

VIRAL GASTROENTERITIS

Infection Prevention and Control Policy No 7

Policy Title:	Viral Gastroenteritis
Policy Number:	7
Version:	6
Approved by:	SMT
Date of Approval:	December 2008
Policy supersedes:	Viral Gastroenteritis Version 5
Name of originator(s)/author(s):	Adele Dyche, Senior Nurse Infection Prevention and Control Revised by Sian Owens, Infection Prevention and Control Nurse
Date issued:	April 2009
Review date:	December 2010
Target audience:	Accountability – Executive Directors Responsibility – senior managers in corporate functions and senior operational managers Implementation – all Trust staff
Key words	Infection Prevention and Control (IPC), Viral Gastroenteritis, norovirus, rotavirus, diarrhoea, source isolation, outbreak, cohort

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EXECUTIVE SUMMARY

Scope of policy

This policy applies to:

- All patients at LTHT
- All staff employed at LTHT

Key Points:

- The most common causes of viral gastroenteritis include norovirus and rotavirus.
- Communicate early with the Infection Prevention Team (IPT) when you have two or more patients or staff with symptoms of unexplained diarrhoea and/or vomiting
- Any patient who is admitted to a ward and has had contact with a known case of viral gastroenteritis must be placed in source isolation for a period of 48 hours.
- Refer to the LTHT Outbreak Control Plan (which is located at each nurses' station) in conjunction with the Infection Prevention Team's advice.
- Effective hand hygiene is essential to minimize the spread of infection.
- Following spillage, excreta/vomit must be covered immediately, removed and then the area decontaminated using the ward or department biohazard spill kit.
- Keep accurate records of who develop symptoms (staff, patients and relatives).
- A patients' treatment must not be compromised whilst the ward is restricted due to outbreak of viral gastroenteritis.

Aims

- To prevent transmission of viral gastroenteritis within LTHT.

Objectives

- For staff to understand the significance and potential consequences of viral gastroenteritis within LTHT.
- To enable staff to ensure the appropriate risk assessment is performed.
- To ensure all staff are aware and apply the appropriate Infection Prevention interventions and precautions when caring for patients with suspected/confirmed viral gastroenteritis.
- To enable staff to be able to identify viral gastroenteritis symptoms early in order to prevent transmission and outbreaks occurring.
- To enable staff to be able to appropriately manage viral gastroenteritis outbreaks if they occur.

1 INTRODUCTION

Common causes of Viral Gastroenteritis (VG) include norovirus and rotavirus. The commonest cause of hospital outbreaks of VG is norovirus, which has the ability to spread very quickly within a hospital environment.

Viral gastroenteritis is acquired by ingestion of the virus. Virus is transmitted from infected faeces or vomit by person-to-person spread, ingestion of contaminated food/water, contact with contaminated fomites or aerosolisation. Symptoms typically consist of nausea, diarrhoea and /or vomiting, but may also include headache or abdominal pain. The condition is self-limiting.

Norovirus is highly transmissible, requiring ingestion of as few as 10 virus particles to cause infection. Although infectivity may precede clinical illness and viral shedding may be prolonged, the period of infectivity is considered to last from the onset of symptoms until 48 hours after the last episode of diarrhoea or vomiting. During vomiting there is potential widespread contamination of the environment, and it is common for virus to be transmitted to patients, staff, students and visitors.

The incubation period is usually from 24-48 hours, although as little as 12 hours has been reported.

2 PURPOSE

The purpose of this policy is to define the procedure to be followed on confirmation of one or more cases of viral gastroenteritis, or where viral gastroenteritis is considered likely, in order to prevent further spread.

Failure to follow this policy could result in the instigation of disciplinary procedures.

3 DEFINITIONS

- Diarrhoea can be defined as frequent, loose watery stools.
- Source isolation is the physical separation of one patient from another in order to prevent the spread of infection.
- Cohort refers to the physical separation of a group of patients from other patients in order to prevent the spread of infection.
- Outbreak of infection can be defined as a small, localised group infected with the same disease.

4 DUTIES

4.1 Duties within the Organisation

As a healthcare establishment, LTHT has a duty of care that is covered by the Health and Safety Act (1974) (HSE 2003), COSHH (HSE 2005) and The

Health Act (DH 2006). The management of viral gastroenteritis is covered in core duties 3, 4, 5, 6 and 8 of this Act.

4.2 Consultation and Communication with Stakeholders

The Infection Prevention and Control Committee, The Chief Nurse Team and The Infection Prevention Team have commented on and contributed to this policy. The policy will be approved by the Infection Prevention and Control Committee and the Senior Management Team.

5 ACTIONS TO BE TAKEN ON IDENTIFICATION OF ONE OR MORE CASES OF UNEXPLAINED DIARRHOEA AND/OR VOMITING

- The LTHT Gastrointestinal Infections policy should be followed. This policy gives advice on diagnosis and management of patients with unexplained gastrointestinal symptoms.
- Where there are two or more patients and/or staff members affected, the IPT (or, if out of hours, the on call consultant microbiologist) must be informed immediately.
- Senior nursing staff should make a decision as to whether viral gastroenteritis is the likely cause (in consultation with the IPT if the above applies). If VG is considered likely the IPT should be informed immediately. The following features suggest viral gastroenteritis as a likely cause:
 - Affected patient(s) has/have had recent contact with viral gastroenteritis cases;
 - Clinical features are highly suggestive of VG e.g. rapid onset of symptoms and/or projectile vomiting
 - There is rapid spread of gastrointestinal infection, often affecting multiple patients, visitors, members of staff and students.
- If a patient vomits and no clinical explanation can be given and an infectious agent is suspected, the patient must be isolated in accordance with LTHT source Isolation Policy. If unable to isolate within 2 hours, the escalation procedure must be followed.
- The existing bay must then be restricted for 48 hours (the time period is to commence after the index case has been isolated) to cover the incubation period of viral gastroenteritis and prevent any further transmission.
- If another patient develops vomiting symptoms before the index case is isolated, the bay should then be restricted and no patient movement should occur.
- Nurse affected patients using strict isolation precautions either in a single room or cohort in a bay.

- Stool specimens should be sent from all symptomatic patients. Request forms should include “Outbreak” in Clinical Details, and “Norovirus” in Tests Requested. It is recommended to complete all forms and labeling of pots prior to obtaining the specimen, and hands should be washed thoroughly afterwards. This will help to prevent cross contamination from your hands to the surrounding environment.
- Where there is more than a single case a list should be compiled, including members of staff and visitors, stating the symptoms and the date/time that these started. This information is vital in assisting the IPT to undertake accurate risk assessment when they visit the ward. (See Appendix B, documentation)

6 ACTIONS TO BE TAKEN WHERE VIRAL GASTROENTERITIS IS CONFIRMED MICROBIOLOGICALLY

- The nurse in charge should contact the IPT (in office hours) or the on call Consultant Microbiologist (out of hours). This person will carry out a risk assessment and advise the ward of any further precautions required.
- Patients who have had diarrhea and/or vomiting within the previous 48 hours should be isolated immediately and managed according to the LTHT source isolation policy.

7 PREVENTION OF SPREAD LOCALLY

- In some cases the IPT or on-call consultant microbiologist will recommend restriction of all or part of the ward, and will inform the Matron for the area (or, if out-of-hours, clinical site managers). In this situation the Infection Prevention and Control Team will issue an email to all Divisions and Departments within the Trust including the Chief Nurse, Divisional Medical Manager and Divisional Nurse, informing them of the situation.
- The IPT and/or on-call microbiologist will provide daily advice if a ward is restricted due to VG and the LTHT Outbreak Control Plan should be followed.
- Depending on the individual circumstances the IPT may consider it necessary to invoke the LTHT Control of an Outbreak of Infection policy.
- Adequate hand hygiene is vital in controlling the spread of infection. The requirements of the LTHT Hand Hygiene in Practice Policy should be followed at all times.
- Protective clothing must be used when handling excreta or vomit and when in close patient contact. Aprons and gloves must be removed before leaving the patient’s environment and hands should be decontaminated immediately (see LTHT Source Isolation Policy for details).

- There is no evidence to support the use of masks when caring for patients with suspected viral gastroenteritis. The use of masks may instill a false sense of security and are not a substitute for adequate Infection Prevention and Control Management.
- Decontamination of all vomit or faecal spillage is vital to ensure viral particles are killed. This can be achieved effectively with a 10,000ppm hypochlorite solution which can be found in your ward /department biohazard spill kit.
- Environmental cleaning: It is essential that this is carried out to a high standard and cleanliness is maintained. The ward must be physically cleaned and disinfected at least once a day with 1,000ppm Chlor-clean solution (one tablet to one litre of water). Special attention must be given to toilet and bathroom areas, commodes, all horizontal surfaces and frequently touched surfaces such as the nurses' station, nurse call system, telephones, door handles/ push plates, sinks and taps.
- It is not recommended that carpets are present in clinical areas. Pre-existing carpets if soiled should be cleaned with a neutral detergent and warm water after removal of infective material. Effective disinfection is also achievable by steam cleaning.
- There is no current evidence to suggest that curtains are a source of VG transmission. Therefore the IPT does not advocate the changing of curtains following an outbreak. Curtains should however be routinely changed and laundered every 6 months or immediately if visibly contaminated with blood or body fluids.

8 PREVENTING SPREAD TO OTHER CLINICAL AREAS

On restriction, the ward will be issued with an outbreak pack containing posters, information leaflets for patients and relatives, patient record sheets, advice about cleaning and general do's and don'ts. It is the responsibility of the nurse in charge to make sure that a ward restriction notice is placed at all the entrance/exits to the ward and that all patients and relatives have access to an information leaflet and alcohol hand rub.

- Where appropriate an Infection Prevention Nurse will visit the ward every weekday in order to assess the ward. Out of hours, your ward will be assessed by the on call consultant microbiologist, who can be contacted via switchboard.
- Patients should not be accepted to a restricted ward/area, unless they have been previously discharged from the same ward within the past 48 hrs.
- Patients can be discharged to their own home as long as they are asymptomatic and not requiring nursing or social care at home. They should be advised to inform the admitting officer if readmission occurs

within 48 hrs of their discharge. Patients from restricted wards should not be placed in a discharge lounge whilst waiting for transport. Patients should be collected from the ward.

- Patients should not be transferred to other wards within the hospital or to other institutions (e.g. other hospitals or residential homes) without consultation with the IPT.

Advice should be sought from the IPT before transferring patients

- If an internal transfer is necessary due to clinical need (e.g. to ICU or theatres), then advice should be sought from the IPT, who will need to undertake a risk assessment, and the receiving unit should be informed of the situation.
- Symptomatic patients should not be sent to other departments unless it is unavoidable. Where possible, investigations/treatments should be postponed or carried out at the patient's location. If this is not possible, the receiving department should be informed so that they can make appropriate arrangements e.g. minimum time spent in the department, no contact with other patients and limiting the amount of staff who deal with the patient.
- A patient's treatment must not be compromised whilst the ward is restricted due to viral gastroenteritis.
- Visiting staff e.g. Physiotherapists, Occupational Therapists, Phlebotomists should still continue their service to the ward. If possible, the affected ward(s) should be the last to be visited. Only essential procedures should be carried out on the symptomatic patients (refer to LTHT outbreak control plan).
- Staff in affected areas should not be transferred to other wards/departments. Bank staff should be discouraged from working on other wards if they have recently worked on an affected ward. It may be sensible to arrange for bank staff to work a block of shifts with days off 48 hours before returning to a non-infected ward.

9 WHEN IS THE PATIENT/WARD CLEAR OF INFECTION?

- Viral particles can be excreted before the onset of symptoms and for up to two weeks after recovery. However, transmission of infection is considered unlikely after more than 48 hrs following the last episode of diarrhea and/or vomiting. Therefore patients can be removed from isolation at this time.
- During a ward restriction due to viral gastroenteritis, the restriction can usually be lifted 48 hrs after the last patient has had any symptoms (NB: The IPCT must be involved in deciding whether restriction can be relaxed).
- Clearance stool specimens are not required.

10 AFFECTED STAFF

- Staff and health care students are often affected during an outbreak of viral gastroenteritis.
- Staff/Students should not return to work until a period of 48 hrs has elapsed from their last symptom, unless otherwise advised by the IPT.
- Other than patient meals, food should not be available or eaten in clinical areas during known or suspected episodes of VG or when a ward/area is restricted. This includes chocolates, sweets etc, which are often left open and therefore carry a high potential for contamination by other staff members and the surrounding environment.

11 VISITORS

- Visitors may contribute to ongoing spread of VG. In general, visitors should be discouraged from attending the wards that are restricted due to VG. This applies especially to elderly, immunocompromised or very young visitors, in whom infections may be more severe/hazardous.
- People should be advised not to visit if they have symptoms of gastroenteritis or have had recent contact with a person with diarrhoea and/or vomiting. This includes recent visits to other wards or departments affected with viral gastroenteritis.
- People who have had recent contact with diarrhea and/or vomiting should be asked not to visit until they have remained symptom free for 48hours following exposure.
- Visitors should decontaminate their hands on entering and leaving the ward (by hand washing or alcohol rub).
- The Patient and Visitor Information Leaflet “viral gastroenteritis” should be given and made available to all patients and visitors to the ward (these should be ordered directly from the LTHT print unit).

12 RECURRENT SYMPTOMS

- Recurrence of symptoms may represent prolonged infection, re-infection or infection with a different organism.
- The IPT should be contacted immediately for a further risk assessment.
- The patient should be isolated as soon as possible.
- If staff have symptoms that recur they should be excluded from work and should not return until 48 hours have elapsed from their last symptom.

**Remember to use STANDARD INFECTION PREVENTION PRECAUTIONS
at ALL times.**

13 RESPONSIBILITY FOR DOCUMENT DEVELOPMENT

Lead Director: Ruth Holt, Director of Infection Prevention and Control

Membership of the Steering Group:

Sian Owens

Gillian Hodgson

Richard Hobson

Consultation through Infection Prevention and Control Committee

14 EQUALITY IMPACT ASSESSMENT

The Policy has been assessed for its impact upon equality, Appendix A. The Leeds Teaching Hospitals Trust is committed to ensuring that the way that we provide services and the way we recruit and treat staff reflect individual needs, promote equality and does not discriminate unfairly against any particular individual or group.

15 IDENTIFICATION OF STAKEHOLDERS

The key stakeholders in this policy are staff involved in caring for patients with known or suspected infections and managers responsible for the provision of facilities for this patient group.

16 CONSULTATION PROCESS

This policy will be consulted on by the Infection Prevention and Control Committee and its sub groups and the Chief Nurse Team.

17 APPROVAL AND RATIFICATION

This policy will be approved by the Senior Management Team.

18 PROCESS FOR REVIEW/REVISION OF THIS POLICY

This policy will be reviewed two years from the date of approval or following significant changes in the management of patients with known or suspected infection.

19 COMMUNICATION/DISSEMINATION OF THIS POLICY

Directors – communication directly by e-mail and discussion at SMT
Senior operational and corporate managers – communication directly by e-mail and to be notified by Directors through line management briefing
All staff – Trust communications channels including e-Bulletin

20 IMPLEMENTATION OF THIS POLICY

This policy will be implemented immediately following dissemination.

21 PROCESS FOR MONITORING COMPLIANCE/EFFECTIVENESS

Any time a patient cannot be isolated appropriately this must be recorded by clinical staff and communicated to the IPT.

Records of non-availability of single rooms and hand hygiene audit compliance should be monitored by the Divisions and reported to the IPCC via the Divisional IPCC Group.

22 REFERENCES/ASSOCIATED DOCUMENTATION

Chadwick P.R, Beards G et al, "Management of Hospital outbreaks of gastroenteritis due to small round structured viruses", Journal of Hospital Infection 2000 45:1-10

Centres for Disease Control and Prevention, "Norwalk like viruses:" public health consequences and outbreak management. MMWR 2001; 50 (no.RR-9)

Cowden J. "Winter Vomiting", Infections due to Norwalk –like viruses are underestimated, British Medical Journal 2002, volume 324, 2nd February 249-250.

Farr B.M, "Nosocomial Gastrointestinal Tract Infections", (cited in Mayhall C.G Hospital Epidemiology and Infection Control 1999 2nd Ed, Lippencott Williams and Wilkins, Philadelphia.

Appendix C - Checklist for the Review and Approval of Policy

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To be completed and attached to the policy when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	Title		
	Is the title clear and unambiguous? Is it positively named in respect of the behaviour, actions, established position it seeks to achieve?	Y	
	Is it clear whether the document is a policy, guideline, protocol or standard?	Y	
2.	Rationale		
	Are reasons for development of the document stated?	Y	
3.	Development Process		
	Is the method described in brief?	N	
	Are people involved in the development identified?	Y	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	
4.	Content		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are the references cited in full?	Y	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Are supporting documents referenced?	Y	
6.	Approval		
	Does the document identify which committee/group will approve it?	Y	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	Dissemination and Implementation		
	Is there a communications plan to identify how this will be done?	N	
	Does the implementation plan include the necessary training/support to ensure compliance?	N	
8.	Document Control		
	Does the document identify where it will be held?	Y	
	Have archiving arrangements for superseded documents been addressed?	N/A	
9.	Process to Monitor Compliance and Effectiveness		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y	
	Is there a plan to review or audit compliance with the document?	Y	
10	Review Date		
	Is the review date identified?	Y	
	Is the frequency of review identified? If so is it acceptable?	Y	
11	Overall Responsibility for the Document		
	Is it clear who will be responsible for	Y	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	co-ordinating the dissemination, implementation and review of the document?		

Individual Approval

If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.

Name		Date	
Signature			

Committee Approval

If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.

Name		Date	
Signature			