

Hospitals not learning from measuring infections

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Suffering from an infection during a hospital stay is a common care-related injury. To prevent spreading and to work preventively, all hospitals measure the occurrence of care-related infections. But the time-consuming measurements are not followed up on. One reason is that the staff has no faith in the results, as shown in one of the studies in a thesis on patient safety from Linköping University.

Every year, approximately nine percent of hospital patients in Sweden suffer from care-related injuries. It's often a matter of infections, such as urinary tract infections, infections after an operation, or pneumonia. In order to be able to improve their work, work preventively, and monitor outbreaks, all Swedish hospitals have since 2008 been measuring the occurrence of care-related infections over one day. This is done twice a year in a 'point prevalence' measurement consisting of all patients on hand at the hospital and two thirds of the patients in psychiatry. But the results of the measurements do not lead to action, as Mikaela Ridberg's doctoral thesis shows.

"This system exists because we want to reduce infections and increase safety for patients. But when our operations don't trust the results, what we could have learned from the measurements is not forthcoming," Ms Ridberg says.

A lot of time is therefore put into gathering and analysing data, but less time is put into turning into work that could reduce care-related infections.

Ms Ridelberg's study includes 22 persons who work with care-related infections in hospital wards around the country. These people stated different reasons for mistrusting the measurements. The foremost reason is that the technology is considered complicated, the system difficult to report in, and their own results difficult to find. The interviewees think that the evaluation may be able to provide a picture of the spreading of care-related infections on a national level, but on the other hand not at the ward level. The interviewees also believe that the method of measuring only during one day means it could give a false picture of the ward, if there is an outbreak of infection on precisely that day.

"There are a number of excuses, such as 'we had gastric influenza in our ward', 'the patient came from another ward and brought the [infection](#) with them to us'. I wish they'd looked at their figures instead and said 'OK, we have a problem with catheters and [urinary tract infections](#), we'll work on that'," Ms Ridelberg says.

She thinks vigorous efforts is needed to create structures in order to learn from the improvement [work](#) being done. Not only within their own clinics and organisations, but also among clinics and organisations.

Apart from the recurring finding that [patient safety](#)-related data does not lead to learning, the five studies of the thesis show that increased knowledge through training in the subject of patient safety is needed for everyone within health and medical care.

More information: [www.diva-portal.org/smash/get/ ...
21217/FULLTEXT01.pdf](http://www.diva-portal.org/smash/get/.../21217/FULLTEXT01.pdf)

Provided by Linköping University

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