UNIQUE IDENTIFIER NO: G-75-2008
EQUIP-2017-037
Review Date: August 2021
Review Lead: Lead Infection Prevention & Control Nurse

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Section E - Outbreak of Infection Policy

Version 8

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

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Committee Name	**Committee Chair**	**Date**
Infection Prevention & Control Committee	Consultant Microbiologist/Infection Prevention & Control Doctor	August 2018
Other Stakeholders Consulted		
All members of Infection Prevention and Control Committee		
Does this document map to other Regulator requirements?		
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Document Version Control	
Version 8	Addition of Covid19 exposure in the hospital
Version 7	The document has been reviewed and updated with amendments, including additional section on management of Influenza. Minor changes to contact telephone numbers and role specifications.
Version 6	The document has been reviewed and updated with minor amendments.
Version 5	The document has been updated and amendments made to the chairing of the OCG meetings.
Version 4	The document has been reviewed and updated with minor amendments to Appendix 2 – Standard for managing an outbreak of gastroenteritis.
Version 3	General update.
Version 2	The document has been redesigned to ensure that all new and revised procedural documents are set out to a Trust wide format and the content of which includes a minimum set of criteria which include: ▪ the training requirements for implementation ▪ monitoring arrangements for the document ▪ Equality Impact of the document In addition, the monitoring arrangements for this document have been included.

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Contents

1. Introduction

This document sets out the Trust's plans for dealing with outbreaks of infectious diseases, where collaboration and co-ordination with the Trust and with other agencies is required in order to ensure speedy and effective remedial action.

1.1 Key Points

- Information for staff on the prevention, management and control of infectious diseases within Calderdale and Huddersfield NHS Foundation Trust.

2. Purpose

A plan for the Control of Outbreaks and Incidents of Infection and Food Poisoning in the Hospitals and Health Care Premises of Calderdale and Huddersfield NHS Foundation Trust.

It is the responsibility of all staff that suspects an outbreak of infection to notify a member of the Infection Prevention and Control Team (IPCT) at the earliest opportunity.

3. Definitions

'Outbreak': maybe an episode where:

- Laboratory surveillance of microbiology reports may show an increase in the number of isolates of a single species.
- Medical or nursing staff notices an increased incidence of a specific organism or similar symptoms, from a clinical area.

'Diarrhoea': maybe defined as:

- 'The passage of three or more loose or liquid stools (or more frequent passage than is normal for the individual)' (WHO, 2009).

a) Major Outbreak of Infection

A major outbreak is difficult to define in terms of numbers of patients and staff involved. Numbers of cases have been suggested, but two, or even one, of a hazardous infection e.g. diphtheria, might be considered to be a major outbreak. The decision should be made by the Infection Prevention and Control Doctor (IPCD), based on factors such as severity and communicability of the infections, the necessity of closing the ward and the need to prevent transfer of patients and staff to other wards.

If there is any doubt that an outbreak may have started, the IPCT must be consulted, BEFORE any other action is taken.

It is recognised that outbreaks of viral gastroenteritis, which can be common especially during the winter months, are usually managed without the need for the Major Outbreak Control Plan to be initiated. This decision is at the discretion of the IPCD.

Further information about the management of such outbreaks is outlined in Appendix 2 and 3.

b) Highly Infectious Diseases

If even a single case of any of the following highly infectious diseases, which may spread from person to person, occurs within a hospital, then the Major Outbreak Control Plan may be initiated.

- Diphtheria
- Poliomyelitis
- Lassa, Ebola or Marburg Fever
- Smallpox
- Middle Eastern Respiratory Syndrome (MERS)
- Avian Influenza
- Covid-19

4. Duties (Roles and Responsibilities)

The Chief Executive has the ultimate responsibility for ensuring that there are effective infection control arrangements in the Trust

4.1 The Infection Prevention and Control Doctor (IPCD) for the Trust has overall responsibility for:

- The management of outbreaks in the Trust. If the IPCD is unavailable, this role will be assumed by the Consultant Microbiologist on-duty or on-call.
- Chair the OCG in the absence of the Director of Infection Prevention and Control/deputy
- Communication with appropriate staff and external agencies
- Advice on ward closures
- Production of reports on major outbreaks
- Review of the outbreak plan in light of lessons learned from outbreaks
- Present the findings to the Infection Control Committee

4.2 The Infection Prevention and Control Nurse (IPCN) has responsibility for:

- Performing baseline observational audit of the affected area at an early stage
- Collection of relevant information on affected patients/staff
- Advice on control measures to be used for affected patients
- Regular communication with appropriate staff and external agencies
- Monitoring of agreed control measures

- Attendance at OCG
- Giving adequate notice and advice about cleaning during an outbreak and when the final terminal clean is required
- Production of final reports on minor outbreaks

4.3 The Director of Infection Prevention and Control (DIPC) has responsibility for:

- Liaison with Chief Executive
- Convening of an Outbreak Control Group (OCG)
- Chair the OCG
- Reporting to the Board any immediate or long-term resource requirements which may arise

4.4 The Executive Director of Nursing has responsibility for:

- Ensuring that effective systems and processes are in place to minimise the risk of infection to patients, staff and visitors

4.5 The Consultant Microbiologist has responsibility for:

- Ensuring that appropriate laboratory support is available and that appropriate investigations are carried out
- Provide advice on the criteria, if applicable, for identifying patients who may be classed as 'contacts' and need further interventions such as immunoglobulin
- Liaise, as required, with the Regional Virologist for further advice

4.6 General Managers have responsibility for:

- Liaison with appropriate staff within directorate to ensure control measures are carried out
- Provision of secretarial support for OCG if IPCT secretary is not available

4.7 Facilities Site Managers have responsibility for:

- Mobilisation of support services e.g. domestic and portering
- Authorisation/co-ordination of 'terminal clean' once outbreak is over

4.8 Clinical Directors have responsibility for:

- Advice on special aspects of medical care
- Informing other consultants associated with ward(s)
- Assessing implications for critical care and liaison with on-call anaesthetist
- Arranging for additional medical staff to be mobilised if necessary
- Arranging for the assessment of patients who are identified as contacts, as required and advised by the IPCT

4.9 Matrons have responsibility for:

- Overseeing implementation of advice given by IPCT and OCG

- Managing staffing levels on wards
- Ensuring adequate supplies of equipment are available
- Ensuring ward staff receives appropriate support
- Facilitating cleaning of the area prior to re-opening

4.10 Occupational Health Physician/Nurse has responsibility for:

- Identifying staff contacts
- Confirming suitability of individual members of staff to work in affected areas
- Liaison with staff member's GP
- Monitoring progress of staff absent due to illness and advise on return to work
- Ensuring that, where appropriate, specimens and results from staff members are received and followed up

4.11 Head of Communications has responsibility for:

- Clarification of the need to supply statements to the press and the content of the statements with Director of Nursing and IPCD

4.12 Consultant for Communicable Disease Control (CCDC) has responsibility for:

- Leading on aspects of the outbreak relevant to the community
- Leading on epidemiological investigations
- Liaison with Environmental Health Department where appropriate
- Communication with relevant external agencies serving the community

4.13 Environmental Health Officer has responsibility for:

- Working under the direction of the OCG and CCDC in the investigation of suspected food borne outbreaks of infection

4.14 Ward Managers have responsibility for:

- Overseeing the implementation of control measures as advised by the OCG
- Supporting staff on ward/department
- Facilitating cleaning of the ward prior to re-opening
- Providing a list of patients, if required, that have been in contact with the infected patient/s, as advised by the infection prevention and control team

4.15 Associate Director / Risk Management has responsibility for:

- Ensuring the incident is reported appropriately internally and externally
- Tabling final report as an agenda item at future Clinical Effectiveness Committee

4.16 Infection Prevention and Control Secretary has responsibility for:

- Arranging the OCG when convened by DIPC

- Taking minutes, maintaining the action log and circulating both appropriately

See Appendix 1 for Directory of Key Personnel.

5. Procedure

5.1 Recognition of Outbreak

An outbreak may be recognised first by medical, nursing, other health care professionals or laboratory staff. In all cases, notification of an actual or suspected outbreak should be made to the IPCT.

5.2 Preliminary Action

- The nurse in charge of the ward will seek evidence of other cases of infection and inform the IPCN if there is suspicion of an outbreak. Outside normal working hours, the nurse in charge of the affected service should contact the on-call IPCN via switchboard. (Outbreak documentation for D&V is available on the IPCT intranet site and should be completed): http://intranet.cht.nhs.uk/clinical-information/infection-prevention-control/viral-gastroenteritis/
- The IPCN will inform the IPCD or on-call microbiologist if appropriate
- Assessments of available information will be made by the IPCN and the IPCD where appropriate (with input from the CCDC when also appropriate). Possible conclusions are:
- **No outbreak**: Advice on management of non-linked cases will be given by the IPCD and/or IPCN. Feedback should be given to the clinical area in question
- **Possible Outbreak**: Insufficient evidence to declare an outbreak but the possibility cannot be excluded. An 'alert' situation where infection prevention and control measures will be implemented at the discretion of the IPCT
- **Suspected Viral Gastroenteritis Outbreak:** The outbreak will be managed using the standard for managing an outbreak of gastroenteritis (Appendix 2). The IPCD will advise on ward closure or other alternatives, if appropriate. The IPCD may still decide to institute the major outbreak plan if there are multiple wards or if there are serious issues with implementing the standard.
- **Suspected COVID-19 outbreak**: See appendix for definition.
  IPCD/on-call microbiologist will arrange an outbreak control meeting along with external partners (PHE and CCG representatives)
  IPCN will iform the Yorkshire Regional Incident Coordination Room Email: ICC.YorkshireHumber@phe.gov.uk/Phone: 01133860300 within 24 hours of the outbreak identification

IPCD/on-call microbiologist will complete an outbreak notification form (appendix 3) and email england.eprrney@nhs.net within 24 hours of the outbreak identification
IPC matron/ Senior IPCN will provide updates to the national ICC via the IIMARCH form (appendix 3) and email to england.eprrney@nhs.net within 24 hours following the outbreak meeting
IPCD/IPC Matron will inform CQC via the Trust CQC communication officer (if required)

- **Major Outbreak**: The IPCD or deputy, after consultation with other appropriate key personnel, including the Consultant for Communicable Diseases (CCDC), will decide whether an outbreak does exist and whether the Major Outbreak Plan should be brought into action. It may be necessary to take emergency action before the Outbreak Control Group (OCG) has been convened. This may include the need to close a ward, department or even the Accident and Emergency department. This decision should be made by the Chief Executive on the advice of the IPCD or the DIPC. It is important that no action be taken by others that would prejudice considerations at this point.

Outbreaks, which originate within the community, may have serious implications for the Trust and vice versa. It is expected that the IPCT will be informed by the Consultant in Public Health (CCDC) Health Protection or the Community Infection Prevention Team. Any expected admissions may need to be diverted from the Accident and Emergency Department to a designated area.

5.3 Immediate Actions:

- If suspicion of a major outbreak is valid, the IPCD will inform the Clinical Director for the affected service(s), outside normal working hours, the On-call Microbiologist will contact the Trust On-call Manager and the Nurse in Charge for the affected ward. The IPCD will inform the DIPC and the CCDC or, outside normal working hours, the On-call Public Health Doctor. The IPCD will inform the Director of Nursing, the Medical Director and Occupational Health
- The IPCN will inform the Ward Manager, the Senior Nurse/Matron for the affected service and the Director and Associate Director of Risk Management
- Appropriate specimens must be submitted to the laboratory as soon as possible after guidance from the IPCD or IPCN
- Affected patients should be isolated and/or segregated from unaffected patients, as appropriate. Advice on this will be given by the IPCN and IPCD
- Where deemed appropriate by the IPCN, staff will be advised not to travel home in workwear/uniform for the duration of the outbreak and Dissolvable polythene bags for patient clothing will be provided to transport clothing home for laundering

- The IPCN will monitor all reports (verbal and laboratory) of infection and will liaise with the IPCD on a continual basis
- Existing guidance within the following policies will be implemented:
  Hand Hygiene
  Contact Precautions
  Isolation

6. Management of a Major Outbreak

6.1 If the incident has been designated a major outbreak, arrangements to convene the OCG as soon as possible will be made. The first meeting should be arranged within 24 hours of declaring a major outbreak. See action cards in Appendix 5**.**

6.2 Outside of normal working hours officers providing cover for the OCG will be invited to the OCG as appropriate.

6.3 Outbreak Control Group Membership

- IPCD (Consultant Microbiologist)
- DIPC
- Exec Lead for Infection Control
- Matron of Infection prevention and control
- Medical Director
- Associate Director of Nursing of unit involved
- Communication Manager
- Director of Estates and Facilities
- PHE representative
- CCG representative

The following may also be present:

- Matron
- Ward/Department Manager.
- Consultant(s) in charge of affected patients and/or Clinical Director of the division involved
- Occupational Health Advisor
- Catering Manager, if outbreak is food poisoning
- Microbiology Laboratory Manager
- Other Trust Managers, depending on nature of outbreak
- Director of Pharmacy

Consideration will be given to inviting the following:

- Director of Public Health
- Regional Epidemiologist
- Regional Director of the Public Health England

- Regional Consultant in Infectious Diseases
- Representative of Water Authority (for water-borne outbreaks)
- Environmental Health Officer (if food poisoning outbreak)
- Veterinary Officer (for zoonoses)

6.4 The OCG has the responsibility for agreeing an action plan on the management of the outbreak and for ensuring implementation of this plan. Each member will be given an 'action card' which will outline his/her duties and responsibilities (see Appendix 5). A reactive press statement will be prepared at the initial meeting and be updated at each subsequent meeting.

6.5 Subsequent meetings will review progress of the outbreak and its management.

6.6 The IPCD will produce interim reports as requested by the Trust.

6.7 The OCG will have the responsibility of declaring when the outbreak is over. This fact must be communicated to all affected wards and involved persons.

6.8 Once an outbreak is over, cleaning of the affected area will be required. This will be requested but not arranged by the IPCN. Responsibility for co-ordination of cleaning sits with the Facilities Site Manager/Matron/Ward Manager.

6.9 Once the outbreak is over the OCG will meet to review the management of the outbreak and recommend any changes to practice necessary.

6.10 The final report on the outbreak will be written by the IPCD with input from other members as appropriate and will be circulated to:

- All members of the OCG,
- Chief Executive of Calderdale and Huddersfield NHS Foundation Trust.
- Regional Epidemiologist.
- Quality Committee (via Infection Control Committee).
- IPCT members.

6.11 Funding: Excess costs associated with outbreaks are funded by the Clinical Division and not the IPCT unless otherwise agreed by the OCG.

7. Management of an Outbreak of Viral Gastroenteritis

7.1 Outbreaks of suspected and confirmed viral gastroenteritis (VGE) will be managed using the standard (Appendix 2).

7.2 The flowchart in Appendix 3 should be followed for closure of wards due to VGE.

7.3 An IPCN will attend bed meeting on the affected site, whenever possible, to ensure good communication is maintained.

7.4 An IPCN will communicate with appropriate staff members on at least a daily basis, most usefully via email.

7.5 During an outbreak of diarrhoea/vomiting, gastroenteritis guidelines must be followed.

7.6 When an outbreak is declared to be over an IPCN will communicate this information to appropriate staff and will produce a final report on the outbreak, highlighting any changes in practice required.

7.7 During periods of bed pressures the decision to admit patients to an outbreak ward should only be made following direct communication between the On Call Director and the IPCT.

8. Management of an Outbreak of Influenza

8.1 Outbreaks of suspected and confirmed Influenza will be managed using the standard operating procedure (Appendix 4).

8.2 An IPCN will attend the bed meeting on the affected site, whenever possible, to ensure good communication is maintained during an outbreak or an increased incidence of influenza.

8.3 An IPCN will communicate with appropriate staff members on at least a daily basis, most usefully via email.

9. Management of hospital contacts of Covid-19

The management of Covid-19 is changing rapidly. **Always refer to the latest management guidelines on the intranet.** Both staff and patients can become an infection risk to others. Clear assessment and management of such situations is essential to prevent onward spread and service disruption.

Information regarding the infectious nature of patients and staff can be identified via admission screening; pre-admission screening; diagnostic sampling and NHS track and trace. Once identified as an infection risk, immediate actions are to be taken.

9.1 **Patient contacts of a patient**: Patients who are identified as a contact of a case of Covid-19 are to be notified of the contact and cohorted together or isolated where cohorting is impracticable for 14 days from the last contact. Their notes are flagged to alert staff to their exposure and prompt daily assessment for symptoms. If a contact is discharged during that 14-day

period, they must be advised to complete their self-isolation at home. A record of patient contacts are held by the IPCT.

9.2 **Staff contacts of a patient:** Staff are only considered contacts of a positive patient where they have failed to wear PPE that protects them from Covid-19 exposure i.e. respiratory protection and eye protection. Any staff members identified as contacts of a positive case must be referred to Occupational Health and may be required to self-isolate for 14 days. A record of staff contacts are held by Occupational Health.

9.3 **Staff contacts of a staff member:** where a staff member is identified as positive for the virus, their management and that of other staff exposed will be managed by Occupational Health. Key to the assessment is the following by all staff of PPE requirements plus social distancing in the area of work and when on breaks. Staff contacts will be assessed by Occupational Health and required to self-isolate for 14 days where assessed as exposed. A record of staff contacts are held by Occupational Health.

9.4 **Patient contacts of a staff member:** where a staff member is identified as positive for the virus, patient contact will be assessed by the IPCT. Patients will only be considered at risk if the staff member has failed to wear PPE that protects others from Covid-19 exposure i.e. fluid resistant surgical mask (FRSM) or FFP3 mask. The risk assessment will consider if the staff member was working with symptoms and also if the staff member was wearing a valved FFP3 mask which may provide less protection against droplets than a FRSM. A record of contacts are held by the IPCT.

10. Dissemination and Implementation

The policy will be available on the Trust intranet for all staff to access.

11. Monitoring Compliance with this Document

This policy will be monitored by the IPCT following each outbreak and prior to a final report being produce. Formal monitoring of the policy will be by the Infection Prevention and Control Committee.

12. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, gender reassignment, race, disability, age, sexual orientation, religion or religious/philosophical belief, marital status or civil partnerships.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

13. Associated Documents

- Section A Control of Infection Arrangements Policy
- Section B Notifiable Disease Policy
- Section C Standard Precautions Policy
- Section H Hand Hygiene Policy
- Section K Isolation Policy
- Covid-19 policy (in development)
- COVID-19: Actions to be taken following an exposure incident at CHFT
- Current Covid-19 SOP for clinical management

14. References/ Further Reading

Department of Health (2015) The Health and Social Care Act 2008: Code of Practice of the prevention and control of infections and related guidance

Hawker J et al (2019) Communicable Disease Control and Health Protection Handbook (4th Edition) Wiley-Blackwell publishing Ltd. Chichester.

Public Health England (2016) Infection control precautions to minimise transmission of Respiratory Tract Infections in healthcare settings. Version 2

Loveday HP et al (2103) epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. Journal of Hospital Infection 86S1 (2014) S1-S70

Public Health England (2020)
https://www.gov.uk/government/collections/wuhan-novel-coronavirus

Public Health England (2020)
https://www.gov.uk/government/collections/middle-east-respiratory-syndrome-coronavirus-mers-cov-clinical-management-and-guidance

APPENDIX 1

Title	Contact Number
Infection Prevention & Control Doctor (IPCD)	HRI 01484 355366/ CRH 01422 222305
Director of Infection Prevention and Control of Infection	HRI 01484 343906
Matron of Infection Prevention & Control	HRI 01484 355258
Infection Prevention & Control Nurses (IPCN)	CRH 01422 222376/2096 HRI 01484 342447/7358
Consultant for Public Health (Health Protection) formerly referred to as the CCDC (Proper Officer) Health Protection Nurses (HPN)	Public Health England Blenheim House West One Duncombe Street Leeds LS1 4PL Tel: 0113 3860300

OUTSIDE NORMAL DUTY HOURS, the home telephone numbers of the key personnel will be held by the switchboard at both Calderdale Royal Hospital and Huddersfield Royal Infirmary.

For the names of the above personnel, please refer to Section A of the Infection Control Policy Manual.

APPENDIX 2

Standard for managing an outbreak of gastroenteritis

Definition of an outbreak of gastroenteritis

An outbreak of two or more patients or staff complaining of one or more of the following symptoms, in any combination: diarrhoea, vomiting, nausea and abdominal cramps. The most likely cause of an outbreak of gastroenteritis is viral, however this is usually confirmed by laboratory testing.

Identification of an outbreak

This is usually a phone call from ward staff to the IPCT but may be identified by the laboratory staff either by the increased numbers of specimens received in the laboratory or two or more positive results from the same area.

Symptoms of gastroenteritis, particularly diarrhoea and vomiting can be associated with other medical conditions and therefore some suspected outbreaks may not be due to an infective cause. All reports of a suspected gastroenteritis outbreak should be approached in the same way.

Useful (*Kaplan) criteria for viral gastroenteritis

These criteria may be useful when assessing whether an 'outbreak' of gastroenteritis symptoms may be the result of viral gastroenteritis:

- Sudden onset of symptoms usually over a period of 15-50 hours.
- Average duration of symptoms 12-60 hours.
- Vomiting is observed in 50% of cases.
- Stools negative for bacterial pathogens.
- Staff as well as patients may have symptoms.
- High attack/secondary rate.
- Over half have nausea; stomach cramps and over third have malaise, low grade fever, myalgia and headache.

Infection Control Action

1. The ward should download and complete the 'initial diarrhoea and vomiting' report form that can be obtained from the intranet hthttp://intranet.cht.nhs.uk/clinical-information/infection-prevention-control/viral-gastroenteritis// and complete prior to the IPCN visiting the ward.
2. An IPCN will visit the ward and collate patient information. During the 'out of hours' period this maybe done over the phone by the On-call IPCN.
3. Transfers from the ward should be restricted until a full assessment can be carried out.
4. IPCN will inform cleaning services/ISS and request 'outbreak cleaning' for the affected ward.
5. Isolate or cohort symptomatic patients where appropriate.
6. Specimens should be requested from all symptomatic staff and patients.
7. The IPCN will liaise with the Microbiology lab regarding outbreak wards
8. Where applicable ward bays may be restricted or closed rather than the whole ward but this would be on the advice of the IPCT.

9. If 'closure' of the whole ward is advised appendix 3 should be followed prior to closure.
10. If 'closure' of a ward is advised then the matron of the affected ward or bed manager will be informed.
11. 'Closure' is defined as no new patients to be admitted to the affected ward and no patients should be transferred or discharged to any other healthcare setting from the affected ward until advised by the IPCT.
12. 'Restricted' is defined as no patients should be transferred or discharged to other healthcare settings unless there is a clinical need; clinical need should be discussed with the IPCT and the risk should be managed appropriately.
13. Staff should not be moved from an outbreak ward whilst the ward is closed or restricted.
14. Non essential staff should not work in or visit an affected ward.
15. Staff should be advised not to travel home from work in their workwear/uniform. Dissolvable laundry bags will be available to transport workwear/uniforms home for laundering.
16. Written guidance will be provided to the ward staff, these guidelines must be adhered to during the outbreak. Any change in practice to these guidelines should be discussed with the IPCT.
17. The patients on the ward will be reviewed by the IPCN daily until symptoms in all patients have ceased for a minimum of 48 hours, ideally 72 hours or an infectious cause for the symptoms has been ruled out.
18. Following the daily review by the IPCN an email will be sent (Monday to Friday) to the following key staff:
    - IPCT
    - Director of Nursing
    - Medical Director
    - Bed Manager
    - Microbiology laboratory manager
    - Communications staff
    - Matrons
    - Associate Nurse Director of affected division
19. At the end of the outbreak when the ward has been closed, a report will be produced for the Ward Manager, Matron and Associate Nurse Director.
20. During periods of bed pressures the decision to admit patients to an outbreak ward should only be made following direct communication between the On Call Director and the IPCT.
21. If there is a clinical need to admit to or transfer out of a closed or restricted ward this should be first discussed with the IPCT.

<u>Criteria for re-opening a bay/ward following an outbreak</u>

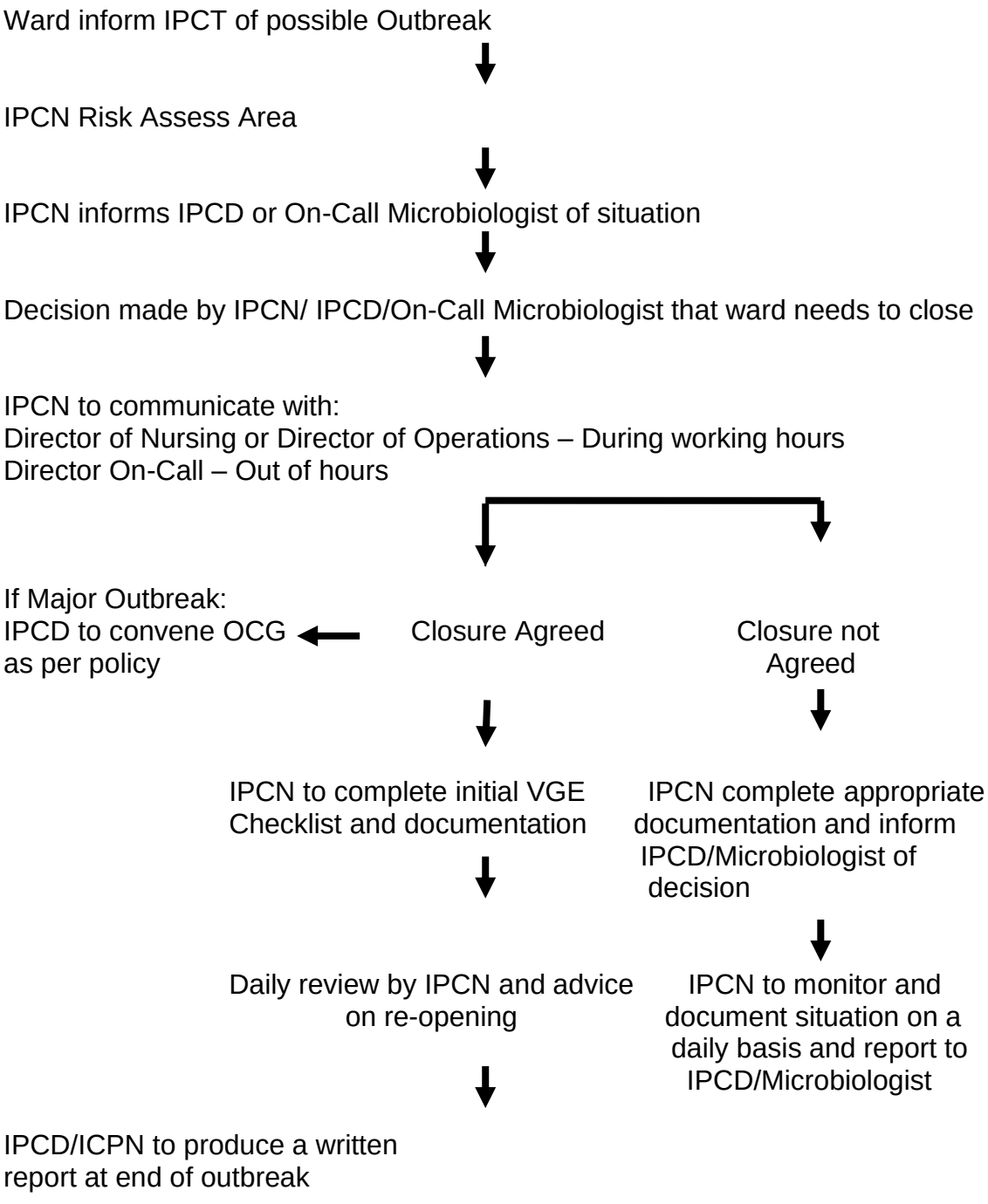
1. All patients should be 48 hours symptom free.
2. No new cases identified for the last 72 hours
3. Consideration may be given to re-opening if all patients in bay areas have been asymptomatic for 48 hours and symptomatic patients are isolated in side rooms.
4. The ward has been thoroughly cleaned
5. The decision to re-open a ward following an outbreak of gastroenteritis should be made by the IPCT.
6. Admission to outbreak wards against the advice of the IPCT must be discussed with the Director on call.

References/Suggested further reading

Ayliffe et al (2000). *Control of Hospital Infection: A practical handbook*. 4th ed. Arnold, London
Hawker et al (2005). *Communicable Disease Control Handbook*. Blackwell Publishing. London
Norovirus Working Party. (2011). *Guidelines for the Management of Norovirus outbreaks in acute and community health and social care settings.* Norovirus Working Party. London

APPENDIX 3

Process for Ward Closures due to Viral Gastroenteritis



APPENDIX 4

Influenza Standard Operating Procedure

General Information	Influenza is an acute viral infection of the respiratory tract 3 types: A, B & C (A&B responsible for most cases)
Incubation Period	1-3 days
Signs & Symptoms	Sudden onset of fever, chills, headache, myalgia, extreme fatigue, dry cough, sore throat and stuffy nose
Infectivity	The amount of viral shed and hence infectivity is highest in the first 2/3 days of infection. <u>Isolation</u> • In general, both adults and children should remain in isolation until 7 days after the onset of symptoms. After this isolation measures can cease providing they have been asymptomatic for at least 48 hours. • If the patient has had Tamiflu for 5 days, the period of infectivity is reduced and isolation measures can cease after day 5 providing the patient has been asymptomatic for 48 hours. <u>Ventilated patients</u> Ventilated patients with signs of pneumonitis should remain isolated beyond 7 days. They may shed virus for prolonged periods (weeks if symptomatic) and should have at least a 10 day course of Tamiflu. Ventilated patients who have had, and are recovering from severe pneumonitis may be considered for step down provided: • They have completed a course of Tamiflu as above • They are clearly improving. In practice this means they are: • Extubated or heading towards extubation • Are free of fever
Transmission	<u>Respiratory and Contact Transmission:</u> Aerosol, droplets or direct/indirect contact with respiratory secretions from someone with influenza or from their surrounding environment.
Infection Prevention & Control measures: ***Suspected & confirmed cases***	• Hand Hygiene • Respiratory isolation precautions – wearing of surgical mask unless cough inducing procedure then a FFP3 mask must be worn. • PPE (poster via hyperlink below, for reference not display) http://intranet.cht.nhs.uk/typo3/mod.php?M=web_WorkspacesWorkspaces&moduleToken=e8e38f8e3c51ad0ae1d0021285b7a57963785547&tx_workspaces_web_workspacesworkspaces%5Baction%5D=index&tx_workspaces_web_workspacesworkspaces%5Bcontroller%5D=Preview&id=1386 • Commence Tristel cleaning of the environment • Request a contact list from the clinical area and advise risk

	assessment of the patients that have been involved. • Clinician liaison with consultant microbiologist as required. • Terminal clean and curtain change of bed space/side room on patient discharge
High risk groups	Children < 6 months, elderly, those with underlying disease especially cardiac disease, chronic respiratory disease, immune-compromised, pregnant women, Obesity BMI 40 or more
Contact tracing	Risk assessment of patient contacts exposed to the index case needs to be undertaken by the clinician involved.
Viral swabs	Viral swabs are available from the pathology central reception on both hospital sites. If this is not the case, ring pathology during working hours on CRH 4457 or the on call pathology staff out of hours, via switchboard. The viral packs contain transport medium and 1 swab. A further dry swab is required in addition to this. 2 swabs should be taken, one nose, one throat. The swabs should then be broken off and placed together in the viral medium. If there is no viral medium available, 2 dry swabs will suffice (the lab will place in viral medium on receipt). NB; Upper respiratory tract specimens may be false-negative in patients with evidence of lower respiratory tract involvement; ET aspirates or BAL samples should be obtained in these patients, in addition to upper respiratory tract samples.
Antiviral prophylaxis	There are antiviral drugs available that can be used under certain circumstances to either prevent or treat influenza. NICE has issued guidance on the use of antiviral drugs for the prevention and treatment of influenza at: https://www.gov.uk/government/publications/influenza-treatment-and-prophylaxis-using-anti-viral-agents

Influenza Clinical Risk Assessment The list above is not exhaustive, and the medical practitioner should apply clinical judgement to take into account the risk of influenza exacerbating any underlying disease that a patient may have, as well as the risk of serious illness from influenza itself. Trivalent influenza vaccine should be offered in such cases even if the individual is not in the clinical risk groups specified above.	
Chronic respiratory disease	Asthma that requires continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission. Chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema; bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children who have previously been admitted to hospital for lower respiratory tract disease.
Chronic heart disease	Congenital heart disease, hypertension with cardiac complications, chronic heart failure, individuals requiring regular medication and/or follow-up for ischaemic heart disease.
Chronic kidney disease	Chronic kidney disease at stage 3, 4 or 5, chronic kidney failure, nephrotic syndrome, kidney transplantation
Chronic liver disease	Cirrhosis, biliary atresia, chronic hepatitis
Chronic neurological disease (included in the DES directions for Wales)	Stroke, transient ischaemic attack (TIA). Conditions in which respiratory function may be compromised due to neurological disease (e.g. polio syndrome sufferers). Clinicians should consider on an individual basis the clinical needs of patients including individuals with cerebral palsy, multiple sclerosis and related or similar conditions; or hereditary and degenerative disease of the nervous system or muscles; or severe neurological or severe learning disability
Diabetes	Type 1 diabetes, type 2 diabetes requiring insulin or oral hypoglycaemic drugs, diet controlled diabetes.
Immunosuppression	Immunosuppression due to disease or treatment. Patients undergoing chemotherapy leading to immunosuppression. Asplenia or splenic dysfunction. HIV infection at all stages. Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone at 20mg or more per day (any age) or for children under 20kg a dose of 1mg or more per kg per day. It is difficult to define at what level of immunosuppression a patient could be considered to be at a greater risk of the serious consequences of influenza and should be offered influenza vaccination. This decision is best made on an individual basis and left to the patient's clinician. **Some immunocompromised patients may have a suboptimal immunological response to the vaccine
Pregnant Women	Pregnant women at any stage of pregnancy (first, second or third trimesters).

Reference (Chapter 19): https://www.gov.uk/government/organisations/public-health-england/series/immunisation-against-infectious-disease-the-green-book

APPENDIX 5

COVID-19: Actions to be taken following an exposure incident at CHFT

Contents

Follow Trust SOPs for minimising transmission of COVID-19 at CHFT

- ✓ All patients with suspected or confirmed COVID should be isolated on admission (https://intranet.cht.nhs.uk/fileadmin/site_setup/contentUploads/Communications/Documents/Wuhan_coronavirus/COVID-19_SOP_for_suspected_and_confirmed_cases_Version_13_Final.pdf)
- ✓ The following groups of asymptomatic patients should be isolated on admission (https://intranet.cht.nhs.uk/fileadmin/site_setup/contentUploads/Communications/Documents/Wuhan_coronavirus/COVID-19_SOP_for_NEGATIVES___ASYMPTOMATIC_SCREENS_2020_V1_FINAL_03.07.2020.pdf)
- All care home admissions-These can be stepped down if COVID PCR negative and remain asymptomatic
- Shielded patients (Guidance on shielding and protecting people who are clinically extremely vulnerable from COVID-19 - GOV.UK) They should be isolated for their duration of in-patient stay regardless of the COVID result.

Definitions

IPCD	Infection control doctor
IPCN	Infection control nurse
IMT	COVID-19 Incident management team
OH	Occupational Health
OCG	Outbreak control group
Definite HOCI	Patient is admitted for a non-COVID pathology, admission and day 5 COVID PCR is negative and a repeat >14 days after admission is positive.
Probable HOCI	Patient is admitted for a non-COVID pathology, admission and day 5 COVID PCR is negative and a repeat between 8-14 days is positive
Outbreak	See page 2
Infectious period	Defined as 48 hours before onset of symptoms or 48 hours before the time of the PCR test if the person is asymptomatic
Significant contact[1]	Any of the following **without appropriate PPE being used during the infectious period**: • Direct Face-to-face contact (e.g. talking) for any length of time; or • Being within 1m for 1 min or longer; or • Being within 2m for 15 mins or longer

NHS Test and Trace

- Any person that received a positive test result will be included in NHS Test and Trace. They will receive a text or phone call asking them to go online to complete an online form which includes information about them and the people they have been in contact with
- For healthcare workers, and cases that involved contacts in healthcare settings, the process will automatically be escalated to the local Health Protection Team (HPT).
- When the local HPT is notified of a healthcare worker case, the social contacts (household, those they have had contact with outside work) will normally have been traced through the national process
- The HPT will pass on details of the case to the agreed single point of contact email address. At CHFT this is the Incident Control Centre (Incident.ControlCentre@cht.nhs.uk).
- The incident control centre will pass the information on to Occupational health and the infection prevention and control team within 24 hours
- OH will follow up on staff contacts if any and ensure complete documentation of the process is available
- IPCT will follow up on patient contacts if any and ensure complete documentation of the process is available

OUTBREAK CRITERIA
(CASES MAY BE STAFF, PATIENTS OR VISITORS)

	Criteria to declare an outbreak	**Criteria to end an outbreak**
Inpatient setting	Two or more confirmed cases of COVID-19 OR clinically suspected cases of COVDI-19 among individuals associated with a specific setting. For linked patients this will be onset dates 8-14 days after admissions within the same ward or wing of CHFT	No confirmed cases with onset dates in the last 28 days in that setting.
Outpatient setting	Two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days AND: Identified direct exposure between at least two of the confirmed cases in that setting (e.g. within 2 metres for >15 minutes) during the infectious period of the putative index case	No confirmed cases with onset dates in the last 28 days in that setting.
Non-clinical workplace	Two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days AND: Identified direct exposure between at least two of the confirmed cases in that setting (e.g. within 2 metres for >15 minutes) during the infectious period of the putative index case	No confirmed cases with onset dates in the last 28 days in that setting.

UNIQUE IDENTIFIER NO: G-75-2008
EQUIP-2017-037
Review Date: August 2021
Review Lead: Lead Infection Prevention & Control Nurse

ACTIONS FOLLOWING A PATIENT EXPOSURE IN AN OPEN BAY

- ✓ IPCN to datix as an ORANGE incident. If a definite OR probable HOCI, will need an RCA (appendix 5)
- ✓ Clinically assess all other patients in the bay for COVID-19 symptoms/signs i.e. fever; respiratory symptoms; myalgia; headache; diarrhoea +/- abdominal pain; compatible radiology (CXR or CT findings)
- ✓ Screening questionnaire for relevant staff (appendix1)
- ✓ assess patients and staff for significant exposure

Any other suspected case(s) identified?

YES

Follow CHFT outbreak of infection policy
https://intranet.cht.nhs.uk/chft-documentation/uploads/495/G-75-2008%20-%20Major%20Outbreak%20Policy%20v7.pdf

- Close affected Bay
- If > 1 bay affected, consider ward closure And PCR testing beyond affected bay
- If initial negative PCR results re-test contacts at day 5 or if develop symptoms
- Discharge pts where possible with advice for 14 days self- isolation from date of last contact
- Where possible within 14 days, clear bay(s) by moving remaining contacts into single rooms on ward

If unable to clear bay then reopen once 14 days from latest positive case identification AND no new cases identified in that area

Staff follow-up

- Assess for symptoms and exclude from work if symptoms develop OR if staff is identified as a significant contact (see staff screening questionnaire-appendix 1)
- OH to review staff absences from affected ward

- If a cluster of new staff/patient cases are identified, in discussion with IPC team & OH, screen all ward based staff in order to pick up any new, asymptomatic or pre-symptomatic cases

YES

NO

- Isolate the index case in a side room or move to a COVID positive cohort ward
- Close the affected bay and block beds*
- Send a COVID PCR screen on all patient contacts if contact is ≥ 24 hours

Any additional cases identified on testing or further symptomatic case(s)

NO

- If initial PCR is negative results then re-screen remaining contacts at between day 5 or if develop symptoms
- Discharge where possible with advice for 14 days self- isolation/IC precautions from date of last contact
- Clear bay by moving remaining contacts into single rooms on ward where possible
- If unable to clear bay then reopen once 14 days from last positive case identification AND all patients remain asymptomatic
- Clinical team to remain alert for further symptomatic cases on the ward

*If unable to block beds in the bay for the 14 day period, the following principles should be applied:

- Do not admit shielded patients into affected bay
- The following groups of patients can be transferred to the affected bay;
- ✓ Asymptomatic patients exposed to confirmed cases within the last 14 days
- ✓ COVID recovered cases

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ACTIONS FOLLOWING A STAFF EXPOSURE

HCW has a household → Inform their line manager and self-isolate for 14 days, in line with the stay at home guidance https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance

HCW identified by NHS 'test and trace' scheme as a significant contact by OH

↓

Self-isolate for 14 days, in line with the Test and Trace guidance and arrange a COVID PCR test. If positive, reduce isolation to 10 days

HCW is a contact[1] of a confirmed /suspected in-patient of COVID-19

↓

Line manager to determine if there a significant breach[2] in their PPE while providing personal care?

- YES → Stay off work for 14 days from date of contact
- NO → No further action required

HCW has been notified that they are a contact[1] of a co-worker who is a confirmed case

↓

Were they wearing appropriate PPE at the time of the contact? OR Was there appropriate (≥ 2m) social distancing?

- NO → Stay off work for 14 days from the date of contact and arrange for a COVID PCR test. If positive, reduce isolation to 10 days if asymptomatic.
- YES → No further action required

Infectious period starts 48 hours before symptom onset or date of positive test if asymptomatic

1. **Definition of contact** is any of the following **without appropriate PPE** used during the infectious period:
   - Direct Face-to-face contact (e.g. talking) for any length of time; **or**
   - Being within 1m for 1 min or longer; **or**
   - Being within 2m for 15 mins or longer

2. Significant breach of PPE should take into consideration the severity of patient symptoms, the length of exposure, the proximity of the case, whether the patient was wearing a mask, the activities that took place when the worker was in proximity (such as aerosol-generating procedures (AGPs), monitoring, personal care) and whether the member of staff had their eyes, nose or mouth exposed

ROLES, RESPONSIBILITIES and TIMESCALES:

COVID POSITIVE in-patient exposure in hospital

Action	Responsible individual/team	Time frame
Inform IPCT of in-patient exposure	Clinical team	Immediately following suspected or confirmed COVID
Datix incident	IPCN	By the next working day
Inform on-call microbiology cons/IPCD	IPCN	Immediately
Identification of significant patient contacts	Clinical teams (IPCNs to support)	Timeline within 24 hours
Identification of significant staff contacts	Clinical team to identify if PPE breech and inform OH	Timeline within 24 hours by OH
RCA documentation if probable or definite HOCI (appendix 3)	Clinical teams	As per orange incident (Datix)
Incident management meeting if required	IPCD/On-call micro consultant	Within 24 hours
Outbreak identification	OCG	Immediately if criteria are met

Test and Trace notification of contact

Action	Responsible team	Timeframe
Identification of significant contacts[1] in Staff	Occupational health	Timeline within 24 hours
Identification of significant contacts[1] in patients	IPCN/on-call micro OOH	Timeline within 24 hours
Incident management team meeting (if required)	IPCD/on-call microbiologist	Within 24 hours of notification of significant contacts.
Outbreak identification	OH and IPCT via OCG	Immediately if criteria are met

COVID POSITIVE staff exposure in hospital

Action	Responsible team	Timeframe
Identification of significant contacts[1] in Staff	Occupational health	Timeline within 24 hours
Identification of significant contacts[1] in patients	IPCN	Timeline within 24 hours
Incident management team meeting (if required)	IPCD/on-call microbiologist	Within 24 hours of notification of significant contacts.
Outbreak Identification	OH and IPCT via OCG	Immediately if criteria are met

OUTBREAK MANAGEMENT PLAN

Once an outbreak is identified (see page for definitions), follow the CHFT outbreak of infection policy (https://intranet.cht.nhs.uk/chft-documentation/uploads/495/G-75-2008%20-%20Major%20Outbreak%20Policy%20v7.pdf)

In addition, the table below states the requirement for external notification and update of Covid-19 outbreaks

Action	Responsibility	Timeline
Arrange an outbreak control meeting along with external partners (PHE and CCG representatives)	ICD/on-call microbiologist	asap
Inform the **Yorkshire Regional Incident Coordination Room** Email: ICC.YorkshireHumber@phe.gov.uk Phone: **01133860300**	IPCN	Within 24 hours of the outbreak identification
Complete the outbreak notification form (appendix 3) and email england.eprrney@nhs.net	IPCD/on-call microbiologist	Within 24 hours of the outbreak identification
Regular update to the national ICC via the **IIMARCH** form (appendix 3) and email to england.eprrney@nhs.net	IPC matron/ Senior IPCN	Within 24 hours following the outbreak meeting
Inform CQC via the Trust CQC communication officer (if required)		

Appendix A. Minimum dataset of significant patient contacts

Index case (MRN number)				
Name and MRN number of contact	**Nature of contact e.g. cared for by staff or shared bay or waiting area with patient.**	**For out-patients were facial coverings worn and social distancing maintained?**	**Action taken**	**By whom**

Appendix B. Staff screening form for Occupational Health

CONTACT TRACING TOOL TO BE USED BY LINE MANAGER FOR ALL EMPLOYEES FOLLOWING AN EXPOSURE INCIDENT

Employee name: **DOB:**
Contact number: **Role:**
Usual location of work:
Location of contact (if different):
Index case (IC) (specify staff/patient, provide initials and MRN if patient):
Date of IC onset of symptoms or swab if asymptomatic:
Date of contact (IC and employee) :
Was IC symptomatic at time of contact:
Activity performed:
Duration of activity:
Please document PPE worn/breached/reason for breach (for each task performed within contact of the IC, was the correct PPE worn, if not, please provide full details of this):

Please answer the following questions:
When answering the questions below, please consider all aspects of contact, to include, patient care, changing room areas, break/dining areas or any other area where close contact may occur (Was the patient wearing a mask)

1)Has there been Face to face contact with someone less than 1 metre away where one or both were not wearing PPE appropriate to the task **YES/NO**
2)Did the staff member spend more than 15 minutes with someone within 2 metres where one or both were not wearing PPE appropriate to the task **YES/NO**
3)Have staff members travelled in a car or small vehicle / confined space for any length of time, without PPE as appropriate **YES/NO**

Risk assessment of close contact should include

- Severity if the symptoms of the index case
- The length of the exposure
- Clinical vulnerability of contacts (immune suppression)
- Activities being performed on the index case (Aerosol generating)
- Appropriate rigor of IPC measures – hand hygiene, PPE use, environmental cleaning

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To be completed by Occupational Health

Date Occupational Health department informed of significant contact:
Has PCR testing of employee been identified as necessary and an appointment made?
Date of PCR test: Location of PCR test:
Result of PCR test and date result reported:
Has employee reported any symptoms:
Isolation period advised and if so, who by?
Length of isolation period and dates from and to:
Any other comments (including any clinical vulnerability needing to be considered):

Appendix C. Outbreak Notification Form

Question	Response
1.Date Identified	
2. How many patients do you think are involved, and what wards/departments are involved, and over what time period?	
3. Has ward/department been closed to admissions/ a. If so, date closed b. Numbers of patients affected c. Numbers of staff affected?	
4. How many staff members do you think are involved?	
5. Do you think this is an outbreak? If so, have you involved PHE?	
6. Do you have any concerns with compliance with infection prevention and control policies and practices? a. Hand Hygiene b. Environmental cleanliness c. Personal protective equipment d. Social distancing for patients and staff	
7. What is the current and anticipated impact on the trust and activity?	

Appendix D. IIMARCH form to update Regional Covid-19 ICC

Name of Organisation: **Date:**
Name of person reporting the outbreak
Email: **Phone Number:**
National Incident Number for outbreak (ICC to add on receipt of first IIMARCH form)

Element	Key questions and considerations	Action
I	**Information** **What, where, when, how, how many, so what, what might?** Timeline and history (if applicable), key facts reported using M/ETHANE Has the ward department been closed to admissions? Date Number of patients affected Number of staff affected Number of relatives affected	
I	**Intent** **Why we are here, what are our strategic objectives are to address?** Strategic aim and objectives, joint working strategy Enhanced cleaning in place in Department/ Ward, internal Trust/organisation discussion undertaken with a view to potential decant of affected area and deep clean as well as reinforce social distancing in all areas to include rest rooms Assessment of impact of service delivery and business continuity plans	
M	**Method** **How are we going to do it?** Command, control and co-ordination arrangements, tactical and operational policy and plans, contingency Do you have any concerns with compliance with infection prevention and control policies and practices? a. Hand Hygiene b. Environmental cleanliness	

Element	Key questions and considerations	Action
	c. Personal protective equipment d. Social distancing for patients and staff	
A	**Administration** **What is required for effective, efficient and safe implementation?** **I**dentification of commanders, tasking, timing, decision logs, equipment, dress code, PPE, welfare, food, logistics	
R	**Risk assessment** **What are the relevant risks, and what measures are required to mitigate them?** Risk assessments (dynamic and analytical) should be shared to establish a joint understanding of risk. Risks should be reduced to the lowest reasonably practicable level by taking preventative measures, in order of priority. Consider the hierarchy of controls. Consider Decision Controls	
C	**Communications** **How are we going to initiate and maintain communications with all partners and interested parties?** Radio call signs, other means of communication, understanding of inter-agency communications, information assessment, media handling and joint media strategy	
H	**Humanitarian issues** **What humanitarian assistance and human rights issues arise or may arise from this event and the response to it?** Requirement for humanitarian assistance, information sharing and disclosure, potential impacts on individuals' human rights	

Appendix E: RCA Documentation

NAME _____MRN_____DATE_____
Datix ID_____

Hospital Onset Covid-19 Infection (HOCI) investigation tool - RCA

1. Investigation and action plan to be presented to the Divisional PSQB by the Matron.
2. Trust wide learning to be taken to IMT

Timeline – WHY & WHEN was the patient admitted /respiratory issues identified/deterioration/COVID samples?		
Brief account		
Screening	Yes/No	Comments and further explanation
Was screening performed on admission?		*Where? delays?*
Is the positive result the admission screen or other?		*Reason?*
Placement		
Where was the patient prior to this result?		
Was this appropriate for their status?		
For possible/confirmed cases of Covid, are the patients wearing face masks where able?		
Are patients supported with respiratory hygiene? *i.e. provided with tissues/hand wipes/education*		
Exposure		
Any significant confirmed patient contact? *Note the name, MRN, date and ward and if known to be positive at time of exposure or subsequently positive and isolated if appropriate?* Any significant Staff contact ? *(OH to provide information for staff absences due to COVID and line manager to assess along with OH if there was a PPE breach)*		

Hand Hygiene		
Alcohol gel is available at the point of care?		
Hand hygiene audit scores?		*Scores:*
Staff bare below the elbow?		*If gowns, managed well?*
Personal Protective Equipment		
Is the right PPE readily available **now**? **then**?		
Are staff using PPE appropriately? Standard and/or enhanced donning and doffing		*Question staff/observe*
If AGPs carried out, are settle times known and followed for rooms affected?		
Is reusable PPE stored clean and dry?		
Are filters in date where applicable?		
Patient Equipment		
Are equipment cleaning schedules up to date?		
Is patient equipment single use for the isolated patient? If not, what has been used?		
Is the reusable patient equipment clean?		
Environmental cleaning		
Is enhanced cleaning incl touch points in place?		
FLO scores (+QI if recent) for previous month		*Scores?* *Concerns?*
Cleaning scores?		*Scores?* *Concerns?*
Staff training		
Are nursing and medical staff up to date with IPC training i.e. Level 1, 2 ANTT and fit testing?		*Percentages:*
Issues to escalate		

Action Plan						
Issue	**Current position**	**Actions required**	**Lead**	**Time scale**	**Date completed**	**Evidence**

References;

1. Letter to NHS Trusts on 19th May from the UK's Chief Nursing Officer
2. Email to Trusts on 5th June RE: "action required for healthcare worker contacts and minimising transmission of Covid-19 between healthcare workers" from K Smith, Deputy Director, Healthcare North East and Yorkshire Region Public Health England

APPENDIX 6

Outbreak Action Card 1

INFECTION PREVENTION & CONTROL DOCTOR or DEPUTY	
In Hours	Out of Hours
Trust Nominated ICD	On Call Microbiologist

RESPONSIBILITIES DURING OUTBREAK / INCIDENT

1. Verify Outbreak
2. Inform IPCN, Microbiologist and Laboratory
3. Determine appropriate response:
    a) Local management by the IPCT or
    b) Call an Outbreak Control Group (OCG) for further assessment or to declare an outbreak / incident and activate the plan.
4. On calling an OCG, inform:

In Hours	Out of Hours

5. Discuss with the IPCNs and Clinical Staff the need for specific control measures and treatment.
6. Attend the first OCG meeting to provide expert advice on management of the outbreak.
7. Ensure daily review and documentation of the outbreak / incident in collaboration with the IPCNs.
8. Provide continuing expert advice to clinical staff on management of the outbreak and treatment of the patients affected.
9. Attend subsequent and final outbreak meetings.
10. In collaboration with the Matron for Infection prevention and control, recommend appropriate isolation of patients, particularly if single rooms / cohort ward is not available. This will include advice on the use of cohort bays or isolation wards.
11. Advise the OCG of the need to escalate to major incident status, the emergency plan or other disease specific control plans.

Outbreak Action Card 2

Outbreak Action Plan

CHAIR OF THE OUTBREAK CONTROL GROUP (OCG)	
In Hours	Out of Hours
Medical Director or IPCD or in their absence DIPC	Exec Director on Call or On Call Microbiologist

1. Keeps the Chief Executive informed at all times.
2. Direct and co-ordinate the team.
3. Ensure that each member knows what action is to be taken by themselves and by others.
4. Ensure that records of addresses and telephone numbers of all those likely to be needed at short notice are available.
5. Ensure that adequate and timely information is given to everyone affected by the incident.
6. Ensure clear lines of communication are established with the Community Infection Prevention & Control Team and external agencies.
7. Agree a strategy of communication with the media including information to be released.
8. Hold copies of the action cards for all OCG members.

Outbreak Action Card 3

Outbreak Action Plan

CCDC	
In Hours	Out of Hours
CCDC	On Call Public Health Doctor

1. Act as the link between the OCG and the Yorkshire and Humber region NHS England.
2. Provide expert advice on the control of the outbreak.
3. Inform other agencies as appropriate e.g. DH, CDSC, Regional Epidemiologist, CCDCs in neighbouring PCTs.
4. Provide epidemiological advice.
5. Provide public information and media handling as required.
6. Access support from PHE if required.
7. In outbreaks that have major public health implications the CCDC will normally lead and co-ordinate outbreak control, working closely with colleagues in the Community Infection Control Team including the IPCD. The IPCD will be responsible for hospital aspects of the outbreak.

Outbreak Action Card 4

Outbreak Action Plan

MATRON OF INFECTION PREVENTION & CONTROL	
In Hours	Out of Hours
Matron of IPCT or in her absence Senior IPCN	On Call IPCN

1. Liaise with the IPCD.
2. Cancel planned IPCN activities, if required, in order to respond immediately to the outbreak. Co-ordinate and direct IPCNs to visit affected areas and collect information immediately. Assess the level of information that can be gathered prior to the OCG meeting. (Initial assessment, further assessment and additional information if time allows – see Action Card 5).
3. Commence outbreak documentation.
4. Collate initial information on the extent of the outbreak, incorporating information provided by IPCNs visiting the affected areas.
5. Assess the requirements for isolation of patients, particularly if single rooms / cohort ward not available. Consider the options of cohort bays / isolation wards and advise the IPCD / OCG accordingly.
6. Provide initial briefing to direct IPCNs as per their action card.
7. Liaise with the laboratory to inform them of the outbreak.
8. Report findings and advise the OCG meeting.
9. Keep the bed co-ordinators informed at all times.
10. Liaise with key people, as allocated by the OCG chair.
11. Report the outcome of the OCG meeting to IPCNs and continuing actions as required.
12. Produce written information control advice for dissemination to affected areas.

MATRON OF INFECTION PREVENTION & CONTROL
(Continued)

13. Direct IPCNs to:
    - Ensure OCG actions are implemented.
    - Visit affected areas as allocated.
    - Complete individual outbreak documentation.
    - Disseminate written infection control advice.

14. Collate information on facilities and additional supplies required in affected areas, and liaise with key staff to ensure these are provided.

15. Review the outbreak daily, in collaboration with the IPCD and CCDC.

16. Attend meeting of the OCG, and report on current situation, control measures and difficulties with implementation.

17. Contribute to outbreak reports including the final report.

Outbreak Action Card 5

Outbreak Action Plan

IPCNs Assisting the MATRON for the IPCT	
In Hours	Out of Hours
IPCN	On Call IPCN with assistance from the Duty Matron and Ward Team

1. Undertake the initial visit to the affected areas as directed by the Matron of the Infection Prevention & Control Team. No advice on movement must be given until after the Matron or Out of Hours Deputy has collated the information from the initial visits.

   Information required:

   Initial assessment must include:
   - A list of affected patients, staff and visitors
   - A patient location sheet should be completed

   Further assessment will include:
   - Name, hospital number and date of birth
   - Date of admission
   - Diagnosis, antibiotic therapy

   Additional information required may include:
   - Use of aperients
   - Food history, including enteral and sip feeds
   - Recent travel
   - Other as determined by the Matron

2. Report back to Matron as soon as possible with initial documentation.

3. Return to the area, complete information gathering. Implement actions as directed by the Matron.

4. Provide support to clinical staff.

5. In collaboration with the Nurse in Charge and Cleanliness Supervisors, assess the adequacy of supplies and facilities including:
   - The availability and siting of hand gel.
   - Liquid soap and paper towels.

IPCNs Assisting the Lead IPCN
(Continued)

- Protective clothing.
- Disposable equipment
- Linen
- Cleaning products
- Waste bags
- Commodes

6. Report back to Matron, clearly identifying requirements for each affected area.

7. Visit affected areas daily, as directed by the Matron, ensuring completion of outbreak documentation.

Outbreak Action Card 6

Outbreak Action Plan

For Nurse in Charge of the Affected Area	
In Hours	Out of Hours
IPCT	On Call Microbiolgist

1. Inform Ward Matron and/or Matron of the Day of outbreak/incident.

2. Collect the following information ready for the IPCN.
   - A list of affected patients, staff and visitors.
   - A list of patients that may have been in contact with the affected patient/s as requested by the IPCN.

   Information should include:
   - Name, ID number and date of birth
   - Date of admission
   - Diagnosis, antibiotic therapy

   Additional information required may include
   - Use of aperients
   - Food history, including enteral and sip feeds
   - Recent travel
   - Other as determined by the IPC Matron

3. Assess the availability of isolation nursing facilities, ensuring all patients currently in isolation have up-to-date isolation scores.

4. In collaboration with the Nurse-in-Charge and Cleanliness Supervisors, assess the adequacy of supplies and facilities including:
   - The availability and siting of hand gel
   - Liquid soap and paper towels
   - Protective clothing
   - Disposable equipment
   - Linen
   - Cleaning products
   - Waste bags
   - Commodes

5. Restrict patient movement until advised by IPCN.

For Nurse in Charge of the Affected Area
(Continued)

6. Report back to IPCN, clearly identifying additional requirements for the area.
7. Keep clear written records of the resources needed and the actions taken.

Outbreak Action Card 7

Outbreak Action Plan

For Ward Matron / Matron of the Day

Out of Hours this role would be undertaken by the Bed Manager / Night Co-ordinator

1. Visit the affected area and liaise with the Nurse in Charge and IPCN.
2. Cancel planned activities, if required, in order to respond to the outbreak.
3. Support the Nurse in Charge in gathering information prior to the OCG meeting.
4. Review staffing levels in affected areas.
5. Advise Head of Clinical Services and the Bed Manager / Night Co-ordinator of the outbreak / incident.
6. Commence outbreak documentation as advised by the IPCN.
7. Attend OCG meetings, and report on current situation, control measures and difficulties with implementation.
8. Liaise with key people as allocated by the OCG Chair.
9. Report the outcome of the OCG meeting to Nurse in Charge and relay continuing actions required.
10. Liaise with the IPC Matron to collate information on facilities and additional supplies required in the affected areas.
11. Review the outbreak daily, in collaboration with the IPC Matron.
12. Keep clear written records of actions agreed, when implemented and resource implications.

Outbreak Action Card 8

Outbreak Action Plan

For Occupational Health Nurse

1. Identify any specific Occupational Health measures that should be taken as soon as you are informed of the outbreak. Ensure colleagues in your department are informed of the outbreak.

2. Prepare any written information on staff health issues that may be required for staff information.

3. Attend OCG meeting, and advise on Occupational Health measures required.

4. Provide advice and support for staff with regard to their own health and support managers in managing any staff health issues.

5. Advise managers on the need for RIDDOR reporting, in line with the following statement:
    - Reporting injuries, Diseases and Dangerous Occurrences Regulation (RIDDOR) quickest way to report a problem is to use the online form, once this is submitted you will receive an acknowledgement. If unable to use the form, phone on 0300 003 1647 and the form will be completed with you. Lines are open Monday to Friday from 8.30am to 5pm (on Wednesdays open from 10am to 5pm).

6. Carry out any other actions as agreed at the OCG meeting.

7. Lead on any screening of staff if required.

Outbreak Action Card 9

Outbreak Action Plan

Associate Director of Nursing (or Nominated Matron)	
In Hours	Out of Hours
Divisional AND	On Call GM or Duty Matron

Responsibility During Outbreak / Incident

1. Produce and maintain lists of all staff (including night duty) working in the affected areas for IPCT and OH Department.
2. Assess the levels of sickness and need for additional staff.
3. Make arrangements to call in additional nursing staff either from home or bank nurses.
4. Reallocate nursing staff as required and ensure that staff who have worked in the affected areas do not work elsewhere until the outbreak has subsided or until the incubation period has lapsed; including night staff.
5. Monitor sickness amongst staff and liaise with OH and IPCN as appropriate.
6. Continue to monitor situation and be vigilant for cases within other areas and report further cases to the IPCT.
7. Ensure that staff have sufficient isolation equipment and liaise with Supplies.

Outbreak Action Card 10

Outbreak Action Plan

Communications Manager	
In Hours	Out of Hours
Head of Communications	On Call Communications Manager

Responsibility During Outbreak / Incident

1. Inform switchboard and PFI partner as appropriate and instruct that all general and press enquiries will be dealt with by the Comms Manager with support from OCG.
2. Attend OCG meeting.
3. Prepare press statements with assistance of OCG.
4. Speak directly to the media as appropriate.
5. Assist members of the OCG who may be required to give media interviews.
6. Liaise with Comms Dept in the PCTs and SHA as appropriate.

APPENDIX 7

Draft Agenda for Incident/Outbreak Control Group Meeting

1. Introduction and reminder of confidentiality

2. Minutes of last meeting (if applicable) including reviews of actions agreed

3. Overview/resume

4. Control measures

    - Specific control measures
    - Restrictions on patient movements and where they should apply
    - Review of staff groups attending the ward and any alterations to their provision for service
    - Sampling required

5. Cleaning

6. Patient Care

7. Communications

    - Patients and visitors
    - Affected ward staff
    - Senior clinical staff and management
    - All other staff
    - General practitioners
    - Other organisations e.g. PHE, CCG, Local Authority
    - The media

8. Other issues or concerns

9. Responsibilities

10. Summary

11. Date, time & venue of next meeting