

Physicians' Newsletter

July—September 2008 Issue 3

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A N A C C R E D I T E D P U B L I C H E A L T H D E P A R T M E N T

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Patient Safety Indicators

One would have to be deaf, dumb and blind to not have noticed the Ontario movement towards hospital reporting of patient safety indicators. Nosocomial *Clostridium difficile*-associated Disease (CDAD) is now being reported by all hospitals across Ontario, and a slew of further indicators are planned for public reporting over the next 6-8 months.

It's interesting to note that the research literature indicates that public reporting of health outcome indicators does not have much effect on the public, in terms of choice and utilization, but it can be a stimulus to institutional learning and improvement. Public Health is quite a part of this whole process, both in the extent to which we sit on hospital bodies responsible for quality assurance and improvement, e.g. the Niagara Health System Infection Prevention and Control Committee and the Medical Advisory Committee, as well as being recipients of reports of events that form part of patient safety indicators. In this latter instance, the Reportable Disease Regulation 559/91 under the *Health Protection and Promotion Act* has been revised to now require reporting of CDAD outbreaks in public hospitals. This gives us the opportunity to see the bigger picture of CDAD outbreaks across hospitals throughout Ontario, and also gives us statutory authority to intervene if and when necessary to assure that full and effective prevention and control measures are implemented in the event of CDAD outbreaks (although given the detailed attention of hospitals in our Region to prevention, detection and control, I'm not sure I'll ever have to use legal powers).

Reported indicators may not always meet with public and/or media expectations. This is especially the case with CDAD, where some voices in the media are urging CDAD-related deaths, as well as rates of nosocomial infections/1,000 patient days, be reported. There are substantial challenges in attributing deaths to infectious diseases, with a number of methods being used/proposed:

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A copy of this newsletter is also available at www.niagararegion.ca/doctors/

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Public Health and Infectious Disease Surveillance (Continued)

- Death certificates, which the literature indicates can substantially underestimate the extent to which CDAD is a direct or contributory factor;
- All-cause 15-day or 30-day mortality in people who contract CDAD, which have significant problems with sensitivity (e.g. deaths due to CDAD may occur after these time periods) and specificity (e.g. deaths within these periods may have nothing to do with CDAD);
- Chart reviews/specialist adjudication, as was the case in the CDAD mortality review undertaken by Joseph Brant Hospital earlier this year, which may be the best method but, certainly in the case of Jo Brant, were enormously time and resource-consuming.

Many of us would argue that the best methods of reporting on CDAD (and other infectious disease) attributable mortality may come with inordinate opportunity costs. We need to focus people and resources on prevention, detection and control as more fundamentally vital to patient safety/quality-of-care.

Further patient safety indicators are on the way, and one wonders whether this will remain confined to hospitals or whether it may, over time, extend to other health care system entities, e.g. long term care

facilities, community-based services, primary care, etc.? There may be a misplaced sense of security in the reporting of patient safety indicators, as in many cases they may represent only the tip of the iceberg of events, resources and practices that are essential to the prevention and control of health care-associated infections, such as:

- ongoing surveillance activities;
- adequate infectious disease and infection prevention and control (IP&C) human resources;
- well-designed facilities;
- IP&C policies and procedures;
- ongoing IP&C education and audits of practice;
- senior leadership commitments and the active role of key health care opinion leaders.

The ongoing work of Dr. Michael Baker, Executive Lead for the Patient Safety Working Group, merits careful and supportive attention.

*Douglas M. Sider, MD MSC FRCPC
Associate Medical Officer of Health*

Prescribing Epinephrine for Anaphylactic Children Attending School

The arrival of the Twinject™ two-dose epinephrine auto-injector is a welcome addition for parents concerned about having a back-up dose available for their children should one become necessary in the event of anaphylaxis. However, both the Niagara Catholic District School Board and the District School Board of Niagara have recently revised their anaphylaxis policies to reflect that school staff are not expected to administer medication by injection with the exception of auto-injectors.

The first dose of the Twinject™ is an auto-injector, whereas the second dose is a small manually administered syringe injection which re-uses the fully exposed needle of the first dose. School personnel will

be instructed by Niagara Region Public Health school nurses on the administration of epinephrine by auto-injector only. Principals are expected by their boards to ask the parent/caregiver to provide two auto-injectors if parents/caregivers desire that a second dose be available.

We therefore encourage physicians to prescribe two Epi-Pens® per child attending school instead of one Twinject™ – one for the child to keep on their person and the other to be kept in the school's office.

*Submitted by:
Gloria Morris RN, MScN
Manager, School Health Program*



A Community Partner for Physicians and Teen Clients

Niagara Region Public Health has a team of secondary school nurses who have weekly access to all high schools in Niagara. The school nurse advocates for youth during their growth and maturation process. Working together with the school, the nurse provides health teaching, support and resources to teachers, students and parents on the importance of a healthy lifestyle. Referrals to the nurses may be made by phone or through the schools.

Within the World Health Organization's Comprehensive School Health Model, the foundation of their work is based on the Search Institute's much publicized Forty Developmental Assets, which outlines how a caring, sharing, supportive community can support youth to develop into healthy, caring, responsible adults. Research has demonstrated that the fewer the number of assets present, the greater the possibility youth will engage in risky behaviours such as drug use, unsafe sex, and violence.

The school nurses in working with youth can provide the following:

- Brief one to one counseling and linkage with community supports
- Referral, education and mental health promotion
- Sexual health services in designated schools including:
 - counselling and teaching
 - AIDS and STI information/counseling/testing
 - safe sex/decision making/abstinence
 - safe relationships
 - preconceptional and prenatal health
 - counseling around issues related to sexual orientation, whether gay, lesbian, bi-sexual, transgendered or queer
- Liaison between community agencies, schools and families
- Coordinate and assist community groups such as:
 - Heart Niagara
 - Immunization clinics
 - MADD
 - OSAID (Ontario Students Against Impaired Driving)
- School presentations and resources are available on the following topics:
 - Alcohol
 - Dangerous Driving
 - Designer Drugs
 - Tobacco
 - Hosting safer parties
 - Sun Safety
 - Heart health
 - Violence and Bullying
 - Body Image
 - Healthy Eating
 - Physical Activity
 - Sexual Health

Please feel free to call the Secondary School Health Program if we can be of help to you or your clients at 905-688-8248 ext. 7516 or visit our website at www.niagararegion.ca -- Quick Links, Public Health, School Health.

Submitted by:
Laurie Columbus, RN, MScN
Manager, School Health Secondary



Pacifier or Soother Usage in Infants

Soothers should not be used by breastfeeding babies in the first month of life in order to allow breastfeeding to become established (SIDS Canada, 2008). Experience has shown that a small minority of babies may require a longer period of time to establish breastfeeding, and health professionals should therefore monitor this on an individual basis. La Leche League International recommends that pacifiers never be used as a substitute for the mother's breast or used for comforting. However, they also state that pacifiers can be of help to a breastfeeding mother when used judiciously, for short periods of time and in limited circumstances.

Due to the lack of strong evidence, either for or against the use of pacifiers, selective and safe use cannot be over-emphasized. The CPS states that no recommendation to use pacifiers to reduce the risk of SIDS can be made at this time. It is important that families make an informed decision regarding soother use. Parents should be advised that it is recommended

to not use a soother until breastfeeding is well established and to use the soother only when settling the baby to sleep. It is also important to teach parents to recognize feeding cues and to not replace breastfeeding with a soother, which may detrimentally impact a mother's milk supply.

Counsel about safe and appropriate use of pacifiers should be part of routine anticipatory guidance in the care of newborns, infants and children (CPS, 2007). Until further research leads to more conclusive evidence on adverse outcomes, health care professionals should recognize pacifier use as a parental choice determined by the needs of their infant.

Submitted by:

*Debra Baker R.N., BScN, IBCLC
Maureen Sharp R.N., BScN, IBCLC
Catharine Lowes R.N., BScN, IBCLC*

Reporting Communicable Diseases

It has recently been brought to my attention that physicians sometimes do not report communicable diseases as required under Section 25 of the *Health Protection and Promotion Act*. In particular, HIV infection and clinical diagnoses of AIDS are under-reported in Niagara. We are told by physicians that they (correctly) assume that the Ontario Public Health laboratory will report positive HIV results to the Medical Officer of Health. It is, however, a purposefully double-reporting system. Laboratory reporting mechanisms can break down at times causing loss of significant data and opportunity for follow-up action.

Reporting of HIV/AIDS provides epidemiology to the Medical Officer of Health as well as the opportunity to provide case management follow-up. Such interventions can lead to decreased transmission of communicable diseases. Reporting of AIDS cases is an exclusive role of physicians since the case definition is based on a clinical diagnosis.

Control of HIV disease has been impeded since the start of the epidemic by stigma and discrimination toward HIV positive individuals and their families. Health authorities have attempted to decrease stigma

through public awareness and categorizing HIV as a mainstream medical/social issue. Experience in Niagara has demonstrated that follow-up counselling by public health staff has been a beneficial intervention for HIV/AIDS patients.

With respect to reporting communicable diseases, Section 30 of the *Health Protection and Promotion Act* also states that physicians who sign a medical certificate of death under the *Vital Statistics Act* where the cause of death was a reportable disease or a reportable disease was a contributing factor to the death, must report to the Medical Officer of Health.

If you wish further discussion regarding reporting under the *Health Protection and Promotion Act*, please contact Alan Spencer, Manager, Sexual Health Program at ext. 7249 or Dr. Doug Sider, Associate Medical Officer of Health at ext. 7477.

Submitted by:

*Andrea Feller, MD, MS, FAAP
Associate Medical Officer of Health*



Head Lice

This is the time of year when the steady stream of phone calls about head lice start coming in to Niagara Region Public Health. In Niagara, school nurses haven't screened students for head lice in over 20 years, yet are still seen as the experts. As a result, the School Health Program keeps an up-to-date web page about head lice as well as comprehensive guidelines to support schools in dealing with head lice in their school populations. School nurses will train groups of parent volunteers willing to be screeners for their schools. Given the parental demand for lower cost and/or pesticide-free treatment, we have developed and posted a fact sheet about the wet combing method on the Public Health web page.

Used widely in the UK and supported in the literature, wet combing involves a process of methodically combing through the hair with a nit comb while it is wet & drenched with ordinary hair conditioner. This process is repeated every four days for a two-week duration and works by combing out live lice, thereby interrupting the lifecycle. Live adult lice are combed out while the newly hatched lice are combed out prior to laying more eggs, thus ending the infestation.

For more information about head lice and the wet combing method, please visit www.niagararegion.ca.

Submitted by:

Gloria Morris RN, MScN

Manager, School Health Program



a second is all it takes

Cell Phones and Driving Don't Mix

According to recent research from the Ontario Medical Association (OMA), speaking on a phone while driving puts drivers at a significantly greater risk of a collision.

The evidence is clear that driving while using a mobile phone is dangerous to the driver, their passengers and others on or near the roadway, "said Dr. Ken Arnold, President of the OMA. "Doctors know all too well the consequences of driving while distracted and its time that the right steps are taken to ensure the safety of all Ontarians."

As you may know, Niagara has one of the highest numbers of fatal and serious injury motor vehicle collisions per capita compared to other Ontario regions. In an effort to reduce this alarming reality, the Regional Niagara Road Safety Committee (RNRSC) are also working hard on its Think and Drive Road Safety Strategy urging Niagara motorists to do just that—"Think and Drive".

The research found that talking on a cell phone while driving:

- led to a large reduction in the driver's functional

field of view;

- changed average driving speed;
- decreased safe distance between vehicles;
- slowed brake reaction time;
- slowed response times to traffic light changes;
- resulted in a 15% increase in non-response to stoplights;
- slowed braking by 18% and slowed the time it took to come back up to speed by 17%;
- reduced visual monitoring of mirrors and instruments with some drivers abandoning them entirely;
- fewer inspection glances at traffic lights and an increased tendency toward hard braking.

Ontario's doctors want the provincial government to take action to protect the lives of all drivers and passengers. "Too many drivers treat talking on a phone while driving as a harmless practice," said Dr. Arnold. "It's not an easy prescription to give, but this practice has to be curtailed."

Please ask your patients to take personal responsibility for their safety on our roads by:

(Continued on page 6)



Cell Phones and Driving Don't Mix (Continued)



- Refraining from using cell phones while driving
- Reducing their speed
- Always wearing their seatbelt
- Driving straight and sober
- Staying focused on the road and
- To use extra caution while driving on rural roads

Your patients see you as a valuable resource. Let's collaboratively raise awareness about the road safety problem in Niagara and educate drivers about how they can make a difference on our roads. Please visit www.thinkanddrive.net for more information.

Source: CNW Group (formerly known as Canada NewsWire)

Submitted by:

Nicole Rusling, RPN, BA

Health Promoter, Injury Prevention Program

We all share a common interest in road safety and a common goal to reduce the serious collisions that continue to occur in Niagara.

Niagara Region Yellow Fever Vaccination Centres

As a signatory to the International Health Regulations, Canada must designate Yellow Fever Vaccination Centres. In Canada, the Public Health Agency of Canada designates Yellow Fever Vaccination Centres.

Clinics which are currently designated Yellow Fever Vaccination Centres in the Niagara region are:

Travel Health Niagara
Niagara Region Public Health
2201 St. Davids Road
Campbell East
Thorold
905-688-8248 ext. 7330

Travel Health MD
532 Lake Street
Suite 101
St. Catharines
905-984-6776

Medisys – St. Catharines Travel Health Clinic
589 Lake Street
Suite 101
St. Catharines
905-228-6136

Medisys – Niagara Falls Travel Health Clinic
6150 Valley Way
Suite 104
Niagara Falls
905-228-6136



Niagara Region Public Health Immunization Campaign History

From time to time we receive phone calls from physicians uncertain as to which vaccines children/youth in their practices may have received via Public Health school-based immunization activities. The following is a list of routine, yearly school-based clinics offered by our Vaccine Preventable Disease Program, to enable you to be aware of potential vaccines received by your patients.

School Year

- 1994-1995 Hepatitis B 3-dose immunization series begins for grade 7 students.
- 2000-2001 Hepatitis B immunization introduces a 2-dose series for Grade 7 students.
- 2005-2006 Conjugate meningococcal C immunizations begin in conjunction with the Grade 7 hepatitis B immunizations.
- 2007-2008 3-dose HPV immunization with Gardasil® begins for Grade 8 females.

In addition to the above annual school-based immunization programs, a series of one-time school-based immunization activities have taken place over the past 1-2 decades:

- January-June 1996 A province-wide “catch up” campaign to provide all school children with a second dose of measles vaccine takes place, using a monovalent measles vaccine (with subsequent first and second doses using MMR vaccine).
- January 2005 Conjugate meningococcal C immunizations offered to students in grades 9-12 in all 42 High Schools across Niagara Region (at the same time as this vaccine was being offered to 12 month old infants and via Grade 7 school-based clinics).
- January 2006 Diphtheria/tetanus/acellular pertussis immunization with Adacel® and conjugate meningococcal C immunization offered to all grade 9 students across Niagara Region (to provide booster immunizations with Adacel and to provide meningococcal C immunizations for students who were in Grade 8 the previous year and who would have missed the onset of the Grade 7 program and the Grades 9-12 catch-up activities the previous year).
- November 2006-
January 2007 Seasonal influenza immunization and Adacel® offered to all students in Grade 9-12 across Niagara Region (the school-based influenza immunization was a one-year pilot effort to determine if school-based provision of this vaccine would increase uptake by teens).

In addition to these school-based immunization clinic activities, Niagara Region Public Health began to actively promote and provide weekly immunization clinics throughout the Region during July/August 2008, focusing on offering the age 14-16 Adacel® booster dose as well as DTP and MMR for children ages 4-6. These clinics were meant to complement, not substitute for, primary care immunization activities, and sought to provide another venue of access for immunizations necessary under the *Immunization of School Pupils Act*.

If you have any questions or inquiries please feel free to contact the Vaccine Preventable Disease Program at 905-688-8248 Ext. 7425.

Submitted by:
Donna Kalailieff RN, BScN, M.Ed
Manager Vaccine Preventable Disease Program



New Resources

Ontario Best Practice Manual: Surveillance of Health Care– Associated Infections in Patient and Resident Populations

This document is intended as a guide for Infection Control Professionals in acute and long-term care, to ensure that the critical elements and methods of surveillance for health care –associated infections (HAIs) are incorporated into their practice. It provides guidance for each of the building blocks of the surveillance system including planning, data collection, interpretation, analysis and communication, to inform infection prevention and control practices and will result in effective surveillance in hospitals and long-term care homes.

The best practices for surveillance described in this document should assist acute and long-term care settings in Ontario in establishing surveillance systems. Effective surveillance should lead to process improvements that will result in decreases in HAI rates, morbidity, mortality and health care costs. Although the primary audience for this document comprises those directly involved in surveillance, it also serves as a resource for anyone seeking to improve their understanding of best practices in nosocomial infection surveillance.

The best practices in this document recommend a standardized approach to the surveillance of health care-associated infections that will allow for the comparison of rates within facilities, across facilities as well as comparison to provincial and national benchmarks. This document forms one component of an effort to enhance patient safety and improve the quality of health care in Ontario.

The document can be downloaded at http://www.health.gov.on.ca/english/providers/program/infectious/diseases/ic_hai.html

Best Practices for Infection Prevention and Control Programs in Ontario in All Health Care Settings

The purpose of this document is to provide recommendations for :

- specific activities for Infection Prevention and Control (IPAC) programs across the continuum of health care delivery in Ontario; and
- adequate and appropriate resource allocation for IPAC programs across the continuum of health care delivery.

This document is targeted to senior administration in health care settings, medical officers of health, as well as others in a management role, and may be of interest to administrators in local health integration networks. These best practices will be useful for developing and prioritizing IPAC programs and engaging in strategic planning activities for the future.

The responsibility for the infection prevention and control program in the health care setting lies primarily with the senior administration of the organization. Implementation of the program rests not only with the IPAC team, but also with nursing managers, Environmental Services, Occupational Health and Safety, directors of medical services, central reprocessing and other departments and individuals in the facility impacted by the effective delivery of the program.

The document can be downloaded at http://www.health.gov.on.ca/english/providers/program/infectious/diseases/ic_ipcp.html