

Royal Berkshire NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Overall summary

We carried out an unannounced focused inspection of the acute services provided by Royal Berkshire NHS Foundation Trust to review infection prevention and control. As part of our continual checks on the safety and quality of health care services, data showed the trust had experienced an increase in hospital acquired healthcare infections such as MRSA, and bacteraemia.

The Royal Berkshire NHS Foundation Trust is part of the Integrated Care System (ICS) Buckinghamshire, Oxfordshire, Berkshire (BOB). The trust has 687 inpatient beds for a catchment population of approximately 500,000 and provides healthcare services to include acute medical, surgical and maternity services across Reading, Wokingham, Newbury and West Berkshire. They also provide and specialist services such as cancer, dialysis and eye surgery to a wider population across Berkshire and its borders.

The trust is a designated specialist centre for renal, cancer, bariatric care, heart attack and stroke services and provides specialist care through its networks in neonatal, maternity, trauma, critical care and vascular services

The trust also has five other sites - Windsor Dialysis unit, The Prince Charles Eye Unit (PCEU), Bracknell Healthspace, West Berkshire Community Hospital (WBCH), Townlands Memorial Hospital.

Services are commissioned principally by local clinical commissioning groups (CCG's) including Buckinghamshire and Oxfordshire. Services are also commissioned through NHS England Specialist Commissioning.

The Board supports leadership relationships and governance to enable delivery of the joint system operating plan, which includes initiatives across the whole system for improved patient care and system sustainability.

Services we did not inspect

We did not inspect areas where aerosol generating procedures were carried out and we did not attend the intensive care unit. We continue to monitor these areas in line with our methodology.

Inspected but not rated

This was an inspection of infection prevention and control procedures at the trust. We did not rate the service at this inspection, and all previous ratings remain.

We found:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.
- The trust leaders had the skills and abilities to run the service. They understood and managed the priorities and issues surrounding infection prevention and control.
- There was good social distancing between beds in the areas/wards and temporary doors had been erected to maintain a safe infection prevention and control environment.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The leaders in the service were highly visible and approachable for patients and staff. They supported staff to develop their skills, knowledge of infection prevention and control measures and applied them in practice.
- Staff told us there was a caring and supportive culture, the executive team was visible and fully engaged. Staff well-being strategies had been further developed and continued throughout the pandemic.
- Staff on the wards received good support and information from the infection control team to support effective infection prevention and control practices.
- There was a multi-disciplinary approach to managing infection control risks, which included the sepsis team, infection prevention and control (IPC) team, and microbiologists.

Summary of findings

- We recognised that the changing landscape of the COVID-19 infection will continue to be challenging, however, the team felt assured that systems and practices were sufficient to manage and adapt to the ongoing and future challenges.
- The CQC team were assured by the audits being carried out, that governance was strong enough to provide the oversight needed to identify risks and provide the hospital with the information to manage any challenges and issues moving forwards.
- Leaders and staff actively engaged with patients, staff, the public and local organisations to plan and manage infection control practices. They collaborated with partner organisations to help improve services for patients.
- The trust recognised the challenges around their facilities and estate and continued to assess and develop plans to mitigate these risks.

However:

- There were inconsistencies in the management of PPE for visitors on the wards. On some wards, visitors were given PPE at the entrance and in others they were already on the wards before they were given appropriate PPE.
- Some staff in the accident and emergency department said that they did not always feel supported, as they felt the IPC team did not answer their questions and were directed to the standard operating procedures.
- Although hand gels were available at entrances, it was not always in a prominent position with prominent signage to inform visitors to the trust.
- At the entrance to the emergency department, neither masks nor hand gel were in the direct path or vision of the visitors and access to them was obstructed by wheelchairs. The masks were on a table with no signage and hand sanitiser was on the wall.

How we carried out the inspection

Prior to the site visit, we carried out four interviews with the Director and Deputy Director of Infection Prevention and Control, the Lead Nurse and Lead Microbiologist for infection prevention and control. This was to allow us to understand the trust's response to the increase in hospital acquired infections. We also interviewed the trust's sepsis leads (Consultant Antimicrobial

Stewardship Lead and Clinical Nurse Specialist for Sepsis) and the antimicrobial leads (Consultant Microbiologist and Lead Antimicrobial Pharmacist) who were part of the multi-disciplinary infection control and sepsis team.

We visited the Royal Berkshire Hospital on 29 April 2021 to observe infection prevention and control measures, practices, and speak with the staff. We visited the emergency department, medical assessment unit, the augmented area outside the intensive care unit (ICU) and nine wards. We also visited public areas and staff rooms to observe social distancing practices.

We spoke with approximately 18 staff members including consultants, nurses, allied healthcare professionals, housekeeping staff, security staff and reception staff. We observed practice and reviewed patients' records, infection control and COVID 19 policies and procedures, board assurance and other data received from the trust to assess compliance with national guidance.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Is this organisation well-led? Inspected but not rated

Leadership

Leaders understood and managed the priorities and issues the service faced. The infection prevention and control (IPC) leadership team had the skills, abilities, and commitment to provide guidance and manage the priorities in terms of IPC. They were visible and approachable for both patients and staff.

The trust had opted for a gold and silver command working approach. Gold (strategic) command was led by the Medical Director, Chief Operating Officer and the Director of Infection Prevention and Control (DIPC). Silver command (tactical) was led by the Directors of Operations and Nursing who sought the advice of the infection prevention and control (IPC) team, microbiology department, pathology services and occupational health service to provide operational instruction to all local teams, wards and departments.

The trust Emergency Preparedness, Resilience and Response (EPRR) plan was reviewed in September 2020. This was used in conjunction with the pandemic

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response plan which provided guidance and an understanding of developing ways of caring for large numbers of infectious patients, of all ages requiring intensive and high dependency care.

The trust board had invested in improvements to the infrastructure, equipment and services and planning for COVID-19. Their focus as the pandemic progresses was on the immediate plans, but they also considered long term planning, such as increasing intensive Care Unit (ICU) capacity. They had invested in the installation of new oxygen production, extra ventilators and ward equipment.

The trust identified that its priorities for infection prevention were;

- Enhanced cleaning programme,
- Reduced movement and cohorting of patients and staff
- Addressing staff welfare and wellbeing.
- Testing of staff and patients

The trust vaccination programme had been one of their priorities to manage infection prevention and control and to reduce staff absence, which also contributed to improved infection prevention and control.

The Director of Infection Prevention and Control and the IPC team took the lead role of IPC management and was represented at board level by the Chief Nursing Officer. The Director of Infection Prevention and Control and infection control leads had enough training, expertise and time allocated to meet the demands of the role.

The Director of Infection Prevention and Control, IPC lead nurse, lead pharmacist and the antimicrobial stewardship lead worked collaboratively and had a good understanding of the most significant challenges across the trust. They individually identified the greatest risks and could articulate the current action plans around these. For example, the trust has recently introduced a strategic plan to decrease the number of healthcare associated infections (HCAIs) and the trust was currently assessing and addressing poor ventilation in some areas.

The trust held a collaborative weekly meeting, including patient safety, mortality leads, IPC and legal services, who reviewed all patients who had died with COVID-19. In December 2020, the Mortality Service submitted a review

of their findings for the Royal College of Physician (RCP) COVID-19 Study. The purpose of the study was to describe a national picture of the major themes that had emerged relating to the care delivered during the pandemic.

Vision and Strategy

The trust had a clear vision and strategy for continuously improving practices related to infection prevention and control and an action plan to meet identified goals. The action plan was aligned to plans within the local and wider health economy.

The trust had a clear vision and strategy for continuously improving practices related to infection prevention and control. An annual infection prevention and control programme had been completed and presented to the trust board in June 2020. The trust identified among its priorities for infection prevention to include reduced movement of patients and staff, improved ventilation, improve communications, testing of staff and patients, cleaning, vaccinations and addressing staff fatigue and wellbeing.

Each priority action was ongoing, and the measures being taken to address the issues and monitoring of outcomes was updated on the action plan. The trust strategy for improving infection prevention and control practice, was aligned with strategies in other departments and the wider healthcare system.

The systems implemented during the pandemic meant trust management had a clear strategy and were focussed on areas that needed to be improved. The staff told us that the 'augmented' area outside the intensive care unit had been reviewed and equipped and addressed important infection control issues. They were ready should this be needed for another wave.

The trust's annual quality priorities programme had been working towards a reduction in hospital acquired infection including MRSA and *Clostridioides difficile* (C. Diff). There was a commitment to improving sepsis management and screening practices. The trust was recognised regionally for their high quality blood culture standards, with high positivity rates of sample and low usage of broad spectrum antibiotics.

The infection prevention and control team were focused on continuous improvement and education of both staff

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and patients throughout the hospital. There was collaborative working within the wider health economy. For example, the trust had delivered training and support to local care homes at the start of the pandemic.

Planned weekly meetings were held for the infection control team and included pharmacists and microbiologists and any specialist input needed. These meetings also included other areas of infection for example MRSA and *Clostridioides difficile*. They reviewed the processes for managing outbreaks, as well as any actions needed or learning outcomes were disseminated to the wider trust team. Information was disseminated from each of the teams attending using

hospital bulletins, emails and visiting wards and departments.

The lead pharmacist took the lead with any new medicine and discussed with consultants and antimicrobial committee and the pharmacy clinical governance. The trust had a strategy for safe antimicrobial prescribing and audits were used to address any shortfalls.

Culture

Staff felt supported, respected and valued. The trust took various measures to support staff mental and physical health during the pandemic.

Staff felt respected, supported, and valued. They were focused on the infection prevention and control needs of patients receiving care.

The service operated an open culture where patients, their families were supported. Any incidents were shared with them, particularly during the pandemic. Staff said they were confident in raising concerns and felt they were listened to as the trust executive team, matrons and senior staff were fully engaged and worked to resolve issues raised.

Staff had thorough risk assessments completed and the trust supported them in making adjustments, including facilities to work from home as appropriate. The trust was one of the first to initiate staff risk assessment and their risk assessment template designed was adopted by the region.

The trust managed the COVID-19 outbreaks by holding daily meetings chaired by the Deputy DIPC and Director

of Nursing for Urgent Care and worked with their microbiologists to follow their local evidence. In areas where there had been an outbreak, the staff were enabled to wear FFP3 masks, in line with their own assessment. The trust has told us staff were provided with these masks, even when not conducting aerosol generating procedures (AGPs) which exceeded PHE guidance.

FFP3 masks are single use masks designed to help protect against infectious respiratory disease and for use in aerosol generating areas.

The culture centred on the infection prevention and control needs of patients, staff and visitors. During the early stage of the pandemic, they developed pathways to enable the redirecting of patients to NHS 111 and GP slots and streaming to different parts of the hospital. This meant reduced traffic and reduced transmission of infection risks.

The trust recognised the needs and problems around staff breaks and communal staff areas due to the restrictions on permitted numbers. The trust understood the affect this had on staff during the first COVID-19 wave and reviewed break areas where social distancing could still be maintained. This included a staff room in ED as part of the refurbishment.

The trust had introduced measures to promote staff physical and mental wellbeing during the pandemic and beyond. This included access to 24 hour, seven-day-a-week counselling and psychological support, listening events and thank you gifts for all staff across the trust.

The trust had enlisted a group of trained peer support staff working across the hospital to support their staff. There was also support from clinicians providing psychiatric support in post-traumatic stress disorder (PTSD) who worked with across the trust including high pressure areas such intensive care unit, elderly care wards and respiratory staff. Staff we spoke with were positive about the peer support programme and felt the trust had made a commitment in supporting their physical and mental wellbeing as much as possible.

The trust recognised early in the pandemic how this affected the welfare and wellbeing of their staff and set up a wellbeing village within a week. Staff were provided with accommodation close to the hospital and access to clinical psychologist.

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All efforts were made to engage with the staff including the black and minority ethnic group, setting up antibody testing and staff engagement exercise developed such as 'What matters programme'.

The trust had refreshed their staff health and wellbeing Spring care pack for 2021. This was aligned to the trust core values of compassionate, aspirational, resourceful and excellent. Taking time out at the beginning and end of shifts and checking in with each other and providing support as needed.

It was expected that managers held regular wellbeing conversations with their team in order to support staff to work most effectively, and guide staff to further support where required. It also contained information and links to other support such as pastoral care, online courses on mindfulness and resilience. The Employee Assistance Programme (EAP) was available 24/7, 365 days a year and the staff support trust led 'Wellbeing Matters' psychological support service offered support and advice from trained professionals.

Governance

Staff at all levels were clear about their roles and accountabilities in relation to infection prevention and control. Governance structures and the communication within them ensured that changes and learning supported patient safety across the trust.

The trust had a comprehensive assurance system for infection prevention and control which enabled performance issues and risks to be reviewed. Risks related to COVID-19 and any other infection control risks including hospital acquired infections were recorded on the trust risk register and monitored through the IPC and risk committee and discussed at the governance committee meetings.

The trust initiated a strategic response to the pandemic with a multi-disciplinary team approach to monitoring and managing the spread of infection, maintaining services and minimising disruption. The infection prevention and control (IPC) team provided support and used existing protocols in

identifying, managing and reporting infection prevention and control incidents and outbreak of infection within the Trust at all times.

The trust had identified an increase in Gram Negative Bacteraemia. They took a collaborative approach in managing this, working with the sepsis team, IPC team, anti-microbial stewards and microbiologists. The sepsis team had been working to maintain improvements in relation to clinical indication, improved collection to loading times and a reduction in contamination rates. The trust was keen to purchase a 24/7 rapid response laboratory for sepsis, pneumonia and respiratory panel testing. This would have benefits to more efficient targeted antibiotic therapy for better, targeted source control and more robust microbiology input to patient care.

Monthly infection control information such as HCAI incidents was reported in the Quality Governance report. The total number of *Clostridioides difficile* cases reported to date for financial year 2020/21 stands at 34. NHSI have not yet released the trust upper limit for this financial year.

The IPC Board Assurance Framework was updated and presented to the Board in April 2021. The IPC action plan was reviewed, and mitigating action plans were developed to address any gaps in assurance, meeting the standards.

The trust advised that partnership working had been effectively managed and included daily Intensive Care Unit (ICU) calls across the Buckinghamshire, Oxfordshire and Berkshire (BOB) Integrated Care System (ICS) during the pandemic. This was particularly successful during the second wave and escalation periods where ICU demands had exceeded all expectations and increased to 42 beds.

The trust reviewed COVID-19 outbreaks daily, all patients were tested for COVID-19 on admission and on day three and five following admission. All new positive patients were reviewed, and learning was disseminated by the care group leads to the affected wards.

There was a multi-disciplinary approach to infection prevention and control which included the infection prevention and control team and a consultant microbiologist attended the daily meetings. In addition, as part of the Gold command meetings, key messages were disseminated to all staff.

The trust had adequate supplies of PPE to maintain safe care. PPE management for the COVID-19 Pandemic was managed by a designated procurement team. Any issues

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the team identified with PPE availability were raised locally, and at Board level by gold and silver command, as well as at daily operational meetings with matrons and clinical leads.

The trust had a system that demonstrated fit testing was embedded, maintained staff safety and provided safe care across all care settings. This system included a centrally held record of results. The IPC team used an on-line surveillance system to monitor areas with higher risks. The dashboard had oversight of all other elements for infection prevention control to include other hospital acquired infections such as *Clostridioides difficile* and norovirus.

The trust had recognised early during the pandemic, changes of guidance required constant reviews to achieve optimum care of COVID-19 patients. Early in the first wave empirical prescribing was to treat bacterial community acquired pneumonia. The guidelines were changed from an antibiotic administered four times a day to one administered once daily to reduce infection risks and only required one antibiotic injection in the emergency department (ED).

The trust changed their practice, which was supported by testing, as the initial pneumonia was generally viral (COVID-19) and not bacterial. Therefore, the guidelines were revised for a first dose of antibiotic to be given in ED and reviewed at 24hrs. Whilst the respiratory team were quickly on board with this change, it took longer for the care of the elderly team to gain confidence in the adoption of the revised pathway.

The trust developed clear guidance which was shared at the matron's meeting to assess and differentiate between COVID-19 hospital probable onset healthcare associated infection, such as a positive specimen date 8-14 days after hospital admission, and a hospital onset definite healthcare associated infection which would be a positive specimen date, 15 or more days after hospital admission.

This was used to appropriately categorise these incidents and staff followed guidance for the isolation and testing regime to minimise the risk of cross infection.

The team had reviewed all hospital acquired COVID-19 deaths and infection control

complaints or concerns. The team contacted all these patients and their families and Duty of Candour was considered in each case, to ensure an ongoing supportive response to patients and families. As of 1 April 2021, there were 76 hospital acquired COVID-19 deaths which met the threshold for a patient safety investigation and Duty of Candour has been undertaken with the families.

We found antimicrobial stewardship was assured. However, the management of COVID-19 and COVID-19 outbreaks took a considerable amount of time. Whilst new ways of working due to shielding and conference calls improved productivity, we were told that further developments and the reintroduction of a complete antimicrobial audit programme would require additional staff resources. We do not know whether there are plans for a business case to be submitted in order to support this.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The emergency department had been configured into separate areas for suspected and non-suspected cases. During the height of the pandemic, patients were cohorted; COVID-19

positive patients were nursed in designated wards or isolated in relevant clinical speciality as appropriate. This included designated cohort bays and bed spaces, separated by curtains and rigid screens. Temporary doors have been fitted in some areas to create cohort bays areas and the trust was in the process of replacing them with permanent doors.

The trust undertook a thorough review of the environment and identified infection prevention and control challenges. This led to some significant changes, which included designated 'hot' and 'cold' areas to separate patients with confirmed or suspected COVID-19.

Between January 2020 and January 2021, the trust was in the lowest (worst) 25% for reported Gram-negative bacteraemia hospital acquired infection (HCAI):

- E. Coli (38.5 %)
- Klebsiella (19%)
- Pseudomonas aeruginosa (8.6%).

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- MRSA (2.3%)
- MSSA (13.2%).

The trust was pro-active in reporting, recording, and completing root cause analysis (RCA) for HCAI incidents. The latest RCA report relating to the MRSA Bacteraemia, concluded it was likely unavoidable, due to the acuity of the patient. However; IPC practice within the wider ICU was being addressed to ensure risks of acquisition of HCAI is reduced.

The sepsis team continued to have a multi-disciplinary approach to managing and increasing staff's knowledge in the collection of timely blood cultures and the administration of adequate antimicrobial treatment for hospital acquired bacteraemia.

Other measures included the optimisation of microbiology laboratory processes to be compliant with national institute for health and care excellence (NICE). They followed the recommended turn-around times for identification and antimicrobial susceptibility, testing results of pathogens isolated from blood cultures collected from patients with sepsis, to improve clinical outcomes in sepsis.

The increase in bacteraemia infection was reviewed, the causes identified included an increase in ICU patients, with 60-70% agency staff in ICU (who were unfamiliar with the trust environment). The board was appraised of the situation and mitigating actions developed. Priorities were making sure that the environment and pathway were COVID-19 safe.

The trust reduced the risk of patients with suspected/ actual COVID-19 transmitting this to other patients by introducing point of care testing (POCT) on arrival to hospital. All patients were screened before being admitted to wards and then again on day three and day five.

On Mortimer ward, the staff told us that patients were screened on admission, then on day three and five and then every 72 hours. Patients required a negative swab before discharge.

Planning for a third wave had started, the vaccination programme had been well received with 98% of staff

having their first vaccines. Twice-weekly lateral flow testing was in place trust wide. Weekly PCR testing was used on high risk / outbreak wards. Twice weekly PCR testing was used on Oncology/ Haematology.

The IPC team was supporting the elective recovery pathway and making it as accessible and safe. Patients were required to have a COVID-19 test 72 hours prior to their planned surgery. They then had to self-isolate before surgery and tested further on day three and five post-surgery.

The trust was working from the national target to reduce gram negative bacteraemia by 50% and C. diff by 20% compared to last year. The trust told us this C. diff reduction is a locally agreed objective. Patients were routinely tested for MRSA on admission, and records of these were seen in patients' notes.

The ward layouts were re-assessed with increased spacing between ward beds and floor markings were introduced. Signage to support these changes was provided. Some of the wards had been relocated to other areas, in order to reduce transmission and increase spacing between beds. This included introducing 'cold' wards as part of the recovery and start of the elective surgery pathway. The beds in the bays were distanced apart to maintain good social distancing for both staff and patients and windows opened for ventilation.

Staff rooms had maximum occupancy on the door to ensure staff adhered to social distancing during breaktimes.

Staff assessed patients COVID-19 status when they were transferred from other hospitals before arriving, so they could be placed in the appropriate area. If the patient's status was not known, they followed their pathway and came via emergency department, where point of care testing was carried out and result shared with the wards.

We observed staff adhered to infection control procedures, donning and doffing PPE, as appropriate. During our inspection staff used full PPE in a bay where patients were waiting for carbapenemase producing enterobacteriaceae (CPE) tests results. These are bacteria that usually live in the gut and does not cause any problems. However; if the bacteria enter a wound or the

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bloodstream, they can cause infection. The staff followed infection control processes on entering and exiting this area. PPE were discarded in the appropriate clinical waste bins to minimise the spread of infection.

Visitors were supported to maintain good infection control procedures when they visited the wards. However; there were some inconsistencies, in some wards visitors were supplied with PPE at the entrance to the wards. In other ward areas we saw visitors were in the wards prior to using PPE.

However, we saw that at the entrance to the emergency department, the face masks were on a table with no signage and hand sanitiser was on the wall. Neither were in the direct path or vision of the visitor and both were obstructed by wheelchairs.

Patients who presented in the emergency department were not screened at booking, nor were they asked the COVID-19 questions or had temperature checked, as this was done at triage. Though encouraging social distancing and the use of PPE, this meant newly presenting patients were waiting with other patients and their COVID-19 status was unknown. The best practice guidance issued by the Royal College of Emergency Medicine (June 2020) states that, "All patients should be screened on arrival for the symptoms of COVID-19 (and other infectious diseases which need isolation) and after being given a face mask cohort in an appropriate area. There should be a staff member in sufficient PPE able to provide immediate care to a person before their infectious status is known." Senior staff at the trust told us they no longer carried out temperature checks on patients when they presented in emergency department.

The trust told us that since the inspection all patients who presented at the emergency department were screened on arrival, assessed for COVID-19 risk, and had their temperature checked, prior to triage. Information was documented on their electronic patients record.

We observed at an eye clinic, the receptionist asked patients the COVID-19 questions and temperature check carried out. Anyone suspecting of COVID -19 would be taken to a side room and handed over to a member of the clinical team.

Following assessment in the emergency department, patients were moved to the acute medicine unit, (AMU) and high care medicine unit (HMU) if they required further

monitoring and admission to hospital bed. HMU had doors on two of the bays which enabled staff to turn the bay into a COVID- 19 positive cohort area, when needed. During the inspection staff were using the bays to cohort those patients who required aerosol generating procedures (AGPs.)

In the emergency department, staff managed the flow well, some patients were moved to the short stay unit whilst awaiting COVID-19 test results. There were bedded bays, where patients were socially distanced, while they awaited test results, thus reducing the risks of cross infection.

Staff working in clinical areas with suspected / confirmed COVID- 19 patients or looking after "at risk" patients who would be isolating at home were supplied with surgical masks and FFP3 Masks as per Public Health England (PHE) guidance. Posters and communications regarding mask and other PPE usage were available to staff.

The trust had made reasonable adjustments to support their staff to continue in their roles. Staff had been fit tested for FFP3 and provided with respiratory hoods, personal reusable FFP3. Those staff who are unable to pass a fit test for an FFP3 respirator, were redeployed using the nationally agreed algorithm and a record was kept in staff members personal record and occupational health service record.

Consistency in staff allocation had been maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.

The trust recognised that in some specialities, such as the renal and coronary care units, it was not possible to have separate elective and urgent care pathways. The specialist care could only be provided in these designated areas. Mitigations included temporary doors to separate elective and urgent referrals in order to reduce risk of patient cross-over and infection control risks.

On admission to hospital, patients were triaged to identify those with pre-existing conditions or those who were at a higher risk, for example, members of Black and Asian Minority Ethnic communities. Side rooms were used on wards to treat people who had an increased risk of developing serious effects from the infection. If there

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were not sufficient side rooms available, a bay within a ward would be allocated for patients with confirmed positive results to be segregated and the risk of cross infection managed.

Patients discharges were planned to mitigate infection control risks to the community. Procedures had been developed for discharges to a care home. All patients were tested for COVID-19, up to 48 hours prior to discharge, unless they had tested positive within the previous 90 days as per public health guidance. The results were communicated to the receiving organisation/ services prior to discharge and patients COVID-19 status shared. Those being discharged to a care facility within their 14 day isolation period were discharged to a designated care setting

The pharmacy lead held a monthly meeting to advise on PPE. Staff received advice and support on aerosol generating procedures. All pharmacy teams were fit tested as priority, as were staff who were covering the 'hot' wards. All pharmacy teams were given scrub suits and masks. Staff checked the wards COVID-19 status first, before visiting to reduce transmission risks. Medicines stock items, and returns were quarantined for 5 days, including controlled drugs.

On one of the wards, the clinical team had developed a cleaning schedule spreadsheet that they filled in for the areas they were responsible for; this included IT equipment, nurses' station and clinical areas. We saw that these was completed fully. Clean equipment seen was labelled with 'I am clean stickers' to inform staff that this equipment was safe and ready to use.

There was a programme of continuous audits to monitor infection prevention and action plans were developed to mitigate any risks identified and learning from audits were shared including change in practice.

During the early phase of the pandemic, the trust had identified some staff were using hand gel on gloves instead of changing these. Immediate actions were taken. Infection prevention audits had a multi-disciplinary approach and included cleaning audits, risk assessments, environmental audits, prescribing audits, and regular hand hygiene audits.

Staff worked in either the 'Hot' or 'Cold' bays to minimise risks cross-infection. However, staff told us at that at the height of the pandemic this was not possible due to high levels of staff sickness.

The lack of side rooms impacted at times on isolation of COVID-19 positive patients and so they were cohorted in bays. The ward staff felt some outbreaks were due to lack of isolating facilities in the early stage of the pandemic. To mitigate this, they carried out patients' testing more regularly. For example, they swabbed patients for COVID-19 every 48hrs. The wards reported all incidents where they were unable to isolate patients to evidence the need for side rooms in the department.

The trust used learning from incidents to minimise patients risks and improve practices. An example was developing new screening protocols for CPE infection, such as screening the whole ward and the renal population who came in for dialysis. A COVID-19 outbreak within the renal patient's population during the first wave was reported as serious incidents and investigated. Learning was shared and change in practice included offering single patient transport, where no more than one patient was transferred at a time.

The staff said the suspension of commissioning for quality and innovation (CQUIN) had meant a loss of focus on antimicrobial resistance (AMR), which they had raised with the trust. The staff felt the silent pandemic of antimicrobial resistance could present a risk and the trust should be looking at investing further in the AMR agenda.

Information Management

The infection prevention and control teams collected reliable data to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.

During the pandemic, when the national status was at high alert, all information was received via the system email to operational command and was then cascaded down internally. Other alerts came via the regional NHSI to the trust IPC lead nurse who was responsible for monitoring the guidance and alerts.

There was an established pattern of command meetings, including a daily outbreak meeting. Tactical (Silver)

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command meetings were held daily whilst strategic (Gold) command meetings were scheduled to allow for the review of alerts and ensure all changes were communicated and initiated.

Information technology systems were used to share, monitor and report infection prevention and control concerns and closing ward areas to mitigate risk and spread of infection. The trust operation centre had clear and up to date information on the pressures across the hospital to assist flow of patients. Staff could see where beds were available, when they were likely to become available and where the flow was a potential issue.

The trust had an established process of carrying out daily safety huddles and documented this. There was a set format and information recorded onto an electronic tablet device which was then saved, provided an audit trail and information could be retrieved, which the ward sister said worked well.

The infection prevention and control team worked with the wards and other departments to ensure IPC procedures were followed. They used data such as infection control audits, identifying clusters and hand washing audits to monitor and report on infections control risks and containing outbreaks.

The operations centre tracked inpatient testing at three and five days and showed up to date COVID-19 status of all patients to improve compliance. This information was used effectively to ensure patients were held in the correct areas and reducing the risks of cross contamination. The pharmacy staff told us that they had clear information prior to visiting the wards which included known areas where aerosol generating procedures were undertaken.

We saw that patients who were admitted via the emergency department had COVID-19 tests, therefore their COVID-19 status was known before arriving on the ward and they could be placed in the appropriate area.

Patients underwent further testing on day 3 and 5 and every couple of days following their admission and this information was recorded in their electronic patient record (EPR) so was accessible to the staff.

Following the first wave of Covid-19, the trust implemented 'Friday afternoon catchup' with microbiologists, which provided opportunity to share information. They ensured that IPC strategic meetings were scheduled in their diaries.

The trust worked with Berkshire West ICS who reviewed each other's hospital acquired infections and shared learning. The system recognised that some nursing homes were struggling and sent out a team of nurses to support them locally.

The staff followed their internal process for sharing infection control information history when referring, admitting, transferring, discharging, and moving service users within and between health and adult social care facilities. The handover sheets contained infection prevention and control, HCAI and COVID-19 information and patients testing reminders.

On one of the wards, they had developed a spreadsheet for the ward to help with the cleaning schedules, completion of fit testing, patient COVID-19 screening, visitor slots to help keep track of the ward's status.

The patients' records were maintained securely and accessible to staff. We saw examples of care plans, records of care and treatment which were completed by the multi-disciplinary team caring for the patients. COVID-19 testing was recorded in the patients' records notes. We were told patients were advised of their COVID-19 status informally, however there were no record that showed patients had been told of their COVID-19 results.

Engagement

Leaders and staff collaborated effectively with partner organisations to help improve infection prevention and control processes across all services.

Communication was reviewed and strategy developed to ensure effective communication was maintained. Any changes to the PHE national guidance on PPE were quickly identified and effectively communicated to staff

Changes in protocol / PPE practices were communicated at Operational meetings and by "face to face" discussions locally within clinical areas. The trust communications / message of the day was constantly refreshed. Trust PPE

Summary of findings

posters with updated guidance were provided and old versions were archived. Gold Command meeting notes, emails detailing required changes in protocol and practice were cascaded to the staff.

During the early stage of the pandemic, the trust had engaged with local community and organisation to ensure they had adequate PPE. They took a collaborative approach and worked with the local university who provided the trust with testing solutions in order to continue with their testing programme and provide safe care.

The trust continued to support their volunteers in providing more than 1,000 hours of their time every week, to support to staff, patients and visitors. The volunteers were part of the trust's vaccination programme and training was offered to ensure they were able to continue providing support safely.

The trust recognised the impact of reduced/ no visiting caused by the pandemic; the visiting policy impacted on how involved the next of kin felt at times, despite there being evidence of multiple conversations with family and friends.

As part of the recovery, the trust had developed 'cold' wards for patients who were following their elective pathways. At the time of the inspection, there was no visiting and patients were supported to maintain contacts with their family and friends to via the ward tablet device. The nurse in charge told us they had worked out the best time for calls was between 11am and 4.30 pm.

Patients were encouraged to book slots to speak with their family and friends using the tablet device. This was working well and meant patients could communicate with their family and keep the ward safe.

The Royal College of Physician study report showed that communication with family members and next of kin were consistently maintained during this phase of care with some patients having video calls. There was clear evidence that the palliative team had early involvement and provided good symptom management. For some patients, deterioration would have occurred without the diagnosis of COVID-19 and this was managed in the same way, with early input from the palliative care team.

The trust had communicated with every family member of patients whose deaths were linked with hospital

acquired COVID-19 outbreaks and informed them of the investigations. They had a summary report sent to them, or the trust was in the process of doing so. They were offered the opportunity and support to ask the trust any questions they might have.

Staff had effective training on infection prevention and control and received regular feedback from the trust via newsletters, emails and in person. Staff we spoke with felt communication around infection prevention and control changes and PPE, had been well managed. Staff reported that they had all completed personal risk assessments and felt that their individual needs were considered.

The trust had set up a COVID-19 vaccination hub, with the pharmacy team involved in the ordering of the vaccines. There was good collaborative work with the IPC lead nurses and pharmacy stores. They were involved with the quality assurance; mapping of the fridges and dealt with COVID-19 related queries attended the weekly COVID-19 vaccine meetings.

There was a variety of information available for patients and their carers and advice about COVID-19, the risks and visiting restrictions. We saw several posters, free standing boards and leaflets for patients and their visitors explaining changes to the hospital made during the pandemic. Staff told us these were available in different formats and languages if needed.

Learning, continuous improvement and innovation

The senior management team and staff were committed to continually learning and improving services.

The trust promoted a continuous improvement culture around infection prevention and control. Sepsis data in September 2020, highlighted improvement on the inpatient wards. A trust study day for sepsis champions and practice educators was unfortunately cancelled due to the pandemic but it was hoped this will be rescheduled for later in 2021.

Learning from outbreaks had been key and any learning or proposed changes for infection prevention and control (IPC) went through the Clinical Outcome and Effectiveness Committee. For example, the spike in bacteremia's which were isolated to certain areas,

Summary of findings

resulted in a programme of work in the ICU looking at their local practice, working closely with IPC team. Learning from wave 1 of the pandemic was implemented in wave 2.

The trust found patients who were admitted with community onset COVID19, in the first 7-10 days of their admission, did not have any bacterial infections. These infections started to appear 10 days post-admission. Recognition of this allowed for improved planning of care.

The bacterial infections were showing due to damage caused by the COVID-19 virus and the prolonged time on mechanical ventilation. This data was used to drive the targeted therapy and treatment of patients.

Relevant diagnostic processes were used to rule out typical infections. The team had secured COVID 19, serum PCT which supported the staff in making diagnosis and anti-micro stewardship in patients with systemic infections.

At the time of the inspection, ICU was the only one in the country which used a treatment regime of 3 days of antibiotics for ventilator acquired pneumonia (VAP).

During the pandemic, the trust pharmacy team piloted full working days at the weekends, targeting additional clinical pharmacy input to the medical admissions unit. This improved patient throughput and reduced the backlog of work the pharmacy team had to clear on Monday morning. However, these changes have not been made permanent and we were told a business case would be submitted for consideration.

Outstanding practice and areas for improvement

Outstanding practice

We found the following outstanding practice:

- The trust had a proactive approach to infection prevention and control demonstrated from floor to board. Royal Berkshire Trust was one of the first to introduce point of care testing (POCT) in their accident and emergency department.
- The trust was recognised regionally for their high quality blood culture standards, with high positivity rates of sample and low usage of broad spectrum antibiotics.
- The trust was one of the first to initiate staff risk assessment and their risk assessment template design was adopted by the region.
- The trust offered access to 24 hour, seven-day-a-week counselling and psychological support for all staff affected by the pandemic.

Areas for improvement

Action the trust SHOULD take to improve

We told the trust that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

Trust wide

- The trust should continue to focus on reduction of Healthcare Associated Infection (HCAI) rates and maintain compliance with all requirements of the Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections. Healthcare associated infections are infections that occur in a healthcare setting (such as a hospital) that a patient did not have before they came in.
- The trust should continue to review clinical areas and their consideration of additional doors in bays to allow for effective isolation of positive patients.
- The trust should continue their programme to upgrade equipment, ventilation and the ageing environment to minimise infection control risks.
- The trust should consider adopting the Royal College of Emergency Medicine Best Practice Guidance which is that, “All patients should be screened on arrival for the symptoms of COVID-19 and after being given a face mask cohort in an appropriate area. There should be a staff member in sufficient PPE able to provide immediate care to a person before their infectious status is known.”