

**INFECTION
CONTROL**
**Nosocomial Infection Control
and the Smaller Hospital—
What Do We Know, What Do We Do?**

In a 1976 *Journal of the American Medical Association*, Dr. Michael Britt and his colleagues reviewed data from one-day prevalence surveys of nosocomial infections in 18 small (each less than 75 beds) hospitals in small communities dispersed throughout the five state intermountain area around Utah.¹ The paper suggested that the prevalence of nosocomial infections, community acquired infections, and antibiotic use was similar to published reports from larger community-teaching hospitals. This was especially true when the data from all the hospitals were pooled into one data set. The paper concluded that full time infection control nurses and full time specialists in infectious diseases were economically unrealistic resources for each of these widely scattered hospitals to acquire individually. Modification of existing surveillance methods to better suit smaller hospitals, and development of regional cooperative efforts in infection control were recommended for future consideration.

Since the Britt paper, very little has been published specifically focusing on nosocomial infection control issues and answers for the smaller hospitals. The time has come to develop better information rather than to assume that what is appropriate for a 400-bed community teaching hospital is also applicable to a 40-bed rural hospital. The most recent data available from the American Hospital Association lists 5,830 short term general community hospitals in the United States. Of these, 2,750 (47%) have 99 beds or less. This 47% group of smaller hospitals accounts for only 10% of the surgical operations, 12% of the births and 12% of the patient days of the 5,830 community hospitals.² It is probable that patient populations are different in terms of ratios of categories of underlying illness, and therefore susceptibility to infection, in comparing the small and the large hospital. This was clearly shown to be an important factor when reviewing the literature on the incidence of community acquired and nosocomial septicemia among university hospitals, government hospitals and community teaching hospitals.³

This type of information suggests strongly that careful analyses of nosocomial infection control issues among groups of small hospitals would be a fruitful area of review and study. The much discussed SENIC (Study of the Efficacy of Nosocomial Infection Control Practices) and NNIS (National Nosocomial Infection Study) data of the Centers for Disease Control⁴ have virtually excluded the smaller hospitals because of the practical considera-

tion of sampling errors and statistical problems with these institutions.

The following questions need to be answered:

1. Given the statistical realities of small hospitals, what types of surveillance methods—periodic prevalence surveys, general surveillance, focused surveillance, etc.—are the most reliable? Are any of them necessary?
2. Which of the many infection control practices recommended by the CDC, the Joint Commission on Accreditation of Hospitals, and others are applicable to all hospitals despite their size; and which, if any, are not applicable to small hospitals?
3. What resource sharing of existing expertise, from larger hospitals, health departments, groups such as the Association of Practitioners of Infection Control and the Society of Hospital Epidemiologists of America, and others can be developed for smaller hospitals in cost effective and realistic ways?
4. Should smaller hospitals be required to have the same type of multidisciplinary infection control committees required of larger hospitals or can the responsibilities of the committee be delegated to a smaller group such as one nurse and one staff physician?

Small hospitals are generally located in rural areas and small communities. Groups such as the Rural Wisconsin Hospital Cooperative, an association of 10 rural hospitals in South Central and South Western Wisconsin, are developing programs to answer these questions in the next few years. Other regional groups, and state programs such as the one in Virginia, have the capacity for answering these questions and others. The ultimate goal is the same: let us provide the safest, most medically and cost effective care for all patients in all hospitals—no matter what the size, no matter what the location.

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