[redacted]
Executive Director of Nursing | Gweithredol Cyfarwyddwr Nyrsio

[redacted]
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Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Your ref: [redacted]

18 December 2024

Private & Confidential
Caroline Saunders
Senior Coroner for Gwent

SENT VIA EMAIL: [redacted]

Dear Ms Saunders

Re Aneurin Bevan University Health Board response to Regulation 28 Report received following the inquest touching on the death of Jean Thomas

Thank you for your letter and accompanying report, which the Health Board received on 23 October 2024.

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 Jean Thomas.

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 required the Heath Board to provide you with the following information.

Reassurance that fluid balance is monitored by the nursing and medical staff, and the response must contain details of action taken and proposed to be taken, setting out the timetable for actions.

Firstly, the Health Board would like to provide assurance that it is committed to improving what is basic but vital monitoring documentation to prevent deterioration and to monitor patients' health needs. The Health Board has a commitment to improved compliance, which is demonstrated through our ward accreditation process where fluid balance performance forms part of multiple audits including daily, weekly, and monthly monitoring. We aim to enhance education through the Cross Divisional Task and Finish Group and adopt a multi-disciplinary approach to the use of fluid balance monitoring to improve patient outcomes and prevent avoidable harm.

Following the raising of the matters of concern, it is recognised that additional training and education is required to ensure that staff are clear on their responsibilities and the importance of using the fluid balance tool to prevent patient harm.

The action plan the Health Board has developed will enable the improvement of monitoring of patient fluid balance across the organisation, improve management of patient's fluid balance by the multi-disciplinary team, and provide assurance on the review of quality and compliance of fluid balance monitoring as an ongoing quality indicator.

A review of current Health Board documentation and monitoring tools across the Region, alongside a review of recommended National Guidelines has taken place to provide the evidence base that will lead to best practice.

Learning implemented to date and future plans:

A pilot project on fluid balance monitoring will be initiated on a surgical ward, incorporating education, information boards, and sharing and auditing of data. The pilot will evolve into a broader implementation project once the PDSA improvement tools demonstrate progress in the pilot area.

A Health Board Multidisciplinary Fluid Balance Task & Finish Group has formed with key objectives set which include:

(1) Standardisation of Fluid Balance monitoring documentation across the organisation.
(2) Exploration of the possibility of utilising a digital observation platform to record fluid balance.
(3) Development of a multidisciplinary Fluid Balance Standard Operating Procedure.
(4) Increase awareness about the expected standards for fluid balance monitoring across the Health Board through various communication methods, such as feedback sessions, posters, emails, ward meetings, weekly cross-divisional ward meetings, and learning events.
(5) Identification and delivery of the multidisciplinary training requirements to ensure sustainable improvement in fluid balance monitoring.

Education programs will be strengthened to support multidisciplinary team members understanding of their roles and responsibilities in managing patient fluid balance, in accordance with NICE guidelines. The programme will equip staff with the knowledge required to ensure best practice.

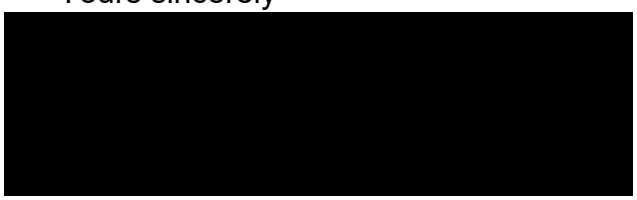
Compliance with fluid balance monitoring and subsequent improvements will be incorporated into the work of the Nutritional and Hydration Committee. Senior medical staff will be engaged clinically to support education and establish clinical expectations. Learning from Medical Examiner feedback and the Quality Safety Learning Forum will be incorporated into the improvement plan.

The AMAT tool will be used to standardise the audit process for fluid balance compliance across the health board. Audits will be carried out in accordance with the Ward / Team Accreditation process and will be reported to the Nutrition & Hydration Committee.

Fluid balance monitoring will be added to the Nutrition and Hydration Committee risk register and will be kept under review until improvements in standards are consistently achieved.

I would like to personally assure you that there is Health Board wide multidisciplinary commitment to ensuring improved standards are met and sustained in relation to fluid balance monitoring. I trust this information and the enclosed detailed action plan provides the necessary reassurance regarding the matters raised. Should further clarification or additional assurance be required, please do not hesitate to contact me.

Yours sincerely



Prif Weithredwr | Chief Executive

Enc. Action Plan