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'Somebody else's problem'? What do we know about staff perceptions of the sources and control of Healthcare Associated Infection?

Reducing Healthcare Associated Infection (HCAI) rates and improving hospital cleanliness remains a high priority for the NHS[1]. In spite of considerable evidence of success in reducing HCAI[2], staff infection control behaviours are often less than optimal and there is an ongoing need to address the issue in all care settings including care homes. Drawing on a recent NNRU study, this Policy+ examines the possibility that, in the context of uncertainties about the source and control of HCAI across health systems, staff may perceive infection spread as caused by others and as something which happens elsewhere – in fact 'somebody else's problem'.

What is known about the sources and staff control of HCAI?

Across the healthcare system advances in HCAI policy and practice have not always impacted upon individual staff behaviours and most HCAIs continue to result from cross-transmissions related to poor infection control practices[3]. Studies of staff infection control behaviour tend to ascribe poor practice simply to a lack of staff knowledge. Yet, provision of infection control education frequently fails to improve knowledge and good levels of knowledge do not always correspond with good practice[4].

Staff working in acute settings are generally very aware that infection risk is associated with patient factors (such as age, health status, previous history of infection) and they recognise the importance of infection control practices[5]. The identification of reservoirs of colonisation in care homes, however, creates ambiguity about the original sources of HCAI[6]. This reduces the sense of responsibility and ownership of the problem that has been key in successful action so far.

Preventative strategies in care homes may be suboptimal. Care homes often lack clear up-to-date policies for infection control and many of the measures undertaken in hospitals such as surveillance, screening, isolation and decolonization[2] are not recommended because these facilities are considered a person's home[6]. At the same time, other research suggests that transmission of antibiotic resistant bacteria and the development of infection in care homes are both uncommon events[7]. It could be that the 'reservoir' in care homes consists largely of people who were carriers at discharge from hospital[6].

In the face of uncertainty and incomplete information, particularly in community settings[8], theories from behavioural science show some promise in explaining infection control behaviours[9]. They also highlight potential challenges for maintaining momentum and spreading effective action to the community.

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What is known about staff perceptions of the sources and control of HCAI?

Research reviewed includes a Scottish study of 301 nurses, a US study of 44 nurses in one long-term care facility, and an NNRU London based study of staff in one general hospital (44) and six local care homes (53).

- A Scottish study of the 'false consensus' effect[10] shows teams can operate under false consensus about what is normal and acceptable infection control practice. Staff who said they believed or practised a particular behaviour, were more likely to think that their peers believed/behaved in the same way as them.

- A US study of nursing staff's perceptions of MRSA, infection control and prevention strategies[11] found that staff perceptions of risk of MRSA transmission varied considerably but overall staff perceived the risk to be greater elsewhere. Lack of supplies (26%) and lack of information/communication (24%) were reported as primary barriers to infection control. All participants perceived patient behaviour to be a barrier to infection control.

- A recent NNRU study[12] used causal attribution theory to examine staff perceptions of the sources, risks and prevalence of MRSA on either side of the hospital/care home interface. Key findings were that:
  - Staff in both hospital and care home settings generally perceived the risk of MRSA to be high (56.5%, [52] regarded MRSA as posing a serious threat to society). However participants found it difficult to estimate prevalence and transmission of MRSA in relation to their own work environments.
  - While 45 of 53 care home staff (84.9%) attributed the source of most MRSA infections to hospitals, only 11 of 44 hospital staff (25%) felt hospitals were the main source. Their perception was that the majority of cases originated in the community, including care homes.
  - Individual staff tended to attribute the source of MRSA to external human factors (not self) including patient risk factors and poor infection control practices of others.
  - Teams tended to attribute group 'successes' in infection control to good team infection control policy and performance, whilst attributing their 'lapses' to situational factors including high risk client groups, patient movement through systems of care, and work pressures.
  - Overall, staff stated they are motivated by a range of factors including: personal safety, fear of blame or stigma, 'bad press' from the media/public opinion, as well as positive feelings of wanting to deliver high quality patient care and willingness to behave in accordance with clear organisational practices.

Conclusions and implications

- In the absence of information about where the risk of HCAI is coming from staff tend to perceive the problem as being caused by other staff elsewhere in the health system.
- This creates a lack of ownership within and between organisations.
- The existence of such perceptions may present challenges to extending effective infection control into community settings and also challenge the sustainability of efforts to encourage ownership of the problem by staff in hospitals.

Key issues for policy

- Infection control teams and service managers have a key role to play in comparing performance across and between organisations allowing benchmarking to reduce the potential of false consensus.
- Education and promotion campaigns should engage more with staff's willingness to understand the specific reasons behind their 'successes' and 'lapses'.
- Control of HCAI requires strategies that are jointly owned and implemented by staff in hospital and staff in care homes in order that action on one side of the hospital/ care home interface is not perceived as reducing the need for action in the other.

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In the text, we use the English spelling *meticillin* rather than the US spelling *methicillin*. References retain the spelling used in the original document.