American Journal of Infection Control 44 (2016) 846-50

Contents lists available at ScienceDirect

American Journal of Infection Control

journal homepage: www.ajicjournal.org

Brief Report

Prevention of transmitted infections in a pet therapy program: An exemplar

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Key Words:
Pet therapy
infection prevention

The focus of the patient experience in health care delivery has afforded the opportunity to integrate pet therapy as a part of patient care. The purpose of this article is to present the implementation of a pet therapy program that includes guidelines for the prevention of transmitted infections. Consideration of infection prevention strategies has resulted in a 16-year program with no documented incidences of transmitted infections, averaging 20,000 pet therapy interactions per year.

PET THERAPY INFECTION MONITORING

The focus of the patient experience in health care delivery has afforded the opportunity to integrate pet therapy as a part of patient care. Evidence of the human-animal bond,[1] and the therapeutic benefits of using pets for improving patient outcomes,[2-8] strengthens the validity of including pets in a holistic approach to patient-centered care. Transmission of infections from animals to humans creates a necessity to consider infection preventive strategies in the implementation of a hospital-based pet therapy program. Guidelines have been recently published by the Society for Healthcare Epidemiology of America on the safe oversite and management of animals in the health care setting.[9] The purpose of this article is to present the implementation of a pet therapy program in a regional tertiary care hospital that began prior to the guidelines being published. The strategies of implementation include the infection prevention considerations that resulted in a 16-year program with no documented incidences of transmitted infections from an average of 20,000 pet therapy interactions per year between patients and dogs (Table 1).

PET THERAPY TEAM

Since 1999, the pet therapy team at the regional tertiary care hospital included infection prevention to develop program policies and protocols, along with risk management, child life specialists, safety officers, security, volunteer services, veterinarians, and administration. In addition, other health care facilities were consulted and literature was reviewed to gather information relevant to any transmission of infection from dogs to humans in the hospital setting. The conclusion was reached by the pet therapy team that with careful preparation of the dogs, handlers, environment, and patients that the risk of infection was very low, and the benefit to the patient outweighed the risk.

PREPARATION OF HANDLERS AND THERAPY DOGS

The handler-dog team must be registered with either Pet Partners or Therapy Dog Inc, which are national animal human bond registration organizations. The human handler must pass an online class and be evaluated as a human-dog team by a licensed evaluator. The evaluation includes a combination of human and dog temperament, skills, and aptitude.

Once the handler-dog team is registered, the volunteer handler goes through the process of becoming a hospital volunteer that included application, interview, orientation, background check, proof of immunizations for both human and dog, and references. Handlers shadow experienced teams prior to bringing their dog partner into the hospital. Identification badges are issued for both the handler and the dog, and dress code requirements are reviewed. Records are kept on both volunteer handlers and dogs and have been reviewed in The Joint Commission visits, County Health Department visits, and other accrediting organizations.

Part of the expectations for dogs participating in pet therapy is an up-to-date veterinary record and grooming requirements prior to visits. Dogs must have their identifications badges clearly displayed and adhere to leash, collar, or harness requirements. For example, retractable leashes, prongs on collars, and metal or choke collars may not be used during pet therapy visits.

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Conflicts of interest: None to report.

0196-6553/© 2016 Published by Elsevier Inc. on behalf of Association for Professionals in Infection Control and Epidemiology, Inc.
http://dx.doi.org/10.1016/j.ajic.2016.01.007

Table 1
Patients, staff, and visitors served in 2014 by a pet therapy program in a tertiary care regional health system shown by area or facility

Area/facility	No. of patients	No. of staff	No. of visitors	Service start date
Adolescent copestone*	357			July 2013
Adult oncology†	106	238	190	May 2001
Asheville cardiology	427	454	183	February 2014
Asheville specialty hospital*	138	350	279	January 2004
Cardiology step down†	105	407	106	November 2009
Children's copestone*	424			June 2009
Geriatric copestone*	176			April 2004
Heart tower waiting†		9	674	July 2013
Huff center waiting†	1,198	303	1,420	July 2008
Infusion services†	937	567	796	March 2012
Medical-surgical progressive care†	135	651	634	June 2012
Neurotrauma ICU waiting room†		404	819	July 2002
Neurosciences/spine†	155			June 2002/January 2010
Pediatric inpatient†	511	304	441	October 1999
Pediatric hematology/oncology†	145	253	261	March 2006
Pulmonary†	20	68		June 2014
Radiation therapy†	1,708	1,482	1,700	January 2009
Rathbun house		78	742	May 2007
Renal medicine†	52	221	52	July 2013
Reuter waiting†	649	602	480	February 2013
St. Joseph's waiting†		38	128	August 2014
Staff visits†		77		September 2013
Surgery waiting		345	1,962	June 2007
Trauma care/general surgery†	129	413	349	June 2009
Women's surgery/maternal-fetal†	202	503	380	February 2005/June 2009
Total	7,574	7,767	11,596	Grand total: 26,937

NOTE. The pet therapy program began in 1999 on the pediatric inpatient unit. Program growth is shown through 2014. This growth has been possible through administrative support provided by funding and program personnel. Oncology service areas are included because of selective screening of patients by clinical personnel. References to surgery or ICU refer to waiting rooms only in which services are provided to visitors and hospital staff and provide no patient contact.
ICU, intensive care unit.
*Areas with clinical staff.
†Areas with leash-less volunteers.

POLICY PLANNING AND INITIAL PILOT OF PET THERAPY PROGRAM

An initial 90-day pilot was designed by the pet therapy team and included strict protocol for implementation. Included in the protocol were the following characteristics: (1) the patient's physician had to agree to order a pet therapy visit; (2) the physician assessed the patient's immune status, current infection status, surgical status, and readiness for the pet therapy visit; (3) logs were kept of the patient visits; and (4) evaluation by the health care team and infection prevention staff to determine any change in the patient's infection status was performed after every pet therapy visit.

Within the policy of the pet therapy program are patient and area restrictions that include the following: (1) patients having a surgical-invasive procedure within the last 24 hours; (2) patients with compromised immune systems (absolute neutrophil count <1,500); (3) patients with dog allergies; (4) patients with fear of dogs; and (5) isolation patients. To protect the environment from contamination, pet therapy is restricted from the following areas: (1) pre- and postoperative areas; (2) operating rooms; (3) intensive care units; and (4) areas where food, medication, sterile supplies, and linens are kept (Table 2).

INDIVIDUAL VISIT PROCESS

Each handler-dog team has a designated area and time for their visit. Each unit designated as an approved area for pet therapy has a health care staff member that creates a list of potential patients who are eligible for the pet therapy intervention. The list is provided to a leash-less volunteer that reports to the unit prior to the handler-dog team visiting the area. The leash-less volunteer explains the pet therapy program to the individual patient and family and secures consent for the program. The leash-less volunteer then meets the handler-dog team in the main lobby of the hospital and escorts the handler-dog team to the patient area. The leash-less volunteer also accompanies the pet therapy team to the individual patient rooms that have consented.

Hand hygiene is a cornerstone to prevent infection; therefore, each volunteer has alcohol-based hand hygiene solution that is used before and after petting the dog. A clean sheet is placed on the bed or lap prior to the dog visiting. After the visit, the sheet is folded carefully and placed with the dirty linen. The area is cleaned by environmental services after each animal visit.

OUTCOMES AND CONCLUSION

A strong foundation was laid in 1999 by the pet therapy team, which has provided the program with growth opportunities as shown by Table 1. Services began on the pediatric floor and have grown to serve 28 areas of the health system in 2014. This solid base has also allowed for program personnel and funding, which supports service expansion. By having infection prevention professionals on the pet therapy team from the start resulted in strict design protocols and no documented transmitted infection rate. The program creation closely matched the Society for Healthcare Epidemiology of America guidelines, and the few contradictions have been carefully considered with the benefits thought to outweigh the risk. Current research is being proposed to further measure positive patient outcomes using pet therapy and demand increases for this valuable patient intervention.