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Trust Guidelines on the Management of Limited and Major Outbreaks and Incidents of Infection

For Use in:	Norfolk and Norwich University Hospital NHS Foundation Trust
By:	All Staff
For:	Recognising, assessing and managing minor and major outbreaks and incidents of infections
Division responsible for document:	Clinical Support Services
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Version and Document Control:

Version No.	Date of Update	Change Description	Author
5.2	18/10/2018	• Defining key staff roles (WHWB & ICD) • Minor amendment to quick reference flowcharts • Addition of responsibility to record Datix if a patient is admitted to a closed ward. • Minor amendments to MOCG meeting agenda, Outbreak debrief tool and outbreak impact assessment tool. • Inclusion of cohort isolation audit tool • Systematic department cleaning sign off forms included in this policy as links. • Updating job titles of staff involved in reviewing this document.	IP&C
6	04/07/2022	Reference and supporting document updates	IP&C

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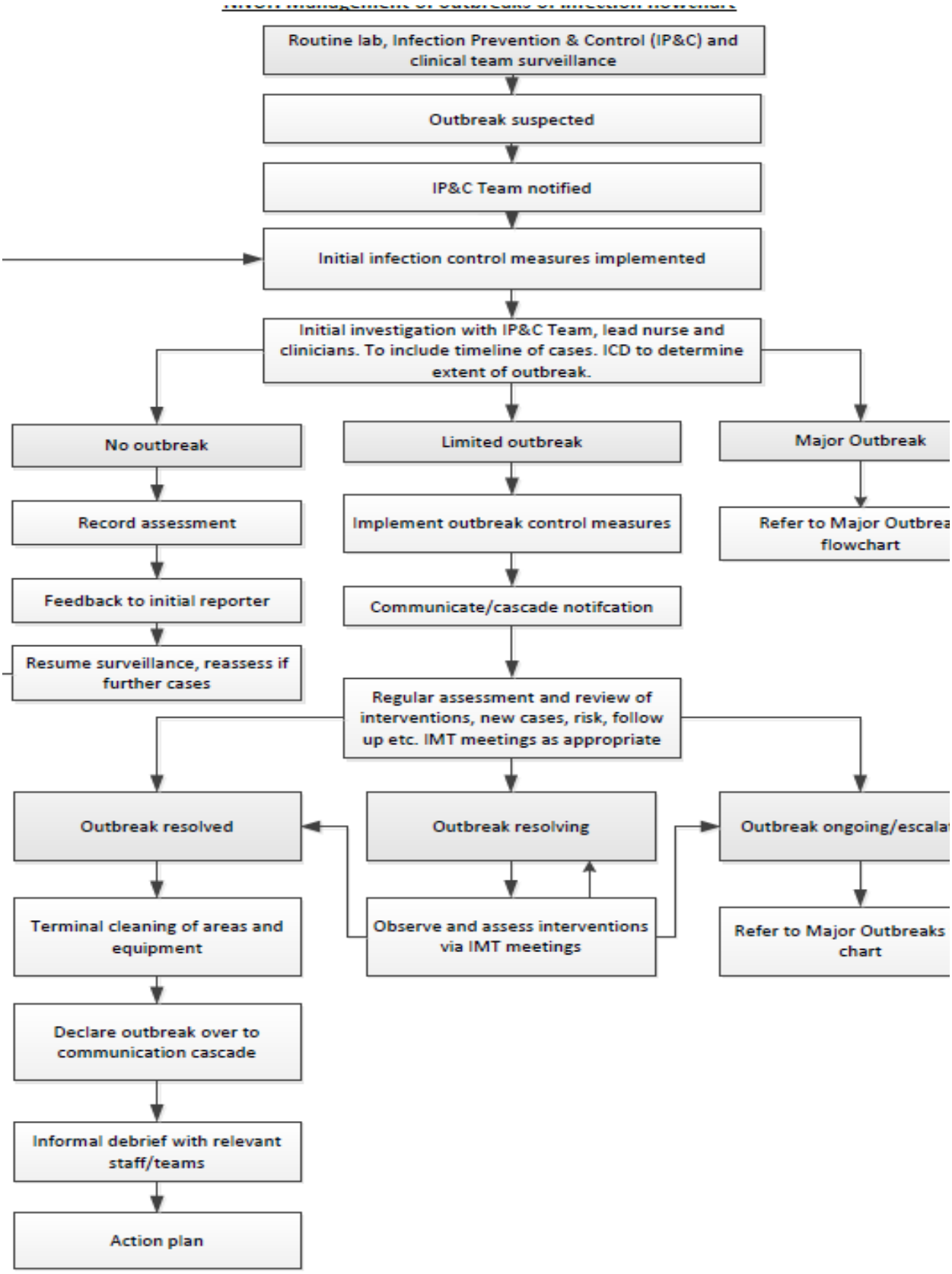
Printed copies of this document may not be up to date. Please check the hospital intranet for the latest version and destroy all previous versions.

1. Contents Page

2. Definitions of Terms Used

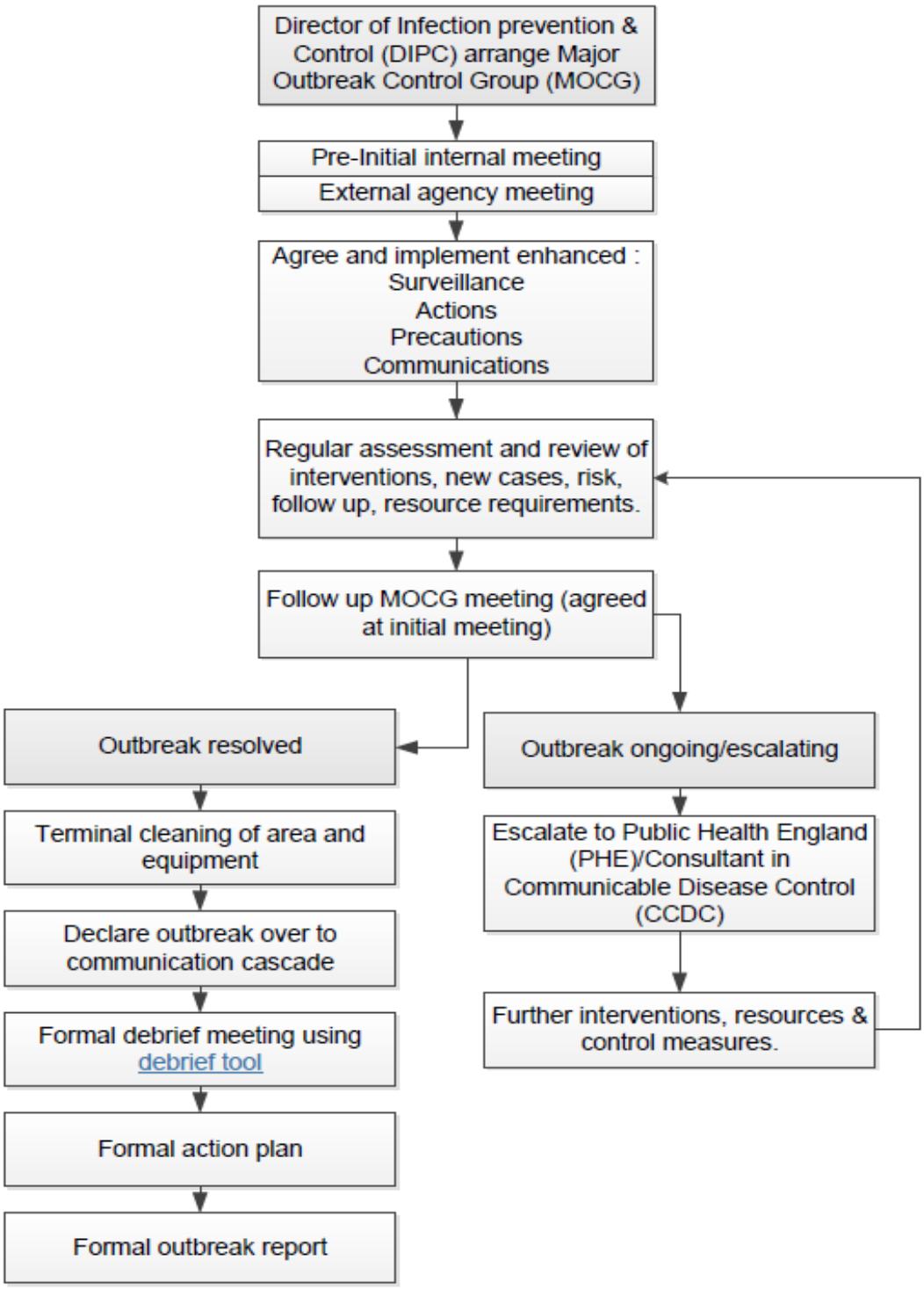
CCDC – Consultant in Communicable Disease Control
CCG – Clinical Commissioning Group
DIPC – Director of Infection Prevention and Control
DDIPC – Deputy Director of Infection Prevention and Control
EPRR - Emergency Preparedness, Resilience and Response
H&S – Health and Safety
HICC – Hospital Infection Control Committee
HPU – Health Protection Unit
ICD – Infection Control Doctor
IMT – Incident Management Team
IP&CT – Infection Prevention and Control Team
MOCG – Major Outbreak Control Group
NNUH – Norfolk and Norwich University Hospital NHS Foundation Trust
PHE – Public Health England [changed to UK Health Security Agency from 1st April 2021]
PPE – Personal Protective Equipment
UKHSA - UK Health Security Agency [formally PHE, changed to UKHSA 1st April 2021]
WH&WB – Workplace Health and Wellbeing

3. Quick reference guideline/s



Links to Appendices Documents Some of these documents can be printed and displayed for information To open link hold the Ctrl button on your keyboard and click the link with your mouse.
1. Outbreak Assessment Tool
2. Outbreak Impact Assessment
3. Major Outbreak Control Group Meeting Agenda
4. Healthcare Outbreak Debrief Tool
5. Management of cohort isolation audit tool
6. Diagnosis Specific Precautions A-Z Guide

Major Outbreak or incident of infection Flowchart



4. Objective

This policy aims to ensure an effective and coordinated approach is taken in the assessment and management of an outbreak, from initial detection to formal closure of the outbreak and review of lessons learnt. The main purpose of this policy is to ensure that prompt action is taken in order to limit the extent of any outbreak and therefore protect patients, staff and visitors from avoidable harm.

5. Rationale

Outbreaks of infection are often complex and require a prompt, thorough and coordinated intervention to ensure that patients, visitors and staff are protected from avoidable harm and that the operational impact is minimised. This policy has been based on recently updated national and regional communicable outbreak/incident guidelines as well as established practice and experience within this organisation.

To ensure effective and efficient management of all outbreaks, this policy is based on the principles of:

- Personal responsibilities of named individuals
- Clear lines of communications between all agencies involved
- Frequent revision and updating of the guidelines and policy regarding the management of any outbreak
- Evaluation of lessons learnt.

5.1 Staff groups

All Staff - have a responsibility to ensure they follow this policy and must ensure they attend appropriate training. Any deviations from this policy must be clearly documented in the patient's care notes, including risk assessments made. Staff are to be aware of IP&C alerts on electronic systems (PAS and ICE), to check microbiology results in a timely manner and follow other IP&C guidelines and policies. Staff must report any suspected outbreak or incident in their local area at the earliest opportunity.

It is the responsibility of each employee to be aware of the procedural documents which relate to their department/area of practice.

Chief Executive - has overall responsibility for ensuring there are effective procedures and resources in place to enable the implementation of this policy.
Director of Infection Prevention and Control (DIPC) - has strategic responsibility within the Trust for the development, resourcing and implementation of Infection Prevention and Control (IP&C) best practice and guidelines.

Divisional Managers/Matrons/Ward Managers - are responsible for ensuring they have a process in place to reassure the organisation that all staff are aware and receive appropriate training. Are also responsible for ensuring adequate resources are available to manage an outbreak/incident and that relevant information is communicated effectively to patients, visitors and staff.

Divisional Triumvirate – The Chief of Division (COD), Divisional Nurse Director (DND) and Divisional Operational Director (DOD) within each division have a responsibility to mitigate the risks of an outbreak or incident through planning, workforce management.

They will also play a role in supporting local clinical and operational teams to manage and recover operational activity during and following an outbreak or incident.

Infection Control Doctor (ICD) – A Microbiology Consultant with responsibility for providing specialist Infection Control advice and support to the Infection Prevention and Control Team and the wider Trust.

IP&C Team (IP&CT) - is responsible for reviewing the IP&C aspects of this guidance and amend as required on the review date, or prior to this following new developments to reflect current best practice. The IP&CT will have alert organism surveillance systems in place to identify and alert potential outbreaks and incidents. The IP&CT have a responsibility to offer training and specialist advice and support to staff regarding the IP&C aspects of this policy.

Microbiology & Virology departments - is responsible for advising on diagnosis and clinical management of communicable diseases, processing specimens, reporting the results (including suspicions of an outbreak), sending the suspected specimens to the reference laboratory, informing the IP&CT, the patient's clinicians and the Consultant in Communicable Disease Control (CCDC).

Operations Centre Managers – are responsible for supporting the assessment and management of a limited or major outbreak, particularly outside of the usual working hours and always when patient flow or hospital resources may be affected. They are also responsible for completing an incident form if patients are admitted to a ward closed due to an infectious outbreak.

Workplace Health and Wellbeing (WHWB) – provide NNUH employees with occupation health advice and support. WHWB support the management of limited and major outbreaks of infection as part of the investigative or control measures implemented as directed by the ICD/DIPC.

6. Processes to be followed

6.1 Recognising a potential Outbreak

Outbreaks may manifest themselves clearly from the outset, or more insidiously and reach considerable proportions before becoming apparent.
Only continuous clinical surveillance, daily examination of laboratory reports and routine checks of patient symptoms will alert nursing and medical staff, and enable early recognition of an outbreak. Existing surveillance and alerting systems are in place in clinical areas (PAS and ICE alerts), laboratory setting and the Infection Prevention and Control team (IP&CT) to assist in identifying potential outbreaks and incidents.

At a patient care level, a patient with symptoms of a communicable disease (e.g. food poisoning) or a greater than expected surgical site infection rate may well come to the attention of ward staff in the first instance. The doctor and nurse in charge should consider if the patient(s) need isolation or barrier nursing in accordance with the Isolation Procedures policy and must notify the IP&CT as soon as possible of their suspicions. They may also consider what microbiological/ virology specimens are required in conjunction with these laboratory teams.

6.2 Staff illness

In the case of staff illness seemingly due to a communicable disease, this should be promptly reported by the member of staff to their line manager and to the Workplace Health and Wellbeing Department (WH&WB). Out of usual working hours for WH&WB, staff can refer to the Out of Hours WHWB guidance and the operations centre team should be notified.

The WH&WB team will liaise with the DIPC and IP&CT to notify them of staff who are being investigated, ensuring that staff confidentiality is protected.

6.3 Defining an outbreak / incident

An outbreak or incident can be defined as:

- An incident in which two or more people experiencing a similar illness are linked in time or place.
- A greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred.
- A single case for certain rare diseases such as diphtheria, botulism, rabies, viral haemorrhagic fever or polio.
- A suspected, anticipated or actual event involving microbial or chemical contamination of food or water.

Any suspicions of an outbreak should be reported promptly to the ICD and the IP&CT to allow a more detailed investigation and assessment to be undertaken. The DIPC should be kept informed of the outcome of these assessments if an outbreak or incident is suspected.

6.4 Investigation of a Suspected Outbreak

The IP&CT and clinical management team (Consultants and Matron/Senior Nurse) for the affected area/s will coordinate the collection of data and evidence to assess the potential outbreak and liaise with the ICD/ DIPC to evaluate its extent and whether there are implications for the community generally. The Outbreak assessment tool should be used to record the assessment, the assessors and the outcome.
Once it has been agreed that there is an outbreak/incident, the ICD/ DIPC will lead the assessment of whether this is a limited or major outbreak. Given the potential complexity of an outbreak and the range of organisms, patient groups, physical locations and other variables that are involved in an infection outbreak, the Outbreak impact assessment tool can be used to inform this assessment. As an outbreak or incident develops, the impact assessment should be reassessed at regular intervals.

If **No Outbreak** is identified, the person who made the initial notification should be reassured that an outbreak has not occurred. Reasons for this decision should be given and personnel should not be discouraged from future reporting. The Outbreak assessment tool should be filed electronically by the IP&CT.

If the outbreak/incident under investigation is judged by the ICD/ DIPC to be a **Limited Outbreak** (depending on its extent, nature of organism, background levels, susceptibility of patients & locations etc.), this will be dealt with by the IP&CT in consultation with the clinician in charge and a senior nurse/Matron from the area affected via an Incident Management Team (IMT) meeting. A period of increased incidence (PII) of MRSA, Clostridium difficile and Multi-drug resistant organisms (MDRO's) will be managed through

an established NNUH IP&CT tool called 'supportive measures'. Should the incident/outbreak extend beyond the remit of supportive measures, the process detailed in this policy should be followed. The Operation Centre Team must be informed and they should liaise with the senior nurse/Matron regarding the ongoing outbreak management plan, staffing and bed status.

If the outbreak/incident is judged to be a **Major Outbreak** (depending on its extent, nature of organism, background levels, susceptibility of patients & locations etc.) by the ICD/ DIPC the Major Outbreak Control Plan will be instigated and convene the Major Outbreak Control Group (MOCG).

6.5 Limited Outbreak control plan

When the management of a limited outbreak extends beyond the remit of the supportive measures process, the following outbreak control plan should be followed to ensure a methodical process and that a clear record of the progress and interventions implemented is maintained. An IMT meeting will be held with key personnel from the clinical area (Nurse in charge, Matron, Consultant and/or Clinical director, operational manager and members of the IP&C team). The Matron and Nurse in charge of the affected area are responsible for ensuring this plan is implemented and that resource needs are escalated to the divisional trimvirate.

The following outbreak control measures may be implemented according to the organism, patient group, location and available resources as advised by the IP&CT.

Descriptive Epidemiology
Initial information will be collected jointly by the department team and the IP&C team to establish the number of probable and confirmed cases based on the agreed case definition. A description of the outbreak in terms of person (e.g. age, sex, ethnicity or other relevant factors), time (preferably onset date) and place (geographical distribution of cases across hospital) will be formulated.

Isolation

- Effective segregation and isolation of symptomatic and exposed patients is crucial to restrict the outbreak from affecting any more patients.
- Refer to the Isolation procedures policy for guidance on which isolation precautions are required, the relevant posters and prioritisation guideline for isolation of patients with an infection.
- All single rooms should be reviewed on a daily basis by the medical and nursing teams on each ward, overseen by the matrons, to ensure that patient placement is optimised within the available resources in the hospital.
- If the number of patients and/or contacts increases beyond the ward capacity to isolate, cohorting in multi occupancy rooms may be necessary, this will require discussion with the IP&C team. The management of cohort isolation audit tool must be completed each day that cohort care is provided. Copies of these audits should be retained by the department for at least 5 years as per the Health Records Retention Schedule.
- The principles of isolation in a single room must be applied per patient in the multi occupancy room to minimise the risk of cross infection.

- Specialised isolation facilities (e.g. negative pressure rooms) may be required for the effective isolation of patients with highly transmissible infections. Some of these facilities may not be available at NNUH which would require a referral to a specialist infectious disease unit. For more information see Diagnosis Specific Precautions A-Z Guide

Patient Movement

- Patients should not be transferred/discharged to another healthcare facility unless for clinically urgent reasons.
- If a patient from the closed ward or multi occupancy room requires transfer to another department within the Trust or organisation, for clinically urgent reasons (e.g. Critical Care Complex or other Acute Trust), this should be discussed with the IP&CT prior to the transfer to co-ordinate a safer transfer.
- Clear communication and precautions are essential to minimise the risk of any further transmission. This patient should be cared for on a clean bed and mattress in isolation for a period of time to ensure they were not incubating the infection at the time of the transfer.
- The operations centre team can help to facilitate timely transfers and terminal cleans if the operational need requires this.

Hand hygiene

- All staff must decontaminate their hands as per the Hand hygiene policy with the right product, right technique and at the right moments during their care.
- Depending on the organism and the extent of the outbreak, alcohol based hand rubs (ABHR's) may be removed (on the advice of the IP&CT) from a clinical area with signs to direct staff, visitors and patients to the nearest hand washing sinks.

Personal Protective Equipment (PPE)

- Refer to the Isolation procedures policy for guidance on what PPE is required and the relevant signage to display prominently.
- Adequate supplies of the necessary PPE is crucial, particularly when there are extended bank holidays. The ward sister/charge nurse and Matron are responsible for ensuring they have adequate supplies of the necessary PPE.
- PPE must fit the wearer to provide adequate protection and be appropriate for the tasks being undertaken.
- Staff requiring FFP3 masks must have been fit tested for the brand of mask being worn. Each time a mask is applied it must be fit checked. Procedure for Personal Protective Equipment (PPE) policy
  Enhanced precaution supplies are required for cases of new and emerging and highly transmissible infectious organisms. Initial supplies of enhanced precautions must be available on all admission units. A small supply is also available via the operations centre team. Further supplies can be ordered from Procurement
- PPE must be applied and removed in the correct order to minimise the risk of cross infection and self-contamination.

Equipment

- Dedicated patient observation and handling equipment should be clearly identified and stored appropriately.
- Single use, disposable items should be used when able to minimise the risk of cross infection.

Cleaning

- Daily cleaning and disinfection with Trust approved disinfectant as per the Cleaning and Disinfection Policy is required of the affected area
- Trust equipment must be thoroughly cleaned and disinfected in a systematic method after use and should include documented guidance of being cleaned. Particular attention is necessary when specialist equipment is not dedicated to the affected patient group to minimise the risk of cross infection.
- Close attention to the level of cleanliness in the general environment is also crucial to ensure the contracted domestic services are performing to the required levels. Any concerns should be escalated through the NNUH facilities department.
- Additional domestic cleaning and auditing of cleanliness may also be required during an outbreak/ incident as directed by the IP&C team or IMT.

Samples and Screening

- Proactive screening and samples from symptomatic and potentially asymptomatic contacts may be required in certain outbreaks; this will be directed by the ICD/DIPC, and IP&CT. Staff screening is only required in exceptional circumstances and is directed by the ICD/DIPC and WH&WB to maintain staff confidentiality. The senior laboratory biomedical scientist teams must be informed in advance of any additional screening samples which will be discussed at the IMT meeting and the process agreed.

Antimicrobial Stewardship

- In certain circumstances it might be necessary to alter the prescribing and dispensing of particular antimicrobials from the NNUH antimicrobial policies. This will be advised and managed by the consultant microbiologist and/or antimicrobial pharmacist.

Communication

- Clear and timely communication that is disseminated to all necessary levels and groups of staff is vital to ensure the effective and efficient management of an outbreak.
- The NNUH communications department will usually be involved in the initial management group, however if they are not, their support can be accessed when required.
- Any communication directed to those outside the organisation should be coordinated by the NNUH communications department with support from the ICD/ DIPC, including notification to the CCG/ HPU.
- Initial communication with staff should include details about;
    - The current situation
    - The organism, how it spreads and the interventions that reduce the risks to patients, staff and visitors.
    - Changes to processes and high risk contamination procedures
    - Escalation procedures and out of hours support and advice

Patient information

- Information leaflets should also be made available for patients and visitors in the affected area. The While you are in isolation leaflet is a generic IP&C leaflet that can be offered alongside organism specific leaflets that are available via the Care guidance and patient information leaflets intranet page or IP&C department intranet page. Certain disease specific leaflets are also available from this link.

- Communication with Patients and visitors is crucial and the efforts to share information with these groups must be recorded, either in individual patient's notes or as part of the outbreak management records.
- The Consultant, Matron and nurse in charge are responsible for ensuring all the necessary patients have been communicated with.

Closing the Limited Outbreak

- The limited outbreak will be formally closed at the point the ICD/ DIPC and IP&CT are confident that there is no longer a risk of transmission or cross infection. The time between the final case and closing the outbreak will depend on the organism, patient group and location.
- A thorough and systematic clinical clean of the affected areas is required as part of the outbreak coming to a conclusion, according to the Cleaning and Disinfection Policy. Appropriate visual inspection and sign off for each room/area utilising the Clinical Clean Bay or Single Room Form and Clinical Clean Ward Hub Form forms should be recorded and held for as evidence of completion.
- Ongoing routine surveillance and monitoring from the clinical team, laboratory team and IP&C team will resume.

Debrief

- An informal debrief of the limited outbreak with all the key staff/teams involved through the IMT is considered best practice to allow an evaluation of what went well and what improvements could be made should the situation arise again. The Healthcare Outbreak debrief tool can be utilise as a template.
- An action plan may be required following the debrief. Clear responsibilities and timeframes must be agreed, and the action plan should be shared with the appropriate levels of management, clinical teams and IP&CT.

6.6 Major Outbreak control plan

If a Major outbreak is declared (at any time), the ICD must notify the Operations Centre Team, who will in turn inform the Duty Executive and the Duty Medical Director. It is the duty of the DIPC/ Hospital Infection Control Doctor (ICD) to institute the major outbreak control plan and convene the initial Major Outbreak Control Group (MOCG) meeting as soon as possible but no later than 3 days from the major outbreak being declared (depending on its extent, nature of organism, background levels, etc.).

Major Outbreak Control Group membership and objectives

The MOCG should include:

- Director of Infection Prevention and Control (DIPC) to Chair or Deputy Director of Infection Prevention and Control (DDIPC) in the absence of the DIPC .
- Infection Control Doctor (if different from above) (Deputy Chair)
- Infection Prevention and Control Nurse/s
- Trust Executive for IP&C (unless covered by one of the above roles)
- Trust Divisional Management representative i.e. Divisional clinical director or deputy, and/or Divisional executive of the affected area/s
- Medical Director/ deputy medical director
- Chief Nurse/ deputy chief nurse

- Clinicians involved (Clinical director/Lead Doctor, Nurse in charge of ward/department)
- Senior Nurse/ Matron for affected area/s
- Operations centre representative
- Contracted Service Providers Manager (e.g. Serco/Norse)
- Director of Facilities, Estates/Operational Director
- Trust Communication Manager
- NNUH Lead for EPRR & Business Continuity
- Administrator to record and disseminate accurate minutes
- Infection Prevention and Control Commissioners (CCG)
- NNUH Risk Manager
- CCDC from UKHSA
- Divisional Clinical Governance facilitators

Other representatives may also be co-opted, as required, from the following areas;

- Environmental Health Department (Local Authority)
- Catering Manager
- Sterile Services Department
- Health and Safety Team representative
- Workplace Health and Wellbeing representative
- Head of Pharmacy Services
- Antimicrobial pharmacist
- Purchasing Department
- Estates Department
- East of England Ambulance Service NHS Trust
- Union/Staff representative
- Microbiology laboratory Manager
- Legal Department representative

- Additional expertise will be called upon in outbreaks which involve particular types of infection or environments (e.g. water expert).
- The DIPC/ ICD will chair the MOCG, though in the case of a major outbreak with implications for the health of the wider local community, the Consultant in Communicable Disease Control (CCDC) from UKHSA will assume an overall co-ordinating role
- All members of the MOCG should have well defined duties and responsibilities, set out at the first meeting and revised according to local requirements.
- A template MOCG meeting agenda should be used and the frequency of MOCG meetings should also be agreed at each meeting.

The objectives and functions of the MOCG will be:

- To establish if there is a major/severe outbreak of a communicable disease and declare an outbreak if applicable

- To define its epidemiological characteristics (identity, source, transmission routes and aetiology) and agree a case definition.
- To determine the need to instigate elements of the Major Incident Plan, including entrance/exits from the hospital and facilities for mass prophylaxis if required.
- To assess the impact of the outbreak using the Outbreak impact assessment tool
- To develop and oversee the implementation of control measures to stop the spread of the outbreak and prevent its recurrence
- To maintain good communications with patients, visitors, staff and relevant external agencies
- To take all steps for the continuing clinical care of patients during the outbreak
- To consider the need for outside help and expertise
- To clarify the resource implications of the outbreak and how they will be met (e.g. additional supplies of PPE and staff)
- To define the end of outbreak, evaluate and disseminate lessons learnt.
- To prepare interim and final reports.

Ward Closures

- If the outbreak is not able to be contained by closure of part of the ward, for example in single rooms or bays with doors, a member of the IP&CT may close the ward to further admission and transfers. This decision will be made following discussions with the ICD/ DIPC, the nurse and clinician in charge of the ward and the Operations Centre manager.
- The Senior nurse/Matron for the area must make alternative arrangements for patients requiring admission whenever possible with the assistance of the Operations Centre Team. The Operations Centre Team will also liaise with the Duty executive and Duty Medical Director.
- If an exceptional situation arises where a patient is required to be admitted to a closed ward, this must be discussed primarily with the ICD/ DIPC. Out of hours, this should be discussed with the on-call microbiology consultant, who can liaise with the on-call IP&CN if required. The Operational Site team must complete a Datix to record the rationale for this decision.
- Thorough escalation plans to address such a situation should be made during working hours and clearly communicated to the necessary staff to ensure appropriately risk assessed decisions are made. Such decisions must be clearly documented on the daily Situation Report that the Operations Centre Manager distributes.

Cancelled admissions

- Elements of the Major Incident response plan may be initiated by a major outbreak/incident of infection. This plan details the requirement for discharging patients and managing the bed capacity within the Trust.
- Clear communication with staff, patients and visitors is crucial to minimise the impact of such closures and the communications team can assist with this process.
- When a ward is closed, posters should be positioned by staff in that area in a prominent place at the entrance to the ward and any adjoining wards, providing staff, patients and visitors with clear information of the necessary control measures.
- Operations Centre staff and Operational Directors will support the management of cancelled admissions.

Patient information

- During a major outbreak, specific written patient information and communications may be required. The NNUH communications team, ICD, DIPC, IP&CT and clinical teams will assist in the development and distribution of these materials.

Staff information

- Staff affected by the major outbreak must be kept up to date with relevant changes in situation, risk, practice and procedures by their line managers.
- WH&WB will be responsible for coordinating the assessment of staff health during the outbreak which may include staff screening following discussion with the ICD/ DIPC.
- The communications team can assist WH&WB and DIPC/ICD in producing staff communications, which the Matron/Consultant and nurse in charge will help to distribute.

Patient transfers

- Patients should not be transferred/discharged to another healthcare facility unless for clinically urgent reasons.
- If a patient from the closed ward or multi occupancy room requires transfer to another department within the Trust or organisation, for clinically urgent reasons (e.g. Critical Care Complex or other Acute Trust), this should be discussed with the IP&CT prior to the transfer to co-ordinate a safer transfer.
- Clear communication and precautions are essential to minimise the risk of any further transmission. This patient should be cared for on a clean bed and mattress in isolation for a period of time to ensure they were not incubating the infection at the time of the transfer.
- The operations centre team can help to facilitate timely transfers and terminal cleans if the operational need requires this.

Procurement

- During a major outbreak, large quantities of supplies may be required, depending on the nature of the outbreak. As part of the MOCG, representatives from the procurement team and facilities management team may be required to assist in the sourcing and supply of adequate levels of PPE, linen, specialist equipment and signage.
- Authorisation, resources and storage of these supplies may need to be agreed and facilitated with the support from the senior divisional management team at the NNUH.

Formal Outbreak closure

- The Major outbreak will be formally closed at the point the MOCG are confident that there is no longer a risk of transmission or cross infection. The time between the final case and closing the outbreak will depend on the organism, patient group and location.
- Ongoing surveillance and monitoring will continue to ensure the outbreak has resolved.
- A thorough and systematic clinical clean of the affected areas is required as part of the outbreak coming to a conclusion according to the Cleaning and Disinfection Policy prior to the clinical area returning to normal unrestricted activities.

Formal Debrief

- Following a major outbreak, a formal debrief should be conducted in a timely manner to review the identification, assessment and management of the outbreak. The Healthcare Outbreak debrief tool should be utilised as a structured tool.

- The person leading the formal debrief should not have been involved in the outbreak in order to provide an objective oversight.

Formal Report

- The chair of the MOCG will ensure the production and distribution of interim and final reports, with contributions from MOCG members as relevant. The nature of the outbreak, the investigations undertaken and the intended audience will influence the final format.
- Purpose of Final Outbreak Report
    - To record the management of the outbreak.
    - To present the investigative methods, control measures and communication.
    - To document any learning and changes required to outbreak plans.
- In writing the report, confidentiality aspects (patients, clients, businesses, etc.), media issues and legal disclosures need to be borne in mind.
- The final report should be suitable for publication and be circulated as appropriate following agreement by the MOCG. The aim should be to agree a final report within six weeks of the end of the outbreak investigation, but this may not always be possible. It should be submitted to the appropriate committees of the lead organisation as the formal route into the public domain and, as relevant, the appropriate committees of other involved organisations. In some cases, it may be necessary to delay or limit the publication of the report pending legal action, as directed by the Trust legal advisors.

7. Clinical audit standards

To ensure that this document is compliant with the above standards, the following monitoring processes will be undertaken:

- A selection of Outbreak assessment forms will be audited to ensure that any reported suspicion of an outbreak is reviewed appropriately.
- Following a Major outbreak, the debrief tool and any reports (interim and final) can be audited to check compliance with above guidance.

8. Summary of development and consultation process undertaken before registration and dissemination

The authors listed above drafted this document on behalf of the IP&C Department who has agreed the final content.

During its development it has been circulated for comment to:

• Matrons and Senior Nurses	• HICC members
• Ward Sisters and Charge Nurses	• Consultant Microbiologists and Virologists
• Health and Safety Department	• Operations Centre Manager
• Workplace Health and Wellbeing	• Communications Team
• Divisional operational management representatives	• Divisional Triumvirate

• Associate Director of Quality & Safety, Risk Management	• EPRR

Comments received were incorporated; other respondents confirmed they had no comments.

This version has been endorsed by the Hospital Infection Control Committee.

9. Associated documents

NHS England, 2022. National infection prevention and control manual for England and National IP&C manual glossary of terms [Accessed 16/06/2022]
Available from: https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

Public Health England (2014) Communicable Disease Outbreak Management – Operational guidance. Accessed: 17/06/2022. Available from:Communicable disease outbreak management: operational guidance - GOV.UK (www.gov.uk)