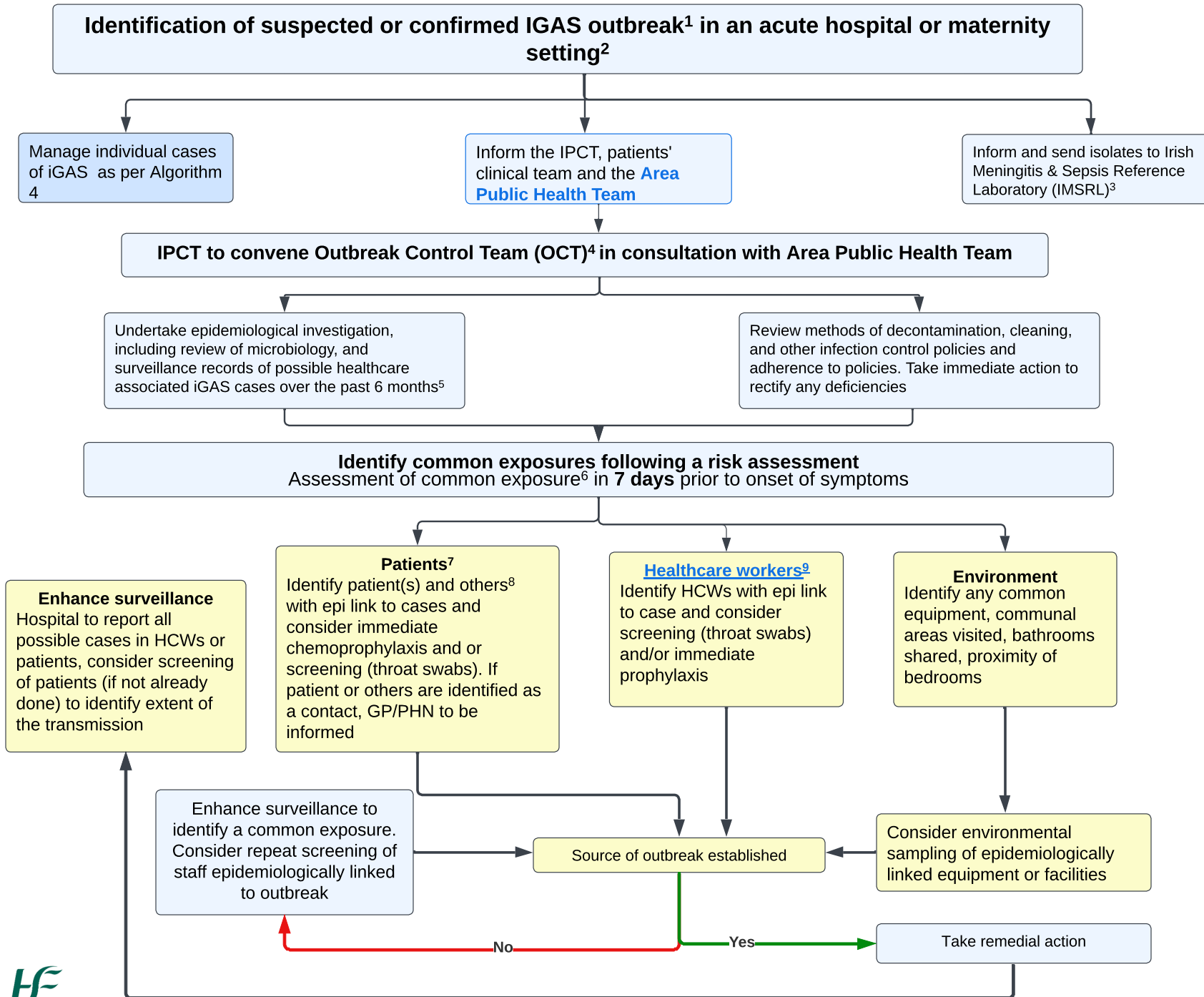




1. Consider outbreak if there are two or more cases of probable or confirmed iGAS infection related by person, place or time. Cases will usually be within a month of each other but interval may extend for several months. A single case of iGAS infection with one or more cases of non-invasive GAS infection, although not considered an outbreak, may still warrant investigation and ongoing management taking into consideration time interval, number of cases, and epidemiological links.
2. Includes hospital inpatients, patients recently discharged within **7 days** and women who gave birth in any setting including at home.
3. Clearly label isolates sent to IMSRL as part of a suspected outbreak to prioritise processing. Epidemiological investigations and preventative measures should not await results of typing.
4. OCT membership may include but is not limited to: Administrators (medical and nursing), managers of implicated areas, relevant Clinical Directors/Chief Clinical Directors, IPC Professional, Clinical Microbiologist, Public Health Physician, Infectious Diseases Physician, Epidemiologist, Occupational Health Physician, Chair (Clinical Director or Senior Hospital Management), Cleaning services and estates, Food services, others as defined by circumstances. For outbreak closure, a conservative approach of 60 days since last iGAS case (2 x 30 day period).
5. Other patients, HCWs, equipment and the environment are possible sources of outbreaks. Develop timelines and inpatient journeys to identify overlaps of hospital stays and common exposures
6. Assess common exposures according to cases movements or contacts in the **7 days** prior to their respective onset of symptoms. Close contact is defined as someone who has had prolonged* close contact with the case in an acute hospital setting during the **7 days** before onset of illness and up to 24 hours after initiation of appropriate antimicrobial therapy in the index case. *Note: HCWs caring for patients with standard precautions and wearing appropriate PPE are not considered close contacts.*
7. Symptomatic patients or others with an epi-link to a case should be clinically assessed and managed as a case if confirmed.
8. Carers, peripatetic staff (hairdressers, podiatrists, hospital chaplains, contract cleaners etc.), visitors, volunteers, other patients with direct contact or close proximity to case within 7 days prior to onset of illness and up to 24 hours after initiation of appropriate antimicrobial therapy in the index case. Consider kitchen staff.
9. Symptomatic HCWs should attend their treating physician for clinical review and management. Indications for this may include, strong epidemiological link, absence of alternative potential source for the infection and/or where patients developed iGAS infection. HCWs who require antibiotics due to symptoms or positive throat swab should be excluded from work until 24 hours after starting antibiotics. The OCT should risk assess if asymptomatic HCWs should be invited for screening and agree a pathway for same.

*Prolonged close contact as defined by OCT Risk Assessment. Example of a patient close contact is an individual who has an overnight stay in the same room/bay as the case.