

VIRAL GASTROENTERITIS GUIDANCE

Post holder responsible for Policy:	Lead Nurse
Directorate/Department responsible for Policy:	Infection Prevention & Control
Contact details:	Judy Potter Stewart Smith House Ext 2355
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Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

The Strategic Directions 2007-2012 were agreed by the Board of Directors in October 2007 to support the Trust's vision "Respond, Deliver, Enable". The Key Milestones below will ensure there is a shared understanding about what needs to be delivered.

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience		Waiting	
Assurance Framework		Privacy and Dignity	
Monitor/Finance/Performance		Efficiency and Effectiveness	
Care Quality Commission Outcomes:	8	Delivery of Care Closer to Home	
		Infection Control	✓
NHSLA Risk Management Standards for Acute Trusts			
NHSLA CNST Maternity Clinical Risk Management Standards:			
Other (<i>please specify</i>):			
Note: This policy has been assessed for any equality, diversity or human rights implications			

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1. Introduction

Viral gastroenteritis is an infection of the stomach and intestine, commonly caused by Norovirus, leading to symptoms of diarrhoea and vomiting. The disease was historically known as “winter vomiting disease” due to its seasonality and typical symptoms. It is also known as small round structured virus (SRSV) or Norwalk-like virus. Within the general community, circulation of Norovirus is common particularly, causing sporadic or small clusters of cases. Large outbreaks can occur in semi-closed settings such as hospitals, nursing/residential homes, schools and hotels. Other viruses may cause diarrhoea and vomiting especially rotavirus, which is commonly seen in children (see Source Isolation Policy).

This guidance is based on the national guidelines (2000) and local experience.

2. Clinical features

Viral gastroenteritis has an incubation period of between 12-72 hours. The onset of symptoms may be gradual or abrupt. Symptoms can include diarrhoea, vomiting, which may be projectile, abdominal pain, headaches and low-grade fever. Symptoms are self-limiting and generally last for between 24-72 hours. Collection of stool samples for virology may facilitate diagnosis.

3. Transmission

Viral gastroenteritis may be transmitted from person to person directly via the faecal-oral route. Widespread aerosol dissemination of virus particles produced during vomiting or explosive diarrhoea cause environmental contamination and subsequent indirect person to person spread. Transmission can also take place by exposure of oral mucous membranes to aerosols of vomit.

4. Control of sporadic cases

All cases of suspected infectious diarrhoea need to be isolated in a single room preferably with en-suite facilities and must be nursed in accordance with the Source Isolation Policy. Cases presenting in admission areas, please refer to management guidance in appendix A.

5. Ward closure

Norovirus has a considerable propensity to spread within hospitals resulting in ward or hospital-wide outbreaks. Temporary closure of a bay or ward is sometimes required to prevent any further spread of the illness (Please refer to D&V Outbreak pack documents available on the Intranet). Although individual cases are only infectious for a few days, the regular introduction of new patients who are susceptible to infection could sustain the outbreak. Success in limiting outbreaks depends heavily on early recognition of those who may be infected in order that appropriate action can be taken. The Infection Control Team should be notified immediately when cases are suspected. All suspected cases and their symptoms should be listed on the ward outbreak sheet available in the D&V Outbreak pack. Outbreaks of viral gastroenteritis can often be diagnosed presumptively on clinical grounds from the presenting clinical features and the occurrence of both symptomatic staff and patients. (For further information please refer to the Ward Closure Policy).

6. Containment of cases

When an outbreak is suspected it is imperative that control measures are implemented immediately. Affected patients i.e. those who are symptomatic or who have been nursed within the same bay as those with symptoms must be isolated appropriately. This may be within single rooms preferably with en-suite facilities or within a designated cohort bay, which has an allocated toilet or designated commode facilities. **It may take up to 24-48 hours before those exposed develop any symptoms and it is imperative that those patients who are potentially incubating the infection are not transferred from these areas until after this time or after consultation with the Infection Control Team.**

Symptomatic cases are generally considered to have resolved when they have had no further symptoms for 48 hours or more. Affected staff must not return to work until at least 48 hours have elapsed from their last symptom.

7. Hand hygiene

In addition to routine hand hygiene at the point of care, hands should be washed with soap and water after removing personal protective equipment prior to leaving the cohort bay or isolation room. Once outside the bay or isolation room repeat hand hygiene.

8. Personal Protective Clothing

The environment will be contaminated with virus particles therefore; gloves and aprons must be donned on entry to the side room or cohort bay. If an outbreak is confirmed, raspberry coloured scrubs suits will be provided for all staff working in the area to wear. Essential staff visiting the ward who need to enter the affected bay must also change into scrubs if they intend to be in the area for more than 30 minutes.

9. Discharges and transfers

During ward closure, transfers of patients to other wards, hospitals or nursing homes should be avoided unless indicated due to clinical need and following consultation with the Infection Control Team. If transfers have to take place, the receiving unit must be notified of the situation on the ward in order that appropriate infection control measures can be taken. Discharges to patients' own homes can go ahead.

10. Movement of staff between wards

Staff working between affected and non-affected areas within a period of duty would normally be discouraged (refer to Ward Closure Policy). Use of Bank and Agency staff should be minimised wherever possible. If staff movement is unavoidable, a change of uniform and preferably a shower is required before working in a non-affected area. Doctors and other peripatetic staff e.g. phlebotomists and physiotherapists, should either be designated to work on affected areas only or order their work load so that they visit unaffected areas prior to visiting affected areas.

11. Environmental decontamination

Following discharge of a patient or an outbreak on a ward the environment must be thoroughly decontaminated. Please refer to the terminal cleaning guidelines in the Source Isolation Policy or terminal cleaning poster on the ward.

12. Relatives and Visiting

Temporary closure of a ward or bay is required to prevent and control the risk of viral gastroenteritis illness spreading in the RD&E hospital and community. If a ward is closed with confirmed cases of Norovirus, normal visiting arrangements for the entire ward area are suspended. Patients will be allowed a named visitor each day who may visit in the afternoon and/or evening for 30 minutes. Please seek advice from infection control. When a bay is closed, restrictions on visiting apply to that bay only. Clearly, exceptions to these restrictions are necessary for children, critically ill patients, dying patients and those with special needs. The ward matron/sister will ensure that these exceptions are identified and visiting allowed.

Visitors must wash their hands with soap and water upon leaving a closed bay/room. Display the ward/bay closure signs notifying all visitors of the outbreak and provide the RD&E Trust letter for patients and visitors – “Diarrhoea and vomiting illness – important information”, supplied by the Director of Nursing & Patient Care.

13. Staff

Staff with gastroenteritis should remain off duty until 48 hours have elapsed from their last symptom. In certain cases i.e. in those who have returned from foreign travel, whose symptoms are persistent or unusual e.g. bloody diarrhoea, or where there is the need to investigate a cluster of cases, a stool specimen may be required. After certain bacterial infections, clearance specimens may be necessary before an individual can return to work.

14. Ending of precautions

The decision to re-open affected areas will be made by the Infection Control Team in liaison with clinical and managerial staff.

References

Public Health Laboratory Service Viral Gastroenteritis Working Group. Management of Hospital Outbreaks of gastroenteritis due to Small Round Structured Viruses. Journal of Hospital Infection. Vol. 45. Issue 1. May 2000. available from; http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1194947408355

Management of Patients with Diarrhoea and Vomiting in EMU, ED or Other Admission Areas

- ◆ On admission, the diarrhoea and vomiting assessment will be completed for all patients. This will help to identify patients who have had symptoms in the previous 48 hours and those who have been exposed to someone else with symptoms in the last 48 hours.
- ◆ The Nurse in Charge will review all patients in single rooms on EMU on at least a daily basis to determine whether they require single room accommodation. The Infection Control Team can be contacted for advice either by phoning the office ext. 2355 Mon-Fri, or by contacting the on-call Infection Control Nurse (weekends).
- ◆ Patients admitted with active D&V and those who have had symptoms in the preceding 48 hours will be assessed in a side room on EMU/ED and, if other causes for the symptoms cannot be established, it must be assumed that Norovirus infection is the most likely cause.
- ◆ If Norovirus infection is suspected and the patient needs to remain in hospital, he/she will usually be transferred to a single room on Torridge ward within **4 hours** of admission to EMU/ED. NB. Wherever possible, direct admission to a Torridge isolation room is preferred.
- ◆ If the patient with suspected Norovirus infection needs to be admitted to a specialist unit, rather than Torridge, they must be admitted to a single room on the appropriate unit/ward with strict isolation precautions in place.
- ◆ Whilst on EMU/ED strict isolation precautions must be maintained for patients with D&V i.e.
 - isolation card on door with required precautions indicated
 - side room door closed
 - number of people entering room kept to the necessary minimum
 - commode allocated, if patient unable to use en-suite toilet
 - staff to wear gloves and aprons worn on entry to room
 - gloves and aprons removed prior to leaving the room
 - hands washed with soap and water prior to exit from room
 - patient's relatives should be advised of risk of infection, and told to:
 - wash their hands prior to leaving the room,
 - not to eat and drink in room
 - avoid hand to mouth contact
- ◆ Patients who have been exposed to D&V prior to admission may be in the incubation period and must be admitted to a single room, on the most appropriate medical ward. Isolation precautions must be applied. If the patient remains asymptomatic isolation precautions may be lifted after 48 hours. This information must be communicated to the receiving ward by the EMU/ED nurse arranging the transfer.