A Personal View of Infection Prevention
Prof. Andreas Voss, Radboud University, Netherlands
Broadcast from the Infection Prevention Society conference (www.ips.uk.net)

‘A personal view on infection control’

- We have trouble to communicate
- We have asked for the wrong things
- We did not involve our patients
- We lost the colleagues perspective
- We believe in theory and miss the reality
- We separated MMB-ID-IC
- We ignored behavioural science
- We lack implementation skills
- We re-acted instead of acted
- We did not promote infection control

We have trouble to communicate

Infection control talks are generally rated as “therapeutic” for HCWs with sleeping disorders.

Semmelweis

Semmelweis was the first to prove that hand-washing alone is not sufficient.

&

... the first to prove that IC can’t communicate!

Please dear colleague
disinfect your hands
to effectively save your patients’ life.

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Not speaking the same language?

While – as in your case – clinicians and members of the ICT both speak English, it seems like we do not get our message across.

Guidelines as our way to communicate

What do HCWs think about guidelines

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...luckily both groups agree on one thing...

Infection Control don’t know what they are doing

Are your guidelines to the point?

Are you really consequent...

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Guidelines do not free you from thinking about what you should do ...

Conclusion: Communication

- The training of ICPs and MDs (at least in my country) does not include:
  - Communication
  - Behavioural science
  - Cognitive sociology
  - Implementation strategies
  - Change management

Education needed!

Asking for too much and for the wrong things

IC = asking HCWs to keep the speed limit

Easy during school hours!

Less easy at midnight with no one around

Monitoring

Single control
Continuous control

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New ways of monitoring in healthcare

What is the problem?

If hospital bugs would look like this - compliance with hand hygiene would be 100%

Only implement needed rules ...

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... and ensure that they are correct

Infection Control Teams

“Size matters”

ICT a la SENIC

Patient Safety – friend or foe

The SENIC standard is completely out-dated!

Patient safety departments quickly arise in many hospitals –

❖ with bigger budgets
❖ larger amount of people
❖ partly overlapping tasks

Our bike looks more like this ...

Infection Control Team

If you can’t beat them, join them/cooperate

❖ Cooperate where possible
❖ Ensure secretarial and data-management support
❖ Focus the ICP’s work to what you need an ICP for
❖ Use techs and/or ICT for data collection
❖ Shed non-IC tasks
❖ Pick the moment to ask for changes in structure
❖ straight after the outbreak
❖ Watch out, don’t over-ask
Do you need what you want?

Not involving our patients

Should we involve our patients?

While I used to be against it …

- and agree with those who say that patients should not be responsible for their own safety
- … we should look for new ways of involving patients
- Now would be the time to present such an idea but I never had it – hope you do!
  - Change their expectations – through the media

Lost our customer’s perspective

Keep your customer in mind

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Change your expectations!
- Do you expect your clinical colleagues to know all your guidelines?
- Assuming that most of you silently answered the question with “yes”...
- Do you find yourself looking-up your own guidelines to know what to advice?

Prioritize your guidelines

Try to see “their” need

Meet your new surgical team

Incidence of SSI associated with robotic surgery
Three possible reasons (2 according to authors, 1 according to me):
- Learning curve associated with the use of the robot
- Increased time of the operations with new technique
- Possible problems with cleaning & sterilization
- Presence of accumulated organic debris on robot arm cables

Use new techniques or not?
- Central sterilization considers cleaning and sterilization “unsafe”
- Surgeons/urologists consider it an advance in their possibilities (and a great toy)
- Hospital spent millions on the robot and 10K for the instrument-arms (good for 10 go’s)
- What to do?
  - Not allow the robot
  - Use arms as disposables
  - Allow but watch and check re-processing closely

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Incidence of SSI associated with robotic Surgery
- Third not-mentioned complication

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Conclusion
Keep your customer’s view in mind ..

Implementa& use of guidelines

100% Target audience
80% Heard about it
50% Seen it
30% Got it/bought it
20% Used it
5% Used it as intended

Nasal decolonization

Bode et al. NEJM 2010, January 7th
**S. aureus decolonization**

Very few Dutch hospitals have implemented the intervention as described in the publication
- some never implemented the intervention
- many stopped screening and started treating every patient

Non-implementation or not according to protocol is not an exception but a frequent event

**Hospital Cleaning**

Who is cleaning this in your hospital?
- Roomservice
- House keeping
- Registered nurse
- Nurse-assistent
- Cleaning

Vacant responsibility

**Separation MMB-ID-IC**

**Difference – theory vs reality**

**Outsourcing of Clinical Micro**

- One of the factors of success of CM/ID/IC was the integration within the hospitals
  - We are colleagues & advisors that help with all aspects of infections
- Outsourcing of CM is putting this elementary “trias” at risk
  - “Distance microbiology” is difficult
  - “Distance infection control” is impossible

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Ignoring behavioral science

Dangerous micro-organism: MRMS

MRMS
- Resistant to good advice
- Allergic to (professional) guidelines
- Non-compliant with IC measures
- Blind to HAI (especially their own)
- Other priorities

Behaviour

While we wish to make the most thoughtful, fully considered decision possible ... we frequently resort to comply on basis of a single piece of information (trigger)

Reaction to single piece of information

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The Broken Windows Theory
- Signs of chaos and disorder lead to “unwanted behavior”
- Chaos spreads...
- When we see others ignoring rules and guidelines we tend to do the same!

www.sciencexpress.org / 20 November 2008 / Page 1 / 10.1126/science.1161405

The Spreading of Disorder
We need “order” in our hospitals and people showing appropriate behavior!

How to change HCWs behavior?
- “People are willing to change if they feel: good, flattered, powerful or sexy”
- not when they are bombarded with facts

Hodgkin 1999

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Gimme an Rx!
Cheerleaders Pop Up Drug Sales
Onya, the Redskins cheerer (who asked that her last name be withheld, citing team policy), has her picture on the team’s Web site in her official bikini-like uniform and also reclining in an actual bikini. Onya, 27, who declined to identify the company she works for, is but one of several drug representatives who have cheered for the Redskins

Infection Control Team in my hospital
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Re-act instead of acting

- Understaffing, outbreaks, (re-)emerging threats, increasing surveillance and data collection for patient safety/insurances → prioritizing of work
- Re-acting instead of acting is less of a choice than a must ...

Are we so used to re-act that we can’t act anymore?

Better promote IC

Better advertisement
“For the little things you forget”

Hand hygiene campaigne

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Don’t get the wrong idea!

You, your society, we all do a great job, actually bending backwards for patient’s safety, but we can still improve...

They old measures work!

Hand hygiene
With bed-side dispensers and pocket-bottles any excuse to not reach out for the alcohol handrub is gone. Thus, … “Just do it!”
Furthermore, hand hygiene should be seen as only one of the classical preventive measures all of which deserve our attention and HCW’s compliance.

Surveillance

HAI-surveillance
Internal quality versus public reporting.
Reporting real HAI rates (e.g. VAP) instead of low public rates and creating new diseases such as ventilator-associated tracheobronchitis

GI Infections

GI-tract infections
Increasing rates of C. difficile and norovirus. With regard to norovirus: impact on the patient outcome as well as the overall possibility to deliver care is frequently underestimated
The unnecessary and wrong use of antibiotics needs to stop. In the light of the emergence of MDR-m.o. we can not afford to booster the trend by selecting more resistance and waste the limited antimicrobials we have during indications that need no or other antibiotics.

**Control of antibiotic use**

Fighting community and zoonotic pathogens

CA-MRSA, LA-MRSA, NDM-1 & Co. Emerging pathogens and mobile transmissible elements through the food-chain/bio-industry or from travellers to countries with poor sanitation will be a major challenge to infection control.

**Integration of Healthcare**

Influencing public and political expectations

YES to “zero tolerance” but NO to zero infections! Zero HAIs is impossible unless one reports a “median” after looking for the right stretch of time. This gives consumers a completely wrong picture and encourages politicians & insurance companies to come up with unwanted rules.

**Hospital-structure**

Outsourcing of clinical microbiology and infectious diseases services are contra-productive to what makes Infection Control work in countries like the NL: direct accessibility and integration (within the healthcare setting) of all infectious diseases services.

**Commerce**

Up-hold and improve hospital structure and “HCW to patient ratio’s” to allow infection control measures to be applied, and improve hospital design to allow optimal workflow.

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Why do healthcare workers believe that if they adhere to 70% of the rules that they are doing an outstanding job? In other industries that is a reason to get fired!

Final wisdom of behavioral science

“Before you criticize someone you should walk a mile in their shoes ...”

... that way, if he gets angry, he’ll be a mile away, and you have their shoes “

Homer Simpson

Thank you very much for Inviting me to give this precious lecture!