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Infection prevention and control board assurance framework

24 December 2021 Version 1.8

Updates from version 1.6 are highlighted in yellow.

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have further developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with UKHSA Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 and other related infection prevention and control guidance to identify risks associated with COVID-19 and other seasonal respiratory viral infections The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors, and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, guidance on the required infection prevention and control measures has been published, this has now been updated and refined to reflect the learning from the SARS-CoV-2 and to acknowledge the threat from other respiratory viruses. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users, and staff.

This framework has been developed and updated following updates in the guidance to help providers assess themselves as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors, and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self -employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. Local risk assessments should be based on the measures as prioritised in the hierarchy of controls. In the context of SARs-CoV-2 and other seasonal respiratory viruses, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed, and mitigated effectively.

Infection prevention and control board assurance framework – LPT self-assessment V1 14.1.21

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility service users and any risks their environment and other users may pose to them				
Key lines of enquiry	**Evidence**	**Documents**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • a respiratory season/winter plan is in place: o that includes point of care testing (POCT) methods for seasonalrespiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services o to enable appropriate segregation of cases depending on thepathogen. o plan for and manage increasing case numbers where they occur. o a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units aspart of the Trusts winter plan.	Paper/verbal update at OEB on 5.12.21 to outline decision to maintain current IPC pathways, testing and patient placement Clinical Reference Group oversees all clinical decision making processes which then escalates to the ICC	Revised UKHSA IPC guidance November 2 CRG TOR updated 28012022 (002).docx		Safe systems of working, Red, Amber & Green, POCT for all in-patients, segregation of cases
• health and care settings continue to apply COVID-19 secure workplacerequirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Covid secure risk assessments completed for every area. Reviewed and updated with any change to service or after an outbreak. 401 COVID secure risk assessments completed. A spreadsheet includes data sign off and review dates.	Local LPT Covid Secure RA - July 2021 A Template - Covid Secure Certificate - M		
• Organisational /employers risk assessments in the context of managingseasonal respiratory infectious agents are:	Every action count risk assessment adopted to risk assess admissions to a Covid-19 outbreak	Admission to an area where there is a Covic		

○ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in thelocal area. ○ applied in order and include elimination; substitution, engineering,administration and PPE/RPE. ○ communicated to staff. • safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have beenapproved through local governance procedures, for example Integrated Care Systems.	Clinical Reference Group oversees all clinical and decision-making processes which then escalates to the ICC. Add in system quality meeting Action to review pathways and plans longer term and process for risk assessing			

• if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems. • risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents. • if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered. • ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services. • the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	LPT follows national guidance. Action cards developed in line with the guidance Every action count risk assessment adopted to risk assess admissions to a Covid-19 outbreak Risk assessment sign off includes Lead IPC nurse and DIPaC. Access to specialist Authorised Engineer (AE) or advisors e.g Health & Safety, Ventilation. C1490_i_EAC risk assessment tools - pri Risk assessment and sign off through CRG Admission/Transfer risk assessment and Outbreak Management Policy. Identified Red areas for patients with covid19. Single rooms first option for patient with any infection. COVID-19 outbreak agenda.docx Currently Covid-19 is the only respiratory infection		

	reported to Trust Board		
• there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	DoN/Deputy clinical visits undertaken regularly. NED visits currently paused		
• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	Covid-19 observational tool completed weekly currently on paper includes all staff completed weekly and daily in an outbreak meeting Hand hygiene audits inputted to a Trust App. Monthly reports produced and submitted to IPC group Programme of IPC environmental audits for all inpatient areas Full IPC Audit - FINAL.docx	Do not have a full IPC dashboard for Trust oversight	Hand hygiene app and monthly reporting Mattress checking audit – AMAT Covid-19 observational audit including, PPE on paper
• the application of IPC practices within this guidance is monitored, e.g.: o hand hygiene. o PPE donning and doffing training. o cleaning and decontamination.	Touch point cleaning As above for audits. Training compliance through uLearn 2 hourly touch point cleaning.xlsx		
• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	Updates included in six monthly IPC Board updates		Weekly outbreak meetings Trust oversight and scrutiny of actions, lessons to be learned chaired by

• the Trust Board has oversight of ongoing outbreaks and action plans. • the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	Daily outbreak summary M-F and nosocomial data reported weekly to the ICC and in the IQPR Nosocomial Data - 25.01.2022.msg Outbreak Summary - 25.01.22.pdf Aggregated review to Trust Board Aggregated COVID-19 Outbreak F		exec DoN/DIPaC

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	Plan identified as part of the 6 monthly IPC trust board update. Revised plan NSoHC board paper HW update 2022 01 2 Working group to identify	Changes to functional use of space are requested via the Strategic Property Group or via capital bids. There is a process to agree any changes needed to ensure the space is compliant with IPC and H&S via the capital design procedures/sign off. LPT property manager attends both meetings and can capture any requests that have not	Revised programme submitted – confident that the plan can be brought back on track as the plan had 4 weeks contingency built in to meet the NSoHC start date of May 2022. Cleaning standards are audited in line with existing NCS 2007 frequencies. 12 month rolling programme of audits attached.

• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms • cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a cleanenvironment. • increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas. • Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined	any changes to functionality of areas/ rooms. Agreed SPG TOR Oct 2020 v2.docx Accommodation-and -Space-Policy-exp-De Cleaning increased to two full cleans and a third check clean with increased incidents/outbreaks. UHL 2022 audit schedule.xlsx NHS PS cleaning audit scores.xlsx Touch point cleaning in place 2 hourly 2 hourly touch point cleaning.xlsx The action for an alternative to chlorine-based solutions has not been undertaken. UHL facilities team are now looking this urgently, will agree with IPC any options, obtain the COSHH sheets and update the	been through an approval process from IPC.	Cleaning in all inpatient facilities increased to x2 cleans per day and a third clean in outbreak areas. Two hourly high touchpoint cleaning is undertaken daily in all in-patient facilities (recorded via clinical teams) and additional high touchpoint cleaning is undertaken in circulation spaces via the facilities team (not recorded) and SOPs exist within admin areas for desk and high touch point cleaning by the users (not recorded).

solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. • if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses. • manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products. • a minimum of twice daily cleaning of: o patient isolation rooms. o cohort areas. o Donning & doffing areas o 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. o where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea	cleaning manuals with processes. Cleaning in all inpatient facilities increased to x2 cleans per day and a third clean in outbreak areas. Two hourly high touchpoint cleaning is undertaken daily in all in-patient facilities and recorded by the clinical team and additional high touchpoint cleaning is undertaken in circulation spaces via the facilities team (not recorded) and SOPs exist within admin areas for desk and high touch point cleaning by the users (not recorded).	Part of the SOP/cleaning manual – Facilities Manager for UHL to provide the evidence for UHL – Facilities Coordinator NHS PS to provide the evidence for NHS PS. COSHH data sheets are kept in all cleaners' cupboards. Copy of cleaning manual and SOPs are held locally in cleaners' cupboards.	

A terminal/deep clean of inpatient rooms is carried out: o following resolutions of symptoms and removal of precautions. o when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); o following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • reusable non-invasive care equipment is decontaminated: o between each use. o after blood and/or body fluid contamination o at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment. • As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities. • the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the	The implementation of the Rapid Response team allows for responding to deep cleans following isolated outbreak areas. Curtain changes form part of the SOP for deep clean of infected areas. Cleaning-and-Decontamination-Policy.pdf Cleaning-and-decontamination-of-the-env Cleaning-of-workstation-May-2021-Final1. (The above policy and action cards are being updated) Environmental audit? Cleaning audits – 12-month scores attached UHL rolling 12 month audit scores.xls At installation stage, mechanical systems perform at a rate to meet compliance with guidance of that time.		

organisations, authorised engineer. • a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • where possible air is diluted by natural ventilation by opening windows and doors where appropriate • where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group. • when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	In recognition of new guidance the Ventilation Safety Group has requested the AE (V) to reinspect existing mechanical systems for the purposes of auditing performance. COVID risk assessments identify ventilation means including mechanical and natural (opening windows) and activity. Outbreak actions/environmental actions – wards/clinical activity SOPs implemented for the use of fans. Review other alternatives with AE(V) – action for VSG All screens installed are designed to have air flow above and at desk height. Cleaning is undertaken as BAU		

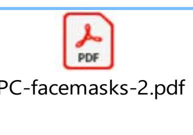
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and process are in place to ensure that:
• arrangements for antimicrobial stewardship are maintained
• previous antimicrobial history is considered
• the use of antimicrobials is managed and monitored:
  ○ to reduce inappropriate prescribing.
  ○ to ensure patients with infections are treated promptly with correct antibiotic.
• mandatory reporting requirements are adhered to, and boards continue to maintain oversight.
• risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.
	Lead pharmacist for antimicrobial stewardship.
	
	Trust Policy to detail strategy and KPIs
	
	Prescribing protocols to make formulary adherence easier to achieve.
	
	Antimicrobial stock lists reviewed based on needs of each ward.
	
	Pharmacy check for each inpatient prescription
	
	Annual inpatient audit taking place around November. This has recently moved to bi-annual (November and April). This checks that rationale and choice is appropriate.
	
	Inpatient consumption data collated and analysed quarterly to pick up anomalies
	
	Adherence to formulary/guidelines checked by way of all the above interventions ensures antibiotics which are restricted or have tendency to cause other		

	complications are used very carefully (e.g. cephalosporin and macrolides). 6 monthly updates to IPC group and included in the 6 monthly IPC update to Trust Board 6 monthly updates to IPC group and included in the 6 monthly IPC update to Trust Board		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national guidance on visiting patients in a care setting is implemented . • restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	604-Guide-to-safer-visiting-2.pdf Standard-Operating-Guidance Inpatien Included on outbreak meetings on agenda and decisions recorded in outbreak meetings COVID-19 outbreak agenda.docx 23 December 2021 inpatient face mask p		

• if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	Risk included in the screening within the SOP		

• visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. • visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian. • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted [C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)]	Included in the SOP Included in the SOP Elements that have been incorporated Creating-covid-secure-environments-acros BBE-poster-including-admin-staff-every-ac Back-to-Basic-Update-29.11.21.pdf IPC-donning-and-doffing.pdf IPC-Testing.pdf IPC-safe-breaks.pdf IPC-car-sharing.pdf		

	 IPC-facemasks-2.pdf 50183_NHS_IPC_Staf f_A4_Poster_Simi.pdf		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	NEW-PPE-Door-sign. pdf Communicated for Covid-19 further work around other high consequence respiratory infections Are you suffering from any respiratory s		
• infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	Signed off Covid 19 Questionnaire_17.12.2		
• staff are aware of agreed template for screening questions to ask.	Screening on admission and thereafter		
• screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	Triage and screening on SystmOne – as above		

• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Routine testing in place for patients no process or system for collating evidence of compliance LPT Inpatient Wards swabbing following le	Increased cases are being identified through routine testing	
• patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. • patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing. • patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	Action-card-Surgical-Masks-for-Patient-Us Admission pathways, IPC policies and source isolation This has been impacted by number of single rooms for source isolating within LPT Management-of-a-Patient-Requiring-Sourc MRSA Policy.docx This has been impacted by number of single rooms for source isolating within LPT		Patients are assessed on admission and as part of the screening process for an inpatient for wearing of face masks. Documented in patient electronic notes

• where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • face masks/coverings are worn by staff and patients in all health and care facilities. • where infectious respiratory patients are cared for physical distancing remains at 2 metres distance. • patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff. • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative. • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	Mandatory for staff. Patients – see action above. Spot check audits will be carried out. Standard practice All areas have had a COVID secure risk assessment Current pathways in place to support		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
• appropriate infection prevention education is provided for staff, patients, and visitors. • training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	Level 1 and level 2 IPC mandatory training. Donning and Doffing training mandatory, refreshers during outbreaks. FFP3 training system in place. 604-Guide-to-safer-visiting.pdf		

• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; • • adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk. • gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance. • staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace • staff understand the requirements for uniform laundering where this is not provided for onsite. • all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance. • to monitor compliance and reporting for asymptomatic staff testing • there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	 Final-Action-card-for-External-Professional Trust Donning and Doffing e-Learning module Covid-19 observational audit to Management-of-Sharps-and-Exposure-to-B To review 1 metre HR advisory reporting Return-from-isolation-SOP-v4-Jan-2022-f Nosocomial review weekly, surveillance testing and outbreak management Management-and-Reporting-of-Covid-19-i Scoping template for reporting hospital out		

• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Outbreak form.xlsx Increased incidence pack V4.odt Outbreak policy and triggers working as evidenced through outbreak reporting and management		

7. Provide or secure adequate isolation facilities

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions

Systems and processes are in place to ensure: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. • patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals. • patients are appropriately placed ie, infectious patients in isolation or cohorts. • ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements). • standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and TBPs continued to be applied when caring for the deceased	Patient mask use spot check audits completed – gaps identified (see action plan) IPC spot check report - v1 210122.docx Included in the COVID secure risk assessment Review of respiratory pathway and move away from RAG pathways Currently source isolated in single rooms, Red Wards are cohorted. Health & Safety review of bed spacing 3 Bed Ward - 2 metre distance April 5 Bed Ward space layout.pdf 4 Bed Ward - 2 metre distance April Patient pathways and placement Care of the deceased policy and action card		

	LPT-Inpatient-Care-of-the-Deceased-Suspe Care-of-the-Deceased-Policy-exp-Oct-22.p		

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals. • patient testing for all respiratory viruses testing is undertaken promptly and in line with [national guidance;](#)	LPT Inpatient Wards swabbing following le LPT-Inpatient-Wards-Units-swabbing-on-ac All admissions, 3. 5. 7. 13 and weekly	Service level agreement with microbiology	

• staff testing protocols are in place	Twice weekly asymptomatic screening	
• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	N/A	
• there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	N/A	
• screening for other potential infections takes place.	Screening in place with associated policies	
• that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	 Action-Card-swabbing-V6-09.06.20.docx	
• that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.	(Action card being updated)	
• that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	Yes routine swabbing	
• that sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	Part of outbreak management	
• that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	 Access-to-Nursing-Homes-and-other-com	
• those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	See action card above	
• there is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients whoare fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	Every patient undergoing ECT is required to have a weekly negative PCR test and this is in place immediately prior to commencing ECT so that it ensures one weeks cover.	

	Evidence	Gaps in assurance	Mitigating actions
	Any positive results are asked to put on hold ECT until current self-isolation period is complete and then they return to weekly PCR tests.		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). • staff are supported in adhering to all IPC policies, including those for other alert organisms. • safe spaces for staff break areas/changing facilities are provided. • robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak. • all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance. • PPE stock is appropriately stored and accessible to staff who require it.	GAP in terms of an IPC dashboard Hand hygiene audits – app Mattress – AMAT Covid-19 observational – paper audit This is included in the COVID secure risk assessment and consideration given to COVID outbreak areas for a changing and welfare facility on the ward	Hand hygiene APP and data Paper audit of Covid-19 observational tool – goes live on AMAT 1 March 2022 Mattress checking audit on AMAT	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy. • bank, agency, and locum staff follow the same deployment advice as permanent staff. • staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-	UHL service level agreement Local induction and training		

isolate (see Staff isolation: approach following updated government guidance)	 Return-from-isolation-risk-assessment-sta		
• staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	Level 1, 2 and Donning & Doffing		
• a fit testing programme is in place for those who may need to wear respiratory protection.	L & D programme		
• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: o lead on the implementation of systems to monitor for illness andabsence. • facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce • lead on the implementation of systems to monitor staff illness, absenceand vaccination against seasonal influenza and COVID-19 • encourage staff vaccine uptake.	Staff referral to OH		
• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.			
• a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. o A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; o that advice is available to all health and social care staff, including specific advice to those at risk from complications. o Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. o A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	Employee Risk assessment to be updated to include respiratory infections		
• vaccination and testing policies are in place as advised by occupational health/public health.			
• staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.	Yes		
• staff who carry out fit test training are trained and competent to do so.			
• all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is			

used. • all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation. • those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respiratorsand hoods. • that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions. • members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. • consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance. • health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone. • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing. • staff who test positive have adequate information and support to aid their recovery and return to work.	Need to strengthen process for suitable alternatives, sign off and governance		Currently staff are referred to IPC and discussion with line manager to order alternative equipment for example hoods for staff in ECT