Hospital hygiene in an age of Diagnostic Related Groups (DRG), Protection against Infection Act (IfSG), Book V of the German Code of Social Law (SGB V) and administrative reforms – facts and visions from Bavaria

Krankenhaushygiene in Zeiten von DRG, IfSG, SGB V und Verwaltungsreform – Fakten und Visionen aus Bayern

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Abstract

Since 1 January 2001, German hospitals and establishments engaged in outpatient surgery are obliged to continually record and evaluate nosocomial infections and the emergence of nosocomial pathogens showing special resistance and multi-resistance profiles. A survey conducted among 164 hospitals revealed that 79 % of establishments already carried out separate surveillance and evaluation of postoperative wound infections, while 77 % also recorded nosocomial infections and 91 % recorded pathogens with special resistance and multi-resistance profiles. However, only the larger hospitals had their own in-house infection control physician, while the smaller establishments generally consulted external infection control physicians. When asked how long such experts made their services available to the hospitals, no clear answer was given. Furthermore, only two-thirds of hospitals had their own infection control nurses (most of whom worked part time). These findings have induced the State Office for Health and Food Safety (LGL) in Bavaria to expand its advisory and information services and to formulate standards in consultation with partners at state level.

The public health offices are legally obliged to supervise infection control policies in hospitals and medical establishments. These supervisory activities have not always been conducted in a uniform manner, thus engendering anxiety among the institutions to be supervised when it comes to discharging their prescribed duties. A concept devised to improve and standardize the monitoring of hospital hygiene is to be used to standardize supervision of infection control practices (by the statutory authorities). With the incorporation of the, hitherto, State Office for Occupational Safety, Occupational Medicine and Safety Engineering into the LGL, the specialist centers for public health and the Trade Supervisory Office will be united under one umbrella. The idea is to avail of the resulting improved cooperation possibilities, so as to avoid duplication of effort as regards the overlapping areas of medical and trade supervision and limit contradictory commentaries and avoid a situation whereby several public health officials have to pay visits to the various establishments. This will also reinforce partnerships between medical establishments and the public health authorities at local level. Some thirty years ago, while the present author could possibly dream of such an outcome when he took his first steps into the, at times arduous, terrain of hospital hygiene, he probably would not have dared to express it.

Zusammenfassung

Seit dem 1. Januar 2001 müssen Krankenhäuser und Einrichtungen zum ambulanten Operieren nosokomiale Infektionen und das Auftreten von Krankheitserregern mit speziellen Resistenzen und Multiresistenzen

fortlaufend aufzeichnen und bewerten. Im Rahmen einer Befragung von 164 Krankenhäusern stellte sich heraus, dass bereits 79% der Häuser postoperative Wundoperationen gesondert erfassen, 77% auch nosokomiale Infektionen. 91% erfassen Erreger mit speziellen Resistenzen und Multiresistenzen. Dafür verfügen nur die größeren Häuser über einen eigenen Hygieniker, während die kleineren vorzugsweise mit externen zusammenarbeiten. Die Frage nach der Zeit, in der diese Externen den Krankenhäusern zur Verfügung stehen, konnte nicht eindeutig geklärt werden. Nur Zweidrittel der Häuser verfügen zudem über Hygienefachkräfte (hauptsächlich teilzeitbeschäftigt). Die Ergebnisse bestärkten das Landesgesundheitsamt in Bayern, sein Beratungs- und Informationsangebot zu verstärken und gemeinsam mit den Partnern auf Landesebene Standards zu entwickeln.

Die Gesundheitsämter sind gesetzlich verpflichtet zur infektionshygienischen Überwachung der Krankenhäuser und medizinischen Einrichtungen. Diese Überwachung wurde nicht immer einheitlich durchgeführt, was bei den zu Überwachenden Unsicherheit hinsichtlich der zu erfüllenden Vorgaben schafft. Ein Konzept zur Verbesserung und Standardisierung der krankenhaushygienischen Überwachung soll dazu dienen, eine Vereinheitlichung der infektionshygienischen Überwachung zu erzielen. Mit der Integration des bisherigen Landesamtes für Arbeitsschutz, Arbeitsmedizin und Sicherheitstechnik in das Landesgesundheitsamt werden die fachlichen Leitstellen und die Gewerbeaufsicht zudem unter einem Dach vereint. Es gilt, die sich hieraus ergebenden verbesserten Kooperationsmöglichkeiten zu nutzen, um auf den sich überlappenden Feldern der Medizinal- und der Gewerbeaufsicht unnötige Doppelarbeit, sich widersprechende Stellungnahmen und Multipräsenz von Behördenmitarbeitern vor Ort einzugrenzen. Dies wird auch das partnerschaftliche Miteinander von medizinischen Einrichtungen und öffentlicher Verwaltung auf lokaler Ebene stärken. Eine derartige Vision vor etwa 30 Jahren zu entwickeln, hätte sich der Autor bei seinen damaligen ersten Schritten auf dem bisweilen glatten Parkett der Krankenhaushygiene vielleicht zu träumen, aber wahrscheinlich nicht zu formulieren gewagt.

Text

Since 1 January 2001, German hospitals and establishments engaged in outpatient surgery are obliged to continually record and evaluate nosocomial infections and the emergence of nosocomial pathogens showing special resistance and multi-resistance profiles. (Section 23(1) of the Protection against Infection Act IfSG). Bearing in mind the recommendations of the Robert Koch Institute (RKI) and of the Commission for Hospital Hygiene and Infection Prevention [KRINKO] at the Robert Koch Institute for implementation of Section 23 IfSG, the Bavarian public health offices carried out a survey in 2003, using a questionnaire drafted by the State Office for Health and Food Safety (LGL), in a total of 164 hospitals (care levels II, III, IV and F as per the Bavarian Hospital Schedule and some university hospitals) on the implementation of Section 23 IfSG. The questions posed comprised, inter alia, the availability of staff with expertise in infection control (infection control nurse (*Hygienefachkraft*), infection control specialist (*Hygienebeauftragter*), infection control physician (*Hygieniker*)), surveillance of postoperative infections as well as of infections in intensive care units (staff member, method of surveillance, criteria used, comparison with reference data) as well as recording of nosocomial pathogens showing special resistance and multi-resistance profiles.

A cursory glance at the data collected revealed rather satisfactory findings. Virtually all the hospitals surveyed disposed of the services of infection control nurses and infection control specialists. 79% of all establishments carried out separate surveillance and evaluation, as per their own criteria, of postoperative wound infections, while around the same number of institutions (77%) stated that they recorded and evaluated nosocomial infections separately for the intensive care unit. 91% of all hospitals recorded pathogens with special resistance and multi-resistance profiles separately.

However, a closer look at this situation quickly reveals that there is need for improvement in certain respects. While almost 90% of the larger hospitals had their own in-house infection control physicians, this was the case in only around 30% to 50% of hospitals of other categories. But many establishments stated that they consulted external infection control physicians. When asked how long such experts were in service, no answer was given in up to 60% (!) of cases, and this time was less than one hour per week in a quarter of the hospitals and ranged

between 1-2 hours in around 15% of hospitals; only in isolated cases did this period of service amount to more than 2 hours per week.

As regards infection control nurses, it emerged that in total two-thirds of hospitals had their own staff, with again two-thirds working part time. On asking the remaining one third about the periods of service of the external infection control nurses, no answer was given by one fifth, this time was less than 5 hours per week in around half of establishments and only in 10% of cases did this amount to more than 10 hours per week.

Only in 60% of hospitals was information provided on the service times of infection control specialists. The response rate showed little variation among hospitals offering different levels of care. Only in isolated cases did this time amount to more than 5 hours per week outside the levels IV/uni, with the most common pattern being less than 3 hours. When asked about the specialist qualifications (1-week course as per RKI curriculum) the smaller establishments performed somewhat better, where two-thirds of physicians had taken such a course.

The findings relating to the process quality of infectiology surveillance were not surprising in view of the staff shortages outlined. The data provided in this respect by the LGL staff in recent weeks at the 54th Public Health Service (ÖGD) Congress in Bamberg and at the 6th Ulm Symposium clearly revealed that many hospitals were making a real effort to implement the statutory regulations. But here too relatively simple subsequent enquiries showed that there was need for improvement in the methodical approaches taken. For example not even in 40% of establishments was risk stratification conducted; likewise, only half of the hospitals compared their own data for pneumonia, septicemia and urinary tract infection with official reference data.

These findings, of which only a few aspect are addressed here, induced the LGL, in its capacity as the principle specialist center for the public health service in Bavaria, to expand its advisory and information services with respect to the provisions enshrined in IfSG. For somewhat the past year it has fortunately been possible to avail of the competence of a working group comprising renowned Bavarian infection control physicians from large hospitals and the public health service establishments.

An outline paper “Hospital hygiene and infection prevention” is being currently drafted as a first step towards formulating consensus-based orientational guides for medical establishments and public health offices in Bavaria. On that basis it is then hoped to devise standards and standard parameters in cooperation with partners at national level (politicians, paying authorities, medical insurance funds, associations, statutory authorities).

Independently of the responsibility borne, for their part, by the hospitals and medical institutions pursuant to Book V of the German Code of Social Law (SGB V), the public health offices are legally obliged as per Section 36 IfSG to engage in supervision of infection control policies. The experiences gleaned over the past few years show that this supervisory activity is not being accomplished in a uniform manner. This engenders anxiety among the institutions to be supervised when it comes to discharging their prescribed duties. The health supervisory body thus makes itself vulnerable to criticism and, besides it fails to optimize patient care by checking for compliance with the specified standard (consensus recommendation of the Commission for Hospital Hygiene and Infection Prevention [KRINKO] at the Robert Koch Institute.

This lack of uniformity in supervisory activities can be explained by, apart from different interpretations of existing scientific studies and the setting of different priorities, different levels of staffing in the public health offices and by inadequate specialist knowledge. A concept devised in the meantime by the LGL aimed at improvement and standardization of the monitoring of hospital hygiene is intended as a means of providing training to colleagues in the health offices in matters relating to hospital hygiene to attain uniform supervision of infection control, promote dialog between the establishments to be supervised and the supervisory authorities, thus overall optimizing patient care. Our own experiences from Baden-Württemberg of the implementation of such approaches give us reason to hope that in 2 to 3 years time important progress will have been made in the formulation of standards throughout the entire country.

The measures currently underway for incorporating the State Office for Occupational Safety, Occupational Medicine and Safety Engineering into the LGI will help to increase the efficiency of public health management. As such, the principle specialist centers for public health and the Trade Supervisory Office will be united under one umbrella. The idea is to be able to avail of the resulting improved cooperation possibilities, so as to avoid duplication of effort as regards the overlapping areas of medical and trade supervision and limit contradictory commentaries and avoid a situation whereby several public health officials have to pay visits to the various establishments. This will also reinforce partnerships between medical establishments and the public health authorities at local level. Some thirty years ago, while the present author could possibly dream of such an outcome when he took his first steps into the, at times arduous, terrain of hospital hygiene, he probably would not have dared to express it.

Curriculum Vitae

Univ.- Prof. Dr. med. habil. Volker Hingst

Figure 1

Figure 1: Volker Hingst

Doctor of Microbiology and Infection Epidemiology, Doctor of Hygiene, President of Bavarian Board for Healthcare and Food Safety.

Volker Hingst studied medicine in Kiel and Graz (Austria), successfully passed his state examination in 1973 and finished a further education as assistant doctor at different hospitals of the University of Kiel. He completed his basic military service (as a Kiel-born citizen almost inevitable) as Surgeon Major of the German Navy.

He starts his career in 1977 at the Institute for Hygiene and Microbiology of the University in Kiel. 1981 he moves on to the Hygiene Institute of Heidelberg University. In 1985 he habilitates on the subject of Hygiene and Medical Microbiology and one year later receives the *venia legendi*.

In 1992 he becomes president of the Federal Healthcare Board in Baden-Württemberg and is also appointed supernumary professor at the University of Heidelberg. Professor Hingst coming from the „north of the north“ of Germany arrives at „deep south“ namely in Munich and becomes president of the Bavarian Board for Healthcare and Food Safety in 2002. Many important awards bestowed upon him along his way through Germany are giving proof of the recognition of Professor Hingst.

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