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MPH 611

Part II: Hand Hygiene Behavior among Healthcare Workers in the United States

Interventions

The first Intervention is Naikoba and Hayward's (2001) supplemental hand hygiene program, which was found effective in promoting compliance with handwashing behaviors. The supplemental hand hygiene program was designed to help healthcare workers, especially nurses, comply with hand hygiene protocols. The focus of this program was on individual nurses, where these caregivers were provided with tools to help improve compliance ratings with the laid standards. Specifically, this intervention involved improving the hospital setting by offering additional tools, including posters, reminders, and regular training on the proper procedures. The program was implemented by ensuring adequate posters, reminders, and in-house training on staff to observe hand hygiene practice. Hospital administrators would deliver the program by equipping their staff with reminders, wall posters, and regular hand hygiene training (Naikoba and Hayward, 2001). The program was designed to help care providers operate in a motivating environment supporting hand hygiene protocols. This program targeted the individual healthcare practitioner by giving them the supplemental tool for compliance with hand hygiene practices.

The second intervention is Huis et al. (2011) team-based program promoting hand hygiene practice among healthcare providers. Unlike the previous plan that targeted the individual healthcare provider, this one targeted teams. Implementing the team-based hand hygiene program has two major influences on the staff within a hospital setting. First, it affects the team members through social influence. Social influence happens through the team's role in

influencing their behaviors in the workplace. In this program, staff members are encouraged to develop a spirited fight for hand hygiene. Team members can develop accountability mechanisms encouraging colleagues to comply. For instance, teams can be involved in ensuring easy access to sanitizers, water, and soap. Teams are also involved in analyzing the gaps and fixing them to encourage compliance. On the other end, there is the organizational influence under this model which is sustained by the managers through their leadership. This model is administered by organizational managers and team leaders in the hospital setting. The target is to promote healthcare workers to work as a team to promote the usage of hand hygiene standards.

The third intervention is the Chun et al. (2015) mixed-media education program supporting hand hygiene practice among healthcare workers and individuals in the society. This program targets not only healthcare workers but other parties, such as patients and the general community. The program involves use of mixed-media education to improve the capacity of masses to observe hand hygiene standards. Chun et al. (2015) found that various education methods on hand hygiene could help groups and communities appreciate the need to comply with hand hygiene protocols. Various methods of education of the masses about hand hygiene could lead to compliance. However, for these methods to be effective, there is a need for program administrators to develop initiatives linked with subsequent feedback. This approach will increase community awareness on the need to take part in hand hygiene. In the end, it would improve the frequency and quality of hand hygiene activities among communities.

Evaluation

The three most popular methods of evaluating public health programs and interventions are quality, accessibility, and costs. The quality assessment method focuses on assessing the time and value of the intervention on the patient. The accessibility evaluation method involves

assessing the usefulness of a program in leading to easy access to service delivery. Lastly, the cost assessment method focuses on the affordability of the intervention. For this task, the researcher adopts the quality and accessibility methods of evaluating the above three programs. Naikoba and Hayward's (2001) supplemental hand hygiene program meets the quality criteria, as it improves the ease at which healthcare workers can maintain hand hygiene. Also, it enhances the accessibility of care by helping healthcare workers find tools to maintain hand hygiene protocols. On the other end, Huis et al.'s (2011) team-based program adds value to the quality and accessibility of care. Through team engagement, staff members can be more available to patients while maintaining the hand hygiene protocols. Chun et al. (2015) mixed-media education program is a suitable intervention for reaching a wider pool of people. This intervention boosts the accessibility of communities to information on handwashing protocols.

Relationship

The Social-Ecological Model (SEM) model has four segments: individual, relationship, community, and society. The individual levels deal with personal history factors, while the relationship deals with group member influences. The community deals with settings, such as hospitals, workplaces, and neighborhoods, while society deals with far-reaching social policies, such as those regarding health. Chun et al.'s (2015) mixed-media education intervention program relates with SEM's society segment. The Naikoba and Hayward (2001) supplemental hand hygiene program deals with SEM's individual and relationship segments. Lastly, Huis et al.'s (2011) team-based intervention program is related to the SEM's community segment.

Intervention Replication

Two of the three interventions could be replicated as designed and originally implemented. However, the first intervention, Naikoba, and Hayward's (2001) supplemental

hand hygiene program may need to be modified and packaged differently in order to be replicated. In this regard, the program was implemented using paper stickers and reminders placed on doors and entrances. This model would need to be changed and incorporate digital reminder systems to better reach the audience during this technology-ruled era. These gadgets can be placed next to toilets and room entrances. Besides, software programs on smartphones could be adopted with the permission of the staff. In regards to the REAIM criteria, this program has a wider reach if replicated in hospitals. Moreover, hospital administrators are likely to adopt the program. High-quality implementation could be adopted through close monitoring of staff. In terms of maintenance, little effort is needed since the program attracts minimal costs.

Recommendation for our local community

The Naikoba and Hayward (2001) supplemental hand hygiene intervention approach should be implemented in the Virginia Beach local community. This approach best suits our Virginia Beach local community, whose members rely on local healthcare centers and hospitals for their medical and healthcare needs. Besides, the growing number of aging and compromised patients such as the elderly and young children in hospitals makes the Naikoba and Hayward (2001) supplemental hand hygiene intervention timely and relevant in the Virginia Beach community. In this context, the use of reminders, alarms, posters, and other tools could significantly improve compliance with hand hygiene protocols. In Virginia Beach, hospital administrators and managers would implement the program across the different facilities in the area. Public health officers would collaborate with local hospitals to install and place the reminders, posters, and other tools to improve compliance with hand hygiene standards.

References

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