Livewell Southwest

Management of an Outbreak in a Clinical Area

Version No.1.3

Review: May 2019

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

Author: **Director of Infection Prevention & Control**

Asset Number: **223**

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Document review history

Version no.	Type of change	Date	Originator of change	Description of change
1	Updated for PCH	January 2015	Infection Prevention and Control Manager	PCH Policy supersedes PHNT's Management of D & V in a Clinical Area v.5.
1.1	Updated	April 2016	Infection Prevention and Control Manager	Appendix O added. Updated to Livewell Southwest.
1.2	Updated	May 2016	Infection Prevention and Control Manager	We have merged two policies together to make it easier for staff to read. We have added an influenza outbreak flow chart as a guide. All changes are highlighted in yellow
1.3	Updated	January 2017	Infection Prevention and Control Manager	Appendix D & E updated.

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Management of an Outbreak in a Clinical Area

1. Summary

- An outbreak can be easily recognised or at times it can be unclear in character, depending on the characteristics of the causative pathogen. Surveillance plays a pivotal role in the early recognition of a potential or actual outbreak and its subsequent management.

- A multidisciplinary and multi-agency approach to recognition is required to optimise the preparedness and implementation of preventative and remedial outbreak action plans.

- Staff in clinical areas should suspect an outbreak has occurred when two or more patients present with comparable signs and symptoms of a single micro-organism at one time, or over the preceding few days. The Infection Prevention and Control Team (IPCT) should be notified immediately.

- The IPCT Office is open between 07.00hrs – 16.30hrs Monday to Friday. Outside these hours, the appropriate on call co-ordinator, ward manager or covering doctor should be informed. If appropriate, they will contact the on-call Consultant Medical Microbiologist for further advice.

- Patients should be isolated into single rooms immediately if they pose a risk to other patients and staff. Cohorting of patients should only occur with the direct supervision of the IPCT.

- Hand hygiene, correct use of personal protective equipment (PPE), correct waste disposal, handling of linen and environmental cleanliness are key infection control precautions which reduce the risk of cross infection and need to be put in to place.

- Affected staff should remain off work until advised to return by the Occupational Health & Wellbeing Department.

- Staff, patients and if appropriate visitors, with infective gastroenteritis should submit a faecal specimen (even if their only symptom is vomiting). In this instance the stool specimen <u>does not</u> need to be liquid.

2. Introduction

2.1 The spread of infection is limited largely by adherence to good infection control practices in the clinical setting. Staff should be aware of the infection prevention and control policies, guidelines and procedures of the organisation.

2.2 This guidance concerns instances when it is recognised that the potential for cross-infection is emerging, or has occurred during care of patients in a hospital setting. It describes what is

meant by cross infection, outbreak and what action should be taken at different levels within Livewell Southwest when such events are suspected, recognised and if apparent, escalating.

3. Guideline Objectives

3.1 The aim of this guidance is to:

1. Ensure that all actual or potential outbreaks arising from any micro-organism are:
    a. Recognised at the earliest opportunity using surveillance systems and processes.
    b. Appropriately assessed.
    c. Managed and controlled to minimise transmission of infection within the hospital and disruption to service provision.
    d. Reported.

2. Describe what action staff in clinical areas should take for patients presenting with comparable signs and symptoms of an infection.

4. Definition

4.1 Cross-infection is defined as the spread of a micro-organism from one individual to another. This is most often considered when two or more patients become infected with an indistinguishable organism, but can also occur when a member of staff colonised or infected with an organism transfers this to patients or colleagues.

4.2 An 'outbreak' is deemed to have occurred when multiple individuals become infected with the same micro-organism. This is typically detected when the frequency of cases is in excess of the normal expected. Within a single ward/departmental setting, staff should suspect an outbreak has occurred when two or more individuals present with comparable signs and symptoms of an infection at one time, or over the preceding few days. An outbreak can affect more than one ward/department. Outbreaks which are likely to be recognised sooner will be those which are severe, caused by uncommon organisms or organisms with unusual antibiotic resistance patterns. However, all clusters of similar infections should be suspected to be cross-infection and steps initiated to investigate and control spread.

4.3 Counteractive measures need to be designed to prevent the potential for, or respond to, an escalating outbreak.

4.4 Diarrhoea should be classified using the Bristol Stool Chart, type 6-7 (Appendix A). Diarrhoea is considered apparent when a patient has two or more episodes of type 6-7 stools in a 24 hours period.

4.5 Depending on the nature of the outbreak, a ward or bay may be '**closed'** to admissions and discharges. <u>This does not mean the ward will be vacated</u>. In cases where it is unclear whether there is an outbreak, patients may still be admitted (i.e. the ward or bay is **'restricted'**). In the event of a ward being closed or restricted, all discharges to external agencies should be suspended. Patients can still be discharged to their own home.

5. What should arouse suspicion?

5.1 There are several types of infection that should arouse suspicion of potential or actual outbreaks, and where even single cases of which should always be reported to the IPCT.

Infections should be reported to the IPCT when two or more patients present with comparable signs and symptoms of an infection at one time, or over the preceding few days. These include the following:

1. Patients with nausea, diarrhoea or vomiting, regardless of the suspected cause of the symptoms.
2. Wound infections
3. Organisms with unusual resistance patterns (e.g. MRSA, VRE, Glycopeptide-resistant gram-negatives and ESBLs)
4. Suspected or confirmed influenza / respiratory tract infections.

6. Preparedness – Responsibility of the Outbreak Management Team

6.1 The Outbreak Management Team members will be dependent on the nature of the outbreak.

6.2 The Infection Prevention and Control Team will on a case-by-case basis, lead or determine who the lead should be, for other aspects of outbreak management.

7. Action of ward staff on recognition of an infected patient

7.1 The following should be considered by all health care staff whenever a patient under their care is suspected to have been admitted with, or has developed an infection in hospital:

- Assess the patient and ask yourself: "Does this patient pose a risk to other patients or staff?" Identify if the case should be reported to the IPCT (e.g. is this a single instance of an 'alert condition', cross-infection or part of an outbreak). For guidance refer to "Isolation and Management of an Infected Patient", which also identifies whether isolation procedures need to be instigated. If still in doubt, consult the IPCT.
- Inform the ward manager or nurse-in-charge immediately if there is any suspicion the patient has had exposure to or symptoms of infections with high virulence factors e.g. gastroenteritis or influenza. The ward manager or nurse-in-charge must inform the IPCT. If a patient cannot be allocated a side room in the appropriate ward or directorate, the IPCT will assist the Operational Support Team in identifying a side room in another clinical area.

- Raise the relevant care plans which can be found on systmOne

- Obtain personal protective equipment (PPE) and place clean supplies outside of the room (for access to the PPE stores contact the IPCT or site assistants)

- Follow the guidance on flow charts Appendix D or E on the appropriate use and disposal of PPE

- In the event of a suspected or confirmed outbreak of respiratory infection obtain the Respiratory Outbreak Box (ROB) and use the contents as per the printed guidance contained

in the box. Appendix O.

Place relevant poster at ward entrance/on patient's room door

- Appendix G Infection Control Alert Poster "Ward Closed"
- Appendix H Infection Control Alert Poster "Ward Restricted"
- Appendix I Infection Control Alert Poster "Please Keep The Doors Closed"
- Appendix J Poster to remind visitors not to visit if they have had any flu like symptoms
- Appendix K Poster to remind visitors not to visit if they have had any D&V symptoms
- Appendix L Infection Prevention and Control Precautions in Place "Blue Poster". This is to be placed on isolation room doors to alert staff to patient infectious status. Blue posters are for patients with D&V symptoms. Rooms must be enhanced cleaned (twice daily). Please refer to the Decontamination (Cleaning and Disinfection) Guidelines and Procedures.
- Appendix M Infection Prevention and Control Precautions in Place "Green Poster" (All other infections). This is to be placed on isolation room doors to alert staff to patient infectious status. Green posters are for patients with infections that do not involve D&V symptoms. Rooms must be enhanced cleaned (twice daily). Please refer to the Decontamination (Cleaning and Disinfection) Guidelines and Procedures.
    - Comply with the transmission precautions detailed on the care plan; these will include hand hygiene, PPE, decontamination, waste disposal and the handling and disposal of linen.
    - Request the appropriate environmental cleaning for the patient bed space (see Decontamination Guidelines and Procedures (Cleaning and Disinfection of medical devices and patient care equipment)
    - Ensure all relevant microbiology samples are collected as soon as symptoms are present and sent for processing without delay. Ensure clinical details are fully completed.
    - Ensure that the doctor attending the patient notifies the Consultant for Communicable Disease Control (CCDC) if this is a notifiable disease (appendix B)
    - Pregnant and susceptible staff may be excluded from care of patients with certain infections; other wards and departments may need to be advised of the risk of cross infection; visitors may need to be restricted. Advice is available from Occupational Health and Well Being and the IPCT

7.1 **DO NOT DELAY contacting the IPCT if you suspect an outbreak.** It is far preferable that false alarms are raised than for the IPCT to discover an outbreak has become firmly established and is already widely disseminated because ward staff were unsure whether it was serious enough to report.

- Ensure that the advice of the IPCT is followed, in conjunction with the clinical teams responsible for care of the patients affected (Appendix D & E).

- Co-horting of patients with similar symptoms should only be undertaken with the direct supervision of the IPCT.

- Isolation or other control measures applied in response to the reported incident may be discontinued only on the approval of the IPCT.

- The nurse-in-charge of the affected area should keep an up to date record of all cases using the template provided in the outbreak pack (Appendix F).

8. Action on confirmation of an outbreak

8.1 The Infection Prevention and Control Team will:

- Ensure that the manager of the affected ward(s) or department(s) are informed as soon as an outbreak is confirmed.

Advise on the necessary action(s) to be taken to control the outbreak. This may involve restriction or closure of all or parts of the ward/department (see definitions above). The final decision of ward closure is the responsibility of the ward manager / matron and the registered ward manager, with advice from the IPCT. Out of hours the responsibility of ward closure will be the on-call director.

- On closure of the ward, the IPCT will call an outbreak meeting which should be attended by relevant ward, medical, operational and domestic staff. Appropriate control measures will be recommended at this meeting and a report with associated action plan produced and disseminated.

- Arrange with the Department of Microbiology for the processing of appropriate laboratory samples.

- Inform the CCDC, Local Environmental Health Departments, Centre for Infections and other external agencies as appropriate.

- Liaise with IPCTs in neighbouring hospitals, if appropriate.

- Inform the clinical teams, domestic and support services, the operational team and the Press and Communications Office.

- Take appropriate action to prevent a recurrence where possible.

- Determine when an Outbreak is over. Depending on the nature of the outbreak this will be the DIPC, and the IPCT.

8.2 Members of the Outbreak Management Team will:

- Action their respective systems according to the level of the outbreak across LSW.

- Facilitate the escalation and de-escalation of control measures as advised by the IPCT.

- The admission of patients to a closed ward can never be recommended and should only be considered when, on the balance of risks, not admitting is likely to cause more distress and harm to the patient than admitting. **In the event of a bed crisis, the decision to admit to closed wards suspected or known to have gastroenteritis / influenza should only be made by the on-call Executive Director, who will be advised of the problem by the on-call Manager/Bed Managers.** All other reasonable alternative solutions must have been exhausted.

8.3 The Matron and Ward Manager will:

- Ensure that all staff understand their level of responsibility in helping to prevent, or manage and control, an outbreak.
- Ensure that all staff have access to these guidelines and a complete outbreak pack.

- Monitor their clinical area daily during an outbreak and oversee all health professionals in their adherence to infection control practices and record keeping as advised by the IPCT.

- Where a ward or bay closure has occurred, prior to any decision to re- open the Ward Manager / Matron must complete and sign a Post outbreak deep clean checklist (Appendix N); a copy of which must be given to Hotel Services for them to retain. The completion of this checklist will represent the final 'sign off' for all stakeholders to resume full clinical activity in the affected area.

- Ensure that on the re-opening of the ward or affected areas of it, that any receiving unit is informed that the discharging ward has been closed or restricted and that they may consider isolating the asymptomatic patient on transfer.

- Ensure staff remain alert to the potential for a re-emergence of an outbreak. Standard contact precautions should remain in force for all aspects of patient care.

9. General Guidance

9.1 Patient Investigations and Treatment

- Although the movement of patients from a closed ward should be restricted, this should not delay essential clinical investigations or procedures. In such cases, a risk assessment should be performed and the IPCT are available to assist with this process.

- Affected patients requiring surgery should go straight from the ward to the operating room and be recovered in the operating room before transfer back to the ward. Theatre circulating staff should wear gloves and aprons and remove them on leaving the theatre. Where possible it is advisable for patients to be placed last on any list in order for thorough cleaning to take place on vacation of the patient. The theatre should be cleaned then disinfected with a standard hypochlorite solution and left closed for 15 minutes before the next case.

9.2. Staff movement

- Certain infectious conditions, even with proper precautions, pose a significant risk to staff. In addition, staff may also be responsible for the transmission of disease. In the event of an outbreak, restrictions on staff movement may be recommended. Staff working on affected wards should be restricted to that ward for the duration of the outbreak. Doctors and coordinators can continue to work on both affected on unaffected wards where this is absolutely necessary to maintain overall patient safety e.g. if there is only one doctor available, it is essential to identify a central base.
- However, affected wards should be visited last whenever possible. Under these circumstances, meticulous hand hygiene, including the use of alcohol gel on entering and leaving clinical areas, and the correct use of protective personal equipment are particularly important.

- Community teams visiting a community outbreak area must arrange to visit the patient / client last and only if the visit is essential and cannot be postponed. In these circumstances all infection prevention and control measure must be put in place, especially hand hygiene measures. Once the patient has been visited staff must, shower and change clothes at the earliest opportunity.

- During an outbreak, and with good hygienic precautions, there is no reason why staff cannot use communal hospital facilities and public transport. Staff whose uniforms become soiled should change into a clean uniform.

9.3 Gastroenteritis

9.4 Staff

- Staff with symptoms of gastroenteritis should inform their line manager immediately and then leave work. They should be issued with a specimen pot and yellow request form in order that they can submit a stool specimen. The form should clearly indicate where they work in the hospital and may be submitted to Microbiology either directly or via their General Practitioner. Occupational Health & Wellbeing need to be informed when a sample has been sent to microbiology, by contacting the Duty Nurse on 01752 437222. Staff should not return to work until 48 hours free of symptoms.

- If agency staff are used, they will need to be offered 2-3 days of work, as they will be unable to work elsewhere in the hospital for 48 hours following their contact with the ward during the outbreak.

9.5 Influenza

Prompt recognition of healthcare workers with influenza is essential to limit transmission and is particularly important during a pandemic. Healthcare workers with influenza should be excluded from work. Staff who have symptoms of influenza, including those who are beginning to experience symptoms or are recovering from influenza, should not work, so as to avoid infecting patients, colleagues and others. This is particularly important for staff working with patients at high-risk for complications from influenza.

- The number of visitors should be restricted and in some circumstances it may be preferable to exclude
- Close contacts of a probable or confirmed influenza patient should be screened for signs and symptoms.
- Visitors entering the isolation room must wear PPE
- Visitors should be trained in the appropriate use of PPE.
- A log of all visitors should be kept.
- Appropriate information should be given to family or other contact of patients.

9.6 As a general principle, healthcare workers who care for influenza patients should not care for other patients, although again exceptions may be necessary. Healthcare workers at high-risk for complications from influenza, such as those with chronic respiratory disease (including asthma), chronic heart disease, chronic renal disease, chronic neurological disease, diabetes, immunosuppression or who are pregnant, should not provide direct care to patients known to have influenza. Bank and agency staff should follow the same deployment advice as permanent staff. In a pandemic, staff should be segregated into those dealing with influenza patients and those not.

If agency staff are used, they will need to be offered 4 days of work, as they will be unable to work elsewhere in the hospital for 4 days following their contact with the ward during the outbreak.

9.7 Visitors

- During an outbreak the ward manager, in consultation with the IPCT, may decide to restrict visiting. Visitors should be advised of the situation and warned that they may be at risk of illness. This should occur prior to them entering the ward in order that they can make an informed decision on whether to visit. Visitors should be limited to a maximum of two adults per patient. Very young, very old or debilitated visitors should be discouraged from visiting. Hand washing facilities must be available to visitors.

- Visitors should be asked to stay away from the hospital if they have symptoms of gastroenteritis / influenza and to continue to do so until they are symptom free. Visitors should not bring gifts of chocolates or fruit during an outbreak.

10. At the end of an outbreak

10.1 When no new symptoms have occurred for the duration of the incubation period for the organism e.g. 48 hours for diarrhoea and vomiting in either staff at work or patients the DIPC or the Infection Prevention and Control Team will declare the outbreak at an end. There may

be an opportunity to isolate, with precautions, any remaining symptomatic patients.

10.2 At this point a deep clean of the affected area(s) are undertaken, this will be planned with hotel services and on completion of the deep clean the ward can be declared re-opened, with information to this effect circulated to other relevant organisations.

11. Reporting

11.1 Following an outbreak, the DIPC or the Infection Prevention and Control Team will:

- Produce a report of the Outbreak for selected distribution, which must include the Livewell Southwest Board, the relevant Locality Managers / Directors and other stakeholders as indicated by the nature of the Outbreak. The report will describe the outbreak, action taken and its effectiveness. This should be sent to Public Health England.

- Report major outbreaks as Serious Untoward Incidents.

11.2 A review of the Outbreak should be undertaken to identify any lessons learned for future outbreaks. The Infection Prevention Control Committee should be considered as an appropriate forum so as to provide a record of this.

12 Bibliography

Guidelines for the management of norovirus outbreaks in acute and community health and social care settings, hospital infection society, 2012 at http://www.his.org.uk/files/9113/7398/0999/Guidelines_for_the_management_of_norovirus_outbreaks_in_acute_and_community_health_and_social_care_settings.pdf

Communicable Disease Outbreak Management Operational Guidance, Public Health England 2014 at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/343723/12_8_2014_CD_Outbreak_Guidance_REandCT_2__2_.pdf

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Lead Nurse, Director of Infection, Prevention and Control

Date: 12th May 2016

Appendix A

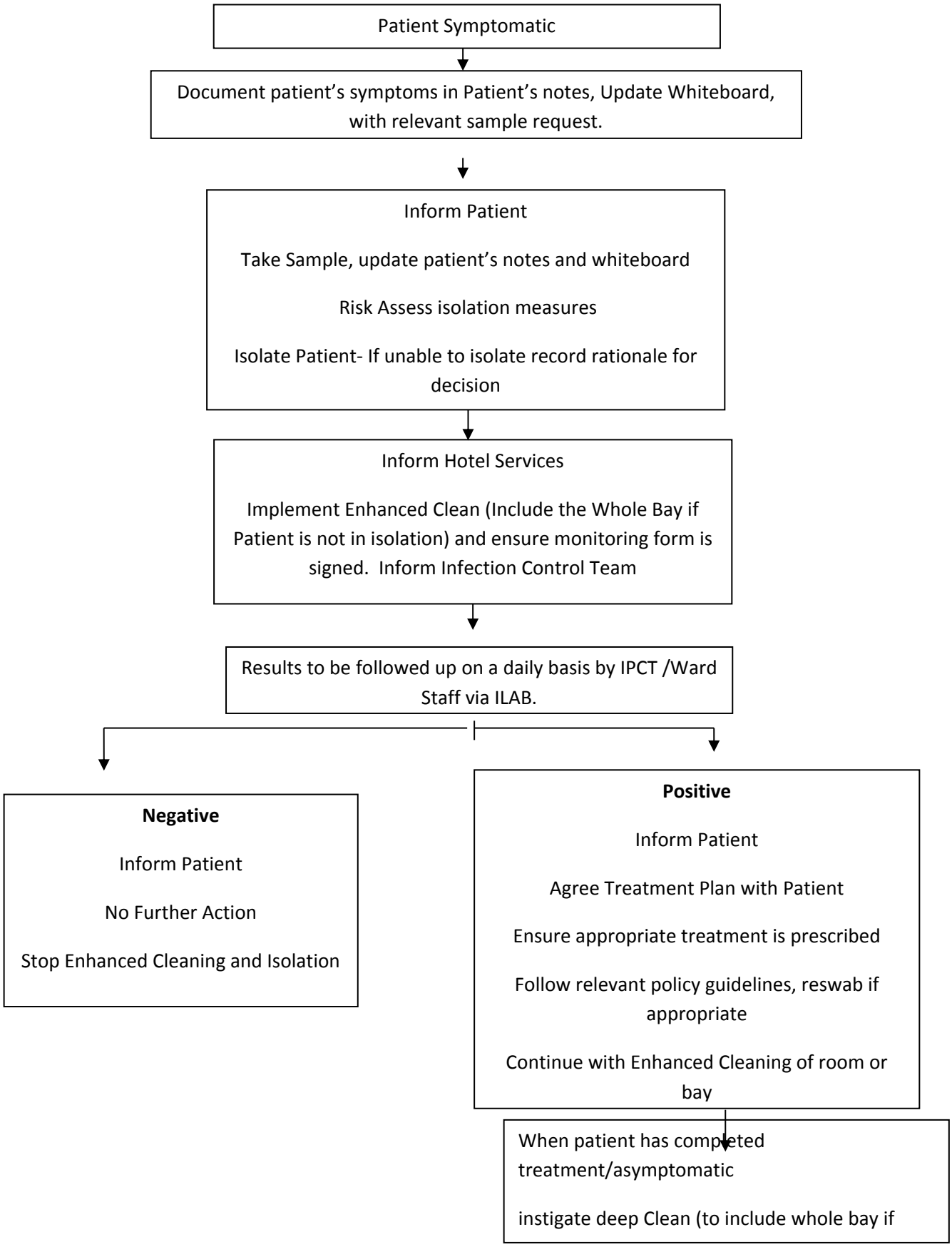
Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

Suspected or proven infective diarrhoea and/or vomiting, especially when occurring in a cluster (including dysentery and food poisoning)	Meningitis (including 'aseptic', viral, bacterial and fungal)
Typhoid Fever	Meningococcal septicaemia
Diphtheria	Acute encephalitis
Acute poliomyelitis	Tuberculosis
Anthrax	Measles
Cholera	Mumps
Typhoid and paratyphoid fever	Rubella
Viral haemorrhagic fever	Scarlet Fever
Leprosy	Whooping cough
Leptospirosis	Ophthalmia neonatorum
Malaria	Viral Hepatitis
Plague	Rabies
Typhus	Relapsing fever
Tetanus	Smallpox
Yellow fever	Legionnaire's disease
	Listeria
	Haemophilus influenzae Type B
	Epiglottis
	Haemolytic Uraemic Surndrome.

Appendix C

Flow chart for In-Patients with a Suspected Infection

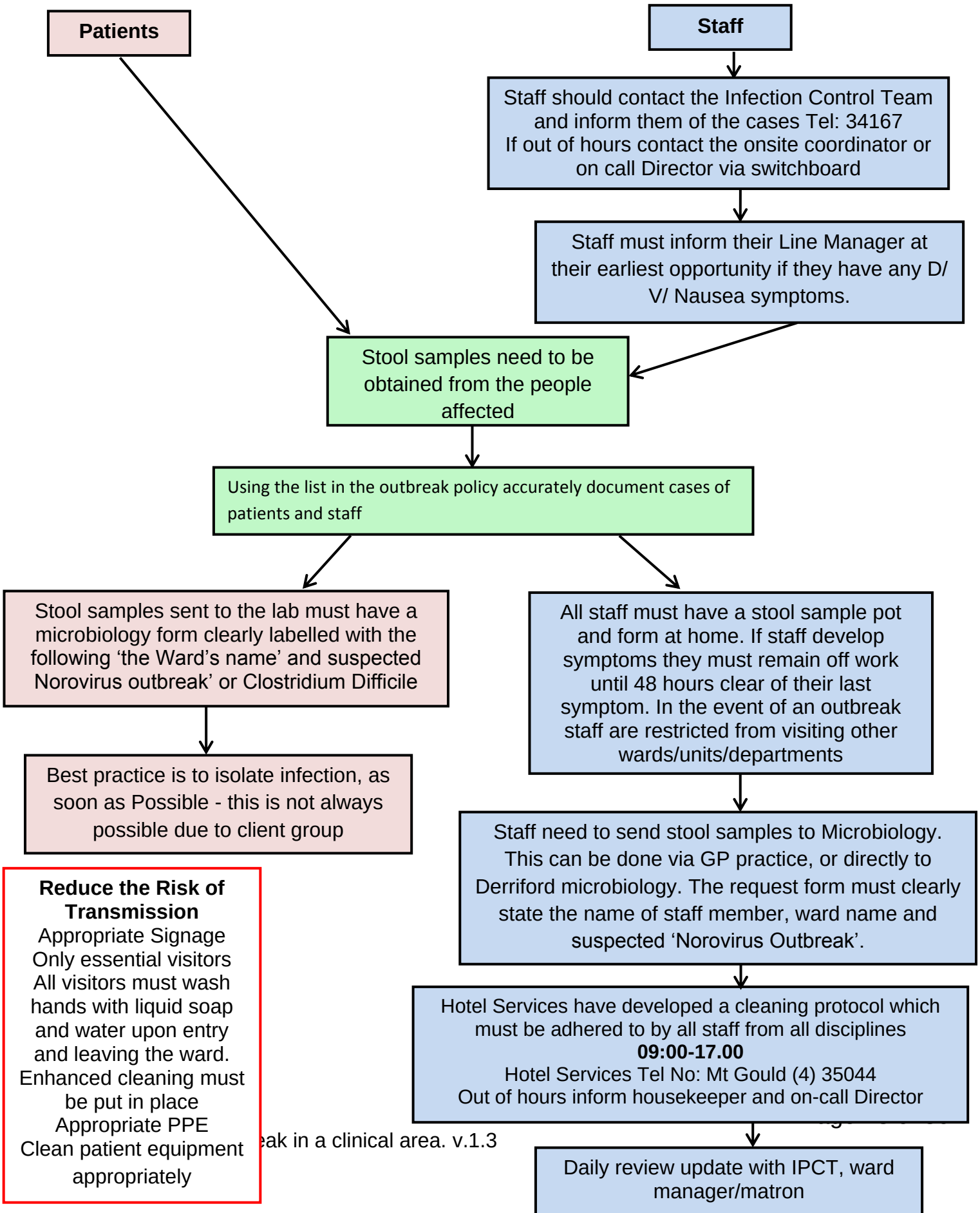


Appendix D How to respond to a Diarrhoea / Vomiting Outbreak

If there are two or more cases of **Diarrhoea** or **vomiting** on the Ward, staff must implement the Infection Prevention Control Outbreak Policy

Closure/restriction of wards & bed moves is the decision and responsibility of the ward manager / matron and the registered locality manager, with advice from the IPCT.

Out of hours ward closure will be the on-call Director or onsite coordinators responsibility.



Appendix E **How to respond to an influenza Outbreak**

If there are two or more concurrent suspected cases, staff must implement the Infection Prevention & Control Outbreak Policy

Closure/restriction of wards (2 or more patients with confirmed cases). The final decision of ward closure is the responsibility of the ward manager / matron and the registered ward manager, with advice from the IPCT. Out of hours the responsibility of ward closure will be the on-call director.

Suspected cases are those who have signs and symptoms & are awaiting results

Confirmed cases Are patients who have positive results

Obtain the Respiratory Outbreak Box and follow the instructions when using the contents. All staff must be trained before using FFP3 respirators

Patients

Staff

Staff must contact the Infection Control Team and inform them of the cases Tel: 34167 (Answerphone).
Out of hours, then contact on call coordinator /Director

Staff must inform their Line Manager at their earliest opportunity if they have any flu like symptoms and follow guidance from Occupational Health and Wellbeing
In the event of an outbreak staff are restricted from visiting other wards/units/departments

Virology screening kits can be obtained from Microbiology Level 5 Derriford

30010

Virology throat samples need to be obtained from people affected (see policy for guidance)

Using the list in the Outbreak Policy Accurately document all cases of patients and staff

Samples sent to the lab must state "suspected influenza" and be clearly labelled with name of ward.

Best practice is to isolate, as soon as possible. Incubation period for influenza is 1-4 days. Infectious period 1 day after onset of symptoms, until 3-5 days later. Keep a list of contacts during the incubation period

Staff experiencing flu like symptoms must remain off work. Incubation period for influenza is 1-4 days. Infectious period 1 day after onset of symptoms, until 3-5 days later

Send a throat swab to Microbiology. This can be done via GP Practice
Request forms must state staff name and the name of the ward you work on. Write on the form 'suspected influenza'

Hotel Services have developed a cleaning protocol which must be adhered to by all staff from all disciplines
09:00-17.00
Hotel Services Tel No: Mt Gould (4) 35044
Out of hours inform housekeeper and on-call director

Daily review update with the IPC team, Ward Manager/Matrons

Reduce the risk of transmission Confirmed cases
It may be feasible to prioritise isolation of patients with cough and sputum production
Always keep the isolation door closed and Keep PPE outside the room
Do not remove your FFP3 until outside the isolation room
Only essential visitors to enter closed/restricted areas
Use single use, disposable tissues, encourage HH Catch it, bin it, kill it
Enhanced cleaning must be put in place
Use respiratory PPE (see PPE training, on staff intranet)
The virus can survive on hard surfaces for 24 hours, and on other surfaces i.e. Pajamas, tissues & magazines for 2hours.

Appendix F

Infection Prevention and Control Outbreak Record

1. Ward ……..
2. Date started ……
3. Date outbreak over ……
4. Ward closed Y/N
5. Date deep clean request …….
6. Date ward closed ……
7. Date ward re-opened ……..
8. Number of days ward closed ……..
9. Number of Bed days lost …….

		Total
No of Patients affected		
No of staff affected		

Patient NHS Number	Micro-organism Isolated	Date of Isolate

Infection Control Outbreak Record

Ward: _____ Outbreak No. _____

Bay	Patient Sticker/Name	DOA	Reason for Admission	Spec Sent	Date											
			Treatment/Medication	Result												
Bed		From														

Bay	Patient Sticker/Name	DOA	Reason for Admission	Spec Sent	Date											
			Treatment/Medication	Result												
Bed		From														

Bay	Patient Sticker/Name	DOA	Reason for Admission	Spec Sent	Date											
			Treatment/Medication	Result												
Bed		From														

STAFF OUTBREAK RECORD

Ward _____

Number	Staff Name	Designation of staff	Date of Onset	Date of last shift	Specimen sent	Document symptoms ongoing **EACH SHIFT** as per key														
						Date:			Date:			Date:			Date:			Date:		
						E	L	N	E	L	N	E	L	N	E	L	N	E	L	N

Number	Staff Name	Designation of staff	Date of Onset	Date of last shift	Specimen sent	Document symptoms ongoing **EACH SHIFT** as per key														
						Date:			Date:			Date:			Date:			Date:		
						E	L	N	E	L	N	E	L	N	E	L	N	E	L	N

Appendix G

INFECTION CONTROL ALERT

THIS CLINICAL AREA IS CURRENTLY CLOSED DUE TO AN OUTBREAK

ALL STAFF PLEASE WASH YOUR HANDS WITH LIQUID SOAP AND WATER ON ENTERING AND EXITING THE CLINICAL AREA.

VISITORS PLEASE REPORT TO THE NURSE IN CHARGE.

Appendix H

INFECTION CONTROL ALERT

THIS CLINICAL AREA IS CURRENTLY RESTRICTED DUE TO AN OUTBREAK

ALL STAFF PLEASE WASH YOUR HANDS WITH LIQUID SOAP AND WATER ON ENTERING AND EXITING THE CLINICAL AREA.

VISITORS PLEASE REPORT TO THE NURSE IN CHARGE.

THANKYOU

Appendix I

Infection Control Notice

Please keep these doors closed

Thank you

Appendix J

Please can we remind all visitors not to Visit if you have any Flu like symptoms

A sudden fever , dry/chesty cough, headache, tiredness and weakness, chills, aching muscles, limb or joint pain, sore throat, runny or blocked nose, sneezing, loss of appetite

Appendix K

Please can we remind all visitors not to Visit if you have any of the following symptoms
Diarrhoea, Vomiting/Nausea

If you should experience any of these symptoms please do not visit until you are 48 hours clear of any symptoms thank you

Appendix L

INFECTION PREVENTION

AND

CONTROL PRECAUTIONS IN PLACE

Please speak to a nurse before entering.

Please ensure that you wash and dry your hands before entering and leaving the room/unit.

Thank you

Appendix M

INFECTION PREVENTION

AND

CONTROL PRECAUTIONS IN PLACE

Please speak to a nurse before entering.

Please ensure that you wash and dry your hands before entering and leaving the room/ unit.

Thank you

Appendix N Post outbreak deep clean checklist

It is the responsibility of ward staff to clean all the clinical equipment and clear the ward/space/bay/room of extraneous items i.e. flowers, newspapers and magazines.

Hotel services are responsible for managing the environmental clean only.

At the start of the deep clean nominate a co-ordinator (often the nurse in charge is best placed to undertake this) to maintain a flow of the clean i.e. moving patients and no bed space omissions or double cleaning of spaces.

First nursing staff to clean equipment prior to removing it from the deep clean space, consumable items in the space e.g. paper towels, gloves and aprons, patient care cloths should be disposed of including extraneous items as they may all been contaminated. **Consent** from the patients must be obtained before personal items are disposed of.

Hotel services can then begin the environmental clean, which may involve nursing staff moving patients out of the room to a temporary care space, this patient movement will be the responsibility of the co-ordinator to arrange to ensure patient safety.

The room(s) are then deep cleaned using a systematic plan to ensure no omissions or double cleaning of spaces.

Care areas come first, followed by corridors, kitchens, treatment and multi-use rooms e.g. dining rooms and lounges.

The final spaces to be cleaned are the sluice and the cleaning cupboard.

Waste goes into orange bags and prompt removal from the ward/clinic arranged.

Areas that have been cleaned are re-stocked with consumables.

As each area clean has been completed the co-ordinator will check that it has met with the standards required and at the end of the clean the whole space is re-checked and the clean can be signed off as complete.

The signature slip goes to Hotel Services and is retained in case of queries

I ……, as deep clean co-ordinator, confirm that the deep clean has been completed to a satisfactory standard on ……ward

Date …… Time ……

I will now inform clinical teams, managers, care staff, IPCT (34167) that the ward can now be opened.

Signed …….

Appendix O

Location of Respiratory Outbreak Boxes/Link to donning and removal of PPE

Location
LCC Central Store (Basement)
Trelawney GP Surgery
Ernesettle GP Surgery
Cumberland MIU
Lee Mill (Infection Control Cupboard)
Glenbourne (Hotel Services Manager)
Syrena (Clinic room)
Hotel Services Delivery Store MG
LCC Primary Care Centre
ASR Team MG (Clinic room)
Kingsbridge Hospital
Tavistock Hospital

PPE Video Link

http://pchnet.derriford.phnt.swest.nhs.uk/Staff/Training/PPETraining.aspx