THE STATE HOSPITALS BOARD FOR SCOTLAND

MANAGEMENT OF PATIENTS WITH LOOSE STOOLS

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The date for review detailed on the front of all State Hospital policies/ procedures/ guidance does not mean that the document becomes invalid from this date. The review date is advisory and the organisation reserves the right to review a policy/ procedure/ guidance at any time due to organisational/legal changes.

Staff are advised to always check that they are using the correct version of any policy/ procedure/ guidance rather than referring to locally held copies.

The most up to date version of all State Hospital policies/ procedures/ guidance can be found on the intranet: http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx

REVIEW SUMMARY SHEET

No changes required to policy (evidence base checked)	☒

Changes required to policy (evidence base checked)	☐
Summary of changes within policy:	

	Contents	Page
	Norovirus decision tree	4
	Management of in-patients with loose stools	5
1	Gastrointestinal Outbreak	5
2	Classification	5
3	When A Suspected Outbreak Occurs	5
4	Cleaning Spillages Of Vomit And Faeces	6
5	Significant Exposure/ Contamination To Vomit/ Faeces	7
6	Duties Of The Nurse In Charge Of The Affected Area	7
7	Duties Of The Infection Control Team	8
8	General Control Measures	8
9	Environmental Cleaning	9
10	Protocol For Staff With Gastrointestinal Illness	9
11	Resource Implications	10
12	Communication	10
13	Equality Impact Assessment	10
14	Format	10
15	Monitoring and Review	10
16	Stakeholder	10

Is it Norovirus Outbreak?
A decision tree to help clinical staff

Outbreaks can start abruptly and spread quickly – to minimise their impact on patients and the hospital they must be recognised, reported and controlled very swiftly.
This flow chart will help you make the right decision.

Is there anyone else on the ward (patient or staff) with unexplained diarrhoea and/or or vomiting?

YES

NO

Isolate symptomatic patients in a single room if possible, with the door closed to reduce the possibility of cross-infection

Are two or more of these "Norovirus Outbreak Markers" present?

- Symptom onset was sudden
- Vomiting is projectile
- Diarrhoea is watery and not blood stained.
- Symptomatic patients have not had laxatives or enemas within past 48hrs.
- Negative stool for C.diff, Salmonella, E.coli 0157, Cryptosporidium, Shigella and Campylobacter. **(But don't wait for results before reporting a suspected outbreak).**

Not an outbreak (yet)

- Isolate the patient where possible.
- Start contact precautions.
- Send a stool sample to bacteriology and virology.
- Be extra vigilant for other patients or staff developing symptoms.
- Continue to monitor the patients' condition.
- Send symptomatic staff home.

YES

NO

Likely to be a Norovirus Outbreak Alert the Infection Control Team

- Isolate the patient or if the number of symptomatic patients exceeds available single room, cohort isolate
- Send a stool sample to bacteriology and virology.
- Contact precautions for all symptomatic patients, send symptomatic staff home.
- Start Norovirus Outbreak Data Record for all symptomatic cases.
- **Record in Datix**

Less likely to be Norovirus

- Isolate the patient(s) where possible
- Use contact precautions
- Send stool samples for culture
- Consider other causes of diarrhoea such as antibiotics, laxatives, constipation, food related etc.
- Inform the Senior Nurse for Infection Control or Infection Control Team if you are concerned or if the situation changes
- **Record in Datix**

MANAGEMENT OF IN-PATIENTS WITH LOOSE STOOLS

Due to the danger of transmission of enteric pathogens and the ease with which pathogens may transmit between in-patients in a healthcare setting, it is necessary to have strict guidelines for the management of any patient with loose stools.

1. GASTROINTESTINAL OUTBREAK

Background

Gastrointestinal symptoms can be caused by numerous factors. Outbreaks within healthcare settings are generally caused by viral pathogens most commonly Norovirus, however they can be caused by bacterial infections. Outbreaks of viral disease, in particular Norovirus are more common during the winter months, they have a short incubation period and usually cause vomiting and/or diarrhoea. Other clinical features consist of abdominal pain and a low-grade fever. A viral gastrointestinal illness is highly transmissible and is usually passed from person to person often by vomit/faecal contamination and is the main cause of outbreaks within healthcare settings.

2. CLASSIFICATIONS

A LOOSE STOOL IS DEFINED AS ONE WHICH CONFORMS TO THE SHAPE OF ITS RECEPTACLE (for visual aid/guidance refer to Appendix 1- should be either **6** or **7** on Bristol Stool Chart)

Where any patient develops loose stools:

- Standard infection control precautions (SICPs) must be implemented (Infection Control Manual chapter 1).
- The patient should be isolated until advice should be sought from a member of the Infection Control Team (ICT) (Appendix 2).
- If this is not possible then make all attempts to isolate the patient in an area of the ward and identify a toilet for their use only.

DIARRHOEA IS DEFINED AS THREE OR MORE LOOSE STOOLS WITHIN A 24 HOUR PERIOD

Some patients may regularly suffer from diarrhoea; however any variation in the normal stool pattern is indicative of a problem.

3. WHEN A SUSPECTED OUTBREAK OCCURS

Early evidence of outbreaks of infection is usually detected by ward based nursing/medical staff.

It is recognised that there cannot be absolute criteria for defining an outbreak or problem and in certain circumstances staff may have to act on the grounds of 'reasonable suspicion'. Staff should act promptly and seek advice where there is concern rather than worry about 'false alarms'. It is much better to be cautious, and to report early, rather than to wait until a major problem is evident.

Any of the following is suggestive of a problem

1. Three or more episodes of unexplained /sudden diarrhoea in a 24hour period
2. Any patient with a confirmed laboratory report of a gastrointestinal pathogen such as salmonella
3. Unexplained diarrhoea in two or more patients within the same 24hr period
4. Unexplained vomiting in two or more patients within the same 24hr period

Ward staff responsibilities for suspected outbreak

1. Contact Senior Nurse for Infection Control (SNIC) (in the first instance) or a member of the ICT (Appendix 2).

2. Contact the Health Centre for labels and specimen bottles. Obtain a stool specimen and send it to the Microbiology Department (see page 6 obtaining specimen samples).
3. Place patient in isolation preferably in their room but if their mental state is fragile then nurse them in the side room identifying a toilet specifically for their use.
4. Commence patient on a food and fluid balance chart, (Appendix 3), monitoring closely what the patient is eating and drinking, perhaps removing food items from their room.
5. Complete a food diary for the patient for the previous 48hours (Appendix 4).
6. Commence patient on physical observations chart using the National Early Warning Score (NEWS) for blood pressure, temperature, pulse & respirations (Appendix 10).
7. Contact Catering Department to arrange a light, plain diet if there is nothing suitable on the menu.
8. Takeaway meals should be cancelled to avoid further irritation of the gastrointestinal system.
9. Omit laxative prescriptions where appropriate until advice sought from SNIC/ICT.
10. Record in DATIX under:
    a. **Type** - Infection Control
    b. **Category** – Patient Suspected Contagious Illness
    c. **Sub Category** – Vomiting/diarrhoea
11. All treatment and precautions implemented must be clearly documented in the patient's notes. Any paper copies of observations charts etc should be scanned onto RiO.
12. If more than one patient has symptoms of vomiting and / or diarrhoea then complete appendix 5 daily 'patients with vomiting and diarrhoea'.
13. Relatives should be apprised of the patient being in isolation at the earliest opportunity in order that they can reschedule any planned visits.

Nb Anti-diarrhoeal medication should not be prescribed.

If 2 or more patients have diarrhoea or vomiting and are being nursed separate from their peers then the ward should close immediately as it will be assumed there is the potential for an outbreak situation. This means*:*

- No patient movement to hub area, Skye centre etc.
- No internal or external visitors.
- Restrict staff members movement across the site (where possible).
- We cannot prevent patients attending tribunals or court appearances however receiving staff should be made aware of the situation.

If the diarrhoea ceases then the patient may, after being symptom-free for 48hrs and following consultation with the ICT, resume normal activities. This can be carried out prior to confirmation of the laboratory results, provided he is continent and can be relied upon to maintain good hand hygiene.

If diarrhoea continues beyond 24hrs, and in the absence of any positive microbiology, two further specimens should be sent **24hrs apart, unless advised otherwise by a member of the Infection Control Team.**

If these three specimens are **negative** then, after consulting the Infection Control Team and medical staff, the patient can return to their usual placement even if diarrhoea continues, provided that he can maintain good hand hygiene.

If any of the samples test **positive** the patient may require treatment. Staff **must** contact the SNIC or any member of the ICT who will give further advice as required.

4. CLEANING SPILLAGES OF VOMIT AND FAECES

The following precautions should be followed by staff when cleaning vomit or faeces: (Appendix 6) Wear disposable gloves and plastic aprons. A surgical type face mask may be worn to prevent inhalation of contaminated aerosols during this procedure, particularly where a patient has vomited.

Use disposable paper towels to soak up any excess liquid. Transfer these and any soiled matter into a clinical waste bag.

Clean and disinfect soiled area as per Appendix 6 and the Infection Control Manual Management of Blood and Body Fluid Spillages .

Dispose of paper towels, gloves and aprons into the clinical waste bag.

5. SIGNIFICANT EXPOSURE/CONTAMINATION TO VOMIT/FAECES

Any member of staff who has had a significant exposure to faecal matter, either by the definition below or by having their clothing grossly contaminated, must fill out a DATIX form.

A significant exposure/contamination to blood/body fluid is defined as a contact of broken skin, mucous membrane or eyes with another person's blood or body fluid.

6. DUTIES OF THE NURSE IN CHARGE OF THE AFFECTED AREA

Ensure a notice indicating that the ward is closed due to an outbreak of diarrhoea and vomiting, is placed on the ward door asking people entering the ward to report to the nurse in charge

Notify relatives as soon as possible of any restrictions in place

Other staff groups should be informed of the outbreak situation e.g. Pharmacists, Physiotherapists, Occupational Therapists, Social workers etc

All relevant information for each affected patient must be documented daily on the 'patients with vomiting and diarrhoea' (Appendix 5). Ensure that ongoing accurate records are maintained

Obtaining Specimen Samples
As soon as possible, a specimen of faeces, or if not possible to obtain a faecal sample, a sample of vomit should be obtained from all patients with symptoms. Specimen's bottles and documentation can be obtained from the Health Centre. The specimens should reach the hospital reception before 1330 in order for them to be uplifted and sent to the laboratory. Other specimens may be requested at a later date.

Out of hours
If specimens are requested after 1330 (weekdays) or outwith normal hours by the on call medic then it is up to the Nurse in Charge of the ward to seek approval (via Senior Cover and on call medic) for the specimens to be sent via taxi to the laboratory. This should be in emergencies only. It is essential that the accompanying request form is filled in as accurately and as comprehensively as possible. Staff should complete daily 'patients with vomiting and diarrhoea' form (Appendix 5).

If specimens are requested outwith normal working hours specimen bottles and bags are available and located in the health centre (in the blood box).

Ensure patients, staff and visitors pay strict attention to hand hygiene using either non alcohol / alcohol based hand rub (when hands are visibly clean) or hot water and soap. It is important to remember that in the event of a norovirus outbreak that the hand rubs are not effective and everyone should revert to using hot water and soap.

Ensure contaminated linen is disposed of as foul/infected and other materials are handled in the correct manner (see Safe Management of Linen Policy)

Where staff are affected, ensure that the protocol for employees with gastrointestinal illness is strictly adhered to. All symptomatic staff should be referred to SALUS Occupational Health

It is advisable that, during outbreaks, staff do not travel to and from work in their uniforms (this will reduce the risk of transmission to their families). If uniforms are contaminated by blood/body fluid they **must** be handled according to the section within the Standards of dress and clinical-nonclinical policy, Guidelines for Staff Laundering their Uniforms at home.

Ensure a high standard of cleanliness is maintained at all times throughout the ward.

7. DUTIES OF THE INFECTION PREVENTION AND CONTROL TEAM

- If practical, visit the affected area on a daily basis; if not then phone the area daily.
- Ensure that staff adhere to outbreak control measures.
- Liaise with the Nurse in Charge / Senior Clinical Cover and the Microbiologist on a daily basis to ensure all control measures are in place.
- Where appropriate e.g. Salmonella infection, full food histories should be obtained, in consultation with the Consultant in Public Health Medicine, to allow for a more in depth analysis to be done.
- Ensure that all the relevant information is collated accurately and that the 'patients with vomiting and diarrhoea' form is completed daily (Appendix 5).
- Convene an outbreak team. The roles and responsibilities are outlined in Appendix 7 with a draft agenda presented in Appendix 8.
- In the case of norovirus ensure that staff are provided with information on management of norovirus (Appendix 9).
- Issue a daily update on the outbreak situation to all relevant parties by e-mail.
- Complete a summary report template on completion of the outbreak.
- Conduct a debriefing exercise and review DATIX entries.

8. GENERAL CONTROL MEASURES

Staff Movement
Asymptomatic nursing/domestic staff working in an affected area (across the NHS) should not move to an unaffected area until the outbreak is declared over, following being asymptomatic for fully 48hrs.

Symptomatic staff should remain off work until they are 48hr symptom free.

Physiotherapists and Occupational Therapists should not treat patients unless it is deemed essential and so far as is possible, should not move from an affected to an unaffected area.

Social work staff should liaise with the nurse in charge of the ward in relation to visiting patients. Difficult situations should be discussed with the ICT.

Patient Movement
The ward should be closed and movement restricted .e.g. patients should not be able to go on ground access, placement or groups. If a patient is due for transfer or pre transfer visit the receiving unit should be notified.

Exceptions: Patients will be permitted to attend tribunals, court appearance if they are able; however ICT should be appraised prior to the event.

Visitors
Ideally visitors should be discouraged from visiting until the outbreak is over; however in exceptional circumstances e.g. where a relative has come from a considerable distance this can be permitted after advice has been sought from Infection Prevention and Control Team. Visitors must be encouraged to practice appropriate hand hygiene, i.e. use hot water and soap or the non alcohol gel.

Food Hygiene
Staff working for the Catering Department should not directly access the affected ward. Food trolleys will be delivered to the ward and dishes washed in the normal way.

Nursing staff serving meals should be aware of the need for stringent hand hygiene practices.

9. ENVIRONMENTAL CLEANING

Single use disposable plastic apron and gloves must be worn when carrying out general cleaning duties.

Where environmental contamination occurs, refer to Appendix 6 and Management of Blood and Body Fluid Spillages.

Domestic staff must clean the general ward environment thoroughly each day, using a solution of detergent and warm water. A high level of general cleanliness must be maintained at all times, cleaning from unaffected to affected areas. In areas where there are affected patients the area/s (horizontal surfaces, floors, toilets and door handles) should be cleaned using a solution of detergent with a chlorine releasing agent. Dilution should be 1,000ppm (refer to container for guidance on dilution).

The housekeeping domestic should ask the nurse in charge each day at the start of their shift if there are any additional changes to the cleaning regimes

At the conclusion of the outbreak the area should be deep cleaned as per local protocol. Housekeeping staff should be identified / designated for the area. They should not undertake housekeeping duties in an unaffected area across the site. Staff working at the weekend will need to discuss their role with their supervisor.

10. PROTOCOL FOR STAFF WITH GASTROINTESTINAL ILLNESS

Any member of staff displaying unexplained sudden onset gastrointestinal symptoms of either vomiting and/or diarrhoea should refrain from duty until they have been asymptomatic for a period of a full 48hrs.

If a member of staff becomes ill, whilst on duty, they should be sent home immediately.

The individual staff member or nurse in charge should inform SALUS Occupational Health, as per Attendance management policy (section 4) who will in turn follow-up the staff member until they return to duty.

Staff suffering from diarrhoea may be asked, if possible, to provide a stool sample. This would be under the direction of Occupational Health or the Senior Nurse for Infection Control. Samples if requested would normally be sent to the laboratory via the staff member's G.P.

11. RESOURCE IMPLICATIONS

There are no resource implications.

12. COMMUNICATION

Policy will be launched and distributed as follows:

- Via the Staff bulletin
- Published on the intranet page under “The State Hospital Infection Control Manual”.

13. EQUALITY IMPACT ASSESSMENT

This policy is included in the Infection Control Manual EQIA.

14. FORMAT

The State Hospitals Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information / documents in alternative formats and are happy to discuss with you the most practical and cost effective format suitable for your needs. Some of the services we are able to access include interpretation, translation, large print, Braille, tape recorded material, sign language, use of plain English / images. If you require information in another format, please contact the Person Centred Improvement Lead on 01555 842072.

15. MONITORING AND REVIEW

All documents are monitored and reviewed on an ongoing basis by the policy Lead Author and Advisory Group as part of working practice. Formal review will be 2 yearly.

16. STAKEHOLDERS

Key Stakeholders	Consulted (Y/N)
Patients	Y
Staff	Y
TSH Board	Y
Carers	Y
Volunteers	Y

THE BRISTOL STOOL FORM SCALE

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces ENTIRELY LIQUID

INFECTION CONTROL TEAM CONTACTS

Please contact **Karen Burnett** (during office hours) in the first instance. If Karen is off site or on annual leave you are advised to contact any member of the Infection Control Team who will endeavour to answer your query or direct you appropriately**.**

Infection Control Team Available during 9am -5pm Monday – Friday	**Extension Number**
Karen Burnett Senior Nurse for Infection Control	2174 Pager 1030
Pamela Burnett Housekeeping and Linen Services Manager	2097
Mark Richards Director of Nursing, AHPs and Operations	2002
Occupational Health Advisor	2120

Out of Hours & Public Holidays

NHS Lanarkshire	**Telephone Number**
Dr Tom Gillespie Consultant Microbiologist & The State Hospital Infection Control Doctor	Speed dial 123 (ask for Dr Gillespie)
On Call Consultant Microbiologist (who will deputise for Dr Gillespie in his absence)	Speed dial 123 (ask for On Call Consultant Microbiologist)

The State Hospital

Food & Fluid Balance Chart – New chart for each day

Patient Name: Ward:
DOB:

	Input					Output		
Time	**Food eaten** (description)	**Amount** (portion)	**Fluid consumed** (describe)	**Amount** (mls)	**Comments**	**Urine**	**Other**	**Signed**
Example 8:30am	**Cornflakes**	**bowl**	**Tea with milk and 2 sugars**	**200**	**Only half cornflakes eaten but all tea drunk.**			
24 Hour	**Total Input**					**24 Total**	**Output**	

Poly cup = 180mls average Mug = 260mls average milk portion on cereal 100mls **The average output ranges from between 800-2000mls**

Appendix 4

Patients Food diary

In order to try and establish a cause of the patient's diarrhoea and/or vomiting it would be advantageous to record a food diary for the previous 48hours

Please complete the following questions with the information available at the time.

	Yes	No
1. Did the patient consume food from the patient menu in the previous 48hours?	☐	☐
If yes a. what meals did he consume		
b. did other patients have the same meals	☐	☐
c. if yes, are they experiencing similar symptoms	☐	☐
2. Did the patient consume a carry out meal in the previous 48hours?	☐	☐
If yes a. What meal did he consume		
b. did other patients have the same meals	☐	☐
c. if yes, are they experiencing similar symptoms	☐	☐
3. Has the patient been involved in a therapeutic kitchen activity in the last 48hours?	☐	☐
If yes a. What meal did he consume		
b. Did other patients have the same meal	☐	☐
c. If yes are they experiencing similar symptoms	☐	☐
4. Has the patient purchased and consumed large quantities of confectionary in the previous 48hours	☐	☐

Please make this information available to the Senior Nurse for Infection Control

Appendix 5

Patients with Vomiting and Diarrhoea

Ward **Date**

Nursing staff to complete
Please record all patients with vomiting and diarrhoea / loose stools
A new chart should be stated each morning at 9am by the day staff. A member of the ICT will visit the ward to take and retain copies of the of the previous days chart
Every episode of vomiting and diarrhoea should be recorded with a tick ✓

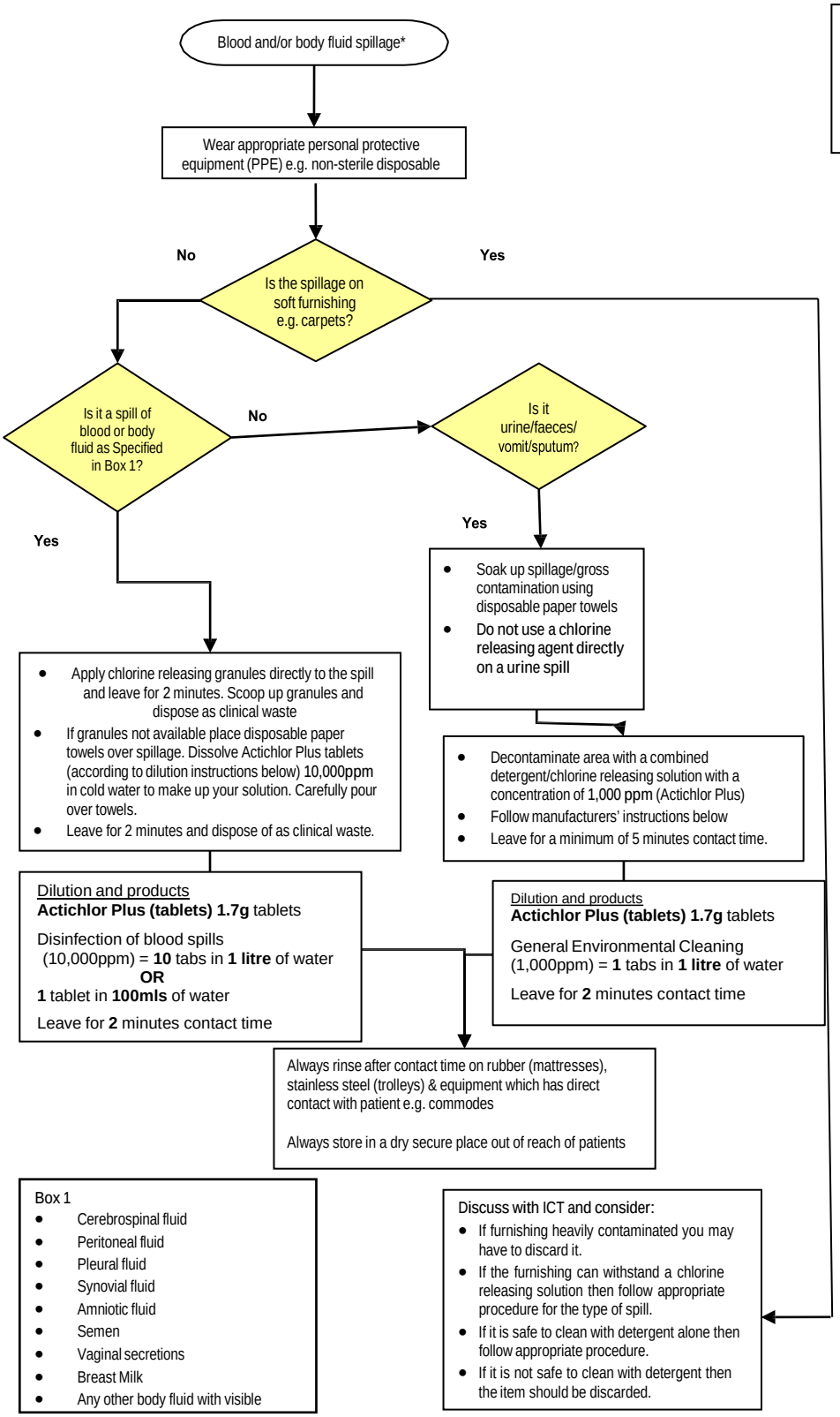
Patients Name	Date Sample obtained	Vomiting	Diarrhoea

Management of blood and body fluid spillages

Infection Control Team

Name: **Karen Burnett**

Designation: **Senior Nurse for Infection Control**
Contact Number: **x2174 or pager 1030**



*it may be appropriate to use external contactors where there is a significant amount of blood and bodily fluids. This decision will be made by the Senior Clinical Cover (and where possible the Senior Nurse for Infection Control / Estates Manager). Estates department should be contacted to arrange the visit or alternatively when out of hours this should be arranged by the Control Room staff.

* Scottish National Blood Transfusion Service and Scottish Ambulance Service use products that differ from those stated in the National Infection Prevention and Control Manual

THE ROLE OF THE INFECTION CONTROL OUTBREAK TEAM

A member of the ICT will immediately initiate such investigation as is necessary to confirm the possibility of an outbreak.

The State Hospital Infection Control Team will meet as the multidisciplinary Outbreak Control Team in the event of a ward closure with assistance from outside agencies as appropriate.

- Consultant Microbiologist
- Environmental Health Officer if appropriate

Other individuals who may be co-opted as appropriate e.g., Security Manager, Pharmacist, General Practitioner, Health & Safety Executive, and any other department or discipline specified by the ICT.

Detailed recording of all aspects of the outbreak and its management must be carried out. All meetings of the ICT should be formally minuted. Actions agreed and by whom should be clearly defined. Minutes and actions should be issued timeously and reviewed at the following ICT meeting. All documentation relating to the outbreak must be retained.

The role of the ICT is:

To agree and co-ordinate the activities involved in the investigation (e.g. liaison with the Environmental Health Officer if appropriate) in order that the aetiology, vehicle and source of the outbreak are identified as soon as possible, so that control measures may be implemented, and if required, legal advice sought.

This may involve all or some of the following:

- Case finding and interviews
- Changes to the standard procedure for investigation of sporadic cases
- Clinical and environmental sampling
- Inspection of suspected premises
- To identify the need for appropriate medical care facilities for patients, and ensure that State Hospital emergency plans are activated if large numbers of people are ill
- To agree action to control the outbreak and prevent further spread by means of exclusion, withdrawal of food thought to be hazardous, closure of premises etc
- To agree and co-ordinate the provision of advice to general practitioners and other professionals and to the public including the setting up of a helpline if required
- To agree arrangements for media liaison including press statements and the regular release of information
- To produce a full report or reports, including lessons learned for appropriate parties.

It is imperative that members of the ICT share all the available information even if it is still confidential in nature.

At the end of the outbreak the ICT will meet in order to:

- Review the experience of all those involved in the management of the outbreak
- Identify any shortfalls encountered and highlight areas which worked particularly well
- In the light of experience revise the Outbreak Plan
- Produce a written report which will include a full review of the outbreak and its cause, management and recommendations for change in procedures to prevent a further recurrence.

Appendix 8

Infection Control Outbreak Team Meetings

Draft Agenda

1. Introduction and reminder of “confidentiality”

2. Minutes of last meeting (if applicable) including review of actions agreed at previous meeting.

3. Outbreak Update

    3.1 General situation statement
    3.2 Patient(s) report
    3.3 Microbiological report
    3.4 Environmental Health report (if required)
    3.5 Other relevant reports, e.g. Control of Infection Nurse, Occ Health etc.

4. Management of Outbreak

    4.1 Control Measures
        - Patients
        - Staff
        - General (e.g. EHO inspection of premises, closure of premises, withdrawal of food).

    4.2 Care of Patients
        - hospital

    4.3 Investigation
        - Inspection
        - Epidemiological
        - Microbiological aspects (specimens and resource)

5. Communications

6. Date and time of next meeting

NOROVIRUS INFECTION CONTROL
STAFF INFORMATION

NOROVIRUS – AN OVERVIEW

Noroviruses (NV), previously known as small round structured viruses (SRSV's) and Norwalk like viruses (NLV's) are the most common cause of outbreaks of gastro-enteritis in hospitals, schools, nursing/residential homes etc. These viruses can be highly infectious causing high attack rates among patients and staff within the hospital setting. Attack rates can reach as high as 50%-70% in patients and staff.

Gastro-enteritis caused by Norovirus infection produces a self-limiting, mild to moderate disease with clinical symptoms of nausea, vomiting (often projectile), diarrhoea, abdominal pain, myalgia, headache, malaise, low grade fever or a combination of these symptoms which can last 12-72 hours. The elderly and patients with pre-existing chronic medical conditions may develop more serious symptoms. Treatment in most cases is replacement fluids.

IDENTIFICATION

The virus may be identified in stool or vomit specimens, particularly if the specimen is obtained at the onset of symptoms.

RESERVOIR

Humans are the only known reservoir.

ROUTE OF TRANSMISSION

Probably by the faecal – oral route, although indirect transmission from environmental contamination and via aerosol has been suggested to explain the rapid spread in hospital settings. Food may also be a vehicle for transmission of infection.

CHARACTERISTICS

A rapid onset of diarrhoea and/or vomiting is commonly seen with a rapidly rising attack rate in both staff and patients alike.

INCUBATION PERIOD

Usually 12-48 hours.

PERIOD OF COMMUNICABILITY

During the acute stage of the disease, and up to 48 hours after diarrhoea/vomiting stops.

SUSCEPTIBILITY

Susceptibility is widespread and short-term immunity lasting up to 14 weeks has been reported.

(Must be printed in colour)

Reason for NEWS: IM PRN ☐ Post Restraint ☐ D&V ☐ Deteriorating Patient ☐ Olanzapine Depot ☐ Other ☐

0 1 2 3

Appendix 10

DATE OF BIRTH | DATE OF ADMISSION

Year	DATE		DATE
	TIME		TIME
A+B Respirations Breaths/min	≥25	3	≥25
	21–24	2	21–24
	18–20		18–20
	15–17		15–17
	12–14		12–14
	9–11	1	9–11
	≤8	3	≤8
A+B SpO_2 Scale 1 Oxygen saturation (%)	≥96		≥96
	94–95	1	94–95
	92–93	2	92–93
	≤91	3	≤91
SpO_2 Scale 2† Oxygen saturation (%) Use Scale 2 if target range is 88–92%, eg in hypercapnic respiratory failure †ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O_2	3	≥97 on O_2
	95–96 on O_2	2	95–96 on O_2
	93–94 on O_2	1	93–94 on O_2
	≥93 on air		≥93 on air
	88–92		88–92
	86–87	1	86–87
	84–85	2	84–85
	≤83%	3	≤83%
Air or oxygen?	A=Air	2	A=Air
	O_2 L/min		O_2 L/min
	Device		Device
C Blood pressure mmHg Score uses systolic BP only	≥220	3	≥220
	201–219		201–219
	181–200		181–200
	161–180		161–180
	141–160		141–160
	121–140		121–140
	111–120		111–120
	101–110	1	101–110
	91–100	2	91–100
	81–90		81–90
	71–80		71–80
	61–70	3	61–70
	51–60		51–60
	~~≤50~~ ~~≥131~~		~~≤50~~ ~~≥131~~
C Pulse Beats/min	121–130	2	121–130
	111–120		111–120
	101–110	1	101–110
	91–100		91–100
	81–90		81–90
	71–80		71–80
	61–70		61–70
	51–60		51–60
	41–50	1	41–50
	31–40	3	31–40
	≤30		≤30
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert		Alert
	Confusion	3	Confusion
	V		V
	P		P
	U		U
E Temperature °C	≥39.1°	2	≥39.1°
	38.1–39.0°	1	38.1–39.0°
	37.1–38.0°		37.1–38.0°
	36.1–37.0°		36.1–37.0°
	35.1–36.0°	1	35.1–36.0°
	≤35.0°	3	≤35.0°
NEWS TOTAL			**TOTAL**
Monitoring frequency			Monitoring
Escalation of care Y/N			Escalation
Initials			Initials

Chart 1: The NEWS scoring system

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

Chart 2: NEWS thresholds and triggers

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.

**The response team must also include staff with critical care skills, including airway management.

Chart 4: Clinical response to the NEWS trigger thresholds

NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS monitoring
Total 1-4	Minimum 4–6 hourly	• Inform registered nurse, who must assess the patient • Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more Urgent response threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients • Provide clinical care in an environment with monitoring facilities
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level • Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills • Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU • Clinical care in an environment with monitoring facilities