

Qualitative Study on Hospital Staffs' Attitude towards Hand Hygiene in a Secondary Care Hospital in the Srinagar City

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Abstract: ***Background:** Horizontal transmission of bacterial organisms continues to lead to a high nosocomial infection rate in healthcare settings, and hospital-acquired infections are a growing global health concern. It is believed that healthcare workers' hands are the main means of transmission for most nosocomial infections. Hand washing is a useful tool for lowering infection rates. **Objectives:** To determine the health care professionals' attitude regarding hand hygiene practices. **Materials and Methods:** Qualitative study was undertaken to assess infection transmission, hand hygiene recommendations and implementation issues, and ways to increase compliance. Data was collected by Focus group discussions, that were recorded, verbatim transcribed, translated into English (when held in Kashmiri or Urdu), and then subjected to content analysis. **Findings:** Two themes emerged: "roles and responsibilities for sustainable and efficient implementation of context-relevant approaches and interventions" and "interrelationship of knowledge, beliefs, motivation, practices, and needs." Although most staff members understood the value of hand hygiene in preventing infections linked to healthcare, they saw practical difficulties with implementation. If the hospital provided the necessary resources, the staff appeared willing to follow hand hygiene recommendations and suggested a variety of interventions.*

Keywords: Hand hygiene, health care workers, qualitative study, focus group discussions

1. Introduction

The global problem of infection brought on by hospital-acquired microbes is growing, and healthcare facilities continue to experience a high rate of nosocomial infections as a result of horizontal bacterial transmission. Poor hand hygiene-related nosocomial infections are a significant contributor to rising morbidity, mortality, and health care costs among hospitalised patients globally. (1) The high prevalence of these infections, as high as 19%, in developing countries poses a challenge to health care providers. The single most economical public health measure for preventing infections linked to healthcare is considered to be practising good hand hygiene (HCAI). (2) Healthcare workers frequently spread virulent and drug-resistant strains of pathogens through their contaminated hands, which is how most pathogens associated with healthcare are transmitted. Health care workers are hesitant to implement advised practises to stop these infections, despite the fact that they can be prevented with a simple hand washing. (3) Despite evidence and professional opinion to the contrary, health care workers rarely demonstrate sustained improvements in adherence to hand hygiene recommendations and proper hand washing technique. (4) Campaigns to raise awareness of HCAIs, commitment at the highest level, and testing implementation strategies have been suggested as three main strategies to reduce HCAIs. (5)

The majority of quantitative research on infection prevention and control is published. This falls short of explaining how healthcare workers approach their work, why they disregard policies, and how various factors influence infection control procedures. These gaps can be filled by qualitative research because it offers in-depth understanding of people's thoughts. Therefore, This qualitative study was carried out to discover how staff members felt about hand hygiene and how to make changes

2. Methods

In the Sub District Hospital in Hazratbal, Srinagar, a qualitative study was undertaken using focus group discussions (FGDs) to collect data. Three focus groups were conducted: one with doctors, one with nursing personnel, and one with laboratory workers. Oral information about the study was provided to participants, and written consent was obtained; participation was voluntary. The origin, transmission, and prevention of HCAIs; awareness of and adherence to HH guidelines; and ideas for increasing adherence to HH guidelines were the subjects of an all-encompassing FGD guide with minor adjustments for each staff group. 30 participants were involved in three FGDs that took place between January and March 2022. Age, gender, and work experience were taken into consideration when choosing the participants. The FGDs lasted between 60 and 80 minutes, were conducted in settings specified by the participants, and were recorded. The audio files were verbatim transcribed, including English translations of the Kashmiri/Urdu transcriptions. The transcripts were sorted into "meaning units" after being subjected to a content analysis. In qualitative content analysis, the concept of a meaning unit is frequently employed. It makes reference to a section of the original transcript that has a particular meaning and typically consists of a number of words that are taken straight from the transcript. Condensed meaning units for each unit were created, and codes were then generated. The creation of themes resulted from the grouping of related codes into subcategories, which were then sorted and subsequently combined into categories.

3. Result

The content analysis of the FGD revealed two themes: "roles and responsibilities for sustainable and effective implementation of context-relevant approaches and

interventions" and "inter-relationship of knowledge, beliefs, motivation, behaviours, and needs." Each theme is described in the text below with its categories (subcategories are in parenthesis) and several examples.

Theme I: "Relationships among knowledge, beliefs, motivation, practises, and needs"

Everyone who participated understood how important their hands were in the spread of HCAs. Other transmission methods, such as through patients or visitors, were also covered. In the early FGD doctors, the topic of contaminated hands came up, whereas in a focus group with nurses, the conversation started with food. Doctors from a range of medical specialties talked about the many ways that particular pathogens are transmitted. The idea spread that improper HH practises could lead to higher rates of infection for everyone, a greater need for antibiotics, patient morbidity, longer hospital stays, and even mortality. "Hand washing is a really small aspect, but by concentrating attention on these small actions, we can prevent some significant problems," a nurse stated plainly. The majority of medical professionals thought that hand washing was the best treatment for HH. Many emphasised that improper hand washing was occurring because it was impractical. The personnel used a wide range of HH practises, from just washing hands with water up to the wrist joint to a complete scrub utilising antiseptic soap, antiseptic solution, and alcoholic preparations up to the elbow. Liquid antiseptics and hand sanitizers with alcohol were harder to find than conventional solid soap. The most popular technique emerged as hand washing with running water. "Washing hands is a time-consuming operation, thus chemicals like alcohol and spirit should be available", laboratory technician pointed out. Lack of wash basins and their distance from patients were the main causes of non-compliance with HH procedures. These issues were seen as the most significant by the participants. There was also the idea that adherence to HH practises was influenced by the patient's hygiene and socioeconomic position. Participants believed that there was a lack of nurses and cleaning personnel, that there were no norms and regulations in place, which allowed people to act irrationally, and that there were insufficient active or passive behaviour change communication links between hospital employees and management.

Theme II: "Roles and responsibilities for sustainable and efficient implementation of context-relevant methods and interventions"

Many participants agreed that staff involvement, the creation of a protocol or hospital infection control policy, and the establishment of a hospital infection control committee should all be the basis for interventions (HICC). These were considered the "cornerstones of everything" and the "centre of all interventions." Rules and category-wide protocols, according to several participants, should be one of the main interventions along with the HICC. These should be designed, explained, and put into practise in a fair way. Posters placed in key locations and training were suggested as two different instructional inputs. The participants proposed pre-training instruction, "on-the-job" instruction, and post-training follow-up activities including lectures,

speeches, workshops, competitions, etc. The doctors' and administrators' main concerns were raising awareness and instilling discipline. Doctors talked about monitoring blinded surveys and proposed using infection surveillance input as performance feedback and positive reinforcement. Nurses supported the use of cameras, alerts, and other reminders, as well as "spot checks" and inquiries from their superiors. "Reminder is absolutely preferable. One additional technique is that you demonstrate the microbiological results, so they can see what happens when you practice this. It will therefore motivate them, but not immediately; it will take at least six months to a year, so your surveillance must be on-going." suggested one doctor.

4. Discussion

The discussion's theme deeply captivated the participants. Although the reported use of HH was not widespread, the level of knowledge was nevertheless rather high. If the hospital had the appropriate facilities, participants appeared ready to follow HH guidelines and proposed numerous solutions. The staff's participation emerged as essential to the successful execution of interventions. The requirement for higher authority and specialist support was highlighted by the participants as being needed in the form of an HICC, institutional leadership, influence from role models, guidelines, procedures, standing orders, checklists, incentives, and positive reinforcement. A multi-modal strategy is likely to be the most effective in promoting HH habits, according to earlier studies. (6) Additionally, if the cost of clean water, clean towels, additional employees, and additional wash basins necessary for hand washing was compared with the cost of ABHR, the ease of use, time savings, and cost benefit of ABHR would become apparent. There is evidence demonstrating how ABHR availability affects HH compliance. (7-10) Other sources have reported on the causes of non-adherence to HH practises and the obstacles to adherence discovered during the FGDs. (11-14) Adherence to HH practises is influenced by a variety of factors, including knowledge and cognitive factors, social and behavioural factors, work and system restrictions, and the influence of institutional leadership. (15-17) The use of lectures and training programmes, with the assistance of "master trainers" or "role models" chosen from the wards, to be supported by posters and videos, exhibitions, community awareness drives, and education programmes for patients and their relatives was another educational intervention suggested in the current study. Numerous research have highlighted the helpful role that educational interventions have in promoting HH practises. (18-20) In conclusion, the staff at this secondary care hospital in India seems willing to abide by the HH rules if the facility was made available.

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