Northern Health Infection Prevention and Control Program

Annual Report, 2008/2009

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Infection Prevention and Control

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Executive Summary

The annual report of the Northern Health Infection Prevention and Control Program (IPCP) provides the opportunity to highlight the infection prevention and control activities that have occurred throughout the health authority as well as illustrate the full scope of responsibilities that fall within the Infection Prevention and Control program.

The Northern Health Regional Infection Prevention and Control program (NHIPCP) was established in November 2003. At that time there were three members of this team, two Infection Prevention and Control Practitioners (ICP's) and one Regional Manager. Human resources have grown incrementally. Currently there are ten people filling eight full time equivalencies plus the Sterile Processing Department Regional Coordinator and the Regional Manager. NHIPCP functions within a matrix organization structure with the ICP's reporting to the regional manager for program development and the Health Service Administrator for site specific operations.

NHIPCP has developed into a program with credibility and influence within the organization. A sustainable structure for reporting of infection rates and infection control issues has been developed and implemented. NHIPCP has built collaborative working relationships with IC practitioners throughout the region and with the Provincial Infection Control Network (PICNet) to ensure that Northern Health is using current best practices and participated in collaboration on provincial initiatives and pilot projects.

While substantial progress has been made in surveillance and education of staff, this remains a significant area for development. Surveillance that has been implemented has enabled Infection Control Practitioners to identify outbreaks or increasing rates of organisms of concern and respond appropriately to contain these situations. Surgical site surveillance completed has demonstrated rates that are within nationally recognized benchmarks. (adapted from 2007/2008 Annual Report)

Membership Infection Prevention and Control Committees

Northern Health Regional Committee

Regional Director Diagnostics and co-chair Northern Interior HSDA committee
Chief Pathologist PGRH and co-chair Northern interior HSDA committee
Regional Director, Pharmacy
Medical Health Officer, North East HSDA
Chief Medical Health Officer
Regional Director Support Services
Pathologist and Chair of NEHSDA committee
Regional Director Quality and Risk Management
Regional Coordinator Sterile Processing
Physician, Internal Medicine and Infectious Diseases
Regional Director Plant and Property
Health Services Administrator and Chair NWHSDA committee
Regional Manager Public Health, Communicable Diseases
Regional Director Workplace Health and Safety
VP Planning, Quality, and Information
Regional Manager Infection Prevention and Control
Education/Consultant Provincial Infection Control Network

Northern Interior HSDA Committee

Representative Workplace Health and Safety
Regional Director Diagnostics – co-chair
Chief Pathologist, PGRH – co-chair
Physician, Pediatrics and Infectious Diseases
Surgeon, PGRH
Regional Manager Infection Prevention and Control
Manager Material Services and Sterile Processing PGRH
Coordinator Prince George Communicable Diseases
Manager Plant and Property PGRH
Director of Care, McKenzie Hospital
Infection Control Practitioner, PGRH
Infection Control Practitioner, GR Baker
Infection Control Practitioner, Vanderhoof
Regional Epitech/ICP
Head Nurse, McBride Hospital
Site Administrator Lakes District Hospital
Area Director Home and Community Care
Complex Care Program Manager, Vanderhoof
Supervisor Housekeeping PGRH
Head Nurse, Stuart Lake Hospital

North East HSDA Infection Control Committee

Pathologist (Chairperson)
Medical Health Officer
Representative Workplace Health and Safety
Infection Control Practitioner MMH/KGH
Service Administrator, Fort St. John
Infection Control Practitioner, Fort. St. John
Infection Control Practitioner, Dawson Creek
Director of Care, Chetwynd Hospital
Director of Care Hudson Hope Health Center
Laboratory Manager Dawson Creek District Hospital
Manager Plant and Property Services
Director of Patient Care, Dawson Creek District Hospital
NE Regional Laboratory technologist
Manager Support Services
Regional Manager Infection Prevention & Control

North West HSDA Infection Control Committee

Health Services Administrator, (Chairperson)
Surgeon, Kitimat
Infection Control Practitioner, Prince Rupert
Regional Manager Infection Prevention & Control
Infection Control Practitioner, Mills/Kitimat
Infection Control Practitioner, Smithers
Manager Support Services Mills Memorial/Kitimat
Supervisor Support Services QCI
Site Administrator Queen Charlotte City Hospital
Supervisor Plant Services, Mills Memorial
Representative Workplace Health and Safety
Communicable Disease Nurse Public Health
Head Nurse Operating Room, Mills Memorial
Charge Laboratory Technologist, Prince Rupert
Head Nurse, Bulkley Valley Hospital
Head Nurse Acute Care, Terrace

Who We Are

Northern Health is responsible for primary care, acute care, home and community care (LTC/Complex Care), mental health and addictions and public health. The Northern Health Infection Prevention and Control Program (IPCP) is a key quality and patient safety program within the health authority. The IPCP functions across the continuum of care and the spectrum of care settings.

The program functions under the direction of the Regional Manager. Currently, there are Eleven ICP positions which fill a combined total of 9.2 full time equivalencies. One of these positions has a regional scope to provide expertise and leadership for surveillance as well as provide backup Infection Control support to the Infection Control Practitioner (ICP) at Prince George Regional Hospital.

Another position, Regional Coordinator for Sterile Processing, is responsible for implementing and monitoring quality assurance processes and education of staff in Sterile Processing. (adapted from 2007/2008 Annual Report)

Structure of Northern Health Infection Prevention and Control Program

Northern Health operates as 3 semi-autonomous geographic Health Service Delivery Areas (HSDA), each with Infection Prevention and Control Committee and a Medical Advisory Committee. The HSDA Infection Prevention and Control Committee reports to the Northern Health Infection Prevention and Control Committee (NHIPCC) and the HSDA Medical Advisory Committee. Each of these, in turn, reports through Northern Health Medical Advisory Committee to the NH Executive and the Board.

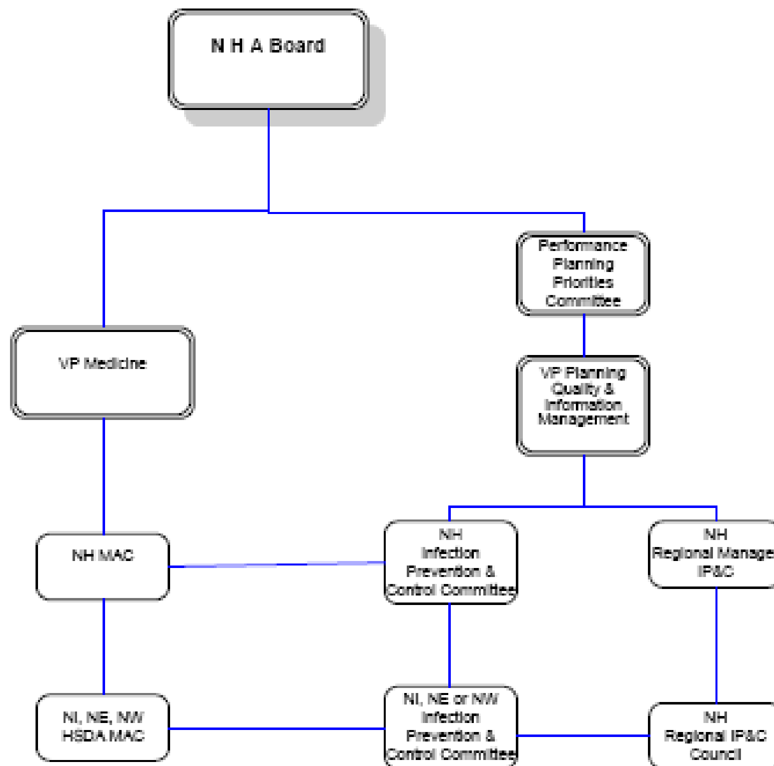
The role of IPCP is to develop and implement standardized approaches to best practices, surveillance, education, outbreak prevention and control and consultation to all sites within Northern Health as well as organizations within Northern Health communities.

Practice changes process includes:
The majority of Infection Prevention and Control decisions regarding best practices/ policies are researched and evaluated within the Infection Control Practitioner (ICP) Council which is led by the Regional Manager. Other health care disciplines/stakeholders are consulted where appropriate.

When the ICP Council reaches consensus that a policy or decision has been researched and that the evidence supports its implementation, the policy is submitted to the three HSDA Infection Prevention and Control Committees. The HSDA committees are multidisciplinary and report to the respective Medical Advisory Committees (MAC) for endorsement. The new recommendation is then forwarded to the Northern Health Regional Infection Prevention and Control Committee and if approved will be sent to the Northern Health Medical Advisory Committee for their endorsement.

This approach encourages collaboration and engagement necessary for change management and ensures that many perspectives are considered. Unique circumstances in individual facilities may require variations in how recommendations may be implemented, this process allows for some flexibility while ensuring that interpretations and actions remain consistent with best practices. (adapted from 2007/2008 Annual Report)

The diagram below illustrates the reporting structure of the NHIPCP and the flow of information.



Purpose of NHIPCC is an advisory committee for the development, implementation, and ongoing review of Infection Prevention and Control activities to prevent acquisition and transmission of infection across the continuum of care in Northern Health. This committee integrates staff from each HSDA, Regional Directors, Workplace Health and Safety and Public Health.

The vision of IPCP is to "Provide a comprehensive Regional Infection Prevention and Control Program utilizing modern and innovative approaches throughout Northern Health".

The Mission statement of IPCP is "The Northern Health Infection Prevention and Control Program works to prevent and control infections for the well-being of patients/residents/clients, healthcare workers/volunteers and visitors. The program will demonstrate leadership and commitment to caring, respect, fiscal responsibility, education and quality improvement".

Strategic Direction

Northern Health will ensure quality in all aspects of the organization

• Infection prevention and Control data entered quarterly on Accreditation Canada indicators.

• Aggregated surveillance data is reported to the HSDA, NH Infection Prevention and Control Committees, Senior Administration and Northern Health Medical Advisory Committee (MAC) quarterly.

• Accreditation Canada indicators, progress of the IPCP, and issues arising are reported to the Northern Health MAC directly and to the Executive via the VP of Planning, Quality, and Information Management quarterly.

• Number of acute care sites who monitor and report on MRSA, VRE and CDAD has increased by one. The implementation of the Health Link North information system has enabled ICPs to provide oversight at those acute care facilities that do not yet have an ICP presence. However, the information is not statistically significant limiting inclusion of these cases on the surveillance database. It does allow the ICP to identify an increase in cases and then engage the nursing leadership locally and regionally in control strategies.

• The number of sites involved in surgical site surveillance has increased to 6 (to include Terrace) and the types of procedures for surgical site surveillance has increased in sites previously conducting surveillance.

Northern Health will create a dynamic work environment that engages, retains and attracts staff and physicians

• Strategies have been used to increase uptake of education by staff, however access to staff continues to be a challenge.

• All sites with ICPs on site have an Infection Prevention and Control in-service during new staff hospital orientation.

• New ICP staff complete a basic Infection Prevention and Control course endorsed by CHICA

• Three positions were added to the ICPC program, a full time ICP with an emphasis on Complex Care at PGRH (remains posted), 0.6 FTE position in Smithers (posted and filled) and 0.6 FTE position in Vanderhoof (remains posted).

Northern Health will lead initiatives that improve the health of people we serve

• The Regional Manager continues to sit on the Provincial Infection Control Network (PICNet) Advisory committee, the Communication committee and the GI working group. The NHIPCP continued to work with the new protocol for collecting data for the CDAD database. This is the first provincial project that will standardize the way data is collected and reported in British Columbia. Final revisions are underway at the date of writing prior rolling out this surveillance strategy to all health authorities under the auspices of PICNet.

• Regional Manager participates on committee with the leads in Infection Prevention and Control in BC

• Several ICPs from NH have also been active on working groups within PICNet. These working groups are also striving to standardize best practices for specific diseases

Overarching NH objectives of the IPCP are:

1. Establish standardized IPC activities across NH.

2. Increase the capacity for best practices in Infection Prevention and Control for all sites within NH.

3. Introduce effective and evidence-based practice.

4. Develop key relationships with internal and external stakeholders

5. Maintain highly trained and educated staff.

(adapted from 2007/2008 Annual Report)

The following table illustrates 2008/2009 milestones reached towards the goals and objectives of the IPCP and the work that is continuing.

GOALS	MILESTONES
Establish standardized IPC activities across NH: a) Targeted audits for best practices.	Regional ICP and SPD Councils operational • ICP and SPD council meets monthly • ARO screening form audits • Unit specific audits • SPD audits (Completed yearly) • Shared database for all surveillance
Increase capacity for best practices in Infection Prevention and Control: a) Increase positions for ICPs in acute care b) Education of staff	• New position in Smithers (0.6 fte.) • New position at PGRH (Complex Care – 1 fte.) • New position in Vanderhoof (0.6 fte.) • Increase in position in Terrace 0.75 to 1FTE • Increase in positions in Prince Rupert, Dawson Creek and Fort St John from 0.6 fte. to 0.8 fte. • Total increase 3 FTE's • In-services and orientation for new staff • Just in time in-services for specific issues • Bug Bytes newsletters (I- portal) • Sterile processing teleclasses • On-line Infection Prevention and Control Module (from VCH &PICNet) (I-portal) • Hand Hygiene module (Ontario Ministry of Health and Long Term Care) (I-portal) • Hand Hygiene game (National patient Safety Agency UK) (I-portal)
Introduce effective and evidence-based practice: a) Standardized protocols b) Resources for sites	• Respiratory Illness outbreak protocol/process • Gastrointestinal Outbreak protocol • Increased scope of targeted SSI surveillance • Increased scope of Complex Care Surveillance • Home and Community Care Manual (March 2009) • Revised Acute Care Manual (March 2009) • I-portal Infection Prevention and Control webpage • Bug Bytes newsletters (I- portal) • On-line Infection Prevention and Control Module (from VCH &PICNet) (I-portal) • Hand Hygiene module (Ontario Ministry of Health and Long Term Care) (I-portal) • Hand Hygiene game (National patient Safety Agency UK) (I-portal) • Sterile Processing Policy/Procedure Manual (January 2009)
Develop key relationships with internal and external	• ICPs have participated in working groups in

stakeholders	PICNet, BCCDC. • ICPs have provided education and consultation to groups such as the LPN/RN programs, Fairview Management. • ICPs have participated on internal committees such as product selection, construction/renovation, and WH&S

Human Resources of the Northern Health IPCP

During the fiscal year 2008/2009, the IPCP increased its human resources in acute care by two positions; an ICP in Smithers and an ICP in Vanderhoof. As of April 1, 2009 the IPCP increased its human resources by one position and 5 existing positions increased their fte. The administrative assistant position has been postponed for one year in relation to the current budget constraints.

The table below illustrates how ICP resources are deployed across Northern Health

Regional Manager =1.0 FTE.

Community	ICP (FTE)	Designated Responsibilities	Consult/support
*Prince Rupert	0.8	PRRH, Acropolis Manor	QCC, Masset
Terrace/Kitimat	1.0	MMH, KGH (including MLC)	Terraceview Lodge Home Support and Community Nursing
Prince George	1.0 1.0 (vacant)	PGRH, Jubilee Lodge Complex Care	Rainbow, Parkside, Simon Fraser
Quesnel	0.6	GR Baker,Dunrovin	
*Dawson Creek	0.8	DCDH, Chetwynd	Rotary Manor, Pouce Coupe, Tumbler Ridge
*Fort St. John	0.8	FSJH, Ft. Nelson	North Peace Care Home, Hudson Hope
Regional Epitech	1.0	Surveillance in Northern Health	Back up support to ICP at PGRH
Smithers	0.6	Bulkley Valley Hospital	Bulkley Lodge
Vanderhoof	0.6 (vacant)	Vanderhoof, Burns Lake	Stuart lake

* In Prince Rupert, Dawson Creek and Fort St. John, the ICP is also funded an additional 0.2 fte. from Workplace Health and Safety to perform some duties traditionally covered by this department such as occupational exposure follow-up, immunization histories and influenza vaccination.

Projects and Initiatives 2009/2010

The Regional Manager of Northern Health IPCP and the Regional Epitech have been active in a provincial initiative with PICNet to standardize surveillance data for Clostridium difficile Associated Diarrhea (CDAD) across British Columbia. This initiative is in the final stages of planning and has begun to roll out to the health authorities.

Accreditation Canada identified the Infection Prevention and Control program as an "organizational strength" Accreditation Canada noted that the IPCP had four areas for improvement. The IPCP gathered and submitted evidence to support the 4 indicators. Evidence and data are inputted on a quarterly basis to Accreditation Canada. Indicator 6.6 remains to be met; "the organization specifically monitors staff members', service providers', and volunteers' compliance with the organizations hand hygiene policies and procedures and provides them with feedback to increase compliance". Hand Hygiene initiative will be a focus for 2009/2010

The Regional Manager maintains the IPCP site within NH iPortal. The site is routinely updated as new information becomes available.

The Acute Care Manual was revised in June 2008 available in 2009. The Home and Community Care Manual was completed and available January 2009. Hard copies of the manual were sent to the appropriate departments. The Acute Care Manual, Complex Care Manual, Home and Community Care Manual and the SPD Manual are all available electronically across NH on iPortal.

Surveillance

The IPCP continue to establish standardized surveillance activities across the health authority. Substantial progress has been made, however further development is required. All of the individuals who have taken positions in Infection Prevention and Control have continued to add to their experience in surveillance. Two ICP's have completed a formal course in surveillance.

The Epitech maintains and monitors the common databases in which each ICP enters data. The Regional Epitech analyzes the data and creates reports on a quarterly basis. In NH, common databases include MRSA, VRE, ESBL, CDAD and targeted surgical procedures.

Antibiotic Resistance Organisms (ARO)

In the acute care sites in Northern Health, a standardized screening questionnaire is completed for all patients who are admitted to hospital to determine the risk for colonization of an ARO. Swabs are only taken if the responses to the questions indicate that the individual is at risk for being colonized with an ARO.

This process allows for the early identification of potential reservoirs and allows staff to implement appropriate precautions to protect other patients or to use routine precautions with confidence.

The number of nosocomial acquired cases of AROs are influenced by: a) the complexity of the patient's health condition, b) severity of the illness, c) exposure to invasive devices during treatment, d) types of rooms (i.e. single vs. four bed), e) shared washrooms, f) intensity of activity and g) overcrowding of units.

Nosocomial acquired HAMRSA (hospital associated MRSA) and CAMRSA (community associated MRSA).

Originally MRSA was predominantly acquired in health care settings. However, in the past decade new strains have emerged which are predominantly transmitted in the community.

The type of individuals affected by these strains differs. Typically those who acquire HAMRSA have had health conditions, several recent encounters with health care facilities and antibiotic use. Those who acquire CAMRSA are often young healthy individuals who have little, if any, exposure to antibiotics in the past. An individual may become colonized (carry on mucus membranes, skin etc.) or infected with MRSA. NH statistics do not differentiate between these two types of patients.

The extent CAMRSA strains are transmitted in hospitals is unknown although an increase in cases has been seen in the community, however the IPCP continues to monitor and record data on this. (adapted from 2007/2008 Annual Report)

Vancomycin Resistant Enterococci (VRE)

Enterococci are bacteria found in the stomach and bowels of about 19 out of every 20 healthy people. The bacteria can be present in or on the body but not cause illness (colonization). Enterococci can get into open wounds and skin ulcers and cause infections. Less often, they can cause more serious infection of the blood, urine, or other body tissues.

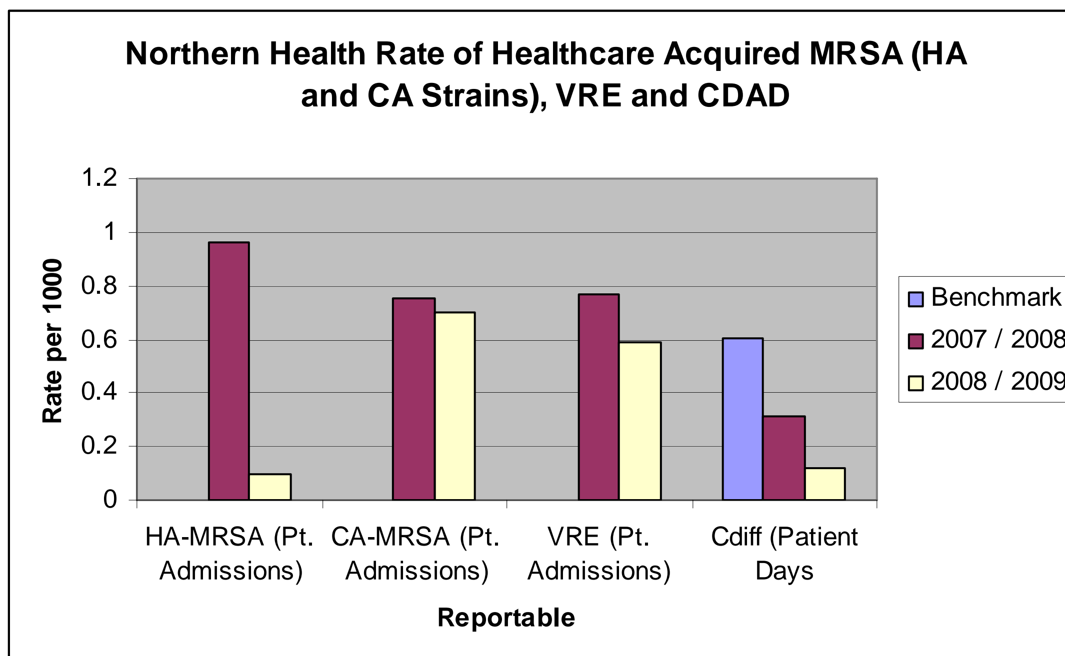
Vancomycin is an antibiotic that is used to treat enterococcal infections. Vancomycin Resistant Enterococci (VRE) are Enterococci that have become resistant to Vancomycin. VRE is not easier to catch or cause more severe infections than other Enterococci. Serious infections caused by VRE may be hard to treat because they are resistant Vancomycin which may sometimes be the only antibiotic to treat Enterococci.
Source: BC Health Files

Clostridium Difficile Associated Diarrhea (CDAD)

Infection Control Practitioners have made a huge impact on CDAD through the implementation of a number of interventions including educating both the nursing and housekeeping staff. The national average rate for CDAD is 0.68 – 0.77 cases per 1000 acute patient days. (adapted from 2007/2008 Annual Report)

The table and graph below compares the current Northern Health rate of healthcare acquired MRSA (HA and CA strains), VRE, CDAD with previous fiscal years. Data is collected at 7 Northern Health facilities (Prince Rupert, Prince George, Dawson Creek, Fort St. John, Terrace, Kitimat, and Quesnel).

Reportable	**Benchmark**	**2007, 2008 Fiscal Year**	**2008/2009 Fiscal Year**
HA-MRSA	Not Established	0.96/1000 Pt. admissions	0.10/1000 Pt. admissions
CA-MRSA	Not Established	0.75/1000 Pt. admissions	0.70/1000 Pt. admissions
VRE	Not Established	0.77/1000 Pt. admissions	0.59/1000 Pt. admissions
Cdiff	<0.6/1000 Patient days	0.31/1000 Pt. days	0.12/1000 Pt. days



Reporting on these indicators meets the new requirements for hospitals seeking accreditation. Accreditation Canada 2009 requires hospitals to report on either MRSA or CDAD. This data is entered on a quarterly basis.

This surveillance is currently only conducted in acute care sites. All positive reports are viewed by the nearest Infection Control Practitioner who provides a high level of oversight of all incidences of MRSA, VRE and CDAD in Northern Health.

Surgical Site Infection Surveillance

PICNet is reviewing parameters required to best standardize the surveillance of SSIs across the province. NHIPCP will review any recommendations made and participate in any provincial initiatives that are established as they apply to NH strategic plan/priorities.

NH surveillance targets specific procedures in sites where ICPs have sufficient training to collect reliable data. Case definitions and classification criteria from the Center for Disease Control (Atlanta) and benchmarks from the NNIS are used.

Data is reported by service and not by specific surgeon or specific procedure (exception is Cesarean sections and Abdominal Hysterectomies).

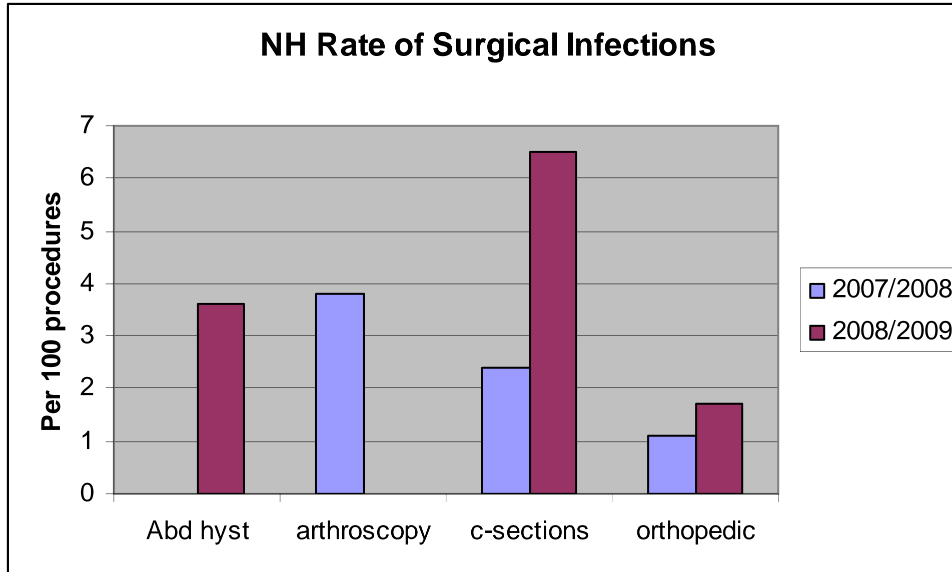
Post discharge surveillance is completed for the targeted surgeries by the ICP's. For most surgeries, this is completed at 30 days. Those procedures in which an implant is used (e.g. total knee or total hip replacement) are followed for one year. Patients are interviewed before discharge, whenever possible, then called at home at regular intervals. If the patient indicates that an infection may have occurred, it first must meet the case definition and then be confirmed with the physician. (adapted from 2007/2008 Annual Report)

The table below compares the current Northern Health rate of SSI surveillance with previous fiscal years. Data is collected at 7 Northern Health facilities (Prince Rupert, Prince George, Dawson Creek, Fort St. John, Terrace, Kitimat, and Quesnel).

Service	Benchmark	2007, 2008 Fiscal Year	2008/2009 Fiscal Year
Abdominal Hysterectomy	2.7 - 7.5 per 100 procedures	No Surveillance	5/138 (3.6/100 procedures)
Arthroscopy	0.88 - 2.5 per 100 procedures	4/104 (3.8/100 procedures)	0/116
Caesarian Sections	2.7 - 7.5 per 100 procedures	10/416 (2.4/100 procedures)	41/630 (6.5/100 procedures)
General	1.4 - 5.2 per 100 procedures	2/11 (18.2/100 procedures)	4/177 (2.3/100 procedures)
Orthopedic	0.88 - 2.5 per 100 procedures	4/349 (1.1/100 procedures)	6/360 (1.7/100 procedures)

Arthroscopy – Data collected in Ft. St. John only
General – Abdominal and inguinal hernias data collected in FSJ, PR, and Quesnel
Orthopedic – Total primary hip and total primary knee arthroplasty

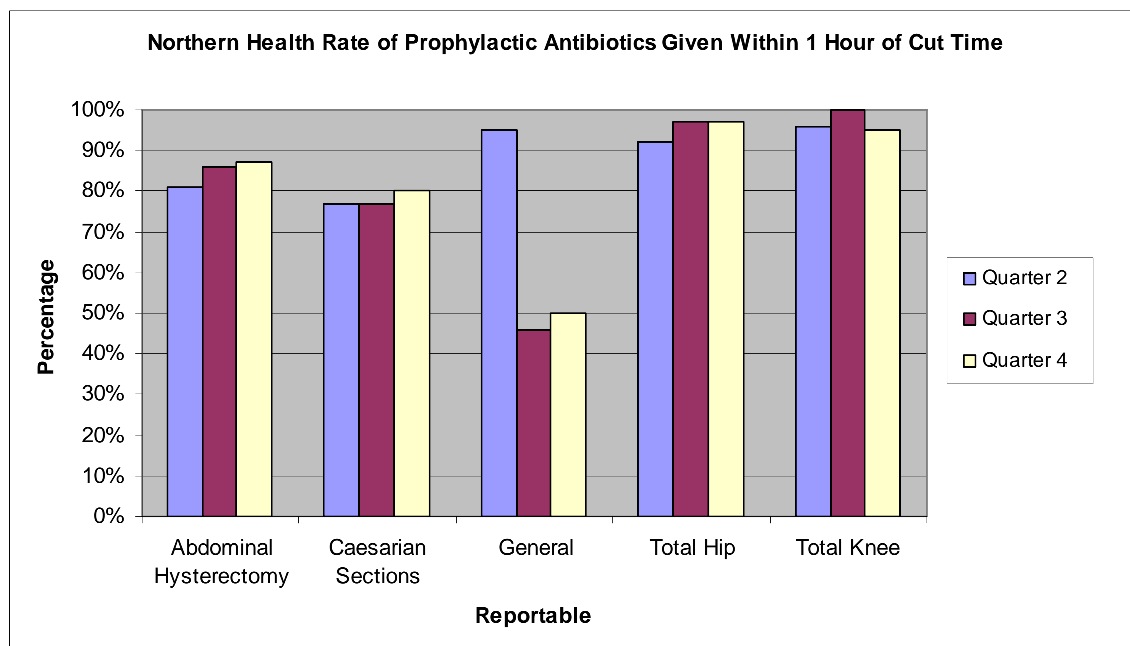
In conclusion, the overall SSI rates for the above procedures performed during the 2008/2009 fiscal year were found to be within acceptable limits



NOTE: Abdominal Hysterectomies surveillance began in 2008
Infections were not noted in arthroscopy procedures in 2008
General Surgery was not included on the graph as the denominator was not met.

The table below compares the current Northern Health rate of prophylactic antibiotics given within 1 hour of incision time. Collection of this data began in quarter 2 of the 2008/2009 fiscal year. Data is collected at 7 Northern Health facilities.

Reportable	Quarter 2	Quarter 3	Quarter 4
Abdominal Hysterectomy	81% (29/36)	86% (25/29)	87% (39/45)
Arthroscopy	0/33	0/37	0/7
Caesarian Sections	77% (107/139)	77% (123/160)	80% (119/148)
General	95% (19/20)	46% (29/63)	50% (24/48)
Total Hip	92% (12/13)	97% (32/33)	97% (34/35)
Total Knee	96% (48/50)	100% (68/68)	95% (61/64)



Outbreak Management

The IPCP created a Gastrointestinal (GI) and a Respiratory Illness (RI) outbreak kit that was distributed to the supervisors and the long term care facilities to assist in Outbreak Management when an ICP is not available.

In the 2008/2009 fiscal year, ICPs were involved in gastrointestinal outbreaks at the following sites: Kitimat General Hospital, Acropolis Manor, Dunrovin Lodge, GRB Hospital the ALC unit, Baker Lodge, Psych Dawson Creek, North Peace Care Home. The average length of an outbreak was one week

In the 2008/2009 fiscal year ICPs were involved in respiratory outbreaks at the following sites: Dunrovin Lodge, North Peace Care Home.

The average length of an outbreak was one week.

Education

Several strategies have been used to bring education to front line staff. ICPs continue to find access to staff for an appropriate uninterrupted time period a challenge. Support for designated IC education varies from site to site.

The table below represents the estimated number of hours spent giving education:

Type of education	PRRH	MMH/KGH	PGRH	GRB	DCDH	FSJ
Orientation	82	15	36	10	16	12
Exposure follow-up	25	*0	*0	*1	25	20
SSI Follow up phone calls	64	22	254	31	33	132
Support Services	6	6	6	6	4	1
Informal education on units/telephone	60	86	240	93	24	110
Community groups	6	6	0	0	0	0
Planning	15	15	30	15	5	34
IC Champions	5	0	3	0	0	11
ARO education/follow up	49	48	103	53	44	49

* Exposure follow up is not the responsibility of the ICP.

Sterile Processing

Provincial Reprocessing (Critical and Semi Critical devices) Audits

Background:

Throughout 2008, 27 sites were audited for reprocessing critical and semi critical medical devices throughout Northern Health.

Of these 27 sites, 12 sites direct operating rooms and 15 sites are Diagnostic and Treatment Centers or smaller sites that do have emergency rooms and acute patients staying at these sites.

Of the 15 sites that were reprocessing, including sterilization, 8 of these sites to date have amalgamated with larger sites. These 8 sites are Masset, Houston, Granisle, Chetwynd, Tumbler Ridge, Fort St James, Valemount and McBride Hospital.

Work Completed:

1) Sterilizers are now all monitored with chemical and Biological monitoring
2) Printouts of sterilizers are being signed off after every load
3) Policies and Procedures are now available and accessible on the iPortal.
4) Areas using high level disinfection solutions have been given a log to sign re the mixing, testing and device use for HLD.
5) Renovations are either complete (Quesnel) or in progress (Fort Nelson) to separate the cleaning area from the assembly area.
6) SPD Policy and Procedure Manual is available on-line through i-portal.

Work in progress:

1) Policies and Procedures will continue to be ‘work in progress’.
2) Meetings are set for discussions with CNC and VCC to look at the prospects of a practicum program, or full course for new and existing staff.

SPD Council Meetings

Continue to meet monthly.

Sterile Processing Theory Course

1) There were 10 students throughout Northern Health that were chosen to take the theory course. Of these 10, 2 have dropped out. Course was offered to other staff. All 8 passed the course.
2) No Northern Health staff have the full course for Sterile Processing. They are required to have the theory only. The ministry standard is to have staff and their

supervisors in the smaller sites that are doing reprocessing activities to obtain the full course. For existing staff who do have the theory this will include passing the Medical terminology and Interpersonal communication skills (both 30 hours) and being assessed for their practical application.
There is also a strong recommendation for annual skill testing.

Extended Cycles
Prince George has gone live with this cycle in accordance with manufactures recommendations.
Prince Rupert & Vanderhoof have also started without any issues. Kitimat and Dawson Creek have also been in-serviced but not started yet

Terminology used and Abbreviations

ARO – Antibiotic Resistant Organism

CAMRSA – Community Associated Methicillin Resistant Staphylococcus aureus.
Several strains of antibiotic resistant Staphylococcus aureus (bacteria) which have originated and are predominantly spread within the community

CDAD – Clostridium difficile Associated Diarrhea. A common cause of healthcare acquired diarrhea which can have serious consequences.

CHICA – Community and Hospital Infection Control Association of Canada.

CNISP – Canadian Nosocomial Infection Surveillance Program within the Public Health Agency of Canada

DCDH – Dawson Creek District Hospital

FSJH – Fort St. John Hospital

GI – Gastrointestinal Illness, which may caused by bacteria, viruses or be food or waterborne

HAMRSA – Healthcare Associated Methicillin Resistant Staphylococcus aureus. Strains of antibiotic resistant Staphylococcus aureus (bacteria) which appear to have originated and are predominantly spread within healthcare settings.

HSDA – Health Service Delivery Area

ICP – Infection Control Practitioner

IPCP – Infection Prevention and Control Program

KGH – Kitimat General Hospital

LTC – Long Term Care

MAC – Medical Advisory Committee

MMH – Mills Memorial Hospital

MRSA – Methicillin Resistant Staphylococcus aureus. Strains of antibiotic resistant Staphylococcus aureus (bacteria) which may be acquired in community or healthcare settings

NEMAC – Northeast Medical Advisory Committee

NHIPCP – Northern Health Infection Prevention and Control Program

NIMAC – Northern Interior Medical Advisory Committee

NNIS – National Nosocomial Infection Surveillance. A program for surveillance that was established by the Center for Disease Control in Atlanta.

NWMAC – Northwest Medical Advisory Committee

PGRH – Prince George Regional Hospital

PRRH – Prince Rupert Regional Hospital

QCCH – Queen Charlotte City Hospital

RI – Respiratory Illness

SHEA – Society for Healthcare Epidemiology of America

SSI – Surgical Site Surveillance

TB - Tuberculosis

VP – Vice President

VRE – Vancomycin Resistant enterococcus. Strains of enterococcus (a common bacteria) which have become resistant to many antibiotics.