Ashford and St. Peter's Hospitals
NHS Foundation Trust

Diarrhoea, Vomiting, Gastroenteritis and Foodborne Infections Infection Prevention and Control Policy

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Executive Lead: Mark Roland, Director of Infection Prevention and Control / Chief Medical Officer

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History

Issue	Date Issued	Brief Summary of Change	Written by/approved by
1	May 2009	New policy	Clinical Governance Committee
2	Feb 2010	Updated in line with the Trust's Policy Writing and Ratification Policy	Caroline Becher, Chief Nurse
3	May 2023	Total rewrite of policy, expanding section on infection prevention and control precautions	Shila Patel, Nurse Consultant Infection Prevention & Control / Control of Infection Committee
4	June 2026	Review and update	Shila Patel, Nurse Consultant Infection Prevention & Control / Control of Infection Committee

For more information on the status of this document, please contact:	
Policy Author	Shila Patel, Nurse Consultant Infection Prevention &Control / Infection Prevention and Control Team
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Audience	All clinical staff

Executive summary

Diarrhoea and / or vomiting can occur due to a variety of causes, such as *Clostridioides difficile, Norovirus*, or food-borne infections such as *Salmonella, Campylobacter* or *Clostridium perfringens*. In the hospital setting, *Clostridioides difficile* and *Norovirus* are the most common infectious cause of diarrhoea, however, it is important to bear in mind there are other infectious causes, as well as non-infectious causes. Therefore, at the onset of symptoms, it is important to carefully assess the patient and where an infectious cause is suspected, infection prevention and control precautions must be implemented at the earliest stage to reduce the risk of cross-infection to others.

Much of the detail in this policy relates to *Norovirus* (section1). For other types of gastroenteritis (including food borne infections) staff should refer to the Quick Reference Guide for Common Gastrointestinal Infections in section 2 of this policy, and the Trust Major Outbreak Plan.

Where *Clostridioides difficile* is suspected / confirmed staff should refer to the Trust policy for *Clostridioides difficile*.

This policy sets the Trust standards for infection prevention and control (IPC) when caring for patients with suspected or confirmed infectious diarrhoea and/or vomiting (other than *Clostridioides difficile*).

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To be read in conjunction with:

- Standard infection prevention and control precautions policy / National IPC Manual

1. Introduction and Background

1.1 Diarrhoea and / or vomiting can occur due to a variety of causes, such as *Clostridioides difficile, Norovirus,* or food-borne infections, such as *Salmonella, Campylobacter* and *Clostridium perfringens*. In the hospital setting, *Clostridioides difficile* and *Norovirus* are the most common infectious cause of diarrhoea, however, it is important to bear in mind there are other infectious causes, as well as non-infectious causes. Therefore, at the onset of symptoms, it is important to carefully assess the patient and where an infectious cause is suspected, infection prevention and control precautions must be implemented at the earliest stage to reduce the risk of cross-infection to others.

1.2 Much of the detail in this policy relates to *Norovirus* (section1). For other types of gastroenteritis (including food borne infections) refer to the Quick Reference Guide for Common Gastrointestinal Infections in section 2 of this policy, and the Trust Major Outbreak Plan.

1.3 Where *Clostridioides difficile* is suspected / confirmed refer to the Trust policy for *Clostridioides difficile*.

1.4 This policy sets the Trust standards for infection prevention and control (IPC) when caring for patients with suspected or confirmed infectious diarrhoea and/or vomiting (other than *Clostridioides difficile*).

2. Scope

2.1 This policy applies to all Trust staff, particularly staff working in patient wards and departments, including Trust employees, temporary staff (agency, bank, locums, students, and contractors), as well as visitors and carers.

3. Purpose

3.1 The purpose of this policy is to set the Trust standards for infection prevention and control when caring for patients with suspected or confirmed infectious diarrhoea (other than *Clostridioides difficile*), in order to minimise the risk of cross-infection from one patient to another and to minimise the risk of outbreaks of infectious diarrhoea.

4. Duties and responsibilities

4.1 Chief Executive

- Has overall responsibility for infection prevention and control across the Trust. This includes implementation of this policy.
- Has responsibility for ensuring that appropriate actions are taken to protect patients, staff and others who may be at risk of acquiring healthcare-associated infections.
- Has responsibility for ensuring adequate resources are available for infection prevention and control.
- Is legally responsible for identifying, assessing, and controlling the risk of infection in the workplace but may delegate operational responsibilities.

4.2 **Director for Infection Prevention and Control (DIPC)**

- Is accountable for the implementation of the Health and Social Care Act (2008), which includes overseeing implementation of Trust infection prevention and control policies. and guidelines, including this policy.
- Has responsibility for reporting directly to the Board about all matters relating to infection prevention and control.

4.3 **Chief Nurse / Deputy Chief Nurse**

- Has responsibility for the implementation of this policy within Nursing and Midwifery.
- Has responsibility for ensuring high standards of patient care are maintained, including adherence to infection prevention and control, as detailed within this policy
- Has responsibility for ensuring wards / departments are adequately staffed (nursing), to implement infection prevention and control to a high standard.

4.4 **Divisional Chief Nurses / Divisional Directors**

- Has responsibility for ensuring adequate dissemination and implementation of this policy within each Division.
- Has responsibility for ensuring all staff are aware of their respective roles and responsibilities in relation to infection prevention and control, including this policy.
- Are accountable for ensuring that appropriate/agreed actions are carried out where areas of concern or deficiencies are identified.
- Has responsibility for monitoring compliance with this policy within each Division and for reporting compliance and remedial actions taken to the Trust Control of Infection Committee, as appropriate.

4.5 **Matrons / Ward Managers / Department Managers**

- Are responsible for implementing and monitoring compliance with this policy in their wards / departments.
- Are responsible for challenging poor compliance / practice as necessary.
- Are responsible for supporting staff in following this policy by releasing staff to attend infection prevention and control training.

4.6 **Associate Director IPC / Nurse Consultant IPC / Lead Doctor IPC / IPC Team**

- Are responsible for setting the Trust standards for infection prevention and control in line with national guidance, current best practice, and any changes in legislation.
- Are responsible for ongoing surveillance of healthcare associated infections, for early identification and control of clusters / outbreaks, in line with national guidance, and advising the Trust as appropriate to prevent further spread.
- Are responsible for monitoring patients with known cross-infection risks, to advise on the use of appropriate infection prevention and control precautions and to support staff where needed, challenging non-compliance with this policy / poor practice as necessary.
- Advice on / reinforce the standards detailed within this policy.
- Provide training about standard infection prevention and control precautions and use of isolation precautions.

4.7 **Control of Infection Committee (COIC)**

- Has responsibility for monitoring and reviewing all issues relevant to infection prevention and control within the Trust, including hand hygiene compliance, training attendance and adherence to infection prevention and control policies, including this policy.

4.8 **Clinical Practice Educators / Training Department**

- Are responsible for adhering to the standards detailed within this policy when providing education and training (and must not educate/train to other standards).

4.9 **Laboratories**

- Are responsible for processing microbiology and virology samples and to provide quality results, ensuring accuracy and in a timely manner, to aid appropriate patient care.

4.10 **Housekeeping Manager / Team**

- Are responsible for high standards of environmental cleaning in all areas of the Trust, in line with the national standards of cleanliness for the NHS.
- Are responsible for ensuring adequate resources (staff and cleaning equipment) are available to facilitate thorough cleaning of the environment.

4.11 **All Staff Working in Wards / Departments**

- Are responsible for familiarising themselves with the standards detailed within this policy and for adhering to these standards.
- Are accountable for their own practice, particularly for any deviation from the standards detailed within this policy.
- Where the standards cannot be implemented for a good reason, staff are responsible for escalating this to the manager-in-charge.

5. Policy

Section 1 – Viral gastroenteritis due to *Norovirus*

5.1 **Assessing for diarrhoea**

On admission, assess all patients' normal bowel motions / habits to establish their baseline. This makes it easier to assess for diarrhoea, as and when it occurs, and helps to establish whether the diarrhoea is likely to be infectious.

Throughout patients' hospital admission, record their bowel motions at least daily, using the categorisation types provided in the Bristol Stool Chart. If the patient does not open their bowels, it is equally important to record this (in the patient's electronic patient record, this is recorded as number 8, which means bowels not opened).

The Bristol Stool Chart provides objective categorisation of bowel motions using types 1-7, see chart overleaf. It is NOT acceptable to use subjective terms, such as loose or runny, as each person's interpretation of such adjectives varies from one person to another and makes assessing for infectious diarrhoea very difficult.

Bristol Stool Chart		
Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely liquid**

5.2 **What is viral gastroenteritis?**

Viral gastro-enteritis, e.g. *Norovirus*, is characterised by acute onset vomiting and/or diarrhoea. Vomiting induces aerosol virus particles which may spread directly to other susceptible individuals or indirectly via the environment. It can survive for several days in the environment. Therefore, *Norovirus* has high infectivity. It commonly affects children in schools, residents in nursing/residential homes, people on cruise liners and other places where people gather together, including hospitals. *Norovirus* seen in the hospital setting is usually a reflection of *Norovirus* circulating in the community.

5.3 **Incubation period**

The incubation period is short, typically 24 to 48 hours.

5.4 **Signs & Symptoms**

Signs and symptoms may include, but are not limited to, the following. Patients may not present with all of these features and may only experience one or more of the symptoms listed. Therefore, a targeted history should be undertaken to identify symptoms that may not be volunteered by the patient. Therefore, patients may need to be explicitly asked if they have:

- Abdominal pain
- Diarrhoea
- Vomiting (often projectile)
- Occasionally fever
- Headache and myalgia

5.5 **Mode of Transmission**

- Faecal – oral route
- Direct or indirect contact with faeces
- Aerosol spread.

Patients are most infectious whilst vomiting or having active diarrhoea and remain infectious for up to 48-72 hours after symptoms have ceased.

5.6 **Infection Prevention and Control**

Transmission based contact precautions

Any patient with symptoms of diarrhoea and/or vomiting that could be due to an infective cause should be isolated in a single room as soon as possible (ASAP).

If there are 2 or more patients at the same time in the same ward/department/unit with unexpected symptoms of diarrhoea/vomiting that may be infectious, then an outbreak should be suspected, and further advice sought ASAP.

5.6.1 **Initial Management**

- Collect faecal samples ASAP (they can be collected even if contaminated with urine)
- Isolate the patient(s) as detailed below, **DO NOT** wait for specimen results, **ACT** on the symptoms.
- If an outbreak is suspected, the nurse-in-charge must inform other relevant staff:
  - Infection control team (or the on-call Consultant Microbiologist out-of-hours)
  - Site management team
  - Matron / Senior nurse
  - Relevant patient doctors.

5.6.2 **Ongoing Management**

5.6.2a **Isolation**

Individual cases

- Isolate the patient in a single room, ideally with ensuite facilities, from onset of potentially infectious diarrhoea (do NOT wait for stool sample results to institute isolation precautions as this increases the risk of cross-infection to others).
- Keep door to single room closed, as much possible.
- If a single room is not available on the originating ward, liaise with the IPC Team / Site Management Team, for further advice. In the interim, isolate the patient in their bedspace in the multi-bed area.
- Prominently display a source isolation / contact precautions sign (on door to single room, or on the wall above the bedspace).
- Source isolation can be discontinued when the patient has been asymptomatic for 48-72 hours. A negative stool sample is NOT required before de-isolating the patient, as infectivity to others is determined by the presence or absence of symptoms.

Two or more cases

- Where 2 or more cases occur in the same bay or different bays on the same ward and at the same time, isolate patients in line with Summary Options for Norovirus Patient Management Chart (refer to page 13) and contact the Infection Control Team ASAP during office hours or Matron / Site Manager out-of-hours who will fully assess

the situation and provide advice about whether to close the bay to new admissions. Seek advice from the on-call microbiologist as necessary.

- Prominently display a source isolation / contact precautions sign on the door(s) to affected bay(s) or door to ward if the whole ward is affected.
- Do not use the ward as a general thoroughfare.

5.6.2b **Communication**

- Inform the patient about why they are being moved to a single room, i.e. the potential risk of infectious diarrhoea and/or vomiting to others.
- If stool sampling confirms an infectious cause, it is the responsibility of the clinicians caring for the patient, to inform the patient about the diagnosis
- If the patient lacks capacity, inform their next-of-kin.
- Ensure the patient's symptoms are included in handover from one shift to another, so staff caring for the patient(s) are aware & use the correct precautions.
- If the patient requires transfer to another healthcare facility (because it is clinically essential), inform the receiving area in advance about the patient's symptoms, so the patient can be isolated on transfer.
- If the patient needs to attend another department, e.g. radiology, for urgent investigation/procedure, the receiving department should be informed in advance so the patient can be scheduled at the end of the list (where possible, to allow for thorough cleaning of the room prior to reuse) & correct precautions used.
- Visitors to the ward should be informed there is D&V on the ward (taking care not to breach the confidentiality of individual patients), along with the IPC precautions they should take.

5.6.2c **Hand hygiene**

Staff

- Clean hands thoroughly in line with the 5 Moments for Hand Hygiene in healthcare
- Wash hands thoroughly with soap and water after attending the patient / before leaving the single room/isolation area (alcohol hand sanitiser is not effective against *Norovirus* and must not be used in this scenario).

Patients

- Encourage / assist patients to clean their hands before all meals and after toileting to reduce the risk of patients ingesting *Norovirus*/other organisms causing infectious diarrhoea.

Visitors

- Advise visitors to clean their hands on entering and prior to leaving the patient's room (before leaving hands should be washed with soap and water, as alcohol hand sanitiser is ineffective against diarrhoea caused by Norovirus).

5.6.2d **Personal protective equipment**

- Assess the task to be performed to determine whether personal protective equipment (PPE) is required.
- Where contact with blood/body fluids, non-intact skin or mucous membranes is anticipated, put on gloves/apron (and eye/face protection for splashing to eyes/face), as appropriate.
- For tasks involving minimal contact with the patient/their environment, e.g. delivering meal tray or giving medication, PPE is not required. Hand hygiene should nevertheless be carried out before and after the task.

- Discard used PPE as clinical waste.
- Wash hands thoroughly with soap and water after PPE removal.
- Visitors are not required to routinely wear PPE but should be worn if providing direct personal care.

5.6.2e **Management of Equipment**

- Provide the patient with dedicated and labelled equipment.
- If the single room does not have ensuite facilities, or the patient cannot mobilise to the ensuite bathroom, or the patient is isolated in a bedspace in a multi-bed bay, provide a dedicated and labelled commode (label with the patient's first/last names)
- Clean all commodes with Chlorox wipes.
- Where possible provide single-use or single-patient use equipment, e.g. single-patient use BP cuffs, slide sheet and hoist slings. Label all single-patient use equipment with the patient's first and last names, to prevent inadvertent reuse on another patient(s).
- For multi-patient use equipment, decontaminate thoroughly in line with the manufacturer's instructions, prior to reuse for another patient.
- Limit the amount of equipment left in the single room/affected bays to essential items only, to reduce the potential for cross-contamination.

5.6.2f **Management of Linen**

- Treat all used linen from the affected patient(s) as being infectious.
- Take used linen skip/bag to the patient's single room/bedspace. Do not walk with used linen from one area to another; this increases the risk of cross-contamination
- Place used linen into a red soluble bag and then into an outer white/clear transport bag.
- Do not overfill bags, tie securely when ¾ full.

5.6.2g **Management of Waste**

- Treat all waste from the affected patient(s) as being infectious. Discard as clinical waste, into orange waste bags.
- Do not overfill bags, tie bags securely when ¾ full and tag to identify place of origin.

5.6.2h **Routine environmental cleaning**

- Routinely clean the patient's single room or bedspace (if isolated in a multi-bed bay) using a chlorine-based disinfectant or other disinfectant approved by the IPC Team, focusing on cleaning all horizontal surfaces, at least daily and ideally twice daily.

5.6.2i **Terminal cleaning**

- Terminally clean the single room/bedspace using a chlorine-based disinfectant or other suitable alternative approved by the IPC Team and change bedside curtains.
- Housekeeping staff are responsible for carrying out terminal cleaning of environmental surfaces and changing bedside curtains.
- Nursing staff are responsible for terminally cleaning the patient's bed mattress and any multi-patient use equipment, using Chlorox wipes (for multi-patient use equipment check equipment manufacturer's instructions to ensure compatibility).

5.6.2j **Patient visits to other departments**

- Where possible undertake investigations/procedures in the patient's single room
- Where this is not possible, ideally delay investigations/procedures in other departments until the patient has stopped having diarrhoea/vomiting or infection has been ruled out.
- Where this is not possible and the patient clinically needs to have an investigation/procedure urgently in another department, e.g. radiology, inform the receiving department about the patient's symptoms in advance so the patient can be scheduled at the end of the list (where possible), to allow adequate time for environmental cleaning to take place after the patient has vacated the room.
- Decontaminate all surfaces the patient has had direct or indirect contact with, e.g. procedure couch/table, using Chlorox wipes (check equipment manufacturer's instructions for compatibility).

5.6.2k **Care of the deceased patient**

- In the event of death, use the same infection control precautions as used when the patient was alive.
- A body bag is not routinely needed, however, if there is uncontrolled leakage of body fluids, then a body bag should be used.

5.6.2l **Staff issues**

- In the event of partial ward / bay closure, nursing staff should be segregated so there are separate staff caring for affected and non-affected patients.
- Staff with diarrhoea and/or vomiting should remain away from work until symptom free for 48 hours, from the last symptoms experienced.
- Staff working in food preparation areas should seek advice from their GP / Occupational Health prior to returning to work.
- Staff must not eat / drink in patient areas, e.g. inside patient bays or single rooms. Staff drink bottles should be stored in a designated central location where it is safe for staff to drink, i.e. central desk area, with bottles stored in a clearly marked plastic container and shouldn't be stored anywhere else (including on workstations on wheels).
- Staff should follow the precautions detailed in this policy to reduce the risk of spread, protect themselves, patients and visitors (this equally applies to disabled staff who may be caring for the patient). For specific concerns, staff should raise these with their line manager, and Occupational Health as necessary for individual risk assessment.

5.6.2m **Possible/confirmed outbreak management**

- An outbreak is defined as two or more cases related in time and place (where symptoms of diarrhoea and/or vomiting are not due to other known causes).
- The IPC Team will assess the situation to help determine whether an outbreak is occurring and will advise the Trust, including the Site Management Team and ward staff, whether it is necessary to close beds / bays / the whole ward to new admissions
- The afore mentioned IPC precautions must be implemented rigorously.
- As a general rule, if the affected patients are confined to one bay, then only that bay will need to be closed to new admissions. However, if two or more bays are affected, then the whole ward will need to be closed (although in some situations it may be

possible to close just the affected two bays depending on the layout of the ward concerned), see summary options below.

- Medically fit patients may be discharged to their own home, but should NOT be transferred to other wards, care homes or other hospitals.
- Where transfer is clinically essential, e.g. to a speciality area, adequate communication must take place in advance of the transfer taking place.
- Ward staff should maintain an accurate record of current and new cases, using the data collection form (appendix 3) and provide for the IPC Team each day during the duration of the outbreak.

Summary Options for Norovirus Management

	Single case	Two or more cases in one bay only	Two or more cases in more than one bay
Favoured option	Isolate in single room on original ward	Isolate all patients (affected and exposed) in single rooms on original ward. Clean & reopen bay	Close whole ward (Depending on the ward layout, it may be possible to close the bays, whilst keeping the remainder of the ward open. This must be discussed and approved by the IPC Team)
	Isolate in single room on another ward	Isolate affected patients in single rooms on original ward. Leave exposed patients in original bay, close bay to new admissions / transfers	
	Isolate in original bay on original ward	Keep affected and exposed patients in original bay and close bay to new admissions / transfers	
Least favoured option	Isolate in another bay on original ward		

Section 2: Infective Causes of Gastroenteritis

Causative organism	Incubation period	Typical symptoms	Duration of illness (approx.)	Transmission	Comments
Bacillus cereus	1-6 hours 8-16 hours	Vomiting Diarrhoea / abdominal pain	24-36 hours	-Consumption of contaminated food	Found in the environment. Spores not always destroyed by cooking. Frequently found in rice dishes. No risk of person-to-person spread.
Campylobacteriosis / Campylobacter	2-5 days	Diarrhoea (sometimes bloody), abdominal pain, fever	2-7 days	-Consumption of contaminated food -Direct contact with infected animals, e.g. farm animals -Person-to-person spread is possible (low risk)	Undercooked poultry and meat, un-pasteurized milk, contact with domestic/farm animals.
Cholera / Vibrio cholerae 01 & 0139	2 hours-5 days	Profuse watery diarrhoea	Up to 7 days	-Consumption of contaminated water and food, particularly shellfish	A large infectious dose is required so secondary transmission is not likely in countries with good sanitation, e.g. UK.
Clostridium perfringens	6-24 hours	Vomiting, abdominal cramps, diarrhoea	24 hours	-Consumption of contaminated food	Present in soil, human/animal excreta, raw meat and poultry. Spores can survive cooking – need to ensure correct temperature control of cooked foods. No risk of person-to-person spread.
Cryptosporidiosis / Cryptosporidium	3-12 days	Profuse watery diarrhoea, abdominal cramps, vomiting, mild fever	Up to a month	-Ingestion of oocysts in contaminated water -Contact with infected animals -Person-to-person spread	Mainly affects children.

Causative organism	Incubation period	Typical symptoms	Duration of illness (approx.)	Transmission	Comments
Escherichia coli	1 hour to 7 days	Diarrhoea (all types) often watery, abdominal pain, nausea, vomiting	Variable	-Person-to-person (some types) -Consumption of contaminated food or water	Found in the gastrointestinal tract of humans and animals.
Giardiasis / Giardia duodenalis	1-28 days	Diarrhoea, abdominal pain, malaise, flatulence, nausea	Variable – relapse can occur	-Person-to-person (particularly within families / households) -Waterborne, including swimming, -Direct contact with infected animals, -Foodborne transmission, -Sexual transmission	Cases may be associated with recent foreign travel. Family clusters are common. Can be infectiousness up to 2 weeks after symptoms have stopped.
Hepatitis A	15-50 days	Extremely variable, severity increases with increasing age. Malaise, fever, jaundice	Less than 1 month	-Faecal oral transmission -Sexual transmission -Transmission within households is common	No longer endemic in the UK. Can be acquired abroad and cases or contaminated food imported into the country.
Listeriosis / *Listeria monocytogenes*	1-70 days	Asymptomatic infection, diarrhoea with fever, mild flu-like symptoms, muscle aches, headache	Variable	-Consumption of contaminated food -Mother to baby transmission -Direct contact with infected animals	Pregnant women and those who are immunocompromised are more susceptible to infection

Causative organism	Incubation period	Typical symptoms	Duration of illness (approx.)	Transmission	Comments
Norovirus (formerly known as Norwalk like viruses and small round structured viruses)	6-84 hours	Sudden onset nausea, projectile vomiting, watery diarrhoea	2 days or less in healthy people, may be longer in older people	-Person-to-person -Inhalation of aerosols following an episode of projectile vomiting -Contact with contaminated environmental surfaces -Ingestion of contaminated food (oysters) or water	Outbreaks occur in semi-enclosed environments, such as schools, hospitals and care homes.
Rotavirus (serogroups A, B and C are the most common)	1-4 days	Watery diarrhoea, vomiting, fever, abdominal pain, dehydration	Up to 2 weeks	-Person-to-person -Contact with contaminated environmental surfaces	Main cause of gastroenteritis in children in developed countries. Outbreaks are common in nurseries.
Salmonellosis excluding Salmonella typhi / paratyphi	4-120 hours	Watery / bloody diarrhoea, abdominal pain, headache, nausea, vomiting, fever	4-7 days	-Consumption of contaminated food -Person-to-person	Many reptiles, including those kept as pets, carry salmonella in their guts without exhibiting symptoms but may transmit infection to humans.
Shigellosis / *Shigella* species	Up to 1 week	Diarrhoea, abdominal pain, fever	Up to 14 days	-Person-to-person -Contact with contaminated environmental surfaces	Transmission between men who have sex with men is an important transmission route.

For full details, including for causative organisms not included in this table, refer to Recommendations for the Public Health Management of Gastrointestinal Infections 2019 (Public Health England and Chartered Institute of Environmental Health, 2020).

6. Training

- Training about infection prevention and control (IPC) precautions for patients with diarrhoea is included in induction and update IPC training, delivered by the IPC Team. Training compliance is monitored by the Learning and Development Department. Reasonable adjustments will be made for staff attending training, as required.

7. Stakeholder Engagement and Communication

- This policy has been circulated to all relevant stakeholders via the Control of Infection Committee (COIC), which includes representation from all directorates and other relevant departments, such as Housekeeping and Estates. The COIC members have been asked to comment on the Policy, so relevant feedback can be incorporated into the policy standards.

8. Approval and Ratification

- This policy has been approved / ratified by the Control of Infection Committee.

9. Dissemination and Implementation

- The policy is available to all staff on the Trust intranet and disseminated for implementation via ward managers / matrons.

10. Review and Revision Arrangements

- The policy will be reviewed every 3 years, or sooner, if new national guidance is issued / becomes available.

11. Monitoring compliance with this Policy

Measurable Policy Objective	Monitoring/ Audit method	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/ committees, inc responsibility for reviewing action plans
Assess / check adherence to isolation precautions for patients with potentially infectious diarrhoea / confirmed infectious diarrhoea	Hand hygiene audits	Monthly	Clinical areas	COIC, QoCC
	Ward IPC audits	Monthly	Clinical areas	COIC, QoCC
		Annual	IPC Team	COIC, QoCC
	IPC ward rounds	Daily / ongoing	IPC Team	Feedback given to relevant ward managers where there are concerns and escalated to relevant matron / divisional chief nurse as appropriate

12. Supporting References / Evidence Base

NHS England / NHS Improvement (2025) National infection prevention and control manual for England. Accessed: NHS England » National infection prevention and control manual (NIPCM) for England

Public Health England and Chartered Institute for Environmental Health (2020) Recommendations for the Public Health Management of Gastrointestinal Infections 2019.

Uk Health Security Agency (2026) Clostridioides difficile infection How to deal with the problem, interim update. Accessed: Clostridium difficile infection: how to deal with the problem: interim update April 2026

APPENDIX 1

Equality Impact Assessment

1. What is the project, who is leading on it and what is its purpose?

Review and update of the Policy for Diarrhoea, Vomiting, Gastroenteritis and Foodborne Infections, i.e. this policy. Led by Shila Patel (IPC Nurse Consultant)

2. Who will be impacted by this?

Patients, staff and visitors.

3. Checklist

Questions	Yes	No
Is there any indication or evidence (including from consultation with relevant groups) that different groups with regards to protected characteristics have different needs, experiences, issues and priorities in relation to the proposed policy or proposal?	☐	x ☐
Is there potential for or evidence that the proposed policy or proposal will affect different geographical population groups differently (including possibly discriminating against certain groups)?	☐	x ☐
Have there been or are there likely to be any public concerns (including media, academic, voluntary or sector specific interest) about the policy or proposal?	☐	x ☐
Could the proposal affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	x ☐
Could the proposal affect our workforce or employment practices?	☐	x ☐
Is there potential for or evidence that the proposed policy or proposal will not promote equality of opportunity or promote good relations between different groups?	☐	x ☐
Please explain responses above		
The infection prevention and control standards detailed within this policy follows national standards when caring for patients with suspected or confirmed infectious diarrhoea / Norovirus, to help minimise the risk of cross-infection from one patient to another. The standards as detailed, apply universally to all patients, staff and visitors and does not discriminate against any one group of people, based on any characteristics.		

4. Equality Impact Assessment

Table 1.
Please complete this table for changes / new policies / services affecting workforce as well as those affecting patients. Please only consider negative impacts to these groups.

Protected characteristic	Describe here the considerations and concerns in relation to the programme/policy for each group.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
Age	None	
Disability	In line with Trust obligations under the Equality Act 2010 and occupational health principles, any member of staff with a disability or underlying health condition who has concerns regarding their ability to undertake specific clinical duties should discuss these with their line manager. Where appropriate, an individual risk assessment should be undertaken in conjunction with Occupational Health to determine whether any reasonable adjustments are required.	Standard Infection Prevention and Control Precautions and the appropriate Transmission-Based Precautions, including the use of the recommended personal protective equipment and strict hand hygiene with soap and water following patient contact, are designed to minimise the risk of transmission to both patients and staff. Individual concerns relating to health conditions or disability should be managed through an occupational health-led risk assessment and consideration of reasonable adjustments on a case-by-case basis.
Gender reassignment	None	
Marriage and civil partnership	None	
Pregnancy and maternity	None	
Race	It is recognised there are cultural differences in expressions of pain, and where overt signs of pain are not apparent this does not mean a patient is not experiencing pain.	To help overcome any cultural differences in expressions of pain, patients must be explicitly asked about their pain levels, working in collaboration with patient families as appropriate.
Religion or belief	None	
Sex	None	
Sexual orientation	None	
Carers*	None	

*This is not a protected characteristic as defined in the Equality Act 2010 but must be considered for the purpose of the EIA.

In addition to Table 1, please complete this table for changes / new policies / services affecting patients. There is no need to complete this table if your change / new policy / service affects only workforce. Please only consider negative impacts to these groups.

Other groups / existing inequity	Describe here the considerations and concerns in relation to the programme/policy for each group.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
Armed forces	None	
Digital exclusion	None	
Victims of domestic abuse	None	
Low levels of literacy	None	
Homeless	None	
Looked after children	None	
Rural/urban geographies	None	
Socioeconomic disadvantage	None	
People with addiction or substance misuse problems	None	
People on probation	None	
Prison population	None	
Undocumented migrants, refugees, asylum seekers	None	
Sex workers	None	
Other	None	

5. Submission

Please submit to the EIA Panel for review: asp-tr.ediasph@nhs.net

6. Decision

When was this EIA discussed?	30.07.2026		
By whom?	Ishbel Davis		
Was it approved?	Yes		
Notes:	All concerns either addressed or explained why an edit isn't needed.		
Signed:	I.Davis	Date:	30.07.2026
Position:	EDI Officer		

APPENDIX 2: CHECKLIST FOR THE REVIEW AND APPROVAL OF DOCUMENTS

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Diarrhoea, Vomiting, Gastroenteritis and Foodborne Infections Infection Prevention and Control Policy

Policy (document) Author: Shila Patel, Nurse Consultant Infection Prevention and Control

Executive Director: Mark Roland, Director of Infection Prevention and Control / Chief Medical Officer

		Yes/No/ Unsure/ NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	Yes	
	Is the purpose of the document clear?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	Yes	
	Who was engaged in a review of the document (list committees/ individuals)?	Yes	Control of Infection Committee members
	Has the policy template been followed (i.e. is the format correct)?	Yes	
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?	Yes	Control of Infection Committee
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?	N/A	
6.	**Dissemination and Implementation**		

		Yes/No/ Unsure/ NA	Comments
	Is there an outline/plan to identify how this will be done?	Yes	Via the Control of Infection Committee, to be made available on TrustNet, all staff messaging to go out to inform staff about the updated policy
	Does the plan include the necessary training/support to ensure compliance?	Yes	Via Trust induction and Mandatory IPC update training
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	Yes	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	The IPC Team
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Yes	

Committee Approval (insert name of Committee)			
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner			
Name of Chair	Mark Roland, Director of Infection Prevention and Control / Chief Medical Officer	**Date**	10/06/2026
Ratification by Management Executive (if appropriate)			
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: n/a			

Appendix 3: Data Collection Form

Patient name & Hospital number	Symptoms at onset	Date of onset	Location on ward	Daily record of symptoms							Specimen collected & results	Comments e.g. laxatives, antibiotics, etc
				Date:	Date:	Date:	Date:	Date:	Date:	Date:		