Released September 18, 2015 ISSN 0799-3927

Week ending September 5, 2015 Epidemiology Week 35

WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight

Flooding and communicable diseases ….

Image source: http://indianexpress.com/article/cities/mumbai/leptospirosis-cases-11-out-of-16-deaths-caused-due-to-delay-in-treatment/

Risk assessment

Floods can potentially increase the transmission of the following communicable diseases:

- Water-borne diseases, such as Typhoid Fever, Cholera, Leptospirosis and Hepatitis A
- Vector-borne diseases, such as Malaria, Dengue and Dengue Haemorrhagic Fever, Yellow Fever, and West Nile Fever

Water-borne diseases

Flooding is associated with an increased risk of infection, however this risk is low unless there is significant population displacement and/or water sources are compromised.

The only epidemic-prone infection which can be transmitted directly from contaminated water is Leptospirosis, a zoonotic bacterial disease.

Transmission occurs through contact of the skin and mucous membranes with water, damp soil or vegetation (such as sugarcane) or mud contaminated with rodent urine.

Vector-borne diseases

Floods may indirectly lead to an increase in vector-borne diseases through the expansion in the number and range of vector habitats.

Preventive measures

Communicable disease risks from flooding can be greatly reduced if the following recommendations are followed.

(Including)…Chlorination of water, vaccination against hepatitis A (for high risk groups-involved in the management of drinking water, waste water or sewage), (use of) insecticides, and health education.

Adapted from: http://www.who.int/hac/techguidance/ems/flood_cds/en/index1.html

EPI WEEK 35

NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

HOSPITAL ACTIVE SURVEILLANCE-30 sites*. Actively pursued

SENTINEL REPORT- 79 sites*. Automatic reporting

*Incidence/Prevalence cannot be calculated

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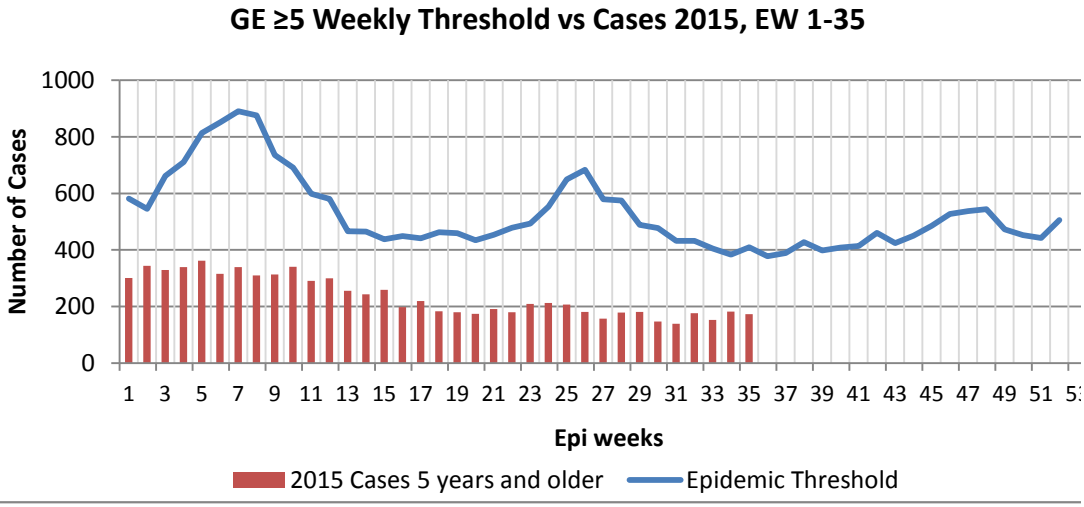
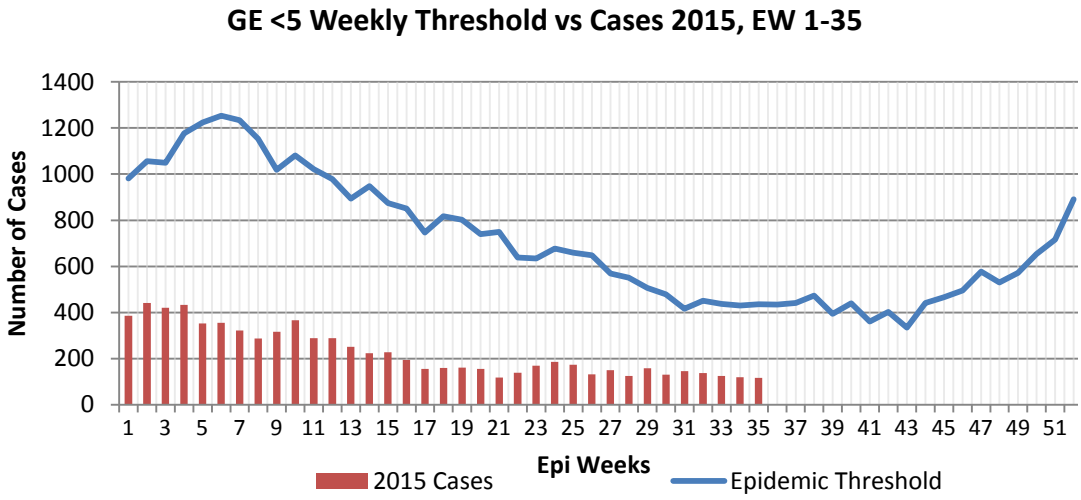
REPORTS FOR SYNDROMIC SURVEILLANCE

GASTROENTERITS

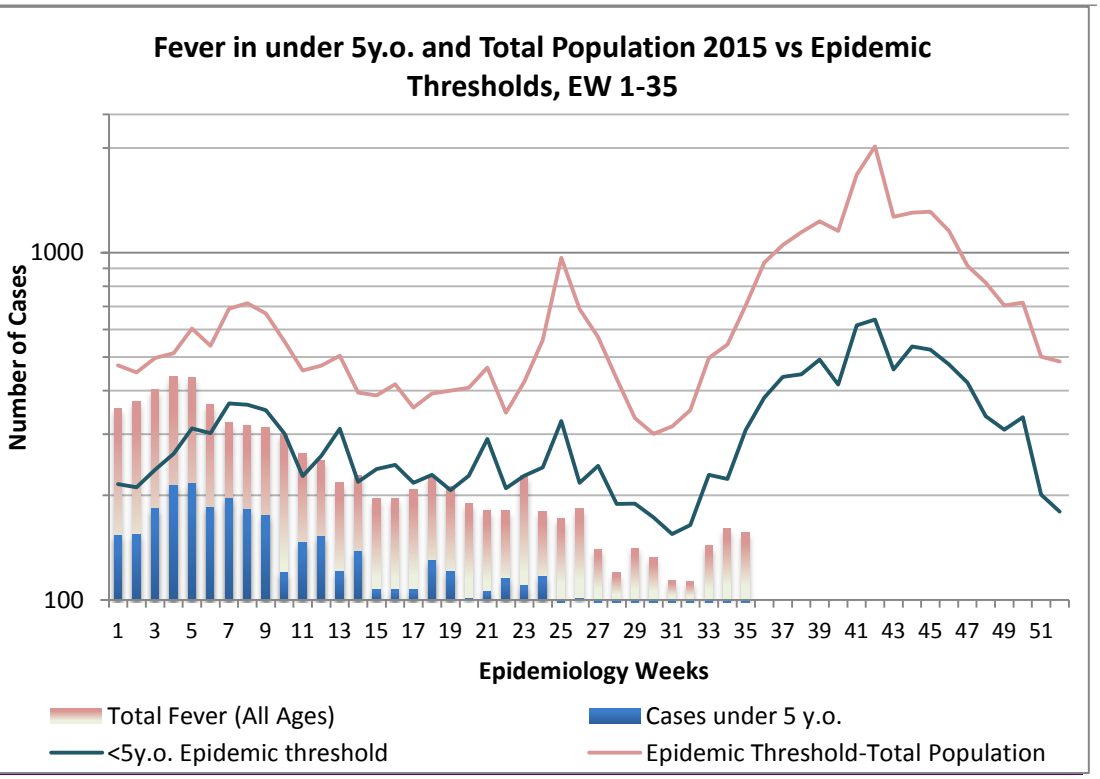
Three or more loose stools within 24 hours.





FEVER

Temperature of $>38^0C$ /100.4^0F (or recent history of fever) with or without an obvious diagnosis or focus of infection.



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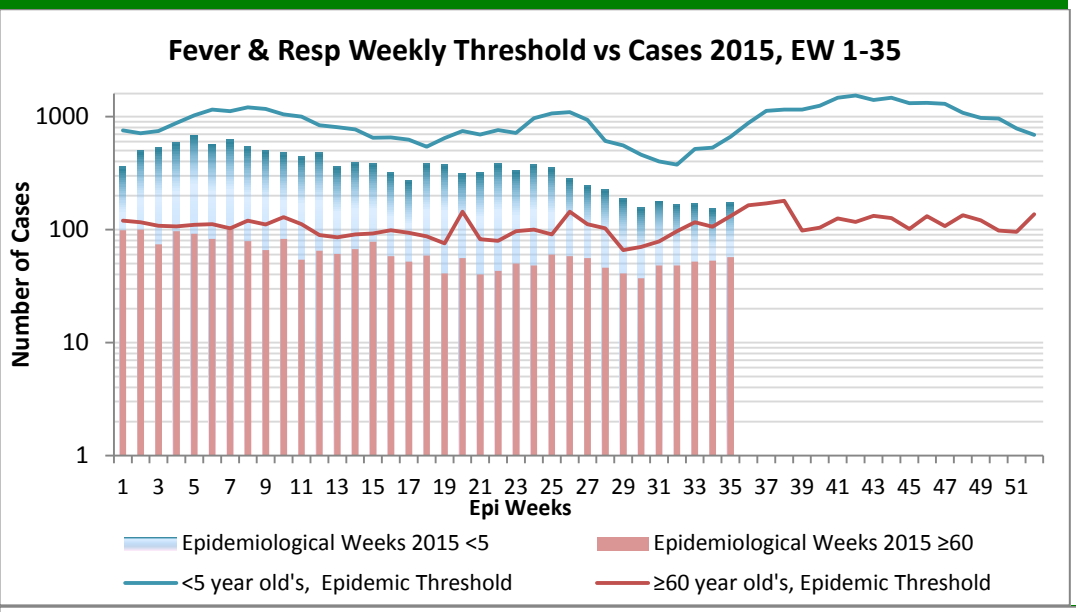
REPORTS FOR SYNDROMIC SURVEILLANCE

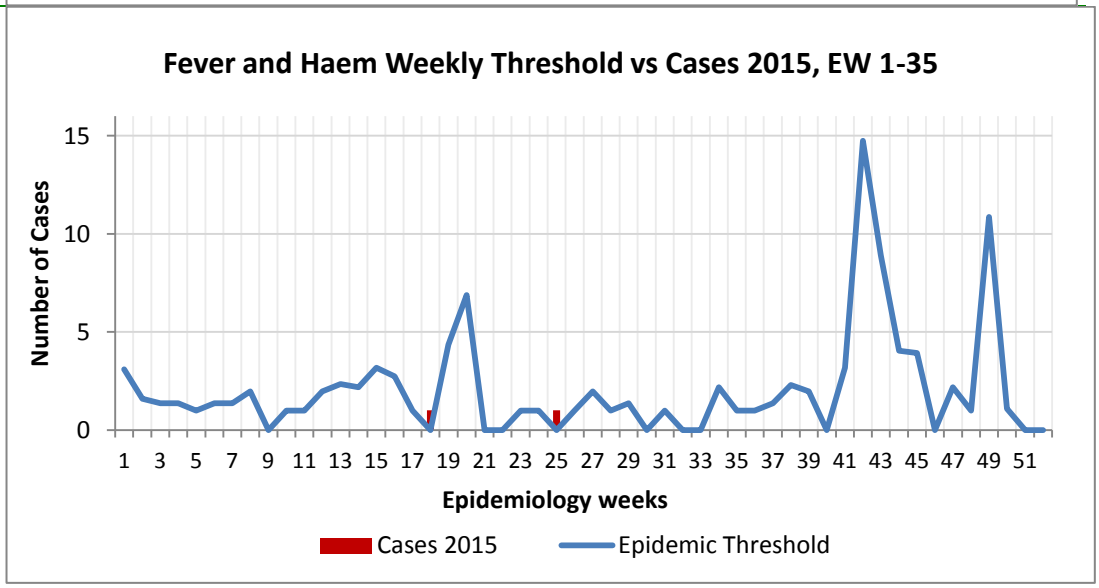
FEVER AND RESPIRATORY

Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person with or without respiratory distress presenting with either cough or sore throat.



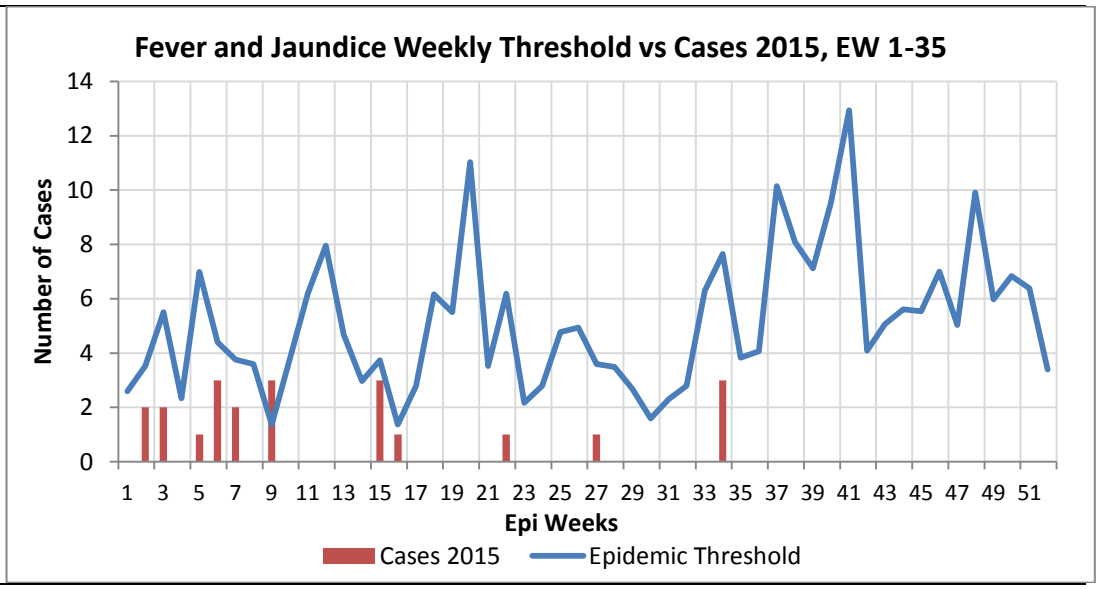
FEVER AND HAEMORRHAGIC

Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



FEVER AND JAUNDICE

Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with jaundice.



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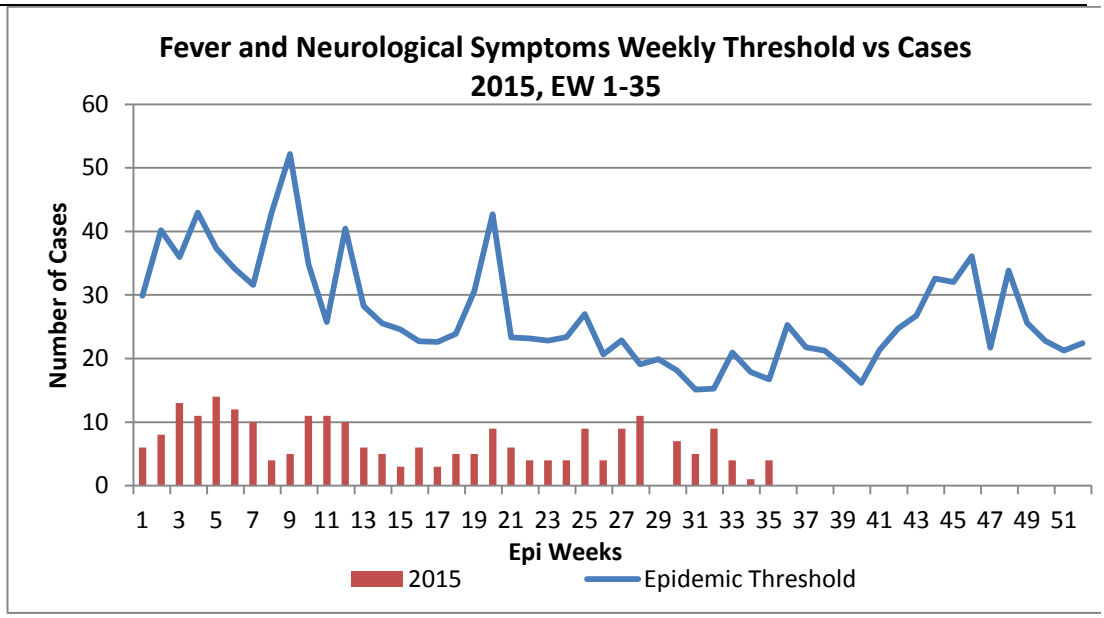
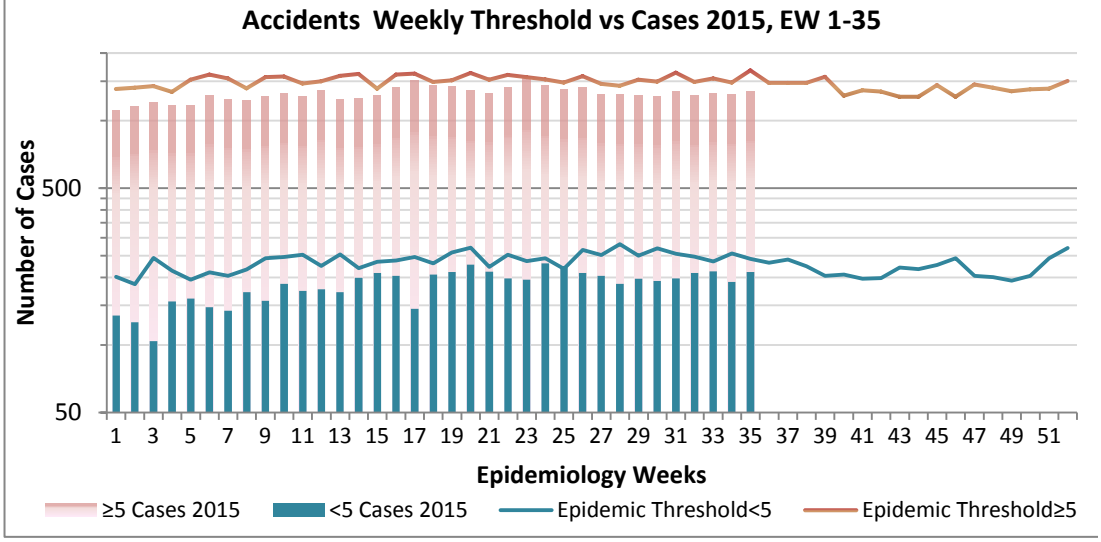
FEVER AND NEUROLOGICAL

Temperature of $>38^0C$ /100.4^0F (or recent history of fever) in a previously healthy person with or without headache and vomiting. The person must also have meningeal irritation, convulsions, altered consciousness, altered sensory manifestations or paralysis (except AFP).



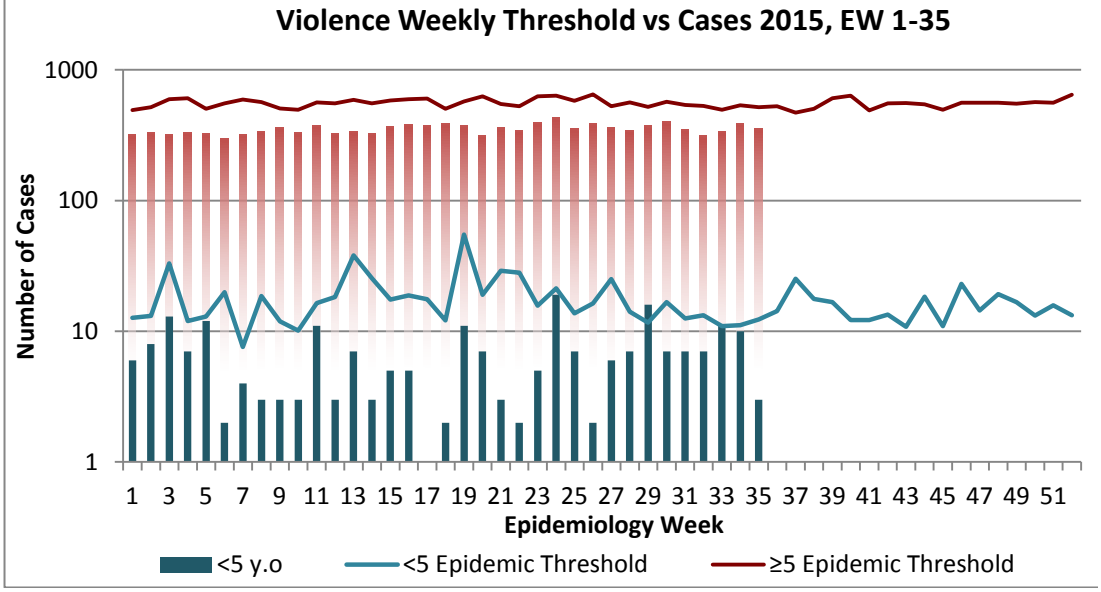
ACCIDENTS

Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.



VIOLENCE

Any injury for which the cause is intentional, e.g. gunshot wounds, stab wounds, etc.



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CLASS ONE NOTIFIABLE EVENTS and LEPTOSPIROSIS

	CLASS 1 EVENTS		CONFIRMED YTD CURRENT YEAR	CONFIRMED YTD PREVIOUS YEAR
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		425	433
	Cholera		0	0
	Dengue Hemorrhagic Fever[1]		0	0
	Hansen's Disease (Leprosy)		1	1
	Hepatitis B		14	55
	Hepatitis C		2	11
	HIV/AIDS - See HIV/AIDS National Programme Report			
	Malaria (Imported)		2	1
	Meningitis		249	491
EXOTIC/ UNUSUAL	Plague		0	0
H IGH MORBIDIT/ MORTALIY	Meningococcal Meningitis		0	0
	Neonatal Tetanus		0	0
	Typhoid Fever		3	0
	Meningitis H/Flu		0	0
SPECIAL PROGRAMMES	AFP/Polio		0	0
	Congenital Rubella Syndrome		0	0
	Congenital Syphilis		0	0
	Fever and Rash	Measles	0	0
		Rubella	0	0
	Maternal Deaths[2]		27	37
	Ophthalmia Neonatorum		174	197
	Pertussis-like syndrome		0	0
	Rheumatic Fever		5	14
	Tetanus		1	0
	Tuberculosis		55	39
	Yellow Fever		0	0
UNCLASSED**	Leptospirosis		16	9

Comments

AFP Field Guides from WHO indicate that for an effective surveillance system, detection rates for AFP should be 1/100,000 population under 15 years old (6 to 7) cases annually.

Pertussis-like syndrome and Tetanus are clinically confirmed classifications.

The TB case detection rate established by PAHO for Jamaica is at least 90% of their calculated estimate of cases in the island, this is 180 (of 200) cases per year.

*Data not available

**Leptospirosis is awaiting classification as class 1, 2 or 3

1 Dengue Hemorrhagic Fever data include Dengue related deaths;

2 Maternal Deaths include early and late deaths.

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NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 35

August 30 – September 5, 2015 Epidemiology Week 35

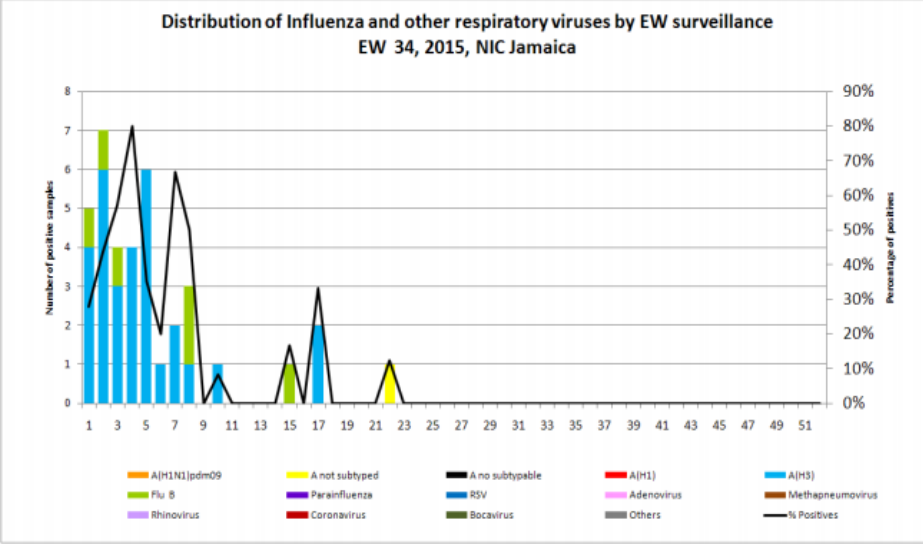
September, 2015	EW 35	YTD
SARI cases	15	607
Total Influenza positive Samples	**0**	**37**
Influenza A	**0**	**31**
H3N2	0	30
H1N1pdm09	0	0
Influenza B		**6**

Admitted Lower Respiratory Tract Infection and LRTI-related Deaths

	Current year		Previous year	
	Week 35 2015	**YTD** 2015	Week 35 2014	YTD 2014
Admitted Lower Respiratory Tract Infections	52	2669	67	2337
Pneumonia-related Deaths	4	45	1	53

Comments:

Influenza A/H3N2 is the predominant circulating virus (81%), while Influenza B Yamagata continues to circulate at low levels of 16%. Both viruses are components of the 2014 -2015 Influenza Vaccines for the Northern Hemisphere. There has been no detection of the influenza variant A/H3 virus (A/H3N2v), influenza Avian H5 or H7 viruses among samples tested.



INDICATORS

Burden

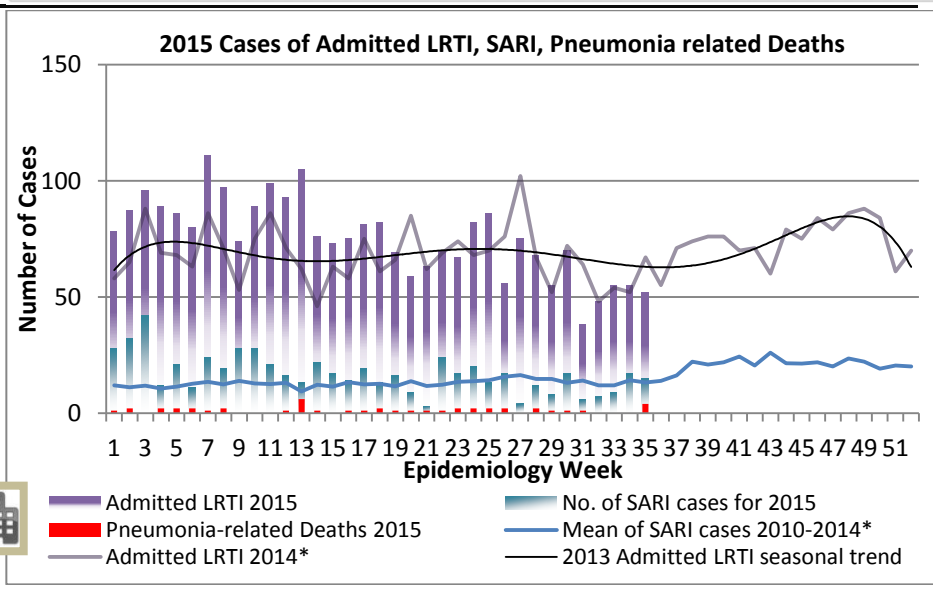
Year to date, respiratory syndromes account for 3.3% of visits to health facilities.

Incidence

Cannot be calculated, as data sources do not collect all cases of Respiratory illness.

Prevalence

Not applicable to acut respiratory conditions.



***Additional data needed to calculate Epidemic Threshold**

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Dengue Bulletin

August 30 – September 5, 2015 Epidemiology Week 35

DENGUE AND SEVERE DENGUE

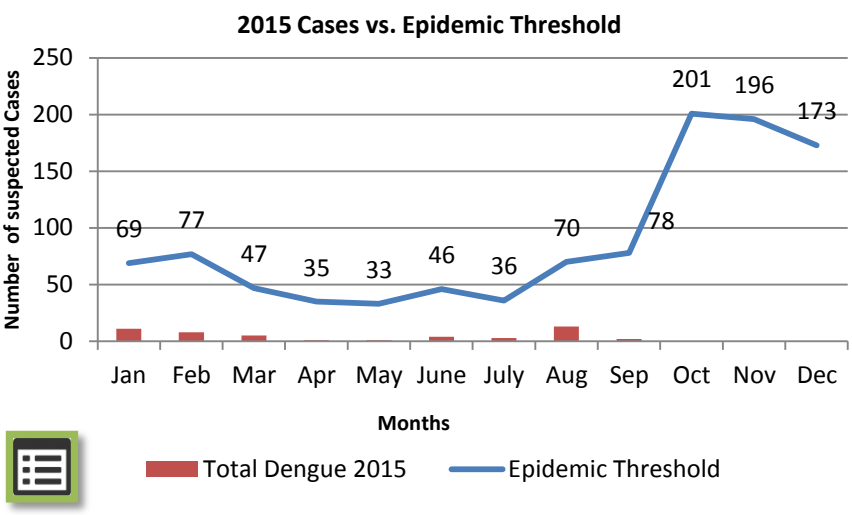
Classic dengue incidence per 100,000 (CI -95%): 14.6 (12.0–17.1)

Hemorrhagic dengue incidence per 100,000 (CI- 95%): 0.14 (0.03–0.24)

Classic dengue lethality % (CI- 95%): 0.12 (0.04–0.26)

Classic dengue mortality per 100,000 (CI -95%): 0.02 (0.00–0.04)

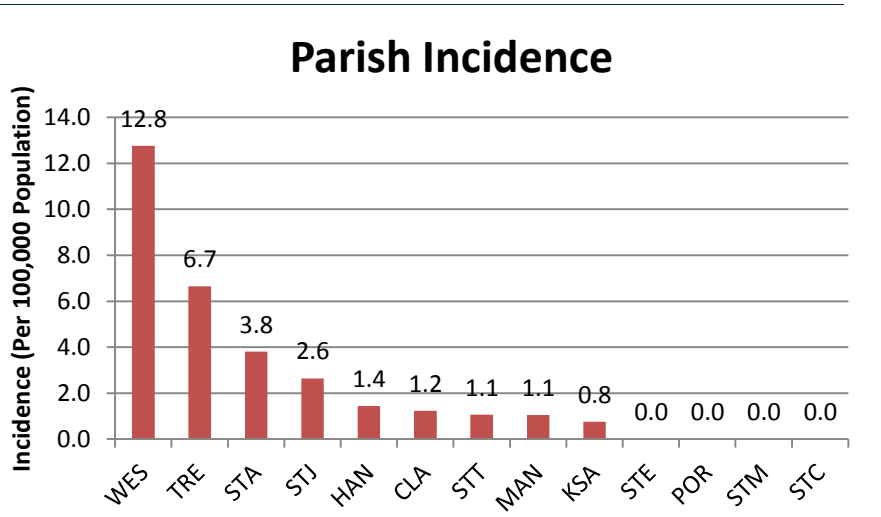
Source: Pan American Health Organization



DISTRIBUTION

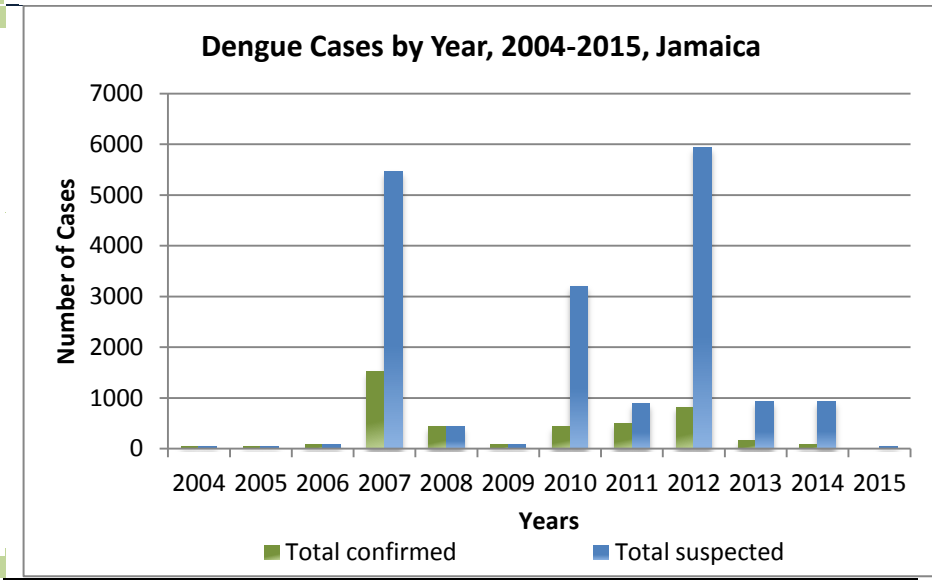
Year-to-Date Suspected Dengue Fever

	M	F	Total	%
<1	3	2	5	10.0
1-4	1	0	1	2.0
5-14	3	7	10	20.0
15-24	10	3	13	26.0
25-44	7	7	14	28.0
45-64	3	2	5	10.0
≥65	1	1	2	4.0
Unknown	0	0	0	0
TOTAL	**28**	**22**	**50**	**100**



Weekly Breakdown of suspected and confirmed cases of DF,DHF,DSS,DRD

		2015		2014
		EW 35	YTD	YTD
Total Suspected Dengue Cases		0	50	206
Lab Confirmed Dengue cases		0	3	5
CONFIRMED	DHF/DSS	0	0	0
CONFIRMED	Dengue Related Deaths	0	0	0



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Gastroenteritis Bulletin

EW 35

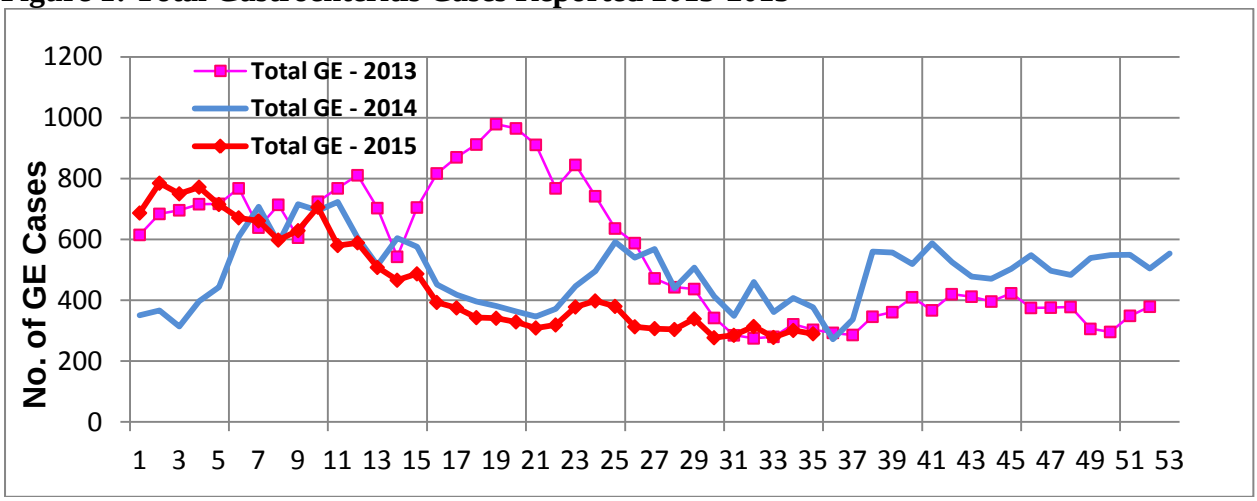
August 30 – September 5, 2015 Epidemiology Week 35

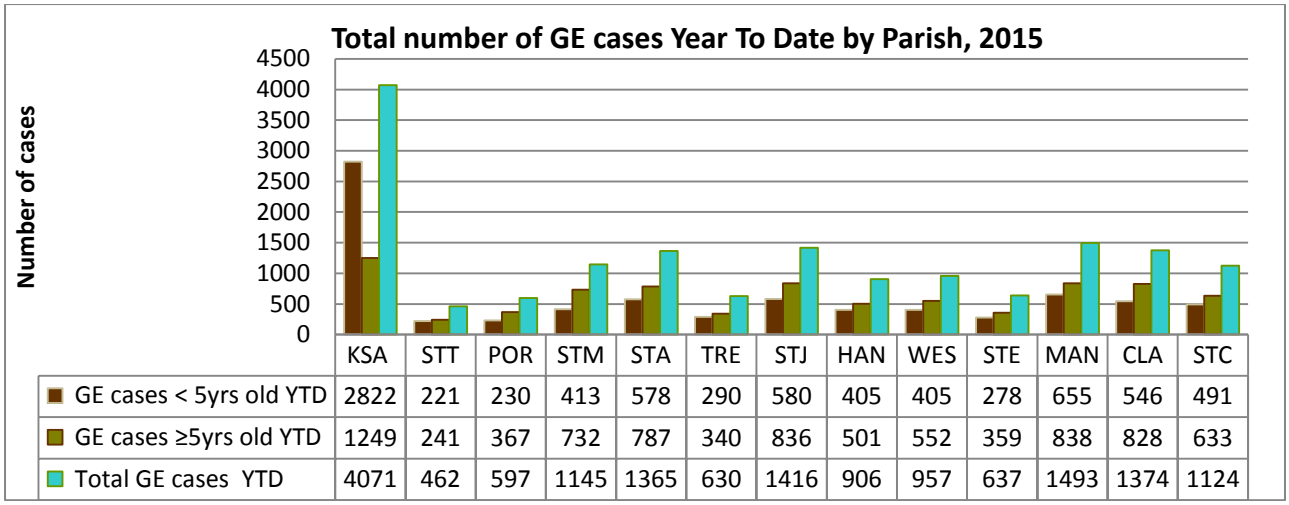
Weekly Breakdown of Gastroenteritis cases

Year	EW 35			YTD		
	<5	≥5	Total	<5	≥5	Total
2015	117	173	290	7914	8263	16177
2014	174	203	377	8576	8297	16873

In Epidemiology Week 35, 2015, the total number of reported GE cases showed a 23% decrease compared to EW 35 of the previous year.
The year to date figure showed a 4% decrease in cases for the period.

Figure 1: Total Gastroenteritis Cases Reported 2013-2015





	KSA	STT	POR	STM	STA	TRE	STJ	HAN	WES	STE	MAN	CLA	STC
GE cases < 5yrs old YTD	2822	221	230	413	578	290	580	405	405	278	655	546	491
GE cases ≥5yrs old YTD	1249	241	367	732	787	340	836	501	552	359	838	828	633
Total GE cases YTD	4071	462	597	1145	1365	630	1416	906	957	637	1493	1374	1124

RESEARCH PAPER

A Description of Registered Nurses' Documentation Practices and their Experiences with Documentation in a Jamaican Hospital

C Blake-Mowatt, JLM Lindo, S Stanley, J Bennett
The UWI School of Nursing, Mona, The University of the West Indies, Mona, Kingston 7, Jamaica

Objective: To determine the level of documentation that exists among registered nurses employed at a Type A Hospital in Western Jamaica.

Method: Using an audit tool developed at the University Hospital of the West Indies, 79 patient dockets from three medical wards were audited to determine the level of registered nurses' documentation at the hospital. Data were analyzed using the SPSS® version 17 for Windows®. Qualitative data regarding the nurses' experience with documentation at the institution were gathered from focus group discussions including 12 nurses as-signed to the audited wards.

Results: Almost all the dockets audited (98%) revealed that nurses followed documentation guidelines for ad-mission, recording patients' past complaints, medical history and assessment data. Most of the dockets (96.7%) audited had authorized abbreviations only. Similarly, 98% of the nurses' notes reflected clear documentation for nursing actions taken after identification of a problem and a summary of the patients' condition at the end of the shift. Only 25.6% of the dockets had nursing diagnosis which corresponded to the current medical diagnosis and less than a half (48.3%) had documented evidence of discharge planning. Most of the nurses' notes (86.7%) had no evidence of patient teaching. The main reported factors affecting documentation practices were workload and staff/patient ratios. Participants believed that nursing documentation could be improved with better staffing, improved peer guidance and continuing education.

Conclusion: Generally, nurses followed the guidelines for documentation; however, elements were missing which included patient teaching and discharge planning. This was attributed to high patient load and nurse /patient ratio.

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