

The management of patients with diarrhoea and/or vomiting suspected or confirmed infectious Policy

This policy describes the processes to be followed for the management of 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 there is an increased incidence or outbreak of diarrhoea and/or vomiting which is being considered as infectious.

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D&V Policy

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Policy on a page

Summary and aim

The aim of this policy is to provide a trust wide guidance for all staff with regards to the clinical management of patients who have diarrhoea and/or vomiting that is suspected or confirmed to be of an infectious nature.

This policy will also describe the clinical management and procedures that are required to be followed by staff when there is an increased incidence or outbreak of diarrhoea and or vomiting which is being considered as infectious.

Target audience

This policy applies to all staff providing care to patients under the care of Leicestershire Partnership Trust (LPT) who experience episodes of diarrhoea and/or vomiting which is confirmed/suspected to be infectious.

Training

Infection Prevention & Control Level 1 (Non-clinical staff & clinical staff groups)

Infection Prevention & Control Level 2 (Clinical staff Groups)

IPC delivery of additional Infection specific training as may be required.

Key requirements

This policy is designed to provide trust wide guidance for staff on the process for the management of patients experiencing episodes of diarrhoea and/or vomiting which is confirmed/suspected to be infectious.

The key requirement of this policy is to ensure that patients with increased episodes of diarrhoea and/or vomiting that are suspected/confirmed to be infectious are safely managed within an inpatient or outpatient area to ensure that the situation is controlled and managed with minimal risk to other patients and staff whilst continuing to maintain public safety.

Introduction and Purpose

The purpose of this policy is to ensure that all healthcare staff within Leicestershire Partnership Trust (LPT) are aware of the IPC measures that are required to safely manage patients who experience diarrhoea and/or vomiting which is suspected or confirmed to be of an infectious nature.

Staff ability to recognise symptoms of viral diarrhoea and or vomiting will allow the prompt implementation of good IPC standards to reduce further risk of infection transmission. This alongside reduction in the movement of affected patients and potential contacts will also assist staff to prevent any further cross infection or contamination within the wider healthcare environment.

This policy will also 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 an inpatient ward area where there is an increased incidence or outbreak of infection.

Policy Requirements and Objectives

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.

However, 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. If this is the case any faecal samples must only be taken and sent for analysis 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
- Bacterial such as those caused by food poisoning e.g. salmonella, campylobacter.
- Parasites
- Bacteria that produce a toxin such as Clostridium Difficile.

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It is important that staff can recognise diarrhoea and vomiting that may be of an infectious nature to enable them to instigate procedures to reduce the spread and transmission as promptly as possible.

There are also many causes of increased incidences and outbreaks of diarrhoea and/or vomiting, this particular policy will apply to all cases of enteric diseases including gastroenteritis, with the most common cause of gastroenteritis being Norovirus which is one of the most infective agents seen within our health & social care settings.

Process

1.1 Enteric Diseases

Enteric diseases are caused by micro-organisms such as viruses, bacteria & parasites which can cause intestinal illness,

These diseases most frequently result from the consumption of contaminated food or water and can be quickly spread from person to person.

A common example of this is gastroenteritis which is a very common illness which affects the individuals gut and is often highly contagious. Gastroenteritis is usually triggered by an infection that causes inflammation of the lining of the digestive system.

In the table below is listed some of the common organisms which can cause enteric diseases including gastroenteritis:

Viruses that cause enteric disease

Organism	Incubation period of organism	Symptoms of organism	Causes
Norovirus	12-48 hours	• Nausea/vomiting (Vomiting can often be projectile) • Diarrhoea • Fever • Headache • Stomach pain/cramps • Body aches/Pains	Contracted through: • Close contact with someone with Norovirus • Touching surfaces or objects that have the virus on them, then touching your mouth. • Eating food that has been prepared or handled by someone with Norovirus. • Drinking unclean water that may be contaminated with Norovirus.
Rotavirus	24-48 Hours	• Fever • Nausea/Vomiting • Diarrhoea (Can be watery) • Stomach pain/cramps	Contracted through: • Close contact with someone with Rotavirus • Direct contact with infected faeces-This could be whilst changing nappies or whilst caring for a person with Rotavirus • Touching surfaces or objects that have the virus on them, then touching your mouth • Eating food that has been prepared or handled by someone with Rotavirus
Adenovirus	2-14 days most people will begin to show symptoms around 5-6 days after exposure.	• Common cold or flu-like symptoms • Fever • Sore throat • Acute Bronchitis • Pneumonia • Pink eye	Contracted through: • Close contact with someone with Adenovirus • Airborne (By coughing, sneezing) • Touching surfaces or objects that have the virus on them, then touching your mouth.

		• Nausea/Vomiting • Diarrhoea • Stomach pain/cramps	• Direct contact with infected faeces-This could be whilst changing nappies or whilst caring for a person with Adenovirus. • Swimming pools/ Lakes/rivers or other natural bodies of water where water that is contaminated may be swallowed whilst participating in swimming, water sports. • Eating food that has been prepared or handled by someone with Adenovirus
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Bacteria that commonly causes enteric disease

Organism	Incubation period of organism	Symptoms of organism	Causes
Salmonella	12-72 hours	• Diarrhoea (Can be watery/bloody) • Fever • Stomach pain/cramps) • Nausea/vomiting	Contracted through: Most causes of salmonella are through consuming food/water contaminated with faeces which include: • Raw & undercooked meat (Especially chicken) • Raw eggs from chickens • Unpasteurised milk & dairy products • Contaminated fruit • Contaminated sea foods • Contact with infected animals (dogs, cats, terrapins & tortoises)

			• Direct contact with infected faeces-This could be whilst changing nappies or whilst caring for a person with salmonella. • Touching surfaces or objects that have the virus on them, then touching your mouth • Eating food that has been prepared or handled by someone with. Salmonella.
Shigella	Typically, 1-3 days but can range from 12 hours up to a period of 7 days.	• Diarrhoea (Can be watery/bloody) • Fever • Stomach pain/cramps • Nausea/Vomiting	Contracted through: infected faecal matter. Most commonly spread through close contact with other people. Other risk factors • Lakes/rivers or other natural bodies of water where water that is contaminated may be swallowed whilst participating in swimming, water sports. • Eating food that has been prepared or handled by someone with Shigella. • Direct contact with infected faeces-This could be whilst changing nappies, through sexual contact or whilst caring for a person with shigellosis.
E. coli	3-4 days after exposure, though symptoms can occur as early as 1 day or as late as 8-10 days	• Diarrhoea (Can be watery/bloody) • Stomach pain/cramps • Loss of appetite • Fever (Low grade)	Contracted through: • Eating contaminated foods-Including undercooked meats and Raw fruit and vegetables.

	depending upon the strain, amount of bacteria ingested & individual immune response.		• Drinking un-pasteurized beverages-This includes milk, cider or juice & foods made from them such as cheese or ice-cream. • Lakes/rivers or other natural bodies of water where water that is contaminated may be swallowed whilst participating in swimming, water sports. • Drinking water that has not been sanitized • Eating food that has been prepared or handled by someone with E-coli. • Direct contact with infected faeces-This could be whilst changing nappies or whilst caring for a person with E-coli • Touching surfaces or objects that have the virus on them, then touching your mouth.
C.Difficile	7 days from point of exposure, however exact length of time can vary, and some may not display symptoms immediately after exposure.	Symptoms can vary from mild to moderate but remain extremely unpleasant. • Diarrhoea (Can be watery & may contain blood/mucous). • Fever • Loss of appetite • Nausea/vomiting • Stomach pain/cramps Symptoms of C. difficile can range from Mild to severe.	Contracted through: • Direct contact with infected faeces, this could be whilst changing nappies or whilst caring for a person with C, difficile infection. • Touching surfaces or objects that have the virus on them, then touching your mouth. • Increased use of antibiotics-Antibiotics used to treat infections tend to destroy some of the helpful bacteria as well as the harmful bacteria in the body. Without enough helpful bacteria in the gut C difficile can grow out of control quickly and make the individual unwell.

Parasites that commonly causes enteric disease

Organism	Incubation period of organism	Symptoms of organism	Causes
Giardia	1-2 weeks after exposure, however not all individuals will display symptoms of Giardia infection.	• Nausea/vomiting • Watery explosive diarrhoea • Bloating • Passing excessive odorous wind • Stomach pain/cramps • Fatigue • Reduced appetite/weight loss	Contracted through: • Lakes/rivers or other natural bodies of water where water that is contaminated may be swallowed whilst participating in swimming, water sports. • Drinking water that has not been sanitized or eating fruit/vegetables washed in un-sanitized water, • Eating food that has been prepared or handled by someone with Giardia. • Direct contact with infected faeces-This could be whilst changing nappies or whilst caring for a person with Giardia • Touching surfaces or objects that have the virus on them, then touching your mouth.
Cryptosporidium	3-12 days after exposure.	• Watery diarrhoea • Nausea/vomiting • Fever • Reduced appetite/weight loss Symptoms can last around 12-14 days but can sometime last as long as a month.	Contracted through: • Cryptosporidium passes out in the faeces of infected humans and animals. It can then be found in soil, water, and food, or on surfaces that have been contaminated. • Human-to-human transmission of infection is possible - for example, by not washing your hands after changing the nappy of an infected child and then putting your hands in your

			mouth or caring for a patient with this infection. This is known as faecal oral transmission. • Outbreaks can occur within a household or, for example, within nurseries/health care facilities. • Animal-to-human transmission is also possible. This is commonly through contact with infected animals in farms or zoos or through contact with infected animal faeces. • You may also become infected if you drink contaminated water. In fact, the largest outbreaks of cryptosporidiosis have occurred when drinking water becomes contaminated with sewage or manure. Adequate filtration of water is needed to remove the parasite. • Swimming in contaminated water (for example, water from lakes or rivers) can also cause infection. Outbreaks have also occurred through swimming pool contamination, as chlorination doesn't always kill the parasite. • Eating contaminated food is a less common way that you may become infected with cryptosporidium. For example, food that is washed in contaminated water or fruit or vegetables that are contaminated by infected manure that has been used to encourage them to grow. • Unpasteurised milk may also be a source of infection.
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			• If you travel to countries which have poor sanitation, you may be at a greater risk of developing cryptosporidium infection. • Sexual contact may also spread the infection.
Cyclospora	2 days-2 weeks after exposure.	• Diarrhoea which can be watery and explosive. • Nausea/vomiting • Low grade fever • Stomach pain/cramps • Passing excessive odorous wind • Body aches/other flu like symptoms • Prolonged fatigue • Loss of appetite/weight loss	Contracted through: • Consumption of contaminated water or eating food that has been contaminated. • Consumption of undercooked/raw meats, fruits and vegetables that have become contaminated. Cyclospora is a common parasite that is found in parts of: • Central & South America • South & Southeast Asia • The middle East • Africa It is rare to catch it from close contact with someone who has it.

The overall infectious period of these diseases is very much dependent on which organism is the cause, however if a patient is symptomatic and is suspected/confirmed that these are being caused by an infection the patient will need to have Source isolation precautions put into place.

1.2 Management of Patients with Diarrhoea and/or vomiting that is suspected or confirmed to be of an infective nature.

Loose stools are defined as bowel movements that are softer than normal and may include the following types:

- Watery stools that are completely liquid and lack solid form
- Mushy stools that are soft and may have a fluffy appearance
- Shapeless stools that do not hold a defined shape and may appear more like a puddle.

(Please refer to the Bristol stool chart appendix 1 for more information)

Any patient who is admitted to hospital/inpatient facility with diarrhoea (Type 5-7 stools) symptoms or develops diarrhoea and or/vomiting and is under the care of LPT then staff must as a priority assess & document the Cause of the diarrhoea and/or vomiting-This includes establishing if the patient has any of the following:

- Any underlying conditions Including previous history of Clostridium Difficile Infection (CDI) or underlying bowel disease),
- Any antibiotic treatments the patient may be prescribed or have recently had,
- laxatives they have had or are still prescribed,
- Proton pump inhibitor medication
- Nutrition/dietary fibre
- History of any recent travel
- Any recent anaesthetic or bowel surgeries.
- Stool type (Is it watery, bloody, fatty), Duration, Frequency, odour, severity of symptoms.
- Accurate fluid balance management must be initiated and clearly documented

Once a new onset of acute diarrhoea has been established the application of the acronym SIGHT must be instigated (DOH 2009).

S	Suspect that a case may be infective where there is no clear alternative cause for the diarrhoea.
I	Isolate the patient while determining the cause of the diarrhoea and consult with the Infection Prevention & Control team.
G	Gloves & Apron must be used for all contacts with the patient and their environment.
H	Handwashing 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, stool sample to be collected for microbiology and/or virology screening.

How do we apply SIGHT

	Action	Application
S	Suspect that a cause may be infective where there is no clear alternative cause for the diarrhoea.	- Review other potential causes of the diarrhoea this includes medication, treatments for constipation and any underlying illness particularly bowel pathology that may be contributing to loose stools. - Stop any medications that are not required especially in terms of antibiotics and any other drugs that may cause diarrhoea symptoms. However, if following review these medications are assessed as essential, then consider using an alternative that is less likely to cause diarrhoea. - Review if the patient is prescribed any proton pump inhibitors- Consider alternative medication if acid suppression is still required. - Any anti-motility agents must not be newly prescribed for management of acute diarrhoea when infection is suspected/confirmed. Nonsteroidal anti-inflammatory drugs (NSAIDS), angiotensin-converting enzyme inhibitors (ACE), angiotensin receptors blockers (ARBS), diuretics as these may cause dehydration if the patient is also having severe diarrhoeal symptoms and will need to be considered.
I	Isolate the patient while determining the cause of the diarrhoea and consult with the Infection Prevention & Control team.	If the onset of the diarrhoea and/or vomiting is sudden and the symptoms are not clearly attributable to an underlying condition or therapy, the patient must be immediately isolated preferably in a single side room with own ensuit (Do not wait for further episodes of diarrhoea and/or vomiting or sample results).

		• Source isolation will need to continue until the patient has had no further episode of loose stools (Type 5-7) for 48 hours and they have passed a normal stool for the patient or other potential cause of the loose stools has been established. • If an ensuit is not available, then the patient will need to be allocated a toilet/bathroom which they can use for their sole use. • Any equipment in the patient's room must be kept minimal and cleaned before and after each use. • Infection Prevention and control source isolation care plan will need to be implemented within the patient system one record. • Clear signage will need to be placed on the patient door to alert staff/visitors that the patient is in source isolation (See appendix 8 transmission-based precautions/source isolation posters) Facilities team will need to be contacted to inform that twice daily cleaning of the room will be required If a patient is not able to source isolate, then a risk assessment must be undertaken (See appendix 7) and the IPC team informed. Once Isolation has been stepped down a full post infection (Terminal clean) will be required of the area. (see appendix 11)
G	Wear gloves & Aprons appropriately (Personal Protective Equipment (PPE)).	• Staff will need to ensure that they wear appropriate PPE when in contact with the patient and their environment. • PPE should include Gloves and apron as a minimum. • FRSM is recommended where Norovirus infection is suspected or confirmed due to the risk of airborne transmission.

		Care must be taken when staff are donning and doffing PPE to reduce any risk of contamination of the PPE, uniform, hands etc. (See appendix 9 for donning/doffing PPE guidance)
H	Wash hands with soap and water (Hand hygiene).	- Good hand hygiene practice will need to be carried out after each contact with the patient and their environment, before donning and after doffing of PPE. - Hands should be washed with soap and water; Alcohol-based hand rub must not be used for decontamination of hands as this can be ineffective against diarrhoea causing infections. - Patients who are suspected/confirmed to have an infection should also be encouraged to carry out regular good hand hygiene practice with soap and water after each episode of toileting and before food. (See appendix 10 for handwashing technique)
T	Send a stool specimen for toxin testing without delay to the microbiology laboratory (Testing).	Faecal samples should only be collected if an infectious cause of the loose stools is being considered. - When collecting faecal samples screening request should include Microscopy, culture & sensitivity (M, C&S) & CDT screening (1 sample can be tested for the presence of these infections). A microbiology form will also need to be completed and sent with the sample; all sections on the form must be completed (See section 1.3 sampling for further guidance)

Once the patient has been isolated, please contact the Infection Prevention & control team to inform us. This will allow the IPC team to support you with ensuring that all measures are in place to safely manage the patient and reduce the risk of further transmission to others.

1.3 Sampling for potential infective causes of new onset of diarrhoea and or vomiting

NB: Faecal samples should only be taken if considering an infectious cause for the diarrhoea and/or vomiting episodes that the patient is experiencing (**Please do not send samples of vomit as these samples will not be tested**).

The M, C & S test is a three-step laboratory investigation which is used to detect and identify microorganisms (usually bacteria or fungi) in any biological sample, determining their concentration, and to assess their sensitivity to antibiotics. This test is typically carried out when an infection is suspected, to guide appropriate treatment.

1. Microscopy:

The first step involves examining the biological sample (urine, blood, sputum, wound swab, or stool) under a microscope. This then allows the scientists to observe microscopic elements such as bacteria, pus cells, fungi, parasites, or epithelial cells, offering early clues about the type of infection.

2. Culture:

In this step, the sample is placed in a special medium that encourages the growth of any microorganisms present. After incubation for 24 hours, the scientist identifies the type of organism based on its appearance, colour, shape, and growth pattern alongside suitable biochemical tests.

3. Sensitivity (Antibiotic Susceptibility Testing):

Once the organism is identified, it is tested against a range of antibiotics to determine which ones are most effective in killing or inhibiting its growth.

1.3.1. Norovirus screening

It is important to note that stool samples obtained for Norovirus screening will not routinely be screened in labs unless the sample is being sent as part of a suspected increased incident/outbreak of Norovirus (Please see section 2.0 for managing increased incidence/outbreak of infection for further guidance).

Once an outbreak of Norovirus has been confirmed by sampling any further samples sent from symptomatic patients **will not be screened**.

Any subsequent symptomatic patients will therefore need to be treated as infectious and appropriate IPC measures will need to be put into place.

Faecal samples taken on a weekend or bank holiday should be sent the

same day, via taxi if necessary, and in an appropriate sealed leakproof container.

NB: A delay in sending samples could result in potential delays in commencing any appropriate treatment for identified infective causes of the diarrhoea and/or vomiting.

1.4 How to make a referral to the Infection Prevention and Control (IPC) team

A referral to the IPC team can be made by staff in the following way:

Telephone-01162952320

Email- lptipcteam@nhs.net

You can also contact the Infection Prevention & Control team by

- Creating an electronic referral in system one
- Via staff net: Send an automated email alert to IPC via Staff net
<https://staffnet.leicspart.nhs.uk/support-services/infection-preventioncontrol/contact-us/ipcform/>

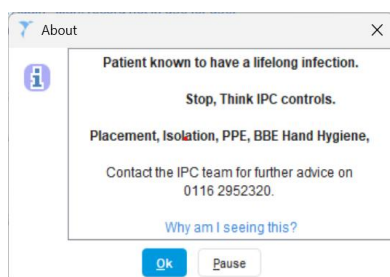
Referral to the IPC team should be completed as soon as possible and the date, time and reason for the Source Isolation Precautions (SIPS) being implemented must be documented in the patient's system one record.

Once the IPC team have been notified that a patient has an infection an alert marker (See below) will be placed on to the patient's electronic record. This applies to any patient who has or are identified as a known carrier of a communicable disease (i.e. in the case of patients with *Clostridium difficile* infection).



Patients with a lifelong infection will have this icon in the demographic box on their system one record, if this is missing then please contact the IPC team

A pop-up box will also appear on the patient record to alert you that the patient has a lifelong infection.



It is imperative that staff check the infectious status of all patients when they first come under their care.

2.0 Management of an increased incidence or outbreak of diarrhoea and/or vomiting suspected or confirmed as infectious

The general public, patients and staff have a right to expect that any potential hazards in healthcare environments are adequately controlled. Therefore, it is expected that 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 patients with whom they provide care for, but it is also their responsibility to themselves and to other patients and members of staff under the health and safety at work etc act (1974) (Nursing & Midwifery Council (NMC) 2015).

Increased incidences and outbreaks of infections due to diarrhoea and/or vomiting are a potential risk to patients, staff and public health and wellbeing, therefore, 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.

2.1 What is an increased incidence/outbreak of infection?

An increased incidence or outbreak of infection 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 infections in hospitals
Department of Health, 1995)

NB: If the disease is notifiable by law, the medical practitioner responsible for the patient must also notify the consultant in public health at the UK Health Security Agency (UKHSA), East Midlands Health Protection Team Please refer to the LPT infection Prevention & Control Policy '**The reporting of known or suspected infectious diseases to the UK Health Security Agency**' for further guidance).

(Please refer to appendix 2 for the checklist of activities that should be instigated by ward on initial suspicion of an increased incidence/outbreak of infection).

NB: For further guidance on management of a suspected/confirmed increased incidence/outbreak of infection please refer to the LPT infection Prevention and Control Policy '**Escalation Process to be followed when there is a suspected or known increased incidence or outbreak of infection within LPT inpatients.**

This policy provides further guidance on the procedures to be followed to ensure that the correct persons are informed and processes are followed when there is a suspected/confirmed increased incidence or outbreak of infection within LPT.

2.2 Documentation to be completed when an increased incidence or outbreak of infection is suspected or confirmed

If an increased incidence/outbreak of infection is being considered then Staff will need to ensure that they clearly document the patients bowel and vomiting episodes on any current system of communication used by the ward, this will ensure that it is readily available and ensure effective communication between the ward and the Infection Prevention and Control team can be carried out regarding the current status of any increased incidence or outbreaks of infection.

Where there are cases of increased incidence or outbreak of infection the IPC team will contact the affected areas daily (Except weekends and Bank holidays) to gather information on the current status of the situation and advise on the management of the increased incidence or outbreak.

As mentioned above appendix 2 of this policy examples a check list of activities that should be instigated by the ward area on initial suspicion of an increased incidence or outbreak of infection which will assist in the overall management of the patients that have been identified as part of the increased incidence or outbreak of infection.

Appendix 3 is an example of a chart which can be implemented to document the bowel and vomit episodes of each of the symptomatic patients which can be a useful tool when review of each of the patients takes place.

2.3 Patient placement within the ward

If an increased incidence or outbreak of infection is being considered, then it is important that patients are not moved around the ward in order to transfer them into single rooms or COHORT all affected patients in one bay

It may happen that the first patient with diarrhoea and/or vomiting symptoms is moved into a single room, as at that point the ward may be following this policies earlier guidance regarding isolation of patients who have developed a new onset of diarrhoea and/or vomiting which is suspected or confirmed as infectious. **However, when an increased incidence or outbreak of infection is being considered then movement of any further affected patients should cease.**

If a single patient presents with diarrhoea and/or vomiting then consideration at this early stage should be given as to whether the cause is thought to be viral, if thought to be of a viral cause (e.g. Norovirus) **then the patient should not be moved into a single side room.**

All patients within that bay who have had potential contact must receive source isolation precautions on an individual basis. **This will apply regardless of whether the patients who have been identified as contacts are symptomatic or not.**

The rationale for this is that the patients who are nursed in the same bay as the affected patients may be incubating the infection and therefore if the affected patient is moved out of the bay and a new patient is placed into their vacated bed space then this may increase their risk of also becoming infected by the other patients in the bay who have been identified as contacts.

All patients within the affected bay who have been identified as potential contacts must be risk assessed to identify if they have any underlying conditions which may increase their risk **as additional IPC controls** may need to be put into place.

When risk assessing patients for safety of their placement, please consider their current clinical condition & the below list for increased vulnerability to infection: -

****High risk currently includes some people who have:**

- Down's syndrome, or another chromosomal disorder that affects their immune system.
- certain types of cancer or have received treatment for certain types of cancer.
- sickle cell disease
- certain conditions affecting their blood.
- chronic kidney disease (CKD) stage 4 or 5
- severe liver disease

- an organ transplants.
- certain autoimmune or inflammatory conditions (such as rheumatoid arthritis or inflammatory bowel disease)
- HIV or AIDS who have a weakened immune system.
- inherited or acquired conditions affecting their immune system.
- rare neurological conditions: multiple sclerosis, motor neurone disease, Huntington's disease, or myasthenia gravis.

Any empty beds in that bay **must be closed to new admissions** until the last symptomatic patient is 48 hours asymptomatic of diarrhoea and/or vomiting and they have passed a normal stool

Closing a bay to admissions is not the same as closing a ward to admissions and staff will need to be clear that if a bay is closed to admission there is still the capacity to admit into a 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 the patients affected has been 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 individual source isolation precautions in place at the bedside.
- 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 bedside 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 and must not be left at the bedside within the affected bay.
- If a patient is nursed in a single side room which does not have their own ensuite, then a commode if used where possible should not be left in the room. If the patient is independent, then they should where possible be allocated a toilet for their sole use-if this is not possible then the allocated toilet will need to be thoroughly cleaned after each use by the patient.
- If it is deemed that the commode should remain at the patient's bedside within a single side room, then a risk assessment will need to be undertaken.
- Source isolation precautions cannot be discontinued until all patients in the bay/double side rooms are 48 hours asymptomatic of diarrhoea and/or vomiting and for those patients who experience diarrhoea they must have passed a normal stool (The only exception for this would be if a patient has

had negative screens for suspected infection and have been reviewed by the ward 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 can 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.

3.0 Movement of patients with diarrhoea and/or vomiting and patients who are being nursed as part of an increased incidence/outbreak of infection

Symptomatic patients with diarrhoea and/or vomiting or patients who are being nursed as part of an increased incidence/outbreak of infection **must not** be transferred to other wards within LPT except for purposes of isolation or on a clinical based need.

For all transfers the essential steps for inter-healthcare transfer form must be completed and accompany the patient (See appendix 4), this decision must be made in consultation with the Infection Prevention and Control team or the on-call manager of that department.

The decision must be made 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 also be kept to a minimum, however when this is necessary either for investigation or treatment prior arrangements must be made with the manager of that department. This will enable trust source isolation precautions & cleaning and decontamination policies to be implemented.

If possible and where it does not impinge on their clinical state, consideration should be given to delaying these visits until the patient is asymptomatic of diarrhoea and/or vomiting for 48 hours and the patient has passed a normal stool for them.

If the patient needs to be transferred to another hospital due to clinical need, then the receiving hospital and ward must be informed of the increased incidence/outbreak of infection and the symptoms that the patient is displaying.

The ambulance service transferring the patient must also be informed so they can take the necessary precautions required.

Symptomatic patients should be seen immediately or at the end of the working session and they should only be sent to the department when they are ready to see them.

They should never be left in the waiting room/area where they may come into contact 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 the patient should be treated at the end of a session and their waiting time in the department should be kept to a minimum.

The patient must be transported via the ambulance service, and they must also be made aware of the patient's status in advanced to ensure that they can take the necessary precautions to facilitate a safe transfer.

The patient must not be allowed to travel with other patients in the same vehicle to reduce any potential cross-contamination risks.

A full terminal post infection clean must be carried out for every bed area and piece of equipment used with the patient as well as the vehicle that is used to transport the patient where applicable.

An increase in patient throughput and admission to the acute hospitals during the winter period may also put additional pressure on the availability of beds.

in order to support the admissions of patients into beds with the most clinical need during periods where there are high levels of Norovirus/viral diarrhoea and/or vomiting, patients may be discharged after 24 hours of being asymptomatic if they are clinically fit to be transferred.

This 24-hour default position currently is not in line with national policy and must only be done with consultation from the IPC team and in conjunction with the service lead/manager and chief nurse for LPT.

4.0 Visiting arrangements for patients with diarrhoea and/or vomiting and patients who are being nursed as part of an increased incidence/outbreak of infection

Visits from relatives or friends' plays a vital role in maintaining the wellbeing of our patients this is equally important for patients who are source isolated and have limited interaction with others.

To support the wellbeing of patients who are source isolated and ensure that they continue to be visited by their family & friends it is important that the following IPC measures be implemented:

Visitors do not routinely need to wear protective garments during their visits; however, advice must be provided by the nursing staff if the relative is to be involved in any direct patient care which should include the following:

- **PPE**-Relatives should be provided with gloves, apron and FRSM if the patients have viral diarrhoea.
- Relatives must be instructed on how to apply and remove PPE and directed to suitable waste receptacle for safe disposal.
- **Hand hygiene**-Relatives should be informed to wash hands before and after contact with the patient and their environment.

It is also important to advise that if relatives are suffering from diarrhoea and/or vomiting symptoms then they should not visit the ward and also cease visiting for at least 48 hours after symptoms have resolved.

It may be necessary in some rare circumstances that ward be closed in its entirety to visitors, however this will only be carried out following discussion with the IPC team and key individuals.

4.1 Visiting health care staff, volunteers and ad hoc workers to the area

Any volunteers must report to the nurse in charge for advice and guidance on what duties they may undertake with regards to symptomatic patients.

It is the responsibility of the nurse in charge to ensure that the volunteer is aware of any precautions that they may need to take.

Visitors such as hairdressers, trolley vendors and similar non-essential visitors must not be allowed into restricted areas until all the restrictions have been lifted and appropriate cleaning of the area has been carried out.

5.0 Therapy treatment for patients with diarrhoea and/or vomiting and patients who are being nursed as part of an increased incidence/outbreak of infection

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

Patients who are being source isolated or are identified as being part of an increased incidence or outbreak of infection can continue to be assessed and treated by therapy staff i.e. physiotherapists and occupational therapists following a risk assessment.

Patients are also able to participate in physiotherapy on the ward and in the gym or occupational therapist specific clinical areas with the following measures in place:

- The patient will need to be seen last on the list for the day their therapy/therapy assessment is planned for
- The patient WILL NOT be able to attend any group activities that take place on the ward during their period of isolation due to the risk of transmission of infection to others
- If the patient needs to have gym practice, then the patient will need to be the only patient within that area at the time of the session/assessment taking place.
- All therapy staff will need to ensure that they wear appropriate PPE when in contact with the patient and their environment.
- Please also encourage the patient to wear a FRSM if they are safe/able during the therapy session taking place.
- Good hand hygiene with soap and water will need to be carried out after each contact with the patient, before donning and after doffing of PPE and before any care is carried out with other patients on the ward.
- Please also encourage the patient to practice good hand hygiene pre and post therapy session/assessment.
- Any equipment that will not be required must be removed to prevent any contamination from occurring.
- Any equipment that is used will need to be minimal and will need to be decontaminated with chlorclean after use in line with the LPT cleaning and decontamination policy.
- The environment must also be cleaned with chlor-clean after the patient has attended prior to the next patient.

6.0 Discharge of patients with diarrhoea and/or vomiting and patients who are being nursed as part of an increased incidence/outbreak of infection

Patients who are symptomatic with diarrhoea and/or vomiting may be considered for discharge to other hospitals and nursing & residential homes.

However, this must be discussed in advance with the receiving area/carers to ensure that adequate facilities are available such as their ability to provide source isolation precautions and ensure that they have necessary equipment available.

The receiving hospital, nursing home or residential home must confirm that the appropriate arrangements are in place prior to their admission.

This must be clearly documented in the patient's electronic patient record and also in their discharge documentation.

7.0 Infection Prevention and Control measures required for visiting a patient in their own home.

When visiting patients who are suspected of or are confirmed to have diarrhoea and/or vomiting which is suspected or confirmed to be infective in their own home then good Infection Prevention and Control precautions must be maintained to prevent the carriage of any transient organisms between patients and staff.

All of the IPC practices identified earlier in the policy for caring for a patient in an inpatient area who has diarrhoea and/or vomiting which is suspected or confirmed to be of an infective nature must be adhered to including:

- Use of appropriate PPE (Minimum of gloves and Apron)
- Good standard of hand hygiene practice
- Cleaning and decontamination of equipment used during the visit

Information on how to manage symptoms of diarrhoea and/or vomiting whilst at home should also be given to the patient/carer and include the following:

- Encourage the patient to drink plenty of fluid
- Encourage patient/Carer to practice good hand hygiene following for example
 - Removal of gloves/aprons
 - After using the toilet
 - After changing nappies/incontinence products
 - After handling of waste
 - Before/after handling of food
 - Keep all surfaces clean and free from clutter (Surfaces to be cleaned with household bleach or detergent on all surfaces that can withstand this)
 - The importance of regular washing of bed linen, towels and clothing on the hottest wash cycle the fabric will allow. (Inform that soiled linen should not come into contact with any ordinary household laundry).

NB: Carers and/or relatives who are caring for someone with a positive stool sample or clinical symptoms for clostridium difficile infection must be advised in addition to the above of the following:

Arrangements must be put into place through either the patient/family member, carer or district nurse to carry out a daily assessment to identify/report any worsening symptoms and to alert the patients General practitioner (GP)

- Temperature-Is it raised

- Is the abdomen bloated
- Is the patient experiencing pain in their abdomen
- Increased frequency and/or change in stool type (Use Bristol Stool Chart to record frequency & type).
- Monitoring of Hydration & Nutritional status

if this advice is given to relatives, it is imperative that the staff giving the advice ascertains if the relative is able and in agreement to take on this responsibility.

This must also then be documented accordingly in the patients system record.

8.0 Management of patients with suspected or confirmed Clostridium Difficile infection (CDI).

8.1 What is CDI?

Clostridium difficile is a bacterium which lives harmlessly in the gut of many individuals, approximately 3 in every 100 healthy adults and as many as 7 in 10 healthy babies have a number of C. difficile bacteria living in their gut.

Usually, the number of C. difficile bacteria that lives in the gut of healthy individuals is kept in order by all of the other harmless bacteria that is also living within the gut.

C. difficile produces spores (Similar to seeds) which can be very resistant to high temperatures. The spores are passed out of the body through stools of people who have C. difficile in their gut.

The spores can live in the environment for example on surfaces, clothing and bedding for several months if not effectively cleaned.

8.2 Who is at risk of contracting CDI?

There are many risk factors that may increase the risk of an individual developing C. difficile infection (See figure 1 below for list of potential risk factors for CDI)

Figure 1: Risk factors for development of CDI

Risk Factor	Rationale
Increased age	Patients who are more than 65 years old have an increased risk of C. difficile infection.
Antibiotic treatment-	The use of antibiotic treatment disrupts the microbiota of the gut, allowing the proliferation of C. difficile. Almost all drugs with antibacterial activity have been

	implicated with antibiotic-associated diarrhoea (NICE, 2015). The risk of CDI is also increased with longer durations of antibiotic treatment, multiple antibiotics prescribed concurrently, or multiple courses of antibiotics (Smits, 2016, Mc Donald 2018)
History of CDI	Patients who have had previous reported Clostridium Difficile infections are at greater risk of re-infection.
Exposure to other infected people.	The incidence of CDI is 13 times higher among people exposed to an infected person. Exposure to those already infected can also lead to outbreaks of disease if cases are not effectively managed (Sams 2017).
Current use of Proton Pump inhibitor or other acid-suppressive drugs (Such as H2-receptor antagonists)	The increased risk of CDI associated with PPI is attributed to several factors: • Gut Microbiome, the use of PPI may alter the balance of gut bacteria, potentially increasing risk of CDI. • Increased gastric PH, usage of PPI increases the gastric PH, which can facilitate the bacterial colonisation and can increase the persons susceptibility to infections. • Duration of use, the risk of CDI increases with the duration of acid suppressive therapy.
Underlying morbidities	Underlying morbidities such as abdominal surgeries, chronic renal disease, inflammatory bowel disease, immunosuppression (Such as solid organ or haematopoietic stem cell transplant recipients, people with HIV infection, people undergoing cancer chemotherapy treatments) and vitamin D deficiency increases the individual's susceptibility to infection (Mc Donald, 2018).
Prolonged hospitalisation or residence in a nursing home.	The increased number of asymptomatic carriers within these settings increases the risk of potential infection spread to others (BMJ, Best practice, 2022).

8.3 What are the symptoms of CDI?

The symptoms of CDI can range from mild to moderate and can include the following:

Symptoms of CDI-Mild to moderate infection:

- Watery diarrhoea three or more times a day for more than 1 day
- Mild abdominal cramping and tenderness

Symptoms of CDI-Severe infection:

- Watery diarrhoea as often as 10-15 times a day
- Abdominal cramps and pain which may be severe
- Increased heart rate
- Loss of fluid/dehydration
- Fever
- Nausea/vomiting
- Increased white blood cell count
- Abdominal distension
- Weight loss
- Lack of appetite
- Blood/mucous or pus in the stools

Patients with a severe case of CDI tend to lose excess bodily fluid and are at extreme risk of dehydration. The infection can in some cases also cause the colon to become inflamed and form patches of raw tissue that can bleed or make pus.

Due to the increased risk of dehydration an accurate fluid balance management plan must be implemented, and documentation should include the following:

- Accurate fluid balance chart
- Loose stools checklist (See appendix 5)
- Bristol stool chart
- Nutritional assessments and referral to the dietic team
- Electrolyte replacement
- Guidance on the management of CDI

8.4 Assessment of patients with a CDI

When patients are suspected or confirmed to have CDI it is important that a full assessment of the patient is carried out to establish the following:

- Whether this is their first infection or a further episode (Relapse or recurrence)
- The severity of the CDI (See table below)
- If any individual factors such as age, frailty or comorbidities are present that may affect the risk of complications or recurrence of CDI.

Figure 2: 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 $<15 \times 10^9/l$

	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 of serum creatinine (ie, >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 toxic megacolon, or CT evidence of severe disease.

Department of health: Clostridium difficile infection updated guidance on management & treatment 2022.

In Most cases of CDI, the illness is usually mild and full recovery without complications is usual.

Patients with more severe diarrhoea can very quickly become seriously ill with dehydration.

In some patients who have severe illness as a result of the CDI the colon can become ulcerated and bleeding may occur (Colitis) and in the worst cases patients may develop a severe form of the disease called pseudomembranous colitis (PMC) which causes significant damage to the lining of the large bowel which may then lead to a dilated bowel or even an intestinal perforation, toxic mega colon and potentially sepsis which can in some cases be fatal.

In some cases, severe CDI may occasionally be characterised by ileus with no diarrhoea symptoms present.

8.5 Infection Prevention & Control measures required for patients with suspected/confirmed CDI.

If a patient is suspected or confirmed to have CDI, then SIGHT guidance will need to be implemented (See section 1.2 Management of Patients with Diarrhoea and/or vomiting that is suspected or confirmed to be of an infective nature).

(Please refer to appendix 6 Aide memoire-lifelong infection CDT infection quick reference guide).

8.6 Screening for CDI

When obtaining stool samples for suspected CDI, consideration must also be given as to whether the patient may have had a previous positive result for CDI.

To establish whether the patient has a previous positive result for CDI, consider contacting the patients GP or referring hospital for further information. Samples may have been sent outside of LLR geographical area dependent on the patient home address and may not appear on ILAB reporting system used within LPT.

Where there is no previous history of CDI and an infective cause is being considered, faecal specimens should be collected and sent immediately to the microbiology department requesting M, C&S & CDT screening

Faecal samples taken on a weekend or bank holiday should be sent the same day, via taxi if necessary, and in an appropriate container.

NB-A delay in sending samples could result in a delay in appropriate treatments being implemented.

A patient previously known to have CDI within the last 28 days **does not require a further faecal sample to be tested**, and samples must not be sent, however they should be treated as if they are positive for CDI. Treatment advice can be obtained from microbiology.

If their 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.

The Department of Health defines CDI as being either mild, moderate, severe or life threatening. A patient diagnosed with CDI, must have clear documentation in the electronic patient records as to the classification of the CDI which is being considered by the clinician in charge of the patient care (please refer to the patient CDI sensitivity table above- figure 2)

NB: If a negative sample for CDI 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.

8.7. What is the treatment for CDI

When prescribing antibiotics for suspected or confirmed CDI in adults aged 18 and over the below table (Figure 3) should be followed.

NICE guidance for the Treatment for CDI infection should always be followed for patients who have a recurring case of CDI or have developed a new CDI infection.

Figure 3 Choice of antibiotics for adults aged

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 <i>C. difficile</i> infection	Vancomycin: 125 mg orally four times a day for 10 days
Second-line antibiotic for a first episode of mild, moderate or severe <i>C. difficile</i> infection if vancomycin is ineffective	Fidaxomicin: 200 mg orally twice a day for 10 days
Antibiotics for <i>C. difficile</i> 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 or without Metronidazole: 500 mg intravenously three times a day for 10 days
Antibiotic for a further episode of <i>C. difficile</i> infection within 12 weeks of symptom resolution (relapse)	Fidaxomicin: 200 mg orally twice a day for 10 days
Antibiotics for a further episode of <i>C. difficile</i> 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 <i>C. difficile</i> 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.

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9.0 Staff Sickness due to Diarrhoea and/or vomiting

Any members of staff diarrhoea and or vomiting symptoms will require a referral to the occupational health service for further advice.

The role of the Occupational Health Department is to provide a professionally independent, impartial, and completely confidential source of advice on all aspects of the relationship between work and health.

A particular responsibility is to assist in the protection of healthcare staff from infections which may be acquired in the course of their work and to protect patients from infections which may be transmitted by staff.

Specialist occupational health professionals contribute to the development of local policies and guidelines for the Prevention and Control of Infection within Leicestershire.

There should be access to competent Occupational Health (OH) advice within Leicestershire Partnership Trust (LPT) as required by the Management of Health and Safety at Work Regulations 1999. All Health Service staff has access to the services of the Occupational Health Department. Any alternative advice may be sought from the UK Health Security Agency (UKHSA).

The Occupational Health Departments offer: -

- Confidential advice to individual members of staff
- Appropriate screening of healthcare staff if required before employment is confirmed and during employment, e.g.in the event of an infection outbreak.
- Work related immunisation programs
- Advice to staff and managers on exclusion from work when appropriate
- Liaison with other professionals locally in relation to control of infection.

- Work related health support

Occupational health contact details are as follows: Telephone -01162585307

Please note that occupational health service, advice and support is provided to LPT externally through University Hospitals of Leicester (UHL).

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11.0 Staff Roles and Responsibilities

Lead Executive Director

Responsible for ensuring that this policy is carried out effectively and that cases of diarrhoea and/or vomiting are managed effectively across the organisation.

Will communicate, disseminate, and ensure directorates commence implementation of this policy and provide assurance through the trusts quality Governance Framework.

Executive Management Board

Responsible for ensuring that his policy is carried out effectively and cases of diarrhoea and/or vomiting is addressed and managed effectively across the organisation.

Will communicate, disseminate, and ensure directorates commence implementation of the policy and provide assurance through the trusts quality governance framework.

Governance Group level 1 and 2

Responsible for ensuring that all relevant staff are aware of Diarrhoea and/or vomiting suspected/confirmed infectious policy and adhere to the principles and guidance that is contained within it.

Policy Team

To ensure that the Diarrhoea and/or vomiting suspected/confirmed infectious policy is reviewed in accordance with identified timescale and implementation of monitoring and effectiveness has been planned and is reviewed by the directorates and appropriate governance group.

Policy Authors

Responsibility for ensuring that the Infection, Prevention and Control team identify best learning and practice to inform this policy and update accordingly.

To ensure that this policy is reviewed in accordance with identified timescale and implementation of monitoring and effectiveness has been planned and is reviewed by the directorate and appropriate governance group.

Operational leads

Are responsible for ensuring implementation within their area and for ensuring all staff who work within the area adhere to the principles of this policy at all times.

Staff

Each individual member of staff, substantive and temporary worker within the trust is responsible for complying with this policy.

Clinical staff involved in care of patients affected by Diarrhoea and/or vomiting that is suspected/confirmed as infectious will ensure that they familiarise themselves with the content of the policy and work in accordance with this.

Staff will also ensure that they provide support and education to the patient, carer, and family where appropriate. They will also be a source of knowledge and skill for colleagues where appropriate as well as ensure that they remain up to date with training in line with competencies of their job role.

12.0 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivery

Governance

Version control and summary of changes

Version number	Date	Description of key change
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.
Version 2	August 2026	Review of policy

Responsibilities

Responsibility	Title
Executive Lead	<i>Group chief nurse</i>
Policy Author	<i>Head of Infection Prevention & Control</i>
Advisors	<i>Infection Prevention & Control assurance Group.</i>
Policy Expert Group	

Governance

Governance Level	Name
Level 1 Assurance Oversight	<i>Quality & Safety Committee</i>
Level 2 Delivery Group for policy approval and compliance monitoring	<i>Quality forum</i>

Compliance Measures

KPI (only need 1-2 KPI's per policy)	Where will this be reported and how often
Should describe how you are monitoring what you say you will do in the policy e.g., 100% of nurses will be on the NMC register	Where will this information be reported, what format and how often?
Isolation precautions audits. Hand hygiene audit on AMAT Cleaning & Decontamination Audit	Reported through IPC assurance Group Annually.
Review of attendance sheets of meetings held, minutes, action g, and future meeting dates.	Reported through IPC assurance Group Annually.

14.0 Training Requirements

IPC level 1 e-learning clinical & non-clinical staff groups

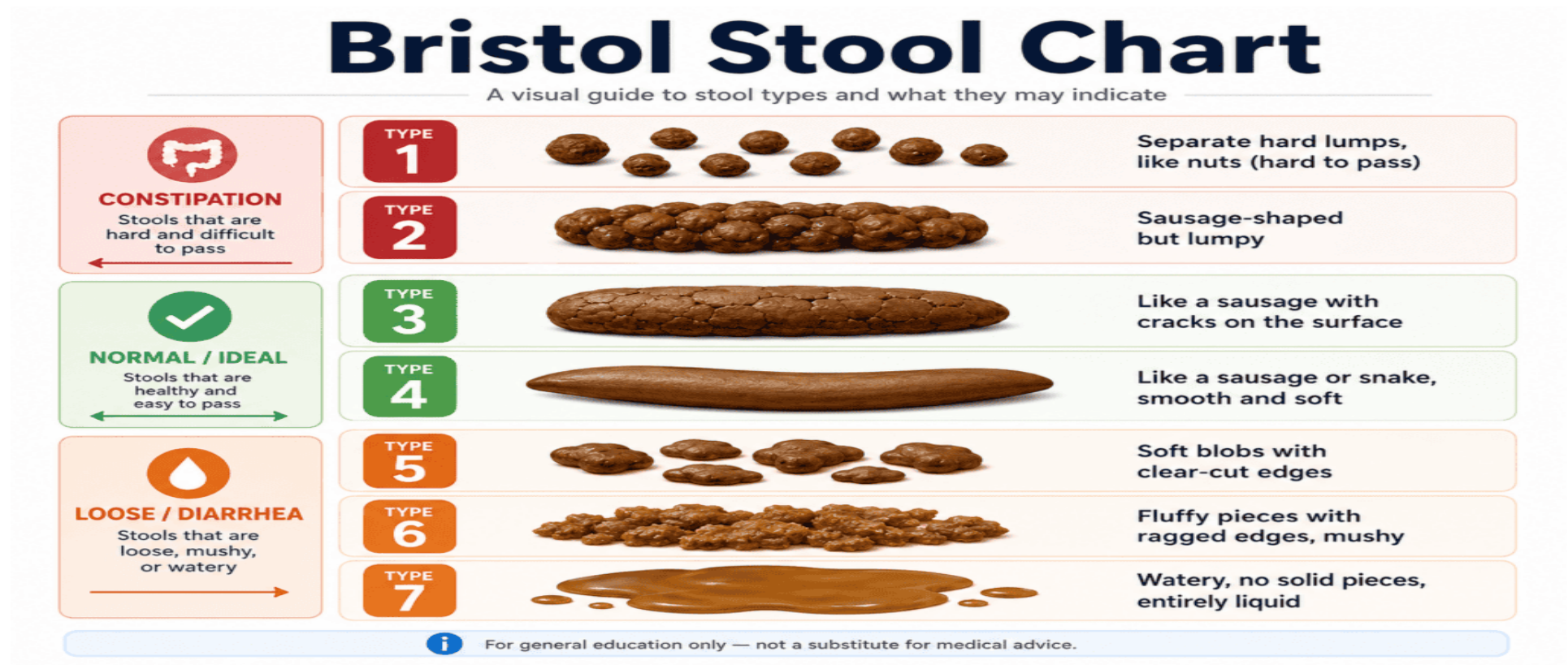
IPC level 2 e-learning Clinical staff groups

15.0 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 is 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, and 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 esophagus.
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.

Appendix 1: Bristol chart



Source: <https://www.bristolstoolchart.com>

Appendix 2: checklist of activities that should be instigated by ward on initial suspicion of increased incidence/outbreak of infection.

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 from ward ☐
- Record keeping ☐
- Incidence form completed ☐

Infection Prevention and Control Team

Patient Name	Placement on ward	Date:	AM:	PM:	NIGHT:

Appendix 4 Inter-healthcare infection control transfer form

Patient/Client details (insert label if available). Name: Address: NHS number: Date of Birth:	Consultant: GP: Current patient/client location Transferring facility – hospital, ward, care home, other: Contact No: Is the ICT aware of the transfer? Yes/No								
Receiving facility – hospital, ward, care home, district nurse Contact No: Is the ICT/ambulance service aware of transfer? Yes/No	Is the patient/client an infection risk? <i>Please tick most appropriate box and give confirmed or suspected organism.</i> <table border="0"> <tr> <td>Confirmed risk</td> <td>Organism:</td> </tr> <tr> <td>Confirmed risk</td> <td>Organism:</td> </tr> <tr> <td>Suspected risk</td> <td>Organism:</td> </tr> <tr> <td>No known risk</td> <td></td> </tr> </table> Patient/client exposed to others with infection. e.g., D&V Yes/No	Confirmed risk	Organism:	Confirmed risk	Organism:	Suspected risk	Organism:	No known risk	
Confirmed risk	Organism:								
Confirmed risk	Organism:								
Suspected risk	Organism:								
No known risk									
If the patient/client has diarrhoeal illness, please indicate bowel history for last week: (Based on Bristol stool from scale see reverse side) Is the diarrhoea thought to be of an infectious nature? Yes/No									
Relevant specimen results (including admission screens – MRSA, glycopeptide-resistant enterococci SPP, <i>C. difficile</i>, mutli-resistant <i>Acinetobacter</i> SPP) and treatment information, including antimicrobial therapy: Treatment information: Other information: Is the patient/client aware of their diagnosis/risk of infection? Yes/No Does the patient/client require isolation? Yes/No Should the patient/client require isolation, please phone the receiving unit in advance.									
Signature of staff member completing form: Print name: Contact number:									

Appendix 5 Loose stool staff checklist

	Leicestershire Partnership Trust Infection Prevention & Control Team LOOSE STOOL STAFF CHECKLIST
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Infection Prevention & Control Checklist for a patient who has loose stools and or Vomiting of Unknown Origin Gastroenteritis.

	Date							
Patient Placement/ Assessment of Risk	Daily Check (Y/N)							
Patient Isolated in a single room with en-suite facilities own toilet/commode until 48 Hours asymptomatic and they have passed normal stool. If a single room is not available, an IPC risk assessment is completed.								
The Yellow IPC Isolation sign Must be placed on the door to the patient's room, In Mental health services on advice of the IPC team.								
Door Isolation Room is closed when not in use, if for any reason this is not appropriate then a Risk assessment must be completed, and outcome documented in patient Sytemone record.								
A Bristol stool chart is in use and patient bowels are being accurately recorded.								
Hand Hygiene								
All staff must use the correct 6 step technique for hand hygiene at 5 key moments with liquid soap and water.								
Hand hygiene Must be offered to patients after using the toilet and prior to mealtimes etc (Clinical handwash basin/wipes should be used where applicable).								
Personal Protective clothing								
Disposable Gloves and Apron should be worn, FRSM is advised for routine care if patient is								

vomiting. Staff to risk assess Visor and Gown if there is a risk of splash from blood/body fluids. Hand Hygiene must be carried out before donning and after doffing of PPE and before carrying out care with other patients.								
Safe Management of care equipment								
Single use items are to be used where possible or equipment that is dedicated to the patient whilst they remain in isolation.								
There are no non-essential items in the room (e.g., Excessive patient belongings, equipment, furniture etc).								
Twice daily decontamination of the patient equipment is in place using Chlorclean cleaning product.								
Remove any uncovered food items from patient's lockers/bedside tables.								
Laundry and Watse								
All laundry must be placed in a water-soluble bag, then a white outer bag, tied and placed in a linen basket.								
Clean linen must not be stored in the isolation room.								
All waste should be disposed of within the isolation room as clinical waste.								
Information for patients and their carers								
The patient has been given appropriate Information on their infection/isolation and have been provided with a patient information leaflet where available.								
If the patient is taking their soiled clothing home, carers have been issued with washing clothes at home information leaflet. Personal laundry has been placed in a water-soluble bag and then into a patient belongings bag before being given to the carer to take home.								

Staff initials (To be signed daily).

--	--	--	--	--	--	--	--

Date isolation ceased/terminal clean completed.....Signature.....

Date.....

Date specimen obtained:

Culture & Cdiff samples	Virology
1	1.
2.	2.
3.	3.

Appendix 6 Aide Memoire Lifelong Infection Clostridium difficile infection
(Inpatient setting)



Clostridium Difficile Infection Aide Memoir (Lifelong infection)

Consult Policy and isolate in a single room with:

- ✓ Ensuite/own commode
- ✓ Door closed.
- ✓ IPC yellow sign on door
- ✓ Dedicated equipment
- ✓ Care checklist completed daily.

Patient is
assessed
daily.

YES

- ✓ Stop Isolation Precautions
- ✓ Undertake terminal clean of patient room, including change of curtains.

Clostridium Difficile (CDT) guidance -Guidelines for patient Isolation

Personal Protective Equipment (PPE)

Gloves, Apron & FRSM (Risk assess visor and Gown if risk of splash from Blood/body fluids)

Hand Hygiene

Use soap and water staff to remain BBE.

Environment

Area to be cleaned twice daily, Full post infection clean including change of curtains once SIPS have been stepped down.

Laundry

All linen and laundry will need to be treated as infective and will need to be disposed of in the appropriate waste streams.

Waste

All waste will need to be treated as infective waste and will need to be disposed of into the appropriate waste streams.

Period of Isolation-Until the patient has had no further episodes of loose stools (Type 5-7) for 48 hours and they have passed a normal stool, or they are discharged Home.

Transmission route

Direct contact, Droplet & Airborne

For further advice contact the IPC team on 01162952320

Appendix 6 Aide Memoire Lifelong Infection Clostridium difficile infection (community setting)



Leicestershire Partnership Trust Infection Prevention & Control Team

Clostridium Difficile (CDT)



Clostridium Difficile Infection Aide Memoir (Lifelong infection)

What is this?

Clostridioides difficile (also known as *Clostridium difficile*, *C. difficile* or *C. diff*) is a type of bacteria that can cause diarrhoea and can be highly contagious. It often affects people who have taken antibiotics as these types of medicines can disrupt the normal flora of the gut allowing *C. diff* to proliferate.

For further guidance please refer to: LPT The-management-of-patients-with-Diarrhoea-and-or-vomiting-suspected-or-confirmed-infectious-policy

What are the signs & symptoms?

Symptoms of *C. diff* can vary from mild to moderate but remain extremely unpleasant for those affected.

Symptoms include:

Diarrhoea which can be watery and may contain blood/mucous.

High temperature

Loss of appetite

Nausea/vomiting

Abdominal pain/cramping

What is the incubation period for this infection? The incubation period for *C. difficile* infection is generally around 7 days from point of exposure, however the exact length of time the incubation period can vary, and some individuals may not develop symptoms immediately after exposure.

How long are IPC measures required for?

IPC visiting precautions will need to remain in place until the patient has had no loose stools (Type 5-7) for 48 hours and they have passed a normal stool.

Clostridium Difficile (CDT) Guidelines for patient visits

Personal Protective Equipment (PPE)

Gloves, Apron (Risk assess visor and Gown if risk of splash from Blood/body fluids)

Hand Hygiene

Use soap and water staff to remain BBE.

Environment

Only take minimal amount of equipment required during visit-

Post visits all equipment will need to be cleaned with Chlo clean.

Waste

All waste will need to be treated as infective waste and will need to be disposed of into the appropriate waste streams.

Risk factors

Risk factors include recent use of antibiotics, patients over the age of 65, immunosuppressed individuals and those who have recently been admitted into healthcare facilities.

Transmission route

Direct contact, Droplet & Airborne

For further advice contact the IPC team on 01162952320

Appendix 7 Infection Prevention & Control risk assessment for patients with a known or suspected infection who are unable to source isolate.

	Leicestershire Partnership Trust Infection Prevention & Control Team Infection Prevention & Control Risk Assessment For patients with a known or suspected infection who cannot be isolated
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This assessment tool must be Reviewed/completed daily during period of isolation.

	Comments	Date	Date	Date	Date	Date	Date	Date	Daily assessment completed by staff Initials
Known or Suspected infection e.g., Unexplained loose stools, MRSA, C. difficile, Covid, influenza etc	Please state:								
Infection Control Risks identified , e.g., unable to isolate, unable to close door of isolation room/area.	Please state:								
Reason why unable to isolate/ close door to isolation room , e.g., falls risk, observation required, clinical condition.	Please state:								

Additional Precautions put into place: e.g., Nursed at end of ward, trolley containing appropriate PPE at end of bed, next to low-risk patients, clinical waste bin placed next to bed space:	Please state:								
Infection Prevention and control team have been informed of patient's admission and are aware of inability to adhere to IPC policies.	Please state:								
Summary detail of resolution									

Daily risk assessments are no longer required.

Staff Signature:

Date:

Appendix 8 Transmission based precautions/source isolation posers

Transmission based precautions are the second tier of basic infection control and are to be used in addition to standard precautions for patients who may be infected or colonised with certain infectious agents for which additional precautions are needed to prevent further infection transmission.

Type of precaution	Definition/when to be used	Isolation	PPE	Transport/movement of patient
Contact	Patients with known or suspected infections that represent an increased risk for contact transmission such as CDT, CRO or MRSA.	• Appropriate patient placement • Single room with en-suite if available	• Gloves • Apron • Gown (only if risk of splash from blood/bodily fluids) <i>Don PPE before room entry and doff appropriately before exiting the patient's room. Ensure hands are washed using soap and water.</i>	Risk assessments must be completed for any activities outside the patient's room. Areas visited outside the patient room must be cleaned after use.
Droplet	Patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing or talking.	• Appropriate patient placement • Single room with en-suite if available	• Gloves • Apron • Gown (only if risk of splash from blood/bodily fluids) • FRSM to be worn by staff and patient (if able to) <i>Don PPE before room entry and doff appropriately before exiting the</i>	Risk assessments must be completed for any activities outside the patient's room. Areas visited outside the patient room must be cleaned after use.

			<i>patient's room. Ensure hands are washed using soap and water.</i>	
Airborne	Patients known or suspected to be infected with pathogens transmitted by the airborne route such as Tuberculosis, Measles, Chickenpox, disseminated herpes zoster.	• Appropriate patient placement • Single room with en-suite if available • Restrict susceptible healthcare personnel from entering room of patients known or suspected to have Measles, Chickenpox, disseminated zoster or Smallpox if other immune healthcare professionals are available.	• Gloves • Apron • Gown (only if risk of splash from blood/bodily fluids) • FRSM/FFP3 to be worn by staff dependent on infection type* *Discuss with the IPC team <i>Don PPE before room entry and doff appropriately before exiting the patient's room. Ensure hands are washed using soap and water.</i>	Risk assessments must be completed for any activities outside the patient's room. Areas visited outside the patient room must be cleaned after use.

Airborne Precautions

A set of measures used to prevent the spread of infectious diseases transmitted through the air

Anyone entering this room must wear the following Personal Protective Equipment (PPE):

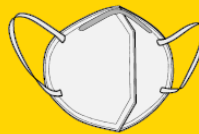
Gloves



Apron



FFP3 mask



PPE applies whether or not contact with the patient or patient's environment is anticipated.



Patient Visitors

Please do not enter until you have spoken with the nursing team who will inform you of any precautions that may be required during your visit.

Droplet Precautions

A set of measures used to prevent the spread of infections
that are transmitted through respiratory droplets

Anyone entering this room must wear the following Personal
Protective Equipment (PPE):

Gloves



Apron



PPE applies whether or not contact with the patient or patient's
environment is anticipated.



Patient Visitors

Please do not enter until you have spoken with the nursing team who will
inform you of any precautions that may be required during your visit.

Contact Precautions

A patient with a known or suspected infection that can be spread through direct or indirect contact

Anyone entering this room must wear the following Personal Protective Equipment (PPE):

Gloves



Apron



PPE applies whether or not contact with the patient or patient's environment is anticipated.



Patient Visitors

Please do not enter until you have spoken with the nursing team who will inform you of any precautions that may be required during your visit.

Appendix 9 Putting on and removing Personal Protective equipment (PPE)

Before undertaking any procedure or task, staff should assess the risk of exposure to blood and/or other body fluids, non-intact skin, mucous membranes, or any equipment or items in the care environment that could be contaminated, and wear PPE if required. PPE must protect adequately against the risks associated with the procedure or task. The items of PPE worn will vary based on the type of exposure anticipated, and not all items of PPE may be required.

Putting on Personal Protective Equipment (PPE)

Before beginning, check which items of PPE are required and that these are available in the correct size.

The order for putting on PPE is Apron or Gown, Fluid Resistant Surgical Mask (FRSM) Respiratory Protection Equipment (RPE) (FFP3), Eye protection then gloves.

1  Apron: Pull over head and tie securely at the back.	2  Gown: Fully cover torso neck to knees, arms to end of wrist and wrap around the back. Fasten at the back.	3  FRSM or RPE (FFP3)¹: Secure ties or elastic bands at middle of head and neck. Fit flexible band to nose bridge. Fit snug to face and below chin. Respirators must be fit checked if being worn.
4  Eye Protection (Goggles/Face Shield): Place over face and eyes and adjust to fit.	5  Gloves: Pull on taking care to minimise contamination of the outer surface by holding gloves at the wrist opening only. Extend to cover wrist (over gown cuffs, if applicable).	

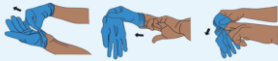
Removing Personal Protective Equipment (PPE)

Removing Personal Protective Equipment (PPE)

When removing PPE, the correct technique is essential to avoid touching the most contaminated areas of PPE e.g., the outside of gloves and front of aprons/gowns, eye protection, and FRSM/RPE.

The order for removing PPE is Gloves, Apron or Gown, Eye Protection, then FRSM/RPE (FFP3) ¹.

6



Gloves: Pinch and lift the outside of the glove in the palm area with the opposite gloved hand; peel off while turning inside out. Hold the removed glove in the gloved hand. Slide two fingers of the ungloved hand under the remaining glove at the wrist. Peel the second glove off over the first glove and discard.

7



Apron: Unfasten or breakneck ties and allow apron to fall forward. Unfasten or break waist ties and pull apron away from the body touching the inside only.

Fold or roll into a bundle and discard.

8



Gown: Unfasten neck, then waist ties. Remove using a peeling motion; pull gown from each shoulder towards the same hand turning gown inside out. Hold removed gown away from body, fold or roll into a bundle and discard.

9



Eye Protection (Goggles/Face shield): Handle eye protection only by the headband or the sides. Face shields/goggles should be removed by grasping sides and pulling directly forward, away from face. To remove goggles with an elasticated headband, tilt head forward and grasp the headband with index fingers and thumbs, lift the headband upwards whilst pushing frame away from face, lower goggles away from face and discard.

10



FRSM or RPE (FFP3) ¹: Unfasten the ties.

- first the bottom, then the top or, if elasticated, pull top and bottom elastics together. Handling the ties/elastics only pull away from the face without touching front of mask/respirator and discard.

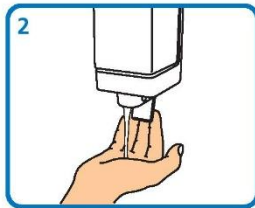
Appendix 10 How to wash your hands



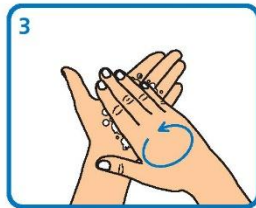
Hand-washing technique with soap and water



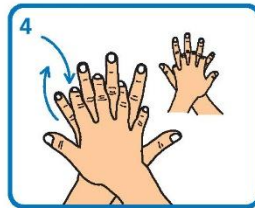
Wet hands with water



Apply enough soap to cover all hand surfaces



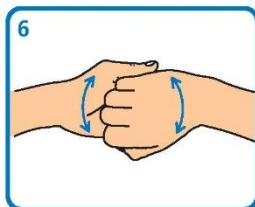
Rub hands palm to palm



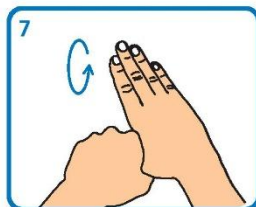
Rub back of each hand with palm of other hand with fingers interlaced



Rub palm to palm with fingers interlaced



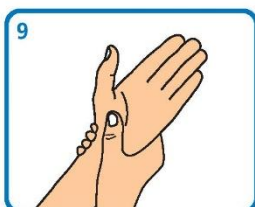
Rub with back of fingers to opposing palms with fingers interlocked



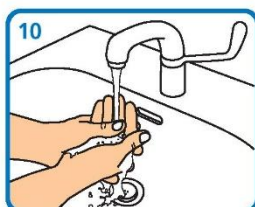
Rub each thumb clasped in opposite hand using a rotational movement



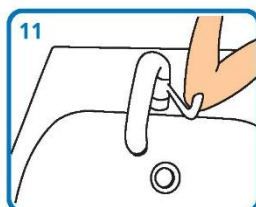
Rub tips of fingers in opposite palm in a circular motion



Rub each wrist with opposite hand



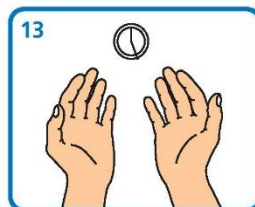
Rinse hands with water



Use elbow to turn off tap



Dry thoroughly with a single-use towel



Hand washing should take 15–30 seconds



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



Appendix 11 Post infection cleaning sign off form

Guidance on how to use the Post infection Clean/Terminal Clean request sign off form.

This sign off form has been developed to give assurance that the post infection clean/terminal clean is completed to a standard that is acceptable and all elements are carried out to a satisfactory level. It has been developed following concerns from a number of ward staff around the standards of cleaning and decontamination of the environmental area following the discontinuation of source isolation precautions.

Who should complete the form?

The member of nursing staff that is requesting the post infection/terminal clean should complete the form relating to the request.

The member of nursing staff that is checking the elements to ensure that the post infection/terminal clean is undertaken to an acceptable standard should complete those elements of the form.

If any elements are not deemed to be to an acceptable standard this should be rectified at the time and before any source isolation precautions are discontinued if the patient is remaining in bed space, or a new patient is transferred into that bed space.

If the area consists of several bed spaces (i.e. a bay or dormitory) then all elements of that area need to be cleaned to an acceptable standard before the form is signed off

The elements that are to be cleaned and decontaminated by nursing staff also need to be completed correctly prior to the form being signed off.

The elements of the form can be completed by a healthcare assistant; however, the form must be signed off by a qualified nurse who has overall responsibility for ensuring the elements have been completed satisfactorily.

When should the form be completed?

The form should be completed each time a post infection clean/terminal clean is requested. Source isolation precautions need to be continued until the post infection clean/terminal clean has been carried out in its entirety.

Where should the form be stored?

These forms should be stored locally; a suggestion is that they are stored within the assurance folder, but this is not mandatory. The important factor to be considered is that they need to be available for audit purposes and to be checked during matron walk rounds/IPC walk rounds.

Who should be form escalated to?

If there are any issues with the cleaning and decontamination of the environment, they need to be escalated at the time. The issues also need escalating to the ward manager/matron so that trends can be monitored through the service directorate IPC meeting and the cleaning forum.

Infection Prevention and Control Team

Post infection clean/terminal clean request sign off form.

Hospital **Ward**

.....

	Yes/No/comment
Person requesting clean	
Date clean requested	
Time clean requested	
Bed space or area required for clean	
Person accepting task	
Date clean commenced	
Time clean commenced	
Chlor clean used	
Domestics wearing appropriate PPE	
Yellow coded cleaning equipment	
All areas checked as clean:	
Building: Floor Windowsil l etc.	
Fixtures and Fittings: Light fittings Switches Curtain Rails Shelving Door handles radiators etc.	
Furniture: Table Wardrobe/cupboard Chair. Bed frame etc.	
En-suite: toilet Fixtures and fittings Floor	

Bin: Outside New bin liner	
Hand Wash sink Deb dispensers. Paper towel dispenser	
Any other items specific to the area	

Items to be cleaned and decontaminated by nursing staff.

Nursing Duties

	Yes/No/Comments
Wardrobes and cupboards emptied and cleaned inside	
Air mattress sent to Medstrom for decontamination, or non-air mattress cleaned at ward level using chlor clean	
All sundry items removed and disposed of	
All nursing equipment cleaned and decontaminated using chlor clean	
All beds within bay/area/room that were. in areas receiving source isolation precautions made with clean linen	
Any other items (please specify)	

Signed as completed by qualified nurse.

Name

.....

...

Designation

.....

Date

.....

Time

.....