



Review Article

An Integrative Model of Workplace Self-protective Behavior for Korean Nurses



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SUMMARY

Purpose: This study was conducted to develop and test a hypothetical stage model of workplace self-protective behaviors with respect to blood transmitted infections and musculoskeletal injuries for Korean nurses.

Methods: A nonexperimental, cross-sectional study design was adopted. The study participants were 320 nurses at two Korean university hospitals. Perceived sensitivity, severity, barriers, benefits, self-efficacy, social support, and safety climate were assessed.

Results: Overall, fit indicators showed a good fit for the hypothetical model of self-protective behaviors against blood transmitted infections and musculoskeletal injuries. The significant factors of self-protective behaviors against blood transmitted infections were perceived barriers and social support. The significant factors of self-protective behaviors against musculoskeletal injuries were perceived benefits, barriers, and self-efficacy.

Conclusion: Our findings suggest that the significant psychosocial constructs of stages of self-protective behavior are dependent on health problem type. Accordingly, we advise that characteristics of behavior and types of disease and health problem should be given priority when developing intervention programs for particular self-protective health behaviors.

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Introduction

Much research has described work-related health problems in nurses (Castiglia et al., 2008; Smith, Kondo, Tanaka, Hirasawa, & Yamagata, 2003; Smith et al., 2006; Stone, Clarke, Cimiotti, & Carrea-de-Araujo, 2004). Musculoskeletal disorders are among the most common health problems related to nursing practice (Lee, Faucett, Gillen, Krause, & Landry, 2010; Pompeii, Lipscomb, & Dement, 2008). Smith et al. (2003) reported a 12-month prevalence rate of musculoskeletal injury of 92%, and that low back pain was the most common musculoskeletal injury with a prevalence of 83%, followed by injuries of the shoulder, neck, and knee. In addition, musculoskeletal injury has been reported to contribute to nurse turnover (Trinkoff, Brady, & Nielsen, 2003). The next most

common work-related health problem for nurses is blood transmitted infections from sharps or needles contaminated with blood or body fluid, and the most frequent are blood-transmitted hepatitis B and C and HIV infections (Grosch, Gershon, Murphy, & DeJoy, 1999).

Recent studies regarding self-protective or health-protective behaviors in the workplace, including self-protective behaviors against blood transmitted infections and musculoskeletal injuries, have addressed the following four topics: (a) the relationship between characteristics of workers and injury experience, (b) the relationship between the characteristics of workers and safety performance, (c) modification of safety-related behavior through reinforcement, and (d) identification of the organizational and environmental correlates of safety performance (Grota, Meinzen, & Burleson-Rine, 2009; Lee et al., 2010; Reddy, Welch, Thorne, & Ameratunga, 2012). These studies have provided good descriptive details of the characteristics of workers, jobs being performed, and working environments with respect to safety performance, but have not provided a comprehensive understanding of workplace

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self-protective behaviors. Furthermore, few studies have been conducted on the development and testing of comprehensive workplace self-protective behavior models that provide a systematic and integrative understanding of self-protective behavior in the workplace.

Because work-related health problems are common among nurses, the development and implementation of an intervention program to facilitate self-protective behavior is important. However, a comprehensive workplace self-protective behavior model for nurses needs to be devised and verified to enable the design of an effective intervention program.

Theoretical background

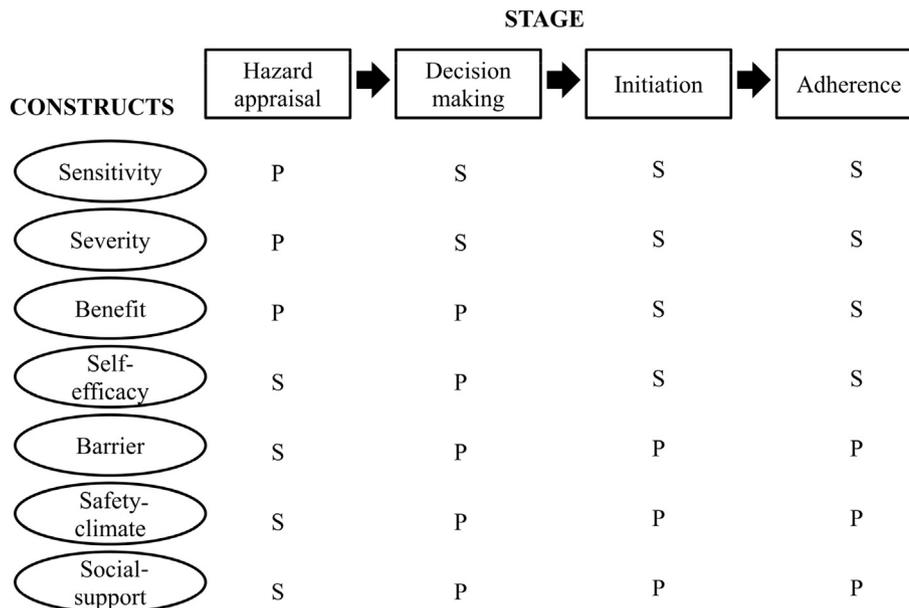
Value-expectancy models and the transtheoretical model (TTM) (Ben-Ami, Shaham, Rabin, Melzer, & Ribak, 2001; Chia et al., 2005; Ozakan, Lajunen, Dogruyol, Yildirim, & Coymak, 2012; Reid & Aiken, 2011) have been generally adopted to conceptualize the behavioral change process. Value-expectancy models include the health belief model (HBM), the theory of reasoned action (TRA), and theory of planned behavior (TPB). Some investigators have expressed doubts regarding the contributions made by such health behavior models/theories to the accretion of knowledge in the health behavioral field. Based on such considerations, investigators have proposed that more effort is needed to develop integrative models by combining highly explicable constructs extracted from previous empirical evidence.

Even before this opinion was widespread, Dejoy (1996) developed an integrative health protective behavior model based on the HBM, TRA, TPB, and TTM. Based on the assumption that an integrative model consisting of previously verified constructors of health behavior may provide a more complete understanding and prediction for health behavior, Dejoy included five major constructs extracted from the HBM, TRA, and TPB, and four stages of workplace self-protective behavior as proposed by the TTM in the integrative health protective behavior model. The four stages are: (a) the hazard appraisal stage, (b) the decision-making stage, (c) the

initiation stage for self-protective action, and (d) the adherence stage for self-protective action. The five major constructs of the Dejoy’s model are threat-related beliefs (beliefs about hazard susceptibility and severity), response efficiency (perceived effectiveness or benefits of self-protective behavior), self-efficacy (individuals’ beliefs regarding their ability to perform a self-protective behavior successfully), facilitating conditions (expands the concept of barriers relative to its usage in the value-expectancy models and emphasizes the importance of social supports in self-protective behavior), and safety climate (a combination of social and organizational factors).

Different factors are expected to be important at different stages, and therefore, factors important in one stage may be unimportant in another (Dejoy, 1996). For the hazard appraisal stage, beliefs of personal dimensions, such as, threat-related beliefs and response efficiency, have been proposed to be the primary factors of self-protective behavior. However, for the initiation and adherence stage, factors of environmental dimension, such as, facilitating conditions and safety climate, have been proposed to be more important (Dejoy).

Dejoy’s model is an exemplary integrative model because it contains various influencing factors extracted from verified theories, and systemizes stages of behavioral change. However, of the five major model constructs, facilitating conditions were considered to require modification. As mentioned above, facilitating conditions was vaguely defined as an expanded concept of barriers and a combination of social supports in Dejoy’s model (1996). Because such conceptual ambiguity inevitably made it difficult to be measured, facilitating conditions was decoupled into conceptually more concrete components, barrier and social support, in the present study. Various value-expectancy models include barrier and social support as major constructors, and also specifically define threat-related beliefs as perceived sensitivity and severity (Ben-Ami et al., 2001; Chia et al., 2005; Ozakan et al., 2012; Reid & Aiken, 2011). Therefore, perceived sensitivity, severity, benefits, self-efficacy, barriers, social support, and safety climate were included in our hypothetical model (Figure 1).



P: Primary strategy S: Secondary strategy
(adopted from the Dejoy’s model)

Figure 1. Hypothetical model of workplace self-protective behavior stage for nurses.

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