Vol. 21 No. 4
Winter 2006

CHICA-CANADA

INSIDE:

The Canadian Journal of Infection Control

Revue canadienne de prévention des infections

Publications Mail Agreement #40065075
Return undeliverable Canadian addresses to:
CHICA Canada
P.O. Box 46125, RPO Westdale, Winnipeg, MB R3R 3S3
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The Canadian Journal of

INFECTION CONTROL

Revue canadienne de prévention des infections

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.

The Canadian Journal of Infection Control is the official publication of the Community and Hospital Infection Control Association (CHICA)-Canada. The Journal is published four times a year by Craig Kelman & Associates, Ltd. and is printed in Canada on recycled paper. Circulation 3000.

ISSN - 1183 - 5702

Indexed/abstracted by the Cumulative Index to Nursing and Allied Health Literature, SilverPlatter Information Inc. and the International Nursing Index (available on MEDLINE through NLM MEDLARS system).

The Canadian Journal of Infection Control is a "Canadian periodical' as defined by section 19 of the *Canadian Income Tax Act*. The deduction of advertising costs for advertising in this periodical is therefore not restricted.

SUBSCRIPTIONS
Subscriptions are available from the publisher at the following rates:
All Canadian prices include GST. Prices are listed as personal/institutional.
Canada: $30/$38 (GST # 100761253); USA (in US funds): $28/$36;
Other countries: $45/$60.

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Publications Mail Agreement #40065075
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Pat Piaskowski, RN, HBScN, CIC
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Canadian Journal of Infection Control

www.chica.org — A world-class website

Hearty congratulations to our current webmaster Shirley McDonald, her predecessor Adrienne Brown, and others who have been and are responsible for bringing CHICA-Canada to the world stage through our website.

If one was to conduct a Google™ search for 'infection control', the first item to appear is our website with a statement about CHICA-Canada. Clicking on the link to our site will bring the viewer to a wealth of information and links related to infection prevention and control.

The website was established in 1998 with Adrienne Brown at the helm. The website continued to grow and improve and soon became the home for CHICA-Canada documents such as the Annual Reports. Adrienne Brown was honoured with a CHICA-Canada award of merit in 1999 for her work on the creation and development of the website.

In 2001 the face of the website was changed to improve accessibility and navigation.

Our current Webmaster Shirley McDonald was appointed in 2003 and re-appointed as Web Communications Manager in 2006. Shirley continued the improvement of the website through expanding information tools and use of the website increased significantly. A members-only page was developed which has today grown to include access to CJIC articles. In addition, Shirley has been working with the International Federation of Infection Control to maintain an international events page, which brings more credit to CHICA-Canada and acknowledges Shirley's expertise and knowledge.

In 2006 the website underwent another metamorphosis, with a totally redesigned look and improved accessibility. This new look was unveiled at the CHICA-Canada conference in London Ontario. Jim Gauthier is our colleague responsible for the new bulletin board 'CHICA Connections', and Pamela Chalmers is the web designer who brings it all together with appealing graphics and user-friendly maneuvering.

Members of CHICA-Canada and the infection prevention and control professionals around the world now have ready access to all that CHICA-Canada has to offer.

I encourage all members to make www.chica.org their homepage and to access this wealth of information regularly. Check out the members-only section and see all that it has to offer members. Encourage other health care professionals in your workplaces to access the website – they may decide to join CHICA-Canada or at least visit the site regularly for up-to-date infection prevention and control access.

Keep up the good work Shirley, and thanks for bringing CHICA-Canada to the world! ●

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The future looks bright

Karen Hope, BSc, MSc

As the year draws to a close, I am reminded of the old adage that "time flies when you are having fun." If the warp speed passage of 2006 is any indication, I had a very enjoyable year indeed. This is an exciting time for our profession on many fronts, as new interagency relationships are formed and previously existing ones are strengthened. It is essential to move forward with a strong focus on the strategic plan initiatives, in order to maintain a steady course and not get overwhelmed by CHICA-Canada's recent popularity.

The first element of the plan is to expand member services through a variety of methods, including continual enhancement of electronic communication avenues such as the web site. A Chapter President's orientation teleconference, held in January 2006, was evaluated as an important way of connecting the incoming presidents with the Board. It will be provided again in early 2007. Education opportunities have been increased, with the provision of several online courses, including the CHICA-Canada sponsored *Basic Infection Control*, which is currently running during fall 2006/winter 2007. As well, the 2007 Annual Conference in Edmonton promises to provide a challenging and innovative scientific program with something for novice and senior members. Online membership renewal and conference registration are being explored as ways of further streamlining membership services.

Enhancement of CHICA-Canada's profile, both nationally and internationally, is occurring through collaborative relationships with many external agencies, including the Canadian Patient Safety Institute, Public Health Agency of Canada, Safer Healthcare Now, and the Canadian Council of Health Services Accreditation. CHICA-Canada is also involved in new initiatives with existing partners such as APIC and CBIC, and is proud to support fellow member, Carol Goldman, on the IFIC Board. Future goals are to further develop marketing and communications strategies through key messaging and branding.

The third strategic direction of developing entrepreneurial ventures to generate funds is also being actively led forward through the joint committee collaboration of Programs & Projects and GaPac, and is investigating further cultivation of initiatives with industry partners. Review and redesign of the current Patron members program and exploration of increased web site revenue generation are upcoming projects.

Finally, in order to support the accomplishment of these lofty goals, it is critical to enhance the organization's infrastructure. This includes hiring of additional personnel such as an Education Coordinator to manage and expand the *Basic Infection Control* online course and strengthening the organization's administrative office support.

These are dynamic times. To assist in moving the organization forward in this strategic direction, CHICA-Canada is fortunate to have access to the outstanding talents of several new individuals who are joining the Board. Please welcome Marion Yetman, as the incoming President-Elect; Bonnie Henry, Director Standards and Guidelines, and Karen Clinker, Director, Programs and Projects. I look forward to the upcoming year when Joanne Laalo takes over as President, knowing that her enthusiasm and proficiency will guide the organization successfully toward its collective vision. I also want to recognize my fellow outgoing Board members, who served as strong role models through their dedicated and unwavering commitment to CHICA-Canada – Bruce Gamage, Director, Programs & Projects; and Rick Wray, Past President and mentor extraordinaire. Special thanks are also extended to Gerry Hansen, my number one advisor, who guided me through the myriad and sometimes overwhelming responsibilities of the year and ensured that the experience was both rewarding and memorable. ●

L'avenir s'annonce prometteur

L'année tire à sa fin, ce qui me rappelle que le temps passe vite quand on s'amuse et, si la rapidité avec laquelle l'année 2006 peut servir d'indication, je peux affirmer que j'ai vécu une année très agréable en effet. C'est une période exaltante pour notre profession à plusieurs égards, étant donné que nous assistons à la formation de liens interagences et au renforcement d'autres liens. Il est essentiel d'avancer en axant nos efforts sur les initiatives du plan stratégique afin de tenir le cap et de ne pas nous laisser emporter par la popularité qu'a connue récemment CHICA-Canada.

Le premier élément du plan consiste à enrichir les services aux membres par un éventail de moyens, y compris l'amélioration de moyens électroniques tels que le site Web. La conférence téléphonique d'orientation des présidents de section, tenue en janvier 2006, a été considérée comme un mécanisme important qui permet d'établir un lien entre les nouveaux présidents de section et le conseil d'administration; cette activité sera reprise au début de 2007. Les possibilités de formation ont augmenté; en effet plusieurs cours sont donnés en ligne, y compris le cours *Basic Infection Control*, parrainé par CHICA-Canada, qui se donne actuellement à l'automne 2006 et à l'hiver 2007. De même, le congrès annuel 2007, qui aura lieu à Edmonton, promet d'offrir un programme scientifique ambitieux et novateur visant les nouveaux venus tout comme les membres chevronnés. Nous explorons la possibilité d'offrir le renouvellement des cotisations et l'inscription au congrès en ligne pour bonifier encore davantage les services aux membres.

Le profil de CHICA-Canada, tant sur le plan national qu'international, gagne en visibilité grâce à la collaboration avec de nombreux organismes externes, y compris l'Institut canadien sur la sécurité des patients, l'Agence de santé publique du Canada, la campagne Soins de santé plus sécuritaires maintenant ainsi que le Conseil canadien d'agrément des services de santé. CHICA-Canada participe également à de nouvelles initiatives avec des partenaires actuels, tels que l'APIC et CBIC, et est fière d'appuyer une membre de CHICA-Canada, Carol Goldman, au conseil d'administration de l'IFIC. Parmi les objectifs futurs, citons la poursuite du développement de stratégies de marketing et de communication orientées sur des messages clés et la valorisation de la marque.

La troisième orientation stratégique, soit la création de projets d'entreprises dans le but de générer des fonds, est aussi étudiée activement par le comité conjoint Programmes et projets et GaPac. On envisage aussi de cultiver plus d'initiatives avec des partenaires de l'industrie. La revue et la refonte du programme actuel des membres bienfaiteurs et l'exploration d'avenues pour augmenter les revenus tirés du site Web sont d'autres projets à venir.

En dernier lieu, afin de concrétiser ces nobles objectifs, il est essentiel d'améliorer l'infrastructure de notre organisme. Ceci comprend l'embauche d'une personne de plus, par exemple un coordonnateur de la formation qui gérera et enrichira le cours en ligne *Basic Infection Control*, et le renforcement du soutien administratif de l'organisme.

Nous traversons une période dynamique. Pour aider notre organisme à progresser vers ses objectifs stratégiques, CHICA-Canada a la chance de pouvoir compter sur les compétences de plusieurs nouvelles personnes qui font leur arrivée au conseil d'administration. Je souhaite la bienvenue à Marion Yetman, présidente désignée, Bonnie Henry, directrice des normes et des lignes directrices et Karen Clinker, directrice, programmes et projets. J'anticipe avec joie la prochaine année. Joanne Laalo prendra ma relève à la présidence et je sais que son enthousiasme et sa compétence rapprocheront notre organisme de sa vision collective. J'aimerais aussi remercier mes collègues du conseil qui nous quittent. Par leur dévouement indéfectible à CHICA-Canada ils ont été des modèles formidables – Bruce Gamage, directeur, programmes et projets, ainsi que Rick Wray, président sortant et mentor extraordinaire. J'adresse également des remerciements particuliers à Gerry Hansen, conseillère hors pair, qui m'a guidée dans mes innombrables et parfois écrasantes responsabilités tout au long de l'année et a fait en sorte que j'en tire une expérience gratifiante et mémorable! ●

2007 Teleclass Lecture Series

Syed A. Sattar, PhD[a], and Paul Webber[b]; Centre for Research on Environmental Microbiology[a]; Webber Training Inc.[b]

Teleclass Education is a telephone-based, internet supported lecture series, run entirely by volunteers around the world. Funding from corporate sponsors permits a registration fee of just $35 per teleclass per site (not per participant). Some teleclasses are free registration. Healthcare professionals in developing nations are entitled to full access without charge. For more information on Teleclass Education and registrations, refer to **www.webbertraining.com** or **info@webbertraining.com.**

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9 - *The UK Infection Prevalence Survey*, Chris Perry, UK
18 - *Personal Hygiene Measures to Prevent Influenza Transmission*, Dr. Elaine Larson, USA
25 - *Twenty First Century Plagues*, Prof. Robert Prait, UK

February

8 - *Influenza – Of Poultry, Pets and People*, Dr. Corrie Brown, USA
15 - *Fresh Produce and Human Pathogenicity*, Prof. Keith Warriner, Canada
21 - *Infection Control in the Endoscopy Clinic*, Dr. Richard Everts, New Zealand
22 - *Best Practice for Hospital Construction Management*, Andrew Streifel, USA

March

6 - *Tuberculosis in the Modern Age*, Evonne Curran, UK
8 - *Voices of CHICA*, CHICA-Canada Board & Guests
22 - *A Year of Cleaner, Safer Care - A Worldwide Experience*, Dr. Didier Pittet, Switzerland
29 - *Environmental Control Strategies for C. diff*, Dr. Lynne Sehulster, USA

April

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19 - *Bacterial Resistance to Biocides in the Healthcare Environment*, Dr. Jean Yves Maillard, UK
25 - *Making IC Really Work - Managing the Human Factor*, Prof. Seto Wing Hong, China
26 - *Environmental Surveillance for Infection Control*, Andrew Streifel, USA

May

8 - *Panton-Valentine Leucocidin Producing Staph. aureus*, Brenda Dale & Adam Brown, UK
10 - *Infection Control in the Dialysis Clinic*, Dr. Charmaine Lok, Canada
17 - *Ethics of Care During a Pandemic Crisis*, Dr. Eric Wasylenko, Canada
24 - *Importance of Vaccination Among Dialysis Patients*, Dr. Matthew Arduino, USA
31 - *Evaluation and Management of Outbreaks in Nursing Homes*, Dr. Chesley Richards, USA

June

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20 - *Central Venous Lines and Prevention of Infection, Dr. Steve Chambers*, New Zealand

July

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August

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September

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November

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8 - *Hazard Vulnerability Analysis for Infection Control*, Andrew Streifel, USA
15 - *An Approach to Outbreak Management- Using Biostats to Clobber Bugs*, Dr. Dick Zoutman, Canada
29 - *Effective Infection Control Promotion in 3-to-5 Steps*, Allen Soden, USA

December

13 - *Water Quality Issues Pertaining to Medical Device Reprocessing*, Dr. Michelle Alfa, Canada

Hands on for Health

Hands on for Health: Promotion of respiratory etiquette in healthcare and community settings

Donna Meyer, RN, BScN and Janie Tyrrell, RN, BScN
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Funding received from Capital Health Patient Safety Initiative, Devon Hospital Foundation, Tri-Community Hospital Foundation, and Fort Saskatchewan Ladies Auxiliary

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ABSTRACT

The Hands on for Health Program was an education initiative intended to mobilize the public and healthcare facility staff to reduce the spread of respiratory illness in places where people congregate. The project involved the development, delivery and evaluation of a proactive program through a strategy termed 'respiratory etiquette'. An important component of this initiative involved promoting the use of alcohol-based hand cleanser and recognizing it as an effective and efficient alternative to soap and water. The target audience included healthcare workers, patients/clients in waiting rooms, elementary school students and the community at large.

Utilization-focused evaluation of the project, using both quantitative and qualitative methods, measured short-term outcomes (one year) and documented lessons learned about program implementation. Data collection included before-after surveying of optimal samples of target populations and showed changes in knowledge, attitude and behaviours in the area of respiratory etiquette and hand hygiene.

Key words: respiratory etiquette, hand hygiene, alcohol-based hand washing gel

INTRODUCTION

The threat of pandemic influenza and the emergence of SARS-like illnesses, stress the need to address the transmission of respiratory illness in healthcare settings and in the community. Studies show that people do not consistently employ simple infection control measures such as covering their mouths when they cough and practicing correct hand hygiene, thereby increasing the risk of exposure to respiratory pathogens (1, 2). There is also evidence that most people are aware of the importance of hand hygiene, yet this knowledge is not always transferred into everyday practice (3).

In early 2004, the Suburban/Rural Communities of Capital Health (Edmonton and area) were successful in receiving funding to proceed with a one-year patient safety initiative entitled "Hands on for Health". The project involved the development, delivery and evaluation of a proactive education program focused on mobilizing healthcare workers and the public to reduce the spread of respiratory illness through a strategy termed 'respiratory etiquette'.

The target audience included patients/clients in waiting rooms, elementary school students, healthcare workers and the community at large. The long-term goal of the project was to influence attitudes, behaviours and practice through the use of 'respiratory etiquette' among the public in waiting rooms, schools and healthcare workers to reduce the spread of respiratory pathogens. Respiratory hygiene/cough etiquette (4) has been proposed as a strategy to help decrease the spread of respiratory infections. To contain respiratory secretions, persons with signs and symptoms of a respiratory illness are instructed to cover the nose and mouth with a tissue when sneezing or coughing, dispose of used tissues in a waste receptacle and to perform hand hygiene after contact with respiratory secretions and contaminated objects or materials (4).

The Suburban/Rural Communities of Redwater, Fort Saskatchewan, Leduc, Devon, Stony Plain, and Evansburg are within the greater Capital Health Region of Edmonton, Alberta. Most of these communities are within 30 minutes of tertiary centers in Edmonton and serve a mix of suburban and rural populations. Each community is unique in its location and population characteristics. Each hospital in these communities varies in size and types of services offered. Services provided include emergency services, acute care in-patient services, outpatient clinics, surgery, laboratory, radiology,

obstetrics, long-term and continuing care, public health and mental health services. Evansburg does not have a hospital, but does have a health unit that is attached to a private continuing care center. In excess of 10,000 patients/clients use waiting rooms in the suburban/rural communities each month. Due to the structural limitations of these hospitals, well individuals, including those waiting for diagnostic tests, prenatal visits and those accompanying ill family members, congregate with unwell persons in these waiting rooms. Similar conditions prevail in physician office waiting rooms of well and unwell clients sharing an enclosed space, magazines, chairs and other inanimate objects. This puts people at risk for the spread of many illnesses, especially those transmitted by droplet/contact routes (5).

Schools and hospital waiting rooms share similar predisposing factors for the transmission of pathogens such as a close environment, sharing inanimate objects and low compliance to hand washing (6). Studies show that hand washing is most often taught to young children by a parent or care-giver on a one-to-one basis using repetitive and observational strategies. However, this practice does not appear to evolve into the middle or high school populations (6). There is also difficulty ensuring regular and efficient hand washing among the student population due to student behaviour, logistics, time constraints and lack of facilities (7). This increases the risk of spreading respiratory and other pathogens to other students, teachers and the community.

Hand hygiene compliance among healthcare workers remains unacceptably low (< 50%), depending on differences between hospital wards, professional categories of healthcare workers, and working conditions (8). Studies show that some deterrents to proper hand washing include time constraints, heavy workloads, skin irritation and poor access to sinks (9). Hospital-acquired infections are a major cause of morbidity and mortality and due to antibiotic resistant organisms and with the threat of pandemic influenza, this issue demands increased attention (10). Staff education, using the principles of adult education, has been shown to influence awareness and promote reevaluation of staff practices (11).

Hand hygiene, using alcohol gel, is a well-established method of preventing the spread of respiratory and other pathogens (12). Hand rubbing with an alcohol-based, waterless gel also appears to be the best method of increasing hand hygiene compliance. However, after years of imposing the concept of soap and water to perform hand washing, it becomes a challenge to introduce alcohol gel as a substitute (13). An important component of this initiative involved increasing the use of alcohol-based hand cleanser and recognizing its use as an effective and efficient alternative to soap and water.

METHODS

E.J. Turnbull and Associates was contracted to complete the evaluation of the Hands on for Health Project and worked closely with the project coordinators throughout the implementation. Staff from each community's hospital were recruited as 'Program Champions' to help with the dissemination of information, arranging of education sessions and the collection of data. This plan was of considerable value to the project due to the challenge of multiple sites covering a wide geographic area. Schools were chosen with the intent of maintaining representation from all of the communities with both a suburban and rural mix. The program coordinators made project presentations to school staff and principals. All of the schools approached were enthusiastic about a program on respiratory etiquette for their students. Two continuing care centers involved in the project were the Westview Health Centre and a private facility in Evansburg.

The Hands on for Health Project included five sub-projects:

- Respiratory etiquette video production and dissemination in waiting rooms
- Respiratory etiquette kits in emergency and/or outpatient waiting rooms and select physician offices
- Elementary school education pilot
- Staff education pilot
- Continuing care pilot

Respiratory etiquette video

A video was produced as a method of education for clients attending outpatient and physician waiting rooms. Waiting rooms are an ideal arena to provide health education to the public (14, 15) and videotape instruction has been documented to be an effective and efficient strategy for the communication of health information in waiting areas (16, 17, 18, 19, 20). The launch of the video was timed to be shown in outpatient waiting rooms during the influenza season (October through February, 2004) in addition to respiratory etiquette posters for walls and waste receptacles provided by Capital Health through a similar initiative. The video presents an entertaining narrative and includes subject matter covering modes of respiratory infection transmission, respiratory etiquette, cross-infection in places where people congregate, hand hygiene using soap and water and/or alcohol gel and the use of masks to prevent respiratory infection transmission in waiting rooms. Provided to six participating patient/client waiting rooms, the video was played through a continuous video loop and was also shown in uninterrupted settings such as staff education and community presentations. Data was collected through questionnaires completed at staff education sessions, post-exposure surveys of public viewers in emergency/outpatient waiting rooms and video satisfaction surveys completed by people in uninterrupted settings. The total number of viewers is unknown, but is estimated to be about 6,100 (not included are people who may have accompanied patients) and is based on conservative estimates of the percentage time the video was actually played, multiplied by the average number of patient visits during those months in those waiting rooms (21).

Respiratory etiquette kits

ER/outpatient waiting rooms at five hospitals, one health unit and eight physician offices were chosen to distribute respiratory etiquette kits. Kits included a mask, tissues, alcohol gel, a bag for tissue disposal, a card describing the steps of respiratory etiquette, and a chit enclosure for clients to volunteer to be called by telephone at a later date to provide their feedback on the kit. Prior to implementation of this program (pre-testing phase), clients who visited these waiting rooms were asked a series of questions through a questionnaire about their knowledge of transmission of respiratory illness and respiratory etiquette. At implementation, each receptionist area and physician's office was supplied with kits to be offered to any client who exhibited or reported respiratory illness symptoms. Staff in these reception areas and physician offices were given instruction and education on how and who to present the kits. A telephone survey of the recipients was planned through client-provided contact information from the included chits. Following implementation of the program (post-testing phase), clients were asked similar questions about their knowledge of respiratory illness transmission, respiratory etiquette and the use of alcohol-based gel. Because the pre- and post-testing was not conducted on the same individual clients, a large test sample was required to assure the 'representative-ness' of the pre-test data (21).

School pilot

Grades 4, 5 and 6 were chosen for the education sessions to avoid duplication and confusion for the students due to an existing program for the primary grades in the Capital Health School Program, which also contains a hand hygiene component. Education packages were developed by the program coordinators on respiratory etiquette and delivered to the students through 30-minute education sessions. Nursing students from the University of Alberta Faculty of Nursing and Grant MacEwan College of Nursing assisted with this program in the school settings. Students were presented with the Community and Hospital Infection Control Association of Canada video entitled *Sudsy Says Just Wash 'Em*. An education session on 'coughing and sneezing manners' was presented to the students following the video. Incentives were provided to all students including Sudsy stickers, pencils, bookmarks, and wordfinds. Following the education, participating classes were given alcohol gel to be used in their classrooms under the supervision of their teachers. A poster contest was held as part of the project and 26 posters were judged by an independent panel and displayed in the health centers and physician offices. Prizes and a monetary award were included as incentives for the winners of the contest. Students were pre-tested prior to education sessions on their knowledge of respiratory illness transmission, respiratory etiquette and the use of alcohol-based gel as an

alternative to soap and water. Teachers were asked to distribute post-tests to their students two to three weeks after the sessions in order to evaluate behaviour changes, knowledge retained, and if they used the alcohol-based gel provided. A telephone survey of a sample of the parents of the participating children was done to see if any of the information taught was shared at home, and a teacher survey was also completed to get feedback from the teachers whose students participated in the program.

Staff education pilot

Education on hand hygiene and respiratory etiquette was presented to staff at five hospitals and one health unit. A total of 26 sessions were offered. Staff were encouraged to attend with the use of incentives and by offering the sessions during day, evening and night shifts. In total, 164 staff members attended education sessions, which included nursing and non-healthcare personnel. Education included a PowerPoint presentation, interactive activities, and use of *The Sneeze* video from Canadian Learning Co. Staff who attended education sessions were given pre-tests to evaluate their knowledge of respiratory illness transmission, respiratory etiquette, hand hygiene frequency and the use of alcohol-based gel. At the time of the education sessions, staff were given post-tests in a sealed envelope, asked to complete the surveys in a two- to three-week period and return them to the program coordinators via the Program Champions. The purpose of the post-test was to assess knowledge retained and behaviour change. Three to four months following the staff education sessions, staff satisfaction surveys were delivered to all staff members who had attended sessions in order to elicit information on long-term changes in hand hygiene practices, including the use of alcohol-based gel as an alternative to soap and water, continued awareness of the importance of respiratory etiquette, and if they believed this program should be available region-wide.

Continuing care pilot

Staff and residents at two continuing care centers received education that included hand hygiene and respiratory etiquette messages. Alcohol gel dispensers were installed in all resident rooms at the Westview Centre. Alcohol gel dispensers were previously in residents' rooms in the private facility. Pre- and post-presentation surveys were conducted with the staff at both facilities to determine their knowledge of respiratory illness transmission, respiratory etiquette, the use of alcohol-based gel and behaviour and practice change.

RESULTS

Respiratory etiquette video

The number of emergency/outpatient waiting room clients who completed the questionnaire and reported viewing the video was very small. There were only nine respondents, six of whom reported being able to describe respiratory etiquette post-viewing. There were, however, 106 respondents who returned completed video satisfaction surveys after viewing the video in an uninterrupted setting. These respondents were predominantly female (98/106) and 75/106 were 21 to 51 years old, while 28/106 were 51 years or older. They were asked to use scales to rate the video on four criteria: interesting, understandable, will remember messages, and length. The respondents who viewed the video in uninterrupted settings, a captive and voluntary audience characterized by low stimuli and stress levels, indicated a high approval rating on all four criteria with 94 per cent reporting that they would remember the messages (21).

It was determined that this video is most appropriate for contained and controlled venues, has limited use in high traffic areas with busy staff such as hospital emergency rooms, and that the automated repetition of a short video message might be better received (21). This does not take away from the success of the video as it was selected out of five finalists to receive the Alberta Motion Pictures Industries Association (AMPIA) Award (2005) for best video in the communication/training category.

Respiratory etiquette kits

Although a telephone survey of the recipients of the respiratory etiquette kits was planned as part of the evaluation, none of the contact information chits were returned. Of the pre-test sample (496), the majority of the respondents were female, 21 to 51 years of age. Post-tests of waiting room clients (114) were analyzed, and revealed that just over one-third claimed previous knowledge of respiratory etiquette and about one-third credited the respiratory etiquette kits they had received in the waiting room with increased knowledge of respiratory etiquette (21). While most respondents reported a previous awareness of the potential spread of respiratory illness by sneezing/coughing or touching contaminated objects, 77 per cent reported using their hands to cover their mouth/nose when sneezing or coughing and only 19 per cent reported using a tissue in the pre-testing phase of the survey. In the post-testing phase of the survey, 27 per cent reported using their hands to cover their mouth/nose when sneezing or coughing and 72 per cent reported using a tissue (21). This shows an increase of knowledge in the concept of coughing or sneezing into a tissue to contain respiratory secretions. The surveys also showed a change in the positive perceptions of alcohol gel as an effective hand cleanser from 30 per cent of respondents prior to exposure to the kits to 78 per cent after. This indicates the effectiveness of the messages from the respiratory etiquette kits and the receptivity of the public to this content (21).

The provision of respiratory etiquette messages via respiratory etiquette kits was useful in terms of increasing general knowledge of respiratory etiquette and the benefit of alcohol-based hand gel. For future studies, a more effective means of encouraging participation in a post telephone survey should be considered (21).

Physicians reported that they felt that this project was beneficial to their clients and that it was an important message to deliver. Some physicians

also reported that being exposed to the information on respiratory etiquette had changed some of their own behaviours in their contact with patients (21).

School pilot

The results of the pre- and post-education testing of the students did not show a significant change, yet the post-test results were higher for all questions in their knowledge or attitudes about respiratory etiquette and the spread of respiratory illnesses. The high scores on the pre-tests may indicate that knowledge in children at these grade levels is already strong, or that the questions were developed at a level too simple for the ages of these children. Post-testing revealed that 54 per cent of the children had used the provided alcohol gel at least once a day. According to the students' own reports, the respiratory etiquette program was enjoyable and informative (21).

Twenty-eight parents were surveyed by telephone for information on observed behaviour changes in their children with regard to respiratory etiquette and hand hygiene. Of the 28 parents who responded to the survey, 84 per cent stated that their child did follow all three components of respiratory etiquette. All of the parents surveyed stated that they believed it was important for their child to be taught respiratory etiquette at school.

Seventeen teachers returned surveys following the program and reported that students were using the alcohol-based gel regularly (at least eight times per day) and that this behaviour lasted more than two months. While changes in knowledge, behaviour and attitude of the students following the program were noted, additional intervention may facilitate further compliance (21).

Staff education (including continuing care)

Comparison of pre- and post-test responses on several key questions assessing knowledge and attitude show improvement after staff had taken the education. Pre-tests showed that 59 per cent of the staff correctly identified how respiratory illness was spread, compared to 75 per cent following the education. Frequency of hand washing was reported to be one to five times per day by 7 per cent of the staff to more than 20 times per day by 37 per cent of the staff. Prior to the education sessions, participants (n=138) were asked to rate how often they washed their hands at work and how often they washed their hands when they had a respiratory illness. Staff members' report of their hand washing behaviours (8 per cent from one to five times per day to 43 per cent more than 20 times per day with a respiratory illness) indicates very little recognition of the need for increased vigilance when they have respiratory infections (21). This emphasizes the need for staff education and reinforcement on respiratory etiquette and hand hygiene on an ongoing basis.

The Hands on for Health education sessions were viewed by staff to be extremely valuable and served a useful purpose in terms of staff education. Staff members' knowledge, attitudes and behaviour change concerning respiratory etiquette improved following the provision of the respiratory etiquette program (21).

DISCUSSION

The Capital Health Hands on for Health Project was successfully implemented in five pilot sub-projects in multiple suburban/rural settings. A variety of strategies presenting the respiratory etiquette messages were utilized in conducting the pilots within these diverse settings.

Responses to the program in schools, uninterrupted settings and among healthcare staff were enthusiastic and produced positive outcomes. Behaviour and attitude changes among the students were noted by teachers and parents and through students' self-reporting. Two of the schools reported continued use of alcohol-based gel in all classrooms following participation in the Hands on for Health Program. Healthcare facility staff members' knowledge, attitudes and behaviour improved following the delivery of the program and staff satisfaction with the program rated high. From the compiled questionnaire data, it is evident that a significant need for the delivery and reinforcement of these messages remain. While improvements were noted during this pilot project, deficits in compliance with respiratory etiquette and appropriate hand hygiene practices continued to be self-reported by surveyed staff members (21). Since the implementation of the Hands on for Health Project, respiratory etiquette and hand hygiene have been included in mandatory education at all sites in the suburban/rural communities. While playing the respiratory etiquette video in uninterrupted settings was effective and well-received, piloting the use of the video in emergency and outpatient waiting rooms proved to be less successful due to distractions and the high level of acuity in those areas. Physicians supported the availability of respiratory etiquette messages in their offices and indicated positively to having these materials on an ongoing basis (21).

The evaluation (21) revealed that the target populations were satisfied with the program and its tools. Health promotion requires a proactive approach to prevent illness. This project provided an opportunity to promote health through simple, evidence-based practice.

ACKNOWLEDGEMENTS

The authors would like to recognize the valuable contributions made by the Program Champions, Brenda Smith (Leduc Health Centre), Deb Greniuk (Devon Health Centre), Dawn Mulgrew (Evansburg Health Unit), Jeannie Hare (Redwater Health Centre), Sharon Cornelius (Westview Health Centre) and Carol Furrer, (Fort Saskatchewan Health Centre) whose efforts helped make this project such a success.

The authors would also like to recognize the leadership, guidance and inspiration for this project

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Is routine surveillance valued?

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ABSTRACT

Daily surveillance activities are a key function of the infection prevention and control role. Given the hectic pace and many requirements placed on Infection Control Practitioners, it is possible that tracking of sentinel organisms is undervalued. Analysis of types and rates of organisms may not always be part of routine surveillance. Administrative support for the provision of reliable denominator data used for creation of infection rate thresholds is not always optimal. The practitioner to patient ratio and the devaluing of analysis can further hinder accurate maintenance and measurement of site specific infections against established infection rate thresholds. A national expectation of the consistent provision of a minimum data set from Canadian hospitals should increase the value placed on infection surveillance and analysis.

INTRODUCTION

Routine surveillance[1] is only one of many functions that must fit into the busy life of an infection control practitioner. With meetings, outbreak management, manual creation, education sessions, facility planning, unusual occurrences, and many other more exciting or demanding tasks, routine surveillance may be perceived as mundane and unimportant. Lack of experience and training, or inadequate numbers of infection control practitioners may create the sense that infection rates are stable or diminished, when in reality they may be increasing. "Fluctuations of a surveillance rate have no meaning unless the same level of data collection is maintained."[1]

RECOMMENDATIONS

Two of the eight recommendations for infection control and prevention programs include 1) managing critical data and information and 2) direct intervention to prevent the transmission of infectious disease.[2] Without the recognition and comprehension that organisms are clustering or that surgical wound infection rates are on the rise, the cost in morbidity and the eventual fiscal cost and increased difficulty controlling the resultant situation, diminishes program efficacy and credibility.

This is the age of information, and both a comprehensive technological program and a skilled practitioner must work in harmony to receive, trend, and analyze data to interpret the results based on established infection rate thresholds. This means that input and output of information must be timely, and analyzed on an ongoing consistent basis to be meaningfu1.[1] Sentinel organisms must be tracked for increases to rule out common source spread such as geography, environment or personnel, or emergence due to antibiotic prescription patterns.[3]

This routine surveillance system must be highly sensitive with analysis leading to rapid intervention and investigation to permit effective eradication of organism transmission. Databases that retain information and are updated and reviewed frequently permit the establishment of acceptable thresholds. Infection control practitioners who do not comprehend that prevention means knowing these thresholds and substantiating them with case line listings are less likely to intervene prior to a cluster erupting into an outbreak. Without the understanding of the value of early intervention, data entry will be seen as unimportant, and result in an 'out of sight, out of mind' response. Thresholds may rise over time, but without discussion and the analysis around why an organism now predominates on a unit, the prevention component is lost from the infection control role.

Health authorities have the responsibility to provide reliable denominator data in a timely fashion so that the practitioner can interpret rates in a consistent and meaningful fashion. Operative procedures improperly categorized, or lack of surgeons' operative procedure rates results in spurious interpretation of crude infection numbers. Critical value organism results and routine microbiology reports must be provided to practitioners in a timely manner. Access to patient information such as room numbers occupied, and date and results of cultures are crucial tracking elements.

In addition, facility personnel must communicate with practitioners when changes are implemented to permit correct monitoring, detection and intervention. New procedures, new equipment or its processing, construction or the quality of air control can all affect vulnerable patient populations and result in potentially preventable nosocomial infection.

Administrative personnel, who recognize the value of early intervention in quality care, must be cognizant of the need to communicate procedural or plant issues to the practitioner as soon as they occur. The onus is then on the practitioner to monitor the current infections against the site's established thresholds with the confidence that baseline numbers are reliable and inclusive. Without knowledge of the usual, the unusual is indiscernible.

The contemporary infection control practitioner must have both technical computer ability and comprehensive interpretive skills. Basic spreadsheet and database usage are key tools of the trade for efficient data organization, but these skills are worthless without the ability to value the purpose of ongoing data entry and trending, and how and when to intervene in a given situation.

Once supplied with reliable denominator data, the prime key to success of infection control and prevention programs relies on educating and mentoring practitioners regarding the practical value of the application of epidemiology on a

routine daily basis. Practitioners need to be accountable to establish ongoing surveillance programs that have valid, reliable thresholds of infection rates and sensitive detectors of infection rate deviations. With targeted surveillance focusing on specific surgical procedures or dedicated system infections only, it takes a caring and astute practitioner to note a cluster of urinary organisms on a unit when urinary tract infections may not be part of routine surveillance. Will the practitioner note a clustering of organisms across all surgical specialties when an environmental problem has occurred, if only a few representative surgical procedures are routinely being surveyed? To achieve this surveillance awareness requires tracking of sentinel organisms and constant, continual experienced practitioner coverage.

Currently, the lack of epidemiologist and practitioner staff is interfering with competent surveillance in many health authorities. A recent Canadian survey found that in 42.1 per cent of responding Canadian hospitals, there was less than one infection control practitioner for 250 beds.[4] Computer expertise is obligatory for data to be retrievable and retained for comparison purposes yet many programs lack personnel with basic computer skills.

Analysis must be continuous and with intervention as the uppermost thought, to avoid seeing data entry as boring and purposeless. Clerical staff can enter data, but the skilled practitioner is the one who rapidly interprets any deviations. This early intervention can result in lessened patient suffering while eliminating the prolonged stay and financial costs associated with hospital-acquired infections.[5]

The second key to the success of the infection control and prevention program is ensuring that administrative staff is educated regarding the cost effectiveness of skilled practitioners.[1] "The scientific basis for claims of efficacy of nosocomial infection surveillance and control programs was established by the Study on the Efficacy of Nosocomial Infection control Project. Subsequent analyses have demonstrated nosocomial infection prevention and control programs to be not only clinically effective but also cost effective."[2]

This means that infection control staff must be supported with adequate staff ratios, reliable accessible denominator data, computer expertise, and frequent evaluation of the productivity of the local infection control practitioner and their program. "Demonstration of quality health care includes documentation of outcomes of care."[2]

Practitioners must be accountable to ensure they are not working in a 'counting widgets' mode, but rather have elevated their practice to a state where interventions and recommendations are implemented and evaluated for positive outcomes. In many countries standardized definitions, surveillance and reporting of hospital-acquired infections have elevated the value of surveillance.[6,7,8] Practitioners who have administrative support and who are mentored to value surveillance, data measurement and analysis with appropriate intervention will provide the prevention and control that patients have the right to expect from contemporary health care.[9] ●

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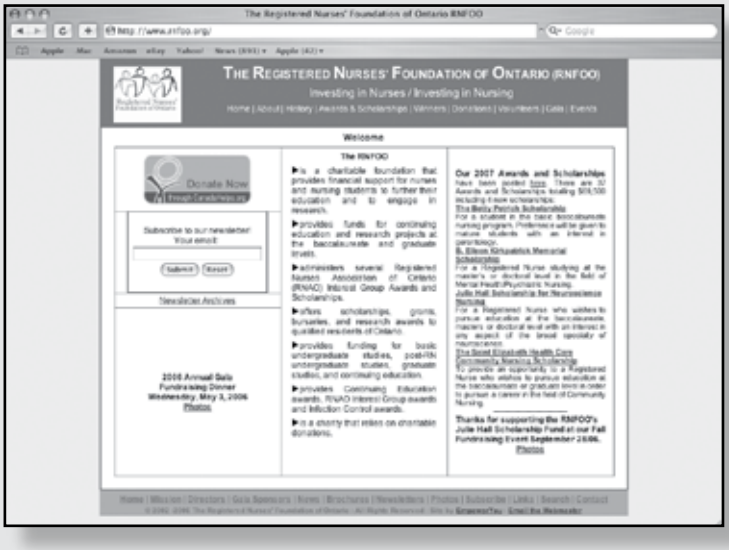
ANNOUNCING

The Rolling Stones/CPI Scholarship for The advancement of professional practice in infection control

The Registered Nurses' Foundation of Ontario (RNFOO) is very pleased to have received the proceeds from a CD produced at the SARS Memorial Concert that featured The Rolling Stones. Scholarships will be provided to enhance professional practice in infection control.

See www.rnfoo.org for details.



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Health care workers are on the front line in the fight against infectious diseases. We need to learn and practice the infection prevention and control procedures that will protect our patients, ourselves and our families. This 28 minute video is designed to clearly teach those practices, and emphasizes the importance of following proper infection prevention and control procedures at all times.

This training video is a valuable tool for training new staff and providing regular reminders of the methods and importance of infection prevention and control practices to all staff working in health care settings. The video contains three distinct modules that can be viewed together, or taught in separate sessions:

1. **Routine Practices**
2. **Additional Precautions – Droplet, Contact, and Airborne Transmission**
3. **Combined Precautions – Routine Practices combined with Additional Precautions to prevent the spread of new infectious diseases such as SARS**

Copies of this video are available at the cost of $100 for VHS, or $150 for DVD or CD format.

To order copies of this video in VHS, DVD or CD format Contact Capital Health
Phone: 780-413-5147 • Fax: 780-413-7950 • E-mail: cpenner@cha.ab.ca

The Registered Nurses' Foundation of Ontario Molson Canada SARS Memorial Fund Providing Grants to Infection Control Practitioners

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 health care settings. Grants can be applied to continuing education, certification/ re-certification and professional development.

The fund of $175,000.00 is to be administered over three years, allowing for the allocation of approximately $58,000 per year in support of individuals pursuing formal education and certification in the area of infection control.

The next deadline date for applications is April 1, 2007.

RNFOO

Handling of expressed breast milk (EBM) in acute care facilities

Position statement
Pediatric Interest Group
CHICA-Canada

Breast milk is an important source of nutrition and immunological protection for an infant. Since breast milk is a body fluid, many aspects of handling in hospital are guided by practices used for other body fluids, e.g. blood, blood transfusions. Breast milk can also be a source of infection. To minimize the risk of spreading infection in acute care facilities the principles for safe handling of expressed breast milk (EBM) listed below should be followed. Please note: each facility needs to adapt these practice statements based on what makes sense in their own facility with the resources they have.

1. The mother should be taught the basic principles of asepsis as it applies to collection, storage, and handling of breast milk.
2. EBM must be collected in an aseptic container (single-use sterile bottles and sterile lids should be used for every pumping session) and labeled to include contents, baby's name, mother's name, hospital identifier, date/time of pumping, date/time of freezing, and date/time of thawing.
3. Freshly expressed breast milk should be used within 48 hours or otherwise frozen in a dedicated freezer. Unrefrigerated fresh breast milk should be used within four hours or discarded.
4. Each mother should be assigned a dedicated labeled freezer container for her baby's milk.
5. Frozen breast milk should be thawed in the refrigerator and used within 24 hours. Use of multi-bottle water baths should be discouraged; if used, care should be taken to protect the bottles from direct contact with the water to avoid contamination.
6. EBM that has been fortified must be used within 24 hours of preparation. Details should be reviewed with the hospital formula room and/or dietitian.
7. When administering EBM, principles of routine practices should be followed.
8. At a minimum a double-check mechanism should be used at the time of administration to avoid errors in administration. In facilities with large numbers of mothers who express milk, long-term consideration should be given to automated systems such as bar coding to avoid errors in administration.
9. A comprehensive written policy including disclosure and course of action should be available in the event of errors involving breast milk. Viral testing of 'donor' and 'recipient' mothers should occur as well as administration of post-exposure prophylaxis if indicated.
10. The maximum hang time for continuous feedings is four hours. The administration set should be changed every four hours.
11. Because of the higher risk of environmental contamination and the potential for cross-contamination in the hospital environment, breast pump kits should be reprocessed after each use by a minimum of high level disinfection.
12. Breast pump tubing and membrane filters can be difficult to clean adequately depending on the make of pump and facility reprocessing expertise. In general, they should be discarded if they come in contact with breast milk.
13. The breast pump should be cleaned with a low level disinfectant after each use.
14. Banked human milk is available by prescription and can be considered in selected circumstances from a reputable donor human milk bank where adherence to rigorous guidelines (e.g. Human Milk Banking Association of North America) occurs. ●

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Silly questions

Sometimes we get the silliest questions! Whether by pager, telephone or in person, these questions can give us a smile or an outright laugh. Send us the silliest question you have ever received on infection prevention and control. The Infection Prevention and Control Vignettes session on **June 14, 2007** will reveal the 'silliest questions'. You could have the winning submission!

Send to the Membership Services Office (chicacanada@mts.net) by **April 9, 2007.**

Call for Infection Prevention and Control Vignettes

Submit your interesting, difficult, head-scratching infection prevention and control dilemmas for the 2007 National Education Conference. We look forward to a lively vignette session on Thursday, June 14, 2007.

The session will discuss challenging infection prevention and control dilemmas. If your vignette is accepted, the facilitators will work with you to develop the most appropriate method of presentation.

Your vignette should include: **1)** an outline of the problem; **2)** a short discussion on the instructive value of the case; **3)** your contact information including name, address, telephone, fax, e-mail address.

The deadline for submission is **April 9, 2007**. Cases must be e-mailed to the Membership Services Office – chicacanada@mts.net. DO NOT SUBMIT VIGNETTES ONLINE AT www.chica.org. If your case has been accepted, you will be notified by the end of April 2007. No registration discounts are provided for submitters. One submitter will receive a waived registration to the 2008 National Education Conference. If you have any questions, please contact the Conference Planner at chicacanada@mts.net or at (204) 897-5990/1-866-999-7111.

Jim Gauthier, ART, CIC
Diane Roscoe, MD, FRCPC
2007 Scientific Program Committee

CALL FOR ABSTRACTS

Deadline for submission: March 12, 2007
ABSTRACTS MUST BE SUBMITTED ONLINE ONLY.
LINK FROM WWW.CHICA.ORG

Abstracts for presentation at the 2007 National Education Conference of the Community and Hospital Infection Control Association – Canada will be accepted until the close of business (5:00 p.m. Pacific Standard Time) **March 12, 2007**. The Abstract Committee reserves the right to select papers for presentation on the basis of relevance and interest, and to choose the type of presentation.

Abstract Preparation and Guidelines for Acceptance

A. Content

1. Abstracts should be based on results that have not or will not be published or presented before the meeting date.
2. The potential significance of the observations, as well as the scientific and/or educational quality of the work will influence which abstracts are accepted. Where possible, the author(s) should emphasize the features of the project that are new or different.
3. All concepts and abbreviations must be defined at first use in the body of the abstract.
4. Any corporate assistance must be acknowledged.
5. Any sources of funding must be acknowledged.

B. Format

Abstracts should be submitted in one of the following formats:

Format 1: This format is intended for abstracts involving the presentation of scientific research findings, such as those involving randomized clinical trials, case-control, observational or descriptive studies, or outbreak investigations where appropriate comparisons or analysis of data has been performed.
NOTE: The abstract should disclose primary findings and not include statements such as 'experiment in progress' or 'results will be discussed.'

Abstract Title: (CAPITAL LETTERS)
Authors: The presenter must be denoted with an asterisk, e.g.: Whyte, S*, General Hospital, Edmonton, Alberta
Background/Objectives: Outline study objectives, the hypothesis to be tested, or description of the problem.
Methods: Report methods used or approach taken.
Results: Indicate essential results obtained in summary form with appropriate statistical analysis (p value, confidence intervals, odds ratio, etc.)
Conclusions: Provide a summary of findings as supported by results with implications and conclusions.

Format 2: The format is intended for abstracts involving the description of educational or performance improvement programs, observations, or other infection prevention activities, including descriptions of facility or community-based programs or interventions, discussions or infection prevention policy, and descriptions of a particular prevention model or method.

Abstract Title: (CAPITAL LETTERS)
Authors: (The presenter must be denoted with an asterisk, e.g. Oiler, W*, Muttart, S, General Hospital, Edmonton, Alberta
Issue: Identify the specific problems or needs addressed. Provide brief introduction of the proposed topic. Include important background and current information on issues.
Project: Description of the intervention/program
Results: Specific results in summary form.
Lessons Learned: Summary of the lessons learned and implications.

C. Major interest (select one)

Clinical Infectious Diseases
Infection Prevention and Control

D. Subject categories (select one)

The author(s) should select the one subject category that best categorizes the submissions. This will assist conference planners in organizing the program. If the presenting author prefers a poster presentation, that preference must be indicated at the time of submission.

Antimicrobial Resistance	Long-term Care
Ambulatory Care	Molecular Epidemiology
Antisepsis/Disinfection/ Sterilization	Occupational Health
Cost Effectiveness	Outbreak Investigation
Device-related Infections	Pediatrics
Emerging Pathogens	Product Evaluation
HIV/AIDS/Hepatitis	Quality/Process Improvement/ Adverse Events
Home Care	Surveillance
Infection Control Programs	Site-specific Infections (SSI, Pneumonia, UTI, Infections in the Immunocompromised host bloodstream)
Tuberculosis	Other

E. Preferred method of presentation if abstract selected (choose one)

- ☐ Poster
- ☐ Oral presentation
- ☐ No preference

F. Guidelines for abstract selection

Abstracts not meeting the stipulations outlined under both A (Content) and B (Format) above will not be considered for acceptance.

Submission of Abstracts

1. Abstracts must be submitted online. Link to abstracts submission page via www.chica.org.
2. Abstracts must be submitted by close of business (5:00 p.m. Pacific Standard Time) Mach 12, 2007.
3. Abstracts will be reproduced and submitted for inclusion in the pre-conference issue of the Canadian Journal of Infection Control. Abstracts will be posted to the 2007 conference page of www.chica.org prior to the conference. Presenters must be registered at the conference.
4. Instruction for online submissions will be available at the abstracts site. Information to be included:
   - Full name, professional mailing address, telephone and email address of the author who will present the paper.
   - Preference: Oral presentation, poster presentation, or no preference
   - Indication if the presenter is a first-time presenter.
   - Indication if the authors are interested in writing an article for publication in either journal.

Ecolab Poster Contest

An Annual Poster Contest is sponsored by Ecolab and supported by a Chapter of CHICA–Canada to give ICPs an opportunity to put their creative talents to work in developing a poster which visualizes the Infection Control Week Theme.

The winner of the Annual Poster Contest is announced at the annual CHICA-Canada Conference. Winners receive full registration at the next CHICA–Canada conference.
Deadline Date: January 30, 2007

Send submissions to:
Director of Programs and Projects,
c/o CHICA–Canada
PO Box 46125 RPO Westdale,
Winnipeg MB R3R 3S3.

Courier address:
67 Bergman Cresent,
Winnipeg MB R3R 1Y9
Fax: 204-895-9595
E-mail: *chicacanada@mts.net*.

Include your name, address and phone number on the back of your entry.

GRAND PRIZE:
Full registration at the 2007 CHICA–Canada National Education Conference in Edmonton, Alberta. No limit to number of entries, so enter often!

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You are invited to design a poster that will be used for **Infection Control Week 2007** using the following theme:

"Infection Prevention and Control – Practice and Participate"

- Your entry should be informative, eye-catching and applicable to both healthcare and community settings.
- Your entry will be judged 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 CHICA–Canada.

Bruce Gamage and Esther Giesbrecht, winner of the 2006 Ecolab Poster Contest.

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The mandate of the *Canadian Journal of Infection Control (CJIC)* is to provide readers with access to published scientific research and expertise, as well as updates on information relating to infection prevention and control to assist Infection Control Professionals in their practice. *CJIC* is an opportunity for members to discover what is occurring in their association and how member benefits are being enhanced.

Because of the increase in submissions of articles of a scientific nature, the editor and publisher have revamped the organization of *CJIC* to allow more room for the publication of scientific information. This new *Association News* section will provide readers with first announcements of CHICA-Canada initiatives and opportunities. Readers are invited to visit the CHICA-Canada website for follow-up information and updates.

Future Conferences

Association for Medical Microbiology and Infectious Diseases (AMMI Canada)
2007 Annual Conference
Halifax, Nova Scotia, March 14-18, 2007
www.ammi.ca

5th World Congress of the World Society for Pediatric Infectious Diseases
Bangkok, Thailand, November 15-18, 2007
www.kenes.com/wspid

Virox Technologies Partnership Scholarship

Through the financial support of the Virox Technologies Partnership, 10 CHICA-Canada members were awarded scholarships to attend the 2006 National Education Conference in London, ON. CHICA-Canada and its members thank Virox Technologies and their partners for their initiative to make the national education conference accessible to those who may not have otherwise been able to attend.

Applications for the 2007 Scholarship are to be submitted in writing to the Secretary/Membership Director of CHICA-Canada no later than **Jan. 31, 2007**. Please mail applications to CHICA-Canada, PO Box 46125 RPO Westdale, Winnipeg MB R3R 3S3, fax to 1-204-895-9595, or email to *chicacanada@mts.net.*

For more information and the application form, visit the CHICA-Canada website at *www.chica.org* or the Virox website at *www.virox.com*, or contact CHICA-Canada.

3M Canada Infection Prevention Research Grant

As part of an ongoing initiative to promote innovative infection control and prevention practices in Canadian healthcare, 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.

One research grant of $6,000 to the Principal Investigator of the successful application will be presented at the 2007 CHICA–Canada National Education Conference (Edmonton, Alberta - June 9-14, 2007) (travel, accommodations and meals will be provided by 3M Canada Company for the successful recipient).

An application form is available at *www.chica.org* . Deadline date for applications: March 1, 2007.

Applications must be sent to:
Secretary/Membership Director
CHICA-Canada
PO Box 46125 RPO Westdale
Winnipeg MB R3R 3S3

Or courier to:
Secretary/Membership Director
CHICA-Canada
67 Bergman Crescent
Winnipeg MB R3R 1Y9

3M Innovation

Industry Partners

In addition to supporting CHICA-Canada National Education Conferences through sponsorship and exhibits, and facilitating national sponsorship and awards opportunities, throughout the year our Industry Partners are prominent at chapter levels with their support and expertise. CHICA-Canada would like to take this opportunity to thank industry representatives who have assisted our chapters with various events and projects in 2006.

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Tyco Healthcare
Virox Technologies
Webber Training
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Wyeth Pharmaceuticals

30th Anniversary Award

CHICA-Canada 2006 President Karen Hope (r) presents a commemorative 30th Anniversary plate to Mary LeBlanc, a CHICA-Canada Past President and CHICA-Canada archivist. Mary was unable to attend the 2006 National Education Conference because of illness – her first absence ever!

Teleclass CDs

Available exclusively from CHICA-Canada in partnership with Webber Training Inc. See page 192 for order form. 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?

Membership fee formula changed

As of renewals for 2007, the annual CHICA-Canada Membership Fee will change to:

Individual	$125.00
Institutional	$175.00 *for the first representative;* $75.00 *for each representative thereafter*
Silver/ Student	$75.00

All fees include membership in one chapter of CHICA-Canada. The choice of chapter will be designated at time of renewal or new membership. Additional chapters may be added for $25.00 each.

New Board of Directors elected

Bonnie Henry, MD, FRCPC
Director, Standards & Guidelines (3-year term)

Dr. Bonnie Henry is currently a Physician Epidemiologist with the British Columbia Centre for Disease Control and is responsible for the provincial West Nile virus and other Vectorborne Diseases program as well as coordinating a provincial program for surveillance and control of healthcare associated infections. She is on the Steering Committee of the newly formed BC Provincial Infection Control Network (PICNet) and chairs the PICNet Priority and Planning Committee. Previously she was Associate Medical Officer of Health for Toronto Public Health, where she was responsible for the Emergency Services Unit and the Communicable Disease Liaison Unit which was formed to strengthen connections in infection prevention and control between TPH and hospitals in Toronto. She is a specialist in Community Medicine and is Board Certified in Preventive Medicine in the U.S. She graduated from Dalhousie Medical School and completed a Masters in Public Health in San Diego, residency training preventive medicine at the University of California, San Diego and in community medicine at the University of Toronto. More recently, Dr. Henry worked with the WHO/UNICEF Polio eradication program in Pakistan in 2000 and with the World Health Organization to control the Ebola outbreak in Uganda in 2001. In 2003, she was one of the leads in the response to the SARS outbreak in Toronto. She was on the executive of the Ontario SARS Scientific Advisory Committee and is an assistant professor at the University of British Columbia, Faculty of Medicine. She is Vice-Chair of the Canadian Coalition for Immunization Awareness and Promotion and founding Director of the Canadian Centre for Excellence in Health Emergency Preparedness.

Philosophy: The role of Infection Prevention and Control as an essential component of the healthcare system has been highlighted in the past few years with issues such as MRSA, VRE and CDAD as well as the emergence of such new diseases as SARS and H5N1 Avian Influenza. I believe there is a continuum of IPC that ranges from the community, through homecare and long-term care to acute care facilities. As budgets in facilities and public health were cut in the 1990's, IPC programs were easy targets. This erosion of the IPC infrastructure in all facets of the system meant more isolation of the ends of the continuum with public health focusing their limited resources on the community (from physician offices to schools and daycares to long-term care) and hospitals focusing on their facility and subsisting with often inadequate resources. The SARS outbreak in 2003 highlighted this erosion and stovepiping when we most needed to communicate and respond seamlessly. Since the SARS outbreak I have worked to develop the links between public health and facilities in Ontario and most recently in BC. I see CHICA-Canada as uniquely positioned to overcome any political or budgetary barriers to help strengthen a coordinated, evidence based IPC community in Canada. Through the position of Director, Standards and Guidelines, I hope to be able to create a virtual network of expertise across the country to identify critical issues in IPC and develop evidence based guidelines and position statements that can be used by all members. My vision is to expand the influence of CHICA-Canada into the community in a more meaningful way. I hope CHICA-Canada can become the primary credible resource and support for those with responsibility for IPC in long-term care, home care and the community, as it has been for many years for the acute care community.

Karen Clinker, MEd, BScN, CCOHN/CM, CIC
Director of Programs & Projects (3-year term)

Karen Clinker is an infection control specialist with the Northwestern Ontario Infection Control Network in Dryden, Ontario. Her responsibilities include conference planning, CIC study group support, ICP education and resource development. A member of CHICA Northwestern Ontario, Karen recently moved to Ontario from Alberta where she was a member of CHICA Northern Alberta. As a CHICA member, she is active in her chapter and participates on the CHICA-Canada working group to review additions to the infection control audit toolkit.

Philosophy: Infection control is a risk management issue – an occupational hazard for employees and a patient hazard for those in our care. As such, these hazards (infectious agents) need to be managed as any workplace hazard with proper engineering, administration and PPE controls. I am interested in assisting CHICA in the development of processes and controls to manage infections through promotional programs and projects. I am interested in guidelines and best practice documents addressing the management and control of infections in various practice settings. Adult education options and tools for practitioners at the front lines for infection control are essential. We need to ensure accountability for infection control at all levels. In order to do this, we need continued surveillance tools and audits to address infection control activities for a variety of settings.

Marion Yetman, RN, BN, MN, CIC
President-elect 2007

Marion Yetman is the Provincial Infection Control Nurse Specialist with the Department of Health and Community Services, Government of Newfoundland Labrador. She has been an infection prevention and control professional and a member of CHICA-Canada for 14 years. Marion has held the positions of infection control nurse coordinator, infection control nurse for pediatrics, nurse research, clinical nurse educator and intensive care unit staff nurse. She first received her certificate in infection control in 2000, and has renewed successfully twice. She attended the infection control course at Centennial College and received a master's degree in nursing in 1999. Marion was co-chair of the 2002 National Education Conference held in St. John's, Newfoundland and is currently serving on the scientific program committee for the 2007 conference. She is a past president of CHICA Newfoundland Labrador, and is also co-chair of the CHICA-Canada pediatric interest group.

Philosophy: We are at a critical turning point in infection control. SARS has highlighted the impact of inadequate infection control resources and the Canadian Patient Safety Institute has focused on the importance of the prevention of health care-associated infections as one of its primary patient safety strategies. However, recent reviews of infection control programs in Canada have identified shortages of infection control practitioners compounded by insufficient infection control training programs. There is an urgent need to recognize the fundamental importance of developing a range of training options and components for new practitioners and to increase accessibility of continuing education programs for current practitioners. CHICA-Canada must continue to lobby government and health agencies in an effort to increase allocation of funds into the infection control arena if we are to stabilize and strengthen the infection control workforce. I am most interested in being a part of the CHICA-Canada team as it continues its efforts to improve the infection control infrastructure in Canada.

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November 2006 Revision

CHICA-Canada Strategic Direction and Planning Document 2006-2009

BACKGROUND:

Initially, the 2000-2003 Strategic Plan served as the backbone for this document. The process for developing the strategic direction for the organization was derived from consensus discussion with the CHICA-Canada Board of Directors, Chapter Presidents, member groups and individual member feedback. The key directions in the document were derived also through the consensus process involving the groups cited above. In 2005 the Plan was revisited by the Board of Directors to extend the strategic vision into 2009 and beyond.

Setting four strategic directions for the organization allows for flexibility. This three-year plan then provides the opportunity for short and long-term goals and objectives within the context of each direction. Initiatives are reviewed, assessed and evaluated annually, and when required, to assure continued appropriateness, focus and continuity with CHICA-Canada's overall mission statement.

2006-2009 STRATEGIC DIRECTIONS

1. **To expand member services to meet the needs of the CHICA-Canada membership.**
2. **To expand CHICA-Canada's influence and profile nationally and internationally, as a leader in infection prevention and control.**
3. **To develop entrepreneurial ventures to generate funds necessary for the continued support of initiatives/strategic direction.**
4. **To develop an enhanced infrastructure required to support the strategic directions.**

INITIATIVE	RESPONSIBILITY	TARGET DATE	OUTCOME
1. To expand member services to meet the needs of the CHICA-Canada membership. Two major domains identified – Education and Communication			
Short Term Education:			
A) Increase accessibility to basic entry course through additional and/or distance education offerings, and expansion of current programs with distance component	Director of Education/Board		Completed
i) Assessment of on-line distance education pilot project launched June 2005		2006	
ii) Expansion of course providers		2007	
iii) Establish mechanism for ongoing maintenance		2007	
iv) Assess need for French version		2008	
B) IP&C Core Competencies	Director of Education/Board		Completed
i) Complete HCW version		2007/08	
ii) Develop ICP version		2007/08	
iii) Develop implementation and evaluation plan		2008/09	
C) Mentoring	Director of Education/Board		
i) Develop description of mentoring levels	2007 Scientific Program Committee	2007	2007 conference
ii) Plan for conference "Mentor Day"		2007	

INITIATIVE	RESPONSIBILITY	TARGET DATE	OUTCOME
Long Term Education:			
A) Continue planning for advanced level courses.	Director of		
i) Define levels of expertise	Education/Board	Ongoing	
ii) Develop certificates for recognition of educational advancement		2007/08	
iii) Advocate and provide support for advanced level education	Director of Programs &	Ongoing	
iv) Continue development of resources for ICPs (toolkits, audit tools, etc).	Projects/Board	Ongoing	
Short Term Communication:			
A) Redesign website for improved navigation/ increased profile	Web Communications Manager	2006	Completed
B) Increasing online services			
i) Re establish regular broadcast emails	MSO	2006	Completed
ii) Provide for online abstract submissions	MSO	2007	Completed
iii) On-line registration and payment for memberships and conference	MSO	2007	
iv) Enhance framework for growth/support of Interest Groups	President-Elect/Web Communications Manager/Board	Ongoing	
Long Term Communication:			
i) CHICA Position Statement on CIC - as applicable to members and Board	Board	2007/08	
ii) Enhance translation and services to French-speaking members.	MSO/Board	2008/09	
2. To expand CHICA-Canada's influence and profile nationally and internationally as a leader in infection prevention and control.			
A) Promotion of the profession			
i) Promote recognition of Infection Prevention and Control as being an unique body of knowledge.	Board	Ongoing	
B) In related organisations, conferences and scientific meetings:			
i) Continue to collaborate with relevant national and international organizations in the development of future infection prevention and control initiatives and communicate same	Board	Ongoing	
ii) Continue support of collaborative groups, e.g. International Infection Control Council.	Board	Ongoing	
iii) Support CHICA representation at major infection control conferences as representative of CHICA-Canada, (e.g. APIC and IFIC)	Board	Ongoing	
iv) Establish nomination criteria for IFIC Board.	Board	2006	Completed
v) On-going support of CHICA representative on IFIC Board.	Board	Ongoing	
vi) Initiate an annual collaborative business meeting with international IPC partners (e.g. CBIC, APIC, IFIC and ICNA) at CHICA conference	MSO/President CHICA and IFIC Web Managers	2007 Ongoing	
vii) Continued growth of International Calendar on website			
viii) Establish criteria for president or alternate's atten-			

INITIATIVE	RESPONSIBILITY	TARGET DATE	OUTCOME
dance at additional international conferences	Board	2006	Completed
ix) Memorandum of Understanding established between CCHSA/CPSI/PHAC/CHICA.	Board	Ongoing	Completed
x) Further development of strategic partnership with previous group.	Board	2007	
xi) Explore relationship with Canadian Public Health Association			
xii) Facilitate access to provincial projects with national potential (e.g. RNFOO,Core Competencies)	Board/MSO/Web Communications Manager	Ongoing	
C) Development of a marketing and communication strategy	Board	2007/08	
i) Arrange one year service agreement with consultant			
ii) Identify best marketing strategies, such as messaging/ communications/media/press/lobbying /branding deliverables.	Board/Consultant	2007/08	
3. Revenue Generation (Entrepreneurial Direction) To develop entrepreneurial ventures to generate funds necessary for the continued support of initiatives/strategic direction.			
A) Cultivate strong industry relationships to advance common issues (e.g. hand hygiene)			
i) Establish industry relationship working group under GaPAC as a pilot with evaluation after 12 months	Government and Public Affairs Committee/MSO	2007/08	
ii) Redesign and expand Patron membership program	GaPAC/MSO	2007/08	
B) Expand website revenue generation opportunities with corporate/industry/healthcare partners			
i) Redesign website job posting process using/charging HR departments	Board/MSO/Web Communications Manager	2006	Completed
C) Commitment to increasing frequency of conjoint conferences	Board	Ongoing	
D) Explore new markets for revenue-generating products and services	Director, Programs & Projects/Board	Ongoing	
4. To develop an enhanced infrastructure required to support the strategic directions.			
i) Hire Bookkeeper to assist Finance Director with day-to-day financial operations.	Director of Finance/ MSO	2006	Completed
ii) Provision of regular operating budget reports to board members	Bookkeeper	Ongoing	
iii) Hire Education Coordinator to facilitate continuation of CHICA basic infection control course.	Board	2007	
iv) Establish Web Communications Manager position	Board	2007	Completed
v) Develop job description for Communications Director	Board	2007/08	
vi) Transition to full time administrative support position and separate conference planner	Board	2007/08	
vii) Ensure succession plan and contingency plan in place for both positions	Board/MSO	2007	
viii) Evaluation of CHICA BOD portfolios	Board	Ongoing	
ix) Continued development of a "consent agenda" and structured Board reports.	Board/MSO	Ongoing	
x) Establish schedule of Board teleconference meetings	Board/MSO	Ongoing	
xi) Identify and track success indicators per portfolio (e.g. increase in membership etc)	Board/MSO	2007/08	

CHICA-CANADA 2006/2007 PRODUCT ORDER FORM

PRODUCT	QUANTITY			MEMBER RATE	NON-MEMBER RATE	TOTAL
Just Wash 'Em VHS Video© – no workbook				$34.95	$39.95	
Just Wash 'Em VHS Video© with workbook				44.95	49.95	
Just Wash 'Em DVD© – no workbook				38.95	43.95	
Just Wash 'Em DVD© With workbook				48.95	53.95	
10% Discount on 3 or more!						
Lavez les! VHS Video© – no workbook				34.95	39.95	
Lavez les! VHS Video© with workbook				44.95	49.95	
Lavez les! DVD© – no workbook				38.95	43.95	
Lavez les! DVD© with workbook				48.95	53.95	
10% Discount on 3 or more!						
Sudsy Stickers/English or French (While stock lasts)	500			4.95	4.95	
ARO Video© – Across the Spectrum of Care				20.00	25.00	
Le MRA© – Dans tout le spectre des soins				20.00	25.00	
Infection Control Audit Toolkit				120.00	150.00	
Strategies for Pandemics and Disasters Toolkit				120.00	150.00	
ESBL Toolkit				120.00	150.00	
Webber Training Teleclass CD (attach list of recordings to be ordered)				55.00 – no shipping & handling fee	55.00 – no shipping & handling fee	

CHICA-Canada
PO Box 46125 RPO Westdale
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Orders $101-$150 - $12.00
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SUB-TOTAL	
Shipping & handling +	
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*GST/HST – GST 6% of total amount, including shipping & handling; HST 14% of total amount including shipping & handling (payable by residents of New Brunswick, Newfoundland, Nova Scotia). No GST/HST applicable on orders from outside Canada.

☐ I am paying by cheque, payable to CHICA-Canada – enclosed

☐ I am paying by credit card – VISA/MasterCard/AMEX

Credit Card Number _____ Expiry Date _____

Name of Cardholder (print) _____

Signature of Cardholder _____

SHIP TO:

Name _____

Address _____

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Telephone _____

CHICA-CANADA

Community And Hospital Infection Control Association – Canada
Association Pour La Prévention Des Infections Á l'hôpital et dans la Communauté – Canada

2007 Membership Application and Payment Verification

Enjoy the many benefits of CHICA-Canada Membership

MEMBERSHIP BENEFITS

- Subscription to *The Canadian Journal of Infection Control*
- Annual Member and Source Guide
- Professional exchange of ideas
- Access to CBIC certification
- Local Chapter activities and support
- Development of infection control standards
- Reduced registration fees for annual conference and other education offerings
- Access to Members Only section of website, www.chica.org
- Push emails, providing timely infection control updates
- Access to on-line distance education

MEMBERSHIP CATEGORIES

Active/Professional: Individuals occupationally or professionally involved in the practice of Infection Control and/or Epidemiology. May vote, hold office and serve on committees.

Associate/Business: Industry representatives, as well as those not actively involved in the practice of infection control and/or epidemiology. May not vote or hold elected office.

Institutional: Health care related institutions or agencies interested in fostering the purposes and objectives of the Association. Representatives receive the same benefits as Active members.

Student: Full-time student attending an infection control related program. May not vote or hold elected office. Applications for Student membership must be accompanied by a letter of attestation that you are a full-time student attending an infection control related program.

Silver Membership – Retired: Neither employed nor seeking employment in Infection Prevention and Control. Non-voting membership.

The membership year is the calendar year, January 1st to December 31st of the same year. New membership application and dues received prior to November 1st are effective immediately and expire December 31st of the same year. Those received after November 1st are effective immediately and expire on December 31st the following year. Memberships are transferable during the membership year with a $25.00 administrative fee. Fee will not be refunded after 30 days of receipt. There will be a $15.00 charge for all returned cheques. Payment must accompany application. No post-dated cheques.

Section 1: APPLICATION FOR INDIVIDUAL MEMBERSHIP – (Active, Associate or Student/Retired)

NOW INCLUDES CHAPTER MEMBERSHIP OF YOUR CHOICE

Individual Membership fees: $125.00 (CAD$) **or** Retired or Student fees $75.00 $_____ (Sub Total A)

Section 2: APPLICATION FOR CHAPTER MEMBERSHIP – For your nearest Chapter, see reverse

☐ I am a member of/I am joining _____Chapter. (See list of Chapters on second page. Geographic locations of Chapters can be found on www.chica.org.)

☐ Additional chapters (in addition to primary chapter) - $25.00 each

Names of additional chapters I wish to join _____ $_____ (Sub Total B)

☐ I am declining Chapter Membership.

Section 3: APPLICATION FOR INSTITUTIONAL MEMBERSHIP (Active or Associate)

This category will be beneficial to those agencies which have two or more representatives to the Association and/or a turnover of representatives in any calendar year. An "institution" is defined as **one physical site** with representatives to the Association employed at that site. If any agency has more than one physical location throughout the province or the nation, each site would be designated a separate "institution" for purposes of membership.

An annual fee of **$175.00** for the first representative of the institution **and an annual fee of $75.00** for each additional representative from the institution. Membership fees include Chapter Membership, please indicate chapter choice above. If one representative leaves during the calendar year and the institution names another representative, the $75.00 fee would again apply and the previous membership would be cancelled. **At least one representative must be named. Additional representatives**: List on a separate page and return a completed Membership Application Form **for each name** on the list.

Facility/Agency_____ First Representative: _____

Address:_____

Street City Prov/State Code

Tel: ( )_____ Fax: ( )_____ Email:_____

Institutional Membership fee: $175.00 (includes first representative and chapter membership) Institutional Fee: $_____

Additional Representatives: $ 75.00 each (includes chapter membership) x _____ = Additional Reps: $_____

Total Institutional Membership Fees: $_____ (Sub Total C)

Section 4: TOTAL MEMBERSHIP FEES DUE

Sub Total of Membership Fees from sections 1 and 2 or 2 and 3, above $_____ (Sub Total D)

Enclosed is my additional donation to CHICA-Canada in the amount of: $_____ (Sub Total E)

TOTAL AMOUNT ENCLOSED: (**GST/HST NOT APPLICABLE**) $_____ (TOTAL)

☐ Please charge my VISA, MASTERCARD or AMEX Number:_____ Expiry Date:____/____

Cardholder's Name (please print):_____ Cardholder's Signature_____

Or send cheque or money order, payable to CHICA-Canada, to the address on reverse. No post-dated cheques please

Membership and Expert Resource Information

Please complete all applicable sections. This information will provide accurate demographics for our Association and assist in our planning for the future. It also provides a resource of experts in the field of Infection Control, Epidemiology and associated disciplines.

MEMBERSHIP CATEGORIES

Please check one (see reverse for category definitions). MEMBERSHIP FEE NOW INCLUDES CHAPTER MEMBERSHIP

ACTIVE - $125	☐ Renewal	☐ New Member	ASSOCIATE - $125	☐ Renewal	☐ New Member
INSTITUTIONAL $175/$75	☐ Renewal	☐ New Member	SILVER/RETIRED - $75	☐ Renewal	☐ New
STUDENT - $75	☐ Renewa	☐ New Member			

I am replacing the following CHICA-Canada Member:_____
A **$25.00 administration fee applies to membership transfers made during the calendar year**

This section to be completed only by new members or if information has changed since last application.

Name:_____ Academic Designations_____

Position:_____

Place of Employment:_____

Address of Employer:_____
Street Address City Prov/State Code

Office Tel: ( )_____ Extension: _____ Office Fax: ( )_____

Email:_____ Send information to my: ☐ Office ☐ Home address (below)

The employment information given above will be included in the CHICA-Canada Member and Source Guide. If you do not wish to have your information printed in the Guide, advise the Membership Services Office in writing by December 31st each year.

Home Address (optional)_____
Street Address City Prov/State Code

Home Tel (optional): ( )_____ (please list if no employer listed above, for contact info only)

DISCIPLINE:	☐ RN	☐ Microbiologist	☐ MD	☐ Technologist	☐ Other_____
EDUCATION	☐ Diploma	☐ Bachelor	☐ Master	☐ Doctorate	☐ Other_____
CERTIFICATION	☐ CIC – Year of Exam_____			☐ Other_____	
INSTITUTION:	☐ Hospital	☐ Long Term Care	☐ Community Health	☐ Industry	☐ Other_____
# OF BEDS:	☐ 1 to 99	☐ 100 to 249	☐ 250 to 499	☐ 500 to 699	☐ 700 to 999 ☐ 1000 or more ☐ N/A
COMMUNICATION:	☐ English	☐ French			

CHAPTER MEMBERSHIP

Chapter membership is not compulsory for membership in CHICA-Canada; however, Chapter members **must** be members of CHICA national (CHICA-Canada Policy 8.60). There are 20 local Chapters of CHICA-Canada (see list below). Membership in your local Chapter provides invaluable networking, education and communication opportunities**. Individual Chapter Membership is included in your CHICA Membership Fee (see reverse)**. Please indicate choice of chapter or decline of chapter membership on reverse page. To contact your nearest chapter or determine their geographic location, see www.chica.org. NOTE: Chapters may assess additional fees to their members. NOTE: Membership in more than one chapter is $25.00 per chapter.

*Newfoundland and Labrador
*New Brunswick/PEI
*CHICA-Nova Scotia
*Montreal P.I.
*CHICA-Eastern Ontario
*Renfrew County Organization for Professionals in Infection Prevention and Control (RCOPIC)
*Central Ontario Professionals of Infection Control (COPIC)
*CHICA-Ottawa Region
*Southern Ontario Professionals in Infection Control (SOPIC)
*Toronto and Area Professionals in Infection Control (TPIC)
*CHICA-HANDIC
*Huronia Professionals of Infection Control (HUPIC)
*CHICA Northeastern Ontario
*CHICA Northwestern Ontario
*Manitoba Chapter
*Saskatchewan Professionals in Infection Control (SASKPIC)
*CHICA - Southern Alberta
*CHICA- Northern Alberta
*CHICA- BC -
*CHICA-Vancouver Island

Please forward this completed form, with payment to:

CHICA-Canada PO Box 46125 RPO Westdale, Winnipeg MB R3R 3S3
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Business Number 11883 3201 RT0001
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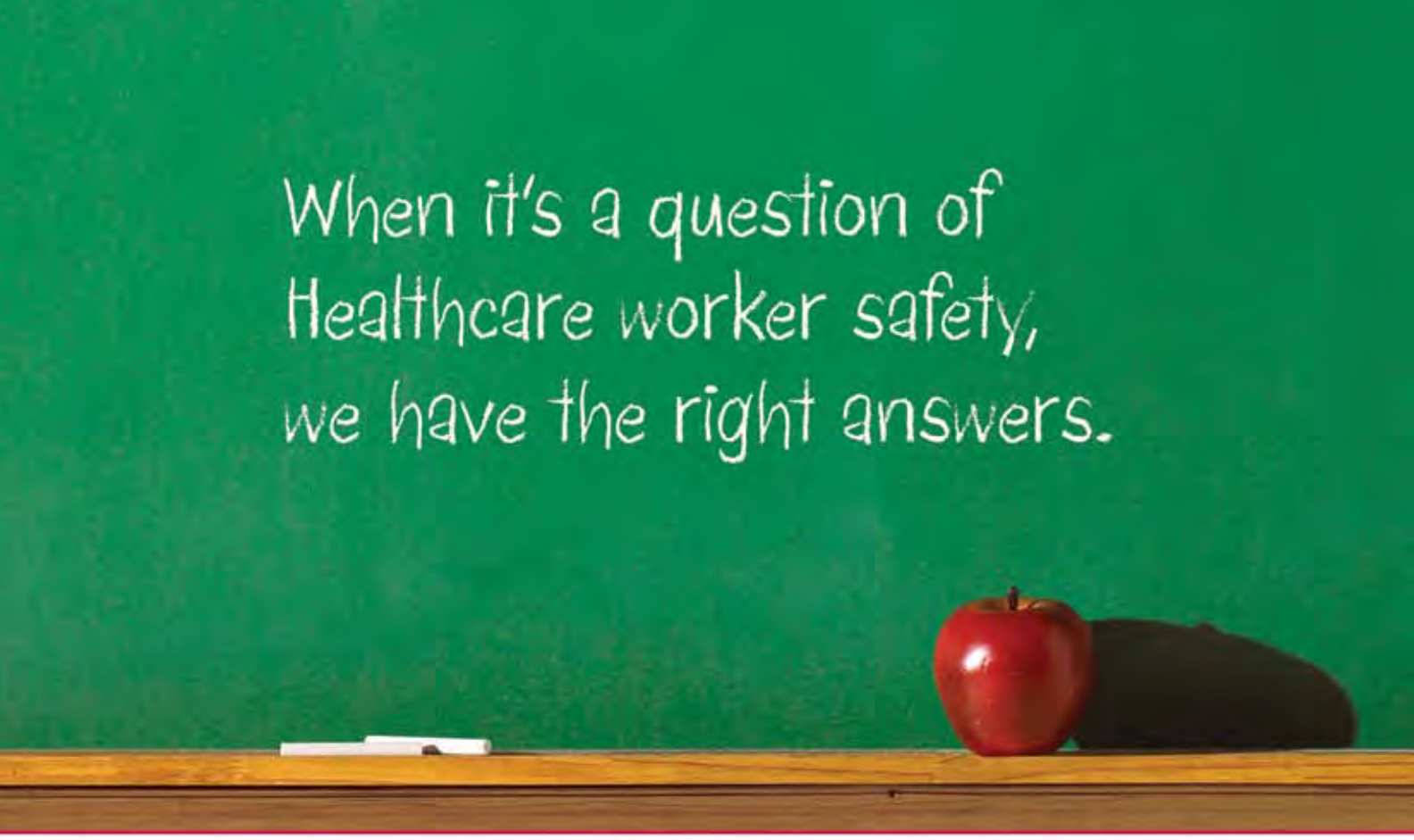

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1. Chaiyakunapruk N, Veenstra DL, Lipsky BA, Saint S. Chlorhexidine compared with povidone-iodine solution for vascular catheter-site care: a meta-analysis. *Ann Intern Med*. 2002;136:792-801.
2. Ostrander RV, Botte MJ, Brage ME. Efficacy of surgical preparation solutions in foot and ankle surgery. *J Bone Joint Surg*. 2005;87:980–985.

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New Canadian study: Resistance to first-line antibiotics to treat community-acquired pneumonia linked to treatment failure

According to study data presented at the Third International Symposium on Resistant Gram-Positive Infections, and recently published in the journal *Clinical Infectious Diseases*, the class of antibiotics recommended as first-line therapy in Canadian Guidelines for the Initial Management of Community Acquired Pneumonia (CAP) has been linked to treatment failures due to the development of resistance.

The prospective, population-based surveillance study was conducted by the Toronto Invasive Bacterial Diseases Network (TIBDN) over a five-year period. It showed that resistance to macrolides – the class of antibiotics most often used first-line to fight the *Streptococcus pneumoniae* bacterium – the most commonly identified cause of serious illness in young children and of CAP in adults – is an important cause of macrolide therapy failure.[1]

In the past 20 years there have been an increasing number of patients with *Streptococcus pneumoniae* infections who are failing to recover after treatment with certain macrolides.

"This study shows us that macrolides should be avoided as empirical therapy in certain patients due to emerging resistance issues," says Dr. Donald Low, one of the study investigators and a Toronto microbiologist. "The treatment paradigm is shifting due to new antibiotic resistance trends. Physicians need to assess patients' antibiotic treatment histories as part of their evaluation and consider using the most effective agents first. Taking this approach may help get patients on their feet faster and avoid contributing to growing resistance with the macrolide class of medications."

Despite macrolide-related pneumococcal antibiotic resistance rates in excess of 18 per cent,[2] macrolides (erythromycin, azithromycin and clarithromycin) are the class of antibiotics recommended in Canadian guidelines as first-line therapy for pneumococcal infections, including CAP. Respiratory fluoroquinolones (moxifloxacin, levofloxacin and gatifloxacin), oral -lactams (amoxicillin-clavulanate + macrolides, cephalosporins + macrolides) and tetracycline (doxycycline) are other antibiotic treatment options recommended in the Canadian guidelines to treat CAP.

About the Study

The study, *Macrolide Resistance in Bacteremic Pneumococcal Disease: Implications for Patient Management* was a prospective population-based surveillance program of pneumococcal disease in Toronto and Peel regions between January 1, 2000 and December 31, 2004. During the five years of surveillance, 60 out of 1,696 cases of pneumococcal bacteremia (8.5 cases/100,000) were reported as failures of outpatient macrolide therapy. The study found that macrolide-resistant bacteria were more commonly isolated in cases that had failed on macrolide therapy compared to all other cases (after failure of non-macrolide antibiotics, or cases that occurred without prior antibiotic therapy) ($p < 0.001$).

Based on the study results, macrolide antibiotic use should be avoided for patients with known clinical risk factors for macrolide resistance (including patients treated with macrolides within the previous three months[3,4], patients treated with penicillin or trimethroprim-sulfamethoxazole[5,6], extremes of age[6], HIV infection[5], and exposure to siblings with resistant isolates including children attending daycare[7]) and for patients residing in areas with high rates of macrolide resistance.

Patients admitted to the emergency department with CAP who are deteriorating despite receiving macrolide therapy should also receive treatment with a different class of antibiotics.

Bayer Inc., the makers of AVELOX® (moxifloxacin hydrochloride), an antibiotic in the fluoroquinolone class, was among the companies that supported the TIBDN surveillance through an unrestricted educational grant.

About Toronto Invasive Bacterial Diseases Network (TIBDN)

The TIBDN is a collaboration of 25 hospitals, 19 microbiology laboratories, infection control practitioners, physicians and 85 long-term care facilities serving the population of metropolitan Toronto and Peel Region. All surveillance activities are coordinated with local and provincial health departments.

The goal of the network is to reduce morbidity and mortality from infectious disease by using surveillance to better understand risk factors for infection, and to improve the prevention, diagnosis and treatment of infection.

About Bayer Inc.

Bayer Inc. (Bayer) is a Canadian subsidiary of Bayer AG, an international research-based group with core businesses in health care, crop science, and innovative materials.

[1] Daneman N, McGeer A, Green K, Low DE. Macrolide Resistance in Bacteremic Pneumococcal Disease: Implications for Patient Management. *Clinical Infectious Diseases* 2006; 43: 432-438.

[2] Green K, Powis J, Pong-Porter S, Plevneshi A, McGeer A, Low DE, Trends in Antimicrobial Prescribing and Pneumococcal Resistance, Canada, 1993-2005. *Canadian Bacterial Surveillance Network.*

[3] Niederman MS, Mandell LA, Anzueto A, et al. Guidelines for the management of adults with community acquired pneu-

monia: diagnosis, assessment of severity, antimicrobial therapy, and prevention. AM J Respir Crit Care Med 2001; 163:1730-54.

[4] Bartlett JG, Dowell SF, Mandell LA, File TM Jr, Musher DM, Fine MJ, Infectious Diseases Society of America. Practice Guidelines for the management of community-acquired pneumonia in adults. Clin Infect Dis 2000; 31:347-82.

[5] Vanderkooi OG, Low DE, Green K, Powis JE, McGeer A. Predicting antimicrobial resistance in invasive pneumococcal infections. Clin Infect Dis 2005; 40:1288-97.

[6] Clavo-Sanchez AJ, Giron-Gonzalez JA, Lopez-Prieto D, et al. Multivariate analysis of risk factors for infection due to penicillin-resistant and multidrug resistant *Streptococcus pneumoniae*: a multicenter study. Clin Infect Dis 1997; 24:1052-9.

[7] Samore MH, Magill MK, Alder SC, et al. High rates of multiple antibiotic resistance *in Streptococcus pneumoniae* from healthy children living in isolated rural communities: association with cephalosporin use and intrafamilial transmission. Pediatrics 2001; 108:856-65.

CHICA would like to welcome Rubbermaid as a new Patron Member, and thank the company for continued support.

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The Rubbermaid Microfibre Cleaning System is an integrated system of soft goods, handles and frames, and specialized buckets. Cleaning with microfibre improves efficiency, is cleaner, and environmentally friendly.

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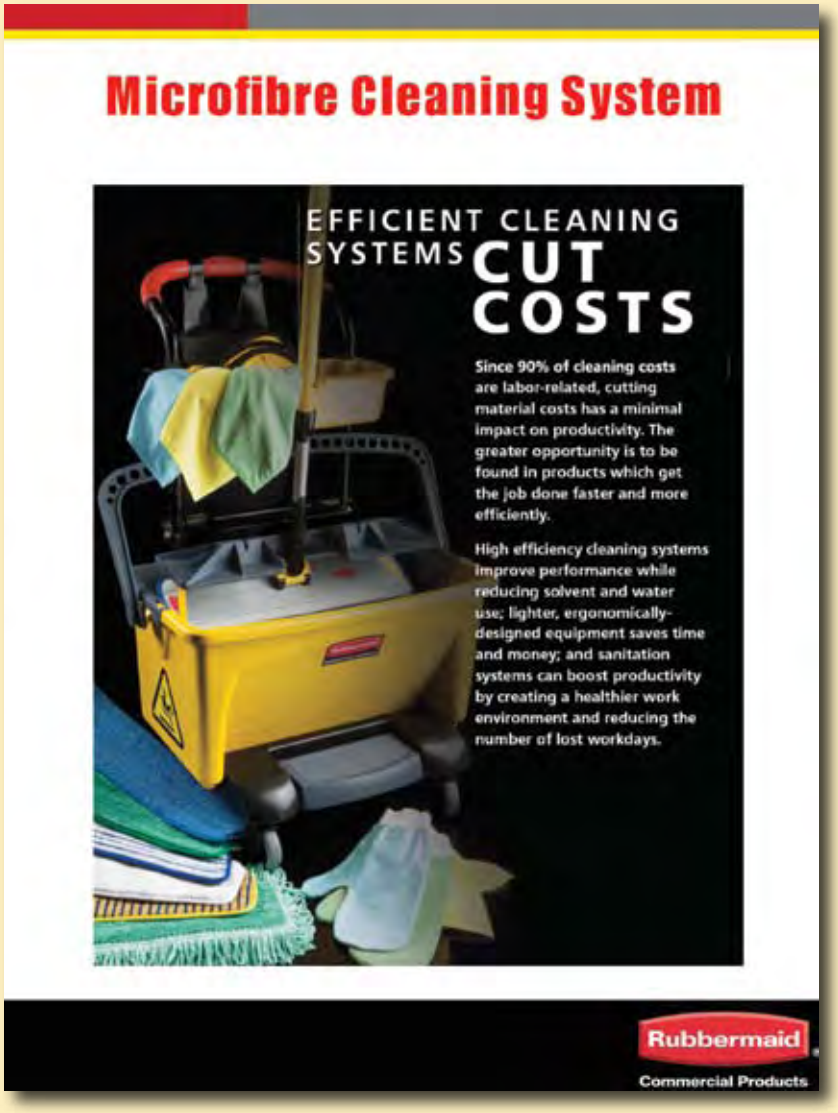
CHICA would like to welcome Rubbermaid as a new Patron Member, and thank the company for continued support.



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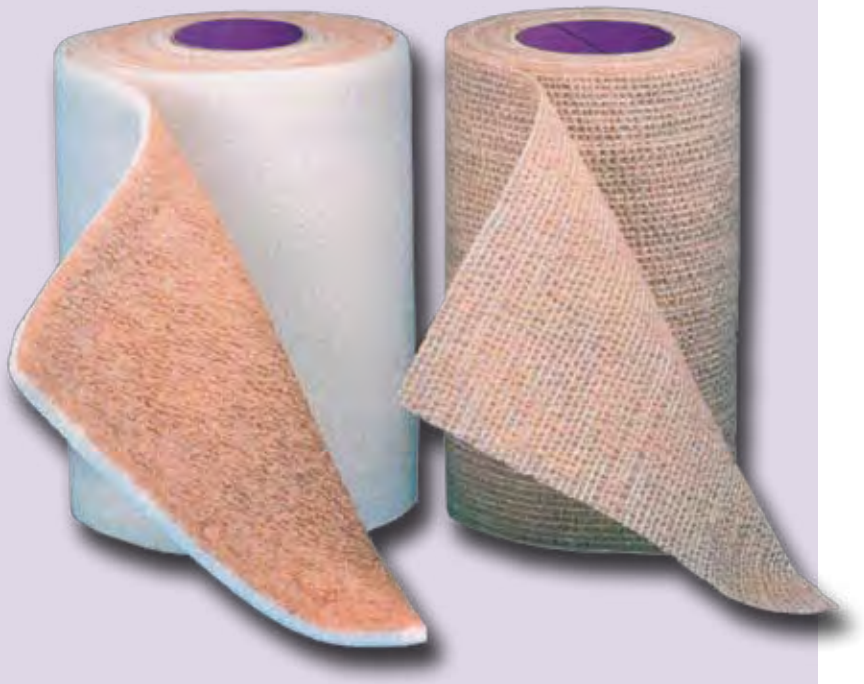
For more information on the system, visit www.3M.com/ca/healthcare or call 1-800-364-3577.



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PALL MEDICAL PRODUCTS	165	800-465-8555	matthew_antoine@pall.com	www.pall.com
PDI - PROFESSIONAL DISPOSABLES INTERNATIONAL	171	800-263-7067	info@pdipdi.com	www.pdipdi.com
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Biogel® Patented Puncture Indication System | **spot** the risk.

Hep C and other bloodborne viral infections don't have a face. But they do have an impact. Approximately 2.7 million Americans are chronically infected with HCV.[1] Is your next patient infected? Why risk it? Only the Biogel double gloving patented puncture indication system alerts you and your staff with visible evidence of a perforation, in the presence of fluid, as it happens. This alert allows you to react, change gloves and resume doing what you do best.

Double Glove with Biogel® Patented Puncture Indication System

- Reduce your risk without losing tactile sensitivity[2]
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Biogel® Indicator™ Underglove with Biogel® Eclipse™ as outer glove.

Dark green spot enables rapid detection of glove perforation in the presence of fluid.

*U.S. Patent #5,224,221 and 5,524,294.

[1] NIH Consensus Statement on Management of Hepatitis C:2002. NIH Consensus and State-of-the-Science Statements; Vol 19 No 3, June 10-12, 2002. National Institutes of Health, Office of the Director. Accessed at : http://consensus.nih.gov on January 28, 2004.

[2] Forman S., Nicols R.L. et al. Efficacy of Double Gloving with an Intrinsic Indicator System, Surgical Infections, 2006; 4:385-395.

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