Keywords: Discourse/HCAI/Infection/ Infection control/Infection prevention

The language used in infection-control discourse often lacks objectivity, and can affect staff compliance with policies and guidance, as well as patient outcomes

How language choice can affect HCAI prevention

In this article...

- What is meant by the term 'discourse'
- How hand-hygiene policies illustrate the power of discourse
- Implications of strict guidance that is not evidence-based

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The financial and human costs of healthcare-associated infections have prompted many local and national policies/guidelines aimed at controlling or preventing infection. However, the language used in the discourse of this area of practice tends to lack objectivity and may make unachievable demands of staff. This article explores how such language can negatively affect staff behaviour and drive poor practice underground.

Healthcare-associated infections (HCAIs) affect up to 4.1 million people in the European Union each year (World Health Organization, 2011). In England alone, 300,000 patients a year acquire an infection during NHS care, leading to increased morbidity, mortality, length of stay and healthcare costs (National Institute for Health and Care Excellence, 2012). The prevalence of HCAIs can cause anxiety for patients and relatives, and undermines confidence in the NHS (Royal College of Nursing, 2012).

Many evidence-based guidelines, advisory structures, expert committees and Department of Health diktats have sought to reduce the burden of HCAIs. A common by-product of such intense scrutiny and discussion is that a dominant, accepted language (referred to hereafter as "discourse") can develop that presents the problem and solutions in certain ways. This may galvanise changes in practice, but it can have unintended consequences.

Discourse

Discourse in this context can be defined as the communication of thought through words. It can be considered a neutral servant of the people, a transparent medium that conveys the nature of the world, as well as people's thoughts and impressions of it. For example, people discuss HCAIs because the related morbidity, mortality and economic costs are unacceptable.

Discourse can do more than communicate thoughts and ideas: it can also be used to negotiate with and influence people, by highlighting certain ways of seeing the world while downplaying others. It can reflect the world as it is, as well as construct it.

A good example is the concept of zero tolerance. In 2012 it was proposed that healthcare had reached a critical juncture between patient safety, infection prevention and quality of care. The Association for Professionals in Infection Control and Epidemiology (2012) argued that it was time to commit to an uncompromising vision of an infection-free healthcare system. Although well intended, a zero-tolerance approach ignores the fact that a range of factors make the eradication of HCAIs unrealistic.

These include:

- Ageing populations;
- Concurrent use of invasive procedures;
- Higher throughput of patients in hospitals;
- Increased bed occupancy;
- Shorter turnaround times between patients;
- Economical staff-patient ratios.

In these circumstances a more realistic aim is to manage HCAIs.

Of course, there is nothing wrong with

5 key points

1. Every year, millions of healthcare-associated infections are recorded in the EU
2. Contracting a HCAI can be fatal
3. Many trusts have infection-prevention strategies in place to improve patient safety and lower healthcare costs
4. Health professionals can be blamed for errors without due attention being paid to the system within which they are working
5. Evidence on the effectiveness of hand-hygiene policies is likely to be limited due to the high number of variables that can affect outcomes

The discourse around hand hygiene highlights the power of language

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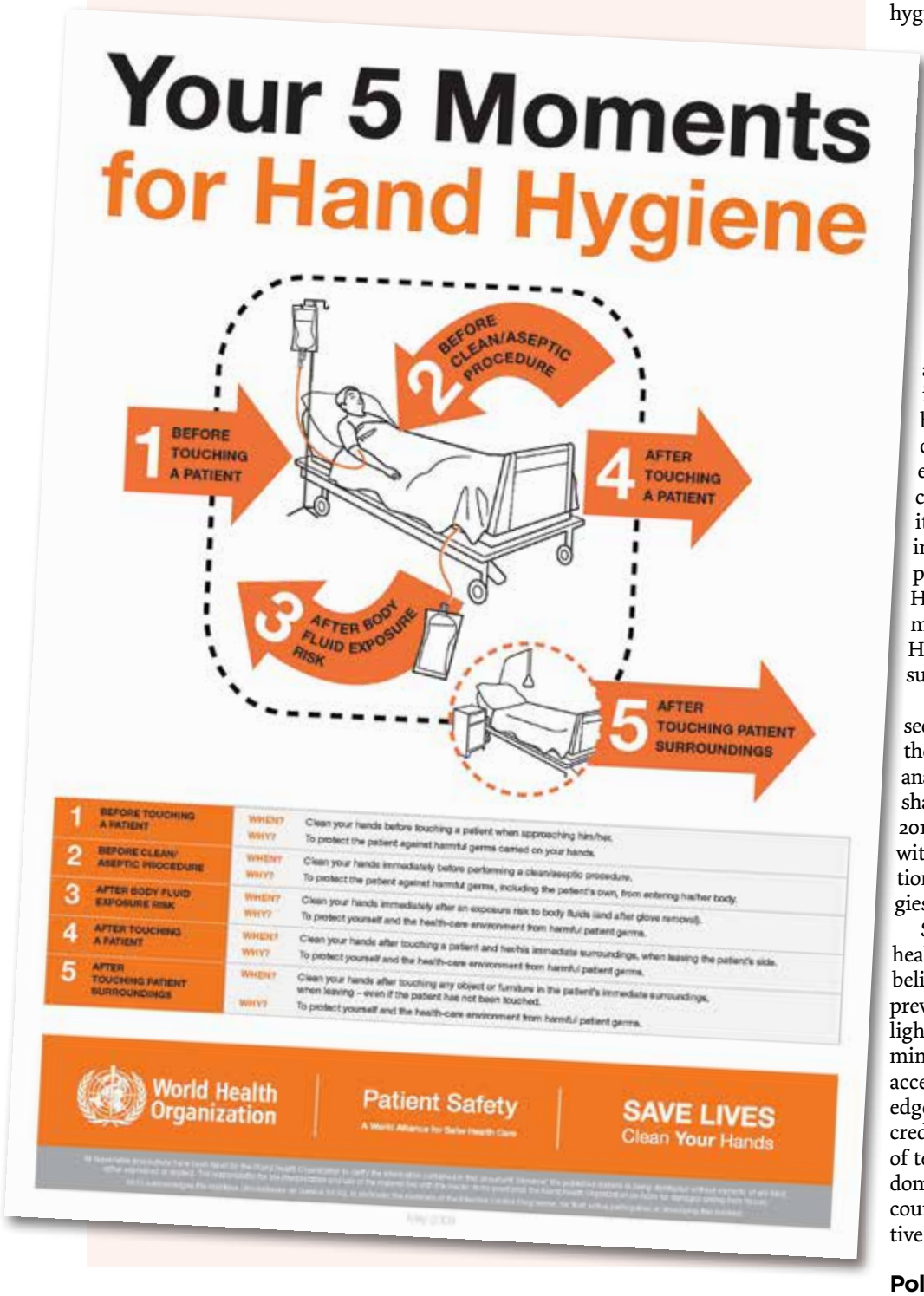
FIG 1. **THE WHO'S FIVE MOMENTS FOR HAND HYGIENE**



Hand hygiene

The discourse associated with hand hygiene – generally regarded as the first, second and third most important activity in infection control (Armellino, 2012) – is an interesting example of the power of language. Any cursory examination of the literature reveals how hand hygiene is promoted as "the single most important factor in the control of infection" (Weston, 2013). With closer inspection of the evidence, the considerable methodological and ethical problems associated with producing reliable, valid hand-hygiene data become apparent. It is difficult, or almost impossible, to isolate specific effects of hand hygiene or any other component of an infection-control strategy. In evaluating the NHS's "cleanyourhands" campaign, Stone et al (2012) stated that it was impossible to disentangle the impact of hand hygiene from other policy initiatives introduced to reduce HCAIs. Hand hygiene may well be the most important measure to prevent HCAIs, but establishing evidence to support its effectiveness is difficult.

Confirmation bias suggests people seek out evidence that is consistent with their beliefs and expectations, and so they analyse information in an efficient but shallow way (Hernandez and Preston, 2012). The efficacy of hand hygiene fits well with those wanting common-sense solutions, quick fixes and eye-catching strategies to complex problems (Dancer, 2010).

Sax et al (2009) revealed that 75% of healthcare workers in one institution believed that good hand hygiene could prevent at least 50% of HCAIs. This highlights what discourse analysts might call mind control – that is, recipients tend to accept without question beliefs, knowledge and opinions from what they see as credible sources. As a superficial reading of texts depicts hand hygiene positively, a dominant discourse flourishes and a counter-discourse providing an alternative view becomes marginalised.

Policy discourse

Policy discourse examines, in part, how managers promote certain world views and realities among staff (Hatch and Cunliffe, 2009). It is strongly aligned to evidence-based practice because of an underlying assumption that both are driven by facts rather than values (Russell et al, 2008), rendering them objective, logical and value free. However, in many cases, there is no such thing as evidence. As Rycroft-Malone

"It is important that organisations produce fair policies that balance staff accountability with an acknowledgment of deficiencies in the system"

the aspiration, and what is really meant here is zero tolerance of "avoidable infections". However, it is difficult to establish which HCAIs are avoidable and which are inevitable.

The discourse of zero tolerance has promoted the idea that, in the 21st century, it is unacceptable for any patient to acquire a HCAI; it is debatable whether this is a helpful position.

(2006) noted, evidence is rarely static, and is often uncertain and individually determined. Health professionals interpret and implement evidence-based recommendations depending on specific environmental and patient circumstances. Scientific justification alone does not necessarily convince an audience. As well as providing evidence, policies are used to regulate and control staff behaviour (Naidu and Rao, 2009); policymakers must make a moral choice and, to decide on the best course of action, a value judgement.

Hand hygiene policies

All NHS trusts in England must have written policies, procedures and guidance promoting timely and effective hand decontamination. They are required to audit these and are encouraged to put results in the public domain (Department of Health, 2008). To some, for a policy to be considered good depends on it being clear and easy to understand, which requires simple language and a lack of jargon or undefined terms (White, 2010). Policy language tends to be couched in the obvious and unquestionable. It states what ought to be done, what stands to reason and cannot be negotiated. The DH states that staff "need to understand what is expected of them as individuals and for what they will be held to account" (DH, 2008).

QUICK FACT
300,000
Estimated annual number of HCAIs in England resulting from NHS care

"Modality" refers to the way language is used to influence and instruct people and events, and is an important part of how authority is articulated and legitimated. In policy documents, modality is commonly used to denote obligation and expressed through words such as "must", "should" and "may". Lomotan et al (2010) found that health professionals believe "must" conveys a higher level of obligation than "should"; this is supported by NICE's (2012) guidance on infection control, which proposes that "must" always be used when an omission of care could cause serious consequences for patient safety.

Unsurprisingly, "must" tends to appear frequently in hand-hygiene policies, particularly when relaying when and how often health professionals should clean their hands. By using the more authoritative "must", rather than "should" or "may", hand-hygiene policies espouse the clarity of a "good" policy, while echoing the zero tolerance advocated by the DH – something it argues is a powerful tool to address non-compliance with key policies and procedures (DH, 2008).

There is a sense that hand-hygiene policies first establish obligations with words such as "must" and "should", then use words like "accountability" and "responsibility" to appeal to staff professionalism. If this fails, there is a subtext of zero tolerance and punitive action, which would be taken against non-compliers.

Zero tolerance advocates consequences, often severe, punitive and intended to be applied regardless of the seriousness of the behaviour, mitigating circumstances or situational context (Teske, 2011). This resonates with hand-hygiene policies as they seldom acknowledge any risk assessment. These policies tend to extol the "5 moments for hand hygiene" (WHO, 2014), but make no distinction between high-risk or low-risk activities – this is less a risk assessment than an educational tool. Although cross-contamination can occur through low-risk activities, a literal interpretation of the five-moments model can result in hand-hygiene opportunities escalating to a level with which it is impossible for staff to comply.

Conclusion

Hand hygiene is undeniably an important aspect of infection prevention and control, but hand-hygiene policies are something of a nirvana concept – they state the ideal and are used to continually drive up standards. But when associated with the authoritative, punitive language of zero tolerance, these policies become more sinister: omissions of care become characterised as mistakes, imbued with a moral loading they may not deserve. Portraying all omissions as neglectful excludes other views of the same action; for example, staff may not see a hand-hygiene omission as a mistake, but as an inevitable consequence of the goals they are set and the resources available to achieve them being irreconcilable.

It is important that organisations produce fair policies that balance staff accountability with an acknowledgment of deficiencies in the system. Using "must" for high-risk activities and "should" for low-risk activities does not reduce the obligation placed on staff to clean their hands wherever practicably possible, but it does acknowledge that stating the ideal and placing a burden on health professionals does not necessarily produce miraculous improvements; instead, it can drive poor practice underground, where organisations can neither effectively address it nor learn from it. **NT**

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