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NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Infection Prevention and Control Board Assurance Framework

October 2020, Version 1.5

NHS

Executive Lead:	Delivery Lead:	Performance Management Team
Dr April Brown **Chief Nurse** **Director of Infection, Prevention and Control (DIPC)**	**Sarah Morter** **Interim Lead IP&C Nurse**	**Phil Tydeman**

Date Updated	Updated by	Comments
9th September 2020	Carmel O'Brien, Director of Patient Safety	Amended to reflect July 2020 issue Version 1.3
7th October 2020	Mustafa Kahn, Risk Manager	Amended to incorporate the learning from Covid-19 as detailed in the presentation for the Patient Safety Learning Event in September 2020

Glossary

- IPC- Infection Prevention and Control
- ASG-Antimicrobial Stewardship Group
- ED - Emergency Department
- SOP -Standard Operating Procedure
- ICT - Incident Control Team
- BAME - Black, Asian and Minority Ethnic Group
- PPE – Personal Protective Equipment
- BAF- Board Assurance Framework
- HICC- Hospital Infection Control Committee
- PIR- Post Infection Review
- PHE- Public Health England
- HCPC-Health Care Professional Council
- HPV- Hydrogen Peroxide Vapour
- UV- Ultra Violet
- EPMA-Electronic Prescribing and Medicines Administration
- OPAT-Out-patient Parenteral Antibiotic Therapy
- HCPC-Health Care Professional Council

Evidence

- Staff information/comms red button
- External comms
- Minutes of meetings
- Log book entries
- Perfect ward audits
- Cleaning C4C audits

- IPC audits e.g. hand hygiene, commodes
- Other audits e.g. antimicrobial
- Training records
- Policies, SOPS, Action cards
- Presentations e.g. cleaning
- Infection rates

1 Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
1.1 Infection risk is assessed at the front door and this is documented in patient notes	There is a system in place which includes: • Process in place to complete a check list on all emergency admissions based on COVID questions • Public Health COVID screening questions used by all staff (includes pre-alert). • Minutes of ED clinical meetings. • An audit of 5 sets of notes has been completed and identified that all notes had a completed risk assessment sheet • There is no evidence or reported Datix that risk assessments have not been completed. • Related SOP or guideline in place • Streaming triage in place	• Comprehensive audit	• Dissemination through clinical meetings • Safety rounds
1.2 Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• Related SOP or guideline • Patient internal transfer sheet • Patient management flowchart approved through ICT	• Initially occasionally patients were moved without clinical review • May have issues at time of high patient flow re de-escalation	• Step down document written to advise on review and criteria to move from a yellow area • Individual risk assessment • Engage with partners • De-escalate to primary care

1.3 Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• Guidance followed from 19th March • Hospital discharge leaflet distributed to wards March 2020 • Gap analysis and action taken March 2020 • Flow chart April 2020 • SOP from April sent through CPS • Paper approved by ICT March 2020 • Discharge letters amended to reflect guidance	• Only gap was contact post discharge for pathway “0” patients by wards	• None identified.
1.4 All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	• All information relating to PPE is accessible for all staff via the Covid-19 intranet site. • Regular communications have been sent out across the site advising of any changes to guidance • Training department has records • Assurance received through ICT. • Donning and doffing training has been undertaken in conjunction with practice development and IP&C teams • All guidance available to staff via Red Covid button on Trust intranet	• Accessing all staff • Supply chain changing masks and requirement to fit test staff for every new brand/style of mask	• PPE safety officers were in place for practical advice and guidance during height of pandemic • Train the trainers so able to fit test out of hours • Comms awareness for staff
1.5 National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• The ICR checks the national guidance on a daily basis and are reported at the ICT meeting and then disseminated to the appropriate staff • Central point EPR lead, point of contact for all national guidance through divisions and out for discussion.	• Single responsible person, needs to be manned if not around.	• None identified.

1.6 Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• All actions are logged in the Silver log book and the ICT ensures all actions are completed. This is then transferred to the electronic action log and is signed off when the action is completed. The ICTIs led by the Chief Operating Officer • Silver log book • Electronic action log • Board papers and minutes of board meetings	• None identified	• None identified.
1.7 Risks are reflected in risk registers and the Board Assurance Framework where appropriate	• Minutes of A&REG and ICT meeting • Risks relating to COVID 19 and access to PPE are included in the Trust's risk registers. • COVID 19 risks are cross referenced in the Trust's BAF as they are significant risks (Graded 15+) for the Trust • Significant risk register monitored through Assurance and Risk Executive Group to Senior Leadership Team and Board sub-committee oversight • Significant risk register monitored through Trust Board monthly • Trust Board Assurance Framework monitored every other month at Trust Board • Infection Prevention Control risks monitored through HICC each month	• HICC monitoring action plan	• None identified.

1.8 Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Access for all staff to IP&C guidelines and policies on the intranet http://qehkl-inet/ipac/ • Regular updates for IP&C link practitioners • Surveillance of alert organisms and infections undertaken daily/weekly • using databases and ICNet software alerts • Clinical areas commence supportive measures for periods of increased incidence • C. diff learning from PIR • Non covid IP&C reminders • Policies and guidelines e.g. CPE • Monitored through HIC	• None identified.	• None identified.

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:			
2.1 Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• Staffing for the areas has been assessed in terms of establishment numbers and skill mix. • Additional training was provided where appropriate to mitigate and/or staff were moved to further support/mitigate case mix changes. • Introduced plan for the management of COVID-19 and non-COVID-19 patients with yellow and green phasing Matron in place • All staffing reviewed through "Bed team" meetings as business as usual. Staffing meetings reported into flow meetings. • Skill mix paper • Training logs/programmes • Revised nursing and staffing log & Medical rota	• The rapidly changing picture in terms of capacity and demand for yellow and green and challenging elective care activity with additional staffing complexities result in a continual gap/risk assessment process and mitigation plan	• Twice daily senior nurse meeting • Quality Matron/Senior Nurse presence rota • Escalation reporting processes • Medical rota review and plan • Medicine 'reset' Revision to silver rota
2.2 Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• All relevant staff had one to one training to ensure compliance with the correct use of PPE. • Trainer signed off each staff member. • Training sheets including for UV and HPV training • Cleaning sign off sheets	• None identified	• None identified.

2.3 Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Decontamination is carried out in line with PHE and other national guidance. • Cleaning Sign off sheet • Related SOP or guideline • Cleaning for Credits (C4C) audits monitored through HICC and Divisional Boards (on dashboard)	• None identified (audits in place)	• None identified.
2.4 Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• Cleaning Policy • Cleaning schedules • This is captured in the cleaning schedules • Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas New communal team place, since the beginning of June • Sign off sheet completed • Audits completed to evidence compliance	• None identified	• None identified.
2.5 Cleaning is carried out with neutral detergent, 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) should be consulted on this to ensure that this is effective against enveloped viruses	• Already in place pre-COVID-19 • Cleaning carried out with appropriate disinfectant in line with national guidance. Where there were changes to usual stock training was carried out to ensure staff could use the new products.	• None identified	• None identified.

2.6 Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant products	• Evidence noted in 2.2 • Already in place pre-COVID-19 • Cleaning carried out with appropriate disinfectant in line with national guidance. Where there were changes to usual stock training was carried out to ensure staff could use the new products.	• None identified	• None identified.
2.7 As per 'national guidance: 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over bed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids	• Domestic Services provide increased touch point cleaning, providing at least twice daily decontamination	• This is dual responsibility with the housekeeper. • Housekeepers are responsible for Patient call bells and bed rails.	• None identified
2.8 As per 'national guidance: Electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned a minimum of twice daily	• Housekeepers responsible and included in the Housekeepers cleaning schedule	• Inconsistencies of application • No audit	• None identified
2.9 As per 'national guidance: Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Evidence noted in 2.2 • These are cleaned twice daily • Audits take place on wards	• None identified	• None identified

2.10 Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Linen policy is in place • Linen segregation poster • Waste guidance • Reminder email/comms to ensure that all Linen double-bagged with red dissolvable inner as agreed with service provider (Elis). No compliance issues raised by Elis.	• None identified	• None identified
2.11 Single use items are used where possible and according to Single Use Policy	• Single use items are not used by Domestic Services, cloths and mops are laundered on site	• None identified	• None identified
2.12 Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• Cleaning Policy • Mandatory Training • Reusable mop handles, cloths and buckets used in the Trust are decontaminated appropriately	• None identified	• None identified
2.13 Ensure the dilution of air with good ventilation e.g. open windows in admission and waiting areas to assist the dilution of air	• Ventilation reports and maintenance records	• None identified	• None identified

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 processes are in place to ensure:			
3.1 Arrangements around antimicrobial stewardship are maintained	• Audit data • Antibiotic guidelines available on the intranet and on Microguide • Minutes from Antimicrobial Stewardship Group (ASG) • The AMS team consists of a Consultant Microbiologist and an Antibiotic Pharmacist who only started regular antibiotic duties only in July 2020. • Antibiotic ward rounds consist of review of all patients in a single ward, noting the antibiotics, duration, indication, consistency with guidelines with follow-up as necessary. • Currently reviewing Necton, Elm, Stanhoe, Marham, Oxborough wards in a repeating weekly cycle until end of August, when another cycle of wards will be started. Audit data will be prepared from this data, to identify areas which need further attention. • Monthly review of antibiotic usage • Monthly review of antibiotic incidents • Regular antibiotic audit to determine in particular documentation of indication for an antibiotic in	• Antimicrobial pharmacist started formal antibiotic pharmacist duties in July 2020. • Education of junior doctors has not yet been undertaken. • Regular review of antibiotic usage is difficult as Electronic Prescribing and Medicines Administration (EPMA) is not yet in use in the Trust. In the meantime, we are using antibiotic purchase data which provides some measure of usage, albeit imprecise. • Although we are in the process of modifying the antibiotic guidelines to limit use of Co-Amoxiclav, currently this is widely used within the Trust.	• Started performing the antibiotic ward round in five wards at present (Necton, Elm, Stanhoe, Marham, Oxborough) • Several of which have had issues identified which require a focus on prescribing practice in these areas. This effectively corrects problems in prescribing, and provides education to the junior medical staff. • AMS was completed as part of the mandatory training of junior doctors on 27th August 2020, • EPMA role out is planned for early • January with complete roll out by end April 21 • AMS - new policy has been developed and discussion ongoing with Division to agree, • AMS group meets weekly to progress AMS

	chart/notes, medical review of antibiotic prescription within 72h, and compliance with guidelines (Point of Prevalence Study of Antibiotic Prescribing, 2019, attached). • CQUIN data acquisition and submission, quarterly as required. Currently suspended nationally. • Education of junior doctors to improve understanding of the principles of AMS. Part of mandatory training with possible online modules • Out-patient Parenteral Antibiotic Therapy (OPAT). The OPAT team consists of 4 Community Nurses & JK. Weekly review of OPAT patients is currently by teleconference. • Regular antibiotic surveillance to ensure that antibiotic choices within guidelines are relevant and optimised • C. difficile ward round. Attendance as weekly round to review infected patients. • Antibiotic guidelines – regular review as necessary. • Plan to limit use of Co-Amoxiclav in the Trust in development • Antibiotic guidelines are available on the intranet and on Microguide • Antimicrobial Stewardship Group (ASG) meets quarterly, representative medical and surgical consultants are routinely invited. .	The Antibiotic addresses this in the meantime, but we need a more efficient and long-term limit on its use, and this will be achieved as soon as possible.	work plan

3.2 Mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Audit data is available • Antibiotic guidelines available on the intranet and on Microguide • Reports • Minutes from Antimicrobial Stewardship Group (ASG) • We have committed to provide a monthly report on Antimicrobial Stewardship (AMS) to the Hospital Infection Control Committee (HICC) (see report on Antibiotics for IP&C Report 2019-2020, attached) and a bimonthly report to the Medicines Forum (first submission in August 2020). • CQUIN reports will be submitted as required; currently suspended nationally. • Additional reports on antibiotic usage and compliance with guidelines will be prepared in response to particular periods of increased incidence of C. difficile, for example. • Reports on Antibiotic Audit are prepared following particular audits. For example, the Point of Prevalence Study on Antibiotic Prescribing, 2019	• None identified	• None identified

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:			
4.1 Implementation of national guidance on visiting patients in a care setting	• The patient experience meeting led by senior nurse has overseen all actions involving visiting patients and all changes are sent to the ICT for approval and are signed off on the electronic action log section 13 including: • Leaflets availlable for visitors • Internal and external comms • Related SOP or guideline • Regular regional meetings to work towards consistency across Norfolk /the STP. • Use of media to advise visitors or restricitons, logged through ICT	• None identified	• None identified
4.2 Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• Agreed yellow and green areas and applied posters and posters on all entrance and exit doors to the hospital • Markings added to floor areas "Walk this Way" signs	• None identified	• None identified
4.3 Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Trust website's COVID-19 page links to all national government guidance. Contact details are available on the gov.uk site to request information in alternative and accessible formats	• None identified	• None identified

4.4 Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• As per national guidance • Process in place – all swabbed with result before discharge to care home, residential home or own home with package of care, in line with national guidance. • Transfer documentation developed in line with national guidance and well cascaded • Discharge from hospital stay • Discharge SOP • Discharge letter	• None identified	• None identified

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:			
5.1 Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non-Covid-19 cases to minimise the risk of cross-infection as per national guidance	• At height of pandemic two separate EDs that have triaging in place for minor and major patients • Follow national guidance • Trust pandemic plan allowed for segregation and we followed our plan completely • Triage continues, includes Ambulance Services	• None identified	• On the occasion a patient attends the wrong ED process in place to allocate the patient in an appropriate side room and ensure appropriate PPE in place
5.2 Mask usage is emphasized for suspected individuals	• Advised ward staff to follow the guidance and where tolerated patients with suspected/known COVID-19 to wear a mask • All patient letters have guidance and masks at all hospital entrances • Signage	• None identified	• None identified
5.3 Ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	• Protective screens installed following a cross divisional review meeting completed • Outcomes through ICT for appropriateness of placement of screens in line with national guidance and advice from IPAC team • Continues to be under review to allow staff to be back to work with social distancing.	• None identified	• None identified

5.4 For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	• COVID-19 management flowchart in place describing isolation, available through internet red button.	• None identified	• None identified
5.5 Patients with suspected COVID-19 are tested promptly	• All patients swabbed on admission in ED, repeat swab at 7 days and on discharge if meet criteria	• Missed swabs	• Report required for wards as a prompt • Awareness raising at safety huddle and ward visits • Datix as we are aware of missed swabs
5.6 Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	• All patients who have ongoing symptoms or who develop symptoms while an inpatient are risk assessed and moved to the appropriate swabbing area	• Limited beds available on swabbing Ward • Additional capacity identified	• Patient moved to a side room while awaiting an available bed
5.7 Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	• During Covid all outpatients appointments stopped. Telephone assessments. • Re-introduction as part of transformation, pts asked re symptoms and temperature checked. • Patients who attend for appointments are all screened, if they are symptomatic for Covid-19 this is recorded in the patients notes and the patient's appointment rebooked • Process developed and is now in place ensuring all elective patients and outpatients have opportunity for screening in advance of coming to hospital • Patients attending for procedures or outpatient appointments where they	• None identified	• None identified

	have symptoms are asked to go home and self-isolate • Comms re outpatient screening		

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**
Systems and processes are in place to ensure:			
6.1 All staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• Donning and doffing training has been undertaken in conjunction with practice development and IP&C teams. • All information relating to PPE is accessible for all staff via the Covid-19 intranet site. • Regular communications have been sent out across the site advising of any changes to guidance • Evidence available - Training records and Posters	• Accessing all staff	• PPE safety officers in place for practical advice and guidance
6.2 All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• As above • Perfect ward PPE questions audit • Team of trainers to support correct use of PPE through the Practice Development Team and developed a network of ward based Fit Testers • Staff risk assessments	• None identified	• None identified
6.3 A record of staff training is maintained	• Staff training record from ESR system	• Sometimes there is a data lag in information being uploaded to ESR	• None identified

6.4 Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert and is properly monitored and managed	• Visor cleaning document • CAS alert circulated via the Covid team and incidents reported via Datix • Systems and processes in place for single use items managed in line with national guidance	• No robust audit of re-use of single use items	• None identified
6.5 Any incidents relating to the re-use of PPE are monitored and appropriate action taken	• ICT received daily incident report at initial phase of COVID this moved to a weekly ICT dashboard	• None identified	• None identified
6.6 Adherence to PHE national guidance on the use of PPE is regularly audited	• All staff were reminded of the requirement for use of PPE available via COVID button on the intranet	• We do currently audit the use of PPE guidance	• None identified
6.7 Staff regularly undertake hand hygiene and observe standard infection control precautions	• Observational audit of hand hygiene audited by IP&C team. • Trust hand hygiene policy • Introduced mask, decontamination and hand gel stations at all hospital entrances to enable staff to have good hand hygiene practice	• Non-compliance by staff	• HoN's to report as part of their HICC part of the divisional report
6.8 The use of hand air dryers in toilets 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	• Hand driers removed from all areas. • Extra sinks were installed at entrances	• None identified	• None identified
6.9 Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• Toilets audited every month through domestic services team	• None identified	• None identified

6.10 Staff understand the requirements for uniform laundering where this is not provided for on site	• Dress code policy on the Trust internet has the washing requirements for staff uniform off site • Additional communications to staff during COVID-19 • Laundry bags provided and clarity about washing uniforms • Comms to staff regarding not wearing uniform outside of the Trust • Travel arrangements	• None identified	• None identified
6.11 All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	• NHS England and NHS Improvement coronavirus information available on trust intranet COVID-19 home page • Regular COVID-19 updates when PHE changes occur that affect healthcare staff emailed to staff via communications • Local ward, department monitoring and recording via e-roster • HR monitors the absence due to staff isolating or having symptoms. • Occupational health department offer advice to staff • Risk assessments for staff • Process in place in line with national guidance for line manager sign off prior to annual leave	• None identified	• None identified

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:			
7.1 Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• All patients confirmed Covid-19 are promptly transferred to Tilney Ward. • All suspected Covid-19 patients are assessed on Stanhoe Ward and moved to an appropriate Yellow/Green area depending on result • Pandemic flu plan - As the surge capacity increases the following wards will become flu related wards: ○ Windsor ○ Oxborough ○ Necton ○ Marham • In relation to critical care implemented segregation of patients in line with national guidance	• Spike in demand leading to no beds on Tilney/Stanhoe	• Oversight of all capacity is led by Chief Operating Officer and reviewed daily to accommodate all eventualities
7.2 Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• All yellow areas have had a full environmental audit undertaken. • Audit • Due to the current estate the hospital is not able to fully comply with current PHE national guidance. However, risk assessment is completed and mitigation put in place. • Have reviewed hospital COVID-19 transmission rates and are not an outlier	• None identified	• None identified

7.3 Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Guideline on the intranet for the Prevention and Control of Multidrug Resistant Organisms (MDRO) including Multi-Resistant Gram-negative Bacteria (like ESBLs) and Glycopeptide resistant enterococci (GRE/VRE)	• IP&C team have not had the resources in the team to audit compliance with this policies	• Weekly surveillance meeting to look at alert organism figures including MDRO to see if there are signs of hospital transmission

8 Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
8.1 Testing **is undertaken by competent and trained individuals**	• Staff are Health Care Professional Council [HCPC] registered • Competency records for training are • available	• None identified	• None identified
8.2 Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Patient COVID-19 testing taking place on all possible patients plus admission screening of asymptomatic emergency admissions • Local lab testing for patients samples enable a turnaround time of approx. 24hrs	• New COVID-19 framework requires 5-7 day screening of all inpatients and elective programme screening	• New process is in place & agreed through ICT, a daily list is provided to wards with swab packs with f/u following day
8.3 Screening for other potential infections takes place	• Patients screening as part of the CPE/MRSA/PVL guidelines available on the intranet. • MRSA screening compliance reported at hospital infection control committee [HICC] • Patient and staff screening guidance in major outbreak guidelines • Staff screening guidelines for starters to include TB and blood borne viruses [BBV's]	• None identified	• None identified

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:			
9.1 Staff are supported in adhering to all IPC policies, including those for other alert organisms	• All COVID -19 NHSE/I guidance available on the Trust COVID-19 site on the internet • Access to IP&C guidelines and policies on the intranet • Induction and annual mandatory training • Ad hoc training in clinical areas when IP&C team attend for clinical input • Link practitioner programme • Root cause analysis for key alert organisms that are HAI • Learning shared from SI's, C. diff ward round and RCA's • Audits to include hand hygiene, MRSA screening • Regular COVID-19 updates where PHE and local advice are emailed to staff via communications	• Some areas have not met the mandatory training target of 75% • Face to face training has reduced due to COVID-19 and the need to socially distance	• During COVID-19 most face to face training is now able to take place either on-line or via trust workbooks
9.2 Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Electronic action log section 14 • The ICR monitors all changes to National guidance and all actions and changes are report through the ICT and communicated to all appropriate staff and when completed signed off on the electronic action log section 14	• None identified	• None identified

9.3 All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• No compliance issues raised by waste handler • Process as for other orange bagged waste from infected patients. Agreed with service provider (Stericycle). Guidance received from NHSI, EA, CIWM, Stericycle and others, all consistent. • Stericycle service in line with contract, so no waste stored for extended periods. Increased tonnage of 18.01.03 HT/HN waste as expected. • No compliance issues raised by Stericycle	• None identified	• None identified
9.4 PPE stock is appropriately stored and accessible to staff who require it	• Trust-wide communications regarding ordering processes • Procurement operating a 7-day service • Daily stock reports, • Trust-wide communications regarding ordering processes, • Procurement operating a 7-day service	• Stocks are `pushed' to the Trust rather than under order control	• NSDR process exists to enable emergency supply

10 Have a system in place to manage the occupational health needs and objectives of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
10.1 Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Clinical psychology support • Wobble rooms • MH first aid trainers • BAME network • Communications and regular briefings • Additional showers and changing facilities upgraded • Food and drink available in yellow areas and overnight for all staff • Clinical Psychology support, self-referral, drop in sessions on wards plus targeted sessions • New Clinical Psychology & PTSD/CBT specialist posts • Five mental health first aiders trained • Thank you letters and weekly wellbeing calls to shielding / unwell staff • Offered enhanced PPE to BAME staff and those with risk factors early	• None identified	• None identified
10.2 Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• Training records on ESR and on an additional record held in H&S which gives details on the mask type • All staff who have been fit tested since January 2020 are recorded on ESR and on an additional record held in H&S which gives details on the mask type • Fit testers on wards/departments	• Gap in compliance with new staff being fit tested	• Fit Testing to become mandatory for all new clinical staff within the first month of employment and where staff on clinical areas can do this it is completed. • H&S Officer is available to complete where gaps

			in ward areas
10.3 Consistency in staff allocation is maintained, reducing movement of staff and the cross-over of care pathways between planned/elective care pathways and urgent/emergency care pathways, as per national guidance	• Deputy Chief Nurse leads a daily safety huddle takes responsibility for ensuring safe staffing and management of high risk areas, this includes processes put in place specifically related to COVID-19. In a situation where staff are moved from one area to another, there is a conscious decision that it needs to be within the same group of wards/units, i.e. red to red or green to green areas. • If moving staff is inevitable between red and green areas or vice versa, mitigation is put in place by asking the member of staff to change into scrubs	• None identified	• None identified
10.4 All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Put in place systems based on national guidance to enable staff to socially distance • Remind staff for the requirements for social distancing and use of face masks • Risk assessments for COVID-19 secure areas • Completed mapping of all areas used for training and non-clinical meeting areas • Invested in new technology to support people in working from home	• None identified	• None identified
10.5 Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	• Public areas, shop and in staff Hub reduced number of people, social distancing, staggered breaks	• None identified	• None identified

10.6 staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Staff support pack in place • Wellbeing monitored through return to work interviews and other processes	• None identified	• None identified
10.7 staff who test positive have adequate information and support to aid their recovery and return to work.	• Process for swab team to call patient, hand over result and provide support for positive results	• None identified	• None identified
10.8 All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Put in place systems based on national guidance to enable staff to socially distance • Remind staff for the requirements for social distancing and use of face masks • Risk assessments for COVID-19 secure areas • Completed mapping of all areas used for training and non-clinical meeting areas • Invested in new technology to support people in working from home	• None identified	• None identified