Released March 4, 2016 ISSN 0799-3927

Week ending February 20, 2016 Epidemiology Week 7

WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight

World Salt Awareness Week 2016

World Salt Awareness Week has been confirmed! Monday 29th February - Sunday 6th March will see World Action on Salt and Health (WASH) celebrating 10 years since we first set out to reduce salt in people's diets worldwide and improve public health.

Many of us know that eating too much salt is bad for our health and are actively looking to reduce the amount we eat. This is in comparison to a few years ago, when the dangers of salt on health were widely unknown to the general public. Thanks to efforts by the food industry, governments and health organisations like WASH, salt is well and truly on the health agenda across many countries worldwide. As such we will be highlighting the great achievements that have been made in that time.

With that said however, we are still well away from the global maximum salt limit of 5g per day, highlighting a need for more action. Many foods still have lots of hidden salt in them, even foods that don't necessarily taste salty. We all have a responsibility to read the labels and choose foods with less salt, but it is down to the food companies to provide us with low salt options! It is equally much harder to eat less salt when eating out in restaurants and ordering takeaways, so for this years World Salt Awareness Week we will be asking all companies to think with their hearts and add less salt!

During World Salt Awareness Week we will be calling for more action from everyone; governments, the food industry, catering sectors, health professionals and the general public. We can all do our bit to #EatLessSalt

Source:
http://www.worldactiononsalt.com/awarenessweek/World%20Salt%20Awareness%20Week%202016/169049.html

EPI WEEK 7

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HOSPITAL ACTIVE SURVEILLANCE-30 sites*. Actively pursued

SENTINEL REPORT- 79 sites*. Automatic reporting

*Incidence/Prevalence cannot be calculated

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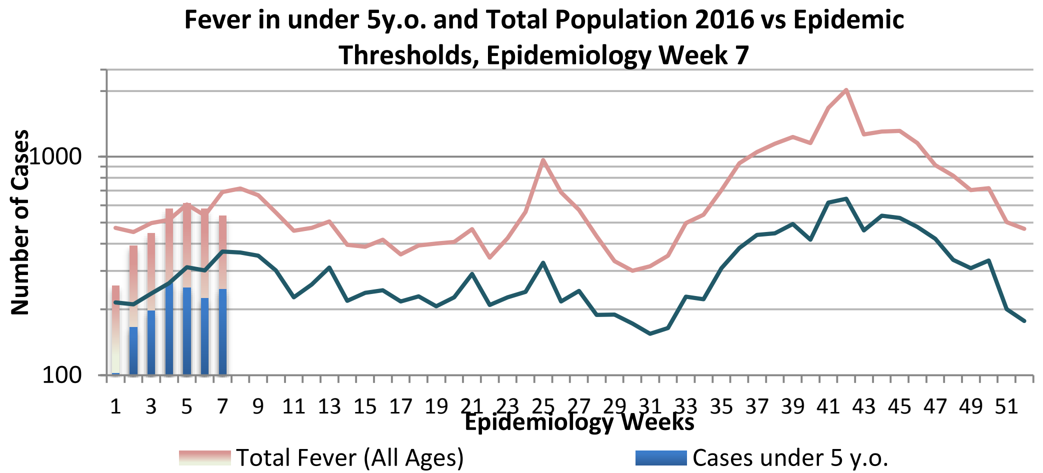
REPORTS FOR SYNDROMIC SURVEILLANCE

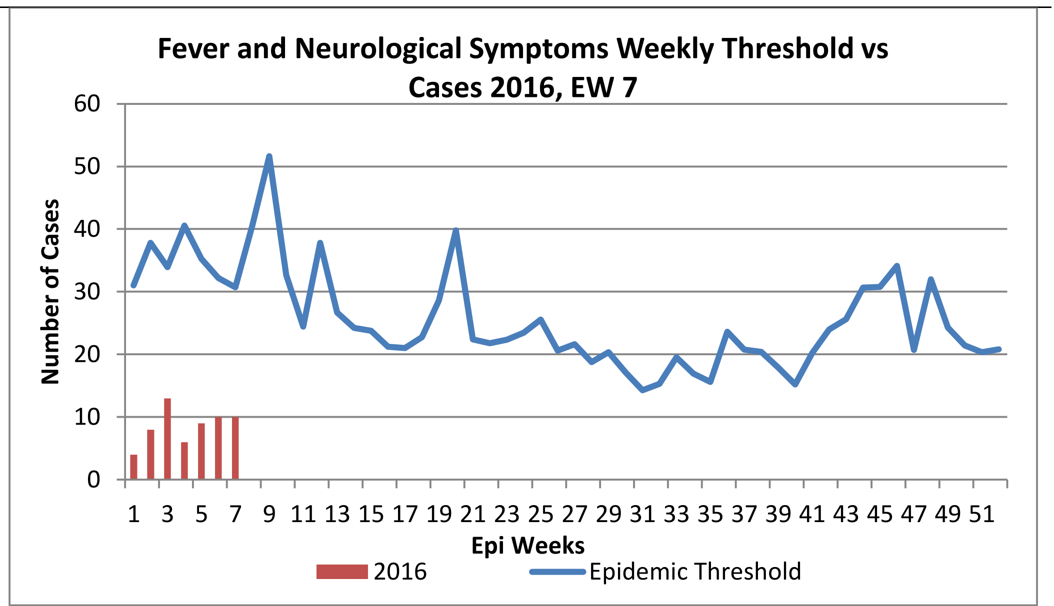
FEVER

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



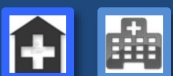
FEVER AND NEUROLOGICAL

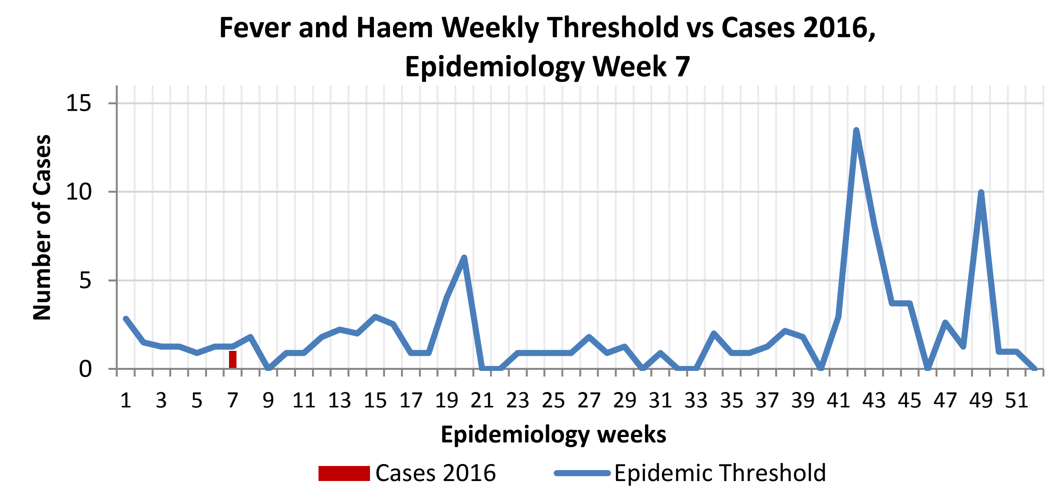
Temperature of >380C /100.40F (or recent history of fever) in a previously healthy person with or without headache and vomiting. The person must also have meningeal irritation, convulsions, altered consciousness, altered sensory manifestations or paralysis (except AFP).



FEVER AND HAEMORRHAGIC

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





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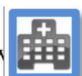

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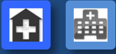
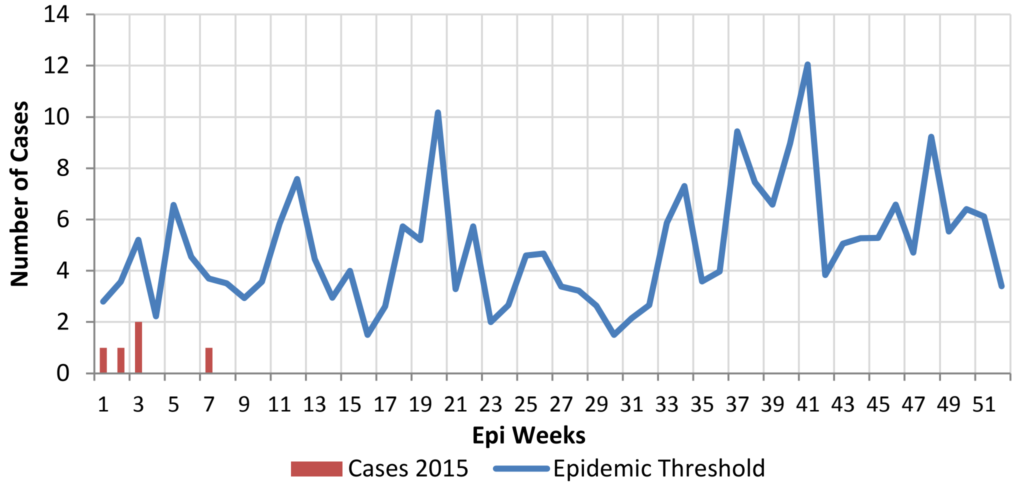
FEVER AND JAUNDICE

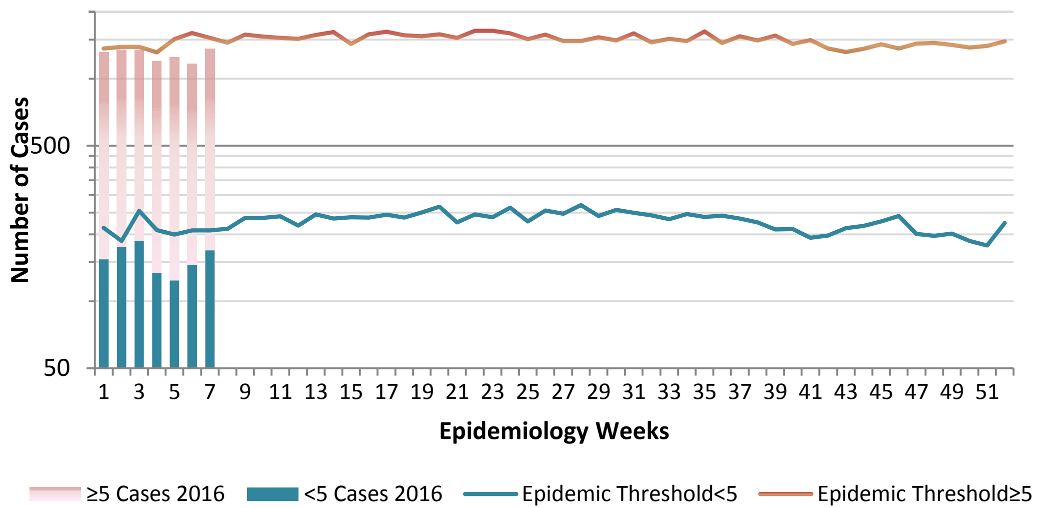
Temperature of >38⁰C /100.4⁰F (or recent history of fever) in a previously healthy person presenting with jaundice.





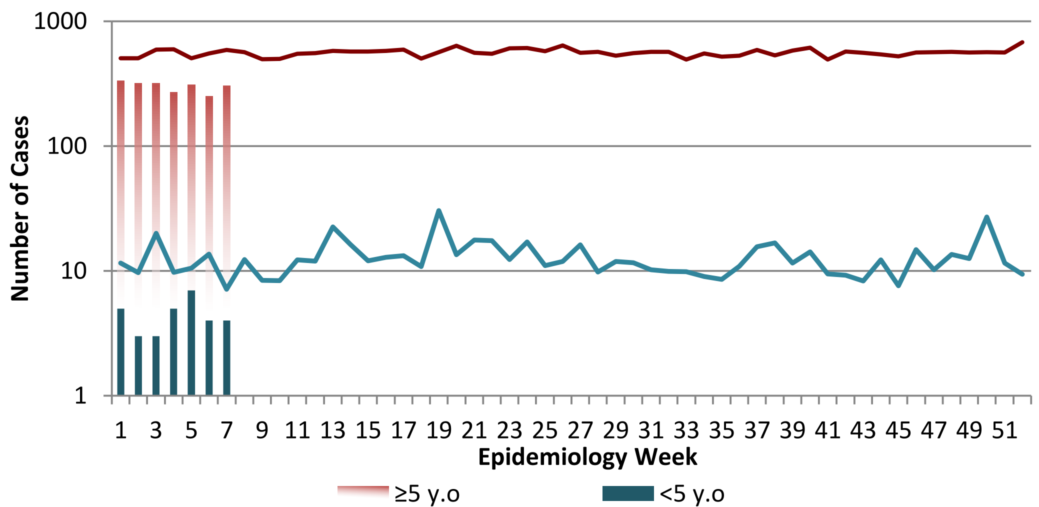
ACCIDENTS

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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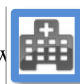

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CLASS ONE NOTIFIABLE EVENTS

	CLASS 1 EVENTS	CONFIRMED YTD	
		CURRENT YEAR	PREVIOUS YEAR
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning	2	27
	Cholera	0	0
	Dengue Hemorrhagic Fever[1]	0	0
	Hansen's Disease (Leprosy)	1	0
	Hepatitis B	0	7
	Hepatitis C	0	1
	HIV/AIDS - See HIV/AIDS National Programme Report		
	Malaria (Imported)	1	0
	Meningitis	2	18
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
	Fever and Rash – Rubella	0	0
	Maternal Deaths[2]	7	9
	Ophthalmia Neonatorum	54	61
	Pertussis-like syndrome	0	0
	Rheumatic Fever	0	2
	Tetanus	0	1
	Tuberculosis	0	0
	Yellow Fever	0	0
	Chikungunya	3	1
	Zika Virus	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.

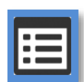
Pertussis-like syndrome and Tetanus are clinically confirmed classifications.

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

1 Dengue Hemorrhagic Fever data include Dengue related deaths;

2 Maternal Deaths include early and late deaths.



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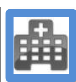

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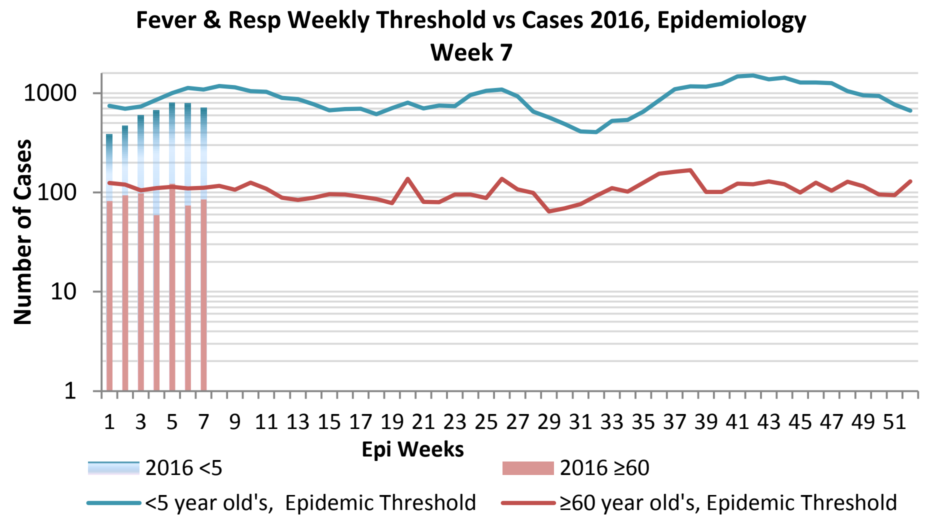
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

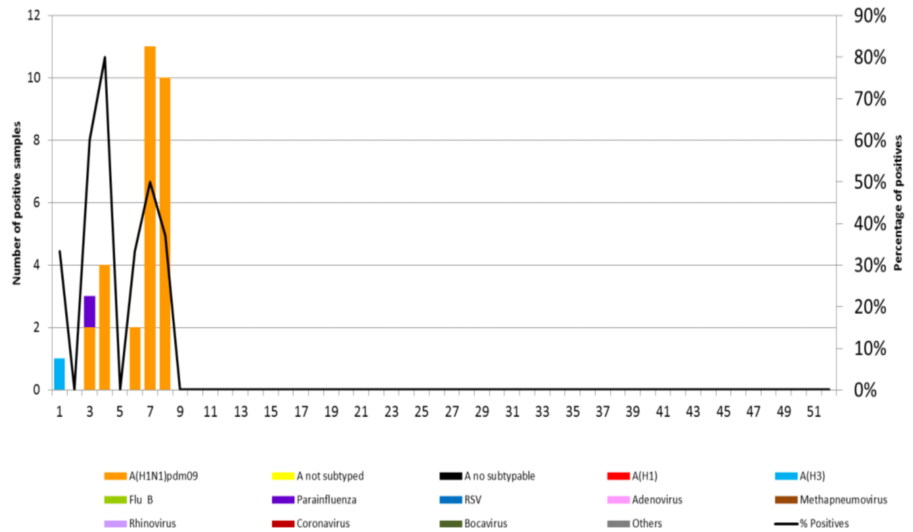
EW 7

February 14– February 20, 2016 — Epidemiology Week 7

February, 2016	EW 7	YTD
SARI cases	35	204
Total Influenza positive Samples	**11**	**21**
Influenza A	**11**	**20**
H3N2	0	1
H1N1pdm09	11	19
Influenza B	0	**0**
Other	0	**1**



Comments:
The percent positivity of influenza viruses circulating among respiratory samples tested in EW 7, 2016 among SARI cases was 67% (N=3). Influenza A(H1N1)pdm09 continued to circulate as the predominant virus at 67%. No Influenza B viruses have been detected since 2016. There has been no detection of the influenza A/H3v or A/H1v variant viruses, or avian H5 and H7 viruses among human samples tested. From epi weeks 1 to 7, 2016; 32 respiratory samples were tested by the NIC Jamaica. 31% of all samples tested, influenza was detected.

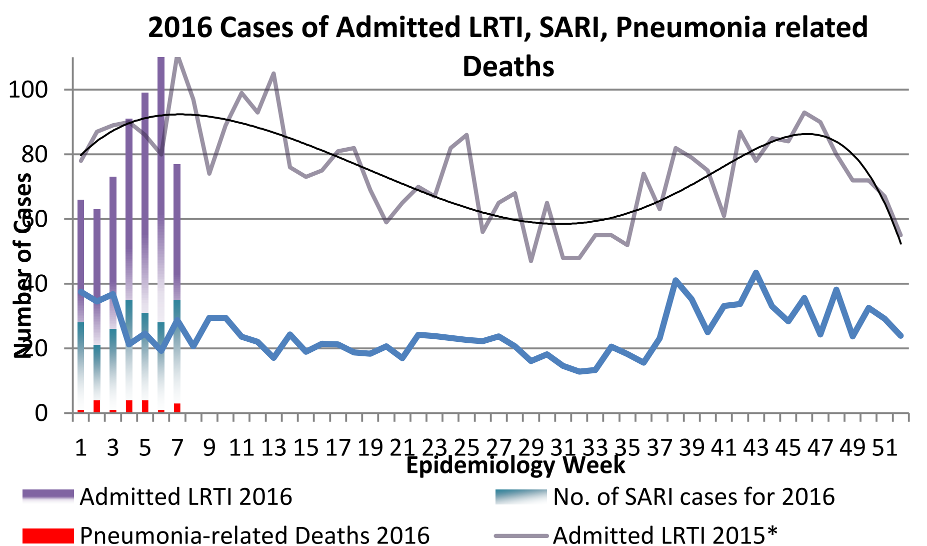


INDICATORS

Burden
Year to date, respiratory syndromes account for 6% 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.



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

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Dengue Bulletin

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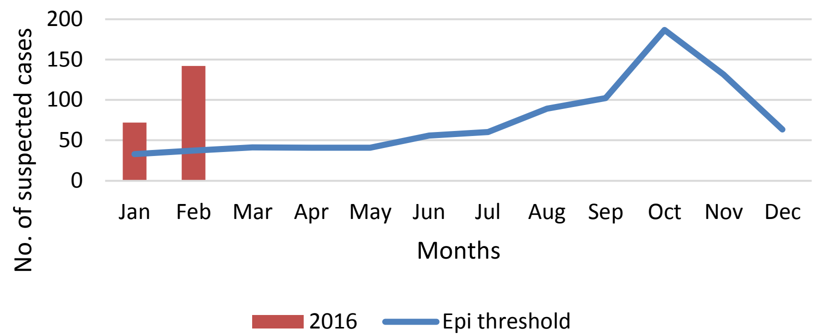
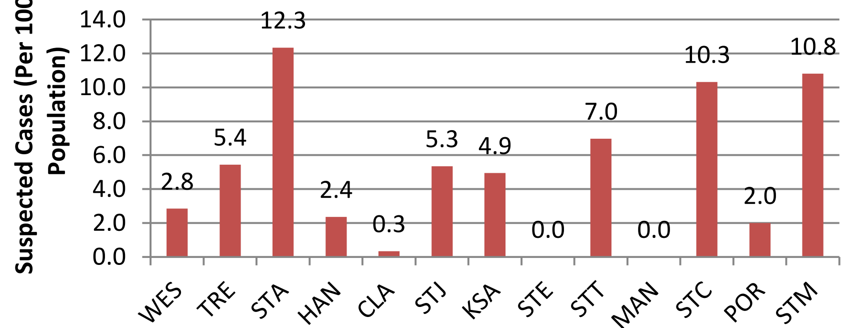


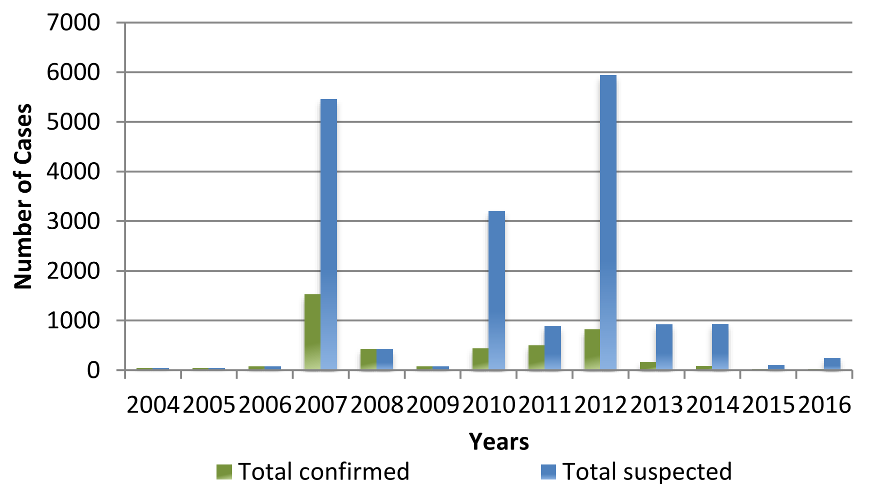
DISTRIBUTION

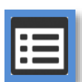
Year-to-Date Suspected Dengue Fever				
	M	F	Total	%
<1	0	2	2	2
1-4	1	0	1	1
5-14	2	2	4	3
15-24	1	2	3	2
25-44	1	0	1	1
45-64	0	0	0	0
≥65	0	0	0	0
Unknown	135	100	115	91
TOTAL	**140**	**106**	**246**	**100**



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

		2016 EW 7	2016 YTD	2015 YTD
Total Suspected Dengue Cases		40	246	16
Lab Confirmed Dengue cases		0	23	0
CONFIRMED	DHF/DSS	0	0	0
CONFIRMED	Dengue Related Deaths	0	0	0

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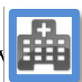
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Gastroenteritis Bulletin

EW 7

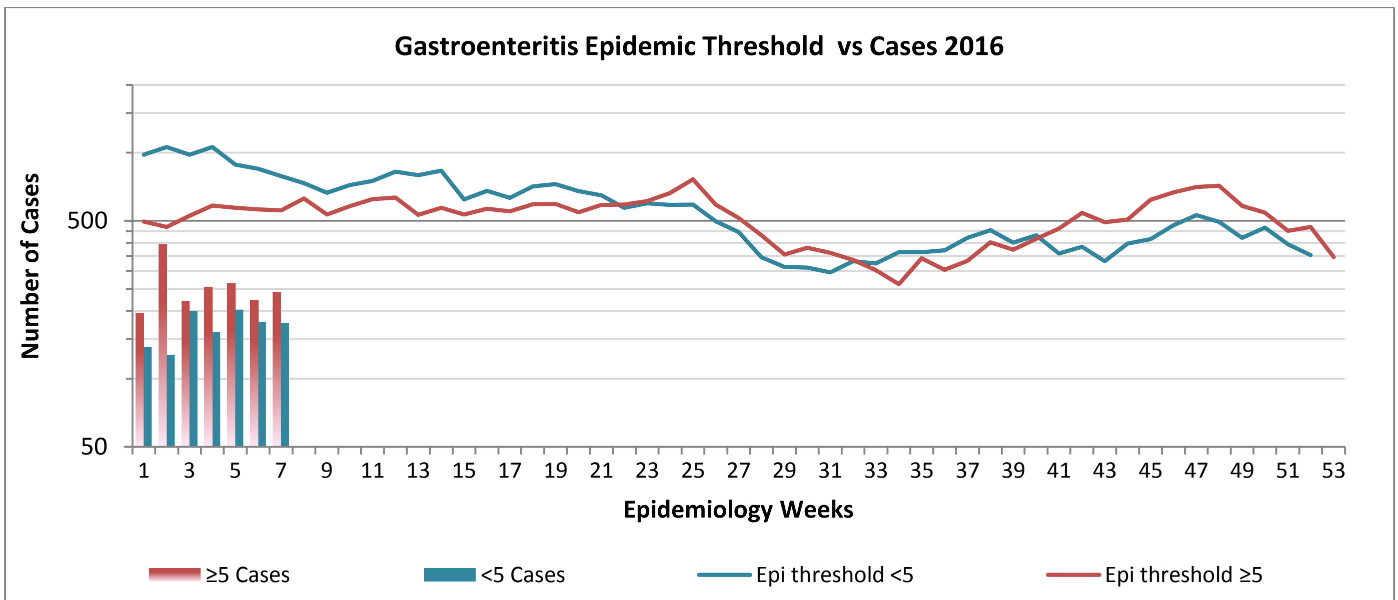
February 14– February 20, 2016 | Epidemiology Week 7

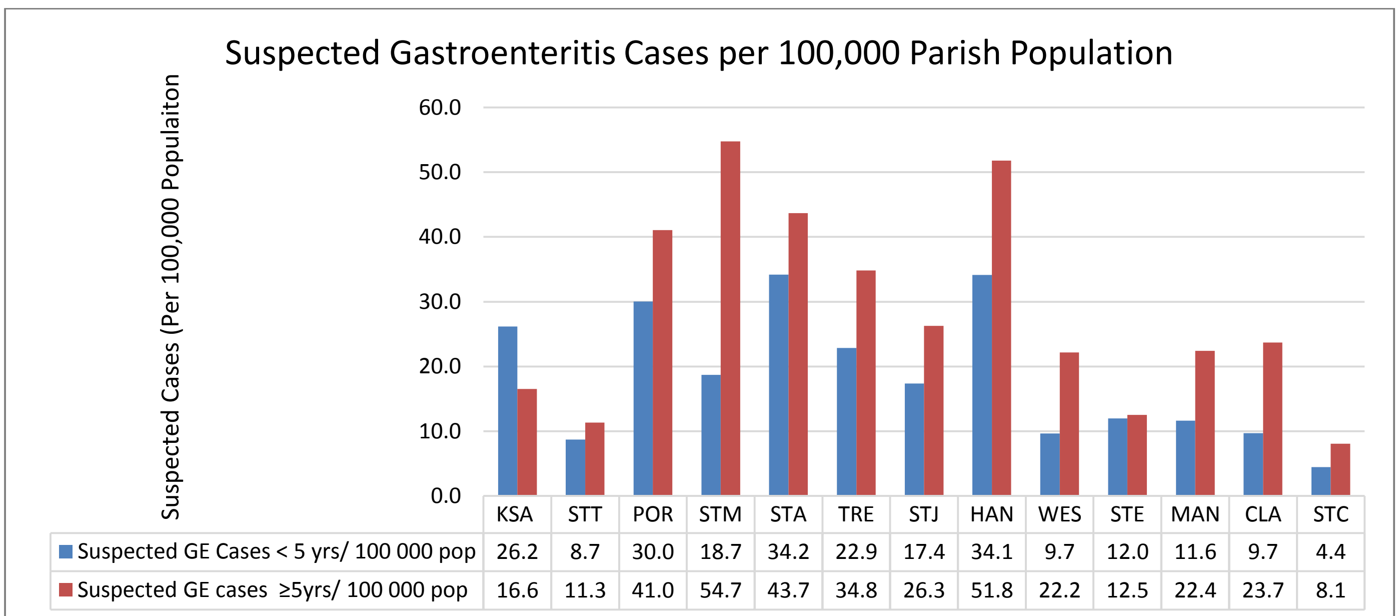
Weekly Breakdown of Gastroenteritis cases

Year	EW 7			YTD		
	<5	≥5	Total	<5	≥5	Total
2016	177	241	418	1184	1594	2778
2015	322	339	661	2711	2330	5041

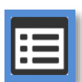
Gastroenteritis: Three or more loose stools within 24 hours.
In Epidemiology Week 6, 2016, the total number of reported GE cases showed a 45% decrease compared to EW 6 of the previous year.
The year to date figure showed a 44% decrease in cases for the period.

Figure 1: Total Gastroenteritis Cases Reported 2014-2016





	KSA	STT	POR	STM	STA	TRE	STJ	HAN	WES	STE	MAN	CLA	STC
Suspected GE Cases < 5 yrs/ 100 000 pop	26.2	8.7	30.0	18.7	34.2	22.9	17.4	34.1	9.7	12.0	11.6	9.7	4.4
Suspected GE cases ≥5yrs/ 100 000 pop	16.6	11.3	41.0	54.7	43.7	34.8	26.3	51.8	22.2	12.5	22.4	23.7	8.1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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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