Norovirus, Diarrhoea and/or Vomiting Outbreak Policy
NB This policy must be read in conjunction with the Outbreak Management Policy

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Brief Summary of Document: The purpose of this policy is to provide staff who work in the health care setting / hospital wards of Hywel Dda Health Board with a robust framework of principles and practices to enable them to effectively manage and control any outbreak of Norovirus

To be read in conjunction with: Isolation/Infectious Diseases Policy/ Standard Infection Precaution Policy/ Personal Protective Equipment Policy

Classification: Clinical  Category: Policy  Freedom Of Information Status: Open

Authorised by: Caroline Oakley  Job Title: Director of Nursing  A signed copy is kept in Corporate Services
**Norovirus, Diarrhoea and/or Vomiting Outbreak Policy**

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**CONSULTATION**

- **Individual(s):**
  - Infection Control Nurses
  - Date(s): November 2012

- **Group(s):**
  - County Heads of Nursing, Medical Director, Assistant Director of Nursing Practice
  - Date(s): January 2013

- **Committee(s):**
  - Infection Prevention & Control Committee
  - Date(s): November 2012

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**RATIFYING AUTHORITY**

(in accordance with the Schedule of Delegation)

**NAME OF COMMITTEE**

- Clinical Policy Review Group
  - FR
  - 13/11/12

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**Date Equality Impact Assessment Undertaken**

- 8th November 2012

**Group completing Equality impact assessment**

- Jackie Hooper
- Tracey Nicholas

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**Please enter any keywords to be used in the policy search system to enable staff to locate this policy**

- Isolation Infections, Outbreak Management, Norovirus

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**Norovirus, Diarrhoea and/or Vomiting Outbreak Policy**
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<td>Policy Coordinator</td>
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<tr>
<td>Advertise Published policy via global email</td>
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<td>Awareness workshops across the Health Board</td>
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1. EXECUTIVE SUMMARY

- An outbreak of infection is generally deemed to have occurred when multiple individuals become infected with the same organism within a healthcare setting. Suspicion of an outbreak includes the occurrence of two or more cases linked in time or place with symptoms of nausea, diarrhoea and/or vomiting.
- Suspected Norovirus outbreaks must be reported immediately to:
  a. County IP&CT (Consultant microbiologist out of hours).
  b. County Management Team to include the County Head of Nursing/County General Manager/County Assistant General Manager/Acute Service Nurse Manager/Senior Nurse/Bed Manager
  c. Clinical Team responsible for affected area
  d. Hospital Director for Clinical Care
- On closure of the ward the County IP&CT will call an outbreak meeting as soon as possible which will be then convened daily as a minimum during the course of the outbreak.
- Ward/Departmental managers are responsible for completing an IR1 on the electronic datix form in relation to the outbreak incident.
- The isolation of cases within single rooms and bays as opposed to the early closure of complete wards allows flexibility of response and the early terminal cleaning and re-opening of affected sub-ward areas. Only when there is evidence of a failure of containment within all available single-occupancy rooms and bays must whole ward closure be considered.
- Hand hygiene is considered to be the single most important practice in reducing the transmission of infectious agents including Norovirus. Good hand hygiene is essential during outbreaks.
- Respiratory hygiene and cough etiquette is designed to contain respiratory secretions caused by excessive vomiting which can generate aerosols.
- Use gloves and apron to prevent personal contamination with faeces or vomit.
- The use of shared equipment must be avoided wherever possible through the use of disposables and reusable equipment dedicated for single patient use for the duration of the outbreak.
- Routine environmental cleaning in accordance with current national & local standards and specifications must be enhanced during an outbreak of norovirus. Key control measures include increased frequency of cleaning, environmental disinfection with Chlorine Dioxide (Tristel) and prompt clearance of soiling caused by vomit or faeces.
- For all in-patient areas all linen must be processed as infected linen (please refer to Management of Linen policy) during the Outbreak.
- During an outbreak all waste must be placed into orange infected waste bags for disposal.
- The vomit and faeces of a symptomatic norovirus patient are highly infectious. To prevent exposure to the virus and minimise the likelihood of transmission, environmental contamination with vomit and faeces must be cleared immediately whilst using appropriate PPE.
- Ensure all staff are aware of the norovirus situation and how norovirus is transmitted and that all staff are aware of the work exclusion policy and the need to go off duty at first symptoms.
- Staff with symptoms to remain off duty until 48 hours symptom free.
- The visitor who has norovirus is a transmission risk and the visitor who does not have norovirus is at risk of contracting it during a visit. The first is obvious infection.
prevention and control hazard but the second is usually not, although there are exceptions (e.g. children who may introduce it to their school). Restrictions on visiting (other than by symptomatic persons) are mainly intended to assist ward staff in outbreak control by reducing the distractions caused by having to attend to visitors.

- If a clinical area or unit has both closed and non-closed areas within it, the non-closed areas will remain open to admissions but a risk assessment must be made as to whether patient transfers from the non-closed areas to other clinical areas must be delayed until the risk of the outbreak emerging within the non-closed area is sufficiently low.
- Closure refers to the restriction of incoming and outgoing personnel, equipment, materials (including patient notes) to an unavoidable minimum. The fewer times that the portal of a closed area is crossed, the less is the risk of transmission of virus and further spread to other areas
- The ward/unit is not to be reopened until all affected patients are 48 hours symptom free and terminal cleaning has been completed. The Infection Prevention and Control Team (IPCT) shall then declare the Outbreak over.

2. INTRODUCTION
This policy is based on a principle of minimising the disruption to services and maximising the ability of Hywel Dda Health Board to deliver appropriate care to patients safely and effectively. This policy advocates an escalatory system of isolation using single rooms and cohort nursing prior to complete ward closure without compromising patient care.

3. POLICY AIM
The general public and staff have a right to expect any potential hazards in a healthcare environment to be adequately controlled. All staff must possess an appropriate awareness of their role in the prevention and control of infection in their area of work. Not only is this part of their professional duty of care to the patients with whom they are involved, but it is also their responsibility to themselves, to other patients and members of staff under the Health & Safety at Work Act (1974). This policy provides a framework for the reporting, investigation and control of outbreaks within in-patient areas of Hywel Dda Health Board and to assist staff in the safe management and control of any outbreak of infection.

The main aims of this policy are:
- To ensure staff are able to appropriately identify a Norovirus outbreak situation and implement appropriate infection prevention and control measures / restrictions.
- To ensure all relevant parties are informed of the Norovirus outbreak situation and have a clear understanding of their role and duties in the outbreak situation.
- To manage and control the spread of infection.
- To quickly identify the source, method of spread and causative organisms responsible for the outbreak.
- To disseminate information concerning the Norovirus outbreak efficiently.

4. OUTBREAK RECOGNITION
An outbreak of infection is generally deemed to have occurred when multiple individuals become infected with the same organism within a healthcare setting. It is the responsibility of the Infection Prevention & Control Team (IP&CT) to define an outbreak and risk assess the need to bring the Health Board’s outbreak policy into action. Suspicion of an outbreak includes the occurrence of two or more cases linked in time or place with symptoms of nausea, diarrhoea and/or vomiting.
5. OUTBREAK REPORTING PROCEDURE
Suspected Norovirus outbreaks must be reported immediately to:
- County IP&CT.
- County Management Team to include the County Head of Nursing/County General Manager/County Assistant General Manager/Acute Service Nurse Manager/Senior Nurse/Bed Manager
- Clinical Team/Staff responsible for affected area
- Hospital Director for Clinical Care
- Support Services

Out of Hours suspected outbreaks must be reported to:
- The Consultant microbiologist on call
- The Night Nurse Practitioner/Site Manager

Please refer to Appendix 1 Diarrhoea and Vomiting Outbreak Advice Flowchart and Appendix 2 Norovirus Tree for advice regarding patient management.

Once the IP&CT team have confirmed an outbreak then a Serious Incident Form needs to be completed by the Acute Service Nurse Manager/Assistant General Manager and the County Infection Prevention & Control Nurse (IPCN). This needs to be submitted to the County Quality Manager who will liaise with the Executive Director on call to obtain signatory.

If the IP&CT do not deem the situation as an outbreak, then the IP&CT will inform ward/unit staff involved in making the initial referral of a suspected outbreak situation and the reason why it is not deemed an outbreak.

6. OUTBREAK MEETING AND MEMBERSHIP
On closure of the ward the County IP&CT will call an outbreak meeting as soon as possible which will then be convened daily as a minimum throughout the outbreak. An Outbreak Control Team (OCT) meeting will be convened at the earliest opportunity. The extent of the membership of this group will depend on the extent/severity of the outbreak. The Acute Service Nurse Manager/General Manager will be responsible for chairing and organising the meeting and also ensure dissemination of the outbreak minutes to all managers so that all departments are aware of the outbreak situation. Due to potential implications of bed flow with closed wards then it may be appropriate at times for the daily Bed Management Meeting and OCT Meeting to be amalgamated especially as membership of OCT and bed management will overlap.

6.1 Membership:
- Nurse in charge of ward or a representative.
- Senior nurse/senior manager of outbreak area.
- County General Management Team
- County IP&CT.
- Lead Clinician of outbreak area.
- Hotel Services Manager/Deputy.
- Bed manager.
- Acute Service Nurse Manager.
- Occupational Health Doctor/Nurse.
- Communication/media/press officer.
- Secretarial support – minutes/photocopying etc.
- Clinical support Services

NB. Other members of staff may be included in the meetings as necessary e.g.
6.2 Outbreak Meeting
The Terms of Reference of the outbreak meeting will be complied with. A member of the IP&CT will take responsibility for taking minutes of the meeting and the Acute Service Nurse Manager /deputy will then agree the minutes and cascade them appropriately. The Acute Service Nurse Manager / deputy will take responsibility for chairing the meetings and ensuring all senior staff are kept informed of meetings i.e. Chief Executive, Director of Nursing and Midwifery. It is the responsibility of the Consultant Microbiologist / Senior Nurse IP&C to update the CCDC as appropriate.

6.2.1 Terms of Reference of the Outbreak Control Team
- To be advised by the IP & C Nurse and consultant Microbiologist on the likely source and cause of the outbreak.
- To monitor the effectiveness of infection prevention & control measures.
- To facilitate the optimal clinical care of patients.
- To receive information relating to the outbreak / incident and the results of epidemiological and microbiological investigations including data collection and analysis, and to identify actions that may reduce likelihood of future outbreaks.
- Decide the need for outside help and expertise.
- To manage the communication between relevant agencies and those with a legitimate interest in the outbreak, including patients and their families.
- To define the end of the outbreak.
- To evaluate the lessons learned and prepare a report / recommendations of the outbreak for the Infection Prevention & Control Committee and the Health Board.
- To provide clear guidelines for communication with patients, relatives, staff and the general public.
- Ensure that individuals with assigned individual responsibilities within the outbreak policy are executing their roles.

6.2.2 Agenda for Initial Outbreak Meeting
The initial agenda for the first outbreak meeting will include:
- The outbreak policy and individual actions / responsibilities.
- Initial assessment of the outbreak.
- Case definition.
- Reporting mechanisms.
- Management / investigation of outbreak.
- Control measures and effectiveness.
- Communication channels.
- Frequency of Outbreak Meetings.
7. ROLES / RESPONSIBILITIES / FUNCTIONS
It is important that the following key staff understand their individual roles in the outbreak situation in order to effectively manage and control the outbreak situation:

7.1 Chief Executive
The Chief Executive has ultimate responsibility for infection prevention and control within Hywel Dda Health Board. This responsibility is delegated to the Director of Nursing and Midwifery who will inform the Chief Executive immediately on being informed of the outbreak situation by the Infection Prevention & Control Team.

7.2 Executive Director and Senior Managers
The Director of Nursing and Midwifery has delegated responsibility for infection prevention and control in the Health Board and along with senior managers must be familiar with the outbreak policy and support the implementation of the policy throughout the organisation. In the event of an outbreak the Executive Director of Nursing and Midwifery and Senior Managers must comply with their individual responsibilities as laid out in the Hywel Dda Health Board’s outbreak policy. The Executive on call will inform the Welsh Government using the Serious Incident reporting procedure.

7.3 County Management Team
The County Management Team is responsible for regular communication and update to the Executive Director on call and to the communication/media department on the outbreak situation and in the absence of the Consultant Microbiologist liaise with the Consultant in Communicable Disease Control (CCDC) as appropriate.

7.4 Senior Nurse - Infection Prevention and Control
Operational responsibility for infection prevention and control within the Health Board lies with the Senior Nurse Infection Prevention & Control who is responsible for supporting the County IP&CTs during the outbreak of infection and ensuring that the outbreak policy is complied with. The Senior Nurse of IP&C is responsible for ensuring mandatory training includes education on outbreak management and control. The Senior Nurse of IP&C is responsible for regular communication and update to the Director of Nursing and Midwifery and the communication / media department on the outbreak situation and in the absence of the consultant microbiologist liaise with the CCDC as appropriate.

7.5 County Infection Prevention & Control Team
The County IP&CT will liaise with the outbreak area(s) and assess the control of infection and assess all control measures in place and revise as necessary. The County IP&CT will assess the scale of the outbreak & circulate situation reports daily. This assessment will inform managers of the possible duration and implication on hospital services / activities of the outbreak as well as any additional resources / manpower required for the outbreak area. All updated information must be communicated and agreed at the outbreak control team meeting prior to circulation within the County/Health Board.

7.6 Ward / Unit Managers / Department Leads
Ensure all staff are familiar with the outbreak policy and control measures and ensure the policy is complied with. The ward / unit managers / department leads are responsible for ensuring any deficits in resources such as medical and surgical supplies are promptly acted upon. They are also responsible for ensuring non-essential staff and visitors are excluded for the outbreak area and that there is appropriate staffing of the outbreak area (inclusive of staff movement restrictions).
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7.7 All Clinical Staff
All health care workers are required to be familiar with the outbreak policy and comply with its contents and are responsible for informing the IP&CT and their manager immediately of any situation whereby an outbreak is suspected.

7.8 Ward / Unit Staff - On Suspicion of an Outbreak in a Ward or Clinical Setting:
Inform County Management Team to include the County Head of Nursing/ Acute Service Nurse Manager/ General Manager/Senior Nurse/ Hotel Services Supervisor of suspected outbreak. Inform the County IP&C Nurse or the on-call microbiologist out of hours. Inform bed manager of suspected outbreak and possible bed flow restrictions in the outbreak area i.e. partial or full closure of beds and restricted transfers / discharges.

Ward/Departmental managers are responsible for completing an IR1 on the electronic Datix form in relation to the outbreak incident.
NB a risk assessment must be taken on all staff who are working in the affected area to identify those that may have to be excluded from working in the identified area e.g. pregnant members of staff, immunosuppressed or any other issues that may need to be considered.

8. WARD / UNIT STAFF – ON CONFIRMATION OF AN OUTBREAK BY THE IP&CT:
On confirmation of an outbreak the following Standard Infection Control Precautions (SICP’s) must be implemented with an appropriately placed outbreak / ward closure posters at entrance to ward.
The following instructions must be implemented;

8.1 Patient Placement
The isolation of cases within single rooms and bays as opposed to the early closure of complete wards allows flexibility of response and the early terminal cleaning and re-opening of affected sub-ward areas. Only when there is evidence of a failure of containment within all available single-occupancy rooms and bays must whole ward closure be considered.
If a patient can be safely discharged home, they must be provided with appropriate patient information to enable their clinical well-being and to minimize the risk of spread within the household.

Close affected bay(s) to admissions and transfers. Healthcare Staff must;

- Keep doors to single-occupancy room(s) and bay(s) closed
- Place signage on the door(s) informing all visitors of the closed status and restricting visits to essential staff and essential social visitors only
- Place patients within the ward for the optimal safety of all patients

This must be carried out according to local IPC policies with reference to norovirus control measures.
b. Single cases without available single-occupancy room provision.
When single-occupancy rooms are not available, a symptomatic patient must be nursed wherever they are at the time they become symptomatic. Other patients in the immediate vicinity of a symptomatic case are considered as exposed contacts. If the patient is in a bay, then that bay must be closed and all patients in it must be managed as potential cases.
c. Multiple cases in excess of available single-occupancy room provision. Those cases who cannot be placed in single-occupancy rooms must be cohort nursed in bays. Sometimes there may be individual cases scattered through multiple bays with a larger number of asymptomatic exposed patients in adjacent beds. In such situations, each bay containing a case must be closed and managed as a separate IPC unit.
d. Open plan wards. The presence of even a single case on an open plan ward can be problematic. Such wards have no physical barriers between patients and additional attention needs to be given to the distance between beds for optimal prevention of transmission of infection. Also, attention will need to be given to the requirements of single sex accommodation. In such circumstances, there may be no alternative to whole ward closure. However, local solutions must be sought whereby a degree of physical segregation may be made possible.
e. Norovirus isolation wards. The creation of short term norovirus isolation wards is not recommended because, unless these wards are part of the routine configuration of the hospital, there may be an unacceptable safety risk to patients as a result of suboptimal management of their other medical conditions. The routine transfer of patients into an isolation ward does not prevent (or even perhaps reduce) the continuing outbreak on the original wards. Also, norovirus illness is of short duration. There may however, be a role for such a ward in hospitals experiencing prolonged outbreaks but careful selection of patients will be required in order to avoid compromising patient safety.
f. Decant Wards. If two or more wards are affected by a norovirus outbreak, in the later stages of the outbreak there may be value in moving all infected patients and recovered patients to one ward to allow earlier cleaning and re-opening of an empty ward.
g. Multiple Ward closures. Organisations must recognise the risk of multiple wards being affected by norovirus outbreaks and they must consider, during their preparedness or winter pressures planning, the impact of such a situation on their overall activity.
NB In the event of a bed crisis any decision to admit to an affected ward must be discussed between the Infection Prevention and Control Team, the Site Manager and the Nurse in charge of the ward.

8.2 Surge Capacity Consideration
Acute Service Nurse Manager and the Site Manager will discuss any potential areas for surge capacity to accommodate emergency activity continuation of service provision.

8.3 Hand Hygiene
Hand hygiene is considered to be the single most important practice in reducing the transmission of infectious agents including Norovirus. Good hand hygiene is essential during outbreaks. All staff and patients must;

- Use liquid soap and warm water as per WHO 5 moments for Hand Hygiene
- Encourage and assist patients with hand hygiene especially at meal times and toileting.

Alcohol based hand rubs (ABHRs) must be used for hand hygiene and must be available to staff as near to the point of care as possible.
If hands are visibly dirty or soiled and/or when exposure to gastro-intestinal infection e.g. norovirus, is suspected/proven, ABHR must not be used alone and hands must be washed first with non-antimicrobial liquid soap and water.
8.4 Respiratory Hygiene/Cough etiquette
Respiratory hygiene and cough etiquette is designed to contain respiratory secretions caused by excessive vomiting which can generate aerosols:
- cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose
- dispose of all used tissues promptly into an orange waste bin
- wash hands with liquid soap and warm water after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions; and
- keep contaminated hands away from the mucous membranes of the eyes and nose

Staff must promote respiratory hygiene and cough etiquette to all individuals and help those who need assistance with containment of respiratory secretions e.g. those who are immobile will need a receptacle (e.g. plastic bag) readily at hand for the prompt disposal of used tissues and offered hand hygiene facilities.

8.5 Personal Protective Equipment (PPE)
Use gloves and apron to prevent personal contamination with faeces or vomit. Consider use of face protection with a mask only if there is a risk of droplets or aerosols. Hand hygiene must be performed on removal of any personal protective equipment.

8.6 Management of Care Equipment
The use of shared equipment must be avoided wherever possible through the use of disposables and reusable equipment dedicated for single patient use for the duration of the outbreak.
Decontaminate all other equipment immediately after use.

8.7 Environmental Cleaning/Decontamination
A clean and safe environment is essential for effective Infection Prevention and Control. Routine environmental cleaning in accordance with current national & local standards and specifications must be enhanced during an outbreak of norovirus. Key control measures include increased frequency of cleaning, environmental disinfection with Chlorine Dioxide (Tristel) and prompt clearance of soiling caused by vomit or faeces. Remove exposed foods, e.g. fruit bowls, and prohibit eating and drinking by staff within clinical areas.

8.7.1 Disinfection
Effective cleaning and removal of organic soiling prior to disinfection is essential to maximise the effectiveness of surface disinfectants. Disinfection must be carried out with a solution of Chlorine Dioxide (Tristel) on a daily basis taking into account manufacturer’s guidance with regards to preparation, usage, contact times, storage and disposal of unused solution. Staff must wear appropriate protective clothing and follow standard infection control precautions.
It is essential that appropriate training of staff occurs and they have the knowledge to handle and use these products safely.

8.7.2 Environmental decontamination during an outbreak
Cleaning staff and other staff who undertake cleaning tasks must follow standard infection prevention & control precautions and wear appropriate personal protective equipment (PPE) including disposable gloves and apron
- Increase frequency of cleaning using dedicated domestic staff where possible and avoiding transfer of domestic staff to other areas
Clean from unaffected to affected areas, and within affected areas from least likely-contaminated areas to most highly contaminated areas
Use disposable cleaning materials including mops and cloths
Dedicate reusable cleaning equipment to affected areas and thoroughly decontaminate between uses e.g. mop handles and buckets
After cleaning with detergent, disinfect with Chlorine Dioxide (Tristel).
Pay particular attention to frequently touched surfaces such as bed tables, door handles and taps
The frequency of cleaning and disinfection of toilet facilities must also be increased including flush handles, toilet seats, taps, light switches and door handles
National and local colour coding for cleaning equipment must be adhered to, in order to avoid cross contamination

8.7.3 Terminal cleaning following discharge or transfer of patient, or resolution of symptoms for 48 hours
This can take place in the presence of recovered asymptomatic patients although it is preferable to empty a clinical area of patients beforehand. The principles of terminal cleaning cover the disposal of materials where possible, the removal of curtains, the rigour of cleaning, the disinfection of equipment and surfaces and the precise order in which individual tasks are carried out as follows:
1. Discard unused disposable patient-care items
2. If items cannot be appropriately cleaned, consider discarding these items
3. Remove window and privacy curtains avoiding unnecessary agitation and send for laundering
4. Remove bed linen and unused linen and send for laundering
5. Decontaminate all equipment in accordance with manufacturer’s instructions
6. Thoroughly clean all surfaces with a neutral detergent or consider the use of ultra heated dry steam vapour cleaning
7. Steam cleaning of upholstered furniture and bed mattresses present in rooms upon patient discharge is suggested
8. After cleaning, disinfect with Chlorine dioxide (Tristel).
The use of ultra heated dry steam vapour cleaning has been found to be effective for removing organic matter and can raise levels of microbiological cleanliness as well as aesthetic cleanliness.
In addition:
The use of upholstered furniture (unless manufactured with cleanable surfaces which can also be disinfected) and rugs or carpets in patient care areas is to be avoided as these objects are difficult to clean and disinfect effectively. Where they are in use then contamination with vomit or faeces must be cleaned immediately with a suitable cleaning/disinfecting product in accordance with manufacturer’s instructions. The use of chlorine dioxide will have a bleaching effect and must be avoided unless the fabric or carpet is compatible with chlorine. The use of steam cleaning is recommended. During an outbreak of norovirus the continued use of microfibre mops & cloths is dependent on compatibility with chlorine. Alternative chlorine compatible disposable microfibre or traditional cloths and mops must be used where microfibre materials in general use are not compatible with chlorine. Alternatively, disposable mop heads and cloths may be used during the outbreak.

8.8 Laundry
For all in-patient areas all linen must be processed as infected linen (please refer to Management of Linen policy) during the Outbreak.
Norovirus, Diarrhoea and/or Vomiting Outbreak Policy

Staff must follow standard infection control precautions including the use of PPE when handling used and soiled linen to minimise the risk of personal exposure to the virus.

- Linen and other items of laundry must not be held close to the chest to prevent contamination of the uniform (an apron must be worn).
- Staff must carefully handle used and soiled linen from symptomatic patients or residents avoiding unnecessary agitation of sheets during bed making to avoid dispersal of the virus into the environment.
- If clothing from symptomatic patients or residents is returned to relatives or carers for laundering, they must be given verbal and/or written instruction on how to safely launder the items in the home setting.
- Unused linen stored in an affected area e.g. isolation room or cohort bay, must be laundered before use by another patient or resident.

Washing at Ward level should be discouraged. Where this cannot be avoided washing machines must not be overloaded. Any segregation required prior to washing must be carried out before transport to the laundry area, precluding the need for additional handling within the laundry. Staff must never empty bags of linen onto the floor in order to sort the linen into categories as this increases the risk of virus transmission. Heavily-soiled items must also undergo a pre-wash/sluice cycle. To achieve best practice outcomes, an enhanced process must use a washing cycle that has either a thermal disinfection cycle that reaches 71°C for at least three minutes or 65°C for at least ten minutes. All items must go through a drying process (if the item is compatible) and stored in a clean area away from the laundry area and above floor level.

8.9 Prompt clearance of soiling and spillages

The vomit and faeces of a symptomatic norovirus patient are highly infectious. To prevent exposure to the virus and minimise the likelihood of transmission, environmental contamination with vomit and faeces must be cleared immediately whilst using appropriate PPE.

Prompt decontamination of soiling and spillages;
1. Wear appropriate PPE including disposable gloves and apron and fluid repellent surgical mask if indicated
2. Clear up bulk of spillage using paper towel and discard immediately into dedicated orange waste bag
3. Use fresh paper towel/disposable cloth to clean the area with neutral detergent and hot water. Dry the area
4. Then disinfect the area using a solution of 0.1% sodium hypochlorite (1000ppm available chlorine*)/ Chlorine Dioxide (Tristel) in accordance with manufacturer’s instructions
5. Dry the area thoroughly
6. Discard all PPE and disposable materials into the dedicated orange waste bag
7. Wash hands with liquid soap and warm water

8.10 Safe Disposal of Waste

During an outbreak all waste must be placed into orange infected waste bags for disposal.

8.11 Information for staff

- Ensure all staff are aware of the norovirus situation and how norovirus is transmitted (see Appendix 3 – Information for Health Care workers leaflet)
- Ensure all staff are aware of the work exclusion policy and the need to go off duty at first symptoms
HYWEL DDA LOCAL HEALTH BOARD

- Allocate staff to duties in either affected or non-affected areas of the ward but not both unless unavoidable (e.g. therapists)
- Avoid staff cross cover between affected and non-affected patients (ideally post affected staff to nurse affected patients).
- Only essential staff to visit ward, to reduce the risk of infection spreading to other areas, wards and departments
- The Infection Prevention and Control Team would recommend that staff take their breaks on the ward. Local arrangements to be made regarding this at the first meeting of the Outbreak Team.
- Hotel Services staff working on the affected wards must not provide cover to unaffected ward areas. Hotel Services Supervisor to ensure appropriate cover is provided.
- Agency Staff must not work on affected wards. However, Bank Nurses and Nurses from other areas could work on the ward providing:
  - They remain rostered to the affected ward for the duration of the outbreak.
  - They have their 2 days off before working on another ward.
  - They inform the Bank Nurse office.
- Staff with symptoms to remain off duty until 48 hours symptom free. A specimen must be submitted, either via the Occupational Health Department, or their GP. Refer staff reporting sick to Occupational Health Department.
- Limit the number of personnel accessing the ward; paramedical staff, such as Physiotherapy, Occupational Therapy must only enter the area if therapy is considered essential.
- Phlebotomists must not access the area for obtaining routine blood samples.
- Staff are advised not to leave ward during outbreaks, liaise with Hotel Services department to arrange portering duties/support wherever possible, e.g. deliver samples to laboratory.

**Staff to wear Infection Control scrub suits (contact Hotel Services Supervisor). At end of shift, scrubs to be placed in allocated linen bag; staff are not to wear scrubs outside the clinical environment.**

8.12 Information for visitors
The visitor who has norovirus is a transmission risk and the visitor who does not have norovirus is at risk of contracting it during a visit. The first is obvious infection prevention and control hazard but the second is usually not, although there are exceptions (e.g. children who may introduce it to their school).
Restrictions on visiting (other than by symptomatic persons) are mainly intended to assist ward staff in outbreak control by reducing the distractions caused by having to attend to visitors:
- Provide all affected patients and visitors with information on the outbreak and the control measures they must adopt (Appendix 4,5 + 6)
- Advise visitors of the personal risk and how they might reduce this risk. Visitors who have vomiting and/or diarrhoea. Visitors who are symptomatic must not visit until at least 48h after the resolution of their symptoms.
- Visits by children of school age must be discouraged for the duration of an outbreak because of the risk of sudden symptoms developing without warning in school.
- Visitors must be allowed in extenuating circumstances on the decision of the senior manager in the ward or home. Terminally ill patients, children, vulnerable adults and those for whom visiting is an essential part of recovery must be allowed visitors at the discretion of the senior manager. Clinical and social judgment needs to be applied sensitively and compassionately whilst recognising the duty of care for the health and
well being of all patients, staff and visitors. Those who have travelled a long distance, taken time off work, or in other ways have been significantly inconvenienced, may be allowed to visit patients on outbreak restricted areas provided that they observe IPC measures.

- All visitors must be made aware of the need to decontaminate hands before and after visiting.
- Non-essential visitors. Visits from newspaper vendors, hairdressers, mobile libraries and similar services must not be allowed to an outbreak restricted area until the outbreak is declared over and terminal cleaning successfully completed. However, provision of reading materials such as newspapers can be an important part of recovery and can be provided to patients in other ways which do not jeopardise outbreak control. Used reading materials must be disposed of as clinical waste.
- Appropriate instructions must be given to contractors before they enter a closed area. However, only work that cannot be postponed until after re-opening of the closed area must be allowed.

9. MANAGEMENT OF SUSPECTED AND CONFIRMED CASES
If a clinical area or unit has both closed and non-closed areas within it, the non-closed areas will remain open to admissions but a risk assessment must be made as to whether patient transfers from the non-closed areas to other clinical areas must be delayed until the risk of the outbreak emerging within the non-closed area is sufficiently low. This risk assessment will take account of the behaviour of the outbreak, the provision of estate and resources to maximise containment of the outbreak, the prevalence within the local community and other local factors. If there is a significant risk that patients in the non-closed areas might be incubating norovirus infection, then it would be prudent to restrict their transfers to other clinical areas for 48 hours after their most recent possible contact with a symptomatic case.

If a patient in the outbreak area requires an investigation, the patient’s clinician must decide if it is urgent or non-urgent. Those patients who require urgent investigations must be allowed to attend the department, e.g. X-ray etc. Contact the Infection Prevention and Control Team for advice. The investigating department must be informed prior to the patient visiting the department. The patient must be fast tracked through, preferably at the end of the session (if possible). Departmental staff must wear gloves and aprons. Strict hand hygiene to be adhered to at all times.

9.1 The definition of closure
This definition applies to single-occupancy rooms, bays, wards and other unit areas capable of segregation.

- Closure refers to the restriction of incoming and outgoing personnel, equipment, materials (including patient notes) to an unavoidable minimum. The fewer times that the portal of a closed area is crossed, the less is the risk of transmission of virus and further spread to other areas.
- Patients must only be transferred for investigations and interventions that cannot be safely delayed.
- There must be an **obvious boundary between open and closed areas** to signal to everyone that restricted access is in place. This boundary must consist of doors and high visibility signage. There must be provision of hand hygiene facilities at each boundary.
- All non-essential personnel must be prohibited from entering the closed area. This includes nonessential social visitors of patients.
Admissions to a closed area must be restricted to patients who are known to have been exposed to norovirus, whether potentially incubating, symptomatic, recovered or deemed unlikely to develop disease (e.g. patient with definite exposure who fails to develop symptoms).

Closed areas must, ideally, be self-contained with hand washing facilities and ensuite toilet facilities. The use of commodes and communal toilets may increase the risk of spread in an outbreak and this must be mitigated by the implementation of an intensive and frequent cleaning schedule.

Dedicated Healthcare staff must be assigned to closed areas for each work shift.

9.2 Avoidance of admission

A rise in the incidence of cases and outbreaks of norovirus in institutions often reflects a similar increased incidence in the wider community. It is important to keep the numbers of patients admitted to hospital with norovirus to an absolute minimum. The considerations which must form part of a local, multi-agency plan, involving local health protection organisations, Primary Care, Ambulance Service, Nursing and Residential Homes and Local Authorities, to ensure the avoidance of unnecessary admissions to hospital are set out below.

The avoidance of admission measures must include:

- A sensitive surveillance system to alert all agencies to any increase in norovirus activity and daily situation reports at times of significantly increased activity.
- Robust local communication channels between agencies
- Timely advice to General Practitioners about the diagnosis and management in the community of norovirus patients including the provision of outreach services for rehydration therapy
- The implementation of a hospital norovirus admissions protocol to include:
  a. Immediate triaging of patients with vomiting and/or diarrhoea to a segregated area close to the relevant hospital portal (e.g. A&E, Admissions Unit)
  b. Rapid clinical assessment of the patient by a doctor with full competence to decide on the destination of the patient.
  c. The deployment of outreach services to the patient’s home to manage rehydration in those cases for which simple discharge home is not sufficiently safe.
  d. The admission of patients to be restricted only to situations in which the diagnosis is significantly uncertain or complications are a risk and in which simple rehydration is unlikely to suffice.

9.3 Clinical treatment of Norovirus

The mainstay of the clinical treatment of norovirus is the avoidance or correction of dehydration.

This may be achieved through any standard oral rehydration regimen in patients who can tolerate oral fluids. For those who cannot, subcutaneous or intravenous administration of appropriate fluids is indicated. These measures are particularly important in the elderly and in those who have underlying conditions or illnesses which render them more vulnerable to the effects of dehydration. Rehydration therapy must be carried out in the community if appropriate. Specialist outreach teams must be established to administer this treatment and thereby avoid admission of the patient to hospital solely for this purpose.

Stool samples must be sent from all symptomatic patients and staff as soon as possible. Ensure stool charts are completed for all symptomatic patients.
9.3.1 Antiemetic drugs
These are not recommended routinely although some doctors find them useful. There is no evidence for the efficacy of these drugs in adults and conflicting evidence for their use in children for whom side-effects may be an issue. There is also the risk of compromising IPC measures through masking the infectivity of patients. For example, their use in children may lead to a premature return to school.

9.3.2 Anti diarrhoea drugs
These are not recommended routinely but some doctors find them useful in cases where other causes of diarrhoea have been excluded. They can be dangerous in some conditions such as Clostridium difficile disease and may also mask the infectivity of patients.

9.4 Patient discharge
Patients must be discharged from hospital as soon as their health permits. Recommendations on discharge are as follows;
- Discharge to own home. This can take place at any time irrespective of the stage of the patient’s norovirus illness. It is not necessary to delay the discharge of symptomatic patients or those who may be incubating norovirus
- Discharge to nursing or residential homes. Discharge to a home known not to be affected by an outbreak of vomiting and/or diarrhoea must not occur until the patient has been asymptomatic for at least 48hours. However, discharge to a home known to be affected by an outbreak at the time of discharge must not be delayed providing the home can safely meet the individual’s care needs. Those who have been exposed but are asymptomatic may be discharged only on the advice of the health protection team and IPCT.
- Discharge or transfer to other hospitals or community-based institutions (e.g. prisons). This must be delayed until the patient has been asymptomatic for at least 48hours.
- Urgent transfers to other hospitals or within hospitals need an individual risk assessment

10. DEFINING THE END OF AN OUTBREAK
The definition for the end of an outbreak is 48hours after the resolution of vomiting and/or diarrhoea in the last known case and at least 72hours after the initial onset of the last new case. This is also the point at which terminal cleaning has been completed. Often, there is a small number of patients with persistent symptoms and it is advisable to segregate those patients in order to facilitate a return to normal activity. Symptomatic patients may be moved into single rooms or otherwise within a cohort away from the area to be cleaned. There is thought to be little risk of prolonged airborne persistence of virus and terminal cleaning of an area such as a ward can commence immediately after removal of symptomatic patients.

11. EVALUATION AND MONITORING
Implementation of policies and procedures can only be effective if adequate evaluation and monitoring is used to check the system and ensure any shortcomings are identified and dealt with. Managers are responsible for initiating an ongoing monitoring process within their areas of responsibility.
From an organisation perspective, the Infection Prevention and Control Committee shall be responsible for monitoring that this Policy and that appropriate actions are being taken to maintain patient safety.
12. REFERENCES
Welsh Government Draft Communicable Disease Outbreak Plan for Wales (July 2010)

Health Protection Agency Guidelines for the management of norovirus outbreaks in acute and community health and social care settings March 2012

Public Health Wales Guidelines on Decontamination of the Environment in Care (Nursing & Residential) Homes during Outbreaks of Viral Gastroenteritis March 2011
**Diarrhoea and Vomiting Outbreak Advice Flowchart**

**Pre Outbreak Monitoring**
If more than one patient suddenly develops diarrhoea and/or vomiting in a ward area, please do not move the patient until the situation has been discussed with a member of the Infection Prevention & Control Team.

**Steps to Minimise Spread of Diarrhoea & Vomiting**

**Initial Management**
- In the event of a bed crisis, any decision to admit to an affected ward must be discussed between the Infection Prevention & Control Team, the Site Manager and the Nurse in Charge of the ward.
- Initial Management – Contact Ward Manager on entry to ward.
- All personnel must perform hand hygiene when entering or leaving the ward, gloves and aprons must be worn. Strict hand washing must be adhered to.
- Erect signs advising of ward closure and precautions that need to be implemented; keep entrance door to ward closed.
- Where possible, cohort nurse affected patients together.

**Role of Acute Response Team (ART)**
In an outbreak situation, to avoid admitting patients to hospital with symptoms of diarrhoea and vomiting, ART must be contacted to request that they assess the patient in their own home to facilitate admission avoidance where possible.

**Surge Capacity Consideration**
Senior Nurse to discuss with Infection Prevention & Control and Site Manager the potential for Surge Capacity management to accommodate emergency admission activity and continuation of service provision.

**Staff**
- Only essential staff to visit ward.
- Staff must not move between wards. Avoid staff cross cover between affected and non-affected patients.
- Staff with symptoms to remain off duty until 48 hours symptom free. A specimen must be submitted. Staff with D&V must be referred to Occupational Health. Staff breaks must be taken on the ward.

**Patients**
- Admission to a closed ward must be avoided wherever possible. If this is not feasible, please ensure that all patients are consulted prior to being admitted to a ward that has an outbreak. The patient’s clinician must be consulted before admission to a closed ward.
- If a patient is admitted with suspected infectious diarrhoea and vomiting, they must be admitted directly to a ward side room/cubicle.
- Observe patients for symptoms of diarrhoea and/or vomiting. Stool samples must be sent from all symptomatic patients. Ensure stool charts are completed for all symptomatic patients.
- If a patient requires investigation, e.g. X-Ray, please discuss with Clinician as to urgency and inform the department if patient is being transferred (normally will be placed last on the list). Gloves and aprons must be worn.

**Visitor**
Visiting must be discouraged in all cases when this cannot be avoided visitors must be made aware of the need to decontaminate hands before and after visiting. The frail and elderly may want to refrain from visiting until the outbreak is over. It is advised that children must not visit the ward during an outbreak. Visitors and relatives must be advised not to visit the ward if they have symptoms of diarrhoea.

**Outbreak Surveillance**
Infection Prevention & Control Team to conduct daily visits to affected area to monitor progress of outbreak, advise on management arrangements and provide written daily updates.

**Environmental**
Surfaces within ward to be kept clear to allow for effective cleaning. Food not to be left on patient’s bedside table. Retain food trolley outside immediate ward environment. Daily cleaning & disinfection of all areas to be undertaken using Chlorine Dioxide/Hypochlorite Solution. Additional ad hoc cleaning/disinfection of sanitary to be advised by Infection Prevention & Control Team. All curtains to be changed in affected area.
14. APPENDIX 2 – NOROVIRUS DECISION TREE

Is it a Norovirus Outbreak?  
A decision tree to help clinical staff

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

A patient develops diarrhoea and/or vomiting. An infectious cause is possible – is it part of an outbreak?

YES

Is there anyone else on the ward (patient or staff) with diarrhoea or vomiting?

YES

Are two or more of these “Norovirus Outbreak markers” present?
- Symptom onset was sudden
- Vomiting is projectile
- Diarrhoea is watery and not blood stained.
- Symptomatic patients have not had laxatives or enemas within past 48hrs.
- Negative stool for C. diff, Salmonella, E. coli O157, Cryptosporidium, Shigella, and Campylobacter. (But don’t wait for results before reporting a suspected outbreak).

YES

Likely to be a Norovirus Outbreak
- Alert the Infection Control Team
- Isolate the patient
- Send a stool sample to bacteriology and virology.
- Contact precautions for all symptomatic patients, send symptomatic staff home.
- Start Norovirus Outbreak Data Record for all symptomatic cases.

NO

Less likely to be Norovirus
- Isolate the patient(s) if possible.
- Use contact precautions.
- Send stool samples for culture
- Consider other causes of diarrhoea such as antibiotics, laxatives, constipation, food related, etc.
- Call the ICT if you are concerned or if the situation changes.

Not an outbreak (yet)
- Isolate the patient.
- Start contact precautions.
- Send a stool sample to bacteriology and virology.
- Be extra vigilant for other patients or staff developing symptoms
- Continue to monitor the patients’ condition.
- Send symptomatic staff home.

NO

Isolate symptomatic patient in a single room with the door closed to reduce risk of cross-transmission.

November 2009
APPENDIX 3 – INFORMATION FOR HEALTH CARE WORKER LEAFLET

WHAT IS VIRAL GASTROENTERITIS?
Viral gastroenteritis is usually a self-limited, mild to moderate disease that often occurs in outbreaks in the community and occasionally in the hospital setting. Clinical symptoms of nausea, vomiting, diarrhoea, abdominal pain, myalgia, headache, malaise and low grade fever may be experienced by individuals. Gastrointestinal symptoms characteristically last for 24 - 48 hours. A common cause of viral gastroenteritis is due to Small Round Structured Virus (SRSV) / Norwalk-like virus. The virus may be identified in the stools of ill individuals.

HOW IS IT TRANSMITTED?
Transmission can occur through vomit (by aerosol / airborne), by faecal-oral spread or by consumption of contaminated food or water. During outbreaks of viral gastroenteritis with patients, staff are susceptible to the infection due to their close interaction with patients.

IF I ACQUIRE THIS VIRUS WHAT ARE THE RISKS OF MY FAMILY ACQUIRING IT?
The virus is spread easily from person to person so your family are possibly at risk of acquiring the virus if you are in close contact with them when you have clinical symptoms. The incubation period is 10-50 hours.

HOW CAN I REDUCE THE RISKS TO MYSELF OF ACQUIRING THIS VIRUS?
- Follow the additional infection control advice during the outbreak.
- Ensure you decontaminate your hands with alcohol hand rub.
- Wash and dry your hands before and after patient / environmental contacts.
- Wear gloves and aprons for contact with infected patients / environment.
- Do not eat any food products in the infected ward environment.
- If your uniform becomes contaminated with vomit or faeces, it must be changed immediately.

WHAT DO I DO IF I BECOME UNWELL WITH VIRAL GASTROENTERITIS?
- Report any symptoms to your manager and maintain contact with your manager.
- DO NOT come to work, even if you feel relatively well.
- Please provide a stool specimen if you have diarrhoea and either take it to your GP or nearest Microbiology Laboratory.
- Do not return to work until you are symptom free for 48 hours.
  Contact the Occupational Health Department on extension 3217.

WHAT DO I DO IF I FEEL UNWELL IN WORK WITH NAUSEA / VOMITING / DIARRHOEA?
- Report to your manager immediately who will arrange for you to be relieved of your duties ASAP.
- If you vomit in a staff toilet or other area please report this to your manager.
  NB. Staff toilets closed off for 24 hours to prevent aerosol spread to other staff.

WILL ACTIVE INFECTION WITH VIRAL GASTROENTERITIS MEAN I WILL BE IMMUNE FROM THE INFECTION IN THE FUTURE?
Short term immunity has been known to last for approximately 14 weeks but long term immunity is variable. It is possible for you to have viral gastroenteritis again in the future.

WHAT IS THE CRITERIA FOR SUSPECTING AN OUTBREAK ON MY WARD?
- Rapid / sudden onset of diarrhoea and / or vomiting in patients and staff with no explainable cause e.g. change of medication.
- Illness duration 12-60 hours.
- Vomiting in over 50% of symptomatic patients.

WHAT ARE MY INDIVIDUAL RESPONSIBILITIES DURING AN OUTBREAK OF DIARRHOEA AND VOMITING ON MY WARD?
- Maintain high standards of environmental cleaning / hygiene.
- Maintain high standards of hand decontamination and hygiene.
  Emphasise the importance of handwashing and use of alcohol hand rub post handwashing.
- Ensure correct decontamination of any vomit / diarrhoea or any other body fluid spillage as per Health Board body fluid spillage policy.
- Ensure you report all new cases to the Infection Control Team as soon as possible.
- Isolate or cohort nurse symptomatic patients and persons exposed to the virus, who may well be incubating the condition.
- Offer patients handwash facilities / wipes after toileting.
- Obtain faecal specimens from all affected patients.
- Do not allow patients to eat food / fluids that have been left open on their lockers e.g. fruit in bowls.
Avoid transfer of patients to unaffected wards / departments or other hospitals (unless medically urgent and after consultation with infection control staff). The priority is to stop the spread of the virus to other areas.

Patients, if clinically well, may be discharged to their own homes (not nursing / residential homes).

Minimise your movements throughout the hospital to prevent spread of the virus. Go straight home after work.

Bank and agency nurse’s movements must be limited.

Any essential diagnostic procedure in other departments - liaise with the IPCT.

Any patients personal laundry to be carefully bagged in 'Dissolvosack' and relative advised to place in domestic washing machine.

Document all episodes of symptoms with patients e.g. stool chart.

Ensure all visitors are informed that there is an outbreak on the ward and caution them that they may be exposed to the infection.

Ensure patients and relatives have access to information leaflets regarding the infection (i.e. information leaflet and visitor information leaflet).

Wherever possible, exclude children and the frail / elderly from the affected area.

Advise relatives not to visit if they are feeling unwell or have had diarrhoea and / or vomiting(exclude from visiting until 72 hrs asymptomatic).

Advise relatives to use alcohol hand rub on entering and leaving ward.

**WHEN IS IT SAFE TO RE-OPEN A BAY OR WARD POST INFECTION?**

- This will be decided by the Infection Prevention and Control Team in liaison with Hotel Services and line managers. Do not take this decision on by yourself.
- The minimum requirement is for all patients to be symptom free for 48 hours.
- The ward environment and equipment must be thoroughly cleaned and disinfected prior to reopening (curtains changed).
- Any disposable items e.g. suction catheters in affected bays must be disposed of and replaced.
- The Infection Prevention and Control Team will confirm when the ward is ready to accept new patients.

For any further information, please contact the Infection Prevention & Control Department.
APPENDIX 4 – INFORMATION FOR PATIENTS LEAFLET

WHAT IS VIRAL GASTROENTERITIS?

A virus known as small round structured virus (SRSV) is a frequent cause of diarrhoea and vomiting in the community and is most common during the winter. It is sometimes called ‘winter vomiting disease’.

WHY IS IT A PROBLEM?

These small round structured viruses (SRSV) cause symptoms of ‘gastric flu’. It generally lasts 2-3 days and the person will have diarrhoea and / or vomiting. Some people may have a raised temperature, headaches and aching limbs. The illness is usually mild in nature and gets better quickly. SRSV does however spread easily in the hospital due to the close contact between patients and staff. Large numbers of patients and staff can be involved and it is important to stop the illness from spreading around the hospital or to relatives and friends.

HOW DOES THIS AFFECT ME?

If you become unwell on the ward you may be moved to a sideroom or to an area with other patients with the same illness. You must have as few visitors as possible and they will need to wash their hands before and after seeing you.

WILL I NEED TREATMENT?

Antibiotics are not effective against this viral infection. The main treatment is making sure you drink plenty of fluid. If you develop diarrhoea and vomiting a stool sample may be sent to the laboratory for testing. Once the illness is over no further action is necessary and your treatment will continue as before.

CAN I HAVE VISITORS?

Yes you can have visitors but we advise that you and your family restrict the amount of visiting. Although the symptoms are mild, children must be discouraged from coming to visit you, as they may be particularly susceptible to the virus. Friends or relatives that are unwell or suffering from diarrhoea and vomiting themselves must also not visit. If you have any concerns at all about someone visiting please discuss this with a doctor or nurse. To prevent the spread of infection your visitors must avoid visiting other wards and hospital food establishments where possible.

DO VISITORS NEED TO TAKE PRECAUTIONS WHEN VISITING ME?

Visitors must wash their hands thoroughly both before and after visiting you. It is also advisable to keep your number of visitors to a minimum as they may pick up the virus when on the ward. It is important that your relatives / visitors do not visit you if they feel unwell or have nausea (feeling queasy) or have diarrhoea and vomiting as this may cause further spread of illness in the hospital.
VIRAL GASTROENTERITIS

INFORMATION FOR PATIENTS IN HOSPITAL
17. **APPENDIX 5 – INFORMATION FOR VISITORS LEAFLET**

**WHAT IS THE PROBLEM?**

There is an outbreak of viral gastroenteritis on this ward and tests are taking place to find the specific cause.

**WHAT SYMPTOMS DO THE PATIENTS HAVE?**

Affected patients are suffering from nausea/vomiting and diarrhoea. **This is not a serious illness.** Symptoms generally last 2-3 days.

**WHY ARE PATIENTS ISOLATED IN SIDEROOMS OR BAYS?**

We isolate patients who are suffering from diarrhoea so that risk of spread to other patients, staff and visitors is reduced.

**HOW ARE PATIENTS TREATED?**

In the main by replacing fluids into the patient which have been lost from the body through diarrhoea. But each patient will be treated as indicated by symptoms.

**WHAT IS THE RISK TO ME AND MY FAMILY?**

The virus is spread very easily from person to person and from contaminated hard surfaces and bed linen, so visitors to a patient suffering diarrhoea symptoms could possibly be affected.

**WHAT PRECAUTIONS MUST I TAKE?**

If you are only paying a social visit to the patient, we would ask you not to eat food in the ward, or from patient’s lockers.

Restrict the number of visitors.  
Do not bring children to visit.  
Do not visit other patients during this time.

Extra precautions may be necessary such as wearing a plastic apron and gloves if you are giving hands on care to your relative or friend, in addition to good hand washing.

Please ask a member of staff for help or if other information is required.

**Please do not visit if you feel unwell or have nausea (feeling queasy) or have diarrhoea and vomiting.**

Wash and dry your hands and apply alcohol hand rub before leaving the ward.
VIRAL GASTROENTERITIS

INFORMATION FOR VISITORS

Produced by the Infection Prevention & Control Team, November 2001 Updated August 2002, Updated February 2003; Updated 2009
18. APPENDIX 6 – INFORMATION FOR RELATIVES/VISITORS
WHEN A PATIENT IS IN ISOLATION LEAFLET

REMEMBER

Handwashing / use of alcohol hand rub are one of the most important ways of preventing the spread of infection.

If you have any further questions then please speak with the ward staff or ask to speak to the Infection Prevention and Control Nurse.
1 For what reason are patients nursed in isolation in hospital?

(a) The patient may be more at risk of acquiring an infection if their immune system or resistance is impaired. A room of their own will reduce the risks of acquiring infection from other patients on the ward.

or

(b) The patient may have an infection; - a room of their own and additional nursing procedures will prevent spread of the infection to other vulnerable patients on the ward.

2 As a visitor to a patient isolated due to an infection, are there any risks to my health by visiting them?

The majority of infections will pose no risk at all to the health of visitors. It is advisable to liaise with ward staff prior to bringing in babies and small children, as they may be vulnerable to infection. There will be a need, when the patient has certain infectious diseases, for the ward staff to enquire whether visitors have previously had the disease or been immunised e.g. mumps, measles, rubella, chickenpox / shingles and tuberculosis of lung. The ward staff will seek advice from the Infection Prevention and Control Team if there are any queries.

3 As a visitor, what do I need to do when visiting a patient in isolation?

(a) Prior to entering the isolation room, speak with the ward staff in order to ascertain what is required of you when visiting.

(b) If you are unwell, e.g. ‘flu’ / cold, diarrhoea and vomiting, then you must not visit until you are well.

(c) Ensure any cuts / wounds you may have are covered with a waterproof plaster / dressing.

(d) During your visit to the isolation room, you will not need to put on gloves and aprons. If you are assisting the nurses to carry out care procedures then you will be required to wear gloves and apron.

NB Nurses wear gloves and aprons within isolation rooms as they have contact with lots of other vulnerable patients and need to prevent cross infection.

(e) Before leaving the isolation room, wash and dry hands thoroughly and apply alcohol hand rub from the trolley outside the room.

(f) If you are washing used nightwear / towels then ensure you take them home in a plastic carrier bag. Items can be machine washed on the hottest possible wash for the fabric and then dried and ironed in the normal way. Alternatively, items can be hand washed in the hottest possible water for the fabric. It is preferable that items are washed on their own and not mixed with other household washing.
19. APPENDIX 7 – HAND HYGIENE INFORMATION LEAFLET

FACTS ABOUT HANDWASHING
1. Handwashing can significantly reduce the level of potentially harmful germs and bacteria on your skin.
2. Handwashing is a simple and important method for reducing infections being passed from person to person.
3. Handwashing with liquid soap and warm water is all that is needed to effectively kill most germs and bacteria.
4. Even if doctors and nurses are wearing protective gloves, handwashing is still required to ensure hands are clean after removal of gloves.

WHAT MUST I USE TO CLEAN MY HANDS?
- Traditional washing with liquid soap and water is the easiest option. Please don’t be afraid to tell staff if there is no soap in the dispensers – they will be happy to replace it for you.
- Staff use alcohol hand gel – all you do is rub the gel onto visibly clean hands after each patient contact and let it dry (NB. If hands are visibly dirty then handwashing at a sink is required).

HOW OFTEN MUST YOU CLEAN YOUR HANDS?
We ask that all patients, visitors and staff follow this simple advice:

PATIENTS
PLEASE CLEAN YOUR HANDS: -
- Before meals.
- After each time you use the toilet, bathroom or a commode.
- If you have had skin to skin contact with another patient.

VISITORS
PLEASE CLEAN YOUR HANDS: -
- After visiting the toilet or bathroom.
- Before helping a patient with their meal.
- Before and after visiting a patient who is ‘isolated’ due to an existing infection.

STAFF
MUST CLEAN THEIR HANDS: -
- Each time they have direct contact with a patient (touching).
- Between contact with different patients.
- Before handling food or medicines.
- After helping patients to use the toilet, bathroom or commodes.
- Before and after gloves are worn.
- After contamination by bodily fluids.
- After using the toilet.
- At the beginning and end of each shift or break.

WHAT DO I USE TO DRY MY HANDS?
- Please use the paper towels that are available above every sink. If they are empty, please tell a member of staff who will be happy to replace them.
- To prevent skin on your hands becoming dry, please use the moisturising hand cream that is available in the green dispensers.
HANDWASHING – HOW TO DO IT RIGHT!
The handwashing stages shown below must take 15-30 seconds and is suitable for all wards and departments.

Wet hands, apply 3-5mls of liquid soap to hands and rub together 5 times for each of the six steps shown.

Alternatively, 1ml of alcohol gel at the end of your bed can be used to decontaminate visibly clean hands.

If you require further information, please contact the Infection Prevention and Control Department.

Thank you for your co-operation.