

# Infection prevention and control board assurance framework

1 September 2022 V1.11

Updates from November 30<sup>th</sup> V1.8 highlighted

## Foreword

NHS staff should be proud of the care being provided to patients and the way in which services adapted and responded during the COVID-19 pandemic.

Effective infection prevention and control **must continue and to support service recovery we have updated** this board assurance framework (BAF) to support all healthcare providers to effectively self-assess their compliance with **the National Infection Prevention and Control Manual (NIPCM)** <https://www.england.nhs.uk/publication/national-infection-prevention-and-control/>

and other related infection prevention and control guidance to identify risks associated with **infectious agents** **and provide an additional level of assurance to the Board**. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors, and directors of nursing by assessing the measures taken in line with the NIPCM or existing local policies whilst the NIPCM is being implemented. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

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



Ruth May  
Chief Nursing Officer for England

# 1. Introduction

The application of Infection Prevention and Control (IPC) measures has been key in the response to the SARS-CoV-2 pandemic.

The [UKHSA guidance](#) was archived at the end of April 2022, the proposal is that NIPCM combined with this version of the Board Assurance Framework (BAF) will support this transition.

This will **continue to** ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users, and staff.

The update of **the BAF** helps providers to assess against the NIPCM as a source of internal assurance. It will also identify any areas of risk and the corrective actions required in response. The **BAF** provides assurance to trust boards that organisational compliance has been systematically reviewed.

The **BAF** is intended to support local organisations with decision making and be used by directors of infection prevention and control, medical directors, and directors of nursing if required unless alternative internal assurance mechanisms are in place.

# 2. Legislative framework

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

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

Risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. Local risk assessments should be based on the measures as prioritised in the **hierarchy of controls** <https://www.england.nhs.uk/publication/national-infection-prevention-and-control/>

. In the context of infectious agents, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed, and mitigated effectively.

## Infection Prevention and Control board assurance framework

### 1. Systems 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 their environment and other users may pose to them

| Key lines of enquiry  | Evidence  | Gaps in Assurance            | Mitigating Actions  |
|---|---|------------------------------|---|
| <p>Systems and processes are in place to ensure that:</p> <ul style="list-style-type: none"> <li>• A respiratory plan incorporating respiratory seasonal viruses that includes: <ul style="list-style-type: none"> <li>○ point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services</li> <li>○ segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g clinically immunocompromised.</li> <li>○ A surge/escalation plan to manage increasing patient/staff infections.</li> <li>○ a multidisciplinary team approach is adopted with hospital leadership, operational teams, estates &amp; facilities, IPC teams and clinical and non- clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan.</li> </ul> </li> <li>• Organisational /employers risk assessments in the context of managing infectious agents are: <ul style="list-style-type: none"> <li>○ based on the measures as prioritised in the hierarchy of controls.</li> </ul> </li> </ul> | <p>Respiratory Virus policy in place detailing, testing, patient placement and segregation, escalation and multi- disciplinary input</p> <p>Risk assessments in place using hierarchy of controls</p> | <p>Policy expires 1/4/23</p> | <p>Currently being rewritten– to be submitted IPC April 23.</p> |

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| <ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE.</li> <li>○ communicated to staff.</li> <li>○ further reassessed where there is a change or new risk identified eg. changes to local prevalence.</li> </ul> </li> <li>• the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.</li> <li>• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents.</li> <li>• ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons.</li> <li>• resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors).</li> <li>• the application of IPC practices within the NIPCM is monitored e.g. 10 elements of SICPs</li> <li>• the IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level.</li> <li>• the Trust Board has oversight of incidents/outbreaks and associated action plans.</li> <li>• the Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.</li> </ul> | <p>Discussed previously at Silver Command Group</p> <p>Completed by Infection Prevention Team (IPT)</p> <p>Included in policy</p> <p>Audit programme in place to monitor adherence to standard infection control precautions.<br/>Reports submitted to Infection Prevention Committee<br/>BAF submitted to Trust Board</p> <p>Outbreaks reported via command structure</p> <p>Multiple respirator mask types available in PPE store in accordance with national procurement strategy</p> |  |  |
| <b>2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections</b>   |  |  |  |

| Key lines of enquiry   | Evidence   | Gaps in Assurance                                       | Mitigating Actions   |
|--|--|---|--|
| <p>Systems and processes are in place to ensure that:</p> <ul style="list-style-type: none"> <li>the Trust has a plan in place for the implementation of the <a href="#">National Standards of Healthcare Cleanliness</a> and this plan is monitored at board level.</li> <li>the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room</li> <li>cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.</li> <li>enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections <b>as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained.</b></li> <li>manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.</li> <li>For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: <ul style="list-style-type: none"> <li>patient isolation rooms</li> <li>cohort areas</li> <li><b>donning &amp; doffing areas – if applicable</b></li> <li>'Frequently touched' surfaces e.g., door/toilet handles, <b>chair handles</b>, patient call bells, over bed tables and bed/<b>trolley</b> rails.</li> <li>where there may be higher environmental contamination rates, including: <ul style="list-style-type: none"> <li>toilets/commodores particularly if patients have diarrhoea and/or vomiting.</li> </ul> </li> </ul> </li> </ul> | <p>Implementation group in place including IPT, Matrons, Hygiene services</p> <p>Functionality reviewed by Group<br/>Audit schedule in place with multi-disciplinary group</p> <p>Cleaning schedules in place</p> <p>Included in schedules<br/>Frequently touched surfaces included as part of cleaning schedule – cleaned x 2 daily.<br/>Monitored as part of Matrons audits.</p> | <p>Gaps in audit schedule for Cath Lab and Theatres</p> | <p>Included in multi-disciplinary group audit schedules for the future</p> |

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| <ul style="list-style-type: none"> <li>• The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the <a href="#">National Standards of Healthcare Cleanliness</a></li> <li>• A terminal clean of inpatient rooms is carried out: <ul style="list-style-type: none"> <li>○ when the patient is no longer considered infectious</li> <li>○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens).</li> <li>○ following an AGP if <b>clinical area/room</b> is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).</li> </ul> </li> <li>• reusable non-invasive care equipment is decontaminated: <ul style="list-style-type: none"> <li>○ between each use</li> <li>○ after blood and/or body fluid contamination</li> <li>○ at regular predefined intervals as part of an equipment cleaning protocol</li> <li>○ before inspection, servicing, or repair equipment.</li> </ul> </li> <li>• compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.</li> <li>• ventilation systems, should comply with HTM 03:01 and meet national recommendations for minimum air changes <a href="https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/">https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/</a></li> <li>• ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible.</li> </ul> | <p>Cleaning policy and schedules in place</p> <p>Terminal decontamination carried out after patient discharge and is logged onto a database</p> <p>Cleaning schedules and protocols in place. Monitored via audits Certification of equipment prior to repair in place.</p> <p>Audit schedule in place, monitored by Cleaning Group</p> <p>Ventilation systems assessed by Estates team Critical systems inspected annually, including POCCU, ITU, Theatres, Cath lab and Cherry ward. Signed off by authorised engineer.</p> |  |  |
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| <ul style="list-style-type: none"> <li>where possible air is diluted by natural ventilation by opening windows and doors where appropriate</li> </ul>   |   |  |  |
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| <b>3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance</b>   |   |  |  |
| Key lines of enquiry  | Evidence  | Gaps in Assurance  | Mitigating Actions   |
| <p><b>Systems and process are in place to ensure that:</b></p> <ul style="list-style-type: none"> <li>arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated</li> <li>NICE Guideline NG15 <a href="https://www.nice.org.uk/guidance/ng15">https://www.nice.org.uk/guidance/ng15</a> is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use</li> <li>the use of antimicrobials is managed and monitored: <ul style="list-style-type: none"> <li>to optimise patient outcomes</li> <li>to minimise inappropriate prescribing</li> <li>to ensure the principles of Start Smart, Then Focus <a href="https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus">https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus</a> are followed</li> </ul> </li> <li>contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including: <ul style="list-style-type: none"> <li>total antimicrobial prescribing;</li> <li>broad-spectrum prescribing;</li> <li>intravenous route prescribing;</li> </ul> </li> </ul> <p>adherence to AMS clinical and organisational audit standards set by NICE: <a href="https://www.nice.org.uk/guidance/ng15/resources">https://www.nice.org.uk/guidance/ng15/resources</a></p> <ul style="list-style-type: none"> <li>resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must</li> </ul> | <p>Antimicrobial Pharmacist is operational lead. Director of Infection prevention is Executive lead</p> <p>Antimicrobial stewardship group in place, overseeing stewardship programme and audit programme</p> <p>Some information gathered as part of stewardship programme</p> <p>Training provided by pharmacists. Critical care ward rounds in place and referral system for</p> | <p>Key performance indicators not currently included in reporting schedule to the board.</p> | <p>Antimicrobial pharmacist to collate data quarterly and include in DIPC report</p> |



| include all care areas and staff (permanent, flexible, agency and external contractors).   | microbiology and antibiotic therapy patient reviews  |                   |                    |
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| <b>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.</b>   |  |                   |                    |
| • Key lines of enquiry   | Evidence   | Gaps in Assurance | Mitigating Actions |
| <p>Systems and processes are in place to ensure that:</p> <ul style="list-style-type: none"> <li>IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use</li> <li>visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors</li> <li>national principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. <a href="#">national guidance</a> on visiting patients in a care setting is implemented.</li> <li>patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice.</li> <li>restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives.</li> <li>there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. <b>The use of</b></li> </ul> | <p>Advice included in welcome booklet and on website</p> <p>Visiting guidelines in place to support patients</p> <p>Visitors allowed to accompany patients if clinically suitable and not in restricted area</p> <p>Included in outbreak policy</p> <p>Hand hygiene posters/notices displayed<br/>Facemasks no longer used routinely although used</p> |                   |                    |

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| <p>facemasks/face coverings should be determined following a local risk assessment.</p> <ul style="list-style-type: none"> <li>if visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE.</li> <li>Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting.</li> <li>Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.</li> <li>implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required <a href="#">C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)</a></li> </ul> | <p>according personal preference<br/>Information displayed on posters at entrance to room</p> <p>Included in patient information</p> <p>Visitors not present during AGPs unless exceptional circumstance</p> <p>Toolkit reviewed by Silver Command.<br/>Screen savers, posters and regular updates/reminders in place.</p> |  |  |
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## 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                                     |
|---|--|---|--|
| <p>Systems and processes are in place to ensure that:</p> <ul style="list-style-type: none"> <li>all patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients).</li> <li>signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform</li> </ul> | <p>Assessment of infection status included in admission document</p> <p>Signage in place</p> | <p>Some signage out of date and/or no longer required</p> | <p>Review to take place with capital planning team</p> |

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| <p>receiving reception staff, immediately on their arrival (see NIPCM).</p> <ul style="list-style-type: none"> <li>the infection status of the patient is communicated <b>prior to transfer</b> to the receiving organisation, department or transferring services <b>ensuring correct management /placement</b></li> <li>triaging <b>of patients for infectious illnesses</b> is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission <b>and a facemask worn by the patient where appropriate and tolerated.</b></li> <li>patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated.</li> <li>patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result <b>and a facemask worn by the patient where appropriate and tolerated</b> (unless in a single room/isolation suite).</li> <li>patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results <b>and a facemask worn by the patient where appropriate and tolerated</b> only required if single room accommodation is not available.</li> <li>patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation</li> <li>if a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.</li> </ul> | <p>Infection status included in transfer documentation by discharge planning team</p> <p>Patients assessed by clinicians<br/>Isolated if symptomatic as per policy</p> <p>Patients with suspected or confirmed respiratory virus isolated in single rooms as policy</p> <p>Patient prioritisation discussed with IPT and co-ordinators if single room availability is limited</p> <p>Single room provision allocated on a daily basis, patients prioritised if clinician requests</p> <p>Clinicians informed of suspected/positive patients and the decision on treatment is made dependant on clinical urgency</p> |  |  |
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| <ul style="list-style-type: none"> <li>• The use of facemasks/face coverings should be determined following a local risk assessment.</li> <li>• patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy.</li> <li>• Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection</li> <li>• Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.</li> </ul>   | <p>Facemasks not in routine use currently, to be reviewed if prevalence changes significantly</p> <p>Staff vaccination and awareness programme in place</p> <p>Outbreaks monitored and reported by IPT</p>  |                   |                    |
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| <b>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</b>   |   |                   |                    |
| Key lines of enquiry  | Evidence  | Gaps in Assurance | Mitigating Actions |
| <p>Systems and processes are in place to ensure that:</p> <ul style="list-style-type: none"> <li>• IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties.</li> <li>• training in IPC measures is provided to all staff, including: the correct use of PPE</li> <li>• all staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM);</li> <li>• adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk</li> </ul> | <p>IPC included in mandatory training. Training provided by education team and also by individual departments e.g. critical care education practitioners regarding PPE and correct donning/doffing.</p> <p>Donning and doffing videos on intranet and staff app. Included in corporate induction</p> <p>Training records held by Education Team</p> |                   |                    |

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| <ul style="list-style-type: none"> <li>gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.</li> <li>hand hygiene is performed: <ul style="list-style-type: none"> <li>before touching a patient.</li> <li>before clean or aseptic procedures.</li> <li>after body fluid exposure risk.</li> <li>after touching a patient; and</li> <li>after touching a patient's immediate surroundings.</li> </ul> </li> <li>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 (NIPCM)</li> <li>staff understand the requirements for uniform laundering where this is not provided for onsite.</li> </ul> | <p>Hand hygiene policy in place , included in education programmes and as part of ANTT assessment</p> <p>No hand driers in clinical areas, disposable towels only</p> <p>No uniform laundering available apart from theatre scrubs. Information in uniform policy</p> |  |  |
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## 7. Provide or secure adequate isolation facilities

| Key lines of enquiry  | Evidence   | Gaps in Assurance | Mitigating Actions |
|---|--|-------------------|--------------------|
| <p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> <li>that clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.</li> <li>patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM.</li> <li>patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory</li> </ul> | <p>Policy in place - Patients with respiratory viruses isolated in single rooms. Masks worn if urgent treatment in another area required</p> <p>Cohort areas decided by Silver Command if required</p> |                   |                    |

| <p>infection with other patients confirmed to have the same infectious agent.</p> <ul style="list-style-type: none"> <li>• standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings</li> <li>• Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization</li> </ul>  | <p>Policy in place, audit programme in place</p>  |  |                    |
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| <b>8. Secure adequate access to laboratory support as appropriate</b>   |   |  |                    |
| Key lines of enquiry  | Evidence  | Gaps in Assurance  | Mitigating Actions |
| <p><b>There are systems and processes in place to ensure:</b></p> <ul style="list-style-type: none"> <li>• Laboratory testing for infectious illnesses is undertaken by competent and trained individuals.</li> <li>• patient testing for infectious agents is undertaken promptly and in line with national guidance.</li> <li>• staff testing protocols are in place for the required health checks, immunisations and clearance</li> <li>• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.</li> <li>• inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise.</li> </ul> <p><b>COVID-19 Specific</b></p> <ul style="list-style-type: none"> <li>• patients discharged to a care home are tested for SARS-CoV-2, 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. <a href="#">Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk)</a></li> </ul> | <p>Laboratory samples sent to LCL, which is an accredited lab.</p> <p>Policy in place.</p> <p>Protocols in place via staff testing team for COVID and Occupational Health for other health checks</p> <p>No information on testing turnaround times for all samples although incident reports have been submitted due to delays</p> <p>Testing for symptomatic patients detailed in policy</p> <p>Included in policy and facilitated by Discharge planning team</p> | <p>No information available from Pathology User Group, regularity of meetings to be confirmed with managers.</p> |                    |

| <ul style="list-style-type: none"><li>for testing protocols please refer to:<br/><a href="#">COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk)</a><br/><a href="#">C1662 covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)</a></li></ul>   |   |                   |                    |
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| 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 |
| <p><b>Systems and processes are in place to ensure that</b></p> <ul style="list-style-type: none"><li>resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors).</li><li>staff are supported in adhering to all IPC and AMS policies.</li><li>policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.</li><li>all clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM</li><li>PPE stock is appropriately stored and accessible to staff when required as per NIPCM</li></ul> | <p>Training and education undertaken. Records held by education team</p> <p>Audit programme and feedback by IPT<br/>Surveillance system in place, surveillance policy and outbreak policy in place</p> <p>Waste policy and Linen policy in place</p> <p>PPE store room, stock control managed by Fit tester</p> |                   |                    |
| 10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection  |   |                   |                    |
| Key lines of enquiry  | Evidence  | Gaps in Assurance | Mitigating Actions |

## Systems and processes are in place to ensure that:

- staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy.
- bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff.
- staff understand and are adequately trained in safe systems of working commensurate with their duties.
- a fit testing programme is in place for those who may need to wear respiratory protection.
- where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:
  - lead on the implementation of systems to monitor for illness and absence.
  - facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice.
  - lead on the implementation of systems to monitor staff illness, absence and vaccination.
  - encourage staff vaccine uptake.
- staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM.
- a risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19.
  - A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups.

Staff referral system to Occupational Health provider

Corporate induction, local induction and mandatory training in place

Fit testing programme in place with dedicated fit tester in post

Referral system to Occupational health provider in place.  
Staff vaccination programme in place led by Risk dept for influenza and COVID and by Occupational Health provider for other vaccinations

Included in the policy

Risk assessments have been undertaken by departmental heads



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| <ul style="list-style-type: none"> <li>○ that advice is available to all health and social care staff, including specific advice to those at risk from complications.</li> <li>○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff.</li> <li>○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.</li> <li>• testing policies are in place locally as advised by occupational health/public health.</li> <li>• NHS staff should follow current guidance for testing protocols: <a href="https://www.england.nhs.uk/c1662-covid-testing-in-periods-of-low-prevalence.pdf">C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)</a></li> <li>• staff required to wear fit tested FFP3 respirators undergo training that is compliant with <a href="#">HSE guidance</a> and a record of this training is maintained by the staff member and held centrally/ESR records.</li> <li>• staff who carry out fit test training are trained and competent to do so.</li> <li>• fit testing is repeated each time a different FFP3 model is used.</li> <li>• all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks</li> <li>• those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood.</li> <li>• that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions</li> </ul> | <p>Included in policy</p> <p>Fit test protocol in place, fit testing carried out by nominated, trained staff. Register of staff maintained centrally by education team</p> <p>Included in fit test programme</p> <p>Powered hoods have been allocated and are available to staff who fail fit testing</p> <p>Decontamination protocol in place</p> |  |  |
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| <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> <li>staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.</li> </ul> | <p>No staff currently require redeployment for this reason as all have been fitted with either FFP3, reusable respirator or hood.</p> <p>Central records maintained and regular updates supplied to managers and departmental heads and via command structure</p> <p>Information provided by staff testing team (COVID) or Occupational Health provider</p> |  |  |
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