Out with the Old, In with the New
The Bureau of Safety and Regulation has changed it's name to the Michigan Occupational Safety and Health Administration (MIOSHA). The MIOSHA website can still be accessed through www.michigan.gov/miosha

MIOSHA is sponsoring three Bloodborne Infectious Diseases half-day workshops, throughout the state, in 2004. These workshops will bring together 3 State of Michigan agencies:

- MIOSHA - BID Overview;
- MDCH - Hepatitis A-E Overview and CDC Post Exposure Management Review;
- MDEQ - Update related to the Michigan Medical Waste Regulatory Program.

Workshop Locations:
- Escanaba - Jan. 28, 2004 at M-TEC at Bay College Contact: Jayne Szukalowski (906) 786-5802 ext. 1510.
- Grand Rapids - Feb. 10, 2004 at the Dominican Center Marywood Contact: Lansing Area Safety Council (866) 423-7233.
- Southfield - March 16, 2004 at the Safety Council of S.E. Michigan. Contact: (248) 557-1281

The cost of the workshop is $25. Please contact Jenelle Thelen at mailto:jthele@michigan.gov

LATE BREAKER - Submitted by, MSIC Advocacy Committee
Governor Jennifer Granholm establishes the new Michigan Department of Labor & Economic Growth (DLEG)
The Governor's Executive Order 2003-18 renamed MI Department of Consumer & Industry Services (MDCIS) as DLEG. DLEG officially opened for business on Dec. 8, 2003. Of note for ICPS, this order transferred the Bureau of Health Services (licenses and regulates health professionals) and Bureau of Health Systems (licenses and regulates healthcare facilities, EMS, and nursing homes and reviews health facility construction plans) to MDCH. You can visit MDCH and DLEG web sites for more details at: http://www.michigan.gov/mdch & http://www.michigan.gov/dleg

Marketing News
APIC CIC Review Study Guides are still available at $49.00 plus $4.00 shipping. Contact Amy Mulonas for orders at 248-693-3474.

Visit us On-Line at: www.msic-online.org
**Immunization Update**

Pediatr Infect Dis. In the fall newsletter the minimum age for Pediarix was stated to be 6 months. According to the CDC guidelines, the minimum age for the first dose of Pediarix is 6 weeks.

**SARS - A Brave New World**

Submitted by Jennifer Sweeney / Managing Editor MSIC News

Health Care was hit hard by the 2003 global outbreak of Severe Acute Respiratory Syndrome (SARS) but it also proved an essential element in eventual containment of this newly emerged disease. The laboratory confirmed case of SARS in the United States was diagnosed in April 2003 and the virus was recently detected in China. As many of us attempt to batten-down-the-hatches for the possibility of a resurgence of SARS, the CDC and WHO websites have a plethora of helpful information for healthcare institutions. Below is information summarized from the CDC's Public Health Guidance Document - SARS Preparedness and Response in Healthcare Facilities. The entire document is available at: http://www.cdc.gov/cidod/sars/sarspre.pdf.

One of the big lessons learned in 2003, was that unprotected exposures to unrecognized SARS cases accounted for significant transmission in healthcare facilities. Strict adherence to infection control practices, and preparedness planning are essential to limiting the impact of future SARS outbreaks. Early identification of cases, prompt isolation of cases, implementation of effective infection control measures, and universal vaccination are key strategies outlined by the CDC as elements on which healthcare facilities should focus their attention in anticipation of reappearance of SARS.

A system for SARS surveillance is important to diagnose and detect cases before transmission occurs. Surveillance is focused on known risk factors. If SARS is detected, it is recommended that screening be expanded to include screening all patients with fever or respiratory symptoms. In the event of an outbreak, SARS transmission can be prevented so start planning NOW! For all of the latest SARS information visit the CDC website at http://www.cdc.gov/ncidod/sars/.

Pneumonia in the event of a potential SARS case. These are available at: http://www.michigan.gov/documents/finalmiscreeningform_62405_7.pdf. In addition, the Michigan Department of Community Health (MDCH) has posted two updated documents on their website; a SARS screening form and guide to collection and arranging testing of specimens from potential cases of SARS. These are available at: http://www.michigan.gov/documents/absenceofsars_94801_7.pdf. Additional information on surveillance and clinical evaluation in the absence of SARS is available at: http://www.cdc.gov/cidod/sars/absenceofsars.htm.

In the event a case of SARS is detected, it is recommended that surveillance be expanded to include screening all patients with fever or respiratory symptoms. SARS risk factors, especially travel to an area where SARS cases are or contact with potential SARS patients. The CDC has on-line SARS clinical algorithms to aid in evaluating patients with SARS risk factors that can be found at: http://www.cdc.gov/cidod/sars/clincialguidance.htm.

As SARS control professionals, what can we do to prepare? Make sure that basic infection control practices like handwashing and proper isolation procedures are fresh in the minds of staff. Ensure that staff is aware of the criteria for evaluating potential SARS cases and that they have access to and training with personal protective equipment. Your facility may want to consider adopting a "respiratory hygiene/cough etiquette" strategy to control respiratory secretions thus potentially reducing SARS transmission in addition to other respiratory pathogens. Establish a plan of communication between your facility and the health department. They will be an important ally in the event of an outbreak.

SARS transmission can be prevented so start planning NOW! For all of the latest SARS information visit the CDC website at http://www.cdc.gov/cidod/sars/.

**National News**

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**Michigan News**

Blue Cross Blue Shield of Michigan (BCBSM): Infection measurement initiative. In the spring of 2003, MSIC was invited to participate in the Center for Healthcare Quality at Blue Cross Blue Shield of Michigan to discuss potential infection-related performance measures pertaining to BCBSM hospital incentive program (Participating Hospital Agreement (PHA)). Dr Shari had solicited input from various clinicians, and continued discussions with a small committee of MSIC members including Jodi Barton, Russ Omsted and Tammy Lundstrom. MSIC members met with the Centers for Disease Control and Prevention (CDC) that estimated that one fourth of the approximately 900,000 HIV-infected people in the U.S. are not aware that they are infected. Because of the potential public health benefits of rapid HIV testing, the CDC and the Centers for Medicare and Medicaid Services (CMS) are working with state and other health officials to make the test widely available, and to offer technical assistance and counseling training for its use.

A Fact sheet about the OraQuick can be found at: http://www.fda.gov/cber/oraqucrkflg.htm.

**PROFESSIONAL DEVELOPMENT** - Paula Hoegemeyer

**National News**

**SARS - A Brave New World**

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To accomplish these requirements, physicians, public health departments, treatment clinics and hospitals must seek mycobacteriology laboratories that are able to test TB. We must be sure our tuberculosis laboratory is able to report microscopic slide examination results on the same day that the specimen was received in the laboratory. We must expect our TB laboratory to perform primary culture using a “rapid broth” AFB growth detection system, which can determine culture positive specimens within two weeks of receipt. We must expect our laboratory to perform a “rapid identification” testing, using either genet-

OSHA tools: Fire threats and mold control

The Occupational Safety and Health Administration (OSHA) announced the online availability of two new resources that may be available to help healthcare providers identify and reduce risks to patients, personnel, and visitors in patient care areas, including patient rooms, operating rooms, and other clinical spaces. The resources are available on the OSHA web site: http://www.osha.gov

State of Michigan Guidelines to Reduce the Transmission of Perinatal HIV, Hepatitis B and Syphilis

Each guideline in the state of Michigan, newborns are perinatally infected with the human immunodeficiency virus (HIV). Newborns are at risk for infection with hepatitis B virus (HBV) and hepatitis C virus (HCV) via breast milk.

FDA Approves New Rapid HIV Test Kit - OraQuick

The U.S. Food and Drug Administration has approved a new rapid HIV diagnostic test kit that provides results with 99.6 percent accuracy in as little as 20 minutes. Using less than a drop of blood collected, this new test can quickly and reliably detect antibodies to HIV- 1, the HIV virus that causes infection in most cases in the U.S. Unlike other currently available HIV tests, this diagnostic test, known as OraQuick, requires no specialized equipment, and may be considered for use outside of traditional laboratory or clinical settings. The newly approved test kit is called OraQuick Rapid HIV-1 Antibody Test, manufactured by OraSure Technologies, Inc., Bethlehem, Pennsylvania. The test is designed to search for HIV antibodies, but has nothing to do with testing for oral condylomatous papillomas or oral syphilis, which are sexually transmitted diseases.

Michigan Department of Community Health

The Centers for Disease Control and Prevention (CDC) has issued a guide intended to help health care providers recognize exposure to chemical agents in the event of a covert chemical release. The Chemical Agent Recognition Guide is an outline of symptoms of each of the nine chemical agents currently known to cause human illness and the potential risk to patient isolation, treatment and infection control decisions. So, we must consider our laboratory service provider wisely, to assure that the best TB laboratory services are selected, services which meet CDC recommendations and provide rapid and accurate AFB test results to enhance the ability of TB case managers to provide the best health care and TB case management possible.

The JCAHO released revised infection control standards that will become effective January 1, 2005 during the National Infection Control Conference. The revised infection control standards cover a variety of topics, including how to identify and correct, and prevent indoor air problems; how to implement an effective air quality plan; and resources on mold, asbestos, asthma and allergies, and chemical safety. The NIOSH topic page is at www.cdc.gov/niosh/topics/indoorenv

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The Experience of a Norovirus Outbreak in a Long Term Care Facility Submitted by Yvette Haddix, Evangelical Homes Speaking from first hand experience as an Infection Control Coordinator in a long term care facility that has had to deal with this situation twice, I wonder if it was coincidence or bad luck? Call it what you want, but I would not wish these kinds of unfortunate events on anyone.

The first time that our facility experienced a norovirus outbreak we did not know exactly what kind of a GI problem we were dealing with. Symptoms included diarrhea, nausea, vomiting and low grade temperatures. One of the reasons that we were unsure was the residents with symptoms were sporadically located through out our facility. Within 24 hours, we had fourteen residents that were affected. It was then that we realized exactly what our facility was dealing with.

The second time we dealt with the norovirus situation was exactly one year to the day that our first case had occurred. This time we knew exactly what we were dealing with. This time the residents that developed symptoms were all located on one unit. As soon as we realized these residents had the same symptoms of nausea, diarrhea, vomiting and low grade temperatures, we knew what we were dealing with. It was one efficient GI virus.

The most important thing to avoid during these times is the residents becoming dehydrated. We provided extra fluids any chance that we could; during medication pass and at all meals. Extra fluids, such as juices, jell-o, broth and Gatorade were also encouraged on the units throughout the day.

Secondly, we needed to stop the virus from spreading. We encouraged residents to stay in their rooms and closed the unit doors to keep residents out of the rooms. It was helpful for wandering residents. We closed the dining rooms, so that residents had to eat in their rooms and cancelled group activities. All of these things were important factors in stopping the spread of the virus.

Staffing was also important to remind staff how crucial hand washing was to stop the spread of the Norovirus. We reminded staff to change their clothes as soon as they got home. Employees were encouraged not to show up for work when they were sick and to try to remain at home for 48 hours after their symptoms had ceased. By far, this was one of the biggest challenges. Visitors were aware of what was occurring in the facility and the signs were posted on all entrances to the building. The signs alerted the facility was experiencing a high volume of residents that had gastrointestinal symptoms. They were instructed to speak with the nurse before entering the resident room. We also included a reminder to the visitors that they should wash their hands well before leaving the facility.

Random stool cultures were also obtained on approximately five residents to confirm that this indeed was Norovirus and all cultures did return positive. Between the outbreaks, greater than fifty percent of our residents and staff were affected.

During these times the Infection Control Coordinator I contacted the Medical Director of our facility and the county health department. They were great resources during both outbreaks. The Internet was another great source of information. We all learned a lot from both outbreaks in our facility. Hopefully someday this virus will be prevented by a simple vaccine like the influenza vaccine.

On the Flu Front Submitted by Sallie A. Bidol, MPH - Michigan Department of Community Health / Bureau of Epidemiology 2003-04 Influenza Season As of September 7, 2003, the Centers for Disease Control and Prevention (CDC) reported the availability of influenza activity in several areas, including school outbreaks of laboratory-confirmed influenza A infections in Texas. Preliminary laboratory analyses conducted at the CDC on influenza A H3N2 isolates from Texas have shown that while most are antigenically similar to the current vaccine strain, some are antigenically drifted. This coincides with analyses of the Texas isolates performed in February and September showing that about a third have drifted antigenically from the current A H3N2 vaccine. According to the CDC, while vaccine protection against the A H3N2 drift variants may be lower, the vaccine is expected to provide some degree of protective effect.

To view real-time information on influenza activity in Michigan, please visit the Michigan Department of Community Health (MDCH) website at http://www.michigan.gov/mdch. This information is updated regularly throughout the flu season. National influenza surveillance summary information for the current week is available at the CDC website http://www.cdc.gov/ncidod/diseases/flu/weekly.htm

Enhanced Surveillance for Emerging Influenza Strains

What is Michigan doing to detect and track influenza infections directly from animals, sporadic human infections and limited outbreaks caused by avian influenza A viruses have been reported in the world in recent years. As recently as this past winter (2003), there were separate reported occurrences of human infections with avian influenza viruses in two countries. The Netherlands reported more than 80 confirmed cases of influenza A H7N7 infections among poultry workers, followed by more than 60 cases of influenza A H7N7 infections in their families following exposure to infected poultry. At least 12 of these infections began in chickens. The majority of these human illnesses were mild and were characterized by clinical signs of conjunctivitis; however several persons experienced respiratory symptoms and one person died. In another discrete occurrence, two human cases of influenza A H7N7 infection were confirmed in a single family of Hong Kong residents who had traveled to mainland China. Both patients were hospitalized and one died.

The above scenarios illustrate the ongoing potential for emergence of avian or other animal influenza viruses that are capable of causing human infections. Surveillance of these outbreaks is accomplished through sentinel provider surveillance and, influenza-like illness activity. In response to these situations, the CDC has recommended enhanced influenza surveillance for state health departments to rapidly identify an importation of a novel strain of influenza A virus into the United States. As part of this effort, Michigan along with other states have continued laboratory and sentinel provider surveillance activities year round, uninterrupted. Currently there are 40 sentinel physician sites established throughout Michigan that provide weekly information on influenza-like illnesses among their patient populations in addition, physicians and hospitals are asked to perform viral culture on all patients meeting both of the following criteria: Patients hospitalized with unexplained pneumonia, acute respiratory distress syndrome (ARDS), or severe respiratory illness AND Travel to Asia within ten days from onset of symptoms.

For more information on the Michigan sentinel surveillance system or to inquire about becoming a sentinel site, please contact MDCH at 517-335-8159.

Serious Influenza-Associated Illness and Deaths in Children – Jan-Feb 2003 During the first quarter of 2003, MDCH worked with the CDC and several Michigan local health departments to investigate a series of severe illnesses or unexplained deaths among children following a brief upper respiratory syndrome. Fourteen such occurrences among children were evaluated. Eighteen children died and an additional 4 children were hospitalized. 4 of the 18 children had evidence of encephalopathy and one case had evidence of myocarditis. The children ranged in age from 14 months to 14 years of age, most residing in the southeast region of the state. There were no recognized common exposures or epidemiologic links among the cases. Following extensive laboratory studies, influenza virus was detected in all 14 of the cases, including influenza A (H1N1) and influenza B (B/Victoria/02/3). In addition, the H1N1 and influenza B (B/Victoria/02/3) viruses were isolated from all 18 of the children. The H1N1 virus was isolated in 12 of the 18 cases, and the B virus was isolated in 3 of the 18 cases.

The four fatalities associated with influenza occurred in healthy children considered low risk for influenza complications, and for whom influenza vaccination was not encouraged or recommended. None of the children had received vaccination. The recommendations of the Advisory Committee on Immunization Practices (ACIP), influenza vaccination of healthy children aged 6–23 months continues to be encouraged when feasible [1]. Vaccination of children aged >6 months who have certain medical conditions continues to be strongly recommended.

The complete study can be found in the Morbidity and Mortality Weekly Report. Complete. Severe morbidity and mortality associated with...
The Experience of a Norovirus Outbreak in a Long Term Care Facility

Submitted by Yvette Haddix, Evangelical Homes

Speaking from first hand experience as an Infection Control Coordinator in a long term care facility that has had to deal with this situation twice, I wonder if it was coincidence or bad luck? Call it what you want, but I would not wish these kinds of unfortunate events on anyone else.

The first time that our facility experienced a Norovirus outbreak we did not know exactly what kind of a GI problem we were dealing with. Symptoms included diarrhea, nausea, vomiting and low grade temperatures. One of the reasons that we were unsure was the residents with symptoms were sporadically located throughout our facility. Within 24 hours, we had fourteen residents that were affected. It was a very busy time for the local health department as well as our facility. They were great resources during both outbreaks. The Internet was another great source of information. We all learned a lot from those outbreaks.

The second time we dealt with the Norovirus situation was exactly one year to the date that our first case had occurred. This time exactly what we were dealing with. This time the residents that developed symptoms were all located on one unit. As soon as we realized these residents had the same symptoms of nausea, diarrhea, vomiting and low grade temperatures, we knew what we were dealing with. This outbreak was much more effective in terms of containment.

In both situations the first thing we needed to avoid is the transmission of the virus. We provided extra fluids any chance that we could; during medication pass and at all meals. Extra fluids, such as juices, jell-o, broth and Gatorade were also encouraged on the units throughout the day.

Secondly, we needed to stop the virus from spreading. We encouraged residents to stay in their rooms and closed the unit doors to keep the virus contained. This was helpful for wandering residents. We closed the dining rooms, so that residents had to eat in their rooms and cancelled group activities. All of these things were important factors in stopping the spread of the virus.

In both outbreaks, staff was also important to remind staff how crucial hand washing was to stop the spread of the Norovirus. We reminded staff and change their clothes as soon as they got home. Employee were encouraged not to show up for work when they were sick and to try to remain at home for 48 hours after their symptoms had ceased. By far, this was one of the biggest challenges.

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Integrated Network system. MI-TRAIN can be accessed via the web site http://mi.train.org/. Through this site, healthcare professionals can quickly and register for many courses, track learning with personal online transcripts, access valuable materials, course reviews/recommendations of the Advisory Committee on Immunization Practices (ACIP), influenza vaccination of healthy children aged 6–23 months continues to be encouraged whenever feasible [1]. Vaccination of children aged >6 months who have certain medical conditions continues to be strongly recommended. The complete study can be found in the Morbidity and Mortality Weekly Report. CDC. Severely morbid and mortality associated with...

§ Defined as altered mental status of any duration, including seizure but not including simple febrile seizures.

References

Testing for Mycobacterium Tuberculosis - What Should You Expect from Your TB Laboratory

Michigan Department of Community Health

Dale E. Berry - TB Lab Manager

Laboratory testing for M.tuberculosis plays an integral part in diagnosis and management of tuberculosis cases. However, when a clinician's specimen is sent to the laboratory for testing, it is already known which antibiotics the patient is susceptible to and whether the tuberculosis case is an initial infection or a reactivation. This is critical in determining appropriate therapy and subsequent tuberculosis case management. It is essential that laboratories provide accurate and useful test results, as rapidly as possible, so that there is minimal delay in case detection and management. This is especially important in cases when the patient has not been previously tested. It is also essential that recipients of TB lab reports understand when to expect lab reports and what kind of information that these reports convey.


To accomplish these requirements, physicians, public health departments, treatment clinics, and hospitals must seek mycobacteriology laboratory testing that meets these standards. We must expect our TB laboratory to be able to report microscopic slide examination results on the same day that the specimen was received in the laboratory. We must expect our TB laboratory to perform primary culture using a “rapid broth” AFB growth detection system, which can determine culture positive specimens within two weeks of the positive AFB culture report. New TB isolates must be tested for susceptibility to primary anti-tuberculosis antibiotics (isoniazid (INH), Rifampin (RIF), Ethambutol (EMB), Streptomycin (ST) and Pyrazinamide (PZA)). Susceptibility results are to be reported within 28 days of receipt of the clinical specimen, usually about one week after a positive TB identification report. This can only be accomplished by employing the use of a rapid broth susceptibility test system. Subsequent testing must be arranged to provide confirmation of the susceptibility test results, when required for alternate antibiotic therapy. A “direct specimen amplified genetic probe” is also offered by some laboratories and can provide identification of M.tuberculosis complex within one day of an AFB positive slide examination report. This test provides the most rapid identification of M.tuberculosis complex or NOT M.tuberculosis within 21 days of receipt of the clinical specimen. A report of “TB” or “Not TB” should be expected within four days of the positive AFB culture report. New TB isolates must be tested for susceptibility to primary anti-tuberculosis antibiotics (isoniazid (INH), Rifampin (RIF), Ethambutol (EMB), Streptomycin (ST) and Pyrazinamide (PZA)). It is advisable for laboratories which decide to perform acid-fast microscopic examination and primary isolation of M.tuberculosis must also perform a rapid identification test to differentiate acid-fast growth as either M.tuberculosis or NOT. Otherwise, culture isolates have to be sent to a reference laboratory to perform the differentiation and may require additional days or weeks, an unacceptable delay which may affect patient and disease control management.

So, to our TB laboratory service provider wisely, to assure that the best TB laboratory services are selected, services which meet CDC recommendations and provide rapid and accurate AFB test results to enhance the ability of TB case managers to provide the best health care and TB case management possible.

State of Michigan Guidelines to Reduce the Transmission of Perinatal HIV, Hepatitis B and Syphilis

Each year, approximately 8,000 HIV-infected people in the US who come to public clinics for HIV testing do not return later to receive new testing services, The OraQuick Rapid HIV-1 Antibody Test, manufactured by OraSure Technologies, Inc., Bethlehem, Pennsylvania, has nothing to do with the use of oral esudate like the OraSure Test,

FD A Approves New Rapid HIV Test Kit - OraQuick

The FDA has approved a new rapid HIV diagnostic test kit that provides results with 99.6 percent accuracy in as little as 20 minutes. Using less than a drop of blood collected, this new test can quickly and reliably detect antibodies to HIV-1, the virus that causes AIDS. Unlike other HIV tests, this test is designed for use in settings where high temperatures, requires no specialized equipment, and may be considered for use outside of traditional laboratory or clinical settings. The newly approved test is called The OraQuick Rapid HIV-1 Antibody Test, manufactured by OraSure Technologies, Inc., Bethlehem, Pennsylvania, has nothing to do with the use of oral esudate like the OraSure Test.

The revised standards emphasize the performance improvement aspects of preventing health care-associated infections (HAIs), integration and collaboration with multiple disciplines and areas within a health care facility, communication among all Health Care Council members and incorporation of a facility’s overall performance improvement program. A rationale and elements of performance are incorporated under each standard. The standards applicable to hospitals seeking accreditation are as follows:

§ 10.10 The risk of development of a health-care-associated infection (HAI) is minimized through an organizational wide infection control program.

§ 10.10 The infection control program identifies risks for the acquisition and transmission of infectious agents on an ongoing basis. The infection control program identifies risks for the acquisition and transmission of infectious agents on an ongoing basis. The risk of development of a health-care-associated infection (HAI) is minimized through an organizational wide infection control program. The risk of development of a health-care-associated infection (HAI) is minimized through an organizational wide infection control program.
Immunoization Update

Pediatx Correction: in the fall newsletter the minimum age for use of Pediatx was stated to be 6 months. According to the CDC guidelines, the minimum age for the first dose of Pediatx is 6 weeks. Additional information on Pediatx is available at http://www.cdc.gov/vip/vaccine/pediatx/pediatx-faqs-hcp.htm - R10

MSCI News Notes: November 2003

Judea Bartley, Advocacy committee

National News

CDC Environmental Infection

The Centers for Disease Control and Prevention (CDC) released the complete 235-page Guidelines on Environmental Infection Control in Health Care, that include background information, recommendations and appendices. CDC announced that the full document may be downloaded on the CDC website. The guidelines were published earlier this year in the June 6, 2003, MMWR. To: http://www.cdc.gov/mmwr

2004 National Patient Safety Goal and Infection Control – Update on Goal 7? HAIs FAQS

On November 3, 2003, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) announced the latest in a series of its Patient Safety Goals (PSGs). The new Goal 7 (HAIs) 2004 National Patient Safety Goals (NSPG). Earlier this year, JCAHO announced that it was retaining each of the six 2003 goals, with some modifications, and adding a seventh goal aimed at reducing the risk of health-care associated infections (HAIs) by reducing nosocomial and community acquired infections that cause suffering, permanent injury or loss of function as the result of an HAIs qualifies as a sentinel event and also requires compliance with the CDC Hand Hygiene Guidelines. More information is now published on the JCAHO web site under the question “Sentinel.”

http://www.jcaho.org/accredited_organizations/patient/safety/04/psg/04_faqs.htm

Alcohol-based Hand Rubs – Update from National Fire Protection Agency (NFPA)

Centers for Disease Control and Prevention (CDC) guidelines for hand hygiene in healthcare settings (1012) calls for the use of alcohol-based hand rubs (hand rubs) as an effective tool in reducing health care related associated infections (HAIs), but fire agencies have prohibited its use in specific areas of health care organizations based on fire safety regulations and precautions for fire risk. Activities resulting from the fire code updates taken by the American Society for Healthcare Engineering (ASHE) and CDC were summarized in MSCI Fall news and can be located at ASHE website listed below.

NFPA meeting: On November 19, 2003 the results of an ASHE-sponsored fire modeling study carried out by Gage-Babcock & Associate (GBA) were presented by Chris Leaver, PE, of GBA to a group of fire safety professionals involved in fire code setting activities. Judeane Bartley, ASHE and AHA liaison to APIC, presented the infection control issues and the urgent need for increased accessibility. Following the presentations, Tom Jaeger PE, GBA, facilitated a panel discussion and question from the audience. Panelists included ASHE Advocacy director, Merle Umbarger; ASHE executive director, Samet, JCAHO standards, and representatives from the VA and long term care facilities. There was increasing agreement by fire marshals and safety professionals to support the use of alcohol in patient rooms. The focus of the meeting was in the fight to reduce HAIs, but differences of opinion on the degree of risk in erasing corridors remain within some groups. Others expressed their conviction that current codes do not prohibit dispenser use in corridors and several avenues are being actively pursued by ASHE and other national organizations to remove any obstacles to a code change. Although the need for a formal determination has not yet been determined for formal resolution, but approval processes for potential changes would not occur before January or February of 2004. In the meantime, all healthcare facilities are urged and encouraged to install these dispensers within patient rooms as appropriate for the population.

http://www.nfpa.org/standards/101/101faqs.htm


http://www.jcaho.org/accredited_organizations/patient/safety/04/psg/04_faqs.htm


Note: Michigan has specific regulations in place that must be followed. Michigan’s Office of Fire Safety encourages contact for questions regarding dispenser placement and should be contacted for direction. Although national codes may be reviewed or changed, any changes made will still require review and consideration from the fire agencies by Michigan’s OFS.

See http://www.msci.org on line for contact information.

Michigan News

Blue Cross Blue Shield of Michigan (BCBSM): Infection measurement initiative

In the fall newsletter, MSCI was invited to the Blue Cross Blue Shield of Michigan to discuss potential infection-related performance measures pertaining to BCBSM hospital incentive program (Participating Hospital Agreement (PHA)). Dr. Share had solicited input from various clinicians, and discussions continued with a small committee of MSCI member Judea Bartley, Russ Omsted and Tammy Lundstrom. MSCI, the

The Centers for Disease Control and Prevention (CDC) has estimated that one fourth of the approximately 900,000 HIV-infected people in the U.S. are not aware that they are infected. Because of the potential public health benefits of rapid HIV testing, the CDC and the Centers for Medicare and Medicaid Services are working with state and other health officials to make the test widely available, and to offer technical assistance and counseling training for its use. A Fact sheet about the OraQuick can be found at: http://www.fda.gov/cber/oraquick.htm

SARS - A Brave New World

Submitted by Jennifer Sweeney / Managing Editor MSCI News

Health Care was hit hard by the 2003 global outbreak of Severe Acute Respiratory Syndrome (SARS) but it also proved an essential part of the medical community’s response. The laboratory confirmed case of SARS in Detroit was recently detected in China. As many of us attempt to button-down-the-hatches for the possibility of a resurgence of SARS, the CDC and WHO websites have a plethora of helpful information for healthcare institutions. Below is information summarized from the CDC's Public Health Guidance Document - SARS Preparedness and Response in Healthcare Facilities. The entire document is available at http://www.cdc.gov/nidod/sars/

One of the big lessons learned in 2003, was that unpreparedness to unrecognized SARS cases accounted for significant transmission in healthcare facilities. Strict adherence to infection control protocols and preparedness planning are essential to limiting the impact of future SARS outbreaks. Early identification of cases, prompt isolation of cases, implementation of effective infection control measures, and Universal precautions as outlined by the CDC as elements on which healthcare facilities should focus their attention in anticipation of reappearance of SARS.

A system for SARS surveillance is important to diagnose and detect cases before transmission occurs. Surveillance is focused on known risk factors.

1) Individuals in previously affected areas 2) Contact with healthcare facilities 3) Contact with other patients with unexplained pneumonia

SARS in Healthcare facilities

In the event a case of SARS is detected, it is recommended that surveillance is expanded to include screening all patients with fever or respiratory symptoms or SARS risk factors, especially travel to an area where SARS cases are present or contact with possible SARS cases. The CDC has on-line SARS clinical algorithms to aid in evaluating patients with SARS risk factors that can be found at: http://www.cdc.gov/nidod/sars/howtoscreen.htm

As infection control professionals, what can we do to prepare? Make sure that basic infection control practices like handwashing and proper procedures are in place in the minds of everyone. Ensure that staff are aware of the criteria for evaluating potential SARS cases and that they have access to and training with personal protective equipment. Your facility may want to consider adopting a “respiratory isolation procedure” that will not soon be forgotten.

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Out with the Old, In with the New

The Bureau of Safety and Regulation has changed its name to the Michigan Occupational Safety and Health Administration (MIOSHA). The MIOSHA website can still be accessed through www.michigan.gov/miosha

MIOSHA is sponsoring three Bloodborne Infectious Diseases half-day workshops, throughout the state, in 2004. These workshops will bring together 3 State of Michigan agencies:
- MIOSHA - BID Overview;
- MDCH - Hepatitis A-E Overview and CDC Post Exposure Management Review;
- MDEQ - Update related to the Michigan Medical Waste Regulatory Program.

Workshop Locations:
- Escanaba - Jan. 28, 2004 at M-TEC at Bay College Contact: Jayne Szukalowski (906) 786-5802 ext. 1510.
- Grand Rapids - Feb. 10, 2004 at the Dominican Center Marywood Contact: Lansing Area Safety Council (888) 423-7233.
- Southfield - March 16, 2004 at the Safety Council of S.E. Michigan. Contact: (248) 557-1281

The cost of the workshop is $25. Please contact Jenelle Thelen at mailto:jthele@michigan.gov

LATE BREAKER: - Submitted by, MSIC Advocacy Committee

Governor Jennifer Granholm establishes the new Michigan Department of Labor & Economic Growth (DLEG)

The Governor's Executive Order 2003-18 renamed MI Department of Consumer & Industry Services (MDCIS) as DLEG. DLEG officially opened for business on Dec. 8, 2003. Of note for ICPs, this order transferred the Bureau of Health Services (licenses and regulates health professionals) and Bureau of Health Systems (licenses and regulates healthcare facilities, EMS, and nursing homes and reviews health facility construction plans) to MDCH. You can visit MDCH and DLEG web sites for more details at:

Marketing News

APIC CIC Review Study Guides are still available at $49.00 plus $4.00 shipping. Contact Amy Mulonas for orders at 248-693-3474.

President's Message

2003 has been an exciting year for MSIC and I have enjoyed being able to serve the membership. The anniversary celebration this fall was a great success. I would like to express much appreciation to Betty Ann Eash, Paula Hoegemeyer, and Maggie Piehl and her team for devoting so much time and effort for planning our 30th anniversary celebration.

With the winter approaching, I hope everyone has taken the flu shot and remains healthy for the New Year. Many of us, however, may still have other viral illnesses as the season progresses. Just remember your tissues, don't take antibiotics, stay home and have a sip of tea while you rest!

The MSIC board meets in January with new leadership and ideas for 2004. Teri Lee Dyke will lead the board as President. Welcome also to Sue Lloyd as President Elect, Deb Leithauser, Professional Development, and Jenelle Thelen MIOSHA Liaison.

We are looking forward to seeing you at our 2004 conferences. The dates are April 22nd and 23rd and the fall conference will be October 7th and 8th. If you would like to consider a poster, visit the MSIC web to identify the chair for that session for more information. Posters are a good way to network with your peers and remain current in the practice of Epidemiology and infection control.

I wish you a happy and healthy New Year.

Regards, Elaine Flanagan, President 2003

Society Changes

It's that time of year again, and I'm not referring to flu season. It's the time of year when we have to stand up and give a big round of applause to our outgoing board members: Sue Bums-Organizational Promotions Chair, Paula Hoegemeyer-Professional Development Chair, Joan Wideman-Past President and Nella Davis-Ray-MIOSHA Liaison. MSIC would like to thank Joan, Paula, Sue and Nella for all their hard work and dedication.

And now a big WELCOME to the new MSIC board members who will take over the reigns in January 2004: Teri Lee Dyke-President, Jennifer Madigan-Organizational Promotions Chair, Deb Leithauser-Professional Development Chair, Sue Lloyd-President Elect, and Jenelle Thelen- MIOSHA Liaison.

Visit us On-Line at:
www.msic-online.org