



From Vision to Practice: How Leadership Shapes Infection Prevention Success in Long-Term Care

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Comagine Health is nonprofit organization that partners with communities, providers, payers and policymakers to advance health and health care for the good of all.

We solve complex challenges others cannot through the combination of data intelligence, clinical rigor, community insight and applied research.

Our work supports improvements throughout the systems shaping health care today.

■ Objectives



Describe what a strong infection prevention and control (IPC) program looks like and leader oversight and engagement functions with the program



Understand the IPC staff role and how you can support and empower your infection preventionist (IP) through visible commitment and allocation of resources



Explain the role of leadership in building a culture of safety, supporting evidence-based practices, and driving continuous improvement to reduce healthcare-associated infections (HAI)



Discuss how the IP and senior leaders can work together to maximize outcomes and protect residents, staff and visitors from HAIs

- **Biggest challenges: What keeps you up at night?**

What do you see as the biggest challenge to the success of your infection prevention and control (IPC) program?

What are your biggest infection prevention concerns?



■ The evolving practice of infection prevention in long-term care settings

- Nursing homes continue to see residents with higher acuity and medically complex needs
- Most admissions are coming from acute care for skilled care/rehabilitation, rather than directly to long-term residential care
- These residents experience higher risks of HAIs and colonization with multidrug-resistant organisms
- A growing number of facilities have expanded services to include specialty units, further increasing risk

Cassone M, Mody L. Colonization with multi-drug-resistant organisms in nursing homes: scope, importance, and management. *Curr Geriatr Rep* 2015;4:87–95.

Mody L, et al. Longitudinal assessment of multidrug-resistant organisms in newly admitted nursing facility patients: Implications for an evolving population. *Clin Infect Dis* 2018;67:837–44.

McKinnell JA, et al. The SHIELD orange county project: multidrug-resistant organism prevalence in 21 nursing homes and long-term acute care facilities in Southern California. *Clin Infect Dis* 2019;69:1566–73.

Rossow J, et al. Factors associated with *Candida auris* colonization and transmission in skilled nursing facilities with ventilator units, New York, 2016–2018. *Clin InfClin Infect Dis* 2021;72:e753–e60.10.1093/cid/ciaa1462.

[Multisociety guidance for infection prevention and control in nursing homes | Infection Control & Hospital Epidemiology | Cambridge Core](#)

■ Turnover and risk to IPC reliability

IPC remains one of the most frequently cited deficiencies nationwide.¹

- Turnover associated with increased infection control citations, especially higher turnover of nursing personnel

Nearly 40% of registered nurses (RNs) said they intend to exit the field within the next five years.²

Findings from Association for Professionals in Infection Control and Epidemiology (APIC) MegaSurveys in 2015 and 2020 point to an older IPC workforce with many planned retirements within the next decade.³

The timeframe to build competency and average short tenure of the IPC role pose challenges.

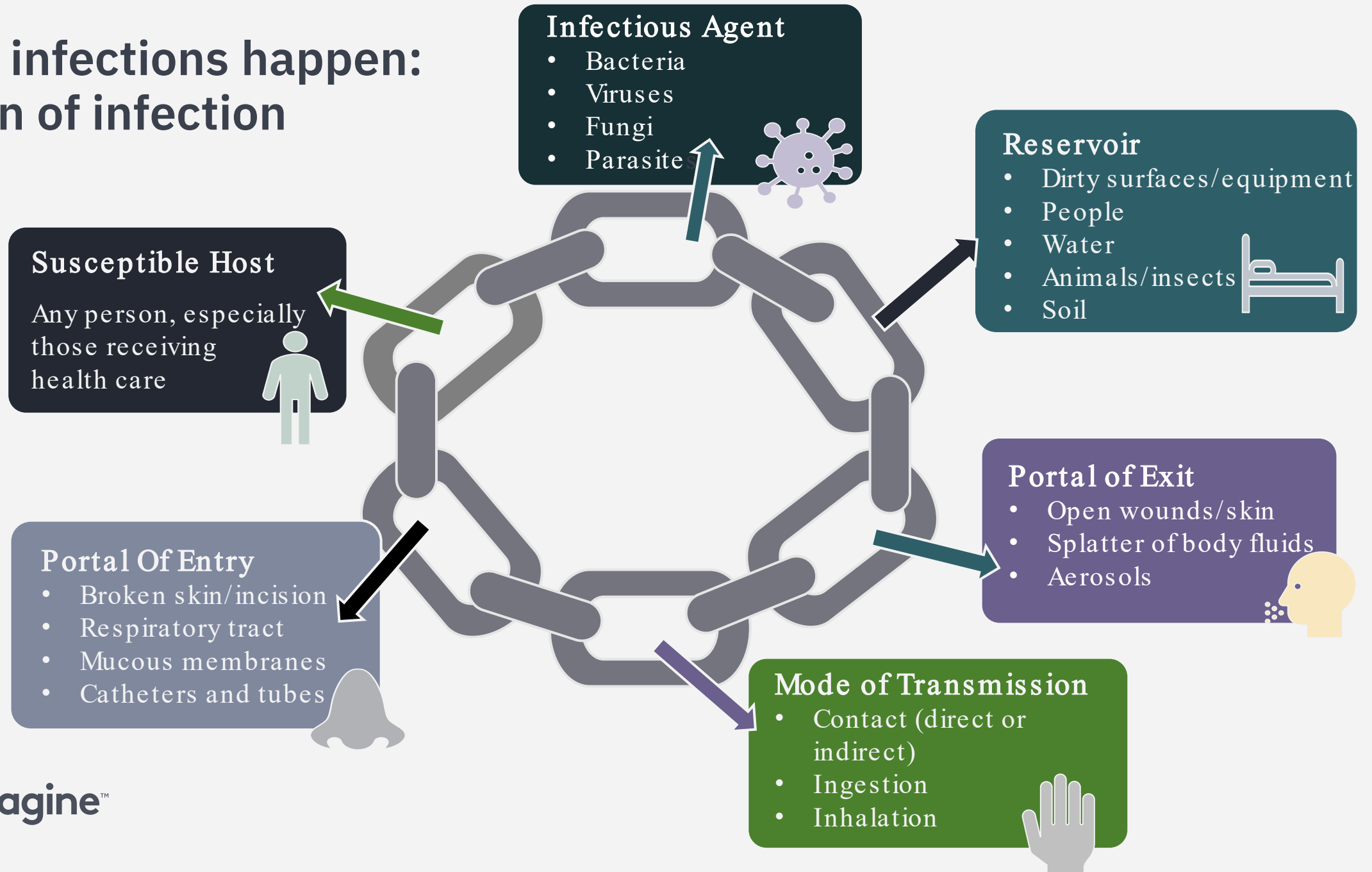
Because infection control standards take time to maintain, they may not be prioritized among other duties staff face when they face workforce shortages due to turnover.⁴

1. [Infection Control in Nursing Homes: Why F880 Remains the Top Citation —and How Leaders Can Build a Stronger Program - Pathway Health](#)
2. [4 nurse retention strategies that work - Becker's Hospital Review | Healthcare News & Analysis](#)
3. Infection preventionist retention and professional development strategies: Insights from a national survey. Gilmartin, H. et al. American Journal of Infection Control, [Volume 49, Issue 7](#), P960-962. July 2021.
4. Loomer, L. et al. Association between nursing home staff turnover and infection control citations. Health Serv Research. 2022;57:322–332 <https://pmc.ncbi.nlm.nih.gov/articles/PMC8928031/pdf/HESR-57-322.pdf>
5. [Multisociety guidance for infection prevention and control in nursing homes | Infection Control & Hospital Epidemiology | Cambridge Core](#)

- **What makes a strong IPC program?**

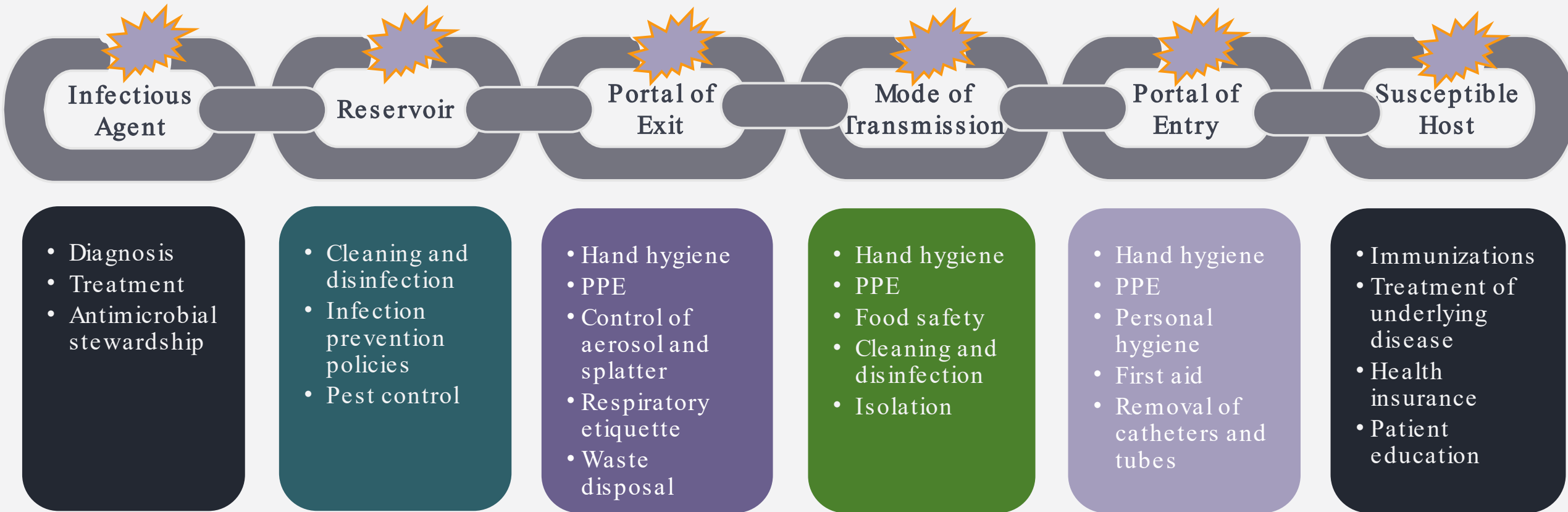


■ How infections happen: Chain of infection



▪ Break the chain of infection

Stop the germs from spreading by interrupting this chain at any link



■ Fundamental components of the IPC program

Annual Risk Assessment

Annual Plan

- Policies and Procedures
- Emergency Management
- Bloodborne Pathogen Exposure (OSHA)
- Respiratory Protection Plan (OSHA)
- TB Exposure Plan (OSHA)
- Water Management (CDC)

Surveillance/Monitoring

- Environment of Care
- Hand Hygiene and PPE
- Emerging Diseases
- Antibiotic Stewardship
- Infections

Communication

- Infection Control Committee
- Regulatory Reporting
- Liaison to Public Health Departments

Quality Improvement

■ The designated IP role: What the guidance says

At least one IP to manage the IPC program who:

- Has ongoing, specialized training in IPC that is financially supported by the nursing home
- Demonstrates commitment to ongoing continuing education in IPC to remain current in developments and strategies to optimize the IPC program
- Has clinical and/or public health experience
- Is an effective communicator, educator, leader, mentor and collaborator
- Receives training in leading and managing programs

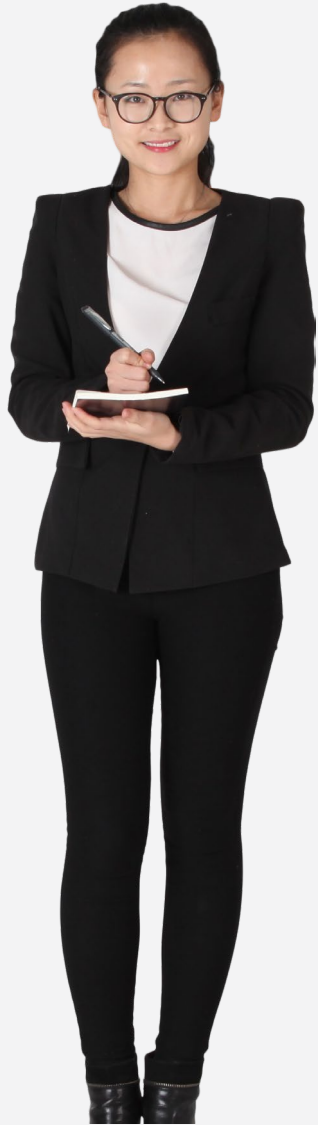
■ Staffing the role



Sufficient dedicated time for the IP(s) to manage the IPC program based on the complexity of the resident population and services provided:

- At least one full-time equivalent (FTE) IP, if the facility has more than 100 licensed beds or provides onsite ventilator or hemodialysis services
- At least 0.5 FTE IP (20 IP hours per week), if the facility has fewer than 100 beds and does not provide on-site ventilator or hemodialysis services

Adequate IPC personnel, time and resources in accordance with the level of acuity and services



Coordinating annual IP risk assessment

Driving work outlined in the annual plan

Conducting surveillance activities

Updating IPC P&Ps

Environmental rounding

Auditing practice

Providing IP guidance to other departments



Data collection and reporting (NHSN)

Coordinating patient and staff vaccinations

Managing outbreaks

Supporting the infection control committee

Educating staff

Coordinating the antibiotic stewardship program

Completing quality improvement projects

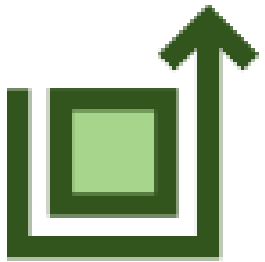
Professional development

- **Healthcare-associated infections are too complex for any single discipline to solve alone**

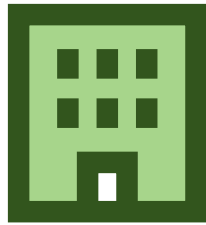
- Nursing, medicine, laboratory, pharmacy, environmental services and leadership each bring distinct, essential expertise.
- Shared protocols, unified workflows and integrated surveillance significantly reduce infection risk.
- Published evidence in the past decade consistently links interprofessional coordination to safer clinical environments.



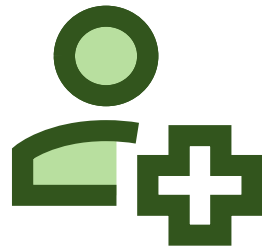
- **Balancing “home-like” and health care environments**



**Design
and
flow**



**Surfaces
and
finishes**



**Shared
treatment
and
recreation
areas**



**Personal
items**



**Clean
Patient
Care
Storage**

■ Bridging the gap for safety

The Ideal Scenario

The American Health Care Association (AHCA) and the Centers for Medicare and Medicaid Services (CMS) recommend that skilled nursing facilities identify and train **two** infection preventionists (IPs) to:

- Ensure availability
- Mitigate turnover

AHCA also recommends administrators consider taking an IPC officer course to:

- Gain deeper understanding of IPC in the overall operation

Association of Infection Prevention and Epidemiology (APIC) strongly recommends:

- “Dedicated” rather than “designated” IP staff member

The Reality

Staffing shortages can make it challenging to have a dedicated IP

- IP staff often hold multiple roles
- Creates difficulty maintaining comprehensive IPC program

LTC facilities are often less resourced than other settings

High staff turnover leads to inconsistent application of IPC protocols, performance gaps, difficulty sustaining education/knowledge

IPs may not always attain the specialized training that enables them to be successful in their role

The goal is protected capacity for essential IPC functions

- **Role of leadership**



- Leadership core functions with the IPC program

01
Designate
Qualified
Leadership

02
Resource
Management

03
Establish
Surveillance
and
Reporting
Systems

04
Develop
Policies and
Staff Training

05
Quality
Assurance

06
State/
Federal
Regulatory
Compliance

07
Facility-Wide
Culture of
Safety

■ Creating your safety culture

1. A culture of safety in health care refers to an organizational commitment to core values that prioritize both worker safety and resident/patient safety.
2. The aim is to reduce risk of:
 - Medical errors
 - Preventable harm
 - Adverse events
3. This risk reduction is accomplished by actively identifying and mitigation potential errors **before** they can cause effects (Proactive vs. Reactive).
4. This enhances patient/resident outcomes, builds trust and drives operational excellence.

- Safety culture attributes



Emphasis on
quality

Teamwork

Leadership
support

Communication

Non-punitive
response to errors

Perception of
organizational
commitment

Work design

Staffing and
workload

■ How IPC fits into your culture of safety

Nursing homes should support a culture that prioritizes safety and emphasizes that everyone has a role in promoting infection prevention

Creating culture of shared accountability for IPC outcomes

Engaging frontline health care personnel (HCP) in identifying solutions to ensure IPC priorities during resident care

Educating residents and their families

Supporting use of innovative IPC programs



■ Benefits of a safety culture

- A safer environment for residents is a safer environment for workers and vice versa.
- Workers are more likely to adhere to standard precautions when they feel that their facility has a strong commitment to safety and implemented targeted interventions to improve employee health and safety.
- Workers who practice safely will be better able to provide error-free care to patients.
- Recognizing that lapses in IPC, fatigue, or faulty equipment that may result in injury or illness to workers, patients, residents and others in the institution can lead to opportunities for improvement through lessons learned and training.

■ Leadership strengthens IPC through commitment and action

- Demonstrate commitment to IPC as part of the organization's culture of safety
- Integrate IPC goals into quality and patient safety priorities
- Support evidence-based practices and continuous improvement to reduce HAIs
- Ensure sufficient resources are available to support IPC work

- Empower IPC leaders with the authority to carry out the program effectively
- Actively engage in IPC meetings and visibly endorse initiatives
- Review data on infectious risks, exposures and illnesses regularly
- Use data, audits, and transparency to track progress and accountability
- Invest in ongoing staff training and professional development

- **Quality Assurance and Performance Improvement (QAPI) and IPC**



- **Addressing human factors**

Natural tendency for individuals to drift – have a plan to address it

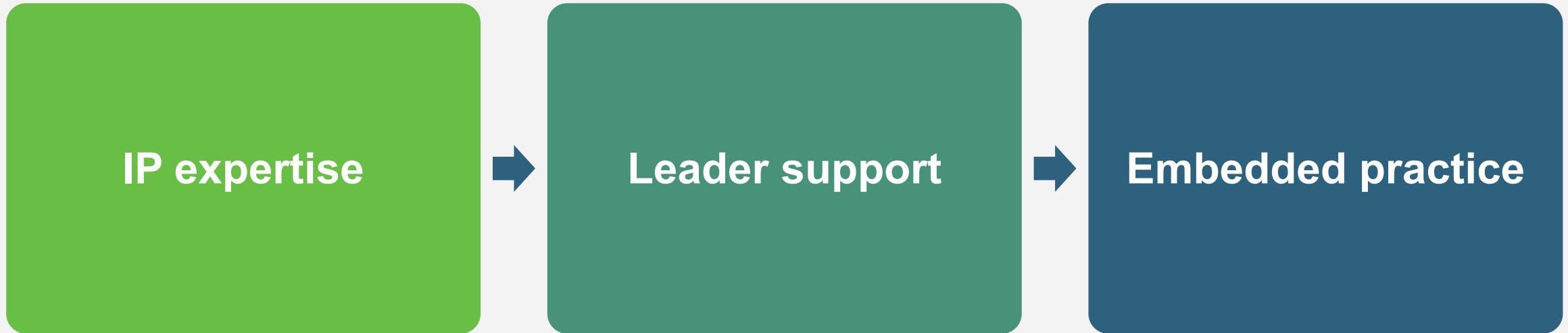
The longer one's task list, the more important the “why” becomes

Leader role is to regularly check in on work as designed vs. work as done, and help identify and address any barriers



- **From partnership to prevention**

Turning collaboration into results:



Higher adherence, fewer healthcare-associated infections, and better outcomes.

- **Working within reality: Succeeding in challenging circumstances**



- Identify priorities
- Leverage high impact, low effort practices
- Foster collaboration
- Optimize the existing workforce
- Create shared culture of accountability

■ Leader strategies for supporting the continuity of your IPC program

Recommendation: Implement strategies to retain and mentor HCP for IPC program continuity so that the IPC program is not dependent on one individual:

Prioritize and invest in personnel retention strategies
Provide ongoing, job-specific IPC training due to impact turnover of HCP leads on efficacy of the IPC program
Establish a mentoring program to foster interest in IPC
Encourage and support participation in public health activities, local (APIC) chapter meetings, and educational offerings from professional organizations that work in IPC
Develop processes for succession planning, transitions and cross-training for activities that support the IPC program
Reduce decision fatigue with checklists and standard processes
Celebrate success and foster a team atmosphere

- Navigating the road together



■ Aligning leader and IP expectations

- The IPC program meets regulatory standards and is survey-ready
- Proactive, safety-focused
- Has good prioritization and communication skills
- Maintains their education and expertise
- Collaborative with internal and external partners
- Can work autonomously on the IPC plan while keeping leadership looped in

- Dedicated time and resources for the program
- Infection prevention is a core value of facility
- Accountability and follow through with resources, support
- Recognizes need for specialized training and, in some cases, additional IPs
- Support for best practices
- Protected time for development of subject matter expertise/professional growth

- **The shared journey for the IP and leadership**



- Build common vision and purpose
- Prioritize doing data-driven work
- Promote building safety and reliability into your facility's IPC program
- Help connect the dots between high-level and granular views of infection prevention for your team

Putting it into practice

■ The meeting paradox...

It's QAPI meeting time, and your IP is reporting out on infection and prevention metrics. They note an increase in facility-onset urinary tract infections, and the continued low compliance with peri-care practices in the report. But everyone in the meeting is either looking at their computer or their cell phone, only half listening to the report out. The IP asks if there are any questions and gets none. The meeting organizer moves on to the next group of metrics, then the meeting adjourns.



- **When drifting practice creeps in**

Every time you do your environment of care audits you note that one staff member who continues to miss their hand hygiene opportunity going into the resident's room. They enter, put gloves on, and address the resident's needs. You've talked to them multiple times about the "why" behind performing hand hygiene on room entry and even escalated to their unit manager for accountability tracking. But neither the staff member or the manager has changed their behavior.



- **Who owns it?**

The IP gathers all facility data for the upcoming annual IPC risk assessment and plan development meeting, and their boss cancels the meeting. They tell the IP the group is stretched thin, and they need the IP to develop the risk assessment and plan and send it to them.



■ Resources

CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings

- <https://www.cdc.gov/infection-control/hcp/core-practices/index.html>

Multisociety guidance for infection prevention and control in nursing homes

- [Multisociety guidance for infection prevention and control in nursing homes | Infection Control & Hospital Epidemiology | Cambridge Core](#)

Tips for Meeting the Infection Preventionist Requirements in Skilled Nursing and Long-Term Care Facilities

- [AHCANAL Tips for Meeting the Infection Preventionist Requirements in Skilled Nursing and Long-Term Care Facilities.pdf](#)

National Institute for Safety in Occupational Health, Safety Culture in Healthcare Settings

- [Safety Culture in Healthcare Settings | NIOSH | CDC](#)

Association for Professionals in Infection Control and Epidemiology

- [APIC professional and practice standards](#)

■ Project Firstline materials

GERMS CAN LIVE IN BLOOD.



WHERE IS THE RISK?

Know where germs live to stop spread and protect patients



Germs That Can Live in Blood

- HIV
- Hepatitis B
- Hepatitis C
- Bacteria (when outside the body)

Healthcare Tasks Involving Blood

- Putting in an IV
- Giving an injection
- Surgery and procedures
- Changing soiled laundry

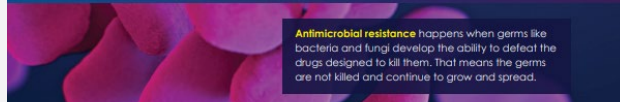
Infection Control Actions to Reduce Risk

- Hand hygiene
- Use of personal protective equipment (gloves, gowns, eye protection)
- Safe injections
- Cleaning and disinfection
- Textile management

- Viruses like HIV, hepatitis B, and hepatitis C can spread in healthcare when contaminated blood is on a sharp item.
- If that item causes a cut or break in someone else's skin (e.g., an accidental needlestick), germs can spread to that person and cause a new infection.
- Reusing needles or syringes is especially risky because germs in the blood can spread from one person to another.
- Blood in the environment – like on linens or a device – grows bacteria and spreads via touch or devices.

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FIGHT ANTIMICROBIAL RESISTANCE WITH INFECTION CONTROL



Antimicrobial resistance happens when germs like bacteria and fungi develop the ability to defeat the drugs designed to kill them. That means the germs are not killed and continue to grow and spread.

As a frontline healthcare worker, you play an important role in fighting antimicrobial resistance.

When you practice infection control, you stop resistant germs from:



Entering the body and causing infections through procedures and medical devices



Spreading to people from surfaces like bedrails or the hands of healthcare workers



Moving with patients when they are transferred between facilities



Spreading into the community, making them harder to control

Infection control fights resistance by:



Preventing new healthcare associated infections



Stopping the spread of resistant germs



Reducing the need for antibiotics or antifungals

Infection control also protects you from getting sick and decreases the risk of spreading germs to patients.

Check out Project Firstline resources to learn more about how you can protect your patients, yourself, and your community from antimicrobial resistance.

www.cdc.gov/ProjectFirstline

WE HAVE THE POWER TO STOP RESISTANT INFECTIONS. TOGETHER

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GERMS CAN LIVE ON DRY SURFACES.



WHERE IS THE RISK?

Know where germs live to stop spread and protect patients



Germs That Live on Dry Surfaces

- Clostridioides difficile (C. diff)
- Norovirus
- Candida (including C. auris)
- Rotavirus

Healthcare Tasks Involving Dry Surfaces

- Anything involving touch
- Using devices
- Patient transport

Infection Control Actions to Reduce Risk

- Cleaning and disinfection
- Device sterilization
- Hand hygiene
- Use of personal protective equipment (gloves and gowns)

- Germs found on the body, in the air, and in stool can often be found on dry surfaces, and some can live for a long time.
- Dry surfaces include "high-touch" surfaces like bed rails, door handles, and light switches. They also include countertops, bed curtains, floors, and things that might not be touched as often.
- Hands can pick up germs from dry surfaces and move them to other surfaces and people.
- Germs from dry surfaces can also get onto devices that are used on or in patients.

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You don't always know which rashes are infectious.



Because you can't always tell what causes a rash, you should always take the following actions to protect patients and yourself from the spread of germs.



Treat broken or irritated skin with care; it's a vulnerable place where germs can enter a patient's body.



Use gloves if you have to touch the rash, to prevent germs from spreading.



Clean and disinfect things that the patient has touched.

Germs Live on the Skin Infographic: <https://bit.ly/3OEGTty>
Gloves and Gowns Session Plan: <https://bit.ly/446GkNz>
Environmental Cleaning and Disinfection Session Plan: <https://bit.ly/2K82TVE>

Learn More

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Thank you

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