Letters to the Editor

Postexposure Varicella Management: Further Comments

To the Editor:

The authors of "Postexposure Varicella Management of Nonimmune Personnel: An Alternative Approach" (1994;15:329-334) would like to respond to Dr. Edward O'Rourke's editorial "New Isolation Strategies: Is There a Need?" (1994;15:300-302). We appreciate Dr. O'Rourke's concern with the approach we describe and would like to respond to several of his specific comments.

He asks (re: our approach), "Is it the only alternative?" and mentions risk of oncology, a neonatal ICU, or a transplant service as "really is not acceptable when incurred only to minimize the disruption of staff schedules caused by an exposure." We state in the last sentence of the article, 'We suggest this approach be considered in appropriate settings." We do not claim that it is the only approach.

Dr. O'Rourke asks, "Is it really safe to assume that employees will wear masks constantly ... or will they change masks every 30 to 60 minutes or when the masks become moist?" Masking protocol for nonimmune employees is a hospital policy, just as is the wearing of masks for respiratory isolation or strict isolation, and yes, we do expect that employees follow hospital policy. The nonimmune exposed employee signs an agreement to do just that and is monitored by the supervisor. Employees who do not wish to comply are required to stay off work, this has seldom occurred.

Dr. O'Rourke asks, 'Will the message to employees be we no longer take varicella exposures as seriously?" This could not be further from the truth. We are very serious about varicella, and employees are made aware of this as soon as they are hired, during their pre-employment physical and educational programs. We have had only a few hospital exposures that occurred because an employee failed to report a home exposure; we challenge whether other institutions who furlough employees can say the same. Cooperation with our program is more likely because employees know they will not need to use their sick or vacation time for their furlough.

Dr. O'Rourke's suggestion of allowing exposed staff to work in nonclinical areas with other immune employees is impractical and ignores the financial issues in healthcare today. We don't know too many hospitals where a nurse or physician could be assigned to "chart review" for 12 days. In addition, an area with immune employees may be one in which the nonimmune employee is not trained to work.

We need to emphasize major points in this discussion. First, we had 45 employees wear masks and only four developed varicella; this was a common finding in the survey comments as well-not all "exposures" result in disease in employees. Second, the employee does not work with varicella. With education regarding prodromal symptoms and screening for symptoms, it is likely that if disease occurs, the employee will refrain from work. Finally, the concept of masking for long periods in healthcare settings is not unique to our approach, nor is it expected to fail. Surgical personnel mask in the operating room, and tuberculosis patients are masked in emergency rooms and clinic waiting rooms. In both cases, the masking period can extend to many hours.

In short, we feel this is a workable, practical, and safe solution that has been demonstrated in our institution. We encourage the readers to evaluate this approach or other alternatives to meet the challenge of providing quality healthcare in this era of rising costs and shrinking budgets.

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The author replies.

I would like to reply to the thoughtful letter from Donna Haiduven, David Stevens, and Carmen Hench. The disruption of both hospital routine and the employee's life following exposure of nonimmune employees to varicella is a difficult and unfortunately common experience. The point of my editorial is that we need to keep patient safety first, even as we explore less disruptive mechanisms to manage the exposed employee problem.

Given the clarification in their letter, we apparently do not disagree regarding the approach to varicella exposure when high-risk patients are involved. They appear to agree with me that such policies as advocated in their article should not be applied in high-risk settings, although no such statement was made in their article. Perhaps my disagreement then is with the rather vague last sentence of their article, which mentions using the strategy in "appropriate settings" but does not indicate clearly what those settings are. However, even with this caveat, I remain pessimistic about their alternative approach because high-risk patients often are found outside the nursery, oncology, or transplant wards.

Regarding the wearing of masks by exposed employees for up to 8 hours a day, I am impressed that the authors have such confidence that there will be excellent compliance just

because it is hospital policy. Do their employees wash their hands as often as the infection control department asks them to? We also expect our employees and medical staff to comply with hospital policy but take into account the likelihood that there will be less-than-perfect compliance. I do not consider asking an employee to wear a mask for an entire shift to be the same as asking the employee to don a mask intermittently when entering the room of a patient on respiratory precautions. Even in the operating room environment, it is rare for an individual to wear a mask continuously for an entire shift. Indeed, in the discussion section of the article, the authors report that one of their varicella-exposed employees did not wear the mask as long as directed and developed varicella while unmasked, exposing other employees and patients. I contend that their own experience with "mistakes" is quite likely to be repeated.

Haiduven and her colleagues point out that only 4 of 45, or about 10% of their employees who reported exposures, developed symptomatic varicella infection. This parallels our experience; we also have a conservative definition of employee exposure. Yet of the four patients at their hospital who did develop varicella, one managed to expose others because of poor compliance with the masking strategy. Although this may be an acceptable failure rate in some settings, for many hospitals and clinics, the costs associated with even occasional failures may exceed the benefits.

Haiduven et al present an interesting challenge to traditional management of varicella exposures among healthcare workers. I would caution that, in the search for cost savings or convenience, we must not embrace options that should work in theory without carefully considering how they might fail in practice.

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Joint Commission Approves Format of Quality Performance Reports for Healthcare Organizations

by Gina Pugliese, RN, MS
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Joint Commission on Accreditation of Health Care Organizations (JCAHO) recently approved the format and content for organization-specific performance reports on healthcare quality. JCAI-IO, the largest healthcare accrediting body in the United States, began releasing these reports in mid-November as part of its expanded public disclosure policy. Reports will be available for approximately 1,500 hospitals, home care, mental healthcare, long-term care and ambulatory care organizations surveyed after January 1, 1994. A full catalog of performance reports on the nearly 11,000 organizations accredited by JCAHO will not be completed until the end of 1996, which will mark the end of the first 3-year accreditation cycle under the revised public disclosure policy.

Each performance report will include 1) a brief overview of the content of the report; 2) the accreditation decision and date; 3) the organization's overall evaluation score in comparison to like organizations surveyed; 4) the organization's numerical scores in a series of specific identified performance areas in comparison to like organizations surveyed; and 5) identified performance areas for which recommendations for improvement were made.

JCAHO's recent action was the result of more than a year of extensive field research to ascertain the interests and needs of consumers, practitioners, healthcare organizations, professional associations, and purchasers regarding performance information about surveyed organizations.

The American Hospital Association has actively supported the public release of hospital-specific quality data, provided that the information released is useful to the public and fair to hospitals. Healthcare facilities would be notified of the public request for the report. Those requesting the facility performance report would also receive a descriptive document explaining the information in the report and its appropriate use and limitations. Reports from facilities that are contesting their survey report will not be released until the review is complete. The cost of the report will be $30. Reports will be available through the Customer Service Center (telephone [708] 916-5800).