Network Recording Declaration

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• This Data will be stored with password protection on the internet.
• This Data will be available for as long as your network continues to meet and will then be taken down from the internet and either stored securely at the Superhub or deleted.

Your ongoing participation in this ECHO session is assumed to imply your agreement to the use of your data in this way.

If you are NOT willing for your data to be used in this way, please LEAVE the session at this point.
Infection Prevention and Control
ECHO Network: Week 1

COVID-19, including lateral flow testing & risk assessments
## Agenda

<table>
<thead>
<tr>
<th>Item</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introductions</td>
<td></td>
</tr>
<tr>
<td>COVID-19 National picture</td>
<td>Dawn Hart, Senior Clinical and Quality Improvement Lead, Hospice UK</td>
</tr>
<tr>
<td>IPC management and COVID-19</td>
<td>Mandy Catchpole, Clinical Programme Lead for Mass Vaccination &amp; IPC, Sussex Commissioning Group</td>
</tr>
<tr>
<td>Case study: Managing a COVID-19 outbreak</td>
<td>Colin Twoney, Clinical Services Director, St Wilfrid’s Eastbourne</td>
</tr>
<tr>
<td>Case study: IPC risk management &amp; COVID-19</td>
<td>Heather McClelland, Chief Nurse, St Gemma’s Hospice</td>
</tr>
<tr>
<td>Summary, Evaluation &amp; Close</td>
<td></td>
</tr>
</tbody>
</table>
ECHO Session Evaluation

Help to shape the sessions

6 quick questions with additional comments welcome

3 minutes to complete

Link will be given in the Chatbox towards the end of the session.

www.hospiceuk.org
COVID-19 Update

Dawn Hart
Senior Clinical and Quality Improvement Lead
Hospice UK
COVID-19 Pandemic

THROUGHOUT HISTORY, as humans spread across the world, infectious diseases have been a constant companion. Even in this modern era, outbreaks are nearly constant.

Here are some of history’s most deadly pandemics, from the Antonine Plague to COVID-19.
COVID-19 World View

COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU)

Global Cases
109,229,002

Cases by Country/Region/Sovereignty
27,895,270 US
10,925,710 India
9,866,710 Brazil
4,059,696 United Kingdom
4,053,335 Russia
3,528,856 France
3,086,286 Spain
2,729,223 Italy
2,594,128 Turkey
2,348,681 Germany
2,198,549 Colombia
2,029,057 Argentina
1,995,892 Mexico
1,596,673 Poland

Global Deaths
2,410,175

US State Level Deaths, Recovered
47,119 deaths, recovered California US
46,000 deaths, 138,542 recovered New York US
41,336 deaths, 2,260,840 recovered Texas US
40,934 deaths, recovered Florida US
29,086 deaths, 776,339 recovered Pennsylvania US


www.hospiceuk.org
Coronavirus COVID-19 (2019-nCoV) (arcgis.com)
## COVID-19 National View

### Coronavirus in the UK

<table>
<thead>
<tr>
<th></th>
<th>Total deaths</th>
<th>Total cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Latest daily figure</strong></td>
<td>230</td>
<td>9,765</td>
</tr>
<tr>
<td><strong>Two-month trend</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **230 new deaths**
- **9,765 new cases**

### People in hospital*

<table>
<thead>
<tr>
<th>Change on day before</th>
<th>Two-month trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>-1,027</td>
<td></td>
</tr>
</tbody>
</table>

- **23,341**

### Total 1st vaccine doses given

- **15,300,151**

- **237,962 1st doses**

*Publication dates differ by nation, most recent data for all nations to 11 Feb
**Figures were weekly until 10 Jan
Source: Gov.uk dashboard

BBC NEWS
Coronavirus spread across the UK per 100,000 in the last seven days to 15 February 2021
Daily confirmed cases to 15 February 2021

Daily confirmed coronavirus cases by date reported

Targeted testing only

Wider testing available

Seven-day average: 12,580

Source: Gov.uk dashboard, updated to 15 Feb 09:00 GMT
Scotland data for COVID-19 hospital admissions to 12 February 2021

Trend data by NHS Board | Local Authority

What information would you like to see?
- Hospital admissions - Scotland only

Select location:
- Scotland

Hospital admissions by admission date in Scotland

Figures for the most recent dates are likely to be incomplete due to the time required to process tests and submit records.
Northern Ireland data for COVID-19 patients in hospital to 13 February 2021
England data for COVID-19 patients in hospital 12 December 2020 to 11 February 2021
Wales data for COVID-19 hospital admissions 1 January to 15 February 2021

NHS hospital admissions by date and patient type

Health and social care > NHS hospital activity > NHS activity and capacity during the coronavirus (COVID-19) pandemic > NHS hospital admissions by date and patient type

NHS hospital admissions by date and patient type (gov.wales)
COIVID-19 Guidance update

Published 10 January 2020
Last updated 21 January 2021

Addition of mental health appendix and title change for IPC guidance to 'Guidance for maintaining services within health and care settings.' Guidance amended to strengthen existing messaging and provide further clarity where needed, such as care pathways to recognise testing and exposure.

The 3 COVID-19 pathways, which remain as:

**High risk:** This includes patients/individuals who are confirmed COVID-19 positive by a SARS-CoV-2 PCR test or are symptomatic and suspected to have COVID-19 (awaiting result)

**Medium risk:** This includes patients/individuals who are waiting for their SARS-CoV-2 PCR test result and who have no symptoms of COVID-19 and individuals who are asymptomatic with COVID-19 contact/exposure identified

**Low risk:** This includes patients/individuals who have been triaged/tested (negative)/clinically assessed with no symptoms or known recent COVID-19 contact/exposure
IPC Highlights
Quick Reference Guide

The guidance includes examples of three care pathways that have been structured to enable organisations to separate COVID-19 risk at a local level and enable service restoration:

<table>
<thead>
<tr>
<th>Care Pathways</th>
<th>High-risk</th>
<th>Medium-risk</th>
<th>Low-risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any care facility where:</td>
<td></td>
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<tr>
<td></td>
<td>untriaged individuals present for assessment or treatment (symptoms unknown)</td>
<td>triaged/clinically assessed individuals are asymptomatic and are awaiting a SARS-CoV-2 (COVID-19) test result with no known recent COVID-19 contact</td>
<td>triaged/clinically assessed individuals with no symptoms or known recent COVID-19 contact who have isolated/shielded</td>
</tr>
<tr>
<td>OR</td>
<td>confirmed SARS-CoV-2 (COVID-19) positive individuals are cared for</td>
<td>testing is not required or feasible on asymptomatic individuals and infectious status is unknown</td>
<td>have a negative SARS-CoV-2 (COVID-19) test within 72 hours of treatment and, for planned admissions, have self-isolated from the test date</td>
</tr>
<tr>
<td>OR</td>
<td>symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who have been triaged/clinically assessed and are awaiting test results</td>
<td>asymptomatic individuals decline testing</td>
<td>individuals who have recovered from COVID-19 and have had at least 3 consecutive days without fever or respiratory symptoms and a negative COVID-19 test</td>
</tr>
<tr>
<td>OR</td>
<td>symptomatic individuals who decline testing</td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>patients or individuals are regularly tested (remain negative)</td>
<td></td>
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</tbody>
</table>

Main Changes on this update

- Sessional use of single use PPE/RPE items continues to be minimised and only applies to extended use of facemasks (all pathways) or FFP3 respirators (with eye/face protection) in the medium and high risk pathway for healthcare workers where AGPs are undertaken for COVID-19 cohorted patients/individuals.

- The use of facemasks for staff and patients (if tolerated) is required across all care pathways in the UK. This is in addition to social distancing and hand hygiene for staff, patients/individuals and visitors in both clinical and non-clinical areas to further reduce transmission risk.

- Physical distancing of 2 metres remains standard practice in all health and care settings (unless providing clinical or personal care, in which case PPE should be worn in line with the pathway requirements).

- Terminology change from ‘shielding’ to ‘clinically extremely vulnerable’ with the definitions highlighted in the glossary.

- Updates to care pathways to recognise testing/exposure.

COVID-19: infection prevention and control (IPC) - GOV.UK (www.gov.uk)
Useful Links

UK
COVID-19: infection prevention and control (IPC) - GOV.UK (www.gov.uk)

Scotland
HPS Website - COVID-19 compendium (scot.nhs.uk)

England
Coronavirus » Infection prevention and control (IPC) (england.nhs.uk)
COVID-19: guidance for health professionals - Public Health England

Wales
Information for Health and Social Care - Public Health Wales (nhs.wales)
Health and social care professionals: coronavirus | Sub-topic | GOV.WALES

Northern Ireland
Coronavirus (COVID-19) HSC service information and guidance - HSCB
Guidance for HSC staff, healthcare workers and care providers | HSC Public Health Agency
NEW: IPC Bulletin

Publication every 2 months
Alternate months to the IPC ECHO sessions

What sort of content?

Some thoughts:
• Latest IPC updates
• Content relevant to each of the 4 nations
• Journal articles
• Reminder of next ECHO date/topic
• Signposting
Infection Prevention and Control

Mandy Catchpole
Deputy Director of Quality & Infection Prevention
Clinical Lead Mass Vaccination programme
Objectives

- National guidance – Infection Prevention
- CQC IPC requirements
- Basic Infection prevention and control precautions
- Outbreak Management
- Environmental and equipment cleaning
- Key focus areas
- Early reopening of any outbreak
- Testing
Infection Prevention guidance

• Care Home or NHS Provider guidance


• Across Sussex ICS we have applied the following:

The IPC principles in this document apply to all health and care settings including acute, diagnostics, independent sector, mental health and learning disabilities, primary care, care homes, care at home, maternity and paediatrics (this list is not exhaustive).
Organisations and employers including NHS Trusts, NHS Boards, Health and Social Care Trusts (Northern Ireland), Local Authorities, Independent Sector providers, through their Chief Executive Officer (CEO) or equivalent must ensure:

- **Monitoring of IPC practices** to ensure that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).

- **Testing and self-isolation strategies** are in place with a local policy for the response if transmission rates of COVID-19 increase.

- **Training in IPC measures** are provided to all staff, including: the correct use of PPE (including a face fit check if wearing a filtering face piece (FFP3), respirator, and the correct technique for putting on and removing (donning/doffing) safely.

- **Risk assessment(s)** is undertaken for any staff members in at risk or clinically extremely vulnerable groups, including pregnant and Black, Asian and Minority Ethnic (BAME) staff.

- **Patients/individuals at high risk/extremely high risk of severe illness** are protected from COVID-19. This must include consideration of families and carers accompanying patients/individuals.

- **Health and care settings are COVID-19 secure workplaces** as far as practical.
What is an outbreak?

**Outbreak:** Two or more test-confirmed or clinically suspected cases of COVID-19 among individuals (for example patients, health care workers, other hospital staff and regular visitors, for example volunteers and chaplains) associated with a specific setting (for example bay, ward or shared space), where at least one case (if a patient) has been identified as having illness onset after 8 days of admission to hospital.


**Cluster:** Refers to the detection of unexpected, potentially linked cases. PHE notes that some cases and clusters of communicable disease may not require a formal outbreak to be declared. It is important that such cases are appropriately recorded and managed for audit purposes; to support surveillance and, any future outbreak management.

Basic Infection Control Principles

Standard precautions are used for all patients in all healthcare settings all of the time on the assumption that contact with blood, bodily fluids, secretions and excretions, non-intact skin and mucous membranes, along with contact with the healthcare environment, that may result in the transmission of infectious microorganisms. If standard precautions are applied appropriately there should be fewer opportunities for cross infection to occur.

Transmission-based precautions related to the isolation of the patient in conjunction with the application of standard precautions, but with increased emphasis on hand hygiene, and appropriate use of personal protective equipment. Transmission-based precautions may be specific to airborne, droplet, respiratory, contact or enteric precautions.

- **Contact**: COVID-19 can be spread via this route.
- **Droplet**: COVID-19 is predominantly spread via this route and the precautionary distance has been maintained at 2 metres in care settings.
- **Airborne**: COVID-19 can spread via this route when AGPs are undertaken.
Considerations when you have an outbreak or a cluster

- Assessment of the outbreak
  - Try and identify the index case and this may be in the current patients still in the care facility or might be a past patient.
  - Consider where these patients are located and how they were managed during their stay.
  - Who they had contact with whether they had symptoms and when the symptoms started or when they had a positive result to help you identify contacts.
- Maintaining Social distancing
- Isolation nursing
- Personal Protective Equipment
- Hand Hygiene
- Cleaning – environmental and equipment
- Waste Management
- Ventilation
- Reporting an outbreak – PHE/CQC
Cleaning

• Stringent application of standard precautions and enhanced cleaning to help support reducing the risk of cross infection.
• Enhanced environmental cleaning and the cleaning of patient equipment will be required.
• Where possible patient equipment should be allocated to the patient where this is not possible this equipment should be cleaned before and after every use on the patient.
• The cleaning of the environment should occur with a quaternary ammonium compound (QACs) or a chlorine-releasing product (1000 ppm available chlorine) on a daily basis.
• Increased frequency of cleaning for highly touched points is also recommended throughout a 24-hour period to support reducing environmental contamination.
Key focus areas

- **Alcohol hand rub** must be available at the point of care with a minimum 60% alcohol content.
- The purpose of isolation is to ask that it will **contain the organism** and its major transmission rather than the patient.
- By implemented **standard precautions** at all times and **transmission precautions** as appropriate will greatly reduce the risk of cross infection occurring.
- Dedicated clinical **hand wash basin** in the single rooms.
- **PPE** at the point of use must be available (sessional fluid repellent surgical masks, single use gloves, single use aprons, visor protection).
- **Equipment** should be dedicated to the patient and if not this must be cleaned before and after patient use.
- **All doors should remain closed** if the door must be kept open for the patient can be readily observed this not be documented in the nursing notes each shift and other mitigators implemented to reduce the risk of transmission i.e. no ventilation and bed away from door.
- **Enhance cleaning** because of the increased risk of environmental contamination including frequently touched points.
- Good **ventilation** to reduce viral load within the environment.
Early opening following an outbreak

- Sussex CCG Quality Team have developed a **checklist** and **risk assessment** process for the early reopening (before the national recommended 28 days by Public Health England) of care settings.
- The checklist forms part of the Provider risk assessment processes to support with the **decision-making** and **governance** processes.
- The **final decision** for reopening earlier than the recommended 28 days from the last positive case during a COVID 19 outbreak rests with the **Provider** as part of their requirements under the CQC registration.
- The checklist is to **support** providers and is not an exhaustive list as each outbreak varies on the impact to individual care settings and further considerations can be added by the care settings as needed.
- It is **not recommended** that care settings open earlier than **14 days** since the last positive COVID 19 case within the care setting (this includes both staff and residents)
## Risk assessment and checklist

### Infection Control Risk Assessment for Care facilities - Covid-19

(Version 2 - updated 25.01.2021)

**Date Completed:**
**Completed By:**

**Amendment to risk assessment:** Version 2 has been updated to include a front page on completing the risk assessment form and following review of the CQC webpage - which was updated on the 19.01.2021.

<table>
<thead>
<tr>
<th>Area of Risk –</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Are All Types Of Visitors Prevented From Catching And Spreading Infection?</td>
<td>National guidance and policies are in place to facilitate the safe movement of people (staff, visitors and patients/residents) within the care facility, with hand gel and masks available on entry, social distancing is followed. LFD/PCR routine testing for our staff and residents is in place and LFD testing for general visitors and visiting professionals who are not part of routine LFD testing via their employing organisation. Visiting of residents/patients followed in line with compassion i.e. end of life as per guidance given Tier and government restrictions. There are processes in place where visitors are asked about symptoms and have a temperature check before entry to the care facility. Information to visitors is available on website or when calling about any restrictions and practices that need to be followed.</td>
</tr>
</tbody>
</table>

**Examples**

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<table>
<thead>
<tr>
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<th></th>
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<tbody>
<tr>
<td></td>
<td>If care requires more than one staff member then the appropriate PPE is worn to prevent PPE breeches, and hand hygiene facilities are available at point of care and throughout the facility. Where individuals walk with purpose measures are in place to support the individual with social distancing, hand hygiene and mask wearing where appropriate and the risk they may pose to others. in office environments COVID secure (HSE) risk assessments have been completed and mitigators such as staff wearing masks, limiting the number of staff in the office to support social distancing, cleaning products are available for cleaning equipment and desks.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsible Person</th>
<th>Target/review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care manager</td>
<td>01/01/1</td>
</tr>
</tbody>
</table>

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*Working in partnership across Sussex*
Testing

- COVID-19 tests that detect different parts of the virus or immune response provide different clinical information that often overlaps:
  - **PCR** (nucleic acid tests) **tests** indicate whether an individual has or recently had infectious virus. The majority of those with positive PCR results are infectious but the virus can persist in some individuals for many weeks and therefore a repeat test is not recommended in someone whose symptoms have resolved.
  - Coronavirus virus Protein **antigen tests** (e.g. Lateral flow devices LFD) indicate whether a person has the virus now and is likely to be infectious to others.
    - Sensitivity to these tests is approx. 70%.
    - LFDs detect approx. 95% of all cases with high viral loads.
  - Coronavirus **antibodies** (proteins produced in response to the infection) are conducted via a blood sample. The indicate if someone has had the virus before.
  - Immunocompetent staff, patients and residents who have tested positive for COVID 19 by PCR should be **exempt** from routine testing by PCR or LFD within 90 days from their initial illness onset or test (if asymptomatic) unless they develop new COVID 19 symptoms.
    - Fragments of inactive virus can be persistently detected by PCR in respiratory tract samples following infection long after a person has completed their isolation period and is no longer infectious.
Testing in practice (Sussex local approach)

- **Patient**
  - PCR testing on admission
  - Weekly whole unit PCR testing for green patients (no previous PCR positive test within 90 days)
- **Staff**
  - Twice weekly Lateral flow device tests (ideally undertaken prior to arrival at work)
  - PCR test if lateral flow positive result – staff member to refrain from work and self isolate until result is known
  - Weekly routine PCR positive
- **Visitor**
  - Lateral flow device test prior to visit
  - Separate area to be designated
  - PPE/Hand hygiene
- Local consideration based on risk assessment for EOLC patients

Useful guidance

- Health and Social Care Act 2008 – Infection Prevention and Control
- CQC Key lines of enquiry
  [https://www.cqc.org.uk/sites/default/files/20180628%20Healthcare%20services%20KLOEs%20prompts%20and%20characteristics%20showing%20changes%20FINAL.pdf](https://www.cqc.org.uk/sites/default/files/20180628%20Healthcare%20services%20KLOEs%20prompts%20and%20characteristics%20showing%20changes%20FINAL.pdf)
- CQC IPC questions for care homes as these are generic and helpful for supporting all care services
- Waste
- Environmental Cleaning
- Testing
- Sussex ICS early reopening risk assessment and checklist

![PDF File](https://example.com/pdf1.pdf)
![PDF File](https://example.com/pdf2.pdf)
Learning from an outbreak

The experience of St Wilfrid's Hospice
The environment
How the outbreak unfolded

- 4.1.21 – commenced regular staff testing
- 5.1.21 – 2 IPU staff positive
- 7.1.21 – 1\textsuperscript{st} patient tested positive
- 8.1.21 – outbreak declared
- 11.1.21 – hospice invoked major incident policy and procedure
After declaration of outbreak

- All patients swabbed then negative patients swabbed day 4 – 7
- All IPU staff daily LFD testing for 1 week
- Daily visitor LFD swabbing
- 16.1.21 – 4 patients tested positive
- 23.1.21 – 8th (and final) patient tested positive
- By 25.1.21 – 50 staff positive (6 Volunteers)
Outbreak management

- Outbreak Management Group (Clinical Services Director, Head of Quality Improvement, Head of IPU, Facilities and Estates Lead)
- HR Team
- Pandemic Planning Group
- Investigation
- Communication: hospice workforce and Trustees, patients and visitors, Health Protection Team, CCG, media
- 7 day senior nursing presence
- Involvement of CCG Infection Prevention and Control Team was critical
Structure of Investigation
Workforce and staffing

- Remained open and staffed with no agency use
- Fear, anxiety, guilt, failure
- Fatigue
- Mental health and wellbeing
- Separate IPU and other teams (sense of isolation)
- Increased staff remote working including community team
Outcome of investigation

- No clear cause of transmission
- Staff mixing
- Some PPE practices
- Ventilation
Some key messages

• Early contact with CCG IPCT crucial
• Contact with other hospices helpful both to gain their learning but also for peer support
• Agree the structure of the investigation
• Senior presence and regular verbal updates
• Update CQC
• Communication across teams including Trustees
Colin Twomey Clinical Services Director
colin.twomey@stwhospice.org

stwhospice.org
01323 434200
hospice@stwhospice.org
Managing the IPC Risks in a Pandemic

Heather McClelland – Chief Nurse
Putting Things in Context

- St Gemma’s Hospice
  - Clinical Services
  - Academic Unit of Palliative Care
  - Support Services & Income Generation

- Mock Inspection

- 2020 – International Year of IPC?

- High Burden of Risk
Risk Management as a Team Effort

- Internal pandemic response
  - Senior Leadership Team
  - Communications
  - Clinical & Non-Clinical Groups

- Identifying Risks
  - All departments equal
  - Risk Assessments & Action Plans

- Early Decision-Making

- City-wide & Regional Impact

‘Be Fast..... Have No Regrets’

‘The Virus will always get you If You don’t move quickly’

‘Perfection is the Enemy of Good.....Speed Trumps Perfection’
What did we do?

Aims

- Protect Patients
- Protect Staff
- Protect Services

- PPE – sourcing, training, updating
- Secure environment – non-essential activity, remote working, social distancing, visiting
- Communication – internal & external
- Risk Assessments – departmental and individual
- Testing and Vaccinations
Outcomes & Reflections

Our Successes
- Access to services
- Caring for Covid +ve and AGP patients
- PPE Supply
- City-wide relationships
- Visiting continued throughout
- Leadership model
- Educational offer

Reflections
- Be courageous, act early
- Work together
- Outbreaks unavoidable?
- Early risk assessments
- Ask for help.
- Take the learning – IPC, pandemic planning
- Support the team
Close of ECHO session

Next ECHO:
13 April, 13:00 – 14:30