DIARRHOEAL INFECTIONS (including NOROVIRUS) POLICY

Document Author	Authorised
Written By: Infection Prevention and Control Team **Date:** October 2018	**Authorised By:** Chief Executive **Date:**12th December 2018
Lead Director: Director of Nursing	
Effective Date: 12th December 2018	**Review Date:** 11th December 2021
Approval at: Policy Management Sub-Committee	**Date Approved:** 12th December 2018

DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
Sep 12	1.2		DIPC	Revision	For ICC Approval
6 Jan 13	1.3		Executive of Nursing & Workforce	Revision	Endorsed at Policy Management Group
Jun 13	1.4		Executive of Nursing & Workforce	Revision	Approved at Trust Executive Committee
2 Sept 13	1.5		Executive of Nursing & Workforce	Revision	Approved at Trust Executive Committee
Sep 15	1.6		Executive Director of Nursing	Revision	IPCC
4 Dec 15	1.6		Executive Director of Nursing	For ratification	Clincal Standards Group
15 Dec 15	2	15 Dec 15	Executive Directorof Nursing	For Approval	Policy Management Group
August 17	2.1		Executive Director of Nursing & Quality	Sentence added to policy	
25 Aug 17	2.1		Executive Director of Nursing & Quality	Amendment ratified	Clinical Standards Group
12 Sep 17	3		Executive Director of Nursing & Quality	Amendment approved	Corporate Governance & Risk Sub-committee
Oct 18	3.1		Director of Nursing	Revision	
5 Nov 18	3.1		Director of Nursing	Agreed at	IPCC
30 Nov 18	3.1		Director of Nursing	Endorsed at	Clinical Standards Group
12 Dec 18	4	12 Dec 18	Director of Nursing	Approved at	Policy Management Sub-Committee

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents **Page**

1 Executive Summary

This document provides best practice and guidance on management of adult patients with potentially infectious diarrhoea.
Applicable to all staff in all Trust healthcare settings, the document advises on;

- Assessment of patients with diarrhoea
- Infection Prevention & Control measures for management of patients with diarrhoea
- Isolation care

It should be read in conjunction with the Clostridium difficile Policy and Norovirus (Viral Gastroenteritis) guidance document on the IPC intranet.

2 Introduction

Diarrhoeal illness is common and, where due to infection, can be transmitted from person to person through the faecal-oral route by direct contact or from contact with contaminated environment or equipment. Testing for *Clostridium difficile* carriage is also important in all patients with diarrhoea in the healthcare setting to minimise spread.
The aim of this policy is to support the early recognition of symptoms, take prompt action if a patient develops diarrhoea and instigate measures to prevent secondary spread of transmissible infection.
The policy provides guidance on isolation criteria, infection control measures and on cleaning and disinfection.

3 Definitions

D&V – Diarrhoea and vomiting
CDI – Clostridium difficile infection
IPCT – Infection Prevention and Control Team
PPE – Personal Protective Equipment

4 Scope

This policy applies to all healthcare staff working in the Trust. Healthcare staff working in community and outpatient healthcare facilities should use the policy where applicable.
It applies to the care of all adult patients with potentially infectious diarrhoea and/or vomiting and is primarily intended for management of adult patients with diarrhoeal illness in inpatient care settings.

5 Purpose

Define the practices that should be adhered to in order to minimise transmission of infectious diarrhoeal illnesses in the Trust.

6 Roles and Responsibilities

6.1 The Director of Nursing / Director of Infection Prevention and Control

Has overall responsibility for the development and organisation wide implementation of this policy**.**

6.2 Infection Prevention &Control Team (IPCT)

The IPCT are responsible for:

- Ensuring this Policy is up to date
- Ensuring that assessment of patients with diarrhoea is supported in the workplace with expert advice and guidance.
- Maintaining communication links (both formal and informal) with the Bed Managers/Site Co-ordinators; being available to discuss and advise on issues relevant to admission, transfer and discharge of patients with, or following diarrhoeal infection, where necessary.
- Management of Outbreak Control Groups where indicated.

6.3 All Clinical staff

It is the responsibility of all healthcare workers to comply with Trust infection prevention and control policies.

All staff are responsible for assessing the patient and implementing isolation care precautions when patients in their area of responsibility are affected with gastrointestinal symptoms. They are also responsible for informing the infection prevention and control team (IPCT) when viral gastroenteritis (norovirus) is suspected, requesting IPCT support with risk assessment, patient placement and isolation care issues as needed and acting on IPC advice given.

6.4 Clinical leaders, Modern Matrons and Ward Sisters/Charge Nurses:

Are responsible for implementing, monitoring and overseeing policy implementation and compliance in their clinical area of responsibility.
They also need to regularly audit compliance with this policy (in line with IPCT and IPC committee guidance) and are responsible for ensuring that action is taken to increase compliance and improve practice standards where necessary.

6.5 The Cleanliness Team

The cleanliness team are responsible for:

- Responding to requests from ward and departmental staff for increased cleaning and/or isolation room cleaning in line with the Clean Patient Environment policy.
- Responding in a timely way to requests from the IPCT or Outbreak Control Group for deep cleaning of areas following incidences or outbreaks of diarrhoeal infection.

6.6 Bed Management/Site Co-ordination Team

The Bed Management team are responsible for:

- Ensuring patients identified with diarrhoeal infection risk or as requiring isolation are appropriately placed, in line with this and other IPC policies, IPCT and Outbreak Control Group advice.
- Liaising with the IPCT as required and seeking their advice (during office hours contact Infection Prevention & Control Nurses (IPCNs) on Ext. 4882; out of hours contact on-call Consultant Microbiologist via switchboard) when necessary e.g to prioritise patients when insufficient side rooms available.

7 Policy detail/Course of Action

(Further details on enteric pathogens that could cause diarrhoea and their infectivity risk are given in the table at Appendix A, page 12 of this document).

7.1 The Patient with Diarrhoea +/- vomiting

Diarrhoea is defined as one or more episodes of loose stool of a consistency that takes the shape of the container. See BRISTOL STOOL CHART (Appendix B, page 13 of this document) types 5 – 7.
Children frequently present with loose stools for a variety of reasons, not all of which represent infection. Whilst this policy can be used to support good practice in Children's units and indicates general principles for management of infectious diarrhoea, use of specific paediatric protocols such as the NICE guidelines for diarrhoea and vomiting in children will apply.

7.2 Assessment

Any patient in hospital or other healthcare institution who presents with or develops diarrhoea must be promptly assessed using the following questions:

- Is the diarrhoea explained by treatment, medication or underlying disease? (if so, a stool specimen must still be tested to rule out C.difficile carriage).
- Does the patient have risk factors for C.difficile? e.g recent antibiotics, previous C.difficile infection (see C.difficile policy)
- Is it of sudden or unexpected onset?
- Is there any associated vomiting or clinical features to suggest norovirus infection? Ask if the patient has vomited and/or feels very unwell, as if they have a stomach "bug" or if any of their contacts have similar symptoms – this could indicate possible norovirus. If so, follow norovirus guidance on IPC intranet site. Intranet > Home > Corporate > Infection Prevention & Control > Norovirus

If the assessment rules out other clinical reasons for symptoms and indicates the possibility of an infectious cause, start appropriate infection control measures without delay.

- The bowel chart should be completed accurately for all adult patients (see Adult Risk Assessment booklet, available from Print Room)

- Arrange for a stool sample to be sent to laboratory without delay (see Appendix C). Label the Bristol stool type of the sample (i.e type 5,6, or 7)
- Inform the clinical team responsible for the patient.
- Inform IPCT (Consultant Microbiologist if out of hours – via switchboard) if Norovirus suspected or multiple patients affected (i.e potential outbreak)

7.3 Infection Prevention & Control measures

See "Algorithm for initial management of patients with diarrhoeal symptoms" (Appendix D). This can also be found in the pocket guide produced by the IPCT. The Isolation Policy also contains further guidance.

- Isolate the patient pending results of stool tests for infection and take SOURCE ISOLATION PRECAUTIONS (including gloves, aprons/gowns) in all cases (see Isolation Policy for further explanation).
- If a patient in a bay has vomiting suspected due to viral gastroenteritis, inform the IPCT (Consultant Microbiologist if out of hours) and close the bay (high risk of transmission to other patients in bay from vomiting).
- **All** hospital inpatients with potentially infectious diarrhoea should be isolated immediately **or at the very latest within 2 hours of diarrhoeal symptoms becoming apparent. Escalate to bed manager if no side room available on ward.** This also applies if diarrhoeal symptoms develop overnight. This is crucial to minimise any risk of cross-transmission. In the event that a patient with potentially infectious diarrhoea cannot be isolated appropriately within 2 hours, an incident form must be submitted by the nurse in charge of the ward at the time.
- If a single room cannot be immediately identified at ward level, contact the site co-ordinator in the first instance for assistance. The Infection Prevention & Control Nurses (IPCNs) or on call Medical Microbiologist (out of hours) should be contacted by the site co-ordinator to undertake risk assessments if a side room cannot be identified. In the event that a side room cannot be identified after these measures, an incident form must be submitted as above. If viral gastroenteritis is clinically suspected, the bay should be closed and isolation precautions implemented in the bay pending IPCT review.
- Wherever possible the isolation room should have en-suite toilet facilities; if this is not possible, the patient must be provided with their own commode that remains in the room with them at all times and is cleaned after every use within the room.
- Minimise transfer from one ward to another (e.g. from MAAU to a Medical Ward), particularly where infective diagnosis suspected. (See also Admission, Transfer and Discharge Policy).

7.4 Hand Hygiene

Effective hand washing is essential in preventing spread of infection.

- Hands must be washed before and after direct patient contact and after contact with patient surroundings, in accordance with the WHO 5 moments (see Hand Hygiene policy).
- Healthcare staff: wash hands with soap and water when providing care of patient with diarrhoea and/or vomiting see Hand Hygiene Policy. Hand gel is not as effective on Norovirus or *C.difficile* spores.

- The affected person should be advised and helped to clean their hands after using WC or commode and before eating. Advice should be given about importance of effective personal hand hygiene. This is particularly important for frail elderly who may need support.
- Visitors should be advised about the importance of effective hand hygiene.

7.5 Personal Protective Equipment (PPE)

All staff and visitors entering the isolation room must wear disposable gloves and a yellow disposable apron or long sleeved gown (as per specific requirements in norovirus guidance and C. difficile Policy) for contact with the patient and the patient's environment. Visitors should be shown how to correctly use required PPE. For relatives spending long periods of time with seriously ill patients, please contact the IPCNs for advice.

- Before leaving the isolation room, the disposable gloves and apron must be removed and hands washed thoroughly with soap and water.
- Masks are not necessary for management of diarrhoea or vomiting unless there is a risk of particles of body fluid being splashed into the eyes, nose or mouth when a surgical mask and eye protection should be worn.

7.6 Cleaning and Decontamination; Patient care equipment

Ensure equipment used in clinical care (monitors, drip stands, pumps, manual handling aids etc) is allocated for individual patient use only.

- After use, patient care equipment must be cleaned as appropriate (see Clean Patient Environment policy) and before use by any other patient.
- Clean lavatories and commodes thoroughly after each use with detergent and water followed by disinfection with hypochlorite solution (Actichlor) or chlorine wipes. Invert commode seat and check that cleaning is complete.
- Ensure the bed frame, bedrails, locker, tabletop and other bed space equipment is decontaminated daily using actichlor plus and whenever soiled

7.7 Room Cleaning

At least daily – as per Clean Patient Environment and Isolation policies

- Clean isolated areas on ward after non-isolated areas
- When the room is vacated, a full terminal AMBER (barrier) clean or specialist RED clean (as appropriate) must be undertaken as per Clean Patient Environment Policy or IPCT advice (may involve use of Hydrogen Peroxide Vaporisation).

7.8 Duration of Isolation Care Precautions

Where infective cause is identified or suspected, isolate until symptoms have fully resolved and formed stools have been observed for 48 hrs or as advised by IPCT. Clostridium *difficile* positive patients will need continued isolation and should not be moved out of isolation except on specific IPCT advice.

If symptoms are ongoing but no enteric pathogen has been identified (or suspected), a clinical risk assessment should be undertaken to determine cause of diarrhoea. If there are no identified risk factors for Clostridium *difficile* infection and there is a clear documented clinical rationale for the ongoing diarrhoea, isolation precautions may be stopped.

7.9 NOROVIRUS (Viral Gastroenteritis)

Norovirus is the most common cause of outbreaks of gastroenteritis; it is very easily spread and can cause outbreaks affecting hospitals and other settings such as schools, nursing homes and hotels.

Sudden onset vomiting is the predominant symptom in Norovirus infection. This may be accompanied by diarrhoea; other symptoms include nausea, abdominal cramps, chills and fever. Symptoms last between 1 and 3 days and recovery is usually rapid once symptoms cease. **Norovirus can still be present in the stools for at least 48 hours after symptoms cease.**

All age groups can be affected by the illness, which has potential to spread rapidly within groups.

- **Transmission**
  Norovirus is spread from person to person by the faecal oral route and by ingestion of aerosol particles caused by vomiting. Widespread environmental contamination can occur which contributes to indirect spread and secondary transmission may occur readily.

- **Prevention of spread**
  As soon as Norovirus infection is suspected, prompt measures must be put in place to prevent spread and minimise environmental contamination.
  This is achieved by strict hand hygiene, and prompt attention to environmental cleaning. Containment is essential to break the cycle of transmission and infection. In hospital, this often means restriction of patient and staff movement and closing bays or wards in areas affected – see 'Outbreak Policy' and norovirus guidance on IPC intranet. In primary care, this may mean restriction of movement and closing affected institutions to new incomers.

- **Norovirus – additional precautions in hospital practice**
  If norovirus is suspected, prompt action must be taken:
  - Inform the IPCT (Consultant Microbiologist out of hours) and instigate infection control measures without delay. If there are more than 2 patients affected, this could be an outbreak.
  - Affected patients and other patients who have been in contact with those affected, must not be moved within the ward, transferred to other areas or discharged to care homes or own home with carers without agreement of the IPCT (the exception to this rule is if patients require critical care, when patient safety takes priority).
  - If an outbreak is suspected, ward staff must instigate precautionary cohort nursing and inform the IPCT immediately for investigation and further

guidance on management. If there is an outbreak (see Outbreak Policy), ward staff must complete an ongoing symptom record as per norovirus guidance on IPC intranet..

- In the event of a norovirus outbreak, the Outbreak policy must be implemented immediately including incident reporting via the Datix system and other required reporting (for example to the local Public Health team) as agreed by the Outbreak Control Group.

7.10 Healthcare staff with diarrhoea and/or vomiting

Healthcare staff should not work if they have potentially infectious diarrhoea and vomiting (D&V). Where symptoms may be due to norovirus infection, staff should not work until symptom free for 48hrs.

- If diarrhoea or vomiting occurs, the healthcare worker should report sick in the normal way.
- The affected staff member should inform their line manager who will ensure 'D&V' is selected as sickness reason on the MAPS system to enable accurate monitoring.
- A stool sample may be required e.g where uncertainty regarding causative organism; Consultant Microbiologist and/or Occupational Health to advise.
- In the event of an outbreak affecting a ward or bay, ward staff should follow advice from IPCT and/or Occupational Health.

8 Consultation

This document has been sent to the following stakeholders for consultation:

- Infection Prevention & Control Committee (IPCC)
- Ward Sisters
- Bed Management
- Occupational Health
- Gastroenterologists
- Microbiology Laboratory Technical Head

9 Training

This Diarrhoeal infections (including Norovirus) Policy has a mandatory training requirement which is detailed in the Trusts mandatory training matrix and is reviewed on a yearly basis

10 Monitoring Compliance and Effectiveness

Infection Prevention and Control Nurses and/or Modern Matrons will monitor the implementation of this policy during any outbreak or period of increased incidence of diarrhoeal infection. Subsequent reports on implementation will be presented at outbreak follow-up meetings where actions will be taken as required. Outbreak summaries will be reviewed at Infection Prevention & Control Committee and where

these are reported as a Serious Incident (SI), reports and action plans will be monitored via the Quality Committee.

Monitoring of adult stool chart will be undertaken by ward staff and overseen by Modern Matrons at local ward level. Stool sampling and isolation after diarrhoea onset will be reviewed at root cause analysis for patients with *C.difficile* infection.

11 Links to other Organisational Documents

Hand Hygiene Policy
Clostridium difficile Policy
Isolation Policy
Outbreak Policy including Bed Closure Policy
Clean Patient Environment Policy
Admission, Transfer and Discharge of the Patient with an Infection Risk Policy
Policy for the Use of Personal Protective Equipment in the direct care of patients
Norovirus pack (on IPC area of intranet site)
Pathology User Handbook

12 References

NICE Clinical Guideline 84 – Diarrhoea and Vomiting in Children. April 2009 National Institute for Clinical Excellence, London

Guidelines for the Management of Norovirus Outbreaks in Acute and Community Health & Social Care settings. March 2012 Norovirus Working Party: an equal partnership of professional organisations

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/322943/Guidance_for_managing_norovirus_outbreaks_in_healthcare_settings.pdf

13 Appendices

Appendix A ENTERIC PATHOGENS AND MODE OF TRANSMISSION
Appendix B BRISTOL STOOL CHART
Appendix C TEST REQUESTS & COLLECTION OF FAECAL SPECIMENS
Appendix D ALGORITHM FOR INITIAL MANAGEMENT OF PATIENTS WITH DIARRHOEAL SYMPTOMS.
Appendix E FINANCIAL AND RESOURCING IMPACT ASSESSMENT ON POLICY IMPLEMENTATION.
Appendix F EQUALITY IMPACT ASSESSMENT (EIA) SCREENING TOOL

Appendix A

ENTERIC PATHOGENS AND MODE OF TRANSMISSION

Enteric Pathogen	Method of diagnosis	Time for result	Mode of Transmission	Risk of person to person spread
Salmonella	Culture	2-3 days	Food borne; secondary person-person spread possible (faecal-oral)	High
Shigella	Culture	2-3 days	As Salmonella (above)	Higher risk than Salmonella
Campylobacter	Culture	2-3 days	Food borne; person to person spread very rare	Negligible
Clostridium Difficile	2-stage test. Contact lab or Consultant microbiologist if urgent testing. (working hours only) Specimens at lab after 16:30 Mon-Fri processed next morning. Morning only service at weekends.	1 hour (working hours only) 24 hours (w'kend& B hol)	Faecal-oral, viable spores contaminate environment	High in hospitals and healthcare facilities
Norovirus	Local test – MUST inform Infection Prevention & Control/Microbiology consultant first. PCR testing on Microbiology consultant referral only	As above. 3-4 days from referral	Faecal-oral, aerosol (droplet/vomit) will contaminate environment	Extremely high

Salmonella, Shigella and Campylobacter

Infections are usually food borne and most commonly seen in primary care, however sometimes symptoms may be severe enough for those affected to be admitted to hospital. If a patient has Salmonella or Shigella in their stools, strict enteric isolation care precautions are necessary to prevent transmission to others.

Clostridium difficile

A particular problem in hospital and healthcare institutions; patients in hospital can acquire gut colonisation with this organism and symptomatic infection can be triggered by exposure to antibiotics. Patients with *C. difficile* colonisation but with diarrhoea due to another cause will also require isolation and Infection Prevention & Control precautions, because they present a risk of spreading *C. difficile*. See *C.difficile* policy for more information.

Norovirus

Highly infectious because virus particles are present in aerosol if an affected person vomits; droplets can then contaminate the immediate environment. It can affect both hospital patients, staff and people in primary care. Very strict measures need to be put in place promptly to prevent further transmission from person to person and to prevent outbreaks. This is particularly important in institutions such as hospitals, schools, hotels and cruise ships for example; outbreaks are common. See also Infection Prevention & Control Outbreak Policy' and Norovirus guidance on IPC Intranet.

Appendix B

Bristol Stool Chart

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 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**

Types 1–2 indicate constipation, with 3 and 4 being the ideal stools (especially the latter), as they are easy to defecate while not containing any excess liquid, and 5, 6 and 7 tending towards diarrhoea.

Appendix C

TEST REQUESTS & COLLECTION OF FAECAL SPECIMENS

Faecal Test Requests

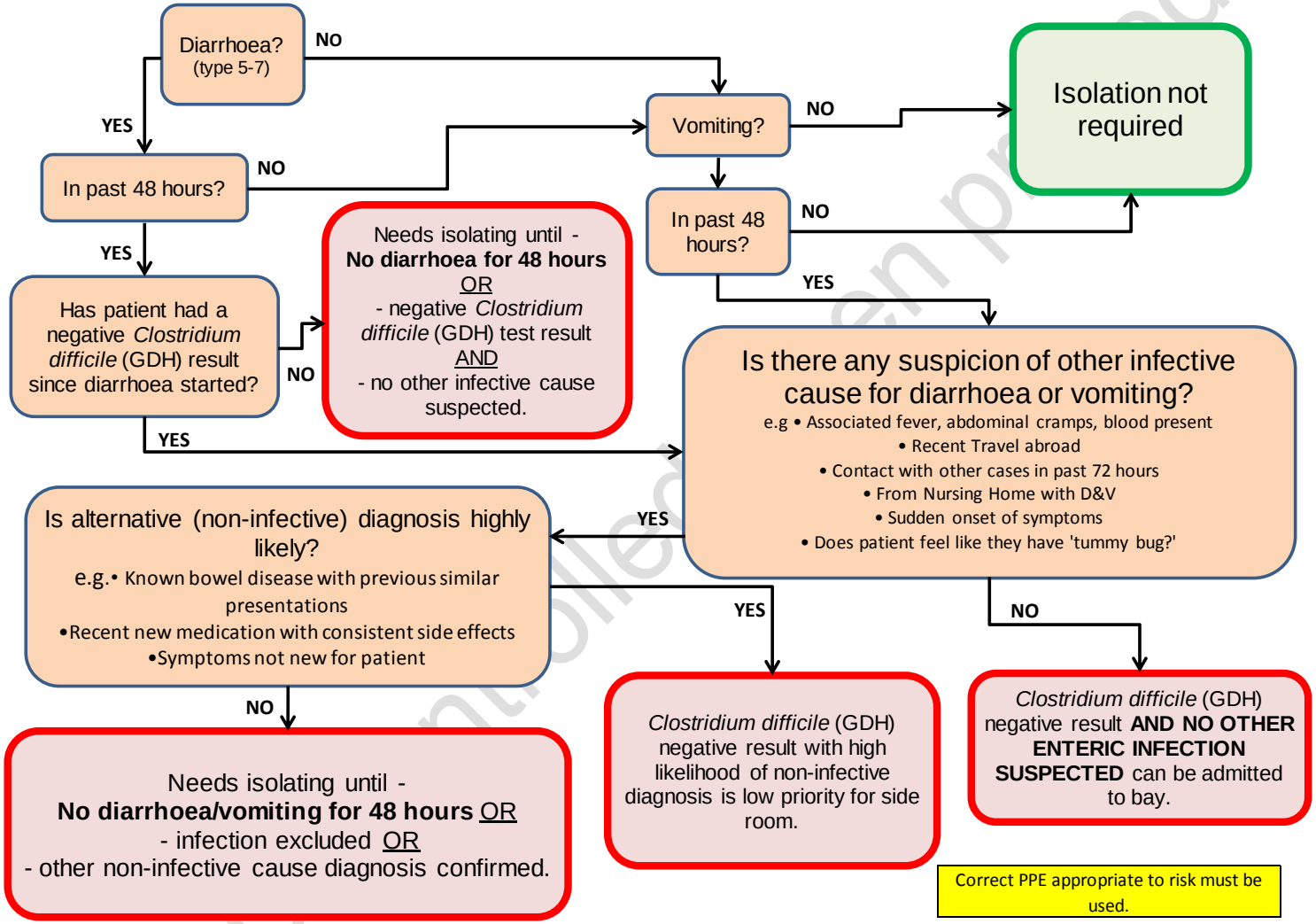
- A faecal specimen for C. difficile testing should be sent at the first opportunity when a patient develops diarrhoea and where an infectious cause is considered possible or C. difficile status unknown.
- Faecal MC&S should also be requested if an infectious cause is suspected (unless already tested recently).
- Request Norovirus test if ward viral gastroenteritis outbreak suspected (ensure IPCT or Consultant Microbiologist aware).
- Previously C. difficile positive (GDH and toxin positive) patients with diarrhoea should have IPC precautions implemented without retesting and should only be retested if there is a clinical suspicion of a new episode of C. difficile infection – (must discuss witht the Consultant Medical Microbiologist for approval and advice, contact as soon as possible).
- Previously C. difficile positive (GDH and toxin positive) patients MUST NOT undergo routine testing to look for C. difficile clearance.
- If a negative C. difficile result has been received, DO NOT routinely send any further samples within a 1 week period unless:
    - there is a clinical suspicion of C. difficile
    - symptoms worsen
    - clinical condition deteriorates
    - Consultant Microbiologist advises
- If a GDH positive toxin negative result has been received and symptoms persist or worsen, discuss with Consultant Microbiologist.

Collecting faecal sample

- Wear appropriate PPE (plastic apron and gloves)
- Obtain a fresh stool specimen from the patient (can send even if contaminated with urine).
- Label a blue topped faecal specimen pot with patient details, date and time of collection and stool type i.e. Bristol Stool Chart type 5,6 or 7)
- Place a portion of stool into the labelled blue topped faecal specimen pot using the spoon supplied in the lid. About 1-2 cm of faeces will be enough.
- If necessary, if the stool is liquid, a large bore syringe may be used to transfer some into the faeces container (CAUTION: care must be taken not to cause splashing when filling the specimen pot – use eye/face protection).
- Fasten the pot SECURELY: check no contamination of the outside of the pot (discard if there is and start again).
- Place the pot in a plastic specimen bag (attached to request form).
- Remove gloves and apron (dispose of as clinical waste) and wash hands.
- **Samples should be sent to the laboratory within 2 hours of collection**.

Contact the Microbiology laboratory with any queries about sample testing. See also Pathology User Handbook (available on Trust intranet).

Algorithm for initial management of patients with diarrhoeal symptoms



Appendix E

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	**DIARRHOEAL INFECTIONS (including NOROVIRUS) POLICY**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs			
Training Staff			
Equipment & Provision of resources			

Summary of Impact: ALREADY IN PLACE AND NO FURTHER RESOURCING IMPACT

Risk Management Issues:

Benefits / Savings to the organisation:

Equality Impact Assessment

- Has this been appropriately carried out? YES/~~NO~~
- Are there any reported equality issues? ~~YES~~/NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs			
Totals:			

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Totals:		

Equipment and Provision of Resources	Recurring £ *	Non-Recurring £ *
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc		
Totals:		

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Appendix F

Equality Impact Assessment (EIA) Screening Tool

Document Title:	**DIARRHOEAL INFECTIONS (including NOROVIRUS) POLICY**
Purpose of document	Define the practices that should be adhered to in order to minimise transmission of infectious diarrhoeal illnesses in the Trust.
Target Audience	This policy applies to all healthcare staff working in the Trust. Healthcare staff working in community and outpatient healthcare facilities should use the policy where applicable. It applies to the care of all adult patients with potentially infectious diarrhoea and/or vomiting and is primarily intended for management of adult patients with diarrhoeal illness in inpatient care settings.
Person or Committee undertaken the Equality Impact Assessment	Karen Robinson. Head of Infection Prevention and Control

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

Revision of existing policy – No potential adverse effect on any group listed. Solely based on clinical risk of transmission to protect <u>all</u> patients, staff and visitors.

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men	no	no	
	Women	no	no	

Race	Asian or Asian British People	no	no	
	Black or Black British People	no	no	
	Chinese people	no	no	
	People of Mixed Race	no	no	
	White people (including Irish people)	no	no	
	People with Physical Disabilities, Learning Disabilities or Mental Health Issues	no	no	
Sexual Orientation	Transgender	no	no	
	Lesbian, Gay men and bisexual	no	no	
Age	Children	no	no	
	Older People (60+)	no	no	
	Younger People (17 to 25 yrs)	no	no	
Faith Group		no	no	
Pregnancy & Maternity		no	no	
Equal Opportunities and/or improved relations		no	no	

Notes:
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)			

Intended		

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?

Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	