Frimley Health NHS Foundation Trust

Quality Report

Portsmouth Road
Frimley
Camberley
Surrey
GU16 7UJ
Tel: 01276604604
www.fhft.nhs.uk

Date of inspection visit: 13 April 2021
Date of publication: 10/06/2021

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

We carried out this unannounced focused inspection of the acute services provided by Frimley Health NHS Foundation Trust to look at 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 Methicillin Resistant Staphylococcus aureus (MRSA), and the rate of COVID-19 infections had risen.

Frimley Health NHS Foundation Trust provides NHS hospital services for around 900,000 people across Berkshire, Hampshire, Surrey and South Buckinghamshire. Services are commissioned principally by local clinical commissioning groups (CCG's) including East Berkshire, Surrey Heath and North-east Hampshire and Farnham CCGs. Services are also commissioned through NHS England Specialist Commissioning. The trust covered the local authority areas of Slough Borough Council, Royal Borough of Windsor and Maidenhead, Bracknell Forest Council, Surrey County Council and Hampshire County Council and worked with these organisations to provide services.

The trust brought together Heatherwood and Wexham Park Hospitals NHS Foundation Trust and Frimley Park Hospital NHS Foundation Trust to create Frimley Health NHS Foundation Trust on 1 October 2014.

The trust is part of the Frimley Health and Care system, one of 29 integrated care systems (ICS) nationally. ICSs are partnerships between providers and commissioners of NHS services across a geographical area with local authorities to help plan and integrate care to meet the needs of their population. The Frimley Health and Care ICS formed in April 2017.

The trust employs around 10,340 staff across three main hospitals - Frimley Park in Frimley near Camberley, Heatherwood in Ascot and Wexham Park near Slough. The trust also runs outpatient clinics and diagnostic services from Aldershot, Farnham, Fleet, Windsor, Maidenhead, Bracknell and Chalfont St Peter. In January 2017, the trust took over north-east Hants community services based at Fleet Hospital.

The trust also hosts the Defence Medical Group (South East) at Frimley Park with military surgical, medical and nursing personnel working alongside the hospital's NHS staff providing care to patients in all specialties.

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 trust's infection prevention and control teams had the skills and abilities to run the service and manage infection prevention and control. They were visible and approachable. Leaders understood and managed the infection prevention and control priorities and issues the trust faced.

- The service had a vision for what it wanted to achieve and an infection prevention and control strategy to turn it into action. The vision and strategy were focused on sustainability of infection prevention and control.
- Staff felt respected, supported and valued. 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.
- Leaders operated effective infection prevention and control governance processes, throughout the service and with partner organisations. Staff at all levels, were clear about their role and responsibilities regarding infection prevention and control. Staff had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used several systems to manage effective infection prevention and control. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- The service collected reliable infection prevention and control data and analysed it. Staff could find the data

Summary of findings

they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly 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.
- All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in infection prevention and control measures.

However:

- Two handwashing sinks on ward 3 at Wexham Park Hospital did not comply with the Health Building Note 00-09: Infection control in the built environment, as they had overflows. The surround/splashback for the handwashing sinks were wooden and damaged which could compromise effective cleaning.
- Not all staff understood maximum room occupancy numbers.
- There was inconsistent practice between hospital sites of taking people's temperatures upon arrival to the hospital.

How we carried out the inspection

The team that inspected the trust comprised a CQC inspection manager, a CQC lead inspector, three CQC inspectors, one assistant inspector and one specialist advisor. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection (South East).

We carried out interviews via videoconferencing with seven of the trust's infection prevention and control staff and leaders to assess the trust's response to the increase in hospital acquired infections and rising COVID-19 infection rates. We also interviewed the chief pharmacist for the trust via videoconferencing.

We visited Frimley Park Hospital and Wexham Park Hospital on 13 April 2021 to observe infection prevention and control measures, speak with staff and to observe infection prevention and control practices. We visited the emergency department on both sites, and a variety of wards. We also visited public areas and staff rooms to observe social distancing practices.

We spoke with 75 staff members including consultants, nurses, allied healthcare professionals, housekeeping staff, security staff and reception staff. We observed practice and reviewed patient notes 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

The trust's infection prevention and control team had the skills and abilities to run the service and manage infection prevention and control. They understood and managed the priorities and issues surrounding infection prevention and control. They were highly visible and approachable in the service for patients and staff. They supported staff to develop their skills and understanding of infection prevention and control measures.

The trust had sufficient leadership and capacity for infection prevention and control. We interviewed two members of the board who were able to tell us about the issues the trust faced and what the trust was doing to manage these. They told us that COVID-19 had been the most significant challenge for infection prevention and control, alongside adapting processes often at short notice, and the impact of a pandemic on staff tiredness and wellbeing.

The trust had a director of infection prevention and control who was the chief of nursing and midwifery. She was appointed in June 2020 and took over the director of infection prevention and control role from the medical director. The director of infection prevention and control represented infection prevention and control at board level and the infection prevention and control teams reported quarterly to the board, although the frequency had increased over the last year.

There was a trust wide infection prevention and control nurse consultant who reported to the director of infection prevention and control and worked alongside a consultant microbiologist. At each hospital site, there was

Summary of findings

a lead infection prevention and control nurse who ran an infection prevention and control team. The infection prevention and control team took the lead role in infection prevention and control management at site level and we spoke to the leads prior to our inspection.

The lead nurse consultant for infection prevention and control met weekly with the director of infection prevention and control and medical director to discuss the top infection prevention and control priorities. The trust operation centre was set up at the beginning of the pandemic and was a central point where updates and guidance were distributed from. Staff told us that it had been helpful in getting out key messages on infection prevention and control.

The trust had a chief pharmacist and anti-microbial pharmacists on both sites. There were four microbiology consultants at the Frimley Hospital site, and two at the Wexham Park site with two vacancies. The trust did not currently employ specialist anti-microbial nurses, but staff told us they hoped to be able to facilitate this in the future.

Staff felt strongly supported by both the trust leadership team and the infection prevention and control team. Staff said the leadership team were visible and approachable and had listened to and acted upon their concerns and challenges. For example, refurbishing staff rest areas to ensure staff had a calm, relaxing and well-ventilated area to take a break away from the clinical environment.

Staff reported that the trust's infection prevention and control team were supportive and visible in all areas. Changes to guidelines were communicated via email, handovers and safety briefings. Staff told us that they received feedback on infection prevention and control audits.

The trust had completed an infection prevention and control board assurance framework. The board assurance framework was a key document used to support all healthcare providers to effectively self-assess their compliance with national COVID-19 guidance. The trust's board assurance framework clearly showed evidence of meeting the standards and if there were any gaps in assurance, mitigating actions were given.

The trust had completed an assessment of their compliance against the Health and Social Care Act, Code of Practice on the Prevention and Control of Infections. This had identified areas of noncompliance which the trust was working to improve. However, the action plan was in draft format and not fully complete at the time of the inspection.

Vision and Strategy

The service had a vision for what it wanted to achieve and trust-wide strategy to turn it into action. There was no infection control strategy in place at the time of our inspection, however there was an action plan which outlined a vision for what they wanted to achieve.

The trust strategy 'Our future 2020 – 2025' included improving quality for patients, supporting staff, collaborating with partners and transforming services. The trust values were 'Committed to Excellence', 'Working Together' and 'Facing the Future'.

There was no infection prevention and control strategy in place at the time of our inspection, however the trust told us they were working on having one for the next financial year. Whilst there was no infection prevention and control strategy in place, there was a draft healthcare associated infection action plan where the vision was: "To prevent any patient from coming to harm from an avoidable healthcare-associated infection, by supporting staff in facilitating best practice, and by ensuring the patient is at the heart of all interventions." There were five objectives, including to promote hand hygiene, learn from post infection reviews, reduce antimicrobial resistance and reduce the risk of COVID-19. The draft action plan included assessment of risk against the Code of Practice, for example, against criterion one (Systems to manage and monitor the prevention and control of infection), there was an action for every post infection review to be held for every trust apportioned bacteremia case.

The trust had made significant changes to the layout and flow of the hospital since the pandemic and took measures to reduce the spread of COVID-19 including floor markings for social distancing, screens to provide a physical barrier between patients, visitor use of facemasks and posters to remind everyone to wash their hands. Signs were displayed on room doors to indicate the maximum number of people allowed in the room so social distancing could be safely maintained.

Summary of findings

During our inspection, most areas had the appropriate number of people in line with the maximum room occupancy. All rooms were risk assessed and had numbers displayed on the doors with the maximum number of staff allowed in the rooms to be COVID-19 safe. We observed the maximum room occupancy to be complied with in most areas we visited, however in one department there was a discrepancy with staff not understanding that the maximum occupancy applied to both patients and staff.

There was signage and posters, at the main entrances to both hospitals, to remind people to keep socially distanced and to wear a face mask, in line with national guidance. There was clear signage to indicate one-way systems at the entrances and in corridors that staff and visitors adhered to. Staff and volunteers were positioned at the entrance to encourage use of alcoholbased hand sanitiser and to provide face masks to those who did not have one or wished to replace one. However, at the Frimley Park site, visitor temperatures were being taken for those who consented, whereas at Wexham Park no temperatures were taken. There was no standard operating procedure for the main entrance so it was unclear whether the temperature checks were necessary.

Reception staff on the front desk had a screen installed to protect them. However, they had reported issues with patients and visitors being unable to hear properly due to the screen. In response to the concerns raised by staff, microphones were added to aid communication which staff said had helped.

The hospital infection control committee meeting minutes from December 2020 showed staff not adhering to social distancing in non-clinical communal areas was a recognised theme from COVID-19 outbreaks. We observed one staff communal area during our inspection and saw that staff were socially distanced and the maximum occupancy was not exceeded.

Staff wore the correct personal protective equipment for the area where they were working. Most staff told us that there was never any issue with having the correct personal protective equipment available. During the first wave, it was identified that the dedicated proning team in critical care were not always changing their PPE between patients, due to concerns over a lack of adequate supply of gloves and aprons. Gloves can transfer bacteria in the same way hands can, this meant as staff did not remove or wear their gloves correctly, there was potential for cross infection. The dedicated team were given additional training, and reassurance to make sure they were compliant with trust policy and national guidance on the correct use of PPE. Proning is a procedure where a multidisciplinary team carefully move a patient's position, so they are lying on their front. All but one member of staff observed during our inspection, were bare below the elbows.

All waiting areas had chairs spaced two metres apart and all beds were spaced two metres apart. Staff maintained social distancing where possible in the clinical setting.

Prior to the inspection, we identified an increase in the number of cases of healthcare associated infections at the trust. We spoke with the lead nurse consultant for infection prevention and control and the director of infection prevention and control who understood the reasons behind the increases and had developed an action plan to address this.

A handover safety message dated 29 March 2021, included information about the recent rise in MRSA cases and reminded staff about hand hygiene. Staff we spoke with were aware of the trust priorities around infection control, including reducing health care associated infections and line safety. The increase in MRSA cases was also on the trust's corporate risk register as a high-level risk.

Infection prevention and control training was tailored to whether a staff member was patient or non-patient facing. Patient facing staff undertook level one and two infection prevention and control training, and non-patient facing undertook level one training. This meant that housekeeping staff had received the same training as their medical and nursing colleagues, except for antimicrobial stewardship as this was role specific. The trust's infection prevention and control training compliance rate was 94% for level one and 88% for level two. This was better than the trust's target of 80%.

The trust's personal protective equipment training compliance rate was 94% for level one and 85% for level two. This was better than the trust's target of 80%. Housekeeping staff told us that they felt supported by the trust and that they felt safe coming to work. The infection

prevention and control board assurance framework acknowledged the importance of all staff understanding what personal protective equipment they should be wearing for each area.

Culture

Staff felt respected, supported, and valued. The trust took various measures to support staff mental and physical health during the pandemic. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke to felt safe to come to work and felt well supported. The 2020 national staff survey showed 71% of staff reported they would recommend the trust as a place to work. This was better than the national average score of 66%.

The trust supported open and fair challenge to infection prevention and control practice. There were posters around the hospital saying it was ok for patients to ask if a staff member had cleaned their hands, prior to any interaction.

From October 2020 to February 2021, the trust's staff flu vaccine uptake rate was 71%. This was worse than the national average of 76% but did demonstrate an improvement from the previous year's figures. As of March 2021, 83% of trust staff had been vaccinated for COVID-19 and all directorates had achieved a vaccination rate of over 70%. There had been discussions on what the barriers were for staff who had not yet had their vaccine, and it was identified that fertility and family planning were a strong theme amongst staff.

Staff recognised that some unpopular choices had to be made, particularly around staff breaks and staff areas due to the restrictions on permitted numbers of people in a room. For example, staff rooms had to be socially distanced and therefore less staff could access the rooms at break times. The trust had understood the effect this had on staff and had in some areas opened parts of the hospital to allow for socially distanced breaks, such as in the Glade café area at the Frimley Park site, where we saw staff were able to take a break whilst socially distancing. Garden areas were also opened on both sites for staff to use.

Many staff had been redeployed to other areas of the hospital during the pandemic. All staff we spoke with felt they were supported during this change. Some members of staff had expressed a desire to keep in touch with the wards they had been redeployed to in order to try and maintain the new skills they had developed, which the trust were supporting.

All staff had been risk assessed for working with COVID-19 patients, this was completed electronically and was regularly updated. Reasonable adjustments were made for staff who were unable to work in high-risk areas or were not able to perform aerosol generating procedures. Aerosol generating procedures are medical procedures that result in airborne particles or respiratory droplets being released, which meant that staff were more at risk from contracting airborne diseases, such as COVID-19. We spoke to staff from ethnic minority groups who confirmed they had all been risk assessed to work in each area or ward, that they were redeployed to.

All staff we spoke with confirmed they had had a risk assessment. The risk assessment had identified some staff that could not work with suspected or confirmed COVID-19 patients. Where this occurred, the staff members were moved to work on non COVID-19 areas.

Leaders at the trust recognised the impact that the pandemic had on staff's wellbeing. Staff were positive about innovations to support their mental health and wellbeing. We were told on the acute admissions unit at Wexham Park, a counsellor had attended the ward at the end of a night shift to offer staff the opportunity to offload and de-brief.

Staff told us that they felt the trust acknowledged how tired the workforce was. For example, staff told us that they received weekly treat boxes from the trust, and snacks were handed out when staff were busy and unable to take a break. We saw that wards and departments had a variety of thank-you cards and certificates to acknowledge staff members achievements and contributions.

On the acute admissions unit, each staff member was allocated a break buddy, who prompted each other to ensure they took their breaks.

Staff told us that reasonable adjustments were made in relation to personal protective equipment. For example, staff who wore a head covering for religious beliefs were given a respirator hood for use when caring for patients

with COVID-19 as the standard FFP3 face masks (a special type of face mask used where aerosol generated procedures are occurring) were not a good fit with a head covering.

Managers had supported staff who were self-isolating or who had tested positive for COVID-19 with regular calls and delivery of food parcels. One member of staff told us that when they were off sick and very unwell with COVID-19, a senior nurse telephoned them regularly to check on their welfare.

Governance

Leaders operated effective infection prevention and control governance processes, throughout the service. Staff at all levels were clear about their role and accountabilities regarding infection prevention and control and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures, processes, and accountability to support standards of infection prevention and control including managing cleanliness and suitable environments. The infection prevention and control team supported staff in the trust and reported to the lead consultant nurse and director for infection prevention and control. Performance metrics were reported to the trust board for review, assurance and approval of actions taken. Where issues were identified, there was an action plan to address and monitor any risks.

Regular audits and spot checks were carried out to ensure compliance with national guidance. For example, hand hygiene and anti-microbial sensitivity audits were undertaken as part of a yearly infection prevention and control audit and surveillance programme. Infection prevention and control practice assurance audits were completed quarterly by clinical areas. Infection prevention and control and hand hygiene audit results were displayed on notice boards within wards. For example, for March 2021, the acute admissions unit achieved 100% compliance for infection prevention and control and hand hygiene. However, hand hygiene compliance across the trust had decreased in the most recent reporting quarter January to March 2021, with scores between 66% and 78% compared to 92% and 91% in the previous quarter.

We saw three examples of MRSA spot check audit results for different areas, and we saw that two areas had achieved 100% compliance, and one ward had achieved 56% compliance. All the spot check results had areas of good practice listed, along with areas for improvements and recommendations.

We interviewed the director of infection prevention and control who felt that there was a clear governance structure relating to infection prevention and control and that it was everyone's responsibility to ensure good practice across the hospital. We found that this was the case with staff throughout the hospital sites.

There were several meetings and committees which included infection prevention and control in their agenda. The committees interacted with each other appropriately and effectively. Learning was shared at infection prevention and control link representative meetings and the link nurses fed back learning to their teams. Infection prevention and control link nurses were nurses who acted as a link between their own clinical team and the infection control team, and often had additional training in infection prevention and control. Additionally, a monthly infection prevention and control newsletter was distributed throughout the trust. The infection prevention and control team attended forums such as the monthly senior sister forums. The lead nurse consultant met with the chief of nursing and midwifery on a weekly basis.

The hospital infection control committee met twice monthly and included the director of infection prevention and control, infection prevention and control team and included representatives from the clinical commissioning groups and public health England. Staff told us the purpose of the committee was to advise and support the infection prevention and control team by ensuring the implementation of best practice in infection prevention and control. Three other committees reported directly into the hospital infection control committee, these were the decontamination steering group, the built environment group and the drug and therapeutics committee. Outbreaks of infection such as COVID-19 were reported and investigated, and learning shared at the hospital infection control committee meetings. The minutes of the December 2020 and February 2021 meetings showed infection prevention and control issues, themes and actions were discussed.

Summary of findings

The director of infection prevention and control was a member of other committees in addition to the hospital infection control committee including the clinical governance group and quality assurance committee.

The infection prevention and control lead nurses were members of various committees including the patient led assessment of the care environment committee, the patient safety committee, and external committees such as Frimley Health and Care System Infection Prevention & Control Group and Surrey Heartlands Infection Prevention and Control Group. The infection prevention and control team reported quarterly to the quality assurance committee.

We saw the latest infection prevention and control yearly report was discussed at the quality assurance committee on 15 December 2020. It is a requirement of the Health and Social Care Act 2008: Code of practice for the NHS on the prevention and control of healthcare associated infections and related guidance for healthcare associated infections summary and relevant assurances to be presented to the board. The report outlined the compliance against the code of practice criterion.

Staff used equipment appropriately and took measures to protect patients, themselves and others from infection. The premises were visibly clean. We saw housekeeping staff in all areas that we visited. Housekeeping staff were aware of, and followed, the trust's standard operating procedures in relation to cleaning. For example, staff explained the colour coding system to aid cleaning equipment, and explained the importance of cleaning high touch points, such as door handles, to prevent the spread of infections and COVID-19.

Cleaning schedules were displayed in all areas we visited, and cleaning records were up to date. Compliance with cleaning was monitored weekly by the housekeeping supervisors and by the ward manager. If a deep clean of an area was needed, this was requested electronically. Staff reported the service was very responsive, usually within 20 minutes.

The date of the last hospital acquired infections such as Clostridium difficile (C. diff) were displayed throughout the wards.

There were enough handwashing sinks for staff to wash their hands, and there was alcohol-based hand sanitiser throughout the areas we visited. However, two handwashing sinks on ward three at Wexham Park did not comply with the Health Building Note 00-09: Infection control in the built environment as they had overflows. The splashback for the handwashing sinks were wooden and damaged which compromised effective cleaning. Non-intact surfaces can harbour dirt and dust and make cleaning difficult. Following the inspection, we requested details of any risk assessments and refurbishments in relation to this ward. We saw that the risk regarding the sinks had been identified in July 2018, and that replacements were due in May 2021.

Staff cleaned their hands with soap and water and used alcohol-based hand sanitiser before and after each patient contact and when entering and exiting different areas. The trust had a hand hygiene policy which clearly set out best practice for hand hygiene. It had last been reviewed in February 2020 but did not have a review date set.

Side rooms had clear signage to indicate any infection control risks and what level of personal protective equipment was required prior to entering the room.

Between July 2020 and March 2021, there were 10 MRSA bacteremia cases. Post infection reviews had been completed for these and we saw the associated action plans. Some of the actions listed included level 2 training compliance, which all patient facing staff were expected to complete. The target for this was 80% and we saw that as of March 2021, the compliance rate was 85.9%. The action plan had also identified that whilst this target had been hit, there was a lower compliance with facilities staff and therefore reminders had been sent to the relevant teams.

Management of risk, issues and performance

Leaders and teams used systems to manage effective infection prevention and control. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The trust had a robust assurance system for infection prevention and control which enabled performance issues and risks to be identified and addressed. This included regular infection prevention and control audits

in compliance with hand hygiene, cleaning, and documenting infection prevention and control processes. Results of these audits were fed back to the clinical areas and shared at meetings and in safety updates.

Staff testing for COVID-19 was embedded practice amongst the staff. All patient facing staff undertook bi-weekly COVID-19 lateral flow tests (a basic self-test procedure). If a member of staff had a positive lateral flow test, then they would arrange a polymerase chain reaction test and isolate until their result had been returned. We saw that to date, 602 staff had tested positive for COVID-19 via a lateral flow device, of which 57 had been negative when completing the polymerase chain reaction test.

Trust data showed staff sickness, that was related to COVID-19, peaked during the second wave in January 2021, but figures had improved from that point with less staff being sick with COVID-19 related illness. Staff reported that the occupational health service were responsive and supportive.

We looked at a 'key messages' document dated March 2021. This was a trust-wide document distributed to staff with updates and key messages on. This had a summary of the healthcare associated infection infections declared by the trust for the financial year 2020 to 2021. It demonstrated that whilst there was a 23% decrease from the previous reporting year in C. diff and E. coli infections, there was a significant increase in MRSA (from 4 to 10) and MSSA cases (22% increase in MSSA). The areas identified for improvement were around a decreased compliance with hand hygiene, and avoidable contamination of blood cultures. We spoke to leaders within the infection prevention and control team who felt the decrease in compliance with hand hygiene was because of an increase in clinical glove use and difficulty in procuring hand sanitiser. Alcoholbased hand sanitiser was available in all areas that we visited around the hospital sites. Another action taken was the implementation of the 'glove me for a reason' campaign which focused on reducing inappropriate glove use, an area which had been highlighted in hand hygiene compliance audits. We also saw that this risk was identified on the trust's corporate risk register as a high-level risk.

We spoke to staff about how they raise issues and concerns relating to infection prevention and control. Matrons and lead staff attended daily infection prevention and control meetings during the pandemic which they found useful. They reported that any issues they brought to the meetings were rectified promptly. For example, a request for additional personal protective equipment was raised at the meeting and the ward received this promptly, and on some occasions, issues had been resolved even before they had returned from the meeting.

Staff completed COVID-19 risk assessments for all patients and we saw this in the notes that we reviewed. In the emergency department, we saw staff asked patients questions related to their risk for COVID-19 and recorded these on an electronic system. The system also alerted staff if the patient had a previous healthcare associated infections.

The trust managed COVID-19 cases, clusters and outbreaks in line with national guidance. A cluster was defined as an unexpected, potentially linked cases, whereas an outbreak was defined as two or more cases in a single setting (e.g. a bay, a ward) that had become symptomatic or detected on screening on or after day eight of hospital admission. Once an outbreak was declared, the area would remain closed until 14 days-post the last positive COVID-19 case identified, or until all patient contacts were isolated in single rooms, or discharged, to complete their isolation period. We saw a summary of the last three COVID-19 outbreaks reported to NHS/England by the trust.

We spoke to pharmacists as part of our inspection. A pharmacist explained that doctors could only prescribe three days of antibiotics in order to prevent over prescribing. In this time, they waited for blood cultures to come back to make a diagnosis. After the three days, the antibiotic prescription was reviewed and then re-prescribed if needed. We saw that pharmacists had reviewed all the medication charts we looked at.

We reviewed two medicine charts for patients receiving intravenous antibiotics. Both had a clinical indication recorded on the chart and medical notes, and had a dose and duration documented. Both had a blood culture recorded as being taken. We reviewed the medical records of these two patients, and both had a record of a discussion with a microbiologist, to ensure the correct antibiotic was prescribed. We reviewed an additional nine

sets of prescriptions in patients notes and saw that six out of nine had been fully completed. However, two out of the three incomplete prescriptions had no duration recorded and three had no indication recorded.

We checked entries in patient records regarding invasive devices. We looked at six records across four patients for peripheral venous cannula checks and found that five out of six were fully completed. Staff confirmed that once they had completed their intravenous medication competency, they then undertook the training and competency to obtain blood culture samples.

Information management

The service collected reliable infection prevention and control data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. The wards used predominantly paperbased records, however the acute assessment unit used mainly electronic records. The staff were positive about the IT system as it was a system shared by the emergency department, site team and medical assessment unit so there was easy access to relevant results and investigations. We saw any infection control alerts and pending COVID-19 results were flagged on the system. Staff explained that the infection prevention and control team also used this system and would add an alert if the patient previously had an infection.

Patients risk assessments were inputted onto an electronic system on admission. There were a number of mandatory questions that staff had to input and they could not skip questions marked as mandatory, to ensure the correct level of information was collected.

An electronic incident reporting system was used to record incidents including infection prevention and control, and the lead nurse consultant told us that they were made aware of these when they were inputted. This meant that infection prevention and control staff were made aware of any infection prevention and control incidents or issues quickly.

All patients attending the emergency department would either have a rapid bedside COVID-19 test if it was critical for their diagnosis or a polymerase chain reaction test. All planned admissions would have a polymerase chain reaction test for COVID-19 and be screened for MRSA prior to admission. Emergency admissions would also be screened for MRSA, once a decision has been made to admit. Staff explained while they waited for a COVID-19 test results, patients would be placed in a side room where possible. In the emergency department we saw they recorded the result of a COVID-19 test result on a green piece of paper to make it visually more obvious.

Patients were tested on day one, three and day six of admission in line with the hospital policy. We saw that due dates of COVID-19 tests were marked on handover sheets and daily huddle proformas. We reviewed the compliance for day three and six inpatient COVID-19 testing. At Frimley Park Hospital, compliance with day three testing between 5 and 11 April 2021 was 88%, and 93% for day six. At Wexham Park and Heatherwood Hospital (combined), compliance with day three testing was 82% and 98% for day six.

On the acute assessment unit, we observed the handover of patients from emergency department staff to ward staff where infection control risks such as a history of diarrhoea were discussed. We observed staff checking the results of COVID-19 swab results on the electronic system and then allocating them an appropriate area on the unit.

The trust had introduced a Clinical Likelihood Assessment of Acute Respiratory Virus Infection tool. This assessment tool was used to assess the likelihood of a patient suffering from a respiratory infection, however in the patient records we reviewed, none of these had an assessment completed.

Engagement

Leaders and staff actively and openly 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.

Summary of findings

The trust was part of the Frimley Health and Care Integrated Care System. Integrated Care System are partnerships between providers and commissioners of NHS services across a geographical area with local authorities to help plan and integrate care to meet the needs of their population. The executive director of quality and the director of infection prevention and control for the integrated care system met weekly. Meeting minutes dated December 2020, January 2021 and February 2021 showed infection outbreaks and actions were discussed. Representatives from the trust were in attendance at all three meetings. We saw minutes of weekly meetings held between trust staff and with the executive director of quality and the nursing director of infection, prevention and control for the Integrated Care System where updates on outbreaks and actions were discussed. We saw a summary of the last three COVID-19 outbreaks reported to NHS/England by the trust.

Infection prevention and control newsletters were available throughout the ward areas and staff said they were useful for keeping up to date. Staff told us that the global communication email system had been used during the pandemic for messages that needed to be distributed to all staff.

On the day prior to our inspection, patient visiting had recommenced but was limited to one visitor per patient which had to be immediate family members or carers. The exception to this was patients receiving end of life care or patients living with dementia. Staff told us that during the first wave, patients were understanding of why they couldn't accompany their relative. However, as restrictions had begun to ease, some patients became frustrated at the restrictions. Staff overcame this by taking the time to explain why this was still important and told us that this had been received well by that patient group.

The acute assessment unit had not recommenced visiting as this was still a high-risk pathway. The exception to this was for patients receiving end of life care or patients with dementia. We saw the ward kept a record of visitors to the unit for test and trace purposes.

The trusts website had up to date information regarding COVID-19 precautions and updated visitor protocols. The website clearly stated which areas were not able to accommodate visitors still due to risk, such as COVID-19 positive wards and some surgical pathways. The website had an option of 'virtual visiting' where a video call could be arranged. There was also a 'message to a loved one' service, where relatives and friends could send letters, photographs etc to a designated email address, and staff would print these out and deliver them to the intended patient.

There was also information and guidance on the website regarding planned admissions and what to do if they become unwell prior to their appointment.

We saw there was a variety of information leaflets for patients being discharged home after having a hospital admission for COVID-19. These were available in different languages for patients whose first language was not English.

Changes to guidelines were communicated via email, handovers and safety briefings. Staff told us that they received feedback on infection prevention and control audits. On the acute assessment, unit each staff member also had designated place for mail/newsletters or information as they didn't always have time to access their emails.

The trust ran 'Values into Practice' awards on a monthly basis. Staff could be nominated by fellow colleagues or by patients and members of the public via the trust's public website for staff who had shown an exceptional commitment to the trust values. We saw on the board minutes that there was an increasing amount of nominations received.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

We saw from various meeting minutes, spot check audits, infection prevention and control newsletters and by talking with staff that learning from reviews or investigations was shared with staff. For example, a decrease in compliance with hand hygiene initiated a push on learning about appropriate glove usage.

Since the pandemic, the trust had to change the way in which it interacted with patients. For patients that needed to come on site, measures were in place to help keep them safe such as one-way systems and the provision of hand gel and surgical masks at the point of entry. For some outpatient appointments and follow up appointments, depending on the speciality, consultations could be made virtual. This meant that

Summary of findings

patients were still able to speak to their consultant, but from the comfort of their own home, reducing footfall on site and contacts. Staff told us that this had allowed clinic rooms to be freed up for on-site consultations, and consultants could use pods or office spaces to carry out the virtual appointments. This in turn made it easier to socially distance patients on site in waiting areas.

The trust had introduced 'navigators' at the front of departments such as outpatients and the emergency department. Navigators greeted patients, took their temperature and asked them about their current health and if they had any COVID-19 symptoms. Patients were also asked to change from a cloth mask to a surgical mask and asked to sanitise their hands, before the navigator would send the patient to the relevant waiting area. Navigators told us that they felt the navigator role worked well, and it had enabled them to turn some patients (very few) away as they had displayed symptoms.

The majority of the patient records in the hospital were paper based. The trust had invested in a new electronic patient records system that would allow real time feedback for better patient tracking, bed management and a drug prescribing electronic system. This was due to be launched in March 2022.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

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 maximum room occupancy numbers are understood and adhered to by all staff.
- The trust should ensure that sinks are compliant with the Hospital Building Note 00-09: Infection control in the built environment.