

Infection Prevention and Control Board Assurance Framework 2020/21

V4 September 2021

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| 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**
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| **KEY LINES OF ENQUIRY** | ***EVIDENCE******The detail of the supporting evidence can be made available upon request*** | **GAPS IN ASSURANCE** | **MITIGATING ACTIONS** |
| **Appropriate systems and processes are in place to ensure:** |
| **1.1** | Infection **risk is assessed** at the **front door** and this is **documented i**n patient notes | * Patient attending Outpatient appointments are triaged on arrival and entering the premises
* Patient COVID-19 status recorded Carenotes/Adastra
* Patient COVID-19 status recorded on the inter healthcare transfer form
* Swabbing of admissions in all wards on day 1, 3 and 7 then weekly
* Screening recorded in Carenotes/Adastra
* Positive results flagged as Alert on Carenotes/Adastra
* Single ensuite rooms where possible for all admissions, for those without ensuite designated bathrooms or commodes
* Cohorting patients in according to national pathways
* **13th March 2020:** Trust Inpatient management pathway SOP, management of COVID patients and PPE requirements
* **29th April 2020:** **Version 2** Principles and guidance for use of PPE during COVID-19 for services that operate in people’s homes, care homes and other home visiting environments (further updates 8th January 2021, 22nd July 2021)
* **27th April 2020:** Update to include patient de-isolation requirements.
* **28th August 2020:** Management of Hospital admissions. This includes patient de-isolation requirements and is based on the traffic light pathways from PHE, IPC guidance updated
* **March 2021:** Management of hospital admissions updated to include information on those who have been vaccinated
* **May 2021:** Isolation guidance for Mental Health inpatients during COVID-19
* **25th June 2021:** Caring for mental health inpatients during COVID-19
* *COVID-19 Safety Rules at our Sites* poster updated:
* Triage COVID-19 questions are on a sign at the entrance doorways updated:
* Triage COVID-19 question for visitors updated:
 | Non-consenting patients especially in MH wards to screening and testing | * **8th May 2020:** Clear guidance (isolation and seclusion) produced for all staff within these settings
* **9th Nov 2020:** New screening form introduced on Carenotes
* Screening refusal recorded on Carenotes/ Adastra
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| **1.2** | There are **pathways in place** which support minimal or **avoid** patient bed/ward **transfers for duration** of admission unless clinically imperative | * Traffic light pathways implemented across the Trust in accordance with PHE guidance
* Isolation guidance implemented in accordance with PHE guidance (see 1.1 above)
* OHFT Outbreak procedure reviewed to reflect the COVID-19 guidance from PHE
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| **1.3** | That on occasions when it is necessary to cohort COVID-19 or non- COVID-19 patients, reliable application of **IPC measures** are implemented and that any vacated areas are **cleaned as per guidance.** | * Traffic light pathways implemented across the Trust in accordance with PHE guidance
* Standard Precaution procedures (HH, PPE) – message reinforced
* Environmental cleaning procedures in place *(available on intranet)*
* Enhanced and terminal cleaning in place across all areas and records kept and held on G drive and ward areas
* Outbreak procedures in placeand reviewed to reflect the COVID-19 guidance from PHE *(available on intranet)*
* Management of Admissions to Community and Mental Health guidance devised

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| **1.4** | ***Monitoring*** of IPC practices, ensuring resources are in place to enable ***compliance*** with IPC practice* staff social distancing across the workplace
* staff adherence to wearing fluid resistant surgical facemasks (FRSM) in:

 a) clinical b) **non-clinical** setting | * Completion of matron’s checklists
* Infection Prevention and Control COVID-19 Management Checklist for Shift Co-ordinators ***monitored*** by matrons, PPE champions and ward managers
* Reported at the weekly Healthcare Associated Infections Update Meeting
* Action plans in place following weekly matron’s audits if low ***compliance*** held by the Directorates
* Reported via directorate governance meetings and SMT’s and up to Trust wide IPC meeting
 | There is no system in place to monitor compliance across non-clinical settings | * IPC guidance for non-clinical setting in place
* Annual IPC mandatory training for non-clinical settings in place
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| **1.5** | ***Monitoring*** of staff ***compliance*** with wearing appropriate PPE, within the clinical setting* consider implementing the role of PPE guardians/safety champions to embed and encourage best practice
 | * Introduction of *PPE Champions* to all inpatient clinical areas
* Introduced a Shift Co-ordinators IPC COVID-19 Management Checklist. Records held within the Directorate (as 1.4 above)
* Completion of PPE competency assessments forms
* ***Training*** records are **also** being held locally
 | * Not **all** community areas have a PPE Champions
* L&D team record PPE competencies on staff ***training*** records
 | * IPC team engaging with all community areas to get a PPE champion
* Annual IPC mandatory training delivered to all clinical staff
* PPE training resources disseminated to all clinical staff and are available on the OHFT webpage
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| **1.6** | Implementation of **twice weekly lateral flow antigen testing** for NHS **patient facing staff**, which include organisational systems in place to ***monitor*** results and staff test and trace | * Clinical staff undertaking lateral flow test twice weekly
* Lateral Flow Testing dedicated page on Trust intranet: <https://ohft365.sharepoint.com/sites/IPC/SitePages/Lateral-Flow-Test-guidance.aspx>
 | Lack of assurance that staff are completing the LFT twice weekly since acquisition process changed  | * LFT information available on the OHFT webpage
* Staff to update own record on portal
* Comms sent out to all staff
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| **1.7** | Additional targeted testing of **all NHS staff**, if your trust has a high nosocomial rate, as **recommended by your local and regional** infection prevention and control/Public Health team. | * All patient facing staff already use lateral flow tests twice weekly (see 1.6)
* Additional information for all staff sent out
* Staff cases ***monitored*** by managers, HR and Occupational Health
* Trust screening team available in 2020 to increase staff screening if required i.e. outbreaks or increased cases
 | Lack of assurance that staff are completing the LFT twice weekly since acquisition process changed No clear pathway to allow staff testing in the event of an outbreak - managed on a case by case basis  | * LFT information available on the OHFT webpage
* Staff to update own record on portal
* Comms sent out to all staff
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| **1.8** | ***Training*** in **IPC standard** infection control and **transmission-based precautions** are provided to all staff | * IPC ***training*** provided virtually via MS teams. ***Training*** includes standard IPC practice, per national content recommendations
* L&D team hold the register of attendees for all MS teams IPC training sessions
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| **1.9** | **IPC measures** in relation to **COVID-19** should be included in all **staff Induction** and **mandatory training** | * COVID-19 IPC measures are included in all IPC training sessions *(as* 1.8 above)
* All patient facing staff complete PPE competencies
* MS teams training sessions for PPE Champions. The PPE Champion file has a graph of numbers per ward who have completed their PPE competency
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| **1.10** | There are **visual reminders** displayed communicating the importance of **wearing face masks**, ***compliance*** with **hand hygiene** and **maintaining physical distance** both in and out of the workplace | * Posters, intranet messages, local reinforcement messaging all in place.
* Chief Nurse webinars, regular reminders on weekly comms bulletins
* PPE champions, matrons, Heads of nursing disseminate the message within the teams
* **March 2021:** Implementation of IPC behavioural tool kit ***“Every Action Count”,*** owned by each Directorate
* Communications Bulletins contain information about wearing face masks, ***compliance*** with hand hygiene and maintaining physical distance
* Information also available on the IPC Trust webpage on intranet
* IPC hand hygiene audits results shard with each Directorate and results displayed on the inpatient IPC notice boards
* **July 2021:** IPC posters updated, and new IPC email signature launched
* **July 2021:** New IPC posters available on the Trust Intranet webpage

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| **1.11** | **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](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) | * Trust followed PHE guidance at all times. Changes issued to staff in relation to PPE on **31st March**, 2**nd April**, **14th April** and **12th June 2020**, **24th December 2020**.
* Designated PPE procurement team in place to manage/monitor PPE acquisition and stocks
* From **15th June 2020**, it becomes a requirement for all NHS staff to wear a mask while at work to reduce the opportunity for the spread of COVID-19
* **5th January 2021:** Guidance updated re RAG pathways re wearing of visors
* IPC intranet page developed so staff can find all information in one place with guidance on PPE, testing and hand hygiene. Updated regularly in line with National/Trust guidance – screen shot embedded. Email sent daily to all staff highlighting any changes.
* The Trust introduced weekly and then twice daily **sitrep reports** from every clinical team. This included reviewing PPE stock levels, supplies and escalating any issues. Overseen by procurement team and discussed in daily escalation calls.
* **23rd April 2021:** Updated PPE guidance issued
* **March and May 2021:** Management of Admissions to Community and Mental Health guidance updated (as 1.3 above)
* MS teams training sessions for PPE Champions (as 1.8 and 1.9 above)
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| **1.12** | National IPC [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) is regularly **checked for updates** and any changes **are effectively communicated** to staff in a timely way | * Chief Nurse and IPC Nurse Consultant on regular calls and webinars with CNO England/ regional NHSE/I calls
* Weekly HAI meetings with DIPC, IPC team and Heads of Nursing
* Dedicated Trust COVID page
* Emergency planning team and director on call
* Guidance issued through Chief Nurse and CEO circulation lists
* Updated guidance for staff sent out via communication team
* All guidance is collated and noted through emergency planning team
* Regular staff briefings and weekly CEO Webinars (bi monthly since May 2021)
* Initial Trust PPE guidance issued **31.3.20** and has been continuously reviewed and updated via designated intranet page and updated as revised guidance is sent from PHE (as 1.5 and 1.11 above)
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| **1.13** | Changes to [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) are **brought to the attention** of boards and any risks and mitigating actions are highlighted  | * IPC is reported and discussed at the following senior/ board meetings:
* Executive Team GOLD command daily / twice weekly when taking place
* Silver tactical calls weekly when taking place
* Trust Board of Directors meetings
* Quality Committee with Board members
* Quality and Clinical Governance Sub-Committee chaired by the Chief Nurse
* HAI weekly senior nurse meeting- chaired by Chief Nurse
* IPCD Committee attended by the Chief Nurse
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| **1.14** | Risks are reflected in **risk registers** and the board assurance framework where appropriate | * The Trust Risk register reflects PPE and IPC separately as potential risks
* Latest risks reported to Quality Committee on 13th May; 8th July; 9th September and 11th November 2020 and every quarter to date (verbal or written report\_
* Review of risk registers with Chief Nurse / IPC Nurse Consultant and Trust risk register lead
* Risk registers reported at Trust Board and Quality Committee
* Each Directorate are responsible for updating their own IPC risk and for escalating if applicable: records held within Directorate
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| **1.15** | Robust IPC **risk assessment** processes and **practices** are in place for non COVID-19 infections and pathogens | * IPCD Committee reporting on all infections
* Weekly review meeting (WRM) reviews all infections and pathogens- formal meeting chaired by Deputy Director of Nursing
* RCA for all other infections such as MRSA and CDiff as ‘usual’ mechanism for reporting and reviewing
* Quarterly health economy review meetings for CDI/MSRA/MSSA cases
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| **1.16** | That Trust Chief Executive, the Medical Director or the Chief **Nurse approves and personally signs off, all** daily data submissions via the daily nosocomial **sitrep.** This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner. | * Process in place- IPCT-DIPC weekdays
* IPC Nurse Consultant or Senior IPCN reviews all cases daily with business and performance team for sign off, against lab results and patient records
* Issues escalated to the Chief Nurse where necessary – Trust executive lead for IPC
 | Incorrect reporting at weekends of new COVID cases during the first wave in 2020 | Throughout the first wave in 2020 the IPC team was on call at weekend for cases review and IPC advise  |
| **1.17** | This Board Assurance Framework is reviewed, and ***evidence*** of assessments are made available and discussed at Trust board | * Weekly Healthcare Associated Infections Update Meeting Minutes
* Trust Board Minutes
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| **1.18** | Ensure **Trust Board** has oversight of ongoing outbreaks and action plans | * Weekly Healthcare Associated Infections Update review meetings attended by Chief Nurse
* Reported by Chief Nurse to Gold command (as required in response to events)
* Reported to Quality Committee
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| **1.19** | There are **check and challenge opportunities** by the **executive/senior leadership t**eams in both clinical and non-clinical areas | * Heads of Nursing and Matrons walk rounds
* Shift coordinators check list (staffing levels and PPE)
* ***“Every action Count”*** **action plan** held by each Directorates and reported through governance structures
* Updates at Quality and CG sub committee
* Weekly HAI meeting including estates rep
* PPE champion challenge/support practice
* 6 weekly PPE team meeting with Chief Nurse and PPE champions
* Annually Mandatory update IPC ***training sessions*** continuous (via MS Teams) – attendance records held by L&D Team
* Quarterly IPCDC committee meeting
* Monthly IPC meetings
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| **1.20** | **Local risk assessments** are based on the measures as prioritised in the **hierarchy of controls**. The risk assessment needs to be documented and communicated to staff. The documented risk assessment includes:* a review of the effectiveness of the **ventilation** in the area.
* operational capacity;
* **prevalence of infection**/ variants of concern in the local area.
* **triaging** and SARS-CoV-2 **testing** is undertaken for all patients either **at point of admission** or as soon as possible/practical following admission across all the pathways.
* when an **unacceptable risk** of transmission remains following the risk assessment, **consideration** to the extended use of Respiratory Protective Equipment **RPE** for patient care in specific situations should be given
 | * Estates have undertaken a full review of all of the Trust estate with regard to room ventilation and operational capacity. Records are held by Estates
* All clinical and non clinical areas have completed a HSE risk assessment re Cvoid-19
* Staff are continuing to work remotely and from home where possible.
* Where staff have to be in direct patient contact, PPE is provided according to their colour pathway for that area and the patient(s)
* All patients are screened on admission and those who refuse it is documented in their Carenotes/Adastra
* All admissions are screened on days 1, 3 and 7 and are to remain in isolation for 7 days (unless positive) if they have not been transferred from another healthcare facility
* Within Mental Health, patients are assessed as to whether maintaining 7 days isolation will be detrimental to their mental health.
* A full risk assessment is undertaken for patients within mental health inpatient settings who cannot be isolated
* Triaging and SARS-CoV-2 testing is undertaken for all patients at point of admission and recoded on Carenotes/Adastra
* Prevalence of infection/ variants of concern in the local area ***monitor***ed
	+ OHFT weekly HoN meeting and on the biweekly meeting with NHSE/I
	+ Weekly Healthcare Associated InfectionsUpdate review meeting
* ***April 2021: Hierarchy of control*** tool kit in place as a systematic approach for controlling risks in the workplace, to be used to inform the “***Every Action Count”***action plan and in conjunction with this IPC Board Assurance Framework document
* **25th June 2021:** Updated guidance on Caring for mental health inpatients during COVID-19 (as 1.1 above)
 | Not able to ***monitor*** screening ***compliance*** from Carenotes | * Carenotes updated to include admission testing results and weekly COVID-19 testing
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| **1.21** | **Patients, visitors and staff** are able to maintain **2 metre social** & physical distancing in all patient care areas, **unless staff** are providing clinical/personal care and are wearing appropriate PPE: | * Social distancing at 2 metre continues
* Optimise bed and chair spacing - 2 metre bed spacing where able
* Bed occupancy and recording of assessment and mitigations where 2 metre bed spacing is not achieved due to operational capacity
* 2-meter distance markings on floors and posters (as 1.10 above)
* Visitors book time to visit, and complete the *COVID-19 Triage form*
* Guidance for staff on use of appropriate PPE in accordance with COVID-19 pathway (as 1.1, 1.5, 1.8, 1.9, and 1.11 above)
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| **1.22** | **All staff** (**clinical and non-clinical**) are ***trained*** in:* putting on and removing PPE;
* what PPE they should wear for each setting and context;
 | * PPE champions on each ward
* PPE ***training*** provided for the PPE Champions and then disseminated to all ward staff
* Staff access the PHE PPE donning and doffing video available on the Trust webpage
* PPE competencies in place for all patient facing staff and recorded by the L&D team
* PPE poster for the RAG Pathways available on intranet
* Staff fit tested for wearing of FFP3 masks
* As per KLE 1.5, 1.9, 1.10 and 1.11 above
 | No PPE champions for Community ServicesStaff only tested for one type of FFP3 mask | * All clinical staff have IPC mandatory training
* All clinical staff asked to watch the PPE videos
* PPE poster on donning and doffing and correct use of masks in all clinical areas, also available on the Trust IPC webpage
* Community HoNs asked to nominate a PPE Champion
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| **1.23** | **Reusable** non-invasive care equipment **is decontaminated**:* between each use
* after blood and/or body fluid contamination
* at regular predefined intervals as part of an equipment cleaning protocol
* before inspection, servicing or repair equipment
 | * Medical devices check list in place: records kept within the Directorate and results reported to quarterly IPCD committee
* IPC annual environment audit: check ***compliance***
* Decontamination record prior to servicing: equipment label as clean
* Clinical cleaned equipment to display “I am Clean” label
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| **1.24** | Implementation of **the Supporting excellence in infection prevention and control behaviours** Implementation Toolkit has been considered [C1116-supporting-excellence-in-IPC-behaviours-imp-toolkit.pdf (england.nhs.uk)](https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/03/C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf) | * ***April 2021: Hierarchy of control*** tool kit in place as a systematic approach for controlling risks in the workplace, to be used to inform the “***Every Action Count”***action plan and in conjunction with this IPC Board Assurance Framework document
* ***“Every Action Count***” action plan in place: each Directorate owns the action plan
* Each Directorate to report progress to the Weekly Healthcare Associated Infections Update meeting
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| **1.25** | Individuals who are clinically extremely vulnerable from COVID-19 **receive protective IPC measures** depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation; | * Patients who are clinically extremely vulnerable will require protective IPC measures depending on their medical condition and treatment e.g., side room prioritisation
 | Number of side rooms available if demand for side room increase | Risk assessment in place to assess the priority of need |
| 1. **Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections**
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| **KEY LINES OF ENQUIRY** | ***EVIDENCE******The detail of the supporting evidence can be made available upon request*** | **GAPS IN ASSURANCE** | **MITIGATING ACTIONS** |
| **Appropriate 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** | * Staff have all received IPC annual mandatory training. IPCT deliver ***training sessions*** virtually via MS teams, e-learning training
* All staff facing patients asked to watch the PHE PPE donning and doffing video for health and social care, which is now part of mandatory IPC training.
* PPE *training on donning and doffing video* can be found on the IPC Trust webpage (link Nurse tab)
* PPE Champions introduced in all inpatient areas
* PPE competencies in place and compliance recorded by the L&D team
* Additional IPC ***training sessions*** and resources provided and over 100 staff undertaking the PPE Champion role
* All areas issued with PPE ***training*** package (including PHE videos’ posters, donning and doffing guidance, flow charts)

March 2020:* Updated IPC guidance and training available on the Trust IPC webpage (see 1.5 above) and through HoN and Matron. Training provided to the PPE champion to cascade the training.
* Completion of matron’s checklists (as 1.4 above)
* Infection Prevention and Control COVID-19 Management Checklist for Shift Co-ordinators ***monitor***ed by and matrons PPE champions and ward managers (as 1.4 above)
* **29th April 2020:** Trust issued SOP and video on resuscitation during COVID-19 for inpatient settings. Level 2 PPE recommended. This was in line with PHE guidance. Emailed to every manager of team with resus equipment.
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| **2.2** | Designated **cleaning teams** with appropriate ***training*** in required **techniques and use of PPE**, are assigned to COVID-19 isolation or cohort areas. | * Housekeeping staff have had all appropriate IPC training: records held by L&D team
* Guidance for domestics issued 03.04.20
* PPE Champion sign off PPE competencies with housekeepers in inpatient areas
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| **2.3** | Decontamination and terminal decontamination **of isolation rooms** or cohort areas is carried out in line with PHE and other [national guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) | * Environmental cleaning, linen and laundry procedure in place from **March 2020.**
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| **2.4** | **Assurance processes** are in place for ***monitoring*** and **sign off terminal cleans** as part of outbreak management | * Terminal clean documentation is signed by the domestic and nursing staff when completed. Records kept by facilities
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| **2.5** | 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 | * Enhanced cleaning and records introduced
* Environmental cleaning, linen and laundry procedure in place (as 2.3 above)
* All cleaning done using Chlor-clean since March 2020 till June 2021
* *“Clinell time”* introduced in each shift (as 2.1 above)
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| **2.6** | 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 | * Chlor-clean standard environmental agent used
* Clinell wipes for equipment in place <https://gamahealthcare.com/latest/clinell-efficacy-against-coronavirus-COVID-19>
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| **2.7** | **Manufacturers’ guidance** and recommended product ‘contact time’ must be followed for all cleaning/disinfectant solutions/ products as per national guidance | * As per 2.6
* Included in mandatory ***training***
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| **2.8** | **“Frequently touched’** surfaces e.g. 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 | * *“Clinell time”* introduced three times a day (handovers) in clinical areas.
* Increased when outbreaks on wards
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| **2.9** | Electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be **cleaned** a **minimum of twice daily** | * Frequently used items/equipment are included in regular *“Clinell time”* cleaning on all wards at every handover and hourly when necessary. Included on the mandatory IPC training
* On handover sheet to remind shift coordinator
* Infection Prevention and Control COVID-19 Management Checklist for Shift Co-ordinators (as 1.4 above)
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| **2.10** | **Rooms/areas** where PPE is removed must be **decontaminated,** ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) | * Designated doffing rooms are included in the cleaning schedule
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| **2.11** | **Linen** from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken | * Environmental cleaning, linen and laundry procedure in place
* Red alginate bags in use prior to the pandemic
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| **2.12** | **Single use** items are used where possible and according to Single Use Policy | * Medical devices policy in place
* Single use item covered in IPC mandatory training
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| **2.13** | **Reusable equipment** is appropriately decontaminated in line with local and PHE and other national policy | * Decontamination procedure in place (as 1.23 above)
* Clear Trust guidance for staff for re-using any PPE - goggles/visors only
* Medical devices and mattresses cleaning records: Kept on the public folder of the G drive
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| **2.14** | Ensure cleaning standards and frequencies are ***monitor***ed in **non-clinical areas with actions in place** to resolve issues in maintaining a clean environment | * Cleaning schedules are established for all areas including non-clinical
* Cleaning schedules are displayed in the non- clinical area
* Facilities monitor cleaning standards and frequencies: records kept with the Trust contract manager and facilities
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| **2.15** | Ensure the **dilution of air** with good **ventilation** e.g. open windows, in admission and waiting areas to assist the dilution of air | * Estates have undertaken a full review of all of the Trust estate with regard to room ventilation and operational capacity (as 1.20 above)
* **9th March 2021:** Version 3 of the Guidance issued for Outpatient clinical services: minimising possible COVID-19 transmission
 | In MH inpatient settings opening windows is restricted  | * CO2 monitoring in place managed by Estates
* Room capacity to be adhered
 |
| **2.16** | ***Monitor*** **adherence** environmental decontamination **with actions in place** to mitigate any identified risk | * Same cleaning regime in place: chlorclean - Cleaning Records kept with facilities
* Processes to monitor the environmental decontamination (as 2.2-2.9 above)
* Matrons checklists implemented (as 1.4 above)
* Infection Prevention and Control COVID-19 Management Checklist for Shift Co-ordinators implemented (as 1.4 above)

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| **2.17** | ***Monitor*** adherence to the **decontamination of shared equipment** with actions in place to mitigate any identified risk | * Evidence as in 1.23 and 2.13 above
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| 1. **Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance**
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| **KEY LINES OF ENQUIRY** | ***EVIDENCE******The detail of the supporting evidence can be made available upon request*** | **GAPS IN ASSURANCE** | **MITIGATING ACTIONS** |
| **Appropriate systems and processes are in place to ensure:** |
| **3.1** | Arrangements around **antimicrobial stewardship** are maintained | * Antimicrobial stewardship programme in place alongside all providers led by CCG
* IPCDC minutes
* DIPC annual report 2019/20 presented to Quality Committee on 7th July and presented at Trust Board on 22nd July 2020.
* DIPC annual report 2020/21 presented to Quality committee on 13th May 2021, and Trust board on 9th June 2021.
* Antimicrobial stewardship is in IPC mandatory ***training***
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| **3.2** | **Mandatory reporting** requirements are adhered to and **boards** continue to **maintain oversight** | * Weekly Review Meeting, escalation to Executive Team weekly.
* Quality committee and Trust Board oversight.
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| 1. **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**
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| **KEY LINES OF ENQUIRY** | ***EVIDENCE******The detail of the supporting evidence can be made available upon request*** | **GAPS IN ASSURANCE** | **MITIGATING ACTIONS** |
| **Appropriate systems and processes are in place to ensure:** |
| **4.1** | Implementation of national guidance on visiting patients in a care setting | * **18th March 2020:** Trust suspended visitors/ contractors apart from in exceptional circumstances. On Mental Health wards visits were individually risk assessed (no blanket bans) and on community hospital wards we followed the national guidance issued on **25th March** allowing exceptions for EOL patients.
* **1st July 2020:** Visiting recommenced under 1 patient/1 visit process, Visitor guidance issued, and risk assessment introduced
* **23rd December 2020**: Visiting in community hospitals was suspended due to increased COVID-19 cases in community. This was not blanket as there were exceptions for *End-of-Life* care
* **March 2021:** Visiting restarted in due to a decrease in national infection COVID-19 rates/cases
* **May 2021:** update of visiting guidance
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| **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** | * Trust standard isolation posters in pace available on the Trust IPC webpage
* All inpatient areas are access controlled
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| **4.3** | Information and guidance on COVID-19 is **available o**n all Trust **websites** with **easy read versions** | * Trust has a designated COVID-19 webpage on intranet: <https://ohft365.sharepoint.com/sites/COVID-19>
* Trust has dedicated IPC webpage with a dedicated COVID-19 section on intranet: [COVID-19 Information (sharepoint.com)](https://ohft365.sharepoint.com/sites/IPC/SitePages/COVID-19%20guidance.aspx)
* Trust website has dedicated COVID section and advice for the general public/ patients <https://www.oxfordhealth.nhs.uk/publication/coronavirus/>
* Easy read versions/ videos of for learning and disability services available [on Trust website developed by L&D service](https://www.oxfordhealth.nhs.uk/learning-disability-service/useful-stuff/)
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| **4.4** | Infection status is **communicated** to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved | * Patient COVID-19 status recorded on the Inter healthcare transfer form
* Patient COVID-19 status recorded on the Referral letter
* COVID-19 Swabbing 48 hours prior to discharge to care homes in place
 |  |  |
| **4.5** | There is clearly displayed and **written information** available to prompt **patients’ visitors and staff** to comply with hands, face and space advice. | * Posters and patient information provided, including Every Action Counts issued 02/06/21
* Hand Hygiene leaflet for patients available
* Newly revised letters to patients re outpatient appointments being updated
* **July 2021:** New IPC posters and IPC available on the OHFT webpage (as 1.10 above)

  |  |  |
| 1. **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******The detail of the supporting evidence can be made available upon request*** | **GAPS IN ASSURANCE** | **MITIGATING ACTIONS** |
| **Appropriate systems and processes are in place to ensure:** |
| **5.1** | **Screening and triaging** of all **patients** as per IPC and [NICE](https://www.nice.org.uk/news/article/nice-publishes-new-covid-19-rapid-guideline-on-arranging-planned-care-in-hospitals-and-diagnostic-services) Guidance within all health and other care facilities **must be undertaken** to enable early recognition of COVID-19 cases | * Processes in place for all admissions – screening on Day 1; Day 3 and Day 7 plus weekly screening of all inpatients across all inpatient services
* Outpatients are risk assessed for contacts before attending and **appointment letters** include advice to contact team via phone if symptomatic or in contact with confirmed cases in the past 14 days
* Documents as per 1.1 above
 |  |  |
| **5.2** | **Front door areas** have appropriate **triaging arrangements** in place to **cohort** patients with **possible or confirmed COVID-19 symptoms** to minimise the risk of cross-infection | * Triage system with screening and designated areas
* Cohorting in community hospitals in place as per IPC team guidance (and other infection management)
* MH settings which have en-suite rooms can isolate patients
* Clear Trust guidance in place for isolation and seclusion (see 1.1 above) Trust guidance on patient management/ cohorting/ testing (see 1.1. above)
* Isolation and seclusion guidance issued for MH and secure settings (as 1.1 above).
 | MH patients may not be compliant with isolation guidance  | * Isolation guidance for MH patient reviewed with mitigation action in place based on a risk assessment to de-isolate on day 7
 |
| **5.3** | **Staff are aware** of agreed template for **triage questions** to ask | * Embedded in guidance and SOP for admission / assessment
* Sign at the entrance doorways with **triage questions**
* Newly revised triage question checklist being established
 | No consistent approach previously now updating guidance to reflect newly revised triage questions |  |
| **5.4** | **Triage undertaken** by clinical staff who are ***trained*** and competent in the **clinical case definition** and patient is allocated appropriate pathway as soon as possible | * All inpatient areas and EMU’s and urgent care pathways follow guidance re RAG pathways as per 1.1
 |  |  |
| **5.5** | **Face coverings** are used by **all patients** and they are always **advised to wear** them | * Guidance issued via posters for patients and included in appointment information
* Available in all services i.e. wards/EMU and risk assessed for safe use
* New posters including Every Action Counts toolkits issued 02/06/21
 | Patients particularly in MH settings may not wear face coverings  | * To record in patient notes if refused or cannot for clinical reasons wear face masks
 |
| **5.6** | Provide **clear advice** to **patients on use of face** masks to encourage use of surgical facemasks by **all inpatients in the medium and high-risk pathways** if this can be tolerated and does not compromise their clinical care  | * Patient COVID-19 Leaflet available on Trust webpage on intranet
 | In MH settings patients may not be able to wear face masks owing to safety and clinical risk reasons (Issued risk note in relation to this- must be risk assessed)  | * Record in patient notes: rationale and risk assessment
 |
| **5.7** | ***Monitoring*** of **Inpatients** ***compliance* with wearing face masks** particularly when moving around the ward (if clinically ok to do so) | * Shift co-coordinator to encourage patients to wear face masks
* Risk assessed for use for patient that are unable to use a facemask must be recorded on Carenotes
 | There is no consistent ***monitoring*** process in place In MH settings where patients are unwell it is challenging to ensure all patients wear face masks when moving around the ward  |  |
| **5.8** | Ideally **segregation** should be with **separate spaces,** but there is potential to use screens, e.g. to protect reception staff. | * Screens installed in outpatients, EMU reception areas.
* Use of screens assessed for each service (risk asses due to concerns with reduced airflow when using screens) where clinical assessment may indicate patients cannot wear masks
 |  |  |
| **5.9** | To ensure **2 metre** social & physical distancing **in all patient care areas** | * Floor markings in situ following Estates / Clinical review
* Patients in community hospitals are 2 meters apart
* The number of patients in bays has been reduced to accommodate this
* Signing with room capacity in place
 |  |  |
| **5.10** | For patients with **new-onset symptoms**, isolation, testing and instigation of **contact tracing** is achieved until proven negative | * All patients are isolated and tested on Day 1,3 and 7 days
* All patients are isolated and tested if symptomatic or +ve - as per Trust IPC guidance
* Alert on Carenotes if COVID +ve
* Any patients returning from overnight leave in MH settings tested as per guidance
 |  |  |
| **5.11** | 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 | * Alert on Carenotes if +ve
* Screening and isolation guidance (as 5.1 above)
 |  |  |
| **5.12** | There is ***evidence* of *compliance*** with **routine patient testing** protocols in line with Key actions: infection prevention and control and testing document | * Weekly screens for each ward
* Results can be seen on ICE by the IPC team
* Screening recorded on individual patient Carenotes record
 | Record screening ***compliance*** in place on individual records however no overall monitoring of this on a ward/unit can take place as a report cannot be taken from Carenotes | Report from Carenotes to be completed and discussions with clinical systems team to see if notification can be  |
| **5.13** | Patients that attend for **routine appointments** who display symptoms of COVID-19 are managed appropriately | * Clear protocol for staff for **Outpatient appointments** available on intranet
* Notices/signage in all areas telling public not to enter if displaying symptoms
* Where possible virtual appointments
* PPE worn on all home and face to face visits / appointments – specific guidance for community staff regarding PPE, embedded is the general guidance, there was also specific guidance created with certain services ie dental team, school nurses for immunisations: [Recommended PPE for COVID-community.pdf](file:///G%3A%5COxfordshire%5CInfection%20Control%5CCOVID-%2019%5CEverything%20to%20date%5CGuidance%5CCommunity%20services%5CRecommended%20PPE%20for%20COVID-community.pdf)
 |  |  |
| 1. **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******The detail of the supporting evidence can be made available upon request*** | **GAPS IN ASSURANCE** | **MITIGATING ACTIONS** |
| **Appropriate systems and processes are in place to ensure:** |
| **6.1** | **Separation of patient pathways** and **staff flow** to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas | * All areas reviewed to ensure one-way systems can be implemented in outpatients’ areas/urgent care where possible
* In inpatient areas oneway systems cannot be maintained given delivery of clinical care.
* All staff wear level 1 PPE and Level 2 if AGP
 |  |  |
| **6.2** | **All staff** (clinical and non- clinical) have appropriate **training,** in line with latest PHE and other national guidance, to ensure their personal safety and working environment is safe | * See ***evidence*** in 2.1 above for clinical staff.
* Non-clinical staff – IPC and mask guidance issued.
* Clear process for contractors led by estates
* HoN and estates reviewing each inpatient area to ensure all IPC measures to prevent Hospital Acquired COVID are in place such as: social distancing in communal areas; use of paper towels; use of appropriate ventilation systems; frequent cleaning of all non-clinical devices such as PC; ‘clinell time’
* PPE champions introduced; ***training*** via webinars with another trust using this system- around 130 in place now across the Trust
* Community hospital wards decided the shift coordinator would be responsible for leading on PPE – ensuring it was being worn and used correctly.
 |  |  |
| **6.3** | 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 don and doff it | * Approved PPE Training;
* Donning and doffing PHE videos;
* PHE posters,
* clear trust guidance,
* ***training*** presentations,
* community hospital audit.
* PPE competencies for every member of staff in inpatient care
* See 1.11 and 2.1 above.
* Updated PPE requirements
 |  |  |
| **6.4** | A record of staff ***training*** is maintained | * IPC annual mandatory ***training:*** (1.7) training, PPE training and e-learning in place: records held by L&D team
* FFP 3 fit testing records held L&D team
 |  |  |
| **6.5** | **Adherence to PHE national** guidance on the **use of PPE** is **regularly audited** with actions in place to mitigate any identified risk | * Trust guidance in place in line with national guidance.
* Audits of mental health and community hospitals in place and reviewed by directorates and heads of nursing- led by the PPE Champions/ Matrons (as 1.4 above)
* All incidents related to PPE are reported on Ulysses system and ***monitor***ed by governance team (*Ulysses reports*)
* Escalated when appropriate through to Clinical Director and then the weekly review meeting every Monday chaired by the Deputy Chief Nurse
* Report to bi monthly Quality Committee on safety issues including all COVID related incidents
 |  |  |
| **6.6** | **Hygiene facilities** (IPC measures) and messaging are **available for all patients/individuals, staff and visitors** to minimise COVID-19 transmission such as:* hand hygiene facilities including instructional posters
* good respiratory hygiene measures
* staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care
* staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace
* frequent decontamination of equipment and environment in both clinical and non-clinical areas
* clear visually displayed advice on use of face coverings and facemasks by patients/ individuals, visitors and by staff in non-patient facing areas
 | * Posters in place
* Including new posters from Every Action Counts Toolkits issued 02/06/21
* As above 5.5
 |  |  |
| **6.7** | Staff **regularly undertake** hand hygiene and **observe** standard infection control precautions | * Trust issued basic IPC principles in form of an infographic for display on all wards and areas
* Posters relating to hand hygiene in place- demonstrating technique
* Trust guidance on all IPC measures on intranet.
* All Matrons and HoNs take lead role in ensuring adherence to basic hand hygiene and IPC measures
* Audits in place for ***compliance*** ***monitoring***
* All measures reviewed weekly at HAI meeting chaired by Chief Nurse
 |  |  |
| **6.8** | 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 | * No hand driers in place in clinical areas
 |  |  |
| **6.9** | **Guidance on hand hygiene**, including drying should be clearly displayed in all public toilet areas as well as staff areas | * Posters in place
* Some soap dispensers have the HH process on them
 |  |  |
| **6.10** | Staff understand the requirements for **uniform laundering** where this is not provided for on site | * Trust guidance issued re uniforms as per PHE guidance
* All Staff working wards issued with scrubs at start of pandemic
 |  |  |
| **6.11** | **All staff** understand the **symptoms of COVID-19** and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other **if they or a member of their household** display any of the symptoms | * Trust guidance on intranet
* Central absence line to manage sickness
* **2020:** Daily briefing emails to all staff
* Cascading information through Service Directors and Clinical Directors
* Visits from Senior nurses, matrons
* HoN leading on IPC measures
* All patient facing staff have access to the LFT kits and advised to undertake twice weekly
 |  |  |
| **6.12** | A rapid and **continued response** through **ongoing surveillance of rates** of infection transmission within the local population and for hospital/ organisation onset cases (staff and patients/individuals) | * Attendance at Public Health Protection Board by the Community Service Director
* Weekly DIPC meetings
* Weekly NHSE/I regional DoN meetings, from 2021 bi-weekly meetings
* Daily PHE alerts
* Weekly HAI meetings
 |  |  |
| **6.13** | **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 procedure in place available in Trust intranet webpage
* Single cases are reviewed and transmission investigation RCA’s completed
* In outbreaks the Trust reports via online system and manages via daily reviews and twice weekly outbreak meetings
* Outbreaks reports are completed for each outbreak
 |  |  |
| **6.14** | Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings. | * Outbreak procedure in place available in Trust intranet webpage

  |  |  |
| 1. **Provide or secure adequate isolation facilities**
 |
| **KEY LINES OF ENQUIRY** | ***EVIDENCE******The detail of the supporting evidence can be made available upon request*** | **GAPS IN ASSURANCE** | **MITIGATING ACTIONS** |
| **Appropriate systems and processes are in place to ensure:** |
| **7.1** | **Restricted access** between pathways if possible, (depending on size of the facility, prevalence/ incidence rate low/ high) by other patients/individuals, visitors or staff | * Outbreak procedure in place available in Trust intranet webpage (as 6.14 above)
 |  |  |
| **7.2** | Areas/wards are **clearly signposted**, using **physical barriers** as appropriate to patients/individuals and staff understand the **different risk areas** | * Signage in place (red, amber, green) in all clinical areas
* Amber for mental health wards
* 2m distancing between beds, in bays
 |  |  |
| **7.3** | Patients with **suspected or confirmed** COVID-19 are isolated in appropriate facilities or designated areas where appropriate | * See ***evidence*** in 1.1 above.
* Confirmed +ve cases alerted via Carenotes
* Isolation guidance in place for clinical areas
 |  |  |
| **7.4** | 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 | * See ***evidence*** in 1.1 above.
* Cohorting in community hospitals (as per other infection management)
* De-isolation flowchart devised
 | Not possible to completely cohort in our MH settings | Using en-suite facilities to isolate +ve patients |
| **7.5** | Patients with **resistant/alert organisms** are managed according to local IPC guidance, including ensuring appropriate patient placement | * Alerts of +ve patients on Carenotes
* Multi Drug Resistant Organisms procedure in place
* RCA of mandatory reportable bacteraemia’s undertaken
 |  |  |
| 1. **Secure adequate access to laboratory support as appropriate**
 |
| **KEY LINES OF ENQUIRY** | ***EVIDENCE******The detail of the supporting evidence can be made available upon request*** | **GAPS IN ASSURANCE** | **MITIGATING ACTIONS** |
| **Appropriate systems and processes are in place to ensure:** |
| **8.1** | **Testing is** undertaken by competent and ***trained*** individuals | * **June 2020:** Specific testing team initially with appropriate training
* Trust SOP issued when regular swab and antigen testing clinics introduced across the Trust
* Clinical Director overseeing testing system and process
* Information about taking swabs sent to all inpatient areas available on the Trust webpage in intranet
 |  |  |
| **8.2** | **Patient and staff COVID-19 testing** is **undertaken promptly** and in line with PHE and other national guidance | * Clear trust guidance for staff and patient testing in line with national guidance: available on the Trust webpage in intranet
* Swabbing on admission in all wards on day 1, 3 and 7 then weekly (as 1.1 above)
* Patient test results provided in Carenotes.
* Central absence line to manage staff sickness.
 |  |  |
| **8.3** | **Regular** ***monitoring*** and **reporting** of the **testing turnaround times**with focus on the time taken from the patient to time result is available | * Results are checked daily by staff
* Turn around review completed in response to national letter and within 24 hours across site
 |  |  |
| **8.4** | **Regular** ***monitoring*** and **reporting t**hat identified cases have been tested and **reported in line with the testing protocols** (correctly recorded data) | * Process in place to validate positive result with exec oversight, as per PHE guidance
 |  |  |
| **8.5** | **Patient and staff COVID-19 testing** is undertaken promptly and in line with PHE and other national guidance | * **2020:** Trust dashboard updated twice daily in order that Trust understands levels of infection daily for patients and staff
* Patients tested on admission at Day 1,3 5-7 plus weekly screening
* Issues reviewed at the Weekly Healthcare Associated Infections Update Meeting
* Staff issued with guidance for LFT available on the Trust webpage on intranet
 | Currently no access to report on patient testing to monitor compliance with patient testingNot all staff are completing LFTs and recording via the portal | * Issues raised at the Weekly Healthcare Associated Infections Update Meeting
* Work being undertaken to take testing compliance reports from Carenotes
 |
| **8.6** | Screening for **other potential infections** takes place | * Multi Drug Resistant Organisms procedure in place available on the Trust webpage on intranet
* MRSA procedure in place available on the Trust webpage on intranet
* Results recorded in Carenotes (alerts on Carenotes)
 |  |  |
| **8.7** | That all emergency patients are tested for COVID-19 on admission. | * EMU/ Minor injuries carry out LFT & PCR tests on admission (as 1.1 above)
 |  |  |
| **8.8** | That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. | * All inpatients that develop COVID- 19 symptoms are retested as per procedure (as 1.1 above)
 |  |  |
| **8.9** | That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission. | * Managed as per management of hospital admissions for community or mental health (as 1.1 above)

  |  |  |
| **8.10** | That sites with high nosocomial rates should consider testing COVID negative patients daily. | * IPC review all incidences and assess screening requirements
 |  |  |
| **8.11** | That those being discharged to a care home are being 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 | * National PHE Guidance is followed
* Use of transfer and discharge forms and recording in patients notes
* [Guidance for stepdown of infection control precautions and discharging COVID-19 patients and asymptomatic SARS-CoV-2 infected patients - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharging-covid-19-patients)
* **25th June 2021:** Caring for mental health inpatients during COVID-19 (as 1.1 above)
 |  |  |
| **8.12** | That those being discharged to a care facility within their 14-day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation. | * National PHE Guidance is followed by inpatient ward areas
* Guidance for stepdown of infection control precautions and discharging COVID-19 patients and asymptomatic SARS-CoV-2 infected patients - GOV.UK (www.gov.uk)
* Use of transfer and discharge forms
 |  |  |
| **8.13** | That all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission. | * The Trust do not have elective patients
 |  |  |
| 1. **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******The detail of the supporting evidence can be made available upon request*** | **GAPS IN ASSURANCE** | **MITIGATING ACTIONS** |
| **Appropriate 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 | * IPC policy and procedures in place available on the Trust IPC webpage on intranet
* IPC committee continued to meet every quarter (minutes available on the G drive)
* IPC agenda item on monthly Quality subcommittee (minutes available on the G drive)
* Weekly Review Meeting which captures all infections and associated RCA’s (minutes available on the G drive)
* IPC team advice / IPC link nurses/PPE champions
 |  |  |
| **9.2** | Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff | * Chief Nurse, CEO and emergency planning team have alerts directly to their inbox.
* Weekly Healthcare Associated Infections Update Meeting
* Changes identified and updated guidance issued on intranet and put in daily briefing to all staff.
* Communication via HON’s and Clinical directors
* Twice weekly communications bulletin for all staff via Chief Nurse and Medical Director in place
 |  |  |
| **9.3** | 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  | * Trust procedure in place and available on the Trust Webpage on intranet
* Comms/ designated intranet pages
* National guidance issued and segregating waste guide provided. This guidance is regularly reviewed and updated
 |  |  |
| **9.4** | PPE stock is appropriately stored and accessible to staff who require it | * **2020:** Procurement and distribution led by DoF and team
* **2020:** Clear process in place, central PPE coordination centre and PPE hubs
* **2020:** Daily teleconferencing and sit reps. See ***evidence*** under 1.4 above
* **2020:** Daily escalation process in place
* Dedicated email to escalate PPE issues
 |  |  |
| 1. **Have a system in place to manage the occupational health needs and obligations of staff in relation to infection**
 |
| **KEY LINES OF ENQUIRY** | ***EVIDENCE******The detail of the supporting evidence can be made available upon request*** | **GAPS IN ASSURANCE** | **MITIGATING ACTIONS** |
| **Appropriate systems and processes are in place to ensure:** |
| **10.1** | Staff in **‘at-risk’ groups** are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported | * Workplace screening assessment introduced for all staff
* Trust introduced an electronic three-step process for rapidly implementing a comprehensive risk assessment and response strategy for our workforce:
	+ Screening for all workers - new and existing
	+ Personalised risk assessment and planning for those at higher risk
	+ Actions and support for higher risk individuals and groups
* We have identified ‘vulnerable’ and ‘at risk’ groups and detailed risk assessment process in place. Local bespoke interventions and plans developed for each individual involving
* Occupational Health where appropriate.
* ***Compliance*** ***monitored*** by executive team on a weekly basis
* BAME engagement / listening events in place to support specific issues
* Trust wide Psycho-social response group in place led by Associate Director of Psychological Therapies.
* Wellbeing lead in place and supporting staff with a wide range of MH and wellbeing support
* Recovery Days provided by pastoral team accessible to all staff
 | Possible backlog of risk assessments causing delays for staff | Process in place with additional capacity if necessary |
| **10.2** | The risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff | * All staff have completed a risk assessment.
* This risk assessment takes account of all risk factors and all staff in high-risk group have an individual risk management plan which includes re-deployment where appropriate
 |  |  |
| **10.3** | Staff required to wear FFP reusable respirators undergo ***training*** that is compliant with PHE national guidance and a record of this ***training*** is maintained and held centrally | N/A |  |  |
| **10.4** | Staff who carry out fit test ***training*** are ***trained***  and competent to do so | * Train the trainer process in place with completion of sign off form
* Trainer records are held with L&D
 |  |   |
| **10.5** | All staff required to wear an FFP respirator **have been fit tested for the model being** used and this should be repeated each time a different model is used | * Additional trainers have been provided by national PPE service to support ***training*** staff on the available FFP3 masks
* ***Training*** continuing for each specific mask
* Current **c*ompliance***for fit testing is over 90%
 |  | PPE orders working to secure stable supply of **2-3 mask models to** enable fit testing of this models to take place in a timely way  |
| **10.6** | **A record of the fit test** and result is given to and kept by the trainee and centrally within the organisation | * Trust lead for fit testing identified, providing weekly updates on the number of staff being fit tested
* Full fit testing register in now in place. Capturing who needs to be fit tested for their role and when they have been fit tested with which mask.
* Local records held and also collated centrally via L&D and linked to individual staff records- this includes fail rates and types of masks successfully fitted for each individual staff member
* Review of Fit testing records weekly (HAI) and actions taken to address by Trust lead
 |  |  |
| **10.7** | For those who **fail a fit test,** there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods  | As 10.6* Trust purchased ambient particle fit testing machines and rolling out to staff who previously failed a fit test
 |  |  |
| **10.8** | For 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 | * As 10.6
* See 10.7
* Discussions with all staff who need re-deployment for a variety of reasons is taking place. A personalised action plan is then developed. See form below.
 |  |  |
| **10.9** | 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 | * This is held within the staff risk assessment documentation
 |  |  |
| **10.10** | Following consideration **of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3,** staff who are unable to pass a fit test for an FFP respirator **are redeployed** using the **nationally agreed algorithm** and a record kept in staff members personal record and Occupational health service record | * This is part of the staff risk assessment process and records kept following any decision making
* Ambient particle fit testing now available.
 |  |  |
| **10.11** | **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 | * SBAR produced identifying current situation with fit testing
* At the start of each shift the shift coordinator completes checklist which includes which staff have been fit tested
* Report escalated to Quality committee if appropriate
* As above 10.6
* SBAR completed and discussed at IPCDC.

  | Staff only fit tested for one type of FFP3Updated reports on staff training  | * Provision of the FFP3 in line with the FFP3 used for fit test
* FFP3 fit test lead to review and escalate as required gaps
 |
| **10.12** | 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 | * System in place
* Wards closed when outbreaks occur in line with guidance
* Staffing solutions informed of any outbreaks and bank and agency workers movement minimised where possible
* Introduction of LFT for agency staff
 |  |  |
| **10.13** | All staff should adhere to national guidance on social distancing (2 metres) **if not** wearing a facemask and in **non-clinical areas** |  |  |  |
| **10.14** | 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 | * Recovery /estates guidance
 |  |  |
| **10.15** | Staff are aware of the need to wear facemask when moving through COVID-19 secure areas. |  |  |  |
| **10.16** | Staff absence and well-being are ***monitor***ed and staff who are self-isolating are supported and able to access testing | * Central absence line to manage sickness established.
* Occupational health referrals where needed
* Personalised risk assessments for all staff.
* Employee Assistant Scheme (EAP) in place for all staff and their families to access
* Psycho-social group in place offering many wellbeing opportunities of support
* Testing guidance issued and staff self-testing with lateral flow devices twice weekly
 |  |  |
| **10.17** | Staff that test positive have adequate information and support to aid their recovery and return to work. | * See above 10.16
* Trust guidance in place.
* Occupational health support if required
* Local manager support
* Bespoke local arrangements for phased return if needed
 |  |  |