Infection Prevention and Control Final Internal Audit Report

April 2022

Hywel Dda University Health Board

NWSSP Audit and Assurance

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Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

The purpose of the audit was to review the arrangements in place to manage the risks relating to IPC, including compliance with social distancing and PPE requirements.

Overview

The arrangements in place for the identification and isolation of patients was considered to be satisfactory.

Visits to wards across four hospital sites identified compliance with IPC guidance requirements and both community hospitals and many of the wards visited at the two main general hospitals.

However, there were some instances where it was observed compliance was not being adhered to including for PPE, social distancing, and hand hygiene facilities. A medium priority recommendation has been raised in respect of this.

One further low priority recommendation has been raised with regards to steering group terms of reference – details are provided in Appendix A.

Report Classification

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

	Assurance objectives	Assurance
1	Patients are isolated promptly	Substantial
2	Non-compliance with isolation requirements is investigated	Substantial
3	High standards of hygiene, PPE requirements and social distancing are maintained	Reasonable
4	There is regular reporting and scrutiny of IPC issues and performance	Substantial

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Maintaining standards of hygiene, PPE requirements & social distancing	3	Operation	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 The review of Infection Prevention and Control was completed in line with the 2021/22 Internal Audit Plan. The executive lead for the review is the Director of Nursing, Quality & Patient Experience.

1.2 The Health Board is committed to promoting a culture of zero tolerance to any healthcare associated infection (HCAI).

1.3 With the COVID-19 pandemic causing widespread disruption to health and care services, infection prevention and control (IPC) measures have never been so important and are the responsibility of all Health Board staff. Such measures include appropriate patient placement, hand hygiene and the use of personal protective equipment (PPE).

1.4 The key risk considered in this review is non-compliance with IPC best practice, potentially resulting in:

- patient harm or poor patient experience;
- extended hospital stays as a result of infection transmission, impacting on inpatient and service capacity; and
- reputational damage.

2. Detailed Audit Findings

Objective 1: Mechanisms are in place to promptly identify patients requiring isolation, with appropriate alternative safeguards implemented where isolation is not possible

2.1 From observations made and interviews conducted with staff at the wards visited and the Infection Prevention Team, it was established there was awareness of the policies and procedures to be followed when patients present with symptoms that may require the patient to be isolated or barrier nursed. The policy contains a guide on the priorities for patient isolation.

2.2 The Infection Prevention Control (IPC) Team maintain a ward summary which documents on a wards basis instances, type and details of patient infections and instances where patients are subject to isolation The IPC Team utilises this record when undertaking side room surveillance checks at ward level. This information contained within the ward summary sheet enables the infection prevention team to work with ward staff to decide where to accommodate patients with infections and manage location of patients during the periods of symptoms, infection, and post infection.

2.3 The report was obtained for the day of the ward visits and reviewed in conjunction the IP Nurse who provided assurance that current patients on the wards visited had been managed appropriately.

Conclusion:

2.4 We have concluded a **Substantial** audit rating for this objective.

Objective 2: Non-compliance with isolation requirements is recorded and investigated where appropriate

2.5 Audit was accompanied by an IPC nurse who provided guidance and insight at each site visit. The IPC nurse was able to clarify and explain the side room surveillance process and confirm whether all appropriate actions had been taken by ward staff at the time of the visits. It was confirmed by ward staff and the IPC nurse that all patients who needed to be isolated at the time of the visits had been satisfactorily accommodated in the side rooms.

Conclusion:

2.6 We have concluded a **Substantial** audit rating for this objective.

Objective 3: Arrangements are in place to enable service users, carers, visitors and staff to achieve and maintain high standards of hygiene, PPE requirements and social distancing

2.7 As part of the audit field work visits were made, in conjunction with an IPC Nurse to a number of wards at Withybush and Glangwili General Hospitals and also to Amman Valley and South Pembrokeshire Community Hospitals. The audit field work included a review of policy documentation, discussions with ward staff and observations regarding compliance IPC and Covid requirements.

2.8 During the visits to both Amman Valley and South Pembrokeshire hospitals in conjunction with the IPC nurse we concluded that that any patients who required isolating had been accommodated appropriately and from our observations and interviews it was considered that protocols regarding social distancing and the wearing of PPE were being complied with.

2.9 From the visits to four wards at Withybush General Hospital we identified no issues of compliance at two wards. However, during the visits to the other two wards, in conjunction with the IPC nurse, a small number of compliance issues were identified including, one instance of a member of staff not wearing a mask, two members of staff not wearing the required PPE and one instance of an inappropriate isolation poster outside a side room.

2.10 From the visits to six wards at Glangwili General Hospital we identified no issues of compliance at three wards. At one ward we identified adherence with compliance requirements with the exception of one issue where more than the permitted number of staff were present in the staff room when the observation took place.

2.11 However, a number of compliance issues were identified on one ward, including several instances where PPE requirements were not being met, and inadequate hand hygiene facilities e.g., lack of Clinell wipes on the ward and a broken hand sanitiser outside the sluice room. Further to this it was noted that the poster setting the maximum staff numbers in the staff room was not present, although at the time only one staff member was in that room.

2.12 Additionally, one of the wards selected for visits had an outbreak at the time of the visit and it was noted that the outer door had been left open contrary to guidance. **[See Matter Arising 1 at Appendix A]**

Conclusion:

2.13 As a result of the compliance issues identified at the ward visits, we have concluded a **Reasonable** assurance rating for this objective.

Objective 4: There is regular reporting and scrutiny of IPC issues and performance at an appropriate forum

2.14 The Infection Prevention Strategic Steering Group (IPSSG) has been established as an operational group of Quality Safety and Experience Committee (QSEC) and was constituted in June 2020, with its function to provide assurance to QSEC around matters relating to the prevention of infection. We established that the IPSSG reports regularly to QSEC, with agendas and minutes reviewed to confirm this.

2.15 We reviewed IPSSG agendas, minutes and work plans to ensure that appropriate key issues are raised and addressed and confirmed that updates relating to infection prevention are presented at each meeting.

2.16 The IPSSG terms of reference stipulate they are reviewed on an annual basis along with operating arrangements; however, this has been delayed due to operational pressures resulting from the pandemic. [**See Matter Arising 2 in Appendix A]**

Conclusion:

2.17 We have concluded a **Substantial** assurance rating for this objective.

Appendix A: Management Action Plan

<table>
<tr><th colspan="2">Matter Arising 1: Maintaining standards of hygiene, PPE requirements and Social Distancing (Operation)</th><th>Impact</th></tr>
<tr><td colspan="2">The ward visits made, in conjunction with the IPC nurse, at the two general hospitals resulted in a number of IPC compliance issues being identified.</td><td>Potential risk of:
• Patient harm or poor patient experience
• Extended Hospital Stays
• Reputational Damage</td></tr>
<tr><th colspan="2">Recommendations</th><th>Priority</th></tr>
<tr><td colspan="2">The Infection Prevention Team highlight the issues identified as part of the audits to the ward staff at each hospital and reinforce the requirements to comply with guidance.</td><td>Medium</td></tr>
<tr><th>Agreed Management Action</th><th>Target</th><th>Responsible Officer</th></tr>
</table>

1.1	Review the detailed findings from the audit, incorporate feedback from IPN who accompanied the auditor and obtain assurance on action taken at the time.	22/04/2022	Meleri Jenkins
1.2	Global communications circulated when issues identified to reinforce current guidance on PPE and Social Distancing.	24/03/2022	Meleri Jenkins
1.3	PPE compliance incorporated into the monthly hand hygiene audit for review at local scrutiny meetings	Monthly	Meleri Jenkins
1.4	Staff Rest room occupancy levels were reviewed following the audit and an additional breakroom was identified. Staff were +1M apart	22/03/2022	Frances Howells
1.5	Compliance issues relating to practice were addressed at the time of the audit.	18/03/2022	Frances Howells
1.6	Compliance relating to Estates - i.e. hand sanitiser dispenser – repaired	22/04/2022	Meleri Jenkins
1.7	Review of supply of patient hand wipes requirement to confirm procurement chain	22/04/2022	Meleri Jenkins
1.8	Liaise with Hand Hygiene product supplier for organisational review of fixtures and fittings.	22/04/2022	Meleri Jenkins
1.9	Isolation posters displayed are audited as part of IP Quarterly Indicator Audit. This was not a theme identified through the audit and education was provided for the identified area on the day.	16/03/2022	Meleri Jenkins

Matter Arising 2 Terms of Reference for the IPSSG (Operation)		**Impact**
The Terms of reference for the Infection Prevention Strategic Steering Group are required to be reviewed annually. It was identified this had not occurred as a result of operational pressures resulting from the pandemic.		Potential risk of: • Issues relating to IP&C are not effectively identified or addressed
Recommendations		**Priority**
The Steering Group Terms of Reference should be reviewed annually and updated as required.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
Terms of Reference are currently under review and are for approval at IPSSG 31st May 2022 and subsequently reported to QSEC in June 2022.	31st May 2022	Sharon Daniel

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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