This true story is a case study in a culture that kills tens of thousands and hurts hundreds of thousands every year.

A frail, elderly, malnourished woman was admitted to the hospital by her cardiologist. On one of my visits, I found her hungry and thirsty. It was noon and she had not had anything to eat or drink since 10 p.m. the night before because she was scheduled for surgery that day. Her toe had to be amputated because “it was terribly infected.” Soon after I arrived, the doctor who was going to perform the amputation stopped by. My initial delight at noticing a familiar wound care certification patch on his coat sleeve and a badge indicating he was in charge of the wound clinic soon was replaced by horror. In response to my question as to how the decision was made to amputate the toe, he volunteered to show me. Without donning gloves or washing his hands, he removed the loosely wrapped piece of gauze, revealing a 1/2-cm round eschar-covered lesion on the top of her toe. Using his index finger, he pushed the eschar, looked up, and said, “see how close this is to the bone? It is infected.” Before I was able to formulate any words (let alone a complete sentence), he put the gauze back, said good bye, left the room, and pushed the elevator button.

While I hope you are as horrified by this scenario as I was, the literature shows such occurrences are not as unusual and rare as they should be. First, guidelines for preoperative care of most individuals issued almost 9 years ago (!) state that clear liquids can be consumed up to 2 hours and solid foods up to 6 hours before any procedure that requires sedation or anesthesia.1 Yet the old non-evidence-based practice of fasting after midnight (drinks at midnight) this means that many patients do not eat or drink for 8 to 12 hours or more before surgery — a practice that can seriously hinder their postoperative recovery.1,2 In the case of this elderly woman, neither the fact that the fasting tradition is outdated and potentially harmful nor her weight (91 lb) and documented malnutrition were sufficient for anyone to reconsider “standard hospital policy.”

Also, while I was unable to assess the validity of the diagnosis and need to amputate, the poking finger explanation was clearly not one would expect from a “wound care expert.” Plus, his position and certification status did not set him apart from others who have ignored the alarm bells about nosocomial infections and healthcare professionals’ role in causing them. Instead of listening and taking responsibility, the global response to this epidemic has been to look for something or someone to blame: systems, other healthcare professionals, other institutions, patients, even visitors are all culprits.3 Evidence of the need for appropriate clinician precautions is ignored. For example, in one recent study,4 the vast majority (70%) of methicillin-resistant Staphylococcus aureus (MRSA) isolates in hospitalized patients were found to be consistent with healthcare-associated, not community-associated, MRSA. This same study also documented that MRSA rates in hospitals were much higher than previously reported (46.3 per 1,000 inpatients) and that only 29% of hospitals conduct active MRSA surveillance. If all hospitals performed surveillance, documented MRSA rates most likely would be higher.

While many hospitals have officially adopted clinical practices recommended in the new Centers for Disease Control and Prevention (CDC) Hand Hygiene Guideline, one study5 showed that 1 year
following implementation, fewer than half of all hospitals demonstrated evidence of a multidisciplinary program to improve compliance. Moreover, despite mountains of evidence that hand-washing practices of healthcare providers remain key to preventing harm, hand hygiene rates in general remain low (between 40% and 56%)—this without considering the potential dangers of personal attire and preferences such as neck ties or certain manicure options. Given the well-known risks to patients of healthcare professionals wearing artificial nails, I guess we should be grateful our wound care colleague who considered his hands immune to cross-contamination did not have artificial nails.

Why have these abysmal hand-washing rates and poor standards of care continued? Why are a reported 87% of hospitals still not following guidelines to reduce the rate of nosocomial infections? Is it because no alarm bells will sound when our actions cause harm? Is the attitude this is simply the cost of doing business more prevalent than we like to believe? If so, that cost is certainly staggering. In one state (Pennsylvania), the difference in average hospital charges between cases with and cases without hospital-acquired infections was estimated at $153,871 per patient for a total $3.5 billion in hospital charges in one year. Although the price paid by patients and families remains largely unknown, mortality rates are estimated to be five times higher when patients acquire an infection in the hospital. New CMS regulations taking effect this year prohibit passing on these costs—sadly, this may be the intervention that will finally result in systemic improvements and caregivers’ realization that they have a duty to perform hand hygiene perfectly and every time and that we cannot blame the system for doing harm.

Wound, ostomy, and continence care practitioners witness daily the devastation of infections—from painful weeping skin lesions and dehisced surgical wounds to osteomyelitis and amputations. Perhaps that is what shocked me most that day. Anyone who works in wound care should be a front-line soldier in the war to stop the epidemic of infections, not a walking, talking fomite.

The outcome of my case study was predictable. Following the amputation, the elderly woman spent 5 days in the hospital and never saw her home again. She was discharged to a nursing home and passed away 5 months later. - OWM

References