from stool cultures. Endoscopes were cultured to rule out cross contamination (all cultures were negative). A silver-alloy/hydrogel–coated Foley catheter was evaluated in an effort to reduce UTIs. The final measures instituted were active culture screening, annual education on VRE policies/procedures, and provision of waterless hand foam at each door in patient-care areas.

RESULTS: Use of silver-alloy–coated Foley catheters resulted in a 52% decrease in catheter-associated UTIs and a drop on the VRE rate to 0.0–0.87/1,000 patient days. Multivariate regression analysis revealed 84% of the variance in VRE transmission rates can be explained by the introduction of silver-coated urinary catheters, waterless hand foam, and active patient screening. VRE rates have remained constant at 0.0/1,000 patient days with only one exception since August 2000.

CONCLUSION: While compliance with established procedures is important, we found that a more aggressive, multipronged approach to control and prevent VRE was the only way to significantly reduce our infection rate.

Prevention of Community-Associated Methicillin-Resistant Staphylococcus aureus Infection among Asian/Pacific Islanders: A Qualitative Assessment

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BACKGROUND: Community-associated methicillin-resistant Staphylococcus aureus (CA-MRSA) has been increasingly reported over the past decade, especially in Asian/Pacific Islanders (A/PIs). Most studies to date have been descriptive and have not identified behavioral risk factors for disease prevention.

METHODS: To identify barriers and to better understand how best to reach these individuals with prevention messages, ten ethnographic interviews were conducted in September 2003 in Oahu and Kauai, Hawaii, with A/PIs identified as having CA-MRSA infections. A standardized script was used which included questions on the transmission, treatment, and prevention of CA-MRSA. Data were coded using qualitative methods; non-response to individual questions was not included in the analysis.

RESULTS: Respondents were predominantly male (80%), with an age range of 20 to >60 years. Most (70%) thought skin infections were not a new problem in Hawaii; however, 75% (6/8) did feel it was a common problem. Many (70%) were familiar with the term “staph,” but only one recognized the term “MRSA.” Responses varied as to how people (in general) get skin infections versus how they personally acquired the infection and most often included open sores/cuts (30% and 50%, respectively), poor hygiene (30% and 10%), and the ocean (30% and 30%). Perceptions regarding how people (in general) and how respondents personally can prevent infection also focused on hygiene (60% and 30%, respectively) and avoiding bodies of water such as the ocean (30% and 30%). Most (89%, 8/9) attempted to self-treat the infection prior to seeking medical care, using a range of home remedies (63%, 5/8) to store-bought solutions (38%, 3/8). Time to medical treatment ranged from 1 day to several months, with none reporting barriers to treatment. When asked about the best method to receive medical
CONCLUSIONS: Potential sources of infection and personal measures for control, including self-treatment, were identified in these ethnographic interviews—information infrequently found in medical records or written surveys. Qualitative assessment allows for the identification of these unique factors and may provide valuable insight into the epidemiology of CA-MRSA.

**Antibiotic Usage Measured by Absence of Microbial Growth on Gram Stain and/or Culture**

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**BACKGROUND:** The nasopharynx is colonized with a variety of mixed normal flora. The lower respiratory tract is normally sterile. Expectorated sputum samples collected, transported, and stored per lab standards, yielding >25 polymorphonuclear leukocytes (PMNs) and <10 epithelial cells per 100X field should result in a positive gram stain and/or culture result of either normal nasopharyngeal flora or bacterial growth. We report a trend in a 170-bed facility over a 60-day timeframe in sputum samples having few to no organisms seen on the smear and few colonies to no growth in cultures.

**METHODS:** All sputum specimens were evaluated for adequacy by a CAP grading system. Group 4 with >25 WBC and 10–25 epi; Group 5 with >25 WBC and <10 epi; and Group 6 with <10 WBC and <10 epi were suggestive of lower respiratory microbial flora, considered “adequate,” and included in this review. A culture was considered “good” if it was collected appropriately, transported to the lab within 30 minutes, and plated out or preserved by refrigeration. A culture was considered “poor” if any of the above conditions were not met. Microbiology staffing during this timeframe was stable, with no change in management, supplies, technique, or procedure. Consideration was given to bacterial pathogens such as Mycoplasma and Chlamydia which are not readily detected, viral infection which might decrease bacterial burden, and use of rifampin which may obviate culture results. All antibiotics used prior to lab submission of the sputum specimen were accounted for by # days of use.

**RESULTS:** Of the 23 specimens evaluated as “adequate,” 8 had a positive gram stain and/or culture result and were considered “good” cultures. The remaining 15 specimens had few to no organisms seen on the gram stain and few to no colonies grow on culture and were considered “poor” cultures. A total of 40 antibiotic days were calculated for the “good” specimens (mean = 5 days) and 202 days (mean = 13.6 days) for the “poor” specimens. Three patients with “good” specimens were antibiotic-free. All others received 1-10 antibiotics.

**CONCLUSIONS:** There were more antibiotic days with the “poor” specimens. The sample size was too small for statistical significance. CDC has focused on the alteration in antimicrobial sensitivity and resistance patterns in hospital settings as a guide for judging antibiotic use (Emerging Pathogens Initiative). Consultation with Microbiology for “adequacy” of submitted specimens might also offer epidemiological staff insight to antibiotic usage.

**Antimicrobial Persistence and Residual Effect in Healthcare Personnel Handwashes**

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