

P=0.057), there was no statistical difference between two groups. There was also no difference between two groups in CBC data.

Conclusions: When the patients were infected with *H. cinaedi*, most of the patients presented with fever, cellulitis, and diarrhea. Every patients recovered from the infections. Based on the previous research, it was thought that the decreased immune function was the risk factor for the *H.cinaedi* infection. However, there was no lab results difference between the patients with and without infections. There were a few reports that there was an outbreak of *H.cinaedi* among immunocomptent patients and this study supports that immunocompromise is not the risk for the infection. The further studies are needed to identify the risk factors for *H. cinaedi* infection.

Presentation Number: 10-119

Interdisciplinary Strategy to Control an Outbreak of Norovirus at a North Carolina Acute Care Hospital

Jeannie H. Vance, RN, ADN, Director, Infection Prevention, Carolinas Medical Center-NorthEast, Concord, NC

Issue: Norovirus is the leading cause of viral gastroenteritis affecting 23 million people yearly in the United States. Norovirus has a low infectious dose, is highly resistant to disinfectants and can remain in the environment for 3-4 weeks. Norovirus spreads easily by multiple routes, with prolonged asymptomatic shedding. Incubation period is 24-48 hours with duration of 12-60 hours. It is characterized by diarrhea, vomiting, abdominal pain, malaise, and low grade fever. Outbreaks can cause a heavy financial impact on organizations if not contained quickly. April 18, 2008 the Infection Control Department was notified of staff absenteeism on a nursing unit. Upon initial investigation 9 staff members on an orthopedic surgical unit reported a sudden onset of profuse diarrhea, nausea, and vomiting over the past 48 hours. Further investigation revealed 20 visitors, patients, and staff were potentially involved. By that evening a presumptive diagnosis of Norovirus was established.

Project: Initial steps: Unit closed to admissions, prevented rotation of staff to other units, work restrictions placed, contact precautions for all patients in unit, droplet precautions for those vomiting, intense cleaning by environmental services and connecting hallway closed to through traffic. Public health notified and enteric specimens for pathogen identification collected. A working case definition was developed. Additional control measure implemented including hand hygiene with soap and water, surface/equipment disinfection with bleach solution, and visitation discouraged. A champion in environmental services ensured all infection control disinfection recommendations were carried out promptly. A total of 57 cases identified; 4 physicians, 19 visitors, and 34 staff. Day 3, an ill dietary employee was reported to the night nursing supervisor who sent the employee home, closed the cafeteria, and called management in for a thorough cleaning of the department. In addition, the supervisor recommended all self service foods be eliminated and utensils be switched to pre-packaged. Conference calls conducted with county and state agencies and local infection control practitioners for guidance. Multiple communication channels were utilized with staff, departments, management, and news media. Infection control reviewed each reported case to ensure the case definition was met. Administration placed hand washing stations at all entrances to enforce a "message" to visitors.

Results: The outbreak lasted two weeks and involved 224 individuals; 155 staff, 24 visitors/family, 31 patients, and 14 undecided cases. The infection control team developed an Outbreak Surveillance Policy outlining methods for employee illness reporting. In addition, a Suspect Norovirus Protocol was also developed to be used during any future suspected outbreak.

Lessons Learned: We felt the aggressive control measures implemented prior to the definitive diagnosis enabled us to establish early interruption of transmission. Utilization of key resources such as public health and the state infection prevention program provided validation of interventions. Staff and administrative support were crucial in rapid implementation of control measures including work restrictions. Physician-to-physician interaction regarding work restrictions was more effective. Two days into the outbreak, personal protective equipment stock was depleted; need to notify those responsible at onset. A computerized line listing on a shared directory simplified data collection and minimized duplication.