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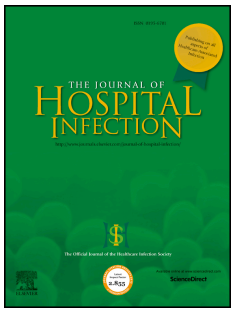

Preventing and managing healthcare-associated infections: linking collective leadership, good management, good data, expertise, and culture change

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Preventing and managing health care-associated infections (HCAIs): linking collective leadership, good management, good data, expertise and culture change

By Ginny Edwards

From the mid to late 1990s intense media coverage of MRSA in the NHS brought the issue to prominence, accompanied by an extensive political response. Around 3000 articles on MRSA were published in 12 UK newspapers between 1994 and 2005, compared with 21 articles in six major US newspapers. The UK articles emphasised personal narratives and focused primarily on environmental cleaning as a solution.[1] Although more recent media coverage has expanded to include *Clostridium difficile*, MRSA has remained highly prominent in popular consciousness.

Of the 6-8% of patients who acquire health care-associated infections (HCAIs), MRSA and *C.difficile* in fact make up only a small proportion; in 2006 1.8% of patients became infected with MRSA, and by 2012 this had been reduced to 0.1%. Similarly, *C. difficile* rates have declined from 2% in 2006 to 0.4% in 2012.[2,3] Recent data show there were just over 800 cases of bloodstream infection with MRSA in England in 2015.[4] Despite a shift in the nature of infections, with infections increasingly caused by other bacteria such as *E. coli* and other Enterobacteriaceae, fear of MRSA and *C.difficile* still dominates public perceptions of HCAIs. HCAI data pose a significant reputational risk to organisations, generating a strong incentive to use HCAI control as a marker for quality.

Performance management approaches have proved influential in driving improvements in infection prevention but, as the paper by Brewster *et al* highlights, are also associated with a range of negative consequences.[5] Performance management might be most valuable as just one component of wider efforts to reduce HCAIs. Preventing and managing HCAI can be viewed as predominantly a 'technical change', a well-defined problem where the solution requires new learning,[6] but it is also a significant leadership challenge. Evidence-based guidelines for reducing HCAIs are available,[7] but from working with hospitals experience has found that the implementation of these guidelines into practice often requires a combination of collective leadership, expertise, good management and culture change.

Reducing HCAI requires a set of inter-related factors: collective leadership, good management, good data, expertise and culture change. The Rapid Spread model reflects these components and is a fast and effective way of managing change,[8,9] developed within NHS organisations, the model offers a multi-component approach to achieving change across healthcare systems on a large scale and fast pace. The use of this approach has been instrumental in achieving significant reductions in HCAI rates in the UK. The methodology incorporates a core set of actions that together have been shown to be effective – the 4Bs: Belief; Behaviour; Be sure; Be helpful.

Belief – Widespread belief that there is a problem and executive level buy-in to solve it are vital. Organisations and wards that accurately capture their performance and benchmark against similar types of organisations have a strong basis on which to make a case for change.

Even with concerted efforts to drive down rates of HCAIs, there continue to be real challenges in implementing guidelines and best practice. Issues around lack of understanding and ownership of good governance still remain. Reports to organisational governance systems may provide false reassurance; reporting HCAI as a risk is of little value if risks are then forgotten about and lessons not learned, shared, or actioned.