TEN THOUSAND MORE VOICES

"Staff Experience of Personal Protective Equipment during COVID-19 Pandemic – First Wave"

September 2020

Share your story, shape our service

ACKNOWLEDGEMENTS

The Public Health Agency would like to express their heartfelt thanks to the many staff who submitted a personal experience of wearing PPE during the first phase of COVID-19 pandemic. We are aware that this may not have been easy; however the valuable contribution of so many has enabled this report to be as comprehensive and rich as it is. Many extracts from the stories and free text questions have been included throughout this report, some of which have been edited to ensure anonymity of respondents. We would also like to thank the members of the Infection Prevention and Control (IPC) Cell and trust Patient Client Experience (PCE) facilitators for their invaluable support in promoting and gathering stories. Without their energy and support it would be have been impossible to have reach so many in such a short time.

" Wearing the PPE created a feeling of safety. We continued to provide our service during the pandemic which patients and family were very grateful for."

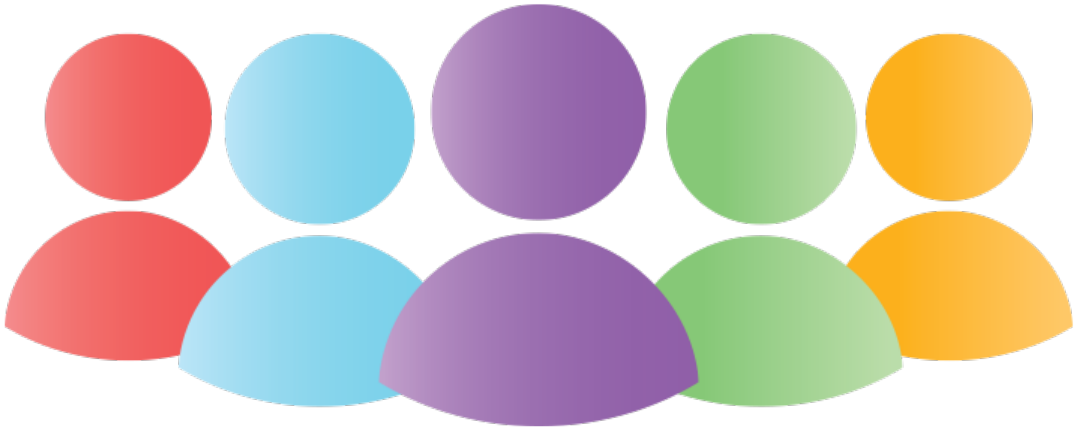


TABLE OF ABBREVIATIONS

Within the stories shared by service users & carers abbreviations are common. The following table outlines the full title for each abbreviation.

Abbreviation	Title
AGP	Aerosol Generating Procedure
BHSCT	Belfast Health and Social Care Trust
HSC	Health and Social Care
HSCB	Health and Social Care Board
IC	Infection Control (also referred to as IPC)
IPC	Infection Prevention Control
NHSCT	Northern Health and Social Care Trust
PCE	Patient Client Experience
PHA	Public Health Agency
PPE	Personal Protective Equipment
SEHSCT	South Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
SLT	Speech & Language Therapy
WHSCT	Western Health and Social Care Trust

CONTEXT

Data collection commenced in 7th September 2020 and ended 15th October 2020. In total **794** stories were collected across the region.

Organisation *Could select more than one*

- BHSCT - **209**
- NHSCT - **300**
- SEHSCT - **114**
- SHSCT - **113**
- WHSCT - **48**
- NIAS - **5**
- Independant Sector - **4**
- Primary Care - **2**
- Other - **4**

Frequency of Wearing PPE

- Sessional - **149**
- Regular intervals - **260**
- Prolonged periods - **265**
- Ad Hoc - **120**

Top 5 Clinical Context *Could select more than one*

- Acute Hospital - **396**
- Community Service - **195**
- Community Hospital - **51**
- Patient/Client's Home - **40**
- Across Directorates - **27**

Top 5 Job Roles

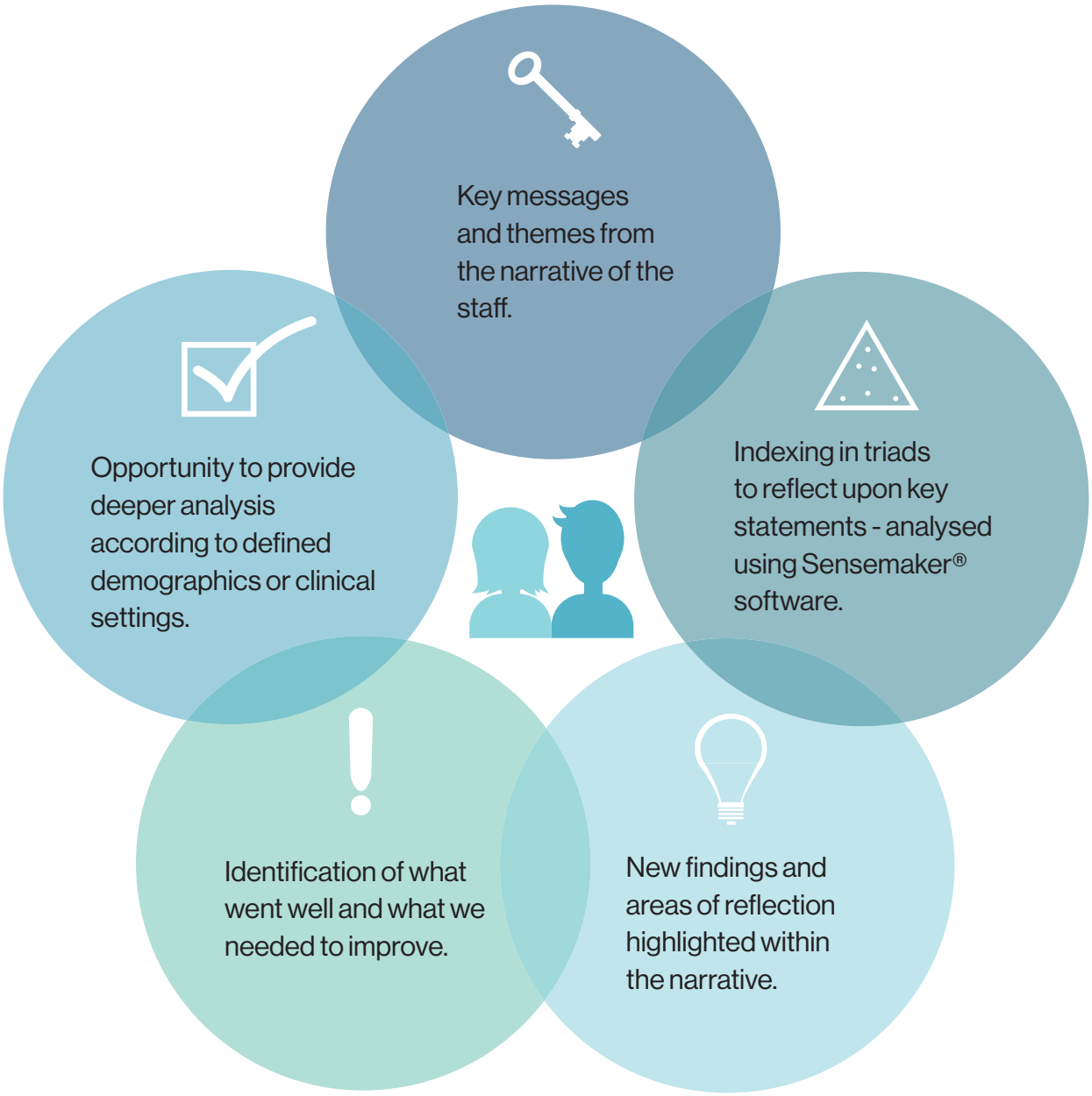
- Nurse - **177**
- Administration Assistant - **64**
- Occupational Therapist - **48**
- Care Assistant - **35**
- Physiotherapist - **34**

Type of PPE *Could select more than one*

- Fluid Resistant Mask - **626**
- Gloves - **617**
- Apron - **591**
- Visor - **392**
- FFP3/FFP2 Mask - **257**
- Gown - **180**
- Other - **99**

ANALYSIS OF SURVEYS

Key messages and areas of reflection highlighted in this report have been identified using a range of analysis tools, these provide rich insight and understanding into the experience of the people who engaged Mental Health Services during COVID-19 pandemic.



RESULTS

Summary of the dominant responses in relation to the key concepts analysed through Sensemaker®.

1

Engagement with IPC Teams

The dominant signifier indicated that 75% of respondants found the IPC team to be accessable. These responses related mostly to those who worked in an Acute Hospital or a Community Hospital setting.

2

Training

78% of respondants indicated that training prepared them for their job and that training helped support anxiety, a new learning experience and was easily put in practice.

3

Information Sharing

79% of respondants indicatied the information they recieved about PPE was in line with current guidelines.

4

Source of Learning

67% of responses indicated the main source of learning regarding PPE was through colleagues.

5

Provision of PPE

79% of responses indicated PPE provided was in line with the current guidance.

6

Support

72% of respondants highlighted the importance of somewhere to go during their shift where PPE was not required.

KEY MESSAGES

The following summarises the collective messages from the staff who shared their experience of wearing PPE during the first wave of the COVID-19 Pandemic.

- **The role of the IPC Team:** IPC provide an important role in training and information sharing in relation to PPE, however there are a number of challenges identified.

    1. Currently there is limited capacity for IPC Teams to effectively reach the whole HSC System (community based services and independent sector)
    2. Standardised general guidelines and training need to be tailored to specific clinical areas.
    3. Support, information and training is limited for staff during out of hours.
    4. Opportunity for training is not always available for all staff groups (for example clerical staff and social work teams).

- **Consistent Messaging:** It is important there is clear consistent regional messaging and communication channels across the whole system.

- **Escalation of Concerns:** It is important there is a process whereby staff can alert an organisation about the changes of quality of PPE provided.

- **Health and Wellbeing:** It is recognised that PPE although essential has impacted upon the health and wellbeing of staff and support stratagies are important for example maintaining hydration and safe areas for breaks.

1.0 INTRODUCTION

In March 2020 the Health & Social care system (HSC) faced one of its greatest challenges as COVID-19 Pandemic took hold in Northern Ireland. As the nation moved into lockdown, teams in HSC system were challenged to adapt current practices to ensure patients, clients, relatives, carers and colleagues were kept safe. Within the Public Health Agency a regional group known as the Infection Prevention and Control (IPC) Cell was formed with representation from across all areas of HSC system (Appendix 1). The Regional IPC Cell has been established to oversee the co-ordination of infection prevention and control across the HSC systems, Primary Care, including services provided by community, voluntary and independent sectors care providers. One of the greatest changes to practice was the implementation of new policy on Personal Protective Equipment (PPE), with many staff embracing these practices for the first time. In advance of further waves of the pandemic the IPC cell recognised the importance of the staff experience and engaged with 10,000 More Voice Initiative to support learning and identification of key messages.

The 10,000 More Voices Initiative has been commissioned and funded by the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) to provide a person centred approach to improving and influencing experience of health and social care services. This initiative supports exploration of people's experience through analysis of their stories- identifying key elements of positive experiences and understanding what needs to be improved through Sensemaker® Analysis. The following report outlines the analysis of stories shared by staff regarding the wearing of PPE during the first wave of the COVID-19 pandemic.

2.0 PROJECT OUTLINE

2.1 Aim

To explore the lived experience of HSC staff within acute and community settings/sectors, inclusive of services in the independent sector.

2.2 Objectives

1. Develop a system to enable feedback from end users around the quality of PPE across all HSC and Independent Sector.
2. To explore the narrative of staff in relation to wearing PPE, inclusive of the journey from March 2020.
3. To analyse core concepts of training, information sharing, confidence and support.
4. Present key areas of learning and reflection to better inform protocols in relation to PPE going forward.

2.3 Audience

The project was open to all staff working on the front line across each HSC trust and independent sector.

3.0 METHODOLOGY

3.1 Survey Design

In line with Experience Based Co-Design (EBCD) 10,000 More Voices promotes the principals of Coproduction through engaging service users in the design of the survey at the start of each project; however in light of the restrictions during the COVID-19 pandemic it was not possible to undertake a design workshop. Therefore the design of the survey was based upon core concepts of previous co-designed staff surveys where the data collection tool had been previously tested and the concepts could be applied to PPE experience. These Core concepts included training, communication and support mechanisms. Following approval through the Regional IPC cell the project launched on 7th September 2020.

3.2 Engagement

Promotion of the project was primarily through infographics on social media platforms, led by PHA and promoted by Trust Corporate Communications teams. The survey was also promoted internally through emails from Trust PCE facilitators and promotion within professional groups. The survey was promoted in a range of formats to support wide engagement.

1. Online product supporting respondents to share their experience directly into the Sensemaker® database.
2. Printed easy read version, made available with stamped addressed envelopes.
3. Interactive pdf version of easy read version to be returned by email.
4. Telephone consultation through 10,000 More Voices Regional Office.

3.3 Data collection

All data collection was anonymous with no personal identifiable detail recorded. For pdf returns forwarded by email, survey attachments were printed and email details deleted. All raw data from postal surveys, pdf returns and telephone consultations was collated and entered onto the Sensemaker® Analyst Online programme by 10,000 More Voices team. This online programme supports the analysis of narrative and identifies the key themes shared by respondents. Data was managed in line with Data Management Guidelines for 10,000 More Voices and 10,000 More Voice Governance Processes. Data collection closed on 30th September 2020.

3.4 Survey Design

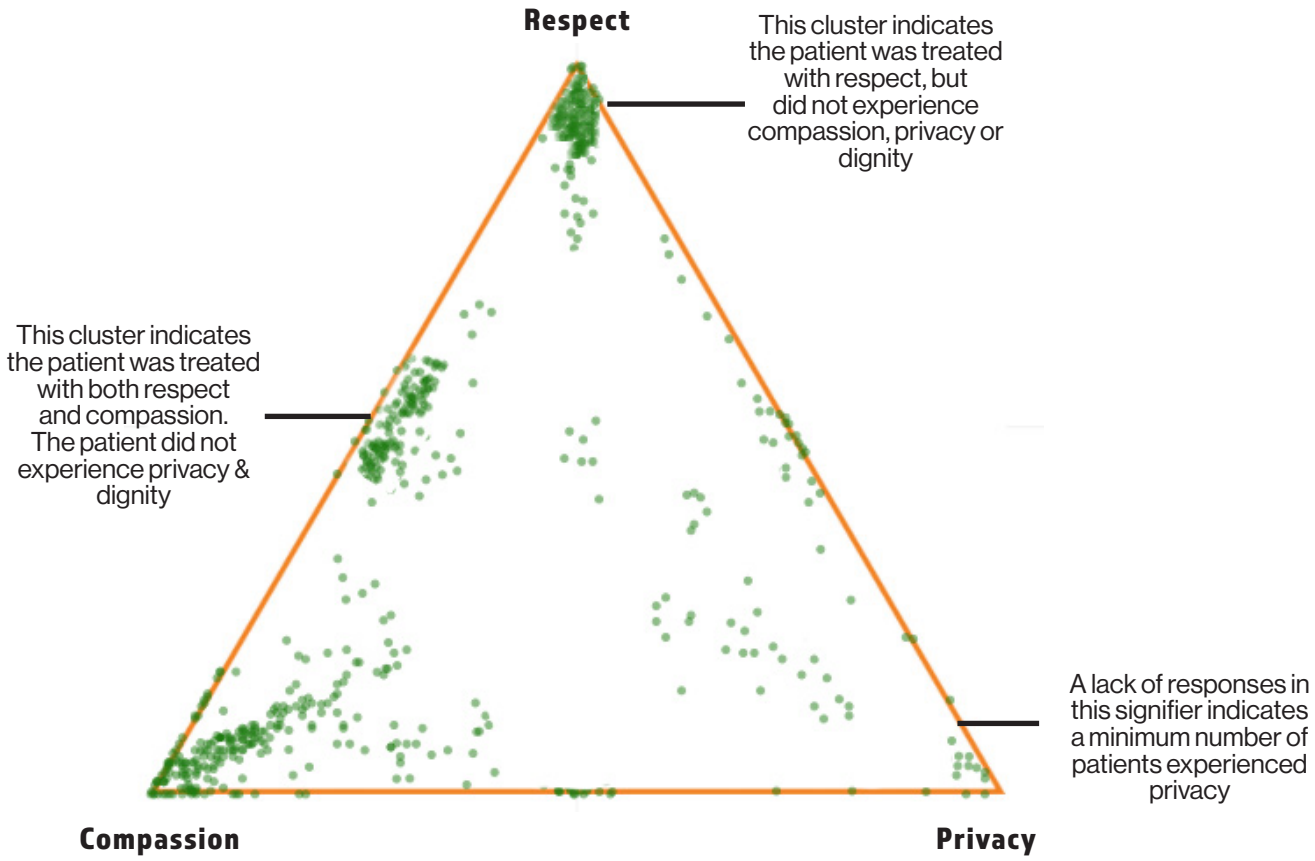
Using Sensemaker®: Understanding the responses.

The following outlines the concept of Sensemaker® with particular reference to the analysis tools known as Triads & Dyads. When completing the survey all respondents were asked to describe their most memorable experiences of wearing PPE during the COVID-19 Pandemic. The second section contained a number of statements to support the respondent to reflect deeper on their experience. These responses are recorded in Sensemaker® in the form of a Triad (triangles) and are included in Sections 4 of this report.

Triads illustrate pattern formation and clusters of response to each statement. In relation to triads the dot was plotted according to the relevant answers selected; if none of the response applied the respondent could tick "this does not apply to me". Each dot within the triad represents an individual experience of the resident, relative or staff, with each individual story accessed through the analysis software. A high concentration of dots in a specific area identifies an emerging pattern in relation to the answer. An example of responses to a triad is demonstrated in Figure 1.

Figure 1. Example of a Triad

Responses to statement: In my experience I was treated with...



3.5 Limitations of the Study

- To integrate the learning from experiences during the first wave of COVID-19 Pandemic into planning for future waves of the pandemic the timeframes for data collection were restricted to 3 weeks.

- Delays in postal services impacted upon the timeliness of processing surveys, with many received up to 2 weeks after the survey was closed. The numbers included in this report are accurate on 16th October 2020.

- Survey design with Sensemaker® is an academic data collection tool requiring a level of understanding around concepts such as triads. To support engagement and understanding with as many staff as possible, the methodology was adapted to support easy read versions and still support data analysis through Sensemaker®.

- Sample selection for the study was opportunistic in a short rapid process of data collection. Although numbers are not statistically representative of over the vast numbers of people employed in the HSC system, it is recognised every story counts and learning can be identified in the collective experience

4.0 FINDINGS & ANALYSIS

4.1 Overview of Returns

From 7th September 2020 to mid-October 2020 (accounting for postal surveys received after the project had closed on 30th September 2020) 794 experiences were shared through the 10,000 More Voices project. The first step of the survey was to build context around the experience through a small number of closed statements as outlined in the following figures. It is important to highlight the subsequent analysis focuses upon the data as a whole, however for each of the following questions briefing papers can be developed to dive deeper into the experiences in a particular context (for example by trust, services etc.).

Figure 2 illustrates the returns according to organisation, demonstrating engagement across the region. It is identified there is limited returns in the Independent sector Primary Care and NIAS. For specific learning in these areas it would be beneficial to undertake a focused study of each area.

Figure 2. Returns per organisation/sector across HSC system

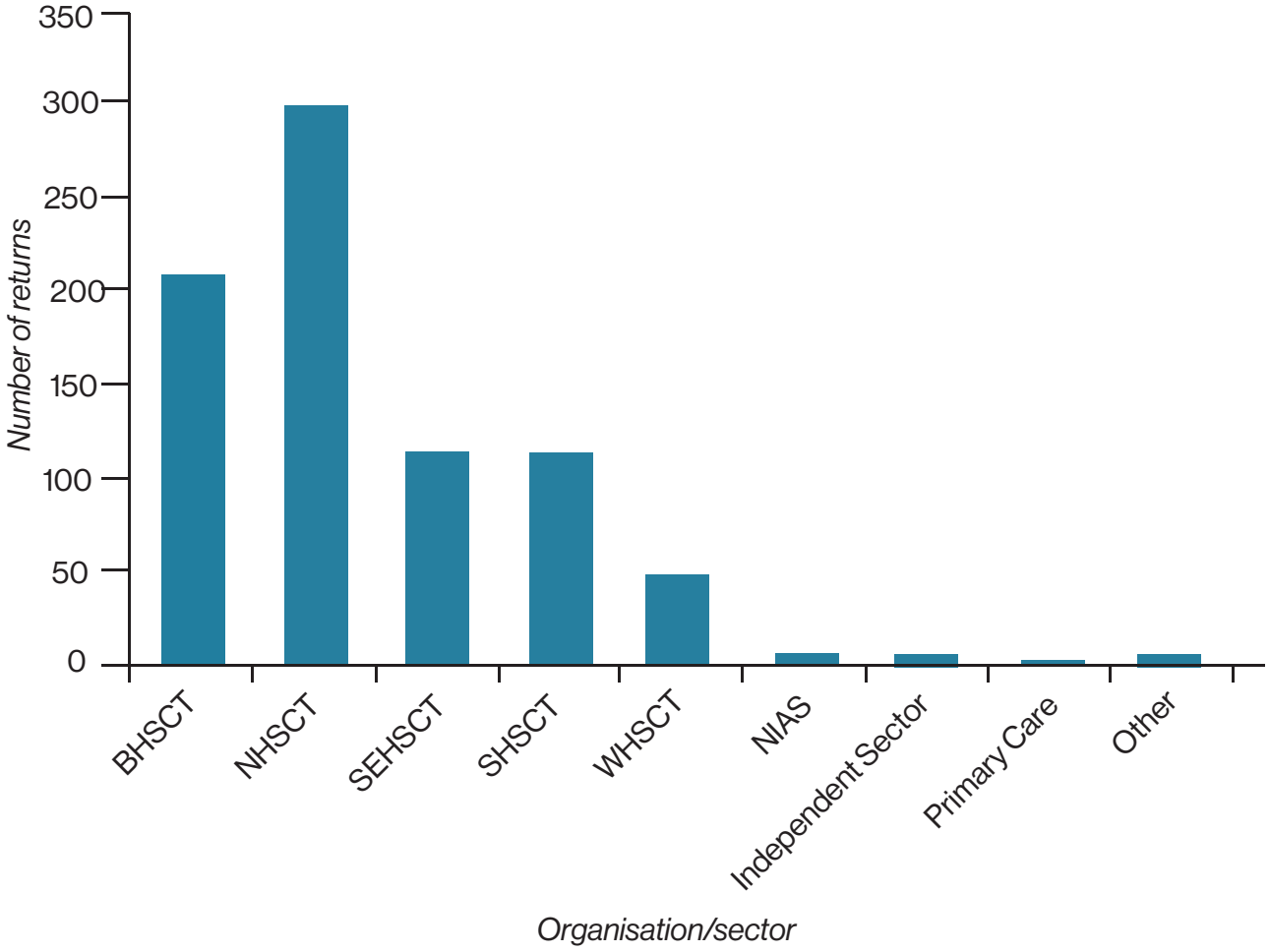


Figure 3 illustrates the professions/job roles represented in the data; It is evident nursing is represented the most. The category "Other" includes domiciliary care, radiographer, psychologists and laboratory technicians. To support deeper dive into other professions future studies could explore the experience of each profession in line with key findings of this project.

Figure 3. Returns per job role/profession across HSC system

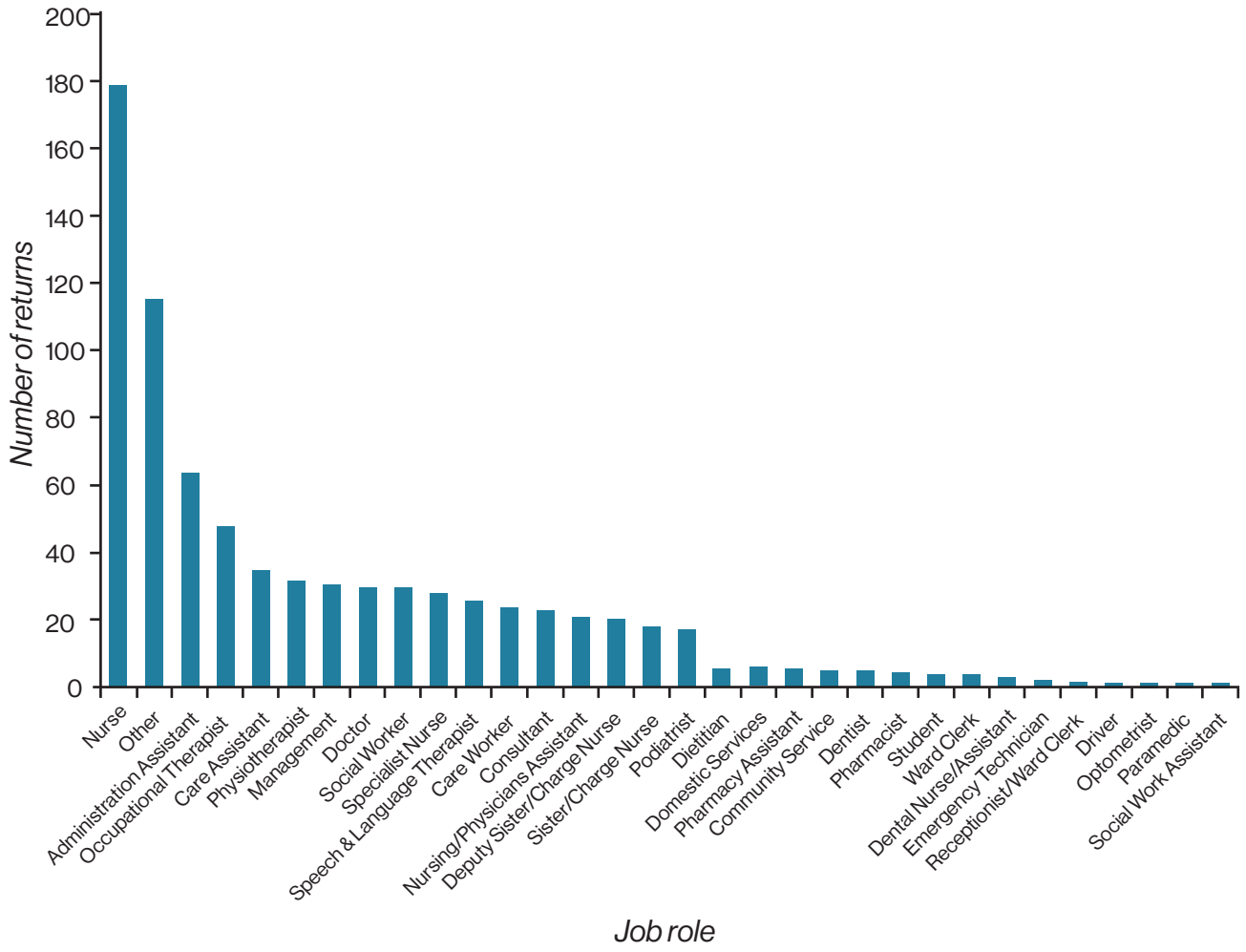


Figure 4 illustrates where the respondents work as defined as their place of work. This is important as the IPC requirements across the region are complex and will vary according to place of work. This is reflected in the analysis. The majority of respondents to the survey worked within the acute hospital setting. The category "Other" refers to offices, occupational health, Learning disability services, domiciliary care, portering and prison healthcare. It is important to note there were no responses from staff in General Dental Practices or Community Pharmacy; also there was minimal response from COVID related services such as COVID-19 Centres/Urgent Dental Care Clinics and other independent sector services such as GP, Care Homes and Supported Living. It would be beneficial to explore a second phase of the project in these areas.

Figure 4. Returns according to the question "At this time where is your place of work for the majority of your working hours?" (more than one could be selected)

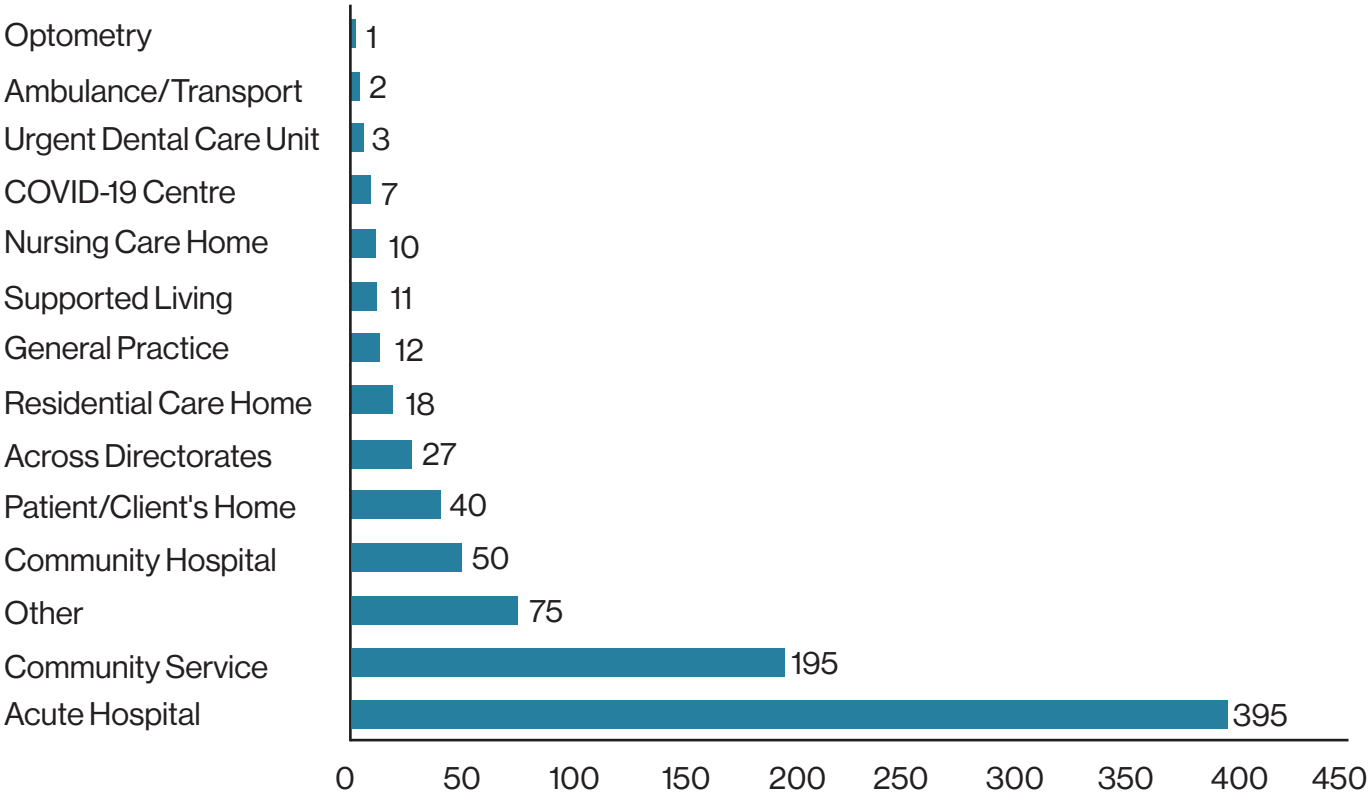
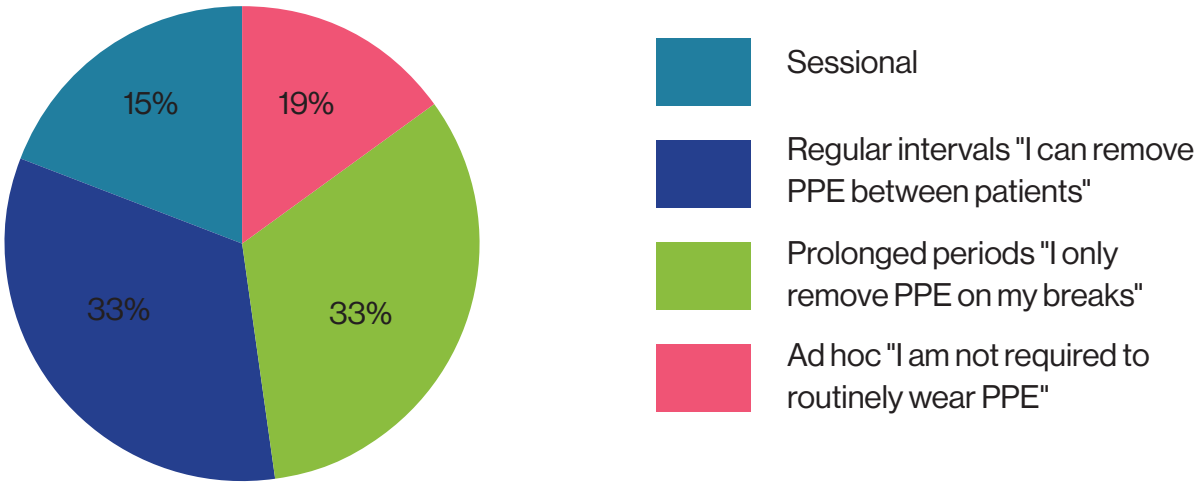


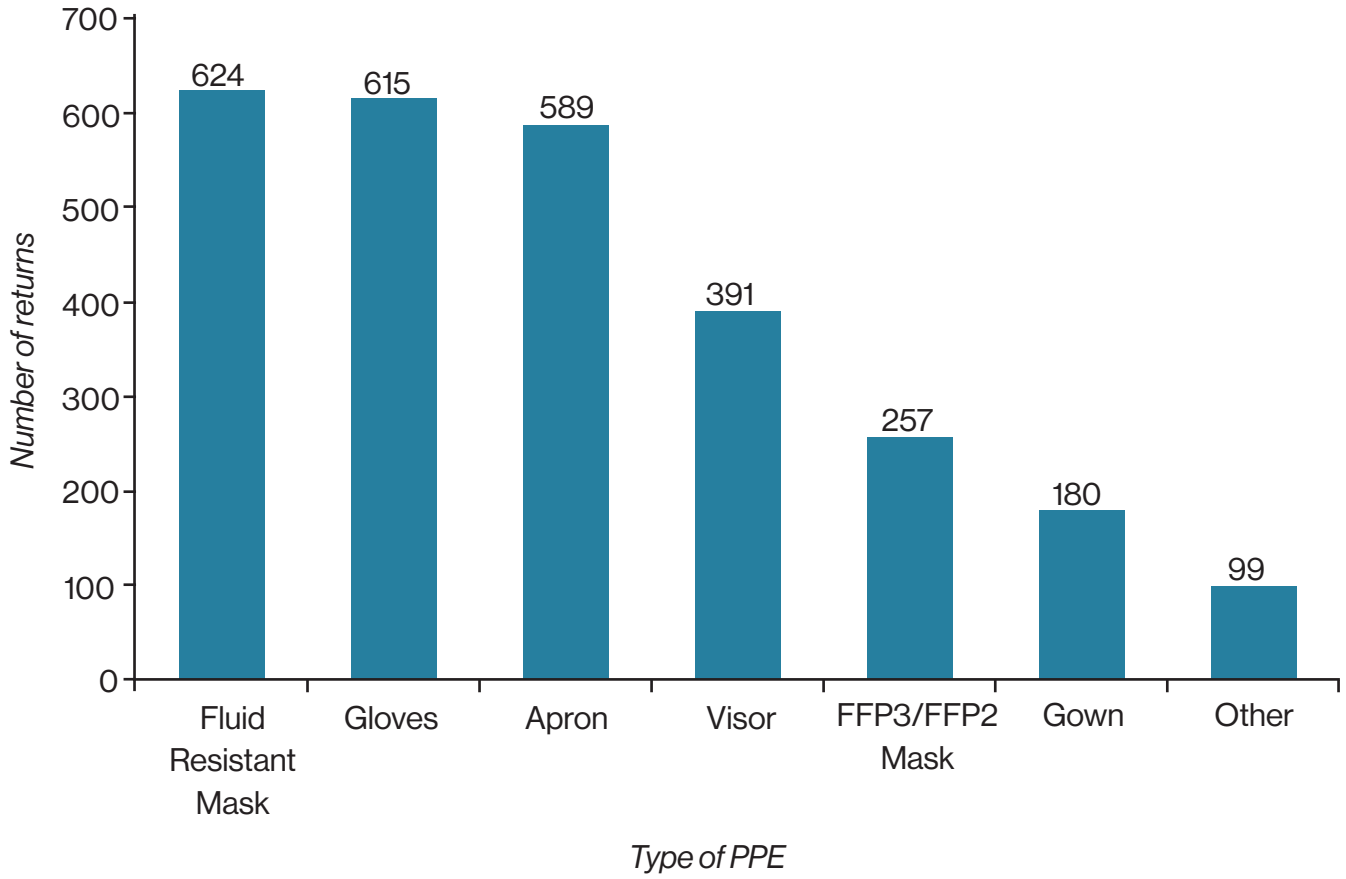
Figure 5 explores the frequency staff wore PPE during the pandemic. In the returns there is a balanced return on experience of regular intervals (remove PPE between patients) and prolonged periods of time (only remove PPE on breaks). There are fewer returns in relation to Sessional working – this refers to a single session/period of time where HSC worker undertakes duties in a specific clinical care setting or exposure environment. This information is integrated into the analysis of the stories to understand how the frequency of PPE relates to core concepts such as support.

Figure 5 (n=794) Returns according to frequency of wearing PPE



The final context is consideration on the type of PPE experience as illustrated in figure 6. Throughout the analysis of the data consideration is given in relation to the type of PPE experienced. The majority of respondents experienced wearing fluid resistant masks, gloves & aprons. Other refers to reusable fabric masks, goggles and scrubs.

Figure 6. Returns according to the type of PPE experienced. (more than one type could be selected)



Appendix 2 includes further context of returns relating to demographics – age, ethnicity, disability.

4.2 Summary of Experiences

The second step of the survey invites respondents to share their most memorable experience of wearing PPE from March 2020 to September 2020. These stories are integrated into the following analysis (section 4.3-4.9). Staff were also invited to summarise their experience in 3 words. Figure 7 illustrates the thoughts and emotions staff related to wearing PPE during COVID-19 Pandemic.

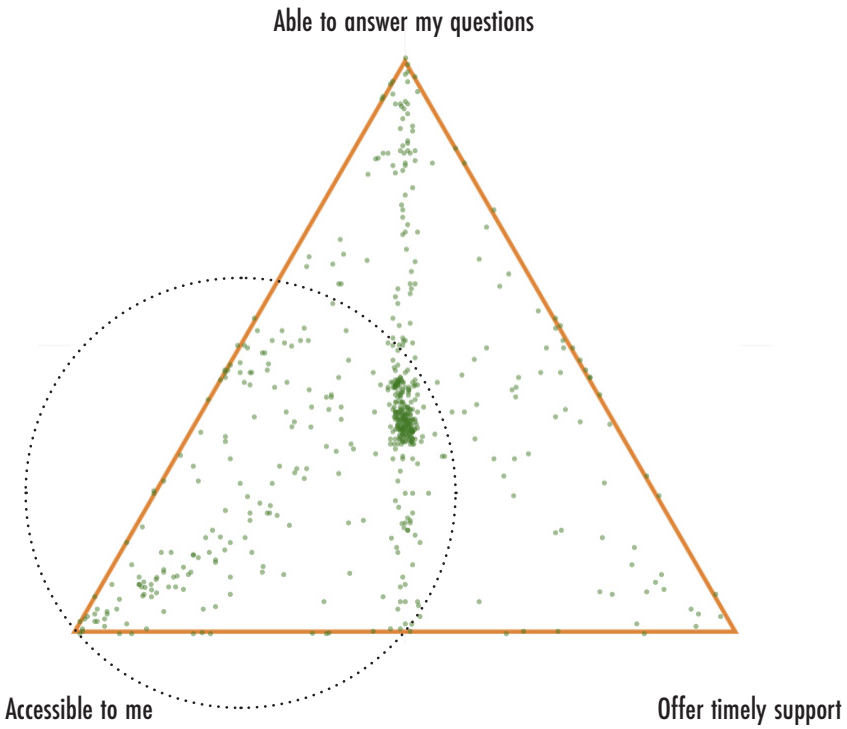
Figure 7. Word Cloud illustrating the response to the statement "Summarise your experience in 3 words"

These words echoed throughout the narrative shared in the following sections which present an overview of the findings of the core concepts included in Step 3 of the survey, providing an understanding of the data as a collective. The response for each statement is illustrated as triads and the key messages in the narrative explored.

4.3 Engagement with IPC teams

Statement 1 considered the interface between the IPC teams in the organisations and the clinical setting. The signifiers explored if the IPC team was accessible, offered timely support and answered the questions of the staff, as illustrated in figure 8. 581 respondents answered this triad, with 213 respondents stating none of the signifiers were applicable to their experience.

Figure 8. Triad 1 (n=581). The Infection Prevention Control (IPC) team are recognised as key stakeholders in the establishment of PPE Protocols. In my role/team, the IPC team are...



The dominant signifier indicated that 75% (n=434) respondents found IPC team to be accessible. It is important to note there is also a central cluster of 43% (n=251) which indicates all three signifiers were experienced – in these cases the IPC team was accessible, answered questions and offered timely advice. In the narrative there were no stories which related to a direct interaction with the IPC team. This pattern formation is mainly from respondents who worked in the acute hospital or community hospital setting and held a clinical role, mainly nursing. In this context, relationships with IPC team would be well established and the staff, particularly nurses, would normally engage with IPC teams.

Conversely reflecting upon the respondents who stated the signifiers were not applicable the majority of the staff worked in clerical roles within offices or members of the wider multidisciplinary teams in the community (for example occupational therapy or social work). In this context IPC teams may not have had the same working relationship prior to COVID-19 or limitations in relation to capacity to engage. It is also important to be mindful of the challenge to the capacity of an IPC team to extend their function and for increased expectations from the team by the system in general.

"...At the start it was unclear what PPE we wore as we heard about different social work teams were wearing different amounts of PPE and had been given things that we hadn't. Other teams seemed to have a mask and gloves long before ourselves. We felt our line manager didn't really know either and wasn't giving us clear advice which was frustrating..."

Within the narrative of the cohort of respondents who did not engage with IPC, they reflected upon a directive approach by management to advice given via IPC teams, a general sense of feeling forgotten and frustrations around mixed messages particularly at the start of the pandemic.

"...people were not given time and space to vent their anxieties during discussions around PPE but just told IPC says do this..."

"... we were forgotten about... it was not considered important what happened in the office or if we were safe... just left to it..."

"...It was very confusing at first, I started wearing a mask and gloves, but there was no evidence or protocol for doing so, then there was confusion and different messages from line management and our IPC nurse...I didn't feel listened to when my team started seeing service users again, and then the guidance moved to the stance that I had taken..."

"...I understand this was and is a very challenging time especially for the IPC team given that this was a new virus which we had very little knowledge of. However, I felt that it was very much a case of the them versus us. We were threatened with disciplinary had we used PPE inappropriately. The goal posts were forever changing. There was a clear lack of understanding between roles and lack of team work...."

"... Lack of IPC involvement except for one short information session in February... conflicting guidelines as opinions varied especially within IPC nurses..."

"I said I am happy to work in the bay with COVID patients but I would like to wear full PPE because of my health. The nurse in charge say that's fine. But in the afternoon infection control nurses came up and they said we were wrong and don't need full PPE... I raised my concern nobody listen ...anyway I continued to wear full PPE that day. Next morning I came back to work there were three or four people from higher authority walking around the ward... they took away the PPE stuff from the ward they said we don't need them in this ward because there was no patients with aerosol generating procedures. I feel really bad - I raised my concerns but they all treated me like a terrorist. It was awful day at work. In 14 years of working in the care field this is first time I feel ashamed to work in this field..."

Also respondents in this cohort expressed concerns seeking advice during out of hours and lack of flexibility or knowledge around a specific clinical area – for example paediatrics.

"...The IPC team gave instructions through managers and no direct advice to the staff on the ground when we had a patient with a positive test. They were not helpful out of hours...There was no realistic advice..."

"...basically they [IPC team] come across as not understanding what they are doing when it comes to paediatrics, demonstrate poor understanding of the practical ways we are forced to work and that policies may need to be adjusted for us..."

".. .The role of the radiographer has been overlooked in many respects throughout the pandemic and it has been offensive to the profession..."

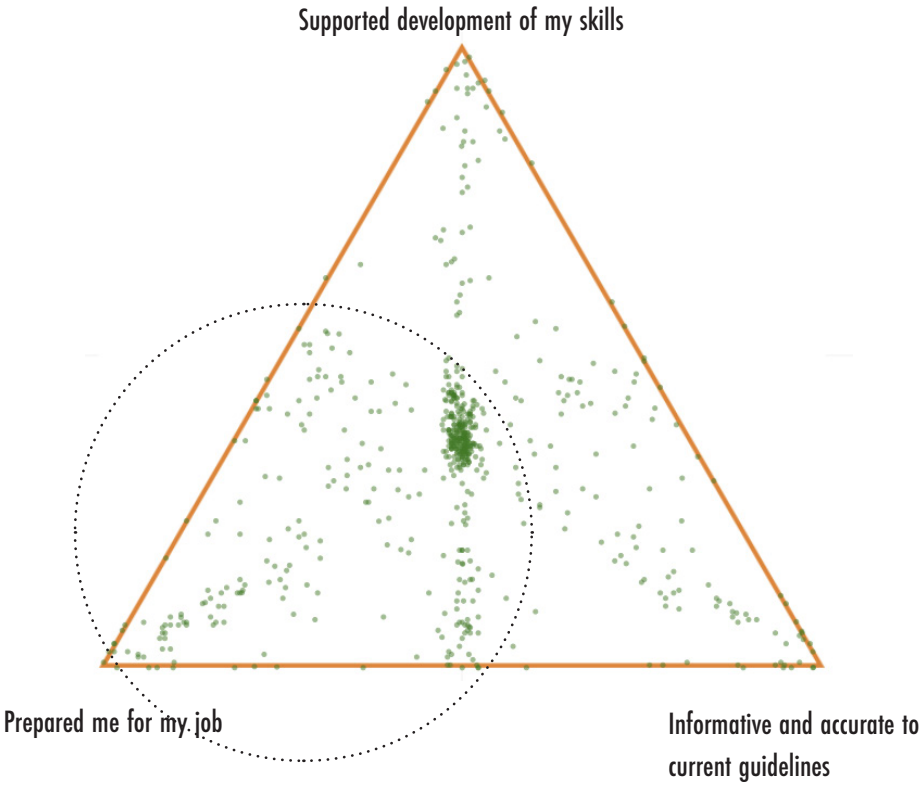
"...I feel that on nights we do not get the same level of support from IPC staff and feel forgotten about...."

The key findings in this triad identify IPC team had a more positive engaged relationship with clinical staff, primarily nursing in the hospital settings. The challenge is to understand and manage the expectation and needs of the workforce regarding the IPC support and how capacity or engagement can be enhanced to support a more positive relationship with the wider HSC system and understanding of the role of IPC team.

4.4. Training

Statement 2 explored the preparedness of staff in relation to the training they received on the management of PPE. The signifiers explored if the training supported development of skills, prepared staff for the job they had to do and was information & accurate to current guidelines, as illustrated in figure 9. 637 respondents answered this triad, with 158 stating none if the signifiers were applicable to their experience.

Figure 9. Triad 2 (n=637). Training on the management of PPE (for example donning & doffing)...



The dominant signifier indicated that 78% (n=497) of respondent who attended training felt it prepared them for their job. Also a central cluster of 42% (n=268) identified that through attending training they were supported in the development of skills (such as donning & doffing), prepared for the job role and provided with information which was informative, accurate and current. In the narrative respondents reflected upon how the training helped with anxieties, a new learning experience and a foundation which could be put into practice.

"...I was very frightened when I attended a training session for donning and doffing at the beginning of the Pandemic. I was afraid of making mistakes and putting myself, colleagues, patients and my family at risk. However, once I actually began using PPE in the clinical setting I was relieved because I felt safe and protected. I am very happy to continue wearing PPE as I feel confident in its effectiveness..."

"...I recall feeling very anxious after watching a video during a staff meeting, when we were preparing for having COVID positive patients. My anxiety was not with regard to having to wear it, but more around how I would remember the correct donning and doffing procedure. I went home and watched the video several times, then practiced with colleagues, before I felt confident that I could ' do it right'. Fast forward a few weeks and donning/ doffing became second nature..."

"...I was taught the appropriate way to don and doff through experience and some direct training... it was a steep learning curve..."

"...despite initially trepidation about wearing PPE, we received appropriate training to be able to get them on an off correctly, which built some confidence. It also gave me some reassurance when interacting on a face to face basis with patients who had COVID..."

"...Initially it was confusing, as the information re what PPE to wear and when, kept changing. An Infection Control nurse visited our facility in April and gave us a talk and a demonstration re PPE and this really helped. I was then able to advise other colleagues working in other community settings as they were confused too..."

In relation to the narrative of respondents who did not identify with the signifiers there was a lack of confidence in the person delivering the training, difficulty adapting the training to the specific clinical setting and the provision of training for out of hours.

"...concerns re training to donn and doff by a trainer who has no infection control background and lack of involvement from IPC - mainly via telephone..."

"... I don't believe she [trainer] really knew what she was talking about ... it was as if she was just reading a script... certainly couldn't answer me questions or concerns..."

"...I feel it's my duty and responsibility to wear PPE, It's my priority to protect my clients. Clients now expect it. We were trained on Donning/doffing PPE but only in a hospital setting. Putting it on in a community setting is very different and we have had little guidance on this thus I feel every team has their own approach..."

".... Training suddenly became an emergency and was rushed, planning was questionable..."

"...We only have access to on-line learning and posters if time permits us to view it. There seems to be lots of support and resources during the day but nothing at night time..."

Also within this cohort of staff (who indicated the signifiers were not relevant to them) a small number (n=31) stated they did not received any training on PPE.

"...In my normal daily role I don't use any PPE, so this was a big change for me- the PPE was quite hot to wear for prolonged periods. I did not receive training in donning/ doffing procedures; I watched the online video and read the signs myself..."

"...I was not given any training in donning and doffing PPE, I was anxious all the time when working with COVID patients. I was exhausted all the time had difficulty breathing and my face was constantly sore. It was not a good experience..."

"...No formal training has been received for donning and doffing PPE during home visits, no formal training has been received on questions to ask pre home visits regarding COVID symptoms. I appreciate that the trust has probably put procedures in place for all the above issues but this has not been filtered down to those of us who are actually completing face to face visits..."

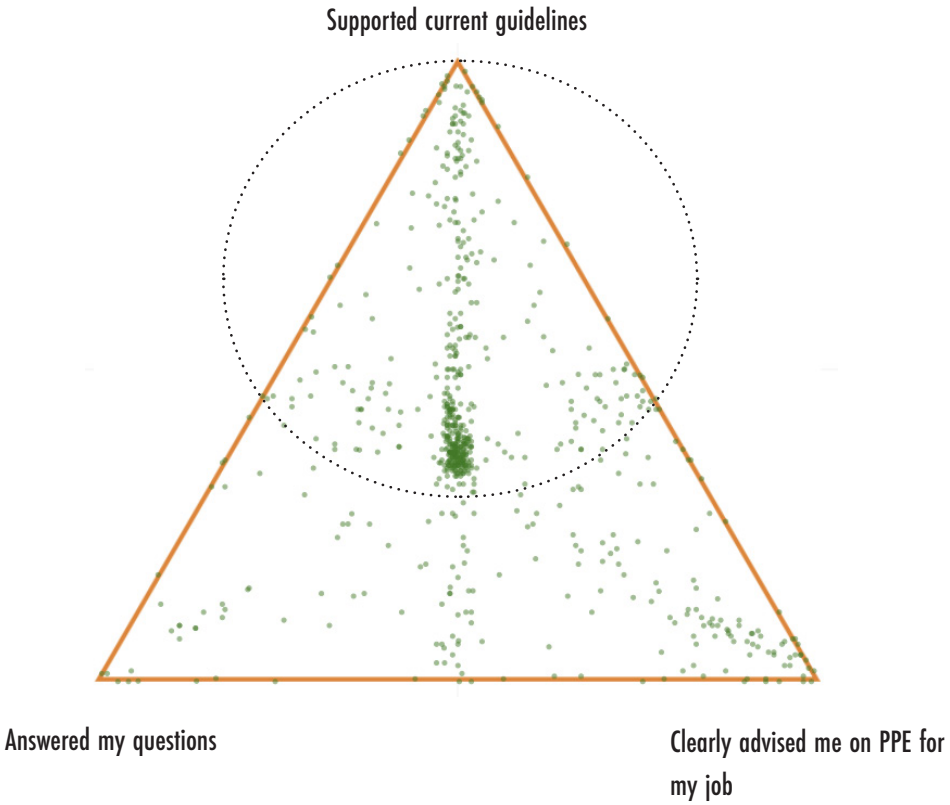
The staff behind these returns were from both acute and community. The professions represented were administration staff, social work and occupational therapy.

The key message in this triad is the majority of staff recognised the training they received prepared them for the job they had to do however respondents also reflected upon the importance of training delivered by trained IPC staff, training available for out of hours and the importance of training for all staff who may engage with patients/clients. It is also identified various training methods were engaged (including online resources and reference documents) to support the roll out of training during the first wave of the pandemic. The challenge is to provide training in a timely and effective manner during a time of high pressure and need. There is also a need to explore and to develop training cohorts of staff who felt less supported during first wave of the pandemic – for example in the case of responses to this survey suggested areas are community staff, staff working out of hours or specific professional groups such as social work/occupational therapy.

4.5 Information Sharing

Statement 3 explored the effectiveness of information received regarding PPE considering if the information was in line with guidelines, answered questions and supported the respondent to do their job role. 704 returns answered this triad with 93 stating the signifiers were not applicable to their experience. Figure 10 illustrates the response to the signifiers with a central cluster of 45% (n=315) stating all three signifiers were part of their experience, reflecting that information received supported current guidelines, helped them fulfil their job role and answered their questions. The dominant signifier "support current guidelines" was selected in 79% (n=556) of responses. There is also second dominant pattern for the signifier "clearly advised me on PPE for my job" selected in 69% (n=486) of responses.

Figure 10. Triad 3 (n=704). Information I received on PPE within my workplace…



"…The initial hype and uncertainty about what I needed to wear and when was a concern. Also, I was vigilant about the correct order for donning and doffing PPE. The posters were very helpful, in this regard…"

"… In XXXX [Care Home Name removed] we had lots of questions. The manager was up at all hours trying to find answers… eventually the information came and with that our anxieties were lessened – we could get on with our job knowing we were doing the very best for our residents…"

"…Direction was not clear at start of pandemic, ward staff arguing about when and who should be wearing PPE, Guidelines are clearer now staff are all aware of when and what areas it is needed for…"

The signifier which had least responses was "answered my questions"; in the narrative respondents reflected upon frustrations around specific clinical procedures or processes; Also there was some conflict in putting the information into practice.

"...At the beginning of the pandemic we asked if we should wear masks or visors and were told not too then we were told we had to wear masks and visors which was all very confusing. Infection control guidance was very confusing as posters stated we should wear visors but were told not to. It was then decided that we should only wear masks and risk assess if visors were required. Guidance was also lacking and confusing when transferring a patient from our day hospital to another unit if the patient displayed symptoms of COVID, we were unsure of what PPE was actually required in this instance leaving us feeling very vulnerable. Guidance is still not clear right now as some teams are still wearing visors and masks."

"...Frustration at the beginning regarding what exactly what we needed to wear and when...issues with chest physio re AGP's difficulty going in and out of red zone to get equipment..."

"...A lot of confusion early on about what to wear and when... Infection control telling us we didn't need FFP3 masks. My ward was closed and I moved to ICU where initially I thought I was at more risk. However all in full PPE and although uncomfortable realised I was well protected... My ward colleagues still in a position of being told not to use full PPE... Drs asking for patients to be tested on ward for COVID and infection control saying not needed..."

"...On treating patients that required AGPs I had to state my rationale for wearing full PPE before my treatment ... which was frustrating... it was like I was in the wrong and had to defend myself..."

"...We initially wore visors with all ?COVID patients, this then changed to only confirmed cases and then changed again to only confirmed cases having aerosol generating procedures - of which coughing and nebulisers were not included. Members of staff in other areas (e.g. DPU) wore more PPE than staff on the COVID ward itself..."

Similar frustrations were expressed in the cohort of returns which stated the signifiers were not applicable. The narrative reflected upon conflicting messaging and individual interpretation of the information received.

"....It's been incredibly confusing, with different messages coming thick and fast regarding what to wear, where, when, how often to change, etc. Sometimes you're told different things by 3 different people on the same day. Too much has been left up to individual interpretation and local implementation at Community sites. There's no one clear message and it's making people more and more anxious....As a SLT it's been a nightmare..."

"...There was instructions coming from senior management about when and where to wear FFP/ fluid resistant masks; however this advice was changing on a daily basis. This caused concern among staff regarding where we appropriately protected? As a staff nurse who works agency in other health and social care trusts, the other hospitals had very different routine of PPE which was better than the current trust I'm employed by..."

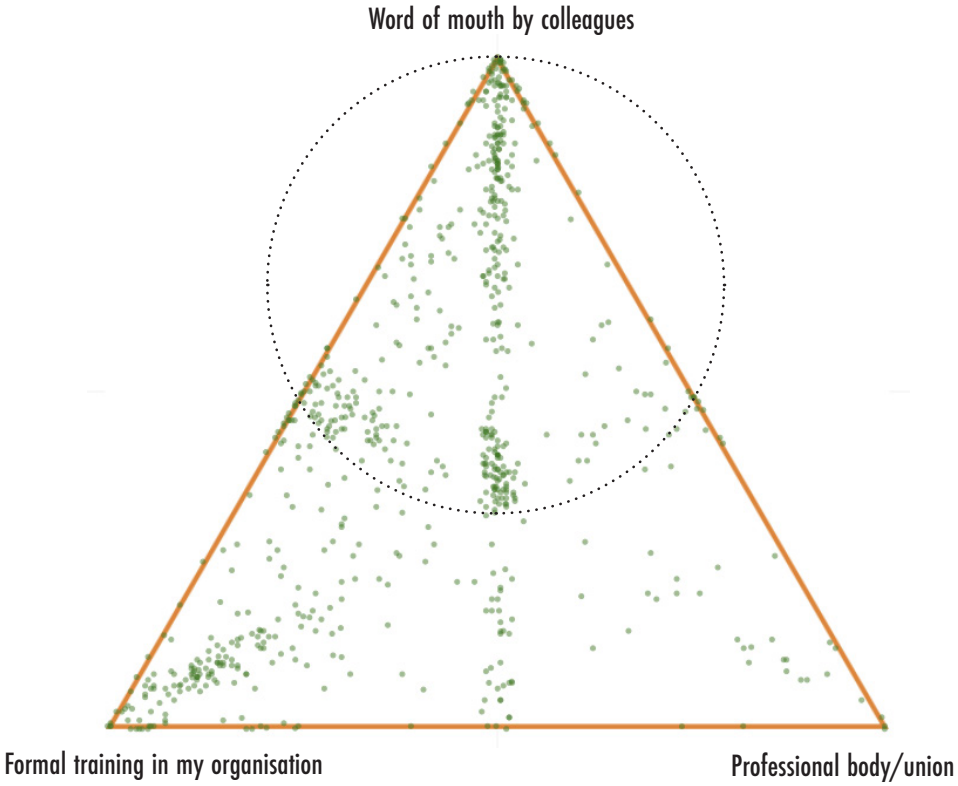
"...Currently, it is felt that standards have slipped a lot on wards and again we are being made to feel that we are going overboard by wearing fluid resistant mask with visor, however we are following the guidelines laid down by the Trust. We need the leaders in each profession to ensure that appropriate PPE is worn by all. One voice for all..."

The key message in relation to information about PPE is that the information received was in line with the current guidelines and supported people to do their job. Identified in the narrative the challenge is ensuring the information is consistent across the organisations and professions. In Wave 1 where staff did not feel the information supported their questions it would be beneficial in future waves to explore the current frequently asked questions and seek to offer clarity within the guidelines.

4.6 Source of Learning

Statement 4 explored the sources whereby staff learned about PPE considering three signifiers – word of mouth by colleagues, training in the organisation or through professional bodies/unions. 735 respondents completed this triad with 61 stating it was not applicable to their experience. The dominant signifier "word of mouth" is indicated in 67% (n=490) of responses; however there is also second pattern formation with the signifier "training in the organisation" indicated in 57% (n=419) of the response., as illustrated in figure 11.

Figure 11. Triad 4 (n=735) The source of my learning regarding PPE is….



In relation to responses to the signifier "word of mouth" which were at the apex (indicating formal training and professional bodies were not a source of information) the narrative highlights a sense of isolation or lack of clear communication from management during the first wave. Respondents reflected upon these factors as source of anxiety and also reliance to learn about PPE from within their team.

"At the beginning of the pandemic, there was no PPE available to our Field work team of Social Workers. Staff took it upon themselves to spend their own money and source their own equipment and cleaning products which was not easy as this was in short supply with local retailers. On one occasion, a manager took some of our PPE and cleaning products (sourced by ourselves) to distribute to another team who also did not have any PPE. There was a belief amongst the team that there was poor communication from above about PPE and there was no clear sense of what mechanism was in place for staff to report low (or no) PPE equipment within the team. There were high levels of anxiety amongst the staff team during Lockdown initially as no one was communicating anything down…"

"...I find it very frustrating that admin staff in buildings on hospital sites but not necessarily the hospital building appear to have been forgotten about. It was mid-May before anyone came to talk to us about desks being 2m apart. We have been told that we are not getting masks provided because we're not in a clinical setting. I strongly fail to see the difference in us and ward clerks and why we have to pay for something mandatory when they don't..."

"...We have always used high level of PPE and IC. However there was a lot of anxiety over the new PPE and poor support from dental hierarchy. Staff on the ground responded excellent and it became a new way..."

The professions noted in this cohort of staff were community based services such as dental services, domiciliary care, optometry and clerical teams within hospital settings. This is similar for responses which indicated professional bodies/unions as a source of learning about PPE. These stories were reflective of information regarding supply and demand of PPE during the first wave or interpretation of the guidelines into specific practices (for example dental surgery)

"...At the start of the pandemic in which fear was a factor, PPE supply and the accurate testing was vital. I did not find any problem accessing the required PPE but the challenge was in using it during surgery. It did take time to get used to wearing it. The recommendations from the various colleges and NHSE helped to guide when it was appropriate to use..."

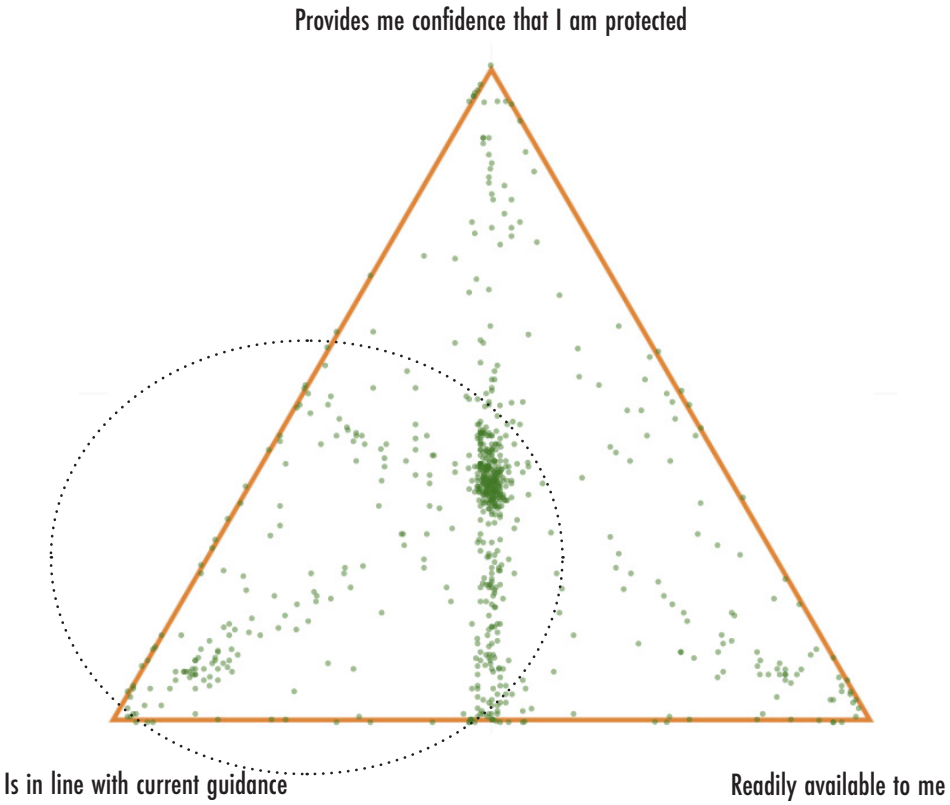
"... the trust has never provided me with a mask that fits ... I have been to my union on several occasions – I'm not sure they can help me either but they assure me they are heavily involved in securing the right equipment – I am happier knowing someone is fighting the side of the staff on the ground..."

The key messaging around the source of information is that training in the organisation and word of mouth between staff are key sources in learning. It is important to highlight there is a challenge regarding consistent messaging across the whole HSC system and in particular ensuring effective channels of communication between staff and management structures in community based services including the independent sector.

4.7 Provision of PPE

Statement 5 reflects upon the current provision of PPE exploring if the current PPE the staff wear provides confidence, is available and is in line with guidelines. 735 respondents completed this triad with 62 staff stating it was not applicable. As illustrated in figure 12, the dominant signifier was that PPE provided was in line with the current guidelines as indicated in 79% (n=577) of responses. There also clear pattern formation that current PPE provision was also readily available to staff as indicated in 66% (n=486) of returns. It is acknowledged in the narrative how the supply of PPE has improved throughout the staffs' journey through the first wave of the COVID-19 pandemic.

Figure 12. Triad 5. (n=735) The PPE I currently wear for my job role….



"…At the start it was also difficult to source adequate quantities of PPE and we were always scared of running out. When we asked for more PPE we were only given small quantities at a time. Portable (pocket sized) hand gel was as scarce as hen's teeth. I eventually got one in one of the goody bags that were handed out to community staff… Eventually in July we were told that we were each being given individual supplies of PPE for our community activities…Supplies have definitely improved now…"

"..Wearing PPE to carry out my role has been challenging. Initially the issue was the provision and sourcing of PPE; Now we have adequate supply however wearing a fluid resistant mask and visor as a glasses wearer is difficult…."

"…. Initially it was hard to get standard masks, but now the supply is very efficient, for the supply of masks, gloves, hand sanitiser and disinfectant wipes. Within the trust we are required to wear masks when entering and leaving the building and when leaving our offices walking along a corridor etc. We are not required to wear them in our own offices…"

"…Initially the big question was, where is all the PPE? Understandably the limited supply went to hospitals but what about community staff, had we been forgotten about? At last the PPE arrived!.."

"…In my current role, which is in a Health Centre setting - face-to-face contact with clients ceased at the start of lockdown. Only in recent weeks, following the directive from Government that PPE should now be worn in work settings has this now been implemented … the wearing of PPE is something which quickly becomes normal and provides reassurance of more security when encountering other staff colleagues and patients entering the same Health Centre facility (who are attending other appointments). A good supply of PPE has been received by my Department for when face-to-face contact resumes again with client…"

Despite the positive messaging that current PPE is available and within guidelines It is important to note that only 52% (n=382) of responses were confident that the PPE protected them. The elements evident in the narrative are concerns raised about the effectiveness of Fit Testing, the use of PPE past the expiry date and a change in the quality of the PPE provided. Also highlighted in the stories is a lack of process to escalate concerns regarding the quality of the PPE provided in the first wave.

"…the wearing of PPE is very important however I do wish the quality was better. Plastic gowns which make you sweat more, gloves which rip quite easily and fluid resistant masks which slip down your face do not make for a pleasant experience. Imagine also having to wear a FFP3 mask which has 2 different expiry dates on them, some of which have an expiry date of 2014, not very reassuring…"

"…The mask we were being given were of very poor quality, straps breaking, leaving us very vulnerable as they didn't give us a tight fit around our face. The number of staff who suffered real anxiety re their own safety was huge!!."

"…. Face masks do not always adequately fit staff members, and some were passed on FFP3 masks with a 40% pass rate during the fit test, which was unacceptable…"

"…. You also did not feel protected as the gowns did not always close properly at the back and were so thin they tore easily. There were no long gloves and people had to ta[e gloves to their gown to stop them rolling down. My gloves rolled up and apron pulled up on several occasions exposing my skin when working with COVID patients in ICU…"

"… it took weeks of form filling to convince people above us that PPE wasn't good enough… this was time we didn't have and we were left feeling that our opinion didn't count and that it was accepted by infection control… for weeks no one listened…"

"…The fact that it took a month of complaints sheets about the ill-fitting ear loop masks to have loop holders provided…"

"…It is awful and there are not enough masks to use them in the recommended way and we have been forced to reuse single use items… The whole experience has been mismanaged and chaotic…"

"…. Initially, it felt like PPE was being stockpiled - we were told to wipe & reuse visors for time which didn't sit well with my colleagues. There has been variations in quality of PPE - aprons have become thinner & at one stage we were using aprons that weren't tie-able… so difficult to get out of…we ended up stepping out of them…felt a bit like wearing a bin bag…"

"...This [dehydration] has gotten worse especially now since we have tie masks not elasticated...not very practical to take off/on... but sure no one would ask us if it was a good idea – we just have to accept it..."

Also in the narrative there is a number of stories relating to concerns about infection control measures specific to community – in particular donning & doffing in the car, disposal of PPE and concerns about transmission of the virus to the staff members home environment. This reinforces previous messaging into the questions around adapting guidelines into community based services.

"..Staff were worried about the level of protection PPE would give them and to a lot lesser extent still have that worry. How and when to don and doff the PPE was stressful for staff in the community - do they do it at the car before going into the home or do it in the home?? What do we do now that the weather is getting colder and wetter - these are the current questions from them...."

"...I have to wear PPE whilst visiting with service users. I transport it and my waste before and after in my car. Coming out the visit is difficult trying to open my car and dispose of my PPE in a sanitary manner which means I am not bringing any contamination into the car for the next visit..."

"...Sorry this was very stressful time in my life I felt I had not got the proper PPE to do my job correctly...when at the patients house I'd take a deep breath get out of the car and prep with PPE- a mask shield gloves and apron ... this often was put on in the pouring rain and high winds. Walking into the house I was scared- 'hello I'm .....I'm here to do a little test on you'. This patient has a cough and Is coughing persistent as I go to swab she states 'what are u doing I'm here?' 'I'm .... I'm here to do a little test on you'... 20 mins pass I finally get to test her this takes time as the patient has dementia ... So I'm thinking 20 mins in a small room with a patient with possible COVID I then walk out take off my PPE with the wind hurling around my face. 'What else can I do?' I ask myself. I drive to my next patient I think 'what do I do if I give this person COVID 'as I still have the dirty scrubs on so I'm contaminated. I pull over the side of the road get into the back of the car hunched down. I change my scrubs and sanitise myself. I place my scrubs in a bag and get back to driving I think to myself 'frig my car seat. It's contaminated now!' This distressed me as I felt that I was not doing my job safely for all the patients. I go home after a long day I say 'what more can I do?'.

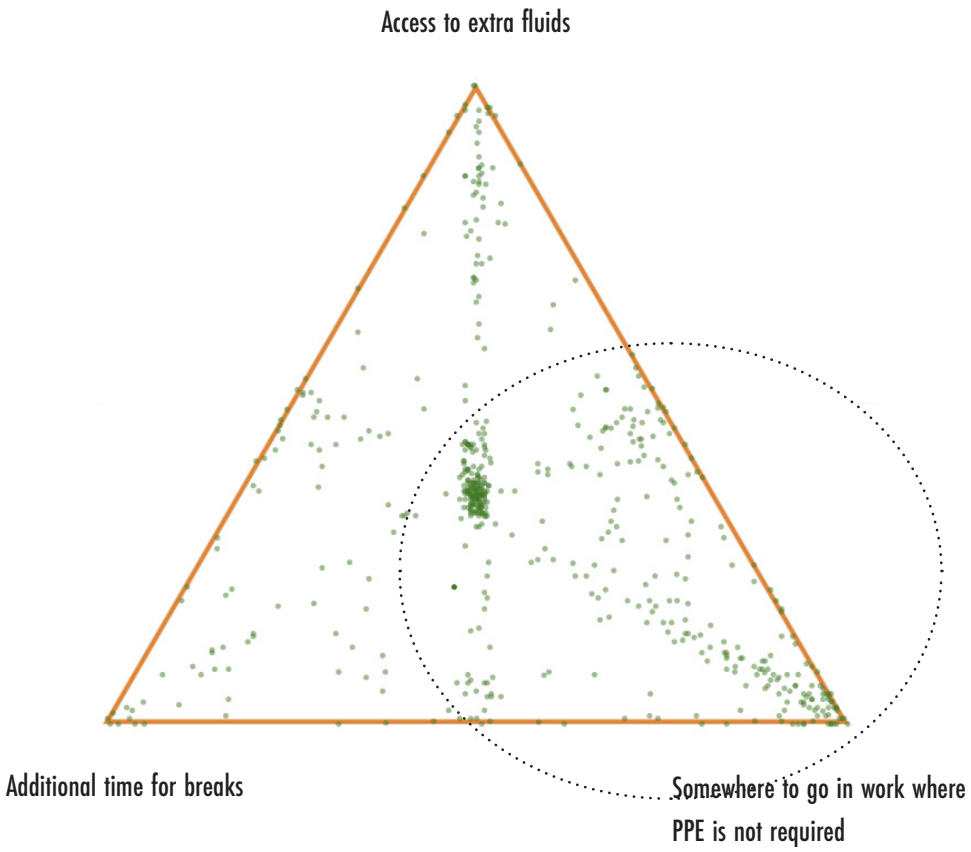
"... my car has become my clinical space... my office.. and then I go and collect my young family... with the best will in the world- how do I know my car is safe?..."

The key messaging in this statement reflected an improvement in the provision of PPE and the application of current guidelines over the journey of COVID 19, moving into a normalising phase of wearing PPE; however there is some limitations shared in the confidence that the PPE provides protection for the staff. The staff indicated the importance of a process to effectively escalate concerns regarding the quality of PPE; There is also the need for reassurance and transparency around fit testing, expiry dates and re-use policies in relation to PPE to support staff to feel confident they are being protected.

4.8 Support

The final probing statement in the survey considers the strategies available to support staff when wearing PPE – exploring access to extra fluids, additional time for breaks and provision of somewhere to go where PPE was not required. 581 respondents completed this triad with 216 indicating this was not part of their experience. It is important to acknowledge the wording of the statement does not indicate if this is something the staff experienced or required so the analysis reflects upon what is important to staff moving forward into the second wave.

Figure 13. Triad 6. (n=581) To help me cope with wearing PPE...



As illustrated in figure 13 the dominant signifier was the importance of somewhere to go in work where PPE is not required as indicated by 72% (n=416) of respondents. There is limited narrative indicating that staff experienced protected spaces; however the narrative very clearly demonstrated both the physical and emotional consequences of wearing PPE, particularly for staff groups who wore PPE for prolonged period or sessional working.

"...it is very hot and uncomfortable - unable to see over the top of mask clearly. The mask presses on bridge of your nose- incredibly painful after 12hrs of wearing. Also making you feel nauseated. Face mask straps cut into top of ears and long gown is restricted in movement... I feel panicked thinking this is the only barrier between you and COVID patient..."

"...Walking into Nightingale intensive care felt like I was walking into war... 2 hours in full PPE felt like 2 days. The fear, the overwhelming sense of panic, claustrophobia, discomfort, heat, the pain and the intolerable urge to run..."

"...painful and necessary – I understand why it has to be done but sometimes three shifts in a row and only getting your FFP3 mask off at breaks is horrendous. Despite trying everything the skin is off your nose by the end of the second day. I've had more headaches recently and I believe it's from continual mask wearing and the lack of ability to get water in between my breaks. Imagine sweating in scrubs, gown, apron and mask visor without being able to get a mouth of water for 4+ hours?"

"...., I find it very difficult to wear PPE for anything more than 30-40mins at one session but this is unfortunately the current situation so I end up feeling physically unwell at times. I have had more headaches and issues with gums/dental issues and skin issues. I actively try to hydrate and take breaks but depending on workload this can be difficult and in this case PPE has a lasting impact on my working..."

"...During the surge I wore full PPE everyday apart from during breaks. In the ward staff were rotated so we had 2 hours in PPE and 1.5 hours on break. The organisation of the staff rotation was changed when the ICU was moved up to the ward so that when I was on nightshift I had spent 9 hours in PPE with only 3 hours out of PPE. This led me to become dehydrated and I woke up with headaches due to dehydration when I was sleeping after my night shift. Another member of staff developed lethargy and headaches which she attributed to wearing PPE for such long periods of time but then came back COVID antibody positive. I thought that it remarkable that the effect of wearing PPE on us could be confused for actually having an episode of COVID infection..."

"...I would be tell them it is horrendous wearing PPE whilst at work. I would say how much we have to wear and how I only get to get out of it on my breaks. I would also say how often I have to change my scrubs due to sweating ++ and how I feel dirty cause my bra is still wet. Wearing the PPE leaves me tired and drained as it is so warm, my skin on my face is dry, behind the tops of my ears hurt. My hair can be soaking to the extent you would think I have had a shower. I am dehydrated during the shift as we can't drink water whilst in PPE..."

"...Another time I was resuscitating and providing one on one care to a very sick extremely preterm baby. I was unable to leave his side to even take a drink of water as he was so sick and every second mattered. The soaring heat from the heater of his incubator made it physically draining. The emotional stress was also continuous as I fought to save his life. For nearly 10 hours I was by his side. I was so dehydrated and hypoglycaemic it was one of the hardest things I have done in my life. Luckily he made it and eventually I was able to give myself a fluid bolus by drinking a litre of water and quickly eating what I could get my hands on!..."

This narrative also reflects the importance of staff staying hydrated due to the impact of wearing PPE for long periods. 59% (n=340) indicated the importance of access to extra fluids to support staff during the pandemic. In the narrative there is some evidence of good practice to support staff to stay hydrated; however in the greater majority staff highlighted challenge and the need for more support to stay hydrated.

"..... We are here on a day to day basis supporting the patients, holding their hands. They are scared. We are scared. Out of our minds... It's lovely to feel appreciated. My Manager provided us with extra bottles of water. If it wasn't for her we would have fallen at the starting line..."

"...On normal days when we are just wearing amber PPE, you can get very thirsty on the ward and it is helpful to have water available at donning as otherwise it is a long journey to the canteen for water which adds to the number of people walking down that corridor..."

"...Wearing masks in corridors & offices is necessary but disheartening for staff when 1st implemented... we are getting used to it... we definitely drink less water as a result - quite often I come home with a full 1 litre bottle of water untouched!.."

Similar messaging exists in relation to the third signifier which is the need for extra breaks. Although this is the signifier with least responses (47%/n=273) it is mentioned within the narrative when reflecting upon the challenge of wearing PPE. Within the narrative there is also the challenge to taking formal breaks due limited capacity - competing pressures due to reduced staffing or increased demand with ill patients.

"...During the COVID-19 pandemic I was working in ICU as a nurse looking after COVID-19 positive patients, in which was a very high risk area. I was working 13 hour shifts, during the day and night shift. On commencing my 13hour shift I went to the donning area where I applied my full PPE, FFP3 mask, hat, visor, gown, apron and gloves - there were staff allocated to assist with this which was great and checked to make sure I had it all on correctly before entering the 'high risk' area. I would have had to wear this for my full 13 hour shift, with only removing it for my breaks. My breaks would have been morning, lunch and tea time all lasting 30 minutes each. On occasions depending who was in charge we would have got an afternoon break around 3pm. It was very warm and suffocating wearing the full PPE for long periods at a time and on occasions I felt myself becoming agitated..."

"...I found wearing the PPE for long periods of time very deflating. Continuously wearing it was draining and to comply with guidelines on negative pressure no windows were aloud open or fans to be switched on. Although ward management facilitated breaks every two hours the heat was unbearable and created very difficult working conditions..."

"...It isn't very pleasant wearing PPE for any length of time, during re-deployment to ICU it was very tiring & hot wearing full PPE and after 2.5-3 hours I felt at my limit of being able to tolerate it & very fatigued. I had to change both top & bottom scrubs after each stint, as you would feel freezing as soon as you came out of the bay and doffed due to excessive sweating in the hot COVID bays where no windows were able to be opened. Feeling the sweat roll down your face behind a mask is not nice & makes the mask feel slippy on your face also. You definitely need more than a 30 minute break when wearing full PPE to allow yourself time to rehydrate and relax. Carrying out physical duties which are heavy in nature is extremely difficult when wearing full PPE, such as lifting an unconscious patient's upper body up off the bed during changes of head position when in prone position"

"...Breaks were treasured and the safe zone where staff could remove PPE and have a break was much appreciated by all..."

Reflecting on the powerful messages within the narrative it cannot be underestimated the key message around the importance of additional support within organisations for staff working on the frontline. Regardless of profession, service or role the changes to PPE requirements has presented massive challenge as demonstrated on the honest and frank memories shared by respondents. The challenge for organisations & services is to embed support into everyday practices to sustain the health & wellbeing of the staff moving into future waves of the pandemic.

5.0 Summary of Key Messages

The following section summarises the collective messages from the staff who shared their experiences of wearing PPE during the first wave of COVID-19 pandemic as identified in section 4.0; it also outlines the challenges and areas for reflection to prepare and support staff during further waves of COVID-19 pandemic.

- IPC team have an important role in training and information sharing on PPE, to support staff to undertake their job role and stay in line with guidelines. Training and information sharing supported staff to manage anxieties in relation to COVID-19; however a number of barriers were identified in the staff experience during the first wave of the pandemic

    1. Limited relationship and capacity for IPC teams to reach the whole HSC system such as community based services and independent sector.

    2. Standardised general guidelines & training were difficult to apply in all settings – there a need for guidelines to be tailored to specific clinical areas such as paediatrics, learning disabilities and patient's homes in collaboration with the health professionals.

    3. Support, information & training was limited for staff working during out of hours in acute settings.

    4. Opportunity for training was not always available to some staff groups such as clerical staff and social work teams.

- Staff valued consistent messaging across the region regarding PPE. Where consistent messaging was challenged there was limited engagement with management or senior structures and there was variation between organisations, trusts or professional interpretation of guidelines. This highlights the importance of clear communication channels regarding PPE across the whole system and the exploration of frequently asked questions regarding guidelines to reduce any ambiguity for specific clinical settings.

- As individuals who wore the PPE for long periods and in the clinical setting, staff indicated the need for a process to ensure timely escalation of concerns to alert organisations about changes in the quality of the PPE provided. Openness and transparency in relation to the provision of PPE was highlighted as important to support staff to have confidence that the PPE provided the right protection.

- Wearing PPE during first wave of COVID-19 Pandemic was a great challenge to all staff across the HSC system. Although recognised as essential it impacted upon the health and well-being of many staff working in all areas of the system. Staff experiences have highlighted the importance of the organisations and services to implement strategies (for example additional time and resources to support staff to stay hydrated during prolonged use) to support staff in further waves of the pandemic.

6.0 Next Steps

Through integration of these key messages from the regional study into future planning regarding PPE the experience of the staff will shape and inform practices going forward; however the key messages and findings within this project extend beyond the Regional IPC Cell - they also challenge wider stakeholders involved in staff health & wellbeing, training and development and workforce planning. It is important the regional report is published and shared widely with strategic forums to ensure staff experience influence in all these areas.

This report presents the overview of all the narrative shared as part of the regional project, however further analysis can be supported to explore through the filter questions for example experience by organisation, profession, clinical setting or frequency of PPE usage. For further information contact Regional 10,000 More Voices Team by email: 10000morevoices@hscni.net.

7.0 Appendices

7.1 Appendix 1: Overview of IPC Cell

The regional IPC Cell has been established to oversee the co-ordination of infection prevention and control across the HSC systems, Primary Care, including services provided by community, voluntary and independent sectors care providers.

Strategic tasks and actions

1. Co-ordination of response to regional COVID-19 Infection prevention and control issues.
2. Influencing, informing, translating and dissemination of policy guidance into practice.
3. Effective regional cluster and outbreak management.
4. Effective communication between bronze, silver, and gold in relation to infection prevention and control issues and concerns.
5. Providing expert and resolved infection prevention control advice and guidance across the HSC system.
6. Support PPE Modelling for the Health and Social
7. Provide resolved IPC advice on PPE products.
8. Provide infection, prevention and control support to emergency contact centres.

Key Work Tasks

- The Northern Ireland IPC cell is part of National IPC Cell in shaping and influencing PHE guidance
- Translation of national guidance for local use. IPC cell have established a PPE product team to review the quality of PPE prior to procurement.
- Co-ordination and standardisation of IPC training across health and social care services.
- Establishment of an Outreach IPC Programme for Care Homes.
- Overseeing the development of a new Regional Fit Testing Framework.
- Development of a framework for the effective utilisation of PPE including decontamination and developing guidance on how to prevent skin damage under respirator masks.
- Development of IPC educational material to support COVID I9 testing.
- 10,000 Voices Survey of staff experience of PPE
- Oversee the development of PPE Modelling Framework in supporting the effective procurement of PPE in response to COVID 19 and service rebuilding programme.

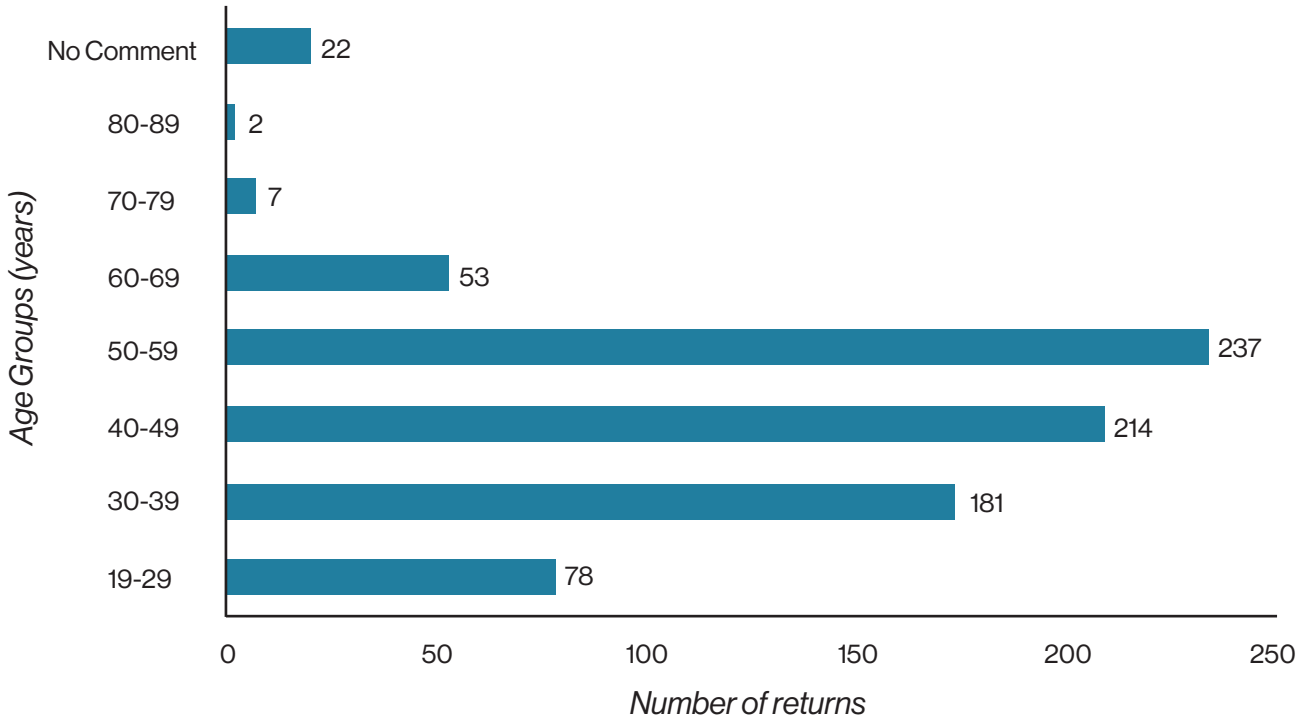
Regional IPC Cell Membership

Name	Role	Organisation
Rodney Morton (Chair)	Director of Nursing	Public Health Agency
Hannah Gamble	Project Manager for IPC Call	
Pauline McMullan	AHP Consultant	
Siobhan Donald	Interim Assistant Director for Nursing	
Fiona Hughes	Health Protection Nurse	
Caroline McGeary	Senior IPC Advisor	
Ruth Donaldson	Social Care Lead	Health & Social Care Board
Gillian Clarke	Medical Adviser	
Jonathan Montgomery	Dental Adviser	
Karen Scarlett	Senior Inspector, Regulation	RQIA
Ruth Finn	Infection Prevention and Control Lead	NIAS
Claire Fitzsimons	Infection Prevention and Control Nurse	BHSCT
Grace Doherty	Infection Prevention and Control Nurse	
Janeen McKeown	Interim Lead Infection Prevention & Control Nurse	
Karen Devenney	Senior Manager Nursing, Quality, Safety & Infection Prevention & Control	
Ruth J Robb	Infection Prevention and Control Nurse	
Naomi Baldwin	Senior Nurse Patient Safety and Performance	NHSCT
Isobel King	Infection Prevention & Control Lead	SEHSCT
Annette O'Hara	Act lead for Infection Prevention and Control	SHSCT
Clare Robertson	Acting Deputy lead IPCN	WHSCT
Wendy Cross	Head of Infection Prevention and Control	

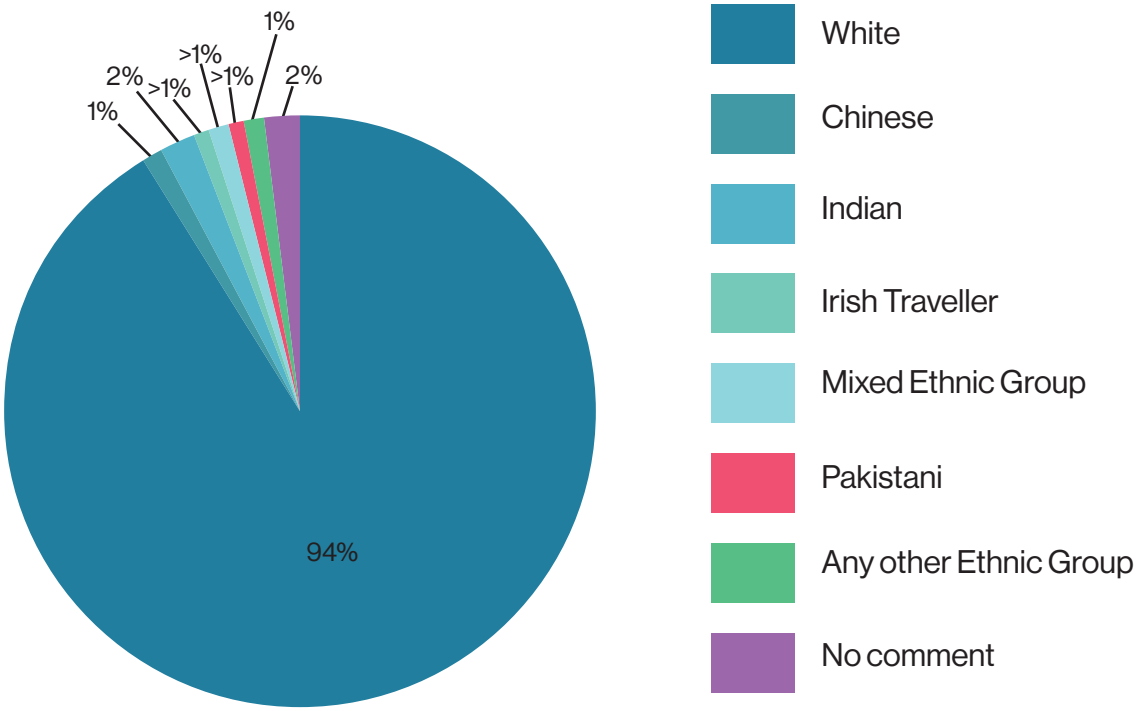
7.2 Appendix 2. Demographics

The following charts summarise the demographics related to returns.

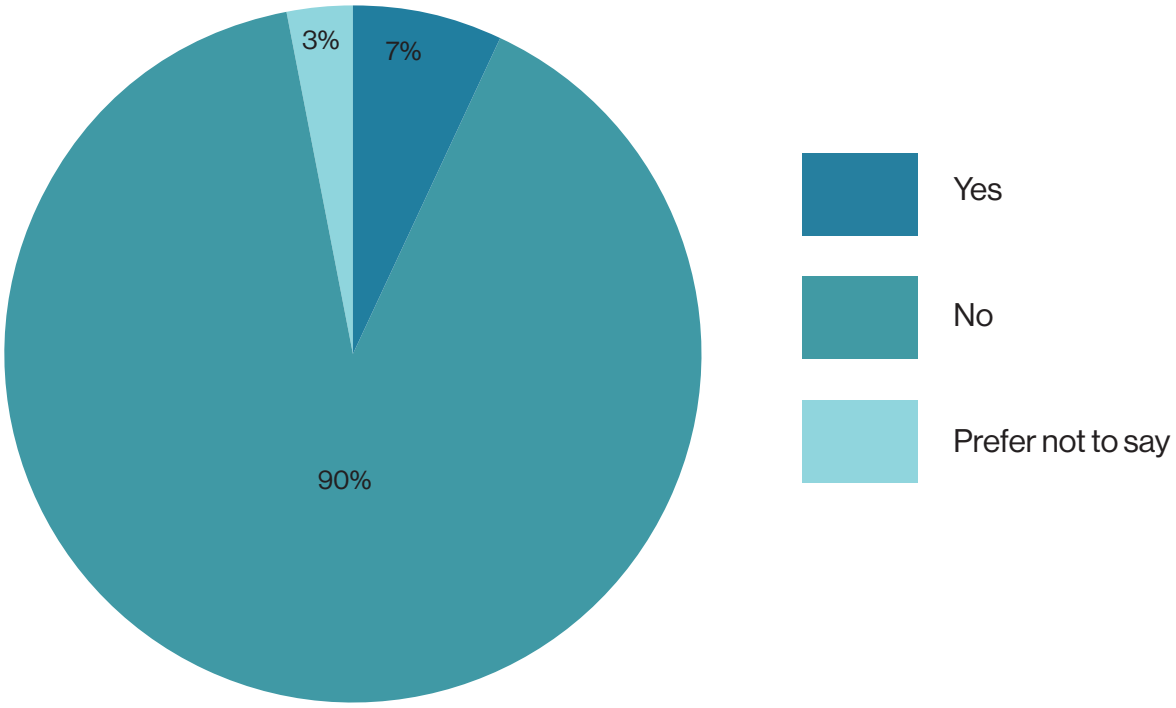
(a) Age



(b) Ethnic Origin

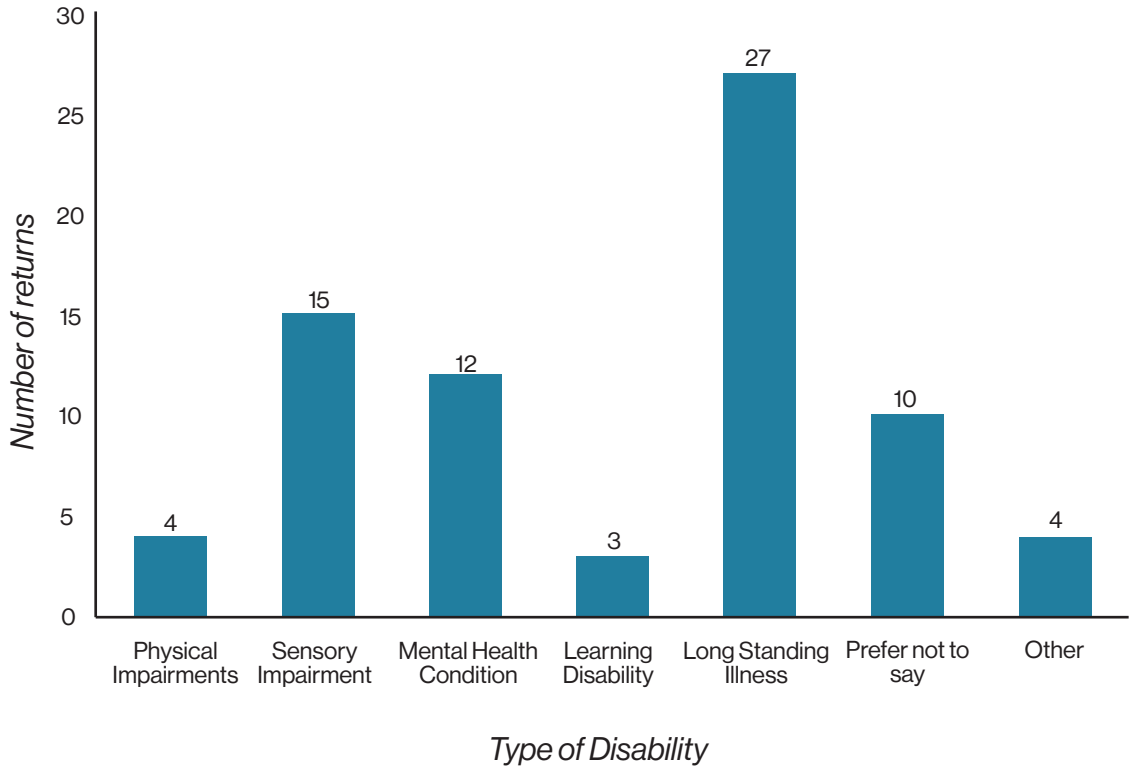


(c) Disability



(d) Type of Disability

53 staff answered yes to (c). The following breaks down this cohort in terms of disability. In this question more than one answer could be selected.



1000 More Voices Initiative is managed by-
Regional Lead for Patient Client Experience (PCE): Mrs Linda Craig: linda.craig3@hscni.net
Assistant Director for AHP, PPI and PCE: Mrs Michelle Tennyson: michelle.tennyson@hscni.net

HSC Public Health Agency

HSC Health and Social Care

http://10000morevoices.hscni.net