Network News

In This Issue:

Waterloo Wellington Infection Control Network

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Waterloo Wellington Infection Control Network

November/December 2007

We Wish You a Happy, Healthy Holiday Season!

Whatever your celebration plans this holiday season, there are 5 simple ways you can prevent the spread of Influenza, Norovirus, the common cold and other infections!

1. Practice hand hygiene

Use alcohol-based hand rub with an alcohol concentration of 60-90% to keep your hands clean. Use soap, water and friction, lathering your hands for at least 15 seconds if your hands are visibly soiled. This prevents viruses and bacteria from traveling on your hands to your eyes, nose or mouth when you touch your face. It also protects others when you shake hands or have close contact with them.

2. Cover your cough or sneeze

Coughing and sneezing into your sleeve prevents the spread of infectious organisms through the air via the droplet route. If you prefer to use tissues, ensure you dispose of them after each use and avoid using a traditional handkerchief or reusing tissues. Remember to perform hand hygiene after disposing of tissues!

3. Stay home if you're sick

If you are not feeling well, stay home to rest and avoid spreading your illness to others. Make phone calls to family and friends when there is the risk that visiting in person might spread illness.

4. Keep your distance

If you or someone you are with is sick, keep a one metre distance from them as much as possible to avoid breathing in infectious particles that may have been coughed out. If you are concerned about shaking hands with someone who may be ill, let the person know and offer warm words instead of contact.

5. Stay healthy

Eat healthy, exercise and get some rest! Take measures to decrease the stress you may experience during this time of the year, and enjoy the season!

Waterloo Wellington Infection Control Network ARO Working Group Update

The Antibiotic Resistant Organisms (ARO) Working Group has been busy since its first meeting in January of this year. The group has representation from acute care, long-term care, public health and community care. The group has produced policy templates for acute care, long-term care and community care for MRSA and VRE

Each of the draft policies will now be reviewed by those in that field to ensure the directions are clear and feasible.

The ARO Working Group will be holding focus groups for long-term care on December 4 and 6 to gather feedback from administrators and infection control professionals.

The ARO Working Group is also working on a plan to gather feedback and disseminate the policy to community care, and an education plan for community physicians.

When the policies are complete, the group will work on developing tools to enhance communication and implementation of best practice in all health care agencies in the Waterloo Wellington area.

For more information about the ARO Working Group, please contact the WWICN office by phone at 519-624-9781 or Cathy Egan at cegan@cmh.org or Ellen Otterbein at eotterbein@cmh.org.

The WWICN would like to acknowledge and congratulate Donna Lyle, Infection Control Professional at Cambridge Memorial Hospital on her recent success with the CIC exam! Way to go Donna!

Health Canada Information Update:

Reminder to use lancing devices for blood sampling as directed

Health Canada recently issued a reminder that lancing devices (lancets used to obtain blood samples from clients) must be used as directed in order to minimize the risk of transmitting blood-borne pathogens, including hepatitis B, hepatitis C and HIV. The reminder was issued following reports of improper use of lancing devices. The lancet device itself, including the cap was reused. While the device was wiped down with alcohol wipes after each use, there was no formal cleaning process used prior to using the alcohol wipes. Alcohol can only be used for disinfection effectively after a surface or piece of equipment has been cleaned of any potential blood or body fluids.

Lancing devices are used by individuals and health care professionals to take blood samples, often for blood glucose monitoring in clients with diabetes. They typically consist of a hand-held tube into which a small surgical knife known as a lancet is loaded. The device is held against the skin and a button is pressed to release the lancet. An end cap controls the penetration depth of the lancet. It is important for users to carefully read the manufacturer's instructions and labeling to ensure that the device is used appropriately.

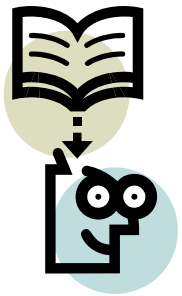
There are three types of lancing devices: disposable, reusable for individual use only, and reusable for multiple clients. Disposable lancing devices are intended to be used once and then the entire unit must be discarded in an appropriate safety container. Reusable lancing devices for individual use only are intended for re-use by one client and should not be shared. Some lancing devices are intended for use on multiple patients and in these cases careful attention must be paid to the manufacturer's cleaning and disinfecting directions, including which components of the device must be discarded and replaced between uses.

The Public Health Agency of Canada (PHAC) states that there is sufficient documented evidence that blood-borne illnesses can be transmitted by sharing finger stick devices. Individuals, clinics, hospitals and long-term care homes must be sure that devices are used according to manufacturer's instructions. Sharing devices is inappropriate unless the device is designed for that purpose.

Users of lancing devices who have questions or concerns about the safe and proper use and handling of these products are urged to communicate with the manufacturer of their device or with a health care professional experienced with the cleaning and disinfection of equipment.

To learn more about Health Canada Risk Communication Products, please see page 4 of this newsletter.

Education Opportunities



Webber Training Teleclasses

Teleclass Topics in November/December Include:

- Commissioning Infection Control Strategy – November 6, 2007
- Hazard Vulnerability Analysis for Infection Control – November 8, 2007
- An Approach to Outbreak Management – Using Biostats to Clobber Bugs – November 15, 2007
- Effective Infection Control Promotion in 3-5 steps – November 29, 2007
- Water Quality Issues Pertaining to Medical Device Reprocessing – December 13, 2007

To participate in these teleclasses, contact Ellen at the WWICN by e-mailing eotterbein@cmh.org.

November 20-21, 2007
Patient Safety: Adverse Events and Infection Control, presented by Insight Information
St. Andrew's Club and Conference Centre, Toronto, Ontario. For more information, visit www.insightinfo.com

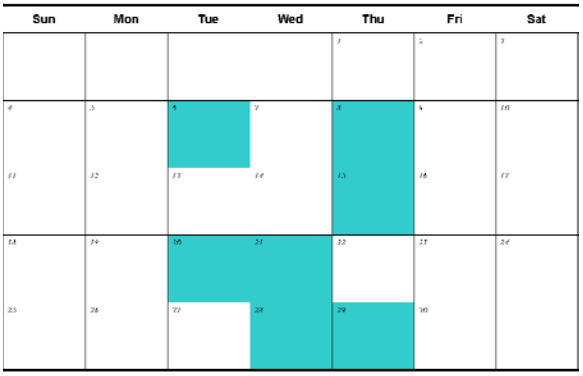
November 21, 2007 from 2:00-3:00pm
The Institute for Healthcare Improvement (IHI) and *The Journal of the American Medical Association (JAMA)* present:
'Author in the Room' Teleconference featuring Monina Klevens, DDS, MPH, author of 'Invasive Methicillin-Resistant Staphylococcus aureus Infection in the United States'.
To register in this free teleconference, please visit
http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/Author+in+the+Room.htm
To listen on-line after the live teleconference, visit the above link and click on the 'Archive' tab.

November 28, 2007
Focus on Antibiotic Use, presented by North Simcoe Muskoka Infection Control Network,
Mariposa Inn & Conference Centre, Orillia, Ontario. For more information call (705) 330-3223 or email nsmicn@osmh.on.ca

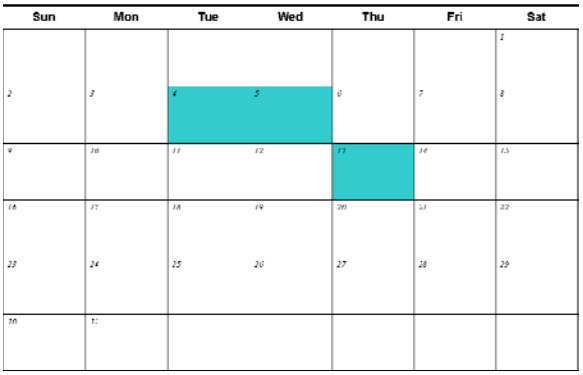
December 4, 2007
Infection Control During Construction or Renovation of Health Care Facilities presented by CSA
Mississauga, Ontario. For more information, visit www.learningcentre.csa.ca

December 5, 2007
Special Requirements for Heating, Ventilation and Air conditioning in Healthcare Facilities presented by CSA, Mississauga, Ontario. For more information, visit www.learningcentre.csa.ca

November 2007



December 2007



Learning without thought is labour lost;
thought without learning is perilous.
-Confucious

Infection Control Week at Wellington-Dufferin-Guelph Public Health

The WWICN thanks author April Hexemer, Health Promotion Specialist in the Control of Infectious Disease Program at Wellington-Dufferin-Guelph Public Health for this contribution

Welington-Dufferin-Guelph Public Health celebrated Infection Control Week by increasing the knowledge and awareness of basic infection control practices amongst all staff. Each day throughout Infection Control Week, all Public Health staff received an e-mail message with an infection control practice tip and a fun activity to complete for the chance to win a prize. Infection control tips included:

- ⇒ Hand hygiene I: what it is and why to do it;
- ⇒ Hand hygiene II: to wash or sanitize;
- ⇒ Respiratory etiquette; and
- ⇒ Have a healthy winter.

The Regional Infection Control Network document *Rise to the Occasion: An Idea Primer to Help You Celebrate Infection Control Week* was an invaluable resource for creating activities that reinforced the infection control messages. Staff had a lot of fun completing the scavenger hunt, word scramble and pictograms. Thank you to the Waterloo Wellington Infection Control Network for supporting this week by developing an incredible document filled with fun ideas and by supplying fabulous prizes for our staff. Everyone learned a little bit about infection control while having a lot of fun!

Website of the Month: Health Canada Risk Communication Products www.hc-sc.gc.ca

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.

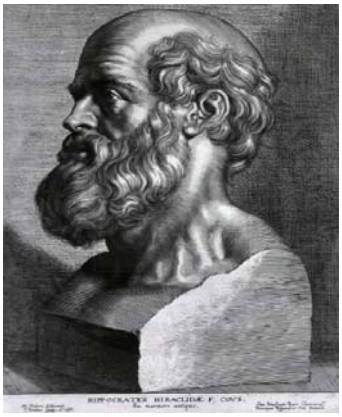
To subscribe to MedEffect, visit: http://hc-sc.gc.ca/dhp-mps/medeff/subscribe-abonnement/index_e.html
To subscribe to the Health Canada Media News Service visit: http://hc-sc.gc.ca/ahc-asc/media/sub-abonn/index_e.html

Infection Control in History: Let's Start from the Beginning…

A look back in time to consider the development and implementation of Infection Prevention and Control Practice

Hippocrates, the 'Father of Medicine' lived from 460-377 BC and worked as a physician on the island of Cos in Greece. His medical practice was based on observation of the human body and his belief that the cause of illness was physical and rational rather than supernatural or related to disfavour of the gods or possession by evil spirits as thought at that time dictated.

Hippocrates held the belief that the body must be treated as a whole and not just a series of parts. He accurately described disease symptoms and was the first physician to accurately describe the symptoms of pneumonia and mumps, as well as epilepsy in children. He noted that there were individual differences in the severity of disease symptoms and that some individuals were better able to cope with their disease and illness than others. He was also the first physician to suggest that thoughts, ideas and feelings come from the brain and not the heart as others of his time believed.



Hippocrates: the Father of Medicine

Hippocrates believed in the natural healing process of rest, a good diet, fresh air and cleanliness. These ideas were embraced and expounded upon centuries later by Florence Nightingale who will be featured in a future edition of the Network News.

Though not specific to Infection Prevention and Control, Hippocrates is credited with the identification of the founding principles of public health practice; the role of seasons (time), geographical areas (place) and types of individuals (person) on the development and resolution of disease and epidemics.

Ask the Expert:

I've always thought that bacteria found in the urine should be treated, but now lately I've heard otherwise. Can you help clarify for me?

Asymptomatic bacteriuria (AB) is defined as bacteriuria in otherwise asymptomatic persons with ≥ 10^5 cfu/ml of the same bacterial strain in 2 consecutive voided urine specimens in women or 1 clean-catch voided specimen in men or ≥ 10^2 cfu/ml in catheterized people. AB is most common in women and particularly associated with sexual activity with 4.6% of premenopausal married women. It is rare in young healthy men but does increase with age in both men and women where >20% of women 80 years of age and older and 6-15% of men over the age of 75 have AB. Another common problem is bacteriuria associated with indwelling urethral catheters and occurs in 2-7% per day for short term catheters and >50% in spinal cord injury patients managed by intermittent catheterization. Residents of long-term care facilities are especially at risk with 25-50% of women and 15-40% of men affected. The treatment of AB is a common dilemma. Recent guidelines from the Infectious Diseases Society of America (IDSA) give recommendations regarding when treatment is appropriate and when it is not. Most cases of AB in adults do not require antibiotic treatment. [1] There are exceptions to this, however. In pregnancy, AB is associated with increased risk of pyelonephritis, prematurity and infant of low birth weight which may be reduced if the AB is treated.[2] Screening for AB is recommended at least once during a pregnancy and typically takes place in the 1st trimester (12-16 weeks) from a urine culture, as pyuria has a low sensitivity (50%).[3,4] Urological procedures have been associated with an increased risk of bacteremia with AB and therefore screening for and treatment of AB, if present, prior to the procedure is indicated for transurethral resection of the prostate (TURP) or other urologic procedures likely to produce mucosal bleeding. There has been no benefit found in treating AB in catheterized, elderly, spinal cord injury or diabetic patients and therefore screening for AB is not indicated. Pyuria is commonly associated with AB and is not an indication for treatment. Additionally, inappropriate antibiotic use can be associated with significant negative outcomes including increased antimicrobial resistance, drug reactions and side effects such as *Clostridium difficile* associated diarrhea.

References:
[1]Nicolle et al. Infectious Diseases Society of America Guidelines for the diagnosis and treatment of Asymptomatic Bacteriuria in Adults. CID 2005: 40; pp.643-654.
[2]Smail et al. Antibiotics for Asymptomatic Bacteriuria in Pregnancy. Cochrane Database Systematic Review 2007:Apr 18;(2):CD000490.
[3]Bachman et al. A Study of Various Tests to Detect Asymptomatic Urinary Tract Infections in an Obstetric Population. JAMA 1993:270;1971-1974.
[4]U.S. Preventive Services Task Force (USPSTF). Screening for Asymptomatic Bacteriuria: Recommendation Statement. Agency for Healthcare Research and Quality (AHRQ); 2004 Feb 5.

The Expert is Dr. Ian Davis, Medical Coordinator of the Central East Infection Control Network

Resource Profile: The Waterloo Wellington Infection Control Network: 'Your One-Stop Shop' for IPAC Resources

"Before the WWICN was in place, I felt like I had nowhere to turn for answers to even simple IPAC questions. I am very glad that now I can access the WWICN for all sorts of resources – from items in their lending library to ideas and equipment for IPAC activities in the workplace to in-services that they present to staff members at my health care setting!!"

The Waterloo Wellington Infection Control Network knows that Infection Prevention and Control (IPAC) professionals are busy people! No matter the health care setting, these professionals often wear more than just the IPAC 'hat' and do a remarkable job upholding the professional standards of accountability, qualification, continual development, leadership and ethical practice. IPAC professionals also strive to incorporate competent infection prevention and control practice, epidemiological concepts and surveillance techniques into their daily tasks as well as providing education and consultation to colleagues, clients and visitors in the health care environment. Performance improvement, program management and evaluation, fiscal responsibility and research are additional elements that IPAC professionals balance on a regular basis! It's no wonder you get tired!

Enter Cathy, Ellen, Martha and Tammie from the Waterloo Wellington Infection Control Network (WWICN) who want to help you with any IPAC issues you might encounter in your daily practice to make your life a little bit easier. Have an IPAC question you've been meaning to find an answer for, but just haven't had the time? Need an in-service for staff about antibiotic resistant organisms (AROs), routine practices, or general infection prevention and control practice but don't have the time to put one together? Want evidence to support a change in IPAC practice at your health care setting?

Whether you are new to the IPAC role or have years of experience, the WWICN is a resource for you! Please contact us by phone, email or fax – we are here to help!

Norovirus and Rotavirus… Foul Weather Friends

Norovirus and Rotavirus infections generally make themselves known in the winter months in our part of the world. Each of these viruses cause short-lived enteric disease that includes vomiting, diarrhea, abdominal pain and sometimes fever. Although neither virus is a welcome presence in our lives, they do tend to run their course relatively quickly, and most healthy individuals will suffer no long term harm from infection. However, they are a curse in healthcare settings, and in extreme cases, and in the wrong host (particularly the elderly or very young), these infections can result in severe dehydration and electrolyte imbalance that requires hospitalization and can result in death.

Rotavirus is well known to affect children, with an estimated 35% of pediatric hospital admissions for gastroenteritis being caused by this organism. Typically, rotavirus infection requires an incubation period of 48 to 72 hours, and symptoms last from 4 to 6 days. Onset is generally quite sudden, with vomiting and fever, which lasts for about 2 days, followed by profuse diarrhea. The virus is actively shed in the feces between the 3rd and 8th day of illness, with viral concentrations of over 1,000 micro-organisms per gram of feces. The virus is stable, with persistence for up to 10 days on inanimate surfaces, including toys. The organism is primarily spread via contact, through the fecal-oral route. The potential for "aerosol" spread has been speculated, but there is no firm data to support this theory. Although adults can be infected, they are often asymptomatic. However, nosocomial outbreaks have been described in adult populations, with severe consequences in immunodeficient individuals and in the elderly. In these cases, a chronic symptomatic diarrhea with prolonged viral shedding may develop.

Noroviruses are very small viral agents that also cause nausea and vomiting with clustering of cases that affects all age-groups. Norovirus is an extremely hardy organism that can withstand freezing, heating, and many common disinfectants. It is also extremely infectious, with fewer than 100 viral particles considered a high enough "dose" to cause infection in a susceptible host. Like Rotavirus, it is primarily spread from person-to-person in a fecal-oral route, but unlike Rotavirus, the Norovirus has been found in vomitus as well as in feces. "Aerosol" transmission from projectile vomiting has been implicated. Incubation period for Norovirus is very short, from 18 to 48 hours. The duration of illness tends to also be quite short, averaging 2 days, with vomiting as the predominant symptom. Viral shedding is most apparent over the 24 to 48 hours after illness develops. Outbreaks are common, with secondary transmission a prominent feature of outbreaks. Most outbreaks will terminate within 1 to 2 weeks, but efforts must be made to avoid sparking separate outbreaks in confined settings such as hospitals, schools, long-term care homes or cruise ships. Norovirus, transmission has been seen from individuals who have recently been ill, and to limit this, individuals should be kept away from healthcare duties or kept on precautions (in the case of patients) for 48 hours after symptoms have resolved.

Prevention and Treatment of Noro- and Rotavirus infection:

1. **Perform hand hygiene.**

⇒ Studies done with 70-90% alcohol hand gels have shown good efficacy against viruses similar to Norovirus.

⇒ It is very important to wash hands with soap and water if visibly soiled.

⇒ Hand washing prior to eating or preparing food is critical as those lone virus particles remaining on your hands can result in infection!

2. **Do not eat or drink in patient care areas, including nursing stations.**

⇒ As the Christmas season approaches, we see more and more sharing of open food in patient care areas. This is a potential method of transmission, as contaminated food becomes a common vehicle for transporting Norovirus to a large group of people.

⇒ Avoid open containers of food anywhere when multiple hands are in contact (bowls of chips, bowls of nuts, sandwich trays etcetera).

3. **Be sure that all surfaces are well cleaned after someone has vomited or had diarrhea.**

⇒ In hospital, if it is suspect that a Norovirus outbreak is occurring, it is recommended to switch from standard cleaning products to an accelerated Hydrogen Peroxide product, as this is known to be effective against Norovirus. At home, a solution of 1 part bleach to 10 parts water is effective.

4. **Report clusters of illness (respiratory illness or gastroenteritis) to your Infection Control staff and local Public Health Unit.**

⇒ The Infection Control or Public Health staff can help to advise on appropriate measures and determine when it is necessary to escalate to outbreak measures.

5. **Patient Care Areas during an Outbreak:**

⇒ Any patient who develops Norovirus-like symptoms (nausea, vomiting, and diarrhea) should be placed on contact precautions. If there is profuse vomiting, droplet precautions are required. Send specimens for virology (small round virus-query Norwalk) culture and electron microscopy and Microbiology (C+S).

⇒ Staff who experience Norovirus-like symptoms should notify Occupational Health.

⇒ Staff assigned to outbreak units should avoid working on non-outbreak units unless they have been off the outbreak unit for 48 hours and are asymptomatic.

6. **Restrict activity on outbreak units.**

⇒ It is recommended that common gatherings and use of conference rooms be halted during the outbreak.

⇒ Consider limiting visitors to immediate family only.

Continued on Page 7…

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**	Rota virus	Norovirus
Mode of transmission	Primarily Fecal-Oral (i.e. contaminated hands coming in direct contact with the oral cavity or with food that is then ingested). Some suggestion of aerosolized virus transmitted during vomiting. Also transmitted through contaminated food and drink, and contact with contaminated objects.	
Susceptibility	Greatest between 6 and 24 months; by age 3, most people have acquired antibodies.	Susceptibility is widespread. Short term immunity (up to 14 weeks) has been demonstrated.
Incubation period	24-72 hours	24-48 hours (range of 10-50 hours)
Duration of symptoms	4-6 days	1-2 days
Period of communicability	During the acute stage (while symptomatic) and later while virus shedding continues	During acute stage and up to 48 hours after diarrhea stops
Shedding of virus in stool	Normally not detectable after about 8 days; prolonged shedding in immunocompromised patients	Greatest up to 48 hours after symptoms abate, but can be prolonged. Hand hygiene is critical.

References:
Heymann, DL. Control of Communicable Diseases Manual (18th ed.) American Public health Association, Washington 2004.
Mandell GL, Bennett JE, Dolin R. Principles and Practice of Infectious Diseases (6th ed). Elsevier. Philadelphia 2005.
Mayhall, CG. Hospital Epidemiology and Infection Control (3rd ed.) Lippincott Williams and Wilkins. Philadelphia 2004.

"Green Goes Blue" Conference – A Great Time Had By All!!

The "Green Goes Blue" Conference was held September 23-25, 2007 at Blue Mountain Resort in Collingwood, Ontario. The conference was organized and delivered through a partnership between the Canadian Association of Environmental Management and the Regional Infection Control Networks of Ontario.

The goal of the conference was to bring together professionals from infection prevention and control and environmental services to discuss their complementary roles in the control of infections in health care facilities. Infections caused by organisms that can be transmitted through contaminated patient care equipment and environmental surfaces such as vancomycin resistant enterococci (VRE) and *C.difficile* are on the rise in Ontario and controlling them successfully will require cooperation between these two disciplines. Environmental services staff may require education on the actions they can take to control these organisms and infection prevention and control professionals need to understand the constraints and challenges for environmental services staff in order to help develop effective control measures.

The conference was attended by 160 individuals from environmental services, infection prevention and control, and administration from acute care, long-term care, public health, community care and other agencies across Ontario.

Participants were asked to complete an evaluation of the conference. The results showed that the event was an overwhelming success! Delegates reported that their expectations were met, the material provided was practical and the conference venue was outstanding. The networking opportunities were appreciated by delegates and vendors alike. The opportunity to catch up with colleagues as well as to meet professionals in other disciplines, including the Coordinator of their local Regional Infection Control Network was very valuable.

In The News: Infection Control Week 2007!

Homewood Health Centre Reaches New Infection Prevention Heights in October!

The WWICN thanks author Jill Richmond, Infection Prevention and Control Professional at Homewood Health Centre for this contribution!

Homewood Health Centre recently held its first ever Infection Prevention and Control Fair. Staff turnout was excellent with over 100 participants from all disciplines taking part over the two fun-filled, interactive days. The fair was comprised of 5 stations that included donning and doffing Personal Protective Equipment (PPE), hand washing, a short infection control computer game, flu immunization information booth and a respiratory etiquette DVD.

Staff were asked to stop in at their convenience. The fair was opened for four hours each afternoon and for two hours each evening. The nurse educator greeted staff at the door and explained an infection control scorecard. The scorecard included the names of the stations with a space for a "bug" stamp upon completion of the station. Staff could then attend all or a few of the stations depending on their individual time constraints. It took 30 minutes to complete and most staff attended all of the stations. If staff completed 2 or more, they could enter their scorecard in a ballot box upon leaving the fair. Prizes (an MP3 player and a steam iron) were awarded the day after the fair.

The bug stamps were a great hit! Staff enjoyed stamping themselves as well as their cards.

Staff also enjoyed coffee and goodies and were able to pick up a piece of Halloween candy upon submission of their scorecard and evaluation. The food was very popular with the participants!

Jill Herne, Director of Patient Care and Chief Nursing Officer with Ram Kaplan, Chaplain

The first station involved practicing donning and doffing PPE. Staff were given the scenario that they were getting ready to go in and see a patient with a fever, severe coughing and possibly some diarrhea. Staff were given rationale as to what pieces of PPE they would safely wear. A plant mister was used to demonstrate a coughing and sneezing patient and the one metre distancing. Staff were also given shaving cream on their gloves to represent fecal contamination. Staff then had to remove their gloves using proper technique to avoid spreading the shaving cream.

Jill Richmond, Infection Control Practitioner at Homewood and Keith Sopha, Environmental Services

The second station demonstrated the importance of hand hygiene. Staff were given a dollop of 'Glitterbug' potion and asked to rub it in. They then washed their hands as they normally would. Their hands were then examined under an ultraviolet light to show the areas commonly missed. Staff were also shown the surface area of the bathroom to see where the 'Glitterbug' was spread during the washing process. Common areas were the paper towel dispenser, faucets, sink, up the wall and the soap dispenser. While staff completed this process, lots of health teaching on the benefits of hand hygiene was provided.

The other three stations were much quicker and staff could navigate them independently. The computer game was set up on a laptop where staff could sit and follow through by clicking the mouse to determine the right answer. The influenza immunization display board was provided by Occupational Health and consisted of a 5 question quiz. Staff could complete the quiz using the answers found on the display and then enter a separate ballot box for a prize donated by Occupational health. The last station was a 4 minute humorous DVD promoting the merits of respiratory etiquette; "Why Don't We Do it in Our Sleeves?" The DVD was well received and laughter was heard often from that area.

Overall, the fair was a great success. Feedback from participants was excellent and everyone enjoyed this novel approach to essential infection control information.