

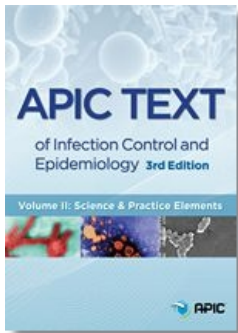
SUMMER 2009

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New Library Resource

The 3rd Edition of the APIC Text is available to borrow from the CSICN lending library! The APIC Text contains the latest information on infection control guidelines, research, technology and clinical standards.



Check out this and all of our other fabulous resources in our on-line lending [library index](#). See other resources you might be interested in borrowing? Drop us a line and we'll be happy to ship it to you free of charge!



Let's Talk...Sharps Safety

Ontario Safety Association for Community and Healthcare (OSACH) assists health care and community sector organizations and their employees achieve safe and healthy work environments. OSACH consultant, Henrietta Van hulle, highlights some key points regarding sharps safety.

- Canada's estimated annual healthcare-associated sharps injuries rate is 21,264. Under reporting is a major problem estimated from 50 to 90%; reasons cited include:
 1. reporting would not change outcome
 2. not enough time
 3. occupational health services were too far away
- Most needle stick injuries occur in hospitals (44%)
- Devices most often involved are syringes/hypodermic needles, needles for blood drawing, suture needles, IV stylets and scalpel blades
- Most sharps injuries occur while using the device (40.7%) and after using the device (45.2%)
- CDC reported that studies have shown a reduction of up to 76% of reported injuries by using safety engineered devices
- In Ontario, needle safety regulations came into force in September 2008 for hospitals and April 2009 for all long term care homes, laboratories and specimen collection centres
- It is expected that the needle safety regulation will be expanded to include the community sector
- The focus of Ontario regulation is **hollow-bore needles** but employers must identify risks related to all sharps and take all reasonable precautions to protect workers from the hazard of injury by any sharp
- Three exceptions to the regulation include when:
 1. Employers cannot locate a safety engineered version commercially
 2. The worker has reasonable grounds to believe a risk of harm exists
 3. There is an emergency or crisis, the supply of safety engineered needles have been exhausted and waiting for new supplies would present a risk of harm to person or public interest

For more information:

Planning Guide to the Implementation of Safety Engineered Medical Sharps: www.osach.ca/products/SEMS/index.html

RICN Non Acute Care ICP Training Program Graduates!

Regional Infection Control Networks (RICNs) are pleased to announce that 26 students from the first "class" of the RICN Non Acute Care ICP Training Program have successfully completed the course.

The RICN Non Acute Care ICP Training Program started in April 2008 and was completed in May 2009.



This course consisted of 11 modules with at least 80 hours of course work. Modules included: Role of ICP, Microbiology, Routine Practices & Additional Precautions, Epidemiology and Statistics, Surveillance, Outbreak Management, Environmental Management, Occupational Health, Clinical Practices and Support Services, Adult Learning and Addressing Key IPAC Issues.



Each student was mentored by RICN staff and were offered learning resources and materials through their local RICN.

Congratulations to all the students for their hard work and dedication in completing this course! The RICNs are now in the process of making changes to this program based on feedback from our students and mentors. We are now looking forward to the second year of our program beginning this fall.

Congratulations!

Barbara Carey

The Brant Centre

&

Linda Winn

Park Lane Terrace



Ask the Expert:

Joanne Habib

Network Coordinator

Central East Infection Control Network

Question: I recently read in the news about an outbreak in a nursery related to *Serratia marcescens*. What is *Serratia* and what can I do to prevent it in my facility?

Answer: *Serratia marcescens* (*Sm*) was discovered by Venetian pharmacist Bartolomeo Bizio as the cause of the blood-red discoloration of polenta in 1819. The organism was named *marcescens* after the Latin word for "decaying".

Sm is a gram negative bacillus that is commonly found in soil and water and in the respiratory and gastrointestinal tracts of hospitalized patients. Due to its preference for damp conditions, *Sm* can be found growing in our bathrooms where it appears on tile grout or shower corners as a pink, slimy film.

Sm was originally thought to be non-pathogenic and because of the red pigment it produces was used widely to trace bacterial transmission. *Sm* is now considered a significant, illness-causing organism and has been found causing urinary tract, wound and eye infections, pneumonia, meningitis, bacteremia and endocarditis. Outbreaks caused by *Sm* are well documented and have been attributed to potable water, contaminated "sterile solutions", inhalation therapy equipment (puffers), IV solutions, disinfectant solutions and hands of hospital personnel.

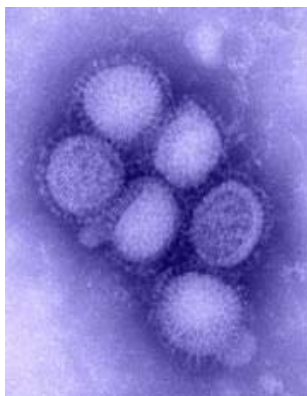
Colonization or infection with *Sm* is often caused by direct exposure to contaminated fluids or medical equipment. Patient to patient transmission can also occur via the hands of healthcare workers.

Prevention and control of infections caused by *Sm* requires attention to many aspects of patient care. Important measures include:

- Routine Practice compliance (glove removal and hand washing before and after each client/patient/resident contact) will minimize the potential for transmission via healthcare workers hands. Consider wearing gloves and a gown when changing dressing and bed linen when wound drainage is present.
- Cross contamination of body site flora should be avoided by taking care between different procedures on the same client/patient/resident.
- Non-sterile tap water should not be allowed to stand in areas where medical equipment or supplies are prepared or stored.
- Sterile water and saline bottles should be dated when opened and discarded after 24 hours.
- Medical equipment should be adequately cleaned, disinfected and/or sterilized between uses such as shared bathtubs.

Prevention and control of *Serratia* infection is paramount, considering that outbreaks of *Serratia* infection occur most frequently in neonates and infants. For more information on *Serratia* contact your local RICN office".

Study Suggests H1N1 Virus More Dangerous than Suspected



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<http://www.infectioncontroltoday.com/>
 Posted on: 07/13/2009

A new, highly detailed study of the H1N1 flu virus shows that the pathogen is more virulent than previously thought. An international team of researchers led by University of Wisconsin-Madison virologist Yoshihiro Kawaoka provide a detailed portrait of the pandemic virus and its pathogenic qualities.

In contrast with run-of-the-mill seasonal flu viruses, the H1N1 virus exhibits an ability to infect cells deep in the lungs, where it can cause pneumonia and, in severe cases, death. Seasonal viruses typically infect only cells in the upper respiratory system. There is clear evidence the virus is different than seasonal influenza and that it has a quality frighteningly similar to those of other pandemic viruses, notably the 1918 virus. There is the possibility of the virus becoming even more pathogenic as the current pandemic runs its course and the virus evolves to acquire new features.

It is now flu season in the world's southern hemisphere, and the virus is expected to return in force to the northern hemisphere during the fall and winter flu season. Kawaoka and his colleagues found that the H1N1 virus replicates much more efficiently in the respiratory system than seasonal flu and causes severe lesions in the lungs similar to those caused by other more virulent types of pandemic flu. The most intriguing finding, was that those people exposed to the 1918 virus, all of whom are now in advanced old age, have antibodies that neutralize the H1N1 virus. The new study also indicates that existing and experimental antiviral drugs can form an effective first line of defense against the virus and slow its spread.

Pandemic References



It's time to start planning!
 Don't know where to go?
 Check out these
 Pandemic Planning links:

- ⇒ [Influenza Fact Sheet](#)
- ⇒ [Pandemic Influenza Information](#)
- ⇒ [Ontario Pandemic Influenza Plan](#)

Pandemic Portal : pandemicportal.ca

Community & Hospital Infection Control Association - Canada (CHICA - Canada)
 ⇒ [Influenza Website](#)

Public Health Agency of Canada

- ⇒ [Important Health Notices from PHAC](#)
- ⇒ [H1N1 Influenza](#)
- ⇒ [Government of Canada Response](#)
- ⇒ [Influenza Information](#)
- ⇒ [Canadian Pandemic Influenza Plan for the Health Sector](#)

***New* Interim Guidance Documents**
<http://www.phac-aspc.gc.ca/alert-alerte/swine-porcine/hp-index-eng.php>

World Health Organization

- ⇒ [Epidemic and Pandemic Alert and Response \(EPR\)](#)
- ⇒ [Current WHO Phase of Pandemic Alert](#)

U.S.A. Organizations

- ⇒ [CDC H1N1 Influenza](#)
Centers for Disease Control (CDC)
- ⇒ [H1N1 Flu Information](#)

Association for Professionals in Infection Control & Epidemiology (APIC)

- ⇒ [Influenza A \(H1N1\) Clinical and Public Health Guidance](#) (CDC)
- ⇒ [Interim Additional Guidance for Infection Control for Care of Patients with Confirmed, Probable, or Suspected Novel Influenza A \(H1N1\) Virus Infection in Outpatient Hemodialysis Settings](#) (CDC)



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 your 5-minute infection connection

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Got Data?

Isn't that a common refrain ICPs are hearing lately from all corners? And, unfortunately, all too often ICPs are expected to collect, analyze and share data without being provided with the proper tools to do so. That's where IPAC SET (Infection Prevention and Control Surveillance and Education Tracking) comes in.



IPAC SET is a database system that was created to address specific needs identified in two separate Regional Infection Control Networks. One of the needs was identified when the Ministry of Health and Long-Term Care rolled out their Infection Control Core Competency modules and hospital ICPs struggled with how to track their staff who had completed the modules. The other need was around a means of tracking surveillance of AROs. Since these two needs were identified, it seemed to make sense to address them through one collaborative project – a simple case of 1+1. Now, if we all think back to elementary school, we'll all recall the sum of 1+1=2... however, according to the new math 1+1=5...read on and it will all make sense.

As the name implies, the database has two main purposes:

1. surveillance – the tracking of specific patients with organisms of interest
2. education – the tracking of education taken by hospital staff (including the core competencies)

However, IPAC SET has the ability to do so much more. Here is a short list of some of it's capabilities:

- [CDAD Surveillance](#)
- [ARO Surveillance](#)
- [Outbreak Management](#)
- [ICP Communication Tool](#)
- [Core Competency and Education Tracking](#)
- [Reportable Disease Tracking](#)
- [Patient Safety Indicator Reporting](#)
- [Incident Management](#)

And all of this in an intuitive, user-friendly, and cost-effective (free is cost-effective, isn't it?) package. So, you may be asking yourself, "How can I get my hands on this database?" IPAC SET is currently being piloted at several acute care sites throughout the province. Once the database has been piloted and any bugs have been worked out of the system, IPAC SET will be rolled-out to hospitals throughout the province. There is also the potential for a LTC version of the database. Stay tuned for more information as it becomes available.

CHICA-HANDIC Keeping The Boat Afloat!



CHICA-HANDIC and the Regional Infection Control Networks held it's annual conference on June 18th at Michelangelo's in Hamilton. Close to 400 delegates attended the education day.



Francois Lagarde

Francois Lagarde set the "Wind in Everyone's Sails" presenting on Using



Barb Shea & Andrea Iacurti

Social Marketing to Promote Infection

Control. Pirate consultants Mark and Virginia demonstrated Francois' topic with a skit on MRSA and C. difficile. Donna Lowe hopes to change our course with Antibiotic Stewardship and

Cindy O'Neill shared glowgerm and cleaning success scenarios. The afternoon speakers : Sue Cooper, Dr. Maureen Cividino and Andrea Iacurti— added a full treasure chest of information on proper specimen collection, CA-MRSA and creating a B.E.T.T.E.R. Infection Control culture. Risa Cashmore summarized the day with a delightful photo synopsis!



Dr. Maureen Cividino



Patient Care Checklist

New influenza A (H1N1)

June 2009

This checklist is intended for use by hospital staff treating anyone with a medically suspected or confirmed case of new influenza A (H1N1) per local definition. This checklist highlights areas of care critical for the management of new influenza A (H1N1).

UPON ARRIVAL TO CLINICAL SETTING/TRIAGE

- Direct patient with flu-like symptoms to designated waiting area
- Provide instruction and materials to patient on respiratory hygiene/cough etiquette
- Put medical/surgical mask on patient if available and tolerable to patient

UPON INITIAL ASSESSMENT

- Record respiratory rate over one full minute and oxygen saturation if possible
- If respiratory rate is high or oxygen saturation is below 90% alert senior care staff for action*
- Record history, including flu-like symptoms, date of onset, travel, contact with people who have flu-like symptoms, co-morbidities
- Consider specialized diagnostic tests (e.g. RT-PCR)
- Use medical/surgical mask, eye protection, gloves when taking respiratory samples
- Label specimen correctly and send as per local regulations with biohazard precautions
- Consider alternative or additional diagnoses
- Report suspected case to local authority

INITIAL AND ONGOING PATIENT MANAGEMENT

Supportive therapy for new influenza A (H1N1) patient as for any influenza patient including:

- Give oxygen to maintain oxygen saturation above 90% or if respiratory rate is elevated (when oxygen saturation monitor not available)
- Give paracetamol/acetaminophen if considering an antipyretic for patients less than 18 years old
- Give appropriate antibiotic if evidence of secondary bacterial infection (e.g. pneumonia)
- Consider alternative or additional diagnoses
- Decide on need for antivirals* (oseltamivir or zanamivir), considering contra-indications and drug interactions

BEFORE PATIENT TRANSPORT/TRANSFER

- Put medical/surgical mask on patient if available and tolerable to patient

BEFORE PATIENT ENTRY TO DESIGNATED AREA (isolation room or cohort)

- Post restricted entry and infection control signs
- Provide dedicated patient equipment if available
- Ensure at least 1 metre (3.3 feet) between patients in cohort area
- Ensure local protocol for frequent linen and surface cleaning in place

BEFORE EVERY PATIENT CONTACT

- Clean hands
- Put on N95 or medical/surgical mask
- Put on eye protection, gown and gloves if there is risk of exposure to body fluids/splashes
- Clean and disinfect personal/dedicated patient equipment between patients
- Change gloves (if applicable) and clean hands between patients

IF USING AEROSOL-GENERATING PROCEDURES ALSO (e.g. intubation, bronchoscopy, CPR, suction)

- Allow entry of essential staff only
- Put on gown
- Put on particulate respirator (e.g. EU FFP2, US NIOSH-certified N95) if available
- Put on eye protection, and then put on gloves
- Perform planned procedure in an adequately ventilated room

BEFORE ENTERING DESIGNATED AREA (isolation room or cohort)

- Clean hands
- Put on N95 or medical/surgical mask

BEFORE LEAVING DESIGNATED AREA (isolation room or cohort)

- Remove any personal protective equipment (gloves, gown, mask, eye protection)
- Dispose of disposable items as per local protocol
- Clean hands
- Clean and disinfect dedicated patient equipment and personal equipment that has been in contact with patient
- Dispose of viral-contaminated waste as clinical waste

BEFORE DISCHARGE OF CONFIRMED OR SUSPECTED CASE

- Provide instruction and materials to patient/caregiver on respiratory hygiene/cough etiquette
- Provide advice on home isolation, infection control and limiting social contact
- Record patient address and telephone number

AFTER DISCHARGE

- Dispose of or clean and disinfect dedicated patient equipment as per local protocol
- Change and launder linen without shaking
- Clean surfaces as per local protocol
- Dispose of viral-contaminated waste as clinical waste

What's Happening...

EDUCATIONAL EVENTS

September 23

Brant County Health Unit presents their annual *Big Shot Challenge* (more details to follow)

September 24

Niagara Region Public Health Department presents: *Niagara Annual Infection Prevention and Control Education Event for Long Term Care Facilities*
Location: Club Italia, Niagara Falls

September 30 - October 1

Canadian Association of Environmental Management (CAEM) and the Regional Infection Control Networks (RICNs) present: *Red, White & Green: Best Practices for Environmental Cleaning*
Location: Grimsby
Click [here](#) for details on how to register.

MEETINGS

Looking for infection prevention and control support? Come join us at the next Long Term Care meeting!

Niagara Long Term Care Infection Control Group **NEW**

August 18 - Meadows of Dorchester
October 20 - Meadows of Dorchester
8:00 am - 9:30 am

Hamilton (and area) Long Term Care Infection Control Group

September 24 - St. Joseph's Villa
8:00 am - 10:00 am

.....*See you there!*

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Call for Interest...

Interested in joining one of our committees? We are currently looking for persons interested in Chairing the CSICN Education and Surveillance Subcommittees. If you would like to find out more about this rewarding position contact Anne Bialachowski, Network Coordinator at bialach@hhsc.ca. Expressions of interest will be accepted until **August 25th**.

WEBBER TRAINING

All teleclasses are offered *free* at the CSICN office from 1:30 to 2:30 pm. Let us know your coming! Call the office to reserve your spot.

August 6

How Professional Associations Can Best Contribute to Infection Prevention Globally

August 13

Safe Childbirth: What Can Infection Prevention Contribute?

August 27

Live Broadcast from the NZICND Conference, New Zealand – *Topic to be Announced*

September 10

Influenza Vaccination of Healthcare Workers

September 21

Live Broadcast from the Infection Prevention Society Conference

September 24

Using Lean Six Sigma to Engineer Infection Prevention into Patient Care

September 29

Voices of CHICA – Part 2

For a complete listing of upcoming teleconferences visit the website at www.webbertraining.com.

This newsletter was prepared by a collaborative effort of the RICNs and this Network.

Central South

Infection Control Network

St. Joseph's Villa
56 Governor's Road, Lower Level, North Tower
Dundas ON, L9H 5G7
Phone: (905) 627-6475
Toll Free: 1 866 681-4916
Email: askcsicn@hhsc.ca



REGIONAL INFECTION
CONTROL NETWORKS

Central South

*Giving Health
a Helping Hand*