A network to promote infection

Specialists in hospital hygiene regularly share and exchange information on an international level. Over time it has become clear that the skills and responsibilities of infection control practitioners are still largely undefined in many European countries. In 2008 this prompted the German Society of Hospital Hygiene (DGKH) to organise a meeting in Berlin for representatives of national associations of hospital hygiene in order to strengthen Europe-wide collaboration. This led to the establishment of the European Network to Promote Infection Prevention for Patient Safety (EUNETIPS) in Venice in October 2011. EUNETIPS has been a fully-fledged association under Italian law since 2012.

Prof. Dr. Walter Popp (pictured) – Head of Hospital Hygiene at Essen University Hospital and a member of EUNETIPS – is delighted by the network’s success. The national associations’ response to EUNETIPS has surpassed all expectations, he wrote in a recent article for the journal ‘Management & Krankenhaus’, with membership now extending to 21 associations from 16 countries. This includes major professional bodies in France (French Society of Hospital Hygiene), Italy (SIMPIOS), Spain (Spanish Society for Preventive Medicine, Public Health and Hospital Hygiene), England (HIS and the Royal College of Nursing) and Germany (DGKH).

EUNETIPS is currently led by a coordinating committee with Silvio Brusaferro from Udine, Italy as president and Walter Popp as Continued on page 2

WHO declares end of Ebola epidemic in Liberia

Seven weeks after the last victim was buried, the World Health Organisation has announced that the outbreak of Ebola virus disease in Liberia is over.

Eighteen months after the outbreak of a devastating Ebola epidemic in West Africa, Liberia appears to have finally won the battle against the disease. On May 9, the World Health Organisation (WHO) declared Liberia free of Ebola virus transmission. Liberia is the first of the three worst affected countries to be classified as Ebola-free. According to official figures, more than 26,000 people were infected with Ebola during the epidemic and some 11,000 of them died, including 500 health workers. With many cases going unrecorded, however, the actual figures may be far higher.

WHO says that significant efforts are still required to keep the disease in check and emphasises that people must continue to be on their guard: “New cases are still being reported in Guinea and Sierra Leone, so there is a high risk that infected people may cross the borders into Liberia.”
in Berlin, Gertie van Knippenberg-Gordebeke – the Dutch infection control expert who runs her own consultancy firm, Knowhow Infection Control – gave a talk on decontaminating care utensils and ensuring patient safety. Explaining the key issues involved, Gertie van Knippenberg-Gordebeke says: “Professor Hugo Sax and Professor Didier Pittet wrote an article years ago in the Journal of Hospital Infection in which they highlighted the limited reach of hand hygiene and isolation procedures when it comes to patient safety. We have to keep striving to optimise both these infection control techniques. It’s equally important to keep optimising hygiene in patient settings. – and that definitely includes the proper handling of care utensils!” In her lecture, Knippenberg warned that more rigorous surface disinfection could actually lead to complacency in regard to contaminated patient environments, because “the problem is that most professional infection control practitioners fail to appreciate the huge role of bedpans in patient settings.”

Knippenberg-Gordebeke regards used bedpans as a huge reservoir of bacteria which contaminate people’s hands and their immediate surroundings. Contaminated surfaces subsequently contaminate other people’s hands, leading to a steady spread of microorganisms.

Gordebeke gave a talk on decontaminating care utensils at the EUNETIPS spring meeting. Photo: Archives

Questions & Answers

Question: Are intestinal bacteria only found in the gut?

Answer: As reported by the American broadcaster Action 7 News, an institute in Albuquerque in the U.S. state of New Mexico recently tested the beard hairs supplied by a number of local men – and the results were decidedly unexpected! The beards contained the kind of bacteria you would normally expect to find on a toilet seat. The tests were carried out on behalf of the Quest Diagnostic Institute by microbiologist John Golobic. “I’m usually not surprised, but I was surprised by this,” the expert was quoted as saying. The bacteria found in the beards “are the types of things you’d find in fecal matter,” said Golobic. Although he emphasised that the bacteria won’t lead to illness, he added that he still found the results “a little concerning”. Yet the connection between beards and bacteria is nothing new, says U.S. magazine The Atlantic, referring to research carried out in 1967. In that test, scientists sprayed bearded and clean-shaven faces with bacteria. They then “collected” the bacteria from their faces and discovered that significantly more bacteria were recovered from bearded men than from clean-shaven men. The experts concluded that beards appear to be an attractive habitat for germs and bacteria.

Another study found that bearded surgeons shed more bacteria beneath their face masks than their clean-shaven colleagues. Bearded men can get some comfort from knowing that the hair on their face isn’t the only place where bacteria thrive. For example, one in six iPhones are apparently populated by intestinal bacteria.

Based on his results, Golobic appealed to beard wearers to maximise hygiene by scrubbing their beards and washing their hands frequently.

Venlo, Netherlands, 28 April 2015

Dear colleagues,

Global estimates suggest that 10 percent of people are carriers of multi-drug-resistant organisms (MDROs) and 10-20 percent of people are carriers of Clostridium difficile, which is often transmitted through liquid faecal matter. Plenty of literature cites toilets and commode chairs as sources of infection, but relatively little has been published on the use of bedpans.

The global survey I conducted in 2010 shows that the risk of healthcare-associated infections stands at between four and 25 percent. Most of the people who participated in the survey do not take this problem into account in infection outbreaks, making the risk even higher.

With the antibiotics used to treat infections becoming less and less effective, the focus is increasingly shifting to prevention and basic measures such as cleaning and disinfection (hand hygiene), as recommended by the APIC.

The HICPAC guidelines on cleaning and disinfection (USA, 2008) continue to follow Spaulding’s 1968 classification of bedpans as a low-risk item. The authors failed to take into consideration the major problems posed by MDROs in bedpans and urine bottles, which represent a significant risk of transmission and contamination due to the spray and aerosol produced by manually emptying, cleaning and disinfecting bedpans and urine bottles in hospitals and other healthcare facilities. The time is ripe to finally make people aware of this issue – not just the medical staff working on the healthcare frontline but, even more importantly, the experts in infection prevention and control.

Most guidelines in many countries fail to even mention this problem and simply offer ineffective recommendations on dealing with faecal matter. Many associations are putting together guidelines on infection prevention based on the US recommendations.

That’s why I would like to emphasize the importance of this key issue to everyone responsible for infection control in the European associations. Every country should be developing guidelines on the optimum management of bedpans which can then be used by multiple organisations all over the world to prevent and control infections that will provide clear benefits to patients and frontline care staff.

I am happy to provide any additional information on request, and I look forward to your response!

Best regards,

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EUNETIPS spring meeting
Outstanding hospital hygiene leads to greater safety and trust

Some websites allow patients to review and rate hospitals, while others let employees rate their employers. Healthcare settings are not normally seen as dream workplaces, largely due to low salaries, shift work, high workloads, and excessive paperwork which reduces the time spent on patients. So the Dietrich-Bonhoeffer Hospital in Neubrandenburg appears to be something of an exception with its excellent ratings on a German employer ranking site and its motto of providing an all-round caring environment. This impression is reinforced when you visit the hospital. Staff members not only acknowledge each other when they’re walking along the brightly lit corridors, they also greet patients and visitors. If you pause with a puzzled expression on your face, someone will ask you if you need any help. This kind of attitude sets a certain mood which has been deliberately cultivated. The fact is that the Dietrich-Bonhoeffer Hospital is a social welfare organisation, and the spirit of welfare work is very much that of serving people.

Every year, more than 40,000 patients are treated on an inpatient basis at the hospital’s extensive facilities in Neubrandenburg, while some 47,000 people use the hospital’s outpatient services. The 29 different departments, each of which is headed by a senior consultant, offer a total of 1,000 beds. Around 10 percent of all hospital cases in the state of Mecklenburg-Vorpommern are treated at the Dietrich-Bonhoeffer Hospital, and its motto is to provide care in a spirit of human warmth and professional competence which gives patients and their family members a feeling of safety and trust.

In an age of constant media reports on killer germs and poor hospital hygiene, providing a sense of safety and trust is one of the key tasks carried out by consulting physician Dr. med. habil. Johannes Hallauer. An infection control specialist and medical director of the Dietrich-Bonhoeffer Hospital, Hallauer takes this responsibility extremely seriously, as do his six-strong team, 26 physicians specialising in infection control, and 31 infection control link nurses. The team even includes a hygiene inspector, says Dr. Hallauer, who adds: “We achieve very high levels of the technology, but also with the after-sales service for the machines.”

Maintaining a clear overview and focusing as much as possible on prevention could be the motto of Dr. Hallauer’s team. Specially designed infection control and disinfection plans ensure ongoing monitoring of the hygiene status quo, especially in high-risk areas such as intensive care and oncology wards. The hospital also runs various modules of the German hospital infection surveillance system KISS and carefully monitors MRSA patients. This latter point won’t be obligatory until 2016. In answer to the question of whether the hospital trains up these highly sought-after specialists itself, Johannes Hallauer smiles and looks at Lorenz Abram: “He’s a good example of that!”

As a medical professional, Hallauer knows that training to be a hygiene specialist is an intellectually demanding task, and he defines the 41-hour basic training required to become an infection control link nurse as a good tool for improving patient safety: “Last year we had participants from four German states doing the course here.”

The importance of hospital hygiene was clear to Hallauer from the moment he began studying medicine: “I remember carrying out a literature search for my doctoral advisor back in 1977 for the first book published by Thieme on hospital hygiene,” he says. His decision to specialise in this area came naturally, and he has already examined the tasks involved from a number of different sides, having worked at the World Health Organisation (WHO) and both the national and state health ministries before finally coming to Neubrandenburg in 2011.

“Your need to carefully examine all your processes,” insists Hallauer, discussing how hospital hygiene works in day-to-day operations. In terms of equipping the utility rooms with MEIKO cleaning and disinfection machines, that works as follows: “We’ve created a kind of log book for each machine and we focus on making sure that the technology provides the level of performance we need, namely an ‘A0 value’ (a measure of microbial inactivation) of at least 600. That takes the official inspections down from every two years to every three. Hallauer explains. Although he emphasised the cost-saving nature of this approach to the accounting department, that is far from being the only goal at the Dietrich-Bonhoeffer Hospital in Neubrandenburg. "Hygiene is a lesson in health and how to maintain it," Hallauer says with conviction, adding "and that’s where we can really benefit our patients!"
COMMENT

Why dirty utility rooms should be a thing of the past

The question of how to deal with human waste has almost as many possible answers as the number of different cultures that inhabit this planet. This was highlighted in 2012 by an online study carried out by the International Federation of Infection Control, the IFIC. The responses were analysed by Professor Dr. Walter Popp from Essen University Hospital. His results showed that when people are in need of care and confined to bed, the excretion process – normally a profoundly intimate activity – changes into a process which, of necessity, involves a whole series of people. In hospitals where conditions are particularly precarious it is often family members or friends who are left to help bedridden patients relieve themselves. Yet few issues are as ignored and ‘hushed up’ as this one! And that’s one reason why we’ll be providing more information on the results of this study in a future edition of Hygiene for the World.

Reports from the frontline – such as the one provided by Daniela Bischler in this issue – are particularly important in this context. As a medical device consultant, she has spent years documenting the conditions in what are typically referred to in Brazil as ‘dirty utility rooms’. Unfortunately the ‘dirty’ element often seems to be the primary focus, because in many cases no effort whatsoever has been made to separate the facility into clean and dirty zones.

Experts in Latin America are just as aware as we are that used care utensils are typically contaminated with hazardous strains of intestinal bacterial. Nevertheless, Brazilian hospitals continue to give care utensils a quick manual clean before sending them off to the central sterilisation unit where they are manually cleaned once again before being sterilised. Anyone who has ever worked with a bedpan washer-disinfector will know how much effort that involves and how many redundancies it brings into the cleaning process – not to mention the unnecessary risks the hospital personnel are exposed to!

As a company working in this industry, we’re therefore delighted to see that things are slowly, but steadily, changing for the better. We can provide evidence that mechanical cleaning is the best choice for care utensils. Our collaboration with partners worldwide has been extraordinarily fruitful and exciting – and the best thing is knowing that it all ultimately helps improve the safety of both staff and patients!

Danielda Bischler discusses her experiences in Latin America

Manual cleaning plus sterilisation results in unnecessarily slow processes

Daniela Bischler has spent the last four years in Latin America representing the German manufacturer of cleaning and disinfection technology. A qualified medical device consultant, she specialises in hospital hygiene and infection control, focusing in particular on the latest scientific advice on how to best dispose of human waste. MEIKO is regarded as a technology leader in the industry and is renowned for its professional service and close ties to customers. We spoke to Daniela Bischler about methods of decontaminating care utensils, norms and guidelines, and the varying standards that apply in different parts of the world.

Question: We already know that some hospitals in Brazil fail to follow proper procedures in central sterilisation units when it comes to cleaning care utensils such as bedpans, urine bottles and suction bottles. Is that something specific to Brazil? How is that task tackled in other countries?

Daniela Bischler: During my years in Latin America I’ve realised that Brazil’s method of decontaminating care utensils in central sterilisation units is actually something of an exception in Latin America. Normally, care utensils are emptied and cleaned manually in patients’ bathrooms or in a utility room, and proper disinfection is rare. In Brazil bedpans are given a quick clean on the ward and are then gathered up and sent to the central sterilisation unit where they are manually cleaned and sterilised. Manual cleaning of care utensils is still the norm in 90 percent of cases in Latin America. The main difference in Brazil is that you have the additional sterilisation stage. That’s extremely time-consuming and the results are often poor because there’s no way of guaranteeing optimum cleaning results in the first step, and that affects the entire process chain all the way through to sterilisation, as well as exposing staff to an unnecessary risk of infection. Unlike in Germany, for example, there are no guidelines in Brazil specifying level. The RKI guidelines stipulate mechanical cleaning followed by thermal disinfection.

Question: You’ve obviously looked into this issue in a fair amount of detail! Daniela Bischler: Absolutely. I’ve been focusing in particular on key issues such as efficiency and cost-effectiveness.

Question: In many countries, automatic cleaning and disinfection machines must conform to DIN EN ISO 15883. What are the key points stipulated in that standard? And do MEIKO products meet the requirements?

Daniela Bischler: EN ISO 15883 is a standard for cleaning and disinfection appliances, and Part 3 states the requirements for washer-disinfectors that use thermal disinfection for human waste containers. The standard says that cleaning and disinfection appliances should meet the following minimum specifications:

- Automatic emptying of care utensils – both bedpans and urine bottles – behind a closed door.
- Automatic program control.
- Two independent temperature sensors to monitor and control disinfection.
- Thermal disinfection is preferred; chemical disinfection is to be avoided.

Question: What are the different stages in the cleaning cycle?

Daniela Bischler: The technology we’ve developed automates the entire process. When you put the care utensil in the specially designed holder and close the wash chamber door, the
Legionella

An infection with Legionella bacteria can lead to Legionnaires’ disease, a form of pneumonitis which is caused by inhaling aerosolised water and which can sometimes be fatal. In some cases it presents as Pontiac fever, a less common respiratory disease which generally includes pneumonia. In some cases Legionella bacteria can also cause endocarditis, wound infections, and pneumatolysis.

Legionnaires’ disease has an incubation period of between two and 10 days. Symptoms are generally non-specific, though infections generally start with a high fever, chills, muscle ache, and a dry chesty cough. Later symptoms may include coughing up blood, difficulty breathing, headache, nausea, vomiting, and a range of neurological symptoms. The mortality rate is around 15 percent in previously healthy individuals.

People with Pontiac fever experience mild, flu-like symptoms without pneumonia. No fatalities have been recorded from Pontiac fever. Legionnaires’ disease is a notifiable disease which must be treated with antibiotics.

Thermal disinfection – a first-line method of tackling Legionella

They thrive in both fresh and salt water and appreciate regular top-ups to their watery surroundings. Comfortable at temperatures of between 25 and 50°C, they are happy just settling in and biding their time. Yet however similar they sound to holiday-makers on the beach, Legionella bacteria have nothing remotely appealing about them! The truth is that this is one of the bacterial strains that causes the most fear and panic everywhere from rental properties and hotels to care homes and hospitals. Legionella is recognised as a potential human pathogen which causes a form of atypical pneumonia commonly referred to as Legionnaires’ disease.

Scientists have so far identified 48 different Legionella species and 70 serogroups. The species which poses the most problems for human beings is Legionella pneumophila. Legionella bacteria thrive in environments such as boilers, water tanks, and other hot water production and distribution systems. They also dwell in dead-end pipes, cold water pipes which remain unused for long periods of time, and water pipes exposed to external heat sources. Air washers, air-conditioning systems, cooling towers and biofilms also provide comfortable breeding grounds.

Legionnaires’ disease is not caused by drinking contaminated water, however, but by inhaling aerosolised water containing the bacteria. This can happen relatively easily in showers, air-conditioned rooms, and hot tubs, as well as in proximity to lawn sprinklers.

Legionnaires’ disease is a relative- ly recent phenomenon. It was first reported in July 1976 at a convention of the American Legion at the Bellevue-Stratford Hotel in Philadelphia. The outbreak led to a total of 180 cases among the 4,400 delegates, 29 of whom died. It took some time for the local health department to realise that they were facing an epidemic. The convention started on July 22, but it wasn’t until August 2 that the outbreak came to the attention of the health authorities. It would eventually take more than six months to isolate the bacteria from the lung tissue of one of the veterans who had died.

The world’s largest outbreak of Legionnaires’ disease took place in the Murcia metropolitan area in Spain in 2001. It involved both a cooling tower at one of the city’s hospitals as well as an air-conditioning system in a local department store. Six people died. In 2005, 127 residents of the Seven Oaks Home for the Aged in Toronto became ill with Legionnaires’ disease, 21 of whom died. And in 2013 there were 39 cases and six deaths at the Wesley Ridge Retirement Community in Reynoldsburg, Ohio, USA caused by contamination of the drinking water and a cooling tower.

There are various ways of preventing outbreaks of Legionella pneumonia. For example, ultrafiltration at temperatures in excess of 70°C can be used to inactivate legionella bacteria in a relatively short period of time. Continuous disinfection can also be achieved by adding chemicals to the water.

The German Society of Hospital Hygiene (DGKH) estimates that up to 30,000 people a year suffer from lung disease caused by Legionella bacteria in Germany alone, resulting in some 3,000 fatalities each year. The DGKH compares this figure to the number of people killed in traffic accidents in Germany in 2011, a total of 2,991.

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People with Pontiac fever experience mild, flu-like symptoms without pneumonia. No fatalities have been recorded from Pontiac fever. Legionnaires’ disease is a notifiable disease which must be treated with antibiotics.

We're trying hard to promote its benefits. It's basically a way of measuring how microorganisms are inactivated by moist heat disinfection methods. Scientists agreed on this value as a means of specifying the required quantity of moist heat offered in a thermal disinfection process. Put simply, the A0 value is the temperature applied to the surface of the instruments or care utensils integrated over time. Users of moist heat disinfection methods can assume that a stated temperature will inactivate a calculable number of microorganisms of a certain level of resistance over a certain period of time. This temperature is monitored and guaranteed by two independently controlled temperature sensors. Should one of the sensors fail or return an inconsistent reading, the user is notified and/or the process is brought to a halt.

Question: Are there any other accessories that can be fitted to the machine?

Daniela Bischler: Absolutely. MEIKO knows how important it is to take into account the entire care utensil cleaning process and examine each customer's needs individually when it develops its products. That's why we offer tailored, turnkey solutions for utility rooms. Right from the planning phase, we believe in making a clear distinction between clean and dirty zones. This is something which is often neglected in Latin America, where the term 'dirty utility room' often seems to have too much of a focus on the 'dirty' element! That brings us back to the topic of preventing infections, because you can't achieve that goal unless you have a well-planned and well-organised utility room which offers plenty of storage space and work surfaces in both the clean and dirty zones. It may sound obvious, but in practice it often doesn't happen. You also need proper hand hygiene facilities for care staff after they've been in contact with contaminated care utensils. That means providing hard wash basins and disinfectant dispensers. There's simply no point in carrying out automated decontamination of care utensils if the overall environment remains contaminated - and that's why our infection-control solutions cover the entire process from start to finish.

Experts also suggest that only two to four percent of Legionella cases are actually reported, even though it is a notifiable disease, which means that between 96 and 98 percent of cases in Germany are never even registered.
A hospital as a work of art

Anyone walking into the SRH Wald-Klinikum Gera could be forgiven for thinking they are in a new exhibition hall rather than a hospital. The corridors are full of natural light, there is no trace of any ‘typical’ hospital smells, and – as well as artworks on the walls – this hospital also features a spacious lobby with a huge screen showing its own television channel. The new building was officially opened in 2013.

"The hospital departments used to be spread across the whole city, but now everything that belongs together is right here," says Katrin Wiesner. Even two years after its inauguration, Wiesner, the hospital’s press officer, is clearly still proud to show people around this superbly equipped hospital, which is also the first one in Germany to present itself as a ‘hospital of art and culture’.

The hospital’s patients – all accommodated in comfortable two-bed rooms with a private patient level of quality – can appreciate art throughout the entire hospital, a key design principle which also helps guide people from one place to another. The various floors of the ward blocks are named after 11 famous figures who had close links to the Thuringia region, including Friedrich Schiller, Carl Zeiss and Walter Gropius.

With 1,000 beds, this is one of the few not-for-profit hospitals in Germany. The parent holding company SRH in Heidelberg is owned by a foundation. It acts as an umbrella organisation for subsidiaries specialising in the fields of healthcare, education and social care, including 10 acute care hospitals and three rehabilitation centres.

"The fact that this is all run by a foundation is something we notice on a day-to-day basis," says infection control practitioner Yvonne Wildensee. A qualified nurse, she has been a dedicated member of the hospital workforce for the last 25 years. "My training coincided with the fall of the Berlin Wall, and I experienced the merging of the Gera Municipal Hospital, built in 1912, with the Wismut Miners’ Hospital," says Wildensee. Before qualifying as an expert in hospital hygiene, she spent several years working as a nurse. She says that the shift from working with seriously ill patients to a job that helps prevent patients from becoming seriously ill in the first place was one of the best decisions she’s made: "It helps that I know the whole organisation inside out and have worked in various departments. And it’s also useful to have several years of professional experience because working in hospital hygiene requires a certain amount of stamina!"

Another key point is that her colleagues have responded so positively to the work she does together with two other infection control specialists. She is supported by between 30 and 35 link nurses and 16 doctors who are responsible for infection control, as well as by the German Hygiene Advice Centre (BZH) in Freiburg. "We can see that people are committed to getting things right because we constantly get calls from colleagues in just about every department asking how they should best solve this or that problem," says Wildensee.

The problem of cleaning and decontaminating care utensils at the Wald-Klinikum Gera has been neatly solved by cleaning and disinfection machines from the company MEIKO, as Wildensee explains: "We’re delighted that we’re able to use the Mercedes of bedpan washers in isolation rooms as well as disinfectant dispensers in the corridors which have helped improve hand hygiene compliance among employees and visitors alike. Staff can also carry small bottles of disinfectant in their jacket pockets, and the hospital favours playful and educational means of highlighting this key issue: "We agreed with the hospital marketing department that the WHO’s Five Moments for Hand Hygiene would appear as a screensaver on all our PCs for one to two days every six to eight weeks." Intelligent and innovative hospital hygiene is clearly an art in itself.
Interview with Siegfried Niklas

"I've seen just about everything"

Siegfried Niklas is a key figure in the field of hospital hygiene in Germany. An independent consultant in hygiene and quality and a specialist in the healthcare sector, Niklas was a member of the Commission for Hospital Hygiene and Infectious Disease Prevention at the Robert Koch Institute and is the co-founder and organiser of German Hygiene Day. He is also a member of the German Society of Hospital Hygiene. Shortly after finishing a帖子 in occupational safety in the service forum of the medical device manufacturer Meiko, Siegfried Niklas spoke to the "Hygiene for the World" editorial team about the potential risks in utility rooms.

Question: Are there around 270 million work-related injuries and illnesses each year worldwide, leading to some 2.2 million fatalities? How important is occupational health and safety in a utility room?

Siegfried Niklas: Obviously it’s a place where you’re constantly dealing with human waste. There’s no risk if you follow the proper procedures, but the challenge is that not everyone follows the protocols all the time. For example, if you work under certain conditions without a white coat, gloves and a mouth mask, you might find yourself dealing with human waste. There’s no risk if you follow the proper protocols.

Siegfried Niklas: Specifically caused by a lack of hygiene or occupational safety?

Siegfried Niklas: It’s sometimes hard to establish direct connections, and luckily they don’t happen all that often. But when I carry out audits I sometimes see instruments that haven’t been cleaned properly. Whenever I inspect utility rooms I check the risks posed by care utensils that haven’t been properly cleaned, I think they’re seriously underestimated.

Question: Why is that?

Siegfried Niklas: Doctors have relatively little contact with human waste. Raising the status of this issue in the infection control arena would require doctors and researchers to engage with the subject more actively.

Question: One of the key hazards in the care environment is surely the act of transporting full, used care utensils from one place to another. What do you think about the idea of specific solutions, in other words having a separate cleaning and disinfection appliance in each patient’s room?

Siegfried Niklas: That would be ideal in the situation! But aside from the financial implications it would have, you would also need to make sure that the water pipes were regularly sluiced out even if a room was left unoccupied for a while. The basic regulations for the construction of care facilities specify that there should be an adequate number of cleaning and disinfection machines for each ward, but they don’t give a precise number...

Question: In your talks you often emphasise that medical devices which haven’t been cleaned properly are one of the causes behind healthcare-associated infections. What’s your opinion on disposa-

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We need a plan at a European level

Nursing care in Europe can and must be made safer! But that requires commitment from everyone in the health-care sector. The European Network To Promote Infection Prevention (EUNETIPS) aims to build more bridges between practitioners and researchers to create a EU-wide improvement in infection prevention and control. This is one of the key prerequisites for guaranteeing successful control of multidrug-resistant bacteria and that doesn’t just mean clinicians and microbiologists. Clearly you need them on board as well as the general practitioners and public health professionals, but there are many other key players involved, too. These include EU citizens themselves, especially in regard to health literacy, because it’s important to remember that we can’t make progress unless people realise that antibiotics are not always the answer. Other key players who are perhaps less well-known include people involved in the veterinary and livestock business, and indeed the food chain itself. That’s where most antibiotics are used at the moment, so clearly intervention is required there, too.

It’s clearly in need of active engagement by European and national legislators as well as public health authorities. If you really want to get somewhere, current figures suggest that we are facing an emergency and that it took us to fully appreciate the risks. Now progress is finally being made, and the key point for me is the recognition that we should adopt extraordinary measures at a European level to tackle this challenge.

Most of Germany’s best hospitals are MEIKO customers

Compiling for patients is nothing new for hospitals. To help patients choose, the news magazine Focus regularly publishes a special ‘Health’ issue which includes a list of key German hospitals, highlighting the best hospitals and university hospitals nationwide.

“This kind of list is extremely useful for people who are about to embark on treatment,” says Frank Hoffmann, examining the latest Focus rankings, the MEIKO sales manager for Germany, Austria and Switzerland noticed that 92 of the 100 hospitals in the list rely on MEIKO technology for their cleaning and disinfection needs. “That’s a figure we’re very proud of!” he says, adding being a partner to the best hospitals out there is a distinction for our company, too.”

Hoffmann argues that people are placing more and more emphasis on good hospital hygiene, but that there is still some way to go. “Even experts are still failing to appreciate the importance of bedpans and urine bottles as medical devices which are highly contaminated after use. That means we still need to put more of a focus on the whole process of cleaning care utensils.”

Question: EUNETIPS was founded in October 2011. How has the network developed since then?

Dr. Silvio Brusaferro: We’re happy that this topic has become a top priority at a European level. The evidence shows that you need constant cooperation among all the stakeholders and that we need to successfully control multidrug-resistant bacteria – and that’s not just a job for clinicians and microbiologists. Clearly you need them on board as well as the general practitioners and public health professionals, but there are many other key players involved, too. These include EU citizens themselves, especially in regard to health literacy, because it’s important to remember that we can’t make progress unless people realise that antibiotics are not always the answer.

Other key players who are perhaps less well-known include people involved in the veterinary and livestock business, and indeed the food chain itself. That’s where most antibiotics are used at the moment, so clearly intervention is required there, too. It’s clearly in need of active engagement by European and national legislators as well as public health authorities. If you really want to get somewhere, current figures suggest that we are facing an emergency and that it took us to fully appreciate the risks.

Now progress is finally being made, and the key point for me is the recognition that we should adopt extraordinary measures at a European level to tackle this challenge.

Dr. Silvio Brusaferro: We’re very much aware that there are major differences in Europe in the way national and regional healthcare systems are organized – and there are even bigger differences in how resources are used. At the same time we have scientific evidence showing effective ways to prevent and control infections, most of which require the entire organisation to be fully engaged to succeed. The situation is clear, but obviously rather inconsistent.

To achieve results, we have to be able to definitely learn from each other’s experiences, but realistically this can only happen in settings where you have similar standards of investment, organization and cultural norms. Having said that, I’m a strong supporter of efforts to make knowledge publicly available and share best practices, and I believe that every organisation should take that as a starting point to find its own particular way of achieving optimum results. I’m not convinced that a simplistic “cut and paste” approach can succeed in all cases. Things have to be adapted, expanded and developed for each local setting, and that needs to be part of the culture of each healthcare organization.

Question: What’s the most important thing you would like to see happen in the future?

Dr. Silvio Brusaferro: I’m convinced that achieving better healthcare in Europe requires commitment from all the stakeholders, starting with all health-care professionals. That’s why the first thing I would like to see in the future is compulsory infection control/hospital hygiene training as part of all courses for healthcare professionals across Europe – at graduate, postgraduate, and professional development levels. Once we reach a stage where all professionals are constantly aware of the risk of infection in their everyday work and see the appropriate behaviours as routine, then we will stand a much better chance of reducing healthcare infections.

Another thing I would like to see is greater harmonisation of patient medical files to eliminate the differences that currently exist between European countries and institutions, so that every EU citizen can enjoy similar standards of safety.

Question: Can examples of best practice always be usefully and constructively transferred to other countries?

Dr. Silvio Brusaferro: The presence of infection control/hospital hygiene (IC/HH) professionals in healthcare organizations is one of the key prerequisites for guaranteeing successful control of effective infection prevention and control. Right now we know this isn’t happening across many parts of Europe, partly because there aren’t enough IC/HH professionals (or none at all in some cases) and partly because training standards vary. In addition, IC/HH professionals are typically asked to perform different tasks depending on where they work. The good news is that we’ve seen some positive changes in recent years.

The first one is the availability of core competencies for infection control professionals in European Union (http://ecdc.europa.eu/en/publications/Publications/infection-control-core-competencies.pdf). This reference document provides a basis for standardising the training of IC/HH professionals across Europe. The second piece of good news emerged from surveys conducted DGVS/MEIKO, which show that almost every European country provided a definition of an IC/HH professional and acknowledged that they are still seeing a prevalence of acute hospitals and, in a growing number of cases, in long-term care facilities, too.

These are really positive steps towards a more homogeneous guarantee of patient safety in Europe. It still isn’t enough of course, and we need to continue our efforts to boost investment in the infection control and hospital hygiene workforce. That includes guaranteeing their presence in all healthcare settings as well as promoting standardized training in line with European standards. EUNETIPS is playing an active role in this process, for example by sharing educational videos which can be downloaded from our website.

Question: What is the future of EUNETIPS, what’s the most important thing you would like to see happen in the future?

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