

## Letters to the Editor

### Additional Pointers for Preparing for a JCAHO Inspection

#### To the Editor:

Inasmuch as our 228-bed community hospital was surveyed by JCAHO in April 1995 without recommendations for infection control, I would like to share that Dr. Nettleman's article gives an excellent overview of the survey process and offers some practical preparation strategies.

Having just "been there and done that," I would like to offer three additional pointers.

First, the Document Review Session that occurs on the first morning of the survey is a great opportunity for infection control to shine. To showcase our program, we created a binder that included (1) a narrative of the JCAHO Ishikawa Chart for Surveillance, Prevention, and Control of Infection that explained how each aspect of the chart was accomplished at our hospital; (2) infection control program goals and evaluations of goals since last survey; (3) key infection control policies and procedures that were annotated with JCAHO standards, eg, IC.1, IC.1.1, LD.2.1, etc; (4) results of direct observational studies of hospital staff compliance with handwashing and body substance isolation and outbreak investigations; (5) an educational activities summary including examples of our internal infection control newspaper and copies of overheads used for staff education regarding our blood-borne pathogens and tuberculosis exposure control plans; (6) examples of intradisciplinary communication; (7) committee minutes since our last survey; and (8) quality improvement activities.

Second, we recommend that you create and distribute a "JCAHO Preparation Sheet" throughout the organiza-

tion (distribution means everything from paycheck inserts to posting in employee rest rooms). Include key employee responsibilities for infection control, such as the system of isolation, exposure control plan purposes and locations, barrier usage, management of waste, etc. Ideally, this should be done 4 to 6 weeks prior to the survey.

Third, conduct your own mock survey. We used name tags that said "JCAHO" and randomly asked staff questions that they could be asked by an actual surveyor. We emphasized that this mock process was educational and that wrong answers just showed where the opportunities for improvement lay. Initially, staff were hesitant to give an answer lest they be wrong; however, that soon changed to eagerness to show knowledge and competence. For maximum effectiveness, begin mock surveys 2 to 4 weeks prior to the survey and continue up to the first survey day.

I hope that these tidbits might be helpful to colleagues who have JCAHO surveys on the horizon.

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#### The author replies

We appreciate Ms. Parini's comments. Her letter underscores the need for preparation and planning prior to a visit from the Joint Commission on Accreditation of Healthcare Organizations. The specific preparatory actions taken by an infection control program will be a function of each hospital's structure and the existing infection control process. Ms. Parini gives some excellent suggestions. It is important to "showcase" success stories and to make certain that the surveyor is aware of significant infection control projects.

Mock surveys can increase the confidence of the staff who are questioned during the actual visit.

Although intensive preparation in the few weeks just prior to the regulatory visit often is emphasized, it is important to note that most of the processes required by the Joint Commission are integral to an effective infection control program and should be in place already. The less "cramming" that is required, the better. Policies and procedures should be communicated effectively to healthcare personnel. This is true for all infection control programs, regardless of whether or not they expect a visit from a regulatory agency.

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### Brita Water Filters Contaminated

#### To the Editor:

Brita Baby Water Filters (Brita Wasser-Filter-Systeme GmbH, Taunusstein, Germany) were marketed in Germany in 1993. It was discovered that some of these filters were contaminated heavily with molds, fungi, and various gram-negative bacteria, including *Enterobacter cloacae*, *Pseudomonas*, and *Aeromonas* species. Brita Baby Water Filters were withdrawn from the German market in 1994, but other styles of Brita filters remained on the market.

We then purchased and tested nine new Brita water filters of a style still marketed worldwide, including the United States and Canada. Five of the filters we tested were contaminated, one with 2,000 molds per filter.

We also used four of these Brita water filters, according to the manu-

facturer's instructions, to filter fresh tap water daily, and checked each day's filtered water for bacterial growth. After 8 days of use, we found that freshly filtered water from two of these filters contained more than 10,000 bacteria per mL (perhaps due to production of biofilm in the filter?), whereas the fresh tap water used for filtration contained less than 100 organ-

isms per mL. *Aeromonas hydrophila* was isolated from the filtered water.

Mothers of newborn babies and other susceptible persons, especially immunocompromised patients, should be warned against using filtered water unless subsequently boiled.

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## Correction

### Clarification of Hepatitis B Vaccine Dose for Infants

by **Gina Pugliese, RN, MS**  
**Medical News Editor**

The medical news bulletin "Clarification of Hepatitis B Vaccine Dose for Infants" and its accompanying Table (1995;16:364) contained an error. The dose read incorrectly as printed. The dose should be measured in micrograms ( $\mu\text{g}$ ), not milligrams (mg). We regret any inconvenience to our readers. The corrected text and table follow

CDC's recently published Recommended Childhood Immunization Schedule-United States, January 1995, stated that infants born to hepatitis B surface antigen (HBsAg)-positive

mothers should receive immunoprophylaxis with 0.5 mL of hepatitis B immune globulin and 0.5 mL of hepatitis B vaccine administered at separate sites. (See *MMWR* 1994;43[51]:959-960.) Hepatitis B vaccines licensed in the US are produced by Merck and Co, Inc. (Rathway, NJ), and SmithKline Beecham (Philadelphia, PA) and are available in various concentrations. The recommended dose of hepatitis B vaccine for infants varies by manufacturer and HBsAg status of mother (Table 1). Merck and Co, Inc, recommends 2.5  $\mu\text{g}$  of Recombivax HB R for infants of HBsAg-negative mothers and 5.0  $\mu\text{g}$  for infants of

HBsAg-positive mothers. SmithKline Beecham recommends 10  $\mu\text{g}$  of Engerix-B R regardless of the mother's HBsAg status. Providers should know the HBsAg status of an infant's mother and should consult the product package insert for the recommended vaccine dose.

Providers also should be aware that the Food and Drug Administration recently lowered the age-appropriate dose of Engerix-B R from 20  $\mu\text{g}$  to 10  $\mu\text{g}$  for adolescents from 11 to 19 years of age.

FROM: CDC. Clarification Vol 43, No 51 & 52. *MMWR* March 10, 1995;44(9):174-175.

**TABLE**

**RECOMMENDED DOSES OF CURRENTLY LICENSED HEPATITIS B VACCINES, BY AGE OR RISK GROUP**

Group	Recombivax HB	Engerix-B
Infants of HBsAg-negative mothers	2.5 $\mu\text{g}$	10.0 $\mu\text{g}$
Infants of HBsAg-positive mothers	5.0 $\mu\text{g}$	10.0 $\mu\text{g}$
Children		
Age 1 to 10 years	2.5 $\mu\text{g}$	10.0 $\mu\text{g}$
Adolescents		
Aged 11 to 19 years	5.0 $\mu\text{g}$	10.0 $\mu\text{g}$
Adults		
Age $\geq$ 20 years	10.0 $\mu\text{g}$	20.0 $\mu\text{g}$
Dialysis patients and other immunocompromised persons	40.0 $\mu\text{g}$	40.0 $\mu\text{g}$