

Infection preventionists know safe care

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There is general agreement among hospital infection preventionists (IPs) with respect to which practices have weak or strong evidence supporting their use to prevent healthcare-associated infection, according to a new study published in the February issue of the *American Journal of Infection Control*, the official publication of the Association for Professionals in Infection Control and Epidemiology (APIC).

Furthermore, IPs with certification in [infection prevention](#) and control (CIC) are two to three times more likely to perceive the [evidence](#) behind certain infection prevention practices as strong, compared to their non-certified [peers](#).

IPs lead programs in hospitals and other healthcare facilities that protect patients and healthcare personnel from infections. The study was conducted to understand how those who lead infection prevention activities perceive the strength of evidence behind practices aimed at preventing device- and procedure-associated infections and lessening the [risk](#) of cross transmission of [microorganisms](#) in [healthcare facilities](#).

A research team led by Sanjay Saint, MD, MPH, of the VA Ann Arbor & University of Michigan Medical School collected survey responses from infection prevention personnel at 478 U.S. hospitals to determine the perceived strength of evidence behind 28 of the most common hospital infection prevention practices. The following practices were perceived by 90 percent or more of the respondents as having strong evidence to support their use: alcohol-based hand rub, aseptic urinary catheter insertion, chlorhexidine for antisepsis prior to central venous

catheter insertion, maximum sterile barriers during central venous catheter insertion, avoiding the femoral site for central venous catheter insertion, and semi-recumbent positioning of patients on ventilators.

Conversely, practices with the weakest perceived evidence were routine central catheter changes, using silver-coated endotracheal tubes for ventilator-associated pneumonia (VAP), nitrofurazone-releasing urinary catheters, and the use antimicrobials in the urinary catheter drainage bag.

According to Dr. Saint, lead study author, "the perceived strength of evidence among infection prevention personnel across the country generally tracked with the actual strength of the evidence for various practices that have been reported in evidence-based guidelines."

The research team further examined the perceptions of evidence supporting practice use between certified and non-certified IPs. Compared to their non-certified counterparts, CIC® IPs were more likely to perceive the strength of evidence as strong for a number of infection prevention practices including: regular interruption of sedation for VAP patients, nurse-initiated urinary catheter discontinuation to prevent catheter-associated urinary tract infection, and antimicrobial stewardship programs.

"Understanding the impact of board certification on the effectiveness of an infection prevention program is imperative," said Russell Olmsted, MPH, CIC, study co-author. "This study adds to mounting evidence that suggests that CIC® may lead to greater evidence-based practice, which may result in the reduction of both healthcare-associated infections and [hospital](#) costs."

Certification in infection prevention and control (CIC®) is the centerpiece of a new competency model developed by APIC to advance the profession. The content areas of the model correspond to the core

competencies as defined by the Certification Board of Infection Control and Epidemiology (CBIC).

More information: "Perceived strength of evidence supporting best practices to prevent healthcare-associated infection: Results from a national survey of infection prevention personnel" by Sanjay Saint, M. Todd Greene, Russell N. Olmsted, Vineet Chopra, Jennifer Meddings, Nasia Safdar and Sarah L. Krein appears in the American Journal of Infection Control, Volume 41, Issue 2 (February 2013).

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