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INFECTION CONTROL

LETTERS TO THE EDITOR

To the Editor:

I would like to respond to the letter from Dr. Nicholson in the July/August 1980 issue.

A very important concept was reiterated and that was "getting back to basics." I wholeheartedly agree that this "has more to do with reducing hospital acquired infections than anything else we can do or have done."

However, as Dr. Nicholson pointed out, he has been retired for several years. As important as our tried-and-true basic practices are, there have obviously been some revisions in these since Dr. Nicholson's involvement in health care. Namely, that of routine bacteriologic checks. This type of predictable monitoring has proven to be a flagrant use of time and money for the information it yields. First, everyone knows it's going to be done (the first and 15th of every month) and responds appropriately and second, no one really knows how to interpret much of the data.

Joint Commission on Accreditation of Hospitals (JCAH) recommends that sampling activities be reserved for specific situations such as evaluating products, procedural changes, or equipment and educational purposes. This recommendation is supported by the American Hospital Association and American Public Health Association, to name a few.

We are required to perform routine checks of our sterilizers (steam and gas) and, in Michigan, commercially-prepared formula/water.

Which brings me to another point: responsibility for the sterility of a product claiming to be sterile lies with the manufacturer. Once we have received the product we are responsible for maintaining sterility by protecting the integrity of packaging through proper storage and monitoring of same, proper rotation and double-check systems for expiration dates.

The point made regarding a proven method for the care of carpeting is well taken. However, to my knowledge, there has never been a nosocomial infection linked to contaminated carpeting.

With our present confinements of *cost-containment, it is really necessary* to sterilize items such as bedpans, urinals, and emesis basins, or is good physical cleaning and disinfection adequate? (For the average, non-infected patient, of course.)

Lastly, proper indoctrination/orientation of *all* hospital employees (not just housekeepers) is our best approach for conformance to basic infection control practices. A good orientation program is our first chance to establish good working habits in a new employee. Although they may be the poorest paid, have language barriers and a lesser education, I have found housekeeping to be the most conscientious of all groups within the hospital.

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To the Editor:

I was interested in the article "Hospital-Acquired Staphylococcal Infection Transmitted by the Hospital Personnel" which appeared in the May/June 1980 issue in the section: The Law and Infection Control. I have also researched the Kapuschinsky case and have examined it in some detail in my article "The Hospital's Obligation to Protect Patients from Carriers of Infectious Diseases" (*Medicolegal News*, Fall, 1979).

I recommend my article to anyone who is interested in further pursuing this very difficult subject. The extensive bibliography might be particularly useful.

Your new publication is quite impressive.

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To the Editor:

As the Infection Control Nurse in a small rural community hospital in Wisconsin, I have been chosen by Administration to develop a viable Infection Control program for nursing staff participation. Our progress has been slow but steady until recently when one of the physicians decided that a doctor is the only individual qualified to order that a patient be placed in isolation. I do not want to antagonize the doctor just because we do not agree on this one particular subject. On the other hand, I do not see how an Infection Control program can be successful in our institution under these circumstances. We are a 41-bed acute care hospital providing Obstetric, Pediatric, Medical, Surgical, Special Care, and Emergency Services as well as outpatient orthopedic and urological clinics. It is not unusual for a nurse to work in two or three of the patient care areas per shift. We have to

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be on our toes to separate "clean" patient care from "dirty" patient care to prevent cross-contamination. We do not have medical students, interns or residents. We do not have a doctor in the hospital 24 hours a day.

I am interested in your feedback on this problem. I intend to submit it to our Infection Control Committee (the physician in question is not on the committee) for consideration, as we will have to prepare a written policy with procedures for placement of a patient in isolation.

Your assistance is greatly appreciated.

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This letter was referred to William E. Scheckler, M.D., and Kathy J. Wydra, R.N., B.S.N., who wrote the following replies:

Although the tradition in most hospitals includes the concept that the physician orders all things relating to the patient, including whether or not isolation is necessary, it is now clear that the hospital has legal and moral responsibilities to the patient as well. The purpose of an isolation policy is to protect other patients, staff and visitors from the transmission of known or suspected infectious illnesses. In my opinion, it is perfectly proper for a hospital to have an isolation policy that permits the Infection Control Nurse, the Chairman of the Infection Committee or the Hospital Epidemiologist, or the attending physician to place a patient with a suspected or proven infection in the appropriate type of isolation. The responsibility of the physician is to indicate on the chart the diagnosis of the infectious illness, or the suspected diagnosis. Based on this information, it is the responsibility of the hospital to be sure that this infection is not spread to other patients or personnel in the hospital. Since the hospital has this responsibility, it follows that the hospital also has a right to see to it that a reasonable isolation policy is implemented. Use of the category "protective isolation" is probably best left up to the attending physician's discretion. The Public Health Service publication "Isolation Techniques for Use in Hospitals" would be an appropriate isolation policy for the hospital to implement.

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Your administration must not only delegate to you the responsibility of developing a viable infection control program, but must also support the decisions you make relative to that program. The Infection Control Committee should be an administrative committee charged with the task of developing, implementing and enforcing the policies it creates. The committee should carefully write isolation policies directed at each clinical disease state requiring isolation and disseminate those policies among the nursing and physician staff. Isolation policies should be regarded as hospital policies and so enforced. Be sure that your policies are well founded and that your facility can "live" with them before finalizing them and you'll find they will be easier to defend.

Members of the professional staff who cannot adhere to the policies should be asked to attend the Infection Control Committee meeting to present rational, well-documented evidence for noncompliance. A staff member who ignores policies must accept the liability for those actions; however, that does not mean the rest of the staff should defy the rules.

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