"Bridging the Gap between Wound Care and Infection Prevention" A CASE REPORT

Lessing R

Introduction

"Disconnect" in the Health Care environment between different disciplines have become more and more evident. Besides many efforts to encourage interdisciplinary association, many gaps are still apparent.

We are still in the mindset of fixing the outbreak, rather than preventing the outbreak. Nurses should take more responsibility for every aspect of their environment and their patients. Awareness strategies with regards to Infection prevention should become more prominent, and everyone should be on the same page. Cross linking of different disciplines across the Health Care environment is extremely important to develop new strategies against HAI's.

Health Care is a constant dynamic science, so is Infection Prevention and Wound Care, therefor these gaps need to be identified and remain closed.

A few examples are mentioned in this article, these examples are meant to stimulate our thinking behavior with regards, to our daily actions.

Approaching wound care HOLISTICALLY¹³ is critical to achieve effective outcomes⁵.

Let us embark on a short journey into the world of wound care, skin health and infection prevention.

Infection Prevention, Skin Assessment and Woundcare Protocols are all intertwined to form a Holistic Approach to achieve effective outcomes in a patient with a wound or skin failure¹⁴. Each and every patient is unique and we should not forget to assess all the other aspects of nursing care.

Infection prevention is the basis of all health care regimes.

The following case report is merely a snapshot of the challenges that exists in our current Healthcare System:

Case study

A 40-year-old man, patient X, was admitted with polytrauma. He was non-responsive, obese, and had a foleys catheter and tracheostomy in situ. Oxygen dependent. Patient X had a stage 4 sacral pressure wound, and bilateral stage 4 trochanter pressure wounds. He also had necrotic pressure wounds on both heels.

The ward staff comprised two registered nurses and five assistant nurses, who had to manage 34 patients per shift. This equals to one registered nurse per 17 patients, and one assistant or student nurse for every 6.8 patients.

The facts of the case study are as follows:

- Patient X took at least one hour to bath
- He needed at least five people at a given time to bath and turn him
- Tracheostomy care took about half an hour
- Wound care took at least one hour
- He had to be turned every two hours to prevent more pressure wounds from developing, and to offload pressure from the current pressure wounds
- He needed to be mobilised and placed in a chair at least twice a day. This took five people roughly a half an hour to achieve
- It took 45 minutes to feed him.

In summary, caring for patient X consumed approximately 11 hours and 15 minutes of a 12-hour shift! Five nurses are occupied full-time for 8.5 hours in a 12-hour shift. In this scenario, the ward was left with only two nurses to care for the other 33 patients. In addition, patient X was not the only
non-ambulant patient requiring full-time special care. In this ward, 18-20 patients had chronic or infected wounds at any given time. Most of the wounds were complicated. Forty per cent of the ward's patients needed similar care.

Other nursing duties involve taking patients to be X-rayed or to other diagnostic departments, administering medication, handing out meals and ensuring that regular four-hourly observation is performed. The staff is also responsible for tending to doctors' rounds.

So, how can this ward manage its time effectively? The answer is that it cannot, as with the number of staff allocated to the ward, it is impossible. This case study is a common occurrence in both the private and provincial sectors.

This situation results in the compromise of Basic care and Infection prevention. Staff members then neglect hand washing and sanitising protocol owing to time restraints and water resources not functioning properly. This scenario is conducive to negative outcomes with regard to hospital-acquired infection rates, and the promotion of cross-contamination between nurses and patients and vice versa, creating a vicious circle. The cost implications to the health system are also astronomical.

A high prevalence of pressure wounds also exists because of the following:
- Negligence in turning patients two hourly
- Pressure, friction and shear
- Skin moisture damage, owing to incontinence and excessive perspiration.

Regular turn and skin inspection regimes are often not possible because of low staff numbers. Pressure, friction and shear are inevitable with the low staff complement. Patients are placed in beds that have no draw sheets. They are fortunate if they receive clean sheets which fit smoothly on the very damaged thin mattress. This increases pressure wound possibility by 100%.

Water cuts are becoming more and more regular, and 50% of the ward basins do not have functioning taps. The soap dispensers are left open and are thus compromised, while none of the pumps are in a working condition. Inevitably, they are critically contaminated. Thus, how can non-ambulant patients receive skin care and cleansing at least once a day?

Waterless disinfection and cleansing have become extremely useful in European countries, who experience the same challenges as healthcare institutions in South Africa. Many articles have been published and studies conducted in this regard. It was proved in one of these studies that waterless cleansing with chlorhexidine wipes or mittens significantly reduced the risk of infection in high-risk patients, because:
- Precious nursing time was preserved
- Water was conserved
- The use of extra linen and towels was lessened
- Skin moisturisers were not required as much
- Moisture-related skin infections and damage were reduced
- The patient was decontaminated and the bio-burden on the skin reduced
- Cross-contamination was eliminated.

Conclusion

The modern era has modern challenges, where healthcare institutions are constantly confronted with challenges, such as staff shortages, water cuts, power cuts, linen shortages and a considerable amount of hospital-acquired infection. Thus, it is necessary to switch to relevant treatment regimes in an effort to prevent resistant bacteria from taking over our hospitals and homes.

We live in a constantly evolving environment. Why do we then continue to do to what we always do, instead of changing the way in which we do things? If we continue to do things the same way, the outcome will always be the same. However, if we do things differently, surely our outcome will be different: “If you always do what you always did, you will always get what you always got” and “Insanity is doing the same thing over and over again, and expecting different results” (Albert Einstein).

References