wider learning which is detailed below, such as improved record keeping and medication reviews.

The best practice guidance is under review for Advanced Nurse Practitioners (ANP) and a regular quality improvement meeting for Independent Nurse Prescribing, chaired on a Health Board wide level by the Deputy Executive Director of Nursing, is held where learning is disseminated on a monthly basis. We expect the review to be completed by 30 September 2022 and the learning and any changes to practice as a consequence will be disseminated through this meeting structure and agenda.

A rolling training programme facilitated by the medicines management nurses is in place and open for all nursing and residential homes across the Health Board. Attendance records are kept for each training session.

Due to the incident not being reported at the time, a formal review was not undertaken or reviewed by the Health Board's Incident Learning Panel. We will conduct a formal internal investigation to identify root causes and lessons learned. Which will be disseminated to all district nursing teams. This will be completed by 30 June 2022.

Concern was also noted that whilst ANPs could access medication charts if required, this was not being done routinely. I can advise changes have been made to the way the local District Nursing team in the Ruthin and Corwen locality work, which incorporates a documented medication review at each visit. A check list has been developed to prompt clinical staff to review key criteria at each visit, including medication changes/administration. The checklist is initialled by both the visiting nurse and the home manager/deputy. The checklist forms part of the patient's individual nursing record for review and auditing.

The learning from this matter, including the medication review issues identified above, will be checked across all district nursing teams to ensure consistent practice across the Health Board. We will survey all teams to assess their level of compliance. This will be completed by 30 June 2022.

Following this survey, all district nursing teams will develop (or review and adapt) a Standard Operating Procedure/checklist to meet the needs of their own services that provides assurance of medication reviews. This will be completed by 31 December 2022. We will discuss with our Clinical Effectiveness Team how this can be audited over a longer period of time, to ensure that we have ongoing assurance that the changes have been embedded and sustained.

We also note your concern that the absence of proper scrutiny or review of the medication of elderly patients in care homes during each visit presents a risk as it can lead to the type of error which occurred in this case not being identified.

In response, I can advise that we have taken the following steps:

As above, the local district nursing team now conducts medication reviews at every visit, which is documented and countersigned by the home manager (or their representative).

The Health Board Policy (MM03) includes audit of prescribing as a standard for all nursing managers and independent prescribers. The Corporate Nursing Team has initiated a task and finish group to plan the launch of the most recent ratification of MM03 in July 2022 which will include re-education of managers and Independent Prescribing responsibilities.

All ANP prescribers are required to sign an annual declaration of compliance. This is stored on a centralised database and is reviewed as part of annual performance and development appraisals.

The Health Board medicines management nurses carry out audits within care homes – although this does not specifically scrutinise prescribing, it covers storage and compliance with administration in care homes identified as being in escalation at the request of the care homes team.

Further learning and action includes:

- The Health Board will undertake a review of the Medicines Policy (MM01) and other related policies to clarify the process of prescribing in community settings, including clarity around the non-medical prescribers' roles, responsibilities and follow up arrangements. This will be completed by 30 September 2022.

- Medication administration training will be delivered to all residential and nursing home settings. The Heads of Primary Care in collaboration with the Area Nurse Director will complete and submit a business case for the required investment. The existing IMTP bid will be escalated back to executives for consideration of regional funding.

- An audit of the existing rolling training programme will be developed to identify homes where training is incomplete or out of date this will include the introduction of a compliance matrix to enable training compliance to be reviewed in real time. This will be completed by 30 September 2022.

- A proposal has been developed (currently under review) for the Central Community Pharmacy team to work more collaboratively with the Central (Area) Community Resource Team (CRT) which will include regular structured medication reviews for nursing and residential home patients.

- A Welsh Government pilot project has been developed (for future implementation) with a view to community pharmacy carrying out medication reviews of patients in care homes.

I hope my letter offers you assurance that we have worked to address the concerns you identified.

One again, please may I offer my condolences to the loved ones of Mrs Foulkes.

Should you require any further information or evidence of the actions outlined above please contact either myself or Matthew Joyes, Associate Director of Quality.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Yours sincerely

Prif Weithredwr/Chief Executive