Infection Prevention and Control board assurance framework

Key lines of enquiry Systems and processes are in place to ensure:	**Evidence (of assurance)**			**Gaps in Assurance**	**Mitigating Actions**	**Assurance level (RAG)**
	1st Line	**2nd line**	**3rd line**			
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						
Infection risk is assessed at the front door and this is documented in patient notes	**Triage –** all patients are processed through a triage system in ED**.** The hierarchy of control measures is: • early recognition or reporting of cases • early assessment or triaging of cases **Swabs –** all patients are swabbed if admission is required. **Evidence**; Compliance against admitted patients and swabs taken data. Physical health check completed on admission recorded on EPR. All attendees at all sites are screened for COVID symptoms	Sit rep at strategic, tactical and operational command detailing swabs taken, results and tracking ward by ward. All areas Quality Assurance visits	CCG/NHSe/I Quality visits cover IPC		GDONs and Matrons are monitoring screening compliance Daily reporting of COVID incidents and tracking of any trends. Processes and guidance is in place. COVID hotspot audits in place	
Patients with possible or confirmed COVID-	. Risk assessed by	Reports on COVID		Bed pressures; individuals	Streaming guidelines	

19 are not moved unless this is essential to their care or reduces the risk of transmission	MDT based on individual need & recorded on EPR	status and swabbing. Sit rep at strategic, tactical and operational command.		refusing to move and/or isolate and or be swabbed	reviewed and updated in line with national standards Patient information leaflet in use setting out standards	
Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	There is a screening protocol in place that includes discharge to Nursing/Care homes. There is recent evidence that you may remain positive up to 90 days, so expecting a negative screen on discharge may not be possible	Trust transfer guidance		Compliance with transfer documentation to be developed	Across system working and ongoing dialogue with the care homes via the PCCT to ensure that care homes are supported and that patients are isolated as required on discharge. Communications have been sent to all care homes via Sandwell Local authority setting out the expectation.	
Monitoring of IPC practices, ensuring resources are in place to enable compliance	Daily matron checklist for wards areas COVID hotspot audits Hand hygiene Audits	Evidence of staff who have been trained deployed to services to provide additional support and training when	Peer review and out of hours review of areas by CNP/mangers			

with IPC practice	Access to PPE daily reviewed/monitored locally and stocks monitored.	indicated. Infection Prevention and Control Committee (IPCAC) minutes and papers.				
Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	Trust staff are regularly updated regarding PPE via the COVID-19 trust-wide bulletins, these updates include links to guidance for staff to follow on how to put on and remove PPE On the Trust's COVID-19 intranet resource page, there is clear guidance on the appropriate use of PPE and this follows PHE guidance - Every clinical area has been provided with pictorial guides - Staff working in high risk areas receive additional PPE training due to the extra PPE required in such	IPC training compliance data Trust guidance -evident on the Connect page Supply data and sit rep submissions Evidence of staff who have been trained deployed to services to provide additional support and training when indicated.	Quality Assurance Visits	There are is not the role of PPE guardians in place will need to be developed	Processes and guidance is in place. IPC advise accessible 24/7	

	areas, this includes how to put on the PPE, remove the PPE and where this should be done					
Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	Individual Covid risk assessments of staff Lateral flow testing introduced – in progress PCCT screen staff if symptomatic and as part of surveillance outbreak management	Information and policies on the connect page Workforce reports		Staff screening and the ability to track them as part of an outbreak needs strengthening. Ability to identify clusters of staff positives quickly needs to be developed	Three times weekly outbreak meetings Daily outbreak dashboard	
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	.IPC mandatory training for all staff provide – high percentage compliance (ESR) Induction for all staff IPC included Locally held records	Policies and procedures in place		Ability to capture compliance with TBP needs to be developed	Peer reviews and spot checks carried out	
all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	Daily bulletin COVID WebEx sessions Team Talk Audit compliance Incident reporting	Policies and procedures in place			Peer reviews and spot checks carried out	

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	Signage is in all areas Pictorial PPE requirements displayed PPE guidance on connect page	Policies and procedures in place		Despite persistent and consistent messages that are circulated there remains a level of none compliance – this is being reviewed in line with policy to assess what action can be taken against persistent breaches in PPE requirements	Peer reviews and spot checks carried out	
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	The COVID inbox is checked throughout every day for updates and any that are sent are recorded on the sit rep along with actions taken. Clinically Advisory Group report daily to tactical/strategic	IPC team regularly review the research and guidance for new evidence and improved ways of working.	Engagement in IPC forums National, regional and STP).		Good processes in place	
risks are reflected in risk registers and the board assurance framework where appropriate	Infection prevention and control risk register COVID risk register	COVID papers to the COVID assurance committee and Board.				
Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and	IPC guidance & policy adhered to for non COVID-19 infections & pathogens.	Infection Prevention and Control Committee (IPCC) minutes and papers.	IPC team daily comms about alert organisms, review of all results		None required	

pathogens 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. Ensure Trust Board has oversight of ongoing outbreaks and action plans.	Clear escalation process in place and sign off by executive Outbreak meeting chaired by Chief Nurse (DIPC) escalation to board			Need to develop the mechanism of follow-up of HOCI – currently being implemented as a mandated requirement	Incidents need to be reported to safeguard for probable (post day 8) and definite HOCI (post day 14)	
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2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	CCS training records/wave 1 and 2 training records. We do not have designated teams however the whole workforce is trained to care for COVID suspected and confirmed cases.	Local training records Tactical log- Issues of concern taken to Tactical for discussion and support/advice from IPCT/others as appropriate.			Processes and guidance is in place.	

Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to 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. Cohorting protocols and plans. Staffing requirements stipulated and training records of staff . All staff in inpatient wards have IPC training Local cleaning schedule records Log of cleaning requests and jobs carried out. Housekeeping staff have received training in cleaning techniques and have routinely completed this.	There is an electronic process for requesting cleaning and decontamination of isolation or cohort areas. Ambinet reports		Completeness of training records	Processes, contract and guidance is in place. facilities team currently gathering this evidence, confirmation regarding training figures Cleaning with confidence roll out to happen	
Decontamination and terminal decontamination of isolation rooms or cohort areas is carried	All deep cleans follow the agreed policy and the required PHE guidance- hospital					

out in line with PHE and other national guidance	cleaning standards policy.					
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	Work plans of bank staff and permanent staff are available that reflect the increased cleaning measures that have been put in. increased touch point cleaning.					
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	In all areas, the Trust moved to using Chlorclean for daily cleaning; this was before the COVID-19 Pandemic					
Manufacturers' guidance and recommended product 'contact time' must be	Chlorclean and Clinell disinfectant is, in the main, used by Estates and					

followed for all cleaning/disinfectant solutions/products as per national guidance	Facilities staff, and they have been trained in its use, which includes following manufacture guidance and contact time					
Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Linen managed as per policy https://connect2.swbh.nhs.uk/wp-content/uploads/2016/07/Hospital-Cleaning-Services-Policy-ORG101-SWBH.pdf?x41267	For contracted out linen services, all used linen bagged are classified as infectious linen and processed off site by specialist linen contractor in line with PHE guidance Internal laundry is processed in line with PHE guidelines and Trust policy		Development of further assurance required	Processes and guidance is in place.	
'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	Local cleaning schedule records Team leader and matron quality walk arounds Workplace risk assessments	Cleaning quality checks by WSO supervisor, peer reviews of areas Cleaning reports to IPC and outbreak meetings			Processes and guidance is in place.	
electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a	'I am clean sticker compliance' expected that the user should clean after use	Cleaning reports to IPC and outbreak meetings		Robust development of checks and reporting needs to be in place	Processes and guidance is in place	

minimum of twice daily	Local cleaning records					
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)	Local cleaning records IPC walk arounds Floor markings for areas that do not have rooms in place	Matron checklist – daily		Reporting	Guidance in place	
Single use items are used where possible and according to Single Use Policy	No deviation from single use items. Log on tactical about the reuse of face visors. Purchase records All single use equipment are disposed as per clinical waste policy. Workplace risk assessments Covid secure risk assessments					
Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Policy available and there is no deviation from this Decontamination records. All reusable clinical equipment is decontaminated as	IPC audit requirements for reusable patient equipment		Rectification plans to be strengthened at IPCAC operational meeting	Decontamination policy in place	

	described above.					
ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Local cleaning schedules Quality checks	Estates reporting Incident reporting				
ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	There a variety of ventilation across the Trust, this needs to clearly set out in a risk assessment. The nightingale wards at City enable better dispersal, due to high ceilings but the bays at Sandwell have low ceilings and small windows.			Risk assessment to be completed	Formal risk assessment requested via Estates that sets out the risks and mitigation in place in line with the HTM requirements for ventilation	
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	This is not applicable at present as we are using clinell and chlorclean in all areas, this has been in place for a significant period of time prior to COVID					
Mandatory reporting requirements are adhered to and boards	Mandatory reporting continues Evidence: HCAI data					

continue to maintain oversight	capture system submission Monthly data submission					
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3. Appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance						
• arrangements around antimicrobial stewardship is maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	AMR – monitoring continues are before, reports available. We have recently updated our pneumonia antibiotic guidelines in lines with NICE guideline for COVID secondary pneumonia. AMR committed minutes Antibiotic app in use	AMR ward round are done through telephonic consults and unity EPR review instead of physical AMR ward round.			Reporting from AMR committed to IPCAC	
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						
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• Implementation of national guidance on visiting patients	In view of the current community prevalence there remains in place	Tactical minutes		There is still some confusion in clinical areas	Monitoring PALs and complaints for any concerns	

in a care setting • Areas in which suspected or confirmed COVID-19 patients are being treated in areas clearly marked 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.	a restriction on visitors. End of life visitors pathway Maternity visitors pathway Information of Trust websites Patient leaflets Posters and information on the wards and provided to carers			about visiting policy this need a relaunch	about visiting	

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						
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Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection 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. 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	There is clear streaming and triage SOPs in place Local training records	Minutes and records of tactical command. Case review of patients pathway		Case presentation may not be clinical COVID – this is difficult to manage if atypical symptoms	Policies in place Senior clinical oversight in ED departments	

face coverings are used by all outpatients and visitors	Risk assessment for the use of masks is documented in EPR for individuals who are refusing to isolate. Appointment letter requesting service users wear a face covering when attending appointments. PPE stations in use	Visual checks PPE usage by PPE stations		Systems and process are in place however there is at time individual none compliance but this is not due to lack of systems in place but to individual exemption	Manned PPE stations and security presence Posters and letters informing patients of expectations	
face masks are available for patients with respiratory symptoms	**Stock levels** **COVID hot spot audits**				Not all patients with symptoms can wear a mask – this must be documented and the patient isolated	
provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	Patient leaflet COVID hot spot audits			How this information is captured and how we monitor this	Documentation on EPR (may not be complete)	
for patients with new-onset symptoms,	Rapid swab testing data via tactical log	Tactical records.				

isolation, testing and instigation of contact tracing is achieved until proven negative ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. 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 patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Outbreak meeting notes HOCI RCA information Workplace risk assessments. Covid secure risk assessments. Screens in place in reception areas. Contact tracing records Patient records				COVID wards and none COVID wards and areas are reviewed via tactical and decisions made on the demand for capacity based on presenting patients	

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

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separation of patient pathways and staff flow to minimise contact between pathways. For example, this could	Flow of ED plans set out BTC OPD pathway in place and visible entrance/exit			Compliance with entry/exit points by patients, both sites have a very big footprint to monitor	Security cameras Locked doors	

include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	Lockdown of side entry doors to patient – staff access only via swipe card					
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	Individual Covid risk assessments of staff Individual training record.			Local training records require development	ESR Local managers knowledge	
all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to Don and Doff it safely	Individual Covid risk assessments of staff Individual training record.	Fit testing records				
a record of staff training is maintained	ESR Local training records					
appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed	Tactical record Health and safety notices					
any incidents relating to the re-use of PPE are monitored and	Safeguard system reports	Observational reviews				

appropriate action taken					
Adherence to PHE national guidance on the use of PPE is regularly audited	Observational support and PPE wardens in place to help staff make the right choice of PPE for the set task	Peer reviews Matron daily checklist		Walk arounds and PPE wardens	
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 • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear advice on use	All areas have had increased poster distribution Promotional TV screen messaging Catch it bin it kill message evident Paper towels evident in all areas Communication messages about symptoms Swabbing pathway for staff Daily dashboards	Peer review Quality reviews Tactical minutes	Log of hand driers requires confirming	Stock levels of paper towels	

of face coverings and facemasks by patients/individual visitors and by staff in non-patient facing areas 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 other if they or a member of their household display any of the symptoms • a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organization 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					

7. Provide or secure adequate isolation facilities						
Key lines of enquiry Systems and processes are in place to ensure:	**Evidence (of assurance)**			**Gaps in Assurance**	**Mitigating Actions**	**Assurance level (RAG)**
	1st Line	**2nd line**	**3rd line**			
Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff Areas/wards are clearly signposted, using physical barriers as	Safeguard incident report Signage on ward areas EPR records Alert notification on EPR Policy in place			Rapid changing community prevalence may impact on the ability to isolate and cohort patients Limited side rooms with toilets	Isolation risk assessment in place	

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 COVID-19 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						
8. Secure adequate access to laboratory support as appropriate						
Key lines of enquiry Systems and processes are in place to ensure:	**Evidence (of assurance)**			**Gaps in Assurance**	**Mitigating Actions**	**Assurance level (RAG)**
	1st Line	**2nd line**	**3rd line**			
• ensure screens	Data submissions	Training video for		Reject swabs continue to be a	Escalation to	

taken on admission given priority and reported within 24hrs • regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available • 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 • 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	daily Swabbing results Flag alerts in EPR Training records	swabbing Lab accreditation		problem	matrons for action daily Training available on connect page IPC support	

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 Systems and processes are in place to ensure:	**Evidence (of assurance)**			**Gaps in Assurance**	**Mitigating Actions**	**Assurance level (RAG)**
	1st Line	**2nd line**	**3rd line**			
• 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 •	Guidance accessible in services including specific arrangements for staff that do not have access to emails Local quality walk around ensure guidance is followed. Safeguard reports of incidents	All policies on line IPCAC minutes Ratification of polices HR reports OH reports				

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Key lines of enquiry Systems and processes are in place to ensure:	**Evidence (of assurance)**			**Gaps in Assurance**	**Mitigating Actions**	**Assurance level (RAG)**
	1st Line	**2nd line**	**3rd line**			
• Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported • 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 fare 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 • a record of the fit test and result is	Daily review via Tactical to ensure that workforce is monitored and actions taken Information	OH help line				
	Wellbeing service in place Individual risk assessment – on line		HSE review has taken place – good practice in place for fit testing			
	Managers risk assessment Fit2fit trained fit testers – certificate of competency Fit testing training records ESR recording of fit testing Hood stock levels and distribution PPE policy updated with fit testing algorithm					

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	External records of fit testing company Local induction records for fit testing Local risk assessment for staff					

• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record • 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 • 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						