In.CONTROL

NSW Infection Control Resource Centre

The Newsletter of the NSW Infection Control Resource Centre
An initiative of the NSW Health Department

Volume 10, Issue 2, July, 2006

New Infection Control Home Page

In demonstrating its commitment to Infection Control, the NSW Health Department has developed and implemented many initiatives in the last decade. The latest initiative is the launch of the Infection Control Home Page on the NSW Health Department's web site www.health.nsw.gov.au which contains a plethora of information, resources and links.

To access the Infection Control Home Page simply click on the 'Quick Links section - Infection Control' on the right-hand side of the NSW Health Home Page. Health Professionals and Consumer links have been developed to provide appropriate information for each group. Click on 'Health Professionals' to access the information and resources for infection control professionals. There you will see information on pandemic flu planning, the latest infection control and quality monitoring manual, healthcare associated infections definitions, and frequently asked questions and answers. You can also access the NSW Health Department Infection Control Program Quality Monitoring Indicators results from these pages.

On the 'Related Links' you will have direct access to the latest Infection Control Policy Directives, Information Bulletins and the Infection Control Regulations for Nurses and Midwives, Medical Practice, Dentists, Dental Technicians, Physiotherapists and Podiatrists. The page also contains documents for Infection Control Program Quality Monitoring, Infection Control Reportable Incidents and Emerging Infection control issues such as SARS. On the Pandemic Flu Planning and the Pandemic Influenza pages, you will find many useful and interesting resources, fact sheets and links. The latest link added is to the 'Clean Hands Save Lives' hand hygiene campaign.

I would encourage all infection control professionals to explore the site. The Infection Control Home Page is a work in progress and further documents, information and links will be added to the site in the near future or as they become available. The next stage on the website will include links specifically for sterilization. NSW Health should be congratulated on this very helpful initiative that is very much a 'one-stop-shop' for those working in infection prevention and control.

Infection Control: The Australian Management Plan for Pandemic Influenza

The Australian Government Department of Health and Ageing released *Annex 6: Infection Control - the Australian Management Plan for Pandemic Influenza* in early June. The document can be accessed at www.health.gov.au/internet/wcms/publishing.nsf/Content/phd-pandemic-plan-5e.htm

This is a 'living document' in that updates and changes will be made as new information and strategies come to hand. For those working in the Public Health sector, any comments or suggested changes to the document are welcome and should be sent to your Area Infection Control Consultant who will forward onto the NSW representative on the Pandemic Influenza Infection Control Subcommittee.

Philip Melling
Editor

In this issue:

NSW DEPARTMENT OF HEALTH: POLICY DIRECTIVES & GUIDELINES (and other related documents)

The following are the latest Policy Directives and Guidelines from June 2004 relating to Infection Control issues that have been released by the NSW Department of Health

PD2005_572 BLOOD ALCOHOL AND DRUG TEST KITS – MODIFICATION OF

PD2005_579 TUBERCULOSIS RELATED SERVICES – CHARGING FOR
(supercedes PD2005_142 [Changing Inpatient/Outpatient services for Medicare Ineligible with suspected/Confirmed Tuberculosis 99/6])

PD2005_580 TUBERCULIN SKIN TESTING (NEW IN 2005)
(supercedes PD2005_070 [Mantoux Test 94/90])

PD2005_581 TUBERCULOSIS CONTACT TRACING (NEW IN 2005)
(supercedes PD2005_212 [2001/76])

PD2005_596 TUBERCULOSIS – INFECTION CONTROL
(supercedes Circular 94/87)

PD2005_604 INCIDENT MANAGEMENT POLICY
(supercedes PD2005_337 [2003/88])

PD2005_608 PATIENT SAFETY AND CLINICAL QUALITY PROGRAM

PD2005_629 OZONE GENERATORS USED FOR THE PURPOSE OF INDOOR AIR CLEANING

PD 2005_634 REPORTABLE INCIDENT DEFINITION UNDER SECTION 20L OF THE HEALTH ADMINISTRATION ACT

PD2006_005 HUMAN IMMUNODEFICIENCY VIRUS (HIV) MANAGEMENT OF NON-OCCUPATIONAL EXPOSURE

GL2006_002 COMPLAINT OR CONCERN ABOUT A CLINICIAN – MANAGEMENT GUIDELINES
(replaces PD2005_610 Complaint or Concern About a Clinician – Management)

PD2006_007 COMPLAINT OR CONCERN ABOUT A CLINICIAN _ PRINCIPLES FOR ACTION
(replaces PD2005_610 Complaint or Concern About a Clinician – Management)

PD2006_014 NOTIFICATION OF INFECTIOUS DISEASES UNDER THE PUBLIC HEALTH ACT 1991
(Supercedes Notification of Infectious Diseases under the Public Health Act 1991 [PD2005_359])

PD2006_030 INCIDENT MANAGEMENT POLICY
(replaces Incident Management Policy [PD2005_604], Incident Information System (IIMS) Policy NSW [PD2005_404])

PD2006_035 HIV ANTIBODY TESTING BY LABORATORIES IN NSW
(replaces HIV Antibody testing by laboratories in NSW [PD2005_194]

PD2006_037 NEEDLE AND SYRINGE PROGRAM POLICY AND GUIDELINES FOR NSW

Copies of NSW Department of Policy Directives and Guidelines can be obtained from the NSW Health web site:
www.health.nsw.gov.au

ALERT

Please note that NSW Health has introduced a new system for policies, guidelines and information bulletins. All Circulars have been given a new document number. However, it is still possible to retrieve documents by entering their old Circular number in the search box on the NSW Health Web site.

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NSW DEPARTMENT OF HEALTH: NEW POLICY DIRECTIVES & GUIDELINES

The NSW Department of Health in recent months issued the following Policy Directives and Guidelines that may be of interest to infection control professionals.

PD2006_030 Incident Management Policy
The policy advises staff on how to respond effectively to all clinical and corporate incidents that occur in the health system. This revised Incident Management Policy strengthens the corporate incident management component of the policy and the requirements for submission of a Reportable Incident Brief (RIB). The requirement for open disclosure is also included in the policy. It contains important legal aspects of health care incident management, the requirements for a privileged Root Cause Analysis (RCA) and extension of the timeframe for submission of an RCA to the Department of Health within 70 days.

PD2006_035 HIV Antibody Testing by Laboratories in NSW
This document states current policy on testing for HIV including the changes arising from the Medical Benefits Schedule listing of HIV antibody testing in November 2005. Issues covered include the principles for HIV testing, the HIV testing classification, authorization of laboratories to perform standard testing, reference testing, the role of medical practitioners and registered nurses, confidentiality and payment.

PD 2006_37 Needle and syringe Program Policy and Guidelines for NSW

Policy and guidelines for the operation of Needle and Syringe Programs in NSW. This replaces the NSW Needle and Syringe Exchange Policy and Procedures Manual, May 1994.

MEDIA WATCH AUSTRALIA

March 2006
Early in March the NSW Health Minister, John Hatzistergos, issued a health alert to Hunter New England residents about **Ross River Fever** following a sudden increase in the number of people reported with the **Ross River Virus**, which is spread by mosquitoes. More than 25 cases had been reported in the northern part of the Hunter New England area, especially in the Moree and Narrabri shires. Mr Hatzistergos urged people to take all measures possible to protect themselves against mosquito borne disease by reducing the chance of being bitten. Effective insect repellants and clothing that covered skin, especially during the hours around dusk and dawn, were advised. Cleaning gutters, ensuring insect screens on windows are in good condition, keeping pools chlorinated, salted or empty, and the removal of any containers of water that allow mosquitoes to breed were also recommended. **Ross River Fever** is caused by a virus and spread by certain types of mosquitoes. The infection is not spread from person to person. Only about 10% of cases of **Ross River Fever** actually get reported. When people are infected many do not get any symptoms but some have an influenza-like illness with a fever, chills, headache, and aches and pains in the muscles and joints. However, most people make a full recovery within a few weeks. One of the main concerns is that a small number of people with **Ross River Fever** go on to have an illness that lasts months or even years. There is no specific treatment for **Ross River Fever** but doctors can advise on medications that will help ease the discomfort of the symptoms.

Six cases of **Legionnaires Disease** were confirmed in the northern Sydney region in March. Public health experts investigated and tested over 70 cooling towers in the Chatswood CBD but no source was identified. GPs and hospital emergency departments were put on alert by NSW Health to look for symptoms of the disease. Symptoms of **Legionnaires Disease** include fever, chills, cough that may be dry or produce sputum, headache, tiredness, loss of appetite and diarrhea. The time from exposure to onset of symptoms is typically around two to ten days.

People who suspect they may have **flu** are being urged to wear surgical-type masks this winter, as NSW Health

officials try to build the public's familiarity with infection control measures that may be needed in the event of a bird **flu** pandemic. The Health Department's Director of Communicable Disease, Dr Jeremy McAnulty, said those who went to a GP or emergency department because they thought they might have **flu** should consider wearing a mask. **Flu** spreads through water droplets from coughs and sneezes that could typically travel one metre. Dr McAnulty said, "masks catch the droplets… we are advocating it for people who have got the **flu** when they are visiting a doctor, who may be in a crowded waiting room with other people who are already sick. In some Asian cities mask use was so routine "that people look at you askance if you have a respiratory illness and you don't have a mask." In the *Sydney Morning Herald*, a public health specialist, Professor Ron Penny, said people with coughs and fever should wear masks on public transport and in crowded places. Professor Penny said advocating masks now was similar to promoting condom use in the late 1980s to prevent **HIV/AIDS**. People with **flu** needed to be aware that it could kill children, elderly or sick people and take responsibility for avoiding its spread. "It's not a big ask."

In late March a new campaign designed to improve hand hygiene and reduce health care associated infections in NSW was launched. The *Clean Hands Save Lives* hand hygiene campaign is a partnership between the NSW Department of Health and the Clinical Excellence Commission. Microbes can be readily transmitted on health care workers' hands and hand hygiene substantially reduces this transmission. Hand decontamination has been shown to prevent the spread of infectious agents in clinical settings for over 150 years. Professor Cliff Hughes, CEO of the Clinical Excellence Commission, said "we know that staff are aware they should clean their hands, but there are many barriers to it happening in practice. Nurses in intensive care, for example, may be required to wash their hands 40 times in any one hour." Evidence from international studies show that by providing alcohol-based hand rubs in patient care areas and raising awareness generally can make a real impact for patients benefit.

April

In April NSW Health released new data showing a number of disease outbreaks on international cruise ships over the last decade. Recent research from South Eastern Sydney and Illawarra Area Health Service Public Health Unit found that in the last seven years, 24 outbreaks occurred on ships that docked in Sydney. These outbreaks affected 2,300 travelers and involved infectious diseases such as **typhoid fever, norovirus gastroenteritis** and **respiratory** infections. NSW public health experts have a comprehensive and successful disease surveillance program, combined with an effective inspection program, to target cruise ships entering Sydney's ports. These are undertaken with the voluntary corporation of the cruise ship industry. Effective quarantine and health care measures can then be planned to contain further spread of disease from infected individuals returning home. NSW has been approached to train officers from other state health authorities in vessel inspection.

May

In the first week of May NSW Health issued an alert to the community amid rising concerns of a **measles** epidemic. The statewide total for March and April was 38 cases of **measles**, compared to just three cases during the same period last year. Dr Vicky Sheppeard, NSW Health Medical Epidemiologist, said this number of cases was far outside the norm and repeated advice for the community to be on the outlook for the signs and symptoms of the disease and ensure their vaccinations are up to date. "I urge people to check their vaccination records. Children and adults under 40 who have not had two shots of **measles** vaccine should see their general practitioner now to be vaccinated," she said. According to Dr Sheppeard, the fact that NSW had not seen an outbreak of **measles** in many years may be part of the cause of the dramatic rise in the number of **measles** cases because people had not developed immunity to the illness. In addition, only 85% of children in NSW have been fully immunized despite two vaccinations being recommended for all children by age four. Babies less than 12 months of age are at particular risk because they are usually not immunized until one year of age. Symptoms of **measles** include fever, tiredness, runny nose, cough and sore eyes and usually begin around 10 days after contact with an infected person. A red blotchy rash then follows and appears three to four days after initial symptoms. The rash starts on the face and then spreads over the body and will last four to seven days. Dr Sheppeard advised that if people believe they may have **measles** they should visit their GP as soon as possible. "We particularly ask that people ring ahead to say that they could have **measles** and ask not to be seated in the waiting room, so as to avoid spreading the disease to others," she said.

MEDIA WATCH

WORLD

Avian Influenza

Internationally, **avian influenza** was the dominant topic in the media during the first half of 2006. In January **avian influenza** spread in wild birds across eastern Europe and Africa infecting humans who worked or lived in close proximity with birds. By early February the H5N1 **bird flu** virus had been detected in wild birds in Western Europe in Italy Greece and Bulgaria. Three more countries, Germany, Austria and Iran, reported cases of **bird flu** in wild swans by the middle of the month and were soon followed by France, Slovakia and Scotland. Strict measures regarding bird farms, transport and handling of birds were implemented and there were cases of human infection in most of these countries.

At the time of this newsletter going to print, Australia, Canada and the United States had so far escaped the spread

of the H5N1 strain of **avian flu**. The main cause of spread appears to be through migrating birds. However, in March the World Organization for Animal Health warned that Australia, Canada and the United States stand a "very high" risk of **avian flu** reaching their shores.
Closer to Australian shores, Indonesia has witnessed more **bird flu** deaths in humans than any other country this year. After Vietnam it has the second highest number of fatalities reported in the world since 2003. Most cases have been in the capital Jakarta and its surroundings, where many people live in close proximity to poultry despite the urban environment, but infected birds have been found in 26 of Indonesia's 33 provinces.

In late May World Health Organization (WHO) officials confirmed one of the world's largest clusters of H5N1 human deaths ever – at least five in one family living on the island of Sumatra, Indonesia. The multiple infections initially raised fears the virus had mutated to a form that could pass more easily from human to human, a scenario that would increase the chances of a global pandemic.

Indonesian health authorities and WHO strengthened their response to the family cluster of cases in Kubu Simbelang village, Karo District, North Sumatra. At the time of going to press, 54 surviving family members and other close contacts of cases had been identified and placed under voluntary home quarantine. All of these people, with the exception of pregnant women and infants, received the antiviral drug, oseltamivir, for prophylactic purposes. Public health teams visited these people daily, checking for symptoms.

In addition, active house-to-house surveillance for influenza-like illness was conducted throughout the village, which has around 400 households. A command post for fever surveillance was also functioning in the village.

By early June the virus has not spread beyond the members of this single extended family. No hospital staff involved in the care of patients have developed the disease even though in some instances care was provided without adequate personal protective equipment The last person in the cluster, who developed symptoms on 15 May and died on 22 May, refused hospitalization. He moved between two villages while ill, accompanied by his wife. His wife was under surveillance and has not developed symptoms.

Despite multiple opportunities for the virus to spread to other family members, health care workers or into the general community, it has not, on present evidence, done so.

Based on an assessment of present evidence, WHO concluded that the current level of pandemic alert is appropriate and does not need to change. The level of pandemic alert in early June remained at phase 3. This phase pertains to a situation in which occasional human infections with a novel **influenza** virus are occurring, but there is no evidence that the virus is spreading in an efficient and sustained manner from one person to another.

Cumulative Number of Confirmed Human Cases of Avian Influenza A/(H5N1) Reported to WHO

23 May 2006

Country	2003		2004		2005		2006		Total	
	cases	deaths	cases	deaths	cases	deaths	cases	deaths	cases	deaths
Azerbaijan	0	0	0	0	0	0	8	5	8	5
Cambodia	0	0	0	0	4	4	2	2	6	6
China	0	0	0	0	8	5	10	7	18	12
Djibouti	0	0	0	0	0	0	1	0	1	0
Egypt	0	0	0	0	0	0	14	6	14	6
Indonesia	0	0	0	0	17	11	25	22	42	33
Iraq	0	0	0	0	0	0	2	2	2	2
Thailand	0	0	17	12	5	2	0	0	22	14
Turkey	0	0	0	0	0	0	12	4	12	4
Viet Nam	3	3	29	20	61	19	0	0	93	42
Total	3	3	46	32	95	41	74	48	218	124

Total number of cases includes number of deaths.
WHO reports only laboratory-confirmed cases.

CURRENT PHASE OF ALERT IN THE WHO GLOBAL INFLUENZA PREPAREDNESS PLAN

Experts at WHO and elsewhere believe that the world is now closer to another influenza pandemic than at any time since 1968, when the last of the twentieth century's three pandemics occurred. WHO uses a series of six phases of pandemic alert as a system for informing the world of the seriousness of the threat and of the need to launch progressively more intense preparedness activities.

The designation of phases, including decisions on when to move from one phase to another, is made by the Director-General of WHO.

Each phase of alert coincides with a series of recommended activities to be undertaken by WHO, the international community, governments, and industry. Changes from one phase to another are triggered by several factors, which include the epidemiological behaviour of the disease and the characteristics of circulating viruses.

The world is presently in phase 3: a new influenza virus subtype is causing disease in humans, but is not yet spreading efficiently and sustainably among humans.

For more information on the phases of pandemic alert visit the WHO website:
www.who.int/csr/disease/avian_influenza/en/

INFECTION CONTROL CONFERENCES

29th ANNUAL CONFERENCE OF THE INFECTION CONTROL ASSOCIATION, NSW INC
"Coughs and harboring colds – what's come through the door"
27-28 July, 2006
Ex-service's Club, Coffs Harbour, NSW
Website: **www.icansw.org.au/conference/html**

2006 AUSTRALIAN INFECTION CONTROL ASSOCIATION CONFERENCE:
THE KEYS TO SUCCESS –
LOCAL SOLUTIONS TO GLOBAL PROBLEMS
20-22 September, 2006
Sheraton on the Park Hotel, Sydney, Australia
Contact: aica@ozemail.com.au

25th NEW ZEALAND NURSES ORGANISATION NATIONAL DIVISION OF INFECTION CONTROL NURSES CONFERENCE
"Infection Control Unmasked"
16-18 August, 2006
The Hotel Grand Chancellor, Christchurch, New Zealand
Website: **www.infectioncontrol.co.nz/files/calendar-detail.asp?EventID=263**

INTERNATIONAL CONFERENCE ON SURGICAL INFECTIONS
6-8 September, 2006
Stockholm International Fairs, Stockholm, Sweden
Email: **icis2006@stocon.se**
Website: **www.ics2006.se**

36th ANNUAL CONFERENCE OF THE INFECTION CONTROL NURSES ASSOCIATION
"Bridging the Gap"
25-27 September, 2006
Brighton, England
Website: **www.comtec-presentations.com.icna/**

6th INTERNATIONAL CONFERENCE OF THE HOSPITAL INFECTION SOCIETY
15-18 October, 2006
Amsterdam, Netherlands
Contact:
Congress Secretariat, HIS 2006, Concorde Services Ltd,
4B/50 Speirs Wharf, Glasgow, G4 9TB
Tel: (44) 141 331 0123
Fax: (44) 141 331 0234
Email: **info@his2006.com**
Website: **www.his2006.com**

3rd INTERNATIONAL CONGRESS OF THE ASIA PACIFIC SOCIETY OF INFECTION CONTROL
8-11 July, 2007
Kuala Lumpur, Malaysia
Contact:
Website: **http://www.apsic2007.com**

New SafeHandS network for the Asia Pacific region!

SafeHandS is an initiative by the Albion Street Centre to develop a 'virtual' network for health care worker safety for the Asia Pacific region. It is being funded by AusAID (the Australian Agency for International Development).

The aim of SafeHandS is to develop a network of health care workers and institutions across the Asia-Pacific region to promote:

- Sharing of information between health care workers and institutions about health care worker safety
- Policy development and program implementation to improve health care workers' safety
- Optimal care for people with blood borne viruses (especially HIV, hepatitis B and hepatitis C) and other communicable diseases
- Promoting practical steps to deal with issues of stigma and discrimination that might otherwise act against optimum health outcomes.

Health care workers are essential in responding to HIV/AIDS and other communicable diseases. In the Asia Pacific region where many countries are facing HIV/AIDS epidemics, health care workers need knowledge, skills and resources to adequately protect themselves and their patients. Resources to achieve standard precautions are often limited in these settings and SafeHandS will provide a forum to share **information, support and practical solutions** to help health care workers feel safe and encouraged to provide optimal care.
Benefits of membership include:

- Receiving a **newsletter** (*In SafeHandS*) every 3 months
- Participating in a **moderated discussion e-list** for posting questions, comments and issues
- Access to a **clearinghouse** of new resources and publications produced by different organisations about health care worker safety (links are posted on the website).
- Access to **resources** developed by SafeHandS
- Joining a **database** of expertise.

If you are working overseas or have an interest in the area of health care worker safety in resource limited settings, we encourage you to join or to pass on the information to colleagues in Australia or overseas. Membership is free. To join, you can either:

Go to the SafeHands website:
www.uow.edu.au/health/safehands/index.html
and click on the 'membership' page.
OR
Email: safehands@sesahs.nsw.gov.au
OR
Call us and we will post or fax you a form.
Contact Peter Said, Albion Street Centre, 61-2-9332 9711.

EMAIL REMINDER!

If you receive your copy of In.Control via email, please remember to inform us if you change your email address!

QUESTIONS & ANSWERS

In.Control *invites readers to contact us with questions they want answered. Names and organisations will* ***NOT*** *be included in the newsletter.*

Q. I work in a small Aged Care Facility and have been instructed by a work colleague that sluicing of soiled linen has been discouraged. Can you tell me if this is the case and if so why?

A. Your colleague is quite correct. Transferring heavily soiled linen to the laundry is often strongly discouraged by laundry staff, therefore standard practice has been to 'debulk' the soiled items prior to transfer to the laundry. Traditional methods of debulking (or sluicing) involved the use of a hand held spray tap attachment that uses force to dislodge and remove soiled bulk from the linen prior to normal laundering. The concern with this form of sluicing is that it is aerosol generating. This is especially problematic as there is major concern for the amount of potential cross contamination that occurs, especially during outbreak situations.

When linen needs to be debulked the preferred method is to either use a spatula to remove excess bulk into a sluice or to use a commercially available debulking machine for this purpose.

Both the NSW Health Department in its Infection Control Policy PD 2005_247 and the Federal Governments' Infection Control Guidelines discourage the use of sluicing by stating that "linen should not be rinsed or sorted in patient care areas."

Q. How should I best clean/decontaminate my dressing scissors between uses? It is common practice in our facility to soak our scissors in a solution we make up with equal parts of alcohol, chlorhexidine and water. Is this an acceptable practice?

A. No, this is not acceptable practice. It appears that many healthcare workers believe that this is not only an approved method of decontamination but many are under the impression that this practice results in 'sterilization' of the item in question (I picture many nodding in agreement.) It's time to clarify some common misconceptions, but firstly one needs to determine what the intended use of the scissors will be and this will then identify the level of reprocessing required.

With reference to the table on page 17 in the NSW Health Infection Control Policy PD 2005_247, instruments are categorised according to their application and this dictates the level of reprocessing required. For example, instruments which enter, or are capable of entering, tissue that would be sterile under normal circumstances require sterilisation. Therefore scissors used to perform procedures that require asepsis, such as during a dressing must be sterile, especially if they are used to cut up or prepare sterile dressing materials.

Soaking of equipment does not result in sterilisation nor does it achieve an acceptable level of disinfection as many of the solutions that nurses choose to soak equipment in are originally produced as topical skin disinfectants. What it does in fact is *encourage* bacterial growth, as the properties of many of these skin disinfectants become unstable very quickly, especially if mixed with other solutions. Equipment left soaking in solutions over night become heavily contaminated with a multitude of micro-organisms and can add to the already significant burden of resistant micro-organisms.

Q. I have just taken over as infection control coordinator in a small Aged Care Facility and wanted to know whether it is standard practice or necessary to do routine environmental swabs?

A. The answer to this question is "no". Environmental swabs have been shown to be of no benefit, except when occasionally they may be indicated during an outbreak situation where environmental contamination is implicated.

The environment, as one would expect, will grow a multitude of micro-organisms. The questions you need to ask are: why are the swabs being performed, do you have an outbreak, do you have increased healthcare associated infections caused by environmental organisms and what to do with the results? As hospitals contain significant reservoirs conducive to micro-organism growth, our advice would be to avoid unnecessary tasks such as routine environmental swabs. They are usually difficult to interpret and are also costly and time consuming.

Q. Our facility recently purchased some new vacuum jugs to keep water cool by the bedside. The old jugs, that have been at the facility for years, were unable to be put through the dishwasher. They were topped up daily and soaked once a week. The new jugs will go through the dishwasher. How often should they be washed?

A. The old method of topping up and soaking of jugs is really not considered safe or best practice. However the new alternative sounds a much better option. I would suggest that the jugs are routinely washed daily. An alternative is to double the number of jugs you have so you are able to wash them daily and have a better turn around time.

Q. One of our staff asked recently about the public phone that many patients use. Should Isowipes or other alcohol preparations be made available for cleaning prior to use? Will this create "superbugs"? What is done at other hospitals?

A. In relation to public phones and other common equipment shared by the public, there is no need for Isowipes or alcohol preparations to be made available. Although there has been significant media publicity around such items as public phones and automatic teller machines (ATMs) and the presence of micro-organisms (especially resistant ones), routine cleaning of these items with neutral detergent and water is sufficient. It is also important to emphasise the importance of hand hygiene to staff, patients and visitors. A routine cleaning programme by housekeeping staff should be adequate.

Test your IC IQ

A new addition to our newsletter is the IC IQ Quiz. Each edition of the newsletter will have a quiz and the answers to the previous edition's questions. Let us know if it is too easy! Select the most appropriate answers (some may have more than one!).

1. **For infections acquired during the provision of healthcare, we now use the term 'healthcare associated infection' (HAI). What term did we use before?**
   a. Healthcare idiopathic infections
   b. Nosocomial infections
   c. Healthcare treated infections
   d. Healthcare transmitted infections

2. **For an infection to be defined as an "HAI" what criteria needs to be met?**
   a. The patient has to have had the infection when they were admitted to the hospital
   b. The patient had to have been ready for discharge and then an infection was found which delayed their discharge
   c. There must have been no evidence of an infection present or incubating at the time of admission
   d. The infection must be resistant to methicillin

3. **What is the single most important procedure in the prevention of infections?**
   a. Use of disinfectants on inanimate objects
   b. Use of surgical masks
   c. Use of sterile technique
   d. Hand hygiene

4. **Respiratory and cough etiquette includes?**
   a. Taking antibiotics
   b. Covering the mouth and nose when sneezing and coughing
   c. Putting a patient into isolation
   d. Using disinfectant sprays on inanimate objects

5. **Which of the following agents used for routine decontamination of visibly clean hands in health care settings is most bactericidal and least irritating to the skin?**
   a. Alcohol based handrub
   b. Antimicrobial soap and water
   c. Plain soap and water
   d. Chlorhexidine handwash

6. **Alcohol-based hand rub should not be used:**
   a. Prior to patient contact
   b. If fingernails are chipped
   c. If the patient has a respiratory infection
   d. If hands are visibly dirty or soiled

7. **Which of the following diseases are preventable by immunisation?**
   a. Diphtheria
   b. Chickenpox
   c. Pertussis
   d. Tetanus
   e. Mumps
   f. Rubella
   g. Hepatitis A

8. **You should not visit patients in a healthcare facility if you have:**
    a. Fever
    b. Sore throat – runny nose
    c. Cough, shortness of breath
    d. Diabetes
    e. Nausea, vomiting or diarrhoea

9. **Which is not considered a potentially infectious material?**
    a. Wound exudate
    b. Saliva
    c. Blood
    d. Sweat

10. **A resident medical officer (RMO) is accidentally splattered with blood on his arms while performing cardiac resuscitation. The source patient, who is HIV infected but is seronegative for hepatitis B and C, has been hospitalised with pneumocystis pneumonia. The RMO immediately washes his arms with soap and water. On examination of his arms, there are no abrasions or lesions. Which of the following is the most appropriate medical management option for the resident?**
    a. Initiate postexposure prophylaxis (PEP)
    b. Monitor closely for any clinical features of acute retroviral syndrome
    c. No further management, this is not considered an exposure
    d. Perform baseline and follow-up serologic testing for HIV, hep B and hep C

EMAIL REMINDER!

If you receive your copy of In.Control via email, please remember to inform us if you change your email address!

Infection Control Systems in Health Care Facilities

Following the success of the Infection Control Systems in Health Care Facilities kit, we still have a limited supply of additional kits and posters available

Kits: contain 1 x A3 and 6 x A4 posters and 1 x smart card

Posters: standard, airborne, droplet and contact precautions posters

The kits may be viewed at:
www.sesahs.nsw.gov.au/albionstcentre

For further information phone the NSW Infection Control Resource Centre (02) 9332 9712

OUT OF STOCK: Individual SMART cards

INFORMATION SHEETS

The NSW Infection Control Resource Centre has developed a series of Information Sheets on the following topics:

- Infection Control in Health Care Facilities
- Hand Washing and Hand Hygiene
- Needlestick Injuries and Other Occupational Exposures
- Cleaning Health Care Facilities
- MRSA – Information Sheet for Patients
- MRSA – Information Sheet for Staff
- Noroviruses: Infection Control Implications for Health Care Facilities
- Management of Scabies in Health Care Facilities
- Cough Etiquette and Respiratory Hygiene in Health Care Settings
- Safety Of Ice Machines in Health Care Facilities

These Information Sheets are ideal for orientation, inservice education, or as reference tools. To obtain free copies, call the NSW Infection Control Resource Centre **(02) 9332 9712.**

PROFILING INFECTION CONTROL

The many faces of an Infection Control Professional

Infection Control Professionals (ICPs) work in a variety of settings and have a range of experiences and educational backgrounds. From the public hospital system to remote rural settings, from the community to resource poor countries and from the correctional setting to private practice, the world of the Infection Control Professional is very diverse.

This regular feature profiles the many faces of the Infection Control Professional. In this issue we profile:

Judy Forrest

Describe your current role.
My name is Judy Forrest and I am the managing Director of Bug Control (Aust) Pty Ltd Infection Control Advisory Service, a private infection control consultancy that I started in 1995. From a "one man band" the business has grown to a busy group of five, providing advice, education, audits and reports for a wide range of "out of hospital" settings including emergency services, residential aged care, child care, day surgery centres, small private hospitals and the corporate sector.

What was your career path that brought you to your current position?
From a position in charge of an emergency room in the United States I moved into infection control in Australia in 1988 and became a clinical nurse consultant in the NSW Public Sector for a group of 6 facilities. I decided to launch into my own business when I started to get requests for training and advice outside the public hospital realm and it became evident to me that a large number of private and aged care facilities needed support for infection control services. Bug Control is now a well known and successful consultancy which consults in all states of Australia and throughout New Zealand.

What do you like most about your job?
I love the variety of the work I do. From policy writing to education one week then problem solving and assisting facilities to meet accreditation the next, the work is always challenging and very satisfying.

What do you dislike about your job?
Running your own business is always challenging. Constantly striving to meet the needs of the clients means that you rarely get a break. The behind the scenes office work keeps me busy so that I often don't get a chance to have a full weekend free. But that all goes with the territory.

What are you reading at the moment?
I am currently reading *Letter from America* by Alistair Cook. Alistair Cook was a journalist and broadcaster who, for over half a century had a weekly BBC radio programme of his observations on American life, both political and otherwise. I always enjoyed listening to him on the radio until his recent death and am now enjoying his stories of meeting with presidents and the famous and infamous.

What is your favourite film?
The Green Mile with Tom Hanks was a movie I particularly enjoyed. Although it highlights mans inhumanity to man, it also told a story of true goodness and love.

What is your favourite saying?
My favourite saying would be "don't expect people to listen to your advice and ignore your example". I guess this relates to all avenues of life, not just to infection control. I try to be an example to my children, my friends and my colleagues.

If you could change anything about the world what would it be?
As this is an article for *In.Control* perhaps I should say I wish everyone would wash their hands when they are supposed to!

What I do wish however is that everyone would adopt the ethos of "do unto others as you would have them do unto you". Perhaps this would then give us some peace and harmony throughout the world and understanding of our fellow man (or woman).

Conference Report: Emerging Infectious Disease and Pandemic Preparedness Conference

By Julie Gallard

The Emerging Infectious Disease and Pandemic Preparedness Conference 2006 was held at the Carlton Crest Hotel Sydney from the 29-30 March, and was attended by a diverse group of delegates from International, Commonwealth, State and Local Health Care Providers, Veterinarians, Scientists and Medical Industry representatives with a distinguished panel of speakers. Infection Control in NSW was well represented by Infection Control Coordinators Network (ICCN) members who were funded by NSW Health to attend the conference. Topics included:

- Emerging Diseases and Pandemics in context
- The Threat of an Influenza Pandemic,
- Surveillance and Detection

- Pandemic Preparedness
- Laboratory Response
- Infection Control Challenges
- Emergency Planning and Risk Management

A recurring message was the complexity of preparation and response to a pandemic and the importance of timely, coherent and consistent ongoing communication between stakeholders. This is already an issue in terms of local planning. This was particularly highlighted in the presentation of Mr Bruce Farr, General Manager- Toronto Emergency Medical Services, who spoke from personal involvement in the Toronto SARS experience. The conference was informed that the Australian Pandemic Plan was in review and will be released in stages, in the near future and that this is vital to inform state and local policy.

Pacific Infection Control Network (PICNet) Launched

The Pacific Infection Control Network (PICNet) is an initiative of the Secretariat of the Pacific Community (SPC) and was officially launched on the 20th of February in Lautoka, Fiji. PICNet is to be used as a tool for communication and sharing of experiences. It will have a particular focus on practical and innovative response to infection control with limited resources. In September 2005 the PICNet webpage was launched as the first step in the development of the network. Included on the page are links to various relevant websites, documents and information sources.

As this was the first meeting of PICNet members it was an opportunity to establish the terms of reference for the network. In addition, inaugural members were given two documents to review and provide feedback on.

As part of the terms of reference objectives were set for PICNet:

1. *Set the minimum standards for infection control in Pacific Island Countries and Territories (PICTs), with adapted evidence-based/best practices.*
2. *Develop infection control capacity in PICTs.*
3. *Raise awareness of infection control issues.*
4. *Develop and maintain infection control links with health (and other) entities (e.g. other governmental and non-governmental agencies, donors).*
5. *Develop a strategic plan for PICNet.*
6. *Future objective: To develop and maintain standardized healthcare associated infection (HAI) surveillance and response mechanisms.*

The mechanism for communication for PICNet will be the use of the website (http://www.spc.int/phs/PPHSN/Activities/PICNet.htm) and an email list server. Membership is open to all who are interested in the field of infection control, particularly those located within the Pacific region.

The establishment of PICNet by the Pacific Public Health Surveillance Network (PPHSN) is an important move forward in the development of infection control capacity within the region. It is essential that this momentum be maintained through the active participation and involvement of all members of PICNet and the SPC. The membership of PICNet acknowledge that they have an ongoing role in infection control in the region including the development of resources such as the Regional Infection Control and Prevention Guidelines and the Management of Occupational Exposure Guidelines. It is recommended that there are annual PICNet conferences and that PICNet members are active in presenting papers or posters at regional and international meetings and in publishing papers in peer review journals.

AUSTRALIAN INFECTION CONTROL ASSOCIATION (AICA) 2006
Fourth Biennial National Conference
The Key to Success
– Local solutions to global problems

By Sonja Eldridge

Planning for the AICA National Conference is progressing well and the program is looking very stimulating. So come along to *your* conference, as it will provide you with the opportunity to liaise with colleagues and build on your network.

Scientific Program

The scientific program with the blend of free paper and invited speakers is looking very exciting. AICA are planning a surveillance forum with a possible overseas video linkup and a hypothetical. The hypothetical promises to be entertaining but informative. There will be breakout sessions before and after lunch on the Thursday program and before lunch on the Friday.

Workshops

The formal conference program will be preceded by 3 workshops on Wednesday 20th September. The topics for the workshops will be along the themes of;

- How to fly through accreditation
- Effective lobbying
- Surveillance

The workshop registration prices have been kept to a minimum ($55.00 for members and $75 for non members).

Social activities

On Wednesday 20th September we are planning a welcome reception cocktail evening amongst the sponsors and exhibitors. The gala social event will be the dinner on Thursday evening 21st September that will be a celebration of AICA's 21st birthday. The presentation of the Elaine Graham Robertson award will be held during the dinner. The organising committee is working with Becton

Dickinson, our foundation gold sponsor, to make the evening enjoyable and at the same time make a contribution to the Starlight Foundation.

Important dates

- 21 July: early bird registration closes
- 25 Aug: standard registration closes
- After 25 Aug: late registration period

On behalf of the Australian Infection Control Association (AICA), the ACT organising committee is pleased to invite you to attend 4th Biennial Conference on **September 20-22, 2006 at the Sheraton – on – the – Park Hotel, Sydney, Australia**.

The Infection Control Association (ICA) NSW Inc 29th Annual Conference Coughs and harboring colds – what's come through the door

By Paul Smollen

The 2006 NSW Infection Control Association's 29th annual conference is to be held at Ex-service's Club, Coffs Harbour, NSW on the 27th & 28th July 2006.

The title of the 2006 conference is *"Coughs and harboring colds – what's come through the door"* and is a play on words due to the conference location, but also builds from the 2005 conference theme of "Opening Doors". ICPs must now face the challenges that were set in 2005 and ICA NSW sees this conference as a means of further developing the skills of an Infection Control practitioner to face the day to day challenges in health care and what paths need and may be taken to continue to grow and expand our service within the current and future health care model.

The Guest Speakers for the 2006 ICA NSW Conference will deliver some thought provoking and practical sessions and workshops aimed at providing delegates with immediate knowledge and skills. The Guest Speakers are;

Dolly Olesen – is the co-director of the Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP) located in Brisbane. Dolly is also the immediate past President of AICA.

Dr Annette Pantle - is the Director Clinical Practice Improvement Projects at the Clinical Excellence Commission. In this role she is responsible for the uptake and application of knowledge about improving practices and systems in the delivery of health care across the state.

Joe-anne Bendall - is the Manager, Healthcare Associated Infections, Prevention and Control Unit at NSW Health. Joe has previously worked in Public Health and Infection Control.

Anne O'Donoghue - is the Area Director of Nursing and Midwifery, North Coast Area Health Service. Anne will be delivering the Opening Address to the delegates.

Lester Partridge - is a Principal of Bassett Consulting Engineers and also the national leader of the company's dedicated research and development group, Bassett Applied Research. Lester is a qualified mechanical engineer, and is recognised in the industry as an expert in sustainability and low energy building design techniques.

Dr Tom Gottlieb - is Senior Staff Specialist in Infectious Diseases and Microbiology at Concord Repatriation General Hospital. In addition Tom is also a Clinical Senior Lecturer, School of Medicine at the University of Sydney.

Brenda Ramstadius - is an independent wound care consultant and current Vice President of the Wound Care Association of NSW. Previously Brenda was a Clinical Nurse Consultant in wound care in the Illawarra Area Health Service and developed the "Ramstadius" Pressure Ulcer Risk Assessment and Intervention Tool.

Patrick Maywood - is the Principal Project Officer with the Bio-Preparedness Unit in the NSW Health Department. Previous to this Patrick enjoyed a long career within the Public Health Unit at Sydney South West Area Health.

The free paper sessions at the conference cover some very diverse and interesting topics which supplement the very hands on clinically focused program that is this year's state conference. Also delegates present at the conference stand a chance win a new vaccine fridge from Fisher & Paykel. ICA NSW hopes to see you in Coffs Harbour on the 27th and 28th of July 2006.

AUSTRALIAN INFECTION CONTROL CREDENTIALLING PROCESS UPDATE

As you may be aware the AICA credentialling package has been extensively reviewed and now utilises a point system to enable prior knowledge, experience and qualifications to be recognised. The new package is currently being trialled by several AICA volunteers, who will provide feedback on the process. Following this, the package may require further minor changes prior to the re-launch of the process at the national conference in September 2006. Jo Winchcombe, a member of the AICA credentialling committee, represented the committee at a recent meeting of the National Nursing Organisations (NNO) in Sydney in May.

Members interested in becoming credentialled when the revised package becomes available should register their

interest with the AICA Secretariat at: aica@ozemail.com.au, or by calling: 07 32114695.

VIDEO LIBRARY

The NSW Infection Control Resource Centre (NSW ICRC) has a multimedia library containing videos, DVDs and CD-ROMs on topics relating to infection control. These may be borrowed ***free-of-charge*** for your orientation, education and inservice sessions.

A catalogue of the library's contents is available to assist you in deciding which items are suitable for your target audience. To borrow items or to obtain a copy of the library catalogue, contact:

NSW Infection Control Resource Centre
Monday to Friday, 8am-5pm
(02) 9332 9712

HAND WASHING POSTERS

The NSW Infection Control Resource Centre, with funding from NSW Health, has developed a series of seven hand washing posters. All the posters are in colour and A3 in size (297mm x 420mm). The posters can be viewed on the NSW Infection Control Resource Centre website at:

www.sesahs.nsw.gov.au/albionstcentre

TO ORDER POSTERS SIMPLY CONTACT
NSW Infection Control Resource Centre
tel: (02) 9332 9712
fax: (02) 9380 6572
e-mail: albicr@sesahs.nsw.gov.au

COSTS MAY APPLY

Join the Campaign to Save Lives – What you do will make a difference

Health-care associated infections affect millions of people worldwide each year. It causes death and increased morbidity.

How can you help? Supporting your peers to clean hands to save lives. You can make a difference.

Hand hygiene is the primary measure to reduce infections.

The Clinical Excellence Commission (CEC) in conjunction with the NSW Department of Health launched the 'Clean Hands Save Lives' Campaign on March 27, 2006.

The Clean Hands Save Lives Campaign aims to reduce Multi Resistant Organisms (MROs) by improving hand hygiene compliance through the implementation of a statewide improvement strategy.

Key elements of the campaign include alcohol hand rub at easy-to-access locations such as near patient beds, treatment trolleys, nursing stations, promotional posters for staff, patients and visitors, patient and visitor brochures translated into 22 languages.

'Clean Hands Save Lives' Campaign resources can be purchased at cost by completing the enclosed order form. Additional order forms and information can be found at http://www.cec.health.nsw.gov.au/campaigns/cleanhandssavelives/index.html

For further information, please contact Kimberley Fitzpatrick, CEC Project Officer at Kimberley.Fitzpatrick@cec.health.nsw.gov.au or 02 9382 7822

Clean hands save lives

CURRENT JOURNAL AWARENESS

The following selected articles appeared in recent journals and may be of interest to our readers. Copies of the articles can be obtained free-of-charge by contacting the NSW Infection Control Resource Centre.

1. **Decrease in the incidence of mupirocin resistance among methicillin-resistant *Staphylococcus aureus* in carriers from an intensive care unit,** Caierão J et al, *American Journal of Infection Control*, vol. 34, no.1, February 2006.

2. **MRSA acquisition in an intensive care unit,** Dancer SJ et al, *American Journal of Infection Control*, vol. 34, no.1, February 2006.

3. **Mentor's hand hygiene practices influence student's hand hygiene rates,** Snow M et al, *American Journal of Infection Control*, vol. 34, no.1, February 2006.

4. **Patient safety perceptions: A survey of Iowa physicians, pharmacists, and nurses,** Durbin J et al, *American Journal of Infection Control*, vol. 34, no.1, February 2006.

5. **Comparative efficacy of ethanol and isopropanol against feline calicivirus, a norovirus surrogate,** Malik YS et al, *American Journal of Infection Control*, vol. 34, no.1, February 2006.

6. **Colonization and molecular epidemiology of coagulase-negative Staphylococcal bacteremia in cancer patients: A pilot study,** Costa SF et al, *American Journal of Infection Control*, vol. 34, no.1, February 2006.

7. **Survival on uncommon fomites of feline calicivirus, a surrogate of noroviruses,** Clay S et al, *American Journal of Infection Control*, vol. 34, no.1, February 2006.

8. **Controlling the usage of intranasal mupirocin does impact the rate of *Staphylococcus aureus* deep sternal wound infections in cardiac surgery patients**, Nicholson MR & Huesman LA, *American Journal of Infection Control*, vol. 34, no.1, February 2006.

9. **Do N95 respirators provide 95% protection level against airborne viruses, and how adequate are surgical masks?** Bałazy A et al, *American Journal of Infection Control*, vol. 34, no.2, March 2006.

10. **Impact of an infection control program on rates of ventilator-associated pneumonia in intensive care units in 2 Argentinean hospitals,** Rosenthal VD et al, *American Journal of Infection Control*, vol. 34, no.2, March 2006.

11. **The pneumonia score: A simple grading scale for prediction of pneumonia after acute stroke,** Kwon HM et al, *American Journal of Infection Control*, vol. 34, no.2, March 2006.

12. **Increased efficiency in evaluating patients with suspected tuberculosis by use of a dedicated airborne infection isolation unit,** Leonard MK et al, *American Journal of Infection Control*, vol. 34, no.2, March 2006.

13. **Infection surveillance and control programs in the Department of Veterans Affairs nursing home care units: A preliminary assessment,** Tsan L et al, *American Journal of Infection Control*, vol. 34, no.2, March 2006.

14. **Nosocomial pneumonia: State of the science**, Flanders SA et al, *American Journal of Infection Control*, vol. 34, no.2, March 2006.

15. **An examination of covert observation and solution audit as tools to measure the success of hand hygiene interventions,** van de Mortel T & Murgo M, *American Journal of Infection Control*, vol. 34, no.3, April 2006.

16. **Factors associated with personal protection equipment use and hand hygiene among hemodialysis staff,** Shimokura G et al, *American Journal of Infection Control*, vol. 34, no.3, April 2006.

17. **Consideration of age at admission for selective screening to identify methicillin-resistant *Staphylococcus aureus* carriers to control dissemination in a medical ward,** Eveillard M et al, *American Journal of Infection Control*, vol. 34, no.3, April 2006.

18. **Gender risk differences for surgical site infections among a primary coronary artery bypass graft surgery cohort: 1995-1998,** Bundy JK et al, *American Journal of Infection Control*, vol. 34, no.3, April 2006.

19. **Infection control program disparities between acute and long-term care facilities in Maryland,** Roup BJ et al, *American Journal of Infection Control*, vol. 34, no.3, April 2006.

20. **Bacterial contamination of nonsterile disposable gloves before use,** Berthelot P et al, *American Journal of Infection Control*, vol. 34, no.3, April 2006.

21. **Enteral tube hub as a reservoir for transmissible enteric bacteria,** Matlow A et al, *American Journal of Infection Control*, vol. 34, no.3, April 2006.

22. **Results of the Spanish national nosocomial infection surveillance network (VICONOS) for surgery patients from January 1997 through December 2003**, Jodrá VM et al, *American Journal of Infection Control*, vol. 34, no.3, April 2006.

23. **Ensuring rational public reporting systems for health care–associated infections: Systematic literature review and evaluation recommendations,** McKibben L et al, *American Journal of Infection Control*, vol. 34, no.3, April 2006.

24. **Alcohol-based hand sanitizer: Can frequent use cause an elevated blood alcohol level?** Miller MA et al, *American Journal of Infection Control*, vol. 34, no.3, April 2006.

25. **Prepackaged hand hygiene educational tools facilitate implementation,** Lawton RM et al, *American Journal of Infection Control*, vol. 34, no.3, April 2006.

26. **The role of chiropractic adjusting tables as reservoirs for microbial diseases,** Bifero AE et al,

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27. **HTLV-II transmission to a health care worker,** Menna-Barreto M et al, *American Journal of Infection Control*, vol. 34, no.3, April 2006.

Visit the *American Journal of Infection Control* online at: **www.mosby.com/ajic**

28. **What Proportion of Hospital Patients Colonized With Methicillin-Resistant *Staphylococcus aureus* Are Identified by Clinical Microbiological Cultures?** Cassandra D. Salgado et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.2, February 2006.

29. **Impact of an Aggressive Infection Control Strategy on Endemic *Staphylococcus aureus* Infection in Liver Transplant Recipients,** Nina Singh et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.2, February 2006.

30. **A Study of the Relationship Between Environmental Contamination with Methicillin-Resistant *Staphylococcus aureus* (MRSA) and Patients' Acquisition of MRSA,** Katherine J. Hardy et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.2, February 2006.

31. **Clinical and Laboratory Features of Community-Associated Methicillin-Resistant *Staphylococcus aureus:* Is It Really New?** Leonard B. Johnson et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.2, February 2006.

32. **Management of Outbreaks of Methicillin-Resistant *Staphylococcus aureus* Infection in the Neonatal Intensive Care Unit: A Consensus Statement,** Susan I. Gerber et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.2, February 2006.

33. **Methicillin-Resistant *Staphylococcus aureus* in German Intensive Care Units During 2000-2003: Data from Project SARI (Surveillance of Antimicrobial Use and Antimicrobial Resistance in Intensive Care Units),** Elisabeth Meyer et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.2, February 2006.

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36. **Nurses and Occupational Exposures to Bloodborne Viruses in Poland,** Maria Garniczak et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.2, February 2006.

37. **Evaluation of a Strategy of Screening Multiple Anatomical Sites for Methicillin-Resistant *Staphylococcus aureus* at Admission to a Teaching Hospital,** Matthieu Eveillard et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.2, February 2006.

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39. **Biofilm Formation by and Accessory Gene Regulator Typing of Methicillin-Resistant *Staphylococcus aureus* Strains Recovered From Patients With Nosocomial Infections,** Kunihiro Manago et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.2, February 2006.

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45. **Prevalence of and Risk Factors for Carriage of Panton-Valentine Leukocidin–Positive Methicillin-Resistant *Staphylococcus aureus* Among Residents and Staff of a German Nursing Home,** Ulla Raab et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.2, February 2006.

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47. **Posttraumatic Stress Disorder After Occupational HIV Exposure: Two Cases and a Literature Review,** Michael G. Worthington et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.2, February 2006.

48. **Favorable Impact of an Infection Control Network on Nosocomial Infection Rates in Community Hospitals,** Keith S. Kaye et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.3, March 2006.

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62. **The Relationship Between Surgical Site Infection and Volume of Coronary Artery Bypass Graft Surgeries: Taiwan Experience,** Shiao-Chi Wu et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.3, March 2006.

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Oguz Karabay et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.3, March 2006.

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67. **Administrative Data Fail to Accurately Identify Cases of Healthcare-Associated Infection,** Eileen R. Sherman et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.4, April 2006.

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FOR DENTAL ASSISTANTS
5 September, 2006
28 November, 2006

This one-day workshop is designed for dental assistants. It provides an overview of current infection control procedures.

TOPICS COVERED
The Principles of Infection Control
Introductory Microbiology and Immunology
Processing Instruments and Equipment
Staff Health
Management of Sharps Injuries

VENUE
The Albion Street Centre
150 Albion Street
SURRY HILLS NSW 2010

COURSE DETAILS:
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INTRODUCTION TO
INFECTION CONTROL NURSING
9 August, 2006
14 November, 2006

This one-day course is designed for nurses who are beginning practitioners in the field of Infection Control, or who are required to take some Infection Control responsibilities in the course of their work.

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The Role of the Infection Control Nurse
Staff Health
Waste Management
Policy and Programs
Networking and Resources

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MANAGEMENT OF NEEDLESTICK INJURIES & OTHER EXPOSURES TO
BLOOD BORNE PATHOGENS
23 - 24 October, 2006

This two-day workshop provides an overview of the management of needle-stick injuries and other exposures to blood and body substances that could potentially contain blood-borne pathogens such as hepatitis B, hepatitis C and HIV

TOPICS COVERED
Risk assessment, protocols for post exposure management, prophylaxis, testing, documentation, counseling the exposed person and policy development.

The seminar is aimed at nurses, doctors, social workers, psychologists and managers who provide advice to health care workers after a needle-stick injury (or other exposure) and/or those developing policy.

VENUE
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HIV and HEPATITIS C
PRE and POST TEST COUNSELLING
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This four-day workshop is designed specifically for counselors and health care professionals who will be providing pre and post HIV test counselling. This is a highly interactive, skills-based workshop focusing on the immediate emotional and psychosocial responses to HIV testing. Other issues to be addressed will include occupational exposures and suicide risk assessment. The workshop includes case discussions and micro skills practice in small groups.

PREREQUISTE:
Basic counseling skills and an introduction to HIV/AIDS course or equivalent knowledge level.
Conditionally registered psychologists: this course has been assessed as suitable for workshop supervision hours for the NSW Psychologists' Registration Board

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