A new role to reduce the incidence of health care-associated infection


Patient may uncover wounds to show visitors without washing their hands, and visitors rarely wash their hands on arriving at hospital, yet have direct contact with patients through handshakes and hugs. If they get to know other patients on a ward, they may also have direct contact with them too.

A new lead in infection control

The DoH (2003) report includes a seven-point action plan to tackle HCAIs on a number of fronts. This includes:

- Instituting additional mandatory surveillance;
- Reducing the risks associated with catheters and other indwelling devices;
- Reducing the use of antibiotics;
- Developing a research strategy.

The report also requires hospital and primary care trusts to take a number of managerial and organisational steps to tackle HCAIs. One of these steps is to designate a director of infection prevention and control (Box 1). But will this have any effect on HCAIs?

Nicola Pratelli, infection control and clinical risk adviser at Richmond and Twickenham Primary Care Trust, believes the new role could work well, but has concerns about the way it is being set up in some trusts. 'The ones I’ve heard about are being set up in tandem with another role. If the role is just tacked on to the job of an already hard-pressed professional they just aren’t going to have the time to do it,’ she says.

Ms Pratelli sees it as a role that many infection control nurses could take on. ‘They have the clinical expertise gained over years, and they’ve had to develop leadership and management skills to do their job. For many of them it’s just a logical step up,’ she says.

A DoH spokesperson confirmed the role will normally be an additional responsibility for an existing senior health care professional, but said this would be a local decision. ‘We would expect senior infection control nurses to be among the professions designated as directors of infection prevention and control,’ she added. The director would be able to offer managerial support to the infection control team, and have the authority to challenge inappropriate clinical practice and antibiotic-prescribing decisions.

At University Hospital Lewisham the role has been taken on by the director of operations and nursing. However, Annette Jeanes, senior infection control nurse, believes it can still be effective. ‘In the last couple of weeks the director has really turned things around,’ she says. ‘She has totally changed the profile of the infection control department – the whole trust is now taking the issue very seriously.

‘It’s allowed us to clarify our role and take infection control to the board in a way they understand. The director is speaking to them about key result areas and demonstrating improvements, so suddenly we have someone on the board who speaks their language.’

Ms Jeanes also believes the director will tackle infection control more widely than the infection control team. ‘Our medical staff are some of the best in terms of hand hygiene because they see patients after discharge, so see the effects of poor practice. Our problems are with other staff such as porters and domestics, who don’t see themselves as having a role in infection control.

‘We’re working to make infection control more inclusive so they can see where they fit in. The beauty of having the director is that she’s not just responsible for nurses, so she can influence all areas of the trust – she has the power to make things happen.’

Ms Pratelli agrees that directors will have more influence: ‘They may be able to influence staff compliance as they’ll be a focus, and they should also have funding. And being a director will give them the clout they need. You often get people saying “Well who are you?” when infection control nurses talk to them about poor practice, but if they’re a director they have that extra influence.’

The Infection Control Nurses Association has welcomed the action plan, although it cautions that it will need full financial and managerial support to succeed – and the staff to make it work.

‘To implement an effective infection prevention and control programme, sufficient numbers of appropriately trained infection control nurses must be in post in every trust,’ says ICNA chair Christine Perry. ‘They must also be given the necessary authority within the trust to implement change and challenge poor practice. Trust cultures must ensure that infection prevention and control is integral to all risk, quality and governance systems.’

Conclusion

The action plan to tackle HCAIs has the potential to significantly reduce the costs incurred by the NHS as a result of these infections – and the suffering caused to patients and their families. However, if it is to have any chance of success, all trusts will have to take infection control issues seriously and ensure all staff adhere to the long-established principles of good practice. This will require support and commitment at board level to ensure there is the necessary financial and managerial support. Properly resourced, the role of director of infection prevention and control may help trusts to make the cultural changes required to protect patients from unnecessary infections.
There have been many initiatives to improve cleanliness and infection control in UK hospitals over the years. These include the establishment of dedicated infection control teams and, more recently, the introduction of modern matrons, who have the authority – and budget – to take action to improve cleanliness in clinical areas.

Countless educational initiatives have been implemented both locally and nationally to inform health care staff at all levels of the importance of basic hygiene measures. In addition, a range of national standards and guidelines has been issued that give health care providers advice on current best practice (Department of Health, 2003, 2000a, 2000b; National Institute for Clinical Excellence, 2003).

However, Strachan-Bennett (2004) reports that health care-associated infection (HCAI) remains a major problem within the NHS. A recent Department of Health report (DoH, 2003) revealed that HCAIs are estimated to cost £1bn a year in the UK. Their cost to patients in terms of suffering, longer stays in hospital, loss of income and even mortality is incalculable.

Increased bacterial resistance to antibiotics makes many infections extremely difficult to treat. Incidence of meticillin-resistant Staphylococcus aureus (MRSA) is increasing in the UK (DoH, 2003) and there have been reports of resistance to vancomycin – the drug of choice to treat MRSA (Health Protection Agency, 2002).

Influencing clinical practice Despite all efforts to reduce HCAIs, there appears to be difficulty in persuading staff to adopt good infection control practice, particularly in the area of hand hygiene. In some cases this may be because busy staff fail to recognise the significance of fleeting contact with patients. However, as Jeanes reports (p49), despite a general understanding of the importance of hand hygiene, some staff appear to feel the rules do not apply to them, and react aggressively when challenged.

As Rowley points out (p50), the existence of different approaches and terminology – often within the same hospital or trust – may cause confusion and result in non-compliance.

The basic principles of infection control were established shortly after the discovery of bacteria and viruses in the late 19th century (Sneddon and Fraser, 2000), and remain largely unchanged:

- Oversee local policies and their implementation
- Be responsible for the infection control team
- Report directly to the trust’s chief executive and board
- Have the authority to challenge hygiene practice and antibiotic use
- Assess the impact of new and existing policies on infection control and make recommendations for change
- Be an integral member of the clinical governance and patient safety teams
- Produce an annual report on HCAIs in their organisation, and make this publicly available

The rise in HCAIs is not only due to poor clinical practice. Some may claim that standards have fallen since the days when nursing was more regimented and controlled by matrons, but nurses today care for patients at increased risk of infection (DoH, 2003).

Advances in technology and medical techniques mean that many patients, such as those receiving treatment for cancer, are particularly vulnerable to infection due to compromised immune systems. This also applies to patients with HIV and Aids. Increased use of indwelling devices such as intravenous (IV) lines and catheters means many patients’ normal defence mechanisms are breached, giving bacteria open access. In addition, factors such as high bed occupancy, poor staff-patient ratios and the mixing of patients with different health problems increases the risk of cross-contamination.

Patients themselves – and their visitors – can also increase the risk of infection (Strachan-Bennett, 2004).