Closure Summary for Serious Incidents

RESTRICTED WHEN COMPLETED

CLOSURE SUMMARY
(FORM SI 3)

WG Ref **NHS Ref**	**005923JUNE2020** **In118504**	NHS Grading	**3 / moderate**
Organisation	Cardiff and Vale University Health Board	Date of incident	13/06/2020
Summary of incident (only complete if there is additional information to the original notification form)	The following information was reported to WG at the time: The Infection Prevention and Control Team have declared a COVID-19 outbreak on Ward East 2 at UHL. Initially the COVID-19 positive patients were located in the Nightingale area of the ward which was closed to admissions and transfers (other than discharge home) on 10.06.2020. On 13.06.2020 a number of patients in the side rooms also returned positive COVID-19 results and the entire ward was closed. Twenty six patients are currently COVID-19 positive on the ward. It is considered that 14 patients have healthcare acquired COVID-19 infection and 12 may be community acquired but this requires further exploration. Three members of staff have tested positive to date.		
Please provide the following: Issues/problems identified Contributory factors Root causes	A Covid-19 outbreak was reported for Ward East 2 University Hospital Llandough (UHL) on 10/06/2020. A total of 31 patients and 13 members of staff tested positive for Covid-19. 14 of these patients were deemed healthcare acquired, 13 probable and 4 possible. Patients were initially isolated to the nightingale area of the ward. The ward was closed for 14 days from the last positive/symptomatic case. The outbreak was closed on 08/07/2020. An investigation meeting was convened on 11/06/2020 chaired by the Deputy Executive Nurse Director, with actions taken immediately alongside a 'live action plan'. This has been updated and continually monitored to ensure all actions are completed. It has also been subject to presentation at the Clinical Board's monthly Quality, Safety and Experience meetings. The Clinical Board have raised the risk that Nightingale wards within UHL complicate the management of infectious outbreaks. All patients/relatives/carers that were affected by the Covid outbreak were spoken to individually to ensure that duty of candour was maintained. Issues identified include: • The Nightingale wards not being conducive to containing infection		

	control outbreaks. • When wards change from 'Red' to 'Amber' Covid streams there is the potential that the risk is seen as diminished, which can lead to variable practices in the use of PPE. This emphasises the need for the reinforcement of the correct use of PPE and hand hygiene at all times. • 2 metre social distancing needs to be adhered to at all times. This was not the case during handovers and time spent in staff rooms. • Confused and wandering patients can contribute to transmission of infection. • Communal areas for staff did not promote social distancing. • The footfall on the ward was high, particularly in the morning periods and needed to be staggered throughout the day. • Patients and staff needed to be reminded of their responsibilities regarding social distancing.		
Cause of death (if applicable)	Not applicable		
Confirmation of actions implemented and arrangements for completing outstanding actions	Weekly meetings were held chaired by the Deputy Executive Nurse Director with representation from the Clinical Board, Microbiology and Public Health Wales until the outbreak was closed.	Timescale (s)	Completed
	Immediate action plan drafted which remains 'live' to ensure all actions continue, and is presented to the Clinical Boards QSE forum.		Ongoing – to ensure compliance continues
	Three beds were removed from the Nightingale area to accommodate 2 metre social distancing.		Completed
	Early identification, isolation/cohorting and testing of symptomatic patients.		Completed
	All patients were tested for Covid 19.		Completed
	The need for 2 metre social distancing was reinforced and when not possible masks to be worn, eg, during handover.		Embedded into practice
	Donning and doffing stations reviewed and the use of PPE reinforced.		Completed and embedded into practice
	IP&C attended the ward daily to offer support and advice and undertook observational audits on the use of PPE and hand hygiene. These continue to be monitored.		Continues
	The outbreak was discussed and reviewed daily in the UHB IP&C meeting with Senior Nurses from Medicine and the action plan		Completed

	reviewed. Staff changing facilities were reviewed. The ward was decluttered. Emails were sent to heads of department to stagger when staff attended the ward to reduce footfall. Learning from this outbreak was shared across the UHB. The development and use of Health Care Worker symptom checker. Cleaning schedules were reviewed including the emphasis on cleaning touching points and equipment. Safety briefings implemented. Operational communication strategy regarding social distancing and PPE within UHL. Shielding guidance added to the discharge checklist. Information was provided to patients to inform them of their responsibilities regarding social distancing. Individual patient hand wipes were introduced. Further office space was introduced for accessing results and printing.		Completed Completed Completed Completed Completed Completed Completed and embedded into practice Completed and embedded into practice Completed Completed Completed Completed
Please indicate if the incident is associated with non-compliance of a patient safety alert, a <u>never event</u> or a schedule 5?	Not applicable		

Arrangements for dissemination of shared learning / action internally and whether they have been shared with any other NHS Organisation / agency externally	Presented to Clinical Board Quality, Safety and Experience Meeting for closure 20th August 2020. Action plan and outbreak discussed at Clinical Board Quality, Safety and Experience meetings 18th June, and 16th July 2020. The UHB continues to use various avenues to share the learning from this incident with staff by reinforcing appropriate use of PPE and social distancing. Senior staff are asked to monitor compliance. Social media channels as well as internal communication mechanisms are frequently used to reinforce messages.		
Is there a recurring Root Cause / Theme / Concern	No, however the arising issues from an outbreak on E2 and E7 were similar in nature.		
Any additional information attached	Yes: [ ] No: [X]		
Disclaimer	I confirm that this incident has been thoroughly investigated and the findings and recommendations have been agreed by the appropriate committee and have either been acted upon or plans are in place to implement the actions within an agreed timescale		
Chief Executive / Executive Sign off **(This section must be completed)**	Signature: [redacted] Print Name: Angela Hughes Title: Assistant Director of Patient Experience Date: 27/8/20		
FOR WG USE ONLY:			
Incident Closed	**Yes: [ ]** **No: [ ]** **Signature:** **Date:**	**Further action required**	