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Letters to the Editor

Entering infection prevention with a master of public health

To the Editor:

Vassallo and Boston[1] have eloquently provided evidence for hiring public health-trained infection preventionists. A concern has always existed about infection preventionists not being "clinical." However, as infection preventionists step from behind the data and become embedded in clinical quality improvement teams, these clinical gaps are filling quickly as they learn from physicians, pharmacists, and nurses. Only 8 of the 37 infection prevention competencies are not addressed by a traditional program. Some master of public health (MPH) candidates interested in infection prevention enroll in MPH programs, focusing on infection control. These programs use the certification in infection prevention and control competency matrix to complement the traditional MPH to cover the competencies that are not addressed by a typical MPH. These MPH candidates are undoubtedly qualified, but they can still have difficulty in gaining employment owing to the pervasive opinion that nonclinical candidates do not make good infection preventionists. As we look to the future, this article will remind us all to consider these MPH candidates because their skill set far outweighs any perceived gaps.

Reference

1. Vassallo A, Boston K. The master of public health graduate as infection preventionist: navigating the changing landscape of infection prevention. Am J Infect Control 2019;47:201-7.

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Environmental conditions and health care–associated infections in wards for noncritical patients

To the Editor:

Recent reports on the seasonality of health care–associated infections (HCAIs) and pathogens have posed new challenges for infection control practitioners.[1] Indeed, "summer peaks" and association with warm periods were detected,[2,3] and a recent study found that the likelihood of acquiring bloodstream infections caused by gram-negative bacilli increased with proximity to the equator.[4] It is worth noting that most studies were conducted in areas with a temperate climate,[1] and they generally used weather parameters measured outside the hospital.[1,3]

To investigate the impact of environmental parameters inside hospital units on the occurrence of HCAIs, we conducted a prospective ecological study. The study setting was the University Hospital of the Botucatu Medical School, a 450-bed facility with 5 intensive care units and 18 wards for noncritically ill patients. We were especially interested in HCAI occurrence in the wards that are not air-conditioned.

Briefly, we studied 3 admission units for adult patients: medical 1 (32 beds), medical 2 (16 beds), and dermatology (16 beds). Serial point prevalence surveys (1 every 2 weeks) were performed to identify HCAIs in the period from July 2017 through June 2018. Temperature and humidity inside one of the patient rooms (randomly chosen) in each unit were measured in the same week the prevalence survey was performed. Poisson regression models, adjusted for the admission unit, were used to identify the association of environmental parameters with the overall prevalence of HCAIs or specific infection sites.

The total number of observations (ie, patients observed during surveys) was 3,201. The aggregate value of HCAI prevalence for all surveys was 4.1%. Detailed results are presented in Table 1. There was no association of temperature and humidity with overall HCAIs. However, temperature was positively associated with surgical site infections (SSIs) and inversely associated with urinary tract infections (UTIs).

Our findings are noteworthy. Even though SSIs are generally acquired inside the operating theater, hypotheses for their summer