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Using a Qualitative Study to Understand the Failure of a Strategy Implemented for Improving Hand Hygiene Adherence in 4 Intensive Care Units

To the Editor—The strategy of active detection and isolation of patients with methicillin-resistant *Staphylococcus aureus* (MRSA) infection has a number of adverse unintended consequences¹ and raises ethical concerns.² Concurrently, certain studies have questioned the effectiveness of associating the screening of carriers and the implementation of contact precautions.^{3,4} Although there are some arguments to support a policy of strict application of standard precautions to control MRSA, the low compliance with hand hygiene reported in most studies constitutes what is probably a major barrier against the effectiveness of this policy.^{5,6}

In a recent study,⁷ we aimed to assess the impact of screening and signaling MRSA carriers on hand hygiene compliance in 4 intensive care units (ICUs) using a strategy of strict application of standard precautions. Although an active campaign of information about MRSA and the potential consequences of MRSA transmission had been performed by the professionals of the infection control (IC) unit of the hospital before this evaluation study, a total absence of impact of the signalization of MRSA carriers on compliance with hand hygiene was recorded.

Concurrent with this study, we performed a qualitative study in the same units, the objective of which was to better understand the feelings of caregivers about IC in general and hand hygiene in particular. The aim of this article is to try to explain the failure of the strategy implemented by using the results of this qualitative study.

This qualitative study included 2 successive phases: a phase of participative observations and a phase of face-to-face interviews. The first phase was conducted during a 4-week period by a master's student in sociology. It is noteworthy that this student was also a registered nurse who did not work in this hospital but concurrently worked in the community setting. She was immersed in the ICUs to observe practices and

to talk with healthcare providers, and she also participated in providing patient care. She was in contact with 20–25 healthcare workers each day except weekends between 8 AM and 5 PM. Overall, she met more than 100 healthcare workers who belonged to all categories of personnel. She made a note of her observations and discussions.

Ten face-to-face interviews were conducted. These interviews took 45–60 minutes and were led by 1 of the 2 interviewers who participated in the study: a professor of sociology and the master's student in sociology. All interviews were conducted in accordance with a semistructured interview guide, recorded with a voice recorder, and fully transcribed. The result analysis was performed on the basis of the participative observations and face-to-face interviews.

Most of the caregivers considered IC to be an essential aspect of their work. However, they also mentioned that the transmission of recommendations by IC professionals usually had a weak impact on their practices. The terms “normally,” “theoretically,” and “in principle” were widely employed by the participants when the protocols and recommendations provided by the IC unit were considered during the interviews. Therefore, these protocols and recommendations seem to have only a relative value. Throughout the conversations with the ICU professionals, the words “we” and “they” were used to refer to ICU staff and the IC professionals, respectively, potentially indicating that the latter were regarded as outsiders whose advice and recommendations were considered an imposition or intrusion upon the culture of the ICU.

In addition, according to the participants, IC is not the only aspect that should be considered during patient care. Other considerations, such as the emergency linked to a clinical situation, can represent a barrier to compliance with good hygiene practices. The desire to protect the relationship between the healthcare professional and the patient can be another barrier. For instance, healthcare workers often expressed concern that wearing gloves, a mask, or goggles might be perceived as hostile to their patients.

Participants reported being more vigilant about prevention measures after contact with patients in situations considered to be physically dirty or “emotionally dirty.” In addition, some participants acknowledged that their main motivation for practicing hand hygiene after contact with a patient was to protect themselves. Therefore, it is probable that subjective criteria and self-protective attitudes have a stronger impact on the behavior of healthcare professionals than do recommendations transmitted by the IC unit.

To our knowledge, few qualitative studies have been used to assess the results of a study evaluating a strategy implemented to decrease the risk of cross transmission. Our findings are consistent with the results of some other previous studies. According to Larson et al,⁸ the diffusion of recommendations from the Centers for Disease Control and Prevention in healthcare settings was not sufficient to change practices. In a recent study,⁹ participants also reported that

the realities of their workload made complete adherence to hand hygiene impossible, because other patient care needs should be prioritized over hand hygiene. Participants clearly cited personal safety as the primary reason for hand hygiene compliance. Concurrently, it has been demonstrated that risk assessment is influenced by individual differences, including differences in knowledge level and in how much control persons believe that they have over their health.¹⁰

In conclusion, beliefs and preexisting knowledge probably had a major role in the failure of our strategy. Urgent care, interruptions of care, self-protective behaviors, and subjective assessment of risk could also interfere with the association between hand hygiene compliance and MRSA carriage. This study underscores that, when envisaging IC measures and the evaluation of their impact, it is important to consider that providing healthcare involves not just a collection of duties but also a social relationship.

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