Keyboard Kritters:

Transferring germs from keyboard to patient

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The quest for safe, effective infection control practices remains a persistent goal for *Association of Dialysis Advocates (ADA). ADA* questions whether it's a standard practice for dialysis facilities to conduct environmental-surface (e.g. keyboards, phones, supply carts) culturing and submits to patients, the public, and Center for Medicare-Medicaid Services (CMS) that conducting unannounced surface culturing of these items and incorporating it as standard practice would increase awareness of the opportunistic nature of pathogens, viral agents, and bacteria among those delivering care.

The inclusion of cultures into existing state surveillance programs and provision of the results to staff--accompanied by supportive, complementary education in cross-contamination--should improve infection control in *ADA's* opinion. The following examples of keyboard cross-contamination can be viewed on the ADA site under the site's *facility inspection reports* menu: Gambro Healthcare in California– Anaheim, Vallejo, Huntington Beach, Garden Grove, Encinitas and Watson; and Wise Dialysis Center (RCG facility) in Tyler, Texas.

Several facilities managed by the same company, and within the same area, all had similar deficiencies. This leads *ADA* to question the efficacy of the parent company's infection control education-training program and whether the facility's management is adequate. Determining whether staff may be deliberately ignoring cross-contamination training is of equal importance.

Computer keyboards are frequently used in dialysis units and are difficult to clean. In one study Dr. Gary Noiskin presented findings demonstrating that "growths of bacteria were evident 24 hours after contamination" and could be transferred from healthcare workers to patients by contaminated fingers--gloved or non-gloved. [*Annual Scientific Session of the Society for Healthcare Epidemiology of American (SHEA*) in Los Angeles, April 2005]

Dialysis patients are highly vulnerable to acquired infections. MRSA (methicillin-resistant Staphylococcus aureus) is bacteria known to be highly resistant to antibiotics usually administered to patients. MRSA transferred from a staff member's hands to patients can be deadly, especially for dialysis patients. Other bacteria--e.g. pseudomonas aeruginosa and vancomycin-resistant enterococci—present dangers to patients and can readily live on computer keyboards. The multiple and frequent transfers between healthcare facilities (hospitals, nursing homes, dialysis units, medical offices), represent another ongoing risk for all patients.

The *Association of Dialysis Advocates* recommends that the dialysis community adopt effective policies and practices that better address the cleaning of computer keyboards. *ADA* also recommends more comprehensive education for staff regarding cross-contamination and increased oversight by CMS for those providing care. Reminding staff to wash hands prior to delivering care should be only the beginning of truly effective infection control for every patient.

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