Research Article

Bacteriological Monitoring of Inanimate Surfaces and Equipment in Some Referral Hospitals in Assiut City, Egypt

Entsar H. Ahmed,1,2 Hebat-Allah M. Hassan,1 Nahla M. El-Sherbiny,1 and Asmaa M. A. Soliman2

1Medical Microbiology and Immunology Department, Assiut University, Asyut, Egypt
2Public Health and Community Medicine Department, Faculty of Medicine, Assiut University, Asyut, Egypt

Correspondence should be addressed to Entsar H. Ahmed; entsar.2012@yahoo.com

Received 27 April 2019; Revised 27 July 2019; Accepted 1 August 2019; Published 3 September 2019

1.Introduction

Hospital or hospital-acquired infections represent a serious public health problem in all countries [1]. The burden of HAI is already substantial in developed countries, where it affects from 5% to 15% of hospitalized patients in regular wards and as many as 50% or more of patients in intensive care units (ICUs) [2, 3].

It is clear that monitoring of the hospital environment is an essential element in the control of nosocomial infections. As possible causes of infection, contamination of surfaces may be mentioned, even if cross contamination by hands is probably the greatest risk. In fact, hospital surfaces colonized by different types of microorganisms constitute special ecological niches that require cumbersome, complex, and costly procedures that are necessary for better safety of the patient [4].

There is a high prevalence of contamination of equipment and high-touch surfaces surrounding the patient [5]. The ability of microorganisms to survive on surfaces is due to their production of adhesion molecules and biofilms [6]. Direct contact primarily with environmental surfaces or equipment transmits the majority of nosocomial infection. Major nosocomial pathogens have been identified. They can circulate between the patients and might persist in the environment for a long time [8].

As established by microbiological studies, certain hospital pathogens can survive on dry hospital surfaces for extended periods [9]. Both Gram-negative and Gram-positive bacteria can survive up to months on dry inanimate
surfaces with longer persistence under lower temperature and humid condition [10]. Surfaces of commonly used medical equipment and high-contrast communal surfaces (e.g., medical chart and telephones) could be contaminated by multidrug-resistant bacteria (MDR) [11]. In the issue of intensive care unit (ICU) where critically ill patients have several risk factors for nosocomial infection, the issue of environmental contamination poses an even greater challenge [12].

Monitoring of the hospital environment is lacking in hospitals in Assiut city, so the main objectives of this study were to determine the percentage of bacterial contamination of environmental samples and to identify potential nosocomial pathogens isolated from environments of seven referral hospitals in Assiut city as identification of bacterial contamination of environmental samples is a guide for appropriate preventive measures of infection.

2. Materials and Methods

This descriptive cross-sectional study was conducted in seven referral hospitals in Assiut city, Egypt, from 2009 to 2015. All hospitals belong to Assiut University Hospitals, except health insurance hospitals, as they are present in Assiut city, they are the most important hospitals in Assiut and for the whole upper Egypt, easy access, large drainage area for Assiut Governorate as well as for nearby Governorates and preferred to other hospitals due to highly qualified medical staff, good equipment, and facilities allowing good percentage of referral from near as well as distant areas. The selection of sampling sites was made in consultation with the heads of departments and targeted to the most representative and most critical location in each hospital. Random, undirected sampling was collected. Sterile swabs were moistened in sterile normal saline and rolled over the targeted inanimate surfaces/equipment separately (e.g., beds, ventilators, monitors, bedside tables, operation tables, anaesthesia equipment, trolley, dressings, bench, and surgical blades) [13]. Samples were transported to the Infection Control Laboratory of Assiut University Hospital. The swabs were cultured on blood agar plates at 35°C for 48 hours and subcultured on MacConkey agar for the selection of Gram-negative bacteria [8].

Colonies were primarily identified by colony morphology, microscopy of Gram stain, and standard biochemical tests. [14] Only pathogenic microbes are examined.

2.1. Statistical Analysis. Data entry and analysis were performed using Statistical Package for Social Science version 14 (SPSS). p value was considered statistically significant when p < 0.05.

3. Results

A total of 12863 swab samples (covering different surface points/equipment) were collected in seven referral hospitals in Assiut city, Egypt, from 2009 to 2015. Most of the samples were collected in the years 2010 and 2011 and the least percentage (1.9%) in the year 2015 (Table 1 and Figure 1).

More than half of the samples (57.5%) were collected from Main Assiut University Hospital and the least percentage (0.2%) from Urology University Hospital (Table 2). Contamination was positive in 25.6% of samples (Figure 2). According to the pattern of contamination, 7% of samples were polymicrobial (Figure 3). About 32% and 26% of isolated organisms were CNS and MRSA, respectively, followed by K. pneumoniae (20.7%) then Gram-positive bacillus sp. (C. difficile) (10.6%) (Table 3). In the year 2011, 31.0% of the samples were contaminated followed by the years 2015 and 2014 (26.9% and 26.7%), respectively, and the least contamination was in the year 2012 (9.0%) with statistically significant difference (p < 0.001) (Table 4).

At Main Assiut University Hospital, 30.5% of the samples were contaminated followed by Al-Ragehy

| Year | Number (n = 12863) | %   |
|------|--------------------|-----|
| 2009 | 624                | 4.9 |
| 2010 | 3668               | 28.5|
| 2011 | 3732               | 29.0|
| 2012 | 922                | 7.2 |
| 2013 | 3152               | 24.5|
| 2014 | 520                | 4.0 |
| 2015 | 245                | 1.9 |

Table 1: Distribution of the studied samples (2009–2015) in Assiut city.

| Hospital                                      | Number (n = 12863) | %   |
|----------------------------------------------|--------------------|-----|
| Health Insurance Hospital                    | 1064               | 8.3 |
| Main Assiut University (MAU) Hospital         | 7397               | 57.5|
| Neuropsychiatric University Hospital          | 217                | 1.7 |
| Pediatric University Hospital                 | 2284               | 17.8|
| Al-Ragehy University Hospital for liver       | 252                | 2.0 |
| Urology University Hospital                  | 27                 | 0.2 |
| Women Healthcare University Hospital          | 1622               | 12.6|

Table 2: Distribution of the studied samples according to different hospitals (2009–2015) in Assiut city.
University Hospital for liver and Neuropsychiatric University Hospital (26.6% and 25.3%), respectively, and the least contamination was at Pediatric University Hospital (15.5%) with statistically significant difference ($p < 0.001$) (Table 5).

For most of the years (2009–2012, 2014), the most common organism isolated was CNS (33.9%, 37.8%, 30.6%, 34.9%, and 24.5%), respectively (Figure 4). In Health Insurance Hospital, Pediatric University Hospital, Women Healthcare University Hospital, and Main Assiut University Hospital, the most common organism isolated was CNS (41.1%, 32.7%, 32.6%, 31.5%, and 24.5%), respectively (Table 6). The majority of organisms from all hospitals were monomicrobial (Table 7).
| Contamination | Health Insurance Hospital | Main Assiut University Hospital | Neuropsychiatric University Hospital | Pediatric University Hospital | Al-Ragehy University Hospital | Urology University Hospital | Women Healthcare University Hospital |
|--------------|---------------------------|--------------------------------|-------------------------------------|-----------------------------|----------------------------|---------------------------|--------------------------------|
| No.          | %                         | No.                             | %                                   | No.                         | %                          | No.                       | %                                   |
| Contaminated | 219                       | 2259                            | 55                                 | 355                         | 67                         | 5                         | 328 20.2                           |
| Clean        | 845                       | 5138                            | 162                                | 1929                        | 185                        | 22                        | 1294 79.8                           |
| p value      | <0.001*                   |                                 |                                     |                             |                             |                           |                                     |
4. Discussion

In this study, we investigated a total of 12,863 samples with 25.6% positivity of bacterial contamination. This was more or less similar to a study by Rozonska et al., as overall, 69.6% of samples exhibited growth of 19 bacterial species. Pathogenic species—representing indicator organisms of efficiency of hospital cleaning—was demonstrated by 21.4% of samples; among them, Acinetobacter spp., Enterococcus spp., and Staphylococcus aureus were identified. Coagulase-negative staphylococci (CNS) were predominant [15].

In another study, 51% of the environmental samples were contaminated with different bacterial species in the studied ICUs [16]. This was more or less twice the results of our study. Discrepancies between studies concerning the impact and degree of environmental contamination may reflect a complex epidemiology, differences in the measurement between studies, or the variable quality of institutional cleaning, which is an important and frequently unmeasured confounder [17].

Regarding the frequency of environmental contamination among hospitals under study, we noticed a wide range of variation that could be explained by the concept of Otter et al., who reported many factors such as method of sampling, organism culturability, and ease of particular environmental contamination (difficulty or cleaning) [9].

Multibacterial contamination of the environmental samples was estimated to be 11% [15]. This agrees with this study (7% polymicrobial). 10.6% of isolated organisms were Clostridium difficile. Spores of Clostridium difficile are durable and resistant to usual cleaning methods. Contamination of the inanimate environment by C. difficile has been reported to occur in areas in close proximity to infected or colonized patients [17].

Gram-negative bacilli: enteric Gram-negative bacilli are not commonly spread to patients from the dry inanimate environment; they are generally not viable after drying, lasting 7 h or less after desiccation [18].

Infection with these organisms is thought to occur because of endogenous spread or cross infection between patients via the hands of healthcare workers. However, Pseudomonas aeruginosa and Acinetobacter baumannii are strongly associated with environmental contamination.

Many studies have documented the contamination of sinks and sink drains by P. aeruginosa [17]. Rates of environmental contamination also vary on the basis of the site of infection in source patients: contamination is more common in the rooms of patients with urinary infection or wounds than in the rooms of patients with bacteremia only [19]. This study found that the proportion of various groups of bacteria significantly varied in respective hospitals.

Poor hygiene compliance facilitates more cross transmission and environmental contamination [20]. Absence of proper infection guidelines contributes to contamination of electrical equipment [21].

Hu et al. found difficulty in the eradication of environmental organisms and explained the survival of those organisms in dry surface biofilms [22].

In our study, CNS was found as the most common environmental isolate (31.9%) followed by MRSA, which was more or less agreed with Mohapatra et al., who reported that CoNs and MRSA are among the common environmental pathogens [23].
Table 6: Distribution of the type of organism isolated according to monitoring from different hospitals (2009–2015) in Assiut city.

| Organism                          | Health Insurance Hospital | Main Assiut University Hospital | Neuropsychiatric University Hospital | Pediatric University Hospital | Al-Ragehy University Hospital | Urology University Hospital | Women Healthcare University Hospital |
|-----------------------------------|---------------------------|---------------------------------|-------------------------------------|-------------------------------|-------------------------------|-------------------------------|----------------------------------|
|                                   | No. | %    | No. | %    | No. | %    | No. | %    | No. | %    | No. | %    | No. | %    |
| MRSA                              | 57  | 26.0 | 609 | 27.0 | 6   | 10.9 | 65  | 18.3 | 26  | 38.8 | 3   | 60.0 | 92  | 28.0 |
| CNS                               | 90  | 41.1 | 711 | 31.5 | 9   | 16.4 | 116 | 32.7 | 18  | 26.9 | 0   | 0.0  | 107 | 32.6 |
| MSSA                              | 19  | 8.7  | 109 | 4.8  | 0   | 0.0  | 116 | 32.7 | 18  | 26.9 | 0   | 0.0  | 44  | 13.4 |
| Enterococcus faecalis (VRE)       | 6   | 2.7  | 49  | 2.2  | 0   | 0.0  | 11  | 3.1  | 5   | 7.5  | 0   | 0.0  | 9   | 2.7  |
| B-Haemolytic streptococci         | 5   | 2.3  | 5   | 0.2  | 0   | 0.0  | 0   | 0.0  | 2   | 3.0  | 0   | 0.0  | 0   | 0.0  |
| E. coli                           | 1   | 0.5  | 61  | 2.7  | 6   | 10.9 | 11  | 3.1  | 2   | 3.0  | 0   | 0.0  | 8   | 2.4  |
| Klebsiella pneumoniae             | 18  | 8.2  | 522 | 23.1 | 3   | 5.5  | 92  | 25.9 | 0   | 0.0  | 1   | 20.0 | 46  | 14.0 |
| Pseudomonas aeruginosa            | 5   | 2.3  | 45  | 2.0  | 4   | 7.3  | 7   | 2.0  | 6   | 9.0  | 0   | 0.0  | 13  | 4.0  |
| Acinetobacter baumannii           | 0   | 0.0  | 60  | 2.7  | 0   | 0.0  | 2   | 0.6  | 0   | 0.0  | 0   | 0.0  | 0   | 0.0  |
| Gram-positive bacillus sp. (C. difficile) | 8   | 3.7  | 275 | 12.2 | 12  | 21.8 | 35  | 9.9  | 5   | 7.5  | 1   | 20.0 | 14  | 4.3  |
| Proteus sp.                       | 16  | 7.3  | 16  | 0.7  | 15  | 27.3 | 3   | 0.8  | 1   | 1.5  | 0   | 0.0  | 0   | 0.0  |
| Number of organisms | Health Insurance Hospital | Main AUH | Neuropsychiatric University Hospital | Pediatric University Hospital | Al-Ragehy University Hospital | Urology University Hospital | Women Healthcare University Hospital |
|---------------------|--------------------------|---------|------------------------------------|-----------------------------|-----------------------------|-----------------------------|---------------------------------|
|                     | No. | %    | No. | %    | No. | %    | No. | %    | No. | %    | No. | %    | No. | %    |
| Monomicrobial       | 212 | 96.8 | 2059 | 91.1 | 55  | 100.0 | 343 | 96.6 | 64  | 95.5 | 5   | 100.0 | 321 | 97.9 |
| Polymicrobial       | 7   | 3.2  | 200  | 8.9  | 0   | 0.0   | 12  | 3.4  | 3   | 4.5  | 0   | 0.0   | 7   | 2.1  |
Gonsu et al. detected 148 bacterial isolates in inanimate surfaces in two referral hospitals, with CNS (57.43%) being the most predominant species [24].

These results are similar to those reported by Tagnounoukam with a predominance of CNS (55%) [25]. This finding is also supported by another study as Lamali et al. found CNS (24%) positivity among environmental samples among a total of 81 investigated samples [4].

Also, these results were in agreement with Sauuide et al., where they found 26% positivity of CNS followed by MRSA 20% then K. pneumonia 16% [26]. In a study by Cordeiro et al., different species belonging to CNS were found in equipment before and after disinfection [27].

In the current study, A. baumannii was isolated from the hospital environments. This finding is supported by a similar study reported that Acinetobacter spp. remains in the hospital environment for a long time, transmitting the infection through staff hands and contaminated surfaces. [28].

We concluded that contamination of high-touch surfaces and equipment of hospital environments by pathogenic bacteria will raise the need for improving its biological safety and hand hygiene compliance of healthcare workers. These bacteria increase the risk of transmission to patient and subsequently hospital-acquired infection. We recommend periodic cultures to reduce the rate of contamination. Local epidemiology strategy is appropriate to address surface contamination.

Data Availability

The data used to support the findings of this study are available from the corresponding author upon request.

Disclosure

Poster of the manuscript was presented in Second International Congress and Expo on Bacteriology.

Conflicts of Interest

The authors declare that there are no conflicts of interest.

References

[1] K. Amazian, J. Rossello, A. Castella et al., “Prevalence of nosocomial infections in 27 hospitals in the Mediterranean region,” Eastern Mediterranean Health Journal, vol. 16, no. 10, pp. 1070–1078, 2010.

[2] World Health Organization, WHO Guidelines on Hand Hygiene in Health Care, World Health Organization, Geneva, Switzerland, 2009.

[3] J.-L. Vincent, J. Rello, J. Marshall et al., “International study of the prevalence and outcomes of infection in intensive care units,” JAMA, vol. 302, no. 21, pp. 2323–2329, 2009.

[4] A. E. O. Lalami, H. Touijer, M. Elayyebi, and N. Benchems, “Microbiological monitoring of environment surfaces in a hospital in Fez city, Morocco surveillance microbiologique des surfaces de l’ environnement d’un hopital dans la ville de Fés, au Maroc,” Journal of Materials and Environmental Science, vol. 7, no. 1, pp. 123–130, 2016.

[5] V. Russotto, A. Cortegiani, T. Fasciana et al., “What healthcare workers should know about environmental bacterial contamination in the intensive care unit,” BioMed Research International, vol. 2017, Article ID 6905450, 7 pages, 2017.

[6] C. Caña, E. Amadio, E. Di Carlo, R. Virruso, T. Fasciana, and A. Giammanco, “Biofilm production in Staphylococcus epidermidis strains isolated from the skin of hospitalized patients: genetic and phenotypic characteristics,” New Microbiologia, vol. 38, no. 4, pp. 521–529, 2015.

[7] M. Zazouli, J. Yazdani-charati, M. Ahanjan, and M. Homayon, “Bacterial contamination of environmental surfaces in two educational hospitals under the auspices of Mazandaran University of Medical Sciences,” Journal of Health in the Field, vol. 3, no. 1, pp. 36–41, 2015.

[8] F. Mehraban, M. N. Rostami, M. Douraghi et al., “Prevalence of environmental gram-negative bacilli in the intensive care units of hospitals from the city of Qom,” Infection, Epidemiology and Medicine, vol. 2, no. 2, pp. 5–7, 2016.

[9] J. A. Otter, S. G. Yezi, G. L. French, and J. A. G. Salkeld, “Evidence that contaminated surfaces contribute to the transmission of hospital pathogens and an overview of strategies to address contaminated surfaces in hospital settings,” American Journal of Infection Control, vol. 41, no. 5, pp. S6–S11, 2013.

[10] A. Kramer, I. Schwebbe, and G. Kampf, “How long do nosocomial pathogens persist on inanimate surfaces? A systematic review,” BMC Infectious Diseases, vol. 6, no. 1, 2006.

[11] S. Galvin, A. Dolan, O. Cahill, S. Daniels, and H. Humphreys, “Microbial monitoring of the hospital environment: why and how?,” Journal of Hospital Infection, vol. 82, no. 3, pp. 143–151, 2012.

[12] K. Huslage, W. A. Rutala, E. Sickbert-Bennett, and D. J. Weber, “A quantitative approach to defining “high-touch” surfaces in hospitals,” Infection Control & Hospital Epidemiology, vol. 31, no. 8, pp. 850–853, 2010.

[13] B. J. Yusuf, “Bacterial contamination of intensive care units at a tertiary hospital in Bauchi, Northeastern Nigeria,” American Journal of Internal Medicine, vol. 5, no. 3, p. 46, 2017.

[14] A. D. Enas, H. A. Entsar, B. M Sh, M. O. Hend, A. M. Hamdy, and A. M. Esam, “Role of bacteriological investigation of endotracheal aspirate in diagnosis of ventilator-associated pneumonia,” African Journal of Microbiology Research, vol. 10, no. 28, pp. 1072–1079, 2016.

[15] A. Różańska, D. Romaniszyn, A. Chmieleczyk, and M. Bulanda, “Bacteria contamination of touch surfaces in polish hospital wards,” Medycyna Pracy, vol. 68, no. 4, pp. 459–467, 2017.

[16] E. Tajeddin, M. Rashidan, M. Razaghi et al., “The role of bacteriological investigation of endotracheal aspirate in diagnosis of ventilator-associated pneumonia,” Clinical Infectious Diseases, vol. 39, no. 8, pp. 1182–1189, 2004.

[17] R. A. Weinstein and B. Hota, “Contamination, disinfection, and cross-colonization: are hospital surfaces reservoirs for nosocomial pathogens? A systematic review,” BMC Infectious Diseases, vol. 6, no. 1, 2006.

[18] A. Kramer, I. Schwebbe, and G. Kampf, “How long do nosocomial pathogens persist on inanimate surfaces? A systematic review,” BMC Infectious Diseases, vol. 6, no. 1, 2006.

[19] J. M. Boyce, G. Potter-Bynoe, C. Chenevert, and T. King, “Environmental contamination due to methicillin-resistant Staphylococcus aureus: possible infection control
implications,” *Infection Control and Hospital Epidemiology*, vol. 18, no. 622–627, 1997.

[20] Y. Longtin, H. Sax, B. Allegranzi, F. Schneider, and D. Pittet, “Hand hygiene,” *New England Journal of Medicine*, vol. 364, no. 13, p. e24, 2011.

[21] T. Lestari, S. Ryll, and A. Kramer, “Microbial contamination of manually reprocessed, ready to use ECG lead wire in intensive care units,” *GMS Hygiene and Infection Control*, vol. 8, no. 1, p. Doc07, 2013.

[22] H. Hu, K. Johani, B. I Gosbell et al., “Intensive care unit environmental surfaces are contaminated by multidrug-resistant bacteria in biofilms: combined results of conventional culture, pyrosequencing, scanning electron microscopy, and confocal laser microscopy,” *Journal of Hospital Infection*, vol. 91, no. 1, pp. 35–44, 2015.

[23] S. Mohapatra, K. Agrawal, S. Chopra, M. Deb, and R. Gaind, “Bacteriological profile of patients and environmental samples in burn intensive care unit: a pilot study from a tertiary care hospital,” *Indian Journal of Burns*, vol. 22, no. 1, pp. 62–66, 2014.

[24] H. K. Gonsu, E. Guenou, M. Toukam et al., “Bacteriological assessment of the hospital environment in two referral hospitals in Yaoundé-Cameroon,” *Pan African Medical Journal*, vol. 20, p. 224, 2015.

[25] N. P. Tagnouokam, *Quantification et Quantification de la Flore Bacterienne de Lenvironnement Hospitalier (Air, eau et surfaces) du CHU de Yaoundé*. Mémoire de Master Microbiologie Medicale FMSB, Universite de Yaounde, Yaounde, Cameroun, 2008.

[26] N. Sauuide el ayne, A. Echchelh, A. Chouch, N. Auajjar, S. Hamama, and A. Soulamyani, “Role de l’ environnement hospitalier dans la prevention des infections nosocomiales: surveillance de la flore des surfaces a l’hôpital el idrissi de kenitra—Maroc,” *European Scientific Journal*, vol. 10, no. 9, 2014.

[27] A. L. A. O Cordeiro, M. M. C. Oliveira, J. D. Fernandes, C. S. M. A. Barros, and L. M. C. Castro, “Contaminação de equipamentos em unidade de terapia intensiva,” *Acta Paulista de Enfermagem*, vol. 28, no. 2, pp. 160–160, 2015.

[28] D. J. Weber, W. A. Rutala, M. B. Miller, K. Huslage, and E. Sickbert-Bennett, “Role of hospital surfaces in the transmission of emerging healthcare-associated pathogens: *norovirus*, *Clostridium difficile*, and *Acinetobacter* species,” *American Journal of Infection Control*, vol. 38, no. 5, pp. 25–33, 2010.