As I write this, I can see the storms that blew in over Easter weekend. To say the least, these are turbulent times, not only weather-wise but also in healthcare as well as around the world. Floods along the Rio Grande last week killing dozens of people and washing away the homes and belongings of hundreds of families, war and terrorism in many parts of the world, emerging infections, changing healthcare regulations, and lots of change here in Texas state government.

As you may know, I am not your usual infection control practitioner. I work for the Texas Department of Health (TDH) as the nurse epidemiologist in the Infectious Disease Epidemiology and Surveillance Division. Later this year (9/1/04), I hope to say I am still an epidemiologist; but I know I won’t be working in IDEAS at the TDH. Both will be dissolved under the massive reorganization of state agencies mandated by last year’s state legislative session. House Bill 2292 mandated state health and human services agencies consolidate into five agencies. TDH will merge with a large portion of Mental Health and Mental Retardation, the Healthcare Information Council, the Commission for Alcohol and Drug Abuse into the Department of State Health Services.

The buzzword around work is “interesting”. And just about everything we hear or told is “interesting”. There are many unknowns about the merging of these agencies. For more information on the consolidation you may look at the Health and Human Services website at: http://www.hhsc.state.tx.us/Consolidation/Consl_home.html I will have more information regarding the transition in future newsletters.

So, here it is spring 2004 and there are so many things going on that it is difficult to get them into any order, but here goes. Due to ongoing conflicts with other offerings in the state, the annual fall education conference has been moved to the spring. For the first time, TSICP will be offering an intermediate infection control training course in addition to the Fundamentals course that is held twice a year. This initial offering is planned for the fall of 2004. There are new JCAHO regulations and more are anticipated by 2005 (Patient Safety). These will impact infection control as well as other departments in many facilities. For more information on JCAHO you may look at their website at: http://www.jcaho.org/accredited+organizations/05_npsg_fr.htm

I just want to finish by saying it is an honor and pleasure to serve TSICP as president for 2004. I also want to add my thanks to all of you for supporting TSICP and being members of our state infection control association. I want to especially thank the Board of Directors. They bring a wealth of experience and ideas to the association. Texas is one of only a few states that have a state infection control organization. Send us your ideas and please consider volunteering to help on the board or as a member of a committee.

Neil Pascoe RN, BSN, CIC
According to a new Israeli study, cell phones may help spread bacteria throughout hospitals. After analyzing a sampling of phones in one hospital, the researchers determined that more than 10% of physicians’ phones were contaminated.

----From Men’s Health January-February, 2004

Chris Allen, RN
On December 31, 2003, OSHA announced that it would apply the general respiratory protection standard to health care facilities. This would include a requirement for **annual fit testing**.

In response to OSHA’s recent decision to apply the General Industry Respiratory Protection Standard to respiratory protection against TB, APIC sent an official letter to OSHA Administrator John Henshaw. This letter, in part, cites that enforcing the General Industry Respiratory Protection Standard to occupational exposure to TB cannot be justified as summarized below.

1. “The General Industry Respiratory Protection Standard is not applicable to occupational exposure to patients. Healthcare facilities cannot measure or accurately determine the potential for exposure and and/or the relevance when dealing with patients who may or may not have an infectious load capable of being transmitted; who may or may not have an organisms that is capable of being transmitted; who may or may not have a way to disseminate their organism; and who may or may not have an organism that is capable of being transmitted via airborne spread.

2. Transmission of TB in Healthcare facilities was controlled prior to the use of certified respirators and/or performing initial or annual fit testing. Outbreaks of tuberculosis were controlled and prevented by early identification of cases, prompt isolation, and appropriate treatment.

3. Current methods of fit-testing N-95 respirators are not reproducible, reliable, or reflective of in-use situations. Priority should be given to the development and assurance of enhanced fit characteristics for particulate respirators for all users regardless of the applicability of this general standard to health care exposures to patients.

4. The decision to impose this new mandate was issued December 31, 2003 without the opportunity to review or provide public comment. OSHA clearly ignored the fact that there is no scientific justification for this practice.”

On January 14, 2004, the Occupational Safety and Health Administration (OSHA) announced a six-month grace period for implementing the new requirements for exposure to TB under the General Respiratory Protection Standard. Facilities are expected to be in compliance by July 1, 2004.

Infection Control Practitioners are encouraged to write to OSHA, explaining what this new fit-testing requirement would mean to your facility. Letter templates are on the APIC website, www.APIC.org.
How do you get surgeons to return their surgery surveillance letters?

Here are a few simple suggestions that might help your return rate.

1. Always, but always, include a self-addressed stamped envelope.
2. Design your return letter so that the surgeon can circle or check mark his answers. The more they are required to write out, the less likely they are to respond.
3. Report their return rates to the surgery committee. Their rate of return will show JCAHO their involvement with the surgery surveillance program.
   Work very hard to get one month’s return rate to 100%. After that no one will want to be the one who keeps the month from being 100%.
4. Call the office managers or their office nurses and ask for their help in getting the surgeon to return the letter.
5. Call a surgeon who has not returned his letter and ask if there is some reason he is not returning his letters.
6. If a surgeon does not send back January’s letter, next month, send him January and February’s letter. If he does not return them, the next month, send him January, February and March letters. Then when they do return their letter, they will send in the back months as well. One surgeon actually waited until the end of the year and sent back all 12 months.

Sharon Kurtz, RN, BA, BSN, CIC

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JCAHO requires that you, as the Infection Control Coordinator, make surveillance rounds to monitor compliance with the Life Safety Codes on the construction projects going on around your hospital or health facility. Whatever are you supposed to be looking for? This is an area where all ICPs tend to be weak because construction is not usually something that is covered in nursing school or during our microbiology training. A helpful book is *Infection Control during Construction, a Guide to Prevention and JCAHO Compliance*. Also ask someone from your engineering department or physical plant department for help. There has to be someone assigned to oversee the construction. Ask them what you should be looking for. They will be pleased that you are asking them for their expertise.

Establish a policy with your construction supervisor that you have the power to shut down the construction should there be none compliance.

1. Check the air quality. You don’t want the air to be filled with construction dust floating out into the hallways for the patients and your staff to be breathing.
2. Dust control. Floors and carpets need to be kept clean of dust and debris. The construction people, not your
housekeeping staff, should be responsible for keeping the area into the construction site clean. If wet mopping needs to be done, then they will have to do this.

3. Check the tacky mats in front of the doors. Traditionally there will be 30 sheets on a tacky mat, the top sheet being number 30. As each sheet is torn off, you can record the number of the top sheet and calculate how many sheets are being torn off each day.

4. Eating and drinking should be done in assigned places and not in the construction areas. You don’t want to have a problem with bugs or rodents in your facility. Some health care facilities permit construction workers in their cafeteria, others do not. You will have to make policy as to how you want to handle this.

5. Barriers that are put up to contain dust will have to be placed all the way to the fire wall and not just to the ceiling. The barriers need to be fire retardant and be sealed thoroughly.

6. Determine before the construction begins if there needs to be an anteroom to enter through to the construction area. This can be set up with a portable negative air pressure machine vented outside. Make sure you check the filters in the negative pressure machine, especially during times of demolition.

7. Once the demolition is done, check the walls behind the wallpaper or behind the sheetrock for stachybotrys organism (black mold) or just plain black fungus or what would be called mildew. Stachybotrys is black, tarry and looks wet. Don’t waste the time or money trying to culture to see if it really is Stachybotrys. Just get a 10 % bleach solution in a spray bottle and spray the walls. Repeat the spray if necessary. Remember to wear your hard hat!!

Sharon Kurtz, RN, BA, BSN, CIC

Texas Influenza Summary 2003-2004 Season

The national reporting period for influenza begins in early fall and continues through late May. State influenza coordinators report on flu activity weekly to the Centers for Disease Control and Prevention in Atlanta. The first lab-confirmed influenza isolate was reported by the Texas Department of Health Virology Laboratory September 29, 2003, from a specimen collected in Travis County. The Texas Children’s Hospital in Houston also identified influenza same week. Outbreaks of influenza-like illness were already occurring in school-aged children in Harris County in early October and by mid-October a statewide health advisory was issued reporting heavier than usual influenza activity and urging people to get a flu vaccination.

The state influenza activity level was widespread* by mid-October and remained at that level for 13 consecutive weeks. Reports from Texas and other states indicated the possibility of higher than usual levels of severe morbidity and fatalities from flu-related complications in pediatric and other populations. TDH received reports of school campus/district closures from 4 counties. In an unprecedented period of heightened demand, injectable flu vaccine became unavailable as supplies were exhausted by mid to late December. FluMist, a recently licensed nasal aerosol vaccine remained available.

One of the issues associated with this flu season was the difference in the primary circulating strain of influenza
compared to the vaccine strain. The selection of vaccine strains for the upcoming flu season is made annually in February and March. The H3N2 (Panama) strain in the 2003-2004 trivalent vaccine (others are H1N1 and B) did not provide “optimal” protection from the circulating (related-but genetically different) Fujian strain. However, the vaccine offered more protection than no vaccination at all.

For the first time, flu activity in Texas peaked unusually early the last week of November. As of March 18, 2004, 1674 respiratory specimens were submitted to TDH. Of those, 884 (53%) were positive for influenza A/H3N2 and one specimen was positive for influenza B. Like other state virology laboratories in the country, TDH submits periodic early, mid, late-season as well as unusual isolates to the CDC for strain characterization. Of the 73 isolates submitted: 8 are classified as A(H3N2) Panama; 57 are A(H3N2) Korea (a Fujian-like strain); 2 are A(H3N2) Fujian, and 1 is negative for influenza.

The flu activity level reported to the Centers for Disease Control has remained low through March 2004.

*the highest activity level. See http://www.tdh.state.tx.us/ideas/influenza/overview/ for more information

Neil Pascoe
Texas Department of Health

and

Peggy Wright
Baylor College of Medicine

The Emergence of Antibiotic Resistance

Ever since antibiotics became widely available about 50 years ago, they have been hailed as miracle drugs—magic bullets able to destroy disease causing bacteria. But with each passing decade, bacteria that resist not only single, but multiple, antibiotics—making some diseases particularly hard to control, have become increasingly widespread. In fact, according to the Centers for Disease Control and Prevention (CDC), virtually all significant bacterial infections in the world are becoming resistant to the antibiotic treatment of choice (CDC 1998).

For some of us, bacterial resistance could mean more visits to the doctor, a lengthier illness, and possibly more toxic drugs. For others, it could mean death. An FDA report that reviewed information from the CDC indicated that for the year 2000, nearly 2 million people in the United States acquired an infection while in a hospital, resulting in 90,000 deaths. More than 70 percent of the bacteria that cause these infections are resistant to at least one of the antibiotics commonly used to treat them (FDA 2002).

Antibiotic resistance, also known as antimicrobial resistance, is not a new phenomenon. Just a few years after the first antibiotic, penicillin, became widely used in the late 1940s, penicillin-resistant infections emerged that were caused by the bacterium Staphylococcus aureus (S. aureus). These “staph” infections range from urinary tract infections to bacterial pneumonia. Methicillin, one of the strongest in the arsenal of drugs to treat staph infections, is no longer effective against some of the strains of S. aureus (CDC 2001, CDC 2003). Vancomycin, which is the most lethal drug against these resistant pathogens, may be in danger of losing its effectiveness. Recently some strains of S. aureus that are resistant to vancomycin have been reported (CDC 2002).

The costs of these dynamics, especially multi drug resistance, is also rising, in terms of mortality, disability, and dollars. Antibiotic-resistant bacteria generate a minimum of $4 billion to $5 billion in costs to U.S. society and individuals yearly, and in 1992, the 19,000 deaths directly caused by hospital acquired infections made them the eleventh leading cause of death in the U.S. population (CDC 1998).

There has been a distinct lag in producing new classes of antimicrobials, despite great advances in the fundamental science that is resulting in pharmaceutical innovation in many other areas. As a result, approaches to management of the specter of emerging antimicrobial resistance have had to innovative and multidisciplinary. One of the major areas where progress has been made in the battle to deal with antimicrobial resistance is in the development of information sources for both clinicians and the general public. The proliferation of the world-wide-web has enabled information and resources to be made available to virtually all corners of the world. This report will briefly review some of the resources available on-line for antimicrobial resistance.

The Centers for Disease Control continue to lead the way in providing an extensive group of references and up to date information on resistance patterns and strategies for patient management and treatment. The CDC site, located at: www.cdc.gov/ncidod/hip/ include the largest variety of informational sources, including patient brochures, professional guidelines, specific infectious disease information, isolation guidelines, training materials, slide presentations, and links to corresponding sites for additional information.
The CDC Division of Bacterial and Mycotic Diseases have launched a program for “Promoting Appropriate Antibiotic Use in the Community”, with extensive information located at: www.cdc.gov/drugresistance/community/partners.htm. Current participants in this program include state and local health agencies, professional organizations, pharmaceutical companies, health care delivery organizations, insurers, consumer groups, and the public. There are currently 26 federally funded sites. This number has grown from the original 8 sites in 2000. When available and appropriate, a link and/or contact information is provided to a specific appropriate antibiotic use program. The site also contains information regarding ordering of educational tools to help individuals learn about antibiotic resistance and appropriate antibiotic use in upper respiratory infections (www.cdc.gov/drugresistance/community/tools.htm).

The Centers for Disease Control have also been instrumental in developing print resources that provide current information and reports on all aspects of emerging diseases, including antimicrobial resistance. The most impressive of the CDC publications is the monthly peer-reviewed journal, Emerging Infectious Diseases. This journal is available in print form, or on the CDC website at: www.cdc.gov/ncidod/EID/index.htm.

The United States Food and Drug Administration (FDA) provide an excellent site for information related to antibiotic resistance. One of the major focus areas of this site is a review of antibiotic resistance that relates to farm and ranch use. The evidence that drugs used in poultry and beef production can cause antibiotic-resistant infections in consumers spurred the FDA’s Center for Veterinary Medicine to take action to recommend limitations for antibiotic use in beef and poultry production (Bren, FDA 2002). Extensive information on antibiotic resistance, antibiotic usage, FDA consumer articles, and veterinary/industry recommendations, can be found at: www.fda.gov/oc/opacom/hottopics/anti_resist.html.

Antimicrobial resistance is not limited to the United States, and is being seen as a worldwide epidemic. Agencies that have attempted to address the problems of resistance on a global basis include the World Health Organization (WHO) and the Pan-American Health Organization. Both agencies maintain web sites with information in multiple languages. The WHO publishes an annual infectious diseases report that includes information on the emergence of antimicrobial resistance. A recent report from WHO was dedicated to “Overcoming Antimicrobial Resistance” and can be found at: www.who.int/infectious-disease-report/2000/. The WHO is attempting to develop a global strategy to contain resistance and build alliances involving all healthcare providers - countries, governments, international organizations, non-governmental organizations, and both the public and private health care sectors. Similarly, the Pan American Health Organization (PAHO) has established a website to address disease prevention and control, including antimicrobial resistance. A recent report from the Surveillance Network for Emerging Infectious Diseases in the Amazon Countries reviews the current state of resistance to drugs used in the treatment of malaria and other tropical diseases. Efforts are being made by this group to develop national standards for antimicrobial use and carefully monitor resistance patterns, particularly in the case of malarial disease. Additional information on the PAHO website may be accessed at: www.paho.org/English/HCP/HCT/MAL.

Additional information on specific drug resistance issues is provided by groups, including the Network on Antimicrobial Resistance in Staphylococcus aureus (NARSA). This site provides extensive information on staphylococcal research and includes numerous links to government agencies and antimicrobial resistance web sites: www.narsa.net/.

In summary, the problem of antimicrobial resistance continues to grow in a world increasing dependent on antibiotic use, both in human and animal populations. With limited development of new classes of antibiotics, the approaches to management of antimicrobial resistance have relied on the dissemination of information and resources to clinicians and consumers. Through education, surveillance, monitoring of antimicrobial use, maintenance of appropriate drug use, and implementation of necessary infection transmission controls, the chances of limiting further resistance patterns are enhanced.

TSICP to Inaugurate Its First Intermediate Course for Infection Control

Watch for information on this new program to be held in Austin on October 21—22, 2004. www.tsicp.org
In response to feedback from the membership, the board recently agreed to implement some exciting changes.

Fundamentals, a course attended by many of you, will be going on the road. TSICP members expressed concerns over travel distances. The course will be held in Austin this July 29-30 (limited to 70 attendees). Subsequently, we anticipate this basic course will rotate between Austin and a different geographic location semi-annually.

Many infection control professionals requested additional higher-level affordable educational programs. Your responses to the recently sent educational needs assessment questionnaire will be used to design the first TSICP Intermediate course on October 21 – 22 in Austin. Sign up early for this new offering! Attendance will be limited to 70 ICPs.

Yes, the Intermediate course will commence in October when the Annual Conference is generally held. That means the Annual Conference dates are moving to April 7 – 8, 2005.

Many competing education programs occur in the fall and members were upset over conflicts. Therefore, the Board decided to forgo the annual conference in 2004, implement the Intermediate course and move the annual conference to the springtime.

Let us know your thoughts about these changes!

Virginia Kennedy, RN, MS, CIC