Key actions: infection prevention and control and testing

Organisations

It is the board’s responsibility to ensure that:

1. Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times every day, with systems in place to monitor adherence.

2. Staff maintain social distancing (2m+) in the workplace, when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace.

3. Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings, with systems in place to monitor adherence. Movement of staff between COVID and non-COVID areas is minimised.

4. Moving patients increases their risk of transmission of infection. For urgent and emergency care, hospitals should adopt pathways that support minimal or avoid patient bed/ward transfers for the duration of their admission (unless clinically imperative). The exception will be patients who need a period of care in a side room or other safe bed while waiting for their COVID test results. On occasions when it is necessary to cohort COVID or non-COVID patients because of bed occupancy, then reliable application of IPC measures must be implemented. It is also imperative that any vacated areas are cleaned as per guidance.

5. Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework is reviewed and evidence of assessments is available.

6. Where bays with high numbers of beds are in use, they must be risk assessed and where 2 metres cannot be achieved, means of physical segregation of patients are strongly considered. The concept of ‘bed, chair, locker’ should be implemented. All wards should be effectively ventilated.

Online COVID-19 guidance

www.england.nhs.uk/coronavirus  GOV.UK  NHS.UK
Staff are tested:
a. Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing.
b. If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control/Public Health team. Such cases must be recorded, managed and reported using agreed regional/national escalation systems.

Patients are tested:
a. All emergency patients must be tested at admission, whether or not they have symptoms.
b. Those who go on to develop symptoms of COVID-19 after admission must be retested at the point symptoms arise.
c. Those who test negative on admission must have a retest on day 3 of admission, and again between 5-7 days post admission.
d. Sites with high nosocomial rates should consider testing COVID negative patients daily.
e. Patients being discharged to a care home must be tested 48 hours prior to discharge and must only be discharged when their test result is available. Care homes must not accept discharged patients unless they have that person’s test result and can safely care for them.
f. Elective patients must be tested within 3 days before admission and must be asked to self-isolate from the day of their test until the day of admission.

Systems

Local systems must:

Assure themselves, with commissioners, that a trust’s infection prevention and control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered.

Review system performance and data; offer peer support and take steps to intervene as required.

Online COVID-19 guidance

[www.england.nhs.uk/coronavirus] [GOV.UK] [NHS.UK]