

Surgical site infections

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Surgical Site Infections Elizabeth Griffor HCA 375 Continuous Quality Monitoring & Accreditation Instructor: Annajane Schnapp October 27, 2012 I chose to do my paper on the hospital-acquired condition of surgical site infections. In this paper I will discuss what a surgical site infection is, why it is considered preventable, the legal implications related to the patient, the role disclosure plays, accreditation expectations, and analyze the cost of continuous quality monitoring as it relates to quality.

Surgical site infections account for 40 % of all hospital-acquired infections (HAIs) and are unnecessary and largely preventable. Use of antibiotics is fundamental in preventing surgical site infection and includes three core elements: 1. appropriate selection, 2. timing of the first dose, 3. and discontinuation postoperatively. It used to be the standard practice to “shave and prep” a patient prior to surgery, but a study done in 1992 revealed that surgical site infections were 50% lower in surgery patients whose hair was removed with clippers rather than a razor.

One of the most common complaints from surgery patients is being cold in the holding area, operating room, and the post anesthesia care unit (PACU) . This is uncomfortable and can increase risk of complications; such as surgical site infections. Glucose control is also important as a method for decreasing surgical site infections (Frances, 2005). Guidelines for preventing surgical site infection are at the preoperative stage, intraoperative stage, and postoperative stage. They are as follows: 1. Preoperative stage: Patient preparation- Identify and treat all infections before surgery; postpone surgery if possible until infection is resolved. * Do not remove hair by the incision site unless it interferes with the operation; use electric clippers

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immediately before surgery if hair must be removed. * Have patients bathe or shower with an antiseptic the day of the surgery or the night before. * Thoroughly wash and clean at and around the incision site to remove gross contamination. * Keep hospital stays as short as possible to limit the patient's exposure to nosocomial infections.

Antimicrobial prophylaxis- * Work with the physician, pharmacist, and administer a prophylactic antibiotic only if it is indicated; antibiotic chosen should be effective against common pathogens that cause surgical site infections. * I. V. administration of the antibiotic should be timed so it is concentrated when the incision is made. * Do not use Vancomycin for antimicrobial prophylaxis routinely. Surgical team preparation- * Keep fingernails short, no artificial nails; bacteria and fungi can colonize on your hands if you wear artificial nails. Surgical team members who have signs or symptoms of an infectious illness need to promptly report this to their manager and occupational health service personnel. * Surgical team members that have draining skin lesions should be relieved from duty until infection has been ruled out, they have had therapy, or the infection is gone. * It is also suggested that no hand or arm jewelry be worn, as well as nail polish. 2. Intraoperative stage: Ventilation- * Maintain ventilation in the operating room and maintain a minimum of 15 air changes per hour. Keep the operating door closed as much as possible. * Limit the number of staff entering the operating room. Surfaces and equipment- * Clean surfaces or equipment with hospital disinfectant if they are soiled with blood or body fluids before the next operation. * Do not perform special cleaning or closing of operating room after contaminated or dirty operations. * Sterilize all surgical

equipment according to guidelines. * Assemble sterile equipment and solutions just before using them. Surgical attire- * Before entering the operating room, a surgical mask and hood that covers the hair on the face or head must be worn. * Sterile surgical gloves must be worn, putting them on after a sterile gown. * Shoe covers are not necessary for preventing surgical site infections. Vascular access- * Adhere to the rules of asepsis when placing intravascular devices and administering I. V. drugs. 3. Postoperative stage: Incision care- * Use a sterile dressing for 24-48 hours on an incision after surgery. * Wash your hands before and after any contact with the surgical site, even when changing the dressing. Use a sterile technique when changing dressings. * Teach the patient and family about incision care, signs or symptoms of surgical site infection, and when to report any symptoms (Adams, 2001). Following these guidelines can effectively reduce or prevent surgical site infections. Although nothing is 100% full proof, surgical site infections can be reduced and prevented in most situations. If an infection is not present at the time of admission and becomes evident after 48 hours of hospitalization; it is considered to be hospital acquired.

Following the above mentioned guidelines indicates quality health care practices. By using these techniques, surgical site infections will be prevented and reduced resulting in quality care; benefiting both the patient and the hospital. A legal implication related to a patient developing a surgical site infection, results in more cost to the hospital, less profit, and leaves them open to possible lawsuits. Hospital acquired infections affect 1. 7 million hospitalizations, cost \$ 8. 1 billion to treat, and lead to 2. 3 million total days of hospitalization.

Infections are the fourth most expensive in hospitals, costing \$ 252, 600 per hospital on average, and each afflicted patient requires \$ 24, 500 more in care on average as a result. Examples of lawsuits filed due to hospital infections are as follows: July 2008, couple awarded \$ 2. 58 million after the patient contracted a deadly type of staph infection (MRSA), resulting in the loss of a kidney, and an amputated leg and foot. November 2008, jury awarded \$ 13. 5 million to a woman's family after she died of an infection caused by flesh-eating bacteria; contracted during cancer treatment. And November 2008, a woman reached a confidential settlement of \$ 16 million when a hospital failed to detect a flesh-eating bacteria, before and after she gave birth, resulting in the loss of three limbs and several organs (Gaffey, 2010). According to the AMA's code of ethics, it is a requirement that a physician should at all times deal honestly and openly with patients concerning medical errors. Several doctors cite the risk of litigation as grounds for caution when discussing medical errors.

Practicing defensive medicine such as ordering more tests or consults has become the norm to avoid malpractice suits. 94% of physicians say they would inform a patient if a mistake was made that caused an injury. Concern regarding legal liability which might result from telling the truth should not affect a physician's honesty with a patient according to the AMA's Code of Medical Ethics, however some skeptics maintain that it is easier to brag about virtue, than actually follow it (Rice, 2002).

For the most part physicians agree that honesty is the best policy. Many doctors in a survey confessed to errors such as; prescribing the wrong medications, wrong dosage, misinterpreting x-rays, misinterpreting lab

reports, etc... One physician stated that being upfront about his mistakes, talking to the family, and apologizing probably avoided a lawsuit. Most doctors agree that it is better to be upfront about a mistake for several reasons, they are: 1. That it always comes out eventually, 2. Dishonesty causes more damage and loses the public's trust, 3.

Honesty decreases the chance of being sued, as well as it is the right thing to do, and 4. They want their patients or family to hear it from them first (Rice, 2002). Communicating with the patient or family, educating them on the procedure and signs or symptoms to look for can prevent surgical site infections. Being open and honest with the patient and their family when an error occurs can possibly help to avoid a lawsuit. Honesty is always the best policy when providing quality health care.

In October 2008, CMS announced that it would no longer pay for hospital-acquired conditions. It is their view that if a hospital has a good standard of practice and multidisciplinary care guidelines that these events should not happen and can easily be prevented. This is not to penalize health care, but to improve the safety of patient care and improve the quality of care by establishing standards of care and protocols. The Joint Commission has also implemented similar reporting and nonpayment initiatives to improve safety and improve the quality of care (Lisa, 2009).

The Joint Commissions new national patient safety goal to prevent surgical site infections includes a requirement to look for surgical site infections for up to 30 days after a procedure. The Center for Disease Control (CDC) estimates that between 12% and 84% of surgical site infections are found after patients are discharged from the hospital. Joint Commission surveyors

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will be looking to see if the following protocols are being followed: * Hospital educates health care workers involved in surgical procedures about healthcare -associated infections, surgical site infections, and the importance of prevention. Before all surgical procedures, the hospital educates patients/family about surgical site infection prevention. * Hospital implements policies and practices aimed at reducing surgical site infections. * Hospital conducts periodic risk assessments for surgical site infections. * Measurement strategies follow evidence-based guidelines and surgical site infections are measured for the first 30 days after surgery. * Hospital supplies surgical site infection rate data and prevention outcome to leaders, practitioners, nursing staff, and other clinicians. Antimicrobial agents for prophylaxis used for a particular procedure or disease are administered according to standards and guidelines. * Administer I. V. antimicrobial prophylaxis within one hour before incision. * Discontinue the prophylactic antimicrobial agent within 24 hours after surgery. * When hair removal is necessary, use clippers or depilatories (Hospital Infection Control, 2008).

Localized improvement occurs when a team is developed to look at a specific problem; such as the rate of surgical site infections. Organizational learning occurs when this process is documented and results in the development of policies that are implemented; such as a protocol for preventing surgical site infections. Process reengineering occurs when a major investment blends internal and external resources to make changes; such as being accredited by the Joint Commission and following their guidelines for prevention of surgical site infections. Evidence-based medicine involves the selection of the best clinical practices; implementing surgical site infection control

guidelines or protocol to reduce cost and increase profit (Sollecito & Johnson, 2013).

The most effective strategies for improving health care quality are: clinician-directed audit and feedback, clinical decision support systems, specialty outreach programmes, continuing professional education based on interactive small-group case discussions, and patient-mediated clinician reminders. Pay-for-performance strategies directed to clinician groups and organizational process redesign are modestly effective (Scott, 2009). In my opinion using the organizational learning strategy would generate the best outcome and cost the least to implement.

Having a team put together to gather data on surgical site infections and implementing a protocol or guidelines to follow to prevent these events would result in less cost and increased profit. In conclusion, surgical site infections are for the most part preventable. Following protocols or guidelines can greatly reduce surgical site infections. Educating staff, patients, and their families, can have a big impact on preventing surgical site infections and implementing these strategies reduces cost and increases profit. References: Adams, A. (2001). Preventing surgical site infection (SSI): Guidelines at a glance. *Nursing Management*, 32 (8), 46-46. Retrieved from <http://search.proquest.com/docview/231438710?accountid=32521>. Frances, A. G. (2005). Best-practice protocol is: Preventing surgical site infection. *Nursing Management*, 36 (11), 20-26. Retrieved from <http://search.proquest.com/docview/231393974?accountid=32521>. Gaffey, A. D. RN, MSN, CPHRM, FASHRM. (2010). Legal Implications of Healthcare- Acquired Infections. Retrieved from <http://www.ahe>. <https://assignbuster.com/surgical-site-infections/>

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