

Control of an Outbreak of Infection in Hospital

Infection Prevention and Control Policy No 14

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EXECUTIVE SUMMARY

Scope

This policy applies to:

All staff employed by the LTHT.

All students practicing within LTHT.

Key Points:

- It is essential that all staff are vigilant and if an outbreak is suspected that it is immediately reported to the Infection Prevention and Control Team.
- Clinical staff should liaise with the Infection Prevention and Control Team in the gathering of information relating to the outbreak.
- If appropriate, following an initial assessment, an outbreak control group will be called.
- The people involved in the outbreak control group will depend on the size and nature of the outbreak.
- The outbreak control group will co-ordinate the investigation and management of the outbreak.
- Any control measures agreed by the outbreak control group e.g. isolation of patients or ward restriction, should be communicated to all necessary people in the Trust to ensure implementation.
- At the end of the outbreak a report will be written and circulated in order that lessons can be learned for future practice.

1 INTRODUCTION

The occurrence of outbreaks of infection in hospitals vary greatly in extent and severity, ranging from a few cases of urinary tract infection to a large outbreak of food poisoning potentially involving hundreds of people.

The majority of infection problems are dealt with on a day-to-day basis by the clinical area involved, in conjunction with the Infection Prevention and Control Team (IPCT).

However, in cases of serious communicable disease, major outbreaks or where there is increased potential for spread, it is necessary for further action to be taken.

This policy intentionally does not specify the types of infection or the numbers of cases that constitutes an outbreak, this will be decided by a risk assessment on a case by case basis by the Infection Prevention and Control Team (IPCT)

However, an outbreak could be defined as a situation where the observed number of cases of an organism in a particular ward or department exceeds the expected number for that area.

2 PURPOSE

The purpose of this policy is to ensure the rapid detection and early management of outbreaks within the LTHT in order to minimise the spread of infection to other patients.

Failure to follow this policy could result in the instigation of disciplinary procedures.

3 DEFINITIONS

Infection Control Doctor - for the purpose of this policy this is the Lead Infection Control Doctor or a designated deputy (e.g. Divisional or other microbiologist)

IPCT – Infection Prevention & Control Team

Outbreak - a situation where the observed number of cases of an organism in a particular ward or department exceeds the expected number for that area.

4 DUTIES

4.1 Duties within the Organisation

As a healthcare establishment, LTHT has a duty of care that is covered by the Health and Safety Act (1974) (HSE 2003), COSHH (HSE 2005) and The Health Act (DH 2006). This is covered in core duties 1, 2 and 3 of this Act.

4.2 Consultation and Communication with Stakeholders

The Infection Prevention and Control Committee, The Chief Nurse Team and The Infection Prevention Team have commented on and contributed to this policy. The policy will be approved by the Infection Prevention and Control Committee and the Senior Management Team.

5 RECOGNITION OF AN OUTBREAK

- The rapid recognition of outbreaks is one of the most important objectives of routine surveillance.
- Outbreaks may be identified in the laboratory or by nursing and medical staff in the clinical areas; particularly if the onset is rapid and affects a significant number of patients.
- Some outbreaks can present suddenly affecting larger numbers of individuals before detection
- All staff should be vigilant and report any suspicions of an outbreak to the Infection Prevention and Control Team (IPCT) immediately

N.B. If the disease is notifiable by law, the medical staff responsible for the patient must also notify the Medical Officer for Environmental Health (MOEH)/Consultant for Communicable Disease Control (CCDC) on the appropriate form. (Please see Infection Control policy Notification of Communicable Diseases).

6 INVESTIGATION OF A SUSPECTED OUTBREAK

- When a possible outbreak has been identified, it is the responsibility of the Infection Prevention and Control Team (IPCT) to investigate further.
- Members of the IPCT will take immediate steps to collect information from all sources to determine whether an outbreak is occurring. This will include the number of individuals affected, symptoms, likely source and mode of spread.
- 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, ward staff will be reassured and care taken to ensure that they are not discouraged from further reporting in the future.

7 ACTION TO BE TAKEN IF AN OUTBREAK EXISTS

Initial outbreak to be discussed directly with and supported by the Divisional General Manager (DGM) and:

- Divisional Medical Manager
- Divisional Nurse
- Directorate Manager

as delegated by the DGM

The initial assessment will determine if an Outbreak Control Group (OCG) needs to be convened.

- If the outbreak is not considered a “Major Outbreak”, the OCG generally consists (at a minimum) of:

- Infection Control Doctor (ICD)
 - Infection Prevention and Control Nurse(s)
 - A Manager representing the Chief Executive
 - Relevant clinician(s)
 - Matron from the affected area
- The outbreak control group is chaired by the ICD.
 - Clerical and administrative support is provided by the relevant clinical team, who are also responsible for minuting the meetings.
 - At the meeting, all the relevant information is presented to the group and an action plan drawn up.
 - In the case of small outbreaks, the OCG may not need to meet again. However, in larger outbreaks follow-up meetings will be required, to monitor the progress of the outbreak and to monitor compliance with agreed actions.
 - The ICD will be responsible for deciding when the outbreak is “closed” and will inform all the necessary individuals.
 - At the end of the outbreak, a short written report will be produced and presented at the Infection Prevention and Control Committee (IPCC). This will assist in surveillance and also in informing staff where lessons can be learnt for the future. The doctor responsible for leading the outbreak investigation will decide who will produce the report.

8 ACTION TO BE TAKEN IF A MAJOR OUTBREAK EXISTS

- The outbreak control group chair will liaise with the IPC team and Lead ICD to determine whether the outbreak constitutes a “major outbreak”. This will be based on a number of criteria, including the number of cases, the pathogenicity of the organism, its potential for spread within the hospital and community, and the likely overall impact of the outbreak on the Trust and surrounding area.

A **Major Outbreak Control Group (MOCG)** will be called, which should consist of the members of a normal OCG and some or all of the following (depending on the nature of the outbreak):

- Director of Infection Prevention and Control
- Additional Hospital Management staff (including clerical support).
- Medical Director.
- Chief Nurse or designated representative
- An Infectious Diseases Physician.
- Occupational Health Doctor (or Nurse).
- Regional Microbiologist
- Consultant in Communicable Disease Control (particularly if the outbreak has implications for individuals outside of the hospital)

- Environmental Health Officer (if the infection is likely to be food or water-borne)
- Regional Epidemiologist.
- Representative from Health and Safety Executive (HSE).
- Senior Manager Estates.
- Director of Operations.
- Head of Hotel Services
- Admissions Co-ordinator.
- Public Relations Representative.
- Microbiology trainee.

Appendix B highlights other key people who may need to be informed in the event of a major outbreak

9 FUNCTIONS OF THE MAJOR OUTBREAK CONTROL GROUP

- To agree a case definition. (what constitutes a genuine case)
- To take all necessary steps for the continuing clinical care of patients during the outbreak.
- To clarify the resource implications of the outbreak and its management, and how they will be met, e.g. additional supplies and staff (particularly nurses, doctors and laboratory staff).
- 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.
- To consider the need for outside help and expertise.
- To ensure that adequate communication channels are established, including nominating responsibility for making statements to the news media throughout the duration of the outbreak.
- To consider the need for a help line (contact head of telecommunications).
- To provide clear instructions and/or information for ward staff and others including contracted staff.
- To agree arrangements for providing information to patients, relatives and visitors.
- To ensure communications with the Department of Health, NHS Executive Regional Offices.
- To ensure that the outbreak is reported as a Serious Untoward Incident.
- To meet frequently to review progress on outbreak investigation and control.
- To define the end of the outbreak and evaluate the lessons learned.
- To prepare interim reports (detailed minutes of OCG meetings) and also a final report.
- To inform others inside and outside the hospital, of lessons to be learned from the outbreak.
- The Lead ICD will take responsibility for production and distribution of any reports and will also decide when the outbreak is "closed".

10 RESPONSIBILITY FOR DOCUMENT DEVELOPMENT

Lead Director: Ruth Holt, Director of Infection Prevention and Control

Membership of the Steering Group:

Sue Horvath

Gillian Hodgson

Richard Hobson

Consultation through Infection Prevention and Control Committee

11 EQUALITY IMPACT ASSESSMENT

The Policy has been assessed for its impact upon equality, Appendix A. The Leeds Teaching Hospitals Trust is committed to ensuring that the way that we provide services and the way we recruit and treat staff reflect individual needs, promote equality and does not discriminate unfairly against any particular individual or group.

12 IDENTIFICATION OF STAKEHOLDERS

The key stakeholders in this policy are staff involved in caring for patients with known or suspected infections and managers responsible for the provision of facilities for this patient group.

13 CONSULTATION PROCESS

This policy will be consulted on by the Infection Prevention and Control Committee and its sub groups and the Chief Nurse Team.

14 APPROVAL AND RATIFICATION

This policy will be approved by the Senior Management Team.

15 PROCESS FOR REVIEW/REVISION OF THIS POLICY

This policy will be reviewed two years from the date of approval or following significant changes in the management of patients with known or suspected infection.

16 COMMUNICATION/DISSEMINATION OF THIS POLICY

Directors – communication directly by e-mail and discussion at TMB
Senior operational and corporate managers – communication directly by e-mail and to be notified by Directors through line management briefing
All staff – Trust communications channels including e-Bulletin

17 IMPLEMENTATION OF THIS POLICY

This policy will be implemented immediately following dissemination.

18 PROCESS FOR MONITORING COMPLIANCE/EFFECTIVENESS

Monitor number of outbreaks and ensure length of outbreak and number of individuals involved is kept to a minimum.

Monitor and audit outbreak documentation to ensure all actions are appropriately completed and outbreak is appropriately managed

19 REFERENCES/ASSOCIATED DOCUMENTATION

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

Philpott-Howard J. & Casewell M. (1994) Hospital Infection Control – Policies and Practical Procedures. Saunders, London.

Appendix A - EQUALITIES IMPACT ASSESSMENT

Section 1 Screening				
<p>Does this policy or procedure impact on staff patients or public? S = Staff PA = Patients PU = Public</p> <p>(enter below)</p>	<p>How relevant is the policy to achieving the duties under race legislation?</p> <p>0 = none 1 = a little 2 = some 3 = very</p> <p>(enter below)</p>	<p>How relevant is the policy to achieving the duties under disability legislation</p> <p>0 = none 1 = a little 2 = some 3 = very</p> <p>(enter below)</p>	<p>How relevant is the policy to achieving the duties under gender legislation</p> <p>0 = none 1 = a little 2 = some 3 = very</p> <p>(enter below)</p>	<p>Could this policy disadvantage any group due to Race, Disability or Gender</p> <p>R = Race D = Disability G = Gender N = None</p> <p>(enter below)</p>
S, PA, PU	0	0	0	N
Section 2 Assessing impact				
<p>Please specify in the relevant box any thing that you have included in the policy which helps to meet the Race Disability or Gender Equality Duties*</p> <p>Please put NA if this is not applicable</p>	Race	Disability	Gender	
	The policy is inclusive and applies to all patients	The policy is inclusive and applies to all patients	The policy is inclusive and applies to all patients	

* The equality duty is to eliminate unlawful discrimination and promote equality of opportunity and good relations between different groups.

Appendix B

Key people to inform in the event of a major outbreak:

Clinical departments:

- Junior and senior medical staff.
- Nursing services.
- X-ray.
- Other laboratories.

Clinical support services:

- Pharmacy.
- Physiotherapy.
- Occupational therapy.
- Occupational health.

Ambulance and Transport Services

Hotel Services

- HSDU.
- Domestic services manager or other appropriate services manager.
- Laundry manager.
- Linen room manager.
- Catering manager or other appropriate services manager.

Others:

- GPs.
- Local NHS Trusts.
- Medical School, Schools of Nursing, Physiotherapy etc.
- Nursing agencies.
- Senior nurse (community).
- Social services.
- Union and staff representatives.
- Switchboard.
- Voluntary services.
- Media.
- Insurance co-ordinator, if appropriate.

National Bodies:

- Communicable Disease Surveillance Centre
- NHS Executive Regional Office
- Department of Health

Appendix C - Checklist for the Review and Approval of Policy

To be completed and attached to the policy when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/Unsure	Comments
1.	Title		
	Is the title clear and unambiguous? Is it positively named in respect of the behaviour, actions, established position it seeks to achieve?	Yes	
	Is it clear whether the document is a policy, guideline, protocol or standard?	Yes	
2.	Rationale		
	Are reasons for development of the document stated?	Yes	
3.	Development Process		
	Is the method described in brief?		
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	Content		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	

	Title of document being reviewed:	Yes/No/Unsure	Comments
	Are supporting documents referenced?	N/A	
6.	Approval		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	Dissemination and Implementation		
	Is there a communications plan to identify how this will be done?	No	
	Does the implementation plan include the necessary training/support to ensure compliance?	N/A	
8.	Document Control		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	Process to Monitor Compliance and Effectiveness		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Not sure	
10.	Review Date		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	Overall Responsibility for the Document		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name	Sue Horvath	Date	10 November 2008
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	
Signature			