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Infection prevention and control board assurance framework

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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 also 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.

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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.

Infection Prevention and Control board assurance framework

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 • patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission • compliance with the national guidance around discharge or transfer of COVID-19 positive patients • patients and staff are protected with PPE, as per the PHE national guidance • national IPC guidance is regularly checked for updates and any changes are effectively communicated to	• Process in place and embedded. EPR flag system • Cohorting policy is updated on a regular basis to identify areas dependent on numbers • Our local SOP's reflect national guidance and are tracked through the command structures in place • Local PPE guidance has been updated in line with changes to national guidance, PPE is managed through a centralized hub with expert clinical advice available	• Staff, in some areas, remain confused over the level of PPE to wear – this is usually in relation to red non AGP areas, and in general relates to temporary staff.. Staff are wearing the correct PPE but believe they should be wearing a higher level (same as AGP area). • Although adhoc observation	• Continue to update communications in relation to PPE. • PPE hub in place to give advice in relation to PPE, this includes coordinated deliveries of the correct PPE to wards. • Audit schedule to recommence from the 1st June 2020. Infection control matron spot

staff in a timely way • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Risk registers updated and monthly update to Board members via regulation committee or Board • Board Assurance Framework updated May 2020 • IPC risk for non COVID continues as per our policies and procedures in place	audits are being undertaken, routine audits not being undertaken on Meridian.	check to be recommenced
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 • designated cleaning teams with appropriate training in required techniques and use	• Staff training and / or information in place for all front line staff (including porters / domestics / temporary workers) • Dedicated cleaning teams in place with HPV / Chlorine and UV in place. PPE training and advice given	• Additional assurance audits have shown that used PPE for decontamination is not always stored correctly • Lack of resources to support deep cleaning on sites	• Additional assurance visits by Chief Nurse team and reiterating correct processes • Case of need for an additional machine has been escalated to Gold,

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 • increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• National guidance is followed and SOP's are in place for all staff • Where an item is for single use only and is being reused (Visor / Goggles and respirators) this has been risk assessed and a process in place. • Reusable equipment is appropriately decontaminated and policies are in place	other than BRI, relating the availability of the HPV machine. • Limited capacity to provide a programme of deep cleaning for all wards on a regular basis above and beyond the normal cleaning schedules. • Limited availability of routine disinfectant products (i.e. chlorox wipes)	approval received 19/5/2020. • Adhoc deep cleaning being provided. • Business case under development by the facilities team to deliver a regular programme of deep cleaning for all areas. • IPC team working in collaboration with Procurement to source suitable alternatives.

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 • mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Anti- microbial pharmacist in place and continues to maintain some of the service. • Reporting continues to be signed off and reported to the national systems. Board dashboard in place	• Consultant microbiologist not on site doing ward rounds	• EPR virtual review • Failsafes within EPR for discontinuation of high risk drugs • Virtual MDT reviews in place
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 where possible being treated in areas clearly marked with appropriate signage and have restricted	• National guidance has been implemented and uploaded onto website, SOP in place • Signage in place	• Although documented we have had a concern raised that we did not notify a care home of potential COVID status (on discharge from AED) • Easy read	• Written information being provided to care homes for all patients who are assessed in a 'non-green area' • Easy read documents under development with the support of

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	• Information available on the website. Easy read versions have been commissioned from Bradford Talking Media • Electronic patient record with alerts clearly in place for all patients at BTHFT. Discharge and transfer documentation clearly states infection status.	information not yet available on the external website.	Bradford Talking Media.
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 to minimise the risk of cross-infection • patients with suspected COVID-19 are tested promptly • patients that test negative but display or go on to develop	• Policies and procedures are in place and embedded. Specific SOPs developed and updated as appropriate.	• We are understanding more about the disease process on a daily basis, this means we need to change and review frequently – sometimes ahead of national guidance	• Command structure in place (including clinical reference group) to evaluate all new findings and decisions.

symptoms of COVID-19 are segregated and promptly re-tested • 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 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	• Training in place for all staff including updated SOP, videos, posters web and face to face. In preparation education sessions aimed purely at COVID and treatment including Donning / Doffing and IPCC	• Changing guidance	• Posters in all clinical areas, ongoing teaching and spot checks. Education content updated as per new guidance.
• 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	• All staff trained but not embedded due to changing guidance		
• a record of staff training is	• Staff training records are maintained for all staff on a	• Inconsistent recording of training	• Local records being

maintained • appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • 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 in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	centralized database • CAS alert reviewed and action plan developed • Regular spot audits are being undertaken in relation to the wearing of PPE, any incidents reported in relation to PPE are reviewed by the infection control team. • Hand hygiene audits have continued and observations taking place • Staff have been advised on the correct temperature to wash uniforms, strict policy of no travelling to work in uniform enforced • Evidence that staff understand the requirements to report / ask for advice / self-isolate	records, with variable use of ESR and ability to pull compliance reports. • Not always full compliance, separation and storage of clean and dirty visors.	kept. Need to revisit reporting arrangements. • Spot checks and Chief Nurse Team assurance visits in place to monitor compliance. • Review existing audit programme and data and undertake a gap analysis which will then inform the training priorities, future audit programme and infection control annual plan.

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 • 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	• Policies and procedures in place to monitor guidance • Cohorting plans in place that are flexed to the different needs of patients and demands • Environmental checks plus additional checks in place • Existing policies in place and maintained – flagging system via EPR	• Not an exact science on how to cohort and this leads to differences in opinion – potentially impacting on practice • Environmental checks are showing areas of concern • Limited access to 24/7 point of care rapid testing. • Old estate, with limited number of side rooms, and adapted nightingale wards.	• Command and control structure in place with consensus gained and reviewed as any concerns arise. • Established operational processes for communication between estates, facilities, infection control and the Clinical Site team to move patients to the most appropriate area in a timely manner. • Minor estates works to improve cohorting within the limits of the estate.
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 • screening for other potential infections takes place	• Managed in collaboration with Airedale and any new guidance is reviewed and implemented • Staff testing uptake has increased as availability improved. Clear database of staff and rational for testing	• No established regular routine reporting in place to check compliance with MRSA screening.	• Regular report to be established through EPR for MRSA screening.
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 related to confirmed or suspected	• As part of business as usual and ongoing checks, evidence is available that we are adhering to policies and addressing any changes • Effective process in place to manage communication of changes to national guidance via command and control structure.		

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	• PPE hub in place offering advice and supply of correct PPE		
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 assessment process in place for vulnerable groups of staff including guidance for managers and risk assessment checklist and template. Documents are regularly updated in line with national guidance. OH support available to staff/managers who have concerns about their vulnerabilities including signposting to psychological support. [local and national]	• Changing guidance and advice re vulnerable groups. • Risk assessments locally held so assurance re completion and follow up.	• Regular communications re risk assessments. • Risk assessment checklist developed for Bame staff which can be used for all colleagues. • Reporting functionality set up on ESR/OLM to record completion. • Spot check audits to be instigated.

• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• Record of training. Staff trained to use respirators by IPC or specially trained staff.	• Inconsistent recording of training. • Staff remaining confused re when to wear FFP respirators.	• Revisiting reporting arrangements. • Advice/comms taking place when issue comes up via risk assessments.
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Staff absence is recorded via Health Roster/ESR, standard operating procedures are in place for all symptomatic staff/symptomatic household contacts to access staff testing. HR/Occupational health helpline in place.	• Timely reporting and recording of absence in all cases.	• HR Helpdesk contact staff on days 1-3 of absence to check testing status and to book test for them if this has not happened.
• staff that test positive have adequate information and support to aid their recovery and return to work.	• In house staff testing results are returned via occupational health, individual staff and managers are provided with appropriate isolation, re-swabbing and return to work advice based on national guidance and local policies/SOPs.	• Staff who book tests in a different name means delays in getting results back to staff. • Staff who book outside the agreed process or via the government system get results directly	• Regular comms and signposting to well-being services. • Development of an on line booking system for staff testing. • Increase in in house testing capacity will negate

		and occupational health are not flagged to chase results. • Testing via Marley site reliant upon staff advising occupational health, again potential delays.	the need for staff to use other services. • Occupational Health Service available over seven days.