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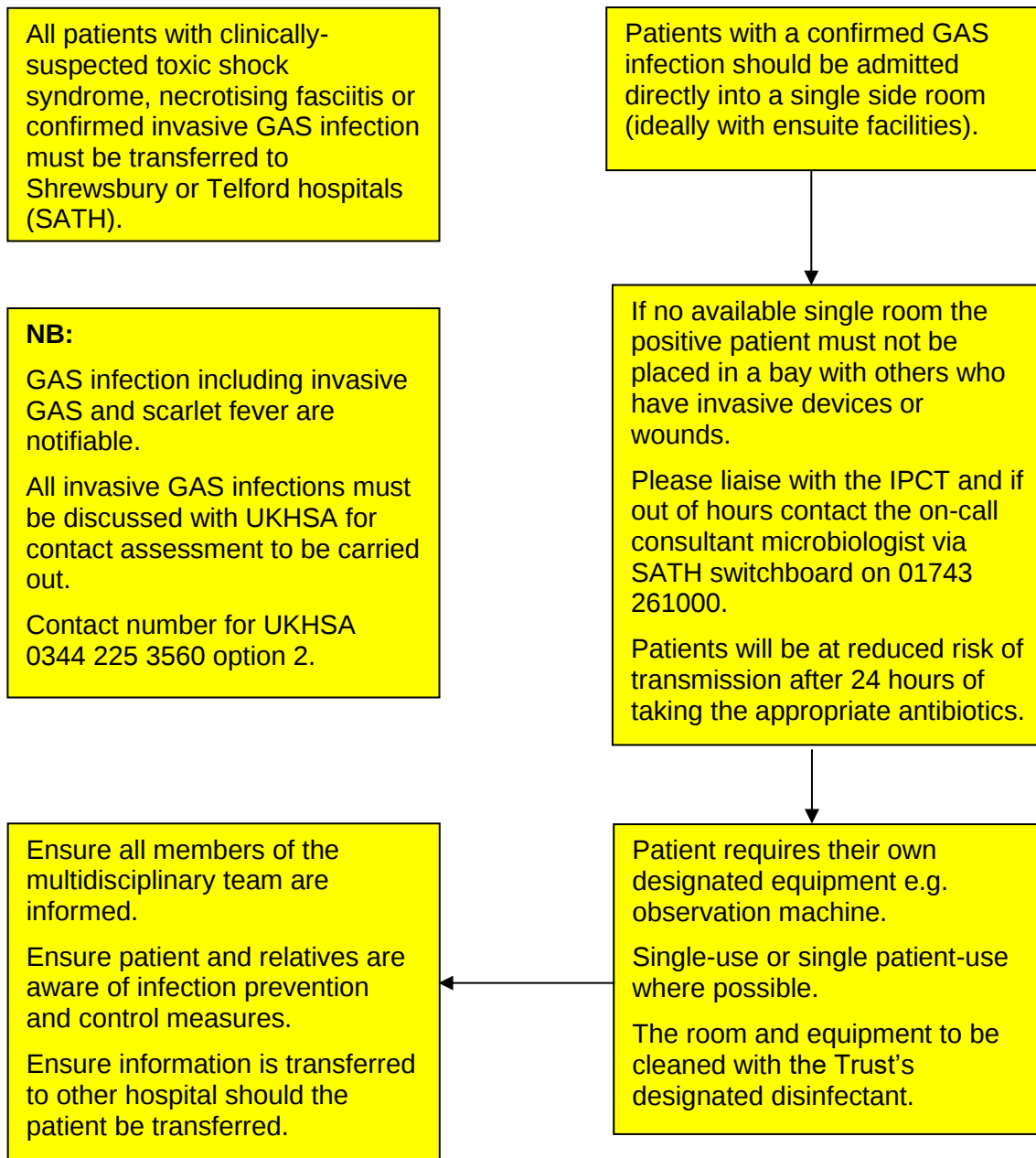
Document Details		
Title		Management of Group A Streptococcus Policy
Trust Ref No		1925-87793
Local Ref (optional)		
Main points the document covers		This policy details: Group A Streptococcus information, Infection Prevention and Control Precautions including advice on isolation, specimens, standard precautions and treatment.
Who is the document aimed at?		All staff who work in Shropshire Community Health NHS Trust
Author		Deputy Director of Nursing, Quality and Infection Prevention and Control
Approval process		
Who has been consulted in the development of this policy?		This policy has been developed by the IPC team in consultation with appropriate senior Operations and Quality managers, Locality Clinical Managers, Specialist Nurses, Medicine Management and Public Health England
Approved by (Committee/Director)		Infection Prevention and Control Committee – notified to Quality and Safety Committee
Approval Date		19 February 2024
Initial Equality Impact Screening		Yes
Full Equality Impact Assessment		N/A
Lead Director		Director of Nursing, Clinical Delivery, Workforce and IPC
Category		Clinical
Sub Category		Infection Prevention and Control
Review date		19 February 2027
Distribution		
Who the policy will be distributed to		IPC Operational Group and IPC Committee Members
Method		Electronically to IPC Operational Group and IPC Committee Members and available to all staff via the Trust website
Document Links		
Required by CQC		Yes
Key Words		Group A Strep; GAS; iGAS; Streptococcus pyogenes
Amendments History		
No	Date	Amendment
1	August 2020	Update throughout policy
2	December 2023	General review
4		
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Policy on a page: Group A Streptococcus (GAS) Infection



1 Introduction

Streptococci are important pathogens and commensals (normal flora) of mucosal membranes of the upper respiratory tract. Lancefield group A streptococci (GAS), also known as *Streptococcus pyogenes*, is a common bacterial pathogen, and is exclusively associated with infections in humans. It causes a wide range of suppurate infections in the respiratory tract and skin, including life threatening soft tissue infections, together with toxin associated reactions. Most severe infections are acquired in the community with approximately 1 in 10 acquired in a healthcare setting. Given the rapid clinical progression of group A streptococci, effective management of invasive group A streptococcal infections hinges on early recognition of the disease and prompt initiation of supportive care together with antibacterial therapy.

2 Purpose

The policy is intended to provide guidance on group A streptococcal infections for the prevention and control of healthcare associated infection (HCAI) and has been written to provide healthcare workers with evidence-based guidance on the treatment and care of patients with a streptococcal infection.

3 Definitions and Abbreviations

Term / Abbreviation	Explanation / Definition
Colonisation	The presence of micro-organisms living harmlessly on a body surface e.g. the skin, mouth, intestines or airway and causing no signs or symptoms of infection.
Contact Precautions	Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment).
DIPC	Director of Infection Prevention and Control
GAS	Group A streptococcus
HCAI	Healthcare Associated Infection
iGAS	Invasive Group A streptococcus
IPC	Infection Prevention and Control
IPCT	Infection Prevention and Control Team
NF	Necrotising Fasciitis
PPE	Personal Protective Equipment
SaTH	Shrewsbury and Telford Hospitals
SCHT	Shropshire Community Health NHS Trust
SIP	Service Improvement Plan
Standard precautions	A set of principles, requiring identification of high risk procedures, minimising exposure to and transmission of microorganisms, including: hand hygiene; managing breaks to the skin; use of PPE; cough etiquette; uniforms; safe disposal of sharps, waste and laundry; management of blood and body fluids.
UKHSA	The UK Health Security Agency

4 Duties

4.1 Responsibility for Infection Prevention and Control (IPC) outside the immediate scope of this policy

For duties and responsibilities for IPC practices outside the specific scope of this policy, please refer to the IPC Arrangements and Responsibilities Policy on the Staff Zone [SCHT Staff Zone \(shropcom.nhs.uk\)](https://shropcom.nhs.uk).

4.2 IPC Duties specific to this policy

4.2.1 IPC Team

Must undertake surveillance activity i.e. recording and reviewing incidents of such infections to identify healthcare associated cases and potential transmission.

5 Infections caused by Group A Streptococci *Streptococcus pyogenes*

The most common infections caused by GAS, *Streptococcus pyogenes*, are relatively mild and non-invasive infections of the respiratory tract (pharyngitis) and skin (impetigo). The most common presentation of a GAS infection in the UK is a mild sore throat known as 'strep throat', less common is scarlet fever.

Complications of non-invasive streptococcal infection/disease can include rheumatic fever, and acute glomerulonephritis, which is primarily, but not exclusively, associated with skin infections.

5.1 Invasive Group A Streptococcal Disease

Invasive group A streptococcal (iGAS) infection/disease is defined as an infection associated with the isolation of group A streptococci from a normally sterile body site e.g. blood, joint aspirate, deep tissue or abscess, bone, pericardial/peritoneal/pleural fluids, cerebrospinal fluid or post mortem.

Three clinical syndromes are described:

- Streptococcal Toxic Shock Syndrome – characterised by shock and multi-organ failure
- Necrotising Fasciitis – characterised by extensive local necrosis of subcutaneous soft tissues and skin
- Other invasive disease – characterised by bacteraemia with/without an identified focus of infection, and focal infections such as meningitis, pneumonia, osteomyelitis, septic arthritis and surgical wound infections.

5.2 Streptococcal Toxic Shock Syndrome

Patients with invasive *Streptococcus pyogenes* (iGAS) infections may develop streptococcal toxic shock syndrome, as the result of the release of streptococcal toxins into the bloodstream. Clinical signs include fever, malaise, nausea, vomiting and diarrhoea, and a flat rash over large parts of the body.

5.3 Necrotising Fasciitis

Necrotising fasciitis (NF) is an uncommon soft tissue infection, which involves superficial fascia, subcutaneous fat (which contains vascular structures and nerves) and deep fascia. It is often associated with severe systemic toxicity and is rapidly fatal unless promptly recognised and aggressively treated. The number and type of organisms present in cases of NF tend to depend on the site of infection, and may be polymicrobial, including aerobic and anaerobic Gram-negative enteric bacilli, enterococci, staphylococci and streptococci.

It can appear in any area of the body but most commonly occurs in the abdominal wall, usually as a postoperative complication of abdominal surgery; in body extremities secondary to trauma, illicit drug use or animal or insect bites, and in the perineum as a

postoperative complication from a pilonidal abscess or a neglected perineal or ischiorectal abscess. Haematogenous spread from a distant site of infection can also occur, such as in streptococcal pharyngitis.

In some cases of NF, where the obvious source is not known or easily identified, the likely cause is a *Streptococcus pyogenes* (GAS) infection arising from either inoculation via undetected breaks in the epidermis, or haematogenous spread.

Surgery is often vital in the management of NF to remove affected tissue. In extreme circumstances, amputation may be necessary to stop the infection spreading.

5.4 Streptococcal Bacteraemia

Bacteraemia is commonly seen in patients with cellulitis, NF and streptococcal toxic shock syndrome.

5.5 Risk Factors for Invasive Group A Streptococcal Infection/Disease (iGAS)

Individuals most at risk from invasive group A streptococcal infection/disease include:

- those who have recently been infected with Varicella (chicken pox) virus
- those who are infected with Human Immunodeficiency Virus
- any underlying illness/disease such as diabetes, heart disease and cancer
- those who are using high dose steroids or intravenous drugs
- those who have undergone recent surgery
- those who are over the age of 65
- pregnant women – at the time of, or after childbirth
- babies born to mothers infected with GAS

6 Routes of Transmission

There are three main routes of transmission of GAS:

- patient to patient
- healthcare worker to patient and vice-versa transmitted by direct, indirect or droplet contact with secretions from the nose, and throat of infected person or by contact with wound secretions or skin lesions of infected person
- environmental contamination including patient equipment, showers, bidets and touch points

Invasion, followed by infection, occurs 1-3 days after initial colonisation.

7 Healthcare Associated GAS infection

A health-care associated GAS infection is defined as a GAS infection that is neither present nor incubating at the time of admission but considered to have been acquired following admission to hospital or as a result of healthcare interventions. Onset of GAS infection is >48 hours after admission, or post operatively at any time after admission and up to seven days following discharge. GAS isolates from patients with healthcare associated infections should be stored locally for a minimum of six months.

8 Reporting Cases

Invasive GAS and scarlet fever are notifiable infection/diseases in England, Wales and Scotland. All iGAS infections should be discussed with UKHSA so that contact assessment can be initiated. UKHSA can be contacted on 0344 225 3560 option 2.

Outbreaks of GAS infection and deaths in patients with Healthcare-associated GAS infection should be reported as serious incidents via SCHAT policy.

9 Infection Prevention and Control Precautions in Hospital

9.1 Isolation Measures

The advice of the infection prevention and control team or on-call Consultant Microbiologist should be sought as soon as possible.

All patients with clinically-suspected toxic shock syndrome, NF or with a confirmed iGAS infection should be transferred to either Shrewsbury or Telford Hospitals (SaTH). Patients with a confirmed or suspected GAS infection in a wound should be admitted directly or transferred to a single room (ideally with a self-contained toilet and its own hand wash basin) and contact precautions must be applied in addition to standard precautions.

If isolation in a single room is not possible because the single room capacity is exceeded, please liaise with the IPC team or out of hours, contact the on-call Consultant Microbiologist via the SaTH switchboard on 01743 261000 and complete a Datix reporting form.

- Place patient in a single room, with a contact precautions sign on the door. Please ensure that arrangements are made to clean and change the curtains of the vacated bed space.
- If there is no available single room a risk assessment should be carried out to ascertain which other patients could share a bay with the patient e.g. not to share with patients who have an invasive device.
- Patients must be isolated in a single room with the door closed at all times, unless a documented risk assessment is undertaken e.g. due to a risk of falls. In this instance, the door must be closed when there is activity within the room.
- Patients must have their own toilet or designated commode and bathroom facility. If this is not ensuite it must be located where the patient does not have to walk past other patients to gain access.
- The patient **MUST** not have contact with other patients and should not be permitted to walk around any other clinical environment. If the patient requires rehabilitation such as physiotherapy outside the isolation room, this must be discussed with the IPC team.
- If there is more than one patient they may be cohorted in a bay on the advice of the IPC team; this accommodation must have doors that are closed at all times. A bay with ensuite facilities is preferable. If this is not available then toilet and bathroom facilities must be provided for the sole use of these patients, located where they do not have to walk past other patient areas to access them.
- Strict hand hygiene is of paramount importance and the frequent use of alcohol gel is encouraged. Patients and visitors must be informed of the need for hand hygiene and products/facilities made available.
- Staff such as Allied Health Professionals (AHPs) should see patients after all other patients, where possible.
- Staff must wear an apron for all direct contact with the patient and their environment. Gloves are worn if the staff member is at risk of coming into contact with bodily fluids.
- Equipment must be kept to an absolute minimum and designated for the sole use of the patient(s) in isolation or cohorted in a bay. This includes a blood pressure monitor, tympanic thermometer, dressing trolley and commode, as required.

- The transfer of patients to other areas and departments must be avoided where possible. If unavoidable, the receiving area and the relevant IPC team must be informed in order to put IPC measures in place.
- The Trust's designated environmental disinfectant must be used as appropriate. Keep environment and equipment clean, clutter and dust free.

Inform patients and their relatives of infection prevention and control measures and provide with the Trust's advice leaflet.

- Inform all multidisciplinary staff members of the need to adhere to contact precautions in addition to standard precautions.
- Linen to be disposed of in a red linen bag with alginate bag lining, be removed immediately and not left in patient's room.

9.2 Duration of Isolation

Isolation should continue until the IPC Team advises that the patient can be taken out of isolation. Usually isolation is required for a minimum of 24 hours from commencement of appropriate antibiotic therapy.

Please note that cases where there is significant discharge of potentially infected body fluids, high risk shedding or an outbreak, cases should be isolated until cultures are negative or on advice from a Consultant Microbiologist.

9.3 Prevention of Spread

9.3.1 Standard Precautions

Standard precautions should be used as with all other patients. Any exposure to bodily fluids must be treated as potentially infectious in line with standard infection prevention and control precautions including hand hygiene and the wearing of personal protective equipment (PPE).

Please refer to SHT Standard Precautions including the Surgical Hand Scrubbing, Gowning and Gloving policy.

9.3.2 Hand Hygiene

9.3.2.1 Staff

Hands must be decontaminated immediately before each episode of direct patient contact and after any activity or contact that potentially results in hands becoming contaminated.

Alcohol hand gel is effective and is an alternative to hand washing provided that the hands are not physically soiled. Hands that are soiled or contaminated with dirt or organic material must first be washed with liquid soap and water.

Staff with skin problems/lesions on their hands must seek urgent advice from the Occupational Health Department on 01743 283280. All cuts and abrasions must be covered with a waterproof dressing.

The use of gloves does not remove the need to perform hand hygiene. Hand hygiene must be performed prior to donning gloves and immediately after their removal.

There is no increased risk to pregnant or immunocompromised staff as long as all policies and procedures are followed. Staff should seek advice from their midwife or GP should they have any concerns following exposure.

9.3.2.2 Patients and visitors

Patients must be offered (and encouraged to perform) hand hygiene before eating, taking medication and after using the toilet/commode. Hand wipes may be used if unable to access the hand wash basin.

Visitors must be advised to decontaminate their hands before and after contact with the patient or their immediate environment and on leaving the isolation room and ward area.

9.4 Personal Protective Equipment (PPE)

9.4.1 Aprons

Following a risk assessment, disposable plastic aprons must be worn for all direct patient contact or contact with the immediate environment, including bed making, as it is inevitable that staff will make some contact with the patient's environment. Risk assessment should include the care required by the patient and/or the task involved.

Aprons should be donned immediately before entry to the isolation room and then removed inside the room and placed in an orange clinical waste bag immediately before exiting the room, unless taking body fluids to the sluice for disposal.

9.4.2 Gloves

If handling patients' urine or other body fluid, disposable gloves must also be worn. These should be removed inside the room and placed in an orange clinical waste bag immediately before exiting the room, unless taking body fluids to the sluice for disposal. In that instance, gloves and aprons/gowns must be removed and hands washed before leaving the sluice.

9.4.3 Face Protection

If there is a risk of blood, body fluids, excretions or secretions splashing the face, masks, goggles or visors should be worn. Surgical masks with integrated visors are an option for eye protection.

10 Disposal of Bodily Fluids

An ensuite toilet, a designated toilet, or designated commode is required. Decontaminate after each use in accordance with the SCHAT Cleaning and Disinfection Policy. Any bedpans which are used should be macerated. If patient uses the toilet on the main ward this must be decontaminated after use with the Trust's designated disinfectant.

11 Disposal of Clinical Waste

All clinical waste should be discarded into an orange infectious clinical waste bag.

12 Linen

Change bed linen and clothing daily wearing PPE as above. Removal and bagging of linen should be performed so as to minimise dispersal of bacteria from the bed linen and clothes.

Hospital linen should be treated in accordance with the SCHAT Linen and Laundry Policy i.e. placed in an alginate bag inside a red linen bag.

13 Medical Equipment

Where possible, disposable, single use equipment should be used or single-patient use equipment designated for the affected patient. Blood pressure cuffs, stethoscopes and thermometers must be single-patient use only.

Where it is necessary to use reusable equipment, it must be appropriately decontaminated during use by/with the affected patient and before it can be used on another patient.

Refer to the SCHAT Cleaning and Disinfection Policy.

14 Environmental Cleaning

Hotel Services' staff should be informed of cleaning requirements for the isolation room or cohort bay, according to the SCHAT Cleaning and Disinfection Policy and Community Hospital Cleaning Policy. Rooms must be cleaned at least daily, paying special attention to dust collecting areas and horizontal surfaces. Separate cleaning equipment must be used for isolation rooms. The isolation room should be cleaned last.

When the patient is removed from isolation or is discharged the room must be terminally cleaned using the Trust's environmental disinfectant agent. Special attention must be paid to dust collecting areas, horizontal surfaces and floors. Curtains must be changed. Only visible splashes on walls need to be removed; full wall-washing is not necessary. Privacy curtains should be removed on cessation of isolation or when visibly soiled and laundered, or single-use curtains used.

Terminal cleaning method is stated in SCHAT Cleaning and Disinfection Policy.

15 Mortuary

In the event of a patient death a cadaver bag should be used. Undertakers should be informed of the risk of infection.

16 Movement of Patients

16.1 Visiting Other Departments

The adoption of contact precautions in addition to standard precautions at all times will allow patients to visit or attend other departments.

The receiving department should be informed in advance of the infection status and precautions required. These patients should spend the minimum time in the department, being sent for only when the department is ready and not left in a waiting area with other patients.

Any colonised or infected lesions should be covered with impermeable dressings wherever possible.

Staff collecting the patient from the ward need only wear protective clothing if their assistance is required to move the patient. In that case the protective clothing should be removed as usual prior to exiting the room and hands then decontaminated.

17 Guidance to Relatives and Carers

Visitors who are visiting other patients in the hospital should be requested to visit the infected patient last.

Visitors should be discouraged from sitting on beds. Visitors only need to wear a disposable apron and gloves if performing, or helping to perform, care activity tasks. Visitors should ensure that their hands are decontaminated on arrival to and departure from the ward, before assisting and following any personal and nutritional care.

The patient should be given a copy of the GAS information leaflet available on the SCHAT website.

18 Contacts of GAS Infection

18.1 Community Contacts and Visitors

Close personal contacts are defined as household or kissing contacts within 7 days prior to the onset of infection.

Management of contacts of GAS and iGAS is the responsibility of UKHSA, who must be notified of cases of iGAS.

18.2 Health Care Workers

Staff should consider themselves exposed to iGAS only if they have had direct contact on their non-intact skin or mucous membranes with secretions from wounds, nasal and oral cavities of a patient with iGAS (e.g. mouth-to-mouth resuscitation, intubation without mask and eye protection, contact with wound drainage, etc.)

If fluid from the nose, mouth, or wound of infected person did not contact mucous membranes or non-intact skin, staff have not been exposed and therefore do not require prophylactic antibiotics.

If exposure is considered likely, advice should be sought from the UKHSA.

If diagnosed with GAS infection, staff should contact the SCHAT Occupational Health Department on 01743 283280 for advice.

If exposed to GAS (including family members), there are no work restrictions or modification of work practices.

For severe exposure e.g. following a needle stick injury, antibiotic prophylaxis may be recommended on the advice of a Consultant Microbiologist or Occupational Health Department.

19 Multiple cases of Group A *Streptococcus* (GAS)

If there is evidence of more than one case of infection or carriage in a ward or unit, the IPC Team will review the cases, and meet with senior medical and nursing staff from the affected area. The outbreak policy should be enacted.

Additional measures may include:

- Additional environmental cleaning using a chlorine releasing agent combined with detergent, with special attention to the cleaning of communal facilities in the ward such as baths and showers.
- The possible closure of the relevant ward to further admissions may be advised following consultation with the Ward Manager, IPC team and Consultant Microbiologist.
- Screening of all staff caring for one or more infected patients to include nose, throat and skin lesion specimens.
- A confidential review with Occupational Health of any staff who may have sore throats or infected skin lesions e.g. secondary to eczema.

The laboratory will send isolates to the reference laboratory and will confirm if they are the same strain by typing. This may take several days.

20 Outbreaks caused by Group G & C *Streptococci*

Certain types of these *streptococci* have the same virulence factors as GAS and have a high mortality. Typing may be important in concluding whether strains are virulent. Outbreaks of infection caused by these streptococci are unusual but should be managed as for GAS infection.

21 Infection Risks within the Patient's Home

The presence of the bacteria, which may disappear quite naturally, should not affect the patient or family at home. Usual personal hygiene and household cleaning is sufficient and there are no restrictions to activities or visitors. However, patients should be advised on the importance of effective hand hygiene before eating and after toileting.

If the hand wash facilities are poor in the patient's home, healthcare workers must take supplies of liquid soap and paper towels or skin cleansing wipes and alcohol hand gel.

Waste should be sealed and disposed of in an outside wheelie bin, not left in the patient's home.

22 Consultation

This policy has been developed by the IPC team in consultation with appropriate Locality Clinical Managers, advisors/specialists (e.g., Medical Director Specialist Nurses, Medicine Management), PHE and IPC Governance Meeting members.

A total of three weeks consultation period was allowed and comments incorporated as appropriate.

22.1 Approval Process

The IPC Committee members will approve this policy and its approval will be notified to the Quality and Safety Committee.

23 Dissemination and Implementation

This policy will be disseminated by the following methods:

- Managers informed via Datix who then confirm they have disseminated to staff as appropriate
- Staff - via Team Brief and Inform
- Awareness raising by the IPC team
- Published to the Staff Zone of the Trust website

The web version of this policy is the only version that is maintained. Any printed copies should therefore be viewed as 'uncontrolled' and as such, may not necessarily contain the latest updates and amendments. When superseded by another version, it will be archived for evidence in the electronic document library.

23.1 Advice

Individual Services' IPC Link staff act as a resource, role model and are a link between the IPC team and their own clinical area and should be contacted in the first instance if appropriate.

Further advice is readily available from the IPC team or the Consultant Microbiologist.

23.2 Training

Managers and service leads must ensure that all staff are familiar with this policy through IPC induction and update undertaken in their area of practice.

In accordance with the Trust's mandatory training policy and procedure the IPC team will support/deliver training associated with this policy. IPC training detailed in the core mandatory training programme includes Standard Infection Control Precautions and details regarding key IPC policies. Other staff may require additional role specific essential IPC training, as identified between staff, their managers and / or the IPC team as appropriate. The systems for planning, advertising and ensuring staff undertake training are detailed in the Mandatory Training Policy and procedure. Staff who fail to undertake training will be followed up according to the policy.

Further training needs may be identified through other management routes, including Patient Safety Incident Response Framework (PSIRF), following an incident/infection outbreak or following audit findings. Additional ad hoc targeted training sessions may be provided by the IPC team.

24 Monitoring Compliance

Compliance with this policy will be monitored as follows:

- Hand hygiene will be audited in accordance with the Hand Hygiene Policy and via peer Hand Washing Assessments
- Cleaning standards within Community Hospitals will be monitored in accordance with the Publicly Available Specification (PAS) 5748 framework
- Environmental and patient equipment cleaning will be monitored as part of local routine cleanliness audits
- Audited locally using the HCAI Prevention audits undertaken by the IPC team and by staff as Self- audits as part of the IPC audit programme
- Additional periodic auditing and self-audits by clinical teams
- The IPC Governance Meeting will monitor compliance of the cleanliness audit scores and the IPC team audit programme

Numbers of staff undertaking IPC training, which includes Standard Infection Control Precautions, will be monitored by the Organisational Development and Workforce Department

As appropriate the IPC team will support Services' Leads to undertake IPC PSIRFs. Managers and Services' Leads will monitor subsequent service improvement plans and report to the IPC Operational Meeting and/or the IPC Committee.

Knowledge gained from PSIRFs and IPC audits will be shared with relevant staff groups using a variety of methods such as reports, posters, group sessions and individual feedback.

The IPC team will monitor IPC related incidents reported on the Trust incident reporting system and, liaising with the Risk Manager, advise on appropriate remedial actions to be taken.

References

Centers for Disease Control and Prevention (7th May 2020) [Group A Streptococcal \(GAS\) Disease](https://www.cdc.gov/groupastrep/diseases-hcp/index.html) <https://www.cdc.gov/groupastrep/diseases-hcp/index.html>

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25 Associated Documents

This policy should be read in conjunction with:

- Cleaning and Disinfection Policy
- Community Hospital Cleaning Policy

- Transmission Based Precautions Policy
- Linen and Laundry Policy
- Standard Infection Control Precautions: Hand Hygiene and Personal Protective Equipment Policy
- Uniform Policy and Dress Code
- Waste Management Policy
- Outbreak management policy