COMMENTARY

Vaccination of Health Care Workers for Influenza: Promote Safety Culture, Not Coercion

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ABSTRACT

Objectives: In British Columbia (BC), Canada, all health care facilities must have a written staff policy on influenza immunization that includes notice that non-immunized staff can be excluded from work without pay during an influenza outbreak in the facility. In light of this policy, our objectives were to explore the views of BC health care workers (HCWs) regarding how best to promote vaccine uptake.

Methods: Long-term care, and acute and community health sites in three of six health regions were divided into thirds, according to their previous season's vaccine uptake rates, and the upper and lower thirds targeted. Ten focus groups were held. NVivo software (QSR International) and a separate editing style were used for analysis.

Results: Four dominant themes emerged: knowledge, communication, perceived punitive nature of workplace policy, and safety climate. HCWs across all focus groups noted that influenza campaign communications should include reinforcement of basic infection control, workplace health and healthy lifestyle choices that affect overall health. HCWs indicated that they wanted a workplace policy that is easy to understand, respectful of individual choice and not punitive.

Conclusions: Our findings highlight the importance of comprehensive approaches, a message that has not appeared as strongly in previous literature. Focus group participants pointed out the importance of health and safety at work generally and felt that creating a healthy workplace culture is necessary to promoting vaccine uptake. Future vaccine promotion initiatives should be integrated into facility-wide workplace health campaigns and care taken to ensure that vaccination campaigns do not appear coercive to HCWs.

Key words: Influenza vaccination; health care workers; health and safety culture

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It is widely acknowledged that vaccination of health care workers (HCWs) is an important tool in protecting both patients and HCWs themselves.[1-3] Since January 1, 2007, the Joint Commission on Accreditation of Healthcare Organizations has required accredited associations to offer influenza vaccinations to staff, including volunteers and licensed independent practitioners, with close patient contact. Influenza vaccination rates for HCWs have tended to be low,[4-6] and despite many campaigning methods to increase uptake many HCWs still choose not be to vaccinated against influenza.[4,7-9] Several studies have been published recently exploring the reasons for HCWs not being vaccinated.[1,9-13] While many studies point to fear of side effects,[14-16] lack of knowledge about the possible severity of influenza,[16] as well as vaccine accessibility[3] as key factors in health care workers' decisions about being vaccinated, few have proposed clear policy implications for the health care system.

In British Columbia (BC), all health care facilities (acute, long-term, intermediate and extended care facilities) are required to have a written staff policy on influenza immunization in place that includes notice that non-immunized staff can be excluded from work without pay in the event of an influenza outbreak in the facility.[17] BC has adopted the stance that "Refusal of health care workers to be immunized implies failure in their duty of care to their patients. Non-immunized staff assist in the spread of influenza and pose an unacceptable risk to patients and co-workers during outbreaks."[18]

This type of policy is now quite common, and mandatory vaccination for HCWs, with a provision for declining vaccination on the basis of religious or medical reasons, is increasingly promoted.[19,20] Fifteen US states have regulations regarding vaccination of health workers in long-term care facilities, three states require that health care facilities offer influenza vaccination to staff, and three states require that HCWs either receive influenza vaccination or indicate a religious, medical or philosophical reason for not being vaccinated.[21]

This article describes the results of a research study in which focus group sessions were held in long-term, acute and community care settings in BC to probe the barriers and facilitators to health care workers being vaccinated against influenza. Our objectives

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were to explore the views of BC health care workers regarding how best to promote vaccine uptake. These focus groups were part of a larger study, which sought to understand the usefulness of a web-based surveillance system in tracking influenza vaccination in health care workers.

METHODS

Setting

Focus group sessions were conducted in three of five geographic health regions in BC: Vancouver Island, and the Interior and Fraser health authorities, together making up 60% of the province's total facility-based health care workforce. The group meetings were held in October and November as the influenza vaccine promotions were just beginning and were open to all HCWs working in these three health regions who identified themselves as having direct patient contact in their work.

Site selection

Sites were chosen on the basis of their staff uptake rates for influenza vaccination in the previous influenza season, by subsector. This study focused on long-term care, acute care and community care facilities. Sites were divided into thirds, by their uptake rates, with the middle third being discounted. The upper third and the lower third were targeted, and sites were chosen according to their geographic locations and size of their workforce (larger sites would be easier to recruit participants).

Focus groups

The study was advertised to eligible HCWs through posters and brochures in their facilities and internal workplace E-mail. Participants pre-registered for the focus groups by telephoning the project coordinator and received an honorarium of CDN $55 for their participation. The vaccination status of individual HCWs was not queried during the focus groups because workforce motivators and/or the barriers to being vaccinated were of main interest and not necessarily what motivated the participants' own actions. Occupational groups were mixed. The questions asked in the focus groups aimed to explore the motivators and barriers to HCWs being vaccinated. They were derived by the research team from findings in the scientific literature.[22-24] and from a telephone survey conducted earlier in 2006.[25] Reasons explored fell into two broad categories: organizational and individual.

Analysis

Coding and analysis of the focus groups' discussions used NVivo software (QSR International, version 7.0), as well as a separate, editing analysis style[26] whereby dominant themes were allowed to emerge from the focus groups rather than being imposed *a priori*. The audio files for each focus group were transcribed verbatim. Each transcript was analyzed independently for common themes by two key readers who examined them for key phrases and recurrent concepts. Focus group outcomes were both analyzed and interpreted by reading transcripts and listening to the recordings of the groups numerous times to better understand the context of the discussions.

RESULTS

A total of 83 HCWs were given the opportunity to speak in 10 focus groups, which lasted approximately 70 minutes (range 50-90 minutes). Study participants included 45 HCWs from long-term care, 23 from acute care and 15 from community care facilities. Overall, 76 women and 7 men participated, covering a wide range of occupations, such as registered nurses, licensed practical nurses, unit clerks, physicians, care aides, dietary staff, housekeeping and kitchen staff, occupational therapists, librarians, hairdressers, laboratory staff, home support workers, psychiatric support workers and recreational aides. The mixing of diverse occupational groups led to rich discussion.

Four dominant themes emerged from the focus groups: knowledge, communication, perceived punitive nature of workplace policy and safety climate.

Knowledge

HCWs who participated in the focus groups felt that they lacked information about the vaccine, its long-term effects and its effectiveness, and were not provided with sufficient information to be able to make an informed choice. Workers also spoke of the personal nature of vaccination and how it should be a choice, an informed choice, as to whether or not they receive the vaccine.

As one focus group participant stated:

Yeah, because getting an immunization I think is a personal choice– And when you're told you're going to be penalized because of your choice, I don't think–that's not right.

Communication

HCWs across all focus groups expressed frustration at the simplicity of the messages put forward in influenza campaigns – they wanted more scientific information (access to both systematic reviews and peer-reviewed materials). They also wanted more targeted information, specific to them as health care workers, rather than the same material used to inform the public on vaccine campaigns. In addition, they noted that the influenza campaign communications should include reinforcement of basic principles of infection control and healthy lifestyle choices that affect overall health. They felt that the current influenza campaign was conducted in isolation from other workplace health promotion activities, and they hoped for a more unified message about the importance of workers' health and safety on an ongoing basis.

Perceived Punitive Nature of Workplace Policy

HCWs strongly indicated that they wanted a workplace policy that is easy to understand, that is not punitive and that respects individual choice. A participant spoke on the importance of choice:

Those e-mails have been sent out is kind of using that ultimatum. It's saying that you have a choice, but, this is what will happen if you get sick. And I think for a lot of people, especially folks who have families, or well, people, money—it comes down to getting a paycheck. Some people can't afford to take the risk of potentially getting the flu for the sake of the fact that they won't be respected for that particular illness because the employer has made a decision for you about how to avoid that illness, whereas they are not making that decision about other illnesses for us. But we're not allowed to decide how we manage that illness really. I mean, we can, but we take the risk of being withheld pay, and I don't think that's necessarily the most effective way to encourage.

Many workers felt in the event of an influenza outbreak in a facility, management should look at alternatives for non-immunized HCWs, such as a temporary re-assignment to other work, and they

felt that they should not be forced to be immunized against influenza through workplace policy. As one participant stated:

I think the coercion backfires in that it gets people's backs up, and then they become more polarized... I think there should be enough education out there that you're allowed to make a respectful independent decision based on your own views and experience with the understanding that our mandate is to protect the elderly.

Another HCW stated:

… it is extreme pressure from, you know, people, the managers, especially in residential. We had an outbreak in September … We had lockdown for ten days, but the families are still allowed to come ... Who knows if they've been vaccinated? They put all this pressure on the staff to get vaccinated but, you know, in residential you can't bar families from seeing their loved ones, which I could see, but you're still having the traffic in and out of people.

Safety climate

Workers felt that the influenza campaign was a standalone push to get workers to be vaccinated. One focus group participant asked:

So if they're going to be so entrenched about one aspect of infection control, which is immunization, why shouldn't they be, you know, equally vigorous about other infection control procedures?

Many focus group participants stated that their workplaces did not promote a culture of safety for them, as workers, and therefore it seemed hypocritical to push workers to be vaccinated when they were not so actively encouraged in other areas (i.e., hand washing, healthy eating, etc.). Workers perceived that management could reassign workers during outbreaks so that those who have not been vaccinated could still work elsewhere, however workers believed there was a lack of interest by management in doing this type of shuffling. Workers consistently focused on the need for their facilities to create a safety culture where vaccination, hand-washing and proper quarantine procedures go hand in hand and are linked with the well-being of the workforce, not just the patient population.

Workers from long-term care facilities who participated in the focus groups (four sites) consistently spoke about the public, such as visitors to the facility, and the need for greater education about the importance of hand washing for visitors. Workers who were in community care facilities and in long-term care seemed to emphasize more the pressure to be vaccinated, which was perceived to come from co-workers as well as from management. One worker in long-term care stated:

I think there's peer pressure, even at our age, I think there is.

While we made no attempt to stratify responses by type of facility, we noted that peer pressure was mentioned in low-uptake facilities, both long-term care and community care, as well as the fact that this pressure can go both ways:

Peer pressure. If there are enough of you in your group and they're all kind of, "Oh, I don't think it's a good idea", then you buy into it, and you strongly believe—I will not.

This group thinking as well as anti-vaccine co-workers were mentioned throughout the focus groups as having a role in an individual's decision-making process.

Workers in acute care stressed the need for more information prior to vaccination but also noted that those providing the vaccine were very accommodating. One participant from an acute site stated:

One of the positive things I think about our centre is that there are a minority of people, which I am one of them, who has a real fear of vaccinations and the centre has really tried to make it easier for us. Like we go to the head of the line to have our vaccinations done and the nurses will even let us choose what site we get it in because I won't take a vaccination in the arm at all. So they say, well do you want it here or there and they never make you feel bad about it, which I think is positive.

Participants within both high-uptake facilities and low-uptake facilities spoke of similar themes, frustrations and strengths of their workplace influenza campaigns. An important discussion stream in both high-uptake and low-uptake facilities focused on the most common source of information about vaccines; workers in both types of facility spoke about getting information from co-workers. This knowledge sharing could be a reinforcing factor in the high-uptake facilities (i.e., most workers are vaccinated and thus are pro-vaccination) whereas in the low-uptake facilities it could result in swaying co-workers in the opposite direction (i.e., a strong anti-vaccine voice changing behaviours against vaccination).

DISCUSSION

There has been debate in the peer-reviewed literature as to whether health care workers should be given a choice to be vaccinated against influenza or whether it should be mandatory.[27,28] Many different opinions have been put forward as to why health care workers must be vaccinated against influenza (including, but not limited to, decreases in influenza-related illness and absenteeism among health care workers, as well as fewer acute care outbreaks and reduced patient mortality in long-term care settings),[29] though clear evidence showing the direct benefit of HCW influenza vaccination is lacking.[30-32] We found, unequivocally across the 10 facilities and all subsectors, that HCWs spoke of the importance of the personal nature of making the choice, or not, to be vaccinated.

We found that HCWs expressed frustration at the simplicity of vaccination campaigns, which they felt lack scientific information, i.e., access to both systematic reviews and peer-reviewed materials. Though previous work has espoused the importance of a multiple intervention approach for this complex issue,[33] this study sought to discover the reasons why HCWs did not feel compelled to be vaccinated, despite multiple promotional/campaigning methods. HCWs expressed the need for a broadened communication campaign with regard to influenza vaccination in which basic principles of infection control and healthy lifestyle choices are included. They felt that current influenza vaccination campaigns were conducted in isolation from other "health promotion" activities, and they wanted a more unified message about the importance of workers' health and safety on an ongoing basis. HCWs want workplace policy that is not punitive and respects individual choice: many HCWs felt that management should re-assign HCWs during outbreaks as an alternative to exclusion from work without pay. Workers also felt peer pressure in the workplace and sensed that they would be punished by management if they did not choose to be vaccinated. HCWs spoke about the need for the vaccine to be available in their workplace, as this access to the vaccine is a key factor in their decision to receive it.

There are limitations to qualitative methods, such as the use of focus groups, the chief one being that this small sample of HCWs cannot be considered representative of all health care workers. Another possible limitation of our study is that we only interviewed workers who identified themselves as having patient contact: HCWs who work with patients may experience very different moti-

vations for receiving the influenza vaccine, in either a positive or negative way (workers who feel that they have done enough for their patients in choosing not to be vaccinated vs. workers who are vaccinated as they "care" about their patients' well-being). We also did not ask individuals in our focus groups to identify their occupation, and so there was no controlling for occupational group in our analyses. Another limitation is that facilities were selected for inclusion on the basis of overall facility uptake of the influenza vaccine in the previous year as well as facility type (acute, community and long-term care), but there was no controlling for other factors, such as facility size or location (urban vs. rural). Also, though facilities were selected according to uptake, individuals were not pre-screened for their individual uptake, and thus we may have had many non-vaccinated in a high-uptake facility, and conversely in a low-uptake facility our focus group may have comprised mainly individuals who were strongly pro-vaccination.

This is one of the first studies in Canada to explore in-depth attitudes towards workplace vaccination in HCWs in the community sector, long-term care, as well as acute care. Our findings highlight the importance of a comprehensive approach, a message that has not appeared as strongly in previous literature. A major theme that emerged in all our focus groups was health and safety at work generally and the importance of creating a healthy workplace culture in promoting adoption of this vaccine. This is also consistent with previous research illustrating that the most consistent determinant of adopting safe work practices is the safety climate, that is, employees' perception of organizational commitment to safety.[34-37] Our previous research[37-40] and that of others[35,36] suggests an important link between providing health and safety training to health professionals and the perceived safety climate in the organization. Indeed, we found that those *required* by their supervisor to take an infection control course were actually *more* likely to make positive statements about the safety climate in their organization than their counterparts who took the course on their own initiative.[41] This suggests that HCWs are not averse to mandatory policies that promote workplace safety but are averse to policies that seem targeted at them as vectors of disease transmission rather than being put in place in an effort to protect their well-being. Workers in this influenza vaccine study reported feeling unsupported, and they wanted a more comprehensive approach to health promotion. We thus conclude that future vaccine promotion initiatives should be integrated into facility-wide workplace health promotion campaigns, and care should be taken to ensure that the vaccination campaign does not appear to HCWs to be at all coercive or punitive.

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RÉSUMÉ

Objectifs : En Colombie-Britannique (C.-B.), au Canada, tous les établissements de soins de santé doivent avoir une politique écrite sur la vaccination antigrippale du personnel. Cette politique prévoit que le personnel non vacciné peut être exclu du travail sans salaire durant une éclosion d'influenza dans l'établissement. À la lumière de cette politique, nous avons voulu connaître le point de vue des travailleurs de la santé (TS) de la C.-B. sur le meilleur moyen de promouvoir l'acceptation du vaccin.

Méthode : Les établissements de soins prolongés, de soins actifs et de santé communautaire de trois des six régions sanitaires de la province ont été divisés en tiers selon leurs taux d'acceptation du vaccin pendant la saison vaccinale précédente et les tiers supérieur et inférieur ont été ciblés. Dix rencontres ont été tenues en groupes de discussion. Les résultats ont été analysés à l'aide du logiciel NVivo (QSR International) et de directives d'édition distinctes.

Résultats : Quatre grands thèmes se sont dégagés : les connaissances, la communication, le caractère punitif perçu de la politique de l'établissement et le climat de SST. Dans tous les groupes de discussion, les TS ont indiqué que les communications sur la campagne antigrippale devraient porter sur le renforcement des mesures de base de prévention des infections, sur la santé au travail et sur les choix de modes de vie qui influencent la santé générale. Les TS ont dit vouloir que la politique de l'établissement soit facile à comprendre, qu'elle respecte les choix personnels et qu'elle ne soit pas punitive.

Conclusion : Nos constatations soulignent l'importance d'une approche globale, ce qui ne ressortait pas aussi clairement dans les travaux publiés auparavant. Les participants des groupes de discussion ont souligné l'importance de la santé et de la sécurité au travail en général; selon eux, pour promouvoir l'acceptation du vaccin, il faut que la santé au travail fasse partie de la culture organisationnelle. Les futures initiatives de promotion du vaccin devraient donc s'inscrire dans des campagnes de santé au travail à l'échelle de l'établissement, et des efforts déployés pour éviter que les campagnes de vaccination semblent coercitives pour les TS.

Mots clés : vaccination antigrippale; travailleurs de la santé; culture de la santé et de la sécurité