Public and Written Comment -- PACCARB Meeting, May 16, 2018

My home state is still having difficulty controlling even common resistant bacteria such as MRSA. Two of our major hospitals have the 6th and 7th highest number of MRSA bloodstream HAI cases in the Nation. Many of the institutions feel hand hygiene is the key to control and are focusing their efforts on this intervention. However, I must stress again that despite being essential to an infection control bundle, In the context of MDROs hand hygiene should be viewed as a back-up measure, since these dangerous pathogens should not be on healthcare workers hands in the first place.

The formulation of optimal interventions has been clouded by both research and editorial integrity problems. For example, before this committee, testimony was given that:

1) unit wide daily chlorhexidine bathing combined with intranasal mupirocin resulted in "major reduction of bloodsteam infections of all causes". But in the referenced study's composite "any pathogen" category the main reduction was seen in commensal bacteria and yeast.

2) In another presentation, it was asserted that this intervention could reduce "uropathogens", but in the study, a significant effect was not observed in high level candiduria in women, and was not effective in high level bacteriuria in either sex.

Student nurses in my state have questioned why hospitals are approaching the MRSA epidemic differently. The excuse I hear is that one size does not fit all, but no one has explained to me why there are different sizes or how these are determined.

I would like to strongly recommend this committee refocus their efforts, focusing on containment and control at the facility level and emphasize surveillance and isolation/decolonization protocols, similar to those adopted by UK's National Health Service and the VA Healthcare Systems.

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