



ReLay Your Health!

Official Newsletter of Tlay Healthcare Services, Inc.

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WELCOME TO THE FIRST ISSUE!



Chiaka Nwoga,
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"It gives me great pleasure to welcome you to the first issue of ReLay Your Health!, the official newsletter of Tlay Healthcare Services, Inc. This bi-monthly newsletter is designed to provide health information and company updates in a concise and orderly format. It is my hope that Tlay clients, caregiving staff, and interested parties increase their awareness of pertinent health issues to ultimately make healthier lifestyle choices. With that said, we hope you enjoy the first issue!"

WHAT YOU NEED TO KNOW ABOUT MRSA

by Chiaka Nwoga, B.H.S.

Many healthy people carry *staphylococcus auerus* bacteria on their skin. Sometimes, these bacteria can enter the blood stream by cuts or breaks in the skin, and cause infection. Normally, such an infection can be treated with medications, particularly antibiotics. The problem is that there are stains called Methicillin-resistant *staphylococcus auerus*, or MRSA, that have become resistant to the medications usually used for treatment. These strains can cause serious illness and long hospital stays. Thus, health-care professions should learn how to identify MRSA, understand transmission, and implement strategies to prevent transmission.

Spread of Infection

In a healthcare facility, MRSA can be spread by direct contact with an infected or colonized individual through nearly any care activity that requires touching the patient.

The most common transmissions occur in the soft-tissues, skin, and surgical sites. MSRA can also be spread through indirect contact with contaminated objects in the patient-care environment. Personal protective equipment, such as gloves or gowns worn by the caregiver, can become contaminated and should be removed prior to leaving the patient room or home.

A new study suggests an increase prevalence of community-acquired strains due to MRSA colonization in domestic animals. Household pets are now considered a potential reservoir for MRSA, and skin infections in dogs and cats can be spread to humans through bites.

Types of MRSA

Healthcare associated- Not present at admission or incubating upon admission. There is evidence infection was acquired during previous care in healthcare environment.

- Typically cause ventilator associated pneumonia, bloodstream infections, or surgical acquired infections.

Community acquired- No evidence linking the infection to healthcare setting. Infection may have started in the home or in the community.

- Presents as skin or soft tissue infection and is sometimes mistaken as spider bites.

Questions? Comments?
We'd like to hear from you.
Please contact
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Signs and Symptoms

MRSA most often appears as a skin infection, like a boil or abscess. Those infected will also experience fever, increased white blood cell count, wound drainage, or change in the character of respiratory secretions. If present, these signs must be reported to a physician especially if the infection persists for 3 or more days. Those that carry either type of MRSA without actually being infected are considered carriers.



Summary

Though most MRSA infections aren't serious, some can be life-threatening. Thus, understanding the different types of MRSA, transmission, and precautions should be the goal of health care workers. Good hygiene is of primary importance in avoiding infection. Therefore, washing hands before and after contact with patients or pets and using personal protective equipment needs to be practiced.

[Note: Staff should review "Employee Orientation Handbook" for applicable policies and procedures]

NOVEL INFLUENZA A (H1N1) VIRUS INFECTIONS AMONG HEALTH-CARE PERSONNEL

from *CDC Morbidity and Mortality Weekly Report*

CDC received 48 reports of confirmed or probable novel influenza A (H1N1) infection among health care professionals (HCP) from 18 states. Detailed information on health-care exposures was obtained for 26 cases (18 confirmed and eight probable) reported from 11 states. Dates of illness onset ranged from April 23 to May 4. Job type was available for 25 HCP: five registered nurses (20%), four nursing assistants (16%), four physicians (16%), and 12 persons in 10 other occupations. Two (8%) of these infected HCP were hospitalized, one of whom reported having underlying medical conditions. Neither hospitalized HCP was admitted to an intensive-care unit; no HCP died. Among the 16 HCP for whom such information was available, eight had been vaccinated for seasonal influenza since September 2008.

Routine infection-control recommendations to decrease the risk for transmission of seasonal influenza to HCP include vaccination, isolation of infected patients in single rooms, and use of standard precautions and droplet precautions. For infections with the novel influenza A (H1N1) virus, because of the lack of a vaccine and little initial information regarding the severity and transmissibility of the virus, CDC's interim infection-control recommendations for the care of patients with such infections have included the use of fit-tested N95 respirators, eye protection, and contact precautions in addition to routine infection-control practices applied to seasonal influenza. In addition, CDC has recommended that aerosol-generating procedures (e.g., bronchoscopy) should be performed in an airborne infection--isolation room with negative pressure air handling.

In this analysis, among the 11 HCP infected because of probable or possible patient to HCP transmission for whom information was available, none adhered to these recommended practices completely. Barriers to adherence can include 1) a belief that these practices are not necessary, inconvenient, or disruptive; 2) lack of availability of PPE; 3) inadequate training in infection control; 4) failure to establish effective, systematic approaches to HCP safety; and 5) failure to recognize patients and activities that warrant specific infection-control practices. Most of the probable or possible patient to HCP transmissions in this report occurred in situations where the use of PPE was not in accordance with CDC recommendations.

Whatever the risk for infection to HCP, much of that risk likely exists in the outpatient setting. As of May 31, only 653 (6%) of 10,053 patients reported with novel influenza A (H1N1) infection had been hospitalized. The findings in this report indicate that six of the 12 HCP with probable or possible patient to HCP acquisition reported working in outpatient settings during the week preceding symptom onset. Many interactions between HCP and infected patients likely occur in ambulatory-care settings and highlight the need for outpatient staff members to follow infection-control recommendations. These results highlight the need to maintain adherence to comprehensive infection-control strategies to prevent transmission of novel H1N1 in health-care settings. These strategies should include administrative controls (e.g., visitor policies and triage of potentially infectious patients), provision of infection-control resources, training in



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