Don't be complacent

THE MOST important point made in the National Audit Office report on hospital-acquired infections is that there are estimated to be around 5,000 related deaths every year, but that some of them are avoidable.

No wonder, then, that the response from NHS chief executive Alan Langlands was seen as complacent. He dismissed the figures on deaths as being based on crude comparisons with American data. And he denied there is an epidemic of methicillin-resistant Staphylococcus aureus (MRSA), instead pointing to the fact that there is now, for the first time, a national strategy for infection control in hospitals.

Certainly this issue has been given much more attention since 1992 when Nursing Standard brought the dreadful state of many hospitals to public attention with our Operation Clean-up campaign. What nurses will want to see, though, is a drop in the overall rate of patient infection from the stubborn 9 per cent, which saw no change between surveys in 1981 and 1996. The NAO report is the most comprehensive analysis yet of the work being carried out by infection control teams in England.

Its many recommendations will come as little surprise to nurses, particularly those already working in this area; infection control requires a higher priority, and more resources should be devoted to keeping hospitals safe. Staff need better education in infection control and senior doctors in particular pay poor regard to the need for robust handwashing.

Some of the report is just plain common sense. Why not? Infection control nurses want improved staffing ratios and the right mix of skills in teams to allow them to be proactive, particularly to carry out the vitally important surveillance work.

The authors of the report rightly recognise the dedication and professionalism of infection control teams and put the task of helping them do their jobs better firmly on trust management. Their response to this challenge will be an important test of the new clinical governance arrangements.

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What happens when visitors tum nasty?

DEPRESSION, physical illness, not wanting to go to work and even a desire to leave nursing – nurses at a north London hospital reported all these symptoms as a result of facing increased levels of violence. Not violence from patients, but from visitors.

Often the abuse is verbal, but this still has a demoralising effect. The survey provides some suggestions. The nurses identified increasing workloads as a third major factor. Poor discharge planning could also be left in the firing line when, because of lack of staff and equipment, visiting services are not provided as a result of facing increased levels of violence. Not violence from patients, but from visitors.

The nurses identified increasing workloads as a major problem. One said: ‘You’ve not got time to sit and talk to every relative and fair enough, they get angry when these were not met.’ The Charter had raised expectations and relatives of the patient were often angry when these were not met.

Another factor. The fact the public has an expectation of a quality health service is commendable, but nurses must not be left in the firing line when, because of lack of staff and equipment, these services are not provided as a result of facing increased levels of violence. Not violence from patients, but from visitors.

Understaffed wards, which mean visitors perceive their relatives are being neglected, were another factor. Poor discharge planning could also spark off violence or abuse from relatives.

Part of the answer lies in staffing levels and support services. Many nurses believed the Patient’s Charter had raised expectations and relatives became angry when they were not met. The fact the public has an expectation of a quality health service is commendable, but nurses must not be left in the firing line when, because of lack of staff and money, these services are not provided as a result of facing increased levels of violence. Not violence from patients, but from visitors.

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