Section 5

Update on the implementation of recommendations from:

Infection Control: Essential for a Healthy British Columbia

March 2007

October 2008

May 1, 2008 719290

Mr. Morris Sydor
Assistant Auditor General
Office of the Auditor General of British Columbia
8 Bastion Square
Victoria BC V8V 1X4

Dear Mr. Sydor:

Please find enclosed the joint response of the Ministry of Health (the Ministry) and health authorities to your request for follow-up information on the implementation status of recommendations in your report, ***Infection Control: Essential for a Healthy British Columbia***.

I am pleased to report that the Ministry and health authorities have made significant progress with respect to this remarkably complex and persistent challenge faced by health care systems around the world. Infection control is a priority at the Ministry, and we remain committed to ensuring government, health providers and citizens continue to work together to improve the safety and quality of care for all British Columbians.

In closing, I would like thank you and members of the Select Standing Committee on Public Accounts for your continued interest in this issue. Should there be a need for a further appearance or presentation to the Committee on this matter, we will ensure that health authority representatives are also available as a resource.

Sincerely,

Original signed by

Gordon Macatee
Deputy Minister

Ministry of Health Office of the Deputy Minister 5-3, 1515 Blanshard Street
Victoria BC V8W 3C8

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

Introduction

The Ministry of Health wishes to acknowledge and thank the Office of the Auditor General and members of the Select Standing Committee on Public Accounts for their continued interest in this important issue. The Ministry would also like to once again recognize the efforts of so many dedicated professionals within British Columbia's health care system, who work tirelessly every day to provide, support and enable best practices in infection control around the province.

Given the relatively short period of time that has passed since release of the Auditor General's final report in March 2007, and the complexity of issues with which it deals, the Ministry and health authorities are confident that significant progress has been made in addressing the report's recommendations. Overall, the Ministry has endeavoured to clarify its role as steward of the health system and create a more comprehensive, consistent and effective provincial approach to infection control. Likewise, health authorities are making extensive improvements to the way they deliver services to ensure patients receive safe and effective care throughout British Columbia.

Infection control is a highly complex and ever-evolving issue that will require the ongoing dedication and persistence of government, health care providers and patients alike. Nevertheless, we are confident that significant improvements have been made and we are committed to continue working together to sustain and advance these improvements.

What follows is a brief overview of the Ministry and health authorities' progress in implementing the Auditor General's recommendations to March 2008. Also attached are submissions from each health authority using the templates provided by your office.

Progress on Recommendations to the Ministry of Health as at March 2008

Over the past year the Ministry of Health has made substantial progress in addressing the Auditor General's recommendations that the Ministry:

- **Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.**

- **Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.**

With respect to the first of these recommendations, the Ministry approaches hospital acquired-infections through the wider lens of patient safety as a potentially preventable adverse effect of the health system. Reflective of the Ministry's commitment to patient safety in general and infection control in particular, an Assistant Deputy Minister of Patient Safety portfolio was created at the Ministry in March 2007, and a program area dedicated specifically to provincial infection control initiatives is presently being created.

Based on stakeholder consultations, as well as a review of international literature, a comprehensive framework was developed to guide the Ministry's provincial approach to patient safety – including infection control. Infection control initiatives as they relate to the core elements of this framework are briefly described below.

a) System-wide leadership and coordination

Aside from the organizational changes within the Ministry, two additional external organizations are intended to provide system-wide leadership and coordination in matters of infection control. The Provincial Infection Control Network (the Network) remains a pivotal organization in this respect. The Network continues to serve as a truly province-wide community of practice, providing a collaborative framework for advancing standards in surveillance, prevention and control of hospital acquired infections throughout British Columbia.

In addition, the 2008 Speech from the Throne gave notice of the Ministry's intention to create a permanent BC Patient Safety Council to provide advice to the Ministry of Health on priority issues in patient safety and to build capacity to address these in a provincially consistent and coordinated manner. Infection control will undoubtedly be among the issues addressed by the Council.

b) Policy, legislation and regulation

With respect to the policy, legislative and regulatory environment for infection control, the Ministry has adopted a non-legislative approach which employs a variety of other instruments, including policy directives, targeted funding, external accreditation mechanisms, and the Ministry's accountability framework with health authorities. Examples here include:

- The Ministry's 2007 policy communiqué on reprocessing of medical equipment and devices (which is likely to become the benchmark for the rest of the country);
- External, high level accreditation reviews conducted by the Canadian Council on Health Services Accreditation which include mandatory performance requirements around patient safety – such as reporting of antibiotic resistant organisms and surgical site infections;
- The Ministry's accountability framework for the health authorities requires (among others):

- Adoption of the Provincial Infection Control Network's surveillance protocol for *C.Difficile* (adoption of other surveillance protocols will be required as these are developed);
- Implementation of a surveillance program for hospital acquired infections approved by the Ministry of Health;
- Continued participation in provincial patient safety initiatives such *Safer Healthcare Now!*, which includes a number of evidence-based interventions for the prevention of surgical site infections, central line-associated bloodstream infections, ventilator-associated pneumonia, and guidelines for the prevention of antibiotic resistant organisms; and,
- Communication strategies to promote and improve patient safety, such as regular reporting on safety and quality issues to health authority Board and Executive.

It should also be noted here that the Ministry is participating in an inter-provincial working group on infection control established by the Deputy Ministers of Health from the four Western provinces and Ontario. The working group is exploring opportunities for collaboration on development of common infection control standards and guidelines, common approaches to surveillance and reporting, and mechanisms for ensuring compliance.

c) Measurement, monitoring and evaluation

As per the Auditor General's second recommendation, the Ministry has provided funding to pilot test a Surveillance of Hospital-Acquired Infections Program for British Columbia (SHAIP-BC) in two health authorities. SHAIP-BC will ensure that standardized surveillance methodologies and definitions for hospital acquired infections are used in every health authority. The program will initially begin with surveillance of surgical site infections, and will later be applied more broadly to other types of infections as standardized surveillance methodologies and definitions are developed for these (PICNet presently has a number of working groups established for this purpose). Pending success of the pilot tests, provincial rollout of SHAIP-BC may begin in late 2008 or early 2009.

Additionally, the Ministry provided additional funding to health authorities to support province-wide rollout the BC Patient Safety Learning System (BC PSLS). BC PSLS is a web-based reporting system which will vastly improve the way we monitor adverse events, hazards and near misses of all kinds throughout the health care system, and will allow for dissemination of information about safety concerns on a province-wide basis. British Columbia will be the first jurisdiction in Canada to monitor adverse events in this province-wide manner.

Both of these surveillance mechanisms will allow the health care system to better understand and evaluate its shortcomings and to respond with effective and evidence-based improvement strategies.

d) Education and Professional Development
The Ministry, primarily through the Provincial Infection Control Network and sponsorship of *Safer Healthcare Now!*, continues to support opportunities to ensure that the distinct body of knowledge and skills associated with patient safety and quality improvement inform education, training, and/or professional development programs for health-care professionals. The Provincial Infection Control Network has completed a "Framework for Staffing and Core Competencies Training Designed for Infection Control Programs," and offers a variety of educational initiatives for infection control practitioners, including:

- Developing a healthcare associated infections surveillance training manual and on-line infection control modules about the prevention of surgical site infections and prevention of central venous catheter infections;
- Providing education and professional support through its educational conferences;
- Sponsoring selected working group members to attend educational conferences; and,
- Sponsoring Webber Training Courses (facilitated tele-classes relating to infection control and prevention) and other lecture series.

The *Safer Healthcare Now!* Western Node Collaborative brings together health professionals from across Western Canada to learn collaboratively about a number of interventions for patient safety and quality improvement, including prevention of surgical site infections, central line-associated bloodstream infections, ventilator-associated pneumonia, and antibiotic resistant organisms

e) Information and communication strategies
An important component of the provincial framework for patient safety is ensuring access to accurate and understandable information, which will help the public and all other stakeholders first understand the system and then participate in improving it. A primary example of this is the "Do Bugs Need Drugs" campaign which aims at educating patients about the appropriate use of antibiotics.

Another important development in this area is the announcement of the Ministry's intention to create Patient Care Quality Review Boards in every health authority in order to deal with patient concerns about safety and quality of care in a more timely and effective manner. Where patients do not feel they have received safe, effective, high quality care, and cannot attain resolution of their concern through existing client relations mechanisms within health authorities, they will have the option of taking their concerns to a Patient Care Quality Review Board for further investigation. The Review Boards will ensure that patient feedback about the safety and quality of care provided in health facilities is incorporated in improvement strategies.

Patient safety literature also recommends that leadership at the highest levels is engaged in safety and quality improvement. As noted earlier, through its accountability framework with health authorities the Ministry has reinforced the need to ensure health authority Boards and Senior Executive are fully informed on the safety and quality of

care delivered under their leadership. This approach mirrors the Auditor General's recommendation that proper reporting is used to hold Medical Advisory Committees to account with respect to infection control.

Progress on Recommendations to Health Authorities as at March 2008
Health authorities have also made significant progress with respect to implementing the eighteen recommendations in the report directed to their performance.

Figure 1. Health Authority Implementation Status Response Summary

HA	Fully		Substantially		Partially		Alternate action		Total
FHA	6	33%	10	56%	1	6%	1	6%	18
IHA	7	39%	6	33%	5	28%			18
NHA	4	22%	9	50%	4	22%	1	6%	18
PHSA	4	22%	7	39%	6	33%	1	6%	18
VCHA	4	22%	10	56%	4	22%			18
PHC*	7	39%	11	61%					18
VIHA	3	17%	9	50%	4	22%	2	11%	18
Overall	35	28%	62	49%	24	19%	5	4%	126

* Providence Health Care

Figure 1 provides a summary of the overall implementation status of recommendations by health authority. The summary indicates:

- Seventy-seven percent of the recommendations have been either "Fully" or "Substantially" implemented;
- Nineteen percent have been "Partially" implemented;
- In four percent of cases an "Alternative Action" was taken to address a recommendation; and,
- In no instance did a health authority indicate a response of "No Action" to any of the recommendations.

With respect to the nineteen percent of recommendations "Partially" implemented, eleven of twenty-four instances are in reference to eight recommendations around the implementation of best practices; six are in reference to three recommendations for implementation of an information management system and resources for data quality support; and, seven occur with reference to the five recommendations for reporting practices within health authorities. In only one instance is the "Partially" implemented response concentrated on one recommendation ("provide information management support to the infection control program for data collection, analysis and reporting").

In general, the Ministry is satisfied that health authorities are taking appropriate actions to improve and are committed to making progress in each case identified as "Partially" implemented. Upon closer examination of the explanatory information provided the information management recommendation described above, the Ministry is confident that all health authorities have taken steps to address the recommendation appropriately and

are committed to ensuring information management requirements for infection control are adequately resourced based on jurisdictional needs. The Ministry will endeavour to monitor ongoing progress in each of these areas.

Of the responses which indicate an "Alternative Action" was taken, three instances refer to the recommendation to "work with the Ministry of Health and BC Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care." The other two instances refer to recommendations to ensure adequate resources to support information management and to ensure health authority Boards hold Medical Advisory Committees to account for their mandate. Again, similar to the "Partially" implemented responses, the Ministry is confident that the alternative actions taken either satisfy the spirit of the Auditor General's recommendations, or are appropriate in light organizational context, and further, that the health authority is committed to making progress in the area.

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please tick implementation status for each recommendation)

Auditor General's Recommendations	Health Author.	IMPLEMENTATION STATUS				
		Fully	Sub-stantially	Partially	Altern. Action	No Action
A provincial framework for infection prevention, surveillance and control is limited to public health						
We recommend that the Ministry of Health: ▪ Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.			X			
• Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.			X			
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities						
We recommend that each health authority: • Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.	FHA		X			
	IHA		X			
	NHA		X			
	PHSA	X				
	VCHA		X			
	PHC	X				
	VIHA	X				
• Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.	FHA		X			
	IHA	X				
	NHA		X			
	PHSA	X				
	VCHA		X			
	PHC	X				
	VIHA		X			

Auditor General's Recommendations	Health Author.	IMPLEMENTATION STATUS				
		Fully	Subs-stantially	Partially	Altern. Action	No Action
Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened						
We recommend that each Health Authority: • Work with the Ministry of Health and the BC Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.	FHA				X	
	IHA			X		
	NHA	X				
	PHSA				X	
	VCHA		X			
	PHC		X			
	VIHA				X	
• Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program	FHA		X			
	IHA	X				
	NHA		X			
	PHSA			X		
	VCHA			X		
	PHC		X			
	VIHA		X			
• Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.	FHA		X			
	IHA			X		
	NHA		X			
	PHSA		X			
	VCHA		X			
	PHC	X				
	VIHA		X			
• Ensure that renovations and new construction designs mitigate the risks of spreading infections.	FHA	X				
	IHA	X				
	NHA			X		
	PHSA		X			
	VCHA	X				
	PHC	X				
	VIHA		X			
• Ensure that all staff receives regular ongoing education in the area of infection control and that medical staff also have access.	FHA		X			
	IHA	X				
	NHA			X		
	PHSA			X		
	VCHA		X			
	PHC	X				
	VIHA		X			

Auditor General's Recommendations	Health Author.	IMPLEMENTATION STATUS				
		Fully	Sub-stantially	Partially	Altern. Action	No Action
• Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education	FHA		X			
	IHA	X				
	NHA	X				
	PHSA			X		
	VCHA		X			
	PHC		X			
	VIHA	X				
• Establish a formal surveillance program appropriate to the programs and services offered.	FHA		X			
	IHA		X			
	NHA		X			
	PHSA		X			
	VCHA		X			
	PHC		X			
	VIHA			X		
• Establish a process for regular formal and informal monitoring of practice.	FHA	X				
	IHA		X			
	NHA		X			
	PHSA			X		
	VCHA		X			
	PHC		X			
	VIHA			X		
An integrated information system for infection prevention, surveillance and control is in place only for Public Health						
We recommend that the Health Authorities: • Provide information management support to the infection control program for data collection, analysis and reporting.	FHA			X		
	IHA	X				
	NHA				X	
	PHSA			X		
	VCHA			X		
	PHC		X			
	VIHA			X		
• Ensure there is staff with appropriate training to support data quality.	FHA		X			
	IHA	X				
	NHA		X			
	PHSA	X				
	VCHA			X		
	PHC		X			
	VIHA		X			
• Work with the Ministry of Health and other stakeholders to ensure data quality.	FHA		X			
	IHA		X			
	NHA	X				
	PHSA	X				
	VCHA			X		
	PHC		X			
	VIHA		X			

Auditor General's Recommendations	Health Author.	IMPLEMENTATION STATUS				
		Fully	Sub-stantially	Partially	Altern. Action	No Action
Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done.						
We recommend that each Board of Directors: • Work with their senior management to determine what infection control indicators they need measured and reported on.	FHA	X				
	IHA			X		
	NHA		X			
	PHSA		X			
	VCHA	X				
	PHC					
	VIHA		X			
• Hold the Medical Advisory Committees accountable for fulfilling their mandates.	FHA	X				
	IHA			X		
	NHA		X			
	PHSA		X			
	VCHA	X				
	PHC					
	VIHA				X	
We recommend that the Health Authorities: • Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.	FHA	X				
	IHA			X		
	NHA			X		
	PHSA		X			
	VCHA		X			
	PHC		X			
	VIHA			X		
• Have their senior management teams identify infection control reports and information that they need to receive on a regular basis	FHA	X				
	IHA		X			
	NHA	X				
	PHSA			X		
	VCHA		X			
	PHC		X			
	VIHA		X			
• Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.	FHA		X			
	IHA		X			
	NHA			X		
	PHSA		X			
	VCHA	X				
	PHC		X			
	VIHA	X				

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please tick implementation status for each recommendation)

Auditor General's Recommendations	Implementation Status				
	Fully (5)	Substantially (4)	Partially (3)	Alternative Action (2)	No Action (1)
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.		√			
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.		√			
Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.				√ *	
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving		√			

consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.					
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.		√			
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.	√				
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.		√			
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.		√			
▪ Establish a formal surveillance program appropriate to the programs and services offered.		√			
▪ Establish a process for regular formal and informal monitoring of practice.	√				
An integrated information system for infection prevention, surveillance and control is in place only for Public Health					
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.			√		
▪ Ensure there is staff with appropriate training to support data quality.		√			
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.		√			
Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done					
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.	√				

▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.	√				
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.	√				
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.	√				
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.			√		

- Acute Care and Residential Care manuals completed and implemented across Fraser Health.

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please provide the information noted below)

A provincial framework for infection prevention, surveillance and control is limited to Public Health

We recommend that the Ministry of Health:

- **Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.**
- **Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.**

See IC Initiatives 15 and 16.

There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities

We recommend that each health authority:

- **Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.**
- **Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.**

FH comment: Please note as reference for the following tables:

Fully Implemented (5)	Substantially Implemented (4)	Partially Implemented (3)	Alternative Action (2)	No Action (1)

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE
Set specific goals and objectives for Infection Control as a patient safety priority for FH in both Operating Plan and Strategic Plan; include key performance measures for surveillance to be reported to Board through the Infection Control Coordinating Committee.	Spring 2007	1	5	Summer 2006 - present: Recruitment for Director positions; expect start date of May 1, 2007. Hired May 01, 2007. Completed.
	Spring 2007	2	5	May 2007: Fraser Health Board of Directors approved a Policy on patients, Clients and Resident Safety which outline FH commitment to ensuring quality care and safety in all Fraser Health programs, services and initiatives.
	ongoing	3	4	Nov 2007: CDAD, MRSA and VRE rates are being monitored on the Patient Safety Scorecard: Key Performance Indicator Report and the Board Balanced Scorecard. These reporting indicators will be tracked, trended and standardized across FH. Mar 2008: CDAD, MRSA and VRE rates continue to be monitored across Fraser Health; they are reported at local Infection Control Committees, at the Acute Care Committee and the regional Fraser Health Infection Prevention and Control Committee. They are also reported on the Board Balanced Scorecard.
	30 April 2008	4	4	Nov 2007: A FH Infection Control Strategic Plan is being developed to outline the service delivery modules for Infection Control across FH, This will include work to clarify organizational mandate, identify and understand stakeholders and their needs; develop mission and values; assess the environment to identify strengths and weaknesses, opportunities and threats. Feeding into the strategic plan will be service delivery modules for key areas of the Infection Control Program such as surveillance, outbreak management, education, accreditation, ARO management, and construction that address quality improvement and patient safety initiatives for Fraser Health. The strategic plan will identify goals, priorities, key performance indicators, barriers, timelines and resource implications to achieve the goals for Infection Control. Mar 2008: CDAD, MRSA and VRE rates continue to be monitored across Fraser Health; they are reported at local Infection Control Committees, at the Acute Care Committee and the regional Fraser Health Infection Prevention and Control Committee. They are also reported on the Board Balanced Scorecard. Infection Control is currently in the midst of developing a comprehensive, regional strategic plan that will define 5 – 6 major goals for 2008/2009. This plan is being developed collaboratively with customers, stakeholders, Medical Microbiologists, Infection Control Practitioners and the Infection Control leadership team (Administrative Director, Medical Director, and two managers). Included in the plan are the major goals and objectives for the year along with action plans and key performance indicators or measurable. The critical issues being addressed in the

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE
				plan pertain to goals for education, surveillance, staff recruitment and retention, Infection Control regional service modules and increase of Infection Control profile across Fraser Health.
Align Infection Control and Public Health goals and objectives to ensure integrated approach to infection prevention, surveillance and control across service delivery areas (i.e. Acute Care, Home and Community Programs, Public Health, GPs' offices, Residential Services)	ongoing	5	4	Relationships between committees strengthened (i.e. between Fraser Health Infection Control Coordinating Committee, its regional sub-committees, local Infection Control Committees, and with HAMAC, Board, and local Medical Advisory Committees). Mar 2008: Infection Control currently sits on numerous committees and participates in many activities and aspects within Fraser Health. IC sits as a Steering Committee member on the Safer Healthcare Now Committee and the Fraser Health Reprocessing Patient Safety Project, and is an active member of the Quality Improvement and Patient Safety Committee, Pandemic Influenza Management Committee to name a few. The members of these committees are representative of the continuum of care across FH which includes Acute Care, Home Health, Health Promotion and Prevention and Community Residential programs. Infection Control, Public Health and Workplace Health (OH PH IC committee) participate collaboratively through a special committee (OH PH IC committee) to ensure these groups are meeting the safety needs of patients, clients, the public and staff. Specific alignment with Public Health occurs through the Regional Infection Prevention and Control Committee as well as on the Acute Care Committee, Residential Infection Control Committee and individual site infection control committees either as standing members or ad hoc members. Liaison and active communication between Public Health and Infection Control occurs regarding specific cases and issues as they arise in the organization such outbreak management of reportable infections including TB, mumps, GI and respiratory outbreaks as well as other unusual occurrences that may affect public safety.
	ongoing	6	4	Nov 2007: The structure of the FH Infection Control Coordinating Committee has been reviewed and renewed; now called the Fraser Health Infection Prevention and Control Committee (FHIPCC). The committee is in the process of reviewing its membership and terms of reference. This membership will include the Community portfolios across FH such as Residential care, Public Health, Quality Improvement and Patient Safety, ensuring an integrated approach to infection prevention and surveillance across all service delivery areas in Fraser Health. A FH Acute Care Committee is being formed and will report to the FHIPCC. Terms of reference and membership are being developed. All acute care sites will be represented by the Infection Control Practitioners and medical microbiologists (excluding BH – no medical microbiologist at this site). Regional programs will report to the Acute Care committees such as Medical Imaging, SPD, Laboratory and Pharmacy.

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE
				Each of the local hospitals will also have their own Infection Prevention and Control Committees. Most committees are currently active; those not in place are currently being developed. At this level of committee structure, the sites will discuss local specific issues, discuss surveillance trends and implement regional initiatives as appropriate that have been approved at the Acute Care or regional FHIPCC committees. Mar 2008: The FH Infection Prevention and Control Committee, the Acute Care Committee and specific site Infection Control committees are now up and running and will continue to grow and develop as the needs for the organization and the committee structure evolve. The Terms of Reference for the committees have been developed and presented to the committees and will be approved at the next meeting.
	ongoing	7	4	All Infection Control stakeholders work together on initiatives to prevent and manage infections; i.e. outbreak management across the continuum (Norovirus, pandemic flu planning, emergency preparedness) – done via existing subcommittees of the Infection Control Coordinating Committee, and task groups comprised of Infection Control, Public Health, Workplace Health, Medical Microbiology, and Infectious Diseases. Nov 2007: Infection Control Practitioners are currently members on a number of committees at the local sites, across Fraser Health and provincially. These committees include Pandemic Influenza Planning, PICNet, CHICA-BC, Construction groups and numerous others groups to manage and prevent infections. Mar 2008: Key stakeholders from programs are invited to be ad hoc members of the Infection Control working groups. This includes staff from Public Health, Residential Care, Housekeeping (Sodexho), etc., ensuring alignment and engagement of stakeholders in Infection Control practices and standards.

Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened

We recommend that each health authority:

- **Work with the Ministry of health and B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE
Complete Regional Acute Care Manual and standardize as per PICNet approach to a provincial, evidence-based manual; link with the new Residential Services Manual (completed Dec/06) to promote continuity of evidence-based practice across various care delivery settings for similar patient and resident populations	May 31, 2008	8	4	FH-wide Residential Services IC Manual completed and distributed across the organization in December, 2006; Fraser Health Acute Care Infection Control Manual developed for all Acute Care areas, to replace pre-existing manuals in Fraser South, East and North –for completion by April/07 and is consistent with the new Residential Manual to ensure continuity of standards and approach wherever applicable. Nov. 2007: The Acute Care Infection Control manual is in the final stages of revisions after receiving initial feedback from key users. This will be distributed to Executive Directors and Medical Directors for their feedback in preparation for presentation to the FHIPCC in January for official approval. March 2008: The Acute Care Manual is being assembled this month and will be distributed in April. A document regarding information on new or updated aspects of the new manual was also included in the distribution. An electronic copy of the new manual was available for on-line for all staff April 1, 2008. The manual went out to Executive Directors and department directors for review and feedback. Edits were completed and the manual was approved at the regional Fraser Health Infection Prevention and Control Committee prior to distribution. A document outlining the changes of the new manual from the previous version has been developed. There will be collaborative work with nursing educators to provide training and education for staff and physicians for those new changes. The Education Service Delivery module for Infection Control will assist in planning the roll-out.

- **Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.**

- **Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Complete recruitment process for key positions and implement new integrated service delivery model with Regional clinical and administrative direction and local delivery.	May 31, 2007	9	4	Integrated IC service delivery model developed Nov. 2005. Budget enhancement proposal resulted in funding for Administrative and Medical Director, 1 additional manager, 2 ICPs and 1 administrative support position. 2 – 1.0 FTE IC managers are in place and continue to define and refine work areas and reporting structures with ICPs.	Increase in ICP FTEs will require additional financial resources which are yet to be identified and need to be prioritized against other equally worthy activities. • 13.5 additional ICPs to provide national standard of service across

Establish clear accountabilities for both IC service delivery and FH committees.				**Nov 2007:** 0.5 FTE Medical Director and 1.0 FTE Administrative Director for Infection Control hired; start date May 1, 2007. 1.0 FTE IC Program Assistant hired June 2007. **Mar 2008:** Increased Medical Director FTE to 0.7FTE. 3.0 FTE Medical Microbiologists are allocated to support Infection Control work across acute care sites in FH. Medical Health Officers support Infection Control across Public Health and Residential Care.	the continuum FH-wide • Epidemiology and Decision Support resources required Medical Microbiologist services required for Burnaby Hospital. Additional Med Micro support being sought for acute care.

- **Ensure that renovations and new construction designs mitigate the risks of spreading infections.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Establish, in addition to enhanced management oversight, a programmatic focus across FH for key priority areas, including environmental planning and consultation for renovations or new construction projects and clinical products/supplies analysis.	Apr 30, 2008	10	4	**Mar 2008:** Infection Control is developing work plan modules that identify key regional services across Fraser and outline a standardized framework for each module. Modules include: o Surveillance/Outbreak Management o ARO o Hand hygiene o Education o Accreditation o Environment o Construction & Design o Product evaluation o Respiratory infections The structure for each module will be similar to each other; they will also align with the strategic plan. The service modules are being led by an Infection Control Practitioner (ICP) in consultation with the Medical or Administrative Director for Infection Control, with other ICPs on the team, as well as appropriate business partners who are invited to participate and provide input as necessary (e.g. Sodexho Housekeeping services).	

- **Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Develop FH staff and physician education program under the direction of the Medical and Administrative Directors of Infection Control.	ongoing	11	4	Mar 2008: The Infection Control education working group had been tasked with the responsibility for developing standardized education programs for staff and physicians. They are responsible to ensure program content and delivery are consistent yet flexible enough to allow variability for modification based on the targeted audience. There are key Infection Control topics that have education programs already developed such as hand hygiene, GI outbreaks, etc. The hand hygiene project presented a 30 minute education session to full and part time staff in acute care sites across Fraser Health. This included open sessions in a classroom setting as well as in-service education delivered in work areas. Hand Hygiene education sessions were also presented to physicians at site medical meetings. Respiratory Flu School was also presented as well as new respiratory outbreak protocol in certain sites. Other infection control topics will be targeted as necessary. This year will see a significant education program developed around reprocessing standards that has surfaced from the MOH Reprocessing audit. This education will be done in collaboration with site and program educators.	
Work with People Development to: • ensure all new staff and physicians are provided with Infection Control orientation • standardize local orientation programs to include the same Infection Control content in all areas across FH.	Dec 31, 2008	12	4	Mar 2008: Infection Control orientation is a key component of the orientation process for all new hires at Fraser Health. This module is standardized for regional orientation for all new staff and is delivered as part of the Fraser Health orientation package. In conjunction with the regional orientation, there is an Infection Control orientation for each of the individual acute care facilities but this has not yet been standardized across Fraser Health, each site has developed their own site specific infection control orientation education. Standardization of the site specific orientation and general orientation for residents and physicians is a goal for 2008. Resident Infection Control orientation for residents is currently only being done at Royal Columbian Hospital.	

- **Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Revise IC orientation and education resource manual for staff and physicians with infection prevention and control roles, designed to complement work of PICNet, and based on standardization of certification qualifications.	Mar 31, 2009	13	3	Nov 2007: Additional funding requests proposed for Education Consultant, Epidemiologist, Epidemiologist assistant and additional ICPs. Mar 2008: Education is one of the core service delivery modules that make up the strategic plan for Infection Control. Resources have been allocated for a Project Coordinator/Educator to develop an Infection Control training program for new ICPs that will outline core competencies and educational material for their development. This person will also lead the ICPs in developing standardized orientation for new staff and physicians at the site level as well as work with nursing educators in developing education material for new Infection Control initiatives across FH. An official IC orientation program for FH has not yet been established. IC staff are asked to participate in the UBC certification course for Infection Control Practitioners. The Education working group is also tasked with exploring other options for certification for Infection Control practitioners and resourcing what other Heath Authorities have developed for orientation and certification, both provincially and nationally.	Additional funding requested for Education Consultant and/or Educational programs, Epidemiologist and Epidemiologist data analyst.

- **Establish a formal surveillance program appropriate to the programs and service offered.**
- **Establish a process for regular formal and informal monitoring of practice.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Establish a formal surveillance program enabling Infection Control KPIs to be regularly reported at organizational and provincial levels using data collection and analysis methods consistent with BC PICNet activities.	ongoing	14	4	FH Infection Control Practitioner participated as co-lead of PICNet SSI Working Group to develop recommendations for province-wide surveillance plan. Mar 2008: Fraser Health continues to work on a formal surveillance plan and the development of IC KPIs consistent with PICNet. MRSA, VRE and CDAD are regularly reported at local Infection Control Committees, the Acute Care Committee and the regional FH Infection Control and Prevention Committee. Surveillance results are also reported on the Board Balanced Scorecard and on the Patient Safety Scorecard of the Quality Improvement and Patient Safety Committee. Development continues on the FH CDAD, MRSA and VRE rate reduction strategies. FH aligning surveillance components with PICNet criteria in preparation for the provincial launch of the CDAD surveillance.	

An integrated information system for infection prevention, surveillance and control is in place only for Public Health

We recommend that the health authorities:

- **Provide information management support to the infection control program for data collection, analysis and reporting.**
- **Ensure there is staff with appropriate training to support data quality.**
- **Work with the Ministry of Health and other stakeholders to ensure data quality.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Coordinate development and implementation with timing of PICNet activities which will occur through 07/08 and 08/09	ongoing	15	4	Mar 2008: Infection Control at Fraser Health is actively engaged with the PICNet group and activities, both at a participant level and on the Executive Steering committees as well as Safer Health Care Now Initiatives. Data Analysts within Decision Support at FH and one of the Infection Control managers support Infection Control surveillance with data analysis and reporting. FH Infection Control Managers continue to work with Infection Control Practitioners to provide consistent definitions, education and training to support accurate data collection.	Resources urgently required for a Infection Control Epidemiologist and data entry and analysis support. This is role is currently being filled by a casual employee on part-time basis with funds from another ICP position.
Determine most cost-effective means to collect, analyze and report on infection control and implement same. Work with PICNet to align Health Authority efforts with possible province-wide solution using standardized data definitions and ensuring data quality	ongoing	16	4	The Fraser Health Surgical Clinical Services Planning and Delivery Team implementing key performance indicators as part of the NSQIP Initiative. Surveillance reporting on SSI, BSI, CDAD, MRSA and VRE, and Noro-virus across Fraser Health underway over the past year with a focus on establishing consistent use of case definitions. Sub-group of the Fraser Health Infection Control Coordinating Committee struck to provide KPI reporting to the Committee and Quality Council and onwards to HAMAC and the Board. Establishing set of Infection Control KPIs to be regularly reported at organizational level, using consistent data collection and analysis methods. Nov 2007: FH surveillance for *Clostridium difficile* includes components that will also be in the PICNet surveillance program. Surgical site infection and antibiotic resistant organism surveillance programs are comprehensive and can easily be adapted for participation in PICNet's future programs. Mar 2008: An Infection Control Manager continues to collaborate with PICNet group on CDAD surveillance. FH is developing an MRSA strategy aimed at reducing the incidence of nosocomial infections across FH.	The ability to provide standardized comprehensive surveillance data is dependent on IM/IT resources and capabilities to interface with current information systems.

Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done

We recommend that each Board of Directors:

- **Work with their senior management to determine what infection control indicators they need measured and reported on.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Establish a formal surveillance program enabling Infection Control KPIs to be regularly reported at organizational and provincial levels using data collection and analysis methods consistent with BC PICNet activities.	ongoing	17	4	FH Infection Control Practitioner participated as co-lead of PICNet SSI Working Group to develop recommendations for province-wide surveillance plan. Mar 2008: Fraser Health continues to work on a formal surveillance plan and the development of IC KPIs consistent with PICNet. MRSA, VRE and CDAD are regularly reported at local Infection Control Committees, the Acute Care Committee and the regional FH Infection Control and Prevention Committee. Surveillance results are also reported on the Board Balanced Scorecard and on the Patient Safety Scorecard of the Quality Improvement and Patient Safety Committee. Development continues on the FH CDAD, MRSA and VRE rate reduction strategies.	
Put systems in place to enable Infection Control KPIs to be regularly reported at organizational and provincial levels, using consistent data collection and analysis methods. Identify data collection methods that enable capture of data across continuum and outside FH (i.e. GP offices) and develop a feasible approach to same (Align with PICNet data definitions and standardized collection procedures.	ongoing	18	4	Mar 2008: Infection Control KPIs regularly reported at ICCC and Quality Council including consistent data collection and analysis methods - underway for 3 months; IC surveillance incorporated into improvement efforts within the FH SSI Collaborative for Safer Healthcare Now. Improvement practices from the VAP bundle are being rolled out by ICU collaborative teams. FH teams and Infection Control are initiating efforts to implement the bundle to reduce CLIs.	A review of the IM/IT infrastructure will be part of the analysis and delivery of the key performance indicators.

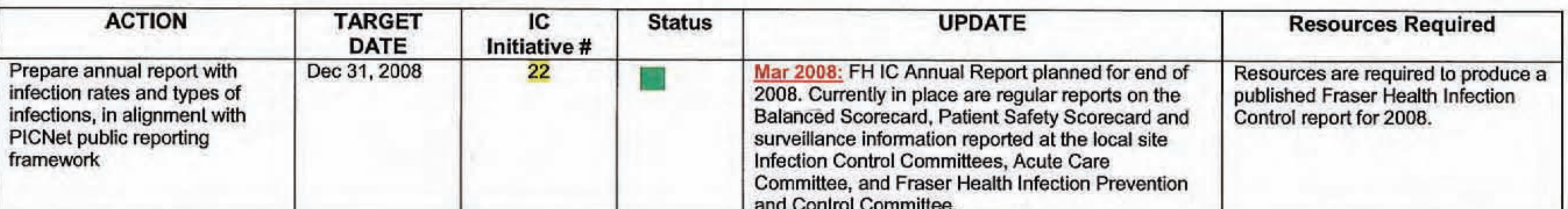
- **Hold the Medical Advisory Committees accountable for fulfilling their mandates.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Establish regular reporting from ICCC to HAMAC and promotion by HAMAC of Infection Control principles and practices with physicians	ongoing	19	5	Mar 2008: Minutes from the Regional Fraser Health Infection Prevention and Control Committee are presented to HAMAC and reviewed at their meetings. The Medical Director and Infection Control practitioners liaise with physicians through the local Infection Control committees, the Medical Microbiologist network and through direct communication as issues and questions about Infection Control practices and standards arise.	

We recommend that the health authorities:

- **Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.**
- **Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Develop and implement FH-wide surveillance and reporting plan for regular submission to Board. Establish information systems to enable data collection and reporting.	ongoing	20	5	Mar 2008: Over the past year a formal and consistent surveillance reporting mechanism has been established for SSI, CDAD, MRSA, VRE, and GI outbreak across Fraser Health. Reports are presented to Board using Balanced Scorecard, to Quality Improvement and Patient Safety Committee through the Patient Safety Scorecard, at the local Infection Control Committees and the Acute Care Committee. A comprehensive Fraser Health surveillance report is being discussed which will identify all surveillance activities being done in the organization, including the surveillance independent of Infection Control.	The ability to provide standardized comprehensive surveillance data is dependent on IM/IT resources and capabilities to interface with current information systems.



Build into Executive Committee Annual Organizational Objectives as a key component of the FH Patient Safety Strategy, including regular reports on KPIs to support decision-making, evaluation, and priority-setting. Specific objectives will include, in addition to the Hand Hygiene Campaign, a strategy for CDAD prevention and ARO.	ongoing	21	5	Nov 2007: This is one of the key initiatives for Service delivery module on Surveillance. Five (5) Key Performance indicators will be reported on a monthly basis. Mar 2008: Quarterly Infection Control surveillance reports pertaining to MRSA, VRE, CDAD, Hand Hygiene compliance and GI outbreak rates will be provided on the Patient Safety Scorecard that is part of the Quality Improvement and Patient Safety Committee and is also reported to the Quality Performance Committee of the Board. Serious respiratory infections (SRI) will also be included in the reporting.	

- **Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.**

ACTION	TARGET DATE	IC Initiative #	Status	UPDATE	Resources Required
Prepare annual report with infection rates and types of infections, in alignment with PICNet public reporting framework	Dec 31, 2008	22		Mar 2008: FH IC Annual Report planned for end of 2008. Currently in place are regular reports on the Balanced Scorecard, Patient Safety Scorecard and surveillance information reported at the local site Infection Control Committees, Acute Care Committee, and Fraser Health Infection Prevention and Control Committee.	Resources are required to produce a published Fraser Health Infection Control report for 2008.

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please tick implementation status for each recommendation)

Auditor General's Recommendations	Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.		✓			
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.	✓				

Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.			✓		
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.	✓				
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.			✓		
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.	✓				
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.	✓				
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.	✓				
▪ Establish a formal surveillance program appropriate to the programs and services offered.		✓			
▪ Establish a process for regular formal and informal monitoring of practice.		✓			
An integrated information system for infection prevention, surveillance and control is in place only for Public Health					
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.	✓				
▪ Ensure there is staff with appropriate training to support data quality.	✓				
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.		✓			
Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done					

We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.			✓		
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.			✓		
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.			✓		
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.		✓			
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.		✓			

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

In the period since the audit was done, Interior Health has been successful in implementing many of the recommendations. The Interior Health Infection Prevention and Control manual has been distributed throughout Interior Health and is in use in all IH facilities as well as the contracted facilities. The manual is available in hard copy as well as on the Interior Health website and the Intranet.

The 1st Infection Prevention and Control annual report is available on the Intranet.

The IH wide surveillance program is approximately 75% implemented in all acute care sites throughout the health authority. The residential component will be implemented and completed by the end of March, 2009

At the present time Interior Health is working with Vancouver Coastal Health on a pilot surgical site infection project. If successful this program will be the basis for a provincial surgical site infection surveillance program.

An Interior Health hand washing initiative has been implemented in most sites throughout the region with education to all staff.

Infection Prevention and Control has been included on the Public Health CD committee.

A provincial framework for infection prevention, surveillance and control is limited to Public Health

We recommend that the Ministry of Health:

- **Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.**

  Status – Unable to respond to this recommendation as it is a Ministry recommendation.

- **Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.**

  Status – Unable to respond to this recommendation as it is a Ministry recommendation.

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There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities

We recommend that each health authority:

- **Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.**

  Status – Substantially completed.

  The Surveillance system (Picis) is approximately 75% implemented in the acute care sites. This implementation will be completed in all acute care sites by June 30, 2008.

  Interior Health will be doing surveillance on Surgical Site infections, Central Lines (ICU patients only at this time), Ventilator Associated Pneumonias, Health Care Associated Pneumonias, Antibiotic Resistant Organisms, C Difficile and Outbreaks (in conjunction with Public Health).

  The Residential care component of the program will be implemented by March 31, 2009. The surveillance program will be in place in all Interior Health facilities.

  At the present time, the program has a Practice Leader who is responsible for the implementation of standardized policies and procedures, surveillance program using standard definitions etc. The Infection Control Practitioners report to a manager in the respective HSAs. The Practice Leader works in collaboration with the managers to ensure consistency in the program. A practice committee is in place and reports up through the Health Authority Infection Prevention and Control Committee.

  The program has had an external review performed in December, 2007 and the results will be presented to the Senior Executive Team in April, 2008 with recommendations on the structure and revised plan.

- **Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.**

Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened

Status – Fully completed

The Practice Leader sits on the CD Committee and works in collaboration with the MHO as well as the manager of the CD team to ensure all aspects are included in the planning of the programs. Public Health is represented on the Practice Committee as well as the Health Authority Infection Prevention and Control Committee.

We recommend that each health authority:

- **Work with the Ministry of health and B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.**

  Status – Partially completed

  The Interior Health Infection Prevention and Control Manual is in use in all IH facilities as well as the contracted facilities. This manual is available in hard copy as well as on the Inside Net and the IH website.

  Infection Control Practitioners from Interior Health sit on the PICNet guideline groups as they are formed and give input to the process.

- **Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.**

  Status – Fully Completed

  A review of the Interior Health Infection Prevention and Control Program was conducted in December, 2007. All stakeholders including Public Health were included in the process. Recommendations were received and the report will be taken to the Senior Executive Team in April, 2008.

- **Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.**

  Status – Partially Completed

  The review was completed, but the physician support remains lacking throughout Interior Health.

- **Ensure that renovations and new construction designs mitigate the risks of spreading infections.**

  Status – Fully completed

  The ICPs are included in all renovations and construction projects. The policy is in place in the IC manual as well as the manual in Facilities Management. The IH document is given out to all contractors doing work for IH. This document is included in the documents given out for tendering.

- **Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.**

  Status – Fully completed

  The ICPs are doing inservicing as required on the units. They are included in all new staff orientation. The ICPs in facilities attend unit meetings and present education to the staff

on a regular basis. One on one education is also provided as required. Physicians are included in all education sessions if they wish to attend.

- **Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.**

  Status – Fully completed

  The Health Service Areas have an education budget specifically for Infection Control. There is also some budget at the corporate level to ensure ICPs have access to education sessions and current resources

- **Establish a formal surveillance program appropriate to the programs and service offered.**

  Status – Substantially completed

  As stated above.

- **Establish a process for regular formal and informal monitoring of practice.**

  Status – Substantially completed

  At this time, the Practice Leader works in conjunction with the Health Service Area ICP Manager to ensure practices are current. The Practice Leader gives input to the performance appraisals as requested.

  An audit tool pertaining to the implementation of the Interior Health Infection Control Manual is in place. There is an audit component within the Picis surveillance system and within our process. The Practice Leader will be able to ensure compliance with best practices using this tool. This will be implemented by June 30, 2008.

  All sites have had Infection Prevention and Control audits done on a 3 year cycle to ensure compliance with standards and best practices. Feedback is given to sites following the audit and this is used to improve practice as needed. All repeat audits have been completed in the acute care sites and the residential sites will be completed by June 30, 2008.

An integrated information system for infection prevention, surveillance and control is in place only for Public Health

We recommend that the health authorities:

- **Provide information management support to the infection control program for data collection, analysis and reporting.**

  Status – Fully completed

  As part of the Picis implementation Infection Prevention and Control has a Systems Analyst on an ongoing basis. A 0.5 FTE Report Writer is also part of the surveillance program that is being implemented throughout the Interior Health.

- **Ensure there is staff with appropriate training to support data quality.**

  Status – Fully completed

  The IMIT staff are fully trained in data quality and on the Picis system and can provide excellent support to the Infection Prevention and Control Program.

- **Work with the Ministry of Health and other stakeholders to ensure data quality.**

  Status – Substantially completed

  Infection Prevention and Control has not been asked to provide any data from the Ministry at this time. Public Health works in collaboration with the Ministry of Health and reports data to the Ministry and other stakeholders as required.

Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done

We recommend that each Board of Directors:

- **Work with their senior management to determine what infection control indicators they need measured and reported on.**

  Status – Partially Completed

  Interior Health will be capturing surveillance data on Surgical Site infections, Ventilator Associated Pneumonias, Health Care Associated Pneumonias, Antibiotic Resistant Organisms, CDAD, Outbreaks in conjunction with Public Health and Central lines in ICUs only at the present time. This will be gradually implemented and is slated for completion by June 30, 2008. Reports will be taken to the Senior Executive Team by the Chief, Planning and Improvement Officer, on a regular basis.

- **Hold the Medical Advisory Committees accountable for fulfilling their mandates.**

  Status – Partially Completed

  We have taken a dashboard of key performance indicators to the Board which includes targets and indicators for specific procedures. These indicators will be reported to the board on bi-monthly basis as well as going to HAMAC.

  The physician leader for IPC is an attending member of HAMAC and IPC is a standing report on the month agenda.

We recommend that the health authorities:

- **Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.**

  Status – Partially completed

  We completed an audit of hand washing practices and have shared these with the sites and are working on various improvement strategies to improve the overall hand washing rates.

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The surveillance data will be made available to all programs once the implementation is complete and the data quality has been tested. Complete implementation will be done by March 31, 2009 and reports will be available at that time.

Audit reports are made available to all programs i.e. the Sterile Processing audit has been used to provide sites with education and to improve practice.

- **Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.**

Status – Substantially Completed

Senior Executive and the Board will be receiving a bi-monthly update on infection rates across the health authority for specific areas and specific procedures. Work continues on the implementation of an IMIT platform and data base for infection. Anticipated that implementation will be complete in late spring with data available in early summer. This system will offer standardised and automated reporting on specific infection issues across IH

The Chief, Planning and Improvement Officer reports on the infection control issues and their status on a regular basis.

- **Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.**

Status – Substantially Completed

The 1st Annual Report is posted on the IH intranet. All IH staff have access to the intranet. The 2nd Annual Report will be completed and posted in May 2008.

northern health

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please tick implementation status for each recommendation)

Auditor General's Recommendations	Implementation Status				
	Fully	**Substantially**	**Partially**	**Alternative Action**	**No Action**
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.		Substantially: Plan developed by Regional Manager IPC in 2007. Approved, in principle by NH Executive. Plan does not formally extend into Home and Community care beyond provision of manual. Pre hospital care requires more collaboration and development. Work collaboratively with Public Health on appropriate communicable disease cases			
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.		Substantially: Progress has been made with integrated planning Examples include TB algorithm, outbreak management			
Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.	Fully: Not a provincial template but the manuals in NH are consistent with recommendations from the BCCDC.				
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of		Substantially: Formal review undertaken and included in plan with estimates for human resources in IC based on complexity of care. Reviewed residential care. Mental health not included currently			

Recommendation	Fully	Substantially	Partially / Alternative Action
staff. They should also ensure adequate medical and clerical support for the program.			
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.		Substantially: The structure for IPC program includes involvement of physicians on IC committees. IP&C reports to the MACs and the VP Medicine Medical Health Officers are part of the IP&C committees	
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.			Partially: The policies developed and endorsed by IP&C committee and MAC. In practice there are still gaps in involving ICPs in planning, especially during initial stages.
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.			Partially: ICPs have used several strategies to bring education especially to the smaller rural facilities. Access to staff has been variable. Online resources are not accessed by staff as one would expect. Orientation programs with ICP participation varies across NH and related to individual site process and capacity i.e. number of ICP to do education in each facility.
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.	Fully: All new ICPs receive a formal IC course through a college/university. All ICP have access to ongoing tele-classes given by experts. All ICPs are supported for one conference per year and provided reference textbooks and other literature as needed. All ICPs encouraged to become involved in a working group under PICNet		
▪ Establish a formal surveillance program appropriate to the programs and services offered.		Substantially: In areas with ICPs – targeted surveillance programs have been developed appropriate to programs and services	
▪ Establish a process for regular formal and informal monitoring of practice.		Substantially: Some formal audits done. ICPs are visible presence on the acute care units daily for formal and continuous informal monitoring of practice. ICPs involvement in the 2007 reprocessing audit provided other opportunities to identify gaps in practice. Formal progress of audit development limited by the number of ICPs available.	
An integrated information system for infection prevention, surveillance and control is in place only for Public Health			
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.			Alternative Action: Currently IT resources have not been identified to support IC. Basic databases have been created by the Regional Manager for data tracking.

Recommendation	Fully	Substantially	Partially
▪ Ensure there is staff with appropriate training to support data quality.		Substantially: Basic surveillance training is included in formal IC courses. Further training has been provided during educational conferences. Quality of data is monitored by Regional Manager and epi tech	
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.	Fully: NH has availed itself of all opportunities to work with provincial stakeholders to develop standardized methodology in surveillance		
Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done			
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.		Substantially: Information supplied to the Board Performance, Aboriginal and Quality committee by the Regional Manager of IPC on infection control and discussion commenced on indicators to be reported	
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.		Substantially: Work has started on a MAC performance scorecard that includes infection control indicators	
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.			Partially: Targeted surveillance reports are available to programs. Formal structure of specific services continue to evolve
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.	Fully: Specific criteria is reported to NH executive and the Board on a regular basis		
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.			Partially: Annual report for 2007-2008 currently being developed for NH Executive. Public access will be determined.

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please provide the information noted below)

There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities

We recommend that each health authority:

- **Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.**
- **Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.**

A three year strategic plan was developed by Regional Manager IPC in 2007. Approved, in principle by NH Executive. Plan does not formally extend into Home and Community care beyond provision of manual.

Pre hospital care requires more collaboration and development.

IPCP works collaboratively with Public Health on appropriate communicable disease cases

Progress has been made with integrated planning

Examples include TB communication algorithm, outbreak management

Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened

We recommend that each health authority:

- **Work with the Ministry of health and B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.**

A provincial template has not been realized yet; however the manuals in NH are consistent with recommendations from the BCCDC and Health Canada. Manuals are completed for Acute Care, Complex Care (LTC) and the manual for Home and Community Care is in the final editing process.

- **Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of**

staff. They should also ensure adequate medical and clerical support for the program.

Formal review undertaken and included in plan with estimates for human resources in IC based on complexity of care, including complex (residential care). Mental Health and Home and Community Care not included. Increases will be incremental over a three year period.

- **Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.**

The structure for IPC program includes involvement of physicians on IC committees. IP&C reports to the MACs and the VP Medicine
Medical Health Officers are part of the IP&C committees

- **Ensure that renovations and new construction designs mitigate the risks of spreading infections.**

There are policies developed and endorsed by IP&C committee and MAC. In practice there are still gaps in involving ICPs in planning, especially during initial stages.

- **Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.**

- **Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.**

All new ICPs receive a formal IC course through a college/university. All ICP have access to ongoing tele-classes given by experts. All ICPs are supported for one conference per year and provided reference textbooks and other literature as needed. All ICPs encouraged to become involved in a working group under PICNet

- **Establish a formal surveillance program appropriate to the programs and service offered.**

In areas with ICPs – targeted surveillance programs have been developed appropriate to programs and services and these will be phased in to other sites as ICP presence increases.

- **Establish a process for regular formal and informal monitoring of practice.**

Some formal audits done. ICPs are visible presence on the acute care units daily for formal and continuous informal monitoring of practice.
An integrated information system for infection prevention, surveillance and control is in place only for Public Health

We recommend that the health authorities:

- **Provide information management support to the infection control program for data collection, analysis and reporting.**

Alternative Action: Currently IT resources have not been identified to support IC. Basic databases have been created by the Regional Manager for data tracking.

- **Ensure there is staff with appropriate training to support data quality.**

Basic surveillance training is included in formal IC courses. Further training has been provided during educational conferences. Quality of data is monitored by Regional Manager and epi tech

- **Work with the Ministry of Health and other stakeholders to ensure data quality.**

NH has availed itself of all opportunities to work with provincial stakeholders to develop standardized methodology in surveillance

Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done

We recommend that each Board of Directors:

- **Work with their senior management to determine what infection control indicators they need measured and reported on.**

Information supplied to the Board Performance, Aboriginal and Quality committee by the Regional Manager of IPC on infection control and discussion commenced on indicators to be reported

- **Hold the Medical Advisory Committees accountable for fulfilling their mandates.**

Work has started on a MAC performance scorecard that includes infection control indicators

We recommend that the health authorities:

- **Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.**

Targeted surveillance reports are available to programs. Formal structure of specific services continue to evolve

- **Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.**

Specific criteria is reported to NH executive and the Board on a regular basis

- **Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.**

Annual report for 2007-2008 currently being developed for NH Executive. Public access will be determined.

PHSA: SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
as of March 2008

March 25, 2008; compiled by Dr. Eva Thomas, Corporate Director for Infection Prevention and Control

Auditor General's Recommendations	Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
A provincial framework for infection prevention, surveillance and control is limited to public health					
We recommend that the Ministry of Health: ▪ Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.					Not applicable at HA level
▪ Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.					Not applicable at HA level
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.	Fully				
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.	Fully				

Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.					Other Action
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.			Partially		
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.		Substantially			
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.		Substantially			
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.			Partially		
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.			Partially		
▪ Establish a formal surveillance program appropriate to the programs and services offered.		Substantially			
▪ Establish a process for regular formal and informal monitoring of practice.			Partially		
An integrated information system for infection prevention, surveillance and control is in place only for Public Health					
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.			Partially		
▪ Ensure there is staff with appropriate training to support data quality.	Fully				
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.	Fully				

Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done					
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.		Substantially			
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.		Substantially			
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.		Substantially			
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.			Partially		
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.		Substantially (not yet publicly available			

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

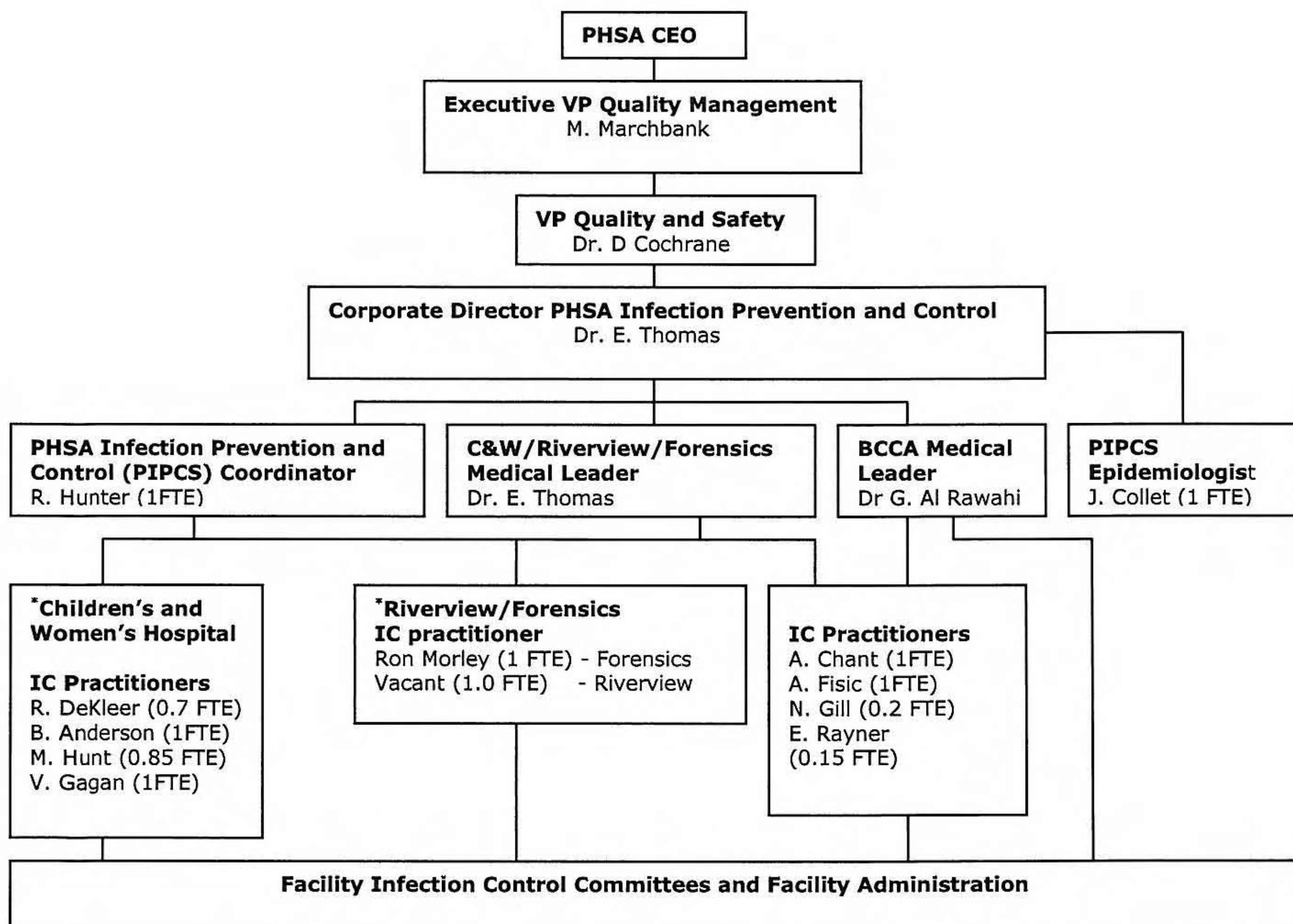
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

PHSA Response to request for Follow up review on the Auditor General's Report on Infection Control.

Introduction:

- Until May of 2005, the PHSA Infection Control Services were left within their respective Agency and were organizationally separate. The Agency control for Infection Control lay with Administration in the case of the BCCA and Riverview or with the Department of Pathology as in C&W. In response to a CCHSA review of infection control services at BCCA it was decided that the needs of the various populations would be best served by a coordinated corporate infection control service. In 2006 organizational structure was modified to bring the PHSA Infection Prevention and Control service under the portfolio of the VP Quality and Safety.
- In 2007, funding increases were approved for PHSA infection prevention and control, and the institution specific budgets were rolled into a single corporate cost centre. This has enabled PHSA to reorganize and strengthen institution specific and PHSA wide infection prevention and control services. In 2007, 1.4 additional infection control practitioner FTE and 1 FTE infection control hospital epidemiologist were approved. A Corporate Director position was created to provide medical and administrative coordination of the service.
- The Corporate Director meets every three weeks with the VP of Safety and Quality and has excellent relationships with administration in all PHSA institutions.
- The job descriptions of all PHSA IC practitioners have been revised and are now uniform across PHSA.
- A new organizational reporting structure was created for PHSA Infection Prevention and Control Service (PIPCS) – please see chart below.
- PIPCS have monthly meetings to discuss infection control issues
- MAC receives bimonthly reports from the Infection Control Committee and additional updates as necessary

Provincial Health Services Authority



***PHSA Infection**
Prevention and Control after hours Medical Call Group
Coverage through 604-875-2161 Children's Hospital paging*

Dr. E. Thomas. Medical Microbiologist
Dr. R. Tan, Medical Microbiologist
Dr. E Blondel-Hill, Medical Microbiologist
Dr. S. Dobson, Infectious Disease
Dr. G. Al-Rawahi, Medical Microbiologist

We recommend that the Ministry of Health:

- **Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.**
- **Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.**

Not applicable at the HA level.

We recommend that each health authority:

- **Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.**
- **Implementation Status (Fully):** The Corporate Director and the PHSA Infection Prevention and Control Service (PIPCS) developed a strategic plan in 2006 for the reorganization of IC services PHSA wide. We are well on our way to address infection prevention, surveillance and control across the continuum of care.
- **Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.**
- **Implementation Status (Fully):** The Infection Control structure outlined in the organizational chart above was established to ensure integrated planning and service delivery across the HA. Communicable Diseases are instantly reported to Public Health from all PHSA IC teams. There are Public Health representatives on the C&W and the BCCA Infection Control Committees. The presence of Public Health representatives on the Riverview and Forensics IC Committees has been suggested.

We recommend that each health authority:

- **Work with the Ministry of health and B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.**
- **Implementation Status (Alternative Action):** While it is not a practical solution for the highly specialized, tertiary care PHSA institutions, it may be helpful for acute care and residential care with limited IC support on site and should be developed through PICNet. We deem it more realistic to focus on reviewing and improving the existing PIPCS

institution specific infection control manuals. For BCCA, we are working on a new, comprehensive manual that will cover all Cancer Clinics in B.C

- **Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.**
- **Implementation status (Partially):** A review of the PIPCS staffing needs was performed in the summer of 2006 by the newly appointed PHSA Corporate Director, a medical microbiologist and infection control expert, through site visits and consultation with facility administrations and infection control practitioners. Recommendations were discussed with the VP of quality prior to submitting budget requests and budget requests were submitted for 2007-2008. Status indicated in table below.

Institution	Existing in 2006	Recommended total FTE in 2008	Approved in 2007	Current 2008	FTE Shortfall 2008
Infection Control Practitioner FTE:s					
C&W	3.5	3.5	n/a	3.5	0
BCCA-Vancouver	0.8	1.5	0.7	1.5	0
BCCA - Fraser	0.2	0.5	0.3	0.5	0
BCCA - Abbotsford	0	0.5	0.4	0.4	0.1
BCCA - Victoria	0.2	0.5	0	0.2	0.3
BCCA - Kelowna	0.2	0.5	0	0.2	0.3
Riverview	1.0	1.0	n/a	1.0	0
Forensics	0	1.0	1.0	1.0	0

Infection Control Epidemiologist					
PHSA	0	1.0	1.0	1.0	0
Infection Control Coordinator					
PHSA	0	1.0 (in 2007-2008 budget request)	0	0	1.0
Clerical Support					
PHSA	0	1.0	0	0	1.0

- **Communicable disease nurses:** PIPCS does not need communicable disease nurses, as we report and interact with Public Health in all cases of communicable disease that have ramifications for the public and community care.
- The corporate director has now identified that PIPCS, resulting from its expansion, is in urgent need of an experienced IC coordinator. This request has been submitted in 2008-2009 Budget. We have recently identified a highly qualified person for this position, who will be starting mid April. This was deemed unique opportunity, as recruitment of experienced ICP:s is recognized to be challenging. This recruitment also allows for appropriate succession planning.
- **Review their infection control structures to ensure there is appropriate and designated medical support in place for the program**
- **Implementation status (substantially):** A single PHSA Infection Prevention and Control Service (PIPCS) are now in place to provide infection prevention and control arrangements for PHSA. The service comprises of infection control practitioners, a corporate director (Medical), Medical Microbiologists and a part time designated IC physician at BCCA
    - **Current PIPCS Medical Staff:**
    - **PHSA:** Dr. Eva Thomas, Corporate Director, PIPCS
    - **BCCA:** Dr. Ghada Al – Rawahi (0.5 FTE), Medical staff BCCA
    - **On call service:** Medical Microbiologists: Dr. Rusung Tan, Dr. Edith Blondel Hill, Dr. Eva Thomas. Infectious Disease: Dr. Simon Dobson

- **New request:** 0.5 additional Medical FTE needed to ensure support for BCCA, Riverview, Forensics, transplant services and STD/TB Clinic at BCCDC.

- **Ensure that renovations and new construction designs mitigate the risks of spreading infections.**

- **Implementation status (substantially):** PIPCS is very cognizant of IC risks associated with renovation and construction, particularly in our large immune compromised patient population at BCCA and also at Children's hospital. PIPCS works closely with the planning department, plant services and is notified and involved when new projects are planned. In fact, we are commonly involved already during the design phases.
- Several of our IC practitioners have attended construction workshops (organized by CSA – Canadian Standard Association).
- C&W has a construction /renovation policy that is based on CSA guidelines. We do regular assessments of construction areas during all phases and follow best practices as outlined by CSA, APIC and 2006 Guidelines for Design and Construction of health Care Facilities, American Institute of Architects Academy of Architecture for Health, Construction and Renovation - 2005 Association for Professionals in Infection Control and Epidemiology text of Infection Control and Epidemiology. June 2007 Infection Control during Construction, Renovation, and Maintenance of Health Care Facilities - Canadian Standards Association.
- BCCA has 2 containment units with HEPA filter at VCC, (one that has been in use for a few months, another very recently purchased). There are no BCCA owned containment units at the other BCCA sites, however because of the differing relationships with host hospital facilities & departments at each BCCA site there may be access to containment units.
- C&W has had 3 such units in place since 2005.

- **Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.**

- **Implementation status (partially):** All new PHSA medical and non medical employees receive introductory infection control education as part of the hiring process, organized by Employee Health, but provided by PIPCS. We also provide regular Hand Hygiene (HH) lectures and other education as needed. We are working on a web based HH module for physicians in conjunction with St Paul's Hospital. We do not yet have a system in place for other ongoing education, but provide IC education on an ad hoc basis. At C&W, new medical students and nurses receive regular IC orientation every 6 weeks at C&W. Plant services have regular IC updates as per request. Other "in service" IC education is offered as needed and upon request both at C&W, BCCA, Riverview and Forensics. At BCCA we do monthly VCC new employee orientations, monthly VCC and FVCC nursing orientations, and FVCC new employee orientations as they are offered - usually every few months. We intend to develop other staff education sessions, some of which would be offered on a regular basis (perhaps ARO updates, isolation precaution reviews etc.).

- **Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.**

- **Implementation status (partially):** Our current budget allows for 2 education opportunities/year for the entire IC practitioner team + 1 opportunity for medical staff. We have requested an increase to include 1 opportunity/year for all IC practitioner staff/year.

- **Establish a formal surveillance program appropriate to the programs and service offered.**

- **Implementation stage (substantially):**

  - **C&W:** Since the opening of the hospital in 1984, C&W has had a formal paper based surveillance program of hospital acquired infections in place which included daily, comprehensive ward rounds. In 2003, a handheld data entry tool was developed in-house. This tool is well liked by the IC practitioners and used routinely. The data is down-loaded to an Access data base, which allows the generation of regular IC reports of hospital acquired infections. Blood stream and surgical site infections are reported through decision support services, which provide appropriate denominators for the IC data. Additionally, our newly hired IC epidemiologist has been successful in downloading MRSA epidemiology data form the laboratory information system (MISYS), and has produced epidemiological MRSA reports for the first time in 2008. Our VRE rates are very small (1-2 new cases/ year) and are therefore reported manually. We have also produced data for *C difficile* infections this year – but the definitions of hospital acquired *C difficile* infections must be reviewed in the context of paediatrics, as children < 1 year of age can carry the organism asymptomatically.

  - **BCCA:** Very limited surveillance was in existence prior to the formation of PIPCS. Currently, daily rounds on inpatient wards at the Vancouver Centre are performed where hospital acquired MRSA, VRE and *C difficile* infections are monitored, as well as any other infection of concern, such as for example respiratory infections. An MRSA, VRE "verbal" screening tool is being developed, as most BCCA patients are tertiary care outpatients. This verbal screening tool as well as a new MRSA protocol is being developed to suit not only the Vancouver Clinic, but also Surrey, Victoria, Kelowna and Abbotsford. Very limited surveillance in place at these clinics – primarily due to IC staff limitations who are focused on outbreak management, consultation and education. We plan to address the surveillance concerns in a focused fashion when staffing is available.

  - **Riverview and Forensics:** A database exists for infections in Riverview patients, but no formal reporting from this has occurred to date. The Riverview ICP position is currently vacant and surveillance capability has to be reassessed when this position is filled. Currently the Forensics ICP provides "Outbreak" coverage for Riverview.

- **Establish a process for regular formal and informal monitoring of practice.**

- **Implementation stage (partially):** IC practitioner performance reviews now occur yearly and will be a task for the new IC coordinator

We recommend that the health authorities:

- **Provide information management support to the infection control program for data collection, analysis and reporting.**

- **Implementation stage (Partially):** We work with decision support service and IMIT. PIPCS is evaluating two tools at the moment; one is a web enabled data collection tool (based on the Patient Safety Learning System), the other is a data-mining and reporting tool.

    - **Web enabled data collection tool:** requires further modification with the support of PIPCS IC practitioners and IMIT. We plan to develop, test and use this tool, beginning with C&W as a pilot, then roll out to BCCA, Riverview and Forensics..

    - **Data-mining tool:** We have reviewed several data-mining/IC soft ware products for the purpose or surveillance, monitoring and reporting. (ACE, ICNet, Riverview's in-house program and Medmined). At this point in time we favour Medmined, but further integration testing is required. The issue of privacy protection is being explored by Cardinal Health, the vendor of Medmined. This project is likely 1-2 years away from implementation.

- **Ensure there is staff with appropriate training to support data quality.**

- **Implementation stage (Fully):** We hired a full time infection control epidemiologist, Jun-Chen Collet, in October of 2007. She has already greatly enhanced the quality of our data. For example, C&W participates in CNIPS (Canadian Nosocomial Infection Surveillance network) and our epidemiologist has reviewed this data and made significant improvements of the quality. The same is true for our MRSA, VRE and *C difficile* data.

- **Work with the Ministry of Health and other stakeholders to ensure data quality.**

- **Implementation stage (fully):** The PIPCS epidemiologist participates in the PICNet working group for *C difficile* infections. The Corporate Director is a member of the PICNet Steering Committee.

We recommend that each Board of Directors:

- **Work with their senior management to determine what infection control indicators they need measured and reported on.**

- **Implementation stage (Substantially):** The new CCHSA (Canadian Council on Health Services Accreditation) regular reporting requirements include: Hospital acquired

MRSA, VRE, *C difficile*, post surgical infections and the rate of timely administration of prophylactic antibiotic. C&W can currently report on MRSA, VRE, *C difficile* and surgical wound infections, with the caveat that wound infections are only monitored in inpatients and readmissions).We also report on blood stream infection surveillance and catheter related bloodstream infections using line days as a denominator (please see below). BCCA Vancouver Clinic can report these parameters on inpatients only. We will continue take direction from senior management to improve the reporting system.

- **Hold the Medical Advisory Committees accountable for fulfilling their mandates.**

- MAC receives bimonthly reports from the Infection Control Committee and additional updates as necessary. Occurrence rates for nosocomial infections, post surgical infections and timely administration of prophylactic antibiotics are reported and discussed.
- Agency based nosocomial infection rates are also reported to the Executive Leadership Council and the Board

We recommend that the health authorities:

- **Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.**

- **Implementation stage (substantial)**: The IC teams in the respective PHSA institutions provide monthly reports both to the corporate director as well as their institutional infection control committees. These reports are then forwarded to the VP of Quality, institutional MAC's, site nursing and administrative managers. They are also summarized in the monthly PIPCS meetings and the minutes from this meeting are distributed to the PIPCS members, site management and the VP of Quality and Safety.

- **Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.**

Implementation stage (Partial):

- At C&W PICU participates in the Intensive Care Unit Collaborative using Institute of Healthcare Improvement initiatives.
- NICU (Safer HealthCare now for Catheter related blood stream infection) – these initiatives have improved the dialogue between infection control and clinical services, and we all now have a better understanding of what kind of data we are able to provide and what is required. At BCCA we are working on an expansion of data reporting as well.

- **C&W regularly reports after consultation with medical management teams:**

    - **PICU** – all hospital acquired infections, surgical site infections, UTI:s, respiratory infections including ventilator associated pneumonia (VAT) and any other wounds etc. Reports go to Medical Head, PICU.

- **Paediatric Oncology:** Catheter related blood stream infection are reported to –, Medical Oncology Head, Oncology Nursing Manager
- **NICU**- Hospital acquired bloodstream and surgical site infections only – Reports go to Medical Heads of NICU.
- **C&W:** Hospital acquired blood stream and surgical site infections are reported to the Hospital Presidents, and Chair, Quality and Safety at Children's Hospital.

▪ **BCCA** – the Safer Health Care Now program for line insertions is now being piloted at the Vancouver Clinic.

▪ **Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.**

▪ **Implementation stage (Substantially)** The First Annual PIPCS report will be ready on March 31, 2008 – not yet publicly available.

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008
FINAL RESPONSE;
Vancouver Coastal Health Authority

Auditor General's Recommendations	Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.		X			
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.		X			
Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.		X			
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.			X		
▪ Review their infection control structures to ensure there is appropriate		X			

and designated medical support in place for the program.					
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.	X				
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.		X			
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.		X			
▪ Establish a formal surveillance program appropriate to the programs and services offered.		X			
▪ Establish a process for regular formal and informal monitoring of practice.		X			
An integrated information system for infection prevention, surveillance and control is in place only for Public Health					
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.			X		
▪ Ensure there is staff with appropriate training to support data quality.			X		
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.			X		
Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done					
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.	X				
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.	X				
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.		X			
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.		X			
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.	X				

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please provide the information noted below)

VANCOUVER COASTAL HEALTH AUTHORITY

FINAL RESPONSE

MARCH 2008

A provincial framework for infection prevention, surveillance and control is limited to Public Health

We recommend that the Ministry of Health:

- **Establish and implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting.**
    - The Provincial Infection Control Network (PICNet) has established a collaborative framework for the sharing of best practices as well as consensus standards for surveillance.
    - VCH is actively participating on many working groups:
        - Respiratory Outbreak Prevention and Control Guidelines Working Group. This working group established guidelines (June 2007) for the prevention and control of respiratory infections in all health settings.
        - Antibiotic Resistant Organisms Working Group. This working group is currently working on revising the current BCCDC antibiotic resistant organism guidelines. In addition to updating the existing guidelines, the working group will enhance them to include section on hemodialysis and occupational health.
        - Clostridium difficile associated disease (CDAD) Surveillance Working Group. The CDAD surveillance working group is coordinating the implementation of a standardized surveillance protocol throughout the province. Supporting the implementation, the working group has also developed a Participation Agreement outlining roles and responsibilities of the collaborators for information sharing, as well as standards for provincial reporting of CDAD rates and outcomes.
- **Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.**

- VCH is actively involved in PICNet's CDAD Surveillance Working Group. The CDAD Surveillance working group has developed a surveillance protocol with standardized definitions and minimal data set, as well as consensus standards for provincial-level reporting. The goal is to build upon the work of this group to expand provincial surveillance to other healthcare associated infections.
- VCH and the Interior Health Authority are currently collaborating on a pilot project for the development of a standardized surveillance protocol for surgical site infections. Standard definitions and a minimal data set have been developed. Consensus case finding methods have been developed and implemented in the two pilot facilities (Vancouver General Hospital and Kelowna General Hospital).
- VCH has established standardized surveillance and reporting for MRSA, VRE and CDAD. VCH participates in national surveillance for these organisms through the Canadian Nosocomial Infection Surveillance Program (CNISP). Standardized annual reporting has been in place since 2005/2006. Working with key stakeholders, reporting of nosocomial rates by administrative period is currently underway for the seven acute care facilities.

There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities

We recommend that each health authority:

- **Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.**
  - VCH has a regional infection control team with local responsibility. The Medical Health Officer attends infection control meetings regularly. There are integrated mechanisms in place that coordinate infection prevention and surveillance across the continuum. In addition, because infection prevention involves employee infection prevention as well there are structures and procedures in place to support the coordination of these efforts with Occupational Health and Safety.
  - VCH has established a long term/residential care working group aimed at identifying priority areas for infection control surveillance for benchmarking and ongoing monitoring in the region's directly funded long term/residential care facilities. Surveillance definitions and protocols applied in acute care are not directly transferable to the long term/residential care setting. As a result, new definitions and protocols will need to be developed.
  - PICNet recently accepted a proposal submitted by VCH to examine infection control in long term and residential care across the province. Building on the previous PICNet needs assessment, the primary objectives of the proposal are to: (1) establish the current status of infection surveillance in long term care and rehabilitative care (LTRC) province wide; (2) identify resources and needs in infection control in LTRC; and (3) identify priorities for infection control in LTRC. The working group will get underway in April 2008.
- **Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.**

- Current structures within VCH support the integration of infection control with public health in residential care practices however, further opportunities to better align and integrate services across VCH still exist.
- In collaboration with Occupational Health and Safety we have further established committees, policies and procedures, outbreak management protocols, algorithms, and communication tools to better align these structures.

We recommend that each health authority:

- **Work with the Ministry of health and B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.**
  - VCH has completed a regional manual that is available to all practitioners within residential and acute care facilities across VCH via hard copy as well as intranet. This addresses common procedures as well as signage across VCH. There are numerous resources available for our contracted facilities, primary care clinics and public health staff.
- **Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.**
  - VCH Infection Control participated in the Provincial Needs Assessment. It was determined that VCH resources fell below the national standards for the number of Infection Control Practitioners per bed ratio.
  - VCH Infection Control has submitted a business case to address these needs.
  - Communicable disease control has received MOH funding the last 2 years to enhance their capabilities for surveillance, reportable disease management, and education.
- **Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.**
  - The VCH Infection Control business case addresses the need for a dedicated Infection Control Officer (0.2 FTE) at Lion's Gate Hospital. Other HSDAs have medical support for infection control in place as well as a Regional Medical Director for Infection Control. Infection Control Officers responsible for the Acute and Residential Care facilities work collaboratively with Medical Health Officers to ensure continuity of care for patients, clients, residents and staff as well as the public.
  - VCH has a regional community infection and prevention educator who supports the contracted facilities, primary care clinics and the public health staff.

- **Ensure that renovations and new construction designs mitigate the risks of spreading infections.**
  - The Infection Control Team across VCH is involved in all construction activities within the acute and residential care sites to ensure awareness and understanding of CSA construction guidelines for construction and renovations. Infection Control Practitioners from across VCH recently participated in a regional construction standards workshop hosted by the Facilities Department of VCH. There is a lot of internal collaboration with construction and renovation activities.

- **Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.**
  - VCH has a comprehensive Hand Hygiene program in place. The on-line resources are made available to all staff including physicians. All physicians will be completing these on-line modules as a condition of their ongoing renewal of privileges at VCH. This on-line learning module has been made available to other health authorities as well as schools of medicine and nursing.
  - All new staff to VCH receives infection control education during orientation as well as more detailed information on aseptic techniques in clinical orientation. In addition, regular educational sessions are given at each site.
  - Numerous on-line resources are also available on the Infection Control, Learning and Development, Centre for Surgical Excellence and Innovation intranet sites.
  - The Innovation Fund recently supported the development of an eLearning module for physicians and nurses that addresses the best practices techniques for the insertion, care and maintenance of central lines. This will also be made widely available.

- **Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.**
  - VCH Infection Control Practitioners not only participate in a variety of conferences and activities to maintain best practice standards they are also involved in providing educational sessions to other agencies.
  - VCH Infection Control Team is involved in numerous provincial, national and international activities. We participate in a variety of ways with Health Canada, CSA, Public Health Agency of Canada, CNISP (Canadian Nosocomial Infection Surveillance Program), Safer Health Care Now! (Canadian Patient Safety Institute), PICNet, and ISO.
  - The VCH Regional Infection Control Coordinator participated as a working group member on the Canadian Committee on Antibiotic Resistance (CCAR) 2007 publication, *Infection Prevention and Control Best Practices for Long Term Care, Home and Community Care including Health Care Offices and Ambulatory Clinics.*
  - In the past year two members of the team were invited to assist in the establishment of an infection control program in hospitals in Guatemala and

South Africa. One member is currently in South Africa assessing the success of the program.

- Through PICNet, the VCH Infection Control team as well as that of the other Health Authorities receive access to WEBBER teleclass lectures in infection control. Lectures are scheduled weekly and involve speakers from around the world.

- In the last year, members of the VCH Infection Control team have presented at multiple conferences and meetings, including CHICA, APIC

  - June 01, 2007 – "*Clean Hands for Life*™: Innovation in Poster Presentation" poster presentation at Innovations in Health Care Best Practices Forum, BC Ministry of Health, Vancouver, BC.

  - June, 2007 – "Ventilator Associated Pneumonia in Residents Chronically Ventilator Dependent". Poster presentation at CHICA, 2007. Edmonton, AB.

  - October 26, 2007 – Hand Hygiene. Oral presentation at CHICA-BC Education Day. Vancouver, BC.

  - June 2, 2008 – Invited panellist for Surveillance Programs across Canada at CHICA, 2008. Montreal, QC

  - June 15, 2008 – *Clean Hands for Life*™: Results of a Regional Hand Hygiene Campaign Abstract accepted for poster presentation at APIC. Denver, Colorado.

- The Infection Control Team currently has grants with CIHR to assess the effectiveness of on-line learning and another with the CIHR/MSFHR Strategic Training Program Grant to assess the needs for occupational health and safety and infection control and to establish a sustainable occupational health and infection control program in a public/private/academic ambulatory care setting. Another is in partnership with Bayer Healthcare Canada for the Clean Hands for Life hand hygiene campaign.

- Numerous members of Infection Control and Medical Microbiology have published research articles and continue to participate internationally in research programs.

- **Establish a formal surveillance program appropriate to the programs and service offered.**

  - VCH Infection Control publishes an Annual Report which formally assesses all activities of the Infection Control Department. This report is published to the internet site of VCH. We are in the process of evaluating all of our services via an internal customer satisfaction survey.

  - VCH has a standard surveillance program for MRSA, VRE and CDAD in its acute care facilities. Surveillance results are continuously updated on the shared drive. Standard reports include nosocomial rates by administrative period for

MRSA, VRE and CDAD for each facility. Reports of the number of cases acquired on a given service/ward are also prepared regularly.

- **Establish a process for regular formal and informal monitoring of practice**
    - Within the Infection Control Team there is a well established process for review of our own practices. Clear roles and responsibilities for each team member have been defined and practices are monitored against these standards. We have regular team meetings and routinely share issues and concerns across the health authority.
    - In addition to the surveillance programs in place the Infection Control department participates in audits, quality assurance and quality initiative activities. For eg. Operating Room Audit, Surgical antibiotic review, C. Difficile procedures, review of CJD practices, outbreak management and debriefing, involvement in critical incident reviews that have an infection control component. Infection Control participates with the review of audit results for certain contracted services as well.
    - VCH has a standard surveillance program for MRSA, VRE and CDAD in its acute care facilities. Surveillance results are continuously updated on the shared drive. Standard reports include nosocomial rates by administrative period for MRSA, VRE and CDAD for each facility. Reports of the number of cases acquired on a given service/ward are also prepared regularly.

We recommend that the health authorities:

- **Provide information management support to the infection control program for data collection, analysis and reporting.**
    - Numerous data and information sources are available to Infection Control. VCH recognizes the challenge of multiple information databanks and is working on a plan to coordinate all of these data sources into one comprehensive system. In addition, VCH is actively participating with PICNet in establishing a provincial database for surveillance data.
- **Ensure there is staff with appropriate training to support data quality.**
    - The infection control team has participated in the establishment of common definitions for data quality and routine auditing of data quality processes are in place. However, there remains the challenge of meeting the demands for staff to input data and to maintain those processes once established.
- **Work with the Ministry of Health and other stakeholders to ensure data quality.**
    - VCH is involved in a data quality working group with the Canadian Nosocomial Surveillance Program (CNISP). Random samples of data submitted from participants of the national surveillance program are resubmitted and evaluated for quality and accuracy. The results of the analysis will be presented at the next CNISP annual meeting.
    - VCH routinely examines its surveillance data for completeness and accuracy. We are currently working with QUIST and ORMIS to examine data quality issues in denominator data required to support surgical site infection surveillance.

- The PICNet CDAD surveillance project will involve routine evaluation of the surveillance program and the data collected.

Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done

We recommend that each Board of Directors:

- **Work with their senior management to determine what infection control indicators they need measured and reported on.**
  - In collaboration with the Senior Executive Team for VCH as well as the Health Authority Medical Advisory Council infection control indicators have been developed. These rates are regularly reported to the local infection control committees, medical advisory committees, and senior management teams as well as to the Board of VCH.
  - As noted previously the VCH Infection Control Annual Report is available to all staff as well as the public via the internet.
- **Hold the Medical Advisory Committees accountable for fulfilling their mandates.**
  - Guidelines and reporting structures ensure compliance by the Medical Advisory Committees across VCH.
  - The Health Authority local Medical Advisory Committees receive reports from their local infection control committees.
  - The Health Authority Medical Advisory Committee (HAMAC) receives reports on infection control matters through its Quality of Care Committee.
  - The HAMAC has mandated that all medical staff must take and pass the on-line hand washing module and the infection control module before their 2009 re-credentialling.

We recommend that the health authorities:

- **Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.**
  - Each HSDA has mechanisms and structures in place to disseminate surveillance and audit information for infection control. For eg. Each HSDA has an Infection Control Committee that is multidisciplinary. These committees report to the local medical advisory committees and then to the Health Authority Medical Advisory.
  - As well, numerous program areas receive regular 'report cards' from infection control. This includes information and trending on infection control indicators for that department or functional program– We are in the process of spreading this activity to multiple program areas across VCH.

- **Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.**
    - See above. In addition regular reports are reviewed by each of the HSDA senior leadership teams via the infection control committees.
- **Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.**
    - VCH has published their annual report to the public for the past 3 years.

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

(Please tick implementation status for each recommendation)

RESPONSE FROM PROVIDENCE HEALTH CARE

Auditor General's Recommendations	Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.	√				
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.	√				
Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.		√			
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of		√			

staff. They should also ensure adequate medical and clerical support for the program.					
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.	√				
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.	√				
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.	√				
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.		√			
▪ Establish a formal surveillance program appropriate to the programs and services offered.		√			
▪ Establish a process for regular formal and informal monitoring of practice.		√			
An integrated information system for infection prevention, surveillance and control is in place only for Public Health					
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.		√			
▪ Ensure there is staff with appropriate training to support data quality.		√			
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.		√			
Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done					
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.					
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.					
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.		√			

▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.		√			
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.		√			

How you want to be treated.

PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: ***The Provincial Overview***
As at March 2008

(Please provide the information noted below)

There is little or no integrated planning for infection prevention, surveillance and control across the continuum of care in the health authorities

We recommend that each health authority:

- **Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.**
  - *PHC has a strategic plan, which guides prevention, surveillance and control across the continuum of care (see attached strategic plan).*
  - *The strategic plan was finalized in 2005 and will be reviewed in 2008.*
- **Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.**
  - *The structure of infection control at PHC was formally reviewed by an independent consultant in 2005 and a report with recommendations was produced.*
  - *The Vision of the PHC Infection Prevention and Control Team (IPAC) is to create and sustain a culture in which infection control is integrated into all aspects of care.*

Demonstrating best practices in infection prevention, surveillance and control needs to be strengthened

We recommend that each health authority:

- **Work with the Ministry of health and B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.**
  - *PHC has an IPAC website which includes an on online manual.*
  - *This manual is accessible by all acute care sites, and residential care sites (with the exception of Marion Hospice which has a CD of the IPAC manual), and is also available through the VCH website.*

- *VCH Communicable Disease Control has suggested that this manual used as a potential template for the Region and is available as a possible template at the provincial level.*

- **Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.**

    - *In 2005, a business case detailing the requirements for a functional infection control program at PHC was performed.*

    - *Since then, the PHC IPAC Team has been expanded to include: one IPAC Physician Leader/Medical Microbiologist, two part-time Physicians (acute and residential care), one full-time Epidemiologist, one full-time clerical position, 5 full-time Infection Control Practitioners, as well as access to a Molecular Biologist.*

- **Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.**

    - *The PHC IPAC Team has been expanded to include: one IPAC Physician Leader/Medical Microbiologist, and two part-time Physicians (acute and residential care).*

    - *Two additional Medical Microbiologists participate in IPAC at PHC and allow for 24 hour / 7 days per week coverage.*

- **Ensure that renovations and new construction designs mitigate the risks of spreading infections.**

    - *The IPAC Team is involved in all new construction and renovation projects, e.g., renovation of the St. Paul's Hospital Emergency Department, PHC Renewal project.*

- **Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.**

    - *The IPAC Team provides education to all areas, including medical staff.*

    - *Detailed information on educational activities can be found in the annual report.*

- **Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.**

    - *The IPAC Team participates in teleconferences, seminars, workshops and other educational opportunities, which are available locally.*

    - *In addition, ICPs attend workshops in other geographical locations as funding permits.*

- *IPAC medical staff attends and present at national and international medical conferences.*

- **Establish a formal surveillance program appropriate to the programs and service offered.**
  - *A full-time Epidemiologist oversees the design and implementation of a formal surveillance program and multiple surveillance systems, including:*
    - *Acute Care: comprehensive surveillance for MRSA, VRE, TB, and C. difficile; surveillance for surgical site infections, ventilator-acquired pneumonia, and catheter-related bloodstream infections is partially implemented.*
    - *Residential Care: surveillance for C. difficile, TB, influenza-like illness, and viral gastroenteritis is currently performed.*

- **Establish a process for regular formal and informal monitoring of practice.**
  - *Hand hygiene audits are performed periodically using a standardized format; data are presented to all PHC staff.*
  - *Weekly IPA0C ward rounds are performed on the wards in acute care facilities.*

An integrated information system for infection prevention, surveillance and control is in place only for Public Health

We recommend that the health authorities:

- **Provide information management support to the infection control program for data collection, analysis and reporting.**
  - *The IPAC Team includes a full-time Epidemiologist to support data collection, analysis and reporting.*
  - *Members of IPAC have access to multiple computerized databases and statistical computer programs, including: ADT, LIS, SCM, SPSS, MS Access, ORMIS, Sunset, and others.*

- **Ensure there is staff with appropriate training to support data quality.**
  - *The IPAC Team includes a full-time Epidemiologist to support data quality.*
  - *Data quality systems are incorporated in to all aspects of laboratory testing.*
  - *IPAC staff attends education sessions on computer programs and applications.*

- **Work with the Ministry of Health and other stakeholders to ensure data quality.**
  - *IPAC staff collaborate with provincial and regional partners (including VCH Communicable Disease Control) to ensure data quality.*
  - *Members of IPAC participate in various provincial projects coordinated through PICNet BC, including the Steering Committee.*

Reporting on prevention, surveillance and control of infections varies by the health authority and, overall, is not well done

We recommend that each Board of Directors:

- **Work with their senior management to determine what infection control indicators they need measured and reported on.**
  - *The IPAC Medical Director meets with senior management and the PHC Board of Directors to report on indicators.*
  - *The senior management "Balanced Scorecard" includes the following infection control indicators: hand hygiene compliance, and the prevalence of antibiotic-resistant organisms (VRE and MRSA).*
- **Hold the Medical Advisory Committees accountable for fulfilling their mandates.**
  - *All Infection Control Standard Committee minutes are provided to MAC.*
  - *The IPAC Medical Director presents at MAC meetings and supports MAC on all issues relating to the prevention and control of nosocomial infections.*

We recommend that the health authorities:

- **Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.**
  - *Members of IPAC have presented results on hand hygiene audits to front-line health care workers and senior management teams.*
  - *In addition, data and rates are available to all staff via the intranet site, and will be available to the public in the coming fiscal year.*
  - *The annual report for 2006/7 has been reported; the report for 2007/8 will be available in April 2008, and available on the IPAC website.*
- **Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.**
  - *The 2006/07 IPAC Annual Report has been presented to senior management teams and is available on the intranet site.*
  - *For the coming fiscal year, IPAC will be working to produce quarterly infection prevention and control reports.*
- **Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.**
  - *The first annual report was produced for the 2006/07 fiscal year and has been presented internally to senior management teams for approval and posted on the IPAC intranet site.*

- ***The 2007/08 report will be completed in April 2008; in order to make these reports available to the public, they will be posted on the Providence Health Care internet site.***

Completed March 27, 2008.

SUMMARY OF STATUS OF IMPLEMENTATION BY RECOMMENDATION
Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008
(Please tick implementation status for each recommendation)

Auditor General's Recommendations	Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
THERE IS LITTLE OR NO INTEGRATED PLANNING FOR INFECTION PREVENTION, SURVEILLANCE AND CONTROL ACROSS THE CONTINUUM OF CARE IN THE HEALTH AUTHORITIES					
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.	X				
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.		X			
DEMONSTRATING BEST PRACTICES IN INFECTION PREVENTION, SURVEILLANCE AND CONTROL NEEDS TO BE STRENGTHENED					
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.				X	
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.		X			
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.		X			
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.		X			
▪ Ensure that all staff receive regular ongoing education in the area of infection		X			

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Auditor General's Recommendations	Implementation Status				
	Fully	Substantially	Partially	Alternative Action	No Action
control and that medical staff also have access.					
▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.	X				
▪ Establish a formal surveillance program appropriate to the programs and services offered.			X		
▪ Establish a process for regular formal and informal monitoring of practice.			X		
AN INTEGRATED INFORMATION SYSTEM FOR INFECTION PREVENTION, SURVEILLANCE AND CONTROL IS IN PLACE ONLY FOR PUBLIC HEALTH					
We recommend that the health authorities: ▪ Provide information management support to the infection control program for data collection, analysis and reporting.			X		
▪ Ensure there is staff with appropriate training to support data quality.		X			
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.		X			
REPORTING ON PREVENTION, SURVEILLANCE AND CONTROL OF INFECTIONS VARIES BY THE HEALTH AUTHORITY AND, OVERALL, IS NOT WELL DONE					
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.		X			
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.				X	
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.			X		
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.		X			
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.	X				

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PROGRESS ON IMPLEMENTING THE RECOMMENDATIONS ON

Infection Control: Essential for a Healthy British Columbia: *The Provincial Overview*
As at March 2008

Vancouver Island Health Authority Response:

The Vancouver Island Health Authority has in the last two years made substantial progress towards meeting the Recommendations outlined in the Office of the Attorney General's Report. These have included the establishment of an infrastructure through the provision of additional funding that supports a regional infection prevention and control (IPC) Program that covers the spectrum of health services (acute, long term care, and community) as well as creating linkages between the programs that promote IPC practices (Public Health, Wellness & Safety, Laboratory, Infection Prevention and Control). A number of initiatives and projects have occurred, such as the Hand Hygiene Initiative, amalgamation of existing IPC manuals into one regional manual that is available through the Intranet, development of Outbreak management toolkits for Residential and Assisted Living Sites. The IPC Program positions have all been filled with the most recent practitioner arriving in September 2007.

Auditor General's Recommendations	VIHA Response		Rating
	Progress	Work Plan	
THERE IS LITTLE OR NO INTEGRATED PLANNING FOR INFECTION PREVENTION, SURVEILLANCE AND CONTROL ACROSS THE CONTINUUM OF CARE IN THE HEALTH AUTHORITIES			
We recommend that each health authority: ▪ Develop an integrated plan for infection prevention, surveillance and control across the continuum of care.	VIHA Infection Prevention and Control Program Plan 2006-2010 approved by the Board. Includes coverage for services across acute, long term care and community through collaborative and consistent practices with Public Health and Wellness and Safety.		Fully

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Auditor General's Recommendations	VIHA Response		Rating
	Progress	Work Plan	
▪ Assess their current Public Health and infection control structure to ensure integrated planning and service delivery for infection prevention, surveillance and control.	CD Program and IPC have established cross-representation on committees to support integrated planning and service delivery; especially around influenza immunization program and outbreak management. Work developed jointly includes: Roles and Responsibilities in Outbreaks (delineation between amalgamated/ affiliated facilities), Outbreak Management Toolkit for Residential Facilities, Management of Gastrointestinal or Respiratory Illnesses in Assisted Living Residences, Guidelines during Outbreaks (staff restrictions, return of residents to LTC facilities during outbreaks), Health Space (broad reporting to Acute and LTC facilities of LTC facilities experiencing outbreaks). Public Health has established CD Program Hubs (PHNs and EHOs) to respond to outbreak situations in affiliated LTC facilities. IPC covers outbreaks in amalgamated acute/LTC facilities. VIHA participated in review of Public Health Core Services documents. CD Program and IPC are involved in pandemic planning. The lab supports outbreak management throughout VIHA with results provided to public health and IPC.	- Build upon work already underway to continue developing consistent guidelines implemented across the sectors, and maintain and build upon established practices (consultation on renovations and new construction; provision of education; pursuit of innovative ways to provide ongoing education to staff). - Additional positions for the IPC Program have been identified and submitted through the VIHA budget request process.	**Substantially**
DEMONSTRATING BEST PRACTICES IN INFECTION PREVENTION, SURVEILLANCE AND CONTROL NEEDS TO BE STRENGTHENED			
We recommend that each health authority: ▪ Work with the Ministry of Health and the B.C. Centre for Disease Control to establish a basic template for a provincial manual for infection control in acute and residential care.	MOH/BCCDC/Health Authorities through PICNet develop provincial guidelines. VIHA has revised its IC Manual, which has been adopted island wide. It will be web-based and will have ongoing realtime review and revision. This manual is consistent with provincial guidelines and is applicable to the services VIHA provides.	- Phase 1 is complete. - Phase 2, which includes outbreak management, housekeeping and other specific service sections, is anticipated for Fall 2008. - Phase 3, which incorporates any additional areas that have been identified for inclusion,	**Alternative Action**

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Auditor General's Recommendations	VIHA Response		Rating
	Progress	Work Plan	
		will be completed for Winter 2008.	
▪ Undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; the complexity of care provided; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.	All current IPC positions are filled. IPC staff requirements have been reviewed and additional resources identified through the VIHA budget approval process. A formal review of the public health communicable disease requirements was completed in 2006 and recommendations were made to establish a specialized CD control program for the HA with CD offices in South, Central and North. These recommendations were implemented in fiscal 2007/08 and the three CD offices have been established and staffed. A post-implementation evaluation of the CD service is occurring.	Building upon work already underway to continue developing consistent guidelines implemented across the sectors, and to maintain and build upon established practices (consultation on renovations and new construction; provision of education; pursuit of innovative ways to provide ongoing education to staff). - Additional positions for the IPC Program have been identified and submitted through the VIHA budget request process.	Substantially
▪ Review their infection control structures to ensure there is appropriate and designated medical support in place for the program.	Currently have 2 physicians allocated to the IPC Program (Medical Microbiologist and Infectious Diseases Physician). Have identified need for 1 additional IPC physician position, which is being considered through the physician approval process. Work closely with the VIHA Medical Health Officers and BCCDC.		Substantially
▪ Ensure that renovations and new construction designs mitigate the risks of spreading infections.	IPC representation on Capital Projects Committees (SI, CI/NI), involved in all new construction and major renovation projects, working relationship with Facilities Maintenance Operations at all sites.	Building upon work already underway to continue developing consistent guidelines implemented across the sectors, and to maintain and build upon established practices (consultation on renovations and new construction; provision of education; pursuit of innovative ways to provide ongoing education to staff). - Additional positions for the IPC Program have been identified and submitted through the VIHA budget request process.	Substantially
▪ Ensure that all staff receive regular ongoing education in the area of infection control and that medical staff also have access.	Provide IPC principles to Acute/LTC nursing staff as part of their orientation to VIHA. Developing presentation for inclusion in New Employee Orientation. Ongoing education is provided to staff in a number of venues: staff inservices, formal presentations, point-in-time education, initiatives such as Hand Hygiene update. Currently determining the educational needs in community. IPC physicians will be developing a resource for physicians. Limited in what can be accomplished by the availability of resources (IPC practitioners/ physicians and clinical staff relief).		Substantially

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▪ Ensure that the infection control team has adequate resources to maintain current practice standards through ongoing education.	VIHA has funded Webber teleconference education sessions, attendance at IPC conferences locally, provincially and nationally (Infectious Diseases, PICNet, CHICA), as well as supporting IPC practitioners in acquiring an approved Infection Control course through nationally recognised universities (McMaster, University of Calgary, University of BC).		Fully
▪ Establish a formal surveillance program appropriate to the programs and services offered.	Data definitions consistent with provincial/national criteria, have been established for surveillance of AROs, CDAD, surgical site infections, and outbreaks. IPC is currently doing only targeted surveillance as our contribution to Safer Health Care Now. It works collaboratively with the department of surgery to collect targeted surveillance. VIHA has IPC representation on the PICNet Community IPC Working Group to participate in the development of surveillance guidelines for community.		Partially
▪ Establish a process for regular formal and informal monitoring of practice.	There are a number of audits/inspections that occur within VIHA facilities: inspections completed by the Community Care Licensing staff and Environmental Health Officers, IPC practitioner walk-abouts with a focus to promote IPC principles and practices through point-in-time teaching, identification of problem areas with recommendations on how they can be resolved. Recently with the assistance of two Employed Student Nurses (ESN), the Program audited the implementation of the ARO screening questionnaire and hand hygiene practices at NRGH, RJH, and VGH. Housekeeping services has an annual audit completed by external auditors. IPC has done spot environmental swabs post-cleaning during recent outbreaks, which has improved outbreak management. VIHA participates in CCHSA accreditation.	- Continue to maximize on opportunities to regularly monitor practice (employed student nurses, staff on LTD who are preparing to return to the work place). - Additional positions for the IPC Program have been identified and submitted through the VIHA budget request process. - Cerner (operating system) is currently being rolled out throughout VIHA. Continue working with IMIT to access reports and modules through the Cerner system that will support surveillance and case management.	Partially
AN INTEGRATED INFORMATION SYSTEM FOR INFECTION PREVENTION, SURVEILLANCE AND CONTROL IS IN PLACE ONLY FOR PUBLIC HEALTH			
We recommend that the health authorities: ▪ Provide information management support to the infection control	Rollout of the Cerner operating system throughout VIHA, including St. Joseph's General Hospital in 2008 will provide the IPC program the capacity of working off the same client record. Working with IMIT to access reports and modules through the	- Cerner (operating system) is currently being rolled out in VIHA - Continue working with IMIT to access reports and modules	Partially

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Auditor General's Recommendations	VIHA Response		Rating
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program for data collection, analysis and reporting.	Cerner system that will support surveillance and case management. Currently all IPC practitioners are using a "home grown" Access database for data collection and reporting.	through the Cerner system that will support surveillance and case management.	
▪ Ensure there is staff with appropriate training to support data quality.	Program has developed data definitions that are used by all staff in data collection and reporting. Access database has been developed to display many of these definitions or to provide a drop down list, to improve data quality.	- Continue developing and refining data definitions to ensure they are consistent with provincial and national agencies.	Substantially
▪ Work with the Ministry of Health and other stakeholders to ensure data quality.	Program uses criteria set by provincial (PICNet, BCCDC) and/or national agencies (CNISP, Safer HealthCare Now) in developing its data definitions. There is sometimes variance in data definition between these agencies, and these are raised by VIHA representatives for consideration and resolution.	- Work with IPC practitioners to enhance data consistency and quality. - Have identified the need for an epidemiologist as a resource within the IPC Program. This has been submitted through the VIHA budget request process.	Substantially
REPORTING ON PREVENTION, SURVEILLANCE AND CONTROL OF INFECTIONS VARIES BY THE HEALTH AUTHORITY AND, OVERALL, IS NOT WELL DONE			
We recommend that each Board of Directors: ▪ Work with their senior management to determine what infection control indicators they need measured and reported on.	The IPC Program reports its status on activities identified in the IPC Program Plan, as well as its hospital acquired infection rates, as a component of the Quality and Patient Safety quarterly and annual report to the Board.	- Continue working with senior management to determine what additional indicators and reports they require and are required by the Board. Based on this information, the IPC program will determine what data collection is required, and develop or access a system to collect, compile, and report this data. - Have identified the need for an epidemiologist as a resource within the IPC Program. This has been submitted through the VIHA	Substantially

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		budget request process. - Continue working with IMIT to access reports and modules through the Cerner system that will support surveillance and case management.	
▪ Hold the Medical Advisory Committees accountable for fulfilling their mandates.	The Board of VIHA holds the Health Authority Medical Advisory Committee accountable for ensuring that quality review mechanisms are in place in relation to IPC. When compromises to IPC principles/practices are reported quality reviews occur.		**Alternative Action**
We recommend that the health authorities: ▪ Ensure that infection control surveillance and audit reports are available and used by all programs to improve practice across the health authority as appropriate.	Reports of housekeeping and environmental audits are provided to the managers. Have initiated an Outbreak Management Summary Report, which is completed in conjunction with the unit manager, and identifies successes and areas for improvement. The regional IPC team will review these reports to determine options in promoting decrease in transmission of disease and length of outbreaks. Issues requiring further review will be forwarded to IPC Quality Committee and VIHA Quality Council. Informal feedback and recommendations occur as routine IPC practice. Developing process for regular quarterly reporting to program areas. Provision of tracking and trending reports is limited by available IPC resources.	- Continue providing those reports that are currently being provided. - Additional positions for the IPC Program have been identified and submitted through the VIHA budget request process. - Cerner (operating system) is currently being rolled out throughout VIHA. - Continue working with IMIT to access reports and modules through the Cerner system that will support surveillance and case management.	**Partially**
▪ Have their senior management teams identify infection control reports and information that they need to receive on a regular basis.	See response above. The information requested has been identified (i.e., trends in infection rates, outbreaks – numbers/types/length). The provision of these reports is limited by available IPC resources.		**Substantially**
▪ Ensure that the infection control program issues a comprehensive annual report that includes rates and types of infections. This report should be available to the public.	2006/07 Regional IPC Annual Report is posted on the VIHA website. Report includes rates and types of infections, based on the data collected. It incorporates an excerpt from the Public Health annual report to provide a broader perspective of influenza immunization rates and outbreaks in affiliated LTC facilities.		**Fully**