Tameside and Glossop Integrated Care NHS Foundation Trust

VIRAL GASTROENTERITIS POLICY

Management of Viral Gastroenteritis in a Hospital Setting

EQUALITY IMPACT

The Trust strives to ensure equality of opportunity for all both as a major employer and as a provider of health care. This policy has therefore been equality impact assessed by the Infection Control Committee to ensure fairness and consistency for all those covered by it regardless of their individual differences, and the results are shown in Appendix 7.

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VERSION CONTROL SCHEDULE

viral gastroenteritis policy

Version Number	Issue Date	Revisions from previous issue
1.0 draft	11.01.2011	1st draft No comments received following consultation ICC and HR.
1.0 final	25.01.2011	Authorisation by Infection Control Committee after 2 week consultation.
2.0 final	19.03.2014	Infection clean process added (level 3 clean following outbreak) Cross referenced with PHE guidelines for management of norovirus outbreaks in health care settings (March 2012)
3.0 Final	26.07.2016	Introduction updated. Level 3 clean changed to Infection Clean. MAU changed to AMU Community / Nursing and Care home advice included into the policy. Cross referenced with PHE guidelines for management of norovirus outbreaks in acute and community health care settings (March 2012). Norovirus patient leaflet added to Appendix
4.0 Final	01.11.2018	I log information added. Emergency cupboard (ward 46) removed regarding storage of norovirus signs out of hours.
5.0	19.10.2020	Policy review.

1. INTRODUCTION

Norovirus (previously Norwalk) and Rotavirus are the most common cause of outbreaks of gastroenteritis worldwide and both hospitals and nursing homes are significantly associated with high attack rates. Outbreaks occur throughout the year, although cases rise to more than 80% from November to April (Rajagopalan & Yoshikawa (2016). Hospital / community outbreaks can often lead to ward or area closure and cause major disruption in hospital activity.

The financial implications with regard to ward closure and its associated costs in acute care facilities are far reaching. Norovirus has been estimated to cost the NHS in excess of £100million in years of high incidence (Norovirus Working Party 2012).

Norovirus can be spread via several different routes; faecal-oral, vomiting and aerosolisation, and through contaminated food and water. Viruses may be introduced into the hospital environment via any of these routes and propagated by person to person spread, whereby hands are contaminated from the environment and virus ingested by mouth.

Symptoms typically consist of nausea, diarrhoea and / or vomiting, but may also include headache or abdominal pain. The condition is self–limiting with symptoms usually lasting between one to three days. During vomiting there is potential widespread contamination of the environment.

Norovirus is highly transmissible requiring ingestion of as few as 10-100 viral particles to cause illness. The incubation period is usually 24-48 hours although as little as 12 hours has been reported.

Although infectivity may precede clinical illness and viral shedding may be prolonged, the period of infectivity is considered to last from the onset of symptoms until 48 hours after the last episode of diarrhoea or vomiting.

2. PURPOSE

The policy is intended to ensure that all members of clinical and non-clinical staff including non-permanent members of staff working within the Trust adhere to and follow this policy.

The purpose and overall aim of this policy is to provide and ensure a safe environment for patients, other staff groups and visitors in the interests of preventing and controlling the spread of infection.

3. SCOPE

This policy applies to all Trust staff (including contracted, PFI and community), patients and visitors.

4. DEFINITIONS

4.1 Source Isolation Source Isolation consists of physical separation of a patient with an identified or suspected transmissible infection (alert organism / condition) into a single room.

4.2 Cohort Refers to the grouping of patients with the same clinical diagnosis, suspected symptoms or clinical risk category in relation to known or suspected transmissible infection. (Refer to the trust Isolation policy).

4.3 Diarrhoea can be defined as frequent, loose watery stools, which on sampling take the shape of the container and are described as type 5-7 on the Bristol stool chart.

4.4 Outbreak of infection can be defined as a localised group infected with the same disease in the same space at the same time.

5. DUTIES

5.1 Chief Executive (CE)
The CE is responsible for the prevention and control of hospital acquired infection. The CE delegates responsibility for the development and implementation of this policy to the Director of Infection Prevention and Control.

5.2 Director of Infection Prevention and Control (DIPC)
The DIPC has delegated responsibility for the following;
- Reporting directly to the CE and the Board on matters pertaining to policy compliance.
- Being an integral member of the organisation's clinical governance and patient safety team and structure.
- Producing an annual report on the state of HCAI in the organisation including policy and compliance.

5.3 The Trust Infection Prevention Team (IPT)
- Overseeing the development and implementation of the viral gastroenteritis (norovirus) policy.
- Assessing the impact of the existing policy and making recommendations for change where appropriate.
- Ensuring the clinical areas are supported in carrying out risk assessments to determine the level of precautions to be instigated.
- Ensure daily (Mon – Fri) e-mail communication to a designated distribution list with an outbreak update.
- To give advice to nursing and residential homes on the management of norovirus (gastroenteritis) outbreaks

5.4 Trust Directors / Assistant Chief Nurses / Matrons – acute trust

Directors / Assistant Chief Nurses / Matrons must ensure that the following occurs:

- The immediate and on-going dissemination and implementation of the viral gastroenteritis (norovirus) policy.
- Staff will be made aware of the viral gastroenteritis (norovirus) policy and the actions to be taken.
- Alongside other members of staff, Directors / Assistant Chief Nurses / Matrons must take steps to ensure that the appropriate resources are available in their area of responsibility to allow patients, staff and visitors to comply with this policy.

5.5 Trust Ward / Departmental Mangers, Senior Sisters, Charge Nurses

These members of staff must;

- Assist and support Matrons / Senior Nurses in the implementation of this policy.
- Ensure that staff are aware of and adhere to the policy and that it is implemented in clinical practice.

5.6 All staff – Acute and Community (including contractors and PFI) practicing within the Trust.

These members of staff must:

- Demonstrate adherence to Trust policy at all times.
- Behave in a safe and responsible manner taking all appropriate steps to comply with the viral gastroenteritis (norovirus) policy.
- Contractors working on site will take advice on continuation of work from the Infection prevention team and/or project lead.

6. POLICY STATEMENT

As a healthcare establishment the Trust has a duty of care that is covered by the Health and Safety at Work Act (1974) (HSE 2003), COSHH (HSE 2005) and The Health and Social Care Act – Code of Practice (DH 2006 revised 2008, 2012, 2015).

This policy takes into account guidance issued by the Norovirus Working Party on behalf of the Department of Health (2011) which was further reviewed in March 2012.

The main focus is based on the principle of minimising the disruption to important and essential services and maximising the ability of the Trust to deliver appropriate care to patients safely and effectively.

All staff must understand the significance and potential consequences of norovirus within health care settings and ensure they are aware of and apply the appropriate infection prevention interventions and precautions when caring for patients with suspected / confirmed norovirus.

Staff must be able to identify the symptoms of norovirus early in order to prevent transmission and outbreaks occurring and must be able to appropriately manage norovirus outbreaks when they do occur.

7. THE POLICY

7.1 Identification of a Case / Cases

CASE DEFINITION
Early identification of norovirus is imperative to minimise person to person spread and subsequent transmission to the rest of the healthcare environment.

The following case definition must be used for the purpose of identification of norovirus:

A suspected case:
Symptoms =
Vomiting Two or more episodes of vomiting of a suspected infectious case* occurring within a 24 hour period
Diarrhoea Two or more loose stools in a 24 hour period*
Diarrhoea and Vomiting One or more episodes of both symptoms occurring within a 24 hour period*

* Not associated with prescribed drugs or treatments and not associated with reaction to anaesthetic or underlying medical condition or existing illness. In addition to the symptoms above patients may also exhibit nausea, pyrexia, headache and abdominal cramps.

A confirmed case:
= symptoms as per suspected case above and microbiological confirmation.
(HPA 03/10).

7.2 Criteria for Suspecting an Outbreak

Two or more staff and patients/residents affected fitting the case definition that occurs in a ward or department within the hospital or community setting without laboratory confirmation.

The following criterion acts as an indicator of a norovirus outbreak in the absence of laboratory confirmation:

- Vomiting in >30% of cases.
- Affected patient(s) has / have had recent contact with norovirus positive patient.
- Clinical features are highly suggestive of norovirus (see case definition) e.g. rapid onset of symptoms and / or projectile vomiting.

- There is rapid spread of gastrointestinal infection, often affecting multiple patients, visitors, members of staff and students.
- No bacterial agent found.

7.3 Actions to be taken on Identification of Two or More Cases of Unexplained Diarrhoea and / or Vomiting

Careful clinical assessment of the causes of vomiting and diarrhoea is important. Even in the midst of an outbreak there will be patients who have underlying pathologies. Senior nursing staff in conjunction with medical staff / GP and the Infection Prevention Team (using the case definition) should make a decision as to whether norovirus is the likely cause.

7.4 Management of Increased Numbers of Patient Cases
(Period of increased incidence (PII))

Hospital

- Affected patients must be cared for using isolation (single room or cohort) and standard Infection Prevention / Control precautions. (Refer to the THFT Isolation Policy and see appendix 1).

- In areas where it can be demonstrated that symptomatic persons can be physically and safely separated from non-symptomatic individuals through cohorting it may not be necessary for the full ‘closure’ or instigation of restrictions on an entire ward.

- Where cohort nursing is in operation within a bay area personal protective equipment (PPE) should be worn and changed in between caring for each patient and hands must be decontaminated thoroughly with soap and water. PPE should be removed and hands washed prior to leaving the cohort area or single room.

- Where there is more than a single case a list should be compiled, including patient’s members of staff and visitors, stating the symptoms and the date / time that these started. This information is vital in assisting the IP team to undertake accurate risk assessment when they visit the ward. This form can be found at the end of this policy as appendix 6.

- Further cases should be added to the list as they occur and these will be monitored and documented during the IP team daily review.

- In situations where additional cases occur in locations other than the initial cohort bay or side rooms in wards that are not fully ‘closed’ the IP/C team need to be informed immediately (or on call manager / bleep holder out of hours), as risk assessment may indicate the need to progress to a full ward ‘closure’ / restrictions.

Care Home Settings

- Any resident with possible infectious diarrhoea and/or vomiting needs to be segregated from other asymptomatic residents. If an affected resident is sharing a room and there is a vacant room available, temporary use of that room to be used by the affected person (unless separation causes distress to the resident).
- If a vacant room is not available, isolation precautions and rigorous IPC procedures including increased cleaning need to be put in place.
- Symptomatic residents should be advised not to attend communal areas, including shared bathrooms, until they are recovered and have been symptom free for 48h. If possible residents should be provided with their own designated toilet or commode.

7.5 Sampling

It is imperative that stool samples are obtained from all symptomatic cases. This is to enable the IP Team to identify the cause of the outbreak and to rapidly implement the correct control measures to prevent further spread to the rest of the hospital setting. (Further guidance can be found in appendix 2). There is no requirement to provide clearance stool samples.

7.6 Definition of a 'Closed' / Restricted Area

In some cases the IP team will recommend closure of all or part of the ward/care home or affected area, and will inform the Matron, Bed Manager, Ward Manager or person in charge at the time. Out of hours this decision lies with the on call manager supported by senior clinical staff on duty / bleep holder.

Nursing/residential home managers must inform the Duty Officer at Public Health England Northwest (Greater Manchester) and The Trust Infection Prevention Team of the suspected outbreak.

The definition of 'closure' / restriction refers to the restriction of incoming and outgoing personnel, patients, residents, equipment and materials to an unavoidable minimum.

In broad terms a ward or bay closure (cohorting) means that there are no new admissions in or discharges out of the area. (Unless cases are going to their own homes or in emergency situations i.e. this is the last bed in the hospital for admission purposes. This does not allow for transferring from AMU to the affected ward in order to create space on AMU.) Where possible ward / bay activity and traffic is reduced to its absolute bear minimum to prevent spread to:

a. Currently asymptomatic patients on the ward.
b. Visiting healthcare workers from other departments.

c. The rest of the hospital environment.
d. Visitors and relatives.

The actions taken must be based on a very careful risk assessment of the patients needs. If based on clinician assessment the patient requires admission to hospital then the Trust do admit to a restricted area if it is the last bed in the hospital as to deny the patient admission could have dire consequences in its own way.

Patient placements must be based on an assessment of the risks involved i.e.

- Taking into account the main reason why the patient was admitted in order to facilitate the most appropriate treatment and care.

- Taking into account the risk to the patient of not admitting to the most appropriate area or not admitting at all and / or transfer to another hospital (who may also have wards affected by norovirus).

7.6.1 The following applies to wards, bays and other unit areas capable of segregation.
Closure / increased restrictions refers to the restriction of incoming and outgoing personel, equipment and materials to an avoidable minimum. The fewer times that the boundary of a closed area is crossed, the risk of on-going transmission is significantly reduced.

- There should be an obvious boundary between open and closed areas to signal to people that restricted access is in place. The boundary should consist of doors and high visibility signage.
- Closed / restricted areas should be self-contained with access to hand washing facilities and its own dedicated washing and toilet facilities.
- There must be no traffic of patients between the closed / restricted area and the open areas of the ward (except direct to a bath / shower room).
- Patients should only be transferred for investigations and interventions that cannot be safely delayed, preferably at the end of the procedure list and patients must not wait in a public waiting area.

7.6.2 Admissions to a closed / restricted area must be restricted to:
A - Patients who are known to have been exposed to norovirus or have been identified as norovirus positive within the previous 72 hours. This relates to all areas except ACU (Treat and Transfer cardiology) which must remain closed to admissions until their restrictions have been lifted.
B - Patients who have been readmitted to hospital from a previously closed ward elsewhere in the trust up to 72 hours post discharge.
C - Patients from wards where norovirus has been confirmed microbiologically (2 or more confirmed cases).

7.6.3 Asymptomatic patients with no previous exposure must not be admitted to wards that are closed / have restrictions in place unless this is the last bed in the hospital and with prior knowledge of the IP team or Manager on call and the patient / family.

- The decision to admit patients into a closed / restricted ward **must not** be undertaken without a prior risk assessment from the IP Team in hours or the on call Consultant Microbiologist / on call Manager out of hours.

7.7 Actions to Be Taken When an Outbreak is Declared / Outbreak Control Measures

In situations where a ward has been 'closed' (restrictions put in place) and an outbreak declared the IP Team will visit the area daily (Mon – Fri) within the Trust, and contact by telephone nursing / residential homes.
IP Team will provide via email to all Divisions and Departments within the Trust and the Community including the Chief Executive, Directors, Assistant Chief Nurses, Matrons, Bed managers and other nursing, medical and allied healthcare staff and will include the CCG /TMBC/ PHE and local GP when an outbreak is declared in the community, the email will give an updated position which includes:

1. Number of staff and patient / resident cases
2. Number of wards affected
3. Nursing / residential home involved
4. Whether restrictions are on-going or have been lifted.

Between the hours of 5pm and 8am the on call Consultant Microbiologist can be contacted via switchboard for advice.

On ward closure within Tameside Hospital or Stamford Unit, the ward will be issued with an outbreak 'pack' containing a norovirus outbreak alert sign which must be placed at the entrance to the ward, Norovirus guidance poster for staff, information leaflets for patients and relatives and a patient record sheet to note all symptomatic patients. Staff should ensure that they have a sufficient number of Norovirus signs available for out of hours use and the Norovirus leaflets can be downloaded from the intranet. It is the responsibility of the nurse in charge to make sure that the ward restriction notice is placed at the entrance to the ward and that all patients and relatives have access to information leaflets and hand hygiene facilities.

It is the wards responsibility to ensure an accurate patient list is compiled, which also details members of staff and visitors (appendix 6). This information is vital in assisting the IP team to undertake accurate risk assessment when they visit the ward.

- All **non-essential** personnel should be prevented from entering a closed area. This includes, where possible, non-essential social visitors (appendix 5).

- Strict application of personal IP measures (e.g. strict hand hygiene with soap and water and the use of PPE) as described in this policy is essential (appendix 1).

- Strict adherence to food consumption and patient meal service (appendix 4).

7.8 Clinical Treatment of Norovirus

7.8.1 Dehydration

The mainstay of clinical treatment is the avoidance or correction of dehydration which may be achieved through any standard oral rehydration regimen if tolerated. For those who are unable to take oral then intravenous administration of appropriate fluids is indicated. These measures are particularly important in the elderly and those with underlying conditions or illnesses.

7.8.2 Antiemetic

These are not recommended routinely although some doctors find them useful. There is no current evidence for the efficacy of these drugs in adults and conflicting evidence for their use with paediatric patients for whom side effects may be an issue.

There is also the risk of compromising IP measures through masking the infectivity of patients.

7.8.3 Anti-diarrheal drugs

These are not recommended routinely but some doctors find them useful. There is however the risk of compromising IP measures through masking the infectivity of patients.

7.9 Preventing Spread to Other Areas.

- Visiting staff e.g. Physiotherapists, Occupational Therapists, Phlebotomists should still continue their service to the affected area. The affected area(s) should be the last to be visited. Only essential procedures should be carried out on the symptomatic patients / residents.

- Staff in affected areas should not be transferred to other areas except when deemed unavoidable by risk assessment for the necessary care of patients / residents. Bank staff should be discouraged from working on other areas if they have recently worked on an affected area. It may be sensible to arrange for bank staff to work a block of shifts with days off 48 hours before returning to a non-infected area.

- Patients / residents should not be transferred to other healthcare environments unless in an emergency situation. If an internal hospital transfer is necessary due to clinical need (e.g. to ICU or theatres), then a risk assessment will need to be undertaken, and the receiving unit should be informed.

- Symptomatic patients / residents should not be sent to diagnostic departments unless it is unavoidable. Where possible, investigations / treatments should be postponed or carried out at the patient's location. If this is not possible, the receiving department should be informed so that they can make appropriate arrangements e.g. minimum time spent in the department, no contact with other patients and limiting the amount of staff who deal with the patient.

- **A patient's treatment must not be compromised whilst the ward is restricted due to viral gastroenteritis.**

7.10 Avoiding Unnecessary Admission

A rise in the incidence of cases and outbreaks of norovirus in institutions often reflects a similar increased incidence in the wider community. It is important to keep the numbers of patients admitted to hospital with norovirus to an absolute minimum.

Prevention of hospital admissions:
- Wherever possible, symptomatic residents should be managed in the home and hospital admission should only be contemplated for those who are at serious risk of complications.
- Residents must be closely monitored especially rehydration with fluid balance and stool charts.
- In the event of hospital admission the hospital should be informed before transfer of the possibility of incubating norovirus in the resident. The ambulance crew who transport the resident should also be informed.

The following should be considered within the Accident and Emergency / AMU:

- Infection prevention screening must be completed in A+E of patients with vomiting and or diarrhoea; patients should be assessed / treated in a segregated area to prevent transmission to other patients within the department.

- Patients should be routinely asked during triage if they have come into contact with anyone suffering with diarrhoea and vomiting within the previous 72 hours or if they themselves have experienced / are experiencing symptoms currently. This assessment of risk must be clearly documented in nursing / medical notes.
- Rapid clinical assessment of the patient by a sufficiently senior doctor.
- Where possible, the admission of patients will be restricted only to situations where the diagnosis is significantly uncertain or complications are a risk and simple rehydration is unlikely to suffice.
- If admission is required the patient must be isolated in to a single room and stool sample collected as soon as possible. If no single rooms are available a risk assessment must be conducted with the IP Team / Clinical Microbiologist.

7.11 Discharge of Patients during an Outbreak

7.11.1 Discharge to own home

Patients can be discharged to their own home at any time irrespective of the stage of the patient's Norovirus illness. It is not necessary to delay the discharge of symptomatic patients or those who may be incubating Norovirus.

Care must be taken however to ensure the patient / patients carer will be able to manage on-going symptoms at home, ensure a norovirus leaflet is given for advice.

Should readmission be necessary the patient should be advised to inform the admitting officer on return to the hospital.

7.11.2 Discharge to Nursing or Residential homes

Discharge to a nursing or residential home must not occur until 48 hours after the last documented patient case.

However if the patient has had symptoms and recovered and has been asymptomatic for 48hrs the patient can be discharged on the advice of the Infection Prevention Team and with the full knowledge of the care home involved.

7.11.3 Discharge or transfer to other hospitals or community based institutions

This must be prevented until the patient has been asymptomatic for at least 48 hours. Urgent transfers to other hospitals need individual risk assessment and the IP Team should be contacted.

7.12 When is the Patient / Ward / Care Home Clear of Infection?

- Virus particles can be excreted before the onset of symptoms and for up to three weeks after recovery. However, transmission of infection is considered unlikely after more than 48 hrs following the last episode of diarrhoea and / or vomiting. Therefore patients can be removed from isolation at this time.

- During a 'closure', restrictions can usually be lifted 48 hrs after the last patient has had any symptoms (NB: The IP team must be involved in deciding whether any control measures can be relaxed).

- A ward 'closure' may be converted to a single bay restriction (cohort) or single room restrictions if all remaining affected patients less than 48 hours symptom free can either be isolated in single rooms on the parent ward or cohorted in a bay area.

- Clearance stool specimens are not required.

7.13 Infection Clean – Tameside Hospital

Norovirus has the ability to remain viable for up to 12 days in the environment therefore it is imperative that a thorough Infection clean is conducted before the ward can re-open. (This does not include 'Fogging' with Hydrogen Peroxide).
A Infection clean should take place at least 48 hours after the onset of the final case and 48 hours since the last episode of uncontrolled vomiting / diarrhoea.

(Please see appendix 3 *Procedures for environmental cleaning, decontamination of patient shared equipment including Infection clean and the removal of soiling and spillage).*

Nursing / residential homes and Community Services

Routine and enhanced cleaning regimes apply to community healthcare settings as they do in the acute trust, all IP precautions must be adhered to as per guidelines for the management of Norovirus outbreaks in acute and community health care settings.

7.14 Affected Staff

Staff of all disciplines and health care students are often affected during an outbreak of norovirus.

- All staff who are taken ill at work with either diarrhoea and / or vomiting should be sent home immediately without completing the shift. It is the individual's responsibility to communicate to colleagues that the bathroom / toilet area requires immediate decontamination before use by other staff members. This is to prevent spread to other members of staff on the ward.

- All Trust Staff and students working within hospital and community settings must not return to work until a period of 48 hours symptom free has elapsed. The period of exclusion is to prevent further transmission to the healthcare environment due to continued viral shedding which can occur up to 48 hours after symptoms have ceased. **Staff and students working within the Trust are to be advised that this exclusion is mandatory.**

- The submission of a stool sample by staff is also a requirement if the reason for staff sickness is diarrhoea and vomiting. Samples should be submitted via the Occupational Health Department or G/P.
Advice and guidance can be sought from the IP Team or Occupational Health team should this situation arise.

- If staff have symptoms that reoccur they should be excluded from work and should not return until 48 hours have elapsed from their last symptom. In line with the attendance management policy this will be recorded as sickness absence and the exclusion will be on full pay.

7.15 Visitors

Visitors may contribute to the on-going spread of norovirus. Visitors where possible should be discouraged but not prevented from attending areas that are 'closed' / have restrictions in place due to norovirus. This applies especially to the elderly, immunocompromised or the very young, in whom infections may be more severe. This also applies in the same way to nursing / residential homes. However relatives that have travelled a long distance or have been significantly inconvenienced should be allowed to visit residents in outbreak restricted areas.
(appendix 5).

7.16 Reoccurring Symptoms

- Recurrence of symptoms may represent prolonged infection, re-infection or infection with a different organism.
- The IP Team should be contacted immediately for a further risk assessment.
- The patient(s)/ resident (s) should be isolated as soon as possible.

8. POLICY DEVELOPMENT & CONSULTATION

Following initial discussion within the IP team, the Infection Prevention Committee (IPC) is the main forum through which consultation is achieved. The policy is circulated to key stakeholders: via members of the IPC and to those named in the policy as having a particular role / responsibility.
The policy is authorised by the IPC and is placed on the Trust intranet.

9. IMPLEMENTATION

Once authorised by the Infection Prevention Committee this policy will be uploaded to the Trust intranet. The Director of Infection Prevention / Control, Assistant Chief Nurses, Matrons and Ward Managers will ensure that robust processes are in place for all appropriate staff groups to ensure this policy is implemented.

0. REVIEW

This policy will be formally reviewed 2 years after approval (as stated on the title page), or earlier depending on the results of monitoring, audit results, new national guidance or recommended changes in practice.

1. MONITORING

Compliance with this policy will be monitored by the IP team on behalf of the Infection Prevention Committee. This monitoring will take place in the event of an outbreak on a daily basis.

12. REFERENCES

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13. APPENDICES

Appendix 1 – Infection Prevention / Control Precautions

Appendix 2 – Sampling Procedures

Appendix 3 – Procedures for environmental cleaning and decontamination of patient equipment including infection clean and the removal of soiling and spillage.

Appendix 4 – Consumption of food and patient meal service

Appendix 5 – Special instructions for Visitors and Relatives

Appendix 6 – Diarrhoea and Vomiting Investigation report

Appendix 7 - Equality Impact Assessment

Appendix 8 - Norovirus Patient and Relatives/Friends Information Leaflet

Appendix 1

Infection Prevention / Control Precautions

Acute / Community Ward Area

Restrict admissions, transfers and discharges to all or part of the ward if cohorting.

Keep side room, bay and ward doors closed.

Place signage on the ward door informing all visitors and staff of the ward status and restricted visiting.

Place patients within the ward for the optimal safety of all patients.

Prepare for re-opening by planning the earliest date for an infection clean.

Patients and Residents

All patients and Residents on the ward or health care setting (symptomatic and asymptomatic) should be commenced on the Bristol stool chart. This is to ensure that accurate information can be provided to assist the Infection Prevention (IP) Team in undertaking the daily risk assessment.

Sample all symptomatic patients / residents (Culture and Norovirus). C.difficile tests should only be considered after consultation with the IP team.

Provide adequate opportunity to allow patients/residents to decontaminate their hands at regular intervals particularly prior to consuming food and after going to the toilet with soap and water.

Healthcare workers

Ensure all staff are aware of the necessary control measures within the restricted area.

Allocate staff **where possible** to care for affected or non-affected patients.

Ensure symptomatic staff refrain from work until they are 48 hours clear of symptoms.

Prevent **non-essential** clinical / non-clinical staff visiting the acute trust area. The ward manager and Consultant in charge of the ward must decide which staff are essential / non-essential.

Patient / resident and relative information

- Provide all patients and relatives with information on norovirus and the necessary control measures that they should follow.
- Advise visitors on restricted visiting.
- Advise visitors of their own personal risk.

Continuous monitoring and communication

- Maintain an up to date record of all patients / residents with symptoms and the number of staff affected.
- Monitor all affected patients / residents for signs of dehydration and correct as necessary.

- Ensure the Acute / Community hospitals divisional teams are aware of the outbreaks progress. Communicate to the wider multidisciplinary team on a daily basis (IP team via e-mail).

Personal Protective Equipment

Use apron and gloves as indicated to prevent transmission between patients/ residents.

Personal Protective clothing (PPE) must be used when handling excreta or vomit and when in close patient/resident contact. Aprons and gloves must be removed before leaving the patient's/residents near environment and hands should be decontaminated immediately.

PPE must be removed and hands washed prior to leaving the cohort area, single room / ward.

Consider the use of facial protection if there is a risk of body substances contaminating the face of the healthcare worker. [2]

Hand hygiene

Adequate facilities for hand hygiene must be provided; hand wash basins must be accessible and regularly restocked with liquid soap and paper towels.

Use liquid soap and water to decontaminate hands using the correct technique (WHO 5 moments).

Encourage and assist patients/residents to perform hand hygiene at regular intervals. See special considerations[1]

Environment

It is essential that environmental cleaning is carried out to a high standard and cleanliness is maintained.

Remove exposed foods (please see appendix 4 consumption of foods including meal service.

Intensify cleaning ensuring affected areas are cleaned with the appropriate chemicals (domestic services).

Decontaminate frequently touched surfaces with disinfectant Wipes as a minimum twice daily.

Procedures for environmental cleaning, decontamination of patient shared equipment, including infection clean and soiling and spillage can be found in appendix 3 of this policy.

Equipment

All patient/resident shared equipment must be thoroughly decontaminated after every use to prevent person to person spread.

- Use single patient use equipment whenever possible.
- Decontaminate all non-disposable equipment after use in an appropriate manner.
- Procedures for environmental cleaning, decontamination of patient shared equipment, including Infection clean and soiling and spillage can be found in appendix 3 of this policy.

Linen – Acute / Community Hospitals

Used and soiled linen from affected patients should be bagged and transported in accordance with the trust guidance. (Red alginate bag into white plastic laundry bag) – see infection prevention / control procedure manual for further guidance access via the trust intranet.

Beds (not in use) should not be remade until the ward is 'reopened' mattresses and bed frames must be thoroughly cleaned before remaking.

Ensure adequate supplies of linen are available to the ward.

Nursing and Residential Homes.

Used and soiled linen from affected patients should be bagged and transported in accordance with local guidance, referring to the Department of Health, HTM01 -04 for handling of laundry in care homes.

Spillage

- Decontamination of all vomit or faecal spillage is vital to ensure virus particles are killed.
- Clean and disinfect all faecal and vomit spillages
- Facial protection may be required. See special considerations[2]

Special considerations

[1] Hands decontaminated with soap and running water for at least 30 seconds using the appropriate technique is the most effective way to reduce norovirus contamination on the surface of the hand.

Whilst the efficacy of alcohol based products against norovirus remains in question alcohol sanitiser serves as an effective adjunct between full hand washes and should not be removed from the ward environment. Alcohol sanitisers however should not be considered a substitute for soap and water. (Please refer to the Trust Hand Hygiene Policy).

[2] There is limited evidence to support the use of masks / other facial protection when caring for patients with suspected norovirus. The use of masks may instill a false sense of security and are not a substitute for adequate Infection Prevention and Control Management. Facial protection however should be worn during cleaning and disinfection of vomit / faecal spillage if there is a potential for splashing of body substances or cleaning products into the face.

Appendix 2

SAMPLING PROCEDURES

Stool specimens must be sent from all symptomatic patients. Diarrhoea can be defined as frequent, loose watery stools which on sampling take the shape of the container and are described as type 5-7 on the Bristol stool chart.

The date and time the sample was obtained must be recorded in the outbreak documentation. An I Log number will be provided by the Infection Team and the I log number must be documented on the sample bottle and request form. The I log number is a means of identifying samples from an outbreak and these are processed together at the Central Manchester Pathology Laboratory.

Contamination of a stool sample with urine does not affect specimen quality and should still be submitted for testing.

Request forms should include C+S (Culture and Sensitivity) and Virology.
It is recommended to complete all forms and labelling of pots prior to obtaining the specimen. Hands should be washed thoroughly with soap and water using the correct technique afterwards. This will help to prevent cross contamination from your hands to the surrounding environment.

Nursing / Residential home managers should contact the General Practitioners of affected residents and ensure that faeces specimens from cases are collected without delay. Specimen containers should be ordered from the local GP practice or trust laboratory.

There is no current requirement to provide clearance stool samples from patients or residents to define the end of an outbreak.

Appendix 3

Procedures for environmental cleaning and decontamination of patient equipment including Infection clean and the removal of soiling and spillage in the Acute Trust

The frequency of cleaning the ward environment must be increased and one extra toilet clean to take place. It is preferable for the affected areas to have dedicated domestics who are not shared. However if this is not possible and domestic staff clean more than one area they must clean the unaffected areas first and go to the affected areas last.

Regular additional checks of toilet and bathroom areas by all staff must occur throughout the day to prevent any transmission from patient to patient.

Clean from unaffected (clean) to affected (dirty) particularly if ward is in a cohort situation.

Vermop microfibre mops and disposable cloths should be used by the domestic in conjunction with a disinfectant product. Ward staff must use the ward mop and bucket to clear spillages. The mop head is disposable and during this type of outbreak situation must be changed after each use. Neutral detergent and Haz Tabs must be available for ward staff to use out of hours.

Special attention must be given to toilet and bathroom areas, commodes, all horizontal surfaces and frequently touched surfaces such as the nurses' station, nurse call system, telephones, door handles, sinks, taps and light switches. All surfaces should be cleaned and disinfected by the domestic staff and on a continuing basis with the 3 in 1 disinfectant wipes by the nursing staff.

Cleaning staff and staff who undertake cleaning tasks should follow standard infection control precautions and wear appropriate personal protective equipment including disposable gloves and apron.

Infection clean *(After outbreak declared over)*

- Discard unused disposable patient care items.

- Items that are not able to be cleaned appropriately must be discarded including contaminated foodstuffs.

- Remove window and privacy curtains preventing unnecessary agitation and send for laundering – window blinds must be wiped down.

- Remove bed linen and any unused linen and send for laundering.

- Decontaminate all equipment in accordance with manufacturer's guidance.

- All surfaces should be cleaned and disinfected with a disinfected product and universal sanitising wipes.

Decontamination of spillages

- Staff should wear appropriate PPE including disposable gloves and apron.

- Soak up the spillage with disposable paper towels or absorbent blue roll and dispose of into clinical waste.

- Clean the area with neutral detergent and hot water.

- Disinfect the area using chlorine releasing agent in accordance with the manufacturer's instruction (Haz Tabs).

- Dry the area thoroughly.

- Discard PPE and disposable materials (including mop head) into a dedicated waste bag.

- Wash hands with liquid soap and water.

Decontamination of re-usable equipment

- Staff should wear appropriate PPE which includes disposable gloves and apron.

- Equipment must be cleaned in between uses with disinfectant wipes.

- Equipment should be cleaned from the top to the bottom.

- PPE and disposable materials should be discarded into the clinical waste stream.

- Hands should be washed with soap and water using the correct technique

Appendix 4

Consumption of food and patient meal service – Acute and Community Hospitals

Other than patient meals food stuffs should not be consumed in the ward environment. This is to prevent the risk of on-going transmission of norovirus from person to person. Foods should not be shared or offered between colleagues or between patient to patient.

It is advised that the following is considered:

Patients in affected bays should have open and exposed foods discarded.

Staff must not consume foods or beverages anywhere other than the staff room; this includes food such as sweets, chocolates biscuits and other confectionery.

Staff and patient crockery (including patient meal trays) are thermally disinfected in an industrial dishwasher where the final rinse cycle reaches a temperature of 82 degrees.

Meal service delivery should occur from clean (asymptomatic patient areas) to dirty (symptomatic areas). Therefore closed bays and side rooms should receive meals last.

It is suggested that a second member of staff will be required to assist in the delivery of patient meals to closed bays and side-rooms this is to allow meals to be passed into an affected area, preventing unnecessary traffic and preventing the risk of cross contamination to the wider ward environment.

Patients must be provided with the opportunity to decontaminate their hands at regular intervals particularly prior to consuming food.

The same procedure should be adopted for the collection of meal trays (collecting from unaffected areas first and subsequently collecting from the affected area last. It is suggested that a designated cleanable trolley should be used to prevent trays being placed inappropriately on horizontal surfaces during collection.

Aprons and gloves should be changed and hands washed with soap and water before entering the kitchen.

At the end of the meal service the designated trolley should be cleaned with a Disinfectant Wipe.

All horizontal surfaces in the kitchen / ward area should be wiped down with Disinfectant Wipes.

Appendix 5

Special instructions for Visitors and Relatives – Acute and Community Hospitals

- Visitors should be advised not to visit if they have symptoms of gastroenteritis or have had recent contact with a person with diarrhoea and / or vomiting. This includes recent visits to other wards or departments affected with norovirus.

- Visitors where possible should be **discouraged but not prevented** from attending the wards that are 'closed' / have restrictions in place due to norovirus. This applies especially to the elderly, immunocompromised or the very young, in whom infections may be more severe.

- Visitors should decontaminate their hands on entering and leaving the ward by either hand washing (using liquid soap and water) or with alcohol hand sanitiser if access to a hand wash basin is not possible without entering an affected area to do so. Visitors should decontaminate their hands with soap and water when leaving the ward area.

- If clothing from symptomatic patients is returned to relatives or carers for laundering, they should be given verbal instruction on how to safely launder the items in the home setting.

- Soiled and contaminated clothing should be presented to relatives in a soluble bag. Specific laundry bags compatible with domestic washing machines are recommended.

- The Patient and Visitor Information Leaflet "Viral Gastroenteritis" should be given and made available to all patients and visitors to the ward.

Nursing / Residential Homes

The above advice also applies in the same way to nursing / residential homes. It is important to assess the needs of residents to have visitors with the duty of care to other residents and visitors.

Visitors should be advised not to visit if they have symptoms of gastroenteritis or have had recent contact with a person with diarrhoea and / or vomiting.

Children of school age and non-essential visitors should be discouraged from visiting. Residents that are terminally ill for whom visiting are essential should be allowed visitors at the discretion of the home manager. However consideration for relatives that have travelled a long distance or have been significantly inconvenienced should be allowed to visit residents on outbreak restricted areas.

lnvestigation Re no rt .... Date outbreak commenced• .....

Name	Bay/ Bed No	DOB	NI-IS No	Date Started (D&V) ¯Note s m toms	V X a	Complete daily symptomatic - symptomatic Days 1-7						Date Stopped (D&V)	Sample Taken	Result
					J.	2	3	4	5	6	7			

'tKey for symptoms: D = jaancrisie_a F = Fever V = Vomiting A = Abdominal pail

Appendix 7

Equality Impact Assessment

		Yes/No	
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

Appendix 8

If you have a visual impairment this leaflet can be made available in bigger print or on audiotape. If you require either of these options please contact the Patient Information Centre on 0161 922 5332

Language, Interpretation and Patient Support Service (LIPS):
If you require an interpreter to assist your appointment, please ask an appropriate family member to contact our central booking office between **Monday to Friday 8am to 5pm** on **0161 922 6991** to arrange this for you. Further information can be found on the Trust public website https://www.tamesidehospital.nhs.uk/patients/lips.htm

語言 翻譯及病者支持服務 **(LIPS):**

如果閣下需要翻譯員在您的預約當日幫助您的話 請共一名合適的家庭成員 **0161 922 6991** 聯絡本中

央預約辦事處來您您安排 我們的辦公時間是星期一至星期五 上午 8 時至下 午6時

Językowo Tłumaczeniowa Usługa Pomocy dla Pacjenta (*Language, Interpretation and Patient Support Service* LIPS):

Jeśli potrzebujesz pomocy tłumacza w trakcie swojej wizyty, proszę poprosić odpowiedniego członka rodziny o skontaktowanie się z Centralnym Biurem Zamówień (*Central Booking Office*), w celu zorganizowania tłumacza pomiędzy poniedziałkiem a piątkiem w godzinach od 08:00 - 17:00 pod numerem 0161 922 6991.

لینگویج، انٹرپریٹیشن اینڈ پیشنٹ سپورٹ سروس (لپس)

اگر آپ کو اپنی اپائنٹمنٹ کے لئے مترجم کی مدد کی ضرورت ہو تو براہ مہربانی اپنے خاندان کے کسی موزوں فرد سے کہیں کہ وہ ہمارے سنٹرل بکنگ آفس سے پیر سے جمعہ 8.00 بجے صبح سے 5.00 بجے شام کے دوران 01619226991 پر فون کر کے اس کا بندوبست کریں۔

Help us to help you It is important that we keep your records up-to-date. If the information about you is incorrect, we may be unable to contact you should we need to inform you about any changes to your appointment. Therefore, if you change your GP/Dentist, address or telephone number, please contact us as soon as possible. Please provide a mobile number where possible as we operate an appointment reminder service via text message.

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NHS
Tameside and Glossop Integrated Care
NHS Foundation Trust

Norovirus
Patient and Relatives/Friends Information Leaflet

WHAT IS IT?

Norovirus is an illness which can cause vomiting and/or diarrhoea, abdominal pain and sometimes headache. Although the illness is unpleasant, it usually lasts only one or two days.

Outbreaks can occur at any time but they are more common in the winter.

HOW DO YOU CATCH IT?

The virus is found in faeces and vomit of infected people and can continue to be excreted for up to 48hrs after recovery. It is highly infectious and can be spread by airborne particles (released when someone vomits) being ingested, it can also be spread by poor hand hygiene. Virus particles can also survive in the environment, and on patient equipment.

HOW CAN IT BE AVOIDED?

Cambria 12 Styles

This illness is highly infectious. The following steps should be taken to reduce the risk of infection:

- Wash hands thoroughly with soap and water especially before eating, after using the toilet, before and after contact with others, before leaving the ward /department.
- Thorough cleaning of spillage after someone has vomited and /or used the toilet. Please tell a nurse if spillage has happened.
- Do not keep food (fruit, biscuits, sweets and chocolate etc.) at the bedside; alternately keep inside the locker / food storage container.
- Visitors may be kept to a minimum during periods of infection or asked to take extra precautions when visiting; this will be explained fully by the nursing team.

WHAT SHOULD I DO IF I AM ILL?

People with symptoms should stay away from work or school and if possible should not visit people in hospital until they have had no diarrhoea/vomiting for 48hrs. The symptoms will usually get better without treatment but it is important to drink fluids in small amounts frequently to reduce the risk of dehydration.

REFERENCE

Guidelines for the management of Norovirus outbreaks (2012) Norovirus working party (HPA, IPS)

If you have any questions you want to ask, you can use this space below to remind you.