Patient Empowerment in Infection Prevention and Hand Hygiene

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No discussion of healthcare reform or quality improvement is complete without addressing the patient empowerment and engagement movement that continues to drive the move from a traditional “disease-centered model” to a more progressive “patient-centered model.” As the Agency for Healthcare Research and Quality (AHRQ) explains, “In the older, disease-centered model, physicians make almost all treatment decisions based largely on clinical experience and data from various medical tests. In a patient-centered model, patients become active participants in their own care and receive services designed to focus on their individual needs and preferences, in addition to advice and counsel from health professionals.”

A recent report from the Robert Wood Johnson Foundation explains the appeal of the patient empowerment movement. As James (2013) notes, “A growing body of evidence demonstrates that patients who are more actively involved in their healthcare experience better health outcomes and incur lower costs. As a result, many public and private healthcare organizations are employing strategies to better engage patients, such as educating them about their conditions and involving them more fully in making decisions about their care. “Patient activation” refers to a patient’s knowledge, skills, ability, and willingness to manage his or her own health and care. “Patient engagement” is a broader concept that combines patient activation with interventions designed to increase activation and promote positive patient behavior, such as obtaining preventive care or exercising regularly. Patient engagement is one strategy to achieve the ‘triple aim’ of improved health outcomes, better patient care, and lower costs. Despite evidence that has been compiled to date of the importance of patient engagement, experts in the field agree that more research will be needed to determine best practices for engaging patients, as well as to more fully demonstrate the relationship of patient engagement to cost savings. In the meantime, considerable efforts are under way to hold healthcare organizations accountable for engaging patients.”

Sharp, et al. (2014) assert that despite increasing attention to prevention, “surprisingly little guidance or literature has addressed whether and how to inform patients and empower them to contribute to HAI prevention.” They say that patient autonomy encompasses informing patients about the risk of HAIs. They add that empowering patients as part of
A multifaceted HAI prevention strategy might be beneficial in reducing HAI and improving outcomes, and they emphasize that two intertwined ethical considerations—patient autonomy and patient welfare—motivate empowering patients for HAI prevention.

Autonomy is one of four principles — including beneficence, nonmaleficence and justice — that guide modern bioethical decision-making (Beauchamp and Childress, 2012). As Sharp, et al. (2014) explain, “Autonomy refers to a person’s ability to pursue his or her own life plans free from controlling, coercive or undue influence from others. Although a basic tenet of bioethics, promoting patient autonomy can seem an abstruse demand in the complex hospital environment. Hospitalized patients are often vulnerable, and vast asymmetries in medical knowledge exist between providers and patients. These conditions can jeopardize adequate consideration of patients’ values and interests. Actively empowering patients, ensuring them an opportunity to act in light of their values and interests, supports patient autonomy. Providing patients with information relevant to medical decisions is essential to this process.”

Bioethics experts say that risk is one of the most salient pieces of information considered in medical decisions and that patients should be provided with information when the risks in question could alter the decisions of reasonable persons who can respond in some beneficial way. They say that disclosing relevant risks that can be acted upon promotes patient autonomy. Sharp, et al. (2014) say that “HAI’s often constitute a material risk, although this determination depends on a wide variety of factors, including the particular patient and the institution. In some settings, the risk of acquiring HAI’s is as high as 10 percent. Patients might consider these risks before making high-stakes decisions, such as choosing a hospital or agreeing to a procedure, and more mundane decisions, such as hygiene and how to interact with healthcare professionals. HAI information can empower patients to make a wide range of decisions about their care accordingly.”

Sharp, et al. (2014) acknowledge the varying opinions on just how much to tell patients: “Some might believe that disclosing HAI information only prior to procedures and interventions suffices to preserve patient autonomy. Although many HAI’s are linked to procedures and devices such as central venous and urinary catheters, healthcare-associated pathogens can affect hospitalized patients even in the absence of procedures, making intervention-specific disclosure inadequate. A larger set of institutional and environmental risks influences HAI transmission and acquisition. Although a patient might not experience the adverse effects of a hospital-acquired pathogen until a device is inserted, prevention with proper hygiene and other safety precautions must begin well before the procedure is performed. Informing and empowering patients at admission as well as prior to interventions and devices can best facilitate this process. Others might object that empowering patients will have little effect since they lack substantive options. The option of refusing to seek care in a hospital is seldom
realistic or desirable. However, a patient might be able to select the most appropriate institution for her care. In one telephone survey, 93 percent said that knowing infection rates would influence their selection of a doctor or hospital. Although many patients—for a variety of practical, economic, and geographical reasons—still lack substantive options, empowerment with information broadens the scope of relevant decisions. Finally, some may argue that HAI information might produce undue stress without expanding patients’ rational options in any meaningful way ... Potential adverse consequences of a limited nature stemming from patient response to risk disclosure should not generally override moral considerations in favor of disclosure, although further research is needed to better understand patient comprehension and reactions to HAI information.”

Experts suggest that more research is needed in the arena of patient empowerment’s impact on actual patient welfare, and whether a well-educated patient could influence healthcare worker behavior that may prevent HAIs. As Sharp, et al. (2014) note, “Improving healthcare personnel hand hygiene, for example, is a major focus of HAI prevention efforts. Soap consumption, an indirect measure of hand hygiene, increased by 34 percent to 94 percent when patients asked providers whether they washed their hands. Other studies confirm that patient engagement improves hand hygiene.”

The World Health Organization (WHO) says that patient empowerment has now been expanded to the domain of patient safety. In its report, “Guidance on Engaging Patients and Patient Organizations in Hand Hygiene Initiatives,” WHO observes, “The opportunity for patients to be involved in their healthcare has evolved over the last decades from passive to more active. There are now many ways in which patients can become involved in the process of their own healthcare and may be encouraged to do so to the level of their own ability and choice. In order for patients to actively participate and be fully engaged/empowered, some critical issues must be addressed. Patients can be empowered only after having gathered enough information, understand how to use the information, and are convinced that this knowledge gives them the opportunity, and the right, to participate in helping to keep healthcare safe while not deflecting the responsibility away from their healthcare workers. The responsibility for hand hygiene rests firmly with the healthcare worker.”

Sharp, et al. (2014) agree: “The obligation to prevent HAI remains squarely with institutions and providers. Nonetheless, evidence suggests that certain strategies could improve patient involvement. First, lack of information about infections was an important predictor of patient reluctance to stop healthcare personnel who were not wearing gloves or masks; simply providing information regarding risk could improve patient engagement. Second, engagement creates an environment more conducive for patients to hold providers accountable. For example, patients were more willing to ask providers about hand hygiene if instructed to do so or educated on hand hygiene by healthcare providers. Making patients true partners means arming them with information.”
There has been some debate about just how far patients will go to remind healthcare workers to wash their hands or engage in other infection-prevention practices, and whether healthcare personnel are receptive to reminders about compliance from their patients. Carol McLay, RN, MPH, DrPH, CIC, an infection prevention consultant and chair of APIC’s communications committee, acknowledges some pushback from healthcare workers. “I think it’s fairly common, unfortunately,” she says. “In some of the larger studies, researchers found that while healthcare workers think that it’s a really good idea in theory to have patients asking them about their practices, about 40 percent of healthcare personnel would not support or appreciate having their patients asking them about it. Somewhat ironically, healthcare workers also said they would be embarrassed if they were caught by their patients not washing their hands; however, they still don’t want to be asked or reminded, which is unfortunate. There haven’t been any studies to differentiate between nurses and physicians; however there has been some anecdotal evidence that it has been an issue among both types of professionals and that there have been some reprisals for patients who have been asking their healthcare workers to do basic things like washing; their hands. While this patient empowerment movement is growing, at the same time we have been trying to improve compliance with hand hygiene for 30 or 40 years and despite a lot of research and education, we really haven’t see any results. So patient involvement in their care is one more tool for our armament to try to turn that around.”

To that end, the Association for Professionals in Infection Control and Epidemiology (APIC) recently launched its Infection Prevention and You campaign to facilitate better dialogue between healthcare professionals and patients/consumer. In addition to hand hygiene, the campaign touches upon a number of key patient-engagement issues relating to infection prevention, including preoperative bathing with chlorhexidine gluconate prior to being admitted for surgery — another intervention that is widely misunderstood by patients. “We also address the importance of patients taking medications as directed, asking about safe injection practices, asking about catheters and if they are still necessary or if they can be removed,” says McLay. “There has been a lot of research showing these catheters are placed in patients and then basically overlooked for a great deal of time and of course for every day you leave a catheter in it increases the risk for an HAI. We also address environmental cleaning — if their room looks dirty, we remind patients to ask to have it cleaned. So we are trying to teach patients and consumers what HAIs are and the risk factors for HAS transmission, and the things that patients and their family members can do to try to reduce those risks.”

While some patients may embrace an increased degree of and responsibility for their own care, others see the patient empowerment movement as a way to make healthcare workers less accountable. “There are some people out there who don’t want to be empowered,”
McLay explains. “It’s not in their make-up and that’s fine, and in that case we also try to provide this information to the patient’s family members or friends so if they are going to beat the hospital, perhaps they can speak up for that patient instead. Quite frankly these patients do have a point — most assume that healthcare workers are washing their hands; however, as we all know, in practice it’s just not happening as often as we would like it to. So we put the emphasis on the patient.”

McLay emphasizes that a balance must be struck, and in doing so, a new culture of safety in healthcare institutions may be forged. “What we are talking about here is changing the culture of healthcare organizations to an overall culture of safety,” she says. “Of course hand hygiene is just one small component of that. Many facilities are starting to examine their culture and what they are practicing, comparing it to best practices from the literature and contemplating how they can improve theirs. Many facilities are using the infographic that we created which explains the basics of infection prevention from the patient perspective. Some hospitals are including this infographic in a packet for patients when they are admitted, or they give them the infographic and a bottle of hand sanitizer and do some education with them one on one. Some facilities have podcasts or videos that patients watch before they are admitted, telling them it is acceptable to speak up and here are the tools. Some hospitals will give patients structured scripts so that they don’t have to come up with questions to ask on their own to make them more comfortable about speaking up. Many hospitals are using visual cues as reminders, such as little badges saying ‘Ask me if I have washed my hands.’ You can also cultivate healthcare champions on each unit, individuals who serve as advocates for patient engagement and empowerment and will speak up about it to other healthcare workers.”

One such champion can be the infection preventionist, although McLay urges IPs to not shoulder this task alone. “You must look at it from a multidisciplinary point of view,” she says. “It also must come down from above, and it does need to permeate the whole culture. It must address not just hand hygiene but many different areas of infection prevention. An important role for the IP is to work on a

APIC Offers
10 Ways to Protect Patients

As part of its Infection Prevention & You campaign, APIC offers 10 Ways to Protect Patients:

1. Wash or clean your hands before and after you provide care to a patient.
2. Use gloves the right way.
3. Get your shots— including your annual flu shot— and make sure everyone in your family does too.
4. Follow the rules of isolation for the patient’s protection, your protection, and everyone else’s protection.
5. Follow safe injection practices – remember One needle, One syringe, Only one time.
6. Make patient identification a priority: right drug, right time, right dose.
7. Keep the patient’s room and equipment clean.
8. Know when antibiotics are appropriate . . . and when they are NOT.
9. What you wear matters! Make sure your attire does not become a source of infection.
10. Know about the infection preventionist.
multidisciplinary committee, looking at challenges overall and coming up with strategies to slowly try to change the culture to one that will provide better outcomes for patients, because that’s what we all want. There are many different strategies in the literature, and there are numerous small changes that you can put into place at your facility to change the culture — but it takes time. IPs are part of a larger team and they are not expected to do it alone.”

While many facilities are still in the implementation stage when it comes to incorporating patient empowerment into their infection prevention programs, eventually there will be a need to measure and quantify the impact this strategy is having on prevention efforts. For example, Berger, et al. (2014) examined how interventions encouraging this patient engagement have been implemented in controlled trials. The researchers searched Medline, CINAHL, Embase and Cochrane from 2000 to 2012 for English-language studies in hospital settings with prospective controlled designs, addressing the effectiveness or implementation of patient/family engagement in patient safety practices (PSPs). They separately reviewed interventions implemented as part of selected broader PSPs by way of example: hand hygiene, ventilator-associated pneumonia, rapid response systems and care transitions. Six articles met the inclusion criteria for effectiveness with a primary focus on patient engagement. The researchers identified 12 studies implementing patient engagement as an aspect of selected broader PSPs. A number of studies relied on patients’ possible function as a reporter of error to healthcare workers and patients as a source of reminders regarding safety behaviors, while others relied on direct activation of patients or families. Definitions of patient and family engagement were lacking, as well as evidence regarding the types of patients who might feel comfortable engaging with providers, and in what contexts. As Berger, et al. (2014) explain, “While patient engagement in safety is appealing, there is insufficient high-quality evidence informing real-world implementation. Further work should evaluate the effectiveness of interventions on patient and family engagement and clarify the added benefit of incorporating engagement in multifaceted approaches to improve patient safety endpoints. In addition, strategies to assess and overcome barriers to patients’ willingness to actively engage in their care should be investigated.”

“I think everyone is trying to get a handle on how to measure effectiveness of campaigns like this because it can be challenging research to conduct,” McLay says. “For now, though, we know that our infographic has been downloaded almost 10,000 times and the website has received more than 41,000 visits. That's one way of measuring it but we'd love to be able to get a better idea of how it's working.”

Dwamena, et al. (2012) explain that “Patient-centered approaches to care delivery in the patient encounter are increasingly advocated by consumers and clinicians and incorporated into training for healthcare providers. However, the impact of these interventions directly
on clinical encounters and indirectly on patient satisfaction, healthcare behavior and health status has not been adequately evaluated.” The researchers sought to assess the effects of interventions for healthcare providers that aim to promote patient-centered care (PCC) approaches in clinical consultations. Keeping in mind an earlier definition of patient-centered care — a philosophy of care that encourages: shared control of the consultation, decisions about interventions or management of the health problems with the patient, and/or a focus in the consultation on the patient as a whole person who has individual preferences situated within social contexts (in contrast to a focus in the consultation on a body part or disease) — the researchers classified interventions by whether they focused only on training providers or on training providers and patients, with and without condition-specific educational materials. They grouped outcome data from the studies to evaluate both direct effects on patient encounters (consultation process variables) and effects on patient outcomes (satisfaction, healthcare behavior change, health status).

Forty-three randomized trials met the inclusion criteria, of which 29 are new in this update. In most of the studies, training interventions were directed at primary care physicians (general practitioners, internists, pediatricians or family doctors) or nurses practicing in community or hospital outpatient settings. Some studies trained specialists. Patients were predominantly adults with general medical problems, though two studies included children with asthma. Descriptive and pooled analyses showed generally positive effects on consultation processes on a range of measures relating to clarifying patients’ concerns and beliefs; communicating about treatment options; levels of empathy; and patients’ perception of providers’ attentiveness to them and their concerns as well as their diseases. A new finding for this update is that short-term training (less than 10 hours) is as successful as longer training. The analyses showed mixed results on satisfaction, behavior and health status. Studies using complex interventions that focused on providers and patients with condition-specific materials generally showed benefit in health behavior and satisfaction, as well as consultation processes, with mixed effects on health status. Pooled analysis of the fewer than half of included studies with adequate data suggests moderate beneficial effects from interventions on the consultation process; and mixed effects on behavior and patient satisfaction, with small positive effects on health status. Risk of bias varied across studies. Studies that focused only on provider behavior frequently did not collect data on patient outcomes, limiting the conclusions that can be drawn about the relative effect of intervention focus on providers compared with providers and patients.

Dwamena, et al. (2012) concluded that, “Interventions to promote patient-centered care within clinical consultations are effective across studies in transferring patient-centered skills to providers. However the effects on patient satisfaction, health behavior and health status are mixed. There is some indication that complex interventions directed at providers and patients that include condition-specific educational materials have beneficial effects.
on health behavior and health status, outcomes not assessed in studies reviewed previously. The latter conclusion is tentative at this time and requires more data. The heterogeneity of outcomes, and the use of single item consultation and health behavior measures limit the strength of the conclusions.”

**Patient Engagement in Hand Hygiene**

While some patients are reluctant to ask healthcare workers to wash their hands, patient empowerment has been identified as a potential tool to improve knowledge and compliance. The road to this kind of success is still a bit bumpy, especially when it comes to an actual confrontation. According to a 2012 study, most patients at risk for healthcare-associated infections (HAIs) agree that healthcare workers should be reminded to wash their hands, but little more than half would feel comfortable asking their physicians to wash. The study, published in Infection Control and Hospital Epidemiology, points to the need for patient empowerment to improve hand hygiene of healthcare workers.

In the study, Ottum, et al. (2012) designed and administered a questionnaire on awareness of HAIs, including information about hand hygiene, to 200 patients who were at risk for or who had a history of infections with methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile, as well as to patients who were at risk for a central line-associated bloodstream infection or surgical site infection. The survey was administered to determine patient beliefs about hand hygiene of healthcare workers and their willingness to engage healthcare workers in proper hand hygiene behaviors.

Nearly all patients (99.5 percent) believed that healthcare workers were supposed to wash their hands before and after caring for patients. Most (90.5 percent) believed that healthcare workers should be reminded to wash their hands if they forget. However, only 64 percent and 54 percent of patients indicated that they would feel comfortable asking nurses or physicians to wash their hands, respectively. Still fewer patients (14 percent) reported having ever asked a healthcare worker to wash their hands.

“Our study shows that patients have a good understanding of the importance of appropriate hand hygiene in the healthcare setting to prevent healthcare-associated infections,” says Andrew Ottum, of the University of Wisconsin and lead author of the study. “What is clear is that more should be done to empower patients to feel comfortable asking their healthcare workers to wash their hands. This should be a focus of hand hygiene interventions.”

Interestingly enough, Ottum, et al. (2012) reported that patients who had worked in healthcare in the past were significantly more likely to feel comfortable asking both nurses and physicians to wash their hands than those patients who had never worked in healthcare, and compared with patients who had no more than a high school education, patients with at least a college degree were nearly twice as likely to feel comfortable asking nurses to wash.
wash their hands. Patients who had a family member who had worked in healthcare were significantly more likely to feel comfortable asking physicians to wash their hands than patients who did not have a family member who had worked in healthcare. There was also a significant positive association between the level of comfort patients had in asking both nurses and physicians to wash their hands and whether they had ever asked a healthcare worker to wash their hands in the past. As Ottum, et al. (2012) emphasize, “Our findings have two important implications. First, within our patient population, baseline beliefs about the importance of appropriate hand hygiene in the healthcare setting were universally high; more education is unlikely to empower patients further. Second, hand hygiene campaigns should focus interventions on making patients more comfortable with asking healthcare workers to wash their hands.”

Pittet, et al. (2011) report that the UK National Patient Safety Agency surveyed the public, inpatients, and healthcare workers, particularly frontline clinical staff and infection control nurses, in five acute-care hospitals to determine whether they agreed that a greater level of involvement and engagement with patients would contribute to increased compliance with hand hygiene and reduce HAIs. Fifty-seven percent (302/530) of the public were unlikely to question doctors on the cleanliness of their hands as they assumed that they had already cleaned them. Forty-three percent (90/210) of inpatients considered that healthcare workers should know to clean their hands and trusted them to do so, and 20% (42/210) would not want healthcare workers to think that they were questioning their professional ability to do their job correctly. Most healthcare workers surveyed (178/254, 71%) said that HAI could be reduced to a greater or lesser degree if patients asked healthcare workers if they had cleaned their hands before touching them. Inviting patients to remind healthcare workers about hand hygiene through the provision of individual alcohol-based handrub containers and actively supporting an ‘it’s OK to ask’ attitude were perceived as the most useful interventions by both patients and healthcare workers. However, the researchers say that further work is required to refute the myth among healthcare workers that patient involvement undermines the doctor- or healthcare-patient relationship.

A 2009 study by Longtin, et al. indicated that approximately 70 percent of patients did not feel comfortable asking HCWs to perform hand hygiene. Longtin, et al. (2009) conducted a cross-sectional survey of patient knowledge and perceptions of healthcare-associated infections, hand hygiene and patient participation, defined as the active involvement of patients in various aspects of their healthcare, in a large teaching hospital. Of 194 patients who participated, most responded that they would not feel comfortable asking a nurse (148 respondents [76 percent]) or a physician (150 [77 percent]) to perform hand hygiene, and 57 (29 percent) believed that this would help prevent HAIs. However, an explicit invitation from a healthcare worker to ask about hand hygiene doubled the intention to ask a nurse (from 34 percent to 83 percent of respondents; and to ask a physician (from 30 percent to
78 percent). In multivariate analysis, Longtin, et al. (2009) report that being nonreligious, having an expansive personality, being concerned about HAIs, and believing that patient participation would prevent healthcare-associated infections were associated with the intention to ask a nurse or a physician to perform hand hygiene.

In their study, Lent, et al. (2009) explored the willingness of patients to participate in empowerment initiatives. They presented patients with a script asking them to remind healthcare workers to wash their hands, and follow-up interviews were conducted. Compliance was reassessed using a modified script in which patients were asked to thank healthcare workers for washing and/or to display a sign stating “Thanks for Washing.” Of the 193 patients presented with the initial script, five stated that they had reminded healthcare workers to wash, and 15 had not commented despite observing healthcare workers failing to wash in their presence. Of the 38 patients given the modified script instructing them to thank healthcare workers for washing, 17 reported mentioning hand hygiene to healthcare workers (13 of whom thanked the caregivers), and six did not comment despite observing healthcare workers failing to wash in their presence. The researchers reported that most patients displayed a sign thanking caregivers for washing; however, no patients were observed to comment on hand hygiene during physician work rounds, and only two of 30 nurses on the study wards reported being thanked for washing.

As Lent, et al. (2009) note, “Our findings suggest that there may be a discrepancy between patients’ self-reported and actual participation in patient empowerment programs. Previous studies suggesting high rates of participation of patients have relied on self-reporting of patients and also on soap or alcohol consumption. McGuckin et al. acknowledged the possibility that patients may give answers intended to please the interviewer rather than reflecting the truth. Soap and/or alcohol use was seen to increase in these previous patient empowerment studies, but whether this was attributable to patients asking about hand hygiene or to other factors is unknown. In our opinion, repeatedly telling healthcare workers that patients are being told to watch and comment on hand hygiene may stimulate increased compliance even if no patients actually comment.”

Landers, et al. (2012) assert that patient-centered hand hygiene is the next step in infection prevention and that more efforts should be directed toward involving patients in their own hand-cleansing practices. As the researchers note, “A positive byproduct of [patient-participation] efforts has been the inclusion of patients in healthcare activities and decisions related to their own safety. Empowering patients to become partners in ensuring safe care has been described as patient collaboration, patient involvement, partnership, and patient-centered care. Studies have shown that patients are willing to participate in hand hygiene programs, but that their participation often depends on the type of program and how it was developed.”

The researchers acknowledge an inherent double-edged sword: “Increasing patient safety through increased patient engagement and empowerment presents a potential paradox.”

Studies have shown that patients are willing to participate in hand hygiene programs, but that their participation often depends on the type of program and how it was developed.”
Along with the desire to improve patient outcomes, there is concern that patients may feel an undue burden for their own safety in these campaigns, and that such perceptions could undermine trust. Despite this paradox, evidence suggests that patient participation does yield positive results, and that most patients are willing and able to participate in their own hand hygiene. Accumulating evidence suggests that attention to patient hand hygiene can play a critical role in preventing the spread of infection, because patients can be involved in the spread of pathogens through multiple routes.”

Landers, et al. (2012) say the evidence points to the benefits of including patients more directly in hand hygiene initiatives, and advocate that healthcare professionals use a framework of patient-centered safety initiatives to provide recommendations for the timing and implementation of patient hand hygiene protocols. The researchers also underscore the need for further research, practice guideline development, and implications for training of healthcare workers.

The WHO HH Mandate and the Program That Launched Patient Involvement in Hand Hygiene

The World Health Organization (WHO)’s Guidelines on Hand Hygiene in Health Care (2009) provides a framework to help the Infection Prevention team smooth the transition when introducing empowerment programs to their hospital, with the following components:

1. System change, including healthcare worker access to alcohol-based handrub at the point of care, as well as to soap, clean towels and a safe, continuous supply of water
2. Staff education and training
3. Monitoring and evaluation, including evaluation of healthcare worker knowledge and providing hand hygiene compliance performance feedback
4. Reminders in the workplace
5. An institutional safety climate, with active and visible participation from healthcare workers, managers and, when feasible, patients.

The WHO Guideline has since inspired further research and program evaluation. As McGuckin and Govednik (2013) note, “Following publication of the WHO HH Guidelines, the research from 2008 to 2012 saw advances in how to empower patients and recognize when they are not engaged, as well as an emerging focus on the roles and attitudes of healthcare workers toward empowerment.”

Maryanne McGuckin, Dr.ScEd, FSHEA, founder of McGuckin Methods International, was an early advocate of including the patient in any interventions to address better hand hygiene. In 1999, McGuckin, along with her colleagues, is creator of Partners in Your Care, one of the earliest programs to facilitate patient empowerment especially when it comes to hand hygiene compliance. McGuckin and colleagues developed an intervention that uses patients as continuous prompters for healthcare workers. The “Partners in Your Care” program has several components, and can be used in conjunction with other strategies directed at healthcare professionals or hospital systems.
Within 24 hours of admission, patients receive a visit from a health educator to discuss the importance of handwashing by staff in preventing nosocomial infections. Patients receive a brochure describing the who, why, how, when, and where of handwashing.

Patients are encouraged to become “Partners in Your Care” by asking all healthcare workers who come into contact with them, “Did you wash your hands?”

As a reminder to ask, or for patients who might be reluctant to ask, the program provides prompting aids. For example, patients receive a tiny furry creature holding a banner that reads, “Did you wash your hands?” to stick on their hospital gowns.

The program worked. McGuckin, et al. (1999) documented that education of patients regarding their role in monitoring handwashing compliance among healthcare workers can increase soap usage and handwashing and provide sustainable reinforcement of handwashing principles for healthcare workers. In this prospective, controlled, six-week intervention/control study was performed in four community hospitals. Each hospital served as its own control. Patients were educated within 24 hours of admission about the importance of asking their healthcare workers to wash their hands. Soap usage and handwashing was calculated by bed-days. Patient follow-up was conducted through telephone interviews two weeks after discharge. The patient handwashing education model increased soap usage by healthcare workers an average of 34 percent; this increase was consistent across hospitals regardless of the initial soap usage rates. Of the patients interviewed, 81 percent read the materials provided, 57 percent asked healthcare workers whether they had washed their hands, and 81 percent of this 57 percent said they received positive responses. In addition, McGuckin, et al. (2004) demonstrated that patient education increased hand hygiene compliance in an inpatient rehabilitation unit by 94 percent during the six-week intervention, 34 percent during the six-week post intervention, and 40 percent at a three-month follow-up.

Because of the importance of preventing nosocomial infections internationally, McGuckin and colleagues adapted and tested the program in the United Kingdom (McGuckin, Waterman, et al. 2001). They added an educational component for healthcare workers, and monitored the use of both soap and antiseptic alcohol gel. The program was implemented on one medical and one surgical ward in Oxford, UK. Of the 98 patients eligible for the study, 39 (40 percent) agreed to participate. Each patient received a visit from an infection control nurse within 24 hours of admission. One week before the program began, physicians received a letter from the hospital medical director, and other healthcare workers received a flyer announcing the program and encouraging their support. At baseline, soap usage per bed-day was 69 percent higher for the surgical ward than the medical ward. This represents three handwashings per bed-day for medical patients versus eight handwashings per bed-day for surgical patients. Alcohol gel was used on less than 1 percent of occasions. As in the initial study, the “Partners in Your Care” program in the UK led to significant increases.
in handwashing activity. Results suggest that adding an educational component aimed at the healthcare worker could improve the program’s effectiveness. Additionally, more than 60 percent of patients felt at ease when asking healthcare workers about handwashing. All patients asked nurses, but only 35 percent asked physicians. Soap and gel usage increased 37 percent from baseline to the control period, when the healthcare worker educational component was implemented. Soap and gel usage increased 10 percent from the control period though the intervention period, when the patient intervention was implemented. Overall, the program achieved a 50 percent increase in soap and gel use. However, use of alcohol gel as a handwashing agent did not increase during the study period, despite its ready availability.

In a review of the past 15 years of research and programs in patient empowerment and hand hygiene, McGuckin and Govednik (2013) suggest there is sufficient evidence to move patient participation from “feasible” to “necessary,” and whether healthcare professionals have enough information to determine if, and under what conditions, patients will be able to play an immediate role in healthcare workers’ hand hygiene behavior. They note, “Studies show increases in hand hygiene compliance and patients are willing to play an active role. It is feasible. One must not get distracted by looking for reasons why patient empowerment does not work. Instead, the focus should be on programs that build on the desire and interest already proven.”

McGuckin and Govednik (2013) reviewed the current literature on patient willingness to be empowered, barriers to empowerment, and hand hygiene programs that include patient empowerment and hand hygiene improvement. They found that several studies show that, in principle, patients are willing to be empowered; however, there is variation in the actual number of patients that practice empowerment for hand hygiene, ranging from 5 percent to 80 percent. They also found that actual performance of patient empowerment can be increased when a patient is given explicit permission by a healthcare worker.

The literature is rife with examples of programs, models and interventions for patient empowerment and hand hygiene. McGuckin and Govednik (2013) identified a wide variety of approaches, including:

- Educational programs
- Reminders and motivational messages
- Role modeling
- Patients as observers
- Automation (technology-driven solutions)

The WHO suggests that healthcare organizations could assist in educating patients and raising awareness of hand hygiene in healthcare in a variety of ways, such as:

- Producing patient information resources (printed material, oral demonstrations, audiovisual) outlining the why, when and how of hand hygiene and its role in the reduction of health care-associated infection
- Distributing information to patients
- Including hand hygiene awareness information on Patient Organization websites (or to provide links to resources on the facility’s website) or in their newsletters
♦ Including hand hygiene in agendas at patient meetings, symposia, lectures, etc
♦ Communicating with patients or the media about the hand hygiene improvements and/or initiatives at the facility

The WHO suggests that healthcare facilities consider providing every patient with information on hand hygiene when they register or upon admission. This information might take the form of a brochure that informs the patient of the following:
♦ Why it is important that all healthcare workers perform hand hygiene at the appropriate moments (consider the usefulness of the “My 5 Moments for Hand Hygiene” approach)
♦ What a patient should expect from the healthcare workers at the facility with respect to hand hygiene: i.e., patients should expect that every healthcare worker cleans their hands in accordance with the “My 5 Moments for Hand Hygiene” approach
♦ The measures in place at the healthcare facility to ensure healthcare workers perform hand hygiene (e.g., the availability of sinks, water and soap as well as alcohol-based handrub at the point of care)
♦ Advice on how to prompt a healthcare worker to clean their hands if the healthcare worker has not performed hand hygiene at the appropriate moment (e.g., many existing patient empowerment initiatives suggest that patients ask the simple question Can you please clean your hands?)
♦ How to provide feedback either positive or negative on the hand hygiene performance by their healthcare workers
♦ Clarification on whether the patients themselves or their visitors should perform hand hygiene and whether they are permitted/invited to use the available resources
♦ Who they can contact or where they can find additional information on hand hygiene in healthcare
♦ While not feasible in all healthcare facilities, and dependent upon resources, some facilities might consider the use of videos or CDs within patient rooms to promote messages on hand hygiene improvement

The WHO also suggests that healthcare workers be properly educated about patient empowerment, noting, “Patients are unlikely to participate unless they feel authorized to do so by their healthcare workers. As a consequence, the successful set-up of a patient empowerment strategy requires the full support of healthcare workers across all levels of the organization. Information sessions may be required to reassure healthcare workers as to the goals of the strategy, i.e., reduction of harm to patients, and to win their full support.” WHO encourages healthcare facilities to display posters throughout the facility that remind healthcare workers to perform hand hygiene. (These posters can be obtained from WHO Patient Safety’s website www.who.int/gpsc/5may/en/). Ideally, WHO says that the messages chosen should be positive and appeal to both healthcare workers and patients. Facilities might also consider posters or promotions that:
1. Inform the patient that all healthcare workers should perform hand hygiene according to the “My 5 Moments for Hand Hygiene” approach
2. WHO says that he “My 5 Moments for Hand Hygiene” approach is gaining significance in hand hygiene improvement strategies globally, and it will likely take time for full
understanding and penetration, both by healthcare workers and patients. Therefore, facilities may choose to focus on one or two of the 5 Moments. A focus on Moment 1 (before touching a patient, when in the patient “zone”) offers a simple and easily understandable starting point. It is important that healthcare workers are knowledgeable about the “My 5 Moments for Hand Hygiene” approach and can explain this to the patient.

2. Provide information on how patients can provide feedback to the healthcare facility if their healthcare worker has not practiced hand hygiene.

3. Encourage patients to remind their healthcare workers to clean their hands.
   - Can be used by the patient to visually remind healthcare workers to clean their hands. For example, patients could be provided with small badges or stickers with a message such as Did you clean your hands? or SAVE LIVES: Clean Your Hands.

4. Inform patients that their participation and empowerment is welcome.
   - For example, healthcare workers could wear badges which explicitly encourage patients to ask about hand hygiene (e.g., “It’s okay to ask”).

Other methods suggested by the WHO include:

- Conducting patient surveys: Information gathered by healthcare organizations regarding patients’ perceptions of hand hygiene at healthcare facilities can be used to inform the facility’s action plan by providing another perspective on the quality of care. This data can also be used for benchmarking the situation at a point in time and assessing how subsequently implemented actions or initiatives have impacted on patients’ perceptions of hand hygiene over a period of time.

- Providing feedback: Healthcare organizations could facilitate a system by which patients can feedback on their experiences regarding hand hygiene at a healthcare facility. A patient who believes that they did not receive optimal care while at a facility may not have had the opportunity to feedback to healthcare workers, or may not have felt comfortable in doing so during their stay. Feedback to a healthcare facility on hand hygiene should be constructive rather than persecutory.

**Which Empowerment Comes First: The Patient or the Healthcare Worker**

McGuckin says that since the dawn of the patient empowerment movement, healthcare professionals have been asking themselves whether too much responsibility is being placed on the patient. “When we started this, it was a whole new concept and back then the biggest hurdle when I would go into a hospital to set up a program, is nursing resistance, but they would eventually come around,” she says, adding that the movement gained ground when the WHO embraced it as part of its guidance on hand hygiene.

The WHO’s Guidance on Engaging Patients and Patient Organizations in Hand Hygiene Initiatives emphasizes that “While the responsibility for hand hygiene rests firmly with the healthcare worker, as part of an all-inclusive multimodal hand hygiene improvement strategy, healthcare facilities should strive to:

- Secure the full support of institutional leaders (e.g. hospital director, CEO, senior nurse) for pursuing patient engagement and empowerment if this is considered appropriate.
Focus on activity designed to ensure buy-in of healthcare workers to support greater engagement and empowerment of patients in hand hygiene improvement

Empower patients and their visitors to proactively help to ensure that hand hygiene is performed at the right times and in the right way, guided always by the patients’ willingness to participate.

Engage Patient Organizations to assist with patient advocacy or education, or to lobby for funding and/or improved facilities.

“During the initial phase of the first global challenge, there was no intention of including information on patient empowerment,” McGuckin explains. “However, as a result of more and more demands by consumers to have information, along with recommendations by NPSF and JC, Didier Pittet asked me if I wanted to address the topic and so that’s how we began to put the chapter on patient empowerment together. We realized in that process that the one thing that was missing was empowerment of healthcare workers first — you can’t just empower patients alone — so we switched that to emphasize the healthcare worker as the driving force because they have to give permission to the patient. So you must get your healthcare workers on board first. As Pittet, Longtin, and others have shown, healthcare workers may not like reminders, but healthcare workers do acknowledge that HAIs could be reduced if patients asked. The way we empower healthcare workers is a crucial step toward embracing reminders. It can be done.”

The WHO Guidelines on Hand Hygiene in Health Care (2009) provides a five-point template to aid in the development of an empowerment program:

1. **Ownership:** develop a shared responsibility
   - Gather the evidence to present to decision makers
   - Decide on the most appropriate terminology to use in your context (e.g. patient empowerment; patient involvement; patient participation; patient engagement)
   - Identify sources of support in your facility, country or region
   - Establish a core support network
2. **Review existing empowerment models/programs**
   - Explore existing models and programs in your country, not solely related to hand hygiene improvement — this may involve engaging existing patient organizations
3. **Develop a program,** taking account of the local context
   - Establish a development team
   - Using WHO or other locally available surveys, determine current perceptions towards patient involvement in hand hygiene / infection control / patient safety improvements
   - Determine the willingness of patients and their families to be involved
   - Determine the barriers to involvement, including healthcare worker preparedness, the status of patients within the health-care system, the resource requirements and availability of promotional materials.
Explore existing culture (particularly relating to power and respect in the health-care worker/patient relationship)
- If a program is feasible, determine how best to incorporate the patient perspective in the development of materials and reminders
4. Implement the program
5. Evaluate the program
- This might be through the use of patient satisfaction surveys, or patients can be invited to observe hand hygiene performance

The Next Frontier: The Consumer

McGuckin says she senses a shift in current thinking, moving toward the inclusion of consumers. “It’s being said that the next big change in healthcare is going to be driven by the patient and the consumer. That’s where we should be going even before the patients — we need to empower consumers so that when they become patients, they are ready to roll with the idea that they must take some control and be responsible for their care too.”

McGuckin notes there is some disconnect between consumer desire to know and use HAI information, and the reality of having to find, read, and understand a state-mandated, data-rich public HAI report. In a study designed to determine consumers’ attitudes about HAIs, hand hygiene practices and patient empowerment, McGuckin and Waterman, et al. (2006) asked consumers about various factors that influenced them when selecting a hospital. They found that 94 percent of respondents rated environmental cleanliness as very important, while 93 percent said that hospital infection rates would influence their decision-making. Four in 5 consumers said they would ask their healthcare worker to wash and sanitize his or her hands. The researchers say their findings suggest that consumers will use infection data in selecting and/or leaving a hospital system and that consumers are ready to be empowered with information to ensure a positive outcome.

However, now that HAI public reports are available in 33 states plus the District of Columbia, the information that consumers have available to them is presented in a reporting style that people from various education levels, language and reading levels, and healthcare competency levels, are required to master and understand. And that depends on consumers knowing the existence of public reports and where to find them.

To investigate this, Govednik, McGuckin and Bunson, et al. (2013) summarize a project funded by the Robert Wood Johnson Foundation’s Public Health Law Research Program (Black et al., 2011) in which the authors sought to determine to what extent do consumers know there are laws requiring public disclosure of hospital HAI rates, and do they use the state-mandated HAI public reports when faced with healthcare decisions. The researchers reviewed state HAI report disclosure programs, assessed the perceptions of hospital infection professionals, and measured consumer awareness and use of state
HAI reports. After interviewing more than 3,000 consumers, they discovered that overall, consumer awareness and use of state-mandated HAI public reports is not high (McGuckin et al., 2013b). Twenty-eight percent of those surveyed were aware of public reporting laws regarding HAI data. They reported that they received this information through their physician or other healthcare worker (46 percent), from the print media (45 percent), from the Internet (35 percent) or from broadcast media (34 percent). The researchers also found that recently hospitalized respondents in states with reports, who are more likely to have discussed HAIs as part of the hospital admission process, reported they learned about HAI rates from their physician or other HCW (58 percent), from the hospital (49 percent), or from official state reports (38 percent).

“We’re not doing a good job of getting the message out, even when we have all of this public reporting of infection rates “ McGuckin says. “The reporting process is supposed to be for the patient and the consumer, but many of them still don’t know where to get the information, and when they do get it, they can’t figure it out.”

As Govednik, McGuckin and Bunson, et al. (2013) note, “When given a list of factors considered for choosing a hospital, physician recommendation, reputation, and insurance were identified more frequently by consumers than a hospital’s infection rate as top priority of factors in their decisions. Even when a respondent had prior hospitalization, only 20 percent said they would consider HAI rates a top priority factor when choosing a hospital in the future. Because HAI rates rank well below a number of other factors, they may not influence actual choice in many instances.

“When choosing a hospital, we found HAIs are often the lowest priority when consumers are given a list of factors, such as insurance coverage of recommendations from physicians, that influence their choices,” says John Govednik, co-author of the study. “We can educate consumers on how to include HAI rates in those other higher-priority factors. For example, ‘of the limited choices covered by insurance, or of the short list of physician-recommended facilities, what is each one doing about their HAI rate and what can I do to help keep me safe?’ A perfect opportunity to invite the patient to remind their healthcare worker to perform hand hygiene as one thing they can do.”

The authors summarize further: “To be empowered to make informed decisions, consumers need knowledge and skills. Using HAI rates as criteria for healthcare decisions is an example. State-mandated HAI reports have the potential to bring this information to consumers. More efforts can be focused toward informing the public that reports exist, where to find them, and how to understand and use the information.”

Govednik, McGuckin and Bunson, et al. (2013) offer the following steps that can elevate consumer knowledge about HAIs:

1. Partner with physicians and other healthcare workers to address HAIs and prevention strategies
2. Enlist a consumer champion who can act as role models and promote the use and understanding of HAI reports within their peer networks.
3. Empower consumers by creating higher visibility of HAI information, including what they are, how common they are, their emotional and financial toll, and the hospital’s ability to prevent them
And what about consumer awareness and use of hand hygiene compliance rates, not typically disclosed in a state report? McGuckin’s latest study is a consumer survey on hand hygiene compliance awareness among consumers. “We surveyed a thousand consumers, asking them to estimate healthcare worker compliance and what source they based their estimates on. The data coming out of that survey was interesting. One of the things revealed was that people based their awareness of healthcare worker hand hygiene on a) no particular source, or b) word of mouth, over sources such as doctors, nurses, or other healthcare workers. Another finding was that people who asked their healthcare workers to perform hand hygiene already perceived compliance to be 75 percent or higher. We were astounded when looking at the data, as you would think people get their information from healthcare authorities, and, you would think people who do the asking might assume compliance was so low that it required asking. Not the case.”

**The Future of Patient Empowerment**

Huckman and Kelley (2013) assert that not only is the public spotlight not aimed at information that most patients value, most patients cannot accurately interpret quality metrics and other healthcare statistics. They explain: “For example, what is the difference between a hospital with a 1 percent complication rate and another with a 2 percent rate? One perspective is that the first facility is twice as good as the second. An alternative view is that the absolute risk of a complication is so low at both institutions that choosing between them should hinge on other factors, such as convenience, cost, and reputation. Patients may favor this latter interpretation more often than we imagine. Even some patients with education beyond high school have difficulty understanding basic statistics, so it’s not surprising that many of them view public reports as unhelpful. Rather than choosing between providers of a specific procedure, perhaps patients are seeking an answer to a more fundamental and personal question: “Is the proposed treatment or procedure the best option given my condition, my financial status, and my social or family situation?”

Huckman and Kelley (2013) observe that we are in a consumer-driven healthcare economy, in which patients undertake the same deliberations regarding medical purchases as they do when purchasing furniture or a new car: “Both government and industry are determined to cut healthcare expenditures. Providers are building infrastructure to prepare for the day when future payment is linked to reducing utilization and cost. Opportunities abound in areas where the healthcare sector has grown the most — diagnostic technology, high-tech procedures, expensive pharmaceuticals and devices, and post-acute care. Patients may welcome this strategy, but they will want information that goes beyond current public reporting. To be sure, technical details of quality, safety, and process will remain important in healthcare, as they are in manufacturing, transportation, and hospitality. But consumers want clear and concise information that they can understand on factors such as out-of-pocket costs, the effectiveness of a procedure or treatment, and applicability to their personal condition and social situation … As patients become more sophisticated purchasers of health care,
they will push competition in health care delivery to look increasingly like that in consumer-goods industries. This competition could lead to product offerings that appeal to consumers with different needs. While some patients may seek greater odds of survival, others may seek a faster return to work or lower out-of-pocket costs. These options are at the core of ‘patient-centered’ care. To move healthcare in this direction, public reporting must shift from ‘one size somewhat fits all’ to an approach that reports metrics reflecting the varied concerns and preferences of consumers. With better information, millions more patients can become smart shoppers and, in the process, help bend the healthcare cost curve.”

The future of patient empowerment may very well be dependent upon more and better research. As McGuckin and Govednik (2013) observe, “While earlier research demonstrates success with patient empowerment and hand hygiene, more recent research focuses on patient willingness to be empowered, or on the HCW’s role (or willingness) to instill patients with the knowledge, skills and attitudes to be partners in the healthcare delivery process. We risk ‘improvement stagnation’ if we become focused more on identifying barriers than we are overcoming ones in programs that are already underway. Patient empowerment interventions and models have, for the most part, not been conducted as randomized controlled trials, controlled clinical trials, controlled before-and-after studies and interrupted time series analyses. At this point, it is not possible to say with scientific certainty that patient empowerment as a single intervention will increase hand hygiene. However, there is support that including patient involvement in a multi-modal program that also includes HCW empowerment and explicit permission can increase compliance. The questions that face research moving forward are: (1) Do we need randomized controlled trials? (2) Do we try to develop new theories on why empowerment might not work? (3) Do we build on proven interventions such as multi-modal hand hygiene programs with educational interventions that stress accountability and empowerment? (4) Do we educate our consumers so that they believe they can impact their healthcare experience when they become patients?”

Patient Involvement and Empowerment

The World Health Organization (WHO) provides the following Q&A:

Q: Is it appropriate to encourage patients to remind staff to clean their hands?

A: The Guidelines recommendation states: “Encourage partnerships between patients, their families and healthcare workers to promote hand hygiene in healthcare settings.” However, the current version of the Guidelines suggests the need for further study in this area to explore obstacles and facilitators in more detail. For this reason, a global survey of patients’ views on their involvement in hand hygiene is under way and the results of the survey, together with new evidence from the literature, will shape the final recommendations. Early indications are that across all regions, patients do want to be involved in efforts and initiatives to improve hand hygiene as a means of reducing healthcare-associated infections.

Q: What role do patients and visitors play in the spread of infection?

A: The Five Moments for Hand Hygiene illustrates in a simple manner the times when hand hygiene should be undertaken in health care, based on the theory of pathogen transmission. Patients themselves can transfer pathogens from one site of their body to another during the “Before Aseptic Task” moment. If patients are having contact with their wound or the insertion site of a device, hand hygiene should be encouraged (the alcohol-based handrubs will enable easy hand hygiene to be performed).

In the same way, if visitors are having contact with the patient, in a way which corresponds with any of the Five Moments,
McGuckin and Govednik acknowledge the immense challenges associated with conducting the kinds of studies needed to better inform thought in this arena. “From a research standpoint it’s hard to design a double-blinded trial,” McGuckin says. “It’s difficult to do the perfect study and so we are left with studies of interventions and post evaluations, which is fine because we can’t say ‘We’re not going to look at anything but randomized controlled trials,’ but it’s challenging to talk about HAI reduction and this kind of intervention without those types of studies.”

There are many programs and strategies that practitioners can choose from, to introduce, fine-tune, and implement in their unique hospital setting. The WHO is an excellent source of ideas and proven programs. Scientific conferences such as APIC and SHEA typically produce one or more abstracts related to patient empowerment and hand hygiene from a hospital’s experience. Let research on barriers and proven methods to overcome them be your guide, and let those pioneering hospitals and healthcare organizations who have shared their experiences be your inspiration. The road to success can be navigated using the right tools.”

Landers, et al. (2012) outline key considerations for future work to promote patient hand hygiene:

1. **Timing and technique**
   - Validate and promote when patients should perform hand hygiene

2. **Product, design, and placement**
   - Determine some of the key challenges, barriers, and needs specific to the patient
   - Evaluate appropriate patient product formulation(s) and delivery vehicles

3. **Patient education and training**
   - Provide educational tools for patients and visitors

4. **Healthcare worker education and training**
   - Provide education and training to healthcare workers on the rationale and technique of patient hand hygiene

5. **Multimodal strategy**
   - Identify opportunities to coordinate efforts to promote the need for and methods of patient hand hygiene to participants in the healthcare setting for healthcare workers, patients, families and visitors alike

Q: Some healthcare facilities actively promote hand hygiene by all staff and visitors entering a ward - is this a good approach?

A: The WHO Guidelines on Hand Hygiene in Health Care (Advanced Draft) clearly recommend alcohol-based handrubbing at the point of care. The approach of positioning alcohol-based handrubs at locations remote to the patient (e.g. at the entrance to every ward or in corridors or at healthcare facility entrances), has been taken in some countries with the rationale that this provides a strong message that the healthcare facility takes the issue of hand hygiene seriously. However, on closer examination of this approach, such a strategy might actually be damaging to long-term success and could result in inappropriate actions and misunderstandings by both staff and patients about how pathogens spread. It can encourage inappropriate and illogical hand hygiene action, which does not correspond to any real indication, and therefore does not contribute to reductions in HAI. Unless educational investment is made to ensure that staff and visitors understand the Five Moments for Hand Hygiene, compliance with the correct indications will likely be sub-optimal.
By necessity, this must include the patient. If ‘patient-centered care’ truly has the patient as the central focus, and patient safety is our top priority, then hand hygiene practices must include patients and their caregiver networks in the process.

As Landers, et al. (2012) summarize, “An approach promoting a culture of safety and HAI reduction involves everyone, top to bottom, in the process. By necessity, this must include the patient. If ‘patient-centered care’ truly has the patient as the central focus, and patient safety is our top priority, then hand hygiene practices must include patients and their caregiver networks in the process. Patient hand hygiene represents the next big step in infection prevention and in the evolving field of patient-centered care. This review suggests that including patients in hand hygiene practices has the potential to provide patients with the knowledge and skill to be true partners in their care. Fully addressing the risk associated with HAIs requires the appropriate education, products, techniques, practices, and promotional tools to directly engage our patients to fully participate in maintaining safety and reducing HAIs through their own hand hygiene.”

**Pointers for Patient Empowerment**

The World Health Organization (WHO) offers the following summary of patient empowerment talking points:

- The engagement and empowerment of patients in hand hygiene improvement in health care should be carefully considered when embarking on a new strategy or reviewing existing strategies.
- Introducing or strengthening this component of the multimodal hand hygiene improvement strategy requires careful planning and this tool is designed to assist with this.
- Patient engagement and empowerment should only be considered once the full buy-in and preparedness of healthcare workers has been secured.
- Healthcare workers need access to all of the infrastructures necessary to enable them to be fully compliant with hand hygiene in healthcare.
- The responsibility for hand hygiene rests firmly with the healthcare worker.
- Clear information on the why, when and how of hand hygiene should be readily available for patients.
- It is important to remember that not all patients will want to be engaged or empowered in relation to hand hygiene improvement in healthcare.
References and Recommended Reading:


Stanton MW. Expanding Patient-Centered Care To Empower Patients and Assist Providers. AHRQ’s Research in Action, Issue 5.
