



# Network News

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## We would love to hear from you!

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## Waterloo Wellington Infection Control Network July/August 2007

### Those Three Little Letters... CIC. Why and How to Get them!

The Certificate of Infection Control and Epidemiology (CIC) is an internationally recognized level of excellence in infection control practice. To earn the designation of CIC, an individual must pass the certification examination administered by the Certification Board of Infection Control and Epidemiology Inc. (CBIC). This certification is valid for five years at which time a recertification is necessary. "CIC" is a legal designation that can only be used by those who have successfully passed the examination.

#### What is the purpose of the CIC?

- To provide standardized measurement of the current basic knowledge required for persons practicing infection control
- To encourage individual growth and promote professionalism
- To formally recognize infection control professionals

#### Who is eligible to write the examination?

Eligibility depends on meeting both the education requirement and the practice requirement.

#### Practice Requirement

Candidates must have practiced infection control for a minimum of two years. Clinical practice of infection control occurs in various settings and its definition includes analysis and interpretation of infection control data, investigation and surveillance of suspected outbreaks of infection, education of individuals about infection risk, prevention and control, development and revision of infection control policies and procedures and consultation on infection risk assessment, prevention and control strategies.

#### Education Requirement

Candidates must have a current license or registration as a medical technologist or clinical laboratory scientist, physician or registered nurse, OR a minimum of a

baccalaureate degree. An educational waiver may be applied for if this is not met but the individual meets the practice requirement.

#### How do I get more information and how do I apply to write the exam?

- Contact your Regional Infection Control Network for information about their CIC study groups, reference materials and study guides.
- Visit [www.cbic.org](http://www.cbic.org) to obtain a Candidate Handbook for details on the exam content and the reference material used to formulate the exam.
- Read two articles from the American Journal of Infection Control:
  - "Infection Control Certification: A Global Priority", AJIC 2007; 35: 141-3.
  - "Certification Board of Infection Control and Epidemiology white paper: The value of certification for infection control professionals", AJIC 2007; 35: 150-156.

Are you interested in joining a study group to assist you in preparing to write the CIC Exam?

The WWICN will be convening another CIC Study Group in September 2007.

For details, please contact Ellen at [eotterbein@cmh.org](mailto:eotterbein@cmh.org) or call 519-624-9781

Please join us for what is sure to be a great learning experience!

## Waterloo Wellington Infection Control Network Activity Update

The following is a summary of the activities of the Network staff at both the local and provincial levels. If you would like further information on these activities, please contact Cathy Egan, Network Coordinator at

[cegan@cmh.org](mailto:cegan@cmh.org)

- Waterloo Wellington Infection Control Network Strategic Planning Day:** June 7, 2007 was a day full of exciting ideas and planning for the future of the Network. Attendees represented a variety of health care organizations from across the continuum of care in our area as well as from our neighbouring RICNs. Their participation is greatly appreciated and we look forward to continued opportunity for development of relationships with our community partners in the future. The Strategic Plan will be disseminated very soon!

*Please enjoy these photographs taken at the Strategic Planning Session on June 7, 2007.*

- Consultations:** In May, a majority of inquiries to the WWICN were about antibiotic resistant organisms (AROs). There were also equal numbers of inquiries regarding the CIC, cleaning, disinfection and sterilization and requests for resources. In June, again the highest number of inquiries were regarding AROs, with cleaning, disinfection and sterilization, requests for resources and hand hygiene information making up a large component of other inquiries.

- ARO Working Group:** The group has finalized its work plan and, using a generic policy template, has ambitiously started drafting standardized policies based on best practices. The group will be focusing on ARO policies that apply to health care settings across the continuum of care.

- CIC Study Group:** The fall is quickly approaching and we look forward to the formation of another CIC study group! If you have thought about writing the exam, your chance to meet and network with others like yourself is coming! Contact Ellen at [eotterbein@cmh.org](mailto:eotterbein@cmh.org) if you would like to be involved!

- Infection Control Week:** October 14<sup>th</sup> through 20<sup>th</sup>, 2007 is Infection Prevention and Control Week! The WWICN is developing provincial materials to celebrate Infection Prevention and Control Week 2007. The theme of this year's week is "Infection Prevention and Control – Practice and Participate". We look forward to working with our partner organizations to mark this week long annual event.



## Looking Ahead: Education Opportunities

### Webber Training Teleclasses

Teleclass Topics in July/August Include:

- CDC Guideline Review – Disinfection & Sterilization
- Outcome Surveillance and Process Surveillance – Tools to Minimize Nosocomial Infection
- ESBLs – Where Are We Now?
- To participate in these teleclasses, contact Ellen at [eotterbein@cmh.org](mailto:eotterbein@cmh.org)

### Canadian Association of Environmental Management Green Goes Blue!

- September 23 - 25, 2007
- Blue Mountain Resort
- For more information visit [www.caha1972.ca](http://www.caha1972.ca)

### Infection Connection Practice and Participate!

- September 26, 2007
- Fergus, Ontario
- Contact Mark Jefferson at [mark.jefferson@wdghu.org](mailto:mark.jefferson@wdghu.org) for more information

### CHICA Northwestern Ontario 007 Live to Die Another Day

- September 27 - 28, 2007
- Airline Travelodge Hotel, Thunder Bay, Ontario
- Contact Brandy Ponka at [ponkab@tbh.net](mailto:ponkab@tbh.net) for more information

### Region of Waterloo Public Health Infection Control Forum

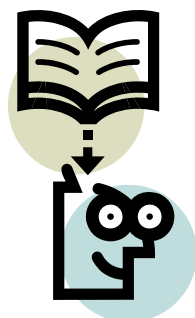
- October 23, 2007, 9:00am – 4:00pm
- 99 Regina St., Waterloo, Room 508
- Contact Brenda Miller at [mbrenda@region.waterloo.on.ca](mailto:mbrenda@region.waterloo.on.ca) for more information

### Algoma District Infection Control Conference You Have a HAND in Infection Control

- November 1 – 2, 2007
- Algoma's Water Tower Inn
- For more information, forward your contact information to [continuingeducation@saultcollege.ca](mailto:continuingeducation@saultcollege.ca)

The great aim of education is not knowledge but action.

-Herbert Spencer



## APIC Webinars – A Free, On-Demand Learning Tool! Try It Out!

“Webinar” is short for web-based seminar. Webinars are like seminars, the difference is that the Webinars take place over the internet. The idea is similar to that of teleclasses but no phone is required. Once participants download the Webinar they want to view, they are able to view the presentation slides and hear the presentation audio recording via the computer.

Throughout 2006 and 2007, APIC is proudly sponsoring an ongoing series of Webinars. All of these APIC Webinars are free, hosted by WebEx, and are sponsored by unrestricted educational grants from APIC industry partners. Access to the internet is required to view these valuable Webinars.

APIC Webinars are available as recorded events 24 hours after the live webinar has taken place.

To Get Involved:

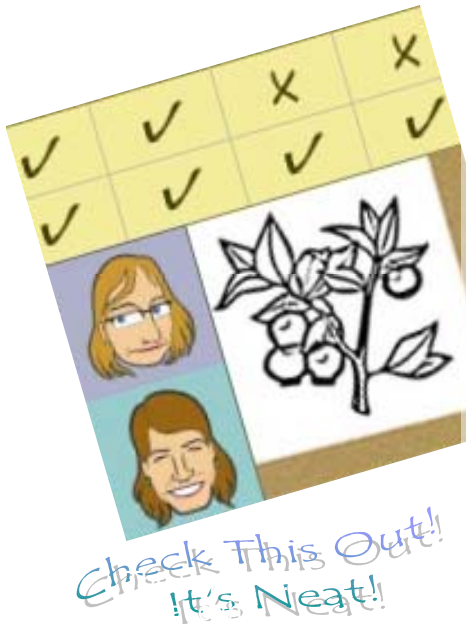
- Visit [www.apic.org](http://www.apic.org)
- Click on the ‘Education’ Heading on the left side of the screen.
- Then, click on ‘Webinars’ which will allow you to either ‘Enroll in a Live Webinar’, or ‘Enroll in a Recorded Webinar’.
- If you want to view a previously recorded webinar, click on ‘Enroll in a Recorded Webinar’, simply click on the first step (it’s a blue colour) and follow the rest of the instructions.
- The presentation slides can be also accessed for printing from [www.apic.org](http://www.apic.org), in the education section, under webinars (follow the steps above). Directly below the ‘Enroll in a Recorded Webinar’ section, you will see a section entitled ‘Slides From Previous Webinars’. Find the webinar you are interested in, click on the blue title and the slides will appear on your screen.

Previously Recorded Webinars that may interest you include:

- 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

Website of the Month: PBS Nova “Disease Detective” Interactive Module

<http://www.pbs.org/wgbh/nova/typhoid/detective.html>



“You are a budding epidemiologist who has been called to a popular national park in the American Southwest to investigate a disease outbreak. Six out of eight people camping in the same area have fallen ill with a serious ailment of unknown origin. Local and state public health officials want you to trace the outbreak to its source so their agencies can implement control measures.” This is the briefing you receive when you arrive to the website. With your trusty virtual note book in hand, you set out to discover what is making the people sick by identifying possible causes and then eliminating them based on the statements of the eight individuals involved.

If you have never had the opportunity to lead an outbreak investigation before, this is your chance to see what it's like. This amazing interactive module allows the user to apply the basic methods of field epidemiology to solve this medical mystery and in so doing, gain a better understanding of theory applied to a realistic situation. This module is a super learning tool for individuals who learn best by doing and having fun. The module is geared toward younger people but rest assured – those young at heart will enjoy this experience as much as anyone!

Infection Control in History: The Lessons Learned from ‘Typhoid Mary’

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



Above: Mary Mallon, AKA Typhoid Mary as a young immigrant woman

At the age of 15 in the year 1884, Mary Mallon immigrated to the United States in search of a bright future. She was employed as a domestic servant, working for various wealthy families in the New York area and discovered that she had a talent for cooking. She was dismayed in 1907, when a civil engineer named George Soper approached her and accused her of spreading typhoid fever through the food she cooked, causing many to become ill and a few to die. Mary felt and looked healthy and could not conceive that she was in any way responsible for the illnesses contracted by those who employed her. Against her will, Mary was detained at a hospital on North Brother Island in New York, from

1907 until 1910. She was released only after authorities felt she had been taught ‘proper hygiene’ and she was ordered never to work in the food industry again. In 1915, authorities were investigating an outbreak of typhoid fever at a hospital in New York when they discovered Mary had taken a job as a cook there under a false name. Mary was again taken and held in the same hospital, although this time she was not released. Mary lived there until her death in 1938, after suffering a severe stroke.

Mary remained in isolation much of her life, despite her healthy outward appearance and lack of symptoms.



Above: An article propagating public fear and anger towards ‘Typhoid Mary’, as she came to be known.



It is not clear how much of an effort was made to educate Mary regarding the rationale behind the order to refrain from cooking for others and then, her indefinite detainment. Many people felt that Mary’s refusal to follow the order issued by authorities indicated her malicious intent to cause harm to others.

There have been a number of instances since the days of Typhoid Mary that have required public health officials to take extreme measures in order to protect the health of the public. Examples of these instances include SARS, the recent XDR TB airplane exposure, and situations in which a person with a communicable disease works in a setting where spread may readily occur.

## Ask the Expert:

I have a patient with *C. difficile* associated diarrhea (CDAD). I want to discontinue isolation. When should I send repeat stool specimens for testing?



*Clostridium difficile* is the most common cause of hospital-associated diarrhea. It is a gram-positive spore forming bacterium that is ubiquitous in the environment, especially in soil. It is found as a normal colonizer in the bowel flora of up to 5% of healthy adults. It is also frequently found in hospitals and long term care facilities. *C. difficile* spores are very hardy and can survive in the environment for many months. As *C. difficile* is so difficult to eradicate from the environment, strict contact precautions need to be enforced for anyone with the disease.

*C. difficile* is intrinsically resistant to many antibiotics. If the bacterial population of the gut is disrupted, for example by the use of antibiotics,

then the *C. difficile* bacteria may increase in numbers. When *C. difficile* proliferates, toxins are produced that result in the fever, increased white cell count and diarrhea that we see in our symptomatic patients. When a stool specimen is sent to the laboratory for testing, we are testing for the presence of toxins as this is what is associated with disease.

Treatment consists of stopping any unnecessary antibiotics, fluid and electrolyte replacement and the use of specific anti-clostridial antibiotics. The recommended first line treatment is metronidazole for a minimum of 10 days. I usually treat for at least 14 days.

Symptoms should begin to resolve by the fourth or fifth day of treatment. Even with resolution of symptoms it is very important to finish the full course of treatment in order to prevent any *C. difficile* bacteria remaining following the first few days of treatment from causing renewed symptoms. When a patient has had at least 48 hours without diarrhea, contact isolation can be discontinued.

You do not need to send repeat stool specimens. Up to 50% of patients will continue to have positive stool assays for as long as 6 weeks after they have completed their course of treatment. Infection control precautions need to be enforced for at least 48 hours after the diarrhea resolves and, as mentioned, the full course of metronidazole needs to be completed. There is no role for repeat testing of stool in this situation.



The Expert is Dr. Martha Fulford, Medical Coordinator of the Waterloo Wellington Infection Control Network

Scanning Electron Micrograph of *Clostridium difficile*



## Resource Profile: No Germs Allowed – How to Avoid Infectious Diseases at Home and On the Road

*Food for Thought from 'No Germs Allowed'... Infection is everywhere. We live in continual contact with microorganisms in our environment and carry billions of bacteria and viruses within us always. Most of us are usually protected from becoming ill in this environment by an intact immune system. However, if we allow ourselves to contact a particularly virulent microorganism that is adept at evading our defenses, or if our immune system becomes impaired, an infectious disease can develop. In most cases, the infection is preventable.*

It's the time of year when we kick off our shoes, pour ourselves a tall glass of ice cold lemonade and enjoy the activities of the hot summer season. We may innocently picnic at the beach or turn the BBQ on for burgers and dogs, potentially risking food poisoning that will cause our summer vacation to take an ugly turn! Infection Control Professionals take holidays, but infectious diseases don't!

In the book 'No Germs Allowed', author Winkler Weinberg shares practical tips and expert advice on how to survive (and maybe even enjoy) daily life while preventing and avoiding as much infection-related suffering as possible. Topics covered consist of infections of daily living, which includes the common cold, strep throat and other strep infections, infections of the urinary tract and integumentary systems, as well as infections you get from your environment, specifically Lyme disease and other tick borne diseases, food poisoning, the health hazards of travel, pneumonia and Legionnaire's disease. Infections you get from others, like tuberculosis, sexually transmitted diseases, hepatitis, and HIV infection and AIDS are covered and Weinberg discusses how people in special situations with unique risk factors for acquiring infection, like having HIV, being pregnant, or being a patient in a hospital can protect themselves from infection. The final chapter of the book is an exploration of infections emerging in the 21<sup>st</sup> century as well as a brief look at bioterrorism. This book is truly a one-stop-shop for the need to know infection prevention and control information that will help you and your family to stay healthy and infection-free!



Please contact us if you would like to borrow this book!

## VRE Transmission in Long Term Care... What is the Risk?

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). Despite the fact that they are part of the normal flora and non-harmful to many people, enterococci are able to subsist independently in the environment for very long periods of time. They are able to share their genes for antibiotic resistance with other microscopic organisms (Crossley, 1998), and they 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, non-existent.

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 the hospital to the home and then back again on their next visit (Cetinkaya, et. al., 2000). Residents who visit the hospital regularly may become colonized with VRE (Armstrong-Evans, et. al., 1999). In order to prevent the spread of VRE to other residents in the long term care setting, the resident known to have VRE need only be cared for by knowledgeable, competent 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 found to be uncommon.
- Crossley (1998) reported during his study of VRE in a long term care setting 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, et. al., 2000).
- Authors Brennan, Wagener, and Muder (1998) showed that the majority of VRE colonized residents became colonized prior to their arrival to the long term care environment and noted that 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 unless there is an outbreak (Bradley, 1999).

When it comes to caring for residents in long term care settings, the research indicates that VRE transmission can be prevented by implementing basic practices as 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).

- 1.Greenaway, C.A., 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, M.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, M.A., Willey, B., Cann, D., Liska, S., Nusinowitz, 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., Alvez, 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.

## In The News: *Hot Off the Press!*

### Public Health Agency Proclaimed under the Health Systems

The Government of Ontario recently passed legislation called the [Health System Improvements Act, 2007](#), a component of Bill 171. This Act includes the establishment of the Ontario Agency for Health Protection and Promotion (Schedule K).

The Ontario Agency for Health Protection and Promotion will be established as a centre for public health excellence that will provide research, scientific and technical advice and support to the government, public health units and health care providers. Following SARS, several high profile reports recommended the creation of an agency in Ontario to provide expertise and support for the public health system. The recommended agency would help to strengthen the provincial response to health emergencies and localized outbreaks, giving timely scientific and technical advice to front-line health care workers.

The so-called 'CDC of the North' was conceptualized as an information hub of specialized expertise in areas such as infectious disease, infection prevention and control, health promotion, chronic diseases and injury prevention, and environmental health, all in the name of protecting the health of Ontarians.

The purpose of the Agency is to ensure that sound, scientific health knowledge and information about risk to health is being captured, coordinated and directed to where it is most needed and will bring together experts from academic, clinical, and governmental fields to create the foundation for excellence in public health in Ontario.

Under the direction of Ontario's Chief Medical Officer of Health and at arms-length from the Ministry of Health and Long Term Care, the Agency will provide support in responding to health related emergencies such as SARS. The Agency will also provide technical and scientific assistance, rapid on-site field support on an as-needed basis, specialized communications and training, as well as providing input on the development of standards and practical tools from implementing best practices. Another core function of this Agency will be to provide laboratory services to health care settings in the province.

For more information on this Act and Bill 171, please visit the following link:

[http://www.ontla.on.ca/web/bills/bills\\_detail.do?locale=en&BillID=519](http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=519)

### CDC Releases Updated Isolation Guidelines

In June 2007, the CDC released the long awaited document "[Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007](#)".

These updated guidelines address the changes that have been reshaping health care since the release of the 1996 'Guideline for Isolation Precautions in Hospitals'. The updated guidelines include recommendations on:

- The provision of health care in non-traditional settings such as home, ambulatory, and long term care settings
- The emergence of new pathogens and renewed concern for evolving known pathogens
- The increase in health care associated infections caused by multi-drug resistant organisms
- Environmental controls to decrease the risk of life-threatening fungal infections in severely immunocompromised clients
- Organizational characteristics that influence health care worker compliance with recommended practices to prevent and control the spread of infection
- Continued use of 'Standard Precautions' as an effective means of preventing transmission of infection, the American equivalent to the Canadian 'Routine Practices' and expansion of these precautions to include Respiratory Etiquette and safe injection practices as supported by a strong body of evidence.

Though these guidelines are tailored to American health care settings, you may find them useful in addressing questions and concerns related to the application of Routine Practices in your daily practice.

To access this document, please click on this link:  
<http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf>

#### Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007

Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marquella Jackson, PhD; Linda Colwell, RN MS; the Healthcare Infection Control Practices Advisory Committee

Acknowledgment: The authors and HICPAC gratefully acknowledge Dr Larry Braubach for his many contributions and value guidance in the preparation of this guideline.

Suggested citation: Siegel JD, Rhinehart E, Jackson M, Chappell L, and the Healthcare Infection Control Practices Advisory Committee. 2007. Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. June 2007.



## In the News: 2007/2008 Seasonal Influenza Vaccine Planning Underway

The National Advisory Committee on Immunization (NACI) provides the Public Health Agency of Canada with ongoing medical, scientific, and public health advice relating to immunization.

The NACI recently published their recommendations for the composition of the vaccine against influenza virus for the upcoming season, November 2007 through April 2008.

The 2007/2008 vaccine should provide immunity to the following strains:

- A/Solomon Islands/3/2006 (H1N1) – like virus;
- A/Wisconsin/67/2005 (H3N2) – like virus;
- A B/Malaysia/2506/2004 – like virus

The NACI considers multiple sources of information when making its recommendations, including the World Health Organization (WHO) internationally, and the Centers for Disease Control (CDC) in the U.S. These recommendations are used by pharmaceutical manufacturers to update the composition of the vaccine, so that vaccine strains are matched as much as possible to strains of influenza that are expected to be circulating the following year.

Influenza activity over the 2006/07 season was mild and increased across Canada from late January to early March. The level of flu activity across the country remained mild to moderate overall.

National Advisory Committee on Immunization (July 2007). Statement on influenza vaccination for the 2007-2008 season. *Canada Communicable Disease Report*. 33(Advisory Committee Statement 7).

Available at: <http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/07pdf/acs33-07.pdf>

## In the News: Alcohol Based Hand Rub – Is It a Fire Hazard?

It is common knowledge today that hand hygiene is the single most significant factor in preventing the transmission of infection. Study after study has shown, however, that despite being the best way to prevent infections, compliance with hand hygiene is deplorably low in a majority of health care settings. A number of studies have also revealed that alcohol based hand rubs (ABHRs) with an alcohol concentration between 60-90% are actually more effective at killing microbes on your hands than traditional hand washing with soap and water are at removing microbial load on your hands, when the ABHR is applied to hands that are not visibly soiled.

But what is the risk of flash fire when using ABHRs?

Since the alcohols contained in ABHRs are flammable, the risk of fire exists. In parts of Europe where many health care organizations have been using ABHR for decades, there have been very few documented incidents of fire related to the use of ABHR. One recently published study of ABHR use in German hospitals showed that over 25,038 hospital years, there were a total of seven fires related to the use of ABHRs. Each of these incidents resulted from a human action, not from technical or product failure (Kramer & Kampf, 2007). There has also been one report of a flash fire in the U.S. that occurred when a health care worker applied ABHR to her hands and touched a piece of equipment that generated an electrostatic shock, igniting the wet ABHR on her hands and causing the

worker to sustain minor burns.

These incidents, though concerning, happen very infrequently. Data from multiple studies suggest that the risk of fire related to the use of ABHR is substantially lower than the risk of acquisition of an antibiotic resistant organism followed by infection.

The fire risk can be mitigated through user education regarding the proper application of ABHRs, including the risk to health if used incorrectly.

Experts also recommend labeling the product to warn people of the potential danger and advise regular cleaning and proper maintenance of product dispensers as means to minimize risk. Children who use ABHR must be carefully supervised and assisted to ensure safety and product effectiveness.



Kramer, A., Kampf, G. (June 2007). Hand rub – associated fire incidents during 25,038 hospital-years in Germany. *Infection Control and Hospital Epidemiology*. 28(6).

## Call for WWICN Steering Committee Member

The Waterloo Wellington Infection Control Network (WWICN) is seeking a representative from community healthcare to participate on the WWICN Steering Committee.

The mandate of the WWICN Steering Committee is to maximize coordination and integration of activities related to the prevention, surveillance and control of infectious diseases across the health care sectors for all health care providers.

The Network Steering Committee membership is comprised of representatives from acute care, long term care, public health and laboratory. Members of the committee represent an area of expertise or discipline and not a specific facility or organization with a fair cross representation from all sectors within the region.

The term of membership is two or three years with option to renew. The steering committee currently meets monthly on Friday mornings (except over the summer) and at call of chair if required. Meetings are held in various locations across the Waterloo Wellington area. Travel expenses are covered according to our travel policy.

If you are interested, please contact the WWICN office for more details on how to apply.

**Waterloo Wellington Infection Control Network**