


COVER SHEET

Meeting and Date of meeting	Trust Board 28 September 2023	
Title of paper	Covid-19 SAI Report 2022	
Accountable Director	Name	Dr Stephen Austin
	Position	Medical Director
Report Author	Name	SAI Review Panel
	Email	
This paper sits within the Trust Board role of:	Accountability	
This paper is presented for:	Assurance	
Links to Trust Corporate Objectives	<input checked="" type="checkbox"/>	Promoting Safe, High Quality Care
	<input type="checkbox"/>	Supporting people to live long, healthy active lives
	<input checked="" type="checkbox"/>	Improving our services
	<input type="checkbox"/>	Making best use of our resources
	<input type="checkbox"/>	Being a great place to work – supporting, developing and valuing our staff
	<input type="checkbox"/>	Working in partnership

	<p><i>The report author will complete this report cover sheet fully. The Accountable Director must satisfy themselves that the cover sheet is accurate and fully reflects the report. The expectation is that the Accountable Director has read and agreed the content (cover sheet and report).</i></p> <p><i>Its purpose is to provide the Trust Board/Committee with a clear summary of the report/paper being presented, how it impacts on the people we serve and the key matters for attention and the ask of the Trust Board/Committee</i></p>
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1. Detailed summary of paper contents:

The Covid-19 SAI Report describes the investigation of Covid-19 Outbreaks occurring between 10 August 2020 and 23 October 2020 in a number of inpatient wards in Craigavon and Daisy Hill Hospitals.

The report was commissioned to review the management of the outbreak, identify system wide strengths and weaknesses in the management of the outbreak, use relevant findings to improve the quality and safety of care and to reduce the likelihood of future outbreaks and mitigate their impact, and engage with all affected patients, their families and staff who were directly affected by this SAI.

A summary of the findings on the report are

- There were 15 deaths among the 32 patients with COVID-19.
- Many of the deceased patients had severe pre-existing comorbidities and limited life expectancy prior to contracting COVID-19. COVID-19 appears to have contributed to the premature death of 12 of the 15 infected patients.
- In the Haematology Ward, prior to contracting COVID-19, two of the seven deceased patients were receiving palliative care due to terminal illness. COVID-19 did not materially contribute to the demise of either of these patients.
- The quality of nursing care that patients received leading up to and during the outbreak was generally of a good standard and compliant with local policies and guidelines. No major deficiencies in nursing care that may have led to the outbreak or affected the care of the patients were identified.
- All but one of the deceased patients had either “probable” or “definite” acquired COVID-19 (HA-COVID-19), according to national definitions.
- Following discharge, two patients died within 28 days of the detection of COVID-19. The underlying condition of three of the seven surviving haematology patients appears not to have been affected by having acute COVID-19 symptoms. Four haematology patients had significant delays to their chemotherapy and in three of these, the delayed treatment may have affected their prognosis.
- Four of the surviving COVID-19 patients in the Male Medical Ward (MMW) were asymptomatic. These patients were only found to be infected as a result of screening during the outbreak. In the MMW outbreak, COVID-19 did not appear to have a major clinical impact on the surviving patients’ underlying condition and its treatment. This was also the case for the three survivors of the outbreak in 4 South.
- There was insufficient and inadequate isolation and toilet facilities and poor ventilation in all the affected wards.
- In keeping with the Northern Ireland regional guidance prior to the outbreaks, there was a relative relaxation of the visitor policy. Furthermore, in keeping with the Northern Ireland regional guidance at the time of the outbreak, there was no regular screening of ‘patient facing’ healthcare workers for COVID-19.
- Although there was screening of patients for COVID-19 at the time of admission, there was no regular screening of in-patients thereafter. This was in keeping with the regional NI testing guidance at the time of the outbreaks.
- Poor ward environments exacerbated difficulties in managing social distancing for patients and healthcare workers.

- Inconsistent and inadequate information was provided to patients and family regarding the outbreaks.
- No formal outbreak reports had been written following the outbreaks. These would have facilitated reflection and learning at ward level.
- Families and patients commented on delays in accessing care; the lack of continuity of care as a result of transfers between wards and hospitals; prolonged hospital stays, too many visitors on the wards, overcrowding and lack of social distancing amongst healthcare workers and patients, improper use of PPE, poor infection control practice, excessive use of temporary healthcare workers, and poor communication.
- Healthcare workers commented on the poor state of the wards and poor ventilation, the inability to maintain adequate social distancing on the wards and in healthcare workers' facilities, inadequate and inappropriate supply of PPE, excessive number of visitor, difficulties in trying to keep up with changing and sometimes conflicting infection control guidance, and poor communication regarding the progress of the outbreaks.

2. Areas of improvement/achievement:

Recommendations for the Trust

1. The SHSCT requires the creation of an Intra-Trust Patient Transfer Policy with guidance in relation to patients with COVID-19 and any other infections with a high risk of transmission.
2. The SHSCT urgently needs to provide a form of audit which provides regular assurance that all relevant staff are aware of: standardised IPC guidance and protocols in relation to Personal Protection Equipment, cleaning of single rooms, cleaning of reusable equipment, appropriate use of single-use equipment, the use of fans in inpatient settings and when to complete relevant Infection Prevention and Control (IPC) risk assessments in relation to reusable equipment or fans.
3. The Southern Trust should ensure that its IPC Policies and guidelines are in line with regional IPC policy
4. The SHSCT IPC Outbreak Policy and Guidance should include a comprehensive IPC Communication Strategy to ensure relevant staff are aware of their roles and responsibilities in relation to communicating screening and test results.
5. The SHSCT should consider creating a bespoke IPC communication strand for managers of healthcare workers in the Trust during an inpatient/ward outbreak of infection.

Recommendations for the Trust, Department of Health, PHA and HSC Board

6. Northern Ireland should implement a NI Infection Prevention and Control Framework to provide consistency between Trusts.
7. The SHSCT should be supported in providing COVID-19 point of care testing for all patients attending SHSCT Emergency Departments to ensure appropriate placement and management
8. The SHSCT should be supported in securing sufficient investment to provide accommodation for Haematology patients and patients in all other augmented care settings that meets Health Building Notes (HBN) and Health Technical Memoranda (HTN) Standards.
9. The SHSCT should be supported in securing sufficient investment to ensure the provision of improved ward ventilation within all inpatient accommodation. Consideration should be given to the creation of a Ventilation Safety Group in each Trust in Northern Ireland.

10. The SHSCT requires urgent support and investment to address the issue of overcrowding. In particular, overcrowding in Emergency Departments continues to increase the risk of exposure and transmission of infection to patients in the Trust.

Recommendations for the Trust, Department of Health, HSC Board and Belfast Trust

11. The NI Regional Virus laboratory in BHSCT should provide whole genome sequencing (WGS) and interpretive support for all positive Covid-19 samples, as part of the investigation of suspected inpatient outbreaks.

3. Areas of concern/risk/challenge:

- The Trust is working to implement the recommendations arising from the Report as detailed in the attached action plan.
- Implementation of some recommendations is dependent on provision of regional approval and funding.

4. Impact: Provide details on the impact of the following and how. If this is N/A you should explain why this is an appropriate response.

Corporate Risk Register

Board Assurance Framework

Equality and Human Rights