Regional Infection Control Networks

Réseaux régionaux de contrôle des infections

Resources and Activities for Infection Prevention and Control in Ontario, 2008

Qualitative Report

Prepared by Research Strategy Group Inc.

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1.0 EXECUTIVE SUMMARY

The purpose of this study was to follow up some of the findings of the province wide quantitative study "Resources and Activities for Infection Prevention and Control in Ontario, 2008" conducted on behalf of the Regional Infection Control Networks (RICNs) and completed in the Spring of 2008 with a qualitative set of interviews with sector and stakeholder organizations. The objective of this study was to further explore gaps and issues identified in the quantitative survey, and to engage organizations in broader discussions about infection control planning issues.

Thirty one qualitative individual face to face interviews were conducted with twelve stakeholder organizations and nineteen sector organizations across the Acute, Non Acute, Community Care, Public Health and Emergency Services Sectors. Interviews were conducted across most regions. (see Chart on page 9).

This research was qualitative in nature, and therefore does not reference any quantitative findings. However, in order to give some indication of the magnitude of the issues which arose, the report uses terms such as 'a few participants', 'some' or 'a number', 'many' or 'most'. In this report:

- 'a few' means that the issue or comment was voiced by enough people to warrant inclusion in the report, but it was not widespread across the participants as a whole.
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1.1 Main Findings

SARS had a temporary positive impact on staffing and resources, but resources were not seen as evenly distributed

Almost all interviewees noted that SARS provided a strong impetus for increased visibility and funding for Infection Prevention and Control (IPAC) activities, but that this support has decreased as the distance from the SARS has increased. Respondents in Community Care and Non Acute Care in particular felt that they had not received the same support as Acute Care or Public Health in terms of funding and resources since SARS occurred, and were still concerned that not enough attention was being paid to their sectors in terms of IPAC.

Other initiatives are competing for time

Other initiatives have evolved since SARS which have infection prevention and control components associated with them, such as patient safety, emergency and pandemic planning. However, these initiatives are generally stand - alone and have not been integrated with each other or IPAC. Most respondents felt that these initiatives were time consuming, poorly integrated, and overlapping. Additionally many stated that they were expected to add these new initiatives to their IPAC activities and that left less time to deal with IPAC issues.

Understanding of IPAC is lacking

Many respondents felt that there was a lack of understanding of the importance of infection prevention and control and its relationship to the day to day work of health care professionals. They emphasized the need to engage health care professionals in understanding that IPAC is integral to the work they do.

Most IPAC staff do not spend much of their time on IPAC

The initial quantitative survey asked about staffing for IPAC, but did not ask how much of the time of an Infection Control Practitioner (ICP) was actually devoted to IPAC activities. The qualitative interviews revealed that many ICPs spend only 5-10% of their actual work time on IPAC. This in turn, leaves little time for training staff or other key activities. Most reported that IPAC is almost always reactive, based on outbreak needs, or in response to seasonal issues, such as flu. Only one or two respondents talked about proactive approaches and their cost benefit.

Training of staff in IPAC is limited

Training was a major issue identified in these interviews (similar to the results of the quantitative survey). The amount of time allotted to training on IPAC in both orientation and ongoing training was minimal. Respondents reported that at orientation, an average

of about 15 minutes might be given to IPAC in a two hour orientation session. Many organizations reported that they do not hold any further training at all on IPAC after orientation.

High turnover impacts training needs

Many respondents noted that high turnover rates in health care staff required that training occur on a frequent basis as new staff come in, adding to the time and resources required. Given that many organizations are already short staffed, it is difficult to allow staff to take time for training during work shifts. Therefore, training is often only available to staff when they are off shift, and they are not training on paid time. This is a major disincentive to attend training, especially if the training is not seen as directly tied to them and their work.

Health care staff lack core competencies in IPAC

Respondents also suggested a need for development of core competencies in IPAC for healthcare staff. Also, suggestions were made to include more material on IPAC for students in health care professions to ensure they understand the importance of IPAC and to ready them for the workplace.

Funding issues

Lack of resources and funding are strongly connected to the amount of time an IPAC practitioner has available to give to training and monitoring compliance of staff. Respondents noted that they are already overwhelmed with reports and with new requirements for reporting; they are very concerned about having resources and time for proactive surveillance and staff training.

Data collection systems are lacking

Many organizations are still paper oriented or using a variety of different systems, some of which collect duplicate data. Most organizations did not have a system that they felt was appropriate for IPAC, with the exception of 'Point Click Care' mentioned by a few.

No common tools

Many respondents talked about the need to utilize common collection tools for IPAC both within organizations and among organizations. This would help to reduce workload and provide comparability for benchmarking purposes.

No consistency to surveillance activities

Surveillance activities depend entirely on the organization and often take place at the discretion of the ICP. Respondents suggested that it would be better if there were specific protocols and consistent approaches to what is surveilled, and the frequency of surveillance activities.

Compliance is difficult to measure or enforce
Monitoring of staff compliance was also seen as a major issue, as the major method utilized is walking around. However, since the ICP is generally known to staff, staff comply when they see the ICP coming, and it is difficult to know what their behaviours are when not being observed.

IPAC credentials and marketing of the role are lacking
In terms of the Infection Control Practitioner position, many felt it was important for these practitioners to have formal credentials, although there was strong acknowledgement of the experience and skills of those who did not have formal training. Additionally there are few formally trained IPACs and it would not be possible to only hire with only a CIC or certificate in IPAC at this point in time. The need to market IPAC more proactively as a career choice was emphasized by many of the respondents.

Role of Public Health vs. RICNs is not entirely clear
There was a lot of confusion in some sectors about the respective roles of Public Health and the Regional Infection Control Networks. It was not clear to many how these two roles were connected or if they were. Even some Public Health staff were unsure of role definition between themselves and the RICNs.

1.2 Observations and Recommendations

Lack of time on Infection Prevention and Control
Findings from the qualitative interviews supported and reinforced some of the gaps and issues noted in the quantitative survey. Of key note is that in addition to the lack of staffing reported in the survey, the interviews revealed that even when staff members are designated as infection control practitioners (ICPs), much of their time is often spent on other activities.
Further research and analysis on the role of the IPAC, and actual time spent on IPAC activities is warranted to determine a baseline of actual time spent, and to gain a fuller picture of what would be appropriate resourcing for these practitioners to allow for the full spectrum of IPAC activities to be undertaken.

Lack of coordination among external program initiatives
This lack of time is further exacerbated by organizational involvement in a number of initiatives in relation to infection control, such as the Safer Healthcare Now campaign, Hand Hygiene campaign, CCHSA accreditation requirements related to infection prevention and control, and new Ministry of Health and Long Term Care reporting requirements.
Better integration and coordination of these initiatives would provide for a more cohesive effort and minimize time spent collecting data in different formats for each initiative. Organizations involved in these activities should consider common

communications which highlight the relationships among the initiatives, and provide common tools and data sets, with the ability to transferable information across initiatives without re-entry or duplication.

Resources and Funding for IPAC

Staff resources are already stretched, and ICPs are limited in their ability to undertake key proactive activities in IPAC such as staff training, and surveillance and monitoring. As additional responsibilities and reporting requirements are introduced, the amount of time available for proactive Infection Prevention and Control will be further limited. Consideration of additionally targeted funding for staff positions and development of common tools to support training, surveillance and monitoring activities would improve the ability of organizations to undertake IPAC activities.

Sector Specific Resourcing

Some sectors appear to be less resourced; notably Community Care and Non-Acute Care settings. Exploration of the needs of these sectors should be considered, as the amount of patient contact and care in these settings is considerable and opportunities for infections and outbreaks are high.

Data Collection Systems

Many organizations are still using manual systems which are time consuming and often duplicate data used by others within the organization. Those with computerized systems do not find them generally useful for IPAC specifically, and these systems often differ within and across organizations.

The development of common data systems for infection prevention and control and the introduction of computerized systems relevant to IPAC needs in organizations that lack them would save considerable time and provide more consistent data for benchmarking.

Staff training and IPAC core competencies

Very little time was devoted to orientation and ongoing training of staff on infection prevention and control. More time should be dedicated to IPAC in orientation sessions as this is often the only training received by staff in relation to IPAC issues.

The approach to training on ICP and how it is presented to staff needs to be rethought. It doesn't resonate as a stand alone item; rather it needs to be connected to the staff in direct relation to their work, their personal risk and understanding that everything they do is related to infection prevention. This is especially important for dietary and housekeeping staff but also for nursing and physicians.

Core competencies in IPAC should be developed for health care providers and more training in these core competencies should occur during career preparation for the various health care professions so that graduates have more knowledge and competencies in IPAC.

Marketing of the Role of the ICP
There is a shortage of well trained IPAC staff to undertake the work required. Awareness of ICP as a career path needs to be communicated more broadly so that it is seen as a viable option for health care professionals. Marketing efforts to high school students as well as those already enrolled in health care professional programs is needed.

External support and expertise
There is confusion as to who to turn to, and what can be provided by external players. There is a need to provide more clarity regarding relative roles of the various external organizations such as Public Health and the RICNs.

2.0 DETAILED REPORT

2.1 INTRODUCTION

2.1.1 BACKGROUND

Various reports (Walker, Naylor, Campbell) following the SARS crisis led the Ontario Government to develop a plan called Operation Health Protection. As part of this initiative, the Ministry of Health and Long Term Care (MOHLTC) implemented the Provincial Infectious Disease Advisory Committee (PIDAC) to guide and develop Regional Infection Control Networks (RICNs) to support increased capacity in infection control and communicable disease prevention and surveillance in Ontario.

The mandate of the networks is to maximize coordination and integration of activities on a regional basis that are related to prevention, surveillance and control of infectious diseases. The networks will not replace existing programs, powers, or duties of the current stakeholders, but are intended to support and enhance the planning, coordination and integration already being undertaken locally.

A province wide quantitative survey was undertaken and completed in spring 2008 which documented resources and gaps in infection control in the Acute and Non Acute sectors, Community Care agencies, Public Health and Emergency Services. This study is a qualitative follow up to that survey.

2.1.2 RESEARCH OBJECTIVES

The primary objectives of this study were to:

1. Follow up on the quantitative survey process to further explore gaps, issues and needs currently existing within infection control environments in various sectors.
2. Engage potential partners and key system players in discussions about issues related to infection control planning and health care advocacy

2.1.3 METHOD

A total of thirty-one in-depth qualitative interviews were scheduled over the course of this research. Interviews were approximately forty-five minutes in length and were conducted either over the telephone or in person, based on respondent convenience and availability. Interviews were completed with twelve stakeholder organizations and nineteen sector organizations across fourteen regions in Ontario between April 17th and June 4th, 2008. Most stakeholder organizations were located in Toronto. The regional distribution of the sector organizations interviewed is shown in the following table:

Regions	Community Care	Public Health	EMS	Not Acute	Acute
CEICN		1			
CRICN					
NEOICN			1	1	
SEOICN			1		1
CSICN		1			
NSMICN					
CICN	2				1
MHICN					
NWOICN		1		1	
WWICN				2	
ESCICN		2			
CWICN					
SWOICN	1			1	1
TCICN		1			

The sector sample was recruited by Research Strategy Group (RSG) from the contact list prepared by each Regional Infection Control Network coordinator for the quantitative study, and was cross referenced with the list of previously interviewed or surveyed organizations which had been interviewed in another RICN study to avoid duplication of interviewees. The stakeholder list was developed by RSG and confirmed by the client. The list of interviewees and sample questionnaires are provided in the Appendices of the report.

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2.2 IPAC AND SARS

The SARS crisis in Ontario in 2003 brought the issue of infection prevention and control into the public and professional consciousness. The outbreak created awareness of infection prevention and control that had not been previously well articulated to the general public and raised the level of importance of the function within various institutions and health care settings.

"What has changed is that we have been put out to the forefront. When people ask me what I do, they have a bit better idea, they have at least heard of it…"

"I've spoken with ICPs who have told me that years ago, nobody cared about the work that they did and that they would go around and promote vaccination and hand washing and not get much respect in the hospital but more and more people are starting to appreciate the importance… the problems have helped promote the issue."

Additional infection prevention and control funding and resources were put in place following SARS. Funding was provided by the Ministry of Health and Long Term Care to increase various resources in infection prevention and control. Types of support depended on the sector. Emergency Medical Service units, for example, received different types of masks and protective equipment, and some sectors such as Public Health and Acute Care received funding for additional staff positions in infection control as well as data collection systems.
The importance attributed to training increased within facilities post SARS. As well, policies were created and/or updated during SARS that focused on emergency procedures and infection control.

"Since SARS, because of the gaps that were identified during SARS, we have tried to increase the amount of training. I feel that we need a whole lot of extra training, from what I can see."

"New things were brought forward that we hadn't thought of before. We developed many more policies that built from the gaps that we identified through the experience. Our emergency planning is much better now…"

However, post SARS activities also brought forward some concerns. One concern raised by some interviewees was that funding and resources were not being properly allocated within the facilities and that funding should be specifically designated for infection control purposes only.

Similarly, many respondents expressed frustration that funding was not being allocated equitably among the sectors. Some felt that there was a relatively low level of importance attributed to IPAC in the Non Acute sector relative to the Acute sector. Many felt that there was a specific need for additional funding in Non Acute Care.

"SARS is the reason for this difference between Acute and Long Term Care. SARS made a bigger difference within Acute Care in terms of support, funding, precautions, staff safety, because SARS was focused on Acute Care facilities."

Inequitable allocation of resources regionally was also raised as a concern. A few respondents felt that resources were not being divided appropriately among regions with more emphasis on provincial resources at the ministry level, and large urban centres, and less emphasis on resources in smaller, more remote areas.

"What did we get on the ground since SARS? We got 180 new staff; 45 of whom went to Toronto, and I got six bloody staff here in ….. Region. Do you think that's fair? So what I'm telling you is, I think the province got its own house in order and they've left us to do our own thing."

Overall, the vast majority of stakeholders indicated that SARS played a significant role in increasing the level of attention paid to public health and infection prevention and control (IPAC). They felt that SARS was a wake-up call to their organization, and one of the key drivers for increased communication (within and across organizations) and funding for infection prevention and control.

Additionally, SARS also engaged organizations in a review of their 'quality standard' processes – i.e., organizational standards for protocols and tools as it relates to data collection, patient safety programs, and sterilization of re-usable medical devices, etc.

Initiatives that were taken as a result of SARS within the Public Health sector seemed to have been maintained to a greater degree than in the other four sectors.

"The changes that were made are maintained at a high level. We have the dollars, the programs are in place and we continue on… We are doing a lot of pandemic planning and we have a health promoter that we didn't have before that is crucial to some of the work that we're doing."

However, the emphasis placed on infection prevention and control activities appears to have diminished to some degree in most sectors since the outbreak of SARS and there was a general feeling expressed by the majority of staff interviewed that their

organizations have reverted back to a reactive approach to infection control rather than a proactive one.

"I think advocacy in the hospitals happened in SARS but it has now waned to tell you the truth. I got a lot of respect then but now I feel that I don't get as much again. Without a crisis it's not paid much attention to because there are no issues and money has sort of gone away from it since SARS."

"SARS was the catalyst for a lot of things… I think that there was raised awareness obviously but I think that that is waning now… I think amongst ICPs that awareness might still be there, but I think amongst everyone else, SARS happened a long time ago."

"During SARS and post-SARS there was a fairly diligent dispatch system in place to do FRI inquiry every time there was shortness of breath or whatever, but that has since gone the way of the dodo birds. We no longer have that information available from dispatch."

2.3 CURRENT STATUS OF IPAC INFRASTRUCTURE

Although in most organizations, there was initially some level of IPAC activity in place, the occurrence of SARS added an emphasis to the importance of the initiative. The increasing awareness of IPAC since the outbreak, along with the growing demand in terms of reporting made the need for a more comprehensive approach clearer. Almost all respondents reported that their organizations had taken a more proactive approach in terms of consistent policy development and review, staff training and monitoring, surveillance and reporting.

However, as the time post SARS increased, some organizations began to put less emphasis on IPAC. Faced with overall funding and staff shortages, many organizations have decreased their resourcing in the area of infection control, or broadened the roles to cover several initiatives, such as patient safety and emergency planning. As well, respondents noted that there appears to be a shortage of qualified IPAC staff to hire. Many organizations throughout the province have struggled and as a result, have had increases and decreases in the number of staff positions that they are able to allocate to IPAC.

2.3.1 ACUTE AND NON-ACUTE FACILITIES

When asked what types of committee structures existed within IPAC in their various institutions, the reported structure and function of IPAC committees varied significantly based, in large part, on the size of the organization.

IPAC committees in a few larger Acute Care facilities generally consisted of a structured team of professionals such as Nurse Practitioners, Nursing Directors, Care Directors, Educators, a representative of the public health unit and ICPs.

Some facilities often had only one dedicated person responsible for IPAC activities within the organization and no formal committee structure. In many cases, this person, typically an ICP, was responsible for not only Infection Prevention and Control, but Patient Safety, Risk Management and Occupational Health as well and would divide their time accordingly. In situations such as these, the ICP will often receive support from infection control staff at their local Public Health unit or from ICPs working at other facilities. These loose networks were often referred to as an informal IPAC committee by respondents.

2.3.2 EMERGENCY MEDICAL SERVICES

EMS organizations did not tend to have an IPAC committee, but instead, IPAC activities often fell within the responsibilities of the Operations Manager or the Quality Assurance Manager at each site. When affiliated with a hospital, IPAC activities were regulated, in most part by the IPAC committee within the hospital.

2.3.3 COMMUNITY CARE ORGANIZATIONS

Within Community Care organizations, respondents noted that Infection Prevention and Control was generally addressed through the Quality Care function, and managed at either the branch level or the corporate level. For some organizations, a 'care manager' was responsible for assuring all sites within the branches delivered safe quality care based on a list of indicators developed corporately. At the corporate level there might be a professional practice team as well as a 'quality team' that could track IPAC activities through quality care indicators, identify issues within the branches, and provide support where necessary. Others reported that the staff were given information about IPAC at orientation and were expected to follow through independently. Incident reports on infection were used by supervisors as a measure of the need for training.

2.3.4 PUBLIC HEALTH UNITS

Public Health units, due to their external IPAC responsibilities, and mandated training responsibilities related to outbreaks of infectious disease, have a broader role in relation to IPAC than do other health care sectors. IPAC staff within the Public Health units are responsible for maintaining proper IPAC protocols and procedures within their clinics, and supporting IPAC initiatives in various institutional settings throughout the community.

However, IPAC was not seen as an 'internal' priority in all Public Health units. A few respondents commented that IPAC was of little concern because they did not typically have any client contact. They did not appear to see a strong need for IPAC training for their own internal staff.

"They (Public Health Inspectors) *are not involved in person to person to person contact, so they are not going to need routine practices or anything because they are not doing primary care […] I mean they do pick up the stool specimens, but again they are not the one collecting the specimen, the specimen is supposed to be contained in a biohazard container."*

2.4 Importance of IPAC Activities

2.4.1 Priority of IPAC

Respondents were asked how important Infection Prevention and Control activities were to their organization. While Infection Prevention and Control was not reported as the top priority at any facility within any sector, it was, in theory, high up on the list of priorities for most.

Respondents generally agreed that it was an important initiative and one that should be taken seriously, but with limited time and resources, it seemed there were a number of other initiatives within the organization, that were more important, or equally as important, that they felt they needed to allot their time to.

"Awareness is probably very high but based on the time spent, I guess it's not a very high priority…"

"It's there, but its not the top priority…"

A few organizations however, took a more proactive approach to IPAC activities. They were aware that an outbreak resulted in a larger drain of their resources than did proactive approaches to infection prevention initiatives within their facility.

"IPAC is a very big priority with us. We do not want to have a huge outbreak because we just can't afford to. Outbreaks cause way more work than preventing them, so yes, prevention is at the top of our list."

While most respondents within the Non-Acute care setting did understand the importance of IPAC within their sector, they did not feel that their sector was receiving the attention it should. Respondents working with the sector were disappointed with the support they were receiving relative to other sectors, and felt that the division of funding was inequitable especially relative to the Acute Care sector.

"In long term care, it isn't given the credit that it deserves. When someone develops something, it spreads through the home so much quicker because the proper level of education was never there relative to the other sectors… it's still not seen as important enough, not just by staff but by residents and their families."

The importance attributed to IPAC was similar at the stakeholder level as it was at the sector level. Although most stakeholders did feel that their organization had a responsibility toward infection prevention and control in the province, most felt that they did not possess the necessary resources to involve themselves to the extent that they would like.

The level of resources and support provided by the ministry during the recent Chronic Disease Management initiative was used as a point of comparison for the level of support that could be attached to IPAC related initiatives. Some stakeholders believed that the success of the chronic disease management initiative in Ontario is due primarily to Ministry support.

"That's why we've been able to do so much with chronic disease management… We've got a number of resource centers, including heart health resource centers with heart health coordinators in each unit. They have their networking opportunities and they put on conferences. We provide newsletters on various chronic disease prevention topics and we do consulting with them as much as we can if they're working with their community."

While the majority of stakeholders were not satisfied with the current level of importance being attributed to IPAC within their organization, many felt that it would continue to become increasingly important over the next few years. Most were aware of the impending Ministry requirements related to reporting and the increased staff dedication that it would entail, particularly within professional and organizational support associations. Some were concerned however, that if resources were not provided to support the increasing demands, the impact could be devastating to existing IPAC activities.

2.4.2 Time spent on IPAC activities

Although there was a person who was assigned responsibility for IPAC in some organizations, they were often not in a full-time position. Whether they were in full or part time positions however, respondents stated that ICPs actually spend a low percentage of their time on infection prevention and control activities. The amount of time dedicated to IPAC did increase during and after outbreaks.

On average, data from the interviews indicates that ICPs spent only approximately 5% of their time during 'normal' conditions and approximately 10% -20% of their time during outbreak situations on IPAC activities. The remaining time was spent on related activities, such as patient safety or risk management and general clinical duties.

"I am responsible for infection control as well as occupational health and they intertwine regularly […] I'm divided in two and I only work three days a week

The only exception was ICPs working within a few larger, well resourced Acute Care facilities, who were dedicated full time to activities relating to infection prevention and control.

"I spend 100% of my time on Infection Control, as do the other four ICPs, we don't wear any other hats."

The time that ICPs allocated to IPAC activities was commonly spent on surveillance, reporting, preparing IPAC resources for staff, and attending meetings. Respondents reported that they spent most of their time on documentation and reporting, and had little time for surveillance and training or development of staff resources.

In addition, facilities participating in the recent Safer Healthcare Now campaign said that they spent a significant portion of their time on the associated interventions, particularly the hand washing intervention.

2.5 Policies

2.5.1 Organizational Approaches to IPAC Policy Development

When respondents were asked about how policies were developed, most stated that policies pertaining to IPAC were generally developed in response to a specific need or in reaction to an infection control issue, or based on publication of best practice documents such as from Provincial Infectious Disease Advisory Committee (PIDAC) or other guidelines, environmental scans, and literature reviews.

At multi-site organizations, the majority of IPAC policies were reported to be developed at the corporate level, with a few policies developed within the individual sites, as a response to local issues. Generally a corporate educator would be responsible for implementation throughout the various sites. At 'stand-alone' facilities, policies tend to be developed by the manager of ICP or a Care Director.

Within the Emergency Medical Services sector policies are developed at the Emergency Health Services Branch of the Ministry of Health and Long Term Care. At the local level, IPAC policy development varied based on the site's governance. EMS units affiliated with hospitals generally reported that they were governed by policies developed by that hospital, while city based units said they were responsible for developing the majority of their local policies.

"We used to be attached to the hospital, now we are city based, we switched in 2002, so we now develop our own policies at the local level. We modify some of them as well."

District Public Health units stated that they develop policies based on recommendations of PIDAC and other guidelines, and share them with the community and with the healthcare providers.

2.5.2 Policy Implementation

Policy implementation varied significantly based on the degree of risk attributed to the particular policy by an organization. If there was concern about a particular practice, then a 'detailed' implementation would take place that generally included initial training and ongoing follow up. In smaller organizations, similar hands-on training approaches, such as lunch-and-learns were executed for high-risk policies. Approaches to implementation were generally determined by the IPAC team in cooperation with an educator, either within the facility, or at the corporate level if applicable.

More often, an indirect implementation approach was used. The policies were sent to the branches and/or to the necessary departments where there was typically a designated person responsible for assuring that the staff received and understood the information. These policies were often added to best practice manuals and posted in facilities or on an intranet site as well.

In Emergency Services units, little direct in- service training appears to be used. All IPAC policies developed within EMS units were implemented using an indirect 'sign-off' system. *"They have to sign-off on it which basically means that they are responsible for having read and understood the material. If they have any questions, they are supposed to come to us."*

Respondents reported the use of a variety of tools serving as 'reminders', such as equipment checklists, carts designed and labeled for particular infectious disease situations, and facility signage for implementation support.

2.6 Staff Monitoring

Staff monitoring in the area of infection prevention and control was an ongoing challenge in most facilities. There were rarely any formal protocols in place.

"There aren't any policies in terms of enforcing these practices or auditing. I tried to write a staff monitoring policy but it wasn't passed."

Many stakeholders addressed the difficulties associated with enforcing IPAC compliance of physicians and other healthcare professionals. Because of the complexity of the field and the wide range of knowledge that healthcare staff are responsible for, respondents felt that IPAC had a tendency to slip off their radar. It was suggested by

some stakeholders that there is a need to teach Infection Prevention and Control in a more integrated way rather than as a stand alone issue.

"Absolutely, basically, I can't speak about other professionals but physicians are more practical and tend to apply knowledge… if you apply it to their practice, you get better uptake."

Many respondents said that people don't understand the term infection control. The term does not ring a bell with them. They said that the staff are uninterested, and don't recognize that it affects everything they do. It was suggested by some that a term that was more relevant or provoked more urgency would be required.

"… many of them know how a disease works and how it transmits and how you can protect yourself and that's actually infection control but nobody calls it that because people don't understand what the term infection control means […]

"House keeping… dietary people… they don't care what infection control does, but the reality is that it affects them and everything that they do is actually infection control but they just don't make that connect. If it's presented as personal risk to them, they'll listen…"

All respondents within the Acute Care and Non Acute Care settings felt that 'walking around' was the most effective way to monitor staff on compliance, and this was the most commonly utilized approach.

"I monitor staff by walking around and I manage a lot of my questions regarding infection control through that mechanism. I basically set aside time to wander around and see what people are doing… there is no better way…"

An important barrier to achieving effective staff monitoring processes, was the familiarity of the auditor. Staff would immediately comply at the sight of an auditor, resulting in inaccurate findings. *"Here comes Jane… everyone wash your hands."*

In an attempt to overcome this issue, one monitoring initiative was rolled out last year at a facility where 'return to work' RNs who were not known in particular units were brought in to do some auditing around hand hygiene.

Monitoring physicians on their compliance to IPAC activities was a difficult task in many organizations based on concerns related to staff hierarchy. Addressing non-compliance in physicians was a daunting task and a very unpopular one amongst staff. It was stated by a few respondents that the staff member responsible for monitoring physician compliance sometimes felt uncomfortable raising these issues with the non-compliant physician because they were in a position of 'lesser status'. As a result, there was usually a negative association with this responsibility and it was often deferred to the physician ICP director.

"When there are problems with the surgical docs we do a physician to physician….takes care of these issues… but it's still a challenge. You know, it's always someone else's fault, he tries but it's a delicate issue"

According to respondents, staff monitoring within the Community Care sector was accomplished primarily through supervisory visits. During these visits, a supervisor would typically engage a client in discussion either over the phone or in the client's home, during which they would ask a list of questions relating to client safety. However, very few questions addressing IPAC specifically were included

Many of these organizations were using internally developed data collection software for this purpose. Supervisors used laptops that were programmed with a list of questions through which they collected the data. The software was also used for incidence reporting that came out of the quality indicator data collected.

Front line staff working in the EMS sector are required to complete a form every time that they utilize protective equipment. Usage is documented in the call reports and reviewed by an operations manager.

"When we go over the call reports and see they had a situation where they should have worn equipment and didn't, we follow up with the crews to see why. We review the reports everyday. If they didn't know, they are referred back to the manual, but sometimes it just simply wasn't documented."

2.7 Surveillance

2.7.1 Overview

Although many organizations had a certain degree of surveillance in place before SARS, respondents stated that the organizational emphasis on surveillance activities expanded to some degree in all sectors post SARS, particularly in Acute and Non Acute Care facilities.

However, there is not consistency among healthcare organizations, who differed in the choice of surveillance activities they undertook to collect on a routine basis within their facility. Decisions on surveillance were often related to particular programs. For example, many facilities, particularly Acute Care facilities, joined the Safer Healthcare Now campaign, which committed them to surveille one or more of Central line associated bloodstream infections (CLI), surgical site infection (SSI) ventilator-associated pneumonia (VAP), or antibiotic resistant organisms (ARO)\Methicillin-resistant staphylococcus aureus (MRSA). Similarly, many surveille the hand hygiene programs or develop approaches to surveillance based on accreditation.

"I collect on ventilator, central line, surgical site infections, prophylactic antibiotics and all that goes with Safer Healthcare Now".

It's almost a total surveillance here because it's a small facility but I'm going to have to start picking and choosing cause I have less time… so I'm thinking I'll keep the SHN stuff, the AROs, MRSAs, VREs and C Diff on a monthly basis."

2.7.2 DATA COLLECTION TOOLS

Data collection in many facilities continues to be conducted manually. Most respondents using the manual approach felt negatively toward the system because it was both time consuming and often redundant. Also many respondents complained that there were too many different collection tools that were not integrated.

"It's all still done on paper, and I have issues with clerical help […] it would be great to use just one spread sheet. RL is a program that I use for Risk Management but we haven't integrated IPAC in to it yet, it would be nice, but it's also a lot of work."

"We have the 'surgical site infection' thing, the 'ventilator associated pneumonias' thing, the 'central line', we have three ORs and then we might be doing the 'ARO' thing soon as well…"

At facilities where the data was collected electronically, software integration was the most significant barrier to an efficient surveillance system.

"It's very inefficient; we have no way to talk to each other between here and xx, and yy. We don't know who is VRE, who is MRSA, and we would really like a comprehensive computer system to help us out."

"Our ICPs are all collecting different data and we all use different software systems… it's a huge gap. Sometimes we're collecting the same data five times, with different software and different datasets. I use Paradox and the others use Excel. We are in dire need of an infection control program and we have been asking for 15 years."

Point-Click-Care was a software tool used by many Acute and Non Acute Care facilities to collect data and all respondents that used the program held it in high regard. Respondents from a few facilities stated that would appreciate some advice from the local RICN on which data system to use.

While EMS organizations did not typically perform routine surveillance, they were able to track infectious diseases, on a needs basis, using the PTAC (Provincial Transfer Authorization Centre) dispatch system. The PTAC dispatch system screened all patients being transferred between healthcare facilities and attributed an MT number for the patient based on the results of the screening process. The system was automated and web-based so that both the sending and receiving facilities, as well as the paramedics were able to view the patients MT number almost immediately.

"Even in cases of an emergency transfer lets say from nursing home to acute care they get an MT number while the ambulance is on the way [...] the sending institution plugs in the patient's condition, and if he or she then slips through all the screens in the algorithm they get a web based number generated back to them within seconds… that's the transfer number that paramedics look for."

The general opinion at facilities toward the dispatch system was that it was an essential component to Infection Prevention and Control within their sector. Some EMS staff were concerned however, that the use of the system had dropped off in the past few years, since SARS.

2.7.3 REPORTING ON SURVEILLANCE

At some Acute and Non Acute Care facilities, data was trended and circulated back to the members of the 'patient care team'/'infection control committee as well as to the respective surgeons (in acute settings) using a code that could be only be deciphered by the intended recipients. This was usually done either monthly or quarterly. Within multi-site organizations, the sites generally would report corporately to the professional advisory committee or quality assurance committee on a monthly basis and have the aggregate data fed back to them quarterly, relative to their individual site and department initiatives.

Facilities in all health care sectors are required to report outbreaks to their regional Public Health units. Staff from Public Health units often sit on various stakeholder committees and organizational joint planning committees where they would share data trends and raise relevant regional issues. Some municipal Public Health units held the data in web based programs to be easily shared with the Ministry of Health and Long Term Care.

"We use a web based program, so the ministry gets all the surveillance data in real time… so they do their own surveillance at their end as well."

Some facilities also chose to voluntarily send regular monthly surveillance reports to their health units.

ICPs were concerned about the time that it will take to do the surveillance and reporting, once more requirements are mandatory in the near future for certain infections. Many felt the highly detailed reporting requirements would be too time-consuming and would only worsen the infection control staff shortage issue. A few respondents in Non Acute Care settings felt that the MRSA reporting is so detailed and so stringent that the program will not succeed.

"I don't know how ICPs will do the MRSA reporting for Safer Healthcare Now. No single person would have the time to do it, unless it was their only responsibility, the reporting is so minute, so detailed.

"We are getting so data heavy that we are losing the essence of infection control; we spend all of our time at our desks rather than on the floor"

" with all the extra precautions, it presses staff more and more and more for time, but we need to afford staff the time to take the right steps"

It also became clear through respondent feedback that adequate resources were essential to roll out a proper surveillance program within these health care facilities, which most organizations do not feel they currently have.

"Take a look at the hospitals that are well resourced and their surveillance programs… Mount Sinai… UHN… Sunnybrook… they have some of the best surveillance programs around and they are very resource intensive."

Due to contractual obligations, Community Care organizations were reporting on various indicators such as 'consistency' and 'significant events' While some of these indicators had IC components, infection was most often reported through tracking of antibiotics usage. Permission from the Community Care Access Centre was then required to increase medications, increase frequency of visits or any other changes to the care plan.

Effective this year, respondents stated that hospitals, nursing homes and other institutions were asked to report their rates of either C. difficile or MRSA to the CCHSA as part of the process for obtaining Canadian Council on Health Services Accreditation. When asked however, if their organization was currently reporting to the CCHSA, most respondents stated that they weren't. A few ICPs within Acute Care settings mentioned that while they were not providing the CCHSA with regular reports on any infectious diseases, the organization did have full access to their data. *"Every time they have an accreditation, they come by and we give them the data they are looking for… they have full access. I think they are starting to pay more attention though. It will be bigger this year."*

Although surveillance systems were generally in place and the infection rates were being reviewed, the information was not always being utilized.

"The organizations might be doing their own surveillance but [there is] a lack of knowing what to do with it and [a need] to talk about it and to share it. Everyone's busy and everyone's a bit protective of their data at times."

Only a very few respondents mentioned utilizing their surveillance data to identify topics for future training or for internal benchmarking…

"I also use the data I collect for benchmarking. By taking a look at it, I will know what is common for the season, or whether we are looking at an outbreak."

And identifying issues…

"I review the trends and then examine them with my professional advisory committee. Why are the numbers so high in that area? Is it because there has been more extensive reporting in that unit, or maybe the physician has been more liberal with his prescribing? Is this preventable or it the nature of the client?"

A few respondents mentioned that reporting on infection rates might help to communicate the need for more funding.

"if we start to get funded according to our infection rates, its going to come back pretty good"

2.8 Resources

A number of stakeholder organizations such as the Ontario Safety Association for Community and Healthcare (OSACH), and the Ontario Hospital Association provide support and resources to health care facilities or to the community at large.

Additionally, ICPs at various health care organizations in all sectors have developed tools and checklists to help staff with compliance.

"I've made lots of my own tools actually, lots of reminders around hand washing and additional precautions. The manual is also very comprehensive because I know I am not always around and I try to think ahead."

"We have a check sheet when someone is checked in or has an ARO that goes on the patient chart with room accommodation, what to wear, how do people come in and out of the room, signed and dated and looked at every week."

"I keep carts together in a storage area, where is someone has two or more of the symptoms listed on the checklist, if he is having trouble breathing etc… the carts are tailored to the various infections."

"I have an audit tool that I use. It's a self made tool based on best practices."

As part of their responsibilities, Public Health units have a large role in the dissemination of IPAC resources to all health care sectors and the community at large. However, some respondents stated that they were not always sure to which degree the resources that they provided were being utilized, and had no way of assessing uptake.

"…I think we try to be very targeted and try not to send people things that will not be relevant to their practice. But that's a challenging issue. You can send it out but can't it's being read on the other end."

2.9 Education and Training

2.9.1 Awareness of IPAC among heath care staff

Many respondents felt the absence of Infection Prevention and Control courses in post secondary education curricula for healthcare professionals left a significant gap in healthcare staff knowledge in the area of infection control.

"I think it should definitely be part of the curriculum. ICPs probably learn it on the job, and as for the ones I've dealt with, they have all been really good but as for the rest of the staff, they need a better understanding of their responsibilities."

Also some respondents felt that marketing of IPAC as a profession more proactively could alleviate some of the current shortages in ICP staffing. They stated that it was important to raise the awareness of infection control as a field of study in order to attract

more students. They suggested that the addition of an IPAC segment to secondary and post secondary curricula could increase interest in that role.

"We don't market ourselves. We should go to the high schools and say 'this is a branch of nursing or lab tech or whatever that you might be interested in…"

"Formal education at the university level would be great. Definitely with the nurses, they don't even know about us… we need to encourage them, let them know that this is a job that they can do, have them come and spend some time with us."

2.9.2 GENERAL STAFF TRAINING

New staff members joining Acute and Non Acute care facilities, Community Care organizations or Emergency Medical Services are required to participate in an orientation session. However, the IPAC training component tended to be very small, with an average duration of approximately 15 minutes. In many cases, this small amount of time spent on IPAC during orientation accounted for the majority of the time or the only time allotted to IPAC for the year.

Most of the respondents from Acute and Non-Acute Care facilities said they had no structured ongoing training program for IPAC, with the exception of one Acute facility that had introduced a thirty minute IPAC segment in their yearly mandatory staff training session. Typically, training in IPAC was introduced only reactively following an outbreak, rather than proactively. Additionally, much of the training was focused on seasonal issues such as flu, rather than emphasizing general infection control practices.

" Every flu season we do in-servicing… whatever seems to be an issue, we will address it informally."

In addition, sporadic education sessions were often implemented when a new policy was developed that was felt to require training or when there was an outbreak situation that needed to be addressed.

"When new guidelines come out, we do education around that for all our staff. When VRE directives came out, we did formal staff in-servicing

The Public Health sector is mandated to provide education days for providers, however respondents noted that the type of education that they are required to provide is not specified.

"We have a requirement to provide an annual education day for providers in long term care and acute care. Whether that education should be a newsletter or a workshop is not defined though and every health unit does it differently."

Some Public Health respondents noted that most of the training is attended by those who are already familiar with the issues and they felt that they were preaching to the converted.

"We used to actively pursue education, but then we started getting the same individuals year after year to the point where we were pushing it and we were just reaching the same people …"

Given the minimal education provided by organizations in relation to IPAC, most respondents felt that an increased level of staff training was necessary, but that the resources were not there to support it.

"They understand the precautions but not much knowledge in the infections. If I had the time I would do one session each week. If I had the funding to increase it, I would be jumping on it."

Respondents also noted that staff are often expected to attend the sessions on their own time. This causes difficulties for many staff, as they cannot always find the time to attend, nor do they necessarily want to attend when they are not being paid for their time. As a result, staff are less likely to attend training and therefore, in some cases, training sessions were likely to be put on hold.

"It is part of their job expectation but we have no funding to pay them and it is very difficult for them to come when they are not on duty."

"Making it mandatory and paying them to do it, that would be ideal, but having the training in the evenings or at lunch, that's a different story and it discourages them."

Many felt they had too little time to provide training, and too few resources on the floor to be able to send staff to training.

The underlying issue, as identified by some working within the Acute Care setting, is that there are not mandatory core competencies in infection prevention and control.

2.9.3 NUMBERS OF ICPS

A lower than anticipated number of reported ICPs were identified through the quantitative survey during the first phase of this research, and it was hypothesized that there may have been some confusion surrounding the definition of ICP used by the respondents in answering this question on the survey.

In this qualitative phase of research, we followed up on this by asking respondents how they defined the term "ICP" and whether they had misconstrued the definition as requiring formal credentials. No one made the assumption that to be an ICP, there was a requirement for either CIC designation or formal training. Rather they defined an ICP as a person who provided infection control expertise to the facility as well as to the community in general. It is therefore unlikely that the numbers collected through the survey were lower than expected due to an incorrect understanding of the term ICP.

2.9.3.1 EDUCATION

ICPs expressed a need for ongoing education opportunities and networking. It was suggested that the RICNs could take on the role of organizing such groups in each region. These types of structured study groups did in fact exist in some regions.

"Having an ongoing study group would be nice… this month we will be talking about such and such through video conference… it would be nice to have this type of ongoing education."

2.9.3.2 IMPORTANCE OF CREDENTIALS

There were mixed views about the need for formal credentials for ICPs. Some felt credentials were very important, and others felt that skills and experience were equivalent to formal credentials, and equally effective in doing the job.

Those who were supportive of having formal credentials felt that there was a lot of expertise required to undertake the IPAC role and that it needed to be taught in a formal program.

"I think it is really important because I don't think it's a skill set that is taught in traditional programs… there is an expert knowledge that is required, that people have to understand transmissibility and so forth."

Some stakeholders also felt that the CIC accreditation was valuable.

"The designation provides further benefit, bringing science and education together; to benefit both the employer and the patients… it promotes consistency of practices at a delivery level."

Additionally, the ICPs that did have credentials commented that they were accorded a greater deal of credibility since their accreditation than they had beforehand. They also noted that the perceived status provided them with the leverage that they needed to address physicians regarding ICP issues.

"I think it's important for credibility […] I have received a lot more credibility for what I am doing since my accreditation. They value my knowledge base more, knowing I have spent the time researching the issues and have the knowledge."

On the other hand those respondents that were not supportive of a requirement for formal credentials, recognized that credentials were an added benefit in their role but felt experience in the field was equally if not more important.

Also, while senior staff at some of the facilities preferred ideally that a few members within their staff have their CIC, they did not always feel that this was feasible due to lack or resources and lack of funding.

"I wish I could send the staff for more training. I think some CIC training would be excellent, but it would be a matter of sending them off the floor and I can't do that… that is the issue."

Although many respondents supported the idea of credentials, there were several concerns expressed about CIC designation. One was the relevance of the CIC curriculum based to the Canadian experience and circumstances.

"It's different here, we have our own standards. Each province is trying to stand alone but we need a good federal department that is supporting us. I mean we're different… they talk about Rocky Mountain Spot Fever and we don't even know what that is."

Another criticism identified by a few respondents was that the course content of the CIC curriculum was highly theoretical and academic in nature. These respondents felt that a component with practical implementation strategies would be beneficial to the graduating ICP as well as to the employer.

"The education processes seem quite good at a basic operational level […] but everyone is sort of left to go away from that program and implement it in their own way. I think if that is a weakness in the way the process works today, they need a good 'how to implement' manual for the knowledge and practices you've come away from the CIC program with…"

"..I'm not sure that all of the knowledge can be put in to context at our centers"

Also, many respondents from various healthcare sectors felt that the CIC curriculum would be of much greater benefit to their organization if it were tailored to their particular sector.

"I think the info should be specific to long term care and whoever is teaching it has to know the logistics of long term care. I think it needs to be specific, I mean there are more long term care homes in Ontario than acute facilities."

Similarly, some people felt other formal accreditation courses were also limiting as they are offered only in a small number of locations. This raised the issue of time and expense for both individuals who wished to pursue accreditation on their own, as well as organizations who felt that they cannot afford to send their staff. Facilities said could not afford to release a staff member due to lack of resources to replace them nor did they feel they had adequate funding in place. There was also some frustration expressed by a few that there was a lack of available information on the existing options for proper accreditation.

"When I went to study in Toronto, it was two weeks, and then you had to wait to write your exam. I think that they need something in Ottawa. I think there needs to be programs in every city to make it accessible."

"People who wanted to take the class room setting at George Brown in Toronto had distance issues […] they couldn't get there and they couldn't take the time away from home and family… the one classroom location is not really great."

"We've got a good thing going right now but we could make it a lot better by expanding the availability. I would love to be able to give a 4-5 thousand dollar grant to put an infection disease professional into each one of the courses… because I think there's only about a dozen or fifteen that have it (CIC)(in the province)"

2.10 WORKING RELATIONSHIPS

2.10.1 PUBLIC HEALTH

All facilities had a relationship with their regional Public Health unit and many considered it their most valuable resource for infection prevention and control.

"The majority of our knowledge comes from public health resources. They are the folks that I go to first; they are only a call away and always provide direction."

"I think that the …Health Unit is meeting most of our needs so far… they have been our biggest supporter… they take care of both the regional and the provincial stuff… I mean they sit on the regional committee so there is no need for us to be there."

The involvement of Public Health units was most often in the area of outbreaks, immunization programs and sitting on advisory committees. Some Public Health units reported that they were responsible for monitoring vaccination uptake by staff in healthcare facilities.

"We collect these rates annually […] we go to the facilities and ask them to provide the data which we look at locally and send to province. We make out a histogram by hospital and we rank them from lowest to highest vaccination rate and compare these to the 70% cut of to see how we're comparing to that benchmark. This is then provided to each hospital showing them how they compare to others."

A few respondents within public health felt that staff vaccination was not a high enough priority. Several procedures were suggested such as mandatory blood testing for staff to confirm vaccination of public reporting on vaccination rates.

Public Health chaired and sat on many IPAC committees.

"We designate physicians, nurses or PHIs from our unit to each complex care or continuing care facility where they attend those regular infection control meetings and provide public health updates."

"Public health sits on the infection control committee and facilitate our long term care pandemic planning committee… they are very supportive."

The extent of the relationship between facilities and their public health units was dependent on the initiative of the particular health unit as well as the level of IPAC expertise felt to be had within the facility.

"I think in xxx, we have some places where they are extremely knowledgeable, like leaders in their area … where they're not going to look as much to us for expertise because they have it in house, and in fact they are probably the experts… so I think in terms of support from the health unit, we might be less helpful to them, or less required."

2.11 INTER-ORGANIZATIONAL RELATIONSHIPS

There are many sector organizations working in the area of infection prevention and control, or having some responsibility for related activities. Respondents were asked which organizations they worked with and which they would like to work with more.

It was clear that some organizations such as the RICNs and the LHINs for example, are still relatively new and roles and responsibilities still need to be worked through.

"I don't know how the relationship is going to evolve.(with LHINs) But potentially in hospitals, we're going to see a public reporting format where we may see organizations who are lower or higher. So what happens is some of those poorer performers, the LHINS may say to us, 'can you go in and help these organizations?' which we can, we're glad to do that, but there's too many organizations for us to help everyone but there may be specific targeted activities we could do to support them."

"The LHINS still sort of know who we are but don't understand us. They probably don't understand a lot of others. I don't even think they understand or know the RICNS"

A few respondents working within the Community Care sector, however, were troubled with the current relationships among some stakeholder groups due to a perception of lack of clear boundaries and minimal integration.

"Right now from a LHIN perspective and from a CCAC perspective, we have not settled in to integration and collaboration. We are still in competition and it's creating a big problem for us…"

Some organizations have however entered into strategic partnerships to define roles and minimize duplication of effort.

"We just signed a Memorandum of Understanding with ---, so they're a strategic partner; mainly in relation to supporting their accreditation process because what our members have said

to us is 'please help us align so we're not caught in this a confusion of doing things for multiple people."

A few organizations were comfortable just to be aware of other organizations in their line of business for now.

"We know of each other, and we will give them time. Eventually, however, we will have to be seen as a partnership"

Some stakeholder organizations said they are being approached by various sector providers but they don't currently have adequate funding to assist them.

"We're underfunded… I can't do more than I'm doing. We're finding now that other associations are coming rapping on our door, which is a good thing… the word is out there… we'll work with people and we'll develop stuff but I'm more and more looking for them [the ministry] to throw in some cash to help with this."

2.12 Lack of Awareness of Existing Organizations

The level of awareness surrounding existing IC organizations was generally low. When asked which organizations that they did not currently have a relationship with, but felt they would like to, many respondents were unaware of the existing options. Respondents that demonstrated low awareness were curious and often asked what their 'options' were. *"I'm not aware of any that exist. I don't think there is enough education* there…"

"I was at the patient safety group last week and much to my horror, I learned that this group that's in charge of developing the reporting for a variety of indicators for the ministry had never heard of PIDAC. I was appalled."

In terms of desired relationships not yet in place, few mentioned specific organizations. Rather, most felt they had already established relationships that they needed and were too busy to look for more

2.13 Role of Public Health vs. RICNs

There was confusion surrounding the respective roles of Public health and Regional Infection Control Networks particularly in terms of IPAC training and support. Sector respondents were often unclear on the proper organization to turn to in particular situations.

A few Public health units were confused in terms of the boundaries of their roles as well.

"I think we have to be better coordinated, I don't think the roles are clear (between public health and the RICNs) but again I haven't been directly involved."

A particular point of confusion was related to the dissemination of resources or best practices and provision of educational offerings.

"I've often wondered who is responsible for both disseminating information and ensuring its uptake. I don't know where the accountability is in terms of uptake… what is the role or RICNs versus public health is still a question in my mind."

"You can tell me the RICNs were set up across the province as they were intended to supplement everyone's business not replace or take away. Our experience so far is that they appear to be taking over the education that we used to provide and I certainly have no problem with that… if they can do it better that's great… but I think there is a lack of communication […] we have people that are working together and yet I don't believe that everybody know their part."

2.14 SECTOR RELATIONSHIPS WITH RICNS

The Public Health units seemed to have a closer relationship with the RICNs than did the other four sectors. Many Public Health units reported that they worked with the RICNs on various IPAC initiatives such as training…

"We have worked with the RICNs with respect to both building up the credentials of our own staff, as well as bulking up the credentials."

A few respondents in the Public Health sector, noted that they had played a role in the development of their respective Regional Infection Control Network and were very familiar with RICNs.

Those in other sectors, and particularly those who weren't involved in the development of the RICNs however had less familiarity with the networks. Some reported that they were aware of the RICN because they received regular correspondence through email and newsletters from the network.

"When I was on maternity leave, there was a formal introduction with the person that was covering my job. We still receive email and newsletters from them frequently"

Others stated that they had not yet been approached by the network and were only aware of their existence through word of mouth. Some found about them indirectly. This seemed to be particularly the case for respondents in the EMS sector.

"We heard nothing about them at all until we started to do our own research. We only heard about them through the rumor mill from some of the hospitals; we weren't even considered for the communications, the announcements weren't even distributed our way"

Others had heard of the RICNs, but had no specific information or details.

"I know they exist… they are set up to bridge hospitals and long term care facilities and public health to develop strategies to control infections so they're prepared if a new virus or bacteria came along… but no we don't have a relationship."

A few expressed disappointed with the slow pace of the ministry's initiatives and those of the RICN. Many didn't feel that the RICN's support was properly directed.

"Actually, I was a part of the developing committee before it was RICN and we are pretty disappointed, because we thought we were going to be purchasing new, better, or at least more efficient software and we haven't gotten anything."

While some respondents were not satisfied with the role of the RICNs and the relationship that they currently had with them, there was a general attitude that the networks were still new in the community and that it was a matter of them finding their niche before effective relationships could be established.

"I believe that these are growing pains because they're brand new. They haven't been here very long, all of us are getting used to each other and we're trying to find our place so everybody is going to start overlapping… I don't think everybody truly knows where they fit yet."

"You know, I'm just watching, to see them mature, and when they are ready… they will probably reach out a little more to us but they are there to work and there is more than enough for all of us"

Roles for RICN

The types of relationships commonly sought out by respondents for the RICN were supportive relationships.

"I like to think of them as a support system so that I don't feel like I am out there all on my own"

Suggestions were made for the following roles:

1. Providing education

Many ICPS suggested that a monthly or quarterly conference (video conference) hosted by the RICN through which ICPs and other staff members within the region could share ideas would be very helpful.

"I like the idea of them doing a major component of education. They have the resources needed to do newsletters, develop workshops etc. I wish that they could do more because that is their only focus, and they could put it out consistently across the province. It could be so much better than what we do."

2. Organizing the standardization of data collection.

Most respondents were looking for someone to take the lead in coordinating the acquisition of IPAC information systems. They were particularly interested in consistency.

"We need better tracking and software systems. I haven't asked for any yet, I'm trying to be patient because the region is supposed to have a common program eventually.

I'm hoping that ….RICN will take the initiative to make sure that everything is standardized."

"I'd like to see us all doing surveillance the same way. I'd like to be able to benchmark within the RICN. I'd like to see similar computer programs…"

3. Providing common resources and signage

Some respondents suggested it would be good not to reinvent the wheel with the development of tools, to share best practices and tools, and to have a common look and feel to them.

"It would be nice if we came together and had resource materials. I mean, we don't have a print shop here and I would like to shake up the signage once in a while. Can we all look the same? I would like to see that cohesiveness."

4. Research into infection control issues

A few saw a role for the RICN in undertaking research on Infection Prevention and Control issues.

"I think it would be great of the RICNs could be looking at what are the issues in all areas… long term care… hospitals… complex continuing care. I just feel there are so many unanswered questions with infection control"

5. Support during outbreaks

A few respondents are also looking for hands on support during outbreaks.

"We felt alone when dealing with our VRE outbreak, with all the tax money we sink into the government, we didn't get any form of support, we had to reach out to the RICNs. I talked to the medical director but because we chose to have everyone do medical gloving which was not in the PIDAC best practices, they couldn't give us any education… so we were pretty disillusioned. We thought when someone was in outbreak, a team from the region would come and help us out, but that hasn't been put in place."

6. Community Education

Many particularly in the Non Acute Care and Community Care sector mentioned the need to heighten community awareness on infection prevention and control in general. RICNs were seen as a conduit for public education campaigns.

2.15 PHYSICIAN SUPPORT

Although the degree of support was varying, all respondents reported that they had access to physician support in the area of infection prevention and control. In many organizations, ICPs had an advising physician at the corporate level with whom the ICP would meet routinely.

"The pathologist is our main IC resource. We meet once a month and we put together a report for the MAC."

Other organizations, mainly the smaller or less resourced facilities had a regional physician whom they would consult when they needed advice or approval. In most cases the supporting physician was a pathologist or a general practitioner.

All respondents working within Acute Care and Non Acute Care facilities felt that physician support was essential to the quality of their IPAC initiative.

"Physician support is very important; I've had it both ways. Program is stronger when you have the support, and you don't feel so much like you are out there on your own."

Some respondents felt that physician support was paramount in physician compliance to IPAC

"…it's very important to me that I have someone else. It will be very difficult to get physicians to comply."

Physician advice and guidance was beneficial to the development of protocols. Also there were reported cases in which physicians preferred to have certain discussions with a fellow physician.

"If a physician that is called in, expresses a concern about a recommendation we've made, he'll talk to me, but it may get to the point where he'll ask for a physician, and I understand that…"

Respondents working within Community Care and Emergency Medical Services, on the other hand, felt that physician support was sometimes helpful but not always necessary. Degree of importance attributed to support it some cases was dependent on the amount of internal knowledge and resources at the respective facility.

"No, we don't have a great need for it…."

"I think it can be helpful to have physician support on questions that are not covered in the existing protocols."

"It's not all that important right now… maybe because I do have a lot of time to spend on it […] and I have education. If someone didn't have the education, maybe the physician support would be more important. So maybe the less resources that an organization has, and the less education that the director has, the larger the need for physician support."

The value of any supporting physician also seemed tied to the physician's specialty as well as their interest in infection prevention and control.

"The support is hugely important but the problem here is that it is not a specialist, it is a GP."

"… all Acute Care and Non Acute care facilities have a professional advisory committee or a infection prevention and control committee and have to have a physician on that committee… and when the physicians are just there because they are told they are supposed to be there but doesn't get it, those don't function very well… but is the physician is understanding the role of the committee and why we're there, there is a lot more accomplished."

Stakeholders were asked how important physician support is to infection prevention and control issues. Most felt the support was key since they can champion infection prevention and control practices.

Physicians have a level of knowledge and expertise and should be encouraged to join round table discussions for strengthening infection prevention and control practices.

"We found that for many of our campaigns, you need their buy in. if you don't get their support, then it can be a deterrent."

"Yes, it's important to have someone in each region"

2.16 Inter-Relationships Among Patient Safety, Infection Control and Occupational Health

Respondents were asked how or if patient safety, infection prevention and control and occupational health activities relate to each other. There was a lack of clarity among sector respondents about how these initiatives fit together; many were unclear about boundaries, and felt there was a lot of duplication of effort.

Although in some organizations, the roles were integrated within one person who was often responsible for Patient Safety, Occupational Health, and Infection Prevention and

Control, most sector respondents agreed that the three areas should be managed separately but that the departments needed to work together more closely and be more integrated in their work. Stakeholders also agreed that the initiatives still needed to be further integrated.

In the view of some, integration was necessary to better ensure patient safety. Others felt it was more a question of efficiency.

"Occ health will report to us all of the employees that are ill and the ICPs will report to us the patients that are ill and we have to collate that together because they won't talk to each other. It's frustrating."

"What we're saying is look at it in a systematic, comprehensive, aligned way, if you're going to deal with the issues. Otherwise, you're back to what the SARS commission found, that the Occupational Health people and the IC people are not talking… We need to find a structure where they are aligned… really aligned."

"We tend to unfortunately end up working in silos. There's a lot of common issues across sectors would be nice and ideal, if we don't duplicate our efforts. But often the left hand doesn't know what the right is doing."

"Safety is a worker, patient and public thing and until you look at all three combined, you're really not addressing the full issue."

Stakeholders commented that although strides have been made in bringing these issues together after SARS, communication gaps are still prevalent and that the relationship could be stronger. A few stakeholders commented that there needed to be more knowledge sharing and efforts to work with Occupational Health and Safety committees while others felt they needed to address the topic of quality as well and integrate it with patient safety and IPAC.

It seems that the need to integrate has been acknowledged by most stakeholders and a few organizations were beginning to take steps in that direction.

"Only recently have people begun thinking of infection prevention and control as a patient safety issue. We need to have stronger relationships with occupational health and safety committees."

"The idea is that they set up a structure with senior executive involvement and they look at risk right across the organization. So, you're looking at your patient risk management, your infection controller, your workplace safety people anybody who's involved […] we're trying to tell people to look at the whole thing".

However, some respondents noted that there was a potential conflict of interest to integrating Occupational Health and Patient Safety given Occupational Health's mandate to protect the worker versus the patient safety imperative for the patient.

2.17 OBSERVATIONS AND RECOMMENDATIONS

Lack of time on Infection Prevention and Control

Findings from the qualitative interviews supported and reinforced some of the gaps and issues noted in the quantitative survey. Of key note is that in addition to the lack of staffing reported in the survey, the interviews revealed that even when staff members are designated as infection control practitioners (ICPs), much of their time is often spent on other activities.

Further research and analysis on the role of the IPAC, and actual time spent on IPAC activities is warranted to determine a baseline of actual time spent, and to gain a fuller picture of what would be appropriate resourcing for these practitioners to allow for the full spectrum of IPAC activities to be undertaken.

Lack of coordination among external program initiatives

This lack of time is further exacerbated by organizational involvement in a number of initiatives in relation to infection control, such as the Safer Healthcare Now campaign, Hand Hygiene campaign, CCHSA accreditation requirements related to infection prevention and control, and new Ministry of Health and Long Term Care reporting requirements.

Better integration and coordination of these initiatives would provide for a more cohesive effort and minimize time spent collecting data in different formats for each initiative. Organizations involved in these activities should consider common communications which highlight the relationships among the initiatives, and provide common tools and data sets, with the ability to transferable information across initiatives without re-entry or duplication.

Resources and Funding for IPAC

Staff resources are already stretched, and ICPs are limited in their ability to undertake key proactive activities in IPAC such as staff training, and surveillance and monitoring. As additional responsibilities and reporting requirements are introduced, the amount of time available for proactive Infection Prevention and Control will be further limited. Consideration of additionally targeted funding for staff positions and development of common tools to support training, surveillance and monitoring activities would improve the ability of organizations to undertake IPAC activities.

Sector Specific Resourcing

Some sectors appear to be less resourced; notably Community Care and Non-Acute Care settings. Exploration of the needs of these sectors should be considered, as the amount of patient contact and care in these settings is considerable and opportunities for infections and outbreaks are high.

Data Collection Systems and Better Integration of information among Departments and Across Organizations

Many organizations are still using manual systems which are time consuming and often duplicate data used by others within the organization. Those with computerized systems do not find them generally useful for IPAC specifically, and these systems often differ within and across organizations.

Consideration of the development of common data systems for infection prevention and control and the introduction of computerized systems relevant to IPAC needs in organizations that lack them, as well as better coordinated systems across organizations would reduce workload and provide more consistent and comparable data for benchmarking.

Staff training and IPAC core competencies

Very little time was devoted to orientation and ongoing training of staff on infection prevention and control. More time should be dedicated to IPAC in orientation sessions as this is often the only training received by staff in relation to IPAC issues. There was a strong need expressed for front line people, in all sectors, to be more aware of IPAC and dedicated to its activities on a daily basis in either occupation. However, the approach to training on ICP and how it is presented to staff needs to be rethought. It doesn't resonate as a stand alone item; rather it needs to be connected to the staff in direct relation to their work, their personal risk and understanding that everything they do is related to infection prevention. This is especially important for dietary and housekeeping staff but also for nursing and physicians.

Core competencies in IPAC should be developed for health care providers and more training in these core competencies should occur during career preparation for the various health care professions so that graduates have more knowledge and competencies in IPAC.

Formal Training and Credentials for IPAC staff

Many respondents felt formal accreditation or training for IPAC professionals would be beneficial. However, there were some concerns about the relevance, cost and availability

of CIC accreditation. Gaining CIC accreditation is costly and time consuming, and many of the formal courses offered by colleges are only available in a few urban centres. In addition, there are challenges in being able to support staff training due to shortages and workload. At the same time, the training needs of IPAC staff need to be accommodated both financially and through provision of time off, and the benefits of training (credentials) needs to be understood and communicated.

Consideration should be given to supporting the cost of getting accreditation on the part of employers or the province to encourage more practitioners to consider formal training options.

Exploration of the current curricula and availability of formal IPAC training should be researched and documented and recommendations developed. Some respondents suggested exploration of an alternative to the CIC that fits more closely with the Canadian system, or a Canadian version of the CIC.

Marketing of the Role of the ICP

There is a shortage of well trained IPAC staff to undertake the work required. Awareness of ICP as a career path needs to be communicated more broadly so that it is seen as a viable option for health care professionals. Marketing efforts to high school students as well as those already enrolled in health care professional programs is needed.

External support and expertise

There is confusion as to who to turn to, and what can be provided by external players. There is a need to provide more clarity regarding relative roles of the various external organizations such as Public Health and the RICNs.

Need to heighten community awareness

Many respondents commented on the need to increase public education on infection prevention and control in general. This was particularly expressed by respondents in Non Acute and Community Care settings. They felt that families and caregivers did not understand the importance of IPAC and their role in supporting it.

A public campaign to emphasize the key role that the public can play in reducing and preventing infection that emphasizes the impact rather than the activity might help to increase awareness and compliance. (i.e. why handwashing is so important)

3.0 APPENDICES

3.1 QUESTIONNAIRE EMPLOYED FOR STAKEHOLDER INTERVIEWS*

NEEDS IN INFECTION CONTROL - QUALITATIVE
- Discussion Guide (Stakeholder) -

Role:	
NAME:	
DATE:	
TIME:	
ORGANIZATION:	
Location:	
Telephone:	

1. Introduction and Background

- This research is being conducted on behalf of the regional infection control networks of the ministry of health and long term care.
- The primary objective is to gain a better understanding of the issues related to infection control from your organization's perspective.
- Reassure on confidentiality
- Ask for thoroughness
- Permission for audio-taping – reassure for research purposes only – for us to verify information. Individual names will not be identified on any of the reports.

1. Can we start with an overview of your organization's mandate and what you see as its primary role?

2. How do infection control issues fit within the mandate?

2. IC Issues

3. Where does IPAC on your current list of priorities?

4. Do you collect data in relationship to infection control activities ?

Note:* Questionnaire is only a composite sample. Questions varied somewhat by stakeholder

5. What issues or gaps currently exist within IPAC from your perspective?

6. Do you have any suggestions on how these issues could better be addressed?

7. What sort of changes if any, have you seen occur within IPAC since SARS?

8. Do you provide any tools for infection control support?

9. Do you feel that the boundaries and interrelationships among patient safety, infection control, pandemic planning and workplace health are clear? If not, what needs to be done to clarify?

10. If I used the term ICP to define an infection control practitioner, what would you assume that term meant?

11. What degree of importance do you attribute to credentials and training programs for infection control? Do you feel that there are any gaps in training?

12. What degree of importance do you attribute to physician support?

13. What external organizations, if any, do you work with in the area of infection control? Are there any organizations that you are not currently connected to but feel you should be?

14. Are you familiar with the RICNs?

15. Do you or does your organization have a relationship with the RICNs? If yes, what does this relationship consist of?

16. Do you see any partnership opportunities with the RICN that aren't currently in place? If yes, what type of benefits could result from this partnership?

17. Are there any additions or alterations that you feel should be made to the way infection prevention and control occurs in the community?

18. What one thing would you like to see implemented and changed in the next year in your organization with respect to ICP?

19. Do you have any additional comments?

3.2 Questionnaire Employed for Sector Interviews

NEEDS IN INFECTION CONTROL - QUALITATIVE
- Discussion Guide (Sector) -

Role:	
NAME:	
DATE:	
TIME:	
ORGANIZATION:	
Location:	
Telephone:	

1. Introduction and Background

- This research is being conducted on behalf of the Regional Infection Control Networks of the Ministry of Health and Long Term Care.
- The primary objective is to gain a better understanding of the issues related to infection control from your organization's perspective.
- Reassure on confidentiality
- Ask for thoroughness
- Permission for audio-taping – reassure for research purposes only – for us to verify information. Individual names will not be identified on any of the reports.

1. Can we start with an overview of your organization and your role?

2. Can you tell me about how infection control is managed at your organization?

2. IC issues

3. Who develops policies (corporate level only?)

4. How are policies implemented and enforced?

5. How much of your time is spent on IPAC activities?
6. How much of an average nurse/caregiver time is related to infection control activities? To Training?

7. How do you monitor your staff regarding infection control practices?

8. Do you provide any tools for infection control support?

9. Where does IPAC on your current list of priorities?

10. What issues or gaps currently exist within IPAC from your perspective?

11. Do you have any suggestions on how these issues could better be addressed?

12. Do you see community care/long term care organizations playing an advocacy role for more support for IP and control?

13. If I used the term ICP to define an infection control practitioner, what would you assume that term meant?

14. What degree of importance do you attribute to credentials and training programs for ICPs?

15. Would you say that the existing credentials and training programs for ICPs are sufficient?

16. Do you feel that there are any gaps in training?

17. Are there any additions or alterations that you feel should be made to the way infection prevention and control occurs in the community?

18. In your view, how does patient safety relate to IPAC?

19. Do you feel that the boundaries and interrelationships among patient safety, infection control and workplace health are clear? If not, what needs to be done to clarify?

20. Do you have any level of physician support with regards to Infection Control in your organization at the local or corporate level?

21. What degree of importance do you attribute to physician support?

22. Do you collect data on any surveillance activities at your organization?

23. Could you tell me a little about what you generally do with the data collected at your facility?

24. Is Public Health involved with your organization in terms of ongoing relationships through committees, or any other process? Corporately, locally?

25. What sort of changes have you seen occur within IPAC since SARS?

26. How would you like to see IPAC evolve in the future?

27. What external organizations if any do you work with in the area of infection prevention and control?

28. Are there any organizations that you are not currently connected to but feel you should be?

29. Are you familiar with the RICNS?

30. Do you or does your organization have a relationship with the RICN? If yes, what does this relationship consist of?

31. Do you see any partnership opportunities with the RICN that aren't currently in place?

32. Do you have any additional comments?