INTRODUCTION

Janet Wiseman and I are colleagues within the Faculty of Health and Social Care at Canterbury Christ Church University, although we are based within different departments. I was particularly keen to have Janet write a chapter for this book to provide a social work/care perspective on infection control, which is an area where this topic is not always given the importance or attention it deserves. Janet offers a rather different perspective on infection control – one I hope you will find interesting.

CHAPTER 9

Reflection as a facilitator of safe professional practice

Janet Wiseman

This chapter seeks to draw attention to the importance of reflection in effective infection control. I will explore some of the barriers to reflection and how it can assist the development of good practice. Throughout the chapter I will present a number of reflection exercises aimed at drawing on the importance of reflection, and highlight misconceptions about reflection, gaps in knowledge and areas for development. However, although it is important for all those involved in healthcare and social work to apply reflection as a means of maintaining safe standards of infection-control practice, it is my intention to discuss the links between reflection and infection control within the context of social work.

Social workers pride themselves on their ability to assess complex situations and plan courses of action or intervention in an appropriate and timely way. To make these judgements they draw on the knowledge, skills and values acquired during the course of their education and training. However, it is also recognised that effective social work, which responds to the needs of diverse individuals in equally diverse contexts, requires more than the application of technical theory acquired during this training.

The use of reflection to increase or enhance knowledge, once the individual is in practice, can be a useful additional tool to draw on (D'Cruz *et al.* 2007). Its most useful application has been described as 'reflection in action' (Schön 1991), which can be applied to many challenging practice scenarios. Using reflection enables social workers to continue to build their knowledge and skills into a wealth of 'practice wisdom' (Saltiel 2003) and can be particularly

useful when applying principles of ethical practice.

It can be argued that social workers have an ethical duty to be well-informed about infection control and to understand the implications of lack of knowledge in this area. However, social workers are unlikely to be fully informed about the issue and may instead be influenced by unreliable sources of evidence.

REFLECTION EXERCISE 9.1

Make a list of all of the words that come to mind when you think about healthcare-acquired infection.

What is it caused by?
Where has your current knowledge come from?

Pre-registration training
Workplace induction
Health and safety awareness training
Colleagues
Personal experience
Popular media.

For example, the popular media portrayal of the untoward spread of infection is that it is caused by unclean hospitals or poor hygiene procedures by doctors, nurses or domestic staff (Washer and Joffe 2006). It is also wrongly suggested by these reports that most infection occurs during in-patient admissions to hospitals. In this sense it might be easy for social workers to assume that they have no part to play in effective infection control. However, social workers certainly have a role to play and a responsibility to neither over- or under-react to the need for effective infection control. They need to use the established evidence base to become well-informed and, in particular, to understand that this is a core social work issue.

REFLECTION EXERCISE 9.2

Consider the list of standard precautions below (*see* List 9.1)

Reflect on your recent practice and decide which precautions have:

1 No relevance }
2 Some relevance } to you professional practice?
3 Significant relevance }

Then consider situations you have been in where standard precautions would have had some or significant relevance.

How well do you feel prepared to address these precautions?

LIST 9.1 STANDARD PRECAUTIONS

1 Recognising the need to adopt standard precautions is the most important aspect. Failing to recognise the need will be governed by the way an individual thinks, which will, in turn, impact upon their perception of the relevance and importance of such precautions. If an individual perceives standard precautions as being irrelevant, unimportant or of less priority, then the potential for non-adherence will be significantly increased.
2 Hand hygiene is vital in facilitating the prevention and reduction of healthcare-acquired infections. Hand hygiene must be carried out frequently, with individuals constantly reflecting upon the principle of, 'What have I just done and what am I going to do now?' If the *just done* constitutes a risk to themselves or others then appropriate hand hygiene must be undertaken prior to proceeding to the *do now*. Further, consideration must also be given to the full undertaking of the hand hygiene process.
3 Hand rubs are an effective method of hand decontamination in the short term. However, they should never be perceived as an absolute substitute for adoption of formal hand hygiene using the hand hygiene process.
4 Disposable aprons can provide some protection for the wearer. However, they should never be perceived as an absolute barrier and must be changed frequently. As a general rule the *just done, do now* approach should be adopted at all times.
5 Disposable gloves must always be worn when handling body fluids or any contaminated substance/materials. As a general rule, if in doubt wear gloves. Management and/or colleagues should not presume to ridicule or restrict an individual's decision to wear gloves.
6 Skin trauma must be dealt with in accordance with your employer's policies and procedures and in accordance with health and safety law. All trauma to the skin, irrespective of how minor, must be cleaned, dried, covered and reported. It is a legal requirement that an accident/incident form is completed and individuals should report to either the occupational health department or to accident and emergency.
7 The eyes should be protected where there is either a potential or actual risk of flying debris or splashes of body fluids/harmful substances. Individuals must determine for themselves when the wearing of appropriate eye

protection is necessary. Management should not presume to restrict such determinations or they may be in contravention of an individual's human rights.

8 Sharps are dangerous and will cause harm. A sharps injury may have consequences for the remainder of an individual's life span. A 'sharp' may be defined as anything that can either penetrate or cause trauma to the skin. Always handle sharps with caution whilst giving consideration to the safety of those around you. The rule is, if you have been using sharps then you clear up what you have used and dispose of them correctly with due consideration for the safety of others.
9 Spillages of any kind can be hazardous to your and others' health and wellbeing. The rule is, if you cause the spillage then you clean it up or ensure it is dealt with in the correct way. Your employer's policies and procedures for dealing with spillages must be adhered to at all times.
10 Waste materials can be divided into three categories: household, clinical and contaminated/hazardous. However, all categories of waste should be handled with caution as all are capable of increasing the risk of cross infection and causing harm to yourself and others. Your employer's policies and procedures for the disposal of waste must be adhered to at all times.
11 Linen, like waste materials, must be handled with care because of the increased potential for cross infection. When handling soiled or contaminated linen appropriate protective clothing should be worn. With regard to the handling of clean linen the *just done, do now* approach should be adopted. Your employer's policies and procedures for the handling of linen must be adhered to at all times.
12 Food handling is an activity that all of us do either at a personal level for self-consumption or at a social level for consumption by others. The mishandling of food is a prime source of cross infection and the use of appropriate protective clothing and meticulous hand hygiene is essential using the, *just done, do now* approach.
13 Environmental contamination, although not always visible to the human eye, is always present. Therefore, regular and rigorous cleaning of healthcare environments is essential in reducing the risk of cross infection. Although many involved in the provision of healthcare perceive such environmental cleaning as being the role of designated cleaners, such a role is arguably the responsibility of all. The rule is, if you cause the contamination, you clean it up or ensure it is cleaned up in an appropriate manner. It is both unethical and unprofessional to simply leave contamination with the expectation that it is someone else's responsibility to clean it up.
14 Personal hygiene of both those involved in the provision of healthcare and

recipients of healthcare is an important measure where the reduction of cross infection is concerned.

Applicants to social work training often state that their main reason for wanting to enter the profession is to help people (Carey 2003). This is an honourable reason, but may, in fact, inhibit effectiveness in certain crucial areas of their role. For example, monitoring or policing poor or harmful practice in themselves or others may be counter-intuitive to the 'benign helper' (*see* Explanation box 9.1).

EXPLANATION BOX 9.1

The concept of the benign helper is drawn from the underlying value base ascribed to helping professionals, including social workers. Although mistakenly thought to have originated in the Hippocratic Oath, the maxim to 'First, do no harm' or '*Primum non nocere*' has been recognised as a guiding principle of doctors, healthcare professionals and social workers alike (Smith 2005). However, I would argue that as members of a caring profession, we are reluctant to recognise that not everything we do will be benign and helpful and understanding that even the most ethical practitioners may cause harm is difficult. We often construct abusive professionals as the 'few rotten apples' in order to maintain a mistaken view that there is possible harm in every intervention we carry out.

This complexity – that we can both help and harm someone at the same time – induces a very real practice dilemma in the professional (Caplan and Caplan 2001). It may be uncomfortable, but easier to recognise when, for example, giving medical treatment that has unpleasant, harmful or unknown side effects, as long as the potential benefits are also recognised. The process is less clear in terms of psychosocial interventions or in the context of the helping relationship. So, for example, the fact that a reassuring touch of the hand of someone in distress may also be a cause of infection may be a very difficult practice dilemma to resolve.

Understanding or accepting the possibility that social workers may harm a client may at best be restricted to notions of abusive practice as opposed to negligence through non-adherence to standard precautions. Even when considering negligent or poor practice, this may be understood in terms of actions omitted or carried out to a low standard as opposed to impact (Day, Klein and Redmayne 1996). This challenges social workers to think about issues of

hand hygiene in a way that may be counter-intuitive to their usual approach to physical proximity and touch. In addition, social workers are used to assessing risk in terms of risk of physical injury to self from or to others as opposed to risk of cross infection.

In terms of infection control, it is well-established that this needs to be a shared responsibility, but it may not always be understood as such. The dominance of health-related jargon, for example HCAI, and substantial guidance being produced by NICE (National Institute for Clinical Excellence) add to the misconception that this is substantially a health professions issue (NICE 2003). There is little similar guidance in social care and that which exists constructs the problem of infection control as being primarily related to social care workers, or those who have direct 'hands on' tasks to perform in residential or nursing home settings or who provide domiciliary personal care (Skills for Care 2005). Education and training on effective infection control is likely to be located at National Vocational Qualification (NVQ) level and is rarely part of a social worker's induction. Likewise, the UK General Social Care Council Codes of Practice for Social Care Workers and Employers does not cover specific aspects of infection control practice, such as standard precautions. However, this could easily be covered under risk assessment and compliance with employers' health and safety policies (General Social Care Council 2002).

REFLECTION EXERCISE 9.3

Think about regular visits you make to individuals in their own homes, in hospital or in care homes.

What are the implications of considering infection control before or after your visit?

Are there some visits where this would 'feel' easier or more appropriate than others?

What are the reasons for this?

Since the implementation in the UK of the National Health Service and Community Care Act (1990) there has been greater emphasis on interprofessional working between health and social services across all adult care sectors, including mental health, learning disability, physical disability and older people (Sharkey 2007). This has led to an increase in the number of social workers and social care workers located alongside health staff in hospitals, general practice surgeries and other clinical settings (Department

of Health 2000). However, working effectively inter-professionally presents many challenges for individual staff, managers, policy makers and educators (Charlesworth 2001). Most notable challenges have included reviewing traditional demarcation lines of roles and responsibilities; redefining some previously profession-specific tasks and ensuring maximum effectiveness with neither overlap nor gaps in provision (Glasby and Peck 2004).

In terms of roles and responsibilities, there has been greater clarity of what a social care professional, as opposed to a healthcare professional, is authorised to do by legal definition and by the implementation of regulations specific to social work and social care. From the service user perspective, it is now possible to receive a holistic single assessment of community care and health need as opposed to being subjected to several repetitive assessments by different professionals located in different agencies and buildings. In terms of professional education and training, many universities now provide this at an undergraduate pre-registration level on an inter-professional basis.

However, the need for a joined-up approach to infection control has not yet gained significant attention in the current debates and this is a worrying omission. For example, the National Service Framework (NSF) for Older People (Department of Health 2001) states in its introduction that it

> . . . sets new national standards and service models of care across health and social services for all older people, whether they live at home, in residential care or are being looked after in hospital.

It aims to tackle age discrimination, health promotion in later life, support a coordinated approach to person-centred care – whether in hospital or community settings – and also to strokes, falls and mental health. It does not mention the need for a coordinated approach to infection control (*see* Explanation box 9.2).

EXPLANATION BOX 9.2

In the UK, there have been many criticisms of health and social care provision, which historically was provided by separate organisations, funded by separate budgets and characterised by a divided approach. Failures in the system were highlighted by high-profile cases involving mentally ill patients in the community who either put themselves at unacceptable risk (McFadyen and Farrington 1996) or who became a danger to the public (Ritchie, Dick and Lingham 1994). Since then, government policy has supported the integration of health and social care services and its practice has developed into a more

integrated or joined-up approach. However, current agendas have focused on areas such as care of the mentally ill, discharge planning for older people, adult protection, partnership with service users and carers and specialisations such as palliative care and dementia. The need to apply this joined-up or partnership approach to infection control has not yet been recognised as a significant area for exploration.

In addition, the issue of hand hygiene (which is raised in one of the first inter-professional pre-registration modules at Canterbury Christ Church University) is the topic most often complained about as being of no relevance to first year social work students and is often characterised as a nursing issue. These assumptions are based on false notions that infections are spread in hospital settings only, that nurses are the only profession who work in hospital settings, and that social workers do not undertake any 'hands on' tasks and therefore are immune from, or not part of, the infection-control chain (*see* Explanation box 9.3).

EXPLANATION BOX 9.3

In the UK, there are areas of personal caring that social workers may not undertake because the law does not permit it, such as giving injections or changing certain dressings. However, there are also areas of work which, because they are traditionally carried out by social care or domiciliary workers, have not formed part of a social worker role. These areas are not defined by statute or law, but are often crudely described as 'hands on' care and that is how I use the term here.

These assumptions must be challenged in both the learning environment and practice. For example, whilst social workers may not see their role as being primarily to offer personal care, there are many situations where their hands may come into contact with a service user.

REFLECTION EXERCISE 9.4

Personal care can be identified as

> . . . care that directly involves touching a person's body, and is distinct from treatment/therapy – a procedure that is deliberately intended to cure or

ameliorate a pathological condition – and from indirect care, such as home help or the provision of meals on wheels (Royal Commission on Long-term Care 1999, p. 67).

Consider what is meant by personal care by the definition above.

Social workers do not carry out physical interventions or treatment, but think about in what way might you touch a client?

Do you shake hands when you introduce yourself?

Do you offer a helping hand on someone's arm if they have a mobility issue?

Do you offer a hand in reassurance if someone is upset?

Do you help someone on or off with their outdoor clothes when taking them somewhere?

Are there other examples?

Should you consider infection control in any of these examples?

How would you manage that?

What would you say to your client about it?

Working inter-professionally requires practitioners to be able to maintain strong individual professional identities and clear demarcation lines about certain roles and tasks whilst understanding the complexity of what might be shared or interchangeable tasks (Brown, Crawford and Darongkamas 2000). For example, whilst a mental health social worker may monitor the compliance of a patient with their monthly depot injection, they are never in a position to administer that injection (Dougherty and Lister 2004). Therefore, their task is perceived as being at a physical distance to the client even though there may be a physical treatment issue involved. In contrast, practitioners need to adopt a shared approach with certain tasks. Some such roles and tasks include assessment of need, care planning, coordination of care and reviewing of care. In other circumstances, tasks can be allocated to a single professional who represents the inter-professional team, such as liaising with carers, discharge planning or referring to their agencies. These different approaches make certain areas of responsibility explicit and clearly attributable, but tasks such as infection control may not have sufficient clarity. In addition, practitioners have been encouraged to minimise the overlap or duplication of tasks and it has therefore become counter-intuitive to do otherwise. Working inter-professionally and safely from an infection-control perspective requires not only an understanding of the distinct and shared roles, but also perhaps a duplication and repetition of tasks. Reflecting on both the implications and

challenges of this counter-intuitive approach can be a useful way of addressing dangerous practices.

The responsibility for infection control in inter-professional teams is not always clearly understood or articulated, particularly when the team is involved in the psychosocial care of clients or patients (Gammon, Morgan-Samuel and Gould 2008). As with difficult patients or clients, there is a danger that it is seen as an issue no one wants and is therefore passed around the team to the person who is least able to resist the pressure to take responsibility. However, there are clearly dangers in this approach as there are occasions when patients fall through the net.

REFLECTION EXERCISE 9.5

Consider the list below and reflect on who you believe is responsible for infection control. Do any of the professions/roles below not have responsibility? Do some of these professions/roles have more responsibility than others? If so why?

Service managers	Doctors
Hospital nurses	Community nurses
Care workers	Social workers
Ancillary staff: porters, cleaners	Administrators/reception staff
Volunteers	Patients/clients
Visitors or friends of patients/clients	Ambulance crews
Dentists	Dental nurses

Now identify whether infection control should be profession- or role-specific, a shared role or an interchangeable role.

Of the above professions/roles, who do you believe is most responsible for cross infection? Now think about your answer and ask yourself the question, 'Is my answer rational or rationalised?'

Vulnerable people have always been accommodated in a variety of in-patient and community settings. This is not a new phenomenon. However, the landscape of coordinated community care has changed and consequently there is a need to widen responsibility for infection control to a broader range of contexts (Skills for Care 2005). For example, there has been an increase in the number of minor operations carried out in general practice surgeries (Brown *et al.* 1997). In addition, patients or clients are being discharged into the community, to their own homes or to supported living, residential or nursing

home care, as soon as they are deemed medically fit for discharge (Baumann *et al.* 2007). This is reflected in the changing context of social work practice and the degree to which social workers in adult care are now firmly established as care managers (Brown, Crawford and Darongkamas 2000). Alongside this, previously hidden groups of patients or clients have emerged. For example, victims of adult abuse, carers, people living with HIV and AIDS – social workers need to take a holistic approach to their needs too.

Planning smooth care pathways and ensuring seamless services between health and social care are the new priorities, but this has not always been the core social work role and is not necessarily welcomed by some current practitioners. Care managers have reported feeling that their profession has become bureaucratised and that this has led to a restriction on their ability to make meaningful and empowering relationships with their clients (Carey 2003; Tanner 1998). For example, having additional procedures to follow to implement infection control may not be welcome in the current climate and may be wrongly perceived as the antithesis of core social work practice. It may also be perceived as a direct result of the implementation of the NHS and Community Care Act (1990) and as such the ambivalence surrounding those imposed changes may impact on a practitioner's willingness to proactively engage with the issue. Furthermore, infection control procedures may not sit comfortably alongside other care management or social work tasks and may be rejected, or their importance diminished, if they are perceived as increasing this bureaucratisation.

REFLECTION EXERCISE 9.6

Think about the different roles/tasks you perform during your working day as a health or social care professional.

Make a list of the roles or tasks you like doing the most.

Which are the ones you least like?

Where would you place infection control in relation to the roles or tasks you like doing most and those you like doing least?

Do you consider infection control as a part of following essential procedures (just something else you have to do) or part of establishing and maintaining safe and meaningful relationships with your patients or clients?

It is often assumed that safe, meaningful relationships between social workers and their clients are at the heart of much social work practice where the

possibility of therapeutic change exists (Beresford, Croft and Adshead 2007; Parry-Jones *et al.* 1998). Such areas of work include work with children, therapeutic work with survivors of abuse or trauma, or counselling people through loss or bereavement.

However, safe and meaningful relationships are considered less often where the possibility of therapeutic change appears less likely. This includes work with older people, people with dementia, learning disabilities or long-term conditions or illnesses. There is a growing body of concern that social workers are failing to see the opportunities to apply their skills in a person-centred way in these areas. For example, living with dementia involves multiple losses for the individual and their family and friends. The condition usually progresses slowly over a considerable period of time and could provide many opportunities for therapeutic work on loss. Unfortunately, this psychotherapeutic intervention is rarely offered or considered when care management priorities and work load pressures restrict the time social workers have available.

Social work tasks are driven by planning care within restrictive budgets and the importance of the interaction or relationship between social worker and client has become secondary. The erosion of this part of a social work role does not help in the implementation of infection control if the main aim is perceived as undertaking bureaucratic tasks as speedily and efficiently as possible.

REFLECTION EXERCISE 9.7

Consider the following statement:

> 'Social workers and care managers do not have time to implement relevant standard precautions of infection control.'

As a social work professional, how do you feel about this?
As a healthcare professional, how do you feel about this?
What are the reasons for feeling this way?
What are the implications of this?
What can you, as an individual, do about this?

Working with human beings in severe distress can be a source of disabling anxiety for health and social care professionals (Menzies-Lyth 1988). However, a crucial part of the role of practitioners is to contain anxiety for their clients, as well as managing their own. Social workers are being increasingly encouraged

to not only use reflection as a way of developing critical practice, but also as a means to gain insight into these anxiety-laden interpersonal processes they engage in with their clients (Ruch 2007). Therefore, holistic reflection can be usefully employed to understand the anxieties inherent in social work practice relating to infection control. The availability of safe arenas for discussion and refection are essential for the containment of anxiety.

REFLECTION EXERCISE 9.8

Think about the anxieties you may have about infection control; for example:

- remembering the standard precautions;
- feeling worried about personal contact with clients;
- feeling worried about how to speak with a client about infection control;
- any others?

Think about arenas where you might discuss anxieties about infection control.
Which arenas would feel the safest:

Individual supervision?
Team meetings?
Multi-professional meetings?
Informal contact with colleagues?

Which arenas would help you to manage your own anxiety?

CONCLUSION

It is a core social work task to adhere to appropriate standard precautions (*see* List 9.1) in the area of infection control. It is important for social workers to be informed about these standard precautions and how to apply them effectively. However, it is also important for social workers to reflect upon barriers to their effective implementation. It is critical that social workers recognise the issue as one of effective partnership in working with health colleagues; as one which draws on their ability to effectively assess risk; as an issue related to ethical behaviour and personal/professional boundaries and one where social workers' knowledge and skills around inequality and empowerment may be crucial.

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