

Evaluation of Transient Microbial Flora on Biometric System as a Potential Source of Infection in Tertiary Care Hospitals

Nancy Suhag¹, Arti Jain^{2,*}, Navinchandra M. Kaore³

¹3rd Year under Graduate Student, ²Assistant Professor, ³Associate Professor, Dept. of Microbiology, People's College of Medical Science and Research, Near Bhopal Memorial Hospital, Karond Bypass Road, Bhanpur, Madhya Pradesh – 462037

***Corresponding Author**

E-mail: artijain.jain2@gmail.com

Abstract

In developing countries, along with the Health Care Providers, Inanimate objects plays a critical role in microbial transmission so also the ability of the microorganism to survive on inanimate objects to cause Hospital Acquired Infections. The purpose of this Study was to evaluate transient microbial flora on Biometric System as a potential Source of infection in hospital settings.

The Cross-sectional Analytical study was conducted in the Department of Microbiology, attached to a Tertiary Care Hospitals in Central India after obtaining ethical clearance over a time period of two months.

Ten out of 30 samples evaluated showed growth of *Staphylococcus aureus* of which 7 (70%) were found to be MRSA & 3(30%) MSSA when tested using Cefoxitin Disk Diffusion Test. MRSA strain were found to be resistant to Erythromycin, Ampicillin, Clindamycin & Cefepime and both MRSA & MSSA strains were sensitive to Co-trimoxazole. Biometric systems in Medical Hospital were found to be carrying the microorganisms more than that of Dental Hospitals and that too which are being used by Para-Clinical faculties.

Present study highlights the need of sensitization & training sessions regarding hand hygiene practices among the health care workers and regular cleaning of inanimate objects like Biometric device for reduction of HAIs.

Key Words- Methicillin Resistant *Staphylococcus aureus* (MRSA), Hand washing practices, inanimate objects, Biometric device, HAIs.

Key Message:

Inanimate objects in hospital settings are prime source of transmission of hospital associated infections. Regular surveillance of such objects along with decontamination strategies plays a important role in containment of resistant strains causing Hospital Acquired Infections.

Access this article online	
Quick Response Code:	Website: www.innovativepublication.com
	DOI: 10.5958/2394-5478.2016.00001.7

Introduction

Fingerprint authentication is one of the most well-known and publicized biometrics technologies.¹ It is important to note that skin surface serve as a habitat of variety of microorganism predominantly consisting of Gram positive bacteria. In addition to it, skin surface of health professionals are being colonized by pathogenic bacteria that are contracted through their contact with the patient.²

Most common microorganisms transmitted through health professionals / physicians contact are *Staphylococcus aureus*, *Pseudomonas aeruginosa* & *Acinetobacter baumannii* and their resistant variants like Methicillin Resistant *Staphylococcus Aureus* (MRSA), Vancomycin Resistant *Enterococcus* (VRE) in Gram

positive bacteria whereas Multidrug Resistant Gram negative bacteria are also not uncommon. These microorganisms have the ability to survive in dry-surface environment, which may then become a source for transmission³.

Most microorganisms survive for more than 30 minutes on the hands and with regular hand hygiene practices it can be controlled⁴, but many bacterial pathogens especially on non-living objects can survive for days to weeks, causing an exogenous source of infection in Hospital Associated Infections (HAI)⁵. Health Care Professionals (HCP) are coming in contact with Biometric system on day to day basis at least twice a day to mark their attendance Various studies shows that the surface of biometric system serve as a potential source of transmission of infection. Thus the study was undertaken to find out transient microbial flora on biometric system along with antibiogram of the pathogenic microorganisms, which might get transmitted from one physician to another causing HAI.

Material and Methods

This Cross-sectional Analytical study was conducted in the Department of Microbiology, attached

to a Tertiary Care Hospital in Central India Over a time period of two months from 1st August to 31st October 2015 after obtaining Ethical Clearance. A total of 30 Biometric systems in one Medical college and 2 Dental Colleges in use by Clinical, Para-clinical & Non-clinical personnel's were included in study.

Collection of Samples: Samples was collected using a sterile cotton swab moistened with Sterile Distilled Water from all the biometric systems by rotating the swab on the area of finger contact for 5 to 10 seconds and were transported immediately to the Microbiology laboratory for further processing. Samples were inoculate on Blood agar and MacConkey agar & incubated at 37 °C for 18-24 hours. Direct smear examination after Gram staining were also observed to rule out contaminants.

After 24 hours of incubation, the isolated organisms were identified using the standard microbiological procedures like colony morphology, Gram staining and biochemical reactions.⁶ Antibiotic sensitivity pattern of the identified organism was done according to CLSI guidelines.⁷

Results

A total of 12, 8 & 10 samples were taken from Group I: Medical College, Group II: Dental Academy

& Group III: Dental Sciences respectively. Each group is further divided in to 3 study units - Clinical(C), Para-clinical (PC) & Non-clinical (NC) units.

Out of 30 samples, 10 (33%) sample were culture positive. The distribution of culture positive samples in different units of the 3 groups is shown in Table 1.

Out of total 10 positive samples, 4 samples (40 %) were culture positive from Para-clinical followed by 3 each (30%) from Clinical & Non-clinical units.

All ten isolated microorganisms on biometric system were *Staphylococcus aureus*. Out of 10 isolated *Staphylococcus aureus*, 7 (70%) were found to be MRSA (Methicillin resistance *Staphylococcus aureus*) & 3 (30%) were MSSA (Methicillin sensitive *Staphylococcus aureus*) when tested for Methicillin resistance using Cefoxitin Disk Diffusion Test.⁷ Antibiotic resistance pattern of the all isolates are shown in Table 2.

The culture positivity was compared between two Groups (Group I & Group III) by using Pearson's Chi-square test & statistically significant difference was observed between the two with p value of 0.0034. Whereas the difference of growth between the Group I & Group II was not found to be statistically significant. We also compared Medical against Dental colleges and statistically significant difference were observed (Table3).

Table 1: Study Unit & Study group wise distribution of culture positive samples from biometric system in a Tertiary care hospitals

	Group I : Medical college (n=12)				Group II : Dental Academy				Group III : Dental Sciences			
	C	PC	NC	Total	C	PC	NC	Total	C	PC	NC	Total
No. of sample collected	4	4	4	12	2	2	4	8	4	4	2	10
No. of culture positive	2	3	2	7	1	1	1	3	0	0	0	0

C=Clinical, PC= Para-clinical, NC= Non-clinical

Table: 2 Antibiotic resistance pattern of the *Staphylococcus aureus* isolated from Biometric systems

Isolated Organisms- <i>Staphylococcus aureus</i> (n=10)		
Antibiotics	MSSA (n=3)(% Resistant)	MRSA (n=7) (% Resistant)
Erythromycin (E)	2(66%)	7(100%)
Clindamycin (CD)	2(66%)	7(100%)
Cefepime (CEF)	0 (0 %)	7(100%)
Ampicillin (AMP)	0 (0 %)	7(100%)
Co-trimoxazole (COT)	1(33%)	1(14%)
Doxycycline (DOX)	0 (0 %)	0 (0 %)
Ciprofloxacin (CIP)	0 (0 %)	0 (0 %)

Table: 3 Comparison of culture positive between Group I & Group III

	Group I (Medical college)	Group III (Dental Sciences)	Total	Chi-square Test
Culture positive	07	0	07	$X^2= 8.55$ P value=0.0034 Highly Significant
Culture Negative	05	10	15	
Total samples	12	10	22	
Comparison between Medical & Dental (Dental Academy + Dental Sciences) Groups:				
	Medical Group	Dental Groups	Total	Chi-square Test
Culture positive	07	03	10	$X^2= 5.62$ P value=0.0177 Significant
Culture Negative	05	15	20	
Total samples	12	18	30	

Discussion

Culture positivity of 33.33 % was observed in our study whereas study done by Christine R. Blomeke (2007) reported 0.10% culture positive by Biometric device². Similar study done by Chigozie J. Uneke *et al* (2010) reported 78.5% culture positive by other inanimate objects like stethoscopes.⁸

Around 40 % samples were culture positive from biometric samples used by Para-clinical personnels. In study done by Chigozie J., Uneke *et al* (2010), out of 84 positive samples, 59 (80.8%) samples were culture positive from Clinical units followed by 25 (73.5%) samples were Non-clinical units.⁸ In both the studies inanimate objects were observed to be harboring the microorganisms which might contribute to spread of HAI. This difference may be due to lack of awareness & practicing hand washing techniques in Para-clinical units in our study area. Failure to wash hands could facilitate the transfer of pathogens on devices that health workers use frequently, such as inanimate objects like stethoscopes, Pen, computer keyboards, biometric systems etc.

Staphylococcus aureus (n=10) was the only isolate with around 70% being MRSA. In other study done by Chigozie J. Uneke *et al* (2010), *Staphylococcus aureus* was commonest isolate (53%) followed by *Pseudomonas aeruginosa* (19.0%), *Enterococcus faecalis* (14.3%) and *Escherichia coli* (13.0%) from other inanimate objects like stethoscopes.⁸ In 2000, in an excellent study in an adult intensive care (ICU), Bures *et al* cultured a number of microorganisms, including MRSA, *Enterococcus* and *Enterobacter* from other inanimate objects like computer keyboards.⁹

Various studies have shown MRSA infection as the most common problem from inanimate objects. It may be due to health workers harbor/colonize MRSA on their hands/skin/ nasopharynx which serve as a reservoir of MRSA that may spread to other health workers with subsequently contact.

HAI associated MRSA are frequently resistant to a range of antibiotics including penicillin group which hinders the effective eradication of MRSA strains.¹⁰ MRSA strain are the strains of *Staphylococcus aureus* having chromosomally mediated resistance gene *MecA*

that code for a unique penicillin binding protein PBP2a not affected and offering resistance to beta lactamase group of drugs Penicillin (methicillin, dicloxacillin, nafcillin, Oxacillin etc.), Cephalosporins like cephalexin, cefuroxime & Ceftriaxone, Monobactams like Aztreonam, Carbapenems like Imipenem. Although predominantly a hospital pathogen, MRSA is becoming more common in community i.e. community acquired MRSA strains (CA-MRSA).

MRSA restricted to hospital setting are named hospital acquired MRSA strain (HA-MRSA). Hospital personnel harboring MRSA have been implicated as the chief source of nosocomial infection.¹¹

Control measures like hand washing, routine screening of healthcare workers and disinfection of biometric device with isopropyl alcohol/ chlorhexidine should be done to minimize spreading of infection.

Most emphasizing point in our study, all of the ten MRSA isolates were found high susceptibility to Co-trimoxazole (67%). A recent multicenter report from several hospitals shows an increased in Co-trimoxazole susceptibility among MRSA isolates.^{12,13} Several factors may have influenced the emergence of *Co-trimoxazole* sensitive MRSA, including reduced usage of the drug in our institution. In setting where *Co-trimoxazole* is extensively used, a substantial increase of MRSA resistance to *Co-trimoxazole* has been observed, for eg: Martin *et al.* described a serial cross-sectional study of resistance to *Co-trimoxazole* among all clinical isolates of *S. aureus* and other *Enterobacteriaceae* during a 16-year period at San Francisco General Hospital.¹⁴ So our data may favor the use of *Co-trimoxazole* as a potentially cost-effective antimicrobial drug for treating MRSA infections in our hospital settings.

Our study shows that, Biometric device might act as fomite playing an important role in the transmission of potential pathogenic organisms, as well as spread of antibiotic –resistant strains in the hospital environment. Screening of Health Care Workers for carriage of MRSA strains and their susceptibility pattern needs to be evaluated further with effective decolonization strategies for MRSA strains to reduce the HAI.

The attitude & practice of hand hygiene amongst the Dental faculties may be the reason for less flora on

the inanimate objects in Dental groups again emphasizing the need for regular sensitization and training for hand hygiene practices Medical College.

Conclusion

Present study highlights the need of sensitization & training sessions regarding hand hygiene practices among the health care workers and regular cleaning of inanimate objects like Biometric device for reduction of HAIs. It also emphasizes the need for regular surveillance of carriage of resistant strains of *Staphylococcus aureus* in Health care personals. Eventually, our data favor the use of *Co-trimoxazole* as a potentially cost-effective antimicrobial drug for treating MRSA infections which needs to be evaluated in context to different hospital settings by multi-centric trials.

Acknowledgement: We acknowledge the Indian Council of Medical Research for choosing the important and relevant topic for short term studentship program.

Conflict of Interest: None

Source of Support: Nil

References

- Jianjiang, F. et al (2007). Combining minutiae descriptors for fingerprint matching, *Pattern Recognition*, pp. 342 – 352.
- Christine R., Bloomeke, Stephen J. Elliott et al (2007). Bacterial survivability and transferability on Biometric devices. 1-4244-1129-7/07/\$25.00 2007 IEEE, pg:80-84.)
- Jonathan A. Otter, Saber Yezli et al. The role played by contaminated surfaces in the Transmission of nosocomial pathogens. *Infection control and hospital epidemiology*, Vol.32, No. 7, July 2011.
- Kampf G, Kramer A. Epidemiologic background of hand hygiene and evaluation of the most important environmental surfaces in primary schools in Leeds. *Epidemiol infect* 1995;115:527-534.
- Kramer A, Schwebkel, Kampf G. et al. How long do nosocomial pathogens persist on inanimate surfaces. A systemic review. *BMC infect Dis* 2006;6:130.
- Collee JG, Duguid JP, Fraser AG, Marmion BP, Simmons A. et al. Tests for the identification of bacteria. Mackie and Mc Cartney Practical Medical Microbiology. New Delhi, India: Elsevier publications; 2011:p131-149.
- National Committee for Clinical Laboratory Standards. Performance standards for antimicrobial susceptibility testing; 24th informational supplement Wayne, Pa: National Committee for Clinical Laboratory Standards; 2014(M100-S24).
- Chigozie J., Uneke et al (2010). Bacterial contamination of stethoscopes used by health workers: public health implication.. *J Infect Dev Ctries* 2010;4(7):436-441).
- Brues S, Fishbain JT, Uyehara CFT, et al. Computer keyboards and faucet handles as reservoirs of nosocomial pathogens in the intensive care unit. *Am J Infect Control*. 2000;28:465-70.
- World health organization. 2000. Overcoming antimicrobial resistance. Available: www. who. int/infectious –disease –report /2000/. Accessed 2 September 2009).
- Ananthanaryan R, Paniker's CKJ. Systemic Bacteriology in: Textbook of Microbiology. 9th Edition. Mumbai, India. Repro publications; 2013: “*Staphylococcus*”, p(60-62).
- Denis O, Deplano A, Nonhoff C, de Ryck R, Rottieres S, Hendricks E, et al. Molecular epidemiology and antimicrobial susceptibility of methicillin-resistant *Staphylococcus aureus* in Belgian hospitals: 2001. 42nd Interscience Conference on Antimicrobial Agents and Chemotherapy. Abstract. San Diego: American Society for Microbiology; 2002. p. 305.
- Ihad Bishara, Silvio Pitlik, Zmira Samra et al. Co-trimoxazole–Sensitive, Methicillin-Resistant *Staphylococcus aureus*, Israel. emerging infectious disease. Vol-9, Nov9-september 2003, p(2-3).
- Martin JN, Rose DA, Hadley WK, Perdreau-Remington F, Lam PK, Gerberding JL. Emergence of trimethoprim-sulfamethoxazole resistance in the AIDS era. *J Infect Dis*. 1999;180:1809–18.

How to cite this article: Suhag N, Jain A, Kaore NM. Evaluation of Transient Microbial Flora on Biometric System as a Potential Source of Infection in Tertiary Care Hospital. *Indian J Microbiol Res* 2016;3(1):1-4.