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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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