Released February 12, 2016 ISSN 0799-3927

Week ending January 30, 2016 Epidemiology Week 4

WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight

February 8-14, 2016: Cardiovascular Week

Cardiovascular disease is caused by disorders of the heart and blood vessels, and includes coronary heart disease (heart attacks), cerebrovascular disease (stroke), raised blood pressure (hypertension), peripheral artery disease, rheumatic heart disease, congenital heart disease and heart failure. The major causes of cardiovascular disease are tobacco use, physical inactivity, an unhealthy diet and harmful use of alcohol.

Here are a few FACTS:

- CVDs are the number 1 cause of death globally: more people die annually from CVDs than from any other cause.
- An estimated 17.5 million people died from CVDs in 2012, representing 31% of all global deaths. Of these deaths, an estimated 7.4 million were due to coronary heart disease and 6.7 million were due to stroke .
- Over three quarters of CVD deaths take place in low- and middle-income countries.
- Out of the 16 million deaths under the age of 70 due to noncommunicable diseases, 82% are in low and middle income countries and 37% are caused by CVDs.
- Most cardiovascular diseases can be prevented by addressing behavioural risk factors such as tobacco use, unhealthy diet and obesity, physical inactivity and harmful use of alcohol using population-wide strategies.
- People with cardiovascular disease or who are at high cardiovascular risk (due to the presence of one or more risk factors such as hypertension, diabetes, hyperlipidaemia or already established disease) need early detection and management using counselling and medicines, as appropriate.

Source: http://www.who.int/mediacentre/factsheets/fs317/en/

EPI WEEK 4

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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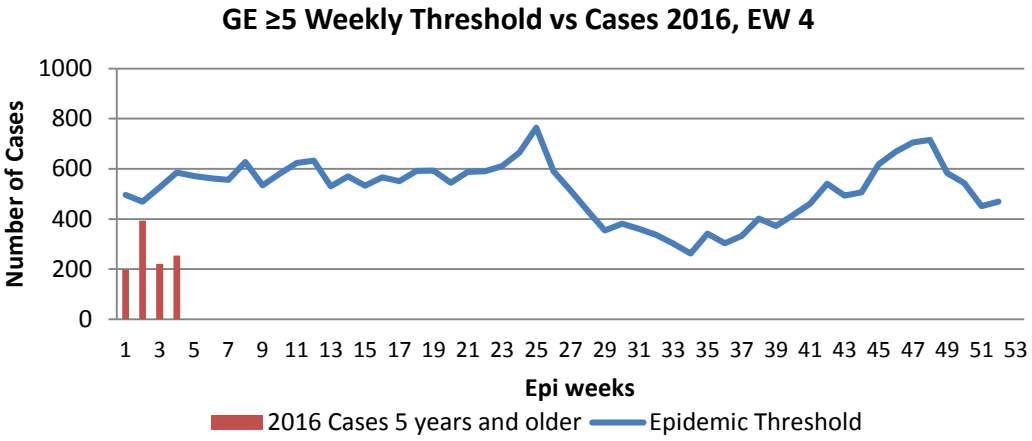
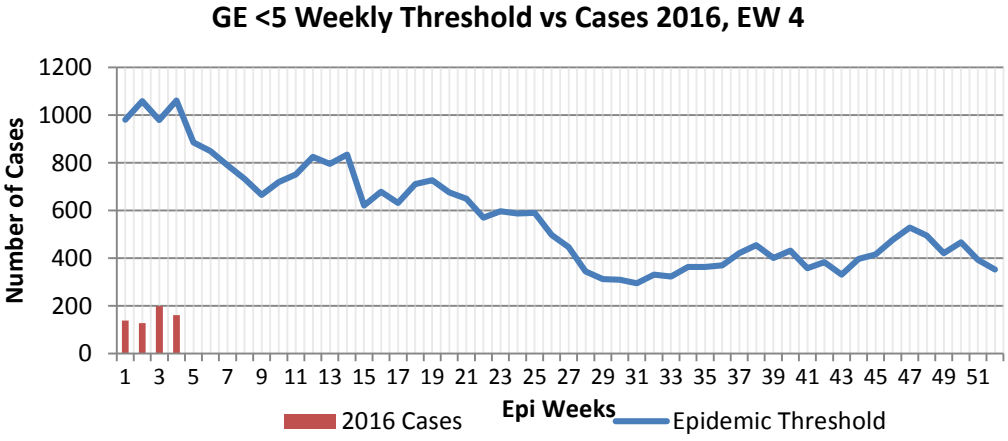
REPORTS FOR SYNDROMIC SURVEILLANCE

GASTROENTERITS

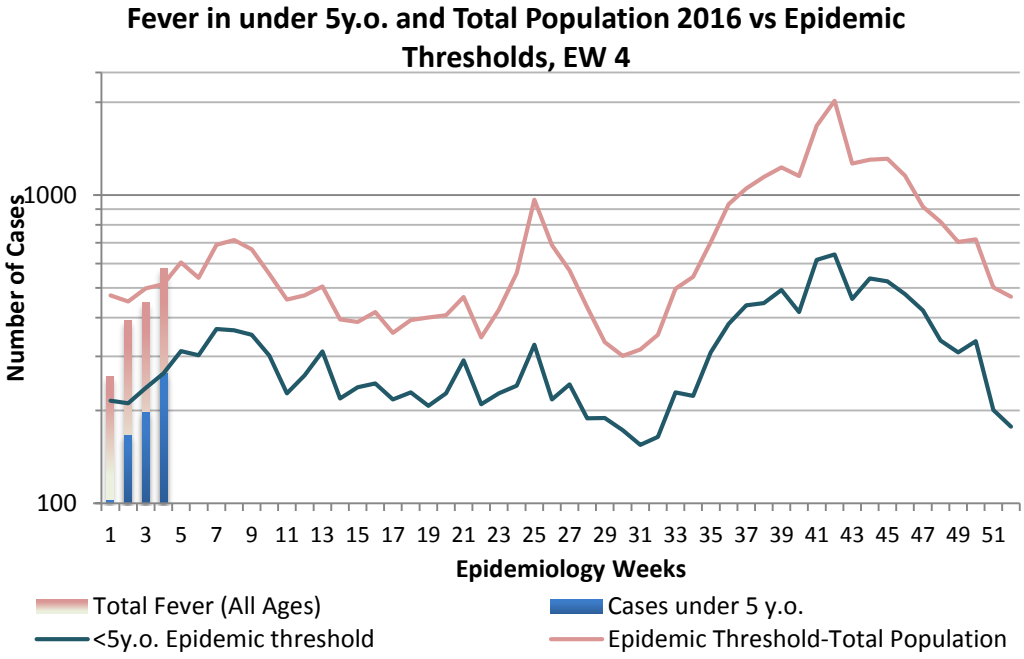
Three or more loose stools within 24 hours.





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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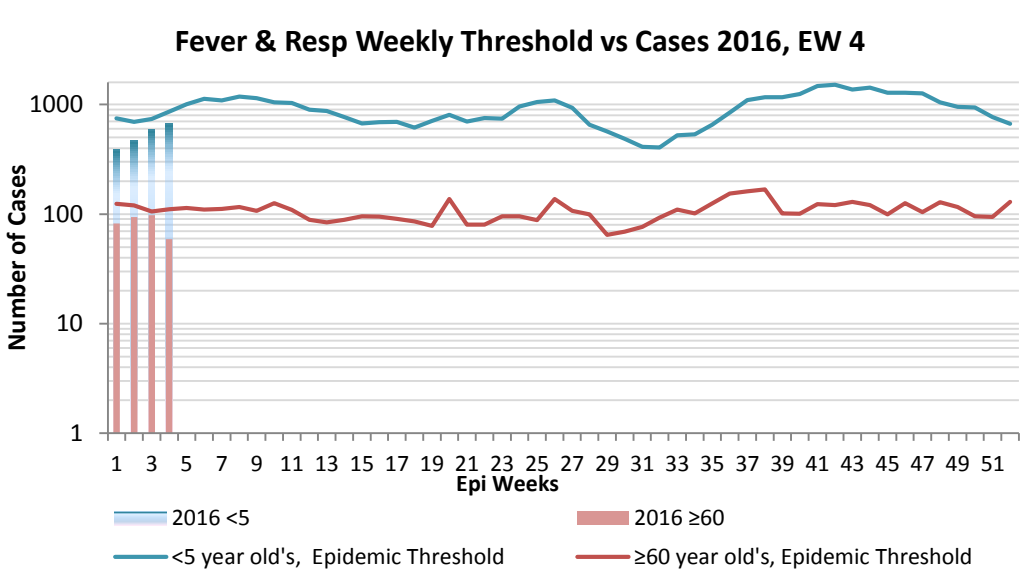
REPORTS FOR SYNDROMIC SURVEILLANCE

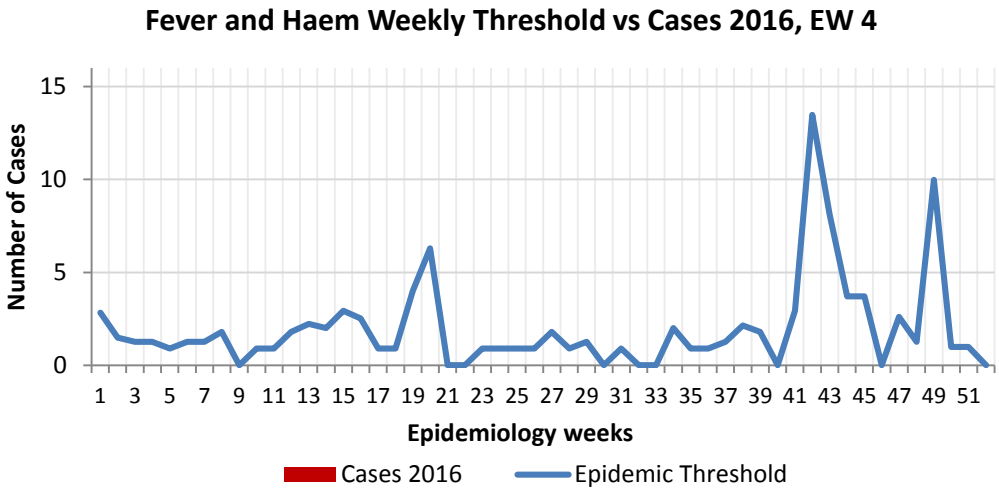
FEVER AND RESPIRATORY

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.



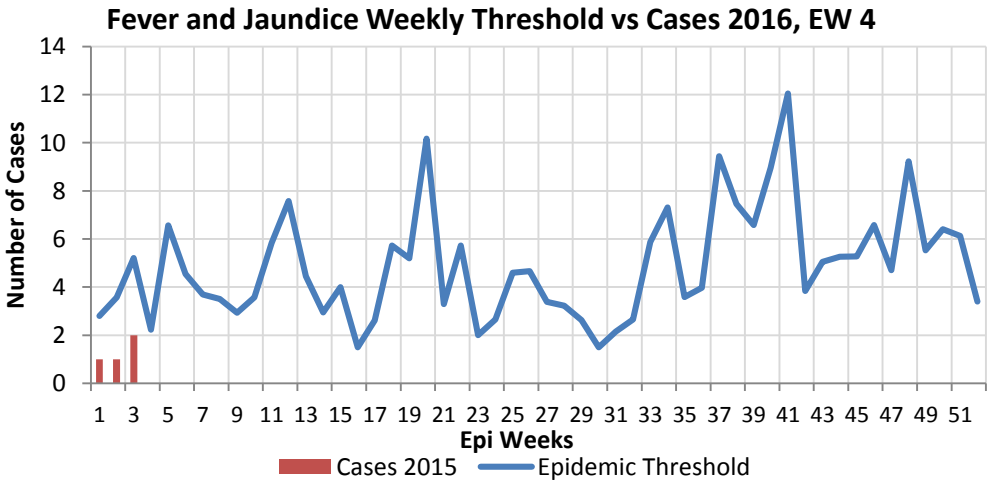
FEVER AND HAEMORRHAGIC

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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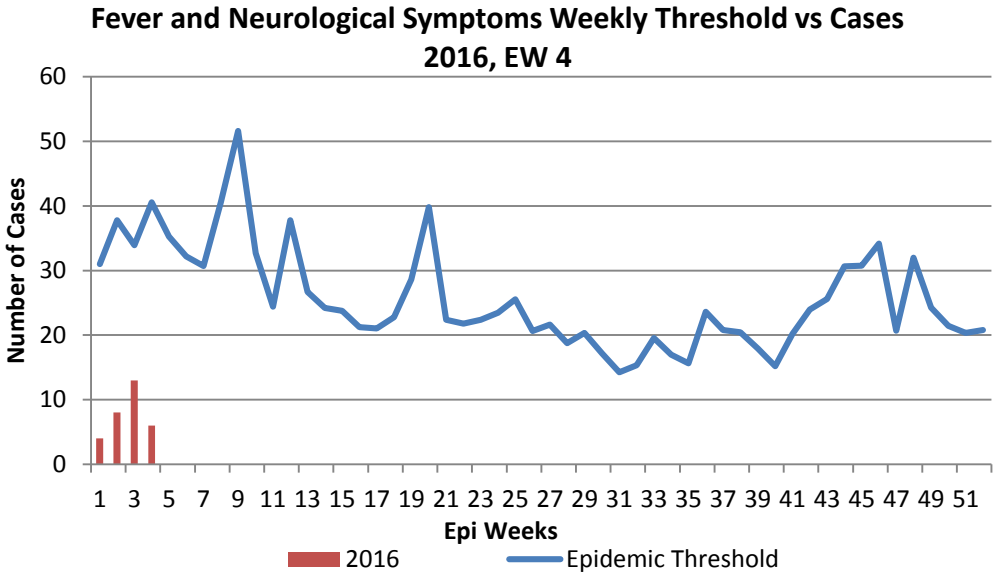
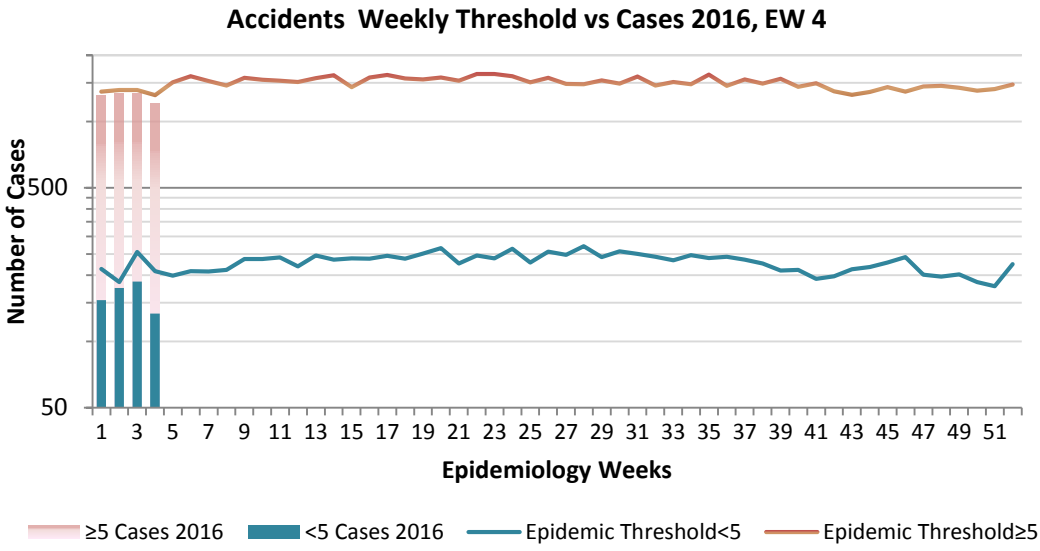
FEVER AND NEUROLOGICAL

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).



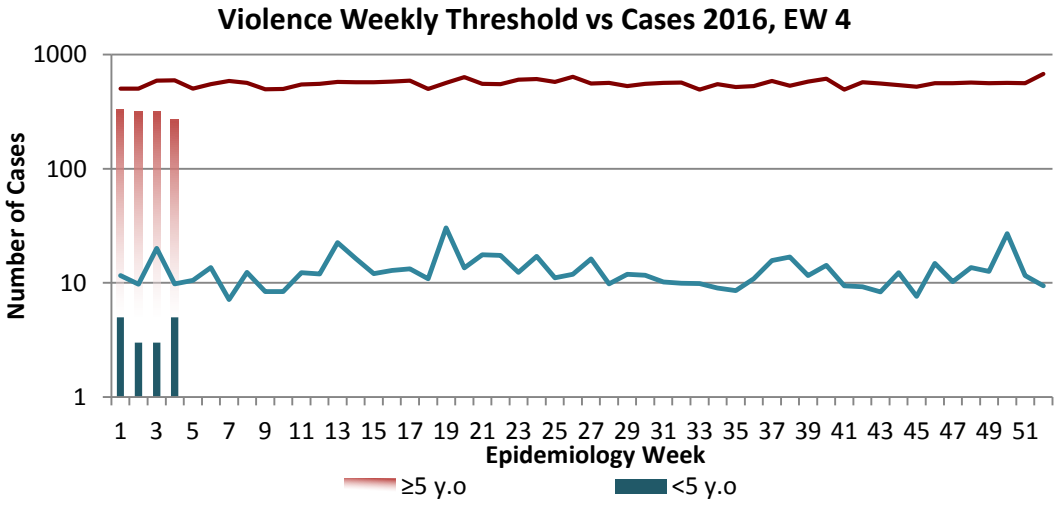
ACCIDENTS

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		18	26
	Cholera		0	0
	Dengue Hemorrhagic Fever[1]		0	0
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		0	2
	Hepatitis C		0	0
	HIV/AIDS - See HIV/AIDS National Programme Report			
	Malaria (Imported)		1	0
	Meningitis		13	28
EXOTIC/ UNUSUAL	Plague		0	0
H IGH MORBIDIT/ MORTALIY	Meningococcal Meningitis		0	0
	Neonatal Tetanus		0	0
	Typhoid Fever		0	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]		0	0
	Ophthalmia Neonatorum		13	22
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		0	0
	Tuberculosis		0	0
	Yellow Fever		0	0
UNCLASSED**	Leptospirosis		1	0

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 70% 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 4

January 24– January 30, 2016 Epidemiology Week 4

January, 2016	EW 4	YTD
SARI cases	35	110
Total Influenza positive	4	8
Samples		
Influenza A	4	7
H3N2	0	1
H1N1pdm09	4	6
Influenza B	0	0

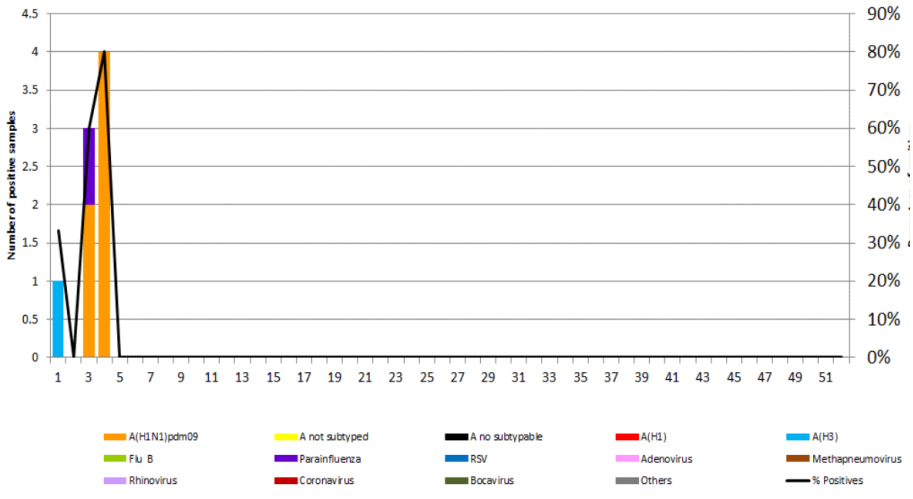
Admitted Lower Respiratory Tract Infection and LRTI-related Deaths

	Current year		Previous year	
	Week 4 2016	YTD 2016	Week 4 2015	YTD 2015
Admitted Lower Respiratory Tract Infections	91	293	89	350
Pneumonia-related Deaths	4	10	2	5

Comments:

The percent positivity of influenza viruses circulating among respiratory samples tested in EW 4, 2016 increase to 80% from 40% in EW 3, 2016. Influenza A(H1N1)pdm09 continued to predominate at 86% followed by A(H3N2) at 14%. There have been no detections of the influenza variant virus A/H3N2v, avian influenza H5 or H7 viruses among samples tested in Jamaica to date.

Distribution of Influenza and other respiratory viruses by EW surveillance
EW 4, 2016, NIC Jamaica



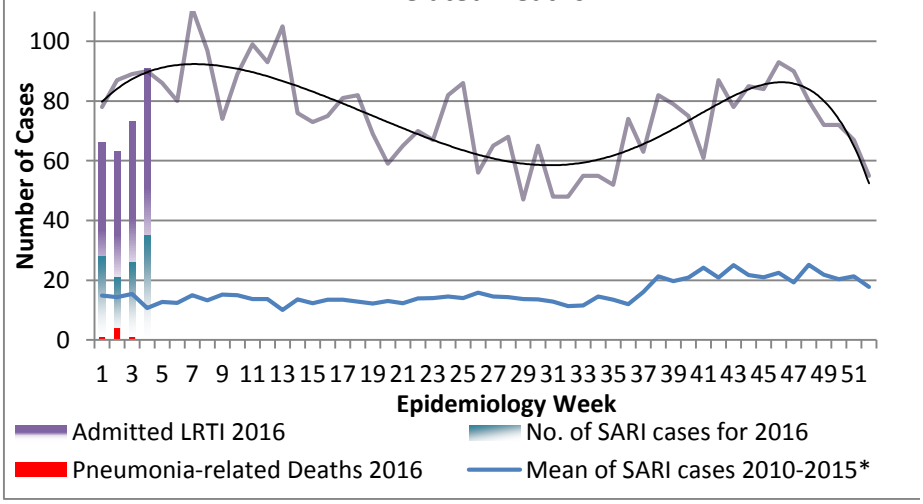
INDICATORS

Burden
Year to date, respiratory syndromes account for 5.3% of visits to health facilities.

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

Prevalence
Not applicable to acute respiratory conditions.

2016 Cases of Admitted LRTI, SARI, Pneumonia related Deaths



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

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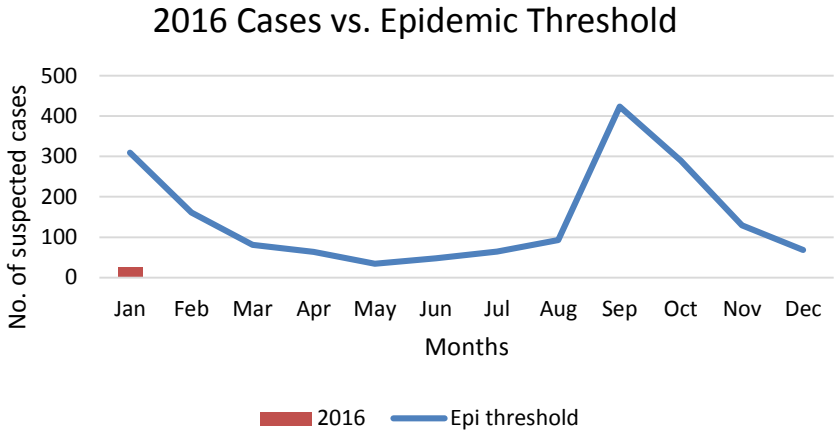
Dengue Bulletin

January 24–January 30, 2016 Epidemiology Week 4

DENGUE

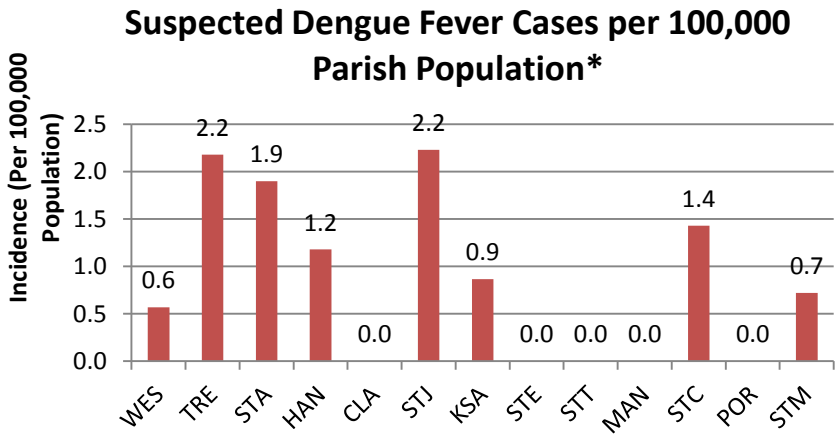
*Parish population is calculated based on census data from STATIN 2012.



DISTRIBUTION

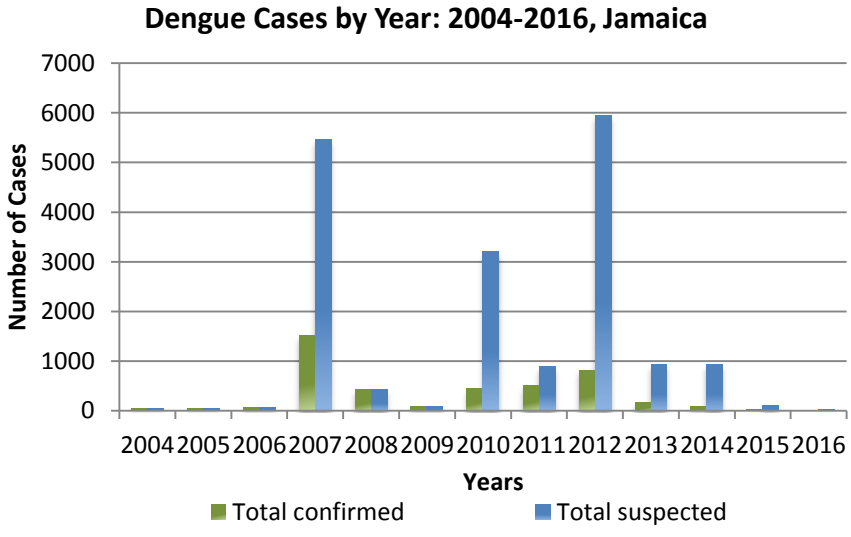
Year-to-Date Suspected Dengue Fever

	M	F	Total	%
<1	0	2	2	8
1-4	1	0	1	4
5-14	2	2	4	15
15-24	1	2	3	11
25-44	1	0	1	4
45-64	0	0	0	0
≥65	0	0	0	0
Unknown	7	8	15	58
TOTAL	**12**	**14**	**26**	**100**



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

		2016		2015 YTD
		EW 3	YTD	
Total Suspected Dengue Cases		8	26	10
Lab Confirmed Dengue cases		4	12	0
CONFIRMED	DHF/DSS	0	0	0
	Dengue Related Deaths	0	0	0



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Gastroenteritis Bulletin

EW 4

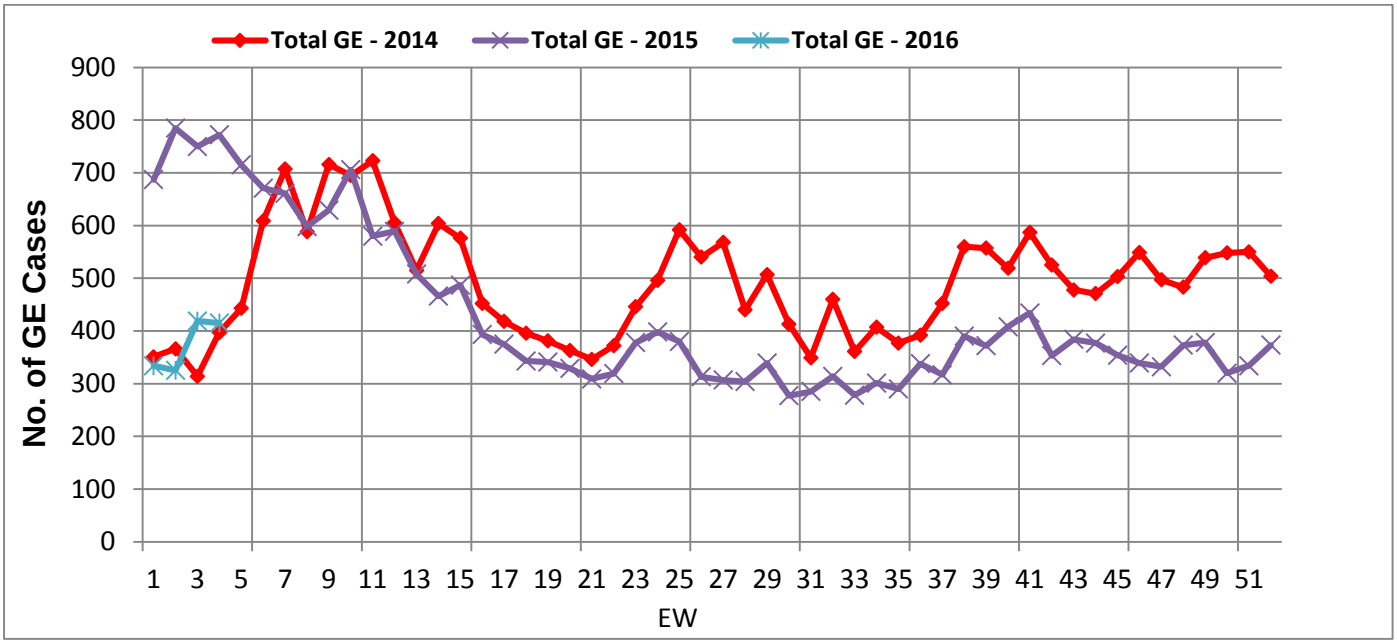
January 24 –January 30, 2016 Epidemiology Week 4

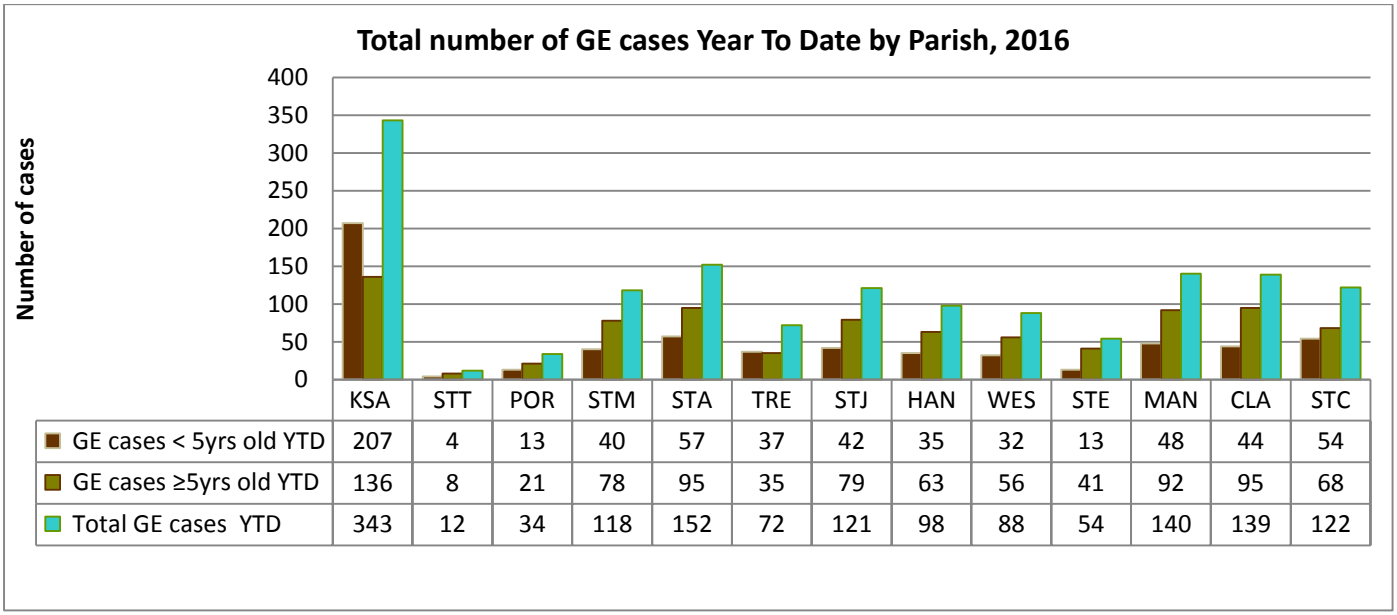
Weekly Breakdown of Gastroenteritis cases

Year	EW 4			YTD		
	<5	≥5	Total	<5	≥5	Total
2016	161	254	415	626	867	1493
2015	433	339	772	1681	1313	2994

In Epidemiology Week 4, 2016, the total number of reported GE cases showed a 46% decrease compared to EW 4 of the previous year.
The year to date figure showed a 50% decrease in cases for the period.

Figure 1: Total Gastroenteritis Cases Reported 2014-2016





	KSA	STT	POR	STM	STA	TRE	STJ	HAN	WES	STE	MAN	CLA	STC
GE cases < 5yrs old YTD	207	4	13	40	57	37	42	35	32	13	48	44	54
GE cases ≥5yrs old YTD	136	8	21	78	95	35	79	63	56	41	92	95	68
Total GE cases YTD	343	12	34	118	152	72	121	98	88	54	140	139	122

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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 assigned to the audited wards.

Results: Almost all the dockets audited (98%) revealed that nurses followed documentation guidelines for admission, 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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