

# Royal Devon and Exeter NHS Foundation Trust

## Quality Report

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

## Ratings

### Overall rating for this trust

# Summary of findings

## Overall Summary

We carried out an announced focused inspection of the acute services provided by the Royal Devon & Exeter Hospital to look at Infection Prevention and Control. As part of our continual checks on the safety and quality of healthcare services, data showed the trust had experienced more than one outbreak of hospital transmitted Covid-19 infection. An outbreak is where there are two or more test confirmed or clinically suspected cases in a specific setting.

The trust provides acute and community services to people in Exeter, East Devon and Mid-Devon. In total the trust has around 845 beds and employs around 11,000 staff. The population served is approximately 460,000; however, during the summer holiday periods this can increase significantly. The Royal Devon and Exeter Hospital also provides community services in Exeter, East Devon and Mid Devon. Community services were transferred to the Royal Devon and Exeter NHS Foundation Trust (RD&E) in October 2016.

Community services include community hospitals, nursing, therapies and some specialist services, there are 13 community hospitals. The trust also acquired Castle Place GP Surgery on 1 January 2018. Most of the RD&E's services, including specialist units such as the West of England Eye Unit and the Princess Elizabeth Orthopaedic Centre, are based at the main hospital site at Wonford. The purpose-built Centre for Women's Health, encompassing maternity, neonatology and gynaecology services, is also based at Wonford. Heavitree Hospital is a separate location and continues to provide a range of outpatient services, as well as accommodation for the Peninsula College of Medicine and Dentistry. Across the Trust locations, the RD&E has more than 30 wards and 20 operating theatres.

Prior to a site visit, we carried out four interviews with key leaders and clinicians, to assess the trust's response to the hospital transmitted outbreaks of Covid-19 infections.

We visited the trust on Tuesday 19 January 2021, to observe infection prevention and control (IPC) measures and to speak with staff about IPC practices. We visited the emergency department, the acute medical unit and Culm East, Durbin, Cardiology, Yeo, Lowman, Torridge, Kenn,

Bovey and Okement wards. We also visited the pharmacy, the security office and the porter's office. We also visited public areas and staff rooms to observe social distancing practices.

We spoke with ten nurses, six doctors, three allied health professionals, two pharmacists, three ward clerks, ten housekeeping staff, three porters and one security staff member. We held a group meeting with four members of the infection prevention and control team and spoke to some members of that team on site. We observed practice and reviewed three sets of electronic patient notes to assess compliance with national guidance.

### Services we did not inspect

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

### Inspected but not rated

We did not rate this inspection and the trust ratings therefore remained unchanged.

**Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.**

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

**Staff felt respected, supported and valued. The service had an open culture where staff could raise concerns without fear. They were focused on the needs of patients receiving care.** It was evident from speaking with staff that the challenges caused by the pandemic were both physically and mentally challenging, but they remained passionate about providing quality care to their patients.

**Leaders operated effective governance processes. Staff at all levels were clear about their roles and**

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**accountabilities. Governance structures and the communication within them were effective to ensure that changes and learning supported patient safety across the trust.** There were effective processes to support standards of infection prevention and control including managing cleanliness and a suitable environment.

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.** Auditing of all infections had identified learning taken forward across the trust.

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure.** The computer system used by the acute and community services in the trust provided the infection prevention and control nurses with a trust wide dashboard of relevant and up to date information.

**Leaders and staff collaborated with partner organisations to help improve services for patients.** Staff described useful links and multidisciplinary working with external agencies.

**All staff were committed to continually learning and improving services.**

There were systems and processes for learning, continuous improvement, and innovation. The trust recognised that better communication was needed to ensure that all information, support, and guidance was consistently received and understood.

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](http://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection).

## Well-led

### Leadership

**Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.**

Leaders understood the challenges to quality and sustainability and could identify actions needed to address them. The executive and leadership teams

considered the whole trust and all its staff members to be one whole team working together to address infection control challenges. The infection prevention and control (IPC) team took the lead role in IPC management and was represented at board level by the Medical Director. The directors of Infection Prevention and Control and infection control leads had enough training, expertise and time allocated to meet the demands of the role.

The trust leadership told us that Covid-19 remained their most significant challenge. They told us that the systems implemented meant trust management had a good line of sight across the trust and highlighted areas which needed ongoing focus. Further to an increase in numbers of patients with Covid-19, they were now cautiously optimistic going forwards that the systems implemented addressed their most important infection control issues.

The trust had a system it could employ to get the right people to the right conversations when the need arose. The trust had opted for a gold, silver and bronze working approach. Gold command was the executive team with silver including external organisations and infection prevention and control (IPC) teams. Bronze consisted of the local teams run by wards and departments themselves and with occupational health support. Bronze calls included the IPC team and a variety of teams on the ground, for example pharmacy and housekeeping, as they were an instrumental part of the outbreak management. The trust leadership considered this approach provided more impetus when addressing local issues. The gold approach enabled executive members to be able to review highlights and add traction to getting issues addressed. All bronze and silver commands fed information to the gold command to ensure clear lines of communication and oversight.

Staff across the trust told us they felt supported by the board and appreciated the personal approach of executives who had been to the wards and departments to review changes and support staff.

### Vision and strategy

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

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The trust had a clear vision and strategy for continuously improving practices related to infection prevention and control. A clear annual infection prevention and control programme had been completed and presented to the trust board in June 2020. The trust identified among its priorities for infection prevention to include reduced movement of patients and staff, improved ventilation, improve communications, testing of staff and patients, cleaning, vaccinations and addressing staff fatigue and wellbeing. Each priority was ongoing, and the measures being taken to address the issues and ongoing monitoring of outcomes was updated on the action plan.

The trust strategy for improving infection prevention and control practice, was aligned with strategies in other departments and the wider healthcare system. The trust told us that community hospitals had become more engaged and more supportive because of better communication. Staff told us they felt they were working as part of a wider team. For example, staff told us the laboratory had been very responsive to testing frequency and prompt results for rapid and routine testing and that microbiology support had been excellent.

The recent implementation of a new electronic patient record had a positive effect on communication. For example, the update meant that easier access for staff to the Covid-19 status of each patient and so an improvement in both patient safety and the safety of their movement through the hospital. The new system also enabled the easier gathering of outbreak data to allow earlier responses.

The trust's Covid-19 vaccination program had been a driving force of a multi-disciplinary team including pharmacy services. At the time of inspection over seven thousand of the eight thousand hospital site staff had been vaccinated. Patients were being vaccinated in line with the government directed vaccine program.

Staff told us that infection control issues, other than Covid-19 remained ongoing. They explained influenza vaccinations had been a challenge and maintaining the campaign had been difficult due to the Covid-19 infection and vaccination focus. The trust told us that it had delivered more influenza vaccines to staff than ever before.

Progress on achieving infection prevention and control improvement actions were monitored and reviewed.

Planned weekly meetings were held for the infection control team and included pharmacists and microbiologists and any specialist input needed. These meetings also included other areas of infection for example MRSA and *Clostridium difficile*. The meetings reviewed the practicalities of managing outbreaks as well as any actions needed or learning outcomes needing disseminating to the wider trust. Information was disseminated from each of the teams attending using hospital bulletins, emails and visiting wards and departments. One of those meetings each month was used for policy review to ensure the trust was updated with current national guidance. Any urgent changes in guidance were reviewed and updated as part of the gold strategic command or gold outbreak meetings.

The movement of staff around the hospital presented a challenge to the trust. Keeping staff movement to a minimum was considered essential in the prevention of cross infection. Teams were whenever possible staying in one clinical area and the monitoring of staff movement was ongoing. We were told by infection control lead staff that staff anxiety was reduced when movement was less.

The trust had a staffing hub to monitor staffing levels and staff movement around the hospital. This included a contingent work force of bank staff and agency staff. The staffing hub monitored daily challenges and deployment and planning for shifts for nursing and medical staff.

At the time of inspection, staff moving ward to ward was being managed and avoided as far as possible to reduce risk of cross infection. Staff lateral flow testing was undertaken twice weekly and recorded on the electronic system. The lateral flow tests were increased to daily when staff had Covid-19 contact, and a polymerase chain reaction test (PCR) test when there had been an outbreak. This did not happen for all outbreaks, only when advised by bronze outbreak group. This was reported back to occupational health and microbiology. If an outbreak occurred, a decision would be made to do additional Covid-19 swab tests for all staff.

Staff were aware of and understood their role in achieving the vision and infection prevention and control priorities. We saw that wards, cubicles and single rooms had signage on the door informing staff of the infection risk and what personal protective equipment they needed to wear before entering. We saw staff putting on personal protective equipment in line with the guidance

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and trust policy before entering. Hand gels were available in each bay. On wards where this was not safe due to the risks of ingestion, risk assessments had been completed and patients were encouraged to wash their hands. Additionally, they were supplied with hand gel by staff when required.

We saw some further signage to inform patients and staff to wipe surfaces after use. We saw staff wiping some surfaces but no patients being advised or supported to complete this task. The IPC team advised that support for all to do this was ongoing and more work to encourage patients to wipe surface after use was underway.

We saw posters and information throughout wards and departments providing information and instruction to support infection prevention. Wards and departments closed to visitors or unnecessary staff had been identified by clear signage and hazard tape.

We observed all ward and department areas being cleaned continuously, and ongoing hygiene was being monitored by housekeepers and the infection prevention and control team. Areas had assigned housekeeping staff who understood their role and followed a cleaning schedule which included high and low areas. Equipment on the wards and departments were cleaned by nursing staff or in the case of the emergency department by support workers. Time was allocated to ensure this cleaning took place and staff confirmed that even when they were busy, allocation to this task was maintained. Following the transfer of any patients with Covid-19 or other infections a specialist cleaning team were used to undertake a thorough and extensive clean of the room or area. Staff told us that the specialist cleaning team were prompt when requested so as not to delay the use of the rooms.

The trust had a strategy for safe antimicrobial prescribing. The strategy included changes in how antimicrobial audits were completed, the strategy had been agreed at board level. Since the outbreak of Covid-19, the trust had stopped the antimicrobial audit. The antimicrobial audit addressed the prescribing of broad-spectrum antibiotics. The pharmacy staff recognised the need to adjust their information gathering format, in order to reduce the risk of further risk of cross infection.

The antimicrobial stewardship team advised that they undertook a daily review remotely, of all patients on

broad spectrum antibiotics. The antimicrobial stewardship team considered that they had a good overview of prescribing which gave them sufficient assurance of current safe practice. Some focused audits had been completed for example treatment of urinary tract infection, to ensure that specific prescribing was continuously monitored.

Pharmacy staff had concerns about the risk of them moving from ward to ward as part of their routine work. This was an infection control risk on wards as they needed to have contact with relevant equipment. Pharmacy staff had access to appropriate personal protective equipment when on wards and in departments. The Covid-19 clinical trial team was involved in reviewing Covid-19 pharmacy activity to ensure pharmacy was up to date with day-to-day changes. The pharmacy team were attending governance groups, but at the time of inspection no prescribing data was being presented to trust board.

## Culture

**Staff felt respected, supported, and valued. The trust had an open culture where staff could raise concerns without fear. They were focused on the needs of patients receiving care.**

The trust had a culture that promoted the delivery of high-quality and sustainable care. It was evident from speaking with staff that the challenges created by the pandemic had a physical and mental effect on their wellbeing, but they remained passionate about providing quality care to patients. We saw staff provide care in a compassionate way regardless of the difficulties created by Covid-19, and patients were comforted and reassured by kind and caring staff.

Staff described a service where infection control was managed as a trust wide team. Ward and department staff were supported by the infection prevention and control team to keep updated with changes in practice. These teams including medical, nursing, pharmacy, allied health professionals, housekeeping, and support services. The staff we spoke to in these groups told us they felt supported to provide safe care and treatment using current infection control guidance.

The trust had internal processes to raise safety concerns relating to infection prevention and control (IPC). An outbreak meeting was called for all outbreaks and was



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attended by one or both of the directors of Infection Prevention and Control (DIPC), the IPC team, clinicians, and microbiologist. The meeting followed a standard agenda and addressed different areas for example, cleaning and ventilation. Occupational health joined all meetings to look at staff sickness and discuss testing for staff.

The trust informed the wider hospital of any outbreak and the infection prevention and control team (IPC) would visit and support with all actions needed. For example, giving advice on patient and staff screening for Covid-19, or ways to limit access to affected wards and departments. A checklist was provided to follow if closing a bay/ward to make sure consistency of practice was maintained.

Staff told us they were able to raise concerns about any infection risks both with their colleagues and with the infection control team. Incidents related to infection control were recorded and included investigations and lessons learned.

Staff received training in safe infection prevention and control procedures in line with national guidance. Staff were aware of the trusts policies and procedures for infection prevention and control and knew where to access updates and any reference material they may need. Staff told us they had received training and support from the infection prevention team and saw them on wards and departments daily. Training compliance trust wide with infection prevention and control training was 71% in December 2020 and showed a decrease from 81% in January 2020. Staff told us, due to capacity issues created by the pandemic training had not always been accessible. Observational monitoring of PPE on Covid-19 wards had been ongoing with auditing of PPE usage and infection control teaching at the time. The team identified that small group teaching sessions had been beneficial, and improvements had been seen in PPE use.

The IPC team monitored staff techniques for the putting on and removal of personal protective equipment. This enabled them to check staff were following guidance correctly. The IPC team observed practice, talked to staff, and informed ward leaders of any development work needed.

The trust had specific arrangements to promote the physical and mental wellbeing of staff during the

Covid-19 pandemic. The executive team had raised fatigue and staff wellbeing as a priority. During the pandemic elevated levels of staff sickness have been experienced by the trust. The strain of this was raised during our inspection by staff and leaders and was recognised by all as a strain on staff wellbeing. We were provided with data which showed that some improvement in staff sickness levels was evident. Senior team leaders considered this was due in part to improved testing of staff and improved infection prevention and control procedures within the trust.

We observed support material and access to support services within the hospital. These included posters, leaflets, and screensavers. Staff told us they were able to raise concerns they may have about their physical and mental wellbeing and felt they would be heard.

The trust promoted risk assessments of all staff and had taken measures to reduce the risk to staff, including those at higher risk of Covid-19. Staff also undertook risk assessments to ensure their work location was appropriate to their health and wellbeing. All staff spoken with confirmed they had completed their risk assessments and revisited the assessments when updated risks were identified. Agency staff also had risk assessments undertaken by their employers to ensure their ongoing safety and wellbeing. We requested assurance of how this information was shared with the trust and were awaiting their response.

All frontline staff were Covid-19 tested twice a week by lateral flow testing and the results uploaded on a central computer hub. This enabled results to be monitored and ongoing changes to staffing managed. Agency and bank staff were tested on their arrival to the ward and had to wait until results confirmed their safety to work. These were lateral flow tests and so the outcome was provided in the space of minutes. Changes were planned in the trust to allow easy access to delivering of tests so that staff inconvenience and safety was minimised.

## Governance

**Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities. Governance structures and the communication within them were effective to ensure that changes and learning supported patient safety across the trust.**

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The trust had outlined clear responsibilities, roles, and systems of accountability to support infection prevention, and these were regularly reviewed. The infection prevention team were led by a microbiologist and a consultant nurse who held the director of Infection Prevention and Control position. The IPC team was a team of 15 nursing staff. The team cover the acute service along with the community infection management service and a further local trust. Two of the staff we interviewed worked in both the acute hospital and linked with community services to increase visibility and access to the trust wide IPC team.

The Deputy Medical Director sat on the infection prevention control (IPC) and decontamination assurance group and worked closely with the Medical Director looking at the annual programme and raising to board level any areas of concern or relevant update. The IPC team, leadership, and ward staff all told us about the good team working across the trust to enable infection prevention and control to be managed as effectively as possible.

The Infection Control team took their annual report to board in July 2020 along with 2021 annual infection control programme. Any actions stood down, for example the pharmacy microbial audit due to Covid-19 pressures were monitored. Updates from the IPC action plan were included when relevant in the trust's Board Assurance Framework, and an updated infection prevention and control Board Assurance Framework was submitted to the governance committee in June 2020. This was to provide a source of internal assurance for the IPC teams, directors of Nursing and Trust boards, that internal guidance and practices for management of Covid-19 were compliant with national guidance.

There were effective processes and accountability to support standards of infection prevention and control including managing cleanliness and a suitable environment. The data gathering systems used by the trust enabled the ongoing review of outbreaks and the tracking of staff contact with each patient. This provided the data needed to review practice and make any changes needed to prevent cross contamination. This data was also used to monitor patient and staff movement through the trust and support changes needed to reduce the risk of transmission.

Audits and monitoring using dashboards enabled the infection control team to monitor areas with higher risks. The dashboard had oversight of all other elements for infection prevention control to include *Clostridium difficile* and norovirus. Some staff could run reports from the system, for example a report of the number of positive infections in the last 24 hours.

If patients were due to have a test for Covid-19, this would alert on the computer system and staff could see a record of each patients results. This meant that all patients had up to date screening, we reviewed examples on the system in several areas and staff told us they found this system to be helpful.

All levels of systems for governance and management interacted effectively. We were told about instances when the trust had recognised Covid-19 risks and had implemented staff wide changes. For example, swabbing of equipment had highlighted that the use of computer keyboards presented a transmission risk. Staff had received training in cleaning shared equipment after use. We saw this taking place in some areas, but not consistently everywhere. The trust continued to identify areas for development for example locating cleaning wipes near door handles to prompt staff to wipe handles after touching them.

When a complaint was raised by a patient or relative relating to infection control, actions were taken to respond in a timely way. A team of staff had been put together to review all Covid-19 and infection control related complaints or concerns raised with the trust. The team looked at each issue and addressed it in conjunction with any other issues raised to ensure a cohesive response was made to the complainant. Duty of Candour was considered in each response to ensure an ongoing supportive response to patients and families. Ongoing monitoring via the trust incident review group was undertaken and letters sent out were scrutinised to ensure they were specific and timely. A thematic review of all complaints was planned to be undertaken looking for lessons learnt.

## Management of risk, issues, and performance

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

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There were clear and effective processes to manage risks, issues and performance relating to infection prevention and control. Updated information and guidance were received by the trust from the external stakeholders via the Emergency Planning and Preparedness team. The infection control team reviewed the government guidance and considered whether internal guidance policies needed to be rewritten or amended. These policies included policies for patients with different and changing needs. One person from the IPC team took responsibility for making amendments and the changes were reviewed by the whole IPC team before being presented to the trust clinical reference group to be agreed. The IPC and decontamination assurance group met quarterly and reported all updates and changes to the safety and risk committee which were then progressed to inform the board.

The trust identified that reduced access to appropriate numbers of staff had been a challenge and had created increased risk during the ongoing pandemic. High staff sickness levels had caused the trust to raise an internal incident in December 2020. Since that time staffing levels were seen to improve with an ongoing reduction of staff Covid-19 related sickness. This was considered by the trust to be due to a combination of the level of testing of staff, the start of the vaccination programme and less transfer and movement of patients and staff around the hospital.

The infection prevention team working with Infection control doctor /microbiologist had reviewed staff and patient data to identify any patterns to Covid-19 outbreaks at the trust. The results had identified that the movement of patients was recognised as an extremely high risk of infection transfer. Work had been undertaken to minimise all patient transfers with a focus on why patients were moved and ensuring that moves were risk assessed and managed safely. Staff were making every effort to keep the patient in one location and the services needed be brought to them.

The ongoing changes in guidance and advice from the wider healthcare system had meant a change in how trust wide communication was approached. Communication strategies had been improved to allow communication with the local and wider teams. Communication through the gold, silver and bronze systems had improved, however the trust told us that

improving communication remained an ongoing area of development to ensure staff were kept informed and updated. They recognised that often changes of guidance were open to misinterpretation, not being heard or impacted by other factors such as staff fatigue. We saw some isolated incidents of infection control practice and use of personal protective equipment which was outside of the current guidance. The infection prevention and control team continued to monitor and observe practice and provide support to all staff to avoid the circumstances that would cause this to happen, and all staff were supported to raise any lapses in compliance.

Leaders recognised the level of staff fatigue was a challenge and had made staff wellbeing a major focus. Additional annual leave, rewards, and a full suite of support for staff psychological and physical health had been implemented. The leaders of the trust told us being aware and open to this challenge was important and they were optimistic that as all the other systems created an improved picture, this would impact positively on staff fatigue and wellbeing.

A recent trust strategy had been to improve ventilation by encouraging windows and doors when possible, to be opened during the day. Ventilation was being enhanced whenever risk assessed and considered safe to do so including widening the window restrictions and when possible creating safe air flow systems using filtered extractors which enable multiple air exchanges each day. The trust IPC staff were looking at all areas and not just Covid-19 areas and aerosol generating procedures (AGP) areas needing negative pressure to see how this could be achieved. Negative room pressure is a technique used in hospitals to prevent cross contamination from room to room.

The trust had a comprehensive assurance system for infection prevention and control which enabled performance issues and risks to be reviewed. Risks related to Covid-19 and any other infection control risks were recorded on the trust risk register and monitored through the governance systems and risk committee. There was a separate board assurance framework for infection control to ensure that the specific risks related to the pandemic were recorded and shared at board level.

Infection control was reviewed as part of an ongoing audit and an annual programme was presented to the board in June 2020. The Infection Prevention and Control



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Annual Programme 2020-2021 was designed to maintain compliance in line with the Health & Social Care Act, Code of Practice on the Prevention and Control of Infections. The annual action plan and tracker was rated by risk and each risk area was allocated to a staff member for responsibility for action.

Updates about risk and performance were provided to staff through the gold (strategic command) team meetings. This information was then disseminated to all trust staff and changes to guidance included. Dissemination of updated information and practice changes were shared by the HUB, this was an internal computer system, to which all staff had access. All guidance linked to national information and Covid-19 updates were stored there. Staff confirmed they were regularly updated and as the infection control team visit wards and areas the information would be discussed with individuals.

Pharmacy teams used information provided by the gold (strategic command) meetings and had amended their visits to the wards. They were avoiding visiting wards and departments when possible but maintaining a review of pharmacy electronic records and supporting ward staff. Pharmacy staff confirmed the new electronic system had been a benefit and recognised that it helped to reduce the infection risk. The pharmacy team were working on getting the balance right between being visible on the ward and not spending unnecessary time there. Pharmacy staff were communicating with the wards from a distance to ensure any prescribing issues were addressed and staff support provided.

The trust had a process to audit infection prevention and control (IPC) practices. There were processes to ensure learning was identified from the audit outcomes to improve IPC quality.

Auditing of all infections had enabled learning to be taken forward by the trust and contributed to the reduction in numbers of hospital acquired infection. Audits were used to monitor infection prevention and included for example, cleaning audits, risk assessment audits, environmental audits, prescribing audits, and hand hygiene audits. Displays of the hand hygiene audit results were seen on the ward.

We saw good hand hygiene and personal protective equipment mostly used correctly.

Staff told us they could raise concerns about infection control management with colleagues. For example, one staff member described a clinical member of the team did not remove their gloves outside of the bay, so they would be comfortable to remind them.

Wards and departments had recognised that some activities created a greater staff risk, for example, staff handovers made social distancing difficult. This risk had been mitigated by reducing staff attendance at handovers. In this instance a system of reduced staff attendance followed by cascaded information had been implemented. Staff confirmed that this arrangement was adequate, and they received the information they needed to work safely.

The trust had processes and systems to identify and treat people who had or were at risk of developing an infection so they did not infect other people. Staff told us there was an overall trust risk assessment and further location risk assessment for specific identified needs such as environmental issues. Dynamic risk assessments were ongoing to manage occurring risks and changing situations. The IPC team were available to provide advice and guidance for any risk management needed.

All patients were tested for Covid-19 with a polymerase chain reaction test (PCR) on admission to the hospital and then on their third and fifth day. There was a plan to increase the frequency of patient testing for Covid-19 to every other day, to allow for a clear view of all patients who may have Covid-19. The plan was due to be implemented within a week of the inspection. This aimed to improve the oversight and management of patients, and patient safety.

On admission to hospital, patients were triaged to identify those with pre-existing conditions or those who were at a higher risk, for example, members of the BAME (Black and Asian Minority Ethnic) communities. Side rooms were used on wards to treat people who had an increased risk of developing the infection. If there were not sufficient side rooms available, a bay within a ward would be allocated for patients with confirmation of the infection to be cared for together. Patients who did not have capacity to understand the risks of infection were allocated specific nurses to support them to be safe and to reduce the risk of cross infection between patients. In

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line with national guidance, the trust had identified ward areas with higher numbers of Covid-19 positive patients and when appropriate had cohorted these patients together.

The electronic system enabled mapping of Covid-19 positive patients and patients with other infections. The system had the ability to map staff contact to track infection outbreaks and inform the trust how outbreaks had occurred. This learning had already been used to identify that outbreaks were not all related but had occurred independently around the trust by other means such as patients being admitted with the infection. At the time of our inspection, the control systems had identified three days without any hospital acquired Covid-19 infection being identified. A hospital acquired infection is an infection acquired in the hospital environment as opposed to the patient being admitted with the infection.

The trust had oversight of risks in all the department and buildings including corporate and public areas. As part of the cleaning audits undertaken, the trust had identified that some areas of the hospital environment created infection control risks. These risks included ventilation and space constraints and we saw that routes through areas had been identified to prevent staff crossing areas. As a result, considerable work was in progress to address where possible, the environmental problems and find practical solutions. For example, the emergency department was undergoing considerable restructure to enable the space reduced by social distancing to be better managed without reducing patient capacity

The trust found that staff rest areas created an elevated risk of cross infection. Staff break out areas had been created to enable staff to use outdoor space for breaks. Gazebos with heating had been built to support staff to leave wards and departments for breaks and fresh air. Wards and departments had controls over the inside space available, with signage on doors indicating the limited numbers allowed in the rest rooms at a given time. All Covid-19 positive cohort wards we visited had an arrangement for a staff break out room. Changes to space and upgrades of areas were noted. Sandwiches and water were being delivered to these wards to reduce the need for staff to leave. If staff needed to leave, they were

required to remove PPE and scrubs. Extra restaurant space had been created to enable staff to sit in a communal space safely, but staff told us they preferred to take their breaks on their wards or in their departments.

Staff changing facilities had improved and when required there was an identified “dirty” changing room. This meant staff could change before they went home and reduce the risk of cross infection. Staff wearing scrubs left uniforms at work to be laundered by the hospital laundry service following infection control guidance.

Staff had reflected on the outbreaks and looked for learning to take forward. They told us about two examples where learning had improved patient safety. They explained that taping the ward doors and no entry signs had reduced footfall of unnecessary people accessing the wards. They also told us posters asking the question, “do you need to be there” had been successful, prompting staff to think about if they needed to enter.

There were effective processes to use equipment, including personal protective equipment to control the risk of hospital transmitted infections. Following discussion with local partners, the executive team and outbreak control team in the trust put in extra measures to manage outbreaks. Infection Prevention and Control Guidance from Public Health England, provided the trust with guidance of the levels of personal protective equipment required for staff. The trust was exceeding that guidance and had provided enhanced personal protective equipment (PPE) for staff who may or may not need this, depending on the area of work. Enhanced PPE described higher levels of personal protective equipment than the standard infection control precautions of disposable aprons, gloves, and masks. In Covid-19 positive cohort or designated outbreak wards, staff were offered the option of enhanced PPE, which was taken up by some staff. The trust told us that this offer in certain areas of the trust had been well received and had a positive effect on staff anxiety. For example, the choice was evident on renal and trauma wards where enhanced PPE was optional for staff and there was a 50% uptake of this offer.

The trust had provided training for the putting on and taking off personal protective equipment, known as donning and doffing. To aid this process donning and doffing support staff had been designated in intensive treatment areas. These support staff assisted all staff

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requiring extra personal protective equipment needed for aerosol generating procedures. This supported staff and made the process quicker and safer. In the emergency department a new system to access personal protective equipment had been set out in the same way as in the intensive care unit. This meant intensive care department staff attending the emergency department in an emergency could find and put on the equipment quickly.

Staff and leaders told us finance had never been a constraint when planning effective infection prevention and control processes or to obtain relevant and enough consumables.

## Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure.**

Information was processed effectively, challenged, and acted upon. The computer system used by the acute and community services in the trust provided the infection prevention control nurses with a trust wide dashboard of relevant and up to date information. The information provided a clear oversight of patient infection status and enabled reports to be run of the most up to date information. This meant decisions could be made more easily, improve patient management and safety. At the time of the inspection this showed the trust was in an improved position with three days of no hospital acquired Covid-19 patients.

The trust used valid, timely, reliable, and relevant measures to evaluate infection prevention and control processes. Information about each patient Covid-19 status was available on the trust wide computer system, enabling community services such as community hospitals to access the patients Covid-19 history. The information available to staff included Covid-19 contact alerts for patients which recorded whether via test and trace or in bay contact, patients had been in contact with an infected patient. Staff were also able to record if patients were displaying any clinical symptoms of having Covid-19, even if their most recent test was negative. The care plan records for patients related to their overall care and included Covid-19 specific instructions and information when identified.

Patient records were clear, accurate and up to date with regards to Covid-19 testing and results were documented in a timely manner. The electronic record system provided clear instruction and records of patient Covid-19 testing. This was accessible to all staff providing care and treatment.

Patients were tested 24 hours prior to being discharged to a care home, to their home with a package of care or if going home to a member of the family who was vulnerable. If discharge was delayed, then patients were retested again before leaving the hospital. These tests and results were recorded on the computer system and clearly visible to the ward teams.

The trust had an infection prevention and control team working across the acute and community services of the trust and another local trust to support and inform control measures. The community infection management service is led by two nurses who rotate through the wider team. Staff worked as a link between the east of Devon community and acute hospital departments. They provided advice, support and communication between the hospital and discharge services, for example, care homes.

This infection prevention and control team was set up in April 2020 and the two staff worked as a link by liaising with care homes and community services. They had supported education for care homes and were developing strong links with the community. This provided means of a two-way communication in and out of the hospital. The team joined outbreak meetings and communicated between the hospital and community services.

There were some challenges surrounding a consistent understanding within care homes about the needs of patients who may test positive after 14 days isolation. Where this was an issue delaying discharge, it could be escalated to be managed by the community team. We heard examples where the team had managed the anxieties and fears of care homes to facilitate more timely discharge from the hospital and for the patient

## Engagement

**Leaders and staff collaborated with partner organisations to help improve services for patients.**

# Summary of findings

Staff and external partners were engaged and involved to support sustainable services.

Information about outbreaks was shared with external services and updates were provided. Staff described helpful links and multidisciplinary working with external agencies and team working with Devon County Council, Public Health England, NHS Improvement/England (NHSI and NHSE) and the local clinical commissioning group. Further to an agreement with clinical commissioning services, the community infection management service had been developed.

Infection control staff told us that the joint working leads of infection control and microbiology roles worked very well. This shared role meant there was always one of the leads available and they brought different strengths to the team. Staff told us that the trust worked well as a team. They were proud of the care provided on the wards and the changes made when there had been outbreaks for example, joint working with cleaning and estates staff.

The trust took account of the views of staff, patients, and the public to improve infection prevention and control (IPC) practices. Staff reiterated to visitors the risks of visiting whilst being supportive and understanding to both patients and visitor's needs. The acute hospital had reduced visiting in line with guidance, and with the support of the patient advice liaison service worked to improve communication with the public. Visiting was limited to access only for those relatives of patients at the end of their lives or who had specific support needs such as patients with a learning disability.

Visitors that were permitted were not tested but ward staff did check for symptoms and they were also given personal protective equipment to wear. Visitors were provided with enhanced equipment if going into areas using aerosol generating procedures and were supported by staff to use this correctly.

The ward staff together with patient advice liaison had worked on using video interactions between patients and their visitors. Staff recognised how difficult it was for patients to communicate in this manner and they understood the difficulty for patients when visitors cannot be present. Staff told us they had worked hard to meet this patient need and took comfort from letters from bereaved families and other families who have used the systems with some success.

The trust had found that in some cases visitors did not want to come in. Electronic pads were available, but staff needed to facilitate this which was not always easy when they were busy. Patients had access to free Wi-Fi if they had their own devices to use.

The trust ensured information on infection prevention and control performances, including information related to outbreaks of infection, were available to staff and to the public.

The trust website had specific information about Covid-19 available to both patients and the public. Information was displayed around the wards and departments to visualise Covid-19 specific points of reminders (for example, posters on HANDS, FACE, SPACE, indication of Covid-19 risk assessed areas).

In the community services, staff could contact the community infection management service. They in turn were informed of all outbreaks in the community and provided advice and reviewed processes to support the service and would visit if requested.

## **Learning, continuous improvement and innovation**

### **All staff were committed to continually learning and improving services.**

There were systems and processes for learning, continuous improvement, and innovation. The trust recognised that better communication was needed to ensure that all information, support, and guidance was consistently received and understood. Senior staff explained that when staff did not understand changes, this caused anxiety, so as part of improved communications, staff webinars were run regularly to update staff. Information was available to both permanent staff and contingent workforces, via the daily bulletin from the gold and silver meetings and trust emails. Covid-19 marshals were used to monitor the infection prevention on wards and hospital areas and support staff to find the updated information they may need.

The trust promoted a continuous improvement culture around infection prevention and control.

There was an ongoing development of the emergency department to increase the space available which had been reduced by social distancing. The rebuild of some

# Summary of findings

areas of the emergency department was planned to include a point of care laboratory testing facility, which would include Covid-19 testing. This would benefit the department and reduce patient waiting time for results.

The trust sought to learn from internal and external reviews as well as from the experiences from other trusts. The trust had Public Health England visit in November 2020 and a subsequent report and we saw that the recommendations had started to be implemented or were already being carried out. We were told by one of the infection prevention team leads that they had visited had another local trust to share experiences and increase learning.

We saw examples of innovation regarding management of infection prevention and control.

We saw that each patient was provided with a welcome pack which included handwipes and items of personal protective equipment. This encouraged patients to be part of the infection prevention culture and promote patient independence.

Improved testing for staff was being piloted. Loop Mediated Isothermal Amplification Testing was being implemented, this is highly specific, low cost, portable, onsite testing and has a quick turnaround. This meant that the trust would be able to carry out more regular staff testing on a large scale to prevent future outbreaks.



# Outstanding practice and areas for improvement

## Areas for improvement

### Action the trust **SHOULD** take to improve

- The trust should continue to monitor compliance with appropriate levels of personal protective equipment, including enhanced personal protective equipment to ensure its use is in line with national guidance. The

trust should improve those areas of infection prevention and control practice which are not currently being followed in line with national guidance.

- The trust should consider ways in which it can further promote staff and patient engagement with compliance with cleaning of shared use equipment.