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INSIDE:

Use of a fluorescent chemical as a quality indicator for a hospital cleaning program

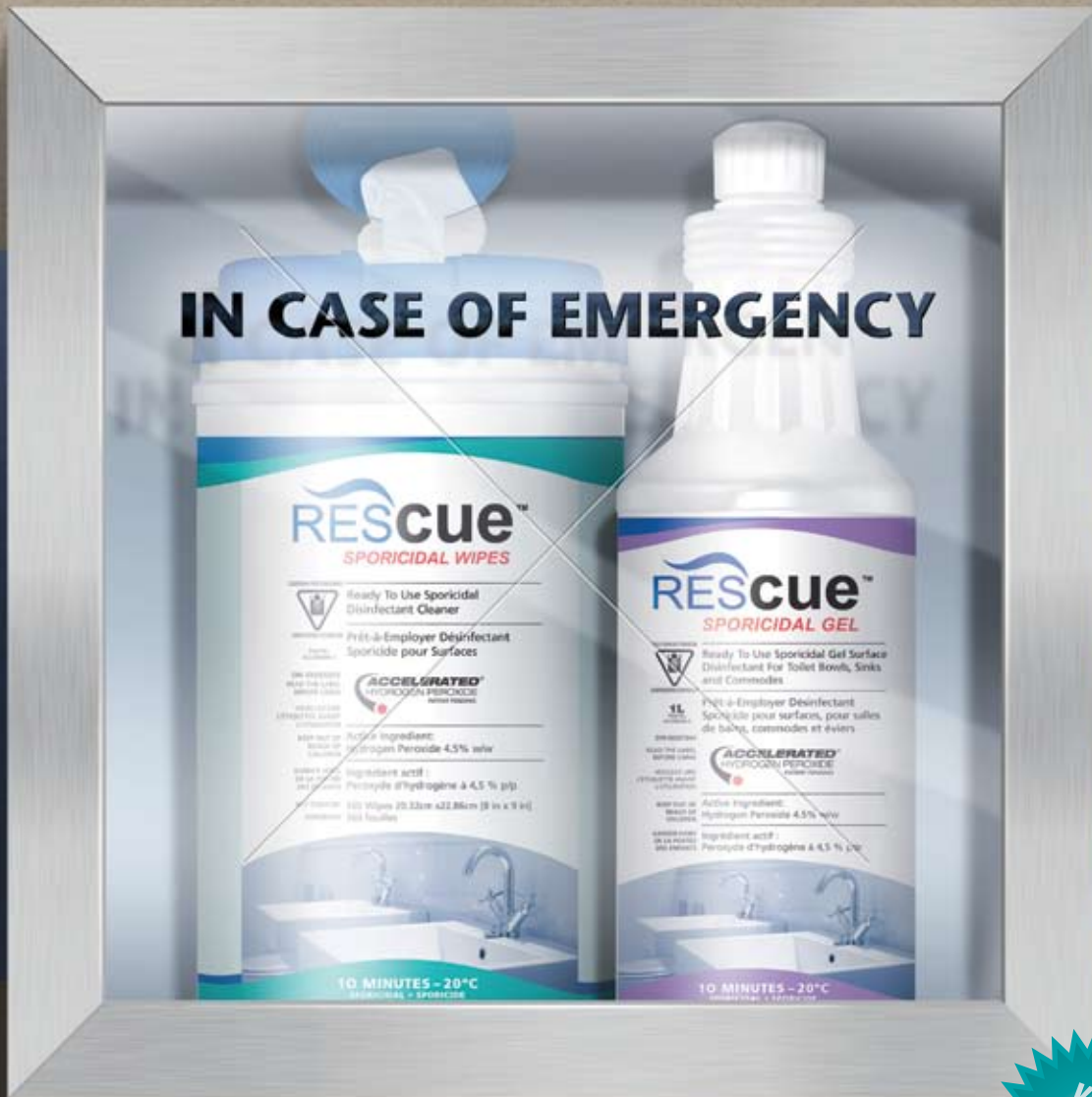
Influenza campaign 2006 and 2007:
A residential care success story

E-learning of infection control: it's contagious

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VISION

CHICA-Canada will lead in the promotion of excellence in the practice of infection prevention and control.

MISSION

CHICA-Canada is a national, multidisciplinary, voluntary association of professionals. CHICA-Canada is committed to improving the health of Canadians by promoting excellence in the practice of infection prevention and control by employing evidence-based practice and application of epidemiological principles. This is accomplished through education, communication, standards, research and consumer awareness.

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Pat Piaskowski, RN, HBScN, CIC
Clinical Editor,
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Infection Control*

Succession planning: replenishing the ranks

With many infection control professionals being registered nurses and the average age of a nurse being in the mid-40s, one could surmise that the average age of an ICP is similar. There are also estimates that about 15-20 per cent of the health care workforce is now over 50 years of age.

From these figures it is a likely projection that we could see many ICPs retiring in the next five to 10 years.

There has also been an influx of new ICPs hired with additional funded positions in some provinces, some of whom are in the same age cohort.

What will this mean to our profession?

- Likely there will be an increased need for training programs across the country to support the learning needs of the new ICP positions including those who replace retired ICPs.
- Along with training, these new ICPs will need mentoring and support to take on their new roles.
- With the constant barrage of new and re-emerging organisms and greater public accountability for prevention of infections there will be increasing pressure to ensure that new ICPs are “up to speed” and fully functioning in a shorter time.
- Certification in Infection Control (CIC) will increase in importance as ICPs face greater public scrutiny and an increased accountability in their key roles in patient safety.
- More attention will be required for succession planning. This will be critical especially in settings where there is only one ICP and the new

ICP may start weeks after the position is vacated.

- Newer generations of ICPs may have a different perspective on the work and personal life balance. They may be more willing to assert their need for a more structured work environment with regular hours and consistent breaks and time off. This may mean that when ICPs who worked day and night in their roles leave it may be difficult for new ICPs to fulfill these demands.

What is the answer? Obviously there is no one clear answer. However, there needs to be dialogue among the members of the profession at the local, regional, provincial, and national level. This will form a first step in the development of a plan for the eventual succession of new ICPs.

ICPs can help with solving this looming issue, at the local level, by actively promoting infection prevention and control as a profession and supporting local, regional, and national efforts to bring new recruits into the field. ●

Correction:

Unfortunately the wrong Aramark advertisement was placed in the Fall issue. Please find the correct ad in this issue on page 236. We apologize for any inconvenience this may have caused Aramark and its clientele.



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Marion Yetman, RN, BN, MN, CIC
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*"If you are planning for a year,
sow rice; if you are planning for a
decade, plant trees; if you are plan-
ning for a lifetime, educate people."
– Chinese proverb*

As the end of my term as president nears it is with pleasure that I reflect on the accomplishments of our organization. This past year has been a period of growth with a number of highlights as evidenced by an increase

A great year

in membership, a greater number of attendees at the national education conference, and an increase in readership of the *Canadian Journal of Infection Control*.

One of our proudest achievements has been our pursuit of educational excellence for our members. This year the widely recognized university credit web-based course sponsored by CHICA-Canada has been reviewed by the Distance Education Coordinator, Karen Dobbin Williams. This evaluation will ensure that the course continues to provide a curriculum which meets the needs of the Infection Prevention and Control Practitioners. In addition to this entry-level course, CHICA-Canada is exploring the possibility of partnering with other Canadian universities in the hope of developing post-graduate courses in infection prevention and control.

This year marks the third year the National Scientific Program Committee has developed the education program for the annual education conference. Informal feedback has indicated that the membership is satisfied with this

method of conference planning. This process also lessens the workload for individual chapters who have had primary responsibility for planning the national conferences in the past.

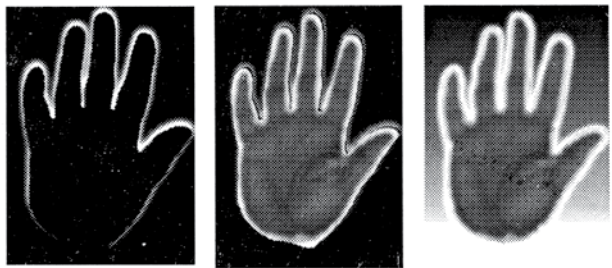
CHICA-Canada has embraced research this year with the membership supporting the allocation of \$50,000 toward a study to increase our knowledge of the prevention, control and eradication of *Clostridium difficile*. Dr. Vivian Loo, McGill University Health Centre, Montreal, has been awarded the research grant and will commence work on her topic "Household Transmission of *Clostridium difficile*."

The strength of our organization is reflective of the commitment of our volunteers. On behalf of all members, I would like to thank Dr. Dick Zoutman for his 12 years of dedication to the position of Physician Director for CHICA-Canada. Joanne Laalo, Past President, and Cindy Plante-Jenkins, Director of Finance, have completed their terms on the board and have also served CHICA-Canada with enthusiasm and devotion.

At the recent board meeting, Dr. Elizabeth (Betty Ann) Henderson, the past Director of Education, was awarded the designation of Honorary Member. This is in recognition of her contribution to infection prevention and control education. In fact, Betty Ann has been described as one who has raised the profile of CHICA-Canada as a leader worldwide "for its innovative and high caliber approach to educational development." Indeed her focus on education has helped position CHICA-Canada in planning for a lifetime of infection prevention and control professionals.

I would like to thank the members of the board of CHICA-Canada, the membership particularly the CHICA-NL group, and Gerry Hansen, who have provided me with support during the past year. ●

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Marion Yetman, Inf., B. Sc. inf.,
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« Si vous planifiez sur un an, ense-
mencez du riz ; si vous planifiez sur
une décennie, plantez des arbres ;
si vous planifiez sur toute votre vie,
éduquez les gens. »
— Proverbe chinois

A lors que la fin de mon mandat à la présidence approche, c'est avec plaisir que je repense aux réalisations de notre organisme. L'année écoulée a été une période de croissance marquée par un certain nombre de faits saillants, comme en font foi l'augmentation du nombre de nos membres, celle du nombre de participants à la conférence nationale sur la formation et celle du lectorat de la *Revue canadienne de la prévention des infections*.

Une année exceptionnelle

Une des réalisations dont nous pouvons être le plus fier a été notre quête de l'excellence en formation pour nos membres. Cette année, le cours universitaire crédité sur le Web, commandité par CHICA-Canada et qui jouit d'une grande renommée, a été réexaminé par la Coordinatrice de la formation à distance, Karen Dobbin Williams. L'évaluation qu'elle a réalisée nous permettra de nous assurer que ce cours continue d'offrir un programme répondant aux besoins des praticiens en prévention et contrôle des infections. En plus de ce cours de niveau d'entrée, CHICA-Canada étudie la possibilité de créer un partenariat avec d'autres universités canadiennes dans l'espoir d'élaborer des cours d'études supérieures en prévention et contrôle des infections.

Cette année marque le troisième anniversaire de l'élaboration, par le Comité du programme scientifique national, du programme d'enseignement en vue de la conférence annuelle sur la formation. D'après les réactions informelles reçues, les membres sont satisfaits de cette méthode de planification de conférence. Ce processus a également l'avantage de

réduire la charge de travail des sections dont la responsabilité première consistait, par le passé, à planifier les conférences nationales.

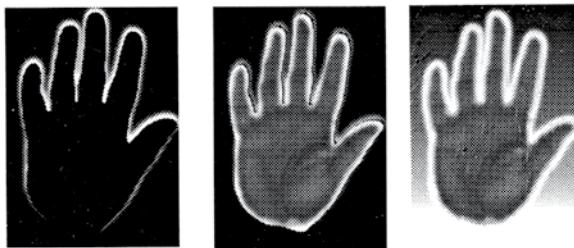
Cette année, CHICA-Canada a abordé la recherche avec les membres en soutenant l'affectation de 50 000 \$ en vue de la réalisation d'une étude visant à élargir notre connaissance de la prévention, du contrôle et de l'éradication du *Clostridium difficile*. La docteure Vivian Loo, du Centre de santé de l'Université McGill, à Montréal, a reçu une bourse de recherche et entreprendra ses travaux sur son sujet, la transmission en milieu familial du *Clostridium difficile*.

La vigueur de notre organisme est le reflet de l'engagement de nos bénévoles. Au nom des membres, je tiens à remercier le docteur Dick Zoutman de ses 12 années de dévouement au poste de Directeur médical de CHICA-Canada. Joanne Laalo, Présidente sortante, et Cindy Plante-Jenkins, Directrice des finances, qui terminent leur mandat respectif au conseil, ont également mis leur enthousiasme et leur dévouement au service de CHICA-Canada.

Lors d'une réunion récente du conseil, la docteure Elizabeth (Betty Ann) Henderson, Directrice de la formation sortante, a été nommée membre honoraire en reconnaissance de sa contribution à la formation en matière de prévention et de contrôle des infections. On a décrit Betty Ann comme une personne qui a attiré davantage l'attention sur le rôle de chef de file mondial de CHICA-Canada « en raison de son approche novatrice et de niveau élevé du perfectionnement de la formation ». Et il est vrai que l'importance qu'elle accorde à la formation a contribué à permettre à CHICA-Canada de planifier une vie entière de professionnels en prévention et contrôle des infections.

En terminant, je tiens à remercier les membres du conseil de CHICA-Canada, les membres ordinaires, en particulier le groupe de CHICA-NL, ainsi que Gerry Hansen, pour son aide au cours de l'année écoulée. ●

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ABSTRACT

Background:

Hamilton Health Sciences is a large teaching hospital with over 1,000 beds and consists of three acute care sites, one Regional Cancer Center and two Rehabilitation/Chronic Care facilities. An environmental cleaning pilot project was initiated at the acute care Henderson site, following an outbreak of vancomycin-resistant *Enterococcus* (VRE). Healthcare-associated infections (HAI) due to antibiotic-resistant organisms are increasing in Southern Ontario.

Environmental cleaning plays a key role in eradicating resistant organisms that live in hospital environments, thereby helping to reduce HAIs.^{1,2,3,4}

The environmental cleaning practices on the Orthopaedic Unit were identified as a contributing factor to the VRE outbreak after visual assessments were completed using a Brevis GlitterBug® product, a chemical that fluoresces under an ultraviolet (UV) lamp. These findings led to a hospital-wide cleaning improvement initiative on all units except critical care areas. The GlitterBug® potion was employed by Infection Control and Customer Support Services (CSS) as a tool to evaluate the daily cleaning of patient washrooms as well as discharge cleaning of contact precaution isolation rooms.

Method:

Over a four-week period, the GlitterBug® potion was applied to seven frequently touched standard targets in randomly selected patient bathrooms on each unit and 14 frequently touched targets prior to cleaning in the rooms used for isolation. The targets were then evaluated using the UV lamp to detect objects that were not cleaned and the

results were recorded on a standardized form. The rate of targets cleaned versus the targets missed was calculated.

Results:

The overall rate for daily cleaning of bathrooms and cleaning of isolation rooms was poor with only 23% of the targets cleaned. Based on these findings, several interventions were implemented. This resulted in a significant improvement in cleaning practices during the pilot project. Greater than 80% of the targets were cleaned compared to the baseline findings of 23%. Subsequently, nosocomial cases of VRE have declined despite the increased prevalence of VRE in the Hamilton and surrounding regions.

Conclusion:

The GlitterBug® product is an effective tool to evaluate environmental cleaning and adherence to policies and procedures and this method was superior to previous visual inspection methods. The use of GlitterBug® potion improved physical cleaning and enhanced staff contribution. The Brevis GlitterBug® product was incorporated into the CSS environmental cleaning program at Hamilton Health Sciences as a quality indicator to monitor environmental cleaning practices.

BACKGROUND

In June 2007, an outbreak of vancomycin-resistant *Enterococcus faecium* occurred on an Orthopaedic Unit at the Hamilton Health Sciences Henderson site, a 300-bed acute care hospital. A total of 25 nosocomial cases were detected during the course of the outbreak. As part of the intervention and audit process, the infection control (IC) team reviewed hand hygiene, equipment disinfection

and environmental cleaning practices on the unit. Environmental testing for VRE was also conducted with limited value, as all cultures yielded negative results. This reflects the information in the literature that does not support routine environmental testing for antibiotic resistant due to poor sensitivity.^{5,6}

Although multiple factors contribute to outbreaks, environmental cleaning practices on the Orthopaedic Unit were identified as a contributing factor to the VRE outbreak after further visual assessments were completed using a Brevis Gitterbug[®] potion. During the assessment, it was identified that the routine cleaning of patient rooms was unsatisfactory and likely a important factor in the ongoing spread of VRE. This resulted in the launch of a cleaning improvement project using a Brevis GlitterBug[®] product, a chemical that fluoresces under a UV lamp. All environmental cleaning Staff receives standard training on the hospital cleaning protocols and disinfectant products, which meet regulatory and professional standards. The pilot project focused solely on physical cleaning practices. This project was a collaborative initiative between the Henderson's Infection Control and Customer Support Service teams and was launched on October 15, 2007.

METHOD

The GlitterBug[®] potion was used by infection control to evaluate the routine cleaning of patient washrooms and discharge cleaning of single rooms used for contact precautions isolation, on all units except critical care areas. The infection control team collected baseline data from October 18 to November 15, 2007. Patient rooms were randomly selected on each unit at the start of a shift prior to daily cleaning. A fingerprint-size amount of GlitterBug[®] Potion was applied to seven frequently touched standard targets in randomly selected patient washrooms (flusher handle, emergency call bell cord, light switch, grab bar, door handle, toilet paper holder, back of toilet seat) as well as an additional seven standard cleaning targets (light

cord, call bell, drawer handle, over-bed table, metal television arm, bed rail, phone receiver) in the rooms used for patients in contact precautions. The following day after cleaning, the targets were evaluated by the infection control team using a UV lamp to detect targets that were missed and not cleaned. The results were recorded on a standardized form. The rate of targets cleaned versus targets missed were calculated and the results were presented to the customer support service teams.

RESULT

A total of 364 targets were evaluated during the baseline data collection period from October to November. The overall rate for cleaning of the bathrooms and discharge cleaning of isolation rooms was poor with only 81 (23%) targets cleaned. Following the implementation of the pilot project and through the course of interventions, subsequent audits and evaluations showed a significant improvement of greater than 80% in cleaning, as shown in Figure 1.

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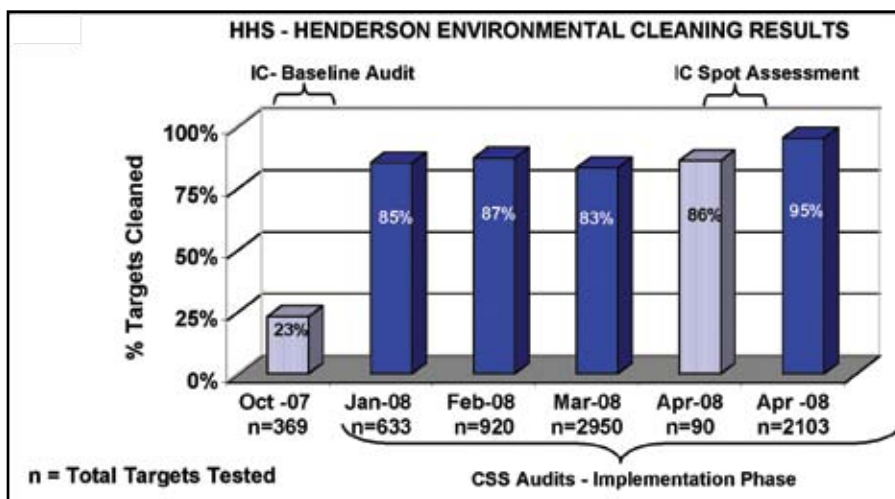
Overall, the labour required to initiate this process was minimal. It took approximately 2 minutes per room to apply the GlitterBug® Potion and 4-5 minutes per room to check results and review with front line staff. The cost of materials was minimal with less than \$200(CA) to supply four team leaders with UV battery-operated lamps and GlitterBug® Potion.

DISCUSSION

Based on the initial assessment and baseline results, several non-punitive measures and interventions were implemented for the pilot project. Key strategies included instituting formal education and review of infection control and hospital cleaning protocols into CSS monthly team meetings, conducting practical show-and-tell environmental exercises for the frontline CSS Staff using GlitterBug® products, performing daily cleaning audits by CSS team leaders on units using GlitterBug® potion with immediate feedback provided to frontline cleaning staff. The environmental roles and responsibilities were also reviewed.

The ongoing audits performed by the CSS leaders showed a steady and significant improvement of greater than 80% in cleaning since the start

Figure 1



of the pilot project. These findings are consistent with the independent spot assessment conducted by infection control team in April 2008 (see Figure 1). CSS Staff were provided the positive feedback. This resulted in a renewed excitement and awareness of the importance of the environmental role and the impact it has in the overall health and safety of patients. According to the responses to a customer satisfaction survey, the program was also well received by patients who were very supportive of the initiative.

SUMMARY

A protocol for audits using GlitterBug® products was developed and incorporated as a quality indicator tool into the CSS cleaning program. Monthly statistics were tabulated and compared for trending purposes. Due to the overwhelming success of the project, a CSS employee rewards and recognition program was developed to acknowledge high performances. Awards are presented to the frontline cleaning staff who achieve 100% of all audits completed in a month and the award is displayed on the clinical units for everyone to celebrate.

Active and passive surveillance for patients with VRE continues on a regular basis at Hamilton Health Sciences as part of the infection control program. The rate of nosocomial cases of VRE has decreased over the past five months since the implementation of the pilot project, as shown in Figure 2. Although it is premature to confirm a sustained VRE reduction, it appears from the conclusion of the outbreak and subsequent VRE statistics, that this hospital environmental cleaning program has been successful in reducing hospital-acquired VRE infections.

CONCLUSION

The GlitterBug® products are an effective tool to evaluate environmental cleaning and adherence to policies and procedures. This method is superior



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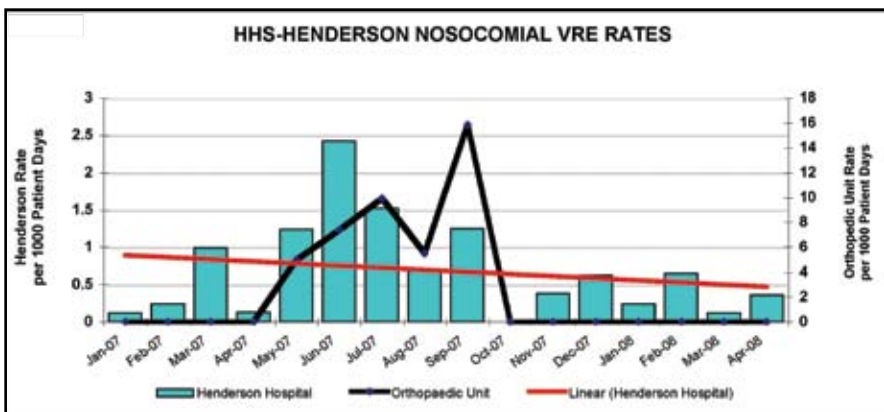
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Figure 2



to the previous visual inspection method. The use of GlitterBug® products improved cleaning and enhanced staff contribution. There is satisfaction for CSS leadership and staff and a renewed excitement for the environmental role. The Brevis GlitterBug® product was incorporated into the CSS environmental cleaning program and is now used as a quality indicator to monitor environmental

cleaning practices at all Hamilton Health Sciences Hospitals. ●

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The Virox Technologies Partnership will again provide a scholarship to assist CHICA-Canada members with attending the 2009 Education Conference in St. John's, Newfoundland Labrador. The 2009 Virox Technologies Partnership Scholarship application is available on www.chica.org.

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Influenza campaign 2006 and 2007: A residential care success story



ABSTRACT:

Objective:

On July 7, 2000, the BC Ministry of Health announced a comprehensive influenza campaign for British Columbia (BC). The Ministry's goals were: to reduce illness and death associated with influenza in the most vulnerable populations; to reduce predictable preventable additional pressures on the health care system that occur during influenza season; and to achieve an 80% immunization rate in health care workers. Since 2000, the staff influenza numbers continue to remain around 45%, with a number of identified influenza outbreaks. Saanich Peninsula Hospital (SPH), a 150-bed extended care unit, challenged their staff to improve and sustain their immunization numbers to 80% for the protection of their residents.

Method:

In response, SPH developed an integrated influenza management plan. The plan focused on an enhanced ability to prevent and control influenza. This would involve a targeted immunization campaign for high-risk groups, including enhanced ability to quickly identify outbreaks, and to implement control measures. SPH along with the Vancouver Island Health Authority, south island (VIHA-si), used a campaign that involved the development of staff policies around influenza immunization and outbreak management, an enhanced media campaign, incentive program for staff and refinement of protocols for quick access and testing of isolates during an outbreak.

Results:

There was an increase in influenza awareness both among health care workers and the general public. In SPH extended care staff there was a 115% increase in staff immunization rates over the 2005 campaign. A 90% immunization rate among residents in residential care facilities was seen. There were no reported outbreaks of influenza in residential care facility within the SPH during the 2006 and 2007 influenza seasons.

Discussion:

Despite the increase in immunization rates among health care workers, in general, the overall rate within the health authority remains low. The success of the SPH extended care campaign may have been a result of the climate of the facility and the commitment of the manager and key staff to the initiative. Future campaigns will be directed to the entire facility, including acute care. It will be interesting to see if these immunization numbers can be sustained in other areas.

Conclusion:

In order to be successful, influenza immunization campaigns must involve management and numerous departments. Early planning is important and must start as soon as the previous year's campaign concludes. A key component to any plan is communication, staff incentives and staff belief in the program. The success or failure of a plan is dependant on the message about immunization that gets out to the at-risk populations. This will continue to be a key component of future influenza campaigns.

On July 7, 2000, after consultation with the British Columbia Center for Disease Control, the BC Ministry of Health announced a comprehensive influenza campaign for British Columbia. The Ministry's goals were three-fold:

- To reduce illness and death associated with influenza, particularly among the most vulnerable populations.
- To reduce predictable, preventable additional pressures on the health care system which occur during flu season.
- To enhance British Columbians' capacity to successfully fight the next influenza pandemic.

The Ministry's campaign involved targeted influenza immunization aimed especially at those at risk:

- Community dwelling seniors and individuals with chronic health conditions.
- Health care workers.
- Emergency and first responders.

The Ministry's campaign was to focus on health care worker immunization, public education about influenza, integrated planning to protect British Columbians in the future, and enhanced influenza surveillance. The aim was to achieve 80% vaccination of people at most risk for influenza and its complications as well as those that provide care and support to them.

Vancouver Island Health Authority

The Vancouver Island Health Authority (VIHA) provides hospital, community, home, environmental and public health services including education and prevention, to the people living in and around Vancouver Island, Canada in over 138 locations by over 17,000 staff.

The region serves over 752,000 residents in an area that stretches the entire Vancouver Island, the islands of the Georgian Strait, and mainland communities North of Powell River and South of Rivers inlet.

In response to the Ministry of Health's announcement for Influenza Campaign 2000, VIHA developed an integrated



influenza management plan. The plan focused on an enhanced ability to prevent and control influenza. This would involve a targeted immunization campaign for high-risk groups, including an enhanced ability to quickly identify outbreaks, and to implement control measures.

The VIHA plan began in May 2000, prior to the Ministry's

announcement in anticipation of the upcoming flu season. The work around the campaign involved Occupational Health, Seniors' Health Program, Regional Infection Prevention and Control Program, Communications, Human Resources, and the Office of the Medical Health Officer. The main focus of the VIHA Flu Campaign was to inform the high-risk groups, including health care workers, about influenza and to provide easy access to immunization.

Despite the campaign, influenza rates only went up slightly among the staff of VIHA, averaging around 43% immunization rates over all, with a slightly higher rate seen in residential care at approximately 60%. VIHA continued to see outbreaks of influenza in its high-risk group.

By 2005, Epidemiology and Disease Control, under the Medical Health Officer, took the lead for the influenza programs under VIHA. The program expanded to include nurse champions on every unit who were



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able to offer education as well as immunization to staff. A coordinated effort to rapidly diagnose and offer treatment or prophylaxis was established. Despite these efforts, staff rates remain low and outbreaks of influenza A continued to be seen in residential care. After one such influenza outbreak in 2005-2006 seasons, a novel approach was taken to improve immunization rates among staff in a particular residential setting.

Flu-campaign summary: Saanich Peninsula Hospital Extended Care Unit

Background

In early 2006, the Extended Care Unit (ECU) at Saanich Peninsula Hospital (SPH) had an outbreak of influenza A on the unit. This resulted in a harsh impact on staff, residents and families

associated with the unit. The manager and the clinical nurse leader (CNL) committed to change the immunization rates for 2006/07.

SPH ECU began their flu-campaign discussion by acknowledging their meagre 37% immunization rates by nursing staff in 2006 for influenza vaccine. Staff held discussions on how they could improve and reach the target of 80%.

Method

The CNL emailed all the other residential care facilities within the area, requesting information about their 2006 staff immunization rates, and suggestions for how they increase compliance.

After completing this research, the CNL concluded that all units have a culture unique to them; determine what makes your culture happy and your immunization rates will go up. The CNL, with the support of her manager, decided to run a campaign offering draws of excellent gifts, starting with

inexpensive gifts up to the top prize which was a dinner for two (value \$150). The very supportive Saanich Peninsula Hospital Foundation generously donated the top prize.

The Activation Department and the CNL made two large fun, colourful posters with picture cartoons and percentage scales; one on each unit that allowed all staff to track the progress as a team with each ECU challenging the other unit.

The first draw was held when they had passed the previous year's immunization rate of 37%. Subsequent draws were held at rates of 50%, 60%, 75% and over 80%. All draws were held with pomp and fanfare, just what was needed during the long winter months. Small prize draws were held in between milestones just to keep the staff interested.

Other factors contributed to SPH-ECU success:

- CNL worked closely with Infection Prevention and

Control, who supported their campaign from the beginning.

- The CNL was available to all the staff to drop in to the office and get their influenza vaccination. This proved to be highly effective since the drawing barrel was located in this office, and names would only be entered after proof of vaccination. The barrel was handsomely handcrafted by the units' social worker.
- Staff encouraged fellow staff members to get their shot, so another drawing could be held.
- Phone calls to casual staffs that do not work at the facility very often were made by the CNL. This was to inform them about the possibility of winning a prize if they could show the CNL of proof of immunization.
- The manager ensured the current staff listings were up to date.

Good, clear communication with the housekeeping supervisor was essential to success with over 90% immunization within this group.

Results

There was an increase in influenza awareness both among health care workers, families, residents and the general public. There was a marked increase in use of alcohol-based hand sanitizer by both staff and visitors.

There was a marked increase in immunization of SPH extended care staff. In 2005/2006 the immunization rate among staff was 39%; this increased to 84% in 2006/2007 and was maintained in 2007/2008 at 83%. This represents a 115% increase in staff influenza immunization rates over the 2005 campaign.

The immunization rate among the residents in the facilities remained constant at 87.6% in 2005/2006, 83.2% in 2006/2007 and 90.4% in 2007-2008 (table 1).

In the 2005/2006 season, 41 respiratory cases were reported among the approximately 150 residents at SPH ECU including one confirmed influenza A outbreak. Within the 2006/2007 the respiratory cases dropped to 11, with seven cases in the 2007/2008 season

despite influenza outbreaks confirmed within the community. There were no reported cases of influenza in the residential care area within the SPH during the 2006 and 2007 influenza season.

Discussion

The success of the influenza campaign can be attributed to an excellent communication campaign and the introduction of novel unit-specific activities. The campaign provided information about influenza immunization and information regarding the availability of clinics. The Influenza Prevention Program Policy established a protocol for reducing transmission and clarified the importance of health care worker influenza immunization as integral to this process.

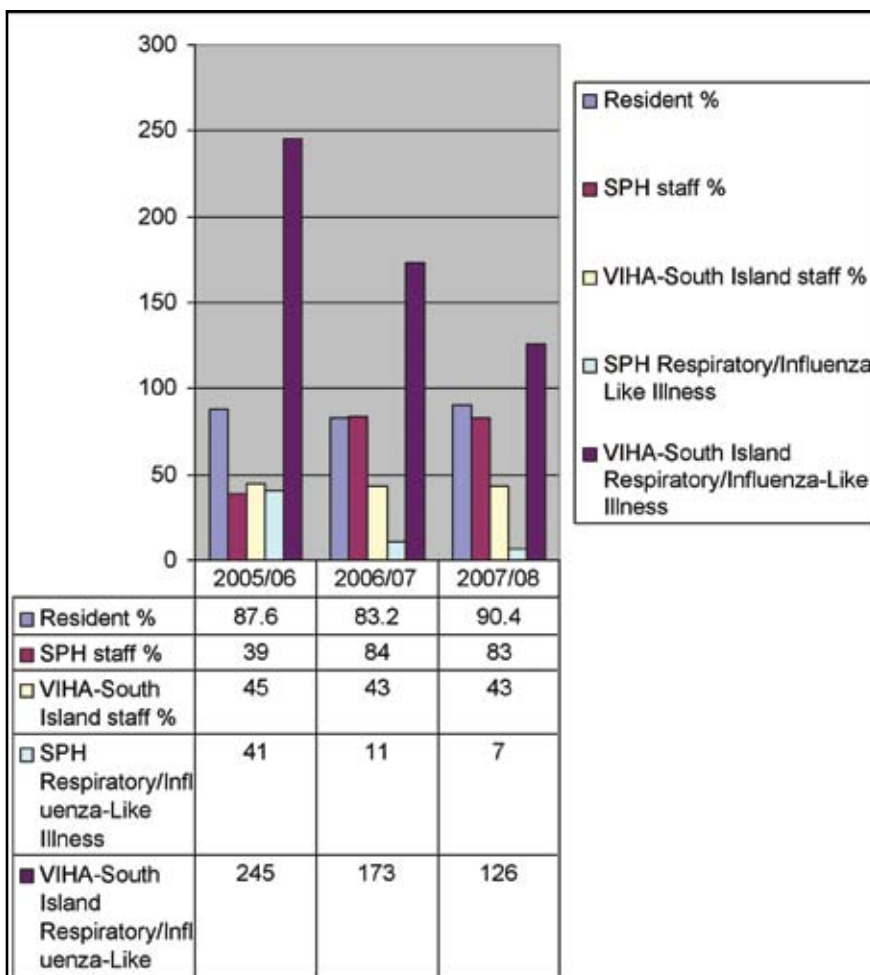
With any endeavour, evaluation of past practice is important to improve future programs. Despite the increase in immunization rates among health care workers at SPH ECU, the overall rate within the health authority remains low averaging 43%. The success of the SPH extended care campaign may have been a result of the climate of the facility and the commitment of the manager and key staff to the initiative.

Following are some recommendations which require review and consideration:

- Offer prize draws as an incentive to become immunized. Prize draws were only offered at SHP ECU. The manager at SPH ECU provided some funding, while staff and the residents' families donated other prizes. For a small amount of funding it would be

Continued on page 227

Table 1



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possible to have regional prizes and provide some fun related to the clinics and other sites challenging each other.

- Future campaigns will be directed to the entire facility, including acute care. It will be interesting to see if these immunization numbers can be sustained in other areas.
- Review locations and availability of influenza clinics to determine if the schedule meets the needs of the employees. Balancing availability for employees and utilization of resources for staffing of clinics is always challenging. Creative alternatives should be explored to meet these two objectives such as having staff on units as influenza champions, and allowing easier access for shift workers to vaccination.
- Establish goals of 60%-80% immunization rates for employees working in high-risk areas (areas with potentially

immuno-compromised patients and residents) through out VIHA. From an infection control perspective the intent of the Influenza Prevention Program Policy is to reduce Influenza transmission especially in high-risk areas.

The high immunization rates that continue to be seen in areas such as Finance, IM/IT Systems and Health Records can possibly reduce absenteeism rates but is of no significance in relation to patient/resident/client safety.

- Increase educational presentations so that employees understand the intent and content of the policy. Education was an important part of the SPH ECU campaign so that staff understood the importance of immunization and the results that low rates can have on the work environment.

Conclusion

Influenza immunization has always been a controversial issue requiring

creative approaches and effective marketing to achieve the desired participation. In order to be successful, influenza campaigns must involve management and other key departments. Early planning is important and must start as soon as the previous campaign concludes. A key component to any plan is communications and meeting the specific cultural needs of individual units. The success or failure of any campaign is in the message that gets to the consumer. In our case, it was important to provide information on the risks and benefits of immunization and influenza outbreaks within VIHA and in particular SPH.

Review of other programs, consultation with managers and employees and a thorough review of all components of the 2007 & 2008 influenza programs will provide the groundwork and building blocks for the development of future programs. A comprehensive communication and novel strategies will continue to be a key component of all future influenza strategies. ●



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ABSTRACT

This article outlines the steps taken to deliver standardized infection control and occupational health training to all healthcare workers across a Canadian health authority, using an online module developed by a multi-disciplinary team. The course had to meet a diverse variety of learner needs, be relevant to day-to-day practice, be accessible, as well as fulfill healthcare guidelines for both infection control and occupational health. The course was designed to be interactive and uses a wide variety of techniques to engage the learner such as video clips describing use of personal protective equipment, and drop-and-drag technology. Since implementation in 2006, the course has been endorsed by stakeholders and used in staff clinical orientations, for residents, for student placements, and for physicians as part of their hospital privileges, as well as healthcare workers across the health authority. Results of the user satisfaction survey (N=280) showed that the course was relevant and simple to navigate. Observations (N=117) of personal protective equipment donning and doffing of staff post-course showed that the module effectively transferred knowledge. Analysis of the interview results (N=50) suggested that making the course required would be seen as an incentive and visible sign of management commitment to safety. Development of the module was instructive both for the learners and the online infection control/education team. The implementation process provided insight into how best to deliver and evaluate healthcare content while ensuring that the product is user friendly. The process underscored the importance of engaging key stakeholders. With this course, learning of infection control principles has been made more efficient and enjoyable.

INTRODUCTION

Consistent application of infection prevention and control (IPAC) principles across the healthcare spectrum has never been more important, particularly with the emergence of SARS, hyper-virulent strains of *Clostridium difficile* (CDAD), pandemic influenza and other communicable diseases. Appropriately applied infection control and occupational health (OH) practices protect patients and healthcare workers (HCWs) from exposure to these and other common health care-associated infections (HAI) such as antibiotic-resistant organisms (ARO). Tools for teaching and reinforcing IPAC practices need to be effective, consistent, and accessible.¹⁻⁶

Unfortunately, the methods used to deliver IPAC and OH information vary across health districts and even within facilities. Demanding workload, shift work and other time constraints limit the amount of IPAC and OH information that can be presented at group sessions, and information on websites or in manuals does not always fully address the educational needs of HCWs on issues such as proper personal protective equipment (PPE) selection and use. Computer-assisted learning has the potential to overcome these limitations through multi-disciplinary course design, self-paced learning, flexibility in scheduling time to learn, and by breaking down the barriers of geographical location, hours of work, and professional domains.

This article outlines the steps taken to deliver standardized IPAC and OH training to all HCWs across a Canadian health authority, using a multi-disciplinary team, from a variety of health settings. The goals of this team were to: (a) create a module that was relevant to day-to-day practice, accessible, clearly understood, consistent, and effective in transferring

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knowledge; (b) achieve acceptance and regular use of the course; and (c) demonstrate that the course transferred knowledge effectively.

PLANNING

The online infection control module was developed collaboratively, in a multi-agency team consisting of educators, professionals from IPAC, OH, and continuing medical education. The team agreed that: 1) healthcare acquired infections and outbreaks must be efficiently controlled; 2) training of all staff in infection control principles and routine practices is imperative, and would be one useful way of preventing transmission; and 3) any course outcomes should match the overall infection control program expectations for healthcare worker competencies.

In order to develop an appropriate intervention that would meet a diverse variety of learner needs, as well as fulfill healthcare guidelines for both infection control and occupational health, the team had to collate many resources and confirm their philosophical approach to the proposed training. The team used:

- Educational evaluations from previous Infection Control educational programs.
- Staff orientation reports, from the Health Authority Employee Engagement department.
- Business intelligence on the numbers and occupational distribution of staff.
- Infection Control and Occupational Health guidelines from the Public Health Agency of Canada (PHAC), and WorkSafe BC.
- Evidence on trends in infection control education from literature searches of peer-reviewed medical journals.
- Fact-finding discussions with medical schools, nursing colleges, and allied health professionals regarding the presence of infection control and occupational health material in their programs.

- Advice from content experts and policy decision-makers.
- Literature review of best practices in self-paced online learning and adult education.
- Baseline annual rates of *Clostridium difficile* (CDAD), *Methicillin Resistant Staphylococcus aureus* (MRSA), *Vancomycin Resistant Enterococci* (VRE) in acute care facilities as documented in Infection Control reports and the Canadian Nosocomial Infection Surveillance Program.

CREATION OF THE MODULE

Content for the module was originally developed by four members representing IPAC and OH and then disseminated to a larger group of Infection Control Professionals (ICPs), Occupational Health Professionals (OHPs), educators and physicians for critical review. The learning outcomes of the module were: 1) be aware of the importance of infection control; 2) be familiar with and apply routine infection control precautions as part of daily practice; 3) know how and when to use personal protective barriers; and 4) be able to describe the various types of isolation.

The course was designed to be interactive and uses a wide variety of techniques to engage the learner such as video clips describing appropriate selection and use of PPE, drop and drag technology and animation (Figures 1-3). The module chapters are: 1) Basic principles of Infection Control; 2) Hand Hygiene; 3) Personal Protective Equipment; 4) Body Fluid Exposures and Clean Up; and 5) Isolation. Learning is self-paced and the modular format allows learners to enter, exit and repeat any point in the course (through bookmarks). Learners are guided through the chapters with clearly marked navigation buttons including help buttons. The module is hosted on the Vancouver Coastal Health Authority Course Catalogue Registration System, which allows each learner to access their educational record and permits tracking of participants.⁷

IMPLEMENTATION

In 2004-2005, a multi-site pilot was conducted (in acute, long term, and community settings with funding by the Canadian Nursing Advisory Council) to analyze the technical and delivery challenges for the module as well as knowledge transfer of content. Revisions and improvements to the module were made based on user feedback, and then launched on the learning management system in March 2006. In addition, a Canadian Institutes of Health Research grant was received, permitting a detailed evaluation of the module over time (from 2005 to 2008). Ongoing evaluation resulted in a third revision to the module in March 2008, including a more rigorous pre and post quiz. At that time, the team assigned joint copyright and licensed the course through the Creative Commons™ so that the module could be shared with other healthcare providers.

OUTCOMES

As part of the planning phase, four outcomes were identified as indicators of success of the online learning project. These were: a) obtain and demonstrate acceptance by key facility stakeholders; b) assess, evaluate and document improvement in infection control knowledge after course completion; c) document user satisfaction post-course; and d) increase the number of HCWs that are taught the basic principles of infection control.

a) Obtain and demonstrate acceptance by key facility stakeholders:

Endorsement to support the on-line course was sought from various internal departments and partnership agencies in an effort to not only achieve but also demonstrate acceptance by key facility stakeholders. Vancouver Coastal Health (VCH) Learning and Development provided an hour of dedicated computer time for the online course as new staff clinical orientation sessions while the Health Services Placement Network of British Columbia made the course required reading for nursing and

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allied health student placements. The Dean's Office for Undergraduate Education at the University of British Columbia required that the course be completed prior to the third year of a medical student's clinical rotation and the Medical Residency Committee made the course a component of the residents' Final In-training Evaluation Report. The College of Registered Nurses of BC accepted the course for professional development credit towards recertification and the Canadian Council on Health Service Accreditation (Accreditation Canada) cited the course as a "leading practice".⁸ The team of infection control, occupational health and education experts, who developed and implemented the course, has won a 2008 Award of Merit for collaboration, from the Health Employers Association of British Columbia.

Physicians are one of the health-care professions known to have less compliance with infection control practices.⁹⁻¹² As noted by Fordis et al., evidence indicates that online learning is increasing among physicians, and that online continuing medical education can produce changes in physician knowledge comparable to those achievable with appropriately designed live interventions and changes in behaviour that have an impact on patient care.⁵ Physicians can also serve as important role models for other members of the healthcare team.¹³

Therefore, including physicians in the same policies that apply to other health professionals was felt to merit serious consideration. This was supported by the regional Medical Advisory Committee who mandated the course as part of yearly physician privileges. The University of British Columbia Department of Continuing Professional Development approved the course for Royal College Maintenance of Certification (section 1; 2007) physician credits providing additional incentive for doctors to complete the module.

b) Assess, evaluate and document improvement in knowledge after course completion:

Several targeted approaches were used to evaluate the course and to assess the quality of the project. These included quizzes/tests and observations of participants. The pre- and post-test results demonstrated a statistically significant increase in post-test scores (pre-average = 18.2, post-average = 21.8, $p < 0.01$). There were no significant differences in scores when stratified by age, occupation, or years of experience.¹⁴⁻¹⁵

During clinical orientation sessions for new hospital staff, 117 participants were asked to apply either airborne, droplet or contact precautions during mock clinical scenarios prior to and immediately after taking the online

module. HCWs were evaluated in a realistic setting for their ability to select the appropriate PPE, as well as don and doff the equipment in the correct sequence without contaminating themselves. It was found that the module effectively transferred knowledge on both PPE selection and sequence of putting on and taking off equipment. The greatest improvement in PPE selection was in the droplet scenario group, the most complex of the clinical situations. An overall improvement (35%) for all clinical scenarios was found in those HCWs with less than one year's experience. Interestingly, the course had the added benefit of increasing awareness of the importance of hand hygiene in all professions regardless of years of experience.¹⁶⁻¹⁷

c) Document customer satisfaction post-course:

A generic user satisfaction survey was employed as well as a survey specific for determining content relevance, intent to comply with infection control procedures after taking the course, and barriers, and facilitators to adhering to IC best practice. Results of the user satisfaction survey (n=280) showed that the course was relevant, enjoyable, and simple to navigate.¹⁴⁻¹⁵ The module was considered effective, able to sustain the participant's interest and indeed, scored high on almost all aspects of user satisfaction. Of note,



Figure 1: Infection Control Basics module (example of drag and drop activity)



Figure 2: Example of participant paced learning (cursor-driven explanations of hand hygiene)



Figure 3: Example of embedded video demonstrations

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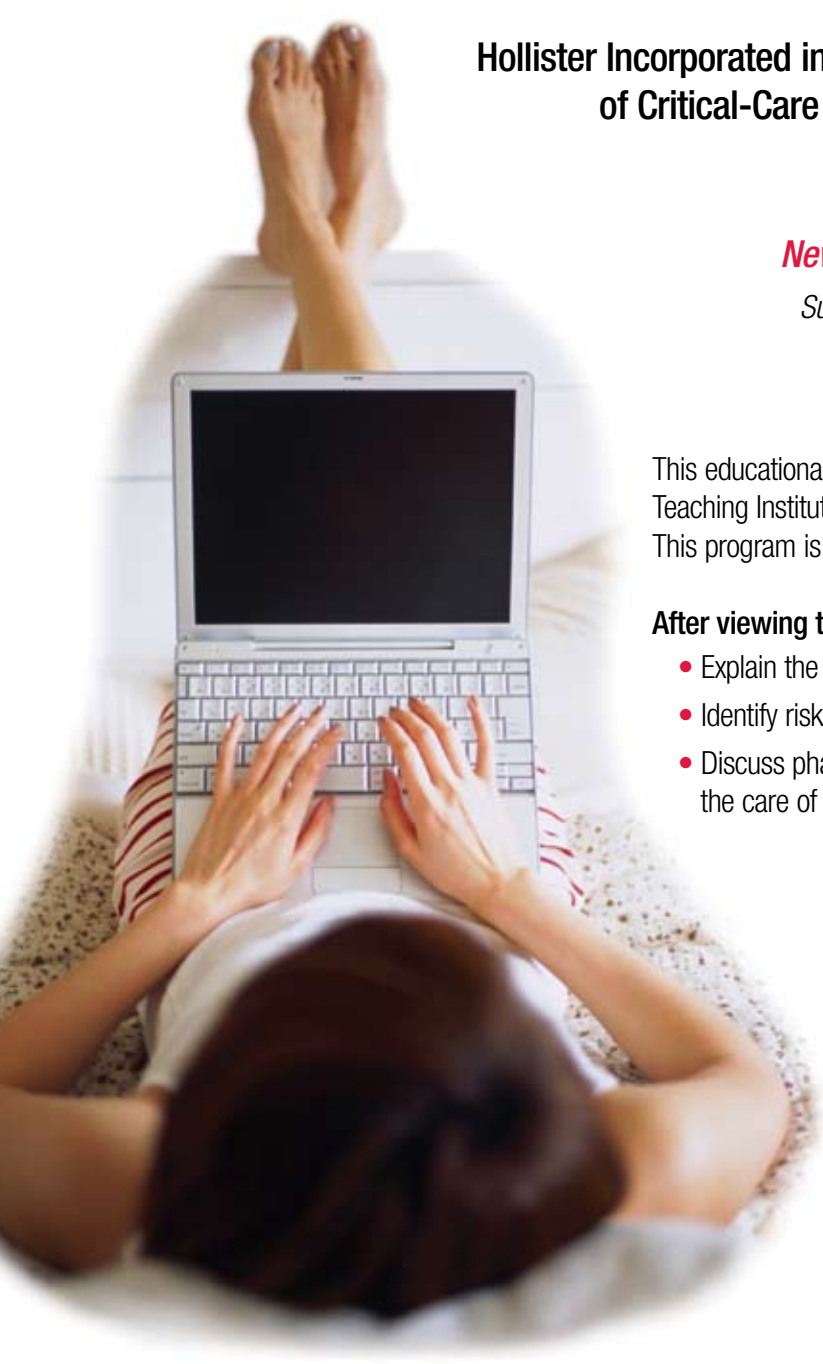
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those who were mandated to take the course stated that they were more likely to comply with infection control guidelines and rated the safety climate in their organization as higher than those who took the course voluntarily, suggesting that mandatory course completion should only enhance the facility's safety culture.

Key informant interviewees (N=50), praised the module's utility as both a refresher on IPAC and as a means of delivering new content. Barriers to engaging in online education cited by interviewees included high workload, limited availability of computers, and limited technology based skills. The lack of time available at work to engage in education was identified as a pervasive organizational barrier. Analysis of the interview results suggested that making the course required (seen as an incentive and visible sign of management commitment to safety), providing dedicated time to complete the course, and ensuring that computers were available to take the module were important measures in ensuring that HCWs completed the course.¹⁸⁻¹⁹

d) Increase the number of HCWs who are taught the basic principles of infection control:

Our target was to increase the number of learners accessing infection control knowledge by 25% (N=300 additional learners/year compared to 1500 HCWs reached by five minutes of traditional teaching at orientation). The team thus increased the uptake of new learners by a very gratifying 900 additional personnel a year, far in excess of the original target of a 25% increase. Importantly, the material covered was much more comprehensive and learners were provided with the ability to self-assess through online quizzes.

CONCLUSION

Development of the module was instructive both for the students and the online infection control/education

team. During the development process, knowledge regarding delivery of healthcare education using web-based technology and techniques, and the use of learning management systems to convey material to a wide audience was enhanced throughout the region. The implementation process also provided insight into how best to deliver and evaluate healthcare content while ensuring that the product is user friendly. It also underscored the importance of engaging key stakeholders, documenting their endorsement of the course, and ensuring that the various professions were aware of this support. User feedback illustrated the importance of careful construction of quiz questions to accurately reflect course content and participant learning. Receiving the grant to assess the module was critical in evaluating the key indicators, as fiscal restraints within the region would have otherwise made this impossible.

Learning of infection prevention and control principles has been made more efficient, economical, effective and enjoyable, while minimizing the barriers of varying professional needs, geographic barriers and time-constraints. The overwhelmingly positive response to the on-line module has spread outside our Health Authority boundary – the module is now being used in other facilities – leading the team to believe that, at least in this case, learning is contagious.

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3M Canada Infection Prevention Research Grant

As part of an ongoing initiative to promote innovative infection control and prevention practices in Canadian health-care, 3M Canada has created a research grant through its Infection Prevention Platform. The research grant is targeted to individual members of the Community and Hospital Infection Control Association – Canada (CHICA–Canada) for use in research studies. The research grant will be a one-time payment offered on an annual basis.

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An application form is available at www.chica.org. Deadline date for applications: March 1, 2009. ●

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Board of Directors elected



Anne Bialachowski, RN, BN, CIC
President-elect (one-year term)

Anne Bialachowski has been a CHICA-Canada member since 1997 and was Chapter President of CHICA HANDIC in 2004-2006. In her current position

as Network Coordinator for the Central South Infection Control Network, she contributes to and maintains the regional network infrastructure; creates, promotes and fosters formal working relationships with stakeholders throughout the region; and assists the Network Steering Committee in developing strategic direction that is clear, measurable and fits within the regional needs. She provides direct supervision to the four Network staff. Prior to her current responsibilities, she was an Infection Control Practitioner at Hamilton Health Sciences Centre.

She has been a member of the Ontario SARS Scientific Committee in 2003, Chair of the Ontario Regional Infection Control Development Working Group, and a member of the Ontario Provincial Infectious Diseases Advisory Committee (2004-present).

Philosophy: CHICA-Canada and its chapters provide a strong national voice for infection control across the continuum of care. Its dedication to the development and implementation of Infection Prevention and Control (IPAC) best practices have made the organization a recognized source of expert information and advice. As provincial governments move to implementing patient safety indicators and public reporting CHICA-Canada will need to ensure that their voice continues to be heard in the emerging cacophony of information and government legislation. I am committed to supporting the existing cooperative network of providers in our CHICA Chapters who are dedicated to improving the prevention and control of infections. Our chapters are our strength and it is through them that we will mentor and develop the next group of IPAC professionals. I am also committed to the promotion of excellence, integration and continuous improvement in infection prevention and control activities across the healthcare spectrum and will support the on-going growth of interest groups that support areas where IPAC information continues to evolve such as community settings. I look forward to my term on the

board with some trepidation and tremendous excitement. I am honoured to have been appointed president-elect and I look forward to working with the board and membership.



Judith (Judi) B. Linden, RN, BN, COHN(C), CIC
Director of Finance (three-year term)

Judi Linden is an Infection Control Professional at the Regional Health Authority of Central Manitoba, located in Portage la Prairie. She has been in infection control

for 25 years and a member of CHICA-Canada for 18. Since joining the RHA in 1999, her responsibilities have been to identify infection prevention and control training and education needs for all health care settings; to plan, develop and provide programs designed to meet the needs; maintain the regional *Infection Prevention and Control/Occupational Manual*; coordinate regional surveillance programs; act as IP&C resource to RHA Central programs; investigation and management of outbreaks; and follow-up of all occupational exposures to blood and high risk body fluids in accordance with Manitoba Health's Integrated Post-Exposure Protocol.

A founding member of the Provincial Network of Infection Control Practitioners, Ms. Linden chairs the Central Manitoba RHA Infection Prevention and Control Committee and is a member of several health promotion and wellness teams. She is Past President of CHICA Manitoba and has held several executive and committee positions in that Chapter, including Treasurer and Finance Committee Chairperson.

Philosophy: Working in infection prevention and control within a rural setting is challenging. CHICA Canada and the MB Chapter have allowed me to become involved with a passionate and accomplished group of Infection Prevention and Control Professionals. These mentors have been, and continue to be, of great value and assistance to me, demonstrating leadership while promoting the prevention and control of infection. As CHICA has supported me through the years I believe it is important to give back to the organization. I have been able to assist the MB Chapter as Treasurer and Finance Committee Chairperson for nine years and now I look forward to the challenge of Finance Director for CHICA-Canada. I believe the infection prevention and control challenges ahead will be less daunting through the collaborative efforts and commitment of members involved locally and as well nationally. Ongoing financial support

from members through membership fees and conference involvement together with support from our industry partners will allow us to move forward as an organization in the commitment to improve health and promote excellence in the practice of infection prevention and control.



**Michael Gardam,
MSc, MD, CM,
MSc, FRCPC
Physician Director
(three-year term)**

Michael Gardam completed his undergraduate degree, master's degree, and medical school training at McGill University in Montreal. He completed training

in internal medicine and infectious diseases and became a Fellow of the Royal College of Physicians and Surgeons of Canada in infectious diseases in 1998.

He subsequently moved to Toronto to complete additional research training in infection prevention and control and completed a second master's degree in Health Policy, Management, and Evaluation at the University of Toronto in 2003.

Dr. Gardam has been Medical Director of the tuberculosis clinic at the Toronto Western Hospital since 2000, and Director of the Infection Prevention and Control Unit at the University Health Network since 2001. He is an assistant professor of medicine and faculty at the School of Public Health Sciences at the University of Toronto. He is

a member of the Community and Hospital Infection Control Association Canada (CHICA) and the national lead for the *Safer Healthcare Now!* MRSA intervention. In 2008, Dr. Gardam became the Director of infectious diseases prevention and control at the newly formed Ontario Agency of Health Protection and Promotion.

Dr. Gardam has acted as a consultant on infection control issues such as SARS, tuberculosis, pandemic influenza and *C. difficile*, at the provincial, national and international level. Within Ontario, he has helped a number of hospitals control outbreaks and develop their infection control programs. In terms of pandemic influenza, he is co-chair of the Toronto Academic Health Sciences Network pandemic influenza planning task force as well as a member of numerous provincial and regional pandemic planning committees.

Dr. Gardam's research interests include the molecular and clinical epidemiology of infectious diseases, as well as health policy and program evaluation.

Philosophy: Patient safety has fortunately become a hot-button issue over the past decade, and finally, there is growing acceptance of healthcare-associated infections as true, often preventable adverse events. We all know the important role we have played in this. If it weren't for our strong Canadian approach to infection prevention and control over the years, I believe our national situation would be far worse; however, our frequent reliance on pushing and cajoling will only take us so far. Infection prevention and control issues largely continue to remain the domain of ICPs. For our healthcare settings to become safer, infection prevention and control needs to be owned by frontline healthcare workers. We need to explore new ways of encouraging their engagement and helping them discover and implement best practices. ●

The Registered Nurses' Foundation of Ontario Molson Canada SARS Memorial Fund providing grants to ICPs

The SARS Memorial Fund for Infection Control Practitioners is a tuition/certification/professional development reimbursement program funded by Molson Canada SARS Concert (2003) and supported by the Ontario Ministry of Health and Long Term Care.

RNFOO manages the SARS Memorial Fund, initiated in January 2005. The fund provides grants to Infection Control Practitioners **from any discipline** to support them in advancing their knowledge to lead infection control practices within their healthcare settings. Grants can be applied to continuing education, certification/re-certification and professional development.

The fund of \$175,000 is to be administered over three years, allowing for the allocation of approximately \$58,000 per year in support of individual pursuing formal education and certification in the area of infection control. ●

See www.rnfoo.org for details.

News from CBIC

By Deanie Lancaster

New self-achievement test available soon

The Certification Board of Infection Control and Epidemiology has been very busy this year. The Test Committee has worked to produce a new computerized Self-Achievement-Recertification-Examination which will be made available as an option for those who are recertifying during spring of 2009. Since the SARE is a self-test, an attestation statement from the candidate will be required stating the answers are solely the work of the individual completing the test. The computer-based test (CBT) will continue to be available at testing sites in the US and internationally.

Revised wording on CIC certificates

Infection Preventionists (IP) who have recertified this year will notice a change in the wording on the certificate. The phrase "Board Certified in Infection Prevention and Control" replaces the previous wording as a step toward congruency with the changes made by APIC this past summer. Additional changes to the CBIC name or designation of CIC are not planned now but may be revisited in the future.

Elimination of the two-year practice requirement

CBIC members voted unanimously to eliminate the two-year practice requirement for taking the initial certification examination. Job responsibilities and tasks must still include those required for the clinical practice of infection prevention and control. Additionally, the initial examination will still be aimed at the two-year IP. All material related to the two-year practice requirement is undergoing revision and will be available after January 1, 2009. There are no changes related to recertification examinations.

Practice analysis participation

The announcement by CMS that US hospitals will no longer be reimbursed for certain hospital-acquired conditions, including three infections, has intensified the need to concentrate on prevention. Our practice is changing at warp speed and we find we must continually reassess and update our knowledge of what is included in our day-to-day activities related to infection prevention and control. Due to the evolving nature of our work, CBIC is considering soliciting your participation in a Practice Analysis during 2009. The importance of your participation in this project cannot be overemphasized because the findings of the Practice Analysis are used to develop the certification examination questions. We will need to know the activities and knowledge required of you and your peers, so please watch for future information about the Practice Analysis.

Certification and you

This past summer in Denver, I attempted to make the case for the importance of certification in infection prevention and control. Some of the examples I used were from the American Association of Critical Care Nurses (AACN), the American Board of Nursing Specialties (ABNS), and the American Society for Clinical Pathology (ASCP). Each of these organizations actively promotes certification of their members as a way to distinguish their dedication to continual improvement and a sense of professional accomplishment and credibility. According to the AACN, ABNS, and ASCP, some of the other reasons for becoming certified include:

- "State licensure provides the legal authority for an individual to practice nursing; certification...reflects achievement of a standard beyond licensure for specialty nursing practice." (ABNS)
- "Better job prospects, higher salaries, the respect of your colleagues, the confidence from knowing you're fully qualified to be a top-notch laboratory professional... ultimately the benefit is of course, the quality of care that patients receive." (ASCP)
- "Certification can serve as a proxy for assessing continued competence since a nationally recognized standard to do so has not been developed." (AACN)

The American Nurses Credentialing Center website states that "Certification validates specialty knowledge, experience and clinical judgment." The Canadian Nurses Association defines certification as the "periodic process by which an organized professional body confirms that a nurse has demonstrated competence in a nursing specialty by having met the predetermined standards of that specialty."

CBIC receives a number of questions about why the examination is required every five years rather than through the use of continuing education. Continuing education is not the same as competency; competence is an ongoing process requiring repeated measurement. There are advances in treatment and technology we must be familiar with and no oversight system exists to ensure continued growth in knowledge, skills and performance.

Most of you are likely familiar with Drs. Elaine Larson and William Rutala who are internationally recognized for their published research on topics related to infection prevention and control. Dr. Larson also edits the American Journal of Infection Control (AJIC) is the Associate Dean for Research and Professor of Pharmaceutical and Therapeutic Research at Columbia University School of Nursing. Dr. Rutala is a Professor of Infectious Diseases at the University Of North Carolina (UNC) in Chapel Hill and also serves as Director of Hospital Epidemiology for the UNC Hospitals. Barbara Soule, who was the APIC President in 2003, now serves as the Practice Leader in Infection Prevention and

Control for Joint Commission Resources. She was also the first Editor in Chief of the APIC Curriculum and continues to serve on the AJIC Editorial Board. You will likely have heard Louise Kuhny's name mentioned in association with The Joint Commission. She is the Senior Associate Director of Standards Interpretation at The Joint Commission and has an MPH and an MBA.

What do Drs. Larson and Rutala, Barbara Soule and Louise Kuhny have in common? All of these well-known individuals are board certified in infection prevention and

control. Why do they continue to maintain their certification when each could probably rest on their past successes? They respect the certification process and value the knowledge mastery it represents to their colleagues.

During the coming year, I encourage you to consider taking the certification examination. Who wouldn't want to be among those listed as certified in infection prevention and control along with all these well-respected individuals? ●



Save the date

Canada's Forum on Patient Safety and Quality Improvement

April 28-30, 2009

With the increasing national and international focus on patient safety, the need for a broad forum for learning has been identified. Canada's Forum on Patient Safety and Quality Improvement will provide multiple learning streams with a national and international flavour. The program for the forum will provide opportunity for a variety of professionals to participate, including, but not limited to, physicians, nurses, pharmacists, health care providers, educators, leaders, researchers, and board members.

A few of the exciting speakers you will see at this event are: Helen Bevan, Director of Service Transformation, NHS Institute for Innovation and Improvement; Lise Mathieu, Retired Major General, Canadian Forces; Commander of the Canadian Forces Health System.

The streams for the forum will fall under the following areas:

- Applied Learning
- Infection Prevention and Control
- Medication Safety
- Patients and Family Involvement
- Patient Safety in Physician Practice
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Member Profile: Ramona Rodrigues, ICP investigator

Working as a nurse on the infant medicine unit at Montreal Children's Hospital got Ramona Rodrigues interested in infection prevention and control. The McGill Infection Prevention and Control Program manager and assistant professor was often the nurse in charge, and also worked as a preceptor, so she got to work closely with the specialists and consultants on the ward. One of these specialists was the ICP.

"I always worked very closely with her, and she really got me interested in infection control," says Rodrigues. "One day she told me her position was coming up, and asked if I was interested in applying. I got the job, and that's how I got involved."

At the time, there were not any IC courses offered in colleges or universities, so she was sent to the CDC in Atlanta for training. "That was even more exciting to me; I couldn't believe I was being sent there."

Always interested in learning and getting involved, Rodrigues got involved with Health Canada working groups. "This was around the time of blood-borne pathogens at the time of AIDS and figuring out who was implementing what kind of precautions – disease-specific isolation – universal vs. body substance isolation." Then came her involvement with Quebec's expert group drafting guidelines and working on the provincial surveillance program.

Rodrigues also pioneered with her

Montreal colleagues the local CHICA chapter. "At the time, we felt the best way to get Quebec on board with CHICA was to create a Montreal chapter." She was on the chapter executive from the beginning until last year.

"The early days of infection control were tough. It took a lot of hard work to be recognized. We weren't given the same recognition as clinical nurse specialists. Risk management and quality assurance weren't being discussed then. It was hard to convince people to implement prevention strategies."

Rodrigues credits her experience in pediatrics for her smooth transition to adult care in infection control. She found that in pediatrics, people were more willing to listen and participate in making life for the child and family easy. In adult wards, she didn't find the same willingness to look at risk and prevention. "I'm so glad I started off in pediatrics, because you get a sense people are listening to you. They integrate your recommendations even though it was not vocalized in the media or in guidelines. It gave me understanding of behaviour change, so I had a tool in my back pocket when I moved to adults."

Outbreaks over the years have created an impetus for infection prevention and control to be seen as significant and important, Rodrigues says. She got involved in getting IC recognized as a specialization with the Order of Nurses of Quebec. The order recognized the specialization

last year. It is now up to the ministry to grant a pay scale and title.

"We've convinced the order, the order has obtained the health minister's agreement to recognize the specialization. Now we have yet to convince the ministry to set a separate pay scale and title for the specialization. It's frustrating when the rest of Canada is not where we'd like to go. It's a tough battle, but I hope to see this happen in my career."

Rodrigues believes ICPs are specialists and should carry the master's degrees skill sets. It takes five years of experience to fully understand the profession. Quebec also has some differences with regards to the profession. "In Quebec, only nurses can be ICPs and the order has made this statement clear."

Behaviour change is the biggest issue facing ICPs today, says Rodrigues. "Knowledge isn't the issue. People are knowledgeable about hand-washing, etc. Time and workload overtake behaviour. The challenge is to endorse preventive behaviour practices."

Life as an ICP is never boring. "It's like being an investigator," she says. "You meet professionals from the hospital CEO to the volunteers and construction workers. You visit every part of the hospital from the attic to the sub-basement. You have to know about ventilation and building function. The job is not about sitting and collecting data. That's part of it, but you have to see the bigger picture. And how you use the data is exciting." ●

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Dr. Lynn Johnston receives Gold-Headed Cane Award



In September, Dr. Lynn Johnston of Halifax received the Gold-Headed Cane Award for medical professionalism from the College of Physicians and Surgeons of Nova Scotia.

Dr. Johnston is an infectious disease specialist, and has been a faculty member of the Dalhousie University Department of Medicine since 1987. She is Professor of Medicine and Division Chief, Infectious Diseases and Hospital Epidemiologist at the Capital District Health Authority, works with the department of Community Health and Epidemiology, and consultants at the IWK Health Centre. Dr. Johnston is a former CHICA-Canada board member.

Dr. Johnston advocates evidence-based medicine and maintains high clinical standards. She is a respected voice of the profession and is highly regarded by her patients, peers, students, and co-workers. She has achieved national recognition as a leader, and is passionate about education and research.

The Gold-Headed Cane is awarded jointly by the College and the Humanities in Medicine Program at Dalhousie University. The award recognizes a Nova Scotia physician who exemplifies selflessness, excellence, service and integrity in the practice of medicine. ●

Roadshows announced

CHICA-CANADA is pleased to continue its partnership with BD Canada to provide a series of educational webinars and roadshows. BD and CHICA-Canada will launch a multi-pronged educational leadership initiative, to include national webinars and regional road shows, to help with CHICA-Canada's commitment to the reduction of *Clostridium difficile* (*C.diff*) and educate on the topic of *Catheter-Related Blood Stream Infections* (CR-BSIs) in Canada.

Following the success of the 2008 MRSA series, a new schedule of roadshows and webinars has been planned to provide information around current issues in infection prevention and control. The roadshows/webinars are designed to educate healthcare professionals and healthcare administrators on decreasing the rate of healthcare-associated infec-

tions with the focus on *Clostridium difficile* (*C.diff*) and *Catheter-Related Blood Stream Infections* (CR-BSIs). Participants will gain knowledge and access to information that is accurate, timely and useful for infection prevention and control practices within each of their institutions.

In early 2009, roadshows will be held in Halifax (Friday, February 20; venue to be announced) and North Bay (venue and date to be announced). The programs will feature nationally recognized infection prevention and control professionals and physicians/microbiologists discussing the consequences of healthcare-associated *Clostridium difficile*, an increasingly prevalent and deadly organism in healthcare facilities.

In addition, CHICA-Canada and BD will host a series of national webinars (tentatively scheduled for January, February and March 2009). The focus of the webinars will be *Catheter-Related*

Blood Stream Infections (CR-BSIs).

CHICA-Canada President Marion Yetman said, "The success of the 2008 MRSA seminars is evidence of the need for these types of educational opportunities. CHICA-Canada is pleased to be able to provide these events to its members and colleagues through a strong collaboration with BD."

The roadshows/webinars program, sponsored by BD (Becton, Dickinson and Company), is aimed at both clinicians and healthcare executives faced with the clinical and financial impact of *C. diff* and CR-BSIs in their facilities.

"BD is proud to work jointly with CHICA-Canada on this important initiative," said James Glasscock, Country General Manager of BD. "As it is central to our commitment at BD to prevent healthcare-associated infections and help all people live healthy lives."

For further information, visit www.chica.org ●

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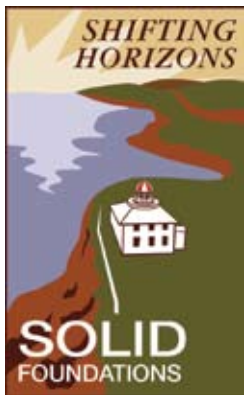
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2009 NATIONAL EDUCATION CONFERENCE

REGISTRATION BROCHURE

Watch for the Registration brochure to be posted in December 2008 and mailed in January 2009.

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Individual reservations: 1-800-268-1133. Identify the Community and Hospital Infection Control Association (CHICA). Deadline: March 13, 2009.

2009 EDUCATION CONFERENCE EXHIBIT AND SPONSORSHIP OPPORTUNITIES

An Industry Showcase will be held to give attendees the opportunity for further knowledge and education through viewing and discussion of products and services in the field of infection prevention and control. Exhibit information packages will be available in the autumn of 2008. Booth rentals are \$1,800 each (6'x10' booth) plus GST. **Set up: Monday, May 11; tear down Wednesday, May 13.**

Guidelines for sponsorship of the conference are available from CHICA-Canada. Sponsors of the conference benefit from additional promotion of their company as well as direct benefits through discounted booth fees, complimentary registration, and the opportunity to hold a mini symposium with specific product information. For more information, contact CHICA-Canada Conference Planner.

RALLY IN THE ALLEY

Wednesday, May 13, 2009

You will be accompanied from the Delta St. John's to famous George Street where you will: Experience the fun and camaraderie of St. John's. Enjoy a lobster dinner,* learn local step

dancing, learn some local songs and be welcomed into the Order of Screechers! It is a time to be remembered for years to come.

Fee \$95.00 per person (includes HST) Fees include: Lobster Dinner, entrance to pubs, one complimentary beverage at each location, a shot of Screech, musicians to lead each group, and entertainment at each venue.

*Chicken or vegetarian alternates available on request (See Registration Form January 2009). (Lobster is traditionally served cold – banquet style).

SIGHTSEEING TOUR

City of Legends – The Far East of the Western World
Tuesday, May 12, 2009

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\$50 per person plus HST (includes a brown bag snack)

Visit the National Park at Cape Spear, the most easterly point of land in North America. See the original lighthouse portrayed in the conference logo. Stand with your back to the Atlantic and face every other being in North America – or turn your back on them. The choice is yours!

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House, and the history surrounding the Colonial Building. Discover the history, legend and lore of St. John's, the oldest community in North America.

OPENING SPEAKER, Tuesday, May 12
Linda Duxbury

You, Me and Them - Understanding Generational Differences In The Workplace

CLOSING SPEAKER, Thursday, May 14
Michael Borg M.D., M.Sc. (Lond), DLSHTM, MMCPATH President, International Federation of Infection Control
Overcoming Limited IP&C Resources: How IP&C is established and sustained when resources are limited – a global view.



CHICA-CANADA STRATEGIC PLAN 2010-2015

CHICA-Canada is currently in the process of preparing for the next phase of strategic planning, the 2010-2015 objectives.

In 1989, a five-year strategic plan was established. The board and chapter presidents have reviewed and updated the plan regularly with major changes in the format occurring in 2000 and 2004. The 2010-2015 revision will require major input from both internal and external stakeholders. To assist with this project, Dr. David Sheridan of Oakville, Ontario has been contracted to facilitate the project in liaison with Gerry Hansen, Executive Administrator.

Preparation for strategic planning discussions will include surveys and interviews with representatives of membership, industry partners, and external stakeholders. The board and chapter presidents will participate in a two-day strategic planning retreat to take place May 7-8 immediately preceding the 2009 National Education Conference. The proposed approach calls for a well-researched, inclusive and conceptually grounded process leading to a strategic plan that is relevant, vital, realistic, and supported by the association's internal and external stakeholders.

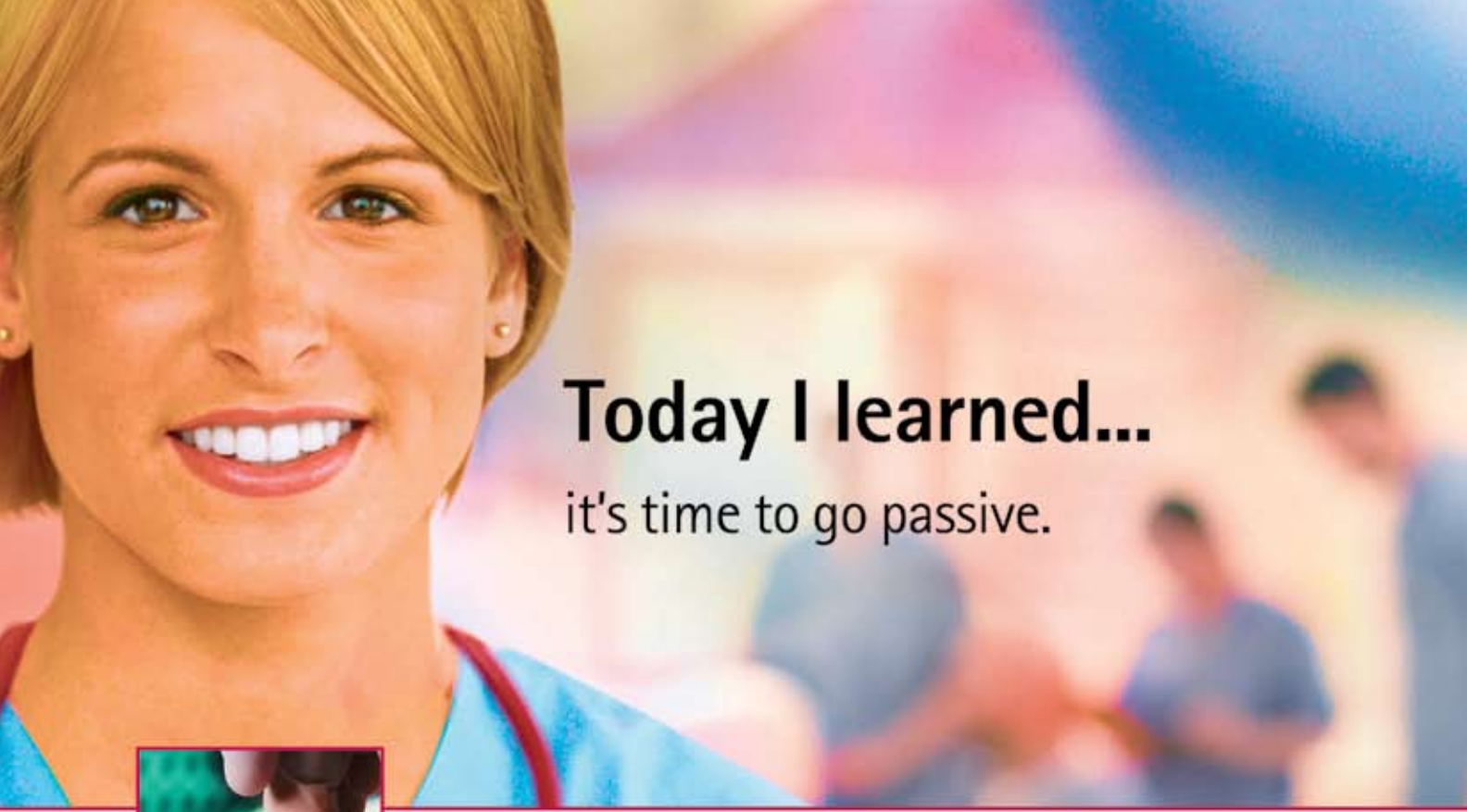
More information on the process of strategic planning for 2010-2015 will be announced as plans progress.

Dr. David Sheridan is a seasoned management consultant, credentialed planner and accomplished process facilitator with an international profile in research, strategic planning and governance for public sector and non-profit organizations. He has a strong background in health care and has worked with countless human service organizations, educational institutions, municipalities, provincial and national associations, networks, community groups, regulatory bodies and all levels of government.



Dr. David Sheridan

His 1998 University of Toronto doctoral thesis on not-for-profit strategic planning won a major international planning award and a prestigious Canadian research award. The unique strategic planning model developed through that research now been adopted by more than 50 not-for-profit and public sector organizations in Canada and the United States, ranging from small volunteer organizations to the government of the State of Maryland. ●



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¹ Perry, Jane. International Healthcare Worker Safety Center. "Preventing Sharps Injuries: Where Do We Stand in 2007?" Presented at B. Braun Medical, Orlando, FL, Feb. 23, 2007. 2003 EPINet data: Of injuries from safety devices, 44% occurred after use and before disposal (potentially preventable if passive or if safety feature activated).

² Mendelson MH, Lin Chen BY, Finkelstein-Blond et al. Study of Introcan safety IV catheter (B. Braun Medical Inc.) for the prevention of percutaneous injuries in healthcare workers [abstract]. Presented at: 13th Annual Meeting of the Society for Healthcare Epidemiology of America (Arlington, VA), 2003.

³ Inuma Y, Igawa J, Takeshita M, et al. Passive safety devices are more effective at reducing needlestick injuries [letter]. J Hosp Infect 2005 (Dec): 61 (4): 360-1.

CHICA-CANADA PRODUCTS

CHICA-Canada Infection Control Audit Toolkit

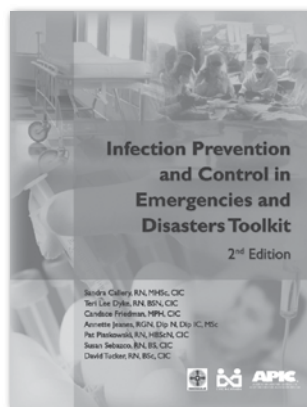
Available from CHICA-Canada through the CHICA-Canada Programs and Projects Committee, this series of infection control audit templates will assist you in your practice of infection prevention and control in a variety of health care settings. Topics include:

- Dental Audit
- Endoscopy Audit
- Haemodialysis Unit Audit
- High Level Disinfection - Outside SPD Audit
- Infection Prevention and Control Risk Assessment Guide
- Hospital-wide Infection Control and Prevention Audit and Template
- Ophthalmology O.R. Cluster Investigation and Procedure Assessment
- O.R. Audit
- Patient/Resident Service Units Audit
- Renal Unit Infection Control Audit
- Respiratory Outbreaks in Long Term Care Facilities Audit

Enhanced Teleclass Recordings on CD

Available exclusively from CHICA-Canada in partnership with Webber Training Inc. Topics include: Disinfecting Patient Care Equipment; Exploring CDC Hand Hygiene Guidelines; Airborne Spread of Human Pathogens; Disinfectants in Infection Control; Hands and the Spread of Human Pathogens; Current Best Practices in Hand Hygiene; Hand Sanitizers and their Effect on Viruses; Innovations in Hand Hygiene; Influenza Pandemic on the Doorstep; Controlling MRSA and VRE; Scientific Solutions to the Norovirus Problem; Strategies for Norovirus Infection Control on Cruise Ships; Relative Impact of Hand Hygiene on Healthcare-Associated Infections; Evidence Behind Control Measures for MRSA and VRE; Environmental Infection Control in Healthcare Facilities; Hand Hygiene – Different Approaches; Antiseptic Practice and Procedure; Glutaraldehyde Toxicology and Management of Risk; New WHO Hand Hygiene Guidelines; Respiratory and GI Outbreaks in LTC; Biofilms in our Environment; Infection Control in Day Care Facilities; Disease Transmission in the Home; Hands and Viral Infections; Infection Control in Long Term Care; Innovations in Hand Hygiene; Preventing MRSA and VRE; Advances in Global Infection Control; Bedside Hand Hygiene Products; C.difficile and Environmental Cleaning; Preventing Ventilator Associated Pneumonia – Applying the Science; C.difficile: Environmental Survival; The Toilet Bowl-Blues; Surface Disinfectants and Environmental Impact; The Spectre of a Flu Pandemic: Is it Inevitable?

ESBL TOOLKIT



Best Infection Control Practices for Patients with Extended Spectrum Beta Lactamase Enterobacteriaceae – An infection control toolkit developed by the International Infection Control Council (APIC, CHICA-Canada, ICNA (UK, Ireland)).

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video aimed at school-aged children. Great for school projects, seminars and demonstrations.

The Infection Control Toolkit: Infection Control in Emergencies and Disasters

revised 2007 (formerly: Infection Control Toolkit: Strategies for Pandemics and Disasters)

The only disaster planning document that presents information specific to the key issues of infection control. Includes all the tools and materials necessary for surveillance, education, communication, laboratory, and management of personnel and patients are included. Handy forms, references, fact sheets, flowcharts, checklists, and samples provide the framework to interface with health-care facilities and local public health preparedness plans. No other disaster planning document presents information specific to the key issues of infection control.

ARO VIDEO

A 15 minute educational video covering topics related to AROs (epidemiology, surveillance and control). Produced in cooperation with Wyeth, with assistance from CHICA-Canada members.

CHICA-CANADA Product Order Form



No returns except in the case of defective products when defective product will be exchanged for corrected product.

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