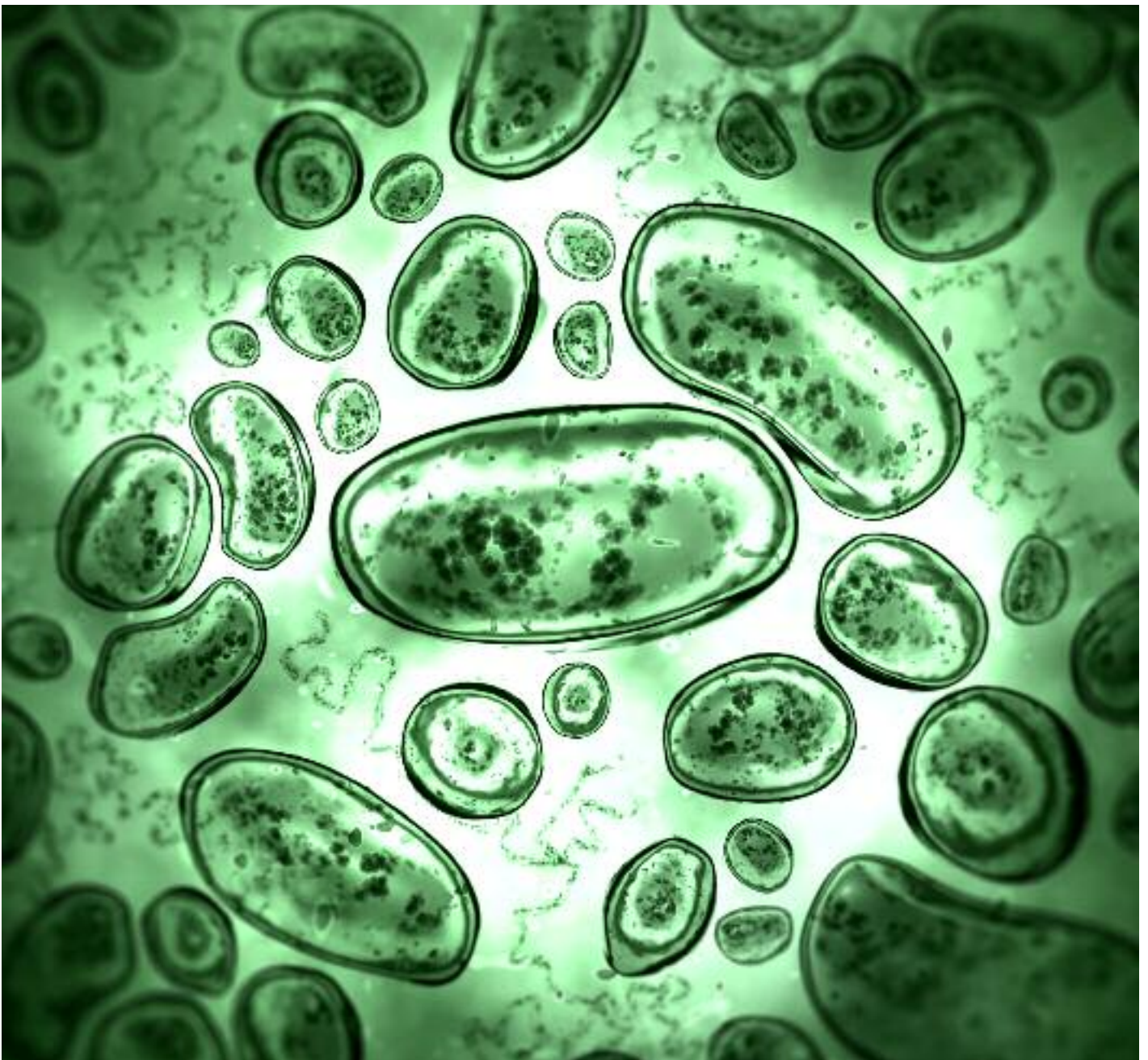




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The role of the link nurse in infection prevention and control (IPC): developing a link nurse framework





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The role of the link nurse in infection prevention and control (IPC): developing a link nurse framework

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1

Introduction

Link nurses (LNs) are traditionally defined as ‘practising nurses with an expressed interest in a specialty and a formal link to specialist team members’ (MacArthur, 1998). In addition to LNs having an interest in particular specialist areas, such staff are often known through their leadership at the local clinical level as an acknowledged ‘link’ or ‘contact person’. They actively nurture relationships between their relevant specialist team and those working in the local clinical environment (ward, department, care home and so forth) and undertake specific tasks or roles as required within their sphere of responsibility. Recognised by colleagues for their unique function and contribution, and with support from their managers, such voluntary roles have the potential to support patient safety strategies through the dissemination of knowledge and best practice in health care settings.

LNs are commonly used to support many areas of specialist nursing practice within the UK. Practice areas which utilise LNs include diabetes, tissue viability, pain, nutrition and infection prevention and control.

The role can be used variably within hospital and community settings in the NHS and the independent sector. Variability can occur in the title used for such a role; for example, champion, nurse, practitioner, liaison or support person. Similarly, there is variability in the prerequisites for undertaking the role, including nursing role/grade or qualification (registered or unregistered nurse and completion or undertaking of a predefined educational course).

This document forms part of a series of resources to support LNs, specialist teams, and managers who may be using or considering a LN system and specifically outlines the benefits of implementing LN roles for infection prevention and control (IPC).

It describes the development of a role framework and associated competences in this area, based on the contribution of specialist infection control nurses and practising/aspiring LNs.

Although this work has originated from, and uses, infection prevention and control (IPC) examples, the principles of this work are relevant to LNs working in all specialties and a generic role framework has been provided for reference and adaptation (see Appendix 1).

Note on language

Link staff roles are historically associated with nursing staff, however current roles are frequently extended to the multidisciplinary team (such as physiotherapists, occupational therapists and bed managers) in acknowledgement of the need for multidisciplinary engagement and ownership of infection prevention and control (IPC). Although the term link nurse is frequently used, other members of the multidisciplinary workforce can and do undertake the role of ‘link person’. Therefore, for the purpose of this guidance, the title link ‘practitioner’ should be considered synonymously with link ‘nurse’.

2

Background

Link nurses (LNs) have been in use since the 1980s in a number of countries. Originally implemented to support education of ward-based staff (Horton 1988), Ching and Seto (1990) expanded the role to investigate the efficacy of such a system to support the implementation of new urinary catheter care guidelines.

The success of this work highlighted the importance of involving clinical staff in the implementation of infection prevention and control (IPC) policies and paved the way for expansion of the LN role and a cultural shift towards the ownership of IPC by clinical staff, as opposed to specialist IPC teams. Likewise in a UK setting, Teare and Peacock (1996) described the need to promote the ownership of local IPC standards by staff themselves in order to improve their status and profile locally.

The popularity of LN systems increased and expanded during the 1990s in line with the growing body of health care literature (Cooper, 2004; Teare and Peacock, 1996; Roberts and Casey, 2004) on the benefits and learning from the implementation of such systems. This included integrating the LN role within local risk management systems and focusing LN activity on issues such as education, surveillance and standard setting linked to audit programmes.

Available literature acknowledges success in local efforts to change the behaviour and attitudes of all health care workers towards IPC, as well as the need for evaluation and consideration of different models to support adaption in different care settings such as care homes.

Since the 1990s the profile of IPC in the UK has increased along with recognition of the practical need to support IPC teams with communication and ownership of IPC at the clinical level. Political, media and public pressures have necessitated a need for organisations to consider local contacts and role models to sustain improvements in IPC and reductions in health-care associated infections.

Central to this is the implementation of evidence and best practice as it evolves. LN systems/networks provide a unique opportunity to establish 'communities of practice' in which research, clinical and patient

experience, and local information are valued and deemed relevant, enabling and supporting the change process as required. The successful engagement of staff and their contribution at an early stage to leadership and service improvement is essential to this (The King's Fund, 2012). Recognising and valuing staff, especially those who take on additional roles such as LNs, is crucial and requires transparent and open organisational commitment, support and recognition in order to succeed.

LN systems are used throughout the UK. Additionally, in 2002 Scotland introduced the role of cleanliness champions (CCs) as part of a national strategy to reduce health-care associated infections. Initially aimed at nurses, this programme is now available to the multidisciplinary workforce and the educational programme underpinning the CC programme is embedded in current undergraduate programmes for nursing, medicine, dental and allied health professionals. Both LNs and CCs exist currently within Scotland. However, a recent evaluation of the CC programme (NES, 2009) did not compare the impact of the role with existing LN systems. Therefore, for the purpose of this document, the two roles are considered as separate but complementary.

Despite some documented evidence of local improvements in IPC as a result of the use of LNs and the popularity of this role, no national role profile or core competences have been developed to date to support link practitioners, their managers (such as ward or department managers) or organisations with such a system.

The RCN recognises the importance and popularity of LN systems in supporting clinical nurse specialists and IPC teams in their role as expert advisers and facilitators. LNs are recognised as important components of organisational structures whereby skills, professional practice standards and knowledge are disseminated via motivated and active staff with an interest in IPC.

The role also provides a unique opportunity for nurses to enhance their personal and professional practice, developing skills such as managing change, education

and leadership. Locally and nationally, LN systems are considered important for developing potential future IPC nurses or other specialist roles (for example, roles associated with risk management or quality) through the development of transferrable skills and attributes developed as a result of their experience.

Many of the skills and objectives underlying LN programmes are reflected in the RCN's *Principles of Nursing Practice*. These eight principles describe what the public can expect from nursing practice in any setting. Produced jointly by nurses and patient groups, the principles are intended for use by nursing teams for the purposes of quality improvement, continuing professional development, and for sharing with patients and carers.

Indeed, infection prevention and control is at the heart of the RCN's *Principles of Nursing Practice*; Principle C – Nurses and nursing staff manage risk, are vigilant about risk and help to keep everyone safe in the place they receive care (Currie et al., 2011).

Investigating the role and value of link nurse systems

Following consultation with RCN members at a number of RCN IPC events in 2010, a formal workstream to investigate this role was developed with a view to establishing a generic role profile for a LN with an additional specific example in use for IPC.

Two workshops held in May 2010 provided the basis for the development of the LN role profile. Information obtained during facilitated discussion was evaluated using an approach termed concept analysis¹ and ascribed to enabling factors, attributes or outcomes of the role. The resulting framework (see Appendix 1) describes this role, and highlights how it can be enabled, and its success recognised, within organisations. Accompanied by the core competences, this framework provides a foundation for the formal recognition of the LN role, further evaluation and future development of the role.

1. An approach that enables a common understanding to be developed about a particular concept through clarifying its characteristics and differentiating it from other related concepts as a basis for further research and development.

3

The key themes of the link nurse role framework

A starting point for the workshops centred on how to recognise or identify link nurses (LNs) as they undertake their day-to-day clinical roles. In order to answer this question, attendees considered behaviours and skills as well as specific tasks or duties that LNs might undertake.

The workshops identified four key themes for role attributes:

- acting as a role model and visible advocate for IPC
- enabling individuals and their teams to learn and develop their infection prevention practice
- communicating and networking around infection prevention practice
- supporting individuals and teams in local audit/surveillance.²

For each of the core characteristics/attributes, a number of examples have been identified and these support the need for the developing practice competences.

Attributes

1. The LN acts as a role model and visible advocate for IPC by:

- providing a visible presence and being accessible in the workplace to clinical teams, patients and service users
- working alongside the clinical team, acting as a role model who demonstrates and promotes best practice at all times
- providing positive feedback to members of the clinical team to support the celebration of success
- challenging/managing poor practice with other local

team members and supporting staff to review and rectify behaviour.

2. The LN enables individuals and teams to learn and develop IPC practice, for example by:

- working alongside clinical team members, particularly students and practice facilitators, to generate creative opportunities for learning
- working with local leaders/managers to develop a culture of learning and development that will sustain improvements in IPC by learning from incidents/complaints and local data supporting evaluation of IPC practice
- utilising opportunities to learn and develop their own IPC knowledge and skills in, and from, practice
- supporting local IPC teams through attending and contributing to LN meetings.

3. The LN acts as a local communicator for IPC issues by:

- collaborating and communicating regularly with the IPC team, supporting them and clinical team members as a local resource for IPC
- developing innovative ways to communicate IPC information including best practice standards and relevant supportive resources
- supporting local clinical leaders and managers in their IPC role through regular two-way communication
- promoting or establishing networks relevant to their role within local governance structures.

2. The last attribute was further classified as optional, in recognition of the variation in audit and surveillance processes between organisations and practice settings.

4. The LN supports local and organisational teams with audit/surveillance as a measure of quality of care (optional) by:

- together with leaders/managers, facilitating ownership of audit/surveillance by the whole local clinical team
- acting as a local resource for audit/surveillance expertise, through the education and training of the local clinical team.

Enabling factors

Enabling factors are those required to successfully implement the LN role. A full description of enabling factors is provided in the role framework (see Appendix 1).

Although the attributes listed above help to clarify how a LN can be recognised in the workplace, enabling factors are critical in supporting the success of the role. These factors are required at the individual, workplace or organisational level. However, at this stage it is unclear which, if any, of these factors is more important and further work in this area is required. The enabling factors and attributes combine to create an effective and supportive workplace structure and culture for infection prevention and control, where safety and quality are valued and sustained rather than just complied with.

The sustainability of any worthwhile improvement programme can be challenging. Sustaining a LN programme and its benefits is central as a quality improvement programme for numerous specialties. For this reason learning from initiatives such as this should be considered and transferred where appropriate. Some LNs are currently struggling to attend local educational events, support groups and networks due to clinical pressures or staff shortages, and IPC teams face significant workload pressures; making the evaluation of the impact and worth of LN programmes particularly important.

A recent review of implementation of the Productive Ward programme (National Nursing Research Unit, 2011) highlighted a number of enabling factors that nurses themselves recognised as essential during workshops used to inform the LN work. Key enabling factors identified include organisational energy, effective communication and engagement with staff in relation to the purpose of the programme and its objectives. Ensuring local assessment of enabling factors is undertaken is deemed to be crucial in order to avoid 'improvement evaporation' and isolated success.

Outcomes of an effective link nurse system

LN systems require energy and resources (staff and time) on behalf of those undertaking the role and the specialist teams supporting the system through mentorship, education and communication. For this reason it is essential that organisations are able to demonstrate and celebrate the value that these systems bring.

The benefits of LN systems may be both quantitative and qualitative. As with the identified enabling factors, the positive outcomes of the effective use of a LN system can be demonstrated at an individual, workplace or organisational level. From a governance perspective, the implementation of a clearly defined and focused programme supports organisations' governance/assurance processes. Examples of where this is of benefit include:

- the LN role is fit for local governance structures
- local education/training needs are supported within the organisation
- evidence is incorporated effectively into clinical practice
- clinical practice is standardised
- the whole audit/surveillance cycle is implemented and managed to enable improvements in care
- IPC is not perceived to be the responsibility of the local IPC team.

Competences supporting the link nurse role

Following the development of the LN attributes the sub-attributes were further developed to produce four simple competences (see Appendix 2). These competences highlight the importance of the attitudes and behaviours considered essential for the LN role.

Attitudes and behaviours have been specifically included to support both staff and organisations. These are considered important in supporting both organisational values as well as professionalism between and within the multidisciplinary workforce. Additionally, acknowledging the positive attitudes and behaviours of staff through the formal appraisal process provides opportunities for positive feedback and reinforcement of the value of such

attitudes and behaviours, all of which are essential to the retention and sustainment of LN systems.

Behaviours have been defined as core and contextual (as aligned to each competence) for the purpose of this competence framework. Developed to enable personal and professional development, the competences are adaptable and reflect core elements of performance aligned to general knowledge and understanding. The competence document reflects one level of practice considered suitable for any person undertaking the link role, regardless of position or role. Educational components of LN systems should be developed locally, based on local need, and are not considered in this document.

The core behaviours considered essential for LNs are:

- passionate about infection prevention and control (IPC)
- responsible for own actions
- an active participant in LN network/system
- approachable
- non-judgemental
- inclusive
- reflective
- respectful.

Contextual factors

A large number of supportive contextual factors exist across the four counties of the UK. For this reason, only generic contextual factors are included in the competence framework. Further country-specific factors can be accessed via the RCN website www.rcn.org.uk/ipc

Next steps and feedback

The RCN is committed to evaluating the implementation of the resulting framework and its impact. This evaluation will consider the implementation from an organisational and personal perspective (from those involved or those who benefit from LN systems). Further information will be available in due course; however in the interim period, feedback on this document is welcome from readers. Please email any comments or suggestions to ipc@rcn.org.uk

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Appendix 1

Framework for the infection prevention and control link nurse role

Enabling factors Factors required to successfully implement the link nurse (LN) role	The essential recognisable characteristics of link nurse activity The link nurse	Outcomes The consequences of having a link nurse (LN) role
<p>Individual:</p> <ul style="list-style-type: none"> • role clarity – for example a role profile in place • up-to-date knowledge, skills and understanding about infection prevention and control (IPC) best practice • knowledge and skills to facilitate learning in, and from, practice. <p>Workplace:</p> <ul style="list-style-type: none"> • interdisciplinary team recognise the role and value of the LN role • active support with engagement from clinical leaders, managers, senior nurses and all members of the interdisciplinary team • access to best practice guidelines and evidence-based practice • local opportunities to regularly review IPC measures, indicators and practice. <p>Organisational:</p> <ul style="list-style-type: none"> • organisational and senior management endorsement, support and active commitment to the role • governance systems in place for monitoring IPC practice and outcomes • regular board reporting and discussion. 	<p>Acts as role model and is a visible advocate for IPC, for example:</p> <ul style="list-style-type: none"> • role models best practice • is visible in the clinical area • actively promotes IPC issues • celebrates achievements and best practice • challenges when standards are not met. <p>Enables individuals and teams to learn and develop their IPC practice, for example:</p> <ul style="list-style-type: none"> • uses opportunities to learn in, and from, practice • creates a culture for learning from incidents/complaints • provides creative opportunities for learning • acts as a local resource for IPC • works with students and practice facilitators on IPC • supports and sustains LN meetings • reviews collaboratively local IPC measures, indicators and IPC practice. <p>Communicates and networks around IPC practice, for example:</p> <ul style="list-style-type: none"> • develops and creates methods for communication such as IPC notice boards, newsletters and blogs • provides regular two-way communication with the IPC team • provides/receives feedback to/from ward/department manager • promotes and establishes local networks • signposts best practice and relevant resources. <p>Supports individuals and teams in local review/audit/surveillance (optional), for example:</p> <ul style="list-style-type: none"> • supports completion of local review/audit/surveillance • facilitates ownership of local review/audit/surveillance • contributes to reporting within local governance structures. 	<p>For the link nurse (LN):</p> <ul style="list-style-type: none"> • LN role is recognised and supported by the wider multidisciplinary team (MDT) • role satisfaction, continued commitment and motivation • role enhances professional and personal development. <p>For the workplace:</p> <ul style="list-style-type: none"> • best practice standards and guidelines are implemented • LN role is actively used by the wider MDT • IPC learning is identified and implemented • reduced IPC-related complaints and incidents • a culture for networking and mutual support is created • success is celebrated • a sustainable body of local expertise around IPC is created. <p>For the organisation:</p> <ul style="list-style-type: none"> • IPC practice is standardised across organisation • findings from reviews/surveillance and audit are implemented • corporate objectives are met, including those around learning and development • IPC is considered everyone's business and responsibility • IPC is embedded within clinical practice • increased uptake and interest in IPC LN role enabling sustainability • positive media messages are developed.

* Please note that you can substitute infection prevention and control with your own specialty.

Appendix 2

Infection prevention and control link nurse competences

Competence	Link to KSF	Performance criteria	Knowledge and understanding	Attitudes and behaviours	Generic contextual factors
<p>1.</p> <p>Acts as role model and local leader and is a visible advocate for infection prevention and control (IPC).</p>	<p>Core 1</p> <p>Core 2</p> <p>Core 3</p>	<p>Role modelling:</p> <p>Articulates the concept and vision of the organisation's local quality and patient safety strategy (including IPC).</p> <p>Role models the use of local and national policy and guidelines.</p> <p>Is visible in the workplace as a resource and champion.</p> <p>Works within own field of competence and is aware of own role limitations.</p> <p>Seeks advice and guidance from IPC team when presented with new or complex situations.</p> <p>Works effectively as team member of the local workplace.</p> <p>Leadership:</p> <p>Supports the workplace manager with the organisation's IPC strategy/work programme.</p> <p>Develops person-centred relationships.</p> <p>Provides feedback to others on their practice.</p> <p>Enables others to challenge practice when standards are not met.</p> <p>Stimulates an interest in others about IPC and the LN role.</p> <p>Celebrates achievements and best practice.</p> <p>Advocacy:</p> <p>Actively promotes IPC issues.</p> <p>Contributes to local risk assessment and patient safety processes.</p> <p>Uses local governance systems to keep the organisation informed of risks and any necessary resources.</p>	<p>Knowledge and understanding of:</p> <p>Local and national strategy/priorities and policies for IPC.</p> <p>Best practice and evidence-based guidelines for IPC.</p> <p>IPC local arrangements and provision.</p> <p>Effective team working.</p> <p>Own competence and its limitations.</p> <p>LN role and responsibilities.</p> <p>Difference between the purpose and function of LN IPC role and infection control team.</p> <p>Local organisational governance and safety systems.</p> <p>Knows how to:</p> <p>Seek feedback on their role.</p> <p>Evaluate their link role</p> <p>Maintain competence.</p> <p>Access professional peer support for local leadership role.</p> <p>Give and receive feedback.</p> <p>Enthuse and motivate others.</p> <p>Provide feedback or challenge.</p> <p>Celebrate achievements.</p> <p>Undertake a risk assessment.</p> <p>Seek necessary resources.</p>	<p>Resilient.</p> <p>Participative.</p> <p>Collaborative.</p> <p>Visible in practice area.</p> <p>Open to receiving feedback.</p>	<p>RCN (2007) <i>Workplace resources for practice development.</i></p> <p>National guidance on IPC.</p> <p>National Regulatory Organisations and Standards.</p> <p>NRIC website.</p> <p>RCN <i>Principles of Nursing Practice.</i></p> <p><i>Making the care for ward sisters/team leaders to be supervisory to practice</i> (RCN, 2011).</p> <p>RCN Clinical Leadership Programme.</p>

Appendix 2 (continued)

Infection prevention and control link nurse competences

Competence	Link to KSF	Performance criteria	Knowledge and understanding	Attitudes and behaviours	Generic contextual factors
<p>2.</p> <p>Enables individuals and teams to learn and develop their IPC practice.</p>	<p>Core 1</p> <p>Core 2</p> <p>Core 3</p> <p>Core 4</p> <p>Core 5</p>	<p>Helps practitioners implement best practice, local and national standards in their every day practice.</p> <p>Uses all opportunities for self and others to learn in and from practice about IPC.</p> <p>Contributes to a team and workplace culture for learning in relation to IPC.</p> <p>Works with local clinical educators/preceptors/mentor to support students, staff and clinical leaders in their learning about IPC.</p> <p>Actively participates in LN meetings.</p>	<p>Knowledge and understanding of:</p> <p>The principles and knowledge base underpinning IPC.</p> <p>Learning cultures.</p> <p>The purpose and function of link work meetings.</p> <p>The local workplace culture (team and patient pathway) and factors that influence it.</p> <p>The role of complaints/feedback in developing a quality service.</p> <p>Processes to support analysis of incidents.</p> <p>Knows how to:</p> <p>Factor that knowledge use and implementation in the workplace (for example, culture, facilitation, leadership, evaluation).</p> <p>Provide creative opportunities for learning across the patient pathway.</p> <p>Facilitate innovation, creativity and solution-focused approaches.</p> <p>Enable learning from incidents/complaints.</p> <p>Enable others to challenge assumptions.</p> <p>Participate in and access link worker meetings.</p> <p>Reflect on practice in a structured way.</p> <p>Enable others to reflect on their practice; IPC information, data, and their implications.</p>	<p>Supportive.</p> <p>Innovative.</p> <p>Willing to reflect on, and learn from, own practice.</p> <p>Values learning.</p> <p>Gives and receives feedback.</p>	<p>Local opportunities for developing learning and development skills.</p> <p>Professional development workplace resources.</p>

Appendix 2 (continued)

Infection prevention and control link nurse competences

Competence	Link to KSF	Performance criteria	Knowledge and understanding	Attitudes and behaviours	Generic contextual factors
<p>3. Communicates and networks around IPC practice.</p>	Core 1	<p>Communicating Acts as a local resource for IPC to all local staff and the infection control team. Liaises with local infection control team. Develops and uses different methods for communicating IPC knowledge, information and issues. Provides regular two-way communication with the infection control team, manager and key staff. Provides/receives feedback to/from workplace manager. Signposts best practice and relevant resources. Contributes to reports to management using local systems.</p> <p>Networking Promotes, establishes and uses local, regional and national networks as required.</p>	<p>Knowledge and understanding of: The range of methods, opportunities and resources that can be used to communicate IPC knowledge, information and issues with different staff groups, the infection control team and patients – for example, IPC notice boards, newsletters, blogs, ward department meetings, websites, e-learning. Ways to provide feedback and common reactions to this. When and how to provide feedback or challenge and when to access local IPC specialists.</p> <p>Knows how to: Communicate key messages, expectations and behaviours. Feed in to the organisations assurance/reporting mechanisms. Find, access and use evidence-based literature in relation to IPC principles. Contact the IPC team. Evaluate the effectiveness of different communication approaches.</p>	<p>Welcoming. Listens. Collaborative. Good communicator.</p>	<p>RCN (2010) <i>RCN Finding, using and managing information</i>. Nursing, midwifery, health and social care information literacy competences. Relevant websites. E-learning modules. RCN IPC Network. Regional IPC networks. MHRA alerts. Local learning and reporting systems. Organisation's annual infection control report.</p>

Appendix 2 (continued)

Infection prevention and control link nurse competences

Competence	Link to KSF	Performance criteria	Knowledge and understanding	Attitudes and behaviours	Generic contextual factors
<p>4.</p> <p>Supports individuals and teams in local review/ audit/ surveillance. *</p>	<p>Core 4</p> <p>Core 5</p> <p>IK1</p>	<p>Participates in local quality and safety systems.</p> <p>Works with others to collect, analyse and interpret local audit and surveillance data.</p> <p>Facilitates ownership of local review/audit/surveillance activities.</p> <p>Works with others to use local audit/surveillance data to improve practice.</p> <p>Works with others to review local IPC practice, measures, indicators and outcomes.</p>	<p>Knowledge and understanding of:</p> <p>The local quality and safety systems including reporting and the local indicators/outcomes of IPC effectiveness.</p> <p>The concept of and approaches to surveillance, as well as the local structures and processes.</p> <p>Audit in relation to IPC standards, the audit cycle, implementing learning from audits and the relationship of IPC audits to other audits.</p> <p>The contribution of complaints (formal and informal) and incident recording in improving practice.</p> <p>Knows how to:</p> <p>Collect accurate data for purposes of audit, surveillance and epidemiology – for example, in outbreak situations.</p> <p>Participate in simple audits.</p> <p>Feed back and explain audit results and their impact to local team.</p> <p>Work with others to implement changes to practice arising from audit and other feedback.</p> <p>Use improvement methodologies such as PDSA (plan, do, study, act) to develop improvement local plans.</p> <p>Use formal and informal opportunities for evaluation and learning from patients and service users' experience.</p>	<p>Logical and methodical.</p> <p>Rigorous.</p> <p>Analytical.</p> <p>Good time management.</p> <p>Good communicator.</p>	<p>Local IPC annual programme and strategy.</p> <p>Local IPC audit tools.</p> <p>Local surveillance policy and protocols.</p> <p>National surveillance programme information.</p> <p>Local IPC policies and procedures.</p> <p>Local clinical audit teams/departments.</p> <p>Organisation's annual report.</p>

* Optional dependent on organisational or local need.



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