

tained within a cloth hamper because of the possibility of bursting on impact.)

3. Contaminated laundry may be sent to the laundry via the laundry chute as long as it is confined and contained in the water soluble bag plus the cloth hamper that has been properly labeled.

If the above procedure is used, there is no immediate need for cleaning the laundry chutes because they will not have been soiled. As for how often to clean, most regulatory agencies recommend cleaning on a regular basis, thus leaving the interpretation to the individual health care agency. The emphasis should be placed on the confinement and containment, then there is no major problem. Remember—when the principles of confinement and containment have been adhered to, the problem ceases to be. Some people recommend that a person, properly attired with gown, gloves, and mask be lowered into the chute to scrub the interior, while others recommend that the cleaning be done only at the entrances and exits to these chutes. Pouring a disinfectant down through the chute is not effective because of the absence of mechanical action to remove the bacteria. Whatever the choice, the procedure becomes complicated, so it is extremely important to avoid contamination by confinement and containment.

Trash chutes:

The principles of cleaning the trash chutes are very similar to the laundry chutes; containment and confinement to prevent contamination.

1. All needles and syringes and soiled

dressings should be considered contaminated and bagged separately for appropriate ultimate disposal.

2. Obvious patient excretions or secretions should not be discarded via the trash chute due to possible spillage.
3. The cleaning of trash chutes should be similar to that of laundry chutes. However, the cleaning of trash chutes is sometimes more difficult. Many hospitals have decided to discontinue the use of trash chutes because of the difficulty of cleaning.

If any of our readers have developed any innovative methods of cleaning these ill-conceived chutes, please share your ideas with us. Infection control practitioners must stay on this type of situation and become involved in planning so that hospital structures will be built that will decrease the risk of contamination, not contribute to it.

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Dose of Contamination Questioned

To the editor:

The article "Bacteriologic studies on electrical hospital thermometers" in the July/August 1981 issue of *Infection Control* brings to mind several questions. The authors did not quantify the dose of contamination. It has been a well established principle in infectious disease literature that the dose of the infectious agent is paramount in order to assess the relative risk of infection. Maki et al have

illustrated this concept of dose relationship in determining the risk of sepsis due to I.V. catheters.

In the specific body cavity addressed by the authors, the oral cavity, the dose/relationship may be particularly important since the mouth has been shown to be quite resistant to colonization when doses far in excess of what would be expected to be found in probe covers were used in a study by Laforce et al and did not lead to colonization.

The mouth is a highly contaminated non-sterile body cavity. As infection control practitioners, we should be very realistic in infection control recommendations and evaluations in order to maintain our credibility—especially now when our medical colleagues and hospital administrators are closely scrutinizing our recommendations and demanding more scientific studies of efficacy for these recommendations. Food, especially uncooked fruit and vegetables (NEJM, Feb. 1981, Please don't eat the salads.), contains millions of bacteria. If probe covers need to be sterilized, what about eating utensils, medicine cups, toothbrushes, toothpaste, etc.?

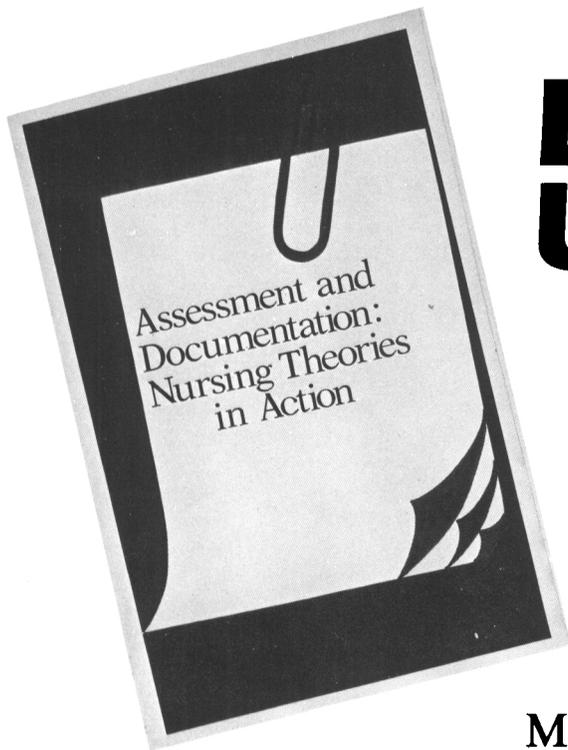
Findings such as this electronic thermometer study may serve to divert efforts and time of infection control practitioners to areas in which the potential risk has not been adequately defined.

Sincerely,
Monique M. Crowley, R.N.
Infection Control Nurse
Robert J. Shannon, M.S.P.H., R.S.
Hospital Epidemiologist
Veterans Administration Medical Center
Boston, Massachusetts

ERRATUM

"Effective and Creative Surveillance and Reporting of Surgical Wound Infections" by Allen B. Kaiser, M.D. was inadvertently omitted from the cover and table of contents of the January/February 1982 issue of *INFECTION CONTROL* (Volume 3/Number 1). The article appeared on pages 41-43.

NURSING THEORY: Expect the Unexpected



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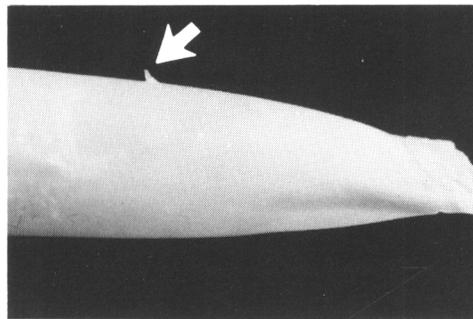
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Problem

Culture specimen collection tubes which utilize a glass ampule for storing transport medium increase the risk of infection via pathogenic microorganisms on the part of physicians, nurses, and medical technologists alike. The manual crushing of the glass ampule, which can require up to 15 lbs. of actuation force, may result in glass fragments puncturing the plastic tube material, lacerating or piercing the finger of the user, and thus permitting immediate or subsequent infection in the handling process.

Recent clinical documentation on the subject has pointed out the potential hazards such tubes present, by providing a portal of entry for such virulent microorganisms as hepatitis A and B, and non-A, non-B hepatitis viruses.¹



Unretouched photograph of glass ampule after crushing.

The fact that most culture tubes are narrow in diameter also increases the risk of contact between the swab and the top of the tube as the swab is returned for immersion into the medium. Again, improper or inadvertent handling of the tube may result in contact with specific pathogens.

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¹ Wasielewski, Joseph, Girard, Susan, and Lim, Audrey. "Injury Resulting from Crushed Glass Ampoules." *Laboratory Medicine*, Vol. 11, No. 9, September 1981. Reprints available on request.



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