

# In.CONTROL



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

**Volume 10, Issue 3,  
October, 2006**

As 2006 draws to a close, it is always useful to reflect on the year that was and what lies ahead for the infection control professional.

2006 has been a year that has focused a lot of effort on preparedness activities. Most notably, significant effort has been made in developing plans at federal, state and local levels for pandemic influenza preparedness. The Infection Control Resource Centre (ICRC) have been involved to support state and local preparedness plans with the development of infection control resources in collaboration with NSW Department of Health. The resources will include a generic set of posters for standard and transmission-based precautions, powerpoint presentations, posters for cough etiquette and respiratory hygiene, audit tools and competency assessments. These resources can be used state-wide ensure a consistent and uniform approach to basic infection control management strategies and also during the phases of a pandemic.

In other news it gives us great pleasure to introduce and welcome Sue Greig who recently joined the team at the NSW ICRC. Having extensive experience as an infection control professional, Sue brings a wealth of knowledge and expertise to the ICRC. As one door opens another door closes so we would also like to take this opportunity to say a 'big' thank you and good bye to Peta-Anne Zimmerman who leaves us this month on maternity leave to pursue the adventure of motherhood. We wish her and her husband all the very best and would also like to acknowledge Peta-Anne's valuable contribution and expertise to the ICRC. She will be sadly missed.

To continue with the welcomes we also would like to introduce Dr Susie Dracopoulos to the ICRC. Susie is an experienced dentist who has a special interest in infection prevention and control and we have been very fortunate to have Susie share her skills and knowledge in this highly specialised and unique area of infection control. Although Susie has been working along side us and contributing to our dental related infection control courses for some time now we invite those in the dental community to correspond with Susie through a new regular feature called "Ask Dr Susie." This is the perfect opportunity to have all those 'hairy' dental related infection control questions answered, which will be published in the next issue. As another regular feature Susie will also contribute a regular quarterly article specific to the dental community and covering a variety of infection control related topics.

In June this year I was invited to work for the World Health Organisation (WHO) as a short term consultant for infection control in Papua New Guinea (PNG). My assignment was of two weeks duration and included identifying the current infection control situation in central and provincial PNG in light of avian influenza, making necessary recommendations and conducting relevant training workshops.

The assignment took me to the country's capital Port Moresby at the only tertiary referral hospital (Port Moresby General Hospital) and then to a western provincial town hospital called Vanimo General Hospital to review infection control programs. The visit highlighted the great disparity that existed between infection control in Australia and countries such as PNG. What

we access everyday for infection prevention and control programs in NSW are very difficult to access in resource poor settings. These include, supplies of soap and running water, consistent supply of personal protective equipment, knowledge of standard precautions and an understanding of disease transmission. This results in poor patient placement and stigma against patients with blood borne viruses especially in relation to HIV.

Resource poor countries such as PNG will need a basic understanding of simple yet highly effective infection prevention and control principles to enable them to combat emerging and re-emerging pathogens that currently face the globe today.



No matter which country, we all still face similar infection control dilemmas

On a personal and a professional level my time in PNG proved both challenging and rewarding and gave me great insight into the complexities that face countries that are attempting to implement effective infection prevention control programs who are faced with limited access to resources and financial support. This valuable opportunity has given me an appreciation for what we have here in NSW in relation to the abundance of health care resources and our ability to implement and maintain effective infection control programs.



The open-plan 'Nightingale' style wards at Port Moresby General Hospital

I would like to take this opportunity to thank our infection control colleagues in PNG for their time and assistance during my visit and also to Congratulate them for their dedication and determination to infection control as a profession in light of the many hardships they continue to face.

**Peter Said**  
**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 relating to Infection Control issues that have been released by the NSW Department of Health*

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 <i>(Replaces PD2005_610 Complaint or Concern About a Clinician – Management)</i>
PD2006_007	COMPLAINT OR CONCERN ABOUT A CLINICIAN _ PRINCIPLES FOR ACTION <i>(Replaces PD2005_610 Complaint or Concern About a Clinician – Management)</i>
PD2006_014	NOTIFICATION OF INFECTIOUS DISEASES UNDER THE PUBLIC HEALTH ACT 1991 <i>(Supersedes Notification of Infectious Diseases under the Public Health Act 1991 [PD2005_359])</i>
PD2006_030	INCIDENT MANAGEMENT POLICY <i>(Replaces Incident Management Policy [PD2005_604], Incident Information System (IIMS) Policy NSW [PD2005_404])</i>
PD2006_035	HIV ANTIBODY TESTING BY LABORATORIES IN NSW <i>(Replaces HIV Antibody testing by laboratories in NSW [PD2005_194])</i>
PD2006_037	NEEDLE AND SYRINGE PROGRAM POLICY AND GUIDELINES FOR NSW
GL2006_010	HAZARDOUS SUBSTANCES AND DANGEROUS GOODS IN NSW HEALTH-GUIDELINES FOR SAFE USE <i>(Replaces Hazardous Substances in NSW Public Health Care Facilities (Policy and Guidelines for the Safe Use) [PD2005_129])</i>
PD2006_058	RESEARCH AND INVESTIGATION AUTHORISED UNDER THE HEALTH ADMINISTRATION ACT 1982
PD2006_057	IMMUNISATION SERVICES – AUTHORITY FOR REGISTERED NURSES <i>(Replaces immunisation services – Authority for registered nurses [PD2005_229])</i>
GL2006_012	ANIMALS – THERAPY COMPANION IN PUBLIC AND PRIVATE HOSPITALS
PD2006_070	LOOKBACK

**Copies of NSW Department of Policy Directives and Guidelines  
can be obtained from the NSW Health web site:**

**[www.health.nsw.gov.au](http://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.**

*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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### **In.Control**

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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\_058 Research and Investigation Authorized Under the Health Administration Act 1982**

The policy outlines the role and functions of the committees which have been authorized under Section 23 of the Health Administration Act. It describes the privilege applying to information obtained by authorized committees and provides guidance on the impact of the privilege and how public health organizations should interact with authorized committees.

### **PD2006\_057 Immunisation Services – Authority for Registered Nurses**

Details the authority that applies to registered nurses with specialist training to carry out vaccination programs, which are complementary to those provided by medical practitioners. This policy directive applies to a class of registered nurses who have completed defined training in immunisation. It is not applicable to registered nurses who have not completed such defined training but who may administer vaccines under the direction and authorization of a medical officer. The policy lists specific vaccines and definitive conditions, to which specially trained registered nurses must conform.

### **GL2006\_012 Animals – Therapy Companion in Public and Private Hospitals**

These guidelines set out the appropriate steps to be taken in implementing a program of animal assisted intervention in NSW public and private health facilities. They seek to standardise practice and to encourage the adoption of animal therapies where appropriate. The guidelines cover issues involved in having a therapy companion animals program. They do not specifically consider issues associated with resident animals, nor do they apply to the use of animals that perform a specific function or task, such as guide dogs, where their management and practice is well established. A section pertaining specifically to infection control is of particular importance to infection control professionals. Here emphasis is made on veterinary screening prior to facility entry in an attempt to minimise the risk of transmission of common zoonoses.

### **PD2006\_070 Lookback**

approach for notification and management of potentially/affected patients when necessary.

# **MEDIA WATCH AUSTRALIA**

## **July**

In promotion of World Breastfeeding Week Parliamentary Health Secretary Christopher Pyne, said that breast-fed babies have greater immunity to **colds and flu** and are less likely to develop other chronic illnesses such as **diabetes, cardiovascular disease and asthma**. The article by AAP reported that a number of national and international health authorities recommend that children should be given only breastmilk, with no other food or infant formula, for the first six months of life. Food can then be introduced after six months, but breastfeeding should continue until 12 months of age.

An article in the *Sydney Morning Herald* reported that the Minister of Health, Tony Abbott, has proposed an upgrade in health services for Saibai Island, Torres Strait, due to the risk of **HIV/AIDS** spreading from Papua New Guinea. Saibai Island is only a 15 minute boat trip from the nearest PNG town, Daru, where there are reportedly hundreds of HIV/AIDS cases. It is estimated that 50,000 PNG citizens visit nearby Australian islands each year, due to relaxed border control in recognition of historic links in the Torres Strait.

Dr Stephen Lambert of the University of Melbourne reported in a *Sydney Morning Herald* article that **influenza** in children costs the community three times as much as

illnesses caused by other viruses, prompting calls for a government funded influenza vaccination program for children. Dr Lambert stated “Not only are there potential benefits in vaccinating children and protecting children themselves against it, but there are also benefits in stopping transmission to parents and grandparents”. A spokeswoman for the Australian Vaccination Network however was reported to say that she could not imagine any cost-benefit of vaccinating children.

An article in the *Sydney Morning Herald* reported that vaccines and vaccination are becoming more popular as acceptance of their effectiveness grows. According to the report Australia’s infants are already the most vaccinated generation in history as under the current immunisation schedule, updated in November last year, babies can expect no fewer than 19 injections before their first birthday.

KR Castlemaine, one of Australia’s largest meat producers, issued a nationwide recall of some of its products after an employee fell ill with **hepatitis A**. The **AAP** article reported that though the illness makes people sick for weeks it is unlikely to be fatal.

An article in the *Courier Mail* reported that Australian businesses, such as Telstra, Bluescope Steel and the Commonwealth Bank are taking the threat of **pandemic influenza** very seriously by establishing pandemic risk committees and pandemic planning project managers. Other companies, such as BHP Billiton, have established stockpiles of antiviral drugs in offices considered at high risk.

#### August

A possible labelling mix-up among 135 people whose blood was tested on the same day by the Western Australian Health Department pathology laboratory led to an alert from health authorities. An **AAP** article reported that health authorities in Western Australia are trying to track down 90 people, believing that one of them may unknowingly have **HIV**. Of the 135 people who had been tested one person had been initially told they had HIV, only to learn a further test had proved to be negative, leaving a positive HIV result with no name. It is thought that the HIV test may have been mistakenly conducted on the blood sample, which may have been collected for other tests.

Scientists have warned that Australia must prepare for an outbreak of **Clostridium difficile**. An **AAP** article, quotes Professor Thomas Riley of the University of Western Australia who warns that Australia could follow the trend in Canada, Europe and the United States which have all recently seen sudden increases in rates of infection and death, particularly among the elderly. Strains of **C. difficile** have also shown increasing resistance to antibiotics. In an article written for the Medical Journal of Australia Professor Riley states, “The value of sensible policies regarding antibiotic use, and good infection control staff and procedures, cannot be overemphasised”.

Professor Jonathon Carapetis of the Menzies School of Health Research in Darwin has been the lead author of the first evidence-based guidelines for the control of acute **rheumatic fever** in Australia, an article from the *Sydney Morning Herald* reports. Rheumatic fever, caused by a **Streptococcal A** bacterial infection, is a painful and potentially fatal disease that is almost never seen in Western society but has reached world-record levels among indigenous Australians. The guidelines are designed to improve diagnosis and management of rheumatic fever and rheumatic heart disease, particularly in this population group.

An **AAP** article reported that a new Federal Government program of \$3.5 million will target Australians at high risk of contracting **chlamydia**. Chlamydia is reported to be Australia’s most common sexually transmitted disease, with approximately 41,000 people contracting it last year. High risk groups which will be targeted include young people aged 16-25 years, Aboriginal and Torres Strait Islanders, homosexual men and pregnant women. Untreated chlamydia infections, which can often present with no symptoms, can lead to complications including infertility.

## MEDIA WATCH WORLD

#### July

A *Sydney Morning Herald* article reported that **GlaxoSmithKline** has developed a vaccine for **avian influenza**, which may be more effective and plentiful than anything invented so far. The company has identified and patented a substance that boosts the effectiveness of the vaccine at about one twentieth of the current dose, hence stretching the vaccine supply twenty fold. The vaccine is still undergoing testing.

A new study, reported in the *Sydney Morning Herald*, has found that **HIV** replicates in the lining of the intestines and does much of the damage to the immune system there. Satya Dandekar, of the Department of Medical Microbiology and Immunology at the University of California Davis Health System, said that because of this efforts need to be focused on improving treatment of gut mucosa and it also explains why drug treatments taken by HIV patients so often fail to work completely.

#### August

A *Reuters* article reported that new outbreaks of **avian influenza** in Thailand and Laos are “fanning fears the disease is flaring up again in Asia”. The article reported that a 35-year old man had been hospitalised in a southern

province of Viet Nam, which borders on Cambodia and that there were signs of spread into central Thailand.

An article from *AAP* reported that seven Indonesians from the same village in North Sumatra have been hospitalised and are being tested for **avian influenza**. The new possible cases come from the same district where bird flu killed seven people in May this year. Indonesian official reported that chickens in the area had died and tested positive for avian influenza. However angry local villagers protested so much that the planned cull of chickens had to be called off and the army was required to restore order in the district. The article reports that many in Indonesia oppose culling, contesting whether the chickens are truly sick and opposing the very small compensation which is paid if a bird is culled. It was still to be established if human-to-human transmission was involved in the latest suspected cases.

It was reported in a *Reuters* article that 10 years after introduction of **HIV/AIDS** drugs in Europe and North America they are still effective, though many patients are not being started on them soon enough. The research had been published prior to an international AIDS conference in Toronto.

A 50 year-old man in Scotland has died from **anthrax**, the first case there since 1987, *Reuters* reported. The man worked with untreated animal hides, which is a risk factor for acquiring anthrax. The man worked from home and it is thought that the man inhaled spores during the course of his work. Health authorities are contact tracing people who may have visited the home during the period when the man contracted the infection.

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## CALLING ALL DENTAL STAFF

***Do you have an related infection control dental related question? Then why not...***

**“ASK DR SUSIE”**

## DENTAL UNIT WATER LINES, WHY FLUSH?

**By Dr Susie Dracopolous**

Dental unit water lines are a breeding ground for biofilm. The wet, stagnant environment allows micro organisms to flourish. Although not visible to the eye, the quality of water emitted from these lines for the first patient on Monday morning after the micro-organisms have had time to multiply over the weekend will make you cringe.

Biofilm cannot be eliminated entirely but can be limited by flushing, chemically treating and maintaining water filters. Flushing air and water lines for two minutes at the beginning of the day causes a mechanical disruption reducing the thickness of biofilm. Flushing for 20 seconds between patients also aids in moving debris from the lines and suction tubes. At the same time you are flushing internal components of devices such as handpieces, ultrasonic handpieces, triplex and suction tips, one of the first steps in the cleaning process.

Other ways to keep dental unit water lines clean is to regularly use a chemical treatment recommended by the manufacturer of the dental unit/ chair. Some units with self contained water bottles can also use continuous chemical treatment of the water by use of hydrogen peroxide tablets. Air purging and drying the water lines at the end of each day also helps eliminate the warm, wet environment needed for bacterial growth.

*The Commonwealth Department of Health and Ageing (2004) Infection Control Guidelines for the Prevention of Transmission of Infectious Diseases in the Health Care Setting (Commonwealth of Australia, January 2004)* recommends that sterile water is used for sterile procedures and that water used for tooth preparation and ultrasonic scaling of teeth be of potable standard < 500CFU. Quality of water can easily and inexpensively be tested by dental staff; even new dental units (one week old) have been reported to have high levels of bacteria in their water lines. It is also important to ensure that water filters are regularly checked and maintained in accordance with manufacture's guidelines.

*Dr Susie Dracopolous is a dentist with a particular interest in infection control. She joined the NSW Infection Control Resource Centre in 2005 as a lecturer and assists in teaching introductory infection control courses for dental assistants.*

## INFECTION CONTROL CONFERENCES

**6<sup>th</sup> 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](mailto:info@his2006.com)

Website: [www.his2006.com](http://www.his2006.com)

**THE NEW ZEALAND DENTAL HYGIENISTS' ASSOCIATION BIENNIAL INTERNATIONAL CONFERENCE**  
2-4 November, 2006  
Auckland, New Zealand  
**Contact:**  
Website: [www.nzdha.co.nz](http://www.nzdha.co.nz)

**INTERNATIONAL MEETING ON EMERGING DISEASES AND SURVEILLANCE (IMED)**  
23-25 February, 2007  
Vienna, Austria  
**Contact:**  
Website: [www.imed.isid.org/](http://www.imed.isid.org/)

**9<sup>th</sup> NATIONAL RURAL HEALTH CONFERENCE**  
7-10 March, 2007  
Albury, NSW, Australia  
**Contact:**  
Email: [conference@ruralhealth.org.au](mailto:conference@ruralhealth.org.au)  
Website: [www.ruralhealth.org.au](http://www.ruralhealth.org.au)

**17<sup>th</sup> SOCIETY OF HEALTHCARE EPIDEMIOLOGISTS OF AMERICA (SHEA) ANNUAL MEETING**  
14-17 April, 2007  
Baltimore, Maryland, USA  
**Contact:**  
Website: [http://www.shea-online.org/about/future\\_meetings.cfm](http://www.shea-online.org/about/future_meetings.cfm)

**COMMUNITY AND HOSPITAL INFECTION CONTROL ASSOCIATION – CANADA CONFERENCE**  
9-14 June, 2007  
Alberta, Canada  
**Contact:**  
Website: [http://www.chica.org/conf\\_registration.html](http://www.chica.org/conf_registration.html)

**34<sup>th</sup> ANNUAL EDUCATIONAL CONFERENCE AND MEETING OF THE ASSOCIATION FOR PROFESSIONALS IN INFECTION CONTROL AND EPIDEMIOLOGY (APIC)**  
24-28 June, 2007  
San Jose, California, USA  
**Contact:**  
Website:  
[www.apic.org/scriptcontenet/custom/sites/ac2007/index.cfm](http://www.apic.org/scriptcontenet/custom/sites/ac2007/index.cfm)

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

**17<sup>TH</sup> INTERNATIONAL SYMPOSIUM ON DENTAL HYGIENE – INTERNATIONAL FEDERATION OF DENTAL HYGIENISTS**  
19-21 July, 2007  
Toronto, Canada  
**Contact:**  
Website: [www.cdha.ca/ifdh.asp](http://www.cdha.ca/ifdh.asp)

**5<sup>th</sup> WORLD CONGRESS OF THE WORLD SOCIETY FOR PEDIATRIC INFECTIOUS DISEASES**  
15-18 November, 2007  
Bangkok, Thailand  
**Contact:**  
Email: [wspid@kenes.com](mailto:wspid@kenes.com)  
Website: [www.kenes.com/wspid/](http://www.kenes.com/wspid/)

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## **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](http://www.uow.edu.au/health/safehands/index.html)  
 and click on the 'membership' page.

OR  
 Email: [safehands@sesahs.nsw.gov.au](mailto: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.

## 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 an agency nurse and often work in aged care facilities. I recently worked for an aged care facility that restricted the use of medical examination gloves to six (6) pairs per shift. I am very concerned about this practice especially in relation to my own safety and also the safety of the residents I care for. Can you tell me is there anything I can do about this unsafe practice?

**A.** This practice is unsafe it is in breach of NSW legislation. This practice potentially breaches the NSW state Infection Control Policy and the Infection Control Regulations for 6 disciplines of health care workers including registered nurses. It is also in breach of the Occupational Health and Safety Act 2000 as it fails to provide a safe work environment.

Gloves are required for standard precautions. Gloves **MUST** be worn if there is actual or potential contact with blood and/or body fluids. It is impossible to estimate the number of gloves necessary to perform the many tasks or

procedures undertaken by healthcare workers on a given day. There are however a number of occasions for which gloves may be used inappropriately such as during bed making. If the issue of reducing glove usage is purely based on financial considerations then perhaps identifying areas where glove usage is not warranted and providing relevant education to support this would be more beneficial and cost effective.

**Q.** I recently read an article in the media about a health care worker who was infected with HIV and was currently practicing. Are there any work restrictions for healthcare workers who have blood borne viruses (BBV)?

**A.** A number of healthcare workers who are infected with blood borne viruses and are practicing in a number of professions safely as the risk of transmitting a BBV to a patient is extremely low. However there are certain procedures that constitute a much greater risk to the patient. Such procedures are termed exposure prone procedures (EPPs) and may be performed by surgeons, dentists and midwives. EPPs according to PD2005\_162 *HIV, Hepatitis B or C – Health care workers infected*, are defined as “a subset of invasive procedures where there is potential for contact between the skin (usually finger or thumb) of the HCW and sharp surgical instruments, needles or sharp tissues (splinters/pieces of bone/tooth) in body cavities or in poorly visualized or confined body sites including the mouth.” In accordance with this policy HCWs who perform EPPs must be aware of their HIV, HBV and HCV status by seeking serological testing and those HCWs who are either HCV PCR positive, or HBeAg positive, or HIV positive must not perform EPPs. Those healthcare workers who are excluded from performing EPPs due to their BBV status may need to have their work practices modified or to be transferred from duties.

**Q.** I recently heard a story on the evening news about a group of school children that were potentially exposed to hepatitis A. Can you tell me how Hepatitis A is transmitted and what the main differences are between hepatitis A, B and C?

**A.** Your question is indeed a very common one. It is probably important to firstly clarify what hepatitis actually is. Hepatitis refers to inflammation of the liver and can originate in a number of ways. It can be caused by chemicals, or drugs, or by different kinds of viral infections. The clinical picture of hepatitis tends to be fairly generic and includes symptoms such as aches and pains, nausea, lack of appetite, abdominal discomfort, darkening of the urine and jaundice. hepatitis A (HAV) is spread by the faecal-oral route and may be transmitted by eating food handled by an infected person or by direct contact with faeces or vomit from an infected person. The symptoms of both hepatitis B (HBV) and hepatitis C (HCV) are similar in presentation to hepatitis A; however their modes of transmission are significantly different. hepatitis B virus is

found in almost all body fluids of an infected person but is particularly infectious in and predominately transferred through blood and sexual secretions. hepatitis C is found almost exclusively in blood and therefore requires blood to blood transmission. Other important differences between hepatitis A and B and C are there are no long-term sequelae caused by HAV, however a person who has HBV or HCV has an increased risk of liver disease and the potential to carry and transmit the disease for life as a result of being infected.

## TEST YOUR IQ

So – how did everyone go on the first quiz? Here is the new quiz followed by the answers to the questions in the last edition of In.Control.

### NEW QUIZ:

1. **Which of the following is not part of acceptable first aid after an occupational blood exposure?**
  - A. Washing puncture wounds with soap and water
  - B. Flushing mucous membranes with water
  - C. Using antiseptics where indicated
  - D. Applying bleach over the wound
2. **Sterilization implies**
  - A. Absence of all living forms
  - B. Inhibition of bacterial growth
  - C. Removal of pathogenic bacteria only
  - D. Removal of pathogenic bacteria, viruses and fungi
3. **The highest numbers of *Streptococcus salivarius* are found in the oral cavity in which areas?**
  - A. Saliva and teeth
  - B. Tongue and saliva
  - C. Teeth and buccal mucosa
  - D. Gingival crevice (sulcus) and tongue
4. **The proper order for REMOVING personal protective equipment (PPE) is**
  - A. Mask, eyewear, gloves then gown
  - B. Gown, gloves, mask then eyewear
  - C. Gloves, gown, eyewear then mask
  - D. Eyewear, mask, gown then gloves

5. **If you MUST recap needles in the dental setting, to safely do so you must use**
  - A. The “one-handed scoop” technique
  - B. A recapping device
  - C. Both A and B are acceptable
6. **If you have a sharps injury and the site is not bleeding, you should squeeze it until it bleeds**
  - A. True
  - B. False

### QUIZ ANSWERS FROM THE LAST NEWSLETTER:

1. **For infections acquired during the provision of healthcare, we now use the term ‘healthcare associated infection’ (HAI). What term did we use before?** b) Nosocomial infections
2. **For an infection to be defined as an “HAI” what criteria needs to be met?** c) There must have been no evidence of an infection present or incubating at the time of admission
3. **What is the single most important procedure in the prevention of infections?** d) Hand hygiene
4. **Respiratory and cough etiquette includes?** b) Covering the mouth and nose when sneezing and coughing
5. **Which of the following agents used for routine decontamination of visibly clean hands in healthcare settings is most bactericidal and least irritating to the skin?** a) alcohol based hand rub
6. **Alcohol-based hand rub should not be used:** d) If hands are visibly soiled or dirty
7. **Which of the following diseases are preventable by immunisation?** All listed
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 and e) Nausea, vomiting or diarrhoea
9. **Which is not considered a potentially infectious material?** 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? C) No further management, this is not considered an exposure, as outlined in NSW Health policy. Reporting of the incident may be required for OH&S requirements.

## Respiratory Hygiene Posters

The NSW Infection Control Resource Centre, with funding from NSW Health, has developed a series of two respiratory hygiene posters, one aimed at healthcare workers and the other at patients and visitors. Developed to coincide with the current influenza season the posters are also equally useful in combating many other respiratory like infections. The posters are in colour and A3 in size (297mm x 420mm).



**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](mailto:albicr@sesahs.nsw.gov.au)  
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# PROFILING INFECTION CONTROL

*The many faces of an Infection Control Professional*

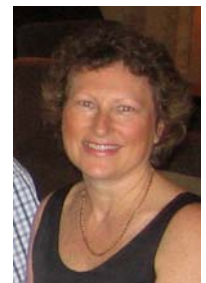
*Infection Control Professionals (ICPs) work in a variety of settings and have a range of experiences and educational backgrounds. From the public hospital system to remote rural settings, from the community to resource poor countries and from the correctional setting to private practice, the world of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

*This regular feature profiles the many faces of the Infection Control Professional. In this issue we profile our two new team members, Sue Greig and Dr Susie Dracopolous.*

## SUE GREIG

### Describe your current role.

I am full time Infection Control CNC at Sydney Hospital and Sydney Eye Hospital. However, from July 2006 to February 2007 I am seconded to the NSW Infection Control Resource Centre for 16hrs/week as well.



### What was your career path that brought you to your current position?

I have been a nurse since about the Dark Ages, training in a large metropolitan teaching hospital and then working in Urology and Intensive Care. I left nursing for about 10 years going into retail to manage a franchise shop in David Jones, renovating a house and having children. Once my children were at school, my brain needed to be stimulated and I went back to nursing in a small private hospital that offered flexibility to my family life. Whilst here, the facility was preparing for Accreditation and I was nominated as the Infection Control nurse. The then DON was very supportive of the importance of infection control and dedicated time was allocated to the position together with the offer of education and professional support. In 1995 I completed the Sydney Hospital Post Registration Infection Control Course and in 1997 I was successful in gaining the position of Infection Control CNC at Sydney Hospital. In 2001, I completed a Masters of Nursing (Infection Control) at the University of Sydney.

### What do you like most about your job?

The variety – you never know what you will be doing next.

### What do you dislike about your job?

Having a 'to do' list that just keeps growing.

### What are you reading at the moment?

'Odd Socks' by Ilsa Evans

### What is your favourite film?

Pretty Woman

### What is your favourite saying?

‘There is nothing common about common sense’

### If you could change anything about the world what would it be?

There are lots of things about the world that we dream about changing but the current theory on ‘social correctness’ that has infiltrated society today allows for discrimination and exploitation – give the right person the job because they are the best person for that position not because of their sex, colour, creed or politics.

## DR SUSIE DRACOPOLOUS

### Please describe your current role.

I am a dentist with an interest in infection control and education. I joined the NSW Infection Control Resource Centre in 2005 as a lecturer and to assist in teaching dental assistants’ introductory infection control courses.



### What was your career path that brought you to your current position?

I graduated from the University of Sydney with a Bachelor of Dental Surgery in 1992. My career as a dentist started at Westmead Centre for Oral Health where I eventually became involved in teaching Four Handed Dentistry to dentists, dental assistants and students. This role also included an element of infection control. After a few years I moved on to work in private practice in a variety of settings including health funds, suburban and CBD clinics. Eventually I returned to Westmead Centre of Oral Health to continue with teaching Four Handed Dentistry and chairing the Infection Control Committee. It was the latter position that allowed me to combine my passion of infection control and teaching to develop my current role as a Dental Infection Control Professional.

### What do you like most about your job?

I love the networking, meeting new people and expanding my knowledge of infection control outside the dental arena.

### What do you dislike about your job?

I don’t dislike being an ICP, I love it! However if I put on my dentist’s hat the answer to the same question can be a little different.

### What are you reading at the moment?

I’d like to say it is the latest best seller but I don’t have time for novels these days. It is usually last month’s ADA (Australian Dental Association) News Bulletin or last month’s *Women’s Weekly* magazine, usually the Colossus crossword puzzle.

### What is your favourite film?

Love Actually

### What is your favourite saying?

“There is no such thing as the three second rule!” Even my 18 month old knows that but I still let him play in the dirt for good measure – he’ll only try eating it once.

### If you could change anything about the world what would it be?

Firstly, establish world peace, abolish hunger and poverty. Then, wouldn’t it be nice if it was possible to do the things you wish you could if only you had the time?

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## NEW VIDEOS

### Infection Control: Chain Reaction

Every healthcare facility requires a comprehensive infection control program. Everyone who works in healthcare should be concerned. This new video program will teach your workers how to protect themselves and their patients from infection. Your employees will learn about the tools needed to break the infection transmission chain.

- Handwashing
- Immunisations
- Standard Precautions
- Placement evaluations

Length: 22mins

### Infection Control – Essential Practices and Procedures

This training presentation details the latest infection control practices and procedures for the health care sector. The guidelines are internationally recognized as current best practice. This presentation is an ideal training aid and safety refresher for all personnel who work in the healthcare industry, particularly long-term care facilities.

Length: 36mins

### Malaria – The silent plague

Forty years ago we believed that science had conquered malaria. But the mosquitoes and the parasites survived and are back stronger than ever. A disturbing picture is emerging of 2 to 3 million people, mostly children dying

annually of malaria in tropical countries – their deaths going largely unnoticed by the international community.

Length: 46mins

### **Confronting Epidemics – Three case studies: SARS, AIDS, Influenza**

This program examines modern day epidemics, using three case studies from the late 20<sup>th</sup> and early 21<sup>st</sup> centuries – SARS, HIV/AIDS, and influenza. Firstly, SARS took the world by surprise in early 2003, and was particularly prevalent in Hong Kong and the south of China. The program looks at the response by authorities in the area, and outlines how the Australian government handles fears. Secondly, HIV/AIDS exists in epidemic proportions in southern Africa, and the program includes reports from ABC journalists from South Africa and Kenya. The third epidemic, influenza has been around for more than a century and has claimed more human lives than any other disease. Experts predict that another epidemic could hit at any minute and the program explores how Australia is preparing itself. Extracts from ABC current affairs programs were used in the making of this program.

Length: 22mins

### **Battle Scars: An overview of our defence against disease**

This program investigates the human immune system and the body's defences against disease. Topics covered in this comprehensive program include:

- A review of the types of disease and the main groups of pathogens
- The first line of defence – physical barriers against pathogens
- How pathogens gain entry into the body
- The formation and main types of blood cells
- The second line of defence – non-specific immune response
- The role of phagocytes
- Complement and marker proteins and 'self' identification
- The third line of defence – specific immune response
- Blood based immune response
- Cell-mediated immune response
- Clonal Selection Theory
- The nature of immunity

This excellent program features dramatized footage, 2-D animation and photo-microscopy.

Length: 30mins

### **Superbugs: A case of natural selection**

Antibiotic –resistant bacteria – “superbugs” – are a growing threat to public health. Where do they come from? And why is the problem getting worse? Superbugs are the result of natural selection. This program examines:

- The essential features of Darwin's idea of natural selection
- Malaria – resistance to anti-malarial drugs in the parasite and mosquito carrier

- Other antibiotic-resistant bacteria (MRSA, VRE)
- How hospitals are grappling with the problem

Length: 20mins

## 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**

## 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**.

FACT FILE  
**MENINGOCOCCAL  
 DISEASE**

A timely Reminder

*Adapted from The NSW Health Department's communicable disease factsheet*

### WHAT IS MENINGOCOCCAL DISEASE?

Meningococcal disease is a serious illness that usually causes meningitis (inflammation of the lining of the brain and spinal cord) and/or septicaemia (blood poisoning). The disease is uncommon. It affects between 150-200 people in NSW each year and the incidence has steadily fallen since the introduction of the meningococcal C conjugate vaccine.

It is caused by infection with *Neisseria meningitidis* bacteria of which there are several different groups. In NSW, *meningococcus* group B causes about half of the cases of meningococcal disease and group C now causes about one tenth of cases.

Meningococcus can live at the back of the nose and throat of 5 to 25 per cent of people, without causing any illness or symptoms. The circumstances that lead to invasive disease are not well understood.

### WHAT ARE THE SYMPTOMS?

Symptoms of invasive meningococcal disease may include sudden onset of fever, headache, tiredness, neck stiffness, joint pain, a rash of red-purple spots or bruises, dislike of bright lights, vomiting and nausea. Not all of the symptoms may be present at once.

Young children may have less specific symptoms. These may include irritability, difficulty walking, high-pitched crying, and refusal to eat.

A rash does not always appear and can be a late sign.

### HOW IS IT SPREAD?

Meningococcal bacteria are spread from person to person by secretions from the back of the nose and throat of a carrier who is usually well. However the bacteria are not easily spread from person to person. Close and prolonged contact such as between household members is usually required.

*Meningococci* do not survive well outside the human body. Sharing drinks, food or cigarettes are no longer thought to be significant in transmission.

### WHO IS AT RISK?

While the disease can affect anyone, those at most risk include:

- Household contacts of patients with meningococcal disease
- Infants, small children, adolescents and young adults
- People exposed to cigarette smoke or to smokers
- Travelers to countries with high rates of meningococcal disease
- People with not working spleen or who have certain other rare medical conditions.

Meningococcal disease occurs more commonly in winter and early spring.

A Person with meningococcal disease does not efficiently transmit the infection to others. People who have had only minor exposure to someone with meningococcal disease have very little risk of developing the disease.

Secondary cases in healthcare workers are rare and healthcare workers are not at increased risk, unless they have been directly exposed to a case's nasopharyngeal secretions, i.e. performed mouth-to-mouth resuscitation or intubated the case without using a face mask.

### HOW IS IT PREVENTED?

Close contacts, such as family members and others with household-like contact, need antibiotics to kill any *meningococci* they may carry in the back of their nose or throat. This antibiotic does not treat the disease, but can help stop the bacteria from spreading to other people if these contacts are also carriers. A wider circle of people are often given information about the disease and the importance of seeking urgent treatment if they develop symptoms.

Homes and cars should be kept smoke free.

Meningococcal disease can also be prevented by immunisation. Two types of vaccine are available:

**Meningococcal C conjugate vaccine** protects against meningococcal group C disease for many years. It is recommended for:

- all children at one year of age (as part of free routine immunization under the National Immunisation Program)
- people who have had meningococcal disease
- control of outbreaks caused by serogroup C.

During 2003 and 2004, this vaccine has been offered via a free school-based program to all NSW school children. The Australian Government has agreed to extend the funding for the provision of free meningococcal C vaccine for those who were aged 1-19 in 2003. This funding has been provided until June 2007.

**Meningococcal polysaccharide vaccine** protects against groups A, C, Y and W 135 for two to three years. It is recommended for:

- travellers to countries where there are epidemics of meningococcal disease, e.g. sub-Saharan Africa
- people traveling to the Hajj in Saudi Arabia (where it is a requirement).

Both vaccines should be given to:

- laboratory workers dealing with *meningococci*
- people without a working spleen and with certain other medical problems.

Vaccines are sometimes used during continuing outbreaks of meningococcal disease in confined environments such as boarding schools, residential colleges and military barracks.

Because vaccines do not protect against the more common meningococcal group B disease, vaccinated people must still be alert for meningococcal disease.

### **HOW IS IT DIAGNOSED?**

Diagnosis is based on the patient's symptoms and signs. Confirmation involves testing samples from the ill patient, including:

- blood for culture, nucleic acid testing (NAT) or serology
- throat swab for culture
- cerebrospinal fluid (CSF) for examination, culture, or NAT
- skin affected by a rash, for examination, culture or NAT.

### **HOW IS IT TREATED?**

It is important to see a doctor early. Patients with meningococcal disease need urgent treatment with antibiotics (usually benzylpenicillin, ceftriaxone or cefotaxime).

Five to ten percent of patients with meningococcal disease die, despite rapid treatment.

### **WHAT IS THE PUBLIC HEALTH RESPONSE?**

NSW hospitals and laboratories must notify cases of meningococcal disease to the local, Public Health Unit. Public Health Unit staff will work with the doctor, the patient or the patient's family to identify close contacts at risk of infection and arrange for those at risk to receive information about the disease, and if necessary, antibiotics.

### **IN-HOSPITAL INFECTION CONTROL CONSIDERATIONS**

**STANDARD PRECAUTIONS** - should be practiced at all times.

**DROPLET PRECAUTIONS** - only need to be continued until the patient has had 24 hours of effective antibiotic treatment. Droplet Precautions require a single room. All people entering the room should wear surgical masks and protective eyewear.

### **Suggested videos available to hire through the NSW ICRC**

1. Fighting Meningococcal Disease
2. Managing Meningococcal Disease - A guide for health professionals (see review this issue)

### **Suggested websites**

[www.health.nsw.gov.au/infect/diseases.html](http://www.health.nsw.gov.au/infect/diseases.html)

<http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/cda-pubs-other-mening.htm>

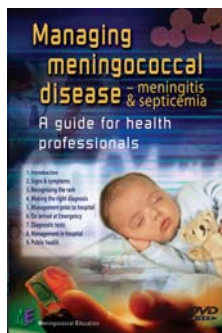
## Multimedia Review

### *Managing meningococcal disease - A guide for health professionals (DVD & Video)*

With meningococcal disease, every minute counts...

The contents of this program are consistent with the Federal Government's guidelines for the early clinical and public health management of meningococcal disease in Australia.

The program chapters include; the signs and symptoms, recognizing the rash, making the right decision, management prior to hospitalization, on arrival at emergency, diagnostic tests, management in hospital and public health issues. The program is delivered by reputable health care professionals and has been partially funded by the NSW State Government. The DVD has been distributed to all public hospital Emergency departments by the NSW Health Department.



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# 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. **Increased incidence of infections associated with peripheral IV cannulae: recognition, investigation, interventions**, Van Gessel H & McCavans C, *Australian Infection Control*, vol. 11, no.2, June 2006.
2. **A new imperative for the Australian infection control community: improving detection of device-related outbreaks**, Murphy C & Resnik S, *Australian Infection Control*, vol. 11, no.2, June 2006.
3. **A clonal outbreak of rifampicin-resistant methicillin-resistant *Staphylococcus aureus* (MRSA) in an intensive care unit**, Friedman ND et al, *Australian Infection Control*, vol. 11, no.2, June 2006.
4. **Influenza vaccination status and influenza-related perspectives and practices among US physicians**, Cowan AE et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
5. **A profile of smaller hospitals: Planning for a novel, statewide surveillance program, Victoria, Australia**, Bennett NJ et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
6. **Confidence in controlling a SARS outbreak: Experiences of public health nurses in managing home quarantine measures in Taiwan**, Hsu CC et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
7. **The effect of performance feedback on wound infection rate in abdominal hysterectomy**, Rodríguez JFG et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
8. **Clinical, microbiologic, and epidemiologic characteristics of *Pseudomonas aeruginosa* infections in a University Hospital, Malatya, Turkey**, Yetkin G et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.

9. **Evolution of infection control in Egypt: Achievements and challenges**, Talaat M, Kandeel A et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
10. **Surgical site infection in patients submitted to digestive surgery: Risk prediction and the NNIS risk index**, de Oliveira AC et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
11. **Blunt and penetrating object injuries in housekeepers working in a Turkish university hospital**, Erdem Y & Talas MS, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
12. **Variation in blood and body fluids exposure when small-gauge needles or peripheral venous catheters were implicated: Results of a 4-year surveillance in France**, L'Hériteau F et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
13. **Infection control knowledge and practices among dentists and dental nurses at a Jordanian university teaching center**, Qudeimat MA et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
14. **National survey of the status of infection surveillance and control programs in acute care hospitals with more than 300 beds in the Republic of Korea**, Oh HS et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
15. **A climatologic investigation of the SARS-CoV outbreak in Beijing, China**, Yuan J et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
16. **Occupational HIV infection among health care workers exposed to blood and body fluids in Brazil**, Rapparini C et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
17. **Prevalence of antibodies against hepatitis B virus and hepatitis C virus among blood donors in Lebanon, 1997-2003**, Irani-Hakime N et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
18. **Device-associated nosocomial infection rates in intensive care units in four Mexican public hospitals**, Ramirez Barba EJ et al, *American Journal of Infection Control*, vol. 34, no.4, May 2006.
19. **Broad-spectrum microbicidal activity, toxicologic assessment, and materials compatibility of a new generation of accelerated hydrogen peroxide-based environmental surface disinfectant**, Omidbakhsh N & Sattar SA, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
20. **Assessment of materials commonly utilized in health care: Implications for bacterial survival and transmission**, Lankford MG et al, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
21. **A problem of hospital hygiene: The presence of aspergilli in hospital wards with different air-conditioning features**, Perdelli F et al, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
22. **Virucidal activity of a quaternary ammonium compound disinfectant against feline calicivirus: A surrogate for norovirus**, Jimenez L & Chiang M, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
23. **A prospective study of the efficacy of routine decontamination for gastrointestinal endoscopes and the risk factors for failure**, Bisset L et al, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
24. **Redesign of portable suction equipment cases: An engineering approach to a disinfection problem**, Neely AN et al, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
25. **Measurement of the microbial barrier effectiveness of sterilization containers in terms of the log reduction value for prevention of nosocomial infections**, Dunkelberg H & Fleitmann-Glende F, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
26. **Biocidal activity of a bioactive glass-protected, preservative-free tattooing solution**, Charnock C, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
27. **An outbreak of noninvasive group A streptococcal disease in a facility for the developmentally disabled**, Dworkin MS et al, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
28. **Who let the dogs out? Infection control did: Utility of dogs in health care settings and infection control aspects**, DiSalvo H et al, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
29. **Prospective surveillance of phlebitis associated with peripheral intravenous catheters**, Malach T et al, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
30. **Infected health care workers and patient safety: A double standard**, Perry JL et al, *American Journal of Infection Control*, vol. 34, no.5, June 2006.

31. **Pasteurization is effective against multidrug-resistant bacteria**, Wang CY et al, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
32. **Systematic risk assessment methods for the infection control professional**, Larson E & Aiello AE, *American Journal of Infection Control*, vol. 34, no.5, June 2006.
33. **Increase in catheter insertion-site infections associated to the introduction of a substandard competitive antiseptic**, Volkow P et al, *American Journal of Infection Control*, vol. 34, no.6, August 2006.
34. **Tuberculin reactivity among health care workers in nonhospital settings**, Shah SM et al, *American Journal of Infection Control*, vol. 34, no.6, August 2006.
35. **Delayed recognition of a pseudo-outbreak of *Mycobacterium terrae***, Bettiker RL et al, *American Journal of Infection Control*, vol. 34, no.6, August 2006.
36. **Cluster of invasive salmonellosis cases in a federal prison in Colorado**, Ghosh TS et al, *American Journal of Infection Control*, vol. 34, no.6, August 2006.
37. **Nurses' beliefs about public health emergencies: Fear of abandonment**, O'Boyle C et al, *American Journal of Infection Control*, vol. 34, no.6, August 2006.
38. **A university hospital's 10-year experience with tuberculin testing: Value of the 2-step tuberculin skin test**, Choudhary M et al, *American Journal of Infection Control*, vol. 34, no.6, August 2006.
39. **Surveillance of hospital-acquired infections: A model for settings with resource constraints**, Brusaferrero S et al, *American Journal of Infection Control*, vol. 34, no.6, August 2006.
40. **Infection risks following accidental exposure to blood or body fluids in health care workers: A review of pathogens transmitted in published cases**, Tarantola A et al, *American Journal of Infection Control*, vol. 34, no.6, August 2006.
41. **Assessment of preventive measures for accidental blood exposure in operating theaters: A survey of 20 hospitals in Northern France**, Tarantola A et al, *American Journal of Infection Control*, vol. 34, no.6, August 2006.
42. **Boosted tuberculin skin testing in hemodialysis patients**, Cengiz K & Şeker A, *American Journal of Infection Control*, vol. 34, no.6, August 2006.
43. **Are antiseptic-coated central venous catheters effective in a real-world setting?** Borschel DM et al, *American Journal of Infection Control*, vol. 34, no.6, August 2006.
44. **Outbreak of *Burkholderia cepacia* bacteremia in immunocompetent children caused by contaminated nebulized sulbutamol in Saudi Arabia**, Ghazal SS et al, *American Journal of Infection Control*, vol. 34, no.6, August 2006.

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[www.mosby.com/ajic](http://www.mosby.com/ajic)

45. **High Rate of Negative Results of Tuberculin and QuantiFERON Tests Among Individuals With a History of Positive Skin Test Results**, Lloyd N. Friedman et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
46. **Screening for Tuberculosis Infection Using Whole-Blood Interferon- $\gamma$  and Mantoux Testing Among Japanese Healthcare Workers**, Nobuyuki Harada et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
47. **Tuberculosis in Healthcare Workers at a General Hospital in Mexico**, Rafael Laniado-Laborín, et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
48. **Tuberculosis in Healthcare Workers: A Molecular Epidemiologic Study in San Francisco**, Adrian Ong et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
49. **Prospective 3-Year Surveillance for Nosocomial and Environmental *Legionella pneumophila*: Implications for Infection Control**, S. Boccia, MSc; P. Laurenti et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
50. **Epidemiologic Study and Containment of a Nosocomial Outbreak of Severe Acute Respiratory Syndrome in a Medical Center in Kaohsiung, Taiwan**, Jien-Wei Liu et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
51. **Cluster of Cases of Severe Acute Respiratory Syndrome Among Toronto Healthcare Workers After Implementation of Infection Control Precautions: A Case Series**, Marianna Ofner-Agostini et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
52. **Lack of Association Between the Increased Incidence of *Clostridium difficile*-Associated Disease and the Increasing Use of Alcohol-Based Hand**

- Rubs, John M. Boyce et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
53. **Why Healthcare Workers Don't Wash Their Hands: A Behavioral Explanation**, Michael Whitby et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
54. **Use of Multistate Models to Assess Prolongation of Intensive Care Unit Stay Due to Nosocomial Infection**, J. Beyersmann et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
55. **Automatic Detection of Patients with Nosocomial Infection by a Computer-Based Surveillance System: A Validation Study in a General Hospital**, L. Pokornyy et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
56. **Detection and Quantification of Dental Unit Water Line Contamination by Oral Streptococci**, Stefano Petti & Gianfranco Tarsitani, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
57. **Screening of Hospital Workers for Pulmonary Tuberculosis in a Medical Center in Taiwan**, Fu-Der Wang et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
58. **The Importance of Two-Step Tuberculin Skin Testing for Newly Employed Healthcare Workers**, Elizabeth C. Frenzel et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
59. **Discontinuation of Respiratory Isolation for Possible Tuberculosis: Do Two Negative Sputum Smear Results Suffice?** Charles S. Bryan et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
60. **An Outbreak of Scabies in a Long-Term Care Facility: The Role of Misdiagnosis and the Costs Associated With Control**, Gretha de Beer et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
61. **Hospital Waste Generation During an Outbreak of Severe Acute Respiratory Syndrome in Taiwan**, Chow F. Chiang et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
62. **Airborne Severe Acute Respiratory Syndrome Coronavirus Concentrations in a Negative-Pressure Isolation Room**, Ying-Huang Tsai et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
63. **Prospective Surveillance Effectively Reduced Rates of Surgical Site Infection Associated With Elective Colorectal Surgery at a University Hospital in Japan**, Tsuyoshi Konishi et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.5, May 2006.
64. **Outbreak of Pertussis Among Healthcare Workers in a Hospital Surgical Unit**, F. Brian Pascual et al, *Infection Control and Hospital Epidemiology*, vol. 27, no.6, June 2006.
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