A Message from the TSICP President...

2010 is off to a quick start. The 2009 board and new 2010 board met in Galveston this past January and strategized for the coming year. We have had great success with our Essentials Class for Infection Prevention and many attendees are raving about their learning and networking experience. This conference is taught by our board members and the expertise is phenomenal. As an IP for 20 years now, I still learn some little tidbit every time. We have scheduled the 2010 Essentials Classes for June in San Marcos and October in Amarillo.

I want to encourage you to invest your time and money to attend our 2010 Annual TSICP conference scheduled for March 25th & 26th in Austin Texas. This is a great value for your education and travel dollars. I know the budgetary restrictions being imposed on all hospitals but the rewards will be worth the expense. We have several knowledgeable speakers scheduled to update us on our current practice and the 2011 mandatory reporting in Texas. The flier is in this TSICP Times and I encourage you to speak with your CEOs and CFOs. We will also have a vendors fair again to see the new state of the art technology and products used in infection prevention. Registration is now open and can be done online.

I want to assure you that TSICP is alive and well in the current economic times. Our Executive Director, Doris Kraft, has done a fantastic job keeping our organization profitable. Doris & her assistant, Jamie, are invaluable in everything they do for our members. TSICP is highly respected at the state level with Department of State Health Services and have been involved with the current mandatory reporting legislation. We have a liaison in Austin watching all the healthcare bills being presented and she informs us of any issues that we need to address. We are working for you, our members.

We will be introducing you to the 2010 board members in each issue of TSICP Times this year. We are always looking for new people to be on our board and always welcome comments and questions from our membership. I look forward to seeing you all in Austin at the Annual Conference.

Val Sparks  RN, BSN, CIC
It will soon be time once again for TSICP’s Annual Conference. The Education Committee has lined up some wonderful speakers including our own, Charlotte Wheeler and Annette Moore, Dr. Perry Pate, Sandy Von Behren, and Allan Morrison (just to name a few)!

If you missed out on the conference this year, take a look at some of the comments from attendees:

1. Thank you for your time & effort to present the different topics of discussion. I am new to Infection Control. This is my second TSICP conference. I look forward to attending another conference. Thank you!!
2. Wonderful presentations. TSICP is such an asset to ICP’s. Thank you!
3. One more time – TSICP Exceeded my Expectations. It is nice to see everyday ICP Heroes like Mary, Ellen, & Brenda share success stories to help others.
4. Hospitality, food, speakers were ALL terrific. Well organized, thank you for all the hard work. Enjoy hearing the current events like the Ike clean up.
5. Excellent seminar. New to infection, good experience.

The conference is once again being held at the beautiful DoubleTree Hotel in Austin, Texas, on March 25 and 26, 2010. Begin making your plans to attend now. Watch our website, www.tsicp.org, for upcoming details on how to register.
Valerie Sparks RN, BSN, CIC
President

Infection Preventionist and Occupational Health / Worker’s Compensation Coordinator at Midland Memorial Hospital in Midland, TX. Val has been certified in Infection Control by CBIC since 1992. Val is passionate about Infection Prevention with EVERY hospital employee. She believes that infection prevention is everyone’s responsibility. The goal of zero tolerance is a lofty one but Val believes that should be every Infection Preventionist dream. She has been on the board of TSICP since 2007 serving on the education committee and as secretary this past year. Val was instrumental in organizing and starting the West Texas Infection Control Practitioners meetings in Midland so the surrounding facilities and local health departments could network about current issues. Val has enjoyed the TSICP network around the state and looks forward to representing you at the state level.

Kathleen Byrne, RN, BSN, ICP
President-Elect

Kathleen has been a nurse since 1973 and an ICP for more than 15 yrs. She has worked as an Infection Control Specialist in the Memorial Hermann Healthcare System since 1997. Additionally, she has worked as an Occupational Health Nurse and Workers Comp Coordinator. She earned an associate degree in Liberal Arts from University of St. Leo, Tampa, FL. She obtained an associate degree in nursing, graduating with honors as an RN from North Harris Community College, Houston, TX. She completed her BSN from Jacksonville University in Florida. Currently, Kathleen is studying for her CIC. Since 1995, Kathleen has been a member of APIC, and her local chapter. She enjoys speaking publicly; therefore, several times a year she speaks in Humble, TX to update the community on flu and MRSA. Likewise, Kathleen developed and published an exposure poster that was sponsored by Roche Pharmaceuticals. Most recently, she completed a PEP poster for Abbott Labs that was distributed to the attendees at the winter 2007 TSICP conference in Corpus Christi, TX. Five hundred of these posters have been distributed to ICPs and MDs throughout Texas and the surrounding states. Kathleen was previously working at the Memorial Hermann Corporate Offices where she worked on Gap analysis and risk assessments, as well as training new ICP’s. Additionally, she worked with ICP’s at 10 other facilities within the Memorial Hermann Healthcare System to assist in doing surveillance, EOC/IC rounds and developing Rounding Tools. In October 2008, Kathleen was responsible for coordinating the IC System Retreat and she is a current board member for TSICP. As of August 2009 Kathleen has now taken the position as the Director of Infection Control for 3 Triumph facilities in the north Houston area.

Kathleen is passionate about infection prevention. It is the ever changing processes and evolution of this industry that she finds the most exciting. With her variety of professional expertise, education and life experience, she is confident that she will be able to fulfill the duties and function as the TSICP President. With your support, she looks forward to continuing to serve TSICP so that she can bring her passion for the industry, as well as her knowledge of the business of medicine to TSICP.
12/03/2009

the FDA notified healthcare administrators and infection control practitioners that STERIS had significantly modified the Steris System 1 and the FDA has NOT approved or cleared this modified product. Briefly the chain of events that lead to this notice was:

1. The FDA warned STERIS May 15, 2008 that it made changes to the System 1 and Sterilant 20 that could affect significantly the safety and/or effectiveness of this device. Modification (changes) of this device caused it to be an unapproved device that violates federal law.

2. STERIS needed to either submit a new application to the FDA for the modified System 1 or take the system off the market.

3. STERIS disagreed with the FDA position, warning, and responded to the FDA. The FDA did not change their decision on the status of the System 1 after reviewing STERIS' response.

4. January 2009 STERIS reached an agreement with the FDA. STERIS stopped marketing System 1s to new customers, agreed to work with customers on a timetable to transition to the purchase of a replacement and submitted an application for a new product.

5. Recent FDA inspection of STERIS and meetings with the firm, FDA is not satisfied that STERIS has been working effectively to transition customers to replacements for the System 1 Processor. Currently FDA recommends if you have an acceptable alternative to the STERIS System 1 to meet the facility’s sterilization and disinfection needs you should transition to that alternative as soon as possible. If you do not have an alternative to the STERIS System 1, you should promptly assess your hospital’s needs and sterilization and disinfection requirements. The FDA’s recommended time table for the transition is six months. The FDA has added alternatives to the STERIS System 1 to its web site. The FDA also has a Questions and Answers document on its web site.

STERIS sent a “Dear Valued System 1 Customer” letter December 4, 2009. In this letter, STERIS disagreed with the FDA’s notice stating System 1 is safe and effective when used as directed. It also stated there has not been a documented case of infection directly caused by a System 1 when certified health professionals follow proper guidelines and instructions. The FDA is to be notified of all suspected device related deaths and serious injuries along with the manufacturer (STERIS).

FDA’s web site: www.fda.gov/MedicalDevices
STERIS’ web site: www.steris.com or you can contact Steris at 440-392-7223 for questions regarding the STERIS System 1.

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Brenda Helms and the "Snow Nurse"

The Dallas area had a "fun" amount of snow--too hard to resist being creative.
Advantages and Disadvantages of QFTG

This article was published in TSICP in 2007, but is being re-released because a recent study in the CDC TB Notes Newsletter report tuberculin skin tests (TSTs) can cause a boosting effect in TB blood tests.

The intended use of the QuantiFERON®-TB Gold (QFTG) assay is to detect latent TB infections among persons at increased risk for TB and has its place among the tools for the diagnosis of latent and active TB. It does this by targeting specific antigens to stimulate t-cells within a patient’s whole blood sample, interferon-gamma (IFN–gamma) secretions are directly measured to indicate if TB infection IFN–gamma is present. The assay provides a clear and simple YES/NO answer. No interpretation of the test result related to the subject’s TB risks is required.

The advantages of the QFTG are as follows:

- Requires a single patient visit to draw a blood sample.
- Results can be available within 24 hours.
- Does not boost responses as noted with the tuberculin skin tests (TST).
- Is not subject to reader bias that can occur with TST.
- Is not affected by prior BDG (bacille Calmette-Guérin).
Eliminates the need for a two-step skin test.

The disadvantages/limitations are as follows:

- Blood samples must be processed within 12 hours after collection while white cells are still viable.
- Limited data for use in children under 17, persons recently exposed, or immunocompromised persons (e.g. HIV, treatment with immunosuppressive drugs, chronic liver failure, diabetes, specific malignancies, etc.).
- Errors in collecting or transporting blood specimens or in running and interpreting the assay can decrease the accuracy.
- TB Gold assay to predict the progression of latent tuberculosis infection to active tuberculosis has not been evaluated. More expensive.

QFT-G can be used in all circumstances in which the TST is currently used including contact investigations, evaluation of recent immigrants who have had BCG vaccination, and TB screening of healthcare workers and others undergoing serial evaluations for M. tuberculosis.

Before considering using the QFT-G, arrangements should be made with a qualified laboratory and courier service, if needed, to ensure prompt and proper processing of blood. In addition, clinical evaluation and additional tests (such as chest radiograph, sputum smear, and culture) are needed to confirm the diagnosis of latent tuberculosis infection (LTBI) or TB.

References:
http://www.cdc.gov/tb/publications/newsletters/notes
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5415a4.htm
The Dengue virus is a member of the virus family Flaviviridae and is transmitted to people through the bite of the mosquitoes *Aedes aegypti* and *Aedes albopictus*. Dengue virus is now believed to be the most common arthropod-borne disease in the world. Dengue is mainly found in the tropics because the mosquitoes require a warm climate. A major fear of epidemiologists is that the mosquitoes will develop resistance to cooler climates and then be able to infect people in the United States and other temperate climates. The virus is transmitted when a mosquito of the *Aedes genus* bites an individual infected with dengue virus. The virus in the blood of the infected individual then infects the mosquito and travels from the mosquito's stomach to its salivary glands were the virus multiplies. The virus is then injected into another person when the mosquito injects anticoagulants that prevent blood clotting when the mosquito is feeding. The mosquito remains able to transmit dengue for its entire life(3).

Dengue virus infection is increasing throughout the Caribbean (1). Although recent surveillance data from Haiti are not available, the documentation of illness and infections among U.S. military personnel confirms the continuing occurrence of DF in Haiti and the circulation of at least two dengue virus serotypes.

The incubation period for DF generally ranges from 2 to 7 days but may be as long as 14 days; therefore, illness may occur while U.S. military personnel or volunteers are in Haiti or after they return to the United States. Illness is characterized by abrupt onset of fever, chills, headache, eye pain, and lower back pain. Common associated symptoms include myalgia, arthralgia, nausea, vomiting, anorexia, malaise, and a blanching erythematous rash. The clinical course may be characterized by recurrence of fever for 1-2 days after initial improvement. Laboratory findings include leukopenia and thrombocytopenia. However, a small proportion of patients may develop dengue hemorrhagic fever (DHF), which is characterized by fever, thrombocytopenia (platelet count less than 100,000/mm3), and abnormal capillary permeability evidenced by hemoconcentration, hypoalbuminemia, or pleural or abdominal effusions. Resulting mild to severe hemorrhage can occur. DHF can result in circulatory instability or shock, and the risk for these complications may be increased among persons with secondary dengue virus infections. Dengue was identified and named in the late 18th century. The first modern pandemic was reported in Southeast Asia during the 1950s. Since then, outbreaks have become common in tropical regions. About 40 million cases are diagnosed each year, with 22,000 deaths.

Most dengue virus infections are self-limited and can be treated with bed rest, acetaminophen, and oral fluids. An individual may suffer from no more than a fever during his first infection but can become susceptible to more serious symptoms -- including circulatory failure -- if infected again.

Laboratory diagnosis of DF includes detection of serum IgM antibodies, which are usually absent in specimens collected while patients are febrile but can be present in specimens collected after fever has abated. Definitive proof of DF requires virus isolation from serum or a fourfold or greater rise in dengue-specific antibody titers between acute- and convalescent-phase samples. The virus can be isolated from serum obtained only while patients are febrile.

Recent relief efforts to Haiti have resulted in an outpouring of humanitarian aid efforts from both military and civilian personnel. As many of these individuals begin returning to the United States, physicians and other health-care providers should consider potential exposure and infection with DF in the differential diagnosis of febrile illnesses from this group.

The endemic nature of DF in Haiti highlights the increasing impact of this disease in the Americas, the need for an effective vaccine, and the need for increased efforts to control *Aedes aegypti*, the mosquito vector of dengue virus. Dengue virus is now endemic in all Caribbean countries except Cuba and the Cayman Islands (1). The potential exists for introduction of dengue virus into the United States, and for secondary transmission in areas with vector mosquitoes, because of increased travel to and from regions of the Americas where dengue is endemic.

**References**


**Greg Bond**, MSN, RN
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www.tsicp.org

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We all have one common goal. Prevent, prevent, prevent. As an IP, my goal is to protect my patient, whether it’s by educating the patient on prevention of healthcare-associated infections or educating the staff on hand hygiene. My institution has designated one day each month devoted completely too patient safety. Directors are expected to attend a 15-30 minute presentation on a focus of interest. Once the presentation is completed, all Directors round on assigned units. Hand hygiene is always a focus and when I saw our rates were not where they should be, I felt a sense of panic and asked myself “how can that be?” But it was, the numbers don’t lie. It was amazing to see our compliance rate when I made rounds compared to other observations made by Directors. Administration took a strong stance and fully supported the Infection Prevention and Control department. An in-service was developed (again) and along with that every single employee was required to sign a hand hygiene acknowledgement form stating he/she would comply with our hand hygiene requirements. Those that don’t comply, including our Physicians, are noted and names are forwarded to the Performance Improvement department. Trends are noted. Those that don’t comply face the possibility of counseling and or termination. Our rates are slowly improving, of course not near fast enough for me but we know human behavior. Sometimes it takes a topic being discussed over and over in order for it to become engrained. Hand hygiene is one of the most difficult things to master, but we must remember it’s the patient that’s at risk. Prevention is the key to our success, because when we prevent a healthcare associated infection we save a life.

Jodene Satterwhite, RN, CIC
This course is designed as a brief overview covering the basic components of an infection control program that can be adapted to any health care setting. The course is recommended for any infection preventionist just starting a career in infection control or who has been working in infection control for a year or less. Enrollment is limited. Advance registration is recommended because space is limited. For further information, please contact Doris Kraft at (512)-263-2480; email: dkraft_1@msn.com; fax: (512)-402-1875.
"Summary Report - Relating to a Pilot Program to Require Reporting of MRSA"

13 page report from the Texas Department of State Health Services

Click on the link on the Newsletter Page below the list of newsletter contents for the full report.