

Curbing Healthcare-Associated Infections

Rosa R. Baier, MPH, and Stefan Gravenstein, MD, MPH

Visiting a patient on hospital consultation yesterday, we donned gowns and gloves following the direction of the signs announcing the patient's methicillin-resistant *Staphylococcus aureus* (MRSA) colonization. The encounter took no longer than 30 minutes. In that time five additional individuals visited the patient: two family members, a registered nurse who checked a blood sugar, a nurse aide, and food service delivering a tray with lunch. None donned a gown or gloves; all made contact with the patient or the table the patient used for her personal effects. Only one "foamed out," none "foamed in."

On leaving the patient's room, we wondered: Would her food trays be inoculated? Would her environment be properly cleansed? We can easily imagine the transfer of organisms to fixed and mobile hospital surfaces, from bathrooms to the cafeteria—resulting in infections throughout the hospital and, eventually, people's homes. We find it easy, too, to believe what we so often hear from physicians and nurses: the information about the patient's infection may be absent (or difficult to locate) on the forms generated at discharge, leaving her next provider ill-equipped to prepare for her arrival or prevent the spread of her MRSA or others' infections.

It is small wonder we have a growing epidemic of healthcare-associated infections (HAIs). Even those who are best trained and equipped to do better are not doing as well as they might—far from it, an ironic semantic twist relating to the "culture of care." How do we combat this epidemic, when we have already placed hand-cleansing foam in facility corridors and endlessly coached healthcare workers on hygiene? The approach must be multifaceted and reach from patient-level care practices to systems-level interventions that change not only the way we think, but also how we individually and collectively become accountable.

This issue gathers a series of articles that tackle HAIs from these perspectives. Mermel describes the burden of HAI and the prevention tactics we must implement to curb the transmission of these infections, while two additional articles describe specific HAIs: *Clostridium difficile* (Pop-Vicas, Butterfield and Gardner) and MRSA (McNicoll and Marsella), with the latter article including tactics to change the culture of care. From a social consciousness perspective, Marshall, Tetu-Mouradjian, and Fulton discuss how to engage healthcare workers to accept influenza vaccination, while Oliver et al. speak to accountability regarding communication during care transitions. Thomas and Viner-Brown further address accountability, describing the evolution of HAI public reporting in Rhode Island, a national leader in transparency regarding health outcomes. Altogether, these articles deal with bedside practices; practice oversight from antibiotic stewardship and communications perspectives; and systems oversight through policies and reporting rates of infection and hygiene practices.

For the culture of medicine to change, we *must* do better with regards to HAIs. Our interventions must touch personal and systems-level accountability, and we must measure what is happening to understand which interventions are improving outcomes, and which need to be further modified or abandoned. This issue points to resources and approaches deployed in Rhode Island and elsewhere toward the goal of safer and better care.

Rosa R. Baier, MPH, is Senior Scientist, Quality Partners of Rhode Island, and Teaching Associate, The Warren Alpert Medical School of Brown University.

Stefan Gravenstein, MD, MPH, is Clinical Director, Quality Partners of Rhode Island, and Professor of Medicine, The Warren Alpert Medical School of Brown University.

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CORRESPONDENCE

Rosa Baier, MPH
Quality Partners of Rhode Island
235 Promenade Street
Suite 500, Box 18
Providence, RI 02908
Phone: (401) 528-3205
e-mail: rbaier@riqio.sdps.org

