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Major Article

Positive deviance and hand hygiene of nurses in a Quebec hospital: What can we learn from the best?

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Background: Although it is well known that hand hygiene is the most effective measure to prevent health care-associated infections, hand hygiene adherence is low in Quebec, as it is elsewhere. For this study, an innovative framework was used to explore the clinical practice of nurses regarding hand hygiene and the factors that influence it: positive deviance, or the idea that there are people who find better solutions to problems than their peers. This study investigated positive deviance at the level of the care team to shed light on group dynamics.

Methods: We conducted focused ethnographies on 2 care units—a medical-surgery unit and a palliative care unit—at a Montreal university hospital. Data collection consisted mainly of systematic observations and individual interviews with nurses.

Results: The results show that positive deviance related to hand hygiene is instigated by social cohesion within a care team, created, in this study, by the mobilizing leadership of the head nurse in the medical-surgery unit and the prevailing humanist philosophy in the palliative care unit.

Conclusions: In health care, it can be useful to apply the positive deviance approach to care teams instead of individuals to better understand the ideologic and structural differences linked to better hand hygiene performance by the nurses.

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BACKGROUND

The growing media coverage of health care-associated infections reveals that this is a real concern for society.¹ Hand hygiene is recognized as the most effective strategy for preventing this type of infection.^{2,3} That said, the weak adherence to this practice by health care professionals has been documented extensively in different care settings,⁴⁻⁶ despite widespread efforts and the use of multiple strategies.⁷ Although a number of factors could explain the weak adherence to hand hygiene, including workload, staff shortage, and lack of hand hygiene products,⁸ the difficulties encountered in improving it suggest that changing this behavior is a complex task. In the early 1990s, a behavioral change approach—positive deviance—

was successfully implemented to combat infantile malnutrition in Vietnam.⁹ Since then, the positive deviance approach has been used in many fields related to public health and medicine to identify and promote better performance in different areas.¹⁰ According to this approach, for any given problematic situation, most settings have positive deviants who find better solutions than other people with access to the same resources.¹¹ The approach typically involves 4 stages: identify positive deviants, use qualitative methods to discover the strategies that allow positive deviants to outperform their peers, verify whether these strategies could apply to more people, and share the successful strategies with key people.¹² On the individual level, positive deviance can be defined as an intentional behavior that differs positively from the norms of a reference group, in terms of intentions and adherence to metanorms.¹³ Whereas norms are the rules that govern a behavior,¹³ metanorms (or hypernorms) go beyond these norms and represent ethical principles that stem from cultural, religious, or philosophic beliefs.¹⁴ “While positive deviance can be used to describe the behaviour of exemplary individuals, the term can also be extended to describe

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the behaviours of successful teams and organisations.”¹⁵ The positive deviance approach has been used to promote hand hygiene, but the works cited do not explain the theoretic criteria used by the researchers to characterize positive deviants.¹⁶⁻¹⁸ This study investigated positive deviance at the level of a group of individuals, specifically, a care team, to shed light on dynamics within the group. To achieve this, we conducted 2 focused ethnographies, which revealed that positive deviance related to hand hygiene was achieved differently in each care team under study and that better hand hygiene practice can depend on factors that differ significantly in different contexts. To our knowledge, this type of comparative focused ethnography from the perspective of positive deviance in relation to hand hygiene has never been conducted before. We hope it will contribute to knowledge development on both hand hygiene and positive deviance.

METHODS

For this study, we adapted the first 2 stages of the Bradley¹² positive deviance approach: identify the 2 top-performing hand hygiene care teams and conduct focused ethnographies to understand the factors that influence this practice in a hospital setting.

Research design

Focused ethnography was selected because it allowed the researcher to observe the care teams in their daily tasks while taking into account organizational culture and various sources of contextual information. This type of ethnography requires less time in the field than the traditional ethnographic approach and is suitable when the researcher is already familiar with the problem.¹⁹ Because the principal author has >20 years of experience in the prevention of health care-associated infections, focused ethnography was an appropriate choice because less time was required to become familiar with the social and clinical dynamics in each unit. (It is important to mention that the principal author had never worked in the hospital under study and was not known to any of the participants). The data collection consisted mainly of systematic observations, individual interviews, field notes, and informal conversations. We also met with the hospital's infection prevention nurses to learn how hand hygiene practices were managed in all care units.

Study setting

This study took place in a university hospital in Montreal, Quebec. It was chosen because hand hygiene audits have been carried out there every 2 months since August 2013, which provided useful data about the nurses' hand hygiene adherence rates in each care unit when the study began in January 2015. In this hospital, when hired, nurses receive 60-90 minutes of training on infection control measures, including hand hygiene. They also have access to an online course on hand hygiene, and distributors of hydroalcoholic solutions are available in each care unit.

Units

We used the results of the hand hygiene audits carried out every second month between August 2013 and December 2014 and calculated a mean (%) hand hygiene adherence rate among nurses in each care unit. (The hand hygiene adherence rate corresponds to the ratio of the number of times hand hygiene was performed by the nurses over the number of opportunities observed during that period). The 2 top-performing care teams turned out to be in a palliative care unit, with an average rate of nearly 70%, and in a medical-surgery unit, with an average rate of nearly 60%. The objective was

to determine whether there were shared or specific factors in these 2 care teams that could explain the high hand hygiene adherence rates. The average adherence rate for the nurses in all care units was just over 30%.

Participants

All nurses working in the selected units were approached to take part in the study. To avoid influencing the behavior of the nurses regarding hand hygiene, the purpose of the study presented to them referred globally to all measures used to prevent health care-associated infections, including hand hygiene. In all, 21 nurses agreed to participate: 15 (of a total of 19) in the medical-surgery unit and 6 (of a total of 9) in the palliative care unit.

Observation

The researcher had the opportunity to access all of the nurses' daily activities. She accompanied and observed the nurses during their clinical interventions, took part in discussions with patients, and asked the nurses questions about what she observed to establish an accurate portrait of the factors that influence hand hygiene. The observations were conducted in blocks of approximately 4 consecutive hours, 2-3 times a week, and took place between January 26, 2015, and March 30, 2015, in the medical-surgery unit and between September 10, 2015, and October 12, 2015, in the palliative care unit. At the same time, the researcher reviewed all the documents on infection control measures available in the units and on the hospital's intranet (manuals, brochures, and posters), and the 20-minute online course on hand hygiene.²⁰

Semi-structured interviews

Participants were questioned individually about their perceptions of infection control on their unit and the constraints and difficulties they face applying the different measures, including specific questions about hand hygiene. With the agreement of the head nurses, most of the interviews were carried out in a closed room, during work hours or, for a few participants, during their meal breaks. These participants were allowed to eat during the interview. Two interviews took place outside the workplace. Most of the interviews ranged from 45-60 minutes, but some lasted 90 minutes. With the agreement of the participants, the interviews were recorded for transcription. They took place from March 22-May 15, 2015, in the medical-surgery unit and from October 1-19, 2015, in the palliative care unit.

Data processing and analysis

All the data collected during the interviews were transcribed verbatim, and those from informal conversations and observations were recorded in writing. All the data were coded using the QDA Miner program (Provalis Research, Montréal, Québec, Canada), and then a content analysis was conducted, using the Patton method.²¹ A qualitative data analysis expert was consulted 3 times to ensure the accuracy of the data analysis process, and the results were presented to the study participants for validation.

Ethics

The study's research protocol was approved by the hospital's ethics committee. The nursing care management offered support by facilitating connections with the infection prevention team and the head nurses of the selected units. After the study was pre-

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