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Week ending May 27, 2017 Epidemiology Week 20

WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight

WHO updates Essential Medicines List

New advice on which antibiotics to use for common infections and which to preserve for the most serious circumstances is among the additions to the *WHO Model list of essential medicines* for 2017. Other additions include medicines for HIV, hepatitis C, tuberculosis and leukaemia.

The updated list adds 30 medicines for adults and 25 for children, and specifies new uses for 9 already-listed products, bringing the total to 433 drugs deemed essential for addressing the most important public health needs.

New advice: 3 categories of antibiotic

In the biggest revision of the antibiotics section in the EML's 40-year history, WHO experts have grouped antibiotics into three categories – ACCESS, WATCH and RESERVE – with recommendations on when each category should be used. Initially, the new categories apply only to antibiotics used to treat 21 of the most common general infections.

The change aims to ensure that antibiotics are available when needed, and that the right antibiotics are prescribed for the right infections. It should enhance treatment outcomes, reduce the development of drug-resistant bacteria, and preserve the effectiveness of "last resort" antibiotics that are needed when all others fail. WHO recommends that antibiotics in the ACCESS group be available at all times as treatments for a wide range of common infections. For example, it includes amoxicillin, a widely-used antibiotic to treat infections such as pneumonia.

The WATCH group includes antibiotics that are recommended as first- or second-choice treatments for a small number of infections. For example, the use of ciprofloxacin, used to treat cystitis (a type of urinary tract infection) and upper respiratory tract infections (such as bacterial sinusitis and bacterial bronchitis), should be dramatically reduced to avoid further development of resistance.

The third group, RESERVE, includes antibiotics such as colistin and some cephalosporins that should be considered last-resort options, and used only in the most severe circumstances when all other alternatives have failed, such as for life-threatening infections due to multidrug-resistant bacteria.

Downloaded from: http://who.int/mediacentre/news/releases/2017/essential-medicines-list/en/

EPI WEEK 21

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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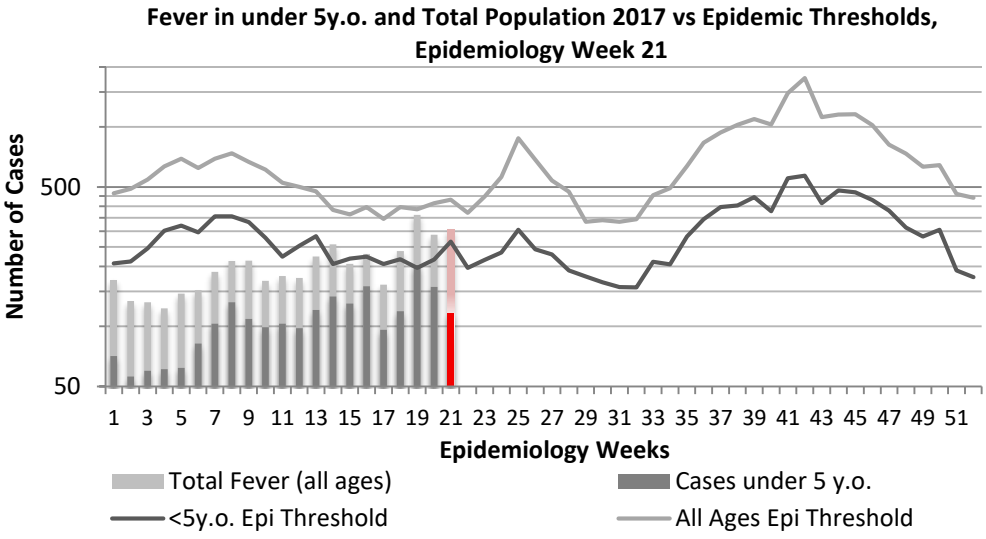
REPORTS FOR SYNDROMIC SURVEILLANCE

FEVER

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

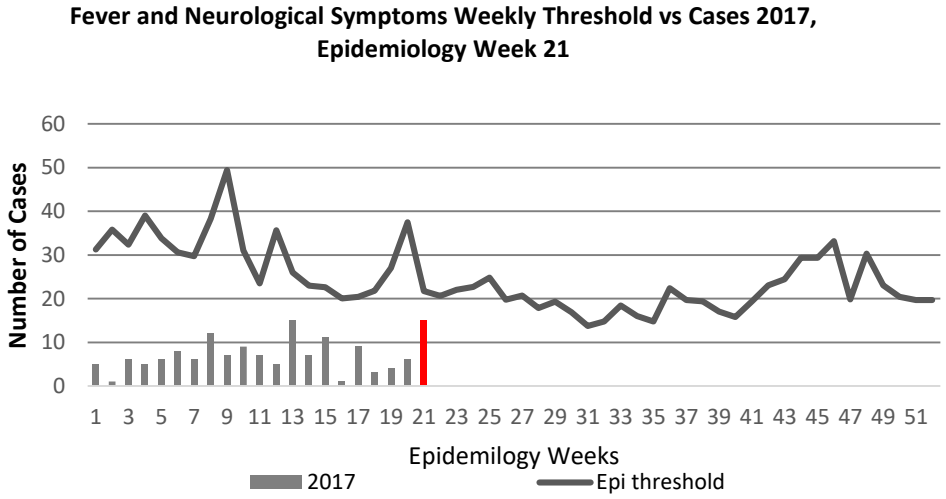
KEY

RED CURRENT WEEK



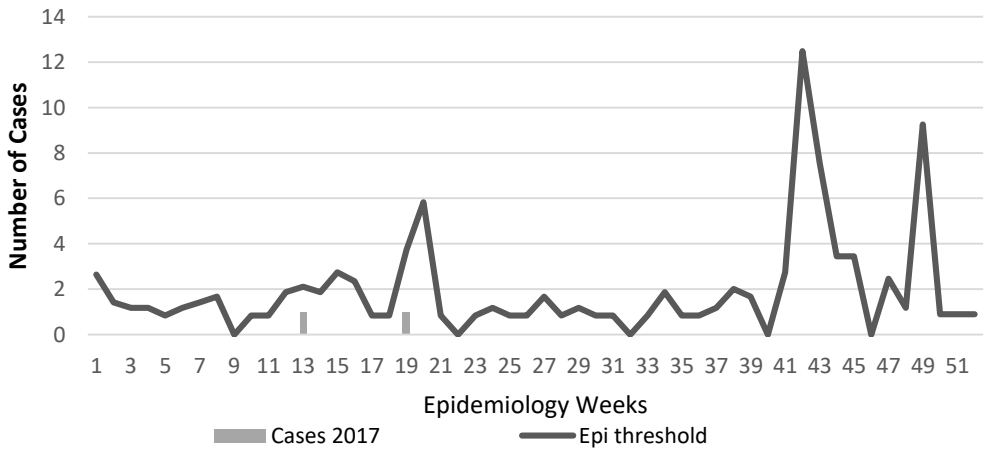
FEVER AND NEUROLOGICAL

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 >38^0C /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.



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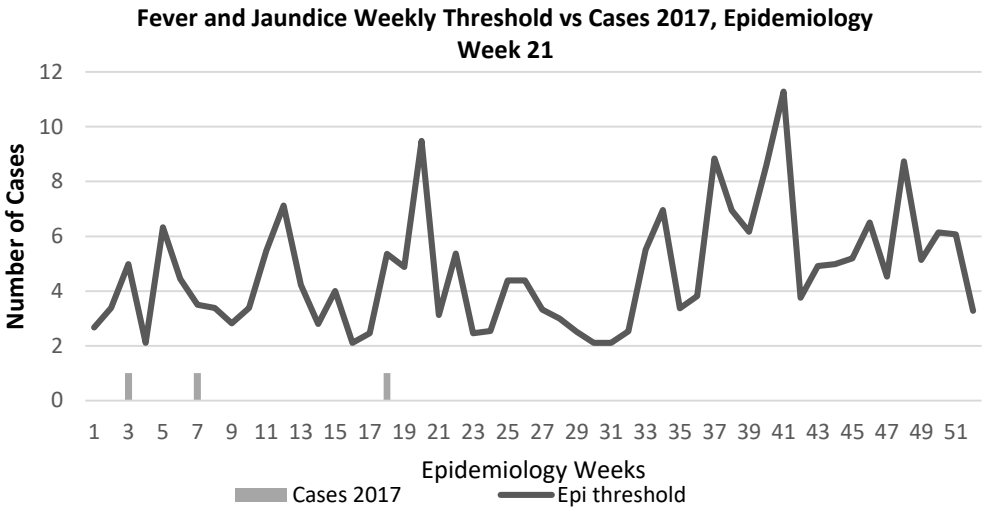
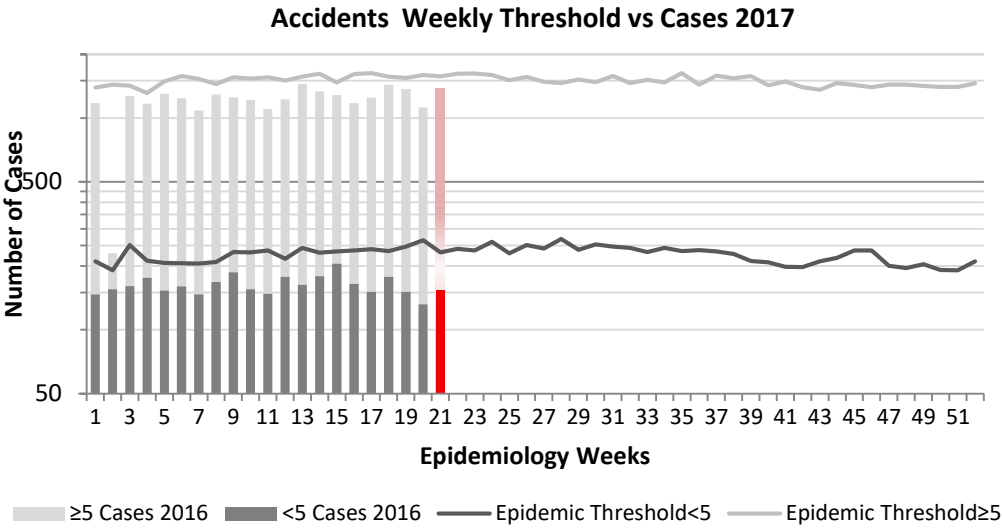
FEVER AND JAUNDICE

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



ACCIDENTS

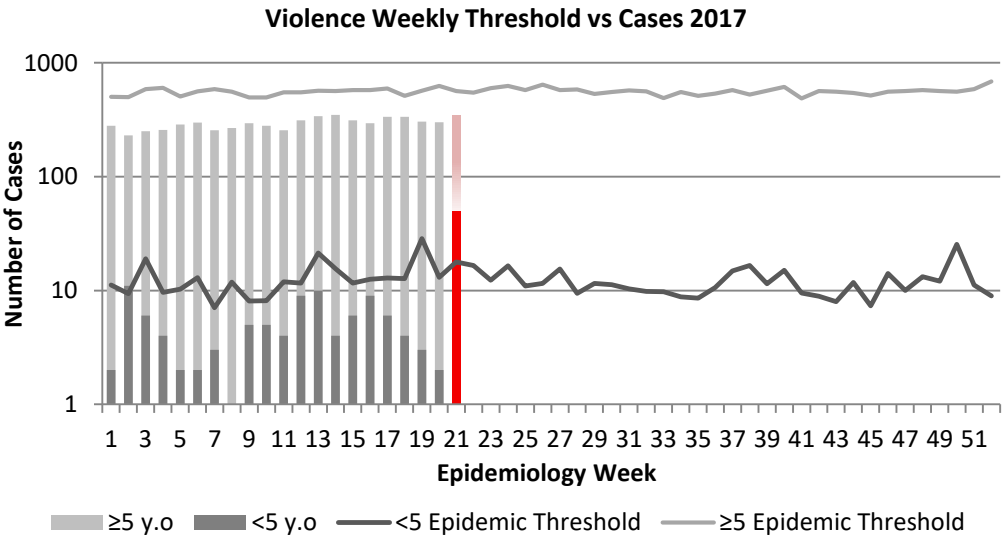
Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.



VIOLENCE

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

The epidemic threshold is used to confirm the emergence of an epidemic so as to step-up appropriate control measures.



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CLASS ONE NOTIFIABLE EVENTS

	CLASS 1 EVENTS		CONFIRMED YTD CURRENT YEAR	CONFIRMED YTD PREVIOUS YEAR
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		37	71
	Cholera		0	0
	Dengue Hemorrhagic Fever[1]		0	0
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		10	14
	Hepatitis C		1	4
	HIV/AIDS - See HIV/AIDS National Programme Report			
	Malaria (Imported)		2	1
	Meningitis (Clinically confirmed)		11	26
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]		16	24
	Ophthalmia Neonatorum		86	192
	Pertussis-like syndrome		0	0
	Rheumatic Fever		1	6
	Tetanus		1	0
	Tuberculosis		0	11
	Yellow Fever		0	0
	Chikungunya		0	0
	Zika Virus		0	18

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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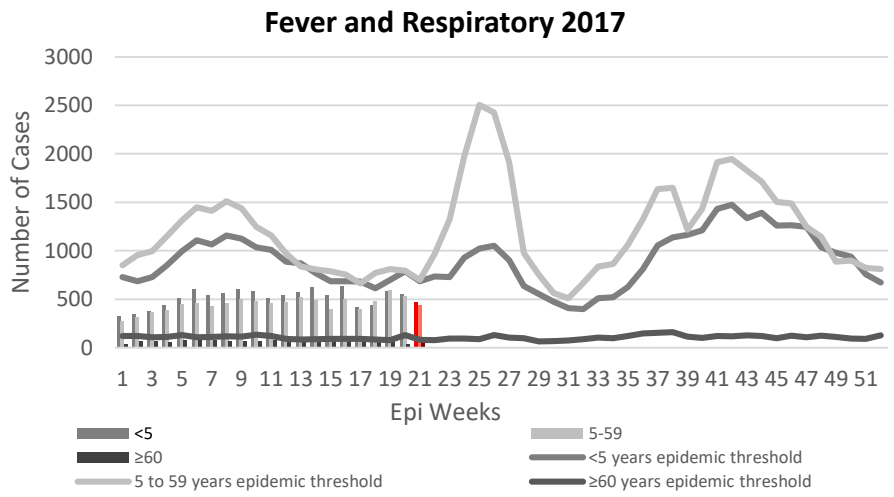
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 21

May 21-27, 2017 Epidemiology Week 21

May 2017	EW 21	YTD
SARI cases	9	232
Total Influenza positive Samples	**0**	**13**
Influenza A	**0**	**0**
H3N2	0	0
H1N1pdm09	0	0
Not subtyped	0	0
Influenza B	0	**13**
Other	0	**0**

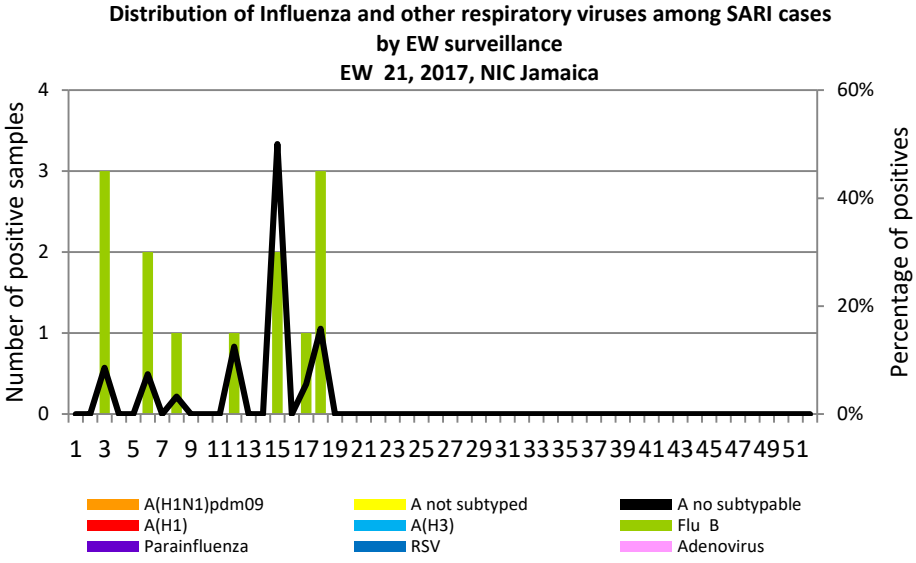


Comments:

During EW 20, SARI activity slightly decreased and was below the average epidemic curve.

During EW 20, SARI cases were most frequently reported among children between 0-4 years of age.

During EW 20, no influenza detections were reported.

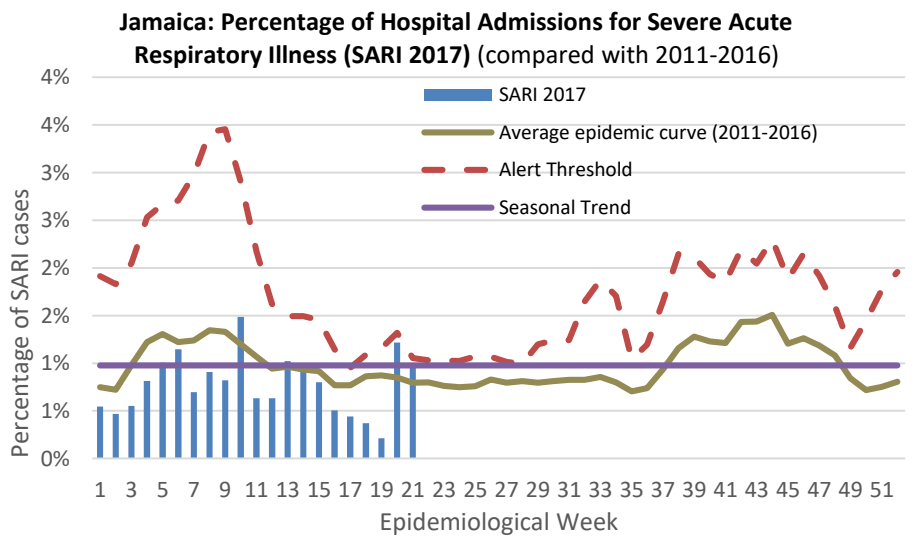


INDICATORS

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 acute respiratory conditions.



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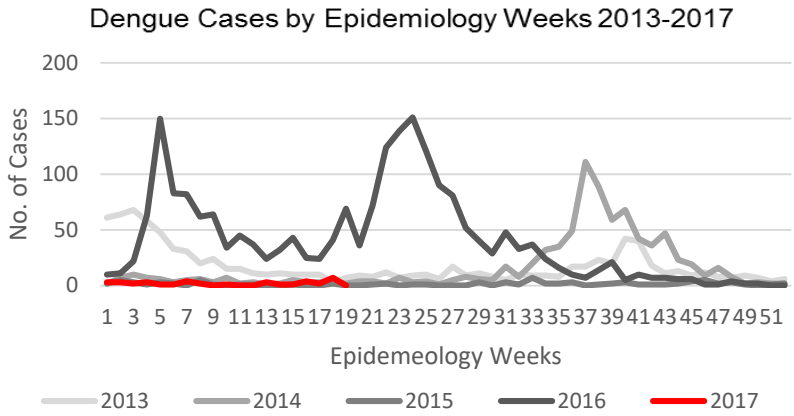
Dengue Bulletin

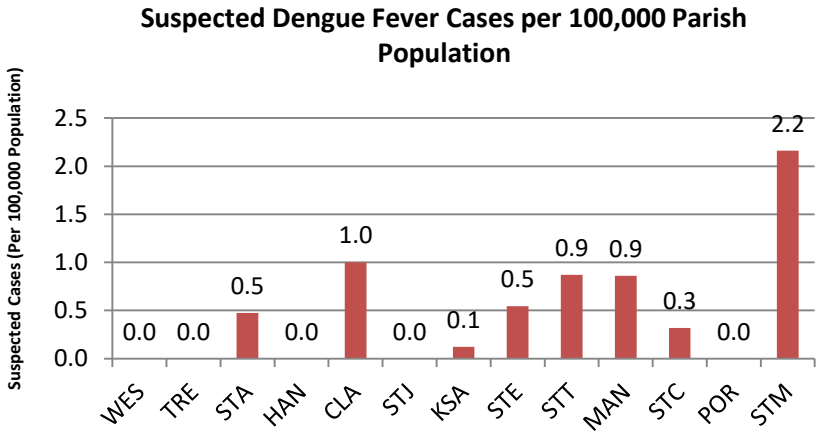
May 21-27, 2017 Epidemiology Week 27



DISTRIBUTION

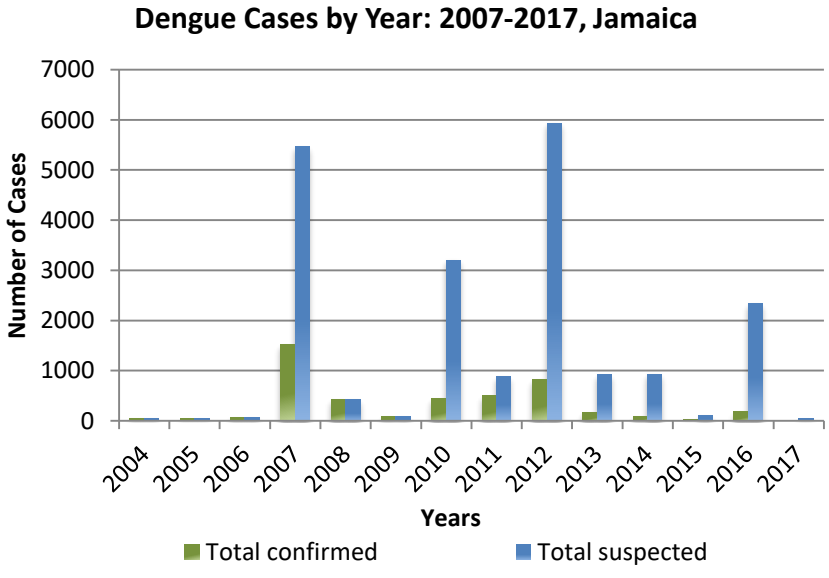
Year-to-Date Suspected Dengue Fever

	M	F	Un-known	Total	%
<1	1	0	0	1	2.6
1-4	2	1	0	3	7.9
5-14	4	5	0	9	23.7
15-24	4	3	0	7	18.4
25-44	6	5	1	12	31.6
45-64	1	3	0	4	10.5
≥65	0	0	0	0	0
Unknown	1	1	0	2	5.3
TOTAL	19	18	1	38	**100**



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

		2017		2016 YTD
		EW 21	YTD	
Total Suspected Dengue Cases		0	38	803
Lab Confirmed Dengue cases		0	0	86
CONFIRMED	DHF/DSS	0	0	3
	Dengue Related Deaths	0	0	0



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Gastroenteritis Bulletin

EW 21

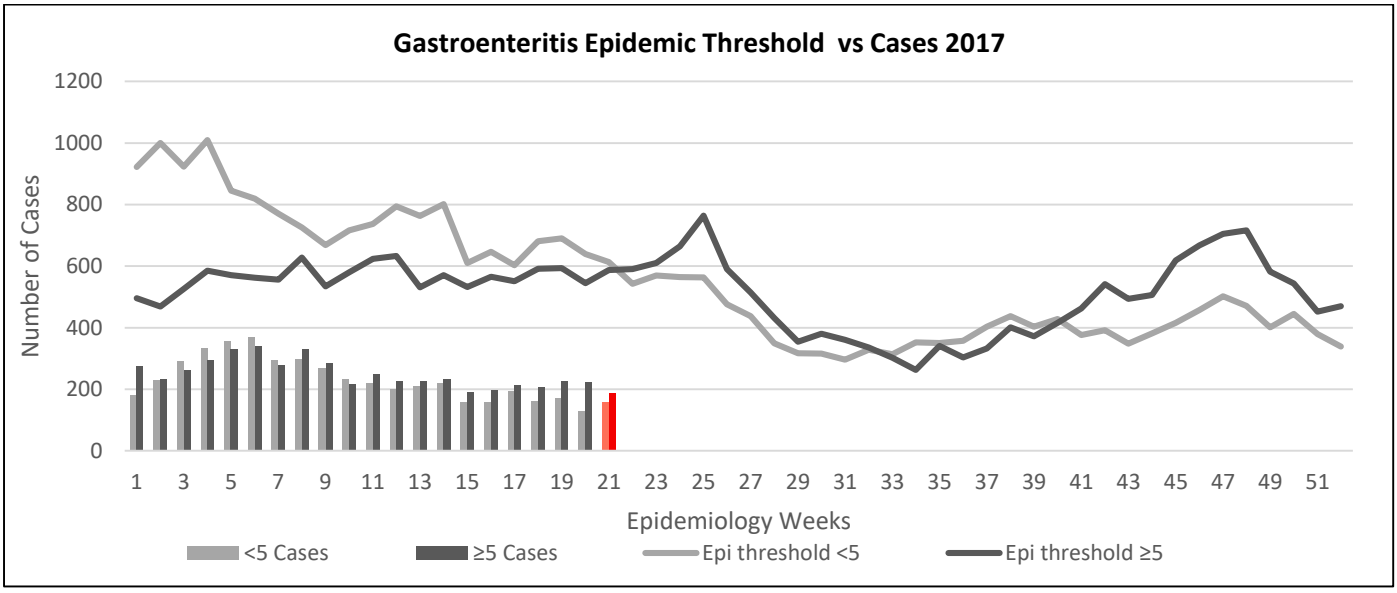
May 21-27, 2017 Epidemiology Week 21

Weekly Breakdown of Gastroenteritis cases

Year	EW 21			YTD		
	<5	≥5	Total	<5	≥5	Total
2017	159	187	346	4,824	5,216	10,040
2016	125	287	412	3,058	4,688	7,746

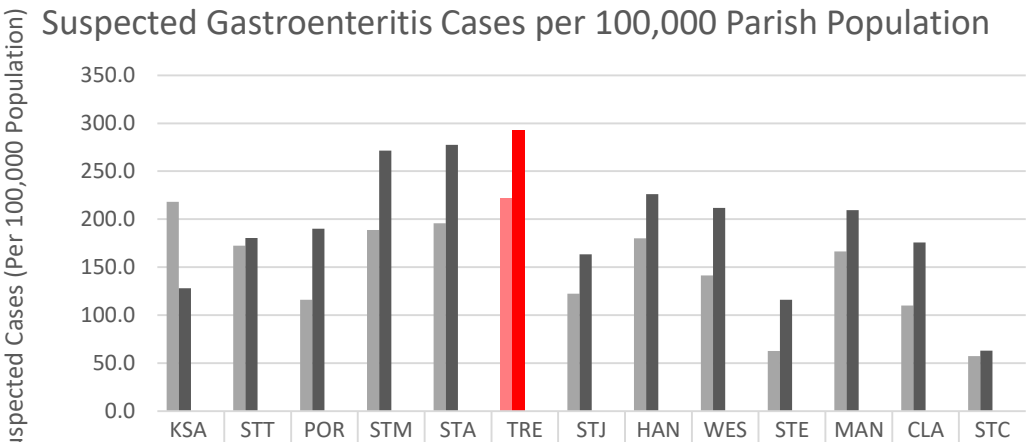
Gastroenteritis:
In Epidemiology Week 21, 2017, the total number of reported GE cases showed an 16% decrease compared to EW 21 of the previous year.
The year to date figure showed a 29% increase in cases for the period.

Figure 1: Total Gastroenteritis Cases Reported 2016-2017



Trelawny reported the highest number of GE cases per 100,000 in their 5 years old and over population

Trelawny reported the highest number of GE cases per 100,000 in their under 5 years old population



	KSA	STT	POR	STM	STA	TRE	STJ	HAN	WES	STE	MAN	CLA	STC
Suspected GE Cases < 5 yrs/ 100 000 pop	218.0	172.5	116.1	188.7	195.7	222.1	122.5	180.1	141.5	62.7	166.4	109.9	57.1
Suspected GE cases ≥5yrs/ 100 000 pop	128.0	180.4	190.2	271.5	277.3	292.9	163.5	226.1	211.9	116.1	209.5	175.7	62.9
Highest number of cases < 5 /100,000 pop													
Highest number of cases ≥ 5/100,000 pop													

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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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