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Ask, speak up, and be proactive: Empowering patient infection control to prevent health care–acquired infections



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Background: Over the last decade, there has been a slow shift toward the more active engagement of patients and families in preventing health care–associated infections (HCAIs). This pilot study aimed to examine the receptiveness of hospital patients toward a new empowerment tool aimed at increasing awareness and engagement of patients in preventing HCAI.

Methods: Patients from the surgical department were recruited and randomized into 2 groups: active and control. Patients in the active arm were given an empowerment tool, whereas control patients continued with normal practices. Pre- and postsurveys were administered.

Results: At the baseline survey, just over half of the participants were highly willing to assist with infection control strategies. Participants were significantly more likely to be willing to ask a doctor or nurse a factual question than a challenging question. After discharge, 23 of the 60 patients reported discussing a health concern with a staff member; however, only 3 participants asked a staff member to wash their hands.

Conclusion: Our results suggest that patients would like to be more informed about HCAIs and are willing to engage with staff members to assist with the prevention of infections while in the hospital setting. Further work is going to need to be undertaken to ascertain the best strategies to promote engagement and participation in infection control activities.

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Despite progress in patient safety and hospital care, health care–acquired infections (HCAIs) continue to develop in hospitalized patients. Many factors promote infection among hospitalized patients: the increasing variety of medical procedures and invasive techniques creating potential routes of infection, the transmission of drug-resistant bacteria, decreased immunity among patients, and poor infection control practices may facilitate transmission.

Surgical site infections (SSIs) are one of the most common HCAIs, contributing to additional treatment costs, significantly

longer length of stay, and higher patient mortality.^{1,2} SSIs are associated with approximately 7–10 additional postoperative hospital days and a risk of death 2–11 times higher than that of operative patients without an infection.^{3,4} It has been estimated that SSI could be costing as much as A\$268 million per year in Australia.⁵

To improve health services, it has long been suggested that patients need to be empowered to take an active role in their own health care.⁶ Empowering patients to become partners in ensuring safe care has previously been described as patient collaboration, patient involvement, partnership, and patient-centered care. The term empowerment can have different meanings and interpretations, but in health care, it generally refers to the process that allows an individual or community to gain the knowledge, attitudes, and skills needed to make choices and participate in their care.⁷ The World Health Organization (WHO) hand hygiene (HH) guidelines define empowerment as “a process in which patients understand their opportunity to contribute, and are given the

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knowledge and skills by their Healthcare worker (HCW) and other educational sources to perform a task in an environment that recognises community and cultural differences and encourages patient participation.”⁸

In high-resource settings, such as the United States and the United Kingdom, the introduction of this concept has been influenced significantly by Institute of Medicine reports on health quality and safety.⁹ A number of initiatives and campaigns have been introduced in these countries, which aim to encourage patient involvement in safety. For example, the National Patient Safety Agency issued a patient safety alert to all acute hospitals in England and Wales in 2004, which included the introduction of a tested and evaluated multifaceted HH campaign to reduce infections.^{10,11} The campaign encapsulated the need for patient involvement; however, this was a less prominent aspect of the program.¹² Two years later, the National Patient Safety Agency initiated the cleanyourhands campaign, aimed at best practices in HH compliance among HCWs, with an emphasis on performing HH “at the right time and in the right place.” A central message of this campaign was “It’s OK to ask,” encouraging patients to ask HCWs whether they had performed HH before providing patient care. In 2009, the SAVE LIVES: Clean Your Hands campaign, an extension of the 2005 Clean Care is Safer Care WHO Patient Safety Challenge, was launched to stimulate international efforts in promoting HH compliance among HCWs in an endeavor to reduce HAIs.^{13,14} Patient empowerment was an integral part of the WHO’s HH multimodal strategy.

To date, empowerment programs have predominately been directed at improving HH compliance among patients and hospital staff. However, infection control programs are multifaceted and include a broad range of processes throughout the hospital. Attention needs to be paid to medical devices (eg, intravascular and alimentation devices, ventilators, equipment used for examination), the physical environment (eg, air ducts, surfaces), surgical wound management, and carriage by employees and other health professionals. There is an opportunity for patients to be engaged with a wider range of infection control strategies beyond HH.

This pilot study aimed to examine the receptiveness of hospital patients toward a new empowerment tool aimed at increasing awareness and engagement of patients in preventing HCAI.

METHODS

Study design

A prospective, controlled intervention study was undertaken in a major public hospital in Sydney, Australia, between November 2013 and February 2014. The study was approved by the Human Research Ethics Committee of the South Eastern Sydney Local Health District-Northern Sector.

Consultation

During the design phase, expert consultations were undertaken with staff members to map out the opportunities for patient involvement in infection prevention. Participants were asked to systematically think about the surgical patient care pathway (for elective surgery patients) and to identify opportunities where patients could assist with preventing HCAs.

Their suggestions were broken down into 2 main categories: prior to surgery (eg, adhering to personal cleanliness and HH, receiving education, asking HCWs to perform HH, staying away from ill contacts) and postsurgery (eg, monitoring their wound, paying attention to the environment, asking questions or asking HCWs to HH). These suggestions formed the main messages used in the patient empowerment tool. In addition, we undertook a series

of in-depth interviews with staff and patients to explore their attitudes toward current infection control practices and the use of patient empowerment strategies. Feedback from the interviews was also used to guide the development of the tool. Finally, we reviewed the following resources: published key discussion and empirical articles.

Participants

Patients who had undergone a number of different surgical procedures were invited to participate. Patients were recruited postoperatively over a 4-month period from 2 surgical wards of the hospital. The inclusion criteria for the study were any patient aged >18 years that had undergone a surgical procedure (elective or emergency), spoke English, and were able and willing to provide consent. Researchers attended the wards on different days and times to recruit participants. Patients were only approached if they were awake, not waiting for surgery or discharge, and not visibly distressed. Researchers were only able to randomly approach a subset of patients during the 4-month period. A member of the research team approached the patients in the wards, spoke to them about the study, and invited them to participate. A \$40 gift voucher was given to all participants to compensate them for their time.

Intervention

Participants were randomized into 2 groups: active and control group. The active group received the empowerment intervention, whereas the control group was not exposed to any additional material. We developed 2 empowerment tools: a flip chart and a brochure. Participants randomized to the active arm received a one-on-one consultation with a study investigator during which time information in the flip chart was verbally delivered and any questions answered. Patients were then given a copy of the brochure that contained the same key messages to keep. The tools covered the following 2 areas: (1) health care—associated infections (what they are and how they occur) and (2) the role the patient can play in preventing HCAI. The slogan Ask questions, speak up, and be proactive was used to breakdown the messages into 3 categories (Table 1). There was no further active engagement with participants while they were still in hospital.

Data collection

Data were collected at 2 time points from all participants via a survey (at baseline and after discharge). Nineteen questions were included in the baseline survey that assessed patient’s knowledge, risk perceptions, and attitudes toward HCAs and their willingness to ask HCWs questions about infection control initiatives and their information needs. Four different aspects of patient willingness were captured in the survey, including patient’s willingness to (1) ask factual questions (What signs should I look out for if my wound is not healing as it should?), (2) ask challenging questions (Have you washed your hands? Should my wound dressing be changed?), (3) refuse treatment (Would you refuse treatment from a doctor or nurse who was coughing or sneezing?), and (4) notify staff of issues (Would you notify a doctor or nurse if you thought your wound had become infected?). To examine the impact of profession, separate items were used to assess patient-reported willingness to participate in these behaviors with either a nurse or doctor. Patients had to answer on a 5-point scale, with scores ranging from highly willing to not at all willing and unsure. Questions were adapted from a patient safety survey undertaken by Davis et al.¹⁵ In addition, patient’s demographic data were collected, along with

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