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INFECTION PREVENTION AND CONTROL STANDARDS

Accreditation Canada's *Infection Prevention and Control (IPC) Standards* provide a framework to plan, implement, and evaluate an effective IPC program based on evidence and best practices in the field. The literature shows that well-designed IPC programs are cost-effective because they reduce health care-associated infections, shorten the length of hospital stays, and decrease the cost of treating health care-associated infections.

The Accreditation Canada standards outline the key routine practices and additional precautions necessary for an effective IPC program, including:

- Point-of-care risk assessment
- Hand hygiene
- Aseptic techniques
- Personal protective equipment
- Cleaning and disinfection of the physical environment
- Handling waste and linen

Promoting a collaborative approach to protecting the safety of clients and the team, the *Infection Prevention and Control Standards* contain the following sections:

1. Planning and Developing the IPC Program
2. Implementing the IPC Program
3. Evaluating the Impact of the IPC Program

Note on Reprocessing of Reusable Medical Devices Standards

Accreditation Canada developed the *Reprocessing of Reusable Medical Devices Standards* to evaluate reprocessing activities that are completed inside the Medical Device Reprocessing (MDR) department.

Accreditation Canada introduced reprocessing content to the *Infection Prevention and Control (IPC) Standards* for organizations that do not have an MDR department and therefore will not be evaluated against the *Reprocessing of Reusable Medical Devices Standards*. To avoid duplication in requirements, the reprocessing section will be removed for organizations that are using the *Reprocessing of Reusable Medical Devices Standards*.

Glossary

Additional precautions: The Public Health Agency of Canada (PHAC) defines additional precautions as “extra measures, when routine practices alone may not interrupt transmission of an infectious agent. They are used in addition to routine practices (not in place of), and are initiated both on condition/clinical presentation (syndrome) and on specific etiology (diagnosis).” Examples of additional precautions include contact precautions for situations when heavy contamination of the client’s environment is anticipated; droplet precautions for microorganisms primarily transmitted by the large droplet route; and airborne precautions for microorganisms transmitted through the air over extended time and distance by small particles.

Airborne infection isolation room: An isolated room that is occupied by one client who is suspected of having or is confirmed to have an airborne infection. Environmental conditions within the room are controlled to prevent the transmission of microorganisms. This is also referred to as a negative pressure or negative pressure isolation room.

Alcohol-based hand rub: As defined by PHAC: “an alcohol-containing preparation (liquid, gel, or foam) designed for application to the hands to remove or kill microorganisms. Such preparations contain one or more types of alcohol (e.g., ethanol, isopropanol or n-propanol), and may contain emollients and other active ingredients.”

Aseptic technique: As defined by PHAC: “the purposeful prevention of transfer of microorganisms from the patient’s body surface to a normally sterile body site or from one person to another by keeping the microbe count to an irreducible minimum. Also referred to as sterile technique.”

Care delivery model: A conceptual model that broadly outlines the way services are delivered. It is based on a thorough assessment of client needs, involving a collaborative approach and stakeholder input, which considers the best use of resources and services that are culturally appropriate. The benefits of using a care delivery model include improving access to services, providing safe, quality care, promoting a client-centred continuum of care, providing access to a balanced range of services, supporting a highly skilled and dedicated workforce, and reducing inequities in health status.

Care plan: May also be known as the service plan, plan of care, or treatment plan. It is developed in collaboration with the client and family and provides details on the client history as well as the plan for services including treatments, interventions, client goals, and anticipated outcomes. The care plan provides a complete picture of the client and their care and includes the clinical care path and

information that is important to providing client-centred care (e.g., client wishes, ability/desire to partner in their care, the client's family or support network). The care plan is accessible to the team and used when providing care.

Client: The recipient of care. May also be called a patient, consumer, individual, or resident. Depending on the context, client may also include the client's family and/or support network when desired by the client. Where the organization does not provide services directly to individuals, the client refers to the community or population that is served by the organization.

Client representative or client advisor: Client representatives work with the organization and often individual care teams. They may be involved in planning and service design, recruitment and orientation, working with clients directly, and gathering feedback from clients and team members. Integrating the client perspective into the system enables the organization to adopt a client- and family- centred approach.

Co-design: A process that involves the team and the client and family working in collaboration to plan and design services or improve the experience with services. Co-design recognizes that the experience of and input from the client and family is as important as the expertise of the team in understanding and improving a system or process.

Electronic Health Record (EHR): An aggregate, computerized record of a client's health information that is created and gathered cumulatively from all of the client's health care providers. Information from multiple Electronic Medical Records is consolidated into the EHR.

Electronic Medical Record (EMR): A computerized record of a client's health information that is created and managed by care providers in a single organization.

Environmental conditions: Refers to temperature, humidity, air circulation, and water quality within the physical environment.

Family: Person or persons who are related in any way (biologically, legally, or emotionally), including immediate relatives and other individuals in the client's support network. Family includes a client's extended family, partners, friends, advocates, guardians, and other individuals. The client defines the makeup of their family, and has the right to include or not include family members in their care, and redefine the makeup of their family over time.

Grey areas: Refers to high-touch surfaces in the physical environment that are usually overlooked during routine cleaning and disinfection. Examples include curtains, bedrails, light switches, and doorknobs.

Health care-associated infections: As defined by PHAC: “infections that are transmitted within a health care setting (also referred to as nosocomial) during the provision of health care.” Examples include *C. difficile*, surgical site infections, seasonal influenza, noroviruses, or urinary tract infections.

Indicator: A single, standardized measure, expressed in quantitative terms, that captures a key dimension of individual or population health, or health service performance. An indicator may measure available resources, an aspect of a process, or a health or service outcome. Indicators need to have a definition, inclusion and exclusion criteria, and a time period. Indicators are typically expressed as a proportion, which has a numerator and denominator (e.g., percentage of injuries from falls, compliance with standard procedures, staff satisfaction). Counts, which do not have a denominator, may also be used (e.g., number of complaints, number of clients harmed as a result of a preventable error, number of policies revised). Tracking indicator data over time identifies successful practices or areas requiring improvement; indicator data is used to inform the development of quality improvement activities. Types of indicators include structure measures, process measures, outcome measures, and balancing measures.

In partnership with the client and family: The team collaborates directly with each individual client and their family to deliver care services. Clients and families are as involved as they wish to be in care delivery.

Interdisciplinary committee: A group of individuals with varying areas of expertise working toward common goals (in this case, for IPC-related goals). Committee membership may include physicians, nurses, and representatives from surgical care, microbiology, medical device reprocessing, environmental services, Occupational Health and Safety (OHS), risk management, quality improvement, and public health.

Interoperable: The ability of two or more systems to exchange information and use the information that has been exchanged.

Medical devices and equipment: An article, instrument, apparatus or machine used for preventing, diagnosing, treating, or alleviating illness or disease; supporting or sustaining life; or disinfecting other medical devices. Examples include blood pressure cuffs, glucose meters, breathalyzers, thermometers, defibrillators, scales, foot care instruments, client lifts, wheelchairs, syringes, and single-use items such as blood glucose test strips.

Medical equipment: A subset of medical devices, considered to be any medical device that requires calibration, maintenance, repair, and user training.

Outbreak: As defined by the World Health Organization: “the occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season.”

Pandemic: An outbreak that has spread worldwide, affecting a significant proportion of the population.

Partner: An organization or person who works with another organization to address a specific issue by sharing information and/or resources. Partners in IPC may include peer organizations, community organizations, professional associations [e.g., Infection Prevention and Control Canada (IPAC Canada); *l'Association des infirmières en prévention des infections* (AIFI)]; OHS bodies; local, provincial/territorial, and federal governments; and public health agencies].

Patient safety incident: An event or circumstance that could have resulted, or did result, in unnecessary harm to a client. Types of patient safety incidents are:

- *Harmful incident:* A patient safety incident that resulted in harm to the client. Replaces adverse event and sentinel event.
- *No harm incident:* A patient safety incident that reached a client but no discernible harm resulted.
- *Near miss:* A patient safety incident that did not reach the client.

Personal protective equipment: PHAC defines Personal Protective Equipment (PPE) as: “gowns, gloves, masks, facial protection (e.g., masks and eye protection, face shields or masks with visor attachment) or respirators.” PPE is used to provide a barrier that prevents potential exposure to microorganisms.

Physical environment: Refers to the various spaces within an organization that require cleaning, such as client care areas (objects and surfaces in the proximate environment of the client), service areas (e.g., operating rooms, medical device reprocessing areas), team areas, and public areas (e.g., washrooms and waiting rooms).

Point-of-care: PHAC defines point-of-care as the place where the following three elements meet: the client, the team member, and care/treatment involving contact with clients or their surroundings.

Policy: A document outlining an organization’s plan or course of action.

Population: Also known as community. A specific group of people, often living in a defined geographical area who may share common characteristics such as culture, values, and norms. A population may have some awareness of their identity as a group, and share common needs and a commitment to meeting them.

Procedure: A written series of steps for completing a task, often connected to a policy.

Process: A series of steps for completing a task, which are not necessarily documented.

Reprocessing: A process to clean, disinfect, and sterilize medical devices/equipment. Spaulding is a recognized classification system used to identify critical, semi-critical, and non-critical items, based on their use and the risk of infection.

Resources: Human, financial, equipment, and/or informational resources needed to support a project or initiative. Examples of resources for IPC may include an IPC professional, interdisciplinary committee, epidemiologist, microbiology laboratory, and any other resource to ensure an effective IPC program based on the organization's IPC priorities.

Respiratory hygiene: Practices to help prevent the transmission of microorganisms when sneezing or coughing. Examples include covering the mouth with a tissue, coughing or sneezing into the upper sleeve or elbow, and hand hygiene.

Routine practices: PHAC refers to routine practices as a comprehensive set of IPC measures that must be used in the routine care of all clients to reduce the risk of transmitting microorganisms. Examples of routine practices include point-of-care risk assessment, hand hygiene (including point-of-care, alcohol-based hand rubs), aseptic techniques, the provision and use of PPE, cleaning and disinfecting the physical environment, and handling waste and linen.

Scope of practice: The procedures, actions, and processes that are permitted for a specific health care provider. In some professions and regions, scope of practice is defined by laws and/or regulations. In these cases, licensing bodies use the scope of practice to determine the education, experience, and competencies that are required for health care providers to receive a license to practice.

Self-efficacy: A person's estimate or judgment of his or her ability to cope with a given situation, or to succeed in completing tasks by attaining specific or general goals. An example of achieving a specific goal includes quitting smoking, whereas achieving a general goal includes continuing to remain at a prescribed weight level.

Team: The group of the care professionals who work together to meet the complex and varied needs of clients, families and the community. Teams are collaborative, with different types of health care professionals working together in service provision. The specific composition of a team depends on the type of service provided.

Team leader: Person(s) responsible for the operational management of a team. Duties include identifying needs, staffing, and reporting to senior management. Team leaders may be formally appointed or take a role naturally within the team.

Timely/regularly: Carried out in consistent time intervals. The organization defines appropriate time

intervals for various activities based on best available knowledge and adheres to those schedules.

Transition in care: A set of actions designed to ensure the safe and effective coordination and continuity of care as clients experience a change in health status, care needs, health-care providers or location (within, between, or across settings (as defined by the Registered Nurses' Association of Ontario).

With input from clients and families: Input from clients and families is sought collectively through advisory committees or groups, formal surveys or focus groups, or informal day-to-day feedback. Input can be obtained in a number of ways and at various times and is utilized across the organization.

Legend

Dimensions

-  **Population Focus:** Work with my community to anticipate and meet our needs
 -  **Accessibility:** Give me timely and equitable services
 -  **Safety:** Keep me safe
 -  **Worklife:** Take care of those who take care of me
 -  **Client-centred Services:** Partner with me and my family in our care
 -  **Continuity:** Coordinate my care across the continuum
 -  **Appropriateness:** Do the right thing to achieve the best results
 -  **Efficiency:** Make the best use of resources
-

Criterion Types

-  **High Priority** High priority criteria are criteria related to safety, ethics, risk management, and quality improvement. They are identified in the standards.
-  **Required Organizational Practices** Required Organizational Practices (ROPs) are essential practices that an organization must have in place to enhance client safety and minimize risk.

Tests for Compliance

Minor Minor tests for compliance support safety culture and quality improvement, yet require more time to be implemented.

Major Major tests for compliance have an immediate impact on safety.

-  **Performance Measures** Performance measures are evidence-based instruments and indicators that are used to measure and evaluate the degree to which an organization has achieved its goals, objectives, and program activities.

PLANNING AND DEVELOPING THE IPC PROGRAM

1.0 The Infection Prevention and Control (IPC) program is planned and developed based on organizational priorities, evidence, and best practices.



Appropriateness



1.1 IPC program components are regularly reviewed based on a risk assessment and organizational priorities.

Guidelines

The Accreditation Canada Infection Prevention and Control Standards identify the key components of an effective IPC program. The standards include criteria on policies and procedures for routine practices and additional precautions, education program, surveillance plan, and ongoing evaluation activities.



Appropriateness

1.2 Evidence and best practices in IPC are reviewed when planning and developing the IPC program.

Guidelines

Evidence and best practices can be accessed through publications, presentations, and conferences. The Accreditation Canada Infection Prevention and Control Standards include a list of references that organizations can refer to as part of this work.



Appropriateness

1.3 The resources needed to support the IPC program are regularly reviewed.

Guidelines

The resources needed to support the IPC program will depend on the size of the organization and the type of services provided. In some jurisdictions, IPC resources are specified in applicable regulations. Determining the resources needed is a collaborative approach that involves different teams in the organization.

The Accreditation Canada Infection Prevention and Control Standards outline the key resources needed to support the IPC program. The standards include criteria on having a qualified IPC physician, an IPC professional, and an interdisciplinary committee to promote the IPC program, as well as access to a microbiology laboratory that can assist with surveillance information.

2.0 A collaborative approach is used to support the IPC program.

2.1 There is an IPC team responsible for planning, developing, implementing and evaluating the IPC program.

Guidelines

IPC programs are coordinated by team members with expertise and experience in IPC and epidemiology. Examples of IPC team members include physicians (e.g., medical microbiologist), nurses, epidemiologists, client and family representatives, and administrative team members.

The size of the IPC team will depend on the size of the organization and the type of services provided. In some jurisdictions, the size of the IPC team is specified in applicable regulations.

2.2 There are one or more qualified IPC professionals as part of the IPC team.



Appropriateness



Appropriateness

Guidelines

IPC professionals are also referred to as Infection Control Practitioners (ICPs). The number of IPC professionals required may be based on the number of in-patient beds and/or the level and type of services provided. For examples, refer to the Provincial Infectious Diseases Advisory Committee (PIDAC) Best Practice Manual: Infection Prevention and Control Programs in Ontario, and the Public Health Agency of Canada (PHAC) Essential Resources for Effective Infection Prevention and Control Programs. In some jurisdictions, the number of IPC professionals required is mandated, and is set out in applicable regulations.

The education and certification requirements for IPC professionals will vary by jurisdiction. IPC professionals have expertise and experience in program administration, surveillance, epidemiology, and critical appraisal of the literature. For example, IPAC Canada and L'Association des infirmières en prévention des infections (AIPI) maintain a list of IPC educational courses on their websites. The Certification Board of Infection Control and Epidemiology (CBIC) also offers certification exams in IPC that are recognized in Canada and the United States.



Appropriateness

- 2.3 There is access to a qualified IPC physician to provide input to the IPC team.

Guidelines

The IPC physician works with the IPC professional to support the IPC program. This may be either an on-site or contract physician with experience and expertise in IPC (e.g., medical microbiologist).



Appropriateness

- 2.4 There is an interdisciplinary committee to provide guidance about the IPC program.

Guidelines

IPC is a collaborative process that involves representatives from across the organization. Committee membership may include representation from physicians, nursing, surgical care, microbiology, medical device reprocessing, environmental services, OHS, pharmacy services, risk management, quality improvement, and public health.

The committee may be specifically assigned to IPC or have IPC as one of its functions. This committee may function at an organizational level, regional or district health authority level, or provincial level. The roles and responsibilities of this committee may include developing IPC policies and procedures, education programs, and evaluation activities. The structure of the committee may vary across organizations. Various subcommittees may be established as needed to meet its functions.



Appropriateness

2.5

The interdisciplinary committee regularly evaluates the program's structure and functions and makes improvements as needed.

Guidelines

This evaluation may look at the structure of the committee, committee membership, terms of reference and work plan, roles and responsibilities assigned to the committee, meeting attendance, and the frequency of meetings.



Appropriateness



2.6

The IPC team is consulted when planning and designing the physical environment, including planning for construction and renovations.

Guidelines

The IPC team is involved during the planning stages of any new construction or renovation project. It identifies IPC-related risks (e.g., *Aspergillus* and *Legionella*) and plans the cleaning and disinfecting work that will take place during and following the renovations or construction. For examples, refer to current CSA Standards Z8000 and Z317.13, and PHAC's Construction-related nosocomial infections in patients in health care facilities: Decreasing the risk of *Aspergillus*, *Legionella* and other infections.



Appropriateness

- 2.7 Input is gathered from the IPC, and the OHS teams to maintain optimal environmental conditions within the organization.

Guidelines

Poor air quality can promote the transmission of microorganisms within the organization. For example, excessive humidity levels can increase the survival rate of microorganisms on surfaces. Optimal environmental conditions are maintained throughout the organization including in airborne infection isolation rooms and sterile supply areas. For examples of optimal environmental conditions, refer to current CSA Standards Z8000 and CSA Z317.2.



Appropriateness



- 2.8 Environmental services and the IPC team are involved in maintaining processes for laundry services and waste management.

Guidelines

This includes environmental cleaning and waste handling. Linen should be handled carefully to avoid the transmission of microorganisms within the organization. For example, clean linen should be transported and stored in a manner that prevents contamination by dust. For examples of routine practices related to laundry services, refer to PHAC's Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings.



Appropriateness



- 2.9 Input is gathered from the IPC team to maintain processes for selecting and handling medical devices/equipment.

Guidelines

Medical devices/equipment are one of the key sources of health care-associated infections.

Handling medical devices/equipment includes 1) safely transporting contaminated medical devices/equipment to a central area for reprocessing, and 2) storing clean medical devices/equipment in separate clean storage areas.

A recognized classification system such as Spaulding is used to identify critical, semi-critical, and non-critical medical devices/equipment based on the use of the medical device/equipment and the risk of infection.



Safety



2.10

Applicable standards for food safety are followed to prevent food-borne illnesses.

Guidelines

Proper storage, preparation, and handling of food are critical to preventing food-borne illness. Food storage, preparation, and handling are monitored even if food is made using pre-prepared mixes or ingredients, or if the preparation is done outside of the main kitchen or off-site. When food services are contracted to external providers, there is a mechanism to define the IPC role of the external contractor and verify the quality of the services provided.

In some jurisdictions, food services are inspected by public health or the Ministry of Agriculture. Areas for improvement identified by these regulatory authorities are followed-up on.



Efficiency

2.11

Input is gathered from the IPC team when planning for pandemics at the organizational level.

Guidelines

Key partners include public health, IPC, and emergency management. Pandemic planning is part of the organization's overall plan for disasters and emergencies (this is covered in the Leadership Standards). In some jurisdictions, the Ministry of Health is responsible for planning for pandemics. In this case, organizations validate the Ministry's pandemic plan at an organizational level.

3.0 The organization collaborates with partners to promote IPC.

- 3.1 The organization partners with organizations across the continuum of care to implement IPC activities.



Population
Focus

Guidelines

The extent of the organization's partnerships will depend on its size, mandate, and scope of services. Examples of IPC activities include hand hygiene, education, and awareness campaigns. Working with partners may include joint initiatives, complementary roles and responsibilities in the community, and creating consistent education and communication messages.

- 3.2 Trends in health care-associated infections and significant findings are shared with other organizations, public health agencies, clients and families, and the community.



Population
Focus

Guidelines

What information is shared, and in what format, depends on the results gathered by tracking health care-associated infection rates. Certain health care-associated infections must be reported to national and provincial public health agencies. The Canadian Nosocomial Infection Surveillance Program maintains a national surveillance network through which participating organizations collect surveillance data that can be used for benchmarking.

IMPLEMENTING THE IPC PROGRAM

4.0 **IPC policies and procedures are maintained based on applicable regulations, evidence and best practices, and organizational priorities.**



Safety



4.1 A risk assessment is completed to identify high-risk activities, and the activities are addressed in policies and procedures.

Guidelines

Risk assessments are completed in collaboration with IPC, OHS, and environmental services. Examples of high-risk activities include performing aerosol-generating medical procedures; handling spills, specimens, and sharps; and exposure to contaminated medical devices/equipment and waste.



Appropriateness



4.2 There are policies and procedures that are in line with applicable regulations, evidence and best practices, and organizational priorities.

Guidelines

Policies and procedures should be clear and concise. The Accreditation Canada Infection Prevention and Control Standards cover key IPC policies and procedures regarding routine practices. The standards include criteria on hand hygiene practices; additional precautions; aseptic techniques when performing invasive procedures and handling injectable products; wearing PPE appropriate to the task; handling contaminated items; and OHS such as work restrictions.

Organizations seek input from clients and families when developing policies and procedures, specifically around hand hygiene.



Safety



4.3 There are policies and procedures for using aseptic techniques when preparing, handling, and administering sterile substances both within the preparation area and at the point of care.

Guidelines

The IPC team is involved when developing relevant medication management processes including the use of aseptic techniques. Adherence to aseptic techniques should be promoted for invasive procedures, including the insertion of central lines, handling intravenous systems, spinal procedures, and safe injection practices (including the use of multidose vials).

Examples include vaccines, parenterally administered medications, total parenteral nutrition (TPN), and diagnostic media. The contamination of medical devices/equipment; a vaccine, medication, or nutrition; or a client, or team member can occur at several points during the preparation and delivery of injected substances.



Safety



4.4

There are policies and procedures for loaned, shared, consigned, and leased medical devices.

Guidelines

If loaned, shared, consigned, or leased medical devices are used extensively, policies and procedures are developed to address their transport to and from the organization, and to handle items that are delivered unexpectedly, unclean, not sterilized, or incomplete. Refer to current CSA Standards Z314.22 for detailed guidelines and standards for the management of loaned, shared, and leased devices and equipment.



Accessibility



4.5

Team members and volunteers are provided with access to IPC policies and procedures.

Guidelines

IPC policies and procedures are available in a written or electronic format that is easily accessible to team members and volunteers.



Appropriateness

- 4.6 Compliance with IPC policies and procedures is monitored and improvements are made to the policies and procedures based on the results.

Guidelines

This includes a process for team members, volunteers, and clients and families to provide feedback and report non-compliance with IPC policies and procedures.

Audit tools can be used to monitor compliance with IPC policies and procedures. For example, IPAC Canada has an Infection Control Audit Toolkit available on its website. The Canadian Patient Safety Institute (CPSI) has also developed a hand hygiene toolkit (Canada's Hand Hygiene Challenge: STOP! Clean Your Hands) that provides instructions on how to monitor compliance with hand hygiene practices.



Appropriateness



- 4.7 IPC policies and procedures are updated regularly based on changes to applicable regulations, evidence, and best practices.

- 5.0 **Team members, clients, families, and volunteers are engaged in promoting an IPC culture within the organization.**



Safety



- 5.1 A multi-faceted approach to promoting IPC is used within the organization.

Guidelines

A broader approach is used to help increase compliance with routine practices and additional precautions for IPC. Examples include posting reminders throughout the organization, providing interactive education sessions, developing promotional videos, and delivering awareness campaigns.



Safety

- 5.2 Team members, clients and families, and volunteers are engaged when developing the multi-faceted approach for IPC.

Guidelines

For example, the organization may set up one or several design teams to identify strategies for promoting IPC based on organizational priorities.



Safety



- 5.3 The multi-faceted approach to IPC includes an education program tailored to IPC priorities, services, and client populations.

Guidelines

Depending on roles and responsibilities around IPC, the IPC education program may cover topics such as IPC policies and procedures, contact information for those responsible for IPC in the organization, and common health care-associated infections affecting the organization and trends. The program also provides access to educational resources such as peer-reviewed journals, technology (e.g., computers, the internet), and linkages with professional associations on IPC (e.g., IPAC Canada, AIPI). For example, WHO and CPSI provide tools for implementing an education program about hand hygiene, and Clean Learning provides educational tools about environmental services.



Safety



- 5.4 Information on how to safely perform high-risk activities is provided, including appropriately using PPE as outlined in its policies and procedures.

Guidelines

High-risk activities require using PPE that is appropriate to the task. Team members learn how to select PPE based on the type of exposure anticipated as well as the PPE's durability, appropriateness, and fit. Team members also know how to select, wear, change, and remove the PPE. This information can be provided through education sessions and/or reminders posted in the organization.



Safety



5.5

Team members and volunteers are required to attend the IPC education program at orientation and on a regular basis based on their IPC roles and responsibilities.

Guidelines

The organization may maintain an electronic learning management system to track attendance at education sessions, identify necessary follow-up training, and identify individuals overdue for education.

Client and family representatives involved in the organization also attend the orientation.



Accessibility

5.6

The effectiveness of the multi-faceted approach for promoting IPC is evaluated regularly and improvements are made as needed.

Guidelines

The multi-faceted approach is evaluated by asking team members for input, and using performance measures for routine practices and additional precautions. For example, the WHO Hand Hygiene Self-Assessment available from CPSI's hand hygiene website may be completed, and a strategy developed to improve compliance with hand hygiene based on the results.

6.0

Clients, families, and visitors are engaged in IPC practices.



Safety



6.1

Clients, families, and visitors are provided with information about routine practices and additional precautions as appropriate, and in a format that is easy to understand.

Guidelines

Clients, families, and visitors play an important role in promoting hand hygiene. Information provided may include the appropriate use of PPE, and the importance and timing of their hand and respiratory hygiene.

Information is provided verbally and in writing. Written materials may be available in a variety of languages depending on the population(s) served. The language used is easy to understand, and may include visual cues to improve understanding. Written materials may include pamphlets, posters, or electronic formats such as in-room televisions.

For example, CPSI has created a Patient and Family Guide: How to Help Prevent Healthcare-Associated Infections, which is available on its website.



Accessibility



6.2

Client, families, and visitors are provided with access to hand hygiene resources and PPE based on the risk of transmitting microorganisms.

Guidelines

Hand hygiene resources include dedicated hand-washing facilities and alcohol-based hand rubs at the point of care. For examples, refer to PHAC's Hand Hygiene Practices in Healthcare Settings.



Appropriateness



6.3

Clients are screened to determine whether additional precautions are required based on the risk of infection.

Guidelines

Team members are trained to determine if additional precautions are required to prevent the transmission of microorganisms within the organization. Team members refer to applicable IPC policies and procedures, and may need to involve the IPC professional as appropriate to complete the risk assessment. This information is documented in the client record by the team member or IPC professional as applicable. Examples may include using appropriate PPE, placing the client in an airborne infection isolation room, and asking the client to use a separate bathroom.



Appropriateness



7.0 The OHS program addresses organizational priorities for IPC.

7.1 There are OHS policies and procedures to reduce the risk of transmitting microorganisms among team members, and clients.

Guidelines

These policies and procedures are part of the organization's OHS program which is based on the level of risk for health care-associated infections. The Accreditation Canada Infection Prevention and Control Standards outline the key safety precautions for team members. The standards include criteria on having a pre-placement policy (including immunization status and tuberculosis screening); providing access to PPE appropriate to the task; promoting sharps safety and preventing exposure to blood borne pathogens; and setting work restrictions if needed.



Safety



7.2 An immunization policy is developed or adopted to screen and offer vaccinations to team members.

Guidelines

Vaccination is a cost-effective method of preventing illness. Possible vaccinations include mumps, measles, rubella, tetanus, diphtheria, pertussis, influenza, hepatitis B, and screening for tuberculosis. In some jurisdictions, specific vaccinations or evidence of immunity are required for team members working in an acute care setting. For examples, refer to the Recommendations from the National Advisory Committee on Immunization (NACI). In some jurisdictions, the organization follows the immunization policy set at the Ministry of Health level such as the immunization protocol issued by the Ministère de la Santé et des Services Sociaux (MSSS).



Safety



7.3 There are policies and procedures for using PPE that are appropriate to the task.

Guidelines

Policies and procedures address when to use PPE and how to wear and remove PPE, as well as N95 respirator fit testing. For examples of appropriate PPE, refer to PHAC's Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings or PIDAC's Routine Practices and Additional Precautions in All Health Care Settings.



Safety



7.4

There are work restrictions that are in line with OHS guidelines for team members, and volunteers with transmissible infections.

Guidelines

For examples of OHS guidelines, refer to PHAC's Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings.

Work restrictions prevent team members, and volunteers with transmissible infections from having direct contact with clients, food, or sterile supplies, devices, and equipment. These restrictions may include limiting roles and responsibilities and wearing PPE as appropriate. Examples of transmissible infections include acute conjunctivitis, acute respiratory infection, gastroenteritis with vomiting and/or diarrhea, varicella, and open, infected skin lesions or herpetic skin lesions on the hands.



Safety



7.5

Policies, procedures, and legal requirements are followed when handling bio-hazardous materials.

Guidelines

This is a collaborative approach that involves IPC, environmental services, and OHS. The appropriate handling of bio-hazardous materials minimizes the risk of exposure to microorganisms. Handling includes collection, storage, transportation, and disposal. Used equipment and devices are considered contaminated and potentially infectious, and they are transported appropriately to a dedicated decontamination or disposal area. Definitions and the disposal of bio-hazardous materials will vary per jurisdiction.



Safety



7.6

There are policies and procedures for disposing of sharps at the point of use in appropriate puncture-, spill-, and tamper-resistant sharps containers.

Guidelines

Sharps include needles and blades.



Safety



7.7

Safety engineered devices for sharps are used.

Guidelines

Safety engineered devices protect the user from exposure to bio-hazardous or chemical substances (e.g., blood borne pathogens, cytotoxic medications). They have a built-in mechanism to protect the user from a sharps injury (e.g., needles that retract after use).

8.0

A comprehensive hand-hygiene strategy is in place.



Safety



8.1

REQUIRED ORGANIZATIONAL PRACTICE: Hand-hygiene education is provided to team members and volunteers.

Guidelines

Hand hygiene is critical to infection prevention and control programs, but adherence to accepted hand-hygiene protocols is often poor. It has been shown that the costs of health care-associated infections significantly exceed those related to implementing and monitoring hand-hygiene programs.

Training on hand hygiene is multimodal and addresses the importance of hand hygiene in preventing the transmission of microorganisms, factors that have been found to influence hand-hygiene behaviour, and proper hand-hygiene techniques. Training also includes recommendations about when to clean one's hands, based on the four moments for hand hygiene:

1. Before initial contact with the client or their environment.
2. Before a clean/aseptic procedure.
3. After body fluid exposure risk.
4. After touching a client or their environment.

Test(s) for Compliance

Major 8.1.1 Team members and volunteers are provided with education about the hand-hygiene protocol.

8.2 There is a process to select and review products for hand hygiene, including alcohol-based hand rubs and hand soaps.



Safety

Guidelines

The process includes seeking input from team members. For examples, refer to the WHO Guidelines on Hand Hygiene in Health Care, CPSI's Hand Hygiene Human Factors Toolkit, and Just Clean Your Hands by Public Health Ontario.



Safety



8.3 Team members, client, families, and volunteers have access to alcohol-based hand rubs at the point of care.

Guidelines

Placing alcohol-based hand rubs at the bedside and/or making portable hand rubs available reminds team members to sanitize their hands before providing care. The WHO guidelines on hand hygiene require that alcohol-based hand rubs be within one metre of where care is delivered. However, fire regulations or other considerations may limit the placement of alcohol-based hand rubs. For examples, refer to PHAC's Hand Hygiene Practices in Healthcare Settings.

The availability of hand-hygiene equipment and supplies in the service environment is audited.



Safety

- 8.4 Team members, and volunteers have access to dedicated hand-washing sinks.

Guidelines

Using dedicated hand-washing sinks helps prevent the transmission of microorganisms. Dedicated hand-washing sinks are only used for hand-washing and should not be used for other purposes, such as the disposal of fluids or the cleaning of equipment. For examples, refer to current CSA Standards Z8000. This requirement is considered when planning for construction or renovations.



Safety

- 8.5 Reminders are posted about the proper techniques for hand-washing and using alcohol-based hand rubs.

Guidelines

Appropriate placement for reminders is determined based on a risk assessment. Examples include CPSI's "4 Moments for Hand Hygiene" poster available on its website and WHO's Clean Care is Safer Care program.



Safety



- 8.6 **REQUIRED ORGANIZATIONAL PRACTICE:** Compliance with accepted hand-hygiene practices is measured.

Guidelines

Hand hygiene is considered the single most important way to reduce health care-associated infections, but compliance with accepted hand-hygiene practices is often poor. Measuring compliance with hand-hygiene practices allows organizations to improve education and training about hand hygiene, evaluate hand-hygiene resources, and benchmark compliance practices across the organization. Studies show that improving compliance with hand-hygiene practices decreases health care-associated infections.

Direct observation (audits) is the best method to measure compliance with hand-hygiene practices. This involves watching and recording the hand-hygiene behaviours of team members and observing the work environment. Observation can be done by a trained observer within an organization, by two or more health care professionals working together, or by clients and families in the organization or in the community. Safer Healthcare Now! offers a variety of tools for measuring hand-hygiene compliance in different settings. Ideally, direct observation measures compliance with all four of the moments for hand hygiene:

1. Before initial contact with the client or their environment
2. Before a clean/aseptic procedure
3. After body fluid exposure risk
4. After touching a client or their environment

Direct observation should be used by all organizations working out of a fixed location (i.e., clients come to them). Organizations that provide services in clients' homes and find that direct observation is not possible may consider alternative methods. As these alternatives are not as robust as direct observation, they should be used in combination (two or more) to give a more accurate picture of compliance with hand-hygiene practices.

Test(s) for Compliance

- | | | |
|--------------|-------|---|
| Major | 8.6.1 | <p>Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in clients' homes, a combination of two or more alternative methods may be used, for example:</p> <ul style="list-style-type: none"> • Team members recording their own compliance with accepted hand-hygiene practices (self-audit). • Measuring product use. • Questions on client satisfaction surveys that ask about team members' hand-hygiene compliance. • Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions). |
| Minor | 8.6.2 | <p>Hand-hygiene compliance results are shared with team members and volunteers.</p> |
| Minor | 8.6.3 | <p>Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.</p> |

9.0 A clean and disinfected physical environment is maintained.

- | | |
|-----|--|
| 9.1 | <p>The areas in the physical environment are categorized based on the risk of infection to determine the necessary frequency of cleaning, the level of disinfection, and the number of environmental services team members required.</p> |
|-----|--|



Safety



Guidelines

This may be done in collaboration with IPC and environmental services. Completing a risk assessment of the physical environment helps identify grey areas in the organization. The physical environment may be divided into several areas depending on the risk of transmitting microorganisms. The criteria used to identify these areas can include the level of client traffic (e.g., in waiting rooms and elevators, on mobile equipment), the type of activity performed (e.g., clinical versus administrative), the type of clients (e.g., clients with an infectious disease or a compromised immune system), and the probability of being exposed to body fluid (e.g., in an operating room or laboratory). The number of environmental services team members required is considered in the event of an outbreak or flood.

For examples, consult the MSSS Les Zones grises : Processus d'attribution des responsabilités and PIDAC's Best Practices for Environmental Cleaning for Prevention and Control of Infections, which provide a risk stratification matrix to determine the frequency of cleaning.



Safety

- 9.2 Roles and responsibilities are assigned for cleaning and disinfecting the physical environment.

Guidelines

Roles and responsibilities address those most involved in cleaning and disinfecting the physical environment, such as environmental services team members. This includes assigning team members to clean and disinfect the gray areas identified in the physical environment. The roles and responsibilities of other team members, and volunteers are also clarified, particularly around checking the cleanliness of the physical environment and reporting problems to the appropriate individual or group.



Safety



- 9.3 There are policies and procedures for cleaning and disinfecting the physical environment and documenting this information.

Guidelines

Cleaning activities cover all surfaces within the organization; the primary focus is on high-touch surfaces in client care areas (e.g., client rooms, bedrails, bathrooms). There are also practices for cleaning the walls, windows, and ceilings; removing waste; promptly cleaning and managing spills; and maintaining general tidiness. Documentation of cleaning activities includes the date and time, the team member's name, and the choice of cleaners or disinfectants used.



Appropriateness



9.4

There are policies and procedures for cleaning and disinfecting the rooms of clients who are on additional precautions.

Guidelines

Policies and procedures cover daily and terminal cleaning of these areas (e.g., after the discharge/transfer of a client) and the use of PPE. For example, PIDAC's Best Practices for Environmental Cleaning for Prevention and Control of Infections includes a sample procedure for cleaning and disinfecting the rooms of clients on contact precautions for *Clostridium difficile* infection (CDI).



Appropriateness

9.5

Compliance with policies and procedures for cleaning and disinfecting the physical environment is regularly evaluated, with input from clients and families, and improvements are made as needed.

Guidelines

This may include client and team surveys, visual assessments, and routine sampling of the physical environment. The information is documented and evaluation results are reviewed to identify areas for improvement with input from team members.



Safety

9.6

When cleaning services are contracted to external providers, a contract is established and maintained with each provider that requires consistent levels of quality and adherence to accepted standards of practice.



Safety

9.7 When cleaning services are contracted to external providers, the quality of the services provided is regularly monitored.

Guidelines

For example, copies of reports and any other documentation that demonstrates the quality monitoring that was performed by the external provider are reviewed.

10.0 Manufacturers' instructions and accepted standards of practice are followed when cleaning, disinfecting, and sterilizing reusable medical devices and equipment.



Appropriateness



10.1 Clear and concise policies and procedures are developed and maintained for cleaning, disinfecting, and sterilizing reusable medical devices and equipment.

Guidelines

The organization's policies and procedures for cleaning, disinfecting, and sterilizing reusable medical devices address all stages of the process (e.g., from disassembly of the device to reprocessing and re-assembly). The policies and procedures address all stages of cleaning, disinfection, and sterilization (as appropriate to the organization's role) and cover the following topics:

- Training and education
- Occupational health and safety
- The management and reporting of patient safety incidents
- Cleaning, disinfecting, and/or sterilizing devices or equipment according to their risk class and the manufacturers' instructions
- Cleaning, disinfecting, and sterilizing loaned, shared, consigned, or leased devices and equipment
- Special precautions for devices or equipment that are difficult to clean, disinfect, or sterilize
- Disassembly and reassembly of devices
- Functional testing of complex devices following reassembly
- Offsite transportation of medical devices (when applicable)
- Quality control
- Recall procedures
- Emergency procedures for various emergencies including sterilizer shutdowns, utility failures, or shutdowns

For more information, see Provincial Infectious Diseases Advisory Committee's Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices In All Health Care Settings.



Safety



10.2

If neurosurgical services are provided, there are policies and procedures to prevent the transmission of Creutzfeldt-Jakob Disease (CJD).

Guidelines

Policies and procedures include completing a pre-operative assessment for high-risk surgical procedures; completing a pre-operative assessment for high risk patients; and having either 1) a dedicated set of neurosurgical, neuroendoscopic, ortho-spine devices and intubation equipment to be used when the diagnosis of CJD has been made or is suspected pre-operatively, or 2) re-usable equipment that is quarantined immediately post-surgery and prior to reprocessing until the post-operative diagnosis of CJD is either validated or ruled out. For more information, refer to PHAC's guidelines for Classic Creutzfeldt-Jakob Disease in Canada.



Safety



10.3

Required training, education, and experience are defined for all team members that participate in cleaning, disinfecting, and/or sterilizing medical devices and equipment.

Guidelines

The required training, education, and experience will vary by role. It may be defined by a professional regulating body, may be formal or informal, and may include lived experience or work experience.

Verifying the qualifications of staff involved in the reprocessing of medical devices/equipment is important in preventing the mishandling or improper reprocessing of these devices.



Appropriateness

10.4

Current manufacturers' instructions are upheld when cleaning, disinfecting, or sterilizing medical devices and equipment.



Appropriateness

10.5

Policies, SOPs and manufacturers' instructions are accessible to all team members.

Guidelines

The instructions may be in written form (e.g., binders, manuals, or monographs) and/or in electronic format. Team members know where and how to access the instructions.



Safety



10.6

Cleaning, disinfection, and sterilization of critical and semi-critical single-use devices (SUD) is not permitted on-site, in line with the organization's policy and regional regulations.



Appropriateness



10.7

If cleaning, disinfection, or sterilization of reusable medical devices and equipment is contracted to external providers, a written agreement or contract is maintained with each provider that outlines requirements and respective roles and responsibilities.

Guidelines

The agreement requires that contracted service providers adhere to accepted standards of practice (e.g., CSA standards), and monitoring the quality of reprocessing services. Examples include daily monitoring of printouts or electronic records, maintaining records of each sterilization cycle, and having a process to report issues with reprocessed devices (e.g. defective wraps or medical devices and equipment that arrive soiled).



Appropriateness



10.8

When cleaning, disinfection, or sterilization of reusable medical devices and equipment is contracted to external providers, the organization regularly monitors the quality of the services provided.

Guidelines

The organization verifies that the external provider follows accepted standards of practice (e.g., accreditation standards or standards from the Canadian Standards Association) to monitor the quality of services (e.g., daily monitoring of printouts and data, reporting systems, and mechanisms to report deficiencies). The organization reviews copies of reports and printouts and any other documentation demonstrating the quality monitoring performed by the external provider.



Safety



10.9

When, cleaning, disinfection, and/or sterilization of medical devices or equipment is done in-house, team members involved in these processes are provided with education and training in how to do so when they are first employed and on an ongoing basis.

Guidelines

Training addresses the organization's policies and procedures; information on cleaning, disinfection, and sterilization (as appropriate); occupational health and safety issues; and infection prevention and control issues related to reprocessing.



Safety



10.10

When an organization cleans, disinfects, and/or sterilizes devices and equipment in-house, there are designated and appropriate area(s) where these activities are done.

Guidelines

The designated area(s) should have adequate space for cleaning and storage and be separate from areas where clean devices and equipment are handled or stored. Air exchanges, temperature, and humidity should be appropriate to the activity and the cleaning products being used (refer to manufacturer's recommendations).

Cleaning, disinfection, and sterilization done outside the designated area should be kept to a minimum.

For more information, see the Provincial Infectious Diseases Advisory Committee's Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings.



Safety



10.11

The area where cleaning, disinfection, and/or sterilization of medical devices and equipment are done is equipped with hand hygiene facilities.

Guidelines

Examples of hand hygiene facilities include designated hand-washing sinks and alcohol-based hand rub stations. Hands that are soiled should be washed with soap and water.



Safety



10.12

Eating and drinking, food storage, cosmetics application, and the contact lens handling are all prohibited in the area where cleaning, disinfection, and/or sterilization of medical devices and equipment are done.



Safety



10.13

Items that require cleaning, disinfection, and/or sterilization are safely contained and transported to the appropriate area(s).

Guidelines

Cleaning, disinfection, and/or sterilization may be done in the organization or at another site or be outsourced to another company.

Used medical devices and equipment should be considered to be contaminated. When transporting contaminated devices and equipment, applicable regulations are followed, environmental conditions are controlled, and clean and appropriate bins, boxes, bags, and transport vehicles are used.

Contaminated items are transported separately from clean items, and away from care delivery areas and high-traffic areas.

For more information, see the Provincial Infectious Diseases Advisory Committee's Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings.



Safety



10.14

Appropriate Personal Protective Equipment (PPE) is worn when cleaning, disinfecting, or sterilizing medical devices and equipment.

Guidelines

Depending upon the task, the appropriate Personal Protective Equipment may include gloves that are appropriate to the task; a fluid-resistant cover garment with sleeves (e.g. backless gown, jumpsuit, or surgical gown); and a full face shield or a fluid-impervious face mask to fully protect eyes, nose and mouth.



Safety

10.15

Contaminated devices and equipment are cleaned before disinfection or sterilization is done.

Guidelines

Devices and equipment that has been used should be considered to be contaminated.

Cleaning is essential before disinfection or sterilization. If an item is not cleaned, soil, such as blood, body fluids, or dirt, can protect microorganisms from disinfection and sterilization processes, or can inactivate the disinfectant so it will not work.

For more information, see the Provincial Infectious Diseases Advisory Committee's Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings.



Appropriateness

10.16

Detergents, solutions, sterilants and disinfectants selected are in line with manufacturers' instructions, and are compatible with the devices being cleaned, disinfected, or sterilized, and the equipment and processes for cleaning, disinfection or sterilization.

Guidelines

All disinfectants have a Drug Identification Number (DIN) from Health Canada. Others in the organization may need to be consulted (e.g. infection prevention and control, or occupational health and safety) when selecting appropriate detergents or disinfectants.



Safety



10.17

For each detergent, solution, sterilant, and disinfectant, manufacturers' instructions for use are followed.

Guidelines

Manufacturers' instructions address topics such as ventilation requirements, contact time, shelf life, storage requirements, appropriate dilution, how to test the concentration and effectiveness, and the appropriate Personal Protective Equipment to wear when handling the detergent, solution, sterilant or disinfectant.



10.18 Each device or set of devices are prepared for sterilization according to manufacturers' instructions.

Appropriateness



10.19 An internal chemical indicator is placed in each package or container, according to the organization's quality control processes, to verify that sterilizer penetration has occurred.

Appropriateness



10.20 Sterilized packages are clearly identifiable and distinguished from non-sterilized items.

Safety

Guidelines

This helps prevent the release and use of non-sterilized medical devices.



10.21 The integrity of each sterile package is maintained.

Safety

Guidelines

Items that have been properly decontaminated, wrapped, sterilized, stored, and handled will remain sterile indefinitely, unless the integrity of the package is compromised. The integrity of the package is based on: the type of wrapper used; the method of sealing the package; the type of shelving used, including open or closed; the method and frequency of handling; the method, frequency, and conditions of transportation and distribution; the environmental conditions of the storage area, e.g. temperature, humidity, ventilation, cleanliness; and, control and monitoring of access to storage areas.



Safety



10.22

There is a process that allows for the tracking of medical devices associated with a sterilizer or sterilization cycle.

Guidelines

The record includes information that may be required for a recall action. Instruments, devices, and supplies could be recalled for a variety of reasons, such as when sterilization activities fail.



Safety



10.23

REQUIRED ORGANIZATIONAL PRACTICE: Processes for cleaning, disinfecting, and sterilizing medical devices and equipment are monitored and improvements are made when needed.

Guidelines

The processes of cleaning, disinfecting, and sterilizing are collectively known as reprocessing, and the level of reprocessing depends on the risk of infection (according to the Spaulding classification). Organizations reprocess equipment based on the Spaulding classification and according to manufacturers' instructions.

Monitoring reprocessing helps to identify areas for improvement and reduce health care-associated infections. The effectiveness of cleaning and disinfection can be measured by monitoring: water quality and washer function, whether appropriate concentrations of disinfectants are available, and whether disinfectants are used according to manufacturers' instructions. The effectiveness of sterilization can be monitored by measuring organic residuals, ATP (adenosine triphosphate), and total viable count; and by using test strips to confirm that devices/equipment are sterilized.

If the organization does not reprocess equipment, it has a process to ensure equipment has been appropriately reprocessed prior to use.

Test(s) for Compliance

- Major** 10.23.1 There is evidence that processes and systems for cleaning, disinfection, and sterilization are effective.
- Minor** 10.23.2 Action has been taken to examine and improve processes for cleaning, disinfection, and sterilization where indicated.

11.0 Specific requirements are followed to reprocess flexible endoscopic devices. [Note: The following criteria are additional requirements that apply specifically to reprocessing flexible endoscopes. Rigid endoscopes are almost exclusively critical devices requiring sterilization, and are addressed by the other standards in this document.]



Safety



- 11.1** Team members are trained on the policies and procedures for reprocessing flexible endoscopes.

Guidelines

Verifying the qualifications and competencies of staff involved in the reprocessing of flexible endoscopic devices is important in preventing the mishandling or improper reprocessing of these devices. Examples of flexible endoscopic devices include gastroscopes, duodenoscopes, colonoscopes, sigmoidoscopes, bronchoscopes, laryngoscopes, enteroscopes, and nasopharyngeal endoscopes.



Safety



- 11.2** Areas for reprocessing flexible endoscopes are physically separate from client care areas.



Safety

- 11.3** Endoscope reprocessing areas are equipped with separate cleaning and decontamination work areas as well as storage, dedicated plumbing and drains, and proper air ventilation.

Guidelines

Ventilation helps remove toxic vapors from the work areas. The storage areas are also well ventilated and are regularly cleaned and disinfected.



Appropriateness



11.4

Manufacturers' instructions are followed to pre-clean flexible endoscopes immediately at point of use.

Guidelines

If cleaning is not done immediately following a procedure, soil residue on the endoscope can harden, becoming very difficult to remove. For examples, refer to PHAC's Infection Prevention and Control Guideline for Flexible Gastrointestinal Endoscopy and Flexible Bronchoscopy.



Safety



11.5

Before cleaning, the flexible endoscope is checked for internal and external damage, and if repair is required, the endoscope is prepared and packaged for shipping in accordance with manufacturers' instructions.

Guidelines

The integrity of the flexible endoscope is verified through leak testing. Damaged flexible endoscopes are identified, removed from service, and shipped for repair following the manufacturers' packaging, labeling, and shipping instructions; the shipping is also done in compliance with federal, provincial, or territorial regulations for the transportation of dangerous goods.



Appropriateness



11.6

Before beginning high-level disinfection, each flexible endoscope is cleaned, rinsed, and dried according to the manufacturer's instructions.



Appropriateness



11.7

Before beginning high level disinfection, immersible endoscopic components are soaked and manually cleaned using water and an approved cleaning agent.

Guidelines

An approved cleaning agent is an enzymatic detergent solution prepared and used according to the manufacturer's instructions and that is compatible with the device.

While immersed, channels and lumens are flushed and brushed to remove debris; brushes are appropriately sized, inspected before and after use, and either discarded or cleaned and dried after use.

Irrigation adaptors or manifolds that are compatible with the endoscopic device may be used to facilitate cleaning.



Safety



11.8

Flexible endoscopes are stored in a manner that minimizes contamination and damage.

Guidelines

The organization does not store flexible endoscopes coiled or in their cases. Flexible endoscopes with channels or lumens are stored with channel valves stored separately. Flexible endoscopes are stored in a validated drying and storage cabinet.



Appropriateness



11.9

A permanent record is maintained of the reprocessing history for each flexible endoscope.



Appropriateness



11.10

The record of endoscopic device reprocessing includes the identification number and the type of endoscope, the identification number of the automated endoscope reprocessor (if applicable), the date and time of reprocessing, the name or unique identifier of the client, the results of the individual inspection and leak test, and the name of the person reprocessing the endoscope.

Guidelines

Identifying the client, the endoscopic device, and the reprocessing equipment used helps facilitate outbreak investigations, device tracking, and quality control.



Appropriateness

11.11

Preventive and scheduled maintenance, including repairs, is completed and documented for each automated endoscope reprocessor.

Guidelines

Documentation about the maintenance and repair of reprocessing equipment assists with device tracking and recall.

EVALUATING THE IMPACT OF THE IPC PROGRAM



12.0 A surveillance plan is in place to monitor health care-associated infections.

12.1 There is a surveillance plan that is in line with applicable regulations, evidence and best practices, and organizational priorities.

Guidelines

The Accreditation Canada Infection Prevention and Control Standards identify the key components of a surveillance plan. The standards include criteria on tracking and reporting health care-associated infections and quickly identifying the source of infections. Results are used to respond to pandemics and outbreaks, and to make improvements to the IPC program such as investing in additional resources, updating policies and procedures, and reviewing education programs.



12.2 **REQUIRED ORGANIZATIONAL PRACTICE:** Health care-associated infections are tracked, information is analyzed to identify outbreaks and trends, and this information is shared throughout the organization.

NOTE: This ROP only applies to organizations that have beds and provide nursing care.

Guidelines

The health care-associated infections most common to the organization's services and client populations are identified and tracked. These could include Clostridium difficile (C. difficile), surgical site infections, seasonal influenza, noroviruses, urinary tract infections, and other reportable diseases and antibiotic-resistant organisms. Tracking methods for health care-associated infections may focus on a particular infection or service area or may be organization- or system-wide. They may include data analysis techniques to help detect previously unrecognized outbreaks. Tracking may include frequencies and changes in frequencies over time, associated mortality rates, and attributed costs.

Teams that are well informed about health care-associated infection rates are better equipped to prevent and manage them. The role or position responsible for receiving information about health care-associated infection rates is identified and a plan is established to regularly disseminate information (e.g., quarterly reports to all departments). In addition to team members, the governing body needs to be informed about health care-associated infection rates and associated infection prevention and control issues. This may be done directly through senior management or a medical advisory committee.

Test(s) for Compliance

Major	12.2.1	Health care-associated infection rates are tracked.
Minor	12.2.2	Outbreaks are analyzed and recommendations are made to prevent recurrences.
Minor	12.2.3	Information about relevant health care-associated infections and recommendations from outbreak reviews are shared with team members, senior leadership, and the governing body.



Appropriateness



12.3 There is a process to promptly detect suspected health care-associated infections in the organization.

Guidelines

Methods of detecting health care-associated infections may be passive (i.e., identified during the course of routine service delivery) or active (i.e., identified by trained professionals using planned monitoring of multiple data and sources).

Voluntary reporting by team members, clients, families, and volunteers is promoted, and additional methods are used to detect infections, such as active identification, automated methods of detection, or centralized identification through the microbiology laboratory.



Safety



12.4

There is access to a microbiology laboratory that offers expertise to the organization about identifying health care-associated infections.

Guidelines

Microbiology laboratories are playing a growing role in IPC surveillance by, for example, identifying new or rare infections, tracking antibiotic-resistant organisms (AROs) such as methicillin-resistant *Staphylococcus aureus* (MRSA) or vancomycin-resistant enterococcus (VRE), and identifying outbreaks.

The microbiology laboratory supports the organization in identifying health care-associated infections by ensuring timely access to laboratory analyses; this includes providing a quick turnaround time when testing for high-risk infections such as *C. difficile*.



Worklife

12.5

Those responsible for receiving and responding to information about suspected health care-associated infections are identified.

Guidelines

Team members, clients, families, and volunteers know to whom they must report IPC issues.



Appropriateness



12.6

The source or cause of health care-associated infections is investigated.

Guidelines

Methods of investigation may include epidemiological, root-cause, or statistical analysis. The investigation process includes identifying high-risk or problem-prone agents or microorganisms requiring special attention or expertise (e.g., antibiotic-resistant microorganisms, airborne agents, or highly contagious agents).



Safety



12.7

There are policies and procedures to contain and prevent the transmission of microorganisms by applying routine practices to all clients and additional precautions as necessary.

Guidelines

Additional precautions may include a private room, isolation facilities, or an airborne infection isolation room. Other measures include vaccination; early detection, testing, and treatment; and post-exposure protocols.

Policies and procedures to contain and prevent the transmission of microorganisms are applicable to everyone who may be at risk, including clients, families, visitors, team members, and volunteers.

Population
Focus

12.8

IPC or public health experts are consulted with to control health care-associated infections, and the necessary information is reported to the appropriate authorities in line with the applicable regulations.

Guidelines

Experts may include infectious diseases physicians, medical microbiologists, nurses, public health, or other professionals.

The frequency and location of certain health care-associated infections must be reported to authorities such as public health agencies (e.g., PHAC). Reporting requirements vary per jurisdiction.



Appropriateness

- 12.9 Standard definitions and accepted statistical techniques are used to share and compare information about health care-associated infections.

Guidelines

Standard definitions are available for many infections to facilitate comparisons. For example, the Canadian Nosocomial Infection Surveillance Program has published definitions on its website for health care-associated infections currently under surveillance.

Statistical techniques may include epidemiological principles to identify at-risk populations, detect infections, and analyze trends and risk factors.



Appropriateness

- 12.10 The results of investigations are used to improve programs, policies, or procedures, and to prevent health care-associated infections from recurring.

- 13.0 There is a coordinated approach for responding to outbreaks.**



Safety



- 13.1 There are policies and procedures for identifying and responding to outbreaks in line with applicable regulations.

Guidelines

Policies and procedures address how to detect an outbreak; identify the cause of the outbreak (including those resulting from contaminated food); collect data and specimens to look for additional cases; and contain an outbreak once it is identified.



Accessibility



13.2

Team members and volunteers are provided with access to policies and procedures for identifying and managing outbreaks.



Appropriateness

13.3

The organization collaborates with its partners, such as public health agencies, to define outbreaks in terms of person, place, and time.

Guidelines

Using the “person, place, and time” approach helps characterize the outbreak and provides the organization with clues about strategies to control health care-associated infections.

Describing the “person” helps to understand the population at risk of acquiring the infection. Client demographics and characteristics such as age, underlying illness, possible exposures to microorganisms, and procedural or therapeutic risks such as surgery are evaluated.

Describing the “place” in terms of service, unit, or location helps an organization understand if the outbreak is localized, or if it has organization- or community-wide implications.

Describing the “time” entails defining the exact period of the outbreak, from the first case or first indications, and drawing the epidemic curve. It is based on diagnosis and a probable period of exposure. It helps determine if the outbreak is from a single (common) source or a propagated source (continuing source or person-to-person transmission).



Safety



13.4

Policies and procedures address how to manage emerging, rare, or problematic organisms, including antibiotic-resistant organisms.

Guidelines

Processes for managing new, rare, or problematic microorganisms may include exchanging information with partners, other organizations, and the community. Please refer to the Antimicrobial Stewardship ROP found in the Medication Management Standards.



Appropriateness

13.5

There are policies and procedures about the roles and responsibilities of team members, and volunteers who are involved in identifying and managing outbreaks.



Appropriateness

13.6

Information is communicated about outbreaks to clients, families, team members, partners, other organizations, and the community when appropriate.

Guidelines

Those responsible for communicating and reporting information about outbreaks are identified.

Information is disseminated to clients and families, team members, partners, other organizations (including public health agencies), and the community. Following an outbreak, a summary report including background information, details of the investigation, results, and recommendations is made available to partners, other organizations, and the community.



Appropriateness

13.7

Policies and procedures are regularly reviewed and improvements are made as needed following each outbreak.



Appropriateness



14.0 Ongoing improvements to the IPC Program are made.

14.1 There is a quality improvement plan for the IPC program.

Guidelines

The Accreditation Canada Infection Prevention and Control Standards outline the key sources for evaluating the IPC program. The standards include criteria on having a surveillance plan to evaluate the impact of the organization's risk-reduction strategies on health care-associated infection rates; monitoring compliance with policies and procedures for IPC (including hand hygiene); cleaning and disinfection of the physical environment; evaluating the IPC education program; seeking input from team members, and clients and families about the IPC program; and monitoring process and outcome measures. For example, CPSI's Safer Healthcare Now! Infection Prevention and Control Getting Started Kit offers strategies for improving and evaluating IPC programs.



Appropriateness

14.2 IPC performance measures are monitored.

Guidelines

Performance measures to monitor IPC are determined based on IPC priorities. Examples of structure-related indicators include the number of interdisciplinary committee meetings per year, or client information booklets containing information on health care-associated infections. Process indicators may include hand-hygiene compliance rates or disinfection audits of surfaces. Outcome measures may include health care-associated infection rates.

For other examples of performance measures related to IPC, refer to A Proposed Dashboard of Indicators to Control Healthcare-Associated Infections by Blais, et al. (2009). CPSI through its Safer Healthcare Now! program also offers an online measurement and reporting tool (Patient Safety Metrics), which contains numerous process and outcomes measures associated with IPC.



Client-centred
Services

- 14.3 Input is gathered from team members, volunteers, and clients and families on components of the IPC program.

Guidelines

Examples include surveys, focus groups, interviews, or meetings.



Appropriateness

- 14.4 The information collected about the IPC program is used to identify successes and opportunities for improvement, and to make improvements in a timely way.



Appropriateness

- 14.5 Results of evaluations are shared with team members, volunteers, clients, and families.

Guidelines

Sharing the evaluation results and improvements helps team members, and volunteers become familiar with the concept and benefits of quality improvement. It also increases clients' and families' awareness of the organization's commitment to ongoing quality improvement.

Resources

Blais R., Champagne F., Rousseau L. (2009). A Proposed Dashboard of Indicators to Control Healthcare-Associated Infections, *Healthcare Quarterly*, 12(Sp), 161-167

Canadian Nosocomial Infection Surveillance Program
www.phac-aspc.gc.ca

Certification Board of Infection Control and Epidemiology Inc. (CBIC)
www.cbic.org

Clean Learning Improving the Quality of Clean through Certification
www.cleanlearning.org

CSA Standards Z314.0 Medical device reprocessing - General requirements
www.shop.csa.ca

CSA Standards Z314.8 Decontamination of Reusable Medical Devices
www.shop.csa.ca

CSA Standards Z314.22 Management of Loaned, Reusable Medical Devices
www.shop.csa.ca

CSA Z317.2 Special Requirements for Heating, Ventilation, and Air-Conditioning (HVAC) Systems in Health Care Facilities
www.shop.csa.ca

CSA Standards Z317.13 Infection Control during Construction, Renovation, and Maintenance of Health Care Facilities
www.shop.csa.ca

CSA Standards Z8000 Canadian Health Care Facilities
www.shop.csa.ca

Canadian Patient Safety Institute (CPSI) Canada's Hand Hygiene Human Factors Toolkit
www.handhygiene.ca/

CPSI Canada's Hand Hygiene Challenge: STOP! Clean Your Hands

www.handhygiene.ca/

CPSI Hand Hygiene e-learning

www.handhygiene.ca/

CPSI Canada's Hand Hygiene Tool Kit

www.handhygiene.ca/

CPSI Canada's 4 Moments for Hand Hygiene Poster

www.handhygiene.ca/

CPSI *Safer Healthcare Now!* Infection and Prevention Getting Started Kit

www.saferhealthcarenow.ca/

CPSI How To Help Prevent healthcare-Associated Infections: A Patient and Family Guide

www.handhygiene.ca/

CPSI Patient Safety Metrics

www.patientsafetymetrics.ca

CPSI online version of the WHO Hand Hygiene Self Assessment Framework

Health Canada Prevention and Control of Occupational Infections in Health Care

www.publications.gc.ca

IPAC Canada - Education Resources for Infection Control Professionals

www.chica.org

IPAC Canada Infection Control Audit Toolkit

www.chica.org

MSSS Cadre de référence sur la prévention et le contrôle des infections nosocomiales à l'intention des établissements de santé du Québec

MSSS Désinfectants et désinfection en hygiène et salubrité: principes fondamentaux

www.msss.gouv.qc.ca/

MSSS Les Zones grises : Processus d'attribution des responsabilités

www.msss.gouv.qc.ca/

MSSS Protocole d'immunisation du Québec

National Advisory Committee on Immunization

Peterson, L.R. , Brossette S.E. (2002). Hunting Health Care-Associated Infections from the Clinical Microbiology Laboratory: Passive, Active, and Virtual Surveillance. *Journal of Clinical Microbiology*, 40(1), 1-4.

PIDAC Best Practices for Environmental Cleaning for Prevention and Control of Infections
www.publichealthontario.ca/

PIDAC Best Practice Manual: Infection Prevention and Control Programs in Ontario
www.publichealthontario.ca/

PIDAC Routine Practices And Additional Precautions In All Health Care Settings
www.publichealthontario.ca/

PHAC Classic Creutzfeldt-Jakob Disease in Canada
www.phac-aspc.gc.ca/

PHAC Essential Resources for Effective Infection Prevention and Control Programs, A Matter of Patient safety: A Discussion Paper - 2009.

PHAC Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings
www.phac-aspc.gc.ca/

PHAC Clostridium difficile infection infection prevention and control guidance for management in acute care settings
www.phac-aspc.gc.ca/

PHAC Hand Hygiene Practices in Healthcare Settings
www.publications.gc.ca/

Public Health Ontario Just Clean Your Hands
www.publichealthontario.ca/

WHO Clean Care is Safer Care
www.who.int/

Accreditation Canada would appreciate your feedback on these standards

Your Name: _____

Organization Name: _____

Email address or telephone number: _____

*(A Product Development Specialist may contact you about your feedback.)***Feedback: Please indicate the name of the standard, as well as the criterion number in your comments. Please be as specific as possible in your comments.***For example: I would like to provide comments on the Long-Term Care Services standards, criterion 3.12. Clients should be included in this process. I suggest you change the wording to "The team engages staff, service providers, and clients in the process to plan services."***You may also submit your feedback online [HERE](#)**

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Thank you for your input! Please send this page to:

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