

## Infection Prevention and Control Board Assurance Framework v 1.4 (Updated Feb 2021)

### 1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> <li>• Infection risk is assessed at the front door and this is documented in the patient notes</li> <li>• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission</li> <li>• compliance with the <a href="#">national guidance</a> around discharge or transfer of COVID-19 positive patients</li> <li>• monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice</li> <li>• monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice</li> <li>• staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase</li> </ul>	<p>Elective patients assessed prior to admission. Emergency patients, e.g. PPCI patients assessed on presentation to the Cath Lab. All patients tested on arrival or pre-admission. Documented in the patient notes.</p> <p>Patients moved to cohort areas according to COVID 19 status and risk pathway.</p> <p>Positive patients tracked on ICNET</p> <p>Protocols in place</p> <p>Patient discharge information leaflet available.</p> <p>Matrons audits and Infection prevention audits performed</p> <p>Compliance monitored regularly by department heads and reported via Silver Command and safety huddles</p> <p>Staff testing and isolation protocols in place. Daily reports of staff testing sent to Silver Command. Liason with staff testing and IPT when positives identified</p>	<p>Mandatory training</p>	<p>To be reviewed and</p>

<ul style="list-style-type: none"> <li>• training in IPC standard infection control and transmission-based precautions are provided to all staff</li> <li>• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training</li> <li>• all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work</li> <li>• 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</li> <li>• national IPC <a href="#">guidance</a> is regularly checked for updates and any changes are effectively communicated to staff in a timely way</li> <li>• changes to <a href="#">guidance</a> are brought to the attention of boards and any risks and mitigating actions are highlighted</li> </ul>	<p>Mandatory Training for all staff in place</p> <p>Staff receive training on handwashing, PPE, Fit testing on induction and also receive information pertinent to their area on local induction</p> <p>Posters and signs in public areas. Information within regular corporate communications and also displayed on screensavers</p> <p>Guidance and posters available regarding PPE for different zones/cohorts of patients. Information and educational materials available on the intranet. Training delivered by the education team and Critical Care and Theatre staff.</p> <p>Updates circulated to group emergency planning email and communicated via Trust command structure. And regular corporate briefings</p> <p>All IPC guidance is actioned as received, reviewed by silver command and shared at Gold command – chaired by CEO</p>	<p>workbooks require annual review</p>	<p>updated by IP team and by end of Feb 21</p>
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<ul style="list-style-type: none"> <li>risks are reflected in risk registers and the board assurance framework where appropriate</li> <li>robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens</li> <li>that Trust CEOs or the executive responsible for IPC approve and personally signs off, all 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.</li> <li>ensure Trust Board has oversight of ongoing outbreaks and action plans</li> </ul>	<p>Risks are reflected in risk registers and reviewed regularly. IPC BAF is shared at all BoD.</p> <p>Protocols and policies in place for prevention of other infections. Audit programme in place and data available. IPC committee continues to review all other infections.</p> <p>.....</p> <p>Outbreak summaries and actions presented to Gold Command as they occur.</p>		
<b>2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections</b>			
<b>Key lines of enquiry</b>	<b>Evidence</b>	<b>Gaps in Assurance</b>	<b>Mitigating Actions</b>
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> <li>designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas</li> </ul>	<p>Teams assigned on a daily basis for COVID 19 isolation All staff working in areas caring for Covid patients receive appropriate training</p> <p>Terminal decontamination carried out according to PHE guidelines and is</p>		

<ul style="list-style-type: none"> <li>decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other <a href="#">national guidance</a></li> <li>increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other <a href="#">national guidance</a> <ul style="list-style-type: none"> <li>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 Manufacturers' guidance and recommended product 'contact time' must be followed for cleaning/disinfectant solutions/products as per national guidance</li> </ul> </li> <li>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 and electronic equipment e.g. mobile phones, desk phones, tablets, desktops &amp; keyboards should be cleaned a minimum</li> </ul>	<p>logged on a database. Additional decontamination using UV-C of single rooms and HPV also used</p> <p>Cleaning Schedules available Robust cleaning schedules in place and enhanced schedules in outbreak areas.</p> <p>1000ppm chlorine based disinfectant product used for terminal and deep clean and in theatres and Cath labs Disinfectant wipes used for equipment</p> <p>Virusolve solution used for bathrooms</p> <p>Frequently touched surfaces included as part of cleaning schedule- cleaned 3x daily. Monitored as part of Matrons'</p> <p>Weekly audits in place Audit data available</p> <p>Cleaning schedules in place</p>		
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<p>of twice daily</p> <ul style="list-style-type: none"> <li>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)</li> <li>linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken</li> <li>single use items are used where possible and according to single use policy</li> <li>reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance</li> <li>ensure cleaning standards and frequencies are monitored in nonclinical areas with actions in place to resolve issues in maintaining a clean environment <ul style="list-style-type: none"> <li>ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air</li> <li>there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants</li> </ul> </li> </ul>	<p>Linen policy in place, managed as infectious linen</p> <p>Included in disinfection policy</p> <p>Monitoring performed by Hygiene supervisors regularly. Data available</p> <p>Additional ventilation cannot always be introduced and windows cannot always be left open due to temperature control</p> <p>Disinfectants used for terminal cleans and bathrooms even in low risk pathway. Agreed at Silver Command</p>		<p>Social distancing and mask wearing in communal areas</p>
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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>			
<b>Key lines of enquiry</b>	<b>Evidence</b>	<b>Gaps in Assurance</b>	<b>Mitigating Actions</b>
<p>Systems and process are in place to ensure:</p> <ul style="list-style-type: none"> <li>• arrangements around antimicrobial stewardship is maintained</li> <li>• mandatory reporting requirements are adhered to and boards continue to maintain oversight</li> </ul>	<p>Critical Care ward rounds taking place with microbiologist</p> <p>Antimicrobial group reconvened and strategy updated</p>	<p>Microbiology cover has been reduced across all Liverpool trusts due to pressures of Covid. This has been discussed at Gold and a plan to support microbiology cover has been developed.</p>	<p>To develop the role of Critical Care ANP to assist in ward rounds on Critical Care and a plan for ward cover. Three times weekly MS Teams virtual microbiologist ward rounds.</p> <p>Actions: Contact numbers distributed; Response QA in place; JD and PS to be complete by end Jan 21;Antibiotic pharmacists now attending CCA micro virtual WR; leave cover to be discussed with CD</p>
<b>4. 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</b>			
<b>Key lines of enquiry</b>	<b>Evidence</b>	<b>Gaps in Assurance</b>	<b>Mitigating Actions</b>
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> <li>• screening and triaging of all patients as per IPC and <a href="#">NICE</a> Guidance within all health and other care facilities must be</li> </ul>	<p>Emergency arrivals are screened for symptoms in the ambulance or on arrival and placed in the appropriate</p>		

<p>undertaken to enable early recognition of COVID-19 cases.</p> <ul style="list-style-type: none"> <li>• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid19 cases to minimise the risk of cross-infection as per <a href="#">national guidance</a> ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff</li> <li>• staff are aware of agreed template for triage questions to ask and 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</li> <li>• face coverings are used by all outpatients and visitors</li> <li>• face masks are available for patients with respiratory symptoms</li> <li>• 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</li> </ul>	<p>area. Elective admissions screened before admission</p> <p>Screens in place at all reception areas Patients with new symptoms are cohorted promptly and immediately tested.</p> <p>Questions in pre-admission template and admission document and also asked prior to day case admission</p> <p>Masks provided at entrance to all patients. Outpatient arrivals overseen by nurse to check compliance</p> <p>Facemasks provided to all patients, encouraged to use by ward managers, especially if mobilizing. Posters displayed</p>		
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<ul style="list-style-type: none"> <li>• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative</li> <li>• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly retested and contacts traced promptly</li> <li>• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately</li> </ul>	<p>Testing protocol in place and Contact tracing undertaken by IP team. Contact tracing initiated on positive result or negative result with strong clinical suspicion Retests performed if new symptoms</p> <p>Patients assessed and temperature checked on admission to Outpatients Screening questions asked of patients for scheduled appointments. prior to admission</p>		
<b>5. 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>			
<b>Key lines of enquiry</b>	<b>Evidence</b>	<b>Gaps in Assurance</b>	<b>Mitigating Actions</b>
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> <li>• 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</li> </ul>	<p>Signage in place. Restricted access to communal areas</p> <p>Training provided by education team</p>		



<ul style="list-style-type: none"> <li>all staff (clinical and non- clinical) have appropriate training, in line with latest <a href="#">national guidance</a> to ensure their personal safety and working environment is safe</li> <li>all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to <a href="#">Don and Doff</a> it safely</li> <li>a record of staff training is maintained <ul style="list-style-type: none"> <li>appropriate arrangements are in place that any reuse of PPE in line with the <a href="#">MHRA CAS Alert</a> is properly monitored and managed any incidents relating to the reuse of PPE are monitored and appropriate action taken</li> <li>adherence to PHE national guidance on the use of PPE is regularly audited</li> <li>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 ,maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care</li> </ul> </li> </ul>	<p>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> <p>Little equipment that is being reused – if so goes through appropriate decontamination Guidance on intranet</p> <p>PPE audits performed weekly</p> <p>Signage and posters displayed in communal areas and at entrances with information on facemasks and hand hygiene Dispensers of hand sanitizer at all entrances and in all areas Masks provided in all areas Social distancing signage in all public areas</p>		
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<p>frequent decontamination of equipment and environment in both clinical and non-clinical areas and clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas</p> <ul style="list-style-type: none"> <li>• staff regularly undertake hand hygiene and observe standard infection control precautions</li> <li>•</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 as per national guidance</li> <li>• guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas</li> <li>• staff understand the requirements for uniform laundering where this is not provided for on site</li> <li>•</li> </ul> <p>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</p>	<p>Hand hygiene and standard infection control precautions observed and audit results available</p> <p>No Hand dryers in situ</p> <p>Hand hygiene posters displayed</p> <p>No uniform laundering available (other than scrubs). Information on requirements is on the Trust intranet</p> <p>Guidance available on intranet. Communicated frequently through safety huddles.</p> <p>Ongoing surveillance via ICNET and regular reports from laboratory. All cases recorded, monitored and tracked.</p>		
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<ul style="list-style-type: none"> <li>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)</li> <li>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.</li> </ul> <p>robust policies and procedures are in place for the identification of and management of outbreaks of infection</p>	<p>Review by IPN for relevant cases. Outbreaks reported – protocol in place</p> <p>COVID outbreak protocol in place and overarching policy for outbreaks of infection in place</p>		
<b>6. Provide or secure adequate isolation facilities</b>			
<b>Key lines of enquiry</b>	<b>Evidence</b>	<b>Gaps in Assurance</b>	<b>Mitigating Actions</b>
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> <li>restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff</li> <li>areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas</li> </ul>	<p>Designated cohort areas separated from other areas. Access restricted to certain areas</p> <p>Signage used to indicate different zones at entrances.</p>		

<ul style="list-style-type: none"> <li>• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate</li> <li>• areas used to cohort patients with suspected or confirmed COVID19 are compliant with the environmental requirements set out in the current PHE <a href="#">national guidance</a></li> <li>• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement</li> </ul>	<p>Patients with Covid 19 are isolated or cohorted in appropriate areas. Designated as red/yellow zones or individual rooms</p> <p>Defined areas agreed by Gold Command. Limited availability of isolation rooms (negative pressure)</p> <p>Patients with alert organisms managed according to IPC guidance, as usual. Monitored and data available</p>		
<b>7. Secure adequate access to laboratory support as appropriate</b>			
<b>Key lines of enquiry</b>	<b>Evidence</b>	<b>Gaps in Assurance</b>	<b>Mitigating Actions</b>
<p>There are systems and processes in place to ensure:</p> <ul style="list-style-type: none"> <li>• ensure screens taken on admission given priority and reported within 24hrs</li> <li>• 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>• testing is undertaken by competent and trained individuals</li> </ul>	<p>Priority levels designated in lab and in testing protocols</p> <p>Turnaround times monitored regularly. Data available</p> <p>Competency tool for staff</p> <p>Testing protocols in place. Audits performed. Staff screening records</p>		

<ul style="list-style-type: none"> <li>patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other <a href="#">national guidance</a></li> <li>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> </ul>	<p>held by test and trace team</p> <p>Cases monitored by Infection prevention team. Records available</p> <p>Screening protocols in place for other infections in place. Audits performed</p>		
<b>8. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections</b>			
<b>Key lines of enquiry</b>	<b>Evidence</b>	<b>Gaps in Assurance</b>	<b>Mitigating Actions</b>
<p>Systems and processes are in place to ensure that:</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>any changes to the PHE <a href="#">national guidance</a> on PPE are quickly identified and effectively communicated to staff</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> </ul>	<p>Training and education undertaken. Records held by education team</p> <p>PHE updates communicated via command structure</p> <p>Waste and linen policy in place.</p> <p>PPE supplies managed by dedicated</p>		

<ul style="list-style-type: none"> <li>PPE stock is appropriately stored and accessible to staff who require it</li> </ul>	team who supply individual areas		
<b>9. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection</b>			
<b>Key lines of enquiry</b>	<b>Evidence</b>	<b>Gaps in Assurance</b>	<b>Mitigating Actions</b>
<p>Appropriate systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> <li>staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported</li> <li>that 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</li> <li>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</li> <li>staff who carry out fit test training are trained and competent to do so</li> <li>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</li> </ul>	<p>Robust staff welfare systems in place including at risk groups Risk assessments have been undertaken</p> <p>Risk assessments have been undertaken by departmental heads</p> <p>Protocol in place for reusable respirators. Register of staff maintained. Fit testing monitored by Silver and Gold meetings for compliance and actions required</p> <p>All staff have received training – training records available</p> <p>Fit testing records available for all staff</p>		

<ul style="list-style-type: none"> <li>• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation</li> <li>• 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</li> <li>• 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. 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>• following consideration of reasonable adjustments e.g. respiratory hoods, personal reusable 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</li> <li>• boards have a system in place that demonstrates how, regarding fit testing,</li> </ul>	<p>Records kept on central database that can be accessed by individual staff</p> <p>All failed fit tests recorded on central database</p> <p>Staff who have failed fit tests have been allocated air powered respirators after consultation with relevant manager. Records available</p> <p>No staff currently require redeployment for this reason as all have been fitted with with either FFP3, reusable respirator or hood.</p> <p>Fit testing results monitored regularly and reports shared with Silver and Gold Command</p>		
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<p>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</p> <ul style="list-style-type: none"> <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 national guidance</li> <li>all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas</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 are aware of the need to wear facemask when moving through COVID-19 secure areas.</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>Unable to completely segregate planned and elective care pathways and urgent and emergency care patients due to limited bed capacity Staff allocation discussed and agreed at Silver Command</p> <p>Monitored and reported regularly by managers</p> <p>Risk assessments undertaken for all workplace areas. Numbers limited in all communal areas.</p> <p>Monitored and audited by Matrons</p> <p>Monitored regularly. Reports available</p> <p>Staff testing guidance / FAQs produced by swabbing team Staff who test positive supported as</p>	<p>Pathways for patients continually under review.</p>	<p>Every effort made to reduce patient and staff moves</p>
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	per normal sickness process by line managers with additional support provided by HR/OH as required		
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