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Long Island APIC NEWSLETTER CHAIR - 2006

Mary Lou Solliday, St. Francis Hospital - Roslyn

UPCOMING CHAPTER MEETINGS - Third Tuesday of each month - *Join Us!*

APIC LONG ISLAND MEETINGS AND PROGRAMS

DATES	TOPIC	SPEAKER	LUNCHEON
September 19, 2006	Highlights APIC '06	Membership	
October 17, 2006	Regional Symposium	George Washington Manor	Full
November 21, 2006	To be Announced		Evening Meeting 4pm-7pm
December 19, 2006	Second Annual Holiday Special and Inservice Exchange	Membership	

***For further program information and other informative links be sure to visit the APIC website at www.apic-longisland.com*

Remember when Answers - Seated from Left to Right: Therese Keelan, Maria Nini Vaggi, Barbara Yanelli & Alice Means

Standing from Left to Right: Peggy Mahorey, Aida Toledo, Enes Bellanore, Inger Gureviteh, Kathy Chaitoff, Lillian Steiert, Joanna Selva & Alice Maroney

Directions to Brunswick Hospital Center Auditorium

Louden Avenue (631) 789-7273 Long Island Chapter Meeting are held the third Tuesday of every month. See back cover for date and agenda

Directions

Take Southern State Parkway to Exit 32 SOUTH Route 110 (Broadway) Amityville. After you see sign Rt. 27 Sunrise Highway, you will be approaching Brunswick Hospital. Take a Right Turn on to Loudon Avenue. Take Loudon Avenue straight down (you will pass Brunswick Hospital) until you see a sign on the right hand side "Brunswick Hall - A Psychiatric Hospital" and a Gatehouse. The Auditorium is through that entrance.

Alternate Route

Sunrise Highway Westbound to Loudon Avenue. Make a left turn at light. Go straight (crossing over County Line Road) and then Auditorium will be on the lefthand side.

ROUTE TO:
INFECTION CONTROL
Quality/Risk Management
Nursing Administration
Staff Development
Employee Health



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**SPRING
2006 NEWSLETTER
PRESIDENT'S MESSAGE
Vita J. Padrone RN, MPA, CIC**

Since 1972 incredible professionals devoted to patient safety have voluntarily joined together in the association that is the APIC Long Island Chapter focused on infection prevention and control. During my first year as President I have felt a weight of responsibility to maintain the standards set by our predecessors while continuing to move the association forward, knowing we would face situations and events over which we have little or no control, and that individually we can feel inundated and sometimes overturned by the events of our day as have leaders before us.

2005-2006 chapter activities could only be managed with the assistance of our Board of Directors. Twenty-one volunteer chapter members fill the elected and appointed positions that permit our association to be sustained and to prosper. This year, once again we have been fortunate to have Board Members with creativity, talent, and other

qualities and characteristics that strengthen, encourage and motivate. We are fortunate, indeed.

Our financial status, already stable and healthy, has been bolstered by a chapter bylaws revision that now includes the position, Treasurer-elect. Lively, well attended networking meetings, outstanding monthly educational sessions, stipends to allow members to attend the National Meeting or other programs, and the scheduling of the next educational program for October 2006, indicate our commitment to education.

Our wonderful chapter website has grown. Professional and fun, information about APIC Long Island and important related resources is available to members, visitors, and other APIC chapters around the world. We remain active in the New York State APIC Coordinating Council (NYSACC) and are preparing to participate in efforts to influence the format of public reporting of healthcare associated infections for New York State. The chapter is also collaborating with the Greater New York Hospital Association to strengthen our efforts to permit the location of alcohol based hand products in facility corridors throughout the area.

As the 2006-2008 Strategic Plan is being formulated, it is most satisfying to note how much of the 2000-2005 Plan has been achieved. My resolve is reinforced, bolstered by the professional relationship of committed colleagues. The tasks before us continue and require the help of all members. Join a committee. Run for an office. Be involved and stay involved. Know the strength and fun of being associated, and experience the strength. You will love it.



GETTING TO KNOW APIC LONG ISLAND BOARD MEMBERS

Spotlight on: *Treasurer Joan Lucchetti, RN*
By *Barbara Lambert*

Joan was originally from southern New Jersey. She attended Thomas Jefferson Medical College and Hospital where she received her RN diploma in 1959. She worked there and then moved to Washington, D.C. where she worked in the Labor and Delivery unit at Washington Hospital Center for two years. The next four years she spent raising her three children. Her Long-Term Care career began when she went back to work part-time in a nursing home in Southern New Jersey. She moved to New York in 1971 and started to work full-time at a Long Term Care Facility in Suffolk County. Joan started to work there at Central Island Nursing Home in Plainview in 1973 while awaiting clearance for a job at the Veteran's Hospital. She started as a part-time supervisor on the night shift and was assigned the task of obtaining and reviewing laboratory cultures and presented Infection Control statistics at quarterly meetings. Gradually she took over more of the infection control duties until she became the Infection Control Practitioner full-time in 1990 and continued to work nights. In 1992 her facility added a sub-acute unit, consequently more surveillance was required. Some of her most challenging Infection Control experiences occurred during the 1990's when she managed an outbreak of upper respiratory infection's which affected 91% of the patient population. and dealt with an outbreak of Chickenpox.

She began to attend APIC meetings in 1990. Several members who she remembers as very helpful included Alice Means, Lillian Steinert, Kathy Chaitoff and and Therese Keelen. She became certified in Infection Control in 1997. She has held many positions in our APIC chapter, working on the Ways and Means Committee, Marketing Committee, Program Committee, and Membership. She became the Treasurer in 1998 and began attending the APIC National Conference, which helped her to fulfill the responsibilities of that office. She is currently mentoring the new Treasurer Elect.

Joan encourages members to attend APIC meetings where you can receive support from other members. She stated "APIC National Conferences provide excellent educational programs which help in your role. I am successful because of my APIC affiliation. It is important to become certified in infection control for credentialing. Networking at meetings is very important, it helps to discuss concerns with your peers."

APIC NYC CHAPTER 13 SYMPOSIUM OCTOBER 19, 2005

CDC/HICPAC and New York State : Guidelines for Public Reporting of Hospital- Associated Infections

Rachel Stricof MT MPH
Epidemiologist , NYS DOH

NYPORTS Update:

As of June 1, 2005 the reporting requirements have changed.

- No longer required to report:
 - *Aspiration pneumonia in non-intubated patient secondary conscious sedation*
 - *IV catheter related necrosis or infection requiring I&D, debridement or surgical intervention.*
- Change in SSI reporting:
 - *Previous requirements: Class I & II requiring drainage during the hospital stay or readmission within 30 days*
 - *Definition medications 2005: includes surgical patients placed on IV antibiotics for SSI.*

NYS Legislation - Public Reporting:

NYS DOH plans to dictate the methods to be used to assure standardized definitions, surveillance methods, same procedures, as well as, risk assessment to provide the ability for comparison. The operating principles include who would have access, confidentiality issues, subpoena legal liability issues and individual patient-identifying information protected under 206 (1)j. Under Section 206 (1)j , provides protection for the "information shall not be admissible as evidence in any action of any kind in any court or before any other tribunal, board, agency or person."

Public reporting will include the following elements: specific infectious agents, site, clinical department or unit, diagnosis on certain relevant surgical, medical or diagnostic procedures. The Core infections of Central Line related bloodstream infections in Critical Care units and surgical wound infections are being included in the initial public reporting. (UTI and VAP infections in critical care units are not required to be reported at this time). Additional indicators may be added which may be fixed or revolving indicators. Ms. Stricof asked for comments / concerns for public reporting to be reported to the New York State DOH through NYSACC. (Linda Kopman) Timeline:

- July 1, 2006: establish system of receiving reports including training and education of hospital reporters
- January 1, 2007: hospitals must have begun reporting. There will be a one year pilot phase which will not be reported to the public. Reporting at 6 month intervals which will be due within 2 months of the end of the period. An audit will be performed by the DOH.
- June 30, 2008 : reports due. These will be assessed for overall accuracy and reported to the governor and legislature.
- Report to governor and legislature by May 1st each year

Submitted by Jeanine Woltmann R.N., B.S., C.I.C.

APIC LONG ISLAND ANNUAL CONFERENCE "INFECTION PREVENTION AND CONTROL: BEYOND THE TIP OF THE ICEBERG"

Be sure to join our annual conference planned for Tuesday, October 17th at the historic George Washington Manor in Roslyn. Topics presented by internationally renowned speakers include:

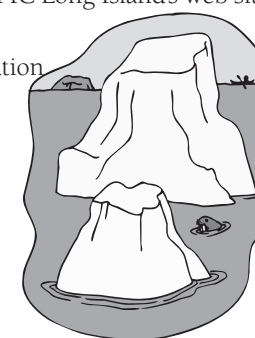
- New York State Mandatory Reporting of Healthcare Acquired Infections.
- Legionella: Compliance to New York State Guidelines
- Interpreting the New CDC Guideline on Prevention of Tuberculosis in Healthcare setting.
- Clostridium Difficile

This is an all day conference and will include breakfast and lunch. You will have the opportunity to view vendor exhibits and discuss the pros and cons of new products with them. Nursing CEUs will be available.

Registration will be available on the APIC Long Island's web site and will also be mailed.

Don't miss this opportunity for education and networking in a lovely setting.

Hope to see you there!



2006 CHAPTER LEADERSHIP AWARD

Marie L. Ciacco - Tsivitis, CIC, MPH, BSMT (ASCP)

A member of APIC since 1985, Marie joined the Long Island Chapter in 1993 bringing with her a special interest in education, apparent in her abstract presentations at APIC National Conferences almost every year since 1987. Her professional commitment to share infection outbreaks events and her ability to present information from experiences in various healthcare settings ranging from critical care to long-term care as in poster presentations sets an example for all APIC members, and speaks to her commitment to the science of infection prevention and control.

Marie has been an asset to our charter working for several years on our Chapter Newsletter Committee and for two years as co-chairperson for the Education committee, and member of the Board of Directors. Most recently she accepted the 2005 and 2006 Education Committee Chairman position, responsible for monthly chapter education programs. Repeatedly, over the years Marie has contacted our membership via e-mail supporting immunization (child and adult), and regarding her special interest in multi-drug resistant microorganisms, and in infection prevention and control across the continuum of care.

Marie's serves our chapter through her professionalism. In addition to promoting CBIC certification for all members, she has personally presented educational programs to our member-

ship including an outbreak of adenoviral conjunctivitis, encouraged our members to participate in activities vital to our profession (she organized and prepared our chapter's response to the OSHA TB Rule), and she has fostered chapter respect for individual members by providing first the tools and then the opportunities for them to highlight their experience and expertise. For example, in addition to teaching members the mechanics of putting together power-point presentations, repeated encouragement and creative program planning has enabled chapter members to share educational material and programs they prepared, bringing a practical and exceptionally useful dynamic to our educational sessions. Marie lives her conviction that the Infection Control Professional is an expert in patient and staff safety, and helps our membership to realize the contributions we make in our roles.

AROUND THE WORLD IN BALTIMORE: APIC NATIONAL 2005

Cecilia Wilfonger RN, BS, CIC

This was not my first visit to Baltimore, nor was it my first encounter at a National APIC Conference. It was the first time, however, that I was aware of the international flavor of the APIC community. The conference had over 3400 registrants, from 64 countries. As a native New Yorker cultural diversity is something I take for granted. Having lunch or coffee and discussing epidemiologically significant issues with infection control practitioners from Latvia, Saudi Arabia, Australia, Sweden, the Philippines and New Zealand was a professional encounter I relished.

At the opening ceremonies, the keynote address given by Dr. Michael Osterhom brought a global perspective to the conference with a presentation on avian influenza. It reminded me that no matter where we practice the issues of infection control know no borders or boundaries. At a luncheon later that day I was privileged to accept our Chapter Leadership Award. Anyone present at the luncheon will tell you how impressive it was to have our Latvian colleague accept the award for best international abstract. Representatives from Australia, Hungary and New Zealand also received funding and scholarships for their work in infection control. Resistant organism spread, Clostridium difficile, hand hygiene, impending influenza pandemics, and central line sepsis are an international language we all speak; challenges, problems and solutions that affect us all.

It brought to mind my reaction to the AJIC journal; reflections of works from around the world that often seem to have no relevance to my world here in New York. We all face the same or very similar problems. Read their problems, share their solutions and see how often we can apply them to our own. There is a wealth of knowledge in that journal and the submissions are there because our colleagues want to share what they have found. They have come to this conference just like me to discover and share experiences, and what I thought was foreign is not. We all left with the same answers and the same challenges.

As I was having dinner at the Aquarium with a mother from Sweden, she told me she was anxious to get home to see her children. Then my cell phone rang and my daughter's voice was at the other end. It reminded me how small the world really is and that we all do face the same problems!

FOCUS ON LONG TERM CARE - WHAT'S NEW?

By Donna Caccavale RN BSN MBA
ICP at Parker Jewish Institute

This past year has been a very busy and productive one for Long Term Care Facilities. Two new regulatory requirements have been added. One involves the use of Automated External Defibrillators, and the other involves CMS requirements for Influenza and Pneumococcal Vaccination.

New York State Public Health Law 3000B and NYC Local Law 20 recently expanded the requirements for placement of Automated External Defibrillators (AEDs) in public places, including Nursing Homes and city funded senior centers. The rules and regulations set forth in these documents are fairly specific as to the number of AEDs required, number of trained responders required, signage and need for a response plan and collaborative agreement with a medical care provider.

- There must be at least one AED in a central location within a public place, and the equipment must be accessible to trained responders within a "timely manner." Facilities with multiple floors must have at least one AED per five publicly accessible floors.
- The number of trained personnel required in a facility is based on the facility's ability to provide rapid response during business hours.
- Public places are required to post signage providing notice to all persons using the facility and placed close to all the AED storage locations. The signs must have specific information, and the height of the lettering must be per specifications.
- Facilities are urged to have a formal written response plan in place, which includes use of the AED and roles of available personnel
- Additionally, facilities may apply for Public Access Defibrillator (PAD) Provider status through REMSCO. This requires a formal, very specific response and equipment maintenance plans as well as a written agreement with an Emergency Health Care Provider. This provides some legal indemnity for the facility, if PAD status is granted.

Implementing this program at Parker Jewish Institute was a very worthwhile project. We took an interdisciplinary approach, convened a small team, and came up with a plan to complete the project prior to the June 1, 2005 deadline. We took the opportunity to revise our response plan and incorporate the American Heart Association model. Parker now has a formal Medical Emergency Response Team (MERT). We purchased 22 AEDs which are located at all programs and all patient care units. Our Medical Director and his designees are our Emergency Health Care Providers, and we have filed for PAD status with Nassau and NYC REMSCO. We report all MERT events into our Quality Management Committee and evaluate our effectiveness as a team. Parker employees adapted quickly to the changes made in our emergency care system. The AEDs not only improve the timeliness and quality of care

for our patients and residents, but are available for use on visitors and employees, in the event of a life threatening cardiac emergency.

Infection Control nurses in long term care probably jumped for joy when the Centers for Medicare and Medicaid Services added Influenza and Pneumococcal (PPV) vaccination to the Minimum Data Sheet (MDS). CMS requires that as a condition of participation in Medicare and Medicaid, all long term care facilities are required to ensure that all residents are offered vaccination. Some long term care facilities have not had the means or systems in place to accurately quantify compliance with the administration of the PPV and Influenza vaccines. At Parker Jewish Institute, we could easily retrieve the information on how many doses of vaccine were ordered for patients and residents by auditing physician order sheets, however, the documentation of whether someone actually received the vaccine or the reason it was refused was lacking. We took example from some other facilities as well as the DOH and developed a form to meet our needs and all the requirements as well. Our form is a combination assessment tool and medication administration record. The nurses assess and document the criteria for receipt of vaccine or exclusion by completing a brief checklist. If the patient is to receive the vaccine, the nurse signs for it in the medication administration record section of the form where the order is preprinted. All additional required documentation such as manufacturer, site, expiration and site are included there as well. The nurse does not have to transcribe the order onto the patient's medication record, which is a time saver for the nurses. The last section of the form is for physician documentation, including the reason vaccination is contraindicated or refused. The form is printed as two copies. The original stays in the medical record, and the copy goes to Pharmacy where actual receipt or refusal of vaccine is recorded in an Excel report. We also took opportunity to look at our employee vaccination consent/refusal form and revise it to the same standard as the patient form. Now we know that we will meet compliance for both residents and employee health, because the new system makes it easy to do the right thing and hard to make a mistake.



RETIRED ICP JOANNE SELVA IS HONORED

Joanne Selva, a founding member of APIC Long Island has been named in the 2005-2006 "Honors Edition" of the Manchester Who's Who Executive and Professional Registry. This is an honor for professional achievement. She has also recently had articles accepted for publication in RN Magazine and APIC publications.

Congratulations for this well deserved honor, Joanne!!

PUBLIC HEALTH PERSPECTIVE

TETANUS: AN OLD BUG THREATENS OLDER AMERICANS

Andrea Genovese-Candela, RN, MBA, CIC

Epidemiologist Nassau County Department of Health

Tetanus is an acute, potentially fatal neurologic disease caused by the toxin-producing bacteria *Clostridium tetani*, a gram-positive, anaerobic, spore-forming rod (1). The spores can be found everywhere in the environment, especially in soil or on objects contaminated with animal and human feces. Tetanus spores are also found in both animal and human intestines (where they are harmless), on the surface of the skin, and in contaminated heroin. Clinical tetanus can occur when the spore form of the bacteria enters the body at the site of an injury, germinates, multiplies under low oxygen conditions, and produces a neurotoxin which acts on the central nervous system (2). Often the injury through which the spores enter the body is not severe enough to warrant any medical attention, or may not even be visible.

The risk for tetanus disease in the U.S. increases with age. This is most likely due to declining levels of protective antibodies, never receiving a primary vaccination series, or not receiving timely subsequent prophylactic tetanus toxoid boosters. From 1980 through 2000, 70% of reported cases of tetanus were in persons 40 years of age or older. The mortality rate increases substantially with age as well, and is highest for people older than sixty. From 1998 to 2000, 75% of deaths due to tetanus in the U.S. were in people older than 60 years (3). This article summarized a recent case of generalized tetanus in a Nassau County resident, and emphasizes the importance of both timely preexposure tetanus boosters and appropriate wound management.

On the morning of September 15, 2005 a forty-nine year old woman sustained a puncture wound approximately one centimeter deep to the bottom of her right foot after stepping on a rusted nail inside her home. The wound became swollen and tender, and she used a needle dipped in alcohol to open the wound, which she described as filled with "black material." On the urging of coworkers, she visited a primary care clinic in New York City the following day. A history was taken during which the patient reported that she had received a primary vaccination series of tetanus toxoid as a child, and her last tetanus booster was approximately twenty-seven years prior to this injury. Td toxoid was administered at the NYC clinic. No wound care was given, and no antibiotic treatment was prescribed.

The next day she was awakened at 4:30 am by pain and swelling on the right side of her face, jaw and gums, and inability to fully open her mouth. She went to a local emergency department concerned that she may have "lock jaw." Findings during her physical exam included right sided trismus (spasm of the jaw muscles) and a small, nontender, nonpurulent, puncture wound under her right foot. She was treated with penicillin G two million units IV and tetanus immune globulin (HyperTET) 250 units IM, and admitted to a medicine floor. The next day, the patient underwent surgical incision and drainage of the wound. On September 19 she was treated again with HyperTET 250 units IM and 250 units infiltrated around the wound. The wound culture taken September 17

grew rare (penicillin G resistant) coagulase negative staphylococcus. Her "lockjaw" gradually improved, and she was released from the hospital on oral Levaquin and Flagyl on September 21.

This article highlights the adverse consequences of missed opportunities for primary tetanus prevention via timely booster vaccination at least every ten years. Virtually all reported cases of tetanus occur in persons who have either never been vaccinated, or who completed a primary series but failed to obtain the recommended booster doses of Td (2). Most cases of tetanus and almost all tetanus-associated fatalities are preventable by adequate vaccination. Moreover, persons with minor or inapparent wounds are still at risk for tetanus, and routine tetanus surveillance data shows that persons with minor tetanus-prone wounds often do not seek medical treatment. Therefore, primary health-care providers should review the vaccination status of all of their adult patients, and administer preexposure Td prophylaxis when indicated to keep their patients fully protected (3).

This case also underscores the need for appropriate wound management in secondary tetanus prevention. Every wound should be carefully evaluated to determine if it is prone to tetanus infection. All wounds should be properly cleaned and surgically treated, as indicated, and in a timely manner (4). Puncture wounds, in particular, should be attended to as soon as possible (5).

References:

1. Tetanus. In: Heymann d, ed. *Control of communicable diseases manual*. 18th ed. Washington, DC: American Public Health Association; 2004:528-33.
2. CDC. In: Atkinson W, Hamborsky J, Wolfe S, eds. *Epidemiology and prevention of vaccine-preventable diseases*. 8th ed. Washington, DC: Public Health Foundation; 2004:65-73.
3. CDC. Tetanus - Puerto Rico, 2002. *MMWR* 2002;51:613-615.
4. Ross SE. *Prophylaxis against tetanus in wound management*. (Poster) American College of Surgeons Committee on Trauma. 1995.
5. Atkinson W. Tetanus, diphtheria, pertussis. *Needle tips*. St. Paul, Minnesota: Immunization Action Coalition; Fall/Winter 1999-2000;9(2):15-16.

Remember When This was our Board of Directors - Circa 1988



How many can you identify?

Answers on page 8

PUBLIC HEALTH PERSPECTIVE

BRUCELLOSIS IN SUFFOLK COUNTY 2005

*Jacqueline Bolta, RN, BSN
Suffolk County Department of Health*

In the spring of 2005, the Suffolk County Department of Health investigated an unusual case of Brucellosis. Brucellosis is a reportable, febrile illness caused by several bacteria of the genus *Brucella*. It is an illness characterized by fever, chills, sweats, headache, myalgia/arthralgia, anorexia, fatigue and weight loss. Other common findings are lymphadenopathy and splenomegaly. It is a rare disease with only about 100 cases reported yearly in the United States (2).

Humans can be infected with Brucellosis by either ingesting contaminated substances, via aerosolization of the organism, or commonly, through abrasions of the skin during the handling of infected mammals. In the United States, it occurs more frequently after ingesting contaminated unpasteurized dairy products (2). Sexual transmission and transmission during breastfeeding, though rare, have also been reported (2). It is also highly infectious in the laboratory because of the risk of aerosolization and requires biosafety level-3 precautions; definitive diagnosis requires isolation of the organism in cultures of blood, bone marrow or other tissues.

Effective treatment of Brucellosis includes a combination of doxycycline and Rifampin for six weeks. Recovery depends on the timing of treatment and severity of the illness, and can take from a few weeks to several months or even up to a year in some cases (1). Sequelae can vary but can include granulomatous hepatitis, peripheral arthritis, spondylitis anemia, leucopenia, thrombocytopenia, meningitis, uveitis, optic neuritis, papilledema, and endocarditis. According to the CDC, mortality is low at less than two percent, and is usually associated with endocarditis.

The Suffolk County case involved a previously healthy 50 year-old male with a history of fever, chills, daily night sweats, and a thirty-pound weight loss during six weeks. He had an extensive workup done by his primary physician before being seen by the infectious disease doctor who sent blood cultures for Brucellosis. Serological tests and the cultures were both positive for *Brucella* and confirmed by the New York State Wadsworth Lab.

The patient's interesting social history easily pointed to several possible sources of infection. He was an avid hunter who rarely purchased meat in stores and fed his family and friends year-round with the meat that he hunted, butchered and prepared himself. He provided a detailed history of his hunting experiences in the last eight months preceding his illness. In that period of time he had hunted, butchered and ingested squirrels, deer, quails, and

alligator. His extensive hunting included trips on Long Island, upstate N.Y., Wyoming, Iowa, Mississippi, Louisiana, and Florida.

The incubation period for Brucellosis is typically more than 30 days but can range from five days to several months. Initially, the two most suspicious scenarios in this case involved the ingestion of raw doe milk in November 2004 and the slaughtering and ingestion of a sick deer in December 2004, with possible exposure to a large aerosol inoculum. As the investigation continued, staff learned that the patient had also hunted, dressed and ingested wild boar from Florida. He also had a habit of ingesting slices of raw meat as he butchered the animals.

The patient customarily butchered the meats in his home, hanging carcasses in the doorway. He lived with his wife, daughter, three year old granddaughter and cared for another one year old child in his home. Fortunately, no other family members exhibited symptoms even though family members and friends helped to cut and hang some of the meat. Serology testing was done on all family members including the young children in the home who were probably exposed to the raw meats. With the exception of the three year old granddaughter, tests on family members and friends were negative. The three year old had an equivocal test result and a decision was made to defer treatment and retest. The child never developed symptoms and did not

require treatment. A friend of the patient who helped carry and butcher meat alongside him complained of headache and fatigue that resolved. He also tested negative. Interestingly, the patient's dog that also ingested raw meat had similar symptoms two weeks before the patient himself. Testing of the dog was facilitated by New York State and Cornell and was also negative.

Large amounts of frozen meat from all of the patient's hunting trips were stored in his freezer and different cuts were sent to the state and CDC for testing. The patient had also distributed frozen meat to various family members and neighbors. Fortunately, all of the recipients had either thrown the meat out or still had it in their freezers. The wild boar meat tested positive for *Brucella*. No one else had ingested any of the boar meat and staff was able to retrieve most of the remaining cuts.

During the last interview with the patient, he reported feeling better but was still experiencing night sweats and some fatigue. According to CDC experts, the most likely cause of infection in this case was the patient's contact with the animal's organs, especially the sexual organs, during the dressing of the meat. The patient reported having cuts on his hands while handling the infected animal.

There is no Brucellosis vaccine available for humans. Health care professionals can assist prevention efforts by making the public aware of the dangers of ingesting raw meat or unpasteurized dairy products. Hunters and animal herdsman should use rubber gloves when handling viscera of animals and masks should be considered if the risk of splashing of fluids or aerosolization is high.


The investigation of this unusual case for Suffolk County illustrates the importance of having a good working relationship between different disciplines, like veterinary medicine, and public health.

References:
 1. American Public Health Association. *Control of Communicable Diseases Manual*. 18th Ed. Washington DC 2004. 75-78.
 2. CDC. *Brucellosis Fact sheet*. October 6, 2005. www.cdc.gov
 3. CDC. *Brucellosis Outbreak at a Pork Processing Plant-North Carolina, 1992*. MMWR 1994; 43(07); 113-116.
 4. CDC. *Epidemiologic Notes and Reports Brucellosis-Texas, 1983*. MMWR 32(42); 548-553.

Establishment of Antimicrobial Stewardship - Experiences From a Community Hospital

Amanda L. Hastings, B.S., Pharm.D., Associate Director of Clinical Pharmacy **Ronald Lenefsky, M.D., Chairman, Antibiotic Committee** **Joan Reilly, RN, MS, CIC, Director of Infection Control**
Daria Avila, MS, ASGP-M, Microbiology Supervisor **Marilyn Fiasconaro, RN, BS, Director of Nursing Education**

Good Samaritan Hospital Medical Center, West Islip, New York



BACKGROUND

- Good Samaritan Hospital Medical Center
 - 2011-2012 Inpatient Discharge
 - 2011-2012 Outpatient Discharge
 - 2011-2012 Total Discharge
- Problems Identified
 - Increasing Antibiotic Use
 - Increasing Cost
 - Increasing Resistance
 - Increasing Infection Rates
- Problems Identified
 - Increasing Antibiotic Use
 - Increasing Cost
 - Increasing Resistance
 - Increasing Infection Rates
- Problems Identified
 - Increasing Antibiotic Use
 - Increasing Cost
 - Increasing Resistance
 - Increasing Infection Rates

MICROBIOLOGY DATA

Escherichia coli

Antibiotic	2001	2002	2003	2004
Ampicillin	100%	100%	100%	100%
Ceftriaxone	95%	95%	95%	95%
Cefepime	95%	95%	95%	95%
Meropenem	95%	95%	95%	95%
Linezolid	95%	95%	95%	95%
Colistin	95%	95%	95%	95%

Proteus species

Antibiotic	2001	2002	2003	2004
Ampicillin	100%	100%	100%	100%
Ceftriaxone	95%	95%	95%	95%
Cefepime	95%	95%	95%	95%
Meropenem	95%	95%	95%	95%
Linezolid	95%	95%	95%	95%
Colistin	95%	95%	95%	95%

Pseudomonas aeruginosa

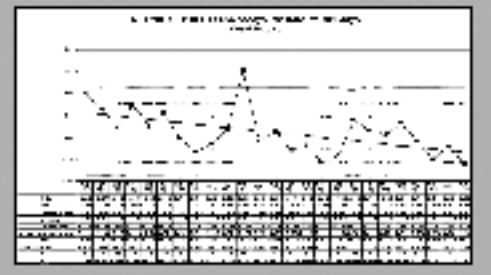
Antibiotic	2001	2002	2003	2004
Imipenem	100%	100%	100%	100%
Ceftazidime	95%	95%	95%	95%
Meropenem	95%	95%	95%	95%
Colistin	95%	95%	95%	95%

METHODS

Interdisciplinary Corrective Action Measures

- Antibiotic Committee Initiated
 - Review of Antibiotic Use
 - Department of Medicine and Hospital Administration
 - Publication of Antibiotic Guidelines
 - Implementation of Antibiotic Guidelines
 - Education of Hospital Staff
 - Education of Patients and Families
 - Education of Community
- Infection Control Committee
 - Review of Infection Rates
 - Review of Antibiotic Use
 - Review of Antibiotic Guidelines
 - Review of Antibiotic Guidelines
 - Review of Antibiotic Guidelines
 - Review of Antibiotic Guidelines
- Pharmacy Department
 - Review of Antibiotic Use
 - Review of Antibiotic Guidelines
 - Review of Antibiotic Guidelines
 - Review of Antibiotic Guidelines
 - Review of Antibiotic Guidelines
- Infection Control Committee
 - Review of Infection Rates
 - Review of Antibiotic Use
 - Review of Antibiotic Guidelines
 - Review of Antibiotic Guidelines
 - Review of Antibiotic Guidelines

RESULTS



Antibiotic Expenditures 2004 vs. 2005

Month	2004	2005
April 2004-2005	\$16,150	\$16,150
May 2004-2005	\$16,150	\$16,150
June 2004-2005	\$16,150	\$16,150
July 2004-2005	\$16,150	\$16,150
August 2004-2005	\$16,150	\$16,150
September 2004-2005	\$16,150	\$16,150
Total Cost Avoidance		\$76,216

CONCLUSIONS

- Program was successful in decreasing antibiotic use
- Program was successful in decreasing antibiotic use
- Program was successful in decreasing antibiotic use
- Program was successful in decreasing antibiotic use
- Program was successful in decreasing antibiotic use