

Being Heard: The IP and Organizational Structure
Janet Glowicz, Centers for Disease Control, Atlanta
Broadcast live from APIC 2016 conference (www.apic.org)

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Being Heard: The IP and Organizational Structure

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Centers for Disease Control and Prevention

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Objectives

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

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Organizational Culture

- There is a need to understand organizational culture and change it when it hinders performance¹
- Direct evidence linking leadership to infection rates is limited but consistent themes have been identified²

Leadership traits that may assist in preventing infections³:

- Proactive, Positive, Visible
- Supportive of Change
- Clear Responsibilities
- Clear Policies

Leadership traits that may be associated with risk²:

- Reactive
- Laissez Faire Management Style
- Failure to assign responsibility/ maintain accountability
- Wide Span of Control

1. De Bono et al., J Hosp Inf (2014) 86:1-6
2. Griffiths et al., J Hosp Inf (2009) 73, 1e14
3. Sinkowitz-Cochran et al., AJIC, 2012; 40, 138-143

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Barriers to Change: Capacity

Capacity may be affected by complex management issues

Nurse Staffing Ratios	• Nurse to patient staffing ratios have been inversely associated with healthcare associated infections (UTI and SSI) ¹
High Occupancy	• Inpatient wards with occupancy rates of 80-89.9 % had CDI rates that were 56% higher than baseline occupancy rates (0-69%) ²
Feeling Overwhelmed	• Stress and chaos may be associated with poorer infection prevention practices ³

Strong leadership at the unit level and above is likely a prerequisite to infection prevention improvements⁴

1. Ciomatti et al., AJIC 2012; 40, 486-490
2. Ahyow et al., ICHE, 2013 34 1062-1069
3. Sinkowitz-Cochran et al., AJIC 2012; 40, 138-143
4. Griffiths et al., J Hosp Inf (2009) 73, 1e14

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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

Conway, et al. *Am J Infect Control*, 2013; 41: 959-964

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Recognizing Inappropriate Roles: An Infection Prevention Action Plan

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

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Appropriate Roles and Responsibilities for the Infection Preventionist

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

Roles with an * are required.

Downloaded from www.catheterout.org

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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

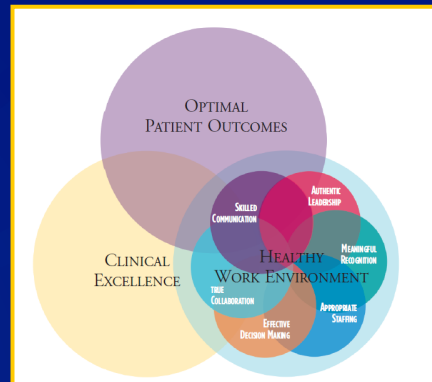
ANA Workplace Violence Position Statement, 2015

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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

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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

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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

AACN, 2004
 Quote from thetechrabbi.com

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Collaborative Prevention Models

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

Initiative	Year Initiative Ended	Effect
National Surgical Infection Prevention Collaborative	2003	27% decrease in SSI ¹
Michigan Keystone Project (ICU)	2005	66% Reduction in CLABSI ²
IHI 100,000 Lives Campaign	2006	Galvanized Efforts to Prevent Harm ³
NY State NICU CLABSI Prevention	2007	25% decrease in CLABSI ⁴
Dialysis BSI Prevention Collaborative	2011	32% decrease in BSI ⁵ 54% decrease in access infections
Wake Up and Breathe Collaborative	2013	Decreased VAE per episodes of ventilation (OR 0.63, CI 0.42-0.97) ⁶

1. Dellinger et al. Am J Surg. 2005; 190: 9-15

2. Pronovost et al. N Eng J Med. 2006; 355:2725-2732

3. Wachther & Pronovost, Jr. Comm J Qual and Safety, 2006; 32: 621-627

4. Wirschafter et al. J Perinatol. 2010; 30:170-181

5. Patel et al. Am J Kid Dis. 2013; 62:322-330

6. Klompas et al. Am J Respir Crit Car Med. 2015; 191: 297-307

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Collaboration is Additive

Themes identified from 5 Regional Collaboratives include:

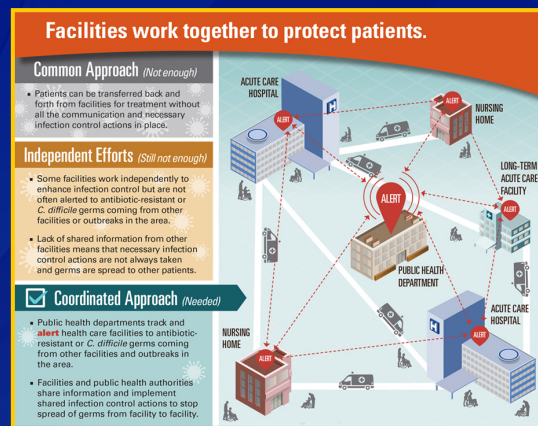
1. Fosters Change
2. Standardizes Processes, Messages and Metrics
3. Encourages Local Focused Implementation
4. Engages Frontline Staff
5. Assists Organizational Learning
6. Provides Support, Resources and Accountability
7. Ensures Feedback and Reinforcement

Welsh et al. Am J Infect Control, 2012; 40 : 29-34

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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



Slayton et al., MMWR, 64 (30), 826-831

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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

AACN, 2004

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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.

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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

SBAR Toolkit: <http://www.lhi.org/resources/pages/tools/sbartoolkit.aspx>

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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.

Type of Personnel	Source of Barrier	Engagement Strategies
Active Resistors Personnel who are highly invested and resistant to change.	<ul style="list-style-type: none"> Culture or behavior is entrenched Disregard recommendations from competing authorities 	<ol style="list-style-type: none"> Data feedback of infection rates Data feedback of compliance rates Collaboration in initiatives that align leadership and clinician goals to reduce harm Effective championing by a respected individual
Organizational Constipators Mid to Senior Level managers	<ul style="list-style-type: none"> Insidious barriers to change Maintain control and create extra work that makes change difficult to accomplish 	<ol style="list-style-type: none"> Engage the individual early in the initiative Work around the individual <ul style="list-style-type: none"> Provide every opportunity to improve or comply Utilize external partners Termination is sometimes needed to bring change

Saint et al. Jt Comm J Qual Patient Saf 2009; 35: 239-246.

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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

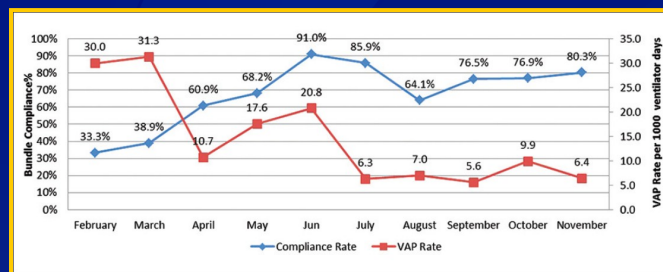
- Strategic delivery

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

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

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Communicating Routine Feedback



Cochrane Reviewers Findings on Feedback:

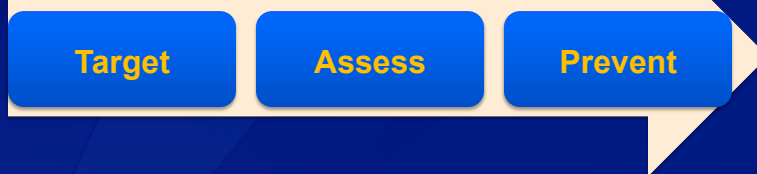
- Most effective when performance is less than optimal
- Person responsible for feedback is a supervisor or colleague
- Is provided more than once
- Is provided verbally and in writing
- Includes clear targets and an action plan

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

<http://www.cdc.gov/haiprevention/tap.html>



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

Metric	Definition	Calculation	Purpose	Limitations
SIR	A risk adjusted summary measure used to track HAIs over time. The SIR is a ratio of the actual number of HAIs reported to the predicted number, adjusted for facility and unit characteristics. An SIR > 1.0 indicates that more HAIs were observed than predicted, whereas an SIR < 1.0 indicates that fewer HAIs were observed than predicted. ¹	$SIR = \frac{\text{Observed}}{\text{Predicted}}$	Used as a <i>comparative</i> metric that adjusts for differences in incidence among risk exposure categories (e.g., location types, bed size, teaching status, facility type).	SIRs will not be calculated in NHSN when the predicted number of infections is < 1; specifying a longer time period may provide enough data to generate an SIR.
CAD	The CAD is the difference between the actual number of HAIs 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 need to be prevented to achieve that goal, assuming the same exposures over the same time period. A CAD > 0 indicates more infections than predicted, whereas a CAD < 0 indicates fewer infections than predicted.	$CAD = \text{Observed} - (\text{Predicted} * SIR_{\text{goal}})$	Used as a <i>prioritization</i> metric to identify the facilities and units with the highest burden of excess infections. Targeting these locations will yield the largest impact on HAI prevention.	Because the CAD is influenced by exposure size (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.

¹Centers for Disease Control and Prevention. National Healthcare Safety Network (NHSN) e-news: SIRs special edition. http://www.cdc.gov/nhsn/PDFs/Newsletters/NHSN_NI_OCT_2010SE_final.pdf Accessed July, 2015.

<http://www.cdc.gov/hai/pdfs/prevent/TAP-Guide-for-Individual-Facility-User.pdf>

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The TAP Report

Click variable name to be directed to more information in this guide.

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

Shown here are overall facility and unit type-specific (ICU, Ward) CAUTI data. CAUTI TAP reports do not include NICU data.

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

Unit-Specific Report - CAUTI example from a Group User
 Date Range: CAU_TAP summary Yr 2013 to 2013

Facility Rank	Facility Org ID	Facility Name	State	Type of Affiliation	Number of Beds	Location (I, W)	Events (I, W)	Device Days (I, W)	DUR % (I, W)	CAD (I, W)	SIR (I, W)	SIR Test	ICU No. Pathogens (EC, YS, PA, KS, PM, ES)	Ward+ No. Pathogens (EC, YS, PA, KS, PM, ES)
1	10000	DHOP Memorial	GA	T	62	6 (8, 8)	13 (10, 3)	1497 (921, 576)	94 (76, 11)	5.7 (6.1, -0.8)	1.3 (1.9, 0.7)		8 (0, 3, 1, 1, 2, 0)	3 (0, 0, 0, 0, 1, 0)
2	17775	PRB Medical Center	GA			1 (1, 0)	0 (0, 0)	30 (30, 0)	10 (10, .)	-0.1 (0, 0)			0 (0, 0, 0, 0, 0, 0)	0 (0, 0, 0, 0, 0, 0)

Data value will be "!" if there is no location reporting.
 SIR set to "!" when expected number of events < 1.0.
 DUR% not calculated if device days or patient days are missing at facility level.
 (EC, YS, PA, KS, PM, ES) = No. of Escherichia coli, yeast (both candida and non-candida species), Pseudomonas aeruginosa, Klebsiella pneumoniae/K. oxytoca, Proteus Mirabilis, Enterococcus species
 Facility Rank = Priority ranking for Targeted Assessment of Prevention by CAD in descending order
 I, N, W = ICU, NICU, Ward
 CAD = (OBSERVED_ICU - EXPECTED_ICU * 0.75) + (OBSERVED_WARD - EXPECTED_WARD * 0.75)
 SIR TEST = 'SIG' means SIR > SIRgoal significantly

Rounding the CAD up to a whole number when explaining the data to a facility ensures that they understand how many infections they would have needed to prevent to reach the SIRgoal.

The SIR will display as missing when the predicted number of events is less than 1.0

If nothing is listed under SIRTest, the SIR is not significantly higher than the SIRgoal. 'SIG' will be displayed if the SIR is significantly higher than the SIRgoal.

<http://www.cdc.gov/hai/pdfs/prevent/TAP-Guide-for-Individual-Facility-User.pdf>

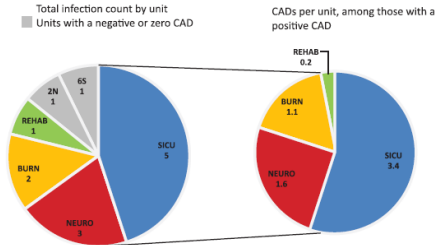
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Targeted Communication: Unit Specific

Graphical representation of unit level TAP Report; Distribution of DHQP Memorial 2014 CAUTI counts total by unit (for units with at least 1 observed infection) and for units with a positive CAD* based on an SIR goal of 0.75.



*Cumulative Attribute Difference = The number of infections each unit would have needed to prevent to achieve the facility-wide national SIR goal of 0.75 during 2014.
 CAD = Number of observed events - (Number of predicted events * SIR goal)

To Facility Leadership:

"This pie chart displays the total number of CAUTIs per unit within DHQP Memorial for 2014. The colored sections indicate units with a positive CAD, or units that had more infections than predicted based on a goal SIR of 0.75. The CADs for each of these units are displayed in the pie chart on the right. Your facility should target CAUTI prevention efforts to these units for the greatest impact on the CAUTI SIR. Specifically, the SICU is the largest driver of the facility CAD and should be an area of focus for CAUTI prevention."

<http://www.cdc.gov/hai/pdfs/prevnt/TAP-Guide-for-Individual-Facility-User.pdf>

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Targeted Communication Facility Specific

Hospital A
 2014 NHSN Data as of July 9, 2015

HAI	Number of Observed Events	Number of Predicted Events	2014 SIR	2013 National SIR Goal	CAD*
CDI (healthcare onset)	23	26	0.9	0.70	5
CAUTI (all locations)	5	4	1.3	0.75	2
CLABSI (all locations)	3	2	1.1	0.50	2

* CAD is calculated by subtracting the designated prevention target from an observed number of HAIs, and is the number of infections your facility needs to prevent to achieve the national goal during 2015, assuming no changes in the population at risk since 2014. The formula is:

$$\text{Number of observed events} - (\text{Number of predicted events} \times \text{national target SIR})$$

"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]."

<http://www.cdc.gov/hai/pdfs/prevnt/TAP-Guide-for-Group-User.pdf>

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Focused Assessment

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

Include frontline providers, mid-level staff and senior leadership

III. Early Detection and Isolation, Appropriate Testing	Response Choices					Comments (and/or "As Evidenced By")
	Never	Rarely	Sometimes	Often	Always	
1. Are patients with diarrhea (at least 3 unformed stools within 24 hrs) without a known cause tested for CDI?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
2. Do providers assess testing patients for CDI for appropriate indications (e.g., testing when no diarrhea is present, testing patients with other known causes of diarrhea such as laxative use, testing for CDI cause)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
3. Are C. difficile tests ordered promptly (i.e., within 24 hours) for patients with suspected CDI?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
4. Are patients presumptively placed on Contact Precautions when a C. difficile test is ordered?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
5. For patients with suspected CDI, is stool collected for testing within 24 hours of the C. difficile test order?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
6. Does your laboratory report initial results of C. difficile testing within 24 hours of stool collection?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

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

Examples of 2 Domains Within the CDI Assessment Tool

IV. Contact Precautions/Hand Hygiene	Response Choices					Comments (and/or "As Evidenced By")
	Never	Rarely	Sometimes	Often	Always	
1. Do patients with CDI remain on Contact Precautions for the duration of diarrhea at your facility?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
2. Do patients with CDI remain on Contact Precautions beyond the duration of diarrhea at your facility?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
3. Are patients with CDI housed separately from patients without CDI (i.e., in private rooms or about with other CDI patients [called "cohorting"]) at your facility?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
4. Are dedicated or disposable noncritical medical items (e.g., blood pressure cuffs, stethoscopes, thermometers) used for patients with confirmed or suspected CDI?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
5. Are Contact Precautions signs used for rooms to designate patients with confirmed or suspected CDI?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

<http://www.cdc.gov/hai/prevent/tap.html>

Align Interventions to Needs

• CAUTI and CDI Implementation Guides

The screenshot shows the CDC website page for Healthcare-associated Infections (HAIs). It features a navigation menu with links for 'Data and Statistics', 'Types of Infections', 'Diseases and Organisms', 'Preventing HAIs', 'Targeted Assessment for Prevention (TAP)', 'TAP CAUTI Toolkit Implementation Resources', 'TAP CDI Implementation Resources', 'State Policy Resources', 'ELC Activities', 'Guidelines and Recommendations', 'Toolkits', 'Basic Infection Control and Prevention Plan for Outpatient Endoscopy Settings', and 'Outpatient Care Guide'. The main content area is titled 'TAP Catheter-Associated Urinary Tract Infection (CAUTI) Toolkit Implementation Guide: Links to Example Resources'. It includes a disclaimer and a list of resources such as 'General Infrastructure, Capacity, and Processes', 'Appropriate Indications for Indwelling Urinary Catheter Insertion', 'Aseptic Insertion of Indwelling Urinary Catheter', 'Proper Indwelling Urinary Catheter Maintenance', 'Timely Removal of Indwelling Urinary Catheter', and 'Preventing Candiduria and Outgoing Asymptomatic Bacteremia'.

Communicate,
 Collaborate,
 Coordinate

The screenshot shows the CDC website page for Healthcare-associated Infections (HAIs). It features a navigation menu with links for 'Data and Statistics', 'Types of Infections', 'Diseases and Organisms', 'Preventing HAIs', 'Targeted Assessment for Prevention (TAP)', 'TAP CAUTI Toolkit Implementation Resources', 'TAP CDI Implementation Resources', 'State Policy Resources', 'ELC Activities', 'Guidelines and Recommendations', 'Toolkits', 'Basic Infection Control and Prevention Plan for Outpatient Endoscopy Settings', and 'Outpatient Care Guide'. The main content area is titled 'TAP Clostridium difficile infection (CDI) Implementation Guide: Links to Example Resources'. It includes a disclaimer and a list of resources such as 'General Infrastructure, Capacity, and Processes', 'Antibiotic Stewardship', 'Early Detection and Isolation, Appropriate Testing', 'Contact Precautions/Hand Hygiene', 'Environmental Cleaning', and 'Laboratory Practices'.

<http://www.cdc.gov/hai/prevent/tap/resources.html>

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

Marsteller et al. Am J Infect Control, 2014; 42: S209-215.

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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.

National Center for Emerging and Zoonotic Infectious Diseases
Place Descriptor Here



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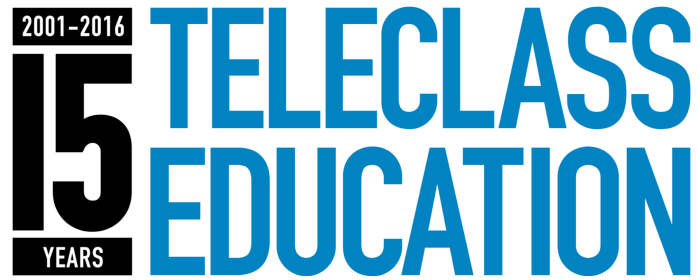
Coming Soon

- 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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