


Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	1 of 27	Approval Date: 01 May 2019
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 <b>GIG CYMRU NHS WALES</b>	<b>Reference Number: UHB 075</b> <b>Version Number: 5</b> <b>Date of Next Review: May 2022</b> <b>Previous Trust/LHB Reference Number: T142</b>
<p align="center"><b>VIRAL GASTROENTERITIS (NOROVIRUS) INFECTION CONTROL IN UNIVERSITY HEALTH BOARD HOSPITALS PROCEDURE</b></p>	
<p><b>INTRODUCTION</b></p> <p><u>Norovirus</u></p> <p>Norovirus is one of the most common causes of outbreaks of gastro-enteritis in hospitals and can lead to ward closures and major disruption in hospital activities.</p> <p>Norovirus can be spread by several routes: faecal-oral, vomiting/droplets, food and water. Outbreaks normally occur during the winter months, but are increasingly seen throughout the year. Outbreaks can be sudden and explosive at their outset particularly when projectile vomiting is a prominent feature.</p> <p>Symptoms include nausea, vomiting, diarrhoea, abdominal pains/cramps and low grade fevers that characteristically last 24 - 48 hours.</p> <p><u>Rotavirus</u></p> <p>Rotaviruses are the most frequent enteric pathogens found in young children and infants, but can also affect adults e.g. on wards with a large number of elderly patients. The mode of transmission is faecal-oral but contact and respiratory spread are possible.</p> <p>Symptoms include sudden onset of fever, abdominal pain and vomiting, and continues with moderate or severe watery diarrhoea that usually lasts for 3-8 days.</p> <p><b>The guidance given in this procedure refers essentially to Norovirus infection but can also be utilised for Rotavirus infection.</b></p> <p><b>AIM</b></p> <p>To provide a structure and appropriate advice to staff for the management of viral gastro-enteritis at all UHB hospitals.</p>	
<p><b>Objectives</b></p> <ul style="list-style-type: none"> <li>To describe the actions required on the admission of a patient with known or suspected viral gastro-enteritis.</li> </ul>	

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	2 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

- To provide the actions required when a case develops in a UHB hospital.
- To provide advice on the action required during an infectious incident or outbreak situation caused by viral gastroenteritis (see also the Infection Control Procedure for Infectious Incidents and Outbreaks 2016).
- To provide advice on the communications necessary whenever a cluster of cases of viral gastroenteritis develops amongst patients and/or staff.

## Scope

This procedure applies to all of our staff in all locations including those with honorary contracts and students.

Cardiff And Vale University Health Board (UHB) accepts its responsibility under the Health and Safety at Work Act etc. 1974 and the Control of Substances Hazardous to Health Regulations 2002, to take all reasonable precautions to prevent exposure to viral gastroenteritis in patients, staff and other persons working at or using its premises.

In order to prevent the possible spread of viral gastroenteritis amongst patients and staff it is recognised that the UHB requires a procedural document to ensure effective management of infection. This is especially necessary in the case of an infectious incident/outbreak, as detailed in the Infection Control Procedure for Infectious Incidents and Outbreaks 2016.

<b>Equality Impact Assessment</b>	<i>An Equality Impact Assessment has been completed. The Equality Impact Assessment completed for the policy found here to be no impact.</i>
<b>Documents to read alongside this Procedure</b>	<a href="#">Transmission Based Precautions</a> <a href="#">Infectious Incidents and Outbreaks</a> <a href="#">Hand Decontamination</a> <a href="#">Standard Precautions Procedure</a> <a href="#">Period of Increased Incidence (PII diarrhoea pack)</a>
<b>Approved by</b>	IPC Group
<b>Accountable Executive or Clinical Board Director</b>	Director of Nursing
<b>Author(s)</b>	Director of IP&C, Clinical Nurse Specialist in IP&C

## Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the [Governance Directorate](#).

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	3 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

Summary of reviews/amendments			
Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	09/2004	11/2004	Original Procedure created
2	2009	2009	Revised Document- Updated guidance
3	02.12.14	22.01.2015	Revised Document- Updated guidance
4	01.02.18	21.02.2018	Revised document- Updated guidance, links and appendices
5	01.05.2019	03.12.2019	Revised document- Updated guidance, links and appendices

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	4 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

## Contents Page

1	Summary	5
2	Control Measures	7
	2.1 Admission of known or suspected cases	7
	2.2 Cases reported after admission	7
	2.3 Patient isolation	7
	2.4 Additional measures for cluster and outbreak situations	9
	2.5 Communication	11
	2.6 Faecal samples	11
3	Resources	12
4	Training	11
5	Implementation	11
6	Further Information	12
7	Equality	12
8	Audit	12
9	Review	13
10	References	13
	Appendix 1 – Flowchart for known or suspected Norovirus	14
	Appendix 2 – Contact Isolation Sign	15
	Appendix 3 – Colour coding for Aprons	16
	Appendix 4 – Norovirus escalation plan	17
	Appendix 5 – Actichlor Plus poster	21

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	5 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

## 1. SUMMARY

### 1.1 NOROVIRUS

1.1.1 Noroviruses are one of the most common causes of outbreaks of gastro-enteritis in hospitals and can lead to ward closure and major disruption in hospital activities.

1.1.2 The faecal–oral route is the most common route of spread, but the virus can also be spread through vomiting/droplet spread or via contaminated food and water. Viruses may be introduced into the ward environment by any of these routes and then propagated by person-to-person spread.

1.1.4 Outbreaks normally occur during the winter month but are increasingly being seen throughout the year. Diagnosis can usually be made rapidly and confidently on clinical and epidemiological grounds especially if vomiting is a prominent symptom. Diarrhoea tends to be short-lived and less severe than with other causes of gastro-enteritis. Outbreaks can be explosive at their outset particularly if projectile vomiting is a prominent feature. Duration of the illness is usually between 24 - 48 hours, with an incubation period of between 15 - 48 hours, and both staff and patients can be affected.

1.1.5 Symptoms include nausea, vomiting, diarrhoea, abdominal pains/cramps, myalgia, headache, malaise, chills, low-grade fever or a combination of these symptoms. G.I. symptoms characteristically last for 24 - 48 hours but can be longer in the elderly. Recovery is usually rapid thereafter. It is recognised that Norovirus infection results in short-term immunity only (up to approximately 14 weeks).

### 1.2 ROTAVIRUS

1.2.1 Rotaviruses are the most frequent enteric pathogens found in young children and infants and are a major cause of nosocomial diarrhoea of newborns and infants. However following the introduction of the rotavirus vaccine for infants in 2013 there has been a decline in laboratory-confirmed rotavirus infections. The total number of laboratory-confirmed rotavirus infections each season has since remained low compared to the pre-vaccine period. Infection of adults is usually sub-clinical, but outbreaks of clinical disease can occur in Older Persons units. Infection rates tend to follow a seasonal pattern with peak instances in winter and spring and lowest incidence in the summer months. Susceptibility is greatest between ages of 6 and 24 months, by 3 years of age most individuals have acquired rotavirus antibody.

1.2.2 The mode of transmission is faecal-oral but contact and respiratory spread are possible. The incubation period is between 24-72 hours.

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	6 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

1.2.3 Symptoms include sudden onset of fever, abdominal pain and vomiting, and continues with moderate or severe watery diarrhoea that usually lasts for 3-8 days.

1.2.4 The guidance given in this procedure refers essentially to Norovirus infection but can also be utilised for Rotavirus infection.

### 1.3 ACTIONS

1.3.1 Standard IP&C precautions should be instituted immediately when viral gastroenteritis is suspected, the Infection Prevention and Control Team (On call microbiology, out of hours) should be informed immediately for assessment and advice on patient placement. If the patient is moved to a cubicle, the cubicle should preferably have its own toilet facilities. If no toilet facilities are available then use a designated commode and ensure it is cleaned after each use, with a combined detergent and chlorine releasing product at a dilution of 1,000 ppm.

1.3.2 Strict compliance with the hand hygiene procedure, using soap and water, must be observed at all times.

1.3.3 Remove exposed food e.g. fruit from the area and discard.

1.3.4 Exclude affected staff immediately and until **48 hours symptom-free**.

1.3.5 Clean and disinfect vomit/faecal spillages promptly using a combined detergent and chlorine releasing product at a dilution of 1000ppm.

1.3.6 Increase the frequency of routine ward, bathroom and toilet cleaning.

1.3.7 Avoid patient movement to unaffected areas unless medically urgent.

1.3.8 Staff must not consume food and drink in clinical areas at any time and this must be reinforced during clusters or outbreak situations, in line with UHB policy.

1.3.9 Collect fresh faecal samples from first diarrhoeal episodes if possible and immediately submit separate samples for routine bacteriology and virology investigations.

1.3.10 Wear appropriate personal protective equipment i.e. facemask with integral visor, orange plastic aprons for close patient contact, gloves for handling body fluids.

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	7 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

## 2. CONTROL MEASURES

### 2.1 ADMISSION OF KNOWN OR SUSPECTED CASES

2.1.1 It is important to place patients with possible infective diarrhoea in a side room / cubicle as soon as possible. Information letters are sent to GPs and the community to advise regarding highlighting any infectious cases to the admissions teams if admission is needed. Admission units should be triaging patients **using the Clinical Risk Assessment tool** and ensuring patient placement is appropriate.

2.1.2 A patient with known or suspected viral gastro-enteritis infection admitted from home, or transferred from another ward or hospital should be admitted directly to a cubicle (preferably with its own toilet facilities) and standard IP&C precautions instituted immediately, ensuring emphasis on hand hygiene with soap and water. If no cubicle is available then the patient should be admitted to the least busy area of the ward, but standard IP&C precautions must be maintained.

### 2.2 CASE REPORTED AFTER ADMISSION

2.2.1 If a patient develops diarrhoea standard IP&C precautions should be instituted immediately and the patient should be isolated as soon as possible in a cubicle (preferably with toilet facilities) whenever available.

2.2.2 If a patient develops diarrhoea and vomiting and they are not in a cubicle restrict patient movement from that area, inform the Infection Prevention and Control team for assessment of the situation and immediately institute standard IP&C precautions. The presence of a single case on an open ward can be problematic; isolation of the index case will not necessarily prevent a secondary case in the immediate vicinity of the original bed space and so ward/room closure is still required after isolation of the index case (seek IP&C advice).

### 2.3 PATIENT ISOLATION

2.3.1 Standard IP&C precautions should be commenced immediately. A single room preferably with its own toilet facilities should be used; if no toilet facilities are available then use a designated commode and ensure it is cleaned after each use, with a combined detergent and chlorine releasing product at a dilution of 1000ppm.

2.3.2 If there are several affected patients, the Infection Prevention and Control Department should be informed as soon as possible. They will consider cohorting, as grouping these patients in an individual ward with designated staff is preferable to side-rooms of different wards.



Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	8 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

Contact precautions should be of the same standard whether the patient is in a cubicle or a ward area.

- 2.3.3 Visitors and members of staff from other departments must report to the Nurse-in-Charge before entering an infected area. Ensure signage informs visitors and staff of infectious incident. Signs are available from the [Period of Increased Incidence pack](#).
- 2.3.4 If the patient is in a cubicle the door of the room should be kept closed at all times unless the clinical need of the patient dictates otherwise. A risk assessment should be undertaken.
- 2.3.5 A contact isolation sign should be displayed on the cubicle door or at the entrance to the bay (see appendix 2).
- 2.3.6 Patients should not leave the room/ward area to attend other departments without prior arrangement/notification to the receiving department.
- 2.3.7 Gloves and orange plastic aprons should be worn for all contact with an affected patient or the contaminated environment. Hands should be washed with soap and water after removal.
- 2.3.8 Facemasks with integral visor (or equivalent) should be worn when in close proximity to or in contact with affected patients.
- 2.3.9 Hands must be washed with soap and water before entering the room, after patient contact, after contact with potentially infected materials and after removal of disposable gloves.
- 2.3.10 Waste should be treated as infectious waste and disposed of as per health board policy for disposal of infectious waste. Hands must be decontaminated after handling any waste.
- 2.3.11 Bristol stool charts should be maintained with times of episodes recorded. Vomiting must also be recorded. Charts must be kept outside of affected areas.
- 2.3.12 The [Period of Increased Incidence Pack](#) should be used at ward level to facilitate the management of the situation with support from IP&C.

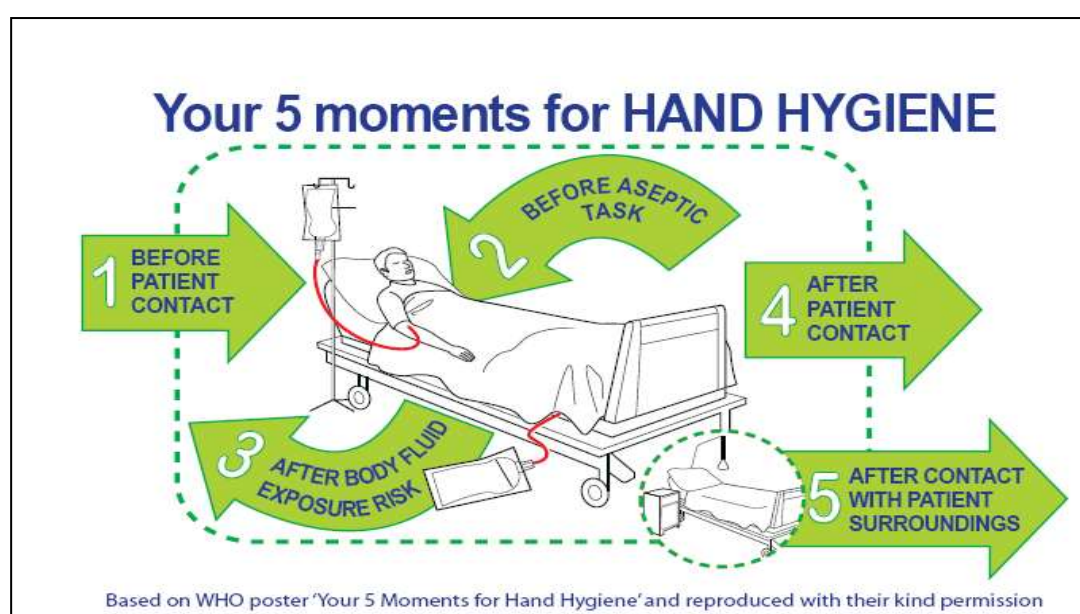


Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	9 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

### 2.3.13 STRICT COMPLIANCE WITH HAND HYGIENE TECHNIQUES USING SOAP AND WATER MUST BE OBSERVED AT ALL TIMES

The key time for general hand decontamination is at the point of care applying the 5 moments for hand hygiene:

- Before entering an isolation room
- Before and after contact with the patient and environment
- After contact with potentially infected materials/removal of gloves
- Before leaving the room



## 2.4 ADDITIONAL MEASURES FOR CLUSTER AND OUTBREAK SITUATIONS

- 2.4.1 Inform the Infection Prevention and Control Team immediately of any suspected cases or out of hours the on-call Microbiologist.
- 2.4.2 Wear appropriate protective clothing when in contact with the contaminated environment or a patient especially if vomiting is present or likely to occur. A fluid repellent mask and integrated visor would be suitable.
- 2.4.3 Wash hands with soap and water before and after contact with affected patients or their environment and after removing gloves and apron.
- 2.4.4 Remove exposed food e.g. fruit and de-clutter the bed area in order to facilitate effective cleaning. Disposable cutlery and crockery is not required whilst in isolation. Cutlery can be washed in the same way as usual.
- 2.4.5 Any affected staff must exclude themselves immediately upon development of symptoms and until 48 hours symptom-free. Affected members of staff should contact Occupational Health and submit a stool sample for testing.

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	10 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

- 2.4.6 Exclude non-essential personnel e.g. WRVS/hospital volunteers.
- 2.4.7 Soak up spillages of vomit/faeces promptly using paper towels or blue roll then clean with a combined detergent and chlorine releasing product at a dilution of 1,000 ppm. For information regarding dilution and contact times refer to appendix 5.
- 2.4.8 Commodes should be cleaned/ disinfected, by ward nursing staff, after each use with a combined detergent and chlorine releasing product at a dilution of 1,000 ppm.
- 2.4.9 Increase the frequency of routine ward, bathroom and toilet cleaning above the normal routine on advice from the IP&C team. Use a combined detergent and chlorine releasing product at a dilution of 1,000 ppm. If curtains are soiled they must be changed immediately, if necessary consider the use of disposable curtains.
- 2.4.10 The IP&C team will determine the need for Bed/ ward closure and/or re-opening in conjunction with clinical staff of the affected area.
- 2.4.11 If part or all of the ward is closed, thorough cleaning of the ward with a combined detergent and chlorine releasing product at a dilution of 1,000 ppm followed by a HPV clean and change of bed curtains (a “terminal clean”) should be undertaken before re-opening. The timing of this terminal cleaning process should be no less than 48 hours post-resolution of the last case.
- 2.4.12 Alginate bags should be used for the transport of soiled/infected linen; Linen bags should not be overfilled.
- 2.4.13 Staff working in affected areas should not work in unaffected areas for 48 hours after last exposure. This includes staff that work for Bank and Agency.
- 2.4.14 Avoid patient movement to unaffected areas unless medically urgent and after consultation with IP&C Team.
- 2.4.15 Staff must not consume food and drink in clinical areas at any time and this must be reinforced during outbreak situations, in line with UHB policy to prevent staff infections.
- 2.4.16 Outbreak messaging at ward entrances should encourage visitors to wash their hands with soap and water on arrival and leaving the ward. See the [period of increased incidence pack](#).
- 2.4.17 Medical and paramedical staff (e.g. physiotherapists) should wherever possible be dedicated to the affected ward(s) during an outbreak and not work in other areas. When this is not possible unaffected wards should be visited first before affected ward areas.
- 2.4.18 If staff shortages require the use of outside/agency staff, they should be booked to work for a block of several days or more to anticipate staffing requirements, even though this may result in direct early costs. It is the responsibility of the Ward Manager or nurse-in-charge of the ward to ensure that all bank or agency staff are aware of the UHB procedure on gastroenteritis.

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	11 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

## 2.5 COMMUNICATION

2.5.1 The Infection Prevention and Control Department should be informed immediately whenever there is a cluster of suspected gastroenteritis cases (e.g. two or more cases) of unexplained vomiting and/or diarrhoea, among patients and/or staff - this will allow rapid institution of control measures after assessment by the Team.

2.5.2 The Infection Prevention and Control Team should ensure that the Consultant in Communicable Disease Control (CCDC) is informed at the beginning of an outbreak and notified whenever outbreak meetings are convened.

2.5.3 A Serious Incident report will be required if an outbreak is declared.

2.5.4 The following departments will be informed by the IPCT (by daily outbreak email):

- Bed management if there is a possible/probable/imminent ward closure
- Nurse Bank Department
- Occupational Health should be alerted for potential symptoms among staff
- All other relevant departments should be informed in accordance with the Infection Control Procedure for Infectious Diseases Incidents and Outbreaks.
- The Virology Department should be informed of suspected cluster/outbreak.

## 2.6 FAECAL SAMPLES

2.6.1 In situations where there is a cluster of cases or an outbreak, collect fresh faecal samples from first diarrhoeal episodes if possible, divide into two separate containers, and submit immediately for: -

- Routine microbiology investigation, including *Clostridium difficile*.
- Virology investigations.
- Ensure forms are clearly marked as coming from a possible outbreak and with date of onset

Faecal samples can be sub-mitted on the weekend; these will be stored ready for testing at the beginning of normal laboratory hours.

Faecal samples can also be submitted if contaminated with urine.

2.6.2 Vomitus should not be submitted.

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	12 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

### 3. RESOURCES

- 3.1 The necessary resources for the management, training, risk assessment, monitoring and auditing for Viral Gastroenteritis are already in place and the implementation of this procedure will not entail additional expenditure.

### 4. TRAINING

- 4.1 Mandatory Infection and Prevention and Control training updated every two years.
- 4.2 Further departmental based training as identified by training needs analysis.

### 5. IMPLEMENTATION

- 5.1 Cardiff and Vale UHB Board is responsible for the approval of the Infection Control Procedure for Viral Gastroenteritis (Norovirus) in UHB hospitals.
- 5.2 Individual directorates will be responsible for the implementation of the procedure document in clinical areas.
- 5.3 Distribution of the procedure document will be through the UHB intranet site.

### 6. FURTHER INFORMATION

- 6.1 This guidance is still current and has been used in the preparation of this procedure which also takes into account local circumstances within the UHB.
- 6.2 Guidelines for the management of Norovirus outbreaks in acute and community and social care settings (2011)

### 7. EQUALITY

- 7.1.1 This procedure has had an equality impact assessment and has shown there has been no adverse effect or discrimination made on any particular individual or group.

### 8. AUDIT

- 8.1 Audit of compliance with the procedure document will be carried out by the Infection Prevention and Control Department as part of their procedure audit programme.

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	13 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

## 9. REVIEW

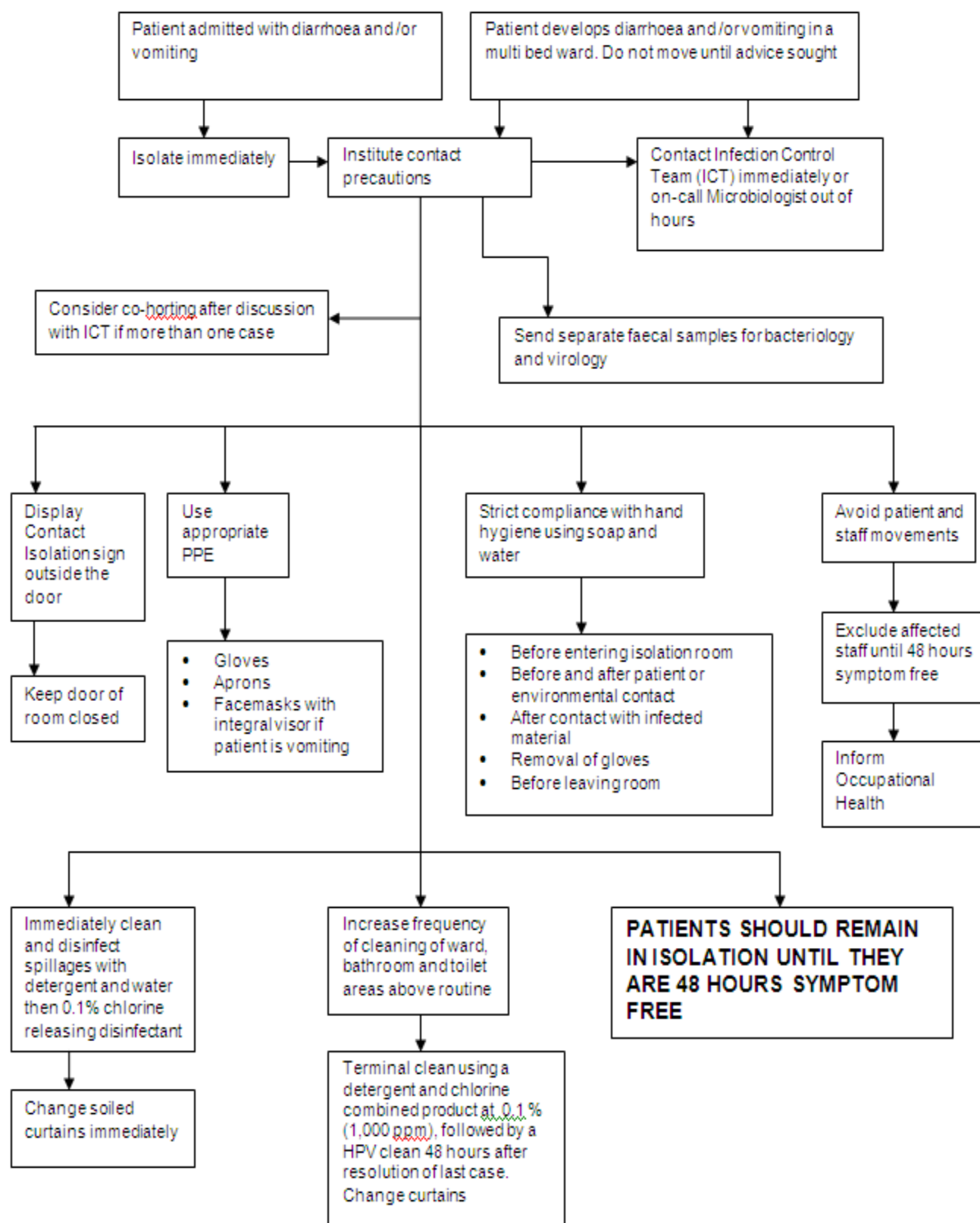
- 9.1 This procedure will be reviewed every three years or sooner if the national guidelines are updated.

## 10. REFERENCES

- 10.1 Management of hospital outbreaks of gastro-enteritis due to small round structure viruses: Journal of Hospital Infection (2000); 45:1-10.
- 10.2 Cardiff and Vale Infection Control Procedure for Infectious Incidents and Outbreaks (2016).
- 10.3 Health and Safety at Work Act 1974
- 10.4 Control of Substances Hazardous to Health Regulations 2002, SI 2002 No 2677, HMSO
- 10.5 Guidelines for the management of norovirus outbreaks in acute and community health and social care settings. March (2012)

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	14 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

## APPENDIX 1 – Flowchart for known or suspected Norovirus







Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	15 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		




## APPENDIX 2

# STOP

## Contact isolation KEEP DOOR CLOSED

unless ward sister/charge nurse instructs otherwise

### Instructions for all staff and visitors

**Hands must be washed**  
when entering and before leaving room

↓

**Wear orange plastic apron**  
when entering the room

↓

**Wear gloves when risk of contamination**  
from blood, body fluids or secretions

↓

**Wear Goggles/Visor**  
if there is a risk of splashing from blood or body fluids

↓

**PPE disposal:**  
Dispose of gloves, apron and face protection  
into orange labelled waste bin before leaving room.


↓

**Wash your hands before leaving room**



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Cardiff and Vale  
University Health Board

Cardiff and Vale UHB



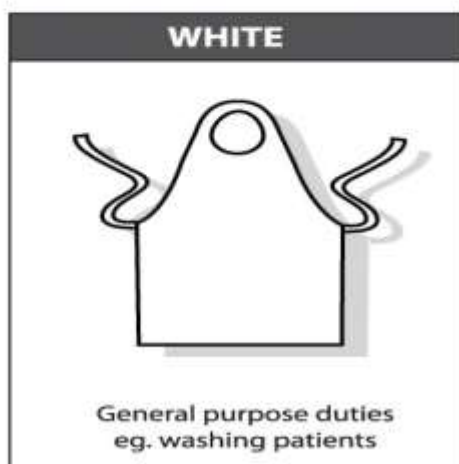
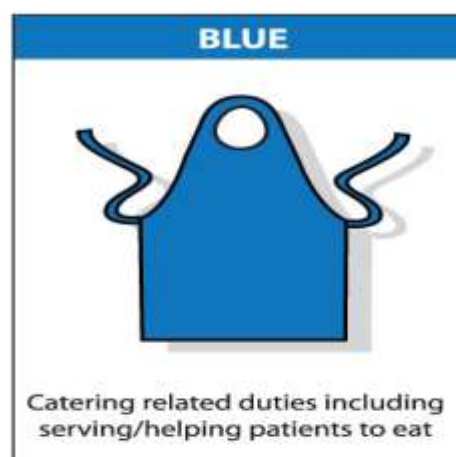
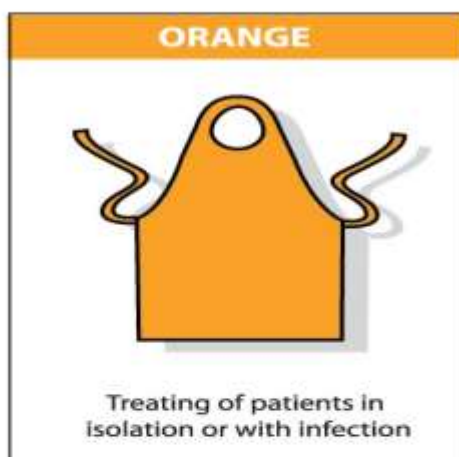
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Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	16 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

## APPENDIX 3

# Cardiff and Vale UHB Colour coding for aprons



Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	17 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 201
Approved By: IPCG		

## APPENDIX 4

### Cardiff and Vale University Health Board Escalation Procedure for Management / Communication of suspected Norovirus outbreak/s

ALERT	TRIGGERS	ACTION	BY WHOM	RESPONSE
GREEN	<b>Pre-Season Preparation</b>	If there is no activity noted in the community at 1 <sup>st</sup> November send out preparatory information anyway.	IP&C team / Local Public Health Team / Health Protection Team (PHW HPT)/ PCIC Clinical Board	Include information in daily bed meetings from 1 <sup>st</sup> November if not previously informed of community activity.  Information to Public on minimising the spread of GI illness to be clearly signposted and made available on the C&V UHB website or via Public Health Wales website.
	<b>Known outbreaks in community.</b>	Information on community cases of <u>norovirus</u> to be communicated to Health Board.	PHW HPT	PHW HPT to inform IP&C team and PAT of the location of <u>norovirus</u> clusters (2 or more cases) in the community.
	<b>No outbreaks within hospital setting.</b>	Raise awareness that <u>norovirus</u> is present in the community to ensure all patients admitted with D&V or who have had contact with anyone with D&V in preceding 48 hours are isolated.  Initiate Responsible Visiting (Visitors asked not to visit if have had symptoms or contact with someone with symptoms within last 48 hours)	IP&C team / Local Public Health Team / Health Protection Team (PHW HPT)/ PCIC Clinical Board and Communications Team	Send out Preparatory Information (letters in toolkit). Cascade information to Admission areas. All patients that present a risk of <u>norovirus</u> (e.g. present with symptoms of diarrhoea and/or vomiting or have been in contact with others with D&V within the previous 48 hours) are admitted <b>DIRECTLY TO A SINGLE ROOM and ISOLATED.</b>  Inform Communications team. Draft media release in preparation Production and placement of posters at entrances to hospital / wards. All wards informed that Responsible Visiting is in place. (Within 1 working day)
		Keep reviewing surveillance data on <u>norovirus</u> activity, e.g. reports from Public Health Wales / Health Protection Teams	IP&C team.	If patients admitted with symptoms are contained and there is no spread to existing in patients status remains at <b>GREEN.</b>

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	18 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
Approved By: IPCG		

YELLOW	<b>Suspected cases on 1 or 2 wards.</b>	<b>Follow actions / response in GREEN and IN ADDITION:</b> Affected bay restricted admissions. Can still admit to rest of ward. Individual risk assessment by ward staff and the IP&C team is required prior to arranging transfer of patients from non-closed areas to other clinical or care areas. Transfer of patients to Nursing Homes to be discussed with IP&C team	IP&C team	Inform relevant operational staff (Bed Managers, Microbiology team, Sister / Charge nurse, Clinical Board Management Team/s, Communications manager, DIPC, Operational Services /Housekeeping Team Managers). Inform local health protection team (PHW HPT).
	<b>Cases confined to bays on the wards.</b>	Escalation of Community Messages to prevent unnecessary admissions	IP&C team / Ward Managers	
		Enhanced Cleaning in affected bay as per Norovirus Outbreak Policy	PCIC Clinical Board / PHW HPT / Communications team	Liaison between UHB Communications Team, PCIC clinical board and PHW HPT to escalate community messages to prevent admissions with <u>norovirus</u> unless clinically necessary and minimise imports via visitors / relatives.
		IP&C nursing and Operational Services representation at bed management meetings.	Operational Services / Housekeeping	Instigate enhanced <u>cleaning</u> , consider need for agency staff if insufficient staff to carry out required additional cleaning.
		Report outbreaks to Public Health Wales HCAI surveillance team and to Welsh Government via “no surprises” reports	IP&C team / Operational Services IP&C team / DIPC / Exec Nurse	<b>If cases contained and resolve without spread return to GREEN.</b>  <b>If cases spread out of bays to the rest of the ward move to AMBER</b>

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	19 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
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AMBER	Suspected cases on 2 wards.	Follow actions / response in GREEN & YELLOW, IN ADDITION: Restrict admissions to affected ward (s) and instigate Norovirus Outbreak Policy.	IP&C Team /Ward staff	Liaise with PHW HPT/CCDC and Directorate Managers Assess ward (s) affected and likely duration of outbreak
	Not confined to one bay area on the wards.	Convene Outbreak meetings and establish actions to reduce impact on bed capacity;  Provide information on current situation: <input type="checkbox"/> IP&C details of ward restrictions <input type="checkbox"/> Health Board wide Bed state <input type="checkbox"/> If bed capacity is at Amber or Red initiate appropriate section of the Health Board Bed management escalation plan  Information on ward closures cascaded to wider Health community  Raise public awareness of outbreak to reduce unnecessary visitors to the HB on next working day.  Information on ward restrictions closures cascaded across the HB.  Admissions to the HB retained for patients who need acute care for whom use of other healthcare facilities or admission avoidance is clinically inappropriate	IPC Team / Patient Access team (PAT)  IP&C team / PAT  PAT  Communications Team  Comms/PHW HPT / Local Public Health Teams  Comms / IPC Team  PAT  PCIC Clinical Board	Assess current Health Board-wide bed state.  All relevant personnel to provide feedback to PAT with outcomes of identified actions as per Health Board Bed Management escalation plan  Instigate Alert Email to group members: All Clinical Board management teams of Health Board, PHW HPT and Local Public Health Team. Escalate to Chief Operating Officer / Clinical Board Leads  Include information on HB public website regarding wards affected by <u>norovirus</u>  Daily update on ward restrictions on intranet and IP&C webpage  Use of escalation letters to be sent out to key stakeholders.  Send e mail to peripatetic clinical staff regarding precautions needed at beginning of outbreak and as restrictions change  Inform Switchboard, Primary Link, Ambulance service, ward co-ordinators on and MAU which wards are closed with <u>norovirus</u> . Daily updates on handover to hospital at night and on-call staff  Inform Acute Care GPs which wards are affected by <u>norovirus</u> .  Cascade letters to GPs to facilitate admission avoidance where clinically appropriate  If wards are resolved without further spread return to <b>GREEN</b> If spread to further wards move to <b>RED</b>

Document Title: Viral Gastroenteritis (Norovirus) IPC procedure	20 of 27	Approval Date: 01 May 2019
Reference Number: UHW 075		Next Review Date: 01 May 2022
Version Number: 5		Date of Publication: 03 Dec 2019
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RED	3 to 5 wards closed	<b>Follow GREEN, YELLOW &amp; AMBER and IN ADDITION:</b>		
		Convene Daily Outbreak Meetings and establish actions to address reduced bed capacity.	IP&C Team	Invite Chief Operating Officer, Clinical Directors, Lead Nurses, Directorate Managers, local public health team, PHW HPT.
		Draw up plans for patient management in context of ongoing outbreak.	IP&C team / Ward Managers / Clinical Teams	Categorise patients on closed wards into: 1. Confirmed norovirus & resolved 2. Currently symptomatic 3. Never had symptoms & incubating Categorise patients on closed wards into: 1. Those who must remain within the specialty 2. Those who may move to another specialty
		Daily assessment of wards with restrictions in place.	IP&C Team	IPC Team to review ward restrictions daily including weekends.
		Initiate Bed escalation plan according to shortfall	PAT / Chief Operating Officer	All relevant personnel to provide feedback to PAT with outcomes of identified actions as per HB Bed Management escalation plan
		Restricted Visiting to be initiated on next working day: <input type="checkbox"/> No visitors on wards with restrictions in place without prior agreement with nurse in charge <input type="checkbox"/> Visiting to all wards restricted to immediate family or close friends	Comms / IPC Teams / Ward Managers	Production and placement of Restricted Visiting posters at entrances to hospital and wards Public announcement via local radio / and possibly social media Update public website with information
		<b>Report as Serious Incident to Welsh Government</b>	Executive Nurse Director	Complete Serious Incident form and initiate accompanying investigation  If wards resolved without spread to any further wards return to <b>GREEN</b> . If spread continues to further wards move to initiating <b>MAJOR INCIDENT PLAN</b> .



Document Title: <i>Insert document title</i>	21 of 27	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

## APPENDIX 5



# ACTICHLOR™ PLUS GENERAL ENVIRONMENT

DISINFECTS AND CLEANS IN ONE EASY STEP



1  
Wear disposable gloves and apron. Safety glasses with side shields are required whilst handling the tablets only



2  
Remove any gross contamination including urine, vomit and faeces with a paper towel before applying Actichlor Plus



3  
Dissolve Actichlor Plus tablets (according to dilution instructions below) in cold water to make your solution. Leave lid off dilution bottle until tablets have dissolved.



4  
Use solution according to your hospital policy. When disinfecting commodes and mattresses, allow the solution to dry fully before rinsing. Actichlor Plus solution must not be sprayed.



5  
Keep solution for no longer than 24 hours. Dispose of remaining solution into appropriate drains with running water e.g. disposal sink, sluice



6  
Dispose of gloves and apron as clinical waste. Wash hands after removing gloves and apron

## DILUTION INSTRUCTIONS

DISINFECTION OF THE ENVIRONMENT (1,000PPM AVAILABLE CHLORINE)			CONTACT TIME
Actichlor Plus 1.7g Tablets	1 Tablet per 1L	Disinfection of the Environment	5 minutes
		Sporicidal – C.difficile	10 minutes

## WARNINGS & PRECAUTIONS

<b>AVOID</b> contact with skin and eyes. <b>DO NOT</b> breathe dust/fumes/powder/vapour/spray.	<b>DO NOT</b> use directly on urine or vomit. Mixing this product with acid or ammonia releases chlorine gas.	<b>AVOID</b> prolonged contact with stainless steel or clothing	<b>ALWAYS</b> dispose used materials as clinical waste. Wash hands thoroughly after handling.	<b>ALWAYS</b> keep container tightly closed. Store in a secure dry place in suitable labelled containers	<b>ALWAYS</b> keep out of the reach of children	<b>ALWAYS</b> dispose of each solution after 24 hours, refer to your SDS and hospital policy	<b>USE ONLY</b> with adequate ventilation

USE BIOCIDES SAFELY, ALWAYS READ THE LABEL & PRODUCT INFORMATION BEFORE USE  
PLEASE REFER TO THE SAFETY DATA SHEET AND HOSPITAL POLICY

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Cardiff and Vale  
University Health Board



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## Equality & Health Impact Assessment for

### VIRAL GASTROENTERITIS (NOROVIRUS) INFECTION CONTROL IN UNIVERSITY HEALTH BOARD HOSPITALS PROCEDURE

1.	Title	VIRAL GASTROENTERITIS (NOROVIRUS) INFECTION CONTROL IN UNIVERSITY HEALTH BOARD HOSPITALS PROCEDURE Reference UHB 075
2.	Name of Corporate Directorate and title of lead member of staff, including contact details	Clinical Nurse Specialists, Infection Prevention and Control (ext 46703), Corporate Directorate
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The objectives of this policy are to provide all staff working within Cardiff and Vale UHB with a comprehensive understanding of patients with confirmed (or suspected) Viral Gastroenteritis.
4.	Evidence and background information considered.	<i>Guidelines for the management of Norovirus outbreaks in acute and community health and social care settings</i>  <a href="https://www.gov.uk/government/publications/norovirus-managing-outbreaks-in-acute-and-community-health-and-social-care-settings">https://www.gov.uk/government/publications/norovirus-managing-outbreaks-in-acute-and-community-health-and-social-care-settings</a>  Outbreak data.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	This procedure applies to all UHB staff involved with the care of patients who may have suspected or confirmed Viral Gastroenteritis.

#### 6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.



How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
<b>6.1 Age</b>	No evidence to suggest a positive or negative impact on any age group.	N/A	N/A
<b>6.2 Persons with a disability as defined in the Equality Act 2010</b> Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	No evidence to suggest a positive or negative impact on any disability group.	N/A	N/A
<b>6.3 People of different genders:</b> Consider men, women, people undergoing gender reassignment	No evidence to suggest a positive or negative impact on people of different genders.	N/A	N/A
<b>6.4 People who are married or who have a civil partner.</b>	No evidence to suggest a positive or negative impact on people who are married or have a civil partner.	N/A	N/A
<b>6.5 Women who are expecting a baby, who are on a break from work after having a</b>	No evidence to suggest a positive or negative impact on women who are	N/A	N/A

<b>How will the strategy, policy, plan, procedure and/or service impact on:-</b>	<b>Potential positive and/or negative impacts</b>	<b>Recommendations for improvement/mitigation</b>	<b>Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate</b>
<b>baby, or who are breastfeeding.</b>	pregnant, on maternity leave or breastfeeding.		
<b>6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers</b>	No evidence to suggest a positive or negative impact on different races, nationalities, colour, culture or ethnic origin.	N/A	N/A
<b>6.7 People with a religion or belief or with no religion or belief.</b> The term 'religion' includes a religious or philosophical belief	No evidence to suggest a positive or negative impact on people with/without a religious belief.	N/A	N/A
<b>6.8 People who are attracted to other people of:</b> <ul style="list-style-type: none"> <li>the opposite sex (heterosexual);</li> <li>the same sex (lesbian or gay);</li> <li>both sexes (bisexual)</li> </ul>	No evidence to suggest a positive or negative impact on a person who is heterosexual/bisexual/lesbian or gay.	N/A	N/A
<b>6.9 People who communicate using the Welsh language in terms</b>	No evidence to suggest a positive or negative impact on	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
of correspondence, information leaflets, or service plans and design	people who use the Welsh language.		
6.10 People according to their income related group:	No evidence to suggest a positive or negative impact on people according to their financial or employment status.	N/A	N/A
6.11 People according to where they live:	No evidence to suggest a positive or negative impact on people according to where they live.	N/A	N/A
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	N/A	N/A	N/A

**7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?**

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
<b>7.1 People being able to access the service offered:</b>	Appears to not have any impact.		
<b>7.2 People being able to improve /maintain healthy lifestyles:</b>	Appears to not have any impact.		
<b>7.3 People in terms of their income and employment status:</b>	Appears to not have any impact.		
<b>7.4 People in terms of their use of the physical environment:</b>	Appears to not have any impact.		
<b>7.5 People in terms of social and community influences on their health:</b>	Appears to not have any impact.		
<b>7.6 People in terms of macro-economic, environmental and sustainability factors:</b>	Appears to not have any impact.		

Please answer question 8.1 following the completion of the EHIA and complete the action plan

<b>8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service</b>	Positive impacts from this procedure are that all staff across C&V UHB would have the ability to manage Viral Gastroenteritis in an appropriate and timely manner.
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### Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
<b>8.2 What are the key actions identified as a result of completing the EHIA?</b>	There are no significant impacts to note.			
<b>8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required?</b>	No.			
<b>8.4 What are the next steps?</b>				