

Queensland Health

Outbreak management in healthcare facilities – infection prevention and control

Version 6.0 2025



Queensland
Government



This document is licensed under a Creative Commons Attribution 3.0 Australia licence. To view a copy of this licence, visit creativecommons.org/licenses/by/3.0/au

© State of Queensland (Queensland Health) 2025

You are free to copy, communicate and adapt the work, as long as you attribute the State of Queensland (Queensland Health).

For more information contact:

Queensland Infection Prevention and Control, Department of Health, Queensland Health, GPO Box 48, Brisbane QLD 4001, email qipcu@health.qld.gov.au, phone 3328 9754.

An electronic version of this document is available at <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/infection-prevention>

Disclaimer

The content presented in this publication is distributed by the Queensland Government as an information source only. The State of Queensland makes no statements, representations or warranties about the accuracy, completeness or reliability of any information contained in this publication. The State of Queensland disclaims all responsibility and all liability (including without limitation for liability in negligence) for all expenses, losses, damages and costs you might incur as a result of the information being inaccurate or incomplete in any way, and for any reason reliance was placed on such information.

Acknowledgement of country

Queensland Health acknowledges the Traditional and Cultural Custodians of the lands, waters, and seas across Queensland, pays our respects to Elders past and present, and recognises the role of current and emerging leaders in shaping a better health system.

Queensland Health acknowledges the First Nations peoples in Queensland are both Aboriginal peoples and Torres Strait Islander peoples, and supports the cultural knowledge, determination, and commitment of Aboriginal and Torres Strait Islander communities in caring for health and wellbeing for millennia.

Clinician quick reference guide

This guide provides all clinicians, including those from specialties other than infection prevention and control and infectious diseases, with support on the immediate outbreak management actions required when a trigger event occurs. It contains instructions on isolation, communication pathways, trigger investigation and escalation.

Instructions
<p>All clinicians should be aware of facility trigger events. A trigger event is a point at which the incidence of a particular infectious organism is higher than would be normally expected.</p>
<p>If a trigger event occurs, take immediate action as per: Trigger investigation flow chart.</p>
<p>Step 1. Isolate the patient/s involved in the trigger event.</p> <ul style="list-style-type: none">• Initiate standard and transmission-based precautions for all symptomatic patients and close contacts (if required).• Acute respiratory infection symptoms: AIRBORNE + STANDARD PRECAUTIONS (PPE is PFR (particulate filter respirator (P2/N95)), protective eyewear, and face shield <u>until causative agent known</u>).• Gastrointestinal symptoms: CONTACT + DROPLET (if vomiting) + STANDARD PRECAUTIONS• Consider applying outbreak prevention infection prevention and control strategies in consultation with senior nursing and medical staff.
<p>Step 2. Alert the care team and relevant discipline leads.</p> <ul style="list-style-type: none">• Follow existing communication mechanisms: key people should include, infection prevention and control (IPC) lead, infectious diseases lead, ward team leader, admitting consultant, allied health, and patient support services.
<p>Step 3. Trigger investigation and risk assessment</p> <ul style="list-style-type: none">• The IPC team (or duty nurse manager after hours) will commence a trigger investigation on detecting a trigger event as per the instructions in Trigger investigation tool.• After hours the duty nurse manager should consult with the infectious disease physician on call or equivalent.• Conduct a risk assessment using the data from the trigger investigation, as per Risk assessment tool.
<p>Step 4. Escalate the trigger event if MODERATE OR HIGH as per facility protocols.</p>
<p>MODERATE OR HIGH - Activate Outbreak management plan IMMEDIATELY in consultation with IPC team and/or senior nursing and medical staff (if after hours).</p>
<p>Patient education considerations</p> <p>An event has occurred during your hospital stay, which means that you have, or might have, been exposed to an infection or infectious disease. This event is also known as an outbreak.</p> <p>Your treating team and the infection prevention and control team are working to understand why this happened and prevent further spread of infection.</p> <p>To protect the privacy and confidentiality of all people involved we can only share certain information with you. You can expect to know:</p> <ul style="list-style-type: none">• which infection you may have been exposed to,• when and where you may have been exposed,• what signs or symptoms to watch out for,• the test results of any samples we ask you for, and• how long the outbreak might last. <p>During an outbreak, you may experience any, or all, of the following:</p>

- You and/or your visitors may be asked to consent to testing that might not be directly related to your care.
- You may be given medication to prevent you from getting sick during the outbreak.
- You and/or your visitors may be asked personal information relating to the outbreak investigation, such as where you have been or what you have eaten.
- You and/or your visitors may be asked to wear personal protective equipment (PPE) around the ward.
- You may be asked to stay in your room or bed space, and you may need to move beds as we manage the outbreak.
- You may be discharged early, or have your discharge delayed, for your own safety or the safety of others.
- Visitors may be restricted, but we will make sure that you have access to a phone or device to have contact with your loved ones.
- Staff may wear PPE when providing care to you, even though you do not have an infection.
- There may be special signage about the outbreak at the ward entry.

If you have questions about the outbreak or any other aspect of your care, please talk with your care team. As with all care that we provide to you, we will seek your consent to participate in the outbreak investigation.

A [consumer guide](#) on outbreak management is provided in the implementation toolkit.

Contents

Clinician quick reference guide	3
Summary	7
Scope	8
Risk impact statement	8
Key recommendations	9
Recommendation 1 – Embed a robust infection prevention and control program at baseline, incorporating legislative requirements.	10
Recommendation 2 – Develop and implement a facility outbreak management plan.	10
Recommendation 3 – Define the outbreak management team roles and responsibilities.	11
Recommendation 4 – Outbreak management plan and infection control management plan provisions should be tested, audited, and evaluated.	11
Recommendation 5 – Systemic provisions should be made to meet the unique needs of priority populations.	11
First Nations considerations	11
Paediatric considerations	11
Other priority population considerations	11
Recommendation 6 – Epidemiology surveillance systems should trigger an IPC investigation.	12
Recommendation 7 – Identify the outbreak early and activate the outbreak management plan.	12
Recommendation 8 – Convene the outbreak management team to investigate the outbreak situation and inform IPC interventions.	12
Recommendation 9 – Co-ordinated and prompt case finding and contact tracing are imperative to reduce ongoing transmission.	13
Recommendation 10 – Stand-up an emergency operations centre if the outbreak impact is anticipated to be significant or involve multiple departments/jurisdictions.	13
Recommendation 11 – Adopt a syndromic approach to applying transmission-based precautions.	13
Recommendation 12 – Plan communication strategy early and proactively communicate with key stakeholders.	13
Recommendation 13 – Ensure that lessons learnt inform timely quality improvements.	14
Safety and quality	14
Human rights assessment	14
Environmental sustainability	14
Consumer engagement	14
Related documents	15
Glossary and abbreviations	15
Editorial independence	17
Expert working group	18
Conflicts of interest	18
System consultation	18
References	19
Appendix 1: Implementation toolkit	22
Implementation resources	22
Implementation checklist	22
Patient and consumer guide	24
Outbreak management plan (sample)	26

Trigger definition	26
Trigger event occurs	26
Step 1. Isolate the patient/s involved in the trigger event.	26
Step 2. Alert the care team and relevant discipline leads.	26
Step 3. Trigger investigation and risk assessment.	27
Step 4. Declare the outbreak.	27
Step 5. Activate the outbreak management plan.	27
Step 6. Initiate IPC strategy.	27
Step 8. Conduct outbreak investigation.	31
Step 9. Declare the outbreak over.	33
Evaluation	34
Outbreak management team	34
Trigger investigation Tool (sample)	37
Trigger investigation flow chart	37
Trigger investigation form (sample)	38
Risk assessment tool (sample)	39
Rationale	40
Define the population to be risk-assessed	40
Validate what is known	40
Consult the evidence-base	40
IPC Outbreak management checklist (sample)	41
Case (suspected or confirmed) investigation form (sample)	43
Daily outbreak response situation report (line list) (sample)	45
SBAR Outbreak communication tool (sample)	46
Appendix 2: Evidence check	47
Evaluation of the current Guideline	47
Methodology	47
Statement of evidence	47
Literature search strategy	48
Inclusion criteria	49
Exclusion criteria	49
Evidence appraisal	49
Evidence appraisal table	51
Evidence synthesis	58
Key recommendations	64
Key recommendations table	65
Document approval details	66
Version control	66
Review plan	66

Summary

The **Outbreak management in healthcare facilities – infection prevention and control guideline** provides an evidenced-based approach to developing hospital and health service (HHS) infection prevention and control (IPC) outbreak management plans to identify and manage outbreaks of infections. The term “communicable disease” will be used throughout this document for brevity but refers to any infectious agent which can be transmitted throughout the healthcare environment by any route, including known and novel communicable diseases (whether notifiable or not) and significant and multi-resistant organisms.

The Guideline is comprised of three sections:

- [Key recommendations](#),
- [Implementation toolkit](#), and
- [Evidence check](#).

The Guideline is separated into these parts to improve accessibility for all readers, especially clinicians and staff from specialties other than IPC and infectious diseases, who can refer to the [Clinician quick reference guide](#) for immediate support in outbreak management response.

The Key recommendations are the evidence-based guidance on outbreak management, which should form the foundations of the HHS response. The Australian Guidelines have been long established as the standard of accepted practice in Queensland Health facilities. The Australian Guidelines were developed using a rigorous methodology, and provide comprehensive detail on most IPC topics¹ Queensland Health IPC guidelines are provided to contextualise and summarise advice provided in the Australian Guidelines. All Key recommendations within this Guideline are considered accepted practice, with no new recommendations made since the last revision.

The Implementation toolkit is provided as an appendix to support the HHS to implement the Key recommendations of the Guideline, and includes an implementation checklist, templates and guides for HHS adaption. The Evidence check is provided as an appendix to substantiate the [Key recommendations](#) with rationale, evidence and recommendation strength and references. Further, it provides evaluation data on the previous version, and extensive detail on the methods of evidence appraisal and synthesis.

The Guideline was developed using the Queensland Infection Prevention and Control Unit (QIPCU) Clinical practice guideline development, review, and evaluation framework (the Framework), which was co-designed by an expert working group of IPC professionals. The Guideline incorporates the key principles of [2016 NHMRC Standards for Guidelines](#) and the [Appraisal of Guidelines for Research and Evaluation \(AGREE\) Enterprise tools](#).^{2,3} Further information on the Framework or this Guideline can be requested by emailing qipcu@health.qld.gov.au.

The Guideline aligns with the [Queensland Health Disasters and Emergency Incidents Health Service Directive](#), the [Queensland Health Disaster and Emergency Incident Plan](#) (QHDISPLAN), the Queensland Health Incident Management System (QHIMS) Guideline and the Queensland Public Health Sub-plan. To support implementation by HHS, the Guideline is arranged within the disaster management approach of **prevention, preparedness, response, and recovery (PPRR)**.

The Guideline incorporates outbreak management and IPC advice from the [WHO Framework and Toolkit for Infection Prevention and Control in Outbreak Preparedness, Readiness and Response at the Health Care Facility Level](#) and the [Australian Guidelines for the Prevention and Control of Infection in Healthcare \(2019\)](#) (the Australian Guidelines).

Scope

The Guideline applies to HHS facilities/services, their employees (permanent, temporary, and casual) and all organisations and individuals acting as their agents (including contractors, consultants, students, and volunteers). This includes acute care, aged care, offender health, dental health, and disability services managed by Queensland Health, though it must be noted that the nuance of these contexts has not been accounted for fully. Queensland-licensed private health facilities may choose to use this Guideline.

The Guideline does not include clinical treatment advice for any communicable disease or condition. While adherence to the Guideline is not mandatory, a robust rationale for any deviation should be documented.

The Guideline assumes that all employees have undertaken IPC mandatory training appropriate to their role on commencement, as per [Human Resources Policy G6 \(QH-POL-183\)](#).

Risk impact statement

The *National Safety and Quality Health Service Preventing and Controlling Infections Standard* requires health service organisations to use evidence-based systems to reduce the risk of infection using the [hierarchy of controls](#) in conjunction with IPC systems. Outbreak management is an administrative control that identifies and mitigates risk to prevent transmission within healthcare facilities. Surveillance data should be used to measure the short- and long-term effectiveness of IPC strategies, including outbreak management.

Surveillance systems can identify infections early, enabling prompt interventions that prevent transmission, reduce patient harm, and improve overall clinical outcomes. By focusing on strategic planning, proactive surveillance and swift IPC responses, healthcare facilities may downgrade the risk rating according to local outbreak management planning. The following table provides general advice on risk rating with and without a facility-wide outbreak management plan.

Table 1: Risk rating

Risk rating without outbreak management plan			
Likelihood	Almost certain – frequency once every week or month.	Consequence	Very High (23) – Intolerable risk level. Additional risk treatment action to be identified, prioritised, and implemented to reduce the consequences.
Risk rating with outbreak management plan			
Likelihood	Almost certain – frequency once every week or month.	Consequence	High (17) – Tolerable risk level with no additional treatments required. Monitored through standard measures.

Source: [Risk Management | Safety and Quality | Metro North HHS \(health.qld.gov.au\)](#)

Key recommendations

Number	Description	Reference	Levels of evidence	Recommendation strength
1	Embed a robust infection prevention and control program at baseline, which incorporates legislative requirements.	(4–11)	6–7	Accepted practice
2	Use a facility-wide outbreak management framework to develop and implement an outbreak management plan.	(4–10,12–17)	5–7	Accepted practice
3	Outbreak management team roles and responsibilities should be clarified during the Preparedness phase.	(4,6,7,9,10,16,17)	5–7	Accepted practice
4	Outbreak management plan and Infection control management plan provisions should be tested, audited, and evaluated.	(4–6,8,10,13,16)	6–7	Accepted practice
5	Systemic provisions should be made to meet the unique needs of vulnerable populations, e.g. children and young people.	(9,13,15,16,18)	6–7	Accepted practice
6	Epidemiology surveillance systems should trigger IPC investigation.	(4–6,10–13,16,18–20)	5–7	Accepted practice
7	Identify the outbreak early and activate the outbreak management plan.	(5,6,9–14,16,18,20)	6–7	Accepted practice
8	Convene the outbreak management team to investigate the outbreak and inform IPC interventions.	(4,6,7,10,12–14,16)	6–7	Accepted practice
9	Co-ordinated and prompt case finding and contact tracing are imperative to reduce ongoing transmission.	(4,6,9–11,14,19,20)	6–7	Accepted practice
10	Stand-up an emergency operations centre if the outbreak impact is anticipated to be significant or involve multiple departments/jurisdictions.	(4–7,10,12–14,16)	6–7	Accepted practice
11	Adopt a syndromic approach to applying transmission-based precautions	(5,6,9,10,12,15,18–20)	5–7	Accepted practice
12	Plan communication strategy early and proactively communicate with key stakeholders.	(4–10,12–19)	5–7	Accepted practice
13	Ensure that lessons learnt informed timely quality improvements.	(4–10,14–16)	6–7	Accepted practice

Please refer to [Appendix 2: Evidence check](#) for detailed explanations of evidence appraisal, synthesis, and recommendation development methodology.

PREVENTION (PPRR)

- Prevention is the elimination or reduction of exposure to an infectious source.

Recommendation 1 – Embed a robust infection prevention and control program at baseline, incorporating legislative requirements.

- Systems should be in place to ensure baseline IPC activities are embedded in all Queensland Health facilities as outlined in the [ACSQHC Preventing and Controlling Infections Standard](#), relevant legislation, guidelines, and standards including the [Australian Guidelines for the Prevention and Control of Infection in Healthcare \(2019\)](#).
- Under the *Public Health Act 2005* each HHS facility should have an [Infection Control Management Plan \(ICMP\)](#) which states the following:
 - infection risks associated with the provision of declared health services
 - measures to be taken to prevent or minimise infection risks
 - monitoring and frequency of reviewing the implementation and effectiveness of the measures
 - details about training in relation to the ICMP for persons employed or engaged at the facility.

PREPAREDNESS (PPRR)

- Preparedness incorporates organisation knowledge and capacities with risk management, contingency planning activities, early warning systems, and testing the system for the response phase.

Recommendation 2 – Develop and implement a facility outbreak management plan.

- It is critical to ensure that HHS adequately prepare for [outbreaks](#) by developing an [outbreak management plan](#) (OMP) articulated in the context of wider facility disaster management planning and that aligns to section 3.4.2 of the [Australian Guidelines for the Prevention and Control of Infection in Healthcare \(2019\)](#). HHS should review this guideline alongside the [Queensland Health Disaster and Emergency Incident Plan](#) and QHIMS Guideline.
 - **Scalable:** arrangements can be applied to any size or type of outbreak
 - **Interoperable:** arrangements promote partnerships between systems, programs, and people
 - **Adaptable:** arrangements can adapt to the changing requirements of the system and remain flexible to the needs of staff and patients.²¹
- The OMP should be reviewed periodically (in accordance with the HHS procedural risk framework) and/or if an outbreak evaluation determines the need. The OMP should be approved by the IPC Committee or equivalent and should include surge capacity provisions for:
 - human resources, including workforce contingencies and business continuity arrangements
 - communications, including media plan, staff briefings, and secretariat support
 - material resources, including incident room, PPE, and cleaning supplies stockpile and storage, supply chain surety
 - education, “just in time” training and IPC upskilling, rapid response teams
 - audit requirements, including tools and quality improvement mechanisms.

Recommendation 3 – Define the outbreak management team roles and responsibilities.

- The roles and responsibilities of staff should be clearly articulated in the OMP and [outbreak management team](#) (OMT) terms of reference.

Recommendation 4 – Outbreak management plan and infection control management plan provisions should be tested, audited, and evaluated.

- Testing, auditing, and evaluating the OMP and ICMP provisions in the live healthcare environment assists to ascertain that HHS have the capacity and resources to recognise and respond to an outbreak.
- Facilities should consider desktop activities, audit mechanisms and incorporating lessons learnt from previous outbreaks to ensure preparedness.

Recommendation 5 – Systemic provisions should be made to meet the unique needs of priority populations.

First Nations considerations

- Outbreak management strategies should prioritise improving health outcomes for First Nations people and communities by preventing onward transmission of infections, while promoting the social and cultural determinants of health.
- Special considerations for applying IPC strategies in First Nations people and communities, should be accounted for in communicable disease outbreak situations. The OMT and IPC Team should ensure that they liaise with local First Nations health workers where First Nations people and communities are impacted.

Paediatric considerations

- Infants, children, and young people may be more, or less, affected by infectious diseases and the IPC strategies, and the following considerations should be incorporated into the OMP and IPC strategies during an outbreak:
 - known severity in paediatric cohorts, e.g. COVID-19 is generally less severe, RSV can be severe for infants
 - role of parents, carers, and family members in transmission events
 - capacity to comply with IPC requirements
 - supply of paediatric consumables and equipment.

Other priority population considerations

- People who live in residential disability care services, residential aged care, correctional facilities, remote areas, and other residential settings should be appropriately protected for the adverse health and social outcomes of communicable diseases outbreaks.
- Outbreak management and IPC strategies should be balanced with a person's right to freedom, agency, and social interaction.
- Advanced provisions for regional and remote facilities and populations who may experience delays or disruptions in supply chain and internet connectivity.

RESPONSE (PPRR)

- Response involves taking appropriate measures to respond to a communicable disease outbreak.

Recommendation 6 – Epidemiology surveillance systems should trigger an IPC investigation.

- Surveillance systems should enable IPC teams to review local significant organism types/numbers and record the number of confirmed or suspected patients daily or more frequently as required.
- [Trigger](#) events should be defined in the OMP and investigated by the IPC team using the following [Trigger investigation tool](#).
- A trigger investigation may confirm the presence of an outbreak requiring immediate escalation and activation of the OMP.

Recommendation 7 – Identify the outbreak early and activate the outbreak management plan.

- An outbreak may be considered where a facility detects an increase in cases of an organism of concern from surveillance data, which exceeds the agreed trigger and:
 - there is suspicion that transmission has occurred between patients who test positive during their inpatient stay, and/or
 - there is evidence to suggest that patients who have been recently discharged or received outpatient services have likely contracted the organism during contact with health services.
- Early outbreak identification can reduce the impact and duration of an outbreak, and the following basic steps are recommended:
 - Confirm the outbreak using information gathered during the trigger investigation.
 - Activate the OMP and take immediate actions required.
 - Gather data on the clinical situation to inform appropriate IPC interventions.
 - Report findings and escalate issues.
 - Consider convening the OMT.

Recommendation 8 – Convene the outbreak management team to investigate the outbreak situation and inform IPC interventions.

- The OMT is responsible for planning and coordinating the investigation. Delays in activating the OMP and convening the OMT may limit opportunities to prevent onward transmission within the facility.
- The outbreak investigation should be conducted using structured tools incorporating epidemiological, laboratory and environmental components.
- A [case definition](#) should be established or confirmed by the OMT during the initial meeting and is formed using standard criteria to determine whether an individual should be classified as a case.

Recommendation 9 – Co-ordinated and prompt case finding and contact tracing are imperative to reduce ongoing transmission.

- A [structured data collection tool](#) should be used to collect detailed case information and active case finding should be undertaken where appropriate.
- [Contact tracing](#) should not be delayed. It is vital to limit onward transmission in the facility and/or community and identify symptomatic contacts. In general, the contact tracing of healthcare facility staff, patients, and visitors should be coordinated by the IPC team and undertaken by appropriately trained appointed contact tracing officers within the facility.

Recommendation 10 – Stand-up an emergency operations centre if the outbreak impact is anticipated to be significant or involve multiple departments/jurisdictions.

- A HHS [Health emergency operation centre \(HEOC\)](#) may be stood up to provide incident management functions, especially if it is anticipated that the response is significant and/or protracted.

Recommendation 11 – Adopt a syndromic approach to applying transmission-based precautions.

- Adopting a [syndromic approach](#) to the application of [standard and transmission-based precautions \(TBP\)](#) is appropriate as the outbreak investigation proceeds.
 - [IPC strategy and instructions](#) provides detailed instructions on IPC advice during an outbreak.

Recommendation 12 – Plan communication strategy early and proactively communicate with key stakeholders.

- Effective communication is essential to the successful management of communicable disease outbreaks and should occur between key stakeholders on several levels and may include:
 - escalation pathway
 - health and non-health professionals within the facility e.g., cleaning, portering, waste, executives, staffing
 - local and State government (local public health unit (PHU), QIPCU, Queensland Health Chief Health Officer (CHO), or Director General (DG))
 - other key stakeholders and where appropriate, with the wider community.
- It is the responsibility of the chairperson of the OMT to determine when to communicate with the local PHU, QIPCU, CDB, CHO or DG.
 - QIPCU, CDB and the CHO or DG should be notified if:
 - the incident is of state significance and/or extends across multiple HHS.
 - the incident is considered a major health event or disaster.

- During office hours, CDB can be contacted on (07) 3328 9754, or CDBadministration@health.qld.gov.au and qipcu@health.qld.gov.au
- Outside of office hours, CDB can be contacted via the on-call public health physician on (07) 3328 9753.
- The OMT should aim to keep the public and media as fully informed as possible without compromising any statutory responsibilities and legal requirements.
- Media statements and enquiries should be dealt with in accordance with the principles outlined in Department of Health Policy: Media Relations (QH-POL-423:2015), and your local HHS media policy.

RECOVERY (PPRR)

- Recovery is the coordinated process of supporting units, wards, facilities or hospital and health services affected by a communicable disease outbreak.

Recommendation 13 – Ensure that lessons learnt inform timely quality improvements.

- A thorough evaluation of the outbreak response helps bring about continuous quality improvements in practice. The evaluation aims to determine if the incident objectives were met, identify positive outcomes, and document improvement areas.
- After the outbreak, a [final report](#) should be prepared. It is recommended the final report be considered a public document. Therefore, due care should be given to confidential aspects of the outbreak investigation.

Safety and quality

Human rights assessment

Human rights are engaged by this guideline and have been addressed and documented by QIPCU. The intended benefits to be gained by temporary limitations on these human rights is to minimise transmission of communicable disease, reduce harm to individuals, communities, and disruption to societal systems. Please contact qipcu@health.qld.gov.au for more information.

Environmental sustainability

Healthcare facilities should adopt strategies to reduce the environmental impacts of healthcare where there is appropriate evidence to support the retention of healthcare standards and the prevention of [healthcare associated infections](#) (HAI). In accordance with the [National Health and Climate Strategy](#), clinicians should prioritise high value care, which is impactful and targeted, and reduce low value care.

Applying environmental sustainability strategies will usually not be appropriate in a communicable disease outbreak, where the priority is avoiding ongoing transmission and preventing morbidity and mortality associated with HAIs.

Consumer engagement

IPC guidelines have a variety of key stakeholders, including, IPC professionals, other healthcare workers, and patients/consumers/residents and their families. The relevant Key recommendations in the Guideline, Clinician quick reference guide and Consumer guide has been reviewed by a nominated healthcare consumer for user acceptability, appropriateness, and feasibility.²²

Related documents

The guideline is to be used in conjunction with:

- [Queensland Health Disaster and Emergency Incidents Policy](#)
- [Queensland Health Disaster and Emergency Incident Plan](#)
- [Queensland Health | Public Health Sub-plan | February 2018](#)
- [Queensland Whole-of-Government Pandemic Plan](#)
- [Queensland Health | Health service directive | Disasters and emergency incidents](#)
- [Queensland Health | Health service directive | Declaration and management of a public health event of state significance](#)
- Existing HHS and/or facility disaster and incident management plans
- [Communicable disease control guidance | Disease control guidance](#) (health.qld.gov.au)
- [Communicable Disease Network Australia Series of National Guidelines](#)
- [Australian Guidelines for the Prevention and Control of Infection in Healthcare \(2019\)](#)
- [Queensland Health Infection Prevention and Control Unit \(QIPCU\) guidelines](#)
- [Hospital and Health Boards Act 2011](#) (legislation.qld.gov.au)
- [Public Health Act 2005](#) (legislation.qld.gov.au)
- [Public Health Regulation 2018 - Queensland Legislation - Queensland Government](#)
- [WHO Framework and Toolkit for Infection Prevention and Control in Outbreak Preparedness, readiness and response at a Facility Level](#)

Glossary and abbreviations

Term	Definition
Acute respiratory infection/illness (ARI)	Acute respiratory illnesses are mainly spread between people when an infected person is in close contact with another person via droplets, aerosols, or indirect contact. Symptoms of ARI may include cough, breathing difficulty, sore throat, and runny nose/nasal congestion, with or without other symptoms. ARI is caused by several pathogens including, but not limited to influenza, pertussis, human metapneumovirus, parainfluenza, respiratory syncytial virus, rhinovirus, and SARS-CoV-2 (COVID-19).
Case definition	A case definition is a set of standard criteria for classifying whether a person has a particular disease, syndrome, or other health condition in an outbreak. A case definition should include well-defined clinical symptoms (+/- laboratory criteria) and restrictions by time, place, and person.
Case finding	The process of identifying individuals who have been diagnosed or treated with a condition. It may include screening of individuals within a defined location or group who may be at risk of a condition, but who are not identified as close contacts.
Communicable disease	The term “communicable disease” will be used throughout this document for brevity but refers to any infectious agent which can be transmitted throughout the healthcare environment by any route, including known and novel communicable diseases (whether notifiable or not) and significant and multi-resistant organisms.
Contact tracing/ contact tracing officer (CTO)	The process of identifying individuals who have been exposed to a case during their infectious period, to provide advice, recommend exclusion or isolation, testing or treatment. Contact tracing officer means a contact tracing officer appointed under Section 90 of the <i>Public Health Act 2005</i> . A clinician who undertakes contact tracing activities while treating a patient under their ‘continuum of care’ is not considered to be undertaking contact tracing activities within the scope of the Act.

Term	Definition
Healthcare-associated infection (HAI)	Healthcare-associated infections are those infections that are acquired as a direct or indirect result of healthcare. ²
Health emergency operations centre (HEOC)	HEOCs are responsible for implementing planned and emerging strategies to manage health incidents. Functions of the HEOC include: <ul style="list-style-type: none"> • coordination of activities and support for the local incident response • management of resources, including accessing CTOs • development and maintenance of situational awareness and reporting upwards to State Health Emergency Coordination Centre (SHECC) (if stood up) • liaison with other agencies as required.
HHS	Hospital and Health Service
IPC professional	Infection prevention and control professional (also known as Infection Control Practitioner (ICP)) – any healthcare worker with advance knowledge and skills in IPC. The IPC professional generally possesses advanced training and/or tertiary qualifications in IPC and may be Credentialed with the Australasian College for Infection Prevention and Control. The term IPC professional usually refers to the IPC clinical lead in a facility but may also refer to the team of IPC professionals led by that role.
IPC	Infection Prevention and Control – the clinical discipline relating to the prevention of HAIs in a variety of healthcare settings.
Notifiable conditions	Under the <i>Public Health Act 2005</i> and <i>Public Health Regulation 2005 (Qld)</i> , laboratories notify the chief executive or delegate (public health physicians may be delegated for this purpose) of all laboratory-confirmed notifiable conditions. Similarly the <i>Public Health Act 2005 (Qld)</i> requires medical officers and directors of hospitals to notify the chief executive or delegate of clinical diagnosis and provisional diagnoses of notifiable conditions (refer to the website List of notifiable conditions for the list of notifiable conditions and report forms).
MRO	Multi-resistant organism
Outbreak	Outbreaks of communicable disease that occur in healthcare facilities, affect patients, carers, clients, staff, visitors, contractors, students, and other users of the health service. Preventing outbreaks reduces the risk of subsequent harm particularly to the elderly and immune-compromised who are more likely to suffer severe outcomes and longer durations of illness. An outbreak may be defined as: <ul style="list-style-type: none"> • occurrence of more than expected number of cases of a disease in an area among a specific group of people over a particular time period • two or more linked cases of the same illness.²³ Common causes of outbreaks in healthcare facilities include, but are not limited to: <ul style="list-style-type: none"> • Acute respiratory infections e.g., COVID-19, influenza, respiratory syncytial virus (RSV) • Gastrointestinal illnesses e.g., norovirus, rotavirus, <i>Clostridioides difficile</i> (<i>C. difficile</i>) • MROs e.g., vancomycin-resistant <i>Enterococcus</i> (VRE), <i>Candida auris</i>, and carbapenemase-producing <i>Enterobacterales</i> (CPE).
OMP	Outbreak management plan
Outbreak management team (OMT)	The OMT is responsible for coordinating the outbreak management process at all phases, as outlined in the Guideline. The key function is to prevent onward transmission of communicable diseases in the healthcare facility.
PHU	Public Health Unit
Standard precautions	The minimum infection prevention and control work practices used for all patients in all situations, which are required to achieve a basic level of infection prevention and control.

Term	Definition
Syndromic approach	<p>Adopting a syndromic approach involves diagnosing and treating patients based on a group of symptoms and signs (syndromes) rather than identifying the specific causative organism. For example, airborne precautions should be applied to all patients with a cough, breathing difficulty, sore throat, and runny nose/nasal congestion, with or without other symptoms, until SARS-CoV-2 is excluded.</p> <p>Further disease-specific guidance can be found in these resources:</p> <p>Foodborne disease outbreaks</p> <p>Queensland Health Guideline for the investigation and management of suspected foodborne illness outbreaks December 2018</p> <p>Gastroenteritis outbreak prevention poster</p> <p>Management of patients with <i>Clostridioides (Clostridium) difficile</i> infection - Department of Health Guideline</p> <p>Management of multi-resistant organisms - Department of Health Guideline</p> <p>Recommendations for the control of carbapenemase-producing <i>Enterobacterales</i> Australian Commission on Safety and Quality in Health Care</p> <p>Acute Respiratory Infection – Infection Prevention and Control - Department of Health Guideline</p> <p>National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities Australian Government Department of Health and Aged Care</p>
Transmission-based precautions (TBP)	Transmission-based precautions are applied in addition to standard precautions and are used for patients suspected or confirmed to be infected with organisms transmitted by the contact, droplet, or airborne routes.
Trigger (trigger event)	<p>A trigger is a point at which the incidence of a particular infectious organism is higher than would be normally expected. A trigger is not necessarily an outbreak. Some triggers may be outbreaks, but some will be natural variation in the incidence of an organism. Triggers are signals to alert the IPC team that further IPC strategies may be necessary to ensure patient safety. A typical example of a trigger would be an increase in <i>Clostridium difficile</i> infection, or a multi-resistant organism detected in surveillance data or transmitted between patients.</p> <p>The trigger in a small multipurpose facility may be a single case, whilst in a larger facility the trigger may be two or more cases that are epidemiologically linked. Where organisms are endemic, the threshold may be higher. The number of cases that meet the trigger response criteria should be decided within each HSS and approved by the relevant committee.</p>
QIPCU	Queensland Infection Prevention and Control Unit is the lead IPC body for Queensland, providing governance and leadership in the prevention of HAI through policy, guidance, surveillance, education, and engagement strategies. QIPCU are the subject matter experts on IPC issues for the Department of Health and provide support to Queensland Health on preventing harm to patients, consumers, and staff from HAI.

Editorial independence

This Guideline has been developed by Queensland Health employees, who are bound by [The National Code of Conduct for Health Care Workers \(Queensland\)](#). The technical writers comply with Departmental conflicts of interest processes. Beyond the documented consultation process, there have been no external parties involved in the development of this document, and no external funding has been received.

	Role	Organisation	Contribution	Conflicts to declare
Kate Allen	CNC Infection Prevention and Control	QIPCU, Queensland Public Health and Scientific Services	Technical writer	Nil
Belinda Andrews	CNC Infection Prevention and Control	QIPCU, Queensland Public Health and Scientific Services	Technical writer, appraiser	Nil

	Role	Organisation	Contribution	Conflicts to declare
Corinne Miles	CNC Infection Prevention and Control	QIPCU, Queensland Public Health and Scientific Services	Technical reviewer	Nil
Matthew McQuilty Trish Hurst Paul Simpson*	CNC Infection Prevention and Control	QIPCU, Queensland Public Health and Scientific Services *Redcliffe Hospital, Metro North HHS	Appraiser	Nil
Toni McLean Kathryn O'Brien Michelle Doidge	Assistant Director of Nursing, Infection Prevention and Control	QIPCU, Queensland Public Health and Scientific Services	Reviewer	Nil

Expert working group

An expert working group (EWG) of IPC professionals is convened by QIPCU for the development of IPC Guidelines. The Guideline has been presented to the Standardising clinical practice guideline development, review and evaluation project EWG members, who participated in a user acceptability, appropriateness, and feasibility survey and were offered an opportunity to provide detailed feedback to QIPCU.²² All respondents reported that they either agreed or completely agreed with all items in the survey. The table below details the project team and EWG members:

- Herston Infectious Diseases Institute (Project team)
 - Dr Jess Schults, Senior Research Fellow, School of Nursing, Midwifery and Social Work, University of Queensland
 - Dr Sally Havers, Nurse Researcher, CNC IPC Darling Downs HHS
- Expert Working Group
 - Dr Keat Choong – Infectious Disease Physician, Sunshine Coast HHS
 - John Gamlin - CNC Infection Prevention and Control – South West HHS (Roma)
 - Trish Hurst– CNC Infection Prevention and Control, QIPCU
 - Alison Kenny – CN, West Moreton Public Health Unit
 - Lea Scheltens - CNC Infection Prevention and Control –North West HHS (Mt Isa)
 - Jemma Shirra-Gibb – A/CNC Infection Prevention and Control, Queensland Ambulance Service
 - Dr Peta-Anne Zimmerman – Senior Lecturer, School of Nursing and Midwifery, Griffith University

Conflicts of interest

The QIPCU technical writer and reviewers of the guideline are Department of Health employees and declare no conflicts of interest relating to this guideline or subject matter. Any conflicts of interest pertaining to the EWG have been managed in accordance with the QIPCU EWG terms of reference, which can be requested via email qipcu@health.qld.gov.au.

System consultation

Targeted consultation has been undertaken, including with:

- Queensland Disaster Management Branch.
- Communicable Diseases Management Unit.

The Guideline (including the Implementation toolkit and the Evidence check) has been offered to Queensland IPC professionals for user acceptability, appropriateness, and feasibility, and all respondents either agree or completely agree on all survey items.²²

References

1. Australian Commission on Safety and Quality in Healthcare. *Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019)* | NHMRC [Internet]. 2019 [cited 2025 Apr 8]. Available from: <https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-prevention-and-control-infection-healthcare-2019#>
2. National Health and Research Council. *2016 NHMRC Standards for Guidelines* [Internet]. Australian Government; 2016. Available from: <https://www.nhmrc.gov.au/guidelinesforguidelines/standards>
3. *AGREE II* | AGREE Enterprise website [Internet]. [cited 2024 Jul 10]. Available from: <https://www.agreetrust.org/resource-centre/agree-ii/>
4. Banach DB, Johnston BL, Al-Zubeidi D, Bartlett AH, Bleasdale SC, Deloney VM, et al. *Outbreak Response and Incident Management: SHEA Guidance and Resources for Healthcare Epidemiologists in United States Acute-Care Hospitals*. *Infect Control Hosp Epidemiol*. 2017;38(12):1393–419.
5. Flinn JB, Britton AD, Garland J, Cuzzolina J, Biddinger PD, Mukherjee V, et al. *Rebuilding for Tomorrow's Outbreak: The State of Special Pathogen Preparedness in the USA in the Wake of COVID-19*. *Current Infectious Disease Reports*. 2023;25(12):313–22.
6. Herstein JJ, Schwedhelm MM, Vasa A, Biddinger PD, Hewlett AL. *Emergency preparedness: What is the future?* *Antimicrobial Stewardship & Healthcare Epidemiology*. 2021;10(14):e29.
7. Orsini E, Mireles-Cabodevila E, Ashton R, Khouli H, Chaisson N. *Lessons on Outbreak Preparedness From the Cleveland Clinic*. *Chest*. 2020 Nov 1;158(5):2090–6.
8. Peiffer-Smadja N, Lucet JC, Bendjelloul G, Bouadma L, Gerard S, Choquet C, et al. *Challenges and issues about organizing a hospital to respond to the COVID-19 outbreak: experience from a French reference centre*. *Clin Microbiol Infect*. 2020;26(6):669–72.
9. Stall NM, Farquharson C, Fan-Lun C, Wiesenfeld L, Loftus CA, Kain D, et al. *A Hospital Partnership with a Nursing Home Experiencing a COVID-19 Outbreak: Description of a Multiphase Emergency Response in Toronto, Canada*. *J Am Geriatr Soc*. 2020;68(7):1376–81.
10. World Health Organization. *Framework and Toolkit for Infection Prevention and Control in Outbreak Preparedness, Readiness and Response at the Health Care Facility Level* [Internet]. World Health Organization; 2022 [cited 2024 Jun 5]. Available from: <https://iris.who.int/bitstream/handle/10665/361522/9789240051027-eng.pdf?sequence=1>
11. Meyer D, Martin EK, Madad S, Dhagat P, Nuzzo JB. *Preparedness and response to an emerging health threat - Lessons learned from Candida auris outbreaks in the United States*. *Infection Control and Hospital Epidemiology*. 2021;42(11):1301–6.
12. Anesi GL, Lynch Y, Evans L. *A Conceptual and Adaptable Approach to Hospital Preparedness for Acute Surge Events Due to Emerging Infectious Diseases*. *Critical Care Explorations*. 2020;2(4):e0110.
13. Anthony C, Thomas TJ, Berg BM, Burke RV, Upperman JS. *Factors associated with preparedness of the US healthcare system to respond to a pediatric surge during an infectious disease pandemic: Is our nation prepared?* *Am J Disaster Med*. 2017 Fall;12(4):203–26.
14. Cheek C, Elmer H, Anderson T, Baxter T, Wooler M. *Decommissioning and recommissioning a regional hospital in response to a COVID-19 outbreak*. *Rural Remote Health*. 2021;21(2):6256.
15. Tunstall AM, O'Brien SC, Monaghan DM, Burakoff A, Marquardt RK. *Lessons Learned from Cross-Systems Approach to COVID-19 Pandemic Response in Juvenile Justice System, Colorado, USA*. *Emerging Infectious Diseases*. 2024;30(13):S13–6.

16. Watkins VJ, Shee AW, Field M, Alston L, Hills D, Albrecht SL, et al. Rural healthcare workforce preparation, response, and work during the COVID-19 pandemic in Australia: Lessons learned from in-depth interviews with rural health service leaders. *Health Policy*. 2024;145:105085.
17. de Rooij D, Belfroid E, Eilers R, Roßkamp D, Swaan C, Timen A. *Qualitative Research: Institutional Preparedness During Threats of Infectious Disease Outbreaks*. *Biomed Res Int*. 2020;2020:5861894.
18. Basseal JM, Bennett CM, Collignon P, Currie BJ, Durrheim DN, Leask J, et al. Key lessons from the COVID-19 public health response in Australia. *The Lancet Regional Health - Western Pacific [Internet]*. 2023;30. Available from: <https://www.embase.com/search/results?subaction=viewrecord&id=L2020648488&from=export> <http://dx.doi.org/10.1016/j.lanwpc.2022.100616>.
19. Beaudry G, Zhong S, Whiting D, Javid B, Frater J, Fazel S. Managing outbreaks of highly contagious diseases in prisons: a systematic review. *BMJ Glob Health [Internet]*. 2020 Nov;5(11). Available from: <https://www.ncbi.nlm.nih.gov/pubmed/33199278>.
20. Hui DSC, Ng SSS. Recommended hospital preparations for future cases and outbreaks of novel influenza viruses. *Expert Review of Respiratory Medicine*. 2020 Jan 2;14(1):41–50.
21. Queensland Health. *Disaster and Emergency Incident Plan - QHDISPLAN, August 2023 [Internet]*. 2023 [cited 2024 Jun 7]. Available from: https://www.health.qld.gov.au/__data/assets/pdf_file/0031/628267/disaster-emergency-incident-plan.pdf.
22. Weiner BJ, Lewis CC, Stanick C, Powell BJ, Dorsey CN, Clary AS, et al. Psychometric assessment of three newly developed implementation outcome measures. *Implementation Science*. 2017 Aug 29;12(1):108.
23. NHMRC. *Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019) [Internet]*. National Health and Medical Research Council; 2019. Available from: https://files.magicapp.org/guideline/7015ba58-c9e0-47fa-8619-7da7b15d32f8/published_guideline_7066-11_18.pdf.
24. Department of Health and Aged Care. *National Guideline for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection in Residential Aged Care Homes [Internet]*. Australian Government Department of Health and Aged Care; 2024 [cited 2024 Sep 12]. Available from: <https://www.health.gov.au/resources/publications/national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-in-residential-care-facilities?language=en>.
25. Health Protection Scotland. *Generic Outbreak Control Measure Trigger Tool (for outbreaks where there has been or might be person-to-person transmission via people, equipment or the environment) [Internet]*. National Services Scotland; 2014 [cited 2024 Sep 12]. Available from: <https://www.ecdc.europa.eu/en/publications-data/directory-guidance-prevention-and-control/prevention-and-control-infections-2>.
26. European Centre for Disease Prevention and Control. *Operational tool on rapid risk assessment methodology - Technical Report [Internet]*. Stockholm; 2019 [cited 2024 Sep 12]. Available from: <https://www.ecdc.europa.eu/en/publications-data/operational-tool-rapid-risk-assessment-methodology-ecdc-2019>.
27. Gilmartin HM, Hessels AJ. Dissemination and implementation science for infection prevention: A primer. *American Journal of Infection Control*. 2019 Jun;47(6):688–92.
28. Umscheid CA, Mitchell MD, Doshi JA, Agarwal R, Williams K, Brennan PJ. Estimating the proportion of healthcare-associated infections that are reasonably preventable and the related mortality and costs. *Infect Control Hosp Epidemiol*. 2011 Feb;32(2):101–14.
29. Shekelle PG, Maglione MA, Luoto J, Johnsen B, Perry TR. Appendix B: Using Six Different Frameworks To Assess the Evidence for Three Examples of Health Interventions or Programs - Table B.9, NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). In: *Global Health Evidence Evaluation*

- Framework [Internet]. Agency for Healthcare Research and Quality (US); 2013 [cited 2024 Sep 3]. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK121300/table/appb.t21/>.
30. Elsevier Author Services. Elsevier Author Services - Articles. 2021 [cited 2024 Oct 17]. Levels of evidence in research | Elsevier Author Services. Available from: <https://scientific-publishing.webshop.elsevier.com/research-process/levels-of-evidence-in-research/>.
 31. Lockwood C, Munn Z, Porritt K. Qualitative research synthesis: methodological guidance for systematic reviewers utilizing meta-aggregation. *Int J Evid Based Healthc*. 2015 Sep;13(3):179–87.
 32. Chapman J, Hamilton B. Rubrics and Worksheets. [cited 2024 Aug 8]. LibGuides: Evaluating Resources: CRAAP Test. Available from: <https://nwtc.libguides.com/c.php?g=43831&p=278105>.
 33. McArthur A, Klugarova J, Yan H, Florescu S. McArthur A, Klugarova J, Yan H, Florescu S. Chapter 4: Systematic reviews of text and opinion. In: Aromataris E, Munn Z (Editors). *JBIManual for Evidence Synthesis*. JBI, 2020. In: *JBIManual for Evidence Synthesis* [Internet]. JBI; 2020 [cited 2024 Aug 28]. Available from: <https://jbi.global/critical-appraisal-tools>.
 34. JBI Critical Appraisal Tools | JBI [Internet]. [cited 2024 Aug 28]. Available from: <https://jbi.global/critical-appraisal-tools>.
 35. Schünemann HJ, Brennan S, Akl EA, Hultcrantz M, Alonso-Coello P, Xia J, et al. The development methods of official GRADE articles and requirements for claiming the use of GRADE – A statement by the GRADE guidance group. *Journal of Clinical Epidemiology*. 2023 Jul 1;159:79–84.
 36. Blakeslee S. Evaluating Information – Applying the CRAAP Test [Internet]. California State University: Meriam Library; 2010 [cited 2024 Aug 7]. Available from: <https://library.csuchico.edu/sites/default/files/craap-test.pdf>.
 37. Aromataris E, Fernandez R, Godfrey CM, Holly C, Khalil H, Tungpunkom P. Summarizing systematic reviews: methodological development, conduct and reporting of an umbrella review approach. *Int J Evid Based Healthc*. 2015 Sep;13(3):132–40.
 38. Griffin KM, Karas MG, Ivascu NS, Lief L. Hospital Preparedness for COVID-19: A Practical Guide from a Critical Care Perspective. *Am J Respir Crit Care Med*. 2020 Jun 1;201(11):1337–44.
 39. Schünemann HJ, Brozek JL, Guyatt GH, Oxman AD. GRADE handbook [Internet]. 2013 [cited 2024 Apr 18]. Available from: <https://gdt.gradeapro.org/app/handbook/handbook.html>

Appendix 1: Implementation toolkit

Implementation resources

It is acknowledged that healthcare facilities within Queensland HHS are diverse in their size, location, resources, and implementation needs. Consequently, the implementation of any clinical practice guideline requires local adaptation and communication.

The sample below can be co-branded, and are designed for adaption by the HHS:

[Implementation checklist](#)

[Outbreak management: Consumer guide](#)

[Outbreak management plan \(sample\)](#)

[Trigger investigation Tool](#)

[IPC outbreak management checklist \(sample\)](#)

[Case \(suspected or confirmed\) investigation form \(sample\)](#)

[Daily outbreak response situation report \(line list\) \(sample\)](#)

[SBAR outbreak communication tool \(sample\)](#)

Implementation checklist

The following checklist provides practice indicators for each Key recommendation to support HHSs in the implementation of the Guideline.

Implementation checklist table

Key recommendation	Key practice indicator	Implementation achieved	Planned ongoing monitoring
1. Embed a robust infection prevention and control program at baseline, which incorporates legislative requirements.	<ul style="list-style-type: none"> Facility ICMP is published and reviewed by the Infection control committee (ICC). Facility HAI surveillance data is reviewed and identified issues are remediated by the ICC. 		
2. Use a facility-wide outbreak management framework to develop and implement an outbreak management plan.	<ul style="list-style-type: none"> Facility OMP is published and widely disseminated to staff. All staff understand their role in the event of an outbreak. 		
3. Outbreak management team roles and responsibilities should be clarified during the preparedness phase.	<ul style="list-style-type: none"> OMT TOR established and the Infection control committee to review annually. 		
4. Outbreak management plan and infection control management plan provisions should be tested, audited, and evaluated.	<ul style="list-style-type: none"> Desktop exercises are undertaken routinely. 		
5. Systemic provisions should be made to meet the unique needs of priority populations, e.g. children and young people.	<ul style="list-style-type: none"> OMP outlines provisions for priority populations. 		

Key recommendation	Key practice indicator	Implementation achieved	Planned ongoing monitoring
6. Epidemiology surveillance systems should trigger IPC investigation.	<ul style="list-style-type: none"> IPC Program includes HAI surveillance activities. Triggers identified in OMP and communicated widely with key staff. 		
7. Identify the outbreak early and activate the outbreak management plan.	<ul style="list-style-type: none"> Key staff are involved in desktop exercises and understand their role in the OMP. All clinicians are aware of the Clinician quick reference guide and know how to respond to a trigger event. 		
8. Convene the outbreak management team to investigate the outbreak and inform IPC interventions.	<ul style="list-style-type: none"> OMT activated in outbreak situation. 		
9. Co-ordinated and prompt case finding and contact tracing are imperative to reduce ongoing transmission.	<ul style="list-style-type: none"> Facility contact tracing officers are identified and receive ongoing training. 		
10. Stand-up an emergency operations centre if the outbreak impact is anticipated to be significant or involve multiple departments/jurisdictions.	<ul style="list-style-type: none"> HEOC provisions are outlined in facility disaster management documents. 		
11. Adopt a syndromic approach to applying transmission-based precautions	<ul style="list-style-type: none"> Outbreak IPC strategies are outlined and implemented as part of trigger investigation. 		
12. Plan communication strategy early and proactively communicate with key stakeholders.	<ul style="list-style-type: none"> OMP includes Communications Plan. 		
13. Ensure that lessons learnt inform timely quality improvements.	<ul style="list-style-type: none"> OMP includes templates and instructions for outbreak recovery during Recovery. 		

Patient and consumer guide



What happened?

There is an outbreak of an infectious disease or infection on this ward. During this outbreak, you might have had contact with this infection or infectious disease.

An **outbreak** is where there are more infections or cases of an infectious disease than expected in a ward or group of patients. An **infectious disease** is one that is easily passed from one person to another, such as influenza or norovirus. Infectious diseases, and some infections, can be passed through direct contact, the air, or on shared environmental surfaces.

Your role and consent

If you have questions about the outbreak or any other aspect of your care, please talk with your healthcare team. As with all care that we provide, we will seek investigation.

Preventing infections in healthcare

During your hospital stay, there are many ways that we will work to protect you from infection. At all times, you can expect us to:

	Clean our hands before and after we touch you, by washing them with soap and water or using alcohol-based hand rub. It is ok to ask us if we have.		Clean any shared equipment used during your care before we use it with you.
	Clean your room or bed space and bathroom each day. This may be more frequent during an outbreak.		Use single-use (or disposable) medical supplies, if they are not easy to clean and disinfect, or they are used inside or close to your body, such as needles and syringes.
	Isolate (keep away from others) any patient who is symptomatic with an infection, such as someone who is coughing, sneezing, or vomiting.		Use personal protective equipment (PPE) to protect you and us when we might be exposed to your blood or body fluids. PPE may include gloves, mask, gown, or apron.

Your safety and well-being are our top priorities. Thank you for your understanding and cooperation.

What are we doing?

Your healthcare team and the infection prevention and control team are working to understand why this happened and prevent further spread of infection.

What you need to know



To protect everyone's privacy and confidentiality, we can only share certain information with you.

Here's what you can expect to know:

- which infection you may have had contact with,
- when and where you may have had that contact,
- what signs or symptoms to watch out for,
- the test results of any samples we ask you for, and
- how long the outbreak might last.

What to expect during an outbreak

During an outbreak, you may experience any, or all, of the following:



You and/or your visitors may be asked to consent to testing that might not be directly related to your care.



You may be given medication to prevent you from getting sick during the outbreak.



You and/or your visitors may be asked personal information relating to the outbreak investigation, such as, where you have been or what you have eaten.



You and/or your visitors may be asked to clean your hands, and wear personal protective equipment (PPE) around the ward.



You may be asked to stay in your room or bed space, and you may need to move beds as we manage the outbreak.



You may be discharged early, or have your discharge delayed, for your own safety or the safety of others.



Visitors may be restricted, but we will make sure that you have access to a phone or device to have contact with your loved ones.



Staff may wear PPE when providing care to you, even though you do not have an infection.



There may be special signage about the outbreak at the ward entry.

Outbreak management plan (sample)

Use this sample to develop an overarching Outbreak management plan (OMP), including detailed instructions for syndromic condition provisions, e.g. gastro, acute respiratory infection (ARI), MRO.

The OMP is a living document and should be saved in a shared location that is updated by the outbreak management team (OMT) contemporaneously. It contains step-by-step instructions, key decisions and should form the basis of the outbreak report.

NOTE: Steps are likely to occur concurrently.

Adapted from Section 3.4.2 of [Australian Guidelines for the Prevention and Control of Infection in Healthcare \(2019\)](#) and [CDNA National Guideline for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection in Residential Aged Care Homes](#).^{23,24}

Trigger definition

Clearly state triggers for syndromic presentations and common communicable diseases and describe how triggers can activate the OMP. These definitions consider facility size and resources, geographic location, population requirements, and local epidemiological trends.

E.g. Is there an increased number of symptomatic patients/cases of like illness within patient/staff cohort?

Two or more symptomatic and epidemiologically linked patients (not symptomatic on admission) = possible gastro/acute respiratory infection outbreak

One or more healthcare-acquired cases of *C. auris* or CPE.

Trigger event occurs

Step 1. Isolate the patient/s involved in the trigger event.

Strictly adhere to standard precautions and initiate transmission-based precautions for all symptomatic patients and close contacts.

Step 2. Alert the care team and relevant discipline leads.

Follow existing communication mechanisms: key people should include, IPC lead, infectious diseases physician lead, ward team leader, admitting consultant, nursing, allied health, and medical executives, OMT Chair.

Step 3. Trigger investigation and risk assessment.

The IPC team (or duty nurse manager after hours) will commence a [trigger investigation](#) and [risk assessment](#). After hours the duty nurse manager should consult with the infectious disease physician on call or equivalent.

Step 4. Declare the outbreak.

Outbreak definition

An outbreak may be defined as:

- occurrence of more cases of a disease than expected in an area among a specific group of people over a particular time period
- two or more linked cases of the same illness.²³

E.g. Two or more epidemiologically linked cases of acute respiratory infection in patients or staff of the facility within a period of 72 hours.²⁴

Step 5. Activate the outbreak management plan.

The data from the [trigger investigation](#) and [risk assessment](#) will inform the decision to activate the OMP. If risk assessment indicates MODERATE or HIGH risk, activate this OMP IMMEDIATELY.

Step 6. Initiate IPC strategy.

Adapt this table to outbreak requirements.

Example IPC strategies and instructions

Strategy	Instruction
Patient placement	<p>Isolate all symptomatic patients. Cohort confirmed cases as required.</p> <p>Close doors to isolation/cohort areas if required (is it safe to close doors?).</p> <p>Consider curtain use and portable air purifiers as necessary.</p> <p>Place transmission-based precautions signage on entry to isolation/cohort areas indicating recommended measures.</p>

Strategy	Instruction
Admission, discharge, transfer, and visitors	<p>Ensure appropriate placement of readmitted patients who are contacts (where recommended).</p> <p>Close the ward or bay as instructed by executive and IPC professional.</p> <p>Limit non-essential visitors (where indicated and in consultation with IPC service).</p> <p>Discharge patients' home if safe to do so (ensure discharge summary and patient/carer are alert for any relevant signs and symptoms, actions to take and any ongoing recommended control measures).</p> <p>Avoid transfer to other healthcare facilities, unless advised and agreed by IPC service.</p> <p>Avoid patient transfer from affected ward/ bay to unaffected another ward/ bay. If essential, confirm with receiving area that they are prepared to continue IPC measures until patient is de-isolated.</p>
Healthcare worker management	<p>Encourage staff to stay home when sick. Refer to the Australian Guidelines for the Prevention of Infection in Healthcare 4.2.2 Exclusion periods for healthcare workers with acute infections and your local health facility staff exclusion guidance.</p> <p>Ensure all staff are vaccinated as indicated.</p> <p>Where indicated by IPC service, dedicate staff to the care of cases for the duration of the incident.</p> <p>Consider strategies for staff working across multiple clinical areas e.g., phlebotomists, physiotherapists to reinforce appropriate IPC measures.</p>
Hand hygiene and PPE	<p>Alcohol-based hand rub is available at point of care. Soap, water, and paper towel is also available, especially for gastro outbreaks.</p> <p>Reinforce the 5 moments of hand hygiene during patient care (e.g. remove gloves in patient zone to perform HH as required, and reapply new gloves).</p> <p>Ensure sufficient and appropriate PPE is available for staff to don before entering the patient care area. Doff PPE in a doffing zone adjacent to the patient care area and perform hand hygiene appropriately.</p> <p>Check hand hygiene auditing data for the affected ward/unit to ensure ward compliance is acceptable. Consider further education specific to hand hygiene if not adequate.</p> <p>Increase auditing of standard and transmission-based precautions - active observation can increase compliance with IPC practices.</p> <p>Consider universal mask use during acute respiratory infection outbreaks as source control.</p>

Strategy	Instruction
Safe environment	<p>Assess for possible aerosol transmission of organism. Reduce and/or remove equipment that may contribute to aerosol environmental contamination, e.g. portable fans.</p> <p>Identify modifiable risk factors during high contamination procedures to reduce healthcare worker, equipment, and environmental contamination.</p> <p>Clean and declutter the ward and clinical space.</p> <p>Increase frequency of cleaning according to IPC professional instructions, as per provisions in the Management of environmental cleaning services guideline. Clarify environmental cleaning roles within the care team. Consider cleaning of heating, ventilation and air conditioning system, and food preparation areas.</p> <p>Ensure adherence to cleaning and disinfection of shared patient equipment.</p> <p>Allocate dedicated patient care equipment for isolation and cohort areas.</p>
Case finding	<p>Consider screening all patients in the ward in consultation with IPC.</p> <p>Consider environmental sampling for environmentally hardy organisms. Consult with laboratory staff.</p> <p>Consider ribotyping <i>C. difficile</i> specimens during this phase to determine if the strains are the same and/or if a hypervirulent strain is present.</p> <p>Consider whole genome sequencing MROs can identify linkages that may be separated by significant time periods and constitute part of an outbreak. Facilities should develop processes to monitor for related infections or colonisation.</p> <p>Ensure patients are receiving appropriate treatment e.g., antimicrobials.</p>
Contact management	<p>Isolate and test all contacts as directed by OMT (IDP/PHP advice).</p> <p>Do NOT cohort contacts with unexposed patients.</p> <p>Ensure that contacts receive immunisation or chemoprophylaxis as appropriate.</p>
De-isolation criteria	<p>Confirmed: Negative test result for xxxx weeks or no symptoms for xxx incubation period.</p> <p>Suspected: Negative test result for xxxx days or no symptoms for xxx days.</p>
Communication	<p>Consider signage at entry of ward.</p> <p>Consider advising patients and carers of outbreak (in person, via phone, or information sheet) while maintaining patient confidentiality.</p> <p>Alert relevant staff to outbreak situation as required.</p>

Adapted from *HPS Generic Outbreak Control Measure Trigger Tool* ²⁵

Step 7. Convene the outbreak management team.

The OMT should make provisions for human and material resources, and communications.

Human resources

Describe detailed instructions for HR management in an outbreak event.

- Processes to ensure close and regular engagement between IPC professionals and healthcare teams (e.g. meetings, rounding).
- IPC professional staffing and contact tracing workforce are sufficient and adequately trained.
- Contingency to expand workforce for surge capacity or sick leave.
- Roles, responsibilities, and accountabilities of all key stakeholders for each stage of PRRR are clearly defined.
- An updated contact list of relevant stakeholders is available.
- Access to staff immunisation records.
- Business support arrangements (e.g., pay arrangements for staff to work outside normal working hours).
- Business continuity arrangements.

Communications

- Ensure that all relevant staff are aware of the IPC requirements.
- Protocols for notifying key personnel are documented, e.g. how and when to notify clinical expert and local public health unit.
- Arrangements for alerting key staff, especially out-of-hours.
- Protocols for safe transfer of care during outbreaks are documented.
- Open disclosure requirements.
- Approved communication pathways and templates are documented, including media plan, staff briefings, and secretariat support.
- Formalised mechanisms for identifying challenges, barriers, and lessons learned.
- Requirement to prepare a final report and disseminate it to all involved stakeholders.
- Evaluate lessons learned to evaluate the response and revise the outbreak management plan.

Material resources

Provide instructions/details on the following items:

- OMT accommodation e.g., incident room.
- Task cards to define roles and duties.
- Process to evaluate PPE and other supplies stockpile and calculate usage rates.
- Availability of single and negative pressure rooms.
- Assessment of types of air handling systems.
- Accessibility and procedures for laboratory sample collection, transport, and analysis.
- Alternative service models (telehealth).
- Surge plans for higher numbers of patients, or sick leave.
- Contingencies during internal emergencies (for example code yellow – power outage).

Step 8. Conduct outbreak investigation.

The OMT investigates the outbreak by synthesising information from a variety of sources, including:

- Gathering information from questionnaires (e.g., patient health records, case report forms, food histories).
- Environmental assessment (e.g., identification of contaminated food or food handling equipment, infection control breaches, cleaning, environmental sampling, adequate/correct equipment).
- Analysis of epidemiological data (e.g., movement and contacts of cases).
- Identifying and investigating contacts considering the disease's communicability and incubation period.
- Collecting demographic, movement, and clinical information data of cases and contacts.

Case definition

Describe the process for determining a case (suspected and confirmed) definition and update the OMP with the case definition when it is confirmed.

A case definition usually includes clinical and epidemiological components:

- clinical and pathological information about the condition.
- Demographics of those affected.
- Information regarding the location and timing of the outbreak.

E.g. The OMT met on Monday 12 July 2024 and confirmed that a case is defined as any person who:

- consumed a meal prepared by hospital food services between Monday 5 July and Thursday 8 July 2024

AND

- developed diarrhoea and at least one of either abdominal cramps, vomiting or fever within 3 days (clinical cases)

OR

- had a confirmed culture of *Salmonella* Typhimurium detected in a stool specimen (laboratory confirmed case).

Case report forms are available for notifiable conditions at [communicable disease control guidance](#) and in the OMP.

Contact tracing

In the case of a notifiable condition, contact tracing must be conducted by an appointed contact tracing officer (CTO) as described in [contact tracing procedure](#) and [Public Health Act 2005 \(Qld\)](#). CTO training is provided on the iLearn training system. Close contact identification and follow-up for other conditions (those not listed in the [Public Health Regulation 2018 \(Qld\)](#), can be completed by appropriately trained and supervised staff. Further information can be found at [Contact Tracing Guideline \(health.qld.gov.au\)](#).

Contact tracing of individuals exposed in the community should be coordinated by the local public health unit (PHU).

Testing Requirements

E.g. During an acute respiratory infection outbreak, patients should be tested in the following protocol:

Symptomatic patients/residents

- PCR urgent (4plex).
- Isolate and implement appropriate precautions (airborne/droplet precautions) until symptoms resolved.

Close contacts patients/residents

- Complete Day 0 PCR.
- Surveillance PCR on day 2, 4 & 6.
- Isolate and implement appropriate precautions (airborne/droplet precautions) for 48 hours after last exposure.

Step 9. Declare the outbreak over.

Outbreak Report

The final report will highlight:

- the results of the outbreak investigation and control interventions
- interventions and actions required to minimise and prevent recurrence
- challenges, barriers, and remedies required to prevent recurrence of outbreak
- recommended revisions to the facility-specific outbreak control plan.

Circulation of the final report may include the following recipients:

- Health facility:
- OMT members, HHS Executive, IPC team, infectious diseases physicians, patient safety and quality committee members, other facility-based managers, and clinicians.
- Queensland Health (where these stakeholders have been involved):
- Director General, Chief Health Officer, QPHaSS Deputy Director General, Communicable Diseases Branch (QIPCU, CDMU, OzFoodNetQLD), Pathology Queensland
- HHS PHU (where relevant).

Education

- Audit and test system, including desktop exercises.
- Staff are educated on IPC principles using a range of education techniques (e.g. simulations, in-service).
- Education program is reviewed to determine opportunities for improvement.
- Existing IPC training programs that could be used are identified.
- Trainers are identified, upskill staff as required.
- Resources are identified in case there is a need to develop new resources and roll out “just in time” education.
- Ensure that audits adequately identify gaps and deficiencies in the IPC performance of the healthcare facility.

Exemplar only, lists are not exhaustive.

Evaluation

Aspects of the outbreak response for evaluation may include:

- preparedness for this type of investigation (includes resources, guidelines, checklists, questionnaires, databases, etc.)
- coordination of outbreak meetings, and communication with stakeholders (including media management)
- data management e.g., administration and record-keeping tasks
- timeliness of outbreak detection, identification of the source, and implementation of control measures
- effectiveness of investigation process and control initiatives implemented.
- the evaluation process and findings should be prepared as part of the final report.

Outbreak management team

The HHS will have existing templates for terms of reference, and the following table will guide role cards for the OMT.

OMT Roles and responsibilities

Adapt to HHS requirements.

Example OMT Roles and responsibilities

Role	Position	Prevention/Preparedness Responsibilities	Response/Recovery Responsibilities
Chairperson	Infection control committee (ICC) chairperson or HHS CE (or delegate) (may also be clinical expert or outbreak coordinator)	<ul style="list-style-type: none"> • Ensure that the OMP is robust and deliverable. • Determine OMT terms of reference. • Chair desktop exercises to test the system. • Ensure there are adequate and appropriate human and material resources for the provision of a safe environment and safe care for patients. 	<ul style="list-style-type: none"> • Declare outbreak and transition through phases of the OMP. • Chair OMT meetings, set meeting times and agenda, and delegate tasks. • Provide advice to Executive on the need to stand-up incident management processes.
Executive sponsor	Executive team member (may not be necessary for smaller events)	<ul style="list-style-type: none"> • Ensure that the OMP is robust and deliverable. • Ensure that desktop exercises are routinely undertaken to test the system. • Ensure there are adequate and appropriate human and material resources for the provision of a safe environment and safe care for patients. 	<ul style="list-style-type: none"> • Ensure appropriate allocation of resources. • Brief executive leadership team as required.

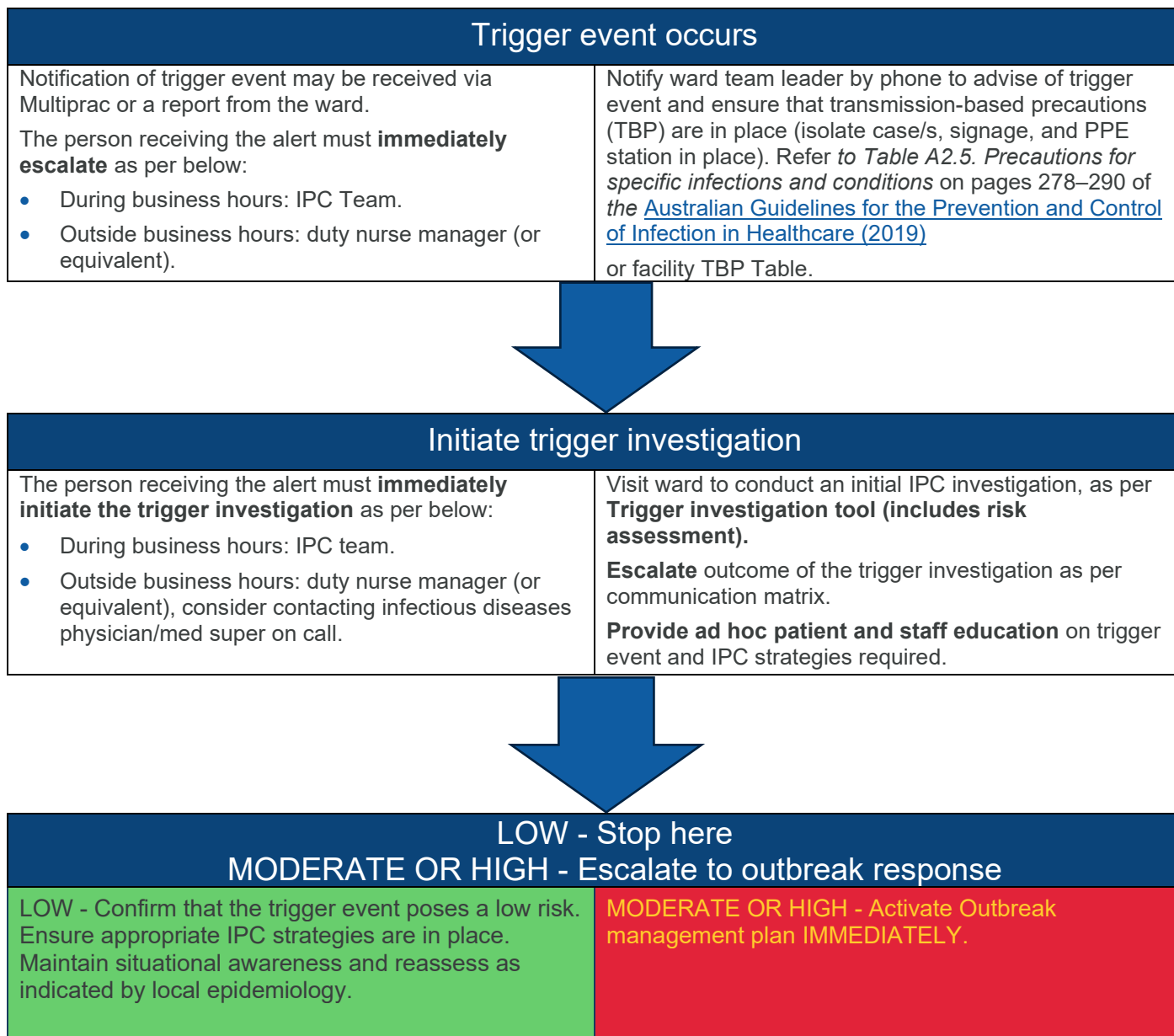
Role	Position	Prevention/Preparedness Responsibilities	Response/Recovery Responsibilities
Secretariat	Experienced executive support officer	<ul style="list-style-type: none"> Develop templates and matrices in preparation of OMT activation. 	<ul style="list-style-type: none"> Document and disseminate minutes for each OMT meeting including allocated tasks and any actions taken or completed. Maintain a central outbreak log of all activities associated with the outbreak investigation, including minutes of meetings, delegated tasks and actions taken by team members, laboratory results and other relevant information.
Outbreak coordinator	IPC CNC or equivalent, and their team as appropriate.	<ul style="list-style-type: none"> Ensure that an appropriate surveillance system exists to facilitate early detection of triggers and investigation of outbreaks. Ensure additional IPC strategies to control transmission are in place and communicate requirements to staff. Audit compliance with IPC strategies, and implement improvements where identified. 	<ul style="list-style-type: none"> Conduct initial trigger and risk assessment when triggers exceed expected incidence. Initiate case investigation and commence when there is suspicion or confirmation of an outbreak. Escalate situation report using the local risk register, existing reporting arrangements, if not completed by ward team leader/ nurse unit manager (NUM). Investigate the outbreak and identify the source. Implement control measures and monitor their effectiveness in preventing further spread. Evaluate the response to the outbreak and implement changes in OMT procedures based on lessons learned. Review causative data and review procedures accordingly.
Clinical expert	Infectious diseases physician/public health physician/ IPC professional	<ul style="list-style-type: none"> Participate in Infection Control Committee and OMT meetings. Maintain awareness of current facility and community epidemiology. Maintain clinical oversight of infectious diseases management best practice. Support IPC professional in progressing quality improvements in IPC. Provide peer education on ID and IPC best practice. 	<ul style="list-style-type: none"> Review all the evidence available regarding the outbreak to confirm the status of the outbreak and determine further investigation required. Develop a case definition to verify known cases and to assist in case finding, taking into consideration clinical, epidemiological and laboratory information available. Notify local PHU/QIPCU/CHO as required. Declare the conclusion of the outbreak, as per identified criteria and prepare and disseminate a final report.
Ward/Team representative	Ward team leader/NUM	<ul style="list-style-type: none"> Implement and ensure compliance with Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019). 	<ul style="list-style-type: none"> Implement and ensure compliance with Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019).

Role	Position	Prevention/Preparedness Responsibilities	Response/Recovery Responsibilities
		<ul style="list-style-type: none"> Support IPC interventions. Ensure staff allocation meets appropriate patient care needs. Facilitate routine audits of IPC system and remediate any issues. 	<ul style="list-style-type: none"> Recognise and report to infection, prevention, and control (IPC) service any incidence where clinical presentation may satisfy the trigger definition (e.g., 1–2 patients with symptoms of diarrhoeal illness). Commence an initial assessment in collaboration with IPC professional. Escalate situation report using the local risk register, existing reporting arrangements. Ensure staff allocation meets appropriate patient care needs. Complete the daily line list.
	Pharmacist/ Central pharmacy	<ul style="list-style-type: none"> Ensure review of antimicrobial regimens in the clinical area are aligned with local policy. Provide antimicrobial prescribing regimens to reduce further risks to patients. Initiate a report to the antimicrobial specialist. 	<ul style="list-style-type: none"> Provide antimicrobial prescribing regimens to reduce further risks to patients. Initiate a report to the antimicrobial specialist. Ensure appropriate stock levels of required antimicrobial and other agents.
Communications/ media spokesperson	Comms/media liaison officer	<ul style="list-style-type: none"> Establish and educate facility on communication protocols, particularly for media. 	<ul style="list-style-type: none"> Develop resources (email banners, posters, communiques) on key messages for key stakeholders on outbreak situation. Develop and maintain communication processes with key stakeholders including CDB or PHU, if appropriate. Keep relevant outside agencies, the public and media appropriately informed.
Other key stakeholders	<p>Manager/clinician representatives from the relevant area</p> <p>Microbiologist</p> <p>Public health physician</p> <p>Epidemiologist/infection control scientist</p> <p>Other relevant stakeholders from facility departments, including operational and food services, pharmacy, sterilising, procurement.</p>	<ul style="list-style-type: none"> Recognise and report to IPC professional any incidence where clinical presentation (e.g., signs and symptoms) may satisfy the trigger definition (e.g., 1–2 patients with symptoms of diarrhoeal illness). Ensure compliance with the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019) and relevant guidelines. Report any concerns regarding IPC practices to IPC professional. 	<ul style="list-style-type: none"> Undertake actions as advised by the OMT. Provide expert advice on patient cohort needs and system issues. Consider the potential for staff training opportunities generated by the outbreak. Identify and utilise any opportunities to contribute to the evidence base of communicable disease management and prevention strategies.

Trigger investigation tool (sample)

Trigger investigation flow chart

Trigger event definitions should be clearly documented in the facility outbreak management plan (OMP), and all key personnel should be competent in identifying these triggers.



Trigger investigation form (sample)

Situation assessment		Date: ____/____/____ (Date trigger is identified)
Location:		
Organism of concern:		
Number of cases/ contacts:		
Trigger response commenced by:		
Trigger assessment confirmation: <ul style="list-style-type: none"> Laboratory result confirmed? Healthcare-associated or acquired in the community? Are there modifiable risk factors in the patient population that could account for this trigger? Can the clinical presentations be explained by other diagnoses? 		
How many patients/staff on this ward are suspected or confirmed to have the organism and/or symptoms currently?		
How many patients/ staff do not have symptoms but confirmed or suspected to the organism currently?		
How many staff are showing symptoms and/or known to be infected with the organism currently?		
In the last 30 days, has the alert organism been recorded in any patient/staff death record?		
Conduct health care facility risk assessment for this trigger.		Red/High Yellow/Moderate Green/Low
If the risk assessment of the trigger is low, STOP here, and confirm that trigger poses a low risk. Ensure appropriate IPC strategies are in place. Maintain situational awareness and reassess as indicated by local epidemiology. (Keep this from as a record of decision making)		Name and signature:
If the risk assessment of the trigger is moderate or high, PROCEED to initial outbreak response .		
Lead IPC team member for this trigger investigation:		
Ward team leader/ nurse unit manager:		

Adapted from [HPS Generic Outbreak Control Measure Trigger Tool](#) ²⁵

Risk assessment tool (sample)

Organisms and diseases are risk assessed for **PROBABILITY (transmissibility)** and **IMPACT (severity)** using the below risk matrices.

Source: Adapted [European Centre for Disease Prevention and Control. Operational tool on rapid risk assessment methodology](#)²⁶ and [Queensland Health: Managing risks, incidents, and injuries](#). (only available on the QHEPS).

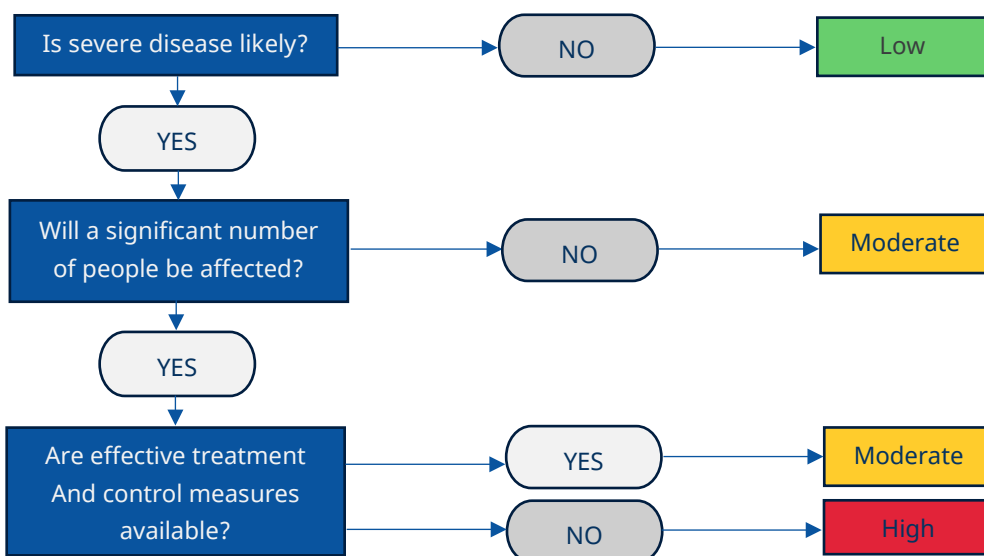
Probability

Transmission route	Risk rating
No human-to-human transmission	No risk
Close contact/contact with body fluids ONLY	Low risk
Body fluid/close contact and environmentally persistent organism	Moderate risk
Respiratory secretions only or in combination with close contact and/or environmentally persistent	High risk

*Please note this algorithm is provided without organism-specific detail that is being assessed. It assumes that standard precautions are in use. If transmission route is unknown, it should be assumed that the risk is considered high until disease spread is characterised.

Impact

The impact assessment should be done with consideration of one population within the facility at a time if the information about the disease/organism indicates a significant outcome in different patient cohorts.



Risk assessment matrix

		PROBABILITY		
		Low	Moderate	High
IMPACT	Low	Low	Low	Moderate
	Moderate	Low	Moderate	High
	HIGH	Moderate	High	High

Actions from risk assessment

The response to different risk ratings will depend on local procedures and conditions but should be proportionate. Actions may include (in consultation with the Executive and IPC professional).

Low	Moderate	High
The importance of standard and transmission-based precautions should be reinforced as per relevant IPC guidelines.	In addition to standard and transmission-based precautions, additional cleaning or organism specific cleaning requirements should be considered.	In addition to moderate risk measures, consider bay or room closures and suspending admissions and transfers in addition to the increased focus on IPC measures.

Rationale

A rapid risk assessment soon after identifying an outbreak will help identify risks to patients, workers, and the community. As information about an organism or outbreak emerges the risk assessment should be revisited. The rapid risk assessment is used to determine the probability of ongoing transmission and the possible impact of the disease. The impact might be increased morbidity and/or mortality but should also consider the impacts on the entire facility including financial impacts.

Define the population to be risk-assessed

Risk may be different across different populations within the facility. If the outbreak involves a communicable disease that will affect some patient types more than others, the risk assessment should be repeated for the different patient populations. This helps determine the risk to the facility should the outbreak become more widespread and to ensure prevention activities are appropriate for that population.

Validate what is known

It is important to revisit the known information about the outbreak to ensure it is valid. Additional information may change the scope and severity of an outbreak or invalidate an outbreak.

Determine appropriate questions to answer considering the outbreak and type of organism.

Consult the evidence-base

Identify if there are existing resources and information available for this disease to support appropriate management. For example, the [Queensland Health Communicable Disease Control Guidance](#) has information about notifiable and other communicable diseases.

Information about a disease must be well understood before commencing the risk assessment. A timely horizon scan of sentinel sources of information (e.g. World Health Organization) may suffice, rather than a full literature review. Findings will provide the evidence for the risk assessment and recommended management actions.

IPC Outbreak management checklist (sample)

Type of outbreak: _____ (e.g., COVID-19, MRO, gastroenteritis, acute respiratory illness)

Date outbreak was reported to infection prevention and control team: ____/____/____

Reported to: _____

Reported by: _____

Outbreak location/facility: _____ Ward(s) affected: _____

Likely mode of transmission: _____

Contact Airborne Droplet Food-borne Unknown Other mode: _____

The OMT ensures that the following steps are initiated as soon as possible and if initiated, completed. The order in which the tasks are undertaken may vary.

Action	Documentation
<p>Outbreak declared i.e., number of cases of infection with the same causative micro-organism (if known in the early stages of the outbreak)</p> <p>Source identified: i.e. organism or reservoir</p>	<p>Completed: <input type="checkbox"/></p> <p>Date/Time: _____</p> <p>Notes:</p>
<p>Convene the outbreak management team (OMT)</p> <ul style="list-style-type: none"> • Refer to the facility outbreak management plan. <p>Gather data the following before convening an OMT:</p> <ul style="list-style-type: none"> • known/likely infectious disease/agent involved • a critical incident team should be established in case of possible healthcare-associated transmission of blood-borne virus • the number of confirmed or suspected cases • large numbers of cases • two or more cases of a notifiable condition in the same ward/area, within an incubation period • the size and nature of the population at risk • the likely source • potential impact on service delivery • involvement of management/executive is required to implement measures to control disease spread e.g., closure of wards/beds • involvement of more than one ward or department. <p>Use the Trigger investigation tool</p>	<p>Completed: <input type="checkbox"/></p> <p>Date/Time: _____</p> <p>Notes:</p>
<p>Staff information</p> <ul style="list-style-type: none"> • Inform relevant staff of possible/actual outbreak including advice regarding infection control measures e.g., pharmacy, operational staff, volunteers, etc. <ul style="list-style-type: none"> - consider the need to inform visitors and patients. • Notify senior nursing and medical staff on duty. • Alert Pathology Queensland to any additional specimen requirements and consider logistics. 	<p>Completed: <input type="checkbox"/></p> <p>Date/Time: _____</p> <p>Notes:</p>

Action	Documentation
<ul style="list-style-type: none"> Assess staff and other close contacts. 	
<p>Patient and staff management</p> <ul style="list-style-type: none"> Ensure appropriate patient isolation measures are applied. Confirm management of staff who are identified as close contacts. 	Completed: <input type="checkbox"/> Date/Time: _____ Notes:
<p>Infection control measures implemented</p> <ul style="list-style-type: none"> As per IPC strategy 	Completed: <input type="checkbox"/> Date/Time: _____ Notes:
<p>Outbreak documentation</p> <p>List all known cases and update information Daily outbreak response situation report (line list) sample</p>	Completed: <input type="checkbox"/> Date/Time: _____ Notes:
<p>Notifiable conditions reporting</p> <p>Ensure local PHU has been notified for outbreaks involving notifiable conditions.</p>	Completed: <input type="checkbox"/> Date/Time: _____ Notes:
<p>Specimen collection</p> <ul style="list-style-type: none"> Observe standard and appropriate transmission-based precautions when collecting relevant specimens e.g., use of PPE. Collect appropriate specimens - liaise with infection prevention and control or microbiology to determine collection method and specimen types. Ensure the laboratory is aware of the outbreak situation and the likelihood of additional collections. 	Completed: <input type="checkbox"/> Date/Time: _____ Notes:
<p>Review and update the Outbreak management plan (sample)</p> <p>Regularly during and at the resolution of the outbreak.</p>	Completed: <input type="checkbox"/> Date/Time: _____ Notes:
<p>Outbreak management report</p> <ul style="list-style-type: none"> Complete outbreak management report highlighting recommendations for facility executive and mechanisms to prevent future outbreaks. 	Completed: <input type="checkbox"/> Date/Time: _____ Notes:

Case (suspected or confirmed) investigation form (sample)

Patient details	
Patient name:	Date of birth:
UR:	Admission date:
Ward/unit and bed number at onset of symptoms	
Has the patient been hospitalised within the last 3 months? <input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> No	
Does the patient come from a long-term care facility? <input type="checkbox"/> Yes, name of facility: _____ <input type="checkbox"/> No	
Date and time of symptom onset:	
Date/Time of isolation:	
Date symptoms resolved:	
Details of antimicrobial treatment at time of onset? (if relevant)	
Details of antimicrobial treatment:	
Details of any antimicrobial treatment in month prior to onset (if relevant)	
Pathology details	
Date of positive specimen:	
Lab number:	
Organisms isolated:	
Ribotyping (if available – <i>C. difficile</i> only)	
Sent for whole genome sequencing and date: <input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> No	

Contacts (Staff contacts: consider PPE use, duration of contact, VPD status)				
Name	UR number	Current location	Pathology	Symptoms
Exposure classification				
Healthcare-associated – healthcare facility onset				
Healthcare-associated – community onset				
Community-associated				
Other facility: facility notified: <input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> No				
Outcome				
Recovered without an adverse event:				
Admitted to ICU due to organism of concern: <input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> No				
Surgery due to organism of concern: <input type="checkbox"/> Yes, date/procedure type: _____ <input type="checkbox"/> No				
Death due to organism of concern: <input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> No				
Other (specify):				
Additional comments:				

Daily outbreak response situation report (line list) (sample)

This line list is intended to be used by wards/units that are in an outbreak response (e.g., multi-resistant organisms, *Clostridioides difficile* infection). It should be completed daily and submitted to the infection prevention and control professional for appropriate dissemination for reporting purposes. Line lists are generally managed using an MS Excel spreadsheet, this sample can be used to develop this.

Ward:					
Date:					
Date trigger response commenced:					
Total number of beds in ward/unit:					
Patient name	UR number	Current location	Source patient	Pathology/symptomatic	Comments
DAILY SUMMARY					
Number of isolated, symptomatic patients:			Name of person submitting report:		
Number of beds closed in ward/unit:			Position of person submitting report:		
Number of staff symptomatic:			Signature:		

SBAR Outbreak communication tool (sample)

This is a prompt only: it is recommended that you use your HHS /facility template and processes during the incident when available.

Date	XX Ward
Situation	<p>Outline the current outbreak situation, e.g.</p> <p>Ward/bed line listing, staff numbers and patient numbers</p> <p style="padding-left: 40px;">Inpatient cases:</p> <p style="padding-left: 80px;">Patients: 38</p> <p style="padding-left: 80px;">Staff: 8</p> <p>Positive cases room occupancy rate: $\frac{\text{total number of cases}}{\text{funded bed stock}} \times 100\%$ (e.g., 38) x 100% funded bed stock (e.g.,250)</p> <p style="padding-left: 40px;">$= \frac{38}{250} \times 100\%$</p> <p style="padding-left: 80px;">= 15.2% of 250 bed stock in a facility is occupied by positive cases</p> <p>Note: Calculate room occupancy rate to understand disease impact on hospital bed stock, understand and plan patient placement during bed surge capacity.</p>
Background	<p>Outline relevant background:</p> <ul style="list-style-type: none"> • causative organism • mode of transmission • evidence source and expert opinion • incubation and infectious period.
Assessment	<p>Outline assessment of current outbreak:</p> <ul style="list-style-type: none"> • date outbreak declared • ward/HHS/facility response • IPC measures implemented.
Recommendations	<p>Outline recommended infection prevention and control actions and strategies for patients.</p>
Staff	<p>Outline the actions and strategies agreed to be implemented for staff.</p>

Appendix 2: Evidence check

Evaluation of the current Guideline

The published version of the Health facilities communicable disease outbreak preparedness, readiness, response and recovery - Department of Health guideline - November 2022 version 5.0 was evaluated by four QIPCU appraisers using the Appraisal of Guidelines for Research and Evaluation (AGREE) II tool and the below table details the results. These results informed areas for improvement in this review and are reflected in the marked improvement in domain scores for version 5.11. Further revisions have been made to the final version based on the version 5.11 scores and feedback.

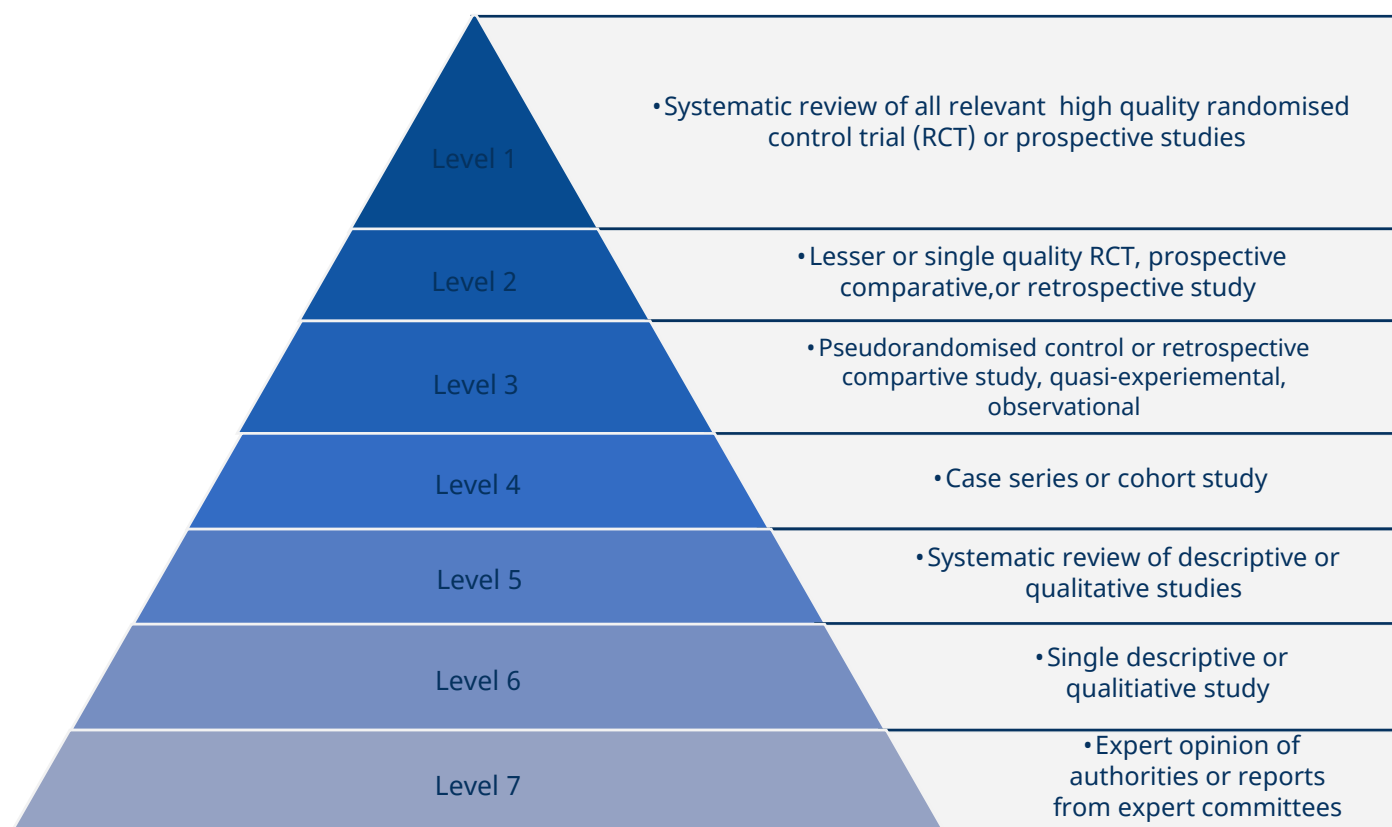
Domain	Domain score – Version 5.0	Domain score – Version 5.11
Scope and purpose	56%	99%
Stakeholder involvement	26%	84%
Rigour of development	13%	79%
Clarity and presentation	29%	79%
Applicability	32%	71%
Editorial independence	10%	85%
Overall guideline assessment	33%	88%

Methodology

The Guideline is designed in keeping with the [2016 NHMRC Standards for Guidelines](#) and the principles of the work of the [Appraisal of Guidelines for Research and Evaluation \(AGREE\) Enterprise tools](#).^{2,3} Further, the Guideline has been developed using the QIPCU Clinical practice guideline development, review and evaluation framework (the Framework) and associated standard operating procedure. Comprehensive information regarding the Framework and SOP can be requested via qipcu@health.qld.gov.au.

Statement of evidence

The inherent difficulties of generating and applying high-level evidence (Level 1) in IPC is well-known, and in the subject area of outbreak management of communicable diseases, it does not exist.²⁷⁻²⁹ There is variation in advice on levels of evidence hierarchy, and expert opinion is often excluded. For this Evidence check the following hierarchy has been used due to the body of evidence which exists for this subject area.



Levels of evidence hierarchy pyramid (adapted from multiple sources: ^{27,29-31})

Where possible primary sources from peer-reviewed journal articles, predominantly evidence from systematic reviews of descriptive and qualitative studies (Level 5), evidence from a single qualitative or descriptive study (Level 6) and evidence from the opinions of authorities or reports from expert committees (Level 7) have been used.^{27,29} From the [Key recommendations](#) and [Evidence appraisal table](#) it is clear that there was a high level of concordance in the themes that emerged from the evidence.

While it would be ideal to have Level 1 evidence for every IPC guideline, in most cases it is not feasible or ethical to apply high quality research design to accepted IPC practice, e.g. comparing communicable disease outbreak health outcomes in an RCT comparing the use of transmission-based precautions or not. In the post-pandemic era, great merit should be placed on the role of expert opinion (Level 7) and the collective lessons learnt by the global IPC professional community.

Literature search strategy

The technical writer conducted a basic literature search using the Clinician’s Knowledge Network (CKN) resource to determine the quantity and quality of peer-reviewed journals available on the guideline subject area using the following PICO (population, intervention, comparison, outcome) search terms and limits and yielded over 17,000 articles, which are detailed in the following table.

Term	Definition
Population	Hospital (healthcare) patients
Intervention	Outbreak management system for preventing communicable (infectious) disease outbreaks (preparedness planning)
Comparison	No system
Outcome	Communicable (infectious) diseases outbreaks
Limits	Full text, published date 2010-2024, English language, natural disasters

[Cochrane PICO search](#) | [Cochrane Library](#)

Next, a medical librarian was enlisted to refine this literature search and 36 references were provided for review by the technical writer. The librarian included articles from countries with equivalent levels of healthcare system resourcing such as, UK, Canada and the US, The Netherlands, France, and Hong Kong. The search strategy focused on clinical events and involved an initial search using Google Scholar. Then, EmTree terms in EmBase and MeSH terms in PubMed were used, and limits were applied to some concepts to title or keyword fields, which are detailed here:

Boolean operators	Search terms
AND	'infectious diseases'/exp OR 'infectious diseases' OR 'communicable disease'/exp OR 'communicable disease' OR emerging infectious diseases OR emerging communicable diseases OR disease transmission
	'hospital' OR 'health service' OR 'facilities and services utilization' OR ((Healthcare OR health care) AND (service* OR australi* OR agenc* OR management))
AND	outbreak AND (management OR preparedness OR response OR recovery OR control) OR 'infection prevention' OR 'infection control'
	austra:ti OR 'united kingdom':ti OR uk:ti OR austral:ti OR australi:ti OR 'new zealand':ti OR australia:ti OR 'united states':ti OR usa:ti
	preparedness:ti,kw OR readiness:ti,kw OR response:ti,kw OR recovery:ti,kw OR trigger*:ti,kw OR 'best practice':ti,kw
Limits	Full text, published date 2010-2024, English language, natural disasters

Inclusion criteria

- Full text.
- Published date 2010–2024.
- English language, country of similar health system capacity
- Communicable disease outbreaks.
- Study type (higher quality study designs were prioritised).
- Outbreak management principles (preparedness, readiness, response, recovery) is main content of the source.

Exclusion criteria

- Natural disaster preparedness.
- Sources that only focused on national or global preparedness.

Evidence appraisal

In addition to the 36 sources supplied by the medical librarian, a sentinel outbreak management source from the World Health Organization was included. The technical writer screened, summarised and reviewed against the inclusion and exclusion criteria, and the CRAAP (currency, relevance, authority, accuracy, purpose) test.³²

The CRAAP test is a basic and rapid-use tool advocated by university librarians to support academic writers to determine the quality and relevance of a variety of information sources.³² More information on the CRAAP test can be found here: [CRAAP Test – Evaluating Resources – LibGuides at Northeast Wisconsin Technical College](#). The 19 excluded sources are available from QIPCU on request.

Data was extracted from the remaining 18 sources, which were then appraised using the [JBI Critical Appraisal Tools](#). The key themes identified were synthesised in the [Evidence synthesis](#) section and used to clarify the [Key recommendations](#).³³ For details on the appraisals and associated recommendations, see [Evidence appraisal table](#).

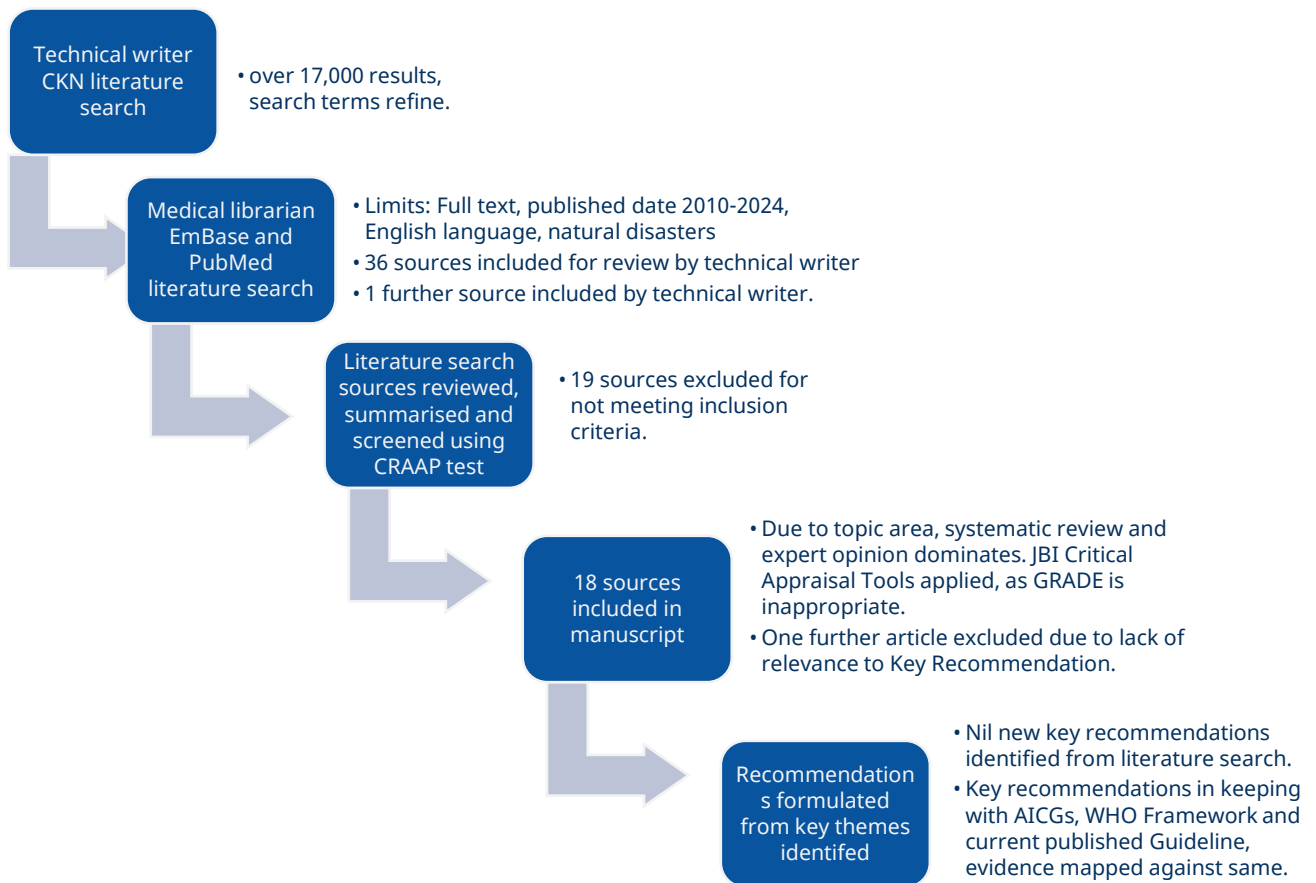


Figure 1: Literature search and appraisal strategy³⁴⁻³⁶

Evidence appraisal table

Number	Author, year, title, URL	Study design/ strengths/limitations	Key points	CRAAP	Appraisal	Level of evidence	Rec #	Rec strength
(4)	Banach, D. B., et al. (2017). "Outbreak Response and Incident Management: SHEA Guidance and Resources for Healthcare Epidemiologists in United States Acute-Care Hospitals." Link	<p>Expert guidance document for healthcare epidemiologists working in acute care hospitals on high-level overview of IM for CD outbreaks: emergency response framework.</p> <p>EWG conducted needs analysis to identify effective strategies for outbreak response and IM. Strong methodology, consensus statements. Literature review 35 articles of 940.</p> <p>Key recommendations clearly articulated.</p>	<p>Key recommendations:</p> <p>An Emergency Management Program (EMP) should guide the phases of IM: preparedness, mitigation, response, and recovery.</p> <p>EMP should create an emergency operations plan (EOP), with six critical components: communications, resources and assets, safety and security, staff responsibilities, utilities, clinical support activities.</p> <p>EOP adequacy should be tested with drills, competency assessments and simulation exercises.</p> <p>The facility should coordinate and communicate outbreak response through a Hospital Incident Command System (HIC).</p>	30	<p>JBI CAT Checklist for Textual Evidence: Expert opinion tool</p> <p>INCLUDE ³³</p>	7	1 2 3 4 6 8 9 10 12 13	Accepted practice
(5)	Flinn, J. B., et al. (2023). "Rebuilding for Tomorrow's Outbreak: The State of Special Pathogen Preparedness in the USA in the Wake of COVID-19." Link QIPCU has full text	Narrative review on special pathogen preparedness in the context of viral haemorrhagic fevers and COVID-19, nil methodology cited.	"Preparing for special pathogens involves use of non-traditional personal protective equipment (PPE), specialised PPE doffing protocols, and complex resources and protocols supporting laboratory testing and waste management."	30	<p>JBI CAT Checklist for Textual Evidence: Expert opinion tool</p> <p>INCLUDE ³³</p>	7	1 2 4 6 7 10 11 12 13	Accepted practice
(6)	Herstein, J. J., et al. (2021). "Emergency	Narrative review on lessons learnt from COVID-19	Lessons learnt for 4 phases of emergency management:	30	JBI CAT Checklist for	7	1 2	Accepted practice

Number	Author, year, title, URL	Study design/ strengths/limitations	Key points	CRAAP	Appraisal	Level of evidence	Rec #	Rec strength
	preparedness: What is the future?" Link	pandemic, nil methodology cited.	<ul style="list-style-type: none"> - mitigate (recurring cycle of planning, training and exercises, business continuity plans (supply chain, workforce maintenance, critical infrastructure) - prepare (scalable emergency operations plans, act early to "identify, isolate, and inform" paradigm) - respond (rapid and timely communication with stakeholders, hospital incident command system, manage operations, information, and logistics systematically) - recover (compile data for lessons learnt on facility, staff and financial recovery, psychological support for staff emphasised). <p>Refers to the Hierarchy of Controls.</p>		Textual Evidence: Expert opinion tool INCLUDE ³³		3 4 6 7 8 9 10 11 12 13	
(7)	Orsini, E., et al. (2020). "Lessons on Outbreak Preparedness from the Cleveland Clinic." Link	Lessons learnt review by clinicians on COVID-19 pandemic preparedness. ? Methodology	<ol style="list-style-type: none"> 1) Do not wait 2) Engage key stakeholders 3) Identify sources of truth 4) Promote creativity 5) Prioritise hospital employee safety and well-being 6) Prioritise collaboration 7) Anticipate resource needs 8) Prioritise mental health 9) Anticipate ethical dilemmas <p>Plan for recovery.</p>	30	JBICAT Checklist for Textual Evidence: Expert opinion tool INCLUDE ³³	7	1 2 3 7 8 10 12 13	Accepted practice
(8)	Peiffer-Smadja, N., et al. (2020). "Challenges and issues about organizing a hospital to respond to the COVID-19 outbreak: experience from a	Lessons learnt review by clinicians on COVID-19 pandemic preparedness. ? Methodology	<p>Key lessons:</p> <p>Management of suspected and confirmed patients with COVID-19: preparedness, adapting to a new microorganism, biosafety levels 3 laboratory examinations, anticipating the increase of cases.</p>	28.5	JBICAT Checklist for Textual Evidence: Expert opinion tool INCLUDE ³³	7	1 2 4 12 13	Accepted practice

Number	Author, year, title, URL	Study design/ strengths/limitations	Key points	CRAAP	Appraisal	Level of evidence	Rec #	Rec strength
	French reference centre." Link		<p>Logistical considerations: moving patients in the hospital, organise the switchboard, links with the pre-hospital care, hazardous waste management.</p> <p>Managing and taking care of healthcare workers: anxiety, workforce provisions.</p> <p>Continuing usual care, research, and teaching: evaluating and anticipating collateral effects, increasing beds.</p>					
(9)	Stall, N. M., et al. (2020). "A Hospital Partnership with a Nursing Home Experiencing a COVID-19 Outbreak: Description of a Multiphase Emergency Response in Toronto, Canada." Link	Expert opinion, narrative review on lessons learnt by a hospital IPC team to a Canadian residential aged care facility during a COVID-19 outbreak. Included as this is unique insight and within the scope of HHS IPC professionals in QLD.	The hospital–nursing home partnership can be characterised in several phases: (1) engagement, relationship, and trust building; (2) environmental scan, team building, and immediate response; (3) early-phase response; and (4) stabilisation and transition period.	30	<p>JBICAT Checklist for Textual Evidence: Expert opinion tool</p> <p>INCLUDE³³</p>	7	1 2 3 5 9 11 12 13	Accepted practice
(10)	World Health Organization (2022). "Framework and toolkit for infection prevention and control in outbreak preparedness, readiness and response at the health care facility level". Link	<p>Expert evidence advisory document. Detailed methodology documented.</p> <p>Sentinel global reference document.</p>	<p>OM Phases at facility level:</p> <ol style="list-style-type: none"> 1) Preparedness 2) Readiness 3) Response 	30	<p>JBICAT Checklist for Textual Evidence: Policy</p> <p>INCLUDE³³</p>	6	1 2 3 4 6 7 8 9 10 11 12 13	Accepted practice
(11)	Meyer, D., et al. (2021). "Preparedness and response to an emerging health threat – Lessons	Semi-structured qualitative interviews of staff in US health care facilities on lessons learnt for preparedness and response	Key themes included surveillance and laboratory capacity, inter- and intra-facility communication, infection prevention and control, environmental cleaning and disinfection,	30	JBICAT Checklist for Qualitative Research	6	1 6 7	Accepted practice

Number	Author, year, title, URL	Study design/ strengths/limitations	Key points	CRAAP	Appraisal	Level of evidence	Rec #	Rec strength
	learned from Candida auris outbreaks in the United States." Link QIPCU has full text.	to <i>C.auris</i> cases or outbreaks. Philosophical perspective of research team not identified, but findings are concordant with other studies.	clinical management of cases, and media concerns and stigma.		INCLUDE ³¹		9	
(12)	Anesi, G. L., et al. (2020). "A Conceptual and Adaptable Approach to Hospital Preparedness for Acute Surge Events Due to Emerging Infectious Diseases." Link	Narrative review: authors are clinicians, cited by 36 other articles. Expert opinion, not research. Highly applicable and reflects current practice across many jurisdictions. NHMRC: N/A	1) a conceptual introduction and approach to healthcare capacity strain including the aetiologies of patient volume, patient acuity, special patient care demands, and resource reduction. 2) a framework for considering key resources during an acute surge event—the "four Ss" of preparedness: space (beds), staff (clinicians and operations), stuff (physical equipment), and system (coordination). 3) common domains that should be addressed during preparation for and response to acute surge events.	30	JBIC Critical Appraisal Tools (CAT) Checklist for Textual Evidence: Narrative INCLUDE ³³	7	2 6 7 8 10 11 12	Accepted practice
(13)	Anthony, C., et al. (2017). "Factors associated with preparedness of the US healthcare system to respond to a pediatric surge during an infectious disease pandemic: Is our nation prepared?" Link (QIPCU has PDF version)	Literature review (162 articles) on infectious disease pandemics affecting the US paediatric population, provides proposed response plan structure. Paediatric focus, but generalisable. Study is dated, but still applicable and highly relevant.	Conceptualised the 4Ss (different from Anesi et al) to be incorporated into response plans: structure, staff, stuff and space. Further, national guidelines must translate into regional response systems that account for local nuance.	30	JBIC CAT Checklist for Systematic Reviews INCLUDE ³⁷	6	2 4 5 6 7 8 10 11 12	Accepted practice
(14)	Cheek, C., et al. (2021). "Decommissioning and recommissioning a regional hospital in response to a COVID-19 outbreak." Link	Narrative review of the COVID-19 outbreak which shut down a Tasmanian regional facility. Nil methodology noted.	Regional hospitals decommissioned following mass transmission event of COVID-19. Useful lessons learnt for pandemic planning: <ul style="list-style-type: none">- Early planned response essential- Early contact tracing and isolation imperative	30	JBIC CAT Checklist for Textual Evidence: Expert opinion tool INCLUDE ³³	7	2 7 8 9 10 12	Accepted practice

Number	Author, year, title, URL	Study design/ strengths/limitations	Key points	CRAAP	Appraisal	Level of evidence	Rec #	Rec strength
			<ul style="list-style-type: none"> - Identify trigger points for early ward containment and hospital closure - Robust, connected, high-level command essential <p>Consider internet connectivity in regional and remote sites.</p>				13	
(15)	Tunstall, A. M., et al. (2024). "Lessons Learned from Cross-Systems Approach to COVID-19 Pandemic Response in Juvenile Justice System, Colorado, USA." Link	Expert opinion, narrative review on lessons learnt regarding IPC in the juvenile justice context.	<p>Whole-person health approach to infection prevention: nuanced IPC guidelines, multi-disciplinary team communication, youth development consideration.</p> <p>"Activate adaptive response efforts, incentivise protocol adherence, and aid in a coordinated and rapid response to emerging infectious disease threats"</p>	30	<p>JBICAT Checklist for Textual Evidence: Expert opinion tool</p> <p>INCLUDE ³³</p>	7	2 5 11 12 13	Accepted practice
(16)	Watkins, V. J., et al. (2024). "Rural healthcare workforce preparation, response, and work during the COVID-19 pandemic in Australia: Lessons learned from in-depth interviews with rural health service leaders." Link	Exploratory and descriptive qualitative design, involving reflexive thematic analysis of semi-structured interviews with clinical staff from 2 rural healthcare facilities in Australia.	Six major themes were identified: Working towards a common goal, delivery of care, education and training, organisational governance and leadership, personal and psychological impacts, and working with the local community. Findings informed the development of an applied framework.	30	<p>JBICAT Checklist for Qualitative Research</p> <p>INCLUDE ³¹</p>	6	2 3 4 5 6 7 8 10 12 13	Accepted practice
(17)	de Rooij, D., et al. (2020). "Qualitative Research: Institutional Preparedness During Threats of Infectious Disease Outbreaks." Link	<p>Qualitative three-step study among infectious disease prevention and control experts (interviews informed framework, focus groups x 2 tested the framework).</p> <p>Philosophical perspective unclear, limitations addressed.</p>	<p>Four preparedness phases identified: GREEN Preparedness – situation without the presence of the infectious disease threat that requires centralised care, anywhere in the world.</p> <p>YELLOW – outbreak in the world with some likelihood of imported cases.</p>	30	<p>JBICAT Checklist for Qualitative Research</p> <p>INCLUDE ³¹</p>	5	2 3 12	Accepted practice

Number	Author, year, title, URL	Study design/ strengths/limitations	Key points	CRAAP	Appraisal	Level of evidence	Rec #	Rec strength
		While this study is not a high-quality study from a QR methodological perspective, the content is valuable and has more rigour than an expert opinion piece.	<p>ORANGE – realistic chance of an unexpected case within the country, or unrest developing among population or staff.</p> <p>RED – cases admitted to hospitals in the country, potentially causing a shortage of resources.</p> <p>Specific preparedness activities included infection prevention, diagnostics, patient care, staff, and communication.</p>					
(18)	Basseal, J. M., et al. (2023). "Key lessons from the COVID-19 public health response in Australia." Link	<p>Authors facilitated an expert (diverse Australian experts in public health, surveillance, epidemiology, ID, virology, child health, vaccination, modelling, social scientists, health literacy, nursing, and IPC) consultation of lessons learnt during the COVID-19 pandemic response, Delphi-style consensus approach for this opinion piece.</p>	<ol style="list-style-type: none"> 1) movement restrictions were effective, but their implementation requires careful consideration of adverse impacts, 2) disease modelling was valuable, but its limitations should be acknowledged, 3) the absence of timely national data requires re-assessment of national surveillance structures, 4) the utility of advanced pathogen genomics and novel vaccine technology was clearly demonstrated, 5) decision-making that is evidence informed and consultative is essential to maintain trust, 6) major system weaknesses in the residential aged-care sector require fixing, 7) adequate infection prevention and control frameworks are critically important, 8) the interests and needs of young people should not be compromised, 9) epidemics should be recognised as a 'standing threat', 10) regional and global solidarity is important. 	30	<p>JBICAT Checklist for Textual Evidence: Expert opinion tool</p> <p>INCLUDE³³</p>	6	5 6 7 11 12	Accepted practice
(19)	Beaudry, G., et al. (2020). "Managing outbreaks of highly contagious diseases in prisons: a systematic review." Link (QIPCU has PDF)	<p>Systematic review to synthesise the evidence (28 relevant studies, 2000-2020) on outbreaks of highly contagious diseases in prison (high income countries, outbreaks – TB, flu, MMRV and COVID-19).</p> <p>Prison context noted, though QH GLs are used by Corrections HCW to manage health services</p>	<ul style="list-style-type: none"> - Interagency collaboration - Health communication - Screening of population - Symptom assessment - Diagnostic capacity - VPD immune status - Restrictions, isolation, and quarantine - Contact tracing 	30	<p>JBICAT Checklist for Systematic Reviews</p> <p>INCLUDE³⁷</p>	5	6 9 12	Accepted practice

Number	Author, year, title, URL	Study design/ strengths/limitations	Key points	CRAAP	Appraisal	Level of evidence	Rec #	Rec strength
		<p>within Queensland Correctional Facilities.</p> <p>Further, people in prison represent many marginal and at-risk communities, and findings may be transferrable to other complex settings, such as residential health and care facilities.</p>	<ul style="list-style-type: none"> - Immunisation programs - Epidemiological surveillance <p>Access to appropriate treatment</p>					
(20)	Hui, D. S. C. and S. S. S. Ng (2020). "Recommended hospital preparations for future cases and outbreaks of novel influenza viruses." Link . QIPCU has full text.	<p>Literature search via PubMed (limited information on methodology, 74 references cited), advice on early identification of influenza cases and administration or antivirals and other agents.</p> <p>Check conflict of interest – ok.</p>	<p>Unique content, novel acute respiratory infection- specific.</p> <p>Content on antiviral and other pharmacological agents (treatment and chemoprophylaxis), is not within the scope of this Guideline.</p> <p>IPC measures – Early recognition and source control, administrative controls, engineering and environmental controls, and rational use of PPE.</p>	30	<p>JBI CAT Checklist for Textual Evidence: Expert opinion tool</p> <p>INCLUDE³³</p>	6	6 7 9 11	Accepted practice

Please note: excluded sources have not be included here for brevity, but can be sought by emailing qipcu@health.qld.gov.au.

Evidence synthesis

The World Health Organization (2022) has developed an expert advisory “Framework and toolkit for infection prevention and control in outbreak preparedness, readiness and response at the health care facility level” which, is the sentinel reference for this subject area.¹⁰ The Framework details three phases for IPC in outbreak management:

- 1) Phase 1: Outbreak preparedness:
 - a. Early priority: develop an IPC foundation (evaluate current function and capacity, develop outbreak preparedness plans, ensure functional surveillance system, establish outbreak response team (ORT))
 - b. Advanced priority: audit and test the system (assess preparedness activities, surge capacity, tabletop exercises)
- 2) Phase 2: Outbreak readiness:
 - a. Early priority: adapt existing tools for IPC in outbreaks (surveillance definitions, standard and transmission-based precautions, identification and isolation of cases, rapid contact tracing, contingencies for material and human resources)
 - b. Advanced priority: audit and test the system (assess preparedness activities, surge capacity, tabletop exercises)
- 3) Phase 3: Outbreak response:
 - a. Immediate priority: activate existing and adapted tools for IPC based on the outbreak context (activate the outbreak response team, ensure coordination between departments/jurisdictions)
 - i. transmission-based precautions for patients with suspected, or confirmed communicable diseases with outbreak or pandemic potential.
 - ii. cleaning and disinfection.
 - iii. waste management.
 - iv. plan for patient placement, internal transfers, transportation and referral.
 - v. PPE requirements for health care workers, other staff and visitors.
 - vi. controls to limit the number of visitors in the health care facility.
 - vii. a policy to test and manage exposed health care workers.
 - viii. a strategy to deal with patient/s exposed to confirmed cases.
 - ix. a strategy to supply staff to support workforce.
 - x. a strategy to train volunteers (non-health care workforce).
 - xi. evaluate PPE stockpiles and calculate ppe burn rates.
 - xii. consult with finance/budget colleagues on activating outbreak response financing plans
 - xiii. communications plan
 - b. Advanced priority: audit and test the system (evaluate response to IPC practices, and develop lessons learnt, report to key stakeholders)
- 4) Feedback and continuous improvement.¹⁰

A narrative review by Anesi et al (2020) written in the context of the COVID-19 pandemic, identified the causes of healthcare capacity strain as patient volume, acuity and special care needs in a reduced resource context.¹² The authors conceptualised their expert opinion into the “four Ss” framework for preparedness: space (beds), staff (clinicians and operations), stuff (physical equipment) and system (coordination), and identify the following domains of focus during acute surge:

- patients under investigation and case definitions
- testing capabilities and logistics

- PPE and isolation precautions
- triage and cohorting
- clinical protocols
- staff health concerns and opt-out
- clinician wellbeing
- communication/ coordination
- surge planning
- scarce resource allocation.¹²

The framework provides comprehensive guidance preparedness and outbreak management activities, and can be viewed here: [An adaptable model for hospital preparedness and surge planning for emerging infectious diseases](#).

The domains of focus identified by Anesi et al (2020) are reiterated in a qualitative three-step study among infectious disease prevention and control experts with pandemic experience by de Rooij et al (2020) on institutional preparedness during threats of infectious disease outbreaks.¹⁷ The authors describe four phases of preparedness, relating to the apparent risk of outbreak, and the actions required across the domains, which can be viewed here: [Figure - PMC \(nih.gov\)](#).¹⁷ Flinn et al (2023) build on previous authors and identify required provisions for “special pathogen preparedness” in the context of VHF and COVID-19, describing:

- use of non-traditional personal protective equipment (PPE) (ensure supply chain reserves of specialist PPE and training in use of same, e.g. PAPR, boot and head covers for viral haemorrhagic fevers),
- specialised PPE doffing protocols (training in donning and doffing protocols, use of trained observer and checklists),
- complex resources and protocols supporting laboratory testing and waste management (detailed plans for storage and transport of pathology specimens and waste, training exercises for same).⁵

Prior to Anesi et al, a comprehensive literature review of 162 articles by Anthony et al (2017) on factors associated with preparedness for an infectious disease pandemic affecting paediatric patients in the US.¹³ The authors asserted that the US was unprepared for a pandemic, and conceptualised the 4Ss (different from Anesi et al) to be incorporated into response plans.¹³ Further, national guidelines must translate into regional response systems that account for local nuance. The 4Ss are articulated below:

- structure
 - 1A: incident command system (effective organisation, use of assets and process to manage an emergency)
 - 1B: pre-hospital planning and transportation (appropriately resourced, triage system and patient flow)
 - 1C: communication (two-way communications with entire system)
 - 1D: disease surveillance (data linkages)
 - 1E: disease prevention and treatment (immunisation program)
 - 1F: education (automated call centres, nursing health lines)
 - 1G: community, local, state, federal responsibilities (frameworks for protocol implementation, financial assistance, ethical decision-making, and resource-provision)
 - 1H: financial matter (purchase bulk supplies, distribute locally)
- staff
 - 2A: education and training (tabletop simulations, annual competencies)
 - 2B: availability and attendance (HR provisions for increased work attendance, provide support (e.g. childcare)

- stuff
 - paediatric equipment availability (extrapolate to any specialist area)
 - estimation calculators (mathematical modelling to estimate bed capacity and resources required)
 - all-hazards approach planning (retain services: back-up electricity, generators, and laboratory services)
 - tools for triage and resource allocation
- space
 - contingencies to rapidly flex-up bed occupancy (especially isolation spaces)
 - control admissions and discharges to preserve bed stock
 - reconfigure existing resources (utilise non-traditional spaces for management of lower acuity patients).¹³

The authors conclude that while preparedness activities are imperative, unforeseen scenarios are best managed by the healthcare leader who can “improvise and provide relief in a dynamic situation”.¹³

Peiffer-Smadja et al (2020) concur the major themes identified by other authors in their narrative review of lessons learnt from COVID-19 in France’s largest healthcare facility and have arranged their recommendations into four categories:

- Management of suspected and confirmed patients with COVID-19: preparedness, adapting to a new microorganism, biosafety levels 3 laboratory examinations, anticipating the increase of cases.
- Logistical considerations: moving patients in the hospital, organise the switchboard, links with the pre-hospital care, hazardous waste management.
- Managing and taking care of healthcare workers: anxiety, workforce provisions.
- Continuing usual care, research and teaching: evaluating and anticipating collateral effects, increasing beds.⁸

Griffin et al (2020) provide a descriptive review of lessons learnt and the approach taken by a US ICU service during the COVID-19 pandemic. The main themes detailed for the critical care context in preparation for a pandemic of massive scale are:

- infection control consultation as central advisors (PPE, aerosol-generating procedures (AGP), interpreting rapidly evolving advice)
- clinical operational challenges (avoid AGPs, avoid high-flow nasal cannula and non-invasive ventilation)
- ICU bed surge capacity (consolidation and expansion of bed stock, cohort strategies)
- adequate staffing of physicians, nurses, and respiratory therapists
- complex ethical dilemmas (ceiling of care and triage of resources)
- staff wellness (referrals for psychological support to preserve workforce).³⁸

Banach et al (2017) reviewed 267 articles and resources and devised expert guidance on outbreak response and incident management for healthcare epidemiologists.⁴ The authors caution against creating emergency operations plans (EOPs) for every possible event, as the basic response elements are common to most potential incidents and “form the backbone of preparedness”.⁴

Key recommendations from the EWG were:

- 1) An Emergency Management Program (EMP) should guide the phases of IM: preparedness, mitigation, response, and recovery.
- 2) All-hazards self-assessment to inform EMP.
- 3) EMP should create an EOP, with six critical components:
 - a. communications (key stakeholder lists, established lines of communication, plain/common language)
 - i. be first, be right, be credible, express empathy, promote action, show respect

- b. resources and assets
- c. safety and security
- d. staff responsibilities
- e. utilities
- f. clinical support activities

4) EOP adequacy should be tested with drills, competency assessments and simulation exercises.

The facility should coordinate and communicate outbreak response through a Hospital Incident Command System (HIC), which has 5 major sections:

- 1) command
- 2) operations
- 3) planning
- 4) logistics
- 5) administration/finance.⁴

The authors assert that this structure allows each specialist group within the facility to focus on their area of expertise, e.g. infection prevention and control, public affairs and supply chain management.⁴

A lessons learnt narrative review by Herstein et al (2021) of the COVID-19 pandemic reiterates the concepts established by Banach et al (2017), and stresses that facilities should “waste no time” in using lessons learnt to “reevaluate and shore up known gaps, drive re-review and revision of existing mitigations strategies”.⁶

Orsini et al (2020) reiterate lessons learnt from the COVID-19 pandemic by the Cleveland Clinic and present 10 general principles for outbreak preparedness:

- 1) Do not wait: build on organisational lessons learnt, e.g. Ebola virus disease preparedness allowed Cleveland Clinic to act early on COVID-19.
- 2) Engage key stakeholders: Incident Command Centre structure allows for organisational engagement of key stakeholders at all levels.
- 3) Identify sources of truth: identify trustworthy sources to provide accurate and reliable information.
- 4) Promote creativity: harness the experience of workforce to provide solutions using the “plan, do, study, act” cycle.
- 5) Prioritise hospital employee safety and well-being: provide appropriate PPE and training in same, audit compliance, “buddy system” for donning and doffing, prioritise staff testing and allow for social distancing.
- 6) Prioritise collaboration: engage non-frontline workers in community who want to help, e.g. IT professionals to assist with tech solutions.
- 7) Anticipate resource needs: particularly specialist material and human resources.
- 8) Prioritise mental health: acknowledge worker stress, provide mental health services, peer support services.
- 9) Anticipate ethical dilemmas: “strategies for triage should prioritise saving the “maximum number of individuals” while maintaining compassion and respect for the dignity of all patients”.
- 10) Plan for recovery: plan for resumption of baseline services, encourage retention of efficiency improvements made in resource-constrained times, e.g. improvements to telehealth capabilities should be retained.⁷

A Delphi-style consensus method was used by Basseal et al (2023) to collate key lessons learnt by a diverse group of healthcare professionals on Australian public health response in Australia.¹⁸ The key lessons relevant to outbreak management in acute healthcare settings were:

- restricting the movement of a population is effective in controlling outbreaks, but human rights must be considered
- disease modeling and epidemiological data have an important role to play in real-time decision-making

- pathogen genomics provides valuable information on contextualising outbreaks
- decision-making that is evidence-informed and consultative is essential to maintain trust,
- workforce illness, low morale, and burnout are important to mitigate against to prevent absenteeism when personnel resources are essential
- robust infection prevention control systems and training are “critically important” to manage outbreaks (mask-wearing, optimal ventilation)
- infants, children, and young people face different impacts and their unique needs “should not be compromised”
- outbreaks of all size are an human and economic risk and preparedness should remain a focus even when the threat of outbreak, epidemic or pandemic is not apparent.¹⁸

Stall et al (2020) present an expert opinion narrative review on lessons learnt by a hospital IPC team providing expert outreach support to a Canadian residential aged care facility during a COVID-19 outbreak.⁹ The hospital–nursing home partnership is categorised into four phases:

1. Engagement, relationship, and trust building: listen to front-line providers on key issues and how to provide tangible support, codesigned multiphase emergency response.
2. Environmental scan, team building, and immediate response: IPC review of the line list and analysis of the epidemiological curve, direct access to other clinical experts, human resource and occupational health support, PPE stockpile, supply chain and expected burn rate, staff relief and medical supplies.
3. Early-phase response: establish infrastructure for virtual care, clinical triage of remaining residents, goals of care discussions, provision of active medical management and high-quality palliative care within the nursing home, IPC training (swabbing, environmental cleaning, donning and doffing stations), work from home arrangements.
4. Stabilisation and transition period: deployment of hospital staff to alleviate shortages, pharmacy and psychiatric services, psychosocial support for staff, embedding improved IPC practices.⁹

A systematic review by Beaudry et al (2020) of managing outbreak of highly contagious diseases in prisons corroborates that the principles of outbreak management and preparedness are transferrable across a variety of contexts and scales.¹⁹ The following key principles identified are like other healthcare studies, specifically:

- interagency collaboration (early to avoid rapid deterioration of situation)
- health communication (multi-modal strategies to communication with populations)
- screening of population (to detect baseline and case find)
- symptom assessment
- diagnostic capacity
- VPD immune status
- restrictions, isolation, and quarantine (effective but can be logistically difficult)
- contact tracing (“key component of outbreak response”, “concentric circles approach” for large numbers of exposed individuals)
- immunisation programs
- epidemiological surveillance (inpatient data, staff, and visitor registries)
- access to appropriate treatment.¹⁹

Tunstall et al (2024) identify that the youth justice context requires novel approaches IPC and outbreak management due to the vulnerable population in confinement.¹⁵ The authors advocate for:

- A whole-person health approach to infection prevention: nuanced risk-benefit analysis of IPC recommendation
 - “Youth have a lower overall risk for severe health consequences from infection but have a higher likelihood of negative social and developmental effects from prolonged isolation and quarantine.”

- Comprehensive multidisciplinary response team communication,
- Youth development consideration (mental health impacts of isolation, alternative strategies for engagement with peers and family).¹⁵

The authors suggest that these lessons can be applied to youth populations in other contexts to “activate adaptive response efforts, incentivise protocol adherence, and aid in a coordinated and rapid response to emerging infectious disease threats”.¹⁵

A narrative review by Cheek et al (2021) on the decommissioning and recommissioning of a regional Australian hospital in response to a COVID-19 outbreak describes the lessons learnt for pandemic planning from this situation as:

- Early planned responses are essential and may preserve health service function.
- Early contact tracing and isolation are imperative in preventing onward transmission.
- Identify trigger points for early ward containment and hospital closure and engage external support arrangements in pandemic preparedness plans.
- Robust, connected, high-level command and communication structures are essential, especially in managing workforce and media scrutiny.
- Consider internet connectivity in regional and remote sites.¹⁴

Watkins et al (2024) conducted an exploratory and descriptive qualitative study, involving reflexive thematic analysis of semi-structured interviews with clinical staff from 2 rural healthcare facilities in Australia regarding lessons learned during the COVID-19 pandemic response.¹⁶ An applied framework has been developed based on the six major themes identified:

1. Working towards a common goal,
2. Delivery of care,
3. Education and training,
4. Organisational governance and leadership,
5. Personal and psychological impacts
6. Working with the Local community.¹⁶

Hui and Ng (2020) provide detailed recommendation and expert opinion in their literature review of recommended hospital preparations for further cases and outbreaks of novel influenza viruses.²⁰ The IPC measures are arranged in the themes of early recognition and source control, administrative controls, engineering and environmental controls, and rational use of PPE.²⁰ The authors provide helpful granular detail, which expands on recommendations in the Australian Guidelines for the Prevention and Control of Infection in Healthcare, and are detailed here:

- Early recognition and source control: determine mode of transmission, promote respiratory hygiene, prompt implementation of IPC measures, reporting and surveillance, treatment to make patients non-infectious.
- Administrative controls: standard, airborne, and contact (with eye protection) until mode of transmission known, droplet and contact for all patients with ARI symptoms, AGPs on airborne (PFR with negative pressure).
- Engineering and environmental controls:
 - adequate ventilation
 - 160 l/s/patient (hourly average ventilation rate) for airborne precaution rooms (with a minimum of 80 l/s/patient) (note that this only applies to new healthcare facilities and major renovations)
 - 60 l/s/patient for general wards and outpatient departments
 - 2.5 l/s/m³ for corridors and other transient spaces without a fixed number of patients
 - minimum room ventilation rate of 6 air changes per hour (ACH) in existing facility and a higher ventilation of 12 ACH for new or renovated construction are required to prevent room

contamination, especially when managing patients receiving mechanical ventilation and during AGPs.

- spatial separation of patients (at least 1m)
- cleaning and disinfection of environmental surfaces
- Rational use of PPE: adequate and regular supplies, adequate staff training, proper hand hygiene and, “in particular, appropriate human behaviour”.²⁰

A qualitative study of lessons learnt from *Candida auris* outbreaks in US hospitals by Meyer et al (2021) identified key themes relating to surveillance and laboratory capacity, inter- and intra-facility communication, IPC, environmental cleaning and disinfection, clinical management of cases, media concerns and stigma.¹¹ The authors recommend:

- enhanced surveillance and laboratory capacity for testing for *C. auris*
- reinforce IPC principles because they prevent transmission of *C. auris*, additional advice on reducing movement of patients, awareness of *C. auris* status, and dedicated staff to provide care
- alert systems that follow patients across jurisdictions and allow for easy identification of colonised patients
- just-in-time IPC training for staff to prevent transmission (decontamination, PPE donning and doffing).¹¹

Key recommendations

Since 2010, the Australian Guidelines for the Prevention and Control of Infection in Healthcare (the Australian Guidelines) have been established as the standard of *accepted practice* in Queensland Health facilities.²³ The Australian Guidelines have been developed using a rigorous methodology, including GRADE evidence appraisal (Appendix 3: Process Report). Consequently, if a [Queensland Health Guidelines for infection control in health care facilities](#) deviates from the Australian Guidelines that QIPCU would employ an advanced evidence appraisal process to formulate new Key recommendations. Key recommendations within this Guideline are considered *accepted practice*, and the level of evidence is recorded.

As previously discussed, the evidence on outbreak management of communicable diseases in healthcare facilities is based on expert opinion, mostly presented as “lessons learnt” narrative reviews. It is anticipated that the transparent and systematic approach adopted in the development of this Guideline promotes clinician confidence and implementation at the local facility level.

Classification	Description
Strong recommendation	It is definite that the desirable effects of an intervention outweigh its undesirable effects, or the undesirable effects of an intervention outweigh its desirable effects.
Weak recommendation	The desirable effects probably outweigh the undesirable effects or undesirable effects probably outweigh the desirable effects. A weak recommendation should not be interpreted as a lack of evidence, rather that it may be unethical to apply high quality research methods to a previously established standard of practice, which has a credible history in preventing healthcare-associated infections, e.g. performing hand hygiene between patients.
Accepted practice	The recommendation is in keeping with current accepted practice and is in accordance with the AICGs. The AICGs refer to “Practice Statements”, which QIPCU attributes as a synonymous term. Adherence to this Key Recommendation is not mandatory, however, a robust rationale should be documented for any deviation.
Statutory requirement	Indicate where there is also a mandated requirement/s by the Commonwealth or the State, which must be considered when implementing the advice at the local level.

Adapted from reference: ^{23,39}

Key recommendations table

Number	Description	Reference	Levels of evidence	Recommendation strength
1	Embed a robust infection prevention and control program at baseline, which incorporates legislative requirements.	(4–11)	6–7	Accepted practice
2	Use a facility-wide outbreak management framework to develop and implement an outbreak management plan.	(4–10,12–17)	5–7	Accepted practice
3	Outbreak management team roles and responsibilities should be clarified during the preparedness phase.	(4,6,7,9,10,16,17)	5–7	Accepted practice
4	Outbreak management plan and infection control management plan provisions should be tested, audited, and evaluated.	(4–6,8,10,13,16)	6–7	Accepted practice
5	Systemic provisions should be made to meet the unique needs of vulnerable populations, e.g. children and young people.	(9,13,15,16,18)	6–7	Accepted practice
6	Epidemiology surveillance systems should trigger IPC investigation.	(4–6,10–13,16,18–20)	5–7	Accepted practice
7	Identify the outbreak early and activate the outbreak management plan.	(5,6,9–14,16,18,20)	6–7	Accepted practice
8	Convene the outbreak management team to investigate the outbreak and inform IPC interventions.	(4,6,7,10,12–14,16)	6–7	Accepted practice
9	Co-ordinated and prompt case finding and contact tracing are imperative to reduce ongoing transmission.	(4,6,9–11,14,19,20)	6–7	Accepted practice
10	Stand-up an emergency operations centre if the outbreak impact is anticipated to be significant or involve multiple departments/jurisdictions.	(4–7,10,12–14,16)	6–7	Accepted practice
11	Adopt a syndromic approach to applying transmission-based precautions.	(5,6,9,10,12,15,18–20)	5–7	Accepted practice
12	Plan communication strategy early and proactively communicate with key stakeholders.	(4–10,12–19)	5–7	Accepted practice
13	Ensure that lessons learnt informed timely quality improvements.	(4–10,14–16)	6–7	Accepted practice

Document approval details

Guideline custodian	Guideline contact details	Approval date	Approver
Belinda Henderson, Chief Infection Control Nurse, QIPCU	Policy and Projects Team, QIPCU, qipcu@health.qld.gov.au	18 March 2025	Belinda Henderson

Version control

Version	Date	Author	Comments
2.0	19 March 2012		
3.0	March 2016		
4.0	15 September 2017		Fixed links, updated resources, added to new template, changes relating to Health Service Directives, overall review, and update to guideline
5.0	31 October 2022	Ivy Gabatan, CNC, CDIM	Comprehensive review of existing guideline. Current evidence based best practices are incorporated.
5.1 – 6.0	May, 2025	Kate Allen, CNC QIPCU	<p>Major review of existing guideline using the QIPCU Clinical practice guideline development, review, and evaluation framework. No major practice changes applied from <i>Health Facilities Communicable Disease Outbreak Preparedness, Readiness, Response and Recovery - Department of Health Guideline - November 2022, v 5.0</i>.</p> <p>Review summary:</p> <ul style="list-style-type: none"> • Key recommendations identified clearly, with references and strength. • Addition of Clinician quick reference guide, Human rights assessment, Paediatric and Other priority populations considerations, Risk impact statement. • Addition of Appendix 1: Implementation toolkit, which includes: <ul style="list-style-type: none"> - Implementation checklist - Consumer guide - Outbreak management plan (sample) - IPC strategy and instructions - Outbreak management team – terms of reference - Trigger investigation (sample) (existing QH Trigger resources incorporated into guideline) • Addition of Appendix 2: Evidence check, which includes: <ul style="list-style-type: none"> - Methodology - Evidence appraisal table - Evidence synthesis - Key recommendations table with references.

Review plan

01 June 2028 or sooner if practice change trigger applied.