INFECTION PREVENTION

ANNUAL REPORT 2024/2025

northern health
the northern way of caring

Table of Contents

Executive Summary

The Northern Health Infection Prevention (IP) program's annual report highlights achievements and challenges facing IP and Medical Device Reprocessing practices throughout the region.

Facilities and the associated staff are more familiar with IP Program/Practitioners roles and responsibilities within the organization. There is an increased awareness that IP support at the site level enables management to implement a preventative approach with communicable disease. With this support from IP, leads and staff have become more confident in the implementation of IP guidance.

This report summarizes the initiatives and accomplishments of the IP program during the 2024/25 fiscal year and outlines major goals and continued priorities for the upcoming fiscal year.

IP Health Care Report Card and Indicators for 2024–2025

IP Health Care Report Card and Indicators for 2024 2025					
Indicator	**Status**	**Target**	**2024–2025**	**Preferred Direction**	**Page #**
Clostridioides difficile	◆	< 0.30	0.54	↓	12
Methicillin-Resistant *Staphylococcus aureus*	◆	< 0.70	0.90	↓	13
Hand Hygiene Compliance	●	≥ 85%	89%	↑	11
*Cases per 1,000 patient days					
**Please see the Hand Hygiene section for further discussion regarding the 2022/23 hand hygiene compliance rates					
● Meeting target ▲ Within 10% of target ◆ Outside of target range by more than 10%					

IP Health Care Report Card and Indicators for 2024 2025				
Indicator	**Status**	**Target**	**2024–2025**	**Page #**
Carbapenemase-Producing Organisms	◆	Reduction in health care associated transmissions	4	14
Surgical Site Infections	●	< 3 per 100 procedures	2 per 100 procedures	15
Outbreak Management	◆	Reduction in # of outbreaks	51 Viral Respiratory clusters/outbreaks	18
			5 GI Outbreaks	
□ Number of cases				
● Meeting target ▲ Within 10% of target ◆ Outside of target range by more than 10%				

IP GOALS
2025–2026

QUALITY IMPROVEMENT

Ongoing quality improvement through the accreditation process.

MDRD

Stabilize and strengthen Medical Device Reprocessing Department (MDRD) services through staff education.

Program Sustainability

Continue to stabilize IP and Control practices throughout the continuum of care.

Introduction

Under the administrative direction of Tanis Hampe, Vice President of Population and Public Health and Dr. Jong Kim, Chief Medical Health Officer, the Northern Health IP program is dedicated to the prevention and reduction of healthcare associated illness in Northern BC patients, residents, and employees through a variety of strategies summarized in this annual report.

The regional program provides on-site and consultative IP and medical device reprocessing expertise to thirty-five acute care facilities, long term care facilities, home and community care, assisted living facilities, diagnostic and treatment (D&T) centers and health centers.

IP liaises with other programs such as Communicable Disease (Public Health), and Workplace Health and Safety (WH&S) regarding communicable diseases and outbreak management.

The program functions in accordance with international, national, and provincial guidelines and best practices across the continuum of care, and influences practice through the following:

- Obtains, manages and disseminates critical data and information, including surveillance for infections; and disseminates information to appropriate stakeholders

- Develops and recommends best practices, policies, and procedures
- Involved in IP issues relating to all construction and renovation projects within NH to ensure that IP strategies are followed during construction and renovation projects according to the Canadian Standards Association (CSA) protocols
- Promotes and facilitates IP education
- Provides consultation and outbreak management support to all acute care facilities, long term care facilities, assisted living facilities, diagnostic and treatment centres, health centres, and community programs within Northern Health
- Provides expertise, and outbreak management support to non-healthcare organizations located in the NH geographic region i.e. work camps

Infection Prevention

Team Members

Vice President, Population and Public Health
Tanis Hampe

Chief Medical Health Officer
Dr. Jong Kim

Medical Lead, IPAC
Dr. John Black

Regional Manager, IPAC
Deanna Hembroff

Medical Device Reprocessing Regional Coordinator
Bonnie Mackenzie

IP/Epi-Tech
Bonnie Schurack

Chris Robberts
Debora Giese
Dianne Pearson
Dinu Kuttamparambil
Janice Muir
Jessica Bauer
Juanita Kerbrat
Katherine Humble
Marcy Palmeter
Micheal Powell
Michelle Parkinson
Monica Sephton
Patti Doering
Priscilla de Medeiros
Sally Macdougall
Timothy Klassen

Administrative Assistant

Cecille Conocido

Contact Information

Regional Manager IP
Deanna Hembroff

Deanna.hembroff@northernhealth.ca
Prince Rupert Regional Hospital
Phone Number: 250-622-6247
Fax Number: 250-622-6522

WORKING GROUPS AND INITIATIVES

- Guidelines and references developed and reviewed:
  - Construction documents reviewed and updated
  - 11 IP policies (reviewed)
- Participated in 25 Northern Health, provincial and national working groups
- IP involvement in NH ongoing construction projects and new builds:

Dawson Creek and District Hospital Replacement

Dawson Creek, BC

Ksyen Regional Hospital

Terrace, BC

Nats'oojeh Hospital and Health Centre

Fort St. James, BC

Education

An integral part of the IP program is ongoing education and training in IP practices, based on current evidence-based recommendations. Current information regarding IP and Medical Device Reprocessing Department (MDRD) services is available on the MyNH website.

Staff workload continues to be a challenge to delivery of education sessions. Elbow-to-elbow or “in the moment” education was the most successful learning delivery method as staff often expressed lack of time to attend classroom sessions.

With Accreditation now occurring on a yearly cycle, the IP program assisted with preparation for the 2025 Long Term Care (LTC) site surveys by creating a series of one-page education sheets regarding IP Required Organizational Practices (ROPs) and standards. The one-page education sheets were distributed to LTC managers in all facilities.

IP TEAM MEMBER EDUCATION

In keeping with the program’s mandate to provide current IP expertise, the IP team participated in the following education in 2024/25:

- 2 IP team members completed the Canadian Standards Association (CSA) IP During Construction, Renovation and Maintenance of Health Care Facilities Course
- 2 IP team members completed the IPAC Canada Essentials in Infection Prevention and Control Course
- 1 IP Team member completed Certification in Infection Control (CIC) Certification
- NH Learning Hub modules completed by team:
    - Thriving Through Change
      Introduction to Leading Change
    - Introduction to ADKAR
    - Introduction to Change Management
    - Antimicrobial Stewardship
      AMS – Urinary Tract Infections
      AMS – Pneumonia

Surveillance

The Infection Prevention (IP) program carries out surveillance on a number of quality and patient safety indicators. This section of the report presents information on a number of these indicators. Surveillance case definitions can be found in Appendix IV.

HAND HYGIENE

Status	Target	Actual (2024/25)	Preferred Direction
●	≥ 85%	Acute Care Facilities (ACF): **89%**	↑
▲	≥ 85%	Long Term Care Facilities (LTCF): **79%**	↑

Hand hygiene (HH) with either soap and water or alcohol based hand rub is recognized as a key component in the prevention of Healthcare-Associated Infections (HAIs). HH is required both before and after contact with patients/residents and their environment. The minimum provincial requirement is 200 observations per quarter for each facility with 25 or more beds.

For facilities with fewer than 25 beds, the audit data is aggregated into NH data.

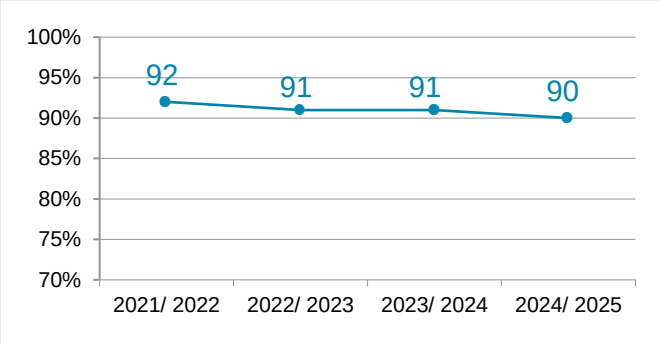
Ongoing challenges within NH are staff engagement and awareness.

Provincial HH audit classification of staff/healthcare provider types is collated into four category codes:

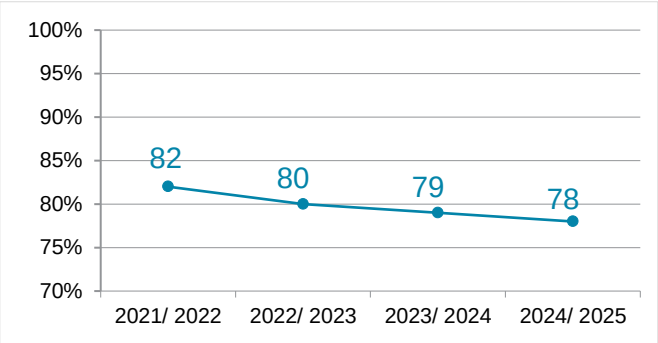
Nurse	NP/RN/RPN, LPN, Care Aide/Student Aide, Student (Nursing)
Physician	Physician, Medical Student/Resident
Clinical	Medical Technician, Respiratory Therapy, Lab personnel, Porter, Social Worker, Rehab Therapy, Dietitian, Pharmacist
Other	Housekeeper, Facilities Maintenance, Volunteer, Food Services, Other

Hand Hygiene Compliance in Acute Care Healthcare Provider Averages (% Compliance 2021–2025)

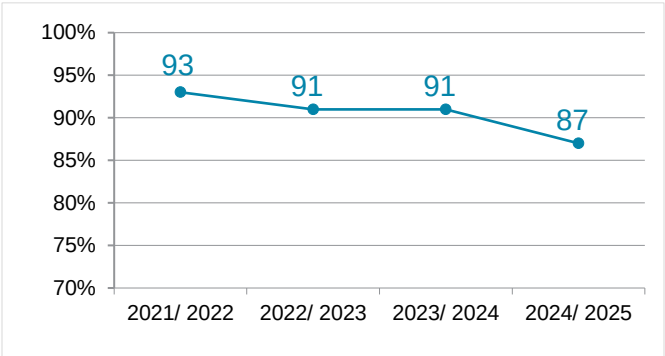
NURSING STAFF 2021–2025



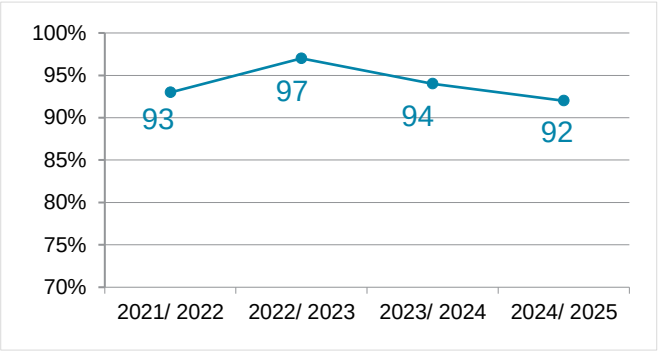
PHYSICIAN STAFF 2021–2025



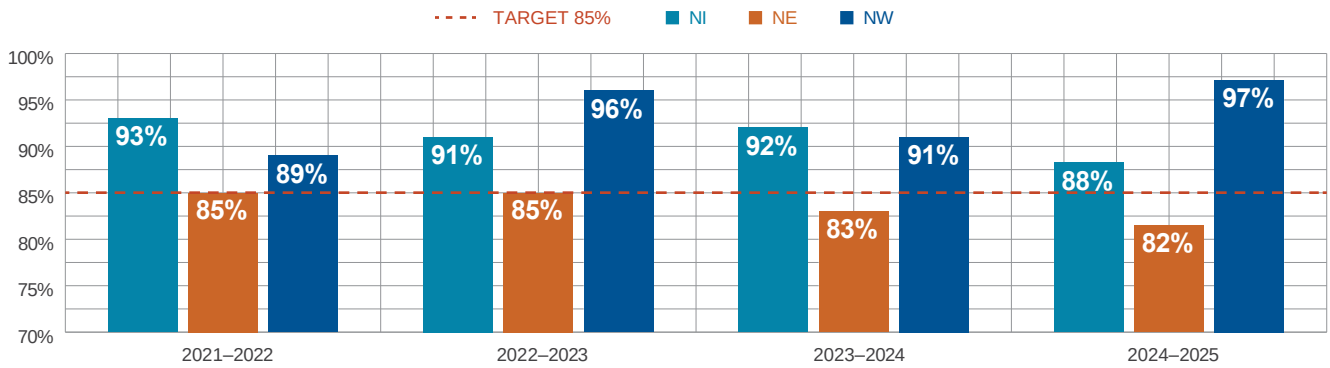
CLINICAL SUPPORT 2021–2025



OTHER 2021–2025



HAND HYGIENE COMPLIANCE IN NORTHERN HEALTH HSDA AVERAGES 2021–2025



Goals for 2024–2025:

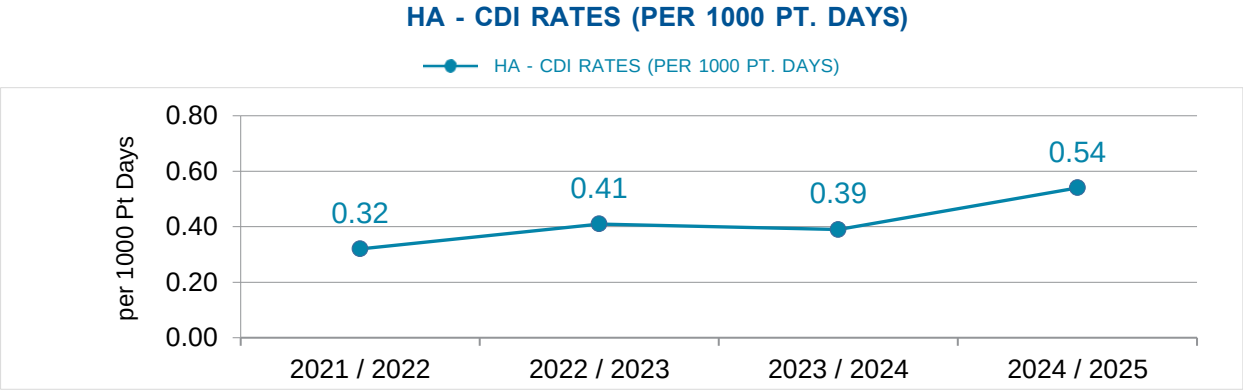
- All Northern Health Acute Care Facilities will complete and submit hand hygiene audits as per provincial requirements
- All Northern Health Long Term Care Facilities will complete and submit hand hygiene audits as per provincial requirements
- Continue to encourage all sites, patients, and visitors to use the Westech Hand Hygiene web-based app.
- Community and Primary Care will complete hand hygiene self-audits and observational audits as per provincial requirements

Healthcare-Associated Infection Indicators

CLOSTRIDIOIDES DIFFICILE INFECTION (CDI)

Status	Target (%)	Actual (2024–2025)	Preferred Direction
◆	< 0.30 per 1,000 pt. days	0.54 per 1,000 pt. days	↓

Clostridioides difficile is a spore forming bacterium that can cause infections of the gastrointestinal system. *Clostridioides difficile* infection (CDI) is one of the most common infections acquired in health care settings as the physical environment plays a significant role in transmission of CDI, more so than any other Healthcare-Associated Infection (HAI).



The annual rate of Healthcare-associated *Clostridioides difficile* infection (HA-CDI) is the number of new cases of CDI in NH facilities, divided by the total number of in-patient days, multiplied by 1,000.

Actions taken in 2024–2025 include:

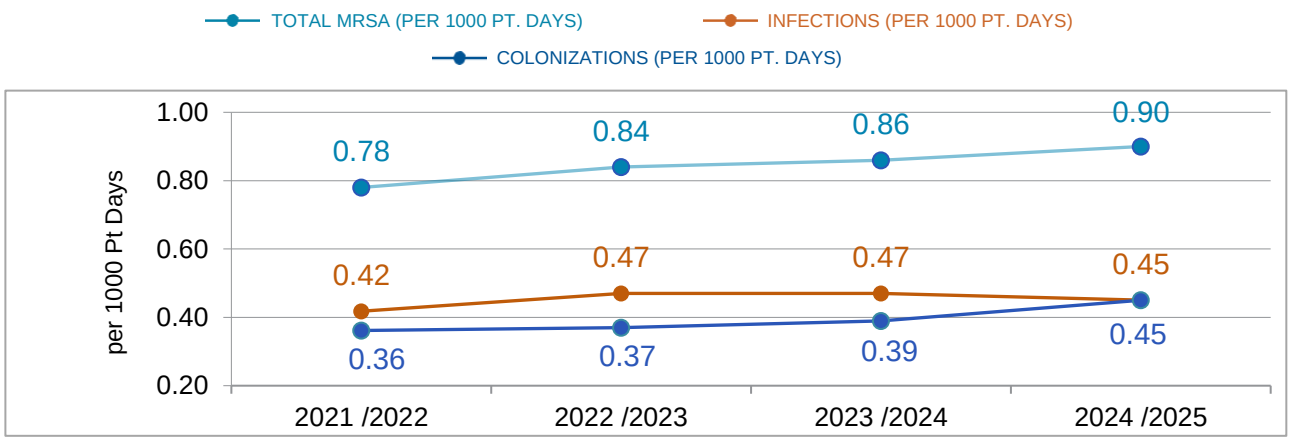
- Education provided on cleaning with sporicidal for all suspected and confirmed cases
- Facilitated increased communication between front line nursing staff and environmental services
- Increased education sessions for Health Care Workers (HCWs) regarding importance of proper protocol, signage and precautions
- Discussed with patients, families and visitors *Clostridioides difficile* transmission

METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

Status	Target (%)	Actual (2024–2025)	Preferred Direction
◆	< 0.70 per 1,000 pt. days	0.90 per 1,000 pt. days	↓

Methicillin resistant *Staphylococcus aureus* (MRSA) is a strain of *Staphylococcus aureus* resistant to a number of antibiotics such as methicillin, penicillin, and amoxicillin. MRSA is primarily spread by skin-to-skin contact or contact with items and surfaces contaminated by the bacteria. The principle mode of transmission in healthcare facilities is considered to be from one (colonized or infected) patient to another via the contaminated hands of healthcare providers. Patients at greatest risk of acquiring MRSA are the elderly, those who have chronic diseases, and/or are undergoing invasive procedures.

MRSA INFECTION AND COLONIZATION RATES



The incidence rate of MRSA is the number of newly identified cases of MRSA (colonized and infected) acquired by patients as a result of their stay in a Northern Health acute care facility, divided by the total number of in-patient days and multiplied by 1,000.

Northern Health MRSA rates have increased to 0.90. Limitations include:

- Overcapacity and older hospital design (e.g., many shared wards) makes it difficult to accommodate patients with an ARO(s) or risk factors for an ARO(s) in appropriate single rooms.
- Staff disengagement with routine admission swabbing

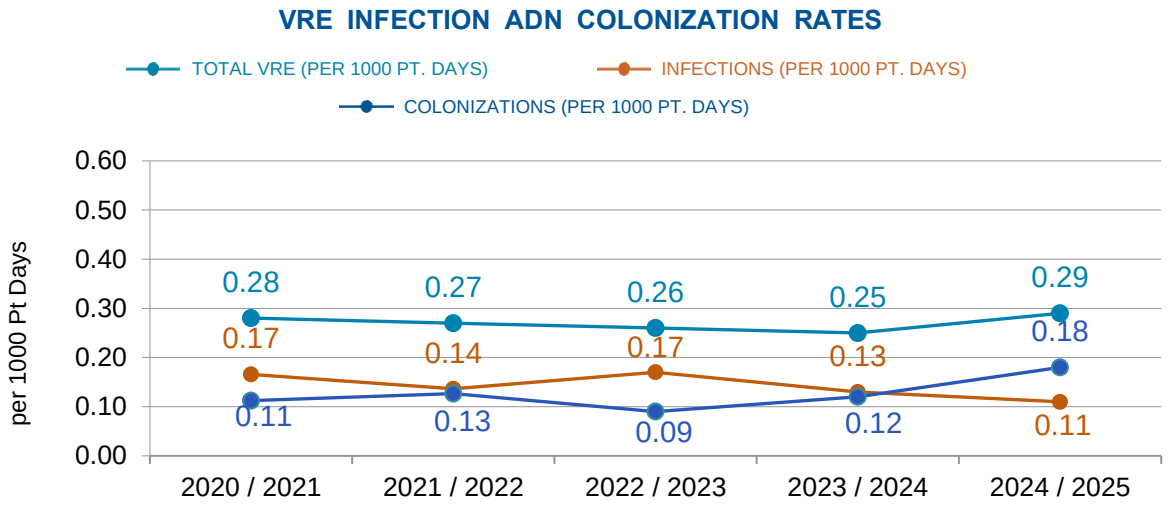
Ongoing Actions:

- All NH patients who test positive for an ARO have their health record flagged with that ARO alert
- Continued 30-day prevalence screening of all previously tested negative i n-patients
- IP education for HCWs regarding importance of HH, environmental cleaning and appropriate disinfection of shared equipment
- IP education for patients, families and visitors
- Discussion with senior management around Healthcare-Associated Infections (HAIs) of MRSA and VRE at operational team meetings

VANCOMYCIN RESISTANT *ENTEROCOCCI* (VRE)

Status	Target (%)	Actual (2024–2025)	Preferred Direction
●	< 0.30 per 1,000 pt. days	0.29 per 1,000 pt. days	↓

The incidence rate of Vancomycin-Resistant *Enterococci* (VRE) is the number of newly identified cases of VRE (colonized and infected) acquired by patients as a result of their stay in a Northern Health acute care facility, divided by the total number of in-patient days, and multiplied by 1,000.



Ongoing Actions:

- All NH patients who test positive for VRE have their health record flagged with an ARO alert
- Continued 30-day prevalence screening of all previously tested negative patients admitted to Intensive Care Units
- IP education for HCWs regarding importance of Hand Hygiene (HH), environmental cleaning and appropriate disinfection of shared equipment
- IP education for patients, families and visitors

MANAGEMENT OF CARBAPENEMASE PRODUCING ORGANISMS (CPO)

Carbapenemase Producing Organisms are gram negative bacteria that harbor Carbapenemase producing genes. These genes allow the organism to be resistant to the carbapenem family of antibiotics. Similar to VRE and MRSA, the most common mechanism of transmission is contact, both direct and indirect.

In 2024–2025, the were 4 cases of CPO identified in NH.

Actions taken in 2024–2025 include:

- Education for HCW about importance of admission screening and screening of transfer patients
- Communication of ongoing CPO investigations within the province to alert staff and management

SURGICAL SITE INFECTIONS (SSI)

Surgical Site Infections (SSIs) are the most common Healthcare-Associated Infections (HAIs) as found in a prevalence study done by the Centre for Disease Control (CDC). SSI's remain a substantial cause of morbidity, prolonged hospitalization, and death.

SSI surveillance is conducted by IP through post discharge surveillance. Surgical procedures surveyed for infection include: caesarean section, total abdominal hysterectomy, total primary hip replacement, total primary knee replacement, and bowel resection (not including the rectum). Surveillance of antibiotic prophylaxis given within one hour of surgical cut time is also monitored.

Prophylactic antibiotic rates vary. Challenges include incomplete or nonexistent documentation when antibiotics were given.

How we collect data:

Patients will be identified by IP via OR slate review as per site specific method. IP follows patients while in hospital starting 48 hours postoperatively for a minimum of 14 days (unless discharged) to determine if signs/symptoms that meet CDC/ National Healthcare Safety Network (NHSN) surveillance definition of infection are present. Monitoring of patients at 30 days (all surgeries) and then at 90 days (total primary hip and knee replacements only) post procedure will be completed by IP to ensure there is no evidence of infection. This includes, but is not limited to:

- Telephone interview
- Review of microbiology, laboratory and imaging reports
- Review of patient's chart
- Review of physician notes
- Review of operation records and any subsequent visits to the Operating Room (OR)
- Review of emergency visits
- Review of clinic visit records
- IP rounds
- Review of pharmacy reports

Actions taken in 2024–2025 include:

- Patients are monitored for up to 90 days for total hip replacement (THR) and total knee replacement (TKR)
- Facilitate communication with surgeons regarding infections
- Clusters are investigated and discussion for quality improvements occur
- Education provided for staff regarding the rationale behind appropriate antibiotic use pre-operatively and the importance of documentation
- Education for patients and families pre and post-surgery

Caesarean Section:

Status	Target	Actual (2024–2025)	Preferred Direction
●	≤ 3 per 100 procedures	3 per 100 procedures	↓

C-sections are performed at a total of **9** Northern Health facilities.

Outcome: 742 C-sections performed in 2024–2025.

- Antibiotics given within one hour of cut time — 93%. Rate of administration has a significant increase from previous year at 87%. Challenges with finding documentation in the patient chart has improved with Electronic Medical Record adoption, in particular emergency C-sections
- 20 SSIs were identified
- The SSI rate was 3 per 100 procedures

Total Abdominal Hysterectomy (TAH):

Status	Target	Actual (2024–2025)	Preferred Direction
▲	≤ 4 per 100 procedures	5 per 100 procedures	↓

Total Abdominal Hysterectomies are performed at **6** Northern Health facilities.

Outcome: 56 TAH performed in 2024–2025.

- Antibiotics given within one hour of cut time — 95%. Rate of administration has a slight decrease from previous year at 96%
- 3 SSIs were identified
- The SSI rate was 5 per 100 procedures

Total Primary Hip Replacement (THR):

Status	Target	Actual (2024–2025)	Preferred Direction
●	≤ 2 per 100 procedures	2 per 100 procedures	↓

Total Hip Replacements are performed at **5** Northern Health facilities.

Outcome: 523 THR performed in 2024–2025.

- Antibiotics given within one hour of cut time — 99%. Rate of administration has a slight increase from previous year at 97%.
- 11 SSIs were identified
- The SSI rate was 2 per 100 procedures

Total Primary Knee Replacement (TKR):

Status	Target	Actual (2024–2025)	Preferred Direction
●	< 2 per 100 procedures	1 per 100 procedures	↓

Total Knee Replacements are performed at **5** Northern Health facilities.

Outcome: 959 TKR performed in 2024–2025.

- Antibiotics given within one hour of cut time — 99%. Rate of administration has a slight increase from the previous year at 98%
- 12 SSIs were identified
- The SSI rate was 1 per 100 procedures

Bowel Resection (not including rectum):

Status	Target	Actual (2024–2025)	Preferred Direction
●	< 10 per 100 procedures	3 per 100 procedures	↓

Bowel Resections are performed at **6** Northern Health facilities.

Outcome: 91 Bowel Resections performed in 2024–2025.

- Antibiotics given within one hour of cut time — 93%. Rate of administration has a slight increase from the previous year at 90%
- 3 SSIs were identified
- The SSI rate was 3 per 100 procedures

SURGICAL SITE INFECTIONS (SSI)

Rate Comparison with Previous Years:

Procedure	2020–2021	2021–2022	2022–2023	2023–2024	2024–2025
Abdominal Hysterectomy	4 per 100 procedures	4 per 100 procedures	3 per 100 procedures	0 per 100 procedures	5 per 100 procedures
Caesarean Section	3 per 100 procedures	2 per 100 procedures	3 per 100 procedures	2 per 100 procedures	3 per 100 procedures
Bowel Resection	2 per 100 procedures	10 per 100 procedures	7 per 100 procedures	1 per 100 procedures	3 per 100 procedures
Total Primary Hip Replacement	2 per 100 procedures	5 per 100 procedures	2 per 100 procedures	1 per 100 procedures	2 per 100 procedures
Total Primary Knee Replacement	2 per 100 procedures	2 per 100 procedures	1 per 100 procedures	0.1 per 100 procedures	1 per 100 procedures

Cluster/Outbreak Management

Outbreak manuals for Viral Respiratory Illness (VRI) and Gastrointestinal Illness (GI) were updated to reflect current best practices. IP collected and provided data for the province regarding COVID-19 statistics (individual cases as well as NH facility outbreaks), influenza and GI illness.

Of note, there were a total 28 COVID-19 related clusters. There were 14 Influenza A, 9 other Viral Respiratory outbreaks and 5 GI outbreaks in NH facilities this fiscal year.

LESSONS LEARNED

- **Timely Application of Precautions:** Lessons learned were well documented and IP team was able to apply them to other clusters/outbreaks in the NH region
- **Communication is Key:** Early notification of suspected clusters/outbreaks to the MHO and IP team was key for early detection and efficient management of outbreaks. Establishment of an initial meeting and huddles was also vital for multidisciplinary collaboration and effective teamwork.
- **Hand Hygiene:** Re-enforcement of diligent hand hygiene practices was essential for ending prolonged or consecutive clusters/outbreaks.
- **Leadership Buy-in Ensures Success:** Facility leadership's active participation in cluster/outbreak preparedness helped prioritize activities such as completing bloodwork and pre-printed orders for administration of antiviral medication.
- **Vaccination Improved Resident Outcomes:** Severity of illness and hospital admissions decreased with timely organization and delivery of resident vaccinations in long term care.
- **Nature of Unit Dictates Extent of Precautions:** Isolating whole units became the exception instead of the norm with widespread vaccination, decreased severity of illness and focus on patient/resident mental health and wellbeing. Entire units were treated as potentially infectious when individual case isolation was not possible (i.e. non-compliant or wandering residents/patients, 4 bed wards)
- **Increasing Reliance on Agency Staff:** Agency staff are often unfamiliar with NH cluster/outbreak protocols. The IP team provided support through mentoring and in-the-moment education.

Quality Improvement

- Follow up of NH Facilities Quality Assessments in Long Term Care (LTC) 2024-2025 were completed

QUALITY IMPROVEMENT CO-LEAD GROUPS

Accreditation

In preparation for the 2025 accreditation cycle, which focused on LTC, the Accreditation Co-leads developed several resources to help LTC leaders and staff to implement practice changes to meet accreditation standards. These tools included: 26 one-page education documents to support NH staff with key messages related to Required Organizational Practices and other standards, a Hand Hygiene Quality Improvement Plan checklist which provides detailed guidance for LTC leaders to ensure they have a site specific plan for meeting hand hygiene requirements,andashort“howto”documenttohelpleaderslocatethe NH Accreditation Support Tool (iGrafx) on MyNH.

Education

Implemented in 2024 and following a newly created education framework, the Education Co-lead group spent 2025 preparing 95 standardized education resources (one-page education documents, five-minute memos, and PowerPoints) that have been organized into education bundles for high priority topics. Goals for the coming year include finalizing an ongoing schedule for monthly education delivered by the department (e.g. education bundle assigned to each calendar month) and reviewing all Learning Hub courses currently owned by IP.

Construction

This year the Construction Co-lead group created a PowerPoint for contractors, Facility Maintenance etc. regarding the role of IP during construction and renovation and CSA Z317 guidelines. The PowerPoint includes the risk assessment as related to scope of work involved and population risk group and construction type. In addition, how to use the matrix and what construction work needs IP consult etc., to assist construction team with completion of the Risk Reduction Report for IP review prior to project start.

The Co-lead group also worked on creating a Kardex document to centralize all construction related IP documents. This supports continuity of care and cross site coverage by other IP team members.

The group also worked on series of concise practical one pagers this year:

- Wood products in facility design
- ABHR and Hand Hygiene sink installation
- Acoustical panels in Health Care Facility (HCF)
- Floor drains
- Plumbing flushing and disinfection
- Preventative measures
- Human waste management
- Water features
- Asbestos

What's Next 2025-26

1. Create a dedicated section for construction on internal platform (IP page, MyNH).
2. Create a centralized searchable SharePoint for Kardex
3. New education resources in development

Surveillance

The focus of the Surveillance Co-leads for 2024/2025 was the review and reinforcement of existing surgical site infection and urinary tract infection (UTI) protocols. This included the re-implementation of the UTI surveillance program in long-term care (LTC).

Education regarding UTI prevention and the importance of surveillance was provided to LTC facilities in each Health Service Delivery Area (HSDA). During this engagement period and attempt at re-implementation, barriers and challenges with surveillance in LTC were identified. This included staff turnover, the ratio of contract staff versus regular staff, complexities in surveillance program communication, and care-based pressures.

What's Next 2025-2026

1. Strengthening relationships with LTC facilities to facilitate a re-implementation of the UTI surveillance program.
2. Provide more concise support for LTC sites involved in the surveillance process, a clearer communication strategy, and a more streamlined approach to UTI surveillance.

Hand Hygiene

Hand Hygiene (HH) is the number one preventive tool we can use in health care facilities. The IP team is responsible for new hire and continuing education sessions for staff.

The HH Co-lead group has been working on collecting IP resources and expanding the use of the NH Westech Hand Hygiene app.

What's Next 2025-2026

1. Hand hygiene observer and leadership toolkits to be developed
2. Updating MyNH HH staff page

Outbreak

Northern Health has implemented several key updates to its outbreak management protocols for the 2024–2025 season, with a focus on improving efficiency and aligning with provincial standards.

Key Changes:

- In-house Gastrointestinal (GI) testing for outbreaks
- Updated Resources:
  - GI Manual
  - Viral Respiratory Illness (VRI) Manual
  - Quick Guide for Frontline Staff
  - VRI Policy
- Ongoing Education:
  - Continued emphasis on staff education both prior to and during outbreak season to ensure preparedness and adherence to best practices.
  - One pagers created for VRI clusters/outbreaks and GI outbreaks.

Policy

Over the past year, the IP team reviewed and updated 11 clinical practice standards. These updates included correcting hyperlinks, clarifying language for improved understanding, and incorporating newly adopted best practices.

There were major changes to the Influenza Outbreak policy to reflect new Viral Respiratory Illness language and include “cluster” language.

Medical Device Reprocessing

Updates on the initiatives for 2024.

EDUCATION

- Five-minute memos were discontinued in 2024 to allow time to work with PICNet on the Best Practice Guideline revision. Upon completion the guideline will be available online for educational purposes.

MDRD INVENTORY LIST

- An inventory list is available on the MDR dashboard to easy reference to MDR specific inventory.

COMPETENCY FRAMEWORK

- Content has been provided to the Organizational Learning Department to redevelop a Learning Hub competency module for ultrasound probes, followed by endoscope cleaning and disinfection.

The Medical device reprocessing department has prioritized three key initiatives for 2025–2026 based on audit results, staff feedback, and MDR provincial working group participation.

DASHBOARD

- A MDR Dashboard was created and uploaded onto the Northern Health website. Individuals utilizing the dashboard will have access to topics such as education; equipment makes, models, installation dates and life expectancy dates; policies; reports; and other data that is relevant to the department. More topics will be added as they are identified.

BEST PRACTICE GUIDELINES

- Continued involvement in the review of the policy communique, and the revision of the Best Practice Guidelines with the ministry of health sub-working groups that include health authority representatives from British Columbia, PICNet, and the Ministry of Health.

MDR POLICIES

- Policy updates to reflect the revision of Best Practice Guideline for ultrasound probes, flexible endoscopes, education and competencies.

Northern Health Facilities

ACUTE CARE

Bulkley Valley District Hospital – Smithers
Chetwynd Hospital and Health Centre
Dawson Creek and District Hospital
Fort Nelson Hospital
Fort St. John Hospital

GR Baker Memorial Hospital – Quesnel

Haida Gwaii Hospital and Health Center – Xaayda Gwaay Ngaayskll Naay – Daajing Giids

Kitimat General Hospital
Ksyen Regional Hospital – Terrace

Lakes District Hospital – Burns Lake

Mackenzie and District Hospital

McBride Hospital

Nats'oojeh Hospital and Health Centre – Fort St. James

Northern Haida Gwaii Hospital and Health Center - Masset
Prince Rupert Regional Hospital
St. John Hospital – Vanderhoof
University Hospital of Northern BC – Prince George

Wrinch Memorial Hospital – Hazelton

ASSISTED LIVING FACILITIES

Alward Place Seniors Assisted Living – Prince George

Gateway Lodge Assisted Living Residence – Prince George
Heritage Manor II – Fort St. John
Laurier Manor – Prince George

McConnell Estates – Terrace

Nick Grosse Assisted Living Residences – Masset

Summit Assisted Living Residences – Prince Rupert

DIAGNOSTIC AND TREATMENT CENTRES, HEALTH CENTRES

Atlin Hospital
Fraser Lake D&T Centre
Granisle Community Health Centre
Houston Health Centre
Hudson Hope Health Centre
Stewart Health Centre
Stikine D&T Centre – Dease Lake
Tumbler Ridge D&T Centre
Valemount D&T Centre

HOME COMMUNITY/PRIMARY CARE

LONG TERM CARE

Acropolis Manor – Prince Rupert
Bulkley Lodge – Smithers
Dunrovin Park Lodge – Quesnel
Gateway Lodge – Prince George
Jubilee Lodge – Prince George
Mountain View Lodge - Kitimat
Parkside Care – Prince George
Peace Villa – Fort St. John
Rainbow Lodge – Prince George
Rotary Manor – Dawson Creek
Simon Fraser Lodge – Prince George
Stuart Nechako Manor – Vanderhoof
Terraceview Lodge – Terrace
The Pines – Burns Lake

Appendices

APPENDIX I: VRI CLUSTER/OUTBREAK – ACUTE CARE

Outbreaks (5)								
Facility/Ward	Causative Organism	Total # of Clients in Facility/ Unit	Total Positive Clients	Total Positive Staff	Total Client Deaths	Start Date (dd-mm-yyyy)	End Date (dd-mm-yyyy)	Length of Outbreak (days)
NEHSDA								
NONE								
NIHSDA								
UHNBC-PCMU	Influenza A	36	7	2	0	09-02-2025	18-02-2025	10
Mackenzie Hospital	Influenza A	12	6	7	1	19-02-2025	06-03-2025	16
UHNBC-Rehab Unit	Influenza A	27	10	0	0	25-02-2025	10-03-2025	13
UHNBC-Psychiatry Uni	Influenza A	22	3	3	0	27-02-2025	07-03-2025	9
NWHSDA								
Prince Rupert Regional Hospital - PCU	Influenza A	30	14	0	0	11-12-2024	20-12-2024	10

Clusters (14)								
Facility/Ward	**Causative Organism**	**Total # of Clients in Facility/ Unit**	**Total Positive Clients**	**Total Positive Staff**	**Total Client Deaths**	**Start Date (dd-mm-yyyy)**	**End Date (dd-mm-yyyy)**	**Length of Outbreak (days)**
NEHSDA								
Dawson Creek Hospital	COVID-19	32	5	0	0	12-07-2024	22-07-2024	10
NIHSDA								
UHNBC - Psych	COVID-19	27	8	0	0	16-04-2024	01-05-2024	16
Nats'oojeh Hospital and Health Centre	COVID-19	12	6	0	0	13-05-2024	26-05-2024	13
GR Baker Memorial Hospital	Para Influenza 3	10	5	0	0	16-05-2024	22-05-2024	7
UHNBC - Rehab Unit	COVID-19	24	15	3	0	03-06-2024	10-07-2024	37
UHNBC - SSMU	COVID-19	26	16	2	1	10-07-2024	26-07-2024	16
UHNBC - FMU	COVID-19	33	11	3	1	12-08-2024	29-08-2024	17
UHNBC - FMU	COVID-19	34	14	0	0	12-09-2024	09-10-2024	27
UHNBC - Rehab Unit	COVID-19	24	3		0	25-09-2024	05-10-2024	10
UHNBC - SN D pod	COVID-19	8	5	0	0	30-09-2024	13-10-2024	13
GR Baker Memorial Hospital	COVID-19	10	4	0	0	01-10-2024	08-10-2024	8
UHNBC Rehab Unit	COVID-19	26	10		0	18-11-2024	02-12-2024	14
UHNBC - SSMU	COVID-19	26	9	0	0	09-02-2025	22-02-2025	13
NWHSDA								
Ksyen Regional Hospital	COVID-19	37	6	0	0	01-10-2024	09-10-2024	8

APPENDIX II: VRI OUTBREAKS AND CLUSTERS – LONG TERM CARE /COMPLEX CARE/ASSISTED LIVING

Outbreaks (9)

Facility/Ward	Causative Organism	Total # of Clients in Facility/ Unit	Total Positive Clients	Total Positive Staff	Total Client Deaths	Start Date (dd-mm-yyyy)	End Date (dd-mm-yyyy)	Length of Outbreak (days)
NEHSDA								
NONE								
NIHSDA								
Parkside Care Home	Influenza A	58	5	0	0	18-02-2025	28-02-2025	10
Gateway Lodge	Influenza A	119	11	5	0	21-02-2025	08-03-2025	15
Jubilee Lodge	Influenza A	66	5	5	0	26-02-2025	07-03-2025	9
Gateway Lodge - upper South	Influenza A	119	3	1	0	12-03-2025	19-03-2025	8
Simon Fraser Lodge	Influenza A	130	11	7	1	26-03-2025	16-04-2025	29
NWHSDA								
Acropolis Manor	Influenza A	56	8	0	1	06-04-2024	19-04-2024	13
McConnell Estates	Influenza A	25	3	0	1	15-02-2025	25-02-2025	10
Terraceview Lodge	Influenza A	99	17	7	1	26-02-2025	13-03-2025	15
Bulkley Lodge	Influenza A	70	13	1	2	17-03-2025	26-03-2025	9

Clusters (23)

Facility/Ward	Causative Organism	Total # of Clients in Facility/ Unit	Total Positive Clients	Total Positive Staff	Total Client Deaths	Start Date (dd-mm-yyyy)	End Date (dd-mm-yyyy)	Length of Outbreak (days)
NEHSDA								
Rotary Manor	COVID-19[1]	117	7	0	0	10-06-2024	24-06-2024	14
Peace Villa	COVID-19[1]	123	28	0	0	04-07-2024	12-08-2024	39
Chetwynd Hospital/LTC	COVID-19[1]	17	8	0	1	04-10-2024	19-10-2024	16
Peace Villa	COVID-19[1]	123	30	0	0	02-11-2024	02-12-2024	30
Rotary Manor	COVID-19[1]	117	7	0	0	05-11-2024	28-11-2024	23
NIHSDA								
Jubilee Lodge	RSV[2]	66	12	0	0	14-04-2024	09-05-2024	25
Dunrovin Park Lodge	COVID-19[1]	41	12	0	1	31-05-2024	13-06-2024	14
Simon Fraser Lodge	COVID-19[1]	130	26	0	2	04-07-2024	24-07-2024	20

Clusters (23) *continued*								
Facility/Ward	**Causative Organism**	**Total # of Clients in Facility/ Unit**	**Total Positive Clients**	**Total Positive Staff**	**Total Client Deaths**	**Start Date (dd-mm-yyyy)**	**End Date (dd-mm-yyyy)**	**Length of Outbreak (days)**
Jubilee Lodge	COVID-19[1]	66	29	0	0	26-08-2024	14-09-2024	32
Stuart Nechako Manor	COVID-19[1]	12	4	2	0	12-09-2024	20-09-2024	12
Gateway Lodge	COVID-19[1]	120	19	5	2	25-09-2024	10-10-2024	20
Stuart Nechako Manor	Unknown	13	4	0	0	01-10-2024	07-10-2024	7
Simon Fraser Lodge	COVID-19[1]	130	29	0	1	22-10-2024	07-11-2024	20
Dunrovin Park Lodge	COVID-19[1]	41	7	2	0	31-10-2024	14-11-2024	15
Parkside Care Home	unknown	58	9	0	0	13-11-2024	21-11-2024	8
Jubilee Lodge	HMPV[3]	66	7	0	0	13-01-2025	27-01-2025	14
Jubilee Lodge	HMPV[3]	66	7	0	1	05-02-2025	14-02-2025	18
Rainbow Lodge	RSV[2]	18	4	3	0	24-02-2025	10-03-2025	14
Parkside Care Home	CoronaVirus OC43	58	27	6	0	31-03-2025	12-04-2025	13
NWHSDA								
Bulkley Lodge	COVID-19[1]	66	19	5	0	27-06-2024	09-07-2024	13
Haida Gwaii Hospital-Daajing Giids	COVID-19[1]	12	6	0	0	12-07-2024	23-07-2024	11
Mountainview Lodge-Kitimat	COVID-19[1]	36	14	0	0	26-09-2024	11-10-2024	14
Acropolis Manor	HMPV[3]	59	22	0	4	07-03-2025	27-03-2025	20

Legend:

1. COVID-19 - Coronavirus disease 2019
2. RSV – Respiratory Syncytial Virus
3. HMPV – Human metapneumovirus

APPENDIX III: GI OUTBREAKS – ACUTE CARE AND LTC

Outbreaks (2)								
Facility/Ward	**Causative Organism**	**Total # of Clients in Facility/ Unit**	**Total Positive Clients**	**Total Positive Staff**	**Total Client Deaths**	**Start Date (dd-mm-yyyy)**	**End Date (dd-mm-yyyy)**	**Length of Outbreak (days)**
NEHSDA								
Peace Villa	Unknown	123	3	0	0	27-04-2024	04-05-2024	8
Peace Villa	Norovirus	123	9	0	0	30-01-2025	10-02-2025	12
NIHSDA								
Nats'oojeh Hospital and Health Centre, AC	Unknown	12	6	0	0	26-08-2024	04-09-2024	10
Jubilee Lodge	Norovirus	66	13	0	0	23-02-2025	07-03-2025	12
NWHSDA								
Acropolis Manor	Norovirus	56	10	0	0	15-06-2024	28-06-2024	14

APPENDIX IV: SURVEILLANCE CASES DEFINITIONS

Clostridioides difficile infection (CDI):

A diagnosis of CDI applies to a person with:

- Presence of diarrhea (e.g. three liquid or loose stools within a 24-hour period) or toxic megacolon without other known etiology, and laboratory confirmation of the presence of C. difficile toxin And/or positive toxin or culture with evidence of toxin production or detection of toxin genes)
- Diagnosis of typical pseudo-membranes or sigmoidoscopy or colonoscopy or
- Histological/pathological diagnosis of CDI with or without diarrhea

A CDI case is considered healthcare-associated when:

- Patient develops symptoms in hospital equal to or greater than 72 hours after admission; or
- Symptoms occur in a patient that has been hospitalized or discharged within the previous 4 weeks, and the patient is not in a long-term are facility

Antibiotic Resistant Organism (ARO) Case Definition:

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

- Laboratory identification of an ARO;
- Patient must be admitted to an acute care facility
- ARO must be newly identified from the specimen collected at the time of hospital admission or during hospitalization
- Patient must have no known history of either infection or colonization with an ARO in any BC acute care facilities

Surgical Site Infection (SSI):

Surgical procedures surveyed for infection include: caesarean sections, total abdominal hysterectomies, total primary hip and knee replacements, and bowel resections that do not involve the rectum.

CDC SSI Definitions:

- **Superficial Incision SSI** – Occurs within 30 days and involves only skin and subcutaneous tissue and the superficial incision is opened by the surgeon unless the incision is culture negative. Does not include stitch abscess or infection at a localized stab wound/drain site. Diagnosis by surgeon or attending physician
- **Deep Incisional SSI** – infection appears to be related to the operative procedure and involves deep soft tissues (fascial and muscle layers) of the incision. Evidence of abscess or infection is found on exam, during re-operation or by histopathologic/radiologic exam
- **Organ/space SSI** – infection appears to be related to the operative procedure and involves any part of the body, excluding the skin incision fascia or muscle layers that is opened or manipulated during the operative procedure. Evidence of abscess or infection is found on exam during re-operation or by histopathologic/radiologic exam

Viral Respiratory Illness (VRI) Case Definition

Acute onset of signs and symptoms of VRI based on clinical judgement AND testing has not yet occurred or results are pending. Signs and symptoms include two or more of the following:

- New or worsening cough
- Fever* or chills
- Shortness of breath
- Runny or stuffy nose (i.e., congestion) or sneezing
- Sore throat or hoarseness or difficulty swallowing
- Loss of sense of smell or taste
- Tiredness, malaise
- Muscle aches (i.e., myalgia)
- Headache

*Note that this does NOT include symptoms with a known cause, such as fever due to urinary tract infection, or diarrhea due to a new medication. Clinical judgement and assessment is required.

Viral Respiratory Illness Case/Cluster Definition

Whenever a cluster of VRI cases occurs, it warrants an investigation to determine possibility of epidemiological links, risk for further transmission, and consideration for additional measures. A cluster may involve a high prevalence of community-associated cases in a unit or localized area or possible healthcare associated cases where epidemiological links cannot be conclusively determined. In community/LTC settings, VRI often reflect community levels of VRI and can be managed with clinical care and IPAC measures.

Note: Once initial testing has identified the causative agent within a select group of symptomatic patients, further testing of symptomatic patients may be suspended at the discretion of the MHO/official designate.

Gastrointestinal (GI) illness case definition

A case of probable GI infection is defined as any one of the following conditions that cannot be attributed to another cause (e.g., laxative use, medication side effect, diet, prior medical condition):

- Two or more episodes of diarrhea in a 24-hour period above what is considered normal for that individual
- Two or more episodes of vomiting in a 24-hour period
- One episode each of vomiting and diarrhea in a 24-hour period
- One episode of bloody diarrhea
- Positive culture for a known enteric pathogen with a symptom of GI infection (e.g., vomiting, abdominal pain, diarrhea)

GI Outbreak Definition

Three or more cases of probable viral GI infection, potentially related within a four-day period, within a specific geographic area (e.g. unit, ward).

APPENDIX V – ABBREVIATIONS AND TERMINOLOGIES

NH

Northern Health

Acute Care (AC)

Sites where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition or during recovery from surgery.

AC/LTC

Combined Acute Care and Long Term Care in a single facility

Alert

An alert is called when there is a high number or proportion of cases on a unit, but the number does not meet the predetermined level for an outbreak to be declared.

Colonization

The presence and multiplication of microorganism without tissue invasion or damage.

GI

Gastrointestinal Illness

HEMBC

Health Emergency Management BC

IP

Infection Prevention

Healthcare-Associated Infections (HAI)

Infections patients acquire while staying in any healthcare facility, which include micro-organism from other patients, the environment or staff – not to be confused with facility-associated infections, which are acquired and identified at the same facility

LTC

Long Term Care in a single facility

SSI

Surgical Site Infection

UHNBC

University Hospital of Northern BC (Prince George)

VRI

Viral Respiratory Illness

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