

# SUMMARY OF FINDINGS

## HOSPITAL SPOT CHECK INSPECTIONS – COVID-19

### Background

HSE inspected 17 acute hospitals, in 13 NHS Trusts in England and 2 NHS Health Boards in Scotland and Wales respectively as part of the national HSE COVID–19 spot check inspection programme. The inspections were led by an HSE Occupational Health Inspector and were carried out between December 2020 and January 2021. Each one focused on 7 key areas to assess the arrangements in place to manage risk arising from COVID-19, but where other matters of evident health and safety concern were identified they were also dealt with.

### Executive summary

#### Overview

The NHS Trusts and Boards had all invested significant time and effort to implement a variety of COVID control measures in the hospitals inspected.

We saw a range of compliance both in terms of comparing the hospitals with each other but also within individual hospitals. Five were highly compliant; four were given advice and 8 required letters to be sent formally requiring remedial action to be taken. The contraventions of health and safety law included in the letters were:

Risk Assessment	Management arrangements Specific to COVID	Social Distancing	Cleaning and hygiene measures	Ventilation	Dealing with suspected cases	PPE
8	6	8	6	5	0	5

A detailed summary is provided in Annex 1 setting out examples of where we saw good practice and where remedial action was required. The common themes were:

#### Leadership

- Higher levels of compliance were seen where the leadership team were visible to staff on the front line and the Infection Prevention and Control (IPC) leads worked alongside health and safety teams.
- Lower levels of compliance were generally found where there were limited or no monitoring arrangements in place to ensure the control measures identified in the risk assessments were implemented and/or maintained.

#### Clinical and Non-clinical areas

- Higher levels of compliance were seen in patient facing clinical areas across most of the 7 areas inspected.
- Lower levels of compliance were frequently found in in non-clinical areas, even when adjacent to clinical areas. Reasonably practicable control measures were often available but not utilised in a variety of locations.
- Arrangements for staff who are displaying COVID -19 symptoms were well established.

Matters of evident concern unrelated to COVID are detailed in Annex 2.

## Recommended action:

We strongly recommend NHS Trusts and Boards review the detailed findings of the inspections in Annex 1 and take the following action to reassure themselves that adequate COVID control measures are in place and remain so during the pandemic:

1. Review their risk management arrangements to ensure they are adequately resourced.
2. Consider how well the various parts of the risk management system coordinate with each other, including the health and safety team, departmental managers, infection control and occupational health colleagues and whether they could be improved.
3. Ensure compliance with their legal obligations to consult with trade unions and employee representatives by ensuring they are engaged in the risk assessment process. Worker engagement in this process is critical to establishing workable control measures.
4. Review all non-patient facing areas to ensure a suitable and sufficient risk assessment has been carried out and the control measures identified have been implemented – in line with relevant guidance, including - [Making your workplace COVID-secure during the coronavirus pandemic \(hse.gov.uk\)](https://www.hse.gov.uk/covid-secure/). Consider how well the risk assessments for these areas have applied the hierarchy of control and have they:
  - Identified the maximum room occupancy numbers and the optimum layout and seating arrangements in all areas? For example, in libraries, the laundry, porters lodge, clinical records, rest rooms, toilets, locker rooms, post rooms, changing rooms, offices, canteens, training rooms, doctors' common rooms
  - Considered how ventilation could be improved in all areas? Could windows be unsealed to open, are doors left open, how are rooms with no windows or air conditioning being ventilated?
  - Implemented mitigating measures where it is not possible to maintain social 2m distancing? For example, by providing physical barriers (screens), one-way systems or rearranging /modifying layout.
  - Checked the adequacy of their cleaning regimes in non-clinical areas? Have they consistently considered high touch surfaces, for example printers, vending machines, kettles, photocopiers, door handles etc?
5. Review the provision of lockers and welfare facilities to ensure they can accommodate the number staff on shift in a COVID secure manner.
6. Establish routine monitoring and supervision arrangements to ensure control measures identified in the risk assessment are implemented and are being maintained.
7. Review your arrangements regularly to ensure they remain valid and act on any findings.

**24 February 2021**

# Annex 1

## INSPECTION FINDINGS

This is the detailed summary of the 17 hospital inspections undertaken. It is broken down in to the 7 key areas that were covered in order to assess the arrangements in place to manage risk arising from COVID -19.

### **1.Management Arrangements**

#### **Examples of good practice:**

- High level leadership provided during the pandemic with establishment of Gold and Silver commands, frequent leadership meetings and briefings provided to staff through a variety of routes including webinars, blogs and social media.
- Board and senior leadership team engaged with staff on the front line thanking them for their hard work and listening to issues they may want to raise.
- Incident command center - staffed 24/7 by senior management.
- Strong links between infection control, health and safety and occupation health.
- Procedures in place for concerns to be raised.
- Departmental managers had access to expert support provided by health and safety team with NEBOSH professional qualifications.
- IPC Board Assurance Framework used to monitor progress and identify risks
- Trade Unions (TUs) engaged and actively encouraged to attend Health, Safety & Environmental committee chaired by head of Occupational Health.

#### **Examples where improvement was required:**

- Monitoring arrangements were not in place to ensure policies and procedures were read and were followed.
- Compliance with risk assessment control measures were not being audited resulting in the non-compliance issues contained in this report.
- Staff behaviour was not being challenged when non-compliance was seen by managerial staff.
- Departmental managers were not aware of their responsibilities for monitoring and maintaining COVID controls.
- Poor consultation with recognised Trade Union Safety Representatives and/or employee representatives during the completion of COVID related risk assessments.
- Sharing of good practice did not occur indicating lack of coordination within the system.

### **2.Risk assessment**

#### **Examples of good practice:**

- Those carrying out risk assessments had been provided with appropriate risk assessment training and were supported by the health and safety team.
- Risk assessments were updated and reviewed by the Health and Safety Committee and Risk Management Committee comprising both senior leaders and frontline staff.
- Risk assessments disseminated to work force via multiple routes - local managers, through intranet/email systems and notice boards.

### **Examples where improvement was required:**

- Risk assessments were not carried out for all areas and did not assess all the issues required, for example ventilation requirements and maximum occupancy were often omitted.
- Risk assessments not being reviewed after; lockdowns, events, such as outbreaks, when guidance changed, or when areas were repurposed e.g. from offices to rest areas.
- Staff had not received training to carry out risk assessments.
- Not all staff had access to the risk assessments, for example some hospitals used their intranet but not all staff have access to computers or were computer literate; there was a reliance on verbal cascade and colleague to colleague communication where English is not the first language.

### **3. Personal Protective Equipment (PPE)**

#### **Examples of good practice:**

- Fit testing of close fitting FFP3 respirators was being carried out by in house trained fit testers or by contractors at all sites inspected.
- Non-clinical workers required to work in red-zones were fit tested, for example, domestics, engineers and chaplains.
- PPE stocks were in good supply, with a variety of respirators available.
- Staff entering red zones checked to ensure respiratory protective equipment (RPE) fit testing record was available for the respirator being worn.
- RPE/PPE Co-Ordinator nominated to monitor usage and stock levels.
- Staff received training in changing cartridges, decontaminating and storing their reusable RPE, and donning and doffing procedures.
- Separate donning and doffing areas were created, whilst maintaining one-way systems with adequate storage accommodation for reusable RPE.
- Contingency planning in place, for example the NHS Trust Alliance in the North West allows sourcing and swapping of PPE/RPE if needed.
- Daily monitoring of wearing of PPE.
- PPE panel were meeting twice a week to discuss stock levels and consider other PPE for introduction or replacement of items no longer available.

#### **Examples where improvement was required:**

- Records were not readily available to ensure the worker was provided with the correct respirator they had been fitted for. Face-fit information was not stored centrally on the person's personal file.
- A buddy/mirror was not always available to ensure a fit check was carried out correctly.
- Records were not readily available at the time of the inspection to demonstrate that additional training had been provided in addition to the suppliers' introductory session on using the PortaCount machine used for face-fit testing.
- Whilst pre-use checks were being carried out reusable RPE was not always being checked at suitable intervals to ensure that defective equipment was not being used.
- Reusable RPE was not always labelled with the individual's name and not stored in an appropriate manner e.g. seen to be stacked on top of one another in a variety of settings.
- RPE was not always located close to the place of use.

- Alternative FFP3 respirators being used without additional face fit testing, where it had not been clearly established from the PPE supplier or manufacturer that the respirators were compatible and could be used without a further face fit test.

#### **4.Social Distancing:**

##### **Variety of areas across the hospital**

##### **Examples of good practice:**

- One-way systems introduced with linear marking on the floor and signage on walls.
- Separate entrances/exits for staff and patients in wards where possible.
- Plastic curtains in wards between beds, instead of fabric curtains to allow easy cleaning and disposal.
- Hand sanitiser at all entrances/exits for staff visitors, and outpatients.
- Staff member stationed at entrances to hand out masks, ensure hand gel was used, control numbers entering and provide directions.

##### **Examples where improvement was required:**

##### **Surgical masks:**

- Surgical masks were being worn as a control measure in lieu of social distancing arrangements, contrary to [IPC guidance](#) that states ' Physical distancing of 2 metres is considered standard practice in all health and care settings, unless providing clinical or personal care and wearing appropriate PPE'.
- Some workers assumed if they were wearing surgical masks they did not need to be socially distanced from their colleagues. For example, staff were seen walking and chatting along corridors within close proximity to each other.

##### **Changing areas/locker rooms/toilets (clinical and non-clinical staff)**

- Maximum occupancy numbers and systems for maintaining social distancing not displayed on entry.
- Where maximum occupancy was identified no arrangements were in place to ensure compliance was possible. For example, no information was available to explain how to achieve the stated maximum occupancy of 10 for a changing/locker room when 120 workers were on duty.
- Sinks adjacent to each other had not been taken out of use/taped over and/or perspex screens provided to ensure separation.
- Floor markings were not provided to identify social distancing, for example to signpost foot traffic through a large changing facility.
- Congestion caused by staff having to queue in the corridor and requiring colleagues to pass by in a narrow corridor space.
- Storage of personal clothing outside of lockers indicating insufficient number of lockers available.
- Changing facilities and lockers not close to the place of work.

##### **Rest areas/common rooms/doctor's mess/pathology**

- Many were multi-purpose, used for breaks, eating, locker storage and working, with inadequate social distancing. For example, a workstation was being used whilst others were eating within 1m.
- Maximum occupancy numbers not being provided.

- Where maximum occupancy numbers provided the number of seats exceeded the limit allowed. On one occasion the maximum was 5 but 14 chairs were available and were positioned close together.
- Tables too small to allow 2m separation e.g. 4 workers were sat around a 1m diameter table facing each other.
- Areas repurposed for rest facilities but were too small to allow social distancing, which was compounded by lack of ventilation.
- Employees seen not social distancing on several occasions including eating within 1m of each other; 15 members of staff sitting in close proximity to each other, and 5 staff sitting at a table for 2.
- Areas were too small to accommodate the number of staff needing to use them at any one time.

### **Specific to the education department:**

#### **Examples of good practice:**

- Virtual training was undertaken where practicable.
- Videos produced to minimise classroom time.
- Seats arranged on a marked floor to ensure separation.
- Rooms ventilated before and after use and at break times.
- Maximum occupancy sign in place.

#### **Examples where improvement was required:**

- Chairs closer than 2m as they had been moved from marked position.
- Chairs arranged close together and side by side.

### **Specific to Offices (including in clinical areas)/post rooms/medical records**

#### **Examples of good practice:**

- Rotas introduced to minimise staff attendance when working from home is not an option.
- Screens provided at receptions to provide separation between patients and staff and in some offices to provide separation between desks.
- Layouts redesigned to avoid face to face working by staggering workstations.

#### **Examples where improvement was required:**

- Maximum occupancy was not known or communicated.
- Maximum occupancy identified but the room was too small to accommodate the numbers.
- Occupancy exceeded at busy times due to lack of sufficient computers/workstations on a ward.
- Desks and workstations were not organised to ensure social distancing. For example, excess seating and chairs were not removed, workers sat side by side or opposite facing each other when additional space was available (in one case 3 computer desks were side by side),
- Screens were not provided where reasonably practicable to do so.
- Screens were not provided despite being required in the risk assessment. For example: failure to provide a screen to separate officer workers from employees accessing the printer.

- Redesigning tasks not considered. For example: a drop off point for post could have been introduced, reducing the need for the worker to enter a small work area; in the reception area in a medical records library the receptionist was handing records through an open sliding window when an alternative method of transfer was possible that would avoid handing records between people.

### **Specific to Canteens/kitchens**

#### **Examples where improvement was required:**

- Failing to supervise controls. For example: staff repositioned tables and chairs for socialising and breaking social distancing controls.
- Failing to address and manage busy times with congestion and breakdown of social distancing measures.
- No mitigation measures in food preparation areas where sinks were provided side by side. For example: no separation screens provided; or adjacent sinks not taped over to indicate they had been taken out of use.

### **Specific to Facilities/engineers/domestics/laundry/library**

#### **Examples of good practice:**

- Plastic screens provided to separate workstations in engineering
- Good social distancing in place in porters lodge i.e. maximum occupancy identified and allocated seats marked out.
- Estates workshop benches socially distanced and with staff being allocated their own workstation.
- Facilities staff deliver to 'ultra-green' wards via lift to avoid the need to enter in person.
- Lunch breaks and shifts staggered in the engineering/domestic department to reduce traffic flow through the building and numbers using the changing and toilet facilities at any one time.

#### **Examples where improvement was required:**

- Poor furniture layout reducing the ability to social distance.
- Reliance on surgical masks where it was reasonably practicable to provide screens at some fixed workstations. For example: 5 employees working around a conveyor belt in the laundry 'classification' area when it was reasonably practicable to stagger them and provide separation screens.
- Floor markings not used to indicate direction of travel and separation distances. For example, walkways in the main library.
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### **Specific to corridors and open waiting areas /lifts**

#### **Examples of good practice:**

- Seats in waiting areas taped over to manage separation and overflow arrangement in place to avoid over-crowding.
- Informative safety posters and directional floor signs provided.
- Wardens deployed to monitor numbers and ensure face masks/coverings were being worn.
- Portacabins provided to increase waiting area capacity.

#### **Examples where improvement was required:**

- In staff only areas a walk on the left side was policy introduced but with no marking or signage and lack of supervision it was not being adhered to.
- Signage not provided in a lift to communicate maximum occupancy.

## **5. Hygiene and cleaning regimes**

### **Examples of good practice:**

- Additional cleaning machines purchased to remove the need for transfer between departments /wards.
- Dedicated cleaning teams provided to individual wards.
- Deep clean teams provided and overseen by IPC team.
- Clear instructions of what is cleaned by the cleaning team and nurses respectively
- Enhanced cleaning in education and libraries with laminated 'action' cards provided to explain cleaning system.
- Instructions for cleaning arrangements of frequent touch points or multi-user equipment clear and monitored to ensure implemented
- Internal hygiene audits carried out to assess compliance.
- Toolbox talks provided twice monthly and safety bulletins to remind staff of IPC procedures and update on changes.
- Cleaning supervisor monitors cleaning daily and in turn this was monitored by a manager.
- Laminated cards used to identify areas that had been used and required cleaning.

### **Examples where improvement was required:**

- Cleaning schedules were not comprehensive, leading to areas being missed. For example, they did not always include rest rooms, porters lodge, staff toilets, changing rooms, doctor's mess, medical records and libraries. In those areas high touch points were not being cleaned in between use, for example telephones, printers, computers, photocopiers, vending machines, kettles, microwaves, equipment in engineering workshops.
- Local instructions for cleaning not available at point of use.
- Cleaning material not available for local point of use cleaning.
- Cleaning after use not occurring despite suitable wipes being provided.
- Insufficient monitoring being carried out to ensure high touch points were cleaned regularly.

### **Specific to canteens:**

- Limited information on cleaning regime for those using the facility.
- Lack of supervision and monitoring. This resulted in tables not being routinely cleaned between use by cleaning staff or those eating at the tables, despite a card system being in place to identify used tables.
- Cleaning material not always available.
- Single wipe being used for multiple tables.
- Surgical masks being placed on tables.



## **6. Ventilation**

### **Examples of good practice:**

- Maxillofacial department in the outpatient's department engaged a competent ventilation contractor to assess air changes in each treatment room. They then implemented a system to ensure those rooms with greatest number of air changes were used for AGPs as their clearance time was shorter.
- Modifications carried out to ventilation system to increase air flow in theatres and ICU.
- Ventilation was checked regularly including velocity, dilution, and dwell times.
- Site wide survey of all mechanically ventilated wards and to identify any issues and rebalance the ventilation system.
- Implemented a schedule of cleaning and maintenance of all mechanical ventilation systems.
- Management regularly communicated to their teams about the need to open windows to introduce fresh air into areas without mechanical ventilation.

### **Examples where improvement was required:**

- Ventilation was not considered when the risk assessment was carried out.
- A room was repurposed as a rest facility but there were no windows or other means of ventilation provided.
- In non-clinical areas rooms were identified with no forced/mechanical ventilation and the windows were secured shut and the risk assessment did not consider whether the windows could have been unsealed to allow opening for ventilation where this was a possibility.
- In areas where AGPs were carried out the clearance time was not available.
- Not all opportunities to open doors and windows were being taken.

## **7. Dealing with Suspected Cases**

- Arrangements for staff who are displaying COVID -19 symptoms were well established.

## **Annex 2**

### **Other health and safety issues requiring enforcement action**

#### **Improvement Notice**

##### **Machinery guarding**

Engineering machinery such as lathes and pillar drills in a workshop were not adequately guarded to prevent access to dangerous parts that could cause injury.

#### **Letters of contravention**

##### **Transport**

Workers were not walking in the designated pedestrian walkways and using designated crossing points exposing them to the risk of being injured by a moving vehicle. Consideration of improving the precautions was required along with additional monitoring and supervision arrangements to manage the on-going risk.

##### **Risk of falling from windows**

A window opened for ventilation purposes in a non-clinical room was not provided with a restraint to prevent a person inadvertently falling through the opening.

##### **Provision of changing facilities**

Changing facilities were not provided for workers in a "Red" ICU. Workers were required to change at work into their scrubs. The only facilities available were two small toilets near to the Manager's office. In addition, they were not provided with suitable storage for their personal clothing so they stored them in bags and stacked them in an adjacent room as lockers were not provided.

##### **Machinery guarding**

A horizontal sawing machine located in a workshop was not adequately guarded. The machine was immediately taken out of service and electrically isolated in order to be decommissioned.

A hired waste compactor was in operation in a publicly accessible area with an unlocked entry panel; this meant that there was direct access to the compaction chamber, which could result in serious injury or death if the machine was operated. Immediate action was taken to secure the access door.

Note: as immediate action was taken to repair these machines or remove them from further use the issuing of enforcement notices was not considered necessary. If the matters had not been resolved immediately enforcement notices would have been served.

##### **Thorough examination and testing of local exhaust ventilation (LEV)**

The local exhaust ventilation systems (LEV) provided to reduce substances hazardous to health, namely, exposure to wood dust and welding fume in the workshops, did not have the legally required current record of thoroughly examination and test.