



## Infection prevention as “a show”: A qualitative study of nurses’ infection prevention behaviours



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### ABSTRACT

**Background:** Control of infection and prevention of healthcare associated infections is an ongoing issue worldwide. Yet despite initiatives and strategies to reduce the burden that these infections cause, healthcare workers’ practice is still reported as suboptimal and these infections persist. Much of the research to date has primarily focused on predicting infection prevention behaviours and factors associated with guideline compliance. While this has given valuable insight, an investigation aiming to understand and explain behaviours that occur in everyday practice from the perspective of the actors themselves may hold the key to the challenges of effecting behaviour change. This study questioned “How can nurses’ infection prevention behaviour be explained?” This paper presents one of three identified themes ‘Rationalising dirt-related behaviour’.

**Design:** This interpretative qualitative study uses vignettes, developed from nurses’ accounts of practice, to explore nurses’ reported infection prevention behaviours.

**Participants:** Registered nurses working in an acute hospital setting and had been qualified for over a year. They were recruited while studying part-time at a London University.

**Methods:** Twenty semi-structured interviews were undertaken using a topic guide and vignettes. Interviews were transcribed verbatim and analysed using the framework method.

**Results:** The findings demonstrate that participants were keen to give a good impression and present themselves as knowledgeable practitioners, although it was evident that they did not always follow procedure and policy. They rationalised their own behaviour and logically justified any deviations from policy. Deviations in others were criticised as irrational and explained as superficial and part of a ‘show’ or display. However, participants also gave a presentation of themselves: a show or display that was influenced by the desire to protect self and satisfy patient scrutiny.

**Conclusions:** This study contributes to the identification and explanation of nurses’ infection prevention behaviours which are considered inappropriate or harmful. Behaviour is multifaceted and complex, stemming from a response to factors that are outside a purely ‘scientific’ understanding of infection and not simply understood as a deficit in knowledge. This calls for educational interventions that consider beliefs, values and social understanding of dirt and infection.

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### What is already known about the topic?

- Healthcare associated infections are a continuing problem within healthcare, and are costly to both health services and users.
- Current policy and guidance provide education and monitoring tools to record and audit infection prevention practices but do not examine the root cause of non-compliance and inappropriate behaviour.

### What this paper adds

- Inappropriate infection prevention does occur in practice but is attributed to others' behaviour rather than own.
- Behaviour is often self-protecting and may be part of a socially constructed reality where a show is performed to convince the audience that practice is based on knowledge.
- Complex social behaviour requires multifaceted interventions which existing policy and guidance do not always provide.

## 1. Introduction

Infection control and prevention of healthcare associated infections are an essential part of healthcare. While there is a body of work that examines factors affecting compliance with guidelines and is aimed at predicting infection prevention behaviours, some behaviour that occurs in everyday practice remains unexplained (Pittet, 2004). Examining such behaviours may provide a key insight into the challenges of behaviour change and may ultimately inform new initiatives aimed at improving practice, increasing quality of patient care and enhancing infection prevention.

As far back as 1860, Florence Nightingale emphasised the importance of hygiene, cleanliness and standards of care, yet despite this infections in hospitals and other healthcare settings continue to be a major concern for health services (Department of Health (DH), 2009). While today's hospitals are much cleaner, safer places than in the 19th and early 20th centuries, dirt and infection still threaten patient safety (DH, 2009) through transmission within the hospital environment. However, despite current scientific knowledge and policies, beliefs and practices associated with cleanliness do not always accord with the implications of the 'rational' scientific approach or even immediate objective evidence (Morrow et al., 2011). For example, despite a clear recognition of the importance of hand washing in reducing transmission of microorganisms, compliance by health professionals is often poor and protective equipment is not always used appropriately (Pittet, 2000).

In 2011 the World Health Organisation (WHO, 2011) reported that healthcare associated infections accounted for 16 million additional days in hospital throughout Europe with total costs estimated at approximately €7 billion, while in the USA the estimated total cost per year was \$6.5 billion. In the UK, the cost of treatment and management of healthcare associated infections has continued to rise with recent estimates of €53.9 million

per year, attributed to the resulting increased length of stay (WHO, 2011).

In the first decade of the 21st century, the control of healthcare acquired infection, most notably the globally problematic meticillin-resistant *Staphylococcus aureus* (MRSA), became a major focus of UK health policy as rates of infection were perceived to be too high (National Audit Office (NAO), 2009). Repeated UK government initiatives (DH, 2001a, 2001b, 2003, 2004, 2005, 2007, 2008) led to some reported improvements in control (NAO, 2009); however evidence suggests that infection spread continues to be poorly understood by healthcare workers and the general population, with practices not underpinned by sound knowledge and evidence (Easton et al., 2007; Nichols and Badger, 2008; Morrow et al., 2011). Furthermore, although the need to understand infection prevention behaviour has been identified as a key factor in improving practice and a significant step towards modifying behaviour (Pittet, 2004), little research has been undertaken regarding the motivation behind specific behaviours. Some studies have identified why certain procedures and practices are not carried out, for example handwashing, but few have considered workers' behaviours as a whole or investigated the key determinants to behaviour and infection prevention practices (Pittet, 2004; Whitby et al., 2006).

Despite training and education, compliance with good practice remains variable. Evidence suggests this is affected by many factors, including perception of one's own practice and intention, motivation, perception of threat and social or peer pressure (Chan et al., 2002; Stein et al., 2003; Pittet, 2004; Akyol et al., 2006). Additionally, knowledge does not necessarily correlate with good practice; low compliance with standard precautions has been noted in those who reported a high level of conflict between providing patient care and the need to protect themselves (Gould, 2004). It has been argued that appropriate responses to infection only occur when there is a perceived risk and when efficacy is expected (Jenner et al., 2002). Jenner et al. (2002) cite self-protection as a motivating factor even when the main organisational purpose is patient protection and infection reduction. Personal responsibility and attitudes are predictors of intention to practice hand hygiene, with behaviour, to some extent, being predicted by perceived behaviour, control and intent (Jenner et al., 2002).

Behaviour, which is influenced by both rational and irrational thoughts, may therefore not be congruent with policy. Paradoxically, policies perceived as rational by government agencies may be adhered to even when healthcare workers believe they are not effective, or may be adapted to accommodate irrational fears (Kennedy et al., 2004). Any behaviour deemed inappropriate warrants further investigation and may require considerable examination and interpretation before the rationale behind it can be explained. Healthcare workers by the very nature of their role may find that their behaviour is influenced and conflicted by automated thinking and what is learnt through education and training, or seen in clinical practice (Curtis, 2007); this conflict may play a significant part in how they behave. Curtis (2007) discusses how disgust of

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