Infection Prevention and Control Board Assurance Framework

Date: July 2020

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**
Systems and processes are in place to ensure: • Infection risk is assessed at the front door and this is documented in patient notes	All patients attending ED are streamed to Hot/Cold ED. This pathway is maintained if the patient is admitted. Each patient is asked a series of questions to ascertain and mitigate risk. (please see embedded document). Documented in patient records. All patients with possible or confirmed COVID-19 infection are nursed in cubicles throughout their stay in ED. Direct GP admissions are reviewed using information from the GP and placed on the appropriate pathway. Covid 19 Navigation document.pdf Trust follows PHE guidance, *Reducing the*	None Possible under-	N/A Ward teams escalate

• Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	*risk of transmission of COVID-19 in the hospital setting* and IPC guidance. Patients only moved unless clinical indication or to isolate effectively – available on Trust COVID-19 HUB. On-call teams and site matrons aware via on-call meetings. Datix used to report any inappropriate patient moves.	reporting in Datix.	through normal escalation process.
• Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Patient transfer documentation used for internal and external transfers – documented if the patient is known to have or is suspected to have an infection. Patients returning to care homes are screened for COVID-19 prior to discharge. Discharge and patient flow team and Rightcare Barnsley part of review process. Datix reporting system in place to highlight non-compliance. Patient discharge information leaflet for patients who are positive for COVID-19	None	N/A
• Patients and staff are	PPE available on all wards and departments.	None	N/A

protected with PPE, as per the PHE national guidance	Out of hours store of PPE available if required – access via site matrons. Daily stock check of PPE undertaken by BFS PPE Action Group convened. Shortages in PPE escalated via recognised channels. Risk assessments in place for BAME staff and when deviating from national guidance. PPE audit used by matrons/lead nurses to monitor the compliance with PPE. PPE enquiry line in operation. Theatre pathway re PPE. Theatre pathway for PPE.pdf		
• National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	IPCN checks guidance for updates. Any significant updates escalated to CBU's via Silver Command. Matrons, ADN's and CD's assist IPCN's in disseminating significant changes. Current guidance available on Trust COVID-HUB. Site matrons and on-call management team assist in communication.	Not all staff may be aware of changes. None	IPCN's visible on wards and available for advice. Significant updates communicated also via Trust wide email. Matrons, ADNs and on-call management team support ward and clinical areas. N/A

• Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Process of escalation from Silver to Gold Command and then to Trust Board. IPCG submits exception report/chairs log to Q&G. Exceptions reported by Q&G to Trust Board.	None	N/A
• Risks are reflected in risk registers and the Board Assurance Framework where appropriate	Risks held on the Trust risk register and local CBU registers. Process for reviewing risk registers in place.		
• Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC policies and procedures in place. Policies all current. IPCN's providing service as normal Microbiologists undertake ward rounds and daily ITU review.	Mandatory training compliance low.	CBU's contacted and requested to support IPC training. Staff who are non-compliant contacted by L&D department. Lead nurses contacted with details on how to access e-learning. Classroom sessions undertaken in May. Training plan in place. Training Plan.xlsx
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 treat patients in COVID-19 isolation or cohort areas	Staff specifically working in COVID 'hot areas' trained in relation to appropriate use of PPE, donning and doffing etc. Wards caring for patients with COVID-19 visited by IPCN/Microbiologist daily. Where ever possible staff are not moved between identified 'hot' and 'cold' areas as per PHE guidance. IPC isolation policy, care of the infectious patient and hand hygiene policies in place. Specific COVID-19 training slides available on COVID-19 HUB. Skills for Health module available via COVID-19 HUB. 5.1_Isolation Policy 2020.doc PHE Taking_off_PPE_for_ PHE_COVID-19_Doffing_gown_version.pdf PHE_COVID-19_Doffing_quick_guide_gow PHE_COVID-19_Donning_gown_version.p PHE Putting_on_PPE_for_ PHE_COVID-19_Donning_gown_version.p PHE_Donning_coveralls_guidance_instruc PHE_Doffing_coveralls_guidance_instructi	Shortfalls in staffing may lead to staff being moved to work on other areas.	Where movement is planned upskilling of teams has taken place. Matrons and IPCN's available for advice and support.
• Designated cleaning teams	Domestic movement between 'Hot' and	Not possible for	Movement between hot

with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	'Cold' areas minimised. Domestic teams trained in donning and doffing of PPE and appropriate use of PPE. Domestic staff mask fit tested for FFP3 masks. Face to face training in isolation room cleaning completed by domestic staff. Annual refresher training completed. Training records available from Domestic Services manager.	domestic teams to be based solely in one place.	and cold areas minimised as much as possible. Domestic teams aware of the appropriate use of PPE. Hand hygiene facilities available. Cleaning equipment not transferred between areas.
• Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other <u>national guidance</u>	Tristel used as standard cleaning product. RAG room cleaning regime in place. Information via communications sent Trust wide in relation to cleaning. IPCN's and Matrons available for advice 6_Barnsley_RAG_poster281119 updated :	None	N/A
• Increased frequency of cleaning, at least twice daily in areas that have higher environmental contamination rates as set out in the PHE and other <u>national guidance</u>	Environment coordinators aware of frequent touch points. Enhanced cleaning (at least 2 cleans per day) in place in high risk areas e.g. 'hot' ED, including resus; 'hot' ITU, respiratory care unit and designated COVID -19 wards. Cleaning schedules updated and placed in all areas. Additional cleans on an ad-hoc basis of bays and cubicles where patients positive	None	N/A

	for COVID-19 are nursed. Requests recorded at BFS Domestic Offices. Schedule in place regarding operating theatres. 17_Cleaning schedule.doc		
• Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas.	Proactive programme of cleaning toilets and bathrooms introduced in 2019. All toilets cleaned with products suitable against COVID-19 (Tristel). Frequent checks of public toilets undertaken by domestic staff. Check sheets in toilet area. Checks of toilets in ward areas also undertaken by nursing staff. 18_Copy of sanitary check sheet.xls	Proactive programme not to plan due to lack of equipment.	Proposal made for additional UV machine.
• 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	All areas cleaned using Tristel. Confirmed as been effective against enveloped virus. Adequate supply of Sochlor in the event of supply issues with Tristel. Communication with Tristel rep, domestic	None	N/A

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.	services and procurement if supply issues anticipated. Tristel and SoChlor available for ward/clinical teams to clean equipment. Disinfectant wipes available for cleaning of non-high risk equipment, effective against enveloped viruses.		
• Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products	Domestic teams and ward staff trained in the use of Tristel. Records available for staff trained. Cascade training implemented. Posters for cleaning products in areas.	None	N/A
• As per national guidance: ○ 'Frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids	Additional cleaning of frequent touch points undertaken by domestic staff. Environment coordinators in post in most wards. Required additions to cleaning SOP's emailed to all lead nurses.	Evidence from clinical teams that this is taking place.	Observations of clinical practice undertaken by matrons and IPCT.
○ Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice	Workplace risk assessments in place – cleaning of office equipment identified. Wipes suitable for the cleaning of electronic equipment available through procurement.	Evidence from clinical teams that this is taking place.	Managers observing practice.

daily ○ Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Ward 37 and ward 24 have cubicle's with anteroom. If covid positive patient nursed in the cubicle, anteroom will be cleaned twice daily. Ward staff spot clean. Doffing area on ITU/Respiratory Care cleaned twice daily. Doffing Checks.doc	Evidence of completion	Check and sign sheets implemented.
• 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 is laundered as per the HTM 01 04, Decontamination of linen from health and social care, all items are put into a water soluble bag before being placed into the relevant coloured plastic linen bag. Monthly meetings held with the laundry provider, yearly audit competed at the premised where calibration certificates, Health & Safety documents and training records are reviewed Face to face training has been completed; all areas have been issued with laundry posters to ensure compliance. PHE guidance available on COVID-19 HUB. Patients clothing quarantined for 3 days before use. Receipt and collection of patient belongs by appointment.	None	N/A

• Single use items are used where possible and according to Single Use Policy	Policies in place. IPC mandatory training highlights use of single use items. IPCN's liaise with procurement and CBU's when purchasing new equipment.	None	N/A
• Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Products on site are suitable for deactivating COVID-19. Decontamination policy in place. Equipment and environment audits undertaken. Environment coordinators on most wards Matrons, lead nurses and IPCN's monitor cleanliness of equipment. All high risk re-useable medical equipment is decontaminated on-site centrally. 2_Decontamination.doc 10_INFECTION CONTROL AUDIT TO(10_INFECTION CONTROL AUDIT TO(	None	None
• Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	Waiting areas naturally ventilated. Doorways opened to improve airflow and reduce contact. Social distancing in place.	None	N/A

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 are maintained	Although AMS ward rounds were limited to reduce footfall on the wards and improve social distancing, review of patients on antibiotics is completed over the phone by Microbiologists and on Careflow by the AMS pharmacist. On Careflow a dedicated AMS portal is used by ward pharmacists to report patients in need of a review. Mandatory reporting continues as usual.	Re-establish ward rounds and AMS group meetings to help improve AMS stewardship.	Work underway to re-establish AMS ward rounds whenever safe to do so.
• Mandatory reporting requirements are adhered to and boards continue to maintain oversight	Reports to IPCG, Trust Board oversight via Q&G.	None	N/A
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	Information cascaded via communications, re-enforced by CBU. Information available on COVID-19 HUB.	Staff may not be aware of process.	IPCT provide a facility to 'ask the team a question' via IPC HUB.

	IPCN and senior nursing team available for advice. Site matrons and on call management team provide support to staff. Group convened to plan a safe process to re-introduce visiting. Visiting SOP - Physical Visiting (2).d SOP - Virtual Visiting.doc		Patient Experience message and video calls service. Procurement of electronic devices to help patients keep in touch with visitors.
• Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	ITU – 'Hot' and 'Cold' area identified. Patients having respiratory precautions identified with barrier precautions sign. ED – clear signage and restricted access in 'hot' and 'cold' areas. Respiratory Precautions barrier nursing signage used. 4_Respiratory barrier precaution - g	None	N/A
• Information and guidance on COVID-19 is available on all Trust websites with easy read versions	https://www.barnsleyhospital.nhs.uk/covid-19-coronavirus/ https://www.barnsleyhospital.nhs.uk/news/easy-read-guide-to-explain-covid-19-and-other-resources/	None	N/A

• Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	http://intranet.bdgh-tr.trent.nhs.uk/teams/covid-19/ Infectious state of patient documented on external and internal transfer documentation. Result readily available via IPC in-patient dashboard. Result available on ICE – access available to GP's and other local Trusts. Datix reporting in place to alert to process failures.	None	N/A
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: • Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19	ED has designated space for streaming and then triage in the appropriate areas i.e Hot/Cold. Covid-19 Navigation v2.pdf	None	N/A

cases to minimise the risk of cross-infection			
• Mask usage is emphasized for suspected individuals	Surgical masks provided for patients when appropriate taking into consideration the patient's condition.	None	N/A
• Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	2 metres between bed spaces reiterated. Curtains can be drawn between patients. Perspex screens erected on reception desks	None	N/A
• For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Isolation policy in use. Procedure and algorithm for the management of patients with new onset of symptoms. Contact tracing undertaken by IPCN. Datix reporting if unable to immediately isolate patient. Possibility of co-horting patients assessed. IPCT undertake alert organism surveillance. Able to detect where possible HCAI has occurred. Incident/outbreak meetings held if 2 more cases of possible HACI in one area, minutes available from IPCT. Escalation to ET of possible HCAI. Ward 22 Infection Cluster Investigation 16_Patient pathway for patients in COVID 15_COVID-19 Management of suspe	None	N/A

• Patients with suspected COVID-19 are tested promptly	All non-elective patients swabbed on admission – either in ED or AMU. Datix reporting in place to alert to process failures. Screening process for elective admissions Patients with new onset of symptoms screened. IPCN and microbiologist available for advise re screening.	None	N/A
• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	Process and documentation in place. Site matrons aware of need to isolate. Patients receive regular medical and nursing staff review. IPCN and Microbiologists available for advice. Screening process for elective admissions. Patients with new onset of symptoms screened. Consent process and letter sent to elective patients. Datix completed for all hospital onset cases. Rapid improvement reviews when hospital onset cases identified.	Availability of isolation facilities.	Datix reporting system. IPCN's and microbiologists available for advice (24 hours). Surgical masks available for patient use. Site team have access to IPCT dashboard to aid placement of patients. Patient microbiological alerts on Lorenzo to assist in review and selection of isolation requirements.

	Rapid improvement tool Acute COVID -19		Ward boards link to IPCT dashboard to easily identify patients with alert organisms.
• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Action card developed to guide correct practice in outpatient settings (2) Updated outpatient action carc	Limited evidence of action being required due to the switch to virtual outpatient consultation and very small numbers attending for face to face.	Patients attending outpatients required to wear a face covering.
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
Systems and processes are in place to ensure: • All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	IPC training mandated annually for staff having patient contact and every 3 years for staff who don't have clinical contact. IPC mandatory update and induction updated to include COVID-19. PHE guidance available via COVID HUB. Links to PHE video on donning and doffing on COVID HUB.	Compliance with mandatory training is below Trust target. Limited number of classroom sessions available. Limited support for development of e-learning packages.	IPCT and CBU's promoting e-learning. IPCN's and senior nursing staff challenge poor compliance with IPC precautions and advise on correct procedures.
• All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	Posters on wards – donning and doffing, hand hygiene. Education links can be accessed via the COVID HUB – Skills for Health, COVID-19 slide show FFP3 mask fit testing undertaken. Priority given to those staff regularly undertaking AGP. Posters available on clinical areas advising of appropriate PPE and donning and doffing. Advice to staff by IPCN's, Matrons and ADN's. Additional on-site shower facilities provided.	Temporary delays in mask fit testing due to unavailability of solution and order placed for alternative fit test not fulfilled. Changes in the supply of masks results in staff not being mask fit tested to the current mask in use.	Assistance gained from South Yorkshire Fire and Rescue and other companies to assist with mask fit testing. BFS contracted company to provide mask fit testing.

• A record of staff training is maintained	Record of mask fit testing activity maintained. Able to confirm what types of mask staff are fit tested to. ITU maintained records on training given on donning and doffing. Training records held centrally via ESR Responsibility of Trainers.pdf Qualitive Fit Test Report Sheet.pdf 12_Qualitative Mask Fit test record 2020.› Train the trainer process enhanced. Infection Control SOP for Mask Fit Test Lesson plan for fit mask testing t-code 1 Lesson plan for train the trainer fit mask te	Some returned records are incomplete	IPCT improving system of Train the Trainers with updates.
• Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	Any CAS alerts related to COVID-19 are immediately shared with Silver Command in addition to the relevant teams and departments as per CAS policy. Current Trust advice, not to reuse unless recommended by manufacturer. Risk assessment in place for acute PPE shortages	None	N/A

	PPE shortages.doc Risk assessment in place for acceptance of visors not supplied via normal supply route. Visor.doc Re-processing of visor bands manufactured on site via BFS Decontamination Services. Process validated prior to introducing the visor Gowns suitable for laundering purchased and manufactured by the Trust. Policy and risk assessment for laundering in place		
• Any incidents relating to the re-use of PPE are monitored and appropriate action taken	Not current practice to re-use equipment unless deemed safe to do so by manufacturer. Datix reporting system in place.	None	N/A
• Adherence to PHE national guidance on the use of PPE is regularly audited	PPE audit available and to be undertaken as a minimum weekly. CBU's to monitor actions. Results fed back to the PPE Action Group and then by exception to the IPCG	Audit programme not yet fully embedded	Observation of practice, feedback to individuals at the time.

• Staff regularly undertake hand hygiene and observe standard infection control precaution	PPE.doc Programme of hand hygiene audits undertaken in clinical areas weekly. Monitored by the CBU’s. Compliance escalated to IPCG through exception report. Non-compliance addressed by CBU’s and IPCT. Audit undertaken by volunteers – patient’s observations of hand hygiene amongst staff prior to COVID-19. Observation of practice undertaken by IPCN’s. Portable hand wash basins placed on entrance to high risk areas. Alcohol hand rub available to staff.	Hand hygiene audits not consistently 100%	Non- compliance addressed by medical staff. Hand hygiene champions deliver ward based practical sessions on hand hygiene.
• Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. 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	No hand dyers in the Trust	None	N/A
• Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff		Not all toilets have specific signage on hand drying.	Signage to be sourced, ordered and appropriately placed.

areas	Soap and alcohol gel dispensers have 6 step hand hygiene technique printed onto the dispenser. Hand hygiene prompts in main public toilets Alcohol hand rub dispensers have 6 step technique demonstrated		
• Staff understand the requirements for uniform laundering where this is not provided for on site	Uniform policy in place-specifies laundry requirements. Trust wide email from communications team on laundering. Clinical and non-uniformed staff provided with scrubs to wear and launder.	None	N/A
• All staff understands the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	Advice on COVID HUB COVID reporting line for staff. Advice given regarding swabbing and isolation requirements. All advice then re-iterated and explained by the staff swabbing team when contacting the staff member to arrange the appointment and again at the swabbing appointment.	None	N/A

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: • Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Patients identified on admission whether high risk of COVID. Patients at high risk isolated or cohorted with barrier precautions. Operating theatre cases – revised list to ensure adequate time between cases to allow for cleaning and minimise cross infection. Patients not placed in positive pressure cubicles. Barrier precaution signage in use.	Isolation facilities not always available. Cohorted areas not always situated in desired area on the ward.	Escalation process for unavailability of side rooms. Availability of surgical masks for patients where appropriate. Enhanced cleaning regimes for areas where covid positive patients. Datix reporting to have an overview of the situation.
• 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	Cleaning frequencies increased in high risk areas. RAG decontamination poster in use All cleaning products suitable to deactivate COVID -10 Barrier Precautions signage in place	Unable to guarantee 2 metre space between patients. Not always able to designate separate ends of the ward for cohorted bays.	Use of privacy curtains between bed spaces where safe to do so. Doors closed to bays to ensure segregation from the rest of the ward.
• Patients with resistant/alert organisms are managed according to local IPC	IPC alert system through Lorenzo. IPCT alerted to patients with alert organisms.	None	N/A

guidance, including ensuring appropriate patient placement	IPCT dashboard and case management system. IPC policies in place. Escalation procedure if unable to isolate within isolation policy Site Matron team work with IPCN's to appropriately place patients IPCN's review all patients with an alert organism. Datix reporting system in place IPC dashboard available for viewing by ward and site team. Ward boards linked to IPCT dashboard enabling easy identification of alert organisms.		

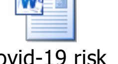
8. Secure adequate access to laboratory support as appropriate

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	Procedure in place for taking swabs for COVID-19. 3_Collection of viral nose and throat swal	None	N/A
• Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Patients tested on admission. Staff assessed for testing when contact COVID reporting line Patients requiring discharge to a care home are swabbed 48 hours before discharge.	None	N/A

• Screening for other potential infections takes place	Drive through facility available for staff testing. IPC policies in place. Microbiologists and IPCN's available for advice. Laboratory facilities available to undertake screening for other infections.	None	N/A
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.	IPC mandatory training annually for clinical staff. Audits of compliance to policies undertaken – feedback given to ward staff. IPCT available for advice and support. Answer phone to pick up out of hours queries. 24 hour microbiologist cover provided. Site matron and on-call management team available outside normal working hours. 'Ask the team a question' facility on the IPC HUB page. IPC HUB with advice. 'Bug of the Month' produced by IPCN's.	None	N/A

	IPCN's visit wards daily. 7_(1) Bug Of The Month Wuhan novel c		
• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Changes communicated via Silver command to CBU's and BFS. Changes alerted to communications team. Suspension of other Trust communications to ensure messages are clear regarding COVID-19. IPCN's visit wards on a daily basis. Site matrons and on-call management team assist in communication.	None	N/A
• All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Waste is disposed of in line with the HTM 07 01, :safe management of healthcare waste, for waste from known or suspected Covid-19 the new guidance from NHSE are followed as listed • *Outer packaging must be removed before going into the wards* • *Confidential Waste in COVID- 19 contaminated areas must be stored for 72 hours before being removed/ shredded.* • *No more use of yellow bags. Areas must*	None	N/A

	move on to using Yellow rigid containers for the duration of COVID 19. • *No double bagging of Orange bags* • *No Domestic waste can go to Landfill* • There is a statement regarding implementing contingency arrangements as there could be a national shortage of Yellow clinical waste carts/ Wheelie bins. The waste register is held with the Facilities Support Manager where consignment notes are held, the quarterly returns are held both electronically and in the register.	None	N/A
• PPE stock is appropriately stored and accessible to staff who require it	All PPE is received into BFS Procurement stores and kept securely in receipts area. All wards and areas get daily stock allocations and daily monitoring is in place across all PPE items. Report on allocation / usage / ward is provided daily to Silver command for review and dissemination Weekly PPE Daily Usage Master.xlsx		
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 and managed appropriately including ensuring their physical and psychological wellbeing is supported	Risk assessments are completed and acted on accordingly, those shielding and or working from home receive welfare calls and agree programme of calls and or signposting to agencies who can offer appropriate support. Risk assessments stored locally and centrally. Covid-19 Risk Assessments - Manag BAME letter 20 5 20 final.doc  Covid-19 risk reduction framework Email wording 26.6.20.docx LETTER - Supporting our BAME staff and th	Where individuals and or manages have not recorded so not on list to follow up.	To send out communication reminding manager and individuals of all guidance and support available and where to send documents to ensure support/welfare of individual.
• Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	All staff informed that must be mask fit tested to safely wear FFP mask. Mask fit testing available to all staff. Undertaken by trained personnel. Record maintained of all trainers Train the trainer system in place Record maintained by IPCT.	Staff wearing FFP3 masks who have not been fit tested. Staff may fail the fit test, alternative PPE not always available.	No evidence to suggest staff undertaking AGP's haven't been mask fit tested. Staff failing fit testing who would potentially undertake AGP's do not perform these procedures. Employee responsibilities in Health and Safety legislation.

• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	Senior member of nursing team holds staffing bleep. Staffing allocation reviewed daily by the CBU matron. As outpatient work stopped, specialist nurses allocated to clinical areas that will support their clinical skill set.	Unable to guarantee that staff not moved between areas.	Any movement of staff is risk assessed. Support provided by CBU to staff who are requested to move areas. Lead Nurses have regular NHSP workers to try and minimise staff working across clinical areas as much as possible. PPE and IPC processes in place.
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Request via communications on social distancing. Posters displayed. Floor markings denoting 2 metre distance All staff wearing surgical masks in public spaces and when 2 metres social distancing cannot be maintained. Furniture removed or marked as not in use to assist with social distancing	Evidence that staff not consistently following social distancing. Further work required.	Increased communications. Further mitigation required.
• Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Staff breaks staggered wherever possible. Posters displayed. Staff requested to use dining room if staff rest areas on clinical areas do not facilitate social distancing.	Not always possible to reduce the number of healthcare workers in one area.	Staff aware of need to socially distance.

• Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	All those shielding and working from home are contacted and assessed, appropriate sign posting is offered, and agree a support package, which includes providing details of how to access swabbing. We also ensure they are aware of how to access Trust communications which is constantly updating with advice.	Where individuals and or manages have not recorded so not on list to follow up.	To send out communication reminding manager and individuals of all guidance and support available and where to send documents to ensure support/welfare of individual. Information from the Trust has also been placed in the local newspaper.
• Staff that test positive have adequate information and support to aid their recovery and return to work.	Staff informed of their positive result, microbiologist available to answer any questions 7 days per week. Staff are called back on receipt of a negative swab, if remain off duty at 7 and 14 days, to provide advice, information and any support to aid recovery and return to work.	Those accessing swabs elsewhere may not receive timely advice from Occupational Health as the team are not informed till much later in the process. Staff may not be able to attend the drive through testing service.	To support staff as soon as become aware of result. Proposal for drop off and collection approved by ET.