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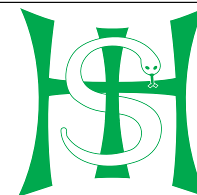

Defining the user role in infection control

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SUMMARY

Background: Health policy initiatives continue to recognize the valuable role of patients and the public in improving safety, advocating the availability of information as well as involvement at the point of care. In infection control, there is a limited understanding of how users interpret the plethora of publicly available information about hospital performance, and little evidence to support strategies that include reminding healthcare staff to adhere to hand hygiene practices.

Aim: To understand how users define their own role in patient safety, specifically in infection control.

Methods: Through group interviews, self-completed questionnaires and scenario evaluation, user views of 41 participants (15 carers and 26 patients with recent experience of inpatient hospital care in London, UK) were collected and analysed. In addition, the project's patient representative performed direct observation of the research event to offer inter-rater reliability of the qualitative analysis.

Findings: Users considered evidence of systemic safety-related failings when presented with hospital choices, and did not discount hospitals with high ('red' flagged) rates of meticillin-resistant *Staphylococcus aureus*. Further, users considered staff satisfaction within the workplace over and above user satisfaction. Those most dissatisfied with the care they received were unlikely to ask staff, 'Have you washed your hands?'

Conclusion: This in-depth qualitative analysis of views from a relatively informed user sample shows 'what matters', and provides new avenues for improvement initiatives. It is encouraging that users appear to take a holistic view of indicators. There is a need for strategies to improve dimensions of staff satisfaction, along with understanding the implications of patient satisfaction.

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Introduction

On patient involvement, the recent All-Party Parliamentary Groups' Report in England highlights a need 'to change the clinical paradigm from "what's the matter" to "what matters to you"'(p.6).[1] This necessary 'shift in culture and power' has

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been highlighted across clinical areas including patient safety.[2,3] There is a well-established discourse surrounding the potential role and benefits of involving service users in co-designing healthcare services and delivery through consultation, followed by feedback and evaluation to improve services.[4—6] Here, users constitute members of the public (as potential users of services), patients as current users, as well as carers and relatives of patients. Involvement of patients in decision making around their own individual treatment plans can result in enhanced self-management, and better health outcomes through increased self-efficacy.[4] Decision making at the organizational level in hospitals may be viewed as a logical extension of such user involvement, if users are viewed as secondary stakeholders or as 'temporary members' of the hospital.[7] Even within a hospital setting with its clearly defined organizational boundary, patients have varying degrees of membership as inpatients, outpatients or those with long-term conditions with complex, blended patient pathways.[8]

Whilst policy makers and academics advocate and evaluate user roles, some aspects of this participation remain inadequately defined.[9] Further research is required regarding the skills and decision-making process employed by users to define their own role in patient safety, specifically in infection control. When thinking of roles, issues of responsibility and blame arise, and clarity of information and checking understanding is crucial. In-depth qualitative research has revealed that surgical site infections were perceived by patients to be as a result of chance or as a result of their own neglect in postoperative care; conversely, meticillin-resistant *Staphylococcus aureus* (MRSA) was viewed as avoidable and hence the result of deficiencies in hospital management and care.[10] Users are exposed to a lot of information and indicators about rates of healthcare-associated infections (HCAIs) via hospital websites as well as the media, but it is not known how users make sense of this information. Additionally, it is not completely clear how users view the espoused and potential roles promoted for them by healthcare organizations. The Chief Medical Officer's 2006 annual report in England talked about 'strengthening the patient's hand' (p.19)[11] in response to low compliance with hand hygiene practices by hospital healthcare workers (HCWs). Some hospitals have sought involvement of patients in infection prevention and control practices at the point of care, specifically by monitoring and reminding HCWs about hand hygiene compliance.[12—14] Some of these practices encourage patients to ask HCWs, at the point of care, 'Have you washed your hands?' This ubiquitous strategy for patient involvement has been reviewed previously.[15]

It is a fitting time to reflect upon positioning patients to monitor and question healthcare staff when, 10 years after the initial Francis report, challenges persist for National Health Service (NHS) staff to 'speak up'.[16]

This paper explores users' self-perceived roles in patient safety, specifically in infection control, describing the information needs of users and potential adverse effects,[15,17,18] with the aim of generating useful evidence before the resourcing of large-scale, controlled, relevant studies.

Methods

In May 2014, a sample of 41 participants (15 carers, 26 patients) was recruited from across London. Recruitment was by quota sampling on ethnicity and satisfaction (measured on a five-point Likert scale) with received care. In order to minimize respondent desirability bias and conflict of interest, participants were recruited via an independent market research organization, and individuals who had received care at the host organization were excluded. To minimize knowledge and confidence bias,[19] HCWs were also excluded. Informed consent was obtained, and participants were reimbursed for their time.

User views were sought through a five-hour consultation event held at Hammersmith Hospital, London. Discussions were organized in groups of seven to nine participants, with an experienced facilitator at each table. Group interviews, self-completed questionnaires, scenario evaluation and discrete choice activities were used to collect data. Following open questions about the meaning of patient safety, open and closed questions were investigated in four main domains: responsibility for patient safety; role of patients in patient safety; specific role of reminding HCWs of hand hygiene; and use of publicly available infection data in hospital choice (Figure 1).

Participants were asked to write free text or fill out short questionnaires before group discussion for each question to capture individual views. Non-participant observers also took notes at each table. Plenary sessions were led by a facilitator from the independent organization to minimize bias. The plenary included an infection control information and 'questions and answers' (Q&A) session to determine if this had any immediate/short-term impact on perceptions; this session was led by an infection control research nurse (ECS) and infection control doctor (WZ). The content of the session is set out in Table I. The multi-disciplinary research team, comprising infection control practitioners, healthcare management researchers and patient representatives, took observation notes and analysed the data. In addition, the project's patient representative (FH) provided inter-rater reliability during data analysis. All discussions were audio recorded and transcribed. Quantitative analysis of the self-completed questionnaires comprised descriptive analysis. An integrated approach to analysis was used for the qualitative data, where an organizing framework or 'start-up' list from the literature[6,20] is followed by an inductive analysis.[21]

Results

Participants talked freely about their hospital experiences and sources of influence, including experiences of friends and family.

Patient safety: meaning and expectations

Participants brought up a number of aspects of patient safety, ranging from structural issues such as levels and consistency of staffing, processes such as cleanliness of the environment and information sharing, and wider cultural aspects of a safe and friendly atmosphere.

Dimensions of patient safety which were seen as important by the participants, in order of prevalence to the open question, 'What does patient safety include?' were as follows: emphasis on cleanliness of the environment, staff and visitors; protecting patients from adverse incidents (e.g. misdiagnosis and wrongly prescribed drugs, infections); having well-trained

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