Welcome to Unit 2, Part I. This lecture will focus on Infection Control Personnel, Management and Program Issues. Before reviewing these slides, please be sure to have access to the Accompanying Materials packet for this section. Each item will be referred to in the lecture notes at the appropriate time.

The positions in an infection control program, from a Human Resources perspective, usually consist of one or more infection control practitioners, a hospital epidemiologist, a secretarial or clerical support position and computer support in the form of a person or physical system. (In the first unit, you learned about Category I, II, & III recommendations from regarding personnel and non-personnel resources). Note that for infection control professionals, the recommendation is to have “one or more”. In 1969, the CDC recommended (and the SENIC project strongly supported this) one full-time IP for every 250 occupied beds. Because this recommendation is very old, staffing recommendations have been updated and the demands on a IP’s time have been increased. In 2002, APIC initiated a Delphi project on the staffing needs for IPs. In this project, they noted that staffing considerations must take into account the number of occupied beds, the scope of the IC program, complexity of the healthcare facility, patient population, and needs of the facility. The result was a median of one (1.0) IP for every 100 occupied care beds in an acute care setting. Existing recommendations regarding the appropriate staffing needs of IPs are incomplete or outdated. Many recommendations were made before the reorganization of healthcare delivery and new demands on infection preventionist roles. The context of healthcare has changed, resulting in changes to the roles and responsibilities of IPs. This is an area where more research is warranted.

The titles for persons who practice infection prevention and control activities have evolved from infection control practitioners (ICPs) to infection control professionals, and most recently, the term has changed to Infection Preventionists or IPs. You may hear any of these terms in relation to infection control personnel, depending upon the dates of the materials you review. An Infection Preventionist is uniquely positioned to prevent infection by connecting the science of infection prevention to the people most deeply and personally affected—patients, visitors, volunteers, employees and healthcare workers. An Infection Preventionist can be found in a variety of healthcare settings, including: Hospitals, Long-term Care, Ambulatory Care, Acute Care, Home Care, Hospices, Public Health, Behavioral Health, Emergency Preparedness, and more. Titles used by IPs include infection control nurse, infection control coordinator, nurse epidemiologist, infection control officer, infection control practitioner, and infection control professional. The IP predominantly has backgrounds in nursing, medical technology, microbiology or public health. Depending upon the institution, IC professionals may report to administration, nursing, medical services, or quality improvement/performance improvement departments. It is also possible for IC to be integrated within risk management,
utilization management or quality improvement services. In 2012, APIC published a Competency Model for the Infection Preventionist. The model is on this slide. The foundational elements (in the center) are centrally positioned to reinforce the significance of patient safety, professional standards, and the Certification Board of Infection Control and Epidemiology (CBIC) core competencies. The green areas indicate critical competencies required for the expanding IP role: Four specific, future-oriented domains radiate outward from the center and include: (1) technical, (2) leadership and program management, (3) infection prevention and control, and (4) performance improvement/implementation science. Finally, 3 career stages are outlined: 1) Early (Novice), 2) Middle (Proficient) and 3) Advanced (Expert). (source: http://www.apic.org/Resources/TinyMceFileManager/epublications/IP_Comp_article_PS1202.pdf)

There are some IPs who, because of the size of the facility or other demands on their time, work less than full-time in infection prevention and control programs. There are some IPs who work in other areas in addition to infection control, including Employee Health, Quality Management or Performance Improvement, or Risk Management. Some may also work in Education. An example of an area where someone may have infection control responsibilities in addition to other roles would be in a non-acute care facility, such as a long-term care facility. In this situation, there will probably not be enough resources to have one full-time employee dedicated to infection control. The person in that role would most likely have numerous other job responsibilities which could include those previously listed as well as: safety, credentialing & licensure of staff, and/or patient/staff education.

Often the core of the IC program consists of the infection preventionist (IP), the chair of the IC Committee, and the hospital epidemiologist. The team is responsible for carrying out all aspects of the IC program. There should be one person, however, who is designated as having responsibility for the program. Team members must be qualified and guided by sound principles and current information. For example, in regard to a system of isolation/precautions, the facility should either adapt existing guidelines from the Centers for Disease Control & Prevention OR develop a hybrid system. If the latter is selected, the system should be based on the most updated information on the modes of transmission as well as patient and facility demographics and characteristics.
Each institution is unique, and its specific needs must be considered when developing or reorganizing an IC program. Factors include size, case-mix, and types of care provided (services, types of surgeries, etc.). Because of the differing needs of healthcare facilities, there may be various groups, individuals, and functions within the organization that are responsible for the IC program. It is essential that the IC program is designed to meet these unique facility needs. For example, the hospital I worked at in California from 1986-2000 was a county hospital. There was a very diverse patient population. There were three predominant languages that covered the majority of the patient population: English, Spanish and Vietnamese. Thus, we designed our isolation signs to be written in those 3 languages and this was an example of designing an IC program based on the patient population.

We will now discuss seven different issues related to Infection Control Committees: Purpose, Authority, Reporting, Membership & Roles, Meetings, Committee Functions, Dissemination of Information, and Review of Activities. In item #1 of the Accompanying Materials, please see an example a policy outlining the authority of the infection control committee from a hospital in Connecticut. Please review this and note especially the charge (#1) and authority (#2) for this committee. (Note: The Infection Control Committee, along with the nomenclature change of the profession, is now being referred to as an Infection Prevention Committee or IPC)

If a facility does have an Infection Control or Infection Prevention Committee, it serves several purposes. First, the Infection Control Program in a facility may have an infection control committee (ICC or IPC) that functions as the central decision-making and policy-making body for Infection Control. The ICC acts as the advocate for the prevention and control of infections in the facility, formulates and monitors patient care policies, and educates staff. If a committee is not used, the IC team needs to develop other mechanisms to obtain multi-disciplinary support for changes and actions. This might include using a larger committee as the forum (e.g., Safety, Performance Improvement). Another option would be to construct multi-disciplinary teams that meet regularly, and are responsible for planning, policy development, interventions, and decision-making in relation to Infection Control. The team leader could be an Infection Preventionist (IP). If you have not done so by now, you should review the 2nd Required Reading set for this part, examples of a poster and handout on an effective infection control committee, presented at a National APIC meeting.

The hierarchy of authority defines “who” reports to “whom”, and the areas of responsibilities of its employees. When discussing the authority of the infection control committee, we need to take a small side step to describe some organizational principles. A “tall” organization is one that has many levels of authority, while a “flat” organization has fewer levels.
Organizational structure involves, in addition to task organizational boundary considerations, the designation of jobs within an organization and the relationships among those jobs. There are numerous ways to structure jobs within an organization, but two of the most basic forms include simple line structures and line-and-staff structures. The line-and-staff organization combines the line organization with staff departments that support and advise line departments. Most medium and large-sized firms exhibit line-and-staff organizational structures. The distinguishing characteristic between simple line organizations and line-and-staff organizations is the multiple layers of management within line-and-staff organizations. On this slide is an example of a line-and-staff organizational chart. Staff positions are designated by broken lines and line positions by solid lines.

**Slide 11**

<table>
<thead>
<tr>
<th>Line Positions</th>
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<tbody>
<tr>
<td>• Directly responsible for the creation &amp; delivery of products &amp; services</td>
</tr>
<tr>
<td>• Carry decision-making responsibility</td>
</tr>
<tr>
<td>• Include those who create &amp; deliver &amp; those who manage the creation &amp; delivery</td>
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A wide variety of positions exist within a line-and-staff organization. Some positions are primary to the company's mission, whereas others are secondary—in the form of support and indirect contribution. Although positions within a line-and-staff organization can be differentiated in several ways, the simplest approach classifies them as being either line or staff. A line position is directly involved in the day-to-day operations of the organization, such as producing or selling a product or service. Line positions are occupied by line personnel and line managers. Line personnel carry out the primary activities of a business and are considered essential to the basic functioning of the organization. Line managers make the majority of the decisions and direct line personnel to achieve company goals. An example of a line manager is a marketing executive. Although a marketing executive does not actually produce the product or service, he or she directly contributes to the firm's overall objectives through market forecasting and generating product or service demand. Therefore, line positions, whether they are personnel or managers, engage in activities that are functionally and directly related to the principal workflow of an organization.

**Slide 12**

<table>
<thead>
<tr>
<th>Staff Positions</th>
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<tbody>
<tr>
<td>• Support those responsible for creation &amp; delivery of products &amp; services</td>
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<tr>
<td>• Focus on providing advice &amp; counsel</td>
</tr>
<tr>
<td>• Can cross many levels but all focus on providing expertise &amp; advice to be applied by others</td>
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Staff positions serve the organization by indirectly supporting line functions. Staff positions consist of staff personnel and staff managers. Staff personnel use their technical expertise to assist line personnel and aid top management in various business activities. Staff managers provide support, advice, and knowledge to other individuals in the chain of command. Although staff managers are not part of the chain of command related to direct production of products or services, they do have authority over personnel. An example of a staff manager is a legal adviser. He or she does not actively engage in profit-making activities, but does provide legal support to those who do. Therefore, staff positions, whether personnel or managers, engage in activities that are supportive to line personnel. Using a hospital example, line positions would be the director of nursing, and the director of pharmacy. Examples of staff positions would be the legal counsel for the hospital and the public relations representative.
On this slide, is an organizational chart of a company, illustrating line positions and staff positions.

Now that we have talked in general about line and staff positions, where do you think Infection Preventionists fit?

Infection Preventionists fulfill both staff and line position job responsibilities. In day to day activities, the IP is considered a staff position: for purposes of surveillance, providing education, making infection control rounds, and consulting to different units, individual personnel or outside contacts. IPs fit in a line position in regards to the authority of the infection control committee. If a patient must be kept in isolation to prevent transmission of a communicable disease, infection preventionists have the authority to place a patient in isolation. If a physician has not yet seen a particular patient and that patient is suspected to have a communicable disease, infection preventionists have the authority to start isolation in the absence of a physician’s order. Look at the organizational chart for the infection control department in your accompanying materials. The infection control supervisor is a line position in that it supervises the other infection control nurses and secretarial positions. However, within the entire organization, the infection control department functions as a staff position to support the function of the hospital, which is to provide safe effective patient care.

In accompanying material item #1, under 1, it states, “The authority statement, reporting mechanisms and the committee’s function and governance are administered through the Office of the Executive Vice president for Health Affairs.” The important points to remember about the organizational role of the infection control department and the ICC/IPC are the differences between line and staff: that the IC program serves mostly in an advisory (staff) capacity. However, in terms of authority, the Infection Control/Prevention Committee does have authority over the entire hospital in terms of protecting patients, staff and employees from communicable diseases and infections.
Reporting

Infection Control Committee Chair reports to either medical staff or administration

Look at item #2 in Accompanying Materials

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Closely related to this issue of authority are reporting relationships within an organization. It is very common, in facilities that have infection prevention/control committees, for the chair of that committee to report either to the medical staff or to the administration. Where I worked in California, our Hospital Epidemiologist reported to the Medical Director of Hospital Administration. The Infection Prevention/Control Committee was a medical staff committee. Now look at the second item in your accompanying materials, the organizational chart for the SCVMC Infection Control department. You can see that the Infection Control Board *(another name for an Infection Control Committee)* reported to the Quality Improvement Committee AND to the Medical Director of Hospital Administration *(designated by “up” arrows)*.

Membership

• Multi-disciplinary
• Composed of representatives from most departments
• Meets regularly

ICC not required by TJC, but some states require

The ICC/IPC must be multi-disciplinary, with representation from clinical, administrative, and ancillary staff. The committee should be comprised of representatives from most departments. Because infection control issues and policies often cross departmental lines, a multi-disciplinary committee is crucial. The committee should meet regularly (e.g., monthly, bi-monthly, quarterly). An ICC/IPC is no longer required by The Joint Commission (TJC) but some states do require an ICC/IPC.

Committee Member Role

• communicates information throughout institution
• supports infection control team
• provides political support to the infection control program
• act as infection control officer for the unit they represent

For those who do serve on the ICC/IPC, there are certain responsibilities and expectations. The member should communicate information on policies, results of reports, educational resources and any other pertinent issues back to the unit they represent. This also includes reporting concerns from their unit back to the IPC. The member should support the infection control team in their activities. Committee members can also provide political support for the IC program. For example, if resources are needed from administration, the members can contribute to requests or recommendations to administration for such resources. Finally, the member serves as an infection control officer for the unit they represent. This means knowing the IC policies, representing the IC team on their unit, and upholding the principles and practices of the IC program.

Meetings

• Agenda very important
• Attendance important—quorum required
• Time of meeting important

Look at item #3 in Accompanying Materials

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When conducting an ICC/IPC meeting, it is important to carefully construct a feasible agenda ahead of time. Feasibility is important, because if there are too many items to cover, the meeting will not be constructive. Most medical staff or other official committees follow some rules of order and many require a quorum *(minimum number of members)* in order to hold the meeting. Therefore, to have a consistent quorum, the time of the meeting is important. We always had our ICC meetings at lunchtime and provided lunch. This may be allowed at some institutions. If NOT providing lunch, then this is not a good time to hold a meeting at all. The reason is that members will have to give up their lunch time AND bring their own food. Having a set date and time may be good but if some members do not ever attend, it may be a good idea to vary the time and date. Another strategy our ICC used was to allow committee members to appoint an alternate if they could not attend. That way we could
almost always assure a quorum. Look at item #3 in your accompanying materials. This is a template of the agenda for the Infection Control Committee from PEEL Public Health in 2011. Standing agenda items included surveillance, outbreaks, antibiotic use, environmental cleaning issues and compliance. The “other” category included upcoming construction projects, and product evaluation.

**Slide 21**

Committee Functions

- Isolation/precautions, regulatory, employee health-related reports
- Approval of policies & procedures
- Infection control problems discussed
- Surveillance reports presented

The ICC/IPC performs a variety of functions. It should develop, provide policies for and educate staff on isolation precautions. The committee should be the guiding body for assuring compliance with infection control regulatory requirements. Employee Health reports should be provided at all committee meetings, to provide evidence that Infection Control and Employee Health work in collaboration. This committee must approve all policies and procedures related to infection control. This meeting is also a forum for discussing current infection control problems. Exposures to communicable diseases from visitors, animal visitation programs in the facility, healthcare-associated infection rates, and compliance with hand washing are a few examples. One of the most important functions of this committee is to discuss surveillance of healthcare-associated infection (HAI) rates as monitored by the facility. Some facilities conduct hospital-wide surveillance on all types of infections. This is labor-intensive and not as common recently. Targeted surveillance (e.g., HAI pneumonia rates, neonatal nursery infection rates) is often more practical and should be based on patient population and facility characteristics. *(You will learn much more detail about the different types of infection control surveillance if you take the fall class, “Disease Surveillance & Monitoring”).*

**Slide 22**

Dissemination of Information

- Dissemination of I.C. info. crucial
- Surveillance data & policy decisions need to be communicated
  - routine reports to clinicians/department heads
  - electronic mail
  - Confidentiality (HIPAA implications) (example)

Dissemination of information is a crucial function of an IPC. Surveillance data and policy decisions should be communicated throughout the organization. This communication may be accomplished through routine reports to clinicians or department heads and through various electronic methods. The issue of confidentiality and compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulations need to be considered with all communications from the IPC. You never know who might be listening or affected by a communication. One morning our infection control team was reviewing laboratory reports before the IPC meeting. There was a case of MRSA in an employee. An Environmental Services staff member was cleaning our office when we were discussing this. After a few minutes, this person said, “Excuse me, but what is MRSA? The reason I ask is because you are talking about my nephew.” Had this person been inside our IPC meeting, it would have been a breach of confidentiality. It is important to think about things like not leaving any reports in the room after you are finished with the meeting, and not leaving anything in the trash that could be retrieved. These are all examples of how important it is to protect the confidentiality of the proceedings of these meetings.
Slide 23

What if Committee Can’t Get Everything Done?

• Form subcommittee
• Form “ad hoc” committee
• Formulate policies, plans
• Report back to full committee

Examples

http://bfglobalgroup.com/careers.html

If there is too ambitious of an agenda or simply too many issues to cover in an ICC/IPC meeting, there are alternative ways to accomplish necessary tasks. Forming a subcommittee with some IPC members and other volunteers is one option. An “ad hoc” or temporary committee with one task can be formed until that task is completed. These ad hoc or temporary committees can develop a policy, procedure or plan of action and then report back to the full committee. When new regulations come out, that is a good time to form a subcommittee. If there is going to be a major renovation or construction activity, all involved units (which may not all be on the IPC) can be involved in a subcommittee to make recommendations to the full committee.

Slide 24

Technology Resources

• APIC on-line resources
• CDC
• Software for collecting surveillance data on patients; sharps injury exposures on employees (e.g., Epi-Info, EPI-NET)
• References for this lecture

There are numerous non-personnel resources to assist in running an effective IC program. The Association for Professionals in Infection Control & Epidemiology (APIC), provides numerous resources, available at www.apic.org. The Centers for Disease Control & Prevention have a wealth of resource and reference materials. These include patient care practice guidelines (e.g., Hand Hygiene, Prevention of Intravascular-device Related Infections, Prevention of Nosocomial Pneumonia, to name a few); training courses; video-conferences (e.g., the Clinician Outreach and Communication Activity {COCA}; and interactive on-line educational programs (e.g., smallpox module, and a plague module). To assist in surveillance data collection and management, there are software programs such as EPI-Info and one specifically designed for managing sharps injury data in healthcare personnel called EPI-NET. For this lecture, the following were used as references:

• APIC Text of Infection Control & Epidemiology, Chapter 1 “Infection Prevention & Control Programs”, 2009.
• A management website:
  http://www.referenceforbusiness.com/management/images/eom_0005_0001_0_img0099.jpg
  www.apic.org
• Santa Clara Valley Medical Center, Infection Control Manual, San Jose, CA, 2000 version.

This concludes Unit 2 Part I.