Algorithm 4: Management of a single case of iGAS infection in an acute hospital or maternity setting[1]

Version 1.1 03/03/2026 *To be read in conjunction with* ***Management of invasive and non-invasive Group A Streptococcal infection for mothers and neonates within 28 days of delivery***

Identification of a single case of iGAS infection in an acute hospital or maternity setting[1]

Hospital in-patients
- Isolate in single room with own toilet/washbasin whilst considered infectious.
- Manage infected patient as per local infection, prevention and control policies

Inform the IPCT, patients' clinical team and the **Area Public Health Team**

Microbiology laboratory to save isolate for 6 months and send directly to Irish Meningitis & Sepsis Reference Laboratory (IMSRL)[2]

Ascertain if iGAS infection is healthcare associated[3]

No → No further investigation in acute hospital or maternity setting. Refer to appropriate algorithm for Public Health management.

Yes

Undertake epidemiological investigation, including review of microbiology, and surveillance records of possible healthcare associated iGAS cases over the past 6 months[4].
Any additional cases identified?

Yes → See **Algorithm 3** if additional cases are identified.

No

Identify common exposures following a risk assessment
Assessment of common exposure[5] in 7 days prior to onset of symptoms

Patients[6]
Identify patient(s) and others[7] with epi link to case and consider immediate chemoprophylaxis and or screening (throat swabs). If patient or others are identified as a contact, GP/PHN to be informed

Health and care workers[8]
Identify H&CWs with epi link to case and consider screening (throat swabs) and/or immediate prophylaxis

Environment
Identify any common equipment, communal areas visited, bathrooms shared, proximity of bedrooms

If further cases are identifed, refer to **Algorithm 3**. If no further cases are identfied, no further investigation required

Consider environmental sampling of epidemiologically linked equipment or facilities

1. Includes hospital inpatients, patients recently discharged within **7 days** and women who gave birth in any setting including at home.
2. Clearly label isolates sent to IMSRL. Epidemiological investigations and preventative measures should not await results of typing.
3. Consider healthcare-associated if symptoms/signs of infection not present on admission or if discharged from hospital or gave birth within the previous 7 days and where there is no other obvious source of transmission e.g. from close hosuhold contacts
4. Other patients, H&CWs, equipment and the environment are possible sources of infection. Develop timelines and inpatient journeys to identify overlaps of hospital stays and common exposures
5. 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: H&CWs caring for patients with standard precautions and wearing appropriate PPE are not considered close contacts.*
6. Symptomatic patients or others with an epi-link to a case should be clinically assessed and managed as a case if confirmed.
7. Carers, peripatetic staff (hairdressers, podiatrists, hospital chaplins, 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.
8. Symptomatic H&CWs 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. H&CWs 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 H&CWs 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.