Community Partners Education Day: The Bug STOPS Here!

Could we please have the words to the hand rub song?

Squirt, swirl, swish swirl, scrub until dry. 'Cos if you do the bugs are going to die!

What type of soap is recommended in a community centre – ordinary soap or antibacterial hand soap?

Antibacterial hand soaps are not recommended for use in areas outside of high risk/critical care settings. They may be used prior to performing aseptic procedures i.e. sterile dressing changes, starting an IV etc.; however, alcohol based hand rubs (ABHR) are effective prior to performing these procedures. Antimicrobial soaps are also harsher on hands than plain soaps, and frequent use may result in skin breakdown. Furthermore, frequent use of antimicrobial soap may lead to resistance. [Provincial Infectious Diseases Advisory Committee (January 2009). Best Practices for Hand Hygiene in All Health Care Settings, p. 26.]

In addition, the Community and Hospital Infection Control Association has published the following position statement on Antibacterial Products in the Community in March of 2005 (www.chica.org/pdf/products.pdf): "Public concern about the emergence of antibiotic resistant organisms (AROs) has created a perceived need for new household products and devices (e.g. toys, hand soaps, towels, animal care products, etc.) that incorporate antibacterial agents. There is little evidence to suggest that these agents reduce infections in the home. Antibacterial agents alter the mix of naturally occurring bacteria killing susceptible organisms and potentially leaving the resistant ones to survive and multiply. Furthermore, the incorporation of low levels of antibacterial agents, which do not kill the organisms, may promote the development of resistant genes.

"Apart from the environmental concerns, most of these new products are expensive and play on the public's fears of contracting an infectious disease from an antibiotic resistant organism. In fact, the most common household illnesses are viral in nature, to which antibacterial agents are ineffective. The focus should continue to be on frequent handwashing, safe food preparation, good personal hygiene, and basic home cleanliness."

Which is the best testing method for mask fit testing- qualitative or quantitative testing? Can you explain both types of tests?

A qualitative fit test is a pass/fail test that relies on the subject's response to a test agent. An administrator challenges a subject wearing a respirator with a test aerosol of saccharine or Bitrex. The subject dons the respirator and a fit test hood. The test aerosol is sprayed inside the hood while the subject performs prescribed exercises. If the subject can taste the test agent, the respirator fails the test and another respirator must be tested. Prior to conducting the test, the administrator must determine if the subject can detect the test agent. If the subject can't detect the test agent, another one that can be detected must be used. The fit test procedure requires about 15 to 20 minutes. The equipment cost of this method is low and it gives simple pass/fail results. However, it relies on the subjective response of the individual being tested.

A quantitative fit test measures the adequacy of a respirator's fit by numerically measuring the amount of leakage into the respirator following either:

- the Condensation Nuclei Counter protocol with a PortaCount tester. The concentration of microscopic dust particles in the ambient air is measured and compared to the concentration of those dust particles that leak into the respirator
- the Controlled Negative Pressure protocol, which measures leak rates through the facepiece to determine its fit for negative pressure respirators.

A quantitative fit test generates numerical results and is not affected by the person's sense of smell, taste or sensitivity to irritant chemicals. It is commonly used in applications where higher fit factors are required, such as in firefighting or haz-mat operations. It is also used for staff who are difficult to fit using the qualitative method or who have failed the qualitative method. However, the equipment is expensive, and it requires probed face piece or probe adaptor and annual recalibration of equipment.

For small individual purse-sized hand sanitizer, can we wash and air dry before refilling? Best practice versus next to best practice?

PIDAC best practice document on hand hygiene does not recommend "topping up" or refilling of any type of dispenser. While cost of disposable dispensers/containers appears to be prohibitive, the process of cleaning and disinfecting these containers effectively after use may be costly as well as time consuming.

In the presentation, it was advised that staff not work until 24 hours afebrile. With H1N1 and ILI they recommend 7 days and symptom free. How do I make that call as an ICN? Is there further risk of infection spread after being afebrile?

The information provided in the presentation was a general rule of thumb. There are specific guidelines with regards to work exclusion/restriction and return to work recommendations based on the specific illness or infection. There are often other factors to consider such as symptoms other than fever. For example, a worker diagnosed with TB or Chickenpox would require work exclusion guidelines specific for these diseases. The Ontario Hospital Association/Ontario Medical Association Communicable Diseases Surveillance Protocols are an excellent resource to assist with work restriction issues. While these guidelines were written for the hospital sector, the information may still be helpful.
www.oha.ca/client/oha/oha_lp4w_lnd_webstation.nsf/page/Communicable+Diseases+Surveillance+Protocols

For H1N1 specifically, the Important Health Notice issued by the Ministry of Health and Long-Term Care on April 29th, recommends that patients with Influenza-like Illness (ILI) self-isolate for 7 days after onset of symptoms. While fever may subside prior to 7 days, the virus may continue to be excreted through respiratory secretions. Practicing good respiratory hygiene may reduce the risk of transmission.

For H1N1 Influenza virus, do we just need to use surgical masks? We've been told that N95 masks need to be used.

The answer to this question is referenced in the document issued by the Ministry of Health and Long-Term Care entitled, "Quick Reference: May 19th Updates to H1N1 flu Virus Guidance Documents". It provides the following recommendation for personal protective equipment (PPE): "Since travel history can no longer accurately predict who is infected with the novel H1N1 influenza virus, the following should be used by healthcare workers when within 2 metres of caring for all patients with ILI:

- Routine Practices including gown and gloves and if widespread contamination with respiratory secretions and hand hygiene, and
- A fit tested N95 respirator and eye protection

This includes reception staff in ambulatory settings if no physical barrier or 2 metre distance from patients is possible. If N95 supplies have been depleted, healthcare workers should don surgical mask, and wherever possible, the patient should remain masked (with a surgical mask) as well. N95 respirator and PPE use by healthcare workers should be prioritized as recommended in chapter 7 of the Ontario Health Plan for an Influenza Pandemic. In patients who do not present with fever and cough, Routine Practices should be followed."

Can you please explain why decolonization of MRSA is not recommended? We find that if we treat someone returning from hospital with MRSA, they will be carriers for a shorter period of time.

See article by Dr. Mary Vearncombe (attached).

For Clostridium difficile specimens, does the stool have to take the shape of the bottle? Is it a must?

The Ontario Public Health Laboratories has published a document in August of 2008 "Labstract: Clostridium difficile toxin testing – Specimen Acceptance Criteria". It states that faeces should be loose / watery enough to conform to the shape of the container. Formed faeces specimens will be rejected unless the requisition indicates the patient may have pseudomembranous colitis.

Can you specify what kind of protective equipment should be carried by speech language pathologists and volunteers while working with clients in their homes?

As mentioned in the presentations, routine practices should be followed by all healthcare providers while caring for any client in the community. At a minimum, this includes:
hand hygiene before and after client contact
use of gloves if you anticipate contact with the client's blood, other body fluids or broken down skin
use of gowns (or aprons) if your uniform or clothing might be soiled with blood or body substances e.g. caring for an incontinent client
mask and goggles or other eye protection if the client may spray body substances into your eyes nose or mouth while you are providing care. Wound irrigation is a good example of this.

All healthcare providers need to carry an emergency personal protective equipment (PPE) bag with them at all times in case of a positive Febrile Respiratory Illness screen.

If your contact with the client's body substances is minimal in your line of work i.e. casual contact, then hand hygiene may suffice. Alcohol-based hand rub (ABHR) is an essential item in your supply kit. If based on your risk assessment, you may be exposed to blood or body fluids, other supplies

such as gloves, gowns, masks and goggles should be available should you require them. It is important that you conduct a risk assessment of the client as well as the procedures being performed to determine what PPE is required.

For clients with identified infection e.g. pneumonia, or colonization e.g. MRSA, additional precautions may be required based on the mode of transmission. For example, a mask and eye protection would be recommended when caring for the client with pneumonia. Gloves and gowns would be required for direct care of the client with MRSA.

As for speech language pathologists, they should be wearing face protection when directly observing/working with a client within 2 metres who is practicing word pronounciation where there is a risk of splash of saliva/sputum. This would be routine practice. Other strategies to minimize splash include staying more than 2 metres away or sitting beside a client instead of directly across.

Can you please provide information on where we can get the masks with the attached eye shields?

3M and Kimberly-Clark both make the mask with visor attached. These are the only two I have heard back on.

What are the 5 C's for community MRSA?

The 5 Cs of community MRSA are:

- Crowded conditions
- Close Contact
- Having Compromised or broken skin
- Sharing Common personal care items (towels)
- Lack of Cleanliness

High risk groups include:

- Athletes, sports teams
- Daycares
- Military personnel
- Homeless shelters
- Intravenous drug users
- MSM (men who have sex with men)
- Inmates of correctional facilities
- People who reside in dormitories

If a total knee patient comes home from hospital and then develops an infection, is it more likely to be MRSA?

There was no literature found to support the notion that an infection is more likely for a total knee replacement. The likelihood of an MRSA infection developing would be more related to the hospital epidemiology (whether or not MRSA is prevalent in the facility) or the patient's history (were they colonized with MRSA pre-op or is this a revision). CNISP and NNIS data do not emphasize MRSA or even tease it out from staphylococcus species in general leading one to question whether MRSA is very common in total knee surgeries. The literature indicates that the overall infection rates for total knee surgery is less than 2% (CNICP and NNIS).

The choice of masks – We have some N95 brands that have an expiry date. Does this mean that different brands have different criteria?

Aerosol penetration through respirator filters depends on many factors, including the filtration characteristics of the filter, size distribution of the droplets in the aerosol, the velocity of the particulate traveling through the filtering material, the amount of particulate contaminant deposited on the filter, and the electrostatic charges on the filter and on the droplets in the aerosol. Because electrostatic filter media can degrade, users should follow the manufacturers' instruction concerning service life to ensure optimum filter performance.

In a centre-based service such as a day program for seniors, do we need to soak the eating utensils in bleach before washing or just put into the ordinary dishwasher and heat dry?

No pre-soaking of utensils is required. The dishwasher action is adequate to sanitize dishes.

If the laundry is soiled with urine/stool/vomit, do we need to disinfect it before sending it out to the industrial laundry?

No, it is not necessary to disinfect laundry before sending it out. Gross soil should be removed with a gloved hand prior to sending out. Anyone handling or sorting soiled laundry should wear personal protective equipment. The laundry should be in a bag that prevents leaking of contents so as to protect those who are transporting soiled bags of laundry.

How do I find out what disinfectants are hospital grade disinfectants? Could I find examples of these in the PIDAC document?

The new PIDAC document for Environmental Cleaning will be released shortly. It contains a table of commonly used hospital grade disinfectants. The definition of a Hospital Grade Disinfectant is "A low-level disinfectant that has a drug identification number (DIN) from Health Canada indicating its approval for use in Canadian hospitals." (PIDAC draft document, 2009)

See the following website to ascertain if a disinfectant has a DIN: www.hc-sc.gc.ca/dhp-mps/prodpharma/databasdon/index-eng.php

Re: "in home" care – Can human waste (colostomy bags) be disposed of in the green compost bin (Toronto) as can pet litter and baby diapers?

Each municipality in the province has a different list of acceptable compostable items. Contact your local municipality to confirm what is acceptable. Stool from a colostomy bag is no different than stool from incontinent products. Be aware that stool that is very liquid may not be able to be contained properly in some compostable bags or containers. The colostomy bag itself is usually comprised of different plastics and, thus, would probably not be acceptable in a compost bag nor in the plastic recycling stream. An alternative is to dispose the contents of a colostomy bag into the toilet, then, discard the colostomy bag into regular garbage.

Information on preventing spread in "homecare" – different homes are not as controlled as per the information and scenarios provided today. Wheelchairs are not cleaned in the home setting if client lives alone or "rough". When dressing, client sits in chair undressed and client may not like suggested precautions i.e. towel on chair. How do we prevent infection and keep staff/client safe?

Hand hygiene is always the single most important action any health care worker can take to prevent the transmission of infection. Assessing the risk to the health care worker is important, too, to ascertain whether personal protective equipment (PPE) is required in any interaction with a client. All home health workers need to carry PPE with them at all times and use PPE based on the assessed risk. Some home settings may never be "clean", thus, it may become routine practice that all health care workers providing direct care in a grossly contaminated setting may always require PPE, depending on the care provided. It is important for health care workers to communicate this need to their multidisciplinary colleagues and other agencies going into the home as well.

Could we please get a copy of the "Making Sense of It All" PowerPoint?

Brenda to provide at a later date . . . stay tuned!

The presenters were great? Any chance they could come to our organization to educate staff?

All of the presentations are being recorded and will be available on the RICN website shortly. Notification of this as well as the link will be sent to you by e-mail. These presentations may be helpful in educating your staff. The RICNs do provide on-site education on request.