In.CONTROL

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

Volume 9, Number 3,
October, 2005

There have been a number of interesting developments and exciting initiatives in the area of infection control in recent months in NSW.

The NSW Health *Infection Control Policy* PD 2005_247 (previously known as Circular 2002/45) is currently being reviewed and revised with a release date of the new version projected for the end of the year or early 2006.

NSW Health has convened a Multi-Resistant Organism (MRO) Taskforce and an MRO Expert Group to address MRO's in the NSW health system. The development of a MRO Policy Directive is a recommendation from the Expert Group. They are being developed and will be released approximately the same time as the Infection Control Policy. Six patient information sheets have already been been developed on *Antibiotic Resistant Bacteria*; *Multi-Resistant Acinetobacter baumanni (MRAB)*; *Antibiotic Use*; *Methicillin Resistant Staphylococcus aureus (MRSA)*; *Vancomycin Intermediate Staphylococcus aureus (VISA)*; and *Vancomycin Resistant Enterococci (VRE)* and are available from:
www.health.nsw.gov.au/health_pr/infectinfo.html
NSW Health will be seeking to have the Fact Sheets written in other languages.

Following a recommendation from the MRO Expert Panel, the Clinical Excellence Commission is developing a Hand Hygiene Project and are in the process of convening a steering committee. A project officer will be recruited to manage the project.

A two-year NSW Health Sharps Safety Project has commenced. This statewide project aims to look at the nature of sharps injuries and develop strategies to minimise or eliminate the risk associated with sharps use.

There has been a lot of high activity in the preparedness of the NSW Health Influenza Pandemic plan. The plan will be based on the Commonwealth Pandemic Plan and will contain broad infection control principles. Resources for each section are currently being developed. The Department of Health and Ageing has produced a film to educate and train 'first responders' on infection control and the correct use of Personal Protective Equipment (PPE). Production of the film was funded through the 2004 Budget Initiative, Australia's preparedness for pandemic influenza, to ensure readiness for borders and essential services. The film has been produced as an interactive DVD, CD-ROM and internet resource and is titled *Prepared and Protected: Infection Control and Personal Protective Equipment for Respiratory Diseases*. It is intended to augment the infection control training of 'first responders', such as international border staff, emergency service personnel, medical practitioners, other health care professionals and any staff, such as receptionists, who might have direct contact with members of the public. Approximately 32,000 copies of the DVD and CD-ROM have been produced. Follow the link: **www.health.gov.au/internet/wcms/publishing.nsf/Content/phd-pandemic-prepared-protected.htm**
Copies of the DVD and CD-ROM can be ordered by phoning (02) 6289 4539.

NSW Health is currently developing an Infection Control website. The site will contain information for the community and healthcare professionals. To date, the first two years of mandatory clinical indicator data is available. There are plans to fully develop the site, so keep this site on your update list:
www.health.nsw.gov.au/health_pr/infect.html

NSW Health requested several small additions to the *Cough Etiquette Information Sheet* that appeared in the last issue of **In.Control**. Those additions appear in the *Cough Etiquette Information Sheet* (page 16) and supersedes the Information Sheet that appeared in the last issue.

Philip Melling, Editor

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

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

PD2005_341	USE AND RETENTION OF HUMAN TISSUE INCLUDING ORGAN DONATION, POST-MORTEM EXAMINATION AND CORONIAL MATTERS *(fully replaces Circulars 84/11, 84/130, 84/207, 92/17, 94/82, 2000/97, 2001/13)*
PD2005_344	REQUIREMENTS FOR THE PROVISION OF COLD AND HEATED WATER *(replaces Circular 2002/10)*
PD2005_354	WORKCOVER NSW REPORTING REQUIREMENTS: OCCUPATIONAL EXPOSURES TO BLOOD-BORNE PATHOGENS
PD2005_359	NOTIFICATION OF INFECTIOUS DISEASES UNDER THE PUBLIC HEALTH ACT 1991 *(supersedes Circular 2003/89)*
PD2005_362	NSW HEALTH PRIVACY MANUAL (VERSION 1) 2004 *(supersedes Circular 99/18)*
PD2005_374	STANDING ORDERS FOR THE ADMINISTRATION OF MEDICATION IN A PUBLIC HEALTH EMERGENCY
PD2005_399	REMANUFACTURE OF SINGLE USE MEDICAL DEVICES (SUDs)
GL2005_060	TUBERCULOSIS IN CHILDREN AND ADOLESCENTS *(supercedes PD2005_069 [Circular 94/89])*
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

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.

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 some infection control professionals.

GL2005_060 Tuberculosis in Children and Adolescents
This Guideline supersedes PD2005_069 (Circular 94/89). Tuberculosis in children and adolescents differs markedly from that in adults. This Guideline has been revised to reflect current evidence regarding risk of infection and infectivity, and to provide guidance on the diagnosis, preventative therapy and treatment of tuberculosis in children and adolescents.

PD2005_572 Blood Alcohol and Drug Test Kits – Modification of
This Policy Directive advises of modification to and compulsory use of a new sampling kit for blood and urine alcohol testing. Previous test kits required division of blood specimen into two tubes that involved additional handling and the risks associated with needlestick injury or a mucosal splash with fresh blood. This modification in blood sampling has removed the requirement to split the specimen into two collection tubes and will improve safety.

PD2005_579 Tuberculosis Related Services – Charging for
This Policy Directive supersedes PD2005_142 (Circular 99/6). To minimise the potential barriers for persons with Tuberculosis (TB) presenting and/or continuing in care. TB investigations, care and treatment services are provided free of charge to persons residing in NSW regardless of Medicare eligibility or residency status. This policy directive has been revised to reflect current practices within the NSW Chest Clinic system and to clarify issues around visa screening, referral to private providers, payment of Medicare benefits, services provided to detainees in immigration detention centres and the financial responsibility for people on an employee sponsored Long Term Business Entry Visa, subclass 457.

PD2005_580 Tuberculin Skin Testing (New in 2005)
This Policy Directive supersedes PD2005_070 (Circular 94/90). The Tuberculin Skin Testing (TST) Policy Directive has been revised to provide guidance to persons undertaking and interpreting TST. These changes were necessary to reflect current practices within NSW Chest Clinics and include: information on composition and safety of the procedure, dosage, storage, method of administration and consent for the procedure; and expanded indications and information on contraindications to undertaking TST. There is further clarification on interpretation of TST and factors that affect interpretation, conversion, boosting, BCG vaccination and exposure to mycobacteria other than TB. The directive also highlights alternative tests for the identification of infection with TB.

PD2005_581 Tuberculosis Contact Tracing (New in 2005)
This Policy Directive supersedes PD2005_212 (Circular 2001/76). Contact tracing is a key element of the NSW Tuberculosis (TB) Prevention and Control Program. This Policy Directive has been revised to clarify the role of TB Prevention and Control Services/Chest Clinics in undertaking and/or coordinating contact screening activities. Additional information includes: the timing and notification of contacts; use of Section 71 of the Public Health Act; and revision of the procedure for airline contact screening.

PD2005_596 Tuberculosis – Infection Control
This policy supersedes Circular 94/87 and looks at infection control in relation to Tuberculosis (TB). These guidelines identify the specifics of infection control precautions with TB. It includes such things as isolation precautions, recommended ventilation requirements, particulate masks for sputum positive persons, various equipment required for each isolation room, personal hygiene issues, waste disposal, cleaning, patient transport, handling of laboratory specimens, staff protection and visitor's responsibilities.

PD2005_604 Incident Management Policy
This Policy Directive supersedes Reportable Incident Briefs to the NSW Department of Health PD2005_337 (Circular 2003/88). The aim of this Policy Directive is to advise clinicians and managers on responding effectively to all clinical and corporate incidents that occur in the NSW health system. It also contains important information about the legal aspects of healthcare incident management.

PD2005_608 Patient Safety and Clinical Quality Program
The Patient Safety and Clinical Quality Program provides a framework for significant improvements to clinical quality in our public health system. It relies heavily on promoting a culture of openness in which errors are acknowledged and reported so as to reduce the opportunity for others to make similar mistakes. The key components of the program are:

- Systematic management of incidents and risks
- A new Incident Information Management System
- Clinical Governance Units in each Area Health Service
- A Quality Assessment Program for all public health organizations
- The establishment of the Clinical Excellence Commission.

These initiatives are designed to support clinicians and managers with improving quality and safety for patients and will focus on promoting and providing the delivery of the best care in health services.

EMAIL REMINDER!

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

In.Control is the official newsletter of the NSW Infection Control Resource Centre (an initiative of the NSW Health Department) and is printed four times a year.

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MEDIA WATCH AUSTRALIA

May 2005

As the winter influenza season approached, most written media published extensive articles about the benefits of the **flu** vaccine and how to relieve symptoms and speed recovery for those unfortunate people who succumb to the virus. The *Sydney Morning Herald's Health & Science* supplement devoted an entire issue to 'winter wellbeing' in late May.

Details of Australia's preparedness for an **influenza** pandemic was a recurring news story throughout the winter months as authorities nervously monitored the progress of the **bird flu virus** overseas. In May there were details of the masks, anti-viral drugs and ventilators that have been stockpiled in case a **flu** pandemic strikes Australia. In June it was revealed that Australia had the largest per capita antiviral stockpile in the world. The Federal Health Minister, Mr Tony Abbott, said, "The current stockpile is about 4 million doses, and this is enough to protect about a million essential services workers for between four and six weeks." In July the Federal Government announced it was sending 35,000 kits to health professionals to help them recognise and manage a **flu** pandemic crisis. In August, details of a "bunker" – a three-room office in Canberra – that is Australia's frontline defense against **bird flu** and biological warfare was released. The specialists who staff the office have the power to organise the set up of six quarantine centres with ventilators to care for 500 sick people for five days. Despite all this **flu** pandemic preparedness Tony Abbott said the public should be "concerned, not panic-stricken" by the risk of an **influenza** pandemic.

A vaccine against the **H5N1 avian influenza** strain will be tested on 200 Australians in October. The Commonwealth Serum Laboratories (CSL) will inject 200 with the vaccine to check whether they develop an immune response to the **flu** that has killed 53 people in Asia. A CSL spokeswoman said they hoped to be able to provide results from follow-up blood tests in December. If the vaccine produces a satisfactory immune response to the **flu** strain, CSL says it will take three months to produce the 50 million doses needed to protect the entire Australian population. CSL said there is no danger its testing program could release the **flu** into the community as it is using an inactive seed version of H5N1 to produce the vaccine. The World Health Organisation says of 97 people infected in Thailand, Vietnam, Cambodia and Indonesia, 53 have died. It is estimated 2.6 million Australians would become infected in a pandemic and 13,000 would die. To date there has been no proven case of the virus being transmitted from human to human but it has been spreading westward through Russia by migrating birds.

June 2005

The month began with blanket coverage in the popular press about the rates of **multi-resistantant *Acinetobacter baumanii* (MRAB)** and **vancomycin resistant *Enterococci* (VRE)** in some of Sydney's hospitals. *'The Superbug Crisis'*, *'Hunting the Superbugs'*, *'Killer Bug Infects Six'*, *'Superbugs Claim More Victims'* and *'March of the Superbugs'* were just some of the sensationalist headlines that appeared in the popular tabloids in the first week of June. The *Daily Telegraph* even asked readers who had had a "superbug" – the newspaper's terminology for drug-resistant organisms - to email the newspaper with their stories! NSW Health assembled an advisory group to review and respond to the outbreaks.

Figures released by NSW Health in June showed that between 2003 and 2004 the number of **salmonella** infections increased by 13% across all age groups. The rate among children aged up to four years leapt by 20%, while the rate for five to nine-year-olds grew 17%. The infection, spread by poor food-handling practices, can lead to death in vulnerable groups such as the young and elderly, through complications such as severe dehydration. In response to these figures, food authorities urged people to take extra care preparing and cooking food.

Chlamydia was the most commonly notified disease in 2003 with more than 30,000 people infected, according to the Federal Government's national notifiable diseases surveillance system report. The report recommended routine surveillance of **chlamydial** infections. Untreated **chlamydia** is the most prevalent, preventable cause of infertility.

A nurse called as a witness to a commission of inquiry into a doctor's unsanitary practices and serious infection rates said the doctor "in all seriousness made a claim that doctor's don't have germs" the media reported in June. Patients were also called in as witnesses to the inquiry. The doctor in question remains in the US refusing to return to Australia

and face charges brought against him. Queensland police are building a case for his extradition.

According to the *Daily Telegraph*, a survey into Australia's hygiene habits revealed that one in four Australians wipe their nose on a shirtsleeve and 22% on other clothing. 2% of Australians claim to be "completely paranoid" when it came to avoiding a virus.

July 2005
The *Health & Science* supplement of the *Sydney Morning Herald* printed an interesting first-person account by a 92 year-old man of his infection with **diphtheria** in 1917 and **scarlet fever** in 1927 and how he was treated. For the **diphtheria** infection his bedroom at home was converted into an isolation ward, with a sheet soaked in carbolic acid hung in the doorway. Anybody that entered the room wore a mask. His bed was a large old-fashioned cot that was converted into a steam tent by being covered with a large sheet. A large kettle with a methylated spirit lamp as a source of heat was installed on a stool at the foot of the bed. The spout protruded into the enclosed cot, thus providing the steam. The idea was to have a moist atmosphere to allow the five-year-old to breathe, as this was supposed to slow any closing of the larynx caused by the **diphtheria**. In 1927 the cause of **scarlet fever** was unknown and the disease was very infectious with significant mortality. The only treatment available was good nursing and the 15 year-old spent three weeks in a hospital bed. The boy was not allowed to have any of his schoolbooks while in hospital as it was feared they would be infected. Regardless, he went on to recover and enjoy a successful medical career. The gentleman is now in his nineties.

MEDIA WATCH THE WORLD

May 2005
Indonesia began vaccinating 6.4 million children in late May to try to halt a **polio** outbreak that had crippled 16 infants and toddlers. A World Health Organisation spokeswoman said it was the country's first outbreak of the disease in a decade. The first vaccinations were in the provinces of West Java and Banten, as well as Jakarta. All the cases have come from around Sukabumi, 100km south of Jakarta. The UN Children's Fund said the outbreak showed Indonesia needed to remain vigilant.

In the UK, **methicillin-resistant *Staphylococcus aureus* (MRSA)** has become one of the largest problems to strike the health system. The number of cases in Britain has skyrocketed six-fold over the past decade. The British Government has committed 2.4 billion pounds-a-year in an attempt to eradicate it.

June 2005
A new experimental vaccine may prevent **shingles,** according to a report in the *New England Journal of Medicine,* and could be on the market as early as next year. **Shingles** is caused by a resurgence of the dormant **chickenpox** virus and can be very painful. **Varicella-zoster,** the microbe that causes **shingles** and **chickenpox**, retreats after a childhood infection, but the virus remains dormant in nerve cells only to resurface decades later as **shingles**. Unlike traditional vaccines that prevent a new disease, the **shingles** vaccination would keep a long-ago acquired infection in check.

Canadian and US scientists have developed vaccines that protect monkeys from the **Marburg** and **Ebola** viruses and show promise for humans, according to a study published in *Nature Medicine*. It will take five or six years to complete research to show the experimental vaccines can be safe and effective for people exposed to the contagious viruses, which are almost always fatal, said Steven Jones, one of the Canadian-based scientists behind the study. "The data would suggest that instead of 100% chance of dying, they would have an 80% chance of survival," Jones reported. It is the first sign of success for a **Marburg** vaccine. Dutch company Crucell is working on commercialising a different type of **Ebola** vaccine. **Marburg** and **Ebola** are spread by bodily fluids including blood, sweat and saliva. Most victims die within days after massive bleeding.

South Africa opened its biggest-ever **AIDS** conference in June with its Health Minister publicly questioning whether life-saving anti-retroviral (ARV) drugs alone could turn back the disease. More than 200,000 people are believed to die of **AIDS** in South Africa every year, with the United Nations estimating that more than five million of the countrys' 45 million people are infected. "Your response cannot be single-minded," Health Minister Manto Tshabalala-Msimang told a news conference at the meeting of 4000 delegates in Durban. "There are other things you must be able to do: nutrition and traditional medicine." South African military officials also revealed that 23% of the country's troops are **HIV** positive.

HIV is now spreading faster in women than any other group according to Professor Thomas Quinn from Johns Hopkins Medical Institutes in Baltimore in the US. Professor Quinn would like to see a global strategy aimed at fighting the impact on women.

A poultry worker who was among 81 people tested for **avian flu** in Indonesia last March tested positive in two rounds of testing conducted in Hong Kong, the *Washington Post* reported in June. It was the first known case of **avian flu** in Indonesia. Other countries with human cases of **avian flu** since 2003 are Cambodia, Thailand and Vietnam. The poultry worker had relatively low concentration of antibodies to H5N1 and has shown no symptoms of illness, authorities told the newspaper.

The *Washington Post* also revealed that farmers in China have tried to halt **bird flu** outbreaks among chickens using an antiviral drug meant for humans. International researchers now say the drug will no longer protect people in the event of a worldwide bird **flu** pandemic. China's use of the drug amantadine violates international livestock guidelines. Amantadine is one of two types of drugs used for treating **flu** in humans. But researchers discovered last year that the H5N1 bird **flu** strain in Vietnam and Thailand had become resistant to amantadine, leaving only one other drug that is difficult to produce in large amounts and much less affordable, especially for developing countries in South-East Asia. "It's definitely an issue if there's a pandemic. Amantadine is off the table," said Richard Webby, an **influenza** expert at St Jude Children's Research Hospital in Memphis, Tennessee.

July 2005

The movie *Bewitched* was condemned by the American Liver Foundation in July. In the film, starring Nicole Kidman, a woman discourages romantic advances by saying she has **hepatitis C**. The foundation said the "remarkably tasteless" comment adds to the stigma people with **hepatitis C** have to cope with every single day.

The World Health Organisation warned that the global capacity to make **influenza** vaccines would not be flexible or large enough to counter a threatened pandemic that could rapidly kill millions of people. The health agency has advised countries about a range of preparative measures to guard against a pandemic, including stocks of antiviral drugs and public health measures. These took into account "that adequate supplies of vaccine will not be available at the start of a pandemic in any country".

August 2005

In an excellent article on childhood immunisation in the *Sydney Morning Herald*, the director of the National Centre for Immunisation Research and Surveillance, Peter McIntyre, said there is no risk that babies' immune systems would be overwhelmed or weakened by multiple vaccines. He cited a paper in the journal *Pediatrics* in 2002 that estimates each infant would have the theoretical capacity to respond to about 10,000 vaccines at any one time. Further, if 11 vaccines were given to infants simultaneously then only about 0.1% of the immune system would be "used up" and that would soon be replenished anyway. In any case, he says parents may take comfort in knowing that although children are having more vaccines than ever before, they are being exposed to fewer antigens (proteins and polysaccharides) than in the past. "We now have more purified versions of vaccines, so there are fewer 'bits' for the immune system to respond to," McIntyre said. For example, the current acellular **pertussis (whooping cough)** vaccine contains between three and five antigens, compared with the previous version that contained up to 3000 antigens.

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 on our website:
www.sesahs.nsw.gov.au/albionstcentre
Or for further information phone the NSW Infection Control Resource Centre on (02) 9332 9712

OUT OF STOCK: Individual SMART cards

INFECTION CONTROL CONFERENCES

AUSTRALIAN CONFERENCES

INFECTION CONTROL PRACTITIONERS ASSOCIATION OF QUEENSLAND (ICPAQ) CONFERENCE
6-7th OCTOBER, 2005
Sunshine Coast, Australia
Contact:
Website: **www.icpaq.org**

TASMANIAN INFECTION CONTROL ASSOCIATION FIRST BIENNIAL CONFERENCE HOSPITALS AND BEYOND
18th NOVEMBER, 2005
Launceston, Australia
Contact:
Email: **nbrown1@iprimus.com.au**

VICTORIAN INFECTION CONTROL PROFESSIONALS ASSOCIATION CONFERENCE AND EXHIBITION
23-25th NOVEMBER, 2005
Melbourne, Australia
Contact:
Email:
vicpa@icms.com.au
Website:
http://www.icms.com.au/vicpa

AICA CONFERENCE: GLOBAL PROBLEMS – LOCAL SOLUTIONS
20-22nd SEPTEMBER, 2006
Sydney, Australia
Details to be announced

INTERNATIONAL CONFERENCES

6th CONGRESS OF THE INTERNATIONAL FEDERATION OF INFECTION CONTROL
13-16th OCTOBER, 2005
Istanbul, Turkey
Contact:
Congress Secretariat
Tel: (90) 216 467 0647-50
Fax: (90) 216 467 0651
Email:
congress@topkon.com
Website:
http://www.ificistanbul.org

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
8-11th JULY, 2007
Kuala Lumpur, Malaysia
Contact:
Website:
http://www.apsic2007.com

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

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

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.

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 our website:
  www.uow.edu.au/health/safehands/index.html

  and click on the 'membership' page.

OR

- Call us and we will post or fax you a form.
  Contact Alex Wilson, Albion Street Centre, 61-2-9332 9697.

MULTI-MEDIA 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

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 am the infection control representative at a small nursing home and hostel. We are having a persistent problem with Norwegian scabies re-infestation even with after following diligent infection control practices. We have had scabies infestations in the past with successful eradication however have been unable to contain this infestation. Could you please advise us on possible solutions or areas that we may be neglecting to address in successfully managing such infestations?

A The first important point to remember here is that Norwegian scabies is an extremely virulent infestation that occurs quite often in the elderly, those who are debilitated and also those who may be immunocompromised. These patients are highly infective and often very difficult to treat. Also called crusted scabies, patients with Norwegian scabies infestations often have large areas of their bodies that appear scaly and crusted with thousands of mites and eggs. It is because of these large crusted areas that traditional control methods such as skin creams and lotions are ineffective as they are often unable to penetrate the crusted thickened skin resulting in treatment failure. Crusted scabies is often misdiagnosed as psoriasis or eczema.

Control of Norwegian scabies is as per contact precautions and is outlined in our *Scabies Information Sheet*. Treatment with a topical scabicide cream/lotion should be as per instructions, and repeated with moderate to severe infections.

Due to the increased crusting present, it is sometimes beneficial to apply the creams and lotions following a bath or shower to reduce the crusting and allow better penetration of the treatment.

It is also important to note that due to higher mite infestation associated with Norwegian scabies the environment especially the floor and bed linen have shown to contain larger numbers of scabies mites, therefore strict cleaning of the patient's own environment and laundering of bedding and clothing is paramount in successful control. Recommended Journal article: *Scabies: diagnosis and treatment,* Johnston, G. & Sladden, M., BMJ 2005;331:619-22 (available by calling the NSW ICRC (02) 9332 9712).

Q I work in a small hostel that has a domestic washing machine and dryer for laundering residents' personal clothing. I was told recently that this was an unacceptable practice and that all items

requiring laundering had to be done utilising a commercial/industrial laundry. Is this true?

A There are a couple of points here that need to be clarified. Firstly this area is not as black and white as it may appear. Many long-term care facilities are equipped with domestic washers and dryers, and are dedicated for the use of residents' only. This is so residents may maintain as close to a home environment as possible and are able to wash and dry their own items of clothing. For this purpose this is fine. However, if staff want to launder a number of residents' personal clothing items, they are required to comply with the Laundry Practice Standard AS /NZS 4146:2000.

A key requirement is that washers are able to achieve thermal or chemical disinfection and subsequent documentation. Thermal disinfection at 65 degrees C for 10 minutes or 71 degrees C for 3 minutes is unachievable in domestic washers, however if facilities source a suitable product, chemical disinfection is achievable even for a domestic washing machine.

Q I am a personal care attendant in a group home and was wondering whether it is mandatory for washed clothes to go into a clothes dryer or is it possible to dry clothing on an outside clothes line.

A It is important that clothes that are washed together in a group home setting receive chemical disinfection and this may be achieved with a number of domestic antibacterial products that can be bought from local supermarkets.

Clothes can then be either dried in domestic dryer or if preferred dried on an external clothesline. It is imperative to remember that a group home is a home and it is important to maintain as close to a home environment as possible.

Q I recently underwent a dental consultation and was concerned about some of the questions that were asked of me in the medical history questionnaire I had to complete prior to seeing the dentist. There were questions that pertained to high-risk behaviours including sexual practices. Do I have to disclose information relating to my HIV, Hepatitis B and C status, and is it relevant for my dentist to ask these questions?

A You are not required to disclose such information and information relating to sexual practices should not be asked of you. However many questionnaires require you to provide a full medical history that may be relevant to the dental procedure/s you may be undertaking. In some instances it may be very relevant for your dentist to be aware of such things as your HIV or HCV status as this may be medically indicated in preventing complications. Such things as possible raised liver function tests and immunosuppression related to a positive HIV or hepatitis B or hepatitis C status may in fact modify your treatment plan and therefore such information is very relevant. Also an ongoing preventative maintenance plan may be considered for implementation based on immune status.

Knowledge of a patient's blood borne virus status is extremely sensitive information and should only be used as outlined above. It should not be used to alter practice or discriminate in any way. It is important to emphasise the role of standard precautions in preventing the transmission of blood borne viruses and that all blood and body substances should be treated as potentially infectious regardless of what we know or perceive the status of a patient or risk of transmission to be.

Q Are there any infection control guidelines specifically for the dental setting and how can they be accessed?

A Yes, there are infection control guidelines for the dental setting. In 2002 NSW Health issued the Infection Control Guidelines for Oral Health Care Settings, GL2005_037 (previously Circular 2002/80) and is still current. The 27-page Guideline contains sections on Standard and Additional Precautions; Personal and Patient Protection; Procedure for Dental and Clinical Practice; Safe Handling and Disposal of Sharps; Processing of Instruments and Equipment; Clinical Practice Environment; Waste Management; Prosthetics/Laboratory; Radiology; Staff Health Issues; Education; and Creutzfeldt-Jakob Disease.

Copies of the Guideline can be downloaded from **www.health.nsw.gov.au**

Q What are the vaccination requirements for staff that work in the on-site laundry at our age care facility?

A By consulting the NSW Health Policy Directive 2005_338 (Circular 2003/91) *Occupational Screening and Vaccination Against Infectious Diseases*, you will see that laundry workers fit into category B. While laundry workers may not have contact with patients or residents, they do have contact with blood and body substances through contaminated linen. Appropriate vaccination in line with the above mentioned policy directive is advised. This includes ensuring staff receive a full course of hepatitis B vaccine, Tuberculosis screening and have documented or serological evidence of relevant childhood vaccinations.

Although the risk of disease transmission from soiled linen is negligible, employees involved in the handling, transport and processing of used linen soiled with blood, body fluids, secretions and excretions should carry out these tasks in a manner that prevents skin and mucous membrane exposure and contamination of clothing.

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:

Peta-Anne Zimmerman

Describe your current role.
I am the Infection Control Consultant/Technical Advisor for International Health Services at the Albion Street Centre. I provide Infection Control technical assistance to other countries through specific projects or as specifically requested, such as through the World Health Organisation (WHO).

What was your career path that brought you to your current position?
I started out, after finishing my Nursing degree, in orthopaedics and was curious as to why some of our patients were transferred to another ward because they had an infection (MRSA). I requested to work in this other ward (Infectious Diseases) and came across a very dynamic and inspiring person called Dolly Olsen, who was the Infection Control CNC at the hospital.

From there I continued to work in Infectious Diseases wards, then started a Masters of Health Science (Infection Control). While I was studying and working in Infectious Diseases I applied for a position in Infection Control and got it. I have worked in Infection Control ever since. In 2003 the Australian Infection Control Association (AICA) received a request for assistance from the WHO for SARS. I applied and was accepted. Since then I have done four consultancies for WHO, the longest being 5 months when I was in Beijing.

After Beijing I realised International Health was my thing and became part of the International Health Services team at the Albion Street Centre, specifically to work on an HIV project in far north-west China. I am now also working my way through a Doctorate of Public Health.

What do you like most about your job?
The variety and the challenges. I am constantly being kept on my toes by my overseas counterparts. Meeting amazing people.

What do you dislike about your job?
The long stretches away from home.

What are you reading at the moment?
A contract for another overseas consultancy.

What is your favourite film?
The Scarlet Pimpernel. [1982 version starring Anthony Andrews and Jane Seymour]

What is your favourite saying?
I have two: *"You can't chi-square social justice";* and *"Don't show them your belly"*

If you could change anything about the world what would it be?
The allocation of resources (including health care resources) and poverty.

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. **Use of quarantine in the control of SARS in Singapore,** Ooi, P.L. et al*, American Journal of Infection Control*, vol. 33, no.5, June 2005.

2. **Infection control and quality health care in the new millenium,** Pittet, D, *American Journal of Infection Control*, vol. 33, no.5, June 2005.

3. **Health care–associated infections in the neonatal intensive care unit,** Brady, M., *American Journal of Infection Control*, vol. 33, no.5, June 2005.

4. **Infectious disease in pediatric out-of-home child care,** Brady, M., *American Journal of Infection Control*, vol. 33, no.5, June 2005.

5. **Surveillance, prevention, and control of legionellosis in a tropical city-state,** Goh, K. et al, *American Journal of Infection Control*, vol. 33, no.5, June 2005.

6. **Risk factors for prediction of surgical site infections in "clean surgery",** Pessaux, P. et al, *American Journal of Infection Control*, vol. 33, no.5, June 2005.

7. **Public attitudes and opinions toward physicians and dentists infected with bloodborne viruses: Results of a national survey,** Tuboku-Metzger, J. et al, *American Journal of Infection Control*, vol. 33, no.5, June 2005.

8. **Short time to positivity in blood culture with clustered gram-positive cocci on direct smear examination is highly predictive of *Staphylococcus aureus*,** Ruimy, R. et al, *American Journal of Infection Control*, vol. 33, no.5, June 2005.

9. **Sporicidal activity in liquid chemical products to sterilize or high-level disinfect medical and dental instruments,** Acosta-Gío, A. et al, *American Journal of Infection Control*, vol. 33, no.5, June 2005.

10. **Monitoring health care workers after smallpox vaccination: Findings from the hospital smallpox vaccination-monitoring system,** Klevens, R. et al, *American Journal of Infection Control*, vol. 33, no.6, August 2005.

11. **Activity of selected oxidizing microbicides against the spores of *Clostridium difficile*: Relevance to environmental control,** Perez J. et al, *American Journal of Infection Control*, vol. 33, no.6, August 2005.

12. **Nosocomial bloodstream infections in ICU and non-ICU patients,** Šuljagić V. et al, *American Journal of Infection Control*, vol. 33, no.6, August 2005.

13. **Genetic relatedness of *Staphylococcus epidermidis* from infected infants and staff in the neonatal intensive care unit,** Milisavljevic V. et al, *American Journal of Infection Control*, vol. 33, no.6, August 2005.

14. **Barrier properties and cost implications of a single versus a double wrap for storing sterile instrument packs,** Webster J. et al, *American Journal of Infection Control*, vol. 33, no.6, August 2005.

15. **Diabetes mellitus and cardiothoracic surgical site infections,** Talbot T., *American Journal of Infection Control*, vol. 33, no.6, August 2005.

16. **A proactive approach to prevention of health care–acquired Legionnaires' disease: The Allegheny County (Pittsburgh) experience,** Squier C. et al, *American Journal of Infection Control*, vol. 33, no.6, August 2005.

17. **Focus group data as a tool in assessing effectiveness of a hand hygiene campaign,** Thomas M. et al, *American Journal of Infection Control*, vol. 33, no.6, August 2005.

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

18. **Tetrasodium EDTA as a Novel Central Venous Catheter Lock Solution Against Biofilm,** Steven L. Percival et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.6, June 2005.

19. **A Randomized, Controlled Trial of a New Vascular Catheter Flush Solution (Minocycline–EDTA) in Temporary Hemodialysis Access,** Anthony J. Bleyer et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.6, June 2005.

20. **Why Is It That Internists Do Not Follow Guidelines for Preventing Intravascular Catheter Infections?,** Lewis Rubinson et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.6, June 2005.

21. **Clinical Outcomes and Costs Due to *Staphylococcus aureus* Bacteremia Among Patients Receiving Long-Term Hemodialysis,** John J. Engemann et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.6, June 2005.

22. **Excess Mortality, Hospital Stay, and Cost Due to Candidemia: A Case–Control Study Using Data From Population-Based Candidemia Surveillance,** Juliette Morgan et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.6, June 2005.

23. **Secular Trends of Candidemia in a Large Tertiary-Care Hospital From 1988 to 2000: Emergence of *Candida parapsilosis*,** Lucía García San Miguel et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.6, June 2005.

24. **Determining the Clinical Significance of Coagulase-Negative Staphylococci Isolated From Blood Cultures,** Susan E. Beekmann et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.6, June 2005.

25. **Dynamics of Hemodialysis Catheter Colonization by Coagulase-Negative Staphylococci,** Christoph A. Fux et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.6, June 2005.

26. **Colonization Status and Appropriate Antibiotic Therapy for Nosocomial Bacteremia Caused by**

Antibiotic-Resistant Gram-Negative Bacteria in an Intensive Care Unit, Stijn Blotn et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.6, June 2005.

27. **Use of Stochastic Epidemic Modeling to Quantify Transmission Rates of Colonization With Methicillin-Resistant *Staphylococcus aureus* in an Intensive Care Unit,** Marie Forrester et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.7, July 2005.

28. **Modeling Transmission of Methicillin-Resistant *Staphylococcus aureus* Among Patients Admitted to a Hospital,** Janet Raboud et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.7, July 2005.

29. **Eradication of Methicillin-Resistant *Staphylococcus aureus* From a Neonatal Intensive Care Unit by Active Surveillance and Aggressive Infection Control Measures,** Jad Khoury et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.7, July 2005.

30. ***Staphylococcus aureus* Colonization and the Risk of Infection in Critically Ill Patients,** Adam Keene et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.7, July 2005.

31. **Methicillin-Resistant *Staphylococcus aureus* Carriage Among Patients After Hospital Discharge,** Menno R. Vriens et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.7, July 2005.

32. **Importance of Control Group Selection for Evaluating Antimicrobial Use as a Risk Factor for Methicillin-Resistant *Staphylococcus aureus* Bacteremia,** Erika J. Ernst et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.7, July 2005.

33. **Use of Strain Typing Data to Estimate Bacterial Transmission Rates in Healthcare Settings,** Brian R. Jackson et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.7, July 2005.

34. **Control of Vancomycin-Resistant Enterococci in the Neonatal Intensive Care Unit,** Nalini Singh et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.7, July 2005.

35. **Reduction in Nosocomial Transmission of Drug-Resistant Bacteria After Introduction of an Alcohol-Based Handrub,** Fred M. Gordin et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.7, July 2005.

36. **Risk Factors for Nosocomial Infective Endocarditis in Patients With Methicillin-Resistant *Staphylococcus aureus* Bacteremia,** Ron-Bin Hsu, *Infection Control and Hospital Epidemiology*, vol. 26, no.7, July 2005.

37. **Catheter Related Vancomycin Resistant *Enterococcus faecium* Bacteremia: Clinical and Molecular Epidemiology,** Issam I. Raad et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.7, July 2005.

38. **Mupirocin for Controlling Methicillin-Resistant *Staphylococcus aureus*: Lessons From a Decade of Use at a University Hospital,** Adriana M. et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.7, July 2005.

39. **Varying Rates of *Clostridium difficile*–Associated Diarrhea at Prevention Epicenter Hospitals,** SeJean Sohn et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.8, August 2005.

40. **Risk Factors for Acquisition of *Clostridium difficile*–Associated Diarrhea Among Outpatients at a Cancer Hospital,** Tara N. Palmore et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.8, August 2005.

41. ***Clostridium difficile* Among Hospitalized Patients Receiving Antibiotics: A Case–Control Study,** Scott Modena et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.8, August 2005.

42. **Spatial and Temporal Analysis of *Clostridium difficile* Infection in Patients at a Pediatric Hospital in California,** Carmen E. Rexach et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.8, August 2005.

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44. **Octenidine Hydrochloride for the Care of Central Venous Catheter Insertion Sites in Severely Immunocompromised Patients,** Andreas Tietz et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.8, August 2005.

45. **The Effects of Prolonged Ethanol Exposure on the Mechanical Properties of Polyurethane and Silicone Catheters Used for Intravascular Access,** Christopher J. Crnich et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.8, August 2005.

46. **Nonuniform Risk of Bloodstream Infection With Increasing Central Venous Catheter–Days,** Mary-Louise McLaws and Geoffrey Berry, *Infection Control and Hospital Epidemiology*, vol. 26, no.8, August 2005.

47. **Cleaning and Sterilization Protocol for Reused Cardiac Electrophysiology Catheters Inactivates Hepatitis and Coxsackie Viruses,** Julian D. Druce et

al, *Infection Control and Hospital Epidemiology*, vol. 26, no.8, August 2005.

48. **Surveillance of Nosocomial Infections in a Neurologic Intensive Care Unit,** Dirk Zolldann et al, *Infection Control and Hospital Epidemiology*, vol. 26, no.8, August 2005.

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50. **An audit of the use of isolation facilities in a UK National Health Service trust,** S. Damji et al, *The Journal of Hospital Infection*, vol.60, no.3, July 2005.

51. **Hand hygiene posters: motivators or mixed messages?** E.A. Jenner et al, *The Journal of Hospital Infection*, vol.60, no.3, July 2005.

52. **Nanocrystalline silver dressings as an efficient anti-MRSA barrier: a new solution to an increasing problem,** R. Strohal et al, *The Journal of Hospital Infection*, vol.60, no.3, July 2005.

53. **Residual antibiotics in allograft heart valve tissue samples following antibiotic disinfection,** J.P. Leeming et al, *The Journal of Hospital Infection*, vol.60, no.3, July 2005.

54. **Non-touch fittings in hospitals: a procedure to eradicate *Pseudomonas aeruginosa* contamination,** N. van der Mee-Marquet et al, *The Journal of Hospital Infection*, vol.60, no.3, July 2005.

55. **Epidemiological analysis of carbapenem-sensitive and -resistant *Pseudomonas aeruginosa*,** F. Walsh et al, *The Journal of Hospital Infection*, vol.60, no.3, July 2005.

56. **Changes in antibiotic resistance of the most common Gram-negative bacteria isolated in intensive care units,** K.G. Makedou et al, *The Journal of Hospital Infection*, vol.60, no.3, July 2005.

57. **Antimicrobial activity of ultrasonic cleaners,** I. Muqbil et al, *The Journal of Hospital Infection*, vol.60, no.3, July 2005.

58. ***Acinetobacter baumannii:* emergence and spread in Israeli hospitals 1997–2002,** M. Paul et al, *The Journal of Hospital Infection*, vol.60, no.3, July 2005.

59. **Does hospital work constitute a risk factor for *Helicobacter pylori* infection?** P. Mastromarino et al, *The Journal of Hospital Infection*, vol.60, no.3, July 2005.

60. **Epidemiological characteristics of occupational blood exposures of healthcare workers in a university hospital in South Korea for 10 years,** H.S. Oh et al, *The Journal of Hospital Infection*, vol.60, no.3, July 2005.

61. **A descriptive, retrospective study of 567 accidental blood exposures in healthcare workers in three West African countries,** A. Tarantola et al, *The Journal of Hospital Infection*, vol.60, no.3, July 2005.

62. **Safe disposal and effective destruction of clinical wastes,** J.I. Blenkharn, *The Journal of Hospital Infection*, vol.60, no.4, August 2005.

63. **Evidence for the use of silver-alloy-coated urethral catheters,** K. Davenport and F.X. Keeley, *The Journal of Hospital Infection*, vol.60, no.4, August 2005.

64. **Does incineration turn infectious waste aseptic?** K. Kanemitsu et al, *The Journal of Hospital Infection*, vol.60, no.4, August 2005.

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66. **Outbreak of methicillin-resistant *Staphylococcus aureus* in two nursing homes in Central Norway,** K.W. Larssen et al, *The Journal of Hospital Infection*, vol.60, no.4, August 2005.

67. **Linkage of microbiology reports and hospital discharge diagnoses for surveillance of surgical site infections,** P. Spolaore et al, *The Journal of Hospital Infection*, vol.60, no.4, August 2005.

68. **Reliability of assessment of adherence to an antimicrobial treatment guideline,** P.G.M. Mol et al, *The Journal of Hospital Infection*, vol.60, no.4, August 2005.

69. **Estimating the proportion of community-associated methicillin-resistant *Staphylococcus aureus*: two definitions used in the USA yield dramatically different estimates,** D.V. Folden et al, *The Journal of Hospital Infection*, vol.60, no.4, August 2005.

70. **Follow-up of antibiotic prophylaxis: impact on compliance with guidelines and financial outcomes,** L. Willems et al, *The Journal of Hospital Infection*, vol.60, no.4, August 2005.

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73. **Colonization by high-level aminoglycoside-resistant enterococci in intensive care unit patients: epidemiology and clinical relevance,** J. Rodríguez-Baño et al, *The Journal of Hospital Infection*, vol.60, no.4, August 2005.

74. **Incidence of surgical site infections and accompanying risk factors in Vietnamese orthopaedic patients,**L.T.A. Thu et al, *The Journal of Hospital Infection*, vol.60, no.4, August 2005.

75. **Needlestick injuries in a tertiary care centre in Mumbai, India,** A. Mehta et al, *The Journal of Hospital Infection*, vol.60, no.4, August 2005.

76. **Medical students' knowledge of sharps injuries**, S.K.F. Elliott et al, *The Journal of Hospital Infection*, vol.60, no.4, August 2005.

77. **Hospital management of animal and human bites,** M. Morgan et al, *The Journal of Hospital Infection*, vol.61, no.1, September 2005.

78. **Antimicrobial susceptibility of polymerase chain reaction ribotypes of *Clostridium difficile* commonly isolated from symptomatic hospital patients in the UK,** R. John and J.S. Brazier, *The Journal of Hospital Infection*, vol.61, no.1, September 2005.

79. **An investigation of the factors that affect surgical hand disinfection with polyvidone iodine,** A. Aksoy et al, *The Journal of Hospital Infection*, vol.61, no.1, September 2005.

80. **Unusual implication of biopsy forceps in outbreaks of *Pseudomonas aeruginosa* infections and pseudo-infections related to bronchoscopy,** P. Corne et al, *The Journal of Hospital Infection*, vol.61, no.1, September 2005.

81. **Monitoring air sampling in operating theatres: can particle counting replace microbiological sampling?** A. Landrin et al, *The Journal of Hospital Infection*, vol.61, no.1, September 2005.

82. **Implementing hygiene monitoring systems in hospital laundries in order to reduce microbial contamination of hospital textiles,** S. Fijan et al, *The Journal of Hospital Infection*, vol.61, no.1, September 2005.

83. **Outbreaks of contaminated broncho-alveolar lavage related to intrinsically defective bronchoscopes,** J.-C. Cêtre et al, *The Journal of Hospital Infection*, vol.61, no.1, September 2005.

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85. **Reduction of exit-site infections of tunnelled intravascular catheters among neutropenic patients by sustained-release chlorhexidine dressings: results from a prospective randomized controlled trial,** S.T. Chambers et al, *The Journal of Hospital Infection*, vol.61, no.1, September 2005.

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87. **A case-control study of risk factors associated with rectal colonization of extended-spectrum beta-lactamase producing *Klebsiella* sp. in newborn infants,** N.-Y. Boo et al, *The Journal of Hospital Infection*, vol.61, no.1, September 2005.

88. **Better late than never: a re-examination of ethical dilemmas in coping with severe acute respiratory syndrome,** K.L. Ovadia et al, *The Journal of Hospital Infection*, vol.61, no.1, September 2005.

89. **Laboratory-acquired brucellosis: a Spanish national survey,** E. Bouza et al, *The Journal of Hospital Infection*, vol.61, no.1, September 2005.

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INFECTION CONTROL FOR CLEANERS OF HEALTH CARE FACILITIES
25 October (morning), 2005

This half-day morning workshop is for cleaners of health care facilities. It provides an overview of current infection control procedures related to cleaning.

TOPICS
Standard Precautions; Preventing the Transmission of Blood-Borne Infections (in particular Hepatitis B & C and HIV); Waste Management; and Cleaning Blood Spills
All information is delivered at a basic and easy to understand level

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

COURSE DETAILS:
$77 (including GST)
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E-mail: albeducation@sesahs.nsw.gov.au

INTRODUCTION TO INFECTION CONTROL FOR DENTAL ASSISTANTS
23 November, 2005

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

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

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COURSE DETAILS:
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INTRODUCTION TO INFECTION CONTROL NURSING
9 November, 2005

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.

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

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HIV PRE & POST TEST COUNSELLING
19 - 22 September, 2005

This four-day workshop is designed specifically for counselors and health care professionals who will be providing pre and post HIV test counseling. 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

VENUE
The Albion Street Centre
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Cough Etiquette & Respiratory Hygiene

IN HEALTH CARE SETTINGS

INFORMATION SHEET

STAFF

- **Cover nose/mouth when coughing, sneezing or spitting**
- **Use tissues to contain respiratory secretions and dispose them in the nearest waste bin or waste bag after use**
- **Perform hand hygiene after having contact with respiratory secretions and contaminated objects/materials by either:**
  ***Hand washing with cleaning solution and water; or**
  ***Alcohol-based hand gel or rub**
- **Staff with a respiratory illness should be clinically assessed prior to working**
- **Staff with a persistent cough lasting longer than 2 weeks should be medically assessed**
- **Reinforce the importance of cough etiquette and respiratory hygiene with patients and visitors**
- **Offer surgical masks to people coughing in common waiting areas, such as Emergency Department waiting rooms, if they are likely to be infectious**

PATIENTS & VISITORS

- **Patients and visitors should be encouraged to cover the nose/mouth when coughing sneezing or spitting**
- **Use tissues to contain respiratory secretions and dispose of them in the nearest waste bin or waste bag after use**
- **Patients and visitors should be encouraged to wash hands with soap and water after covering a cough or sneeze or spitting**
- **Patients coughing or sneezing should be advised to sit at least 1 metre away from others in common waiting areas and asked to wear a surgical mask**
- **Visitors with signs and symptoms of respiratory infection should be sensibly and sensitively discouraged from visiting patients**

HELP PREVENT THE TRANSMISSION OF RESPIRATORY INFECTIONS INCLUDING INFLUENZA (FLU)

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