Stronger Together: Advancing Infection Prevention Through Multidisciplinary Collaboration

New Mexico Hospital Association

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Learning Objectives

The expanding role of the IP professional: from surveillance to system leadership

- Position IP as a multidisciplinary obligation
- Strengthen Quality–IP alignment
- Drive ownership at the employee level
- Re-center on foundational practices
- Use a maturity model to guide program growth

Why IP Cannot Succeed in Silos

Limitations of IP responsibility vs. influence

- IPs are responsible for developing IPC policies and monitoring compliance but often cannot directly influence behavior
- IPs don’t typically control budgets that provide the resources necessary to support IPC best practice (equipment, staffing, technologies)
- Organizational hierarchy can create barriers
- Cultural and behavioral challenges make it difficult for an IP to directly influence necessary change

Why IP Cannot Succeed in Silos:
Common failure points outside IP control

Hand hygiene compliance	Inconsistent use of PPE	Device management practices
Antibiotic prescribing behavior	Communication breakdowns	Staffing shortages and workload pressures
Facility design and infrastructure	Supply chain disruptions	Patient and visitor behavior

Shifting the Focus

Most major failure points are SYSTEM-LEVEL or HUMAN-FACTOR issues outside of the IPs direct influence. This is why IPC is less about control and more about:

1) **Influencing behavior**
2) **Building systems that make the right action the easy action**
3) **Partnering with leadership and frontline staff**

Safety Culture Considerations

- IPC must be recognized as a necessary part of the system, not an individual task
- Psychological safety and speaking up must be encouraged supported at the highest level of the organization

The Solution to this lies in Multidisciplinary Collaboration

The IP's role isn't to control every action—it's to **shape the environment so the right actions happen consistently**.

Role of the Infection Preventionist

- Influencer
- Strategist
- System designer
- Translator
- Change Agent
- Investigator
- Advisor and Collaborator
- Advocate

Mapping Multidisciplinary Touchpoints

- Clinical care teams
- EVS and environmental hygiene
- Facilities, water management, construction
- Supply chain and product decisions
- Quality, risk, and safety
- Executive leadership

Strategies IPs Can Use

- Clearly defining role-based IP accountability
- Leveraging committees and governance structures
- Using data to demonstrate cross-functional impact

The Quality Department & Infection Prevention are Inseparable

These departments should be united through shared goals:

- Patient safety
- Harm reduction
- Continuous improvement
- Regulatory compliance (CMS, TJC, state reporting)

The Quality Department & Infection Prevention Connection

Focus:

Moving from parallel work to true integration

Aligning Language & Metrics

- HAIs as quality outcomes, not "IP numbers"
- Creation of narratives and stories that humanize HAIs and their consequences
- Using quality methodology (PDSA, Lean/Six Sigma) in IP work

Taking Ownership of Infection Prevention at the Employee Level

What "Ownership" Really Means

- Doing the right thing every time
- Knowing the "why," not just the "what"
- Personal accountability and learning from mistakes or lapses

Taking Ownership of Infection Prevention at the Employee Level : EXAMPLES

HAND HYGIENE	Ownership = *"I don't skip it, and I help normalize it for others."*
ENVIRONMENTAL AWARENESS	Ownership = *"If I see a risk, I act—I don't assume it's someone else's job."*
ISOLATION ADHERENCE	Ownership = *"I treat isolation as non-negotiable, not optional."*
PPE USE	Ownership = *"I protect myself and others by doing it right, every time."*
DEVICE NECESSITY CHECKS	Ownership = *"I actively reduce unnecessary risk, not just maintain devices."*
TEAM COMMUNICATION	Ownership = *"I communicate to prevent harm—even if it feels uncomfortable."*

Taking Ownership of Infection Prevention at the Employee Level : EMPOWERMENT STRATEGIES

Clear expectations	Make it obvious what “good” looks like—every shift, every time.
Just culture approach	Encourage speaking up and learning without fear of punishment for honest mistakes.
Feedback loops	Provide timely, meaningful information so staff can adjust behavior.
Recognition of good IP behavior	Reinforce and normalize best practices through positive reinforcement.

The Common Thread

- **Consistency** (doing the right thing every time)
- **Accountability** (not passing responsibility to others)
- **Willingness to speak up** (protecting patients and coworkers)
- **Situational awareness** (recognizing risks in real time)

Infection prevention only works when frontline staff act as the **last line of defense**. Policies and infection preventionists set the framework—but outcomes depend on whether each employee treats IPC as *their responsibility in every moment of care*.

Drivers of Drift from Basics

- Crisis-driven priorities (e.g., pandemics, outbreaks)
- Overcomplexity
- Technology reliance
- Alert and audit fatigue

“Basics” as High-Reliability Practices

Reframing “Basics” as High-Reliability Practices

Consistency over complexity

Doing fewer things better

“Back to basics” ≠ regression

Basics as the foundation of advanced prevention

Back-to-Basics IP Team Strategy

IP teams must model focus, clarity, and partnership

- Risk-based focus vs. doing everything
- Clear standards and expectations
- Simplified policies
- Visibility and approachability
- Aligning activities with outcome impact
- Saying “no” when necessary

Back-to-Basics IP Team Strategy

Partnering with Quality & Operations

- Unit-based champions
- Joint rounding
- Shared dashboards
- Co-led improvement initiatives
- Peer to peer accountability models
- Recognition programs

Measurement That Matters

- Process reliability vs. volume of audits
- Actionable data
- Closing the feedback loop with frontline staff

Education & Communication

- Bite-sized education
- Real-time coaching & feedback
- Storytelling with data

Maturity Model

Why Use a Maturity Model

A **maturity model** is a framework used to assess how developed, effective, and optimized an organization's processes, systems, or capabilities are

- *How good are we at this today?*
- *What does "better" look like?*
- *What steps do we take to improve?*

- Can help IP professionals assess where the IPC program is vs. where it should be
- Shifts focus from activity-based to outcome-based programs
- Guides prioritization and resource allocation

IPC maturity model: https://app.box.com/s/jgpr77byn8u9ngidu5p8eaxzm3qjfofc

Maturity Model Levels

Level 1 – Reactive / Compliance-Driven

- Focus on surveillance and reporting
- IP seen as the "police"
- Education is event-based
- Limited multidisciplinary engagement

Level 2: Structured/Pragmatic

- Standard policies and protocols
- Basic audits and feedback
- Some Quality collaboration
- Unit-level champions emerging

Level 3: Integrated/Proactive

- Strong Quality–IP alignment
- Multidisciplinary ownership defined
- Risk-based prioritization
- Data used for improvement, not just reporting

Level 4: High Reliability/Culture-Driven

- IP embedded in daily operations
- Frontline ownership and peer accountability
- Consistent execution of basics
- Leadership engagement and psychological safety

Using the Maturity Model Practically

- Self-assessment domains:
  - **Governance & Leadership Support**
  - **Quality & Infection Prevention Integration**
  - **Surveillance, Data & Measurement**
  - **Multidisciplinary Engagement & Ownership**
  - **Frontline Accountability & Culture**
  - **Core Infection Prevention Practices (Back to Basics)**
- Identifying gaps and next steps
- Avoiding the trap of “doing more” instead of “doing better”

Domain specifics

Domain 1: Governance & Leadership Support

Which statement best describes your program?

- **Level 1:** IP activities are largely driven by regulatory or reporting requirements. Leadership engagement is episodic or reactive.
- **Level 2:** IP has defined committee structures and reports to leadership regularly, but engagement is mostly informational.
- **Level 3:** Leadership actively partners with IP; HAI prevention is a standing strategic priority with shared accountability.
- **Level 4:** Leadership visibly champions IP, reinforces expectations, and integrates infection prevention into daily operational decisions.

Domain specifics

Domain 2: Quality & Infection Prevention Integration

- **Level 1:** Quality and IP operate in parallel with limited coordination.
- **Level 2:** Quality supports IP with data and reporting; collaboration occurs during events or projects.
- **Level 3:** Quality and IP share metrics, dashboards, and improvement methodology.
- **Level 4:** Quality and IP function as a unified safety system with co-owned outcomes and aligned strategy.

Domain specifics

Domain 3: Surveillance, Data & Measurement

- **Level 1:** Surveillance focuses on NHSN reporting and compliance deadlines.
- **Level 2:** Data are trended and shared, but feedback is delayed or not actionable.
- **Level 3:** Data are timely, meaningful, and used to drive targeted improvement.
- **Level 4:** Data are transparent, trusted, and routinely used by frontline teams to guide behavior.

Domain specifics

Domain 4: Multidisciplinary Engagement & Ownership

- **Level 1:** IP is viewed as primarily responsible for infection prevention outcomes.
- **Level 2:** Some departments participate in IP initiatives, often at IP's request.
- **Level 3:** Roles and responsibilities for IP are clearly defined across disciplines.
- **Level 4:** Multidisciplinary teams proactively own infection prevention within their scope of work.

Domain specifics

Domain 5: Frontline Accountability & Culture

- **Level 1:** Education is the primary response to IP issues; accountability is inconsistent.
- **Level 2:** Expectations exist, but enforcement varies by unit or leader.
- **Level 3:** Staff understand expectations and receive coaching and feedback.
- **Level 4:** Frontline staff hold themselves and peers accountable within a just culture framework.

Domain specifics

Domain 6: Core Infection Prevention Practices (Back to Basics)

- **Level 1:** Compliance with basics (hand hygiene, PPE, device care) is inconsistent.
- **Level 2:** Policies exist, but variation in practice remains common.
- **Level 3:** Core practices are standardized, monitored, and reinforced.
- **Level 4:** Basics are highly reliable, embedded into workflows, and rarely missed.

Driving Employee-Level Ownership Through Maturity

Linking maturity to frontline behavior:

- Mature programs are culture driven and steeped in high reliability practices
- Move from education (in the hopes of adherence) to expectation of adherence and confidence in the process through ownership

Tools for success:

- Clear role-based responsibilities
- Just culture and coaching
- Unit-based ownership models
- Recognition of reliable behaviors

Key Takeaways & Call to Action

Key Messages

- IP maturity determines sustainability
- Multidisciplinary ownership is a hallmark of advanced programs
- Quality alignment accelerates improvement
- Basics executed reliably prevent most infections

Call to Action for IP Professionals

- Identify your program’s current maturity level
- Choose one strategy to advance to the next level
- Commit to one simplification or ownership shift

Practical Examples

CLABSI Examples Across Maturity Levels

- **Level 1 (Reactive):** CLABSIs reviewed retrospectively; focus on documentation gaps and staff re-education after events.
- **Level 2 (Structured):** Central line bundles audited; monthly compliance reported; line necessity discussed inconsistently.
- **Level 3 (Integrated):** Daily line necessity embedded into rounds; unit-level CLABSI data shared with frontline teams.
- **Level 4 (High Reliability):** Units own days-between-CLABSI tracking; peer accountability for line maintenance; leadership reinforces prompt removal.

Common CLABSI Metric Traps: Counting bundle audits without linking to outcomes; focusing on insertion while neglecting maintenance.

Practical Examples

CAUTI Examples Across Maturity Levels

- **Level 1 (Reactive):** CAUTIs trigger chart reviews and re-education on catheter care.
- **Level 2 (Structured):** Catheter days tracked; nurse-driven removal protocols exist but are inconsistently used.
- **Level 3 (Integrated):** Daily catheter necessity prompts; unit-level utilization ratios reviewed with staff.
- **Level 4 (High Reliability):** Catheter avoidance culture; frontline-driven removal; sustained low utilization.

Common CAUTI Metric Traps: Tracking catheter days without acting on necessity; focusing on technique instead of avoidance.

Practical Examples

SSI Examples Across Maturity Levels

- **Level 1 (Reactive):** SSI cases reviewed post-op with focus on documentation and individual performance.
- **Level 2 (Structured):** Surgical bundles monitored; compliance reported quarterly.
- **Level 3 (Integrated):** Multidisciplinary OR ownership; real-time feedback on prep, antibiotics, and normothermia.
- **Level 4 (High Reliability):** OR teams own SSI outcomes; standardized workflows with minimal variation.

Common SSI Metric Traps: Measuring bundle compliance without surgeon engagement; delayed feedback.

Practical Examples

CDI Examples Across Maturity Levels

- **Level 1 (Reactive):** CDI rates reviewed after spikes; emphasis on isolation compliance reminders.
- **Level 2 (Structured):** Environmental cleaning audits; antibiotic stewardship collaboration is limited.
- **Level 3 (Integrated):** Joint IP–stewardship initiatives; timely testing stewardship and cleaning validation.
- **Level 4 (High Reliability):** Consistent diagnostic stewardship; EVS ownership of cleaning outcomes; sustained CDI reduction.

Common CDI Metric Traps: Over-testing without stewardship controls; focusing on cleaning audits without antibiotic use data.

THANK YOU!

Any Questions or Comments?

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