Remain vigilant against Avian Influenza A(H7N9)

According to updates from Centre for Health Protection (CHP), a total of 306 human cases of avian influenza A(H7N9) have been reported in Mainland China since November 2016. In addition, imported cases from the Mainland to Taiwan and Macau were also reported.

Healthcare workers should perform vigilant triage assessment using the FTOCC criteria, in particular, in eliciting exposure history to backyard poultry, poultry markets or farms.

Sharing of Good Practice – Smart Tips for FTOCC Triage in NDH AED

North District Hospital (NDH) has adopted a 3-step strategy, namely “Identify, Isolate, and Inform” for early identification of patients with emerging infectious disease that allows healthcare workers to implement prompt patient management and isolation precautions.

As the first gate of patient contact, the Accident and Emergency Department (AED) has employed screening tools to facilitate FTOCC triage for patient with clinical and epidemiological links to Avian Influenza infection: At the triage station are:

1. A quick reference guide (figure 1) including case definition, isolation precautions and notifications posted up for easy reference.

2. Standardized FTOCC questions designed to elicit significant epidemiological information including travel history and visiting of wet market.

For Patient engagement:

5. A “Notice to All patients” poster (figure 2) has been posted at the entrance to remind patients to actively inform healthcare workers if they have fever and travel history.

4. Running text is shown on electronic screens to alert patients on recognising flu-like symptoms and affected areas while they are waiting for medical consultation.

5. Yellow folders are designated for patients with self-reporting fever at the AED registration counter.

Once a suspect case is identified, patient will be isolated in a designated area with appropriate isolation precautions. A series of notifications will then be activated accordingly.

Figure 1: Quick reference guide for Avian Influenza

Figure 2: “Notice to patient” to remind patients to inform HCWs if they have fever and recent travel history (in particular to those areas affected by avian influenza)

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Positive rate of influenza is stable while activity of parainfluenza and rhinovirus/enterovirus remain high

Although the positive rate of Influenza (all types) has been increasing slowly since the end of 2016 (4.4% in week 52), the rate has stayed at around 8% for four weeks. The activity of parainfluenza and rhinovirus/enterovirus, on the other hand, have remained at a relatively high level for a period of time (10 weeks above 7% for parainfluenza and 20 weeks of approximately 10% for rhinovirus/enterovirus) (Figure 1).

During the peak of the previous two winter influenza seasons, influenza (all types) contributed up to around 70% of all the positive specimens (any positive results of the seven tested viruses) (Figure 2). In the recent weeks however, more than 50% belonged to parainfluenza (yellow area) or rhinovirus/enterovirus (purple area) and less than 30% were influenza (all types). This indicated that the majority of the patients with respiratory infection (usually presenting with ILI symptoms) were likely caused by viruses other than influenza.

Figure 1: Overview – Specimens tested and positive rate of different viruses

Figure 2: Proportion breakdown of the seven tested respiratory viruses among all positive specimens

Journal Sharing

Simplifying the WHO “how to hand rub” technique: three steps are as effective as six – results from an experimental randomized cross-over trial

In 2009, the World Health Organization (WHO) issued guidelines on hand hygiene suggesting a six-step technique for applying alcohol-based hand rub. As most studies focused on the compliance with hand hygiene indications rather than techniques, the compliance for all six steps were noted to be low. This article evaluated a simplified three-step method and compared it to the WHO six-step technique in terms of bacterial counts’ reduction on healthcare workers’ (HCW) hands.

The study was conducted with 32 participants randomly assigned to clean their hands following either the six-step or three-step technique. The assignments were reversed after one day. The level of bacterial killing was measured following the European Norm (EN 1500) for testing hand hygiene products. E. coli was inoculated on participants’ hands and the reduction in bacterial counts was compared between both techniques.

The results from the study started with the bacterial density before the hand hygiene performance between the two techniques to be similar. After hand hygiene, the logarithmic reduction factor was higher with the three-step method as compared to the six-step technique. This suggested that the three-step method was more effective in terms of cleaning hands under experimental conditions.

Even though this study’s results may have achieved an effective alternative method in reducing bacterial count on HCW’s hands, the authors concluded that this simpler technique may only constitute as a safe alternative and an easier way to apply in daily routine. Further research and studies are needed to confirm the performance of this method in daily clinical practice.

Figure 3: Three-step hand hygiene technique