Shropshire Community Health
NHS Trust

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Local Ref (optional)	
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Author	Deputy Director of Infection Prevention and Control
Approval process	
Who has been consulted in the development of this policy?	This policy has been developed by the IPC team in consultation with appropriate senior Operations and Quality managers, Locality Clinical Managers, Specialist Nurses, Medicine Management and Public Health England
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1		
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Contents

Norovirus and other GI Infections

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

A patient develops diarrhoea and or vomiting:

- ☐ Check if there are any other patients and/or staff with these symptoms.
- ☐ Commence stool record chart.
- ☐ Isolate symptomatic patient in a single room with door closed to reduce risk of cross infection.
- ☐ Obtain stool sample (see Section 6 of this policy)

Is **Norovirus** or ***Clostridioides difficile* infection** (CDI) suspected?

Markers for Norovirus

- Symptom onset sudden
- Vomiting is projectile.
- Type 5-7 stool watery and no blood
- Abdominal cramps
- Symptomatic patient(s) not had laxatives or enemas in past 48 hours.
- Other patients and or staff symptomatic
- Norovirus circulating in local community.

Markers for CDI

- Stool type 5-7, very offensive may have blood or mucus present.
- Pyrexia, hypotension, tachycardia, abdominal pain
- No vomiting
- Antibiotic therapy in the last 6 weeks
- On PPIs
- Bowel surgery/GI procedure

Management

Refer to Management of CDI policy. (Appendix 3 – Algorithm on the Management and treatment of CDI)

Suspected Norovirus

- ☐ Isolate or cohort patients.
- ☐ Close the bay until patient(s) who have been 'exposed' are 48hours post exposure and terminal clean is completed.
- ☐ Inform all visiting / therapy staff in order to prioritise assessments – erect relevant banner / signage outside ward.
- ☐ Dispose of open packets of food and fruit, change water jugs twice daily.
- ☐ Inform Domestic Supervisor and ward staff to ensure enhanced and touchpoint cleaning commenced throughout ward.
- ☐ Inform IPC and Clinical Services Manager or On Call Manager
  - *Microbiology should be informed to ensure appropriate testing takes place, this will be done by IPC during normal working hours or the On Call Manager outside of normal working hours.*
- ☐ Source isolation precautions for all symptomatic patients
- ☐ Send symptomatic staff home.
- ☐ Obtain stool samples from first five patients and staff.
- ☐ Commence stool record chart on all symptomatic and 'exposed' patients (Appendix 2)
- ☐ GP to review patients.
- ☐ Discontinue laxatives and DO NOT give anti-diarrhoeal medication.
- ☐ Commence daily D&V monitoring form (Appendix 3) and email a copy to shropcom.ipcteam@nhs.net by 10am each day.
- ☐ Remove fruit bowls, open packets of food etc.
- ☐ Inform visitors, limit visitors if appropriate.
- ☐ Emphasise hand hygiene using soap and water NOT alcohol gel.
- ☐ Check microbiology results to aid patient(s) management / treatment.

Ensure IPC team are informed on:

01743 730510

Out of hours Consultant Microbiologist at SaTH on:

01743 261000

Further information should be accessed from the main text of this policy

1 Introduction

Gastrointestinal (GI) infections may be caused by a variety of agents including bacteria, viruses, protozoa and parasites resulting in diarrhoea and/or vomiting. The most important characteristic of pathogens responsible for infectious GI infections is their ability to be rapidly transmitted in healthcare settings among individuals who often are highly susceptible. However, there are also many non-infective causes of diarrhoea and vomiting including gut and biliary conditions, withdrawal from opiate drugs, laxatives and chemotherapy.

Microorganisms that cause GI infection spread mainly from person to person following contact with excreta by the faecal-oral route. Infection may also occur through contamination of the environment especially with *Clostridioides difficile* and Norovirus. Microorganisms transmitted by food, e.g. Salmonella, Campylobacter, can also be spread to others by cross infection. Salmonella, Campylobacter*, Escherichia coli* 0157 and Cryptosporidium may be seen occasionally but are usually acquired in the community and the patient may be admitted with the infection. The most identified GI infections in the UK are listed in Appendix 1.

2 Purpose

This policy is intended to provide guidance on the management and reporting of Norovirus and GI infections, so that individual cases can be managed appropriately, and potential outbreaks promptly recognised.

The principles contained within this policy reflect best practices and should be adopted by all staff working in a clinical environment and applies to all services provided by Shropshire Community Health NHS Trust.

The policy also applies to individuals employed by agencies and other contractors.

3 Definitions and Abbreviations

Term / Abbreviation	Explanation / Definition
CCDC	Consultant in Communicable Disease Control
CCR	Clinical Case Review
CDI	*Clostridioides difficile* infection
GI	Gastro-intestinal
GP	General Practitioner
HCAI	Healthcare Associated Infections
HPT	Health Protection Team
IPC	Infection Prevention and Control
OHD	Occupational Health Department
PIR	Post Infection Review
RCA	Root Cause Analysis
SaTH	Shrewsbury and Telford Hospital NHS Trust
SCHT	Shropshire Community Health NHS Trust
SIP	Service Improvement Plan
UKHSA	UK Health Security Agency

4 Duties

4.1 Responsibility for Infection Prevention and Control (IPC) outside the immediate scope of this policy

For duties and responsibilities for IPC practices outside the specific scope of this policy, please refer to the IPC Arrangements and Responsibilities Policy on the Staff Zone SCHT Staff Zone (shropcom.nhs.uk).

4.2 IPC Duties specific to this policy

4.2.1 Healthcare Staff

SICPs are to be applied by all staff when caring for any patient. (See Standard Infection Prevention and Control Precautions Policy).

All Healthcare staff have a responsibility to comply with Trust policies for prevention and control of infection; those who provide direct patient care must ensure they are up to date with PPE usage procedures.

4.2.2 Infection Prevention and Control Team

The Infection Prevention and Control Team are responsible for providing advice on the required precautions.

4.2.3 Consultant Microbiologist

The consultant microbiologist is responsible for providing advice on required precautions (including out of hours infection control advice) and advising on management and diagnosis of diarrhoea symptoms.

4.2.4 Occupational Health

The Occupational Health team are responsible for providing advice to staff who have had contact with patients with a diarrhoeal infection regarding their own health. See section 23 for further information.

5 Diarrhoea

Diarrhoea is defined as two or more episodes within a 24-hour period which conforms to the shape of the receptacle i.e. the stool is watery or liquefied. However, in order to comply with the *Clostridioides difficile policy,* regardless of this definition it is recommended that any unexplained episode of diarrhoea (Bristol Stool Chart types 5-7 – see Appendix 2) that is not clearly attributable to an underlying condition (e.g. inflammatory colitis, overflow) or therapy (e.g. laxatives, enteral feeding) is collected, as close to the first onset of the symptoms as possible, and sent to the microbiology laboratory for appropriate testing and the patient is isolated promptly using enteric precautions

Diarrhoea (and vomiting) has many different causes. It is therefore important to distinguish between infectious and non-infectious causes of diarrhoea and whether it is associated with food or water.

Some patients may regularly suffer from diarrhoea. With these patients, any variation in their ‘normal stool’ pattern e.g. increased frequency is indicative of a problem that requires a clinical review and investigation.

6 Groups That Pose an Increased Risk of Spreading Infection

It is particularly important to assess infected people who belong to one of the four groups for whom special action should be considered.

Group A: Any person of doubtful personal hygiene or with unsatisfactory toilet, hand washing or hand drying facilities at home, work, or school.

Group B: Children who attend pre-school groups or nursery.

Group C: People whose work involves preparing or serving unwrapped foods not subjected to further heating.

Group D: Clinical and social care staff who have direct contact with highly susceptible patients or persons in whom a gastrointestinal infection would have particularly serious consequences.

A liquid stool is more likely than a formed stool to contaminate hands and the environment and is consequently a greater risk of spreading faecal pathogens. Formed stools voided by asymptomatically infected people, or people who have recovered from illness, may contain pathogens but are unlikely to transmit infection if good personal hygiene can be achieved. Vomit, like liquid stool, may be highly infectious.

7 Case of Probable Gastro-intestinal (GI) infection

A case of probable GI infection is defined as any one of the following conditions that cannot be attributed to another cause (e.g. laxative use, medication side effect, diet, prior medical condition):

- Three or more episodes of diarrhoea in a 24-hour period – above what is considered normal for that individual

OR

- Two or more episodes of vomiting in a 24 hour period

OR

- One episode each of vomiting and diarrhoea in a 24 hour period

OR

- Positive culture for a known enteric pathogen with a symptom of GI infection (e.g. vomiting, abdominal pain, diarrhoea)

OR

- One episode of bloody diarrhoea

Diagnosis of Norovirus infection is often made on clinical grounds from their characteristic features. However the infection can also be confirmed following testing of a stool sample.

However, if an infectious cause cannot be ruled out, the patient must be isolated promptly using enteric precautions after the 1st episode of vomiting / diarrhoea as any delay may result in transmission of infection to other patients in the immediate vicinity of the patient.

8 Food Poisoning

The most common causes of food poisoning in the UK are Campylobacter and Salmonella. Norovirus can also be food borne. Most of the organisms that cause food poisoning can also be passed from person-to-person by the faecal-oral route.

Staff and contacts of confirmed or suspected cases working in the risk groups outlined in section 6, where food poisoning is suspected, may require clearance specimens before they can return to work. The circumstances for each case, excretor, carrier, or contact will require a risk assessment to be completed. See Appendix 1.

9 Management of Patients with Diarrhoea and/or Vomiting

Clinicians should apply the following mnemonic protocol (SIGHTED) when managing suspected potentially infectious diarrhoea:

S	Suspect that a case may be infective where there is no clear alternative cause of diarrhoea
I	Isolate the patient (within 2 hours), clean vacated bed space and consult with the infection prevention and control team while determining the cause of diarrhoea
G	Gloves and aprons must be used for all contacts with the patient and the patient's environment
H	Hand washing with soap and water should be carried out before and after each contact with the patient, their environment and following removal of personal protective equipment
T	Test faeces, by sending a specimen immediately
E	Educate the patient, family and visitors
D	Document actions – including when isolation is not available

All patients experiencing diarrhoea and/or abnormal bowel habits must be started on the Stool Record Chart and a Fluid Balance Chart. It is the responsibility of the nurse in charge of the patient's care to ensure these are filled out accurately – see Appendix 2 Stool Record Chart.

Laxative prescriptions must be discontinued, and anti-diarrhoeal medication should not be prescribed. Areas experiencing two or more patients with diarrhoea and or vomiting must inform the IPC team in office hours on 01743 730510 or out of hours the on-call Consultant Microbiologist at Shrewsbury and Telford Hospital NHS Trust (SaTH) on 01743 261000.

When an outbreak is declared the Daily Diarrhoea and Vomiting Monitoring Form – see Appendix 3 – must be completed and then emailed before 10am daily to the IPC team: shropcom.ipcteam@nhs.net. The IPC team require this information in order to update the daily outbreak report and to enable decisions to be made regarding bay or ward closures. The reopening of bays/wards should only be by agreement of the IPC team or Consultant Microbiologist.

If *Clostridioides difficile* infection (CDI) is suspected or confirmed refer to Trust *Clostridioides difficile* policy.

10 Norovirus

Norovirus is a major cause of acute gastroenteritis and diarrhoea in children and adults. The cause of illness, Norovirus (previously known as Norwalk-like or Small Round Structured Virus) was described in 1968 in samples from an elementary school in Norwalk, Ohio. The disease is often termed Winter Vomiting Disease because of the increased prevalence in the winter months; however, it can be detected throughout the year.

Norovirus is the most common cause of outbreaks of gastro-enteritis in hospitals and can also cause outbreaks in other settings such as schools, nursing homes and cruise ships. Hospital outbreaks often cause major disruption in hospital activity resulting in ward closures, cancelled admissions and delayed discharges which can significantly reduce clinical activity for the duration of the outbreak. Failure to observe and comply with infection prevention and control practices can lead to further spread of infection and a delay in the hospital returning to normal activity. Outbreaks can affect both patients and staff, sometimes with attack rates in excess of 50%.

11 Signs and Symptoms of Norovirus

The average incubation period for Norovirus associated gastro-enteritis is 12-48 hours.

The illness is characterised by a sudden acute onset of:

- Vomiting (this is the predominant symptom, often projectile, and is seen in 50% of cases, however, clusters can occur where vomiting is infrequent or absent altogether).
- Watery diarrhoea and abdominal cramps
- Nausea

In addition, headache, myalgia, fever and malaise are common. Some or all of the above symptoms may be present.

Symptoms last between one and three days and recovery is usually rapid.

Dehydration is the most common complication and symptomatic patients should have their fluid balance monitored and receive rehydration as necessary.

12 Transmission

Norovirus is highly contagious. It is estimated that 30mls of vomit may contain up to 30,000,000 (30 million) virus particles and 1 gram of faeces can contain up to 5 billion infectious doses of Norovirus. However, it only takes around 10-100 virus particles to cause illness. Noroviruses are transmitted primarily through the faecal-oral route either by person to person spread or via contaminated food or water. In addition Noroviruses can be spread via aerosol dissemination of infected particles following vomiting. Droplets can potentially travel up to three metres.

Transmission can also occur through hand transfer of the virus to the oral mucosa following contact with environmental surfaces, fomites and equipment which have been contaminated with either faeces or vomit. Norovirus can survive on any surface for at least a week and on foods in a refrigerator for up to 10 days.

13 Exposed Asymptomatic Patients

These are patients who have been exposed to a symptomatic, (either possible or confirmed Norovirus case) by being in the same environment (as possible or confirmed cases) and whose last exposure was within the past 48 hours.

14 Outbreak Definition

Suspected outbreak: two or more cases, as outlined in section 11, occurring in a functional care area within the hospital without laboratory confirmation.

Confirmed outbreak: two or more cases, as outlined in section 11, occurring in a functional care area within the hospital with laboratory confirmation.

In the absence of laboratory confirmation, the following criteria can be used as a potential indicator of a norovirus outbreak:

• average duration of illness of 12 – 60 hours,

• average incubation period of 24 – 48 hours,

• more than 50% of people with vomiting,

and

• no bacterial pathogen found.

If an outbreak caused by norovirus is suspected, but it does not strictly meet these criteria, it must still be reported to IPC in-hours and the On-call manager out of hours.

The outbreak is considered over when there have been no new cases for seven days after the last case was considered to be symptom free (PHE 2012). An outbreak is defined as two or more cases with similar symptoms over a given period of time and related to an area/ward/unit.

14.1 Norovirus Outbreak

An outbreak of Norovirus is defined as two or more cases of diarrhoea and or vomiting affecting patients and or staff in the same clinical area within 24 hours of each other and at least one tested positive for Norovirus.

Laboratory confirmation is not a pre-requisite to either the start of an outbreak or to the declaring of an outbreak. When an outbreak is suspected, it is imperative to instigate infection control measures immediately without waiting for virological confirmation from stool testing. However, it is of value for epidemiological surveillance to establish the cause of outbreaks and to exclude aetiological agents.

Refer to section 15 – diagnostic specimens.

14.2 Closure of Whole Ward and/or Bays

There is evidence that outbreaks due to Norovirus can be controlled by containment in bays /rooms with doors closed, adherence with IPC procedures and terminal cleans rather than entire ward closures. It is therefore likely that the IPC team will recommend bay closures rather than whole ward closure unless the symptomatic patients are distributed throughout the ward.

The definition of 'closure'/restriction refers to the restriction of incoming and outgoing personnel, patients, residents, equipment and materials to an unavoidable minimum. In broad terms a ward or bay closure (cohorting) means that there are no new admissions in or discharges out of the area (unless cases are going to their own homes or in emergency situations).

A Datix incident form must be completed by the ward staff in the event of an outbreak of infection and the on call manager and Capacity Hub should also be informed. If the ward is closed escalate to the Trust Risk Manager for reporting as a Serious Incident.

15 Diagnostic Specimens

Obtain faecal samples of all unexplained diarrhoea and send to the pathology laboratory for examination as soon after the onset of illness as possible, as the likelihood of isolating some pathogens (e.g. viruses) decreases substantially within a few days of onset. If there is urine in the sample this is not a problem, the stool sample can still be processed as the urine will not affect the results. As the laboratory will need to divide the specimen into two, half for CDI testing and half for virology the specimen pot should be at least ¼ full and ideally ½ full.

In an outbreak situation, obtain faecal specimens from symptomatic patients in each affected bay/room, unless informed otherwise by the IPC team or Microbiology Laboratory.

Clearly label the specimen and microbiology form stating any relevant clinical history and request Microscopy, Culture and Sensitivity. Also request virology if Norovirus infection is suspected, clearly indicating the sample is part of an outbreak.

For specimens from staff see section 23.

In the event of an outbreak occurring at the weekend, samples can wait until Monday to be sent, unless there is suspicion of *Clostridium difficile* infection, in which case then they must be sent urgently, ensuring the case has been discussed first with the on-call microbiologist and the microbiology laboratory informed of the sample/s being sent for processing.

Follow up (clearance) specimens are not routinely required once the acute symptoms are over and the stool is formed.

Vomit samples are not required and will not be tested by the laboratory.

16 Isolation Practices

- Isolate patient experiencing diarrhoea in a single room with ensuite facilities where possible.

- Isolation checklist must be completed by the ward staff and a copy forwarded to the IPC team via email at shropcom.ipcteam@nhs.net. Checklists are available to download from the IPC page of the Trust website here.
- It is best to keep patients who have vomited cohorted in a multi bedded bay and isolate the entire bay as the others have been exposed.
- Patients in protective isolation must not be cohorted with other patients.
- Designate a commode to patients without ensuite facilities.
- Notes and charts should be kept outside the room/bay.
- Vacated bed spaces in bays must be quarantined until all patients exposed to potential infection and who may be incubating the infection are 48 hours clear of symptoms.
- Vacated bed spaces must be cleaned and left stripped and unmade until the terminal clean has been completed. The "I am clean" Tool must also be completed and held with the patient's notes – available to download from the IPC page of the Trust website here. Under self-audit tools and checklists.
- Ensure that the source isolation sign is clearly displayed on the door or wall to alert staff and visitors to infection prevention and control precautions and ensure that doors are kept closed at all times.
- When there are significant numbers of patients affected with the same symptoms and/ or organism, they may be nursed together (cohorted). This is generally used when the number of cases exceeds single room capacity and where patients with the same infection can be cared for in a dedicated area.
- Allocate staff to duties in either affected or non-affected areas of the ward.
- Therapists should prioritise their workload and see exposed/affected patients last.
- No eating and/or drinking should be undertaken by staff within clinical areas.

17 Hand Hygiene and Personal Protective Equipment

- High standards of hand decontamination minimise risk of cross-infection.
- It is vital to perform hand hygiene before and after each direct patient contact, and following removal of personal protective equipment.
- Hands **must** be decontaminated using liquid soap and water.
- Disposable aprons must be worn by all staff on entering the room/bay, removed and hands decontaminated prior to exiting unless staff are disposing of body fluids in the sluice.
- Disposable gloves must be worn where there is contact with bodily fluids and for handling of contaminated items. The use of gloves does not replace the need to wash hands.
- Encourage patients to wash hands, or use patient hand wipes provided, frequently throughout the day and definitely after using the toilet/commode/bedpan/urinal, and before eating or taking medication.

18 Cleaning and Decontamination

- Designated commodes must be decontaminated with Chlorine wipes in the sluice and stored clean and labelled for use only with the isolation/cohort room.
- Where possible, equipment should be single patient use.
- Multiple patient use equipment must be designated where possible and thoroughly decontaminated with disinfectant wipes between uses.
- Airwaves mattress should be cleaned subject to manufacturer's instructions.

- Linen should be placed in a red alginate bag and then inside a red linen Terylene bag.
- All waste must be categorised as infectious waste and disposed of into orange clinical waste bags, which should be located in the patient's room or cohort bay.
- All staff must be aware of their roles and responsibilities with regard to cleaning and decontamination of patient equipment and the environment and refer to the local cleaning schedules.

18.1 Environment

- Domestic staff must be informed that the patient(s) are in source isolation and they are required to use a combined detergent and disinfectant solution for cleaning.
- The room(s) must be cleaned at least daily (the frequency may be increased on the advice of the IPC team or ward manager/ deputy) with dedicated cleaning equipment – refer to the Trust Cleaning and Disinfection Policy.
- To aid effective cleaning keep room clutter free and request visitors take home unnecessary items.
- Remove open packets of food items and fruit.
- Change water jugs twice daily and ensure lids are in use.
- Ensure water jugs are washed in the dishwasher.
- Ensure ward staff crockery used during an outbreak is decontaminated via the dishwasher.

18.2 Cleaning Requirements During and Following Symptoms of Diarrhoea and/or Vomiting

- Key control measures include increased frequency of cleaning, environmental disinfection and prompt clearance of soiling caused by vomit or faeces.
- The isolation room and/or cohort area and patient care equipment must be cleaned and disinfected daily and after soiling.
- A terminal clean (refer to the Trust Cleaning and Disinfection Policy) must be performed at least 48 hours after the patient/s has been symptom free, this may increase to 72 hours by the IPC team depending on the situation.
- "I am clean" Tool to be completed and stored in the patients' notes. These are available from the IPC page of the Trust website under self-audit tools and checklists.
- The bed(s) must remain stripped and left unmade until the terminal clean has been completed.
- Commodes and toilets must be cleaned with chlorine wipes after each use including the arms and the underside of the seat.
- Specific attention must be paid to all objects and surfaces which are touched frequently, for example, door handles, toilet flush handles, telephones, keyboard and nurse call handsets. **Prior room occupancy is a risk to newly admitted patients if not cleaned with an appropriate disinfectant.**
- Revise and enhance domestic staffing rotas to provide full cover throughout the working day to facilitate twice daily enhanced cleaning and planned terminal cleans.

19 Patient Movement

Transfer and movement of patients should be kept to a minimum to reduce the risk of infection spreading and should only be undertaken for clinical reasons. If a patient needs to attend other departments, a risk assessment will need to be carried out as to the urgency of the investigation/therapy, the outcome of which should be recorded in the patient's notes.

The receiving area should be informed of the infection risk so they can take the necessary precautions.

Advice should be sought from the IPC team regarding patient discharge/transfers or outpatient attendance.

20 Patient Discharge

- **Discharge to own home**: This can take place at any time irrespective of the stage of the patient's GI infection providing the patient can manage at home alone with their symptoms and appropriate advice is given to the patient, family, carers and patient transport.
- **Discharge to nursing or residential homes**: Discharge to a home should not occur until the patient has been asymptomatic for at least 48 hours. Due to the incubation period patients who have been exposed should also be 48 hours clear.
- **Discharge or transfer to other hospitals or community-based institutions (e.g. prisons)**: This should be delayed until the patient has been asymptomatic for at least 48 hours. Urgent transfers to other hospitals or within hospitals need an individual risk assessment.

21 Visitors

Visitors may contribute to the on-going spread of Norovirus. Visitors, where possible, should be discouraged but not prevented from attending areas that are 'closed' or have restrictions in place due to Norovirus. This applies especially to the elderly, immunocompromised or the very young, in whom infections may be more severe.

Staff must provide affected patients and visitors with an explanation of the infection, isolation procedures, treatment and the Isolation Practices, Information for Patients and their Visitors leaflet. This is available from the IPC page of the Trust website here.

In addition:

- Visitors must be advised NOT to visit if they have been symptomatic within the last 48 hours.
- Visitors must be informed of the risk of acquiring possible Norovirus if they do visit the ward.
- Visitors must not visit if they have had recent contact with someone who has had diarrhoea and/or vomiting in the last 48 hours.
- Children must not visit during an outbreak.
- Visitors, including Ministers of Religion, must be advised not to have contact with other patients on the ward/unit unless affected patients are visited last. Visitors should reduce the number of visits whilst the outbreak lasts.
- Visitors must not sit on beds.
- Visitors only need to wear an apron and gloves if performing, or helping to perform, care activity tasks.
- Visitors must make sure their hands are washed with soap and water on arrival to and departure from the ward, before assisting and following any personal and nutritional care.

22 Other Settings

If a patient is known to have symptoms of a GI infection, where possible they should be discouraged from attending a Health Centre/Surgery. If this is unavoidable, then an appointment at a quieter time is preferred to minimise the potential risk of cross infection to other patients and staff.

Staff visiting a patient with known diarrhoea in their home should, if possible, make this the last visit of the day.

23 Staff

Any member of staff who has diarrhoea or vomiting should refrain from work until clear of symptoms (and feels well) for 48 hours.

Staff who develop symptoms of GI infection while on duty should report to their Manager and go off duty immediately and consult their GP if necessary. Staff may also be requested to send a stool specimen as part of the outbreak investigation. Samples from staff must be labelled appropriately and the microbiology form completed with relevant details and request Microscopy, Culture and Sensitivity. Also request virology if Norovirus infection is suspected. The result should be requested to go to Shropshire Community Health Trust Occupational Health Department (OHD) at Gains Park, Shrewsbury. OHD staff will inform the staff and IPC nurses of the result. Staff should ensure that the clinical details include the location of the outbreak and that they are a member of staff.

Staff experiencing nausea or gastro-intestinal cramps during an outbreak should also refrain from work until clear of symptoms, as they can be infectious.

23.1 Staff Ill at Home

Members of staff unwell whilst off duty should telephone their manager in the usual way and state the nature of their illness. If the staff member has diarrhoea or vomiting and there are other cases of diarrhoea and vomiting in the ward or department the manager must inform the IPC team.

24 Reporting

24.1 Reporting Outbreaks of Norovirus

Suspected and confirmed outbreaks of Norovirus are reported electronically to Public Health England West Midlands Centre and to colleagues within the SCHT, SaTH and NHS Shropshire and Telford and Wrekin by the IPC team on the day of the start of and daily until the outbreak is declared over. Any concerns the outbreak may be food or water borne are telephoned through by the IPC team to UKHSA West Midlands Centre.

24.2 Statutory Notification

Doctors in England and Wales have a statutory duty to notify a Consultant in Communicable Disease Control (CCDC) within the local Health Protection Team (HPT) of suspected cases of certain infectious diseases. The attending Registered Medical Practitioner (RMP) should fill out a notification certificate immediately on diagnosis of a suspected notifiable disease and should not wait for laboratory confirmation of the suspected infection or contamination before notification. The certificate should be sent to the Proper Officer within three days or verbally within 24 hours if the case is considered urgent.

All CCDC are required to pass on the entire notification to the HPT within three days of a case being notified, or within 24 hours for cases deemed urgent. HPTs are the primary recipient within the UKHSA Centre of the clinical notifications form.

Notifications sent to the HPU must be made in a secure manner. This may be by telephone, letter, and encrypted email or to a secure fax machine. If in doubt, please contact the local HPT for advice. Contact details: West Midlands North UKHSA Team on 0344 225 3560 option 2.

Out of hours please contact First Response on 01384 679031 and ask for the Consultant on call for West Midlands North UKHSA Team. In office hours the IPC team will notify UKHSA via the daily outbreak emails.

24.3 Declaring an Outbreak Over

When a patient has had no diarrhoea or vomiting for 48 hours they are deemed no longer infectious.

A ‘closed’ bay/room can be re-opened when there have been no new cases and all affected patients have been asymptomatic for 48 hours.

All areas must be deep cleaned and curtains changed before opening.

The decision to reopen a closed bay/room can only be made by the IPC team, Ward Manager or Consultant Microbiologist.

25 Reoccurring Symptoms

Reoccurrence of symptoms may represent prolonged infection, re-infection or infection with a different organism. The IPC team should be contacted immediately for a further risk assessment.

The patient(s) should be isolated as soon as possible.

Please refer to section 16 – Isolation Practices

26 Outbreak Debrief/Post Infection Review

If the IPC team consider a de-brief meeting is necessary, this must be arranged within 10 days of the outbreak being declared over and should be chaired by a member of the IPC team. Attendees should include representation of all staff groups who have worked in the affected area during the outbreak. A service improvement plan will be subsequently developed, with the completion and implementation being the responsibility of the ward manager/team leader. An outbreak summary report will be produced by the IPC team and presented to the IPC Governance Meeting.

Refer to Trust Outbreak Management Policy for further details including outbreak summary, report and agenda templates.

27 Consultation

This policy has been developed by the IPC team in consultation with appropriate clinical services managers, advisors/specialists (e.g., Medical Advisor, Specialist Nurses, Medicine Management), UKHSA and IPC Governance Meeting members.

A total of three weeks consultation period was allowed and comments incorporated as appropriate.

27.1 Approval Process

The IPC Governance Meeting members will approve this policy and its approval will be notified to the Quality and Safety Committee.

28 Dissemination and Implementation

This policy will be disseminated by the following methods:

- Managers informed via Datix who then confirm they have disseminated to staff as appropriate.
- Staff – via Team Brief, digital staff noticeboard and IPC Newsletters
- Awareness raising by the IPC team.
- Published to the Staff Zone of the Trust website.

The web version of this policy is the only version that is maintained. Any printed copies should therefore be viewed as 'uncontrolled' and as such, may not necessarily contain the latest updates and amendments. When superseded by another version, it will be archived for evidence in the electronic document library.

28.1 Advice

Individual Services' IPC Link staff act as a resource, role model and are a link between the IPC team and their own clinical area and should be contacted in the first instance if appropriate.

Further advice is readily available from the IPC team or the Consultant Microbiologist.

28.2 Training

Managers and service leads must ensure that all staff are familiar with this policy through IPC induction and update undertaken in their area of practice.

In accordance with the Trust's mandatory training policy and procedure the IPC team will support/deliver training associated with this policy. IPC training detailed in the core mandatory training programme includes Standard Infection Control Precautions and details regarding key IPC policies. Other staff may require additional role specific essential IPC training, as identified between staff, their managers and / or the IPC team as appropriate. The systems for planning, advertising and ensuring staff undertake training are detailed in the Mandatory Training Policy and procedure. Staff who fail to undertake training will be followed up according to the policy.

Further training needs may be identified through other management routes, including Clinical Case Review (CCR), Root Cause Analysis (RCA) and Post Infection review (PIR), following an incident/infection outbreak or following audit findings. Additional ad hoc targeted training sessions may be provided by the IPC team.

29 Monitoring Compliance

Compliance with this policy will be monitored as follows:

- Hand hygiene will be audited in accordance with the Hand Hygiene Policy and via peer Hand Washing Assessments
- Cleaning standards within Community Hospitals will be monitored in accordance with the Publicly Available Specification (PAS) 5748 framework.
- Environmental and patient equipment cleaning will be monitored as part of local routine cleanliness audits.
- Audited locally using the HCAI Prevention audits undertaken by the IPC team and by staff as Self- audits as part of the IPC audit programme.
- Additional periodic auditing and self-audits by clinical teams
- The IPC Governance Meeting will monitor compliance of the cleanliness audit scores and the IPC team audit programme.

Numbers of staff undertaking IPC training, which includes Standard Infection Control Precautions will be monitored by the Organisational Development and Workforce Department.

As appropriate the IPC team will support Services' Leads to undertake IPC CCRs/RCAs/PIRs. Managers and Services' Leads will monitor subsequent service improvement plans and report to the IPC Governance Meeting.

Knowledge gained from CCR/RCA/PIR and IPC audits will be shared with relevant staff groups using a variety of methods such as reports, posters, group sessions and individual feedback.

The IPC team will monitor IPC related incidents reported on the Trust incident reporting system and, liaising with the Risk Manager, advise on appropriate remedial actions to be taken.

30 References

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Illingworth E, Taborn E, Fielding D et al (2011). Is closing of entire wards necessary to control Norovirus outbreaks in hospital? Comparing the effectiveness of two infection control strategies. *Journal of Hospital Infection*. 79: 1. p32-37

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31 Associated Documents

This policy should be read in conjunction with Trust:

- Cleaning and Disinfection Policy
- Clostridium difficile Policy
- Standard Infection Control Precautions: Hand Hygiene and Personal Protective Equipment Policy Isolation Policy
- Linen and Laundry Policy
- Outbreak Management Policy – Incorporating Bed and Ward Closure
- Waste Management Policy

32 Appendices

Appendix 1 – Common Identified Causes of Gastrointestinal Infection in the UK

- * *Bacillus cereus*
- * Campylobacter
- *Clostridium difficile*
- * *Clostridium perfringens*
- Cryptosporidium
- * *Escherichia coli* Verocytotoxin-producing (VTEC) Serotype 0157 most common in UK
- *Escherichia coli* Enterotoxigenic (ETEC)
- *Hepatitis A
- Norovirus
- Rotavirus
- *Salmonella (excluding typhoid/ paratyphoid)
- Shigella
- *Staphylococcus aureus*

* Food poisoning and Hepatitis A are Notifiable Diseases and should be reported by the doctor to the CCDC and UKHSA.

For further details on actions or management of these infections please refer to the following:

NHS-England-IPC-A-to-Z-pathogen-resource-draft-4.xlsx (live.com)

Appendix 2 – Patient Stool Record

Please attach patient sticker here or record:
Name:.....

NHS Number:.....

Unit Number:.....

Date of Birth: .....

Male *Female* (Please circle)

Consultant:.....

Hospital: .....

Ward: .....

Date specimen sent: .....
Result: .....

More than one test per patient may be required if the first test is negative but there is a strong clinical suspicion of C.diff. Retest a second sample 24 hours later.

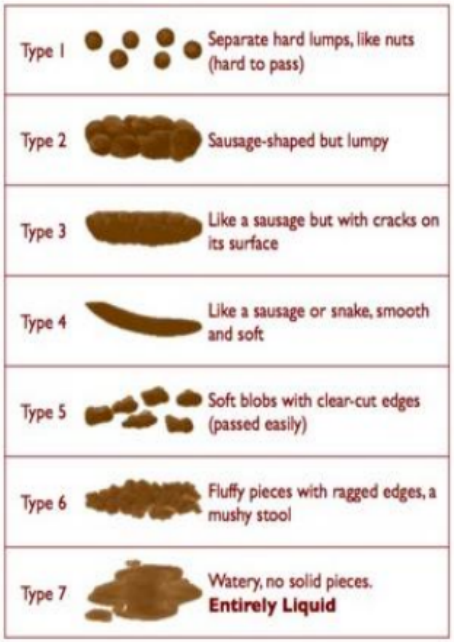
NHS
Shropshire Community Health
NHS Trust

Stool Record Chart

For Infection Prevention and Control related screening and monitoring

Date	Time	CONSISTENCY and DESCRIPTION (Please refer to key and tick all that apply)										Bowels Not Opened	Sample sent Y/N	Signed
		1	2	3	4	5	6	7	Mucus	Blood	Colour			

Key: Bristol Stool Chart



DEFINITION OF DIARRHOEA
Watery or liquefied stools, (i.e. types 5, 6 and 7).

SEND SAMPLE
If unexplained stool type 5,6,7. Isolate patient, send stool sample and consult with IPC Team.

Appendix 3 – Daily Diarrhoea and Vomiting Monitoring Form

Daily Diarrhoea and Vomiting Monitoring Form - Patients											
Ward:		**Bay/Sideroom number:**					**Date:**				
Patient Sticker	**Relevant Past Medical History**	**Previous and Present infection inc antibiotics**	**On Laxatives - name and date stopped**	**Date & Time of 1st Episode**	**Date Stool Specimen Sent** / **Specimen Result**	**Symptoms**					
Patient one							**Time:**	**Time:**	**Time:**	**Time:**	**Time:**
						D*					
						Type					
						V*					
						N*					
Patient two							**Time:**	**Time:**	**Time:**	**Time:**	**Time:**
						D*					
						Type					
						V*					
						N*					
Patient three							**Time:**	**Time:**	**Time:**	**Time:**	**Time:**
						D*					
						Type					
						V*					
						N*					
Patient four							**Time:**	**Time:**	**Time:**	**Time:**	**Time:**
						D*					
						Type					
						V*					
						N*					

KEY: D = Diarrhoea V = Vomiting N = Nausea

Infection Prevention and Control Team September 2015

Type - refer to Bristol Stool Record Chart