2022

CHESTER VILLAGE LONG-TERM CARE INFECTION PREVENTION AND CONTROL PROGRAM

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1. PREAMBLE

This document defines the Chester Village Long-Term Care Infection Prevention and Control (IPAC) Program, which is established current evidence-based practices, utilizing an interdisciplinary approach, and aims to:

- optimize safety in the LTC home to mitigate risk of resident infections
- reduce morbidity and mortality
- prevent the spread of infections among those inside the home (including residents, staff, and others) and transmission from the community into the home.

The *Fixing Long-Term Care Act, 2021* (the "Act" – section 23) and its *Regulation* (section 102) requires that every long-term care home in Ontario has an Infection Prevention and Control program. The LTC Home is required to implement any standard or protocol issued by the Director with respect to infection prevention and control. The Act and O. Reg. Contain requirements related to IPAC and require the LTCH to implement any standard or protocol issued by the Director with respect to IPAC.

The LTC Home ensures that staff roles, responsibilities, and accountabilities related to the implementation and ongoing delivery of the IPAC program are clearly defined and communicated regularly to all staff. The LTC Home keeps written records of the processes described in useable formats and ensures a copy of the record can be readily produced.

The LTC IPAC Program and relevant policies are reviewed at least annually for completeness, accuracy, and alignment with best practices, and are updated based on that review.

2. IPAC LEAD

The LTC Home ensures that the home has an IPAC Lead whose primary responsibility is the home's infection prevention and control program (s. 23(4) of the Act). The responsibilities of the IPAC Lead are detailed in s.102(7) of the Regulation.

As required by the Regulation, the LTCH shall ensure that the IPAC Lead works regularly in that position on site at the home for at least the following minimum hours:

- Chester Village LTCH which has a licensed bed capacity of more than 200 beds, at least 37.5 hours per week.
- IPAC programming and required resources, including resources available on a specific shift, must be sufficient to address home and resident factors such as: age of the home; layout; and resident complexity and/or vulnerability, as these may directly impact IPAC practices. The role is to be prioritized and resourced in a manner that ensures that the required roles and responsibilities can be performed, including daily surveillance.

Education of the IPAC Lead

The IPAC Lead shall have at a minimum, education, and experience in IPAC practices, including:

a) Infectious diseases
b) Cleaning and disinfection

c) Data collection and trend analysis
d) Reporting protocols
e) Outbreak management
f) Asepsis
g) Microbiology
h) Adult education
i) Epidemiology
j) Program management; and
k) Within three years of s.102(6) of the Regulation coming into force, the IPAC Lead shall have current certification in infection control from the Certification Board of Infection Control and Epidemiology (ss.102(5) and 102(6) of the Regulation).

Responsibilities of the IPAC Lead

The IPAC Lead carries out the following responsibilities

1. Working with the interdisciplinary IPAC team to implement the IPAC program
2. Managing and overseeing the IPAC program
3. Overseeing the delivery of IPAC education to all staff, caregivers, volunteers, visitors, and residents
4. Auditing of IPAC practices in the home (please note that auditing of IPAC practices can also include overseeing audit activities performed by other staff in the home in collaboration with, or under the direction of, the IPAC lead)
5. Conducting at a minimum, quarterly real-time audits of specific activities performed by staff in the home, including but not limited to, hand hygiene, selection and donning and doffing of PPE. Reviewing infectious disease surveillance results regularly to ensure that all staff are conducting infectious disease surveillance appropriately and to ensure that appropriate action is being taken to respond to surveillance findings.
6. Convening the Outbreak Management Team (OMT) at the outset of an outbreak and regularly throughout an outbreak.
7. Convening the interdisciplinary IPAC team at least quarterly, and at a more frequent interval during an infectious disease outbreak in the home (this may also include convening the team during other disease outbreaks (i.e., non-infectious).
8. Reviewing the symptom screening gathered every shift,
    a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director.
    b) Symptoms are recorded, and immediate action is taken to reduce transmission and isolate residents.
9. Reviewing daily and monthly screening results to determine whether any action is required.
10. Implementing required improvements to the IPAC program as required by audits, best practice guidance, Public Health or the MOLTC. Implementing, in collaboration with the interdisciplinary IPAC team, required improvements to address any evaluation and/or audit findings as well as recommendations arising from the quality program for IPAC.
11. Ensuring that there is a hand hygiene program in place which includes, at a minimum, access to hand hygiene products at point-of-care

Contact information for the IPAC Lead

The direct contact information, including a telephone number and an email address that are monitored regularly, of all IPAC Leads for the home are provided:

a) To the local medical officer of health appointed under the Health Protection and Promotion Act or their designate; and
b) Where there exists a person or entity that is designated as the relevant IPAC hub for the home under a funding agreement with the Ministry of Health, to that IPAC hub (s.102(19) of the Regulation).

3. INTERDISCIPLINARY COMMITTEE AND CONSULTATION WITH OTHER HEALTHCARE PROFESSIONALS

The LTCH has an interdisciplinary infection prevention and control team that co-ordinates and implements the program (s.102(4)(b) of the Regulation and ensures that staff and leadership participate in the implementation of the IPAC program (s.102(8) of the Regulation).

The interdisciplinary IPAC Team meets quarterly in conjunction with the Professional Advisory Committee (PAC) meeting. The minutes of these IPAC Team meetings are shared, and any relevant topics related to policies and procedures that impact medical care are discussed with the PAC Committee members. The IPAC Lead seeks advice from the interdisciplinary IPAC team and other healthcare professionals in the home (e.g., dietician, occupational therapist) on specific policies and procedures of the IPAC program, those that directly impact resident care.

Membership of the IPAC Team (other team members are invited as appropriate)

- IPAC Lead
- Medical Director
- Director of Nursing and Personal Care
- Administrator/CEO
- the local medical officer of health appointed under the *Health Protection and Promotion Act* or their designate is invited to the meetings
- Occupational Health and Safety representative

The IPAC Team meets on a more frequent basis with an expanded membership during an infectious disease outbreak in the home (see Outbreak Management Section).

The IPAC Team also engages with the Residents' Council and Family Council, if any, on a regular basis (at least quarterly) to seek advice on program improvements related to;

- IPAC measures and their impacts on residents and families/caregivers
- IPAC program evaluation and quality activities.

This shall include the Council(s) providing advice on program improvements.

The IPAC Lead works with the interdisciplinary IPAC team as well as affected departments in the home, including but not limited to

- housekeeping; environmental health
- occupational health and safety

- clinical leadership (where not already represented on the interdisciplinary IPAC team), to develop a comprehensive inventory of evidence-based policies and procedures for the IPAC program.

The IPAC Team has access to expert resources through their own policy development and their IPAC Hub (in this case Michael Garron Hospital).

4. POLICIES AND PROCEDURES FOR ROUTINE PRACTICES AND ADDITIONAL PRECAUTIONS FOR PREVENTING TRANSMISSION OF INFECTION

Routine practices

The LTCH ensures that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices include:

a) The use of infectious disease risk assessments including point of care risk assessments.
b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact);
c) Respiratory etiquette.
d) Proper use of PPE, including appropriate selection, application, removal, and disposal; and
e) Use of controls, including:
    i. Environmental controls, including but not limited to, location/placement of residents' equipment, cleaning, making hand hygiene products available.
    ii. Engineering controls, including but not limited to, use of safety-engineered needles point-of-care sharps containers, disposable equipment, barriers; and
    iii. Administrative controls, including but not limited to, comprehensive IPAC policies and procedures.

At minimum, Additional Precautions shall include:

a) Evidence-based practices related to potential contact transmission and required precautions
b) Evidence-based practices related to potential droplet transmission and required precautions
c) Evidence-based practices related to airborne transmission and required precautions
d) Evidence-based practices for combined precautions
e) Point-of-care signage indicating that enhanced IPAC control measures are in place
f) Additional PPE requirements including appropriate selection application, removal and disposal
g) Modified or enhanced environmental cleaning procedures; and
h) Communication regarding Additional Precautions with transport of residents to other facilities (e.g., Hospital).

5. INFECTIOUS DISEASE SURVEILLANCE

The LTCH follows the surveillance protocols as issued by the Ministry of LTC Director; for communicable diseases or diseases of public health significance (s.102(2)(a) of the Regulation).

The LTCH ensures that on every shift:

a) Symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Ministry of LTC Director; and
b) The symptoms are recorded, and immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required (s.102(9) of the Regulation).

The LTCH ensures that the symptom screening information gathered under subsection 102(9) of the Regulation is analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends, for the purpose of reducing the incidence of infection and outbreaks (s.102(10) of the Regulation).

Daily screening by Registered Staff and/or Nursing Admin Staff
Monthly reviewing and reporting by IPAC

LTC Homes ensure that the following surveillance actions are taken:

a) Training staff on how to monitor for the presence of infection in residents
b) Ensuring that surveillance is performed on every shift to identify cases of healthcare-acquired infections (HAIs), device-associated infections and Antibiotic Resistant Organisms (AROs)
c) Ensuring that established case definitions for specific diseases are understood and used by staff
d) Using common forms and tools, and making them available to staff at locations where they are needed, for surveillance reporting in the home
e) Developing and using a surveillance database and reporting tool for use to collect and collate data
f) Ensuring that surveillance information is tracked and entered in the surveillance database and/or reporting tools
g) Ensuring that staff are aware of requirements for infectious disease reporting within the home
h) Ensuring that the interdisciplinary IPAC team is regularly updated on surveillance findings; and
i) Employing syndromic surveillance regularly to monitor for symptoms, including but not limited to, fever, new coughs, nausea, vomiting, and diarrhea, and taking appropriate action.

6. HAND HYGIENE PROGRAM

The LTCH has a hand hygiene program (s. 23(2)(e) of the Act which is adapted in accordance with any standard or protocol issued by the Ministry of LTC Director under s.102(2) of the Regulation.

The hand hygiene program is multifaceted and multidisciplinary. The program includes training and education, hand hygiene audits, a hand care program, and hand hygiene and hand care support for residents. Hand washing facilities provisioned with appropriate supplies are accessible in common areas and work areas where hand-washing may be required.

The LTCH ensures that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as:

- Hand hygiene signage
- Training and education related to hand hygiene practices at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact)
- Identification and engagement of hand hygiene champions to promote best practice; audits to monitor hand hygiene compliance including feedback and correction of practices when indicated.
- These activities are linked to the overall audit, evaluation, and quality approach for the full IPAC program: A hand-care program to assess and maintain the skin integrity of staff who perform frequent hand hygiene
- Hand hygiene training and awareness as part of orientation and ongoing training of all staff, volunteers, and visitors (including caregivers and family members)
- Involvement of the IPAC Lead and OHS staff in product selection for hand hygiene and skin maintenance, to ensure that PPE durability is not compromised (e.g., interaction of hand care products and the breakdown of latex gloves)
- Support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting; and
- Support for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

7. OUTBREAK MANAGEMENT

The LTC Home has in place, an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the *Health Protection and Promotion Act*, communication plans, and protocols for receiving and responding to health alerts; and a written plan for responding to infectious disease outbreaks (s. 102(11) of the Regulation).

Outbreak Management Team

When an outbreak is declared the outbreak management team is convened for regular huddles (daily, or as appropriate) with OPH. The outbreak management team includes representatives from the various departments in the home including LTC leadership (DOC, Administrator/CEO, and others as appropriate), IPAC Lead, Occupational Health and Safety, Environmental Services, Food Services, Activation, and Administration.

The LTC Homes consider the unique features of the home and the outbreak context in the outbreak management plan such as:

- The size and physical layout of the home including rooms available for separating and/or cohorting residents
- Staffing supply, mix, and models
- Resident population and unique needs and/or features
- Impacts of outbreaks on residents including impacts of social isolation
- Cultural safety; and
- Community impacts

The LTCH engages and communicates with residents, caregivers, families, and staff throughout the outbreak and engages with public health. If required, additional supports are accessed to support the outbreak response.

Following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team will conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings is created, that makes recommendations for improvements to outbreak management practices.

During an outbreak, in addition to the roles outlined above, the IPAC Lead is involved in outbreak management activities in collaboration with the interdisciplinary IPAC team and the OMT in the manner described below.

The IPAC Lead's role shall include, but not be limited to:

a) Advising on IPAC practices to manage the outbreak and minimize risk(s) to residents and staff
b) Assisting with securing IPAC-related resources needed to support the outbreak management response. This may also include working in collaboration with the LTCH and the OMT to secure needed PPE and other supplies as required.
c)

8. TRAINING EDUCATION (AND AUDITS)

The IPAC program includes an educational component in respect of infection prevention and control for staff, residents, volunteers, and caregivers (Act ss. 23(2)(b) and sections 257-263 of the Regulation).

The IPAC Lead develops and oversees the implementation of an IPAC training and education program for residents, caregivers, staff, and visitors which includes at a minimum the following:

a) Caregivers shall receive orientation and training on IPAC policies and procedures appropriate to their role
b) Residents shall also receive training, education, and/or information appropriate to their needs and level of understanding that helps them to understand the IPAC program and specific IPAC practices that may affect them
c) The IPAC lead, or their designate, shall communicate relevant information and requirements and provide education to residents, caregivers, and other visitors (including family members), which includes but is not limited to:
    - visitor policies
    - physical distancing
    - respiratory etiquette
    - hand hygiene
    - applicable IPAC practises proper use of PPE

d) The IPAC lead, or their designate, shall provide retraining and education on an annual basis or more frequently, to respond to emerging public health issues and/or new evidence
e) Training shall be accessible, tailored to learner needs and reduce potential barriers to comprehension including language and literacy; and
f) The IPAC lead shall also ensure that visitors receive information about required IPAC practices that is appropriate to the level of risk that visitors present to themselves and to others in the home.

The IPAC Lead develops and oversees the implementation of an IPAC training and education program for staff and volunteers with the following minimum requirements:

a) The required orientation and training on IPAC under the Act and Regulation shall be appropriate to the staff and volunteer role (refer to Training and Audit document)
b) The training shall be accessible, tailored to learner needs and reduce potential barriers to comprehension including language and literacy
c) IPAC education shall be tailored to the job of the staff member receiving the education.

The IPAC Lead (and designates) plan, implement and track the completion of all IPAC training and:

a) Assessments/audits and feedback processes are used to determine if staff have met training requirements as required by the MOLTC, or when individual staff need remedial or refresher training; and
b) Ensures that audits are performed regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role.

9. IMMUNIZATION AND SCREENING

The IPAC lead shall ensure that the following immunization and screening measures are in place:

a) Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the home. Residents are exempt from screening for TB if they are being relocated to another long-term care home operated by the same licensee and section 240 of the Regulation applies; or if they are transferring to a related temporary long-term care home, a reopened long-term care home or a replacement long-term care home operated by the same licensee
b) Residents must be offered immunization against influenza at the appropriate time each year.
c) Residents must be offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the website of the Ministry of Health
d) The IPAC lead shall ensure that any pets living in the home or visiting the home have up-to-date immunizations. (Regulation ss 102(12)-(14)).

The Department Manager, or designate, responsible for hiring shall ensure that:

a) Staff are screened for tuberculosis and other infectious diseases in accordance with any standard or protocol issued by the Director. This shall include ensuring accordance with evidence-based practices and where there are none, accordance with prevailing practices. This may also include consultation with the local board of health to ensure that screening is undertaken to address specific risks in the community.
b) There is a staff immunization program in accordance with any standard or protocol issued by the Director. The staff immunization program includes informational resources regarding the benefits of immunization to resident and staff safety. This shall also include communicating expectations regarding immunization at hiring (for example, regarding recommended immunizations such as Measles/Mumps/Rubella (MMR) and yearly influenza immunization).

The LTCH works collaboratively with the local board of health regarding immunization of residents and staff, which may include offering immunizations on-site. This may also include offering additional immunizations as recommended by the local board of health. This ensures that staff is screened for tuberculosis and other infectious diseases.

10. Ethical Framework

The LTCH ensures that the implementation and ongoing delivery of the IPAC program includes an ethical framework to inform decision-making.

The LTCH has a clearly documented ethical framework as part of the IPAC program. The ethical framework includes key principles which have been adopted home-wide and discussed with the interdisciplinary IPAC team, the home's leadership team (where not already represented on the interdisciplinary IPAC team), the continuous quality improvement committee and the Residents' Council or Family Council, if any.

The ethical framework for the IPAC program includes the key principles of fairness, equity, transparency, consideration of available evidence, consideration of impacts of decisions on residents and staff, resident quality of life as a primary driver, risk relative to reward of key decisions, and safety.

Precautionary Principle

The LTCH:

- Ensures that the IPAC program is implemented in a manner consistent with the precautionary principle as set out in the standards and protocols issued by the Ministry of LTC Director and the most current medical evidence
- Ensures that the application of the precautionary principle is guided by the key principles in the ethical framework.
- Ensures that when determining whether to apply the Precautionary Principle, they consider recommendations including those of a provincial scientific table, and the Chief Medical Officer of Health appointed under the Health Protection and Promotion Act, where available.
- Ensures that processes are established for the de-escalation of practices where the precautionary principle has been applied. The LTCH shall ensure that as part of this process, the OHS lead, Joint Health, and Safety Committee (JHSC), or health and safety representative, and the interdisciplinary IPAC team are engaged.

11. REGULAR EVALUATION AND QUALITY IMPROVEMENT

The LTCH shall oversee the development and implementation of a quality management program to assess and improve IPAC in the home, as set out in a standard or protocol issued by the Director under subsection 102(2) of the Regulation (s. 102(18) of the Regulation). The LTCH shall ensure that the IPAC program is evaluated and updated at least annually in accordance with the standards and protocols issued by the Director under subsection 102(2) and (s. 102(4)(e)) of the Regulation. The LTCH shall also ensure that a written record is maintained for each evaluation including evaluation dates and time, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

In evaluating and updating the IPAC program (see template in appendix), at a minimum on an annual basis, the LTCH shall:

a) In addition to the requirement to ensure that the IPAC program is evaluated and updated at least annually, ensure that the IPAC program, including the IPAC policies and procedures, are reviewed and updated, more frequently in accordance with emerging evidence and best practices

b) Ensure that the evaluation of the IPAC program also includes specific actions to evaluate outbreak preparedness and response activities

c) Ensure that evaluation approaches also include, at a minimum:

i. A system to monitor the compliance of staff with IPAC program policies and procedures, as well as processes for correcting and improving identified gaps

ii. An audit plan, including audit processes for on-site review of IPAC practices by staff with education and corrective actions; and

iii. Engagement with the Quality Committee to appropriately link program evaluation with Quality initiatives.

d) Ensure that quality reviews shall also be conducted annually in collaboration with home leadership, the Quality Committee, the IPAC Lead, and the interdisciplinary IPAC team.

The LTCH shall ensure, at minimum, that the following activities are carried out in the quality management program:

a) Establishment of goals and key quality indicators (both process and outcome-related) for the IPAC program in the home

b) Training and education for staff related to quality indicators and needed improvements for IPAC in the home

c) Reporting on quality indicators and metrics for IPAC in the home; and

d) Engagement with the Quality Committee, the interdisciplinary IPAC team and family and resident councils related to IPAC in the home.

12. RESOURCES

Infection Prevention and Control (IPAC) Canada. Infection Prevention and Control (IPAC) Program Standard. Can J Infect Control. 2016 December;30 (Suppl):1-97.

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Ontario Agency For Health Protection and Promotion. Provincial Infectious Diseases Advisory Committee. Best Practices for Infection Prevention and Control Programs in All Health Care Settings, 3rd edition. Toronto, ON: Queen's Printer for Ontario; May 2012.

Ontario Agency for Health Protection and Promotion, Provincial Infectious Diseases Advisory Committee. Routine Practices and Additional Precautions in All Health Care Settings. 3rd edition. Toronto, ON: Queen's Printer for Ontario; November 2012.

Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Best practices for prevention, surveillance, and infection control management of novel respiratory infections in all healthcare settings. Toronto, ON: Queen's Printer for Ontario; 2015.

Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Best practices for surveillance of health care-associated infections in patient and resident populations. 3rd ed. Toronto, ON: Queen's Printer for Ontario; 2014.

Communicable disease surveillance and response systems. Guide to monitoring and evaluating. World Health Organization, 2006. https://www.who.int/csr/resources/publications/surveillance/WHO_CDS_EPR_LYO_2006_2.pdf

Annex A: Annual IPAC Program Evaluation Form

IPAC PROGRAM ANNUAL EVALUATION

Date of evaluation:

Names of individuals who participated in the evaluation
Summary of discussion
Summary of changes made to program
Date (s) changes implemented or to be implemented