Charge nurses’ perceptions of infection control

Sarah Freeman reviews evidence that senior staff can reduce the incidence of healthcare-associated infections by taking part in a cleanliness champions programme

Summary
People with mental health problems are as vulnerable to healthcare-associated infections (HAIs) as anyone else. This study examines how a group of senior charge nurses in inpatient, mental health wards changed their practice concerning HAIs after undertaking a ‘cleanliness champions’ training programme. Nurses interviewed after completing the programme reported that it had improved their knowledge and practice of infection control, and their understanding that this is basic to the health and wellbeing of service users, visitors and healthcare staff.

Keywords
Cleanliness champions programme, infection control, mental health wards

HEALTHCARE-ASSOCIATED INFECTIONS (HAIs), which are infections that appear after health care has begun (Health Protection Scotland 2007), are of growing importance to the public, healthcare staff and politicians. Such infections can cause pain, suffering and disability (Wilson 2001) and are a contributory factor to, and leading cause of, death (Plowman et al 1999).

The HAI prevalence survey undertaken in Scotland between October 2005 and October 2006, and involving 13,754 patients, found that the overall prevalence rate of HAIs is 9.5 per cent in acute hospitals and 7.3 per cent in non-acute hospitals (Health Protection Scotland 2007).

In Scotland, national and local initiatives, spearheaded by the government’s HAI Task Force, have been implemented in the fight against HAI. Among these is the ‘cleanliness champions’ programme, launched in 2004, which aims to ensure that at least one member of staff in each clinical area in the country has a clearly defined duty to promote infection control measures, particularly those concerning hand hygiene. The programme was developed by NHS Education for Scotland (NES), a special health board responsible for service support in Scotland, and for providing training and education to NHS Scotland staff.

Cleanliness champions undergo specific infection control training to acquire the skills and knowledge they need to fulfil the role. The core content of the training is theoretical and instructional, and can take place in classrooms, online or by use of a specially devised CD or manual. Some of the training takes place in clinical settings under the supervision of identified mentors.

There is much literature on infection control generally, but little concerning mental health and none concerning infection control in mental health inpatient settings. However, there is evidence to suggest that some mental health nurses lack knowledge about infection control issues. In a study of the extent to which 543 registered nurses understood standard infection control precautions, 26 per cent said their knowledge was ‘inadequate’. Forty per cent of these were mental health nurses and 50 per cent were learning disability nurses (Bennett and Mansell 2004).

There is a growing literature on the cleanliness champions programme. West et al (2006) asked 506 students who had registered on the programme during a calendar year what they thought were its benefits. The answers they most often received were: ‘challenging the practice of others’, ‘acting as a role model’ and ‘improved hand hygiene practice’. In evaluating the programme’s effect on medical students, Phillips and Ker (2006) found that 89 per cent had changed their attitudes to infection control, and most of these had changed their practice. Chalmers and Straub (2005) studied the integration of the programme into undergraduate nursing and midwifery curricula, and found that
students and local infection control teams were generally enthusiastic about the results. In a formal evaluation commissioned by NES and carried out at the Robert Gordon University, Macduff et al (2009) also noted a widespread perception that cleanliness champions improve clinical practice.

Senior charge nurses can help to ensure that infection control policies and procedures are followed by their influence on staff and contribution to junior nurses’ education (Roberts 2000). They can also interrupt the route of transmission of infection (Scott et al 2005). To understand how they perceive the cleanliness champions programme and whether they think it has improved practice, the author undertook a small-scale, qualitative study. This article discusses the results.

Study
Over a three-month period in 2007, the 16 senior charge nurses at NHS Greater Glasgow and Clyde Mental Health Partnership who had completed the cleanliness champions programme over the previous 18 months were invited to take part in a series of face-to-face interviews. Eleven agreed to do so and filled in forms indicating their informed consent to the interview process. None of them was known to the interviewer.

Ethical approval for the interviews was obtained locally from the Mental Health Partnership Team of the NHS board and nationally from the Central Office for Research Ethics Committee, in Glasgow.

The half-hour interviews were semi-structured and questions were open to encourage the interviewees’ narratives. The interviewees’ replies were anonymised, transcribed and organised into themes. The results are discussed below.

Acquiring knowledge The senior charge nurses said that the cleanliness champions programme had increased their knowledge and understanding of infection control issues. Before undertaking the programme, most had believed that their knowledge of infection control was adequate, but they quickly realised that it was not. As one interviewee said: ‘Before taking the programme, I thought my knowledge was pretty good. But I found out I was wrong.’

A number of interviewees described how taking the course had made them more aware of what was happening in their clinical areas and had equipped them with the skills to challenge others whose infection control practice was poor. ‘The programme makes you stop and think’, one said, ‘It makes you aware of hygiene and it also makes you aware of watching other people and what they are doing.’

Senior charge nurses should not only learn and put their knowledge into practice, but should also promote the learning of others. All interviewees recognised the importance of sharing their learning with their team, with one saying that he was ‘desperate’ to pass on his new-found knowledge to his colleagues, but not all found this easy to do. Some would teach by example and explanation, or by organising ‘sit-down’ sessions with small groups of staff to discuss certain issues; others were frustrated in trying to get their staff to take on board the most important messages. One said: ‘There is a certain ethos you can develop in your workplace, but if staff choose not to do it when you are not there, it becomes difficult.’

Changing outlook Completing the course had not only increased interviewees’ knowledge but had also fundamentally changed their outlook on infection control, which is not always considered an important topic in mental health wards, where staff usually focus on behaviour. As one interviewee said: ‘When people think about mental health, they usually think just about the head, but there is more to offering care to people with mental health problems than that.’

Another noted that mental health staff often ‘forget about HAIs’. He thought that some mental health nurses considered HAIs and infection control as issues for general nurses rather than for them, and that they did not need to keep their infection control skills up to date. But, he said, infection control is a crucial issue in his ward: ‘We have patients with wounds and we have dressings to do and other infections to deal with. So I remind the nurses about HAIs and show them what to do.’

Empowerment Interviewees said that the programme had given them more authority to ensure infections were controlled. One gave an example of a discussion with a doctor about certain infection control practices, which the senior charge nurse had insisted the doctor carry out. ‘The programme made me a wee bit more articulate and probably more assertive with my colleagues’, he said.

Some interviewees expressed frustration about having responsibility for the cleanliness of their environments but little authority over domestic services staff. One, for example, questioned whether she had full responsibility for cleanliness standards in her ward: ‘As the senior charge nurse, I have 24-hour responsibility for my ward, but I have no financial responsibility for environmental cleaning services. So I do not really have 24-hour responsibility except when things go wrong.’
Another was frustrated at his inability to act when domestic staff were withdrawn from his ward to address staffing gaps elsewhere, but was clearly prepared to argue his case for more consistent services. ‘I am a bit of a stickler for cleanliness and a bit tidy,’ he explained. ‘The domestic staff knew my standards. If I have a concern, I will raise it with the ward domestic, and if I am not happy with that, I raise it at a higher level. We are allotted a ‘slot’ for ward cleaning, but there is some contention at the moment about evening shift cleaning arrangements. The domestic only does a couple of hours in the ward and is then moved to other areas to accommodate sickness and absences.’

Opportunities for senior charge nurses to determine how frequently the wards were cleaned, but not necessarily by whom, can be taken throughout the domestic monitoring system. One senior charge nurse, for instance, had used the system to tour the ward on a monthly basis with the domestic services manager. However, not all of the senior charge nurses had embraced this system of working.

Some interviewees had problems ensuring their teams adopted good infection control practice, which raised the question of whether cleanliness champions training should be offered to less senior staff, including support workers. A recommendation to this effect has been made in the Robert Gordon University formal evaluation of the programme (Macduff et al 2009).

Changing practice Interviewees were asked if they had changed their practice as a result of undertaking the programme. One described how, after she had returned to her ward area, she had trained staff to use an ultraviolet (UV) box to detect residual contamination on their hands following washing. ‘I brought in the UV box and demonstrated how bad we were at hand hygiene. I think the staff were shocked at how bad we were,’ she said. Hand hygiene practice improved as a consequence.

Another described how nursing staff in rehabilitation wards supervised clients while they prepared food. After attending the cleanliness champions course, he had realised that the staff should have had formal training to carry out this role, and he stopped the practice of food preparation pending staff receiving the appropriate training.

Other interviewees became equally alert to inappropriate infection control practice on their wards. One introduced small sharps disposal boxes at the bedside of clients who had regular blood tests for diabetes; ‘I did not realise that disposal boxes were available’, she said. Another returned to his ward to correct staff practices in caring for a patient with meticillin-resistant Staphylococcus aureus infection.

This attempt to change practice floundered, however, because of external restraints. One senior charge nurse had carried out a clinical waste audit as part of the cleanliness champions programme’s work activities and found that the clinical waste container in the ward did not meet the audit standard. She requested the purchase of a suitable container, citing her rationale for doing so in an action plan, but the clinical waste container could not be afforded. As a result, she became concerned that her colleagues may have thought that she had not attempted to resolve the issue. ‘I identified the problem when I completed the original audit but it made no difference’, she said. ‘When we were audited again it looked like I had not changed anything, and this made me feel a bit dejected.’

Identifying differences in practice A number of interviewees discussed the particular challenges of trying to control infection in mental health wards, and the differences between mental health and acute general settings. One described this in relation to hand hygiene on her ward, where there was a danger that clients would ingest alcohol-based hand-washing gel. A risk assessment had been carried out to determine where the gel dispensers should be placed and it was recognised that these could not be placed in every handwashing facility in the ward, as they would be in adult general wards. ‘This is a secured and locked ward’, she said. ‘Everything is behind locked doors, so we have got to be more aware to wash our hands properly. But the alcohol gel dispensers are only sited in the staff toilets, staff rooms and the treatment room.’

Interviewees spoke of the tension between trying to create an environmentally clean and tidy ward and encouraging service users to develop independence. As one noted: ‘It is about keeping the place clean without doing everything for the patient.’ Another spoke of the difficulties of maintaining environmental standards when ‘patients can throw things and be threatening’.

Several interviewees highlighted the challenges of encouraging mental health nurses to comply with infection control principles that are not always perceived as important. One regretted that she ‘still had to remind people to wear aprons and take simple precautions’, and was concerned that the unit policy of staff out of uniform might actually militate against infection control. ‘Not wearing uniforms seems to make the whole thing much more lax’, she said. Looking back to her earlier days in nursing, she said: ‘You took pride in your appearance.’
Hair was up off the collar, there were no watches or stoned rings, and aprons were always worn. But it is different when we are in our own clothing. Everything is relaxed and that is not for the better.’

Interviewees identified other barriers specific to good infection control in a mental health inpatient settings, such as lack of cooperation from service users and the problem of deviating from individual rehabilitation programmes by changing clients’ personal living space.

**Encouraging visitors to be hygienic** National HAI measures apply to visitors to hospital wards as well as staff, and hospital wards are replete with advice to encourage visitors to observe infection control precautions, particularly in relation to hand hygiene. Some of the interviewees found that some visitors were eager to comply with infection control measures, while others were not. One senior charge nurse, for instance, commented on differing visitor responses during an outbreak of winter vomiting, when vigilance in hand hygiene was especially important: ‘Some visitors were quite understanding and others quite blasé’, she said. ‘Some just did not care.’ Nevertheless, although ward visitors could pose a problem, the general impression from the senior charge nurses was that the public are now more aware of HAI issues.

Generally, senior charge nurses’ are enthusiastic about the cleanliness champions programme and the infection control agenda. The education and experience they received while undertaking the programme convinced them that infection control is an important part of their remit, and their attitudes and practice changed as a result. They reported a sense of increased empowerment, greater willingness to challenge poor practice and heightened confidence in their own practice. These findings are similar to those of other research studies of the cleanliness champions programme (Wakefield et al 2003, West et al 2006).

**Conclusion**
This was a small-scale, qualitative study carried out with interviewees from a single NHS board area. It would therefore not be appropriate to draw wider conclusions from the results. However, the research raises interesting issues about how a national education programme can increase knowledge about, and enthusiasm for, a subject that has great significance for inpatients in NHS hospitals, their visitors and the staff.

It is fair to say that the senior charge nurses’ expectations at the beginning of the programme were low. They emerged from a mental health culture in which infection control was not always considered core business. They did not expect that their attitudes and practices would change substantially as a result of their learning on the programme, yet that is what happened. They came to see the benefits of good infection control practice and became eager advocates despite all the other priorities and pressures they faced as senior charge nurses in mental health units. As Berwick (1994) reminds us, ‘Only those who can provide care can in the end change care.’

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**References**


