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Newsletter

Issue 17, March, 2010

Mission of the HKICNA: promulgating infection control best practice in health care organization and the community.
This newsletter is the official publication of HKICNA and published bi-annually in March and September. Members are entitled to a free subscription. It welcomes articles pertaining to prevention, surveillance and control of infections, and related complications in health care organization and community. Please visit ***http://www.hkicna.org*** *to submit.*

Contents

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Interesting Information from Dashboard

A CICO (Chief Infection Control Officer) brief – Dashboard which is a weekly real time review of infectious diseases of relevance to hospitals has been writing by Dr SETO Wing Hong (CICO) since 2007.

Below is some interesting information from the latest dashboard in 2010 to share with you.

Measuring severity in the HSI pandemic and where does Hong Kong (HK) stand. *(Dashboard-vol. 3, 17th issue: 8th January 2010)*

A recent article in the renowned journal PLOS (Presanis et al: December 2009:6; issue 12, pp2) stated that **the most relevant index to use in the pandemic for comparing severity will be the case-fatality rate (CFR)**. The numerator is the number of deaths and the denominator is the total number of cases. Thus in the WHO and CDC websites (http://www.who.int/csr/don/2009_12_30/en/index.html) (http://www.cdc.gov/h1n1flu/updates/072409.htm), when data are compared, they provide just the number of deaths and total number of cases to enable easy comparison of the CFR. When the CFR is compared, HK is remarkably low presently at 0.16% compared to USA (15.8%), UK (1.1%), Singapore (1.56%), China (0.44%) and Taiwan (0.64%). However there is a concern that the low CFR in HK may be due to the extensive testing done, making the total cases higher than other countries. Two key concepts however should be appreciated.

- As pointed out by Presanis et al, the absence of a widely available serologic test for HSI makes it impossible to measure directly the total number of

cases infected. Nevertheless there are studies that have estimated the total number of cases. Presanis reported it for USA (NY City + Milwaukee) and Singapore reported it in their DH bulletin (http://www.moh.gov.sq/mohcorp/publicationsnewsbulletins.aspx) . In **USA, estimated CFR is 0.007%** while **Singapore is rather similar at 0.006%**. Hong Kong has also estimated the total number of cases to be 15% of the population, based on serology studies and WK Chang's report (Bull. WHO 69:41; 349). The **CFR for HK is then 0.005%. This is reassuring that indeed HK has a low CFR.** Presanis et al also stated that a good rate for comparison is the case-intensive care ratio (CIR) which is the number of HSI admitted to ICU over total cases. Based on the above studies just quoted, the CIR for HK is 1.5% as compared to 2.8% for USA and 3.5% for Singapore. Again, HK is low in comparison.

- What should **not** be used for comparison is the population wide mortality rate which is the number of deaths divided by the total population. A key reason is that in epidemiology, the denominator should always be the "population at risk". Thus for the CFR, the denominator just consists of cases with HSI. It is inappropriate to use the country's population as the denominator as those uninfected are not at risk of dying from HSI. So the WHO and CDC websites do **not** list such population wide mortality rates for comparison. They may be found in some consumer's websites but are not taken seriously by professional epidemiologists. In fact, one of this website with such a list also advertises on the same page a natural remedy for the "flu".

  Based on the present data, HK's low fatality rate is recognized worldwide. Let us be vigilant to maintain it.

What will be the nature of next winter surge? (Dashboard *-vol. 3, 22nd issue: 12th February 2010*):

Essentially we cannot be certain especially in the context of a new pandemic. However it is still worthwhile to summarize what we do know and extrapolate it to explain the present situation. It is known for instance that the winter surge is dependant on various factors including the antigenic structure of the virus, herd immunity and the weather in particular the temperature and relative humidity (RH). A few points in this regard should be noted:

- Why is the winter surge still not evident? A classic study by Palese's group shows that for Influenza virus to spread efficiently in the winter, both the temperature and RH is vital (PLoS Pathog 2007/vol3/issue10/e151). However a key factor is the RH and Palese reported that **"transmission was completely blocked at a high RH of 80%"**. The winter surge in HK usually starts in January to February. Analyzing RH from 2005, the mean for January is always <80% except for 2010. In fact for Feb. 2010 so far, it is >80% every day (Range: 83-96.5). Last year for the same period there is only one day >80% (Range: 68.5-80.5). **The high RH this year should be a key factor for the delayed appearance of the winter surge**.
- What will be the dominant strain for the winter surge? Upphoff et al (Eurosurveillance VOL14/32/1-3) with surveillance data from 1992-2009 and modeling, predicted that chances in seasonal influenza viruses "to lead to considerable morbidity during the coming influenza season 2009-10 to be very low." The model applies to Germany with implications that much of Europe may be similar. **He predicted that HSI will exert "rapid total replacement, as seen in previous pandemics." It may also be the case in HK and it is**

pertinent that for the last three weeks, not a single H3N2 seasonal influenza strain is reported by the PHLC. Upphoff et al also stated that the seasonal strain with the highest possibility to be retained is Influenza B. Thus it is relevant that last week, 62.5% of influenza strains reported in China are Influenza B. The situation deserves monitoring.

- How severe will the winter surge be? One cannot be certain. However the winter surge after the 1968 pandemic was reported as relatively mild. Roden for example reported in UK that "influenza prevalence in the winter of 1968-69 rose to only a moderate height in any one week" (Bull WHO 1969, 41:375). Positively, WHO reports that for now influenza in the northern hemisphere "remain low in most regions" in spite of the cold winter. **If RH remains high and temperature doesn't fall too drastically, HK winter surge may be relatively benign**.

Event-Related Sterility Maintenance in a private hospital

Cinder CHAN & Berni LEE,
Infection Control Team
Matilda International Hospital

Did you ever hear about "sterile items discovered 50 years after World War II"? The story is about a nurse who found gauze and bandages wrapped in muslin in the basement of a hospital in British Columbia, Canada. The finder imagined that they were probably prepared for shipment to Europe. She took them to the laboratory for testing, and cultures showed no growth.[1]

Our hospital then started the principle of "event- related sterility maintenance" for 10 years. The concept of Event Related Sterility assumes a package will remain sterile unless the integrity of the package is compromised.[2]

However, this change did not happen overnight. The policies and procedures must be approved by the Infection Control Committee and the following issues should be addressed:

- Requirements for wrapping, storage, and rotation of sterile supplies.
- Definition of an event that may cause a sterile item being compromised, such as the package being wet or torn, or the seal being broken or tampered with.
- Clear direction that final inspection of the package and the ultimate decision to use the contents of the package rest with the health care worker.
- Orientation, in-service, and audits to assure that all necessary staff understand and implement the policies and procedures.[3]

When we first practised the event-related sterility maintenance (ERSM), we encountered some obstacles such as overcoming resistance to change by managers and staff, and especially the Department of Health. Everyone was concerned that this practice must not compromise patient safety at any time. To practise ERSM, it is no doubt that the CSSD must exercise vigilant control and undertake tests on a regular basis to ensure all related factors are strictly adhered to.

How did we implement the change?

1. Literature research to support the ERSM
   a. **AAMI**, 1993[4]

   Shelf-Life- "The shelf-life of a packaged sterile item is event-related and depends on the quality of the wrapping material, the storage conditions, the conditions during transport, and the amount of handling. There should be written policies and

procedures for how shelf-life is determined and for how it is indicated on the product."

Expiration Dating- "Each item intended for use as a sterile product must be labelled with a lot control number, a control date for stock rotation, and the following statement: 'Product is not sterile if packaging is open, damaged, or wet. Please check before using.'"

b. JCAHO[5] "There are written policies for the shelf-life of all stored items." IC.5.1.2

c. **AORN, Recommended Practice VIII**[6,7] "Shelf-life of a packaged sterile item is event-related,..."

d. **The Australian Standard AS 4187-1998**[8,9] "Event related factors which influence shelf life."

2. Define goals for the policy-to implement evidence based practice as well as reducing costs and improving patient care
3. Review technical documentation on barrier quality of packaging materials – focus on the quality of the filter layer, not number of filter layers
4. Review current practices to establish compliance with AAMI, AORN, JCAHO and CDC
5. Develop and implement initial and on-going testing protocol (Event Related Sterility Check)
6. Develop a policy (for acceptable storage conditions)
7. Define labeling policy (a load and a lot number)
8. Define "events" that would require reprocessing of packages (e.g. torn, dropped on the floor)
9. Define rotation policy (First in First out Basis)
10. Define how to monitor compliance (Audit)
11. In service mandatory training
12. Monitor healthcare associated infection rates
13. Evaluation on staff and manpower utilization
14. Quality Control: written guidelines, periodic inspection, sterility check and audit for compliance.

A SWOT (Strength-Weakness-Opportunity-Threat) analysis was considered for the feasibility of the change, i.e. Event related Vs Time related Sterility Maintenance:

Strength	Weakness	Opportunity	Threat
Evidence based practice from international standards (AMMI, JCAHO, AORN)	Knowledge deficiency of ERSM theory by staff	New learning process	Increase infection rate if not handled or stored properly of the packs
Reduce costs-manpower, repossessing packs costs & wrapping material cost	Initial capital cost-non woven wrap and Genesis pans	New Breakthrough	Not accepted by Department of Health
Manpower – better utilization for other nursing activities	Resistance from staff and it is not widely accepted in Hong Kong	Improve sterile supply management	Staff cut
Time saved on checking, reprocessing, and returning items			
Environmentally friendly-reduced water, wrapping paper, tape & labels consumed			

Considerations are also made on manpower, running costs, capital investment and training:

a. Manpower: checking expiry dates and expired trays returned to CSSD, unwrapping and rewrapping reprocess
b. Running costs: Non-woven wrap
c. Capital investment: Genesis pans – durable containers designed for steam penetration and wrapping is unnecessary
d. Reprocessing: number of cycles run by washer, washing chemicals, maintenance (washer/dryer), manpower, water and electricity.

After implementing ERSM policy, our hospital with 102 beds saved approximately HK$770,000 per year. Costs reduce due to less rewrapping, less reprocessing and less resterilization, resulting in an improvement in our sterile supply management, as well as delighting our staff because we do not have to routinely survey our sterile trays for outdates or for expiration dates. This impact of change is significant: 1) representing savings in both reprocessing and labor costs. 2) The timely and costly practice of reprocessing is greatly reduced. 3) One full time staff is reduced in the CSSD and could spend time in more productive job functions. By controlling costs, we could all put into the quality of patient care. In addition, audits on the knowledge of ERSM and periodic inspection were conducted yearly with over 90% compliance. Our Infection Control Team agreed the changeover has been successful: *"We have had no noticeable change in infection rates that might indicate there have been any problems whatsoever."*

Our success is associated with the total commitment at all levels of the organization, i.e. every staff follows the newly established sterilization standards and practices. A lot of time was spent on educating all those involved and hence satisfactory outcomes resulted. We suggest hospital managers to eliminate sterile outdates by

- Properly selecting sterile packaging
- Monitoring their sterilization processes
- Controlling the event surrounding the handling and storage of sterile items until they are used.
- Staff to follow evidence based practice

The last but not the least, the event related sterility maintenance has gained universal acceptance including countries such as Australia, New Zealand and the US, producing cost saving and measurable results.[10]

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Evaluation of the Effectiveness of Needless Device and Their Acceptance by Healthcare Workers

Man Yin CHOW; Hon Kei SIU; Ka Lam CHENG; Man Kit YU;
Suet Yi LEE; Dominic, Ngai Chong TSANG
Infection Control Team,
Queen Elizabeth Hospital

Background:

Needle stick injuries (NSIs) pose a significant occupational hazard to health care workers especially in the potential transmission of blood-borne pathogens. In QEH, in order to reduce the risk of NSI, the needless connector (Fig. 1) has been introduced to replace traditional heparin locks in various wards since late 2006. However, this safety device could only reduce the exposures of needle when giving bolus injection. NSIs have still been reported during use of intravenous –needle assemblies such as the handling of the intravenous piggyback-needle (Fig. 2) and of dangling exposed needles disconnected from the secondary medication sets (Fig, 3) when patient is on IV line.

In 2008, the intravenous tubing-needle assemblies were the third highest procedure-related cause of NSI, 11% of the total needle stick injury number in our hospital. Aiming to eliminate this problem, a trial of new safety devices has been conducted in selected Medical and Surgical wards in QEH from April 2009 to 30 September. This trial is funded by the OSH Training & Welfare fund.

Fig. 1

Fig. 2

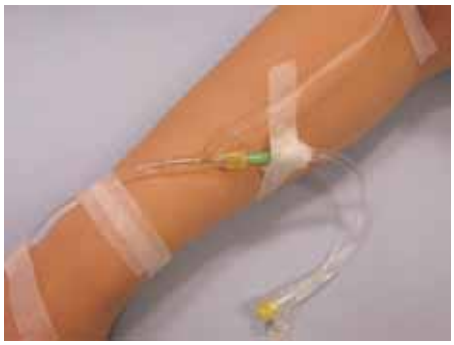


Fig. 3

Objectives:

1)to evaluate the staffs' usability and acceptance in using the new safety device

2)To determine the new safety device's effectiveness in reducing intravenous tubing-needle assemblies related NSIs

Methodology

Study Period: 1st April 2009 to 30th September, 2009.

Study Design: Case control study

Case: 4 wards (2 medical admission and 2 surgical) were chosen for the device trial

Control: 4 wards (2 medical and 2 surgical) were selected as control wards

Subjects: The end-users included nurses and doctors

Intervention: The new device is a single-piece instrument with a bi-directional connector and two swabbable needle-free injection ports. It is designed to avoid the use of needles into the "Y-site" on primary intravenous line (Fig. 4). Training sessions were provided to end-users prior to implementation and regularly reinforced thereafter by infection control nurses. This training included how to operate the device properly and when it should be used in clinical practice.

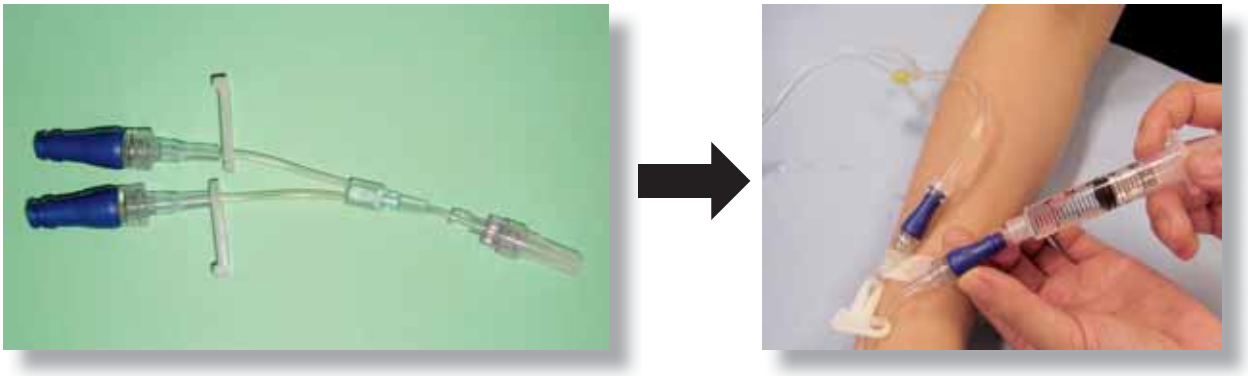


Fig. 4

Data collection Following the completion of the trial, the NSI incidence related to intravenous tubing-needle assemblies were compared between the intervention and control wards as primary outcome. The procedure-related NSI rates of the intervention wards were also compared within the same period (1st April to 30th September 2009) as well as to those from a year ago (1st April to 30th September 2008.)

Health care worker acceptance and usability ratings of the new device were assessed by anonymous questionnaires. Each healthcare worker scored 11 statements concerning their experience and patient or procedure consideration on the device. The statements were rated using a Likert scale in which they either strongly disagreed =1, disagreed=2, neither agreed nor disagreed=3, agreed=4 or strongly agreed=5 with various aspects of using the new device. This assessment included the self-reported compliance rate (0=never use; 10=always use) in using the new device, since personal compliance is an important reflector of acceptance.

Data Analysis: The rates of NSI were calculated over patient bed days on the respective intervention wards and control wards as the denominator. Poisson test was used for evaluating the significance difference. P values of 0.05 or less were regarded as significant. For the questionnaire, the mean score out of 5 with optimum score = 5 was obtained.

Results:

Effectiveness of new device

The NSI incidence of the intervention wards dropped from 1.165/1000 patient-bed days to 0.079/1000 patient-bed days (Table.1). The NSI incidence of the intervention wards was lower than that of the control wards (0.113/1000 patient-bed days) (Table. 2)

Table 1. Compared NSI incidence rate in intervention wards within the same period (1st April to 30th September 2009) and from a year ago (1 April to 30th September 2008.)

	NSI rate associated with intravenous tubing-needle assemblies **/1000 patient bed days**				**Test for comparing the two rates✧**
	2008 1 Apr-30 Sep	**2009 1 Apr-30 Sep**	Diff. in rates	SE (Diff. in rates)	
Intervention wards	0.165	0.079	0.086	0.100	NS
Control wards	0.000	0.113	0.113	0.065	NS
✧Assume the data follow Poisson distribution					"NS"= Not significant

Table 2. Comparison of NSI incidence rate between Intervention wards and Control wards from 1 Apr 2009 to 30 Sep

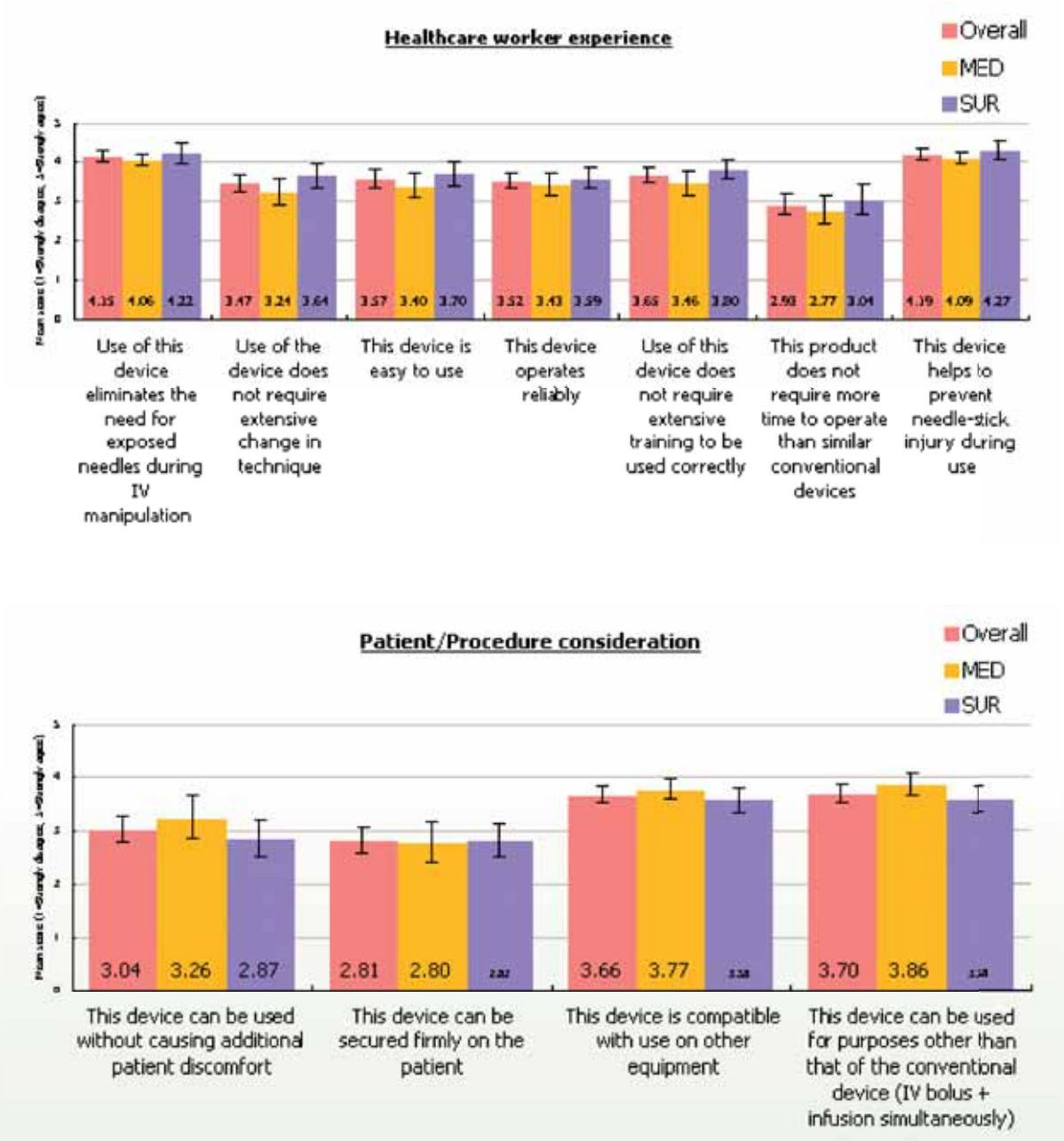
	NSI rate associated with intravenous tubing-needle assemblies **/1000 patient bed days (1 Apr -30 Sep 2009)**				**Test for comparing the two rates**
	Intervention wards	**Control wards**	Diff. in rates	SE (Diff. in rates)	
Overall	0.079	0.113	0.034	0.086	NS
✧Assume the data follow Poisson distribution					"NS"= Not significant

User acceptance and usability

Questionnaires were distributed to 80 nurses and 21 doctors. Of the 101 distributed questionnaires, 79% (63 nurses and 16 doctors; 36 from Medical and 43 from Surgical) were fully completed and returned.

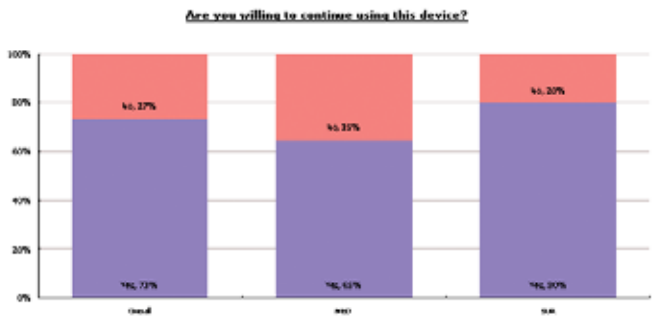
The users' acceptability and usability assessed from 11 statements are shown in Figure 5. The majority of respondents strongly agreed the new device could help reduce NSIs and eliminate the need for needle exposure (overall mean scores 4.19 and 4.15 respectively). However, most respondents felt that they required more time to operate the new device and it was considered rather more difficult to be secured firmly on patients (overall mean score 2.98 and 2.81 respectively).

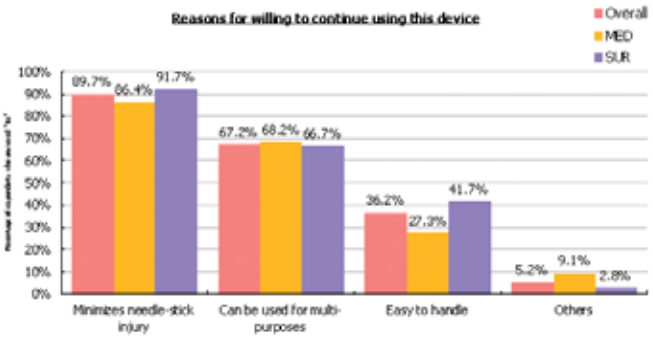
Figure 5. Health care workers' (users) usability on the new needless device

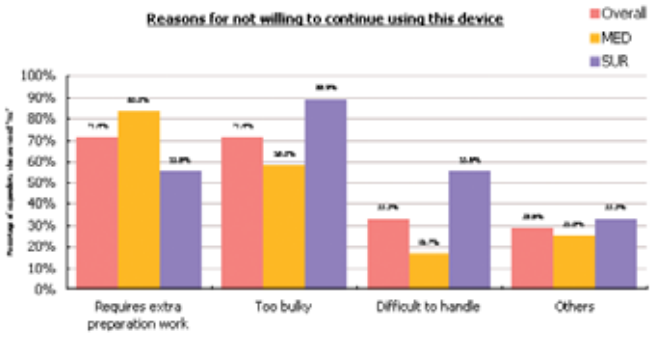


The self-reported compliance in surgical intervention wards was obviously higher (9.34) than in medical intervention wards (5.67). The higher self-reported compliance rate generated more favorable responses towards the new needless device. Of the overall 79 respondents, 73% showed a positive response and they preferred to use the new safety device over the conventional one (Figure 6). "Minimizes NSI" was the strongest motivator. The two main reasons for the negative responses were that the device is too bulky and required extra preparation work.

Figure6. Health care workers' (end-users) acceptance on the new needless device







Discussion

Results demonstrate the decrease of NSIs after the implementation. However, our findings are statistically insignificant. This may be due to the small number of NSI cases specifically related to intravenous tubing assemblies. During the study period, two needle stick injuries occurred in the intervention wards (one each in the Surgical and Medical departments). Both cases occurred in the beginning of the study when the nurses were not yet aware of the implementation of the new device and they sustained needle stick injuries when they used a syringe to access the lines. These two injuries probably could have been prevented if the awareness of the new device had been maintained, such as by frequent promulgation, education and post-implementation communication. These issues can be further targeted in future study programs.

The new device is widely accepted with a 73% favorable overall opinion that they are willing to continue to use. Among them, 90% viewed this device as a useful means to reduce NSI. Among those who did not accept the new device, it was considered "too bulky", and "required extra preparation work" were the important reasons. More than half of the surgical ward staff concerned the device was difficult to handle due to having to manipulate its long tubing, which causes kinking thus affecting the infusion rate. To facilitate the practicability and user acceptance of the device, perhaps if shorter tubing was used could be made possible. However, such a modified device is currently unavailable in the market.

Conclusion

We have shown the use of the needleless device to decrease NSIs in both medical and surgical wards. Furthermore, the device is well accepted by frontline health care workers. To enhance program success, strategies to promulgate before and during program implementation including staff training and education, on-going communication, and understanding of potential problems encountered are crucial.

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Research Grant: 2010-2011

Online application - http://www.hkicna.org

Introduction

Research provides a ground for evidence-based practice in infection control and prevention. Therefore, HKICNA developed a research grant in September 2003.

The achievement will highly depend on members' concerted effort. Keeping this in mind, HKICNA cordially invites all of our members to apply.

Application Online

Every active HKICNA member is eligible to apply for the research grant. For the details of application, please visit http://www.hkicna.org before the closing date.

Members of Research Review Panel:

1. Professor Paul CHAN, Associate Professor, Department of Microbiology, The Chinese University of Hong Kong, Hong Kong.
2. Professor Joanne CHUNG, Chair Professor (Health Studies) & Head, Department of Health and Physical Education, The Hong Kong Institute of Education, Hong Kong.
3. Ms Glenys HARRINGTON, Consultant, Infection Control Consultancy, Australia.
4. Professor William JARVIS, Clinical Associate Professor, School of Medicine, Emory University; Adjunct Assistant Professor, Rollins School of Public Health, Emory University, and private consultant , USA.
5. Ms Patricia LYNCH, Past Chair, International Federation of Infection Control, USA.
6. Professor Didier PITTET, Director, Infection Control Program, The University of Geneva Hospitals, Switzerland; Lead, WHO, World Alliance for Patient Safety.
7. Dr Wing Hong SETO, CICO, HAHO; director of Q&RM, Queen Mary Hospital, Hong Kong.
8. Dr Wing Kin TO, Infection Control Officer, YCH and CMC; consultant, microbiology , KWC, Hong Kong.
9. Professor Samson WONG, Assistant Professor, Microbiology. The University of Hong Kong, Hong Kong.

Funding for Application:

Maximum HKD$100,000 per proposal, the amount granted is subject to the panel's decision.

Vetting Criteria:

1. **FRIEND –F**easible, **R**elevant, **I**nteresting, **E**thical, **N**ovel, **D**eliverable.
2. **Theme** –Related to infection control.

Closing date for Application:

30th June 2010

Result of the Application:

Applicants not notified by 30th September 2010 should consider their applications unsuccessful. The result will be released in the coming issue of this newsletter by September 2010 too.

Undertaking:

The successful candidate is required to sign an undertaking with HKICNA.

News and Information

A. Congress / Symposium:

1. **IFIC collaborative conference with the Infection Prevention and Control African Network (IPCAN)**
   29 August -1.September 2010
   Spier Estate, Stellenbosch, Western Cape, South Africa
   http://www.theific.org/ipcan2010.asp

2. **7th International Conference of the Hospital Infection Society (HIS)**
   10-13 October 2010
   Liverpool , England,UK
   http://www.his2010,com

3. **48th Annual Meeting of Infectious Diseases Society of America (IDSA)**
   21-24 October 2010
   Vancouver, Canada
   http://www.idsociety.org/Content.aspx?id=4244

4. **SHEA (Society for Healthcare Epidemiology of America) Annual Scientific Meeting**
   1-4 April 2011
   Dallas, Texas,USA
   http://www.shea-online.org

5. **APIC (Association for Professionals in Infection Control & Epidemiology) 38th Annual Conference**
   26-30 June 2011
   Baltimore, MD, USA
   http://www.apic.org

B. New / Revised Guideline

1. Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009
   http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/CAUTI_Guideline2009final.pdf

C. Scholarship

The Infection Control Course 2009 was run successfully with 290 participants joined. The TOP student 2009 is Ms LAM Siu Wai, Portia, (RN , Hong Kong Sanatorium and Hospital) who will be presented the scholarship of $ 1000 cash in the coming AGM in April 2010.

D. 21st Anniversary of HKICNA -AGM on 24th April 2010

This year, our Annual General Meeting (AGM) is coming up on 24th April. The details of the AGM have e-mailed to members and uploaded on the web. Members are strongly advised to update us on your e-mail addresses, and to visit our web for information to join us.

E. Infection Control Course for Nurses 2010

This course has been tentatively scheduled on 6th September till 15th November 2010 for 11 consecutive Monday evenings. The details will be uploaded on our home page, by June 2010.

F. Acknowledgment

Ms CHEUNG Kit Chiu, Elizabeth (Council member and the publication editor of this newsletter) has just retired. We would like to thank her for her dedication to HKICNA and wish her all the best in her future endeavors.

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香港控制感染護士會

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4th International Conference of Infection Control

27-29 August 2010

The Expanding Horizons of Infection Control

Guest of Honor: GUO Yanhong

Director of Nursing Division
Department of Medical Administration, Ministry of Health, China

Confirmed Speakers :

William JARVIS (USA)
Elaine LARSON (USA)
Didier PITTET (Switzerland)
Michael TAPPER (USA)
Wing Hong SETO (Hong Kong)

Program Advisors :

Paul CHAN, Hong Kong
Joanne CHUNG, Hong Kong
Wing Hong SETO, Hong Kong
Wing Kin TO, Hong Kong

Abstract Submission Deadline
Early Registration Deadline

15.06.2010

Collaborating Societies:

- Association of Hong Kong Operating Room Nurses (HKORN)
- Hong Kong Association of Critical Care Nurses (HKACCN)
- Hong Kong Emergency Nurses Association (HKENA)
- Hong Kong Society of Endoscopy Nurses
- Hong Kong Sterile Services Management Association
- Hong Kong Society For Microbiology And Infection

Organiser:

Hong Kong Infection Control Nurses' Association

Website: www.mvdmc.com/hkicna

Email: hkicna@mvdmc.com

Conference Secretariat

MV Destination Management Ltd. Tel: (852) 2735 8118 Fax: (852) 2735 8282