University Hospitals of Derby and Burton NHS Foundation Trust

OUTBREAK MANAGEMENT POLICY

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	1	July 2011	H. Forrest	Original Policy
	1.1	May 2015	H. Forrest	Review and Update
	1.2	July 2017	H. Forrest	Review as part of IPC Policy review
	2	March 2019	H. Forrest	Amalgamation of Burton and Derby policies
	2.1	May 2022	J. Halliwell	Reviewed as part of IPC policy review.
	2.2	June 2023	J. Halliwell	Policy review and minor update
Intended Recipients: All medical and clinical staff, Divisional Medical Directors, Service Managers, Divisional Nurse Directors, Clinical Governance Facilitators, and Matrons.				
Training and Dissemination: Dissemination via the Trust Intranet.				
To be read in conjunction with: National Infection Prevention and Control Manual for England UHDB policy and Infection Prevention and Control UHDB policy				
In consultation with and Date:				

Infection Control Operational Group (21st June 2023) Infection Prevention and Control Group (29th June 2023)	
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Approving Body and Date Approved	Infection Prevention and Control Group
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Contact for Review	Deputy Head Infection Prevention and Control (Acute)
Executive Lead Signature	Executive Chief Nurse, Director of Infection Prevention and Control
Approving Executive Signature	

OUTBREAK MANAGEMENT POLICY

1.0 Introduction

Outbreaks of infection may vary in extent and severity ranging from a few cases to a large number of people e.g., viral gastroenteritis or food poisoning cases affecting hundreds of people.

Highly communicable respiratory viral diseases are easily spread. Coronavirus, Influenza A, etc. emerge at intervals from unpredictable combinations of human and animals and are responsible for epidemics and pandemics. They are of importance due to the rapidity with which epidemics evolve, and the seriousness of complications in debilitated people.

Recognition of an outbreak may be difficult; therefore, medical and nursing staff must be vigilant at all times and report any suspected infection to infection prevention and control without delay.

A major outbreak depends not only on the number of people affected, but also on the pathogenicity of the causative organism and its potential for spread in a community, or beyond one ward or department.

An outbreak may be defined as:

- Two or more persons with the same disease or symptoms or the same organism isolated from a diagnostic sample, which are linked through common exposure, personal characteristics, time or location.
- A greater than expected rate of infection compared with the usual background rate for the particular population and period.
- A single case of certain diseases such as diphtheria, rabies, poliomyelitis or viral haemorrhagic fever, may lead to initiation of the major outbreak plan, although not technically an outbreak.

2.0 Purpose and outcomes

The purpose of the policy is to identify procedures for management of outbreaks of infectious diseases to prevent further transmission of suspected or confirmed infections.

Implementation of the policy will ensure:

- Prompt identification of a potential / actual outbreak
- Prompt action in the event of an outbreak of any communicable disease.
- Ensure communications between Trust senior management teams and other agencies with advice from UK Health Security Agency (UKHSA) local Health Protection Team.
- Prevent further spread or recurrence.

3.0 Definitions used

Communicable Disease	A communicable disease is a disease that spreads from person to person.
Outbreak	➢ An incident affecting two or more people thought to have a common exposure to a potential source, in which they experience similar illness or proven infection. ➢ A rate of infection or illness above the expected rate for that place and time, where spread is occurring through cross infection, or person-to-person. ➢ A single case of certain diseases such as diphtheria, rabies, poliomyelitis or viral haemorrhagic fever, may lead to initiation of the major outbreak plan, although not technically an outbreak.
Pathogenicity	The ability to produce pathological changes or disease

4.0 Implementation of the outbreak control policy

4.1 Recognition of an outbreak

Outbreaks may be identified in the laboratory or by healthcare workers in the clinical areas, particularly if the onset is rapid and affects a significant number of patients.

Healthcare workers must contact a member of the Infection Prevention and Control Team as soon as they suspect an outbreak situation is developing in a clinical area or amongst hospital staff.

4.2 Investigation of a suspected outbreak

When a possible outbreak has been recognised, the Infection Prevention and Control team will support the clinical / non-clinical team to manage the outbreak. The Infection Prevention and Control Team will take immediate steps to collect information, from all sources to determine whether an outbreak is occurring. The information gathered allows an assessment of the severity of the problem and initiation of immediate control measures.

If it is found that no outbreak exists staff will be reassured, and care taken to ensure that they are not discouraged from further reporting in the future. If necessary, the IPCT will continue surveillance in the area.

The Director of Infection Prevention and Control (DIPaC) will be appraised of the situation, the measures taken / required and any escalations for support.

4.3 Actions to be taken if an outbreak exists

Initial assessment will determine if an Outbreak Control Group needs to be convened, if deemed necessary this will be convened by the Head of Infection Prevention & Control, or designated deputy.

If the outbreak is not considered to be a major outbreak the OCG generally consists of:

- Director of Nursing
- Head of / Lead Nurse Infection Prevention and Control
- Infection Control Doctor / Consultant Microbiologist
- A Senior Nurse and/or Matron from the area concerned
- Medical representative from the area concerned.
- Facilities Management
- Support services co-opted as required e.g., Housekeeping Services
- Microbiology laboratory representative.
- Occupational Health representative
- Patient flow team representative.
- Communications team
- Flexible staffing representative

For certain specific illnesses which have a major impact on public health the UK Health Security Agency (UKHSA) Consultant for Communicable Disease Control (CCDC) / local Health Protection Team (HPT) will be invited to be a member of the OCG.

All the available information is presented to the group and further action to be taken agreed. In the case of small outbreaks, the OCG may not need to meet again. A representative of the Infection Prevention and Control Team will attend the daily operation management meetings, as necessary, and advise accordingly.

The Infection Prevention and Control team will be responsible for minuting the meeting.

At the end of the outbreak a short-written report will be produced by the Infection Prevention and Control Team and circulated to all members of the OCG and the Trust Infection Prevention and Control Group. This report may assist in surveillance and in informing staff where lessons can be learnt for the future.

4.4 Actions to be taken if a major outbreak exists

The Infection Prevention and Control Team, specifically the Head / Deputy Head of Infection Prevention and Control and / or the Infection Control Doctor, supported by the DIPaC, will determine if a major outbreak exists, with

assistance from the clinical / non-clinical teams and UKHSA. The number of people involved will be considered, but also, more importantly, the pathogenicity of the organism and its potential for spread within the hospital and the community, disruption to the service, and / or public concern / media interest.

Where there is any doubt as to whether a major outbreak is in process the full procedure should be instigated. The Consultant in Communicable Disease Control, (CCDC) has a statutory duty to inform the Chief Medical Officer of any major outbreak and has the responsibility to communicate and consult with the PHE Centre for Infectious Disease Surveillance and Control (CIDSC).

Once a major outbreak has been identified the DIPaC, or identified deputy, will immediately convene a Major Outbreak Control Group (MOCG). In addition to the members of the OCG further specialist help may be co-opted depending on the nature of the outbreak.

The following members should be considered:

- Director of Infection Prevention and Control
- Director of Nursing
- Head of / Deputy Head of Infection Prevention & Control
- Infection Control Doctor / Consultant Microbiologist
- Consultant in Communicable Disease Control / local HPT representative.
- Regional NHSEI IPC Lead
- Medical and nursing representation from the area concerned.
- Representatives from the Divisional Management Team for the clinical services affected by the outbreak.
- Operations / Patient flow team representative
- Head of Communications and Public Relations
- Occupational Health
- Senior Pharmacist / Antimicrobial pharmacist
- Facilities Management
- Chief Environmental Health Officer (if the infection is likely to be food or water borne)
- Health and Safety Manager
- Microbiology laboratory representative
- Senior Contracted Services Managers e.g. Housekeeping, Catering, Portering, laundry, Sterile Services, as determined by Facilities Management
- Flexible staffing

A deputy must represent any member who cannot be present. The DIPaC or deputy will chair the MOCG. Administration support will be provided by the Infection Prevention and Control Team / Corporate Nursing.

4.5 Functions of the M.O.C.G.

1. To confirm the Major Outbreak Control, to agree frequency of meetings and to record the reasons for its implementation.
2. To take necessary steps for the continuing clinical care of the patients during the outbreak.
3. To clarify resource implications of the outbreak and its management, and how they will be met, e.g., additional supplies and staff.
4. To agree and co-ordinate policy decisions on the investigation and control of the outbreak and ensure they are implemented, allocating responsibility to specific individuals who will then be responsible for taking action.
5. To determine what control measures may be necessary in order to control the outbreak which may cause major disruption to the normal functioning of the hospital e.g., ward closures to admission, restricted patient transfer, redirection of resources.
6. To consider the need for outside help and expertise.
7. To ensure that adequate communication channels are established, including nominating responsibility for making statements to the media throughout the duration of the outbreak.
8. To provide clear instructions and / or information for ward staff and others including contracted staff.
9. To determine if any aspects of the MAJAX Plan or the business continuity plans needs to be utilised.
10. To agree arrangements for providing information to patients, relatives and visitors.
11. To agree arrangements for visiting in the outbreak area.
12. To ensure communications with NHSEI and the relevant Integrated Care Board (ICB). The CCDC will notify the Centre for Infectious Disease Surveillance and Control (CIDSC).
13. To meet frequently to review progress on outbreak investigation and control.
14. To define the end of the outbreak and evaluate the lessons learnt.
15. To prepare a preliminary report and any subsequent reports
16. At the conclusion of the outbreak, if required, the MOCG will hold a debriefing meeting and the Head of / Lead Nurse Infection prevention and Control will present a report for the next meeting of the Infection Prevention and Control Group.
17. To inform others inside and outside the hospital the lessons to be learnt from the outbreak.

4.6 Infection Prevention and Control measures to be considered

- Isolation /cohorting of infected patients
- Restriction of movements of staff and/or patients to other wards/departments and transfers to nursing/residential homes or peripheral hospitals to prevent further disease transmission
- Exclusion from the area of symptomatic staff
- Restriction of visitors
- Restriction of admissions; discharges home with care packages and transfers to other care providers.
- Establish communications with the Matrons, multidisciplinary team and contract staff
- Provision of documented control measures as appropriate
- The IPCT will advise clinical areas on specimens required - nature, collection and transport.
- Provision of information leaflets for patients, carers and visitors
- The IPCT will advise managers to arrange for enhanced environmental cleaning by domestic staff, and enhanced decontamination of clinical equipment by nursing staff using appropriate decontamination products.

4.7 Closure of wards / departments

When infected patients, potentially infected and non-infected patients cannot be managed safely on the same ward because of the risk of spread of infection, partial or complete closure of the ward or Department must be considered.

Continued liaison between ward / department staff and Infection Prevention and Control is essential.

Each individual situation is different and must be managed on individual circumstances and will be reviewed daily, by the IPCT, as a minimum, or more frequently as required.

Some wards are more difficult to close than others e.g., ICU, CCU, speciality areas. Early advice from the Infection Control Doctor / Consultant Microbiologists must always be taken. The decision to convene an Outbreak Control Group may be made earlier in high-risk situations.

Ward / bay closure to new admissions may need to be considered on the basis of a risk assessment. Factors influencing consideration of ward closure are:

- The risk status of patients to be admitted e.g., elective orthopaedic in the case of MRSA.
- Number of cases /severity /deaths.
- Organism strain / type / DNA fingerprint, clostridium difficile ribotype
- Availability of alternative facilities
- Staffing issues.

4.7.1 Rationale for bay closure

The decision to close individual bays on a ward but to allow the rest to remain open may be made by the Infection Prevention and Control Team, in liaison with Consultant Microbiologists and the clinical teams.

4.7.2 Rationale for ward closure

The decision to close a ward will be made by the Infection Prevention and Control Team. This may be the only acceptable way to bring the situation rapidly under control.

The Infection Prevention and Control Team will escalate the decision for ward closure to relevant clinicians, including Divisional Nurse Directors, Matrons and the patient's clinical teams.

A closed ward means no admissions from anywhere, transfers or discharges to another ward or healthcare facility.

The exceptions are when patients are fit for discharge to their own home, or in the case of extreme medical need, e.g., transfer to ICU or if the risk of not being cared for in their own speciality outweighs the risk of exposure to the infectious agent. The speciality Consultant in charge of the patient will make this decision.

4.7.3 Transfer of patients to other departments/discharges

Patients who are cared for in a ward or department that has been closed may require tests, procedures or appointments outside the affected ward / department. A risk assessment should be performed, taking into account the following:

- Whether the patient involved has symptoms
- How urgent the procedure is or can it safely be postponed.
- Whether appropriate precautions can be taken by transport and the receiving department.
- Whether the patient can have their investigation or procedure on the ward.

If it is decided the transfer is necessary, the receiving department must be informed in advance so that they can make necessary precaution arrangements.

If an asymptomatic patient is to be discharged to their own home a full explanation of the condition should be given to them and or carers about any symptoms, they should be aware of which may indicate they were incubating the infection or that it has re-occurred.

The community Infection Prevention and Control team should be contacted if a patient is to be discharged to a nursing / residential home. In this circumstance a

single room may be required on discharge to ensure the patient is not incubating the infection. (Depending on the organisms / infection involved).

4.8 Communication

- The decision to close a ward to admissions / transfer will be communicated at the relevant site operations meeting
- The Infection Prevention and Control Team will communicate the decision to close a ward, with regular updates whilst the ward is closed, along with associated control measures throughout the organisation.
- The Communications department will produce a press statement if required

4.9 Re-opening to new admissions

The ward can be re-opened when there is evidence that the outbreak has been contained and on-going transmission halted.

For Example:

- Infected / co-horted patients have all been discharged or moved to adequate isolation facilities.
- Transmission of infection has ceased e.g. no new cases of viral gastro-enteritis in 48 hours.

If a major outbreak, the Outbreak Control Group will make the decision when to re-open, otherwise the Infection Prevention and Control Team will make the decision in conjunction with the clinical team.

Prior to re-opening the bays / ward must be thoroughly cleaned to the level advised by the Infection Prevention and Control Team.

5.0 Monitoring compliance and effectiveness

Monitoring Requirement:	The management of outbreak situations will be constantly monitored by the outbreak control group / major outbreak control group and the infection prevention & control team Closure of wards to communicable disease are reported to the ICB The IPCT will monitor compliance with the management of patients with diarrhoea and vomiting during daily ward reviews Any non-compliance issues will be reported to the division Matron or the site manager as appropriate.
Monitoring Method:	Incidents where non-compliance with this policy is noted should be reported via the incident reporting system. Incidents pertaining to Infection Prevention and Control are monitored at the Infection Prevention and Control Group

	Following the conclusion of an outbreak a report will be presented to Infection Prevention and Control Group
Report Prepared by:	IPCT
Monitoring Report presented to:	Infection Prevention and Control Group
Frequency of Report	As required

6.0 References

Public Health England (2014). Communicable Disease Outbreak Management. Operational Guidance

Norovirus Working Pa (2012). Guidelines for the management of Norovirus outbreaks in acute and community health and social care settings.

Department of Health (1995) Hospital Infection Control: Guidance on the control of infections in hospital. PHLS

Hawker. J, Begg. N, Blair. R, Weinberg. J & Ekdahl. K (2012). Communicable Disease Control Handbook. 3rd Edition. Oxford.