Control of Health Care-Associated Infections

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To the Editor:— We endorse the recommended multidisciplinary approach to address the global proliferation of health care-associated infections (HAIs).¹ The extreme paucity of funds to reduce HAI incidence is a global phenomenon. Nevertheless, local multidisciplinary innovations could be useful even with meager fiscal input. For the past 5 years, we have relied on culture-based surveillance for HAIs among hospitalized patients, laboratory surveillance for notifiable diseases and a rapid turn-around time for reporting of antimicrobial susceptibility on bacterial isolates at the Sant Parmanand Hospital, a multi-disciplinary, tertiary care, 140-bed hospital in Delhi.

Employing a positive culture-based surveillance, all HAIs have been categorized since October 2002 as a possible hospital-acquired or community-acquired one using a cutoff of a 2- or 3-day interval between hospitalization and a positive culture. Suspected cases of hospital-acquired infection are reviewed regularly and the infection rates computed per 100 hospital admissions.² Initial data for the first 6 months serve as the baseline data, when the incidence per 100 admissions was 0.97, standard error 0.26. The subsequent rates have been significantly lower, the latest being 0.42 ± 0.11 and 0.46 ± 0.04 .

There is a 24-hourly screening of laboratory samples received in the laboratory from hospitalized cases. Data on every cerebrospinal fluid sample for turbidity, glucose and protein values and cell counts are used to detect suspected cases of bacterial meningitis. Probable dengue fever cases are selected by platelet counts less than $100 \times 10^9/l$ and/or anti-dengue virus IgM and IgG, while malaria confirmation is based on microscopy of the peripheral blood films.³

The hospital clinical laboratory also observes a 24-h schedule with four laboratory technicians on a rotational 24-h duty. Specimens received from hospitalized patients are cultured

immediately: plates are read every 6 h.⁴ Bacterial isolate identity and antimicrobial susceptibility are communicated straightaway to clinicians or nursing personnel responsible for the hospitalized patients.

Last but not least, there is constant surveillance for reservoirs of colonization by pathogenic bacteria to reduce the incidence of HAIs. Since 2003, swabs have been collected regularly from operative sites and wards for patients in medical, surgical and neonatal intensive care. The pathogens isolated have included *Klebsiella pneumoniae*, *Pseudomonas aeruginosa* and *Proteus* species.⁵

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