Algorithm 6: Identification and Management of suspected or confirmed IGAS outbreak[1] in a Residential Care Facility
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Identification of suspected or confirmed IGAS outbreak[1] in a Residential Care Facility (RCF)

Manage individual cases of iGAS as per Algorithm 5

Inform the IPCT, RCF clinical team and the **Area Public Health Team**

Inform and send isolates to Irish Meningitis & Sepsis Reference Laboratory (IMSRL)[2]

Convene an outbreak control team (OCT)[3]

Implement outbreak measures
- Implement all outbreak control actions to include: case control measures, standard and transmission based precautions, enhanced cleaning, management of admissions, screening, ongoing review of cases and their management
- consider screening and/or prophylaxis of residents and staff, mass vs. targeted swabbing and/or antibiotic chemoprophylaxis should be determined by OCT Risk Assessment
- halt new admissions and new transfers
- seek expert advice where required

Identify common exposures/ possible source following a risk assessment

Assessment of common exposure[4] in **7 days** prior to onset of symptoms

Enhance surveillance
RCF to report all possible cases in H&CWs or residents, consider screening of residents (if not already done) to identify extent of the transmission

Residents and non-staff[5]
Identify residents and other non-staff[6] with epi link to cases and consider immediate chemoprophylaxis and or screening (throat swabs). If resident or other non-staff are identified as a contact, GP/PHN to be informed.

Health & care workers and other staff[7]
Identify H&CWs with epi link to case and consider screening (throat swabs) and/or immediate prophylaxis

Environment
Identify any common equipment, communal areas visited, bathrooms shared, proximity of bedrooms. Ensure cleaning and disinfection is in place as per recommendations as per NCEC

Enhance surveillance to identify a common exposure. Consider repeat screening of staff epidemiologically linked to outbreak. Maintain enhanced control measures until outbreak is brought under control

Source of outbreak established

Risk assess requirement for environmental sampling, as advised by Public Health/IPC Team on outbreak control team.

No

Take remedial action

1. Consider outbreak if there are two or more cases of probable 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 epidemiological links.
2. Clearly label isolates sent to IMSRL as part of a suspected outbreak to prioritise processing. Epidemiological investigations and preventative measures should not await results of typing.
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 30 day period).
4. 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. Consider kitchen staff.
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.