Mass Vaccination Centres Focused Inspections (Unannounced)

Ysbyty Enfys Bangor, Bangor

Ysbyty Enfys Glannau Dyfrdwy, Deeside

Betsi Cadwaladr University Health Board

Inspection date: 11 – 12 March 2021

Publication date: 27 May 2021

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-80195-448-8

Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice
Influence policy and standards:	Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed focused inspections of two mass vaccination centres within Betsi Cadwaladr University Health Board on 11 March 2021 and 12 March 2021. The following centres were visited:

- Ysbyty Enfys Bangor, Ffriddoedd Road, Bangor LL57 2EH
- Ysbyty Enfys Glannau Dyfrdwy, Chester Rd W, Queensferry, Deeside CH5 1SA

Our team, for the focused inspections comprised of two HIW Healthcare Inspectors and one clinical peer reviewer.

HIW explored how the services met the Health and Care Standards (2015).

Further details about how we conduct mass vaccination centre focused inspections can be found in Section 5.

2. Summary of our focused inspections

It was evident that a significant amount of work had been undertaken at pace by the health board to provide temporary environments and sufficient resources to deliver their mass vaccination programme. We found clear management structures in place to oversee the safe implementation of the programme.

We were assured that appropriate arrangements had been established for each stage of the vaccination process, and that safe care was being provided to patients.

An excellent range of infection prevention and control measures were in operation to help reduce the risk of infection and keep patients and staff safe.

Patients that completed the HIW survey provided very positive feedback of their experiences at the centres.

This is what we found the service did well:

- Volunteers and clinical staff spoke to patients in a friendly and respectful manner
- Patients were being assessed for symptoms of COVID-19 before being allowed to enter the centres
- Patients felt that they were able to maintain their dignity, privacy and modesty during their appointment
- Patients received appropriate assessments and sufficient information prior to receiving their vaccination
- Suitable arrangements were in place for the safe management of the COVID-19 vaccines
- An effective system was in place for the timely preparation and administration of the vaccination
- Vaccinators had completed the relevant training requirements to competently provide vaccinations to patients

- Daily checks were being undertaken on the emergency resuscitation equipment to ensure they remained in date and safe to use
- Staff felt supported by senior staff.

This is what we recommend the service could improve:

- Waiting times for patients should be monitored to ensure they are kept to a minimum wherever possible
- Communication on staff rotas should be more timely and transparent.

3. What we found

Background of the service

In response to the COVID-19 pandemic, the health board has worked at pace to plan and deliver a mass vaccination programme across the region to the priority groups set out by the Welsh Government.

Temporary 'rainbow'[1] field hospitals were set up at Deeside Leisure Centre in Flintshire, Venue Cymru in Llandudno and a university sports centre in Bangor last year to protect the main district hospitals from being overwhelmed during the pandemic. These three sites were repurposed as mass vaccination centres and have been operational from January 2021.

The mass vaccination centres were part of a number of delivery models developed by the health board for administering vaccinations, sitting alongside the use of GP surgeries and local vaccination centres. Around the time of the focused inspections, approximately 271,000 vaccinations had been administered in North Wales. Both centres we visited were administering second doses of the Pfizer-BioNTech vaccine to patients.

[1] The three temporary hospitals set up across North Wales were renamed after the rainbow symbol of hope, which become synonymous with the response to the outbreak of COVID-19.

Quality of patient experience

We invited service users to complete a survey on their experiences, to ensure that the service users' perspective is at the centre of our approach to inspection. We looked at whether patients were being treated with dignity and respect, and received timely and accessible information.

We invited patients that have received their vaccination at mass vaccination centres to complete an online survey about their experiences. The survey was promoted by posters at the centres we visited and through HIW's social media channels. A total of 156 surveys were completed by patients within Betsi Cadwaladr University Health Board.

Overall, patient feedback was very positive, with almost all respondents stating their experience was excellent. Respondents told us that they had received clear communication from the health board prior to their appointment.

Almost all respondents agreed that infection control measures were followed well where appropriate, for example social distancing, use of hand sanitisers and use of face masks. Furthermore, all respondents said that the centres were clean and tidy.

Dignified care

During our focused inspections we saw the flow of patients throughout the day was efficient and timely. However, some patients who completed the HIW survey told us that they experienced long delays before receiving their vaccination during the first couple of days of the centres being open. Furthermore, almost a half of respondents said they had to wait over 30 minutes before being seen. The health board must monitor the waiting times to ensure they are kept to a minimum wherever possible.

We noted that patients were required to stand in a short queue before being escorted to their vaccination station. In light of the patient feedback about potential delays, the health board may wish to consider providing chairs for patients who may need them during busier times.

We observed volunteers and clinical staff speaking to patients in a friendly and respectful manner at all times during both of our focused inspections.

The vaccination areas at both centres utilised the infrastructure installed for their previous purpose as a field hospital. Each vaccination station was located

in the spaces allocated for a hospital bed, which meant the stations were well spaced out. Privacy screens were also available to provide privacy to patients and protect their confidentiality. The majority of patients who completed the HIW survey told us they felt able to maintain their dignity, privacy and modesty during their appointment.

Improvement needed

The health board must monitor the waiting times for patients at each mass vaccination centre and ensure they are kept to a minimum wherever possible.

Patient information

We saw that patients were being kept informed by staff about what to do at each stage of their journey through the centres we visited.

We saw that easy read versions of key information was available, and were told that translation services could be accessed, should patients need to communicate in a language other than English or Welsh. We saw that patients were arriving with a card that had recorded the name and date of their first vaccine. We were told that patients are provided with information leaflets following their first vaccination that informs patients on possible side effects and on when to seek help.

All patients that completed the HIW survey said that they were happy with the way things were explained to them during their appointment and that they were given aftercare advice on what to do should they have an adverse reaction.

Delivery of safe and effective care

We considered the extent to which the centres provide high quality, safe and reliable care centred on individual patients.

Safe care

Managing risk and promoting health and safety

It was clear to see that a great deal of planning and preparation had been invested into the transformation of the two centres we visited. We were provided with environmental and fire risk assessments that had been undertaken on the mass vaccination centres across the health board to help ensure the sites were safe and fit for purpose. We saw that evacuation plans were in place in both centres we visited, and staff that we spoke to knew who the designated fire marshals were for that shift, and knew what to do in the event of an emergency.

Each centre we visited had staff situated outside the venue to keep the site secure. We observed staff cross referencing visitors against a list of appointments for that day to ensure only authorised people could enter the centres.

We found that both centres we visited allowed for safe social distancing, and that clear one-way systems were in operation for patients and staff to navigate throughout the venues. The vaccination areas were light, spacious and clean.

Infection prevention and control

We saw an excellent range of infection prevention and control (IPC) measures in place at both centres we visited to help reduce the risk of infection and keep patients and staff safe.

Staff at the entrances were assessing patients for symptoms of COVID-19 before allowing entry. Patients were also reminded of the requirement to wear a mask unless they were exempt to do so. Bottles of hand sanitiser were available at the entrances and at various places throughout the centres to encourage good hand hygiene.

We observed clinical staff wearing masks and sanitising their hands in between patients. A number of hand washing facilities for staff were available within the vaccination areas. Clinical staff cleaned their vaccination station and chairs

between every patient, and we saw staff wiping down chairs after patients left the waiting areas.

We saw that regular IPC checks were being undertaken to monitor compliance. We were told that work was being undertaken to further improve the IPC checklists to ensure they were tailored to the mass vaccination centre environment. A UV light box[2] was available in Bangor to highlight any hand hygiene issues which we noted as good practice.

We were told that all clinical staff must have completed IPC training before beginning their role as a vaccinator at any of the mass vaccination centres across the heath board.

Medicines management

We were provided with the Patient Group Direction for the administration of the Pfizer-BioNTech COVID-19 Vaccine document which provided the guidance and framework to ensure the health board meets the regulatory and legislative requirements governing the use of the vaccine. This was supported by a range of other standard operating procedures around delivery, storage, preparation and disposal.

We found suitable arrangements in place at each centre we visited for the safe management of the COVID-19 vaccines. Vaccines were being stored appropriately in locked fridges in a separate room. Temperature readings of each fridge were being recorded by staff and uploaded onto the electronic Welsh Immunisation System (WIS) for pharmacy colleagues to monitor.

Clinical staff would collect a new vial and record the relevant details of the vaccine and diluent (manufacturer, batch number and expiry date) on a vaccine tracking form, along with the time of reconstitution. These details were then passed onto administration staff to record onto WIS while patients were being vaccinated. We noted that this system seemed to be working well at both centres.

[2] A UV Light Box highlights defects with hand washing and scrubbing techniques to raise awareness of potential hand hygiene issues.

Medical devices, equipment and diagnostic systems

We saw that emergency resuscitation equipment and adrenaline[3] was available within each centre to provide immediate treatment in the event of an anaphylactic reaction[4] or cardiac arrest following a vaccination. All clinical staff had received training in basic life support, and senior clinical members of staff had received training in intermediate life support. We were told that a member of staff trained in intermediate life support was available on every shift, and that staff would only perform skills and use equipment that fell within their abilities in the event of an emergency. Daily checks were being undertaken on the equipment to ensure they remained in date and safe to use.

Effective care

Safe and clinically effective care

Our clinical peer reviewer obtained permission from some patients and staff to observe the care provided to patients at the vaccination station. We were assured at both centres we visited that patients received appropriate assessments to ensure they were suitable for the vaccination and that patients were provided with the right information to give informed consent prior to receiving their vaccination.

We saw resuscitation areas had been set up in both centres we visited to provide treatment and privacy to patients feeling unwell. Multiple trolleys were available to ensure patients could be moved away from the waiting area. Adrenaline was available within each vaccination station in order for it to be administered quickly in an emergency.

Record keeping

In both centres we visited we saw that administration staff were responsible for electronically recording details onto the Welsh Immunisation System about

[3] Adrenaline is a medicine used for the treatment of serious shock produced by a severe allergic reaction or collapse.

[4] An anaphylactic reaction is a severe, potentially life-threatening allergic reaction. It can occur within seconds or minutes of exposure to a medication.

each vaccination administed, such as the medical history of patients and information about the vaccine given. The system developed by NHS Wales Informatics Service enables the health board to receive information on the amount of vaccinations delivered to track progress with the vaccination programme and monitor patient uptake.

We observed clear discussions between clinical staff and administration staff regarding the communication of such information for vaccinations they had administered, and were told that the system had been working well.

Quality of management and leadership

We considered how the centres are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care.

Governance, leadership and accountability

Before the focused inspections we requested evidence and information from the health board in relation to the governance of the vaccination programme. We were provided with the standard operating procedures that set out the arrangements in place to ensure the delivery of the COVID-19 vaccination programme across the health board. The document covered all aspects of the vaccination process that we saw implemented at both centres we visited.

During our focused inspections we were assured that clear management structures were in place. Senior clinical staff had oversight of the clinical workings at each centre and project leads had oversight of non-clinical matters. We observed open communication between such staff during our visits, and staff we spoke to were aware of their responsibilities and told us that the structure was working well.

Staff and resources

Workforce

From our discussions with senior staff it was evident that the identification and availability of workforce, and access to suitable venues, are ongoing challenges faced by the health board. Due to the fast changing nature of the vaccination programme, staff were often being redeployed to provide extra resources where needed. Despite these challenges, we saw that an appropriate number of volunteers, administrative and clinical staff were on site during both of our focused inspections to safely deliver the vaccinations booked in on those days. Staff we spoke to at both centres also said they have felt supported by senior staff in the delivery of their role throughout the vaccination process so far.

The organisation of staffing rotas was the responsibility of senior clinical staff within each of the centres to manage locally. In Deeside, some staff reported to us that communication on various aspects of the rotas could be improved. We discussed these issues with senior members of staff during our visit who took these on board, and agreed to review the current system to make it more timely and transparent.

We spoke with senior staff at each centre about the measures in place to ensure clinical staff provide safe treatment. We were told that the majority of vaccinators working at the centres across the health board were registered clinical staff. Any non-registered vaccinators would be allocated a registered vaccinator to provide supervision throughout all aspects of their role. A full training schedule was developed and all vaccinators had to be assessed as competent by allocated supervisors using the COVID-19 vaccinator competency assessment tool[5] before being able to vaccinate unsupervised.

We were informed that short 'safety huddles' are held every morning for senior clinical staff to communicate key points, issues and actions to staff. Staff arriving for later shifts are updated individually on the same issues by senior clinical staff.

Improvement needed

The health board must ensure that communication about rotas to staff working within each mass vaccination centre is timely and transparent.

[5] COVID-19 vaccinator competency assessment tool

4. What next?

Where we have identified improvements and immediate concerns during our focused inspections which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the focused inspections.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other mass vaccination centres in the health board. This includes findings from appendices A, B and C.
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect mass vaccination centres

Our focused inspections of mass vaccination centres are usually partly announced. This means we will tell the health board we will be visiting a number of centres in a particular time period, but will not give any further information. The health board can then prepare some of the information we need in advance. This reduces the amount of time we need to spend on site, and means the focused inspection causes as little disruption to patients and staff as possible.

Feedback is made available to service representatives at the end of the focused inspection in a way which supports learning, development and improvement at both operational and strategic levels.

We check how the centres are meeting relevant parts of the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These focused inspections capture a snapshot of the standards of care within mass vaccination centres.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the focused inspections

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified during either focused inspection.			

Appendix B – Immediate improvement plan

Centres: Ysbyty Enfys Bangor and Ysbyty Enfys Glannau Dyfrdwy

Date of inspection: 11-12 March 2021

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate improvements were identified on either focused inspection.				

Appendix C – Improvement plan

Centres: Ysbyty Enfys Bangor and Ysbyty Enfys Glannau Dyfrdwy

Date of inspection: 11-12 March 2021

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must monitor the waiting times for patients at each mass vaccination centre and ensure they are kept to a minimum wherever possible.	4.1 Dignified Care	**Ysbyty Enfys Glannau Dyfrydwy** A member of the team is routinely outside to meet and greet and to monitor queues A trigger for opening additional lanes has been identified i.e. if there is a queue reaching beyond the shelter (more than 30 people waiting in total inside and outside) The queues are monitored regularly by the nurse in charge. The DNA's are monitored throughout the day and the additional appointments are offered throughout the day if DNA rate is	Thomas Halpin	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		high to prevent an influx of people at the same time. **Ysbyty Enfys Bangor** Marshalls are allocated to monitor the arrivals for vaccination and undertake a meet and greet role. Should a backlog/queue situation arise this is escalated to the site lead for the day. Should waiting times exceed 20 minutes then action is taken to increase capacity (additional vaccination lanes) until the waiting times reduces. In addition, a token system is being introduced to audit the actual waiting time from point of arrival to vaccination. This involves issuing a slip of paper with the time of booking in to a few patients throughout the day, this will be handed in at the vaccination station and allow calculation of actual time waited. Appropriate action will be taken to reduce waiting times through increasing capacity as per above if required.	Anwen Last Anwen Last Catrin Macey Catrin Macey	Complete Complete W/c 19th April 2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Results of the audit will also be compiled and reviewed weekly. DNAs are a significant contributor to potential for queues therefore the DNA rate is monitored at least 2 hourly throughout the day and a standby/reserve system is in place to backfill DNA slots throughout the day to avoid a bulk of additional patients at the end of the day.	Anwen Last	Complete
Delivery of safe and effective care				
No improvements were identified in this section.				
Quality of management and leadership				
The health board must ensure that communication about rotas to staff working within each mass vaccination centre is timely and transparent.	7.1 Workforce	**Ysbyty Enfys Glannau Dyfrydwy** 1. we will arrange a Deeside staff and Deeside volunteer generic e-mail address as a way of monitoring and maintain communication. Appropriate management staff to have access via outlook and it will be the responsibility of the team on duty to check and respond. This will also provide facility to send mail shots to large groups	Thomas Halpin	30th April 2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		and roster information. 2. Until we are able to provide a more advanced forecast of vaccine availability there will be a delay in providing a long term rota. Routine team meetings are planned with rota updates on the set agenda first team meeting planned for Thursday and moving forward this will occur regularly. 3. We plan to schedule supervision sessions with staff and gain their preferences on working patterns and will endeavour to meet these requests where service provision allows. Staff will be informed of their annual leave entitlements and the process to request specific days off to ensure work life balance until we are able to provide a more advanced rota **Ysbyty Enfys Bangor** There have been challenges related to vaccine supply in producing a roster. The senior nurse team will aim to provide staff with the roster 4 weeks ahead at any given time, rosters will be published each week.	Stacey Jones Stacey Jones Catrin Macey	Complete 30th April 2021 Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		When operational days are uncertain due to vaccine supply the minimum accepted standard for roster production will be two weeks ahead		
		Staff are able to indicate their preference for shift patterns/preferred days on EOL (Employee On Line) and wherever possible these are accommodated within the service delivery requirements.	Catrin Macey	Complete
		There is a WhatsApp group in place for all MVC staff to support communication around the roster, short notice shifts, sickness backfill requirements etc.	Catrin Macey	Complete

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Karen Evans and Eleri Roberts

Job role: Assistant Area Director – East. Vaccination Lead for East Area & West Area

Date: 15 April 2021