which to answer the questions raised by Mr. Birnbaum. This implies a study collecting a wide variety of very detailed data. However, the surveillance data acquired in the NNIS system, which is voluntary, cannot be as detailed and must remain relatively practical. The Centers for Disease Control's intent is to provide information to hospitals that is more meaningful for interhospital comparison, rather than attempt to define a specific patient's risk. The rates that we now advocate, such as device-associated, device-day rates, are meant only as a guide and indicate areas for further investigation. The Joint Commission on Accreditation of Healthcare Organizations in their agenda for change also has accepted the limitations of "benchmark" rates.[4] Censored data and an inconstant infection risk throughout the duration of a device represent only two areas where improvement in these rates are needed. We will continue to improve the NNIS system and provide mechanisms, often through articles in this journal, to help hospitals understand the most appropriate methods to interpret the rates we have recommended.

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Home Healthcare

To the Editor:

I read with great interest the article "Infection Control for Home Health,"[1] as I work for a national organization that provides home services in Canada.

As the authors mentioned in the article, there are scarce data regarding development and transmission of infections in the home setting. I do believe, as they do, that serious infections probably do occur less frequently in the home setting than in the hospital. However, I am not so sure that the home environment is necessarily a safer setting for individuals when there are many factors in the client's home environment that we never control, such as general hygiene, adequate handwashing facilities, home health professionals with communicable diseases, the use of more multiple invasive devices, or an immunocompromising condition. We assume that the home environment is safer, but we have little evidence for that except for the absence of "full-blown" infection. However, could a low-grade infection be associated with a longer healing period in an incisional wound, for example?

I believe that most infection control guidelines are a result of hospital-based research. Yet we have little research to define infection control parameters for the home setting. To make assumptions about the safety of the home environment in terms of infection control, with little data to support that hypothesis, is almost negligent. It certainly behooves us in the community to more rigorously test various infection control hypotheses.

I did want to question the statement regarding sterile irrigation solutions that can be kept open for 72 hours before discarding. Where are the data to support that particular time frame? I am only familiar with the work of Brown et al,[2] in terms of the length of time sterile solutions are kept open, and did not know that any other data existed. I realize that their work is hospital-based.

Because there is little legislation to protect us in the community, we must abide by research-based practice as much as possible.

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The authors reply.

Yes, good infection control data concerning home health are sparse. However, it is not negligent to make recommendations based on the best information available. It is certainly more irresponsible to make no effort at all. Hopefully, our article will stimulate you "to more rigorously test various infection control hypotheses" as you continue your work in the home. At the very least, home health nurses should be collecting reliable surveillance data patterned after data collected in the hospital. Such a simple step would help us answer the question about whether the home environment is safer than the hospital.

Regarding the 72-hour change interval for urinary tract irrigants, I know of no data to support a particular time frame. However, most patients who have chronic indwelling urinary catheters do not have sterile urine. Patients who use intermittent

catheterization often clean their catheters with tap water, which is not sterile. Thus, although contaminated irrigants should be avoided, a sterile bladder is probably uncommon among those likely to receive bladder irrigation in the home. Further, regarding our recommendation, the irrigant should not be "kept open" but should be "stored in an aseptic manner,"[1] which would include recapping the container immediately after use. The recommendations in our article were reviewed by over 30 individuals involved in either home health or infection control. Thus, these recommendations to some degree represent consensus and should be subjected to further study.

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Corrections

In the article entitled "Intervention to Discontinue Parenteral Antimicrobial Therapy in Patients Hospitalized With Pulmonary Infections: Effect on Shortening Patient Stay" (Ehrenkranz NJ, Nerenberg DE, Shultz JM, Slater KC. 1991;13:21-32), all references to Table 5 should be to Table 4.

In the article entitled "Peracetic Acid Sterilization: A Timely Development for a Busy Healthcare Industry" (Crow S. 1992;13:111-113), the third sentence in the section "How Does It Work?" should read "The computer produces a printed document confirming that the sterilization parameters of temperature, exposure time, and concentration are met during the cycle."