SCOTTISH HOSPITALS INQUIRY
Witness Statement of
Lynn Pritchard

This statement was produced by the process of sending the witness a questionnaire with an introduction followed by a series of questions and spaces for answers. The introduction, questions and answers are produced within the statement.

Professional History

1. Please list your professional qualifications, with dates.

A. Registered General Nurse (RGN) – 1988
BSc in Health Care – 1998
BN with Specialist Practitioner Qualification in IPC - 2005

2. Please give your chronological professional history, roles held, where and when- please also provide an up-to-date CV

A. Student Nurse – South College of Nursing & Midwifery 1985 – 1988
Staff Nurse – Wd 56 Southern General Hospital NHSGGC - Orthopaedic / Care of Older People April 1988 – January 1992 (Grading for NHS staff was introduced during this time and I was appointed an E Grade)
Staff Nurse (E Grade) Ward 4 Knightswood Hospital NHSGGC January 1992 – December 1992
Staff Nurse (E Grade) Queen Elizabeth National Spinal Injuries Centre, Southern General Hospital NHSGGC December 1992 – December 1998
Senior Staff Nurse (F Grade) Queen Elizabeth National Spinal Injuries Centre, Southern General Hospital NHSGGC December 1998 – December 2003
IPCN / Senior Infection Control Nurse, NHSGGC IPC Mental Health and Community Team December 2003 – March 2010

Senior Infection Control Nurse, NHSGGC IPC South East Acute Sector - March

2010 – October 2012
SICPs Co-ordinator, NHSGGC IPC - October 2012 – September 2013
Lead Infection Control Nurse – South East Acute Sector – September 2013 – June 2015
Lead Infection Control Nurse – NHSGGC West Sector & Mental Health & Partnerships – June 2015 – October 2015
Lead Nurse NHSGGC NHSGGC South Sector IPCT – October 2015 – September 2022
Nurse Consultant IPCT – NHSGGC Infection Prevention & Control Team September 2022 – Present

3. What specialist interest / expertise / qualifications in any area of Infection control do you hold?

A. I have 20+ years' experience working in Infection Prevention & Control working initially in a team that covered Mental Health in-patient areas and Community Teams. I moved to the acute sector in 2010 but have over the years continued to cover other specialties. I have a BSc in Healthcare and this prompted me to undertake further study. Keen to move into IPC following the role of IPC Link Nurse I commenced a BN (with specialist practitioner qualification in IPC) in September 2003 which I self-funded prior to being appointed my first IPC post. Through my career within IPC I delivered training at Glasgow University School of Nursing delivering sessions to 1st, 2nd and 3rd year nursing students.

Infection Control Team QEUH – 2015 to 2019

4. Please discuss the arrangements for infection control within NHS GGC (south sector) between 2015 and 2019:

a) Please describe the structure of the department / team

A. Within NHS GGC IPC there was an Infection Control Manager, Associate Director of Infection Control, Nurse Consultant, Lead Nurses within each sector and Infection Control Nurses. There was also Infection Control Doctors who covered each Sector team.

b) Please describe the relationship between members of the team, were there tensions in the team? If so, please explain

A. I was not aware of any tension within the local teams or the teams with any of the Senior Management Nursing Team. Some tension developed between myself and 1 of the Infection Control Doctors (ICD). I believe that this was due to a discussion that occurred at a team meeting when the ICD asked that we change PPE practice for a specific organism. I had advised that we could not change practice of PPE use which would result in us not following guidance within the national manual but that I would discuss at the Lead Nurse Meeting which the Associate Director of IPC attended that was taking place that afternoon. It is my belief that this was the start of the tension between us but I was never one hundred percent sure. We continued to work together and I felt that we were both able to act professionally and we did meet to try to resolve the issue but I didn't feel that that improved anything. My manager approached me to advise that 3 other members of the IPCT were arranging a meeting with RCN union to discuss issues that they had with this ICD and I agreed to be part of this.

c) Was there a lack of clarity around roles and decision making?

A. I was aware of my role and was clear on both my role was and that of my team. In relation to the discussion above I felt that at that point the ICD was asking me to do something which went against national guidance and would have been different from the practice in other sectors in NHSGGC.

d) Record keeping - did you take part in this? If so, please describe your role

A. Yes I was involved in record keeping. My role was the same as any other IPCN in respect of record keeping. I used ICNet for recording patient notes and also recorded in patient medical notes if required. There were some paper records kept of organism numbers throughout the month prior to being recorded electronically and submitted to the IC Data Team.

e) Culture and bullying

A. I was not aware of a culture of bullying.

f) Attitude of senior management and board to infection control issues?

A. I did not ever think that the senior management did not take any issues of IPC seriously but I was only working and liaising at a local level. In my role as lead nurse I would have reported at the South Sector Clinical Governance meeting and the Area Infection Control Committee but did not report at any board meetings. If I reported issues to IPC management I always felt that I was listened to and supported and that all issues I raised were taken seriously. I would have been unaware if this was felt at board level.

ICNet – Clinical Surveillance Software

5. In relation to ICNet:-

a) Please explain what ICNet is and what it is used for.

A. ICNet is an electronic patient case note for IPCT. It is used for recording patient IPC notes, recording ward / department outbreaks and reviewing alert organism imports.

b) When was ICNet introduced?

A. ICNet was fully introduced in 2015

c) What is recorded on ICNet and by whom. For how long are records kept on the system?

A. Patient infection control specific notes are recorded which includes advice given. If a patient has an alert organism imported there is an XP section that is also completed as a dropdown option. This includes if HAI or not and if patient is isolated. Also any notes from outbreaks can be recorded on the outbreak utility. ICNs can also record notes in the ward case note. I understand that records remain for as long as ICNet is functioning.

d) Who has access to ICNet?

A. All Infection Control Nurses have access to ICNet and in addition the ICData team and Surveillance team. Senior management have access and ICDs can also request access. I am not sure if they all requested or used ICNet.

e) Does ICNet maintain a record of Healthcare Acquired Infections and/or Heathcare Associated Infections?

A. ICNet will “import” the organism from Microbiology and Virology laboratory results but only organisms that are “selected” as per appendix 13 of the national infection prevention and control manual will be on the “latest alert organisms” tab and these are the ones that the IPCN manages. On the patient’s case note page these show under a tab “results” and there are fields that the ICN should complete, one of which includes HAI/HCAI. This is the responsibility of the IPCN to complete this section, this is not automatically completed. This will remain for the duration that ICNet is active.

f) Does ICNet record the location of a specific organism? i.e. within a patient or ward group?

A. When a member of staff obtains a specimen from a patient they record where the specimen was taken from and the ward / department that obtained the specimen. ICNet will have a record of this information as this will have been added to the lab system. ICNet also records patient placement within the hospital. This feeds from a different system called Trakcare and if this is not accurate then the patient placement will not be accurate.

g) To what extent do you think ICNet is/has been effective?

A. I have found ICNet very effective for IPC Teams. Prior to ICNet all IPC notes were recorded on paper documents and this would have been held at a local site. Pre ICNet the IPCNs did not have a record of all movements of the patient within the sites. ICNet also has a “micro” tab which records all Microbiology and Virology samples taken from a patient, therefore it is easy to find information without logging onto several different electronic systems. ICNet has a “contact tracing” function which has made outbreak management easier and more effective.

HAI SCRIBE

6. Please explain what HAI Scribe is, what it's aims are, and how those aims are

achieved.

A. Healthcare Associated Infection Systems for Controlling Risk in the Built Environment (HAI Scribe) is a risk management tool that allows the person who is completing it to describe the work that is being undertaken and through a question set can identify risks and describe the actions that will be taken to mitigate or manage these risks. It also records the key staff and roles involved in this process. It is also a record of the risks and mitigations within the built environment.

7. Who has overall responsibility for the HAI SCRIBE?

A. The Estates team have overall responsibility.

8. Please discuss your role as Lead Infection and Prevention Control Nurse in relation to the Estates and Capital Planning Teams and HAI SCRIBE.

A. As an IPCN I would be asked to review a HAI Scribe by a member of the Estates Team. Depending on the area where the work is being undertaken and the type of work being completed this would also be reviewed by an ICD. Members of the team who have had supported learning and informal education on reviewing Scribes could review a Scribe so not all Scribes were reviewed by myself.

9. Please see - **A47648572 SMT Meeting - Minutes - 28 April 2016 – Bundle 13, Document 73**

a) What were the issues with HAI SCRIBE at this time?

A. I do not recall but from reading the minutes I would assume that it was the number of Scribes that the IPCT were asked to review.

b) Were the issues isolated to one area of the hospital or did they relate to more than one area of the hospital?

A. As per the minutes I have only raised this as being an issue within the Institute of Neurological Sciences.

c) What action, if any, was taken to resolve the issues, and to what extent was the action effective?

A. I don't recall any actions being completed by myself from this.

Issues relating to Wards 4B and 4C

Please see:

A40241424 - Minutes - AICC Meeting - 05 September 2016 – Bundle 13 – Document 6
A47648655 - SMT Meeting - Minutes - 28 September 2017 – Bundle 13 - Document 85

10. What was the nature of Wards 4B and 4C, and the nature of the patient group, between 2015 to 2019?

A. Ward 4b is a 24 bedded ward with 100% single side rooms. Ward 4c is divided into 10 haematology beds and 15 renal beds. When I moved to the QEUH site in October 2015 I don't recall if the ward was in use, although for a period it was used by Older Peoples services. Older Peoples services used the ward until approx. July 2017 then the haematology patients from ward 4c haematology moved in to ward 4b and work undertaken to replace ceilings in patient's rooms and reconfigure ventilation. BMT moved back to Wd 4b in June 2016.

11. What impact did the nature of the wards and patients have on infection control measures within Wards 4B and 4B? e.g. on ventilation?

A. In relation to the Infection Prevention and Control advice that the nursing team give is the same for all patients. I am not an expert in ventilation so I cannot comment on that specifically.

12. Were you aware of any issues arising in relation to Ward 4B, which led to the decant of the ward to the Beatson in July 2015? If so, what was your understanding of the issues?

A. I did not move to the QEUH until October 2015 and I was not aware what was discussed at the time.

Please refer to:

A32221235 – Minutes – AICC Meeting – 03 July 2017 – Bundle 13 – Document 11

A38244908 – 24.08.2017 Ward 4b Ensuite HAI SCRIBE revised Ian Powrie / Alan Gallacher - Bundle 27 – Volume 6 – Document 1, page 5

13. Were you aware of issues in Ward 4B relating to a leaking pipe, slow to drain sinks, water ingress, flooding from floor drains, and issues with chilled beams? If so, please give details,

A. I do not currently recall specifics of all these issues but I would have been made aware of these at the time if the IPCT had been notified. I reviewed my notes and it was noted that there was a report of water leak from the ceiling on the corridor outside one of the rooms in Wd 4b. Estates investigated in the ceiling space and there was a corroded pipe, damp insulation material and mouldy ceiling tiles. This room was previously positive for fungi on air sampling. The room had already been taken out of use along with the adjacent rooms. I noted that there was a further 2 rooms out of use due to water damage. There had been a report of water dripping from a chilled beam but I do not recall which area / ward this was. I was told at the time that there can be condensation on a chilled beam and if the beam is dusty then if the chilled beam drips the water drip will be dirty. There were reports of "leaking valves" on water pipes that burst causing water to drip onto the ceiling tile and cause a potential leak through a damp tile. I recall this happening several times in Ward 4b. I do not recall specifically slow to drain sinks in Wd 4b, however during my time at QEUH this issue was reported by several areas so this may have been reported in Wd 4b.

a) What was your understanding of the issues?

A. As above.

b) What was the nature of the risk posed to patient safety and care?

A. Air sampling in the room next to the water leak in the corridor showed high fungal counts and the ceiling space showed signs of mouldy ceiling tiles and damp insulation material. Patients within this ward are immunocompromised and at higher risk of disease. Patients can get fungal infection from exposure to fungi.

c) What action, if any, was taken?

A. Rectification work was undertaken in the ward by the Estates team. When the

valves leaked this was often repaired as emergency works and there was a Scribe written for the cleaning of the chilled beams to allow regular cleaning. Latterly I do not recall any reports of leaking from chilled beams.

d) Was any action taken sufficient to address the concern?

A. I am unable to answer this question.

e) What was your involvement / role in relation to the 24.08.2017 HAI SCRIBE?

A. I attended the meetings to review the HAI scribe following some issues being raised by the ICD. I attended as the local IPCN rep.

f) What was your view of the works contained in the HAI SCRIBE?

A. The role of the IPCN is to review the actions taken to mitigate the IPC risks, not to review the works undertaken. This is the role of Estates.

g) Were you aware of issues concerning the final HAI SCRIBE sign off? If so, what was your understanding of the issues? Who raised the issues?

A. From review of notes the issue was raised by [redacted] The issues raised included: commissioning, risk level of patients for the scribe and issues regarding sampling and decision processes leading to patients being allowed back into the ward.

h) Was the HAI SCRIBE signed off? If not, why not?

A. [redacted] confirmed agreement with Scribe and in addition the IPCN comments. When the work was starting the work was stopped by Dr Peters. It was agreed that the Scribe would be reviewed prior to work commencing.

i) Were you aware of any issues with Wards 4C? If so, what was your understanding of the issues?

A. I don't recall any specific issues with Wd 4c.

j) When did you first become aware that the ventilation in Wards 4B and 4C was not to the standard laid down in STHM 03-01? How did you become aware?

A. I am not aware of when I was informed of this. I had been aware that the BMT ward had moved on site when the hospital opened but that they had relocated back the Beatson Oncology Centre at Gartnavel General Hospital Campus. I would have been advised that there was work being undertaken to improve the ventilation but I worked at a sector level and not at board level so would not have been included in board level meetings or discussions.

k) Would you have expected the design of the ventilation system to comply with SHTM 03-01, the national guidance?

A. I am not qualified to answer this.

l) Would you have expected to be told if the ventilation system did not comply with SHTM 03-01?

A. As an IPCN Lead at sector level I would not expect to be told of the specifics of ventilation compliance but would have been made aware of this and advised if work was to be undertaken in a specific area. As I am not an expert in ventilation I would not have been aware of what the specification of the ventilation system should have been.

F. <u>Emerging issues with the water system from 2015 to 2018</u>

Please see:
A47648552 SMT Meeting - Minutes - 27 October 2016 – Bundle 13 – Document 77
A47648678 - SMT Meeting - Minutes - 30 March 2017 – Bundle 13 – Document 80
A40562713 - SBAR - control of toilet plume by fitting toilet seats 22 October 2018 – Bundle 13 – Document 133

14. What can you tell us about emerging issues with the water system?

a) When did the concerns arise?

A. I was aware of possible water issues following an increase of infections in the RHC which was reported at the Lead Nurse meeting and the same organisms being found in the water from sampling. This was around spring / summer 2017.

b) What was the nature of the concerns – specifically what was thought to be wrong with the building system in question?

A. I understood the nature of the concerns to be that there was possibly contamination in the water or water pipes.

c) Were you involved, in your role as Lead ICN?

A. I was not involved in any of the work within the RHC. Neither myself nor my team had been involved in a water incident before and therefore I was taking my guidance from the ICD at the time in relation to actions for the team and guidance given to wards and departments.

d) What was the nature of the risk posed to patient safety and care?

A. I was not aware of specific risks but it had been reported that there were patients within RHC who had organisms isolated that were also identified in water samples from RHC.

e) What action, if any, was taken?

A. As I did not cover RHC I was not involved in any actions.

f) Was any action taken sufficient to address the concern?

A. I cannot answer this question.

15. Were you aware of issues with Flow straighteners / regulators / tap type? If so, please give details.

A. I was aware that there was discussion between ICDs and members of the estates /facilities teams in relation to these but I was not involved in these discussion or decision making.

a) What was the nature of the risk posed to patient safety and care?

A. I cannot answer this question.

b) What action, if any, was taken?

A. I think that following these discussions there was filters placed on taps and shower heads changed to disposable in some area within QEUH.

c) Was any action taken sufficient to address the concern?

A. I am not qualified to answer this question.

16. Please see **A47648613 – SMT Meeting – Minutes - 25 February 2016, Bundle 13 – Document 71**

a) Please expand on the sewage leak in neurology at QEUH and flood in theatre recovery – e.g. please describe where in the hospital these were, the Ward numbers, and nature of issues.

A. The Institute of Neurological Sciences (INS) is a retained site on the QEUH campus. This is not a new building but is linked to the main QEUH via a link bridge. The ingress of water was from the ward above and from reviewing my notes it was suggested that this was from a blocked toilet in Ward 62 Level 2, which caused foul waste to come through the ceiling in Level 1 theatre recovery. This occurred twice in February.

b) What was the nature of the risk posed to patient safety and care?

A. If there is sewage leaking in an area this will contain faecal flora which will land in droplets. This would not aerosolise and travel. However if the area is not cleaned sufficiently or equipment and/or sundries are contaminated and then taken to be used on a patient this may inadvertently infect the patient.

c) What action, if any, was taken?

A. A full terminal clean was undertaken. There was a meeting arranged and initial discussions and actions agreed and the clinical team updated their risk register. Patient cases were relocated to another theatre and the area was closed off. Over the month Estates reviewed the ceiling space and drain survey was to be arranged by estates. There was air sampling undertaken prior to patient surgery being undertaken. At the time of the ingress any exposed sundries were discarded.

d) Was any action taken sufficient to address the concern?

A. This would need to be answered by Estates.

Healthcare Acquired Infections 2015 to 2017

Please see Bundles 1, 2, and 13:

Bundle 13

A32221973 – Minutes - AICC Meeting - 11 Jan 2016 – Bundle 13 – Document 4
A32188434 – Minutes - AICC Meeting - 6 March 2017 – Bundle 13 – Document 9
A32221511 - Minutes – AICC Meeting - 4 September 2017 – Bundle 13 – Document 12
A36356927 - Minutes – AICC Meeting - 06 November 2017 – Bundle 13 – Document 13

Bundle 1 – Hearing Commencing 12 June 2023
A41890305 – 22.09.2017 – IMT Minutes Exophiala in CF – Bundle 1 - Document 12

Bundle 2 – Hearing Commencing 12 June 2023
A41890324 - PAG Minute dated 23 May 2016 - Increased number in Abscessus cases within adult Cystic Fibrosis patients – QEUH— Bundle 2 - Document 1
A41889883 - PAG Minute dated 22 June 2017 - Enterobacter – Neurological Institute – Bundle 2 - Document 16
A41890126 - PAG Minute dated 20 September 2017 - Acinetobacter - Ward 61 QEUH - Bundle 2 – Document 20
A41890276 - PAG Minute dated 27 October 2017 - Pseudomonas - Ward 10D QEUH -Bundle 2 – Document 26

17. IN BROAD TERMS Please tell us about HAI issues in QEUH between 2015 to 2017, including an increase in Exophiala cases in Wards 7A and 7D in August and September 2017. What action, if any, was taken? To what extent was the action effective?

A. All alert organisms reported via “ICNet imports” are reviewed by an IPCN and this includes HAI and non HAI. In relation to exophiala an increase was highlighted by ICD in September 2017 within adult and paediatric patients some of which were cystic fibrosis patients. This was not an organism that the IPCN would have been alerted to via ICNet and this was reported by the ICD when there was an increase of cases over a period of time. The actions following an IMT included dishwashers in the wards being swabbed and tested positive for the same organism and the

dishwashers were taken out of use, the patients were given bottled water for drinking as the patient water jugs were historically washed in the dishwasher. The dishwashers remained out of use. There were some use and maintenance issues with the dishwashers and these would be reviewed. Once these were actioned, the dishwashers would be swabbed again and a decision would be made following results. The dishwashers remained out of use and it was decided the following year that the dishwashers would be removed from use in Level 7 wards QEUH. In May 2016 there was a review of abscessus cases in the adult Cystic Fibrosis patients under the care of the QEUH CF team. There were 3 abscessus cases within a 3 month period (February – April) and 6 cases since the patient group moved to the QEUH site. There was no obvious link found with the 3 recent cases. Typing requested and discussion with CF Nurse re attendance at outpatient clinics to confirm or nullify crossover and cross transmission of patients. The team were moving to water repellent gowns for aerosol generating procedures and direct patient care and review of equipment in use and cleaning of this equipment. Enterobacter (Institute of Neurological Sciences) – I do not recall this incident but I have reviewed the PAG document provided. Three cases reported with crossover of 2 cases in ward and theatre. Typing reported as unique (not the same) and there was no further follow up.

Acinetobacter Ward 61 (Institute of Neurological Sciences) – I do not recall this incident but I have reviewed the PAG document. There was a report of 2 patients in Ward 61 (Neuro ITU) isolated Acinetobacter baumannii complex from sputum samples. These were both identified by Microbiology as having the same antibiogram and typing was requested for the samples. There was a link to time and place for the 2 patients.

Pseudomonas Ward 10D – I do not recall specifics of this incident but I have reviewed the PAG documents. There were initially 2 cases of pseudomonas in Wd 10d which was reviewed by IPCT and actions undertaken and then 2 further cases identified from lookback exercise.

18. Was a link to the built environment suspected in respect of any of the issues. If so, in what respect? Was a link confirmed?

A. I was not aware that any of these were linked to the build environment.

The Water Incident - 2018

Please see Bundle 1:
A36690544 – 23.03.2018 – 9.IMT Minutes Water Incident Ward 2A RHC – Bundle 1 – Hearing commencing 12 June 2023 – Document 20
A36690556 – 27.03.2018 10. IMT Minutes Water Incident Ward 2A RHC – Bundle 1 – Hearing commencing 12 June 2023 – Document 21

19. There were a series of infections in Wards 2A and 2B between March and November 2018, known as the Water Incident:

a) How did you become aware of the issues, what did you understand to be the issues?

A. I did not cover the RHC but I had been made aware by the ICD as water sampling had been undertaken in BMT ward within the adult site. I was asked to take some actions forward for the adult site.

b) What were the infection control measures in place?

A. I can only comment on the measures in place for adult wards. For BMT patients, they were advised not to use the showers; wipes and bottled water could be used for washing. Sterile water was to be used for, drinking, and teeth brushing. If any of the BMT patients were to transfer to a critical care ward, the same guidance should be followed. Information was shared advising staff of this. Point of use filters were fitted to sinks within Level 4, Level 7 (A&D priority), 8C, 9D, 10A and 11C.

c) Was prophylaxis was administered?

A. I would be unable to answer this.

d) Were the actions taken sufficient to respond to the incident?

A. I am unable to answer this.

20. On 23 March 2018, specific infection control measures were in place in the adult wards:

e) Which adult wards were affected?

A. These measures were in place in Wd 4b and if the BMT patient moved to critical care the precautions would be followed in that ward.

f) What were the infection control measures in place?

A. For BMT patients, they were advised not to use the showers, and wipes and bottled water could be used for washing. Sterile water was to be used for drinking and teeth brushing. If any of the BMT patients were to transfer to a critical care ward, the same guidance should be followed. Information was shared advising staff of this. Point of use filters were fitted to sinks within Level 4, Level 7 (A&D priority), 8C, 9D, 10A and 11C.

g) Was prophylaxis was administered?

A. This is not something that I can answer.

h) Were the actions taken sufficient to respond to the incident?

A. This is not something that I can answer.

21. Were you aware of issues with wash hand basins and/or filters? If so, please give details.

A. Some of the basins where the filters were applied were fitted with automatic taps. The filter meant that the sensor was blocked and the tap did not automatically turn on to allow staff to undertake hand hygiene. In addition to this the sinks were small and meant that staff could not undertake hand washing effectively.

a) What was the nature of the risk posed to patient safety and care?

A. These were in non-clinical areas. The ones in the adult hospital that I was aware of were in the kitchen areas. Staff also have access to alcohol based hand wash and could if required access a nearby sink.

b) What action, if any, was taken?

A. I cannot recall but I know initially I advised the use of alcohol based hand gel and if hand washing was required staff could access a sink in another room. I think that the filters were eventually removed from these sinks but I cannot be sure.

c) Was any action taken sufficient to address the concern?

A. As I cannot recall fully I do not feel that I can answer this.

22. What is your opinion on the effectiveness of the Water Incident IMT?

A. I felt at the time that this was triggered by an incident within the paediatric hospital and that there was many long term actions that resulted in this. However as there was positive results in water within the adult wards I think that these actions may have been required to mitigate risks to patients. Other than the point of use filters the precautions were only in place for a very short time.

Healthcare Acquired Infections 2018 to 2019

Please see Bundle 1, Bundle 2, and Bundle 13:

A41890251 - PAG Minute dated 6 February 2018 - VRE - Renal Wards QEUH – Bundle 2 – Hearings Commencing 12 June 2023 – Document 32
A41890240 - PAG Minute dated 21 August 2019 - VRE - Ward 4C QEUH – Bundle 2 – Hearings Commencing 12 June 2023 – Document 51

A36591626 - 14.08.2019 IMT Gram Negative Blood Ward 6A – Bundle 1 – Hearings Commencing 12 Juen 2023 – Document 77

A32221533 - Minutes - AICC Meeting – 16 July 2019, Bundle 13 – Document 22

23. Please tell us about HAI issues in QEUH between 2018 and 2019. What action, if any, was taken? To what extent was the action effective?

A. The incident in Wd 6a IMT Gram negative blood was relating to paediatric patients who were cared for in Ward 6a during that time. In January 2018 there was an increased incident on Vancomycin-resistant enterococci (VRE) within 2 of the renal wards on Level 4, QEUH. In total there was 13 cases which were all HAIs (9 attributed to Wd 4a and 4 attributed to 4d). Actions included; terminal clean of both wards and typing of isolates requested. Dr Inkster was following up the typing results, but agreed that if typing did not indicate cross transmission then there would be no further actions. IPCNs agreed to undertake several hand hygiene audits in each of the 2 wards and review practice. IPC audit was undertaken and action plan provided to SCN for area. In relation to whether the actions were

effective it is difficult to say as the VRE numbers returned to within the normal limits as per SPC charts. All actions whether it is audit or education focusses staff to their own areas for improvement, so these interventions would never be a negative addition. A look back at the previous year showed that there had been previous increases in VRE numbers within this patient group and the numbers would returned to within normal limits. From discussions with the SCNs, they also said that when these patients were nursed at the Western Infirmary, Glasgow there were often increases in VRE cases in this patient group and no specific reason was identified. Within my time at QEUH, there have been occasions where the number of VRE cases within the renal patients has increased to above normal levels (as per statistical process chart). All increases are investigated and managed.

VRE Wd 4c - 4 VRE identified within a 12 day period within haematology beds in Wd 4c. 3 x blood cultures and 1 wound swab. IPC reviewed patient and noted that all had IV lines in situ and 3 had skin breaks of varying severities. Actions include: observation of practice – enhanced supervision of practice undertaken on 2 occasions and the findings were fed back to the SCN for actioning. Hand hygiene audit undertaken and results 100% therefore no improvement required. Typing of the samples undertaken but 2 were confirmed different. There were 2 further patients reviewed by IPCT with VRE positive blood cultures in September and October. As the patients had skin breaks, the tissue viability team was contacted to review any wound care that they may have undertaken or any significant issues in wound care that they may have observed. The tissue viability team do not undertake wound dressings and were unable to offer any significant information. I don't recall the actions from Friends of the Beatson. There were no other clusters of VRE in this ward following this.

24. Was a link to the built environment suspected and if so, in what respect? Was a link confirmed?

A. There was no suggestion that these incidents were linked to the built environment.

Whistleblowers

25. Throughout 2018 there were ongoing Whistleblowing procedures involving several Microbiologists. Were you aware of this at the time? What was your perception of it?

A. I was aware of this. I was surprised but as I was not informed of the details at the time I cannot comment on my perception.

Cryptococcus

Please see Bundle 1, Bundle 2, and Bundle 6:

A36690657 - PAG Minute dated 18 December 2018 - Cryptococcus neoformans Ward 6A QEUH – Bundle 2 – Problem Solving Assessment Group Meeting Minutes – Document 45

A36690569 - 21.01.2019 IMT Cryptococcus – Bundle 1 – Incident Management Meeting Minutes (IMT) – Document 62
A36690579 - 24.01.2019 IMT Cryptococcus – Bundle 1 – Incidence Management Meeting Minutes (IMT Minutes) – Document 64
A36690577 - 25.01 2019 IMT Cryptococcus – Bundle 1 – Incident Management Meeting Minutes (IMT Minutes) – Document 65

26. Had you seen / heard of Cryptococcus in a healthcare setting prior to QEUH?

A. It had been reported that there was a paediatric patient who tested positive prior to the adult patient. I had not seen this organism in patients prior to the paediatric case and then the adult case. This was an unusual organism where 2 patient cases were reported within approximately a 2 week period of each other. I was advised that this is mostly found in soil and pigeon excrement. The common link was that both patients were nursed in QEUH – Level 4 and Level 6 and it was not suspected that the patients would have had exposure to soil. Initially there was a discussion with the aseptic pharmacy to advise if both patients had received medication from there – I was aware that the adult patient had.

27. What were the issues with Cryptococcus at QEUH? When did you first become aware of these issues? What happened in response to these issues?

A. There were 2 cases within RHC and QEUH which I was initially aware of when the paediatric case was reported. The adult case was reported to IPCT in December 2018, the sample obtained from a blood culture taken 4 weeks earlier. The paediatric patient had spent time in a ward that was decanted to the adult hospital (Wd 6a). The common link was that both patients were nursed in QEUH – Level 4 and Level 6. Initially following the PAG there was a discussion with the aseptic pharmacy to advise if both patients had received medication from there – I was aware that the adult patient had. There was evidence of pigeon droppings on external window ledges and courtyards and this was reported to Facilities to ensure that these areas were cleaned. There are no opening windows in the wards and patients do not have access to the courtyard. The courtyards are locked and only accessed by facilities and estates staff for maintenance and cleaning. Air sampling of wards 6a and 4c will be carried out. Over a period of 2 months there was regular IMTs with investigations and actions completed. There was a report that there was evidence of pigeon droppings in some of the plant rooms and live pigeons in 1 plant room and evidence of nesting. Estates would review all plant rooms, clean them and ensure that access is sealed.

The adult patient was commenced on treatment but died [redacted] January 2019 – Cryptococcus was not cited on death certificate. Over the period of 2 months there were regular IMTs with a number of actions that included: bird dropping samples sent to Ayr for testing, review of aseptic pharmacy, regular inspection and maintenance of plant rooms and hospital external areas, air sampling of plant rooms and wards 4c & 6a. Air sampling was later extended or other wards. There were several discussions in relation to reducing pigeon population on the site. Portable hepa filters were placed in wards. Adult wards were asked re stock being delivered to wards and a couple of wards reported that there had been external package boxes noted to have bird droppings visible. High risk patients nursed in Wd 6a would be moved into Wd 4b.

These patients would be managed by paediatric nurses and by the Paediatric IPCT. Shower rooms in Wd 4c were reviewed and several rooms noted to require work to seal or replace vinyl flooring or wall to floor joints, this work was undertaken. Air sampling in Level 7 QEUH fortnightly as an indicator ward. Discussions around

the helipad ramp being a source of pigeon faeces via trolley wheels when the trolley is transported into the wards but this was discounted as the route of arrival if the patient group in question would not be via helicopter. There were no further cases and an additional group was being set up to look at multiple hypotheses for this incident but I was not part of that group.

B. During this period there was communication to patients and staff providing reassurance. Since this incident in 2018/2019 I have not been made aware of any other cases of Cryptococcus neoformans.

Please see **A39235063 – Report prepared by Cryptococcus Expert Advisory Sub-Group dated 5 April 2022 – Bundle 6 - Miscellaneous from Hearings 12 June 2023 – Document 39**

28. Did you read Dr John Hood's report? If so, when did you read the report? What is your opinion of the report? To what extent do you agree/ disagree with its findings?

A. I didn't read this report.

29. What actions were taken following the John Hood report? Did you consider those actions to have been sufficient? If not, why not?

A. I was not aware of the actions following this report.

30. What else could have been done? How could matters have been handled differently?

A. I was not aware of the actions so cannot answer this.

31. Did you have concerns about how matters were dealt with? Did you share those concerns with anyone? If so, to whom and when were your concerns shared? What action, if any, was taken as a result?

A. I was not aware of the actions so cannot comment on this.

HAI Incidents 2019 – 2020

Please see Bundle 2 from the Oral Hearings commencing 12 June 2023:

A41890240 PAG Minute dated 21 August 2019 - VRE - Ward 4C QEUH – Bundle 2 – Document 51
A41890213 PAG Minute dated 17 April 2020 - Enterobacter - Critical Care Unit – Bundle 2, Document 57
A41890214 PAG Minute dated 10 June 2020 - Burkholderia stabilis – Ward 11B/11D QEUH – Bundle 2, Document 58
A41890211 PAG Minute dated 7 September 2020 - Burkholderia stabilis – Ward 10B QEUH – Bundle 2, Document 65

32. Please tell us about HAI issues in QEUH between 2019 and 2020. What action, if any, was taken? To what extent was the action effective?

A. VRE Wd 4c - 4 VRE identified within a 12 day period within haematology beds in Wd 4c. 3 x blood cultures and 1 wound swab. IPC reviewed patient and noted that all had IV lines in situ and 3 had skin breaks of varying severities. Actions include; observation of practice – enhanced supervision of practice undertaken on 2 occasions and the findings were fed back to the SCN for actioning. Hand hygiene audit undertaken and results 100% therefore no improvement required. Typing of the samples undertaken but 2 were confirmed different. There were 2 further patients reviewed by IPCT with VRE positive blood cultures in September and October. Tissue viability contacted but there was nothing of significance from the team as they do not undertake wound dressing but only advise on dressing types. I don't recall the actions from Friends of the Beatson. There were no other clusters of VRE in this ward following this.

Enterobacter aerogenes Critical Care Unit 6 – 2 patients' isolated Enterobacter aerogenes from blood cultures and both linked to time and place. This was a period when COVID activity on the site was high and this ward was a covid hub. Staff ratio to patients was not as it would have normally been and this was thought to be a contributory factor. The hypothesis was patient to patient or staff to patient transmission. IPC increased visits to the ward to observe practice and in particular donning and doffing of PPE and there were no issues noted at the times of the visit. There was no hand hygiene or IPC Audit undertaken due to nature of the ward at the time. Typing for these 2 patients returned the same type. IPCT monitored for further cases and 2 new cases 10 and 12 days following the last

case. An IMT was planned and hypothesis discussed which included the length of time that staff were working while continually wearing PPE for duration of time in the clinical area was challenging and in addition there were staff working in the unit that would not normally work in this setting. Typing for the 3rd case returned the same as cases 1 and 2.

Burkholderia stabilis – Ward 11B/11D – 2 patients with Burkholderia stabilis in blood cultures within 2 days but with no direct crossover. Third case isolated Burkholderia stabilis in September 2020 and then 4th case in January 2021. Over this period PAG/IMT held and discussed possible environment and equipment sources both of which were included in previous outbreaks in Europe. Initially gloves and alcohol gel (level 11) was tested which returned negative. Following 3rd case water testing was also included with approximately 50 samples taken from 3 wards and all returned negative. In addition following identification of 3rd case ultrasound gel and blood bottles were also tested and again all results were negative. An ICD made enquiries as to whether there was any other boards reporting cases but this was negative. Discussions with hospital at night and imaging but both reviews showed no links. All 4 patients returned with the same typing and on typing result for Pt 4 it was noted that this matched 2 patients hospitals in England. Following further discussion the ICD was informed of Public Health England investigating 2 clusters of Burkholderia stabilis (6 cases) which following meeting with PHE with link to “Skintact” Ultrasound Gel which procurement reported that there was sporadic orders for this gel. Discussion with ARHAI Scotland, NHSGGC recalled this gel and sourced an alternative manufacturer. Samples of ‘Skintact’ ultrasound gel used within QEUH site were sent to PHE lab for further testing and PHE confirmed Burkholderia stabilis was not found in any of the ultrasound gels sent. No further cases noted and incident closed.

33. Was a link to the built environment suspected and if so, in what respect? Was a link confirmed?

A. From the hypothesis the built environment was not suspected as contributing to these incidents.

Observations

34. Do you have any reflections on what went wrong and why at the QEUH?

A. I am unable to comment on what went wrong in the QEUH. I was a lead nurse working in the South East Sector at the time and therefore working at sector level on not involved in the design, commissioning etc. I did think that there would be no estates issues within the new building on the site but that was not the case. Many of the issues raised in the media I was unaware of and only covered the adult wards and was not involved with the paediatric patients. As a sector lead nurse I was not always aware of specific issues unless they affected my site or team directly.

Declaration

35. I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

36. The witness was provided the following Scottish Hospital Inquiry Bundles/documents for reference when they completed their questionnaire statement:

Appendix A

A48807918 - Bundle 1 – Incident Management Team Meeting Minutes (IMT Minutes)

A43144419 - Bundle 2 – Problem Assessment Group Meeting minutes (PAG Minutes)

A48890718 - Bundle 13 – Additional Minutes Bundle (AICC – BICC etc)

A43293438 **-** Bundle 6 – Miscellaneous

A38244908 - Bundle 27 – Volume 6