



INFECTION PREVENTION AND CONTROL

PROVIDENCE HEALTH CARE

ANNUAL REPORT
2017 - 2018



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Executive Summary

Infection Prevention and Control (IPAC)

Work Redesign – Back to Basics

The IPAC program evaluated the way work was being done through several planning sessions. We determined that Infection Control Practitioners (ICPs) needed to be more visible on the units, to observe practice, to advise and teach staff and patients about how they can prevent the transmission of infections, and to build awareness of the threat of multidrug resistant organisms and associated preventive measures.

The work redesign resulted in assigning six ICPs to clinical rounding in acute care (St. Paul's Hospital and Mount St. Joseph's Hospital) and Residential Care Homes. In addition to the six rounding ICPs, one position was focused on working to automate surveillance processes and managing office systems in partnership with our epidemiologist. One position was dedicated to construction, renovations, and redevelopment projects. The final position is focused on developing education and orientation programs, Just-in-Time learning for emerging organisms and special incidents and arranging annual events like World Hand Hygiene Day and Infection Control Week.

With the transition to a new workflow, we have:

- made progress in automating data collection needed for surveillance;
- participated in clinical rounds daily in acute care where ICPs work more closely with staff, patients and families improving knowledge of infection prevention and control;
- conducted scheduled rounds in the five residential care homes enabling the ICPs to interact with staff and residents in applying infection prevention measures in this unique environment;
- ensured measures are taken to safely confine areas under construction renovations and provide advice regarding infection prevention and control to areas of new construction;
- participated in the redevelopment planning for the New St. Paul's Hospital providing specific advice on the requirements for IPAC; provided Just-in-Time education for outbreaks or clusters of infections; and ensured education and orientation programs are current and support good infection control and prevention practice.

Our Back to Basics program focuses on preventing the transmission of infection through basic measures like hand hygiene, use of PPE, and cleaning and disinfection.



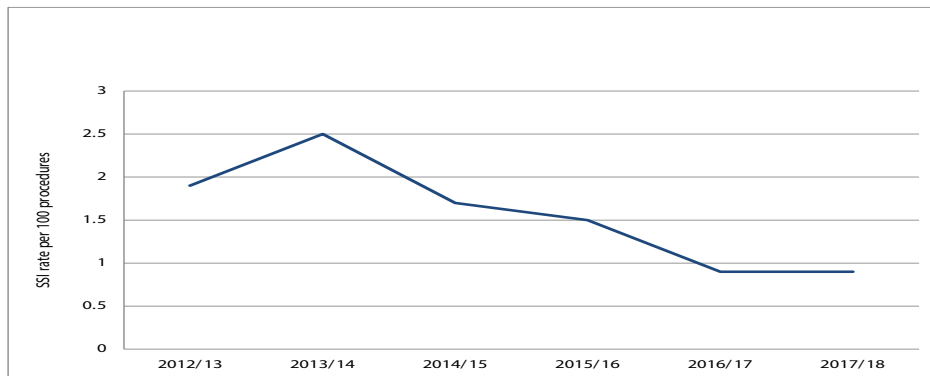
SURVEILLANCE



Surgical Site Infection (SSI) Surveillance

CARDIAC SURGERY

Figure  SSI rate per 100 procedures following CABG and valve surgery, 2012/13 to 2017/18



Background

In collaboration with the Division of Cardiac Surgery, IPAC has conducted SSI surveillance for coronary artery bypass graft (CABG) surgery and cardiac valve replacement surgery for the past four years. Cases are identified by weekly review of the consults seen by the Infectious Diseases service and through cardiac nurse practitioners notifying IPAC of any suspected SSI, via a dedicated phone line.

Outcome

- 762 CABG and cardiac valve replacement surgeries were performed at PHC during 2017/18.
- There were seven cardiac SSI cases (0.9 per 100 procedures).

All cardiac SSI cases were classified as organ space  sternal infections. One case was additionally diagnosed with deep SSI from vein harvest sites, in addition to sternal infection.

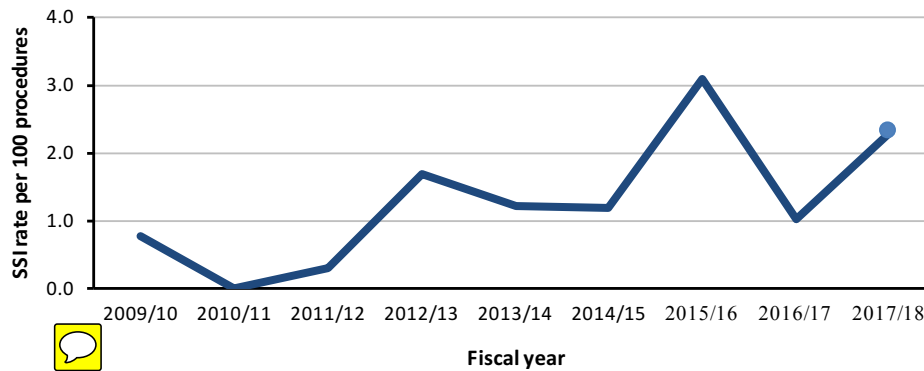
Appropriate pre-operative antibiotics were used in 100% of the SSI cases.

What we are working on

We are exploring ways to better ensure we have adequate case ascertainment. We will work with nurse practitioners and the cardiac surgeons to identify ways for more efficient and comprehensive case follow-up.

Surgical Site Infection (SSI) Surveillance

CAESAREAN SECTION (C-SECTION) SURGERY



Background

Since 2008/2009, IPAC has been working with the Department of Obstetrics and Gynecology at Providence Health Care to conduct SSI surveillance after a Caesarean section. Since length of stay in hospital is short for this procedure, post-discharge surveillance is critical.

Cases are found through daily rounds, review of readmissions and visits to the Emergency Department (ED), and post-discharge surveillance.

In 2015/16, we initiated a web-based platform (Q-Care) to automatically email and text patients for post-discharge surveillance. This became our standard approach in 2017/18. Q-Care received the BC Patient Safety and Quality Award in the Staying Healthy Category in 2016.

Outcome

- 608 C-sections were performed at St. Paul's Hospital in 2017/18
- 69% response rate to 30 day follow-up
- 14 SSIs were identified
- The SSI rate was 2.3 per 100 procedures
- Infections were classified as: 14% organ space ▪ 7% deep ▪ 79% superficial

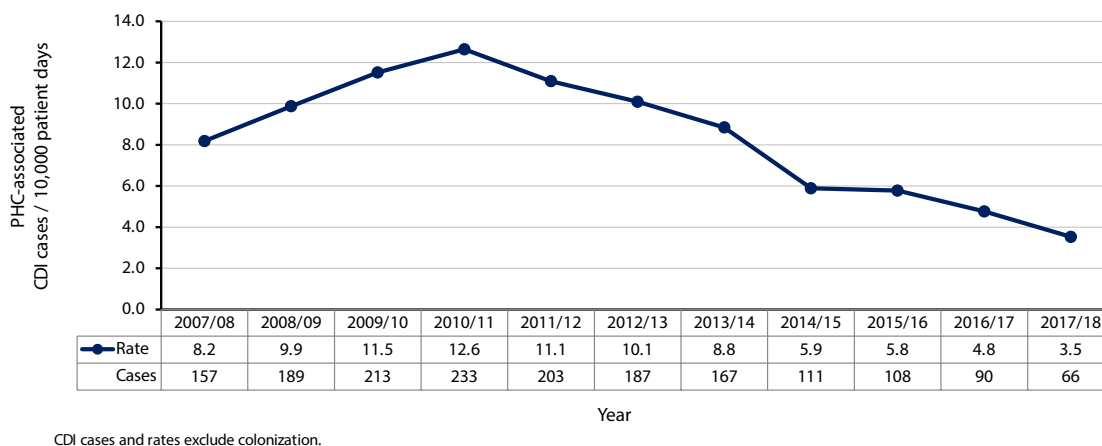
What we are working on

We are currently expanding the automated component of post-discharge surveillance to support sustainability. This automation includes the transfer of information directly from our operating room information system to QCare. We would also like to collect the cellular phone number and emails of patients at the time of registration. We believe this initiative improves the patient experience, engagement, and quality care.

Surveillance — Bacteria

CLOSTRIDIUM DIFFICILE (CDI)

Figure  PHC-associated CDI incidence rate in acute care facilities, 2007/08 to 2017/18



Background

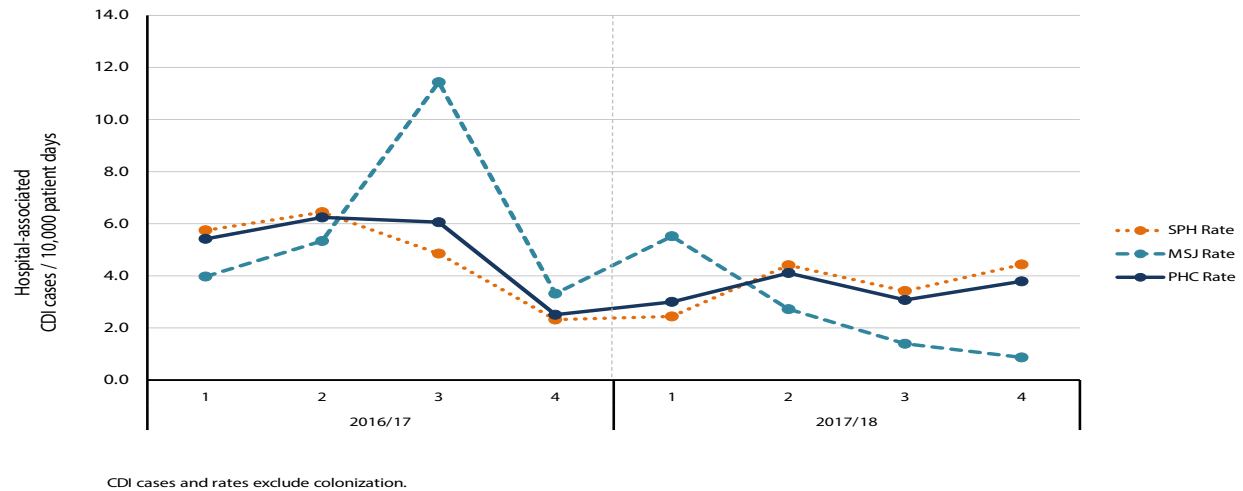
Clostridium difficile (*C. difficile*) is the most common cause of health care-associated infectious diarrhea. IPAC is actively involved in preventing transmission of *C. difficile* at Providence Health Care sites by engaging in the following activities:

- providing education for staff and patients on all positive cases and providing regular education on units with respect to appropriate isolation precautions, cleaning and disinfection practices, and hand hygiene;
- increasing the frequency of communication with environmental cleaning staff to inform them of patient rooms that require enhanced bleach disinfection;
- creating a process for environmental cleaning staff to inform unit staff upon completion of bleach disinfection; and
- notifying the Antimicrobial Stewardship Program (ASP) of inpatient and outpatient cases to ensure our patients and residents receive timely, effective and optimal antimicrobial therapy and management

Outcome

- There were 141 new cases of *C. difficile* infection (CDI) identified at PHC in 2017/18.
- 70 (50%) of these were classified as PHC-associated cases and of these, 66 (86%) were from acute care facilities.
- The incidence rate of PHC-associated CDI in acute care facilities was 3.5 cases/10,000 patient days (95% CI: 2.7-4.5). This is the lowest rate since we started CDI surveillance in 2007.
- The CDI incidence rate at St. Paul's Hospital was 3.8 cases/10,000 patient days (95% CI: 2.9-4.9). This rate was similar to the last fiscal year (4.5 cases/10,000 patient days, 95% CI: 3.5-5.7, $p=0.29$).
- The CDI incidence rate at Mount Saint Joseph Hospital was 2.4 cases/10,000 patient days (95% CI: 1.1-4.7). This rate was statistically lower than the last fiscal year (5.7 cases/10,000 patient days, 95% CI: 3.5-8.8, $p<0.05$).
- The unadjusted incidence, which includes patients colonized with *C. difficile*, was 4.8 per 10,000 patient days (95% CI: 3.9-6.0). This rate was similar to the unadjusted incidence from last fiscal year (6.0 cases/10,000 patient days, 95% CI: 4.9-7.2, $p=0.14$).

Figure 1 HC-associated CDI incidence rate by acute care facility site and fiscal quarter, 2016/17 to 2017/18



Issues

Patients can be colonized with *C. difficile* prior to entering our hospitals and remain asymptomatic without clinical disease, only to develop CDI after receiving antibiotics in hospital.

As a result, some CDI cases that are acquired in the community are misclassified as health care-associated CDI

This year was the second year that IPAC, along with the ASP, clinically reviewed every case of CDI to determine whether the patient had a true infection, rather than colonization. This information is reflected in this year's rate.

What we are working on

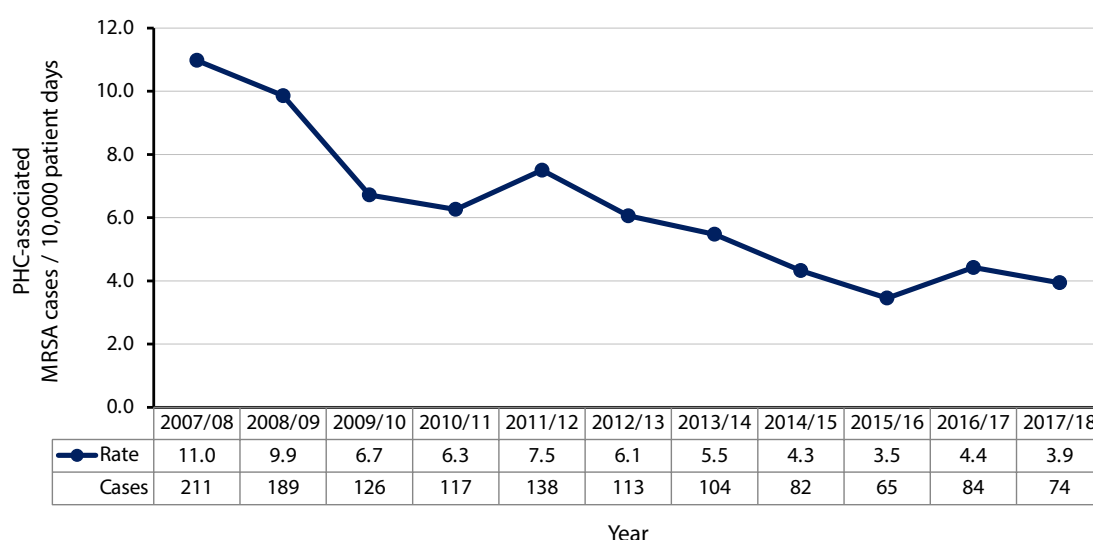
IPAC continues to collaborate with the PHC ASP. This collaboration ensures that upon a patient's new positive or indeterminate *C. difficile* result, the ASP pharmacist and physician receive real-time alerts.

In the last quarter of 2017/18, infection control practitioners started rounding on every CDI case, providing education on contact precautions and hand hygiene for both patients and staff.

Surveillance — Bacteria

METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

Figure  HC-associated MRSA incidence rate in acute care facilities, 2007/08 to 2017/18

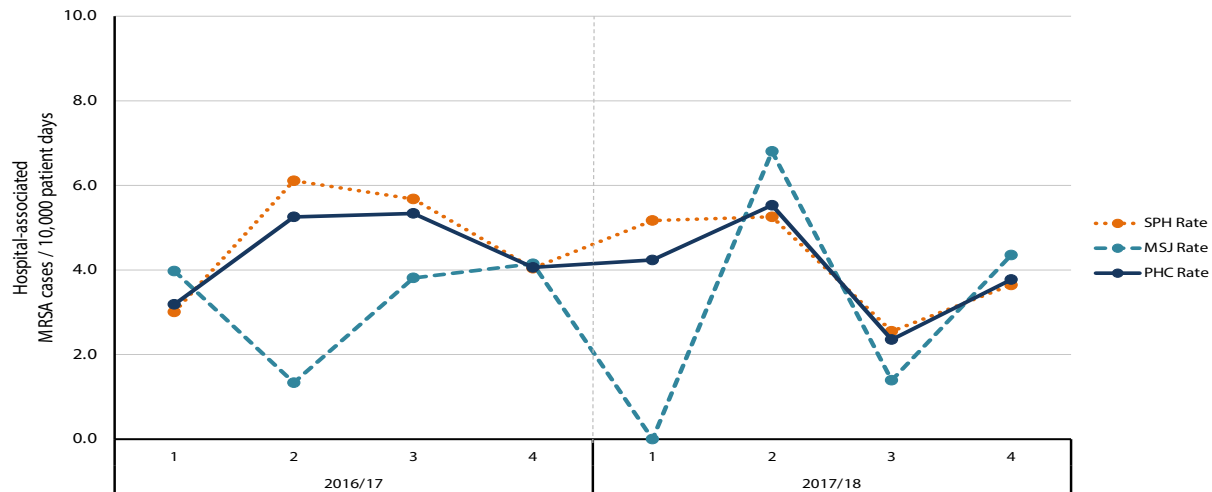


Background

MRSA are antibiotic-resistant bacteria that are transmissible in hospital, long-term care and community settings. MRSA has the potential to cause serious infection for which treatment options are limited.

In hospital, MRSA infections are associated with increased length of stay, higher mortality and increased costs. Early identification of patients colonized with MRSA through admission screening and prompt implementation of infection control measures can prevent transmission of MRSA. Admission screening at St. Paul's Hospital (SPH) and Mount Saint Joseph Hospital (MSJ) is risk-factor based, except for in General Medicine and the Intensive Care Unit (ICU) where all patients are screened. In the ICU, they are screened on admission and subsequently at weekly intervals. All newly identified MRSA cases trigger subsequent screening of a patient's roommates.

Figure 1.1 PHC-associated MRSA incidence rate by acute care facility site and fiscal quarter, 2016/17 to 2017/18



Outcome

In 2017/18, there were 706 new cases of MRSA identified at PHC facilities.

- 83 (12%) of these were classified as PHC-associated cases and of these, 74(89%) were from acute care facilities.
- The PHC-associated incidence rate was 3.9 cases /10,000 patient days (95% CI: 3.9-4.9).
- The PHC-associated MRSA rate in 2017/18 was not statistically significantly different compared to last fiscal year ($p=0.47$).
- 48% of PHC-associated cases were identified through hospital admission screening programs and contact tracing, while remaining cases were identified from clinical specimens.

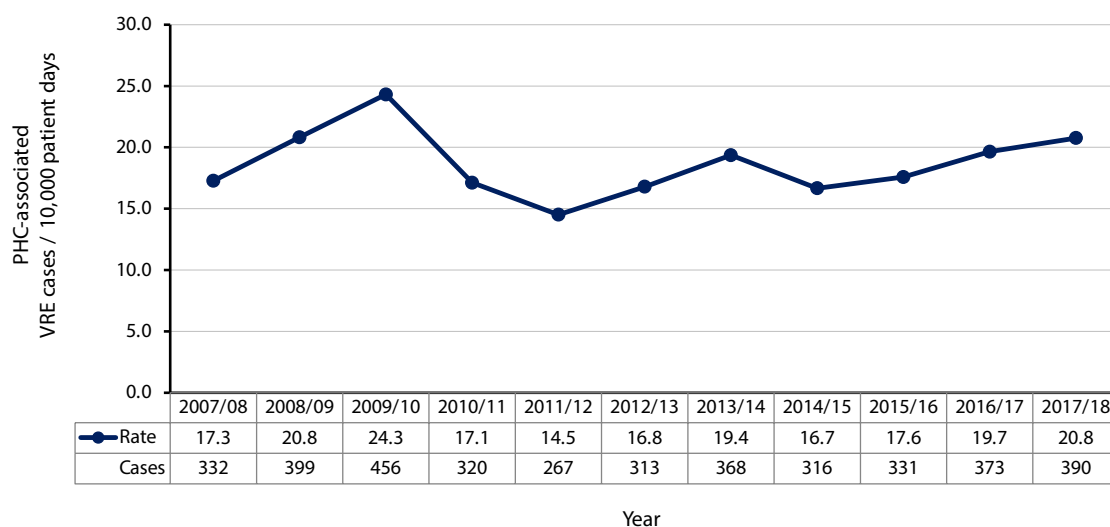
What we are working on

IPAC continues to work closely with leaders and frontline staff of the Emergency and Medicine Departments to ensure timely ordering and collection of the admission screens.

Surveillance — Bacteria

VANCOMYCIN RESISTANT ENTEROCOCCI (VRE)

Figure 1 PHC-associated VRE incidence rate in acute care facilities, 2007/08 to 2017/18



Background

VRE are antibiotic-resistant bacteria that can be transmitted to patients in health care facilities.

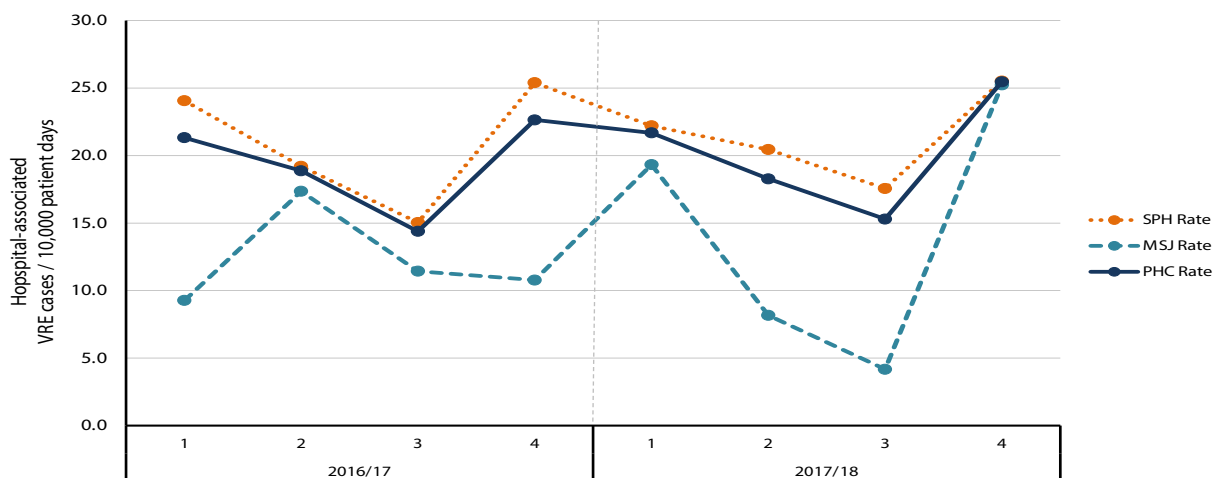
Colonization with VRE is more common than infection, and since colonization is the first step towards infection, preventing it is crucial.

Issue

Discussion continues over the utility of VRE prevention and control programs in Canadian hospitals. The Centers for Disease Control and Prevention (CDC) and Public Health Agency of Canada (PHAC) guidelines currently recommend Contact Precautions for patients with VRE.

Some hospitals have either discontinued or scaled back their VRE prevention and control efforts. Revising precautions for VRE may result in increased transmission of VRE in health care settings, with unexpected impact on neighbouring facilities.

Figure 1. PHC-associated VRE incidence rate by acute care facility site and fiscal quarter, 2016/17 to 2017/18



Outcome

There were 615 new cases of VRE identified at Providence Health Care facilities.

- 401 (65%) of these were classified as PHC-associated cases and of these, 390 (97%) were from acute care facilities.
- The PHC-associated incidence rate was 20.8 cases/10,000 patient days (95% CI: 18.8-22.9).
- The PHC-associated VRE rate in 2017/18 was not statistically significantly different compared to last fiscal year ($p=0.45$).
- 77% of PHC-associated cases were identified through hospital admission screening programs and contact tracing while remaining cases were identified through clinical specimens.

What we are working on

IPAC continues to recommend a risk-informed VRE control program to prevent transmission and protect our most vulnerable patients.

Surveillance — Bacteria

CARBAPENEMASE PRODUCING ORGANISMS (CPO)

Background

CPO are gram-negative bacteria that are resistant to carbapenems (considered antibiotics of last resort) and many other antibiotic classes. CPO infections are associated with high morbidity and mortality. Once established in a health care facility, CPO is difficult to control.

In Canada, cases (infection or colonization) have primarily been identified in patients previously hospitalized in endemic countries (e.g. China, India, USA and Greece). Health care-associated transmission of CPO within British Columbia facilities has also been documented.

At Providence Health Care, an Antibiotic Resistant Organism (ARO) Admission Risk Assessment Order was created and implemented in May 2014 in response to the BC CPO Working Group recommendations for identifying and screening high-risk patients on admission to acute care facilities. Further amendments to the Admission Risk Assessment Form were made in 2015 to create a more focused screening assessment.

Issue

Discussion continues over the utility of VRE prevention and control programs in Canadian hospitals. The Centers for Disease Control and Prevention (CDC) and Public Health Agency of Canada (PHAC) guidelines currently recommend Contact Precautions for patients with VRE.

Some hospitals have either discontinued or scaled back their VRE prevention and control efforts. Revising precautions for VRE may result in increased transmission of VRE in health care settings, with unexpected impact on neighbouring facilities.

Outcome

- A total of 267 screening swabs were collected for CPO at PHC facilities.
- CPO screening was primarily conducted on inpatient units at St. Paul's Hospital and Mount Saint Joseph Hospital but also in the Emergency Department, Community Hemodialysis Units, Holy Family Rehab and residential care.
- Four CPO cases were identified at PHC following screening, but there were no secondary cases due to hospital transmission.

What we're working on

PHC continues to collaborate with other health authorities to maintain a provincial approach to preventing CPO transmission in health care facilities in British Columbia.

In the last quarter or 2017/18, we started a standardized approach of communicating the need for additional screening and precautions.

Surveillance — Bacteria

MYCOBACTERIUM TUBERCULOSIS (TB)

Background

St. Paul's Hospital (SPH) and Mount Saint Joseph Hospital (MSJ) frequently manage patients with active tuberculosis (TB) infection. As TB can be difficult to identify and diagnose, the most important contributor to health care-associated transmission is patients with unrecognized respiratory TB disease. Therefore, preventing in-hospital transmission of tuberculosis relies on a number of components including:

- early identification of patients who are at high risk for active pulmonary disease;
- prompt implementation of airborne precautions when active pulmonary disease is a consideration; and
- maintenance of appropriate precautions until TB is either ruled out and an alternate diagnosis is identified, or the patient is no longer considered infectious.

Outcome

- There were 12 cases of active pulmonary TB diagnosed at Providence Health Care acute care facilities in 2017-2018. Of these, six were diagnosed among inpatients.
- Two inpatient cases required contact tracing, which resulted in 25 patients being identified as contacts. These cases were referred to Vancouver Coastal Health (VCH) Public Health for follow-up.

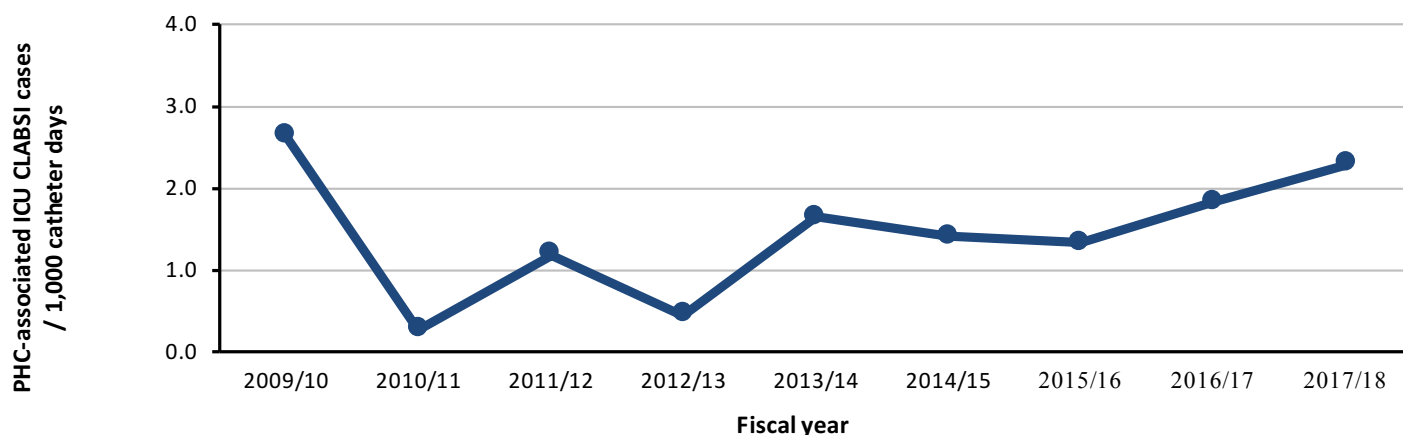
Prevention of in-hospital TB transmission is focused on promoting the appropriate transmission-based precautions for suspect or confirmed TB cases. Physicians and other frontline staff should maintain a high degree of suspicion for TB among high-risk groups and consult with IPAC before discontinuing airborne precautions.

We continue to improve utilization of the Assessment, Communication and Education (ACE) tool to guide risk assessments and standardize Infection Control Practitioners' documentation and recommendations. We also work closely with VCH Public Health, Occupational Health & Safety and Workplace Health Call Centre to align our efforts in contact tracing.

Surveillance — Device-Associated Infections

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)

Figure xx: PHC-associated ICU CLABSI incidence rate by fiscal year, 2009/10 to 2017/18



Background

Central Line-Associated Bloodstream Infection (CLABSI) continues to be one of the most costly hospital-associated infections resulting in prolonged hospital stays and increased patient morbidity and mortality.

IPAC's CLABSI surveillance is focused on cases associated with the intensive care unit (ICU) at St. Paul's Hospital (SPH) and Mount Saint Joseph Hospital (MSJ). Detection of CLABSI-related cases is based on ICP review of all Intensive Care Unit (ICU)-associated positive blood cultures. We use standardized case definitions and methods from the Centers of Disease Control and Prevention's (CDC) National Healthcare Safety Network. Cases are confirmed by an IPAC physician.

Outcome

- There were 6 CLABSI in the first three quarters of 2017/18* and the rate of infection was 2.3 cases per 1,000 catheter days.

What we are working on

IPAC continues to promote best practices in reducing the risk of infection for ICU patients, as well as monitoring and analyzing CLABSI cases. Our efforts continue to be focused on sharing the surveillance information with the ICU to advance the education provided for those inserting and maintaining central lines.

*Note: *Due to the delay in obtaining catheter days from ICU, rate for 2017/18 includes the first 3 quarters only.*

Hand Hygiene

Background

Effective hand hygiene is the single most important strategy to prevent health care-associated infections.

The Ministry of Health target for hand-hygiene compliance is 80%. Providence Health Care's target is 85%.

Outcome

In 2017/18, average PHC hand-hygiene compliance across all health care workers in acute care facilities was 81%:

- 72% before patient contact
- 86% after patient contact

Average PHC hand-hygiene compliance across all health care workers in residential care facilities was 69%:

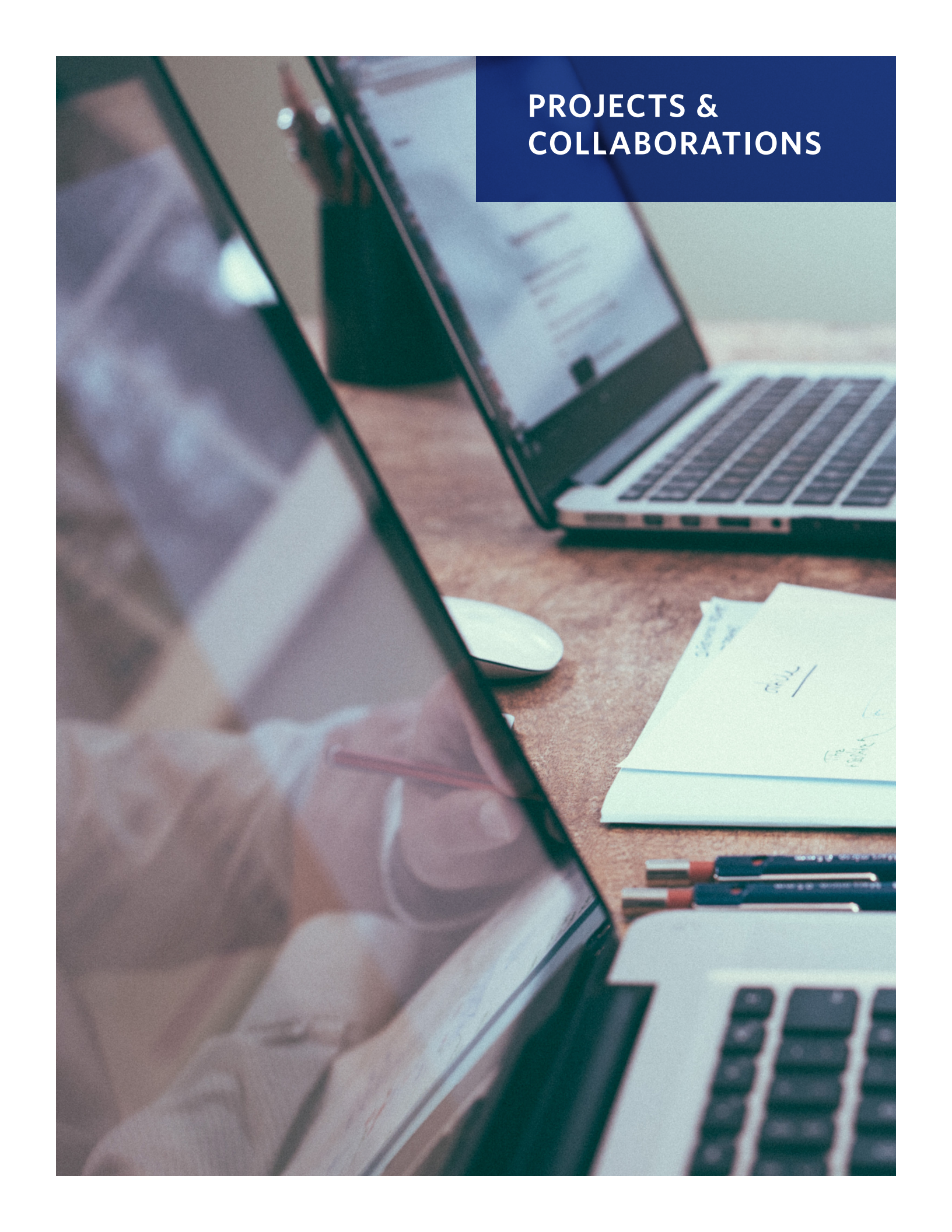
- 58% before patient contact
- 77% after patient contact

This past year, major hand-hygiene educational and promotional activities at PHC included expansion of the patient hand-hygiene initiatives and emphasis on hand hygiene before patient contact. We continue to strive to make improvements in hand-hygiene compliance and practices.

What we are working on

For 2018/19, we will achieve electronic capture of hand-hygiene data and automation for reporting. We will emphasize Just-in-Time education, improving both before patient contact and patient-hand hygiene initiatives. For residential care, we will perform facility risk assessments to target staff/resident engagement and hand-hygiene infrastructure improvements.

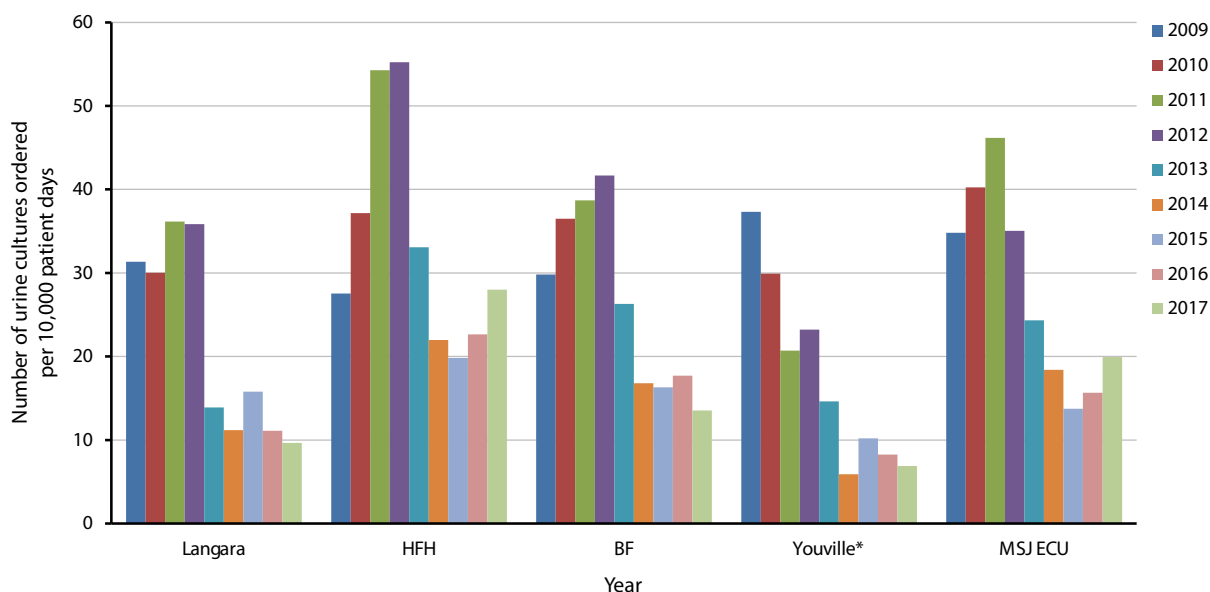


A photograph of a workspace with a laptop, a tablet, and sticky notes. The laptop is open, showing a website. A tablet is leaning against it, displaying a document. Several yellow sticky notes are attached to the tablet. A white mouse is on the desk. The scene is lit with warm, soft light.

PROJECTS & COLLABORATIONS

Projects & Collaborations

URINARY TRACT INFECTIONS (UTI) AND ASYMPTOMATIC BACTERIURIA IN RESIDENTIAL CARE



Note: Intervention of audit and feedback occurred at St. Vincent's Langara in 2013

* Residential care only

Urine culture collection is a primary driver of increased antimicrobial use.

Our goal is to reduce the number of unnecessary urine cultures collected from residents at PHC residential care homes.

IPAC focused on auditing and providing feedback to nurses and physicians for all urine cultures collected at St. Vincent's residence from January to December 2013. This project was a collaboration with the PHC Antimicrobial Stewardship Program.

The intense phase of review and feedback stopped at the end of 2013, but we continued to collect data on the total number of urine cultures ordered and collected at the residential care sites. We conducted

annual follow-up to see if the initial intensive audit, feedback and education for the residential care facilities would be sustained without the need for intense phase interventions. We have continued to see a sustained significant decrease in urine cultures collected from all residential care sites.

The most significant decrease was seen at Langara, where the most intense audit and feedback interventions occurred. The Langara urine culture rate in 2017 (9.7 urines/10,000 resident days) is significantly lower than the pre intervention rate in 2012 (35.9 urines/10,000 resident days $p < 0.01$). All of the other sites have had a significantly lower rate of urine cultures collected since 2012. Antimicrobial use also decreased for suspected UTIs.

Projects & Collaborations

PATIENT HAND HYGIENE

Providing patients with the ability to clean their hands has been a priority this year for IPAC patient education. We recruited five volunteers from the Patient Voices Network who shared their experiences and stories with hand hygiene while receiving care. .

In a two-hour focus group, they told their stories from the perspective of patients experiencing life-threatening and chronic illnesses, as well as caregivers of parents in residential facilities. One clear message from all the participants was that no one had spoken to them about hand hygiene or helped them to clean their hands while in care. They also stated that they trusted health care staff to understand the importance of hand hygiene and that as patients they felt too vulnerable to be able to ask or tell a caregiver to clean their hands.

One of the volunteers visited a nursing unit during Hand Hygiene week and shared stories about how important it was for her to be able to clean her hands when she was a patient. This left a profound effect on staff who admitted that patient hand hygiene was not something they thought about in their everyday work and were concerned that it wasn't more of a priority. Patient hand wipes are becoming available on units throughout PHC for patients and visitors to use to clean their hands. Patients are encouraged to use the hand wipes before meals.

Projects & Collaborations

REDEVELOPMENT: PLANNING THE NEW ST. PAUL'S HOSPITAL

The business case for the new St. Paul's hospital (Jiim Pattison Medical Centre) was submitted to government in January after many months of extensive planning. IPAC contributed to the work, advising on infection prevention and control requirements for the new build. Following completion of the Business Plan, and while we wait for the approval of funding, we are working on defining the clinical specifications for the individual program spaces. During numerous meetings, the interdisciplinary members of programs discuss how they plan to operate their programs in the new space. IPAC's role is to advocate for best infection control practices and ensure key elements are designed into the built environment to prevent the acquisition and transmission of infections.

Projects & Collaborations

REDEVELOPMENT: PLANNING THE NEW ST. PAUL'S HOSPITAL

In the fall of 2017, we identified issues related to management of commode chairs. A multidisciplinary group was formed to assess the functionality of commode chairs at St. Paul's Hospital and to investigate the cleaning and disinfection processes for the chairs. The working group involved stakeholders from Environmental Services, Product Standardization, Mobile Equipment Cleaning and Disinfection.

Findings from the Working Group included:

- 22 commode chairs needed to be removed from service as they were damaged or could not be cleaned;
- No formalized method of cleaning and disinfecting was in place. Chairs were wiped down between use by nursing staff;
- There were a number of different chairs in place and separation of clean chairs and those needing cleaning were an issue.

Based on these findings, the working group was able to:

- remove the damaged chairs from service, obtain funding for their replacement and replace the chairs;
- develop a cleaning and disinfecting procedure for all chairs daily, and after each use, apply a "Green is Clean" sticker to separate the clean from those needing cleaning;
- work with units to designate space in soiled utility rooms for soiled chairs and a separate area for clean chairs;
- designate a standardized commode chair and circulate the information to the SPH managers; and
- repeat the process at Mount Saint Joseph (MSJ) and in residential care.

The work has since been completed at MSJ and is beginning in residential care.

The working group highlighted the critical role of multidisciplinary and collaborative initiatives in ensuring a commitment to improving the patient experience and patient safety.

Outbreak Management

INFLUENZA OUTBREAKS

In 2017/18, there were 13 influenza outbreaks in Providence Health Care facilities (three in acute care, two in a rehabilitation unit, and eight in residential care). Just over half (54%) of the influenza outbreaks were caused by influenza A.

The number of outbreaks is similar to the previous fiscal year. The number of outbreaks at Providence Health Care is consistent with a higher-than-average outbreak season experienced across Vancouver Coastal Health.

GASTROENTERITIS OUTBREAKS

One gastroenteritis outbreak due to norovirus was managed in 2017/18. This figure is consistent with the past two years.

OUTBREAK MANAGEMENT

IPAC continues to focus its outbreak education on improving frontline awareness of signs and symptoms, rapid containment of symptomatic patients/residents, and communication within the clinical team. The management and containment of outbreaks is contingent on a partnership with site and unit leadership, nursing, physicians, allied health, laboratory staff, pharmacy, and support services, such as housekeeping and food services. This collaboration enables ICPs to more fully support the identification, containment and implementation of outbreak measures.

OPPORTUNITIES ARISING FROM OUTBREAK DEBRIEFINGS

Debrief meetings after each outbreak with IPAC and the management team provides an opportunity to review outbreak processes, identify strengths and opportunities for improvement.

Opportunities for improvement include:

- early communication of suspected cases of influenza like illness;
- communication of outbreak status to families and visitors; clarification of patient, resident, and health care worker movement on and off of a unit under outbreak precautions; and
- timely staff and resident annual influenza vaccinations, as well as ensuring appropriate precautions implemented for unvaccinated staff.

Education & IPAC Links

The Providence Health Care IPAC Links Program plays an integral role in promoting multidisciplinary engagement and responsibility for of infection prevention and control. The Links program consists of workers from throughout PHC, including social workers, lab technicians, respiratory therapists, ward aides, and nurses.

The Links Program orientation gives staff an opportunity to learn about broader IPAC topics such as cleaning and disinfection, medical microbiology and adult-learning strategies. “Links” engage with fellow staff members by acting as role models and being visible advocates for IPAC. The Links also enable individuals and their teams to learn more about infection prevention practice and to engage with their local ICP.

A quarterly newsletter entitled “The Bug Brief” provides current and up-to-date information about IPAC topics, with specific focus on the unit level.

The sharing of the IPAC Links Program model throughout the province supports best practices in Infection Control and promotes patient safety.

The PHC IPAC Links Program has trained 300 Links. **PHC Links are an IPAC voice and resource.** This past year, we benefited from three IPAC Links working as Infection Control Practitioners. Two of them have subsequently joined our IPAC team as full-time ICPs.

IPAC encourages those who wish to become a Link to [contact](#) our department.

PHC Facilities

- no text provided

Infection Prevention and Control (IPAC) Team



IPAC's vision and mission are aligned with those of Providence Health Care (PHC).

The vision of the IPAC team is to stop preventable infections.

The purpose of the IPAC team is to protect everyone at PHC, including patients, staff, clinicians from preventable infections and to improve health outcomes with our partners.

Our vision and mission are incorporated into the activities provided by IPAC for PHC:

Surveillance

Case management

Outbreak management

Education

Research

Policies and procedures

2017/18 PHC INFECTION PREVENTION AND CONTROL TEAM

Wendy Hansson

Vice President, Quality and Innovation Chief
Transformation Officer

Camille Ciarniello, BSN, LLB

Corporate Director, Quality, Patient Safety, Risk
Management, Patient
Relations & Infection Prevention and Control

Bonnie Lantz, Director

Director of Risk Management and IPAC

Victor Leung, MD, FRCPC

Medical Director, Infection Prevention and Control
Infectious Diseases Physician / Medical
Microbiologist

Christopher Lowe, MSc D (ABMM), MD, FRCPC

Infection Control Physician / Medical Microbiologist

Michael Payne, D (ABMM), MD, FRCPC

Infection Control Physician / Medical Microbiologist

Elisa Lloyd-Smith, PhD

Epidemiologist

Azra Sharma, MLT, MSc

Infection Control Practitioner/Epidemiologist

Glenn Cardinal, RN

Infection Control Practitioner

Leah Diamond, RN

Infection Control Practitioner

Jason Kent, RN

Infection Control Practitioner

Thomas Kind, RN

Infection Control Practitioner

Mary McNaughton, RN, MSA, CIC

Infection Control Practitioner

Georgia O'Neil, RN

Infection Control Practitioner

Ted Pincock, RN, CIC

Infection Control Practitioner

Danielle Richards, RN, MA

Infection Control Practitioner

Ellen Robson, RN, MPH

Infection Control Practitioner

Luz Vierneza

Administrative Assistant

