Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Nosocomial COVID Programme: end of programme report

Quality, Safety and Experience Committee

February 2024

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with the findings and learning points identified during the case note and thematic Nosocomial reviews for all patients that were suspected of acquiring Nosocomial COVID-19 whilst in acute services in Hywel Dda UHB between March 2020 and April 2022.

The Health Board Nosocomial COVID-19 Review Programme was undertaken as per the requirements of the national Nosocomial COVID-19 programme.

This programme of work does not detract from the UK COVID-19 Inquiry and is not part of the nationally led investigation into nosocomial (hospital-acquired) COVID-19 in Wales.

What is the National Nosocomial COVID-19 Programme?

NHS Wales organisations were requested to conduct proportionate investigations into all patient safety incidents of Nosocomial COVID-19, which occurred between March 2020 and April 2022 in line with the NHS Wales Putting Things Right (2011) guidelines and The Duty of Candour Procedure (Wales) Regulations 2023 (the regulations).

The purpose of the reviews were to answer as many questions as possible relating to the contraction of Nosocomial COVID-19. Patient safety incidents and any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded care such as HCAIs, including COVID-19, will, in certain circumstances, be considered a patient safety incident, depending on how and when the infection was acquired.

To assist NHS organisations investigating patient safety incidents of nosocomial COVID-19, a National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19 was developed by the NHS Delivery Unit, now NHS Wales Executive, to ensure a consistent as possible approach was followed by all NHS Wales organisations and investigations were undertaken once and investigated well. Tools were implemented, including a review template and flowchart and each review at Hywel Dda has been undertaken considering and utilising these tools.

Nosocomial COVID-19 Infection

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"Nosocomial infections, also referred to as 'healthcare-associated infections' (HAI), are infection(s) caught during the process of receiving health care, and where that infection was not present during the time of a person's admission to hospital or healthcare setting. They may occur in different areas of healthcare delivery, such as in hospitals, long-term care facilities, and ambulatory settings. The infection may also appear after discharge from a healthcare setting, but are attributed to the time a person was in contact with the healthcare setting"

Welsh Government (July 2022)

National Nosocomial COVID-19 Programme: patient and family frequently asked questions [HTML] | GOV.WALES

Type of Acquisition - National surveillance definitions for hospital acquired Covid-19.			
Community	Indeterminate	Probable	Actual
specimens taken on day of admission or day after	specimens taken on days 3 to 7 of admission	specimens taken on days 8 to 14 of admission	specimens taken >14 days after admission

Governance of the programme

Corporate Assurance Nosocomial (COVID) Scrutiny Panel

The purpose of the Corporate Assurance Nosocomial COVID-19 (CAN) Scrutiny Panel was to decide, based on the findings of an investigation and broader triangulation of information, whether:

- The care received by a patient was reasonable at the time, and
- Anything further could have been done, in the context of the local operating position during that point of the pandemic, to prevent nosocomial infection of COVID-19.

In scope:

- All investigations which have arisen because of nosocomial COVID-19, where a patient has acquired COVID-19 whilst receiving healthcare services in all settings (not just hospital), and a moderate level of harm or above as a result of COVID-19 has been identified.

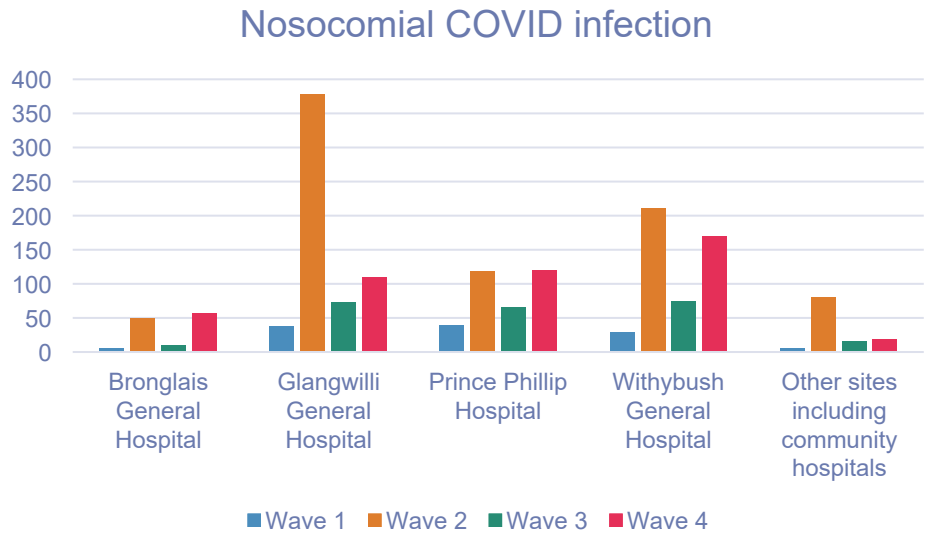
Corporate Assurance Nosocomial (COVID) Strategic Oversight Group

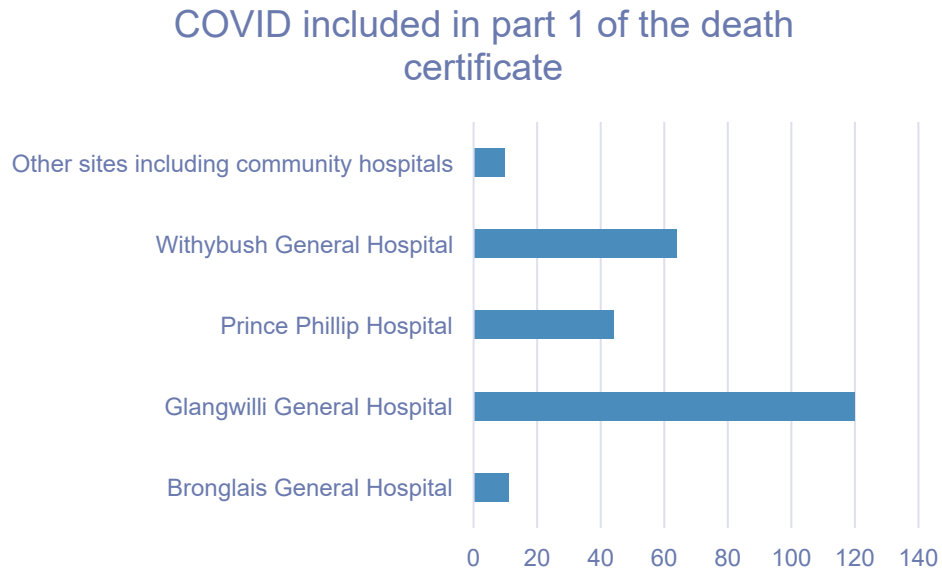
The purpose of the Corporate Assurance Nosocomial COVID-19 (CAN) Strategic Oversight Group was to maintain oversight of and gain assurance on the process for identifying and investigating harm following nosocomial COVID-19 infection.

Quality, Safety and Experience Committee

The Quality, Safety and Experience Committee received regular updates whilst the programme was active on progress of the programme and the learning identified.

2,320 patient case note reviews were undertaken as part of the programme.





Wave 1	Wave 2	Wave 3	Wave 4
(27/2/2020 - 26/7/2020)	(27/07/2020 - 16/05/2021)	(17/05/2021 - 19/12/2021)	(20/12/2021 - 30/04/2022)

The data is currently being validated and final published data may change

The learning identified

It should be recognised that symptoms changed as the pandemic progressed and understanding of the virus grew. Acknowledgment of a high prevalence of asymptomatic patients made it sometimes very difficult for patients to be tested appropriately, or isolated as necessary, with the associated risk of the virus being unknowingly spread.

On positive, documentation demonstrated that regular medical reviews were taking place for patients.

Access to vaccinations - long term inpatients were not always vaccinated, potentially putting them at increased risk of contracting COVID-19 or developing more significant symptoms.

Good practice saw regular COVID-19 testing followed any symptoms presented (until the policy was changed) at the Health Board.

Patient safety incidents outside of NHS Wales hospitals - it was noted that protocols for testing and patient management differed from Health Board to community sites.

Within medical notes it was not always documented why COVID-19 treatment was offered and often reviewers required view of the patient's drug chart to confirm if COVID-19 medication was prescribed.

Patients that were known to have existing respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD) often have lower oxygen saturations as their normal symptom. In these circumstances it is beneficial to reflect this when using a National Early Warning Score (NEWS chart) – a tool utilised which improves detection and response to a clinical deterioration in adult patients - to ensure patients were managed correctly and oxygen was only administered when necessary due to the adverse effects over oxygenation can cause in patients with COPD.

The learning identified

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Review and treatment

The review identified some instances where patients were not seen by the wider Multi-Disciplinary Team due to ward closures or availability of staff may have been detrimental to care or delayed treatment or progress and potentially delayed an earlier discharge.

Cancer patients had chemotherapy /radiotherapy sessions postponed in some instances due to the COVID-19 positive status of the patient. In other cases, chemotherapy treatment went ahead following a review as to which treatment was most beneficial to patients at the time.

Good practice saw the initiation of end-of-life pathways where appropriate for patients, this also allowed visiting for family members, who were provided with personal protective equipment (PPE) to enable the visits to be safer.

Discharge arrangements and planning

Some patients were appropriately discharged whilst having a positive result. These discharges, in the majority of cases, were in consultation with the family and care providers. Discharges to care homes were frequently delayed. Significant number of patients were Medically Fit for Discharge (MFFD) and awaiting a Package of Care (POC) and whilst waiting for discharge some patient's sadly contracted COVID-19 and in some cases sadly died whilst awaiting discharge; this was deemed inappropriate and unnecessary.

Some delays in ward transfers for rehabilitation or to other hospital sites due to patients testing positive were seen. Discharges were delayed due to positive status, in particular, when patients were discharging to a care home. It can be noted that frequently care providers or families remained happy to accept patient's home despite a known positive status.

Long delays in allocation and then assessment by Social Workers was highlighted to play a significant part in the delay of patient's being discharged from hospital. In some cases, Care Homes were only accepting patients with proof of negative tests which again caused delays, these patients were at times tested and often did not receive results for a certain number of days prior to discharge thus voiding the result in real time.

The learning identified

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Communication

Whilst we are very conscious of the significant time and pressure constraints on staff during the pandemic as well as managing staff sickness and managing a high acuity caseload; any communication that occurred with the patient or their Next of Kin was frequently poorly documented, if documented at all, which made it unclear if and when communication occurred or what was communicated when it did.

Good practice was seen in timely communication with family once a result from a swab is known. In some cases, the communication with family was very good, but not so in all cases. The use of technology for communication between patient's and family members has been positive.

The use of Family Liaison Officer's improved communication between patients and family members

Hospital Environment

The Health Board estate is aged and does not provide sufficient space to isolate the numbers of patients that were required to be in hospital during the pandemic and often required patients to use a shared bathroom. Known high risk patients such as those with a terminal illness, or listed as a "Shielding patient" under government guidelines, where unable to be isolated on some occasions due to lack of appropriate bed spaces.

National cleaning standards for hospitals were not being consistently met at the Health Board pre-pandemic and this was further impacted by staff shortages and pressure on the services during the pandemic. Enhanced cleaning was frequently required, and this was limited by the availability and training of staff. The Health Board used UVC decontamination (UV light cleaning utilising a UV light source to identify bacteria and viruses) to provide enhanced cleaning. This was time consuming and required specially trained staff to facilitate. The Health Board, in some instances, were unable to create sufficient space between beds to comply with guidance and this caused a decrease in bed capacity and the requirement to use screens between beds which was also detrimental to some patient's wellbeing. The Health Board were also required to purchase air purifiers in an effort to improve ventilation on the estate.

The learning identified

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Infection prevention and control

Roll out of guidance - at times large volumes of guidance were published and frequently changed or reviewed. The handover of this from shift to shift could prove difficult especially if a large volume of agency staff were working in a team. Guidance was often provided on a Friday afternoon making it harder to provide a full roll out or obtain new equipment that may be required in a timely manner. This is noted alongside a delay in changes of guidance from England to Wales. Frequent changes in research and new evidence from treatments made some of these changes necessary. A timeline of policy changes and location of up to date policies with out of date policies archived would have made it easier to access and locate the correct information when needed.

Outbreak management – the Health Board process for outbreak management developed and improved as the pandemic progressed. The standard agenda for an outbreak meeting covered the status of patients, testing, communications with family, visiting, IPC/ cleaning scores, PPE compliance, likelihood of date isolation can end, plans for discharges, staff affected, histology / tracking information, support for staff affected any other recommendations.

Testing - The laboratory testing infrastructure within Health Boards was tested to the limit during the pandemic when a surge in tests requested was seen alongside the necessity for a fast turnaround for results to allow for appropriate patient management. This was alongside regular / routine work requested. A strategy was then developed that required negative testing before patients were discharged to free up hospital beds. Isolation of suspected or positive cases was an important measure in the limitation of disease spread however it was evident that there were insufficient side rooms for this to be carried out effectively with the Health Board estate. “Cohorting” or grouping patients was undertaken, by risk measures, to maintain operational flow when side rooms where unavailable. Isolation of some patients also then identifies other issues and risks to patients such as falls in those that are older or more vulnerable. These linked issues often led to a patient having to move wards on multiple occasions and this again required increased communication with families as well as potential concerns arising with the continuation of care and an increase in the requirement for the skills of housekeeping staff.

The learning identified

Infection prevention and control continued

Point of Care Testing (POCT) improved the ability to test patients regularly and effectively without burdening the laboratory further. Thematic reviews of outbreaks have been conducted and discussed with Heads of Nursing for each acute and community site. Additional meetings were facilitated if required. It was discussed that Debrief meetings following outbreaks would have been beneficial and can be considered for the future. Collation of outbreak meeting minutes and documents to be archived would be of help for the future.

The testing criteria changed and evolved during the pandemic and this was often difficult to keep track of. To facilitate the large volume of tests a new laboratory was set up at Prince Phillip Hospital. The development of POCT also eased pressure on the laboratories. Patient results were not monitored when patients moved wards thus resulting in missing results for positive patients and potential mixing of negative and positive patients. Limited laboratory capacity at the start of the pandemic with tests being sent to further afield (to Cardiff and Vale, for example) caused a significant delay in receiving results. POCT test results were not always added to the electronic results system and thus positive patient statuses were missed / not clearly documented and handed over.

PPE - Regular changes in requirement for services were noted with PPE together with the limited availability of products for the Health Board was a frequent issue and therefore resources regularly needed to be changed i.e. ward posters, which were both costly and time consuming. Staff acceptance of compliance varied, and staff members felt uneasy when English and Welsh regulations differed. Train the Trainer PPE training was successfully used to roll out for some new procedures. Members of the local community were offering PPE to the Health Board but these were not sadly not deemed usable by the NHS. Is it recognised that there is a need to improve record keeping of staff training.

The learning identified

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Visiting restrictions

Throughout the review process we have heard how limited or precluded visiting caused significant distress to both families and patients. Family assisted with care in some extreme circumstances and a lack of visiting can also be detrimental to patient care both physically and mentally. On a positive note documentation saw the use of Facetime (or similar video calling) /telephone calls/ remote visiting.

We recognised that families and carers are able to notice changes to a patient's physical and mental wellbeing more quickly than hospital staff and therefore the lack of visiting can impact care. Communication with families regarding care and treatment, or the status of a loved one, relied upon telephone calls with either the patient or contact from ward staff. This can be inconsistent and the documentation of this was invariably below standard, especially if wards were busy. What information was given to family members, and when, was often not documented whereas when unrestricted visiting is facilitated then this information can be given freely and easily face to face with relatives.

When visits were documented, it was often unclear as to if visitors had pre-tested for Covid-19 or wore PPE although it should be noted that policies and guidelines differed from wave to wave. Positively it is noted that End of Life visits were facilitated as often as wards were able to do so.

The reasons documented in notes as to why a patient was isolated was not always clear.

Different areas and different hospital sites interpreted policies differently, whilst some ward areas were well set up to facilitate visiting more than others. Use of Family Liaison Officers on wards were noted to be very beneficial both in terms of communication but also the facilitation of visiting.

The learning identified

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The learning identified

Support for service users and families during the investigation process was noted to be lacking with long delays between first and second contact. It should be noted, alongside the much-publicised National COVID-19 review, the Heath Board has received very small numbers of contact from relatives to request information in relation to the reviews undertaken.

Significant distress was unintentionally caused to some family members when they were contacted following CAN Scrutiny panels. Subsequently, consideration has been given to the potential vulnerabilities of family members including consideration of their age, any special or anniversary dates and the timing of telephone calls to avoid clashes when contact is made, to try to minimise this. This has been seen as good practice.

Bereavement support and care /after-death services - it is well recognised that there is an absence of end of life support for families in some areas and that this can delay the grieving process for family heightened by a lack of communication and ability to visit relatives suffering with COVID-19 in some inpatient settings during the end of life window.

Good practice has seen family members visits being facilitated when their relative is at end of life.

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)

The reviews often noted that there was poor documentation of any discussions with a patient's family or their Next of Kin specifically with regard to DNACPR decisions.

Some families have subsequently raised this lack of consultation and subsequently have then disagreed with the decisions made. Conversely others clearly felt a DNACPR was appropriate and supported the decisions made often in view of the patient suffering with significant or other medical conditions. Ceilings of care were implemented regularly but it was not always clearly documented as to the rationale behind these decisions. Positively DNACPR decisions were frequently reviewed and rescinded if the patient's health improved. Other learning arose regarding DNACPR paperwork such as the document was not always countersigned and did not always state other co-morbidities suffered by the patient.

Good practice seen was timely DNACPR decisions with rationale and discussions documented and ceilings of care being agreed and documented.

Death certificates were seen to document COVID-19 as the primary cause of death, however, in some cases patients were already very unwell and often on the palliative care pathway prior to admission which makes the primary cause of death difficult to rationalise. Finally, it was not always clearly documented when a DNACPR was in place.

Good practice saw staff often went above and beyond to support patients, and this should be recognised, however, there are likely to be many other examples of excellent and outstanding care that are not documented and therefore go unrecognised. Patient care was limited at times due to staff sickness and high patient acuity.

The learning identified

Information

Variable quality of record keeping was demonstrated with some handwritten notes being illegible. Positively, the change of some nursing records to electronic made reviews considerably easier in some cases. Inconsistent documentation to demonstrate when or why swabs tests were taken and then the result being received was frequently seen.

Inconsistent documentation such as the location of a patient's bed, for example "SR/Bay", and if the patient was moved once a positive test result was also a key feature.

On a positive note, access to infection control data allowed for more information to be gathered. Inconsistent documentation of visitors and any precautions taken by visitors made it difficult to track patient contacts. Inconsistent documentation of contact with family's, links to the earlier point regarding communication.

Lastly there is a widespread use of unofficial abbreviations in Health Records, and documentation stating "normal for patient" or "obs stable" which is not inappropriate.

The learning identified

Workforce

Staff wellbeing was felt to be overlooked in some cases causing detrimental longer term impacts for staff. In some cases, insufficient staff were available to care for patients on some shifts due to sickness levels, annual leave and isolation guidance following Government advice. Positively countless staff went “above and beyond” to support each other, and some staff took on additional roles i.e. vaccination centre roles or overtime in front line positions to support services. Some staff had to consider vulnerable relatives or “shielding” people at home, which added to their anxiety. In some cases, staff isolated themselves at home, limiting their contact with loved ones to prevent possible cross infection. There is some documented evidence of staff supporting patients especially at the end of life. This gave comfort to families knowing their loved ones were not alone in their final hours. Good collaborative working was noted with GP’s, Community Sites, Mental Health Services and acute sites.

Recognition of work of the community services to support Care Homes was also noted. English and Welsh protocols differed at times and staff were more inclined to follow English guidance in some instances in particular when England were more stringent with their isolation guidance, for example. There is a marked and significant impact on staff from patient deaths, patient’s dying alone and an increase in the number of deaths during the pandemic in comparison to pre-pandemic work normality. Staff were also caring for different speciality patients on wards which they were not used to; this impacted both the staff and patients. Staff could be seen to direct anger, at pressured times, at ward management or other teams such as IP&C.

To enable staff to don and doff off the ward, some ward areas required additional space for staff to change. In some circumstances this meant a required use of shared areas on wards, and this potentially allowed virus transmission. Availability of staff testing and delays for results caused distress but also delays in staff returning to work. Limited access to occupational health had impacts on staff health and wellbeing.

Sharing the learning

The learning identified from the reviews undertaken during the programme has seen some marked lessons in relation to the delays seen in discharges and the challenges with the aged estate when isolating patients.

The learning identified in the reviews undertaken early in the programme was shared across the Health Board through infection, prevention and control colleagues, through outbreak management meetings and through other mechanisms. Regular learning updates were also provided to the Quality, Safety and Experience Committee.

As the programme was concluding the learning from the programme (the individual reviews and the outbreak management reviews) was shared with Directorates.

Services are being challenged to consider the learning identified alongside a review of discharge processes and engagement with social care to attempt to improve the efficiency of discharges as a whole at the Health Board. This work is in conjunction with and linked to work already ongoing within the Transforming Urgent and Emergency Care (TUEC) program as part of the National 6 Goals for Urgent & Emergency Care.

The Health Board's Policy Goal 5 "Optimal hospital care and discharge practice from the point of admission" focuses on improvement work to facilitate improved patient flow and there is a national working group contributing to this work throughout NHS Wales.

A final programme report is being collated and this will be published on the Heath Board website to reach a wider audience.

Recommendations

The Quality, Safety and Experience Committee is asked to receive this report and take assurance that the work of Health Board's Nosocomial COVID Review Programme has been undertaken robustly and that the learning identified has been shared to ensure that improvements are undertaken.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

The Duty of **Candour**

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND