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

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...
Hand hygiene

The discourse associated with hand hygiene – generally regarded as the first, second and third most important activity in infection control (Armel-lino, 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

“...
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).

“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 relying on 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 influences 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-moment 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 and punitive action, which would be taken against non-compliers. This fails, there is a subtext of zero tolerance with an acknowledgment of deficiencies in the system. Using “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.


References


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References


