As most of you are aware, TSICP has been very active in ongoing work to draft the Texas legislation dealing with the mandatory reporting of healthcare associated infections. Several of our members are also active at the national level with APIC in working toward similar ends.

On just a personal note, although one cannot argue with the intent of such legislation, I guess I have always held at least some mixed feelings about the approach that has been taken in creating this movement. I have tried to not take these efforts as a personal affront to my Infection Control professionalism, because like so many of you, I have dedicated my professional career to evaluation and implementation of infection control techniques while constantly striving to make the healthcare facility a safer place for both patients and staff. I regret that those efforts have generally not been recognized by legislators considering reporting laws.

To give you some idea of the momentum that this effort has generated nationwide, take a look at some of the most recent action from around the country:

- **Colorado:** On May 5, the Colorado legislature approved HB 1045, which requires hospitals to report incidents of hospital-acquired infections to the CDC to be analyzed and risk adjusted. The Colorado Department of Public Health and Environment will use that information to provide facility-specific infection rates to the public. Governor Bill Owens has 30 days to sign the bill into law.

- **Connecticut:** Lawmakers in the state approved SB 160, a bill that requires hospitals to report infections to the Connecticut Department of Health. The department will then make hospital-specific infection rates available to the public. The measure must be approved by Governor M. Jodi Rell to become law.

- **New Hampshire:** On May 3, the New Hampshire Senate passed HB 1741, a hospital infection reporting bill previously approved by the House. The bill, which will lead to reports on hospital infection rates, now moves to Governor John Lynch’s desk for his consideration.

- **South Carolina:** On April 27, the South Carolina Senate passed S. 1318, which requires hospitals in the state to disclose the rate at which their patients develop surgical site infections, ventilator assisted pneumonia, central line bloodstream infections, and urinary tract infections. The measure is picking up support in the House and stands a good chance of winning passage before the legislature adjourns on June 1.

- **Alaska:** On May 4, the Alaska Legislature adopted a resolution to create a task force to develop recommendations for hospitals to disclose their infection rates, to be presented in the form of legislation in 2007.

- **Tennessee, Ohio, Rhode Island, and Massachusetts** are also still considering hospital infection reporting legislation.

As the first states began publishing reports on hospital-acquired infections, lawmakers in 32 considered filing public reporting legislation. At least twelve states are expected to have hospital infection reporting laws in place by the end of the 2006 legislative sessions. Infection reporting requirements have been adopted in eight states so far to raise public awareness and encourage hospitals to work harder to implement effective infec-

(Continued page 2)
tion control programs. Another four states are poised to adopt infection reporting bills soon.

At the last meeting of the Texas Advisory Panel, we had an opportunity to review the results from the survey that was sent to all Texas healthcare facilities. Sadly, we only received a 33% response rate from all facilities. About 58% of the responses came from facilities with less than 100 beds. The goal of this survey was to assess the current status of Texas with regard to Infection Control resources, responsibilities, and knowledge. The survey did underscore the vast differences in Infection Control practitioners in terms of scope of practice and overall activities. The Panel felt that this type of survey would be the best way to determine the ability of the state to successfully implement a reporting program, along with the recommendation for the design of such a program.

We also had the opportunity to visit with officials from the Missouri Department of Health and Human services and discuss the Missouri Healthcare-Associated Infection Reporting System (MHIRS). This impressive web-based system requires the practitioner to login to a registration screen and then enter specific information related to the particular facility. Information is tracked for central line associated bloodstream infection (CLAB), nosocomial isolates of MRSA and VRE, and specific surgical site infections. The surgical site infection data requires the transfer of patient specific information from the healthcare facility database. Information related to this program may be seen at the website: http://www.dhss.mo.gov/MHIRS/

I bring all this to your attention because we are due to provide final recommendations to the Legislature by the end of the summer. We need input from our front-line practitioners regarding the feasibility of implementing such a reporting system in Texas. Please feel free to contact me directly or through the TSICP website.

An article regarding handwashing was published in the April 5, 2006 edition of the Wall Street Journal. The article was entitled “Hospitals Get Aggressive About Hand Washing – Staff Surveillance Programs, New Penalties Aim to Boost Sagging Compliance Rates.”

The article reviewed the challenges of handwashing compliance and the many different methodologies to raise handwashing compliance. Compliance rates for hand sanitization remain between 40% and 50% nationwide. In an effort to boost and sustain hand hygiene the CDC and 2 leading Infection Control professional societies have joined efforts with IHI to develop “best practice” guidelines and monitoring programs.

Some hospitals have already engaged tougher tactics to ensure handwashing compliance. Greenview Regional Hospital and the Medical Center, two hospitals in Bowling Green, Ky., share medical staff. The hospitals found widespread non-compliance amongst all healthcare providers including the medical staff. They developed a monitoring plan to identify offenders. Once identified the offenders were required to go through hand-hygiene tutorials and education. Subsequently penalties for further violations were escalated to disciplinary action or dismissal for repeated actions.

Hand hygiene compliance improved to 85% for healthcare workers overall and 95% for physicians. One healthcare worker, who also had other unrelated violations, was dismissed. This program emphasized that the hospital leadership were involved in the monitoring and were prepared to administer disciplinary actions for violations.

JCAHO advises that a punitive approach may not necessarily be the best approach as staff may feel animosity and resentful to those performing the monitoring. Shands Hospital in Florida has used punitive measures for noncompliance at their facility but say that they would rather be taking a positive approach and keep reinforcing the good behavior.

Removing barriers for good hand hygiene is vital. Hospitals should be vigilant about keeping alcohol rub dispensers full and in operating condition. It has also been recommended that hospitals enlist their staff in making decisions regarding the hand-hygiene rules and product selection.

Michelle Peninger, BSMT, CIC
Important Education Coming Soon:

**FUNDAMENTALS COURSE:**
July 13-14 Arlington Texas

**Intermediates Course**
October 20-21 Amarillo Texas

**TSICP 30th Birthday Bash**
March 29-30th Austin Texas

Don't Miss It !!!

Don't Forget.... Register Today

www.tsicp.org
Join us for Education and a Fun Time in Arlington Texas
Home of Six Flags Over Texas

WHO: Anyone who considers themselves new to the Infection Prevention World, or would like to learn more about the Infection Prevention World.

When: July 13-14 2006  7:30 – 4:30

Where: Amerisuites Hotel Arlington Texas
2380 Road To Six Flags E
ARLINGTON, TX, US 76011

HOW: Register online at www.tsicp.org or call 512- 263-2480.  Don’t delay we have limited seating (50)

WIFM: (What’s in it for me?) A great networking opportunity to develop friends you can call for resources, a very nice certificate to show JCAHO, DSHS, or any other regulatory agency that you are competent to be an ICP. Resources galore… CD with policies and procedures, Communicable Diseases in Man resource book and much much more.

Fun: Discount ticket to 6 Flags over Texas (bring the kids). Get away from the grind of the workplace, eat, drink, and be merry.

What you will learn: Basics in Isolation, Educating the Adult learner, Making a Annual Plan and assessing your plan, JCAHO, Infection Control Regulatory agencies, Central Line infections, Pneumonias, Microbiology, Statistics needed for ICP, Urinary Tract Infections, Surgical Site Infections, Infection in the Long Term Setting, Employee Health and Infection Control, Cleaning and Disinfecting.

TSICP Intermediates Oct 19-20th
Amarillo College

Amarillo is famous for George Strait’s song “Amarillo by Morning.”
“Amarillo by morning

We hope you make Amarillo by the morning of Oct. 19, 2006. The sun shines brighter in the Texas Panhandle Sky, and we can promise you a great time of education and fun with TSICP 2006 Intermediate course. The agenda is finalized; the speakers committed; and it will be one of the best programs we have had for TSICP intermediates. We bet our boots and saddle on it. Check out some of the great topics and speakers.

**Saving 100,000 Life – Positive Outcomes for Central Lines in hospitals**
Brenda Hackett MT, MPH, CIC
MD Anderson Hospital

**When Things go wrong with Cleaning and Disinfections**
Barb Moody RN CIC
Denton Regional Medical Center
Denton, Texas

**The latest HIV Update for ICP**
Dr. Daniel J Barbaro, HIV specialist
Ft. Worth, Texas

**Certification in Infection Control**
Fran Slater Feltovich RN, MBA, CPHQ, CIC, CBIC
Board of Directors
The Methodist Hospital
Houston, Texas

**Sharps Injury Follow up**
Kathryn Gardner RNC, CIC
Department of State Health Services
Austin Texas

**Controlling Control Charts/ Interpreting P Values**
Anne Denison RN, BSN, MS
VA Hospital
Amarillo, Texas

**Interpreting the MIC lab results**
Beverley Orr, MT (ASCP)
Trinity Mother Francis
Don’t delay, mark your calendars today, start the process to attend the intermediates course, and we will see you in Amarillo by October morning. Lodging will be located at the Hilton Homewood Suites, and a shuttle will be provided to transport you to the Amarillo College Auditorium.

You may register today at www.tsicp.org

Charlotte Wheeler, BSN, RN, CIC

March 29-30 2007
Celebrating 30 years of effective change in Texas
Looking Backward------And Forward To Continue the Vision

March 2007 will mark the beginning of TSICP’s grand celebration of our 30th anniversary. It seems only fitting to kick off such a special occasion at what is traditionally our biggest event of the year, the TSICP 2007 Annual Education Conference! This year’s conference takes place March 29-30th at the Double Tree Inn in Austin Texas. It will include all of the regular activities associated with a TSICP Annual Conference, plus a few special extras. The education committee has planned an excellent program for 2007. You will not want to miss what the speakers have planned. Also, there’s more to this conference than educational presentations and product exhibits. In recognition of our 30th anniversary, there will be thrills, and unexpected surprises that will be sure to be a memorable event you don’t want to miss. The event promises to be full of surprises as we take a look back at our nostalgic past and look ahead to our bright future.

Mark your calendars for March 29-30th. You may go online today and register at www.tsicp.org

Innovative leadership makes a great organization.

Gerry Haynes – Founder
Elsa Hubert – 1977-1978
Connie Shay – 1979-1978
Martha Landry – 1981-1982
Donna Dryer – 1982-1983
Lynn Brooke-Chambers – 1983-1984
Carolyn Langewisch – 1984-1985 -
Ona Baker – 1985-1986 -
Judy Weaver - 1986-1987
Jerry Amundsen – 1987-1988 -
Judy Prescott – 1988-1989
Maureen Koza – 1989- 1990
Sue Sebazco – 1991-1992
Beverly Gray – 1992-1993 -
Deborah Phillips – 1993-1994 -
Judy Prescott – 1994-1995
Nancy Bjerke – 1995-1996
Mary Butler – 1996- 1997 –
Susan Jones – 1997-1998
Patti Grant 1998-1999 -
Greg Bond 1999-2000
Jose Hernandez 2000-2001
Elicia Berry – 2001-2002
Jessica Hilburn -2003-2004
Neil Pascoe 2004-2005
Michelle Peninger 2005-2006
Greg Bond 2006-2007
TSICP
Annual Conference
April 6 - 7, 2006
Austin, Texas
Patti Grant, Doug Erickson, Teresa Garrison, Lori Henke, Elizabeth Race, Andrew Kroger, Dean Dozier, Teresa Dozier, Donna Weaver, Sue Sebazco and Robert Haley – All of these people have different experience and talents but, what do they have in common? These were the speakers for the 29th Annual TSICP conference held in Austin April 6 & 7, 2006. The attendance was an all time conference high with 138 ICP’s in attendance. As an attendee or speaker the information shared or learned was vast. We found out Infection Control has a new name … Infection Prevention and Control, nosocomial infections now are referred to as Healthcare Associated Infections (HAI). Additionally information provided:

- Remembering to take credit for all your work by adding, “created by.”
- Denominator choices – Patient days or Device days
- How to conduct an Infection Control Risk assessment before and during construction.
- Partner with construction before, during, and after construction projects.
- Present data to create a vision and obtain new or additional resources for the IC budget.
- Classes of Antibiotics and when to use them.
- CA-MRSA vs. HA-MRSA
- Pandemic and Avian Influenza
- Hurricanes and Hospital
- 2006 Immunization updates.
- Root Cause Analysis…The How To
- Mandatory Reporting in Texas – When, What and How to Report

ICP’s from around the State net worked with the Board Member responsible for an assigned region and other ICP’s from the same region.

The Vendors Fair always a success, with great products, food, and door prizes was well attended both by ICP’s and Vendors. TSICP conferences are Texas information, problems, answers, and ideas to improve or fix processes.

Plan to attend the 30th Annual conference in Austin March 29-30, 2007. TSICP is “BIG” in Texas.

Kathleen Byrne, RN, BSN, ICP

What’s up Doc?

Tularemia in West Texas

Recently, we were notified by our officials in Amarillo that a jack rabbit near the Amarillo Airport was found dead and + for Francisella tularensis (tularemia). I don’t know about you, but we don’t see that everyday, so I did a little research as I knew the questions would be flooding in.

First and foremost to all ICP, Tularemia is not known to be spread from person to person. People who have tularemia do not need to be isolated. Standard precautions, and the dead rabbit stays “outside”.

Individuals may be exposed by:
- being bitten by an infected tick, deerfly or other insect
- handling infected animal carcasses
- eating or drinking contaminated food or water
- breathing in the bacteria, F. tularensis

Symptoms: sudden fever, chills, headaches, diarrhea, muscle aches, joint pain, dry cough, progressive weakness

People can also catch pneumonia and develop chest pain, bloody sputum and can have trouble breathing and die if not treated.

Other symptoms of tularemia depend on how a person was exposed to the tularemia bacteria. These symptoms can include ulcers on the skin or mouth, swollen and painful lymph glands, swollen and painful eyes, and a sore throat.

Symptoms usually appear 3 to 5 days after exposure to the bacteria, but can take as long as 14 days.

For the Trivia Buff:

The microbe was discovered in 1911 during an outburst of rabbit fever, when the disease killed a large number ground squirrels in the area of Tulare Lake in California. The lake gave the name to the disease - tularemia. Scientists determined that tularemia could be dangerous to humans: a human being may catch the infection after contacting an infected animal.

The ailment soon became frequent with hunters, cooks and agricultural workers. Pathogenic organisms penetrate into a body through
of 2000 in Kosovo. About 650 people fell ill with rabbit fever by the beginning of May. Kosovo’s water pipelines were destroyed with the bombing - the region was suffering from the shortage of fresh water, and it was impossible to stop the epidemic. Greater than 900 suspected cases of tularemia were identified.

Tularemia became important for the USA in 2001, when tularemia obtained a potential biological threat. Francisella tularensis was a perfect example of biological weapon for terrorists. The microbe possesses a large infecting capacity, which results in a high death rate. In addition, only a microscopic amount of the bacteria will be enough to trigger a massive epidemic. British scientists have recently discovered that the tularemia pathogen contains the genes, which cannot be found in any other organism in the world. The genome has been declassified: humans will soon invent the anti-tularemia vaccine, which will push aside the opportunity of using the disease as a weapon of mass destruction.

A vaccine for tularemia is under review by the Food and Drug Administration and is not currently available in the United States.

Charlotte Wheeler, RN, BSN, CIC

Rabies: What Everyone Should Know to Keep Themselves and Their Families Safe!

On May 12th, 2006 a tragedy occurred in Humble, Texas. A bright, active 16 year old boy died of a preventable disease. Harris County health officials said sometime in April the teen awoke from a nap when he felt something brush against him. He found a bat, which apparently had entered through a window, in his bedroom. The bat was captured with a towel and thrown out the window. The family gave the incident no more thought. About a month later, the young man began exhibiting symptoms and was admitted to Texas Children’s Hospital. Despite state of the art medical care and the prayers of his family and many friends, he died about a week later.

Rabies is an infectious viral disease that affects the nervous system of humans and other mammals. People get rabies from the bite of an animal with rabies (a rabid animal). Any wild mammal, like a raccoon, skunk, fox, coyote, or bat, can have rabies and transmit it to people. It is also possible, but quite rare, that people may get rabies if infectious material from a rabid animal, such as saliva, gets directly into their eyes, nose, mouth, or a wound.

Most people afflicted with rabies begin showing signs of illness one to three months after being infected. Early symptoms include irritability, confusion, headache, fever, hallucinations and itching or pain at the sight of the bite. Once symptoms appear, the disease, which attacks the nervous system, is nearly always fatal within a week.

Because rabies is a fatal disease, the goal of public health is, first, to prevent human exposure to rabies by education and, second, to prevent the disease by anti-rabies treatment if exposure occurs. Tens of thousands of people are successfully treated each year after being bitten by an animal that may have rabies. A few people die of rabies each year in the United States, usually because they do not recognize the risk of rabies from the bite of a wild animal and do not seek medical advice.

Most of the recent human rabies cases in the United States have been caused by rabies virus from bats. Because some areas of Texas are home to some of the largest urban populations of bats, this is of special importance to us.

One reason bats may be the most frequent culprit in human rabies is the fact that they have such tiny teeth, that bites are not always detected. Many of the human cases of rabies occurred after physical contact with bats, but without the victim having any knowledge of an actual bite. Note: Bats are not “bad”. Bats play key roles in ecosystems around the world, especially by eating insects, including agricultural pests and mosquitoes. Most bats do not have rabies, but it is important to know that the best prevention is to avoid physical contact with bats.

What should I do if I come in contact with a bat? If you are bitten by a bat (or any other potentially infected animal) -- or if infectious material (such as saliva) gets into your eyes, nose, mouth, or a wound -- wash the affected area thoroughly and get medical advice immediately. Whenever possible, the bat (or other animal) should be captured and sent to a laboratory for rabies testing. If you awaken and find a bat in your room, see a bat in the
room of an unattended child, or see a bat near a mentally impaired or intoxicated person, seek medical advice and have the bat tested. People cannot get rabies just from seeing a bat in an attic, in a cave, or at a distance. In addition, people cannot get rabies from having contact with bat guano (feces), blood, or urine, or from touching a bat on its fur (even though bats should never be handled!).

**How can rabies be prevented?**

- Teach children never to handle unfamiliar animals, wild or domestic, even if they appear friendly. "Love your own, leave other animals alone" is a good principle for children to learn.
- Teach children and teenagers to tell a parent or other adult if they have come in contact with a bat or other potentially infected animal.
- Wash any wound from an animal thoroughly with soap and water and seek medical attention immediately.
- Have all dead, sick, or easily captured bats tested for rabies if exposure to people or pets occurs.
- Prevent bats from entering living quarters or occupied spaces in homes, churches, schools, and other similar areas where they might contact people and pets.

Be a responsible pet owner by keeping vaccinations current for all dogs, cats, and ferrets, keeping your cats and ferrets inside and your dogs under direct supervision, calling animal control to remove stray animals from your neighborhood, and consider having your pets spayed or neutered. Don't let this happen to anyone you know. Spread the word that rabies is preventable if the exposure is recognized and preventive treatment is administered. For more information on rabies, and specifics on Post Exposure Prophylaxis, visit these on-line references:

http://www.cdc.gov/ncidod/dvrd/rabies/
http://www.cdc.gov/mmwr/preview/mmwrhtml/00056176.htm
http://www.dshs.state.tx.us/idcu/disease/rabies/

**Lynda Watkins**, RN, BSN, CIC

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**PANDEMIC INFLUENZA**

**TABLE TOP DRILL**

On May 24, 2006 Scenic Mountain Medical Center conducted a table top drill for a pandemic flu event. The drill all started with a bus wreck at the Howard County Fair Grounds. The bus contained approximately 20 individuals from Colorado City, Texas where one victim of the wreck refused treatment at the scene and left the accident by a private vehicle. Scenic Mountain was called about the wreck and Code Orange went into operation. The drill went great, all personnel responded as trained. Exit conference was conducted to critique the drill.

**On Friday, May 26, 2006**

Infection Control and staff members were notified that a table top drill was being conducted. A victim starts to feel ill, and goes to HEB to purchase OTC medications. He really doesn’t know which medication is best so he picks up each brand and reads the label. He is still undecided, so he goes to speak to the pharmacist for his suggestion.

**Monday, May 29, 2006**

Individual starts to feel a little better and decides to attend a Memorial Day Bar-B-Que at a friend’s house. In attendance are about 10 close friends. The Pharmacist at HEB starts to develop Flu like symptoms.

**Friday, June 2, 2006**

Individual attends Big Spring High School graduation at the Dorothy Garrett coliseum, despite a decline in health. In attendance of the graduation are approximately 3,000 people. Pharmacist’s health continues to decline, but assumes it is only the flu and continues treatment with OTC meds. Pharmacist’s spouse and cashier at HEB develop flu like symptoms.

**Wednesday, June 7, 2006**

Health of the initial person continues to decline. Individual presents to Scenic Mountain Medical Center ED waiting room. Registration staff takes the needed information and ask the person to sit in the waiting room and wait for the doctor. Individual is seen by the nurse and asked about any recent trips over seas. Individual states that he had just returned from a trip to China the day before the bus wreck on 05/24/06. Nurse notifies Infection...
Control and Risk Management of the problem.

**Friday, June 9, 2006** Pharmacist’s and Pharmacist’s wife present to Scenic Mountain Medical Center ED waiting room with flu like symptoms. Both individuals reply they have not been on a recent trip over seas. Several hundred people from the graduation are having flu like symptoms.

10 people from the Memorial Day BBQ are now suffering from flu like symptoms in various stages, and have presented to the Scenic Mountain Medical Center ED. One of these individuals has just returned from a business trip to New York City, NY. This person flew on a commercial airline with 200 other passengers.

**Sunday, June 11, 2006** 122 people present to the Scenic Mountain Medical Center waiting room with flu like symptoms.

**Monday, June 12, 2006** Test is returned from Department of State Health Services on the initial person, with a diagnosis of Asian flu. When asked about his recent activities, the person states he went to HEB to get some flu medicine, then to a BBQ on Memorial Day weekend, then to graduation at the coliseum.

**Friday, June 19, 2006** Person from Los Angeles, CA, develops flu like symptoms after returning from a business conference in New York City, NY. Individual just thinks he is getting ill and goes to Wal-Mart for OTC medications…………………

You now have the picture of what is going on, and we had a lot of decisions to make when we went through this exercise. The team had to decide what isolation to put the patient in since he had been to Asia; and what test to do; if the health department should be notified at this point. When the Pharmacist and his wife came in, could this have been the reason to get concerned or was this just another case of the flu?

When 10 people from the Memorial Day BBQ were seen was this unusual and should the health department be notified?

When the 122 people were present in our waiting room, we knew we had a problem and activated our disaster mode. The team discussed what our next step would be with getting medication, where to place these people, getting the Health department involved, security, and on and on. I think you get the picture and we really learned a lot but we are not ready by any means. We as a team must continue to plan and practice and be ready when this really happens.

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The lesson learned here was about how easily a flu pandemic can get started with just one person.

Doris Bergerson, RN

Let’s take a short break from our daily work and picture a beautiful windy city called Chicago during the third week of March 2006. Imagine the cold breeze as you are walking along the Lake Michigan shoreline and enjoying a cup of hot tea or coffee in one of the cafés. Then, let your mind wander to some marvelous world-renowned museums and the beautiful Millennium Park. Next, stroll down the famous Millenium Miles where you will find the greatest shopping experience. After the wonderful shopping spree, stop at Hancock Tower and take the elevator to 95th floor where restaurant called Signature Room is located. From this floor, you may enjoy the view of the city while having a slice of chocolate mousse cake or crème brulée.

Now I have your attention about Chicago, continue on reading TSICP Times

The Society for Healthcare Epidemiology of America (SHEA) annual meeting was held in the windy city Chicago in March 2006. The meeting opens with a stimulating topic entitled “How Can We Do Better” which challenges us to improve patient safety and quality of care by bringing our practice in line with our science (evidence-based practice). The rest of the annual meeting was filled with extremely informative and provocative topics such as MRSA, C.difficile, hand hygiene, patient safety, sterilization, avian influenza, and disaster-preparedness.

There are several abstracts that caught my attention during the four days seminar and I would like to mention few of them.

The first abstract was written by Dr. Dennis Maki from University of Wisconsin Hospital titled “Prospective Evaluation of 6 Preoperative Cutaneous Antiseptis Regimens for Prevention of Surgical Site Infection”. The objective
of this abstract was to ascertain the relative efficacy of preoperative antiseptic cleansing with a 2% chlorhexidine gluconate (CHG)-impregnated towelette as well as 3 different antiseptic regimens for preoperative disinfection of the surgical site. The result of the study shows that a preoperative 2% CHG impregnated towelette total-body cleansing done twice prior to anticipated surgery significantly reduces the number of microorganisms on the surgical site at the time of the incision is made using quantitative sampling technique. Dr. Maki also stated that there is an urgent need for a large multicenter trial to determine with clinical outcome data whether a total-body CHG cleansing the night prior to elective surgery significantly reduces the rate of SSI.

The second abstract was about hand hygiene, the most popular topic among Infection Control Professionals. The abstract titled "Ownership: A Key Component in Effective Hand Hygiene among Healthcare Workers in a TriStar Health System Community Hospital" was presented by Dr. Rebecca Shadowen. The main objective of this study was to achieve and sustain effective hand hygiene compliance in TriStar Healthcare System, Kentucky. Emphasis is placed on the hierarchy structure and methods of achieving goals. Basically, the keywords in this study are ownership and accountability. Let’s go straight to the outcome of the study which is between 85-95% compliance in hand hygiene among Healthcare Workers (including physicians). I am sure that all the ICPs around the countries would like to know the secret methodology behind this success story. Non-compliant health care workers were identified, verbally informed and subsequently reported to their manager. Managers were required to report action taken for non-compliance to the administration, which were responsible for further action which includes termination of the employment for the repeated violators.

Physician non-compliers were given a series of letters: the first to the physician themselves; secondly the physician and their department chair; and thirdly to the physician, department head, and credentials committee.

The last abstract was about the organism, Clostridium difficile, that has been around for a long time and still poses significant problems in the healthcare setting. Dr. John Boyce and his colleagues published a wonderful abstract titled "Impact of Hydrogen Peroxide Vapor Room Bio-Decontamination on Environmental Contamination and Nosocomial Transmission by Clostridium Difficile". The objective of the study was to assess the impact of Hydrogen Peroxide Vapor room bio-decontamination (HPV-RBD) on eradication of C. difficile environmental contamination and its effect on Clostridium difficile-associated diarrhea (CDAD). In this study, the HPV-RBD was performed after the routine cleaning of the empty room using the diluted bleach solution. The conclusion from this study was very impressive. HPV-RBD was effective in eradicating C. difficile environmental contamination following routine cleaning which included use of diluted bleach. In addition, eradication of C. difficile environmental contamination may have contributed to a lower incidence of CDAD observed during the study period.

Tjin Koy, ICP, MPH, CIC

Reference:
Final Program of 16th Annual Scientific Meeting of SHEA 2006
Be sure to check out TSICP’s website. You can read the newsletter; download brochures; register online; contact members of the board and the TSICP office; find topics of interest; find links to information you need; and much more.