

Hospital Infection Control & PREVENTION

The Trusted Source for the Infection Preventionist for More Than Four Decades

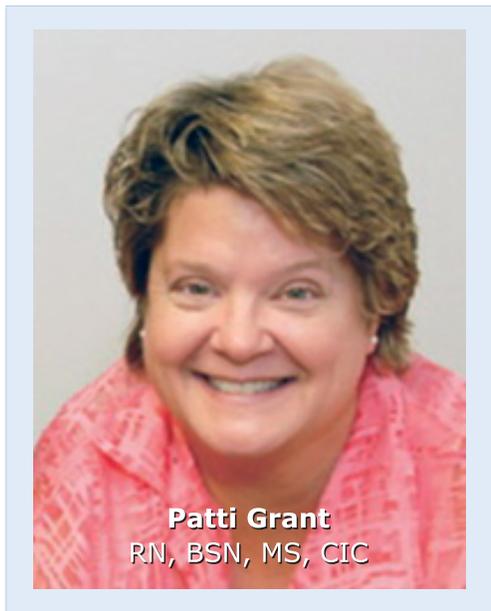
August 2013

Volume 40, No. 8

Pages 85-96

APIC at 40: Full public awareness of IP role critical to future of infection prevention

Paradoxically, in order to lead IPs must 'let go'



Patti Grant
RN, BSN, MS, CIC

The future of infection prevention hinges in large part on greater public awareness of the vital role IPs play in protecting patients throughout the health care system, an acknowledgement that is needed to preserve and expand program resources, said **Patti Grant**, RN, BSN, MS, CIC, president of the Association for Professionals in Infection Control and Epidemiology (APIC).

"Until the public demands our presence in health care we are only going to go so far," she said recently in Fort Lauderdale in delivering the annual president's address at APIC's 40th annual conference.

While patients expect and demand clean hospitals, skilled surgeons and even good food, they rarely inquire about the number and expertise level of a facility's infection preventionists.

"When was the last time anybody from the general public walked into a health care facility, went over to the information desk and said, 'I need to know how many certified IPs are in this hospital?' Until the public demands our presence the way they demand all these other things we are not going to progress much further than where we are," said Grant, director of infection prevention and quality at Methodist Hospital for Surgery in Addison, TX.

For example, Consumers Union, publishers of *Consumer*

In This Issue

- ❑ **Agents of change:** IPs can no longer tolerate non-compliance at the bedside with evidence based practices cover
- ❑ **Silence kills:** Checklists and protocols for clinical care have been highly successful in infection prevention and other fields, but can be easily undercut by a simple non-action: silence 87
- ❑ **The past is prelude:** A look at infection prevention challenges through the decades leads to a call to action in the present . . . 88
- ❑ **The tipping point:** The broad misconception that infectious diseases were fading as a medical concern with the development of antibiotics and vaccines was dashed in dramatic and tragic fashion in 1981 when the first cases of a strange new illness were reported 91
- ❑ **Changing role, inherent tensions:** In-depth interviews with IPs reveal a fascinating look into the trenches at a time of great change. Adaptability and persistence are among the traits needed for survival . . . 93



Financial Disclosure:
Executive Editor Gary Evans, Consulting Editor Patrick Joseph, MD, and Kay Ball, Nurse Planner, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

Reports, began calling for more transparency and accountability on health care associated infections (HAIs) about a decade ago. As IPs began to dialogue with the consumer advocacy group on HAI prevention, Grant wondered why they had not come to APIC in the first place, which has been in existence since 1972. Grant was told the perception was that IPs were “under the radar,” she said.

This has been a recurrent theme in infection control, a field that has long labored under what veteran health care epidemiologist **Vicky Fraser, MD**, once described as “a psychopathology of secrecy.” Liability concerns and other HAI issues likely contributed to this early culture, which included arcane — and presumably protective — language like “nosocomial” infections. However, now the public is much more aware of health care infections, even forming groups like the MRSA Survivors Network.

“What are we not doing that people feel they need to make their own organizations to fight infections,” Grant asked some 4,000 APIC attendees. “Why aren’t they coming to us? I challenge everybody in this room to ask themselves the same question. We’ve come so far in 40 years, what can we do in the next decade so people will know that APIC is the place to come for not just HAIs but for all infections.”

Agents of change

Infection prevention has dramatically moved away from the old passive mindset of benchmark HAI rates and inevitable infections, now pushing for HAI eradication and zero tolerance for non-compliance with proven methods of prevention.

“In order to be successful in the future we are going to have to be obsessed with failure,” Grant said. “I’m not saying we have to do a root cause analysis on every infection. I’m talking about no longer tolerating non-compliance at the bedside, in the sterile processing department, anywhere in health care where we know evidence-based practices work and yet we let business go on as usual. That has to stop. We have got to become change agents. We have to stop rationalizing when we see infections happen.”

This phenomenon is common in other medical specialties, Grant noted, citing the “Silence Kills” work that has been done by the Association for Operating Room Nurses and other groups. (*See related story p. 87.*)

“What is it about our health care system that people feel it is OK to watch a procedure or see something done — know it’s wrong — and not speak up?” she said.

A rhetorical question that adds some “moral

Hospital Infection Control & Prevention®, including **Infection Control Consultant**™ and **Healthcare Infection Prevention**™ (ISSN 0098-180X), is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices. Web: www.ahcmedia.com

POSTMASTER: Send address changes to **Hospital Infection Control & Prevention**®, P.O. Box 105109, Atlanta, GA 30348.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

AHC Media is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media designates this enduring material for a maximum of 18 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity is effective for 36 months from the date of publication.

Target audience: Infection control practitioners and infectious disease physicians.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Executive Editor: **Gary Evans**, (706) 310-1754, (gary.evans@ahcmedia.com).

Production Editor: **Kristen Ramsey**.

Interim Editorial Director: **Lee Landenberger**.

Copyright © 2013 by AHC Media. **Hospital Infection Control & Prevention**® and **Infection Control Consultant**™ are trademarks of AHC Media.

The trademarks **Hospital Infection Control & Prevention**® and **Infection Control Consultant**™ are used herein under license. All rights reserved.



AHC Media

Editorial Questions

For questions or comments, call **Gary Evans** at (706) 310-1727.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6. Monday-Thursday, 8:30-4:30 Friday EST. World Wide Web: <http://www.ahcmedia.com>. E-mail: customerservice@ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), \$499. Add \$17.95 for shipping & handling. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are \$78 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421.

clarity" to the old issue of inevitable infections is: "If it's OK to give an HAI to someone — and we know under even perfect circumstances somebody is going to get an infection — then who is it OK to give the HAI to?" Grant said.

"My mom's had as SSI, my dad has had an SSI, my uncle Bob will never walk again with-

out a walker because a hip got infected and he had to have three surgical procedures," she said. "Everybody in this room probably has a story."

The IPs in attendance should thank their predecessors and the early pioneers in health care epidemiology who established a scien-

Silence kills if no one is willing to speak up

'Make candor a core competence'

Checklists and clear protocols for clinical care have been highly successful in infection prevention and other fields, but can be easily undercut by a simple non-action: silence.

Following up on earlier work on this topic, the Association for Operating Room Nurses (AORN) and several partners reported in *The Silent Treatment* that health care has yet to fully overcome a culture wherein people observe errors but fear the consequences of speaking up.¹

The study included data from more than 6,500 nurses and nurse managers from health systems around the United States during 2010. All research participants were members of the AORN and the American Association of Critical-Care Nurses. The study used two research instruments: a "story collector" and a traditional survey. The story collector generated qualitative data, while the survey recorded purely quantitative data.

The researchers found that 85% of respondents have been in a situation where a safety tool warned them of a problem. In addition, 32% said this happened at least a few times a month, a finding that confirmed that safety tools work and that checklists, protocols, and warning systems have an essential role in patient safety.

However, the research also documented that the effectiveness of safety tools is undermined by so-called "undiscussables." Of the nurses who had been in situations where safety tools worked, 58% had also been in situations "where they felt unsafe to speak up about the problems or where they were unable to get others to listen," the researchers noted.

The research findings pointed to several key hazards, including:

Dangerous shortcuts: Overall, 84% of

respondents said that 10% or more of their colleagues take dangerous shortcuts. Of those respondents, 26% said these shortcuts have actually harmed patients. Despite these risks, only 17% have shared their concerns with the colleague in question.

Incompetence: Overall, 82% say that 10% or more of their colleagues are missing basic skills and, as a result, 19% say they have seen harm come to patients. However, only 11% have spoken to the incompetent colleague.

Disrespect: Overall, 85% of respondents say that 10% or more of the people they work with are disrespectful and therefore undermine their ability to share concerns or speak up about problems. And yet, only 16% have confronted their disrespectful colleague.

"Fortunately, not all survey respondents remained silent," the authors state. "The study identified a small minority of nurses who spoke up when they observed dangerous shortcuts, incompetence, or disrespect. By studying these successful outliers, the research uncovered the high-leverage behaviors all healthcare practitioners should master in order to change the trajectory of harmful patient care."

The report underscores that while safety tools are one part of the solution to improving patient care, they do not compensate for crucial conversation failures in the hospital. "Silence still kills," the authors conclude. "It's time for healthcare systems to make candor a core competence."

Editor's note: The full AORN report is available at www.silenttreatmentstudy.com

REFERENCE

1. Maxfield D, Grenny J, Lavandero R, et al. *The Silent Treatment: Why Safety Tools and Checklists Aren't Enough to Save Lives*. Executive Summary. 2010 Available at: <http://ow.ly/ndnII> ■

tific footing for the fledgling field, she noted. (See related story, this page.) "It was their willingness to learn and their ability to adjust to new experiences," Grant said. "We are here because of their perseverance in paying it forward."

Imagine if an organization like APIC did not exist, she said, recalling her first conference when she entered the field in 1990.

"I have had some phenomenal mentors — I can't believe the people that have blessed me with their teachings — but it was APIC that was my constant through all these years," she said. "There is such an exceptional knowledge base through our membership because we share the vision of health care without infections. I am not talking about the number zero. Our vision of zero infections comes through as zero tolerance with things that we know prevent infections."

Leading by letting go

Now it is time to reach out to others for help in accomplishing the broader goals of infection prevention, no small task for IPs who are used to being relatively autonomous and self-reliant.

"[The future depends] on our collective ability, our collective willingness to ask for the help of others in the fight against infections," she said. "Who are these other people going to be — where are they going to come from? I'm suggesting that they need to come from outside, from beyond our traditional comfort zone. What I'm saying is to get through the next decade — to really push the envelope — we are going to have to let go."

Unless IPs empower others to take the lead in infection prevention initiatives, the field will not grow beyond the silos and turf wars that have held held sway for decades.

"This is a hard one for me to say because I'm like a control freak," Grant said. "But the best teams I've ever been on are ones I did not chair. As long as I continue to do it they are not going to see it as their own. And they quickly learn that it is a lot harder for me to sit back and plant seeds and allow them to do it on their own. They see that it is not done out of indolence — that I'm not being lazy."

Of course, IPs must be present to inform and guide the process. "We have to always be there to reel them in when we start hearing

things like changing [respiratory air] circuits every 48 hours," she says. "We knew 15 years ago that is not going to help. Remember our APIC tag line is 'spreading knowledge, preventing infections.' This is what IPs do. We've got to learn balance and facilitation."

This new role and increasing demands from other sectors have put IPs under considerable pressure, as inevitable tensions arise as more people are brought into the mission of infection prevention and protecting patients. (See related story, p. 93)

"Conflict is inevitable and should be embraced as an inescapable part of learning," Grant said. "Stop and think about everything you've ever learned — most of it was not easy, and certainly in health care, conflict will be involved. We need to learn from those experiences. As we continue to grow and serve, we need to always know when to lead astutely and know when we need to bravely follow."

The shift from the language of "controlling" infections to "preventing" them heralded this change several years ago, as the concept of prevention embraces a much larger group of clinicians and health care workers.

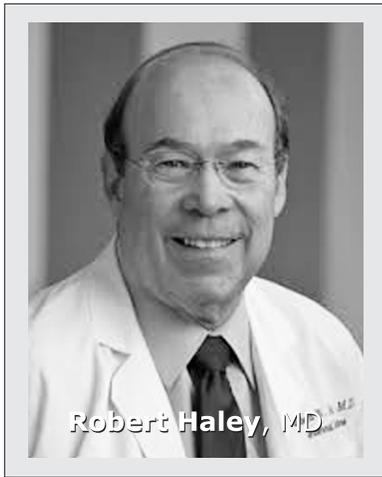
"We call ourselves infection preventionists today not because it's a job title; it's a description that unified us as a body that is fighting infections," Grant said. "It doesn't matter if you're an RN, an MD, an MPH, if you work in microbiology, a respiratory therapist — if your primary function is to help fight infection you are an infection preventionist." ■

A journey through the past leads to a call for action

APIC icons look back, look forward

Though the value of infection prevention programs goes without saying today, there was a time when the field was first forming that there was little to no evidence that the basic tenets of infection prevention were essential to protect hospital patients and prevent what were then called nosocomial infections.

"The future of infection control and surveillance measurement in hospitals was anything but a foregone conclusion — it was contro-



versial," said **Robert Haley**, MD, the epidemiologist who directed the landmark Study on the Efficacy of Nosocomial Infection Control (SENIC) after coming to the Centers for Disease Control and Prevention in early 1970s.¹

As Haley described it, the concept of hospital infection control was just emerging — with the first of the decennial conferences on nosocomial infections held in 1970 — and there was concern that the field was not sufficiently grounded in evidenced-based science. The thinking was that hospitals could eventually cut infection control and surveillance programs if they lacked scientific justification.

Thus began the massive SENIC project, which included a survey in 1976 of all U.S. hospitals to determine specific surveillance and control characteristics of their infection control programs. That was followed in 1975-1976 with a review of more than 339,000 patient medical records in 338 randomly selected U.S. hospitals to determine the presence of nosocomial infections. SENIC found that hospitals reduced their nosocomial infection rates by approximately 32% if their infection surveillance and control program included these four components:

- appropriate emphasis on surveillance activities and vigorous control efforts
- at least one full-time infection-control practitioner per 250 beds
- a trained hospital epidemiologist
- feedback of wound infection rates to practicing surgeons

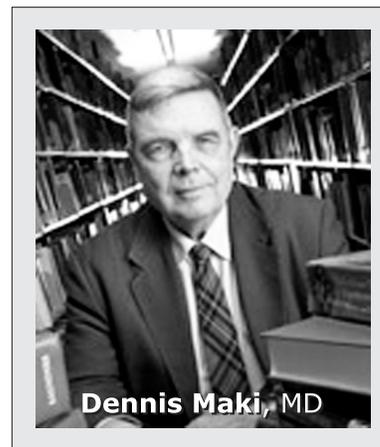
"We found that hospitals that did surveillance and all of these program activities had lower infection rates," Haley said recently in Fort Lauderdale at the 40th annual conference of the Association for Professionals in Infection Control and Epidemiology (APIC). "By showing this, the Joint Commission then changed their recommendations to require these elements. We realized that most of these activities weren't in place in many hos-

pitals."

As calls came in to the CDC from hospitals, it was quickly realized that guidelines needed to be created to standardize practice. Another lasting impact of the project was Haley's emphasis on targeted, objective-oriented surveillance rather than wasting scarce resources gathering house-wide data. This was one of the first shifts of IPs from data collectors to "difference makers," to cite a term frequently used at the APIC conference.

The accidental epidemiologist

Haley participated in an APIC discussion along with several other pioneers and key players in the establishment and growth of the field since the organization's first conference in Toronto in 1972.



Among them was another lion in the field, **Dennis Maki**, MD, the Ovid O. Meyer Professor of Medicine at the University of Wisconsin School of Medicine and Public Health. An internationally recognized infectious dis-

ease expert and author or coauthor of scores of peer reviewed papers on health care epidemiology, Maki recalled with some self-deprecating humor that he got into the field somewhat by accident and with initial regret.

"My career was very serendipitous," Maki said, noting that as a young doctor he was drafted during the Vietnam War. "For reasons it took me decades to find out I got sent to the CDC rather than one of the arms of the uniformed services. They sent me to the EIS [Epidemic Intelligence Service]. I had little or no interest in infectious disease and I was oblivious to infection control."

Assigned to investigate a serratia outbreak, Maki jokingly recalled that he was advised to spend some time in the research library after asking, "What's serratia?"

"The CDC was an extraordinary experience," he said. "It changed the lives of most

of us that were there. I found my career. I was going to be a cardiac surgeon. I was going to go back to Boston, finish my training and do cardiac surgery. But at the CDC they assigned me to the hospital infections branch and I was not very happy about it initially."

Things took a dramatic turn in 1970 when reports began coming in of patients developing gram negative bacteremia infections in an outbreak that would ultimately be linked to contaminated IV solutions and equipment. Thousands of patients were infected and some 15% died as a result, Maki said.

"I had the opportunity to play a major role in the investigation of that outbreak and it was a heady experience," he said. "It made me realize patients are vulnerable to bad things at hospitals. I realized how oblivious I had been to that in my training up to that point in time. It really was a career-changing experience."

In the aftermath of the outbreak, Maki wrote one of the first evidence-based guidelines on preventing line-related sepsis.²

"I laugh when I say evidence based because we really didn't have much evidence," he told some 4,000 APIC attendees. "We put together everything we could extrapolate from the epidemic and we also put together everything else we could find, and it was really the first guideline and it was widely accepted," he said. "It's gone through many iterations and it is full of evidence now. Almost everything that we do to prevent line sepsis is based on studies."

Looking at the evolution of infection prevention through the decades, Maki said in the current era the knowledge gained over the years must finally be translated into "failsafe" systems.

"The decade of the '70s focused on surveillance — defining the problem and being able to put together guidelines," he said. "The era of '80s was big on guidelines and studies to find what measures will reduce risk. The era of the 2000s really has been [an acknowledgement] that it is not enough to know what to do — we have to know how to make it happen. We have to develop systems that are failsafe if we want to really maximize safety."

IPs take the lead in patient safety

On a personal note, Maki thanked APIC for

inviting him to speak on the panel because he has learned so much from infection preventionists over the years

"I have to laugh when we talk about the hospital safety movement as though it was discovered in 1999-2000," he said. "Infection preventionists have been doing hospital safety for 40 years! APIC is the organization that has made it happen at the grassroots level. We can have all of the knowledge, but if we can't apply it and make it happen our patients aren't going to do well."

Indeed, the current patient safety move-



Sanjay Saint, MD

ment is generally traced to the publication of a 1999 Institute of Medicine report that said medical errors were causing between 44,000 and 98,000 deaths in U.S. hospitals every year and some 1 million injuries.³ Noting that health care appeared to be

far behind other high-risk industries in ensuring basic safety, the IOM report captured the public imagination and generated much political capital. Surprisingly, it said very little about HAIs, which are known to cause an estimated 100,000 patient deaths annually.

"Even though the IOM report was 223 pages long essentially only two pages were devoted to infection prevention and those two pages were in appendix E, as in 'easy to overlook,'" said **Sanjay Saint, MD**, professor of internal medicine and director of the patient safety enhancement program at the University of Michigan Medical School in Ann Arbor.

Though given short shrift in the report, IPs joined the patient safety movement and played major roles in the subsequent initiatives.

"As the decade progressed things changed dramatically, and even though the IOM report had only about 1% of its pages devoted to infection prevention, when you look at

(Continued on p. 92.)

Tipping point: HIV begins new era of emerging infections

'It made me feel like I needed to do something'

The broad misconception that infectious diseases were fading as a medical concern with the development of antibiotics and vaccines was dashed in dramatic and tragic fashion in 1981 when the first cases of a strange new illness were reported among groups of gay men in New York, Los Angeles and San Francisco. The AIDS epidemic had begun.

It is estimated that more than 25 million people have died of HIV since those first cases were reported.



Julie Gerberding,
MD, MPH

"HIV was a tipping point," said **Julie Gerberding**, MD, MPH, former director of the Centers for Disease Control and Prevention. "Prior to HIV the dogma in the infectious disease world was that infectious diseases were going to be a thing of the past. We had vaccines, we had

antibiotics and we were cautioned not to go into the profession – it's a dead end street. Then HIV happened and there was an awakening that infections do emerge. Now we live with that knowledge every day, but there was a time when we didn't understand this and that's probably why it took us so long to recognize that in fact it was an infectious disease that we were experiencing in the city."

Now President of Merck Vaccines, Gerberding was an intern at San Francisco General Hospital when the AIDS epidemic began.

"It is really hard to go back and try to think what it was like when we didn't know what [AIDS] was," she said recently in Fort Lauderdale at the 40th annual conference of the Association for Professionals in Infection Control and Epidemiology (APIC).

"All of my patients were dying," she said. "They had pneumocystis, streptococcal meningitis, they had lymphoma and they were dying and we didn't know it was an infectious disease."

Though that seems hard to believe now, the initial cases were clusters of injecting drug users and homosexual men with no known cause of impaired immunity who developed an opportunistic infection typically seen in the immune compromised called pneumocystis carinii pneumonia. In addition, a number of gay men began developing a previously rare skin cancer called Kaposi's sarcoma. It wasn't

until 1983 that it was determined that HIV – a novel retrovirus that would ultimately be traced back to chimpanzees – was causing the infections.

"At the very beginning of HIV, I was an intern and we were up all night with these deadly viruses around us and we didn't realize that we were potentially at risk ourselves," Gerberding said. "It was also a very sad time. As people caught on to the fact that this was an infectious disease they became very frightened and many stopped providing care. It was not just our patients; it was our hair dressers, our neighbors, our faculty. Everybody in San Francisco was affected by AIDS."

Finding herself at the epicenter of a global outbreak, Gerberding determined she must do something. "You really couldn't train there and not step up," she said.

"I think it was that process of just recognizing that it is what it is and we have to roll up our sleeves and figure out how we are going to cope with it. It made me feel like I needed to do something. I wasn't going to be a lab scientist and I wasn't going to be the person that discovered a vaccine, but there was something I could do to contribute to the solution."

A personal incident galvanized her decision, as she acquired occupational hepatitis B virus right at about the time that the CDC was reassuring health care workers that HIV spreads much like HBV, she said.

"I think it was that personalization of the risk that convinced me that prevention was an area where I wanted to commit my career, and HIV prevention as an occupational infectious disease in the context of a city hospital like San Francisco General that had so many nosocomial infections," Gerberding said. "I just became convinced that my contribution would be in the field of infection prevention."

Gerberding and other first responders to AIDS developed a "we are all in this together" mentality, knowing that they had to act despite a lack of science to guide them.

"In HIV we didn't have the science around what was effective infection control and post-exposure prophylaxis," she said. "We had to use what we did know and adapt that logic and information as we went forward. I think that is something that is just so true about people in APIC. Yes we want to be science based, but when we don't have the science the next thing is to use common sense. It's that practical application of what we do know and some reasonable assumptions about what we don't know that have been part of the HIV legacy and really continue today in all of our infection prevention and public health work." ■

(Continued from p. 90.)

the major safety initiatives — the 100,000 lives campaign, the CMS do-not-pay list — between a third to 50% of the patient safety initiatives included HAI prevention,” Saint said.

Indeed, it has been argued that infection control programs — with their use of standardized definitions, surveillance and benchmarking — are the ideal template for non-infectious patient safety initiatives to emulate. That said, with all the science and evidence-based practices established over the years, there are still dramatic differences between hospitals approaching zero for some HAIs while other facilities struggle to implement basic measures and achieve begrudging compliance.

Some of the key reasons for this discrepancy can be found through implementation science, which studies the difficult task of moving prevention measures from published literature and evidence-based guidelines to actual bedside practice, Saint told APIC attendees.

“What helps moving forward are collaboratives with leadership support, identification of committed champions, IPs and bedside nurses and others using bundles and checklists,” he said. “On the flip side there are barriers to implementing evidence-based practices. We have found that certain individuals are ‘active resisters.’ They do things the way they have always done them. Why? Because it has always been done that way. And it tends to be surgeons and anesthesiologists.”

After the supportive applause for that last comment died down, Saint described the other culprits that prevent or delay implementation of best practices somewhat indelicately as “organizational constipators.”

“These are the mid- to high-level individuals who say the right things at meetings but when push comes to shove they don’t do what they need to do to move things forward,” he said.

HAI prevention in Affordable Care Act

As a possible result of such intractability, more federal regulations are mandating infection control measures and incentivizing

prevention by refusing to pay for preventable infections.

“We had seen a dramatic expansion of federal involvement in HAIs,” said **Arjun Srinivasan**, MD, associate director for Healthcare Associated Infection Prevention Programs at the CDC. “We really started seeing this growing national awareness finally that HAIs were preventable and in fact unacceptable. There was a greater and greater call for government entities to take a more active role in trying to enforce prevention of health care associated infections. We saw the advent of state reporting mandates early in the decade and we saw consumers find their voice on the unacceptable nature of health care associated infections and demand action from the government.”

As a result in 2009 the U.S. Department of Health and Human Services (HHS) developed a sweeping national “Action Plan to Prevent Healthcare-Associated Infections,” which took the unprecedented step of combining the vast resources and expertise of all its member agencies from the CDC to the Centers for Medicare & Medicaid Services.

“That action plan then became the foundation of the inclusion of health care associated infections within the Affordable Care Act (ACA),” Srinivasan said. “So with the passage of the ACA the secretary of the HHS was ordered by Congress and the President to implement the HHS action plan and take concrete steps to prevent HAIs.”

Thus, after 40 years or so, IPs have managed to make a “federal case” out of HAIs, which are now officially targeted for prevention in the new national health care system.

“We’re anticipating the development of pay-for-reporting and pay-for-performance with HAIs,” Srinivasan said. “So I think these major transformative events that have happened in the 2000s have changed the practice of infection prevention forever.”

Another huge driver in all of this has been the unmitigated increase in multidrug resistance pathogens, a situation that has led to infections that are essentially untreatable with current drugs. “If you run out of treatment what’s left? Prevention. So now it is on us,” he said.

As a result, infection prevention could not return to its former place of relative obscurity even if IPs wanted to.

"We are now living in a climate where infection prevention is more difficult to practice than it has ever been before," Srinivasan said. "The number of interested stakeholders, the number of people demanding action — who want to know what we are doing and how we are doing it — is greater than ever before. I would argue that this is the time for us — for infection prevention — to redefine our field and to take up the challenge that has been issued to us."

REFERENCES

1. Haley RW, Culver DH, White JW, et al. The efficacy of infection surveillance and control programs in preventing nosocomial infections in U.S. hospitals. *Am J Epidemiol* 1985;121:182-205.
2. Maki DG, Goldmann DA, Rhame FS. Infection control in intravenous therapy. *Ann Intern Med* 1973;79:867-87.
3. Institute of Medicine Committee on Quality of Health Care in America. *To Err is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 1999. ■

Study: Changing IP role creates job 'tensions'

A fascinating look in the trenches

The changing role of infection preventionists is beset with "tensions" as the demand for data increases and IPs try to enlist other health care workers to achieve the broader aims of infection control and patient safety, a researcher reported recently in Fort Lauderdale at the 40th annual conference of the Association for Professionals in Infection Control and Epidemiology (APIC).

The study included in-depth interviews with IPs, providing a fascinating look into the trenches at a time of transition for infection prevention. Adaptability and persistence are among the traits needed by IPs during this period of change, said **Laurie Conway**, RN, MPhil, CIC, PhD Student at Columbia University School of Nursing in New York City.

"The IP narratives revealed that the IP role is indeed changing," she said. "It is progressive in nature and like many changes it is associated with some friction and some uncertainty and what we called 'tension.'"

Conway and colleagues interviewed 19 IPs at hospitals across the U.S. between October

2010 and February 2011.¹ By design, the hospitals were sampled for maximum variation in size, geographic region, health care associated infection (HAI) rates, and degree of implementation of HAI prevention strategies. Topics in the semi-structured interview guide included the structure and function of the infection control department, personnel and roles, education of clinicians, compliance monitoring, facilitators and barriers to infection prevention, and the impact of technological advances and mandatory reporting. Research team members received training in interview techniques from an expert qualitative researcher and engaged in regular peer debriefings. Two IP researchers conducted a qualitative analysis, systematically reviewing and coding the content of interview transcripts in order to derive contextual meaning. The transcripts were read line by line during an extended period of immersion; agreement on emerging themes was reached through consensus. Ideas shared by multiple IPs, as well as divergent opinions, were coded into categories within the themes and captured in "exemplar" quotations.

The interviews documented that the IP role has evolved in response to recent changes in the healthcare landscape, and revealed that this progression was associated with friction and uncertainty.

Tensions inherent in the evolving role of the IP emerged from the content analysis as four broad themes:

- expanding responsibilities outstrip resources
- shifting role boundaries create uncertainty
- evolving mechanisms of influence involve tradeoffs
- stress of constant change is compounded by chronic recurring challenges

'We're used to a certain autonomy'

IPs reported using personal interaction, data feedback, and education to influence clinical practices, Conway said. However, these mechanisms of influence competed for the IPs' time and were not always effective at ensuring compliance with institutional policies.

"The IPs explained to us that shared accountability for preventing infections is absolutely essential for their work, but it has blurred their role boundaries and to some

degree limited their autonomy," she said.

A comment from one of the interviewed IPs in this area was: *"I believe over the last three years unit ownership and departmental ownership of infection prevention measures has gone up significantly. We always recognize in our department that we're not going to do this by ourselves. It's only with their good collaboration that we're going to make progress in reducing infections."*

On the other hand, "some IPs experienced a little bit of ambivalence about this shift," Conway said. "They described that if everyone is sharing a responsibility it is sometimes difficult to understand where their own responsibility begins and ends."

In that regard, another interviewed IP commented: *"I think infection preventionists are the type of people that are usually self-motivated, they want what's best for the patient, but they tend to be...they like to be in charge of certain things....We're used to a certain autonomy."*

Another IP who worked at an institution where the quality department took control of the hand hygiene program as part of expanding the infection control effort, had mixed emotions, commenting: *"We were sort of offended at first because we felt like hand hygiene was our thing, our thing to teach, our thing to improve."*

Many of the IPs interviewed reported their departments had been subsumed under quality or patient safety departments, Conway said. "They reflected that this was a positive change, however there were two problems that they identified," she said. "One was that they were further removed from key decision makers. The other was that the quality managers to whom they reported didn't always have the clinical expertise to understand infection control issues."

One IP told the researchers, *"The most important thing for infection control is to be not too far from the top. The closer you are to the top, the easier it is to get things done. You put too many layers though and...things get lost in translation."*

Regarding the lack of clinical expertise of their new supervisors one IP bluntly noted, *"Our present COO...is very influenced by this quality department. And they don't speak the language. They don't know what they're talking about."*

As IPs shift or refine their roles from being siloed experts to being facilitators of quality improvement, they are trying to bring colleagues from other areas into the overall mission of infection prevention. "This is a growth experience for them and they are having to develop new skills," Conway said.

In that regard, an IP with more than 20 years' experience said, *"We're used to being very good at making decisions...What we're not as good at is getting everybody else's opinions first. And so we're really trying to drive that down and involve as many frontline people as we can before we make a decision to implement a change."*

The responsibility, not the authority

The mechanisms IPs use to influence clinical practice are evolving, but the primary method remains personal interaction, the researchers found. As one IP put it, *"I think if we hardwire processes, then we will eventually have good outcomes. And to hardwire processes you need to change behaviors. And you need to make people see why it's important and that it's real. And what it means to them, why it's important to them. What's in it for me? And in order to do that, I have to get out of my office and away from the computer, and stop crunching numbers and be out there."*

The demands to collect and disseminate data were often described as "overwhelming" and the variety of reports were often confusing, Conway said. Even so, IPs on balance said that data collection and dissemination was still a key mechanism of influence. One IP said, *"The whole mandatory data gathering...I am learning to live with it because it is extremely important when you see the outcomes that you can achieve because you have good information in front of you and you can kind of put it in people's face. It really does make a difference."*

The fine line between being an educator and an enforcer is also an evolving issue. "One of the most complex challenges was how to operate on the border between being an educator and being an enforcer," Conway said. "It was evident to us that there is an assumption among some IPs that education leads to compliance."

The problem arose when the education did

not lead to compliance and the IPs felt like they didn't have any authority over non-compliant clinicians. An IP with only one year of experience, said "We're given the responsibility...but we really don't have any kind of authority over the staff."

Another told the researchers, "I think that in the past the infection control practitioner was the police, and that's not the direction we are going in anymore, because that's just not getting the job done."

Some combination of the various methods of influence was cited as effective by some IPs, with one stating, "I think between bringing the key players to the table and slowly but surely getting their buy-in; and feeding them back information about the successes that they've had as a team on a frequent basis to keep them motivated; I think those are some of the qualities that have helped me be successful. As opposed to being the disciplinarian for bad outcomes."

Overall, the study found that the IP's role, responsibilities and repertoire are expanding. IPs primarily influence colleagues through personal interaction, feedback of local data, and education.

"They face barriers that include limited resources, uncertain role boundaries, and making necessary tradeoffs between their mechanisms of influence," Conway said. "We also found things that facilitate the IP role are a raised profile and their adaptability and persistence."

REFERENCE

1. Conway LJ, Raveis V, Pogorzelska M, et al. Tensions Inherent in the Evolving Role of the Infection Preventionist: A Qualitative Descriptive Study. Presented at the 40th annual conference of the Association for Professionals in Infection Control and Epidemiology. Fort Lauderdale, FL: June 8-10, 2013. ■

CNE/CME Instructions

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

CNE/CME Objectives

Upon completion of this educational activity, participants should be able to:

- Identify the clinical, legal, or educational issues encountered by infection preventionists and epidemiologists;
- Describe the effect of infection control and prevention issues on nurses, hospitals, or the health care industry in general;
- Cite solutions to the problems encountered by infection preventionists based on guidelines from the relevant regulatory authorities, and/or independent recommendations from clinicians at individual institutions. ■

COMING IN FUTURE MONTHS

■ Meeting the new CMS requirements for endoscopy centers

■ Joint Commission supplement: Part two of our report on surgical site infections

■ The Consumers Union is increasing public awareness of infection prevention

■ As flu season approaches: Time to mandate vaccination at your hospital?

■ HAI reduction provisions in the Affordable Care Act, a leverage point for program support?

CNE/CME Questions

1. **Patti Grant**, RN, BSN, MS, CIC, said the future of infection prevention hinges in large part on:
 - A. labor saving electronic devices to assess compliance
 - B. greater public awareness of the vital role of infection preventionists
 - C. a requirement that hospitals have one IP per 100 beds
 - D. all of the above
2. The landmark Study on the Efficacy of Nosocomial Infection Control (SENIC) project found that hospitals that had which of the following reduced their nosocomial infection rates by approximately 32%:
 - A. appropriate emphasis on surveillance activities and vigorous control efforts
 - B. at least one full-time infection-control practitioner per 250 beds
 - C. a trained hospital epidemiologist
 - D. all of the above
3. According to **Julie Gerberding**, MD, MPH, the prevailing opinion prior to the AIDS epidemic was that the development of antibiotics and vaccines had made infectious diseases a concern of the past.
 - A. True
 - B. False
4. Researcher **Laurie Conway**, RN, CIC found that infection preventionists influence colleagues through which of the following:
 - A. personal interaction
 - B. feedback of local data
 - C. education
 - D. all of the above

EDITORIAL ADVISORY BOARD

Consulting Editor:

Patrick Joseph, MD

Chief of Epidemiology
San Ramon (CA) Regional Medical Center and
President, California Infection Control Consultants
San Ramon

Kay Ball,
RN, PhD, CNOR, FAAN
Perioperative Consultant/
Educator
K&D Medical
Lewis Center, OH

Ona G. Baker Montgomery,
RN, BSN, MSHA, CIC
Infection Control Coordinator
Department of Veterans Affairs
Medical Center
Amarillo, TX

Patti Grant,
RN, BSN, MS, CIC
Director: Infection Prevention/
Quality
Methodist Hospital for Surgery
Addison, TX

William Schaffner, MD
Chairman
Department of
Preventive Medicine
Vanderbilt University
School of Medicine
Nashville, TN

Eddie Hedrick,
BS, MT(ASCP), CIC
Emerging Infections
Coordinator
Disease Investigation Unit
Environmental Health and
Communication Disease
Prevention
Missouri Department of Health
and Senior Services
Jefferson City

Marie Ciacco Tsivitis,
MPH, CIC
Hospital Infections Program
New York State Department
of Health
Albany, NY

Katherine West,
BSN, MEd, CIC
Infection Control Consultant
Infection Control/
Emerging Concepts
Manassas, VA

To reproduce any part of this newsletter for promotional purposes, please contact:

Stephen Vance

Phone: (800) 688-2421, ext. 5511
Fax: (800) 284-3291
Email: stephen.vance@ahcmedia.com

To obtain information and pricing on group discounts, multiple copies, site-licenses, or electronic distribution please contact:

Tria Kreutzer

Phone: (800) 688-2421, ext. 5482
Fax: (800) 284-3291
Email: tria.kreutzer@ahcmedia.com
Address: AHC Media
3525 Piedmont Road, Bldg. 6, Ste. 400,
Atlanta, GA 30305 USA

To reproduce any part of AHC newsletters for educational purposes, please contact:

The Copyright Clearance Center for permission

Email: info@copyright.com
Website: www.copyright.com
Phone: (978) 750-8400
Fax: (978) 646-8600
Address: Copyright Clearance Center
222 Rosewood Drive,
Danvers, MA 01923 USA