As of 30/07/2015, there are 186 confirmed cases (including 29 HCWs) in the MERS outbreak in South Korea (figure 1). While 12 cases are still under treatment, 138 cases have been discharged and 36 deaths (including one HCW, 70-year-old ambulance driver) are involved in this outbreak (all-cause mortality rate =19.4%). The age range of the confirmed cases is within 16-87 (median: 55, IQR: 42-66) and male-to-female ratio is around 1.44:1. South Korea’s Ministry of Health and Welfare found that over 90% of the death cases had various underlying disease(s) and all cases were defined as nosocomial cases with exposure history in healthcare facilities, except the index case and her wife (household contact).

According to WHO's data, the symptom onset date of last reported case was on 02/07/2015. The patient was isolated on 03/07/2015 and laboratory confirmed on 04/07/2015. As WHO requires the affected area has no new infection for 28 days (twice of the incubation period) after the last case's laboratory confirm date, it is expected that the outbreak is going to be officially ended after 01/08/2015.

ICT to Note

A. Curtain Practices
An ad hoc Task Force on Infection Control (TFIC) meeting on 29 June 2015 was held to discuss about the current practices of curtain changing frequency, the role of disposable curtain and alternative methods with consensus as follows:

1. Role of disposable curtain:
   i. Cost effectiveness should be further studied.
   ii. BSSD estimated preliminarily that the cost of using disposable curtain is several times higher than that of the curtain in use.
   iii. It is cost effective for SJH which is overwhelming far from PYNEH where the laundry service is available.

2. Alternative methods:

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-part-curtain</td>
<td>To explore other design heat-tolerated during laundering</td>
</tr>
<tr>
<td>Antibiotic impregnated curtain</td>
<td>Majority of the brands were tested but failed to be effective</td>
</tr>
<tr>
<td>Screen with smooth surface</td>
<td>Replaced by screen which could be easily wiped e.g. to be used in special area with high patient turnover.</td>
</tr>
<tr>
<td>Corporate directive to be sought</td>
<td>A control mechanism is required to be developed</td>
</tr>
</tbody>
</table>

B. Assessment of new high-level disinfectant: APERLAN
A high-level disinfectant for Automated Endoscopic Reprocessor (AER), Aperlan has been submitted for assessment at the Disinfectant and Sterilant Assessment (DSAC) Committee meeting. With supporting documents available for assessment, the meeting held in March concluded to make the following advice:

A grace period of one year till 9 March 2016 for the use of Aperlan for the AER already bought in 3 hospitals. During this one year period, user shall have a built-in monitoring system to monitor the usage and the monitoring should be reported back to DSAC. In addition, qualification test (IQ, PQ & OQ) for the AER should be complied to secure the disinfection efficacy.

Further purchase should be hold until further assessment with all documents required.

TIPS: Promote good practice in laundry
To minimize the risk of re-contamination of linen when processing in hospital laundry, it is essential to maintain good practice in managing hospital linen. Here are tips for:

1. Have Hand washing facilities and appropriate Personal Protective Equipment (PPE) for workers.
2. Take special care and attention to prevent contamination to environment and personnel.
3. Keep a functional separation of areas that receive, store, or process soiled linen from areas that process, and handle the hygienic integrity of the processed linen.
4. Schedule cleaning and maintain on a current basis
5. Laundry facilities and equipment:
   i. Follow laundry process as required.
   ii. Prevent re-contamination of washed linen
   iii. Use and maintain as manufacturer’s instruction.
   iv. Document preventive maintenance of equipment.
6. Clean linen storage areas:
   i. Designated for clean linen.
   ii. Designed to prevent accumulation of dust and lint
   iii. Maintain working surfaces (e.g. counter, benches, tables, etc) clean of visible soil, dust and lint;

Reference:
Weekly statistics on laboratory surveillance - Detection of viruses from respiratory specimens
(Data from PHLSB, CHP)
Influenza A positive rate has been dropping to below 10% (8.9% in week 30) (figure 2) while the positive rate of influenza B has been below 2% for three weeks. Although the positive rate of influenza A is on decreasing trend, influenza activity will take several weeks to return baseline level. According to the data from collaborative surveillance between CHP and HA Head Office since 12/06/2015 (up to 28/07/2015), there were 167 adult influenza-associated ICU/death cases (124 death cases).
Positive rate of RSV has been above 5% for three weeks (figure 3) and no decreasing trend has been observed yet.

Journal Sharing: Lasting hand self-disinfection: A backup for hospital hand hygiene?
Background:
5 moments of Hand hygiene are recommended for healthcare worker to adhere during patient care. Mostly it is performed with Alcohol Based Hand rub except when hands are visibly soiled. However, some are missed.
To reduce the risk of infection spread, can we have antiseptic with residual effect like an auto-disinfecting hand hygiene substance?
Thus, this was explored by a 30-minute residual effect with different antiseptic products on endogenous and acquired microbiota.

Methods:
The products tested were 2% and 5% chlorhexidine, 1% and 10% iodine povidone, 60_n-propanol, 0.2% mectronium + isopropanol, and 0.6% chlorhexidine + isopropanol + 0.1% benzalconium chloride. The microorganisms identified were 3 ATCC and 9 multiresistant strains isolated from intensive care unit patients (used as acquired microbiota). Logarithmic (log10) reductions of the colony forming units obtained with each antiseptic product and for each microorganism were calculated via in vivo (6 volunteers) and in vitro tests.

Results:
The result demonstrated that the best products in vivo and in vitro were 2%-5% chlorhexidine and 0.6% chlorhexidine + isopropanol + 0.1% benzalconium chloride, with a residual effect of > 2 log10. This residual effect (> 2 log10) could be considered a self-disinfecting hand status in daily practice.

Discussion and Conclusions:
It was concluded that 0.6% chlorhexidine + isopropanol + 0.1% benzalconium chloride, with its highest residual effect (> 2 log10), is a feasible option for use in clinical settings. This reduction produces a good self-disinfecting hand status, which is very useful in daily practice, ultimately having an influence on patient safety and quality of care.

AJIC 43 (2015) 697-701