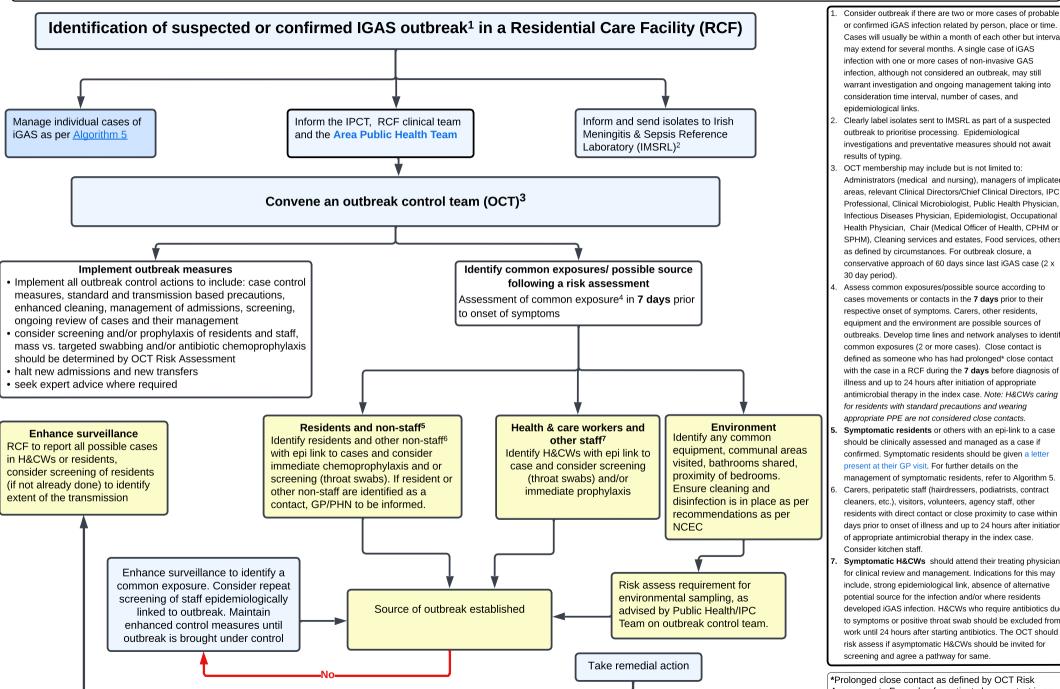
Algorithm 6: Identification and Management of suspected or confirmed IGAS outbreak¹ in a Residential Care Facility Version 1.1 23/01/2024



- or confirmed iGAS infection related by person, place or time. Cases will usually be within a month of each other but interval may extend for several months. A single case of iGAS infection with one or more cases of non-invasive GAS infection, although not considered an outbreak, may still warrant investigation and ongoing management taking into consideration time interval, number of cases, and
- Clearly label isolates sent to IMSRL as part of a suspected outbreak to prioritise processing. Epidemiological investigations and preventative measures should not await
- 3. OCT membership may include but is not limited to: Administrators (medical and nursing), managers of implicated areas, relevant Clinical Directors/Chief Clinical Directors, IPC Professional, Clinical Microbiologist, Public Health Physician, Infectious Diseases Physician, Epidemiologist, Occupational Health Physician, Chair (Medical Officer of Health, CPHM or SPHM), Cleaning services and estates, Food services, others as defined by circumstances. For outbreak closure, a conservative approach of 60 days since last iGAS case (2 x
- Assess common exposures/possible source according to cases movements or contacts in the 7 days prior to their respective onset of symptoms. Carers, other residents, equipment and the environment are possible sources of outbreaks. Develop time lines and network analyses to identify common exposures (2 or more cases). Close contact is defined as someone who has had prolonged* close contact with the case in a RCF during the 7 days before diagnosis of illness and up to 24 hours after initiation of appropriate antimicrobial therapy in the index case. Note: H&CWs caring for residents with standard precautions and wearing appropriate PPE are not considered close contacts.
- 5. Symptomatic residents or others with an epi-link to a case should be clinically assessed and managed as a case if confirmed. Symptomatic residents should be given a letter present at their GP visit. For further details on the management of symptomatic residents, refer to Algorithm 5.
- 6. Carers, peripatetic staff (hairdressers, podiatrists, contract cleaners, etc.), visitors, volunteers, agency staff, other residents with direct contact or close proximity to case within 7 days prior to onset of illness and up to 24 hours after initiation of appropriate antimicrobial therapy in the index case.
- 7. Symptomatic H&CWs should attend their treating physician for clinical review and management. Indications for this may include, strong epidemiological link, absence of alternative potential source for the infection and/or where residents developed iGAS infection. H&CWs who require antibiotics due to symptoms or positive throat swab should be excluded from work until 24 hours after starting antibiotics. The OCT should risk assess if asymptomatic H&CWs should be invited for screening and agree a pathway for same.

*Prolonged close contact as defined by OCT Risk Assessment. Example of a patient close contact is an individual who has an overnight stay in the same room/bay as the case.