Essex Partnership University
NHS Foundation Trust

ICPG1 INFECTION PREVENTION AND CONTROL SECTION 4: COMMUNICABLE DISEASES AND OUTBREAK CONTROL

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PROCEDURE SUMMARY
In the event of an outbreak of a communicable disease on Trust premises, the Trust is responsible for ensuring that prompt controls are implemented to limit the spread of infection. This section supports the Infection Control Policy by setting out the procedures for staff to follow in respect of communicable disease and outbreak control.
The Trust monitors the implementation of and compliance with this procedure in the following ways;
The responsibility for monitoring and reviewing this Procedural Guideline lies with the Director responsible for Infection Prevention and Control. Compliance with this policy and the supporting procedural guidelines will be audited annually using evidence and guidance based approved audit tools. Audit results will be presented to the Infection Prevention and Control Group. Uptake of Infection prevention and Control Training will be monitored as outlined in ICP1 - The Infection Control Policy - section 7.0.

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this policy is The Executive Chief Operating Officer / Executive Nurse

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SECTION 4: COMMUNICABLE DISEASES AND OUTBREAK CONTROL

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SECTION 4: COMMUNICABLE DISEASES AND OUTBREAK CONTROL

INTRODUCTION
In the event of a major outbreak of infection reference should be made to the Essex Partnership NHS Foundation Trust Major Incident Plan and RM14 – Organisational Resilience and Business Continuity Policy

1.0 RECOGNISING OUTBREAKS OF INFECTION

1.1 In the event of an outbreak of a communicable disease on Trust premises, the Trust is responsible for ensuring that prompt controls are implemented to limit the spread of infection

2.0 DEFINITION OF AN OUTBREAK

2.1 An outbreak may be defined in one of three ways;

- An incident affecting two or more people thought to have had a common exposure to a potential source, in which they experience similar illness or proven infection, or where spread is occurring through cross-infection or person to person.
- A rate of infection or illness above the expected rate for that place and time
- A single case of certain diseases such as diphtheria, rabies, poliomyelitis or viral haemorrhagic fever may lead to initiation of the Major Incident Plan, although not technically an outbreak.

2.2 Outbreaks do happen and obtaining help and advice **early** on will help to avoid further problems.

2.3 Any suspicion of an outbreak of any disease should be reported to the relevant Clinical Manager and the Infection Prevention Control Team (IPCT) immediately:

DURING OFFICE HOURS

OUT OF HOURS

Essex – Mental Health and Community Services:

Any **URGENT** enquiries, particularly to report an outbreak of infection within Trust premises – contact the on-call senior manager.

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The senior manager may then contact the Microbiologist on call:
Colchester Hospital (ESNEFT) – [redacted]

Bedfordshire Secure Services

Any **URGENT** enquiries, particularly to report an outbreak of infection within Trust premises – contact the on-call senior manager.

Please ensure the IPCT is informed of any out of-hours calls, on the next working day.

2.4 **The IPCT should be contacted if:**

- There are two or more cases of clients/patients or staff with a potentially infectious illness e.g. vomiting and diarrhoea or upper respiratory tract infection.

- There is a high sickness rate amongst staff, who appear to be suffering from the same infectious disease.

- There is a case of any of the notifiable diseases as in section 5 of this guideline,

Or: a single diagnosis of:

- Coronavirus
- Haemolytic streptococci Group A (Streptococcus pyogenes)
- Chickenpox and Shingles
- Influenza
- Scabies
- Headlice

3.0	**REPORTING AND DOCUMENTATION OF ILLNESS**

3.1 The following details should be kept of all clients/patients, staff members or visitors with a suspected or confirmed illness to assist in the early detection and investigation, of possible outbreaks of infection.

- Name, age and sex of resident/client/staff member/visitor
- General Practitioner's name and Consultant if in-patient
- Date of onset of symptoms
- Type of symptoms (use **Appendix 13** – Bristol Stool Classification Chart ,where relevant)
- Samples sent and results, if known
- Diagnosis
- Source of infection, if known
- Antibiotics prescribed
- Outcome

3.2 If a notifiable disease, record the date of notification/reporting.

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3.3 All incidents must be reported on the Datix reporting system.

3.4 Commence **Appendix 1** – Outbreak Management Checklist upon suspicion of an outbreak please commence one of the following:

3.5 **Appendix 2** - Record of an Infectious Outbreak – Diarrhoea and Vomiting Patients

Appendix 3 - Record of an Infectious Outbreak – Diarrhoea and Vomiting Staff

Appendix 4 - Record of an Infectious Outbreak – Upper Respiratory Tract Infections Patients

Appendix 5 - Record of an Infectious Outbreak – Upper Respiratory Tract Infections Staff

These should be commenced as soon as an outbreak is suspected – one form per outbreak. On completion a copy of the forms should be sent to the IPCT, and another to the relevant Clinical Manager.

4.0 NOTIFICATION PROCEDURES – NOTIFIABLE DISEASES

4.1 Registered medical practitioners (RMPs) have a statutory duty to notify the 'proper officer' at their local council or local health protection team (HPT) of suspected cases of certain infectious diseases.

4.2 Diseases notifiable (to Local Authority Proper Officers) under the Health Protection (Notification) Regulations 2010:

Anthrax	Poliomyelitis (acute)
Acute infectious hepatitis	Rabies
Botulism	Rubella
Brucellosis	SARS
Cholera	Scarlet Fever
Diphtheria	Smallpox
Enteric fever (typhoid or paratyphoid fever)	Tetanus
Encephalitis (acute)	Tuberculosis
Food Poisoning *	Typhus
Haemolytic uraemic syndrome	Viral Haemorrhagic Fever (VHF)
Infectious bloody diarrhoea	Whooping Cough
Invasive group A streptococcal disease and scarlet fever	Yellow Fever
Legionnaires' Disease	
Leprosy	
Malaria	
Measles	
Meningitis (all types)	
Meningococcal Septicaemia	
Mumps	
Plague	

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* Includes disease due to waterborne organisms e.g. Giardiasis, Cryptosporidium.

The above list may be subject to change – it is therefore advisable to check on the PHE website.

Listeriosis and Legionnaires Disease are not notifiable diseases but should be reported to the Consultant in Communicable Disease Control – Public Health England (PHE) – Health Protection Team.

4.3 **Prompt Notification Enables:**

- Prompt treatment or screening of contacts e.g. meningitis and tuberculosis.
- Prompt investigation of potential food or water contamination.
- Control of outbreaks.
- Monitoring of the effectiveness of immunisation programmes.
- Epidemiological investigations.

4.4 **Where do I obtain notification forms?**
Appendix 9 – Notification of Infectious Disease Form

4.5 **How quickly should I notify?**
The law specifies that notification should be "forthwith" i.e. without any delay. Notification forms should be sent out on the same day the patient is seen and not sent in batches.

The notification form should be sent to:
PHE East of England HPT
Public Health England, Second Floor, Goodman House, Station Approach
Harlow, Essex, CM20 2ET
Email
;
Telephone

Out of hours (Essex)

Out of hours for health professionals only (Bedfordshire)
(Medicom)
The aim of notification is to ensure public health action is taken promptly.

In addition the Health Protection team should be telephoned on the day of diagnosis on strong clinical suspicion for **all** notifiable diseases including:

Isolated cases and household contacts with food poisoning (the PHE team would like to be telephoned about any *E Coli* O157 and Listeria)
Chronic hepatitis B and C
Leptospirosis
Malaria
Scarlet fever
Cases of tuberculosis already under the care of a chest physician
Legionella

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Suspected outbreaks of any infection in care homes
Even one case of scabies in a residential care institution
Children found during screening prior to BCG to have a strongly positive skin test

5.0 CONTROL MEASURES TO BE INSTITUTED WHEN AN OUTBREAK OF INFECTION IS FIRST SUSPECTED/CONFIRMED

5.1 It is the responsibility of the nurse in charge to commence an Outbreak Management Checklist to ensure that all precautions are taken, and the correct people are informed in a timely manner. (Appendix 1)

5.2 It is the responsibility of the nurse in charge to report to the IPCT immediately on suspicion of a potential outbreak, or single case as outlined in point 2.4

5.3 Ward/unit staff are required to list all NEW symptomatic patients, staff and visitors affected, including age, area/ unit where resident/working, onset of symptoms, symptoms suffered, duration of illness, and whether a stool sample/viral swab has been taken (**Appendices 2-5**). Accurate documentation of all symptomatic patients is vital in order for the IPCT to make an accurate assessment of the outbreak and plan the correct course of management.

5.4 The IPCT will inform and liaise with:
The Consultant Microbiologist.
The chair of the Infection Prevention and Control Group/Director of Infection Prevention & Control (DIPC), Consultant in Communicable Disease Control (CCDC)/(Public Health England Consultant).

5.5 The Director of Infection, Prevention and Control (DIPC) may convene an 'outbreak control meeting'. Those in attendance will be:
Consultant Microbiologist (if not already present)
Public Health England CCDC
Director of Inpatient Services
Infection prevention and control nurse
Clinical Manager
Clinical lead for the relevant area

5.6 The following representatives may also be included:

Occupational health physician and/or sister
Bed Management
Facilities and catering management
Estates & Patient transport
Representative of environmental health department where appropriate
Head of Communications & Public Involvement

5.7 **NOTE: IN ORDER TO ENSURE THE SUCCESSFUL MANAGEMENT OF AN OUTBREAK, IT IS RECOGNISED THAT IN SOME CASES SEVERAL MAJOR DECISIONS IN RELATION TO THE OUTBREAK MAY HAVE BEEN TAKEN PRIOR TO THE MEETING** e.g. closure of wards and/or premises,

SAMPLE ONLY

exclusion of individuals to work, closure of kitchens and removing staff from duty.

5.8 These decisions can be made at short notice, over the telephone, through liaison of the IPCT, Microbiologist, DIPC, Clinical Leads and Ward Manager.

6.0 WARD/UNIT CLOSURE GUIDELINES

On occasion the most effective measure to shorten an outbreak is to close the affected bay or ward to new patients thus avoiding exposing further patients to the infection.

6.1 When the IPCT has decided an outbreak of infection exists it may advise the medical director/consultant/matron/ward manager, that the ward is closed.

This means

- admissions to the ward will be stopped
- transfers to and from the ward will be stopped
- discharges from the ward will need careful consideration
- where possible staff working on this ward will not work elsewhere whilst the ward is closed
- It may be necessary to close the ward/unit to visitors. The IPCT, in liaison with the senior management team, will make this decision. On closure of the ward the nurse in charge should provide a letter for relatives detailing the reason for closure or enhanced surveillance (**Appendix 6a &6b**).

6.2 The IPCT will meet, or liaise with the relevant clinicians and managers to arrange implementation of the closure.

6.3 A sign should be placed at the entrance of the ward and, where appropriate, on the patient's room door (**Appendices 7a & 7b**) to inform staff and visitors of the situation and asking them to report to the nurse in charge before seeing a patient. Visitors should be asked to postpone their visit, or if essential for personal reasons, to make their stay as short as possible.

6.3 The situation will be monitored closely and updates issued on a regular basis. The IPCT will advise when the ward may be safely re-opened.

6.4 The IPCT will discuss measures to be taken with ward staff, Facilities and Occupational Health department staff. The Infection Prevention and Control Nurse will liaise with all departments as necessary.

6.5 Senior management are to ensure that there is adequate staffing to cope with the extra demands of managing an outbreak. Staff working in the affected ward should not work in other care establishments/wards for 48hrs after the end of the shift, until the outbreak is declared over by the IPCT.

6.6 Agency and Bank Nursing staff who normally work on unaffected wards should not be used to cover shifts on affected wards on an ad-hoc basis.

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6.7 A Deep Clean following an infectious outbreak should be undertaken; ideally 48-72hrs post resolution of the last case before re-opening the ward to admissions (see section 10.0).

6.8 Following the re-opening of the ward, IPCT will arrange a post-infection debrief with ward staff and the Facilities team to identify good practice and any opportunities for future learning.

7.0 SPECIFIC GUIDANCE FOR OUTBREAKS OF DIARRHOEA AND/OR VOMITING

7.1 Staff must report cases of a suspected D & V outbreak to the IPCT Team and their senior manager.

7.2 **Definition of an outbreak** - Two or more cases suffering from symptoms of diarrhoea and vomiting.

Nurse in charge to commence an Outbreak Management Checklist to ensure that all precautions are taken, and the correct people are informed in a timely manner. (**Appendix 1)**

7.3 Isolate symptomatic patients with their own toilet facilities, or a designated commode or toilet, if en-suite facilities are not available.

7.4 Staff should pay attention to all infection control practices, particularly the washing of hands and wearing protective clothing. New gloves and aprons must be worn for each patient.

7.5 Hand decontamination should be via liquid soap and water only as hand sanitiser is ineffective for Norovirus and Clostridium Difficile.

7.6 Patients should be encouraged to wash their hands after using the toilet and before eating.

7.7 Environmental cleaning to be increased. Particular attention should be paid to the toilets, bathrooms, door handles, support handrails and unit kitchens. For the duration of the outbreak, environmental cleaning should be performed using a disinfectant.

7.8 Stool samples should be obtained from patients and staff, on request, if they have symptoms. The microbiology form accompanying the sample should clearly state it is part of an outbreak, as this will determine which specific tests are carried out in the laboratory. If the sample is contaminated with urine it can still be sent.

Faeces can be removed from the sheet or incontinence pad if it is not possible to obtain a sample from the bedpan. **It is important to request both viral and bacterial studies on the request form.** (Samples of vomit are not suitable for testing). Staff **may** be required to take a specimen pot and will be asked to send in a sample via their GP if they are affected.

SAMPLE ONLY

7.9 Symptomatic staff must go off duty as soon as nausea and/or vomiting and diarrhoea commences, a faecal sample may be collected and taken to their GP and they must remain off work until 48 hours symptom free.

7.10 Staff must not handle food if suffering from diarrhoea. Any staff member who develops diarrhoea and/or vomiting should report this to their Manager and Occupational Health. Advice on returning to work should be sought from the Occupational Health in consultation with the microbiologist. If the staff member is a food handler then advice is also required from the Environmental Health Officer.

7.11 Visitors should be informed of the outbreak and unnecessary visits should be discouraged, especially children. Those who choose to visit should wash their hands as they enter and leave the ward and comply with all other hygiene practices in place

7.12 Patient movements from affected areas to unaffected areas should be restricted.

7.13 Patients should only be discharged 48 hours after their last symptom and with the full consent of anyone who may be required to care for them in the community

7.14 The ward should be closed to admissions until the deep clean has been completed.

7.15 Deep Clean should be done ideally 48-72hrs post resolution of the last case before re-opening the ward to admissions.

7.16 Please refer to **Appendix 11** – Outbreak Flowchart D&V

8.0 UPPER RESPIRATORY TRACT INFECTIONS AND INFLUENZA MANAGEMENT IN COMMUNITY INPATIENT SETTINGS – ACTION TO BE TAKEN BY STAFF

8.1 Staff must report cases of suspected/confirmed respiratory illness to the IPCT Team (during office hours) and their senior manager / senior manager on Call. Please refer to **Appendix 12** – Outbreak Flowchart Influenza.

8.2 **Definition of an outbreak -** Two or more cases within the same ward/unit within a 5 day period, suffering from symptoms of an upper respiratory tract infection

8.3 **Definition of influenza -** Case with suspected influenza - fever (≥38$_0$C orally) prostration, (including malaise, cough, sore throat, nasal congestion, headache, aching muscles and joint pains). However, elderly patients may not manifest fever and may exhibit atypical signs and symptoms such as anorexia or mental status changes.

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8.4 Although antiviral medication can be administered to patients for prophylaxis or treatment of influenza (see **Appendix 12 AND Appendix 14**), it must be emphasised that **vaccination is the most effective way of preventing illness from influenza** and that antivirals are not a substitute for vaccination.

8.5 The IPCT will advise the ward to take viral swabs as appropriate (see **Appendix 8** – Viral Swab Collection Guidance)
Please note: samples are unlikely to be positive more than 6 days after onset of illness and positivity falls off after 2 -3 days.

8.7 **Infection Prevention and Control Measures**
Good standard infection prevention and control precautions should be followed plus:

8.7.1 **For patients:**

- Symptomatic patients should be confined to their rooms or cohorted on the affected unit unless otherwise instructed by the IPCT.
- Commence **Appendix 4**

8.7.2 **For staff:**

- Exclude symptomatic employees until 5 days after the onset of their illness
- Commence **Appendix 5**

8.7.3 **For visitors:**

- Advise visitors not to visit the ward during an outbreak where possible.
- If symptomatic, visitors should be excluded from visiting the ward

8.7.4 **Public Health issues:**

- The IPCT will notify the Public Health England Health Protection Team of an outbreak on Trust premises.

8.8 **Prescribing Antiviral prophylaxis or treatment therapies**

8.8.1 Please follow prescribing guidelines in **Appendix 14 –** *Procedural guidelines for the treatment and prophylaxis of suspected influenza in inpatient units*

8.8.2 **During Office Hours:**
The IPCT, in conjunction with Pharmacy and Medical staff, will discuss the need for prophylaxis / treatment medication, as required. It may be necessary to close the ward (usually for 7 days) but the IPCT will advise accordingly.

8.8.3 **Out of Office Hours**
The doctor on call/duty doctor will need to assess the need/appropriateness of prescribing prophylaxis and or treatment to patients on the affected ward.

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This decision should be based on PHE prescribing Guidelines and NICE guidelines as laid out in **Appendix 12 AND Appendix 14**

8.8.4 The Trust will, where practicable, follow the PHE guidelines for prescribing Oseltamivir in outbreak situations.

8.9 **Annual influenza vaccination programmes**
This programme must be actively promoted to encourage all staff and patients to take up the opportunity of vaccination.

9.0 ADMISSIONS, TRANSFERS, DISCHARGES AND MOVEMENTS BETWEEN DEPARTMENTS AND OTHER HEALTH CARE FACILITIES

9.1 **Admissions into the Trust**
On admission, an Infection Control Risk Assessment must be completed by nursing staff, within two hours of the admission. **Appendix 10:** EPUT Infection Risk on Admission/Transfer Form

9.2 Patients with a known or suspected infection will be considered for admission to the care of the Trust, in consultation with the IPCT, when the following criteria are met:

9.3 Adequate isolation facilities are available.

9.4 In the case of a patient with diarrhoea of unknown origin, or known infectious cause, admission will be declined until such time that the patient has had a formed stool for 48 hours. In the event of an emergency admission being required, there must be consultation prior to admission to ensure that the adequate isolation facilities are available.

9.5 In the domiciliary setting (that is the patient's own home or a care home), cases will be assessed on an individual basis, so as to ensure other patients and staff are not put at unnecessary risk.

9.6 **Transfers/ Discharges in and out of the Trust**
When adequate isolation facilities are not available, the Trust will look to find an alternative either within its own resources or in negotiation with the acute providers (with patient and family involvement).

9.7 In addition; in the case of a patient with diarrhoea of unknown origin, or known infectious cause, the patient will not be transferred *within or out of* the Trust, unless the patient's clinical condition dictates and that there is clear communication to the receiving area.

9.8 Prior to any transfer to another healthcare facility (including SEPT facilities), an Infection Risk on Admission/Transfer Form must be completed to inform the accepting facility of any existing infection risk. A copy of this completed form should be kept in the patient's folder.

Appendix 10: EPUT Infection Risk on Admission/Transfer Form

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9.9 If a patient suffers from an infectious disease or a Health Care Associated Infection whilst in the care of the Trust, the patient will receive clear information about their infection, and any appropriate after care. For further support contact the IPCT.

10.0 RE-OPENING WARD/UNIT GUIDELINES

10.1 An outbreak can be declared as resolved when there have been no new cases in staff and patients for 48 hours.

10.2 The IPCT will liaise with the Facilities Supervisor/Officer and the relevant Matron/ward sister regarding planning the deep clean.

10.3 Patients should not be admitted to the ward during the deep clean process.

10.4 Once the decision has been made to deep clean the ward, patients can be discharged home, back to residential care or transferred to other wards.

10.5 The ward must not be declared open until the deep clean is completed to a satisfactory standard

10.6 The IPCT will inform all relevant personnel to notify them that the ward/unit has re-opened.

10.7 Following the re-opening of the ward, IPCT will arrange a post-infection debrief with ward staff and the Facilities team to identify good practice and any opportunities for future learning.

11. OUTBREAKS NOT CONFINED TO AN INDIVIDUAL SITE AND / OR AN OUTBREAK OF MAJOR IMPORTANCE

11.1 The decision that an outbreak is a major incident takes into consideration the number of people involved and the pathogenicity of the organism and potential for transmission within the hospital or community.

11.2 A **single** case of a viral haemorrhagic fever, hospital-acquired legionellosis or diphtheria is a major incident.

11.3 Several hospital patients having linked symptoms and therefore suspected of having the same infection, e.g. food poisoning, also constitute a major outbreak of infection

11.4 The Infection Control Doctor will inform the IPC Team and DIPC that the Major Outbreak Control Group (MOCG) should be convened.

11.5 Major Outbreak Control Group (MOCG): This group is convened in the event of a major outbreak. The decision to convene an MOCG will depend upon the number of cases affected and at risk, the pathogenicity of the organism and the potential or transmission within EPUT and wider community.

11.6 This group will be convened in the event of a single case of Viral Haemorrhagic Fever, diphtheria or Hospital acquired Legionellosis.

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11.7 This group would also be appropriate if food poisoning occurs in hospitalised patients and in major outbreaks of pandemic influenza, and other notifiable conditions such as meningitis or Invasive Group A Streptococcus.

11.8 The group should include the following staff:
- Director of Nursing (DIPC)
- Head of Infection Prevention & Control
- Director for relevant service
- Head of Nursing / Matron for clinical area
- Communications
- Facilities representative (inpatient)
- Infection control Doctor
- CCG representative.
- Occupational health provider representative
- Head of Risk Management
- Clerical Support

Depending on the pathogen / severity the below people may also be included in the group:
- The Consultant in Communicable Disease Control (CCDC) or deputy;
- Director of the Public Health England SW Regional Laboratory (particularly if providing additional laboratory assistance);
- A representative from the Health and Safety Executive;
- Outbreak of Infection: Policy for Management and Control V4 9 May 2015
- Environmental Health Officer (if the infection is likely to be food or water-borne).

12. MANAGEMENT OF OUTBREAKS RELATING TO A PANDEMIC

12.1 In the event of a Pandemic, caused by organisms such as Coronavirus or Influenza, specific guidance will be issued, as appropriate, relating to the management thereof, by Public Health England in conjunction with the Department of Health

12.2 The IPC team will review all guidance issued by PHE and disseminate as appropriate.

12.3 All new guidance should be used in conjunction with existing Infection Prevention and Control guidance and the principles of pandemic management within the Trust's Influenza Pandemic Plan.

12.4 Please see Appendix 15 – Coronavirus Outbreak Management Process

13.0 REFERENCES

Public Health England (2014) Communicable Disease Outbreak Management

Public Health England (2018), PHE guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza

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