Culture, Context, and Change: Foundations for Effective IPC Interventions

Prof. Michael A. Borg

Mater Dei Hospital

Malta

No conflicts of interest to declare

Infection prevention & control

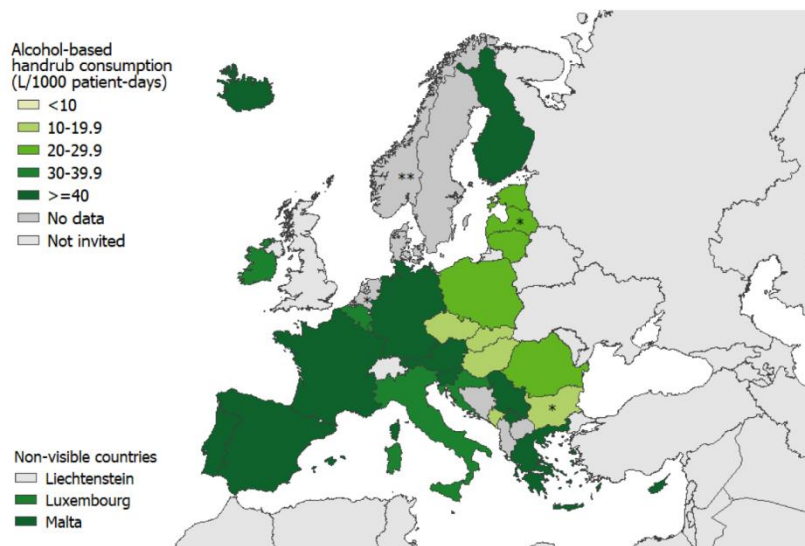IT IS NOT ROCKET SCIENCE

Environmental cleaning

Hand hygiene | Invasive device care

Standard & transmission precautions

Hand hygiene

Point prevalence survey of healthcare-associated infections and antimicrobial use in European acute care hospitals

2022–2023

www.ecdc.europa.eu

Table 37. Alcohol-based handrub consumption (litres per 1 000 patient-days) by type of hospital, ECDC PPS 2022–2023

Type of hospital	No. of hospitals	Alcohol-based hand rub consumption (litres per 1 000 patient-days)					
		Mean	P10	P25	P50	P75	P90
Primary	299	43.2	11.5	18.6	31.1	54.0	92.3
Secondary	392	45.1	14.1	21.3	34.6	57.4	87.2
Tertiary	259	47.0	17.0	25.5	37.7	60.0	96.5
Specialised	123	43.6	7.8	16.0	33.5	54.4	89.9
Unknown	4	40.5	22.9	28.0	39.8	53.0	59.4
EU/EEA	**1 077**	**44.8**	**12.9**	**20.8**	**34.4**	**57.0**	**89.9**

Hand hygiene

Median AHR consumption:

- **37.7 L/1000BD**

3mL = 1 dose
Assuming one dose per application and additional 25% hand washing:

- **15 HH performances** per patient per day

Point prevalence survey of healthcare-associated infections and antimicrobial use in European acute care hospitals

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Point prevalence survey of healthcare-associated infections and antimicrobial use in European acute care hospitals

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www.ecdc.europa.eu

HHOs per patient-day	Large teaching hospital		Small community hospital	
	Adult medical-surgical ICU	Adult medical ward	Adult medical-surgical ICU	Adult medical ward
Shift 1 total (7:00 AM-6:59 PM)	87.1 (79.8-94.4)	33.3 (30.3-36.3)	39.1 (32.4-45.7)	16.6 (12.7-20.6)
Shift 2 total (7:00 PM-6:59 AM)	93.5 (81.4-105.5)	40.7 (32.9-48.5)	29.2 (20.1-38.3)	12.7 (9.1-16.2)
24-hour period total	178.8 (168-189)	71.6 (64.9-78.3)	70.9 (61.0-80.7)	30.3 (24.6-35.9)

Hospital hand hygiene opportunities: Where and when (HOW2)? The HOW2 Benchmark Study

CLEAN CARE IS SAFER CARE

WORLD ALLIANCE WITH PATIENT SAFETY

Median hand hygiene compliance = 25%

- **Only one moment**
- **Typically ⅔ performed after patient contact**

Culture drives behaviour

What is culture?

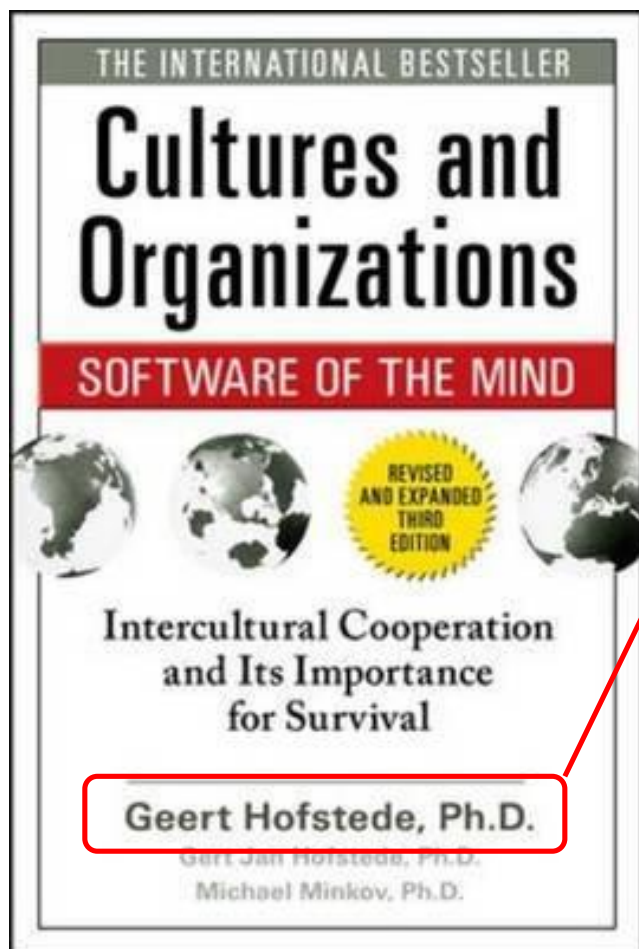

"The way we do things around here!"

Culture

Culture always deals with the **values** of a **group**

- commonly held standards of what is acceptable or unacceptable, important or unimportant, right or wrong, workable or unworkable, etc.
  - Values which are deemed essential for one group may well be unacceptable in another.

Cultural dimensions

- Constructs of identifiable behavioural manifestations
- Provide a model to understand and compare cultural differences

National cultural dimensions

POWER DISTANCE

INDIVIDUALISM VS COLLECTIVISM

MASCULINITY VS FEMININITY

UNCERTAINTY AVOIDANCE

LONG VS SHORT TERM ORIENTATION

INDULGENCE VS RESTRAINT

HOFSTEDE'S CULTURAL DIMENSIONS

Cited in >1,000 sociology and psychology publications

National cultures

https://www.hofstede-insights.com/country-comparison-tool

INFECTION PREVENTION AND CONTROL
MATER DEI HOSPITAL

SPTAR MATER DEI

BioMed Central
Open Access
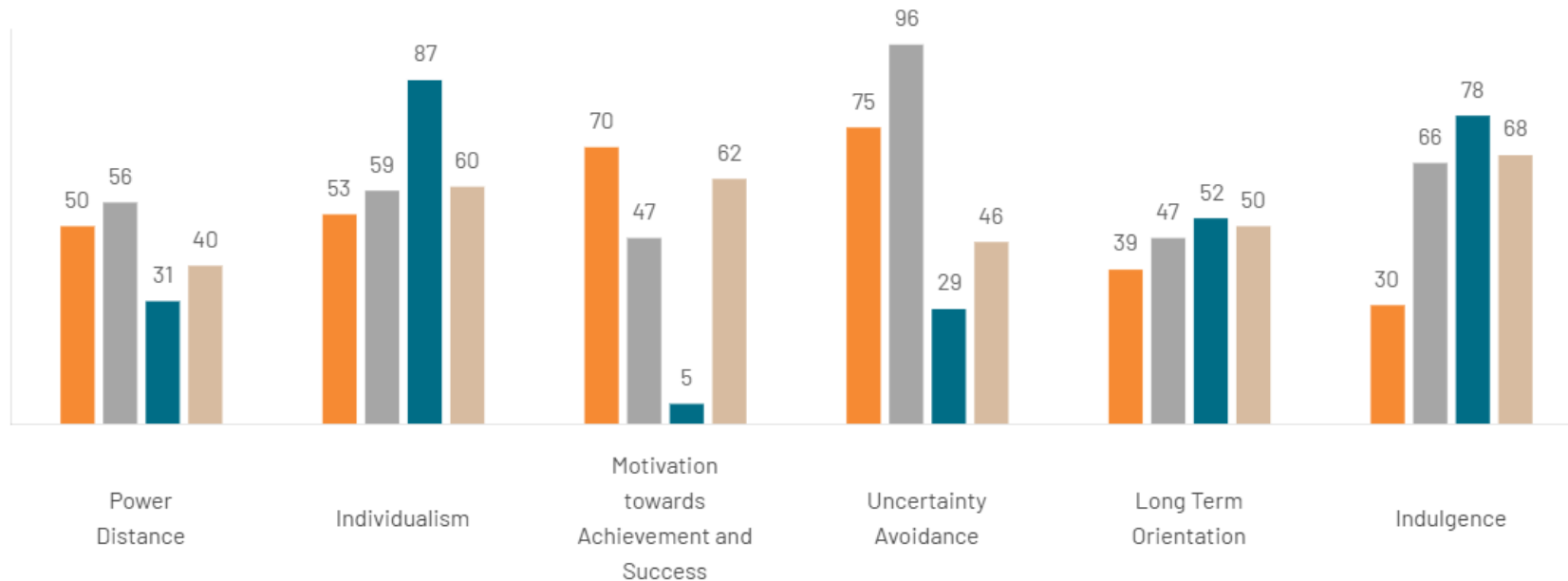
BMC Health Services Research

Research article

Are cultural dimensions relevant for explaining cross-national differences in antibiotic use in Europe?

Reginald Deschepper[1], Larissa Grigoryan[2], Cecilia Stålsby Lundborg[3], Geert Hofstede[4], Joachim Cohen[1], Greta Van Der Kelen[1], Luc Deliens[1] and Flora M Haaijer-Ruskamp*[2]

Address: [1]Department of Medical Sociology and Health Sciences, Vrije Universiteit Brussel, Brussels, Belgium, [2]Department of Clinical Pharmacology, University Medical Center Groningen, University of Groningen, The Netherlands, [3]Division of International Health (IHCAR), Department of Public Health Sciences, Karolinska Institutet, Stockholm and Nordic School of Public Health and Apoteket AB, Göteborg, Sweden and [4]CentER for Economic Research, University of Tilburg, The Netherlands

Touboul-Lundgren et al. BMC Public Health (2015) 15:908
DOI 10.1186/s12889-015-2254-8

RESEARCH ARTICLE

Identification of cultural determinants of antibiotic use cited in primary care in Europe: a mixed research synthesis study of integrated design "Culture is all around us"

Pia Touboul-Lundgren[1,2*], Siri Jensen[3,4], Johann Drai[1,2] and Mo...[3,4]

BMC Public Health
Open Access
CrossMark

Journal of Antimicrobial Chemotherapy

J Antimicrob Chemother
doi:10.1093/jac/dkr541

National cultural dimensions as drivers of inappropriate ambulatory care consumption of antibiotics in Europe and their relevance to awareness campaigns

Michael A. Borg*

J Antimicrob Chemother
doi:10.1093/jac/dkt461

Prolonged perioperative surgical prophylaxis within European hospitals: an exercise in uncertainty avoidance?

Michael A. Borg*

Journal of Antimicrobial Chemotherapy

Journal of Antimicrobial Chemotherapy
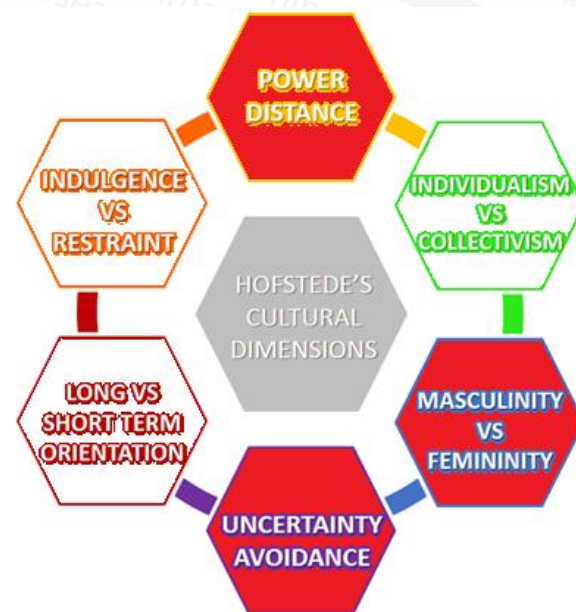
J Antimicrob Chemother
doi:10.1093/jac/dkz312

Broad-spectrum antibiotic use in Europe: more evidence of cultural influences on prescribing behaviour

Michael A. Borg[1,2*] and Liberato Camilleri[1]

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Culture drives antibiotic prescribing in Europe

Cultural determinants arguably best describe variation of antibiotic use between EU countries:

- Levels of antibiotic consumption

- Non-prescribed use

- Use in dubious presentations

  – Esp colds, flu and sore throat

- Emphasis on broad spectrum formulations

- Unnecessarily long duration of surgical prophylaxis

POWER DISTANCE

INDIVIDUALISM VS COLLECTIVISM

INDULGENCE VS RESTRAINT

HOFSTEDE'S CULTURAL DIMENSIONS

MASCULINITY VS FEMININITY

LONG VS SHORT TERM ORIENTATION

UNCERTAINTY AVOIDANCE

Culture drives IPC behaviour

Understanding the epidemiology of MRSA in Europe: do we need to think outside the box?

M.A. Borg [a,*], L. Camilleri [b], B. Waisfisz [c]

What Is Driving the Epidemiology of Methicillin-Resistant *Staphylococcus aureus* Infections in Europe?

Michael A. Borg[1,2] and Liberato Camilleri[3]

Cultural dimensions appear to be key factors affecting perceptions and values among healthcare workers, which in turn are critical for compliance and uptake (of infection control)…

… MRSA hyperendemicity is correlated with a set of sociocultural behavioral constructs that typically manifest themselves in lack of urgency to address risk…

What Is Driving the Epidemiology of Methicillin-Resistant *Staphylococcus aureus* Infections in Europe?

Michael A. Borg[1,2] and Liberato Camilleri[3]

TABLE 3. GENERALIZED LINEAR MODEL RELATING METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* PREVALENCE IN EUROPEAN UNION/EUROPEAN ECONOMIC AREA COUNTRIES TO CULTURAL PREDICTORS

Cultural predictors (scores)	n	Univariate		Parsimonious	
		Wald χ^2	p	Wald χ^2	p
Power distance	27	2.055	0.152	7.315	0.007
Individualism	27	0.198	0.656	—	—
Masculinity	27	7.081	0.008	6.483	0.011
Uncertainty avoidance	27	7.101	0.008	21.470	<0.001
Long-term orientation	27	0.926	0.336	—	—
Indulgence	27	0.278	0.598	—	—

—, Factor rejected by parsimonious model.

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Uncertainty Avoidance

Tolerance of unpredictability and ability to handle ambiguous situations

Uncertainty avoidance is not risk avoidance

Example: *"This patient's intravenous treatment has been stopped."*

Risk avoidance:

"He has no further need for the peripheral cannula. Keeping it in place only risks thrombophlebitis & sepsis → REMOVE it

Uncertainty avoidance:

*"You never know… he may deteriorate and need urgent IV treatment. Having a cannula in situ would be very useful → KEEP it for now…. **just in case**."*

Uncertainty avoidance

In countries scoring HIGH for uncertainty avoidance:

- IPC risk assessment may be challenging
  - Risk may be ignored if addressing it causes personal uncertainty or conflict with other priorities.

- Cognitive dissonance is more evident
  - Difficulty to correlate IPC processes and HAI outcomes

- Prefer to take decisions based on anecdotal personal experience

- Management by crisis
  - Issues only addressed when they create a crisis (e.g. outbreak)
  - Bureaucracy and red tape

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High uncertainty avoidance cultures

- Compliance with IPC Protocols:
  - Emphasize strict adherence to established rules and protocols "on paper".
    - However, these protocols are not followed if perceived as difficult to implement (create uncertainty) or if they clash with other commitments deemed more important and "certain"

- Reluctance to Change:
  - Change creates uncertainty
    - Resistance to adopting new infection control practices or technologies
    - Initiatives expected to perfect in outcome from the start

- Hierarchy and Authority:
  - Behaviour of leaders is crucial
    - If senior staff / leaders do not model appropriate behaviors or emphasize the importance of IPC, junior or other staff will not prioritize them

- Empowerment:
  - o Staff may reluctant to speak up about breaches in IPC protocols or unsafe practices among colleagues and, more, among seniors out of fear of retribution
    - o Lack of a strong culture of safety and accountability regarding infection control.

- Patient care:
  - o Pressure to prioritize other aspects of patient care may lead to shortcuts in infection control practices.
    - o Sub-optimal hand hygiene or proper cleaning procedures, especially when faced with high patient loads or alternative demands.

Not stereotyping...
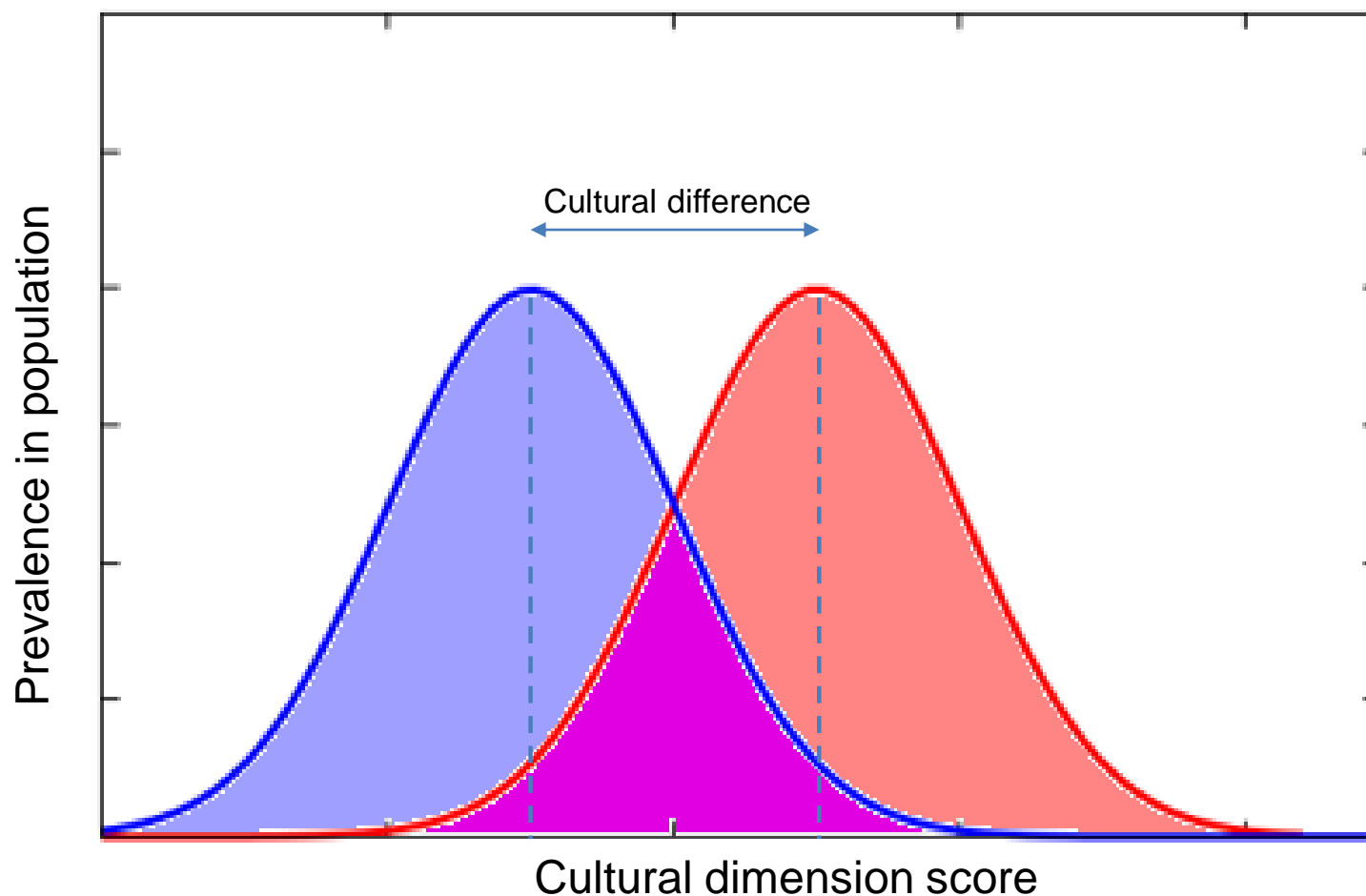
There are no "good" or "bad" cultures…just different

Power distance

Hierarchy, hierarchy, hierarchy….

> All animals are equal but some animals are more equal than others.
>
> ~ George Orwell, Animal Farm

In HIGH power distance countries:

- Power holders
  - Make all the important decisions unilaterally
    - Do not regard consultation as required or, in many cases, useful
  - Lack of accountability
    - Rules do not apply to them…

- Less powerful members
  - Unwilling to contradict or correct power holders
  - Defer decision making as well as ownership and responsibility for outcomes

Teamwork and collegial collaboration (essential for IPC) is likely to be challenging.

Power distance

All animals are equal but some animals are more equal than others.
~ George Orwell, Animal Farm
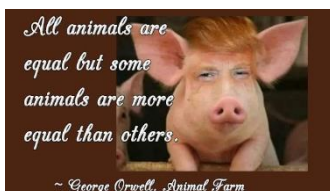
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High power distance cultures

- **Authority and Compliance**:
  - Less likely to question directives from authority figures. If leaders do not prioritize or model good practices, this may result in complacency or non-compliance.
- **Communication Barriers**:
  - Lower-ranking staff feel uncomfortable voicing concerns or suggesting improvements, root causes of HAIs will be missed and peer improvement .
- **Training and Education**:
  - IPC training often relies more on top-down instruction, leading to a lack of engagement or understanding among frontline staff.
- **Resource Allocation**:
  - Decisions about resources for IPC centralized, potentially leading to inequities in access to necessary supplies and training.
  - Lower-level staff might not have a say in what resources they need most.
- **Cultural Norms**:
  - Hierarchy stifles teamwork and collaboration especially with lack of accountability for authority figures.
    - Hinders a collective approach to infection control.
- **Response to Outbreaks**:
  - Responses to outbreaks centralized and less adaptable.
    - Slow down the implementation of necessary changes or adaptations in response to new challenges.
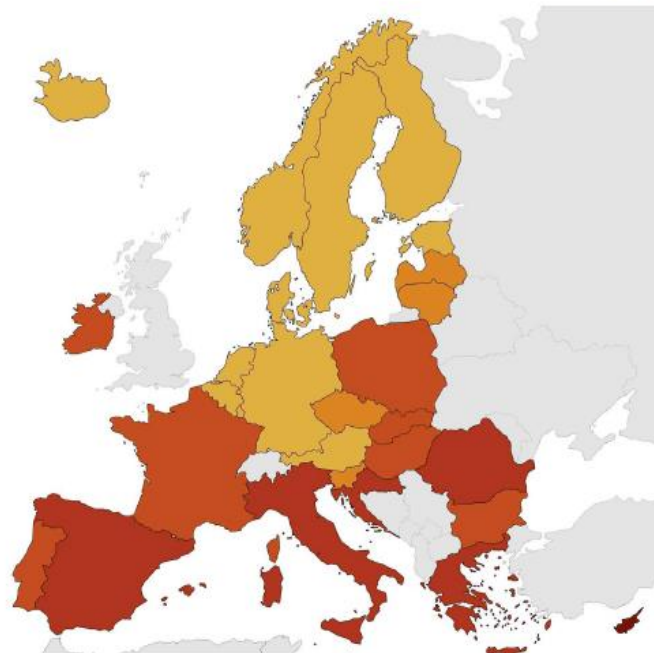
Culture map of Europe

Power distance	+	+	+	++	++	++	+++	+++	+++	No data
Uncertainty avoidance	+	++	+++	+	++	+++	+	++	+++	No data

Figure 8. *Staphylococcus aureus.* Percentage of invasive isolates resistant to meticillin (MRSA),ᵃ by country, EU/EEA, 2022
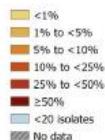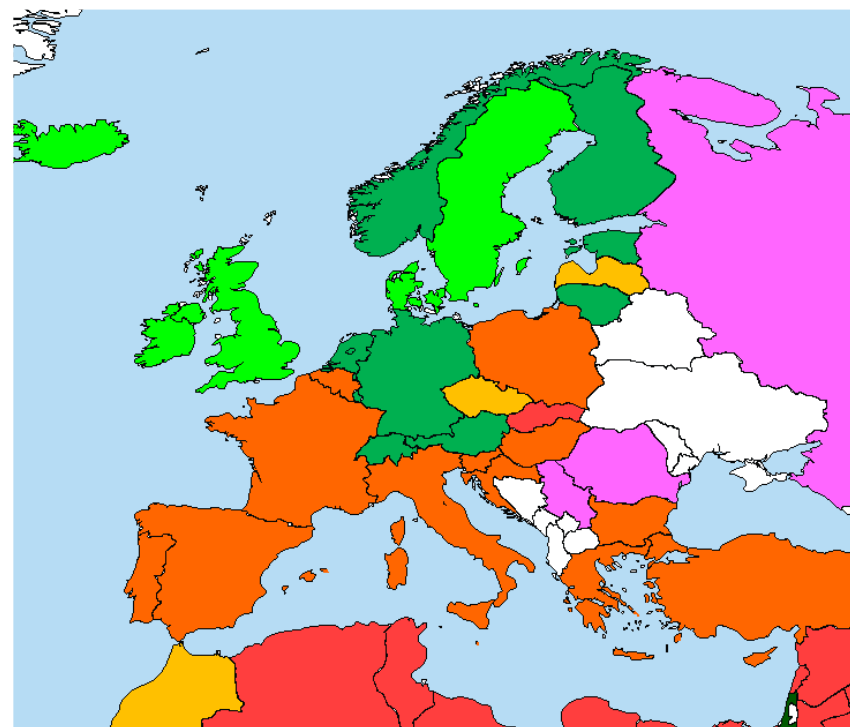
Masculinity

Level of competitiveness and ambition within a society.

- Masculine cultures:
  - Value assertiveness and material success
    - All about outcomes and objectives
    - Heavy emphasis on targets and benchmarking
- *Feminine cultures value good relationships and cooperation.*

High masculinity cultures

- Emphasis on Competition:
  - Prioritize performance and outcomes over collaborative approaches.
  - This could lead to a focus on individual goals rather than teamwork.
  - If the priority procedures are not related (e.g. waiting times), IPC will be ignored

- Risk-Taking Behavior:
  - Tendency toward risk-taking, which could affect adherence to IPC protocols.

- Workplace Dynamics:
  - Can lead to power struggles among staff.
  - May detract from a unified approach to infection control and hinder effective collaboration.

What Is Driving the Epidemiology of Methicillin-Resistant *Staphylococcus aureus* Infections in Europe?

Michael A. Borg[1,2] and Liberato Camilleri[3]

TABLE 4. GENERALIZED LINEAR MODEL RELATING METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* PREVALENCE IN EUROPEAN UNION/EUROPEAN ECONOMIC AREA COUNTRIES TO GOVERNANCE PREDICTORS

Governance predictors (scores)	n	Univariate		Parsimonious	
		Wald χ^2	p	Wald χ^2	p
Accountability	28	3.160	0.075	—	—
Stability	28	2.382	0.123	—	—
Effectiveness	28	0.036	0.850	—	—
Regulatory	28	2.048	0.152	—	—
Rule of law	28	1.171	0.279	—	—
Control of corruption	28	7.763	0.005	18.450	<0.001

—, Factor rejected by parsimonious model.

PLOS | ONE

RESEARCH ARTICLE

Antimicrobial Resistance: The Major Contribution of Poor Governance and Corruption to This Growing Problem

Peter Collignon[1,2]*, Prema-chandra Athukorala[3,4], Sanjaya Senanayake[5,6], Fahad Khan[3]

1 ACT Pathology, Canberra Hospital, Australian National University, Garran, Australia, 2 Canberra Clinical School, Australian National University, Garran, Australia, 3 Arndt-Corden Department of Economics, Australian National University, Acton, Australia, 4 School of Environment and Development, University of Manchester, Manchester, England, 5 Australian National University, Garran, Australia, 6 Canberra Hospital,

Contents lists available at ScienceDirect

Health Policy

ELSEVIER

Corruption and use of antibiotics in regions of Europe

CrossMark

Björn Rönnerstrand[a,c,d,*], Victor Lapuente[b]

a Department of Political Science, University of Gothenburg, Box 700, SE 40530, Gothenburg, Sweden
b Quality of Government Institute, Department of Political Science, University of Gothenburg, Box 700, SE 40530, Gothenburg, Sweden
c Centre for Collective Action Research, University of Gothenburg, Sweden
d Centre for Antibiotic Resistance Reserach, University of Gothenburg, Sweden

What Is Driving the Epidemiology of Methicillin-Resistant *Staphylococcus aureus* Infections in Europe?

Michael A. Borg[1,2] and Liberato Camilleri[3]

"Countries where control of corruption is more lax are characterised by a general tolerance of deviant social norms, which go unchecked and unchallenged by the mainstream.

*That same **normalisation of deviance** will apply throughout society, including in hospitals and in relation to IPC policies and guidelines aimed at controlling MDROs (e.g. hand hygiene)"*

Why bother?

National cultures have developed over millennia and change very slowly
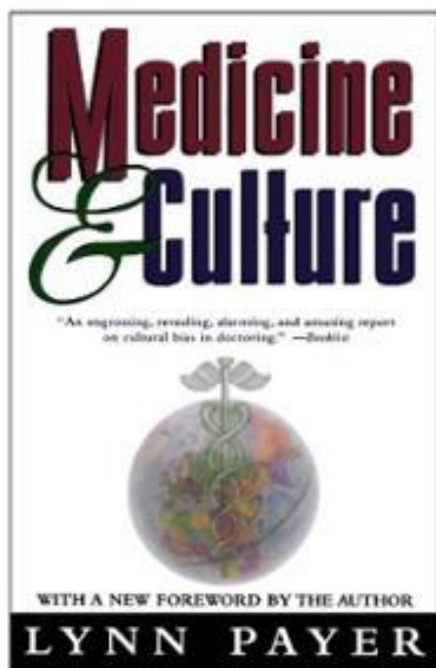
- "Acknowledging the role of culture (should) not become an excuse for fatalism."

- "I do believe you can change things."

- "**But I think you can change them more effectively if you know the culture you are against**."

Lynn Payer

Changing behaviour

Understanding background culture is vital for any behaviour change intervention
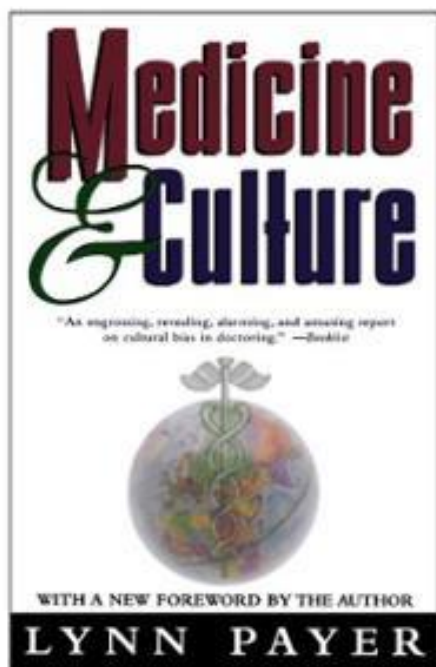
- ***Identify battles you are likely to win***

Review

Patient empowerment and hand hygiene, 1997–2012

M. McGuckin*, J. Govednik

Review

Patient empowerment and hand hygiene, 1997—2012

M. McGuckin*, J. Govednik

Cultural theory suggests this would be best compatible with cultures exhibiting:

- High masculinity
  - assertiveness

- Low power distance
  - temerity to address power holders

- Low uncertainty avoidance
  - potentially stressful interaction

Review

Patient empowerment and hand hygiene, 1997–2012

M. McGuckin*, J. Govednik

Table I
Patient willingness to be empowered, to ask about hand hygiene, and whether they were given permission by their healthcare workers to ask if they have performed hand hygiene. Updated from WHO Guidelines on Hand Hygiene in Health Care (p. 256)

Study origin	Patient believes he/she should be involved	Patient would ask about hand hygiene	Healthcare worker gave permission to patient
England and Wales NPSA (2004)[a]	71%	26%	-
Ontario (Canada)[b]	32%	42%	-
USA consumer survey[c]	-	-	80%
USA web survey[d]	-	60%	-
World Health Organization survey[e]	-	52%	86%
UK[f]	79%	-	-
USA[g]	91%	45%	-
UK[h]	-	-	Significant increase
Switzerland[i]	-	33%	81%
Australia[j]	90%	40%	-

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Cultural dimensions
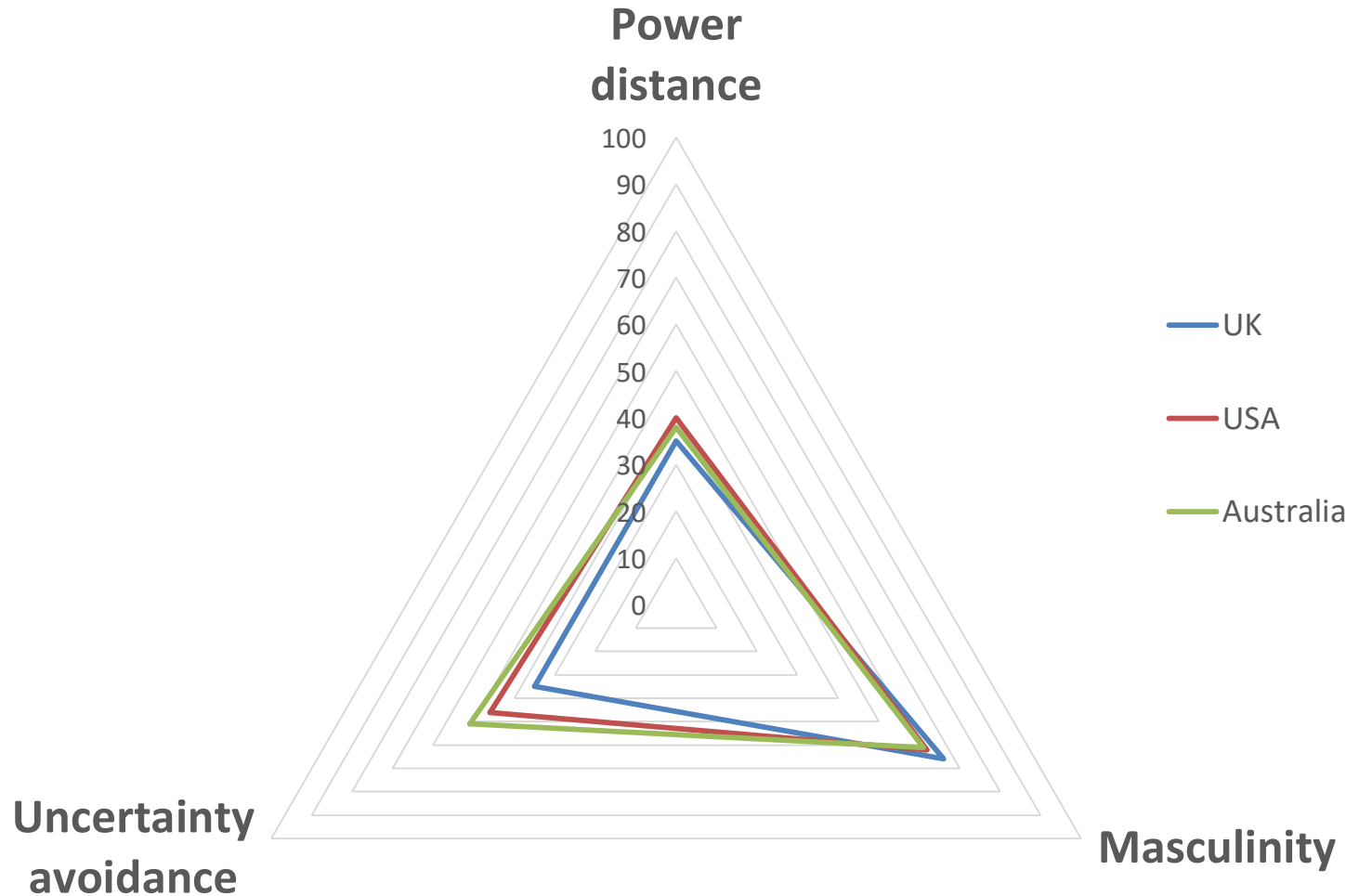
WHO global survey of patient experiences in hand hygiene improvement

If the doctor said, please remind me, I would find it quite easy to say, you asked me to remind you to wash your hands...it would be similar to my saying why I was there, or giving the doctor an update on medication, etc...that is, just part of the routine (survey respondent, USA).
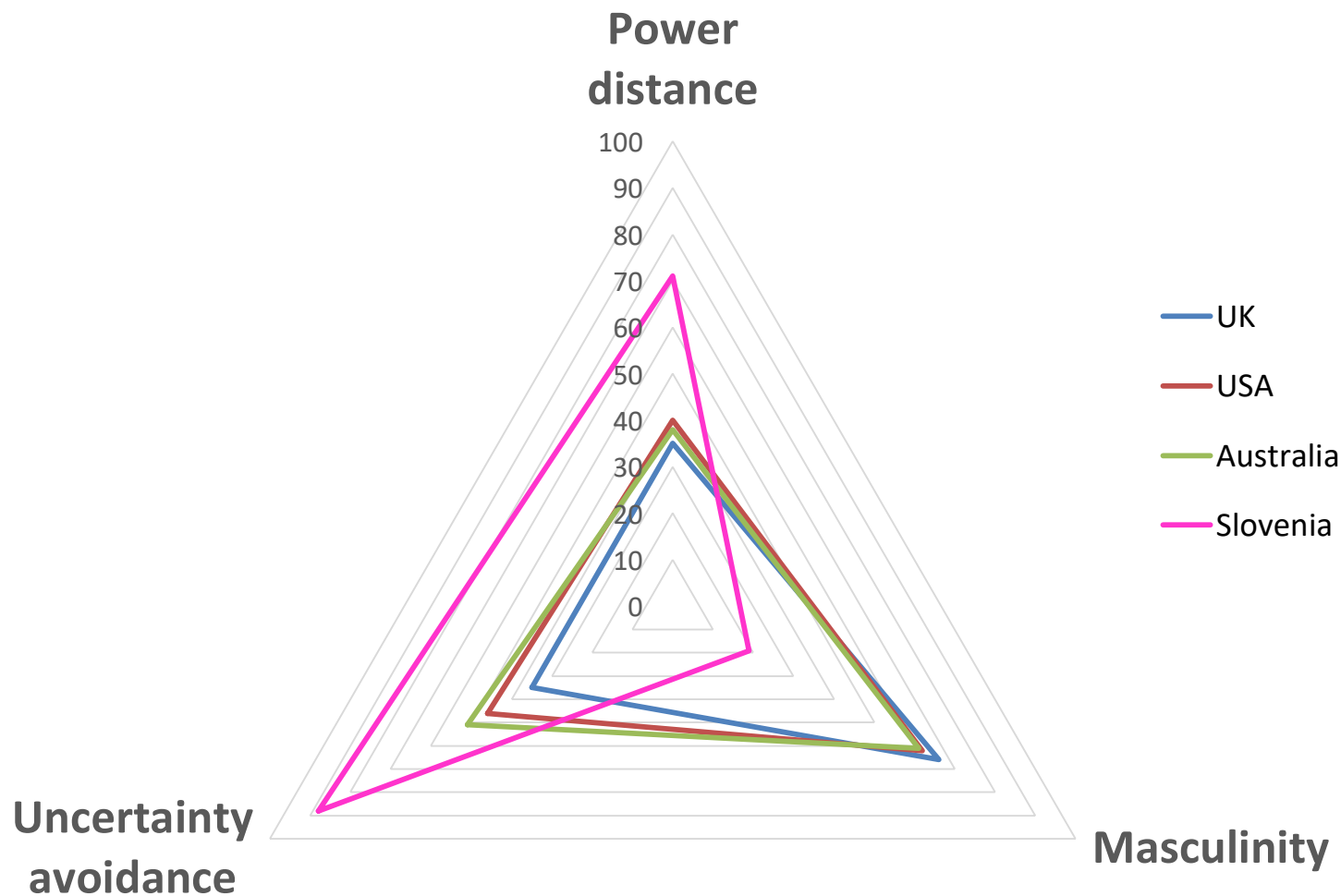
Yes

No

No

First it is necessary to change the cultural barriers: patients have no right to tell the physicians what to do (survey respondent, Slovenia).

1 (0.3%)   1 (1%)

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Cultural dimensions

Power distance

Masculinity

Uncertainty avoidance

- UK
- USA
- Australia
- Slovenia

Cultural dimensions
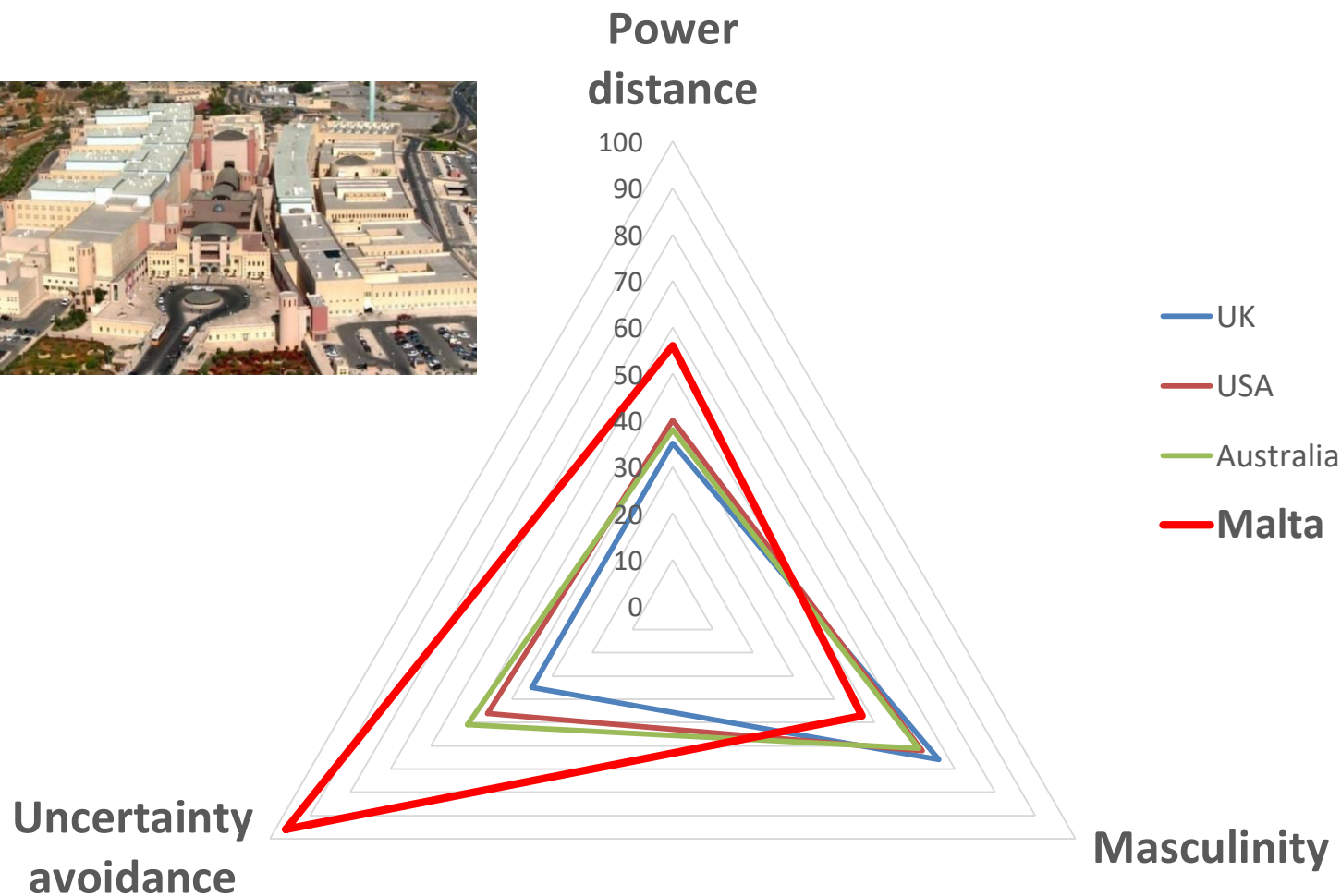
Figure 100 Alcohol-based handrub consumption (litres per 1000 patient-days) by country, ECDC PPS 2016–2017
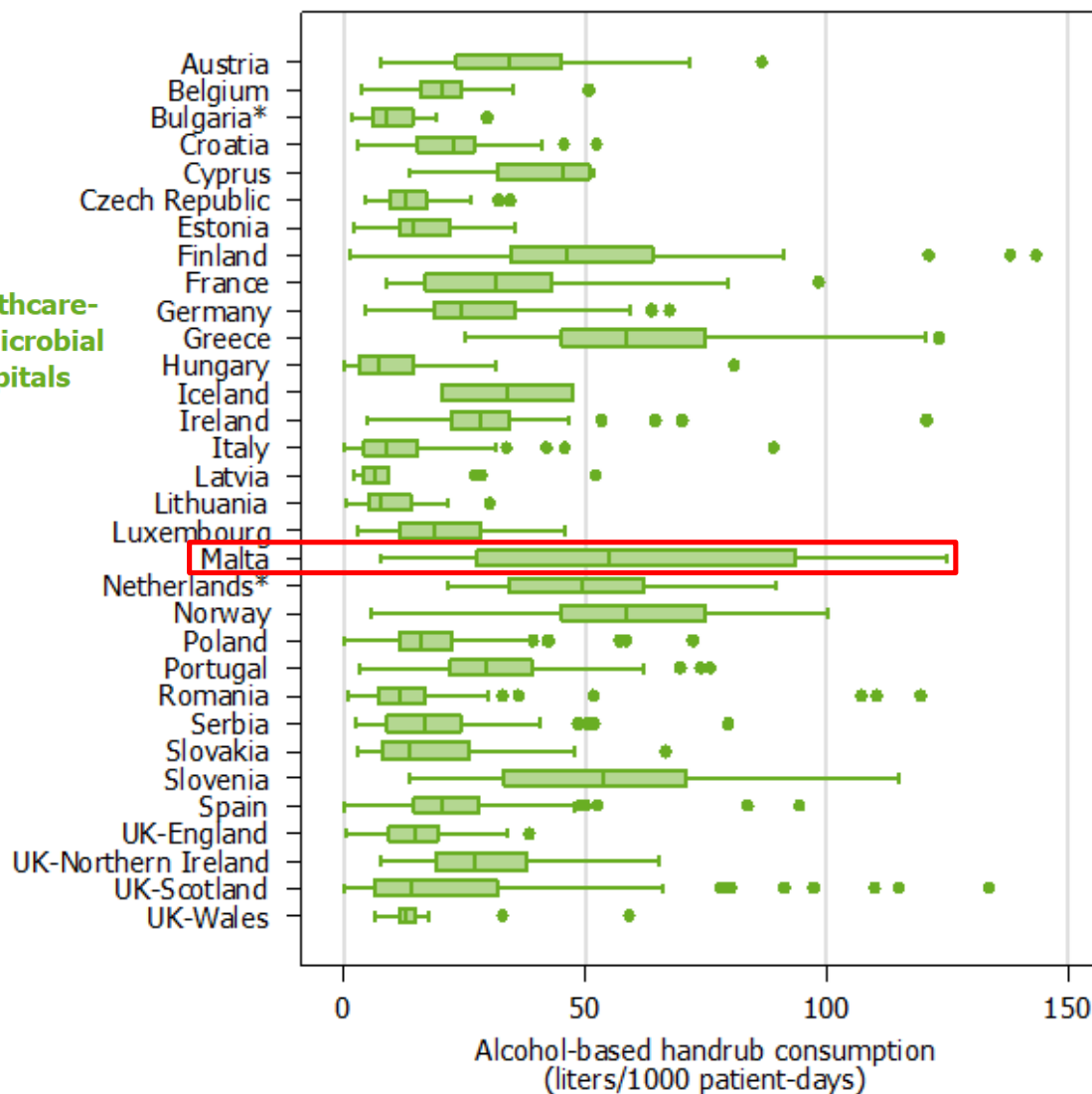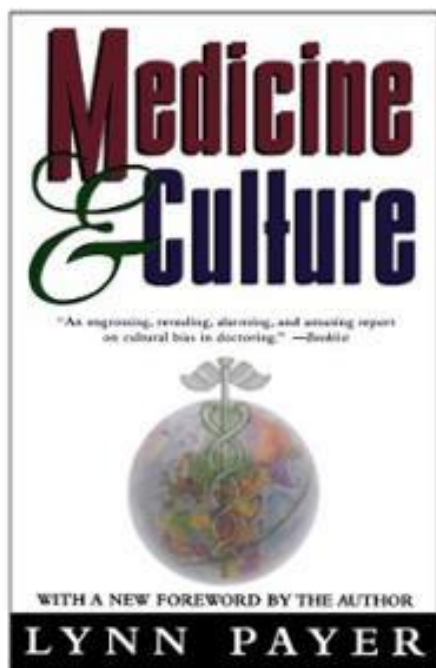
PPS data representativeness was poor in Bulgaria and the Netherlands. Red vertical line=median.

Changing behaviour

Understanding background culture is vital for any behaviour change intervention

- *Identify battles you are likely to win*

- **Design IPC interventions to be compatible with national and organizational culture**

Original Article

Preventing healthcare-associated MRSA bacteremia: getting to the root of the problem

Michael A. Borg MD, PhD[1,2] ⓘ, David Suda PhD[1], Ermira Tartari PhD[1], Claire Farrugia MSc[2] ⓘ, Deborah Xuereb MSc[2] and
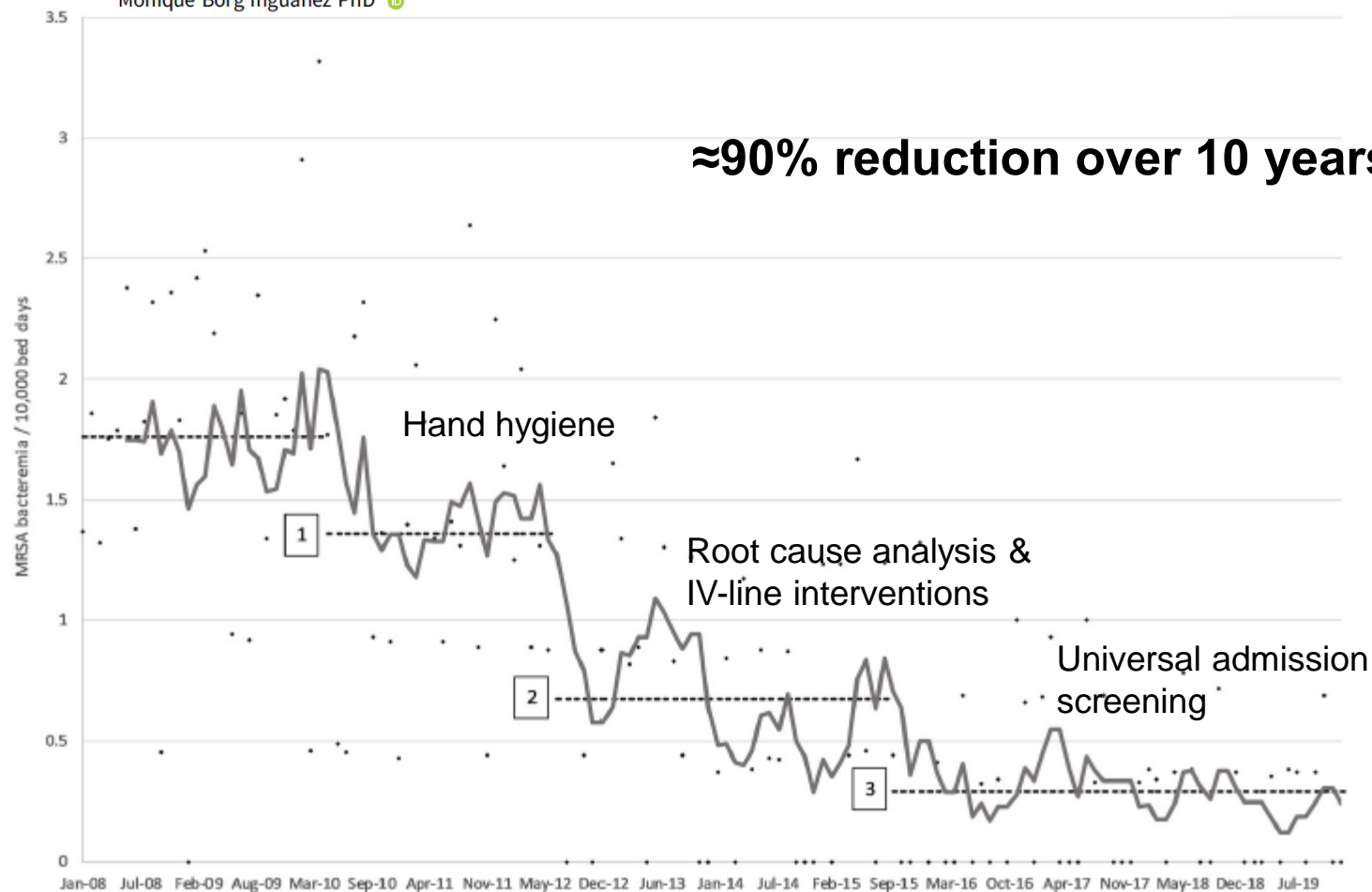Monique Borg Inguanez PhD[1] ⓘ

Figure 2. Monthly incidence of MRSA bacteremia/10000BD (dots) with 6-month moving average (gray line) and average mean incidence for baseline and each of the three change points identified (dashed line).

Hand hygiene interventions

- Focus on alcohol hand rub

- Audits, audits, audits, audits….

- Fully centralised from the Infection Control Dept
  - Healthcare assistant employed on ½ FTE <u>only</u> to do audit
    - Feedback given in real time
  - Compliance raised in hospital management meetings
  - Meetings with ward nurse managers
    - In presence of nursing director
    - *What can we do to help you improve*
      - *We anticipate improvement in next six months*

- INTRODUCE CERTAINTY…

A few seconds can change a patient's life.

Root Cause Analysis (RCA)

- Systematic, formalized approach to
  - review important adverse events and
    - E.g. MRSA bacteraemia, C. difficile etc
  - identify why they were happening
- Forum for key stakeholders to:
  - focus on the problem
  - come to consensus about **factors leading to the problem**
  - **develop effective corrective actions** applicable to the ward or hospital

Driven centrally by IPC team

- Review the case before the RCA
  - identifies key points potentially relevant to the case
- Identifies and invites key stakeholders
  - Doctors and nurses involved in care + relevant others
- Researches and shares applicable standards for care
- Provides a summary of the case at the beginning
- Leads the meeting in a **safe, non-punitive environment**
- Lets everyone provide input, but keep the focus on the event and related processes.
  - Issues, not individuals
- Takes minutes

At the end of the meeting

- Meeting develops action items, based upon root causes conclusions

Infection Control:

- Sends minutes to participants with clear action points and responsibilities
  - Copied to senior management
- Reviews implementation of corrective actions
- Raises lack of action management
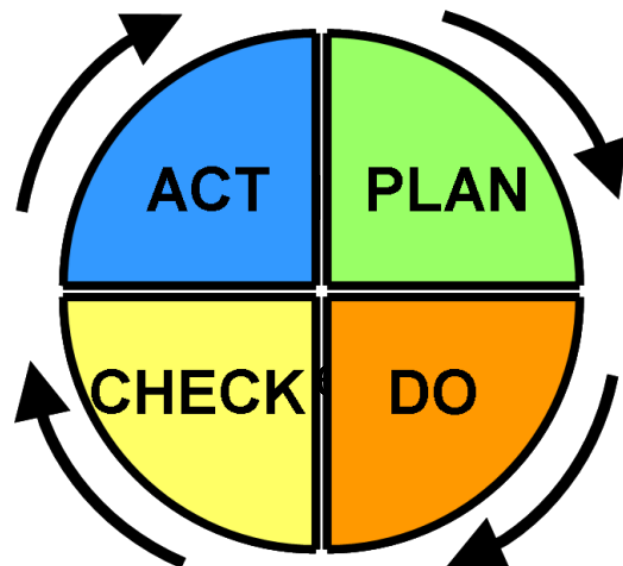
MRSA admission screening

- Undertaken for <u>all</u> patients admitted to medical, surgical, orthopaedic and intensive care departments
  - No risk assessment made

- Completely centralized
  - Infection control support staff identify new admissions
    - Go to respective wards to swab patients
  - Compliance > 98%

- If reported positive, ICNs phone ward and initiate decolonization
  - Mupirocin nasal ointment
  - Chlorhexidine baths

Universal admission screening: a potential game-changer in hospitals with high prevalence of MRSA

M.A. Borg [a,b,*], D. Suda [a], E. Scicluna [b], A. Brincat [b], P. Zarb [a,b]

[a] University of Malta, Msida, Malta
[b] Mater Dei Hospital, Msida, Malta

Contrary to "evidence"

"The few proper randomised trials that have assessed the effectiveness of universal screening have not shown a benefit"

Bonten M, Weinstein RA Lancet Infectious Diseases 2016

NHS Scotland recommendations:

- – screening of intensive care & renal admissions   +
- – high risk surgery (orthopaedics / vascular / cardiothoracic)   +
- – clinical assessment (past history/hospital admission/wound or device)

Coia et al BMJ 2014

- • However, the available studies originated primarily from countries with low colonisation prevalence.
  - – "CRA based screening is more cost effective in low prevalence settings, such as the UK."

Cairns et al BMJ2014

Universal admission screening: a potential game-changer in hospitals with high prevalence of MRSA

M.A. Borg [a,b,*], D. Suda [a], E. Scicluna [b], A. Brincat [b], P. Zarb [a,b]

- *"Dysfunctional systems and cultures appear to be critical drivers of MRSA in highly endemic hospitals*

- *In such environments, effective implementation of a targeted screening policy is unlikely to materialize considering it is dependent on individual risk assessments, undertaken by a multitude of stakeholders institution-wide.*

- *On the other hand, the simple centralized approach adopted at MDH worked because it eliminated this complex variable.*

- *Above all, the 'out-of-the-box' approach, which adapted the science to local circumstances and limitations, achieved significant outcomes at a low cost."*

Original Article

Preventing healthcare-associated MRSA bacteremia: getting to the root of the problem

Michael A. Borg MD, PhD[1,2] , David Suda PhD[1], Ermira Tartari PhD[1], Claire Farrugia MSc[2] , Deborah Xuereb MSc[2] and Monique Borg Inguanez PhD[1]

- *"…transformational change was achieved by recognizing and understanding organizational and national cultural backgrounds and adapting interventions accordingly.*

- *This was manifest in the predominantly top-down approach, coupled with regular communication and feedback with front-line staff.*

  - *heavily centralized approach and extensive day-to-day direct involvement in all aspects of the interventions… (by) the IPC team*

    - *..in line with the high uncertainty avoidance and power distance that characterizes Maltese national culture"*

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- *"Procedures that were part of previously published successful studies were modified because they were deemed to be culturally incompatible and could have undermined the whole project."*

    - *"Whereas evidence-based literature was used to inform the interventions, the setting where these studies were undertaken was always considered."*

    - *"... the organizational context and environment of any successful study needed to be comparable to our own before the intervention was introduced"*

Conclusions

- Infection Prevention & Control is ultimately all about behaviour change
- Cultural determinants - both national & organisational - are recognised as key drivers of human behaviour
- IPC professionals need to understand their cultural background in order to implement effective behaviour change interventions to have the best chance of success
  - Identify whether "evidence-based" IPC research from other countries or institutions is compatible
  - Ensure interventions are culturally congruent

Avoid "copy & paste" approaches

Copy   Paste

Thank you

Culture eats strategy for breakfast!

Peter Drucker