Involving patients in understanding hospital infection prevention and control using video-reflexive methods

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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

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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)

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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”

(Olsen, Aisner, & McGinnis, 2007, p. xiii).

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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., 2012; 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 *(Longtin 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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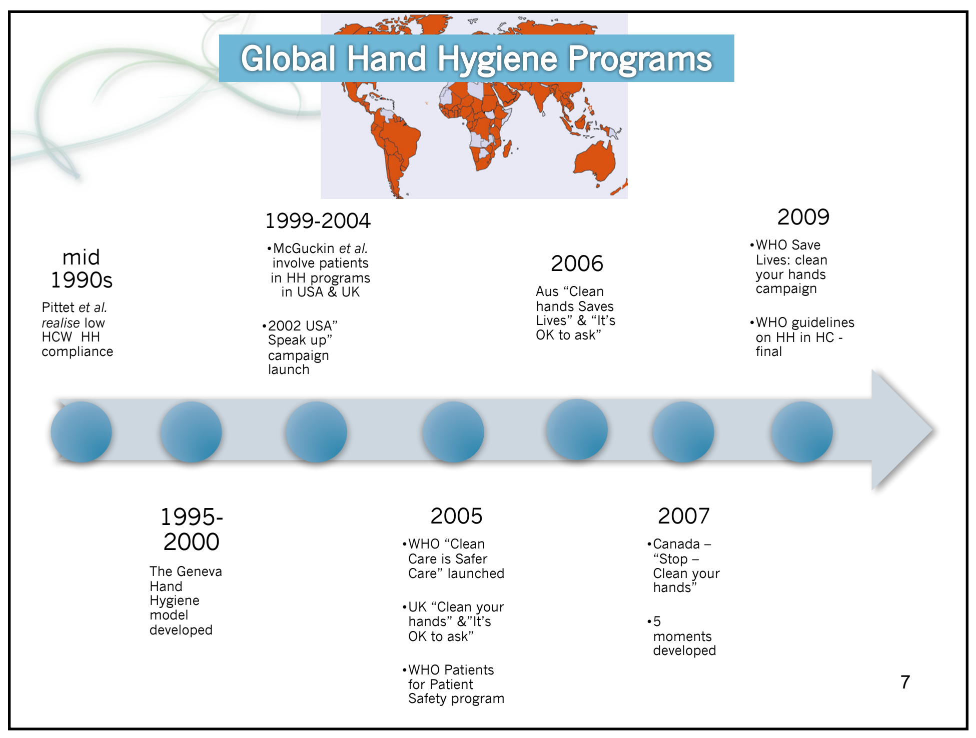

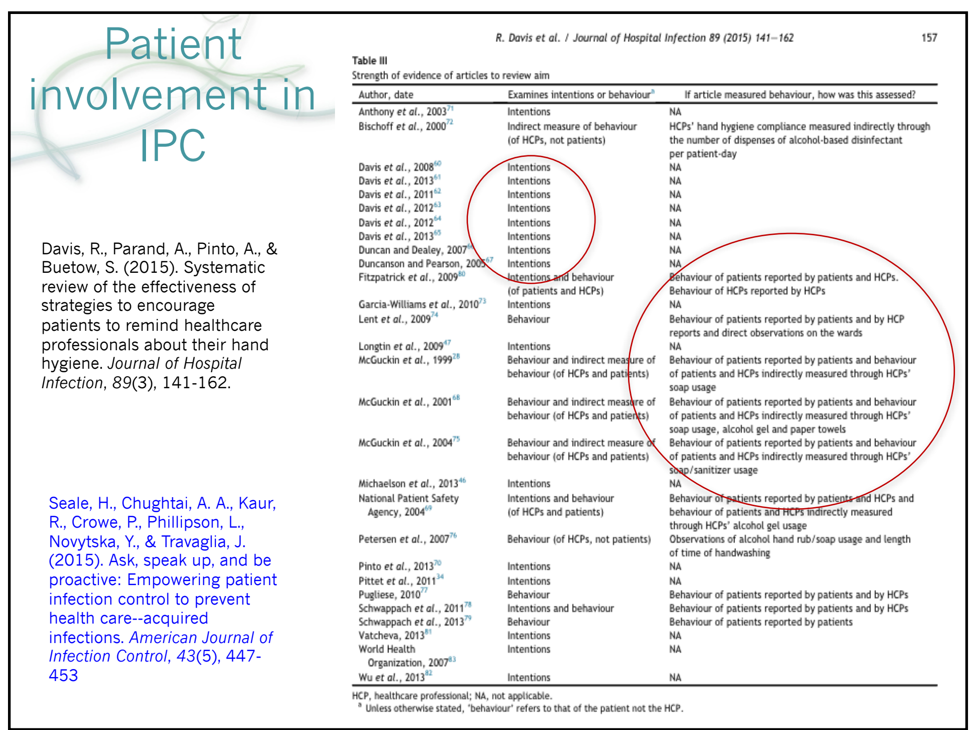

Davis, R., Parand, A., Pinto, A., & Buetow, S. (2015). Systematic review of the effectiveness of strategies to encourage patients to remind healthcare professionals about their hand hygiene. *Journal of Hospital Infection*, *89*(3), 141-162.

R. Davis et al. / Journal of Hospital Infection 89 (2015) 141–162 157

Table III
Strength of evidence of articles to review aim

Author, date	Examines intentions or behaviour[a]	If article measured behaviour, how was this assessed?
Anthony *et al.*, 2003[71]	Intentions	NA
Bischoff *et al.*, 2000[72]	Indirect measure of behaviour (of HCPs, not patients)	HCPs' hand hygiene compliance measured indirectly through the number of dispenses of alcohol-based disinfectant per patient-day
Davis *et al.*, 2008[60]	Intentions	NA
Davis *et al.*, 2013[61]	Intentions	NA
Davis *et al.*, 2011[62]	Intentions	NA
Davis *et al.*, 2012[63]	Intentions	NA
Davis *et al.*, 2012[64]	Intentions	NA
Davis *et al.*, 2013[65]	Intentions	NA
Duncan and Dealey, 2007[66]	Intentions	NA
Duncanson and Pearson, 2005[67]	Intentions	NA
Fitzpatrick *et al.*, 2009[80]	Intentions and behaviour (of patients and HCPs)	Behaviour of patients reported by patients and HCPs. Behaviour of HCPs reported by HCPs
Garcia-Williams *et al.*, 2010[73]	Intentions	NA
Lent *et al.*, 2009[74]	Behaviour	Behaviour of patients reported by patients and by HCP reports and direct observations on the wards
Longtin *et al.*, 2009[47]	Intentions	NA
McGuckin *et al.*, 1999[28]	Behaviour and indirect measure of behaviour (of HCPs and patients)	Behaviour of patients reported by patients and behaviour of patients and HCPs indirectly measured through HCPs' soap usage
McGuckin *et al.*, 2001[68]	Behaviour and indirect measure of behaviour (of HCPs and patients)	Behaviour of patients reported by patients and behaviour of patients and HCPs indirectly measured through HCPs' soap usage, alcohol gel and paper towels
McGuckin *et al.*, 2004[75]	Behaviour and indirect measure of behaviour (of HCPs and patients)	Behaviour of patients reported by patients and behaviour of patients and HCPs indirectly measured through HCPs' soap/sanitizer usage
Michaelson *et al.*, 2013[46]	Intentions	NA
National Patient Safety Agency, 2004[69]	Intentions and behaviour (of HCPs and patients)	Behaviour of patients reported by patients and HCPs and behaviour of patients and HCPs indirectly measured through HCPs' alcohol gel usage
Petersen *et al.*, 2007[76]	Behaviour (of HCPs, not patients)	Observations of alcohol hand rub/soap usage and length of time of handwashing
Pinto *et al.*, 2013[70]	Intentions	NA
Pittet *et al.*, 2011[34]	Intentions	NA
Pugliese, 2010[77]	Behaviour	Behaviour of patients reported by patients and by HCPs
Schwappach *et al.*, 2011[78]	Intentions and behaviour	Behaviour of patients reported by patients and by HCPs
Schwappach *et al.*, 2013[79]	Behaviour	Behaviour of patients reported by patients
Vatcheva, 2013[81]	Intentions	NA
World Health Organization, 2007[83]	Intentions	NA
Wu *et al.*, 2013[82]	Intentions	NA

HCP, healthcare professional; NA, not applicable.
[a] Unless otherwise stated, 'behaviour' refers to that of the patient not the HCP.

Seale, H., Chughtai, A. A., Kaur, R., Crowe, P., Phillipson, L., Novytska, Y., & Travaglia, J. (2015). Ask, speak up, and be proactive: Empowering patient infection control to prevent health care--acquired infections. *American Journal of Infection Control*, *43*(5), 447-453

SYSTEMATIC REVIEW

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

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EXECUTIVE SUMMARY

Background
Healthcare-associated infections pose a significant risk to patients in acute healthcare settings such as hospitals. Increasingly, patients are encouraged to be active participants and partner with healthcare professionals to positively influence their own safety and overall experience throughout their healthcare journey. Patient-focused safety initiatives include the empowerment of patients to be active partners with healthcare professionals in order to influence the hand hygiene behaviors and compliance of the healthcare professionals providing care to them. Partnering within the context of healthcare, and between the patient and healthcare professional, can be considered as a general concept that involves the empowerment of patients to participate in their care. Terms used to describe patient partnering within healthcare vary and include patient participation, patient-centeredness, patient empowerment and patient engagement. Although patients appear generally to have positive attitudes and intentions about engaging in their safety and partnering in the healthcare setting, their intentions and actual behaviors vary considerably. Patients appear less likely to engage in behaviors that require questioning of the perceived or real authority of healthcare professionals. A patient's intention and subsequent act of partnering with healthcare professionals for hand hygiene compliance by the healthcare professional are influenced by complex internal, external and social factors as well as cultural, behavioral and systematic factors.

Objectives

Conclusion
The current review highlights the complexity of the patient's experience of partnering with healthcare professionals for hand hygiene compliance. The experiences reported indicated that there is a possible disparity between the healthcare facility and healthcare professionals' promotion and intention of partnering for hand hygiene compliance, and the actual patient's acceptance, participation, partnership, experience and implementation of this initiative. This disconnect between intent and action appears to be influenced by a number of factors including organizational structures as well as drivers such as cultural beliefs and behavior.

evidence such as text and opinion.

Search strategy
The search strategy aimed to find both published and unpublished studies from 1990 to May 2015. Studies published in English were considered for inclusion in this review.

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REVIEW

An integrative review exploring the perceptions of patients and healthcare professionals towards patient involvement in promoting hand hygiene compliance in the hospital setting

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Funding information
The project is self-funded by the doctoral researcher and the main author of this article.

Aims and objectives: To review patients' and healthcare professionals' perceptions of patient involvement in promoting hand hygiene compliance in the hospital setting.
Background: Initiatives continue to emphasise the importance of involving patients in their safety at the point of care. A patient-centred care approach aimed to empower patients to become active members of the healthcare team. However, understanding the perceptions of patients and healthcare professionals of patient involvement in promoting hand hygiene compliance among healthcare professionals has yet to be fully explored.
Design: Integrative literature review.
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, health-

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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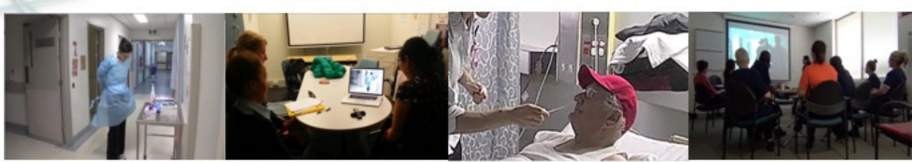
Video-reflexive ethnography



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)

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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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HEALTH IT, SYSTEMS AND PROCESS INNOVATIONS

ORIGINAL ARTICLE

An innovative approach to strengthening health professionals' infection control and limiting hospital-acquired infection: video-reflexive ethnography

Rick Iedema,[1,2] Su-Yin Hor,[2] Mary Wyer,[2] Gwendolyn L Gilbert,[3,4,6] Christine Jorm,[5] Claire Hooker,[3] Matthew Vincent Neil O'Sullivan[4,6]

▸ Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/bmjinnov-2014-000032).

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ABSTRACT

Objective To strengthen clinicians' infection control awareness and risk realisation by engaging them in scrutinising footage of their own infection control practices and enabling them to articulate challenges and design improvements.

Design and participants Clinicians and patients from selected wards of 2 hospitals in western Sydney.

Main outcome measures Evidence of risk realisation and new insights into infection control as articulated during video-reflexive feedback meetings.

Results Frontline clinicians identified previously unrecognised infection risks in their own practices and in their team's practices. They also formulated safer ways of dealing with, for example, charts and patient transfers.

Conclusions Video-reflexive ethnography enables frontline clinicians to identify infection risks and to design locally tailored solutions for existing risks and emerging ones.

INTRODUCTION

Healthcare-associated infections (HCAIs) pose considerable risk for hospital patients and incur huge costs for them and for funders. The US Centres for Disease Control and Prevention (CDC) estimates that "more than two million people are sickened every year with antibiotic-resistant infections, with at least 23 000 dying as a result."[1] The costs of these hospital-acquired infections "have ranged as high as US$20 billion in excess direct healthcare costs, with additional costs to society for lost productivity as high as US$35 billion a year (2008 dollars)."[1]

Moreover, the CDC acknowledges that these estimations "are based on conservative assumptions and are likely minimum estimates." On its part, the European Centre for Disease Prevention and Control estimated that "4 131 000 patients are affected by approximately 4 544 100 episodes of HCAI every year in Europe".[2]

Infection control strategies aiming to address these challenges have largely focused on hand hygiene compliance,[3] but raising hand hygiene rates do not unambiguously correspond to lowering nosocomial infection rates.[4] The relationship between infections and practice cannot be reduced to hand hygiene and thus, is affected by factors that to date have not been adequately illuminated.

The present article reports on a 'video-reflexive ethnography' study[5] that involved frontline nursing and medical staff in reviewing footage of their own in situ practices. The study's aim was to illuminate the full complexity of the practices where infection control is imperative in order to render frontline practitioners' awareness of risk more acute and their infection control more effective.

Since its inception in 2002,[6] video-reflexive ethnography has been adopted globally as a means of involving both frontline clinicians and patients in understanding local risks and the redesigning of practices.[7,8] To date, this methodology

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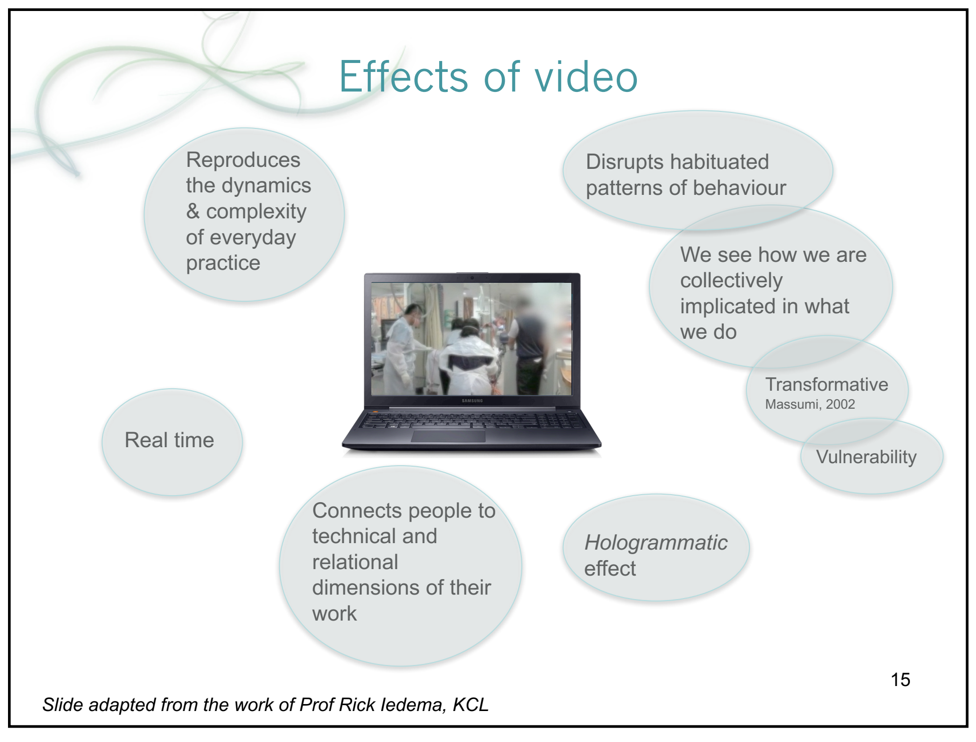

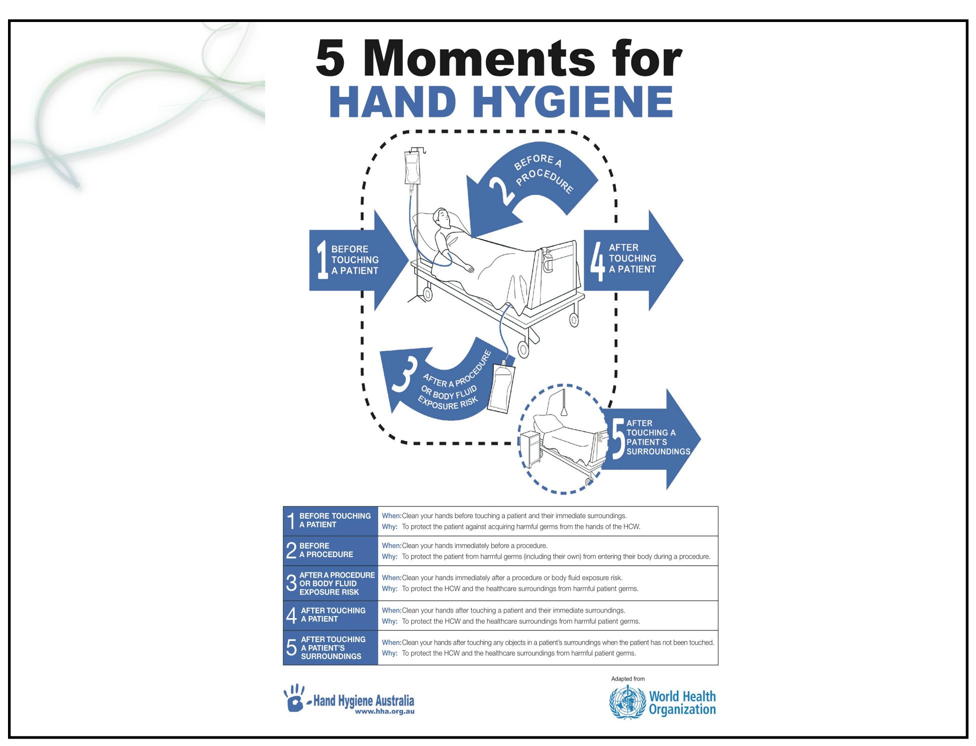

Moment	When / Why
1 BEFORE TOUCHING A PATIENT	When: Clean your hands before touching a patient and their immediate surroundings. Why: To protect the patient against acquiring harmful germs from the hands of the HCW.
2 BEFORE A PROCEDURE	When: Clean your hands immediately before a procedure. Why: To protect the patient from harmful germs (including their own) from entering their body during a procedure.
3 AFTER A PROCEDURE OR BODY FLUID EXPOSURE RISK	When: Clean your hands immediately after a procedure or body fluid exposure risk. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.
4 AFTER TOUCHING A PATIENT	When: Clean your hands after touching a patient and their immediate surroundings. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.
5 AFTER TOUCHING A PATIENT'S SURROUNDINGS	When: Clean your hands after touching any objects in a patient's surroundings when the patient has not been touched. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.

Original Article

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The meaning of home at the end of life: A video-reflexive ethnography study

Aileen Collier[1], Jane L Phillips[2] and Rick Iedema[3]

Abstract

Background: While 'home' is cited most frequently as being the preferred place of death, most people will die in institutions. Yet, the meaning and significance of home for people nearing the end of life has not been fully explored.
Aim: The aim of this article is to critically examine the meaning of home for dying patients and their families.
Design: The qualitative study used video-reflexive ethnography methods. Data were collected and analysed over an 18-month period.
Setting/participants: Participants were recruited from two Australian sites: a palliative care day hospital and an acute hospital. Participants included patients with a prognosis of 6 months or less ($n=29$), their nominated family member(s) ($n=5$) and clinicians ($n=36$) caring for them. Patients and families were 'followed' through care settings including the palliative care unit and into their own homes.
Results: Whether or not participants deemed space(s) safe or unsafe was closely related to the notion of home. Six themes emerged concerning this relationship: 'No place like home'; 'Safety, home and the hospital'; 'Hospital "becomes" home'; 'Home "becomes" hospital'; 'Hospital and "connections with home"'; and 'The built environment'.
Conclusion: Home is a dynamic concept for people nearing the end of life and is concerned with expression of social and cultural identity including symbolic and affective connections, as opposed to being merely a physical dwelling place or street address. Clinicians caring for people nearing the end of life can foster linkages with home by facilitating connections with loved ones and meaningful artefacts.

Keywords
Home care, health facility environment, human geography, patient safety, end-of-life care

What is already known about the topic?

- Most, but not all, people have a preference to die at home.
- For many people, a home death is not possible.
- The meaning of home has ontological and social significance.

What this paper adds?

- The meaning of home takes on heightened importance at the end of life and is closely associated with patient safety.

Implications for practice, theory or policy

- There are opportunities for clinicians to consider how connections with home can be fostered for people hospitalised near the end of life.

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Article

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Article

Patients' and families' perspectives of patient safety at the end of life: a video-reflexive ethnography study

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Abstract

Objective: The aim of this study was to investigate patients' and families' perspectives of safety and quality in the setting of a life-limiting illness.
Design: Data reported here were generated from a qualitative study using video-reflexive ethnographic methodology. Data were collected over 18 months and generated through participant observation, shadowing of clinicians, field-interviews and semi-structured interviews with patients and families.
Setting: The study was conducted at two hospital sites in Sydney, Australia and in patients' homes.
Participants: Patients with an advanced life-limiting illness ($n=29$) ranging in age between 27 and 89 years and family members ($n=5$) participated in the study.
Results: Patient safety remains important to dying patients and families. For dying people, iatrogenic harm is not regarded as 'one off' incidents. Rather, harm is experienced as a result of an unfolding series of negative events. Critically, iatrogenic harm is emotional, social and spiritual and not solely technical–clinical misadventure and is inextricably linked with feeling unsafe. Thus, patient safety extends beyond narrowly defined technical–clinical parameters to include interpersonal safety.
Conclusions: Current approaches to patient safety do not address fully the needs of dying patients and their families. Patients and their families regard poor communication with and by health professionals to be harmful in and of itself.

Key words: palliative care, end-of-life care, patient safety, adverse event, communication, patient-centred care, qualitative research

Introduction

Patient safety is defined as the 'avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of health care' [1]. Iatrogenic harm is defined as 'harm arising from or associated with plans or actions taken during the provision of healthcare, rather than an underlying disease or injury' [2]. How patient safety and iatrogenic harm are defined, however, has largely failed to account for the socio-cultural context in which healthcare is delivered [3]. Defining patient safety and harm is left almost exclusively to clinicians, policy-makers and researchers [4, 5], with the role of patients and families seen as an emerging area [6, 7]. Rarely are patients or families consulted as to what constitutes 'patient safety' and how such harms could be avoided or addressed, yet patients and families hold significant knowledge about healthcare safety and have crucial insights into opportunities for improving care [8]. Previous studies have shown that patients were able to identify adverse events in their own care when not otherwise recorded [9, 10]. Furthermore, the experiences of patients have been

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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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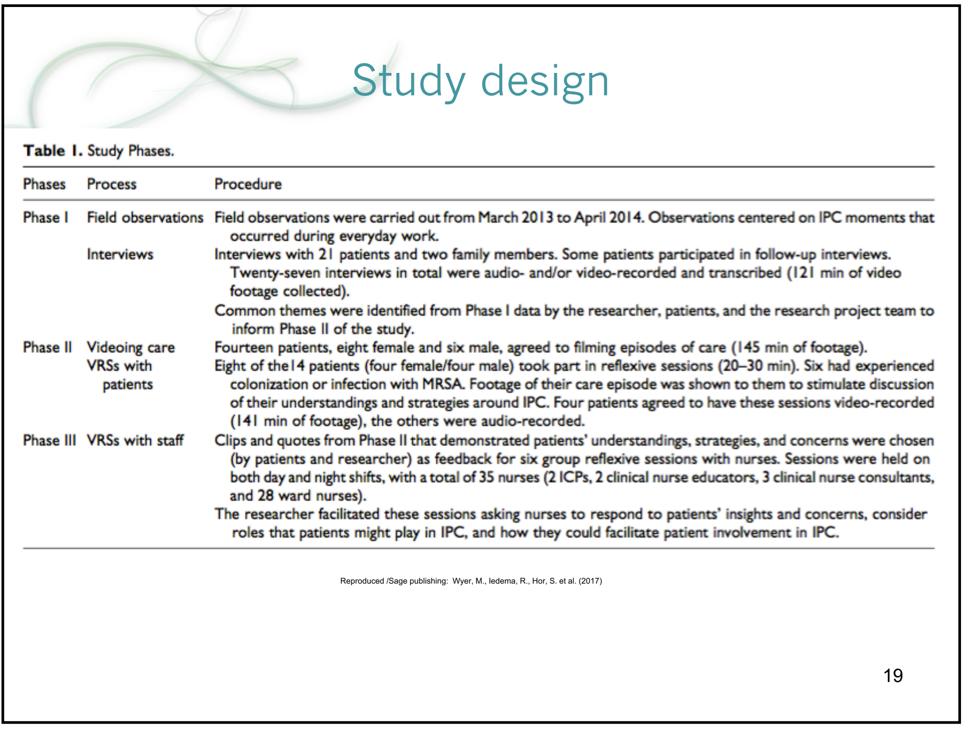

Study design

Table 1. Study Phases.

Phases	Process	Procedure
Phase I	Field observations	Field observations were carried out from March 2013 to April 2014. Observations centered on IPC moments that occurred during everyday work.
	Interviews	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.
Phase II	Videoing care	Fourteen patients, eight female and six male, agreed to filming episodes of care (145 min of footage).
	VRSs with patients	Eight of the14 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.
Phase III	VRSs with staff	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.

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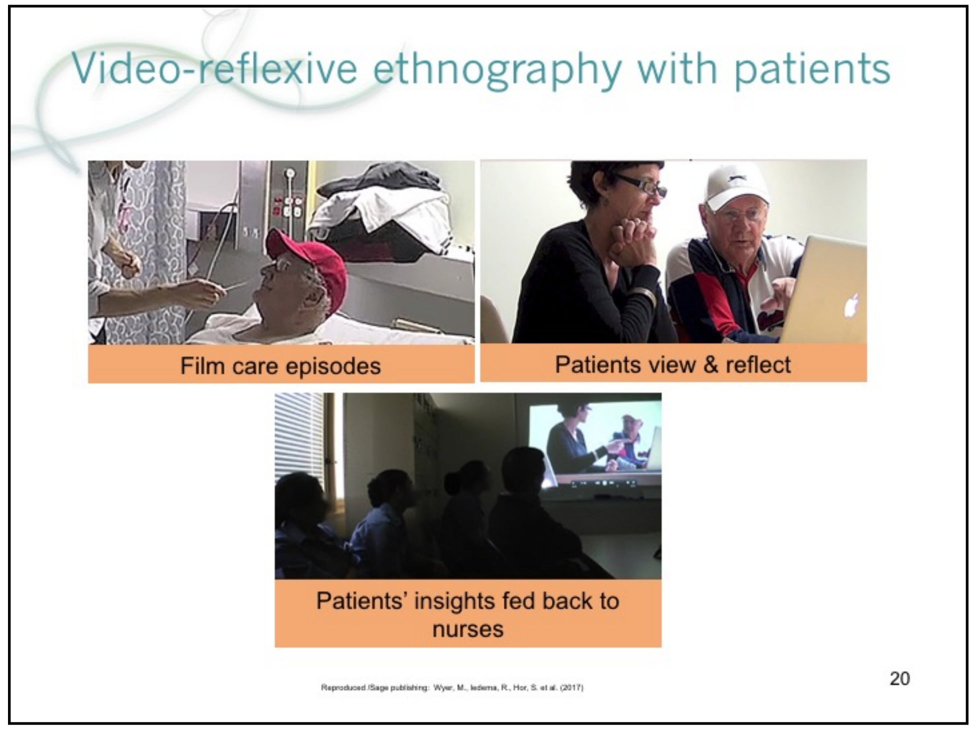

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ORIGINAL ARTICLE
Involving patients in understanding hospital infection control using visual methods
Mary Wyer, Debra Jackson, Rick Iedema, Su-Yin Hor, Gwendolyn L Gilbert, Christine Jorm, Claire Hooker, Matthew Vincent Neil O'Sullivan and Katherine Carroll
Article
Patient Involvement Can Affect Clinicians' Perspectives and Practices of Infection Prevention and Control: A "Post-Qualitative" Study Using Video-Reflexive Ethnography
Mary Wyer, Rick Iedema, Su-Yin Hor, Christine Jorm, Claire Hooker, and Gwendolyn L. Gilbert
Abstract
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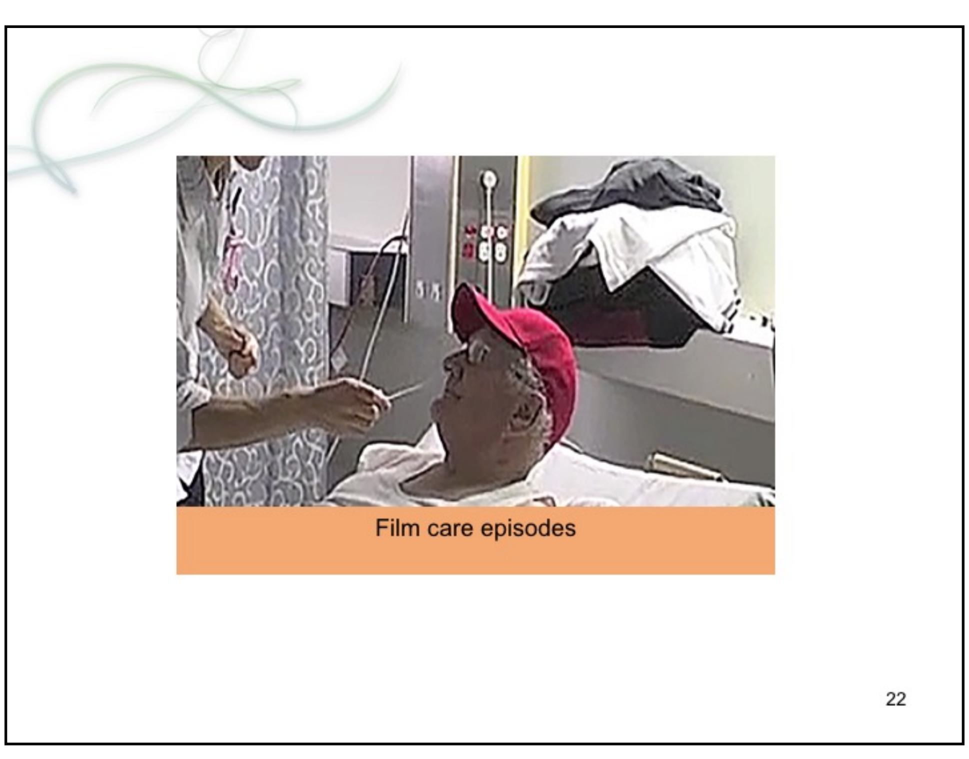
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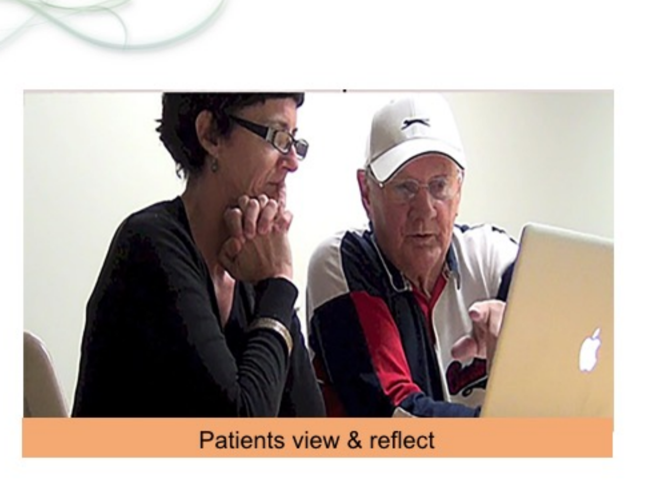

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C: She should wear gloves shouldn't she?

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.

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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)

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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…

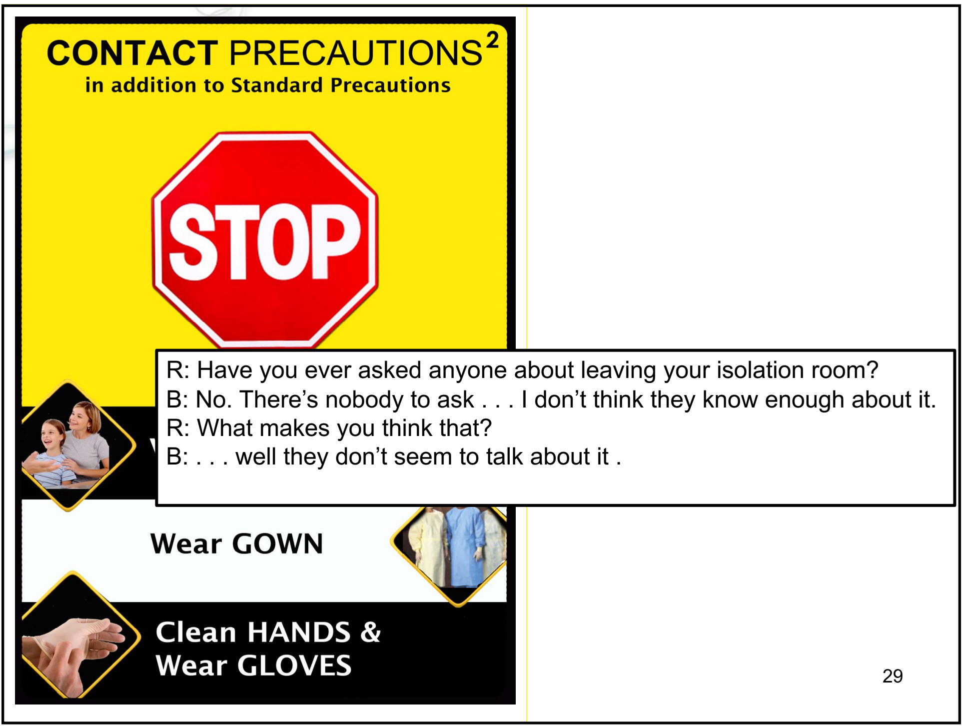
Nurse 1: So, I’m not like that. I put on gloves before I change a bed.

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.

28



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.

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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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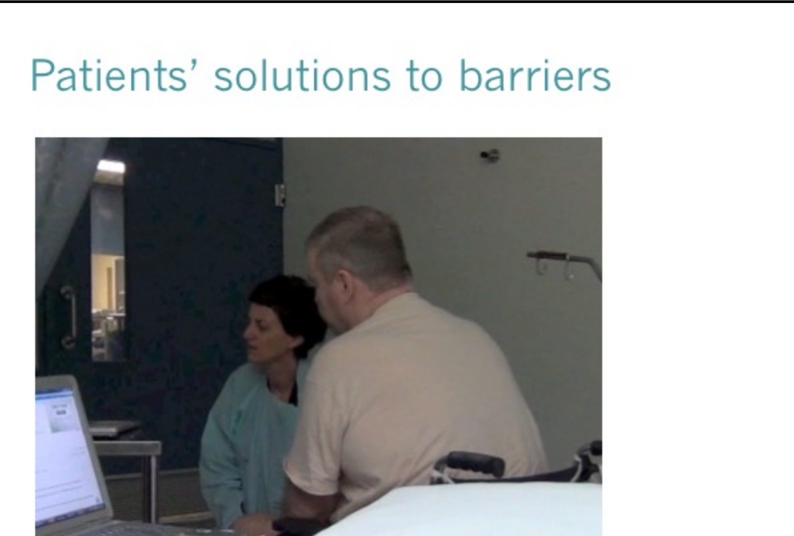
Patients' solutions to barriers



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Negotiating competing viewpoints on PI

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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.

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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 (Dewey 2007)
- 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

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Research Outputs

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June 21, 2018	(FREE Teleclass) THE FUTURE OF INFECTION CONTROL – BRIGHT OR BLEAK? Speaker: **Martin Kiernan**, University of West London
July 17, 2018	(FREE European Teleclass) HOSPITAL INFECTION CONTROL FROM A DEVELOPING COUNTRY'S PERSPECTIVE Speaker: **Dr. Aamer Ikram**, Director, National Institute of Health, Islamabad, Pakistan
July 19, 2018	FLOOD REMEDIATION IN HEALTHCARE FACILITIES – INFECTION CONTROL IMPLICATIONS Speaker: **Andrew Streifel**, University of Minnesota
August 16, 2018	(FREE Teleclass) INTERPRETING RESEARCH EVIDENCE: A KEY SKILL FOR INFECTION CONTROL PROFESSIONALS Speaker: **Prof. Donna Moralejo** , Memorial University School of Nursing, Newfoundland
August 22, 2018	(South Pacific Teleclass) CONTROL OF CARBAPENEMASE-PRODUCING ENTEROBACTERIACEA IN AN ENDEMIC SETTING: DO CLASSICAL IPC METHODS WORK FOR NEW AGE BUGS?

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