# Medway NHS Foundation Trust

## Quality Report

Medway Maritime Hospital
Windmill Road
Gillingham
Kent
ME7 5NY
Tel: 01634830000
www.medway.nhs.uk

Date of inspection visit: 5 May 2021
Date of publication: 01/07/2021

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

# Summary of findings

## Overall summary

We carried out a short notice focused inspection of the acute services that Medway NHS Foundation Trust provided, to look at infection prevention and control.

Medway NHS Foundation Trust is a single-site hospital based in Gillingham, Medway Maritime Hospital, which serves a population of more than 424,000 across Medway and Swale.

The trust employs around 4,400 staff and provides a wide range of specialist and general hospital services to almost half a million patients a year. This includes more than 125,000 emergency department attendances, 88,000 admissions, 278,000 outpatient appointments and more than 5,000 babies born last year. In addition, the trust has 118 apprenticeships and close to 400 volunteers provide invaluable support across the League of Friends, Hospital Radio and the Voluntary Services Department. The hospital site is home to the Macmillan cancer care unit, the West Kent vascular centre, the West Kent centre for urology and a state-of-the-art obstetrics theatre suite. As an NHS Foundation Trust, the organisation has a 24-strong Council of Governors and more than 10,000 public members.

The hospital is made up of two clinical directorates; unplanned and integrated care and planned care that are supported by corporate functions. Each clinical directorate has a dedicated leadership team comprising of a divisional director of operations, divisional medical director and a divisional director of nursing. The board of directors, led by chair Jo Palmer, has nine executive directors including George Findlay, Interim Chief Executive, and seven non-executive directors including the chair.

**Inspected but not rated**

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

We found:

- Leaders had the skills but did not always have the capabilities to manage infection prevention and control (IPC). They did not always have the capacity to support all staff, due to the lack of leadership stability and vacancies within a new IPC team. The trust had an ongoing active recruitment to key positions to strengthen the capacity.
- The trust did not have comprehensive governance systems to support IPC standards. Governance structures were not clear, and it was not clear how and what was communicated within them. It was not clear who had oversight, and if the trust board was fully sighted on IPC issues.
- There was no standardised approach to reporting from leaders of each care group and inconsistent attendance at the trust's IPC committee. This made it difficult to track what was reported at each meeting. The trust was unable to track improvements and variations each month without a standardised approach.
- The trust did not always collect reliable or consistent IPC data and analyse it. The IPC committee did not always receive reports from the leaders of each care group. Inconsistencies in reporting from the care groups made it difficult to track improvements and variations.
- There was no dedicated clinical handwash basin in the adult discharge lounge. Staff could not readily access clinical handwashing facilities to clean their hands appropriately. They could only access a handwashing facility either in the sluice or the two patient toilets.
- There was a lack of space with general clutter and poor layout in the therapies department. The environment did not allow efficient cleaning and is a risk to infection control. The therapies department lacked space and the rehabilitation gym was used for storing equipment. The environment was cluttered and did not allow efficient cleaning which was a risk to infection control.
- Not all staff felt respected, supported and valued. Some housekeeping staff experienced bullying within their teams. Some staff said they did not feel respected and did not receive support from senior leadership.

However:

# Summary of findings

- Leaders on ward levels understood and managed the priorities to manage IPC. They supported staff to develop their skills and understanding of IPC measures.
- The trust had a vision and strategy that included IPC. Their strategy aimed at continuously improving practices related to IPC, and an action plan to meet identified goals. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.
- Most leaders were visible and approachable in the service for patients and staff.
- The trust had an open culture where staff could raise IPC concerns without fear. They were focused on the needs of patients receiving care.
- Leaders used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- Leaders and staff collaborated with partner organisations to help improve services for patients.
- Staff were committed to continually learning and improving services.

**How we carried out the inspection**

The team that inspected the trust comprised of a CQC lead inspector, a CQC inspector and a specialist advisor with experience in infection prevention and control (IPC). The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

We visited Medway Maritime Hospital on 5 May 2021 to assess IPC measures, speak with staff and to observe IPC practices. We observed and visited the accident and emergency department, outpatient clinics, adult discharge lounge (Christina Rossetti), the surgical and medical assessment units and the therapies department - including the rehabilitation gymnasium. We also visited public areas and staff rooms to observe social distancing practices.

During our visit, we spoke with 18 staff members including nurses, doctors, matrons, managers, allied healthcare professionals, housekeeping and support staff. We observed practice and reviewed six sets of patient records and medication charts to assess compliance with national guidance.

Post inspection we reviewed several policies, audit results and data from the trust. We requested further documentation including root cause analysis reports. We carried out three interviews via video conferencing after the site visit, with five of the trust's IPC leaders.

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

## Is this service well-led?

**Leadership**

**Leaders had the skills but did not always have the capabilities to manage infection prevention and control (IPC), and did not always have the capacity to support all staff.** The director of IPC (DIPC) was also the chief nurse and had taken-on the additional role of DIPC in December 2020. The DIPC was supported by an interim associate director of IPC who was the trust's head of IPC, and a recruitment for a permanent appointment was underway. These appointments were made following the departure of two IPC senior leaders in November 2020. An interim IPC matron started work in April 2021 and a permanent appointee to this role starts in June 2021. A new pharmacist also started in April 2021 to support the team and recruitment of a data analyst to support IPC was in progress.

Staff told us there was not always clear nursing leadership of IPC due to the departure of staff, new appointments and vacancies within the IPC team. Recruitment in the IPC team remained a high priority for the trust to enable a strengthened IPC team structure to deliver sustainable change.

**Trust leaders understood and managed the infection prevention and control priorities and issues the trust faced.** Leaders understood the challenges to quality and sustainability and could identify actions needed to address them. We interviewed five members of the executive board who were able to tell us about the issues the trust faced and what the trust was doing to manage these. IPC was a priority for the trust and the board received updates monthly.

Staff felt trust leaders prioritised IPC issues and had supported improvements. Staff in the emergency department felt the trust leadership team had a good understanding of the challenges they faced. Staff said the

# Summary of findings

leadership support had improved in the emergency department. They said this had enabled them to make effective changes to systems and processes to keep staff and patients as safe as possible. The team felt they had been given enough time and support to make IPC a main priority during the second wave of the pandemic.

The trust had assessed their compliance against the Health and Social Care Act 2008: code of practice on the prevention and control of infections which had identified areas of non-compliance which the trust had worked to improve. This was reflected in the trust's IPC improvement plan. The trust board reviewed the IPC board assurance framework, and this was last updated at the board meeting in April 2021.

**Leaders were mostly visible and approachable in the trust for patients and staff however, not all staff experience high visibility of the senior leaders.** Not all staff told us there was visibility from senior members of the leadership team. Staff reported concerns to leaders at the daily site safety huddles. The site safety huddle was a short multidisciplinary meeting held at the same time each day for staff across the hospital to share updates and immediate concerns. Matrons undertook site walkarounds to check compliance with infection control guidance and to interact with staff.

Some housekeeping staff felt there was little visibility of senior managers as they were located on different floors from team leaders and housekeeping teams.

**Leaders supported staff to develop their infection prevention and control skills.** The IPC team supported staff to gain the skills and experience needed to manage IPC. Staff told us that IPC team support had improved and the team had worked with them on the wards to ensure patients and staff stayed safe. This had improved compared with the first wave of the pandemic when staff had limited involvement with the IPC team.

**Vision and strategy**

**The trust had a vision and strategy that included infection prevention and control.** The trust vision was "to deliver brilliant care through brilliant people"which was displayed in the hospital. Staff knew the principles of this statement although they could not always remember the exact wording. The trust's strategy focused on continuous improvement called "best of care, best of people". Staff and executives supported this strategy. Leadership involvement and staff understanding of their vision and strategy had improved within the last four months.

**The vision and strategy were focused on sustainability of infection prevention and control and aligned with local plans within the wider health economy.** In the past four months, the trust had reduced the rate of in hospital transmission of Clostridium difficile infections. Clostridium difficile is a type of infectious bacteria, which can infect the bowel and cause diarrhoea. The antimicrobial stewardship team supported this improvement by identifying medicines being used that could be used less, to reduce the risk of patients developing Clostridium difficile. Leaders had worked with the national NHS England and NHS Improvement IPC team which had helped support the trust's improvement with healthcare associated infections. Leaders had a strategy for the sustainable supply of personal protective equipment. They worked with local and national stakeholders to adjust their rate of supply for items of personal protective equipment when there were changes in guidance or increased usage.

**Leaders and staff understood and knew how to apply and monitor progress of their infection prevention and control vision and strategy.** The trust implemented an action plan in December 2020 to improve IPC in line with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections. The action plan identified 67 actions of which 82% were completed and on track to complete in the four months prior to our inspection. This was reviewed in March 2021. The outstanding actions were being monitored by the IPC team. Key points from the improvement journey were communicated to the board via the IPC committee by the director of IPC. Staff told us they had seen improvements in IPC including an increase in staffing numbers in the surgical assessment unit and the number of wall mounted alcohol-based hand gel dispensers at relevant points in wards and departments.

All the wards and clinical areas we visited had signage on the entrance informing staff of the infection risk and what personal protective equipment they needed to wear. All had alcohol-based hand gel dispensers (that were full), at the entrance to the department, outside each clinical room and on the desk of each consultation room. All

consultation rooms had a clinical handwash sink with a poster showing the five moments of hand hygiene and the correct handwashing technique. We saw staff followed good hand hygiene practice and wore personal protective equipment in line with national guidance and trust policy.

All areas we visited were visibly clean and tidy, except the rehabilitation gymnasium which was cluttered. The rehabilitation gymnasium in the therapies department was not used for carrying out a patient's rehabilitation. Staff said they carried out patient's rehabilitation on wards instead. The rehabilitation gymnasium was used for storage of equipment such as exercise machines and walkers, as the original storage facility had been converted to an office space for another department. A corner of the rehabilitation gymnasium was also used as an open layout office with limited space between desks to enable social distancing. While the whole environment was visibly clean, it was cluttered and almost the entire floor space was packed full of rehabilitation equipment. This did not allow efficient environmental cleaning and posed a risk to IPC. The therapy lead informed us the health and safety team had completed a risk assessment and the therapies team had submitted a business case to source alternative storage facility.

There was no dedicated clinical handwash basin in the open plan adult discharge area. Staff told us this was removed following a risk assessment. Since its removal, staff had used alcohol-based hand gel from wall mounted dispensers located in the area. They could not readily access a clinical handwashing facility unless they moved across clean areas to handwash basins located in the sluice room and two patient toilets. We raised this with the director of IPC during our inspection and requested to review the completed risk assessment. The trust had not provided a completed risk assessment for review however, the director of IPC informed us the handwash basin was removed on 24 February 2021, following a national IPC team recommendation. They informed us the reason for the removal of the sink was based on water safety risks, and the trust had apermanentsink solution.

**Culture**

**Staff felt respected, supported and valued however, not all staff experienced this consistently.** Most staff told us the wards and departments worked together well within their teams and felt a real team spirit. Staff mostly told us they felt their leaders understood the pressures on them, valued the work they did and supported them to complete their work safely.

The trust had internal processes to raise safety concerns relating to IPC. Staff we spoke with described twice daily huddles to discuss IPC including responsibilities, any problems identified and recent incidents. Staff described how they could raise concerns with the matron, lead nurse or IPC team if required.

The housekeeping staff had the same wards and areas assigned for work. Staff worked well with the ward teams. The wards informed staff of any infections on the wards and nurses provided IPC training and reminders to enable housekeeping staff to undertake their roles. Housekeeping staff working in the same wards provided continuity in carrying-out their role such as changing linens, cleaning floors, using cleaning solutions and applying IPC policies. There was a dedicated team that had received a higher training level to work in areas with higher infection risks. Staff told us they felt they played an important role in IPC which is a key objective of the trust's IPC strategy.

However, some housekeeping staff did not feel their senior managers understood the pressures on them and did not feel supported. Team leaders felt previous recruitment was not a fair process with a history of casual recruitment such as employing friends. They felt a culture of bullying where housekeepers had shown lack of respect towards team leaders and that there was no accountability for their behaviour. We were informed senior managers sat on another floor and away from the team. Team leaders raised the above concerns but felt they had not been taken seriously.

We raised this with the head of housekeeping who started in January 2021 and was fully aware of the issues. They informed us improving the culture within the department was their priority. For example, they had linked with the hotel services manager and the culture and engagement team to implement actions for improvements. They held workshops for leaders led by the culture team. The head of housekeeping had also challenged poor behaviour such as some staff taking unauthorised breaks. There was an improvement plan that included an apprentice-style learning programme for housekeepers with a view to reduce staff turnover. The programme required staff to

# Summary of findings

commit to a 15-month learning contract, and on successful completion, staff would be awarded with a qualification. There were also plans to implement new cleaning standards that aligned with national guidance and to provide staff electronic devices to enable more efficient cleaning audits to drive improvement.

**Staff were focused on the infection prevention and control needs of patients receiving care.** Staff and managers told us they were happy to challenge people on non-compliance with IPC policy with a positive focus on protecting patients and staff. Senior staff found it easier to challenge poor IPC practice, but all staff were encouraged to do so. For example, we saw a member of staff challenge a consultant who wore surgical gloves on a ward round without removing them between seeing each patient. The consultant then removed their gloves and used hand gel in between seeing each patient until they had completed the ward round. Gloves can transfer bacteria in the same way hands can, by not removing or changing them between patients there was potential for cross infection.

In the accident and emergency department, the patient clinical COVID-19 pathway was clearly identified and documented in all the six patient records we reviewed. Patients were only moved from the assessment units or the emergency department according to their COVID-19 status to an appropriate cohort ward - unless the patient clinical need was greater. There were no patients with COVID-19 in the department during our visit.

**The trust had an open culture where patients and staff could raise concerns about infection prevention and control without fear.** Staff said they were supported in raising concerns about IPC. Staff told us about learning sessions that some staff had attended which focused on kinder and supportive ways to improve the practice of other staff. We saw a receptionist constructively challenge a member of staff about the way they were wearing a face mask.

**The trust had an emphasis on the safety and wellbeing of their staff however, not all staff consistently felt this.** The trust had arrangements to promote the physical and mental wellbeing of staff during the COVID-19 pandemic. There was a staff wellbeing hub that provided a place for staff to escape from the pressures and have a dedicated space for peace and quiet. The hub also had sofas, bean bags, puzzle books and exercise yoga mats. Yoga and meditation classes took place virtually or face to face in line with social distancing guidance. All staff could access different support services such as the trust's in-house occupational health service and psychological support.

Personal protective equipment was available in all areas we visited. The trust had conducted a COVID-19 vaccination programme for their staff and by end of March 2021 the trust had given a first dose to 82% of their total workforce. Most staff told us they were able to take regular breaks and had rooms to allow them to socially distance while eating and drinking.

Not all therapy staff had office space to complete administrative work resulting in them spending more time on wards than needed. Some therapy staff reported there was insufficient changing facilities for staff when they were expected to change uniform at work, so staff changed in toilets and staff break rooms.

**The trust promoted equality and diversity in their approach to infection prevention and control.** All staff we spoke with told us they had completed a personal COVID-19 risk assessment with their manager, and these were updated when needed. Staff told us they received support identified from these risk assessments such as allowing staff to work from home, where suitable to do so. The trust had promoted COVID-19 vaccination in their black and minority ethnic staff and by end of March 2021 had vaccinated 67% of their staff in these groups. Leaders at the trust told us they were working to have targeted conversations with staff that had declined the vaccination.

**The trust had infection prevention and control training for staff and additional support where needed.** Staff had completed their yearly IPC eLearning which was updated to include information about COVID-19. The trust's compliance with level 1 and level 2 IPC training were both 100% in March 2021. Staff we spoke with confirmed they had received IPC training including the donning and doffing of personal protective equipment.

**Governance**

# Summary of findings

**The trust did not always have clear or consistent structures, processes and accountability to support infection prevention and control standards.**

The trust conducted audits including hand hygiene and personal protective equipment. Following national guidance, the trust had paused these audits due to the pressures of the pandemic and at the time of this inspection they had restarted these audits. Ward staff and managers collected audit information and they acted on any identified issues. The trust had environmental audits that looked at the effectiveness of their cleaning standards. Leaders reviewed these and found they needed to be improved. The trust therefore introduced an action plan to support the improvements identified. The trust IPC team and matrons conducted unannounced site audits. Matrons shared the audit results with their teams at daily huddles to enable learning. All ward areas we visited looked visibly clean and tidy.

Staff told us they reported infection control concerns and received feedback on these. They knew audits and reports were completed and always received feedback about the results of these through their care group leadership team.

Trust information showed the IPC committee met monthly, and the director or executive lead of IPC chaired the meetings. We were told care group heads of nursing and midwifery reported to the committee, including some of the statutory functions detailed in the Health and Social Care Act 2008. However, our review of the trust IPC committee meeting minutes for November and December 2020, January, March and April 2021 showed inconsistencies. These include the inconsistent attendance of members at these meetings, what was reported and how often they attended. The minutes also showed care groups and occupational health had reported intermittently. There were no standing agenda items. Risks related to IPC were not presented in detail and discussed at the meetings. It was unclear how the IPC leadership addressed the inconsistent attendance or reporting.

The March 2021 minutes showed some members of the IPC committee did not have sight of the trust's IPC improvement plan. In April 2021, the minutes of this committee meeting commented the IPC board assurance framework had been updated and presented to the committee, the executive team, the quality assurance committee and trust board. It was unclear how or when the details of the IPC board assurance framework were presented to the IPC committee. The minutes also stated the document outlined gaps including actions contained within the IPC improvement plan which was presented at the March 2021 quality assurance committee and at the trust board meeting in April 2021, but not at the IPC committee.

**Staff were clear about their roles to support effective infection prevention and control and had regular opportunities to meet, discuss and learn.** The trust had site wide safety huddles in the morning of each day. Matrons and ward managers provided any IPC updates on guidance and feedback about areas of concern. Staff told us they found these safety huddles useful to them as a source of information and to quickly raise concerns to the site leaders. Ward staff received information about their IPC responsibilities via ward team meetings, eLearning, ad-hoc training sessions, their line managers, ward-based safety huddles and the trust intranet page dedicated to COVID-19.

The trust had introduced ward-based safety huddles that were conducted twice a day on all wards and departments we visited. Staff told us they felt informed about changes in guidance and they were given opportunities to ask questions.

**Management of risk and performance**

**The trust had an assurance system for infection prevention and control which enabled performance issues and risks to be effectively monitored and addressed however, this was not always consistent.** The director of IPC completed and updated the trust's IPC board assurance framework. This document had not always previously updated regularly or highlighted to the board at every meeting. However, it was presented at the board meeting in April 2021. The IPC leaders were well informed about the contents of the IPC board assurance framework, but it was unclear if the details were presented to the IPC committee.

**The trust carried out infection prevention and control audits to monitor quality and systems to identify where action was needed.** The trust had hand hygiene audits, environmental cleaning audits, personal protective equipment usage audits, urinary catheter

audits and antimicrobial stewardship audits. These audits were reported to the IPC committee. The overall compliance with environmental cleaning audits was 90% and had improved for the week starting 22 March 2021.

The antimicrobial stewardship team had completed antimicrobial audits and identified wards for additional targeted support. The antimicrobial stewardship team in February 2021 carried out a snapshot audit of antibiotic usage for patients with COVID-19. They used this to identify areas for improvement and worked with wards that showed a high usage of restricted antimicrobials to ensure they used them correctly. Antibiotic usage had reduced by 12.6% in comparison to January 2021. This was a year on year improvement of 23.7%.

The trust commissioned a snapshot COVID-19 audit between 18 February to 18 March 2021 which highlighted several areas of IPC concerns. The report suggests recommendations to make improvements and actions from these improvements were monitored.

**The trust had processes to identify and treat people with infection and reduce the risk of these people transmitting these infections to other people.** The trust swabbed all patients on admission to hospital for COVID-19 and MRSA. Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterial infection that is resistant to many antibiotics which makes treatment more difficult. Staff had access to COVID-19 testing kits which they were advised to use twice a week to identify staff who had COVID-19 but had no symptoms. Staff recorded their results on the electronic staff system. Patients with infectious diseases were isolated from uninfected patients.

The trust audited their MRSA testing compliance aligned with their policy for February 2021 and compliance was 60% on admission and 83% on day seven after admission. We raised the low testing compliance on admission in our interview with the antimicrobial team. They informed us they had an action plan to improve testing compliance. For example, to review the data quality and ensure the antimicrobial team continued to increase awareness and provide training to staff. The trust provided information after our onsite visit that showed the MRSA testing compliance rate on admission had continually improved for the months of March, April and May 2021 at 82%, 88% and 94% respectively.

Patients with a negative result for COVID-19 from their first swab were re-swabbed after three days and again between day five and day seven after admission which was in line with national guidance. The trust audited their compliance with their swabbing policy for February 2021 and compliance was 92% for day one, 87% on day three and 82% on day five to seven. We looked at six patient records and found that all six patients were swabbed in line with national guidance.

There were effective processes to use equipment, including personal protective equipment to control the risk of hospital transmitted infections. Staff told us they always had access to the personal protective equipment they needed. Staff put on and took off personal protective equipment in line with Public Health England guidance. All staff wore masks and adhered to social distancing in public areas. Staff applied aprons and gloves when attending to patients then disposed of these in between each patient. There were adequate supplies of PPE in all areas we visited. In the emergency department there was a dedicated donning and doffing area. There were staff at the entrances to the hospital to check the temperature of people entering the hospital. They reminded people to wear a mask and check if they had symptoms of COVID-19. However, these staff were not present after 5pm so people entering the hospital after 5pm were not being screened.

**The trust had arrangements for identifying, recording and managing infection prevention and control risks.** The trust had identified risks about IPC which were included in the trust wide risk register and care group risk registers. These included the risk of spreading COVID-19 between patients including other IPC risks such as MRSA, clostridium difficile and legionella, and difficulty in maintaining social distancing. These registers included the initial risk level, risk controls with an assurance level for each control, required actions with progress noted against each action, the current risk level and a target risk level.

Risks and actions were updated and the trust board reviewed risks monthly. The board had a summary report that highlighted to them the most significant risk level changes from the previous month with a short explanation for the change. Staff knew about the most significant risks related to their wards or departments. Leaders knew the top risks and what the trust was doing

to mitigate these. We saw actions recorded on the risk registers were implemented as described including the emergency department social distancing escalation plan which was in line with the guidance from the Royal College of Emergency Medicine.

**Infection prevention and control effectiveness within the trust had not been constrained by financial pressure.** Leaders and staff told us that despite the trust's financial pressures, there had never been any resistance from the trust to implement infection control measures due to financial controls. The trust board approved a business case which included the funding for an expansion to the trust's emergency department which included the aim to improve social distancing and IPC within the department.

**Information Management**

**The trust did not always collect reliable or consistent infection prevention and control data and analyse it.** The IPC committee received intermittent reports from the leaders of each care group. There were inconsistencies in reporting from the care groups and it was difficult to track what was reported at each meeting. The trust was unable to track improvements and variations each month without a standardised approach. This showed there was lack of oversight on IPC concerns.

After the second wave of the pandemic the trust completed a cluster review of care for patients with COVID-19. This identified learning that the trust used to improve care for patients which included prioritisation for focused improvement on the estate to support IPC. We saw this as a risk identified in the trust risk register.

**The trust used information systems to provide staff with the infection prevention and control information they needed to provide effective care to patients.** Staff recorded and tracked a patient's COVID-19 test result and status in the electronic patient record system. Staff told us this system was helpful and had allowed them to take immediate action on seeing the alert. It also acted as a reminder to staff which patients needed to have swabs each day.

Staff were able to access IPC policies on the trust intranet page. Following the appointment of the director of IPC in December 2020, the trust was reviewing IPC policies for consistency across the trust.

**Wards collected infection prevention and control data efficiently and provided staff with rapid access information to enable them to improve care provided.** Managers had implemented systems to ensure they kept staff up to date with new guidance. For example, ward managers and matrons created IPC checklists when new guidance was issued. Staff completed a daily COVID-19 checklist which included checks on the environment, communication and personal protective equipment. The information we reviewed showed this was consistently completed.

Matrons used a secure electronic application to communicate messages about IPC to staff. Staff told us this was a helpful reminder as they had instant access to the messages.

Staff shared information with a patient's GP and where required a care home on a patient's infection status and history on admission and discharge from the hospital. When a patient was admitted an alert was placed on the electronic patient record system for COVID-19 or other infections. This alert stayed on a patient record as they moved around the hospital and staff could ensure that a patient was looked after safely.

**Staff kept clear patient records for infection prevention and control.** We reviewed six patient records. Staff recorded a patient's COVID-19 test result and status in the electronic patient record system. The system flagged if a patient tested positive for COVID-19 in the last 90 days. The electronic system prompted staff when a patient's COVID-19 test was due and when the last test was completed, this included a flag for the day three COVID-19 test. Records were clear, accurate and up to date with regards to COVID-19 testing and results were documented in a timely manner. Staff clearly recorded a patient's infection history, when necessary, in all the patient records we reviewed. The use of antibiotics was reviewed, as required, in all the six patient medication records we checked.

**The trust shared infection prevention and control information with external stakeholders and other providers.** Patient discharge letters contained a record of the patient's infection status. The trust reported the number of patients with COVID-19 each week and the number of days after admission this had been detected. They reported this information nationally to NHS England

and NHS Improvement. The trust reported the number of patients that had acquired other hospital associated infection nationally and this was published in their public board papers.

**Engagement**

**The trust encouraged staff and patients to provide feedback on infection prevention and control.** Staff told us they felt able to speak up about their concerns and had the opportunities to do this which had improved in the last four months. We looked at three IPC team meeting minutes and saw discussion around feedback and requests for advice from staff. This included staff requesting IPC advice on the appropriate use of a toilet as a changing room facility and the advice to staff was to use designated changing facilities that were available across the trust. There were posters in public areas and on wards advising patients to wear masks. Letters were provided to patients after infection outbreaks which included a request for patients to speak with their nurse or doctor about any concerns. The process following an outbreak on a ward included a prompt for staff to complete the duty of candour process.

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

The trust communicated information about infection outbreaks at their daily site huddles and an outbreak meeting with the IPC team.

**The trust communicated changes in infection prevention and control guidance in a variety of ways.** Posters were displayed about the process for donning and doffing and the correct type of personal protective equipment to wear for different areas or activities. The trust had COVID-19 information leaflets for patients in a range of formats and languages. All staff knew how and where to access these leaflets. We saw a variety of posters providing advice on IPC with pictures clearly showing the messages such as a patient wearing a face mask. The trust website had information about the trust's IPC policy and an advice section for patients and visitors about COVID-19 which included information on how to access services safely during the pandemic.

**The trust collaborated with partner organisations to help improve infection prevention and control for patients.** Quality visit reports and meeting minutes showed that leaders and trust staff worked with NHS England and NHS Improvement, the local clinical commissioning group and other local NHS trusts to improve IPC. External stakeholders gave positive feedback about the trust's engagement with them.

**Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improvement in infection prevention and control.** A trust board meeting minutes showed the board discussed the trust's improvement goals and their ongoing improvement strategy. Staff told us they had seen a slow but sure change in the improvement culture within the trust to one where they were looking for new ways to improve.

The director of IPC who was also the chief nurse shared a monthly bulletin with staff that included IPC updates and learning from incidents or concerns. Staff told us this helped to provide information to staff on relevant IPC issues.

**Staff used improvement methods to identify learning from outbreaks.** The trust developed systems to support staff compliance with hand hygiene and personal protective equipment following an IPC review. The IPC team created a new safety role in March 2021 to help staff follow the correct processes by guiding and challenging staff with kindness. They demonstrated putting on and taking off personal protective equipment, reminding staff of hand hygiene and feeding back issues and concerns to the IPC team to enable learning and improvements.

**The trust had taken learning from other trusts, internal and external reviews of their infection prevention and control practice.** The trust had sought learning from internal and external reviews and experiences from other NHS trusts. For example, they conducted IPC inspections to establish assurance and identify gaps where they could make improvements. The

# Summary of findings

trust had received feedback from NHS England and NHS Improvement on IPC and used this feedback to produce an improvement action plan and ensured active recruitment to key IPC posts was a priority.

Leaders told us they had plans to introduce "every action counts". This was an NHS England and NHS Improvement programme supporting excellence in IPC behaviours. Leaders told us this programme would help persuade staff, patients and visitors to follow good practice in IPC which was key to keeping healthcare settings as safe as possible.

# Outstanding practice and areas for improvement

## Areas for improvement

**Action the trust MUST take to improve**

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

Action the trust MUST take to improve:

We told the trust that it must take actions to meet legal requirements.

**Trust wide**

- The trust must ensure there is readily available clinical wash hand basin facility for staff in the adult discharge lounge to prevent the spread of infection. (Regulation 12(1)(2)(h))
- The trust must ensure there are comprehensive governance systems to support IPC standards. Regulation 17(1)(2)(a))
- The trust must adopt a standardised reporting approach and ensure there is consistent attendance at the infection prevention and control (IPC) committee to enable clearer communication and accountability. (Regulation 17(1)(2)(a))
- The trust must ensure reliable data is collected and analysed to enable clear tracking of IPC issues, variations and improvements. Regulation 17(1)(2)(a)(f))

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

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

**Trust wide**

- The trust should ensure the capacity of the IPC leadership team is adequate to support all staff.
- The trust should ensure there is dedicated storage for rehabilitation equipment and adequate office space to enable efficient cleaning.
- The trust should facilitate social distancing in the therapies department.
- The trust should consider making a changing facility available when therapies staff are expected to change uniform at work.
- The trust should consider how it can further improve the culture within the housekeeping team.