Group A Streptococcal Policy - HH(1)/IC/643/13

Due for latest review on January 2016. CHECK THE INTRANET FOR LATEST VERSION

Location
Policy No
Policy Name
RHCH
CP131
Group A Streptococcal Policy

Document Summary
Hospital outbreaks of invasive Group A Streptococcal (GAS) infection whilst uncommon, can be devastating and have occasionally resulted in the deaths of otherwise previously fit and healthy patients. Rapid and thorough investigation of the source can control and prevent further cases.

Ownership
Author
Job Title
Dr Matthew Dryden
Director Infection Prevention and Control

Document Type
Level
Related Documents
Document Details
Reporting Managing and Learning from Incidents Policy (Including the Investigation of Serious Incidents Requiring Investigation and Being Open)
Diarrhoea and Vomiting Outbreak Management policy
Aseptic Technique Policy
Hand Hygiene Policy
Standard Precautions (including use of PPE) Policy
Antimicrobial Prescribing Guidelines (Adults)
Waste Management Policy

Relevant Standards
CQC Outcome
Outcome 8

Equality Impact Assessment
Completed by
Equality & Diversity Lead
Date Completed
23 April 2013

Final Document Approval
Committee
Policy Approval Group
Date Approved
22 April 2013

Final Document Ratification
Committee
Executive Committee
Date Ratified
25 April 2013

Authorisation
Author
Mary Edwards
Job Title
Chief Executive Officer
Signature

Date Authorised
26 April 2013

Dissemination
Target Audience
All Trust Staff

Dissemination and Implementation Plan
Action
Owner
Due by
Publicise detail of new document via Intranet and Midweek message
IPCT and Communication Team
Within 1 week of publication
Communication to all Senior Managers to advise publication of policy
BNHH Healthcare Library
On publication
The policy will be available on the intranet and web site
BNHH Healthcare Library and Communication Team
Within 1 week of authorisation

Review
Expiry date
April 2016

Review date
January 2016
**Document Control – Document Amendments**

<table>
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<tr>
<th>Version No.</th>
<th>Details</th>
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<th>By whom</th>
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<td>Review to produce harmonised HHFT policy</td>
<td></td>
<td>Dr Matthew Dryden</td>
<td>March 2013</td>
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1. Introduction
The last thirty years has seen periodic increases in cases of invasive Group A Streptococcal (GAS) infections. Current estimates of annual incidence of invasive GAS infection range from 2-5 per 100,000 population in developed countries, with case fatalities ranging from 8-23%. In the United Kingdom in 2003-4 there was a reported incidence rate of 3.3 cases per 100,000 population (Health Protection Agency).

UK data in 2003-4 identified 9% of invasive GAS infection as being healthcare associated, most (58%) being post-surgical infections. 2-11% were associated with recent childbirth. Infection in the mother carries a further immediate risk of infection in the baby.

Each case of GAS infection must be investigated and managed to control the spread, prevent outbreaks and identify hospital acquired GAS infections where transmission from a preventable source may be ongoing. Every case of GAS will be isolated until they have received at least 24 hours of appropriate antibiotic treatment. For patients with invasive GAS infection they must remain isolated until advised by the microbiologist. In Maternal cases they should be isolated till discharge.

It is essential that infection control is seen as an organisational responsibility and priority, that adequate isolation facilities and resources are provided, and that appropriate infection control staff and support services are available.

2. Purpose
This policy is intended to assist Trust staff to manage single cases of GAS infections, invasive GAS and clusters in acute settings.

3. Scope
This policy and procedure will be applied fairly and consistently to all employees and service users regardless of their protected characteristics as defined by the Equality Act 2010 namely, age, disability, gender reassignment, race, religion or belief, gender, sexual orientation, marriage or civil partnership, pregnancy and maternity. For employees this policy also applies irrespective of length of service, whether full or part-time or employed under a permanent or a fixed-term contract, irrespective of job role or seniority within the organisation.

Where an employee or service user has difficulty in communicating, whether verbally or in writing, arrangements will be put in place as necessary to ensure that the processes to be followed are understood and that the individual is not disadvantaged during the application of this policy.
In line with the Equality Act 2010, the Trust will make reasonable adjustments to the processes to be followed where not doing so would disadvantage an individual with a disability during the application of this policy.

This policy complements professional and ethical guidelines and the Nursing and Midwifery Council (NMC) Code of Professional Conduct (NMC 2008).

4. Explanation of Terms

Superficial GAS infection - may be a coloniser in the throat and not cause infection, but is still transmissible. Infection can be tonsillitis, impetigo, sore throat, minor wound and soft tissue infection.

Invasive GAS infection - illness associated with the isolation of GAS from a normally sterile body site such as blood or deep tissue or associated with necrotising soft tissue infection such as necrotising fasciitis. For the purpose of this policy it also includes severe GAS infection, where GAS has been isolated from a non-sterile site in combination with severe clinical presentation such as streptococcal toxic shock syndrome (STSS) or necrotising fasciitis.

Peri-partum GAS infection - for the purpose of this policy, this is defined as isolation of GAS during admission / time of delivery or up to seven days post discharge in the mother in association with a clinical infection such as endometriosis, STSS, wound infection or isolated from a sterile site.

Hospital acquired GAS infection - a GAS infection that is neither present nor incubating at the time of admission. Typically the onset of this GAS infection is >48 hours after admission, or postoperatively at any time after admission and for up to seven days post discharge.

Outbreak - an outbreak should be considered if there is a cluster of two or more cases of suspected GAS infection related to person or place. These cases will usually be within a month of each other but the interval may extend to six months. Typing will be carried out by the reference laboratory to confirm cases are related.

Close personal contacts - defined as sharing a household or kissing contacts within the seven days prior to the onset of the illness. Invasive GAS infection is a notifiable disease. Therefore it is a statutory requirement for the Trust to report all cases of invasive GAS infection to Public Health England (PHE) so that assessment of contact tracing can be initiated.

5. Duties

Post-holders

Chief Executive Officer (CEO) - The CEO has overall responsibility for the strategic and operational management of the Trust ensuring there are appropriate strategies
and policies in place to ensure the Trust continues to work to best practice and complies with all relevant legislation in regard to invasive Group A Streptococcal (GAS) infection.

**Director of Infection Prevention and Control (DIPC)** - The DIPC is the Trust Director responsible to the board for the delivery of IPC standards.

**Director of Nursing** - The Director of Nursing will ensure that the Divisional Directors take clinical ownership of the policy.

**Divisional Operational Directors** - The Divisional Operational Directors will ensure that all healthcare workers comply with this policy and that all healthcare workers attend mandatory infection prevention and control training. They are responsible for ensuring adequate facilities and resources are available to adhere to this policy.

**Clinical Service Managers/Leads** - The Clinical Service Managers/Leads will ensure that a printed copy of this policy is available in all of their areas. They will ensure that all healthcare workers comply with this policy and that all healthcare workers attend mandatory infection prevention and control training.

**All Trust employees** - All Trust employees will comply with this policy and inform the Infection Prevention and Control Team about any issues or concerns relating to the policy. All staff will attend mandatory Infection Prevention and Control training annually. Infection control is the responsibility of ALL staff associated with patient care. A high standard of infection control is required on ALL wards and units, although the level of risk may vary. It is an important part of total patient care.

**Committees/Groups**

**Infection Prevention and Control Team (IPCT)** - IPCT will provide advice to healthcare staff on the treatment and isolation requirements of patients with GAS infection. They will provide ongoing GAS infection surveillance. During outbreak situations the IPCT will lead on the control of the outbreak.

The IPCT will act as a resource for information and support. They will provide education in relation to this policy which includes mandatory training. They will monitor the implementation of this policy via audit within clinical areas and be responsible for regular review of the document.

**Health4Work department** - Health4work will act as a resource for information, and support and consult with managers, the Infection Prevention and Control Team and health care workers regarding the use of personal protective equipment. They will provide advice to staff who have been in contact with a GAS infection. They will also retain the staff contact list.

**Health and Safety** - The Health and Safety Team will act as a resource for information, and support and consult with managers, the Infection Prevention and Control Team and healthcare workers regarding the use of personal protective equipment.
6. **Response to a GAS positive laboratory sample in a hospital patient?**

When a patient is identified as having GAS, the initial investigation should establish if the patient is colonised or infected and if the organism is community or hospital acquired. Assessment must include whether the patient has a history of a sore throat or skin infection (which would be consistent with a GAS infection on or just prior to admission) and whether he/she has been treated previously for presumed or proven GAS infection.

Assessment is also required to identify hospital acquired invasive GAS infections to establish if the case is sporadic or part of a possible cluster. Prospective enhanced surveillance should be carried out following a single case of hospital acquired invasive GAS infection, highlighting with the multi-disciplinary team that all patients’ wounds on the ward are to be screened for GAS. The IPCT must be informed of any cases found. Post discharge surveillance should also be carried out by letter to the patient with a patient information leaflet (see the patient information section on the intranet for latest version) requesting they contact their GP if they have any signs or symptoms and also the Infection Prevention and Control Team.

7. **Routes of Transmission**

There are historical reports of invasive GAS infections acquired from patients by healthcare workers, including a mortician who acquired necrotising faciitis following a needle stick injury. Transmission has also been described following needle stick injury occurring during surgical operations. Any patient identified as being a contact of a GAS person should be discussed urgently with the microbiologist, so that isolation and possible treatment can be commenced.

**Intra-familial spread**

Intra familial spread of GAS is common and enquiries should be made as to whether visitors and close personal contacts are suffering form any illness that could be attributable to GAS. Identification of a close personal contact with GAS infection reduces the likelihood that the infection is acquired from a hospital source. Appropriate specimens should be taken from close contacts to confirm the source if possible.

**Transmission from mother to baby**

Pregnant women who are found to be infected or colonised with GAS during pregnancy but before delivery, should be treated at the time and have this clearly documented in their maternity notes. Babies born to infected mothers may become colonised. Babies at risk should have their umbilicus and ears swabbed. Antibiotics should be administered to mother and baby if either develops an invasive GAS infection in the neonatal period (first 28 days of life). Ideally on admission, all women should be asked about possible recent exposure to sources of Streptococcal infection e.g. household members with tonsillitis, cellulitis or impetigo.

**Transmission from patient to close personal contact**

Antibiotics should not be routinely administered to all contacts of GAS. Close personal contacts of invasive GAS should receive information outlining the signs and
symptoms of invasive GAS infection and advised to seek medical attention if they develop such symptoms within 30 days of a diagnosis of the contact. Friends and family should be provided with a patient information leaflet (see the patient information section on the intranet for latest version). Close personal contacts are defined as sharing a household or being kissing contacts within the seven days prior to the onset of the illness. Contact tracing is the responsibility of Public Health England.

**Transmission from patient to patient**
Transmission from patient to patient is minimised with isolation and good infection prevention and control practice. The IPCT should establish if other recent cases are related. Patients with both community and hospital acquired GAS infection and colonised and infected healthcare workers have caused hospital outbreaks.

**Transmission from patient to healthcare worker**
Transmission from patient to healthcare worker is most frequently described after contact with necrotising faciitis where multiple contacts may become infected or colonised. Healthcare workers working without appropriate personal protective clothing (PPE) whilst a patient is infectious should be advised to check for the signs and symptoms of GAS infection for 30 days after the contact and if symptoms occur, to seek urgent medical advice. Health4Work staff should provide advice for staff.

**Healthcare workers and prophylaxis**
Prophylaxis should be considered for healthcare workers who sustain a needle stick injury or direct contamination of mucous membranes of breaks in the skin with potentially infectious material. Amoxycillin for three to five days is the recommended treatment. Midwifery and paediatric staff who work with young babies and children who have been in contact with GAS may require prophylactic antibiotics after discussion with the consultant microbiologist.

**Transmission from healthcare worker to patient**
For a single case of hospital acquired invasive GAS, all healthcare workers in close contact with the patient should be considered as possible sources of infection. Those most likely to transmit infection are those with direct contact with the patient within 7 days of the onset of infection. The following groups should be investigated:

Those present in theatre and performing post operative dressing changes for surgical cases. Those performing vaginal examinations or dealing with episiotomies and those present at delivery for maternity cases.

Healthcare workers should be asked to take screening swabs if they have suffered a sore throat or skin infection, or have had skin lesions/dermatitis/eczema or vaginitis during the week prior to the index patient’s onset of infection. Health4Work should screen and advise staff.
8. Screening of Healthcare Workers by Health4Work
For asymptomatic healthcare workers, epidemiologically linked to cases of hospital acquired invasive GAS infection, swabs must be taken from the throat and skin lesions (including all exfoliating skin conditions) initially. Samples from dry skin should be taken with a swab moistened with sterile saline.

If the samples are negative but healthcare workers are still thought to be epidemiologically linked to cases, after discussion with the Consultant Microbiologist swabbing of other sites like anus, vagina and anterior nares should be considered as carriage can be at these sites.

Symptomatic healthcare workers should be managed by Health4Work staff in liaison with their GP. Health4Work staff should advise regarding fitness for work: non clinical settings may be suggested until swabs are negative.

Healthcare staff should be re-screened 24 hours after the end of treatment and again at 1, 3, 6 and 12 weeks post treatment. Early consideration should be given to screening the throats, skin lesions and vaginas of their household contacts.

If the healthcare worker is found to be colonised by a strain different from the outbreak strain, clearance screens are not required.

Management of colonised healthcare workers
See Appendix B.

Length of exclusion from work
Healthcare staff with GAS throat carriage should stay away from clinical work until at least 24 hours of appropriate treatment if asymptomatic, and until symptom free if symptomatic.

Healthcare worker with active skin lesions are at increased risk of colonisation and shedding, and have been particularly associated with intra-hospital spread, including the delivery suite. A longer length of time maybe required for any skin lesions to heal or dermatitis to be treated. Health4Work staff and the staff member’s GP should liaise with the consultant microbiologist over treatment.

Where healthcare worker carriage has been linked to transmission of invasive GAS, the duration of exclusion from work should be decided on a case by case basis and will depend on the clinical situation, site of colonisation, risk of further transmission and evidence of previous transmission.

A longer period of time may be required for healthcare workers with skin lesions or in other circumstances where carriage has been linked to transmission. This should be at the discretion of the IPCT in liaison with Health4Work department.
9. **Patients with GAS infections**

Patients admitted with tonsillitis, cellulitis or impetigo where GAS is the presumptive or confirmed diagnosis must be isolated until they have completed 24 hours of appropriate antibiotic treatment. They must remain on at least four hourly observations until symptom free or well enough to be discharged home with a patient information leaflet (see the patient information section on the intranet for latest version).

**Isolation of Patients with invasive GAS infections**

If admitted from a nursing or residential home, the local Public Health England Centre should be informed. When the patient has necrotising fasciitis with significant discharge of potentially infected body fluid, or is at high risk of shedding e.g. eczema, these patients should be isolated until culture negative or the microbiologist advises that isolation precautions can be discontinued.

A list of all healthcare staff who have had contact with the patient within the first 48 hours of antibiotic treatment must be drawn up. A copy must be kept within the ward or department and another copy sent to Health4Work.

10. **Outbreaks**

Hospital outbreaks of invasive GAS infection can escalate rapidly, be prolonged and result in both patients and healthcare workers being infected. Surgical and obstetrics and gynaecology units are most commonly involved. Investigations of these outbreaks have identified a range of transmission routes: colonised healthcare workers to patients, environmental sources to patients and patient-to-patient transmission. Patients with both community and hospital acquired invasive GAS infections have initiated hospital outbreaks, with secondary cases arising within one month of the index case. In the healthcare workers, throat colonisation is the most common source, although skin, vaginal and rectal colonisation has also been linked to outbreaks.

Outbreaks of invasive GAS must be reported as a Serious Incident Requiring Investigation (SIRI) in accordance with the Reporting, Managing and Learning from Incidents policy.

**Management of outbreak of invasive GAS infection**

An outbreak control team should be convened to manage and control a cluster or outbreak of GAS infection as soon as it is identified.

The outbreak team should include:
- Director of Infection Prevention and Control (DIPC)
- Consultant microbiologist
- Infection Prevention and Control Nurse (IPCN)
- Consultant from the speciality involved
- Clinical Service Lead & senior nurse from the speciality
- Health4Work
• Cleaning and facilities manager
• Site co-ordinator
• Communications advisor
• Public Health England Centre representative if required

For further details on the management of a major outbreak, please see the Diarrhoea and Vomiting Outbreak Management policy.

11. Epidemiology
Detailed patient histories and in-patient journeys should be explored to establish common exposures and timely investigation of possible sources of infection must be undertaken for each case of invasive GAS infection. Retrospective and prospective microbiological surveillance of all GAS cases should be undertaken to identify any links. Some of these outbreaks may evolve over several months. Longitudinal surveillance by the IPCT is important.

12. Source of Outbreaks
Healthcare workers as a source of outbreak
Surgeons, nurses, anaesthetists, midwives and wound care teams have all been implicated as sources of outbreaks of infection whilst infected or colonised with GAS. Healthcare workers can transmit infection by direct patient contact but also by airborne disposal from colonised areas like the rectum or vagina.

Environment as a source of outbreak
Baths, bidets, toilets, baths and showers have all been implicated in transmission of invasive GAS infection outbreaks. *Streptococci* can survive in dust, on objects and there are reports of environmental reservoirs being implicated in outbreaks. Environmental sources are prominent in maternity outbreaks and baths, showers and bidets present a particular cross-infection risk to mothers during the postpartum period. It is essential these items are cleaned frequently and between each use and patients have access to Actichlor Plus solution 1,000ppm to decontaminate equipment to clean these items before and after use.

Environmental sampling
If the epidemiology suggests exposure to an environmental source, swabbing of the items should take place. The item may need to be taken out of use until the results of the swabs are known. If the swabs are negative a risk assessment should take place to evaluate the continued use of the item.

Patient screening during an outbreak
Screening patients can identify who is colonised and identify patients at risk of invasive GAS infection. It can also help to identify the source of the outbreak strain. The extent of contact tracing, including patients who have been discharged, should be decided by the outbreak team. The incubation period is short, usually one to three days. It is important contacts are provided with written information prompting them to seek urgent medical advice if they develop symptoms.
Barrier Nursing - Hand hygiene and Personal Protective Equipment (PPE)
Patients with GAS infection must be barrier nursed in a side room. Those colonised with GAS or have a non-invasive infection must be isolated for at least 24 hours after commencing appropriate antibiotic treatment.

Patients with invasive GAS infection or Maternity cases must be isolated until found GAS culture negative or the microbiologist informs staff isolation is no longer required. This will be assessed on a case by case basis according to symptoms. Staff must wear gloves and yellow aprons when in contact with the patient, his/her equipment or immediate surroundings. See Standard Precautions Policy (incorporating Personal Protective Equipment).

Facial protection, such as fluid repellent mask and eye shields or visors, are recommended when a higher risk of transmission from droplets is identified, for example at bronchoscopy, suctioning or change of wound dressings for wounds that are producing a large amount of exudate. See Standard Precautions Policy (incorporating Personal Protective Equipment).

These precautions are important in the first 24 hours of effective antibiotic treatment for most infections, but may be required for longer for invasive GAS. All skin breaks must be covered with a waterproof dressing, as open wounds are a route of transmission from affected patient to healthcare worker. Effective hand hygiene must be carried out after removal of protective clothing. See Hand Hygiene policy.

Anyone, staff or visitor, who has contact with a patient with invasive GAS without wearing protective clothing must be provided with a patient information leaflet (see the patient information section on the intranet for latest version) and advised to contact their GP if they develop any symptoms within 30 days of the contact.

See the British Infection Association, Journal of Infection, national outbreak guidance for further information and details of communication to patients and staff.

13. Theatre Debridement
Fluid repellent surgical masks with visors must be used at operative debridement / change of dressings for cases of necrotising faciitis.

14. Laboratory Samples
Pathology staff should be informed when unfixed tissue from a case of necrotising faciitis is sent for examination, so that should direct contact be made with the sample, the member of staff can be correctly advised.
All GAS isolates from in-patients, peri-natal patients and neonates or those identified as being from the immediate post discharge period e.g. post operative wound swabs sent from general practice should be saved by the microbiology laboratory for at
least 6 months. This is so that retrospective analyses can take place if there is a potential outbreak or cluster of patients.

All invasive GAS isolates should be sent to the Public Health England Respiratory and Systemic Infection laboratory, *Streptococcus* and Diphtheria Reference Unit, for typing to identify a cluster and as part of the national surveillance of invasive disease due to GAS.

15. Treatment
Prophylactic treatment of contacts
Prophylactic treatment is aimed at eradicating carriage in people who have newly acquired the invasive strain of GAS.

Community contacts
Prophylactic treatment is recommended for the entire household contacts if two or more cases of invasive GAS infection occurs within the same household within a 30 day time period.

Healthcare settings
Prophylaxis is not recommended following a single case, except in mother or baby cases during the neonatal period, or if patients have symptoms consistent with localised GAS infections. Whether to treat groups of patients and staff will be made by the outbreak team after considering the nature of the cluster, source of the outbreak, severity of cases and vulnerability of patients

16. Environmental Cleaning
The isolation room, furniture and equipment must be cleaned thoroughly three times daily using Acticlor Plus.

17. Linen and Waste
Whilst the patient is considered infectious to others the linen and waste should be treated as potentially infectious.

- Linen to be placed in alginate bag and clear plastic bag
- Waste to be placed in orange bag

See Standard Precautions Policy (incorporating Personal Protective Equipment) and the Waste Management policy for further information.

18. Mortuary
It is important that the mortuary staff are notified in the event of a death due to suspected invasive GAS infection prior to the arrival of the body. A body bag must be used, not sheets. The body can be viewed but no embalming or other preparation of the body should take place. The mortuary staff must inform the undertaker of precautions required.
19. Communication Strategy

Patients, contacts and healthcare workers should be provided with clear, concise information about GAS infections. An important part of prevention is enhanced surveillance and heightened awareness by medical staff and primary care teams to consider invasive GAS take samples promptly and give early treatment where GAS infection is suspected.

20. Stakeholders Engaged During Consultation

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<thead>
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<tr>
<td>Infection Prevention and Control (Lead Infection</td>
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<tr>
<td>Prevention &amp; Control Nurse)</td>
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<tr>
<td>Health and Safety (Health and Safety Advisor)</td>
<td>18 March 2013</td>
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<tr>
<td>Safeguarding (Trust Safeguarding Lead)</td>
<td>18 March 2013</td>
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<td>Information Governance (Information Governance</td>
<td>18 March 2013</td>
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<tr>
<td>Manager)</td>
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<td>Risk and Compliance Manager (Risk and Compliance)</td>
<td>18 March 2013</td>
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<td>Equality and Diversity Lead (Equality &amp; Diversity)</td>
<td>18 March 2013</td>
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<td>Consultant Microbiologists</td>
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21. Dissemination and Implementation

The policy will be disseminated in the following ways:

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<tr>
<td>Publicise detail of new document via Intranet and Midweek message</td>
<td>IPCT and Communication Team</td>
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<tr>
<td>Communication to all Senior Managers to advise publication of policy</td>
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<td>The policy will be available on the intranet and web site</td>
<td>BNHH Healthcare Library and Communication Team</td>
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22. Training

Individuals in the Trust should receive annual infection prevention and control training to ensure they are aware of their responsibilities. Education and Training will be provided in accordance with the Trust Training Needs Analysis (Learning and Development Policy).

Specific training on GAS and invasive GAS infections will be carried out periodically as part of the ward based teaching sessions and for Infection Prevention and Control Link Practitioners to disseminate to their teams.
If there is an outbreak of GAS infection further local training sessions will be commenced immediately.

23. Monitoring Compliance with the Document

Compliance with the policy will be monitored in the following ways:

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<tr>
<th>Minimum requirements</th>
<th>Requirement Reviewed by</th>
<th>Method of Monitoring</th>
<th>Frequency of Review</th>
<th>Monitoring Committee</th>
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<tr>
<td>A. Effectiveness of policy</td>
<td>Infection Prevention and Control Team</td>
<td>A Root Cause Analysis (RCA) will be undertaken for any healthcare acquired invasive GAS and learning will inform review of policy, procedure and training.</td>
<td>Every healthcare acquired invasive GAS</td>
<td>Infection Prevention and Control Committee</td>
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<td>B. Compliance</td>
<td>Infection Prevention and Control Team and Divisions</td>
<td>Audit of hand hygiene, standard precautions and isolation priorities.</td>
<td>As part of annual environmental audit programme</td>
<td>Ward level and Divisions</td>
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24. References


Guidance from other organisations


25. Associated Documentation

Reporting, Managing and Learning from Incidents Policy (Including the Investigation of Serious Incidents Requiring Investigation and Being Open)
Diarrhoea and Vomiting Outbreak Management policy
Aseptic Technique Policy
Hand Hygiene Policy
Standard Precautions (including use of PPE) Policy
Antimicrobial Prescribing Guidelines (Adults)
Waste Management Policy
Group A Streptococcus Patient Information leaflet
### 26. Contributors

<table>
<thead>
<tr>
<th>Contributor Job Title</th>
<th>Contributor Name</th>
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<tbody>
<tr>
<td>Director Infection Prevention and Control</td>
<td>Dr Matthew Dryden</td>
</tr>
<tr>
<td>Lead Infection Prevention and Control Nurse</td>
<td>Hazel Gray</td>
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Appendix A – Equality Impact Assessment

PART 1
To be completed by the document owner

Document Title: Group A Streptococcal Policy

<table>
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<td>1. Could the application of this document have a detrimental equality impact on individuals with any of the following protected characteristics? (See Note 1)</td>
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<td>Sexual orientation</td>
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<td></td>
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<tr>
<td>Marriage &amp; civil partnership</td>
<td>No</td>
<td></td>
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<tr>
<td>Pregnancy and maternity</td>
<td>No</td>
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<tr>
<td>2. If you have identified any potential detrimental impact, do you consider this to be valid, justifiable and lawful? If so, please explain your reasoning.</td>
<td></td>
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<td>3. If you have answered ‘no’ to question 2, has the policy been amended to remove or reduce any potential detriment?</td>
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<td>• If you answer ‘yes’, please summarise the changes made</td>
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<tr>
<td>• If you answer ‘no’. please explain why not</td>
<td></td>
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<tr>
<td>4. Based on the answers to questions 1 – 3 do you consider that a detailed equality analysis is needed?</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

NAME: Matthew Dryden

JOB TITLE: Director Infection Prevention and Control

DATE: 13 March 2013
PART 2
To be completed by the Trust’s Equality and Diversity Lead

Brief Summary of potential impact of this document and whether sufficient consideration has been given to the Equality Duty

The application of this policy for the Management Group A Streptococcal infections is completely clinically based and ensuring prompt management would be the priority, however the Trust would endeavour to continue to meet patients and employees individual needs as far as is practicable.

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Is this document recommended for publication without amendment?</td>
<td>Yes</td>
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<tr>
<td>2.</td>
<td>Is this document recommended for publication but with recommended amendments? Please specify.</td>
<td>N/A</td>
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<tr>
<td>3.</td>
<td>Is this document not recommended for publication without amendments being made? Please specify?</td>
<td>N/A</td>
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<tr>
<td>4.</td>
<td>Is it recommended that this document requires a more detailed equality analysis to be undertaken prior to publication?</td>
<td>No</td>
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<tr>
<td>5.</td>
<td>Specify with which, if any, individuals and groups you have consulted in reaching your decision.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

NAME: Verity Gibbons

JOB TITLE: Assistant Risk and Compliance Manager

DATE: 23 April 2013

Note 1
Under the terms of the Equality Act 2010’s public sector Equality Duty, the Trust has a legal responsibility to think about the following three aims of the Equality Duty as part of our decision making and policy development.

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- Foster good relations between people who share a protected characteristic and people who do not share it.
Appendix B – Management of Colonised Healthcare Workers

Eradication of carriage is recommended in all cases where onward transmission of invasive GAS has occurred. Healthcare workers who are screened and found to be positive for GAS should be treated. There is a reported failure rate of decolonisation linked to treatment of healthcare staff, this maybe due to recolonisation from their household contacts. Family members can be the source of GAS to healthcare staff. Public Health England will liaise with General Practitioners regarding screening and treatment of household contacts of staff affected by GAS.

The microbiologist and the Health4Work dept will recommend the appropriate treatment for each member of staff based on the site of colonisation or infection. Options include:

For Pharyngeal carriage:

- Oral penicillin V 500mgs qds for 10 days
- Amoxicillin 500mgs tds for 10 days
- Clindamycin 300mgs qds for 10 days
- Azithromycin 500mg day 1 and 250 mg on second to fifth day

Clindamycin should be used for eradication of throat carriage in staff where first line treatment with penicillin has not been successful.

For Non-pharyngeal carriage:

- Penicillin treatment alone is unlikely to be sufficient
- Clindamycin 300mg qds for 10 days
- Azithromycin 500mg day 1 and 250 mg on second to fifth day
- May need combine with oral rifampicin or oral vancomycin