[DATE], 2023

[Contact person name]

[Facility Name]

[Facility address]

[Facility address]

Dear [Facility Contact Person],

In [Month, year], a single case of invasive Group A streptococcal (GAS) infection was identified in a resident of [Facility Name]. Since then, [#] additional case[s] of GAS have been identified. Because of the severity of GAS infections, and the high likelihood of person-to-person transmission, cases of invasive GAS in a nursing care setting require immediate and comprehensive action.

Investigators from the PA Department of Health (DOH) performed a site visit at the [Facility Name] on [Date of Site Visit]. We reviewed infection control practices and made recommendations for improvement. The purpose of this letter is to reiterate our recommendations and provide infection control guidance to reduce the potential for additional cases of GAS and other transmissible infections.

Our recommendations include:

1. Monitoring for additional symptomatic cases
* Monitor residents daily for symptoms of invasive (i.e., blood or other sterile sites) and non-invasive (i.e., wound or throat) infections for 4 months (at least until **XX XX, 20XX**) following the last case identified. Staff should check residents daily for symptoms consistent with GAS (particularly pharyngitis and possible wound infections), maintain a record of symptom checks, and culture anyone with symptoms consistent with a GAS infection. This should include residents in all units. Treat residents with positive cultures as clinically indicated.
	+ [Group A Strep Symptom Surveillance Log](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/Surveillance%20Symptom%20Tracker%20Example.pdf)
* Maintain transmission-based precautions according to the guidance at the following link: [Transmission-based Precautions for Group A Streptococcal Infection in Long-term Care Facilities](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/Transmission-based%20Precautions%20for%20Group%20A%20Streptococcal%20disease%20in%20LTCF.pdf).
* Report both invasive or non-invasive GAS infections immediately to **[DOH contact information]**; additional recommendations will be made as appropriate.
* Monitor staff members involved in direct patient care for symptoms of GAS, and culture anyone with symptoms. Treat symptomatic staff with positive cultures as indicated clinically. Alternatively, refer staff to their personal provider for culture and treatment. Any staff member with a diagnosed GAS infection should be excluded from direct patient care until antibiotic treatment has been administered for a minimum of 24 hours.
	+ [Handout for Healthcare Workers in Long-term Care Facilities](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/GAS_HCW_handout_V3.pdf)
* Ensure that any positive GAS cultures collected for residents at the hospital or other external providers are reported to you or other facility staff responsible for infection control.
1. Identification and decolonization of potential carriers
* Collect samples from all residents to test for the presence of GAS. Samples to be collected include throat swabs and swabs of open wounds, lesions, gastrostomy, and nephrostomy sites. Only include other device insertion sites (e.g., tracheostomy, peripherally inserted central catheters, etc.) if evidence of skin breakdown, redness, or irritation is present.
* Collect samples from all staff members providing direct patient care (in the unit or floor identified, if applicable). Samples to be collected include throat swabs and swabs of open, exposed wounds on fingers, hands, forearms. Any staff member colonized with GAS should be excluded from the workplace until an effective antibiotic has been administered for a minimum of 24 hours.
	+ [How to Collect a Throat Swab for Culture](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/How%20to%20Collect%20a%20Throat%20Swab%20for%20Culture.pdf)
	+ [How to Collect a Wound Culture](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/How%20to%20Collect%20a%20Wound%20Culture_v3.pdf)
	+ [How to Collect an Ostomy Culture](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/How%20to%20Collect%20an%20Ostomy%20Culture.pdf)
* Any resident or staff member found to be colonized with GAS during screening should be prescribed an appropriate antibiotic regimen as recommended by the Centers for Disease Control and Prevention to eradicate the bacteria (benzathine penicillin G + rifampin or a first-generation cephalosporin PO). **Please note that the drug regimen for decolonization is not the same as the treatment for people with symptoms.** DOH will discuss this regimen on a case-by-case basis.
	+ [Antibiotic Recommendations for Decolonization of Asymptomatic People with Group A *Streptococcus* 2023](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/GAS%20Antibiotic%20Recs%20for%20Decolonization.pdf)
* For any resident or staff member found to be colonized, swabs from all sites (including those that were initially negative if more than one specimen was taken) should be collected again 7-10 days after antibiotic completion.
1. Infection prevention and control recommendations
* A certified wound ostomy care nurse (WOCN) or an infection preventionist with expertise in wound care should be available to provide training and education for all staff who perform wound care (including care for minor wounds) and to thoroughly assess wound care practices and policies.
* Develop a facility-specific hand hygiene policy that emphasizes preferred use of alcohol based hand rub (ABHR) over hand washing according to CDC’s [Guideline for Hand Hygiene in Health-Care Settings](https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf) and the Department’s [Alcohol-based Hand Rub Memo](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/ABHRmemo%20final%20approved%20updated%20final%207%209%2019.pdf).
* Perform monthly hand hygiene audits on each floor or unit. If possible, consider a “secret shopper” approach so that staff do not necessarily know they are being observed. Audits should occur during day, night and weekend shifts.
	+ [Hand Hygiene Audit Guidance](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/Hand%20Hygiene%20Audit%20Guidance.pdf)
	+ [Hand Hygiene Audit Tracking](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/Hand%20Hygiene%20Audit%20Tracking.xlsx)
	+ [Hand Hygiene Audit Tool](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/Hand%20Hygiene%20Audit%20Tool.pdf)
	+ [DOH Hand Hygiene Moments Poster](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/Hand%20Hygiene%20Make%20Your%20Intention%20Prevention.pdf)
* Ensure standard precautions during resident care are being followed, particularly during wound care. Gloves should be changed and hand hygiene performed when moving from dirty to clean wound care activities (e.g., removal of soiled dressings, before handling clean supplies). Reinforce the idea that standard precautions include wearing a gown and gloves whenever contact with body fluids might occur.
* Consider implementing surgical mask use during all wound care activities or when handling invasive medical devices for the duration of the outbreak (4 months from the onset date of the most recent case)1 . GAS is a common pathogen for intermittent pharyngeal colonization, often without symptoms. Furthermore, GAS is spread by droplet transmission, which can occur from a distance up to 3 feet.2 This means that wound care staff could be colonized with and transmit GAS even when they do not have symptoms. This recommendation is important and will provide additional protection in preventing potential severe diseases caused by GAS and GAS transmission.
* Ensure only those with appropriate training are performing wound care. Verify that aseptic technique is maintained throughout wound care procedures by performing routine audits of wound care dressing changes and other procedures.
	+ [Wound Care Observation Checklist for Infection Control](https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/Wound%20care%20observation%20checklist.FINAL.pdf)
* Maintain a sufficient quantity of wound care supplies so that supplies are not re-used or shared between residents. All wound care products should be patient-specific, labeled, and stored in a patient-specific area of the wound care cart. If the wound product enters the patient room for wound care, the outside of the tube should be considered contaminated, and stored separately in a plastic bag in the wound cart. Occasionally, wound care products are not designed to be patient-specific. In which case, they should never enter the patient room, should only be accessed with clean, gloved hands, and should be dispensed onto a sterile surface (e.g. gauze, drape or cotton-tipped applicator).
* Consider working with the DOH Bureau of Quality Assurance, Division of Nursing Care Facilities and Division of Safety Inspection to identify ways to increase glove accessibility without compromising resident safety. On several visits to facilities throughout the state, lack of conveniently available gloves were found, which can lead to inadequate glove usage.
* Ensure that medical scissors are disinfected after each use according to manufacturer guidelines. Ideally, scissors used for wound care should be patient-specific.
* Review and audit infection control policies and practices for respiratory care.
* Consider cohorting healthcare providers on affected unit(s) to limit transmission within the facility.
* Improve influenza and COVID-19 vaccine coverage among residents and staff. People infected with respiratory viruses are susceptible to follow-up bacterial infections such as those from GAS, so improving vaccine coverage may reduce the risk of influenza, COVID-19 and GAS.3,4
* For all infection control issues listed above, ensure compliance by continuing to conduct random, periodic review (i.e., audits), documenting results, providing feedback to staff on compliance rates, and retraining staff as necessary.

We appreciate your commitment to patient care, infection control, and reducing healthcare-associated infections at your facility. If you have any questions about this information or to make a disease report consistent with the recommendations above, please contact **[DOH contact info]**.

Thank you for your cooperation.

Sincerely,

Lisa McHugh, PhD, MPH

State Epidemiologist

Director, Bureau of Epidemiology

References

1. [Investigate Outbreaks of Group A Streptococcus Infections in Long-Term Care Facilities | CDC](https://www.cdc.gov/groupastrep/outbreaks/LTCF/investigate.html)
2. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Available from <http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf>.
3. Chertow DS, Memoli MJ. Bacterial coinfection in influenza. JAMA. 2013 Jan 16;309(3):275-82.
4. Lee SE, Eick A, Bloom MS, et al. Influenza immunization and subsequent diagnoses of group A streptococcus-illnesses among U.S. Army trainees, 2002-2006. Vaccine. 2008 Jun 25;26(27-28):3383-6.