

which to answer the questions raised by Mr. Birnbaum. This implies a study collecting a wide variety of very detailed data. However, the surveillance data acquired in the NNIS system, which is voluntary, cannot be as detailed and must remain relatively practical. The Centers for Disease Control's intent is to provide information to hospitals that is more meaningful for interhospital comparison, rather than attempt to define a specific patient's risk. The rates that we now advocate, such as device-associated, device-day rates, are meant only as a guide and indicate areas for further investigation. The Joint Commission on Accreditation of Healthcare Organizations in their agenda for change also has accepted the limitations of "benchmark" rates.<sup>4</sup> Censored data and an inconstant infection risk throughout the duration of a device represent only two areas where improvement in these rates are needed. We will continue to improve the NNIS system and provide mechanisms, often through articles in this journal, to help hospitals understand the most appropriate methods to interpret the rates we have recommended.

**Robert P. Gaynes, MD**  
Centers for Disease Control  
Atlanta, Georgia

#### REFERENCES

1. Centers for Disease Control. Nosocomial infection rates for interhospital comparison: limitations and possible solutions. *Infect Control Hosp Epidemiol.* 1991;12:609-612.
2. Warren JW, Tenney JH, Hoopes JM, Muncie HL. A prospective microbiologic study of bacteruria in patients with chronic indwelling urinary catheters. *J Infect Dis.* 1982;146:719-723.
3. Sofitle FD, Mavie FJ, Prough DS, et al. Nosocomial pulmonary infection: possible etiologic significance of bacterial adhesion to endotracheal tubes. *Crit Care Med.* 1986;14:265-270.
4. *Joint Commission's Agenda for Change.* Chicago, Ill: Joint Commission on Accreditation of Hospitals; 1986.

## Home Healthcare

#### To the Editor:

I read with great interest the article "Infection Control for Home Health,"<sup>1</sup> as I work for a national organization that provides home services in Canada.

As the authors mentioned in the article, there are scarce data regarding development and transmission of infections in the home setting. I do believe, as they do, that serious infections probably do occur less frequently in the home setting than in the hospital. However, I am not so sure that the home environment is necessarily a safer setting for individuals when there are many factors in the client's home environment that we never control, such as general hygiene, adequate handwashing facilities, home health professionals with communicable diseases, the use of more multiple invasive devices, or an immunocompromising condition. We assume that the home environment is safer, but we have little evidence for that except for the absence of "full-blown" infection. However, could a low-grade infection be associated with a longer healing period in an incisional wound, for example?

I believe that most infection control guidelines are a result of hospital-based research. Yet we have little research to define infection control parameters for the home setting. To make assumptions about the safety of the home environment in terms of infection control, with little data to support that hypothesis, is almost negligent. It certainly behooves us in the community to more rigorously test various infection control hypotheses.

I did want to question the statement regarding sterile irrigation solutions that can be kept open for 72 hours before discarding. Where are the data to support

that particular time frame? I am only familiar with the work of Brown et al,<sup>2</sup> in terms of the length of time sterile solutions are kept open, and did not know that any other data existed. I realize that their work is hospital-based.

Because there is little legislation to protect us in the community, we must abide by research-based practice as much as possible.

**Johanne Mousseau, RN, NP, MSc**  
Victorian Order of Nurses for Canada  
Ottawa, Ontario

#### REFERENCES

1. Simmons B, Tiusler M, Roccaforte J, Smith P, Scott R. Infection control for home health. *Infect Control Hosp Epidemiol.* 1990;11:362-270.
2. Brown DG, Skyllis TP, Sulisz CA, Friedman C, Fichter DK. Sterile water and saline solution: potential reservoirs of nosocomial infection. *Am J Infect Control.* 1985;13:35-39.

*The authors reply.*

Yes, good infection control data concerning home health are sparse. However, it is not negligent to make recommendations based on the best information available. It is certainly more irresponsible to make no effort at all. Hopefully, our article will stimulate you "to more rigorously test various infection control hypotheses" as you continue your work in the home. At the very least, home health nurses should be collecting reliable surveillance data patterned after data collected in the hospital. Such a simple step would help us answer the question about whether the home environment is safer than the hospital.

Regarding the 72-hour change interval for urinary tract irrigants, I know of no data to support a particular time frame. However, most patients who have chronic indwelling urinary catheters do not have sterile urine. Patients who use intermittent