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Applying organisation theory to understand barriers and facilitators to the implementation of baby-friendly: A multisite qualitative study

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ABSTRACT

Objectives: (a) to apply an organisation-level, pre-implementation theory to identify and describe factors that may impact hospitals' readiness to achieve the Ten Steps and (b) to explore whether/how these factors vary across hospitals.
Design: a multisite, descriptive, qualitative study of eight hospitals that used semi-structured interviews of health-care professionals. Template analyses identified factors that related to organisation-level theory. Cross-site comparative analyses explored how factors varied across hospitals.
Setting: thirty-four health-care professionals from eight North Carolina hospitals serving low-wealth populations. The hospitals are participating in a quality improvement project to support the implementation of the Ten Steps. This study occurred during the pre-implementation phase.
Findings: several factors emerged relating to collective efficacy (i.e., the shared belief that the group, as a whole, is able to implement the Steps) and collective commitment (i.e., the shared belief that the group, as a whole, is committed to implementing the Steps) to implement the Ten Steps. Factors relating to both constructs included 'staff age/experience,' 'perceptions of forcing versus supporting mothers,' 'perceptions of mothers' culture,' and 'reliance on lactation consultants.' Factors relating to commitment included 'night versus day shift,' 'management support,' 'change champions,' 'observing mothers utilize breastfeeding support.' Factors relating to efficacy included 'staffing,' 'trainings,' and 'visitors in room.' Commitment-factors were more salient than efficacy-factors among the three large hospitals. Efficacy-factors were more salient than commitment-factors among the smaller hospitals.
Key conclusions and implications for practice: interventions focused on implementing the Ten Step may benefit from improving collective efficacy and collective commitment. Potential approaches could include skills-based, hands-on training highlighting benefits for mothers, staff, and the hospital, and addressing context-specific misconceptions about the Steps.

Introduction

Breastfeeding is associated with improved maternal and child health (Ip et al., 2007; Ram et al., 2008; Stuebe et al., 2009; Schwarz et al., 2010a, 2010b; Stuebe et al., 2011; McClure et al., 2012). Supporting breastfeeding is an effective strategy for reducing health-care costs and disease burden (Jones et al., 2003; Bartick and Reinhold, 2010). UNICEF and the World Health Organization (WHO) developed the Baby-friendly Hospital Initiative to support implementation of maternity practices to support and protect breastfeeding: the Ten Steps to Successful Breastfeeding, herein referred to as the Ten Steps (World Health Organization and UNICEF, 1989, 2009) (Table 1). The Ten Steps

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support breastfeeding initiation, exclusivity, and duration (Kramer et al., 2001; DiGirolamo et al., 2008; Abrahams and Labbok, 2009; Nickel et al., 2013). Federal health offices and professional organisations endorse the practice of the Ten Steps (Tayloe, 2009; US Department of Health and Human Services, 2011).

The WHO recommends that clinical maternity staff receive approximately 18–20 hours of training on providing the breastfeeding-supportive care outlined in the Ten Steps (World Health Organization and UNICEF, 2009). Surveillance data suggest that 12% of new maternity nurses in the US received this level of training (Centers for Disease Control and Prevention, 2012).

Data show that fewer than 5% of hospitals within the United States practice all Ten Steps and more than 60% practice fewer than six of the Ten Steps (Centers for Disease Control and Prevention, 2012). Maternity care in the US does not, as yet, entirely reflect the evidence-based recommended maternity care outlined in the Ten Steps (Bartick et al., 2009; Centers for Disease Control and Prevention, 2012).

This suggests the need for studies that identify both barriers and facilitators to implementing the organisational changes necessary to achieve the Ten Steps in US facilities. US-based qualitative studies have largely explored individual hospitals' experiences with implementing the Ten Steps (Wright et al., 1996; Clarke and Deutsch, 1997; Merewood and Philipp, 2001; Hahn, 2005); few compare the experiences of multiple hospitals (Kovach, 2002; Bartick et al., 2010; Weddig et al., 2011; Crivelli-Kovach and Chung, 2011). Many studies were set in regions of the US with higher community-level breastfeeding rates. Their experiences may have actual and/or perceived limited generalisability to hospitals in regions with low breastfeeding rates. Although theoretical frameworks are important for guiding quality improvement efforts, few studies applied organisation-level theory to examine the implementation of the Ten Steps (Sanson-Fisher et al., 2004; Eccles et al., 2005; Grol et al., 2007; Bartick et al., 2009).

This article presents findings from a multisite, descriptive, qualitative study of barriers and facilitators to implement the Ten Steps in eight hospitals in the Southeastern US. The study's objective was to apply an organisation-level theoretical paradigm to the identification and exploration of factors that may impact Ten Step implementation efforts.

Theoretical framework

Hospitals implementing the Ten Steps are engaging in a complex, multilevel organisational change (World Health Organization and UNICEF, 2009; Thomson et al., 2012) (see Table 1 for example practices). Successfully achieving such change requires high levels of organisational readiness (Lehman et al., 2002; Amatayakul, 2005; Weiner et al., 2008, 2009; Weiner, 2009). The theory of 'Organizational Readiness to Change' (ORC) is one proposed framework for identifying and targeting factors that influence an institution's readiness to execute change (Weiner et al., 2008, 2009; Weiner, 2009).

This study applied Weiner's definition of ORC (Weiner, 2009). ORC is a collective psychological state shared by organisation members across hierarchical and professional levels (i.e., hospital staff members, administration, and providers) towards implementing a specific change effort. It is a pre-implementation theory that reflects readiness prior to engaging in change efforts.

Weiner's definition raises two important points: (1) readiness is a collective state shared by organisation members and (2) readiness is specific to a given change effort. The first point highlights (a) that significantly differing perceptions of readiness among organisation members (e.g., various hospital staff members, employees, and providers) may indicate a lack of shared-readiness and (b) that these perceptions are shared among organisation members. The second point emphasises that ORC is specific to each change effort; an organisation may have high readiness for one change effort while possessing low readiness for another.

Organisational readiness has two dimensions: collective commitment and collective efficacy (Weiner, 2009). 'Collective Commitment' refers to whether organisation members, collectively, value the change: do members perceive that the change is necessary and/or important and/or beneficial? 'Collective Efficacy' relates to organisation members' shared perceived ability to mobilise the necessary resources and cognitive abilities to execute the proposed change (Bandura, 1989; Wood and Bandura, 1989; Weiner, 2009). Barriers and facilitators in the form of task demands, resource availability, situational/contextual factors, and the interactions between these three influence organisation members' perceptions of collective commitment and collective efficacy (Weiner, 2009).

Methods

Study setting: Breastfeeding Friendly Healthcare Project

This study explored factors that may influence readiness to implement the Ten Steps in eight North Carolina hospitals serving low-wealth populations participating in the Breastfeeding-Friendly Healthcare Project (BFHC). BFHC is an intervention designed to support hospitals' implementation of the Ten Steps. Eight hospitals expressed interest in implementing the Ten Steps and participated in BFHC. Each hospital formed a taskforce consisting of hospital personnel. Additional information on the BFHC is presented elsewhere (Taylor et al., 2012). This qualitative study took place during the BFHC pre-implementation phase; that is, during the baseline assessment, prior to engaging in implementation efforts. Findings from this study helped inform intervention strategies currently underway. Table 2 presents descriptive information about the eight hospitals.

Study sample

Purposeful sampling was used to ensure interviewees reflected a variety of positions responsible for providing the care outlined in the Ten Steps (i.e., primarily maternity nurses, a limited number of nurse practitioners, paediatricians, and obstetricians, and, where possible, someone from management), shifts (day and night), and attitudes towards providing hospital-based breastfeeding support (Creswell, 2007). These criteria were used to ensure that (a) the key informant had knowledge about barriers and facilitators to implementing the Ten Steps, (b) key informant interviews would reflect a wide variety of perspectives, and (c) data could be used to inform the development and implementation of intervention support.

The research team communicated these criteria to each taskforce. Each taskforce used these criteria to select interviewees. Interviewers were not informed of respondents' attitudes about breastfeeding before the interviews. Thirty-four respondents were interviewed from the eight hospitals (see Table 2). Respondents included five clinicians (paediatrician and obstetricians), three nurse practitioners, six administrators, and 20 staff nurses.