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LESSONS LEARNED: Hepatitis C patients should be counseled concerning not eating raw shellfish. The restaurant added a notification to the menu cautioning immunosuppressed individuals to avoid ingesting raw shellfish.

**Pertussis (Whooping Cough) Exposure in Pediatric Healthcare Workers**

*R Garcia*
L Jendresky
A Maher
J Landeman
E Santos-Cruz

Brookdale University Medical Center, Brooklyn, New York

ISSUE: Brookdale University Medical Center (BUMC) is a 530-bed teaching facility with a 52-bed pediatric unit and 6-bed ICU. On March 7, 2003, a foreign-born pediatric resident developed a sore throat, fever, and cough while working in one of the hospital’s pediatric clinics. She stayed home and took antibiotic therapy for 2 days. After a week, her son was admitted to the pediatric ward for 1 day with excess coughing. Despite taking cough medicine, the child’s coughing increased over a 2-week period, and he was readmitted on March 19, 2003, for 4 days with severe cough and vomiting. Diagnosis with viral syndrome was made. On March 21, 2003, the child was tested for Pertussis, started on erythromycin, and discharged. The resident was also tested for Pertussis and started on erythromycin. Her son become cyanotic and was readmitted the next day to the pediatric intensive care unit (PICU). She stayed with her son in PICU for 3 days. Twenty-three days after initial onset of symptoms, the Employee Health Service of BUMC was notified by the New York City Department of Health of a positive Pertussis test result on the pediatric resident.

PROJECT: To prevent exposure of Pertussis in healthcare settings.

RESULTS: Immunization status of 71 patients in the pediatric clinic exposed to the resident was reviewed. Of the 18 patient cases with less than 2 doses of DPT vaccination, 16 were given prophylactic medicine. Two of five PICU patients required prophylaxis due to age. There were a total of 98 exposed healthcare workers (to both the child and the resident). 90 received prophylactic medication. No additional cases of Pertussis were identified.

LESSON LEARNED: Infection control practitioners should be aware of the potential for adult cases of Pertussis, particularly in healthcare workers who have direct care for patients. Early diagnosis and notification of infection control could prevent exposure of susceptible individuals.

**Better To Be Safe than “Sarry”: Preparing for Severe Acute Respiratory Syndrome**

*D Berriel-Cass*
J Gorczyca
LA Roth
L DeSantis
M Fakih

St. John Hospital and Medical Center, Detroit, Michigan

ISSUE: The emergence of Severe Acute Respiratory Syndrome (SARS) in 2003 challenged the world of infection control. During the SARS epidemic, Toronto was included as a travel location in the SARS definition. The lack of preparedness at our facility became evident in June 2003, when a patient was admitted with a fever, infiltrates,
and recent travel to Toronto. This admission revealed many failure modes in our system for identifying and containing SARS. Twenty-one healthcare workers (HCWs) had unprotected exposure to the suspected case. As a result, the HCWs were screened prior to reporting to work for the 10 days following their exposure. Improper handling of lab specimens delayed testing. The case eventually was ruled out as a SARS case.

PROJECT: A multidisciplinary team was formed to conduct a root-cause analysis (RCA) of the potential SARS exposure. Several process failures were identified, from admission through specimen handling. The team recognized that the frequency of admitting a SARS patient was low; however, the potential health threat was high. Rather than conduct additional educational sessions, a SARS Toolkit was developed for the hospital units. The kit contained step-by-step instructions, visuals, and a notification list. The kit’s built-in forcing functions were designed to move the process along, but not to rely on HCWs memory. The new process was tested in a mock SARS admission drill. Only administration and the RCA team knew about the drill. The drill was completed in 3 hours.

RESULTS: The kit was activated immediately and key departments, including infection control, were notified. Personal protective equipment was obtained and the patient was placed in the proper isolation. Laboratory specimens were processed and handled appropriately. HCW exposure did not occur. The kit assisted in preventing exposures while allowing for patient care. A debriefing followed the drill and included all HCWs involved, administration, and the RCA team. The mock patient was able to provide additional information regarding objects with potential fomite contamination that were brought out of the room.

LESSONS LEARNED: Preparedness for events that may or may not occur challenged us to create a process that would succeed. Overall, the kit proved its worth with well-defined instructions for communication. At any time, it could easily be updated. It was identified that some signage needed clarification, and changes were made to the kit. The kit has since been adopted by our system hospitals.

Interventions To Control an Epidemic of Bloodstream Infections due to Mycobacterium

R Carrico*
L Goss
Y Nakatani
University of Louisville Hospital, Louisville, Kentucky

BACKGROUND: Rapid growing Mycobacterium species are commonly found in water environments but are rarely associated with bloodstream infections (BSIs). During February–June 2002, an outbreak of BSIs due to \( M. \) chelonae and \( M. \) fortuitum was documented. The objective of this study was to describe the outbreak investigation and the interventions implemented to control the epidemic.

METHODS: Isolation of \( M. \) chelonae or \( M. \) fortuitum from one or more blood cultures in a patient with a central venous catheter (CVC) was the case definition. Five patients met the case definition. All patients had underlying malignancies. None of the patients have evidence of local CVC site infection. Prior to development of infection, all patients had the CVC accessed for flushing. No common medications or caregivers were identified. Pulsed-field gel electrophoresis identified as identical three of four \( M. \) fortuitum strains. All environmental cultures were repeatedly negative. We hypothesized that the epidemic was likely related to the CVC flushing procedure and the following interventions were implemented: 1) do not open packages containing profiled saline syringes until immediately prior to use, 2) do not remove the cap and put the needleless device on the syringe until immediately prior to use. The success of control measures was determined by monitoring for recurrence.

RESULTS: No additional cases of \( M. \) chelonae or \( M. \) fortuitum were identified in blood cultures after implementation of control measures. This study indicates that an epidemic of \( M. \) chelonae or \( M. \) fortuitum may result from intermittent, extrinsic contamination of sterile, preservative-free intravenous flush solutions.