



POLICY FOR MANAGEMENT OF DIARRHOEA AND VOMITING

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Summary of Amendments

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21 and 31	--	Nov 2018	Updated appendices – inc. Appendix 2: Flow Chart and Appendix 8: Updated Checklist

Executive Summary

There can be many causes for diarrhoea and vomiting, some of which may be due to infectious agents which pose a risk of onward transmission to other service users, staff or visitors.

The goal of effective management of diarrhoea and or vomiting is to prevent onward transmission to other patients, staff or visitors which impacts upon the patients' recovery and can cause disruption to service delivery.

All cases of diarrhoea and or vomiting should be treated as potentially infectious until an alternative cause has been identified. It is important to recognise individuals may experience an infective episode in addition to pre-existing non-infectious conditions.

This policy will support clinical staff in making a risk assessment based upon the clinical symptoms and patient history.

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1.0 INTRODUCTION

- 1.1 There can be many causes of gastroenteritis (diarrhoea and vomiting), including but not limited to overeating, excess alcohol, medications, food poisoning, bacterial or viral infection.
- 1.2 Symptoms can be varied such as nausea, cramps, headaches, diarrhoea and vomiting. They can range from quite mild to extremely severe.
- 1.3 All episodes of diarrhoea and vomiting should be treated as potentially infectious until fully investigated.
- 1.4 The commonest cause of gastroenteritis in healthcare settings is Norovirus (HPA 2008). Prompt investigation and effective management is vital in the control of this infection for patients, visitors, staff and the organisation.

2.0 SCOPE & DEFINITIONS

- 2.1 This document applies to bank, locum, permanent and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), Non-Executive Directors, governors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, Agency workers, and other workers who are assigned to Solent NHS Trust.
- 2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.
- 2.3 **Clostridium difficile** - an anaerobic, gram positive spore forming Bacillus that can cause a gut infection. The spores are resistant to heat, alcohol and acids in the stomach, and can survive in patients and the surrounding environment for long periods of time. The bacteria can produce two toxins; Toxin A and B. (See Clostridium Difficile Policy).
- 2.4 **Cohort nursing** – a group of service users nursed together because they are believed to all be experiencing the same infection.
- 2.5 **Diarrhoea** – 3 or more episodes of loose stools type 6/7 (see - Bristol Stool Chart – Appendix 7) in a 24 hour period where this is not the patient's normal bowel habit.
- 2.6 **Environmental Contamination** – the immediate area around a symptomatic service user becomes heavily contaminated with microbes capable of causing infection. Microbes may remain viable for many hours, days or weeks, with the potential for onward transmission usually on contaminated equipment or by hands.
- 2.7 **Exclusion Rule** – staff should be excluded from the workplace for 48 hours after their symptoms of diarrhoea and/or vomiting have ceased.
- 2.8 **Hand Hygiene** – Effective hand hygiene with soap and water is essential when caring for patients with diarrhoea and vomiting.
- 2.9 **Isolation room** – A single room; usually with its own clinical hand washing and en-suite toilet facilities.

- 2.10 **Outbreak of diarrhoea and/or vomiting** – when two or more service users present with symptoms of diarrhoea and/or vomiting (not associated with underlying clinical conditions) in the same clinical setting around the same time. Laboratory confirmation is not required to declare an outbreak.
- 2.11 **Serious Incident Requiring Investigation (SIRI)** – an episode that requires reporting and investigating in view of Patient Safety and Quality. Any ward closure is automatically classified as an SIRI.
- 2.12 **Ward/Department closure** – This may occur when the number of affected patients exceeds isolation facilities or where the client group makes isolation difficult, i.e. confused patients.

3.0 OVERARCHING PRINCIPLE WHEN MANAGING DIARRHOEA AND VOMITING WITHIN SOLENT NHS TRUST SERVICES

- 3.1 All clinicians should apply the following mnemonic protocol (**SIGHT**) when managing suspected potentially infectious diarrhoea (DH 2009).
This overarching principle applies regardless of the setting in which the client is cared for.

S Suspect that a case may be infective where there is no clear alternative cause for diarrhoea.

I Isolate the patient and consult the infection team (IPT) while determining the cause of the diarrhoea.

G Gloves and aprons must be used for all contacts with the patient and the environment.

H Hand washing with soap and water should be carried out before and after each contact with the patient and the patient's environment.

T Test the stool for toxin (*Clostridium difficile*) or viral studies for Norovirus, by sending a specimen immediately.

- 3.2 Persons who have currently or previously had *Clostridium difficile* toxin detected should **NOT** be excluded as possible Norovirus cases. (HPA 2011).

4.0 TRANSMISSION OF INFECTION

- 4.1 Transmission of micro-organisms, capable of causing diarrhoea and /or vomiting, can occur by both direct and indirect methods.

- 4.2 Diligent application of standard infection precautions alongside additional interventions of isolation and enhanced environmental cleaning are essential to prevent onward transmission.

5.0 LABORATORY TESTING

- 5.1 Use of laboratory testing in cases of diarrhoea can be extremely useful. If a causative organism is identified it may be possible to predict the period of infectivity, pattern of spread and likely duration of symptoms.

- 5.2 Staff must obtain a stool specimen as soon as practicable when a patient presents with diarrhoea of unknown cause. A stool specimen can be taken if contaminated with urine.

- 5.3 Every specimen and request form must contain a minimum of 3 points of patient identification before it will be processed.
- 5.4 Clinical details aid the laboratory staff in forming a diagnosis. It is vital to include details of recent antibiotics or if suspecting a viral outbreak.
- 5.5 *Clostridium difficile* will automatically be tested on a liquid stool, if suspecting a viral outbreak 'full enteric screen' should be requested.
- 5.6 Responsibility for following up specimen results is incumbent upon the clinical team responsible for the patients care.
- 5.7 If a stool specimen does not identify any infectious organism but symptoms continue please liaise with Infection Prevention Team (IPT).

6.0 ISOLATION

- 6.1 Patients with unexpected diarrhoea and or vomiting should wherever possible be nursed in isolation with dedicated en-suite bathroom facilities and a clinical hand wash basin.
- 6.2 Solent NHS Trust cares for clients for whom isolation is not possible or desirable due to medical or psychological needs. Should this occur and the client fulfils the criteria of isolation clinical staff must liaise with the IPT to consider the risk for the wider department.
- 6.3 Clients who are suspected as being high risk for *Clostridium difficile* infection; recent broad spectrum antibiotics, previous CDI infection, recent exposure to CDI must take priority for a single room. If the department does not have such facilities available this must be escalated immediately to IPT or to site manager (See *Clostridium Difficile* policy).
- 6.4 Should the number of symptomatic patients exceed the number of suitable isolation rooms co-horting may be considered. It is important to only cohort patients who are believed to be experiencing the same infection i.e. do not mix a patient identified with food poisoning with another affected by Norovirus.
- 6.5 Patients in their own homes do not need to be isolated but where possible family members may be advised to use other toilet facilities and informed of the importance of hand hygiene.
- 6.6 Symptomatic patients must not have clinically urgent investigations cancelled, however staff must make a risk assessment and communicate risk to receiving and transporting staff. Patients with diarrhoea and vomiting must not wait in communal waiting areas.

7.0 PATIENT MANAGEMENT

- 7.1 Where there are two or more patients with unexplained diarrhoea and or vomiting who are linked in time and place staff should use the flow sheet in appendix 2 to assess the likelihood of an outbreak. Referral to the IPT must be made if this suggests there is a risk.
- 7.2 The paperwork in appendix 4 should be completed by the department as soon as the suspicion arises. This provides valuable information about the pattern of spread and can assist in assessing the causative agent prior to receiving microbiological results.
- 7.3 Patients with diarrhoea and vomiting can deteriorate rapidly. Monitoring of vital signs and general condition should be undertaken as a minimum of 4 hourly using the National Early

Warning Score (NEWS) charts if inpatient. Escalation to medical staff should be made either upon NEWS criteria being met or upon clinical judgement.

- 7.4 Every patient with active diarrhoea of unknown cause must have an Integrated Care Pathway found in appendix 3
- 7.5 Medications must be reviewed to omit aperients and laxative but to also review where absorption may be affected by current symptoms of vomiting or rapid gastric transit. Intravenous medications may need to be considered.
- 7.6 Most outbreaks will be managed on a day to day basis by the IPT. If deemed necessary, the Director of Infection Prevention and Control (DIPC) will convene an Outbreak meeting.
- 7.7 Large outbreaks or outbreaks involving highly pathogenic organisms will be overseen by a Major Outbreak Committee. This committee will be convened by the DIPC.
- 7.8 If the outbreak is as a result of a notifiable disease the microbiology department will liaise with the IPT and inform Public Health England.

8.0 WARD CLOSURE

- 8.1 Declaration of an outbreak does not automatically mean a ward must close. The IPT will undertake a risk assessment and liaise with the person in charge of the shift, duty managers and microbiology as required. Where the clients can be managed safely and effectively employing enhanced infection prevention practices and isolating affected clients it is feasible to continue running the department as normal.
- 8.2 Ward closure may be necessary if the numbers of affected patients exceeds isolation or co-horting facilities or if the client group is unable to comply with isolation.
- 8.3 A closed ward/department is unable to accept new admissions or inter ward/ hospital transfers; neither can it discharge patients to other health or social care premises without consultation with the Infection Prevention Team. Staff transfers both into and out of the ward and use of agency/bank staff should be limited and would normally be discouraged.
- 8.4 To avoid disruption to patient flow within Solent NHS Trust and our partner organisations, wherever possible ward closure should be avoided. Nevertheless the control of spread of infection to new admissions or visitors is paramount.
- 8.5 Within core office hours the IPT will visit the ward or department and assess the situation. The associated documentation (**Appendix 4**) must be ready for inspection by the IPT. Following a risk assessment a plan including if it is advisable to close the ward or department will be made by the IPT.
- 8.6 Out of core hours the risk assessment will be undertaken by the duty manager. Should the subsequent IPT assessment conclude the symptoms are not suspicious of an infective cause or can be managed without the entire ward being closed it may be recommended that the ward is reopened immediately.
- 8.7 The final decision to close a ward/department will be made by the Hospital /Service Manager or nominated Deputy.

9.0 PATIENTS/ SERVICE USERS IN THE COMMUNITY (e.g. supported living) WITH DIARRHOEA AND VOMITING

- 9.1 These patients are under the care of their own General Practitioners who should be advised of the patient's condition if the symptoms are severe.
- 9.2 Members of healthcare staff who work with the affected patient/service user must adopt Standard Infection Control Precautions particularly in regards to hand hygiene.
- 9.3 Patient/service users and carers in these settings should have the importance of Hand Hygiene and all other precautions explained. Patients/service users in the community who are symptomatic should not attend community day care clinics/facilities until 48 hours after their symptoms have resolved.

10.0 PATIENTS/SERVICE USERS COMMUNITY RESPITE FACILITIES

- 10.1 Unless clinically imperative patients/service users who have symptoms of diarrhoea and vomiting should not be admitted for respite care until 48hours after symptoms have resolved or known to be not infective.

11.0 PATIENT MOVEMENT, TRANSFERS AND VISITS TO SPECIALIST AREAS

- 11.1 The transfer of patients affected by vomiting and/or diarrhoea to other wards/departments should be minimised to reduce the risk of spread, but this should not compromise other aspects of care, such as emergency treatment. Transport of the infected patient should be carefully supervised. Before transfer of a patient staff should ensure they:

- Have their hygiene needs met.
- Have clean clothing.
- Are transferred to a bed with clean linen. The patient's original bed and bed linen should be left behind on the ward for decontamination.
- Have any wounds/lesions covered with impermeable dressing.
- Attendants who may be in contact with the patient should wear disposable plastic aprons to protect their clothing whilst in contact with the patient.
- Aprons should be removed when contact with the patient has finished and disposed of as infectious waste.
- Gloves need only be worn if staff transporting the patient have skin abrasions.
- The trolley or chair should be decontaminated in accordance with local policy after use by the patient and before being used for another patient. All linen should be dealt with in accordance with local policy as infected.
- Staff should wash their hands thoroughly after dealing with the patient and cleaning the trolley or chair.
- Are whenever possible seen at the end of the working session (this should not compromise clinical need).
- Do not spend time in the communal waiting area but are seen as soon as possible.
- Any area visited by the patient/service user should be cleaned and then disinfected with 1000ppm chlorine releasing solution i.e. Actichlor plus. (See Decontamination Policy).

12.0 HAND HYGIENE

- 12.1 As a minimum hands must be washed with soap and water at the start and end of clinical duties, when hands are visibly soiled or potentially contaminated, following removal of gloves,

before and after any clinical interaction with patients and upon leaving an isolation room or cohort area. (See Hand Hygiene Policy).

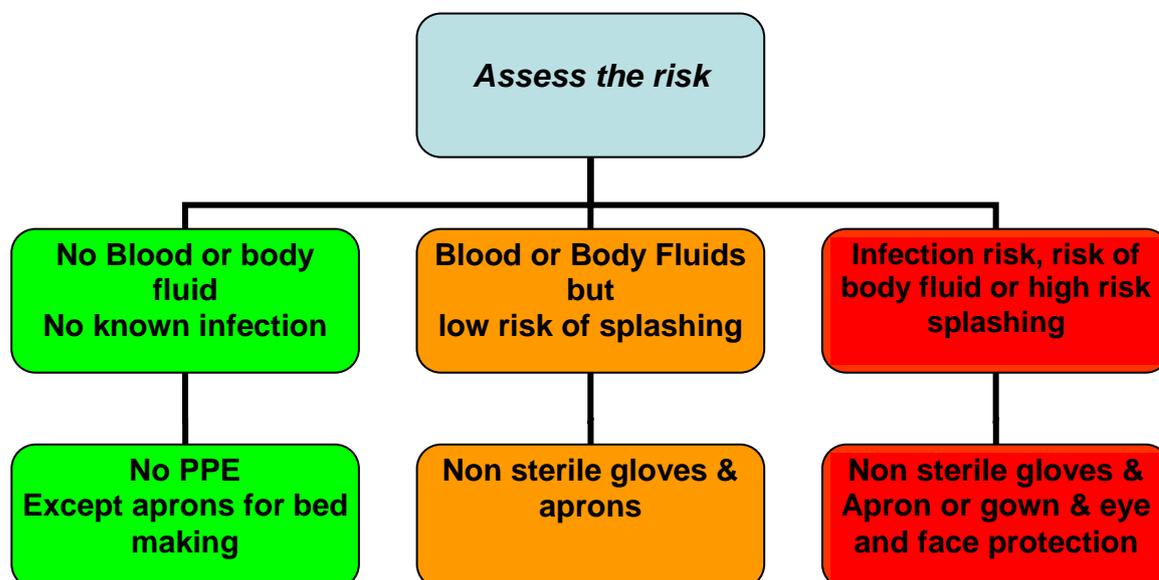
12.2 Alcohol gel must not be used to decontaminate hands when caring for patients with diarrhoea and/ or vomiting. In a community setting if soap and water are not available individual Clinell hand wipes must be used.

12.3 Bare below the Elbow principles must apply at all times when working clinically.

13.0 PERSONAL PROTECTIVE EQUIPMENT (PPE)

13.1 Wearing PPE serves to protect the healthcare worker from contamination with blood, body fluids or pathogens and to prevent the onward transmission of potentially pathogenic microorganisms onto service users, colleagues, or to their own family members.

13.2 The use of PPE should be guided by risk assessment and the extent of anticipated contact with blood, body fluids or pathogens.



13.3 The minimum PPE that must be available for all clinical staff when dealing with patients with diarrhoea and or vomiting.

- Plastic aprons.
- Non sterile gloves (general use).
- Eye and face protection – fluid/splash repellent standard.

13.4 General principles

Aprons or gowns

- Aprons are inexpensive yet effective at reducing contamination to the front of clothing where most contamination occurs.
- Aprons are single use items and must be changed between patients.
- Aprons must be changed between dirty and clean procedures on the same patient i.e. after toileting then assisting with a meal.
- Long sleeved gowns are appropriate when staff need to cover arms i.e. close contact with scabies

Gloves

- Gloves are NOT 100% impervious and hand washing after removal is essential.
- Gloves must be worn if contact with blood, body fluids, secretions, excretions or infection risk.
- Disposable gloves are single use items and must be discarded after each procedure.
- Gloves must be changed between dirty and clean procedures on the same patient.
- Gloves used in healthcare must conform to current BN standards (BS EN 455); be marked with the CE logo and are neither powdered or polythene.

Masks, spectacles or visors

- Eye protection (visor or goggles) and/or surgical masks should be used when mucous membranes are likely to be exposed to body fluids (or splashes of hazardous chemicals).

13.5 Removal of PPE

PPE should be removed in a specific order to minimise the potential for cross- contamination.

This is gloves, apron/gown, eye and face protection (if worn).

Gloves

- Grasp the outside of the opposite gloved hand, peel off holding the removed glove in the gloved hand.
- Slide the fingers of the un-gloved hand under the glove at the wrist, peel forward.
- Discard both gloves in clinical or offensive waste stream as appropriate.
- Hand hygiene must follow removal of the final item of PPE.

Apron/Gowns

- Pull ties to break.
- Pull away from neck.
- Wrap apron in on itself to contain the 'dirty' side – dispose in clinical or offensive waste stream as appropriate (see Appendix 7).
- Hand hygiene must follow removal of the final item of PPE.

Goggles

- Handle by side arms.
- If disposable discard in appropriate waste stream or if reusable clean with detergent wipe, dry and store.
- Hand hygiene must follow removal of the final item of PPE.

Face mask

- Break bottom ties followed by top ties.
- Pull away from face holding ties.
- Dispose of directly into waste.
- Hand hygiene must follow removal of the final item of PPE.

14.0 SAFE HANDLING AND DISPOSAL OF WASTE (See Solent NHS Trust Waste Policy)

- All staff have a 'duty of care' to ensure that waste must be segregated, handled, transported and disposed of in an appropriate manner to ensure it does not harm staff, patients/service users, the public or the environment. (See Appendix 9 for inpatient guidance).
- Waste generated from patients experiencing diarrhoea and vomiting or from a closed ward must be dealt with as clinical/infectious waste.

- Clinical staff are responsible for changing black domestic and offensive waste bags to orange clinical waste bags at the start of an outbreak and returning them once the outbreak is over and the terminal clean has been requested.

14.1 General Principles

- Waste should be disposed of at point of care in nearest appropriate bin, if necessary take fresh bag to patient's bedside.
- Odorous or infectious waste must be removed from patient areas immediately.
- Waste bags must be changed before $\frac{3}{4}$ full, and at least daily.
- Waste bags must be swan necked when closed as below.



- Holding waste bags slightly away from the body will reduce risk if accidentally containing sharp object.
- The bag must be clearly labelled/tagged with the generators ID as per local protocol.
- Waste bags must be disposed of in an appropriate container, which must always be locked or within a locked compound/room.
- Waste generated by a healthcare worker in the community must be disposed of as per local agreement.

14.2 Soiled – Infected Linen

- All linen from isolation rooms or cohort bays must be treated as infected.
- Bags must be securely tied **prior** to leaving isolation room to prevent further contamination.
- Follow local procedure for handling of infected/soiled linen – using water soluble inner bags and designated outer bags.
- Bags must be tagged with sender's ID/postcode tape.
- Used linen bags must be stored within a designated area which cannot be accessed by the public.

- Hand hygiene is essential after removal of PPE.

15.0 INFECTIVITY

15.1 Viruses which cause gastroenteritis are readily transmitted. Excretion of virus in faeces begins a few hours before the onset of symptoms and can continue for up to 7-10 days with maximum shedding occurring 24-72 hours after exposure. In general, staff must stay away from work areas until 48 hours free of diarrhoea and or vomiting and have recovered enough to return to work. Further advice can be sought from the Occupational Health and Wellbeing Service.

16.0 ENVIRONMENT

16.1 In the event of an outbreak, it is vital to keep the environmental burden of infectious agent as low as possible.

16.2 The area must be de-cluttered to facilitate effective cleaning. Patients should be advised of the rationale so they can support this.

16.3 Open food items such as fruit bowls and unwrapped sweets must be removed as these will become readily contaminated.

16.4 Environmental cleaning should be enhanced. Frequent touch surfaces such as toilets, door handles, telephones and keyboard and high risk surfaces, such as the sluice should be cleaned and then disinfected preferably twice per day using a freshly prepared 1000ppm chlorine releasing solution (Actichlor plus).

16.5 Any environmental soiling should be cleaned up promptly (see Decontamination Policy) and any cleaning equipment used that cannot be chemically or thermally disinfected should be disposed of as potentially infected waste.

16.6 If soft furnishings or carpets are soiled, contact the IPT for further advice.

17.0 TERMINAL CLEANING

17.1 The terminal clean of an isolation room or closed ward will be undertaken on the advice of the IPT. This may occur as one entire ward or more typically separate areas/ rooms as symptomatic clients recover. The IPT will liaise with the department staff and domestic supervisors to provide as much notice as possible to those concerned.

17.2 Terminal cleans must involve a change of curtains.

- Remove all curtains – this can be done as the beds or bays become empty.
- Remove all bed linen from unoccupied beds – this can be done as the beds become empty.
- Decontaminate all care equipment in line with manufacturer's instructions.
- Then thoroughly clean and disinfect all surfaces with a combined detergent and 1000 ppm Chlorine releasing agent (Actichlor plus).
- Once the decontamination procedures are complete then clean curtains can be re-hung and the beds re-made.

18.0 VISITORS

- 18.1 Patients with diarrhoea and vomiting may receive visitors should they wish.
- 18.2 Visitors should be advised of the situation and warned that they may be at risk of illness without breaching the patient's confidence. This should occur prior to them entering the ward in order that they can make an informed decision on whether to visit. Vulnerable visitors, very young, very old or debilitated visitors should be discouraged from visiting.
- 18.3 Hand washing facilities with soap and water must be available to visitors and they should be encouraged to use these.
- 18.4 Visitors must be asked to stay away from clinical areas if they have symptoms of gastroenteritis and to continue to do so until they have been symptom-free for 48 hours.

19.0 STAFF

- 19.1 Staff may also be inadvertently responsible for the transmission of disease. In the event of an outbreak, restriction on staff movement is recommended.
- 19.2 Ideally staff working with symptomatic patients should be restricted to that ward/area until resolved or confirmed as not infective.
- 19.3 Visiting staff including doctors, physiotherapists, radiographers and social workers, can continue to work on both affected and unaffected wards/areas. However, affected wards/areas should be visited last whenever possible. Under these circumstances, meticulous hand hygiene with soap and water on entering and leaving the ward/ clinical area, and the correct use of personal protective equipment is paramount.
- 19.4 During an outbreak, and with good hygienic precautions, there is no reason why staff cannot use communal hospital facilities and public transport. Staff whose uniform becomes soiled should change into a clean uniform (see Uniform and Dress Code Policy).

20.0 DECEASED PATIENTS

- 20.1 Standard and contact precautions should be used when handling deceased patients/service users.
- 20.3 Deceased patients with profuse diarrhoea/gross faecal soiling or where there is potential leakage of body fluids must also be placed in a body bag (HSE 2010).

21.0 DISCHARGE HOME DURING OUTBREAK

- 21.1 If an asymptomatic patient from the ward is to be discharged to their own home a full explanation of the condition should be given to them and/or carers about any symptoms they should be aware of which may indicate they are incubating the infection and actions they should take. If patients require support from healthcare providers the Infection Prevention Team must be consulted prior to discharge arrangements being made. It must also be documented on their G.P discharge letter (and community nurse referral) that they have been/potentially exposed to an infection, and details given.

22.0 REOPENING THE WARD/DEPARTMENT

- 22.1 On-going review of the need for closure will be undertaken by the Infection Prevention Team and reported to the interested parties. The IPT will recommend the reopening of a ward/department as soon as it is appropriate to Hospital/Service Manager. Once the decision to reopen has been made by the Hospital/Service Manager arrangements for terminal cleaning of the area will be delegated to the relevant Service lead and undertaken in advance of the reopening. Please refer to Isolation Policy.

23.0 ROLES AND RESPONSIBILITIES

23.1 The Chief Executive

The Chief Executive and Trust Board have a collective responsibility for infection prevention and control within the Trust.

23.2 The Director of Infection Prevention and Control (DIPC)

The DIPC will have the executive authority and responsibility for ensuring strategies are implemented to prevent avoidable healthcare associated infections (HCAI) at all levels within the organisation.

23.3 Clinical & Operational Directors & Clinical Governance Leads

Have the responsibility for the co-ordination of Health and Safety activities within the service lines or care groups and for ensuring that decisions are implemented in accordance with this policy.

23.4 Infection Prevention and Control Group (IPCG)

The Infection Control Group has a responsibility to ensure that this Policy complies with advice and guidance from the Department of Health and other bodies.

23.5 The Infection Prevention Team (IPT)

Infection Prevention Team work with Learning and Development to advise on the Infection Control element of generic on-line training. Bespoke sessions may be undertaken either at the request of a service or if deemed necessary by a member of the Infection Prevention Team. Compliance with this policy will be monitored by implementing the Quality Improvement Tools as part of the Infection Control audit programme.

23.6 Managers

Managers and supervisors have a responsibility to ensure that staff are aware of their responsibilities under this Policy and associated guidelines. In addition they must ensure that all employees within their area of responsibility comply with this Policy and associated guidelines.

23.7 Employees

All employees have a responsibility to abide by this Policy. This Policy is enforceable through Health and Safety Legislation and Solent NHS Trust disciplinary procedures. If employees are aware that the Policy or associated guidance is not being complied with they must first take the issue to their line manager and if the problem is not resolved they must inform the Infection Prevention Team.

- 23.8 **Link Advisors** are healthcare staff selected by their managers to receive additional training in infection prevention and control. The key role of link staff is to develop best practice within their clinical area.

23.9 Ward / Departments

Ward/clinical areas are responsible for:

- Informing the Infection Prevention Team immediately of any suspected outbreaks/ infection control concerns.
- Providing accurate documented and verbal information on service users/patients and staff to the Infection Prevention Team at the earliest opportunity for a full assessment to be undertaken.
- For all cases of a suspected outbreak of gastro-intestinal illness, the Infection Prevention Team will need to be informed of the information listed **in Appendix 4** for each symptomatic patient.
- Providing on-going, accurate documented and verbal information on service users/patients and staff to the Infection Prevention Team. A stool chart (using Bristol scores) for each symptomatic service user/patient must be maintained and a summary of that information collected on a Diarrhoea and Vomiting Outbreak form (**Appendix 4**) on a daily basis.

24.0 STAFF TRAINING

- 24.1 Solent NHS Trust recognises the importance of appropriate training for staff. For training requirements and refresher frequencies in relation to this Policy subject matter, please refer to the Training Needs Analysis (TNA) on the intranet.
- 24.2 All training undertaken must be recorded on the Organisational Learning Module (OLM) of the Electronic Staff Record (ESR) taken from signing in sheets. Monitoring of the training attendance will be carried out by the Learning & Development.

25.0 SUCCESS CRITERIA/MONITORING COMPLIANCE

- 25.1 Measuring compliance/audit of this policy will be difficult due to the anticipated infrequency with which outbreaks (or potential) of infection which involve ward/department closure are likely to happen within the Trust. Consequently the approach to monitoring will be by retrospective review of outbreak management. The reviews will be led by the IPT.
- 25.2 Bi - Annual Hand Hygiene Observational Audit undertaken by the Link Advisors, results will be collated by IPCT and discussed as agenda item at the Infection Prevention and Control Group (IPCG).
- 25.3 Continual Surveillance of alert organisms and clinically significant microbiological results working with ward areas and Consultant Microbiologist.
- 25.4 In the event of a ward being closed this will be raised as a Serious Incident Requiring Investigation (SIRI) and due process followed.

26.0 EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

- 26.1 The Equality and Diversity and Mental Capacity Impact Assessment (IA) were conducted and no negative impact was highlighted. A copy of the IA is attached as Appendix 8.

27.0 REVIEW

- 27.1 This policy may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed three years after the initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review

28.0 REFERENCES & LINKS TO OTHER POLICIES

Isolation Policy
Hand Hygiene Policy

Clostridium Difficile Policy
Equality, Diversity and Human Rights Policy
Decontamination Policy
Uniform and Dress Code Policy

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Health and Safety Executive. www.hse.gov.uk/pubns/web01.pdf. Accessed: 06.08.2010.

Hawker, et al. 2001. Communicable Disease Control Handbook, Blackwell Science.

Plymouth Primary Care Trust. 2007. Management of Diarrhoea and Vomiting in a Clinical Setting.

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29.0 GLOSSARY

DIPC – Director of Infection Prevention and Control

CDI – *Clostridium difficile* infection.

D +/- V - Diarrhoea with or without vomiting

SIRI – Serious Incident Requiring Investigation

NEWS – National Early Warning Score

IPT - Infection Prevention Team

APPENDIX 1

MANAGEMENT OF COMMON INFECTIONS THAT CAUSE DIARRHOEA AND VOMITING

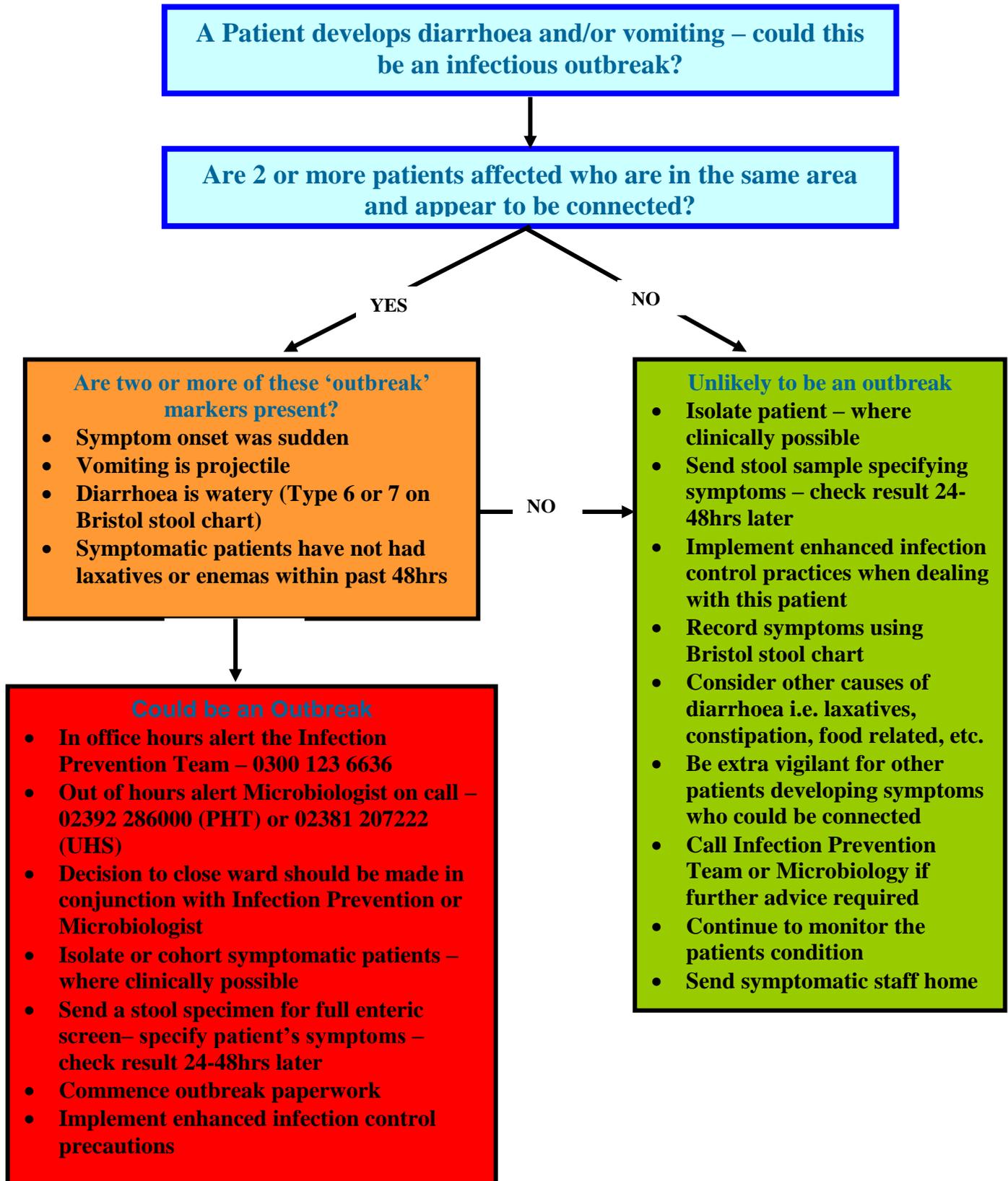
Disease and/or infective agent and clinical features	Transmission	Guidance and Isolation
Small round structured virus (diarrhoea and/or vomiting)	Faecal oral (hand to mouth following direct contact with faeces and/or vomit). <ul style="list-style-type: none"> • Secondary faecal oral spread from infected cases. • Droplet from aerosols from vomit. • Contact with contaminated gloves, shared clinical equipment and the environment. • Unwashed Healthcare Worker's hands. 	Isolate for 48 hours from the last episode of diarrhoea and/or vomiting <ul style="list-style-type: none"> • Staff members who are symptomatic should stay at home for 48 hours from the last episode of diarrhoea and/or vomiting. • Collect patient /service user stool specimens ASAP for virology. Staff stool specimens should be sent via GP ONLY if requested by Occupational Health or Infection Prevention Team
Rotavirus	As above	As above
Hepatitis A	Faecal oral which includes patient to patient spread. <ul style="list-style-type: none"> • Infected food handlers with poor personal hygiene. • Contaminated water and food especially shellfish. • Contaminated drugs and needle sharing equipment in illicit drug users. 	Isolate for one week after the onset of jaundice or in the absence of jaundice until 10 days after the onset of first symptoms. <ul style="list-style-type: none"> • Report cases to the local Health Protection Unit (HPU)
Hepatitis E	Faecal oral person to person spread. <ul style="list-style-type: none"> • Contaminated water and food. 	Isolation for duration of symptoms <ul style="list-style-type: none"> • Observe strict hand hygiene.
Campylobacter (symptoms include profuse diarrhoea malaise, abdominal pain and sometimes vomiting)	Undercooked meat especially poultry. <ul style="list-style-type: none"> • Cross contamination from raw to cooked food. • Food contaminated by unwashed hands and contaminated utensils. • Person to person spread can occur 	Isolate for 48 hours from the last episode of diarrhoea and/or vomiting <ul style="list-style-type: none"> • Collect food history. • Affected persons should not prepare or handle food for others until symptom free for at least 48 hours. Report all cases to HPU

Escherichia coli (<i>E.coli</i>) gastroenteritis Causing diarrhoea and vomiting	Ingestion of contaminated food and/or water. <ul style="list-style-type: none"> • Faecal oral. • Contaminated hands of infected cases. • Contaminated equipment 	Isolate for 48 hours from the last episode of diarrhoea and/or vomiting <ul style="list-style-type: none"> • Collect food history. • Notify the local HPU.
Listeria	Ingestion of contaminated dairy products, meat based products, seafood and vegetable based products.	Person to person spread does not occur except during neonatal period <ul style="list-style-type: none"> • Notify the local HPU. • Antibiotic therapy should be guided by a microbiologist.
Salmonella (vomiting and diarrhoea and fever)	Ingestion of contaminated cooked food by raw food or inadequate cooking temperatures. Eggs, red and white meats, dairy products.	Isolate for 48 hours from the last episode of diarrhoea and/or vomiting Food handlers should not return to work until cleared by Occupational health Report to HPU
Typhoid fever (<i>Salmonella typhi</i>) The infectious period lasts as long as long as bacilli are present in stool.	Ingestion of food and water contaminated by faeces. <ul style="list-style-type: none"> • Faecal oral person to person spread. • Unwashed hands of asymptomatic carriers 	Isolate for 48 hours from the last episode of diarrhoea. <ul style="list-style-type: none"> • Antibiotic therapy guidance from microbiologist. • Obtain travel history. • Exclude affected food handlers until six negative stool specimens taken at 2 week intervals, commencing 2 weeks after completion of antibiotics. • Exclude HCWS who are not food handlers until 3 negative stool specimens taken at 2 week intervals, commencing 2 weeks after completion of antibiotics. Report to HPU.
Cryptosporidiosis gastroenteritis (Protozoan parasite causes watery or mucoid diarrhoea)	Ingestion of contaminated water, food and milk. <ul style="list-style-type: none"> • Faecal oral spread. • Aerosol or droplet spread can occur. • Sexual partners 	Isolate for 48 hours from the last episode of diarrhoea.
Diarrhoea (unknown cause)	Faecal oral person to person spread.	Isolate for 48 hours from the last episode of diarrhoea and/or vomiting.
Bacillus cereus	Contaminated cooked food, mainly rice dishes, occasionally other source such as pasta, meat,	Isolate for 48 hours from the last episode of diarrhoea and/or vomiting

	vegetable dishes, dairy products and sauces.	Report to the local HPU.
Giardiasis (A protozoan parasite that causes diarrhoea and cramps)	<ul style="list-style-type: none"> Faecal oral spread of the cysts and by ingestion of the cysts from contaminated food and water. 	Isolate for 48 hours from the last episode of diarrhoea. <ul style="list-style-type: none"> Report to the local HPU. Antibiotic therapy should be guided by a microbiologist.
Gastroenteritis	Faecal oral route.	Isolate for 48 hours from the last episode of diarrhoea and/or vomiting
Cholera Vibrio cholera (Cases usually admitted to infectious diseases unit)	Faecal oral route. Contaminated food and water.	Isolation for duration of illness and following two consecutive negative stools taken at 24-48 hour intervals.
Staphylococcus aureus Food poisoning	Skin flora and infections in food handlers of cooked food that has then been stored at room temperature and eaten cold Exclude food handlers with septic lesions	<ul style="list-style-type: none"> Report to the local HPU.
Shigella Including bacillary dysentery	<ul style="list-style-type: none"> Faecal oral route. Contaminated food. 	Isolate for 48 hours from the last episode of diarrhoea. <ul style="list-style-type: none"> Clinicians should report to the HPU
Clostridium perfringens	<ul style="list-style-type: none"> Contaminated food. 	No person to person spread <ul style="list-style-type: none"> Clinicians should report to the HPU
Clostridium difficile (A gram-positive anaerobic bacillus that produces toxins). Clinical manifestations include abdominal pain, fever and profuse foul smelling diarrhoea	Diarrhoeal infection is often triggered by the use of antibiotics. <ul style="list-style-type: none"> Direct patient to patient spread by faecal oral route. Unwashed hands of health care workers (HCW) Transferred on contaminated equipment (including healthcare equipment). Contaminated environment. Lack of prudent antibiotic prescribing. 	Isolate until asymptomatic for 48 hours and until stools are normal. <ul style="list-style-type: none"> Collect stool samples for C. difficile toxins. Treat with oral antibiotics as recommended by a microbiologist. Use Chlorine releasing disinfectant to reduce spores in the environment. Mandatory reporting of case to the Department of Health by the Trust.

Is it an Outbreak of D&V? A decision tree to help clinical staff

Outbreaks can start abruptly and spread quickly – to minimise their impact on patients and the hospital they must be recognised, reported and controlled very swiftly.
This flow chart will help you make the right decision.



APPENDIX 3



Integrated Care Pathway for the Review of Patients with Unexpected/Unexplained Diarrhoea

It is the medical staff's responsibility to make final clinical decision about most likely cause of diarrhoea

Patient Name: NHS No: Hospital No:

Integrated Care Pathway for Review of Patients with Unexpected/Unexplained Diarrhoea

Date symptoms of diarrhoea started:/...../.....

The information held in this document is confidential and should not be viewed without receiving consent from the patient or staff member.

This care pathway is intended as a guide to treatment and an aid to documenting patient progress. Practitioners are free to exercise their own professional judgement, however any alteration to the practice identified within this IPC must be noted as a variance on the pathway.

Signature Record – All members of staff using this Integrated Care Pathway (ICP) complete this section. You can then use initials when recording care.

Print Name	Job Title	Signature	Initials

Integrated Care Pathway for the Review of Patients with Unexpected/Unexplained Diarrhoea

It is the medical staff's responsibility to make final clinical decision about most likely cause of diarrhoea

ACTION: Patient with unexpected/unexplained diarrhoea to clinically review symptoms			
Date of onset:	Type of stool: (Circle) 5 6 7	Date & time Nursing review: By whom (PRINT):	
Time of onset:		Date & time medical review took place: By whom (PRINT):	
ACTION: Identify if there could be a "Non-infective" cause for the diarrhoea			
QUESTION	CIRCLE ANSWER		TRIGGERS (not exhaustive):
1. Are the current symptoms part of the patient's normal bowel pattern or an underlying medical condition?	Yes / No		Diverticulitis; Ulcerative Colitis; Crohn's Disease; Liver Disease; Chronic Pancreatitis; Malignancy Senokot; Lactulose; Movicol; Magnesium Hydroxide Picolax; Phosphate Enema Omeprazole; Ferrous Sulphate
2. Is the patient on enteral/supplementary feeds? When did they commence?	Yes / No		Fortisips/juice/creme; high fibre formula; contaminated batch/ administration
3. Could the diarrhoea be diet related?	YES	NO	Excessive consumption of fruit, sugary drinks or diabetic sweets
4. Does the patient have severe constipation with overflow?	YES	NO	Perform rectal exam to confirm/rule out
5. Could the diarrhoea be as a result of 'starvation'?	YES	NO	
6. Has the patient had recent bowel surgery?	YES	NO	
ACTION: Identify if there could be an "Infective" cause for the diarrhoea			
7. a) Was the patient admitted with diarrhoea? b) If 'YES' are any other family members or carers affected? c) Is there a recent history of foreign travel? d) Has the patient attended a recent mass catered event or BBQ? e) Has the patient had a recent 'take-away' or food brought in?	Yes / No, if yes comment:		
8. Has the patient had a recent hospital admission (within the last 28 days)?	YES	NO	Acute or community setting
9. Has the patient had a previous positive <i>Clostridium difficile</i> result? If 'YES', when was it	YES	NO	
10. Is the patient currently on antibiotics, or recently completed a course of antibiotics? Broad-spectrum or narrow-spectrum?	YES	NO	
11. Has the ward Pharmacist been asked to review the patient's antimicrobial prescription?	YES	NO	
12. Does the patient have any raised inflammatory markers/deranged renal function?	YES	NO	Pyrexia; ↑WCC; ↑CRP; U&E
13. What are your findings following abdominal examination?	<u>Findings:</u>		
ACTION: Other considerations			
14. Does the patient have 'chronic' diarrhoea with repeated negative microbiology/virology results?	YES	NO	Consider referring patient to GI team for further investigations.
OUTCOME:			
15. Does the patient have "Potentially Infective" diarrhoea? Yes/No, If yes state suspected infection:	16. If suspected infective cause request faecal specimen sent for appropriate investigations.		
17. Date & time nurse-in-charge informed of outcome of medical review: Signature:	Name: (PRINT)		

APPENDIX 4

Diarrhoea & Vomiting Outbreak Data Record Sheet

Ward

Date outbreak commenced

Please record details accurately as indicated below - this will be used to assess the severity and likely causes for the symptoms and may influence clinical decisions.

NHS Number & Date of Birth	Location in ward	Date	Comments Antibiotics, laxatives, NG feed						
H123456 01.04.15	Room 1 Bed 3	V	D&V	D	Nil				

Please continue on this form until complete and attach subsequent forms together to show progression of symptoms.
Please turn page over for symptomatic staff

INFECTION PREVENTION & CONTROL ACTION CARD

Diarrhoea and/or Vomiting Outbreaks

1.		Inform relevant parties of the D&V outbreak including Infection Prevention or Microbiology out of hours
2.		Restrict Access to all non-essential staff & visitors
3.		Request medical review of symptomatic patients and follow Infection Prevention advice
4.		Document ALL newly symptomatic patients on the 'Daily D&V outbreak sheet'
5.		Obtain a faecal specimen from ALL symptomatic patients
6.		Maintain accurate patient records - including fluid intake/output, Bristol Stool Chart, observations and NEWS 2
7.		Ensure that the ward has adequate supplies of essential items – particularly protective clothing, linen, soap, Actichlor Plus and paper towels
8.		Implement & maintain enhanced levels of environmental cleaning –

9.		Hand hygiene must be undertaken using soap and water only not alcohol gel
----	----------------------------------------------------------------------------------	----------------------------------------------------------------------------------

APPENDIX 6

INFECTION CONTROL ALERT



**Restricted access
to this clinical area**

**Please speak to the nurse in
charge when you enter the area
for guidance and advice**

**Ensure you wash your hands
when you leave!**

Adapted from Norovirus Tools developed by Health
Protection Scotland: National Services Scotland

D&V outbreak daily checklist for ward staff
Ward..... Date outbreak started.....
PATIENTS <ul style="list-style-type: none"> • Urgent medical review for severely symptomatic or deteriorating patients • Symptomatic patients are isolated or cohorted • Outbreak Data Record, stool chart observations and unexplained diarrhoea ICP to be maintained of all symptomatic patients • Patients are aware of the D&V situation. . • Patients are advised about the importance of hand hygiene with soap and water and assistance given when needed
VISITORS <ul style="list-style-type: none"> • Are aware of the D&V situation • Advised not to visit if symptomatic within past 48 hours • Advised about the importance of hand hygiene with soap and water • Offer Public Health England leaflet – “Stop Norovirus Spreading this winter”
ENVIRONMENT <ul style="list-style-type: none"> • Signs: Approved outbreak notice is displayed at ward entrances • External doors must be kept shut • Internal doors to affected rooms should be closed. Waste: All tiger bags are to be replaced by orange bags • Cleaning: Implement enhanced cleaning with Actichlor Plus. In addition to the ward environment equipment i.e. all commodes, toilets, raised seats must be cleaned after every use Remove and clean soiled items immediately i.e. commodes, curtains • Remove food products from bedside area i.e. fruit bowls, sweets • Remove clutter to enable effective cleaning • Spillages: All faecal and vomit spillages are cleaned by staff wearing PPE. Any vomit or faeces is removed with paper towels, and then use Actichlor Plus solution or spill kit to decontaminate. All waste arising is discarded as Clinical waste. PPE is then removed and hands washed with liquid soap and warm water. • Equipment: Where possible use single use patient equipment.. All reusable equipment is decontaminated after use.

SUPPLIES

- Linen – Request sufficient supplies – do not store in affected rooms
 - Linen bags – Ensure sufficient water soluble laundry bags
- PPE – Ensure sufficient supplies i.e. gloves and aprons

FURTHER ADVICE

- Contact Infection Prevention for further advice (in office hours) 0300 123 6636
- Contact on call Microbiologist for further clinical advice (out of hours) **02392 286000 or 02381 207222**

In preparation for reopening - empty beds have been cleaned but left unmade, curtains in empty rooms have been taken down, consider pre-booking a terminal clean

Before reopening: a terminal clean has been performed following IPT recommendation and following the hospital procedure.

Infection Prevention Advice

Safe Disposal of Healthcare Waste Guide



Infectious - Orange Waste stream

- Contaminated items from known or suspected infectious patients
- Infectious disposable PPE e.g. gloves, aprons
- Infectious outbreak waste



Non Infectious - Tiger waste stream

- Contaminated items from non infectious source
- Incontinence pads
- Nappies
- Non infectious disposable PPE eg Gloves, aprons



Domestic waste stream

- Paper towels
- Tissues
- Food waste
- Non contaminated couch roll



Recycling waste stream

- Plastic bottles
- Drinks cans
- Paper
- Cardboard

Sharps and all Medicinal Waste

- | | | | |
|-----------------------------------------|------------------------------------|------------------|--------------------------------|
| Cytotoxic & Cytostatic Medicinal Sharps | Non medicinal Sharps (e.g. Bloods) | Medicinal Sharps | Medicinal Waste (inc POM, OTC) |
|-----------------------------------------|------------------------------------|------------------|--------------------------------|

- | | | | |
|--------------------------------------|---------------------------------------|--------------------------------------|------------------------------------|
| Dispose in a purple lidded container | Dispose in an orange lidded container | Dispose in a yellow lidded container | Dispose in a blue lidded container |
|--------------------------------------|---------------------------------------|--------------------------------------|------------------------------------|



Waste segregation is the only sustainable option; it protects the environment and saves money

JK/Version 2/ WG/Nov 2011

APPENDIX 10

ADVICE FOR ALLIED HEALTH PROFESSIONALS AND OTHER STAFF GROUPS DURING AN OUTBREAK OF DIARRHOEA AND/OR VOMITING

Introduction

Many facets of the patient/service user pathway and effective discharge planning are better facilitated with direct conversation and assessment, and face-to-face interaction. During periods of diarrhoea and vomiting outbreaks there is an understandable caution attributed to attending wards that are 'closed' or have restricted bays within them due to an outbreak.

The caution attributed to a ward being 'closed' has historically led to significant reduction in visiting health and social care services attending a 'closed' area unless it clinically essential. This withdrawal then contributes to a delay in the patient/service user pathway, both in terms of facilitating care, but also achieving a safe and timely discharge.

Purpose

This document has been written to clarify that visits to clinical areas in the execution of patient/service user care and discharge planning may continue and do not need to be deferred, as long as appropriate infection control precautions are followed.

The reduction in discharge associated with outbreak situations often results in higher risk decisions being considered across the organisation in order to sustain an emergency service with reduced available bed stocks.

Essential staff should continue to visit the ward. E.g. physiotherapists, occupational therapists, phlebotomists, social care managers, advocates etc.

Suitability for Discharge During Outbreaks of Diarrhoea and Vomiting

To own home

Patients/service users without symptoms may be discharged home to their own home, provided there are suitable support arrangements in place should they subsequently develop symptoms in the days following discharge. The patient/service users and their family/carers should be informed of the outbreak by nursing staff on the ward and advised to contact their GP if they develop symptoms. The patient discharge letter will advise the GP of the outbreak should the patient need to make contact.

Transfers to other care facilities

Patients who have previously had symptoms, but have been asymptomatic for 48 hours and feel recovered may usually be transferred to other care facilities. Clear infection control advice will be given on transfer as part of the daily outbreak review by Solent infection prevention team. The nurse-in-charge will have up-to date advice.

Other patients from the affected area should not be transferred within the hospital or to any other healthcare facility unless this has been agreed with the infection prevention team. In an emergency situation clinical need overrides this advice. The receiving area will be informed of the outbreak by ward staff, and the patient will be isolated if possible on arrival.

Measures Required for Assessment and Therapy Visits During Diarrhoea and Vomiting Outbreaks

Essential staff should continue to visit the ward. Advice on appropriate infection control measures should be obtained from the nurse in charge of the area upon arrival.

Standard infection control precautions should always be used, regardless of the outbreak situation.

In addition during outbreaks of diarrhoea and vomiting, the use of gloves and aprons for direct 'hands-on' care of patient who have been exposed to the infection is advised.

Further Advice

Further advice during an outbreak can be obtained from the infection prevention team:

Tel No: 0300 123 6636 or email: snhs.infectionteam@nhs.net

Equality and Human Rights Impact Assessment

Step 1

Step 1 – Scoping; identify the policies aims		Answer	
1. What are the main aims and objectives of the document?	To provide Solent NHS Trust staff with clear infection prevention and control guidelines and management process for a ward/clinical area following the identification of an outbreak or potential outbreak of diarrhoea and vomiting.		
2. Who will be affected by it?	All staff and patients/service users of Solent NHS Trust services.		
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	Compliance with: > Health & Social Care Act 2008 > Care Quality Commission Care Standard > National Guidelines: Hospital Infection Society Working Group 2000. Management of hospital outbreaks of gastro-enteritis due to small round structured viruses.		
4. What information do you already have on the equality impact of this document?	Assumption that this will potentially impact on a diverse group of service users based on previous outbreaks of infection.		
5. Are there demographic changes or trends locally to be considered?	Not aware of any local incidents which would have increased local population susceptibility to infections .e.g. public health incident.		
6. What other information do you need?	None		
Step 2 - Assessing the Impact; consider the data and research	Yes	No	Answer (Evidence)
1. Could the document unlawfully against any group?		x	
2. Can any group benefit or be excluded?	X		Of potential safety benefit to all staff and patient/service users.
3. Can any group be denied fair & equal access to or treatment as a result of this document?		X	
4. Can this actively promote good relations with and between different groups?		X	
5. Have you carried out any consultation internally/externally with relevant individual groups?		X	Internal consultation.
6. Have you used a variety of different methods of consultation/involvement		X	
Mental Capacity Act implications		X	
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)		X	
External considerations			

8. What external factors have been considered in the development of this policy?		X	
9. Are there any external implications in relation to this policy?		X	
10. Which external groups may be affected positively or adversely as a consequence of this policy being implemented?		N/A	

If there is no negative impact – end the Impact Assessment here.

05.06.2016: At this time no negative impact identified.

<u>Step 3 - Recommendations and Action Plans</u>	Answer
1. Is the impact low, medium or high?	
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	
3. Are there likely to be different outcomes with any modifications? Explain these?	
<u>Step 4- Implementation, Monitoring and Review</u>	Answer
1. What are the implementation and monitoring arrangements, including timescales?	
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	
<u>Step 5 - Publishing the Results</u>	Answer
How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	

**** Retain as a copy and also include as an appendix to the document****