



Infection Prevention and Perioperative Professionals: A Crucial Partnership



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On any given day, approximately one in 25 patients in the United States acquires an infection during the course of hospital care, which added up to approximately 722,000 infections in 2011, according to new data from the Centers for Disease Control and Prevention (CDC).¹ The CDC *Multistate Point-Prevalence Survey of Health Care-Associated Infections*¹ used 2011 data from 183 US hospitals to estimate the burden of a wide range of infections in hospital patients. That year, 721,800 infections occurred in 648,000 hospital patients.¹ Approximately 75,000 patients with health care–associated infections (HAIs) died during their hospitalizations. The two most common HAIs were surgical site infection (SSI) at 22% and pneumonia, also at 22%.¹

The point-prevalence study also showed that device-associated infections (ie, central line associated bloodstream infection, catheter-associated urinary tract infection, ventilator-associated pneumonia), which have traditionally been the focus of infection prevention programs, accounted for 26% of such infections.¹ Much progress has been made in preventing device-associated HAIs; in addition, the CDC continues to work with regulatory agencies (eg, Centers for Medicare & Medicaid Services),

hospitals, and other health care settings to ensure HAI surveillance and prevention efforts are used outside of intensive care unit settings, such as in ambulatory surgery centers, outpatient dialysis centers, and hospice organizations.² This article identifies ways infection prevention and perioperative staff members can work together to ensure the safest outcomes for their patients.

NEW GUIDELINE

The latest CDC and Hospital Infection Control Practices Advisory Committee draft guideline for the prevention of SSIs was published for public comment in January 2014.³ Prevention of SSI is increasingly important as the number of surgical procedures performed continues to increase.^{4,5} Surgical patients presenting with more complex comorbidities⁶ and the emergence of antimicrobial-resistant pathogens increase the cost and challenge of treating SSIs.^{7,8} Public reporting of process, outcome, and other quality improvement measures is now required,^{9,10} and reimbursements¹¹ for treating SSIs are being reduced or denied. Given the frequency of SSI occurrence, preventing SSIs continues to be of considerable importance in the perioperative environment.

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The goal of the SSI guideline was to develop recommendations based on a targeted systematic review of the best available evidence, with explicit links between the evidence and recommendations.³ To accomplish this, Guyatt et al¹²⁻¹⁴ and Schünemann et al¹⁵ developed an adapted Grading of Recommendations, Assessment, Development, and Evaluation system for evaluating quality of evidence and determining strength of recommendations.

The CDC and Hospital Infection Control Practices Advisory

Committee adopted the methodology, structure, and components of the Grading of Recommendations, Assessment, Development, and Evaluation system in 2009.^{16,17}

The guideline is intended for use by surgeons; physician assistants; perioperative nurses; allied perioperative assistive personnel; anesthesia professionals; postoperative inpatient and clinic nurses; infection prevention staff members; health care epidemiologists, administrators, and other health care providers; and persons responsible for developing, implementing, delivering, and evaluating infection prevention and control programs for surgical procedures performed in an OR (ie, inpatient or ambulatory).³ This guideline does not provide comprehensive infection control recommendations for preventing SSI but can be used as a resource for professional societies or organizations that wish to develop more detailed implementation guidance or to identify future research priorities in which there are evidence gaps for the prevention of SSI.³ This is where the Association for Professionals in Infection Prevention and Epidemiology and AORN must work together to define best practices.

COLLABORATION

Collaboration between infection control and perioperative nursing is essential, particularly if the infection preventionist (IP) has not worked in the

surgical setting. It may be intimidating when an IP must spend time in the perioperative environment observing practice or when an IP is asked specific questions about surgical practice settings. To collaborate, the IP can share information, such as criteria for determining what constitutes an SSI, procedure and patient risk factors, the facility's

current SSI rates by procedure, and results of perioperative practice observations by using tools based on OR policies and procedures. Perioperative personnel can develop

shadowing or training courses for IPs as well as personnel from other departments in which invasive procedures are performed (eg, cardiac catheterization laboratories, interventional radiology departments).

Personnel in the OR suite are role models for a true culture of safety. Quite literally, the OR suite is an environment where infection prevention is a way of life. Adherence to hand hygiene and sterile technique is hard-wired into the system, and perioperative staff members are not only educated about, but are comfortable with, reminding coworkers of potential breaks in technique. Important questions that both IPs and perioperative personnel can ask include

- What components of the OR environment can IPs draw from and use for broader education within other units?
- How can sharing between departments be fostered?
- Can perioperative staff members spread their culture of safety throughout a health care facility?

IMPLEMENTATION SCIENCE

A majority of perioperative practices target the prevention of infection; therefore, the need for collaboration between infection preventionists and

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