

Advice for Directors of Clinical Governance

Reviewing a COVID-19 patient cluster/ outbreak in a healthcare setting

Purpose

To provide revised guidance on the review of COVID-19 patient clusters/ outbreaks in healthcare settings.

This advice sits alongside the NSW Health Policy Directive *Incident Management* ([PD2020_047](#)).

Revision of information in this Advice

- Revised corporate reportable incident brief (RIB) requirement for COVID-19 patient cluster/outbreak in a healthcare setting
- Information about the process for review of COVID-related patient death has been removed from this guidance and can be found in Advice for Directors of Clinical Governance *Reviewing individual cases of COVID-19 patient death* published in September 2021

Revised corporate RIB requirement

A corporate RIB is no longer required for every cluster/ outbreak in a healthcare setting.

Consistent with [PD2020_047](#) section 3.1.2, a COVID-19 cluster/ outbreak incident is to be escalated as a corporate RIB when the Chief Executive determines:

- The incident poses a serious threat to the operations of a healthcare setting e.g., interruption to services, inability to provide services, and/ or
- A state-wide risk is identified, and/ or
- An opportunity for state-wide learnings is identified.

Definitions

Cluster/ outbreak

- A COVID-19 cluster is **two or more** cases linked to the same transmission event.
- A COVID-19 outbreak is **one** confirmed case.

A cluster/ outbreak is confirmed by a designated local authority, such as a laboratory, Public Health, Infectious Diseases, Infection Prevention and Control.

Healthcare setting

A healthcare setting includes hospitals, Special Health Accommodation (SHA), COVID community support accommodation and any other alternate locations of health care.

Notification

- Notify the cluster/ outbreak in ims+ as a corporate incident.
- Notify each patient case separately in ims+ as a clinical incident.
- Link the incidents in ims+.

Classification for the cluster/ outbreak

- Select “**No person**” for “Who or what was most affected?”
- Select “**Facility Outbreak Cluster**” for the “Principal Incident Type” and then “**Respiratory Virus – COVID-19**” in “Please categorise this incident type further”
- Include the term “**COVID-19 exposure**” in “Details”.

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Classification for each patient

- Select “**Patient**” for “Who or what was most affected?”
- Select “**Healthcare Associated Infection**” for the “Principal Incident Type”
- Include the term “**COVID-19 exposure**” in “What Happened? – Details”.

Escalation

Send one **corporate RIB** to the Ministry of Health for the cluster/ outbreak if the Chief Executive considers it necessary to escalate.

If the incident requires a RIB, also undertake a **Safety Check**. Use of the “Safety Check for COVID-19 patient cluster/ outbreak in a healthcare setting” template is recommended.

Review

Cluster/ outbreak review can be undertaken in accordance with local processes based on the outcome of the Safety Check.

The “Cluster/ outbreak review report” template for corporate incidents may be used.

If the Cluster/Outbreak has been submitted as a Corporate RIB, the Review Report should be sent to the Ministry of Health within 45 days.

Team membership

Consider Infection Prevention and Control, Public Health, Infectious Diseases, Nurse Unit Manager, Staff Specialist, Microbiology, Engineering.

Patient/ Family Reports

Provide an individual report to each patient/ family.

Use the patient/ family report template for a COVID-19 cluster or similar local template.

State-wide Learning

The Clinical Excellence Commission will review and analyse the Cluster/ outbreak reviews via a sub-committee of the Clinical Risk Action Group.

Where to find information about hospital acquired COVID-19 related patient death

Refer to Advice for Directors of Clinical Governance *Reviewing individual cases of COVID-19 patient death* published in September 2021 for guidance about:

- COVID-19 deaths which meet the definition of a reportable incident
- Preliminary risk assessment
- Serious adverse event review.

For further information and support, please contact the Clinical Excellence Commission Patient Safety Directorate at CEC-Patientsafety@health.nsw.gov.au