Ethics in Practice

Hand Hygiene as Standard Practice: Do the Rules Apply to All Healthcare Professionals?

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The importance of healthcare professionals performing hand hygiene consistently was first demonstrated by Ignaz Semmelweis in the 1840s. After concluding that puerperal fever was contagious, he directed that all medical students wash their hands with chlorinated lime prior to examining patients. Despite minimizing the rate of maternal death from 12% to 1%, Dr. Semmelweis’ hand-washing practices encountered opposition from various hospital and medical leaders. One hundred sixty years later, incidences of failure to protect patients from harm simply by performing hand hygiene continue.

Ethical Case*

While informally meeting with staff nurses in a nursing station, Molly, a midlevel nurse leader, was distracted by an event taking place across the unit hallway. Molly could not help but notice that an attending physician and medical student had just entered a patient room requiring contact isolation precautions neglecting to don personal protective equipment (PPE) or perform hand hygiene.

In addition, the attending physician was sipping on a cup of coffee as the duo entered the patient’s room, engaged in conversation with the patient and family, viewed the various monitor displays and exited the room on to their next destination again without performing hand hygiene.

Excusing herself from her meeting, Molly walked over to the attending physician, taking in every nuance of this encounter remained silent and followed the attending physician into the next patient’s room, also without performing hand hygiene.

Once the duo had disappeared into the patient’s room, a group of staff nurses in the nursing station, who unbeknown to Molly had been observing the encounter, offered up a small round of applause while exclaiming, “Way to go! Wish we could do that!” The nurses’ response was disconcerting to Molly because she viewed patient advocacy as the first and foremost role of every nurse. She believed that she was simply fulfilling her obligation to promote safety, an ordinary act, something every nurse should feel compelled to do as a patient advocate.

Upon returning to her office, Molly began to wonder who the physician was and reflected on what her next steps should be because her encounter did not inspire the physician to perform hand hygiene. Using the hospital’s online provider directory, Molly identified that the physician held a senior leadership position within the institution as well as the medical school. Concerned about...
the potential ramifications from her encounter with this physician, Molly felt compelled to disclose the event with the director of nursing (DON). The DON strongly encouraged Molly to file an event report using the hospital’s computer event reporting system stating, “This is an opportunity to create a teachable moment for the organization. No healthcare professional should be above the rules when patient safety is concerned.” Thanking the DON for her support, Molly knew she could not submit an event report without carefully thinking through the potential professional, personal, and ethical ramifications.

Validating Standards, Assumptions, and Professional Obligations

Molly took some time to sort out her thoughts related to the facts of the ethical situation she had just experienced. She quickly recognized that she was working on a variety of assumptions and professional beliefs, but was not confident that she could substantiate these assumptions and beliefs.

STANDARDS

First, Molly verified whether there was, in fact, a national standard related to hand hygiene in the acute healthcare setting. She quickly found that goal 7 of the 2010 Joint Commission National Patient Safety Goals is to “reduce the risk of healthcare-associated infections.” Also, the Centers for Disease Control and Prevention® and the World Health Organization® have hand-hygiene guidelines that promote hand hygiene as the best practice for preventing healthcare-associated infections.

After confirming the hand-hygiene guidelines, Molly wondered, “Surely all practicing physicians in America are aware of the myriad challenges associated with infection prevention and are all too familiar with the national campaigns to reduce hospital-acquired infections. What was that physician thinking?” Molly’s next step was to review the organization’s hand-hygiene policy. She noted the clarity and specificity with which it was written, including “Applicability: all healthcare providers” and “all healthcare workers caring for patients must perform appropriate hand hygiene.”

ASSUMPTIONS

Molly took one more step and consulted with a physician colleague to confirm her assumption that physicians have received education regarding hand-hygiene policies and procedures. As anticipated, she was informed that a requirement of the hospital’s initial physician credentialing process as well as the medical staff reappointment process, which occurs every 2 years, includes the successful completion of an online hand-hygiene competency tutorial and assessment. Thus, as an organizational leader and medical school faculty member, this attending physician would be expected to have the knowledge and an obligation to serve as a role model for all healthcare providers and medical students, especially related to an action as basic as hand hygiene.

PROFESSIONAL OBLIGATIONS

The American Nurses Association’s (ANA’s) Code of Ethics for Nurses With Interpretive Statement® states that “The nurse’s primary commitment is to the patient” (provision 2) and that the “nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient” (provision 3). Since her first day in nursing school, Molly had been told and believed that the nurse’s role is to advocate for and protect all patients from harm. In fact, Molly’s institutional job description stated that she was expected to

- provide broad clinical oversight in the development and maintenance of systems that support evidence-based nursing practice across the organization,
- assume accountability for meeting standards of professional performance [through] contributing to the professional development of peers and colleagues, and
- make decisions and take actions in an ethical manner.

Taking the time to process this encounter and validate her assumptions in a relaxed moment gave Molly the courage and confidence to complete the organizational event report about the situation, knowing that doing so was absolutely the right next step to do.

Seeking an Ethics Consultation

Identifying the Ethical Issue

This nurse leader was fortunate to possess a wealth of positive professional experiences that over time have helped her to develop moral courage and a sense of professional power. As she deliberates, it will be important for her to avoid experiencing moral distress (lingering feelings that one has morally compromised himself/herself).® While faced with a variety of ethical questions, this nurse leader clearly understood that she was not experiencing moral distress, which “is the presence of constraints, either internal (personal) or external (institutional) . . . that prevent one from taking actions that one perceives to be morally right.”® In fact, Molly clearly identified several institutional supports, such as the hospital’s initiative to minimize hospital-acquired infections, the hospital’s event reporting system, and the organizational systems that review the events, considering them as learning opportunities through performance of root-cause analysis. However, when initiating an informal ethics consultation, the nurse leader described how her desire to preserve and protect her professional career within the
physician's actions need to be reported and that, if she fails to follow through, her sense of integrity will be violated as illustrated by her comment “I would feel like a hypocrite when teaching.” The second question related to fear appears to be the key question with which this nurse leader is grappling. Molly’s decision to “sleep on it” allows for reflection and minimizes the potential to act rashly. Additionally, this nurse leader’s willingness to seek advice from a colleague as well as an ethicist provides her with the opportunity to identify and analyze the potential personal as well as professional risks that might be associated with completing a hospital event report.

Preventing Harm

**Physical Harm**

Infection prevention is the root of this ethical situation. “Hospital managers have a heightened responsibility to reduce the burden of adverse consequences attributable to preventable infection, and...” Additionally, the Joint Commission has a national Speak Up Campaign, urging “patients to take a role in preventing healthcare errors by becoming active, involved, and informed participants on the healthcare team.” Infection control practices, such as the use of PPE and hand hygiene, are implemented to minimize the spread of infection between patients, healthcare professionals, and the public. The Centers for Disease Control has readily available guides, tools, and resources as the need to minimize hospital-acquired infections is a national priority.

Nonmaleficence or do no harm is the primary ethical justification for infection control practices and limiting human liberties, such as freedom of movement or patient privacy by the use of signage. In this scenario, the fact that healthcare professionals are required to wear PPE and engage in hand hygiene is clearly publicized upon entry to the patient’s room as well as in the patient’s medical record. In addition, physicians within this institution are required to pass a hand-hygiene competency as part of their credentialing, appointment, and reappointment processes every 2 years. Thus, the physician’s freedom to move about the hospital and drink coffee without restrictions is being limited based on the potential of harm to self if he were to be exposed to the infectious agent and/or also potential harm to others (such as patients, visitors, other healthcare professionals, or even his significant others) if the physician’s hands or clothing were to come in contact with the infectious agent. Because of increased potential of risk of exposure, the Occupational Safety & Health Administration stipulates that “eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.” Thus, drinking coffee while providing patient care places the healthcare provider at increased risk.

**Professional Harm**

Molly’s concerns about potential personal and professional harms if she were to complete a hospital event report are realistic and related to the concepts of positional power and equity. Does that fact that the physician holds a senior leadership position place him above or outside the institution’s usual monitoring and disciplinary policies and procedures? Equity requires that like persons be treated similarly in similar situations. How should the term similar be interpreted in this situation? Because the isolation policy directs that every person entering the room must comply with the identified restrictions and directions, the policy does not provide for exclusions, rather every healthcare professional, hospital employee, and visitor is held to the same standard.

How the hospital enforces this policy reflects the institution’s organizational ethics. The principle of equity would require that the same disciplinary actions be implemented for every hospital employee (regardless of rank or job description) observed to be in noncompliance with isolation precautions despite the person’s role. If an institution does, in fact, believe that no person is above the rules, then the organization would need to be equitable with all disciplinary actions regardless of the employee’s rank or title. For example, if the institution would terminate a member of the housekeeping department after 3 witnessed violations of the isolation procedure, then the hospital must also be willing to terminate the employment of any nurse, physician, or administrator with a similar pattern of behavior.

When considering whether to file a hospital event report, Molly must...
consider the potential that the physician through official or unofficial means might be able to initiate acts of retaliation toward Molly. For example, would the physician be able to block a future promotion for Molly or create a negative work environment for Molly or other nurses? Consulting a nurse leader colleague (the DON) was a wise and appropriate action because the DON is able to provide guidance and positional support if Molly chooses to submit a hospital event report.

Prior to completing the hospital event report, Molly should review the hospital’s event reporting policy and follow the steps accurately. She should also verify the presence of any institutional retaliation policy or state retaliation legislation. For example, in 2007, Colorado enacted legislation “to protect healthcare workers from retaliation for making a good-faith report or disclosure regarding patient safety information or quality of patient care.”

When making a good-faith claim, the reporter is noting a breach in the standard of good-faith claim, the reporter is noting a breach in the standard of care that places patients at risk and is made without “malice or consideration of personal gain.”

Finally, Molly should keep a written record of the incident as well as any encounters or discussions that transpire as she deliberates and/or after filing a hospital event report. Molly is to be commended for first approaching the physician directly with her observations. Because the physician seems to have made a conscious decision to not follow basic hand-hygiene principles and isolation procedure, Molly has a professional obligation to report this incident of negligent behavior. Provision 3.5 in ANA’s Code of Ethics for Nurses With Interpretive Statement (2001) stipulates,

As an advocate for the patient, the nurse must be alert to and take appropriate action regarding instances of incompetent, unethical, illegal, or impaired practice by any member of the healthcare team or the healthcare system or any actions of others that places the rights or best interests of the patient in jeopardy.

Theoretically, completing a hospital event report is an example of internal whistle-blowing since “whistleblowers are people who expose negligence, abuse, or danger such as professional misconduct or incompetence that exists in the organization in which they work.”

Thus, Molly is correct to act with careful consideration and to garner support from the DON.

Benificence

The ethical principle beneficence requires that after preventing harm, one must also act to promote a separate good. In this scenario, Molly’s interaction with the physician illustrates her commitment to beneficence. First, she is promoting the image of and power of nursing by role modeling for the staff nurses how to professionally address a clinical issue with another healthcare professional. As a result of this interaction, further assessment of the nurse-physician dynamic within this unit is warranted as well as staff education on professional communication and collaboration. Second, the nurse leader is augmenting the medical student’s understanding of isolation protocol and professional accountability.

Recommendation for Nurses

When challenging situations emerge, such as witnessing noncompliance with hand hygiene, the nurse should remember to involve nursing leaders in the decision-making process and to conscientiously follow the institutional chain of command as well as policy and procedure when reporting the issue. Second, the nurse should also carefully reflect on how his/her action or inaction might impact the nurse personally as well as professionally.

Third, the nurse should consider the element of timeliness when considering how to respond to a challenging situation. Finally, all nurses should strive to create a culture of no blame and mutual reminding because healthcare is recognized as a team effort, and every healthcare provider’s primary focus should be on the safety of the patient.

Recommendations for Nurse Managers

1. Infection prevention is everyone’s responsibility (patient, visitors, and healthcare professionals). Thus, unit-based nurse managers need to keep apprised of their institution’s infection prevention initiatives and policies and work to establish a culture that expects and promotes infection prevention practices (especially including hand hygiene) routinely.

2. The ethical principle of justice suggests that healthcare institutions develop disciplinary policies that treat all employees equitably when infection prevention policies and procedures are not implemented consistently.

3. Nurse managers need to be visible within the clinical setting to role model and support the staff nurse’s attempts to promote infection prevention practices throughout the interdisciplinary healthcare team. Nurse managers may want to consider providing staff nurses with the opportunity to role play and practice communication strategies that focus on the art of inquiry and promote a culture of mutual reminding based on the foundational concept of doing what is right for the patient. The staff nurses could practice role playing their skills in a safe environment, such as with actors serving as “standardized healthcare professionals” or learn
Future Research Questions

Ethical situations related to nurse empowerment and interprofessional dialogue and accountability are prime topics for future research and quality improvement projects. For example,

1. What are the ethical and clinical situations that staff nurses experience but do not feel empowered or safe to act upon?
2. What types of issues are reported in hospital event reports? What types of outcomes are associated with the different issues? Are there equity and consistency in outcomes? If anonymous reporting is available, is there a difference between the issues identified anonymously versus known reporters?

Summary

This case study provides an in-depth look at a scenario that many nurses encounter every day. Nurses are not the hand-hygiene “police,” nor should they take on that role. However, nurses are patient advocates and peers of other healthcare professionals. In this case, Molly concluded that the physician should be knowledgeable about and aware of his professional obligation to practice hand hygiene routinely. The ANA’s Code of Ethics for Nurses With Interpretive Statements, her job description, her knowledge of the Joint Commission National Patient Safety Goals, and her own organization’s institutional priority to reduce/prevent hospital-acquired infections gave her the validation she needed to act after recognizing the physician’s breach of standards. Molly’s sense of responsibility was further heightened by her dual role as a practice coordinator and adjunct nursing professor, seeking value consistency as well as “practicing what she preached.” Even after going through all the steps outlined above, validating standards, assumptions, and professional obligations, as well as seeking the counsel of a nursing director, Molly still had some minor remnants of doubt after filing the event report and therefore sought out an informal ethics consult. The ethics consult provided Molly with a professional sounding board, negating any doubts that she harbored about the steps she took or the way she went about addressing this challenging situation. The overlay of organizational politics, relationships, familiarity, and the ever present realization that “our patients” could be us or one of our loved ones can create both a hesitancy and a compulsion to act.

REFERENCES