

Infection Prevention and Control Board Assurance Framework v 1.6 (Reviewed July 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"> local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff; the documented risk assessment includes: <ul style="list-style-type: none"> a review of the effectiveness of the ventilation in the area; operational capacity; prevalence of infection/variants of concern in the local area. triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways; when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given; <ul style="list-style-type: none"> There are pathways in place which support minimal or avoid patient bed/ward transfers 	<p>Risk assessments done for all areas previously</p> <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 allocated areas according to their specialty. Some will require moves in line with their clinical</p>	<p>Assessments need to be reviewed and include hierarchy of control format.</p>	<p>Rewrite assessments with new format Audit and reassess all areas (23/7/21 IPT)</p>

<p>for duration of admission unless clinically imperative</p> <ul style="list-style-type: none"> that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance. monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice including Staff adherence to hand hygiene patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE; Staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: <ul style="list-style-type: none"> a)clinical b)non-clinical setting <ul style="list-style-type: none"> monitoring of compliance with wearing appropriate PPE within the clinical setting implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in 	<p>pathway.</p> <p>Patients moved to cohort areas according to COVID 19 status and risk pathway. Positive patients tracked on ICNET Protocols in place All cohorted areas deep cleaned on inpatient discharge, records held with hygiene services.</p> <p>Matrons audits and Infection prevention audits performed</p> <p>Hand hygiene audit programme in place.</p> <p>Risk assessments for all work areas in place to maximize social distancing. PPE audits.</p> <p>Infection Prevention and Matron's audits to monitor compliance with IPC practices for patients and staff. In addition there is a daily safety huddle where all managers update on their compliance with IPC standards.</p> <p>Weekly LAMP testing now in place and compliance reported through Gold Command. Awareness</p>		
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<p>place to monitor results and staff test and trace</p> <ul style="list-style-type: none"> • Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team. • training in IPC standard infection control and transmission-based precautions are provided to all staff • IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training • all staff (clinical and non-clinical) are trained in; <ul style="list-style-type: none"> -putting on and removing PPE; -what PPE they should wear for each setting and context; • all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance; • there are visual reminders displayed communicating the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work 	<p>campaign on intranet.</p> <p>Staff testing and isolation protocols in place. Liaison with staff testing and IPT when positives identified. Targeted testing of staff has been done in specific circumstances.</p> <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>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. Posters and signs in public areas. Information within regular corporate communications and also displayed on screensavers</p> <p>All national guidance is received by the DIPC and processed and actions by silver command.</p> <p>The Trust holds gold and silver</p>		
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<ul style="list-style-type: none"> national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted risks are reflected in risk registers and the board assurance framework where appropriate robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens that Trust Chief Executive, the medical director or the Chief nurse approves and personally signs off all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner. The IPC Board Assurance Framework is reviewed, and the evidence of assessments are made available and discussed at Trust board. ensure Trust Board has oversight of ongoing outbreaks and action plans there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas 	<p>meeting weekly. PPE supplies and adherence are monitored through all these meetings</p> <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 receives reports on all other infections.</p> <p>Data submissions signed off by Executive during the week and by on call manager at weekends.</p> <p>IPC BAF is shared at all BoD meetings to update Board members.</p> <p>Outbreak summaries and actions presented to Gold Command as they occur.</p> <p>Walkarounds by members of the senior staff and executive team.</p>		
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	Regular discussions with all departmental heads at weekly bronze meeting.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> • Designated nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID 19 isolation or cohort areas. • designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management 	<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>Hygiene services assign staff who are appropriately trained and maintain training records.</p> <p>Terminal decontamination carried out according to PHE guidelines and is logged on a database. Additional decontamination using UV-C of single rooms and HPV also used.</p> <p>Records held on an electronic system.</p>		

<ul style="list-style-type: none"> increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance <ul style="list-style-type: none"> 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 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 electronic equipment e.g mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily rooms/areas where PPE is removed must 	<p>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>be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)</p> <ul style="list-style-type: none"> • reusable non-invasive care equipment is decontaminated: <ul style="list-style-type: none"> o between each use o after blood and/or body fluid contamination o at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing or repair equipment; • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • single use items are used where possible and according to single use policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance • cleaning standards and frequencies are monitored in nonclinical areas with actions in place to resolve issues in maintaining a clean environment • ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the 	<p>Matrons and infection prevention audits of equipment Cleaning schedules Policy and protocols in place. Certification of equipment prior to repair in place</p> <p>Linen policy in place, managed as infectious linen</p> <p>Included in disinfection policy</p> <p>Audits in place.</p> <p>Monitoring performed by Hygiene supervisors regularly. Data available</p> <p>Additional ventilation and air dilution provided when practicable. Windows cannot always be left open due to temperature control.</p>		
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dilution of air			
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>Systems and process are in place to ensure:</p> <ul style="list-style-type: none"> • arrangements around antimicrobial stewardship is maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight 	<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 the pressures of Covid and a shortage of staff</p>	<p>To develop the role of Critical Care Nurse to assist in ward rounds on Critical Care and a plan for ward cover. Three times weekly antimicrobial rounds and held virtually if microbiologist is unable to be present.</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:</p> <ul style="list-style-type: none"> • implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are being treated are clearly displayed with appropriate signage and have restricted access • information and guidance on COVID-19 is available on all trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved • there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice. • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk) 	<p>Visiting advice available on intranet. Suspended at present apart from specific circumstances</p> <p>Signage in place where appropriate.</p> <p>Information is available on the website regarding precautions advice for visitors and patients.</p> <p>Discharge planning team note this on their referrals.</p> <p>Information boards and posters in all areas across the trust.</p> <p>Toolkit reviewed by Silver Command. Screen savers, posters and regular updates/reminders in place. Safety huddles Walkrounds and audits with feedback to areas. Staff wellbeing action plan 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:</p> <ul style="list-style-type: none"> • screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. • 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 national guidance • staff are aware of agreed template for triage questions to ask • 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 • face coverings are used by all outpatients and visitors 	<p>Emergency arrivals are screened for symptoms in the ambulance or on arrival and placed in the appropriate 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 Facemasks provided to all patients, encouraged to use by ward managers, especially if mobilizing. Volunteers stationed at entrances to</p>		

<ul style="list-style-type: none"> • individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation; • clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; • patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. • isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly retested and contacts traced promptly 	<p>advise patients and visitors coming in. Posters displayed</p> <p>Patients prioritized for siderooms by the capacity management team</p> <p>Ward managers monitoring in clinical areas.</p> <p>Social distancing and screens in place.</p> <p>Contacts recorded and monitored in database.</p> <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>		
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<ul style="list-style-type: none"> There is evidence of compliance with routine patient testing protocols in line with Key:Actions infection prevention and control testing document. patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately 	<p>Patient testing protocol in place and regularly audited.</p> <p>Patients assessed and temperature checked on admission to Outpatients Screening questions asked of patients for scheduled appointments. prior to admission</p>		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
<p>Systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas all staff (clinical and non- clinical) have appropriate training, in line with latest national guidance to ensure their personal safety and working environment is safe 	<p>Signage in place. Restricted access to communal areas</p> <p>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.</p>		

<ul style="list-style-type: none"> 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 Don and Doff it safely a record of staff training is maintained <ul style="list-style-type: none"> appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed any incidents relating to the reuse of PPE are monitored and appropriate action taken adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: <ul style="list-style-type: none"> -hand hygiene facilities including instructional posters, - good respiratory hygiene measures - staff maintain physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care -staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to 	<p>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> <p>Messaging on intranet and via corporate comms.</p>		
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<p>follow public health guidance outside of the workplace</p> <ul style="list-style-type: none"> -frequent decontamination of equipment and environment in both clinical and non-clinical areas - clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas <ul style="list-style-type: none"> • staff regularly undertake hand hygiene and observe standard infection control precautions • • 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 • guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and 	<p>Posters displayed</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>		
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<p>other if they or a member of their household display any of the symptoms</p> <ul style="list-style-type: none"> 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) 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. robust policies and procedures are in place for the identification of and management of outbreaks of infection 	<p>Ongoing surveillance via ICNET and regular reports from laboratory. All cases recorded, monitored and tracked on database.</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>		
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"> restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff 	<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"> • areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement 	<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>		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
<p>There are systems and processes in place to ensure:</p> <ul style="list-style-type: none"> • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance 	<p>Competency tool for staff</p> <p>Testing protocols in place. Audits performed. Staff screening records held by test and trace team</p> <p>Priority levels designated in lab and</p>		

<ul style="list-style-type: none"> • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data) • screening for other potential infections takes place • that all emergency patients are tested for COVID-19 on admission. • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. • that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID negative patients daily. • that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge 	<p>in testing protocols Turnaround times monitored regularly. Data available</p> <p>Cases monitored by Infection prevention team. Records available Screening protocols in place for other infections in place. Audits performed</p> <p>Testing protocol in place, regular audits performed and fed back to clinical areas and through command structure.</p>		
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<ul style="list-style-type: none"> that those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting where they should continue their remaining isolation that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission 			
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>Systems and processes are in place to ensure that:</p> <ul style="list-style-type: none"> staff are supported in adhering to all IPC policies, including those for other alert organisms any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance PPE stock is appropriately stored and accessible to staff who require it 	<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>		

	team who supply individual areas		
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
<p>Appropriate systems and processes are in place to ensure:</p> <ul style="list-style-type: none"> • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported • 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 • 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 • staff who carry out fit test training are trained and competent to do so • 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 	<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</p>		

<ul style="list-style-type: none"> • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation • 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 • 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 • 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 • boards have a system in place that demonstrates how, regarding fit testing, 	<p>staff</p> <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>		
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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"> 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 all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas 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 staff are aware of the need to wear facemask when moving through COVID-19 secure areas. staff absence and well-being are monitored and staff who are self isolating are supported and able to access testing staff who test positive have adequate information and support to aid their recovery and return to work 	<p>Fit testing results monitored regularly and reports shared with Silver and Gold Command</p> <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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