

Protocol for the Control of Outbreaks of Communicable Infections

The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This procedural document has been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individual differences and the results are shown in Appendix A

Policy Profile			
Policy Reference:	CCP2 – Appendix D to Clin 2.0 Infection control policy		
Version:	Version 2		
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Executive sponsor:	Director of Infection Prevention and Control		
Target audience:	All Trust Staff		
Date issued:	18 th January 2012		
Review date:	Dec 2014		
Consultation			
Key individuals and committees consulted during drafting	Infection Control Committee	Dates	June 2011
	Infectious Diseases/HPU	Dates	June 2011
	Estates and Facilities	Dates	June 2011
Approval			
Approval Committee:	Infection Control Committee		
Date:	June 2011		
Ratification			
Ratification Committee:	Chair's Action		
Date:	18 th January 2012		

Document History			
Version	Date	Review date	Reason for change
V1	2009	2011	
V2	Dec 2011	Dec 2014	Updated to comply with current practices. Incorporation of Community Services Division.

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Related Trust Policies

Infection Control Policy
Notification of Infectious Diseases
Isolation
Influenza
Meningococcal Meningitis
Hand Hygiene

Executive Summary

The effective control of any infection within the hospital or in the community requires a detailed knowledge of its epidemiology, clinical features and immunology, including symptoms, signs, diagnosis, causative organism, incidence, prevalence, trends, reservoir, mode of transmission, incubation period and communicable period.

To prevent the spread of infection, a case should be promptly identified, measures need to be taken to control the source of infection and the route of transmission. Where possible, susceptible individuals can be offered protection with antibiotics or immunisation.

These measures are directed at the individual or case, their contacts, the environment and the wider community. These control measures should be proven to be effective or at least rational. (Ayliffe, 2000).

Control of outbreaks within a healthcare setting is paramount to reduce the spread of infections and to minimise interruptions to patient care.

This policy applies to all staff (temporary or permanent) **working in all the locations registered by St George's Healthcare NHS Trust** with the Care Quality Commission, to provide its regulated activities.

This also includes volunteers, contractors, students and/or trainees.

This protocol is an appendix to the Infection Control Policy. Refer to the Infection Control Policy for information on the criteria, responsibilities and systems required to prevent and control Healthcare Associated Infections (HCAIs).

Introduction

This document describes the arrangement for the investigation, management and control of outbreaks or increased incidence of infections or infectious disease within the Trust.

Each incidence is unique. Certain arrangements in every case are necessary and these will be applicable to the surveillance, investigation, management and control of infection.

Some outbreaks can be prevented. This requires careful observance of policies and procedures relating to patient care, skill mix and staff health. Suspected outbreaks must be notified to the Infection Prevention and Control Team as soon as possible.

1. Definition

An outbreak may be defined as;

- two or more related cases of the same infection,
- a sudden appearance of increasing incidence of one type of infection in a ward
- a sudden appearance of a number of cases with similar symptoms of infection, either in patients or staff. An **outbreak** is an incident in which two or more people, thought to have a common exposure, experience a similar illness or proven infection (at least one of them having been ill). (HPA Definition from intranet)
- Once a possible outbreak has been recognised, the Infection Control Doctor (ICD) is the person primarily responsible for action within the hospital / St George's healthcare settings. The ICD and the Infection Control Nurse (ICN) will take immediate steps to collect information from wards, the laboratory and if appropriate from other units to determine whether an outbreak is occurring and to establish a case definition.

Immediate action is needed to prevent further spread to patients, staff and the wider public. Outbreaks can be classified as minor and major according to the type of infection and the number of patients affected. The infections may manifest themselves in patients on the same ward, clinics or departments but different wards/areas may be involved with patients having a common source of infection. The urgency of a situation is determined by the virulence of an organism, the nature of the disease involved and by the vulnerability of patients concerned. (See also Serious Incident Policy 2011).

2. Organisms Requiring Infection Control Guidance:

Acinetobactor

Aspergillosis/Nocardiosis

Clostridium difficile

E-Coli

Enterobacter cloacae

Food poisoning

Gastro-enteritis or other Enteric Infections

Hepatitis Influenza

Legionellosis

Meningococcal Disease

Methicillin Resistant Staphylococcus aureus (MRSA)

Multiply Antibiotic Resistant Organisms/Pseudomonas Species

Norovirus

Respiratory Syncytial Virus (RSV)

Tuberculosis/MultiDrug Resistant Tuberculosis/XDR TB

3. Notification and Management of Outbreak(s)

On first suspicion, ward/healthcare staff should:

- Record all the cases (including staff if applicable) , noting the time of onset of symptoms in each suspected case, and the dates of admission to the hospital/premises and ward plus the ward area/bed/ any transfers
Inform the Infection Control Team, 0208725 extension 2459. Out-of-hours air call the on-call Consultant Microbiologist via the St Georges hospital switchboard. 0208 672 1255.
- Collect appropriate microbiology specimens after consultation
- Isolate the index cases where possible
- Make a list of those affected with admission dates and date of onset of the infection

The Infection Control Doctor (ICD) will decide whether the episode should be declared a major outbreak and this plan will be activated. If an outbreak is declared, the ICD will inform the Director of Infection Prevention and Control (DIPC) and the Health Protection Unit.

3.1 Alerting:

3.1.1 Internal alerting:

Infection Control Team, 0208725 ext. 2459. Out-of-hours air call the on-call Consultant Microbiologist via the St Georges hospital switchboard. 0208 672 1255

3.1.2. External alerting:

- South West London Health Protection Unit on call team (020 8812 7850). The SWLHPU will notify local DPH of outbreak reported to them but the trust should do so too
- NHS London,
- Environmental Health (if relevant)
- (The Department of Health would have to be notified of some major outbreaks with significant mortality/morbidity)

3.2 Emergency Outbreak Control Team (OCT) Meeting (OCT is the recognised term)

The Infection Control Doctor will manage the outbreak with the assistance from the infection control team and the support of the Director of Infection Prevention and Control (DIPC).

3.2.1 Procedure of the meeting

The Infection Control Doctor will arrange an emergency meeting (teleconference should be also be considered especially if needing offsite colleagues/partners input at short notice) at the earliest opportunity (usually within 24 hours of declaring outbreak)with the Outbreak Control Team (OCT). This group will comprise:

- Infection Control Doctor or Deputy Infection Control Doctor – Chairman
- Consultant microbiologist/virologist
- Director of Infection Prevention and Control
- Consultant in Infectious Diseases
- Infection Control Nurse

- Consultant in Communicable Disease Control/senior health protection nurse or practitioner (or both) from SW London Health Protection Unit (SWLHPU)
- Divisional Director of Nursing and Governance of affected department
- Link Nurse for Infection Control of affected ward/department
- Nurse Manager/Matron of the affected ward/department
- Consultant Physician or Surgeon from relevant specialty
- Consultant in Occupational Health
- Clinical Site Manager for St George's site or Community services on-call manager for Community Division premises / sites
- Head of Offenderhealthcare, HMPW (if appropriate)
- Note taker/administrative support
- Communications Manager

Other personnel, who also may need to attend according to the extent of the outbreak, include:

- Director of Public Health
 - General Managers
 - Medical Director
 - Principal Engineer
 - General Manager Facilities
 - Sodexo representative if Queen Mary's Roehampton, or Contracts manager Community Clinics, Dawes House. Offender healthcare according to the HMPW Outbreak policy.
 - TSSU Manager
 - Senior Pharmacist
 - Officer, HMPW
 - Environmental Health Officer
 - HPA Epidemiologist
-
- The meeting will be chaired by the Infection Control Doctor or Deputy IC Doctor
 - The Chairman will briefly explain to the meeting the nature of the outbreak. He will then remind the senior representatives of each discipline present that they are personally responsible for the work of their discipline in the management of the outbreak
 - **Need to agree TOR plus an agenda looking at summary of situation and case/contacts/surveillance (epi curve etc)**
 - The purpose of the first meeting is to ensure that all reasonable measures are implemented to safeguard patient safety
 - If any discipline is not represented at the meeting, urgent action will be taken to communicate decisions made and ensure participation in any future meetings
 - At this or subsequent meetings, depending on the extent of the outbreak, the Chair may need to consider invoking the trust's corporate Business Continuity Plan for Internal Disaster Recovery
 - At the close of the meeting, the chairman will state the date, time and place of the next meeting and make sure that all the representatives will either come or send a deputy.
 - Notes and actions to be documented as an accurate record of events

3.3 Communication

- The Chief Executive, in liaison with the Director of Infection Prevention and Control and the Communication team will be responsible for the release of information. No information concerning the outbreak will be released to the press or public from staff on the unit. A holding/ reactive/proactive press statement should be drafted and agreed by OCT, the trust communication manager and partner communication Officers (e.g. HPA London via SWLHPU, LA press office dept). A press conference should be arranged if necessary
- Telephone switchboard staff at St George's Hospital, Queen Mary's Hospital, Intermediate Care (Dawes House) or Offender Healthcare / HMPW, will be instructed by the Communication Officer where to direct all outside enquiries concerning the outbreak as appropriate

3.4 Subsequent Meetings

- At subsequent meetings the Chairman will ask for an update from each member of the OCG
- The purpose of subsequent meetings is to ensure that the cause of the outbreak is identified and controlled and that appropriate measures are taken to reduce the risk of a recurrence
- An outbreak should be declared over by OCT using agreed criteria

3.5 End of Outbreak

- Final report compiled and circulated to relevant outbreak control team.
- A final debrief meeting of the Outbreak Control Group will be held within a week to consider how the outbreak has been managed, identify any follow up action required and initial lessons learned.
- Lessons learned should be identified by OCT and action plan developed with timelines and person/s identified to be responsible for undertaking /co-ordinating the actions. Wider lessons learned should be disseminated/embedded within wider organisation e.g. staff training may need to be reviewed following an outbreak.

SPECIFIC OUTBREAK MANAGEMENT ACTIONS/CONSIDERATIONS POINTS OF ACTION FOR SPECIFIC ORGANISM GROUPS:

4. Hospital Acquired Aspergillosis and Nocardiosis

Immunocompromised patients are at risk of pneumonia caused by inhaled airborne pathogens. The fungus, aspergillus and the bacterium nocardia, are both wide spread in the environment, the air or soil, respectively. Large numbers of spores can be generated into the air after and during building work. The infections have a high mortality, even with specific treatment. Non-immunocompromised hospital patients and staff are rarely, if ever infected by these organisms.

The Infection Control Doctor and the clinician managing high dependency units should always have a high index of suspicion of an outbreak if two or more cases of Aspergillosis or Nocardiosis are diagnosed within a two week period. The Infection Control Doctor will be informed of the culture results by the laboratory. He/she will assess the likely time and mode of acquisition of the infection. In the case of a major outbreak an urgent meeting of the full Infection Control team and OCT will be required.

5. Suspected Food Poisoning or Other Enteric Infections (diarrhoea and/or vomiting) Outbreaks

Definition

- 1) Food poisoning - an acute attack of diarrhoea and/or vomiting in relation to food consumption.
- 2) Enteric infection - an attack of diarrhoea and/or vomiting that is not related to food consumption.

Food poisoning is a notifiable disease. Responsibility for statutory notification to the Environmental Health Officer/HPU lies with the clinician in charge of the case, although it is likely that the microbiologist involved will have discussed outbreaks with the CCDC and Regional Epidemiologists (are these HPA Epidemiologists?).

When two or more cases with similar symptoms occur at the same time in patients or staff they should be notified immediately by telephone to the Infection Control nurse on 0208 725 ext 2459 or, if not available, to the microbiology signing Consultant on 0208 725 ext 1970. Out of hours the on-call microbiologist can be contacted via the St Georges hospital switchboard.0208 672 1255.

The cause of the outbreak could be bacterial, viral or rarely chemical. The source may be contaminated food or faecal to oral spread from an infected patient. Also see Norovirus and *Clostridium difficile* protocol for more information.

Causes and Incubation Period:

<i>Staphylococcus aureus</i>	2 – 4 hours
<i>Bacillus cereus</i>	1 – 2 hours or 10 – 12 hours
<i>Vibrio parahaemolyticus</i>	8 – 16 hours
<i>Clostridium perfringens</i>	12 – 24 hours
Salmonella species	12 – 48 hours
Campylobacter species	3 – 5 days

Other Organisms:

Shigella species	3 – 5 days
Enteropathogenic <i>E. coli</i> and <i>E. coli</i> O157	2 – 3 days
Rotavirus, Astro virus, Norovirus	1 – 2 days

Staff Ill Whilst at Work

Staff who develop diarrhoea and /or vomiting whilst at work should report to the nurse in charge and then contact the Occupational Health Department (Monday - Friday, 8am – 4pm) on 0208-725-1661, Ext. 1661. If considered to be probable infectious origin, they should not complete their shift and go home. Out of hours they should attend the Accident and Emergency Department if very ill, otherwise to be sent home for GP follow up. Stool samples should be sent via GP/hospital for laboratory analysis.

Staff should stay off work until they are completely free of associated symptoms (i.e. diarrhoea and/or vomiting) and have been so for 48 hours.

Staff Ill Whilst at Home

Staff who develop diarrhoea and /or vomiting at home should phone their manager who will notify St Georges Hospital Occupational Health Department on 0208 725 e Ext 1661. If the member of staff works in the kitchen or other areas where food and enteric feeds are handled the Catering Manager and Infection Control Team should also be informed.

If the stool culture yields a transmissible pathogen, a medical microbiologist will inform the Infection Control Team and Occupational Health.

Before returning to work staff should consult with the Occupational Health Department or have been 48 hours symptom free.

Patients with Gastrointestinal Symptoms

- Patients with symptoms should be nursed in a side-room
- If a side-room is not available, affected patients should be nursed together as a cohort - an area of the ward close to toilet and hand washing facilities and apart from other patients (see the Isolation Protocol)
- Relevant food samples may be requested. The Infection Control Doctor will arrange for stool samples as soon as possible
- The Infection Control Nurse will arrange for food sheets (**see appendix x**) to be completed for all the people affected
- Record whether the patient has received antibiotics or laxatives

If the culture sample is positive, isolation of patient and exclusion of staff must be continued.

Isolation may terminate after discussion with the Infection Control Team or Medical Microbiologists.

If a patient contracted a notifiable disease before admission the admitting clinician should inform the Consultant in Communicable Disease Control / HPU and the Community Infection Control nurse via the hospital switchboard.

In suspected outbreak situations

The Infection Control doctor and nurse will be responsible for the management and investigation of the incident.

Out-of-hours the on call medical microbiologist should be contacted via St George's hospital switchboard 0208 672 1255.

6. Seasonal Influenza

Influenza is an acute viral disease of the respiratory tract characterised by fever, headache, joint pain, sore throat, running nose and cough. Epidemics can evolve rapidly with widespread mortality.

The Virologist will liaise with the Infection Control Team, clinicians, HPU and Clinical Site Managers to assess the scale of the outbreak.

Action:

- Cohort patients.
- Use Personal Protective Equipment when dealing with infectious secretions i.e. sputum. Refer to PPE policy for advice about use of face masks especially for new strains of influenza
- Strict hand washing
- The use of prophylactic antiviral drugs e.g. Oseltamivir, Zanamivir may be considered.
- Restrict visitors to two at a time in affected areas if possible. (See Influenza Guidelines) on the Trust intranet
- Vaccination

7. Hospital Acquired Legionella Infection

Legionella Infection

Legionella bacillus is a Gram negative rod. It can live in water systems. It grows well in temperatures from 20-50°C. The disease is associated with respiratory symptoms.

It is responsible for outbreaks of respiratory infections.

There are many types of the organism but *Legionella pneumophila* type 1 is the most common pathogen of the group. Incubation period is between 2 – 10 days.

Pontiac Fever (Non-pneumonic Legionellosis)

Pontiac fever has the same initial symptoms as pulmonary Legionella but not associated with pneumonia or death and patients recover spontaneously in 2 – 5 days without treatment.

Legionella does not spread between patients. Aerosols from water systems e.g. showers etc. are the usual route of transmission. If Legionellosis is confirmed by serology or culture, the Infection Control Doctor must be immediately notified.

Action:

- The Infection Control Doctor and the Infection Control Nurse should visit the ward and discuss the case with the clinical team, to make a preliminary assessment of the likely time and mode of acquisition of the infection

- If the patient has developed his symptoms before or after admission, in relation to the incubation period, the Consultant in Communicable Disease Control / HPU should be informed immediately by the Infection Control Doctor

Incubation Periods: Pontiac Fever	1 – 2 Days
Legionnaire's Disease	2 – 10 Days

- If the patient develops signs compatible with Legionella infection after admission or an outpatient appointment, particularly if the patient was admitted with an illness other than a respiratory tract infection, nosocomial Legionella should be suspected. The Infection Control Doctor and team will start investigating the source with the help of the Facilities department and the Health Protection Unit
- The Infection Control doctor should then arrange an emergency meeting of the Infection Control Group. The group will advise on case finding and water testing if needed. (See Legionella Policy on the Trust intranet)

8. Meningococcal Meningitis

Meningococcal meningitis is caused by *Neisseria meningitidis*, which is carried naturally in the back of the throat in 2-3% of the population. The bacteria cannot live long outside the body and is spread only by close direct contact between people, by respiratory secretions, nose and mouth e.g. coughing, kissing. Most people who acquire the organism that way will carry it for days or weeks and will not develop infection. A small proportion of carriers develop invasive disease shortly after they acquire the organism.

Meningitis and Septicaemia caused by *Neisseria Meningitidis* (see Meningococcal Meningitis protocol).

Control measures

Isolate patients in single room until 24hrs of appropriate antibiotics therapy is completed. Blue surgical should be worn for care or procedures where there is a risk of exposure to nasopharyngeal secretions i.e. intubation or suctioning if not using a closed circuit system during the first 24 hours. (See Meningococcal meningitis protocol 2010) on the Trust intranet. Prophylaxis and vaccination as per HPU guidelines and in consultation with HPU

9. Multiply Resistant Coliforms, Pseudomonas Species and Vancomycin Resistant Enterococci

Coliforms, which include, *E. coli*, *Klebsiella*, *Acinetobacter*, *Enterobacter*, *Serratia* and *Proteus* species may be part of normal colonic flora, but are an important cause of opportunistic infection in patients undergoing complex medical and surgical procedures. *Pseudomonas* are rarely found in the normal gut although hospitalised patients may become colonised. These organisms are usually found in a moist environment, which may provide a common source of organisms e.g. contaminated enteral feeds, inadequately disinfected bedpans, suction catheters and ventilators. The most common method of spread is by hand directly from patient to patient or patient to staff and then to another patient.

The *pseudomonas* species have fondness for water and therefore can be found in wet areas and build up biofilms in sink plugholes, shower heads and toilet rims.

Most of these organisms may cause wide cross-infection and cross- colonisation.

The ability to acquire resistance to gentamicin and to virtually all used antimicrobial agents presents a therapeutic problem.

Enterococcus species (e.g. *Streptococcus faecalis*) are part of the normal colonic flora but coliforms are important causes of opportunistic infections. They are the second most common cause of urinary tract infection and can play a major role in post-surgical sepsis.

Clinical areas which have a higher risk of transmission of multi-resistant organisms:-

- Intensive Care Units
- Units caring for neutropenic patients (Haematology Units)
- Burns units
- Hydrotherapy pool

If two or more multiple antibiotic resistant isolates of the same species are detected on a ward or in related wards, an outbreak should be declared and an OCT should be formed. The OCT should review/request:

- 1) The number and type of patients involved including symptomatic and asymptomatic colonised patients.
- 2) Review of ward and ward kitchens, nasogastric feeds, and medicine from opened bottles, disinfectants and moist equipment that comes into direct contact with one or more patients to exclude a common source of outbreak.
The dirty utility / sluice, bed pan washer / macerator, treatment room facilities and preparation area for enteric feeds should all be inspected.
- 3) Review management and use of hydrotherapy pool where applicable. E.g. management of filters, treatment of water, exclusion of users with enteric symptoms etc
- 4) Perianal/rectal swabs, sputum (if productive) and urine specimen should be examined on all the other patients in the same bay as the index case.
Other sites and samples will be determined by the Infection Control Team according to each outbreak.
- 5) A review of isolation arrangements and hand hygiene practices amongst medical and nursing staff.
- 6) Ensure there is an adequate supply of disposable plastic aprons, gloves and hand disinfectants.
- 7) Restriction of admission would be assessed between the Infection Control Team and the clinicians.
- 8) Review of antibiotic policy will be discussed by the medical microbiologist and the clinicians.
- 9) Arrange urgent typing of the organism. The Infection Control Doctor will be responsible for this.
- 10) Prepare information sheet for staff, patients and relatives.
- 11) Environmental swabbing including sinks and plugholes, shower heads, toilet bowl and rims should be considered to exclude a common cause for the outbreak. Samples of hydrotherapy pool water if advised.

- 12) Inform the SW London Health Protection Unit. (on 0208 812 7850)

10. Respiratory Syncytial Virus (RSV)

Respiratory syncytial virus outbreaks occur yearly and last for 2 - 5 months mainly during winter. It causes serious disease in healthy infants and young children and is associated with lower respiratory infection in the elderly. The disease carries a high mortality in patients with compromised cardiac, immune or pulmonary systems.

Nosocomial infections have been associated with a prolonged hospital stay and increased mortality.

Action:

- The virologists notify the clinical team with the diagnosis. HPU may be involved.
- The Infection Control Team monitor the number of cases admitted with RSV and reduce the chance of viral spread by:
 1. Using side-rooms / cohorting patients and restricting staff movement.
 2. Use Personal Protective Equipment when in contact with infectious secretions.
 3. Strict hand washing.

RSV On PICU:

- ◆ Patients who are ventilated may be nursed with precautions (i.e. gloves and aprons) on the open unit following risk assessment.
- ◆ If patients are not ventilated, they should be nursed in a side-room, and source isolation.
- ◆ No repeat virology specimens need to be sent after the initial result, unless the patient is immunocompromised (see below).
- ◆ Source isolation in a side-room or precautions on the open ward should continue for a minimum of 4 days from the initial specimen date. Patients must be assessed on an individual basis for cough, fever etc. and in consultation with Infection Control before relaxing precautions.
- ◆ If the patient is immunocompromised (including those on steroids) precautions should continue until three clear specimens have been received (ETT secretions, NPA or sputum). A weekly specimen is adequate unless otherwise advised by the Infection Control Team.
- ◆ If the index case is nursed with precautions on the open unit, other patients must be located and nursed such that the most susceptible patients are placed at the maximum distance from the index case.

11. Infection Control Measures – environmental cleaning, hand hygiene, waste, isolation/exclusion, use of PPE

• Environmental Cleaning and Disinfection

Environmental cleaning and disinfection is carried out using Chlor-clean 1,000 ppm, a chlorine-containing cleaning agent. A solution of Chlor-clean 1,000 ppm should be made daily and stored in accordance with manufacturers' instructions. A poster detailing how to make up Chlor-clean 1,000 ppm is displayed in all sluice rooms. The use of Chlor-clean or a suitable

alternative at HMPW requires approval by the Health and Safety Officer and / or the Governor. This is referred to in the Prison Outbreak Policy (see references)
Cleaning of rooms or bed spaces during outbreaks should be carried out at least daily using Chlor-clean 1,000 ppm.

All clinical areas should be regularly assessed by the ward sister. / person-in-charge for cleanliness and results fed back to clinical and cleaning teams. Infection prevention and control teams, matrons and cleaning staff should meet regularly (at least monthly) to discuss results across the hospital (ie MEAT meeting) or Cleaner Hospital Group at QMR.
Terminal cleaning of a mattress, bed, bed space, equipment, the bay or ward area after the discharge, transfer or death of a patient with infection should be thorough. All areas should be cleaned using chlorine-containing cleaning agents (at least 1,000 ppm available chlorine), and the curtains should be changed.

The ward environment should not be cluttered. Frequent blockages of sinks, toilets, macerators and showers should be logged via Estates and actioned as soon as possible. Routine environmental cleaning is important following blockages to contain the outbreak. At the end of the outbreak deep cleaning of the environment is recommended.

Regular cleaning of patient equipment should be performed and where possible use disposable items.

- **Signage**

Closed bays and ward posters must be put on doors or screens outside closed wards and bays. Signs are available from the Infection control Team 0208 725 ext. 2459. Posters must be removed once the ward or bay is reopened.

The signs for Queen Mary's Roehampton are kept in the in-patient's matrons office or the 'Shell Space'.

- **Meals**

Staff on wards closed due to known or suspected Norovirus should have meals e.g. sandwiches delivered to the ward to reduce the need to leave the ward. This may be arranged by contacting MITIE helpdesk for St George's on Ext. 4000 with a relevant budget code. Queen Mary's staff should contact the helpdesk on extn 6100 staff in other community settings should contact their respective managers. (see Norovirus protocol).

- **Hand Hygiene**

Good hand hygiene is essential for the prevention of cross-infection. Staff must follow the 'Bare below the elbow' policy Alcohol-based hand gel may be used as staff/general public enter the affected bay or ward but *after* contact with infective (or suspected infective) diarrhoea i.e. leaving the bay or ward, hands **must be** washed with soap and water, as alcohol gel is ineffective in diarrhoea cases. Hands must be washed after removal of gloves and between each patient. Hands must be thoroughly dried after washing. (See Hand Hygiene Policy 2011) on the Trust intranet.

The location of Alcohol-based hand gels is based on risk assessment eg Offender healthcare in the prisons.

- **Entering Closed and Partially Closed Bay(s) or Wards**

Staff should only enter closed or partially closed wards and bays if absolutely essential, minimal number of staff only. Preferably visit closed wards and closed or partially closed bays last, with the exception of Medical Assessment Units (MAUs) due to turn around.

Visiting Medical Teams and Other Staff (e.g. Therapists, Bed Management, General Management, CSSD staff, Phlebotomists, ECG technicians) must be restricted, if possible.

Students must not be permitted to visit.

Porters may deliver items to the ward but should have minimal contact with patients or staff, quickly leave the ward and wash hands with soap and water on entering (this contradicts advice on hand hygiene which says hand gel can be used on entering the area) and leaving the ward.

Bank Nurses / Agency staff who work on affected wards especially wards affected with Norovirus should not work on unaffected wards or departments at least for 48hrs.

Phlebotomists should go to affected ward last using gloves and aprons and wash hands with soap and water before leaving the ward.

- **Scrubs and Protective Clothing**

Protective clothing must be worn and changed as outlined below.

Closed Ward

- **Scrubs.** All clinical staff, including medical staff **based on the ward** must wear scrubs. Scrubs may be ordered from Facilities on 0208 725 1833/0781, ext. 1833 or 0781. Staff working at Queen Mary's Roehampton should contact the helpdesk ext. 6100. Staff at Dawes House and Offender healthcare need to contact their managers..... Staff should not leave the ward unnecessarily if wearing scrubs. However, if this is absolutely necessary then scrubs must be covered with a clean outer garment or changed.
(See protocol for closure of wards) on the Trust intranet.

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Guidelines on Prevention and Management of Probable/ Confirmed Viral Outbreaks of Diarrhoea and Vomiting in Care Homes, Schools, Nurseries and other Child Care Settings
HPA (Sept 2010)

Appendix A

QUESTIONNAIRE TO BE COMPLETED BY STAFF & PATIENTS WITH SUSPECTED FOOD POISONING

NAME: STAFF PATIENT DATE:

WARD: HOSPITAL NO.

SITE:

AGE / DOB: OCCUPATION:

HOME ADDRESS

DATE & TIME OF ONSET OF SYMPTOMS:

Nature of Symptoms

	Yes	No		Yes	No
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>			

DURATION OF SYMPTOMS:

FOOD HISTORY

Breakfast Lunch Tea Supper

Day illness started:

Food/Drink/Place of preparation:

One day before:

Two days before: