AJIC commentary

Staffing and structure of infection prevention and control programs

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The results of the *Prevention of Nosocomial Infections and Cost Effectiveness Analysis*, phase 1, published by Pat Stone et al in this issue of the *AJIC*, describes the current state of infection prevention and control (IPC) practice in US acute care hospitals. Using activities categorized by the Certification Board for Infection Control's 2008 practice analysis, the study reports on the fundamental work and typical responsibilities of over 800 infection preventionists (IP). Yet, in reality, nothing about today's IPC program leader is typical, as Stone and her colleagues observed. We have a broader scope of practice and responsibility than ever before. The environment in which we work demands a nimble, flexible response to a rapidly changing health care system, and we find ourselves pulled in many directions. Staying focused on the core business and mission of improving patient safety through elimination of health care-associated infections (HAI) is a daily challenge.

Leadership competencies, principles of management, and performance measurement and improvement skills are critical program elements. A benefit of being an APIC volunteer leader is receiving professional development and leadership training, skills that can be applied in all aspects of our work. In the 7 Measures of Success,[1] a book that APIC Board and committee chairs were asked to read, the authors describe the most successful organizations and leaders as ''those who can preserve the core (business) while stimulating progress in reponse to a changing environment.''

The changing environment is quite obvious and easy to articulate. We know there is increasing consumer awareness and media influence, regulatory agencies and legislators dictating IPC practice, and burgeoning ''experts'' in what has traditionally been 'our' scope of practice. All of these things may be seen as double-edged swords, making the importance of our work more visible while at the same time increasing demands and performance expectations.

However, to preserve our core, we must agree on what the *core* of infection prevention and control includes in 2009. Certainly, the roles and responsibilities (and inferred competencies) outlined in the Staffing and Structure of IPC Programs Report are the foundation. Surveillance, data management (collection, organizing, analysis, reporting), education, and controlling the spread of infection will always be fundamentals of IPC practice. Now, using data to drive improvement requires expertise to facilitate the redesign, implementation, and *sustainment* of safer and more reliable patient care practices. Developing these competencies will no longer be optional but critical to the success of an IP and their program. Competition for resources is so fierce that the art of negotiation and conflict resolution must be added to our skill set as well. We used to be somewhat safe from budget cuts because, as specialists, our knowledge of surveillance, statistics, standards, and regulatory requirements was invaluable. Now, other quality, compliance, and data management experts can weigh in on some of the areas that were exclusively ours. It seems that experts willing to expand scope and develop more general competencies have become more valuable to executive teams. And IPs have the potential to be both specialist and generalist. This is not to imply that we can turn away from the core business; instead, we are challenged to expand it without losing our content expertise in IPC.

In order to expand the scope of already overstretched IPs, our practice must include a process for selection and prioritization of projects and a routine deselection exercise (ie, create a ''stop doing'' list). Not taking these steps may leave us doing what we've always done—and getting the same result: no time to work on improving practices that prevent HAIs.

The breakdown of teamwork and communication is reported as the primary root cause of adverse events

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that harm patients.[2] As patient safety officers, IPs must also be able to influence health care teams to adopt and sustain safe practices through effective teamwork and communication. The study of human factors can also aid us in better understanding people and their tools in the environment in which they work. Learning from other disciplines that can help us drive consistently safe behaviors to the bedside can only benefit our own effectiveness as program leaders.

The American Society of Association Executives (ASAE) measure of success project challenges leaders to focus on the core and experiment around the edges, and IPs have many edges to cover. The Center for Associated Leadership encourages leaders who want to be not just good or even great, but *remarkable* to:

- Keep eyes and minds wide open. Services and work should emanate from 2 places, the mission and the customers' needs.
- Develop and foster a strong customer service culture.
- Keep the balance. Remain firm about the what (your mission) and flexible about the how (your products and services).
- Clean your plate! As you add new services, eliminate those that no longer serve a need. Have only 1 ''sacred cow''—your mission.
- Seek to influence, not control. A leader's job is to facilitate visionary thinking and be a broker of ideas, not to force others to adopt his or her vision.
- Be secure and confident enough to seek partners and projects that complement your mission and vision (or purpose).
- Communicate results broadly, with candor and respect.
- Foster change in areas identified by the data as problematic.
- Remain humble. You don't know it all. The best source of information about what people need are the people themselves. Seek out their views in a variety of ways.
- Be a good neighbor. Seek out and foster relationships with partners that may not share your overall mission but do share your desire to accomplish certain goals.

As we review the current state of IPC documented in Stone's article, and realize where we must go next in order to remain effective as program leaders, let's continue to keep APIC and *AJIC* at the top of our list of leadership development resources.

References

1. Center for Association Leadership. 7 Measures of success: what remarkable associations do that others don't. 1st ed. Washington, DC: American Society of Association Executives; 2006.
2. World Health Organization (Switz). Patient safety solutions. Volume 1, solution 3. Geneva: WHO; May 2007.