Livewell Southwest

Management of an Outbreak, including Diarrhoea and Vomiting, in a Clinical Area

Version No.1.1

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

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Asset Number: **223**

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	of Winter across NHS South West for 2010/11. National Health Service England (2010). The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Regulation 12, Cleanliness and Infection Control. Department Of Health (2010). The Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and Related Guidance.
Supersedes document	This new LSW policy which supersedes PHNT's Management of D & V in a Clinical Area v.5.
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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	LSW 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 16 added. Updated to Livewell Southwest.

Management of an Outbreak, including Diarrhoea and Vomiting, in a Clinical Area

1. Summary

- The recognition of an outbreak can be easily noticeable or hidden in nature, 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 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 – 17.00hrs 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 interventions which reduce the risk of cross infection.

- 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 This guidance applies equally to adult and paediatric clinical areas.

2.2 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. These are to be found on the intranet. In particular, these guidelines should be read in conjunction with the following documents: Infection Control Hot Spots; Management of the Infected Patient; Guidelines

for the Prevention and Control of Meticillin Resistant *Staphylococcus Aureus* (MRSA); Policy for the Admission, Transfer & Discharge of the Infected Patient and *Clostridium difficile* Guidelines.

2.3 This guidance concerns instances when it is recognised that the potential for cross-infection is emerging, or has occurred during care of patients in hospital. It describes what is meant by cross infection, outbreak and what action should be taken at different levels within the LSW when such events are suspected, recognised and if apparent, escalating.

2.4 The following documents have been consulted to ensure this guidance meets legislative requirements:

- National Health Service England (2010). The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Regulation 12, Cleanliness and Infection Control.
- Department Of Health (2010). The Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and Related Guidance.

2.5 The following documents have been consulted to ensure this guidance reflects current best practice; with modifications made for local use:

- The Department of Health (2011) Guidelines for the Management of Norovirus Outbreaks in Acute and Community Health and Social Care Settings - Working Draft.
- The NHS Southwest Norovirus Tool Kit Package (All Documents 9 December 2010).
- The Winter Plan 2010/11 Arrangements for the Management of Winter across NHS South West for 2010/11.

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 ((1997), 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. This does not mean the ward will be vacated. 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 (see also Policy for the Admission, Transfer & Discharge of the Infected Patient). Admission, Transfer & Discharge of the Infected Patient v1:5

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. The most common of such 'alert conditions' are identified in Table 1, but this list is not comprehensive and it may also be appropriate to report other conditions. Many of these are also statutorily notifiable diseases that must by law be reported to the Consultant in Communicable Disease Control (CCDC), preferably by telephone as well as on the prescribed form. The books of forms for Notification of Statutory Notifiable Disease should be kept on each ward and can be obtained from the Public Health England.

Table 1. Alert conditions which should always be reported to the IPCT

Suspected or proven infective diarrhoea and/or vomiting, especially when occurring in a cluster (including dysentery* and food poisoning*)	Acute encephalitis*
Methicillin-resistant *Staphylococcus aureus*	Meningitis* (including 'aseptic', viral, bacterial and fungal)
Vancomycin-resistant enterococci (VRE)	Meningococcal septicaemia*
Severe soft tissue infections including major post-operative wound infections, severe cellulites, gas gangrene and necrotising fasciitis	Tuberculosis*
Gentamicin-resistant gram-negatives	Influenza
Extended-beta lactamase producers (ESBLs)	Legionella infection
Scabies	Chicken pox/Shingles
Typhoid and paratyphoid fever*	Measles*
Diphtheria*	Mumps*
Suspected viral haemorrhagic fever*	Rubella*
Malaria*	Scarlet Fever*
Ophthalmia neonatorum*	Whooping cough*
Viral Hepatitis*	

* Diseases which must be notified to the CCDC in addition to being reported to the IPCT. A full list of these is given in Appendix B.

Other 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 (see table above).
3. Organisms with unusual resistance patterns (e.g. MRSA, VRE, Glycopeptide-resistant gram-negatives and ESBLs).

6. Preparedness – Responsibility of the Outbreak Management Team

6.1 The Outbreak Management Team members will be dependent on the nature of the outbreak. It is recommended that the Chief Operating Officer should lead annual pre-season preparatory meetings for outbreaks related to winter pressures**.**

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

6.3 Depending on the nature of the outbreak other members of the team may comprise representatives from Professional Practice, Estates and Facilities

Management, Materials Management, Service Improvement, Social Services, SHWB, Primary Care commissioners and providers and the Health Protection Unit.

Table 2: LSW Team Members' Areas of Responsibility are:

Responsible Person	Area of Responsibility for Preparedness
Director of Infection Prevention and Control (DIPC)	Liaise with the Health Protection Unit regarding epidemiological surveillance for emerging threats within the local health community. In partnership with the Microbiology Laboratory Manager, ensure the capability of diagnostic and reporting laboratory services are responsive to escalating demands. Provide expert advice to the Operational Site Management Team with regard to their preparedness strategy. Keep the Chief Executive informed of the onset, progress and de-escalation stages of the outbreak.
The Infection Prevention and Control Team (IPCT)	Support the DIPC in providing expert advice to the Operational Site Management Team. Disseminate surveillance information on the local health community to the Operational Site Management Team and Communications Team to support preparedness strategies. Co-ordinate LSW wide awareness programmes for clinical areas and advise on pre-scripted text for public awareness distribution via the Communications Team. Ensure all clinical areas know how to contact the IPCT during office hours. Also, when and how to contact the on-call Microbiologist outside of 08:00-21:00hrs. Prepare a system to record the IPCT's daily review of the outbreak. Prepare an outbreak pack for use at ward level. This pack should include a quick reference flow chart, patient status template (Appendix 3), signage and a de-escalation check list. Produce and maintain an up-to-date patient information leaflet for the relevant organism; especially Norovirus.
Staff Health & Wellbeing (SHWB)	Prepare, establish and resource a system which is capable of responding to an outbreak involving staff groups arising from any micro-organism.
Operational Site Management Team	With support from the DIPC, and the IPCT, establish an escalation system that will be used at the outset and throughout the course of the outbreak. This should include: 1) a dialogue with other organisations to prevent unnecessary

	admissions due to Seasonal Influenza and Diarrhoea and Vomiting. 2) a policy on the movement of patients and staff. Prepare to implement a reporting service for Norovirus and Influenza as required by the Health Protection Unit.
Professional Practice	Prepare, establish and resource a staffing system which is capable of supporting the system prepared by the Operational Site Management Team.
Estates & Facilities Management **Materials Management Teams**	Prepare and establish a system with guidance from the IPCT, which is capable of accommodating an increase in demand for: 1) Environmental cleaning and provision of other resources, such as waste removal and linen services, to manage the containment of the outbreak. In certain circumstances consideration to other bespoke resources may be required, such a sticky mats and temporary screens. 2) PPE stock levels.
Communications Team	Prepare and co-ordinate an internal and public communication system, utilising a range of media channels, to reflect an early warning and informing service. The frequency and content will be guided by the DIPC/ IPCT.
All LSW Staff	Take the action below if suffering an infection which may cause serious harm if transmitted to patients (Appendix 4): ▪ Consult Occupational Health & Wellbeing, who, in conjunction with the IPCT and relevant specialities, will advise about fitness to continue working with patients. ▪ Cease working in the clinical area if advised to do so. ▪ Inform line manager. ▪ Do not return to work until advised by Occupational Health & Wellbeing Department and/or Infection Prevention and Control that it is safe to do so. ▪ Rarely, urgent out-of-hours advice from the on call Consultant Microbiologist is required. In general, advice should be sought from Occupational Health & wellbeing during the working day.

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 "Management of the Infected Patient in Hospital", 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 and 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 where these have been pre-printed and made available for ward use by the IPCT, e.g. diarrhoea care plan (Appendix 5). The IPCT will issue a care plan on a case by case basis for all other relevant organisms, including seasonal influenza (Refer to the policy on the Management of Seasonal Influenza).

    a. The relevant monitoring charts should be raised as advised on the relevant care plan. Diarrhoea should be classified using the Bristol Stool Chart, type 6-7 (1997).

    b. 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's bed space see Appendix 6.

- Ensure all relevant microbiology samples are collected as soon as symptoms are present and send for processing without delay. Ensure clinical details are completed in their entirety. Remember that early diagnosis facilitates the best clinical outcome for the patient.

- Ensure that the doctor attending the patient notifies the Consultant for Communicable Disease Control (CCDC) if this is a notifiable disease. The table in Appendix 2 gives guidance on the infections which should be reported to the CCDC.

- 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 Wellbeing and the IPCT.

- Contacts of the case may require specific protection or monitoring – the need for this will be advised by the IPCT, Consultant Microbiologist or CCDC as appropriate (e.g. meningococcal disease, open pulmonary tuberculosis).

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.

- 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 9).

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).

- 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.

- Advise on the instigation of a ‘re-opening’ checklist. This will include the elements inherent in an environmental deep cleaning programme, a checklist of contacts to advise of the de-escalation of precautions.

8.2 Members of the Outbreak Management Team will:

- Action their respective systems according to the level of the outbreak across the 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 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. Information for on-call managers and nurse managers admitting patients into a ward closed due to gastroenteritis is given in Appendix 8.

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, complete and sign a de-escalation checklist; a copy of which must be given to the IPCT and a copy retained by the ward. The checklist may include a whole ward deep clean or specific area(s) within the ward. 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. Other staff, including Doctors, Physiotherapists, Occupational Therapists, Radiographers and Social Workers can continue to work on both affected and unaffected wards. 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.

- 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

9.3a Staff

- Staff with symptoms of gastroenteritis (Refer to Appendix 5) 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.

9.3b Visitors

- During an outbreak of gastroenteritis, 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 and to continue to do so until they have been symptom-free for 48 hours. Visitors should not bring gifts of chocolates or fruit during an outbreak.

10. Reporting

10.1 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 LSW Board, the relevant Directorate leads 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.

10.2 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.

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: Deputy Director of Professional Practice, Safety and Quality

Date: 13 May 2015

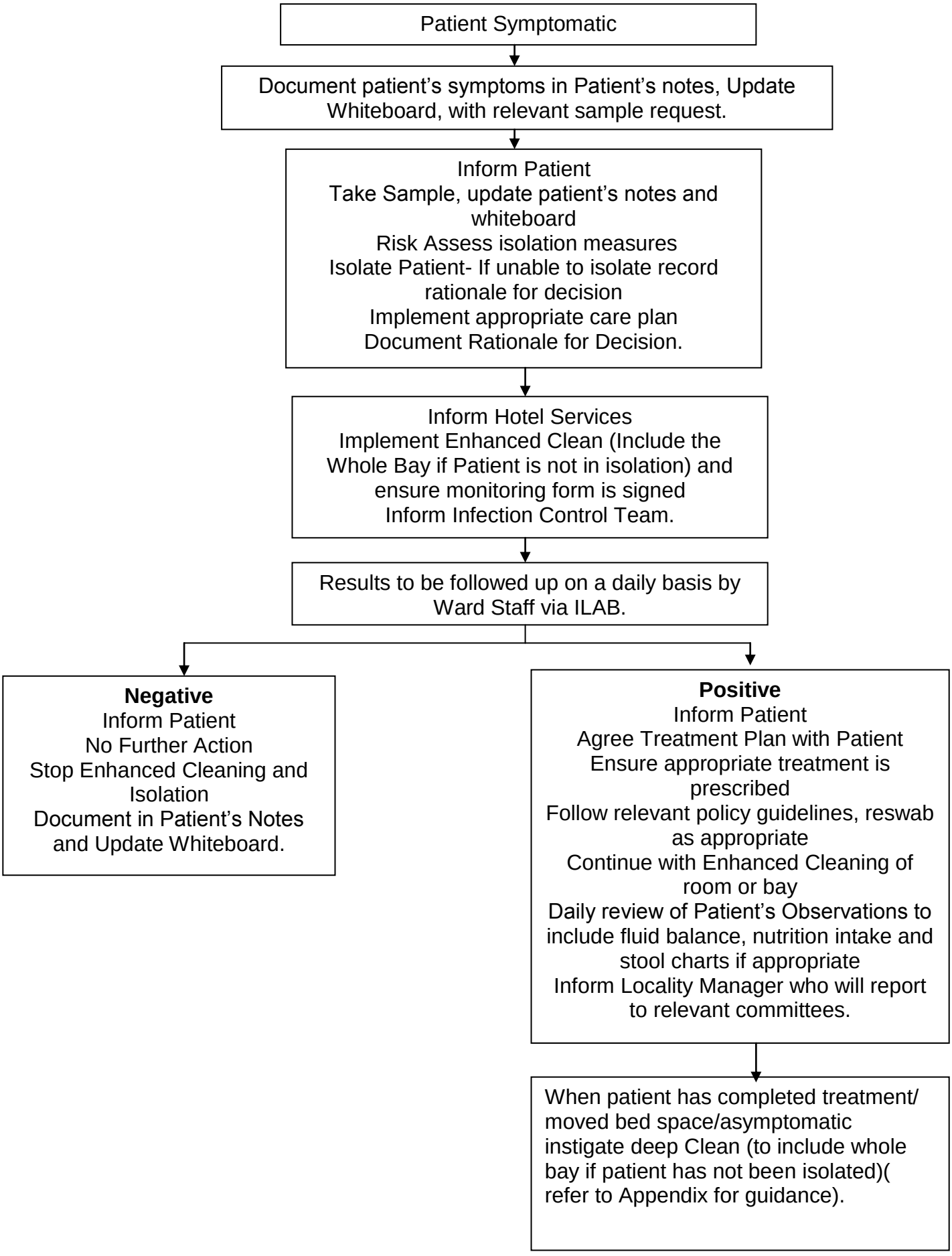
Bristol Stool Chart

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) Typhoid Fever Diphtheria Acute poliomyelitis Anthrax Cholera Typhoid and paratyphoid fever Viral haemorrhagic fever Leprosy Leptospirosis Malaria Plague Typhus Tetanus Yellow fever	Meningitis (including 'aseptic', viral, bacterial and fungal) Meningococcal septicaemia Acute encephalitis Tuberculosis Measles Mumps Rubella Scarlet Fever Whooping cough Ophthalmia neonatorum Viral Hepatitis Rabies Relapsing fever Smallpox Legionnaire's disease Listeria *Haemophilus influenzae* Type B Epiglottis Haemolytic Uraemic Surndrome.

- Intestinal
- Suspected or proven infective diarrhoea and/or vomiting
- Respiratory
- Influenza (if confirmed by a doctor on clinical or laboratory evidence)
- Group A streptococcal pharyngitis (notably in operating theatres and surgical wards)
- Tuberculosis
- Skin & soft tissue
- Boils
- Infected eczema
- Suppurating lesions (conjunctivitis, otitis externa)
- Herpetic whitlow (if working with neonates or the immunosuppressed)
- Shingles
- Scabies
- Meticillin-Resistant *Staphylococcus aureus* (MRSA)
- Rashes
- Chickenpox
- Hand, foot & mouth disease
- Scabies
- Other
- Mumps
- Acute infection with a Blood-Borne Virus (HIV, Hepatitis B and Hepatitis C)

Appendix 4 Flow chart for In-Patients with a Suspected Infection



Appendix 5

Management of Patients with Diarrhoea

If a patient has one bout of D/V/D&V the patient must be isolated until 48 hours clear of any symptoms. A risk assessment must be implemented before isolating patients. If patients cannot be put into isolation the reason must be clearly documented into the patient's notes.

- A stool sample must be obtained and sent to microbiology.
- Hotel services must be informed immediately so that they can commence an enhanced clean both in the patients bed room and allocated toilet/en suite (please refer to page 23 in the Decontamination Guidelines and Procedures. (Cleaning and Disinfection). Version No 1.2 Policy).
- Clear documentation of the enhanced clean must be kept up to date by the domestics.
- Hand Hygiene must be encouraged to patients and visitors.
- Hand hygiene must be adhered to by all staff (in the event of D&V liquid soap and running water must be used when decontaminating hands).
- Where possible patients must be allocated their own equipment. If this is not possible patient equipment must be decontaminated effectively in-between patient use. (Please refer the Decontamination Guidelines and Procedures. (Cleaning and Disinfection). Version No 1.2 Policy for guidance on cleaning equipment).
- Good personal hygiene must be encouraged to patients.
- A Bristol stool chart must be implemented and kept up to date (Appendix 1).
- Patient monitoring must be implemented and kept up to date (MEWS/daily observations / food and fluid charts).
- Patients who cannot be isolated must be allocated their own toilet/commode.
- Isolation and Daily Review Care Plan must be implemented (Appendix 6).
- Appropriate signage should be put in place (Appendix 16).

Once the patient is 48 hours clear of the last symptom a deep clean must be commenced in both the patient's room and allocated toilet/en suite **(**Please refer to Appendix 8).

Appendix 6 **Isolation and Daily Review Care Plan**

Patient Name ……

NHS Number ……

Reason Isolation Required
……

Date and Time of Sample
……..

Date and Time of Results
……..….

Date Isolation Started ……

Date IPCT informed ……

IPCT contact telephone number: 34167

Please use the blue sign

Standard Isolation for Diarrhoea & vomiting Norovirus, C diff.
Wear apron and gloves when entering the room
Discard apron and gloves in the clinical waste bin inside the room
Wash hands before leaving the room
Always keep the door closed
Enhance clean twice daily (please see bed space cleaning guidance)
Treat all waste as infectious clinical
Treat all linen as infected (place in soluble bags and use red linen bags)

Equipment decontamination
Clean with detergent and disinfectant after each use and label.

Commodes/Bodily fluids
Clean with detergent followed by disinfectant.

Please complete a daily review of the patient's infectious status and isolation requirements (Please see reverse side of this Daily Care Plan).

Please use the green sign

Standard Isolation for TB, MRSA, Serratia marsecesens, PVL, Klebsiella, pseudomonas, neisseria, meningitis, E coli, enterococcus, & ESBL , GRE/VRE, CPE.
Wear apron and gloves when entering the room
Discard apron and gloves in the clinical waste bin inside the room
Wash hands before leaving the room
Always keep the door closed
Enhance clean twice daily (please see bed space cleaning guidance)
Treat all waste as infectious clinical
Treat all linen as infected (place in soluble bags and use red linen bags)

Protective Isolation (Please use green sign)
Isolation measures are the same as standard isolation. Protective isolation is to protect susceptible patients from acquiring an infection from other sources.

Equipment decontamination
Clean with detergent after each use and label.

Commodes/Bodily fluids
Clean with detergent followed by disinfectant.

For patients being treated for any other infections please contact the IPCT (34167) for a specific care plan

Daily Review for isolation

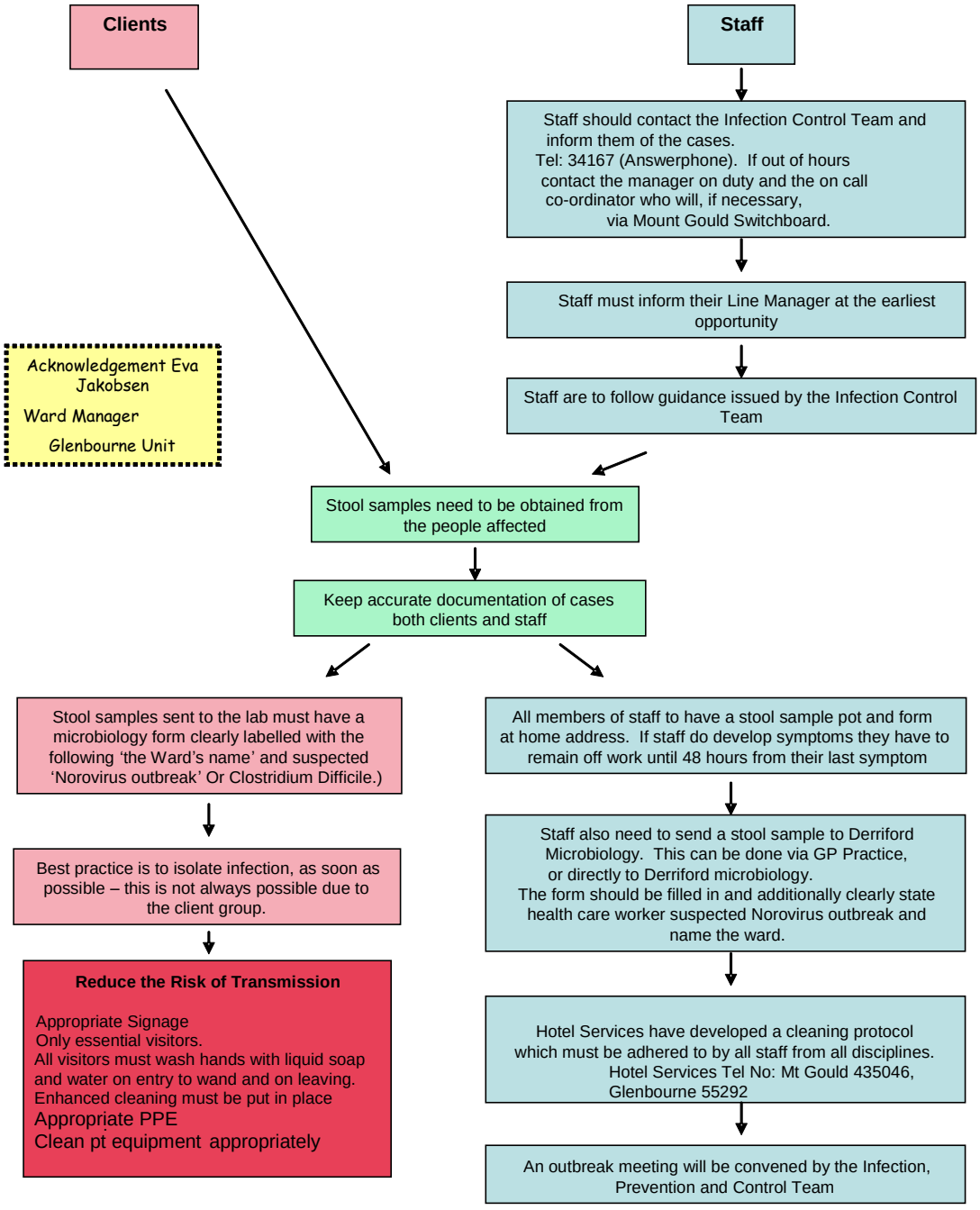
Date	Is the patient in a side room?	If the patient is not in a side room please document reasons for this decision	Are all standard IPC measures in place?	Please print name, job title and sign care plan on a

Adapted from: PHNT IPC Isolation Care Plan and Daily Review Tool v1.3

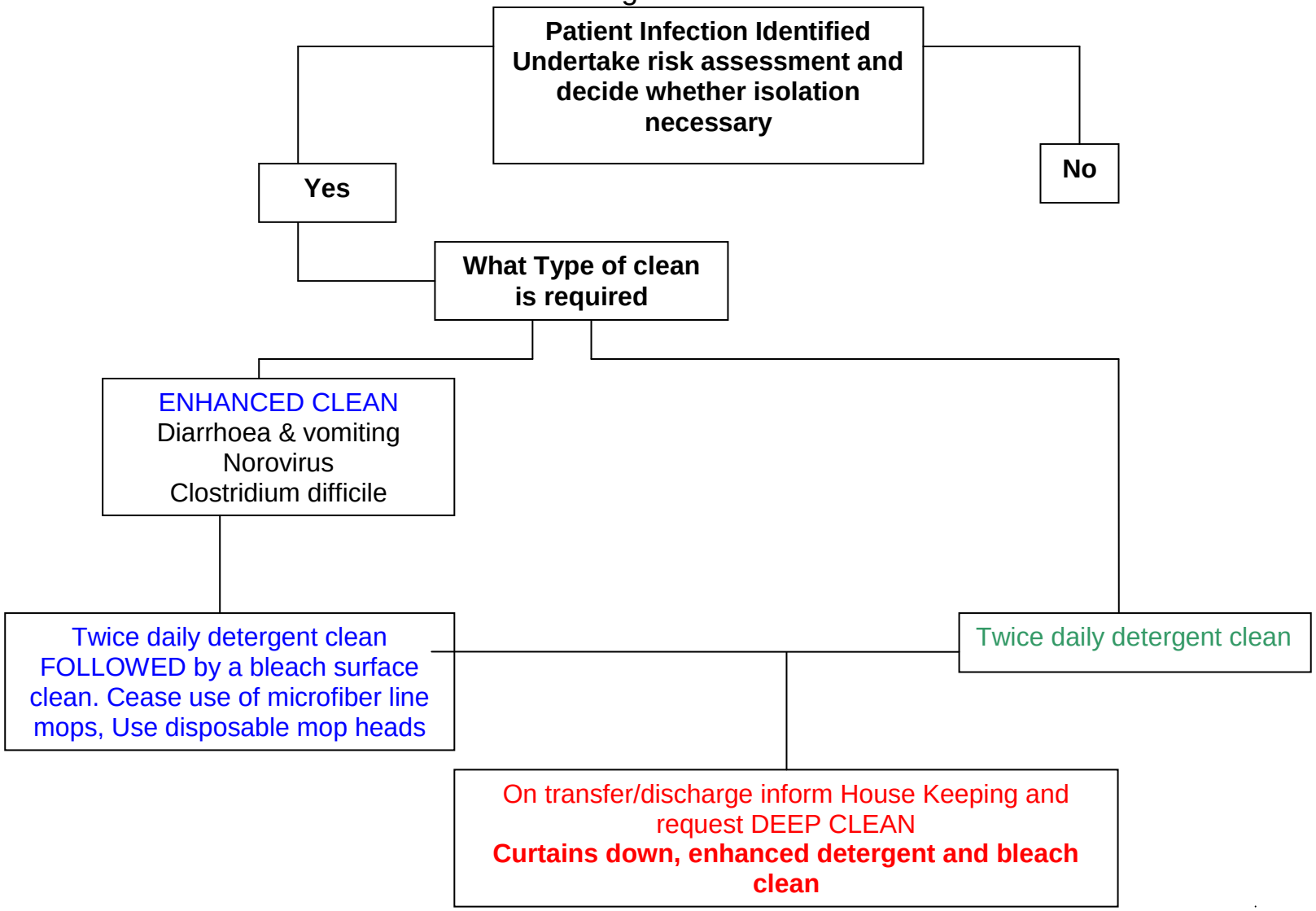
Appendix 7 How to respond to a Diarrhoea / Vomiting Outbreak

As part of the Infection Prevention and Control Policy, All Services have a duty to respond quickly and effectively

If there are two or more cases of DIARRHOEA or vomiting On the Unit, staff must implement the Infection Prevention Control Outbreak, including D&V Policy



Appendix 8 Outbreak Record – Diarrhoea & Vomiting



Appendix 9

STAFF OUTBREAK RECORD – DIARRHOEA AND VOMITING

Ward _____

Key: **D** = Diarrhoea, **SF** = Soft Formed, **NS** = Normal Stool, **V** = Vomiting, **N** = Nausea

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

Key: **D** = diarrhoea, **SF** = soft formed, **NS** = Normal Stool,
V = Vomiting, **N** = Nausea
24, 48, 72 etc. = Number of hours symptom free
H = Home

Patient Infection Control Outbreak Record – Diarrhoea & Vomiting

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														

Information for on-call Managers admitting patients to a ward closed due to Gastroenteritis	Appendix 10

In the event of a bed crisis, the decision to admit to wards suspected or known to have gastroenteritis should only be made by the on-call Executive Director, who will be advised of the problem by the on-call Manager/Bed Managers.

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. All other reasonable alternative solutions must have been exhausted.

To ensure patients and staff are fully protected and aware of why potentially contradictory decisions are being made:

- Patients being admitted to a closed area must be informed, as should accompanying relatives.

- The on-call Manager/Nurse Manager must inform the patient that they are being admitted to an affected ward and why. This information should be documented in the patient's notes.

- If possible, position the patient in a side room or a bay with the least symptoms or into a bay that has been thoroughly cleaned.

- Re-assure the patient that every measure will be taken to reduce the risk of their being infected with gastroenteritis. Reiterate the importance of hand washing.

- Explain the symptoms of gastroenteritis and hand them an appropriate information leaflet. Viruses such as the Norovirus are the most common cause of community acquired gastroenteritis, with up to 5% of the population having disease in any one year. The hospital's problems mirror what is occurring in the community.

- Explain when they are admitted into the ward that discharge will be to the patient's own home only. Transfer to other establishments will be avoided to reduce the risk of further spread in the short term.

- Vital and urgent treatments will not be affected – the individual's urgent clinical needs will supersede all other considerations.

- Routine non-urgent investigations may be delayed because of being on a closed ward.

Appendix 11

INFECTION CONTROL ALERT

THIS CLINICAL AREA IS CURRENTLY CLOSED DUE TO AN OUTBREAK OF DIARRHOEA AND VOMITING

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 12

INFECTION CONTROL ALERT

THIS CLINICAL AREA IS CURRENTLY RESTRICTED DUE TO AN OUTBREAK OF DIARRHOEA AND VOMITING

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 13

Infection Control Notice

Please keep these doors closed

Thank you

Appendix 14

Please can we remind all visitors not to Visit if you have any of the following symptoms Diarrhoea, Vomiting or 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 15

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 16 PPE Guidance

	Apron	Looped Apron	Gloves	Face Mask	Face shield	Eye Protection	Hand Hygiene
Influenza		✓	✓	✓	✓	✓	✓
TB		✓	✓	✓	✓	✓	✓
Ebola/VHF HH Liquid soap and running water		✓	✓	✓	✓	✓	✓
C Diff HH Liquid soap and running water	✓		✓				✓
MRSA	✓		✓			✓	✓
VRE/GRE	✓		✓				✓
CPE HH Liquid soap and running water		✓	✓				✓
Personal Care	✓		✓				✓
Risk of Bodily Fluids HH Liquid soap and running water	✓	✓	✓			✓	✓
Risk of Splashes	✓	✓	✓		✓		✓
Diarrhoea and Vomiting HH Liquid soap and running water	✓		✓				✓
Scabies	✓		✓				✓
Ecoli/ESBL	✓		✓				✓
PVL	✓		✓				✓