# Provincial Infection Control Network
# Third Stakeholder Summit – Full Steam Ahead
# June 21, 2006
# Report

## Review of Summit Goals and Objectives
## Dr. Judy Isaac-Renton, Co-Chair, PICNet Steering Committee

Judy welcomed everyone to the 3rd Stakeholder Summit and thanked them for coming. She also acknowledged the one-year anniversary of PICNet. Our theme for the coming year is "Full Steam Ahead".

She acknowledged the support from the Ministry of Health, especially the Provincial Medical Services Committee (PMSC). Judy also thanked the PICNet Management Office, including Margaret Litt and her team for all their efforts. She noted that her co-chair Dr. Elizabeth Bryce was away on holidays, but sent greetings to the group.

Judy made reference to the goal of the Summit which is: To enable PICNet's community of practice to gain an understanding of the activities underway within PICNet and engage in the development and implementation of future priorities.

The objectives are as follows:

- To provide highlights of PICNet's progress to-date
- To review PICNet's structure and processes in support of its mandate and direction
- To initiate the development of deliverables as they relate to PICNet's key themes
- To showcase recent infection control initiatives within British Columbia

## PICNet Overview
## Margaret Litt, PICNet Coordinator

Margaret provided an overview of PICNet's role and reviewed activities and achievements from the past year. Her presentation included an overview of PICNet's reporting structure, Steering Committee, and working group model. Margaret reported that, in response to feedback provided by PICNet members, a Priority and Planning Committee has been established to act as the operational arm of PICNet and will have up to four working groups reporting through it. She emphasized the importance of everyone in the room communicating with their colleagues on what PICNet is, and how to get involved.

Margaret noted that the first PICNet Annual report will be available shortly via the PICNet website. Anyone with questions or comments can contact Margaret directly. A copy of Margaret Litt's presentation is available by ***clicking here***

**Questions/Responses**

***Q- The money and idea for PICNet came from the Provincial government – what have we heard from them? What do they think about what we're doing?***

**Response:**
We have a number of formal and informal communications processes with the Ministry of Health (MoH). The Assistant Deputy Minister of Performance Management sits on the Provincial Medical Services Committee (PMSC) which PICNet reports to quarterly. (As well, the VPs of medicine from all the Health Authorities sit on PMSC and have been very supportive). A representative from the MoH also sits as a non-voting member on PICNet's Steering Committee.

***Q- You were talking about the Long Term Care survey. When it was sent around the LTC list was incomplete. Did the list ever get reconciled/updated? This should be a priority. What about facilities that don't have an ICP attached to them? How will their data be gathered/incorporated into the survey***?

**Response**
We will follow-up to ensure the list is updated and determine what the completion rate is for the surveys. We'll also make suggestions and advise on what sections should be focused on.

## Working Group Updates

### Valerie Schall, Summer Student, Seasonal Feveral Respiratory Illness (FRI) outbreak prevention and control guidelines

Valerie explained why this topic is a priority for PICNet and provided an overview of the project. ***(For link to presentation click here***) The final and most important phase is the formation of a working group to collaborate on how to control FRI. A meeting will take place in the next few weeks with representation from all stakeholder areas to ensure that appropriate guidelines/recommendations are available for the coming flu season. She hopes to have a report ready by September to give time for approval process.

**Questions/Responses**

***Q - Are these guidelines for all health care settings?*** **Response:** Yes.

***Q- How will these guidelines fit with existing guidelines in place in facilities?***

**Response:**

We are referring to existing guidelines and best practice information to develop these guidelines. If you have guidelines in place these should fit well with them.

Additional questions/comments can be directed to Valerie at the PICNet office.

**Steve Gaspar, Summer Student, MRSA Surveillance**

Steve is studying MRSA and looking at what PICNet's role should be as it relates to MRSA surveillance. His report will be presented to the Priority and Planning Committee this fall where next steps will be determined. ***Click here for link to presentation.***

**Questions/Responses**

***Q - Some of this data was collected in the Needs Assessment Survey – will you refer to this in the report.***

**Response:**
Yes. It also needs to be determined if focus will be on Acute Care or Community.

***Q - Are you focusing on only one or the other (Acute Care or Community)***

**Response:**
Yes, due to time constraints the focus will have to be narrowed..

**Fred Roberts, Surgical Site Infection Surveillance Working Group**

Fred acknowledged his Co-chair, Felicia Laing, who was absent. He emphasized that they had a small working group, and that remarkable progress had been made in the past three months. He emphasized the large and complex nature of this topic and the challenge of coming up with ideas/guidelines for what should be done. ***Link to full presentation***.

**Questions and Responses:**

***Q- Should we consider a risk index scale to address issue of physicians with more complicated patients?***

**Response:**
You could try this. But there are only three basic factors in it right now. There are two basic approaches we are looking at. One is to take procedures with high infection rates and where there is also a registry. We can download the info the hospital collects in the registry and then calculate the rates. We could do this in the health authorities for procedures like total hips – these could be set up as a separate group. You can look at contributing factors to infection rates. This could be a province-wide program managed at the HA level. Risk indexes would fit well here. When you get into other types of surgery where there are no registries, then you have to pull your information from another source. This presents challenges and makes it very difficult to compare and rate. Any info that can be provided by PICNet members is appreciated. There is no ideal existing system.

**Comment:**
***What do you think about rates dropping, when pressure is exerted on groups to move ahead with safety initiatives?***

**Response:**
That is the second half of a surveillance program, which you have to have. We want the Health Authorities to work with the hospitals to put in place better procedures and processes. There are many ways of indirectly putting the pressure on. Although PICNet would never be directly involved in an audit or accreditation, they are a great way to identify gaps and provide feedback to health authorities

Margaret also emphasized that PICNet is working closely with Safer Healthcare Now! campaign with the hope that their process indicators and our outcome indicators will combine to enhance our ability to monitor and affect change in this area.

**Needs Assessment – High level overview of findings**
**Colleen Hawes, Co-Chair, Needs Assessment Working Group**
**Bruce Gamage and Sue Pollock, Working Group Members**

A summary of the Needs Assessment Working Group Report was provided in the Summit Binder. A copy of the presentations made during the Stakeholder Summit is available on the PICNet website ***(click here to see the NAWG Summary)***. It was emphasized that the Needs Assessment was conducted in response to information gaps identified at the first PICNet Stakeholder Summit that was held in June 2005. It was also recognized that this is a starting point and that in the future more assessments will likely occur.

While the data has been aggregated for confidentiality purposes, each health authority will receive a report and presentation summarizing the data gathered from that region.

**Questions and Responses:**

***Q- The majority of facilities don't have adequate staffing – if the data is aggregate, how can we demonstrate that?***

**Response:**
We will be presenting individual HA data, so each understands the issues/opportunities specific to that region.

***Comment:***
***The problem is that some areas are below what they need and others have very little – these are two different problems and need to be addressed individually***

***Comment:***
***It's really difficult to draw generalities – Statements such as "all health authorities, all sites…" are misleading. It is difficult to draw these***

***generalities. Our HA has allocated additional resources and these generalities aren't accurate.***

**Response:**
We felt it was important to aggregate the data – some health authorities did not want us sharing their data. It presents a challenge. Our HA presentations will look at specific HA info.

We are going into the breakout groups and ask people to give us feedback, validate/respond to the results from the perspective of the situations in your Health Authorities. The final recommendations of the report will reflect the feedback received in the breakout groups.

***Q- We don't know what percent of time is spent on OHS infections – we have to be careful what we say regarding adequate resourcing. Both Public and Occupational Health duties should go beyond infection control – we don't know what the optimum resources are, so we shouldn't generalize.***

***Comment***
***I represent contract facilities. When you talk about resources available, you need to look at "stakeholders' within a health authority – 66% of our facilities don't have an OHS Infection control practitioner.***

**Infection Control Surveillance,**
**Monali Varia, consultant epidemiologist**
Monali provided an overview of the surveillance component of the Needs Assessment.

**<u>Questions and Responses:</u>**

***Q- How did you define surveillance, was it just data collection?***

**Response:**
Surveillance incorporates data collection through to the dissemination of results, however, the two main areas captured in the survey focused on data collection and dissemination.

***Comment:***
***I haven't heard of admission screening for CDAD***

Response:
CDAD admission screening is not commonly done. It is a GI screen (it was noted as admission screening)

***Q - Were facilities admitting people with diarrhea screening for other things?***
– yes

***Comment:***
***There is a growing trend of hospitals keeping a database of patients discharged from hospital with CDAD and other illnesses, because we know they are long term carriers.***

## Needs Assessment Breakout Sessions

- ***Reviewing Common Themes and Opportunities***

**Janice DeHeer, PICNet Steering Committee Member** reviewed the processes for discussing the Needs Assessment results during the afternoon breakout sessions.

## Summary of Breakout Session reports:

### *Group 1 – Inconsistent standards for education/training to develop the skill set for provision of infection control services.*

| **Priorities Identified** | **Approach** |
| --- | --- |
| Establish basic skill sets for infection control, i.e. those outlined in the certification program<br><br>Support practitioners in acquiring core competencies within a reasonable timeframe | Ensure that these core competencies/basic skill sets are incorporated into formal educational programs for all disciplines. |
| Create more educational opportunities for infection control across all disciplines | HAs need to dedicate resources and support professional development opportunities.<br><br>Include infection control education requirements in strategic planning activities<br><br>Identify infection control education requirements as part of quality management initiatives |
| Create more educational opportunities for infection control across all disciplines | Use PICNet website to promote educational opportunities<br><br>PICNet make educational opportunities available via teleconference or other technologies<br><br>PICNet provide educational modules – place existing modules on website<br><br>PICNet create an inventory of programs that are available to share and a list of individuals who can serve as resources.<br><br>Influence other educational institutions to incorporate infection control standards in educational programs for all disciplines. |

| | |
|---|---|

## *Group 2 – Insufficient number of skilled staff to provide infection control services.*

### Evidence-based Practices/Existing Standards

- Succession planning is needed to utilize existing expertise and to prevent shortages.
- Use clarity between guidelines and standards
- Agreement required on what guidelines to use.

| Priorities Identified | Approach |
|---|---|
| Response to Survey | Refine questionnaire in future |
| Support developmental activities of ICPs | Mentoring, access to leadership within networks (eg. BCPIC, CHICA) |
| Language around results is strong and generalist | Needs to be addressed |
| Promotion of Team Approach in infection prevention and control to include IT/admin/dedicated physician support and leadership | Support HAs in achieving this |

## *Group 3 – Consistency of standards in surveillance and best practices to guide those who deliver infection control services.*

| Priorities Identified | Approach |
|---|---|
| Surveillance – is it really being done?<br>- morbidity/rationale for performing (aka prioritization)<br>- Need education/training, dissemination (to achieve best practice)<br>- Why bother? What is done with data? | Form a surveillance WG. Ensure all the right people are included (across continuum) |
| Define what is a core infection control program | PICNet shows/provides components of IC program…<br>- We launch from needs assessment<br>- Standard definitions; develop continuity<br>- Present to PMSC and get endorsement<br>- HAs need to implement |

**Open Forum Discussion:**
The following provides a summary of comments, questions and responses provided during the afternoon report back and discussion following the breakout sessions.

***Comments:***

- PICNet must be careful to put information/recommendations into context when submitting reports like the Needs Assessment. This is a snapshot in time of specific areas. It is not a comprehensive review.

- Some of the data is dated already, but there were still valid points that could be concluded.

- It is clear that there is a need to establish basic definitions and standards – what are core competencies?

- We need to get out to schools/educational institutes so they incorporate infection control into training programs for all disciplines.

- Training programs and core competencies and education are different. There is a period of time when you are in the role before you get a sense for doing the job – an independent mentor training program is recommended. This is a standard in other countries. You would go through the independent mentor program before you are on your own in the role.

Margaret Litt concluded the discussion period by reminding the group that one year ago everyone had opinions of what the issues were, but there was no evidence. Everyone agreed that the Needs Assessment was an incredibly ambitious undertaking. It was even more overwhelming than imagined. It is recognized that this was a snapshot in time and the final report will emphasize this. However, this snapshot provides excellent insight and information that can guide future activities and priorities for PICNet.

She noted that all three groups identified common themes and where we can go from here.

All this input will be incorporated into the final Needs Assessment Working Group Report. It will go to PMSC sometime this summer. The report couldn't have been finalized the report without this input.

**Health Authority Presentations:**

- Dave Forrest and Dan Costella from VIHA – Isolation based on symptoms

- Tracey Sapergia and Laura Book - Implementing VIRAP in the NHA

- Bonnie Henry, BCCDC – Legionella in LTCF