The Shrewsbury and Telford Hospital NHS Trust

Infection Prevention and Control Board Assurance Framework

RAG Key:

Action Complete	Action in Progress	Action off Track

Version Number	Date Reviewed	Reviewed by	Change made
3.1	23.02.2021	Janette Pritchard, Kara Blackwell	Full Review and update
3.2	09.03.2021	Janette Pritchard	Full review and update
3.3	04.04.2021	Kara Blackwell	Update
3.4	26.05.2021	Janette Pritchard	Update
4.0	10.06.2021	Janette Pritchard, Joanne Yale, Rebecca Hawkins, Kath Titley	Update
4.1	11.06.2021	Kara Blackwell	Review and Update
5.0	05.07.2021	Janette Pritchard	Updated following publication of V1.6
5.1	01.09.2021	Janette Pritchard	Review and update
5.2	02.12.2021	Janette Pritchard	Review and update
6.0	06.01.2022	Janette Pritchard	Updated following publication of V1.8

Version	Date Presented	Committee	Presented by
5.0	04.08.2021	IPC Operational Group	Kara Blackwell
5.1	08.09.2021	IPC Operational Group	Janette Pritchard
5.2	09.12.2021	IPC Operational Group	Janette Pritchard
6.0	11.01.2022	IPC Operational Group	Janette Pritchard

Key lines of enquiry		Evidence	Gaps in Assurance	Mitigating Actions	RAG Rating
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					
Systems and processes are in place to ensure:					
1.1	A respiratory season/winter plan is in place:	Draft plan in place			Amber
1.1a	That includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs prevalence, and care services	The Trust undertake Radi/POCT which are run from the lab	The Trust do not have a POCT so this does not take place in emergency care	Rapid test takes place in the lab Discussions are taking place to see if there is an opportunity to have POCT in ED	Amber
1.1b	To enable appropriate segregation of cases depending on the pathogen.	Mediscreens and clear plastic curtains are in place on acute ward areas to provide a physical barrier between patients when 2 metre distancing cannot be achieved Screens have been purchased for outpatient administration areas where unable to maintain social distancing.	A QIA has been completed by the Trust relating to removal of beds to facilitate distancing, however this was deemed not possible and created further risk	Mediscreens and clear plastic curtains are in place on acute ward areas to provide a physical barrier between patients	Green
1.1c	Plan for and manage increasing case numbers where they occur	As above			Green
1.1d	A multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of	Draft plan in place (put draft in)			Green

	adequate isolation rooms/units as part of the Trusts winter plan				
1.2	Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Covid-secure risk assessments are supported by the H&S Team. See SaTH Intranet - New Ways of Working for supporting information and records of risk assessments received and approved by the H&S Team.	The H&S Team map risk assessments received to ESR cost codes to ensure 100% coverage of workplaces. This exercise reveals a very small number of areas not addressed, some of which are likely to be included within other risk assessments. Most now require review and updating to current guidance, given recent changes.	Current status of covid-secure risk assessments is reported to Health, Safety, Security and Fire Committee, Infection Prevention and Control Operational Group, and Infection Prevention and Control Assurance Committee.	Amber
1.3	Organisational/employers risk assessments in the context of managing seasonal respiratory infectious agents are:				
1.3a	Based on the measures as prioritized in the hierarchy of controls, including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concer4n in the local area	Hierarchy of control, ventilation, space/ capacity (social distancing at 1m+) are addressed. Where a concern regarding ventilation is observed, support from Estates is available with H&S Team input. At time of writing, ventilation is not evaluated on a room-by-room basis. Prevalence and variants are not addressed in the covid-secure risk			Amber

		assessments but are taken into account in decision making at various Trust forums including Silver meetings, IPCOG, IPCAC etc.			
1.3b	Applied in order and include elimination; substitution, engineering, administration and PPE/RPE	Included in advice to managers completing local covid-secure risk assessments where appropriate.			Green
1.3c	Communicated to staff.	The Trust has adopted a model of local risk assessments, and managers are expected to communicate the outcome of the risk assessments to their own staff supported by posters, Communications Team updates, messages from Directors, etc. Risk assessments are published at SaTH Intranet - New Ways of Working in order to make them easily accessaible to staff.			Green
1.4	Safe systems of working; including managing the risk associated with infections agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	Safe systems of work are contained in guidance within IPC policy documents and covid-secure guidance. These are approved via the appropriate governance committee/ meetings at Trust level. These are accessible via SaTH Intranet - Coronavirus Homepage.			Green
1.5	If the organisation has adopted practices that differ from those recommenced/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for	Practices are broadly in line with UK HSA, HSE and covid-secure guidance. Local variations with respect to RPE use have been adopted by way of learning from the Cambridge studies - Efficacy of FFP3 respirators for			Green

	example Integrated Care Systems	prevention of SARS-CoV-2 infection in healthcare workers (nih.gov). This is incorporated into IPC policy documents and supporting information including PPE posters.			
1.6	Risk assessments are carried out in all areas by a competent person with the skills, knowledge and experience to be able to recognise the hazards associated with respiratory infectious agents.	The H&S Team support managers with local covid-secure risk assessments and matters arising from those.			Green
1.7	If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	See 1.5, above – this is incorporated into IPC policy and reflected in PPE posters in recognition of inability to achieve 2m social distancing in most inpatient settings.			Green
1.8	Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	All patients are screened on admission to the Trust as per national guidance – patients that are identified as high risk of COVID cohorted on designated wards. Patients who are confirmed as positive are isolated in side rooms. See link for policy at bottom of document	It has been identified that the trust has a lack of side rooms that will be addressed by the Hospital Transformation Plan	Patients who have been identified as positive COVID 19 will only be moved if they are being transferred to one of the COVID high risk wards. Where possible any one identified as a contact of a COVID positive case will also not be moved, with the exception of when the hospital is full and there is no	Amber

				admitting capacity. An SOP has been created to guide executives on the least risk options  SOP for Managing COVID Contacts whe	
1.9	The Trust Chief Executive, the medical director or the chief nurse has oversight of daily sitrep in relation to COVID 19, other seasonal respiratory infections, and hospital onset cases	"nosocomial" sitrep is signed off by either CE/MD/DoN			Green
1.10	There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	Regular Confirm and Challenge meetings for Divisions are held which are attended by a member of the executive team			Green
1.11	Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	The IPC Team perform regular Quality Ward Walks on all wards in the Trust. If a ward has been identified as an outbreak ward, then a weekly enhanced Quality Ward walk will be completed. This observes adherence to Hand Hygiene, social and physical distancing and adherence to wearing surgical facemasks in both clinical and non-clinical settings. All areas (clinical and non-clinical) are required to provide Health and Safety risk assessments of their areas including maximum capacity to facilitate	2 metre distancing of patients in most ward areas is not achievable. A QIA has been completed by the Trust relating to removal of beds to facilitate distancing, however this was deemed not possible and created further risk	Mediscreens and clear plastic curtains are in place on all ward areas to provide a physical barrier between patients.	Green

		distancing. (see 1.1 for link to document) The Ward Managers and Matrons are responsible for monitoring compliance with staff wearing appropriate PPE with support from the IPC Team. This is formally audited on the Gather platform (audit platform) in the Trust			
1.12	The application of IPC practices is monitored e.g.				
1.12a	Hand hygiene	Training has taken place for all medical/nursing staff on PPE usage and Hand Hygiene. X:\StaffComplianceReports\Statutory & Mandatory Training Report			Green
1.12b	PPE donning and doffing training	All patient facing clinical and non-clinical staff have been trained to follow PHE guidance on PPE usage and have had donning and doffing training, there are posters in all areas, and advice readily available on the Trust intranet. The compliance is recorded by corporate education see above			Green
1.12c	Cleaning and decontamination	The Trust uses the national guidance for decontamination in all areas as per the guidance for pathways. The Trust also additionally use HPV cleaning when able to access areas and Facilities keep an account of areas which have been HPV cleaned. Facilities have compiled a proactive/reactive dashboard on			Green

		HPV/UV cleaning which is kept on shared drive. Z:\Facilities\Cleanliness Decontamination Dashboard facilities managers now form part of a monthly triangulated QWW at both ED sites in order to ensure there is timely identification and escalation of any issues			
1.13	The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust Board.	BAF is reviewed at IPCOG & IPCAC and was included monthly in the IPC Report to Board. This is now reported Quarterly to Board NHSE&I Visit IPC Board Paper March 2(Latest board paper requested from Trust Board EA.			Green
1.14	The trust board has oversight of ongoing outbreaks and action plans	Reported monthly to IPCOG & IPCAC. This is now reported Quarterly to Board See evidence in 1.21			Green
1.15	The trust is not reliant on a particular mask type and ensure that a range of predominantly UK make FFP3 masks are available to users as required	The H&S Team runs RPE fit testing sessions via a core of 3 WTE staff plus 2 WTE Ashfield fit testers at Jan 22. The H&S Team Manager sets a priority order for a total of 10 FFP3s in fit testing practice which aims to fit as many staff as possible to a UK Make FFP3. In current fit testing data it is notable that there is a reliance on Alpha Solway (Globus) products, however this is considered tolerable as these are UK			Green

		Make products. Fit testing results are published at SaTH Intranet - FFP3 Mask Fit Testing by the Corporate Education and H&S Teams on a regular basis, usually weekly and shared with Incident Command Centre, IPC, Procurement and Communications colleagues via email.			
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections					
Systems and processes are in place to ensure:					
2.1	The Trust has a plan in place for the implementation of the national standards of healthcare cleanliness and this plan is monitored at board level.	Implementation reported via IPCOG and IPCAC which feeds through to Quality and Safety Committee. Paper being provided to IPCAC for February meeting on progress for implementation for 1 April 2022 • The Trust uses the national guidance for decontamination in all areas as per the guidance for pathways. • The Trust also additionally use HPV cleaning when able to access areas and Facilities keep an account of areas which have been HPV cleaned. • Facilities have compiled a proactive/reactive dashboard on HPV/UV cleaning which is kept			Green

		on shared drive. This is monitored via IPCAC			
2.2	The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	The Trust have a space utilisation group which is responsible to communicate changes			Green
2.3	Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Cleaning service is accessible across the Trust and the Trust COVID 19 policy indicates the need for twice daily detergent and water/tristel (dependant on pathway) cleaning of all areas and more frequent cleaning of touch points. Ward Staff are also cleaning lockers, tables and contact points twice daily (as per PHE guidance) and cleaning records are completed.			Green
2.4	Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	Heads of Nursing confirm that all electronic equipment is cleaned twice daily. This is reviewed by the IPC team on their ward visits. Facilities decontaminate these areas twice daily.			Green
2.5	Where patients with respiratory infections are cared for: cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine	The Trust uses the national guidance for decontamination in all areas as per the guidance for pathways. Environmental cleaning is carried out with detergent/chlorine mix (Tristel Fuse). Contingency plan to use detergent clean followed by sodium			Green

	as per national guidance	hypochlorite (Milton) 1,000ppm in case of Tristel Fuse shortage The Trust also additionally use HPV cleaning when able to access areas and Facilities keep an account of areas which have been HPV cleaned. Facilities have compiled a proactive/reactive dashboard on HPV/UV cleaning which is kept on shared drive. Z:\Facilities\Cleanliness Decontamination Dashboard facilities managers now form part of a monthly triangulated QWW at both ED sites in order to ensure there is timely identification and escalation of any issues			
2.6	If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	Currently no alternative is used			Green
2.7	Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Facilities SOP follows recommended contact time of 5 minutes.			Green
2.8	A minimum of twice daily cleaning of: • Patient isolation rooms • Cohort areas • Donning and doffing areas • 'frequently touched' surfaces e.g. door/toilet handles, patient call	Cleaning service is accessible across the Trust and the Trust COVID 19 policy indicates the need for twice daily detergent and water/tristel (dependant on pathway) cleaning of all areas and more frequent cleaning of touch points. Ward Staff are also cleaning lockers,			Green

	bells, over bed tables and bed rails • Where there may be higher environmental contamination rates including: • toilets/commodes particularly if patients have diarrhoea.	tables and contact points twice daily (as per PHE guidance) and cleaning records are completed. Heads of Nursing confirm that all electronic equipment is cleaned twice daily. This is reviewed by the IPC team on their ward visits. Facilities decontaminate these areas twice daily. The Trust also additionally use HPV cleaning when able to access areas and Facilities keep an account of areas which have been HPV cleaned. Facilities have compiled a proactive/reactive dashboard on HPV/UV cleaning which is kept on shared drive. Z:\Facilities\Cleanliness Decontamination Dashboard			
2.9	A terminal/deep clean of inpatient rooms is carried out: • Following resolutions of symptoms and removal of precautions • When vacated following discharge or transfer (this includes removal and • disposal/or laundering of all curtains and bed screens) • Following an AGP **if room**	Terminal cleans are signed off by the Ward Manager and Cleanliness Technician on the Ward cleaning checklist once complete and the Cleanliness team also maintain their own terminal clean records Operational Cleaning Policy.pdf Actions and mitigations are discussed			Green

	vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	during COVID outbreak meetings with support of senior nursing team and external partners			
2.10	Reusable non-invasive care equipment is decontaminated • Between each use • After blood and/or body fluid contamination • At regular predefined intervals as part of an equipment cleaning protocol • Before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment	Decontamination of all non-invasive care equipment is detailed in the Cleaning, Disinfection and Sterilization policy which is available on the Intranet https://intranet.sath.nhs.uk/infection_control/Infection_control_policies_and_related_information.asp			Green
2.11	As part of the Hierarchy of controls assessment; ventilation systems particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance.	• Increased air-changes via mechanical ventilation to ensure air dilution. • Areas have been encouraged to open windows where possible • Non circulating portable air conditioning units may be considered • Matrons were emailed in October with PHE paper & requested implementation : Simple summary of ventilation actions to mitigate the risk of COVID-19, 1 October 2020 • Ventilation assurance is provided at COVID outbreak meetings			Green

2.12	The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations authorised engineer.	Annual audit undertaken by AE. This took place in Nov 2021 The estates department & ventilation group will review the report in February's meeting			Green
2.13	A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	Ventilation monitored by wards x 4 daily. This involved ensure windows are open for at least 10 minutes		Current risk assessments refer to the need to increase ventilation by opening windows/ doors where possible. Operational capacity is addressed with reference to room occupancy, and social distancing measures e.g. in waiting rooms which limit throughput of people in a given time period.	Amber
2.14	Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	• Increased air-changes via mechanical ventilation to ensure air dilution. • Areas have been encouraged to open windows where possible • Non circulating portable air conditioning units may be considered • Matrons were emailed in October with PHE paper & requested			Green

Commented [PJ(NIPaC1]: Will/Chris can we review ventilation

Commented [PJ(NIPaC2]: Will/Chris can we review ventilation

		implementation : Simple summary of ventilation actions to mitigate the risk of COVID-19, 1 October 2020 Ventilation assurance is provided at COVID outbreak meetings			
2.15	Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group	Wherever the situation arise ventilation safety group is made aware & discussion takes place			Green
2.16	When considering screens/partitions in reception/waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place	Mediscreens and clear plastic curtains are in place on acute ward areas to provide a physical barrier between patients when 2 metre distancing cannot be achieved Screens have been purchased for outpatient administration areas where unable to maintain social distancing.	A QIA has been completed by the Trust relating to removal of beds to facilitate distancing, however this was deemed not possible and created further risk	Mediscreens and clear plastic curtains are in place on acute ward areas to provide a physical barrier between patients	Green
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
Systems and process are in place to ensure:					
3.1	arrangements for antimicrobial stewardship are maintained	• Antibiotic Policy in place. • Antibiotic prescriptions are reviewed by a pharmacist wherever possible. • E-Script pharmacy program used to record antibiotic prescriptions, data entered by pharmacy staff and occasionally doctors when undertaking	Antibiotic policy in place. Pharmacy medicines management under increasing pressure, not all antibiotic prescriptions are able to be reviewed daily or seen at start of	Pharmacy seeks to prioritise undertaking a full Medicines Reconciliation as soon as possible after admission and to see all patients at discharge.	Amber

Commented [PJ(NIPaC3]: Will/Chris can we review ventilation

		discharge summaries. • Prescriptions are screened to ensure compliance with Trust Antibiotic Policy and Stewardship, including choice, course length, and review periods. • Overall antibiotic usage is average see Fingertips Portal. High usage of WHO access group antibiotics due to longstanding antibiotic policy decisions which are reviewed regularly. • Monthly internal snapshot audits undertaken and fed back to care groups. • Antimicrobial Management Group (AMG) should meet every 2 months membership includes representatives from microbiology, pharmacy, nursing and clinicians from each care group.	course meaning possible delay in querying prescribing. E-Script program still in use and antibiotics are entered and recorded when seen by pharmacy staff and doctors undertaking discharge summaries, no electronic prescribing so some antibiotic prescriptions may be missed. All reviewed antibiotic prescriptions are checked against the antibiotic policy, where not in line they are queried with the medical team, course lengths and route are also queried. Regular AMG meetings have been difficult to hold and often not quorate due to lack of clinical representation.	Restriction of stock antibiotics on wards to guide prescribing. Antibiotics not stocked must be requested through a pharmacist and be reviewed against antibiotic policy/microbiologist recommendations. See Trust board sign off for Wave 3 of NHSE/I funding for EPMA system. This is a 2-3 year plan. Business case submitted on 15th September 2020 and approved by Trust however delayed until at least 2023 due to requirements from NHSE/I. Continue to seek engagement from clinicians to attend AMG from care groups.	
3.2	Previous antimicrobial history is	• During medicines reconciliation	No data on whether		Green

Commented [PJ(NIPaC4]: Rebecca can you review please

	considered	by pharmacy on admission previous antibiotic courses are noted but no policy currently in place for formalised review. • Multiple antibiotic courses whilst in hospital are queried by the pharmacy medicines management team.	prescribers review previous antibiotic treatment in all cases. Capacity and flow mean that pharmacy do not see all patients within 24hours of admission.		
3.3	The use of antimicrobials is managed and monitored: • To reduce inappropriate prescribing • To ensure patients with infections are treated promptly with correct antibiotic	• Medicines management pharmacy team review antibiotics prescribed on drug chart and query off guideline usage, long courses, intravenous to oral switch etc. • Interventions recorded in escript pharmacy program. • Wards have specific stock lists of antibiotics appropriate to their area. In addition all areas have either a sepsis box/drawer or trolley stocked with antibiotics required for the prompt treatment of sepsis.	Availability of electronic prescribing will assist in ability to monitor and query antimicrobial prescribing. Feedback at time if any issues identified in prescribing, followed up by ward pharmacy teams.	• See section 3.1	Green
3.4	Mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Monthly reports on antimicrobial spend sent out to care groups. • Monthly snapshot audit of antimicrobial prescribing undertaken by medicines management team. • Quarterly reporting to IPCOG and IPCAG.	Only generalised reports available currently due to lack of electronic prescribing.	• See section 3.1	Green
3.5	Risk assessments and mitigations are in	The Trust has a policy and procedure in			Green

	place to avoid unintended consequences from other pathogens	place for sharps/ splash incidents including a post-exposure protocol administered with Occupational Health service support. IPC policies addressing specific pathogens are 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					
Systems and process are in place to ensure:					
4.1	Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	Currently the Trust are reviewing opening visiting again. Currently this will be 1 visitor for 1 hour but this is being reviewed & should be in place in April 22			Amber
4.2	National guidance on visiting patients in a care setting is implemented https://www.england.nhs.uk/coronavirus/publication/visitor-guidance/	The Trust has adopted the national guidance and this is on the Trust public facing internet website.		End of life Care visiting line with national guidance. Visiting restrictions have been revised in Maternity, Neonatal unit, and paediatrics in line with national guidance. Managers are aware that there are times when discretion can be used when it is in the patient's best interests and they	Green

				may deteriorate without this contact. Another exception to this is when a young person is admitted to an adult ward, they can have a guardian present in line with paediatric guidance.	
4.3	Restrictive visiting may be considered appropriate during outbreaks within inpatient areas. This is an organisational decision following a risk assessment	As above 4.2			Green
4.4	There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing	Posters have been produced & are displayed in patient environment leaflettemplateA5covid copy.pdf Covid Aware Patient Hygiene.docx			Green
4.5	If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	Nurse in charge would inform visitor. There are also posters that have been produced & are displayed in patient environment leaflettemplateA5covid copy.pdf Covid Aware Patient Hygiene.docx			Green

Commented [PJ(NIPaC5]: Ruth can you update please

4.6	Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g. parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	SOP Compassionate Visit			Green
4.7	Visitors are not present during AGP's on infectious patients unless they are considered essential following a risk assessment e.g. carer/patient/guardian	A conversation with the Health and Safety Team will be required, a risk assessment undertaken and provision of a Hood may be required. During office hours it may be possible to fit test a visitor to an FFP3 depending on timescales and the Health and Safety Team can advise on availability of this service on request.			Green
4.8	Implementation of the supporting excellence in infection prevention and control behaviour implementation Toolkit has been considered https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/03/C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf	Use of toolkit raised with Trust silver command, currently being reviewed to identify appropriate lead for this.			Green
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					
Systems and process are in place to ensure:					

5.1	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival	All wards have appropriate signage to differentiate pathways			Green
5.2	Infection status of the patient is communicated to the receiving organisation, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred	All infection status information is included in any transfer information including COVID status. COVID 19 cases and contacts are flagged on the trust PAS and PSAG boards			Green
5.3	staff are aware of agreed template for triage questions to ask	The triage/navigator form asks the 3 key questions related to covid to allow appropriate immediate identification of the appropriate pathway for that patient			Green
5.4	Screening for COVID 19 is undertaken prior to attendance wherever possible to enable early recognition and clinically assess patients prior to any patient attending a healthcare environment.	The Emergency department have a SOP for admissions, which covers a process to risk assess all patients as they arrive in ED. ED have also introduced an ASK 5 audit to ensure that screening questions are asked during the booking in process and details entered to SEMA. Navigator flow chart for PRH.docx Navigator flow chart for RSH.docx SOP Management of potential Coronavirus			Green

		Samples from patients in both ED's have rapid tests performed.			
5.5	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID 19/other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	The triage/navigator form asks the 3 key questions related to covid to allow appropriate immediate identification of the appropriate pathway for that patient			Green
5.6	Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	Initial Assessment, Navigator and pit stop nurses are trained in Manchester triage ED also have Manchester triage train the trainer ED senior staff in both depts Screening questions also asked as part of the booking in process and are monitored via an ASK 5 audit. 100% compliance for both sites recorded since early Sept 2021			Green
5.7	There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Dashboard in place showing compliance with admission, Day 3, Day 5-7, day 13 and every 7th day afterwards swabs. Discharge testing is completed by ward 48 hours prior to discharge Offsite screening pathway in place for elective patient screening			Green
5.8	Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	All patients are given a Type llR mask. Staff encourage patients to wear facemasks, it this cannot be tolerated or patients refuse this is documented in the patients notes			Green
5.9	Patients with respiratory symptoms are	See Section 1: Emergency Department			Green

	assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	SOP (1.3).			
5.10	Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	See Section 1: Emergency Department SOP (1.3).			Green
5.11	Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered	Individuals who are clinically extremely vulnerable are prioritised for isolation as per Trust COVID policy (link below)	The Trust has a low number of side rooms, therefore in areas where a large number of patients are clinically extremely vulnerable they may need to be cohorted together (Oncology, Haematology and Renal)	Renal Ward has moved to an area with more side rooms. Oncology and Haematology have reduced their bed base to ensure 2 metre distancing is in place	Green
5.12	Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	Medical teams consider this			Green
5.13	Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance	Mediscreens and clear plastic curtains are in place on acute ward areas to provide a physical barrier between patients when 2 metre distancing cannot be achieved Screens have been purchased for outpatient administration areas where unable to maintain social distancing.	A QIA has been completed by the Trust relating to removal of beds to facilitate distancing, however this was deemed not possible and created further risk	Mediscreens and clear plastic curtains are in place on acute ward areas to provide a physical barrier between patients	Green
5.14	Patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas;	Mediscreens and clear plastic curtains are in place on acute ward areas to	A QIA has been completed by the	Mediscreens and clear plastic curtains	Green

	ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	provide a physical barrier between patients when 2 metre distancing cannot be achieved Screens have been purchased for outpatient administration areas where unable to maintain social distancing.	Trust relating to removal of beds to facilitate distancing, however this was deemed not possible and created further risk	are in place on acute ward areas to provide a physical barrier between patients	
5.15	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	The Trust policy advises actions to take when this happens. Please refer to Section 6.2 of Trust COVID policy (link at bottom of document).			Green
5.16	Isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative	• Patient is isolated or cohorted appropriately • Contact tracing is commenced upon positive result ○ This is done by IPC team who look back 48 hours following a positive result of bay contacts via the SQL			Green
5.17	Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Where possible routine appointments are being carried out over the telephone, when a patient must attend in person, information regarding COVID symptoms are included in their appointment letter.			Green
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					
Systems and process are in place to ensure:					
6.1	Appropriate infection prevention education is provided for staff, patients and visitors	All patient facing clinical and non-clinical staff have been trained to follow PHE guidance on PPE usage and have had donning and doffing training, there are			Green

		posters in all areas, and advice readily available on the Trust intranet. The compliance is recorded by corporate education see above			
6.2	Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning and doffing) PPE safely	All staff should have received training on hand hygiene, PPE usage relevant to their roles. Further training is provided as required.	There are some members of staff who have not accessed this training or have not recorded their compliance. The Heads of Nursing report that the specific COVID data provided by corporate education does not match the monthly mandatory training report.	Ward managers, Matrons are to ensure that staff have completed the required training. All managers have been contacted by the IPC team to ensure their staff have completed the training and that the details of staff who have completed training has been provided to the education department to ensure records are correct Corporate Education Department Manager is reviewing data for accuracy and to feedback to Divisions in relation to compliance.	Amber

				Local records being held by departments of staff trained, DivisionalCare Leads ensuring managers send this information to Corporate Education	
6.3	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 put it on and remove it	All staff should have been trained in the use of and donning and doffing of PPE. There are posters available for this and all staff should have access to the Trust intranet which also has this information accessible. http://intranet.sath.nhs.uk/coronavirus/ppevideos.asp Matrons audit PPE usage as part of their monthly audits	As above	As above Donning and doffing training has been provided by IPC Team and videos are available on the Trust intranet	Amber
6.4	Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	IPC Team undertake PPE audits as part of QWW for wards Matrons undertake audits on this via gather.			Green
6.5	Gloves are worn when exposure to blood and/or body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's	The Trust has a standard precautions policy for staff to follow Microsoft Word - 608001865_0786.doc (sath.nhs.uk)			Green
6.6	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent,	Hand dryers have been removed and replaced with paper towel dispensers			Green

Commented [PJ(NIPaC6]: Donna/Michelle/Julie/Ann marie/Nicci do you have any updates?

	disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance				
6.7	Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	The Trust policy advises actions (see link at bottom of document). This is addressed in covid-secure risk assessments.			Green
6.8	Staff understand the requirements for uniform laundering where this is not provided on site	All staff are asked change into their uniform at work. There is no provision for uniform to be laundered on site, and scrubs only are sent to an off-site laundary. Uniforms should be transported home in a disposable plastic bag, which can then be washed separately from other linen in a half load then iron or tumble dry for at least thirty minutes. http://intranet.sath.nhs.uk/document_library/viewPDFDocument.asp?DocumentID=10065			Green
6.9	All staff understand the symptoms of COVID 19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance	If staff are symptomatic, they are to contact their manager and access a test via the government route keeping their manager informed of any updates at all times Staff who need to self-isolate due to contact with a positive case report to their manager who will record this on Health roster and this is monitored by workforce			Green

6.10	To monitor compliance and reporting for asymptomatic staff testing	There is a mechanism in place for staff to report their Lateral Flow test results and we ask staff to report at lerast twice weekly. This via a web based portal which we monitor and provde daily report to managers.			Green
6.11	There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patient/individuals)	Every positive COVID result is reviewed daily and all cases are assigned a category based on PHE guidance. System wide groups monitor and discuss community situation with regards to prevalence and also have a dashboard that reflects the local data			Green
6.12	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	All patients who are positive on day 8 or after will trigger an RCA Two or more cases linked by time and place trigger an outbreak & are investigated with the involvement of NHSEI and PHE.			Green
7. Provide or secure adequate isolation facilities					
Systems and process are in place to ensure:					
7.1	That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) provided it can be tolerated and is not detrimental to their (physical or mental) care needs.	Staff encourage patients to wear facemasks, it this cannot be tolerated or patients refuse this is documented in the patients notes			Green
7.2	Separation in space and /or time is maintained between patients with and	Mediscreens and clear plastic curtains are in place on acute ward areas to	A QIA has been completed by the	Mediscreens and clear plastic curtains	Green

	without suspected respiratory infection by appointment or clinical scheduling to reduce waiting times in reception areas and avoid mixing or infectious and non-infectious patients	provide a physical barrier between patients when 2 metre distancing cannot be achieved Screens have been purchased for outpatient administration areas where unable to maintain social distancing.	Trust relating to removal of beds to facilitate distancing, however this was deemed not possible and created further risk	are in place on acute ward areas to provide a physical barrier between patients	
7.3	Patients who are known or suspected to be positive with a respiratory pathogen including COVID 19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Any patients who are tested positive are isolated in side rooms. Patient placement is based on previous PHE high/medium/low risk pathways. Patients who fall into the high risk pathway are either isolated or cohorted appropriately. Patients who fall into the medium risk pathway are COVID swabbed as per guidelines and placed according to pathway. Low risk patients are mainly elective surgical who have ring-fenced wards/beds.		If positive patients cannot be isolated in a side room, then they will be cohorted in a bay of positive patients	Green
7.4	Patients are appropriately placed i.e. infectious patients in isolation or cohorts	All patients with alert/resistant organisms are managed as per normal Trust policy. The Trust also have an isolation risk assessment tool that is available to all staff http://intranet.sath.nhs.uk/Library_Intranet/documents/infection_control/Ward_guidance_folder/isolation on admission tools poster.pdf			Green
7.5	Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs	Mediscreens and clear plastic curtains are in place on acute ward areas to provide a physical barrier between patients when 2 metre distancing	A QIA has been completed by the Trust relating to removal of beds to	Mediscreens and clear plastic curtains are in place on acute ward areas to	Green

	(dependant on clinical care requirements).	cannot be achieved Screens have been purchased for outpatient administration areas where unable to maintain social distancing.	facilitate distancing, however this was deemed not possible and created further risk	provide a physical barrier between patients	
7.6	Standard infection control precautions (SIPC's) are used at point of care for patients who have been screening, triaged, and tested and have a negative result	Any patients who are tested positive are isolated in side rooms. Patient placement is based on previous PHE high/medium/low risk pathways. Patients who fall into the high risk pathway are either isolated or cohorted appropriately. Patients who fall into the medium risk pathway are COVID swabbed as per guidelines and placed according to pathway. Low risk patients are mainly elective surgical who have ring-fenced wards/beds.		If positive patients cannot be isolated in a side room, then they will be cohorted in a bay of positive patients	Green
7.7	The principles of SICP's and TBP's continued to be applied when caring for the deceased	See 7.6.3 Seasonal Respiratory Infections (including COVID-19 and Influenza)			Green
8. Secure adequate access to laboratory support as appropriate					
Systems and process are in place to ensure:					
8.1	Testing is undertaken by competent and trained individuals	• The laboratory at SaTH is UKAS accredited • All staff are HCPC registered • Quality assurance training and competence assessments are all in place.			Green
8.2	Patient testing for all respiratory viruses testing is undertaken promptly and in line	Patient testing is in place in (for COVID, Influenza and RSV) in accordance with			Green

	with national guidance	National and PHE guidance for all admissions, inpatients at day 3, 5-7 & 13, and for patients who are discharged to a care setting. In addition to this any patients with new symptoms are tested immediately.			
8.3	Staff testing protocols are in place	If staff are symptomatic, they are to contact their manager and access a test via the government route keeping their manager informed of any updates at all times			Green
8.4	There is regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Reported daily on PLACERS data return			Green
8.5	regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	Cases are reported electronically twice daily via SGSS and there is a daily sitrep (PLACERS) for all positive reported cases			Green
8.6	Screening for other potential infections takes place	All screening for other organisms usually monitored continue to be performed in the as per guidelines			Green
8.7	That all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	Patient testing is in place in accordance with National and PHE guidance for all admissions, inpatients at day 3, 5-7 & 13, and for patients who are discharged to a care setting. In addition to this any patients with new symptoms are tested immediately.			Green
8.8	That those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.	Wards are aware of the requirement to swab for new onset of symptoms, and the request forms have the option to select new onset symptoms. See link to current Trust policy at bottom of			Green

		document			
8.9	That emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission.	SQL report set up to inform Ward Managers when days 3, 5 & 13 COVID screens are due, and dashboard in place to show compliance by ward area			Green
8.10	That sites with high nosocomial rates should consider testing COVID negative patients daily.	When outbreaks have been identified, additional testing is implemented. This is done for patients on alternate days.	Depending on lab capacity and staffing, we may not be able to test all negative patients daily	Test all contacts daily during high activity to ensure timely isolation/cohorting. Consider testing wards on alternate days if transmission high and unable to test all. Or test high risk wards only	Green
8.11	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	All wards are aware of the requirement to test as per policy (see link at bottom of document)			Green
8.12	Those patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting (link below), where they should complete their remaining isolation as per national guidance. https://www.gov.uk/government/publications/designated-settings-for-people-discharged-to-a-care-home/discharge-into-care-homes-designated-settings	Following PHE and regional guidance on discharging patients who have tested positive for Covid 19 to the community. All patients will be given appropriate advice when they are discharged. Many patients will no longer be infectious by this time. Patients who are being discharged to nursing homes are only discharged if they are no longer infectious unless the nursing home is able to isolate patients with Covid and			Green

		has agreed to take the patient			
8.13	There is an assessment for the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of a case suspected/confirmed case of COVID 19 within the last 10 days. Instead these patients can take a lateral flow test (LFT)	All elective surgery patients are tested 3 days prior to admission & are ask to comply with self-isolation. Unless paediatric as per guidance via NICE. Trust have reviewed the process for COVID screening for elective lower GI scopes, in line with other Trusts in the region SaTH no longer screen these cases to facilitate restoration of services. The only other exception is for local anaesthetics and patients that need to backfill due to late cancellations, these can be tested via LFT with agreement of clinician			Green
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections					
Systems and process are in place to ensure:					
9.1	The application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	The IPC team monitor daily alerts and ensure staff follow the appropriate policy, this includes phone calls and daily ward visits which monitor this. This is also reported to Trust IPCOG committee, via Divisional reports and IPC team QWW reports.			Green
9.2	Staff are supported in adhering to all IPC policies, including those for other alert organisms.	The IPC team monitor daily alerts and ensure staff follow the appropriate policy, this includes phone calls and daily ward visits which monitor this.			Green

		This is also reported to Trust IPCOG committee, via Divisional reports and IPC team QWW reports.			
9.3	Safe spaces or staff break areas/changing facilities are provided	Welfare arrangements are compromised by space constraints. Mitigations (maximum occupancy posters, staggered breaktimes, provision of external seating areas etc.) are addressed in covid-secure risk assessments.	The Trust has insufficient changing facilities which comply fully with the Workplace (Health, Safety and Welfare) Regulations 1992, as identified via H&S audit.	Issue considered by Health, Safety, Security and Fire Committee January 2022, discussed at Silver and for SLC-O consideration of potential solutions including mobile changing units next.	Amber
9.4	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak	The IPC team monitor daily alerts and ensure staff follow the appropriate policy, this includes phone calls and daily ward visits which monitor this. This is also reported to Trust IPCOG committee, via Divisional reports and IPC team QWW reports. The Trust also has a policy for the management of outbreaks which includes the documented recording of an outbreak.			Green
9.5	All clinical waste related and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	All clinical waste and linen/laundry is handled, stored, managed & disposed of as per national guidance. See section 7.9 & 7.10 of SaTH COVID Policy linked at bottom of document. Management, storage and disposal of			Green

		linen in also reference in Linen Policy CS02 https://intranet.sath.nhs.uk/infection_control/Infection_control_policies_and_related_information.asp			
9.6	PPE stock is appropriately stored and accessible to staff who require it	The stock of PPE is continually monitored and the Trust send a daily PPE submission to the Regional West Midlands COVID. Procurement are available from 7.30am until 11pm Monday to Friday. Saturday and Sunday 7.30am until 1pm from 11.30pm-7.30am daily there is a stores and procurement person on call to allow staff to contact if required. SaTH are also part of the LHRP PPE Task and Finish group.			Green
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection					
Appropriate systems and process are in place to ensure:					
10.1	Staff seek advice when required from their local IPCT/occupational health department/GP or employer as per their local policy	Staff can seek advice from our occupational hrealth as per Human Resources Policy No. HR65			Green
10.2	Bank, agency and locum staff follow the same deployment advice as permanent staff.	All staff including bank and agency are provided the same advice.			Green
10.3	Staff who are fully vaccinated against COVID 19 and are a close contact of a case of COVID 19 are enabled to return to work without the need to self-isolate (see	Staff need to have had a PCR & completed a risk assessment. This risk assessment is reviewed by the Trust DMG & a decision is made if the			Green

		member of staff can return to work			
10.4	Staff understand and are adequately trained in safe systems of working, including donning and doffing of PPE	During the course of the fit test staff are trained to don the respirator correctly, and to perform a fit check specific to the valved/ unvalved type of respirator they are fitted to. Practice in the fit testing open sessions conforms to HSE guidance on reducing the risk of transmitting coronavirus during the fit test, and this information was cascaded out to Divisional fit testers for local implementation on 25 March 2020 and 6 April 2020, via email and is addressed in in-house refresher training sessions. The PHE videos covering donning and doffing of PPE, including FFP3s, have been promoted via the Trust intranet and via sessions held in the Education Centre lecture theatres. Training records relating to those videos are held on ESR, and a report is available on request from Tom George, Corporate Education.			Green
10.5	A fit testing programme is in place for those who may need to wear respiratory protection	An RPE fit testing service is currently available office hours on most weekdays at RSH and PRH. This is staffed by fit testers trained in qualitative and quantitative methods by a Fit2Fit accredited training provider, Fire Safe International of Atcham. Outcomes are			Green

		recorded on staff ESR records and summary reports published at SaTH Intranet - FFP3 Mask Fit Testing.			
10.6	Where there has been a breach in infection control procedures, staff are reviewed by occupational health who will: • Lead on the implementation of systems to monitor for illness and absence • Facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce • Lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID 19 • Encourage staff vaccine uptake	Occupational Health not provide anti-viral treatment and have no facilities to do so. However do implement vaccination programmes, excluding covid-19. Staff will be reviewed by OH if they are referred, or contacted by IPCC to become involved in a breach, for example a TB exposure. Occupational health support delivery of Flu programme each and help encourage vaccine uptake.	Occupational health do not currently provide anti-viral treatment	As part of reviewing future service provision requirements this will be considered in service specification going forward.	Amber
10.7	Staff who have had and recovered from or have received vaccination for a respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	All patient facing clinical and non-clinical staff have been trained to follow PHE guidance on PPE usage and have had donning and doffing training, there are posters in all areas, and advice readily available on the Trust intranet. The compliance is recorded by corporate education see above			Green
10.8	A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza	Staff are risk assessed by managers and appropriate mitigation taken including remote working / working away from high risk areas.			Green

	and severe illness from COVID 19 • A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups • That advice is available to all health and social care staff, including specific advice to those at risk of complications • Bank, agency and locum staff who fall into these categories should follow the same deployment advice as permanent staff • A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff	Staff in at risk groups have been prioritised for remote working. A range of support activities have been put in place for staff during this time including: • Comprehensive FAQs for staff • Staff App – Regularly updated with guidance • Team Prevent – Managers Advice Line (Occupational Health) • Employee Assistance Programme • HR Advice and Support - Extended Hours Support for COVID-19 • SaTH Trained Listeners - Hotline Coaching hotline • A free wellbeing support helpline • Peer-to-Peer Listening • Coaching and listening ear support lines available • Redeployment Coaching Support • Wellbeing Hubs • Headspace - Free subscription • Trust Coaches • Freedom to Speak Up Guardians • Accommodation for Staff in Critical Service Roles Staff are being risk assessed taking into consideration the health, age, ethnicity and gender. Risk assessment process in place with support also available via occupational			

		health (as required). Documents available on intranet and SaTH app.			
10.9	Vaccination and testing policies are in place as advised by occupational health/public health	Occupational Health have an immunisation policy in line with PHE/DOH.			Green
10.10	Staff required to wear FFP reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records	Staff are fit-tested to FFP3s, in accordance with HSE guidance on tight-fitting RPE. The Trust uses both qualitative and quantitative (ambient particle counting) methods. During the course of the fit test staff are trained to don the respirator correctly, and to perform a fit check specific to the valved/ unvalved type of respirator they are fitted to. This is recorded on the fit test report form which is scanned and held electronically by the H&S Team, and the original hard copy form is returned to the employing department for filing on personal files. The outcome of each fit test is recorded in ESR and a summary report published at SaTH Intranet - FFP3 Mask Fit Testing. The PHE videos covering donning and doffing of PPE, including FFP3s, have been promoted via the Trust intranet and via sessions held in the Education Centre lecture theatres. Training records relating to those videos are held on ESR, and a report is available on			Green

		request from Tom George, Corporate Education.			
10.11	staff who carry out fit test training are trained and competent to do so	The majority of RPE fit testers have been trained by a Fit to Fit accredited external trainer. A smaller number were trained in-house by a member of the H&S Team. A list of current, trained fit testers is maintained at https://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp and this was last updated on 29 March 21 and remains correct. This includes dates of in-house refresher training and competency assessments.			Green
10.12	all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Fit tests are undertaken for every make and model of FFP3/ reusable respirator issued to staff. The H&S Team work closely with Procurement colleagues to coordinate fit testing provision with stock changeovers. A weekly report on fit testing outcomes is escalated to the Incident Command Centre.			Green
10.13	All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	All staff are requested to come forward to be fit tested to two, ideally three FFP3s as a contingency plan in case of stock shortages. Progress is reported to HSSFC, IPCOG, IPCAC and the Incident Command Centre.			Green
10.14	a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	Records of fit tests are recorded on each staff member's ESR record, and a report on current fit test data by	A copy of the fit test record is not given to the staff member at	Staff are encouraged to access the fit testing report on the	Green

		individual is produced by Corporate Education weekly and published at https://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp. The original fit test records are scanned for H&S Team files, then returned to the employing ward department to be held on personal files. Staff are not given a copy of the fit test record at the time of the fit test, but are given a sticker with the makes/ model they do and do not fit to, and encouraged to make a note/ take a photograph of the FFP3 they fit to in order to foster familiarity, and are informed that their name will be published on the intranet within a week for future reference.	the time of the fit test, but a sticker summarising fits and fails to specific makes and models is provided for immediate reference pending update of records at SaTH Intranet - FFP3 Mask Fit Testing.	intranet to look up their own records. The H&S Team support staff and managers who ask for help to do so.	
10.15	those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods	Records of failed fit tests are managed in the same way as records of successful fit tests, as described above.			Green
10.16	That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions	Staff who cannot wear an FFP3 in stock have access to loose-fitting RPE and, in Critical Care areas, reusable tight-fitting RPE. SOPs for decontamination of hoods and reusable respirators are published at SaTH Intranet - PPE.			Green
10.17	Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and	Staff who cannot wear any of the alternatives to FFP3s are assigned to suitable duties by their own line			Green

	options commensurate with the staff members skills and in line with nationally agreed algorithm	managers, with HR support. If staff still cannot tolerate a hood, they are recalled to be retested if new masks are introduced. Further options are then explored, if staff still cannot be fitted, they are referred to Occupational Health who will keep a record on the member of staffs personal file and their line manager will also receive this information. Please see national supporting document below: supporting-fit-testing-steps-actions-to-be-undertaken-use-of-ffp3-masks.pdf (england.nhs.uk)			
10.18	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	If staff still cannot be fitted, they are referred to Occupational Health who will keep a record on the member of staffs personal file and their line manager will also receive this information.	A copy of the fit test record is not given to the staff member at the time of the fit test.	Staff are encouraged to access the fit testing report on the intranet to look up their own records.	Green
10.19	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 syst4em should include a centrally held record of results which is regularly reviewed by the board.	Results are published at https://intranet.sath.nhs.uk/health/FFP3_Mask_Fit_Testing.asp. A report on fit testing outcomes is presented to the IPC Operational Group and the IPC Assurance Committee, and also to the quarterly Health, Safety, Security and Fire Committee.			Green
10.20	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	**Medicine and Emergency Divisions** – due to the current vacancies and the staff sickness this can be challenging. This is kept to a minimum where possible.	There is still some movement of staff between areas to ensure safe provision of staffing due to gaps	Matrons are responsible for ensuring daily staffing plans are in place which mitigate the movement of	Amber

		Surgery Division –there is some movement of staff to cover sickness/gaps in rosters, however this is kept to a minimum. The elective ward is protected. **Women's and Children's Division** – Paediatrics and Neonates allocate staff between Covid /Non Covid/symptomatic areas. Gynae – there are only 2 RN's on shift, so can be a challenge where joint RN input is required. Allocation of 1RN/1HCA where possible is the aim with the least interaction as possible. **Maternity** – this area is challenging as there are women on the planned and unplanned pathways in the same areas and staff will be caring both groups of patients. There is a dedicated team running the planned Caesarean Section list		staff between areas but maintain safety and that these are communicated to the Clinical Site Team out for out of hours. Monthly staffing report provided to Workforce assurance committee Clinical staff are trained in the appropriate donning and doffing techniques to reduce the risk of contaminating oneself Staff are required to complete a Datix report if looking after both COVID positive and negative patients during the same shift	
10.21	Health and care settings are COVID 19 secure workplaces as far as practical, that is, that any workplace risks(s) are mitigated maximally for everyone	Covid-secure guidance, including templates for risk assessments, was produced by the H&S Team and is published at			Green

Commented [PJ(NIPaC7]: Donna/Michelle/Julie/Anne Marie/Nicci can you update please

		https://intranet.sath.nhs.uk/coronavirus/waysofworking.asp. A list of completed and missing risk assessments is maintained at the same page, and updated frequently. Completed covid-secure risk assessments are published at the same page. From time to time physical inspections of covid-secure areas are undertaken by the H&S Team and reported via the Health, Safety, Security and Fire Committee.			
10.22	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	If staff are symptomatic, they are to contact their manager and access a test via the government route keeping their manager informed of any updates at all times. Occupational Health also complete a well-being check on those staff self-isolating due to a positive result. Staff who need to self-isolate due to contact with a positive case report to their manager who will record this on Health roster and this is monitored by workforce			Green
10.23	Staff who test positive have adequate information and support to aid their recovery and return to work	The feedback of results is provided via our system occupational health team. The information on results and advice is provided to staff via qualified occupational health professionals that can provide support and advice to aid recovery.			Green

		Staff only return to work when fully fit and do so as part of the return to work process. This includes a return to work discussion with their manager and completion of return to work assessment. This details any known risks underlying health conditions any adjustments that need to be made and referral to occupational health if required.			

SaTH COVID Policy Link: http://intranet.sath.nhs.uk/coronavirus/ipc.asp

RAG	Total Number
	118
	12
	0