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Dirt and disgust as key drivers in nurses' infection control behaviours: an interpretative, qualitative study

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SUMMARY

Background: Infection prevention remains a significant challenge for healthcare systems. Yet despite considerable work to provide clear policies and scientifically proven techniques to reduce infection transmission, beliefs and practices of healthcare workers do not always concur with scientific rationale.

Aim: To provide explanations for nurses' infection prevention behaviours.

Methods: An interpretative, qualitative approach was taken using semi-structured interviews. Twenty interviews with registered nurses working in an acute hospital setting were conducted. Analysis was conducted using the Framework method.

Findings: This paper focuses on the theme 'protection from dirt'. Within the findings clear distinction was made between infection and dirt. Fear of contact with dirt, particularly dirt belonging to those who were unknown, was a key driver in behaviour carried out to reduce threat. Familiarity with the patient resulted in a reduction of the protective behaviours required. These behaviours, which initially appeared as part of an infection prevention strategy, were primarily a form of self-protection from patients, who at first encounter were considered as dirty.

Conclusion: Behaviours do not always fit with a rational response to infection, but instead may be responses to dirt. Any programme that simply attempts to address scientific knowledge and behaviour deficits is unlikely to have the desired goals if it does not take into account existing social constructions of dirt and the response it evokes.

Introduction

The control and prevention of infection within the hospital setting presents a significant challenge for healthcare systems worldwide and constitutes a considerable drain on resources. Preventable deaths from healthcare-acquired infections continue to occur despite wide-reaching initiatives and the increase in scientific knowledge and understanding of infection aetiology.

In the UK, though there has been recognition since the 19th century that hygiene and cleanliness play a pivotal role in standards of care, infection transmission continues to present a major problem for health services.[1] In response, considerable work has been undertaken to provide clear policies and scientifically proven techniques to reduce infection

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transmission. Yet despite this, beliefs and practices do not always concur with any scientific rationale and may be driven by other factors – for example, culture, as considered by Douglas; or automated hygiene behaviour initiated through feelings of disgust, as argued by Curtis.[2–4] Whereas Douglas asserts that culture is the driving force that creates the concepts of dirt and taboo, Curtis challenges this notion by drawing comparison with the natural world; disgust of dirt is characterized as an instinctual response influenced by evolution.[3,4] Curtis argues that humans exhibit automated hygiene behaviours prompted by feelings of disgust, which exists to produce avoidance of elicitors and thus avoidance of contamination; this means that higher-level thinking is not required to avoid dirt or disease.[5] This thinking and level of response will of course have implications for healthcare workers, who at times are required to act against the automated response of avoiding contamination, as their role may involve contact with potential contaminants. Behaviours may be influenced by the conflict between automated thinking and what is learnt through education and training or what is seen in clinical practice. Additionally if there is a gut feeling to avoid sick members of society, healthcare workers may experience a conflict in their role as it involves close contact with the sick, which compromises the need to protect self.[5] This conflict, combined with gut feeling, may play a significant part in how healthcare workers behave.

If this response leads to the correct procedures and appropriate behaviour being carried out, then it would not need addressing further. However, evidence suggests that this does not always happen; behaviour is not always 'correct' and may in some instances be identified as harmful.[6]

Nurses provide a significant percentage of the healthcare workforce, and Curtis' view could provide a novel explanation for their behaviours in an attempt to understand how practice is enacted, and in considering the scientific view of infection versus natural instinct.[5] This paper presents one of three themes from a larger study which sought to identify what influenced nurse infection-prevention behaviours. Through eliciting their explanations of protective behaviours, the study identified the concept of dirt and the disgust that this dirt provoked, thus providing insight into behaviour that has not previously been fully explained.

Methods

An interpretative, qualitative approach using in-depth interviews was used to explore nurses' infection prevention behaviours, their perceptions of risk and contagion, and the explanations they provided for their own and others' behaviours. The study was designed in two stages, so that data from discussion around observed infection prevention behaviours collected in the first stage could be analysed, and then used to represent practice in the form of vignettes to the participants in the second stage.

Registered nurses working in UK acute settings were interviewed over a 14-month period in two distinct stages. Participants were approached while attending a professional development course at a local university. Nurses were excluded if they were not working in an acute setting or were not in a position to observe and comment on practice; additionally it was a requirement of their study course that they had been qualified for a minimum of one year and had had some experience of working as a qualified nurse. Thirty registered nurses expressed an interest in the study and twenty were interviewed. The sample was both convenient and purposeful.

Stage 1 consisted of eight semi-structured interviews using a topic guide developed from the literature, focusing on nurses' perception of risk in the hospital setting, on their concerns regarding the potential to contaminate family and friends, and on whether they believed that policies influenced their own practice. This was combined with a discussion around observed infection control behaviours, particularly those deemed inappropriate by the participants. Stage 1 interviews were subject to initial preliminary analysis to inform the development of vignettes representing various behaviours. Only behaviours identified by two or more participants were considered for the vignette development. An example behaviour described by a number of participants was healthcare workers wearing gloves and aprons to carry out routine observations on patients who did not have a recognized infection and posed no infection risk. This type of behaviour was then incorporated into the vignette as 'A nurse is recording the blood pressures of all the patients. She is wearing the same gloves and an apron which she keeps on for all eight patients.'

Stage 2 consisted of the same semi-structured interview and a discussion around the vignettes with the remaining 12 participants. Participants were asked whether they recognized the behaviours in the vignettes and for any explanations of behaviour they considered inappropriate.

Interviews lasted between 30 and 45 min, were audiotaped, transcribed verbatim and analysed using the Framework method, which comprises a set of predetermined analytical phases.[7] Any identifying information was removed and participants were allocated pseudonyms to maintain confidentially. Full analysis of all stage 1 and 2 interviews was conducted. This analysis commenced with familiarization of the data by a process of immersion. Preliminary emerging issues and themes were recorded, allowing data to be organized. A thematic framework was then identified by drawing on the topic guide and the emerging themes, and by recording any recurrence or prevailing patterning. The next phase, indexing of the data, was completed by applying the framework to all the interview transcripts. In the final phase the data were considered again as a whole, the main focus being to provide explanations, although other elements of the process enhanced the findings and added insight. In the final interviews no new themes emerged and the data generated confirmed what previous participants had said; thus, no more than twenty interviews were conducted.

All participants were sent verbatim transcripts of their own interviews at the end of each interview stage and asked to comment on them as a process of member checking.[8] Participants in the final stage were also sent emerging themes. The responses did not identify any discrepancies with the content of the interview or the emerging themes; comments related primarily to respondents' own use of language. Emerging themes were not influenced by any feedback received. Finally, an independent nursing academic reviewed the data and identified comparable themes, thus increasing credibility.

Participants

In total, 13 female and seven male registered nurses, who had been qualified for between 18 months and 20 years, were

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