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Infection prevention and control board assurance framework

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Updates from V1.5 highlighted

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

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

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

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

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

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

1. Systems are in place to manage and monitor the prevention and co 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**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative • 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, resources are in place to enable compliance with IPC practice ○ staff adherence to hand hygiene?	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 All areas Quality Assurance visits Deep clean process in place	Patients can be moved due to specialty and clinical need this increase the risk of potential transmission Compliance with staff completing on line results for lateral flow, system in place online	Daily meetings with capacity and infection control

o staff social distancing across the workplace o staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical ▪ b) non-clinical setting • monitoring of staff compliance with wearing appropriate PPE, within the clinical setting consider implementing the role of PPE guardians/safety champions to embed and encourage best practice • implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace • 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	PPE audits/COVID hot spot audits Health and safety risk assessments of non-clinical spaces Lateral flow in place move to LAMP testing planned 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 Posters in place in all ward entrances Trust staff are regularly updated regarding PPE via the COVID-19 trust-wide bulletins, these updates include links to guidance forstaff to follow on how to put on and remove PPE Evidence of staff who have been trained deployed to services to provide additional support and training when indicated.		

• 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 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 • there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace • national IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to national 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	COVID WebEx sessions Team Talk Audit compliance Incident reporting Signage is in all areas Pictorial PPE requirements displayed PPE guidance on connect page 3 x weekly tactical – national guidelines reviewed CAG updates to strategic and tactical		

• 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. • This Board Assurance Framework is reviewed, and 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	Board papers/IPCAC papers		
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**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and	Local cleaning schedule records Log of cleaning requests and jobs carried out.	We are currently assured of the processes in place	Ongoing monitoring as part of the business as usual monitoring program.

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 • 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 • 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	There is an electronic process for requesting cleaning and decontamination of isolation or cohort areas. Checklist in place for handover and sign off with WSO and IPC and matron/ward manager Enhanced cleaning Rota in place SWB policy to use chlorclean – records kept at ward level and checked on audit tool		

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 all 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 be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Facilities staff, and they have been trained in its use, which includes following manufacture guidance and contact time Local cleaning schedule records Team leader and matron quality walk arounds Workplace risk assessments		

• 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	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		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	Audit of 'of I am clean'		
• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Audit system – ambient		
• ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	COVID hotspot audits	Pending ventilation risk assessment by the Authorizing Engineer for Ventilation.	Small number of HEPA filters being used on one ward. This will need to be reviewed and a risk assessment undertaken with a view on how we utilize this technology for our ward areas.
• monitor adherence environmental decontamination with actions in place to mitigate any identified risk	Ambient system in use by Hotel services		
• monitor adherence to the decontamination of shared equipment			

with actions in place to mitigate any identified risk			
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**
Systems and process are in place to ensure: • 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 committee minutes	We are currently assured of the processes in place	Antimicrobial committee monitor outcomes
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**
Systems and processes are in place to ensure: • 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	In view of the current community prevelance there remains in place a restriction on visitors. End of life visitors pathway Maternity visitors pathway Information of Trust websites Patient leaflets	Maternity visiting still under review, there needs to be an area identified to enable lateral flow testing of parents that are attending for scans and births.	Monitoring PALs and complaints for any concerns about visiting

• 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.			
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**
Systems and processes are in place to ensure: • 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 Covid-19	There is clear streaming and triage SOPs in place Local training records Review of EPR	It was noted that the two ED departments were using different tools Case presentation may not be clinical COVID – this is difficult to manage if atypical symptoms	On tool developed and is now in use across site Policies in place Senior clinical oversight in ED departments POCT now in place

cases to minimise the risk of cross-infection as per national guidance			
• staff are aware of agreed template for triage questions to ask	Triage tool		
• 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	Training records		
• face coverings are used by all outpatients and visitors	Offered on attendance – visible review of PPE stations		
• face masks are available for all patients and they are always advised to wear them	Face masks are available at entrances – PPE stations in place		
• provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care	Record of face masks is now recorded on EPR in nurse rounding – report developed	Report is new and need to develop a system of reporting and action plans by the matrons	Oversight and review by the IPC team
• monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	Rapid testing of symptomatic patients in place. Adherence to swabbing regime monitored	Confirmation that escalation of non compliance to swabbing regime needs to be established	Review at tactical via ops managers areas where swabbing pathway not compliant.

• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. • to ensure 2 metre social & physical distancing in all patient care areas • for patients with new-onset symptoms,isolation, testing and instigation of contact tracing is achieved until proven negative • 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 • there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately			
6. Systems to ensure that all care workers (including contractors and responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure: • 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 PHE and other national guidance to ensure their personal safety and working environment is safe • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it. • a record of staff training is maintained • 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	Flow of ED plans set out BTC OPD pathway in place and visible entrance/exit Lockdown of side entry doors to patient – staff access only via swipe card Individual COVID risk assessments of staff Individual training record. Individual training record. Fit testing records COVID hot spot audits ESR records PPE – a risk assessment was completed and a decision was made based on the high community prevalence of COVID to increase the level of PPE – FFP3 masks were required for close patient contact	We are currently assured of the processes in place	Monitoring of data sickness and community prevalence to determine when the PPE can be changed back to FRSM

patients/individuals, staff and visitors to minimise COVID-19 transmission such as: o hand hygiene facilities including instructional posters o good respiratory hygiene measures o staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care o staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace o frequent decontamination of equipment and environment in both clinical and non-clinical areas o clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	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 Staggered break times Car sharing information on Connect page Visual review of posters Intranet page		

• staff regularly undertake hand hygiene and observe standard infection control precautions	Hand hygiene audits COVID hot spot audits		
• 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	Not in place		
• guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	Information evident at all sinks		
• staff understand the requirements for uniform laundering where this is not provided for on site	Comms and uniform policy		
• all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance 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	Daily dashboards and reporting to strategic and tactical meetings		

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. This includes the documented recording of outbreak meetings.	Outbreak meeting minutes Patient timelines Quarterly report SOP in place Policy – management of outbreaks		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • 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 appropriate	Safeguard incident report Signage on ward areas EPR records Alert notification on EPR Policy in place	Limited side rooms with toilets	Isolation risk assessment in place IPC support Daily IPC and capacity meetings to discuss patient flow and outbreaks

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	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • 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 of the testing turnaround times with focus on the time taken from the patient to time result is available	Data submissions daily • Test turnaround times • Swabbing compliance for day 0 , day 3 and day 7 recorded • Number of urgent swabs record Swabbing results Flag alerts in EPR Training records	We are currently assured of the processes in place	

• 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 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	Alert organism reporting/HCAI datacapture system Reports to tactical PCCT reports Incident report Feedback from the LA	This will need to be discussed further due to lab capacity. Current numbers of positive cases are decreasing. But this will be considered if cases begin to rise.

• 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 complete 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**
Systems and processes are in place to ensure that: • 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 Daily PPE stock records		

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**
Appropriate systems and processes are in place to ensure: • 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 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	HR reports OH reports Review via Tactical to ensure that workforce is monitored and actions taken Information Individual risk assessments in place – manager checklist in place Fit testing records Training records – fit2fit accreditation Fit testing records ESR records	We are currently assured of the processes in place	

repeated each time a different model is used • 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 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	PPE policy updated with fit testing algorithm	OH records to be clear on how this is managed and how they liaise with the line manager to determine risk to staff member	Hood availability

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.	External provision of Fit testing in place Eroster Health and Safety risk assessment of work space Signage on doors Posters/comms/audits/staff side audits	This is not ongoing	IPC team is currently developing a proposal for fit testing. To have a fit test coordinator and 2 x full time fit testers in place

• 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	HR records OH reports and contact logs		