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# Update on the review of nosocomial COVID-19 infections

# Situation

- The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an update with regards to the Health Board review of suspected in-patient nosocomial COVID-19 infections.
- The Health Board is using the all Wales Protocol for the Review of Patient Hospital Onset COVID-19 Infections and supporting toolkit to support the review process. The aim of the review is to:
  - Understand the factors that contributed to nosocomial COVID-19 infections;
  - Identify the impact on patients; and
  - Identify potential learning from the outbreaks which will be shared across the organisation.
- This report provides an update to QSEC on the current position of the early learning from themes identified through the thematic reviews completed to date.

## Review of COVID-19 HCAI incident

(Appendix 1 of the Protocol for the Review of Patient Hospital Onset COVID-19 Infections)

Patient receives positive COVID-19 diagnosis

An initial determination is required using the agreed nationally agreed surveillance in order to determine the level of investigation. Weekly surveillance will be provided by Public Health Wales from ICNet

Community Onset

Indeterminate

Probable & Actual

No further investigation required

No

Patient death

Patient death

Yes

Yes

No

Report incident via Datix

Report incident via Datix

Undertake a review using COVID-19 review toolkit

Has an outbreak been declared?

Yes

No

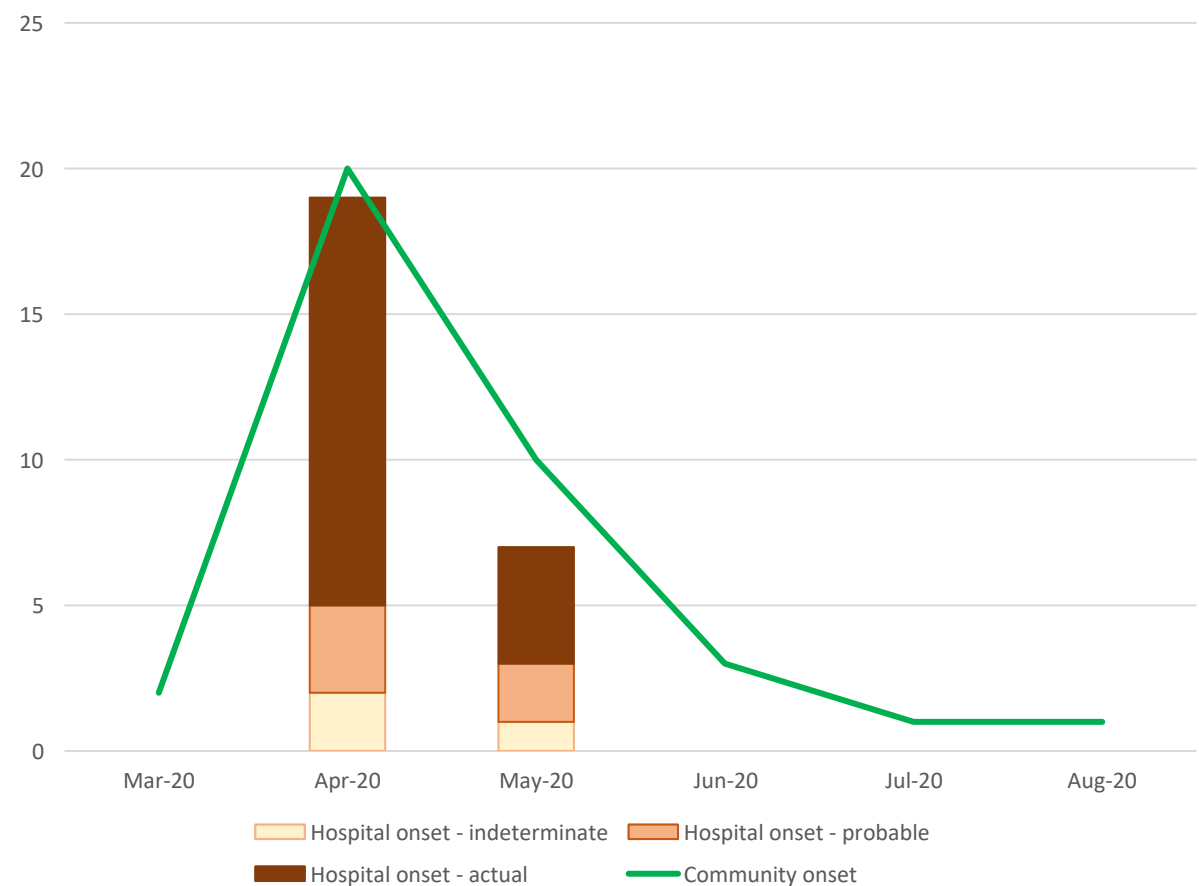
Commence outbreak management and investigate in accordance with local outbreak procedures. Report outbreak on Datix

Undertake proportionate and timely investigation.

Community onset	specimens taken on day of admission or day after
Hospital onset - indeterminate	specimens taken on days 3 to 7 of admission
Hospital onset - probable	specimens taken on days 8 to 14 of admission
Hospital onset - actual	specimens taken >14 days after admission

# Nosocomial COVID-19 infections

March 2020 to August 2020 (Wave 1)



Review complete	Apr-20	May-20	Jun-20	Total
Nosocomial infection - for review	19	7	<5	
Number of reviews complete	TBC	TBC	TBC	
Percentage	TBC	TBC	TBC	TBC

This is provisional data which has been gathered using the data reported of in-patients who have died within 28 days of a positive COVID-19 infection and admission information from Welsh Patient Administration System (WPAS).

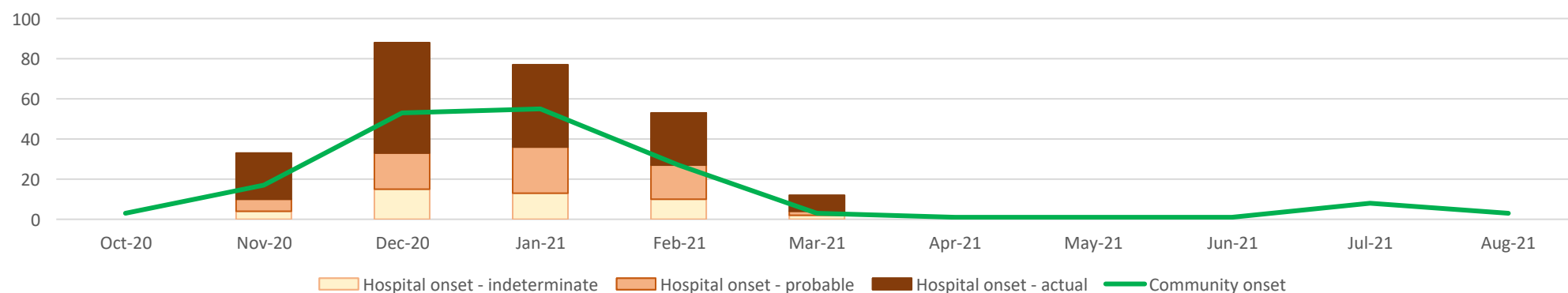
The surveillance definition may change as the review for each patient is completed and the final report produced.

During Wave 1, the all Wales toolkit was in development and therefore a proportionate investigation was undertaken rather than use of the toolkit. Work is underway to check that the investigation has been completed appropriately.

For June 2020 the number of patients was less than 5 and therefore this data has not been included. For March, July and August 2020 there were no deaths that were within 28 days of a positive nosocomial COVID-19 infection.

# Nosocomial COVID-19 infections

## October 2020 – August 2021 (Wave 2)



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Total
Nosocomial infection - for review	<5	33	88	77	53	12	<5	<5	<5	<5	<5	
Number of reviews complete	<5	32	85	76	49	12	<5	<5	<5	<5	<5	
Percentage	100%	97%	97%	99%	92%	100%	100%	100%	100%	100%	100%	97%

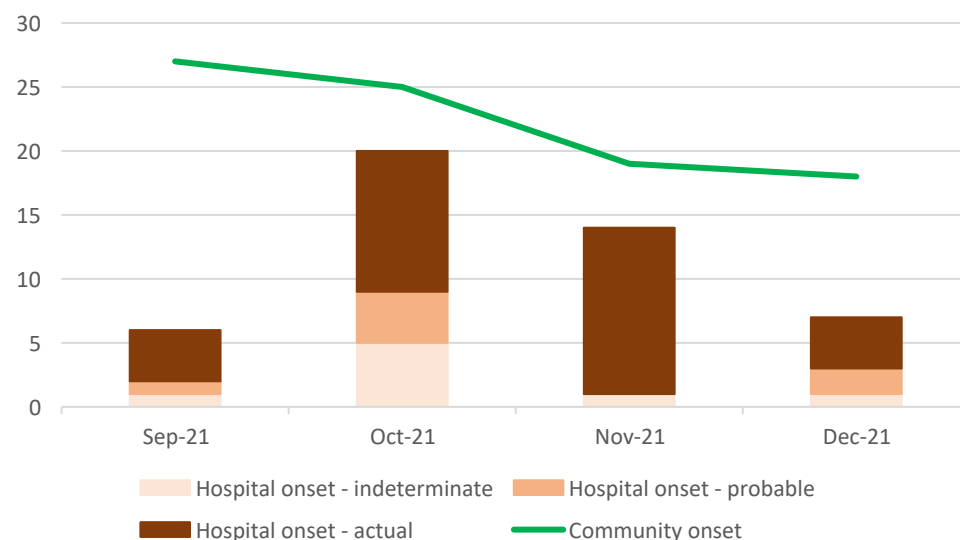
This is provisional data which has been gathered using the data reported of in-patients who have died within 28 days of a positive COVID-19 infection and admission information from WPAS.

The surveillance definition may change as the review for each patient is completed and the final report produced.

For October 2020 and April to August 2021 the number of patients was less than 5 and therefore this data has not been included.

# Nosocomial COVID infections

## From September 2021 (Wave 3)



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Total
Nosocomial infection - for review	6	20	14	7	<5	
Number of reviews complete	6	17	14	5	<5	
Percentage	100%	85%	100%	71%	33%	86%

This is provisional data which has been gathered using the data reported of in-patients who have died within 28 days of a positive COVID-19 infection and admission information from WPAS.

The surveillance definition may change as the review for each patient is completed and the final report produced.

The data for January is currently being collated.

# Outbreak reviews – position as at 10/01/2022

- The majority of nosocomial COVID-19 infections are linked to a ward outbreak. Therefore it is proposed that the learning of each patient review will be included within a ward outbreak thematic review.
- Wave 1
  - Quality assurance of the reviews is being undertaken to confirm that all nosocomial deaths have been reviewed appropriately.
  - This work is expected to be completed by the end of February 2022.
- Wave 2
  - There will be approximately 45 separate reports (we are working through ensuring that where wards were not closed or ward outbreaks were linked, the final report reflects the right information).
  - For wave 2, the patients recovering from probable and actual nosocomial COVID-19 infection have been reviewed as well as the deceased patients (numbers shown on slide 5).
  - For 26 of the outbreaks, **all** patient notes have been reviewed using the all Wales Toolkit.
  - 26 outbreak thematic reports for wave 2 are in draft and are being quality checked prior to sharing with the Triumvirate Teams for approval and development of a directorate improvement and learning action plan (where recommendations are specific for the directorate).
  - This work is expected to be completed by the middle of March 2022.
- Wave 3
  - The Quality Assurance and Safety Team are continuing to review the patient health records using the all Wales toolkit
  - Outbreak debrief meetings are now being held to ensure that learning is captured and shared at an earlier opportunity.

# Learning identified (since previous report to QSEC)

## Areas for improvement

- Timely discussions regarding ceilings of care (sometimes more than 5 days after COVID-19 positive test)
- Documentation that video call / contact with family has happened
- Timely communication from community to hospital e.g. care home closed due to outbreak, ward informed 3 days after care home closed

## Good practice

- Ceiling of care discussion with patient and family documented
- DNACPR discussions with patient and family documented
- Initiation of end of life pathway where appropriate
- Regular COVID-19 testing following any symptoms

## Observations from outbreak reviews

- We may be unable to categorically answer how patients became nosocomial COVID-19 positive e.g. staff contact / other patient contact / visitor contact

## Early wave 3 outbreaks observation

- It would appear that outbreaks are being contained to bays or parts of wards rather than the whole ward being affected



# Learning identified (as reported previously to QSEC)

## Areas for improvement

- COVID-19 testing when symptomatic e.g. patient diagnosed and admitted with an infection (not COVID-19), patient has spike in temperature which was attributed to current infection, COVID-19 test not taken but patient later identified as COVID-19 positive
- Routine retesting of in-patients. It must be noted the guidance on COVID-19 testing changed as wave 2 progressed
- Documentation of communication with patient or their next of kin
- Compliance with hand hygiene less than 85% in some areas (audit result from month prior to ward outbreak)
- Track and trace documentation for staff providing care
- Documentation of where a patient is nursed e.g. bed 1

## Good practice

- Documentation of the rationale for the swab being taken
- Testing on admission and prior to transfer (this quickly became more robust as wave 2 progressed)
- Compliance with hand hygiene excellent in some areas (100%) (audit result from month prior to ward outbreak)
- Good audit results for cleaning standards (above 80%; most areas 100%)
- Family Liaison Officers to maintain communication with families

## Challenges

- Wandering patients
- Aging estate
- Capacity for testing (early stages of wave 2)

# Nosocomial COVID-19 infections - next steps with regards to the review process

## Health Board

- Finalise the remaining outbreak thematic review reports
- Present the findings of the reviews to the Triumvirate Team for approval of the report
- Agree process and resources for contact with next of kin / patient. This will be informed by all Wales discussions

## Recommendation

The Quality, Safety and Experience Committee is asked to:

- Note the information provided in the report
- Take assurance that the Health Board is reviewing all cases where nosocomial COVID-19 infection is suspected and taking action to address areas for learning and improvement.
- Take assurance that the Health Board has systems and processes in place to respond to, and monitor, emerging trends and issues associated with COVID-19.