



focus

on infection prevention and control

A Newsletter from the Central South Infection Control Network

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MUMPS - A New OHA/OMA Communicable Diseases Surveillance Protocol (CDSP)

There have been recent outbreaks of mumps in the United States and Canada in highly vaccinated populations, largely involving adolescents and young adults, often college or university students. In July 2007 there were 555 confirmed cases in Nova Scotia and New Brunswick with sporadic exportations to six other provinces. The reasons for these outbreaks are unclear but may be due to variable vaccine coverage, close living quarters (e.g. college dormitories), subclinical disease in vaccine recipients, waning immunity and failure of cold chain in vaccine distribution. Mumps transmission in health care settings has been described although most cases of mumps in health care workers (HCWs) are community acquired.

Mumps is an acute viral disease characterized by fever, swelling and tenderness of one or more salivary glands. About 40% of those infected develop

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OHA Pandemic Planning Toolkit for SRN Hospitals Now Available!

The Ontario Hospital Association (OHA) is pleased to announce that it has released the "OHA Pandemic Planning Toolkit for Small, Rural and Northern (SRN) Hospitals". The Toolkit was developed by OHA in response to the unique issues and challenges faced by SRN hospital in developing emergency response plans specific to an influenza pandemic. The goals of the Toolkit are to provide practical strategies, checklists and templates to assist these hospitals with the development and implementation of a Hospital Pandemic Plan. A hard copy of the Toolkit is being sent to all acute care hospital CEOs this week.

Hospitals are encouraged to review the Toolkit for information that will help guide their own pandemic influenza planning activities. The information includes:

- ⇒ A chapter on Community Pandemic Planning and Response, outlining what pandemic planning could look like at the community level
- ⇒ "Seven Steps to developing a Hospital Pandemic Plan", which is outlined in the Hospital Pandemic Plan Response chapter
- ⇒ Details about what the various levels of government are doing to meeting information needs and how to develop a communications plan
- ⇒ Chapters providing guidelines and tools for how to develop service reductions, human resources, and equipment and supplies plans

OHA members will be able to download the Toolkit from the OHA website at www.oha.com on December 14, 2007. Additional hard copies of the toolkit can be ordered online by visiting "Communication—Publications for Sale—Publication #319 or by calling 416-205-1350. For further information about the Toolkit, contact either Karen Sequeira at 416-205-1328 (ksequeira@oha.com) or Michelle Caplan at 416-205-1391 (mcaplan@oha.com)

MUMPS - A New OHA/OMA Communicable Diseases Surveillance Protocol (CDSP)

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acute parotitis, which is unilateral in 25%. Complications can include post-pubertal orchitis (20-30%), oophoritis (5%), aseptic meningitis (10%), sensorineural hearing loss in both adults and children, and rarely mumps encephalitis. About one third of infections are subclinical.

Mumps is spread by large respiratory droplets and direct contact with saliva of an infected person. The incubation period is usually about 16-18 days (range from 12-25 days). The period of communicability is from 7 days before to 9 days after onset of parotitis.

In compliance with The National Advisory Committee on Immunization (NACI) August 2007 [Statement on Mumps Vaccine](#), the CDSP for mumps recommends that at preplacement, HCWs should have documented receipt of 2 doses of a mumps-containing vaccine, or provide proof of laboratory confirmed mumps immunity or disease, or be born before 1970. A single dose of MMR vaccine may still be considered for those born before 1970. Catch-up of existing HCWs with a second dose of MMR should be considered. MMR is the only current mumps-containing vaccine in Canada.

Only immune HCWs should be assigned to care for patients with suspected or confirmed mumps. If the presence of a susceptible HCW within 1 metre of a patient with suspected or confirmed mumps is essential for patient care, personal protective equipment to prevent droplet transmission must be worn (i.e. surgical mask, gloves, gown, eye protection). Susceptible exposed HCWs must be excluded from any hospital work from the 10th day after the first exposure through the 26th day after the last exposure, regardless of whether they received vaccine after the exposure. If clinical mumps develops, the HCW must remain off work until 9 days after the onset of parotid swelling. Occupational Health Services should inform Infection Prevention and Control of HCWs with suspected or confirmed mumps when exposure of patients or other HCWs may have occurred.

Mumps is reportable to the local Medical Officer of Health, and if acquired due to an occupational exposure, this is also reportable to the Ministry of Labour and WSIB.

The Communicable Disease Surveillance Protocols have been developed jointly by the Ontario Hospital Association and the Ontario Medical Association and approved by the Minister of Health and Long-Term Care. They are in compliance with Regulation 965, Section 4, under the Public Hospitals Act. The regulation requires that each hospital has by-laws that establish and provide for the operation of a communicable disease surveillance program that considers all persons carrying on activities in the hospital.

References

1. Mumps Surveillance Protocol for Ontario Hospitals, OHA/OMA Joint Communicable Diseases Surveillance Protocol Committee http://www.oha.com/client/oha/oha_lp4w_ind_webstation.nsf/page/Communicable+Diseases+Surveillance+Protocols
2. National Health Advisory Committee on Immunization (NACI), Statement on Mumps Vaccine, **CCDR 33:ACS-9, August 2007.** http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/07vol33/acs-08/index_e.html
3. Control of Communicable Diseases Manual, Heymann DL, 18th edition, American Public Health Agency and World Health Organization, 2004
4. Canadian Immunization Guide, 7th Edition (2006), Public Health Agency of Canada

Adapted from above sources by Dr. Maureen Cividino, CSICN Medical Coordinator

How to Submit an Article to the CHICA Journal

The Canadian Journal of Infection Control publishes member-supplied articles as feature technical article or as "News from the Field". All materials submitted is reviewed by an editorial board consisting of CHICA-Canada members. If you are not sure about your writing skills, get your idea down and ask a colleague or member of the editorial board for help. Full requirements for technical articles can be found at http://www.chica.org/inside_cjic_journal.html, but here are some tips for getting started:

- 1) The author of the content must be clearly identified by name, title, organization and both a telephone number and email address must be supplied for contact purposes.
- 2) The subject of the material must be relevant to the interests of infection control practitioners.
- 3) The material should be submitted electronically via email as a Word document.
- 4) Length of submitted material is to be limited to a maximum of 1,500 words.
- 5) No part of the submitted material is to included what can be construed as sales-oriented promotion of specific individuals, companies, products or services.
- 6) Any photographic images to be included with the material must be free and clear of any copyright and must be submitted electronically as JPGs or TIFFs that are high resolution (at least 300 dpi) and a minimum of 6" X 9" in size. Image files should be sent separately, not embedded in the Word document.
- 7) In the event that the material is accepted for publication in *CJIC*, the author agrees that the first publication rights for the material belong to *CJIC* magazine and that any subsequent publishing of the material can only be done after the author or publisher is granted reprint approval in writing from CHICA-Canada and *CJIC* magazine.



Alert: Multi drug Resistant *Acinetobacter baumannii*



Agence de santé
publique du Canada

Public Health
Agency of Canada

Canadian Forces soldiers returning to Canada who have been treated in Afghanistan or at Landstuhl Regional Medical center (LRMC) in Germany may be infected or colonized with multi drug resistant *Acinetobacter* (MDRA) and may be sources of introduction of this organism to Canadian health-care institutions. In order to prevent secondary transmission of this organism, the following is recommended for patients admitted to Canadian hospitals following treatment in Afghanistan or LRMC:

1. Place on Contact Precautions according to PHAC Infection Control Guidelines: *Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care*, pending results of screening cultures (pages 45-51). <http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/99vol25/25s4/index.html>. If pneumonia is suspected with productive sputum individuals should be placed on both contact and droplet precautions.
2. Screening cultures for *Acinetobacter* should be taken from: groin, wounds or medical device exit sites, urine, and sputum or endotracheal secretions.
3. The microbiology laboratory should test the screening specimens submitted from these soldiers for multi-drug resistant *A.baumannii* (MDRA). Tests for other antibiotic resistant organisms (AROs) including methicillin resistant *Staphylococcus aureus* (MRSA), vancomycin resistant enterococcus (VRE) and extended-spectrum beta-lactamases (ESBLs) should also be done.
4. If screening cultures are positive and/or the patient is known to be colonized or infected with MDRA upon arrival a consult with an Infectious Disease physician is recommended. If screening cultures are negative, contact (and droplet if applicable) precautions may be discontinued.
5. Patients with positive screening cultures should remain on contact (and droplet if applicable) precautions until they have 3 sets of negative specimens taken at least one week apart for all previously positive sites. If a patient tests positive in Landstuhl they still would require 3 negative tests in Canada before being taken off contact precautions. If they test negative in Landstuhl they still need to be tested in Canada.
6. In order to monitor the situation at a national level, the National Microbiology Laboratory would like to examine the molecular epidemiology of strains identified in these individuals. Please submit any organisms you identify (*A.baumannii* or other AROs) from these individuals (infections or colonization) to:

Dr. Michael Mulvey
National Microbiology Laboratory
1015 Arlington St., Winnipeg, Manitoba R3E 3R2
Tel: (204) 789-2133 FAX: (204) 789-5020
Email: Michael_Mulvey@phac-aspc.gc.ca

7. The Nosocomial and Occupational Infections Section if you receive a patient from Afghanistan and test for *A.baumannii*. **It is important that you contact us regardless of the test results so that we can keep track of the number of individuals tested.** We will also provide you with a one page questionnaire to complete at that time.

Contact: Ms. Shirley Paton Shirley_Paton@phac-aspc.gc.ca
Phone: 613 957-0326

8. If a soldier tests positive for MDR *Acinetobacter* within your facility you should monitor for *A. baumannii* within the facility for at least 6 months post identification of the organism to determine if there has been any secondary transmission.

A Note from A. Bialachowski, Network Coordinator:

A.baumannii can live in the hospital environment longer than many other Gram-negative pathogens. It has been responsible for outbreaks in hospital ICUs. More information about environmental management can be found in the January 2008 article Multi-resistant infections in repatriated patients after natural disasters: Lessons learned from the 2004 tsunami, for hospital infection control. *Journal of Hospital Infections*. 68(1), 1-7. This article and others on *A. baumannii* and housekeeping are available from the CSICN library.



The ICP: Infection Prevention and Control Practitioner or Infection Prevention and Control Professional?

Article Courtesy of NWOICN—Pat Plaskowski, Network Coordinator

Are we having an identity crisis as ICPs? Is there a difference between an infection control practitioner or infection control professional? In recognition of the true nature and scope of our roles should we not include the term “prevention” in our title? In any health care setting or gathering of ICPs it is not uncommon to hear the term infection control practitioner being used. Although in many cases we are speaking to those who understand the role, there are many cases where we are speaking to those who may not clearly understand.

Does this “multiple branding” confuse our public and other health care partners? As infection prevention and control practices continue to gain recognition as the foremost patient safety initiatives perhaps we should be clearer on who we are. According to Merriam-Webster’s Medical Dictionary (Retrieved September 18, 2007, from Dictionary.com website <http://dictionary.reference.com/browse/>), a practitioner is “one who practices a profession and especially medicine: and a professional is “a person who is professional; especially: a person who engages in a pursuit or activity professionally.”

Which of these definitions describes who we are and what we do?

The choice of title is clearly articulated in CHICA-Canada’s mission statement: “CHICA-Canada is a national multidisciplinary association of *professionals*. CHICA-Canada is committed to improving the health of Canadians by promoting excellence in the practice of infection prevention and control by employing evidence based practice and application of epidemiological principles. This is accomplished through education, communication, standards, research and consumer awareness.”

In addition, there are the APIC/CHICA-Canada infection control and epidemiology: Professional and practice standards which were first published in 1999 (AJIC 1999;27:47-51). The preface to these standards themselves and the standards use the term “infection control professional” throughout. The document is divided in two sections and addresses both infection prevention and control practices as well as professional standards.

We need to use a clearer and more concise description of who we are and what we do...in other words our profession as Infection Control Professionals. We can all do this through consistent use of the term of “infection prevention and control professional” in our conversations, professional presentations and in our articles and submissions. Each CHICA chapter can also promote the term to their individual members and encourage it’s use at the local, regional, provincial or national levels.

VRE Transmission in Long Term Care

What are the Risks?

(Adapted from an article by Ellen Otterbein, WWICN)

Enterococci, especially those resistant to Vancomycin (VRE) are organisms of increasing concern to Infection Control Professionals (ICPs) in all health care settings across the continuum of care (Greenaway & Miller, 1999., Bonilla, et. al.1997). Enterococci are able to subsist independently in the environment for very long periods of time, so the environment may act as a reservoir for transmission. They are able to share their genes for antibiotic resistance with other microorganisms (Crossley, 1998), and act as pathogens in residents whose immune systems are compromised (Greenaway & Miller, 1997). A trend of increasing resistance to antibiotics has been noted by researchers, to the point that many VRE are resistant to all antimicrobial therapies that are currently available (Crossley, 1998). In other words, if a resident were to get an infection with VRE, the treatment options would be limited or, in the worst case scenario, nonexistent.

Transmission of VRE between residents in the long term care setting has been documented, though research indicates that this transmission does not take place as readily as it does in the acute care setting. In fact, a resident who is colonized or infected with VRE may be cared for in a long term care setting with minimal risk to other residents of developing a health care associated infection. Residents of long term care homes may pick up VRE while they are admitted as patients in acute care facilities (Nicolle, 2001). In this way, these residents can become reservoirs of VRE, bringing it from

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VRE Transmission in Long Term Care - What are the Risks?

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the hospital to the home (Cetinkaya, et. al., 2000). In order to prevent the spread of VRE to other residents in the long term care setting, the resident known to have VRE should be cared for by knowledgeable staff who are able to identify possible risks and take action based on their assessment to protect themselves and other residents from acquiring VRE.

- Bonilla, et. al. (1997) found that the transmission of VRE in the long term care setting among roommates of a resident colonized with VRE was uncommon.
- Crossley (1998) reported during his study of VRE in long term care that the transmission of VRE was not observed between residents and that preventing organisms like VRE from entering long term care settings is likely impossible since they are so common in acute care settings.
- Another study noted stable rates of colonization among residents in a long term care home over a 2.5 year surveillance period. During this same period, only three instances of VRE transmission were identified (Cetinkaya, 2000).
- Authors Brennan, Wagener, and Muder (1998) showed that the majority of VRE colonized residents had become colonized prior to their arrival at the long term care facility. Very few residents became VRE positive as a result of transmission in the long term care environment. Additionally, a study by Bradley (1999) indicated that only 8% of residents in a long term care setting acquired VRE during their stay and a majority (65%) of residents in the same setting never acquired an antibiotic resistant organism while living in the home. This finding suggests that spread between roommates is not common in this setting (Bradley, 1999).

When it comes to caring for residents in long term care settings, the re-search indicates that VRE transmission can be prevented by implementing the basic practices recommended in the PIDAC Best Practices document.

- VRE spread was found to be prevented when the receiving facility was notified of the resident's possible colonization prior to the resident's arrival to the facility (Silverblatt, et. al., 2000).
- Isolation precautions modified from those in acute care were sufficient to prevent the spread of VRE and were performed effectively in the long term care setting (Bradley, 1999).
- A high level of staff compliance with recommended infection control measures supports the lack of VRE spread (Greenaway, et. al, 1999).
- Control measures other than complete client isolation are effective in preventing the transmission of VRE in the long term care setting (Greenaway, et. al., 1999).
- Residents in long term care settings are not more susceptible to colonization with VRE than members of the general population and therefore, less intensive isolation practices are required to provide protection from VRE (Silverblatt, et. al., 2000).

References

1. Greenaway, CA., Miller, M.A.(1999). Lack of transmission of VRE in three LTCFs. *Infection Control and Hospital Epidemiology*. 20(5) 341-343
2. Bonilla, H.F., Zervos, M.A., Lyons, K.J., Bradley, S.F., Hedderwick S.A., Ramsey, M.A., Paul, L.K., Kauffman, C.A.(1997). Colonization with vancomycin resistant enterococcus faecium: comparison of LTC unit with an acute care hospital. *Infection Control and Hospital Epidemiology*. 18(5) 333-339.
3. Armstrong-Evans, M., Litt, M., McArthur, MA., Willey, B., Cann, D., Liska, S., Nusinowia, S., Gould, R., Blacklock, A., Low, D.E., McGeer, A. (1999) Control of transmission of vancomycin-resistant enterococcus faecium in a LTCF. *Infection Control and Hospital Epidemiology*. 20(5), 312-317.
4. Crossley, K. (1998). VRE in LTCFs. *Infection Control and Hospital Epidemiology*. 19(7), 51-525.
5. Gilmore, M.S.(ed)(2002). *The enterococci: pathogenesis, molecular biology, and antibiotic resistance*. ASM Press, Washington, D.C.
6. Cetinkaya, Y., Falk, P., Mayhall, C.G.(2000). Vancomycin-Resistant Enterococci. *Clinical Microbiology Reviews*. 13(4), 686-707.
7. Silverblatt, F.J., Tibert, C., Mikolich, D., Blazek-D'Arezzo, J., Al'ea, J., Tack, M., Agatiello, P. (2000). Preventing the spread of VRE In a LTCF. *Journal of American Geriatric Society*. 48 (10), 1211-1215.
8. Brennan, C., Wagener, M.M., Muder, R.R. (1998). VRE faecium in a LTCF. *Journal of the American Geriatric Society*. 46. 157-160.
9. Bradley, S.F.(1999). Issues in the management of resistant bacteria in LTCFs. *Infection Control and Hospital Epidemiology*. 20(5), 362-366
10. Nicolle, L.E.(2001). Preventing infections in non-hospital settings: LTC. *Emerging Infectious Diseases*. 7(2), 205-207.

To assist network members with VRE questions the WWICN and CSICN, in addition to using the PIDAC best practices, have collaborated to create a literature review table. It is available at <http://www.ricn.on.ca/centralsouthhomec47.php>

MRSA Roadshow

SEMINARS

&

MRSA WEBINARS

CHICA-Canada and CD (Becton Dickinson) will host a series of "MRSA Road Show Seminars" and "MRSA Webinars" starting in February 2008. The "Road Show Seminars" and "Webinars" are designed to educate healthcare professional and healthcare administrators on decreasing the rate of healthcare-associated infections with the focus on Methicillin Resistant Staphylococcus Aureus (MRSA), the antibiotic resistant bug impacting millions of patients worldwide.

REGISTRATION FOR THE ROADSHOWS AND WEBINARS IS FREE!

The dates and locations for the MRSA Roadshows are:

Thursday, June 5, 2008

Palais des Congrès
Montreal, Quebec
(following the close of the 2008 Education Conference)

The dates for the Webinars are:

Tuesday, March 25, 2008

Outbreak Management
Presenters: Mary Lou Card/Dr. Michael John / Kathy McGhie

Tuesday, April 15, 2008

Antibiotic Stewardship
Presenter: TBA

Thursday, May 1, 2008

MRSA Screening
Presenter: Dr. Michael Gardam

To register and to see the session objectives, go to: www.chica.org The MRSA Roadshow button is on the Home Page.

What's On-Line...



APIC Webinars

Throughout 2008, APIC is proudly sponsoring an ongoing series of Webinars. All of these APIC Webinars are free and available as recorded events 24 hours after the live broadcast has taken place.

- 🔗 CDC Isolation Guidelines on Multi-Drug Resistant Organisms (MDROs)
- 🔗 Designing a Program to Eliminate MRSA Transmission Part I: Making the Clinical Case
- 🔗 Designing a Program to Eliminate MRSA Transmission Part II: Making the Business Case
- 🔗 Workplace Cultural Transformation—Using Positive Deviance to Eliminate MRSA Transmission
- 🔗 The Role of Surveillance in a Successful Program to Eliminate MRSA Transmission
- 🔗 The Role of Isolation and Contact Precautions in the Elimination of Transmission of MRSA
- 🔗 TB in the U.S... Déjà vu? Raising Awareness for Healthcare Facilities
- 🔗 HICPAC Isolation Guideline: Infection Control on the Horizon

To access the recordings listed above, please visit: <http://www.apic.org/Content/NavigationMenu/Education/OnlineLearning/>

Federal MRSA-Study Legislation Introduced in the House

Representative Stearns [R-FL] introduced H.R. 4451, the MRSA Research and Study Act. This legislation would add a grant program to the Public Health Service Act for research on the prevention and treatment of MRSA as well as to find its cure.

The bill is available for viewing at:

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h4451ih.txt.pdf

Federal MRSA Legislation Introduced in the Senate

On December 19, 2007, Sen. Robert Menendez [D-NJ] introduced S. 2525, "MRSA Infection Prevention and Patient Protection Act." This bill would require hospitals to report no later than Jan. 1, 2009 via NHSN the number of cases of HA-MRSA.

For more information please visit:

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:s2525is.txt.pdf

Senator Menendez also introduced S. 2526, the "Worker Infection Protection Act" on December 19, 2007. This legislation, cosponsored by Senators Durbin [D-IL] and Kennedy [D-MA], would direct Secretaries of Labour and HHS to jointly develop and issue workplace standards, recommendations, and plans to protect healthcare workers and others.

For more information please visit:

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:s2526is.txt.pdf

Website of the Month...

Health Canada
Health Canada



Health Canada Risk Communication Products

http://www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/fact-feuille_e.html

Since May 2006, Health Canada has been using four communication products to keep Canadians apprised of potential risks to their health. Each of the four products has a specific use and a unique method of dissemination.

Public Warning

Issued in the most urgent situations, public warnings inform Canadians when there is a high probability that a product will cause death or other serious adverse health effects, such that the public should stop using the product immediately. Warnings are sent to the media and posted on the Health Canada website and distributed through the MedEffect electronic bulletin and the Health Canada media e-mail list.

Public Advisory

Issued through the same channels as warnings, Health Canada empowers Canadians through public advisories to make informed decisions concerning the continued use of consumer and marketed health products that may cause possible serious health hazards.

Information Update

Information to be conveyed about a product that carries a lower level of risk or that affects a very small group of people is contained in information updates. This risk communication product is also used to indicate the progress of Health Canada's review of a risk situation or to reinforce previously issued safety recommendations. An example of the latter type of information update is available on page 2 of this newsletter. Information updates are posted on the Health Canada website and distributed using the Health Canada media e-mail list and through MedEffect when marketed health products are involved.

Foreign Product Alert

Foreign Product Alerts advise consumers of health risks related to foreign products not authorized for sale in Canada and not found on the Canadian marketplace, but which may have entered the country through personal importation or by purchase over the internet. E-mail notice is sent to the Health Canada media list when a foreign product alert is issued.

To subscribe to MedEffect, visit:

http://www.hc-sc.gc.ca/dhp-mps/medeff/subscribe-abonnement/index_e.html

To subscribe to the Health Canada Media News Service visit:

http://www.hc-sc.gc.ca/ahc-asc/media/sub-abonn/index_e.html#media

CSA Standard Z317.13-07 Revision Now Available

CSA Standard Z317.13-07 Infection Control During Construction, Renovation and Maintenance of Health Care Facilities has been reissued in its revised form. Many of the networks have this standard in the resource libraries. The document is available from CSA at the link below:

<http://www.csa-intl.org/onlinestore/GetCatalogDrillDown.asp?Parent=3392>



What's Happening....

Educational Events Occurring in April and May

Webber Training

CSICN hosts Webber Training Sessions at St. Joseph's Villa office. Participants who would like to attend on-site are asked to contact Oksana Zaporzan zaporzan@hpsc.ca to register. For more information on participating via teleconference visit <http://webbertraining.com/schedulep1.php>.

- March 27 **Novice - Surveillance Success**
Speaker: Dr. Mary Andrus, CDC
- April 3 **The Human and Environmental Toxicity of Microbiology Chemicals: Are Safer Alternatives Available?**
Speaker: Dr. Susan Springthorne
- April 10 **Disease Problems in the Global Food Supply**
Speaker: Dr. Corrie Brown, College of Veterinary Medicine, University of Georgia
- April 16 **(South Pacific Teleclass) Antibiotic Resistance - Can We Hold Back the Tide?**
Speaker: Dr. Mark Thomas, Auckland District Health Board

- April 17 **CBIC Teleclass 2 - Study Strategies for the CIC Exam**
Speaker: CBIC Board Members & Guest
- April 22 **(British Teleclass) Live Broadcast from Central Sterilizing Club Conference UK**
Speaker: To Be Announced
- April 24 **Case Study in Infection Control #1**
Speaker: Dr. Dick Zoutman, Queen's University
- May 1 **Infection Control in Personal Service Settings**
Speaker: Dr. Bonnie Henry, BC Centre for Disease Control
- May 8 **Biocidal Testing and Label Claims - Truth In Advertising?**
Speaker: Prof. Syed Sattar, University of Ottawa
- May 15 **Adverse Events in Dialysis**
Speaker: Dr. Matthew Arduino
- May 22 **Bedpan Decontamination - Manual vs Mechanical**
Speaker: Gertie van Knippenberg Gordebeke

April 2008

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May 2008

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Workshop March 28, 2008
CSICN Surveillance Workshop for Acute Care
 Casablanca Winery Inn
 Grimsby, ON



REGIONAL INFECTION CONTROL NETWORKS

Central South

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a Helping Hand*

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