Healthcare associated infections (HAI)

HAI a major patient safety issue
(WHO, 2011; ACSQHC, 2011)

Infection prevention & control (IPC) strategies for reducing HAI
- Top down
- Education/compliance model
  (eg. Siegel et al., 2007)
- Yet HAI remains one of the most frequent adverse events for patients in hospitals
Fresh approaches to patient safety

- Compliance model may hinder the optimization of care safety & quality
  (Allard & Bleakley, 2016)
- Frontline actors as experts
  (Bevan & Fairman, 2014; Danish Ministry of Health, 2015)

A further shift going forward in health and care improvement will be an increasing focus on tacit knowledge rather than explicit knowledge for change. It is tacit knowledge, or know-how, created by learning in action and experience that is the most valuable knowledge for improvement and is most likely to lead to breakthroughs in thinking and performance … Tacit knowledge is best developed and shared through dialogue, conversations and social relationships.

*Bevan and Fairman (NHS)* (2014)

**Institute of Medicine - Learning health care system**

Such a system prioritizes constantly generated, real-time learning through the integration of clinical research and practice, whereby the processes of generating and applying the best evidence are “natural and seamless components of the process of care itself”

Fresh approaches to patient safety

- **Compliance model may hinder the optimization of care safety & quality**
  (Allard & Bleakley, 2016)

- **Frontline actors as experts**
  (Bevan & Fairman, 2014; Danish Ministry of Health, 2015)

- **Increased interest in patient involvement (PI) at policy level**
  (Brett et al., 2012; INVOLVE: PCORI)

- **Translation into practice not straightforward**
  (Fox, 2003)

- **Feasibility & acceptance of PI in everyday IPC largely unknown**
  (Davis et al., 2015; 2014)

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What do we know about patient involvement in IPC?

**Patients**

- **Willing to be involved**
  (McGuckin & Govednik, 2013; Seale et al., 2015; Kim et al., 2015)

- **Face barriers**
  (McGuckin & Govednik, 2013; Butenko, 2015; Seale et al., 2015)

**Healthcare professionals**

- **Little known about HCP views on PI in IPC**
  (Langtin et al., 2012; Alzyood et al., 2018)

- **Accept PI may improve safety**
  (McGuckin & Govednik, 2013)

- **Receive little guidance on how to implement PI**
  (Schwappach et al., 2011; Seale et al., 2015)

- **May hold narrow views about PI**
  (Martin, Navne, & Lipczak, 2013)
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Global Hand Hygiene Programs

1990s
- McCulloch et al. involve patients in HH programs in USA & UK
- 2002 USA Speak-up campaign launch

1995-2000
- The Geneva Hand Hygiene model developed

2005
- WHO “Clean Care is Safer Care” launched
- UK “Clean your hands” & “It’s OK to ask”
- WHO Patients for Patient Safety program

2006
- Aus “Clean Hands Saves Lives” & “It’s OK to ask”

2007
- WHO guidelines on HH in HC - final
- Canada – “Stop – Clean your hands”
- 5 moments developed

2009
- WHO Save Lives: clean your hands campaign

1999-2004
- Pittet et al. realise low HCW HH compliance

Patient involvement in IPC


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Patient experiences of partnering with healthcare professionals for hand hygiene compliance: a systematic review

Background
Healthcare-associated infections pose a significant risk to patients in acute healthcare settings such as hospitals. Involving patients in the management and control of healthcare infections is essential to improve hand hygiene compliance among healthcare professionals. However, the perceptions of healthcare professionals and the strategies adopted to improve hand hygiene compliance in healthcare settings have yet to be fully explored.

Objectives
To review patients’ and healthcare professionals’ perceptions of patient involvement in promoting hand hygiene compliance in the hospital setting.

Methods
A five-stage review process informed by Whittemore and Knafl’s methodology was conducted. MEDLINE and CINAHL were searched for papers published between January 2009–July 2017. Data were extracted manually, organised using NVivo 11 and analysed using thematic analysis.

Results
From an identified 240 papers, 19 papers were included in this review. Thematic analysis revealed two main themes with three related subthemes. Patients were willing to remind healthcare professionals (especially nurses) to wash their hands, healthcare professionals’ perception towards patients’ involvement varied from one study to another. However, an overall positive attitude towards patient involvement was related to how patients asked and how healthcare professionals responded to being asked.

Conclusion
There is limited evidence regarding patients’ actual intention to ask healthcare professionals to wash their hands, and some evidence that patients are reluctant to do so. Further research is required to understand this area thoroughly, including which situations patients would feel more empowered to speak up.

Relevance to clinical practice
Simple messages promoting patient involvement may lead to complex reactions in both patients and healthcare professionals. It is unclear, yet how patients and staff react to such messages in clinical practice. There is a need for a deeper understanding of how they can work together to support harm free care.

KEYWORDS
hand hygiene compliance, integrative review, patient engagement, patient involvement, patient participation

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Video-reflexive ethnography

Working with participants to video practices of interest, and then showing back the footage to them in reflexive sessions.

- Engages with the expertise of frontline staff, patients & visitors
- Makes explicit the complex reality of clinical work
- Raises awareness of taken-for-granted practices
- Results in learning and change (practice improvement)

Strengthening frontline clinicians’ infection control:
A multi-method study to reduce MRSA infection and transmission

Slide courtesy Dr. Su-Yin Hor

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Slide courtesy Dr Su-Yin Hor

http://innovations.bmj.com/content/suppl/2015/07/23/bmjinnov-2014-000032.DC1

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Effects of video

Reproduces the dynamics & complexity of everyday practice
Disrupts habituated patterns of behaviour
We see how we are collectively implicated in what we do
Transformative
Massumi, 2002
Vulnerability

Real time

Connects people to technical and relational dimensions of their work
Hologrammatic effect

We see how we are collectively implicated in what we do

Slide adapted from the work of Prof Rick Iedema, KCL

5 Moments for HAND HYGIENE

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My PhD

Aim: To use video-reflexive ethnography, in new ways, to assist patients, clinicians and myself to explore the practical and relational complexities of patient involvement in IPC

Supervisors: Prof Rick Iedema, Dr Su-yin Hor, Dr Clarissa Hughes (Prof Debra Jackson)
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### Study design

<table>
<thead>
<tr>
<th>Phases</th>
<th>Process</th>
<th>Procedure</th>
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<tbody>
<tr>
<td>Phase I</td>
<td>Field observations</td>
<td>Field observations were carried out from March 2013 to April 2014. Observations centered on IPC moments that occurred during everyday work.</td>
</tr>
<tr>
<td>Interviews</td>
<td>Interviews with 21 patients and two family members. Some patients participated in follow-up interviews. Twenty-seven interviews in total were audio- and/or video-recorded and transcribed (121 min of video footage collected). Common themes were identified from Phase I data by the researcher, patients, and the research project team to inform Phase II of the study.</td>
<td></td>
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<tr>
<td>Phase II</td>
<td>Videoing care VRGs with patients</td>
<td>Fourteen patients, eight female and six male, agreed to filming episodes of care (145 min of footage). Eight of the 14 patients (four female/four male) took part in reflexive sessions (20-30 min). Six had experienced colonization or infection with MRSA. Footage of their care episode was shown to them to stimulate discussion of their understandings and strategies around IPC. Four patients agreed to have these sessions video-recorded (141 min of footage), the others were audio-recorded.</td>
</tr>
<tr>
<td>Phase III</td>
<td>VRGs with staff</td>
<td>Clips and quotes from Phase II that demonstrated patients' understandings, strategies, and concerns were chosen (by patients and researcher) as feedback for six group reflexive sessions with nurses. Sessions were held on both day and night shifts, with a total of 35 nurses (2 ICPs, 2 clinical nurse educators, 3 clinical nurse consultants, and 28 ward nurses). The researcher facilitated these sessions asking nurses to respond to patients' insights and concerns, consider roles that patients might play in IPC, and how they could facilitate patient involvement in IPC.</td>
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### Video-reflexive ethnography with patients

- **Film care episodes**
- **Patients view & reflect**
- **Patients’ insights fed back to nurses**

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http://journals.sagepub.com doi/suppl/10.1177/1609406917690171#articleShareContainer
C: She should wear gloves shouldn’t she?
R: Why do you think she should wear gloves?
C: Well because she’s approaching my person without gloves and that can transfer infection.
R: Transfer infection...?
C: To me
R: What if she has washed her hands beforehand? Would you still like her to have gloves on as well?
C: Yeah.
R: What do the gloves do that make you feel safer?
C: They’re sterile. They’re branded sterile aren’t they? So anything that happens between putting them on and coming to me, it’s a smaller risk.
R: Have you seen the ones that sit just outside the doorway in the boxes?
C: Those blue ones?
R: Yeah. They’re the ones that they’re putting on.
C: No – I’ve had the white ones.
R: The white ones they tend to use for dressings and they are sterile. But . . . if this nurse was going to put gloves on she would just put blue ones on.
C: And what sort of sterility percentage are they? Are they sterile gloves or just gloves?
R: They’re just clean gloves.
C: Well I’d be as happy with clean hands. It’s just as good as the blue gloves. In fact [the blue ones are] probably worse, they’re just hanging on the wall. Goodness knows what gets in there [laughs]. Correct? . . . A glove to me is a sterile glove. It’s not just a glove hanging off the wall.
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Seeing IPC from patient perspectives

From his perspective he just sees the gloves and thinks, “Yeah I’m protected from infection because they’re wearing gloves.” But then he doesn’t know whether or not people have washed their hands before they put the gloves on. So unless you wash your hands before you put gloves on, you may as well not have put your gloves on. … it’s interesting that people feel safe when they see the gloves and gowns and things like that. (Nurse 27)

IPC can be confusing for staff too

Nurse 13: It’s a bit confusing sometimes because even when like the nurses are doing beds, in a four-bedded room [where other patients are watching], they wear gloves. … Why? I don’t know … But if there’s not bodily fluid on the sheet, nothing like that, so I’m not going to. I’m going to just make that with my bare hands.

Nurse 1: But if the patient’s been sweating in the bed all night, are you just going change your sheets?

Nurse 13: Sure, if it’s dry, it’s OK. If there’s something like, you know, body fluid, blood, faeces, urine…

Nurse 1: So, I’m not like that. I put on gloves before I change a bed.

Nurse 21: It’s the same thing [for nasal swabs], it’s still body fluids. … So she has to wear gloves for that.

Nurse 13: For the nose, I wouldn’t be wearing gloves. For the armpit too, I wouldn’t be. But for the perineum yes I would be wearing gloves.

Nurse 17: There is policy but there is also each nurse; a different interpretation of what the risk and what the policy actually says. Because the policy is not black and white with every single situation. … So it depends on each individual interpretation and then you just have to educate the patient on the situation themselves, and make sure that the basic glove principle is abided by.
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**CONTACT PRECAUTIONS**

in addition to Standard Precautions

STOP

R: Have you ever asked anyone about leaving your isolation room?  
B: No. There’s nobody to ask . . . I don’t think they know enough about it.  
R: What makes you think that?  
B: . . . well they don’t seem to talk about it .

Wear GOWN

Clean HANDS & Wear GLOVES

Interpersonal barriers to PI in IPC

- N3: We cannot stop them walking around, using our kitchen. They’ve been told [not to] but they’re still doing it.
- R: Say you see someone walking [out of their source-isolation room] do you then go and tell them, “You’re not supposed to be outside”?
- N3: Oh, no …They would be offended if you do that…..
- N32: When I ask [visitors] to do it… to use a like a gown, some of them they do use it, but some of them…they might even turn around to abuse you.
- N3: I think we need to have the courage to talk to the patients.
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• R: …who informs them?
  • N31: No one.
• R: So, who do you think should inform them?
  • N32: Well, I guess everybody.
  • N3: And the nursing staff too. We should start telling them . . . You know, in a way, it's not a jail—to keep them in the room. It's already depressing being in a single room . . . . It's not fair.
  • N3: Like, in a way, we shouldn’t be offended [if they question us]. Because it’s their life, not our life. You know what I mean?
  • N31: Yeah, yeah. They have rights too.

Interpersonal barriers to PI in IPC

• Nurse 21: It depends on what kind of relationship you have with the nurse. Because … I have looked after him; he is very good with me. But a lot of other nurses he has been very blunt with. So he doesn't have the rapport. So he will probably ask me something that that he wouldn't ask someone like [Nurse 17]. Because he doesn't get along with her.

• Nurse 17: Yeah I think he is actually right. Like I admit it, I wouldn't be able to answer all of his questions. … But if he were to ask me, it would start the ball rolling and then I would go and search for the information that he needs … I guess probably [he didn’t ask] because he didn't feel he had that rapport or was comfortable enough to ask.
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Patients’ solutions to barriers

Negotiating competing viewpoints on PI

It's interesting what they do notice actually because you don't think about it.

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Negotiating competing viewpoints on PI

R: Do you think it’s important for patients to know what you do for infection control?

N27: I guess so, but then … It brings up a whole range of educational issues that they need to be aware of. Like, it then just opens the floodgates.

N3: Yeah, they have the right [to question clinical practice] because it’s their health, not ours. And we’re protecting ourselves as well.

N2: Some people are very obsessive, demanding, I should say. Where they want you to do everything their way.

N17: I wouldn’t mind if a patient asked me and reminded me to wash my hands and for them to see me do it. Because the chances… if you wash your hands and you’re on your way to the patient’s room and something else happens and you touch something else, even though you’ve washed your hands you don’t realise that you’ve done something in between and you didn’t go just straight to the patient. So, I think it is good when the patient sees you wash your hands or put some alcohol on your hands … before you do something.

Negotiating competing viewpoints on PI

N2: But we should be at the level where we shouldn’t let the patients tell us to do that, that’s part of our job anyway.

N27: It’s one of the most dangerous things, going into hospitals, because of the rates of infections. … If I was in this hospital myself, I would for sure be asking someone if they washed their hands if I didn’t see it. … So, I wouldn’t really mind someone asking me had I washed my hands but, um, it becomes difficult, especially in this day of like Dr Google … when you say, “Oh, yes, I have actually washed my hands,” or used alcohol-based hand rub or whatever, that’s fine. If they then question you further, like, because then it sort of like takes away your authority as a healthcare worker. If you accept that they’ve asked you that question and then you provide them with the education surrounding it and then they still don’t accept it, I think that’s where people are getting a bit worried about them asking that kind of thing… it’s making people feel a bit defensive. … I could see their point of view as well but then I can see ours…
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Strengthening patient involvement through targeted practice intervention

Video-reflexive ethnography

- Anchored in theory that people learn & change through being enabled to question & disrupt habituated ways of being
- A democratic processes of data collection & analysis
- A way of reducing the feedback loop between patients and staff that care for them
- A means to examining the complexity of relationships & practices in situ
- Capable of making tangible and discussable the affective/emotional dimensions of practices that can influence behaviour
- Excellent for acknowledging the team-based essence of how safe care and PI is collectively negotiated

References


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Research Outputs


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