Somerset Partnership NHS
NHS Foundation Trust

OUTBREAK OF INFECTION:
POLICY FOR MANAGEMENT AND CONTROL

(to be read in conjunction with all other Trust Infection Prevention and Control Policies)

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Relevant Staff Groups	All Inpatient Staff

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DOCUMENT CONTROL

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Amendments	Updated the Relevant Care Quality Commission (CQC) Registration Standards		
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Lead Director	Director of Infection Prevention and Control		

CONTRIBUTION LIST Key individuals involved in developing the document

Name	**Designation or Group**
Karen Anderson	Head of Infection Prevention and Control/Decontamination Lead
All members	Infection Prevention and Control Assurance Group
All members	Senior Managers Operational Group
All Members	Clinical Governance Group
All Members	Clinical Policy Review Group
Andrew Sinclair	Head of Corporate Business

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1. INTRODUCTION

1.1 Outbreaks of infection vary greatly in extent and severity and this plan recommends general procedures, which are to be followed in all types of outbreaks. The Infection Prevention and Control Team will deal with the majority of infection problems on a day-to-day basis.

2. PURPOSE & SCOPE

2.1 The purpose of this policy is to ensure that the organisation is able to initiate prompt recognition of an outbreak of a healthcare associated infection or a communicable disease, to control further spread, prevent recurrence and to maintain satisfactory communication with other agencies having a legitimate interest in the outbreak.

2.2 The statements included in the policy apply to all in-patient areas across the organisation. Where special circumstances apply, this is made clear within the policy.

3 DUTIES AND RESPONSIBILITIES

3.1 **The Trust Board, via the Chief Executive is responsible for:-**

- Establishing and maintaining adequately resourced infection prevention and control arrangement throughout the Trust;
- Minimising the risks of infection and the general means by which it prevents and controls such risks;
- Ensuring that the role and functions of the Director of Infection Prevention and Control (DIPC) are satisfactorily fulfilled by appropriate and competent persons as defined by the Department of Health (2008)

3.2 **Director of Infection Prevention and Control (DIPC):-**

Has Executive responsibility to the Trust Board for infection prevention and control, including outbreak management and will undertake the following in the event of an identified outbreak;

- Advise the Chief Executive of the progress of the outbreak and control measures implemented;

- Oversee the local control of and the implementation of the Outbreak Policy;

- It is the responsibility of the DIPC to determine whether an Outbreak Control Group (OCG) is required. This will be based on the number of affected cases, the pathogenicity and potential for spread in the affected area. The DIPC will chair the OCG to guide the group in the instigation of the outbreak plan if required;
- In the absence of the DIPC the Infection Prevention and Control Doctor will lead the outbreak investigation, with the support of Infection Prevention and Control Team;

- In the event of a predominantly community associated outbreak the Public Health England South/ South West Protection Team Consultant in Communicable Disease Control (CCDC) will take the lead.

- The DIPC or deputy will provide a final report for the Trust Board/members of the Outbreak Control Group and/or the Major Outbreak Control Group and any other external agencies involved.

3.3 **Infection Prevention and Control Group is responsible for:-**

- Ensuring that procedures for the implementation of the Outbreak Policy is continually reviewed and improved as required within the Trust.

3.4 **Ward staff are responsible for:**

- Reporting suspected outbreaks immediately to the Infection Prevention and Control Team. Out of hours the on call manager and the Consultant Microbiologist should be contacted for advice.
- Booking themselves onto initial and update mandatory training and for attending mandatory training, regardless of their grade, role or status, including permanent, temporary, full-time, part-time staff and locums, bank staff, volunteers, trainees and students.
- Any member of staff going off duty because of a suspected infectious disease, (e.g. chicken pox, diarrhoea and vomiting, influenza) including Medical Staff should inform their Line Managers. Staff should not return to work unless symptom free. Further advice maybe sourced via the Occupational Health Service or the individual's General Practitioner.

3.5 **Ward Manager or deputy is responsible for:-**

- Ensuring infection prevention and control precautions are carried out as detailed in this policy.
- Ensuring that staff are aware of the policy and requirements for attending training as identified in the Training Matrix. Managers will ensure that staff have attended all relevant training and have current updates
- Ensuring that staff are released to attend relevant Training and for recording attendance at training in local training records. All non-attendance at training will be followed up by managers.
- Ensuring individual staff and team's training needs are met through Individual Performance review and in line with the Training Matrix. Training information should be passed to the Learning and Development Department who will update the electronic staff record.

3.6 **Learning and Development Team are responsible for:-**

- Recording attendance at Training and will advise Operational Managers of non-attendance.

3.7 Infection Prevention and Control (IPC) Team

- Outbreaks may be detected by the Infection Prevention and Control Team directly on the basis of culture results from the Microbiology Laboratory and /or during routine surveillance by the Infection Prevention and Control Team. However it is often the vigilance of healthcare workers that alert the Infection Prevention and Control Team or on call manager for out of hours service, to the possibility of an outbreak at the earliest opportunity

- Recognition of other infections such as surgical wounds or intravascular cannulae are also often highlighted by the ward staff and it is for this reason that close liaison between healthcare workers and the Infection Prevention and Control Team and /or Tissue Viability team is essential

- All reports of suspected outbreaks will be treated seriously. If a report of an outbreak is found to be established the Infection Prevention and Control Team will determine the severity of the outbreak by undertaking the following:

    - Data will be collected following discussion with the Ward Manager
    - Case definition and collation will be established together with microbiological sampling and type;
    - The Infection Prevention and Control Team will liaise with the Occupational Health Team to identify any potential staffing involvement;
    - Identification of hazards and elimination of risk identified;
    - Isolation procedures or potential for cohorting patients identified and implemented;
    - If necessary implementation of restrictions to ward/bays identified and increased cleaning requirements instigated;
    - Should the outbreak be attributed to Noro-type Virus the Norovirus Trigger Tool will be activated (Appendix F). This tool maybe activated by the wider health community during periods of escalation.

- An outbreak of MRSA, C Difficile or Norovirus will be reported as per national policy.

3.8 Outbreak Control Group (OCG):

- The OCG / MOCG will discuss the available information and agree an action plan. The Manager for the affected area will be responsible for implementation and closure of the action plan.

3.9 **Major Outbreak Control Group (MOCG):**

- The overall function of the MOCG is to co-ordinate the investigation and control of a major outbreak. This will include the following:

  i. To agree a case definition;
  ii. To inform and involve as appropriate key hospital and community personnel and services (see Appendix B);
  iii. To take all necessary steps for the continuing clinical care of patients during the outbreak;
  iv. To clarify the resource implications of the outbreak and its management, and how they will be met (e.g. additional supplies and staff);
  v. To agree and co-ordinate policy decisions on the investigation and control of the outbreak (e.g. possible need for an isolation ward) and ensure they are implemented, allocating responsibility to specific individuals who will then be responsible for taking action;
  vi. To consider the need for outside help and expertise;
  vii. To ensure that adequate communication channels are established, including nominating responsibility for making statements to the news media throughout the duration of the outbreak;
  viii. To consider the need for a help line;
  ix. To provide clear instructions and / or information for ward staff and others including contracted staff;
  x. To agree arrangements for providing information to patients, relatives and visitors;
  xi. To ensure communications with the Department of Health, NHS Executive Regional Offices;
  xii. To meet frequently to review progress on outbreak investigation and control;
  xiii. To define the end of the outbreak and evaluate the lessons learned;
  xiv. To prepare interim reports (detailed minutes of MOCG meetings) and also a final report;
  xv. To inform others inside and outside the hospital, of lessons to be learned from the outbreak.

4. EXPLANATIONS OF TERMS USED

4.1 **Outbreak:** A greater than expected rate of infection for a given time and place. Examples include a single case of Viral Haemorrhagic Fever or hospital acquired legionellosis or a period of increased incidence (PII) of Clostridium difficile associated diarrhoea with evidence of cross transmission.

4.2 **Healthcare Associated Infection:** An infection where the epidemiology or circumstances suggests acquisition within the Trust. For example when the infection develops after the patient has been in the Trust longer than the expected incubation period.

4.3 **Incubation Period:** The time, which normally elapses between, acquiring an infectious agent and developing symptoms. This will normally be expressed as a range.

4.4 **Surveillance:** The systematic, active ongoing observation of the occurrence and distribution of disease in a population using consistent definitions.

4.5 **IC Net:** An electronic system utilised by Somerset Acute and Community based IPC Teams to enable robust management and surveillance of Healthcare Associated Infections.

4.6 **Cohort Nursing:** A system of caring for patients separately from those not showing signs of the infection, by dedicated nursing staff. Usually affected and unaffected patients will be nursed in different bays.

4.7 **Outbreak Control Group (OCG):** This group is convened in the event of an outbreak of limited extent and without involvement of patients outside Somerset Partnership. The membership should include:

- Representative from Somerset Partnership Infection Prevention and Control Team
- The Manager for the affected area;
- The Matron/Ward Manager for the affected area or deputy;
- A Clinician for the affected area or deputy;
- The Director of Infection Prevention and Control or deputy;
- Facilities Manager
- Hotel Services Manager
- Infection Prevention and Control Doctor

4.8 **Major Outbreak Control Group (MOCG):** This group is convened in the event of a major outbreak. The decision to convene an MOCG will depend upon the number of cases affected and at risk, the pathogenicity of the organism and the potential for transmission within the Somerset Partnership and wider community.

This group will be convened in the event of a single case of Viral Haemorrhagic Fever or Hospital acquired Legionellosis. Also this group would be appropriate if food poisoning occurs in hospitalised patients and in major outbreaks of pandemic influenza.

The group should include the OCG plus:

- The Consultant in Communicable Disease Control (CCDC) or deputy;
- Director of Infection Prevention and Control;
- Occupational Health Nurse or Doctor;
- Director of the Public Health England SW Regional Laboratory (particularly if providing additional laboratory assistance);
- SW Regional Epidemiologist (if available);
- SW Regional Microbiologist (if available);
- A representative from the Health and Safety Executive;

- Health and Safety Manager;
- Estates Manager
- Press Officer for the Trust;
- Clerical support;
- Environmental Health Officer (if the infection is likely to be food or water-borne).

5. INVESTIGATION OF A SUSPECTED OUTBREAK

5.1 The Infection Prevention and Control Team will initially investigate suspected outbreaks. From the initial assessment it should be determined if:-

- Outbreak is confined to an individual site;
- Outbreak is not confined to an individual site or is of major importance.
- On the basis of the information and assessment of the situation it will be determined if this constitutes an outbreak, if so the policy will be put into action.

6. REPORTING OF OUTBREAKS

6.1 All outbreaks of infection should be reported as serious untoward incidents as detailed in the Trust Untoward Event policy. The Matron/Ward Manager must update the Datix report, once the outbreak is resolved, to include the actions that took place including terminal cleaning.

6.2 Outbreaks of MRSA, C. Difficile and Norovirus will be reported to the Public Health England using their reporting tools.

7. OUTBREAK CONFINED TO AN INDIVIDUAL SITE

7.1 In the case of an outbreak confined to an individual site, the Infection Prevention and Control Team will manage the outbreak liaising with the appropriate clinicians and nursing staff. The Infection Prevention and Control Team will initiate infection control procedures to include:-

- Informing the Directorate Manager and DIPC
- Isolation/cohort nursing if appropriate;
- Case finding;
- Data collection;
- Diagnostic and screening microbiological tests;
- Restriction of admissions and transfers where applicable.

7.2 The Infection Control Doctor is the person primarily responsible for advising on the actions required to control the outbreak. An Outbreak Control Group (OCG) may be convened following discussion between the Infection Control Doctor, the IPC Team and the DIPC.

8. OUTBREAKS NOT CONFINED TO AN INDIVIDUAL SITE AND / OR AN OUTBREAK OF MAJOR IMPORTANCE

8.1 The decision that an outbreak is a major incident takes into consideration the number of people involved and the pathogenicity of the organism and potential for transmission within the hospital or community.

8.2 A **single** case of a viral haemorrhagic fever, hospital-acquired legionellosis or diphtheria is a major incident.

8.3 Several hospital patients having linked symptoms and therefore suspected of having the same infection, e.g. food poisoning, also constitute a major outbreak of infection

8.4 The Infection Control Doctor will inform the IPC Team and DIPC that the Major Outbreak Control Group (MOCG) should be convened.

9. TRAINING REQUIREMENTS

9.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs analysis) (where mandatory training is indicated). Where no mandatory training is indicated please specify how training will be provided for this policy (e.g. local induction, recommended training, etc). All training document referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

- Trust Induction Training
- Hand Hygiene Training
- Infection Prevention and Control Training
- Untoward Event Training

10. EQUALITY IMPACT ASSESSMENT

10.1 All relevant persons are required to comply with this policy and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

11. MONITORING COMPLIANCE AND EFFECTIVENESS

11.1 Monitoring arrangements for compliance and effectiveness

- Overall monitoring will be by the Infection Control Assurance Group

11.2 **Responsibilities for conducting the monitoring**

- The Infection Prevention and Control Assurance Group will monitor procedural document compliance and effectiveness where they relate to clinical areas.

11.3 **Methodology to be used for monitoring**

- The Infection Prevention and Control report at the conclusion of an outbreak should include comment as to whether the procedure within this policy has been followed. Any actions identified will be implemented and monitored via the Infection Prevention and Control Assurance Group.

11.4 **Frequency of monitoring**

- The Infection Prevention and Control Assurance Group reports to the Clinical Governance Group quarterly.

11.5 **Process for reviewing results and ensuring improvements in performance occur.**

Audit results will be presented to the Senior Managers Operational Group for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring improvements, where necessary, are implemented.

12 COUNTER FRAUD

12.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

13 RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

13.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 14:	Meeting nutritional and hydration needs
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing

Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

13.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16:	Notification of death of service user
Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents

13.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

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Relevant National Requirements

HSG (95)10: Hospital Infection Control, 1995, HMSO

14. REFERENCES

Department of Health (2009) The Health and Social Care Act 2008, Code of Practice for health and social care on the prevention and control of infections and related guidance.

Health Protection Agency (2011) Guidelines for the Management of Norovirus outbreaks in acute and community health and social care settings

Cross reference to other procedural documents

- All other Infection Prevention and Control Policies
- Consent to Examination and Treatment Policy
- Consent and Capacity to Consent and Treatment Policy
- Development and Management of Organisation-wide Procedural Documents Policy and Guidance
- Hand Hygiene Policy
- Infection Prevention Control Policy
- Learning Development and Mandatory Training Policy
- Record Keeping and Records Management Policy
- Risk Management Policy and Procedure
- Staff Mandatory Training Matrix (Training Needs Analysis)
- Training Prospectus

- Untoward Event Policy
- Serious Incidents Requiring Investigation
- Pandemic Influenza Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on ‘Policies and Procedures’). Trust Guidance is accessible to staff on the Trust Intranet.

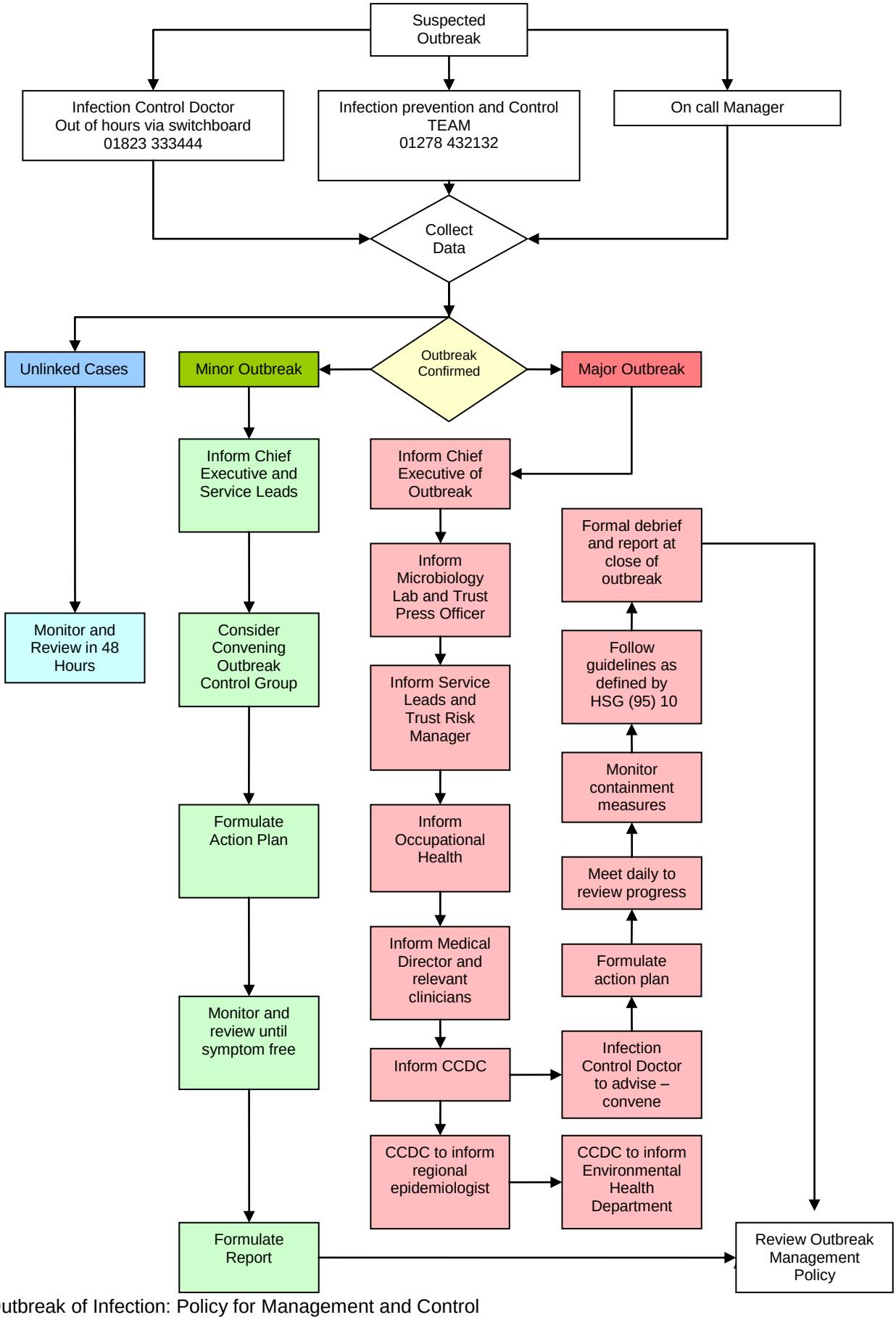
15. APPENDICES

15.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A	Outbreak Management Algorithm
Appendix B	Initial action plan for Infection Control Team
Appendix C	Membership and Terms of Reference for Outbreak Control Group OCG
Appendix D	Responsibilities and Tasks of the OCG/MOCG
Appendix E	Key Contact List
Appendix F	Norovirus Toolkit
Appendix G	Norovirus Trigger Tool

APPENDIX A

Outbreak Management Algorithm



APPENDIX B

Initial Action Plan for Infection Prevention and Control Team

- **Investigate outbreak** – visit site or telephone site out of hours. Review all evidence / data and assess if this is an outbreak. ICD / IPC Team to discuss with DIPC and agree on appropriate action to be taken.

- **Provide infection prevention and control advice to limit spread** – isolate potentially infectious patients. Cohort nurse affected patients in bays (where case numbers exceed isolation facilities) and arrange for contacts to be screened if required.

- **Potential outbreak situation** – Inform Service Manager, Head of Service. DIPC to inform Chief Executive or deputy. Advise on restriction of admissions and transfers to ward. Out of hours inform Senior Manager on call.

- **Outbreak control group to be convened** – OCG or MOCG (See section 3, section 4 and Appendix C).

- **Liaise with CCDC** – in the case of a major outbreak with community involvement the CCDC will co-ordinate the outbreak.

- **Liaise with support services** – additional ward cleaning specifications, linen and laundry, supplies.

- **Assess outbreak at regular intervals** – advise and update Trust Management of developments and progress with implementation of Infection Control precautions. Advise on additional precautions to be taken if outbreak control measures are failing.

- **Staff education** – increase staff awareness of the organism involved and mode of transmission. Rationale for actions being taken. Involve Occupational Health Service if screening needed or for reassurance and support.

- **Patient information** – updating patients on the situation is the role of the clinicians and nursing staff.

- **Prepare reports** – disseminate information and findings to those who need to know.

APPENDIX C

Membership and Terms of Reference of the Outbreak Control Group (OCG)

The DIPC will convene an outbreak control group consisting of:

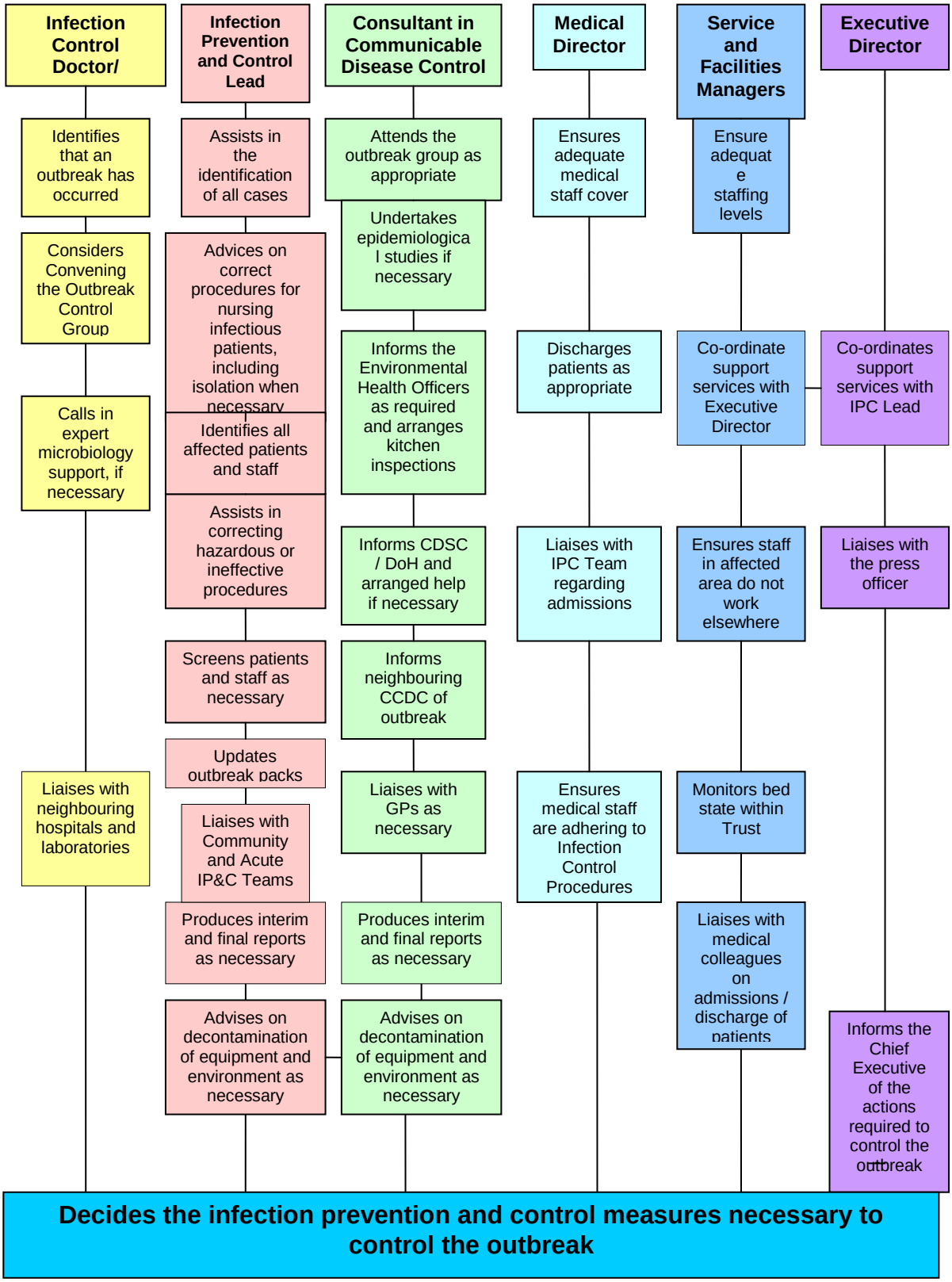
- Infection Prevention and Control Doctor;
- Representative from Somerset Partnership Infection Prevention and Control Team
- The Service Manager for the affected area;
- The Matron/Ward Manager for the affected area or deputy;
- A Clinician for the affected area or deputy;
- The Director of Infection Prevention and Control or deputy;
- Facilities Manager
- Hotel Services Manager or Deputy

Terms of Reference for Outbreak Control Group

- To investigate the source and cause of the outbreak
- To implement measures necessary to control the outbreak
- To monitor the effectiveness of control measures
- To provide clear guidelines for all staff involved in the outbreak
- To inform all members of the Trust that an outbreak is occurring
- To evaluate the overall experience of controlling the outbreak

APPENDIX D

Responsibilities and Tasks of the OCG/MOCG



APPENDIX E

Key Contact List

Key Contacts	
Contact	**Telephone**
Infection Prevention and Control Team (Sompar)	01278 432132
IPC Lead (Sompar)	07768703715
DIPC (Sompar)	01278 432000
Medical Director (Sompar)	01278 432000
Facilities Manager (Sompar)	01278 432000
Hotel Services Manager (Sompar)	01278 432000
On Call microbiologist	01823 333444
Infection Control Doctor (MPH)	01823 333444
The Consultant in Communicable Disease Control (CCDC) or deputy;	01823 287817
Director of the Public Health EnglandSW Regional Laboratory (particularly if providing additional laboratory assistance);	0117 342 5551
SW Regional Epidemiologist (if available);	01453 829 740
SW Regional Microbiologist (if available);	01752 792 366
A representative from the Health and Safety Executive;	0117 988 6000
Environmental Health Officer (if the infection is likely to be food or water-borne).	01823 356 356

Norovirus Checklist

This checklist is intended for use by healthcare staff dealing with a suspected case of gastrointestinal infection. It is not intended to replace universal infection

Upon arrival to Clinical Setting / Start of Symptoms

- ☐ Direct patient with existing / recent history of diarrhoea and / or vomiting to designated area (cubicle/ single room) and **ISOLATE**
- ☐ Ensure staff wear gloves and aprons for direct patient contact or contact with equipment
- ☐ Identify single patient use toilet / commode where possible
- ☐ Complete clinical assessment to confirm symptoms are of infectious origin (sudden onset, projectile vomit, history of contact)
- ☐ Assess risk of other infectious origin (recent antibiotics, history of travel, food history)

Initial Assessment

- ☐ Record date of onset of symptoms
- ☐ Obtain specimen of stool for MC&S/Virology/C.diff as indicated (or vomit for Norovirus)
- ☐ Label specimen for viral testing and send as per local regulations following biohazard precautions.
- ☐ Report suspected cases to IP&C team / HPU
- ☐ If two cases or more instigate outbreak approach
- ☐ Commence outbreak reporting

Initial and Ongoing Patient Management

Supportive therapy as for any case of gastrointestinal infection

- ☐ Isolate in single room with dedicated toilet facilities where possible
- ☐ Post restricted entry and infection control signs
- ☐ Provide dedicated patient equipment if available
- ☐ Ensure local protocol for frequent and enhanced cleaning and linen change is implemented
- ☐ Record fluid balance and commence stool chart
- ☐ **DO NOT GIVE ANTIEMETICS OR ANTIMOTILITY AGENTS**

Before Every Patient Contact

- ☐ Clean hands
- ☐ Put on PPE
- ☐ Clean and disinfect patient equipment between patients
- ☐ Wash hands / change gloves between each patient

After Every Patient Contact

- ☐ Remove PPE
- ☐ Wash hands with soap and water
- ☐ Clean and disinfect patient equipment
- ☐ Dispose of infected linen and waste in designated bags

Control of Designated Area (Single room or Bay/Ward)

- ☐ Instigate local closure protocol
- ☐ Instigate Outbreak Management Policy
- ☐ Inform HPU and Partner Agencies (see escalation tool)
- ☐ Post restricted entry and infection control signs at Designated Area Entrances
- ☐ Provide patient / visitor / carer / staff information
- ☐ Restrict visiting according to local policy
- ☐ Involve communications lead and provide pre-prepared press releases to local media
- ☐ Ensure local protocol for enhanced surface cleaning using effective products (detergent with hypochlorite/sporicidal agents)
- ☐ Remove all fruit/ food items
- ☐ Consider use of hospital scrubs for ward staff where appropriate

Patient and Staff Movement

- ☐ Advice on placement of further suspected cases should be sought from IP&C team
- ☐ Restrict movement of ward/bank staff/junior medical staff
- ☐ AHPs to allocate nominated individual to designated area *or*
- ☐ AHPs/Medical staff to visit designated area last on round
- ☐ Allocate staff to Designated area if limited to Bay/Rooms
- ☐ Avoid cross working between affected and unaffected patients where possible
- ☐ Movement of patients from ward to ward for cohort management is **NOT** recommended
- ☐ Risk assess all potential patient discharges prior to decision to discharge (especially care home residents, those with vulnerable relatives or carer responsibilities)
- ☐ Agree patient transfers with receiving areas following individual assessment and for urgent clinical need only
- ☐ Symptomatic staff should remain absent

72 hours after Cessation of Uncontained Symptoms/Discharge

- ☐ Decision taken with advice from IP&CT/DIPC and according to local protocol
- ☐ Provide patient advice re hand washing and hygiene at home
- ☐ Instigate designated area deep clean
- ☐ Change curtains and all linen items
- ☐ Complete deep/final clean checklist prior to opening to further admissions

Trust Escalation Procedure for Management / Communication of Suspected Norovirus Outbreak

ALERT	TRIGGERS	ACTION	BY WHOM	RESPONSE
GREEN	**Known outbreaks in community.** **No outbreaks within hospital setting.**	Raise awareness that norovirus 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 72hrs are isolated. Initiate Responsible Visiting (Visitors asked not to visit if have had symptoms or contact with someone with symptoms within last 72 hrs)	IP&C team Clinical Site Team / IP&C Team Communication Manager / IP&C team	CST / Matrons / On call manager informed via daily bed meeting Cascade information to Admission areas. All patients that present a risk of norovirus (e.g. present with symptoms of diarrhoea and/or vomiting or have been in contact with others with D&V within the previous 72 hrs) are admitted directly to a single side room and **ISOLATED**. Inform Communications team. Production and placement of posters at entrances to hospital / wards. All wards informed that Responsible Visiting is in place. (Within 1 working day) **If patients admitted with symptoms are contained and there is no spread to existing in patients status remains at GREEN.**
YELLOW	**Suspected cases on 1 or 2 wards.** **Cases confined to single bays.**	Follow actions / response in GREEN and in addition: Affected bay restrict to admissions. Can still admit to rest of ward. No transfers out from ward to other wards or hospitals except for urgent clinical need (e.g. ITU). Transfer of patients to Nursing Homes to be discussed with IP&C team Enhanced Cleaning in affected bay as per Gastroenteritis Outbreak Policy Instigate Outbreak Monitoring	IP&C team IP&C team Cleaning Co-ordinators Ward staff	Inform relevant operational staff (Bed Managers, ICD, Matron, Sister / Charge nurse, Directorate Manager, Clinical Director, Divisional Director, Communications manager, DIPC, Cleaning Co-ordinators). Inform Partner organisations according to county escalation tool. Assessment of risk and liaison with Community IP&C teams Ward own team and relief team to be mobilised to instigate enhanced cleaning Consider need for agency staff if ward staff unable to carry out required additional cleaning. **If cases contained and resolve without spread return to GREEN.** **If cases spread out of bays to the rest of the ward move to AMBER**

AMBER	**Suspected cases on 1 or 2 wards.** **Not confined to single bay.**	Follow actions / response in GREEN & YELLOW, in addition: Restrictions in place and instigate Outbreak Policy. Convene Outbreak meetings and establish actions to reduce impact on bed capacity: Provide information on current situation: • IP&C details of closed ward (s) • Trustwide & community bed state • If bed capacity is at Amber or Red initiate appropriate section of Trust Bed management escalation plan Information on ward closures cascaded to wider Health community via Countywide Escalation Process Raise public awareness of outbreak to reduce unnecessary visitors to the Trust on next working day. Information on ward restrictions cascaded across the Trust. Admissions to the Trust retained for patients who need acute care for whom use of other healthcare facilities or admission avoidance is clinically inappropriate	IP&C Team /Ward staff IP&C Team CST CST Comms Team Comms/ IPC teams IP&C Team CST Switchboard MAU coordinator HPU	Liaise with HPU/CCDC and Directorate Managers and liaise with Community IP&C Assess ward (s) affected and likely duration of outbreak Assess of current Trustwide bed state. Liaise with in-reach team for community bed status All relevant personnel to provide feedback to CST with outcomes of identified actions as per Trust Bed Management escalation plan Instigate Alert Email to group members: Internal teams, PCT teams, Secondary Care Providers, PHE, SWAST, PCT to support Countywide escalation process. Initiate recorded message for all external calls to switchboard stating wards have restrictions in place , recommending responsible visiting Include information on Trust public website regarding ward restrictions . Daily update on wards restrictions on intranet and IP&C webpage 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 restricted with norovirus Daily bleep message to on call medical, surgical and orthopaedic SPRs informing them which wards have restrictions in place with norovirus Inform Acute Care GP which wards have restrictions . Cascade letters to GPs to facilitate admission avoidance where clinically appropriate **If wards are resolved without further spread return to GREEN.** **If spread to further wards move to RED.**

RED	**3 to 5 wards closed**	Follow GREEN, YELLOW & AMBER and in addition: Convene Daily Outbreak Meetings and establish actions to address reduced bed capacity. Daily assessment of ward restrictions Initiate Bed escalation plan according to shortfall Restricted Visiting to be initiated on next working day: • No visitors on wardswith restrictions in place without prior agreement with nurse in charge • Visiting to all wards restricted to immediate family or close friends Consider reporting as Serious Untoward Incident	IP&C Team IP&C Team CST Comms / IP&C Teams IPC Team	Invite PHE/CCDC, Directorate Managers, Director of Operations, PCT and liaise with Community IPCTs IPC Team to review ward restrictions daily including weekends. All relevant personnel to provide feedback to CST with outcomes of identified actions as per Trust Bed Management escalation plan Production and placement of Restricted Visiting posters at entrances to hospital and wards Public announcement via local radio / Press Update public website with information Alter recorded message for all external calls to switchboard to state restricted visiting in place Complete SUI and initiate accompanying investigation **If wards resolved without spread to any further wards return to GREEN.** **If spread continues to further wards move to BLACK.**
BLACK	**More than 5 wards closed**	Follow GREEN, YELLOW, AMBER, RED & in addition: Convene Daily Outbreak Meetings and establish actions to address reduced bed capacity and service delivery, consider cohort wards Provide information on current situation: • IPC to provide details of and ongoing advice to closed wards including at weekends • Clinical details of patients on closed wards • Current number of empty beds on each closed ward, number of non-movers e.g. nursing home patients • Initiate appropriate section of bed management escalation plan according to shortfall • Consider co-horting of wards with restrictions.	IP&C Team Nurse in charge / Clinical Director CST IP&C Team / CST / On call/Responsible Manager	Invite Director of Operations, Divisional Directors Categorise patients on restricted ward 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 All relevant personnel to provide feedback to CST with outcomes of identified actions as per Trust Bed Management escalation plan Assess if wards at similar stage of outbreak Assess clinical risk of current shortfall in bed capacity Countywide approach to capacity issues via Outbreak Management Group and in accordance with countywide escalation approach.

Countywide Escalation Tool for Response to Norovirus

	Location			Action	Inform
Level	**Acute Trust (Hospital)**	**Community Hospital**	**Care Home - Residential or Nursing Home**	**Each level's actions are in addition to lower level response**	☎ **Refer to communication Cascade**
0	No cases	No cases	No cases		
1	2 cases in single ward	2 cases in single ward	2 cases in single home	Local Response Implement control & investigation measures	Internal outbreak alert PHE notified. If food poisoning suspected PHEto alert EHOs Refer to Trust:- Isolation, Management of Norovirus/D+V/Outbreak Management Policies
2	More than 2 cases in a single ward	More than 2 cases in a single ward	More than 2 in a Care Home	Instigate local OMT meeting - commence outbreak monitoring and management approach. Implement additional control measures (enhanced cleaning, cohort nursingPHE to follow care home guidance.	External outbreak alert. External communication cascade:- Partner ICTs, Commissioners,PHE,SHA/SW AST/GP cascade including OOH/Primary Link/Inreach/Outreach teams
3	>2 wards with cases +	>2 community wards/hospitals affected +/-	>2 Care Homes	Inform SHA If more than one setting affected - Step up to Emergency Winter Plans Implement countywide Outbreak Management Team / Cross reference PHE Policy Commence countywide OMT meetings	
4	6-10 wards affected	6-10 wards / hospitals affected	6-10 homes affected	Countywide OMT meetings. CEO involvement.	Re-inform following previous actions
5	>10 wards	>10 wards affected	>10 homes affected	Strategic level decision making for elective workload, management of emergency admissions SHA Lead	

Public Health England

Stop norovirus spreading this winter

Norovirus, sometimes known as the 'winter vomiting bug', is the **most common stomach bug** in the UK, affecting people of all ages. It is **highly contagious** and is transmitted by contact with contaminated surfaces, an infected person, or consumption of contaminated food or water.

The symptoms of norovirus are very distinctive – people often report a sudden onset of **nausea** followed by **projectile vomiting and watery diarrhoea.**

Good hand hygiene is important to stop the spread of the virus.

People are advised to:

- Wash their hands thoroughly using soap and water and drying them after using the toilet, before preparing food and eating
- Not rely on alcohol gels as these do not kill the virus

An infection with norovirus is self-limiting and most people will make a full recovery in 1-2 days. It is important to keep hydrated – especially children and the elderly.

Do not visit either A&E or GPs with symptoms as this may spread the virus.

Further information and advice is available from NHS 111, including an online symptom checker at nhs.uk.

Gateway Number: 2013189

Norovirus
Fact Sheet

What are noroviruses?

Noroviruses are a group of viruses that are the most common cause of gastroenteritis (stomach bugs) in England and Wales. In the past, noroviruses have also been called ‘winter vomiting viruses’, ‘small round structured viruses’ or ‘Norwalk-like viruses’.

How does norovirus spread?

The virus is easily transmitted from one person to another. It can be transmitted by contact with an infected person, by consuming contaminated food or water or by contact with contaminated surfaces or objects.

What are the symptoms?

The symptoms of norovirus infection will begin around 12 to 48 hours after the patient becomes infected. The illness is self-limiting and the symptoms will last for 12 to 60 hours. They will start with the sudden onset of nausea followed by projectile vomiting and watery diarrhoea. Some people may have a raised temperature, headaches and aching limbs. Most people make a full recovery within 1-2 days, but some people (usually the very young or elderly) may become very dehydrated and require hospital treatment.

Why does norovirus often cause outbreaks?

Norovirus often causes outbreaks because it is easily spread from one person to another and the virus is able to survive in the environment for many days. Because there are many different strains of norovirus, and immunity is short-lived, outbreaks tend to affect more than 50% of susceptible people. Outbreaks usually tend to affect people who are in semi-closed environments such as hospitals, nursing homes, schools and cruise ships.

How can these outbreaks be stopped?

Outbreaks can be difficult to control and long-lasting because norovirus is easily transmitted from one person to another and the virus can survive in the environment. The most effective way to respond to an outbreak is to disinfect contaminated areas, to institute good hygiene measures including hand-washing **(alcohol hand gel is not effective against norovirus)** and to provide advice on food handling. Those who have been infected should be isolated for a minimum of 48 hours after their symptoms have ceased. Affected members of staff should be excluded from work until they have been **free from symptoms for 48 hours**.

How is norovirus treated?

There is no specific treatment for norovirus apart from letting the illness run its course. It is important to drink plenty of fluids to prevent dehydration.

If I’m suffering from norovirus, how can I prevent others from becoming infected?

Good hygiene is important in preventing others from becoming infected – this includes thorough hand washing before and after contact. Food preparation should also be avoided until 3 days after symptoms have completely resolved.

Who is at risk of getting norovirus?

No specific group is at risk of contracting norovirus infection. It affects people of all ages. The very young and elderly should take extra care if infected, as dehydration is more common in these age groups.

Norovirus outbreaks are reported frequently in semi-closed institutions such as hospitals, schools, residential and nursing homes and hotels. Anywhere that large numbers of people congregate for periods of several days provides an ideal environment for the spread of the disease. Healthcare settings tend to be particularly affected by outbreaks of norovirus. A recent HPA study shows that outbreaks are shortened when control measures in healthcare settings are implemented quickly, such as closing wards to new admissions within 4 days of the beginning of the outbreak and implementing strict hygiene measures.

How common is norovirus?

Norovirus is not a notifiable disease so reporting is done on a voluntary basis. The HPA receives reports of outbreaks and we see between 130 and 250 of these each year. It is estimated that norovirus affects between 600,000 and a million people in the UK each year.

Are there any long-term effects?

There are no long-term effects from norovirus.

What can be done to prevent infection?

Good hygiene measures (such as frequent hand washing) around someone who is infected is important. Certain measures can be taken in the event of an outbreak, including the implementation of basic hygiene and food handling measures and prompt disinfection of contaminated areas; the isolation of those infected and the exclusion of affected staff members **until 48 hours after their symptoms have ceased**.

Available online at: https://www.gov.uk/government/collections/norovirus-guidance-data-and-analysis

OUTBREAK - DEEP CLEAN CHECK LIST

LOCATION

BAY / SIDE ROOM	Cleaned by dated	Checked by dated
ALCOHOL GEL / DISPENSER		
BED		
BED LIGHT		
CEILING VENTS		
CHAIR		
CLINICAL WASTE BIN		
CURTAINS		
DOOR		
DOOR HANDLE		
HANDTOWEL DISPENSER		
HOUSEHOLD WASTE BIN		
INTERNAL GLAZING		
LOCKER		
LOW LEVEL DUSTING		
MIRROR		
PATIENT HAND BOOK		
PATIENT NAME PLATE		
PATIENT NOTES CLIP BOARD		
SINK		
SOAP DISPENSER		
SWITCHES		
TABLE		
TELEVISION		
WALL VENTS		
WINDOW LEDGES		

TOILET AREA		
CEILING VENTS		
CLINICAL WASTE BIN		
DOOR		
DOOR HANDLE		
HANDTOWEL DISPENSER		
HOUSEHOLD WASTE BIN		
INTERNAL GLAZING		
LOW LEVEL DUSTING		
MIRROR		
SINK		
SOAP DISPENSER		
SWITCHES		
TOILET		
WALL VENTS		
WINDOW LEDGES		
SLUICE AREA		
ALCOHOL GEL / DISPENSER		
CEILING VENTS		
CLINICAL WASTE BIN		
DOOR		
DOOR HANDLE		
HANDTOWEL DISPENSER		
HOUSEHOLD WASTE BIN		
INTERNAL GLAZING		
LOW LEVEL DUSTING		
MIRROR		
SINK		
SOAP DISPENSER		
SWITCHES		
WALL VENTS		
WINDOW LEDGES		

APPENDIX G

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST NOROVIRUS ESCALATION TRIGGERS AND ACTION PLAN

Level	Community Hospital	Action	Responsibility
0 (White) **Preparedness and Long Term Planning**	**No Cases**	Check Somerset Norovirus intranet page daily for county wide outbreak information http://nww.somerset.nhs.uk/welcome/directorates/nursing-and-patient-safety/who-we-are-what-we-do/infection-control/norovirus-current-restrictions/	Infection Prevention and Control Team
		Work with families and informal carers to highlight risks of Norovirus and promote ways to avoid spreading	Somerset Partnership - District Nurses/Health Visitors/School Nurses
		Review surge capacity and the need for, and availability of, staff support in the event of a Norovirus outbreak in in-patient facilities	Heads of Service/Matrons and Ward Sisters
		Distribute Norovirus advice and guidance to Managers, Matrons and Community Staff. Ensure Norovirus is part of induction and infection control education programme Present and distribute the Norovirus action plan at Community Hospital Working Group and make available on the intranet.	Infection Prevention and Control Team

Level	Community Hospital	Action	Responsibility
1 (Green) Internal Alert and Readiness	**2 cases in single ward- Period of Increased incidence (PII)**	Note PII and implement local response, control and investigation measures as per outbreak policy	Infection Prevention and Control Team
		Notify • NHS Somerset of outbreak (intranet inclusion) • Microbiology Laboratory • Primary Link service • Local GP providers (with admitting rights)	Infection Prevention and Control Team Infection Prevention and Control Team Infection Prevention and Control Team Matrons of affected Unit/Hospital
		If food poisoning suspected alert Environmental Health Officers	Health Protection Unit
		Implement all containment measures as per outbreak policy	Infection Prevention and Control Team
		Consider formation of local Outbreak Management Team	Infection Prevention and Control Team and Director of Infection Prevention & Control (DIPC)
		Consider on call telephone advice system for weekends 10.00hrs – 14.00 hrs	Infection Prevention and Control Team

Level	Community Hospital	Action	Responsibility
2 (Yellow) External Alert and Readiness	**More than 2 cases in a single ward or more than one ward with cases**	Implement daily local Outbreak Management Team meeting.	Infection Prevention and Control Team and DIPC
		Implement additional control measures (enhanced clearing, cohort nursing as per the outbreak guidance)	Matrons
		Review elective admissions and non – essential activities, put on standby for potential cancellation	Head of Adult Services
		Review patients for early discharge, with emphasis on patients suitable for discharge to their own homes	Matrons
		Consider on call telephone advice system for weekends 10.00 – 14.00 hrs	Infection Control Team
		Brief On – Call Directors and Chief Executive Officers	DIPC
		Maintain a watching brief and prepare to participate in Countywide Outbreak Management Team Conference Call	Infection Prevention and Control Team Lead
		Prepare to implement SITREP Reporting	Infection Prevention and Control Team Lead

Level	Community Hospital	Action	Responsibility
3 (Amber) Minor Service Disruption	**2-5 community wards/hospitals affected**	Implement organisational cascade of information via daily alert email	Infection Prevention and Control Lead
		Review all elective admissions and non – essential activities, put on standby for potential cancellation	Head of Adult Services
		Implement on-call telephone advice system for weekend 10.00hrs- 14.00	Infection Control Team
		Participate in County wide Outbreak Management Conference Call	Infection Prevention and Control Lead
		Consider invoking restrictive visiting arrangements (see visiting times policy)	DIPC and Infection Prevention and Control Lead
		Implement SITREP reporting	Infection Prevention and Control Lead
		Continue On – Call Directors and Chief Executive Officer briefings	DIPC

Level	Community Hospital	Action	Responsibility
4 (Red) Severe Service Dsiruption	**6-10 wards affected Across all hospitals**	Implement restrictive visiting arrangements and inform affected patients next of kin	Matrons as per policy
		Continue organisational cascade of information via daily alert e mail	Infection Prevention and Control Lead
		Continue with Countywide Outbreak Management Team Meetings	Infection Prevention and Control Lead
		Continue SITREP Reporting	Infection Prevention and Control Lead
		Continue On – Call Directors and Chief Executive Officer briefings	DIPC

Level	Community Hospital	Action	Responsibility
5 (Black) Critical Service Disruption	**>10 wards affected across all hospitals**	Continue to enforce restrictive visiting arrangements	Matrons
		Continue SITREP Reporting	Infection Prevention and Control Lead
		Continue organisational cascade of information via daily alert e mail	Infection Prevention and Control Lead
		Continue SITREP Reporting	Infection Prevention and Control Lead
		Continue On – Call Directors and Chief Executive Officer briefings	DIPC