Boomer, Joanne HLTH:EX

From: Whitmarsh, Graham HLTH:EX
Sent: Thursday, March 1, 2012 5:58 PM
To: Boomer, Joanne HLTH:EX
Subject: Fwd: C. diff issue

Meeting ASAP

Begin forwarded message:

> **From:** "Whitmarsh, Graham HLTH:EX" <Graham.Whitmarsh@gov.bc.ca>
> **Date:** 1 March, 2012 5:57:21 PM PST
> **To:** "XT:Mitchell, David HLTH:IN" <Dmitchell@knv.com>
> **Subject: Re: C. diff issue**
>
> Ok, thank you for this. I believe we can look at all 13 recommendations and demonstrate progress on all. I will discuss with Nigel.
>
> I will try to arrange a meeting on this next week.
>
> Thank you for your support.
>
> Best regards
>
> Graham
>
> On 2012-03-01, at 5:55 PM, "Dave Mitchell" <DMitchell@knv.com> wrote:
>
> > Graham, I have spoken to Nigel and Andy regarding this issue this afternoon. I have also reviewed the FH News Release of today's date and quickly reviewed the Gardam Report.
> > Based on this I feel more comfortable with the background on this issue(s) from a BOD perspective, that said I passed along the desire to come out with comments that acknowledged FH's acceptance and desire to implement the Gardam recommendations without caveats being added. (3 of the recommendations will need to be looked at more closely to ensure the best approach is taken to achieve the desired result(s) but the intent is understood and agreed.)
> > At some point I think it would be worthwhile to have a discussion between yourself, Nigel and I (I would prefer face to face for this) to discuss the bigger issue of the relationship that leads to this type of action being taken by our Docs.
> >
> > Thanks for the call today,
> >
> > **Dave Mitchell**
> >
> > <image001.jpg>
> >
> > **KNV Chartered Accountants LLP**
> > Tel: 604-536-7614 (Extension 247)
> > Toll Free: 1-800-761-7772

Turner, Julie HLTH:EX

From: Davidson, Heather (ADM) HLTH:EX
Sent: Wednesday, March 7, 2012 8:14 PM
To: XT:HLTH Krystal, Arden; Turner, Julie HLTH:EX
Subject: Re: Burnaby hospital

There's a call being set up tomorrow am with DM - you should come on call. Thanks for offer

----- Original Message -----
From: Krystal, Arden [mailto:Arden.Krystal@fraserhealth.ca]
Sent: Wednesday, March 07, 2012 07:57 PM
To: Henry, Effie HLTH:EX; Davidson, Heather (ADM) HLTH:EX
Subject: Burnaby hospital

Andy has been taking the lead on this and has been in direct contact with the DM (and is talking with him tomorrow as well), but I just wanted to extend the offer that if you need any information related to this file, I'm happy to help. The ED and the site director are working very hard to keep the staff focused during this media storm....it is unfortunate, as BH has actually done a lot of work on quality improvement over the last few years, including making a real dent in cdiff rates. There are some very strange circumstances surrounding these latest revelations...in any event, just wanted you to know that I'm around...

Turner, Julie HLTH:EX

From: Boomer, Joanne HLTH:EX
Sent: Thursday, March 8, 2012 8:05 AM
To: XT:HLTH Korabek, Barbara; XT:HLTH Webb, Andrew; XT:HLTH Woods, Brian; XT:HLTH Krystal, Arden; McKnight, Elaine L HLTH:EX; Bethel, John HLTH:EX; Davidson, Heather (ADM) HLTH:EX; Stewart, Michelle GCPE:EX
Cc: Turner, Julie HLTH:EX
Subject: Conference Call Request 9:30am Today - Burnaby Hospital

Graham Whitmarsh would like you to join a conference call today Thursday March 8 at 9:30am. Dial in information is below.

umber: S 15
ant Conference ID: S15
tor (Graham)

Joanne Boomer | Senior Executive Assistant
Office of the Deputy Minister | Ministry of Health
5-3, 1515 Blanshard Street | Victoria BC | V8W 3C8
P: 250-952-1590 | F: 250-952-1909

WIN like you're used to it. LOSE like you enjoy it. (Jeremy Gutsche)

Turner, Julie HLTH:EX

From: Davidson, Heather (ADM) HLTH:EX
Sent: Thursday, March 8, 2012 8:37 AM
To: Turner, Julie HLTH:EX
Subject: Fw: CDiff contractor
Attachments: FraserHealthrecommendations Final February 2011.pdf

Should be attached here

----- Original Message -----
From: Webb, Andrew [mailto:Andrew.Webb@fraserhealth.ca]
Sent: Wednesday, February 29, 2012 06:34 PM
To: XT:HLTH Korabek, Barbara; Davidson, Heather (ADM) HLTH:EX; XT:HLTH Murray, Nigel
Subject: RE: CDiff contractor

The report is attached but I would prefer it not be released to the public yet. It was received on Febraury 20th and my team have been reviewing it to prepare an action plan to dicsuss with our exec. Clearly it would not be reasonable to have media circus on this before we have had a chance to digest it!

It was commissioned as a result of our known high Clostridium difficile rates and to see whether there were external recommendations we had not thought of within our ongoing improvement plans. Michael Gardam is an internationally known infectious disease expert with a particular interest in infection prevention and control. He hails from Toronto.

The sporicidal cleaning recommendation ahs already been implemented along with FH wide enhanced ED cleanaing and enhanced outbreak cleaning response.

Andy

Dr AR Webb MD FRCP MFMLM
VP Medicine, Fraser Health Authority
Clinical Professor, UBC Faculty of Medicine

Suite 400, Central City Tower
13450-102 Avenue
Surrey, BC V3T 0H1, Canada

Telephone (604) 587 4659
Mobile S17

From: Korabek, Barbara
Sent: February 29, 2012 6:15 PM
To: 'heather.davidson@gov.bc.ca'; Murray, Nigel; Webb, Andrew
Subject: Re: CDiff contractor

I am just adding in Dr. Webb who maybe also able to respond quickly.

----- Original Message -----
From: Davidson, Heather (ADM) HLTH:EX [mailto:Heather.Davidson@gov.bc.ca]
Sent: Wednesday, February 29, 2012 06:13 PM
To: Murray, Nigel; Korabek, Barbara
Subject: CDiff contractor

Nigel, can we get some info asap on the consultant you have engaged on C Diff. Who is it, has report been complete, what were recommendations? If there is someone I can connect with, that would be great but there's quite an urgent need to get some info to Minister. Thanks - this is what they were phoning me about during meeting.

Virdi, Anjali HLTH:EX

From: Davidson, Heather (ADM) HLTH:EX
Sent: Wednesday, February 29, 2012 6:39 PM
To: XT:HLTH Webb, Andrew; XT:HLTH Korabek, Barbara; XT:HLTH Murray, Nigel
Subject: RE: CDiff contractor

Thanks Andy. MOH would not release - that should be FHA call - thanks for providing.

Heather Davidson
Assistant Deputy Minister
Ministry of Health

From: Webb, Andrew [Andrew.Webb@fraserhealth.ca]
Sent: 29 February 2012 18:34
To: XT:HLTH Korabek, Barbara; Davidson, Heather (ADM) HLTH:EX; XT:HLTH Murray, Nigel
Subject: RE: CDiff contractor

The report is attached but I would prefer it not be released to the public yet. It was received on Febraury 20th and my team have been reviewing it to prepare an action plan to dicsuss with our exec. Clearly it would not be reasonable to have media circus on this before we have had a chance to digest it!

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with, that would be great but there's quite an urgent need to get some info to Minister. Thanks - this is what they were phoning me about during meeting.

A Review of *C. difficile* Control Measures for the Fraser Health Medicine Inpatient Programs at Burnaby Hospital and the Royal Columbian Hospital

Prepared by: Michael Gardam MSc, MD, CM, MSc, CIC, FRCPC
Director, Infection Prevention and Control,
University Health Network
and Women's College Hospital;
Division of Infectious Diseases,
University Health Network
Toronto, Ontario

Submission date: February 6, 2012

Summary of *C. difficile* Review Recommendations

1. Insisting that healthcare workers use soap and water for hand hygiene when caring for patients with *C. difficile* is likely undermining the medicine program's hand hygiene program for several reasons including: there are very few hand hygiene sinks available, and soap and water takes longer and is more drying on the hands. It is recommended that the current policy be changed to state that either alcohol based hand rub or soap and water is acceptable.

2. Organizational/program ownership of *C. difficile* control needs to be clarified as it was unclear whether the medicine program, facility, or both are ultimately responsible for addressing the issue. Clear focus and accountability will be required to address the myriad issues that influence *C. difficile* transmission.

3. The Fraser Health Regional Infection Prevention and Control (IPAC) program is considerably under resourced compared to other jurisdictions in Canada and the United States. Given that the program covers 12 acute care hospitals with thousands of inpatient beds, as well as more than 7000 residential care beds, the number of trained infection control practitioners (ICPs) belonging to the program is less than half what would be considered acceptable by current standards. This directly impacts the control of organisms such as *C. difficile* as the IPAC resources appear overwhelmed.

4. It is recommended that sporocidal agents (such 1:10 sodium hypochlorite or Virox Rescue) be used to clean inpatient rooms and bathrooms according to the following steps:
    i. Clean all inpatient rooms and bathrooms on the medicine units and other units/programs that have close associations with medicine due to transfer patterns (such as the ICU) twice daily with a sporocidal agent (depending on the agent used, this may require a first clean with detergent followed by a disinfection step using the sporocidal agent). The cleaning should focus on high touch surfaces and spend less time on walls and floors. This should be done for approximately 1-2 weeks;
    ii. Then scale back to twice daily sporocidal cleaning of all inpatient rooms and bathrooms only on units that continue to have a high incidence of nosocomial cases. Continue this approach until the incidence decreases;
    iii. Then scale back to twice daily sporocidal cleaning only in *C. difficile* patient rooms and bathrooms. Continue this indefinitely.

Should the number of either nosocomial cases or community cases rise on a unit to the point where IPAC feels there is a high burden of disease, the program should move back to step (ii) and clean the entire unit with sporocidal agents, scaling back once the number of cases decreases.

5. Continue with antimicrobial stewardship efforts. Start with programs that are interested in stewardship rather than those that may appear to need the most help. Recognize that the stewardship process is slow and may need to be different for different programs.

6. There is a lack of point of care alcohol-based hand rub (ABHR) in several of the clinical areas visited. It is recommended that the program install more ABHR and that front line staff should be consulted on location. It is recognized that the current ABHR contract will soon be up for review; however, non-permanent options such as point of care brackets etc. could be used as a temporizing measure until a new product is chosen. It is recommended that front line staff should have a major say in choosing the next ABHR product as they will be the ones using it. Encourage front line teams to develop their own visual reminders to help improve hand hygiene compliance.

7. As part of a larger hand hygiene program, the medicine program is encouraged to publically report (on the internet, using local signage etc.) program and unit hand hygiene compliance rates. These rates should be fed back widely throughout the medicine program along with other rates such as those for MRSA and *C. difficile*.

8. In addition to the *C. difficile* toolkit, it is recommended that the program deeply engage front line staff in the locally appropriate ways to implement the best practices contained therein. Toolkits provide the "what" you need to do, but not the "how". Using liberating structures such as positive deviance should help with frontline engagement, empowerment, and compliance.

9. While crowded, the physical layouts of the medicine wards are not as challenging as many others. It has been recognized that clean and dirty utility rooms are not ideal on some floors. It is recommended that front line staff be consulted to determine the best layout of these rooms and to identify processes that work for them.

10. The program is currently using a cytotoxin assay to detect *C. difficile*. This test is highly sensitive and specific. The only significant drawback to this test is a slower turnaround time. The program could consider moving to a PCR-based testing platform, which has a similar sensitivity but a faster turnaround time. Given that the cytotoxin assay is relatively expensive, it may be that moving to PCR will not require a significant increase in laboratory funding.

11. The program should consider revisiting its VRE control policies as other BC health regions have done. Considerable effort is being spent on controlling VRE, which leads to isolation fatigue and makes it harder to control *C. difficile* by using up precious isolation resources such as single rooms.

12. The Aramark housekeeping staff appear quite dedicated to their tasks and understand the important role they have in patient safety. Given the additional cleaning being recommended, it may be that existing contracts will need to be

revisited. The existing external auditing of housekeeping activities should continue. Furthermore, the program should ensure that appropriate occupational health and safety measures are taken to protect staff from exposure to caustic disinfection agents. Finally, housekeeping staff should be fully engaged in future improvement efforts and activities.

13. A standardized review process i.e. incident reporting system should be implemented for healthcare associated *C. difficile* infections. This would require nurse managers to review the *C. difficile* control measures on their units (including hand hygiene, environmental cleaning, antimicrobial stewardship etc.) which would help foster ownership. Incident reviews would also require the engagement of different team members, including physicians to discuss management issues and environmental services to discuss cleaning.

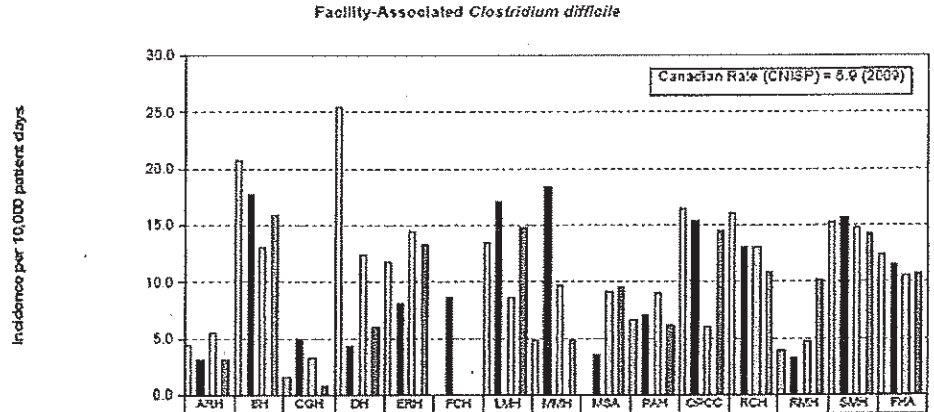
Background

This review of *C. difficile* control measures for the inpatient internal medicine program of Fraser Health was conducted at the request of Ms. Petra Welsh, Director of the Fraser Health Regional Infection Prevention and Control Program. I performed site visits at Burnaby Hospital and the Royal Columbian Hospital on November 25, 2011. Prior to my visit, I reviewed epidemiologic data provided by Ms. Welsh. During the review, I met with multiple people representing the following areas:

- Site administration;
- Environmental services (Aramark);
- Infection Prevention and Control;
- Front line staff, including nursing, pharmacy, physical therapy etc.;
- Medical staff

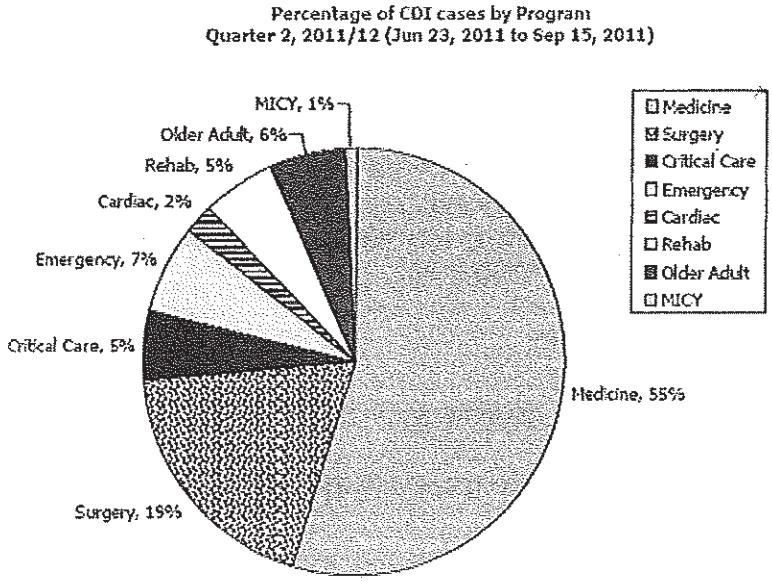
Due to the brevity of my visit, I was unable to meet with the medicine program medical leadership.

A review of Fraser Health *C. difficile* rates shows that Burnaby Hospital is slightly above the health region average while the Royal Columbian is roughly at the average (see figure below).[1] Of note, these rates are above the national Canadian Nosocomial Infection Surveillance Program (CNISP) average for teaching hospitals and two to three times the Ontario provincial average.[2]

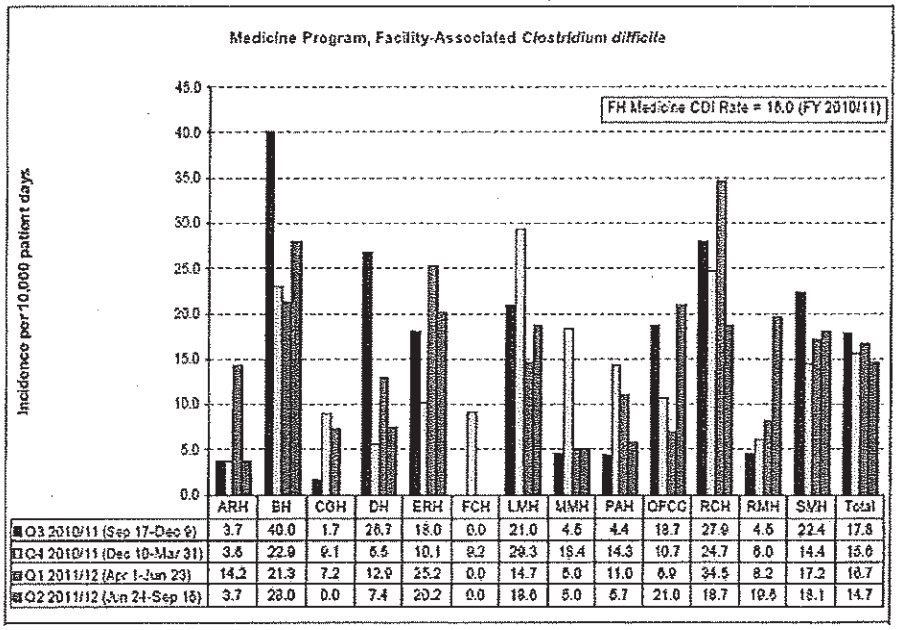


	ARH	BH	CGH	DH	ERH	FCH	LMH	MMH	MSA	PAH	GPCC	RCH	RMH	SMH	FHA
Sep 17-Dec 9/10	4.4	20.7	1.6	25.4	11.6	0.0	13.4	4.8	0.0	6.7	16.5	16.0	3.9	15.3	12.4
Sep 17-Dec 9/10 (03565)	10	53	2	13	11	0	23	1	0	11	6	57	5	67	261
Dec 10/10-Mar 31/11	3.2	17.8	5.0	4.3	8.1	8.7	17.1	18.4	3.5	7.1	15.4	13.1	3.3	15.7	11.4
Dec 10/10-Mar 31/11 (03566)	10	51	9	3	10	1	39	6	1	15	12	63	6	96	332
Apr 1/11-Jun 23/11	6.6	13.1	3.3	12.4	14.5	0.0	8.6	9.6	9.2	9.0	6.0	13.9	4.8	14.7	10.6
Apr 1/11-Jun 23/11 (03567)	15	34	4	8	14	0	14	2	2	15	6	48	6	69	232
Jun 24/11-Sep 15/11	3.1	15.9	0.6	6.0	13.3	0.0	14.8	4.8	9.5	6.2	14.5	10.9	10.2	14.2	13.7
Jun 24/11-Sep 15/11 (03568)	7	41	1	3	12	0	25	1	2	13	12	59	15	66	253

The Medicine program accounts for the majority of *C. difficile* cases at Fraser Health (see pie graph below). This is not surprising as inpatient medical programs typically house the majority of *C. difficile* cases, followed by inpatient surgery programs.



Of the Fraser Health facilities with inpatient medicine programs, Burnaby Hospital and the Royal Columbian have the highest rates:



	ARH	BH	CGH	DH	ERH	FCH	LMH	MMH	PAH	QFCC	RCH	RMH	SVH	Total
Q3 2010/11 (Sep 17-Dec 9)	3.7	40.0	1.7	26.7	18.0	0.0	21.0	4.5	4.4	18.7	27.9	4.5	22.4	17.8
Q4 2010/11 (Dec 10-Mar 31)	3.6	22.9	9.1	6.5	10.1	9.2	29.3	18.4	14.3	10.7	24.7	6.0	14.4	15.6
Q1 2011/12 (Apr 1-Jun 23)	14.2	21.3	7.2	12.9	25.2	0.0	14.7	5.0	11.0	6.9	34.5	8.2	17.2	16.7
Q2 2011/12 (Jun 24-Sep 15)	3.7	28.0	0.0	7.4	20.2	0.0	18.6	5.0	6.7	21.0	18.7	19.6	18.1	14.7

Figure 1. Medicine program, facility-associated rates of *Clostridium difficile* in Fraser Health acute care facilities, Sep 17/10 to Sep 15/11.

The program has identified *C. difficile* as an issue at these two sites. Both hospitals have recently developed a *C. difficile* toolkit, including nursing checklists to help with patient management; however there is frustration that there has not been a significant change in healthcare associated *C. difficile* rates. Discussions with medical and IPAC

staff suggest that rapid patient isolation, diagnosis, and appropriate treatment of *C. difficile* are generally occurring.

My Experience

I am an infectious diseases physician with additional fellowship training in healthcare epidemiology and hold a Master's degree in Health Policy, Management and Evaluation from the University of Toronto. I have been the Director of Infection Prevention and Control at University Health Network since 2001 and at Women's College Hospital since 2011. In these roles, I oversee 25 staff, including two physicians. Our program also provides consulting services to multiple Ontario hospitals.

From 2008 to 2010 I was the founding Director of the Infectious Disease Prevention and Control program at the Ontario Agency for Health Protection and Promotion (OAHPP). In this role, I oversaw multiple programs including the Regional Infection Control Networks, the provincial "Just Clean Your Hands" program, Infection Control Resource Teams and paved the way for the transfer of other government programs to OAHPP. Infection Control Resource Teams deserve special mention as these were created to help hospitals control *C. difficile* outbreaks. As the leader of this program, I have visited and helped numerous Ontario hospitals control *C. difficile*.

Finally I am the Physician Director of CHICA Canada, Canada's infection control association as well as the national lead for the Canadian Patient Safety Institute's hand hygiene program.

Recommendations and Rationale

1. **Insisting that healthcare workers use soap and water for hand hygiene when caring for patients with *C. difficile* is likely undermining the medicine program's hand hygiene program for several reasons including: there are very few hand hygiene sinks available, and soap and water takes longer and is more drying on the hands. It is recommended that the current policy be changed to state that either alcohol based hand rub or soap and water is acceptable.**

The Fraser Health IPAC program has recommended the use of soap and water over alcohol based hand rub (ABHR) for hand hygiene when caring for patients with *C. difficile*. This is not a unique recommendation as several authorities recommend this approach, including British Columbia's PICNet[3] and the US Centers for Disease Control and Prevention.[4] The preferential use of soap and water is based on laboratory evidence that *C. difficile* spores are not killed by ABHR.

Despite these laboratory studies, the CDC also acknowledges that there is no epidemiologic evidence that relying on ABHR as opposed to soap and water results in increased *C. difficile* incidence. Indeed, the CDC has recently begun to soften its stance on this issue because of the following points:[5,6]

1. ABHR is preferred over soap and water washing for multiple reasons, including improved skin integrity, superior efficacy for non-spore forming organisms, accessibility and rapidity;
2. Lack of epidemiologic evidence as mentioned above;
3. Use of gloves when caring for *C. difficile* patients which may contain most spores;
4. Preferential use with *C. difficile* patients implies that all patients shedding *C. difficile* are known and accounted for.

Of note, both the World Health Organization and the Ontario Provincial Infectious Diseases Advisory Committee (PIDAC) guidelines do not stress soap and water washing over ABHR when caring for *C. difficile* patients for similar reasons.[7,8] To summarize these guidelines, soap and water may be used if a sink is readily available; otherwise, ABHR is an acceptable alternative. In my experience I have seen many Ontario hospitals substantially decrease their *C. difficile* rates using ABHR exclusively.

The current physical layouts of the inpatient wards at both hospitals do not provide an adequate number of hand hygiene sinks to support soap and water washing. When questioned, front line staff said they were unable to comply with the soap and water requirement and some stated they relied more heavily on glove use to prevent *C. difficile* transmission than hand hygiene.

2. Organizational/program ownership of *C. difficile* control needs to be clarified **as it was unclear whether the medicine program, facility, or both are ultimately responsible for addressing the issue. Clear focus and accountability will be required to address the myriad issues that influence *C. difficile* transmission.**

The inpatient medicine program was relatively recently restructured from a facility-based program, to a regional program that encompasses all of Fraser Health. Responsibility for the program rests with the program medical lead and all Fraser Health medicine programs, regardless of which hospital they are located in, report to this lead. In this model, the different facets of hospital care report to different regional program managers rather than all reporting up to one lead at the hospital site.

It was not clear to staff interviewed during this review how facilities issues that affect patient care are dealt with in this model. For example, if issues such as clean and dirty utility room design, human waste management, placement of alcohol gel dispensers, and environmental cleaning need to be addressed in order to contain *C. difficile* transmission, it was unclear who is responsible to ensure that this happens. In general, most front line staff appeared to be confused and did not know where to start to address their concerns.

While strictly speaking these issues are not medical care issues, they do directly impact upon patient quality of care as well as patient morbidity and mortality. Given the impact that *C. difficile* has had on patients in the medicine program, a clear accountability framework will need to be developed to ensure that issues are addressed in a timely fashion. Many organizations have dealt with this by setting up a *C. difficile* task force that is empowered to bring about the necessary changes to get the organism under control.

3. **The Fraser Health Regional Infection Prevention and Control (IPAC) program is considerably under resourced compared to other jurisdictions in Canada and the United States. Given that the program covers 12 acute care hospitals with thousands of inpatient beds, as well as more than 7000 residential care beds, the number of trained infection control practitioners (ICPs) belonging to the program is less than half what would be considered acceptable by current standards. This directly impacts the control of organisms such as *C. difficile* as the IPAC resources appear overwhelmed.**

Determining the number of ICPs required to run an effective IPAC program is an inexact science; however several bodies have attempted to document and rationalize IPAC resources. In summary:

- The American SENIC study (1985) regarding infection control resources was the first of its kind.[9] Haley and colleagues recommended a minimum of 1 ICP per inpatient 250 beds. While a landmark study, this almost 30-year-old recommendation is also widely recognized as being out of date with respect to the role ICPs are now expected to play in patient safety and quality.

- A survey of participants of the American National Nosocomial Infection Surveillance system in 1999 identified a mean of 1 ICP per 115 inpatient beds[10].
- A Canadian Consensus Panel (2001) determined that roughly 3 ICPs were required per 500 inpatient beds.[11] Importantly this panel felt that this level of staffing was only appropriate in settings where there were no significant issues with antimicrobial resistant organisms, no hemodialysis programs, and no major subspecialty surgical programs.
- An American Delphi project (2002) recommended 1 ICP for every 100 inpatient beds, regardless of the acuity of care.[12]
- Following province-wide concern about *C. difficile*, the Quebec government recommended 1 ICP per 100 beds in acute care, 1 per 133 beds in hospital areas of lower acuity, and 1 per 250 beds in long term care.[13]
- The Ontario Provincial Infectious Disease Advisory Committee (PIDAC) has recently issued detailed recommendations for IPAC program requirements, including skill mix and staffing levels.[14] Specifically, PIDAC recommends:
    a) a minimum ratio of 1.0 FTE ICP per 115 acute care beds;
    b) a minimum ratio of 1.0 FTE ICP per 100 occupied acute care beds if there are high risk activities (e.g., dialysis);
    c) an additional ratio of 1.0 FTE ICP per 30 intensive care beds be considered where ventilation and haemodynamic monitoring are routinely performed;
    d) 1.0 FTE ICP per 150 occupied long-term care beds where there are ventilated patients, patients with spinal cord injuries and dialysis or other high acuity activities;
    e) 1.0 FTE ICP per 150-200 beds in other settings depending on acuity levels.

Based on the above, it is evident that the Fraser Health regional IPAC program does not meet any modern staffing recommendations. Burnaby Hospital and the Royal Columbian Hospital currently have a total of 4 ICPs who provide services for roughly 800 inpatient beds, including intensive care units, sub-specialty surgery services and a large trauma program as well as large outpatient programs. Furthermore, each ICP also has program responsibilities that involve areas outside of their facility. My impression after speaking with the ICPs at these sites was that they are clearly dedicated to their roles, but also overwhelmed. Their days are spent "putting out fires" and they are unable to work on more preventative activities.

4. **It is recommended that sporocidal agents (such 1:10 sodium hypochlorite or Virox Rescue) be used to clean inpatient rooms and bathrooms according to the following steps:**
    i. **Clean all inpatient rooms and bathrooms on the medicine units and other units/programs that have close associations with medicine due to transfer patterns (such as the ICU) twice daily with a sporocidal agent (depending on the agent used, this may require a first clean with detergent followed by a disinfection step using the sporocidal agent). The cleaning should focus on high**

touch surfaces and spend less time on walls and floors. This **should be done for approximately 1-2 weeks;**

ii. **Then scale back to twice daily sporocidal cleaning of all inpatient rooms and bathrooms only on units that continue to have a high incidence of nosocomial cases. Continue this approach until the incidence decreases;**

iii. **Then scale back to twice daily sporocidal cleaning only in *C. difficile* patient rooms and bathrooms. Continue this indefinitely.**

Should the number of either nosocomial cases or community cases rise on a unit to the point where IPAC feels there is a high burden of disease, the program should move back to step (ii) and clean the entire unit with sporocidal agents, scaling back once the number of cases decreases.

This cleaning recommendation is based on experience with controlling more than 30 *C. difficile* outbreaks (either unit based or facility-wide) and on the published literature regarding the ability of *C. difficile* spores to grossly contaminate the environment and be resistant to usual hospital disinfectants. Typically, infection control guidance documents recommend the use of sporocidal agents when in outbreak situations and/or on the advice of IPAC.[15] Given the rates of nosocomial *C. difficile* at the two hospitals and specifically on the inpatient medical floors, it is strongly recommended to take this aggressive approach.

The cleaning staff I spoke with appeared quite engaged in their work and clearly recognized the importance of their roles in patient safety. However, during my interviews there was a great deal of discussion around whether the existing Aramark contract would allow for any additional cleaning. This is an issue that needs to be quickly investigated and resolved.

We have learned that enhanced environmental cleaning can be accomplished quickly, as opposed to improving hand hygiene compliance and antimicrobial use, which require longer term behavioural change. This is why we aggressively focus on this component of *C. difficile* control while the program is working towards improving other control measures.

5. **Continue with antimicrobial stewardship efforts. Start with programs that are interested in stewardship rather than those that may appear to need the most help. Recognize that the stewardship process is slow and may need to be different for different programs.**

Antimicrobial stewardship is recognized by the program as a key area requiring development. Both hospitals have taken steps to develop antimicrobial stewardship by identifying key pharmacy resources; however the programs are not mature.

Limiting and rationalizing antibiotic use has been identified as a key component of *C. difficile* control.[16,17] In addition Accreditation Canada will shortly be announcing a new Required Organizational Practice relating to antimicrobial stewardship that will come into effect January 2013. Consequently, it is important that Fraser Health continue to build this program.

Having been involved in several stewardship programs, my experience is that the interpersonal skills of the pharmacists and physicians providing the feedback are critical to the success of the program. In addition the program receiving the feedback also has to be receptive to it, and have a desire to improve practice. My recommendation is thus to start in an area within the internal medicine program where physicians are the most open to feedback: ideally on nursing units where physicians have been requesting help with antibiotic choices. Once the program has had some success there, it can spread to other areas.

6. **There is a lack of point of care alcohol-based hand rub (ABHR) in several of the clinical areas visited. It is recommended that the program install more ABHR and that front line staff should be consulted on location. It is recognized that the current ABHR contract will soon be up for review; however, non-permanent options such as point of care brackets etc., could be used as a temporizing measure until a new product is chosen. It is recommended that front line staff should have a major say in choosing the next ABHR product, as they will be the ones using it. Encourage front line teams to develop their own visual reminders to help improve hand hygiene compliance.**

Having ABHR available at the point of care is considered a key requirement to improve hand hygiene compliance.[18] As an important patient safety measure that directly impacts patient morbidity and mortality, this issue needs to be addressed. As mentioned, there are multiple options available to improve point of care access without having to significantly modify nursing units. The Canadian Patient Safety Institute has commissioned an excellent human factors toolkit to help with the installation of ABHR which may be of help.

7. **As part of a larger hand hygiene program, the medicine program is encouraged to publically report (on the internet, using local signage etc.) program and unit hand hygiene compliance rates. These rates should be fed back widely throughout the medicine program along with other rates such as those for MRSA and *C. difficile*.**

Patient safety measures like hand hygiene are not top of mind for many healthcare workers. Feeding back data to front line staff and the public will help foster engagement. Furthermore, holding medical leaders and nurse managers accountable for hand hygiene compliance rates in their areas will send a clear message that the health region considers this important.

8. In addition to the *C. difficile* toolkit, it is recommended that the program deeply **engage front line staff in the locally appropriate ways to implement the best practices contained therein. Toolkits provide the "what" you need to do, but not the "how". Using liberating structures such as positive deviance should help with frontline engagement, empowerment, and compliance.**

Our program has used complexity science-based front line engagement techniques for several years and has found them to be highly effective at improving hand hygiene compliance and decreasing antibiotic resistant organisms such as MRSA.[19] We have also led several collaboratives through Safer Healthcare Now! to introduce these approaches to Canadian and American healthcare facilities.

Central to this approach is leadership stepping back, encouraging and allowing the front line to implement its own improvement ideas. While the end result of improvement efforts is standardized between areas i.e. effective cleaning, high level of compliance with hand hygiene etc., the route to get to improved practices is left up to individual areas. The BC Patient Safety and Quality Council has developed considerable expertise in this approach and is working with several BC hospitals.

9. **While crowded, the physical layouts of the medicine wards are not as challenging as many others. It has been recognized that clean and dirty utility rooms are not ideal on some floors. It is recommended that front line staff be consulted to determine the best layout of these rooms and to identify processes that work for them.**

Having visiting numerous hospitals, I found the physical layout at Burnaby Hospital and the Royal Columbian Hospital to be better than average from an infection control perspective. There are however areas that could be improved, in particular the clean and dirty utility spaces. As with recommendation #8, any renovation or changes to these spaces will be far more functional if the frontline are engaged in designing the changes.

10. **The program is currently using a cytotoxin assay to detect *C. difficile.* This test is highly sensitive and specific. The only significant drawback to this test is a slower turnaround time. The program could consider moving to a PCR-based testing platform, which has a similar sensitivity but a faster turnaround time. Given that the cytotoxin assay is relatively expensive, it may be that moving to PCR will not require a significant increase in laboratory funding.**

I understand that a pilot project using PCR testing for *C. difficile* is currently underway at a Fraser Health hospital. Information from this pilot can be used to model whether larger scale adoption of this technology is appropriate for the region.

11. **The program should consider revisiting its VRE control policies as other BC health regions have done. Considerable effort is being spent on controlling**

VRE, which leads to isolation fatigue and makes it harder to control *C. difficile* by using up precious isolation resources such as single rooms.

There is a growing movement to challenge existing Canadian VRE control policies that is being led by several Canadian academic teaching hospitals, including two BC centres. Current Canadian infection control guidelines recommend that VRE transmission be controlled based on the assumption that spread of VRE colonization will lead to increased VRE infections with serious adverse effects on patients, and out of concern that vancomycin resistance genes may be transferred to other organisms, including S. *aureus*.[20,21] Control measures include screening for VRE carriage on admission to hospital, and if VRE is detected, isolating patients in single rooms using contact precautions. Depending on the circumstances, patients may also be screened on discharge or transfer, and contacts of colonized patients may also be screened and possibly isolated pending the results of their screening tests. As VRE carriage is typically prolonged, this approach results in patients being isolated for long periods of time, including being isolated on repeat admissions.

The *status quo* is quite expensive and has the potential to undermine *C. difficile* control measures by competing for resources. *C. difficile* is a very real patient safety threat, while 20 years of experience with VRE has shown that it is not a significant cause of patient morbidity and mortality. Vancouver Island Health Authority stopped any significant VRE control measures more than a year ago and Vancouver General Hospital is considering similar significant changes to its program. It is recommended that Fraser Health discuss possible options for modifying the existing VRE program.

12. **The Aramark housekeeping staff appear quite dedicated to their tasks and understand the important role they have in patient safety. Given the additional cleaning being recommended, it may be that existing contracts will need to be revisited. The existing external auditing of housekeeping activities should continue. Furthermore, the program should ensure that appropriate occupational health and safety measures are taken to protect staff from exposure to caustic disinfection agents. Finally, housekeeping staff should be fully engaged in future improvement efforts and activities.**

As mentioned previously, those interviewed were unclear whether Aramark staff would be able to increase cleaning activities based on the existing contract. Several interviewees also expressed concern that an outside company may not be held accountable for upholding cleaning practices. In my experience, the quality of cleaning is less related to whether the cleaning services are delivered by local employees or from a contracted service, and more related to whether cleaning expectations are made clear to whoever is doing the work.

Given the recommended amount of disinfection with sporocidal agents, I would expect that some cleaning staff may develop some occupational health issues. While a 1:10 dilution of household bleach has been shown to be effective at killing *C. difficile* spores,

it is also more difficult to work with than other available sporocidal agents. Unfortunately other agents such as Virox Rescue are considerably more expensive than bleach.

As per recommendation #9, it would be very important to include Aramark staff in any local quality improvement projects.

13. **A standardized review process i.e. incident reporting system should be implemented for healthcare associated *C. difficile* infections. This would require nurse managers to review the *C. difficile* control measures on their units (including hand hygiene, environmental cleaning, antimicrobial stewardship etc.) which would help foster ownership. Incident reviews would also require the engagement of different team members, including physicians to discuss management issues and environmental services to discuss cleaning.**

In such a system, a new case of healthcare associated *C. difficile* or perhaps a cluster of cases would trigger an incident report that would require the treating team to consider and answer a series of questions, including:

- Was the patient in contact with other *C. difficile* patients? Were they isolated appropriately?
- Has this patient shared a room or bed previously occupied by a *C. difficile* patient?
- What are the cleaning protocols on this unit? Are they being followed?
- What is the hand hygiene compliance on this unit?
- How quickly was this patient diagnosed? How quickly were they isolated?
- How quickly were they started on treatment? What drug? Correct dose?
- Did this patient receive antibiotics? What drug and how long? What was the indication? Were the antibiotics necessary?

Typically the first few times teams are required to think about these questions they are a bit lost. Over time however this process typically highlights multiple patient safety and quality issues that have not previously been focused upon. We have used a similar process at my own hospital and it has proven to be quite useful in raising awareness of the issues that can cause *C. difficile* outbreaks, fostering local ownership, and helping to create innovative solutions.

Conclusion

The Fraser Health medicine programs at Burnaby Hospital and the Royal Columbian Hospital are facing considerable *C. difficile* related issues including high healthcare associated rates, a lack of infection control resources and current confusion around ownership of the issue. These and other issues are not insurmountable; however it will likely take a concerned effort to get *C. difficile* under control.

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Boomer, Joanne HLTH:EX

From: Whitmarsh, Graham HLTH:EX
Sent: Thursday, March 1, 2012 11:58 AM
To: XT:HLTH Murray, Nigel
Subject: Fwd: Cdif

This must not go until we see it

Sent from my iPhone

Begin forwarded message:

> **From:** "Stewart, Michelle GCPE:EX" <Michelle.Stewart@gov.bc.ca>
> **Date:** 1 March, 2012 11:54:07 AM PST
> **To:** "XT:Nuraney, Naseem GCPE:IN" <Naseem.Nuraney@fraserhealth.ca>, "Jabs, Ryan GCPE:EX" <Ryan.Jabs@gov.bc.ca>, "Whitmarsh, Graham HLTH:EX" <Graham.Whitmarsh@gov.bc.ca>, "Davidson, Heather (ADM) HLTH:EX" <Heather.Davidson@gov.bc.ca>
> **Cc:** "XT:Thorpe, Roy HLTH:IN" <Roy.Thorpe-Dorward@fraserhealth.ca>
> **Subject: RE: Cdif**
>
> WE NEED TO SEE IT FIRST _ DO NOT SEND UNTIL WE GIVE GO-AHEAD
>
> Michelle Stewart, Communications Director
> Ministry of Health, Government Communications & Public Engagement
> Phone: 250-952-1889 Cell: 250-812-5571 Fax: 250-952-1883
> Michelle.Stewart@gov.bc.ca

From: Nuraney, Naseem [mailto:Naseem.Nuraney@fraserhealth.ca]
Sent: Thursday, March 1, 2012 11:50 AM
To: Stewart, Michelle GCPE:EX; Jabs, Ryan GCPE:EX
Subject: Cdif

Roy will be sending our news release shortly - just refining after Andy/Nigel review. Will go out for noon with the review.

Media we will do right after:
Sunny Dillon, Globe and Mail
Jonathon Fowlie, Vancouver Sun
Simi Sara Show, CKNW
Jeff Nagel, Black pres

.....
Naseem Nuraney
Director Public Affairs
Communications and Public Affairs
Fraser Health | Better Health. Best in Health Care.
office: 604-587-4606
mobile: S17
Follow us: http://twitter.com/Fraserhealth

Boomer, Joanne HLTH:EX

From: Whitmarsh, Graham HLTH:EX
Sent: Thursday, March 1, 2012 2:29 PM
To: XT:HLTH Murray, Nigel
Subject: CDiff

Which 3 recommendations of the Gardom report are you not implementing?

Boomer, Joanne HLTH:EX

From: Whitmarsh, Graham HLTH:EX
Sent: Friday, March 2, 2012 1:19 PM
To: XT:HLTH Murray, Nigel
Subject: Some quick thoughts of messaging

We take the issues raised in burnaby with the utmost seriousness I know our Board and our entire executive team is committed to full implementation of the recommendations....and we intend to work proactively with the physicians at Burnaby General on ensuring their concerns are addressed This includes looking closely at our existing resources for infection control and ensuring our actions and the follow-up measures we take are transparent to the public.... It is because of our commitment that we brought in Dr. Gardam in the fall - to help guide us in our actions.
We expect every member of our staff to play a role in infection control.

If asked about the second letter:

Yes I can confirm the physicians have now responded to our letter and I have called/will call for a meeting in person to discuss these important issues face to face.

Boomer, Joanne HLTH:EX

From: Whitmarsh, Graham HLTH:EX
Sent: Sunday, March 4, 2012 5:51 PM
To: XT:Mitchell, David HLTH:IN
Subject: Re: Monday....

We will see. This is the Ministers call, so we will make the most of it.

On 2012-03-04, at 2:10 PM, "Dave Mitchell" <DMitchell@knv.com> wrote:

> I'll be there,
>
> Province page 22 today.
>
> Are we breathing life into a story that has run its course?
> I hope not
> See you in the morning
> Dave
> ---
> David W. Mitchell, CA
> KNV Chartered Accountants LLP
> 200 - 15300 Croydon Drive
> Surrey, B.C. V3S 0Z5
> Phone: 604-536-7614
> Toll Free: 1-800-761-7772
> Fax: 604-538-5356
>
> ---
>
> **From:** Whitmarsh, Graham HLTH:EX [mailto:Graham.Whitmarsh@gov.bc.ca]
> **Sent:** Sunday, March 04, 2012 01:45 PM
> **To:** Dave Mitchell
> **Subject:** Fwd: Monday....
>
> FYI will I see you there?
>
> Begin forwarded message:
>
> > **From:** "Maksymetz, Richard HLTH:EX" <Richard.Maksymetz@gov.bc.ca>
> > **Date:** 4 March, 2012 1:42:45 PM PST
> > **To:** "Stewart, Michelle GCPE:EX" <Michelle.Stewart@gov.bc.ca>, "Whitmarsh, Graham HLTH:EX" <Graham.Whitmarsh@gov.bc.ca>
> > **Cc:** "Porter, Rodney GCPE:EX" <Rodney.Porter@gov.bc.ca>, "Wright, Jenn HLTH:EX" <Jenn.Wright@gov.bc.ca>, "Jabs, Ryan GCPE:EX" <Ryan.Jabs@gov.bc.ca>
> > **Subject: RE: Monday....**
> >
> > Dr. Kirby will be emailing his list of attendees to me in the next 2 hours, I've asked him to keep it to a maximum of 6 people including himself. I assume the attendees on our end will be the Minister, Graham, Nigel, David Mitchell, and Kathy Heritage from Burnaby General - anybody else?

Meeting is from 10:30am to 11:30am.

Minister will be on site around 10:10am - we'll need a holding area or a private room where he can go over some last minute messaging with Graham prior to the start of the meeting. The Minister doesn't require any printed materials outside of what has already been provided, wants all of the attendees in the room upon his arrival, including FHA folks. He wants to scrum around 11:45am (allows for a bit of flex in between the meeting end in case there is any messaging to work out from the meeting. He wants to scrum by himself (no Nigel, no Dr. Kirby in the shot) but thinks they should be nearby in case the media wants comments from them.

It would be preferable if the backdrop for the scrum has the words Burnaby General somewhere in the shot. Although we're all in agreement that a tour is probably unnecessary, if there is some opportunity for some b-roll to be filmed very quickly in the immediate vicinity (ie him nearby some medical equipment or talking to a health care professional) that would be good. That's it for now.

Richard

-----Original Message-----
From: Stewart, Michelle GCPE:EX
Sent: Sunday, March 4, 2012 1:24 PM
To: Maksymetz, Richard HLTH:EX; Whitmarsh, Graham HLTH:EX
Cc: Porter, Rodney GCPE:EX; Wright, Jenn HLTH:EX; Jabs, Ryan GCPE:EX
Subject: Re: Monday....

Thanks!

----- Original Message -----
From: Maksymetz, Richard HLTH:EX
Sent: Sunday, March 04, 2012 01:22 PM
To: Stewart, Michelle GCPE:EX; Whitmarsh, Graham HLTH:EX
Cc: Porter, Rodney GCPE:EX; Wright, Jenn HLTH:EX; Jabs, Ryan GCPE:EX
Subject: Re: Monday....

I'll have a number of updates in the next 30 mins.

----- Original Message -----
From: Stewart, Michelle GCPE:EX
Sent: Sunday, March 04, 2012 01:19 PM
To: Maksymetz, Richard HLTH:EX; Whitmarsh, Graham HLTH:EX
Cc: Porter, Rodney GCPE:EX; Wright, Jenn HLTH:EX; Jabs, Ryan GCPE:EX
Subject: Re: Monday....

Re-sending as we need to sort out today to get things in order for am....

----- Original Message -----

From: Stewart, Michelle GCPE:EX
Sent: Sunday, March 04, 2012 07:20 AM
To: Maksymetz, Richard HLTH:EX; Whitmarsh, Graham HLTH:EX
Cc: Porter, Rodney GCPE:EX; Wright, Jenn HLTH:EX; Jabs, Ryan GCPE:EX
Subject: RE: Monday....

For the sake of argument - there is another option and that is proceeding with the meeting without a formal media avail.....
We won't really know until tomorrow whether the wind has died out of this - but the story in the Province this morning was really straight up and focussed a lot on hand=washing.....

From: Stewart, Michelle GCPE:EX
Sent: Sunday, March 04, 2012 7:04 AM
To: Maksymetz, Richard HLTH:EX; Whitmarsh, Graham HLTH:EX
Cc: Porter, Rodney GCPE:EX; Wright, Jenn HLTH:EX; Jabs, Ryan GCPE:EX
Subject: FW: Monday....

couple of things we need to nail down....

1. do we have the complete list of attendees now? did dr. kirby provide a list of names as we'll need to get a complete list to the security folks at burnaby general - including who is accompanying the minister
2. Is the scrum/availability after the event just the minister - or does he want to be flanked by Nigel....or Dr. Kirby or both....on that front see below from fraser health
3. Are we going to allow for other media to listen in? has largely been a gallery story but assume minister can talk to them when he is back in victoria....
4.do we need to allow for any kind of pre-brief before the meeting....with nigel/graham/the board chair?
5. rodney can we arrange for someone on the vancouver side to record the media avail - or should we leave that to whoever is accompanying the minister...

From: Nuraney, Naseem [Naseem.Nuraney@fraserhealth.ca]
Sent: Saturday, March 03, 2012 9:37 PM
To: Stewart, Michelle GCPE:EX; Porter, Rodney GCPE:EX
Cc: Jabs, Ryan GCPE:EX
Subject: Re: Monday....

Nigel is happy to be with him, but it would be awkward for Kirby to be there as well.
Is the expectation that the minister will have Nigel and Dr Kirby at the scrum together?

-----Original Message-----
From: Nuraney, Naseem [mailto:Naseem.Nuraney@fraserhealth.ca]
Sent: Fri, March 2, 2012 9:44 PM

To: Stewart, Michelle GCPE:EX; Maksymetz, Richard HLTH:EX; Wright, Jenn HLTH:EX; Whitmarsh, Graham HLTH:EX
Cc: Porter, Rodney GCPE:EX; Jabs, Ryan GCPE:EX
Subject: Re: Monday....

The meeting will take place in the Board Room on the Ground floor.

We will meet the Minister/DM at the entrance of the Optimization Clinic (also on the ground floor) and I can take them to the Board Room

If someone can please call me when you are arriving that would be helpful. My cel: S17

If media scrum is being considered I would suggest media meeting at the Patient Education Centre located on the Main floor off parkade entrance.

If there are any changes to this plan I will let you know.

Thank you.

------Original Message------
From: Michelle Stewart
To: Richard HLTH:EX Maksymetz
To: Jenn HLTH:EX Wright
To: Graham HLTH:EX Whitmarsh
Cc: Naseem Nuraney
Cc: Rodney PAB:EX Porter
Cc: Ryan Jabs
Subject: Re: Monday....
Sent: Mar 2, 2012 8:26 PM

Great and thanks

----- Original Message -----
From: Maksymetz, Richard HLTH:EX
Sent: Friday, March 02, 2012 08:26 PM
To: Stewart, Michelle GCPE:EX; Wright, Jenn HLTH:EX; Whitmarsh, Graham HLTH:EX
Cc: XT:Nuraney, Naseem GCPE:IN; Porter, Rodney GCPE:EX; Jabs, Ryan GCPE:EX
Subject: Re: Monday....

Yes, let Dr. Kirby know that time. He is emailing me the list of attendees from their side (should be 5-6 in total). We should keep the total meeting to a max of 10-12 participants. Re-emphasized that it is a closed event and that they shouldn't talk to the media about the meeting prior to it starting.

----- Original Message -----
From: Stewart, Michelle GCPE:EX
Sent: Friday, March 02, 2012 08:13 PM
To: Maksymetz, Richard HLTH:EX; Wright, Jenn HLTH:EX; Whitmarsh,

Graham HLTH:EX
Cc: XT:Nuraney, Naseem GCPE:IN; Porter, Rodney GCPE:EX; Jabs, Ryan GCPE:EX
Subject: Re: Monday....

Richard did you tell the folks you talked to 1030? Graham will you let board chair know?

----- Original Message -----
From: Maksymetz, Richard HLTH:EX
Sent: Friday, March 02, 2012 06:59 PM
To: Stewart, Michelle GCPE:EX; Wright, Jenn HLTH:EX; Whitmarsh, Graham HLTH:EX
Cc: XT:Nuraney, Naseem GCPE:IN; Porter, Rodney GCPE:EX; Jabs, Ryan GCPE:EX
Subject: Re: Monday....

Make it a 10:30-11:30am meeting instead of a 10:00am start.

----- Original Message -----
From: Stewart, Michelle GCPE:EX
Sent: Friday, March 02, 2012 05:44 PM
To: Maksymetz, Richard HLTH:EX; Wright, Jenn HLTH:EX; Whitmarsh,

------Original Message Truncated------

Boomer, Joanne HLTH:EX

From: Schroeder, Tracey [Tracey.Schroeder@fraserhealth.ca]
Sent: Thursday, March 8, 2012 11:41 AM
To: Boomer, Joanne HLTH:EX
Subject: RE: Daily Burnaby Hospital Conference Calls

Thanks Joanne. I will get back to you once logistics have been sorted out on this end.

Tracey L. Schroeder
Executive Assistant to the President and CEO
Fraser Health

PLEASE NOTE NEW ADDRESS
Suite 400, Central City Tower
13450 102nd Avenue
Surrey, BC V3T 0H1
phone: 604-587-4624
fax: 604-587-4666
email: tracey.schroeder@fraserhealth.ca

From: Boomer, Joanne HLTH:EX [mailto:Joanne.Boomer@gov.bc.ca]
Sent: March 8, 2012 11:30 AM
To: Schroeder, Tracey
Subject: Daily Burnaby Hospital Conference Calls

Hi Tracey, I understand that Fraser Health Authority will be scheduling daily 15 minute conference calls regarding Burnaby Hospital. Would you be including the following from Ministry of Health? Graham Whitmarsh, John Bethel, Elaine McKnight, Heather Davidson and Michelle Stewart. Thanks.

Joanne Boomer | Senior Executive Assistant
Office of the Deputy Minister | Ministry of Health
5-3, 1515 Blanshard Street | Victoria BC | V8W 3C8
P: 250-952-1590 | F: 250-952-1909

WIN like you're used to it. LOSE like you enjoy it. (Jeremy Gutsche)