

Comparative evaluation of nosocomial infections in two major hospitals in Calabar Metropolis, Cross River State

Abstract

Aim: This study comparatively evaluates nosocomial infections in two major hospitals in Calabar metropolis, Cross River State.

Place and Duration of Study: This study was carried out in two major hospitals including General Hospital and Infectious Disease Hospital located in Calabar, Cross River State, Nigeria. The study lasted for 2 months from samples collection to report writing.

Methodology: Bacteria and fungi were isolated using settle plate technique.

Results: A total mean load of 1002 cfu/m²/hr was recorded of which 612.1cfu/m²/hr was recorded in General hospital and 389.9cfu/m²/hr was recorded in Infectious Disease Hospital (IDH). Out of a total of 187 isolates characterized, 98 (54.4%) were gram negative, 33 (17.6%) were gram positive bacteria while 56(29.9%) were fungi. Furthermore, in General hospital, 99(52.9%) organisms were isolated of which 51 (51.5%), 16(16.2%) and 32(32.3%) were gram negative, gram positive bacteria and fungi respectively while in IDH, 47(53.4%), 17 (19.3%) and 24 (27.3%) out of 88 (47.1%) organisms isolated were gram negative, gram positive and fungi respectively.

Conclusion: The test isolates when subjected to antimicrobial susceptibility testing exhibited varied patterns of resistance to antibiotics/antifungal agents. This calls for effective monitoring of the air quality in healthcare settings in a bid to reducing nosocomial infections.

Keywords: Nosocomial infections, airborne, microbial load, resistant profile, Hospitals, Calabar

Introduction

Airborne sources of possible bacterial contamination of the environment of hospitals have long been debated as potential causes of increasing incidence of nosocomial infections. This has contributed to the already existing burden of nosocomial infections in the health care setup [1]. Nosocomial Infections (NI) also known as healthcare-associated infections (HCAI) or Hospital-acquired infections (HAI) are infections that arise within few hours of admission into the hospital and were not present at the time of admission. They have been reported globally in hospital environment resulting in major hazard confronting patients and personnel who are hospitalized [2]. These infections have been reported by Witherspoon [3] to be most often silent while the patient is still in the hospital and account for significant morbidity and mortality due to the daily interaction existing among personnel and asymptomatic individuals assembled under one roof, thereby encouraging the proliferation, spread and transmission of nosocomial infections among patients and hospital workers.

The healthcare environment including its units as revealed by Gupta [4] represent a significant facility in the healthcare settings, providing segregation, special care, accommodation, succor and protection for the sick. Despite advances in human capacity and technology development in the healthcare sector, many hospitals especially in developing countries are still faced with the challenges of nosocomial infections [5]. This may be due largely to the poor infection control practices in these hospitals [6]. The development of nosocomial infections and its severity involves locally recognized agents. However, the emergence and re-emergence of highly virulent infectious agents further compound the menace, contributing to the increase morbidity and mortality observed in hospitalized patients; increased burden of discomfort and high socio-economic cost [7].

Poor disinfection practices, ineffective use of antibiotics, monitoring of the hospital's air and units against overcrowding, management and inadequate surveillance teams to manage,

sustain and ensure that aseptic hospital ethics has further aggravated the problem [8]. In developing countries including Nigeria, these inadequacies abound in the hospital settings, creating a safe haven for nosocomial infections [9]. This has been confirmed by several reports including the one recorded by Muhammed *et al* [11] who reported high frequency of pathogenic bacteria including *Staphylococcus aureus*, *Proteus species*, *Pseudomonas aeruginosa*, *Escherichia coli*, *Bacillus cereus*, *Klebsiella species*, *Salmonella species* and *Shigella species* from hospital sinks, floors, bed covers, toilets and ward walls. Despite the clinical implications associated with nosocomial infections, few studies if any, have evaluated the impact of nosocomial infections within the major hospitals of the state. This study therefore was aimed at evaluating nosocomial infections in two major hospitals in Calabar metropolis, Cross Rivers State.

MATERIALS AND METHODS

Study site

This study was carried out in two major hospitals including General Hospital and Infectious Disease Hospital, all in Calabar metropolis, Cross River State, Nigeria which are located on latitude 4°59N and longitude 8°15E.

Sources of samples

Samples were collected in December 2016 using settle plate technique from various units including pharmacy, theatre, laboratory, blood bank and patient wards of General Hospital and Infectious disease hospital, all in Calabar metropolis, Cross River State.

Microbiological analysis

The air qualities of five units of each hospital was assessed by exposing plates in triplicates containing Nutrient agar, Sabouraud dextrose agar and blood agar, respectively for 1hour following procedures described by Centre for Disease Centre [11] after which plates were aseptically packaged and immediately transported to microbiology laboratory where they were incubated at 37°C for 24-48hours. After incubation, the plates were examined for growth and microbial load determined. Purified colonies were identified and characterized following standard microbiological procedures [12].

Antimicrobial susceptibility testing

This was done following procedures described by CLSI, (2004) and CLSI (2014) [13][14] for fungi and bacteria, respectively. Standardized inoculums were inoculated into plates containing freshly prepared Muller Hinton agar and allowed to stand for 15minutes. Then, antibiotic discs were placed aseptically on the surface of the inoculated plate using sterile forceps and pressed lightly to ensure contact with the agar surface and the plates were incubated at 35°C for 24-48hours. After incubation, zones of inhibition were measured and compared with appropriate interpretive charts.

Determination of Minimum Inhibitory Concentration (MIC) and Minimum Bactericidal Concentration (MBC)

This was performed following procedures described CLSI (2014)[14]. Briefly, 2-3 colonies of the test isolate was inoculated into 5ml of sterile peptone broth/SDB and incubated for 30 minutes. Antibiotics of various concentrations were dissolved in sterile test tubes containing 5ml of diluents (distilled water and DMSO, respectively) to make stock solutions. Doubling dilutions of the antibiotics in the order of 1:2, 1:4, 1:8, 1:16, 1:32, 1:64, 1:128, 1:256, 1:512 and 1:1024 were carried prepared. Standardized inoculums were added to each of the tubes

and incubated for 24-48hrs. The MICs were then determined. The MBCs were determined by sub-culturing tubes which showed no growth (turbidity) during the MIC tests into plates containing freshly prepared nutrient agar and sabouraud dextrose agar plates, respectively and incubated for 24-48hrs at 37°C.

Data analysis

Descriptive analysis such as simple percentages and student t-test was employed in this study.

RESULTS

Microbial load

The result of the microbial load and their percentages as observed in various units of GH and IDH are summarized in Table 1 and Table 2, respectively. In GH, pharmacy had a mean load of 128.9cfu/hr (21.1%) while ICU had a mean load of 129.9cfu/hr (21.2%). However, Laboratory, Blood bank and Ward had mean loads and percentages of 124cfu/hr(20.3%), 136cfu/hr(22.2%) and 93.7(15.3%), respectively. Similarly, in IDH, Pharmacy had a mean load of 67.4(17.4%), ICU 59.7(15.3%), Laboratory 115.8(29.7%), Blood bank 68.6(17.6%) and Ward78.4 (20.1%). Thus, a student t-test analysis of the sampled units revealed that only the intensive care unit was significant with a probability value of 0.02 at 0.05 significant levels.

Table 1: Microbial load in General Hospital (GH)

Units	Mean load	% load
ICU	129.9 cfu/hr	21.2%
Pharmacy	128.9 cfu/hr	21.1%
Ward	93.7cfu/hr	15.3%
Blood bank	135.6cfu/hr	22.2%
Laboratory	124cfu/hr	20.3%
Total mean load	612.1 cfu/hr	100%

Table 2: Microbial load in Infectious Disease Hospital (IDH)

Units	Mean load	% load
ICU	59.7 cfu/hr	15.3%
Pharmacy	67.4 cfu/hr	17.3%
Ward	78.4 cfu/hr	20.1%
Blood bank	68.6 cfu/hr	17.6%
Laboratory	115.8 cfu/hr	29.7%
Total mean load	389.9 cfu/hr	100%

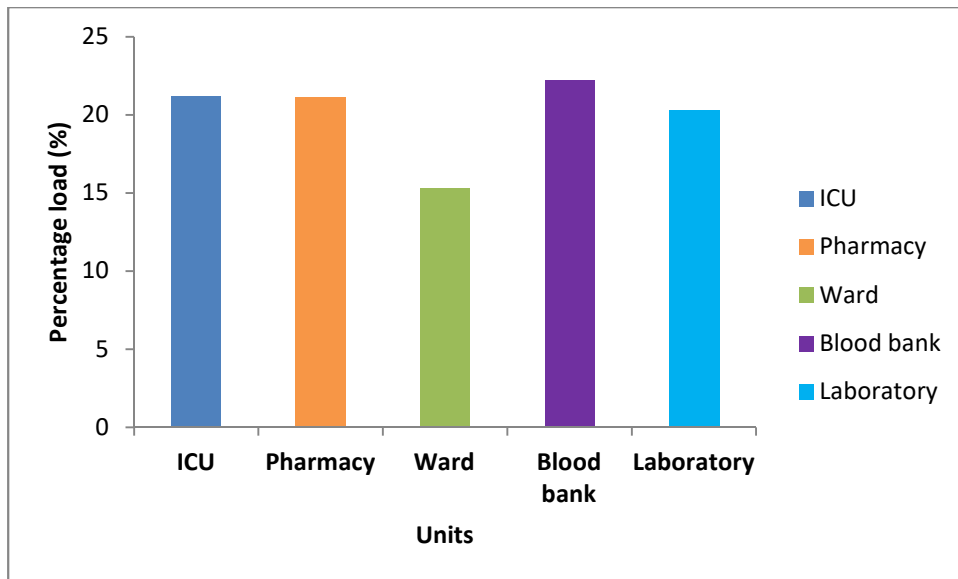


Figure 1: Percentage microbial load in General Hospital.

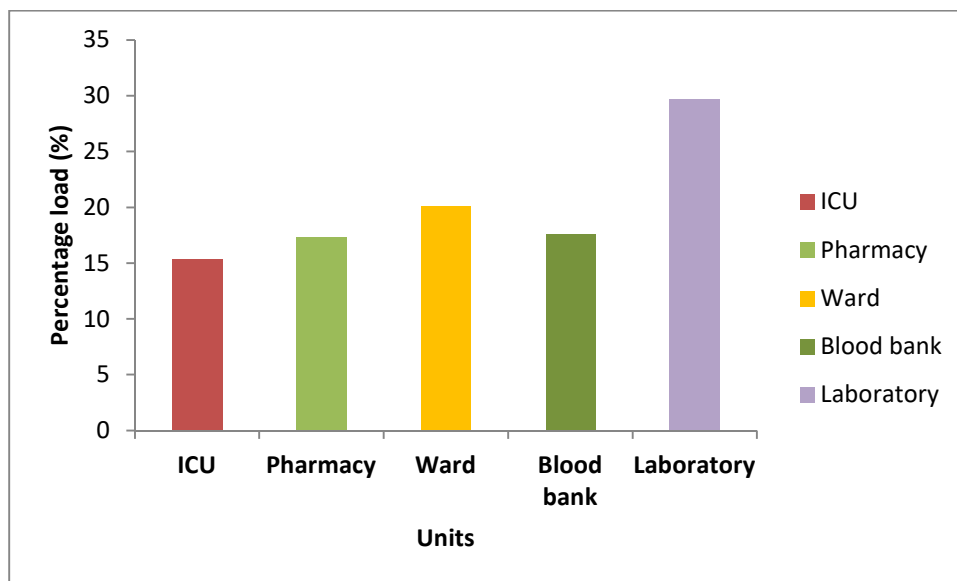


Figure 2: Percentage microbial load in Infectious Disease Hospital.

Table 3: Mean bacteria load (CFU/m²) of both locations

Units Sampled	GH	IDH
Intensive Care Unit (ICU)	129.90	59.70
Pharmacy	128.90	67.40
Ward	93.70	78.40
Blood Bank	135.60	68.60
Laboratory	124.00	115.80

*Represents significant probability at 0.05 level of significance.

A total of 187 isolates were recovered of which 99 (52.9%) and 88(47.1%) were recovered from General Hospital (Table 4) and Infectious Diseases Hospital (Table 5), respectively. In General hospital, the ward had the highest number of isolate of 23(23.2%) followed by, pharmacy 22 (22.2%), laboratory 21 (21.2%), Intensive care unit 17 (17.2%) and Blood bank 16 (16.1%). Similarly, in Infectious Diseases Hospital (Table 5), Blood bank and ward recorded the highest number of isolates 19 (21.6%), respectively followed by pharmacy 18(20.5%) while ICU and laboratory recorded 16 (18.2%), respectively.

Table 4: Distribution of Isolates in General Hospital units

Isolates (n-99, 52.9%)	Units				
	ICU (n-17, 17.2%)	Pharmacy (n-22, 22.2%)	Ward (n-23, 23.2%)	Blood Bank (16, 16.1%)	Laboratory (n-21, 21.2%)
<i>Escherichia coli</i> (9)	1(11.1)	3(33.3)	1(11.1)	1(11.1)	3(33.3)
<i>Salmonella</i> (9)	0(0.0)	3(33.3)	3(33.3)	1(11.1)	2(22.2)
<i>Candida species</i> (14)	3(21.4)	3(21.4)	2(14.3)	2(14.3)	4(33.3)
<i>Klebsiella species</i> (11)	3(27.3)	2(18.1)	3(27.3)	2(18.1)	1(9.1)
<i>Proteus mirabilis</i> (12)	2(16.7)	3(25.0)	3(25.0)	2(16.7)	2(16.7)
<i>Pseudomonas aeruginosa</i> (10)	3(30.0)	1(10.0)	2(20.0)	1(10.0)	3(30.0)
<i>Staphylococcus aureus</i> (11)	4(36.4)	1(9.1)	3(27.3)	1(9.1)	2(18.1)
<i>Pencillum species</i> (9)	0(0.0)	2(22.2)	3(33.3)	2(22.2)	2(22.2)
<i>Streptococci species</i> (5)	1(20.0)	1(20.0)	0(0.0)	2(40.0)	1(20.0)
<i>Aspergillus sp</i> (9)	0(0.0)	3(33.3)	3(33.3)	2(22.2)	1(11.1)

TABLE 5 : Distribution of Isolates in Infectious Disease Hospital (IDH)

Isolates (n-88, 47.1%)	Units				
	ICU (n-16, 18.2%)	Pharmacy (n-18, 20.5%)	Ward (n-19, 21.6%)	Blood bank (n-19, 21.6%)	Laboratory (n-16, 18.2%)
<i>Escherichia coli</i> (10)	3(30.0)	1(10.0)	3(30.0)	2(20.0)	1(10.0)
<i>Salmonella species</i> (12)	3(25.0)	1(8.3)	2(16.7)	2(16.7)	4(33.3)
<i>Candida species</i> (5)	1(20.0)	1(20.0)	2(40.0)	0(0.0)	1(20.0)
<i>Klebsiella species</i> (9)	2(22.2)	4(44.4)	1(11.1)	2(22.2)	0(0.0)
<i>Proteus mirabilis</i> (8)	0(0.0)	2(25.0)	3(37.5)	1(12.5)	2(25.0)
<i>Pseudomonas aeruginosa</i> (8)	1(12.5)	3(37.5)	1(12.5)	3(37.5)	0(0.0)
<i>Staphylococcus aureus</i> (7)	2(28.6)	2(28.6)	1(14.3)	0(0.0)	2(28.6)
<i>Penicillium sp</i> (10)	0(0.0)	2(20.0)	3(30.0)	2(20.0)	3(30.0)
<i>Streptococci species</i> (10)	3(30.0)	1(10.0)	1(10.0)	3(30.0)	2(20.)
<i>Aspergillus species</i> (9)	1(11.1)	1(11.1)	2(22.2)	4(44.4)	1(11.1)

Antimicrobial susceptibility pattern of isolates recovered from General hospital and IDH

Isolates employed in this study exhibited varying degrees of resistance to commonly used antibiotics as presented in Tables 6 and 7. In General hospital, *Salmonella species* showed resistance to tarivid and nalidixic acid. Other microbial isolates showed moderate to low resistance to antibiotics and antifungal agents as shown in Table 6. However, in IDH as shown in Table 7, *Escherichia coli*, *Salmonella species*, *Klebsiella species*, *Proteus species* and *P. aeruginosa* exhibited a wide range of resistance against tarivid, reflacine, ciproflox, ceporex, nalidixic acid and moderately ampiclin. These organisms however, showed low resistance to augmetin, gentamycin, septrin and streptomycin as shown in Table 6. In addition, *Staphylococcus aureus* strains exhibited marked resistance against norfloxacin, ciproflox, streptomycin and levofloxacin while *Streptococci* showed resistance to norfloxacin, amoxil, ciproflox, chloramphen, erythromycin, ampiclox and levofloxacin. Furthermore, *Penicillium* and *Aspergillus species* showed resistance to ketoconazole.

Table 7: Resistant patterns of test organisms isolated from IDH

Gram negative bacteria	OFX	PEF	CPX	AU	CN	S	CEP	NA	SXT	PN
<i>Escherichia coli</i> (10)	8(80.0)	9(90.0)	8(80.0)	4(40.0)	3(30.0)	2(20.0)	7(70.0)	7(70.0)	4(40.0)	5(50.0)
<i>Salmonella sp</i> (12)	8(67.0)	8(67.0)	7(58.0)	4(33.0)	6(50.0)	4(33.0)	6(50.0)	8(67.0)	8(67.0)	7(58.0)
<i>Klebsiella sp</i> (9)	8(89.0)	6(67.0)	7(78.0)	5(56.0)	6(67.0)	5(56.0)	6(67.0)	6(67.0)	5(56.0)	7(78.0)
<i>Proteus mirabilis</i> (8)	6(75.0)	7(88.0)	6(75.0)	5(63.0)	4(50.0)	3(38.0)	5(63.0)	6(75.0)	4(50.0)	6(75.0)
<i>Pseudomonas sp</i> (8)	6(75.0)	5(63.0)	5(63.0)	4(50.0)	6(75.0)	4(50.0)	5(63.0)	6(75.0)	5(63.0)	7(88.0)
Gram positive	NB	AML	CPX	RD	CN	S	CH	E	APX	LEV
<i>Staphylococcus aureus</i> (7)	6(86.0)	5(71.0)	6(86.0)	5(71.0)	4(57.0)	4(57.0)	6(86.0)	5(71.0)	5(71.0)	6(86.0)
<i>Streptococcus sp</i> (10)	6(60.0)	9(90.0)	6(60.0)	5(50.0)	5(50.0)	3(30.0)	7(70.0)	6(60.0)	6(60.0)	8(80.0)
Fungal Isolates	K	NY								
<i>Candida albicans</i> (5)	3(40%)	1(20%)								
<i>Penicillium sp</i> (10)	7(70%)	2(20%)								
<i>Aspergillus sp</i> (9)	6(67%)	2(22%)								

Table 6: Summary of resistant patterns of test organisms isolated from GH

Gram negative bacteria	OFX	PEF	CPX	AU	CN	S	CEP	NA	SXT	PN
<i>Escherichia coli</i> (9)	4(44%)	5(56%)	2(22%)	2(22%)	1(11%)	0(0%)	2(22%)	3(33%)	1(11%)	4(44%)
<i>Salmonella sp</i> (9)	6(67%)	5(56%)	3(33%)	3(33%)	4(44%)	2(22%)	5(56%)	6(67%)	5(56%)	4(44%)
<i>Klebsiella sp</i> (11)	5(46%)	4(36%)	5(46%)	3(27%)	3(27%)	3(27%)	4(36%)	5(46%)	3(27%)	4(36%)
<i>Proteus mirabilis</i> (12)	4(33%)	5(42%)	5(42%)	2(17%)	2(17%)	1(8%)	3(25%)	4(33%)	2(17%)	3(25%)
<i>Pseudomonas sp</i> (10)	4(40%)	3(30%)	3(30%)	2(20%)	5(50%)	0(0%)	3(30%)	4(40%)	3(30%)	5(50%)
Gram positive	NB	AML	CPX	RD	CN	S	CH	E	APX	LEV
<i>Staphylococcus aureus</i> (11)	5(46%)	5(46%)	4(36%)	3(27%)	2(18%)	2(18%)	4(36%)	3(27%)	4(36%)	4(36%)
<i>Streptococcus sp</i> (5)	4(80%)	3(60%)	4(80%)	3(60%)	3(60%)	1(20%)	4(80%)	3(60%)	2(40%)	2(40%)
Fungal Isolates	K	NY								
<i>Candida albicans</i> (14)	2(14%)	0(0%)								
<i>Penicillium sp</i> (9)	5(56%)	1(11%)								
<i>Aspergillus sp</i> (9)	4(44%)	1(11%)								
Keys:	OFX = TARIVID PEF = REFLACINE CPX = CIPROFLOX AU = AUGMETIN CN = GENTAMYCIN S = STREPTOMYCIN NY=NYSTATIN		CEP = CEPOREX NA = NALIDIXIC ACID SXT = SEPTRIN PN = AMPLICIN NB = NORFLOXACIN AML = AMOXIL			RD = RIFAMPICIN E = ERYTHROMYCIN CH = CHLORAMPHENICOL APX = AMPICLOX LEV = LEVOFLOXACIN K = KETOCONAZOLE				

Minimum Inhibitory Concentrations (MIC) and Minimum Bactericidal Concentrations (MBC) of test isolates

The MICs and MBCs of microbial isolates from the various locations are as shown in Tables 8 and 9, respectively. The MICs and MBCs of *E. coli*, *Salmonella species* and *P. aeruginosa* to various antibiotics ranged from 1:16 - 1:64 and 1:8 - 1:32 while that of *Klebsiella species* ranged from 1:16- 1:128 and 1:8-1:64, respectively. Furthermore, *S. aureus* recorded MICs and MBCs of 1:32 and 1:16 respectively while *Streptococci* recorded 1:16-1:64 and 1:8-1:32 respectively. In addition, *Candida* and *Aspergillus species* recorded MICs and MBCs in the range of 1:16-1:32 and 1:8 and 1:16 respectively. However, in GH, *E. coli* and *Streptococci* recorded MICs and MBCs in the range of 1:32-1:512 and 1:16-256 respectively while *Salmonella species*, *Klebsiella species* and *Proteus species* exhibited MICs and MBCs in the range of 1:64-1:512 and 1:32-1:256 respectively. Meanwhile, *S. aureus* and *P. aeruginosa* had MICs and MBCs in the range of 1:64-1:512, 1:32-1:128 and 1:32-1:1024 and 1:16-1:64 respectively. *Aspergillus species* recorded 1:64 and 1:32 as MIC and MBC while *Candida albicans* recorded 1:32-1:64 and 1:16-1:32 as MICs and MBCs respectively as shown in Table 9.

Table 8: Summary of MICs and MBCs of test isolate in IDH

Isolates	Test	OFX	PEF	CPX	AU	CN	S	CEP	NA	SXT	PN	NB	AML	RD	E	CH	APX	LEV	K	NY
<i>Escherichia coli</i>	MIC	1:32	1:32	1:12	1:64	1:16	1:32	1:16	1:16	1:64	1:32	NT	NT	NT	NT	NT	NT	NT	NT	NT
	MBC	1:16	1:16	1:64	1:32	1:8	1:16	1:8	1:8	1:32	1:16									
<i>Salmonella species</i>	MIC	1:32	1:32	1:32	1:16	1:32	1:64	1:64	1:32	1:32	1:64	NT	NT	NT	NT	NT	NT	NT	NT	NT
	MBC	1:16	1:16	1:16	1:8	1:8	1:32	1:32	1:16	1:16	1:32									
<i>Candida species</i>	MIC	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	1:16	1:32
	MBC																		1:8	1:16
<i>Klebsiella species</i>	MIC	1:64	1:128	1:64	1:64	1:16	1:32	1:64	1:16	1:32	1:64	NT	NT	NT	NT	NT	NT	NT	NT	
	MBC	1:32	1:64	1:32	1:32	1:8	1:16	1:32	1:8	1:16	1:32									
<i>Proteus mirabilis</i>	MIC	1:64	1:64	1:32	1:64	1:32	1:64	1:64	1:32	1:32	1:64	NT	NT	NT	NT	NT	NT	NT	NT	
	MBC	1:32	1:32	1:16	1:32	1:16	1:32	1:32	1:16	1:16	1:32									
<i>Pseudomonas aeruginosa</i>	MIC	1:32	1:32	1:64	1:16	1:16	1:16	1:128	1:64	1:64	1:32	NT	NT	NT	NT	NT	NT	NT	NT	
	MBC	1:16	1:16	1:32	1:8	1:8	1:8	1:64	1:32	1:32	1:16									
<i>Staphylococcus aureus</i>	MIC	NT	NT	1:32	NT	1:32	1:32	NT	NT	NT	NT	1:32	1:32	1:32	1:32	1:32	1:32	1:32	NT	
	MBC			1:16		1:16	1:16					1:16	1:16	1:16	1:16	1:16	1:16	1:16		
<i>Penicillium species</i>	MIC	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	1:64	
	MBC																		1:32	
<i>Sreptococcus species</i>	MIC	NT	NT	1:32	NT	1:32	1:64	NT	NT	NT	NT	1:16	1:64	1:32	1:16	1:32	1:32	1:64	NT	NT
	MBC			1:16		1:16	1:32					1:8	1:32	1:16	1:8	1:16	1:16	1:32		
<i>Aspergillus species</i>	MIC	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	1:32	1:16
	MBC																		1:16	1:8

Table 9: Summary of MICs and MBCs of test isolates in General hospital

Organisms	TEST	OFX	PEF	CPX	AU	CN	S	CEP	NA	SXT	PN	NB	AML	RD	E	CH	APX	LEV	K	NY
<i>Escherichia coli</i>	MIC	1:128	1:256	1:128	1:256	1:512	1:128	1:32	1:32	1:256	1:128	NT	NT	NT	NT	NT	NT	NT	NT	NT
	MBC	1:64	1:128	1:64	1:128	1:256	1:64	1:16	1:16	1:128	1:64									
<i>Salmonella species</i>	MIC	1:64	1:64	1:512	1:512	1:64	1:512	1:256	1:64	1:128	1:128	NT	NT	NT	NT	NT	NT	NT	NT	NT
	MBC	1:32	1:32	1:256	1:256	1:32	1:256	1:128	1:32	1:64	1:64									
<i>Candia species</i>	MIC	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	1:32	1:64
	MBC																		1:16	1:32
<i>Klebsiella species</i>	MIC	1:512	1:512	1:256	1:128	1:64	1:64	1:512	1:64	1:128	1:256	NT	NT	NT	NT	NT	NT	NT	NT	NT
	MBC	1:256	1:256	1:128	1:64	1:32	1:32	1:256	1:32	1:64	1:128									
<i>Proteus mirabilis</i>	MIC	1:64	1:64	1:512	1:64	1:256	1:256	1:64	1:64	1:64	1:256	NT	NT	NT	NT	NT	NT	NT	NT	NT
	MBC	1:32	1:32	1:256	1:32	1:128	1:128	1:32	1:32	1:32	1:128									
<i>Pseudomonas aeruginosa</i>	MIC	1:128	1:128	1:128	1:32	1:64	1:32	1:64	1:128	1:64	1:64	NT	NT	NT	NT	NT	NT	NT	NT	NT
	MBC	1:64	1:64	1:64	1:16	1:32	1:16	1:32	1:64	1:32	1:32									
<i>Staphylococcus aureus</i>	MIC	NT	NT	1:128	NT	1:128	1:128	NT	NT	NT	NT	1:128	1:64	1:64	1:256	1:64	1:128	1:512	NT	NT
	MBC			1:64		1:64	1:64					1:64	1:32	1:32	1:128	1:32	1:64	1:256		
<i>Penicillium species</i>	MIC	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	1:128	1:64
	MBC																		1:64	1:32
<i>Streptococcus species</i>	MIC	NT	NT	1:64	NT	1:32	1:32	NT	NT	NT	NT	1:64	1:32	1:64	1:64	1:64	1:64	1:512	NT	NT
	MBC			1:32		1:16	1:16					1:32	1:16	1:32	1:32	1:32	1:32	1:256		
<i>Aspergillus species</i>	MIC	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	1:64	1:64
	MBC																		1:32	1:32

Discussion

The hospital environment is a complex environment on its own and as such different microorganisms come to interact interchangeably resulting to infections and re-infections [16]. Several factors may determine which microorganism that will be responsible for a particular infection. Such factors may include the length and nature of which the patient was exposed, virulence, microbial load of microorganism and also the state of the patients defense [16]. Airborne source of possible bacterial contamination of the environment in the hospital setting has long been debated as potential threats for being an important cause of increasing incidence of nosocomial infections [16]. This can contribute to the already existing burden of nosocomial infections in health care set up [17].

This study revealed the total mean microbial load of various units in General hospital and Infectious disease hospital to be 612.1cfu/m²/hr and 389.9 cfu/m²/hr, respectively. The mean load observed in this study is higher than the results obtained by Omoigberale [18] in Ekpoma, Edo State, Nigeria. In addition, a higher mean load (612.1cfu/m²) was observed in General hospital (612.1cfu/m²) compared to 389.9cfu/m² recorded in IDH which is extremely above the acceptable 35cfu/m³ per room [16]. In General hospital, blood bank had the highest mean load of 135.6cfu/m² (22.2%) whereas in IDH, the largest was in the laboratory unit which accounted for 115.8 cfu/m² (29.7%). The higher load in blood bank unit could be due in part to moisture properties of the unit as well as the temperature which is usually maintained at a somewhat lower rate and to a larger extent, contamination due to poor disinfection of the phlebotomy site [19]. In addition, the finding of a higher mean load in the laboratory may not be unconnected to the fact that clinical samples containing a vast majority of microorganisms are usually collected and processed there. The temperature, humidity, nutrient media used in the laboratories as well as storage conditions could be contributory factors [20]. Also, this high mean load could also be attributed to poor ventilation in the units. A mean load of 129.9cfu/m² (21.2%) observed in the intensive care unit of GH where patients with critical conditions are kept is worrisome and calls for urgent review of disinfection protocols. Studies have shown that air, temperature, relative humidity, ventilation systems, outdoor penetration and occupant density influence the quantity of airborne pathogens [16][21].

Furthermore, a total of 99 isolates were recovered from General hospital of which 67(67.7%) were bacteria and 32 (32.3%) were of fungal origin while in IDH, a total of 88 isolates were recovered of which 64(72.7%) were bacteria and 24 (27.2%) were fungal isolates. Organism including *Escherichia coli*, *Salmonella species*, *Klebsiella species*, *Candida species*, *Staphylococcus aureus*, *Aspergillus species*, *Penicillium species*, *Proteus mirabilis*, *Streptococcus species* and *Pseudomonas aeruginosa* were isolated in both hospitals [17]. The most isolated organisms in location one were *Candida sp* and *Staphylococcus aureus* were the most common in the laboratory and intensive care unit whereas in IDH, *Salmonella sp*, *Klebsiella sp*, and *Aspergillus sp* which showed high occurrence in laboratory, pharmacy and blood bank respectively whereas in location two, Generally, fungal isolates accounted for 29.9% of all microbial isolates. Though, 32.3% and 27.3% of fungi were isolated from General hospital and IDH, respectively.

In addition, gram negative organisms were more predominant (52.4%) in the environment of these two hospitals than gram positive organisms (17.6%) and fungi (29.9%). This is in line with researches conducted by Musaddiq [22] and Garcia-Cruz [23] where they observed that gram negative organisms were more common in the hospital environment than gram positive ones. The high percentage of gram negative organisms observed in this study is extremely higher than 4.9% reported by Lemmen [24]. The high occurrence of gram negative bacteria in the hospital environment may also be due to their ability to withstand

adverse environmental conditions. Also, fungal isolates including *Aspergillus*, *Candida* and *Penicillium species* were the most dominant fungi isolated from these hospitals. This is consistent with findings of other researchers including Garcia-Cruz [23], and Abdollahi and Mahmoudzadeh [25] who confirmed the dominance of *Penicillium* and *Aspergillus species* in hospital units.

Furthermore, test isolates were subjected to a series of susceptibility testing in General hospital were observed to be less resistant to commonly used antibiotics than test organisms isolated in IDH. *E. coli* isolated from IDH showed considerable resistance to antibiotics including tarivid, reflacine, ciprolox, augmentin, gentamycin, streptomycin, ceporex, nalidixic acid, septrin and ampicin compared to *Escherichia coli* strains isolated in General hospital where the highest number (5) was observed with reflacine. The percentage of *P. aeruginosa* resistance (30-63%) to ciprofloxacin recorded in this study is in line with 60-70% reported by Kumari *et al* [25]. 33-80% resistance exhibited by gram negative organisms against tarivid in this study is somewhat lower than 91% reported by Gandham and Amatullah [27]. The resistance range of 27-71% of rifampicin against gram positive organism observed in this study is extremely higher than 14% reported by Omoigberale *et al* [18]. However, amoxil resistance of 100% against gram positive organism reported previously [18] is consistent with 46-90% observed in this study.

In IDH, *Salmonella species* showed more resistance (8) to tarivid, reflacine and nalidixic acid while in General hospital, the highest (6) was seen with tarivid and nalidixic acid, respectively. *Klebsiella species* and *Proteus mirabilis* isolates showed a peak resistance with tarivid and reflacine respectively in IDH while in General hospital, both isolates were high respectively. *Pseudomonas aeruginosa* from IDH showed a higher rate of resistance with ampicin compared to General hospital that showed resistance to both ampicin and gentamycin.

Also, gram positive and fungal isolates from IDH also displayed greater resistance patterns compared to General hospital. This marked resistance of isolates observed in IDH may be due to poor use and misuse of antibiotics in the hospital environments.

The MIC and MBC of the test isolates obtained in this study showed General hospital has the highest MIC and MBC values compared to IDH. *Escherichia coli* showed a maximum MIC and MBC with Ciprofloxacin (MIC 1:128; MBC 1:64) in IDH while in General hospital, gentamycin (MIC 1:512; MBC 256) were the known concentration. *Salmonella species* has a maximum concentration of MIC and MBC of 1:64, 1:32 with ceporex and ampicin respectively whereas in IDH, the highest concentration of *Salmonella species* isolates were with ceproflox, augmentin and Streptomycin at MIC 1:512 and MBC 1:256 respectively, *Klebsiella species* in General hospital showed MIC and MBC of 1:512 and 1:256 for tarivid, reflacine and ceporex respectively while in IDH, it was just reflacine at a concentration of 1:128 and 1:64. *Staphylococcus aureus* and *Streptococcus species* which were the gram positive showed the same concentration of MIC and MBC with levofloxacin in General hospital but this varied in IDH. For fungal isolates in IDH, the concentration of MIC and MBC was seen with ketoconazole (MIC 1:64, MBC 1:32) for *Penicillium species* whereas *Penicillium species* which is the highest also in General hospital were MIC1:128 and MBC1:64 with the same antibiotics.

Conclusion

The findings in this study highlight the fact that air quality of the hospital environment is an important reservoir of microbes and thus, there is need for monitoring of the hospital air especially in the units. Furthermore, hospital management, medical personnel and patients should be encouraged to imbibe good levels of hygiene in order to help reduce nosocomial infections.

Conflict of interest

The authors declare no conflict of interest exist.

References

- [1] Saini S, Munshi N. Hospital infection control: overview and introduction In: Hospital infection control. S. Saini and R. Saini (Editors) 1st edition, Paras Medical Publisher, New Delhi; 2012
- [2] Rubino JR. Infection control practices in institutional setting. *American Journal of Infection Control*. 2001; 29:241-243.
- [3] Witherspoons H. Nosocomial infection [http://Articles.com/Expert=James waterspoon](http://Articles.com/Expert=James%20waterspoon). Retrieval 12/05/2017; 2012.
- [4] Gupta S. Operation theater design In: Hospital infection control, S. Saini and R. Saini (Editors) 1st edition, Paras Medical Publisher, New Delhi; 2012.
- [5] Shorr AF. Review of Studies of the impact of gram-negative bacterial resistance on outcome in the intensive care unit. *Critical Care Medicine*. 2009; 37: 1464-1469.
- [6] Samuel SO, Kayode OO, Musa OI, Nwigue GC, Aboderin AO, Salami TA, Taiwo SS. Nosocomial infection and the challenge of control in developing countries. *African Journal of Clinical and Experimental Microbiology*. 2010; 11: 102-110.
- [7] Maudlin PD, Salgado CD, Hansen IS. Attributes hospitals with health care-associated infection caused by antibiotic-resistant gram-negative bacteria. *Anti-microbial Agents and chemotherapy*. 2010; 52: 813-821.
- [8] Larson EI, Quire D, Lin SX. Dissemination of the COCs hand hygiene guidance and impact on Infection rates. *American Journal of Infection Control*. 2007; 35: 666-675.
- [9] Jombo G TA, Emanghe U E, Amefule EN, Damen JG. Urinary tract infection at a Nigeria University hospital: Causes, pattern and antimicrobial susceptibility profile. *Journal of Microbiology and Antimicrobial*. 2011; 3: 153-159.
- [10] Muhammed UK, Mustafa AI, Zainab, MA. Distribution of potential nosocomial pathogens isolated from environment of four selected hospital in Sokoto, North Western Nigeria. *Journal of Microbiology and Biotechnology Research*. 2013; 3:139-143.
- [11] Centers for Disease Control and Prevention (CDC). Guidelines for environmental infection control in health-care facilities: recommendations of CDC and the healthcare infection control practices advisory committee (HICPAC). *MMWR*. 2003; 52:89-94.

- [12] Holt JG, Kreig PHA, Sneath & Wilkins ST. Bergey's manual of determinative bacteriology. 9th edition, Maryland, Williams and Wilkins Baltimore, USA; 1995.
- [13] Clinical Laboratory Standard Institute (CLSI) (2004). Method for disk diffusion susceptibility of yeast. Approved guidelines-third edition, M44-A. CLSI document, PA, USA, Wayne; 2004.
- [14] Clinical Laboratory Standards Institute (CLSI) (2014). Performance standards for antimicrobial susceptibility testing; Twenty-fourth informational supplement, M100-S24. PA, USA, Wayne; 2014.
- [15] Anderson KN, Andereson LT, Glanzc WD. (Editors). Mosby's Medical, Nursing and Allied Health Dictionary. (6th edition) St. Louis: The C. V. Mosby Company; 2006.
- [16] Prathab AG, Lalitha C. Microbiological surveillance of air quality in operation Theatres-comparison of the conventional settle plate techniques vs use of an air sample device. Journal of Evolution of Medical and Dental Science.2012; 1;371.
- [17] Huang P, Shi ZY, Chen CH, Den W, Huang, HM, Tsai JJ. Airborne and surface bound microbial contamination in two intensive care units of a medical central Taiwan. Aerosol and Air quality Research. 2013; 13: 1060-1069.
- [18] Omoigberale MNO, Amengialore OO, Iyamu MI. (2014). Microbiological assessment of hospital indoor air quality in Ekpoma, Edo State, Nigeria. *Global Research Journal of Microbiology*. 2014; 4:1-5.
- [19] Honohan, A. Olthius, H. Bernards, A. T. Van. Beckhoven J. M. & Brand A. (2002). Microbial contamination of cord blood stems cells. *Blackwell Science Ltd VoxSanguinis*, 82: 32-38
- [20] Moses DN. Isolation, identification and characterization of microbial contaminant in selected biosafety laboratories in Kenya submitted to Kenyatta University Institutional Repository. A Master of Science Thesis; 2015.
- [21] Chang C, Tseng I, Ynag I. Microbial air contamination in an intensive care unit. Institute of Advance Engineers and Science. 2015; 4:145-151.
- [22] Mussaddiq M, Snehel N. Antimicrobial susceptibility pattern are enteromicrobial susceptibility pattern of Enterobactenaceae isolated from tertiary care unit in Akola city. *Pratibha: International Journal of Science, Spirituality Business and Technology*. 2012; 1:1.
- [23] Gracia-Crux CP, Arguilar MJM, Arroyo-Helguera OE. Fungal and bacterial contamination on indoor surface of a hospital in Mexico. Jundishaper Journal of Microbiology. 2012; 4:460-464.
- [24] Lemmon SW, Hafiner H, Zolldann O, Stanzel S, Luttichek R. Distribution of multi-resistant gram-negative versus Gram-positive bacteria in the hospital inanimate environment. Journal of hospital infection.2004; 56:191-197.

- [25] Abodullahi A, Mahmoudzadeh S. Microbial profile of air contamination in hospital wards. *Iranian Journal of Pathology*. 2012; 7:177-182.
- [26] Kumari HB, Nagerathna S, Chandranmuki A. Antimicrobial resistance pattern among aerobic gram-negative bacilli of lower respiratory tracts specimens of intensive care unit patients in neuro-centre. *Indian Journal of Chest Diseases and Allied Science*. 2007; 49:63-7.
- [27] Gamgham P, Amatullah P. Antibiotic susceptibility and resistance pattern of Enterobacteriaceae in a teaching hospital in a rural area. *Journal of Microbiology and Biotechnology Research*. 2015; 5:1-4.