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Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Wednesday 15 May 2024

Caroline Saunders
Senior Coroner (Gwent)
[redacted]

Dear Ms Saunders

Re: Regulation 28 Report received by Aneurin Bevan University Health Board further to the inquest touching on the death of Neil Francis Edwards which concluded on 8 March 2024

Thank you for your Regulation 28 Report dated and received by the Health Board on 20 March 2024.

I am writing to provide you with the Health Board's response to the Regulation 28 Report to Prevent Future Deaths, which was issued following the inquest into the death of Mr Neil Francis Edwards.

As requested, the information presented below is intended to describe the actions which have been taken/are being taken by Aneurin Bevan University Health Board to mitigate the risk of future deaths. You require the Health Board to provide you with the following information:

1. **Confirmation as to whether it remains the policy of ABUHB to investigate deaths arising from in-patient falls.**

The Health Board has a Falls Policy in place for Hospital Adult inpatients. The Falls Policy must be implemented at all levels within the organisation to ensure a safe and consistent approach is adopted. The aim is to reduce avoidable, injurious falls whilst ensuring appropriate management of patients who experience a fall, to include collaboration with intermediate care and the frailty programme.

In order to discharge the requirements of the policy the Health Board has in place a Falls Review Panel (FRP) which meets monthly to review incidents of injurious inpatient falls. All inpatient falls that result in a fracture need to be reviewed by the panel and there is a focus on identifying learning and agreement of appropriate actions in support of the reduction of incidents. The incidents discussed are those identified as high severity due to associated fractures.

Falls are reported via the Health Board's incident reporting procedures, namely by completing an incident report via our electronic 'RL Datix Incident' reporting system. These reports are circulated to relevant staff and senior managers for review and action. Where any concerns are identified, consideration will then be given to the form and type of post fall investigation required. For cases identified where moderate harm or above, these will be managed in line with the Health Board's

‘Patient Safety Incident Reporting and Management Policy (Duty of Candour: Moderate/Severe Harm).’

The aim of the panel is to reduce the number of in-patient falls and the number of in-patient falls with a fracture.

The objectives of the Falls Review Panel are to:

- Put processes in place to identify all inpatient falls with fractures and to monitor the number of cases and their location.
- Review individual cases to check whether appropriate care has been provided to prevent falls, including risk assessments and care plans.
- Ensure wards put in place appropriate action plans to address any deficiencies identified
- Identify factors that are most often present in falls with fractures and ensure these are part of the risk assessment process and training.
- Make recommendations on good practice to Falls Bone and Health Steering Group
- Make recommendation re specific training needs/actions where themes/clusters are found.
- Identify issues where a specific piece of work is required to assess effectiveness, for example the use of pressure sensors in acute wards
- Determine whether cases should be referred to the Division for further consideration for redress
- Support the reporting of a fractured neck of femur from inpatient falls as a Serious Incident to Welsh Government, and the timely closure of cases.
- Provide summary reports to the Falls Bone and Health Steering Group /Quality and Patient Safety Committee as required.
- Review National Reports that benchmark ABUHB against similar organisations and National Guidance on Falls Prevention and support actions to improve the prevention of falls.

A representative from the ward where a patient sustained the fracture attends the panel to describe the patient’s risk factors for falls and the actions that were put in place to reduce the risk of the patient falling. The main focus of the Panel is to learn more about what we can do to prevent in-patient falls, the ward staff are the experts in this and therefore all staff attending the Panel are encouraged to share their learning in relation to falls and what can be changed to reduce the number and severity of in-patient falls.

In line with current processes each reported incidence of a fall with fracture is subject to an investigation by the respective ward, these findings are presented to FRP. Aligned with the objectives of the panel, factors for discussion include the circumstances surrounding the incident, the status of the patient on admission leading up to and post fall, the contributory factors and overall provision of care to include all risk assessments.

There is an investigation form that must be completed about the fall that is presented to the panel and there also needs to be a full copy of the multi factorial falls risk assessment (MFRA) tool and Care Plan for the patient to be discussed at the panel too. Other relevant supporting information or evidence (e.g. bed rails assessment) is also encouraged at the meeting to enable a thorough discussion, the incidents are also reviewed in the context of compliance with the ‘Falls Policy for Hospital Adult Inpatients’ (ABUHB: 2021).

The FRP is constituted of a multidisciplinary substantive membership alongside those clinical staff presenting the incidents. It provides a forum for open discussion on the factors identified during the investigation, subsequent actions implemented by the ward and the associated monitoring processes. The FRP reviews the associated themes across the cases presented which may be

cross Divisional and the actions requiring implementation with escalation as necessary through the Health Boards defined quality, patient, safety governance structures. Documented outcomes of the FRP discussions are provided to those present at the panel reviewing the individual cases together with the substantive membership for onward cascade and to inform discussions and actions at Divisional level.

As I have set out previously Falls incidents are identified through RLDatix and falls of moderate harm and above are discussed weekly with Clinical Executives to discuss what immediate investigation is needed. Falls data is analysed weekly and a falls report is sent out to all ward managers. Incident reports with themes and trends, including the number of in-patient falls, key variations by Division and the severity of harm are produced for the Patient Quality and Outcomes Committee.

Where it is identified that the fall and therefore NHS care and treatment provided to the patient has or may have, contributed to unexpected or unintended, moderate or severe harm or death, this will also trigger a formal Duty of Candour review as required by the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and a Serious Incident Investigation will be commissioned.

The Health Board's Serious Incident Process has been reviewed to improve the scrutiny of incidents. Serous Incident meetings are considered mandatory and investigating officers are now appointed in advance of the first meeting to ensure the investigating officer can be present and engaged from the outset. The Health Board has been delivering Investigating officer training since September 2020 which includes SIs and complaints. The workshops are human factors based and provide Investigating Officers with a range of methodologies to use in their investigations.

Improved and standardised agendas have been introduced as part of the SI process to ensure that the scope of investigation and robust terms of reference are captured and referred back to at the end of the process and this will include the involvement of patient families and any concerns they may have, from the outset. The standardised agenda includes a prompt to ensure reporting to external Agencies such as NHS Executive and the HSE.

Once the investigation has been completed the governance of each report follows a robust three stage process: Divisional Director/Nurse approval of the report and action plan this is then approved by the Chair of the Serious Incident process, and finally there is Clinical Executive approval. This is in addition to the Patient Safety Incident team scrutiny for quality.

2. **Confirmation whether, in light of the circumstances described at the inquest, action is being taken to ensure that patients who require 1:1 observation are afforded this level of care in the future.**

In August 2021, the Health Board developed and then launched a person-centred Enhanced Care Framework. The purpose of the framework is to provide personalised, appropriate, consistent and high-quality enhanced observation/care for those patients deemed appropriate to receive such care requirements. The person-centred Enhanced Care Framework incorporates an individual management plan and tool kit to aid assessment of a patient's needs and supports the delivery of safe and dignified patient centred care.

Supported by the patient centred care team the framework has been rolled out across all acute and community wards to ensure patients requiring a level of enhanced observation and supervision, either through an increase in observation, being cared for in a cohorted environment or requiring 1:1 nursing care, are identified and appropriate care and observation initiated.

The Health Board has recently (May 2024) revised and updated the Person-centred Enhanced Care Framework. Lessons learned from patient safety incidents, feedback and audits have informed the revised framework. The main focus of the revised framework is to ensure patients receive the

appropriate level of enhanced care / supervision that is proportionate to their needs and that this is based upon careful risk assessment and care planning.

The revised framework has been developed by the Patient-Centred Care Team, Divisions of Medicine, Surgery, Urgent Care and Primary & Community Care to ensure it is robust and appropriate to meet the needs of patients requiring enhanced care / supervision.

The launch of the revised framework will be supported by a bespoke education package to ensure all staff fully understand the revised framework. A full communications programme will also take effect to ensure there is widescale awareness of the changes.

In summary, a number of changes have been made to the Enhanced Care Framework:

- Amended the enhanced care framework document to a 7-day document - to keep all relevant paperwork together
- Included collaboration with patient and family in the enhanced care management plan section, in addition staff must make a record of any conversation in the patient's clinical records with family members on expected levels of care delivery and involvement, plus carer information leaflet to be given.
- Included a blank management plan into the enhanced care document to ensure anything that is specific to the patient is included and it is person centred
- Included agreed delegation of care to non-healthcare worker in the management plan
- Changed green level of care to yellow following feedback from staff, findings from audit and coroner's reports
- Strengthened the mental capacity/best interest and deprivation of liberty section by making it clearer what is required by staff
- Devised a new risk assessment so it aligns with the enhanced care framework document
- Created an 'are you considering enhanced care' flow chart as a staff aid, to highlight least restrictive practice and alternative support.
- Added the staff requirements when caring for a patient at a red level and 24-hour supervision where the patient must not be left unattended.
- Whatever level of supervision the patient has been assessed as requiring must be provided. For example, if a patient has been assessed as requiring continuous 1:1 direct supervision, this must be fully provided at all times. If there is any reason why this cannot be provided this will be escalated as appropriate to ensure the patient's safety is maintained – this may on occasions result in a temporary delay in other non-urgent care delivery tasks as the priority must be towards providing enhanced care / supervision to maintain safety.
- Enhanced care / supervision will be provided by substantive staff in the first instance as apposed to non-substantive staff.
- Positive progress is being made to appoint Activity Co-ordinators for all acute and community wards to ensure meaningful activities are encouraged appropriate to individual needs.

The implementation and impact of the changes to the framework will be monitored closely to ensure optimal patient experience and safety. Ward Managers will be accountable for ensuring the revised framework is followed.

In order to support safe nurse staffing levels, the Health Board has implemented Health-Roster & Safe-Care across the Health Board. This is a digital platform which gives nurses the visibility of staffing levels across wards and departments, allowing them to maintain safe and compliant patient care based on patient numbers, acuity and dependency. It supports day-to-day operational changes to the roster in real time, facilitating the redeployment of staff to support enhanced care

requirements. The system enables a review of daily staffing levels and whether they are deemed safe to meet clinical demand.

Safe-Care provides the functionality to enter acuity and/or dependency data to inform evidence-based decision making on staffing requirements and workforce. This provides a visual platform of establishments, skill mix, patient demand/acuity in real-time to ensure informed decisions are made and supports acuity-driven staffing level requirements

In line with the Nurse Staffing Levels (Wales) Act 2016 the Health Board undertakes a bi-annual audit of patient acuity which informs a recalculation of nurse staffing levels. Any changes outside the bi-annual audit to the purpose of a ward, requires an additional recalculation. By way of assurance Board receives the outcome of the recalculations on an annual basis. Significant investment into nurse staffing levels has been secured since the inception of the Act.

The Health Board has a well-established process to manage and escalate nurse staffing deficits ensuring all reasonable steps have been followed to maintain nurse staffing levels, these include, a Nurse Staffing Operational Framework to standardise and inform staff groups of their responsibilities, processes and procedures for ensuring appropriate and carefully considered nurse staffing in all areas. Staffing deficits across the Health Board are reported weekly to include:

- Filled and unfilled Registered Nurse (RN) shifts against planned rosters
- Filled and unfilled Health Care Support Worker (HCSW) shifts against planned rosters
- Percentage of substantive staff versus agency staff populating rosters to gauge quality, safety, and continuity of care.
- A workforce tracker is presented to the Executive Team detailing progress on recruitment, bank and agency usage, turnover, and absenteeism.
- Daily review of nurse staffing levels is undertaken by the divisional and site teams – to manage and mitigate risk.
- A Nursing, Midwifery and SCPHN Workforce Strategy 2023-26 was approved by the Board in May 2023. Positive progress has been made against the priority action plans aligned to the strategy.

I trust that this information reassures you with regard to the matters raised, however, if you require any further information or assurance, please do not hesitate to contact me.

Yours sincerely

Prif Weithredwr | Chief Executive