Leicestershire Partnership NHS Trust

The clinical management of patients' nursed as an In-patient within LPT with an increased incidence or outbreak of diarrhoea and/or vomiting policy

This policy describes the clinical management and procedures to be followed by staff on the ward where an increased incidence or outbreak of infection of diarrhoea and/or vomiting is considered.

This policy has been developed for staff working within community inpatients.

Please also refer to the infection prevention and control policy titled "*The escalation process to be followed when there is a suspected or known increased incidence and/or outbreak of infection within LPT facilities"* for information regarding the procedure to be followed to ensure the correct persons are informed and processes followed when an increased incidence and/or outbreak of infection is suspected.

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Target audience:	All LPT Staff	
Type of Policy:	Clinical √	Non Clinical
Which Relevant CQC Fundamental Standards?		

Contents

Version control and summary of changes

Version	Date	Comment
Version 1	September 2015	Development of policy to give clear guidance for ward staff when and increased incidence of infection or outbreak of infection is suspected or confirmed. Referenced against national guidance
Version 2	October 2017	Change of title to differentiate more clearly this policy which relates to the clinical management of patients to the policy relating to the escalation process for an increased incident and/or outbreak Review of policy to ensure it is still relevant in line with national guidelines and other Infection Prevention and Control policies
Version 2	November 2018	Amendment to the Increased Incidence or outbreak of diarrhoea and/or vomiting policy. This policy has been updated to include a possible caveat from Public Health England (PHE) where they might advise to allow a shorter period of time for patients to be asymptomatic prior to admitting into areas/allowing transfer from the acute trust. This will only be implemented where the demand for beds across LLR outweighs the number of beds available due to an increase in incidences or outbreaks. Prior to this caveat being used PHE will advise Infection Prevention and Control, who will send out information to the inpatient areas to make them aware of the temporary change in policy. In patient areas are not to make this decision independently.

For further information contact: Infection Prevention and Control Team

Definitions that apply to this policy

Consultant in Public Health	A consultant who is knowledgeable in Infectious Diseases
Diarrhoea	Diarrhoea is the increased frequency of passing a loose stool that is either a stool loose enough to take the shape of a container used to sample it or as Bristol Stool Chart types 5-7 (Appendix 2) that is not attributed to any other cause
Health protection professional	A person suitably qualified in the field of health protection and registered with an appropriate body such as the Faculty of Public Health, the Chartered Institute of Environmental Health and/or the Nursing and Midwifery Council or the General Medical Council
Increased Incidence	The occurrence of two or more cases of the same infection linked in time or place or the situation when the observed number of cases exceeds the number expected.
Infection	An organism present at a site and causes an inflammatory response, or where an organism is present in a normally sterile site.
Infection control incidence	This can be defined as an outbreak of infection or infectious disease requires a more in depth level of strategic management
Infectious	Caused by a pathogenic micro-organism or agent that has the capability of causing infection
Outbreak	The occurrence of two or more cases of the same infection linked in time or place or the situation when the observed number of cases exceeds the number expected.

1.0 Purpose of the policy

The purpose of this policy is to ensure that all staff employed by LPT are aware of the processes to be followed with regards to the management of patients who are nursed on a ward where there is an increased incidence or outbreak of infection

2.0 Summary of the policy

This policy provides trust wide guidance for staff at ward level with regards to the clinical management of patients nursed on a ward where there is an increased incidence or outbreak of infective diarrhoea and/or vomiting.

There are many causes of increased incidences and outbreaks of diarrhoea and/or vomiting and this policy will apply to all viral gastroenteritis. The most common cause, however, is norovirus which is also one of the most infective agents seen in health and social care establishments.

Guidelines for the management of norovirus outbreaks in acute and community health and social care settings (Norovirus Working Party, 2012)

Further guidance for healthcare workers and other staff who work in prisons and places of detention can be found in 'Prevention of infection and communicable disease control in prisons and places of detention – A manual for healthcare workers and other staff.

3.0 Introduction

The general public and staff have a right to expect that any potential hazards in a healthcare environment are adequately controlled. All staff must possess an appropriate awareness of their role in the prevention and control of infection in their areas of work. Not only is this part of their processional duty of care to the patients with whom they are involved (NMC 2015), but it is also their responsibility to themselves, to other patients and members of staff under the Health and Safety at Work Act (1974).

Increased incidences and outbreaks of infection due to diarrhoea and/or vomiting are a potential risk to patient, staff and public health and wellbeing. The appropriate and timely management of increased incidences or defined cases of an outbreak of infection is a definitive process in controlling and bringing to a close, cases of infection that may otherwise continue to occur. This policy is to provide staff with clear guidance on the procedures to be followed should an increased incidence or outbreak of infection be suspected or confirmed within LPT inpatient facilities.

It is extremely important that the following procedures are adhered to in the event of a known or suspected increased incidence or outbreak of infection.

An increased incidence or outbreak can be defined as either:

- The occurrence of 2 or more cases of the same infection linked in time and place

  OR

- The situation when the observed number of cases exceeds the number expected

Hospital Infection Control – Guidance on the Control of Infection in Hospitals (DH, 1995)

NB: If the disease is notifiable by law, the medical practitioner responsible for the patient must also notify the Consultant in Public Health, Public Health England (East Midlands Health Protection Team). Please refer to the Infection Prevention and Control Policy for Notifying Known or Suspected Infectious Diseases.

4.0 Documentation to complete when an increased incidence/outbreak of infection is suspected

Staff need to ensure that as well as documenting the patients bowel and vomit episodes on any current sytems of communication used by the ward they also document on the increased incidence paperwork (Appendix 1) and that this is readily available to enable effective communication between the ward and the infection prevention and control team who will ring on a daily basis (not weekends or bank holidays) regarding the status of the increased incidence or outbreak of infection.

Appendix 2 can be referred to as a checklist of activities that should be instigated suspicion of increased incident.

NOTE: Please also refer to the Infection Prevention and Control policy entitled “The escalation process to be followed when there is a suspected or known increased incidence and/or outbreak of infection within LPT facilities” for information regarding the procedure to be followed to ensure the correct persons are informed and processes followed when an increased incidence and/or outbreak of infection is suspected.

5.0 Patient placement within the ward

If an increased incidence or outbreak of infection is being considered it is important that patients are not moved around the ward in order to transfer them all into single rooms or cohort them in one bay. It may happen that the first patient is moved into a single room, as at that point the ward may be following the policy for the management of individual patients that present with diarrhoea and/or vomiting, but at the point when an increased incidence or outbreak of infection is considered patient movement should cease.

If a single patient presents with diarrhoea and vomiting, consideration should be given at this early stage as to whether the cause is thought to be viral. If the cause is thought to be viral, then the patient should not be moved into a single room, and all patients within the bay must receive source isolation precautions on an individual basis. This applies whether the other patients are symptomatic or not.

The rationale for this is that the patients who are nursed in the same bay as the affected patient may be incubating the infection and therefore if the affected patient is moved out of the bay and a new patient placed in their vacated bed space this will put that patient at risk of also becoming infected from the other patients in that bay.

All the patients in a bay with an affected patient must be nursed with source isolation precautions on an individual basis. Any empty beds in that bay must be closed to admissions until the last symptomatic patient is 48 hours asymptomatic of vomiting and/or diarrhoea, and a normal stool for them is passed.

Patients must not be moved out of single rooms and cohorted in a bay with symptomatic patients unless a confirmed diagnosis for **all** patients is made. The rationale for this is that there are many causes for diarrhoea and/or vomiting and without a diagnosis it is impossible to definitively state if all the patients are suffering from the same infection.

All the patients in the bay must have an allocated toilet which must be cleaned and decontaminated between use. Commodes must only be used at the bed space as a last resort and a risk assessment must be completed. The rationale for this is that diarrhoea produces spores which will land on inanimate objects, such as clothing or furniture (also known as fomites), and any food or drink that is also within the bay and thus contaminate or re-contaminate the environment or patient via the faecal oral route.

If a commode is used then the commode needs to be completely dismantled and cleaned and decontaminated between each use. It must not be left at the bedside within a bay.

If a patient is nursed in a single room which does not have en-suite, the commode wherever possible should not be left in the single room and should be completely dismantled and decontaminated between each use. If it is deemed that the commode must be left at the bedside within the single room a risk assessment must be completed. In these circumstances it is acceptable to clean the commode between uses and completely dismantle, clean and decontaminate it once the commode is removed from the room

Closing a bay to admissions is not the same as closing a ward to admissions and staff need to be clear that if a bay with affected patients is closed to admissions there is still the capacity to admit into single rooms or bays where there are no affected patients.

Source isolation precautions cannot be discontinued until **all** the patients in the bay/double side room are 48 hours asymptomatic of diarrhoea and/or vomiting, and for those patients who have experienced diarrhoea they must also have passed a normal stool for them. The only exception to this is if patients have negative screens

for the suspected infections and have been reviewed by a medic/ANP who is satisfied that their diarrhoea and/or vomiting is of a non-infectious cause.

When an increased incidence is in progress an extra clean should be requested by the nurse in charge to the cleaning services staff. This extra clean should be carried out daily until the incidence has been closed and the post infection terminal clean has taken place.

Prior to discontinuing source isolation precautions a post infection clean **will need to be undertaken** in the following circumstances:

- If samples have not been obtained for the individual patient within a single room, or, in the case of where a bay is isolated if samples have not been obtained for **ALL** patients who are symptomatic within that bay.
- If samples have been obtained and a positive result for an infection has been identified. In the case of where a bay is isolated if a single patient has a positive result the bay will need to undergo a post infection clean.

If a patient, or in the case of where a bay is isolated, **ALL** patients who are symptomatic within the bay have had samples sent and **ALL** the samples have resulted as negative, then providing the medical staff/ANP are satisfied that the symptoms are not due to an infective cause and document this in the patients notes, then the source isolation precautions can be discontinued without the need for a post infection clean.

It is important for staff to remain vigilant for symptoms of diarrhoea and/or vomiting during the period immediately following the discontinuation of source isolation precautions as there is a risk of re-emergence of symptoms at that time. Should any patients re-commence with loose stools and/or vomiting, the source isolation precautions must be re-commenced.

There may be cases where, upon guidance from Public Health and communicated by the Infection Prevention and Control Team, the standard of waiting for patients to be 48 hours asymptomatic and passing formed stools may be deviated from.

This should only occur where there is notification from Public Health that this is acceptable and will be in response to a wider LLR outbreak of norovirus within the hospitals and where a risk assessment has been undertaken by Public Health against the need to admit patients to the acute setting and/or community hospitals against the risk of exposing patients to norovirus.

6.0 Movement of patients

Patients who are being nursed as part of an increased incidence or outbreak of infection must not be transferred to other wards within LPT, except for purposes of clinical need. For all transfers the Essential Steps Inter-healthcare Transfer Form **must** be completed and accompany the patient (Appendix 4). This decision must be made in consultation with the infection prevention and control team or the on call manager and be based on a clinical assessment of the risk to other patients in the receiving area as well as the individual patient who is being considered for transfer.

If patients need to be transferred to other hospitals due to clinical need the receiving hospital and ward must be informed of the increased incidence/outbreak of infection and the symptoms that the particular patient is displaying. The ambulance service must also be informed so they can take the appropriate precautions.

Visits to other departments must be kept to a minimum. When this is necessary, either for investigation or treatment, prior arrangements must be made with the manager of that department, so that the Trust source isolation policy and the Trust guidelines for cleaning and decontamination can be implemented. Symptomatic patients should be seen immediately or at the end of the working session. They should only be sent for when the department is ready to see them; they should not be left in the waiting room/ area with other patients. If at all possible and where it does not impinge on their clinical state these visits should be delayed until the patient is asymptomatic of diarrhoea and/or vomiting for 48 hours and has passed a normal stool for the individual.

If visits to other hospitals are considered necessary the receiving area should be informed of the increased incidence/outbreak of infection and of the patient's status in advance. Where possible patients should be treated at the end of a session and their waiting time in the department kept to a minimum. If at all possible and where it does not impinge on their clinical state these visits should be delayed until the patient is asymptomatic of diarrhoea and/or vomiting for 48 hours and has passed a normal stool. Advice may be sought from the Infection Prevention and Control team.

7.0 Therapy treatment for patients

All therapists must be informed of patients who are receiving source isolation precautions.

Patients can still be assessed and treated by therapy staff, ie; physiotherapists and occupational therapists following a risk assessment. They are able to participate in physiotherapy on the ward and in the gym or occupational therapist specific clinical areas.

Therapists need to ensure they adhere to the source isolation precautions being implemented as per this policy. They need to, where possible, arrange the patient as the last therapy session.

Any equipment that will not be required needs to be removed, where possible, covering any remaining equipment and worktops etc that will not be used with plastic sheeting. The environment and used equipment must be used with chlor clean after the patient has been attended to and prior to the next patient.

Any equipment/worktops that have not been used but have not been covered with plastic sheeting or removed from the clinical area also need to be cleaned and decontaminated with chlor clean after the patient has been attended to and prior to the next patient,

8.0 Precautions to be undertaken

Signage

Clear laminated signage must be placed at entrances to the ward and affected bays or patient rooms to alert visitors, staff and the public to the fact that there is an increased incidence/outbreak of infection in the area.

Following the discontinuation of an increased incidence or outbreak of infection the laminated signage must be cleaned and decontaminated if it is to be reused.

Hand hygiene

Transmission of infectious diarrhoea is commonly via the faecal-oral route. Infectious organisms can be present in the environment, on equipment and be transferred on the hands of staff, visitors and patients. Contaminated hands are the most common routes of transmission of infections.

Hands must be decontaminated after contact with a patient or their environment, after completing any task or following the use of any equipment (World Health Organisation 5 Moments for Hand Hygiene 2009). Staff must always wash their hands after removal of Personal Protective Equipment (PPE). This must be done using liquid soap and water following the approved hand washing technique ensuring hands are thoroughly rinsed and then dried using disposable paper towels.

After hand washing with soap and water, alcohol sanitiser must be used to reinforce hand washing but **must not** be relied upon for hand decontamination for diarrhoeal disease, as alcohol does not readily kill spores or viruses.

For further information regarding hand hygiene see LPT Infection prevention and Control Hand Hygiene Policy.

Staff must always ensure that **all** patients are advised and **if necessary assisted** to wash their hands after using the toilet/commode/urinal and before meals.
It is important to ensure that visitors to the ward are aware of the need for them to undertake hand hygiene on entering and exiting the ward and also before and after visiting their relative who is a patient on the ward.

Personal protective equipment (PPE)

Disposable nitrile gloves and a disposable plastic apron must be worn whenever there is contact with a patient (or their environment) having source isolation precautions. They must be changed and disposed of as clinical waste after and between each task and/or contact.

Personal Protective Equipment (PPE) must be donned after obtaining any items required for the task to be undertaken and immediately prior to the clinical care. PPE must be removed immediately after completion of the task, followed by hand hygiene.

If patients are cohorted in an affected bay then each patient must be treated individually with regards to personal protective equipment; the PPE must be changed between individual patients and different tasks with the same patient.

For further information regarding PPE see LPT Infection prevention and Control Policy for the use of Personal Protective Equipment.

Cleaning and decontamination of the environment

The domestic staff will need to be informed that source isolation precautions are being taken with patients and that a second daily clean will be required in those areas in addition to the daily clean. (Appendix 3)

Cleaning and decontamination of equipment

All equipment that has come into contact with the patient or their environment, must be cleaned and disinfected with a chlor-clean solution as per the LPT Infection Prevention and Control Policy for Cleaning and Decontamination.

9.0 Clinical treatment of viral gastroenteritis

There is no specific treatment for many of the viral gastroenteritis infections. The main treatment is the correction or avoidance of dehydration.

Antidiarrheal medication is not routinely recommended although it is acknowledged that some medics may find them useful in specific cases where other infective causes of diarrhoea have been excluded. It is important to note that they can be contra-indicated in some conditions, such as Clostridium *difficile* and may also mask the infectivity of patients.

Vomit must not be sent to microbiology for testing, it will be discarded without testing if received by microbiology.

In the event of an increased incidence/outbreak of infection, 2 separate faecal samples should be collected and sent for testing. One sample to be sent to microbiology to test for MC&S and CDT to microbiology, and one sample must be sent to virology to test for norovirus. Virology must also be contacted by telephone to inform them that an increased incidence or outbreak of infection is being considered.

Norovirus can be detected in patients for days or weeks after initial infection. Clostridium *difficile* can be detected in patients for weeks or months after initial infection. There is no requirement to send faecal samples for clearance testing in patients who have formed stools. indicate that any bacterial load present would be minimal (not detectable) and would therefore pose a minimal risk of further transmission.

In certain cases, and with consultation of the IPC team it may be prudent to resample patients who have known norovirus and continue with loose stools for a length of time, for example over 7 days. In this case a negative screen would not definitively rule out that norovirus was still present, but it would indicate that any

bacterial load present would be minimal (not detectable) and would therefore post a minimal risk of further transmission. Examples of when re-sampling would be appropriate, include, but are not limited to, when a patient has another underlying cause for loose stools, such as IBS, Chrons etc

10.0 Visiting arrangements

Patients in source isolation may be visited by family and friends. Visitors do not routinely need to wear PPE. However, if relatives are involved with direct patient care, they should wear disposable nitrile gloves and aprons, removing them after use and placing them into clinical waste, then wash their hands with soap and water and dry them, before decontaminating them with alcohol sanitiser.

If patients are being nursed with source isolation precautions due to the fact that they are nursed in a bay with symptomatic patients but are themselves asymptomatic visitors to these patients still need to adhere to the advice above.

There may be occasions when the advice from the infection prevention and control team is that **all** visitors to a ward need to don nitrile gloves and disposable aprons. In such cases the infection prevention and control team will advise the ward accordingly.

11.0 Volunteers

Volunteers must report to the nurse in charge for advice and guidelines on what duties they may undertake with regard to areas that are undergoing source isolation precautions. It is the responsibility of the nurse in charge to ensure the volunteer is aware of any precautions that need to be taken.

12.0 Discharge of patients

Patients who are symptomatic with diarrhoea and/or vomiting may be considered for discharge to other hospitals, nursing and residential homes. This must be discussed in advance with the receiving area/carers to ensure that adequate facilities (i.e. ability to provide source isolations precautions) and necessary equipment are available. The receiving hospital, nursing or residential home must be informed that the patient is part of an increased incidence or outbreak of infection as this has separate implications than if the patient was an isolated case.

The receiving hospital, nursing or residential home should then confirm appropriate arrangements are in place prior to admission. This must be documented in the patient's notes and discharge documentation.

In the event that the place of discharge does not have the appropriate facilities to isolate the patient, the transfer then must be delayed until the patient has been symptom free for at least 48 hours. In the case of patients with diarrhoea they must have been symptom free for at least 48 hours and have passed a formed stool (or one that is normal for the patient).

Symptomatic patients with diarrhoea and/or vomiting can be considered for discharge to their own home if they are deemed to be medically fit and will be able to care for themselves whilst they are symptomatic either independently or in between carer visits if these are in place. This must be discussed in advance with the community services and family if they are going to be involved in their care or living with them. This must be documented in the patient's notes and discharge documentation.

It is the responsibility of the discharging Doctor to communicate with the General Practitioners (GP) about symptomatic patients who are being discharged into the care of the community. The GP should also be informed of those patients who have recovered from diarrhoea and/or vomiting but are no longer symptomatic on the discharge letter.

The infection prevention and control team must be informed of the final decision regarding the discharge of symptomatic patients.

13.0 Transport for symptomatic patients

If a symptomatic patient is to be discharged or transferred from a community hospital to another place of care or to their own home, transport arrangements must be planned in advance.

If the patient is to be transferred by ambulance, the ambulance liaison officer must be advised of the patient's diagnosis or symptoms and the need for a designated ambulance.

Patients must not be transferred by taxi or volunteer services.

If the patient is to be discharged using personal private transport the driver must be provided with the appropriate equipment (i.e. disposable vomit bowls and continence pads). The driver must be advised of the infection prevention and control precautions necessary in the event of a body fluid spillage. The importance of hand washing using soap and water following handling of body fluids and waste must be discussed.

14.0 Staff health

Occupational Health must be informed of symptomatic staff. All staff must remain off work until they have been symptom free for 48 hours. Advice regarding symptomatic staff will be given by occupational health.

Infection prevention and control will need to be informed of staff that are symptomatic as they will keep a list within their records

15.0 Training

There is no additional training requirement identified within this policy.

16.0 References and associated documents

DH Health & Social Care Act 2015 (revised)

DH Health and Safety at Work etc Act (1974)

Guidelines for the management of norovirus outbreaks in acute and community health and social care settings (Norovirus Working Party, March 2012).

Hospital Infection Control – Guidance of the Control of Infection in Hospitals (DH 1995)

LPT Cleaning and Decontamination of Equipment, Medical Devices and the Environment (including the management of Blood and Body Fluid Spillages), Infection Prevention and Control Policy

LPT Hand Hygiene Policy, Infection Prevention and Control

LPT Management of a Patient Requiring Source Isolation Precautions, Infection Prevention and Control

LPT Management of a Patient Requiring Source Isolation Precautions, Infection Prevention and Control

LPT Personal Protective Equipment for use in Healthcare Policy, Infection Prevention and Control

LPT Staff Health relating to Communicable Disease Policy, Infection Prevetnion and Control

LPT The escalation process to be followed when there is a suspected or known increased incidence and/or outbreak of infection Policy, Infection Prevention and Control

Prevention of Infection & Communicable Disease Control in Prisons & Places of Detention – A manual for healthcare workers and other staff. (HPA 2011)

Appendix 1

Infection Prevention and Control Team

Documentation of symptomatic patients' bowel and vomit episodes

Patients Name	Placement on ward	Date: AM PM Night			Date: AM PM Night			Date: AM PM Night			Date: AM PM Night			Date: AM PM Night			Date: AM PM Night			Date: AM PM Night		

Appendix 2

Infection Prevention and Control Team

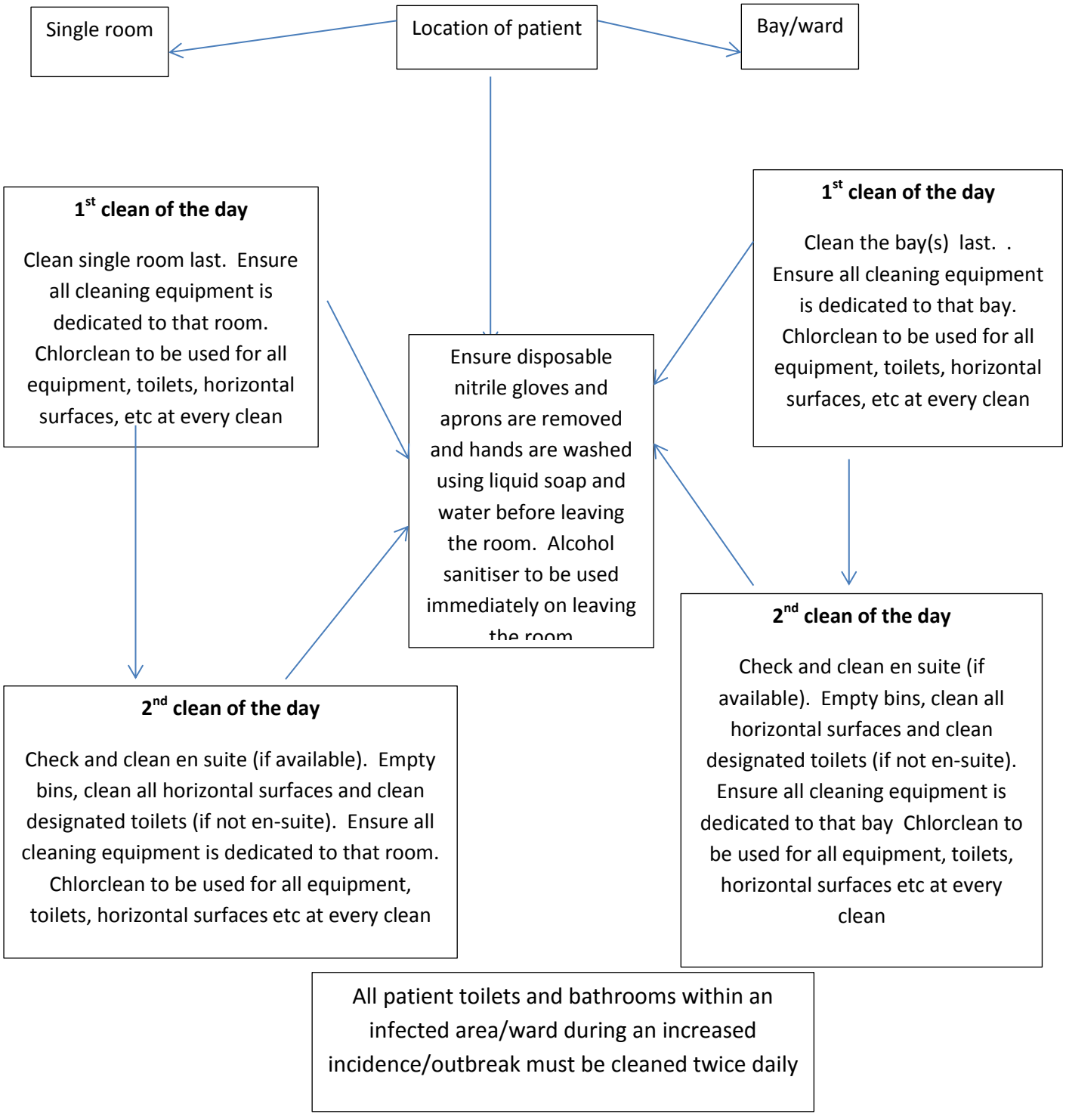
Checklist of activities that should be instigated by ward on initial suspicion of increased incidence

- Isolation of affected patients □
- Increased cleaning and disinfection to affected areas □
- Alerting managers of other departments □
    - Physiotherapy □
    - Occupational therapy □
    - Podiatry □
    - Hotel services □
    - Portering services
    - Dieticians □
    - Speech and language therapists □
- Consideration of closing affected area to admissions □
- Stopping transfers of affected patients out of the affected area □
- Opening of affected area (if closed) □
- Communication strategy □
- Staff surveillance, immunisation, and exclusion form ward
- Record keeping
- Incidence form completed □

Appendix 3

Infection Prevention and Control Team

Cleaning Algorithm for an increased incidence/outbreak of infection for environmental cleaning



Appendix 4

Inter-Healthcare Infection Control Transfer Form

<table>
<tr><td>Patient/Client details (insert label if available).
Name:
Address:

NHS number:
Date of Birth:</td><td>Consultant:

GP:

Current patient/client location

Transferring facility – hospital, ward, care home, other:

Contact No:
Is the ICT aware of the transfer? Yes/No</td></tr>
<tr><td>Receiving facility – hospital, ward, care home, district nurse

Contact No:

Is the ICT/ambulance service aware of transfer? Yes/No</td><td>Is the patient/client an infection risk?
Please tick most appropriate box and give confirmed or suspected organism
☐ Confirmed risk Organism:
☐ Confirmed risk Organism:
☐ Suspected risk Organism:
☐ No known risk

Patient/client exposed to others with infection e.g. D&V
…….. Yes/No</td></tr>
<tr><td colspan="2">If the patient/client has diarrhoeal illness, please indicate bowel history for last week:
(based on Bristol stool form scale see reverse side)

Is the diarrhoea thought to be of an infectious nature? Yes/No</td></tr>
<tr><td colspan="2">Relevant specimen results (including admission screens – MRSA, glycopeptide-resistant enterococci SPP, C. difficile, mutli-resistant Acinetobacter SPP) and treatment information, including antimicrobial therapy:

<table>
<tr><td>Specimen:</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Date:</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Result:</td><td></td><td></td><td></td><td></td></tr>
</table>

Treatment information:</td></tr>
<tr><td colspan="2">Other information:</td></tr>
<tr><td colspan="2">Is the patient/client aware of their diagnosis/risk of infection? Yes/No</td></tr>
<tr><td colspan="2">Does the patient/client require isolation? Yes/No

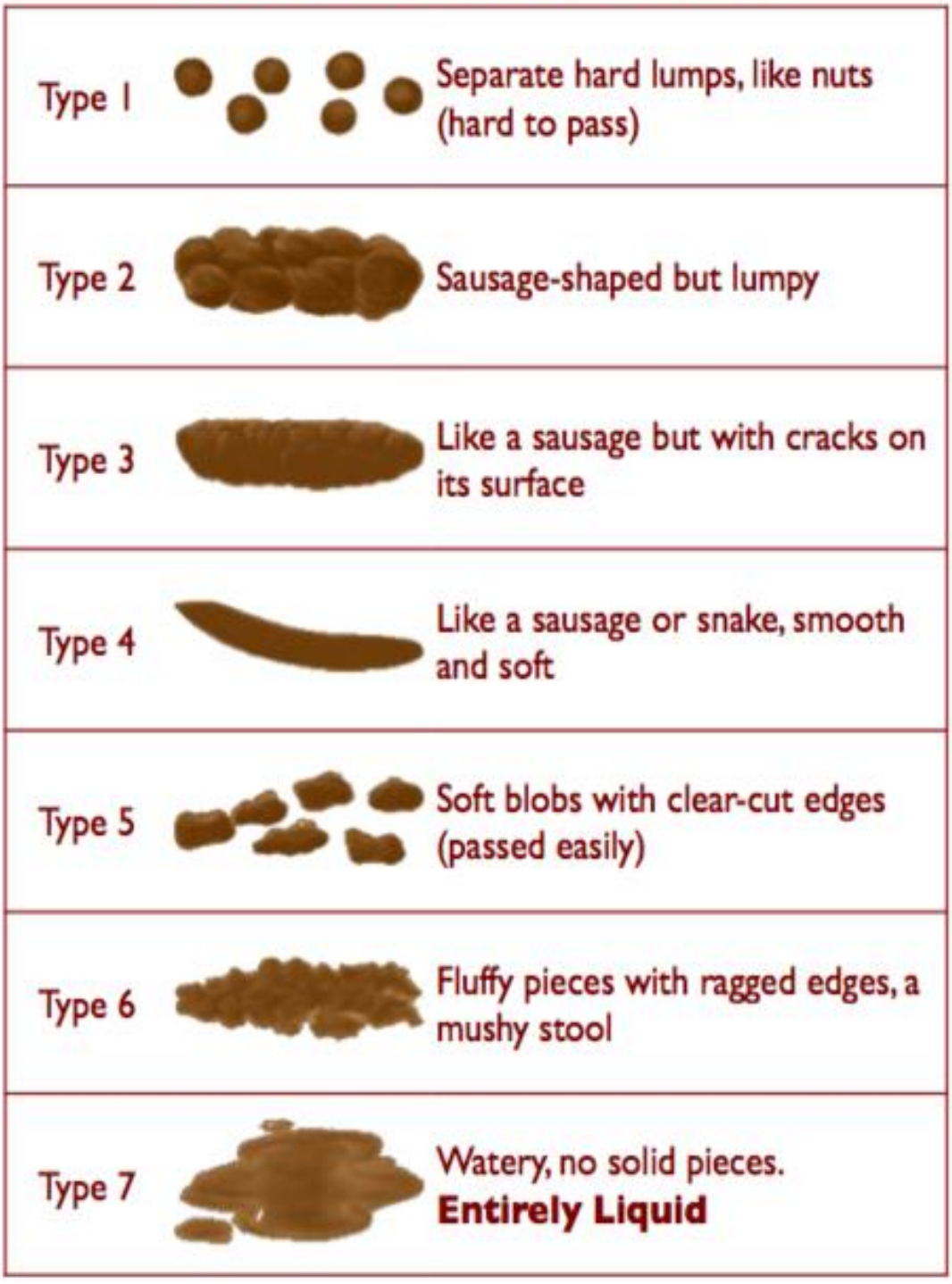
Should the patient/client require isolation, please phone the receiving unit in advance.</td></tr>
<tr><td colspan="2">Signature of staff member completing form: ……
Print name:
Contact number:</td></tr>
</table>

For further advice please contact your infection control team/advisor
Please refer to this chart when making a bowel history diagnosis on the form overleaf.

Definition of diarrhoea: An increased number (two or more) of watery or liquefied stools (i.e. type 6 and 7 **only**) within a duration of 24 hours. **Please remember:** hands must be washed with soap and water when caring for patients with diarrhoea

NB Hands must be decontaminated after glove use.

Bristol Stool Chart



Appendix 5

Stakeholders and Consultation

Key individuals involved in developing the document

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