

William Harvey Hospital

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Ratings

Are services safe?

Inadequate ●

Summary of findings

Overall summary of services at William Harvey Hospital

During the Covid-19 pandemic, we received information of concern from staff, stakeholders and members of the public about poor infection control practices. In response to these concerns, we asked the trust for information about their governance and management of infection prevention and control. Following the trust's response, we issued a warning notice under Section 29A of the Health and Social Care Act 2008 on 3 August 2020.

Following the core service inspection on 11 August 2020, we gave the trust some initial feedback and took urgent enforcement action. The trust has responded to this and provided us with evidence showing they have started working on the concerns raised.

We issued one requirement notice to the trust. Our action related to breaches of one legal requirement in urgent and emergency services and medical care at the William Harvey Hospital.

We issued an urgent Notice of Decision under Section 31 of the Health and Social Care Act 2008, on 20 August 2020. The notice imposed two conditions on the trust registration as a service provider in respect of one regulated activity: Treatment of disease, disorder or injury. These conditions set out specific actions to enable the improvement of safety within the service.

For more information on actions we have taken, see the sections on Areas for improvement and Regulatory action.

As this was a focused inspection, we did not inspect the key lines of enquiry and therefore the overall ratings for medical care and urgent and emergency services have not changed. The ratings from the previous reports still apply. However, we took enforcement action as result of our concerns at the trust, so this limits the rating of safe to inadequate, so this key question has been rerated. The hospitals overall rating for safe has changed to inadequate as the ratings for the key question of safe have changed to inadequate for medical care and urgent and emergency services.

Entrance to hospital

Before entering the hospital, hospital staff took each member of the inspection team's temperature, ensured they were wearing a face mask and were asked to use alcohol hand rub. We were also asked about why we were attending the hospital. We noted the portable hand sink at the main entrance to the hospital was working but did not have any soap to allow people to wash their hands. Following our inspection, the trust told us they no longer used the portable sinks at the entrance but had moved to using alcohol hand rub with monitors at the entrances.

Urgent and emergency services

Requires improvement ●

Summary of this service

We did not change the overall rating for urgent and emergency services at this inspection. We did a focused inspection on infection prevention and control within safe. However, we took enforcement action as result of our concerns at the trust, so this limits the rating of safe to inadequate, so this key question has been rerated.

We carried out an announced focused inspection of urgent and emergency services on 11 August 2020. We spoke with 19 members of staff on site including domestic staff, administrative staff, nurses, doctors and managers. We also invited trust staff to call our National Customer Service Centre to provide feedback about their experiences during the pandemic. We observed infection prevention and control practices and reviewed four sets of patient records.

The trust identified two streams for patients during the pandemic to minimise the risk of spreading the infection. The blue stream was for patients with confirmed or suspected Covid-19. The red stream was for patients who tested negative for Covid-19 and had no symptoms. At William Harvey hospital, there was a designated respiratory area which formed the blue stream in the emergency department. We visited the designated 'blue' and 'red' areas within the emergency department during this inspection.

At the time of our inspection, the national guidance which was in place was Public Health England's 'Covid-19 infection prevention and control' dated 18 June 2020. We are aware there have been updates to this guidance, however these updates have not been considered in this report as they were not in place at the time of this inspection.

Is the service safe?

Inadequate ● ↓

Our rating of safe went down. We rated it as inadequate because:

We took enforcement action to tell the provider they must improve.

We found these areas for improvement:

- The service did not always control infection risk well.
- There was not always adequate provision of suitable hand washing facilities and antimicrobial hand rubs where appropriate.
- Staff did not always adhere to social distancing.
- Managers had not kept up to date with national guidance.
- Staff were not all updated and informed about the trust's policies relating to the management of patients with symptoms of Covid-19.
- Staff were not always supported by the environment to protect their patient and themselves from infections.

However:

- Staff cleaned equipment before and after patient use.
- All staff were bare below the elbows.
- Staff handled clinical waste appropriately.

Urgent and emergency services

- Staff wore personal protective equipment in line with trust policy and Public Health England's guidance.

Detailed findings from this inspection

Is the service safe?

Infection prevention and Control

Information sharing

Staff were not always kept up to date with changes to policies and procedures related to Covid-19.

Updates and changes to guidance were not always shared effectively. Staff were not always complying with trust policies including (June 2020) "Working Safely During COVID-19 Guidance for Managers and Staff" and Public Health England guidance (18 June 2020) "COVID-19: infection prevention and control guidance". Staff told us they did not receive updates from managers. Managers told us they held a daily site huddle with other staff from across the hospital where updates were shared from senior managers. Staff we spoke to were aware of these site level huddles but said they did not receive feedback from these about updates. We were also told the trust had an electronic system that contained all updates to policies and procedures that staff could access on their smart phones. Staff we asked lacked knowledge on accessing updates via the electronic system. However, we saw the donning area for staff entering the Covid-19 positive area of the emergency department had up to date guidance on the use of personal protective equipment.

The department had a digital system to alert staff to each patient's Covid-19 swab test status. This system displayed orange if the swab needed to be sent and green if the swab had been sent while awaiting a result. Then the date would change colour when the result had been received to blue for positive and red for negative. The hospital used blue for their Covid-19 positive stream and red for Covid-19 negative stream. These results were displayed on large screens in the nursing station areas of both the blue and red areas as well as being able to be displayed on the department's computers on wheels.

Personal protective equipment (PPE)

Staff followed national guidance in relation to personal protective equipment. However, trust policy was not always clear on how staff should use PPE.

Staff had access to personal protective equipment (PPE) including; gloves, aprons, masks, and eye protection. Staff told us at the start of the pandemic there had been supply issues with PPE especially masks, but this had not been a problem for a couple of months at the time of the inspection. We observed eight glove dispensers, which contained small, medium and large glove sizes. There were two areas where staff could access replacement masks. We noted six apron dispensers, one of which was empty but was replenished swiftly.

Staff used PPE in line with Public Health England guidance (18 June 2020) "COVID-19: infection prevention and control guidance" to reduce risk to themselves and patients. We observed 17 staff and 16 of them used PPE correctly, the last person did not take their single patient use PPE (gloves and apron) off after being in contact with a patient.

The Covid-19 positive area of the emergency department had a dedicated donning and doffing area. The donning area was supervised by a PPE officer whose role was to help staff and ensure correct usage of PPE.

Staff in the emergency department knew what PPE to wear for performing chest compressions as part of a resuscitation effort. The department always had one member of staff in enhanced PPE including a gown and FFP3 mask. This person

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was ready to respond to patients that needed chest compressions while other staff donned enhanced PPE. This was in line with the guidance from the Resuscitation Council and the Royal College of Emergency Medicine which required chest compressions to be treated as an aerosol generating procedure and thus required staff to wear the higher level of PPE.

The trust policy (Personal Protective Equipment (PPE) Policy for SARS-CoV-2 virus, 20 July 2020) on the use of PPE related to Covid-19 did not make it clear to staff what PPE was required when performing chest compressions and thus did not protect staff or patients. This policy said chest compressions were not considered aerosol generating procedures and stated staff could start chest compressions without enhanced PPE. The policy was not clear as it stated staff may choose to wear PPE when performing chest compressions. This policy also said staff may choose to wear this enhanced PPE when performing chest compressions when there is widespread transmission of Covid-19 in the community. This was not in line with the Resuscitation Council and the Royal College of Emergency Medicine that requires chest compressions to be treated as an aerosol generating procedure and thus require enhanced PPE. However, Public Health England does not consider chest compressions to be an aerosol generating procedure but states, 'Healthcare organisations may choose to advise their clinical staff to wear FFP3 respirators, gowns, eye protection and gloves when performing chest compressions but we strongly advise that there is no potential delay in delivering this life saving intervention'. The guidance from Public Health England requires healthcare organisations to choose if to advise their clinical staff to wear enhanced PPE and not for clinical staff to decide.

Equipment

Staff cleaned equipment before and after each patient use.

Staff reduced risk of infections to patients by keeping equipment clean. We saw in the Covid-19 positive area of the emergency department each patient had their own observation machine with blood pressure, pulse and oxygen saturations, and the thermometers which were shared were cleaned between patients. In the majors assessment area, where the observation machines were shared between patients, we saw these were cleaned between each patient. We saw equipment not in use being stored in a dedicated room. We saw eight pieces of equipment which had green stickers to show staff they had been cleaned. All eight appeared visibly clean and the date on them indicating they had been cleaned on the day of inspection.

The department kept its equipment in good condition which helped reduce the risk of infection transmission to patients and staff. The eight pieces of equipment we looked at appeared in good physical condition.

The department's furniture and beds were wipeable in patient and staff areas. We saw staff cleaning down a patient area after they had been discharged.

Cleaning

Staff did not always record when they had carried out cleaning in patient areas.

Cleaning was not being completed in line with Public Health England guidance (18 June 2020) "COVID-19: infection prevention and control guidance". We looked at cleaning schedules for the two weeks prior to the inspection, these had been partially completed but had gaps present for the cleaning of toilets and sinks. The gaps suggested that on these days the toilets and sinks were not cleaned. The cleaning schedule for the Covid-19 positive area of the department listed 29 items which were required to be cleaned daily and nine items to be cleaned weekly, with the remaining one item (toilets and sinks) to be cleaned twice daily. These items noted for daily cleaning included: chairs, doors, and bedframes. The Public Health England guidance states this cleaning should be done at a minimum of twice daily. Staff told us there had not been an increase in cleaning since the start of the pandemic. However, following the inspection, the trust told us there were 35 hours of cleaning provided to the emergency department each day before the Covid-19 pandemic. During the Covid-19 pandemic and at present, this had increased to 81.5 hours of cleaning each day.

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We were present in the emergency department for over four hours and did not see any domestic staff performing cleaning. However, following the inspection, the trust told us at the exact time of our visit there were nine domestics and one team leader working in the emergency department.

Staff told us they had to request cleaning staff to attend each day otherwise cleaning was not completed in areas including the patient toilets. However, all the areas we visited looked visibly clean.

Clinical waste

Staff handled and disposed of clinical waste and sharps safely.

Staff separated clinical waste in line with Public Health England guidelines. We saw in the Covid-19 positive area of the emergency department all waste was being treated as infectious waste and disposed of into bins with orange bags.

Staff disposed of used sharps safely in sharps bins. We looked at three sharps bins and these were all assembled in line with trust policy with the date assembled recorded and signed by the person who assembled them. All had the temporary close lids closed to protect patients and staff from needle stick injuries.

Environment

Staff were not always supported by the environment to protect their patient and themselves from infections.

Not all rooms in the department had signs to inform staff of how many people could be in that room while being able to safely social distance. We saw five rooms with signs however we also saw four rooms without signs. Managers told us every room should have these signs. This was a risk as the rooms without signs may become overcrowded without staff being aware and overcrowding increases the likelihood of Covid-19 being transmitted between staff and therefore passed onto patients.

The department had two isolation rooms to protect patients and staff from the transmission of infectious diseases. These rooms had been created since the beginning of the global pandemic. These were both negative pressure side rooms with anterooms to don and doff PPE in. To don means to put on their PPE and to doff means to take off their PPE. These rooms were used for aerosol generating procedures. Aerosol-generating procedures were procedures that stimulate coughing and promote the generation of aerosols which can more easily transmit Covid-19 to other patients or staff.

We saw in the triage and the ambulance entrance area there was no posters to remind patients and staff of the symptoms of Covid-19. Staff told us there had been posters at the start of the pandemic, but these were not present at the time of our inspection.

We asked for evidence to show completion of the two-hourly checks by the nurse in charge which were part of the trust's emergency department action plan submitted to CQC following concerns identified in our March 2020 inspection. This action plan said the nurse in charge would perform two-hourly checks including cleanliness of the environment. In response to our request, a trust executive said the trust does not do this. However, for the days the matron was present on site they perform four-hourly checks within the department that included looking at environmental cleanliness.

Infection control risk assessment

Staff were not all updated and informed about the trust's policies relating to the management of patients with symptoms of Covid-19. Managers had not kept up to date with national guidance.

There was not a clear or consistent approach to triage of walk in patients with Covid-19 symptoms. We were told by different staff members three different ways they would handle these patients. One staff member said symptomatic

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patients would wait in a queue inside the reception area to be booked in; which was not what the managers told us was the current plan. This queue was also used by patients without symptoms of Covid-19. This suggested staff were not being updated effectively of changes to the department's policy and thus increasing the likelihood of transmission of Covid-19.

Staff had no awareness of any guidance to help them with triaging or risk assessing a patient's level of risk of Covid-19 when they arrived into the blue area of the emergency department. The blue area of the emergency department was used for patients with confirmed or suspected Covid-19. Managers showed us a patient flowchart for the management of patients with symptoms of Covid-19. However, staff we spoke to, working in roles where they were required to use this flowchart told us, there was no guidance to help them make decisions about patient's Covid-19 risk level. We saw this confusion lead to a patient being transferred from the Covid-19 positive area to the Covid-19 free area and then back to the Covid-19 positive area. The lack of structure to support staff exposed patients and staff to increased risk of transmission of Covid-19. Staff told us junior nurses with limited knowledge or no triage training were completing triage on walk in patients.

Patients who were admitted to wards from the emergency department with suspected Covid-19 did not always have a risk assessment recorded. The hospital had four categories to cohort patients which were: patients with a confirmed test result for Covid-19; patients at high risk of having Covid-19; patients at low risk of having Covid-19; and patients without Covid-19. We looked at four records for four patients with completed Covid-19 clerking proformas and three did not have this risk assessment completed.

Vulnerable patient groups did not always have a personalised care plan. Not all staff knew what personalised care to provide for patients with weakened immune systems.

Staff did not always follow social distancing guidance set out by Public Health England (18 June 2020) "COVID-19: infection prevention and control guidance". We saw clinical staff talking to each other standing closer than two meters apart even though there was enough space to stand two meters apart.

There was no process to assure staff the number of patients in each area of the department had not exceeded the maximum occupancy to allow safe social distancing. Managers were unaware of the Royal College of Emergency Medicines guidance, "Best practice guideline: Emergency Department Infection Prevention and Control (IPC) during the Coronavirus Pandemic". Managers had not followed this guidance to complete a risk assessment to identify their maximum occupancy of patients in each area of the department. They had also not completed a social distancing escalation plan. Nurses we spoke to were unable to tell us how many patients could safely be in their areas while adhering to safe social distancing. However, after the inspection the service submitted evidence to show maximum occupancy and social distancing was now being considered by the Matron in their four-hourly rounds.

Handwashing

The department was not compliant with trust policy. Staff and patients did not always have access to sufficient hand washing facilities. Staff were bare below the elbows.

Staff and patients did not always have access to sufficient hand decontamination gel or handwashing facilities within the emergency department. There were two entrances to the majors assessment area, and they had hand sanitiser points, but both were empty. We informed the nurse in charge of this area and on return in the afternoon, these were still empty. We saw queues of people waiting to use the hand washing sinks within the department.

The department was not compliant with the trust's policy (Hand Decontamination Operating Standard, 30 July 2020) on hand washing which required that alcohol hand rub should be accessible at the point of care, every bed/trolley space, in clinics and triage rooms. In the 'treatment area' of the major's assessment area, there was designated spaces for four patients but only two hand sanitiser stations which were both empty. This meant each point of care did not have its own sanitiser station.

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We looked at six sinks. Of these two had no soap and three had no hand towels. This made it more difficult for staff to comply with the World Health Organization's five moments for hand hygiene. In the majors cubicles area there were gel dispensers for each patient and we checked five of these, but one was empty.

Not all sinks had signs to prompt staff and inform patients of the correct steps for effective handwashing. We looked at eight sinks and five of these had no guidance on the correct way to wash hands. However, the department had two sinks with signs and one sink had a video that played to tell people how to correctly wash their hands. The department's compliance with hand hygiene training was 33% for May 2020.

We saw staff cleaned their hands with decontamination gel or washed their hands between patients after having removed their gloves. The department had performed hand hygiene audits and for May 2020 the department achieved compliance of 96.6%. Staff in the majors assessment area were dependent on individual bottles of hand decontamination gel they carried with them. However, staff told us they did not know how or where they would get more when the bottle they had been given ran out.

All staff we saw were bare below the elbows in line with trust policy. This allows staff to effectively clean their hands.

Patient information

Patients were not always provided with written or visual information.

The provider did not have suitable information resources for patients on infections. Staff told us they had information leaflets about Covid-19 to give to patients at the start of the pandemic but had not had any for several weeks. We looked and could not find any patient information leaflets about Covid-19 or any other infections.

There were some signs for patient information. We saw there were two-metre distancing floor signs in the reception area to alert patients waiting to be booked in to remain two meters apart. However, there were no signs to help patients find the Major Assessment area.

Areas for improvement

We took enforcement action to issue a section 29A Warning Notice because the quality of healthcare required significant improvement relating to infection prevention and control. In summary the reasons we issued this notice were:

The trust could not provide assurance as to who was the executive lead for Infection Prevention and Control.

The board could not provide evidence that the board had been sighted on the risks associated with infection prevention and control.

The board could not demonstrate they had oversight of the management of infection prevention and control during the global pandemic.

We will add full information about our regulatory response to the concerns we have described to a final version of this report, which we will publish in due course.

Action the provider MUST take to meet the regulations:

The trust must ensure all staff are updated with changes in Public Health England guidance and trust policies. Regulation 12

The trust must ensure they have a clear policy for what personal protective equipment staff are required to use when performing chest compressions. Regulation 12

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The trust must ensure cleaning is carried out in accordance with their policy and Public Health England guidance. Regulation 12

The trust must ensure all rooms have signs to inform staff how many people can be in that room before becoming overcrowded. Regulation 12

The trust must ensure staff are supported with up to date information about symptoms and pathway streaming is displayed in the triage and ambulance entrances areas. Regulation 12

The trust must ensure they comply with their emergency department action plan. Regulation 12

The trust must ensure there is clear and consistent approach the triage of walk in patients with symptoms of Covid-19. Regulation 12

The trust must ensure a risk assessment is recorded for all patient admitted with suspected Covid-19. Regulation 12

The trust must ensure all immunocompromised patients have a personalised care plan to put appropriate additional precautions in place to protect them. Regulation 12

The trust must ensure staff always adhere to social distancing when possible. Regulation 12

The trust must ensure a risk assessment is completed to identify the maximum occupancy of each area within the emergency department. Regulation 12

The trust must ensure there is a social distancing escalation plan for the emergency department. Regulation 12

The trust must ensure staff and patients have access to decontamination gel and handwashing facilities. Regulation 12

The trust must ensure all sinks have signs to prompt staff and inform patients of the steps to follow for effective handwashing. Regulation 12

The trust must ensure patients with symptoms of Covid-19 are offered an information leaflet to inform them about Covid-19. Regulation 12

Medical care (including older people's care)

Requires improvement ●

Summary of this service

We did not change the overall rating for medical care at this inspection. We did a focused inspection on infection prevention and control within safe. However, we took enforcement as result of our concerns at the trust, so this limits the rating of safe to inadequate, so this key question has been rerated.

We undertook an announced focused inspection of medical care on 11 August 2020. We spoke with 23 members of staff on site including domestic staff, physiotherapist, administrative staff, nurses, doctors and ward managers. We also invited trust staff to call our National Customer Service Centre to provide feedback about their experiences during the pandemic. We observed infection prevention and control practices and reviewed three sets of patient records.

The trust had identified two streams for patients during the pandemic to minimise the risk of spreading the infection. The blue stream was for patients with confirmed or suspected Covid-19. The red stream was for patients who had tested negative for Covid-19 and had no symptoms. At William Harvey hospital, there were three designated medical wards in the blue stream and one outbreak ward at the time of our inspection. We visited the following wards:

- Suspected ward where patients had Covid-19 symptoms and were awaiting their test results
- Covid-19 ward where patients have tested positive for Covid-19
- Non Covid-19 ward where patients do not have Covid-19 and do not have any symptoms of Covid-19
- Outbreak ward where there was an outbreak of Covid-19 and subsequently the ward was closed to new admissions

At the time of our inspection, the national guidance which was in place was Public Health England's 'Covid-19 infection prevention and control' dated 18 June 2020. We are aware there have been updates to this guidance, however these updates have not been considered in this report as they were not in place at the time of this inspection.

Is the service safe?

Inadequate ● ↓

We rated safe as inadequate.

We found:

- The service did not always control infection risk well.
- Safety huddles did not take place at the start of every shift and the documentation of these were poor.
- Documentation to record infection prevention and control measures, such as equipment and environmental cleaning, were not always completed.
- There was not always adequate provision of suitable hand washing facilities and alcohol hand rubs where appropriate.
- Staff did not always adhere to trust policy and national guidance on wearing personal protective equipment.
- Not all staff had received training on personal protective equipment.
- Staff did not always adhere to social distancing.

Medical care (including older people's care)

- Compliance to the environmental audits carried out by the infection prevention and control team were significantly below the trust target.
- There were no local environmental risk assessments for individual wards.
- There was poor compliance to hand hygiene training.
- Staff did not always undertake hand hygiene.
- There was no standardised approach to providing patients with information on Covid-19 upon discharge.
- Staff were unclear on the trust's Covid-19 testing methodology.

However;

- All staff were bare below the elbows.
- Staff cleaned equipment before and after patient use.
- Staff handled and disposed of clinical waste, linen and sharps safely.
- The trust implemented a patient tracking system to identify the Covid-19 status of all patients.
- The trust had tested all staff for Covid-19 over a five-day period.
- The trust had carried out individual risk assessments for staff.
- Compliance to infection control level one e-learning training was above the trust's target for the general and specialist medicine care group.
- The trust's visiting policy was in line with national guidance.

Detailed findings from this inspection

Is the service safe?

Infection prevention and Control

Information sharing

Staff were kept up to date with changes to policies and procedures related to Covid-19. Safety huddles, used to escalate safety concerns, did not take place at the start of every shift and the documentation of these were poor.

Trust guidance on safety huddles, stated 'the nurse in charge of each ward should initiate a safety huddle meeting at the beginning of every shift to pass on relevant safety information about patients and the environment'. In response to the pandemic, the safety huddle checklist included Covid-19 as a point for discussion. Staff told us they had a nursing safety huddle at 8am and a medical safety huddle took place at 8.30am. We were unable to observe any safety huddles during our inspection. However, we reviewed the completed nursing safety huddle checklists for two wards between 27 July and 8 August 2020. On the negative Covid-19 ward, the Covid-19 section of the checklist was completed on two out of 13 days. There was no record of the discussion for five out of the 13 days. On the suspected Covid-19 ward, the Covid-19 section of the checklist was completed on eight out of 13 days. There was no record of the discussion for three out of the 13 days. The documentation showed safety huddles were not undertaken at the beginning of every shift. Staff on the outbreak ward told us the infection prevention and control nurse visited them daily but did not attend the safety huddle meetings.

Medical care (including older people's care)

The trust told us there was a dedicated portal on their intranet which was created to cascade communication about the trust's response to Covid-19. The intranet was accessible on any electronic device. Any updates made on the portal was highlighted in the daily email sent to all staff. Nursing staff told us they were also kept up to date on Covid-19 information through a group messaging application.

Personal protective equipment (PPE)

Staff did not always follow trust and national guidance in relation to personal protective equipment. It was unclear if all staff had received training in personal protective equipment.

In line with national guidance, the trust provided changing and shower facilities where staff could change into uniforms on arrival to work. All staff wore theatre scrubs and told us the hospital laundered these. This reduced the risk to staff by not taking potentially contaminated uniform home to be washed.

The trust's 'Personal Protective Equipment Policy for SARS-CoV-2 virus' (dated 22 July 2020) states it will 'provide all staff with instruction/training in correct 'donning' and 'doffing' techniques. Donning is the term used for putting on PPE and doffing is the term used for taking off PPE. During our inspection, some staff told us they had not received PPE training. Data from the trust showed donning and doffing training sessions were held in March and April 2020. These were attended by 1157 members of staff at the William Harvey hospital including nursing/midwifery staff (262), medical staff (64), therapy staff (155) and domestic staff (54). The trust did not state how many staff are yet to receive PPE training. The trust told us the infection prevention and control team also undertook additional training with staff during ward walkarounds. However, these numbers were not formally recorded. This meant the trust were not able to assure themselves that all staff had received training in using PPE safely or effectively.

National guidance recommended 'patients with possible or confirmed Covid-19 wear a surgical face mask if this can be tolerated to reduce direct transmission risk and environmental contamination'. The trust's 'Personal Protective Equipment Policy for SARS-CoV-2 virus' (dated 22 July 2020) reflected the national guidance. However, we did not observe patients with confirmed Covid-19 wearing face masks in clinical areas or during transportation. Staff on the outbreak ward told us that patients wore face masks when nursing staff carried out personal care. However, staff told us there were no Covid-19 specific risk assessments for patients. This meant patients were not risk assessed to determine if they could or could not tolerate wearing a face mask.

National guidance recommended eye protection is worn when there is risk from splashing or secretion (including respiratory secretions). The trust's 'Personal Protective Equipment Policy for SARS-CoV-2 virus' (dated 22 July 2020) reflects the national guidance. However, staff on the Covid-19 ward told us they did not have access to eye protection such as visors or goggles. Following our inspection, the trust told us they had updated their advice to staff to wear eye protection when providing care for patients with Covid-19. The trust reported they had a significant supply of suitable eye protection in the trust at the time of our inspection.

Staff did not always wear PPE correctly. We saw a senior nurse ask nursing staff to wear their face mask correctly over their mouth and nose on six occasions on the Covid-19 ward. We saw a senior nurse ask a member of the nursing team to wear their face mask correctly over their mouth and nose on the outbreak ward. Wearing a face mask incorrectly is not in line with national guidance which states, 'A fluid resistant (Type IIR) surgical facemask (FRSM) should be worn whenever a health and social care worker enters or is present inpatient area (for example, ward) containing possible or confirmed COVID-19 cases, whether or not involved in direct patient care'.

Staff did not always remove their PPE upon entering a new clinical area. On the Covid-19 ward we saw a doctor enter the ward wearing gloves. This was not in line with the trust's 'Personal Protective Equipment Policy for SARS-CoV-2 virus' (dated 22 July 2020) which stated, 'Aprons and gloves are subject to single use as per Standard Infection Control Precautions (SICPs)'.

Medical care (including older people's care)

Staff did not always put on or take off their PPE when entering and exiting patient bays. On the non-Covid 19 ward, we saw two members of staff walk in and walk out of patient bays either not wearing PPE or not changing their PPE. On the suspected Covid-19 ward, we saw a phlebotomist leave the patients bay wearing their apron and we saw a member of the nursing team exit the red bay wearing full PPE to speak to another nurse at the nursing station. This was not in line with the trust's 'Personal Protective Equipment Policy for SARS-CoV-2 virus' (dated 22 July 2020) which states, 'Standard infection control precautions for Healthcare Associated Infections must still be adhered to in all areas'.

Staff did not always wear the correct PPE for the patient care they were delivering. We saw a porter not wearing an apron while helping a patient with Covid-19 to get into their bed. This was not in line with national guidance which stated, 'Aprons, FRSMs and gloves should be used by health and social care workers transferring possible or confirmed COVID-19 cases and for other duties that require direct contact or that within 1 metre of a case'.

There was enhanced PPE on the resuscitation trolleys for staff use should they choose to wear it prior to carrying out chest compressions. The trust's 'Personal Protective Equipment (PPE) Policy for SARS-CoV-2 virus' (dated 20 July 2020) reflected Public Health England's guidance which states, 'Healthcare organisations may choose to advise their clinical staff to wear FFP3 respirators, gowns, eye protection and gloves when performing chest compressions but we strongly advise that there is no potential delay in delivering this life saving intervention'. Aerosol generating procedures are more likely to generate higher concentrations of infectious airborne particles than coughing, sneezing, talking, or breathing.

Equipment

Staff cleaned equipment before and after each patient use and the wards were clutter free. However, staff did not always record when they carried out equipment cleaning or decluttering.

Staff on the Covid-19 ward and the outbreak ward used 'I am clean' labels after cleaning equipment. This meant other staff knew the equipment was clean and ready for use.

We saw staff cleaning equipment before and after each patient use. Staff on the suspected Covid-19 ward explained after their morning safety huddle, they spent 15 minutes cleaning the equipment in each bay. This helped to reduce the spread of infection.

However, staff did not always complete the equipment daily cleaning checklist. The checklist was displayed outside each patient bay and nursing staff signed against each piece of listed equipment to say they have cleaned it. The list of equipment included drip stands, notes trolley bedside tables and patient lockers. We reviewed the completed equipment daily cleaning checklists for two wards between 27 July and 9 August 2020. On the suspected Covid-19 ward the checklist was fully completed on 10 out of 14 days (red bay), eight out of 14 days (blue bay) and eight out of 14 days (yellow bay). On the non Covid-19 ward it was fully completed on 11 out of 14 days. However, none of the checklists on the Covid-19 ward and only 12 out of 21 weeks on the suspected Covid-19 ward had the bay in which they related to written on them. This meant the trust could not be assured equipment was cleaned daily to prevent the spread of infection.

Most furniture and equipment were in reasonable condition and were visibly clean. On the non Covid-19 ward, we saw two office chairs which were broken and taped being used by staff at the computers. Senior nursing staff told us they had removed the chairs previously. Broken equipment is difficult to clean and therefore increases the risk of the spread of infection.

Staff cleaned commodes to prevent the spread of infection. The commode audit results for May 2020 showed the compliance rates were 99% for the suspected Covid-19 ward, 98% for the Covid-19 ward, 100% for the negative Covid-19 ward and there were no results for the outbreak ward. Staff told us the commode audits were unannounced and carried out by a colleague from another ward.

National guidance recommended, 'The care environment should be kept clean and clutter free.' All wards we visited appeared clutter free. However, the daily declutter checklist was only in use on the non Covid-19 ward and this was

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only completed on 10 out of the 15 days we reviewed. Decluttering also featured in the daily safety huddle checklist but this documentation was not always completed. This meant the trust could not be assured staff were decluttering the wards daily to reduce the spread of infection. Following the inspection, the trust told us it had implemented a trust wide programme of decluttering after there was a rise in hospital acquired infections and outbreaks.

Cleaning

Staff did not always record when they had carried out cleaning in patient areas and curtains did not always have a date on them to show when they were changed.

All furnishings in patient areas were made of wipeable material. This meant they could be thoroughly cleaned to reduce the risk of the spread of infection. However, on the outbreak ward, some furnishings in the staff room were not made of wipeable material. This meant they could not be thoroughly cleaned and posed an infection control risk. Following the inspection, the trust told us they would remove all soft furnishings from rest areas if they are not wipeable.

Staff told us if a patient had a positive Covid-19 test result whilst being nursed in a bay, the bay was closed to new admissions and deep cleaned. Staff discarded all disposable equipment and non-disposable equipment was cleaned. On the suspected Covid-19 ward, we saw four out of nine curtains did not have dates on to show when they were changed. On the non Covid-19 ward, we saw six out of 18 curtains did not have dates on them. This meant the trust was not able to assure themselves that curtains were being changed between patients.

Nursing staff did not always undertake two hourly cleaning to reduce the spread of infection. We reviewed the two hourly cleaning checklists between 27 July and 8 August 2020 for two wards. On the non-Covid-19 ward it was completed for 13 out of 15 days. On the suspected Covid-19 ward, the two hourly cleaning checklists was completed for three out of 14 days. On the non-Covid-19 ward it was completed for one out of 14 days. This meant the trust were not able to assure themselves that two hourly cleaning was always completed.

The domestic staff undertook twice daily cleaning of the ward to reduce the spread of infection. Nursing staff told us once the cleaning was completed the domestic staff spoke with the nurse in charge who signed the amber cleaning checklist to demonstrate it had been performed. We reviewed the amber cleaning checklists for two wards. On the non-Covid-19 ward it was completed for 13 out of 15 days. On the suspected Covid-19 ward, the amber cleaning checklist was complete for 10 out of 18 days. This meant the trust were not able to assure themselves that amber cleaning was always completed.

Each ward had an electronic whiteboard which displayed patient bed numbers within each patient bay. When staff requested cleaning of a patient bed space, the patient space was highlighted on the whiteboard. We saw this system working on the suspected Covid-19 ward. This aided conversations between domestic and ward staff as there was a visual reminder to show staff had requested cleaning and where the cleaning needed to take place.

Clinical waste

Staff handled and disposed of clinical waste, linen and sharps safely.

Staff disposed of clinical waste in line with national and trust guidance. We checked clinical and domestic waste bins and saw staff segregated waste into the correct colour coded bins.

Staff disposed of linen in line with national and trust guidance. Infected linen was placed in an alginate bag and then into a red bag. However, staff told us alginate bags were in low supply so were using red fabric sacks in the interim. Staff told us this issue was raised to the infection prevention and control lead and to the matron during a safety huddle. Alginate bags dissolve in water which removes the need to personally handle potential contaminated linen.

Staff safely handled and disposed of sharps correctly in line with national and trust guidance. All sharps bins we saw were signed, dated and not overfilled.

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Environment

Staff were not always supported by the environment to protect their patient and themselves from infections. Environmental risks specific to individual wards were not mitigated. Staff did not always observe social distancing when it was possible to do so.

National guidance recommended 'the use of privacy curtains between beds of patients with possible or confirmed Covid-19 to minimise opportunities for close contact'. During our inspection, we did not observe curtains drawn between beds. Staff told us there were no Covid-19 specific risk assessments for patients. This meant patients were not risk assessed to determine if their safety would be or would not be compromised if privacy curtains were used.

National guidance recommended designated areas for the treatment and care of patients with Covid-19 should have signage displayed warning of the segregated area to control entry. We did not see signage on the entrance to the designated Covid-19 ward. This meant staff/visitors unfamiliar to the ward may not be aware of the additional infection prevention and control measures they needed to take when in this area. We did see signage at the entrance to the suspected Covid-19 ward to make staff/visitors aware the ward was within the Covid-19 secure area.

National guidance recommended 'staff adhering to social distancing (2 meters) wherever possible'. Staff did not know whether social distancing should be maintained within patient bays. On the Covid-19 ward, we saw five staff members in the staff room at once which meant social distancing could not be practiced. On the non Covid-19 ward, we saw staff sitting in close proximity while using the computer workstation located in the ward corridor.

We did not see any signs on non-clinical areas such as ward offices, storage rooms or staff rooms to indicate the maximum capacity of that room. This meant staff did not know how many people could be in a room at any one time to safely maintain social distancing. Following the inspection, the trust told us the health and safety, and PPE officers would revisit clinical areas to check signs on offices and rest rooms.

National guidance recommended 'staggering staff breaks to limit the density of healthcare workers in specific areas'. The suspected Covid-19 ward did stagger staff breaks. We saw the nurse in charge agreed timings with each staff member at the start of the shift and wrote this on the whiteboard at the nursing station. However, staff breaks were not always staggered on the Covid-19 ward and we saw five staff members in the staff room at once.

Patient beds were not always placed two metres apart to enable social distancing. On the suspected Covid-19 ward, we saw a bed rotated at 90 degrees to the neighbouring bed which made the distance less than one metre apart. The trust, as part of their infection prevention and control improvement plan (dated 6 August 2020), had an action to review inpatient bed numbers to enable safe spacing of beds. This review was due for completion by September 2020. It was unclear why this review was not prioritised and undertaken sooner.

None of the wards we visited had doors on the patient bays. Doors help to prevent the spread of infection by providing a physical barrier between the patient area and the rest of the ward. One staff member told us this issue was raised with the estates department in February 2020 and has been raised again since. We reviewed the trust's infection prevention and control improvement plan (dated 6 August 2020) which showed this was part of the phased environment upgrades and works were due to commence on 10 August 2020.

There was no system to reduce the footfall of people through the Covid-19 (blue) wards. We saw the corridor on the suspected Covid-19 ward was congested throughout our inspection, with staff using the ward as a shortcut to reach other areas. We raised this issue to an executive leader who stated the foyer between the suspected ward and another ward should not be used by staff. We asked the trust to provide us with evidence to demonstrate how environmental risks on individual wards are identified and mitigated, such as local risk registers. However, the trust did not provide us with this information. The trust told us it uses environmental audits, peer review audits, weekly matron's audit and regular ward observational audits to identify risks for action. As these reviews were standardised, they did not identify local risks that were specific to each ward and the subsequent mitigations.

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The infection control team and the 2gether Support Solutions team carried out separate environmental ward audits. Both audits generated actions plans which were shared with the ward manager and domestic manager. The frequency and compliance target were determined by the ward's risk category. All four wards we visited were categorised as high risk and therefore required monthly auditing. We noted the 2gether Support Solution audits were carried out weekly and compliance for all the wards we visited consistently scored above the 95% trust target.

In contrast, there was poor compliance to monthly environmental audits carried out by the infection control team. The trust's monthly infection prevention and control report showed compliance rates in June 2020 were 59% for the non Covid-19 ward. There was no data for the suspected Covid-19 ward within the report. However, information submitted to CQC showed the audit was carried out on 21 June 2020, but the compliance rate was not calculated. There was no data for the outbreak ward for June 2020. However, the audits submitted to CQC showed in July 2020 the compliance rate was 68% and 71% in August 2020. The trust told us the infection prevention and control team had not undertaken environmental audits on the Covid-19 ward because the ward was commissioned during the pandemic. However, we saw environmental audits results for this ward in the infection prevention and control monthly report for June 2020 which showed compliance was 53%. The audit results for all wards we visited were below the trust target of 95%. The trust told us the audits had highlighted issues with the estates and internal fabric of the wards; a refurbishment programme commenced on 17 August 2020.

Infection control risk assessment

The trust had completed individual risk assessments and Covid-19 testing for all staff. The hospital had a patient tracking system to aid contact tracing.

Staff followed the trust's 'Standard operating procedure for transfer of patients through Covid-19 wards (blue stream)', dated 11 August 2020, which stated all patients with confirmed Covid-19 on admission should be admitted directly to the Covid-19 ward. Any patient whose subsequent Covid-19 test results were positive during their admission should also be transferred to this ward. It was unclear through our conversations with staff, what policy or procedure was in place prior to our inspection. The trust noted a standard operating procedure for patient transfers was still to be developed within its infection prevention and control improvement plan dated 13 August 2020.

The hospital used their live patient tracking system to identify each patient's Covid-19 status; confirmed, suspected and negative. This system enabled the trust to identify patients who had been in contact with a confirmed Covid-19 patient. All patients known to have been exposed to a confirmed Covid-19 patient were observed in their bay, which was closed to new admissions, for 14 days (or until discharge). This reduced the spread of infection by minimising the movement of potentially infectious patients.

Staff completed a mandatory outbreak template when they identified a Covid-19 outbreak. This template was submitted to the integrated care system for onward transmission to NHS England/NHS Improvement. An integrated care system relates to NHS organisations, who in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. Public Health England's definition of an outbreak is defined by two or more people having the same disease, symptoms or excretion of the same pathogens in which there is also an association of time, place and/or contact between them. At the time of our inspection, there was one outbreak and we saw the completed outbreak template for this. The template showed initial actions taken to prevent the spread of infection which included closing the ward to new admissions and identification of staff and patient contacts.

The hospital used an electronic system to record patient observations such as blood pressure and pulse. Once nursing staff entered the readings onto hand held devices, the system automatically generated the patient's National Early Warning Score (NEWS). This tool was used to identify clinical deterioration in adult patients. If the score was outside acceptable limits, a prompt for the nursing staff to act was displayed on the hand-held device. The prompt would only disappear once the nursing staff had confirmed action was taken.

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Staff told us each patient's early warning score was displayed on the ward's electronic whiteboard and notifications were sent to the hand-held devices when the patient's next set of observations were due based on their previous score and subsequent frequency of observations.

Staff on the outbreak ward told us on arrival to work their temperature was checked, they changed into their theatre scrubs and wrote their contact details in the Covid-19 ward folder. We saw contact detail sheets were used in three of the four medical wards we visited. The inspection team were asked for their contact details on one of the four wards we visited. This system aimed to enable contact tracing which helped to prevent the further spread of infections by identifying who may have been in contact with a patient with Covid-19.

Staff told us they had completed an individual risk assessment to assess their risk of contracting Covid-19. Staff completed these electronically and have recently re-completed these as the risk assessment was updated to include body mass index and age in line with updated national guidance. As of 11 August 2020, the trust reported 96% of all trust staff risk assessments were complete.

All trust staff were tested for Covid-19 over a five-day period commencing 17 July 2020. Staff knew what to do if they experienced Covid-19 symptoms and staff who had recovered from Covid-19 told us they had followed trust policy by informing their line manager and self-isolated at home.

Hand hygiene

There was not always adequate provision of suitable hand washing facilities and alcohol hand rubs where appropriate. Staff did not always undertake hand hygiene and compliance to hand hygiene training was poor.

The portable hand sink at the entrance to the Covid-19 ward did not have any hand towels. This meant staff were unable to dry their hands.

Only sinks used by staff had accompanying posters displaying the correct steps for hand hygiene. We saw on the suspected Covid-19 ward posters were not displayed in patient toilets. This meant patients did not have an aide memoir to show them how to wash their hands.

Staff did not always follow the trust's, 'Working Safely During COVID-19 Guidance for Managers and Staff' which encourages *'everyone to wash their hands regularly for 20 seconds and more frequently than normal'*. Staff did not wash their hands on two of the four wards we visited. Although staff did use alcohol hand rub to decontaminate their hands before and after delivering direct patient care, over use of alcohol hand rub is not considered best practice. As stated in the trusts' 'Hand Decontamination Operating Standard' (dated 30 July 2020), *'alcohol hand rub cannot be used if hands are visibly soiled or potentially contaminated with blood or other body fluids. It is ineffective when caring for patients with Clostridium difficile, GDH antigen positive, VRE, CPO and other diarrhoeal/vomiting illness such as Norovirus'*.

Staff did not always use alcohol hand rub to clean their hands upon entering and leaving wards. We saw at least seven members of staff from an adjacent ward entering and leaving the suspected Covid-19 ward, sometimes to enter the fluid store room or main store room, without performing hand hygiene to reduce to the spread of infection. We saw there was no provision of hand rub between the two wards for staff to use. We escalated this to the ward manager who took immediate action and put a stop sign and a trolley with masks and alcohol hand rub at the door.

Staff told us hand hygiene audits were carried out by a colleague from another ward. The hand hygiene audit results for May 2020 showed the compliance rates were 93% for the suspected Covid-19 ward, 96% for the Covid-19 ward, 85% for the negative Covid-19 ward and there were no results for the outbreak ward.

All staff were bare below the elbows. This reduces the risk of spreading infection by facilitating good hand hygiene. Hand hygiene is most effective when hands and forearms are free of jewellery and sleeves are above the elbow.

All staff completed infection control level one e-learning training. Data from the trust showed, the general and specialist medicine care group had an average compliance rate of 95% in May 2020. This was above the trust's target.

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There was poor compliance to hand hygiene training. Staff told us ward infection prevention and control link nurses trained their colleagues in hand hygiene and records were kept locally. Data from the trust showed, the general and specialist medicine care group had an average compliance rate of 36% in May 2020. This was significantly below the trust's target.

Not all patients had access to alcohol hand rub at the point of care. There were no alcohol hand rubs on any of the patient beds on the suspected Covid-19 ward and not all patient beds on the other wards we visited had alcohol hand rub available. We saw this was escalated within the monthly infection prevention and control report for June 2020 following feedback from the ward environmental audits, however the report stated the issue was addressed since the matter was escalated to senior infection prevention and control staff.

Patient information

There was no standardised approach to providing patients with information on Covid-19 upon discharge. Staff were unclear on the trust's Covid-19 testing methodology. The trust's visiting policy was in line with national guidance.

Staff on the Covid-19 ward told us they did not have access to printed information about Covid-19 to give to patients on discharge. One member of staff checked the trust intranet for patient information but could not find any. Staff told us upon discharge they spoke to patients to advise them on any precautions they should take at home. However, on the non Covid-19 ward, staff had access to patient advice sheets that could be found on the discharge coordinator's desk. In the monthly infection prevention and control report for June 2020, it stated the infection prevention and control support officer sends Covid-19 result letters and patient information leaflets to the discharged patients. This meant there might be a time delay in notifying patients and providing the subsequent self-isolating advice.

The trust implemented a live patient tracking system which identified patients with Covid-19 and which streams and wards the patient had been in on each day of their admission. This system enabled contact tracing which helped to prevent the further spread of infections by identifying a confirmed case and who they had been in contact with.

All wards we visited had an electronic whiteboard which pulled information from the trust's patient administration system. Staff explained the whiteboard showed each patient's bed number and a range of symbols which indicated interventions or additional needs. In response to the pandemic, new symbols were developed to indicate the patient's Covid-19 status. All but one patient, had a symbol to indicate their Covid-19 status on the wards we visited. Staff told us this one patient, had recently been admitted to the ward and the system was yet to update itself. Following our inspection, the trust told us they had updated the system on 13 August 2020 to highlight when patients' Covid-19 swab is due.

In response to the pandemic, an additional column had been added to the nursing handover sheet to include Covid-19 test results. Staff told us this information was pulled automatically from the trust's patient administration system. However, in the handover sheets we reviewed there was different formats to indicate negative tests results such as '-ve' or 'NEG' and staff were not clear whether the dates were the swab date or the result date. Staff were unclear on the trust's Covid-19 testing methodology with some staff stating patients are tested every three days, although staff knew the procedure for testing patients due to be discharged into nursing or residential homes.

Staff told us they did not allow visitors of patients to the ward unless there was a prior agreement, for example because the patient was at the end of their life. The trust had updated their visiting policy and this was in line with national guidance.

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Areas for improvement

We took enforcement action to issue a section 29A Warning Notice because the quality of healthcare required significant improvement relating to infection prevention and control. In summary the reasons we issued this notice were:

- The trust could not provide assurance as to who was the executive lead for Infection Prevention and Control.
- The board could not provide evidence that the board had been sighted on the risks associated with infection prevention and control.
- The board could not demonstrate they had oversight of the management of infection prevention and control during the global pandemic.
- We will add full information about our regulatory response to the concerns we have described to a final version of this report, which we will publish in due course.

Action the provider MUST take to meet the regulations:

The trust must ensure all rooms have signs to inform staff how many people can be in that room before becoming overcrowded. Regulation 12.

The trust must ensure staff always adhere to social distancing when possible. Regulation 12.

The trust must ensure staff follow trust policy on personal protective equipment. Regulation 12.

The trust must ensure staff and patients have access to alcohol hand rub and handwashing facilities. Regulation 12.

The trust must ensure all sinks have signs to prompt staff and inform patients of the steps to follow for effective handwashing. Regulation 12.

The trust must ensure patients, upon discharge, are offered information about Covid-19 and infection control precautions. Regulation 12.

The trust must ensure staff record infection prevention and control measures taken to prevent the spread of infection. Regulation 12.

The trust must ensure staff understand the trust's Covid-19 testing methodology. Regulation 12.

The trust must improve its compliance to hand hygiene training. Regulation 12.

The trust must ensure all staff receive training on personal protective equipment. Regulation 12.

The trust must ensure safety huddles take place at the start of every shift and the discussions are recorded. Regulation 12.

The trust must risk assess individual wards and mitigate any risks associated with infection prevention and control. Regulation 12.

The trust must improve compliance to the environmental audits carried out by the infection prevention and control team. Regulation 12.

Our inspection team

The team that inspected the service comprised a CQC Inspection manager, three CQC inspectors, and two specialist advisers. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Section 29A HSCA Warning notice: quality of health care

Regulated activity

Treatment of disease, disorder or injury

Regulation

Section 31 HSCA Urgent procedure for suspension, variation etc.