Multidrug-Resistant Organisms on Patients’ Hands: A Missed Opportunity

Multidrug-resistant organisms (MDROs) are increasingly prevalent in post–acute care (PAC) facilities.1,2 Increased contact between health care workers, the environment, and patients in PAC facilities can increase the risk of MDRO cross-transmission1,4 because PAC patients may need assistance with activities of daily living and are encouraged to be mobile outside of their room for rehabilitation, dining, and other recreational activities. Much more than other anatomic sites, patients’ hands are more likely to come in contact with environmental surfaces, health care workers’ hands, and other patients in PAC facilities. Our objective was to evaluate baseline, new acquisition, and duration of MDRO hand carriage among patients newly admitted to PAC facilities from acute care hospitals.

Methods | This prospective observational cohort study in 6 PAC facilities in metropolitan Detroit and Southeast Michigan was approved by the institutional review board of the University of Michigan. After obtaining written informed consent, the dominant hands of newly admitted PAC patients were sampled. We swabbed the palm, fingers, and around nails of patients’ hands. Samples were collected at baseline (day of enrollment), day 14, and monthly for up to 180 days or until discharge from the facility. Methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant Enterococcus (VRE), and resistant gram-negative bacilli (RGNB) were identified using standard microbiological methods. Gram-negative bacilli resistant to either ceftazidime, ciprofloxacin, or imipenem were defined as RGNB.

Results | Of 826 consecutive eligible PAC patients approached for the study, 357 (43.2%) agreed to participate and were followed for 806 visits (mean, 2.3 visits; range, 1-8 visits). Most participants were female (54.9%), with a mean age of 75.8 years. Nearly one-quarter (86 of 357 (24.1%)) had at least 1 MDRO on their hands on discharge from an acute care hospital and admission to the PAC facility (Table). Baseline hand carriage rates of VRE, MRSA, and RGNB were 13.7%, 10.9%, and 2.8%, respectively. During follow-up (Figure), 34.2% of patients’ hands (122 of 357) were colonized with an MDRO, with 10.1% of patients (36 of 357) newly acquiring 1 or more MDROs. Specifically, 7.1% (22 of 308 at risk), 6.3% (20 of 318)

Table. Baseline Patient Hand Carriage of MDROs in 6 Post–Acute Care Facilities

<table>
<thead>
<tr>
<th>Facility (Patients, No.)</th>
<th>Organisms, No. (%)</th>
<th>MRSA</th>
<th>VRE</th>
<th>RGNB</th>
<th>Any MDRO*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (81)</td>
<td></td>
<td>8 (9.9)</td>
<td>7 (8.6)</td>
<td>2 (2.5)</td>
<td>16 (19.8)</td>
</tr>
<tr>
<td>2 (47)</td>
<td></td>
<td>6 (12.8)</td>
<td>6 (12.8)</td>
<td>1 (2.1)</td>
<td>12 (25.5)</td>
</tr>
<tr>
<td>3 (85)</td>
<td></td>
<td>9 (10.6)</td>
<td>9 (10.6)</td>
<td>2 (2.4)</td>
<td>19 (22.4)</td>
</tr>
<tr>
<td>4 (81)</td>
<td></td>
<td>8 (9.9)</td>
<td>16 (19.8)</td>
<td>2 (2.5)</td>
<td>21 (25.9)</td>
</tr>
<tr>
<td>5 (26)</td>
<td></td>
<td>3 (11.5)</td>
<td>5 (19.2)</td>
<td>3 (11.5)</td>
<td>8 (30.8)</td>
</tr>
<tr>
<td>6 (37)</td>
<td></td>
<td>5 (13.5)</td>
<td>6 (16.2)</td>
<td>0</td>
<td>10 (27.0)</td>
</tr>
<tr>
<td>Total (357)</td>
<td></td>
<td>39 (10.9)</td>
<td>49 (13.7)</td>
<td>10 (2.8)</td>
<td>86 (24.1)</td>
</tr>
</tbody>
</table>

Abbreviations: MDRO, multidrug resistant organism; MRSA, methicillin-resistant Staphylococcus aureus; RGNB, resistant-gram negative bacilli; VRE, vancomycin-resistant Enterococcus.  
* At least 1 MDRO.
at risk), and 3.1% (11 of 347 at risk) of patients newly acquired VRE, MRSA, and RGNB colonization, respectively. MRSA and VRE colonization were more likely to be persistent, with 37.3% (22 of 59) and 22.5% (16 of 71) of patients colonized at multiple visits, whereas RGNB colonization on the same patient’s hand was never obtained at follow-up. Overall, 67.2% of MDRO-colonized patients (82 of 122) remained colonized at discharge.

Discussion | Our study shows that patients commonly bring MDROs on their hands on discharge from an acute care hospital and acquire more during their stay at the PAC facility. This, combined with frequent antibiotic use in PAC patients, increases the probability that MDROs introduced to a PAC facility will be transmitted to other frail patients and to healthcare workers—and, most important, that the MDRO will persist in the facility. Current quality measures that address infection prevention fail to adequately address patient hand hygiene. Despite concerns raised by some recent studies,5-7 patient hand-washing is not a routine practice in hospitals to date. Owing to PAC patients’ increased mobility and interaction with the environment, health care workers, and other patients, we believe that it is even more important to implement routines that enforce washing of patients’ hands than in the acute care setting.1

We did not conduct molecular typing for MDROs, and our analysis was limited to patients who were newly admitted to PAC facilities. Therefore, our estimates do not reflect the patients who were already residing in the facility, some of them long-term, and may underestimate the magnitude of hand colonization and its impact on transmission.

Our study provides critical and emerging evidence that patient hand hygiene is a greatly underappreciated strategy for MDRO reduction efforts in PAC facilities as well as acute care hospitals. Further interventions and development of performance measures to address this issue are overdue.

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Obtained funding: Mody.

Administrative, technical, or material support: Lansing, Mody.

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Conflict of Interest Disclosures: None reported.

Funding/Support: This research was supported by National Institute on Aging grant R01AG032298 (Dr Mody), grant R01AG041780 (Drs Min, Foxman, and Mody), and grant K24AG050685 (Dr Mody).

Role of the Funder/Sponsor: The funding sources had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Previous Presentation: Preliminary data from this article were presented at the Annual Scientific Meeting of the American Geriatrics Society; May 15, 2015; National Harbor, Maryland.

Additional Contributions: We thank all the post-acute care facilities, health care workers, and patients for their participation.


Published Articles Reporting Studies by Industry Employees on Interventional Cardiology Devices: Scope and Association With Study Outcomes

Employees of industry coauthor clinical studies published in academic, peer-reviewed medical journals.1 Although the practice remains controversial because of perceived conflicts of interest (COI),2 the association between industry-employee authors (IEAs) and trial outcomes remains poorly characterized. Clinical trials in interventional cardiology have substantial industry involvement and afford opportunities to explore the impact of IEAs. We reviewed studies of devices used in interventional cardiology to examine authorship by industry employees and its association with published study outcomes.

Methods | We searched PubMed for all prospective studies of cardiovascular devices published between January 1, 2010, and December 31, 2012, in 9 journals that publish a large number of trials in interventional cardiology. Studies were included if they evaluated the clinical performance, efficacy, or safety of specific devices used in interventional cardiology in adult humans. Primary and major secondary reports and substudies of randomized clinical trials (RCTs), first-in-human studies, early feasibility studies, and registries, including prospective cohort