

do not result in a full investigation remain open for extended periods should additional cases be identified and additional data can be collected to identify disease transmission. An electronic means of tracking investigations is planned but has yet to be developed. Since 2004, 76 investigations have followed the guideline. Of the 76, 27 (36%) were assigned to more extensive or full epidemiologic investigation. Of the 27, seven resulted in notification of 9,429 patients of possible bloodborne pathogen exposure and recommendation for serologic testing.

Lessons Learned: Public health investigation of healthcare-related disease transmission is inherently complicated and demanding on time and resources. The guideline has helped to ensure a consistent approach to investigating possible transmission events, and the efficient and effective use of limited resources to investigate each case report while thoroughly investigating those of highest priority. Tracking investigations electronically may increase the identification of events requiring more extensive investigation.

Presentation Number 9-096

A Multidisciplinary Approach to Vancomycin-resistant *Enterococcus* Outbreak Management

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Issue: Vancomycin resistant *Enterococcus* (VRE) outbreaks can be difficult to control. January 2009 to June 2009 London Health Sciences Centre experienced a VRE outbreak involving 4 medical units. Previous outbreak management was confusing due to inconsistent communication and fragmented implementations.

Project: A multidisciplinary team was created to provide clear communication and implementation to staff on a weekly basis. Four major areas of focus were; infection control, education, cleaning and physician initiatives. Infection control implementations were prevalence screening, chlorhexidine bathing, creation of outbreak binders and additional protocols for patient transfer/placement. Educational methods were role playing/case reviews, observational/environmental audits and "ask the experts" bulletin boards. Cleaning initiatives involved checklists and spot checks. Physicians incorporated infection control content into orientation sessions and a "physician pause" to determine appropriate measures required for entering a room.

Results: The multidisciplinary team provided comprehensive outbreak initiatives and improved communication which contributed increased compliance to outbreak implementations. The outbreak binders and cleaning checklists gave staff a guide to consult for appropriate outbreak measures. The role playing and case reviews helped staff understand the impact of VRE to patient morbidity/mortality. In addition, the audits, cleaning spot checks and "ask the expert" bulletin boards provided staff with feedback and a forum to have questions answered. Many of these initiatives, including the physician initiatives, was continued after outbreak resolution and is believed to contribute to sustained resolution.

Lessons Learned: Involvement of multiple services created a united front and proved to be effective outbreak management. Relationships were strengthened between infection control, the leadership team and front line staff.

Presentation Number 9-097

An Outbreak of Community Acquired Methicillin-resistant *Staphylococcus aureus* (CA-MRSA) in a Pediatric Hospital Burn Unit

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Issue: Transmission of CA-MRSA within hospitals is being reported with an increased frequency. These infections usually present as minor skin and soft tissue infections, but more invasive disease has also been described. The