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An elicitation study of critical care nurses' salient hand hygiene beliefs

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ABSTRACT

Aim: To describe critical care nurses' hand hygiene attitudinal, normative referent, and control beliefs.
Background: Hand hygiene is the primary strategy to prevent healthcare-associated infections. Social influence is an underdeveloped hand hygiene strategy.
Methods: This qualitative descriptive study was conducted with 25 ICU nurses in the southeastern United States. Data were collected using the Nurses' Salient Belief Instrument.
Results: Thematic analysis generated four themes: *Hand Hygiene is Protective*; *Nurses look to Nurses*; *Time-related Concerns;* and *Convenience is Essential.*
Conclusion: Nurses look to nurses as hand hygiene referents and believe hand hygiene is a protective behaviour that requires time and functional equipment.

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Implications for Clinical Practice

- Critical care nurse participants look to unit nurse leaders and fellow nurses for hand hygiene performance and believe hand hygiene is a protective behaviour that requires time and functional equipment positioned in strategic locations.
- Heightened awareness of the incidence of healthcare associated infection in the critical care setting may explain why nurses believe hand hygiene benefits themselves and the healthcare institution.
- To the extent that nurses value their nurse leader's opinion, nurses may perceive social pressure to perform hand hygiene from unit nurse leaders and fellow nurses. Consequently, future hand hygiene work should focus on exploring social strategies paying particular attention to the nurse leader because nurses identified them as the most important referent.
- Institutions should select high quality functional hand hygiene equipment that is strategically located near the patient's door and at the patient's bedside.

Background and significance

Healthcare-associated infections (HAIs) acquired while receiving medical or surgical care are the most common hospital care complication (>700,000 annually) and result in 99,000 deaths each year with estimated annual direct hospital costs up to $45 billion (Agency for Healthcare Research and Quality [AHRQ], 2014; Scott, 2009). These infections are associated with prolonged hospital stays, increased hospital costs, increased mortality rates, and the need for further clinical interventions and therapies (AHRQ, 2014; Scott, 2009).

Research suggests that most HAIs are related to cross-contamination from inappropriate patient care practices (World Health Organization [WHO], 2009). The World Health Organization and the Centers for Disease Control and Prevention report hand hygiene (HH) as the primary strategy to prevent HAIs (Centers for Disease Control and Prevention [CDC], 2002; WHO, 2009). Despite the overwhelming evidence that contaminated healthcare workers' hands transmit pathogens and proper HH prevents the transmission of these pathogens, overall HH adherence rates, among healthcare workers, remains less than 40% (WHO, 2009).

Due to their large group size and abundant opportunity for patient contact, nurses are frequently targets of HH interventions (Pittet et al., 2000). Hand hygiene research suggests that nurses

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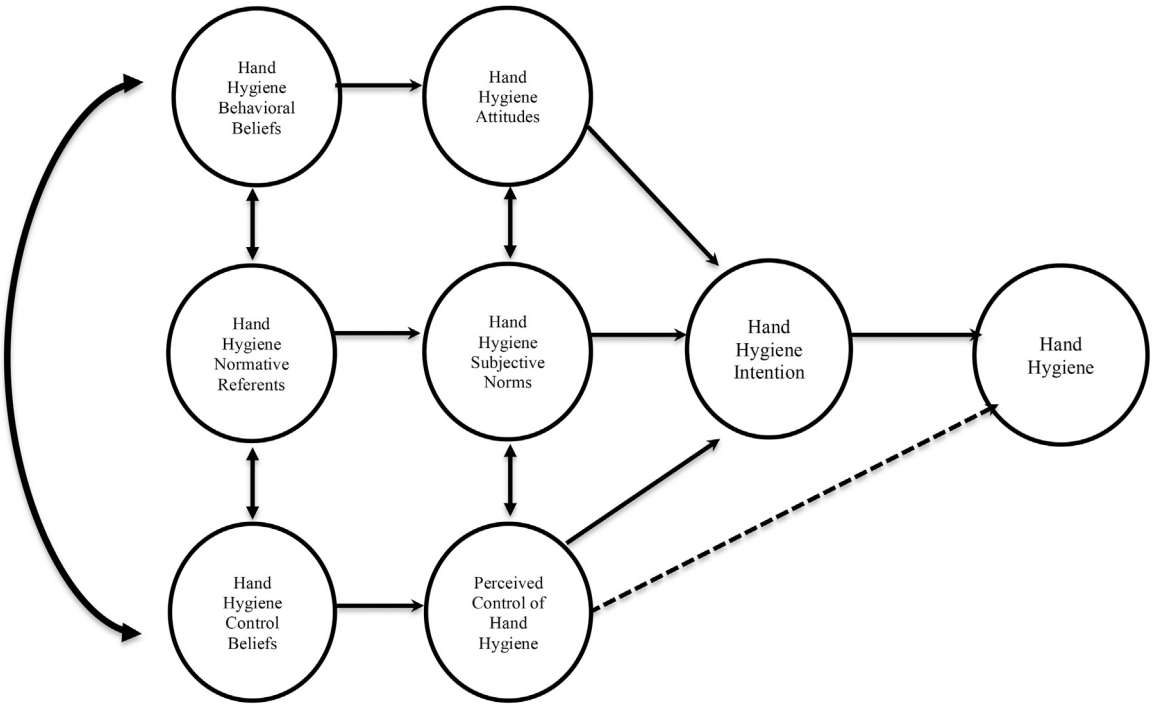

Fig. 1. Theory of Planned Behavior adapted for hand hygiene (Ajzen, 1985).

are more likely to wash their hands than other healthcare workers (WHO, 2009); however, the challenge of channelling the benefits of HH into sustained HH behaviours persists. Despite tremendous efforts, nurses' HH adherence rates are suboptimal at <60%. (Kingston et al., 2016).

Healthcare-associated infections affect approximately 30% of patients in the adult Intensive care unit (ICU) with nurses providing 92% of the direct patient care in the ICU (Page, 2004; Vincent, 2003). For this study, the population of interest is the registered nurse (RN) providing bedside patient care in the ICU.

Multiple strategies have been implemented to increase nurses' HH rates. Strategies have targeted (a) nurses' awareness (HH prompts and signage); (b) environmental accessibility (sink, soap and soap dispenser manipulation); (c) sense of regulation/competition (feedback from peer performance scores); (d) learning (HH training); and (e) motivation (patient empowerment) (Hart, 2012; Larson et al., 2005; Larson, 2013). These strategies address the cognitive, self-regulatory, and environmental domains of HH behaviour; however, these strategies fail to address the social domain of nurses' HH behaviour.

Healthcare delivery is a social process that requires social moderators to facilitate adherence with HH recommendations (Pittet, 2004). Social influence research suggests that individuals may subordinate their own thoughts, feelings, and attitudes to conform to a desired individual's identity, thus supporting the influence of normative referents (role models) on one's behaviour (Mittman et al., 1992). There is insufficient research regarding the effect of social influence on nurses' HH adherence rates; study of effect, if any, may suggest ways to increase nurses' HH rates (WHO, 2009).

Study purpose

The aim of this two-phase project is to describe the effect of social influence on critical care nurses' HH adherence. Using the Theory of Planned Behavior (TPB) as a guiding framework, the primary research aim of this phase-one qualitative descriptive study is to identify and describe nurses' salient HH behavioural attitudes, normative referents, and control beliefs using the Nurses' Salient Belief Instrument.

Theoretical framework

Since the ground-breaking work conducted by LaPiere with Chinese-Americans, researchers have explored the enigmatic gap between one's intention to perform an overt behaviour and the actual demonstration of the behaviour (LaPiere, 1934). The most widely accepted theory used to describe, explain, and predict overt choice behaviour is the TPB.

The TPB is a social cognitive theory that posits an individual's expectations and values about performing a behaviour contribute to their behavioural, normative, and control beliefs (Ajzen, 1991). Respectively, these beliefs contribute to one's (a) **attitude**: one's hypothetical disposition towards a behaviour; (b) **subjective norms**: one's perception of social pressure to perform or not perform a behaviour; and (c) **perceived behavioural control**: the unrestrained ability to perform or not perform a behaviour with regards to internal or external factors (Ajzen, 1985, 1991). Finally, behavioural intention, how motivated an individual is to perform a behaviour, is a direct determinant of actual behaviour performance (Ajzen, 1985). The TPB clearly depicts the three beliefs that contribute to the TPB constructs (attitude, subjective norm, and perceived behavioural control) that, in turn, may influence the central determinant of intention on actual behaviour performance (Fig. 1). The dashed arrow between perceived control and HH (Fig. 1) serves as a direct link to HH only when perceived control serves as a proxy for actual control over barriers to HH performance (Ajzen, 1991).

The TPB has a strong presence in the health literature because it parsimoniously addresses the intrapersonal (attitude, control beliefs, and intention) and interpersonal (subjective norms) dimensions associated with human behaviour (McEachan et al., 2011). To determine the beliefs that serve as a basis for theory constructs, Ajzen and Fishbein suggest conducting an elicitation study using an open-ended question format (Ajzen, 2006; Ajzen and Fishbein,

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