

MAJOR OUTBREAK PLAN

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<p>Controlled document</p> <p>This document has been created following the Royal Devon and Exeter NHS Foundation Trust Policies, Procedures, Protocols, Guidelines and Standards Policy. It should not be altered in any way without the express permission of the author or their representative.</p>	

Please specify standard/criterion numbers and tick ✓ other boxes as appropriate

The Strategic Directions 2007-2012 were agreed by the Board of Directors in October 2007 to support the Trust's vision "Respond, Deliver, Enable". The Key Milestones below will ensure there is a shared understanding about what needs to be delivered.

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience		Waiting	
Assurance Framework		Privacy and Dignity	
Monitor/Finance/Performance		Efficiency and Effectiveness	
Care Quality Commission Outcomes:	8	Delivery of Care Closer to Home	
		Infection Control	✓
NHSLA Risk Management Standards for Acute Trusts			
NHSLA CNST Maternity Clinical Risk Management Standards:			
Other (please specify):			
Note: This policy has been assessed for any equality, diversity or human rights implications			

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1. INTRODUCTION

This policy is designed to provide the initial framework for the control of an outbreak of infection on Trust premises and the Trust's response to a major outbreak in the general community. Outbreaks of infection vary greatly in extent and severity. It is impossible to provide a detailed policy to cover all eventualities. Consequently this document gives the general procedure to be followed.

2. INFORMATION SOURCES

Initial information may come from a whole range of sources, e.g. ward staff, laboratory staff, GPs, and must be channelled to the Infection Prevention and Control Team (IPCT). It is most important that staff act promptly if an outbreak is suspected. It is far better to act on suspicion than to delay until it becomes a certainty.

3. DECISION ON OUTBREAK STATUS

This is a critical decision and will be based on a number of factors: number of cases, severity of infection and the mode of transmission.

In some situations a single case, e.g. of healthcare acquired legionella or post operative tetanus, would require a Major Outbreak Control Group (MOCG) to be assembled. The decision will be taken by the Director/s of Infection Prevention & Control (DIPC/s) (or out of normal working hours the on-call Microbiologist/Infection Prevention and Control Nurse) but will require discussion with an Executive Director.

Examples of major outbreaks:

Food borne salmonella outbreak in hospital
Hospital acquired tuberculosis
Hospital acquired legionnaires' disease
Diarrhoea and/or vomiting on multiple wards/units

Examples of outbreaks of limited extent:

Cluster of diarrhoea cases on a ward/unit
Cluster of MRSA cases on a ward/unit

4. OUTBREAK OF LIMITED EXTENT

4.1 Outbreak Control Group (OCG)

The exact composition of the group will vary from outbreak to outbreak depending on the nature and location of the problem. Led by the DIPC/s, the group may include:

Appropriate members of the Infection Prevention and Control Team (IPCT)
Relevant Clinical Director or Deputy
Relevant Lead Nurse or Senior Midwife or Matron
Relevant Directorate/Locality manager
Consultant in Communicable Disease Control (CCDC) by invitation where relevant

4.2 Outbreak Management

- OCG convened
- IPCT presents the available information
- Plans for future action are drawn up
 - These may include
 - Further microbiological/epidemiological investigations
 - Management of cases
 - Decisions on isolation facilities required
 - Decisions on control measures/ward closure
 - Decisions on need for environmental / equipment
 - Decontamination
 - Information to staff on the situation and the proposed action
- In the case of small, localised outbreaks the OCG may not need to meet again.
- A short report should be prepared by the IPCT at the end of the outbreak for circulation to all members of the OCG and the Infection Control Committee

5. MAJOR OUTBREAKS

5.1 Major Outbreak Control Group (MOCG)

If the decision is made that the outbreak is major, an MOCG is immediately convened by the DIPC/s:

Members of OCG

Director/s of Infection Prevention and Control

Infection Prevention and Control Team

Chief Executive or deputy

Director of Nursing/Medical Director

Other relevant members of the Executive Team

Relevant Clinical Director or Deputy

Lead Nurse/ Head of Midwifery/Matron from affected area

Occupational Health Physician or Nurse

Operations Manager/Bed manager

Director of Public Health

Chief Environmental Health Officer, if food or water borne infection

CCDC

Secretarial support

Additional expertise from the HPA (or Public Health equivalent) can either be accessed directly through the Centre for Infections, or via the CCDC who is the HPA's local representative.

5.2 Functions of the MOCG

- **Treatment**
Ensure all affected patients/staff are being optimally treated. This may involve advice from an Infectious Disease Physician.
- **Resources**
Clarify the resource implications of the outbreak and its management and how they will be met including additional laboratory, nursing, medical and clinical staff, extra secretarial support, infection control overtime, extra telephones etc.

- **Policy**
Agree and co-ordinate decisions on investigations and control of the outbreak (see below). Allocate responsibility to specific individuals who will then be accountable.
- **Additional membership**
The group will review the need for co-opting other staff e.g. from Estates Dept as relevant to the outbreak.
- **Outside Help**
Consider the need for outside help from HPA (or their Public Health equivalent), Regional Epidemiologist, SHA (or regional equivalent).
- **Communication**
Ensure adequate communications are established including nominating one person to be responsible for making statements to the news media and informing DH, HPA (or their Public Health equivalent), Regional Epidemiologist, Care Quality Commission etc.
- **Advice to Staff**
Provide clear written instructions +/- information for ward staff, housekeeping staff etc.
- **Isolation Facilities**
Decide whether existing isolation facilities are adequate or whether an isolation ward needs to be created.
- **Patient information**
Agree arrangements for providing information to patients, relatives and visitors.
- **Meetings**
Meet frequently, usually daily and review progress on investigation and control. Written agendas will be required with minutes and action notes produced. This will require clerical support, computing facilities and staff to assist with data entry.
- **Report**
Prepare a preliminary report, ideally within 48 hours, interim reports as necessary and a final report.

5.3 Laboratory Investigations

Where possible, specimens should be collected immediately and before control measures are introduced.

The ability of the laboratory to process the additional specimens should be assessed if necessary outside assistance arranged.

5.4 Epidemiological Investigations

- Agree on a case definition
- Define population at risk and list of suspected/confirmed cases
- Characterise cases by time, place and person
- Consider analytical studies e.g. case control.

5.5 Control Measures

These may include:

- Antibiotic therapy/prophylaxis
- Immunisation
- Patient isolation
- Restrictions of admissions, transfers, discharges
- Staff education in infection control measures
- Decontamination of ward areas or equipment
- Staff screening

CONTACT NUMBERS CONTROL OF INFECTION TEAM

POSITION	EXTENSION	BLEEP	OUT OF HOURS
Infection Control Doctor	01392 402961	#6 645	Via Wonford Switchboard
Lead Nurse	01392 402690	#6 579	Via Wonford Switchboard
Medical Microbiologists	2973/2970/2961	Bleep 176	Via Wonford Switchboard
CCDC	01803 861 833		Via Wonford Switchboard
Infection Prevention and Control Nurses	01392 402355	Various pager numbers via Switchboard	

6. TRUST RESPONSE TO MAJOR OUTBREAKS OF INFECTION IN THE COMMUNITY

6.1 Introduction

Community outbreaks have the potential to place heavy and unexpected demands on hospital services.

6.2 Types of Outbreak

Acute - Occurring over a few hours from a point source e.g. staphylococcal food poisoning

Non acute - Developing over days or even weeks e.g. Salmonella food poisoning and influenza; major outbreaks of legionnaire's disease.

6.3 Acute outbreaks

These are likely to place a major burden on Trust resources. As soon as the scale of the problem is apparent the Major Outbreak Control Group should be constituted as above.

Decisions will need to be made rapidly as to the need for isolation of large numbers of cases since this will pose major logistic problems.

6.4 Non-Acute outbreaks

In this situation different management arrangements are required. In addition to any CCDC led Outbreak Control Group for the Community, a Trust Response Outbreak Control Group (TROCG) will be convened to co-ordinate the Trust's response, together with Community Trust where it affects both Trusts.

6.5 Membership of TROCG

DIPC/s
Infection Prevention and Control Team
Chief Executive or appropriate deputy
Relevant members of the Executive Team
Relevant clinician(s)
CCDC

Depending on the circumstances others may include:

Operations Manager/ Bed Manager
Occupational Health Physician
Environmental Health Officers, Water Company etc

6.6 Outbreak Management

This will be similar to the Major Outbreak Response.

7. FUNDING OF OUTBREAKS

The Trust considers it inappropriate to keep a specific reserve for outbreak investigation and control. For purely Trust based outbreaks involving considerable expense the MOCG will keep the Trust Executive apprised of anticipated additional expenditure. For major outbreaks in the community the Trust would liaise with the PCT, Devon Health Protection Unit and/or Strategic Health Authority (or their Primary Care, public and regional health equivalents), as appropriate, to highlight additional unbudgeted costs.