



FALL 2017

NEWS



IPAC Canada National Conference
Banff, Alberta
May 27 - 30, 2018

Preliminary Program
www.ipac-canada.org
Registration to open in December 2017

INSIDE:

Chapter News

Surveillance Definitions of Infections in Canadian Long Term Care Facilities

Board Elections



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Infection Prevention
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Prévention et contrôle
des infections Canada

FALL 2017

NEWS

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VISION

IPAC Canada – a national and international infection prevention and control leader.

MISSION

IPAC Canada is a multidisciplinary member based association committed to public wellness and safety by advocating for best practices in infection prevention and control in all settings.

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Molly Blake, BN, MHS, CIC

President, IPAC Canada

And So It Begins...

As I sit to write my first President's Message, I wonder what I've gotten myself in to. Truthfully, I've had this thought more than once in my lifetime – but that's a whole different message. In fact, I consider what this position means, and what this organization represents, in the provision of quality, safe healthcare. As healthcare systems in Canada continue to transform, we at IPAC have a unique perspective to share and can serve as champions for protecting the health of all Canadians. Championing the provision of safe care is a great responsibility, but one I think we are all more than capable of undertaking.

So I remind myself, take a deep breath; take it one day at a time; and consider the tools in my toolbox. In this IPAC role, and in my "real job," one such tool is the LEADS in a Caring Environment (LEADS) Framework. This capabilities framework provides a foundation for health leadership development in Canada. It defines the knowledge, skills, and attitudes a leader needs to exhibit in order to successfully contribute to an effective and efficient Canadian health system. LEADS is an evidence-based framework that guides individual career-long learning, builds organizational capacity for excellence in leadership, and provides a common leadership language throughout the healthcare system. And as we know, leadership and IPAC are intimately connected; leadership is not dependent on a specific job title. In fact LEADS Canada, along with IPAC Canada, is an Accreditation Canada International Program Partner. LEADS is based on the concept of distributed leadership which maintains any person can be a leader depending on the situation. The LEADS framework has five domains; each domain consists of four core measurable capabilities:

- L: Lead Self (*self-aware; manage selves; develop selves; demonstrate character*).
- E: Engage Others (*foster development of others; contribute to creation of healthy organizations; communicate effectively; build teams*).

- A: Achieve Results (*set direction; strategically align decisions with Vision, Values, and Evidence; take action to implement decisions; assess and evaluate*).
- D: Develop Coalitions (*purposefully build partnerships and networks to create results; demonstrate a commitment to customers and service; mobilize knowledge; navigate socio-political environments*).
- S: Systems Transformation (*demonstrate systems/critical thinking; encourage and support innovation; orient themselves strategically to the future; champion and orchestrate change*).

The underlying assumption of LEADS is effective personal leadership is associated with a set of definable skill sets or capabilities that can be learned by conscious, intentional effort. Leadership development starts with focusing on understanding and developing your own personal beliefs, attitudes, capabilities, and skills. Inherent to the role of an ICP is leadership, whether formal or not. We work collaboratively to engage others in embedding the IPAC agenda across all levels of our systems. Our work supports the values and vision of our organizations and drives accountability for safe care. The coalitions we develop at all levels of healthcare ensure we positively impact the broader communities we serve.

The LEADS framework aligns with so much of what we do – we see it reflected in the CIC content and throughout the IPAC Canada Program Standard. Finding ways to engage others, to lead them with a strong intentional vision, to capture their commitment and energy, and to help them grow as leaders will make our system stronger.

Further information can be found at: www.leadscanada.net/ and www.cchl-ccls.ca/document/631/CCHL_CHE-LEADS-Framework_EN.pdf ✳

"Success is to be measured not so much by the position that one has reached in life as by the obstacles which he has overcome while trying to succeed."

– Booker T. Washington, *Up From Slavery* (1901)



Molly Blake, BN, MHS, CIC

Présidente, PCI Canada

Et c'est parti!

Je m'appête à rédiger mon premier « message de la présidente » et je ne peux m'empêcher de me demander dans quoi je me suis embarquée. À vrai dire, je me suis souvent posé cette question, mais le message est bien différent cette fois. En réalité, je m'interroge sur ce que signifie cette fonction et ce que représente notre organisation au regard de la prestation de soins de santé sûrs et de qualité. Les systèmes de santé canadiens continuent d'évoluer et nous, de PCI, jouissons d'une perspective unique, qu'il nous revient de faire connaître. Nous pouvons devenir les défenseurs par excellence de la santé de tous les Canadiens. C'est une lourde responsabilité, certes, mais nous sommes, à mon avis, parfaitement en mesure de l'assumer.

Je m'exhorte donc à respirer profondément, à franchir une journée à la fois et à ne pas oublier les outils dont je dispose. À PCI comme dans mon « vrai travail », l'un de ces outils s'appelle LEADS in a Caring Environment. Il s'agit d'un cadre de compétences qui propose une base de perfectionnement en leadership en santé au Canada. Il définit les connaissances, les compétences et les attitudes dont le leader a besoin pour contribuer à l'efficacité et à la rentabilité des systèmes de santé au Canada. Fondé sur des données probantes, il est conçu pour guider l'apprentissage individuel tout au long de la carrière, aider les organisations à se doter d'une direction d'exception et fournir un langage commun. On sait du reste que le leadership et PCI sont intimement liés. Ajoutons que le leadership n'est pas l'apanage d'un poste particulier. De fait, LEADS Canada, tout comme PCI Canada, est partenaire du programme d'Agrément Canada International. LEADS repose sur le concept du leadership partagé, selon lequel toute personne peut devenir leader, selon la situation. Le cadre s'articule en cinq domaines, dont chacun consiste en quatre compétences de base mesurables :

- L: Lead self ou être son propre leader (se connaître; se prendre en charge; se perfectionner; avoir de la force de caractère)
- E: Engage others, ou mobiliser les autres (favoriser le perfectionnement des autres; contribuer à la création de saines organisations, communiquer efficacement, cimenter l'équipe)

- A: Achieve results, ou obtenir des résultats (orienter; aligner les décisions sur la vision, les valeurs et les données probantes; donner suite aux décisions; évaluer)
- D: Develop coalitions ou coaliser (former des partenariats et des réseaux pour obtenir des résultats; démontrer un engagement réel à l'égard des clients et du service; mobiliser les connaissances; connaître l'environnement sociopolitique)
- S: Systems transformation ou transformer les systèmes (adopter une pensée systémique et critique; favoriser l'innovation; choisir une orientation stratégique axée sur l'avenir; favoriser et orchestrer le changement)

LEADS repose sur l'hypothèse d'un leadership personnel efficace, couplé à un ensemble de compétences définissables ou de capacités que l'on peut apprendre au prix d'un effort conscient et déterminé. Pour devenir leader, il faut d'abord comprendre et développer ses propres convictions, attitudes, capacités et compétences. Les professionnels en prévention des infections sont forcément des leaders, officiellement ou non. En effet, nous travaillons de concert pour inciter d'autres personnes à intégrer le programme de PCI à tous les paliers de nos systèmes. Notre travail respecte les valeurs et la vision de nos organisations; il favorise la reddition de compte et, partant, la prestation de soins en toute sécurité. Enfin, les coalitions que nous formons dans toutes les sphères des soins de santé assurent une incidence positive sur les communautés plus vastes que nous servons.

Le cadre des compétences du programme LEADS est très proche de ce que nous faisons, comme en témoignent le contenu du programme de certificat en contrôle des infections et la norme de programme de PCI Canada. Nos systèmes seront d'autant plus forts que nous trouverons comment mobiliser les autres, comment les guider grâce à une vision ferme et déterminée, comment canaliser leur énergie et leur volonté de participer, et comment les aider à devenir leaders.

Si vous voulez en savoir davantage, je vous suggère ces deux sources [en anglais]: www.leadscanada.net/ et www.cchl-ccls.ca/document/631/CCHL_CHE-LEADS-Framework_EN.pdf 🌸

« Le succès ne se mesure pas tant à la position à laquelle on parvient qu'aux obstacles qu'il a fallu surmonter pour réussir. »
 – Booker T. Washington, *Up From Slavery* (1901)



Gerry Hansen, BA

Executive Director, IPAC Canada

Antimicrobial Resistance: Our Role as an Advocate for Change

In August, IPAC Canada sent a brief to the House of Commons' Standing Committee on Health in view of its study of antimicrobial resistance. In our brief, we encouraged Federal engagement with provincial and territorial partners at the ministerial and deputy ministerial level to establish a consistent national surveillance system with nationally approved case definitions in order to close gaps in the currently fragmented system of measurement for AMR. This will ensure AMR in Canada is reliably defined, that new threats and changing patterns in AMR are identified in a timely manner, and that measures taken to combat AMR are having a measurable impact. This will build on work already under way, and aligns with and supports implementation of the National Integrated Action Plan and the existing *Antimicrobial Resistance and Use in Canada: A Federal Framework for Action*.

This also allows the federal government to fulfill its mandate of accountability to all Canadians. It will support this Committee in understanding whether recommendations it makes regarding AMR are having measurable results. As a result of our brief, IPAC Canada has been invited to appear before the committee on November 2, 2017. A copy of IPAC Canada's brief can be seen at <https://ipac-canada.org/antibiotic-resistant-organism-resources.php>

In collaboration with the Canadian Patient Safety Institute, AMMI Canada, HealthCAN and other healthcare partners, additional briefs have been sent to the committee with a call to action. This includes a direct message to the upcoming G7 2018 advocating that "Canada demonstrate leadership, galvanize global attention, and marshal resources to address antimicrobial stewardship and antimicrobial resistance." 🌸

Definition of an ICP

The Board of Directors has confirmed the following definition of an Infection Prevention and Control Professional (ICP):

An Infection Control Professional (ICP) is an individual who has responsibility in their workplace for development, implementation, evaluation, and education related to policies, procedures, and practices that impact the prevention of healthcare-associated infections.

Integral competencies to the role include knowledge of infectious disease processes, microbiology, routine practices and additional precautions, surveillance, principles of epidemiology, research utilization and education. The performance of these activities and application of competencies will vary depending on the setting in which the ICP functions. Additional supporting competencies

include communication, leadership, and professionalism. An ICP who demonstrates infection prevention and control competencies should be Certified in Infection Control (CIC®), having successfully passed the initial certification exam and recertification every five years.

- Accepted alternative terms, meaning the same thing:
- Infection Prevention and Control Practitioner
- Infection Prevention and Control Professional
- Infection Control Practitioner
- Infection Control Specialist
- Infection Control Consultant
- Infection Preventionist

Refer to IPAC Canada Core Competencies for Infection Control Professionals: https://ipac-canada.org/photos/custom/pdf/2016_IPAC_Canada_CoreCompetenciesforICPs.pdf 🌸

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Agence de la santé
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2018 Diversey Scholarship

Through the generous support of Diversey Inc., 19 IPAC Canada members were supported to attend the 2017 annual conference in Charlottetown. The recipients included members with novice, intermediate, and advanced expertise. IPAC Canada thanks Diversey Inc. for the opportunity for selected candidates to have the support needed to attend the conference. See the criteria and application at <https://ipac-canada.org/sealed-air-diversey-scholarship.php>.

Deadline date for 2018 scholarship applications:

January 31, 2018. *



2018 Sage Products LLC (now part of Stryker) Scholarship

The purpose of the Sage Products LLC Scholarship is to provide financial assistance to eligible infection prevention and control professionals from under-resourced nations to attend an IPAC Canada National Education Conference.

The award will include registration for the entire conference, including both pre and post conference education sessions, economy air travel, and a maximum of five (5) nights' accommodation, and meals. In addition, the applicant will receive one complimentary ticket to the conference special event(s).

See the criteria and application at <https://ipac-canada.org/sage-international-attendee-scholarship-2.php>. Deadline date for 2018 scholarship applications: **November 30, 2017.** *



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– S. Anderson, Educator

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For information see the Learning Object Repository page at <https://ipac-canada.org/learning-object-repository-2.php>

IPAC Canada Chapter News



IPAC BC

IPAC BC is maintaining membership with 195 members in 2017. Our 2016 education day, “More Than Just Infections,” was a large success with 90 attendees, six speakers and 22 vendors. We are ramping up to our 2017 education day where we will be celebrating our 30th anniversary as a chapter.

The CIC® working group continues to work diligently preparing our members for the CIC® exam. Last year we ran our first fall study series that brought members from across the province together by teleconference and went through all eight CIC® exam modules in a four-month span. We had excellent feedback from our members and have scheduled the same program for fall 2017.

IPAC BC was thrilled to sponsor five chapter members to attend this year’s IPAC Canada conference in PEI. At the conference we launched our Twitter account, sharing our experiences and connecting with the IPAC community globally. Proudly representing BC, our members took home the Top Oral Presentation, Top Poster Presentation and Best First Time Abstract awards. With great solidarity, BC members also teamed up for the largest participation with the IPAC Canada conference app, taking home the grand prize!



Members of IPAC BC enjoying the beautiful venue at the 2017 conference.



IPAC Manitoba

IPAC-MB hosted another successful annual education conference in June 2017. Over 100 attendees, vendors, and speakers came together to learn, network, and share – with the common goal of advancing IPAC practices and reducing healthcare-associated infections. Topics and speakers included:

- **Dr. Elizabeth Bryce, Regional Medical Director for Vancouver Coastal Health Infection Prevention and Control** History of Infection Prevention and Control and What Does the Future Hold? Innovative Strategies to Address Environmental Disinfection

- **Poh-Lin Lim , RN, BN, MEd, GNC (C), IIWCC, Clinical Nurse Specialist Victoria General Hospital** Wound Management and Infection Prevention and Control
- **Monique Liarakos, BA, RN, BN, Manager of Infection Prevention and Control for WRHA Long Term Care Program**HAI Surveillance in Long Term Care
- **Jennifer Dunsford, RN, MN, Regional Director for WRHA Ethics Services** What Goes Around Comes Around: Ethics in Infection Prevention and Control



The 2017 Education Day Committee with IPAC Canada President Molly Blake (back, third from right) and Executive Director Gerry Hensen (front right).



IPAC Ottawa Region

IPAC Ottawa Region (IPAC OR) uses a blended approach, Adobe platform and in-person, for our Chapter meetings which supports our philosophy of “paying it forward”. At our meeting in June we had membership from two neighbouring IPAC chapters who called in and listened to the education portion of our meeting. The IPAC OR executive has committed to extending the invitation for our chapter meeting education sessions to chapters across Ontario, assuming the topic would be of provincial interest.

IPAC OR has a very successful education evening in 2016, which brought in 100 stakeholders from community settings to learn about IPAC and reprocessing. Building upon the philosophy of reaching out to new stakeholders or pushing the envelope on IPAC topics, we are having another education evening, 2017 on *C. difficile*.

During the fall of 2016, IPAC OR ran a successful CIC® study group. We had overwhelming participating from our membership and this year, we now have four new CIC®s. As a result, we are hosting another CIC® study group, which will have eight sessions covering topics that the study group feels they need support on, while ensuring we touch base on all sections of the CBIC outline.



IPAC-Newfoundland Labrador 2017

Monthly IPAC-NL meetings have resumed after a summer break and are well attended using the IPAC Canada platform. All meetings include an educational presentation. IPAC-NL will hold its 5th Provincial Education Day on Oct 18 via webinar, once again including the IPAC experience from a family's perspective. Partnering with clients and their families is important in advancing the practice of IPAC.



IPAC-NL had 10 members attend this year's IPAC Canada conference and were able to provide limited financial assistance to several members. Two members were conference presenters, one on the planning committee and four were Diversey Scholarship recipients. In September one of our members attended the national CHES conference, which this year is heavily focused on IPAC issues.

CIC® certification is strongly encouraged and again this year we have newly certified members. To show our support we have decided to continue the practice of awarding CIC® pins to those who are successful in writing the CIC® exam.

Financial challenges remain, but for the first time in two years the Provincial Infection Control Network – NL (consisting of IPAC-NL members) was successful in obtaining approval for a face-to-face meeting. This committee is responsible for developing guidance documents for our members.



IPAC SASKPIC

Our Spring Chapter meeting and Education webinar was held on April 4th. **Highlights from the 2016 CAMDR Conference** was presented by Vi Burton to IPAC Members and our MDR colleagues.

Preparing for Change was the theme of our 2017 Education Day on September 17th. Back by popular demand was Jim Gauthier with two sessions: *Becoming Better Educators* and *How to Safely Bend IP Rules*. TB Prevention and Control Saskatchewan presented on **Think TB: A Tool for Healthcare Providers** and **Extrapulmonary TB**. A transition update on the new Saskatchewan Health Authority was provided and highlights from the National IPAC Conference were presented by the three SASKPIC members who received funding to attend.



IPAC SASKPIC Executive

A CIC® Rose ceremony was held to acknowledge the six SASKPIC members who achieved their CIC® or recertification during the past year.

Vi Burton was presented with a **Member Recognition Award**. She has been active in SASKPIC for 13 years, serving as chapter Treasurer for two terms and President in 2012 when the National Conference was held in Saskatoon. She is a member of several IPAC Canada interest groups and has participated in numerous provincial IPAC groups and subcommittees. Her practical wisdom and pursuit of excellence make her a great teacher and mentor. ❁



Rose Ceremony for CIC New and Recertified Certificants



Gwen Cerkowniak (right) presents Vi Burton with the SASKPIC Member Recognition Award



Vi Burton accepting SASKPIC Member Recognition Award

News From CBIC

As the year winds down, you have much to celebrate about certification. At the time of writing this article, we are on track to end 2017 with an estimated 7,000 CIC®-certified infection prevention professionals across the world! This is the highest number of certified IPs in the history of the Certification Board of Infection Control and Epidemiology, Inc. (CBIC). I've had the opportunity to speak to many IPs while traveling this year and I continue to be inspired by the level of passion and commitment towards pursuing the highest level of professional skills and competence. No matter the patient population; outpatient endoscopy, behavioral health, long term care or inpatient facility, you always talked about your pride in becoming CIC® certified. You enthusiastically discussed what certification means to you personally and professionally and how it helps to ensure that all healthcare patients receive care in a way that minimized their risk of healthcare associated infections. Some of you had full support, and sometimes incentive, from your employer to become certified, while others took motivation from internal sources or from peers. You've proven that regardless of the practice setting, certification is valuable to you and your patients.

However, less than half of eligible IPs are currently certified. Surveys, focus studies and group discussions have uncovered several barriers. Lack of financial support and unrecognized value of certification by healthcare administrators are often cited as reasons that keep IPs from becoming certified. One of the CBIC projects that I'm most excited about this year is the research project that is being undertaken to help tear down these barriers. This project will take place over the next several months and will help us to quantify the value of certification to you, your facility and your patient. This information will help

build a business case for certification in terms that can be used to garner support for more IPs to become certified.

One of the frequently unspoken barriers to obtaining certification has nothing to do with financial commitment or lack of employer support, but is so powerful that it stops many IPs from ever pursuing certification. What is this powerful force that prevents skilled and experienced IPs from demonstrating their competence? Fear of failure. Too many times, this commanding fear is at the heart of IPs not trying to become certified. Did you know that about 70% of initial certificants are successful on their first certification exam? And that many of those who aren't initially successful learn from that experience, revise preparation plans, and are successful on a later attempt. If fear of failing is proving to be a barrier to obtaining your CIC®, create a written plan that includes step-by-step actions and a realistic timeline. Hand that plan to a colleague or friend who will help you keep on track, then watch that fear start to slowly drip away. Eloise Ristad voices this phenomenon well: "When we give ourselves permission to fail, we, at the same time, give ourselves permission to excel."

It has been my honor and pleasure to serve as the President of CBIC in 2017. I would like to extend my greatest appreciation to outgoing Board members Chris Zirges, Connie Cutler and Ruth Carrico. I applaud your generous and transformative leadership and will always value the lessons you've imparted. I am pleased that this tradition of inspired leadership will

continue when Joann Andrews takes over as CBIC President in 2018. ✨



Lita Jo Henman, MPH, CIC
President

EIGHTEENTH CONGRESS OF THE INTERNATIONAL FEDERATION OF INFECTION CONTROL (IFIC)

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A CONFERENCE WITH A DIFFERENCE!

IFIC is pleased to announce the 2018 IFIC CONFERENCE, to take place in KRAKOW, Poland, from April 25 to April 27.

Our new, exciting format will provide even more opportunities for networking in the setting of state-of-the-art participative workshops, and highly interactive key-pad sessions, as well as our traditional key note lectures, debates and symposia.

The workshops, to be conducted in English, are aimed to ensure a high level of interaction, and the presence of Polish participants will enhance the experience for local attendees.

Interactive keypad sessions with some translation into Polish and full translation of all plenary sessions will make this an attractive mix for all.

All workshops (two half day ones and one full day) are limited in space, and will be allocated on a first-come first serve basis. Do not miss the opportunity to participate in what promises to be an innovative and highly educational Congress, covering most key aspects of Infection Prevention and Control.

Further information:
www.ific2018.com

Surveillance Definitions of Infections in Canadian Long Term Care Facilities

Jennifer Happe, MSc¹; Faith Stoll, BScN, RN, CIC¹; Laurel Biluk, BN, RN, CIC¹; Karen Cargill, BN, RN, GNC(C)²; Alisa Cuff, BN, RN, CIC²; Gwen Cerkowniak, BSN, RN, CIC³; Blanda Chow, MPH, RN¹; Jean Clark, BN, RN, CIC²; Betty Anne Elford, BN, RN²; Darlene Fawcett, BN, RN²; Yvette Gable, BN, RN²; Sukhpreet Jagpal, BEH, CPHI(C)¹; Lesley McLeod, MSc, CIC¹; Caroline Meguerditchian, CIC¹; Daphne Murray, BN, RN, CIC²; Smit Patel, MSc¹; Nathalie Pigeon, BSc⁴; Blair Ranns, MPH²; Monica Sephton, BN, RN²; Paula Stagg, MN, RN, CIC¹; Marilyn Weinmaster, BScN RN CIC²

¹ Infection Prevention and Control Canada (IPAC Canada), Surveillance and Applied Epidemiology Interest Group;

² IPAC Canada, Long Term Care Interest Group;

³ IPAC Canada, Network of Networks Interest Group;

⁴ L'Association des infirmières en prévention des infections

In partnership with:

Accreditation Canada; Association of Medical Microbiology and Infectious Disease Canada; Canadian Patient Safety Institute; Centre for Communicable Disease and Infection Control, Public Health Agency of Canada; IPAC Canada

BACKGROUND

The Canadian Patient Safety Institute (CPSI) and the Public Health Agency of Canada (PHAC) hosted a national infection prevention and control summit in November 2014. Participants came together with the goal of advancing infection prevention and control practices and reducing healthcare-associated infections (HAI) in Canada. During this meeting, measurement and surveillance, specifically improving consistency in surveillance practices across the country, surfaced as a key theme and an action plan was created. Under the leadership of Infection Prevention and Control Canada (IPAC Canada) and the Association of Medical Microbiology and Infectious Diseases Canada (AMMI Canada), a national committee was created to help establish and implement standard infection case surveillance definitions for HAI in acute care and long term care (LTC) facilities. Members of IPAC Canada's Surveillance and Applied Epidemiology, LTC, and Network of Networks Interest Groups and the L'Association des infirmières en prévention des infections formed a working group to revise the existing Society for Healthcare Epidemiology of America LTC facility infection surveillance definitions. Case definitions were updated based on the Canadian healthcare system and an increase in evidence-based literature about infections that occur in residents of LTC facilities.^{1,2}

METHOD SUMMARY

The Centers for Disease Prevention and Control (CDC) Healthcare Infection Control Practices Advisory Committee (HICPAC) guideline development methodology was used to revise the definitions.³ This included a structured review of evidence found in peer reviewed primary research reports and systematic and meta analyses. Changes to LTC infection case definitions were determined by consensus between working group members and reviewed by content experts including infectious disease physicians, epidemiologists, infection control professionals and public health officials. An annex describing the methodology used to produce these definitions, together with the literature search strategy, critical appraisal and stakeholder review and approval process, is available upon request.

GUIDING PRINCIPLES

Clinically relevant infections that occur in LTC facility residents are defined here for surveillance purposes. Infection presentation in the elderly may be atypical and failure to meet these surveillance definitions does not necessarily exclude the presence of infection. Further, as with the original definitions, key conditions must be met when applying the definitions: signs and symptoms must be new or acutely worse than the resident's baseline; non-infectious causes should be considered first; and identification of an infection should be based on both clinical presentation and diagnostic testing.^{1,2}

Limited resources are available for infection prevention and control in many LTC facilities. As a result, it is recommended that surveillance focus on infections with the most potential for prevention, transmissibility, incidence, morbidity and/or mortality based on the local context. Attribution of an infection to a LTC facility for surveillance purposes should occur if there is no evidence the infection was incubating on admission to the facility and if infection onset occurs >2 calendar days after admission or >3 days after admission for *Clostridium difficile* infections (CDI).^{1,4} This is in keeping with the Canadian Nosocomial Infection Surveillance Program (CNISP) case classification rules for CDI in acute care.⁴ Finally, these definitions have not been tested in Canadian LTC facilities in advance of their publication.

DEFINITIONS

Constitutional Criteria for Infection

The constitutional criteria in Table 1 serves to establish parameters for common signs and symptoms of infection present in the clinical syndromes defined in this document. The only change to constitutional criteria from the original definitions is to leukocytosis. Normal levels of total leukocytes (including neutrophils, eosinophils, basophils, lymphocytes, and monocytes) in adults range between 4 to 10 x 10⁹ cells/L.^{5,6,7,8} Thus, a cell count above the normal range is considered leukocytosis. Further, the left

TABLE 1: Definitions for Constitutional Criteria

A. Fever
1. Single oral temperature >37.8°C OR
2. Repeated oral temperatures >37.2°C or rectal temperatures >37.5°C OR
3. Single temperature >1.1°C increase over baseline from any site (oral, tympanic, auxiliary)
B. Leukocytosis > 10 x 10⁹ leukocytes/L
C. Acute change in mental status from baseline (all criteria must be present; see Table 2)
1. Acute onset
2. Fluctuating course
3. Inattention
4. Either disorganized thinking or altered level of consciousness
D. Acute functional decline
A new 3-point increase in total activities of daily living (ADL) score (range, 0–28) from baseline, based on the following 7 ADL items, each scored from 0 (independent) to 4 (total dependence)
1. Bed mobility
2. Transfer
3. Locomotion within LTC facility
4. Dressing
5. Toilet use
6. Personal hygiene
7. Eating

shift (bandemia) criterion was removed from the leukocytosis definition. Bandemia is a marker for a variety of inflammatory processes, tissue damage or necrosis, seizures, toxic ingestions, and metabolic abnormalities. It is not a specific marker for infection.^{9,10,11,12} Measurement methods are also subject to inaccuracy due to sampling bias and variance in normal band reference ranges between laboratories.^{13,14,15}

Confusion Assessment

Altered mental status can be a nonspecific sign of acute infection in LTC residents.^{2,16,17} Table 2 outlines criteria from

the Confusion Assessment Method (CAM) to detect delirium.^{18,19} Meta analyses show this criteria has helped to improve identification of delirium in clinical and research settings.^{20,21} CAM should be conducted during a formal interview with the resident and by trained personnel.²¹ CAM has higher specificity than sensitivity and does not replace clinical judgment.

Respiratory Tract Infections (RTI)

Research shows that a resident can have a laboratory confirmed RTI (e.g. positive nasopharyngeal [N/P] swab) but few signs and symptoms of an infection due to the lack of immune response in the elderly.^{22,23,24} Influenza like illness (ILI) clinical definitions, for instance, have performed poorly in studies for this reason.^{25,26,27} Therefore, an N/P swab positive for a respiratory pathogen was added to the common cold syndrome and ILI definition sets in Table 3. ILI criteria were further updated to align with the PHAC case definition.^{28,29}

In practice, laboratory specimens may not be collected during RTI outbreaks once a causative organism is identified. Residents experiencing symptoms in line with the identified disease agent and have an epidemiological link to a known positive case are considered clinically positive cases but do not technically qualify as surveillance cases. Consequently, it is recommended that inclusion of an epidemiological link in lieu of a laboratory confirmed positive specimen be used to meet case definition criteria during an outbreak. A case is considered epidemiologically linked by direct contact to a laboratory-confirmed case through person-to-person transmission (e.g., common caregiver), if there is geographic proximity in the facility or through a common exposure.

Urinary Tract Infection (UTI)

Minor changes were made to the UTI definitions. Acute dysuria can be a symptom of a UTI in the absence of an indwelling catheter. Recent literature shows acute dysuria alone is insufficient and at least one other sign or symptom must be present, in addition to microbiological confirmation, for a UTI to be classified as such.^{30,31,32} Subsequently, acute dysuria was removed from criteria 1a in the original definition and included in criteria 1b and

TABLE 2. Confusion Assessment Method Criteria

Criteria	Comments
Acute onset	Evidence of acute change in resident’s mental status from baseline
Fluctuating	Behavior fluctuating (e.g., coming and going or changing in severity during the assessment)
Inattention	Resident has difficulty focusing attention (e.g., unable to keep track of discussion or easily distracted)
Disorganized thinking	Resident’s thinking is incoherent (e.g., rambling conversation, unclear flow of ideas, unpredictable switches in subject)
Altered level of consciousness	Resident’s level of consciousness is described as different from baseline (e.g., hyper alert, sleepy, drowsy, difficult to arouse, nonresponsive)

TABLE 3. Surveillance Definitions for Respiratory Tract Infections (RTI)

NOTE. Epidemiological confirmation, instead of a laboratory confirmed positive specimen, can be used to meet case definition criteria during an outbreak.

Criteria	Comments
<p>A. Common cold syndrome or pharyngitis (at least 2 criteria must be present)</p> <ol style="list-style-type: none"> 1. Runny nose or sneezing 2. Stuffy nose (i.e., congestion) 3. Sore throat or hoarseness or difficulty in swallowing 4. Dry cough 5. Swollen or tender glands in the neck (cervical lymphadenopathy) 6. N/P swab positive for a respiratory pathogen 	Fever may or may not be present. Symptoms must be new and not attributable to allergies.
<p>B. Influenza-like illness (criteria 1 and/or 2 must be present, AND 3 or 4)</p> <ol style="list-style-type: none"> 1. Fever 2. New and or increased cough 3. At least 2 of the following influenza-like illness subcriteria <ol style="list-style-type: none"> a. Chills b. New headache or eye pain c. Myalgias or body aches d. Malaise or loss of appetite e. Sore throat f. Arthralgia (joint pain) 4. N/P swab positive for Influenza virus 	Fever may not be present in the elderly. If criteria for influenza-like illness and another upper or lower RTI are met at the same time, only the diagnosis of influenza-like illness should be recorded. Because of increasing uncertainty surrounding the timing of the start of influenza season, the peak of influenza activity, and the length of the season, “seasonality” is no longer a criterion to define influenza-like illness.
<p>C. Pneumonia (criteria 1 and 2 must be present, OR criteria 1 and 3)</p> <ol style="list-style-type: none"> 1. Interpretation of a chest radiograph as demonstrating pneumonia or the presence of a new infiltrate 2. At least 1 of the following respiratory subcriteria <ol style="list-style-type: none"> a. New or increased cough b. New or increased sputum production c. O₂ saturation <94% on room air or a reduction in O₂ saturation of >3% from baseline d. New or changed lung examination abnormalities e. Pleuritic chest pain f. Respiratory rate of ≥25 breaths/min 3. At least 1 constitutional criteria (see Table 1) 	For both pneumonia and lower RTI, the presence of underlying conditions that could mimic the presentation of a RTI (e.g., congestive heart failure or interstitial lung diseases) should be excluded by a review of clinical records and an assessment of presenting symptoms and signs.
<p>D. Lower respiratory tract infection (bronchitis or tracheobronchitis; all 3 criteria must be present)</p> <ol style="list-style-type: none"> 1. Chest radiograph not performed or negative results for pneumonia or new infiltrate 2. At least 2 of the respiratory subcriteria (a–f) listed in section C above 3. At least 1 of the constitutional criteria (see Table 1) 	(See comment for section C above.)

1c of Table 4 for residents without an indwelling catheter. In catheterized residents, purulent discharge from around the catheter insertion site can be a symptom of a UTI in males and females. This criterion was grouped with acute pain, swelling, or tenderness of the testes, epididymis, or prostate criteria in males in the original definitions but is separated here for clarity. Finally, the original definitions allow for a UTI in the absence of localizing symptoms if a blood culture isolate is the same as the organism isolated from the urine and there is no alternate site of infection but this information was not included in the tabular definitions. This was added to Table 4.

Surveillance definitions of UTI in older adults are highly specific and rely on localized genitourinary symptoms.

Infections in the elderly often have atypical clinical presentation and residents of LTC can also be cognitively impaired or have comorbidities like dementia and stroke that impede communication of symptoms.^{17,33,34} Studies show that there is a gap between qualifying surveillance cases and the number of clinically diagnosed and treated cases for residents without an indwelling catheter. A change in mental status is often one of the reasons a UTI is suspected and treated in LTC settings.^{35,36,37,38} Some researchers have called for the inclusion of altered mental status to the definition set to close the gap between surveillance and clinical cases for residents without an indwelling catheter.^{35,39} A change in mental status has been statistically associated

TABLE 4. Surveillance Definitions for Urinary Tract Infections (UTI)

NOTE. A urinalysis negative for leukocytes effectively rules out a UTI while a urinalysis positive for leukocytes does not differentiate symptomatic UTI from asymptomatic bacteriuria.

Criteria	Comments
<p>A. For residents without an indwelling catheter (criteria 1 and 2 must be present with no other identified source of infection, OR criteria 2 and 3)</p> <p>1. At least 1 of the following sign or symptom subcriteria</p> <ul style="list-style-type: none"> a. Acute pain, swelling, or tenderness of the testes, epididymis, or prostate in males b. Fever or leukocytosis (see Table 1) and at least 1 of the following localizing urinary tract subcriteria <ul style="list-style-type: none"> i. Acute dysuria ii. Acute costovertebral angle pain or tenderness iii. Suprapubic pain iv. Gross hematuria v. New or marked increase in incontinence vi. New or marked increase in urgency vii. New or marked increase in frequency c. In the absence of fever or leukocytosis, then 2 or more of the following localizing urinary tract subcriteria <ul style="list-style-type: none"> i. Acute dysuria ii. Suprapubic pain iii. Gross hematuria iv. New or marked increase in incontinence v. New or marked increase in urgency vi. New or marked increase in frequency 	<p>UTI should be diagnosed when there are localizing genitourinary signs and symptoms and a positive urine culture result. A diagnosis of UTI can be made without localizing symptoms if a blood culture isolate is the same as the organism isolated from the urine and there is no alternate site of infection. In the absence of a clear alternate source of infection, fever or rigors with a positive urine culture result in the noncatheterized resident or acute confusion in the catheterized resident will often be treated as UTI. However, evidence suggests that most of these episodes are likely not due to infection of a urinary source.</p>
<p>2. $\geq 10^8$cfu/L of no more than 2 species of microorganisms from a midstream urine OR $\geq 10^5$ cfu/L of any number of organisms in a specimen collected by in-and-out catheter</p>	<p>Urine specimens for culture should be processed as soon as possible, preferably within 2 hours. If urine specimens cannot be processed within 30 minutes of collection, they should be refrigerated. Refrigerated specimens should be cultured within 24 hours. In and out catheter collection is the gold standard for urine collection in residents without an indwelling catheter.</p>
<p>3. A blood culture isolate is the same as the organism isolated from the urine and there is no alternate site of infection</p>	
<p>B. For residents with an indwelling in a single catheter urine specimen or in a midstream voided urine specimen from a resident whose catheter has been removed within the previous 48 hours (criteria 1 and 2 must be present with no other identified source of infection, OR criteria 2 and 3)</p> <p>1. At least 1 of the following sign or symptom subcriteria</p> <ul style="list-style-type: none"> a. Fever, rigors, or new-onset hypotension, with no alternate site of infection b. Either acute change in mental status (see Table 2) or acute functional decline (see Table 1), with no alternate diagnosis and leukocytosis c. New-onset suprapubic pain or costovertebral angle pain or tenderness d. Purulent discharge from around the catheter e. Acute pain, swelling, or tenderness of the testes, epididymis, or prostate in males 	<p>Recent catheter trauma, catheter obstruction, or new onset hematuria are useful localizing signs that are consistent with UTI but are not necessary for diagnosis.</p>
<p>2. Urinary catheter specimen culture with $\geq 10^8$cfu/L of any organism(s)</p>	<p>Urinary catheter specimens for culture should be collected following replacement of the catheter if the current catheter has been in place for >14 days.</p>
<p>3. A blood culture isolate is the same species as the organism isolated from the urine, with the same resistance pattern, and there is no alternate site of infection</p>	

TABLE 5. Surveillance Definitions for Skin, Soft Tissue, and Mucosal Infections

NOTE: For wound infections related to surgical procedures, LTC facilities should use the CDC’s National Healthcare Safety Network Surgical Site Infection criteria and report these infections back to the institution where the original surgery was performed.

Criteria	Comments
<p>A. Cellulitis, soft tissue, or wound infection (at least 1 of the following criteria must be present)</p> <ol style="list-style-type: none"> 1. Pus present at a wound, skin, or soft tissue site 2. New or increasing presence of at least 4 of the following sign or symptom subcriteria <ol style="list-style-type: none"> a. Heat at the affected site b. Redness at the affected site c. Swelling at the affected site d. Tenderness or pain at the affected site e. Serous drainage at the affected site f. One constitutional criterion (see Table 1) 3. Non-commensal organism isolated with 1 or more signs or symptoms from criterion 2 	<p>Presence of organisms cultured from the surface (e.g., superficial swab sample) of a wound is not sufficient evidence that the wound is infected. More than 1 resident with streptococcal skin infection from the same serogroup (e.g., A, B, C, G) in a LTC facility may indicate an outbreak.</p> <p>Common commensal organisms include diphtheroids (<i>Corynebacterium spp.</i> not <i>C. diphtheria</i>), <i>Bacillus spp.</i> [not <i>B. anthracis</i>], <i>Propionibacterium spp.</i>, coagulase-negative staphylococci (including <i>S. epidermidis</i>), viridans group streptococci, <i>Aerococcus spp.</i>, and <i>Micrococcus spp.</i></p>
<p>B. Scabies (both criteria 1 and 2 must be present)</p> <ol style="list-style-type: none"> 1. A maculopapular and/or itching rash characteristic of scabies 2. At least 1 of the following scabies subcriteria <ol style="list-style-type: none"> a. Physician diagnosis b. Laboratory confirmation (scraping or biopsy) c. Epidemiologic linkage to a case of scabies with laboratory confirmation 	<p>Consider the appearance and distribution of the rash. The most common symptom of scabies is itching (pruritus) especially at night and pimple (papular) like rash. The itching and rash may affect much of the body or be limited to common sites such as wrists, elbow, armpit, webbing between the fingers, nipple, penis, waist, beltline and buttocks. Tiny burrows that are raised and crooked, grayish white or skin coloured lines on the skin surface. They are found most often in the webbing between the fingers, in the skin folds of the wrist, elbow or knee and on the penis, breast or shoulder blades. If rash presentation is atypical, lab confirmation is recommended.</p> <p>A case is considered epidemiologically linked by direct contact to a laboratory-confirmed case through person-to-person transmission (e.g., common caregiver), if there is geographic proximity in the facility or through a common exposure. Care must be taken to rule out rashes due to skin irritation, allergic reactions, eczema, and other noninfectious skin conditions.</p>
<p>C. Fungal oral or perioral and skin infections</p> <ol style="list-style-type: none"> 1. Oral candidiasis (criteria a and b must be present) <ol style="list-style-type: none"> a. Presence of raised white patches on inflamed mucosa or plaques on oral mucosa b. Diagnosis by a medical or dental provider 2. Fungal skin infection (criteria a and b must be present) <ol style="list-style-type: none"> a. Characteristic rash or lesions b. Either a diagnosis by a medical provider or a laboratory confirmed fungal pathogen from a scraping or a medical biopsy. 	<p>Mucocutaneous <i>Candida</i> infections are usually due to underlying clinical conditions such as poorly controlled diabetes or severe immunosuppression. Although they are not transmissible infections in the healthcare setting, they can be a marker for increased antibiotic exposure.</p> <p>Dermatophytes have been known to cause occasional infections and rare outbreaks in the LTC setting.</p>
<p>D. Herpesvirus skin infections</p> <ol style="list-style-type: none"> 1. Herpes simplex infection (criteria a and b must be present) <ol style="list-style-type: none"> a. A vesicular rash b. Either physician diagnosis or laboratory confirmation 2. Herpes zoster infection (criteria a and b must be present) <ol style="list-style-type: none"> a. A vesicular rash b. Either physician diagnosis or laboratory confirmation 	<p>Reactivation of herpes simplex (“cold sores”) or herpes zoster (“shingles”) is not considered a healthcare-associated infection. Primary herpesvirus skin infections are very uncommon in a LTC facility except in pediatric populations, where it should be considered healthcare associated.</p>
<p>E. Conjunctivitis (at least 1 of the following criteria must be present)</p> <ol style="list-style-type: none"> 1. Pus appearing from 1 or both eyes, present for at least 24 hours 2. New or increased conjunctival erythema, with or without itching 3. New or increased conjunctival pain, present for at least 24 hours 	<p>Conjunctivitis symptoms (“pink eye”) should not be due to allergic reaction or trauma.</p>

TABLE 6. Surveillance Definitions for Gastrointestinal (GI) Tract Infections

NOTE. Epidemiological confirmation, instead of a laboratory confirmed positive specimen, can be used to meet case definition criteria during an outbreak.

Criteria	Comments
<p>A. Gastroenteritis (at least 1 of the following criteria must be present)</p> <ol style="list-style-type: none"> 1. Diarrhea: 3 or more loose or watery stools above what is normal for the resident within a 24 hour period 2. Vomiting: 2 or more episodes in a 24 hour period 3. Both of the following sign or symptom subcriteria <ol style="list-style-type: none"> a. A stool specimen testing positive for a pathogen (e.g. <i>Salmonella</i>, <i>Shigella</i>, <i>Escherichia coli</i> O157:H7, <i>Campylobacter</i> species, rotavirus) b. At least 1 of the following GI subcriteria <ol style="list-style-type: none"> i. Nausea ii. Vomiting iii. Abdominal pain or tenderness iv. Diarrhea v. Mucous in stool 	<p>Care must be taken to exclude noninfectious causes of symptoms. For instance, new medications may cause diarrhea, nausea, or vomiting; initiation of new enteral feeding may be associated with diarrhea; and nausea or vomiting may be associated with gallbladder disease. Presence of new GI symptoms in a single resident may prompt enhanced surveillance for additional cases. In the presence of an outbreak, stool specimens should be sent to confirm the presence of norovirus or other pathogens (e.g. rotavirus or <i>E. coli</i> O157:H7).</p>
<p>B. Norovirus gastroenteritis (both criteria 1 and 2 must be present)</p> <ol style="list-style-type: none"> 1. At least 1 of the following GI subcriteria <ol style="list-style-type: none"> a. Diarrhea: 3 or more loose or watery stools (i.e. Conforming to the shape of the specimen collection container) above what is normal for the resident within a 24 hour period b. Vomiting: 2 or more episodes in a 24 hour period 2. A stool specimen for which norovirus is positively detected by electron microscopy, enzyme immunoassay, or molecular diagnostic testing such as polymerase chain reaction (PCR) 	
<p>C. <i>Clostridium difficile</i> infection (both criteria 1 and 2 must be present)</p> <ol style="list-style-type: none"> 1. One of the following GI subcriteria <ol style="list-style-type: none"> a. Diarrhea: 3 or more loose or watery stools (i.e., conforming to the shape of the specimen collection container) above what is normal for the resident within a 24 hour period b. Presence of toxic megacolon (abnormal dilatation of the large bowel, documented radiologically) 2. One of the following diagnostic subcriteria <ol style="list-style-type: none"> a. A stool sample yields a positive laboratory test result for <i>C. difficile</i> toxin A or B, or a toxin-producing <i>C. difficile</i> organism is identified from a stool sample culture or by a molecular diagnostic test such as PCR b. Pseudomembranous colitis identified during endoscopic examination or surgery or in histopathologic examination of a biopsy specimen 	<p>A “primary episode” of <i>C. difficile</i> infection is defined as one that has occurred without any previous history of <i>C. difficile</i> infection or that has occurred 8 weeks after the onset of a previous episode of <i>C. difficile</i> infection. A “recurrent episode” of <i>C. difficile</i> infection is defined as an episode of <i>C. difficile</i> infection that occurs 8 weeks or sooner after the onset of a previous episode, provided that the symptoms from the previous episode resolved. Individuals previously infected with <i>C. difficile</i> may remain colonized even after symptoms resolve. During a GI infection outbreak, individuals could have positive test results for the presence of <i>C. difficile</i> toxin because of ongoing colonization and also be co-infected with another pathogen. It is important that other surveillance criteria be used to differentiate infections in this situation.</p>

with bacteriuria plus pyuria without distinguishing between true UTI and asymptomatic bacteriuria.^{40,41} These symptoms may manifest in asymptomatic bacteriuria cases because of confounding factors like dehydration.^{1,40,42} This suggests altered mental status is not specific for UTI and is excluded from this definition set to ensure reported UTI surveillance cases are accurate.

Skin, Soft Tissue, and Mucosal Infections

A single addition was made to the cellulitis, soft tissue or wound infection definition based on expert opinion. Specifically, a cellulitis, soft tissue or wound infection can be

identified by isolating a non-commensal organism with the presence of one or more signs or symptoms of infection. No data were found to support revisions in the remainder of the skin, soft tissue and mucosal infection definitions.

Gastrointestinal (GI) Tract Infections

The definitions for GI tract infections are generally unchanged from those proposed in the original surveillance definitions. The current gastroenteritis definition includes mucous in stool in the signs and symptoms subcriteria. Both viral and bacterial enteric pathogens can trigger excess mucous production including norovirus, rotavirus,

Helicobacter pylori, *Escherichia coli* and *Salmonella*.^{43,44,45,46,47}

The definition of diarrhea now states loose stools instead of liquid stools to align diarrhea criteria with the Bristol Stool Chart.⁴⁸ Finally, as with RTI, laboratory specimens may not be collected during GI outbreaks once a causative organism is identified. Residents experiencing symptoms in line with the identified disease agent are considered clinically positive cases but do not technically qualify as surveillance cases. Consequently, it is recommended that inclusion of an epidemiological link in lieu of a laboratory confirmed positive specimen be used to meet case definition criteria during an outbreak.

Blood Stream Infections (BSI)

Special criteria to define BSI and unexplained febrile episode criteria in the elderly continues to be scarce, despite exhaustive review of the literature. BSI criteria by the CDC's National Healthcare Safety Network were reviewed and consensus is to use these definitions for LTC facility surveillance.

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**RECOMMENDATION LIST
COMING SOON!**

NURSING: INFECTION PREVENTION AND CONTROL

7 Things Nurses and Patients
Should Question



Board of Directors Elections



MOLLY BLAKE, BN, MHS, CIC has commenced her role as President of IPAC Canada (2017-2019). Molly has been an Infection Control Professional for over 17 years, and is currently the Program Director, Infection Prevention and Control, Winnipeg Regional Health Authority. She has served on many working and interest groups at the local, provincial, national, and international level. She has been an IPAC member (local chapter – Manitoba) for as long as she has been an ICP, and has been involved for several years in IPAC Canada activities through the Conference Planning Committee and Interest Groups (e.g., Dialysis Interest Group). Molly undertook her undergraduate nursing training and received her Bachelor of Nursing at the University of Manitoba. She completed a Masters of Health Studies from Athabasca University. She received initial certification through the Certification Board of Infection Control and Epidemiology, Inc. in 2008 (and recertified in 2013).



BARBARA CATT, RN, BScN, CIC, MEd has worked in the field of IPAC for many years. Her nursing work experiences include emergency room, operating room, ICU, medical-surgical, long-term care, and professor of nursing at college and university levels. She has also worked in a variety of health care settings such as public health, small community hospital and large tertiary health care centre. Barbara holds a Master in Education where her research was focused on principles of adult learners. She has been involved in research and publications regarding disease transmission and education such as core competencies. She currently works at Public Health Ontario as IPAC Manager Response and System Support. Barbara is a past member of IPAC Canada Standards and Guidelines and HealthPro Clinical Advisory Committees and past president for IPAC Greater Toronto and Area. She continues to be an active participant on committees such as IPAC Canada Prehospital Care Interest Group, IPAC Canada Education Core Committee and now is President Elect for IPAC Canada.



New to the Board is **JENNIFER HAPPE, BSc, MSc** who takes on the position of Secretary to the Board. Jennifer started her career as a medical researcher investigating alternative therapies for *Clostridium difficile* infection (CDI), including novel antibiotics and fecal transplants, before transitioning into the role of an Infection Control Professional (ICP) in Central Alberta. Jennifer has a varied portfolio and oversees acute care and mental health units at Red Deer Regional Hospital, acute and long-term care units at Lacombe Hospital, and cancer care at the Central Alberta Cancer Center. Jennifer's enthusiasm for infection prevention

and control led to her appointment as the Chair of IPAC Canada's Surveillance and Epidemiology Interest Group (SAEIG) and an IPAC Canada representative on the Canadian Patient Safety Institute (CPSI) national surveillance definition standardization project. She has been instrumental in facilitating the review of acute care and long term care case definitions. When she's not busy with work, Jennifer enjoys traveling and volunteering at the SPCA.



Also new to the Board in the position of Director (Education), **KIM ALLAIN, BSc, RN, MHS** who began her career in infection prevention and control in 2002. Kim has worked in a variety of roles including as an infection control practitioner in an acute care facility, and as the provincial infection control consultant for the NS Department of Health and Wellness. Kim is currently the Quality Improvement and Safety Leader (IPAC) for the Nova Scotia Health Authority (NSHA). Kim's role provides leadership within the NSHA's overall provincial/zone programs for quality, safety, accreditation, infection prevention and control, and risk management. Kim graduated from Dalhousie University School of Nursing, and holds a Masters degree in Health Studies (teaching focus). Kim has maintained her CIC designation since 2005 and has held several positions in IPAC Nova Scotia, as a past Chapter President and Education Coordinator. She has been active on several IPAC Canada Interest Groups. Kim was a member of the Scientific Program Committee for the 2014 IPAC Canada National Conference in Halifax. She served as Scientific Program Co-Chair for the 2016 National Education Conference in Niagara Falls and served as Chair for the 2017 IPAC Canada National Education Conference in Charlottetown. Away from the excitement of IPAC, Kim spends her time at the soccer field or rink with her two active boys.



RAMONA RODRIGUES, RN, BSc, MSc(A), CIC, CNS returns for her second term on the Board of Directors as Director (Chapters and Interest Groups). She is a Clinical Nurse Specialist in IPAC at McGill University Health Center in Montreal. She has been an ICP for 29 years and a member of IPAC Canada for 28 years. Ramona was a member of the Program Wide Standard development committee and has participated on the Distance Education Endorsement Committee. She is a member and Past President of PCI Montreal as well as an IPAC Canada national conference committee member. Ramona is very active in her profession in Quebec including acting as a member of the Regional Table for IPAC, Regional Housekeeping Table, Program Reviewer and Lecturer. In her current Board position, she chairs the meetings of Chapter Presidents, Interest Group Chairs and the new Chapter Council.



SUZANNE RHODENIZER ROSE, RN, BSCN, MHS, CIC

Suzanne is the Provincial Director of Medical Device Reprocessing at the Nova Scotia Health Authority. Prior to transitioning to the health authority, she held various roles at the Nova Scotia Department of Health & Wellness (DHW), including Acting Executive Director, Health System Quality and Director, Health System Quality and Infection Prevention and Control Nova Scotia, and provincial infection control consultant. Before joining DHW, she held infection control and nursing leadership roles with South Shore Health. She has published articles on infection prevention and control in multiple publications and has contributed at various national and international infection control symposiums. Her academic background includes a Bachelor of Science in Nursing from St. F.X. and a Master of Health Studies from Athabasca University. She is also the Past President for IPAC Canada. With 2017 By-law amendments returning the current President to the Board as Past President for a one-year term, Suzanne will support the Board through her experiences as President. ✨

Board of Directors News



Suzanne Rhodenizer Rose congratulates Marilyn Weinmaster for her six years of service as Secretary to the Board.

2018 ECOLAB Poster Contest



An annual poster contest is sponsored by Ecolab and supported by a chapter of IPAC Canada to give infection prevention and control professionals (ICPs) an opportunity to put their creative talents to work in developing a poster which visualizes the infection Control Week theme. 2018 National Infection Prevention and Control Week is October 22-26.

THEME: Infection Prevention and Control – No Borders!

DESCRIPTION OF THEME: No borders in a facility – all departments and disciplines must be concerned about IPAC. No borders throughout the world – all countries have a part to play (e.g., countries’ antibiotic stewardship plans, involvement in global responses to emerging diseases or outbreaks).

PRIZE: Waived registration to 2018 IPAC Canada National Education Conference or \$500.

REMINDER: Posters should have meaning for the public as well as all levels of staff across the continuum of care.

The poster should be simple and uncluttered, with strong visual attraction and minimal text.

Judging will be on overall content. Artistic talent is helpful but not necessary. The winning entry will be submitted to a graphic designer for final production. Your entry will become the property of IPAC Canada.

HOST CHAPTER: IPAC PANA

SUBMISSION: Submissions will only be accepted by email. Send submission to info@ipac-canada.org.

Email title: 2018 Ecolab Poster Contest

Submission format:

- Electronic file in Word or PDF format only.
- Files less than 5 MB preferred.
- File Size – must print out to 8.5”x11” paper.
- Name, address and telephone number must be included in the covering email.
- DO NOT include identifiers in the poster submission.

DEADLINE: January 31, 2018 ✨

Bring In A New Member Contest

Membership has its benefits – education, collaboration and representation. The IPAC Canada website (www.ipac-canada.org) has so much information on the benefits of being a member.

The annual member resource guide for finding other IPAC Canada members, links to infection control sites, audit tools, the audit tool app, upcoming mentor program, Learning Object Repository...the list is extensive. Tell another Infection Prevention and Control Professional (ICP), tell an infection control or ID physician, tell your Medical Laboratory Technologist, tell Environmental Services, tell EMS, tell your designate, and tell your director about the benefits of joining our national organization.

If that person joins IPAC Canada by March 31, 2018, both you and the new IPAC Canada member will be eligible to win a complimentary 2018 conference registration (Monday-Wednesday, value \$650). You are eligible for the draw with every new IPAC Canada member that you get to sign up from April 1, 2017 to March 31, 2018 inclusive. The New Member Contest form is available from <https://ipac-canada.org/photos/custom/Members/pdf/2017BringinaNewMemberContest.pdf>. Membership applications can be found at http://www.ipac-canada.org/about_join.php. 🌸

CIC® Graduates

New and certified CIC®s from a variety of healthcare settings have spent hours studying, digesting facts, and reading current literature. This information and life experience, along with a successful completion of the CIC® examination, ensure infection prevention and control professionals deserve to place a CIC® after their names. Congratulations to the following April-June 2017 and July-September 2017 list of graduates.

New Certificants

Dr. Adeshola Abati, BSc, MBBS, MPH, CIC
Lisa Acorn, RN, BN, CIC
Ajak Ajang, RN, BN, CIC
Heather Bergen, RN, BScN, CIC
Jodi-Marie Black, RN, BScN, CIC
Jeanine Bursey, RN, BN, CIC
Volha Checha, CCRA, CIC
Murtuza Diwan, MSc, CIC
Karrie Dunn, RN, BScN, CIC
Mary Ann Head, RN, BN, CIC
Katherine Ives, RN, CIC
Annie Lord-Stephens, RN, CIC
Dana Male, RN, BN, CIC
Dr. Meenakshi Malhotra, MBBS, MD, CIC
Radojka Mamula, RN, BN, CIC
Caroline Meguerditchian, CIC
Jalene Molloy, BN, RN, CIC
William (Larry) Morrell, RN, BScN, CIC
Eleanor Paget, RN, BScN, CIC
Shelly Rempel, RN, BN, CIC
Brian Sammon, MSc, CIC

Paul A. Seguin, ACP/A/RCO, CIC
Jannice So, HBSc, MPH, CIC
Karen Stoopnikoff, BSN, MSN, CIC
Lorinda Stuber, BSc, MSc, BScN, CIC

Recertified

Patricia Bedard, RN, BSc, CIC
Megan Clarke, RN, MN, CIC
Cheryl Collins, RN, BScN, CIC
Susan Cooper, MLT, CIC
Sandra Comand, ART, MLT, CIC
Carla Corpus, RN, BScN, CIC
Bonny Duncan, RN, BSN, CIC
Nicki Gill, RN, BSN, CIC
Susan Jacka, RN, MN, CIC
JoAnne de Jager, RN, BScN, CIC
Mark Jefferson, RN, BScN, CIC
Tammy MacDonald, RN, BScN, MBA, CIC
Jo-Anne McConnell, RN, BScN, CIC
Sally MacInnis, RN, BScN, CIC
Tanya MacNeil, BScN, RN, CIC
Sonya Morey, MLT, CIC
Lorna Morgan, RN, BScN, CIC
Cindy O'Neill, MLT, ART, CIC
Francine Paquette, CPHI(C), BAsC, CIC
Patricia Peltsch, RN, CIC
Erin Roberts, RN, BScN, CIC
Aurora Wilson, RN, BScN, MN, CIC

Distance Education Graduates

IPAC Canada congratulates the graduates of the 2016-2017 Distance Education Online Novice Infection Prevention and Control Course. The following group of graduates has successfully completed the course.

This course also provides IPAC Canada members with the opportunity to share their expertise in the roles of coordinators, instructors, and discussion facilitators. Many thanks go to the faculty of the course and to the families and colleagues of the students for making it all possible for students to strengthen their knowledge and skills. We know that they are ready and eager to apply them to practice.

Congratulations and best wishes to:

Olumuyiwa Akingunola, ARO, Abeokuta, Nigeria

Seyed Naser Aklagh, Burnaby, BC

Ashley Allan, Barrie, ON

Melissa Beck, Lethbridge, AB

Kristy Bigelow, Winnipeg, MB

Lynn Roberts Branconnier, Swan River, MB

Nicole Callahan, Nappan, NS

Charlene Cameron, Rothesay, NB

Victoria Chatten, Thunder Bay, ON

Linda Choy, Vancouver, BC

Scott Christie, Terrace, BC

Jodi Chubbs, Orilla, ON

Olga Colton, Winnipeg, MB

Sarah Cowan, Tillsonburg, ON

Jaime Daniel, Calgary, AB

Suzanne Desaulniers, Ottawa, ON

Wendy Feindel-Finlayson, Oakhill, NS

Jennifer Forman, Winnipeg, MB

Jacqueline Fortin, Dauphin, MB

Heather Gagnon, Calgary, AB

Abu Gbondo, Freetown, Sierra Leone

Wendy Gonzalez, Edmonton, AB

Ashley Grimes, Bishops Falls, NL

Michelle Hart, Coaldale, AB

Juliana Hatch, Vancouver, BC

Janet Hope, Vegreville, AB

Jenna Horner, Vancouver, BC

Cecilia Yuko Horton, Victoria, BC

Rebecca Manders, Warman, SK

David Miller, Grand Falls-Windsor, NL

Sonja Mitkovska, Aurora, ON

Michele Money, Jerseyville, ON

Wendy Nelson, Calgary, AB

Heidi O'Grady, Calgary, AB

Myda Paguyo, Toronto, ON

Katherine Patry, New Maryland, NB

Ornela Polovina, Vancouver, BC

Nisha Punja, Calgary, AB

Rita Shek, Prince Albert, SK

Philina Sky, Eagle River, ON

Katharina Specht, Calgary, AB

Judith Sperling, Edmonton, AB

Kristin Stewart, Balmoral, MB

Heather Thornton, Kingston, ON

Sebora Turay, Grande Prairie, AB

Nathan Wilson, Winnipeg, MB

Amber Woods, Strathroy, ON

2016-2017 Faculty

- **Heather Candon**, BSc, MSc, CIC
Course Coordinator/Instructor
- **Jane Van Toen**, MLT, BSc, CIC
Course Coordinator/Instructor
- **Jill Richmond**, BA, RN, BN, CIC
Practicum Coordinator/Facilitator
- **Laura Fraser**, RN, BScN, CIC
Instructor
- **Leila Kipke**, MLT
Instructor
- **Sue Lafferty**, RN, BScN, CIC
Instructor/Facilitator
- **Lesley McLeod**, BSc, MSc, CIC
Instructor
- **Julie Mori**, PhD
Instructor
- **Anne Augustin**, MLT, CIC
Facilitator
- **Tina Stacey-Works**, MLT, CIC
Facilitator
- **Elizabeth Watson**, RN, BScN, CIC
Facilitator

For more information on upcoming course offerings, see IPAC Educational Opportunities on the website. Applications for the 2018-2019 session will be accepted from January 1 to March 17, 2018. ✨

2016-2018 STRATEGIC PLAN

UPDATES AND GAPS – as of February 2, 2017							
Strategic Goals	Objectives	Strategy	Responsibility	Timeframe	Update		
Raise our Leadership Profile	1.1 Increase public, government and organizational awareness of IPAC Canada	1.1.1 Assess current state of awareness and develop a communication strategy	Consultant	2016	Assessment completed first quarter of 2016. Communication plan developed first quarter of 2016.		
		1.1.2 Invite a public representative to sit on Board	Board	2016	Stephen Palmer elected as Public Representative for three year term to 2019.		
		1.1.3 Seek representation on decision making and policy tables	Board	Ongoing	Current representation at PHAC – EWG, PHAC – AMS, C.N.A., CPSI, CBIC, Accreditation Canada.		
	1.2 Improve level and speed of responsiveness to issues	1.2.1 Identify infrastructure and identify a rapid/real time response system	1.2.1 Identify infrastructure and identify a rapid/real time response system	Staff and Consultant	2016 onwards	Real time response system discussed with Consultant; assistance received from Consultant.	
			1.3 Increase political advocacy and influence	1.3.1 Increase engagement at federal, provincial and territorial level	Board	Ongoing	Increased representation at FPT tables; advocacy for IPAC in Nova Scotia; communication with Federal MPs.
			1.3.2 Partner with non-traditional groups		Board; Chapter Presidents	Ongoing	Groups suggested by Chapter Presidents were already on our communication list. Continuing to communicate with new groups as introduced.
	1.4 Establish an international presence	1.4.1 Support developing countries on initiatives such as 'Twin City'	1.4.1 Support developing countries on initiatives such as 'Twin City'	Chapters	Ongoing	Some chapters have designated a Twin City or country for assistance. IFIC mentorship information forwarded to chapters.	
			1.4.2 Leverage association with international organizations	Education Core Committee; Consultant	2016 onward	President-elect and Executive Director received media and government relations training from consultant re advocacy. Additional education to be planned	
			1.4.3 Continue to promote international call outs and opportunities for members	Staff	Ongoing	International education and professional opportunities posted and promoted.	
Recalibrate Our Product Mix (continued on next page)	2.1 Offer informed commentary on standards and guidelines across federal, provincial and territorial jurisdictions	2.1.1 Maintain a functional repository of federal, provincial and territorial guidelines	Standards and Guidelines; Web Communications Manager	Ongoing	Links/Resources section of website constantly updated.		
		2.1.2 Review and disseminate information, updates, etc. through membership	Standards and Guidelines; Chapter Presidents	2017 onwards			
	2.2 Accelerate development and dissemination of audit tools	2.2.1 Utilize survey results to inform audit tool kit development	Audit Tool Committee; Programs & Projects; Specific interest groups; Ad hoc experts	Ongoing	Needs Assessment Survey 2017. New audit tools to be developed by Programs & Projects; current tools to be reviewed by Audit Tool Committee.		
		2.2.2 Review information/approval process and formalize Terms of Reference of Audit Tool Committee	Audit Tool Committee; Programs and Projects; Executive Director/ Board	2016	Completed		
	2.3 Enhance education emphasis to reflect fundamental infection and control principles	2.2.3 Develop an App for audit tools	Audit Tool Committee	2016-2017	Board engaged HandyMetrics to develop audit tool app; currently working with Focus Group; launch in 2017.		
		2.3.1 Identify broad high-level principles related to identified education needs	Education Core Committee	Ongoing	Provide education sessions that would ensure the interests of both novice and experienced ICPs; gather information through Needs Assessment.		
	2.3.2 Increase use of technology in educational delivery in real time	Education Core Committee	2017 onwards	Use of Adobe Connect provided for interest groups, chapters and committees.			

Strategic Goals	Objectives	Strategy	Responsibility	Timeframe	Update
Recalibrate Our Product Mix <i>(continued from previous page)</i>	2.4 Continue to develop CJIC as a cited peer review journal	2.4.1 Dedicate CJIC to scientific information and field material, migrating non-scientific components to other communication venues	Editor and Editorial Board	2016 onwards	More scientific articles are being published. Association News to move to Supplement in 2017. PubMed submission to occur in 2018/19.
		2.4.2 Promote CJIC as a peer-reviewed citable journal	Editor and Editorial Board	Ongoing	Promotion of CJIC with other associations enhanced, e.g., AIPJ, APIC, IHI.
		2.4.3 Establish on-line searchable index	Editor and Editorial Board; Web Communications Manager	2017 onwards	To be developed on new website.
Grow Our Capacity	3.1 Promote the value of IPAC Canada memberships to key target audiences	3.1.1. Develop messages for specific target groups	Membership Core Committee; Special Interest Groups	Ongoing	In 2016, the following groups were targeted for membership: foot care, midwives, respiratory, (Ontario) housekeepers, Medical Device Reprocessing, and PICnet BC.
		3.1.2 Enhance current new member promotion package	Staff	Ongoing	Web-based new member package regularly updated.
		3.1.3 Profile successful chapters and develop a repository of successful practices	Chapter Council; Web Communications Manager	2017 onwards	Under discussion.
	3.2 Make innovative use of technology to engage and educate	3.2.1 Seek opportunities to integrate technology into product mix	Programs and Projects; Education Core Committee	Ongoing	Technology Committee tabled. Adobe Connect utilized for education and networking. Technological advances under regular discussion.
		3.2.2 Develop a social media strategy	Social Media Manager	2016	Under discussion with Consultant; Social Media Manager communicates IPAC Canada news and other info on Twitter.
		3.2.3 Use on-line connectivity tools to enhance collaboration committee work	Web Communications Manager	Ongoing	Adobe Connect and Google Docs used for committee collaboration; website technology under discussion.
		3.2.4 Enhance website to include on-line searchable member directory	Web Communications Manager	2017 onwards	Under discussion.
	3.3 Expand mentorship	3.3.1 Develop a handbook for mentors	Membership Core Committee	2016	Completed
		3.3.2 Develop a Chapter Council	Board, Staff, Chapters	2016	Completed
		3.3.3 Implement mentor programs for chapter executives, new members, individuals with new roles	Membership Core Committee; Chapters	Ongoing	Mentor program to be launched in 2017
	3.4 Build and leverage relationships with industry	3.4.1 Identify ways to use scientific knowledge to leverage industry to support our needs	Corporate Relations Committee; Director (MD); Specific Interest Groups	2016 onwards	Ongoing discussions with CRC and Board
		3.4.2 Support industry adherence to IPAC principles and practices in products and services	Standards and Guidelines Committee	2016 onwards	Under discussion
		3.4.3 Partner with industry to address technology needs	Corporate Relations Committee	2016 onwards	Under discussion
	3.5 Seek additional sources of funding	3.5.1 Establish a formal fundraising program	Board; Consultant	2016 onwards	Under discussion
		3.5.2 Increase industry sponsorships	Board; Corporate Relations Committee	Ongoing	Under discussion
	3.5.3 Identify and apply for relevant grants	Staff/Consultant in consultation with specific Committees and Interest Groups	2016 onwards	Under discussion	

A 2019-2021 Strategic Plan Retreat will be held in Banff, May 26-27.
The Board, Chapter Presidents and other Leaders will meet to develop plans for future goals and objectives.



IPAC Canada National Conference
Banff, Alberta
May 27 – 30, 2018

2018 NATIONAL EDUCATION CONFERENCE

WHO SHOULD ATTEND?

Infection Prevention and Control Professionals and healthcare providers interested in the prevention and control of infections in all healthcare settings.

MORE INFORMATION:

IPAC Canada
Telephone: 1-866-999-7111
Email: info@ipac-canada.org
www.ipac-canada.org

REGISTRATION:

Will commence December 2017
See www.ipac-canada.org
for program information

EDUCATION HIGHLIGHTS:

- Disinfection and Reprocessing
- IPAC in Construction
- Aboriginal Health
- Surgical Site Infection
- UTIs in Long Term Care
- Occupational Health
- SPECIAL GUEST: Dr. Patch Adams



To reach infection control professionals across Canada through the **Canadian Journal of Infection Control** and its targeted readership, please contact me at



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