Homerton University Hospital NHS
NHS Foundation Trust

Policy for Control of Diarrhoea and Vomiting due to Norovirus

Author(s)	Vickie Longstaff (Infection Control Nurse Consultant)
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Review Body	Infection Control Committee
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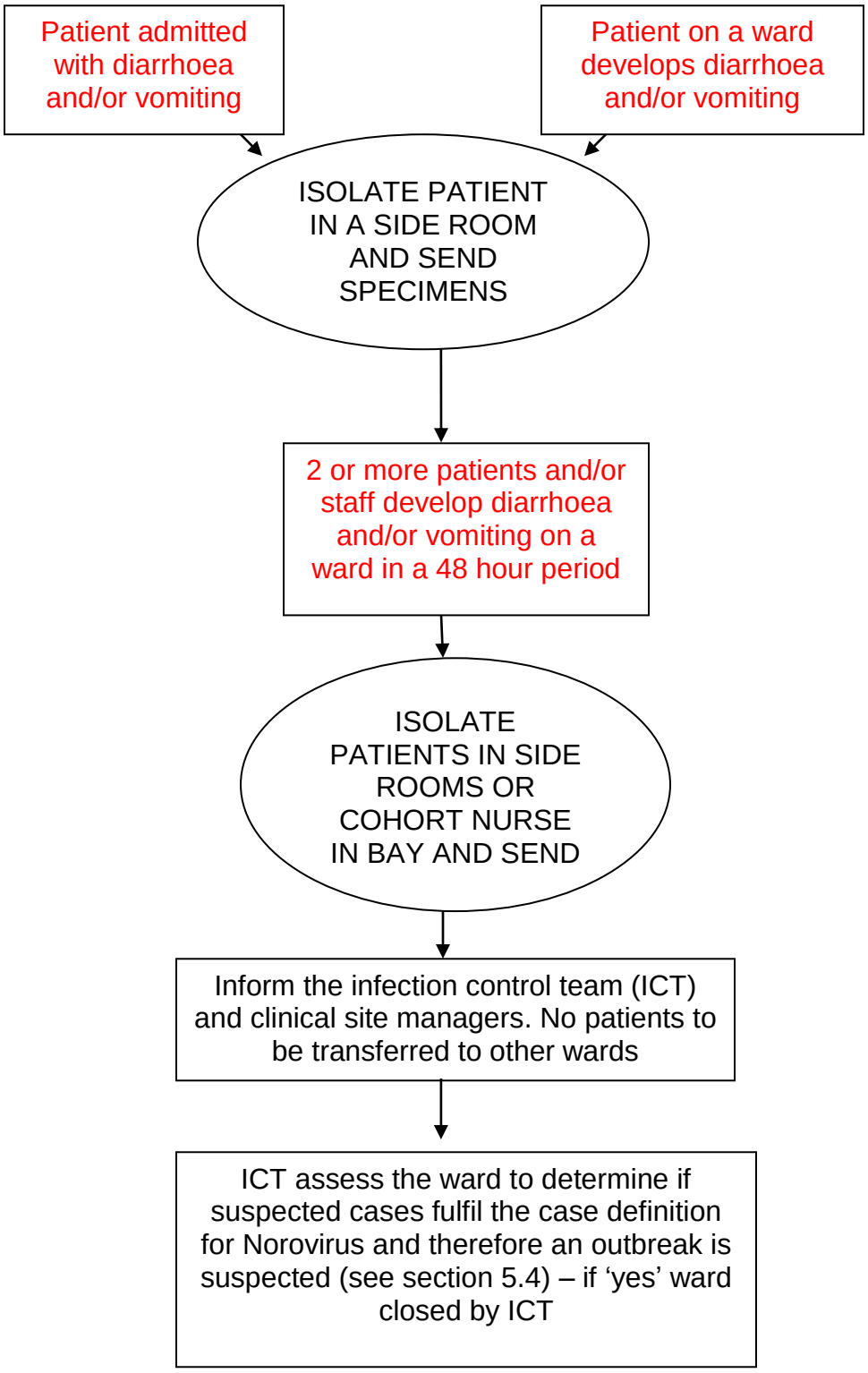
Contents Page

1.0 Summary- Immediate action to be taken for cases of Diarrhoea and Vomiting



2.0 Introduction

Diarrhoea and/or vomiting may be due to infectious or non-infectious causes. Since the causative agent of a case or cases of infectious diarrhoea may take several days to be isolated in the laboratory, it is essential that all patients with diarrhoea and/or vomiting of a potentially infectious origin are isolated in a side room on 'stool/enteric precautions' and the Infection Control Team informed immediately to prevent the spread of infection to other patients and members of staff.

This policy relates specifically to diarrhoea and vomiting caused by Norovirus. The '*C.difficile* policy' covers all aspects of *C.difficile* prevention and management and the 'Isolation policy' covers precautions to be taken for other bacterial and viral causes of diarrhoea and/or vomiting. Both these policies are available on the intranet.

Viruses, notably small round structured viruses (SRSVs, Norovirus, winter vomiting virus), are readily spread from person-to-person through aerosols and environmental contamination from vomiting. Outbreaks of infection in hospitals caused by cross-infection are frequently reported. It is essential that action is taken quickly in suspected outbreaks in order to avoid rapid spread of Norovirus leading to hospital wide outbreaks. In the event of the discovery of 2 or more cases of diarrhoea and/or vomiting on a ward i.e. a potential outbreak scenario, it is vital that the Infection Control team and Clinical Site Managers are informed immediately so that a risk assessment can be performed and an outbreak management plan (including isolation or cohorting of the affected patients; quarantining of the bay or ward and sending of appropriate samples to Microbiology) can be initiated.

SRSVs affect people of all age groups. It is recognised that SRSV infection results in short-term immunity only.

Symptoms
Vomiting is classically documented as the prominent symptom in SRSV (Norovirus) associated gastroenteritis, but occasional clusters of cases occur where vomiting in infrequent or absent. Diarrhoea tends to be short lived and less severe than with other causes of gastroenteritis. Other symptoms include nausea, abdominal cramps, headache, myalgia, chills and fever.

Duration of symptoms
Symptoms last between 24-48 hours and recovery is usually rapid thereafter. Asymptomatic carriage is common.

Incubation
Usually 10-72 hours.

This policy has been developed by the Infection Control Team. It was then distributed to the Infection Control Committee and key staff members for comments and endorsement (See appendix 1). The final draft was then sent to the Policy Group for ratification.

3.0 Scope-

This policy applies to all employees of the Trust in all locations including the Non-Executive Directors, temporary employees, locums and contracted staff.

4.0 Roles and Responsibilities –

Infection Prevention and Control (IPC)Team
To provide training on infection prevention and control procedures which include isolation precautions and management of patients with infective diarrhoea and/or vomiting to all staff on formal induction programmes and refresher training courses. To liaise with clinical team, monitor the outbreak, advise on isolation, bed management and ward closure.

Divisions
To ensure that all staff within their teams attend training and comply with Trust practices.

Medical Staffing and Education Team
To ensure that all appropriate training incorporates infection control and prevention training. To organise, maintain records and follow up on non-attendance for induction of all staff.

Department/Team Managers
To ensure that staff have infection prevention and control included in their personal development plan and attend Trust induction and refresher training on infection control and areas of poor practice/non-compliance are addressed.

Clinical staff
To ensure that they are adequately trained and aware of precautions to be taken when caring for patients with diarrhoea and/or vomiting.
To comply with the standards in this document.

5.0 Body of Policy or Procedure

5.1 Management of the patient with diarrhoea and/or vomiting

- Any patient admitted to hospital with diarrhoea and/or vomiting where the cause is unknown and could be infective must be isolated in a side room on stool/enteric precautions (see below). It is the presence of diarrhoea and/or vomiting which determines that the patient should be isolated not the presence of a diagnosed named bacteria or virus as laboratory results can take up to 4 days.
- Any patient who develops diarrhoea and/or vomiting while an inpatient must be moved into a side room and isolated on stool/enteric precautions.
- The side room must have its own toilet facilities or a designated commode must be placed in the room.
- A ‘stool/enteric precautions’ isolation card must be placed on the door.
- The need and reason for isolation must be explained to the patient and relatives.
- Hand washing is paramount in controlling spread to patients, visitors and staff.
- Stool specimens should be obtained as soon as soon possible – in most cases stool should be sent for M, C&S, *C.difficile* toxin and Norovirus testing. The IPC Team will advise if any other samples are required.

5.2 Stool/Enteric Precautions

Stool/Enteric precautions should be used for the care of patients known or suspected to be infected with micro-organisms that can be transmitted by faecal oral route.

Precaution	Guidance

Patient placement	• The patient should be placed in a single room with en suite toilet facilities or designated commode kept in the room. Consult the Infection Control Team for advice.
Hand hygiene	• Soap and water after patient contact.
Gloves (non-sterile)	• For patient contact.
Mask, eye and face protection	• Only if risk of splashing with body fluids. • Masks to be worn if there is a risk of droplets or aerosols e.g close contact with a patient who is vomiting.
Apron/ gown	• For patient contact.
Patient transport	• Where possible the patient should not be transferred to other departments. If this is necessary inform the receiving department. If in doubt consult the Infection Control Team.
Patient care equipment	• Where possible the patient should have dedicated equipment for their use. • Wear gloves and aprons to handle equipment soiled with blood and body fluids – decontaminate the equipment as per guidance in the 'Decontamination of reusable medical devices' policy. • If the equipment is single use dispose of as clinical waste.
Environment	• A high standard of cleanliness should be maintained in the patient's environment. Source isolation daily cleans will be performed by the domestic services. A terminal clean of the room will be required.
Linen	• Gloves and aprons must be worn and the linen placed in a red alginate/dissolvable bag.

5.3 Admission Assessment in A&E

On presentation to A&E patients are assessed based on clinical symptoms - this includes diarrhoea and/or vomiting. If they are not acutely unwell they are referred to the Primary Urgent Care Centre (PUCC) and sent home with appropriate advice. If acutely unwell they are referred to A&E Majors. All A&E assessments are documented on EPR and the free text allows the assessing nurse to document symptoms of diarrhoea and/or vomiting.

In Majors, patients with diarrhoea and/or vomiting will be nursed in cubicle on enteric/stool precautions. They maybe be given IV fluids and sent home if possible and clinically stable

enough. If admission is required, A&E request a side room from ACU staff and they are admitted directly into a side room on enteric/stool precautions.

During the high risk Norovirus season (beginning of October to the end of March), A&E staff will assess all patients requiring admission in relation to contact with possible cases of Norovirus.

1. All patients requiring admission will be asked if they have been in contact with anyone who has had diarrhoea and/or vomiting in the last 4 days.
2. If 'yes', this will be documented in the A&E documentation.
3. ACU will be informed and advised to observe for symptoms of diarrhoea and/or vomiting.
4. The patient details will be emailed to the Infection Control Team infectioncontrol@homerton.nhs.uk
5. The IPC Team will review and follow up patients referred to them via the link and advise accordingly.
6. If the patient states that they believe they are part of an outbreak in the community (e.g. have come from a nursing home, or are part of a party that attended an event or restaurant), then please inform the local Public Health England team (Tel: 0207 811 7100). They will coordinate with community-based services and undertake a risk assessment. The PHE team is available 24/7.

5.4 Norovirus case definition and outbreak criteria

Norovirus Case Definition

Suspected case	a) Vomiting: Two or more episodes of vomiting of suspected infectious cause occurring in a 24 hour period (NOT associated with prescribed drugs or treatments or a reaction to anaesthetic or an underlying medical condition or illness). b) Diarrhoea: Two or more loose stools (Bristol stool type 5, 6, 7) in a 24 hour period (NOT associated with prescribed drugs or treatments or a reaction to anaesthetic or an underlying medical condition or illness). c) Diarrhoea and vomiting; One or more episodes of both symptoms occurring in a 24 hour period.
Confirmed case	a, b or c above with microbiological confirmation

All suspected or confirmed cases must be isolated in a single room on enteric precautions (see 5.2) and the Infection Control Nurses informed.

Criteria for suspecting an outbreak

Suspected outbreak: two or more cases, as defined above without laboratory confirmation.

Confirmed outbreak: as above with laboratory confirmation

If 2 or more patients/staff develop the above symptoms contact the Infection Control Nurse immediately. If out-of-hours then contact the clinical site manager who will inform the on-call Microbiologist if necessary.

5.5 Outbreak control measures for Norovirus within affected clinical areas

a. Inform the IPC Team and clinical site manages immediately on suspecting an outbreak – see summary on page 2.
b. The IPC team will review the ward and assess if a bay or ward needs to be closed to admissions. (see Appendix 2 for escalation process for closure of bays versus the ward)
c. If the decision is made to close the bay/ward the IPC team will inform the staff groups in the Diarrhoea and Vomiting outbreak checklist Part 1 (Appendix 3).
d. The patients must have a dedicated toilet facilities or a commode.
e. Assess patients for risk of other infectious diarrhoea e.g. recent antibiotic treatment and potential *C.difficile*.
f. Wear gloves and aprons for contact with an affected patient or environment. These must be removed and hands washed with soap and water prior to leaving an isolation room or cohort area.
g. Wash hands with soap and water after contact with an affected patient or environment.
h. Send stool specimens immediately for Norovirus testing
i. The Infection control nurses will review patients daily Monday-Friday. If patients are still symptomatic and Norovirus test is negative additional tests such as culture (M,C&S) and *C. difficile* toxin testing maybe requested.
j. Ward staff are to record all episodes of diarrhoea and/or vomiting on the patients stool chart.
k. Diarrhoea outbreak monitoring documentation to be maintained by ward staff on the Diarrhoea and Vomiting ward record sheet (Appendix 3).
l. Remove exposed food such as fruit and biscuits.
m. Restrict access to the ward by placing notices on ward entrance and notice to restrict use of fire doors connecting wards and departments.
n. Exclude affected (symptomatic) staff from work immediately and until 48 hours symptom free. All affected staff must contact Employee Health.
o. No patients to be transferred to other clinical areas unless medically urgent and discussed with the IPC Team
p. Risk assess discharges especially those who are being discharged to nursing and care home facilities.
q. Exclude non-essential staff from the ward. The IPC team will inform all departments when a clinical area is affected so that staff movement can be minimised (Appendix 2).
r. Staff working in an affected area should not work in other clinical areas where possible. Where movement between clinical areas is required e.g. medical staff they must ensure that hand washing is performed prior to leaving the affected area and where possible visit the affected ward/s or areas last. The IPC team will inform all departments when a clinical area is affected so that staff movement can be minimised.
s. Advise visitors on the importance of hand hygiene when visiting the ward and in some cases restricted visiting maybe required. This will be advised by the IPC team. Give visitors and patient information leaflet.
t. Clean and disinfect vomit and faeces spillages promptly. Wear disposable gloves and aprons. Use paper towels to soak up excess liquid, transfer the matter into an orange clinical waste bag, clean the spillage area with a Tristell solution. Dispose of gloves, aprons and clothes into an orange clinical waste bag and wash hands with soap and water.
u. The IPC team will inform the domestic manager and arrange to increase the frequency of routine ward cleaning and disinfection of hard surfaces and bathroom areas.
v. The IPC team will inform all staff groups and departments of a ward closure – see Appendix 2 for staff list.

w. A member of the IPC team will review the ward twice daily and attend the daily bed meeting to update on situation. A timeline and outbreak record will be maintained by the IPC team
x. The IPC team will complete the Public Health England online reporting of outbreaks. http://www.hpa-bioinformatics.org.uk/noroOBK/home.php
y. The Diarrhoea and Vomiting checklist Part 2 in Appendix 2 must be used to ensure that all precautions have been implemented.
z. Outbreak to be reported as an SI and RCA completed by the IPC Team.

5.6 Outbreak control methods when 2 clinical areas are affected/closed

The control measures in 5.5 will be implemented for all suspected and/or confirmed outbreaks in a single ward. If there are 2 wards affected and closed to admissions the following additional measures maybe required.

a. Convene Daily Outbreak Meetings and establish actions to address reduced bed capacity.
b. The closed wards will be assessed twice daily by the IPC Team, (once daily on weekends).
c. Initiate Bed escalation plan according to shortfall.
d. Restricted Visiting to be initiated on next working day:
   Visiting to closed wards restricted to immediate family or close friends.
e. Outbreak to be reported as a Serious Incident.

5.7 Outbreak control methods when 3 or more clinical areas are affected/closed

The control measures in 5.5 will be implemented for all suspected and/or confirmed outbreaks on a single ward. If there are 3 or more wards affected and closed to admissions the following additional measures maybe required. See Appendix 5 for countrywide escalation tool.

a. Convene Daily Outbreak Meetings as per major Outbreak Policy available on the Trust intranet and establish actions to address reduced bed capacity. Invite HPU/CCDC, Divisional Managers, Chief operating officer, and liaise with Community IPCTs
b. The closed wards will be assessed twice daily by the IPC team (once daily on weekends).
c. Initiate Bed escalation plan according to shortfall.
d. Restricted Visiting to be initiated on next working day:
   No visitors on closed wards without prior agreement with nurse in charge.
   Visiting to all wards restricted to immediate family or close friends.
e. Outbreak to be reported as a Serious Incident.
f. All relevant personnel to provide feedback to CSM with outcomes of identified actions as per Trust Bed Management escalation plan.
g. Production and placement of Restricted Visiting posters at entrances to hospital and wards.
h. Public announcement via press and communication department
i. Update public website with information.
j. Alter recorded message for all external calls to switchboard to state restricted visiting in place.
k. Assess clinical risk of current shortfall in bed capacity.

5.8 Criteria and management of re-opening wards

The criteria for re-opening a ward or bay will be both:

72 hours since the last new case

AND

48 hours since the last uncontained vomit and/or diarrhoea (i.e. contained in a side room)

The ICT will be responsible for determining if a ward can be safely re-opened.

Actions to be taken when re-opening a ward or bay: as per environment and isolation room cleaning policy (available on the Trust intranet);
A deep disinfection clean of a clinical area will be requested by the ICT this will involve

- Disinfection of all surfaces, walls and equipment using a Tristel® solution.
- Curtain changes in bays or the whole ward (including windows) as requested by the ICT.
- Any empty beds should be stripped and not re-made until the ward is deep cleaned and re-opened.

A member of the IPC Team will sign off the deep clean on completion.
All staff groups will be informed of the re-opening and the checklist completed (see Appendix 2).

5.9 Bed Management and isolation

The Infection Control Nurses routinely visit all wards three times per week to assess patients in single rooms and being nursed with infection control precautions on open wards. This information is presented in a spread sheet (see 'Isolation policy') and these instructions are shared with the Clinical Site Managers (CSMs). The patients are classified into one of three groups to aid bed management and appropriate patient placement by the CSMs.

Red – must stay in side room unless discussed with infection control team prior to the move.
Yellow – may be moved out by CSMs if a higher priority patient requires isolation (see summary), Infection Control Team to be notified next working day.
Green – may be moved out of the side room by CSMs.

If a patient is assessed as requiring a side room and there are none available, the Clinical Site Managers will discuss this with the IPC Team or, out–of- hours, the on-call Microbiologist. Unavailability of side rooms must always be escalated to the IPC Team and reported on the Trust incident reporting system.

Percentage of side room availability is calculated on every side room list and if the availability falls below a set trigger an escalation will be put in place. The set escalation triggers are set as below.

Escalation triggers set at	
	20% Mon-Thur
	40% Fri for weekend

If side room capacity is reduced this will be managed at the bed meetings and systems put in place to create cohort facilities as required.

In the event of an outbreak the IPC Team will attend the daily bed meeting to update CSM and senior staff on the current situation.

6.0 Training and awareness

All Infection Prevention and Control training sessions for medical staff contain a section on standard infection control precautions including isolation precautions, actions to be taken for patients with diarrhoea and or vomiting and where to access further information on infection control procedures. Infection Prevention and Control training is part of the Trust mandatory training programme contained in the Trust Mandatory training Policy.

Managers are responsible for identifying staff training requirements, booking and following up attendance/non attendance of Infection Control mandatory training. Identification of what training staff require can be found in of the Trust mandatory training policy.

The infection control team each year will send information to all staff about Norovirus control and management to raise awareness of prevention and control measures. Signs will also be displayed in public areas for the public.

7.0 Review

Mandatory: This policy will be reviewed in *3* years time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

8.0 Monitoring/Audit

Monitoring of training requirements, attendance and non-attendance is the responsibility of the line managers of staff. Attendance compliance is monitored by the Training Committee, Infection Control Committee and reported to the Trust Board via the mandatory training balance score card and infection prevention and control balance score card. Divisions are responsible for monitoring their staff attendance and addressing non-attendance.

On the three times weekly ward rounds the Infection Control Nurses are constantly monitoring practice to maintain high standards and assessing capacity of side rooms. Any instances of non-compliance with isolation practices will be reported as an incident on the Trust incident reporting system and investigated accordingly.

The isolation audit is completed bi-annually as part of the infection prevention and control audit programme. The standard used for audit is this isolation policy and Clean Safe Care summary of best practice for isolation and assessing the isolation room capacity. This monitors isolation practices generally in the Trust

Outbreaks are reported as a Serious Incident investigated and reported to the Patient Safety Committee.

Measurable Policy Objective	Monitoring/Audit	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/committees, inc responsibility for reviewing action plans
Isolation precautions and availability of isolation facilities.	Isolation audit report presented to ICC	Twice a year	Infection Control Team	Infection Control Committee
Monitoring of patients in isolation performed informally 3 x weekly by Infection Control Nurses on ward rounds	Clinical ward rounds, issues with non-compliance dealt with immediately and reported as incident	3 times a week	Infection Control Nurses	Incident review group
Infection control precautions for control of infectious diarrhoea	Any instances of non-compliance with this policy will be reported as an incident on the Trust incident reporting system and investigated accordingly.	As required	Clinical staff	Incident review group

Sources of Evidence; References / Bibliography –

Chadwick,P.R, Beards,G, Brown,D, Caul,E.O, Cheesbrough,I, Clarke,I, Curry,A, O'Brien,S, Quigley,K, Sellwood, and Westmoreland,D. 2000. Management of hospital outbreaks of gastro-enteritis due to small round structured viruses. *Journal of Hospital Acquired Infection* **45:** 1-10.

NHS Southwest London. 2009. Norovirus Tool Kit

NHS London. 2009. Norovirus Recommend Control Measures Checklist.

Health Protection Agency. 2010. Norovirus Toolkit. A set of resources for care home staff.

Guidelines for the management of norovirus outbreaks in acute and community health and social care settings HPA; British Infection Association; Healthcare Infection Society; Infection Prevention Society; National Concern for Healthcare Infections; NHS Confederation - Publication date: March 2012
http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317131639453

Appendix 1 Escalation Process for Closure of Bay and Ward

1. Suspected outbreak and symptomatic cases on ward – No patient to be transferred to other wards. Ward is under surveillance until cleared by the ICT.

2. Symptomatic case in a bay – isolate the patient/patients in a single room. All other patients in the bay should be considered exposed contacts and not moved from the bay until 72 hours after the last contact with the symptomatic case. If another patient in the same bay develops diarrhoea and/or vomiting, the bay is to be closed to admissions if it has sliding doors, if not consider closing the ward.

3. If a patient in another bay became symptomatic and there are no further single rooms available on the ward for patients with diarrhoea and vomiting and the bay has sliding doors on it, the bay with the symptomatic patients should be closed to admissions. The rest of the ward may remain open to admissions BUT NO TRANSFERS TO OTHER WARDS, If the bay does not have sliding doors on it consider closing the ward.

4. If a ward has bays closed to admissions there needs to be instruction to staff on movement of equipment and restricted staff access as for a complete ward closure. Signs must be placed on the bay doors with protective clothing available at the entrance to the bay. Patient will need dedicated toilet facilities either a commode or dedicated toilet which is not used by other patients.

5. If there are more than 2 bays involved on one ward it is considered that spread is not controlled and consideration should be given to closing the ward to admissions.

Appendix 2

Diarrhoea and Vomitting Outbreak Checklist Part 1

Ward _____

Date outbreak declared	
Date ward/bay closed	
Ward nursing staff informed of ward closure and restrictions in place	
Ward medical staff informed to restrict numbers of staff entering the closed ward and practices required	
CSM informed of ward closure and restrictions on patient movement	
Chief Executive, Chief Nurse, Medical Director, Director of Environment, Director of HR, Chief Operating Officer informed	
Deputy Chief Nurse and Divisional Heads of Nursing informed.	
Lead nurse/matron informed to restrict numbers of staff entering the closed ward	
Domestic services informed and additional cleaning requested	
Porter and waste manager informed to restrict numbers of staff entering the closed ward	
Catering services informed to restrict numbers of staff entering the closed ward	
Hotel services informed	
Radiology informed to restrict numbers of staff entering the closed ward	
Staff bank informed to restrict movement of staff	
Therapy services informed to restrict numbers of staff entering the closed ward	
Phlebotomy services informed to restrict numbers of staff entering the closed ward	
Employee health informed	
Shop trolley etc access restricted	
Local HPU informed and HPA online reporting completed	

Date all of the above informed that the ward has re-opened

_____

Diarrhoea and Vomitting Outbreak Checklist Part 2

Ward

Control measure	Date implemented
Date ward closed.	
Isolation and/or cohort facilities put in place.	
Dedicated toilet facilities or a commode provided.	
Patients assessed for risk of other infectious diarrhoea e.g. recent antibiotic treatment and potential *C.difficile.*	
Staff informed of precautions to be taken – leaflet provided. Wear gloves and aprons for contact with an affected patient or environment. These must be removed and hands washed with soap and water prior to leaving an isolation room or cohort area.	
Stool specimens requested for culture (M,C&S), *C. difficile* toxin testing and laboratory informed.	
Diarrhoea and Vomiting record sheet in use for all symptomatic patients (Appendix 3).	
Diarrhoea outbreak monitoring documentation in use.	
Exposed food such as fruit and biscuits removed.	
Access to the ward restricted by placing notices on ward entrance and notice to restrict use of fire doors connecting wards and departments.	
Affected staff excluded from work immediately and until 48 hours symptom free. All affected staff must contact Employee Health.	
Patient transfer to other clinical areas restricted unless medically urgent and discussed with the Infection Control Team (ICT).	
All discharges risk assessed especially those who are being discharged to nursing and care home facilities.	
Non-essential staff excluded from the ward.	
Staff movement from the affected area to other clinical areas restricted where possible.	
Information and advice provided for visitors on the importance of hand hygiene when visiting the ward and in some cases restricted visiting when required. Leaflets provided.	
Vomit and faeces spillages promptly dealt with using a freshly prepared Haz-Tab® 10,000ppm solution.	
Increase the frequency of routine ward cleaning and disinfection of hard surfaces and bathroom areas requested through domestic services.	
Ward/bay re-opening Ward deep disinfection clean performed, all curtains changed and checked by ICT.	

Appendix 3 Diarrhoea and vomiting record sheet to be completed by the ward staff

In the date columns complete the type of symptoms and frequency for each patient. If no symptoms or symptoms have resolved put **X** in the box

D = diarrhoea **V**=Vomiting **N**=Nausea **SC**=stomach cramps

Patient Name	**Hospital number**	**Bed number**	**Day 1** --/--/----	**Day 2** --/--/----	**Day 3** --/--/----	**Day 4** --/--/----	**Day 5** --/--/----	**Day 6** --/--/----	**Day 7** --/--/----

Appendix 4 Diarrhoea and Vomiting Ward Record sheet for infection control nurses to complete

D = diarrhoea **V**=Vomiting **N**=Nausea **SC**=stomach cramps

Patient Name	Hospital number	Bed number	Date of onset	Symptoms (D, V, N, SC)	Laxatives or antibiotics? If so what	Date of specimen	Date symptoms resolved	Specimen results

Appendix 5

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 HPU notified. If food poisoning suspected HPU to 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 nursing) HPU to follow care home guidance.	External outbreak alert. External communication cascade:- Partner ICTs, Commissioners, HPU,SHA/SWAST/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 HPA 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	

Equalities Impact Assessment

This checklist should be completed for all new Corporate Policies and procedures to understand their potential impact on equalities and assure equality in service delivery and employment.

Policy/Service Name:	**Control of Diarrhoea and Vomiting due to Norovirus**
Author:	**Vickie Longstaff**
Role:	**Nurse consultant Infection Control**
Directorate:	**CSDO**
Date	**12th March 2013**

Equalities Impact Assessment Question	Yes	No	Comment
1. How does the attached policy/service fit into the trusts overall aims?	Yes		Compliance with health and social care act 2009
2. How will the policy/service be implemented?			Norovrius management and control measures included in all training sessions and in infection control newsletter.
3. What outcomes are intended by implementing the policy/delivering the service?			Reduction in potential exposure of staff and patients to infectious disease and reduce risk of outbreaks
4. How will the above outcomes be measured?			Outbreak reporting
5. Who are they key stakeholders in respect of this policy/service and how have they been involved?			Infection control committee given opportunity to comment and endorsed the policy
6. Does this policy/service impact on other policies or services and is that impact understood?		NO	
7. Does this policy/service impact on other agencies and is that impact understood?		No	
8. Is there any data on the policy or service that will help inform the EqIA?		No	
9. Are there are information gaps, and how will they be addressed/what additional information is required?		No	

Equalities Impact Assessment Question	Yes	No	Comment
10. Does the policy or service development have an adverse impact on any particular group?		No	
11. Could the way the policy is carried out have an adverse impact on equality of opportunity or good relations between different groups?		No	
12. Where an adverse impact has been identified can changes be made to minimise it?		N/A	
13. Is the policy directly or indirectly discriminatory, and can the latter be justified?		No	
14. Is the policy intended to increase equality of opportunity by permitting Positive Action or Reasonable Adjustment? If so is this lawful?		N/A	

EQUALITIES IMPACT ASSESSMENT
FOR POLICIES AND PROCEDURES

2. If any of the questions are answered 'yes', then the proposed policy is likely to be relevant to the Trust's responsibilities under the equalities duties. Please provide the ratifying committee with information on why 'yes' answers were given and whether or not this is justifiable for clinical reasons. The author should consult with the Director of HR & Environment to develop a more detailed assessment of the Policy's impact and, where appropriate, design monitoring and reporting systems if there is any uncertainty.

3. A copy of the completed form should be submitted to the ratifying committee when submitting the document for ratification. The Committee will inform you if they perceive the Impact to be sufficient that a more detailed assessment is required. In this instance, the result of this impact assessment and any further work should be summarised in the body of the Policy and support will be given to ensure that the policy promotes equality.

Policy Submission Form

To be completed and attached to any policy or procedure submitted to the Trust Policy Group

1	**Details of policy**	
1.1	Title of Policy:	Control of Diarrhoea and Vomiting due to Norovirus
1.2	Lead Executive Director	Chief Nurse and Director of Governance
1.3	Author/Title	Vickie Longstaff (Infection Control Nurse Consultant)
1.4	Lead Sub Committee	Infection control committee
1.5	Reason for Policy	To provide concise information on the isolation and control measures necessary to prevent the spread of Norovirus in the Homerton University NHS Trust. This policy should be used the major outbreak policy if required.
1.6	Who does policy affect?	All staff
1.7	Are national guidelines/codes of practice incorporated?	yes
1.8	Has an Equality Impact Assessment been carried out?	Yes
2	**Information Collation**	
2.1	Where was Policy information obtained from?	See reference list/sources of evidence
3	**Policy Management**	
3.1	Is there a requirement for a new or revised management structure if the policy is implemented?	No
3.2	If YES attach a copy to this form	N/A
3.3	If NO explain why	Infrastructure already in place
4	**Consultation Process**	
4.1	Was there internal/external consultation?	Infection control committee
4.2	List groups/Persons involved	Infection control committee

4.3	Have internal/external comments been duly considered?	
4.4	Date approved by relevant Sub-committee	
4.5	Signature of Sub committee chair	
5	**Implementation**	
5.1	How and to whom will the policy be distributed?	All staff will be made aware of the update and the policy will be on the Trust intranet
5.2	If there are implementation requirements such as training please detail?	Non required
5.3	What is the cost of implementation and how will this be funded?	No cost implication
6	**Monitoring**	
6.1	List the key performance indicators e.g. core standards	CQC standard and Health and Social care Act
6.2	How will this be monitored and/or audited?	See section 8 of the policy
6.3	Frequency of monitoring/audit	See section 8 of the policy

Date policy approved by Trust Policy Group:

23/5/2013

Signature of Trust Board Group chair: