Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 November 2020
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Learning from COVID-19 Outbreaks
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani – Director of Nursing, Quality & Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sharon Daniel – Assistant Director of Nursing, Workforce and Professional Standards

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Board (HB) is currently managing three COVID-19 outbreaks with differing presentation in three very different acute settings. These are the first patient COVID-19 outbreaks that the Health Board has had to manage since the start of this pandemic. Currently all outbreaks are stable.

This update reflects on the lessons that have been learnt during the management of these outbreaks. It should be recognised that this information is current at the time of the writing and that any further updates will be provided verbally at the meeting.

The Quality, Safety and Assurance Committee is asked to receive an assurance from the findings related to the learning from these outbreaks. .

Cefndir / Background

The three COVID-19 outbreaks have been identified in different circumstances, and going forward the three scenarios will be considered as typical representations of how outbreaks may be identified during this pandemic.

It was agreed at the inaugural meeting of each Outbreak Control Team (OCT) meeting that the Health Board Hospital Outbreak Policy would be enacted (in line with the Policy direction outline in the All Wales Communicable Disease Outbreak Plan).

Asesiad / Assessment

The first outbreak was identified due to a COVID-19 positive patient being transferred from Morriston Hospital to the Health Board. The ward had been informed that the patient had received a negative test result prior to transfer and consequently did not enact the HB COVID-19 protocols when the patient developed a cough. The patient had been on the ward for 24 hours before a positive result was received from a second test taken prior to transfer. The patient journey has been reviewed, with the patient and two contacts being isolated immediately on the COVID-19 designated ward for the hospital. Whilst initially it was believed

that this situation had been contained, when a second patient on the ward that the patient from Morriston had initially been transferred to tested positive, this was managed in the same way and again, thought to be contained. As time progressed, it was apparent that there had been onward transmission of infection from the index case to patients and staff. The reasons for this are multifaceted as this is a highly infectious virus. Whilst the COVID-19 ward had previously achieved high standards around Personal Protective Equipment (PPE), hand hygiene, equipment cleaning, isolation and social distancing, it was evident from the outbreak investigation that these standards required reinforcement given that it had been a number of months since the ward had cared for COVID-19 positive patients. The type of patients on the ward made quarantining/isolating patients difficult due to the requirement for one to one nursing care, wandering patients with cognitive impairment and due to the increased risk of falls. In total, 11 patients and 12 staff related to this outbreak have tested positive thus far almost 3 weeks into the outbreak.

The second outbreak was identified when a patient due for discharge to a care home was screened and received a positive COVID-19 result. The patient was in an Older Adult Mental Health ward and the nature of the patients in this area means that many of them are not able to comply with isolation requirements, face coverings or social distancing. This was deemed to be a Healthcare Associated Infection as the patient had been hospitalised in excess of 14 days prior to the positive test result. At the time, there were no symptomatic staff or patients on the ward and the decision was taken to screen all the patients in an attempt to identify an index case. This process identified a further 4 positive cases. The ward was closed to new admissions and all staff were screened resulting in further positive cases. The presentation of the infection in these patients was very different, with atypical symptoms such as increased lethargy, decreasing engagement, increasing delirium and this was recognised early in the outbreak. In total, 10 out of 14 patients and 17 out of 54 staff have tested positive thus far 3 weeks into the outbreak.

The third outbreak was identified when a patient developed a cough and screened positive for COVID-19 on the Acute Stroke Unit (ASU) in Prince Philip Hospital (PPH). The ASU is attached to Ward 9 Rehabilitation. Patients are initially admitted to the ASU for intense care and then moved out to the main ward as appropriate. This meant that contacts had been transferred into bays on the ward, requiring all patients to be screened; this highlighted further cases. The investigation identified that a patient had been admitted to the ASU from a Care Home one week prior to the outbreak. This patient had been symptomatic on admission however, was not tested for COVID-19. In parallel to this, two staff tested positive for COVID-19 with possible community links. As there was no clear index for these combined cases, the decision was taken to screen all staff linked to Ward 9. To date,14 patients out of 28 and 17 staff out of 103 have tested positive for COVID-19 3 weeks into the outbreak.

The investigations associated with each outbreak and discussion at the OCT has identified the following learning/observations.

Decision Making

In the first OCT, the process for managing the outbreak was discussed with the Consultant for Communicable Disease Control (CCDC) with the decision made that the Health Board Hospital Outbreak Policy would be used to manage the outbreak.

- Health Board Outbreak Policy used to manage the outbreaks and format OCTs.
- All decisions taken at OCT to be upheld unless changes have been agreed at Executive level.
- Engagement has been consistent from all parties. Meetings are chaired by the Hospital Head of Nursing, membership, although not exclusive, includes Hospital Director, General

Manager, Clinical Medical Lead, Nursing, Facilities, Infection Prevention, Microbiology and Consultant in Public Health. The Director of Nursing, Quality & Patient Experience and the Director of Operations also join meetings.
- An incident meeting is always considered calling when an issue is identified as it gives all parties an opportunity to voice concerns, review the situation and take the necessary action.

Testing
- Decisions around extended testing will always be undertaken through discussion at the OCT with input from all parties.
- All new admissions are screened with appropriate precautions applied until results are known. COVID-19 Admission Testing Standard Operating Procedure approved at Tactical Group.
- Wards are reminded that retesting is only required if patients become symptomatic unless specific instructions are agreed otherwise.
- The Testing Cell were included in decisions to screen staff and supported this process.

Disease Presentation
- In outbreak areas, there is a need to recognise atypical symptoms such as delirium, gastrointestinal upset, decreased engagement.
- Staff were supported in having a low threshold for retesting patients and recognising atypical presentation.

Patient Management
- Collaborative working between clinical teams worked well, specifically with PPH consultants supporting colleagues in the Mental Health ward with patient management and decision making.
- Review of patient resuscitation status involving discussion with the family, if required, should be a priority.

Communication
- The importance of good lines of communication were noted.
- Representation from all staff groups at OCTs continues to work well.
- Staff receiving daily updates from Ward Managers worked well.
- Communication with families is key for patients and family.
- Patient Information - patients need to be reminded not to interact closely with other patients and the need for social distancing.
- Patient information leaflet has been developed and is in the process of being printed.

Staff
- When an outbreak is declared, there is a need to ensure that staff working on that ward are not working in other areas.
- Hospital management to link with Bank Office to advise on restricted areas.
- Link with nursing agencies as appropriate to advise.
- Block book staff for outbreak areas where possible.

Personal Protective Equipment (PPE) and Hand Hygiene
- Review of practice by Infection Prevention Team early in the outbreak to provide assurance on policy compliance and identify education gaps.
- Sufficient quantities of PPE were available in all areas.
- All staff grades were compliant with ‘Bare Below the Elbow’.
- It was identified that one area required additional access to alcohol gel at point of care for hand decontamination and personal individual issue ‘tottles’ were procured for staff.

Environment/Equipment decontamination

- Enhanced cleaning put in place at the start of the outbreak – daily use of disinfectants in all outbreak areas.
- No significant issues were raised with the fabric of the Estate in any of the areas.
- Ultraviolet Cleaning (UVC) technology was used in communal areas to additionally reduce environmental contamination.
- Cleaning schedules and Credits for Cleaning Scores were found to be good, however have been reinforced with staff.
- Wards have taken the opportunity to declutter.
- Cleaning of equipment with universal disinfectant wipes between patients reinforced.

Car sharing

- Identified issue as historically staff have car shared to travel to work.
- Learning fed back to all sites.
- Global communications issued to remind staff of the need to wear face coverings if car sharing to/from work.

Reporting

- Welsh Government (WG) is looking at a daily reporting system although, this is not currently in place.
- Outbreak to be reported via Datix as one incident.
- No Surprises proforma completed for each outbreak and returned to WG.
- Reporting of COVID-19 deaths is currently having to be completed twice by clinicians via the notifiable diseases form and Welsh Clinical Portal.
- Established reporting arrangements between each OCT and each County Incident Management Team (IMT).

Argymhelliad / Recommendation

The Quality, Safety & Experience Assurance Committee is asked to note the findings related to learning from these outbreaks as summarised within this report, and take assurance that incidents of COVID-19 infection are being effectively managed, with learning from all cases being rapidly disseminated.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.5 Provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that sources of internal assurance are reliable, there is the capacity and capability to deliver, and lessons are learned from patient safety incidents, complaints and claims.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.4 Infection Prevention and Control (IPC) and Decontamination 2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care

Effaith/Impact:	
Ariannol / Financial: **Ansawdd / Patient Care:** **Gweithlu / Workforce:** **Risg / Risk:** **Cyfreithiol / Legal:** **Enw Da / Reputational:** **Gyfrinachedd / Privacy:** **Cydraddoldeb / Equality:**	Contained within the body of the report