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:**	01 December 2020
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	COVID-19 Risk Assessments: • Patient Profile for admission to Field Hospitals during high incidence of COVID-19 in Secondary Care • Nationally agreed epidemiological definitions for coronavirus (COVID-19) outbreaks and clusters in particular settings
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani, Director of Quality, Safety and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mandy Rayani, Director of Quality, Safety and Patient Experience

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 following two COVID-19 Risk Assessments have been prepared for Extraordinary Gold Command Group consideration called specifically for this item on 23rd November 2020: :

- Patient Profile for admission to Field Hospitals during high incidence of COVID-19 in Secondary Care
- Nationally agreed epidemiological definitions for coronavirus (COVID-19) outbreaks and clusters in particular settings

Cefndir / Background

Following discussions at Gold Command on 23rd November 2020 where the Risk Assessments were acknowledged and supported, it was proposed that for assurance purposes these should also be presented to the Quality, Safety & Experience Assurance Committee (QSEAC), and are attached at Appendix 1 and 2.

Asesiad / Assessment

Patient Profile for Admission to Field Hospitals During High Incidence of COVID-19 in Secondary Care (Risk Score 10) (Appendix 1).

This risk assessment was undertaken following an exceptionally challenging weekend where pragmatic decisions had to be made regarding patient flow and bed capacity, and to determine whether a change in process could allow the field hospitals to be utilised as previously agreed by Gold Command Group. The challenges related to the two groups of patients, Group 1 (post COVID-19 patients) and Group 2 (green COVID-19 patients with negative PCR tests).

It is recommended that the patient profile for admission to Field Hospitals during high incidence of COVID-19 in Secondary Care be amended to patients who are post COVID Infection/COVID recovered patients –14 days post symptoms/positive test (if asymptomatic). If in the first instance there are inadequate numbers of Level 0 to Level 2 patients meeting this criteria then it is recommended that the Patient Profile be amended to incorporate Green COVID patients with negative PCR tests – Group 2 patients

This will reduce the risk of COVID-19 Transmission in our Field Hospitals as all Group 1 patients will be post infection and therefore considered non-infectious. In general, patients with COVID-19 who are admitted to hospital will have more severe disease than those who can remain in the community, especially if they have been severely unwell. This proposal recommends that we adhere to the 14 days minimum prior to transfer to Field Hospital acknowledging that this may limit the cohort of patients who meet the criteria for step down.

Gold Command Group sought assurance that this still complies with the original Gold Command Group instruction i.e. '***To establish sufficient capacity (existing hospital and Field Hospital (FH) sites) to accommodate 613 COVID-19 patients during Q3/Q4 and 47 Intensive Care Unit (ICU) COVID-19 positive beds. The Tactical Group should assume that the peak in COVID-19 patients will coincide with non COVID-19 winter peaks and plan to have sufficient capacity for both, concurrently. Additional FH beds should be capable of being mobilised at a maximum of 14 days' notice of their operational need***' and it was confirmed that this is the case.

Members were advised that the current R transmission figure is less than the Swansea University model and that the Health Board remains comfortable that there is sufficient capacity planned.

However, given the potential need to change the patient profile of those transferring to field hospitals, the risk assessment will be required to be kept under regular review to ensure patient and staff safety.

Nationally Agreed Epidemiological Definitions For Coronavirus (COVID-19) Outbreaks And Clusters In Particular Settings (Risk Score 15) (Appendix 2)

It is recommended that the definition for ending an outbreak of COVID-19 in our Acute Hospital Settings during high incidence of COVID-19 in Secondary Care be amended to 14 days post the last positive case. This will require challenge to the current PHW guidance (specific to Care Homes) which stipulates that 28 days must elapse before the Outbreak is declared closed. It was noted that the guidance from PHW is not specifically for acute settings, hence the recommendation that Gold Command Group support the approach detailed in the risk assessment.

In areas where there is no option to re-direct services or convert pathways it will enable us to re-open facilities after 14 days from the last positive case as opposed to 28 days. By negotiating a redaction of the requirement to screen patients and obtain a negative COVID PCR test prior to discharge to a Care Home it will enable the Health Board and its partners to explore system to safely discharge patients into care homes or other identified step down facility in a more timely fashion. This will benefit patient flow and release capacity to provide care for emergency admissions to hospital and some urgent planned care.

Argymhelliad / Recommendation

For QSEAC to receive assurance from the preparation of the attached Risk Assessments, which have received the acknowledgement and support of Gold Command Group.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.5 Provide assurance to the Board that current and emerging clinical risks are identified and robust management plans are in place and any learning from concerns is applied to these risks as part of this management.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the body of the report.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply

Effaith/Impact:	
Ariannol / Financial: **Ansawdd / Patient Care:** **Gweithlu / Workforce:** **Risg / Risk:** **Cyfreithiol / Legal:** **Enw Da / Reputational:** **Gyfrinachedd / Privacy:** **Cydraddoldeb / Equality:**	Outlined within the attached risk assessments.

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:	01 December 2020
TEITL YR ADRODDIAD: TITLE OF REPORT:	Field Hospital Patient Profile Risk Assessments
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mandy Rayani, Director of Quality, Safety and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Mandy Rayani, Director of Quality, Safety and Patient Experience

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 Field Hospital Patient Profile Risk Assessments, are presented to the Quality, Safety And Experience Assurance Committee (QSEAC) due to a risk that the provision of Unscheduled Care will be compromised due to the high level of COVID-19 positive patients in Glangwili and Prince Phillip Hospitals.

Following discussions at Gold Command on 23rd November 2020, where the Risk Assessments were acknowledged and supported, it was proposed that for assurance purposes they should also be presented to QSEAC, and are attached as Appendix 1and 2.

Cefndir / Background

The risk assessments were undertaken following an exceptionally challenging weekend where pragmatic decisions had had to be made regarding patient flow and bed capacity, and whether a change in process could allow the field hospitals to be utilised as previously agreed by Gold Command Group. The challenges related to the two groups of patients, Group 1 (post COVID-19 patients) and Group 2 (green COVID-19 patients with negative PCR tests), however, risk assessments will still need to be undertaken given the continuing issues with the negative PCR as evidenced by previous experience.

Asesiad / Assessment

Patient Profile for Admission to Field Hospitals During High Incidence of COVID-19 in Secondary Care (Risk Score 10) (Appendix 1).

It is recommended that the Patient Profile for admission to Field Hospitals during high incidence of COVID-19 in Secondary Care be amended to patients who are post COVID Infection/COVID recovered patients –14 days post symptoms/positive test (if asymptomatic). If in the first instance there are inadequate numbers of Level 0 to Level 2 patients meeting this criteria then it is recommended that the Patient Profile be amended to incorporate Green COVID patients with negative PCR tests – Group 2 patients

This will reduce the risk of COVID-19 Transmission in our Field Hospitals as all Group 1 patients will be post infection and therefore considered non-infectious. In general, patients with COVID-19 who are admitted to hospital will have more severe disease than those who can remain in the community, especially if they have been severely unwell. This proposal recommends that we adhere to the 14 days minimum prior to transfer to Field Hospital acknowledging that this may limit the cohort of patients who meet the criteria for step down.

Nationally Agreed Epidemiological Definitions For Coronavirus (COVID-19) Outbreaks And Clusters In Particular Settings (Risk Score 15) (Appendix 2)

It is recommended that the definition for ending an outbreak of COVID-19 in our Acute Hospital Settings during high incidence of COVID-19 in Secondary Care be amended to 14 days post the last positive case. This will require challenge to the current PHW guidance (specific to Care Homes) which stipulates that 28 days must elapse before the Outbreak is declared closed.

In areas where there is no option to re-direct services or convert pathways it will enable us to re-open facilities after 14 days from the last positive case as opposed to 28 days. By negotiating a redaction of the requirement to screen patients and obtain a negative COVID PCR test prior to discharge to a Care Home it will enable the Health Board and its partners to explore system to safely discharge patients into care homes or other identified step down facility in a more timely fashion. This will benefit patient flow and release capacity to provide care for emergency admissions to hospital and some urgent planned care.

Argymhelliad / Recommendation

For QSEAC to receive assurance from the development of the attached Field Hospital Patient Profile Risk Assessments.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.5 Provide assurance to the Board that current and emerging clinical risks are identified and robust management plans are in place and any learning from concerns is applied to these risks as part of this management.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the body of the report.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.

Effaith/Impact:	
Ariannol / Financial: **Ansawdd / Patient Care:** **Gweithlu / Workforce:** **Risg / Risk:**	Outlined within the attached risk assessments.

Cyfreithiol / Legal: **Enw Da / Reputational:** **Gyfrinachedd / Privacy:** **Cydraddoldeb / Equality:**	

Datix ref: Date of entry:		**Any previous reference number:**	
Name of person identifying risk :	Sharon Daniel	**Contact email/phone:**	Sharon.daniel5@wales.nhs.uk

Risk Ownership

Executive Directorate:	Mandy Rayani, Executive Director of Nursing, Quality & Patient Experience
Delegated Risk Owner: (OPS ONLY)	Andrew Carruthers, Executive Director Of Operations
Management/Service Lead:	Dr Meinir Jones

Risk Location

Directorate:	Acute Services	**Service or Department:**	Field Hospitals

Risk Identification

Title of risk:	Patient Profile for admission to Field Hospitals during high incidence of COVID-19 in Secondary Care						
Date risk identified:	19.11.2020		**How risk was identified (risk source):**		Inability to maintain patient flow		
Type of Risk choose one √			Strategic	√	Project		

Recommendation:

Outline the Recommendation for GOLD Command Consideration
It is recommended that the Patient Profile for admission to Field Hospitals during high incidence of COVID-19 in Secondary Care be amended to patients who are post COVID Infection/COVID recovered patients – 14 days post symptoms/positive test (if asymptomatic). – Group 1 patients If in the first instance there are inadequate numbers of Level 0 to Level 2 patients meeting this criteria then it is recommended that the Patient Profile be amended to incorporate Green COVID patients with negative PCR tests – Group 2 patients With both groups an antibody test may be helpful in determining lower risk patients. Based on assumption that post COVID patients (Group 1) will not present a COVID infection risk to patients on green pathway (Group 2). Any Group 2 patient with detected antibodies will be considered a Group 1 patient.

Benefits:

Outline the Benefits
1. This will reduce the risk of COVID Transmission in our Field Hospitals as all Group 1 patients will be post infection and therefore considered non-infectious. In general, patients with COVID-19 who are admitted to hospital will have more severe disease than those who can remain in the community, especially if they have been severely unwell. In addition, they are more likely to have pre-existing conditions such as severe immunosuppression. There will be patients who are PCR positive on admission but whose primary diagnosis is not directly related to COVID – i.e. COVID asymptomatic

Risk Matrix	**Likelihood →**				
Severity ↓	**Rare - 1**	**Unlikely - 2**	**Possible - 3**	**Likely - 4**	**Almost certain – 5**
Catastrophic - 5	**5**	**10**	**15**	**20**	**25**
Major - 4	**4**	**8**	**12**	**16**	**20**
Moderate - 3	**3**	**6**	**9**	**12**	**15**
Minor - 2	**2**	**4**	**6**	**8**	**10**
Rare - 1	**1**	**2**	**3**	**4**	**5**

but with alternative diagnoses. It is thus recommended that all patients with COVID-19 who have been admitted to hospital should be isolated within hospital or remain in self-isolation on discharge for 14 days from their start of symptoms or first positive SARS-CoV-2 PCR test in those COVID asymptomatic who have been admitted for other clinical reasons, compared to the 10 day isolation rule for patients with milder disease managed in the community. This proposal recommends that we adhere to the 14 days minimum prior to transfer to FH acknowledging that this may limit the cohort of patients who meet the criteria for step down.
https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharging-covid-19-patients

https://www.nhs.uk/conditions/coronavirus-covid-19/self-isolation-and-treatment/how-long-to-self-isolate/ .

2. Will also provide a step down facility from the acute hospitals for post COVID patients increasing capacity in red areas to manage acutely unwell COVID positive patients.

Current Reality & Costs:

Outline the Current Reality & Costs

- On Wednesday 18.11.2020 there were 79 COVID positive patients in our hospitals with no identifie step down facility. A large proportion of these patients will require packages of care on discharge. Current Welsh Government Guidance prohibits discharging patients to Care Homes without a negative PCR test in the 24 hours prior to admission. This could prolong the length of admission for up to 49 days (some literature suggest longer)
- There are currently 6 wards across our Health Board that are closed due to Outbreaks of COVID – 3 acute medical/surgical, 2 community hospitals and one MHLD older adult assessment unit. We also have 3 other wards that are being closely monitored and reviewed daily.
- Cumulative cases of COVID-19 associated with these Outbreaks to date equals 55 patients and 86 staff.
- Current Public Health guidance recommends not re-opening these areas until 2 incubation periods have passed since the last case i.e. 28 days. Thus the impact on service delivery is significant.
- Ysbyty Enfys Selwyn Samuel (YESS) opened on Monday 16th November. Four patients identified from the Green Pathway with negative COVID screens were transferred into the facility. On Wednesday 18.11.2020 two of the patients developed symptoms associated with COVID one subsequently tested low positive potentially compromising the Green pathway.
- Some staff working in this area have been risk assessed as being vulnerable and it may not be appropriate for them to manage COVID positive patients.

Risk Matrix	**Likelihood →**				
Severity ↓	**Rare - 1**	**Unlikely - 2**	**Possible - 3**	**Likely - 4**	**Almost certain – 5**
Catastrophic - 5	**5**	**10**	**15**	**20**	**25**
Major - 4	**4**	**8**	**12**	**16**	**20**
Moderate - 3	**3**	**6**	**9**	**12**	**15**
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Rare - 1	**1**	**2**	**3**	**4**	**5**

Risk Statement:

Describe the risk, work activity, environment or process being assessed. What is the risk to the Health Board?
There is a risk that the provision of Unscheduled Care will be compromised due to the high level of COVID positive patients in Glangwili & Prince Phillip Hospitals.
This is caused by Outbreak control measures such as ward closures and mass screening which have reduced hospital bed capacity and staffing levels (all disciplines). The situation is exacerbated by the inability to discharge patients into care homes or into post COVID step down facility.
This could lead to, or have an impact on patients being able to access acute hospital care in emergency situations impacting on patient safety and ambulance delays. It could also impact on treatment provision for urgent suspected cancers and other elective procedures.
Location of the Risk All In-patient areas

What is the cost of correcting the loss if the risk materialises:	Unquantifiable – impact on patient safety	**What is the financial cost based on?**	No financial cost

Please √ the one DOMAIN under which this risk lies:					
Safety, patient staff or public	√	**Quality, Complaints or Audit**		**Workforce & OD**	
Statutory Duty or Inspection		**Adverse Publicity or Reputation**		**Business Objectives or Projects**	
Finance including Claims		**Service/Business interruptions/disruptions**		**Environmental**	

Inherent Risk Score (Likelihood x Severity = Risk Score)

What is the score **WITHOUT** any control measures?

Using the risk matrix overleaf, evaluate the **inherent** risk rating. This is the risk score **WITHOUT** control measures in place.					
Inherent likelihood	5	**× Inherent impact**	5	**= Inherent risk rating**	25

Control Measures currently in place - List the current control measures in place to minimise the potential impact of harm and reduce the risk, these must be **IN PLACE AND WORKING** to be a control.

Current Control measures
Red COVID areas identified and expanded in Secondary Care to accommodate increased incidence of COVID in the community and nosocomial transmission of COVID. This permits cohorting of COVID positive patients in designated areas.
Outbreak Wards closed to new admissions and proactive programme of patients and staff screening implemented.

Risk Matrix	**Likelihood →**				
Severity ↓	**Rare - 1**	**Unlikely - 2**	**Possible - 3**	**Likely - 4**	**Almost certain – 5**
Catastrophic - 5	**5**	**10**	**15**	**20**	**25**
Major - 4	**4**	**8**	**12**	**16**	**20**
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Rare - 1	**1**	**2**	**3**	**4**	**5**

All areas continue to implement Table 4 in the UK Guidance for Personal Protective Equipment in Clinical settings and compliance with legislation relating to face coverings in all Hospitals.
Enhanced environmental cleaning in place. Assurance checks in place to monitor compliance with PPE and Standard Infection Prevention & Control Precautions.

Current Risk Score (Likelihood x Severity = Risk Score)

Using the risk matrix below, identify the **current** risk rating. This is the risk score **WITH** control measures in place.					
Current likelihood	4	**× Current impact**	5	**= Current risk rating**	20

Risk Action Plan Please specify actions that address the cause of the risk **(clear and concise)**)

Actions must be SMART: Specific, Measurable, Achievable, Realistic and Time-bound.	**By whom**	**By when**	**Cost of action**
1. Option a) Amend Patient Profile for admission to Field Hospitals to Post COVID Infection. COVID recovered patients.	MJ	20.11.2020	Nil
Option b) Amend Patient Profile for admission to Field Hospitals to include mixture of Green COVID and Post COVID Infection patients. Based on assumption that post COVID patients will not present a COVID infection risk to patients on green pathway.	MJ	20.11.2020	Nil
• Conduct daily PCR test on Group 2 non COVID patient transfers for early identification of infection (for first 14 days post transfer)	AL/MJ	20.11.2020	Negligent
• Utilise CDC COVID Symptoms check for 14 days post admission to FH https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html	AL/MJ	20.11.2020	Nil
2. Conduct antibody test pre transfer to Field Hospitals: Positive antibody result – assume non infections: Categorise Group 1 patient regardless of PCR results being negative or low positive Negative antibody result; post COVID with negative or low positive PCR – assume non-infectious 14 days post symptom presentation/sample date: Categorise Group 1 patient. Negative antibody result; negative PCR Green pathway patient: Categorise Group 2 patient	Referring Clinician	20.11.2020	20.11.2020
3. For Group 2 Green COVID Patients (PCR negative; antibody negative): • Extend Social Distancing rules to 4M between beds.	AL/MJ	20.11.2020	Nil

Risk Matrix	**Likelihood →**				
Severity ↓	**Rare - 1**	**Unlikely - 2**	**Possible - 3**	**Likely - 4**	**Almost certain – 5**
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Rare - 1	**1**	**2**	**3**	**4**	**5**

• Patients to be informed not to socialise with other patients within the 4M parameter. • Criteria for transfer to FH to exclude patients who walk 'with purpose'. • Group 2 Patients to be requested to wear surgical face mask if tolerated.			
4. All staff working in the Field Hospitals to wear PPE as per National Guidance i.e. FRSM Type IIR, Gloves, Apron but Face Visors to be mandated at all times.	AL/MJ	20.11.2020	Negligible
5. Enhanced cleaning protocols to be implemented including daily Tristel clean and planned UVC decontamination as deemed appropriate by IPC Team. Weekly Credits for Cleaning audits to be conducted and monitored by Triumvirate Team.	AL/MJ	20.11.2020	Potential cost of leasing UVC machine.
6. Monitor air quality within the facility to provide assurances re humidity and CO_2 levels.	Facilities and H&S Team	27.11.2020	Negligible
7. All patients to have a clinical review prior to discharge with ceiling of care/escalation plans clearly definedYE	Referring Clinician	20.11.2020	20.11.2020

Target Risk Score (Likelihood x Severity = Risk Score)

Using the risk matrix, identify the **target** risk rating. This is the risk score you are trying to achieve when the actions are put in place.					
Target likelihood	2	**× Target impact**	5	**= Target risk rating**	10

Risk Review & Monitoring (for management completion)

Identify the Lead Assurance Committee or Sub-Committee this risk should be reported to?	QSEAC		
Identify the local management group should this risk should be monitored at?	Acute Bronze		
Is this risk to be entered onto your service risk register in Datix? (yes/no)		**Frequency of review.**	Weekly

Risk Matrix	**Likelihood →**				
Severity ↓	**Rare - 1**	**Unlikely - 2**	**Possible - 3**	**Likely - 4**	**Almost certain – 5**
Catastrophic - 5	**5**	**10**	**15**	**20**	**25**
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Rare - 1	**1**	**2**	**3**	**4**	**5**