Community of Practice:
IPAC Hub

Regional Infection Control Practitioners

Royal Victoria
Regional Health Centre

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Topics Covered

1. The Hub
2. IPAC 101
3. The COVID-19 Vaccine
4. The future of IPAC in Congregate Care Settings
5. Questions

The Hub Model

- Created as a response to the COVID-19 pandemic, but also to be sustained for any infectious/communicable diseases such as influenza and other respiratory pathogens.
- Hospitals, Public Health, Local Health Integration Networks (LHIN) work together to provide IPAC support to community based congregate living settings

  Examples are: Long-term Care Homes (LTCH), Retirement Homes (RH), shelters, supportive housing, etc.

- Goal has been and continued to be for these congregate living settings to be able to access IPAC expertise and eventually build their own IPAC program

Role of the Hub

- Provide a Community of Practice (CoP) for Facilities to engage in discussion with external IPAC experts as well as other facilities.
- Partner with Facilities to enhance existing IPAC practices
- Partner with Facilities to identify gaps in IPAC practices and collaborate on reducing those gaps
- Partner with Facilities to build IPAC capacity within
- Hospitals can also provide consultation and services for Occupational Health and Safety, Environmental Services and Laboratory Services as needed

Roles and Accountabilities

Clearly defined roles and accountabilities for stakeholders

IPAC Hub is responsible for:

- IPAC Risk Assessments
- Scheduling and Chairing Suspect / Confirmed Outbreak meetings
- Provide advice on which residents/staff need to be tested
- Advice on resident accommodations and placement recommendations
- Advice on IPAC management of positive staff and high risk staff exposures
- Advice on outbreak measures

What happens when a positive case is identified?

- Notification usually comes from either the Facility or Public Health
- Gather the information
- Set up a meeting if needed
  - The Facility, IPAC Hub, Public Health can join at times
- Different measures depending on staff or resident case
  - Generally more interventions if it's a resident case
- In collaboration with Public Health, recommend action items for the Facility
- A single staff case is (usually) = Suspect Outbreak
- A single resident case is (usually) = Outbreak
- Suspect/Outbreak declaration is Public Health responsibility
- Perform an IPAC Risk Assessment and provide a written report for the Home
- Daily updates from the Home

IPAC Risk Assessment and Report

Public Health Ontario | Santé publique Ontario

Christie Gardens

CHECKLIST

COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes

When to use this checklist?

This checklist helps guide infection prevention and control (IPAC) professionals in conducting IPAC assessments related to COVID-19 in long-term care and retirement homes. It can be used during in-person or virtual visits to provide advice on preparedness and management of COVID-19.

This outbreak checklist is to be used in addition to—and does not replace—the advice, guidelines, recommendations, directives, or other direction of provincial Ministries and local public health authorities. The checklist was informed by the documents listed under Sources.

Contents

1. Entrance

1	Entrance	Yes	No
1.1	**Passive Screening and Signage:** There is signage at the entrance prompting health care workers (HCWs), other staff, and essential visitors to self-identify if they have signs and symptoms of COVID-19. There are also: • Reminders to perform hand hygiene • Reminders to follow respiratory etiquette • Steps to be taken if COVID-19 is suspected or confirmed • Access to alcohol based hand rub (ABHR) in an alcohol concentration of 70 – 90 %, tissues, no touch waste receptacles and signage for proper mask use	√	
1.2	**Active Screening:** Using the COVID-19 Screening Checklist, there is a screener present at the entrance to actively screen all HCWs, other staff and essential visitors, with the exception of emergency first responders, for signs and symptoms (including taking temperatures) as they enter the building. Active screening procedure occurs 24 hours a day, seven days a week. Screeners ask all HCWs, other staff and essential visitors if they are working or visiting at other facilities or homes. • Those who respond yes to working/visiting in another facility are to contact their immediate manager/supervisor.	√	
1.3	**Ongoing Monitoring**: All HCWs, other staff, and essential visitors are to be screened twice daily, including temperature checks. HCWs and staff screening is done at the beginning and end of the day or shift. Essential visitor screening is done upon entry and exiting the home. See How to Self-Monitor.		√
1.4	HCWs, other staff and essential visitors who screen positive are: • not allowed in the home • to notify their immediate manager/supervisor and/or Occupational Health and Safety Department. • instructed to contact their health care provider, Telehealth (1-866-797-0000) or their local public health unit.	√	
1.5	• There is a process to record who has entered and exited the home. • There is a process to identify who is an essential visitor (full name, contact information, the resident they are visiting, and the in/out time).	√	
1.6	The screener wears – at a minimum—a mask, eye protection and gloves OR is behind a Plexiglas partition.		√

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IPAC Safety Report

ADMINISTRATIVE INFORMATION	
Name of Home	
Name of Administrator	
Facility Information	
Date of IPAC Assessment	Date: _____ ☒ Initial Assessment ☐ Follow-up ☐ Phone call
Date of swabbing (if applicable)	
Prepared by	
IPAC Assessment Team	

GENERAL SUMMARY	
Theme	Comments
Staffing	•
Equipment	•
Break Areas	•
Environmental	•
Hand Hygiene	•
PPE	•
Signage	•
Dress Code	•

RECOMMENDATIONS		
Concern	Recommendations	Accountable Person / MRP
Other		
Next Visit Scheduled:		

Sign-off

Print Name	Position/Title	Signature

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Building IPAC Capacity

- Current partnership model will likely change
- Goal is to help support Facilities with their own IPAC program
- Begin at the basics, most individuals were “thrown into the fire”
- Most Facilities have a shared IPAC resource if any (individual also has another role within the Home) making it challenging to focus on IPAC

IPAC 101

Organisms spread three ways (and a combination of those ways)

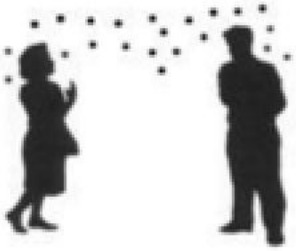
1. Contact
2. Droplet
3. Airborne

Contact Transmission

from Hands (Direct) or Objects (Indirect)

Droplet Transmission (up to 2 metres)

from Coughing or Sneezing



Airborne Transmission (> 2 metres)

Organism/Disease

Common organisms and their mode of transmission.

Organism/Disease	CONTACT	DROPLET/ CONTACT	AIRBORNE	AIRBORNE/ CONTACT	AIRBORNE/ DROPELT/ CONTACT
MRSA					
VRE					
CPE/CPO					
Diarrhea NYD					
Norovirus					
C. *difficile*					
Scabies					
COVID-19					
Influenza					
RSV					
Meningococcal Disease					
Group A Streptococcus					
Tuberculosis					
Measles (Rubeola)					
Chickenpox					
Shingles (disseminated)					
Shingles (localized)	Routine Practices				
Novel Respiratory Illness/Hemmoragic Fever					

COVID-19 and the Future in Congregate Settings

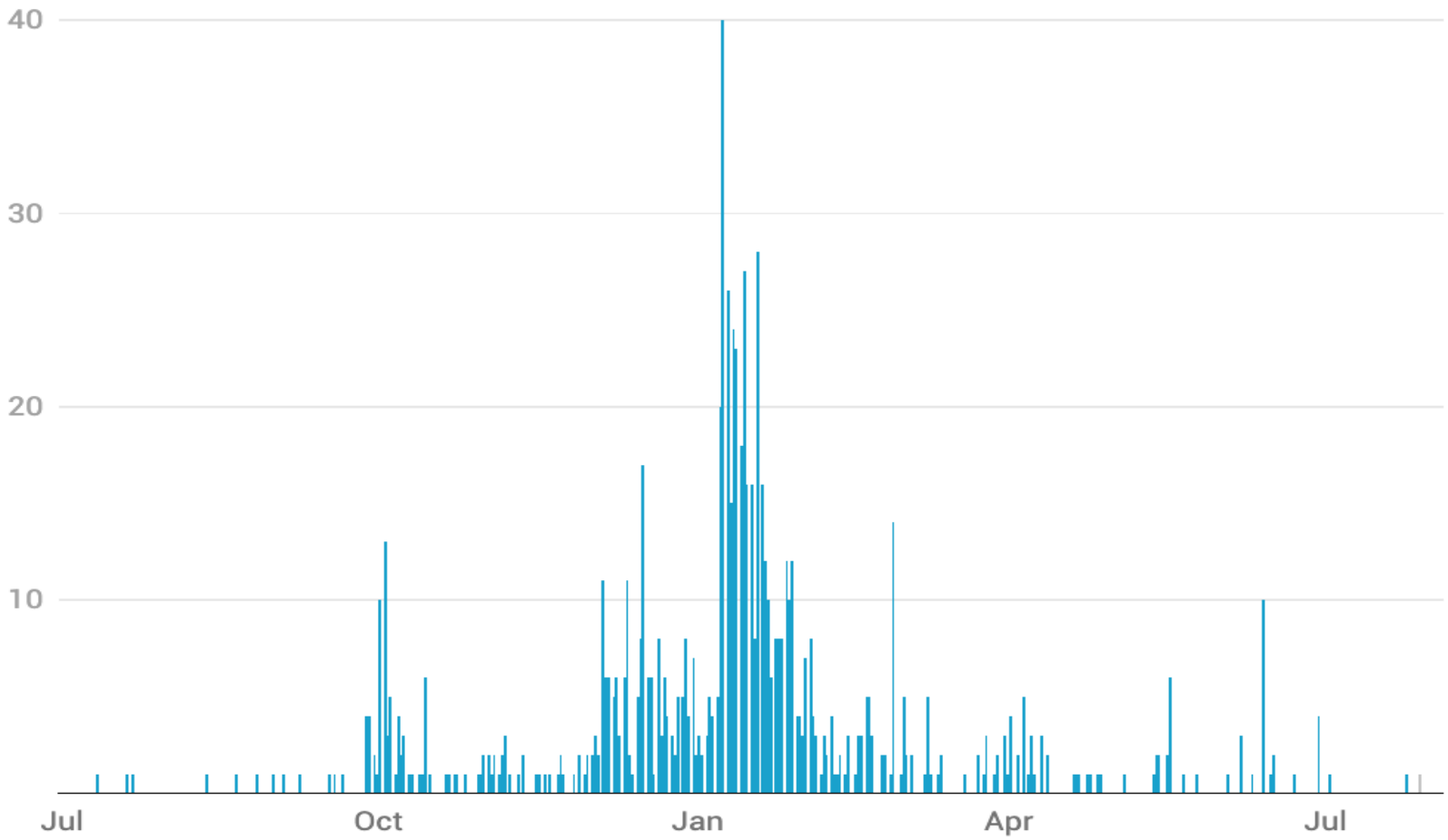
COVID-19 Prevention Efforts = General Infection Prevention Efforts

- The work that you have all done in your setting will be valuable in the future, for COVID-19, and other infectious/communicable diseases.
- An improvement of the baseline understanding of the "Fundamentals of Infection Control" has been seen.

Update on Facility Outbreaks over time

Category	Sub-Category	Total Outbreaks	Total Cases	Total Deaths
Institutional Setting	Long-Term Care Home	51	537	112
Institutional Setting	Retirement Home	28	58	3
Institutional Setting	Hospital	6	158	33
Institutional Setting	Corrections	2	51	0
Congregate Setting	Group Home	29	134	0
Congregate Setting	Respite/Hospice	2	17	2
Congregate Setting	Shelter	3	3	0
Congregate Setting	Other	5	8	0

Institutional Outbreak Cases Over Time



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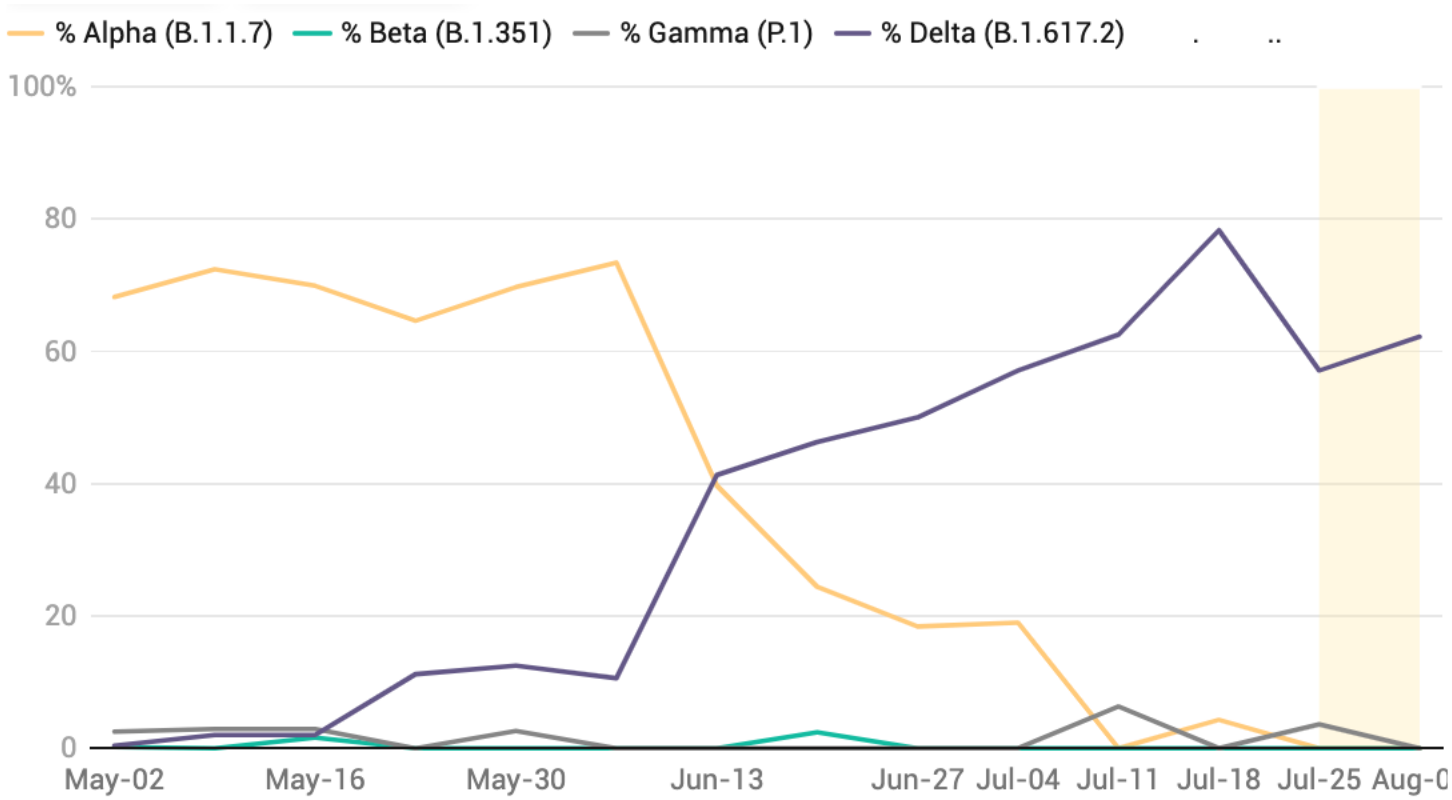
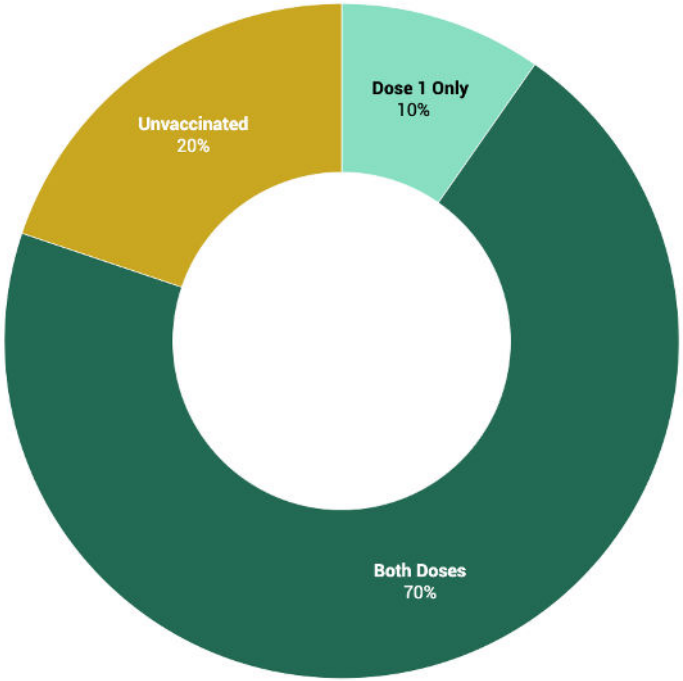
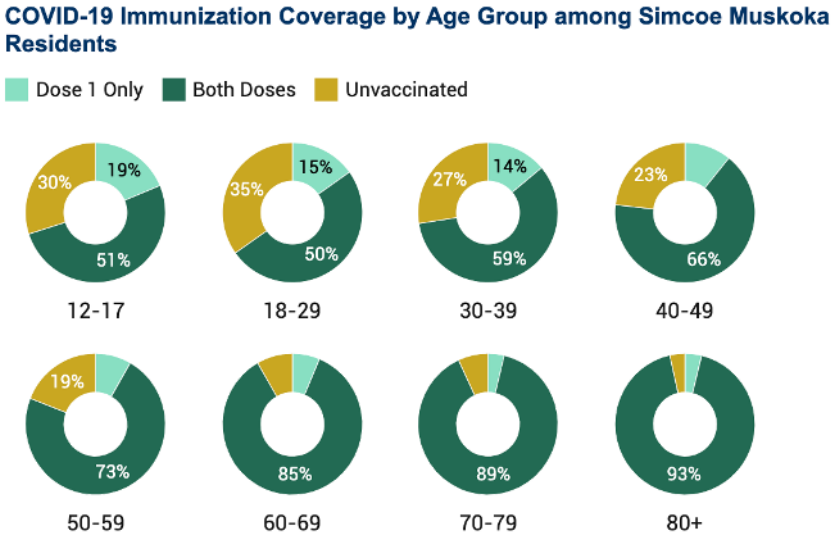
Update on VOCs



COVID-19 Vaccine Data





COVID-19 immunizations with the Pfizer-BioNTech vaccine began in Simcoe Muskoka on December 22, 2020.

Thank you!

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Questions?