Leicestershire Partnership NHS Trust

The management of patients with diarrhoea and/or vomiting suspected or confirmed as infectious including: The clinical management of patients nursed as inpatients within LPT with an increased incidence or outbreak of diarrhoea and/or vomiting.

This policy describes the management and procedures for patients who have diarrhoea and/or vomiting that is suspected or confirmed as infectious, the policy *also describes the clinical management and procedures to be followed where an increased incidence/outbreak of infection of diarrhoea and/or vomiting is being considered.*

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Contents

1.0 Quick Look Summary

This policy provides trust wide guidance for all staff 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.

It is imperative that a patients normal bowel habit, type and frequency is identified and documented when the patient first comes under the care of LPT. Without this documented assessment it is not possible to determine if a patient is passing a stool that is not part of their normal bowel habit.

- There can be non-infectious reasons for a patient to experience diarrhoea and/or vomiting which needs to be eliminated before an assumption is made that it is of an infectious nature.
- It is reasonable to instigate source isolation precautions for a patient whilst this assessment is being undertaken if there is a considered risk of infection, however, Faecal samples must only be sent if an infectious cause is being considered.
- Infectious diarrhoea and vomiting may be due to a wide range of micro-organisms, but the ones most likely to be encountered in healthcare settings are viruses such as norovirus, and bacteria such as those that cause food poisoning e.g., salmonella, Campylobacter and bacteria that produce a toxin such as clostridium difficile.
- It is important that staff can recognise diarrhoea and vomiting that may be of an infectious nature and instigate procedures to reduce spread and transmission as promptly as possible.

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 community health and social care settings Norovirus working party, 2012).

1.1 Version Control and Summary of Changes

Version number	Date	Comments
Version 1	June 2023	Amalgamation of the existing 'The management of patients with diarrhoea and/or vomiting suspected or confirmed as infectious and 'The clinical management of patients nursed as an inpatient within LPT with an increased incidence or outbreak of diarrhoea and/or vomiting policy.

1.2 Key individuals involved in developing and consulting on the document

Name	Designation
Accountable Director	Dr Anne Scott
Author(s)	Claire King Infection prevention and control nurse
Implementation Lead	Amanda Hemsley Lead for infection prevention and control
Core policy reviewer group	Infection prevention and control Assurance group
Wider consultation	Infection prevention and control assurance group members
Trust policy experts	

1.3 Governance

Level 2 or 3 approving delivery group	Level 1 Committee to ratify policy
Infection prevention and control Assurance Group	Quality and safety committee

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity.

1.5 Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

1.5 Definitions that apply to this Policy.

Adenovirus	Types 40 and 41 cause gastroenteritis especially in children under the age of two. The virus is transmitted by the faecal-oral route with an incubation period of 3-10 days and lasts approximately one week. Diarrhoea is more prominent than vomiting or fever, and respiratory symptoms are often present. Long term immunity is acquired in childhood.
Asymptomatic	Having no symptoms of illness or disease
Bristol Stool Chart (BSC)	The Bristol stool chart is a diagnostic medical tool used to classify the form of human faeces into seven categories
Clostridium difficile Infection (CDI) Clostridium difficile toxin	Clostridium difficile infection (CDI) or Clostridium difficile toxin as it is also referred to is caused by toxin-producing bacteria that causes a more severe form of antibiotic associated diarrhoea. The disease ranges from mild diarrhoea to severe colon inflammation that can be fatal
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 noted on the Bristol Stool Chart (BSC) types 5-7 (appendix 3)
Increased incidence	Where cases of the same infection linked in time or place are greater in number than is considered 'normal' or acceptable for that area
Infection	The invasion and multiplication of microorganisms such as bacteria, viruses and parasites that are not normally present within the body
Infectious	A disease- or disease-causing organism able to be passed from one person, animal, or plant to another.
Isolate (isolation)	When a patient is cared for in a separate area or room from others, due to them having an infection that may be detrimental to another patient/person's health.
Organism	An individual animal, plant, or single-celled life form
Outbreak	A disease outbreak is the occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area, or season.
Personal Protective Equipment	Specialised clothing or equipment worn by employees for protection against health and safety hazards e.g., single use gloves, aprons, surgical gowns, masks, and eye protection
Rotavirus	This is the most common cause of severe diarrhoea among infants and young children. Immunity develops with each infection, so subsequent infections are less severe; adults are rarely affected. Rotavirus gastroenteritis is characterised by vomiting and watery diarrhoea, ad low grade fever. The incubation period is around two days. Symptoms often start with vomiting followed by four to eight days of profuse diarrhoea. Rotavirus vaccine is now routinely offered to infants.
Vomiting	The act of ejecting the contents of the stomach through the mouth as a result of involuntary spasms of the stomach or oesophagus.
Viral infection	Caused by the presence of a virus in the body.
Consultant in public health	A consultant who is knowledgeable in infectious diseases
Health protection professional	A person who is 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.
Infection control incidence	This can be defined as an outbreak of infection or infectious disease that requires a more in-depth level of strategic management.
Fluid resistant surgical face mask (FRSM)	These are masks that are fluid-resistant and provide barrier protection against respiratory droplets reaching the linings of the mouth (mucosa) and nose, for example during general conversation or through coughing.

2.0. Purpose and Introduction

The purpose of this policy is to inform all healthcare staff within Leicestershire Partnership Trust (LPT) of the management and actions required in the management of patient/s who experience diarrhoea and/or vomiting which is of a suspected or confirmed infectious nature. Prompt recognition of viral diarrhoea and vomiting will reduce the risk of transmission of infection by reducing the movement of patients and contacts and therefore preventing cross infection or contamination within the healthcare environment. This policy is also 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.

3.0 Duties within the Organisation

Duties in regard to this policy can be located in the LPT infection prevention and control assurance folder.

Consent

•Clinical staff must ensure that consent has been sought and obtained and recorded in the Electronic Patient Record (EPR) before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

• In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded in the EPR. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.
- Communicate the decision.

4.0 Policy requirements

4.1 Management of patients with diarrhoea and/or vomiting of a suspected or confirmed infectious nature.

S	Suspect that a case may be infective where there is no clear alternative cause for diarrhoea
I	Isolate the patient while determining the cause of the diarrhoea
G	Gloves and aprons must be used for all contacts with the patient and their environment.
H	Hand washing with soap and water should be carried out before and after each contact with the patient and their environment.
T	Test the stool for infection by sending a specimen immediately, send for Microbiology and/or Virology.

4.2 Initial individual patient management (Viral and Bacterial)

once establishment of new onset acute diarrhoea has been established, application of the acronym **"SIGHT"** (DH 2009) must be instigated.

If the onset of diarrhoea and/or vomiting is sudden and the symptoms are not clearly attributable to an underlying condition or therapy, the patient must be isolated. Do not wait for further episodes of diarrhoea and/or vomiting.

NB: Faecal samples should be only taken if considering an infectious cause.

Any patient who is admitted to hospital/inpatient facility with or develops diarrhoea (stool types 5-7) and/or vomiting and under the care of LPT staff must, as a priority, have the following assessed and documented: when they are well, it may not necessarily be the bowel function they present with on admission to hospital.

• Assess cause of diarrhoea and/or vomiting including underlying conditions (including previous history of CDI or underlying bowel disease), antibiotics, laxatives, proton pump inhibitors, nutrition/dietary fibre, history of recent travel, any recent anaesthetic or bowel surgery.

• In assessing diarrhoea, it is important to determine the duration, frequency, pattern, type (watery; bloody; fatty), odour and severity of symptoms.

• Accurate fluid balance management must be instigated and documented

Please contact the Infection prevention and Control team using 1 of the 3 following methods to inform us of any patients with diarrhoea and vomiting symptoms:

• Create an electronic referral in Systmone

• Leave a message on the answerphone (0116 2952320)

• Via Staff net https://staffnet.leicspart.nhs.uk/support-services/infection-preventioncontrol/contact-us/ipc form.

Patients with a lifelong infection will have this icon  in the demographic box on SystmOne, if missing contact the IPC Team. The electronic patient system (HISS) will also alert staff of patients previously identified as CDT carriers. The HISS system identifies the patient details and will display SR CDT on screen. The special register within HISS is updated by the microbiology department at UHL and therefore relies upon the samples being processed within Leicester, Leicestershire, and Rutland. It is imperative that staff check the infectious status of all patients when they first come under their care. If staff do not have access to HISS, they can contact the Infection Prevention and Control Team within LPT who will be able to undertake this for them. However, as discussed above only those samples that have been sent to the microbiology department at UHL will be entered onto HISS.

4.3 Patients with suspected/confirmed symptomatic Clostridium difficile.

The following documentation must be completed, and plans commenced:

- Review of the patient's current medication by the doctor/ANP/Healthcare practitioner (to include):

STOP:
Antibiotics - consult microbiology if antibiotic therapy is still needed for treatment of underlying infection.
Proton Pump Inhibitors (PPIs) - consider alternatives if acid suppression required
Laxatives and prokinetic agents e.g., metoclopramide.
Anti-motility agents e.g., loperamide

Where possible STOP:
Immunosuppressant therapy/steroids, Opioids

Review:

- **Nonsteroidal anti-inflammatory drugs (NSAIDs), Angiotensin-converting-enzyme inhibitors (ACEI), Angiotensin receptor blockers (ARBs), Diuretics** – may cause problems in dehydration.

Due to the increased risks of dehydration accurate fluid balance management must be instigated and documented including:

- Fluid balance chart
- Diarrhoea checklist
- Bristol stool chart
- Electrolyte replacement
- Nutrition assessment and requirements
- Management of CDT guidance

Obtaining specimens must include the consideration that the patient may have had a previous positive result for CDT:

- Consider contacting the patients GP or referring hospital for further information as samples may be sent outside of LLR's geographical area dependent on the patient's home address.
- Where there is no previous history of CDT, and an infectious cause is being considered a faecal specimen should be collected and sent to the microbiology department requesting microscopy, culture and sensitivity (MC&S) and CDT.
- Faecal samples taken on a weekend or bank holiday should be sent the same day, via taxi if necessary, and in an appropriate container. A delay in sending samples could result in a delay in appropriate treatment.
- A patient previously known to have CDT within the last 28 days does not require a further faecal sample to be tested, and sample must not be sent, but they should be treated as if they are positive for CDT. Treatment advice can be obtained from microbiology.
- If condition has not improved from day 28 to 12 weeks since first episode a repeat sample should be considered.
- Clearance and repeat specimens for Clostridium difficile toxin are not necessary after initial diagnosis.
- A patient with a positive sample for CDT must be managed using the CDT care pathway and the clinical management of CDI for adult patients/service users in the community.
- The Department of Health defines CDI as either mild, moderate, severe or life threatening. A patient diagnosed with CDT, must have clear documentation in the electronic patient records as to the classification the CDT is considered by the clinician in charge to be. (See appendix 11)

NB: **If a negative sample for CDT is obtained and the patient is still having diarrhoea and/or vomiting of an unknown cause it is important that other causes are considered and investigated. symptoms suspected/confirmed infectious**.

Please refer to the below flow chart for the Care and management of patients in regard to source isolation precautions when having diarrhoea symptoms which are suspected/confirmed as being CDT Positive:

Leicestershire Partnership NHS Trust

Patient Care and management regarding source isolation precautions with diarrhoea symptoms which are suspected/confirmed as CDT Positive

Is the patient having diarrhoea (type 5-7 stools)

YES

Source isolation to commence.

Obtain stool samples for M,C&S & CDT (This will need to be sent with a microbiology request form

Move to single side room wherever possible if not already nursed in one.

A risk assessment must be carried out and clearly documented in patient records if side room not available.

All staff to wear appropriate PPE including **gloves and apron** when in contact with the patient and their environment.

FRSM masks are required to be worn by patients and staff in all areas where there is an increased incidence outbreak, patients will need to be risked assessed for their ability to wear a mask and outcome documented in the patients records.

Where possible the single room or bay should have a door, and this should be kept closed.

If it is not possible for the door to be kept closed a risk assessment must be completed and documented in the patients records, this should identify and potential

Patient charts and electronic records must not be taken into the single room.

Patient must be allocated a toilet for their sole use.

If not able to allocate toilet, then a risk assessment must be carried out, identifying processes that have been put in place to minimise risk of cross contamination.

Patient must continue to source isolate until they have been symptomatic for at least 48bhours and have passed a formed stool or normal stool for them or following discussion with the infection prevention and control team.

Commode must not be used at the bedside (as other patients will be eating, drinking, and sleeping in this area

The infection prevention and control team will need to be informed of patients requiring source isolation precautions as soon as practicable.

The source isolation form (Appendix 5) must be completed and placed outside the patient single side room or bed space.

Once SIPS have been stepped down a post infection clean will be required including change of curtains

NO

No source isolation required.

4.4 Patient/s with suspected/confirmed Viral diarrhoea and/or vomiting.

a) The following documentation must be completed, and care plans commenced.

• Fluid balance chart

• Diarrhoea checklist

• Bristol stool chart

• Electrolyte replacement

• Nutrition assessment and requirements

(B) Review of the patient's current medication by the doctor/ANP/Healthcare practitioner is to include:

• Current antibiotic treatments

• Laxatives

Please refer to the below flow chart for the Care and management of patients in regard to source isolation precautions when having diarrhoea symptoms which are suspected/confirmed as Norovirus:

NHS
Leicestershire Partnership
NHS Trust

Patient care and management regarding source isolation precautions for patients with diarrhoea symptoms suspected/confirmed as Norovirus

Norovirus infection confirmed or suspected.

YES

All staff to wear appropriate PPE including gloves and apron when in contact with the patient and their environment. FRSM masks are required to be worn by patients and staff in all areas when in close contact with patients where there is an increased incidence/outbreak, patients will need to be risked assessed for their ability to wear a mask and outcome documented in the patients records.

Collect stool sample for testing if not already done so.

Samples being sent for Norovirus must be sent with a virology request form.

Vomit must not be sent to microbiology If sent it will be discarded and not tested.

Stool samples must be taken from every patient who has diarrhoea and thought to be infected. Sample should contain the runniest part of the sample.

If sample is contaminated with urine, it can still be sent for testing.

Faeces scraped of the bed linen or incontinence products can also be used if unable to obtain a sample from a bedpan/toilet.

Faecal samples taken on a weekend or bank holiday should be sent the same day via taxi if necessary and in an appropriate container. A delay in sending samples until the next working day could result in a delay in appropriate treatment, patient care regarding source isolation precautions.

If a patient is having diarrhoea, they should remain in their bedspace and Source isolation precautions commenced immediately irrespective of whether they are in a single room or bay.

If the patient is nursed in a bay, source isolation precautions must be undertaken individually with all patients in the bay.

Where possible the single room/bay will have a door, and this should be kept shut. Ward will need to carry out risk assessment for this.

Patient must be allocated a toilet for their sole use.

If not able to allocate toilet, then risk assessment must be carried out, identifying processes that have been put into place to minimise risk of cross contamination.

Patient must continue to source isolate until they have had no diarrhoea for 48 hours and have passed a normal formed stool or stool which is normal for them or following discussion with the infection prevention and control team.

Commode must not be used at the bedside (as other patients will be eating and drinking and sleeping in these areas

The infection prevention and control team will need to be informed of patients requiring source isolation precautions as soon as possible.

The source isolation form (Appendix 5) must be placed outside the patient single room or bedspace.

ONLY AFFECTED BAYS NEED TO BE CLOSED TO ADMISSIONS **All bed closures must be discussed & decisions supported by the matron/IPC team/on-call manager**.

Once SIPS have been stepped down a post infection clean will be required including change of curtains

5.0 Management of an Increased incidence or outbreak of diarrhoea and/or vomiting

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 professional duty of care to the patients with whom they are involved (NMC 20015), but 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.

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.**
- **The situation when the observed number of cases exceeds the number expected.**
  (Hospital infection control-Guidance on the control of infections 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

For the precautions to be undertaken where increased incidence/outbreak has been identified. Please refer to appendix 10

For further information please refer to the LPT infection prevention and control policy for the use of personal protective equipment in healthcare.

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

Staff need to ensure that as well as documenting the patient's bowel and vomit episodes on any current systems of communication used by the ward and ensure that it is readily available to enable effective communications between the ward and the infection prevention and control team who will ring daily (Not weekends or bank holidays) regarding the status of the increased incidence or outbreak of infection.

Appendix 7 of this policy contains a check list of activities that should be instigated by the ward area on initial suspicion of an increased incidence of infection which will assist in management of an outbreak.

NB: Please refer also 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 further information on regarding the procedures to be followed to ensure the correct persons are informed and processes followed when an increased incidence or outbreak of infection is suspected.

5.2 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 this policy early guidance 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/or 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 regardless of whether the patient is 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 the bay.

NB: All patients in a bay with an infected 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 have passed a normal stool.

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

Patients must also 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 patients within the bay must have an allocated toilet which must be cleaned and decontaminated in between each use.
- Commodes must only be used at the bedspace as a **last resort** and a risk assessment must be completed.

- If a commode is used, then the commode will need to be completely dismantled and decontaminated between each use. It must not be left at the bedside within a bay.
- If patient is nursed in a side room which does not have en-suite, then the commode where possible should not be left in room.
- Commode as above between each use will need to be completely dismantled and decontaminated.
- If it is deemed that the commode should be left at the bedside within the single room, then a risk assessment will need to be undertaken.
- Source isolation precautions cannot be discontinued until all the patients in the bay/double side rooms are 48 hours asymptomatic of diarrhoea and/or vomiting, and for those patients who have experienced diarrhoea they must have passed a normal stool. (The only exception for this is if a patient has had negative screens for the suspected infection and have been reviewed by the Medic/ANP who is satisfied that their diarrhoea and/or vomiting is of a non-infectious cause.

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 present and thus contaminate or re-contaminate the environment or patient via the faecal oral route.

5.3 Movement of patients with Diarrhoea and vomiting and patients who are being nursed as part of an increased incidence/outbreak.

- Symptomatic patients with diarrhoea and/or vomiting or patients that are being nursed as part of an increased infection must not be transferred to other wards within LPT, except for purposes of isolation or on clinical need.
- For all transfers the Essential Steps Inter-Healthcare Transfer Form must be completed and accompany the patient (**See appendix 8**). 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,
- 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 policy for cleaning and decontamination can be implemented. If 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 the patient needs to be transferred to other hospital due to clinical need the receiving hospital and ward must be informed of the increased/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.
- 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 visits to other hospitals are considered necessary, the receiving area should be informed 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.

- The patient must be transported via the ambulance service that must also be made aware of the patients' status in advice.
- The patient must not travel with other patients in the same vehicle.
- A full terminal clean must be carried out for every bed area and piece of equipment.

An increase in patient throughput and admission to the acute hospitals during the winter period may also put pressure on the availability of beds. In order to support the admission of patients into beds with the most clinical need, during periods of high levels of Norovirus/viral diarrhoea and/or vomiting patients may be discharged after 24 hours of being asymptomatic but are clinically fit to be transferred. This 24-hour default position currently is not in line with national policy and must be done with consultation from the IPC team and in conjunction with the service lead/manager and lead nurse for LPT.

5.4 Visiting arrangements.

- Patients in source isolation may be visited by family and friends.
- Visitors do not routinely need to wear protective garments.
- Advice must be provided by the nursing staff if relatives are involved with direct patient care. They should then wear disposable gloves and aprons, removing them after use and placing them into clinical waste, then wash their hands with soap and water.
- Visitors must be advised not to visit if they are suffering from diarrhoea and vomiting and for 48 hours after their symptoms have ceased.
- In some rare circumstances the ward may be completely closed to visitors.

5.5 Visiting health care staff, volunteers, and ad hoc workers.

- Non-essential therapy may need to be delayed or suspended for symptomatic patients if they are unwell.
- A risk assessment must be completed to ascertain the risk to other patients if therapy continues.
- Volunteers must report to the nurse in charge for advice and guidelines on what duties they may undertake with regard to symptomatic patients. It is the responsibility of the nurse in charge to ensure the volunteer is aware of any precautions that need to be taken.
- Visitors such as hairdressers, trolley vendors and similar non-essential visitors must not be allowed to restricted areas until the restrictions have been lifted and appropriate cleaning carried out.

5.6 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, i.e.: 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 that they adhere to the source isolation precautions being implemented as per this policy.

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

5.7 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 confirm appropriate arrangements are in place prior to admission. This must be documented in the electronic patient record 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.
- 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 a package of care in place to ensure that the patient is managed safely. 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 electronic patient record and discharge documentation.
- It is the responsibility of the discharging Doctor/Advanced Nurse Practitioner 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. Page 12
- The infection prevention and control team must be informed of the final decision regarding the discharge of symptomatic patients.

5.8 Transport of symptomatic patients

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

- If planning in advance is not possible due to the patient requiring an emergency transfer, then where possible the ambulance crew and receiving hospital must be informed of the patient's symptoms and potential infection risk.
- If the patient is to be transferred by ambulance, the ambulance liaison officer must be advised of the patient's diagnosis and the need for a designated ambulance. The ambulance liaison officer will need to be informed of the source isolation precautions required.
- Patients must not be transferred by taxi or volunteer cars.
- A patient who is discharged and is using personal private transport must be provided with the appropriate equipment (i.e., disposable nitrile gloves, disposable aprons, disposable vomit bowls and continence pads) for the driver, who must be advised of the infection prevention and control precautions necessary in the event of a body fluid spillage.
- The importance of hand decontamination following handling of body fluids and waste must be discussed as well as the importance of hand washing using soap and water

at the earliest convenience. Any waste must be double bagged and disposed of as normal household waste.

5.9 Infection prevention and control precautions in a patient's own home

- When visiting patients who are suspected of or have a confirmed vomiting and/or diarrhoeal infection in their own home, a good standard of infection prevention and control precautions must be maintained to prevent carriage of transient organisms between patients.
- All practices identified for caring for a patient in an inpatient area including hand hygiene, use of personal protective equipment and cleaning of equipment (belonging to LPT) must be adhered to for patients in their own home. Page 13 Carers and/or relatives caring for someone with suspected vomiting and/or diarrhoea should be encouraged/advised:
- That (if prescribed) the patient must complete a course of antibiotics even if they feel better.
- Encouraging the patient to drink fluids.
- To practice good hand hygiene (following removal of gloves and aprons) for example, after using the toilet / changing nappies, after handling rubbish and before and after preparing food and drinks • To keep all surfaces clean. (With a bleach-based household detergent if the surface will withstand it).
- The importance of washing all bedding, towels, and clothing on the hottest cycle the fabric(s) will allow.
- Foul linen should not come into contact with ordinary household laundry.

NB: Carers and/or relatives caring for someone with positive stool sample/clinical symptoms for Clostridium difficile infection must be advised (in addition to the above) on:

- Arrangements need to be in place (e.g., patient/family member, carer, district nurse) to carry out DAILY assessment to identify and report worsening symptoms and to alert the patient's General Practitioner on:
- Temperature – is it raised?
- Is the abdomen bloated?
- Is there abdominal pain?
- Increased frequency and change of stool type (use Bristol Stool Chart and record frequency and type)
- Hydration and nutritional status If this advice is given to relatives, it is imperative the staff giving the advice ascertain that the relative is able and happy to take on this responsibility, and this must be documented accordingly.

6.0 Staff sickness due to diarrhoea and/or vomiting.

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

7.0 References and Bibliography

Ahmed SM, Hall AJ, Robinson AE et al, Global prevalence of Norovirus in cases of gastroenteritis: a systematic review and meta-analysis. Lance infectious diseases 2014;14, 725-730

Department of health & social care act 2015 (Revised)

Health and safety at work act, 1974

Health and social care act, DH 2008 Updated 2015

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

Leicestershire Partnership Trust, Cleaning, and decontamination of equipment, medical devices, and the environment (Including the management of blood and body fluid spillages Policy November 2022

Leicestershire partnership trust, hand hygiene policy, including bare below the elbows, June 2022.

Leicestershire Partnership trust, the management of a patient requiring source isolation, April 2022.

Leicestershire Partnership trust, The management of staff health relating to communicable diseases policy, November 2022

Leicestershire partnership trust, Personal protective equipment for use in healthcare policy November 2022

Leicestershire Partnership trust, Waste management policy November 2022

National institute for health and care Excellence (NICE) www.nice.org.uk

NHS England National infection prevention and control manual for England 2023

Public health England, Updated guidance on the management and treatment of clostridium difficile infection May 2013

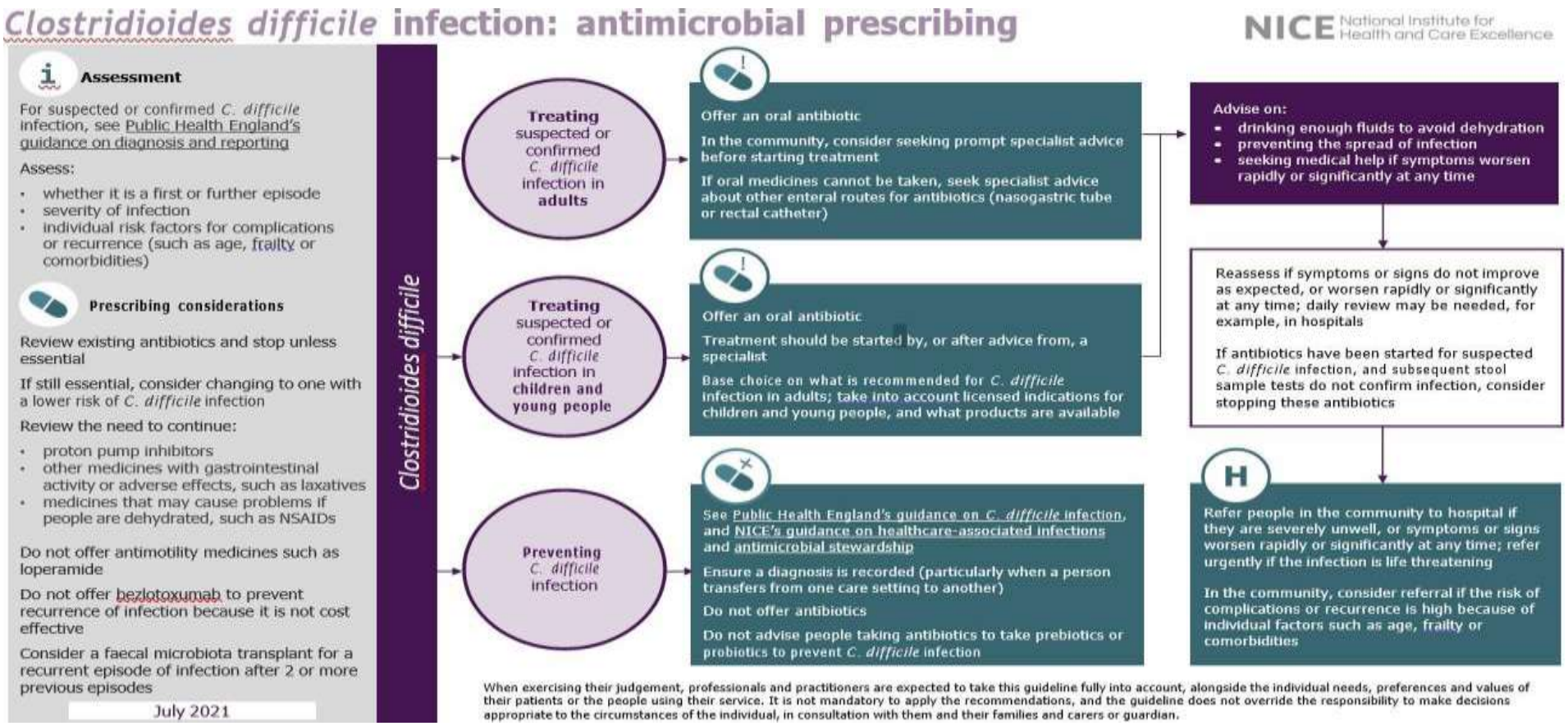
Royal college of nursing 2013, The management of diarrhoea in adults. RCN guidance for staff London

UK Health security agency 2022, Clostridioides difficille infection Updated guidance on management and treatment.

World health organisation (WHO): Guidelines on hand hygiene in healthcare- The 5 moments for hand hygiene (2012).

Nice Guideline NG 199 Clostridioides difficle infection: antimicrobial prescribing, Nice, July 2021.

Appendix 1 Clostridioides difficille infection: Antimicrobial prescribing



Appendix 2 Clostidioides difficle infection: Antimicrobial prescribing

Clostridioides difficile infection: antimicrobial prescribing

NICE National Institute for Health and Care Excellence

Choice of antibiotic for adults aged 18 years and over

Treatment	Antibiotic, dosage and course length
First-line antibiotic for a first episode of mild, moderate or severe *C. difficile* infection	**Vancomycin**: 125 mg orally four times a day for 10 days
Second-line antibiotic for a first episode of mild, moderate or severe *C. difficile* infection if vancomycin is ineffective	**Fidaxomicin:** 200 mg orally twice a day for 10 days
Antibiotics for *C. difficile* infection if first- and second-line antibiotics are ineffective	Seek specialist advice. Specialists may initially offer: **Vancomycin**: Up to 500 mg orally four times a day for 10 days **With our without** **Metronidazole**: 500 mg intravenously three times a day for 10 days
Antibiotic for a further episode of *C. difficile* infection within 12 weeks of symptom resolution (relapse)	**Fidaxomicin**: 200 mg orally twice a day for 10 days
Antibiotics for a further episode of *C. difficile* infection more than 12 weeks after symptom resolution (recurrence)	**Vancomycin**: 125 mg orally four times a day for 10 days **OR** **Fidaxomicin**: 200 mg orally twice a day for 10 days
Antibiotics for life-threatening *C. difficile* infection	Seek urgent specialist advice, which may include surgery. Antibiotics that specialists may initially offer are: **Vancomycin**: 500 mg orally four times a day for 10 days **With** **Metronidazole**: 500 mg intravenously three times a day for 10 days

See the BNF for appropriate use and dosing in specific populations, for example, hepatic impairment, renal impairment, pregnancy and breastfeeding.
See Specialist Pharmacy Service guidance on choosing between oral vancomycin options. If ileus is present, specialists may use vancomycin rectally.
Use clinical judgement to determine whether antibiotic treatment for *C. difficile* infection is ineffective. This is not usually possible to determine until day 7 because diarrhoea may take 1 to 2 weeks to resolve.
There is no agreement on the definition of relapse or recurrence in *C. difficile* infection. For this guideline, 12 weeks was agreed as the cut-off point between relapse and recurrence.

Appendix 3 Bristol stool chart

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 the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

Appendix 4 Source isolation precautions poster

SOURCE ISOLATION PRECAUTIONS

TO HELP US PREVENT THE SPREAD OF INFECTIONS

Everyone* entering this room must:

Be “Bare Below the Elbows” Wash

their hands.

Wear Gloves

Wear an apron.

This applies to all staff entering the room whether or not in contact with the patient or environment is anticipated.

Please keep the door closed.

Visitors dont need to wear an apron and gloves but must wash their hands prior to entering and leaving the room

NHS
Leicestershire Partnership
NHS Trust

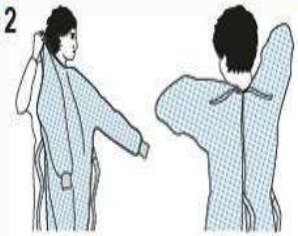
Infection Prevention and Control Team

Sequence for Donning PPE

1

Apron
Pull over head and fasten at back of waist.

2

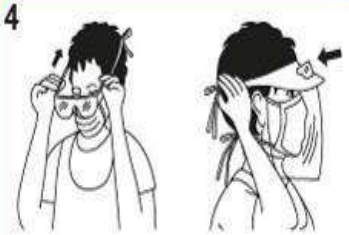


Gown/Fluid repellent coverall
Fully cover torso neck to knees, arms to end wrist and wrap aroundthe back. Fasten at the back.

3

Surgical mask (or respirator)
Secure ties or elastic bands at middleof head and neck.Fit flexible band to nose bridge.Fit snug to face and below chin.Fit/check respirator if being worn.

4



Eye Protection (Goggles/Face Shield)
Place over face and eyes and adjust to fit.

5

Gloves
Select according to hand size.Extend to cover wrist.

6

Outside of gloves are contaminated. Grasp the outside of the glove with the opposite gloved hand; peel off.

7

Hold the removed glove in the gloved hand. Slide the fingers of the ungloved handunder the remained glove at the wrist. Peel the second glove off over the first glove. Discard into an appropriate lined waste bin.

8

Apron
Apron front is contaminated. Unfasten or break ties.Pull apron away from neck and shoulders touching inside only. Fold and roll into a bundle. Disacard into an appropriate lined waste bin.

9

Gown/Fluid repellent coverall
Gown/Fluid repellent coverall front and sleeves are contaminated.Unfasten neck, then waist ties.

10

Remove using a peeling motion; pull gown/fluid repellent coverall fromeach shoulder towards the same hand.

11

Gown/fluid repellent coverall will turn inside out. Hold removed gown/fluid repellent coverall away from body, roll into a bundle and discard into an appropriatelined waste bin or linen receptacle.

12

Eye Protection (Googles/face shield)
Outside of googles or face shield are contaminated.Handle only by the headband or the sides.Discard into a lined waste bin or place into a receptacle for reprocessing/ decontamination.

13

Surgical Mask (or repiratory)
Front of mask/respirator is contaminated - do not touch. Unfasten the ties - first the bottom, then the top. Pull away from the face without touching front of mask/respirator. Discard disposable items into an appropriate lined waste bin I or reusable respirator place in designated receptacle for processing/ decontamination

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Leicestershire Partnership
NHS Trust

Infection Prevention and Control Team

GUIDELINES FOR THE USE AND DISPOSAL OF PERSONAL PROTECTIVE EQUIPMENT

GENERAL PRINCIPLES: To prevent the transmission of blood-borne viruses and to prevent the transmission of other pathogens

Gloves

Must be worn:

>When in contact with body fluids and substances

>Mucous membranes

Gloves must be changed after contact with each patient and at the end of each procedure.

Disposable plastic aprons

>For direct contact with a patient when providing personal or clinical care.

>For cleaning activities and bed making.

Aprons must be worn if wearing gloves.

Single use items should not encounter more than one patient and be disposed of after use.

Surgical face masks

>Procedures likely to cause splashing of body substances into mouth and nose of the HCW.

>procedures when an aerosol from body fluids may be created.

>To protect the patient from exposure to risk of infection from HCW.

>When there is an increased incidence/outbreak of infection where there is close contact with patients.

Eye protection (Or face visors)

>Aerosol or splash contamination of body substances.

>Aerosol or splash contamination from chemicals

Arm protection

>Procedures likely to cause probable scratching/biting to HCW

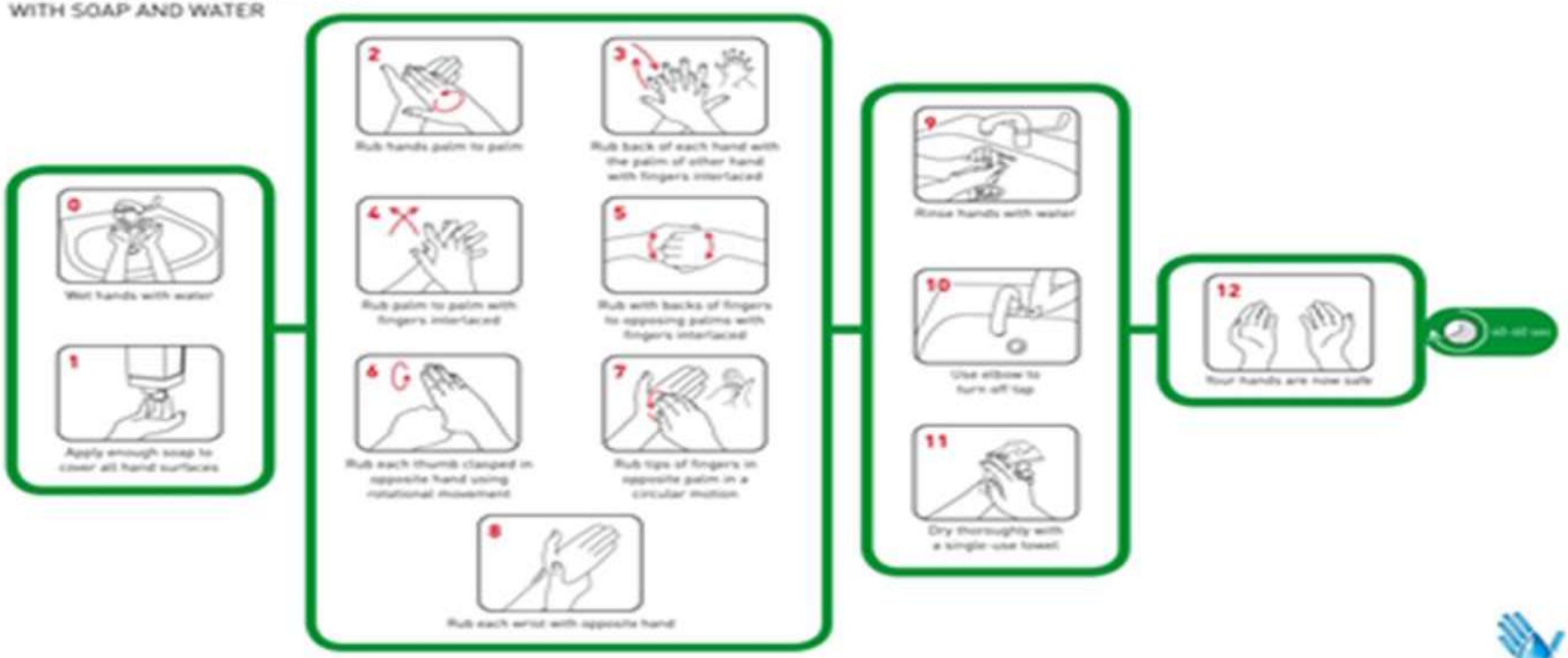
Personal protective equipment must be disposed of into a clinical waste bin.

HAND CLEANING TECHNIQUES

NHS
National Patient
Safety Agency

How to handwash?

WITH SOAP AND WATER



www.npsa.nhs.uk/cleanyourhands

Adapted from World Health Organization Guidelines on Hand Hygiene in Health Care
T36/1.0/9

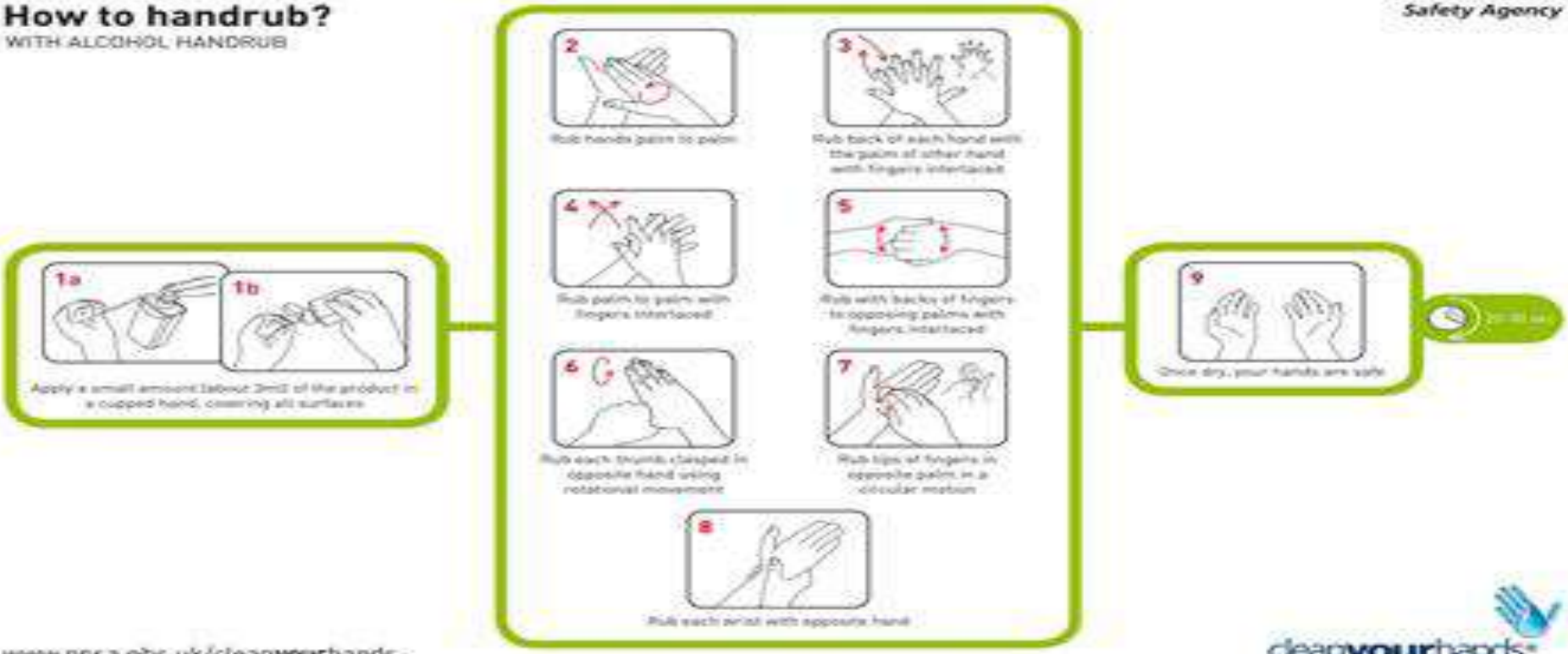
cleanyourhands campaign

HAND CLEANING TECHNIQUES

How to handrub?

WITH ALCOHOL HANDRUB

NHS
National Patient Safety Agency



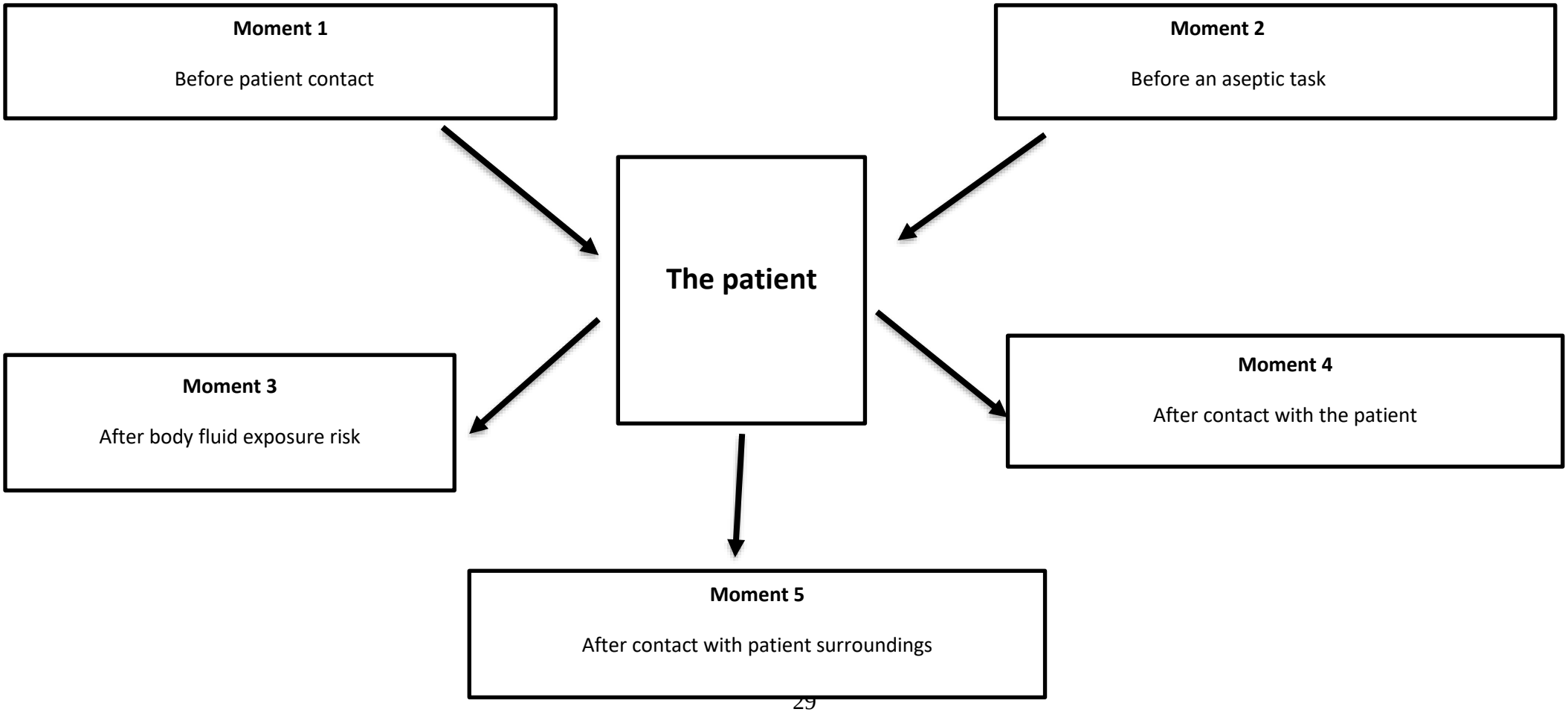
www.npsa.nhs.uk/cleanyourhands

Adapted from World Health Organization Guidelines on Hand Hygiene in Health Care
FINAL

cleanyourhands campaign

The World Health Organisation developed evidence-based recommendations for when hand decontamination should be carried out. This is known as the "five moments for hand hygiene" (WHO 2012), and are numbered according to a natural sequence of workflow: (See diagram below)

Your 5 Moments of hand hygiene



Appendix 6 Documentation of symptomatic patients' bowels and vomit episodes chart

Infection Prevention and Control Team

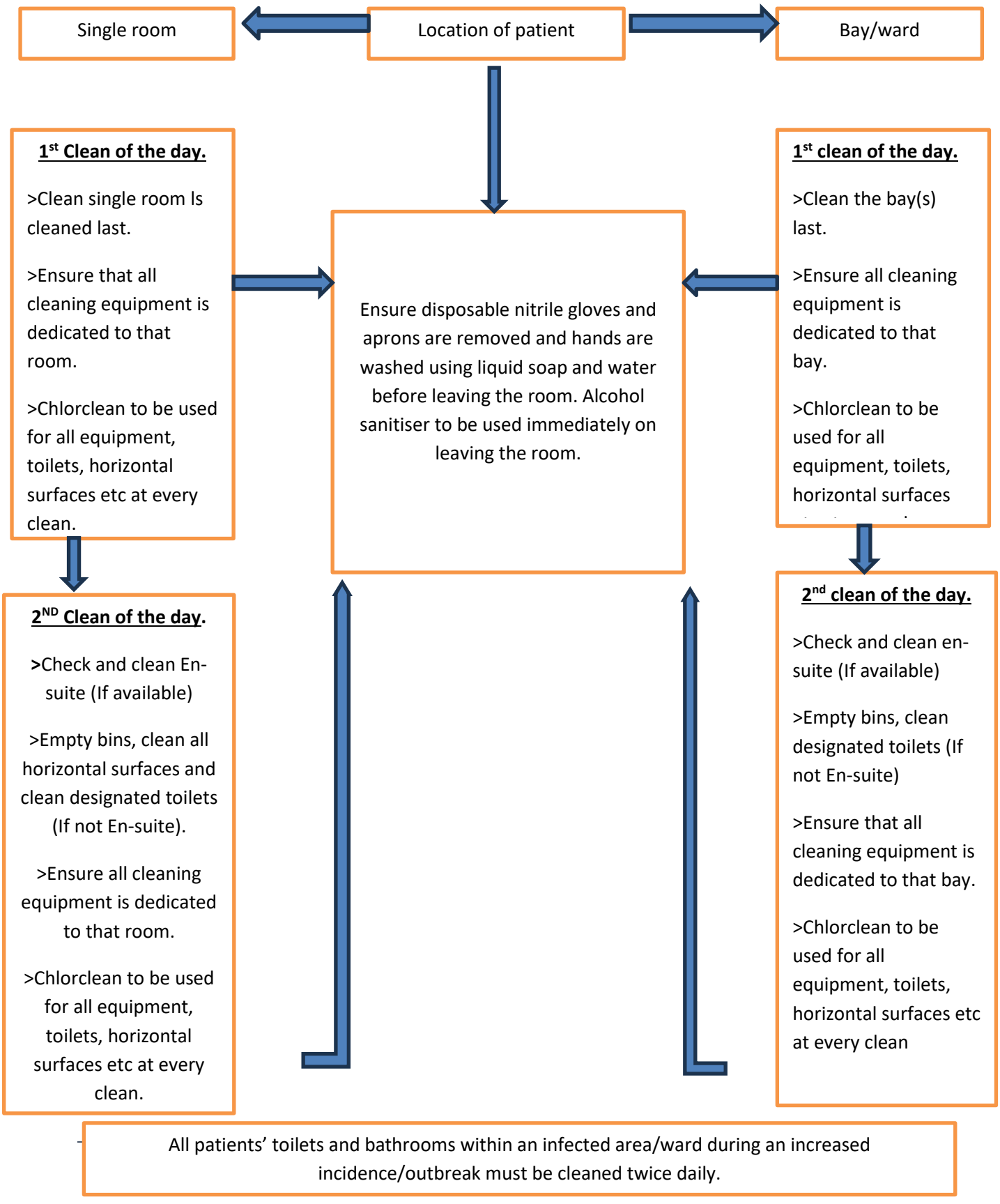
Patients Name	Placement on ward	Date: AM PM Night			Date: AM PM Night			Date: AM PM Night			Date: AM PM Night			Date: AM PM Night			Date: AM PM Night			Date: AM PM Night		

Appendix 7 Checklist of activities that should be instigated by ward on initial suspicion of increased incidence.

Infection Prevention and Control Team

- 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 8 Cleaning algorithm for an increased incidence/outbreak of infection for environmental cleaning



Appendix 8 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:

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>

Appendix 10: Precautions to be undertaken when there is an increased incidence/outbreak of infection flow chart.

Signage

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

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 of 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.

Please do not use alcohol sanitiser to decontaminate hands 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.

Personal protective equipment (PPE)

Disposable Nitrile gloves & a disposable apron must be worn whenever there is contact with a patient (or their environment) having source isolation precautions.

>Gloves and Apron must be changed and disposed of as clinical waste after and between each task.

>PPE must be donned after obtaining any items required for the task to be undertaken and immediately prior to the clinical activity of 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 PPE, the PPE must be changed between individual patients and different task with the same patient.

>FRSM are required to be worn by patients and staff in all areas where there is an increased incidence/outbreak of infection. Patients will need to be risked assessed for their ability to wear a mask and the outcome of the risk assessment should be clearly documented in their systmone

For further information regarding PPE please refer to the infection prevention and control Policy for the Use of personal protective equipment in healthcare

Appendix 11 CDI infection severity table

Mild CDI	Not associated with a raised WCC Typically associated with <3 stools type 5-7 on the BSC per day
Moderate CDI	Associated with a raised WCC that is <15 x 10 9/L Typically associated with 3-5 stools on the BSC per day
Severe CDI (One or more)	Associated with a WCC >15x 10 9/L **Or** Acute rising serum creatinine (i.e., >50% increase above baseline) or Temperature of >38.5 c **Or** Evidence of severe colitis (abdominal or radiological signs) The number of stools may be less reliable indicator of severity.
Life-threatening CDI	Includes hypotension, partial or complete ileus or toxic megacolon, or CT evidence of severe disease.

Department of health: Clostridium difficile infection Updated guidance on management and treatment 2022.

Appendix 12 CDT patient leaflet

Infection Prevention & Control

Clostridium Difficile

Patient Guide

What is Clostridium Difficile?

Clostridium Difficile is one of many bacteria that live harmlessly in the human bowel. 'Good' bacteria keep it in check. Some antibiotics can 'kill off' the good bacteria and occasionally damage the lining of the bowel.

Sometimes there are no symptoms of Clostridium Difficile, but often it presents itself as diarrhoea, fever; loss of appetite; nausea and abdominal pains and tenderness.

Why is Clostridium Difficile so widespread now?

Clostridium Difficile has been around since the 1970's however, only recently an accurate test for it has been developed. There are several reasons it appears to be more widespread now. These include:

- Infections may have gone undiagnosed in previous years.
- Older people in our society are getting illnesses connected to long-term health problems which require antibiotics.
- We treat illnesses, such as tonsillitis, with antibiotics, and when given time the body can usually heal itself.
- Bugs are becoming harder to treat with antibiotics as they find ways to resist medicine.

How do people get Clostridium Difficile?

When normal bacteria in the bowel is disturbed Clostridium Difficile can multiply and produce toxins which irritate the bowel and cause diarrhoea. Those suffering from Clostridium Difficile shed bacteria or spores in their faeces. These spores survive unseen and can be carried on the hands or lie on surfaces such as bedpans and toilets. If good hand hygiene is not observed, spores picked up on hands can be swallowed when eating or drinking.

Those over 65 years of age are more at risk, particularly if they are being treated with antibiotics for an underlying illness. It is imperative that our hospitals are kept clean, and staff work hard to make sure that happens.

Is Clostridium Difficile treatable?

Yes

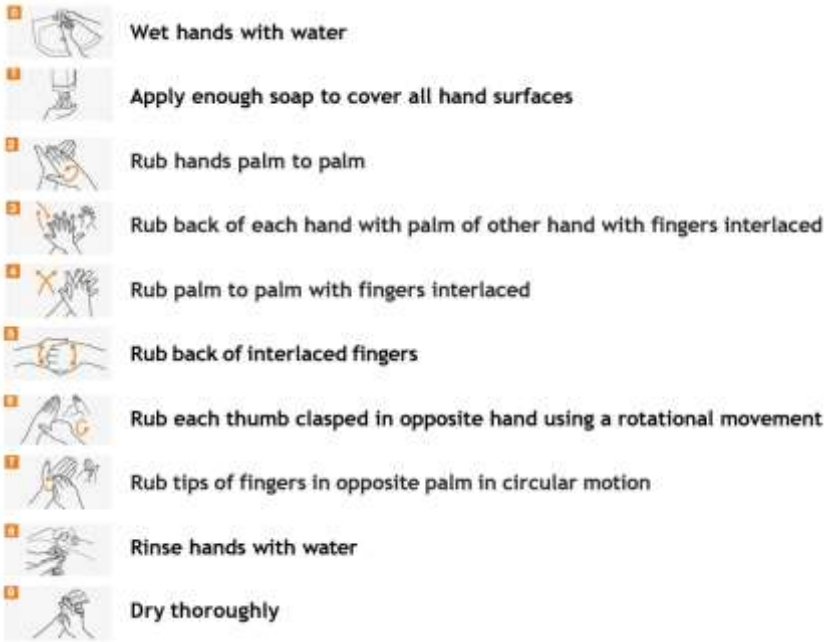
Stopping antibiotics is the most effective treatment. In cases where antibiotics are needed a different sort of antibiotic is used. Most patients with Clostridium Difficile diarrhoea make a full recovery, but those with other underlying illnesses may have a more severe cause. Occasionally, infections in these cases can be life-threatening.

If you have been treated for Clostridium Difficile and you no longer have diarrhoea you are not considered a risk to others providing you observe good hand hygiene. This means washing your Hands with soap and clear running water after using the toilet and before preparing food.

Those with a history of Clostridium Difficile who have no further symptoms of diarrhoea can return to their own home, care home or nursing home. Those who develop symptoms when they have been discharged from hospital will be monitored by a healthcare professional in the community.

Clean hands

Washing your hands with soap and clear running water reduces the spread of infection. Alcohol cleansing gels / hand rubs are NOT effective for Clostridium Difficile. When you wash your hands, it is important to include palms, thumbs and fingers, including tips, and backs of hands. The recommended way of washing your hands is shown below. Spending at least 30 seconds washing your hands will help fight infection.



If I have Clostridium Difficile how can I protect those around me?

If you're in hospital

- Bring your own toiletries. Do not share toiletries with others.
- Make regular and thorough hand washing part of your daily routine especially:
  - Before eating or handling food
  - After handling rubbish
  - After touching a public surface, such as flushing a public toilet
  - When hands look or feel dirty
  - Keep your bedside table free from clutter. This makes cleaning easier.
  - Report anything that doesn't look clean to staff caring for you.

If you're receiving visitors

- Ask them to adhere to guidelines on how many visitors are expected at one time.
- Make sure they wash their hands before and after they enter the ward.
- Limit clutter and gifts - the less presents, food, and magazines the easier it is for staff to clean the area.
- If your visitors have had diarrhoea, they must wait two days AFTER the symptoms have cleared up before they visit.

At home

- Make sure you finish your course of antibiotics even if you feel better
- Drink plenty of fluids to help stop dehydration
- Make sure you, your visitors and carers wash their hands after:
  - Using the toilet / changing nappies
  - After touching animals or animal waste
  - After handling rubbish
  - Before and after preparing food and drinks
  - When hands look or feel dirty

- Tell friends and family not to visit if they are feeling unwell
- If your visitors have had diarrhoea, they must wait two days AFTER the symptoms have cleared up before they visit
- If possible, convalesce into a room to yourself and make sure the toilet use is kept clean
- Keep all surfaces clean with bleach-based household detergents/disinfectants
- Remember to wash your hands after each episode of toileting, before preparing food and before you eat.

It's ok to ask

If you have any concerns about cleanliness, Clostridium Difficile and how it is treated, ask the nurse and they can help put your mind at ease.

Don’t be frightened to ask your carers if they’ve washed their hands. They will expect it and by doing so you will be helping to control infection.

Appendix 13 Norovirus Patient Leaflet

Infection Prevention & Control Team

Norovirus

Patient Guide

What is Norovirus?

Noroviruses are a group of viruses that cause nausea, vomiting and diarrhoea.

What are the symptoms?

- Nausea, vomiting, diarrhoea, and stomach cramps.
- In some cases: low grade fever (<38.5°C), chills, headache, muscle aches/fatigue.

How does it spread?

Norovirus is known to be spread in 2 different ways through direct and indirect contact as explained below:

Direct contact

When you come into direct contact with the faeces or vomit of an ill person.

Indirect contact

The virus gets on an environmental surface (i.e., doorknob, light switch, etc.) that is then touched by other people.

Both direct and indirect transmission usually happens when someone comes into contact with faeces or vomit of an ill person and then eats without first washing their hands.

Where is it found?

Norovirus is usually found in the gastrointestinal tract and faeces and vomit of a person who is infected with the virus.

Norovirus can survive on hard surfaces for up to 12 hours and is also commonly found on “high touch surfaces” such as sinks, bed rails and handrails.

Prevention and control

If it is suspected that Norovirus is causing you to have D&V symptoms, then you will be asked to isolate until you ae feeling better, there also other precautions that can be taken to prevent it spreading to others as we have listed below:

- When staff are carrying out care activities with you and are in contact with your environment, they will need to wear gloves and an apron as well as a face mask if there are also other patients on the ward with the same symptoms. This is to help stop the spread of infection to others.
- After you have used the toilet or before you eat food it is important to wash your hands with soap and water.
- Staff that care for you will also wash their hands before and after carrying out care with you or being in contact with your environment.
- You may continue to have visitors whilst you are isolating on the ward, however we would advise anyone who is vulnerable and young children not to visit whilst you are still feeling unwell.
- Visitors to the ward will be asked to wash their hands before entering and on leaving the ward, visiting time may need to also be restricted if there are other patients on the ward who are experiencing the same symptoms.
- If you are well enough your rehabilitation/therapy will continue to prevent any delays with your discharge from hospital.

It's ok to ask.

If you have any concerns about cleanliness, Norovirus and how it is treated then please ask your nurse, they can help put your mind at rest.

Don't be frightened to ask your carers if they have washed their hands. They will expect it and by doing so you will be helping to control infection.

Monitoring Compliance and Effectiveness

Compliance with this policy is outlined in the LPT infection prevention and control assurance policy.

Training Requirements

Training Needs Analysis No training required for this policy

Training topic:	
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☐ Role specific ☐ Personal development
Directorate to which the training is applicable:	☐ Mental Health ☐ Community Health Services ☐ Enabling Services ☐ Families Young People Children / Learning Disability Services ☐ Hosted Services
Staff groups who require the training:	
Regularity of Update requirement:	
Who is responsible for delivery of this training?	
Have resources been identified?	
Has a training plan been agreed?	
Where will completion of this training be recorded?	☐ ULearn ☐ Other (please specify)
How is this training going to be monitored?	

The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers	☐
Respond to different needs of different sectors of the population	☐
Work continuously to improve quality services and to minimise errors	☐
Support and value its staff	☐
Work together with others to ensure a seamless service for patients	☐
Help keep people healthy and work to reduce health inequalities	☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☐

Due Regard Screening Template

Section 1	
Name of activity/proposal	The management of patients with diarrhoea and/or vomiting suspected or confirmed as infectious including: The clinical management of patients nursed as inpatients within LPT with an increased incidence or outbreak of diarrhoea and/or vomiting.
Date Screening commenced	17-07-2023
Directorate / Service carrying out the assessment	Infection prevention and control
Name and role of person undertaking this Due Regard (Equality Analysis)	Claire King infection prevention and control nurse
Give an overview of the aims, objectives, and purpose of the proposal:	
AIMS: The aim of this policy is to provide clear guidance to all trust staff on their responsibilities in relation to infection prevention and control	
OBJECTIVES: This policy clearly identifies the aims and goals for infection prevention and control within LPT, thereby providing a coherent strategic objective. This policy should be reviewed whenever there is a need to adapt to the changing regulatory environment or in response to ongoing risk assessment to ensure a safe environment exists for all patients, visitors, and staff	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact, please give brief details
Age	None identified
Disability	None identified
Gender reassignment	None identified
Marriage & Civil Partnership	None identified
Pregnancy & Maternity	None identified
Race	None identified
Religion and Belief	None identified
Sex	None identified
Sexual Orientation	None identified
Other equality groups?	None identified

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	No x
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4.

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
This policy forms part of the overarching policy for all subsequent infection prevention and control policies This policy takes into consideration the needs of patients and staff and the safeguarding of same. It follows government legislation and relevant bodies have been consulted prior to the development of any policies prior to having them agreed at trust level.			
Signed by reviewer/assessor	Claire King infection prevention and control nurse	Date	17-07-2023
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Amanda Hemsley	Date	17.7.23

Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**The management of patients nursed diarrhoea and/or vomiting suspected or confirmed as infectious including the clinical management of patients nursed as inpatients within LPT with an increased incidence or outbreak of diarrhoea and/or vomiting.**	
Completed by:	Claire King	
Job title	Infection prevention and control nurse	Date: 17-07-2023

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	**Emma Wallis-Associate director of Nursing & professional practice**
Date of approval	**17-07-2023**