East of England Ambulance Service NHS Trust

Infection Prevention and Control Audit Policy

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Document Status:	Approved
Version:	V5.0

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
Code of Practice	September 2010	Infection Control Specialist Clinical Quality Manager
Version	**Date**	**Comments (i.e., viewed, or reviewed, amended approved by person or committee)**
Final V1.0	March 2011	Approved
Final V2.0	June 2015	Approved at EMB

Version	Date	Comments (i.e., viewed, or reviewed, amended approved by person or committee)
Draft V2.1	November 2017	Approved by IPCG Chair's action
Draft V2.2	December 2017	Approved by CQSG subject to formatting with new corporate template
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Final V3.0	23 September 2019	Approved at MAG
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Final V4.0	September 2021	Approved at CRG
Draft V4.1	August 2022	Approved at IPCG
Final V5.0	September 2022	Approved at CRG

Document Reference	Relevant Trust objective: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (Code of Practice for the Prevention and Control of Healthcare Associated Infections 2015) Directorate: Clinical Quality
Recommended at **Date**	IPC Group August 2022
Approved at **Date**	Compliance and Risk Group 12 September 2022
Valid Until Date	September 2024
Equality Analysis	Completed
Linked procedural documents	Management of Infection Prevention and Control Policy Safe Practice Guidelines CSOPs, SOPs, CIs: currently under review to be updated when review complete
Dissemination requirements	All staff via intranet and within the IPC Manual Public – via Trust website
Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination based on spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

Contents

1 Introduction

"Good infection prevention and control are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone.

Good management and organisational processes are crucial to make sure that high standards of infection prevention and control are set up and maintained"

Code of Practice (2015)

2 Purpose

The purpose of the East of England Ambulance NHS Trust's (EEAST) Infection Control Audit Policy, is to state the Trust's audit systems and processes in compliance with criterion 1.5 of the Code of Practice for the prevention and control of infections and related guidance (2015). This policy sets out the audit schedule including: accountability, timescales, reporting mechanisms, review and feedback processes.

This will be achieved by defining:

- The standards to be achieved
- Clear and measurable outcomes
- Allocation of responsibility
- Audit schedules and frequencies
- Reporting requirements
- Analysis of data
- Identification of lessons learned
- Feedback process to staff and Trust groups, committees and externally as required

3 Duties

The East of England Ambulance Service NHS Trust is the 'responsible body' and must make arrangements for ensuring compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and associated Code of Practice (2015). The IPC reporting structure is illustrated in Appendix A and the IPC team structure is illustrated in Appendix B.

3.1 Trust Board

The East of England Ambulance Service NHS Trust is the 'responsible body' and must make arrangements for ensuring compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and associated Code of Practice (2015).

As part of this process, the Trust Board will receive monthly information in regard to Infection Prevention and Control (IPC) audit outcomes in the form of the monthly quality report.

3.2 Chief Executive Officer

The Chief Executive is the 'responsible person' and has overall responsibility for the implementation of the Trust's Infection Prevention and Control Policy. The functions of the 'responsible' person may be performed by any person authorised by the 'responsible person' to act on their behalf. This responsibility has been devolved to the Director of Nursing, Clinical Quality and Improvement in their role as Director of Infection Prevention and Control (DIPC).

3.3 Director of Infection Prevention and Control (DIPC)

The DIPC is accountable directly to the Chief Executive Officer (CEO) and to the Trust Board for IPC activities.

The DIPC is responsible for: -

- Ensuring compliance with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Cleanliness and Infection Control) as defined in the Code of Practice for the prevention and control of infections and related guidance (2015).

- Ensuring an Annual IPC Programme is in place to address all aspects of the Code for compliance purposes
- Providing reports to the Quality Governance Committee on compliance with the Annual IPC Programme
- Chairing the Infection Prevention and Control Group which oversees all activities outlined in the Annual IPC Programme
- Co-ordinating the activities of the IPC Team and associated specialists
- Advising the Trust Board on key risks relating to Infection Prevention and Control and Decontamination
- Presenting an annual report to the Board
- Ensuring that information is available to patients and the public about the organisation's general processes and arrangements for preventing and controlling healthcare acquired infections. Ensuring the IPC Annual Report is publicly available
- Ensuring that the Trust has access to suitably qualified infection prevention and control specialist advisors when needed

3.4 Quality Governance Committee

The Trust's Quality Governance Committee will report to the Trust Board on the operation of the

Trust's Infection Prevention Control Audit Policy. The Committee will consider regular reports provided by the Infection Prevention and Control Group (IPCG) and make recommendations to the Trust Board as appropriate. The DIPC is also a member of the Quality Governance Committee.

3.5 Compliance and Risk Group (CRG)

The Trust's CRG provides appropriate levels of assurance to the Quality Governance Committee that risks relating to IPC have been identified, monitored and mitigated.

3.6 Infection Prevention and Control Group (IPCG)

The Infection Prevention and Control Group (IPCG) provide the DIPC and Executive Leadership Board (ELB) with advice and guidance whilst acting as a working group of the Compliance and Risk Group (CRG). Its membership comprises senior Trust personnel with expertise and knowledge of infection prevention and control relevant to their role and responsibilities. Its Terms of Reference provide it with accountability and responsibility for the implementation of all Trust activity in relation to infection prevention and control and for providing assurance to the Trust Board in relation to compliance with the Code of Practice (2015).

3.7 Head of Infection Prevention and Control

The Head of IPC is a member of the IPCG and is responsible for the development and management of the IPC audit programme reporting on audit outcomes to:

- IPCG
- CRG
- Management – Emergency and Primary Care Operations, Clinical Quality
- Trust Board via the IPC Monthly Reports
- Reviewing the IPC Audit tools and schedule annually (or earlier if required to meet changes in national guidelines)

3.8 Managers (Operational and Clinical)

Managers in all areas of the Trust are responsible for ensuring implementation of this policy and its associated audit programme by:

- Undertaking audits within their areas of responsibility as per the audit schedule (appendix A).
- Ensuring that all data collected is submitted online via the appropriate tools according to defined timescales, as defined in the audit schedule.

- Ensuring that feedback communication from the Clinical Quality department is disseminated to all staff.
- Taking remedial actions to improve patient and staff safety where areas of concern are highlighted through the audit.

3.9 All Staff

All staff are expected to understand their role and responsibilities for IPC audit, familiarise themselves with audit feedback and adopt any changes to practice evolving from learning outcomes.

3.10 Consultation and Communications with Stakeholders

Key Stakeholders are represented on the Trust Infection Prevention and Control Group which will review and approve the policy and are included within the audit tools and schedule review.

4 Definitions

4.1 The Trust

East of England Ambulance Service NHS Trust

4.2 The Policy

The Trust's Infection Prevention and Control Audit Policy

4.3 Staff

Includes all Trust staff, including volunteers working on behalf of the Trust

4.4 Station

Any operational base which is equipped with a medical consumables store, linen store and / or a dirty utility room

4.5 Response Post

Any operational base which does not have a medical consumables store, linen store and / or a dirty utility room

5 Development

5.1Prioritisation of Work

This policy is essential to ensure the monitoring of compliance with the Trust's Infection

Prevention and Control systems, procedures and practices as defined by *Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010* and implemented by the *Code of for the prevention and control of infections in health and social care and related guidance (Practice 2015).*

5.2 Identification of Stakeholders

The key stakeholders include the Clinical Commissioning Groups, Health Protection England, Health watch and patients.

5.3 Responsibility for Document's Development

The policy was reviewed by the Head of Infection Prevention and Control in conjunction with the Infection Prevention and Control Group.

6 Infection Prevention and Control Audit Policy

The Infection Prevention and Control audit policy sets out the IPC audit requirements, to ensure compliance with the Trusts infection prevention and control procedures and practices as set out in the Trusts Infection Prevention and Control Safe Practice Guidelines.

6.1Levels of IPC Audits

The audit programme has been devised considering:

- National guidance e.g. National Patient Safety Agency (NPSA) Cleaning Standards
- Locally agreed priorities based on identified risks e.g. station spot checks

Levels of audit include:

Technical Level: such audit activity will be carried out by a range of staff as part of the day-today supervision of service delivery. Staff

should have detailed knowledge of the process and should be competent to judge what is acceptable in terms of IPC and cleanliness. Audits at this level will be undertaken frequently and reported regularly in accordance with the Trust's IPC Audit Schedule (Appendix A).

Managerial Level: such activity will be carried out by senior Trust management and IPC team. Such managers should have detailed knowledge of the process and should be competent to judge what is acceptable in terms of IPC and cleanliness. Audits at this level will be undertaken throughout the year to provide comparative data and to act as a control measure against Technical Level audits.

External audits and assessments: such activity will be carried out by commissioners of services, patient representatives (Community Engagement Group), Non-Executive Directors and external bodies e.g. NHSI, CQC. The Trust also commissions independent audits on an annual basis, to determine adequacy of Trust controls. Audits at this level will be undertaken throughout the year to provide comparative data and to act as a control measure against Technical and Managerial Level audits.

6.2 Audit Tools

All audits are submitted and monitored electronically via specialist audit software, which generates automatic alerts and actions for local management and Trust wide review.

6.2.1 Vehicle Cleanliness

This audit tool is based on 'The national specifications for cleanliness in the NHS – ambulance' (NPSA 2009) and has been modified to accommodate all types of patient attending vehicles not just emergency ambulances.

6.2.2 Ambulance Station (Housekeeping)

This locally devised audit tool enables the Trust to capture data reflecting day to day housekeeping standards in clinical areas of Operational stations.

6.2.3 IPC Practice

Based on national best practice guidance, this audit tool enables the Trust to capture data reflecting the staff understanding of the principles of IPC and application of IPC practice at the point of care.

6.2.4 Uniform Compliance – Spot Check

Based on the Trust Uniform Policy and incorporating the NHS "Bare below the elbows" best practice guidelines. These audits can be performed at any point during the shift including during observation of clinical practice.

6.2.5 Quality Assurance (QA) 10

This locally devised audit tool has been designed to provide an observational audit of core IPC clinical practice and encompasses;

- vehicle and personal issue equipment,
- decontamination of reusable patient contact equipment (e.g. trolley, stethoscope etc.),
- compliance with standard infection control precautions
- insertion of peripheral intravenous devices

6.2.6 Observational Audits

This audit tool has been designed to provide an observational audit of core IPC practice, generally to be conducted by the IPC team at A&E departments, and encompasses;

- PPE being worn by staff members
- decontamination of the vehicle and reusable patient contact equipment (e.g. trolley, stethoscope etc.),
- compliance with standard infection control precautions

6.2.7 COVID-19 Working safely audits (As required during pandemic and/or outbreak response)

The audit programme has been devised taking into account:

This locally devised audit tool has been designed to provide assurance that premises and staff are compliant with advised IPC related working safely precautions, which includes

- Conducting risk assessments
- Working from home
- Furniture adjustments

- Social distancing
- Decontamination
- Barriers and screening
- One-way systems
- Reducing staff contacts
- Track and Trace
- Ventilation
- Personal Protective equipment (wearing masks in Trust premises)
- Routine checks by managers
- Measures that are introduced throughout emerging situations

Details of all audits including:

- Type
- Frequency
- Responsibilities
- Feedback

Are defined within the audit schedule (Appendix A).

6.2.8 IPC Audit Action Plans

Action plans and exception reports are automatically generated through the Trust online audit software; these require updating by the local management teams for review within the operational delivery group meetings and IPC group meeting.

6.3 Audit Schedule

Details of the level, frequency, responsibilities, and feedback can be found in the Audit Schedule in Appendix A.

7 Equality Impact Assessment

The Equality Impact Assessment Executive Summary can be found in Appendix D.

8 Dissemination and Implementation

8.1Dissemination

The policy will be available electronically on the Trust Intranet site EAST 24. Printed copies will be placed in the Infection Prevention and Control Manual which is available on stations. Staff will be informed of the revisions to the policy via Trust bulletins and emails.

8.2 Implementation

The Audit policy has been successfully implemented across all areas of the Trust since 2009.

9 Process for Monitoring Compliance and Effectiveness

It is the responsibility of the Infection Prevention and Control Team to monitor compliance with this policy, results of which will be reported locally and externally in line with the duties outlined in Appendix C.

10 Standards/Key Performance Indicators

The key standards against which IPC performance is measured are: The Health and Social Care Act 2008 *Code of Practice for the prevention and control of infections and related guidance (2015).* National patient Safety Agency National Specifications for Cleanliness in the NHS: Ambulance Trusts 2009 and NICE Infection Prevention and Control of health care associated infections in primary and community care (2014)

Key performance indicators for IPC are station and vehicle cleanliness, hand hygiene and uniform compliance. These are monitored via monthly technical audits and regular managerial and external audits plus completion of QA10 assessments for operational staff. The results are reported to the IPCG and CRG and reported in the quarterly Clinical Quality Report and IPC annual report.

In line with the Trust's Resource Escalation Action Plan (REAP) considerations will be given to reducing the audit requirements during episodes of sustained increased REAP levels. This will be reviewed by the DIPC, Head of IPC and Chief Operating Officer

11 References

Health and Social Care Act 2008 Code of practice for the prevention and control of infection and related guidance (2015)

NICE Infection Prevention and Control of Health Care Associated Infection in Primary and Community Care (2014)

12 Associated Documents

This policy should be read in conjunction with the below documents:

- Infection Prevention and Control Management policy
- IPC Audit tools
    - Vehicle cleanliness audit form
    - Ambulance station audit form
    - QA10 audit form
    - IPC Practice audit form
    - Uniform compliance audit form
    - IPC Observational audit form
    - COVID Secure audit form
    - IPC audit action plan
- Station audit rationale
- Decontamination manual
- Ambulance Trust COVID Working Safely Guidance

13 Policy Review

This policy will be reviewed bi-annually or sooner if prompted by the release of any further guidance from statutory bodies.

Appendices

A Audit Schedule

B Checklist

C Monitoring Table

D Equality Impact Assessment Executive Summary

Appendix A: Audit Schedule

Audit Criteria		Audit Level	Audit Form	Submission Method	Trust Standard (Per AGM/ management area)	Report
Vehicle Cleanliness	All marked up vehicles (Emergency DSA & RRV)	Technical Managerial External	Vehicle Compliance Audit Form Online audit system bases questions on designated vehicle type	On-line - EAST24 (IPC Section)	85% of vehicles will be audited each month. Every Operational vehicle must be audited at least once per quarter. Average cleanliness	Monthly IPC Performance Summary (Trust Dashboard) to Board Individual station and locality feedback to local management teams- Monthly Audit Update Individual station and locality
	HART- Only USAR, RRV & DSA	Technical Managerial External				

	All vehicles- PTS (Scheduled Transport)	Technical Managerial External			target is 95% which is defined locally and exceeds the national guidance of 85%. Any audit which fails to achieve 85% cleanliness will produce an email and action plan to	feedback to local management teams- Monthly Audit Update & Posters . Feedback to DIPC via IPCG and CRG. Sector feedback to local management teams at locality meetings.

Audit Criteria		Audit Level	Audit Form	Submission Method	Trust Standard (Per AGM/ management area)	Report
					local management which will require an explanation of resolution.	
	Operational ambulance stations, HART facilities	Technical Managerial	Ambulance Station Compliance audit Form	On-line - EAST24 (IPC Section)	Each premise is to be audited monthly by	Monthly IPC Performance summary (Trust Dashboard) to Board

Estates

Audit Criteria		Audit Level	Audit Form	Submission Method	Trust Standard (Per AGM/ management area)	Report
	and depots (not including response posts / stand by points)	External Community Engagement Group	Additional working safely audits as required during pandemic/outbreak management		area management. Frequency of additional premise auditing during outbreaks determined on risk assessment	Individual station and locality feedback to local management teams- Monthly Audit Update. Local management teams at locality meetings.

Staff	Clinical staff (all staff groups)	Technical Managerial	QA10, HALO observational audits	On-line - EAST24 (IPC Section) Community Engagement Group CCG auditors	All clinical staff ECO, PTS & HART receive at least one per year. 10% of staff per month	Monthly IPC Performance summary (Trust Dashboard) to Board Individual station and locality feedback to local management teams- Monthly Audit Update. Sector feedback to local management teams at locality meetings by request
	ECO & HART Clinical staff measured against the uniform policy	Technical Managerial	Uniform Compliance		30 staff per AGM area audited for uniform compliance	
		External			Observational audits to be undertaken at each receiving unit frequency determined by external bodies	Quarterly within the Monthly Audit update. Results fed back to DIPC and reviewed by IPC Group

Quality Assurance	Operational vehicles (Emergency DSA, RRV & PTS)	Quality Assurance	Online audit system bases questions on designated vehicle type	Conducted by IPC Team member	15% of operational fleet spread across all Sectors*	Monthly IPC Performance summary (Trust Dashboard) to Board Individual station and locality feedback to local management teams- Monthly Audit Update. Local management teams at locality meetings.
	Operational ambulance stations, HART facilities and depots	Quality Assurance	Ambulance Station Compliance Audit form		10% of operational stations across all sectors*	
	Operational ambulance stations, HART facilities and depots (not including response posts / stand by points)	Quality Assurance	IPC Management Area Visit	Conducted by IPC Team member	Each management area receives a pre-scheduled visit to include a local area manager, 6 monthly for the main site	

				and annually for the satellite stations.	
Clinical measure of IPC Practice/ Knowledge	Quality Assurance	IPC Practice Audit, Uniform Compliance & QA10 Audit, Observational A&E audits		IPC Practice: 50 staff Uniform: 60 staff QA10: 4 staff Observational audit: 40	

*The aim is to visit each sector monthly however due to adopting a pro-active approach to addressing areas of concerns some areas may not receive monthly visits to allow capacity to support areas of concern.

Emergency Care Operations, HART & PTS Monthly Schedule

Requirements	Audits Required (per AGM/ Management area)	Submission Method	Submission Deadline
Monthly	85% of Vehicles	On-line - EAST24 (IPC Section)	Last day of month
	15 Uniform audits		
	100% of Stations		
	10% of staff QA10		
	15 HALO audits		

Every operational vehicle must have been audited at least once during the quarter

IPC Practice and quality assurance auditing of vehicles, staff and station compliance will be coordinated dynamically by the IPC Team, along with Management Area Visits in line with Trust requirements. Locations and quantities may vary from month to month.

Appendix B: Checklist

This should be completed and attached to any procedural document when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/ No/ N/A	Comments
1.	**Purpose**		
	Are the reasons for the development of the Document stated?	Yes	
2.	**Definitions**		
	Have all key terms been clearly defined?	Yes	
3.	**Consultation**		
	Have relevant stakeholders and/or users been consulted with?	Yes	
4.	**Equality Impact Assessment**		
	Has the Trust Equality Impact Assessment Screening Form been completed and attached by the author and approved by the responsible Executive Director?	Yes	
5.	**Monitoring**		
	Has the Monitoring Table been fully completed and attached?	Yes	
6.	**References/Associated Documents**		
	Are key references cited?	Yes	
	Are linked documents identified where appropriate?	Yes	

6.	**Approval**		
	Does the Document identify which committee/group will approve it?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Review Date**		
	Is the review date identified?	Yes	

Information Governance Lead (or delegated authority)			
This Procedural Document complies with the Policy for the Development of Procedural Documents			
Name		Date	
Clinical Quality Team			
The Procedural Documents complies with the relevant NHSLA standards			
Name		Date	
Please attach to the procedural document and forward to the relevant committee for approval			

Appendix C: Monitoring Table

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
Compliance with the Health and Social Care Act 2008 and key national guidance (NPSA and NICE)	Infection Prevention and Control Group Clinical Quality and Safety Group	Infection Prevention and Control audit tools.	Technical audits will be carried out monthly for vehicles and bimonthly for stations, hand hygiene and uniform compliance. Managerial and external	The IPC audit submissions will be held as an audit trail. All IPC audit reports will be stored within the IPC share-point site.	The IPC Group monitor compliance. The IPCG reports to the Trust board and lead commissioners. The IPC Team is expected to read and interrogate audit reports to identify deficiencies in	The IPCG and IPC team undertake action planning act on recommendation. Other departments such as estates are also required to act on relevant issues. Required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
			audits will be carried out throughout the year. Reports for technical audits will be produced quarterly, with monthly results available via the IPC		the system and act upon them		

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
			share-point site. An annual managerial audit report will be produced.				

Appendix D: Equality Impact Assessment Equality Analysis

Title: IPC Audit Policy
What are the intended outcomes of this work? The aim of the policy is to set out the means by which Infection Prevention and Control will be audited in the Trust. To ensure compliance with the Health and Social Care Act 2008 and the Code of Practice for the prevention and control of infections in health and social care and related guidance (2015).).
Who will be affected? Staff, third party contractors, patients and general population
Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. 1*
Disability The policy can be made available in different formats if required.
Gender No evidence found to highlight any differences/ allowances required
Race The policy can be made available in different formats if required.
Age The policy can be made available in different formats if required.
Gender reassignment (including transgender) No evidence found to highlight any differences/ allowances required
Sexual orientation No evidence found to highlight any differences/ allowances required
Religion or belief No evidence found to highlight any differences/ allowances required
Pregnancy and maternity No evidence found to highlight any differences/ allowances required

Carers No evidence found to highlight any differences/ allowances required
Other identified groups

No evidence found to highlight any differences/ allowances required
Engagement and involvement Policy presented and discussed at IPCG meeting as part of approval process
Summary of Analysis No evidence to suggest that there is any potential differential impact for any of the protected characteristics.
Eliminate discrimination, harassment and victimisation No evidence to suggest that there is any potential differential impact for any of the protected characteristics.
Advance equality of opportunity No evidence to suggest that there is any positive or negative impact for any of the protected characteristics.
Promote good relations between groups No evidence to suggest that there is any positive or negative impact for any of the protected characteristics.
What is the overall impact? No evidence to suggest that there is any positive or negative impact for any of the protected characteristics.
Addressing the impact on equalities No actions required

For the record

Name of person who carried out this assessment: Shaun Watkins (Head of IPC)

Date assessment completed: September 2022

Name of responsible Director: Melissa Dowdeswell, Director of Nursing, Clinical Quality and Improvement, DIPC.