

East Kent Hospitals University NHS Foundation Trust

Quality Report

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Date of inspection visit: 2 March 2021
Date of publication: 23/04/2021

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

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

We found:

- Leaders had the skills and abilities to run the service and manage infection prevention and control. Trust leaders understood and managed the infection prevention and control priorities and issues the trust faced. Leaders were visible and approachable. Leaders supported staff to develop their infection prevention and control skills and take on more senior roles.
 - The trust had a vision and strategy that included infection prevention and control. The vision and strategy focused on sustainability of infection prevention and control and aligned with local plans within the wider health economy. Leaders and staff understood and knew how to apply and monitor progress of their infection prevention and control vision and strategy.
 - Staff felt respected, supported and valued. They were focused on the infection prevention and control needs of patients receiving care. The trust had an open culture where patients and staff could raise concerns about infection prevention and control without fear. The trust had an emphasis on the safety and wellbeing of their staff. The trust promoted equality and diversity in their approach to infection prevention and control. The trust had infection prevention and control training for staff and additional support where needed.
 - The trust had structures, processes and accountability to support infection prevention and control standards. The trust's infection prevention and control governance and management structure ensured two-way communication. Staff at all levels were clear about their roles to support effective infection prevention and control and had regular opportunities to meet, discuss and learn.
 - The trust had a comprehensive assurance system for infection prevention and control which enabled performance issues and risks to be monitored and addressed. The trust had a programme of infection prevention and control audits to monitor quality and identify where action was needed. The trust had processes to identify and treat people with infections and reduce the risk of spreading infections. The trust had arrangements for identifying, recording and managing infection prevention and control risks. Infection prevention and control effectiveness within the trust had not been restricted by financial pressure.
- The trust collected reliable infection prevention and control data and analysed it. The trust used information systems to provide some staff with the infection prevention and control information they needed to provide effective care to patients. The trust collected infection prevention and control data efficiently and provided staff with rapid access to enable them to improve the care provided. The trust shared infection prevention and control information with external stakeholders and other providers.
 - The trust encouraged staff and patients to provide feedback on infection prevention and control. The trust communicated their infection prevention and control performance with staff and the public. The trust communicated changes in infection prevention and control guidance in a variety of ways. They collaborated with partner organisations to help improve infection prevention and control for patients.
 - All staff were committed to continually learning and improving infection prevention and control performance. Some staff had a good understanding of quality improvement methods and used them to improve infection prevention and control practice. Staff used improvement methods to identify learning from outbreaks. The trust had taken learning from other trusts, internal and external reviews of their infection prevention and control practice.

However:

- Due to vacancies within the team, the infection prevention and control leadership team did not always have capacity to support all staff.
- Not all staff received feedback about the outcomes of infection prevention and control audits and performance information.
- The trust did not always have clear patient records for infection prevention and control.

Summary of findings

- Not all staff had comprehensive support for their safety and wellbeing.

How we carried out the inspection

The team that inspected the trust comprised a CQC inspection manager, a CQC lead inspector, three CQC inspectors and two specialist advisors with experience in infection prevention and control. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection (South East).

During the inspection, we visited the Queen Elizabeth the Queen Mother Hospital and the William Harvey Hospital. We spoke with 47 staff including; nurses, doctors, managers, allied health professionals and support staff. During our inspection, we looked at six sets of patient records. We carried out interviews via videoconferencing with 13 of the trust's infection prevention and control staff and leaders.

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

Leadership

Leaders had the skills and abilities to run the service and manage infection prevention and control.

However, the leadership team did not always have capacity to support all staff.

The trust had an experienced interim director of infection prevention and control. The trust was successful in appointing a substantive full-time director of infection prevention and control who started with the trust two weeks after inspection. However, the trust had a vacant position for the deputy director of infection prevention and control. Staff told us there was not always clear nursing leadership of infection control due to this vacancy. The trust appointed an interim deputy director of infection prevention and control in February and they started work in mid-March following the inspection. The substantive deputy director of infection prevention and control starts in June. The trust had completed an assessment of their compliance against the "Health and Social Care Act 2008: code of practice on the prevention and control of infections" which identified areas of noncompliance which the trust had worked to improve.

Trust leaders understood and managed the infection prevention and control priorities and issues the trust faced.

We interviewed three members of the executive board who were able to tell us about the issues the trust faced and what the trust was doing to manage these. Infection prevention and control was a priority for the board with the board receiving updates monthly. Staff told us they felt the trust's leaders prioritised infection prevention and control issues and had supported improvements. The trust board had reviewed the annual report on infection prevention and control, and they told us this year had required some significant changes for their planned approach due to the new pressures of the global pandemic. The annual infection prevention and control report was based on the previous year's information, which was before the extent of the pandemic was seen or was understood.

Leaders were visible and approachable in the trust for patients and staff.

Staff told us they reported concerns to senior leaders at the daily site safety huddles. The site safety huddle was a short multidisciplinary meeting held at the same time each day for staff across the hospital to share updates and immediate concerns. The executives did site walkarounds to check compliance with infection control guidance and to interact with staff on all trust sites. The interim chief nurse sent a letter to all inpatients which explained the additional infection prevention and control measures in the hospital and invited patients to report their concerns. All new inpatients received this letter upon admission.

Leaders supported staff to develop their infection prevention and control skills and take on more senior roles.

The trust's infection prevention and control nursing team had development posts for nurses to gain the skills and experience needed to proceed to a more senior role.

Vision and strategy

The trust had a vision and strategy that included infection prevention and control.

The trust vision was "great healthcare from great people" which was displayed in the hospital. Staff knew the principles of this statement although they could not always recall the exact wording. The trust's strategy focused on continuous improvement

Summary of findings

called “we care”. Staff and executives supported this strategy. The leadership involvement and staff understanding of their vision and strategy had improved since our last inspection.

The vision and strategy were focused on sustainability of infection prevention and control and aligned with local plans within the wider health economy.

The trust had set themselves five breakthrough objectives one of which was reducing healthcare associated infections. In the past six months, they had reduced the rate of in hospital transmission of *Clostridium difficile* infections. *Clostridium difficile* is an infectious bacterial infection primarily spread by healthcare staff from infected patients with diarrhoea. The antimicrobial stewardship team supported this improvement by identifying medicines being used that could be used less to reduce the risk of spreading of this infection. The trust was part of the region’s infection prevention and control group that met monthly to share concerns and learning. This group had helped support the trust’s improvement with healthcare associated infections. Leaders had a strategy for the sustainable supply of personal protective equipment which included holding stock of at least 21 days of each item for the trust’s projected usage. Leaders worked with local and national stakeholders to amend their rate of supply for items of personal protective equipment when there were changes in guidance or increased usage.

Leaders and staff understood and knew how to apply and monitor progress of their infection prevention and control vision and strategy.

The trust had an action plan for the improvement of infection prevention and control with 117 actions identified, of which 80% were completed in the past six months. The outstanding actions were being monitored by the Trust’s infection prevention and control improvement group who met weekly. Key points from the improvement journey were communicated to the Board via Infection Prevention and Control Committee (IPCC) by the interim director of infection prevention and control. The directors knew about the progress against this plan. Staff told us they had seen improvements in infection prevention and control including an increased access to hand

decontamination gel at entry points to wards and departments. Every ward entrance we visited had hand decontamination gel and face masks. Staff cleaned their hands and changed their masks on entering wards.

Culture

Staff felt respected, supported and valued. Staff told us the wards and departments worked together and felt like families. Staff told us they felt their leaders understood the pressures on them, valued the work they did and supported them to complete their work safely.

They were focused on the infection prevention and control needs of patients receiving care. Staff and managers told us they were happy to challenge people on noncompliance with infection prevention and control policy with a positive focus on protecting patients and staff. The trust had clear plastic curtains between each bed and trolley space to reduce the risk of spreading infections. These clear plastic curtains were in addition to the privacy curtains. The wards had infection control focused checklists that were completed daily which included making sure the clear plastic curtains were pulled all the way forward between each bed space and that each patient area had the windows open. Staff meticulously cleaned these plastic curtains using cleaning chemicals suited to reducing the risk of COVID-19 and *Clostridium difficile*.

The trust had a policy to protect clinically vulnerable patients. In the emergency departments there were gold coloured shield signs at the entrance to the bed area to indicate to all staff that these patients were vulnerable. There were dedicated rooms for these patients throughout the emergency department to reduce the risk to them from other patients. Staff used a screening tool for patients as they entered the department to identify vulnerable patients. This included asking patients if they had been sent a shielding letter but also a list of other questions that triggered staff to place the patient into the vulnerable patients’ stream.

The trust had an open culture where patients and staff could raise concerns about infection prevention and control without fear. Staff reported being supporting in raising concerns about infection prevention and control. Staff told us about a culture programme

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some staff had attended which focused on kinder and supportive ways to improve the practice of other staff. We saw a manager constructively challenge a member of staff about the way they were wearing a face mask.

The trust had an emphasis on the safety and wellbeing of their staff however, this was not experienced consistently by all staff. Some staff told us there were wobble rooms they could use. However, other staff told us these rooms were not easily accessible to them due to their locations. Wobble rooms are dedicated quiet rooms that staff can visit if they are feeling overwhelmed and need some peace and quiet. Personal protective equipment was available in all areas we visited. The trust had conducted a COVID-19 vaccination programme for their staff and by February 2021 the trust had given a first dose to 85% of their total workforce. Most staff told us they were able to take regular breaks and had rooms to allow them to socially distance while eating. The hospital restaurants had one-way systems, clear plastic screens separating seating areas and dividing tables. There was clear guidance displayed and staff in the restaurants were happy to challenge non-compliance.

Staff told us the doctors mess had not been optimised for social distancing. Not all therapy staff at the Queen Elizabeth the Queen Mother hospital had an office space to complete administrative work resulting in them spending more time on wards than needed. The trust provided scrubs for staff working on wards with patients with COVID-19. These scrubs were cleaned by the hospital laundry service to reduce the risk of spreading COVID-19. Some staff reported there was insufficient changing facilities for staff, so staff changed into scrubs in toilets and staff break rooms.

The trust promoted equality and diversity in their approach to infection prevention and control. All staff we spoke to told us they had completed a personal COVID-19 risk assessment with their manager, and these were updated when needed. Staff told us support identified from these risk assessments was provided by the trust. The trust had promoted COVID-19 vaccination in their black and minority ethnic staff and by February 2021 had vaccinated 89% of their staff in these groups. Leaders at the trust told us they were working to have targeted conversations with staff that had declined the vaccination. The trust produced an infection prevention

and control training video for their support staff. These support staff worked for a private provider supplied under a service level agreement with trust. The trust also translated this video into Nepalese as this provider has a high number of staff whose first language was Nepalese.

The trust had infection prevention and control training for staff and additional support where needed. Staff told us they had completed their yearly infection prevention and control eLearning which was updated to include information about COVID-19. The trusts compliance with level 1 infection prevention and control training was 94% in February 2021. The trusts compliance with level 2 infection prevention and control training was 79% in February 2021. All staff we spoke to told us they had also seen the trust video explaining COVID-19 precautions, donning and doffing personal protective equipment. The trust had made watching this video mandatory for all staff and had achieved 87% compliance in February 2021. Staff told us they received feedback on their practice from other staff and from the infection prevention and control nursing team. This included spontaneous short training sessions by the infection prevention and control nursing team delivered on wards to target identified additional needs for those wards.

Governance

The trust had structures, processes and accountability to support infection prevention and control standards. The trust had audits including hand hygiene and personal protective equipment. These audits were collected and acted on by ward staff and managers. The trust had environmental audits that reviewed the effectiveness of their cleaning standards. Leaders reviewed these and found they needed to be improved, at the time of this inspection, this work was in progress but would not be completed until May 2021. Until these were completed the trust was supporting their cleaning standards by providing additional training for their cleaning staff from the British Institute of Cleaning and the trust's facilities managers conducted unannounced site inspections. All areas we visited looked visibly clean and tidy.

All levels of the trust's infection prevention and control governance and management interacted with each other however, not all staff received

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feedback on audit outcomes. Some staff told us they reported infection control concerns and received feedback on these. Other staff told us they knew audits and reports were completed but did not always receive feedback about the results of these. At the time of our last inspection, feedback on audit results was not being given to all staff and trust leaders were still working to improve this feedback process. Ward staff reported their concerns and audits through their care group leadership team. This team then reported these results to the infection prevention and control committee. This committee reported to the quality committee that subsequently reported to the trust board. The minutes of these meetings showed concerns were escalated where needed through these levels and information was communicated back down.

Staff at all levels were clear about their roles to support effective infection prevention and control and had regular opportunities to meet, discuss and learn.

The trust had site wide safety huddles in the morning of each day. These included a dedicated slot for the infection prevention and control team to provide any updates on guidance and feedback about areas of concern. Staff told us these safety huddles were useful to them as a source of information and to quickly raise concerns to the site leaders. Ward staff received information about their infection prevention and control responsibilities via the trust intranet page on COVID-19, via ward team meetings, ad-hoc training sessions, eLearning, their line managers and ward-based safety huddles.

The trust had introduced ward-based safety huddles, but these were not consistently being completed across the wards we visited. Staff told us they felt they were informed about changes in guidance and given opportunities to ask questions. The trust had audited their compliance with daily ward safety huddles which was 95% for the William Harvey Hospital during February 2021 for their general and specialist medicine care group and the surgical and anaesthetics care group was 80%. This had been improving since our last inspection and the trust was continuing to work on this. Staff were compliant with national guidance on hand hygiene and the usage of personal protective equipment except for one member of staff not wearing a mask correctly. Most

staff were compliant with the trust's policy to be bare below the elbow however we saw two staff that were not compliant. Managers challenged these staff about their noncompliance and the issues were resolved quickly.

Management of risk and performance

The trust had a comprehensive assurance system for infection prevention and control which enabled performance issues and risks to be monitored and addressed.

The interim director of infection prevention and control completed and updated the trust's board assurance framework for infection prevention and control. This board assurance framework was updated monthly, and the changes were highlighted to the board every meeting. The interim chief nurse and the chief medical officer were well informed about the contents of the board assurance framework and knew how this was representative of their patient's experience of infection control. This had been used to inform the board of an emerging national risk of Burkholderia aenigmatica related to the multi-use bottles of ultrasound gel in intensive care units. Burkholderia aenigmatica is a group of bacteria found in soil and water which can lead to serious respiratory infections. There were no incidents of this infection locally however, the interim director of infection prevention and control had identified this as a concern from monitoring national risks. Following this the trust had changed to single use sterile ultrasound gel packets within its intensive care units.

The trust had a systematic programme of infection prevention and control audits to monitor quality and systems to identify where action was needed.

The trust had hand hygiene audits, environmental cleaning audits, personal protective equipment usage audits, vulnerable patient policy compliance audits, urinary catheter audits, peripheral lines audits, commode audits, central line audits, and antimicrobial stewardship audits. These audits were reported to the infection prevention and control committee. The hand hygiene audits were completed daily by all wards and departments. The compliance with hand hygiene had been improving and for the week ending the 23 March 2021 compliance was 94% for Kent and Canterbury Hospital, 94% for Queen Elizabeth the Queen Mother Hospital and 99% for William Harvey Hospital. To make the results of this audit robust the trust had staff from other areas complete these audits and required each

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area to complete at least five audits each day. The number of departments and wards participating in the daily audits was improving. Staff had completed the required number of audits in 30 out of 31 wards and departments at the William Harvey Hospital in the week commencing 2 March 2021.

The antimicrobial stewardship team had completed antimicrobial audits and identified wards for additional targeted support. Following national guidance, the team had not re-audited these areas to see the effect of this improvement work due to the pressures caused by the pandemic. The antimicrobial stewardship team in January 2021 carried out a snapshot audit of antibiotic usage for patients with COVID-19. They used this to identify areas for improvement and had increased the visits from their team to wards with high usage of restricted antimicrobials to ensure they were being used correctly.

The trust had processes to identify and treat people with infection and reduce the risk of these people transmitting these infections to other people.

The trust swabbed all patients on admission to hospital for COVID-19 and MRSA. Meticillin-resistant *Staphylococcus aureus* (MRSA) is a bacterial infection that is resistant to many antibiotics which makes treatment more difficult. Staff had access to COVID-19 testing kits which they were advised to use twice a week to identify staff who have COVID-19 but have no symptoms. Patients with infectious diseases were isolated from uninfected patients.

Patients with a negative result for COVID-19 from their first swab were re-swabbed after three days and again between day five and day seven after admission which was in line with national guidance. The trust had audited their compliance with their swabbing policy for December 2020 and January 2021 and compliance was 97% for day one, 37% on day three and 73% on day five to seven. After inspection the trust shared with us their re-audit from March 2021 which showed a small improvement of their compliance to 99%, 39% and 80% for day one, day three, and day five to seven. We looked at ten patient records and found nine patients has been swabbed in line with national guidance. The one that had not been completed correctly had the day three swab taken a day early on day two. Leaders told us they were working to improve compliance with day three swabbing by ensuring all staff know the correct days patients

required swab testing for COVID-19. All levels of the trust infection prevention and control governance structure were monitoring the results of these audits and promoting improvement in compliance.

Staff told us they always had access to the personal protective equipment they needed. Staff put on and took off personal protective equipment in line with Public Health England guidance. The trust had staff at the entrances to the hospital to check the temperature of people entering the hospital, remind them to wear a mask and check if they had symptoms of COVID-19. However, these staff were not present at night so people entering the hospital at night were not being screened.

The trust had arrangements for identifying, recording and managing infection prevention and control risks.

The trust had identified risks about infection prevention and control which were included in the trust wide risk register and care group risk registers. These included the risk of spreading COVID-19 between patients and difficulty in maintaining social distancing. These registers included the initial risk level, risk controls with an assurance level for each control, required actions with progress noted against each action, the current risk level and a target risk level.

Risks and actions were updated and the trust board reviewed risks monthly. The board had a summary report that highlighted to them the most significant risk level changes from the previous month with a short explanation for the change. Staff knew about the most significant risks related to their wards or departments. Leaders knew the top risks and what the trust was doing to mitigate these. We saw actions recorded on the risk registers were implemented as described including the emergency department social distancing escalation plan which was in line with the guidance from the Royal College of Emergency Medicine.

Infection prevention and control effectiveness within the trust had not been constrained by financial pressure. Leaders and staff told us there had never been any resistance from the trust to implement infection control measures due to financial controls. The trust board in December 2020 approved a business case

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which included the funding for an expansion to the trust's two emergency departments which included the aim to improve social distancing and infection prevention and control within the departments.

Information Management

The trust collected reliable infection prevention and control data and analysed it. The infection prevention and control committee received reports from the leadership team of each care group. The trust produced a template for these reports, to guide the care group leaders and to improve consistency of reporting from the care groups. This standardised approach helped the trust track improvements and deteriorations each month. After the first wave of the pandemic the trust completed a cluster review of care for patients with COVID-19. This identified learning that the trust used to improve care for patients which included ensuring prompt response to positive COVID-19 results.

The trust used information systems to provide staff with the infection prevention and control information they needed to provide effective care to patients. Staff used a patient tracking system that logged patients COVID-19 swab results, and this was linked with the laboratory records system which allowed clinicians to see results as they were recorded in the laboratory. This system was also linked to the trust's digital whiteboards displaying patient information at the nurses' stations on each ward and department. Colour coded symbols were used to show the Covid-19 status of patients. Staff told us this system was helpful and had allowed them to take immediate action on seeing the symbol change colour. The digital whiteboards also displayed a flashing swab icon next to the 'C19' symbol when the patient was due for their next swab. Staff told us this was a helpful reminder of which patients needed to have swabs each day.

The trust collected infection prevention and control data efficiently and provided some staff with rapid access to enable them to improve care provided.

Managers had instant access to the results of hand hygiene and personal protective equipment audits on their trust smart phones. Managers used this data to take immediate action to improve compliance where it was

most needed. Managers told us this had allowed them to identify groups of staff that were showing noncompliance which had led to more rapid improvement within the departments and wards.

Staff did not always keep clear patient records for infection prevention and control. Inconsistencies in record keeping increased the risk staff would not share all infection prevention and control information efficiently.

Staff completed stickers with the relevant information for blood cultures. Medical teams had clearly recorded diagnosis and plans for infection management. We looked at six patient records that showed all patients had been screened when applicable for MRSA, COVID-19 and Carbapenemase-producing organisms.

Some patient records had board round stickers that summarised actions needed. However, these were not used in all patient records. Nursing staff recorded care and treatment for patients and in some patient records a nursing care proforma had been used that clearly laid out all the nursing information in one place. However, these were not used in all patient records.

Four antibiotic medication records had a diagnosis, name, dose, route, frequency, and pharmacy review recorded. However, three had no reason for continuing beyond five days, and none had an intended duration recorded.

The trust shared infection prevention and control information with external stakeholders and other providers. Patient discharge letters contained a record of the patient's infection status. The trust reported the number of patients with COVID-19 each week and the number of days after admission this had been detected. The trust reports the number of patients that had acquired other hospital associated infection nationally and this was published in their public board papers.

Engagement

The trust encouraged staff and patients to provide feedback on infection prevention and control. Staff told us they felt able to speak up about their concerns and had the opportunities to do this which had improved since our last inspection. The infection prevention and control team meeting minutes discussion around feedback and requests for advice from staff. This included staff from the maternity unit requesting infection

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prevention and control advice on the use of a new area in the unit for women in labour. There were posters in public areas and on wards advising patients to wear masks and to talk to staff if they had any concerns about this. Letters had been provided to patients after infection outbreaks which included a request for patients to speak to their nurse or doctor about any concerns. The process following an outbreak on a ward included a prompt for staff to complete duty of candour.

The trust communicated their infection prevention and control performance with staff and the public.

The trust published their performance report on their public website which includes information on the number of patients with MRSA and Escherichia coli within the trust. Escherichia coli is a bacterial infection from contaminated food or water which causes diarrhoea and vomiting. Some staff told us they received feedback about the trust's infection prevention and control performance however, other staff told us they were not included in this information sharing process.

The trust board meeting minutes showed the board responded to questions about infection prevention and control from members of the public and trust governors. This included a question about the provision of additional levels of personal protective equipment. The chief executive responded to this with assurance the trust followed the advice of Public Health England on what level of personal protective equipment to provide to staff. The trust communicated information about infection outbreaks at their daily site huddles and an outbreak meeting with the infection control team.

The trust communicated changes in infection prevention and control guidance in a variety of ways. There were posters displaying the process for donning and doffing and the correct type of personal protective equipment to wear for different areas or activities. The trust had Covid-19 information leaflets for patients in a range of formats including a video with sign language used. Most staff knew how to access these leaflets however, on Cambridge J2 a COVID-19 positive ward, staff did not know where to access them. We saw a variety of posters providing advice on infection prevention and control with pictures clearly showing the

messages such as a patient wearing a face mask. The trust website had an advice section for patients and visitors about COVID-19 which included information on how to access services safely during the pandemic.

They collaborated with partner organisations to help improve infection prevention and control for patients. Meeting minutes demonstrated that trust staff worked with NHS improvement, the local clinical commissioning group and other local NHS trusts to improve infection prevention and control. External stakeholders gave positive feedback about the trust's engagement with them.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improvement in infection prevention and control.

We observed a trust board meeting where they discussed their improvement goals and their ongoing improvement strategy. Staff told us there had been a change in the improvement culture within the trust to one where they were constantly looking for new ways to improve. The antimicrobial pharmacy team told us they were working on a new program that will reduce the waiting time for results from blood culture tests. This will mean patients will receive targeted antibiotics more quickly, reducing the risk of spreading infections.

Staff used improvement methods to identify learning from outbreaks. The trust improvement plan included learning from the recent Clostridium difficile outbreak. Improvements identified included strengthening the support for their antimicrobial stewardship team and ribotyping all Clostridium difficile samples. Ribotyping is a process to identify more detailed information on the type of a bacterial infection which is used to indicate the likelihood infections were spread between patients. Learning was discussed at the infection prevention and control committee and the infection prevention and control improvement group.

Some staff had a good understanding of quality improvement methods and used them to improve infection prevention and control practice. The trust had an improvement programme called 'we care' focused on continuous improvement with infection prevention and control as one of its key focuses. This programme included training for staff on quality

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improvement methodology to give them additional skills to continue driving improvement throughout the trust. However, some staff said they were not involved in improvement work.

The trust had taken learning from other trusts, internal and external reviews of their infection prevention and control practice. The trust had taken learning from another NHS trust and introduced infection control champions within their medical teams. Leaders told us this had improved engagement with changes in

infection control practice from the doctors within the trust. The trust had received feedback from CQC and NHS improvement on infection prevention and control. The trust had used this feedback to produce an improvement plan with 117 actions on and setup an infection prevention and control improvement group to ensure a focus on this action plan. The trust also had their infection prevention and control committee that met monthly to review internal audit data and lead improvements based on this information.

Outstanding practice and areas for improvement

Outstanding practice

We found the following outstanding practice:

Trust wide

- In the emergency departments, there were negative pressure rooms used for patient resuscitation with support rooms that were linked via video and audio. During resuscitation, staff in the support rooms supplied the resuscitation staff with medicines and equipment which reduced the need to store items in the resuscitation area. This reduced the risk of spreading COVID-19 to patients and staff.
- The trust had developed a thorough approach to screening for clinically vulnerable patients including shielding them from other patients. This helped to reduce the risk they would contract an infection from other patients.
- The trust continued to look for new infection prevention and control risks during extraordinary pressure on their resources. This reduced the risk to patients from new infections.
- The trust had rerecorded their infection control training video in Nepalese. This allowed the staff whose first language was Nepalese to gain more from this training.

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 ensure that the capacity of the infection prevention and control leadership team is sufficient to support all staff.
- The trust should consider the layout of the doctor's mess to facilitate social distancing.
- The trust should consider the supply of administrative space for therapy staff to reduce the number of staff required to be on wards.
- The trust should ensure that when wards are converted to the COVID-19 positive stream, consideration is given to staff changing facilities.
- The trust should ensure that all staff receive feedback about infection prevention and control audit outcomes and performance information.
- The trust should ensure that they continue to improve their compliance with daily ward safety huddles.
- The trust should ensure that staff continue to challenge noncompliance with the trust's policy for staff to be bare below the elbow.
- The trust should continue to improve their compliance with their COVID-19 testing policy.
- The trust should ensure that throughout the night, people entering the hospital are consistently screened for COVID-19 symptoms.
- The trust should consider standardising nursing documentation across all wards.
- The trust should ensure that all staff know how to access patient information leaflets.
- The trust should consider how to increase staff involvement in their quality improvement projects.