AMERICAN JOURNAL OF INFECTION CONTROL
The Official Publication of the Association for Professionals in Infection Control and Epidemiology, Inc.

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DESCRIPTION

AJIC covers key topics and issues in infection control and epidemiology. Infection control professionals, including physicians, nurses, and epidemiologists, rely on AJIC for peer-reviewed articles covering clinical topics as well as original research. As the official publication of the Association for Professionals in Infection Control and Epidemiology (APIC), AJIC is the foremost resource on infection control, epidemiology, infectious diseases, quality management, occupational health, and disease prevention. AJIC also publishes infection control guidelines from APIC and the CDC. AJIC is included in Index Medicus and CINAHL.

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Reviewer #1:
Strengths: new material, large sample size of observations, next step in attacking the problem of non-adherence to stethoscope hygiene, specific barriers and their relative perceived importance given. Honest conclusion (no impact on adherence), realistic setting and participants.

Thank you!

Weaknesses: no comparison among methods used for convenience, preference by percentage, or other factors. Few comments on any teaching done, but maybe this was because they were isolating the effect of the visuals on behavior.

We agree. While we did survey the providers as to which method they found more effective in terms of bioluminescence vs seeing cultures, in hind sight we could have been more rigorous about trying to compare the two methods. Despite using both bioluminescence and showing providers images of their cultures, we did not see objective impact on adherence therefore I suspect if we had done either in isolation, we would not have seen an objective impact on adherence. We agree that while our prior QI project had focused on education and failed to change behavior, this project focused on whether the visual impact of seeing what?s growing on one?s own stethoscope and seeing the large drop in bioluminescence scores could change behavior. If successful, our hope was actually to create a visual tool which could be disseminated to other VA hospitals.

Reviewer #2:
This was a nice follow up to the initial study. The data and stats support your conclusions. Thank you.

There are still important questions either to answer in this or future articles. It appears that visual proof for the participants was not enough to increase adherence to stethoscope hygiene, as they had stated. Did you collect data regarding WHICH method of cleaning was preferred, and if this choice impacted compliance for both hand and stethoscope hygiene? It would seem that conducting BOTH hand and stethoscope hygiene with ABHR would have advantages over barriers stated in the conclusion, namely: forgetfulness, time constraints, and limited access to supplies. It would be interesting to see why participants preferred a given method.

Unfortunately, we did not collect data regarding which cleaning method was preferred. We did give providers a choice of what disinfection method to use before reculturing their stethoscope or doing the post-disinfection bioluminescence swabs. Anecdotally some providers said ?well I usually use
method therefore let's do the ___ method? but we did not formally track this and we did not link any survey responses or objective measurements to disinfection method. However, we agree this would be an interesting thing to explore in the future. We agree that the perceived barriers of forgetfulness, time constraints and limited access to supplies should be much less of a factor if at all with ABHR which is why we wanted to visually demonstrate that it works as well as the other methods, and that ?all 3 methods work-take your pick- just do something!?

It would also be interesting to see if those who used a stethoscope on a patient cleaned their scopes, and what percentage this represents. Could the group be polled after a patient encounter and "observation" of hygiene to see how many used their stethoscopes and then recalculate compliance?

This is one of our limitations. We are unable to retrospectively ascertain who did or did not use their stethoscopes during an encounter as our observations were anonymous and did not record providers' names. Our methodology relied on secret observers outside the room so that providers were unaware that they were being observed. Anecdotally we have noticed that how team rounds are done is very attending dependent, where sometimes only one or two providers on a team entering the room used their stethoscope but it is very variable depending on the attending. For our work, we mentioned it as a limitation but I think it would require an imbedded observer in the room itself in future work.

This comment is off the record, but it seems there may be more cultural influences at work than suspected. Is it possible to give the attendings and other leaders the task of DEMONSTRATING the technique and monitor them confidentially on rounds and let them know their compliance? They may believe this is the "flavor of the month" and give lip service. It is also a new concept compared to hand hygiene. I think too if one sees the combination of hand and stethoscope hygiene with ABHR, their may clear advantages (no need to find wipes, throw them away, then find ABHR for hands... etc).

I fully agree. We intentionally did not track compliance by attending or level or training so that we wouldn't have identifiers however anecdotally if I consistently demonstrate the technique when I am on the rounds, I do think that the team does a better job with it. I agree that this could be a strategy to pursue in the future. Thank you for the suggestion.

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