Copper surfaces are associated with significantly lower concentrations of bacteria on selected surfaces within a pediatric intensive care unit

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Background: Health care–associated infections result in significant patient morbidity and mortality. Although cleaning can remove pathogens present on hospital surfaces, those surfaces may be inadequately cleaned or recontaminated within minutes. Because of copper’s inherent and continuous antimicrobial properties, copper surfaces offer a solution to complement cleaning. The objective of this study was to quantitatively assess the bacterial microbial burden coincident with an assessment of the ability of antimicrobial copper to limit the microbial burden associated with 3 surfaces in a pediatric intensive care unit.

Methods: A pragmatic trial was conducted enrolling 1,012 patients from 2 high acuity care units within a 249-bed tertiary care pediatric hospital over 12 months. The microbial burden was determined from 3 frequently encountered surfaces, regardless of room occupancy, twice monthly, from 16 rooms, 8 outfitted normally and 8 outfitted with antimicrobial copper.

Results: Copper surfaces were found to be equivalently antimicrobial in pediatric settings to activities reported for adult medical intensive care units. The log10 reduction to the microbial burden from antimicrobial copper surfaced bed rails was 1.996 (99%). Surprisingly, introduction of copper objects to 8 study rooms was found to suppress the microbial burden recovered from objects assessed in control rooms by log10 of 1.863 (73%).

Conclusion: Copper surfaces warrant serious consideration when contemplating the introduction of no-touch disinfection technologies for reducing burden to limit acquisition of HAIs.

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INTRODUCTION

Hospital–associated infections (HAIs) continue to be one of the most common and significant complications associated with hospitalization across the globe. Patients admitted to intensive care units (ICUs) are at an increased risk of being colonized or of developing an infection from microbes that are resident within the clinical environment. These increased risks result from the contribution of many factors, such as underlying disease of the patient, medical circumstance requiring hospitalization, use of invasive...
medical devices, stochastic and frequent contact with health care workers, exposure to antimicrobial agents, emergence and increased frequency of the presence of antibiotic-resistant microbes in the clinical environment, prolonged lengths of hospitalization, and lack of compliance with existing infection control guidelines. Less than 10% of hospitalized patients require ICU treatment. However, care in the ICU accounts for >20% of HAIs acquired by hospitalized patients. Additionally, pediatric intensive care units (PICUs) and neonatal ICUs have higher documented HAI acquisition rates than those seen for adult populations.

Most HAIs are thought to occur via transmission from the microbiome of the patient. However, there is ever increasing evidence suggesting significant transmission of microbes from personnel and the clinical environment to patients. Otter et al have delineated the complex, continuous, and omnidirectional movement of microbes within the clinical space. Investigators have also shown that the gloves of nurses frequently are contaminated with viable methicillin-resistant Staphylococcus aureus (MRSA) after touching objects near MRSA-colonized patients. Further, studies have found that controlling the contamination of common hospital touch surfaces from hand to surface contact and via versan can be an effective strategy to limit burden and control infections.

Recently, we have witnessed an increased incorporation of no-touch technologies as a component in systematic approaches for infection control. Ultraviolet light and the introduction of vapor phase oxygen radicals (hydrogen peroxide vapors [HPVs]) into the hospital environment exert their antimicrobial activity passively through an episodic introduction into the care space. Both technologies have been found to reduce the bacterial burden by at least 4 log10 within the clinical environment. In one 30-month study evaluating the environmental and clinical impact of the episodic use of HPVs involving 6 high-risk units in a large tertiary care hospital, it was learned that patients admitted to rooms decontaminated with HPV were 64% less likely (P < .001) to acquire any multidrug-resistant microbe and were 80% less likely to acquire vancomycin-resistant enterococci (VRE). These 2 systems require skilled labor to place and initiate the episodic application of their use and the exclusion of patients and health care workers from the environment.

Solid copper and its alloys have been used as an antimicrobial agent for millennia. They intrinsically display strong antibacterial activities in aquatic systems and dry surfaces. Controlled studies within the clinical environment have evaluated the effects that antimicrobial copper surfaces have on the microbial burden and acquisition of HAIs. In 2008, the U.S. Environmental Protection Agency registered 5 families of copper-containing alloys as antimicrobial, therefore offering that products manufactured-surfaced from one of these alloys can kill 99.9% (log10 2.0) of bacteria within 2 hours of exposure. Casey et al observed a median microbial reduction of between 90% and 100% (log10 1.95-2.0) on copper-surfaced push plates, faucet handles, and toilet seats, whereas Schmidt et al demonstrated significantly lower bacterial burdens on 6 frequently touched clinical surfaces, averaging an 83% (log10 1.93) reduction for all of the objects over the course of a 43-month multicenter trial. In the conduct of the same multicenter trial, it was learned that concomitant with a reduction to microbial burden, antimicrobial copper surfaces were found to significantly lower the rate of HAI acquisition by 58% from 8.1% to 3.4% (P = .013). Analysis of the quartile distribution of infection acquisition stratified by microbial burden established a significant association (P = .038), establishing linkage between microbial burden and infection acquisition. Specifically, of the HAIs acquired, 89% were found to occur in rooms where the microbial burden was >500 aerobic colony forming units (ACF).

In this study we expanded these observations by characterizing the microbial burden associated with commonly touched objects surfaced with and without copper in PICUs to understand whether or not a significant reduction to microbial burden and HAI acquisition observed within adult ICUs would be duplicated within a pediatric setting housing multiple patients within each room.

**MATERIALS AND METHODS**

**Study environment**

The study was conducted at a 249-bed tertiary care facility, Hospital de Niños Roberto del Río, which is located in Santiago, Chile. Two, high acuity pediatric units were selected for the intervention; 8 rooms from the ICU (PICU) and 8 rooms from the intermediate care unit (PIMCU). Eligible participants were patients admitted to one of the study units based on their respective medical needs to be housed in either the PICU or PIMCU. On admission, patients were sequentially assigned to an intervened (copper) or control room. Patient occupancy of the beds and cradles was noted at the time the samples were collected. Informed consent was not required to collect burden from the objects.

The PICU has six 2-bed rooms and 2 additional rooms containing a single bed. The PIMCU has one 4-bed room, 5 rooms with 3 beds, and 2 rooms containing a single bed. Eight rooms were furnished with copper surfaced items, and 8 rooms remained unchanged. The rooms were located in an alternate fashion. The copper surfaced items were beds rails, bed rail levers, intravenous poles, faucet handles, and the surface of the health care workstation. The copper alloys used to surface the objects were among those registered with the U.S. Environmental Protection Agency as being antimicrobial and are principally brass (C27200 and C23000 [bed rails, bed lever (DUAM S.A., Santiago, Chile), faucet (Chase Brass, Montpelier, OH), and work surface]) or Eco Brass (C69300 [faucet, faucet handles]). Presuty handwashing procedures and cleaning routines were maintained and remained unchanged through the study period. The hand hygiene compliance rate of health care workers was assessed quarterly by staff not affiliated with the trial. Compliance was monitored and reported quarterly as a measure of health care worker adherence to the established protocol for hand hygiene before and after patient contact. For the period of the trial, the mean compliance rate for the health care workers observed in the units (N = 153), expressed as a percentage of individuals that complied entirely with the hospital standards for the PIMCU and PICU wards, was 93% (range, 80%-100%).

**Sampling plan**

The microbial burden resident in the built clinical environment is not normally distributed on surfaces because of individualization care provided to patients, variations to room occupancy, individualized shedding of microbes by patients, and health care workers and visitors with subsequent deposition and retention of viable microbes onto surfaces. Given the nonparametric distribution of the microbial burden resident on the surfaces sampled, the Mann-
Whitney test, Wilcoxon 2-sample test, or Kruskal-Wallis test (Epi Info; Centers for Disease Control and Prevention, Atlanta, GA) was used to compare differences between microbial burden collected from control and intervention surfaces. Sample size was estimated on the basis of available local data collected during a pre-intervention period. It was anticipated that there might be some seasonal variation; the study was statistically powered to test for differences on a monthly basis. Fifty samples per group per month were found to yield an approximate 90% statistical power to show a 90% reduction of the bacterial burden in the intervention group compared with the control group, with a 2-sided type I error of 0.05. Having sufficient power to compare means enabled sufficient power to test differences between the medians observed using the Mann-Whitney test, Wilcoxon 2-sample test, or Kruskal-Wallis test (Epi Info; Centers for Disease Control and Prevention, Atlanta, GA).

Rooms were sampled on alternating weeks for the length of the trial. A total of 734 samples were collected during the pre-intervention phase as delineated in Table 1, and 1,230 samples were collected during the intervention (Table 2). Each of the surfaces monitored (Fig. 1) was assessed for total ACC, expressed as viable colony forming units (CFU) per 100 cm², and the presence of indicator microbes, staphylococci, MRSA, VRE, and gram-negative microbes as previously described.11

Statistical methods

The mean and median microbial burden of each item assessed during the interventional period was determined, and the significance of the data was assessed using the Kruskal-Wallis test to compare the microbial burden associated with objects and rooms.
found to be significantly lower, with copper surfaced cradles harboring 19-fold lower concentration of bacteria recovered from occupied and unoccupied groups found that the average concentration from unoccupied control objects was 47% (bed rails) and 46% (cradles) lower than the concentration of ACC recovered from occupied objects. The average concentration between unoccupied and occupied copper surfaced bed rails was also significantly lower than unoccupied beds, having approximately 40% fewer bacteria than their occupied counterparts. However, the concentration observed for the unoccupied copper cradles did not significantly differ.

**DISCUSSION**

The role that the built environment serves in the transmission of pathogens has received increased attention from the infection control community. The data reported here established that antimicrobial copper surfaces are equivalently effective for their ability to control the environmental microbial burden in a pediatric setting. Collectively, an 88% reduction (log10 1.944) was observed when considering the values from the 3 objects sampled, whereas an 83% reduction (log10 1.919) was reported from a comparable study where the efficacy of 6 antimicrobial copper surfaces were evaluated from adult Medical Intensive Care Units.11

This study represents the first comprehensive evaluation of the effectiveness of copper to limit bacterial contamination on surfaces within multbed rooms. Substantial variability was seen among samples collected from within the control and intervention (copper) groups (Fig. 2). This observation well illustrates the nonparametric distribution of bacterial contamination associated with surfaces within the built environment. Similar to the adult study, such variation encountered in the pediatric setting was attributed to the stochastic nature of care common to the PICU and PMICU and the level and extent to which patients and health care workers shed his or her respective flora. However, in this trial additional confounding variables could have impacted the nonparametric distribution of microbes within the built environment. Unlike adults in the MICU trial, where there was only 1 patient per room,13 in our study each room could host multiple patients with variable rates of occupancy. On discharge, the formerly occupied bed and immediate area associated with the care area of the discharged patient was terminally cleaned and not permanently cleaned again until subsequent patient occupancy and discharge. This resulted in the observation that occupied beds and occupied cradles had higher concentrations of bacteria than the unoccupied beds or unoccupied cradles (Fig. 2). During 2 of the 12 months of the trial (July and August 2013), occupancy exceeded 100% for 36 days. During the clinical surge, noncopper objects were
introduced into the copper rooms as a consequence of the increased clinical need. Therefore, the likelihood of introducing additional microbial burden into the patient care setting, irrespective of cause, was increased. However, in spite of increased opportunities to introduce additional burden into the patient care setting, the antimicrobial efficacy of the copper surfaces monitored was consistently <500 CFU/100 cm² for most of the samples evaluated regardless of occupancy status (Fig. 2). Although it was observed that health care staff caring for patients made no distinction as to whether they were assigned patients in an intervention or control group, there is still a formal possibility that bias might be introduced into the unblinded study. The antimicrobial activity of the copper surfaces is continuous and requires no intervention on the part of the study or health care teams to exert its ability to disinfect the surfaces to which it was applied.

Presently, regulatory agencies assessing the antimicrobial efficacy of surface disinfectants require that products under evaluation reduce the microbial burden, using a de
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Fig 2. Copper surfaces limited the concentration of bacteria associated with the intervention objects within the PICU and PIMCU. Bed rails, cradles, and faucet handles were sampled twice each month as described in the Materials and methods section. The concentrations recovered for the rails are plotted against the date of collection and whether or not the bed was occupied (filled squares: control rails; filled triangles: copper rails) or unoccupied (open squares: control rails; open triangles: copper rails) at the time of sampling. The solid grey line denotes the average concentration of occupied control beds. The dashed grey line represents the average concentration found on unoccupied control rails. The dashed black line denotes the average concentration for unoccupied copper beds. The dotted line denotes the average concentration for occupied copper beds. The red line drawn at 500 CFU/cm² suggests an average concentration at which the risk of microbial transference may increase.

Fig 3. Copper surfaces were consistently able to limit the concentration of bacteria associated with commonly touched surfaces within the PICU and PIMCU. The antimicrobial consistency of copper surfaces was assessed by determining the frequency at which bed rails, cradles, or faucet handles sampled from the PICU and PIMCU were observed not to exceed 500 CFU/100 cm². The frequency that the microbial burden was below the limit of detection (green bars), above the limit of detection but less than the risk threshold (<500 CFU/cm²; yellow bars), or exceeded the risk threshold (>5 CFU/cm²; red bars) was determined by scoring the number of occasions that the ACC for individual surfaces was sampled at the time of sampling. The solid grey line denotes the average concentration of bacteria associated with those surfaces to which the microbial burden plays in HAI acquisition. The approach was based on a comparison of the frequencies with which individual samples from control and copper groups harbored concentrations of bacteria above which the risk of HAI acquisition and microbial transference was thought to increase. Salgado et al reported when the microbial burden for environmental surfaces collectively exceeded 500 CFU in an adult MICU, the rate with which HAI was acquired significantly increased. Here, we learned that collectively only 3% of the copper bed rails, 6% of the cradles, and 9% of the faucet handles from the pediatric sites were found to harbor concentrations above the postulated HAI risk threshold of 500 CFU/100 cm², whereas 68% of the polypropylene bed rails, 80% of the cradles, and 30% of the faucet handles from the control groups were found above this concentration (Fig. 3). However, more remarkably were the number of occasions when the microbial burden associated with copper surfaces fell below the limit of detection for our sampling protocol. Here 62% of the copper rails, 56% of the cradles, and 56% of the faucet handles failed to yield any microbial burden when sampled, whereas this was only the case for 1% of the control rails and 6% of the faucet handles (Fig. 3).

Interestingly, when the mean microbial burden of pre-intervention phase control objects was contrasted with the intervention phase control objects, the concentration observed was significantly lower; the mean ACC observed for the rails was reduced from 4,800 to 1,313 CFU/100 cm² and from 5,200 to 1,412 CFU/100 cm² for the faucet handles. This represented an almost 2 log10 reduction (log10 1.86; 73%) to the microbial burden resident on these critical surfaces in the control rooms (Table 3). A similar result was seen in the trial conducted in adult MICUs. Here, in a similar log10 reduction, 1.80 (63%) was observed for the microbial burden associated with bed rails from the preintervention phase when contrasted against the mean observed for the control beds, suggesting that an introduction of a continuously active, no-touch antimicrobial solution, such as copper surfaces, could have an ability to suppress the microbial burden in rooms located in close proximity to those containing an active antimicrobial agent, such as copper surfaces. Given that the study design was similar for both trials and the antimicrobial effect observed between the copper arms was nearly equivalent (log10 1.99 adult MICU vs log10 2.0 PICU), these data offer insight into future trial designs that will evaluate the utility of no-touch disinfection strategies for mitigating risk from the intangible microbial burden present in the patient care setting.
More than 45 years ago Spaulding suggested a predicted degree of risk associated with inanimate objects. Unfortunately, many of the objects found in the setting of patient care were relegated to the category of noncritical items, leading the infection control community to consider them unlikely to be responsible for significant transmission of infectious agents to patients given adherence to accepted hand hygiene practices and routine cleaning. However, it is now recognized that the bacteria responsible for many of the severe and debilitating hospital-acquired infections can survive for days, weeks, or months on these surfaces in spite of the best efforts of the health care team to keep the bacterial burden within limits considered safe for patient care. Several publications have argued that terminal cleaning must achieve a threshold where the microbes resident on those surfaces might be transferred to health care workers or patients, with others linking microbial burden to HAI risk. However, the frequency and efficacy with which cleaning may occur, especially in multibed rooms, represent a substantial challenge to the infection control community. Schmidt, Attaway, and colleagues established that in spite of the best cleaning and disinfection efforts, microbes easily re-establish themselves on frequently encountered surfaces within the patient care setting, such as the rails of beds. Copper-alloyed surfaces such as the ones used here offer a continuous way to limit and control the microbial burden. Hospital and environmental services need not perform additional steps, follow complex treatment protocols, or require additional training, oversight, or support from other workers for copper to manifest its antimicrobial activity.

It is intuitive to argue that to minimize the risk of HAI acquisition among the pediatric population, any method that can augment the effectiveness of hand hygiene and routine cleaning will likely contribute to the transmission of hospital pathogens and an overview of strategies to address contaminated surfaces in hospital settings. Am J Infect Control 2013;41 (Suppl):S6-S11.


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