



Interior Health

**Annual Infection Prevention
&
Control Report

2010– 2011**

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Executive Summary

In order to provide a safe environment for patients, staff and visitors the Interior Health Infection Prevention and Control (IPAC) Program has three principle goals in preventing infectious agents from spreading within the healthcare environment:

- Protect the patient, healthcare provider, visitors and others in the healthcare environment.
- Follow established guidelines and protocols to improve our current infection rates.
- Accomplish these goals in a cost-effective manner whenever possible.

SURVEILLANCE

- Expanded the residential surveillance processes to include all Interior Health sites.
- Healthcare Associated Infections (HAI) Residential indicators:
 - Lower Respiratory Tract Infection (LRI)
 - Skin & Soft Tissue Infection (SSTI)
 - Clostridium *difficile* Infection (CDI)
 - Catheter Associated Urinary Tract Infection (CAUTIs)
- HAI Acute indicators:
 - CDI, Surgical Site Infection (SSI)
 - Antibiotic Resistant Organisms (AROs)
 - Ventilator Associated Pneumonias (VAPs)
 - Central Line Infections (CLIs)
- Determined Interior Health Hand Hygiene Initiative (IH HHI) benchmarks.
- Ongoing development of Insight Reports for data analysis and reporting.

EDUCATION

- Ongoing development of educational tools for Infection Control Practitioners.
- Initiated the IPAC Link Nurse program at Royal Inland Hospital, providing the inaugural education session for 20 participants.
- Hand Hygiene Program now includes 'Your Four Moments'. Ongoing education is provided to all healthcare providers.
- Two educational face to face meetings were provided:
 - Positive Deviance – Positive deviance tools were used to identify IPAC program priorities
 - Surveillance
 - Dr. Blondel-Hill presented on ARO's

ACHIEVEMENTS

- Presented Hand Hygiene Poster at Community & Hospital Infection Control Association-Canada (CHICA-Canada) annual conference.
- A major project was completed. The IPAC Manual was completely updated with standardized formatting and links to include external references.
- Dr. Edith Blondel-Hill, Medical Director, Infection Prevention & Control received the following awards:
 - The **Interior Health (IH) Award of Excellence** for her contribution to the Quality Work & Service Recognition Program, which is meant to help promote a workplace climate of respect, recognition, and health by recognizing the outstanding work of Interior Health's staff, managers, leaders, volunteers and physicians.
 - A **Healthcare Hero (Interior Health) Gold Apple** for being a driving force behind the national *Do Bugs Need Drugs* campaign for antimicrobial stewardship and handwashing and the *Bugs and Drugs* antimicrobial reference guide for Canadian clinicians. Through her leadership, these programs have reached millions of Canadians who have learned about the inappropriate use of antibiotics and the importance of regular handwashing.
 - **British Columbia Medical Association (BCMA) Award of Excellence**

Based on this year's report, the key priorities for next year will be:

Priority 1:

Developing & implementing a new application for electronic HAI surveillance processes. An Epidemiologist will be recruited to support the program.

Priority 2:

Ensuring Hand Hygiene meets the expectations of the Auditor General and the Ministry of Health. A Project Leader will be recruited to support the program.

Priority 3:

Reviewing auditing processes to include appropriate follow-up to improve outcomes and ensure implementation of best practice.

Priority 4:

Developing the IPAC Link Nurse Program for implementation with a phased in approach across Interior Health.

Introduction

INFECTION PREVENTION AND CONTROL PROGRAM

Infection Prevention & Control is a corporate program with a Corporate Director and a Medical Director under the administrative direction of the VP, Medicine/Quality.

The overarching goal of Infection Prevention and Control is to prevent infections from occurring in patients, residents, clients, visitors, physicians and employees. If, for whatever reason, an individual with an infection is in a facility or program, the goal of Infection Prevention and Control is to prevent the infectious agent from spreading to others.

Key improvements to monitoring infection prevention & control practices and improving safety for patients/residents/clients have been made. It is our intention to do everything possible to reduce the risk of infections.

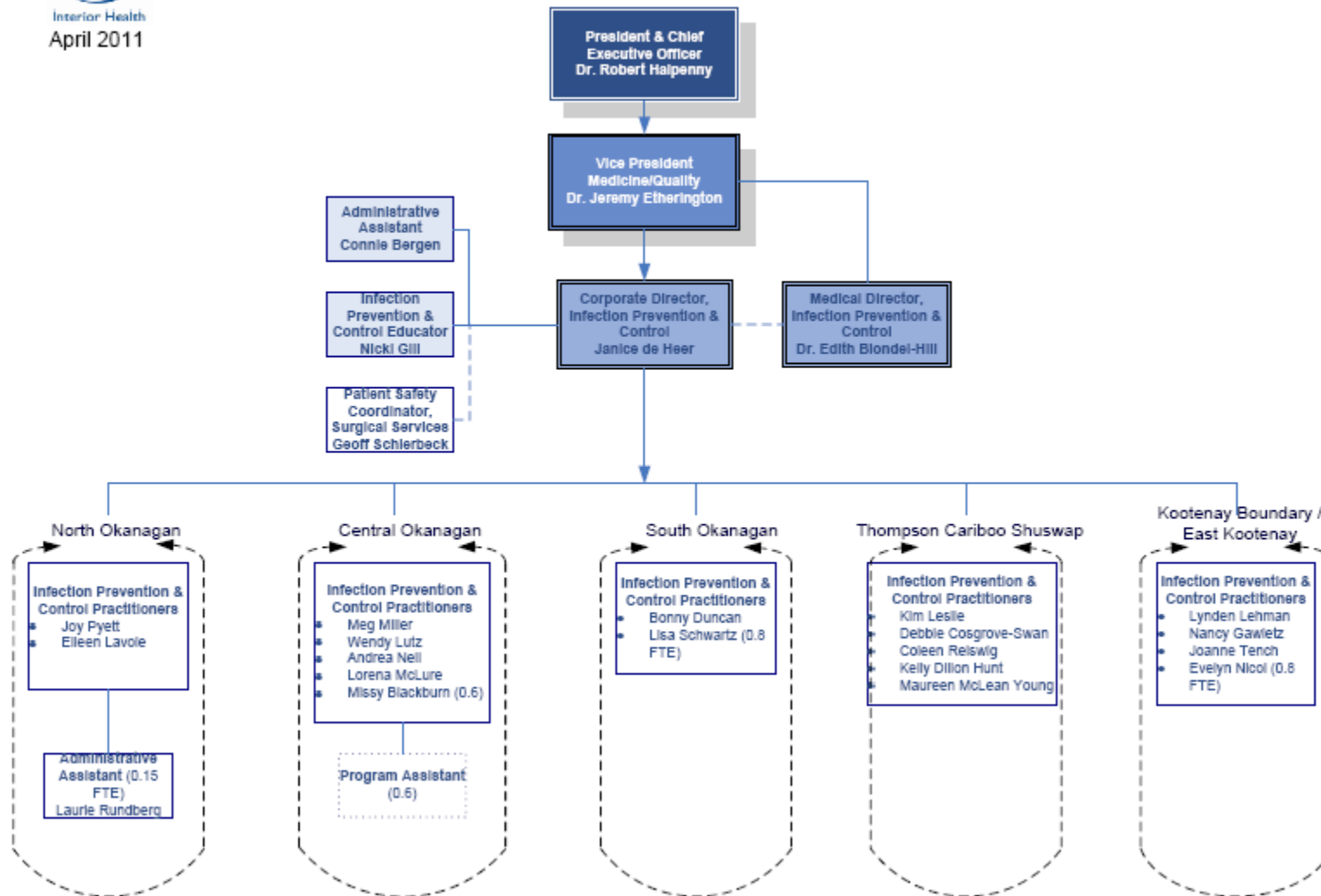
The Infection Monitoring Prevention and Control Team (IMPACT), formerly Health Authority Infection Prevention & Control Committee (HAIPCC), will report, via the minutes to Health Authority Medical Advisory Committee (HAMAC), the Senior Executive Team, and the Board Quality Care Committee. Twice a year, Dr. Blondel-Hill will present an in person report to HAMAC.

The Senior VP, Medicine/Quality is designated as the SET member responsible for the IMPACT.

Infection Prevention and Control crosses sectors, departments, and communities. Infection Prevention and Control liaises across the continuum with other programs such as Public Health in regards to communicable disease and outbreak management.

For this reason there is an extensive network of committees responsible for Infection Prevention & Control. For purposes of practice, the IPAC Practice Committee provides recommendations through the Infection Prevention & Control Corporate Director to the IMPACT. For purposes of communication and quality, minutes from the fifteen sites and community Infection Prevention & Control committees are reviewed by the Corporate Director and issues are taken forward to IMPACT as required.

Infection Prevention & Control (IP&C)



ACKNOWLEDGEMENTS

Infection Prevention & Control would like to thank

- IH Medical Microbiology departments
- Dr. Dwight Ferris, Infectious Disease Physician
- IH Medical Health Officers

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INFECTION CONTROL PRACTITIONERS Contact List


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- D -			
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- G -			
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- P -			
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- R -			
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Note: If you are within the same community do not use the QuickDial option.

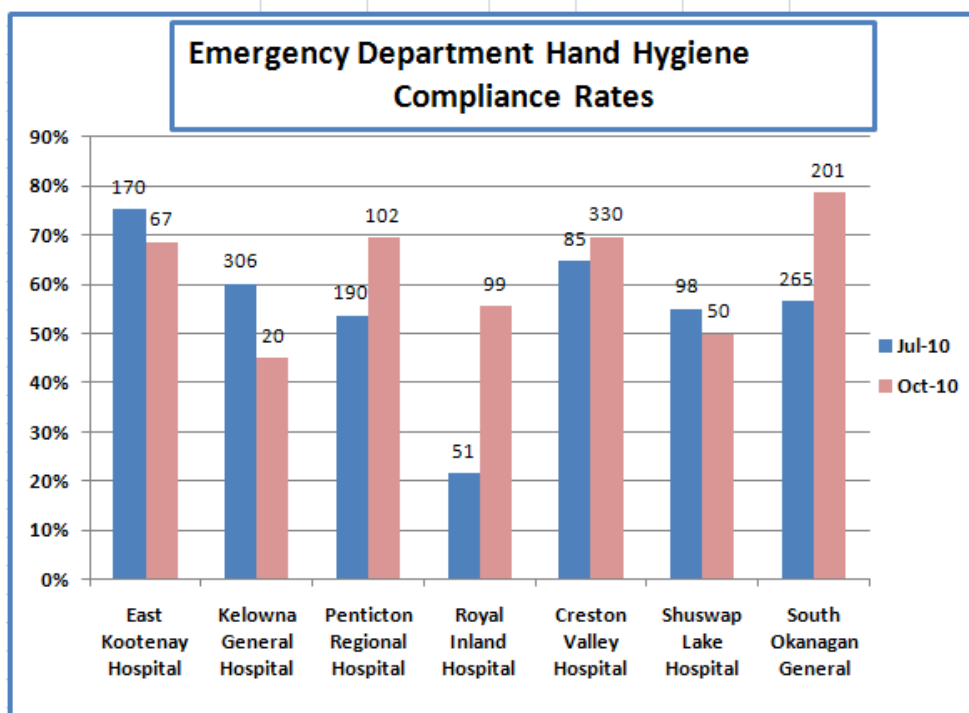
Health Care Associated Infection (HAI) Indicators




HAND HYGIENE COMPLIANCE

Trend*	Target	Actual
	To increase hand hygiene compliance and reduce HAIs	68%

The Interior Health Hand Hygiene Initiative's goal to increase hand hygiene compliance and reduce health care associated infections continues to be the focus of this program. The most recent 2010 initiative focused on hand hygiene compliance in Emergency Departments throughout the health authority. Emergency Departments (ED) were selected based on their low compliance rates in a previous audit. The same audit tool and methodology were employed as in previous audits. The facilities included were two tertiary sites, 2 regional sites and 2 community sites.

The pre audit hand hygiene (HH) compliance rate in ED averaged 59% and increased to 68% by the end of the 4 month implementation. Further audits were not completed due to the proposed Provincial Program being implemented across all health authorities.




*  = improving; at least 4 consecutive data points moving towards target  = deteriorating; at least 4 consecutive data points moving away from target  = steady; fewer than 4 consecutive data points moving in either direction

Healthcare workers audited were categorized as follows:

- Nursing - registered nurses, licensed practical nurses, health care aids and nursing students
- Medical - physicians and medical students
- Clinical Support Staff - physiotherapists, occupational therapists, respiratory therapists & radiology technologists
- Support Services - client transporters, dieticians, food services, housekeeping and maintenance staff

The next phase of the IH HHI will be based on the requirements of the Provincial Hand Hygiene Working Group (PHHWG).

Clostridium *difficile* Infections (CDI) Incidence Rate

TREND* 	Target Zero	Actual 0 – 15.90 cases per 10,000 patient days
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What is being measured?

The incidence rate of *Clostridium difficile* infection (CDI) per *10,000 patient days*, which is the number of new cases of CDI acquired by patients as a result of their stay in a hospital, divided by the total number of inpatient days over a specified time frame.

PICNet Definition:

A diagnosis of CDI applies to a person with:

- Acute onset of diarrhea (> 3 loose stools within a 24 hr period) without another etiology (loose stool is defined as that which takes the shape of the container that holds it).

And one or more of the following:

- Laboratory confirmation (positive toxin or culture with evidence of toxin production)

OR

- Diagnosis of typical pseudo-membranes on sigmoidoscopy or colonoscopy or histological/pathological diagnosis of CDI.

OR

- Diagnosis of toxic megacolon.

Source:

Quality Management Enterprise – QME (computerized surveillance program).

Target:

Interior Health’s annual target is zero.

Benchmark & Comparators:




IH Benchmark: **6 per 10,000 patient days.**

PICNET benchmark:

[http://www.picnet.ca/uploads/files/CDI Surveillance Report FY2010 11%20final.pdf](http://www.picnet.ca/uploads/files/CDI_Surveillance_Report_FY2010_11%20final.pdf)

Trend:

The rates of CDI are Increasing at 50% of the sites whose rates are above the IH benchmark of 6 cases per 10,000 patient days.

*  = improving; at least 4 consecutive data points moving towards target  = deteriorating; at least 4 consecutive data points moving away from target  = steady; fewer than 4 consecutive data points moving in either direction

Explanation:

- Four small rural sites had increased rates of CDI – with less patient days, ongoing single cases significantly increases the incidence rate of CDI.
- One tertiary site had steady rates above the benchmark.

Over the past year the following actions have been taken to reduce the incidence of CDI:

- Review of antibiotic utilization
- Review patient placement.
- Review of cleaning of the patient care environment
- Pre-printed physician orders for the appropriate treatment of CDI available across IH
- Outbreak Management Guidelines for CDI are now included in the IPAC Manual

Methicillin-resistant *Staphylococcus aureus* (MRSA) Incidence Rate

Trend* ➔	Target Zero	Actual 0 – 14.28 cases/10,000 patient days
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What is being measured?

The incidence rate of Methicillin-resistant *Staphylococcus aureus* (MRSA) cases per **10,000 patient days**, which is the number of new cases of MRSA acquired by patients as a result of their stay in hospital or previous contact with a healthcare facility or program, divided by the total number of inpatient days over a specified time frame.

Definition (currently being developed by PICNet):

An MRSA case is defined as meeting ALL of the following criteria:

- Not previously positive for MRSA **AND**
 - Current hospitalization > **3 calendar days** (unless an indwelling medical device in place) **OR**
 - Prior contact with any Health Care facility including surgery, dialysis and LTC admissions **in previous 12 months OR**
 - Newborns if mother not known to be a case on admission or suspected to be colonized
 - **Does not include** Emergency Room and Ambulatory Care outpatient visit
 - **Data collected for acute inpatients only** as of September 17, 2010

Source:

Quality Management Enterprise – QME (computerized surveillance program).

Target:




Interior Health's annual target is zero.

Benchmark & Comparators:

IH Benchmark: **5.6 per 10,000 patient days.**

Trend:

The MRSA rates are decreasing at most sites and are below the benchmark of 5.6.

*  = improving; at least 4 consecutive data points moving towards target  = deteriorating; at least 4 consecutive data points moving away from target  = steady; fewer than 4 consecutive data points moving in either direction


Explanations

One rural site and one regional site identified increasing trends of MRSA cases. This may be due to increasing amounts of MRSA circulating in the Community.

Actions over the past year:

- Review of admission screening processes for MRSA to ensure these are being followed appropriately
- Review of appropriate use of Contact Precautions with patients with MRSA
- Reinforce appropriate staff hand hygiene practices
- Review the process for patient care environment cleaning.

Vancomycin-Resistant *Enterococci* (VRE) Incidence Rate

Trend* 	Target Zero	Actual 0 – 10.64 cases/10,000 patient days
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What is being measured?

The incidence rate of Vancomycin-Resistant *Enterococci* (VRE) per 10,000 patient days, which is the number of new cases of VRE acquired by patients as a result of their stay in hospital or previous contact with a healthcare facility or program, divided by the total number of inpatient days over a specified time frame.

Definition:

A VRE case is defined as meeting ALL of the following criteria:

- Not previously positive for VRE **AND**
 - Current hospitalization > 3 calendar days (unless an indwelling medical device in place) **OR**
 - Prior contact with any Health Care facility including surgery, dialysis and LTC admissions in previous 12 months **OR**
 - Newborns if mother not known to be a case on admission or suspected to be colonized
 - **Does not include** Emergency Room and Ambulatory Care outpatient visit
 - **Data collected for acute inpatients only** as of September 17, 2010

Source:

Quality Management Enterprise – QME (computerized surveillance program).

Target:




Interior Health's annual target is zero.

Benchmark & Comparators:

IH Benchmark: **1.1 per 10,000 patient days.**

Trend:

Significant increases were identified throughout the last half of the year in most sites that exceeded the benchmark of 1.1 cases per 10,000 patient days.

*  = improving; at least 4 consecutive data points moving towards target  = deteriorating; at least 4 consecutive data points moving away from target  = steady; fewer than 4 consecutive data points moving in either direction

Explanations


This increase correlates with additional screening for VRE of stool samples submitted for *Clostridium difficile* testing.

Point prevalence studies were implemented during an outbreak at Kelowna General Hospital (KGH) which significantly increased the rate of VRE cases.

Actions over the past year:

- Outbreak Management Team established at KGH
- Review of admission screening processes for VRE to ensure these are being followed appropriately
- Review of appropriate use of Contact Precautions with patients with VRE
- Reinforce appropriate staff hand hygiene practices
- Review cleaning of the patient toileting facilities, including commodes
- Implementation of collaborative cleaning processes with nursing and housekeeping staff
- Reinforce reducing clutter in the patient care areas

Surgical Site Infection (SSI) Incidence Rate

Trend* 	Target Zero	Actual Clean SSI rate 0-1.43% Clean Contaminated SSI rate 0 – 1.59%
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What is being measured?

The overall incidence rate of Clean SSIs and Clean Contaminated SSIs.

Definitions:

(Reference National Healthcare Safety Network (NHSN) 2008

An infection in the area affected by a surgery within 30 days of the procedure, or within 365 days if an implant is in place and infection related to the operative procedure. Surgeries under surveillance do not include those without an incision or surgeries performed in the Ambulatory Care setting.

Clean Wounds (Class I) – uninfected operative wound in which no inflammation is encountered, involve access only to the sterile body sites and carry the lowest risk (e.g. less than 5%) of surgical site infection.

Clean-Contaminated Wounds (Class II) – those in which respiratory, gastrointestinal, urinary, or genital tracts were involved under controlled conditions and without unusual contamination. A minor break in surgical sterile technique in an otherwise clean procedure would fit into this class.

Source:

Quality Management Enterprise – QME (computerized surveillance program).

Target:




Interior Health’s annual target is zero.

Benchmark & Comparators:

IH Benchmark: **less than 1% for clean and clean contaminated surgeries.**

Trend:

In most sites the Clean SSI rate and Clean Contaminated SSI rates are consistently low. Four sites are marginally above the IH benchmark of 1%.

*  = improving; at least 4 consecutive data points moving towards target  = deteriorating; at least 4 consecutive data points moving away from target  = steady; fewer than 4 consecutive data points moving in either direction

Explanation:

- Smaller rural sites performing surgeries do not have computerized technology for SSI surveillance data collection and analysis.
- Due to the small number of surgeries in some sites one infection will significantly increase the incidence rates.
- Procedures done in Ambulatory Care are not standardized throughout IH. This may result in inconsistencies related to “excluded procedures”.

Actions taken over the past year:

- As increasing SSI trends are identified, assessments of processes and practices related to the surgical procedure are completed. Recommendations are then made to Surgical Services to improve outcomes.



Ventilator Associated Pneumonia (VAP) Incidence Rate

Trend* 	Target Zero	Actual 0 – 11.30 VAPs/1000 ventilator days
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What is being measured?

The incidence rate of Ventilator Associated Pneumonias per **1,000 ventilator days**, which is the number of new cases of VAP acquired by patients as a result of their stay in ICU and being on a ventilator divided by the total number of ventilator days over a specified time frame.

Definition:

A VAP case is defined as meeting ALL of the following criteria:

- Clinical presentation meets criteria for Pneumonia, including x-ray confirmation - **there is no minimum time for a patient to be on a ventilator.**
- Pneumonia identified by using a combination of the following criteria:
 - Radiologic - two or more serial chest x-rays with new or progressive & persistent infiltrate, consolidation, cavitation (only one x-ray if no lung/heart disease).
 - Clinical S&S- breath sounds, fever, altered mental status, sputum, cough, increased respiratory rate or oxygen needs.
 - Lab - sputum culture, elevated WBC.

Source:

Quality Management Enterprise – QME (computerized surveillance program).

Target:

Interior Health's annual target is zero.




Benchmark & Comparators:

IH Benchmark: **5 per 1,000 ventilator days.**

NHSN

CDC National Healthcare Safety Network

<http://www.cdc.gov/nhsn/PDFs/dataStat/2009NHSNReport.pdf>

*  = improving; at least 4 consecutive data points moving towards target  = deteriorating; at least 4 consecutive data points moving away from target  = steady; fewer than 4 consecutive data points moving in either direction

Trend:

Kootenay Boundary Regional Hospital has decreased their rates by 50% over the past year.

Explanation:

- Smaller sites have significantly less ventilator days, so one VAP case can significantly increase the overall incidence rate.

Actions over the past year:

- Each VAP case is investigated to determine potential risk factors and recommendations made to staff to improve outcomes.

Outbreaks

Infection Prevention & Control reports all outbreaks to Interior Health's Communicable Disease Unit where statistics are generated and reported to British Columbia Centre for Disease Control (BCCDC).

Ongoing surveillance continues for the following outbreaks:

- Tuberculosis
- Respiratory Illness including influenza
- Gastrointestinal Illness including Norovirus

Additional information on IH Outbreaks can be accessed by viewing the Communicable Disease Annual Report 2010 located on the CD website under Activity Reports:

[http://inet.interiorhealth.ca/clinical/PH/CDunit/Documents/IH%20CD%20Annual%20Report%202010%20v2.0 %20dmc final.pdf](http://inet.interiorhealth.ca/clinical/PH/CDunit/Documents/IH%20CD%20Annual%20Report%202010%20v2.0%20dmc%20final.pdf)

Education

Ongoing education provided to healthcare workers includes review of:

- Routine Practices (including hand hygiene)
- Additional Precautions
- Specific Diseases (as incidents arise)
- Outbreak Management
- IPAC Manual Updates

Infection Prevention & Control was involved in the development of presentations including Cleaning Patient Equipment, Housekeeping & Infection Control, Outbreaks for Frontline Staff, Measles Mumps Rubella and Influenza Staff Education.

Developed presentations for two face-to-face IPAC meeting days.

Workshop prepared and presented for the initial education day for IPAC Link Nurse.

In addition Infection Control Practitioners (ICPs) attended various training sessions including the following:

Type	Description	Participants	Estimated Time
Teleclasses	Webber training	Available to all IH ICPs	Occur weekly
Conference	CHICA 2010 Annual Conference in Vancouver”	Attended by 6 ICPs	5 days per participant
On site and by phone, computer and Live Meetings	Orientation/training of ICPs	1 new ICP (Residential) 1 Acute with previous residential experience	10 days per participant
Education Workshop	Canadian Patient Safety Institute (CPSI) Conference/Workshop on Hand Hygiene in Vancouver	1 ICP	1 day
Education Workshop	Canadian Nosocomial Infection Surveillance Program (CNISP) in Ottawa	Attended by 2 ICPs	2 days per participant
Quality Conference	Unleashing Creative Action at the Front Line in Kelowna	Attended by 7 ICPs	2 days per participant
Certification Exam	Certification in Infection Control	1 ICP	Challenge exam (unable to determine)

Projects & Initiatives

(Infection Prevention & Control) IP&C Manual – Revision

- Description:**
- The entire manual was reformatted and standardized.
 - Links have been added to enable the user to move throughout the manual with ease.
 - The revised **IH Infection Prevention & Control Manual** is now available and can be found on the InsideNet at [Clinical Resources](#) or [Policies & Procedures](#) or [Quality & Patient Safety](#) and on the Internet at:
<http://www.interiorhealth.ca/information.aspx?id=732&terms=infection+control+manual>
 - All staff are expected to use the “on line” copy of the manual which contains the most up to date information.
 - There will be **one “hard copy”** of the manual available at each Acute and Residential site in the event that the electronic copy cannot be accessed.
 - Staff education provided on accessing the manual on line.
 - Challenges identified:
 - Technology not always readily available to staff at point of use.
 - Not everyone is computer literate.
- Status:** Complete
- Organizational Impact:**
- Online version is sustainable, lean and financially responsible. This is a more efficient process that has shown the way to greater accuracy and relevancy because it allows for real-time updates.
 - Processes are standardized across the continuum of care and across all IH sites and programs.
 - Facilitates collaboration with non IH sites to ensure implementation of standardized processes.
 - Contains the most up to date information and is readily available.

Construction (2 Large scale capital projects, one in Vernon and one in Kelowna plus the clinical support building in Kelowna)

- Description:**
- Two ICPs have been designated as the main point of contact for construction information and development of standardized processes.
 - Developing a condensed version of the draft (Canadian Standards Association) CSA Z8000 Canadian Healthcare Facilities document specific to IH Infection Prevention & Control.

Status: Ongoing

Organizational Impact: Standardization of IP&C practices during new construction and renovations.

Computerized HAI Surveillance

- Description:**
- Completed implementation of residential HAI surveillance at all IH sites.
 - Developed cumulative report for SSIs, CDI, AROs and VAPs to facilitate reporting IH wide data.
 - All period end reports for HAI indicators are available on Insight, internal reporting system.

Status: Ongoing

- Organizational Impact:**
- System wide computer failure leads to inaccessibility of HAI surveillance data.
 - Standardized definitions assure the quality of data is valid.

CNISP (Canadian Nosocomial Infection Surveillance Project)

- Description**
- Weekly HAI data entry into computerized program and minimum quarterly reporting by Kelowna General Hospital.
 - Influenza surveillance has been added to this project.

Status: Ongoing

- Organizational Impact:**
- IH is now part of a national program and will benefit by receiving the latest national standards, data analysis information, and recognition.
 - Receive a financial benefit that is to be used for educational purposes.
 - ICP resources are provided by IH for the data entry process.
 - Laboratory resources are provided to ensure specimens are sent to the national laboratory.

Airborne Isolation Rooms

- Description**
- A review of existing airborne isolation was completed.
 - A decision brief was present to the Senior Executive Team that addressed the necessary upgrades.

Status Ongoing

- Organizational Impact:**
- Increased capacity for caring for patients requiring Airborne Isolation.
 - Improved safety for patients and staff.

Terminology & Abbreviations

Annual Target - A goal that is set on a yearly basis.

ARO – Antibiotic Resistant Organism.

Benchmark - A point of reference for judging value, quality, change, or the like; standard to which others can be compared.

CAUTI – Catheter Associated Urinary Tract Infection.

CDI - *Clostridium difficile* Infection also *C. difficile* – *C. difficile* is a bacteria that produces a toxin that can cause diarrhea and serious illness of the bowel. Generally, *C. difficile* does not cause problems in healthy people; however, CDI can be serious in people who are sick, elderly, or have weakened immune systems. In rare cases it can be fatal.

Central line - An intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood, or hemodynamic monitoring.

CHICA – Canada - Community and Hospital Infection Control Association – Canada.

CIC Exam – Certification in Infection Control Exam.

CLI – Central Line Infections: (reference CNISP and NHSN 2008)

Population is patients in ICU with a central line who:

- Has a recognized pathogen cultured from one or more blood cultures, unrelated to infection at another site (includes common skin contaminant if cultured from 2 or more blood cultures drawn on separate occasions not more than 2 days apart).
- BSI not present prior to insertion of central line.
- BSI onset during ICU stay or within 48 hours of leaving ICU.
- Rate calculated as # of CLIs divided by # CL days multiplied by 1000.

CNISP – Canadian Nosocomial Infection Surveillance Program.

Facility Type – A healthcare facility categorized by the range of services offered.

HH - Hand Hygiene – Preventing the spread of illness and infection by washing hands with soap and water or cleaning hands with alcohol based hand-rubs.

HAI – Healthcare Associated Infections *also Nosocomial Infections* – Infections patients get while staying in a healthcare facility or utilizing services provided by a healthcare facility or program. These infections can include germs from other patients, the environment, or staff.

HA IPCC – Health Authority Infection Prevention & Control Committee.

HAMAC – Health Authority Medical Advisory Committee.

Hospital Acquired Pneumonia (HAP) –Case definition – Clinical presentation meets criteria for Pneumonia, including x-ray confirmation. Symptoms start more than 48 hours after admission to, or within 48 hours of discharge from, an IH facility.-Primary source for definition: CDC/NHSN (National Healthcare Safety Network) guidelines, 2008.
Pneumonia identified by using a combination of the following criteria:
Radiologic – two or more serial chest x-rays with new or progressive & persistent infiltrate, consolidation, cavitation (only one x-ray if no lung/heart disease)
Clinical S&S- breath sounds, fever, altered mental status, sputum, cough, increased respiratory rate or oxygen needs.
Lab – sputum culture, elevated WBC.

IMPACT – Infection Monitoring Prevention and Control Team

Indicator – A statistical measurement that provides information about an outcome or predicts a suspected outcome.

IPAC – Infection Prevention and Control

Limitations – Limits or restrictions.

LRI – Lower Respiratory Tract Infection.

MRSA – Methicillin-Resistant *Staphylococcus Aureus* – *Staphylococcus aureus* is a bacteria that is normally found on the skin and in the nose of healthy people. Some bacteria have become resistant to the medicines used to treat infections (antibiotics). MRSA is a type of *Staphylococcus aureus* that is resistant to most antibiotics, including the antibiotic called penicillin. *Staphylococcus aureus* can cause minor skin infections such as boils, or infections in a surgical incision site.

Methodology – The methods, principles, and rules used to for the activity or result.

PICNet – Provincial Infection Control Network of British Columbia.

QM Enterprise (QME) is a powerful and efficient quality management tool developed by Picis. Interior Health Infection Prevention and Control Practitioners use QME for Health Care Associated Infection (HAI) surveillance.

Responsible Organism – The microorganism causing the infection.

SHN - Safer Healthcare Now! Reducing Harm, Improving Healthcare, Protecting Canadians.

Source – The person or thing that gave the information.

SSI – Surgical Site Infection.

SSTI – Skin & Soft Tissue Infection.

TB – Tuberculosis.

Trend - The general movement or direction of change.

UTI – Urinary Tract Infection.

VAP - Ventilator Associated Pneumonia

- Case definition - Clinical presentation meets criteria for Pneumonia, including x-ray confirmation. Symptoms start more than 48 hours after admission to an IH facility. - Patient has been on a respirator continuously in the 48 hours before infection onset
- Primary source for definition: CDC NNIS (National Nosocomial Infection Surveillance) guidelines, 2004.

VRE - Vancomycin-Resistant *Enterococci* - *Enterococci* are bacteria that are commonly found in the stomach and bowels of healthy people. Some bacteria have become resistant to the medicines used to treat infections (antibiotics). Vancomycin is an antibiotic used to treat serious infections. VRE is a type of *Enterococci* that has become resistant to Vancomycin. These germs rarely cause illness in healthy people. However, when VRE gets into open cuts and skin sores, they can cause infections. Occasionally, VRE can also cause more serious infections of the blood or other body tissues.