Lincolnshire Partnership NHS
NHS Foundation Trust

Infection Prevention & Control

Annual Report 2012/13 and Work Plan for 2013/14

Foreword

As the Executive Lead for Infection Prevention and Control, I am pleased to introduce you to Lincolnshire Partnership NHS Foundation Trust's Annual Infection Prevention and Control Report.

All our staff understand that good infection prevention and control is essential to ensure providing safe and effective care. This report evidences governance and accountability, and compliance with the Health and Social Care Act 2008.

We have demonstrated progress against our work programme for the year, and compliance with the 10 criteria for registered providers.

The Infection Prevention and Control Committee oversees the Trust's governance arrangements, supports improvements in practice and internally regulates our response to audits and inspections.

Our staff are proud of the improvements that they have demonstrated in this report and are committed to further success for patients.

Dr Julie Hall
Executive Lead for Infection Prevention and Control
Director of Nursing and Operations

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Purpose of the Report

To provide assurance to the Board of Directors and the public on compliance with the Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (commonly known as The Hygiene Code) and also in relation to NICE guidance.

Key Issues, Options and Risks

Good infection prevention and control is essential to ensure that people who use Trust services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone. The publication of an Annual Report is a requirement to demonstrate good governance and public accountability. It provides assurance about our systems and processes in relation to infection prevention & control. The Health & Social Care Act 2008: Code of Practice for Health & Adult Social Care on the prevention and control of infections, sets out 10 criteria against which a registered provider will be judged on how it complies with the registration requirements for cleanliness and infection control. It sets the basis of our work plan which is monitored via the Trust Infection Prevention and Control Committee. This report summarises our progress against the work plan for 2012/13 and will also outline the key priorities and challenges for the year ahead.

10 Criteria

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3. Provide suitable accurate information on infections to service users and their visitors.
4. Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.
5. Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
6. Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.
7. Provide or secure adequate isolation facilities.
8. Secure adequate access to laboratory support as appropriate.
9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10. Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

Criterion 1
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

Governance arrangements
The Board of Directors has a collective responsibility for keeping to a minimum the risk of infection. The Board discharges this responsibility in the following ways:

The Director of Nursing & Operations is the designated Director with responsibility for infection prevention and control (DIPC). This post reports directly to the Chief Executive and the Board of Directors. Infection rates are reported to the Board monthly and the Infection Prevention Control Committee reports activity to the Quality Committee which is a sub committee of the Board.

Infection Control Team
The Trust has a service level agreement for specialist support from a Consultant Microbiologist and an Infection Control Nurse and draws on support from the Health Protection Agency (now known as NHS England), Occupational Health Specialists and facilities and estates management. In addition the Trust Matrons and a representative from the Medical Consultant body have a key responsibility for oversight of clinical practice and a network of link nurses are in place for each inpatient unit.

Infection Prevention and Control Committee
The Infection Prevention and Control Committee is chaired by the Deputy Director of Nursing & Clinical Governance (on behalf of the DIPC) and provides six month review of progress and the annual report to a Board Committee and the Quality Committee. In addition the Board of Directors receives an exception report on a monthly basis setting out newly identified isolates and outbreaks and any areas of concern.

Infection Control Audits
Each inpatient area is audited on a biannual basis. Reports with resultant action plans are then developed. Progress against recommended actions is tracked by the Matrons and the Infection Prevention and Control Committee. In addition the Infection Prevention and Control Team carries out unannounced visits and inspections of Trust sites.

PEAT and Cleanliness Audits
Audits of the general environment against the PEAT criteria are carried out biannually and cleanliness audits are carried out biannually. PEAT has been replaced by PLACE (Patient Led Assessment of the Care Environment) for 2013/14.

Policies and Procedures
An Infection Control Manual is available on the Trust Intranet. This sets out the framework for safe and effective practice. This policy was reviewed in 2012/13 as part of the Trust policy project, and is pending re - publication this Autumn.

Criterion 2
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Decontamination of Medical Devices
The Medical Director is the designated lead for decontamination and is supported by the Matron (General Adult Services). The ongoing work plan and the CQC Essential Outcome 9 standards highlight the key areas for the Medical Devices group and identify compliance. Currently the Trust has contracted with NRS to supply, maintain and decontaminate equipment for loan within community services. This service provides a high standard of performance providing full compliance with this standard.

The current outstanding challenges identified are:
- Inventory returns – maintaining an accurate list of equipment in all units which is updated annually.
- Ensuring the consistent procurement of standardised equipment with associated maintenance arrangements across the Trust.
- Reviewing the structure and remit of the Trust Medical Devices Group, ensuring that all aspects of this area are robustly managed.
- Full compliance has been demonstrated against standards of decontamination in Appendix A.

Supply and Provision of Linen and Laundry
The linen contract and local laundry arrangements comply with HSG (95)18. Compliance of local arrangements is audited as part of the routine infection control audit programme.

Policies on the Environment
The Trust has a number of policies in place in relation to cleaning services, building and refurbishment, waste management, infected linen, planned preventative maintenance, pest control, drinkable and non-drinkable water, legionella and road services. Representation at the Infection Prevention and Control Committee by Estates and Facilities is in place.

Cleaning Services
The Trust has made significant improvements in the overall assurances and processes for cleaning during 2012/13 and will continue to monitor standards during 2013/14.

Audit Scores for 2012/13
Reviewing the clinical practice and environment through continued audit is an established component of our compliance. Audit will ensure that we continue to monitor and improve the standards of patient care and environments.

All inpatient areas are audited in the year against standards. The average score for this year is 91.9%. Issues identified have been minor in status; dust, build-up of soap on soap dispensers etc. This year has been particularly affected by the buildings and repair works that the Trust has undertaken to improve our environments.

Cleaning Schedules are made publicly available in all inpatient areas and these are continually under review. A programme of audits is undertaken for the environment and cleanliness though hotel services. The units receive only 24 hours notice that they are being undertaken to support the Trust in its assurance that cleanliness standards are consistent. A comprehensive training and competency package is in place for all housekeeping and cleaning staff.

PEAT

The Trust undertakes regular audits and inspections to monitor the effectiveness of the systems in place with regard to cleanliness of the environment and infection control and prevention. Hotel Services carry out the internal PEAT and Cleanliness Audits based on the National Specifications for Cleanliness in the NHS: A Framework for setting and Measuring Performance Outcomes. These are each done in rotation quarterly and look at not only issues of cleanliness but also environmental factors such as the state of the decoration. Outcomes are communicated to Ward Managers and Matrons and reported back through quarterly PEAT meetings. The Patient Experience Action Group (PEAG) chair and Estates lead sits on the Operational Capital Group meetings to ensure a robust relationship.

2012 PEAT Results & Comparison Scores

Overall, performance has improved in eight areas and remained static in 17 areas. There is no decline in standards over the last year. The seven areas of improvement are in Cleanliness & Environment at Ashley House and Peter Hodgkinson Centre; in Food at Francis Willis Unit, Peter Hodgkinson Centre and Manthorpe Centre; and in Privacy & Dignity at Francis Willis Unit, Ashley House and the Pilgrim Hospital site.

There are scores of Excellent in all areas for the new rehabilitation premise, Discovery House and Maple Lodge retains its excellent score across the board.

The Patient Environment Action Team (PEAT) visit inpatient units and assess against nationally agreed criteria, including the standard of cleanliness, food, environment, décor, access and signage. A PEAT inspection can be carried out by an independent team from outside of the Trust or by an internal Trust team - members include service users, matrons, Directors and Head of Facilities/Estates. Actions are identified and addressed by the relevant teams and action plans are monitored through the Patient Environment Action Group (PEAG), which also has service user representation. Work undertaken to improve the areas which dropped in rating from the previous year, has ensured an increase in rating for those premises affected, and no unit received a score below ‘Good’ for environment. New standards were added in 2010/11 related to privacy and dignity, which have been addressed during 2011/12. The work has included decorating and minor repairs and refurbishments of some areas within units, such as replacement of bathrooms and toilets.

2012 PEAT Results & Comparison Scores

SITE	ENVIRONMENT SCORE					FOOD SCORE					PRIVACY & DIGNITY SCORE				
	2009	2010	2011	2012	Direction of Travel	2009	2010	2011	2012	Direction of Travel	2009	2010	2011	2012	Direction of Travel
Carholme Court	Acceptable	Good	Good	N/A	N/A	Excellent	Excellent	Self catering	N/A	N/A	Good	Good	Good	N/A	N/A
Discovery House	N/A	N/A	N/A	Excellent		N/A	N/A	N/A	Excellent		N/A	N/A	N/A	Excellent	
Francis Willis Unit	Good	Good	Good	Good	↔	Excellent	Excellent	Good	Excellent	↑	Excellent	Good	Good	Excellent	↑
Long Leys Court	Good	Excellent	Good	Good	↔	Excellent	Excellent	Excellent	Excellent	↔	Excellent	Excellent	Excellent	Excellent	↔
Ashley House	Excellent	Good	Acceptable	Good	↑	Self catering	Self catering	Self catering	Self catering	N/A	Excellent	Excellent	Good	Excellent	↑
Maple Lodge	Excellent	Excellent	Excellent	Excellent	↔	Self catering	Self catering	Self catering	Self catering	N/A	Excellent	Excellent	Excellent	Excellent	↔
Manthorpe Centre	Good	Acceptable	Good	Good	↔	Excellent	Good	Good	Excellent	↑	Excellent	Good	Excellent	Excellent	↔
PHC	Good	Good	Acceptable	Good	↑	Excellent	Excellent	Good	Excellent	↑	Excellent	Good	Good	Good	↔
Pilgrim Hospital	Good	Good	Good	Good	↔	Excellent	Excellent	Excellent	Excellent	↔	Good	Good	Good	Excellent	↑
Witham Court	Good	Good	Good	Good	↔	Excellent	Excellent	Excellent	Excellent	↔	Good	Good	Good	Good	↔
Ash Villa	Good	Good	Good	Good	↔	Excellent	Excellent	Excellent	Excellent	↔	Excellent	Excellent	Good	Good	↔

Key:

↑ Performance improved

↓ Performance declined

↔ Performance maintained

The areas where there has been improvement within the environment are Ashley House and the Peter Hodgkinson Centre. Work is continuing at the Peter Hodgkinson Centre during 2013 to provide a refurbished reception and waiting area for service users.

Since the 2012 inspection schedule a significant programme of improvement works has been developed as part of the capital programme. Much of this work continues to focus on improving bathrooms and toilet areas, and significant improvements were made at Ash Villa due to the installation of a new heating system, and new windows. Work has been carried out at Witham Court, Manthorpe Centre, and Peter Hodgkinson Centre.

The catering contract changed in the year enabling changes to menus within each premise which utilises the contract. Hotel Services are working closely with the providers and with unit staff to ensure the new menus are providing nutritious food of good quality. A recent CQC inspection at PHC highlighted the improved quality of the food.

PEAT inspections for 2013 have been nationally replaced with PLACE (Patient Led Assessment of the Care Environment) and will focus much more acutely on service user representation within the inspection team, and the general environment within inpatient units. As the scoring of the PLACE inspections has also changed, there will be significant differences following completion of the inspection programme. Early indications are showing favourable outcomes with the new programme.

Criterion 3
Provide suitable accurate information on infections to service users and their visitors.

The Trust makes available information relating to MRSA screening and decolonisation, C. difficile and other isolates and outbreaks as they arise. Availability of information is audited as part of the routine infection control audit programme.

Criterion 4
Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.

MRSA Screening

A risk based policy for screening patients for MRSA colonisation was introduced in March 2009. Compliance with screening is audited monthly; the Trust remains 100% compliant with the screening of high risk patients for MRSA.

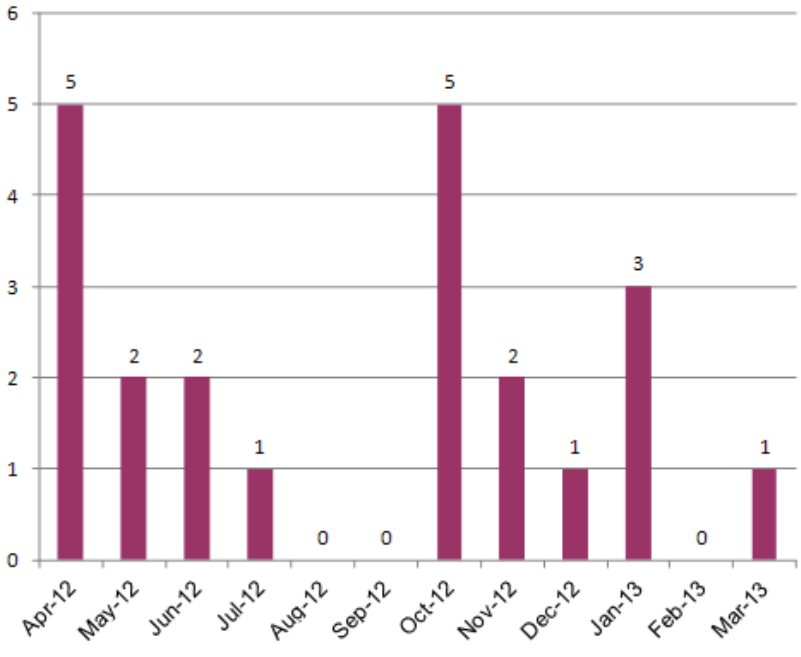
Newly Identified Isolates 2012/13

	Numbers
Group G Strep	0
Group A Streptococcus	0
MRSA Colonisation (Previously known)	1 (Langworth)
MRSA Colonisation (Screened after 48hrs)	1 (HMP North Sea Camp)
MSSA	0
C. difficile	0
Glycopeptide Resistant enterococci	0
Gentamicin resistant coliforms	0
Extended Beta lactamase organism	0
Escherichia coli resistant organism	0

Outbreak Rates April 2012 - March 2013

The graph to the right demonstrates the trend in outbreaks over the year, it should be noted that the numbers are low as would be expected in a trust of this nature. Hand hygiene plays a significant part in these low numbers and there is strict training and monitoring in place.

HCAI Healthcare Associated Infection
Outbreak of Infections



Criterion 5
Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

All infections and outbreaks are reported to the Infection Prevention and Control Committee and to the Health Protection Agency (HPA) as required. There have been no outbreaks or infections of sufficient severity to require reporting to the HPA in 20012/13. Data on all infections and outbreaks are shared with the HPA via the Infection Prevention and Control Committee. From 2013/14 the HPA has now become NHS England.

Criterion 6
Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

Estates and Facilities

Hotel services, in particular Housekeeping services are provided by the Trust's Estates and Facilities Department. The estates maintenance service which is managed and monitored by the Estates and Facilities Team is provided through a service level agreement with NHS Property Services.

In addition infection control professionals have been involved in all stages of the design process for the new rehabilitation scheme. Significant improvements were implemented on the processes for prioritising minor and major capital projects linked to the findings of infection control audits and environmental audits.

Criterion 7
Provide or secure adequate isolation facilities.

Due to the nature of the patient population, it can, at times be difficult to isolate patients to minimise the spread of infection. A local policy based on risk is in place and individual requirements for isolation are managed on a case by case basis.

Criterion 8

Secure adequate access to laboratory support as appropriate.

Laboratory support is provided as part of the Trust's service level agreement. The specification and delivery is fully standard compliant.

Criterion 9
Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

The Trust has a comprehensive infection control manual which is reviewed and updated on an ongoing basis. The policies available are fully standard compliant and due for republication in the Autumn of 2013.

Criterion 10
Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

Hand Hygiene Training

All inpatient clinical staff and housekeepers are required to have hand hygiene training on an annual basis and monthly audits are carried out.

Compliance with hand hygiene training for period 1st April 2012 – 31st March 2013 was 92.7%. Hand decontamination audit results by wards demonstrate a similar figure with a score of 91.6%. This represents an increase overall of 1.7% however the Trust aspired to a compliance rate of 95% for the year and therefore has fallen short. The challenge in this area lies in the issue of all completed training being required to be refreshed in the same period each year. This is further exacerbated by similar issues related to all mandatory training required for staff to undertake and 'technically' as the calendar year for expiry may fall short of when the refresher course can actually be attended, e.g., training may expire on 18th of month when course can only start on 21st meaning that the worker is only out of date by 3 days. Work to 'stagger' the 'compliance year' will be addressed in this year's work plan.

Work Plan for 2012/13 Summary

The work plan for 2012/13 has seen the completion of the following developments and improvements:

- Infection prevention and control is included in the Board's 'Balanced score card' and heat maps.
- There is an effective approved infection prevention and control accountability framework. This includes evidence of specific responsibilities allocated to staff working in, or coming into contact with, clinical areas (reflected in their job descriptions and appraisals).
- Biannual infection control audits have been completed and follow up actions tracked.
- There is an agreed an annual improvement programme for infection prevention and control which is linked to the business planning cycle and has identified actions and resources.
- The Trust can demonstrate a 'self-governance' culture for infection prevention and control. This includes evidence that all staff, from Board to ward, are accountable and take ownership and responsibility for continuous quality improvement.
- The Director for Infection Prevention and Control is involved in contract negotiations with commissioners on the key performance indicators for infection prevention and control.
- The Trust can demonstrate to patients, the public, staff and itself that it is making continuous progress towards meeting all relevant statements in this guide.
- Through the Infection Prevention and Control Committee there is evidence of regular, systematic generation and sharing of learning from Trust's own experiences of infection prevention and control – including good practice and adverse events. This includes evidence that learning is based on a range of intelligence sources and is used to inform, and feed into, clinical and risk management processes.
- The Trusts shares relevant surveillance outputs and data with other local health and social care organisations to improve its infection prevention and control.
- We have evidence that systems are in place for timely recognition of incidents in different spaces (for example, wards, clinical teams, clinical areas, the whole Trust). This includes evidence of regular analyses of data though heat maps.
- The Trust reports all outbreaks, serious untoward incidents (SUIs) and any other significant HCAI related risk and incident to the local health protection unit.
- Surveillance outputs are fed back to relevant staff and stakeholders, including patients, in an appropriate format to support preventive action.

- Staff working in clinical areas, including specialist 'link practitioners', have sufficient time to fulfil their responsibilities on (and objectives for) infection prevention and control. All staff have access to these link nurses to fulfil their responsibilities.

- There is evidence that all staff working in clinical areas are familiar with, and competent in applying, the Trust's infection prevention and control policies and procedures.

- The Trust clearly sets out, and adheres to, a standard of cleanliness that is beyond current national guidance (for example, British Standards Institution PAS 5748 and/or National Patient Safety Agency specifications).

- There is evidence of clear and accessible local policies on cleaning and environmental decontamination. This includes evidence that they take into account the needs of different patient care areas and allow for flexibility in the deployment of resources. There should be evidence, for example, that individual staff understand their role and responsibilities with clear cleaning responsibility matrix and frequency schedule for each patient care area.

- The Trust can evidence its compliance with all aspects of policy ranging from outbreak to decontamination and education of staff with responsibility for cleaning in the use of equipment, disinfection and decontamination.

- The Trust incorporates patient feedback and involves patients and carers in its cleanliness monitoring programmes, with evidence that impacts on standards.

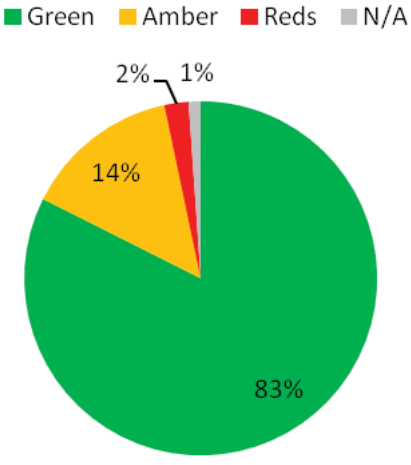
- We work collaboratively with the local health protection unit and other health partners to investigate and manage HCAI outbreaks and incidents. Evidence is particularly needed of collaboration to deal with incidents which may impact on the health of the wider community.

- In year we have reviewed patient information to ensure that patients, carers and visitors have access to up to date, accurate and easy to understand information about their own HCAI (if applicable) or HCAIs generally, in a suitable format. This includes evidence that they have access to information on the potential risk of infection and existing treatment and control measures.

- In year clinical staff have had access to at least two examples of new technologies and innovation which have been disseminated to directorates, along with guidance on evaluation and implementation.

Overall the trust completed all but two of its work plan actions which is evidence of increasing standards.

Summary of Performance against Action Plan 2012/13



Work Plan for 2013/14

Key initiatives for 2013/14 include:

- The reprovision of the infection prevention & control service. In this year we will provide internally infection prevention and control services. With the exception of microbiology services (which will be provided by external contract) the service will be provided entirely in-house. This will be achieved by the reconfiguration and refinement of the current Matron posts. The commencement of this is the 1st January 2014.

- Medical devices including supply, maintenance and decontamination is an area identified within this year's plan for development. Currently the community is serviced through a contract with NRS which ensures we are fully compliant in all areas. The inpatient and other areas now require reassessment, base lining and work plan in order to assure the Trust. This work will be carried forward through this year and will be monitored via the Infection Prevention and Control Committee.

- Hand hygiene training and decontamination compliance – we wish to achieve and sustain 95% compliance.

- Improved integration between Infection prevention & control service and Hotel services to improve and develop robust services.

Executive Analysis

The services of the Trust have performed well over the year. The forthcoming year will provide us with a platform to achieve further success in this area. This report has provided a review of our performance for the year and has outlined the priorities and work plan for next year.

Infection prevention & control remains a high priority for the Board as they are committed to providing safe, effective care. This will be achieved through the appropriate monitoring and governance processes required in this area.

Appendix A - Medical Devices

Care Quality Commission Compliance Check

Outcome 11: Safety, availability and suitability of equipment.

Regulation
16.- (1) The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is:

a. properly maintained and suitable for its purpose; and
b. used correctly.

(2) The registered person must ensure that equipment is available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs.

(3) Where equipment is provided to support service users in their day to day living, the registered person must ensure that, as far as reasonably practicable, such equipment promotes the independence and comfort of service users.

(4) For the purposes of this regulation -
a. “equipment” includes a medical device; and
b. “medical device” has the same meaning as in the Medical Devices Regulations 2002.

Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Ensure equipment is adequate		
Requirement	**LPFT evidence**	**Status**
People are safe because, where equipment is provided or used as part of the regulated activity, the equipment is: • Available in sufficient quantities to meet the needs of people who use the service. • Safe to be used. • Suitable for its stated purpose. • Compliant with all relevant laws. • Installed, used and maintained correctly with reference to the specifications, manufacturer's instructions, legislation and appropriate guidance from expert bodies. • Properly maintained, tested, serviced and renewed under a recorded programme. • Stored safely and securely to prevent theft, damage or misuse. • An approved product list has been established by the Medical Devices Group in conjunction with Clinical Engineering to inform all purchasing. • A service level agreement is in place with UHLT Clinical Engineering for the maintenance and servicing of all medical equipment as required and teams have full instructions on how to access the service. • A central budget is available for the replacement/ purchasing of any essential medical equipment. • Local maintenance records are maintained by local teams and detailed in CQC folders.	The Trust's Medical Devices Policy covers all aspects of availability of equipment, safety checks, and maintenance arrangements. Medical devises group monitors compliance and reports exemptions to Infection Prevention and Control Committee and Medicines management committee. An approved product list has been established by the Medical Devices Group in conjunction with Clinical Engineering to inform all purchasing. A service level agreement is in place with UHLT Clinical Engineering for the maintenance and servicing of all medical equipment as required and teams have full instructions on how to access the service. A central budget is available for the replacement/ purchasing of any essential medical equipment. Local maintenance records are maintained by local teams and detailed in CQC folders.	
People's needs are met because staff using any equipment do so in a way that has regard to their dignity, comfort and safety and promotes their independence by: • Actively listening to their preferences and thoughts about the equipment they need and how it is used. • Supporting the person to understand how and why the equipment is being used. • Taking care in the way they use the equipment to make sure the person is comfortable and safe. • Using the equipment in a way that ensures the person's privacy and dignity.	As a mental health Trust LPFT uses a limited range of medical devices. The privacy and dignity of patients is addressed through staff training and the Privacy and Dignity policy. All staff receive training on the use of medical devices as required and maintain local records and uploaded onto OLM system through L&D Centre. Pertinent to the organisation is the use of resuscitation equipment which is covered in Basic Life Support and Intermediate Life Support mandatory training. Resuscitation training records are maintained by the L&D Centre	

Manage risk through effective procedures about equipment suitability

Requirement	LPFT evidence	Status
People are safe because, where equipment is provided as part of the regulated activity, there are clear procedures followed in practice, monitored and reviewed. Wherever necessary these include: • Identification, assessment and review of risk. • Where risks are identified, a plan for how these are to be managed. • How the equipment is maintained and used. • Ensuring that all staff involved in using the equipment have the competency and skills needed, and where this is not possible, know what to do to ensure the people remain safe. • How staff will know what to do when a person who uses services refuses to allow use of the equipment. • The arrangements for adverse events, incidents, errors and near miss reporting. These should encourage local and, where applicable, national reporting, learning and promoting an open and fair culture of safety. • The training of people who use services about any equipment they are given to use themselves. • Best interest meetings with people who know and understand the person using the services to ensure that treatment and care are taken that reflect the person's best interest. • What will happen in the event of electricity, water or gas supply failure, or other emergencies, that affect the equipment used to meet the needs of people who use services.	There are established and effective risk assessment processes in the Trust. Risks identified with service users (including patients refusing treatment/assessment with equipment) would be managed as part of a multidisciplinary decision making process to meet the needs of the patient and include best interest assessment as required. Maintenance arrangements for all approved medical devices are detailed on the approved product list, There is an established SLA with ULHT Clinical Engineering for the maintenance and servicing of medical equipment. Staff receive mandatory training on the use of resuscitation equipment as required. Other low risk devices used in practice are covered by profession/ or local peer training. The Medical Devices policy provides clear guidance to staff on responsibilities around competence. Adverse incidents and near misses are reported on the Trust's electronic incident reporting system and managed through the incident management process; all reported incidents of this nature are reviewed on a quarterly basis by the Medical Devices Group and follow up action taken if required. Equipment is only provided to service users by Trust Occupational Therapists. Training for service users receiving equipment is detailed in The Prescription of Equipment by Occupational Therapists under The Lincolnshire Community Equipment Service (LCES) guidance document. The range and type of medical devices used by LPFT is such that they would be relatively unaffected by disruption to electricity, water or gas supplies. Some treatments such as ECT could be postponed but alternative arrangements could be put in place. Business Continuity Plans are in place for all services to ensure continued safe service delivery in emergency situations.	

Where people who use services receive care, treatment or support that involves the use of medical devices, the provider has:
 	
• Clear procedures that are followed in practice, monitored and reviewed for the use of medical devices. Wherever they are required these procedures include:
  • implementing guidance issued by experts or professional bodies in relation to the medical devices used
  • acting on alerts from an expert or professional body or a product manufacturer.
	The Medical Devices Group has produced a standardised product list in conjunction with ULHT Clinical Engineering to ensure all devices purchased meet current legislative requirements and identified best practice. This list is updated on a quarterly basis and provided to procurement to inform all purchasing.
	
	There is an established system managed by the Risk department to respond to any Medical Devices Alerts and identify, remove or replace equipment as required.	

People who use services receive care, treatment and support from a service that: • Takes into account relevant guidance, including that from the Care Quality Commission's Schedule of Applicable Publications.	This Guidance is addressed in the Medical Devices Management Policy. Lasers are not used in LPFT. Single use devices are specifically addressed in the Medical Devices Management Policy. There is an established system managed by the Risk department to respond to any Medical Devices Alerts and identify, remove or replace equipment as required. Any new guidance is reviewed by the Medical Devices Group and actioned accordingly.	

Providing personalised care through the effective use of medical devices

Requirement	LPFT evidence	Status

People who use services receive care, treatment and support that:
 	
• Ensures the medical devices used to meet their needs are:
  • not reused if they are manufactured for single use only
  • only modified in line with manufacturer's instructions or guidance
  • only purchased if they meet the necessary legal requirements
  • available when they are required for use
  • supplied with the necessary technical information so that the risk of using them incorrectly is minimised
  • permanently installed where appropriate, in accordance with manufacturer's requirements and published guidance
  • only used by the person, or by staff, once they know how to use and operate them correctly
  • monitored while being used and action taken if they do not appear to be working correctly
	The issues identified in section 11F are addressed through the Medical devices Management Policy.
	
	Single use devices are specifically addressed with instructions for disposal.
	
	The Medical Devices Group has produced a standardised product list in conjunction with ULHT Clinical Engineering to ensure all devices purchased meet current legislative requirements and identified best practice. This list is updated on a quarterly basis and provided to procurement to inform all purchasing.
	
	Routine maintenance and repair arrangements for all approved medical devices are detailed on the approved product list, There is an established SLA with ULHT Clinical Engineering for the maintenance and servicing of medical equipment.	

• routinely maintained in line with the manufacturer's instructions and by people who are competent to do so • repaired when they break down by people who are competent to do so • disposed of or recycled, safely and securely.	Staff receive mandatory training on the use of resuscitation equipment as required. Other low risk devices used in practice are covered by profession or local peer training. The Medical Devices policy provides clear guidance to staff on responsibilities around competence. Disposal of medical devices including WEE regulations is specifically covered in the Medical Devices Management Policy.	

Additional prompts for specific service types

Requirement	LPFT evidence	Status
When equipment is used in a person's own home: • Staff address any concerns in a timely manner where they have identified problems around the safety of the equipment.	Equipment is only provided to service users by Trust Occupational Therapists. Training for service users receiving equipment is detailed in The Prescription of Equipment by Occupational Therapists under The Lincolnshire Community Equipment Service (LCES) guidance document. Concerns would be addressed immediately or escalated through the line management structure. In incident report may also apply and be completed.	
People who use services receive care, treatment and support that: • Ensures equipment required for resuscitation or other medical emergencies is available and accessible for use as quickly as possible. Where the service requires it, this equipment is tamper proof.	The Trust has an established resuscitation policy that addresses the issues identified in this section. Local teams conduct daily checks of resuscitation equipment and these are audited by the Trust's resuscitation lead.	

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