5 editorial.qxd 21/7/05 3:43 pm Page 1

Editorial

First, do no harm

Clinging to the edge of life, a young wife and mother of three fights to survive life-threatening injuries sustained as a result of a 'hit and run' road traffic accident. Intensive care unit staff support her through one crisis after another and finally stabilise her condition. The relief of family and staff is palpable as during the next four days she slowly improves.

And then – a fever develops. As her condition rapidly worsens, a catheter-related bloodstream infection is suspected (and later confirmed) and aggressive antimicrobial treatment initiated. But it's too late, the treatment is ineffective, everything is moving too fast and suddenly she's gone.

Although initial surveillance cultures were all negative for resistant organisms, cultures taken when the fever developed come back positive for both meticillin-resistant *Staphylococcus aureus* and glycopeptide-resistant enterococci. After all that work, all that progress so painfully won, the promise of recovery and life… what happened here? Everyone was confident that she had an excellent chance of recovery – she was young and strong and was being cared for by specialist practitioners.

But recent audits of hand hygiene practices in the unit were disappointing – some staff members were not decontaminating their hands each and every time they should have. There were many reasons for this, such as intense workloads, continuing high bed occupancy, staff fatigue and shortage of staff.

But the reality of this death was that almost certainly someone who cared for her infected her and it was probably preventable. So no rationalising, no excuses, no apologies – 'sorry' doesn't do it. The rate of preventable healthcare-associated infections (HCAI) is unacceptable and it must be reduced – however and whatever it takes.

The UK now holds the European Union presidency and intends to make a substantive and lasting impact on the EU agenda in health inequalities and patient safety. The prevention and control of HCAI, the most common types of adverse events during health care, is an essential element of patient safety.

The Infection Control Nurses Association has been proclaiming for decades that each person working in health care, whether it be in a clinical or non-clinical role, is responsible for taking active measures to minimise the risk of HCAI to patients – it's everybody's business and it's a 24-hours, seven-day-a-week job.

The individual responsibility for protecting patients from infection is not new – it has always been at the core of healthcare practice. The founders of the professions of medicine and nursing stressed the essential need for patient safety. The dictum *Primum non nocere* (First, do no harm), originated from the writings of Hippocrates, the father of medicine, where he said: 'As to diseases, make a habit of two things – to help, or at least to do no harm' (*Of the Epidemics*, 400 BC).

This was further elaborated by Florence Nightingale, who wrote: 'It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm' (from her 1859 document *Notes on Nursing*).

The public could be forgiven for thinking that not harming patients is axiomatically embedded in the day-to-day practice of everyone who works health care, be it in hospitals or in primary and community care settings.

We know how to protect patients from the risk of HCAI and this knowledge is based on good-quality evidence. It seems so simple – effective hand hygiene practice, active HCAI surveillance with meaningful feedback, the safe use of medical devices, good standards of environmental hygiene, and consistently adhering to the infection prevention and control recommendations in national and local guidelines.

If colleagues do just this, HCAI rates will decrease – end of story. But it's not – it's more complex than this and often we don't really comprehend the organisational and individual behaviours associated with failing to effectively use these evidence-based measures to protect patients from HCAI.

We need to develop a better understanding of the factors that influence some healthcare organisations to successfully and effectively translate evolving best evidence for efficacy into local clinical practice.

We also need to know how those factors operate or don't operate in organisations that lack success in consistently using evidence to continuously improve the quality of their infection prevention and control practices and service.

We need to learn the characteristics of 'winning' and 'failing' healthcare organisations, so that we can adapt and support those positive characteristics and organisational traits throughout the service that will result in more healthcare organisations becoming 'infection aware', ie enthusiastically and consistently using best evidence to prevent HCAI and enhancing patient safety.

The profile of infection prevention and control has never been higher and major initiatives are flowing from UK Departments of Health with an urgency that speaks of both alarm and determination. The need for a proactive and responsive ICNA is decisive to the success of any initiative and I'm convinced that the members of our association will make the defining contribution to enhanced patient safety.

Research is one of the crucial ways we will do this, and in this issue of our journal the ICNA Research and Development Group describe our draft research strategy, with more ICNA research initiatives described in forthcoming issues.

Time is moving on and we have long passed that previous point where we tolerated a situation where our patients developed a preventable infection as a result of our care (or lack of care). We understand the evidence that underpins effective measures to prevent HCAI – we just don't fully understand the complex dynamics of why this is not universally incorporated into clinical practice. It's time we did – and removed patients from harm's way.

Professor Robert J Pratt
ICNA president