Leamington Mennonite Home
Long Term Care

INFECTION CONTROL

CATEGORY:	**SUBJECT:**	**SECTION:**
Disease-Specific Precautions	**Invasive Group A Streptococcus (iGAS) Disease**	**H**
		POLICY:
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DATE:	**Administrator's Signature:** J. Im!	
July 12, 2022		
REVISION DATES:	**IPAC Lead's Signature:** L Coppola, RN.	
December 2023		

INVASIVE GROUP A STREPTOCOCCUS (iGAS) DISEASE

POLICY:

There are specific procedures required for the management of Invasive Group A Streptococcal Disease (iGAS) in long term care communities.

PROCEDURE:

When a confirmed case of iGAS Disease occurs, the IPAC Lead or designate will initiate Contact and Droplet Precautions and will:

1) Report the case to the local Public Health Unit.

2) Utilize the daily line listing surveillance to count and keep track of the number of confirmed cases of iGAS within the Home according to a standardized case definition and maintain a summary record.

3) Conduct a retrospective chart review of the entire Home's residents over the previous 4-6 weeks for culture-confirmed cases of GAS disease and any suggested cases of noninvasive or invasive GAS infection, including skin and soft tissue infections (e.g. pharyngitis & cellulitis), excluding pneumonia and conjunctivitis not confirmed by culture.

4) Assess the potential for a source of infection from outside the Home (e.g., regular visits from children who have recently been ill).

If an excess of GAS infection is identified, the following actions should be considered:

1) Screened staff for GAS with throat, nose, and skin lesion cultures.

2) Anyone colonized with GAS should receive chemoprophylaxis.

3) Ask non-resident care team about possible recent GAS infections. Those with a positive history should be screened for GAS, and those who are positive should be treated with antibiotics as per the recommended regimen.

4) All GAS isolates should have further typing. Culture for a test of cure is recommended for individuals found to have the outbreak-related strain, particularly if there is epidemiologic evidence indicating that contact with the individual is significantly related to illness. Culture

for a test of cure is not necessary for individuals infected with a strain of GAS not related to the outbreak.

5) Rescreen all GAS positive residents and staff, including throat and skin lesion(s), 14 days after chemoprophylaxis has been started; this should be followed by screening at two weeks and four weeks after the first re-screening. If the person is found to be positive, a second course of chemoprophylaxis should be offered. If the person is still colonized after the second course, discontinue chemoprophylaxis unless the community has an ongoing problem with GAS infection.

6) Continue active surveillance for GAS infection for one to two months.

7) Collect appropriate specimens for culture to rule out GAS when suspected infections are detected by active surveillance.

Note: If no excess is identified, especially if there is evidence of an outside source of infection for the index case, then active surveillance alone for two to four weeks to establish the absence of additional cases is warranted.

The Nurse will:

1) Initiate Contact & Droplet Precautions when there is a suspected or confirmed case of iGAS.

2) Discontinue Contact Precautions only in consultation with IPAC Lead.

All Staff will:

1) Follow contact and droplet precautions.

The Housekeeping Staff will:

1) Provide twice daily cleaning and disinfection of resident room and bathroom using routine cleaning products.
2) Following proper PPE use when cleaning the room.

The Dietary staff will:

1) Provide resident tray service until out of isolation.
2) Provide disposable dishes for all meals. Dishes are to be disposed of in the resident's garbage.