
POLICY FOR MANAGEMENT OF DIARRHOEA AND VOMITING

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SUMMARY OF POLICY

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 outlines how cases of diarrhoea and vomiting should be managed, with a focus on risk assessment based upon the clinical symptoms and patient history.

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POLICY FOR MANAGEMENT OF DIARRHOEA AND VOMITING

1. INTRODUCTION & PURPOSE

- 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 most common cause of gastroenteritis in healthcare settings is Norovirus (Norovirus Working Party 2012). Prompt investigation and effective management is vital in the control of this infection for patients, visitors, staff and the organisation.

2. SCOPE & DEFINITIONS

- 2.1 This policy applies to 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), bank staff, Non-Executive Directors 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.

Definitions

- 2.3 ***Clostridium difficile* / CDI-** 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 A) in a 24 hour period where this is not the patients normal bowel habit.
- 2.6 **Diarrhoea and Vomiting** – Diarrhoea and nausea or vomiting present within a 48hour period of each other.
- 2.7 **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.

- 2.8 **Exclusion Rule** – staff must be excluded from the workplace for 48 hours after their symptoms of diarrhoea and/or vomiting have ceased.
- 2.9 **Hand Hygiene** – Effective hand hygiene with liquid soap and water is essential when caring for patients with diarrhoea and vomiting.
- 2.10 **Isolation room** – A single room; usually with its own clinical hand wash basin and en-suite toilet facilities.
- 2.11 **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.
- 2.12 **Serious Incident (SI)** – an episode that requires reporting and investigating in view of Patient Safety and Quality. Any ward closure is automatically classified as a SIRI.
- 2.13 **Ward/ Bay/ Department closure** – The restriction of new patient admissions, transfers into or discharges from the affected unit (department, ward or bay within the ward). This may occur when the number of affected patients exceeds isolation facilities or where the client group makes isolation difficult, i.e. confused patients. Entire ward closures are avoided where possible

3. PROCESS/REQUIREMENTS

- 3.1 All clinicians should apply the following mnemonic protocol (**SIGHT**) when managing suspected potentially infectious diarrhoea (Public Health England, 2013). 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 with the infection prevention and control team (IPCT) while determining the cause of the diarrhoea.
G	Gloves and aprons must be used for all contacts with the patient and their environment.
H	Hand washing with soap and water must be carried out before and after each contact with the patient and the patient's environment.
T	Test the stool for toxin, by sending a specimen immediately

3.2 TRANSMISSION OF INFECTION

- 3.2.1 Transmission of micro-organisms, capable of causing diarrhoea and /or vomiting, can occur by both direct and indirect methods.
- 3.2.2 Diligent application of standard infection precautions alongside additional interventions of isolation and enhanced environmental cleaning are essential to prevent onward transmission.

3.3 LABORATORY TESTING

- 3.3.1 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.
- 3.3.2 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.
- 3.3.3 Every specimen and request form must contain a minimum of 3 points of patient identification before it will be processed.
- 3.3.4 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.
- 3.3.5 When sending a stool sample for laboratory testing, both *Clostridium difficile* and a 'full enteric screen' should be requested.

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

- 3.3.6 Responsibility for following up specimen results is incumbent upon the clinical team responsible for the patients care.
- 3.3.7 If a stool specimen does not identify any infectious organism but symptoms continue please liaise with Infection Prevention Team (IPT) before discontinuing barrier nursing and isolation precautions.

3.4 ISOLATION

- 3.4.1 Patients with unexpected diarrhoea and/ or vomiting require immediate isolation, preferably within 2 hours of onset of symptoms until full resolution of symptoms, or until as advised by the IPT.
- 3.4.2 Patients with unexpected diarrhoea and/ or vomiting must be nursed in isolation with dedicated en-suite bathroom facilities and a clinical hand wash basin.
- 3.4.3 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.
- 3.4.4 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).

- 3.4.5 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.
- 3.4.6 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.
- 3.4.7 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.

3.5 PATIENT MANAGEMENT

- 3.5.1 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 B assess the likelihood of an outbreak. Referral to the IPT must be made if this suggests there is a risk.
- 3.5.2 The paperwork in Appendix C 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.
- 3.5.3 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 2 (NEWS 2) charts if an inpatient. Escalation to medical staff should be made either upon NEWS 2 criteria being met or upon clinical judgement.
- 3.5.4 Every patient with active diarrhoea of unknown cause must have an Integrated Care Pathway, found in Appendix D
- 3.5.5 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.
- 3.5.6 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.
- 3.5.7 Large outbreaks or outbreaks involving highly pathogenic organisms will be overseen by a Major Outbreak Committee. This committee will be convened by the DIPC.
- 3.5.8 If the outbreak is as a result of a notifiable disease the microbiology department will liaise with the IPT and inform Public Health England.
- 3.5.9 Inpatient areas should refer to their 'outbreak box' when an outbreak is suspected.

3.6 WARD CLOSURE

- 3.6.1 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.
- 3.6.2 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.
- 3.6.3 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 IPT. Staff transfers (both into and out of the ward) and use of agency/bank staff should be limited and would normally be discouraged.
- 3.6.4 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.
- 3.6.5 Within core office hours the IPT will visit the ward or department and assess the situation. The associated documentation (*Appendix C*) 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.
- 3.6.6 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.
- 3.6.7 The final decision to close a ward/department will be made by the Hospital /Service Manager or nominated Deputy, with input from the IPT.

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

- 3.7.1 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.
- 3.7.2 Members of healthcare staff who work with the affected patient/service user must adopt Standard Infection Control Precautions particularly in regards to hand hygiene.
- 3.7.3 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.

3.8 PATIENTS/SERVICE USERS COMMUNITY RESPITE FACILITIES

- 3.8.1 Unless clinically imperative patients/service users who have symptoms of diarrhoea and vomiting should not be admitted for respite care until 48 hours after symptoms have resolved or known to be not infective.
- 3.8.2 If patients are admitted to respite facilities with symptoms of diarrhoea and vomiting then the appropriate isolation precautions must be taken during discharge and transfer.

3.9 PATIENT MOVEMENT, TRANSFERS AND VISITS TO SPECIALIST AREAS

3.9.1 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 that:

- The patient has their hygiene needs met
- The patient has clean clothing
- The patient is transferred to a bed with clean linen. The patient's original bed and bed linen should be left behind on the ward for decontamination
- If the patient has any wounds/lesions they covered with an impermeable dressing
- Staff or attendants wear disposable plastic aprons to protect their clothing whilst in contact with the patient and ensure aprons are removed when contact with the patient has finished and disposed of as infectious waste.
- Aprons are not worn outside of the ward/ department unless there is a notable risk of body fluid exposure
- Gloves are only worn if staff transporting the patient have skin abrasions.
- The trolley or chair is 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 wash their hands thoroughly after dealing with the patient and cleaning the trolley or chair.
- Patients are, whenever possible, seen at the end of the working session. This should not compromise clinical need.
- Patients do not spend time in the communal waiting area but are seen as soon as possible.
- Any area visited by the patient/service user is cleaned and then disinfected with 1000ppm chlorine releasing solution i.e. Actichlor plus. (See Decontamination Policy).

3.10 HAND HYGIENE

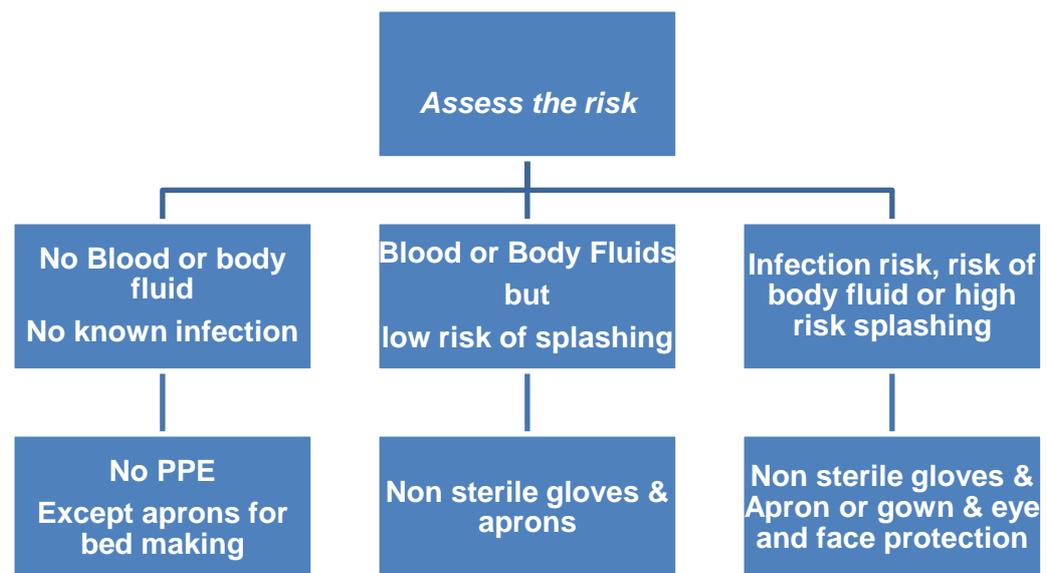
- 3.10.1 As a minimum hands must be washed with liquid soap and water at the start and end of clinical duties, when hands are visibly soiled or potentially contaminated, following removal of gloves, before and after any clinical interaction with patients, before and after assisting patients with meals, and upon leaving an isolation room or cohort area (see Hand Hygiene Policy).
- 3.10.2 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 then individual Clinell hand wipes must be used.

3.10.3 Bare Below the Elbow principles must apply at all times when working clinically (see Hand Hygiene Policy).

3.11 PERSONAL PROTECTIVE EQUIPMENT (PPE)

3.11.1 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.

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



3.11.3 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

3.11.4 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

- Hands must be decontaminated prior to putting on 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.
- The practice of double gloving is not necessary and provides no benefit of use.

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).
- Protection must be worn when making up Actichlor Plus as per manufacturers guidance.

3.11.5 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

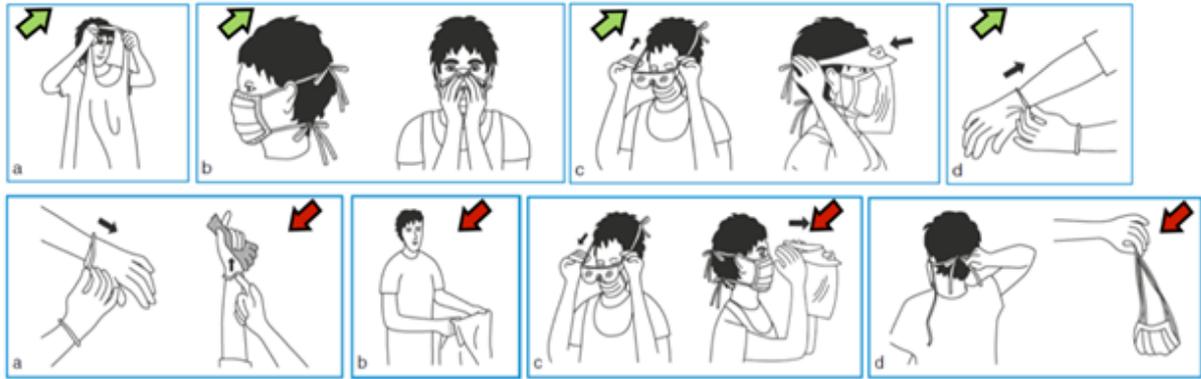
- Pull ties to break.
- Pull away from neck.
- Wrap apron in on itself to contain the 'dirty' side – dispose in clinical or offensive waste stream as appropriate (see Appendix E).
- Hand hygiene must follow removal of the final item of PPE.

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.



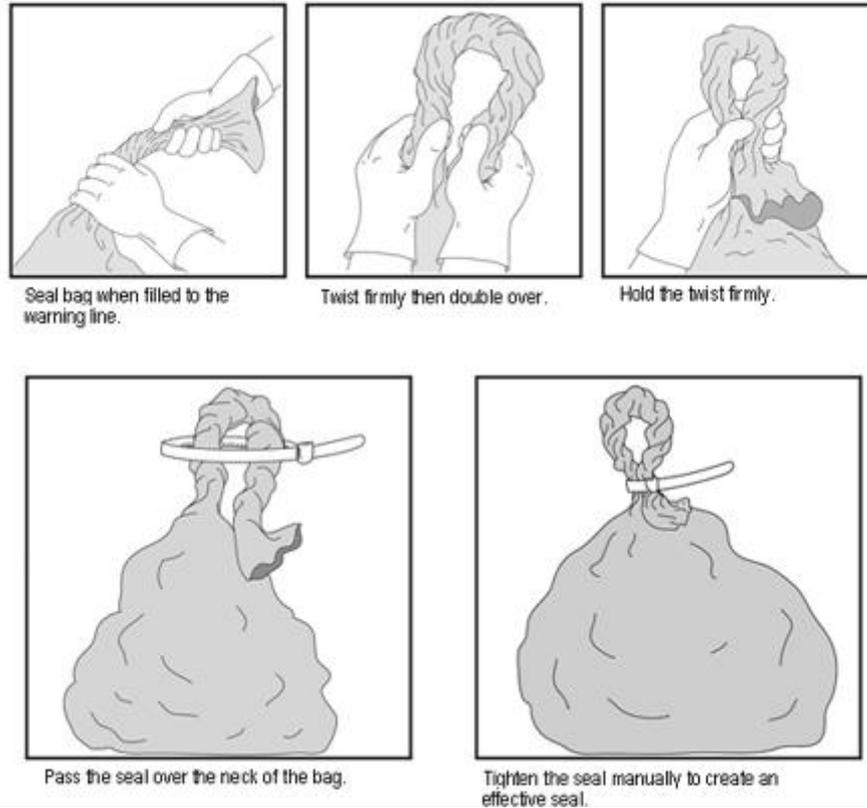
3.11.6 For further guidance on PPE please see the Standard Precautions Policy

3.12 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 E for inpatient guidance).
- Waste generated from patients experiencing diarrhoea and vomiting or from a closed ward must be dealt with as infectious waste.
- Clinical staff are responsible for changing black domestic and offensive waste bags to infectious waste bags at the start of an outbreak and returning them once the outbreak is over and the terminal clean has been requested.

3.12.1 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.
- When infectious waste is generated in the community by a member of staff from Solent NHS Trust then it is the responsibility of Trust staff to ensure it is collected as per local agreement.

3.12.2 Soiled – Infected Linen

- All linen from isolation rooms or cohort bays must be treated as infected.
- Staff must wear PPE when handling soiled or infected linen.
- Staff should avoid shaking linen as this may result in the dispersal of potentially pathogenic micro-organisms and skin scales.
- 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.

3.13 CLEANING AND DECONTAMINATION

3.13.1 Environment

- In the event of an outbreak, it is vital to keep the environmental burden of infectious agent as low as possible.
- The area must be de-cluttered to facilitate effective cleaning. Patients should be advised of the rationale so they can support this.
- Open food items such as fruit bowls and unwrapped sweets must be removed as these will become readily contaminated.
- 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).
- 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.
- If soft furnishings or carpets are soiled, contact the IPT for further advice.

3.13.2 Terminal or Deep Clean

- When an episode of infection is considered to be over it is essential that any residual environmental contamination is removed. This is achieved by undertaking an extremely thorough clean and disinfection of the room which includes changing all curtains.
- Failing to do this may result in pathogenic microorganisms remaining within the environment resulting in possible reinfection of the original patient or resulting in staff or other patients becoming infected by inadvertent onward transmission.
- A deep clean may also be requested during a period of on-going infection when the environmental load is believed to be high (isolation Policy)
- All attempts will be made for the patient to leave the room for the period of deep cleaning however there may be occasions where this cannot happen and the patient will remain in the room whilst this occurs.
- It is acknowledged that providing a thorough deep clean takes time and effort. Clinical staff are requested to alert the domestic teams as soon as possible that a deep clean will be required so that resources can be arranged. If a deep clean cannot occur within a reasonable time frame and affects patient flow or results in prolonged isolation please advise IPT.
- Actichlor Plus must be used for this.

3.13.3 Principles to follow (Not exhaustive)

- Isolation sign must remain on the door until the terminal clean is complete because the room remains a source of potential contamination.
- The patient should be moved to fresh bed in an alternative bed space to facilitate effective cleaning.
- Curtains must be removed and replaced with clean ones (if fabric) or new disposable ones.
- Disposable equipment should be discarded into orange clinical waste bags / correct sharps container.
- All clinical equipment, including bed frames and mattresses should be thoroughly cleaned by clinical staff prior to the domestic team entering to complete the terminal clean. The mattress must be checked for any contamination inside the cover – if found this mattress must not be used again.
- All areas of the room should be cleaned using disposable cloths with particular attention paid to touch points and horizontal surfaces e.g. door handles, taps, dispensers, call bells, toilet areas, bed frame, tables, lockers, chairs.
- All walls must be wiped down where contaminated.
- In the event of patients being co-horted due to an outbreak, the domestic team may want to decontaminate the room in a staged process whereby bed spaces are cleaned either individually (taking into account that patients will still be within the area).

3.13.4 Reusable Equipment

- All reusable equipment that has come into contact with a patient with diarrhoea and vomiting or with their environment should, with exception of items used in toileting, be cleaned with soap and water or detergent wipes and dried.
- Items used in toileting, such as commodes or bed pans, should be cleaned with Actichlor Plus after use.
- **Crockery and Cutlery:**
- Patients with a known infection can use standard crockery and cutlery without it posing a risk to others.

3.13.5 Fans

- Portable fans in clinical areas have been linked to cross infection (MHRA EFA/2019/001)
- Portable fans must not be used during outbreaks of infection or within isolation rooms.

3.14 VISITORS

3.14.1 Patients with diarrhoea and vomiting may receive visitors should they wish.

3.14.2 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.

3.14.3 Hand washing facilities with soap and water must be available to visitors and they should be encouraged to use these.

3.14.4 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. Exceptions can be made in particular circumstances at the discretion of the ward/department manager or in discussion with the IPT.

3.15 STAFF

3.15.1 Staff may also be inadvertently responsible for the transmission of disease. In the event of an outbreak, restriction on staff movement is recommended.

3.15.2 Ideally staff working with symptomatic patients should be restricted to that ward/area until resolved or confirmed as not infective.

3.15.3 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.

3.15.4 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).

3.15.5 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.

3.16 DECEASED PATIENTS

3.16.1 Standard and contact precautions should be used when handling deceased patients/service users.

3.16.2 Deceased patients with profuse diarrhoea/gross faecal soiling or where there is potential leakage of body fluids must also be placed in a white body bag (HSE 2018). Black body bags should only be used when a patient has a notifiable disease.

3.17 DISCHARGE HOME DURING OUTBREAK

3.17.1 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 then the Infection Prevention Team must be consulted prior to discharge arrangements being made. It must also be documented on their GP discharge letter (and community nurse referral) that they have been/potentially exposed to an infection, and details given.

3.18 REOPENING THE WARD/DEPARTMENT

- 3.18.1 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 re-opening. Please refer to Isolation Policy.

4. ROLES & RESPONSIBILITIES

- 4.1 **The Chief Executive** and Trust Board
Have a collective responsibility for infection prevention and control within the Trust.
- 4.2 **The Director of Infection Prevention and Control (DIPC)**
Is responsible for ensuring that this policy is implemented and adhered to across the organisation. In Solent NHS Trust this role is held by the Chief Nurse.
- 4.3 **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.
- 4.4 **Infection Prevention and Control Group (IPCG)**
Has a responsibility to ensure that this Policy complies with advice and guidance from the Department of Health and other bodies.
- 4.5 **The Infection Prevention Team (IPT)**
Are responsible for developing and updating the policy to ensure it complies with Department of Health, Health and Safety Legislation and other national guidance. The IPT will support the provision of training and education both mandatory and bespoke.
- 4.6 **Service Line Managers and Matrons**
Responsible for ensuring that staff are aware of their responsibilities under this Policy. They are also responsible for ensuring that staff have the appropriate resources available for use and education and clinical skills in order to comply with the policy.
- 4.7 **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.
- 4.8 **Infection Prevention Link Advisors (IPLA)**
IPLA's 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. The additional training for the IPLA role is provided by the IPT in the form of a two day course.

4.9 **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 C 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 C) on a daily basis.

5. **TRAINING**

- 5.1 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.
- 5.2 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.

6. **EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY**

- 6.1 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 F

7 **SUCCESS CRITERIA / MONITORING EFFECTIVENESS**

- 7.1 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.
- 7.2 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).
- 7.3 Continual Surveillance of alert organisms and clinically significant microbiological results working with ward areas and Consultant Microbiologist.
- 7.4 In the event of a ward being closed this will be raised as a Serious Incident (SI) and due process followed.

8. REVIEW

- 8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

Isolation Policy
Hand Hygiene Policy
Clostridium Difficile Policy
Equality, Diversity and Human Rights Policy
Decontamination Policy
Uniform and Dress Code Policy
Policy for the Safe Handling and Disposal of Healthcare Waste

Department of Health (2007). Clean, safe care. Reducing infections and saving lives. Department of Health: London.

Health and Safety Executive, 2018. Managing Infection Risks When Handling the Deceased. Hawker, et al. 2001. Communicable Disease Control Handbook, Blackwell Science.

LovedayHP et al (2014) Epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. The Journal of Hospital Infection. 8651, s1-s70

Medicines and Healthcare Regulatory Agency September 2018. Single –use medical devices: implications and consequences of reuse. Estates and Facilities Alert. EFA/2019/001 Portable fans in health and social care facilities: risk of cross infection 11.01.19

Norovirus Working Party 2012. Guidelines for the Management of Norovirus Outbreaks in Acute and Community Health and Social Care Settings.

Public Health England. 2013. Updated Guidance on the Management of *Clostridium difficile* Infection. London: Public Health England.

Youngson Robert 1992. Collins Dictionary of Medicine. Glasgow: Harpers Collins.

10. GLOSSARY

DIPC – Director of Infection Prevention and Control
CDI – *Clostridium difficile* infection.
D +/- V - Diarrhoea with or without vomiting
SI - Serious Incident
NEWS 2 – National Early Warning Score 2
IPT - Infection Prevention Team

1

- **Has your patient recently been on antibiotics?**
- **Has your patient developed or been admitted with diarrhoea (diarrhoea is watery, type 6 or 7 stools on the Bristol stool chart)? (Excludes overflow, laxatives, NG feeds, Crohns/ Colitis etc)**

2

- **If YES isolate patient (where clinically possible and appropriate) preferably within 2- 4 hours**
- **Send a stool sample for a full enteric screen**

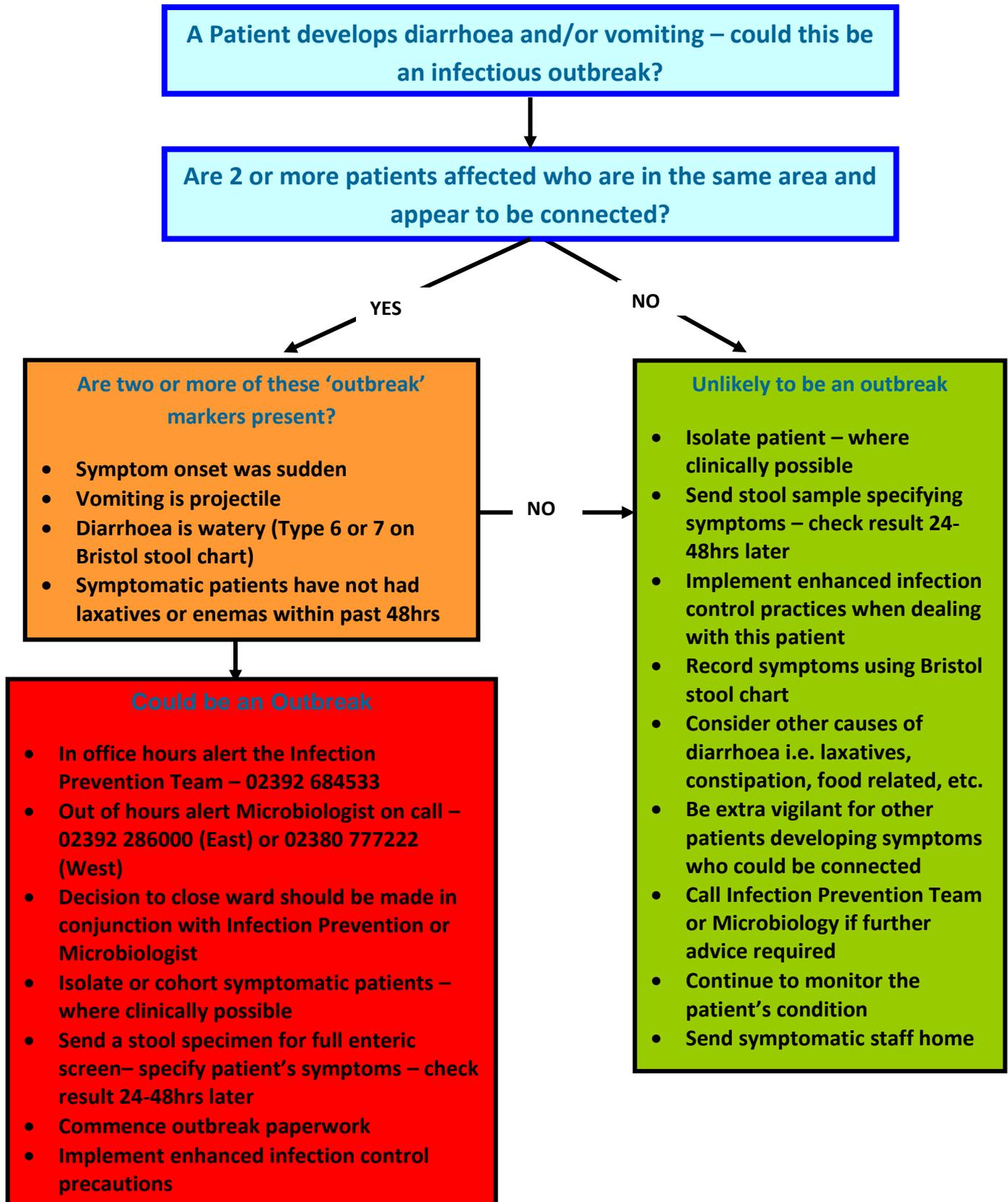
3

- **Strict transmission precautions with gloves, aprons and signage should be put in place**
- **Good hand hygiene with soap and water, avoid using alcohol gels**
- **Contact the Infection prevention team 0300 123 6636**

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.





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:
--

<p>Integrated Care Pathway for Review of Patients with Unexpected/Unexplained Diarrhoea</p> <p>Date symptoms of diarrhoea started:/...../.....</p>

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/mirology 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)	

Safe Disposal of Healthcare Waste Guide



Sharps and all Medicinal Waste



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

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

Equality Impact Assessment

<u>Step 1 – Scoping; identify the policies aims</u>	Answer		
1. What are the main aims and objectives of the document?	To reduce the spread of diarrhoea and vomiting by ensuring staff know what actions to when a patient develops these symptoms		
2. Who will be affected by it?	Service users and all staff who access clinical areas and/ have patient contact		
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	The prevention and reduction of incidence of diarrhoea and vomiting, including the prevention of an outbreak. Replaces previous policy for diarrhoea and vomiting		
4. What information do you already have on the equality impact of this document?	There is no adverse impact		
5. Are there demographic changes or trends locally to be considered?	No		
6. What other information do you need?	None		
<u>Step 2 - Assessing the Impact; consider the data and research</u>	Yes	No	Answer (Evidence)
1. Could the document unlawfully discriminate against any group?		X	
2. Can any group benefit or be excluded?	X		Benefits staff and patients
3. Can any group be denied fair & equal access to or treatment as a result of this document?		X	Part of the aim of this policy is to ensure that patients with diarrhoea and vomiting are not excluded from treatment unnecessarily
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		Feedback from ward managers, Infection Prevention Group and Policy Steering Group
6. Have you used a variety of different methods of consultation/involvement	X		Meetings, email contact and informal face-to-face consultation
<u>Mental Capacity Act implications</u>			

Appendix F

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	None
<u>External considerations</u>			
8. What external factors have been considered in the development of this policy?	X		The transfer and discharge of patients with diarrhoea and vomiting
9. Are there any external implications in relation to this policy?	X		The ability to control an outbreak of diarrhoea and vomiting within Solent has the potential to positively impact neighbouring healthcare providers and the wider community
10. Which external groups may be affected positively or adversely as a consequence of this policy being implemented?	X		A reduction and/ or better control of diarrhoea and vomiting outbreaks may have a positive impact upon other healthcare institutions and the wider community

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

<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	

Appendix F

of why decisions were made).	
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****Retain a copy and also include as an appendix to the document****

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 Control 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	Ingestion of contaminated food and/or water	Isolate for 48 hours from the last episode of diarrhoea and/or

Appendix G

<p>(<i>E. Coli</i>) gastroenteritis Causing diarrhoea and vomiting</p>	<ul style="list-style-type: none"> • Faecal oral • Contaminated hands of infected cases • Contaminated equipment 	<p>vomiting</p> <ul style="list-style-type: none"> • Collect food history. • Notify the local HPU.
<p>Listeria</p>	<p>Ingestion of contaminated dairy products, meat based products, seafood and vegetable based products.</p>	<p>Person to person spread does not occur except during neonatal period</p> <ul style="list-style-type: none"> • Notify the local HPU. • Antibiotic therapy should be guided by a microbiologist.
<p>Salmonella (vomiting and diarrhoea and fever)</p>	<p>Ingestion of contaminated cooked food by raw food or inadequate cooking temperatures. Eggs, red and white meats, dairy products.</p>	<p>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</p>
<p>Typhoid fever (<i>Salmonella typhi</i>) The infectious period lasts as long as long as bacilli are present in stool.</p>	<p>Ingestion of food and water contaminated by faeces.</p> <ul style="list-style-type: none"> • Faecal oral person to person spread • Unwashed hands of asymptomatic carriers 	<p>Isolate for 48 hours from the last episode of diarrhoea.</p> <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.
<p>Cryptosporidiosis gastroenteritis (Protozoan parasite causes watery or mucoid diarrhoea)</p>	<p>Ingestion of contaminated water, food and milk.</p> <ul style="list-style-type: none"> • Faecal oral spread • Aerosol or droplet spread can occur • Sexual partners 	<p>Isolate for 48 hours from the last episode of diarrhoea.</p>
<p>Diarrhoea (unknown cause)</p>	<p>Faecal oral person to person spread.</p>	<p>Isolate for 48 hours from the last episode of diarrhoea and/or vomiting.</p>
<p>Bacillus cereus</p>	<p>Contaminated cooked food, mainly rice dishes, occasionally other source such as pasta, meat,</p>	<p>Isolate for 48 hours from the last episode of diarrhoea and/or vomiting</p>

Appendix G

	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.

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		Follow Infection Prevention advice
4		Document ALL 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, increase observations, 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 – using Actichlor Plus. Consider if extra support from facilities is required
9		Hand hygiene must be undertaken using soap and water only, not alcohol gel

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

D&V outbreak daily checklist for ward staff	
Ward.....	Date outbreak started.....
PATIENTS	
<ul style="list-style-type: none"> • Symptomatic patients are isolated or cohorted • Urgent medical review for severely symptomatic or deteriorating patients • Outbreak Data Record, stool chart, observations and unexplained diarrhoea ICP to be maintained of all symptomatic patients • Patients and visitors 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 	

<p>SUPPLIES</p> <ul style="list-style-type: none"> • 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
<p>FURTHER ADVICE</p> <ul style="list-style-type: none"> • Contact Infection Prevention for further advice (in office hours) 0300 123 6636 • Contact on call Microbiologist for further advice (out of hours) 02392 286000 or 02381 207222
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Before reopening: a terminal clean has been performed following IPT recommendation and following the hospital procedure.
<p>Infection Prevention Advice</p>

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 over rides 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.

Appendix K

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: 0300 1236636 or email: snhs.infectionteam@nhs.net