Being Heard: The IP and Organizational Structure
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Centers for Disease Control and Prevention

Objectives

• Identify attributes of a healthful workplace environment
• Discuss collaboration to build infection prevention competency
• Identify methods of communication that inspire change

No financial disclosures
Organizational Culture

- There is a need to understand organizational culture and change it when it hinders performance.
- Direct evidence linking leadership to infection rates is limited but consistent themes have been identified.

Leadership traits that may assist in preventing infections:
- Proactive
- Positive
- Visible
- Supportive of Change
- Clear Responsibilities
- Clear Policies

Leadership traits that may be associated with risk:
- Reactive
- Laissez Faire Management Style
- Failure to assign responsibility/maintain accountability
- Wide Span of Control

Barriers to Change: Capacity

Capacity may be affected by complex management issues:

- Nurse to patient staffing ratios have been inversely associated with healthcare associated infections (UTI and SSI).
- Inpatient wards with occupancy rates of 80-89.9% had CDI rates that were 56% higher than baseline occupancy rates (0-69%).
- Stress and chaos may be associated with poorer infection prevention practices.

Strong leadership at the unit level and above is likely a prerequisite to infection prevention improvements.

2. Griffiths et al., J Hosp. Inf. (2009) 73, 1e14
3. Sinkowitz-Cochran et al., AJIC, 2012; 40, 138-143
4. Ahyow et al., ICHE, 2013 34 1062-1069
5. Ciomatti et al, AJIC 2012, 40; 486-490
7. Sinkowitz-Cochran et al., AJIC, 2012; 40, 138-143
10. Sinkowitz-Cochran et al., AJIC, 2012; 40, 138-143
### Shifting Boundaries and Role Uncertainty

- The IP must be able to influence operations regardless of his/her formal title or placement within the hierarchy

- Changes in Accountability for HAI
  - Personnel at the unit level “own” the data
  - Increasing engagement of hospital executives
  - Linking reductions in HAI to personnel evaluations and bonuses

- IP Departments subsumed by the Quality Department
  - Layers between IP and Senior Leaders
  - Differing vocabularies
  - Differences in formal titles may influence meeting invitations, visibility, and a seat at the decision making table

### Recognizing Inappropriate Roles:

**An Infection Prevention Action Plan**

<table>
<thead>
<tr>
<th>Opportunity for Improvement</th>
<th>Risk Reduction Strategies</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enforce procedures to ensure all who enter the unit are free from symptomatic illness</td>
<td>Re-educate ancillary staff on the importance of maintaining contact isolation at the bedside</td>
<td>Manager, Infection Prevention Unit Manager</td>
</tr>
<tr>
<td>Ensure ongoing staff competencies specific to the unit</td>
<td>Annual cleaning competence including relocation of the cleaning area</td>
<td>Clinical Educator, Unit Manager</td>
</tr>
<tr>
<td>Implement evidence based care</td>
<td>Create order set for blood and stool cultures and isolation, Restructure nursing care review and revise cleaning practices</td>
<td>Medical Director, Care Coordinator, Unit Manager, Service Line Director</td>
</tr>
<tr>
<td>Minimize contamination in environment of care</td>
<td>Add manufacturer recommendations for cleaning to the policy and procedure web site</td>
<td>Manager Environmental Services, Risk Management</td>
</tr>
<tr>
<td>Ongoing surveillance and reporting</td>
<td>Continue active surveillance</td>
<td>CMO</td>
</tr>
</tbody>
</table>

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Appropriate Roles and Responsibilities for the Infection Preventionist

<table>
<thead>
<tr>
<th>Role or responsibility</th>
<th>Example of personnel to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project coordinator</td>
<td>Infection prevention, quality manager, nurse manager</td>
</tr>
<tr>
<td>* Nurse champion</td>
<td>Nurse manager, charge nurse, staff nurse</td>
</tr>
<tr>
<td>Nurse educator</td>
<td>CNS/nurse educator</td>
</tr>
<tr>
<td>Nurse policy/procedure liaison</td>
<td>Nurse executive</td>
</tr>
<tr>
<td>Medical/physician content expert or opinion leader</td>
<td>Urologist, ID physician, hospital epidemiologist</td>
</tr>
<tr>
<td>* Physician champion</td>
<td>Hospitalist, hospital epidemiologist</td>
</tr>
<tr>
<td>Medical staff policy/executive board liaison</td>
<td>Chief of medicine/chief of staff</td>
</tr>
<tr>
<td>Physician education</td>
<td></td>
</tr>
<tr>
<td>Assessment and Evaluation</td>
<td>Quality improvement/Utilization management/infection prevention</td>
</tr>
</tbody>
</table>

Roles with an * are required.

Workplace Incivility, Bullying, and Violence

“It is important first to recognize the existence of harmful actions taken and not taken in the workplace in order to eliminate them.”

Mobbing may occur when groups strive to maintain mediocrity and compliance with the status quo

The establishment of positive, respectful relationships is crucial to preventing incivility, bullying and workplace violence

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A Healthy Work Environment

American Association of Critical Care Nurses standards for a healthy work environment are interdependent and influence Clinical Excellence and Optimal Patient Outcomes

- True Collaboration
- Skilled Communication
- Authentic Leadership
- Meaningful Recognition
- Appropriate Staffing
- Effective Decision Making

American Association of Critical Care Nurses (AACN), 2004

Collaboration Defined

- Main Entry: col·lab·o·rate
- Pronunciation: \kə-la-bə-rāt\ 
- Function: intransitive verb

Inflected Form(s): col·lab·o·rat·ed; col·lab·o·rat·ing

Etymology: Late Latin collaboratus, past participle of collaborare to labor together, from Latin com- + laborare to labor

Date: 1871

1 : to work jointly with others or together especially in an intellectual endeavor
2 : to cooperate with an agency or instrumentality with which one is not immediately connected
Characteristics of True Collaboration

- Every team member acts with a high level of personal integrity
- Team members are competent appropriate to their roles
- Nurse Managers and Medical Directors are equal partners in fostering collaboration

“Cooperation is when we get along, collaboration is when we use our uniqueness to make something great.”
A fourth grade student

Collaborative Prevention Models

- Diverse Healthcare Associated Infections in diverse settings have responded to interventions introduced through collaborative models

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Year Initiative Ended</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Surgical Infection Prevention Collaborative</td>
<td>2003</td>
<td>27% decrease in SSI$^1$</td>
</tr>
<tr>
<td>Michigan Keystone Project (ICU)</td>
<td>2005</td>
<td>66% Reduction in CLABSI$^2$</td>
</tr>
<tr>
<td>IHI 100,000 Lives Campaign</td>
<td>2006</td>
<td>Galvanized Efforts to Prevent Harm$^3$</td>
</tr>
<tr>
<td>NY State NICU CLABSI Prevention</td>
<td>2007</td>
<td>25% decrease in CLABSI$^4$</td>
</tr>
<tr>
<td>Dialysis BSI Prevention Collaborative</td>
<td>2011</td>
<td>32% decrease in BSI$^5$</td>
</tr>
<tr>
<td>Wake Up and Breathe Collaborative</td>
<td>2013</td>
<td>54% decrease in access infections</td>
</tr>
</tbody>
</table>

Collaboration is Additive

Themes identified from 5 Regional Collaboratives include:

1. Fosters Change
2. Standardizes Processes, Messages and Metrics
3. Encourages Local Focused Implementation
4. Engages Frontline Staff
5. Assists Organizational Learning
6. Provides Support, Resources and Accountability
7. Ensures Feedback and Reinforcement

Collaboration Spans the Care Continuum

Public Health led coordinated prevention approaches have the potential to more completely address the emergence and dissemination of antibiotic resistant organisms and CDI than facility based approaches.

Facilities work together to protect patients.

Collaboration is Additive and Organizational Structure

Janet Glowicz, Centers for Disease Control, Atlanta

Broadcast live from APIC 2016 conference (www.apic.org)
Skilled Communication Inspires Change

Skilled communicators:

- focus on finding solutions
- protect and advance collaboration
- invite and hear all relevant perspectives
- call upon good will and mutual respect
- demonstrate congruence between words and actions

Skilled Communication

• Question from the urologist:
  – Can I flush the ureteroscope with betadine immediately before a procedure instead of reprocessing it?

  The correct response is:
  "This facility does not vary from manufacturer’s instructions for use without formal written communication of updated, FDA approved processes."

  This call resulted in the purchase of additional instruments.
Communicating to Inspire Change: SBAR

**Improving Ultrasound Probe Disinfection**

**Situation**
Ultrasound probes are currently disinfected in the patient exam room. This room lacks appropriate ventilation per OSHA standards.

**Background**
Intra-cavity Ultrasound Probes require High Level Disinfection between each use.

**Assessment**
Patient and Employee safety is compromised by the lack of ventilation and mixing of clean and dirty areas.

**Recommendation**
Purchasing a system that obtains compliance with regulatory bodies as soon as possible is recommended. Cost: $21,840 – Construction: Wall Mounting


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Communicating with Constipators: When Leaders Don’t Want to Move

Recognizing the role of Active Resistors and Organizational Constipators in hindering performance can help overcome barriers.

<table>
<thead>
<tr>
<th>Type of Personnel</th>
<th>Source of Barrier</th>
<th>Engagement Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Resistors</td>
<td>• Culture or behavior is entrenched • Disregard recommendations from competing authorities</td>
<td>1. Data feedback of infection rates 2. Data feedback of compliance rates 3. Collaboration in initiatives that align leadership and clinician goals to reduce harm 4. Effective championing by a respected individual</td>
</tr>
<tr>
<td>Mid to Senior Level managers</td>
<td>• Insidious barriers to change • Maintain control and create extra work that makes change difficult to accomplish</td>
<td>1. Engage the individual early in the initiative 2. Work around the individual • Provide every opportunity to improve or comply • Utilize external partners 3. Termination is sometimes needed to bring change</td>
</tr>
</tbody>
</table>

Communicating Routine Bad News

Everyday feedback

- Less than optimal
- NOT disclosure of an adverse event
- May be considered impolite
- Necessary to avoid
  - Problematic
  - Severely negative feedback episodes

- Strategic delivery
  - Can preserve solidarity and teamwork among personnel
  - Can reduce threats to autonomy and competence
  - Assists personnel in moderating actions to improve performance

Wagner & Waldron S Comm Journal, 1999; 64: 199-210

Communicating Routine Feedback

Cochrane Reviewers Findings on Feedback:
- Most effective when performance is less than optimal
- Person responsible for feedback is a supervisor or colleague
- Is provided more than once
- Is provided verbally and in writing
- Includes clear targets and an action plan

Ivers et al. Cochrane Library, 2012;1
Figure from: Asadat et al. Avicenna J Med, 2012:4

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Targeted Assessment for Prevention (TAP) Strategy

- Target facilities/units with high burden/excess of HAIs
- Assess gaps in infection prevention in targeted facilities/units
- Prevent infections by implementing interventions to address the gaps

Linear progression framework for quality improvement

Benefits of TAP Strategy

- TAP allows you to:
  - Take a focused approach to prevention
  - Map excess HAIs to targeted locations
  - Have a concrete prevention goal (CAD) linked to the SIR
  - Identify specific gaps through a standardized assessment
  - Customize strategies to address gaps

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Appropriate Use of TAP Data

The Standardized Infection Ratio (SIR) is used for comparison
Used to compare performance over time, adjusted for exposure

The Cumulative Attributable Difference (CAD) is used for prioritization
Snapshot of the number of infections which if prevented would result in goal attainment

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>Calculation</th>
<th>Purpose</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIR</td>
<td>A risk adjusted summary measure used to track trends over time. The SIR is a ratio of the actual number of MDs reported to the predicted number, adjusted for facility and unit characteristics. A SIR &lt; 1.0 indicates fewer MDs were observed than predicted, whereas an SIR &gt; 1.0 indicates more MDs were observed than predicted.</td>
<td>SIR = Observed / Predicted</td>
<td>Used as a comparative metric that adjusts for differences in incidence among risk exposure categories (e.g., unit types, bed size, tracking status, facility types).</td>
<td>SIRs will not be calculated in NASS when the predicted number of infections is &lt; 1.0 specifying a longer time period may provide enough data to generate an SIR.</td>
</tr>
<tr>
<td>CAD</td>
<td>The CAD is the difference between the actual number of MDs reported and the predicted number adjusted for facility and unit characteristics. When the predicted number of infections is multiplied by a goal SIR, the CAD calculation gives the number of infections that would be prevented to achieve that goal, assuming the same exposures over the same time period. A CAD &gt; 0 indicates fewer infections than predicted, whereas a CAD = 0 indicates fewer infections than predicted.</td>
<td>CAD = Observed - (Predicted * SIR)</td>
<td>Used as a prioritization metric to identify the facilities and units with the highest burden of excess infections. Targeting these locations will yield the greatest impact on MD prevention.</td>
<td>Because the CAD is influenced by exposure VCV (i.e., a larger hospital with many patient days will likely have a higher CAD than a smaller hospital). It should not be used as a metric to compare performance of units or facilities.</td>
</tr>
</tbody>
</table>


The TAP Report

Each facility that has conferred rights to the group will be included on the TAP Report for Group Users.

No. of pathogens outside the perimeters represents total no. of pathogens reported. Only most common pathogen types are presented in perimeters, and some events may have > 1 type of pathogens.

Facility Name | Facility Type | State | Type of Infection | Number of Infectious | Location (L. W.) | Events (L. W.) | CAD | SIR |
--- | --- | --- | --- | --- | --- | --- | --- | --- |
1 | PHIF | GA | T | 63 | (81.1) | 1200.1 | 1607 | 100.7 | 5.7 (5.1-6.4) | 1.2 | 0.9 | 0.8 | 1.0 |
2 | 2977 | MMH | GA | T | 1 (1.1) | 0.0 | 0 | 0 | 0 | 0 | 0 | 0 |

Data table will be the same for all facilities reporting, except for facility name and state. SIR will be the same for all facilities reporting, except for facility name, state, and year.

The TAP Report


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The tradition of collaboration among Wisconsin hospitals is a proven method for improving healthcare quality, and DPH strongly encourages your facility to participate in one of the collaborative HAI reduction groups led by [the hospital association or the quality improvement organization].
Focused Assessment

TAP Assessments are meant to capture awareness of polices and processes at the facility or unit.

Include frontline providers, mid-level staff and senior leadership.

Examples of 2 Domains Within the CDI Assessment Tool

The greater number of assessments collected, the greater the ability to identify gaps and target prevention.

Align Interventions to Needs

- CAUTI and CDI Implementation Guides

Communicate, Collaborate, Coordinate

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In Summary

Reporting is Required

- Does not teach prevention measures
- Informs need for collaboration and communication

• Collaboration and Skilled Communication Build Credibility
  – Choose projects carefully and participate fully
  – Avoid fatigue by engaging collaborators
    – Encourage unit managers to participate in collaboratives
    – Create standing Infection Prevention Agenda Items for members of collaboratives


Thank you!

Questions?

For more information please contact Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333
Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov  Web: www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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June 16  STRATEGIES TO REDUCE SKIN INJURY IN CRITICALLY ILL PATIENTS
Kathleen M. Vollman, Advanced Nursing LLC

June 23  EXPLORING THE ROLE OF ENVIRONMENTAL SURFACES IN OCCUPATIONAL INFECTION PREVENTION
Dr. Amber Mitchell, International Safety Center, and Barbara DeBaun, Cynosure Health

June 29  (South Pacific Teleclass)
SHARPS INJURY PREVENTION
Dr. Terry Grimmond, Grimmond & Associates Ltd., New Zealand

July 14  RESULTS OF QUALITATIVE RESEARCH ON IMPLEMENTATION OF INFECTION CONTROL BEST PRACTICES IN EUROPEAN HOSPITALS
Dr. Hugo Sax, University Hospital Zurich, Switzerland

July 21  BEHAVIOURAL AND ORGANIZATIONAL DETERMINANTS OF SUCCESSFUL INFECTION PREVENTION AND CONTROL INTERVENTIONS
Dr. Enrique Castro-Sánchez, Imperial College London, England

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