

**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> <p>a respiratory season/winter plan is in place:</p> <ul style="list-style-type: none"> <li>that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services</li> <li>to enable appropriate segregation of cases depending on the pathogen.</li> <li>plan for and manage increasing case numbers where they occur.</li> <li>a multidisciplinary team approach is adopted with hospital leadership, estates &amp; facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.</li> </ul> <ul style="list-style-type: none"> <li>health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.</li> <li>Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: <ul style="list-style-type: none"> <li>based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area.</li> <li>applied in order and include elimination; substitution, engineering, administration and PPE/RPE.</li> <li>communicated to staff.</li> </ul> </li> <li>safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.</li> </ul>	<p>New respiratory virus policy developed including segregation of patients.</p> <p>LFD is used as POCT for emergency patients. Other methods also being explored. Discussed at Gold Command</p> <p>Elective patients assessed prior to admission. Emergency patients, e.g. PPCI patients assessed on presentation to Cath Lab.</p> <p>Segregation and isolation of patients discussed regularly at Silver Command meetings and escalated when necessary</p> <p>Covid secure workplace measures remain in place</p> <p>Clinical areas risk assessment reviewed by IPT based on hierarchy of controls. Communicated via Command structure</p> <p>Non – clinical areas have been assessed previously</p>	<p>Policy ratified at Emergency Planning 09/03/2022</p> <p>Risk assessments for non-clinical areas not updated</p>	<p>Non -clinical areas to be reassessed in accordance with hierarchy of controls submitted to H&amp;S committee (1/5/22)</p>



<ul style="list-style-type: none"> <li>• if the organisation has adopted practices that differ from those recommended/stated in the <a href="#">national guidance</a> a risk assessment has been completed and it has 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 respiratory infectious agents.</li> <li>• if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.</li> <li>• ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.</li> <li>• the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases</li> <li>• there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.</li> <li>• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).</li> <li>☐ the application of IPC practices within this guidance is monitored, eg: <ul style="list-style-type: none"> <li>○ hand hygiene.</li> <li>○ PPE donning and doffing training.</li> <li>○ cleaning and decontamination.</li> </ul> </li> <li>• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.</li> <li>• the Trust Board has oversight of ongoing outbreaks and action plans.</li> <li>• the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.</li> </ul>	<p>Risk assessments done for all areas performed with involvement of IPT</p> <p>Incorporated in policy</p> <p>Patients allocated areas according to their specialty. Some will require moves in line with their clinical pathway.</p> <p>Data submissions signed off by Executive during the week and by on call manager at weekends.</p> <p>Daily feedback to senior teams via Safety huddles</p> <p>Audits by Matrons, ward staff and IP Nurses.</p> <p>National standards for Cleanliness Monitored by IP nurses, hygiene supervisors and matrons</p> <p>Submitted regularly to Board of Directors</p> <p>Outbreaks and actions reported to Gold Command</p> <p>A range of masks has been supplied according to national procurement strategy</p>		
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## 2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of i nfections

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 and this plan is monitored at board level.</a></li> <li>the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms</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>increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.</li> <li>Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per <a href="#">national guidance.</a></li> <li>if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.</li> <li>manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.</li> </ul> <p>A minimum of twice daily cleaning of:</p> <p>patient isolation rooms <b>and</b> cohort</p> <p>donning &amp; doffing areas</p> <p>frequently touched' surfaces eg, door/toilet handles, patient call bells, bed tables</p> <p>where there may be higher environmental contamination rates</p>	<p>Implementation group in place including IPNs, Hygiene services and Matrons</p> <p>Areas/rooms have been assessed by Cleaning group</p> <p>Cleaning schedules in place</p> <p>Included in cleaning schedules</p> <p>1000ppm chlorine disinfectant product (actichlor) used for terminal and deep clean and high risk respiratory virus areas</p> <p>Disinfectant wipes used for equipment.</p> <p>Virusolve solution used for bathrooms.</p> <p>Included in schedules</p> <p>Frequently touched surfaces included as part of cleaning schedule – cleaned x 3 daily.</p> <p>Monitored as part of Matrons audits.</p>		

<p>  A terminal/deep clean of inpatient rooms is carried out:           <ul style="list-style-type: none"> <li>o following resolutions of symptoms and removal of precautions.</li> <li>o when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens);</li> <li>o following an AGP <b>if room vacated</b> (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).</li> </ul> </p> <ul style="list-style-type: none"> <li>• reusable non-invasive care equipment is decontaminated:           <ul style="list-style-type: none"> <li>o between each use.</li> <li>o after blood and/or body fluid contamination</li> <li>o at regular predefined intervals as part of an equipment cleaning protocol</li> <li>o 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>• As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance.</li> </ul> <p><b>In patient Care Health Building Note 04-01: Adult in-patient facilities.</b></p> <ul style="list-style-type: none"> <li>• the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.</li> <li>• a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways</li> <li>• where possible air is diluted by natural ventilation by opening windows and doors where appropriate</li> <li>• where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.</li> <li>• when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.</li> </ul>	<p>Terminal decontamination carried out after patient discharge and is logged onto a database. Area cleaned if AGP for infectious patient e.g. endoscopy room. Additional decontamination using UV-C of single rooms and HPV also used.</p> <p>Cleaning schedules and protocols in place. Certification of equipment prior to repair in place.</p> <p>Audits performed as part of matrons audits and also cleanliness audits Ventilation systems assessed by Estates team Critical systems inspected annually , including POCCU, ITU, Theatres, Cath lab and Cherry ward.</p> <p>Some areas do not have mechanical ventilation. These areas are not used for high risk respiratory virus pathways unless individual single rooms. Window opening encouraged where possible</p> <p>Estate &amp; Hygiene services involved in placement</p>		
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### 3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
<p><b>Systems and process are in place to ensure that:</b></p> <ul style="list-style-type: none"> <li>• arrangements for antimicrobial stewardship are maintained</li> <li>• previous antimicrobial history is considered</li> <li>• the use of antimicrobials is managed and monitored: <ul style="list-style-type: none"> <li>◦ to reduce inappropriate prescribing.</li> <li>◦ to ensure patients with infections are treated promptly with correct antibiotic.</li> </ul> </li> <li>• mandatory reporting requirements are adhered to, and boards continue to maintain oversight.</li> <li>• risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.</li> </ul>	<p>Critical Care wards rounds and complex patient reviews taking place with microbiologist.</p> <p>Antimicrobial group reconvened and strategy updated.</p> <p>Weekly monitoring, reporting of resistant organisms. Policies in place</p>	<p>Consultant microbiologist time is limited to 50% previous service level due to ongoing pressures within the microbiology department</p>	<p>Critical Care infection nurse on secondment to provide assistance for microbiologist and for antimicrobial stewardship agenda. Virtual ward rounds in place. Plans to increase microbiological support when staffing available.</p>

### 4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
<p>Systems and processes are in place to ensure that:</p> <ul style="list-style-type: none"> <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>• <a href="#">national guidance</a> on visiting patients in a care setting is implemented.</li> <li>• restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.</li> <li>• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.</li> <li>• if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.</li> </ul>	<p>Visiting re-introduced February 2022 and initially limited to one visitor for one hour daily. Plan to increase visiting in a stepwise manner in place.</p> <p>Visiting advice available on intranet.</p> <p>Information boards and posters in all areas across the trust</p>		

<ul style="list-style-type: none"> <li>visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.</li> <li>visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian.</li> <li>Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted <a href="#">C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf</a> (<a href="#">england.nhs.uk</a>)</li> </ul>	<p>Assessed by ward staff prior to visit</p> <p>Toolkit reviewed by Silver Command.</p> <p>Screen savers, posters and regular updates/reminders in place.</p> <p>Safety huddles walk rounds and audits with feedback to areas.</p>		
<b>5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment</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>signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.</li> <li>infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.</li> <li>staff are aware of agreed template for screening questions to ask.</li> <li>screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.</li> <li>front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.</li> <li>triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.</li> <li>there is evidence of compliance with routine patient testing protocols</li> </ul>	<p>Posters displayed.</p> <p>Social distance and screens in place.</p> <p>Signage used to indicate different zones at entrances.</p> <p>Information prior to transfer noted on forms and provided by discharge planning team</p> <p>Screening policy in place, all admissions screened prior to/on admission</p> <p>No emergency dept. PPCI patients assessed on admission</p> <p>Patients assessed by clinicians</p> <p>Audits performed</p>		

<ul style="list-style-type: none"> <li>• patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.</li> <li>• patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.</li> <li>• patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.</li> <li>• patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.</li> <li>• where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.</li> <li>• face masks/coverings are worn by staff and patients in all health and care facilities.</li> <li>• where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.</li> <li>• patients, visitors, and staff can maintain 1 metre or greater social &amp; physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff.</li> <li>• 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.</li> <li>• isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.</li> <li>• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.</li> </ul>	<p>Facemasks supplied to patients</p> <p>Nursed in single rooms. Policy in place</p> <p>Single room provision allocated on a daily basis, patients prioritised if clinician requests e.g. if on chemotherapy</p> <p>Risk assessed by clinician on individual basis</p> <p>In place, audited</p> <p>Designated areas with distancing or siderooms used Majority of areas exceed 1 metre, otherwise screens/clear curtains used.</p> <p>In policy</p> <p>Contact tracing undertaken by IPNs Assessed by OP staff on admission</p>		
<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



Systems and processes are in place to ensure that:

- appropriate infection prevention education is provided for staff, patients, and visitors.
- training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.
- all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;
- adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.
- gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP
- the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.
- staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace
- staff understand the requirements for uniform laundering where this is not provided for onsite.
- all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.
- to monitor compliance and reporting for asymptomatic staff testing
- there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).
- 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

Training provided by education team and also by individual departments e.g. critical care education practitioners regarding PPE and correct donning/doffing. Donning and doffing videos on intranet and staff app. Included in corporate induction  
Regular audits by Matrons, IPN  
In IPC policy

Hand driers not in situ

Laundry not available on site  
Guidance on intranet re uniforms in uniform policy  
Highlighted to staff on ongoing basis via safety huddles and corporate comms.  
Testing is monitored regularly and feedback to managers  
Surveillance performed by IP nurses. Database maintained  
Outbreak records available

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 monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.</li> <li>separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.</li> <li>patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.</li> <li>patients are appropriately placed ie, infectious patients in isolation or cohorts.</li> <li>ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).</li> <li>standard infection control precautions (SICPs) are used at point of care for patients who have been screened, triaged, and tested and have a negative result</li> <li>the principles of SICPs and TBPs are applied when caring for the deceased</li> </ul>	<p>Facemask wearing monitored by ward managers</p> <p>Patients assessed in clinic Infectious patients would generally be postponed. If necessary they would be seen in a department at the end of a list</p> <p>Patients cared for in designated areas/siderooms</p> <p>Regular review by Silver Command</p> <p>Standard IPC policy in place</p> <p>Care of the deceased patient policy in place</p>		
8. Secure adequate access to laboratory support as appropriate			
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>• testing is undertaken by competent and trained individuals.</li> <li>• patient testing for all respiratory viruses testing is undertaken promptly and in line with <a href="#">national guidance</a>;</li> <li>• staff testing protocols are in place</li> </ul>	<p>Competency tool for staff.</p> <p>Testing protocols in place. Audits performed. Staff screening records held by test and trace team.</p>	
<ul style="list-style-type: none"> <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>• there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).</li> <li>• screening for other potential infections takes place.</li> <li>• that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.</li> <li>• that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.</li> <li>• that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.</li> <li>• that sites with high nosocomial rates should consider testing COVID-19 negative patients daily.</li> <li>• that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.</li> <li>• those patients being discharged to a care facility within their 14-day isolation period are discharged to a <a href="#">designated care setting</a>, where they should complete their remaining isolation as per <a href="#">national guidance</a></li> <li>• there is an assessment of the need for a negative PCR and 3 days self- isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per <a href="#">national guidance</a>.</li> </ul>	<p>Priority levels designated in the lab and in testing protocols turnaround times monitored regularly. Data available cases monitored by Infection prevention team. Records available screening protocols in place for other infections, Audits performed.</p> <p>Testing protocol in place, regular audits performed and fed back to clinical areas and through command structure.</p> <p>Discharge to care home/care facility and testing co-ordinated by discharge team</p> <p>Discussed with Silver command and the divisions. Decision made to carry on with PCR testing rather than LFT for all elective patients</p>	

## 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>the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice.</li> </ul>	Policy and audits in place		

<p>This must include all care areas and all staff (permanent, agency and external contractors).</p> <ul style="list-style-type: none"> <li>staff are supported in adhering to all IPC policies, including those for other alert organisms.</li> <li>safe spaces for staff break areas/changing facilities are provided.</li> <li>robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.</li> <li>all clinical waste and linen/laundry related to confirmed or suspected COVID- 19 cases is handled, stored and managed in accordance with current <a href="#">national guidance</a>.</li> <li>PPE stock is appropriately stored and accessible to staff who require it.</li> </ul>	<p>Audit programme for IPC in place Staff break areas available. Not all staff areas have changing rooms. Shower/changing available for staff in high risk areas Surveillance performed by IPNs. Outbreaks reported via national outbreak system Linen and Waste Policies in place PPE stored in designated areas, managed by supplies department. Delivered to wards upon request</p>		
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## 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
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**Systems and processes are in place to ensure that:**

- staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.
- bank, agency, and locum staff follow the same deployment advice as permanent staff.
- staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)
- staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.
- 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 antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce
    - lead on the implementation of systems to monitor staff illness, and vaccination against seasonal influenza and COVID-19
    - encourage staff vaccine
- staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance

Staff screening team and IP team available for advice and queries, including bank and locum staff

Protocol and risk assessments in place

Education and training in place. Fit testing programme for all staff – records available

Vaccination, screening and monitoring programme is led by the risk and staff screening teams rather than Occupational Health. Close liaison between staff screening and IP team regarding all issues.

Policy in place

- a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19.
  - A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups;
  - that advice is available to all health and social care staff, including specific advice to those at risk from complications.
  - Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff.
  - A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.
- vaccination and testing policies are in place as advised by occupational health/public health.
- staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.
- staff who carry out fit test training are trained and competent to do so.
- all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.
- all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks
- a record of the fit test and result is given to and kept by the trainee and centrally within the organisation.
- those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.

Robust staff welfare systems in place including at risk groups Risk assessments have been undertaken by departmental heads

Vaccination and testing policies in place according to national guidelines

Register of staff maintained.

All staff have received training – training records available  
Fit testing records available for all staff

Records kept on central database that can be accessed by individual staff

All failed fit tests recorded on central database

<ul style="list-style-type: none"> <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> <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>• 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 <a href="#">national guidance</a>.</li> <li>• 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.</li> <li>• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.</li> <li>• staff who test positive have adequate information and support to aid their recovery and return to work.</li> </ul>	<p>Staff who have failed fit tests have been allocated air powered respirators after consultation with relevant manager. Records available. Staff redeployment has not been required for this reason as yet</p> <p>Fit testing monitored regularly. Reports available.</p> <p>Risk assessments have been completed Staff testing guidance/FAQs produced by swabbing team, positive staff supported as per sickness process by line managers with additional support provided by HR/OH as required.</p>		
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